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The Everett Clinic's Experience with Private Fee for Service Medicare Advantage Plans

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Private Fee for Service Plans in Medicare Advantage: A Closer Look

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Chairman Baucus, Senator Grassley, and members of the Committee, thank you for the opportunity to testify regarding Private Fee for Service Medicare Advantage. My name is Dr. Al Fisk, and I am Medical Director for The Everett Clinic, a 270 physician multi-specialty physician group practice serving nearly 250,000 residents of Snohomish County, Washington, just 30 miles north of Seattle.

The Everett Clinic was founded over 80 years ago and modeled after the Mayo Clinic principles of physician directed, patient centric care. We hold dear three core values:

- We do what is right for each patient
- We provide an enriching and supportive workplace, and
- Our team focuses on value: service, quality, and cost

The Everett Clinic is one of ten participants in the **Physician Group Practice Demonstration Project** sponsored by the Centers for Medicare and Medicaid Services (CMS). We embrace coordination of care and evidence based medicine. We are proud of the fact that we score very high on the quality measures defined in the CMS demonstration project. We are also leaders in the Puget Sound for cost effectiveness with pharmaceuticals, saving nearly $30 Million annually for commercial payers and the Medicare program by high use of generic alternatives. We have put into place an electronic medical record and many other systems for care of patients with expensive chronic conditions. All of these efforts require infrastructure and significant resources but our experience shows they are worth the effort.

My testimony today will focus on four key points:

- Our experience with caring for Medicare patients and particularly patients enrolled in Medicare Advantage Private Fee for Service (PFFS) plans,
- Our decision to stop seeing patients with Private Fee for Service Medicare Advantage coverage effective January 2009,
- Our experience with communicating this decision to patients, and
- Our advice to Congress as providers who want to care for Medicare patients but need to stay viable in doing so.

Our Experience in Caring for Medicare Patients

The Everett Clinic cares for nearly 21,000 Medicare patients. Nearly 7,000 of those patients are enrolled in Medicare Advantage programs. Approximately

5,600 are enrolled in HMO / PPO Medicare Advantage plans and the remaining 1,400 are enrolled in Medicare Advantage Private Fee for Service plans.

The enrollees in the Medicare Advantage HMO / PPO plans are primarily members of four plans in our state, including a Special Needs Plan. We have contracted with those plans to coordinate their many care needs across the care continuum (inpatient, skilled nursing facility, outpatient and ambulatory and home health). Most of these arrangements currently are fee-for-service where we receive funding above Medicare fees to reduce our losses. The coordination of care efforts by our physicians is quite effective. We have programs to target patient populations with chronic illnesses that historically have consumed tremendous resource for the Medicare program. Examples of chronic care programs include: diabetes, coronary heart disease, congestive heart failure, asthma, and high blood pressure. We also partner with our local hospital on a palliative care program that provides a high quality of care at end of life.

The Everett Clinic estimates that we lose nearly $7.5 million per year on providing care to Medicare patients. The Medicare Advantage HMO / PPO plan structure allows us to negotiate with plans and obtain additional funding that pays for very useful care coordination and begins to offset the losses of traditional Medicare funding. Such arrangements are not currently possible with Medicare Advantage Private Fee for Service plans.

Private Fee for Service (PFFS) Medicare Advantage plans are extremely hard to deal with both in terms of negotiating fair rates and collaborating on care coordination. We have been very frustrated with both identifying the PFFS plans and negotiating fair funding. It seems like the intention of Congress with Medicare Advantage plans was to provide an alternative funding mechanism that allowed for care coordination that benefited both patients and providers. Our experience has been positive with Medicare Advantage HMO / PPO plans but abysmal with Medicare Advantage PFFS.

