

**Hearing on Reforming SGR:  
Prioritizing Quality in a Modernized Physician Payment System**

Committee on Energy and Commerce  
Subcommittee on Health  
United States House of Representatives

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## **Overview**

Independent Health (IHA) is an innovative, health solutions company with a passionate dedication to achieving its mission of providing health-related products and services that enable affordable access to quality health care. To control the unsustainable trend of rising health care costs, Independent Health has created wide-ranging community partnerships with physicians and health providers intended to achieve the triple aim of improved health, better care, and lower costs.

IHA has helped pioneer efforts in quality improvement, primary care redesign, and implementation of alternative payment systems. Our provider community is typical of many communities across our country, with an abundance of independently practicing, non-aligned primary care and specialty care providers and hospitals. We believe there are valuable components of our quality, efficiency, and effectiveness programs that are potentially scalable and transferrable to other communities beyond our own. In addition, we have identified a set of critical success factors based upon our experiences that we also believe will help guide innovation on a national level.

Included in this document are detailed descriptions of the various programs IHA has successfully implemented impacting quality and effectiveness of care, as well as a description of our efforts to build improved systems of care based upon the patient-centered medical home model (PCMH) combined with a novel, hybrid reimbursement program that aligns payment with key PCMH design elements.

## **About Independent Health**

Independent Health (IHA) is a regional not-for-profit plan providing health benefits and services to nearly 400,000 individuals in an eight-county region the Buffalo metropolitan area of Western New York. Its affiliated physicians include an open network of approximately 1,200 contracted primary care and 2,300 contracted specialty physicians, with the vast majority practicing in independent small single-specialty group practices or solo practice settings. Two dominant hospital systems provide inpatient and outpatient care services and remain largely unaligned and independent of the physician community.

IHA is nationally recognized for the quality of its services and extraordinary customer satisfaction. IHA is currently ranked among of the top 10% of health plans in the nation for quality by the National Commission for Quality Assurance (NCQA) in its Health Insurance Plan Rankings for commercial, Medicare, and Medicaid products. IHA has achieved and retained a 4.5 Medicare STAR quality ranking since the inception of the quality recognition program. In addition, IHA was named as the top health plan in the nation for customer service for 2009 and 2010 according to the NCQA Quality Compass® and currently is the *nation's* highest scoring health plan in customer satisfaction according to the J.D. Power and Associates' 2013 Member Health Insurance Plan Study<sup>SM</sup>.

Independent Health works to create partnerships and develop initiatives throughout our community to provide a balanced approach to improve quality – accompanied by efforts to contain costs, eliminate wasteful spending, and enhance efficiencies. Much of IHA's success is based upon the collaboration and trust the plan has fostered with the provider community throughout its history.

## **Guiding Principles**

While the Affordable Care Act (ACA) provides a framework for reform, we believe the most sustainable solutions for health care reform will continue to take place at the local level. The following are guiding principles that have governed IHA's approach toward developing improved systems of care, enhanced quality, and greater health care affordability:

- Substantive and sustainable improvement in quality and affordability of the American health care system will require movement away from traditional fee-for-service (FFS) reimbursement systems.
- Primary Care plays a pivotal and foundational role in the transformation to a sustainable high-quality, affordable health care system. Navigation of patients through a complex health system is best coordinated by providers with broad primary care based professional training who can serve as a "medical home" to their patients. Primary care is currently under-resourced and over-burdened. Immediate efforts should be made to strengthen and redesign critical components of primary care to help ensure its future success.
- Patient care is inherently "team-based." Management of preventive health and chronic disease is a shared accountability within both office-based teams and across virtual teams of care providers in multiple settings. Traditional fee-for-service (FFS) reimbursement and early first-generation quality incentives do not sufficiently align performance within or among care teams of diverse providers.

- Historically, highly integrated delivery systems (IDS) have demonstrated the ability to provide exceptional levels of coordinated, high quality, cost effective patient care. In many cases, such systems have evolved over decades and have proven difficult to replicate or sufficiently scale. “Virtually integrated networks” of collaborating providers have the potential to significantly close the performance gap in many communities over a shorter time. Primary care remains centric to the development of such virtually integrated systems and efforts should be made to align incentives among and within primary care practices to fulfill this need.
- No singular payment system is sufficient to simultaneously promote quality, efficiency, and effectiveness. A hybrid approach that balances the best attributes of various payment systems, based upon operational ease and transparent methodologies, is most likely to be effective at aligning incentives with performance.
- Successful transformation of the delivery system will be dependent upon accurate, actionable, and timely reporting, performance data transparency, and resources deployed to help educate and promote “improvement literacy” and care systems redesign with the provider community.

