TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

Statement of John Jenrette, M.D.
CEO, Sharp Community Medical Center
Chair, Governing Board and Executive Committee
California Association of Physician Groups (CAPG)

Testimony before the Health Subcommittee
House Ways and Means Committee

July 24, 2011

Thank you Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee for inviting me to testify regarding physician organization efforts to promote high quality care.

I am pleased to testify today in my capacity as Chief Executive Officer for Sharp Community Medical Group and as a physician. I have firsthand experience with many of the physician quality initiatives that I will speak to in my remarks today and look forward to sharing these insights with the Committee. By way of background, Sharp Community Medical group is the largest independent physician association in San Diego County. We have a network of more than 200 primary care physicians and more than 500 specialists, serving over 170,000 HMO, commercial accountable care organization (ACO) and Pioneer ACO patients.

I also address you today on behalf of the California Association of Physician Groups (CAPG). CAPG represents over 150 California multi-specialty medical groups and independent practice associations (IPAs). Our members serve over 15 million Californians, approximately one half of the state's insured population. Our patient base is larger than the total population of most other states. CAPG members provide comprehensive health care through coordinated, accountable, physician group practices. We strongly believe that patient-centered, coordinated, accountable care offers the highest quality, the most efficient delivery mechanism and the greatest value for patients. California physicians, including CAPG members, have operated under this accountable, budget-responsible model for over 25 years.

The current Medicare fee-for-service (FFS) payment system is unsustainable. It is also a barrier to improvements in quality. Rather than encouraging providers to achieve the highest quality, efficient care for patients, the FFS methodology incentivizes providers to offer greater

volume and intensity of services. In order to truly fix this broken system, we must look at ways to incentivize change in physician behaviors, to encourage team-based care, and to create a culture of quality. In order to take these steps, we also must ensure that physicians have organizational supports in place to accept population-based payments[1] and engage in necessary quality initiatives.

In California, physicians have vast experience with payment models that provide viable alternatives to this failed FFS system. As I will describe today, California's care delivery model includes robust quality measurement and physician involvement in quality initiatives. The population-based payment model that has been in place in California for decades, combined with robust quality reporting and public accountability provisions, and a backstop provided by state regulation of risk-bearing entities provide a model for reforming the flawed fee-for-service delivery system. We believe that our population-based payment system can serve as a model for the rest of the country, especially as health care providers around the nation adopt delivery system reforms, like accountable care organizations (ACOs).

The California Medical Group/IPA Model – Containing Costs

I will begin with a description of the payment model our medical groups operate under, which is predominant in California. Our medical groups and IPAs are paid under a population-based payment model. In this model, provider groups are paid a fixed amount for each enrolled patient for services over a span of time, most commonly per member, per month, regardless of the amount of care the patient consumes. In California, between Medicare Advantage and ACO

[1] We use the term population-based payment throughout but recognize that in the current health policy dialogue, this term can be used to embrace a variety of other concepts, such as bundled payments, partial capitation, condition-specific capitation, virtual partial capitation, and others.

pilots, 53 percent of Medicare beneficiaries are enrolled in models employing population-based payment. Note that the scope of services covered by population-based payments varies by the type of arrangement involved (e.g., commercial versus Medicare).

In California, medical groups and IPAs assume financial risk for patient care through population-based payment, and also have been delegated administrative and care management duties that would otherwise be performed by insurers. Under this "delegated model" the medical groups and IPAs assume certain responsibilities, like utilization management and chronic disease management to a group of physicians, typically a multi-specialty group practice or an IPA. Arrangements involving global payment allow the development of programs and processes that are not seen in the fee-for-service environment. These arrangements allow medical groups to provide the right care, at the right time, including addressing the environmental, social, and behavioral services that are often omitted in the fee-for-service context.

