Medicare Physician Payment Policy:
Lessons from the Private Sector

Senate Finance Committee Roundtable
Thursday, June 14, 2012

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Written Testimony – Peter Edwards
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Humana appreciates the opportunity to share information about the role we are playing in engaging and collaborating with physicians in innovative payment models to drive better health outcomes and quality of care. Like you, we believe payment innovations – if implemented in partnership and in full cooperation with physicians – can truly advance the health care delivery system and most importantly, enhance the quality of care provided to Americans.

Introduction

My name is Peter Edwards. As Humana's President, Provider Development, I am responsible for leading the expansion of Humana's population-health focus by pursuing engaged provider relationships and developing Medical Service Organizations (MSOs) and other joint ventures with providers. In this capacity I oversee the company's MSO services, and the Provider Contracting function.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of health and wellness services and health care coverage products that incorporate an integrated approach to lifelong well-being. Humana's 25-year experience in driving value-based health care delivery system transformation is predicated on creating physician payment models that reward efficient and effective care delivery, and doing so in a way that recognizes the variability in physician practices and tailors programs that engage physicians based on, among other factors, practice resources, geography, and patient panels.

Our perspective is built off of our broad knowledge of different markets and populations across the health care system. Humana is one of the nation's largest Medicare Advantage contractors with 2.2 million Medicare Advantage beneficiaries. In addition, Humana owns over 300 medical centers and has over 250 worksite medical facilities. Across the health care delivery system, Humana offers a wide array of health and supplemental benefit plans for employer groups, government programs, and individuals, serving 11.8 million medical members and 7.7 million specialty-benefit members across the country. Currently, we contract with close to 320,000 physicians, including both primary care physicians and specialists, practicing in urban, rural and suburban settings.

Humana is committed to strengthening our nation's health care system through partnerships with providers to implement new models of delivery and payment that seek to achieve the "Triple Aim" -- improving the individual experience of care; improving the health of

populations, and reducing the per capita costs of care for populations. Fully 1.4 million Medicare Advantage members get their care from physicians in Humana network arrangements that include one of our various payment models. Close to 70 percent of all primary care physicians in Humana's networks participate in our rewards programs.

Humana's Approach to Physician Collaboration and Payment Innovations

Humana brings a unique, comprehensive approach to physician collaboration. Our programs are built around the premise that there is no one-size-fits-all payment model – that health plan/physician collaboration and engagement is fundamental to an effective, successful program, that financial models must recognize and be tailored to varying practice arrangements, and that payment must focus on rewarding physicians for better health outcomes.

Our overall focus is built around the following principles:

- Value-based reimbursement direction (including such programs as physician rewards models, shared risk arrangements and ACOs);
- Shared responsibility for outcomes;
- "Bricks-and-Mortar" relationships (including direct relationships with primary care physicians and clinics);
- Strong physician industry relationships to vet new payment ideas and approaches (including specific engagement with the American Academy of Family Physicians, American Medical Association, American College of Physicians, American Medical Group Association and the Medical Group Management Association);
- Physician/provider/health plan collaboration, focused on providing continuous input on Humana policies and processes;
- Clinically focused activity; and
- Health Information Technology (including relationships to promote connectivity with the following leading electronic medical records vendors: Athena, eClinicalWorks, Allscripts, and NextGen).

Although the majority of our payment innovations center on engagement with primary care physicians (PCPs, we also have included specialists in certain initiatives. Much of specialty care revolves around procedure-based treatments and thus, development of programming based on procedures/bundles can be challenging. Additionally, our experience with primary care physicians is that they tend to be particularly interested in learning more about their practice patterns and how to improve efficiency.

We also recognize the differing practice patterns in rural and urban settings and are working to address variations in approach. For example, because we realize that outreach to rural practices in more remote areas can be challenging, coupled with limitations on access to primary care physicians, Humana is considering adding independent Nurse Practitioners to our

rewards program to help ease the burden of access in rural areas. In more remote areas where payment innovations may not be practical at this time, we have to default to more traditional payment models and/or adopt programs to facilitate a transition to different "engaged" payment models.