## **Experiences and Successful Programs at Independent Health**

### **Quality Enhancement and Pay-for-Performance**

IHA was among the pioneering health plans to initiate quality based reporting and payment incentive programs. Our first generation programs, which began in 2000, were primary care focused, derived data exclusively from administrative claims, and included quality process measures and to a lesser degree, utilization measures. The program was collaboratively designed with the aid of a physician advisory panel, and included meaningful monetary incentives (i.e. up to 10% of the value of the physician's current fee schedule), attainable performance thresholds, actionable reporting, and "improvement literacy" provided by a dedicated team of health plan Practice Improvement Consultants. Within the ensuing three years of this program, significant improvements were achieved in preventive cancer screening and clinical process measures related to diabetes.

As the limitations of claims-based administrative data and focus on process measures became apparent, IHA began a second-generation quality reporting and payment program in 2003. This program, named Practice Excellence<sup>SM</sup>, supplemented administrative data with clinical data derived from the physicians' medical record, and included outcome measures for diabetes, hypertension, cardiovascular risk management, as well as expanded process measures for asthma, emphysema, heart failure, and depression. Unlike the previous program, Practice Excellence<sup>SM</sup> included pay-for-participation, rewarding engagement activities with Practice Improvement Consultants, as well as pay-for-performance measured against fixed performance thresholds. The financial incentive opportunity was enhanced to 15% of the primary care physician's FFS revue.

Within a 5-year period, significant improvement was demonstrated in multiple metrics, particularly those related to diabetes care. For example, blood glucose control (A1C level at goal) increased 67% above baseline and lipid management (LDL at goal) and hypertension management (Blood Pressure at goal) each increased nearly 50% over baseline. Concurrently, IHA's national HEDIS (NCQA-Health Effectiveness Data and Information Set) rankings for comprehensive diabetes care rose from the 50<sup>th</sup> percentile nationally to the 90<sup>th</sup> percentile of comparable health plans. IHA currently maintains the highest quality ranking in the northeastern United States for comprehensive diabetes care based upon HEDIS scoring.

IHA recently began a third generation quality reporting program to measure performance of chronic medical conditions in and across multiple care settings. Recognizing the prevalence of diabetes in Western New York, and diabetes as a critical risk factor contributing to multiple cardiovascular conditions, we have begun reporting diabetes process measures with both cardiologists and their referring primary care physicians. Among diabetic patients currently referred and actively managed within cardiology offices, a surprising 16% lack evidence of blood glucose testing (A1C) within the past year, 18% lack a blood lipid testing, and 36% lack appropriate medication management of coexisting kidney disease.

Cardiologists were initially resistant to assume shared responsibility for these diabetic performance metrics, insisting that clinical management of diabetes is the responsibility of the primary care physician. After meetings and discussions with both cardiologists and primary care physicians (PCP), cardiologists have begun to collaborate with PCPs to co-manage these important clinical indicators. Cardiologists are

now more actively engaged in addressing both quality and efficiency within their practices, especially given IHA's Primary Connections<sup>SM</sup> program, which rewards specialists that achieve better outcomes for their patients. This program is described more fully later in the document.

**Critical Success Factors:**

- Physicians should be involved in the design, development, and monitoring of quality based reporting and incentive programs. Early buy-in of physician attribution methodology, measurement selection, performance thresholds, and design elements for actionable reporting is critical.
- Quality metrics selected should be based upon community health priorities. Measure and incent quality based upon metrics that will have a meaningful impact, not simply those easy to measure.
- Primary care and specialty care providers can be held mutually and collectively accountable for certain quality performance metrics that cross disciplines.
- A combination of accurate performance data, meaningful incentives, and provider education ("improvement literacy") has proven a powerful formula for success.