It is important to point out that these population-based payments I have just mentioned are made directly to the medical groups. Some of these groups then provide downstream payments to primary care or specialty care groups. These downstream payments may take the form of subcapitation, salary, or even some FFS payments in the event the group wants to incentivize higher utilization for a certain type of service, like preventive services. For example, a group might pay a FFS payment for childhood immunizations. The downstream payments also often include payment of incentives for physician performance and outcomes, like quality incentive payments for performance on certain measures. The population-based payment made directly to the group permits this type of flexibility – the ability to encourage the provision of the types of care and patient outcomes that lead to healthier populations at a lower cost.

The delegated model and population-based payments directly to groups enable physicians to take responsibility for certain activities, such as engaging physicians and other care team members in care management activities, promoting prevention, and coordinating care. The monthly, upfront payment of a budget for care for each patient in our population has enabled us to make strides in terms of improving outcomes for patients through initiatives that better manage patient conditions and have the effect of reducing costs in the system. Specifically, Sharp and other California physician organizations have been able to use the flexibility within their payment models to establish programs of care that have the effects of reducing unnecessary hospital admissions, reducing unnecessary emergency department visits, and caring for patients with chronic illnesses. The population-based payment methodology allows us to hold physicians responsible for outcomes and to incentivize a team-based approach that involves partnering with other health care professionals, such as case managers, pharmacists, and mid-level professionals. This team-based approach leads to better outcomes for patients and greater job satisfaction for our professionals. The current fee-for-service reimbursement system in no way encourages team-based approaches to care and this is something that should be addressed under a new payment system.

Accountable Care in California

Our experience with receiving population-based payments tied to a specific population has naturally developed into accountable care-type contracting with commercial payers and ultimately to participation in Medicare's Pioneer ACO pilot.

Recent shifts in the healthcare environment have lead to greater incentives to control costs for fee-for-service populations. As a result, more commercial payers have sought out

opportunities to contract with sophisticated physician organizations, asking these physician organizations to take accountability for specific, identified patient populations.

On the commercial side, these arrangements have been based on certain premises: (1) measuring and improving hospital utilization; (2) measuring and reducing unnecessary emergency department utilization; (3) monitoring and lowering pharmacy costs; and (4) using cost-effective settings. The overall goal of these commercial relationships is to lower the cost trend while improving patient care. The outcome for patients is that they are able to receive support services, outreach, and preventive services they have not previously received.

In December 2011, Sharp Healthcare System was selected as one of 32 Pioneer ACOs. (Five other Pioneers are also located in California). Through the Pioneer ACO model, Sharp Healthcare is working with CMS to pursue a model that enhances the engagement between patients and providers to coordinate care across all aspects of the patient's healthcare needs.

As a result of this initiative, a new group of Medicare beneficiaries is beginning to benefit from improved quality and outcomes as a result of a more efficient and coordinated approach. Initial analysis of this population shows that the Sharp ACO has 32,500 aligned patients. These patients are now beginning to receive outreach, prevention, wellness, and post-hospital discharge follow-up services they had not previously received. In addition, Sharp provides a 24-hour nurse connection hotline to serve patients involved in the Pioneer pilot. The overall care experience is more patient-centered and we believe will lead to better patient outcomes.

Through our participation in this pilot, Sharp has seen additional evidence that the fee-for-service system is failing our seniors. For example, our population analysis shows that the bed days per thousand for this fee-for-service population are 500 above what we experience with

patients covered under population-based payment systems. The average length of stay in a skilled nursing facility is 32 days for this population as compared to 13 for seniors in population-based payment systems. We see tremendous potential to reduce costs and improve care for seniors if we can transition them from the flawed fee-for-service system to coordinated care models that involve population-based payment.

California's Quality Improvement Journey

A critical aspect of the success of our care delivery model is ensuring the highest quality care to patients. In California, we have combined innovative payment modeling with a robust quality measurement infrastructure, from the individual organizational level to the state level.

Specific to our organization, Sharp uses physician report cards to measure individual physician performance. The report cards show a level of detail related to quality performance for each physician and is tailored to their specialty. The physician report card system, combined with the population-based payment methodology, allows us to tie quality to individual physician performance. The population-based payment system allows us to take this one step further - tying physician compensation to quality performance. This system has allowed us to both tailor metrics to individual physicians and use compensation-based incentives to drive the types of behaviors our organization wants to encourage. Note, however, that in terms of developing a broad-based payment system for Medicare, this type of measurement, reporting, and payment requires an organizational structure that can accept data, analyze it, and distribute results in a way that allows the physicians to be successful.

