



The Voice of Accountable Physician Groups

Statement of Dr. Mitchell Lew

CAPG – the Voice of Accountable Physician Groups

Before the House of Representatives Energy & Commerce Subcommittee on Health

March 13, 2014

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) in over 20 states. CAPG members provide healthcare services to over 1.2 million Medicare Advantage beneficiaries. 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 also address you today as CEO of Prospect Medical Group and as a physician. I have been a physician for 23 years and practiced as an OB-GYN for 10 years. By way of background, Prospect Medical Group was formed in 1985 with an emphasis on arranging exceptional medical care, helping patients get the most value from their healthcare coverage, and offering exclusive services to Prospect members. Prospect Medical Systems, Inc., was created in 1996 to develop, implement and manage a full range of services focusing on the doctor-patient relationship.

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Prospect has continued to grow to include medical groups and hospitals in California, Texas, and Rhode Island, with plans to continue to expand its geographic reach.

Prospect Medical Group contracts with about 4,500 physicians in what is called the IPA model. This model allows us to contract with small physician practices underneath the umbrella of one larger organization. We serve approximately 225,000 patients and of those, nearly 40,000 are enrolled in Medicare Advantage (MA).

I am deeply concerned about proposed additional cuts to the MA program. My testimony today will outline the benefits of the MA program for seniors; the popularity of this program among the seniors we treat; and how cuts in existing law and regulation combined with proposed cuts through the regulatory process place the coordinated care model and infrastructure at risk. Prospect Medical Group recently joined over 140 other physician organizations in a letter to CMS Administrator Marilyn Tavenner, urging the agency to use its regulatory authority to offset cuts to MA.

As an organization with extensive experience in coordinated care, Prospect Medical Group knows that the way Medicare pays for physician services can either incentivize or disincentivize care coordination. For example, fee-for-service (FFS) Medicare is a volume-based model. Physicians are paid for each service delivered, without an eye toward providing the best value for the patient. There are minimal incentives in FFS Medicare to coordinate among practitioners, provide preventive services, or focus on population health.

In contrast, the MA payment structure when offered through an accountable physician organization, incentivizes value, preventive services, care coordination, and a focus on quality. In MA, physician groups and IPAs are paid capitation (a defined amount for a population). Specifically, the Centers for Medicare & Medicaid Services (CMS) make a defined payment to a health plan for a specific group of beneficiaries. Health plans then pay the physician group or

IPA a defined amount for each enrolled patient over a span of time, usually a percentage of premium and often described as “per-member, per-month” payment. The amount of the payment made directly to the medical group is set in advance and typically paid each month, regardless of the volume of healthcare services provided to an individual patient. The physician organization is operating within a budget and there is no additional money if the physicians run up additional costs. Therefore, the physician groups must hold their employed and contracted physicians to robust performance standards to ensure that the budget is met in a way that improves patient care.

Physician organizations are responsible for paying their employed or contracted physicians. Physician organizations pay their primary care and specialty physicians, and sometimes hospitals, depending on the contract with the MA plan. Physician organizations have the flexibility to tailor these downstream payments to individual physicians to get the desired patient care outcomes. For example, the organization might pay an individual physician subcapitation, a salary, or even FFS in some cases. For example, if a group wants to incentivize higher rates of preventive services, FFS might be the preferred payment mechanism to drive higher rates of these types of services.

The downstream payments also often include payment of 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.

I. MA's 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 FFS 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.

These arrangements also incentivize physicians 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, when appropriate, patients are safely and appropriately treated in lower cost settings, such as their home. Our 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.

A specific example of these elements coming together to improve patient care comes from Prospect's “Care Plus High Intensity Care” Program. This program is Prospect's medical home model, consisting of proactive management and coordination of services for high-risk patients. The model includes a multi-disciplinary team-based approach, coordinated around the

primary care physician. The Care Plus program engages the patient and, when appropriate, the family or other social support network.

Prospect uses patient stratification techniques to identify patients for the program. We focus on patients with frequent hospital admissions (two or more admissions in 12 months); with frequent emergency department and urgent care visits; with chronic conditions like diabetes or asthma; and high cost utilizers. Once enrolled in the high-intensity care management program, the patient has access to additional services that focus on the patient's healthcare needs. For example, patients enrolled in this program have 24/7 direct telephone access to the care team. The care team identifies specific drivers of hospital admissions and develops specific plans to address the drivers. Patients and their families are engaged in the care plan. The Care Plus program also includes integrated behavioral health management, disease specific action plans, and self-management programs, as appropriate for the patient's specific needs. Within the program, all aspects of the patient's care are coordinated, including ancillary services and physician referrals.