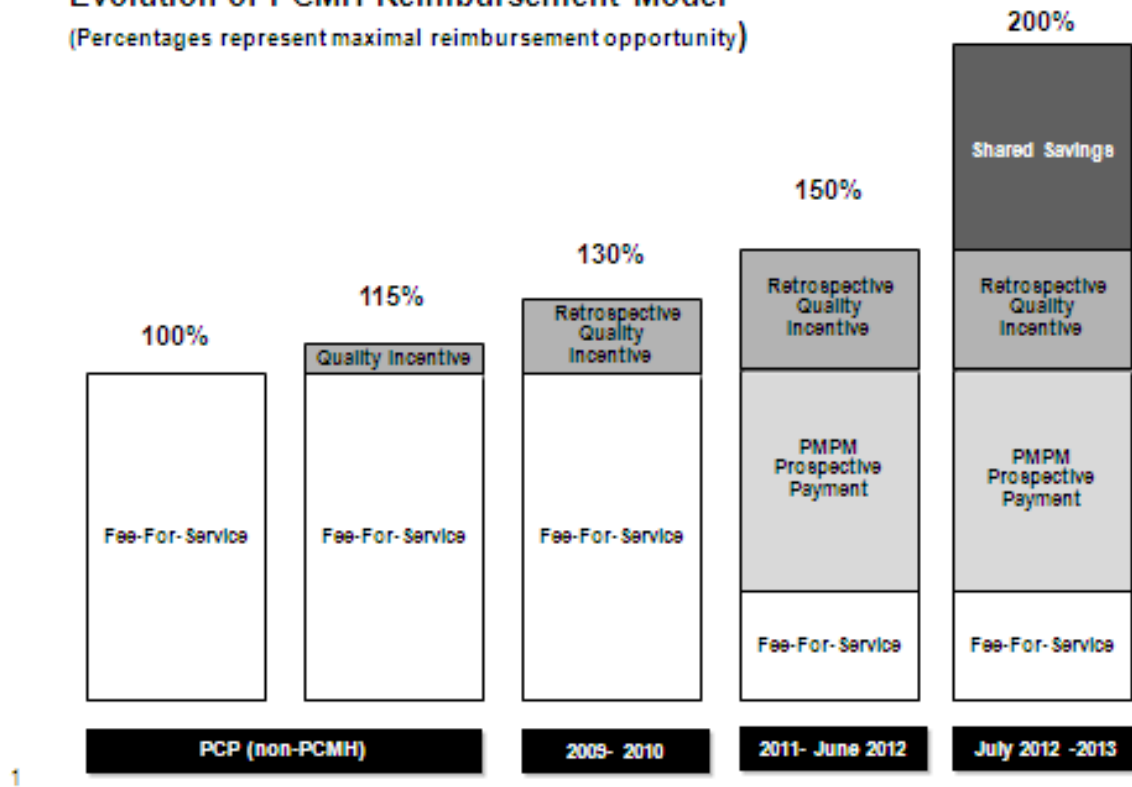
## **Patient-Centered Medical Home and Payment Reform**

IHA has had a long and successful history of collaboration with the region's physician community, particularly the primary care community. In 2008, the health plan initiated discussions with key physician advisors regarding how to successfully rejuvenate and transform primary care to become a central element in the redesign of the local health care delivery system. Concurrent with these efforts, a broader national dialog was emerging regarding the concept to the "patient-centered medical home" (PCMH) and the National Commission for Quality Assurance (NCQA) was completing development of a certification process for such practices.

Following the development of design objectives and eligibility criteria, IHA accepted 16 primary care practices (120 physicians) into its PCMH Pilot Program in January 2009. An important element of PCMH was a proposed alternative reimbursement system that reduced reliance upon traditional FFS reimbursement and, instead, placed emphasis on a prospective risk-adjusted care coordination fee paid on a monthly per-member per-month (pmpm) basis. In addition, existing quality incentive programs were enhanced and carried higher performance thresholds. The intent of this payment transition was to better recognize and reward team-based care within the primary care office, reward and incent exceptional clinical quality, and transition away from the requirement for care to be reimbursed solely upon office based face-to-face encounters.

## Evolution of PCMH Reimbursement Model

(Percentages represent maximal reimbursement opportunity)



Physicians were surprisingly resistant to the proposed rapid transition away from FFS. Therefore, at the formal launch of IHA's PCMH Pilot Program in 2009, FFS was retained and enhanced "earned incentives" for quality were established. The earned incentives were based upon attaining high-threshold quality goals, completion of certification of the practice through the NCQA-PCMH program, and other factors including improved patient experience of care. Overall, practices had the potential to earn up to 130% of their former base revenue.

During the initial 24 month period, all practices attained the highest level of NCQA-PCMH certification and demonstrated moderate trends toward increased efficiency of total cost of care for the populations

they served. Quality performance measurements accelerated at a more rapid pace than other primary care practices not engaged in the PCMH Pilot Program. It proved difficult, however, for practices to engage in development of team-based care and provide substantive non-visit care, despite ongoing education and practice management consultation. There was growing awareness that retaining FFS-based reimbursement was proving a strong deterrent to practice innovation.

Following the completion of the initial PCMH Pilot Program (2009-2010), additional primary care practices meeting eligibility criteria were recruited to participate in an enhanced PCMH program that IHA developed called the Primary Connections<sup>SM</sup>. During the following 18 month period (2011-June 2012), the physician advisory panel accepted the need to transition away from a FFS based reimbursement system. During this period, FFS reimbursement was retained only for those services for which enhanced utilization was desirable, including preventive office visits, immunizations, and select office-based testing. The remaining monetary balance of the FFS revenue was converted, in budget-neutral fashion, to a prospective risk-adjusted pmpm payment. In addition, the retrospective incentive for quality and NCQA-PCMH recertification was retained and enhanced. Overall, participating PCMH practices had the potential opportunity to earn 150% more than non-participating primary care practices.

