



*The Voice of Accountable Physician Groups*

Summary of Statement by Dr. Robert Margolis, CAPG

**The Delegated Payment Model and Medicare Advantage (MA).** Under MA, physician organizations, such as HealthCare Partners (HCP), are paid under a population-based payment model (commonly referred to as capitation). In this model, the Centers for Medicare & Medicaid Services (CMS) makes a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrolled patient for services over a span of time, which is typically a per member, per month payment. Physician groups then have flexibility to structure downstream payments to physicians to incentivize high quality care and low cost care. To ensure that the budget is met in a way that improves patient care, physician groups hold their physicians to the quality reporting and performance standards of the MA 5-Stars program and robust internal quality incentive programs.

**Population-Based Payments to Physician Organizations Lead to Better Care for Patients.** The population-based payment approach reduces high-utilization incentives of the fee-for-service (FFS) system and creates incentives to improve quality. The MA model incentivizes (1) a team-based approach under which all health care providers practice at the top of his or her license; (2) physician organizations to provide the right care at the right time in the most appropriate setting; and (3) physicians to address the patient's total care needs, including mental health, behavioral health, and home environment. Savings achieved by keeping patients healthy are reinvested in patient care.

**Patient Interest in MA is Growing Because Of Its Positive Results.** MA enrollment has grown steadily over the past several years. In many of the areas where HCP operates, over 40 percent of Medicare beneficiaries have selected MA. The benefits that flow to patients are an important factor in the growth in enrollment over the years. Peer reviewed research has consistently shown that MA outperforms FFS Medicare, including in measurements of preventive care and preventable readmissions.

**MA is under Stress – Death by a Thousand Cuts.** The MA program is under severe stress due to a number of cumulative cuts to the program, including: reductions to MA plan benchmarks; coding intensity adjustment; changes to CMS's risk adjustment methodology; sequestration; and the tax on health insurers. Benchmark reductions alone were intended to bring MA to parity with original Medicare. Additional layered reductions cut deeply into the MA program and flow to patients in the form of fewer physician choices, fewer benefits and increased patient costs. The cuts have the net effect of pushing seniors away from MA and into the fragmented FFS delivery model.

**The MA Program Should Be Strengthened, Not Cut.** As Congress considers major policy objectives, like sustainable funding of government programs, the debt ceiling, and reforming the sustainable growth rate formula, efforts should be made to strengthen, not weaken the MA program. I ask that Congress refrain from making further blunt cuts to the MA program, which is the best currently-operating alternative to the flawed fee-for-service program. Instead, I respectfully suggest that you can achieve a financially stable Medicare program through strengthening the MA program – the existing Medicare option that encourages greater care coordination, and consistently outperforms FFS, and improves outcomes for seniors.



*The Voice of Accountable Physician Groups*

**Statement of Dr. Robert Margolis**

**CAPG – the Voice of Accountable Physician Groups**

**Before the House of Representatives Energy & Commerce Subcommittee on Health Hearing:**

**“Medicare Advantage: What Beneficiaries Should Expect Under the President’s Health Care Plan”**

**December 4, 2013**

Thank you Chairman Pitts, Ranking Member Pallone, and Members of the Health Subcommittee for inviting me to testify today.

I am pleased to testify today on behalf of CAPG. CAPG is the largest association in the country representing physician organizations practicing capitated, coordinated care. CAPG members include over 160 multi-specialty medical groups and independent practice associations (IPAs) across 20 states. CAPG members provide comprehensive health care through coordinated and accountable physician group practices. We strongly believe that patient-centered, coordinated, and accountable care offers the highest quality, the most efficient delivery mechanism, and the greatest value for patients. CAPG members have successfully operated under this budget-responsible model for over two decades.

I am a member of the CAPG Board of Directors and a former Chairman of the organization.

I also address you today as CEO of HealthCare Partners, Co-Chairman of Davita HealthCare Partners, and as a physician. By way of background, HealthCare Partners is a physician organization that provides coordinated and integrated care. HealthCare Partners (HCP) operates in five states, Arizona, California, Florida, New Mexico, and Nevada. We treat approximately 270,000 senior Medicare Advantage patients, 400,000 commercial HMO patients, and 100,000 Medicaid HMO patients. We

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employ over 1,000 physicians and contract with nearly 3,000 primary care doctors and over 7,000 specialists.

