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Statement for the Record

U.S. House of Representatives Ways and Means Committee
Subcommittee on Health

Hearing on Programs that Reward Physicians for High Quality and Efficient Care

February 21, 2012

Dear Chairman Herger, Congressman Stark, and Distinguished Members of the Subcommittee on Health:

The Pacific Business Group on Health (PBGH) is one of the nation's leading non-profit business coalitions focused on health care. PBGH works on many fronts to improve the quality and affordability of health care, often in close partnership with health insurance plans, physician groups, hospital systems, and consumer organizations. We leverage the power of our 50 large purchaser members representing a wide range of industries who spend 12 billion dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents.

Private sector and state purchasers have been at the forefront of innovative efforts to reward quality and efficiency in care delivery while reducing complications and wasteful spending. Performance transparency and performance-based payment are critical to addressing affordability and improving health outcomes. The collective experience of private purchasers not only offers important lessons to inform Medicare strategies, it provides hope for what can seem an insurmountable task.

Employers wish to recognize and pay providers favorably for achieving high quality care and efficient use of resources. The critical challenge to implementing such pay-for-value programs is our continuing difficulty in measuring performance along these dimensions of great social and policy importance. Employers wish to pay more to providers who help patients achieve good health outcomes, maintain positive health status and functioning, and make clinical decisions consistent with the best medical evidence. They wish to reward providers who collaborate with other health professionals and facilities, and with caregivers in the community, to manage an entire episode of illness more efficiently. Yet today there is a dearth of measures in these critical domains. As a result, our lessons learned continue to focus on the poor availability of key data and resulting measures. The following are lessons we have learned:

- **Use a parsimonious set of measures that 1) matters to patients, 2) reinforces other programs, and 3) evolves as better measures become available.** Employing a set of high-value measures drives attention to areas of high impact, gives consistent "signals" to physicians on where to focus, and reduces confusion from the cacophony of measures.

- **Identify the ideal dashboard of measures and chart a course for reaching the destination. Existing measures do not cover all the areas that are important to patients and purchasers.** A roadmap on how to fill in the gaps in measures is important to evolving the field of performance measurement and so we can collectively make judicious use of resources.

- **Payment reform will not reach its full potential if it continues to be based on a system that is inherently flawed. We know it will take time to move away from the current RBRVS sy**stem. Thus, making improvements to fee-for-service payment to physicians while also implementing new payment systems is imperative to the affordability and sustainability **o**f health care.

- **Align select program activities (e.g., goals, measurement, and payment) across programs, both public and private sector.** Alignment creates synergies across programs, reduces the amount of effort physicians expend on data collection, and ensures that we are all "rowing in the same direction."

- **Focus on individual physicians, where variation in performance is most evident, and not just higher levels of aggregation, whenever feasible.** Programs generate the greatest improvements if it promotes individual accountability, in concert with shared accountability. Individual accountability reinforces professional motivation for quality improvement, provides information for patients to use in choosing physicians, and identifies improvement areas that are masked by higher levels of aggregation. As we see with the Sustainable Growth Rate and other initiatives, incentives applied at the group level can be less effective.

Below, we provide information on programs implemented by PBGH and its members from which these lessons are drawn.

Ambulatory Intensive Care Unit

The Ambulatory Intensive Care Unit (AICU) is a primary care-led, high intensity care management model for the high risk population. The design was funded by a grant from the California HealthCare Foundation (CHCF) to develop an innovative 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.

The Boeing Company implemented a pilot of this model, which they called the Intensive Outpatient Care Program (IOCP), in Seattle. Key features of the model included:

- The program focused on high risk patients, i.e., the 5-20% who incur the highest costs.
- Each site created a new ambulatory intensivist practice.
- Practices were staffed by a physician, a nurse "health coach", and other support.
- The sites implemented 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.

Over a two-year pilot, Boeing achieved improved outcomes, lower costs, and increased patient access to care. The table on the next page summarizes the results. (Milstein & Kothari, 2009)[1,2]

[1] Milstein, A and Kothari P, Health Affairs, October 20th, 2009. Accessed at http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/.

