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Testimony before the Subcommittee on Health of the House Ways and Means Committee
May 12, 2011**

Thank you Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee for inviting me to testify regarding potential new models for healthcare delivery and paying for the services physicians furnish to Medicare beneficiaries.

I am pleased to testify today on behalf of the California Association of Physician Groups (CAPG). CAPG represents over 150 California multi-specialty medical groups and independent practice associations (IPAs). Our members serve over 15 million Californians, approximately one half of the state's insured population. Our patient base is larger than the total population of most other states. CAPG members provide comprehensive health care through coordinated, accountable, physician group practices. We strongly believe that patient-centered, coordinated, accountable care offers the highest quality, the most efficient delivery mechanism and the greatest value for patients. California physicians, including CAPG members, have operated under this accountable, budget-responsible model for over 25 years.

I also address you today in my capacity as Regional Medical Director for HealthCare Partners and as a physician. I have firsthand experience with many of the payment and quality issues that I will speak to in my remarks today and look forward to sharing these firsthand insights with the Committee. By way of background, HealthCare Partners medical group is composed of more than 50 medical offices and employs more than 700 primary and specialty

care physicians. Our service area includes Los Angeles, Pasadena, the San Gabriel Valley, South Bay, Long Beach, the San Fernando and Santa Clarita Valleys, and Orange County. HealthCare Partners provides health care services to commercial enrollees and fee-for-service patients and is one of the largest providers of pre-paid health care for seniors in California. In addition, the HealthCare Partners Independent Practice Association (IPA) model enables physicians in the community to affiliate with HealthCare Partners. These regional IPAs consist of more than 500 primary care physicians supported by 1400 specialists. The IPA service area surrounds the medial group, providing care to the populations of the San Fernando Valley, Pasadena and the San Gabriel Valley, Central Los Angeles and the South Bay.

We know that the current Medicare fee-for-service (FFS) payment system is unsustainable. Medicare spending is growing at a rapid rate and is consuming an ever greater portion of our federal spending—and the existing Medicare FFS payment methodology does nothing to restrain this growth. It is also a barrier to improvements in quality. Rather than encouraging providers to achieve the highest quality, efficient care for patients, the FFS methodology incentivizes providers for greater volume and intensity of services provided. In order to address the spiraling growth of health care costs, we must look at the underlying payment system and identify ways that it can be fundamentally changed to provide the necessary incentives to modify provider behaviors and move away from utilization-based payments.

In California, we have vast experience with payment models that provide viable alternatives to this failed FFS system. As I will describe today, the California model has used

capitated¹ payments for decades, combined with robust quality reporting and public accountability provisions, and a backstop provided by state regulation of risk-bearing entities. We believe that our capitated payment system can serve as a model for the rest of the country, especially as health care providers around the nation consider delivery system reforms, like accountable care organizations, whether they be Medicare, Medicaid or commercial payer-driven. We also believe that the lessons we have learned can pave the way for a delivery system in a post-SGR world that is more efficient, provides better quality care, and begins to bend the cost curve.

The California Medical Group/IPA Model – Containing Costs

I will begin with a description of the payment model our medical groups operate under, which is predominant in California. Our medical groups and IPAs are paid under a capitated model. In this model, provider groups are paid a fixed amount for each enrolled patient for services over a span of time, most commonly per member, per month, regardless of the amount of care the patient consumes. Nearly a third of California’s population, including employer-based plans, Medicare, and MediCal, are covered under capitated arrangements. The scope of services covered by the capitated payment may vary for each given arrangement.

In California, medical groups and IPAs assume financial risk for patient care through capitation, and also have been delegated administrative and care management duties that would otherwise be performed by insurers. Under this “delegated model” the medical groups and IPAs

¹ We use the term capitation throughout but recognize that in the current health policy dialogue, this term can be used to embrace a variety of other concepts, such as bundled payments, partial capitation, condition-specific capitation, virtual partial capitation, and others.

assume certain responsibilities, like utilization management and chronic disease management to a group of physicians, typically a multi-specialty group practice or an IPA.