As an organization with extensive experience in coordinated care, HCP knows that the way Medicare pays for physician services can either incentivize or disincentivize care coordination. For example, in fee-for-service (FFS) Medicare, physicians are paid for each service provided, and, perhaps understandably, without a real eye toward coordination among other practitioners, prevention, or the health of the larger population. The FFS model incentivizes utilization and drives a high volume of services. The more services a physician provides, the more a physician is paid. In contrast, the Medicare Advantage (MA) program has a long history of a payment structure that incentivizes value. MA creates opportunities and the motivation for physician organizations to focus on care coordination, to build infrastructure to benefit patients, and to improve outcomes and quality.

I recognize that there are efforts underway to move the Traditional Medicare physician payment system to a coordinated care model (e.g., Accountable Care Organizations). I believe that these efforts, when properly structured, can be successful in creating coordinated care for the fee-for-service population. However, to date, Medicare Advantage, with its population-based payments made to physician organizations, is the best example within Medicare of a payment structure that provides appropriate incentives to keep patients healthy, coordinate care across specialists and primary care physicians, and hold physicians and care teams accountable for the quality of services provided. In my remarks today, I will describe how physicians are paid under the MA program, explain how the payment structure allows physician organizations to invest in and improve patient care, and why the MA program is under stress and should be strengthened by Congress.

#### **I. Background on Delegated Payment Model and Medicare Advantage**

Under the MA program, Medical groups and IPAs, such as HCP, are paid under a population-based payment model, also referred to as capitation. In this model, the Centers for Medicare & Medicaid

Services (CMS) makes a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrolled patient for services over a span of time, which is usually a percentage of the premium and often referred to as a per member, per month payment. This fixed payment occurs regardless of the amount of care provided to the patient. In the simplest terms, the physician organization is effectively given a budget to care for a defined group of patients. There is no additional payment for cost over-runs. Physician organizations must manage the population's care needs within the budget. Physician groups hold their employed and contracted physicians to robust quality reporting and performance standards to ensure that the budget is met in a way that improves patient care.

In the "delegated model," which is often used by insurers in MA, medical groups and IPAs are often delegated the administrative duties that in the fee-for-service world are typically performed by insurers. Under the delegated model the medical groups and IPAs perform a wide range of responsibilities associated with care delivery, such as utilization management, claims payment, and quality assurance.

It is important to point out that these population-based payments are made directly to physician organizations. The physician organizations then make downstream payments to primary care and specialty physicians, and sometimes hospitals depending upon the contract with the MA plan. Downstream payments are tailored to provide incentives to achieve the highest quality possible. Downstream payments to the individual physician may take the form of subcapitation, salary, or even FFS payments. (FFS payments are sometimes used when the group wants to incentivize higher utilization for a certain type of service, like preventive services or fitness or wellness program.) The downstream payments also often include payment of bonus incentives for physician performance and outcomes, like quality incentive payments for performance on certain measures. The internal quality measures, evaluations and incentives that physician organizations use tend to be very robust and drive appropriate, high quality care for patients. The internal quality bonus programs are often more

rigorous than the MA Stars program; the two are often carefully and strategically interlinked by the groups.

## **II. Population-Based Payments to Physician Organizations Lead to Better Care for Patients**

The population-based payment made by the MA plan to the physician group creates numerous benefits that are not seen in the fee-for-service environment. The population-based payment methodology allows us to incentivize a team-based approach. This approach deploys other health care professionals, such as care managers, nurses, social workers, care navigators, pharmacists, and other “mid-level” professionals, as part of a team led by a primary care physician. Each team member practices at the top of his or her license. This team-based approach leads to better outcomes for patients and – very importantly in this era of primary care provider shortage-- greater job satisfaction for primary care providers.