[2] This model was also highlighted in Atul Gawande's recent "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

Boeing IOCP pilot, ran from January 2007 through July 2009.

IOCP Boeing Pilot results as published on Health Affairs blog 2009.10.20:

Measure compared to baseline	Result
Health care costs of pilot participants versus control group	- 20.0%
Hospital admissions	- 28%
Improvement in mental functioning of pilot participants	+ 16.1%
Participants feeling that care was "received as soon as needed"	+ 17.6%
Average number of patient-reported workdays missed, 6 months	- 56.5%

Following the success of the Boeing pilot, PBGH worked with CalPERS and Pacific Gas and 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. Leveraging the infrastructure of the medical group to serve a self-funded PPO population, care managers work closely with beneficiaries to coordinate care, design a self-care plan and connect the members to needed resources. In addition to the regular fee-for-service payments, the purchasers pay a monthly case management fee, and agreed to a distribution of shared savings among the purchaser, medical group, and Anthem Blue Cross. This pilot is being expanded in St. Louis, MO and Southern California.

Other PBGH members are experimenting with models for accountable care organizations (ACO). For example, CalPERS implemented an ACO-like pilot with Hill Physicians Medical Group, Dignity Health (formerly Catholic Healthcare West) 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 re-admissions and shorter lengths of stay.[3] 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[4,5].

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

[3] 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

[4] 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

Reference and Value Pricing

Reference pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond the cap. In a Value Pricing arrangement, quality is considered in addition to the standard price. The goals of these programs are to:

- Encourage providers to offer lower prices.
- Encourage member engagement while preserving choice.
- Decrease the substantial price variation per unit.
- Increase value in health care.

Safeway Inc. and CalPERS have introduced reference pricing benefit designs that establish a fixed benefit coverage level for select services to incent selection of high-value providers and identify those providers who are price outliers relative to community averages. Examples of reference-priced services include colonoscopy, cataract surgery, hip and knee joint replacement, arthroscopy surgery, advanced imaging, and routine diagnostic laboratory procedures. For example, Anthem Blue Cross and CalPERS have established a threshold—reference price—of $30,000 for a standard inpatient hip/knee replacement procedure. (Note: prices vary from $15,000 to $110,000 in their commercial PPO population). The program to date has resulted in a 6.8% increase in volume at designated facilities, average facility paid amount per procedure was lowered by 26.5%, and some facilities are negotiating reduced costs to accommodate the program.

California Physician Performance Initiative

The California Physician Performance Initiative (CPPI), launched in 2006, is a multi-stakeholder initiative to measure and report on the performance of individual physicians throughout California using information from a multi-payer claims database. This work is being conducted by the California Cooperative Healthcare Reporting Initiative (CCHRI), a statewide collaborative of physician organizations, health plans, purchasers and consumers that work collectively to help consumers and purchasers make informed health care decisions. CPPI's goal is to improve patient care and its affordability by:

- Reporting results to physicians to help them gauge how well care for their patients meets national standards of care.
- Applying the performance results in ways that help consumers and purchasers get better value when choosing and using health care; and
- Adopting performance measures and reporting methods using the best available science.

CPPI clinical quality results were mailed to more than 13,000 California physicians in July 2009. CPPI's physician-specific results are derived from the medical claims data aggregated across California's three largest commercial PPO health plans (Anthem Blue Cross, Blue Shield of California and United Healthcare) and the Anthem Blue Cross and Blue Shield of California commercial HMO health plans.