The result of this special attention to patients with the greatest need has had tremendous improvement in quality metrics and also patient quality of life. We have seen a reduction in our senior bed days per thousand from 1,260 to 850 and a reduction in senior admissions per thousand from 244 to 218. We have also seen a reduction in our senior 30-day all inclusive readmission rate from 19% to 13%.

II. 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.¹ Although nationally 28% of Medicare enrollees are enrolled in an MA plan, there is broad variation across the states.² In California, nearly 40% of seniors enrolled in Medicare are enrolled in MA. In Rhode Island and Texas, where Prospect Medical also has operations, enrollment in MA is 35% and 27% respectively.³ Importantly, seniors' interest in MA has continued to grow. A recent report by *Health Affairs* showed that more than 50% of new Medicare enrollees are enrolling in MA.⁴

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.⁵ MA beneficiaries have been shown to have lower rates of preventable readmissions than patients in FFS Medicare.⁶

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.⁷ 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.⁸

¹ 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).

² *Id.*

³ *Id.*

⁴ Ann B. Martin, Micah Hartman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, National Health Spending in 2012: Rate of Health Spending Remained Low for the Fourth Consecutive Year, *Health Affairs*, 33, no. 1 (2014): 67-77.

⁵ 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/

⁶ 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.

⁷ Baicker, Katherine. Cherner, Michael. Robbins, Jacob. *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization*. National Bureau of Economic Research. May 2013.

⁸ *Id.*

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.⁹

Notably, the MA program has been particularly popular among low-income and minority beneficiaries.¹⁰ 41 percent of Medicare beneficiaries with MA had incomes of \$20,000 or less.¹¹ 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.¹² 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.

III. Cuts Place this Popular Program at Risk

Despite its success and popularity, 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 the cuts to the MA program will push both physicians and patients out of the program and back into fragmented FFS models.

Below is an overview of the various legal and regulatory cuts imposed on the MA program *prior* to the CY 2015 Advance Notice. Many of these cuts were aimed at the health

⁹ North Star Opinion Research. "National Survey of Seniors Regarding Medicare Advantage Payments February 6-11, 2013."

¹⁰ America's Health Insurance Plans, *Low Income and Minority Beneficiaries in Medicare Advantage Plans, 2010* (May 2012).

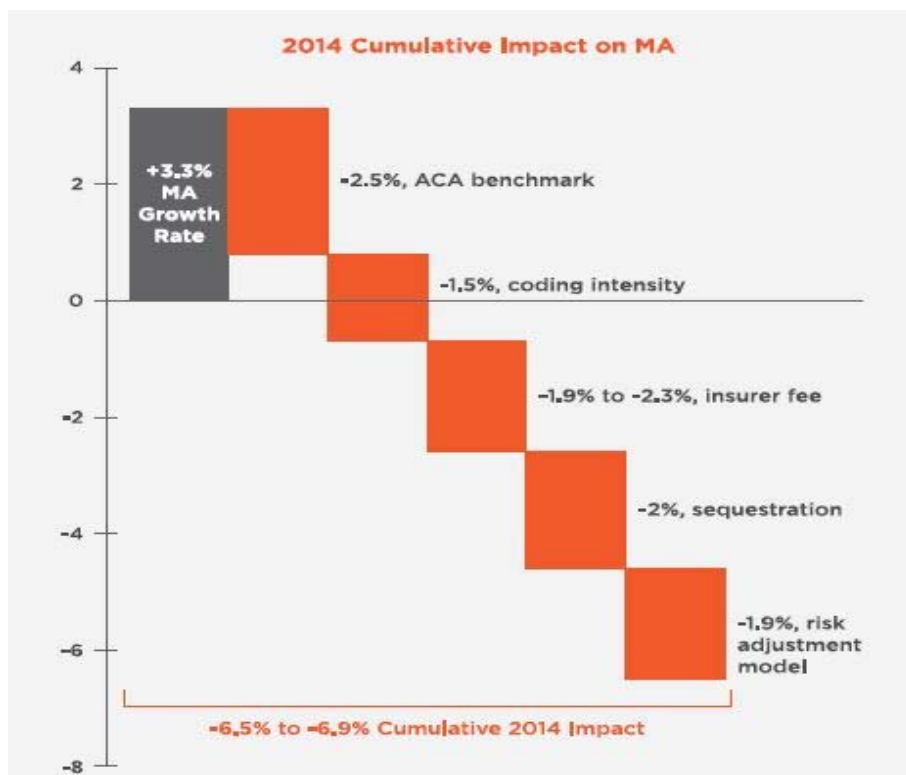
¹¹ *Id.*

¹² *Id.*

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 in the form of a reduction to the amount the plan pays to physician organizations that are contracted to receive a percent of the premium. The cuts are passed through without any corresponding decrease in physician responsibilities.