These arrangements also incentivize medical groups to provide the right care, at the right time in the most cost-effective setting. For example, rather than trying to maximize FFS payments in high-cost settings, if appropriate, patients are safely and appropriately treated in lower cost settings, such as their home. In fact, the HCP experience is that patients have a strong preference to be treated in their homes (and other less-intensive settings) when it is safe and appropriate to do so.

Population-based payments also afford opportunities and incentives to address the environmental, social, and behavioral services that are often omitted in the fee-for-service context. For example, many of our patients need assistance with their mental health needs, commonly depression, in order to be able to truly improve their health status. Our approach takes into account all of these aspects of patient care.

To illustrate how the MA program translates into reality for patients, I will begin with an illustration of two patients, one in a coordinated care environment and one in a fee-for-service environment. In this illustration I focus on the care of two typical patients and I use cost inputs derived from the

standard ICD-9 codes and the current Medicare fee schedule. This illustration is fictional, but it is highly typical, and helps to show the greater efficiency and vastly better patient experience in Medicare Advantage. I will then turn to a specific example from our own experience at HCP.

A. An Illustration of Coordination versus Fragmentation: Donna and Margaret

This illustration compares the care experience and cost for two senior patients, Donna and Margaret. Donna is enrolled in an MA plan and receives care from a coordinated care physician organization. Margaret is in a model with no care coordination, like Traditional Medicare. The table below shows the two patients that begin with the same chronic condition, congestive heart failure and the same two-day inpatient stay.

Beyond the striking cost disparity reflected in this illustration, I would like to focus on the disparity in the care experience and quality between the two models. While both patients are initially hospitalized with the same chronic disease at the same cost, their care experience drastically differs upon discharge from the hospital.

Margaret, who is in an FFS model like Traditional Medicare, is discharged from the hospital without any real post-discharge planning. She might have paper instructions and she might be told to call her physician in a few days, but there is no infrastructure or staff in place to ensure this happens. As a result, Margaret requires an emergency room visit followed by multiple post-discharge complications, landing her back in the hospital multiple times.

In contrast, for patients, like Donna, in Medicare Advantage, upon discharge, a team would spring into action to ensure that her follow-up care is properly managed. A discharge planner would make her appointments with her cardiologist and primary care physician. Staff within the coordinated care model would call her with appointment reminders and ensure she was seen in a physicians' office within a set number of days. A pharmacist would reconcile the medications given to her in the hospital

with the medications she takes for her routine care – this is to ensure there are no complications or duplication that could be potentially life threatening.

As we continue with our two patients on their journey, you can see illustrated below that both women have a fall and suffer a knee contusion. In this instance their paths then diverge again.

Margaret, who is in Traditional Medicare, goes to the emergency department. In contrast, Donna, in Medicare Advantage with a system of supports, calls her care manager or nurse call center, which is part of her coordinated care service team. The call center would direct her to the most appropriate site of care, where she can be seen quickly – in this case, urgent care. Following her visit to urgent care and treatment for her knee, the care team would again spring to action. Case managers would visit her home and ensure it was properly outfitted to prevent future falls. Donna would follow up with her primary care doctor and again with her cardiologist (who, aided by the physician group's electronic medical record, has not forgotten about the congestive heart failure that originally landed her in the hospital).

Margaret has no system in place to ensure that her home is safe when she returns. She falls again, this time breaking her hip and ending up in the hospital for three days, followed by a 10-day stay in a skilled nursing facility for treatment -- a fall and stay that potentially could have been prevented if her home had been properly outfitted for fall prevention.

For too many patients who interact with Traditional Medicare, the experience is like Margaret's. I ask you to think about the care your loved ones have received, or maybe even you have received. Medicare Advantage, and the coordinated care model it represents, offers a different, better model for patients and their families, and in particular for seniors.

