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Supplemental Materials

Pacific Business Group on Health

Hearing before the House Committee on Energy and Commerce
Subcommittee on Health

"Reforming SGR: Prioritizing Quality in a Modernized Physician Payment System"

June 5, 2013

Summary of key testimony messages:

1. Businesses have a big stake in how Medicare works, and Medicare should adopt successful purchasing practices from the private sector.
2. Large employers want to see physician payment directly tied to the value of the services that are provided -- clinical quality, patient-reported outcomes, and total cost of care. PBGH and its member companies strongly support the replacement of the SGR, but only if the new payment system results in significant improvements in health care quality and affordability.
3. Congress should invest in the development of new and better performance measures to undergird the new payment system. The selection of these measures must meet the needs of those who receive and pay for health care – patients, employers and taxpayers.

Supplemental Information for Key Message #1

Large employers have supported innovative approaches to physician payment, such as the Intensive Outpatient Care Program (IOCP) piloted by Boeing and adopted by other large employers[i]. The IOCP is a primary care-led, high intensity care management model for high risk populations. The California HealthCare Foundation (CHCF) provided the funding to develop this groundbreaking model of delivering care as a strategy for reducing costs while maintaining or improving quality. The designs and financial projections underwent a peer review panel of subject matter experts and leaders of traditional and more innovative practices. Key features of the model include:

- A focus on high risk patients, i.e., the 5-20% who incur the highest costs.
- Each site creating a new ambulatory intensivist practice.
- Shared care plans, increased access, and proactively managed care.
- Copays for the initial intake visit were waived; there were no other benefit changes.
- Sites were paid a case rate per member per month (pmpm) to cover non-traditional services; otherwise, the sites continued to be paid based on traditional fee-for-service contracts.

- The sites received a portion of the savings in total medical expenses.

The Boeing Company initially implemented a pilot of this model in Seattle. Over a two-year period, Boeing achieved improved health outcomes (28% reduction in hospital admissions, 16% increase in mental functioning on the SF-36), 20% reduction in costs, and increased patient access to care.[ii,iii]

Following the success of the Boeing pilot, PBGH worked with CalPERS and Pacific Gas & Electric Company (PG&E) to replicate the model in rural Northern California with the Humboldt del Norte Foundation Medical Group. This program targets the top 20 percent of patients in terms of relative health risk. PBGH is now expanding the IOCP to the Medicare population. Under a grant from the CMMI, PBGH is rolling out this model to 17 medical groups in California, covering 23,000 Medicare patients, demonstrating commitment to public and private sector alignment.[iv]

Other PBGH members are experimenting with models for accountable care organizations (ACO). For instance, CalPERS implemented an ACO-like pilot with Hill Physicians Medical Group, Dignity Health and Blue Shield of California that introduced a shared savings model for improving care coordination and quality for 42,000 HMO beneficiaries in the greater Sacramento area. Early results showed a $15.5 million cost reduction annually due to a 17% reduction in patient readmissions and shorter lengths of stay.[v] Five months later, those results were updated to reflect $20 million cost reduction over the two years of the program, largely due to a 22% reduction in hospital readmissions.[vi, vii]

Large employers know, however, that these innovations do not have the scale to drive system-wide change and improve health care across the nation. As the largest health care purchaser, it is important to have the collaboration of the federal government in transforming the way health care

is delivered. Working together is also important to large employers to avoid the shifting of costs from the public to the private sector. In some markets, cost-shifting from Medicare to private payers can be as high as 40%.[viii,ix, x] Instead we should pursue strategies to improve quality while lowering the overall cost of care.

Supplemental Information for Key Message #2

The new physician payment system should encourage individual as well as group accountability. Individual physician accountability reinforces professional motivation for quality improvement, identifies variation that is masked by higher levels of aggregation[xi, xii] and is more appropriate in some instances. Although team-based care is often very effective, patients are most concerned about the performance of individual physicians.

Shared accountability also has a role in driving improvements in health care. It supports team-based care, coordination across providers, and progress toward a genuine system of care. Shared accountability can be accomplished by reporting at an aggregate level, such as the practice site, or basing physician-specific results on both physician and team (e.g., medical group) performance.

The new payment system should also reward high performers at a level that drives behavior. Over time as the program becomes more sophisticated, it should make a significant contribution to total compensation**.** For example, Hill Physicians Medical Group in California physician compensation is comprised of over 15% value-based compensation, and in some instances at high as 30-40%.[xiii] Hill Physicians are consistently rated in the top tier of performance in California's IHA Pay-for-Performance program. In 2010, Hill Physicians distributed $38.6 million from IHA and their internal

value-based payment program.[xiv] Hill Physicians Medical Group is an Independent Practice Association in Northern California, established in 1984, with over 3,800 physicians that serves 300,000 consumers.[xv]

Supplemental Information for Key Message #3

Many parties have a stake in the development and use of better measures for physician payment. PBGH has worked collaboratively with providers, payers, consumers and other stakeholders to support efforts to improve health care quality and outcomes while at the same time getting better value for the health care dollar. We engage in, and sometimes lead, multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal and California-based reporting and payment programs. Physician involvement is critical in this process, but the ultimate stakeholders are those who receive and pay for medical care. It is essential for the process to involve all stakeholders, including strong representation from consumers and purchasers.

