Engaging Physicians and Payers in Innovative Oncology Payment Models

Hill Physicians Medical Group’s Approach

**BACKGROUND**

In 2008, the Hill Physicians Medical Group (“Hill”) Independent Physician Association (IPA) identified the need for a new oncology payment model that would allow its associated physicians and payers to stay competitive in the northern California market. Over the following years, Hill set out to design a payment model that would bend the cost curve while demonstrating improvements in care quality, utilization patterns, and patient and referring-provider satisfaction. Hill leadership successfully designed and implemented an oncology care rate (OCR) model – a prospective bundled payment with a quality management program – which has led to improvements in the overall cost and quality of care. This brief describes the multi-year stakeholder engagement process used by Hill leadership to implement the OCR, which could apply to other organizations implementing innovative payment approaches.

**APPROACH**

In 2008, Hill’s associated physicians and payers were facing a number of financial, regulatory, and technologic pressures to moderate the cancer cost trend. To better stabilize the practice environment and reduce variability, Hill’s leadership set out to align the oncologists’ incentives with those of the organization. To do this, Hill gathered its physician and payer partners to communicate the existential threat to the practices, the IPA, and the health plans and express the need for changes in order to remain viable and competitive. While both the physicians and the payers agreed that market share losses required addressing, it took considerable effort to reach consensus about the best path forward. The payers’ inclination was to reduce provider rates and limit access to technology, but Hill sought a long-term solution that would align incentives across the payers, IPA, and its physicians.

From 2008 to 2010, Hill’s leadership organized monthly in-person meetings with IPA physicians, visiting some practices more frequently if a relationship of trust had not previously been established. During these meetings, Hill explored several payment model options with physicians, using practice’s historical data to model potential outcomes. It was through this modeling of actual data, that the OCR design was eventually determined. However, it took approximately two years to gain full physician support for the change.

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By May of 2010, Hill was ready to put the OCR model into operation. As it rolled out, Hill’s leadership team proactively identified and addressed clinical and operational challenges associated with implementing the case rate model. For example, Hill developed a home-grown solution that would allow practices to run two parallel billing systems for OCR patients and traditional FFS patients. It was imperative that each practice had a capable business or practice manager, as well as physicians who championed the new payment model, so Hill provided supplemental personnel support if a practice lacked such individuals.

Hill also provided support and direction to help providers focus their delivery transformation efforts. For example, since one of the biggest challenges was rising drug costs, Hill shared information with physicians about the price differences between therapeutic equivalent drugs, which many physicians did not previously have. The OCR continued to cover both high-cost and generic drugs, but physicians were given the savings when they chose generic drugs. While Hill continued to pay the same amount for drugs, physicians dramatically changed their prescribing behaviors in response to the new incentive, which increased physician pay. Increased physician pay also benefited payers because there was less pressure to increase their rates, allowing them to retain more customers.

Physician behavior is incentivized through the OCR’s quality management program bonuses, which are determined based on clinical quality metrics, utilization, patient satisfaction, and referring physician satisfaction. Referring physician satisfaction is determined using a survey to ensure that specialists coordinate care with the referring PCPs. Hill adjusts the percentage of the bonus payment linked to each category based on the current improvement priorities. Hill has found that an incentive for physicians to gain up to 10% of gross revenues in bonus is
sufficient enough to significantly change physician behavior.

The latest step in Hill’s stakeholder engagement has been to share each specialist’s financial and clinical performance at the biannual pool meetings of referring doctors. This provides referring physicians with transparency about the quality and cost of each specialist, and it has changed referral patterns in favor of higher value providers.

RESULTS TO DATE

Hill leadership conducts quarterly financial performance reviews and biannual utilization reviews to measure OCR progress. Not only has Hill garnered physician and payer support for the changes, but the resulting model has also improved care quality while creating savings used to reward high-value providers. For example, Figure 1 reflects the differences in oncology drug spend among OCR and non-OCR practices. Hill has found that physicians who are not using the case rate model have costs that are as much as 80% higher than the OCR-participating physicians.

![Figure 1: Trends in Oncology Drug PMPM OCR vs. non-OCR practices](image)

TOOLS & VENDOR PARTNERS

Hill’s payment model transformation has been a grassroots effort. Because there were no ready-made vendor solutions for its particular needs, Hill developed the necessary technologies, including the solution that allowed two parallel billing systems, as well as the survey used to measure referring physician satisfaction. Hill acquired IT staff to help design and run the OCR.

CHALLENGES WITH IMPLEMENTATION

The biggest challenge Hill faced was building consensus around the need for change and the best path forward. Hill invested many hours and resources into meeting with physicians and payers in person to share historical data, allowing them to make fully informed decisions. As an IPA, Hill could act as a third-party intervener between the physicians and payers, which helped overcome any tensions between the two groups.

Hill also learned that payment and delivery reform is a long-term investment. Many wanted to see a return on investment in the first year, or even the first quarter, but it took 2-4 years for the benefits to be realized. Therefore, it requires patience and a long-term commitment to implement these types of changes.

KEY LEARNINGS

- **Appeal to physicians** – When seeking buy-in, understand that physicians are competitive and skeptical by nature. Tailor your pitch.
- **Foster trust** – Visit stakeholders for frequent, face-to-face discussions, cultivating physician champions.
- **Be patient** – Payment and delivery transformation is a long-term investment that often requires 2-4 years before benefits are realized.
- **Give yourself flexibility to change** – When trying something new, organizations need to maintain the flexibility to adapt over time.

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