Table 1: Donna and Margaret, Fragmented versus Coordinated Care

<b>Margaret Hamilton</b>	<b>Traditional Medicare (No Care Coordination)</b>	<b>Donna Rodriguez</b>	<b>MA (with Care Coordination)</b>
Congestive Heart Failure DRG 292/ 2-day length of stay (LOS)	\$7,740.70	Congestive Heart Failure DRG 292/ 2-day length of stay (LOS)	\$7,740.70
911 Ambulance	\$475.52	Cardiology visit	\$160.20
Cardiac Arrhythmia and Conduction	\$6,180.29	Primary Care visit	\$45.51
Congestive Heart Failure	\$7,740.70	Primary Care visit	\$221.60
Cardiology visit	\$60.20	Cardiology visit	\$120.82
Primary care visit x 2	\$98.62		
911 Ambulance	\$475.52	Fall/Knee contusion Urgent Care visit	\$158.30
Fall/Knee Contusion Outpatient ED visit	\$982.78	Primary Care visit	\$45.41
911 Ambulance	\$475.52	Primary Care visit	\$45.41
Inpatient hospital – hip replacement DRG 469/LOS: 3 days	\$26,083.77	Cardiology visit	\$60.20
SNF- 10-day stay	\$4,263.30		
<b>Total</b>	<b>\$54,576.92</b>	<b>Total</b>	<b>\$8,598.05</b>
Patient out-of-pocket	\$10,200.00	Patient out-of-pocket	\$1,600.00

A final point on the cost savings achieved in the coordinated care model. These savings accrue directly to the benefit of seniors. Cost savings are typically reinvested by physician groups in care programs that benefit the patient population – such as quality incentive programs for seniors, special care clinics for the frail elderly, or electronic medical records to better monitor patients. In Medicare Advantage, savings earned by physician groups are reinvested directly into treating seniors.

**B. HealthCare Partners’ Team-Based Approach to Population Management**

HCP has allocated its resources to implement a variety of programs that are tailored to the unique health status of our population. Our process begins by stratifying our patients into appropriate segments according to the needs of the population. Risk stratification requires the support of a strong technology backbone for physician organizations along with disease registries that help track the

population. Strong, accurate, clinical data supports our ability to identify and manage our population – without that data, none of these processes would be able to function at the high level they do today.

Once the population is identified using our technological tools, HCP uses a system that divides the population into one of five levels depending on patient risk:

- Level 5: hospice/palliative care.
- Level 4: home care management for chronically frail seniors. Provides in-home medical and palliative care management by physicians, nurse care managements, and social workers.
- Level 3: high risk clinics. Provides intensive one-on-one physician, social worker, and case management for the high risk and/or post discharge population.
- Level 2: complex care & disease management. Provides whole person care enhancement for the population using a multidisciplinary team approach.
- Level 1: self-management & health education programs. Provides self-management for patients with chronic disease.

Patients are then matched to appropriate programs. As an example, for our Level 3 patients, HCP put in place a comprehensive care clinic (“CCC”) program. The program is particularly designed for patients with complex care needs, those with multiple hospital admissions within a single year, or patients who frequently visit the emergency room or our urgent care centers. In many cases, these patients need more intensive time invested in their care needs. The needs of these patients go beyond what a primary care physician can provide in a typical office visit. The CCC provides the opportunity to work more closely with these patients and their families to address their total care needs.

After a hospitalization, for example, a patient will be identified for the CCC program. Upon discharge, the patient will visit the CCC where the patient will meet with a social worker, a pharmacist will address medication reconciliation, and the care team will provide additional information about community resources from which the patient may benefit. The CCC professionals will talk to the patient about advanced care planning, if a plan had not been completed prior to the visit. All of the information from CCC visits is packaged and shared back with both the primary care physician and the specialists

that are involved in treating the patient inside and outside of the CCC. This information is also shared with families, when appropriate.

The CCC program has shown impressive results. For example, the CCC program shows a 25% decrease in hospital days per thousand, 26% decrease in hospital admissions per thousand, and a 27% decrease in emergency room visits.

**C. Results that are Replicated throughout the Coordinated Care Delivery System**

While the CCC program is unique to HCP, the results that flow from properly structured payment incentives are not. Below is a chart showing a comparison of senior hospital days per thousand and senior admissions per thousand showing comparisons of the FFS population and the MA population.

