The Voice of Accountable Physician Groups

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CAPG – the Voice of Accountable Physician Groups
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Thank you Chairman Brady, Ranking Member McDermott, and Members of the Health Subcommittee for inviting me to testify today. I look forward to describing the role Medicare Advantage (MA) plays in driving innovative, high quality care for seniors. As an example of this, I will describe Sutter Health's Advanced Illness Management (AIM) program for our sickest patients. Our program is one example of the critical role MA plays in the development of a healthcare delivery system built on value rather than volume.

I am pleased to testify today on behalf of CAPG. CAPG is the largest association in the country representing capitated physician organizations practicing 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 believes 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 a budgeted healthcare model for over two decades.

I also address you today as a Senior Vice President for Sutter Health, the Executive Officer of the Sutter Medical Network, the department of Sutter Health tasked with coordinating care to meet the needs of its communities, and as an internal medicine physician. Sutter Health is one of the nation's largest, not-for-profit healthcare systems. We provide

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healthcare to over three million patients spanning 100 communities in Northern California across all payer types, including 49,000 Medicare Advantage beneficiaries and a large proportion of Medi-Cal (California's Medicaid) beneficiaries. Committed to providing access to high quality, coordinated care, Sutter Health includes 5,000 physicians aligned with the Sutter Medical Network, 24 acute care hospitals, home healthcare, and more than two dozen surgery centers. Sutter Health employs about 48,000 people across northern California. This year, Sutter also launched its own HMO health plan offering commercial coverage in a small number of counties in our service area.

The Importance of Population Based Payments: Paying Physicians to Achieve Desired Results

Sutter Health has decades of experience contracting with physicians to provide high value healthcare to patients. Out of this experience, we have learned that a population-based, budgeted monthly payment is an efficient and effective way to incent high quality, low cost care. We see a sharp contrast when physicians are paid fee-for-service (FFS) as compared to a prepaid, population-based payment. In FFS, physicians are paid separately for every service provided. There is less incentive to coordinate the care for the patient or to keep the patient healthy. Incentives simply exist to provide as many services as possible – the greater the volume, the greater the payment.

In contrast, population-based payments to physician organizations in MA create a defined budget for patient care. In MA, the Centers for Medicare & Medicaid Services (CMS) makes a defined payment to a health plan for a pre-determined patient population. In the case of a physician organization, like Sutter Health's aligned medical groups, the health plan then makes a defined payment to the physician organization for the physician organization's patient population. The payment to the physician organization is typically a percentage of premium and is often described as a "per-member, per-month" payment. This amount does not change based

on the volume of healthcare services provided. The physician organization is accountable for operating within the monthly budget and, generally, there is no "extra" money for additional costs. Because there is no "extra" money, physicians have incentives to manage the patient population to stay within the budget.

Physician organizations are responsible for paying their employed or contracted primary care and specialty physicians, and sometimes hospitals depending on the contract with the MA plan. Under MA, physician organizations have the flexibility to tailor these 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 utilization rates for these types of services.

The payment arrangements between the physician organization and the individual physician often include additional payment 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 are closely linked with the CMS 5 Star Program in Medicare Advantage.

The population-based payment made by the MA plan to the physician group creates numerous benefits for patients that are not seen in the FFS environment. The population-based payment methodology incentivizes a team-based approach. This approach encourages deployment of other healthcare 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. The AIM program, described below,

highlights the important role these practitioners play in addressing the full spectrum of healthcare needs of aging 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. We have learned through the AIM program 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 unavailable in the FFS 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.

I. The Advanced Illness Management Program: a Case Study in Coordinated Care

The AIM concept originated in the late 1990s, stimulated by challenges in prognosis and treatment in advanced chronic illness that could not be met by hospice or palliative care. When managed Medicare (Medicare+Choice) aligned financial incentives to reduce utilization and costs, it was clear that home-based transition services could help to limit unwanted admissions. Thus, AIM was built upon the coordinated care foundation of today's Medicare Advantage program.

In 2008, AIM's operational concept and geographic reach were expanded. The model targeted patients with very serious chronic illness, provided high-touch home visits combined with telephone support, and closely coordinated care among physicians, hospitals, home and community.

Many of these patients could be eligible for hospice, but for whatever reason are unprepared to take that step. On average, patients with advanced illness spend 17 days in the hospital; 12 days in the ICU; take 18-30 medications; and make 54 trips to nine different doctors. With all of these various touch points in the healthcare system it is not surprising that many of them do not know who is in charge of their care in a traditional FFS environment. Finally, it is notable that 28 percent of Medicare's total spending is devoted to these patients in the last year of life. Sutter Health recognized a tremendous opportunity to help these patients and their families have a better care experience at a lower cost to the system overall.