Ultimately, though, the HHS Secretary will decide which measures are used in Federal physician payment programs. That said, multi-stakeholder input to HHS via pre-rulemaking of the Measure Applications Partnership is a key part of the consensus-based entity National Quality Forum measure review and endorsement process and both should continue to be supported.

An example of multi-stakeholder collaborative using measures that meet the needs of a variety of users is the California Joint Replacement Registry (CJRR). Joint replacements have become the highest volume—and highest cost—surgeries for both Medicare and private payers. From 2001 to 2009, the rate of primary hip replacements increased by 52%, while the rate of primary knee replacements almost doubled.[xvi] Working with the California Orthopedic Association and the California HealthCare Foundation, PBGH launched the CJRR, a Level 3 clinical registry. The registry is: (1) collecting and reporting scientifically valid data on the results of hip and knee replacements performed in California, including device safety and effectiveness, post-operative complication and revision rates, and patient-reported assessments; and (2) encouraging quality and cost improvements through marketplace mechanisms by using performance information to guide physician and patient decisions and supporting programs for provider recognition and reward. There are 12 sites, which include 61 surgeons, submitting data and represent 20% of the California hip and knee replacement cases each year. An additional 19 sites are in the process of joining the program.[xvii]

[i] Additional information about the IOCP program can be found at http://www.pbgh.org/iocp.
[ii] Milstein, A and Kothari P, Health Affairs, October 20, 2009. Accessed at http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/
[iii] This model was also highlighted in Atul Gawande's "Hot Spotters" article in the New Yorker, and documented on the Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange. http://www.innovations.ahrq.gov/content.aspx?id=2941. Additionally, Steve Jacobson, MD and Jennifer Wilson-Norton of The Everett Clinic presented on "Connecting Providers and Managing High Risk Beneficiaries" at the CMS ACO Accelerated Development Learning Session on September 16, 2011, https://acoregister.rti.org/docx/dsp_lnks.cfm?doc=Module 3B. Connecting Providers Managing High Risk.pdf.
[iv] http://www.pbgh.org/key-strategies/paying-for-value/28-aicu-personalized-care-for-complex-patients.

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[v] CalPERS Press Release. (2011, April 12). *Press Release: April 12, 2011.* Retrieved February 21, 2012, from www.calpers.ca.gov: http://www.calpers.ca.gov/index.jsp?bc=/about/press/pr-2011/april/integrated-health.xml.
[vi] CalPERS Agenda Item 4. (2011, October 18). *Agenda Item 4 Memo to the Members of the Health Benefits Committee.* Retrieved February 21, 2012, from www.calpers.ca.gov: http://www.calpers.ca.gov/eip-docs/about/board-cal-agenda/agendas/hbc/201110/item-4.pdf.
[vii] Blue Shield of California Press Release. (2011, September 16). *HHS Secretary Kathleen Sebelius Reviews Key Pilot Program Tied to Health Care Reform Goals.* Retrieved June 3, 2013, from www.blueshieldca.com: https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/sebelius-reviews-aco-pilot-programs.sp.
[viii] W Fox & J Pickering. Cost Efficiency at Hospital Facilities in California: A Report Based on Publicly Available Data. Millman. Oct 2007.
[ix] Analysis of Hospital Cost Shift in Arizona. The Lewin Group. March 2009.
[x] Health Care Trends in America. BlueCross BlueShield Association. 2009 Edition.
[xi] H.P Rodriguez et al. Attributing Sources of Variation in Patients' Experiences of Ambulatory Care. *Medical Care* 2009; 47: 835–841.
[xii] Massachusetts Health Quality Partners, Quality Insights: Patient Experiences in Primary Care, http://www.mhqp.org/quality/pes/pesTechApp.asp?nav=031638&view=print.
[xiii] T. Emswiler and L. Nichols, Hill Physicians Medical Group: Independent Physicians Working to Improve Quality and Reduce Costs, The Commonwealth Fund, March 2009.
http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/March/Hill%20Physicians%20Medical%20Group/1247_Emswiler_Hill_case_study_rev.pdf.
[xiv] http://www.hillphysicians.com/ourdoctors/ProviderInfo/Pages/Pay-for-Performance.aspx.
[xv] http://www.hillphysicians.com/AboutUs/Pages/fact-sheet.aspx
[xvi] The Agency for Healthcare Research and Quality. National and regional estimates on hospital use for all patients from The HCUP Nationwide Inpatient Sample (NIS). http://hcupnet.ahrq.gov/. Accessed June 3, 2013.
[xvii] http://caljrr.org/about/CJRR-2013-progress-update.aspx.