**Senior Hospitalization Statistics<sup>1</sup>**

Region	Senior Hospital Days/1000	Senior Admissions/1000
Nation’s Trailing Regions Medicare FFS	2,000-2,472	380-402
National Average Medicare FFS	1,897	352
California Average Medicare FFS	1,706	318
California Average MA HMO	1,174	250
CAPG’s Elite Groups MA HMO	<800	<220

**III. Patient Interest in MA is Growing Because of its Positive Results**

MA enrollment has grown steadily over the past several years. Recent analysis by the Kaiser Family Foundation shows that 14.4 million Medicare beneficiaries enrolled in MA plans in 2013 – a nearly 30 percent increase over just three years.<sup>2</sup> Although nationally 28% of Medicare enrollees are enrolled in an MA plan, there is broad variation across geographies.<sup>3</sup> In many of the states where HCP

<sup>1</sup> CMS and SDI, compiled by Managed Care Digest (2012).

<sup>2</sup> Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, Medicare Advantage, 2013 Spotlight: Enrollment Market Update (June 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf> (accessed Nov. 29, 2013).

<sup>3</sup> *Id.*

operates, enrollment in MA is above 35 percent.<sup>4</sup> In Los Angeles, where HCP has a large portion of its patient population, enrollment in MA is above 40 percent.<sup>5</sup>

The benefits that flow to patients may be one explanation for the growth in enrollment over the years. Peer reviewed research has consistently shown that MA outperforms FFS Medicare. For example, MA patients are more likely to get preventive screenings, like mammograms, eye tests for diabetes patients and cholesterol screening.<sup>6</sup> MA beneficiaries have been shown to have lower rates of preventable readmissions than patients in FFS Medicare.<sup>7</sup>

Recent analysis has even shown that the benefits of coordinated care in MA may filter out to the rest of the healthcare system. In some circles it has been described as a halo or spillover effect, where benefits of coordinated care sufficiently improve physician practices such that even patients not enrolled in MA see the benefits of coordinated care.<sup>8</sup> The study showed that a 10% increase in MA penetration is associated with a 2.4%-4.7% reduction in hospital costs for other patients.<sup>9</sup>

Surveys of Medicare beneficiaries have shown that seniors are highly satisfied with the MA program. A recent research survey showed that 94% of beneficiaries are satisfied with the quality they receive in MA and 90% of beneficiaries are satisfied with the benefits received in their MA plan.<sup>10</sup>

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<sup>4</sup> See *id.*

<sup>5</sup> Centers for Medicare & Medicaid Services, October 2013 Enrollment Data, available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html?redirect=/MCRAdvPartDENrolData/01\\_Overview.asp](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html?redirect=/MCRAdvPartDENrolData/01_Overview.asp) (accessed Nov. 29, 2013).

<sup>6</sup> Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et. all. *Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare*. Health Affairs 32. no. 1228-1235. July 2013/

<sup>7</sup> Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104.

<sup>8</sup> Baicker, Katherine. Chernen, Michael. Robbins, Jacob. *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization*. National Bureau of Economic Research. May 2013.

<sup>9</sup> *Id.*

<sup>10</sup> North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

Notably, the MA program has been particularly popular among low-income and minority beneficiaries.<sup>11</sup> 41 percent of Medicare beneficiaries with MA had incomes of \$20,000 or less.<sup>12</sup> 64 percent of minority beneficiaries enrolled in MA in 2010 had incomes of \$20,000 or less; 64 percent of African American and 82 percent of Hispanic MA beneficiaries had incomes of \$20,000 or less.<sup>13</sup> In urban areas, like Los Angeles, low-income beneficiaries rely on this program because of the comparatively low out-of-pocket spending and robust health benefits associated with the program. In addition, all MA plans have an out-of-pocket maximum, a protection that is not offered in the FFS program. This helps protect beneficiaries from catastrophic expenses that threaten seniors' financial security. Downward pressure on the MA program increases the chance that these beneficiaries will face higher cost sharing and will make the program a less attractive option.

#### **IV. MA is Under Stress – Death by a Thousand Cuts**

Despite the positive impact of the MA program, the MA program is under severe stress due to a number of cumulative cuts to the program which, taken together, are having a dramatic and deleterious effect on physician groups in MA. I am concerned that these cuts could have the effect of pushing seniors away from MA and into a fragmented FFS delivery model. And, I think these cuts may drive many physician groups out of the program.