Evolution of Humana's Medicare Payment Model and Continuum

Because we understand the complexity of the various types of physician practice models, we offer innovative payments arrangements that are customized to fit varying practice characteristics, including: enhanced fee-for-service (in the form of an annual bonus payment); monthly care-coordination fees in our medical homes model; quarterly bonus/shared savings incentives, and several types of capitation arrangements. With each of these approaches, we support participating physicians by providing the necessary data and connectivity infrastructure supports to build and manage effective shared-responsibility partnerships.

Our approach to physician payment has evolved over our 25 plus years' experience with physician collaboration. Beginning in Florida in the mid-1980s, we introduced basic capitation arrangements; then moved to global risk arrangements (across all Medicare benefits); then added combined risk arrangements (shared risk for Part A and full risk for Parts B and D); and ultimately introduced Fee-for-Service (FFS) Rewards Programs (established in 2010 in areas where the primary payment model is FFS). This program has four variations designed for differing practice structures and experiences, and includes opportunities to increase payment on a graduated basis as program complexity increases:

1) STAR Quality Program: Increases FFS reimbursement for meeting specific HEDIS measures;
2) Model Practice Program: Quarterly payments for meeting specific HEDIS and utilization measures;
3) Medical Home Program: Prospective quarterly payment for all measures in STAR and Model Practice programs including additional utilization measures; and
4) Shared Responsibility (ACO) Program: Global quality/cost payment model.

Our Physician Engagement Continuum was developed to provide resources to assist primary care physicians in developing the competencies and practice infrastructure necessary to effectively and efficiently care for our members. We believe that many of our primary care physicians will move across the continuum toward risk-based models as they gain these competencies. Additionally, we are addressing value-based payment opportunities as well as bundled payment initiatives to advance coordination between primary care physicians and specialists. For example, we are addressing value-based opportunities in partnership with primary care providers and specialists focusing on bariatrics programming.

Collaborative Approach to Payment Models

Humana focuses on building innovative physician partnerships and models of care that offer better care and better value. By providing detailed reporting and modeling of patient-centered cost and quality information to physicians, our goal is to assist them in more effectively serving their patients, improving quality, removing inefficiencies and being financially rewarded for success. Our experience has shown (whether through discussions with our clinical professionals or by providing clinical resources to a particular practice) that peer-to-peer discussions about quality, efficiency, and chronic care management and enhanced communication between Humana and the practice work best in helping physicians begin the transition. One example that demonstrates our focus on improved physician communication is the development of "PODs." "PODs" is a grouping of our members and their affiliated primary care physicians with a dedicated Nurse. The role of the Nurse is to assist the physician in the management of their specific patient population through data reporting and analytic support, increased disease and chronic care management program awareness, and other clinical supports.

Humana's Physician Incentive Arrangements: Provider Rewards

Humana introduced a unique Provider Rewards program, focused primarily on primary care providers, to encourage improved health outcomes and reward physicians. Unlike other "pay-for-performance" models, Humana's program is designed to help meet physicians on their own terms based on level of practice complexity as well as to encourage quality improvements. We engage physicians with both hands-on assistance and reporting assistance. When we launched this program in 2010, it was focused on PCPs seeing Medicare Advantage members. We began by engaging directly with the Primary Care Physician (PCP) societies (AAFP, AMA, ACP, AMGA, MGMA) and solicited their suggestions and recommendations based on their constituencies. Since then, we have continued to build in opportunities to refine the program with feedback from the physicians involved.

During the first 9 months in 2011, the program resulted in improved health outcomes such as a 2% improvement in colorectal cancer screenings and a 4% increase in spirometry testing. Additionally, over the same time period, there was an over 50% increase in the number of participating physician practices meeting and/or exceeding patient care measures and 40% increase in assuring that patients got needed preventive and chronic care screenings.