It is important to point out that these capitated payments I have just mentioned are made directly to the medical groups. Some of these groups then provide downstream payments to primary care or specialty care groups. These downstream payments may take the form of subcapitation, salary, or even some FFS payments in the event the group wants to incentivize higher utilization for a certain type of service, like preventive services. For example, a group might pay a FFS payment for childhood immunizations. The capitated payment made directly to the group permits this type of flexibility – the ability to encourage the provision of the types of care and patient outcomes that lead to healthier populations at a lower cost.

The delegated model and capitated payments directly to groups enable physicians to take responsibility for certain activities, such as engaging physicians in care management activities, promoting prevention, and coordinating care. The monthly, upfront payment of a budget for care for each patient in our population has enabled us to make strides in terms of improving outcomes for patients through initiatives that better manage patient conditions and have the effect of reducing costs in the system. Specifically, our member groups have been able to use the flexibility within their payment models to establish programs of care that have the effects of reducing unnecessary hospital admissions, reducing unnecessary emergency department visits, and caring for patients with chronic illnesses. I will now describe some of the CAPG members' initiatives in greater detail to give the committee a sense of the types of interventions we are talking about and the potential to improve care for patients.

Customized Care – Aligning Quality, Patient Experience, and Affordability

HealthCare Partners developed a program whereby they could maximize resource use by grouping patients into different levels based on the patients’ health care needs:

- Level 1 – primary care physicians motivate, educate, and engage patients to get involved in their care and self-management with their primary care physician and care team;
- Level 2 – complex care management/disease management provides a long-term enhanced care oversight, multidisciplinary team approach for high activity patients, including those with diabetes, chronic obstructive pulmonary disease, congestive heart failure, chronic kidney disease, depression, or dementia
- Level 3 – comprehensive care and post discharge clinics provide intensive one-on-one physician care and case management for the highest risk patients;
- Level 4 – home care program provides in-home medical and palliative care management, physicians, nurse practitioners, care management, and social workers;
- Hospice/Palliative Care

Among patients enrolled in the program, HealthCare Partners was able to achieve significant results in terms of reducing admissions, reducing days of ER use and reducing urgent care use as shown in Table 1 below.

Table 1: HealthCare Partners Program Results

	Admits/1,000	Days/1,000	ER/1,000	UC/1,000
Pre-Program	1,339	5,460	959	534
In Program	1,144	4,261	141	130

HealthCare Partners has also created special programs, such as a comprehensive care clinic, an ESRD program, and a behavioral health program to assist with the complex needs of certain populations. Each of these interventions have resulted in improved outcomes for patients and cost savings in terms of reducing admissions, reducing lengths of stay, reducing ER use and reducing urgent care use.

Reducing Avoidable Emergency Care

Monarch HealthCare in Irvine California, is an integrated physician association covering all of Orange County with 2,500 physicians, 20 hospital affiliations and approximately 200,000 patients (commercial, senior and MediCal). Monarch recognized that inappropriate ED use often leads to poor care continuity and can contribute to poor patient outcomes. To address the problem of avoidable emergency care use, Monarch created a cross-departmental team, consisting of physicians, nurses, data specialists and provider relations representatives. Monarch then used data to analyze which patients were accessing the ED inappropriately and why. Monarch's team analyzed barriers to care and other reasons why patients were inappropriately accessing the ED, and was able to identify patients accessing the ED frequently and reached out to them directly. Monarch was able to reduce inappropriate ED use by 12.9% in the commercial population and 15.5% in the senior population. Monarch created a standardized reporting format for physicians to use as a platform for engaging patients that frequently access the ED. In addition, Monarch assessed its urgent care sites and created a brochure for patients and physicians listing the urgent care locations and the scope of service provided at each hospital.