Below is an overview of the various legal and regulatory cuts imposed on the MA program. Many of these cuts were aimed at the health plan– that is, a direct reduction to the amount CMS pays to the health plan. However, I want to underscore that these cuts in most cases flow through directly to the amount the plan pays to physician organizations that are contracted to receive a percent of the premium. These cuts have been implemented without any corresponding decrease in physician group

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<sup>11</sup> America's Health Insurance Plans, Low Income and Minority Beneficiaries in Medicare Advantage Plans, 2010 (May 2012).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

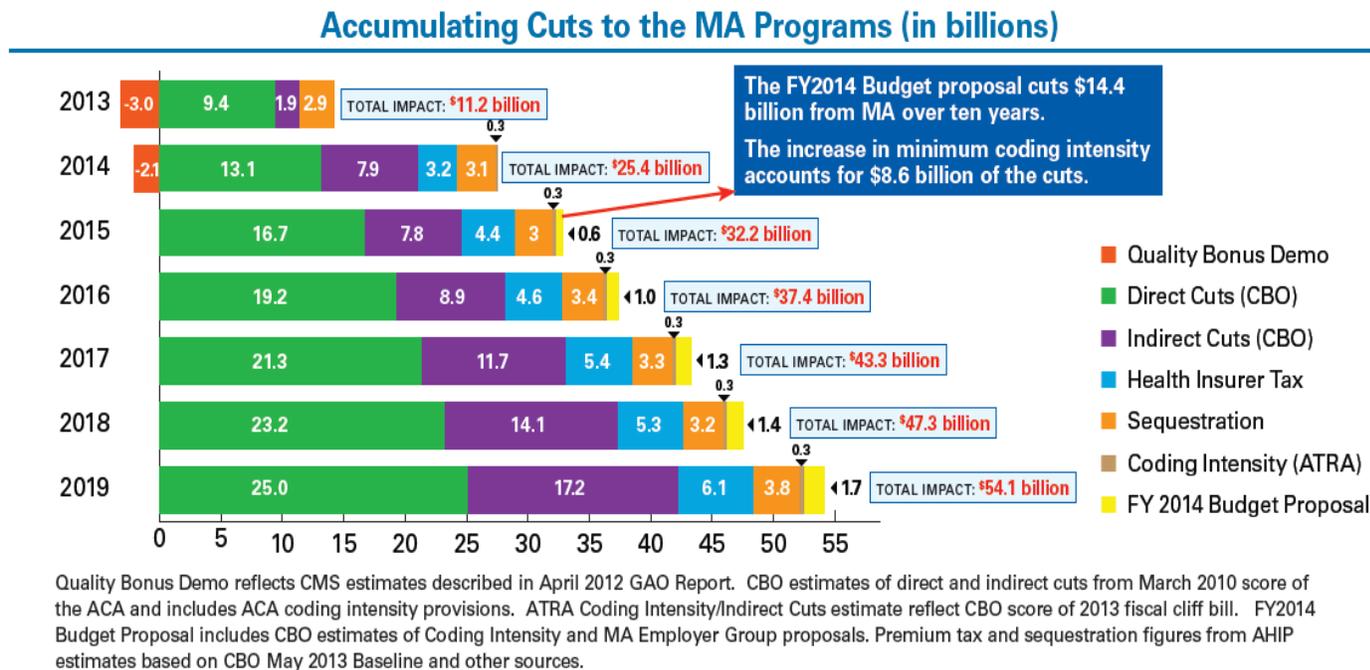
responsibilities, or any reduction in benefit levels. It is incredibly important to consider the total impact to physician organizations and patients that flow from the combined impact of these cuts.