A. A 6.5% Cut in Existing Law and Regulation is Passed Through Directly to Physician Organizations

It is important to understand that deep cuts to the MA program are already taking effect in CY 2014. Although many physician organizations have not felt the full impact of these already required cuts in the first quarter of 2014, the cuts will continue throughout this calendar year and will impact patient care. As shown in the below summary chart, the total impact already required legal and regulatory cuts to MA in CY 2014 is approximately 6.5%.¹³



¹³ Partnership for the Future of Medicare (2014), available at www.futureofmedicare.org.

Below is a brief description of each of these the categories:

- **MA Growth Rate.** In the CY 2014 regulatory process, CMS reversed course on a proposed additional steep reduction to MA rates and instead included a +3.3% MA growth rate. CAPG would like to thank the over 160 Members of Congress for their leadership on this issue.
- **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 to parity 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. MA payments in Los Angeles will go down to 95% of FFS over a four-year transition period.
- **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.
- **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.
- **Sequestration.** Mandatory across-the-board spending cuts resulting from sequestration result in a two percent reduction to plan payments. In many cases, the plans have passed on the 2% reduction to physician organizations.
- **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. The impact of these changes on physician organizations varies depending on the patient population the group serves.

B. CY 2015 Advance Notice – Results in over 10% in Cuts to Physician Groups Over 2-Years

On top of the cuts described above, CMS's most recent regulatory proposal would layer an additional programmatic reduction on top of the approximately 6.5% already unfolding on our organization. As shown below, the *average* reduction under the Advance Notice would be 4.79%.¹⁴ Taken together with the average reduction in CY 2014, this means many physician

¹⁴ Gorman Health Group, A Summary and Analysis of the 2015 Draft Call Letter and February 2014 Medicare Advantage Advance Notice (2014).

organizations participating in MA would face an over 10% reduction over the two year period from 2014-2015.

Impact on Medicare Advantage Earnings: ACA plus the February 21 Advance Notice	
<i>The following are averages. The actual impact on individual companies will vary, in many cases significantly.</i>	
	2015
Advance Notice (February 21, 2014)	
Trends	
Old rates ¹	-3.55%
ACA rates	-1.65%
Average*	-1.90%
Risk adjustment recalibration revisions	0.00%
FFS normalization, change from prior year	3.16%
Total	1.26%
Affordable Care Act and Other Previously Scheduled Changes	
Phase-in of new ACA rates*	-2.00%
Coding intensity adjustment	-0.25%
Plan-specific factors	
End of Quality Bonus Demonstration, Average* impact: from zero, to 3.5%, to as much as 7% in double bonus counties	-2.00%
Revised health risk assessment rules	-1.00%
Recalculation of county-specific FFS cost estimates*	varies by county
Reassignment of counties to different rate quartiles*	
ACA excise tax on revenues*	-0.8%
Combined Impact, Average*	-4.79%

¹The old rate trend of -3.55% will only affect MA payments in 21% of US counties, representing 32% of Medicare Advantage members.

*Impact will vary from market to market and plan to plan.

While some of these cuts come from application of existing law and are described above in the discussion of the CY 2014 payment cut, others are newly slated to begin in CY 2015.

- Rate Book Changes.** Briefly, MA benchmarks are comprised of two components, the “old rates” (benchmark calculated under prior law) and the “ACA rates” (benchmark determined under the ACA). Both are based on the underlying trend in FFS Medicare. In 2015, the MA benchmark represents a blend of these two amounts. Note that the average amount of reduction from the blending of these two rates is -1.9%. However, this is an average and not the actual amount for any particular county in the United States.

In 2014, CMS announced a revised risk adjustment and corresponding cut to MA payment. The new model was to be phased in over a two-year period. In the Advance Notice, CMS proposes delaying full implementation of the new model. This policy, if finalized, would result in a 0% change in CY 2015 and is a positive aspect of the Advance Notice.

Finally, in prior years, CMS has reduced risk scores to compensate for “coding creep” in FFS Medicare. Due to a change in CMS’s methodology in CY 2015, the FFS normalization factor results in a proposed +3.16% improvement in CY 2015. This is a positive development in the rate notice and has the impact of mitigating some of the effect of the negative benchmark updates.