Caring for Patients with Chronic Illnesses

Sharp-Rees-Stealy Medical Group is an integrated medical group in San Diego and part of the Sharp Healthcare System. Sharp-Rees-Stealy created a heart failure disease management program designed to reduce readmissions associated with heart failure. The group employed discharge planners and hospitalists, and implemented a communication system around discharges, including post discharge instructions. The group also measured outcomes. In the last two years, readmissions to the hospital within 30 days for all causes dropped by 33% resulting in a savings of approximately \$2.2 million.

Financial Solvency

It is also important to note that the state has successfully grappled with the financial solvency of provider organizations that enter risk-bearing contracts with health plans. Then State-Senator Jackie Speier sponsored legislation, SB 260, establishing reporting and oversight that is vested in the California Department of Managed Health Care, the state's HMO regulator. Risk Bearing Organizations report their key financial metrics on a quarterly and annual basis to the Department. Five key metrics are used to determine solvency (IBNR, cash-to-claims, claims payment timeliness, etc.). If a risk bearing organization is deficient on one or more of the metrics, corrective action plans are implemented to prevent the entity from closing due to insolvency. Prior to the implementation of this program over 120 such entities had closed their doors. Since implementation, closures have been avoided completely, or other controlled forms of restructuring such as mergers, or "de-delegation" of financial risk have been employed with the result that the market has been greatly stabilized. We believe that this regulatory scheme in the state provides a key backstop, protecting both consumers and healthcare providers as they take on risk.

The California Medical Group/IPA Model – Improving Quality

A critical aspect of the success of our payment models is ensuring the highest quality care to patients. In California, we have combined innovative payment modeling with a robust quality measurement infrastructure, both at the state and organizational level.

First, the Integrated Healthcare Association is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care in the state. The IHA evaluates physician groups based on four categories: clinical quality, coordinated diabetes care, information technology-enabled systems, and patient experience. The IHA's pay for performance programs reward physician practices and other providers with incentives based on their performance on these measures. (Notably, 45 CAPG member organizations, representing approximately seven million patients in the state, were awarded the highest overall quality rating in 2009 from the IHAs statewide pay-for-performance program.)

Pay-for-performance programs, like IHA's, compliment the capitated payment model by providing necessary protections against potential incentives to stint on care. By requiring groups to provide high quality care, and incentivizing quality through the use of financial and other bonus payments, IHA's pay-for-performance program plays a critical role in ensuring that our patients receive the most efficient, highest quality care. One criticism of the capitated payment model is that it incentivizes providers to withhold care in order to maximize their payment. Quality performance programs, particularly those with financial incentives tied to performance benchmarks, can outweigh such incentives in a capitated model.

Furthermore, CAPG has instituted a Standards of Excellence Program for its member groups and IPAs. In 2006, the CAPG Board designed the SOE to annually assess and publicly report the key features and capabilities of coordinated, accountable healthcare organizations to

bring quality and affordability to individual patients and populations. The SOE evaluates groups on four domains:

- Care management – inpatient and outpatient systems to support our physicians and patients to achieve reliable, safe, continuous, and affordable care;
- Health IT – the essential tools to offer timely decision support, consistency in preventive and chronic care, and feedback to doctors for improvement;
- Accountability and transparency – measuring and reporting our work in public, compliance with fiscal responsibility regulations in the state;
- Patient-centered care – features to accommodate individualized patient needs and preferences, embracing our responsible role in a culturally diverse community.

CAPG members are scored on a star basis and the results are publicly available on the CAPG website. Each domain consists of multiple questions with a maximum potential point score. Groups that surpass a certain, pre-determined threshold earn a star for that domain. In addition, groups receive feedback on areas where they can improve.

In 2011, 25 organizations, caring for a population of nearly 10 million Californians, achieved Four Stars, or Elite capability. Five organizations qualified for Three Stars, or Exemplary performance.

This year, SOE added a fifth domain, Administrative and Fiscal Capability, recognizing a national interest in the management of multispecialty networks with multiple revenue streams

with complex payment methodologies. In 2011 this fifth domain was measured, but the results were not reported.