Our Decision to Stop Seeing Medicare Advantage Private Fee for Service Plans

The Everett Clinic has spent years examining how to participate in Medicare in a way that allows us to stay viable. We tried to initiate negotiations with Private Fee for Service (PFFS) plans for 2 years without success. In April of 2005, we began participating in a four-year national Medicare Physician Group Practice Demonstration project for patients on Original Medicare. The program is designed to help providers groups establish clinical care processes that lead to measurably better management of total costs (Parts A and B) and improved clinical quality, while rewarding the provider group for performance. Our decision

to participate in this project was driven largely by our goal to develop a robust clinical care model for all our seniors, based on having the primary care physician and his/her team being the anchor for meeting the patient's total healthcare needs. This enables us to better manage the rise in total healthcare costs by coordinating ambulatory services and facility-based services (hospital and skilled nursing) while improving quality in measurable ways related to preventive care and chronic conditions like diabetes and coronary artery disease.

Recognizing that the Medicare population in our county would grow 20% in 5 years, and that further cuts to the Medicare program were looming, we reached the difficult conclusion that PFFS Medicare Advantage was not the mechanism which would allow us to do what is right for our patients. Therefore, in October of 2007, our Board of Directors announced the decision to no longer see PFFS Medicare Advantage plans after a 15 month period of notice to our seniors. Interestingly enough, during the same time we studied this decision, the product offerings of PFFS Medicare Advantage in our county ballooned from 5 to 45 plans for 2008.

Our Experience Communicating This Decision to Patients

We have approximately 1,400 Medicare Advantage PFFS patients. Knowing that this was potentially an emotional and politically charged issue, we immediately began a process of communicating this decision to three key groups, 1) our patients, 2) our doctors, and 3) our elected leaders. All patients affected received a letter and attachments explaining our decision and offering help in finding a Medicare Advantage Plan that allowed them to keep their physician. They also received a phone call and an invitation to meetings where the CEO of our group or myself could explain and answer questions about the decision.

Over 400 seniors attended these sessions. We explained the financing mechanisms we faced and the rationale behind our decision. Representatives from four major HMO / PPO Medicare Advantage plans that we contract with were also in attendance to meet with beneficiaries and answer questions. Our own analysis of these plans shows that they represent a good value in the marketplace and also allow us the funding to afford proven efforts at coordinating care and adding value.

The feedback we received was reassuring. Patients understood why we needed to make the change. They had no idea that their program, if allowed to grow unchecked, would ultimately threaten the economic health of the clinic, and make it impossible to continue to provide the best possible care to our patients. They were very surprised to learn that the program did not cover its cost.

We now are in the process of working with these patients on other Medicare Advantage alternatives. We have a customer service line established and staffed and remain willing to help patients maintain their relationship with The Everett Clinic. We also plan to continue monthly meetings with our Medicare patients hosted by our senior leadership.

A Provider Perspective on what to do with Medicare PFFS

- We would urge that Congress recognize the value added by Medicare Advantage HMO / PPO plans and maintain their funding levels. The advantages to patients that we have seen through coordinated care and involving engaged providers is significant. Expensive hospital admissions are appropriately lowered by delivering care at the right time and place, patients are satisfied with the attention they receive, and overall quality is improved. This type of delivery system offered by medical groups such as ours offers hope for the future of the Medicare program.

- Our experience suggests that PFFS Medicare Advantage plans do not add value to the patient and represent an area that Congress should scrutinize. In our locale, the high funding levels and "deeming" process allowed Medicare Advantage PFFS has attracted a plethora of plans that do not work with providers to fund efforts at coordinating disease management or compliance with needed preventive care. We support the idea of removing their "deeming " authority and requiring these plans to work with providers in a fashion that promotes care coordination and information sharing.

- Finally, it is important to recognize that the Medicare program is in need of a greater fix than just changes to Medicare Advantage PFFS. Providers in our state are penalized because their care has historically cost less because overall our utilization of services is much lower than other parts of the country. The program needs to evolve to recognize efficiency and reward it.

Thank you for the opportunity to testify on this important subject. I hope that our sharing of experience is helpful to you as you formulate important policy. The Everett Clinic stands willing to serve as a resource to the Senate Finance Committee in the future. Please do not hesitate to contact us if we can be of assistance.