A. Cuts in Existing Law and Regulation

The following series of cuts have already been legislated or regulated. The phase-in of the MA benchmarks alone was intended to bring MA payments to parity with Traditional Medicare. On top of that parity provision are layered additional legal and regulatory provisions that cut deeply into the MA program structure – at the health plan, physician organization, and beneficiary level. Below are the cuts and estimated percentage reductions associated with each:

- **Phase-in of Reduced MA Plan Benchmarks.** The Affordable Care Act revised the methodology and reduced the benchmarks for plan payments. The reductions were designed to bring funding for MA more closely in line with FFS costs by county. The phase-in of these reductions began in 2012 and continues through 2017. The impact of these changes varies by county, but urban counties, like Los Angeles, are particularly hard hit by this provision. *Estimated reduction: -2.0% (varies by county).*
- **Coding Intensity Adjustment.** Existing law requires that the Centers for Medicare & Medicaid Services (CMS) increase the coding intensity adjustment on MA plan payments beginning in 2014. This adjustment will reduce MA payments to account for differences in disease coding patterns between MA and FFS Medicare. *Estimated reduction: -1.5%*
- **Risk Adjustment.** CMS has discretion in selecting the risk adjustment model it uses to adjust payments to health plans based on the conditions of the patients. In 2013, CMS announced that it would implement significant changes to the risk adjustment methodology. This new methodology is being phased in over two years. The impact of these changes on physician organizations varies depending on the patient population the group serves. *Estimated reduction: -2.2% (varies by plan and physician organization)*
- **Sequestration.** Mandatory across-the-board spending cuts resulting from sequestration result in a two percent reduction to plan payments. *Estimated reduction: -2.0%.*
- **Insurer Tax.** MA plans are required to pay an annual fee to offset the cost of the ACA's coverage expansion. In some instances, this tax is passed through to physician organizations. *Estimated reduction: 1.9 to 2.4%.*

The table below shows the accumulating effect of these cuts to the program:<sup>14</sup>



The planned cuts may have the most deleterious effect on Special Needs Plans, a program within Medicare Advantage. These Special Needs Plans (SNPs) were created to improve care for some of the highest risk and sickest Medicare beneficiaries. SNPs are plans that provide benefits tailored to meet the needs of specific patient groups. Congress created the program in law in 2003 and has reauthorized the program multiple times since then. Over 500 SNPs provide care to over 1.5 million Medicare beneficiaries across the country.<sup>15</sup> These plans are a source of coordinated care for seniors with specific conditions and can be very valuable to high intensity patient populations, like those with end stage renal disease. Expiration of the SNP provision is yet another source of risk, instability, and

<sup>14</sup> America's Health Insurance Plans: Accumulating Cuts to MA Program Impact Beneficiaries (2013).

<sup>15</sup> Gorman Health Group, Time to Reauthorize Special Needs Plans (Sept. 2012) available at <http://blog.gormanhealthgroup.com/2012/09/26/time-to-reauthorize-special-needs-plans/> (accessed Dec. 2, 2013).

unpredictability in the MA program. A long-term reauthorization of this program would stabilize care for patients that rely on SNPs.

#### B. 5 Star Quality Program

In 2013, there have been two significant mitigating factors that have prevented some physician organizations from feeling the full impact of MA program reductions. The first is the 5-star quality program, which has been tremendously successful in driving quality at the physician and health plan level.

Under existing law, plans that receive 4 or more stars out of 5 stars from the health plan quality rankings will receive bonus payments beginning in 2012. In addition, an existing CMS quality demonstration expanded the quality incentive program to plans with 3 or more stars and expanding the size of the bonuses. In the 5-star quality program, plans receive a single summary score rating on a scale of 1 to 5. A 5-star rating is the highest. The quality measurement program looks at how often enrollees get preventive care (screenings, tests, vaccines); management of chronic conditions; health plan responsiveness; health plan member complaints and appeals; and health plan customer service.<sup>16</sup>

We are now headed into the final year of the CMS demonstration with many observers citing evidence that the quality program is driving significant improvements: 52 percent of plans are now at 4 stars, up from about 37% of plans; and there are now 16 5-star rated plans.<sup>17</sup> The star ratings program has been an effective tool in driving improvements at the health plan and physician group level.

#### C. Congressional Leadership Leads to Improved Base Blended Rate

The second mitigating factor was a modest improvement in the regulatory notice that sets rates for health plans at the administrative level. During last year's Medicare Advantage rate setting process,

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<sup>16</sup> CMS, 5-Star Plan ratings, available at <http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-5-Star-Enrollment-Period-Job-Aid.pdf> (accessed Nov. 29, 2013).