- **Expiration of the 5-Star Quality Demonstration.** The 5-star quality program 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.¹⁵ The 5-star quality program has driven significant improvement: 52% of plans are now at 4 stars, up from about 37% of plans; and there are now 16 5-star rated plans.¹⁶ The star ratings program has been an effective tool in driving improvements at the health plan and physician group level. Prospect Medical Group is currently ranked between 4 and 5 stars with all of the plans it contracts with.
- **Changes to Health Risk Assessment Rules.** In the CY 2015 Advance Notice, CMS proposes to disregard diagnoses obtained during home visits for the purposes of determining a plan’s risk score. In the Advance Notice, CMS expresses concern that the results from home assessments do not result in treatment and instead are used only to identify and document diagnoses. The result of this proposal is a proposed reduction in MA payments of at least -1%.

¹⁵ 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).

¹⁶ 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).

C. Net Reduction of More than 10% to MA and Physician Organizations Over Two Years

The net effect of these payment policies will be an over 10% reduction over a two-year period. As described above, there is significant variation depending on geographic location and population risk. At Prospect, we expect top line revenue reductions in MA of \$8 million in 2014 and \$7.5 million in 2015. 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. This landscape, along with the potential for future cuts to MA, produces a great amount of uncertainty for physician organizations and beneficiaries.

IV. **Cuts to MA will Undermine Progress in the Delivery System**

I recognize that there are efforts underway to move the Medicare Part B physician payment system to a coordinated care model (e.g., Accountable Care Organizations, bundled payments, and two-sided risk models). As an example, the bi-partisan, bi-cameral legislation to permanently repeal the sustainable growth rate (SGR) includes incentives for physician organizations to enter two-sided risk-bearing models in Medicare Part B.

When properly structured, such models can be successful in improving care coordination for the FFS Medicare population. CAPG members have seen some success with the ACO program in terms of improving outcomes for patients as compared to FFS Medicare beneficiaries without any intervention. However, in nearly every case, this success is directly linked to the organization's experience in the MA program. The MA program provides the infrastructure, things like electronic medical records, care coordination programs, and patient call centers, all of which are factors in improving patient care. Even with the potential for these new delivery models to succeed, the truth remains that MA, with 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.

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

I am very concerned about the proposed additional reductions to the MA program and I urge Congress and the Administration to consider ways that the MA program can be strengthened rather than cut. As Congress considers various ways to improve Medicare Part B, 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 MA 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 and the Administration 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 MA 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.



The Voice of Accountable Physician Groups

Summary of Statement by Dr. Mitchell Lew, CAPG

Population-Based Payment to Physician Groups in Medicare Advantage (MA). In MA, physician organizations, such as Prospect Medical Group, are paid under a population-based, or capitated, payment model. In this model, the Centers for Medicare & Medicaid Services (CMS) make a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrollee for services over a span of time (e.g., per-member, per-month). Physician organizations then have the flexibility to pay specialists and primary care physicians downstream to incentivize high value healthcare. Population-based payment models are bolstered by robust quality reporting and performance standards, including the MA 5-star program and internal programs.

MA's Payment Structure Leads to Better Care for Seniors. The population-based payment model provides incentives for physician groups to provide better care for seniors. The MA model incentivizes: (1) a team-based approach; (2) physicians 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 social, behavioral and mental health.

Patient Interest in MA is growing because of its Positive Results. MA enrollment is growing because of its benefits to patients. A recent report showed that more than 50% of seniors aging into Medicare are electing MA over traditional Medicare. The benefits to patients, including a greater focus on prevention, focus on care coordination, and lower out of pocket spending are important factors in the enrollment growth.

Existing and Proposed Additional Cuts Place this Popular Program at Risk. The MA program is under stress due to numerous cuts from existing law and regulation and newly proposed cuts. For CY 2014, the combination of legislated and regulatory cuts average about -6.5%. Adding proposed cuts in CY 2015 will bring total program reductions to over 10% for the two-year period. These cuts are unsustainable for physician organizations and will flow through to patients.

Cuts to MA Undermine Coordinated Care Goals. Cutting the MA program will undermine efforts to implement coordinated care and two-sided risk contracting and population-based payments in Medicare Part B. When properly structured, coordinate care models can be successful in improving care for the FFS population. But, in many cases, the success of coordinated care models in FFS is directly linked to the organization's experience in MA. I note that MA remains the best existing example of population-based payment to physician organizations. Further cuts to the MA program will undermine care coordination efforts in other settings.

The MA Program should be Strengthened, Not Cut. Congress and the Administration should consider ways that the MA program can be strengthened. MA serves as the foundation for the development of coordinated care models across the healthcare delivery system. This program should be embraced as a mechanism for improving care and outcomes for seniors and as providing the infrastructure and experience for improvement elsewhere in the delivery system.

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