In the AIM program, Sutter Health offers an approach dramatically different from what is offered in traditional Medicare. Our approach is coordinated, patient-centered, and team-based. Sutter Health identifies advanced illness patients at the time of a hospitalization or physician office visit and invites the patient to enroll in the AIM program. Patients eligible for the program are those with more than two chronic illnesses (e.g., chronic heart failure, COPD, cancer); multiple prescriptions; clinical, functional and/or nutritional decline; high utilization of healthcare services; and those who are identified as high risk by their physician. To summarize, these patients are among the sickest in our population and prior to AIM, were the ones that cost the system the most in terms of their intensive healthcare needs and the resources associated with caring for them.

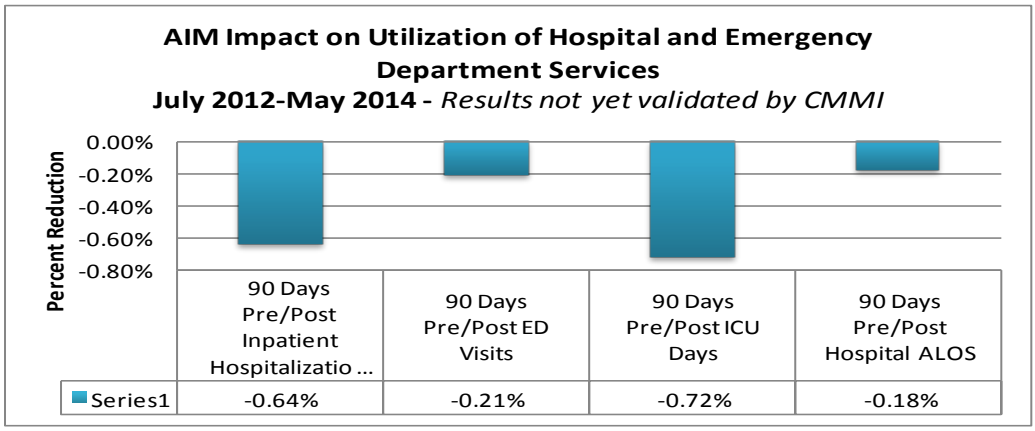
In traditional FFS Medicare, a patient with a chronic condition who is hospitalized has little post-discharge planning. The patient might have instructions to call her physician within a certain number of days of leaving the hospital, but there are few if any supports in place to ensure that the patient calls the doctor or that the appointment is actually scheduled. As a result, FFS patients typically begin a vicious cycle of emergency room visits followed by post-discharge complications, landing the patient back in the hospital multiple times.

In contrast, the AIM program provides an integrated, coordinated approach to healthcare for patients with advanced illness. The AIM program has embedded AIM care liaisons in the hospital. The AIM staff in the hospital approaches the patient and the patient's family to begin coordinating post-discharge care. AIM staff provides coaching for the patient's return home, provides education about the patient's conditions and provides instructions for what to do in the event of an emergency. And unlike traditional discharge instructions, the contact between AIM staff and the patient continues when the patient returns home. AIM staff coordinates care for patients in the home, including providing follow-up home visits. In the home, staff can address unsafe conditions, such as loose carpeting or lack of handrails, which can contribute to falls and repeat hospitalizations in older patients. The staff can reconcile medications, meaning that they look at what was prescribed in the hospital and what the patient was taking prior to their hospital admission to ensure there is no duplication or potentially dangerous drug interaction. The AIM staff also offers telephone support and management for patients who cannot get to a doctor's office.

Three factors fostered AIM's growth: rapid acceleration in demand from aging Baby Boomers with severe chronic illnesses, the emergence of accountable care, and pressure to seek partnerships that addressed concerns about rising costs. Sutter Health also recognized that AIM care management, which united multiple settings, promoted system integration. For all these reasons, Sutter funded the unreimbursed costs of an AIM care management pilot.

Sutter Health began testing the AIM care management pilot in three communities in Northern California in 2009 with its Medicare Advantage population. The pilot demonstrated highly positive outcomes and provided the foundation to expand system-wide in 2011-2012. In order to expand the program, we sought additional funding sources and were awarded a CMS Innovation Center Challenge Grant in 2012. The AIM program currently serves 15 counties and

we plan to continue to develop and improve the program through 2015. Throughout this piloting and implementation, the AIM program has achieved impressive results including substantial reduction in inpatient and emergency department utilization; reductions in ICU days; reductions in length of stay; and cost savings to the healthcare system.