Beyond our physician report cards, Sharp also participates in a number of quality initiatives, including California's Integrated Healthcare Association (IHA) quality initiative,

Medicare Advantage 5-star quality program, Pioneer ACO quality metrics, and quality metrics associated with our commercial agreements. We also have some physician experience with Medicare Part B's Physician Quality Reporting System (PQRS). Overall, in our experience, there is some overlap among these quality initiatives and more could be done to align quality metrics, particularly for the senior population.

In California, the IHA is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability, and affordability of health care in the state and has been doing so for a number of years. The IHA evaluates physician groups based on four domains: clinical quality, coordinated diabetes care, information technology-enabled systems, and patient experience. The IHA's pay for performance programs reward physician practices and other providers with incentives based on their performance on these measures. Physician groups receiving these incentive payments are then free to distribute the payments to make further investments in coordinated, high quality care.

In recent years, health plans involved in this initiative have recommended focusing on cost in addition to quality. The IHA is currently developing a system to look at resource use and efficiency of physician practices by developing efficiency measures. We believe that this initiative will contain important lessons for payers shifting to value-based purchasing methodologies. As this program is formulated and adopted, we are happy to share additional information with the Committee.

Pay-for-performance programs, like IHA's, compliment the population-based payment model by providing necessary protections against potential incentives to stint on care. One criticism of the population-based payment model is that it incentivizes providers to withhold care

in order to maximize their payment. Quality performance programs, particularly those with financial incentives tied to performance benchmarks, can outweigh such incentives in a population-based payment model. In California we have learned that providing the right care at the right time lowers cost, while deferring treatment increases costs.

Furthermore, CAPG has instituted a Standards of Excellence Program for its member groups and IPAs. In 2006, the CAPG Board designed the SOE to annually assess and publicly report the key features and capabilities of coordinated, accountable health care organizations to bring quality and affordability to individual patients and populations. The SOE evaluates groups on four domains:

- Care management – inpatient and outpatient systems to support our physicians and patients to achieve reliable, safe, continuous, and affordable care;
- Health IT – the essential tools to offer timely decision support, consistency in preventive and chronic care, and feedback to doctors for improvement;
- Accountability and transparency – measuring and reporting our work in public, compliance with fiscal responsibility regulations in the state;
- Patient-centered care – features to accommodate individualized patient needs and preferences, embracing our responsible role in a culturally diverse community.

CAPG members are scored on a star basis and the results are publicly available on the CAPG website. Each domain consists of multiple questions with a maximum potential point score. Groups that surpass a certain, pre-determined threshold earn a star for that domain. In addition, groups receive feedback on areas where they can improve. In 2011, 26 organizations

achieved "Elite" status by surpassing thresholds on the four domains that were measured in that year. Five organizations were recognized as "Exemplary."

Finally, I would like to add that health care provider collaboration is critical factor in successful quality initiative development. Successful quality initiatives require close relationships between the primary care team, specialists, and hospitals. In addition, I believe that successful implementation of quality and alternative payment initiatives require strong physician involvement, buy-in, and leadership.

Quality Measurement and Achieving Patient-Centeredness

In addition to the quality initiatives described above, Sharp is focused on providing patient-centered care. We achieve this result through efforts at the organizational level, CAPG's Standards of Excellence, and the statewide IHA pay-for-performance initiative.

At the organizational level, Sharp has invested in a broad-based approach to measuring patient satisfaction. Under our organizational approach, each physician receives 30 to 75 surveys each quarter to measure patient satisfaction at the individual physician level. We believe that the only way to foster an honest, open dialogue about performance is to have this type of measurement within our organization. The results of these surveys are shared by name with all of our physicians and have driven quality improvement efforts within our organization.