<sup>17</sup> Gorman Health Group, Reading the Stars in Medicare in 2014-2015 (Oct. 24, 2013) available at <http://blog.gormanhealthgroup.com/2013/10/24/reading-the-stars-in-medicare-in-2014-2015/> (accessed Nov. 29, 2013).

CMS proposed a significant additional reduction to MA payments. CAPG would like to thank the over 160 Members of Congress, including many on this Subcommittee, for your leadership on this issue. As many of you know, CMS ultimately did not finalize the additional reduction in the rate notice last year. We appreciate the support of Members of Congress in this effort to provide greater stability in the MA program. However, we know that the work is not done and we look forward to continuing to work with you in the future to preserve and strengthen the MA program.

D. Net Reductions to MA and Physician Organizations

The net effect of these payment policies has been significant downward pressure on payment to physician organizations. As described above, there is significant variation depending on geographic location and population risk. Across HCP, we experience top line revenue reductions in MA ranging from 6 to 9 percent from 2013 to 2014. I am very concerned that 2015 and beyond may pose an even bleaker financial picture. As described above, these legal and regulatory changes are phased in over a series of years, with their full impact not being realized until 2017. According to the Coalition for Medicare Choices, only about 10 percent of the already slated cuts to the MA program have taken effect.<sup>18</sup> This landscape, along with the potential for future cuts to MA, produces a great amount of uncertainty for physician organizations and beneficiaries.

**V. Conclusion – The MA Program Should Be Strengthened, Not Cut**

A number of challenges, both specific to Medicare and the broader fiscal climate, remain ahead. As Congress considers major policy objectives, like funding government programs, the debt ceiling, and reforming the sustainable growth rate formula, I am concerned that MA could again become a target of cuts to pay for such policies. I encourage lawmakers to consider the full picture of existing cuts, many of which have not fully unfolded at this time. I ask that Congress refrain from making further blunt cuts to the MA program. Instead, I respectfully request that you consider ways to encourage greater care

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<sup>18</sup> Coalition for Medicare Choices, <http://www.medicarechoices.org/How-Health-Reform-Law-Impacts-MA> accessed Nov. 29, 2013.

coordination delivered by physician organizations, including the expansion and extension of eligibility in the 5 star quality program. The more that we can root out fee-for-service and its flawed incentives, the greater the chance of improving outcomes for seniors and achieving a financially stable Medicare delivery system. I believe there are some real opportunities to drive these types of incentives across the Medicare program, but additional cuts to MA are not compatible with that goal.

As Congress considers various ways to improve Traditional Medicare, whether it is through existing delivery system reforms (e.g., accountable care organizations, duals demonstrations), or through a reform of the sustainable growth rate formula, the role of MA as the backbone of coordinated care should not be ignored. MA provides a foundation on which the rest of the delivery system can build coordinated care. For example, physician organizations with the capability to accept two-sided risk arrangements, in most cases, have the experience required to be successful because of MA. Furthermore, many organizations that have been successful in deploying care coordination techniques in Traditional Medicare have leveraged off of their Medicare Advantage care processes and infrastructure to effectively do so. Chipping away at the MA program will undermine efforts to make progress in Traditional Medicare.

Instead of cutting MA, Congress should develop policies that encourage population-based payments to physician organizations in MA and in Traditional Medicare. This means encouraging the organized practice of medicine; strengthening the coordinated care infrastructure; providing incentives for team-based care and primary care; encouraging physician organizations to develop the ability to accept two-sided risk arrangements. There are existing efforts underway to encourage these types of arrangements, like accountable care organizations and the duals demonstration projects. Congress should keep a watchful eye on these demonstrations to ensure they are appropriately moving toward the goals of coordinated care outlined above.

Thank you for the opportunity to speak to you today. As the Subcommittee continues to consider important Medicare and fiscal policy in the future, I hope you will consider all that the Medicare Advantage program has to offer for seniors. Additional cuts to this program would further undermine the care processes that physician organizations have put in place and will have damaging consequences for the coordinated care model. I am happy to provide additional information.