Humana Payment Approach in Practice: *Patient-Centered Medical Homes & ACOs*

Humana has long supported the notion of patient-centered medical homes through various arrangements. Over the years, we have established Patient-Centered Medical Home arrangements in Florida, Ohio, Colorado, Illinois, Michigan, Kentucky, Texas, Tennessee, Missouri and South Dakota – serving over 70,000 Medicare Advantage and over 35,000 commercial health insurance members. Under some of these arrangements, Humana provides financial assistance to help selected physician practices acquire electronic health record (EHR)

systems, which can help facilitate enhanced care coordination and allow them to meet Meaningful Use criteria.

Humana joined in helping establish the Patient-Centered Primary Care Collaborative, founded by Dr. Paul Grundy – a coalition of more than 900 employers, consumer groups, quality organizations, hospitals and clinicians. The Collaborative is dedicated to advancing patient-centered medical homes that have the following attributes: (1) ongoing relationships with a personal physician; (2) physician-directed medical practice; (3) whole-person orientation; (4) coordinated and integrated care; (5) enhanced access to care; and (6) payment that appropriately recognizes the added value of services provided.

Humana also partnered with physicians affiliated with Norton Healthcare System, a Louisville, Kentucky-based, not-for-profit integrated delivery system, to pilot test an innovative, commercially-insured, ACO-type approach, sponsored by the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution (Dartmouth-Brookings). Participation in this pilot has allowed the development of a global quality/cost payment model. Participating physicians are evaluated based on their performance on specified quality measures, such as diabetes measures, cancer screening, asthma care and cardiac care.

Central to this pilot is accountability of measured outcomes, cost, and patient delivery, focusing on industry-standard performance measures. The partnership is guided by three core principles: 1) integrated care delivery among provider teams; 2) defined patient population to measure; and 3) pay-for-results based on improved outcomes and cost. Recently, the Commonwealth Fund highlighted this partnership in a case study and symposium.[1]
Already, the partnership has shown significant results. Our most recent data, based on Year-Two outcomes, showed marked improvement relative to baseline in quality, utilization and physician visits following hospitalization:

Measure	**Outcome**
Inpatient days/1000	↓29%
ER visits/1000	↓46%
Physician visit within 7 days discharge	↑14.6%
Diabetes- A1c testing	↑6.1%
Cholesterol Management-Diabetes	↑8.6%
Appropriate Imaging-Low Back pain	↑13.9%
Avoidance of Antibiotics w/Acute Bronchitis	↑32%

[1] *Norton Healthcare: A Strong Payer–Provider Partnership for the Journey to Accountable Care*, The Commonwealth Fund, Case Study Series, January 2012.

Our current partnership with Cincinnati, Ohio-based Queen City Physicians similarly is built on a model of integrated care delivery, strong data integration and focused care coordination. This too has shown demonstrable results:

Measure	12/1/08 – 3/31/11 Queen City Physicians	12/1/08 – 3/31/11 Control Group (Cincinnati)	Difference vs. Control Group
Total Medical Expense	↑ 8.8%	↑ 13.2%	Medical expense trend reduced 4.4%
Emergency Room Expense	↓ 9.8%	↑ 2.7%	Emergency room expense trend reduced 12.5%
Pharmacy Expense	↑ 3.8%	↑ 1.9%	1.9% increase in cost of prescription drugs
Diagnostic Imaging Expense	↓ 1.1%	↑ 49.3%	Diagnostic imaging expense trend reduced 50.4%
ER Visits/1,000	↓ 34%	↓ 14%	Emergency room utilization trend better by 20%

Additional examples of Humana's physician engagement initiatives include:

- Partnering with electronic health record (EHR) vendors to advance a Medical Home EHR Rewards Program centered on "Meaningful Use," aiming to support national adoption of electronic medical records in physician practices with subsidies, among other offerings.
- Addressing the shortfalls in primary care access by expanding primary care and urgent care centers and workplace wellness sites in 550 point-of-care locations through our new Concentra business division.
- Partnering with and opening clinic-based Primary Care Centers to provide coverage in specially- designed medical centers to seniors in primarily low income, underserved neighborhoods.
- Partnering with HHS's Center for Medicare and Medicaid Innovation to promote the Comprehensive Primary Care initiative across three geographies.
- Building information and clinical analytical models under our Anvita Health and CareHub systems to enhance care and health outcomes by integrating clinical guidance based on real-time data for physicians, identifying gaps in patient care and alerting both patients and providers to necessary care treatments. For example, our Anvita rules engine identified approximately 355,000 actionable gaps in care for our members that, in turn, generated a multitude of alerts to nurses, providers, members and our service

operations teams. As a result, 31% of these gaps in care were converted into actions to improve outcomes for those members.

- Teaming initially with Blue Cross/Blue Shield of Florida in 2001 (now expanded to include Health Care Services Corporation, Blue Cross Blue Shield of Minnesota and Wellpoint), Humana co-founded Availity, a cross-health plan, cross-provider, health information technology network that physicians and hospitals use free of charge to help with collecting payments, keeping track of referrals, detecting potential adverse drug-to-drug interaction and prescription drug fraud and abuse and ultimately, creating a comprehensive, multi-payor electronic patient health record. Availity now delivers health information solutions to a growing network that currently includes more than 200,000 physicians and providers of care, 1,000 hospitals, 1,300 health plans and 450 industry partners. Over 1 billion transactions are processed annually.

Lessons Learned: Maximizing the Opportunity for Improving Quality and Value System-wide

There are many takeaways from Humana's experience with physician collaborations and payment models over the past 25 years. Among the most impactful are:

- Without incentives, costs run 5%-20% higher.
- The principle reasons why physicians have not participated in our rewards' programs (based on surveys we have conducted) include the facts that: 1) the physicians' panels are not large enough; 2) their panel does not have enough attributable-members; and 3) largely due to previous reasons, the administrative work is too burdensome.
- Any proposals to modify Medicare payment policy should be sufficiently flexible to allow for practice variations. This will allow maximum success and account for all types of practices. One-size-fits-all approach will likely undermine ongoing active collaborations to customize models to meet needs.
- A national, uniform performance and quality measurement strategy is critical across all lines of business – employer/commercial insurance, Medicare, Medicaid and other public programs and payment models (e.g. ACOs; Comprehensive Primary Care Initiative Program). Alignment and harmonization is important – disparate quality metrics, for example, will spread finite resources too thin, diluting the effectiveness of a national strategy. Use of a well-established, tested set of performance measures is critical.
- Data is a critical component of any payment policy initiative. Physicians need regularly reported, credible and actionable data in order to understand practice patterns and ultimately, the cost of care. Better use of near- and real-time data and HIT capabilities to promote information exchange has proven to be essential to making progress toward quality and resource targets, while continuing to advance the national agenda of connectivity.
- Continued exploration of additional ways to recognize the role of the patient in achieving desired outcomes will be necessary to support the health plan and clinician roles.

Future plans

As we continue to develop innovative payment models, we expect to explore variation in models of care coordination and transition between primary care physicians and specialists. Our focus will be on models that reduce fragmentation, improve communication, reduce unnecessary cost and ensure that patients receive the right care at the right time in the right setting from the right level of care practitioner. The challenge across the entire system is that in many cases, providers don't fully understand the variations in cost of care and the impact on patients. We continue to work with physicians and other providers to educate them about the varying costs of care and implications for patients, striving to achieve an environment where fully informed shared decision-making can best take place.

Thank you again for holding this hearing to highlight the important role that the private sector is playing in developing innovative payment policies to drive health care system improvements. We look forward to continuing our work with the Committee in pursuit of these goals.