Measuring Patient Satisfaction – Achieving Patient-Centered Care

In addition to these specific quality initiatives, CAPG member groups, like HealthCare Partners, are focused on providing patient-centered care. We achieve this result through the efforts of the individual groups, CAPG's Standards of Excellence, and the statewide IHA pay-for-performance initiative.

CAPG's Standards of Excellence program contains certain elements that promote patient-centered care, such as ensuring patient access to health information and secure communications with their healthcare provider, looking at the group's capabilities to provide evening and weekend care, language interpretation services, documentation of patient complaints, surveying and monitoring timeliness of appointments, educating patients about their role in their care, and identifying choices, risks and benefits for alternative courses of treatment.

In addition, the IHA uses a Patient Assessment Survey, which is derived from the national standard Clinician Group Patient Experience Survey, endorsed by the National Quality Forum. The IHA survey tool questions address the following areas (1) doctor-patient communication; (2) coordination of care; (3) specialty care; (4) timeliness of care and service; and (5) overall care experience. This focus on patient experience of care provides important feedback to our medical groups in terms of providing patient-centered care.

A Model for the Rest of the Nation

I believe that our successes are achieved in part through the flexibility that is afforded to our groups through the capitated payment model. This payment model is bolstered by strong quality initiatives and by physician leaders who constantly strive to improve the patient experience and care outcomes. I believe that a model based on the lessons learned in California can be successfully implemented throughout the country. However, I hope that the Committee will consider key factors that are necessary to protect and foster the growth of our model.

The existing legal and regulatory framework provides some opportunity for physician groups like ours to further experiment with capitated payment models, such as partial capitation. We believe the opportunity presented is two-fold. First, it will allow us to continue to build upon the successes of our model – to develop additional interventions and care plans for vulnerable populations and further improve the delivery of care to our patient populations. Second, these programs, like accountable care organizations (ACOs), provide an opportunity for California’s medical groups and IPA’s to spread the lessons we have learned to other areas of the country.

However, to gain these benefits, programs like Medicare’s ACO program, must be properly structured. This means that the financial incentives have to be appropriate, the quality metrics must not be overly burdensome and should align with metrics providers are already collecting and reporting, and that the program requirements must be reasonable. Finally, models, like ACOs, must provide the cash flow necessary for providers to start new delivery models. One of our biggest concerns about the proposed ACO regulation, for example, is that although the agency acknowledges substantial start-up costs associated with developing the model, no funding is made available to potential ACOs to build the model. Combined with a FFS payment system and shared savings payments that may lag as much as 18 months to two years from the time services are rendered, it may be incredibly difficult for providers to come up with the

funding to create an ACO. We believe that this weakness in the proposed rule could be addressed in one of two ways. One method is providing start-up funding for ACOs. The other is establishing partially capitated or fully capitated ACOs. Capitated payments could assist in providing the necessary financing on a month-to-month basis that would permit ACOs to acquire the personnel and infrastructure necessary to deliver high quality, coordinated care, without increasing costs to the Medicare program. The existing law permits the creation of capitated ACOs and we believe that such a model would have greater potential to implement the types of care coordination programs that CAPG members have been able to implement, resulting in even greater savings to Medicare through reductions in unnecessary hospitalizations and improving care coordination and prevention for individuals with chronic illnesses. In addition, we look forward to providing comments on the agency's proposed rule and we anticipate that some of the issues we have mentioned may be addressed in the agency's final rule.

In addition, we believe that attention must be paid to the Medicare Advantage (MA) program. In California, Medicare patients who were enrolled in a plan using a capitated payment methodology had hospital utilization rates of 982.2 hospital days per 1,000 as compared to Medicare FFS patients with 1,664 hospital days per 1,000. This lower utilization rate in the capitated model has enormous potential for cost savings. Given the potential for savings and seniors' well-documented satisfaction with this program, we encourage the Committee to consider ways in which this program can be provide value to seniors in the future.

Conclusion

Thank you for the opportunity to speak to the Committee today. I hope that this information has been valuable and I would be happy to provide any additional information for the Committee as you consider alternatives to the sustainable growth rate formula.