

**Statement of Garrison Bliss, MD**  
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**Seattle, WA**

**Ways and Means Subcommittee on Health**  
**Hearing on Reforming Medicare Physician Payments**

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Chairman Herger, Ranking Member Stark, distinguished members of the Subcommittee on Health. It is my pleasure to present testimony to subcommittee today regarding ideas to help the Federal Government move beyond the Medicare Sustainable Growth Rate (SGR) payment formula. First and foremost, I hope to bring a primary care physician's perspective to the debate and offer some concrete and rather simple solutions to the huge problems facing primary care providers with Medicare and private insurance alike.

I have lived on the front lines of primary care for over 30 years, working as a primary care internist in Seattle. I have witnessed the gradual deterioration of primary care and the growth of unsustainable inflation in health care, an inevitable consequence of a fundamentally flawed payment system for primary care.

In 1997 I walked away from the world of fee-for-service medicine, not to seek my fortune, but to explore the possibility of creating a *direct* primary care model that can provide high functioning care that focuses on quality treatment rather than volume. Primary care is the foundation of all health care and the health of primary care drives the health of the rest of the system. It was the best decision I have made in my life. Our highly efficient, flat monthly fee pricing was based on age, not health status—then ranging from \$35 to \$65 per month. We provided unrestricted access to our care. We stopped all fee-for-service billing to our patients or their insurers. And, we limited our practice to 800 patients per physician in order to be able to focus on quality and promised same day care.

In 2007, utilizing these same principles, I co-founded a new health care company called Qliance, which I believe represents the next generation in direct primary care. It too was built on a monthly fee concept, currently ranging from \$49 to \$89 per month depending on age. It is constructed to meet or exceed the objectives of the much discussed Patient Centered Medical Home model, but it is also designed to eliminate the incentives which have brought US healthcare to its knees. All services we provide are included in our monthly fee. A few expensive supplies are charged at our cost. Our providers have the luxury of spending a minimum of 30 minutes with each patient. We limit our patient panels to 800 per provider (compared to 2500 to 3500 in the fee-for-service world). We are open 7 days per week and 12 hours per day on weekdays, giving patients same or next day appointments for any urgent issue, plus 24x7 after-hours phone access to a physician on call. And, our patients have a personal physician who knows them as an individual. We are also deploying an electronic medical record that optimizes clinical care, not billing reimbursement. In sum, we have removed all of the health care misdirection produced by fee-for-service, along with the built-in 40% transaction costs that plague primary care under that system, a system that drives physicians to see 25 to 35 patients a day to cover reimbursement overhead. Our physicians typically see 10-12 patients a day plus provide a handful of phone and email consultations. They have the time to fully treat their patients instead of rushing from one abbreviated appointment to the next.

The result of this effort has been a simple, effective, efficient and humane kind of primary care delivery system, a rarity in America today. Our patients use primary care voraciously (we estimate at least 4-8 times as many face-to-face hours per patient each year). That translates into a dramatic drop in the need for emergency room, hospital and specialist care as well as procedures, surgeries, advanced imaging and the attendant costs and risks these entail (see our 2010 data below). It also translates into

happier patients and providers, and holds the promise to give graduating medical students a reason to aspire to being primary care physicians again.

### Direct Primary Care Medical Homes (DPCMH)

Utilizing the direct primary care medical home (DPCMH) model described above, our physicians have the time to provide the 90% of care most people need to see a doctor for, including routine primary and preventive care, urgent care, and chronic disease management. We also coordinate all care beyond the scope of the primary care we provide directly, an increasingly important service in achieving better medical outcomes at affordable cost in our currently fragmented health care system. We intend to reinsert the concepts of value and humanity back into the health care system. We track not only the quality of our work, but also the quality of patient experience in our clinics. Our patient satisfaction levels put us in the top 1% of all businesses in the United States and far ahead of the general health care sector. We are also building into our next generation health information systems tools that will assess the quality, efficiency, price and patient satisfaction of those we refer to. Our patients will have transparency not only for their costs in our system, but for those outside our system. We intend to put patients in the driver’s seat and empower them to make decisions that work for them. We wish to be their trusted advisor, not their gatekeeper. As patients accept more financial responsibility for their care, they are interested in spending their money wisely and getting optimal health, not just the most expensive care their insurer will allow. We believe that by putting Direct Primary Care Medical Homes on the front end of the delivery system, health care will be more effective and patient-centered while driving down costs and unnecessary utilization. And our early data strongly support that conclusion.

Analysis of our internal data on our under-65 patients’ utilization of downstream, non-primary care services shows that, under the Qliance model, the utilization of emergency room, hospital, specialty care, advanced radiology and surgical care are greatly diminished, as seen below in Table 1. This decrease in utilization translates to a net savings of approximately 22% in overall healthcare costs.

Table 1: Utilization Data – Qliance Members Under 65 (2010)

Type of Referral	Qliance # per year/1000**	Benchmark*	Difference
ER Visits	56	158	-65%
Hospitalizations (visits)	34	53	-35%
Hospitalizations (in days)	105	184	-43%
Specialist Visits	670	2000	-66%
Advanced Radiology	300	800	-63%
Surgeries	22	124	-82%
Primary Care Visits	3540	1847	+92%

\*Based on regional benchmarks from Ingenix and other sources.

\*\*Based on best available internal data, may not capture all non-primary care claims

Source: Qliance Medical Group non-Medicare patients, 2010 (n=3,088)

## **Why not make DPCMH available to Medicare Patients?**

There is no provision to cover monthly fee based payments to primary care physicians who treat Medicare patients. Section 1301 (a) (3) of the Patient Protection and Affordable Care Act (Public Law 111-148) () would allow state-based healthcare exchanges to offer coverage through a DPCMH plan operating in combination with a wrap-around insurance policy as long as the two together satisfy all exchange coverage requirements. There is, however, no option to offer the DPCMH model to patients enrolled in Medicare. Despite this, many Medicare patients choose to pay DPCMH plans like Qliance directly out of pocket —above and beyond the cost of fee-for-service Medicare. This has the strange effect of patients subsidizing Medicare with reduced downstream costs—funded by their own contributions. Not all Medicare patients can afford this. Clearly, Medicare patients would benefit from these innovative arrangements, and if the Qliance data holds, the Federal Government would benefit through cost savings.

DPCMH plans are now offered in as many as 24 states—and provide all primary care services. Under a DPCMH model providing primary care services, insurance would be required only for hospitalization, advanced radiology, surgery and specialty care—to which it is better suited. But as the data in Table 1 suggests, Medicare patients would likely use a lot less of these more expensive services, saving Medicare significantly in the form of administrative expenses and downstream costs.

We think it is imperative that in any redesign of the current payment system incentivize Medicare patients to get as much primary care as they can consume by enrolling in a DPCMH plan. Rather than just trying to fix the SGR yet another time, we urge Congress to consider innovative Medicare payment reforms, such as the flat monthly fee DPCMH model. Only by fixing the underlying problem of relying - exclusively upon a fee-for-service model to finance primary care will Congress truly be able to rein in costs and improve health outcomes in the Medicare population.

\* The intent of the provision is to require the Secretary to permit state exchanges to offer health plans with a Direct Primary Care Medical Home (DPCMH) operating in conjunction with a wrap around insurance product as qualified coverage, so long as the two together meet all the applicable requirements for plans in the exchange.