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[5] Blue Shield of California Press Release. (2011, September 16). *HHS Secretary Kathleen Sebelius Reviews Key Pilot Program Tied to Health Care Reform Goals.* Retrieved February 21, 2012, from www.blueshieldca.com: https://www.blueshieldca.com/bsca/about-blue-shield/newsroom/sebelius-reviews-aco-pilot-programs.sp

Upon mailing the CPPI Performance Reports to physicians, each physician was asked to review and, as needed, correct their demographic record or quality scores. Any corrections provided by the deadline were applied to correct the quality results before the information was provided to health plans. CPPI assessed physician performance using clinical quality measures that are evidence-based, nationally standardized and endorsed by major standard-setting bodies (i.e., the National Quality Forum, or "NQF"). The measures address preventive care and chronic condition management and were approved by the CPPI Physician Advisory Group.

Blue Shield of California has launched its physician quality recognition program based on CPPI results. A set of physicians, who have sufficient patient samples to be reliably scored, was designated as higher quality performing physicians for select preventive screening and chronic care measures. Blue Shield members can view this new information in the plan's online physician directory.

California Joint Replacement Registry

Working with the California Orthopedic Association and the California HealthCare Foundation, PBGH launched the California Joint Replacement Registry (CJRR), a Level 3 clinical registry. The goals of the registry are to: (a) collect and report 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 (b) promote the use of performance information regarding hip and knee replacements to guide physician and patient decisions and support programs for provider recognition and reward, and thereby encourage quality and cost improvements through marketplace mechanisms. The registry is specifically designed to:

- Compile reports assessing the outcomes associated with different devices and surgical techniques.
- Create confidential benchmarking reports for physicians and hospitals on their performance and comparisons to statewide averages.
- Establish a registry-facilitated process for reporting Physician Quality Reporting System (PQRS) measures to CMS for receipt of bonus payments.
- Transmit safety alerts on devices with short-term results that provoke concern.
- Shape a measurement and reporting system for orthopedic procedures.
- Provide patients with useful information about outcomes after surgery to help them make decisions about their care.

In August 2011, the CJRR concluded a three month pilot phase. Three sites, representing 12 surgeons, who perform 5 percent of the hip and knee replacements in California annually, participated in the pilot phase and continue to contribute data to the registry. During 2012, the CJRR will refine its operations and expand to include six additional hospital sites, accounting for 10-15 percent of the hip and knee replacements in California annually. Future strategies also include engagement of health plans to reward providers that participate in sharing their information and engage in quality improvement efforts.

Catalyst for Payment Reform

Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers to catalyze improvements to how we pay for health care in the U.S. to signal powerful expectations for better and higher-value care. CPR was conceived in January 2009 and several of PBGH

members are actively participating. CPR is guided by a multi-stakeholder Leadership Committee of influential experts and decision makers in health care. Key strategies and activities being implemented by CPR include:

- Demanding payments be designed to cut waste or reflect performance
  - Track progress with a National Scorecard on payment reform
  - Improve current payment methods (e.g. FFS) while pushing for new forms of payment
  - Achieve 20% value-oriented payment by 2020
- Leveraging purchasers and creating alignment
  - Encourage use of standard health plan RFI questions and a model contract to open a dialogue with plans about payment reform priorities
  - Alignment with CMS
- Implementing Innovations
  - Encourage price transparency
  - Implement reference or value pricing
  - Change maternity care payment to align with clinical evidence

To conclude, we concur that the Medicare fee-for-service system is financially unsustainable and that the "pay-it-forward" suspension of the Sustainable Growth Rate (SGR) places mounting pressure on the federal budget. Efforts have been made to use value-based payment but it has not been nearly sufficient. Although there are innovative initiatives in physician payments, it is still much more prevalent for physicians to be paid the same irrespective of their quality and efficiency. The federal government must act as a prudent purchaser and support information every American needs to get better care as a public good.

As you consider options to revise Medicare's physician payment system, it is important to recognize that any changes will impact costs and quality in the private sector. Private purchasers are looking to Medicare to be their partner – to work in parallel and take major steps forward together. Thank you for the opportunity to provide comments. If you have any questions or need additional information, please contact William Kramer, MBA, Executive Director for National Health Policy or David Lansky, PhD, President & CEO for Pacific Business Group on Health.