If our experiment shows that the program is replicable and scalable, then AIM may contribute to the health and well being of some of the most vulnerable and costly recipients of American healthcare, and to the economic viability and ethical integrity of the system itself.

I would like to add a point on cost savings achieved in the physician-led coordinated care model. Our cost savings are reinvested in care programs that benefit the patient population. Programs like quality incentives, special care clinics for the frail elderly, and advances in medical records and disease registries are all funded by the reinvestment of cost savings achieved in the coordinated care model.

Care-management programs like AIM are made possible by the pre-payment of population-based, per-member, per-month amounts. These programs require investment in staffing (e.g, hiring case managers), infrastructure (e.g., establishing patient call centers), and electronic health records. All of this investment is only possible with a predictable budgeted payment that allows us to know what money will be coming in and when. The per-member,

per-month payments made by CMS to plans and then to physician organizations are best suited to facilitate this care model. In a FFS environment, a planned and proactive strategy to managing patient health is significantly more difficult and in some cases impossible.

II. MA Provides the Backbone for Care Coordination in Medicare

I recognize that there are efforts underway to move the Medicare Part B physician payment system to a coordinated care model that encourages physician organizations to accept risk (e.g., Accountable Care Organizations (ACO), bundled payments). As an example, recent 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 traditional FFS Medicare beneficiaries. However, in nearly every case, this success is directly linked to the organization's experience in the MA program. The AIM program is yet another example. As described above, Sutter Health began the AIM program in three Northern California communities, primarily around its Medicare Advantage population. We have since been able to expand this program to other populations. Without the infrastructure provided by Medicare Advantage and the certainty associated with pre-paid capitation for our patient population, the AIM program would have been impossible.

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. MA is the only existing example where physician organizations successfully take on two-sided risk. To truly encourage and incentivize the development of additional two-sided risk models in Medicare Part B, the MA program should be not just protected, but strengthened. The lessons and best practices organizations like ours have learned in MA should be shared and disseminated. Cuts to the MA program place all of this innovation, learning, and development at risk.

III. Patient Interest in MA Continues to Grow

Given the success of care coordination programs in improving patient outcomes, it is no surprise that MA enrollment has grown steadily over the past several years. Recent analysis by the Kaiser Family Foundation shows that 15.7 million Medicare beneficiaries were enrolled in MA plans in 2014.[1] This is an increase in enrollment of 41 percent since 2010.[2] Although nationally 30 percent of Medicare enrollees are enrolled in an MA plan, there is broad variation across the states.[3] In California, nearly 40 percent of seniors enrolled in Medicare are enrolled in MA. I think it is because of access to programs like AIM that seniors' interest in MA has continued to grow. A recent report by *Health Affairs* showed that more than 50 percent 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

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[1] Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, Medicare Advantage, 2014 Spotlight: Enrollment Market Update (May 1, 2014), available at http://kff.org/report-section/medicare-advantage-2014-spotlight-enrollment-market-update-overall-trends-8588/.

[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/

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 percent increase in MA penetration is associated with a 2.4 – 4.7 percent reduction in hospital costs for other patients.[8]

Surveys of Medicare beneficiaries have shown that seniors are highly satisfied with the MA program. A recent research survey showed that 94 percent of beneficiaries are satisfied with the quality they receive in MA and 90 percent 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, 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

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[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. Chernew, Michael. Robbins, Jacob. *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization.* National Bureau of Economic Research. May 2013.
[8] *Id.*
[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.*

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.

V. Conclusion – Strengthen the Investment in Medicare Advantage and Population-Based Payment Models

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. In CY 2014, CMS cut MA payments to plans by about 6.5 percent. In CY 2015, CMS cut MA payments to plans by about 3 percent. Many of the cuts to MA were aimed at health plans in the form of direct reductions to the amount CMS pays to the health plan. In most cases, however, these cuts flow through directly as a reduction to the amount the plan pays its contracted physician organizations. Cuts are passed on without any corresponding reduction in physician responsibilities to patients. 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.

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 FFS Medicare have leveraged off of their MA care processes and infrastructure to effectively do so.

Congress and the Administration should develop policies that encourage population-based payments to physician organizations in MA and in traditional FFS 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.

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.