During the ensuing 18 month period, quality performance continued to advance and total cost of care diminished. Since the inception of the PCMH program in 2009, aggregate total cost of care for members assigned to PCMH practices has decreased 3.4% compared to peer averages.

Although PCMH practices had begun to impact total cost of care, the majority of medical expenses arise outside the domain of their primary care practices with expenses related to specialty care, hospital care, and laboratory, radiology and other ancillary services. Primary care reimbursement failed to reward activities related to engagement with the specialty community, development of collaborative programs to coordinate care across disciplines, or efforts to create programs to reduce potentially preventable hospital admissions and readmissions.

With this understanding, IHA developed a new hybrid reimbursement program for Primary Connections<sup>SM</sup> practices beginning in July 2012. This new reimbursement approach now includes a shared savings component that provides an opportunity for practices to earn up to 200% of their former base revenue of four years earlier. As part of this new approach, a funding pool is established representing 65% of any saving on total cost of care compared to the previous year's expenditures of the practices. Earned shared savings therefore represent the collective as well as individual efforts of participating PCMH practices to enhance efficiency and effectiveness of care.

The development of the shared savings model has had a dramatic impact on the interaction of PCMH practices with one another (peer-to-peer collaboration), as well as generating meaningful engagement with specialists. Since shared savings opportunities are dependent upon the performance of specialists, collaborative efforts with cardiology, gastroenterology, neurology, radiology, and orthopedics with the referring primary care physician have emerged. This engagement has included efficiency and quality data reporting of specialty practices with primary care practices, as well as complete transparency among and within the specialty community. Specialty practices have now begun to compete for primary care referrals based upon published efficiency and effectiveness scores, and work within their practices

to eliminate non-value added procedures and tests, work to address avoidable hospital admissions and readmissions, reduce duplicative services and testing, prescribe generic medications where appropriate, and enhance service attributes, care coordination, and communication with referring primary care physicians.

A “ripple effect” of improvement efforts is now evident across the region’s competing hospital systems as well. Since differences within negotiated hospital contract rates directly impact those specialties that are heavily hospital-based, high cost facilities risk disenfranchisement by specialties eager to improve their published efficiency indexes and willing to relocate their facility-based procedures and admissions to other more cost-effective hospitals.

As a virtual high performing network of primary and specialty care physicians and hospitals is now beginning to evolve, IHA is able to design and market tailored network insurance products at attractive premiums to employers and individuals eligible for the Exchange.

**Critical Success Factors:**

- FFS remains a valuable mechanism to promote utilization of important and potentially underutilized services, including preventive services.

- Prospective, risk-adjusted, population-based care coordination fees (distributed on a pmpm basis) give practices the freedom to tailor their care services to member needs and frees them from dependency upon face-to-face interactions.
- Virtual high-performing networks have the potential to emerge organically under the influence of properly designed alternative payment systems. Novel reimbursement programs focused on greater responsibility of the primary care team can have important ripple effects across the broader delivery system. Shared savings programs, even when limited to primary care practices, can have a dramatic impact upon the engagement of other important segments of the provider community (specialists and hospitals) and help communities move toward greater efficiency and effectiveness of health care delivery.
- Trust, transparency, and physician engagement in design elements of alternative reimbursement programs is critical for their successful adoption.
- Existing models of care delivery and reimbursement are potentially scalable and transferable to other settings and can be more rapidly deployed based upon known critical success factors identified in early pilot programs.

## **Concluding Remarks**

Independent Health supports the goals of the House Committee on Energy and Commerce to reform the SGR and we applaud the bi-partisan congressional efforts to shift Medicare physician payment away from fee-for-service and toward payment that rewards performance, quality and value. Given Medicare's prominence as the single largest payer in the nation, fixing the SGR could become a powerful force in aligning incentives in a way that is consistent with the work already underway in the commercial market.

IHA has pioneered efforts in quality improvement, primary care redesign, and implementation of alternative payment systems within a provider community that is typical of many communities across our country, with an abundance of independently practicing, non-aligned primary care and specialty care providers and hospitals. We believe there are valuable components of our quality, efficiency, and effectiveness programs that are potentially scalable and transferrable to other communities beyond our own. In addition, we have identified a set of critical success factors based upon our experiences that we also believe will help guide innovation on a national level.

On behalf of Independent Health, I again thank the Subcommittee on Health for the opportunity to present these perspectives. We look forward to continuing to support and assist in this important work in the months and years ahead.