CAPG's Standards of Excellence program contains certain elements that promote patient-centered care, such as ensuring patient access to health information and secure communications with their healthcare provider, looking at the group's capabilities to provide evening and weekend care, language interpretation services, documentation of patient complaints, surveying

and monitoring timeliness of appointments, educating patients about their role in their care, and identifying choices, risks and benefits for alternative courses of treatment.

In addition, the IHA uses a Patient Assessment Survey, which is derived from the national standard Clinician Group Patient Experience Survey, endorsed by the National Quality Forum. The IHA survey tool questions address the following areas (1) doctor-patient communication; (2) coordination of care; (3) specialty care; (4) timeliness of care and service; and (5) overall care experience. This focus on patient experience of care provides important feedback to our medical groups in terms of providing patient-centered care.

A Model for the Future

I believe that our successes are achieved in part through the flexibility that is afforded to our groups through the population-based payment model. This payment model is bolstered by strong quality initiatives and by physician leaders who constantly strive to improve the patient experience and care outcomes. I believe that a model based on the lessons learned in California can be successfully implemented throughout the country. However, I hope that the Committee will consider key factors that are necessary to protect and foster the growth of our model.

First, the Committee should continue to look for opportunities to incentivize health care teams to provide the right care at the right time, while moving away from a fee-for-service payment model. Second, I believe that the continued development of health information technology, with particular attention to standardization across systems, will be important to future development of coordinated care systems. This technology is essential to providing the foundation for data analytics that are required to successfully manage quality initiatives but more can be done to standardize these systems. Third, the Committee should continue to look for

ways to support primary care teams and their proven role in improving quality and lowering cost. Finally, we encourage the Committee to continue to support organized medicine. We believe that the types of changes that are necessary to fix the fee-for-service system can only be made through infrastructure that is built to handle population-based payments, quality data and analytics, and measuring, assessing, and acting on physician performance information. Such an approach should involve Medicare physician payments that differentiate between organizations that provide care in a more effective and cost efficient manner.

The existing legal and regulatory framework provides some opportunity for physician groups like ours to further experiment with population-based payment models, such as partial capitation and shared savings. We believe the opportunity presented is two-fold. First, it will allow us to continue to build upon the successes of our model – to develop additional interventions and care plans for vulnerable populations and further improve the delivery of care to our patient populations. Second, these programs, like accountable care organizations (ACOs), provide an opportunity for California's medical groups and IPA's to spread the lessons we have learned to other areas of the country. Through our participation in the Pioneer program we have begun shared learning activities with other Pioneers across the country. This is a first step in spreading our knowledge and simultaneously learning what is working in other areas of the country.

I would add that I believe that our country is facing a crisis in primary care. This crisis requires a focus on the academic pipeline, creating a better work environment, and paying critical attention to compensation for the entire primary care team. As Congress revisits the fee-for-service payment system, Medicare payment policy developments should ensure that fees for primary care providers are preferentially adjusted. By ensuring differential payment updates for

primary care and preventive services, we can accomplish two aims: (1) ensuring that seniors in Medicare have access to primary care and preventive services; and (2) ensuring that there is a robust primary care workforce that adopts a team-based approach in the future. This approach should involve primary care physicians and other care professionals, including care coordinators, pharmacists, and social workers, all of whom are practicing to the top of their license. Payment structures that recognize the critical role of primary care providers along with delivery system changes that focus on the role of primary care teams will lead to the development of a workforce capable of handling the challenges that lie ahead.

In addition, attention must be paid to the Medicare Advantage (MA) program. Operating within the broader context of quality and patient-centered care initiatives in California, Medicare patients who were enrolled in a plan using a population-based payment methodology had hospital utilization rates of 982.2 hospital days per 1,000 as compared to Medicare FFS patients with 1,664 hospital days per 1,000. This lower utilization rate in the population-based model has enormous potential for cost savings. Given the potential for savings and seniors' well-documented satisfaction with this program, we encourage the Committee to consider ways in which this program can provide value to seniors in the future.

Conclusion

Thank you for the opportunity to speak to the Committee today. I hope that this information has been valuable and I would be happy to provide any additional information for the Committee as you consider alternatives to the sustainable growth rate formula.