



*The Voice of Accountable Physician Groups*

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

**Before the House of Representatives Energy and Commerce Subcommittee on Health**

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Thank you Chairman Burgess, Ranking Member Green, and Members of the Health Subcommittee for inviting me to testify today. I am pleased to be here today to share with you how the move to alternative payment models is working to transform the delivery of healthcare in our country to a model that is better for patients and physicians.

I am testifying today on behalf of CAPG. CAPG is the largest association in the country representing capitated physician organizations practicing coordinated care. CAPG members include nearly 300 medical groups and independent practice associations (IPAs) in 44 states, Washington, DC and Puerto Rico. CAPG believes that APMs are essential to building a delivery system that can meet the demographic and financial challenges facing the nation. CAPG members have decades of experience with APMs, including those that are risk based or capitated, and have proven that these models of payment and care delivery can lead to lower cost, higher quality care.

I also address you today as a physician and the Chief Executive Officer of Central Ohio Primary Care (COPC). Our group consists of 370 physicians, including 200 adult primary care providers, 60 pediatricians, 75 hospitalists and 25 specialists. COPC is the largest physician-owned primary care practice in the country. Our physicians provide care to over 350,000 patients in 65 offices across central Ohio.

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Let me begin by emphasizing a single point: the value movement is working. To underscore that point, I will share COPC's own journey into APMs with traditional Medicare and Medicare Advantage (MA) plans.

### **COPC's Value Journey**

Like many primary care practices across the country, we started our movement toward value-based care delivery in the patient-centered medical home model (PCMH). At the time, we were looking for a way to organize our own physicians across different offices, in order to improve quality and access. We worked with the health plans in our local market to organize our doctors around a common set of clinical measures, bringing the clinical team together to focus on specific, aligned goals. Our local payers made a financial commitment to the model and as a result, we began to build the infrastructure that is necessary to move to risk-bearing payment models. We quickly saw that the PCMH model was both improving quality and bending the cost curve. We also recognized that PCMH was a stepping stone or building permit to move into shared savings and risk.

Based on PCMH results, we negotiated a shared savings arrangement with the health plans that would allow us to share in some of the cost savings that we were achieving for employers, patients as well as payers. We also entered a shared savings arrangement with our contracted Medicare Advantage (MA) plans for our 25,000 MA beneficiaries. To date, these arrangements have been upside only (we share in the savings but are not at risk for financial losses). In 2018, we will transition into downside risk and delegation for our Medicare Advantage lives.

As you know, in 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA). The law provided additional incentives to move into advanced APMs for our traditional Medicare population. Because of the incentives in the law and our successful

experience with APMs with other payers, we decided to move into Comprehensive Primary Care Plus (CPC+) in 2017. CPC+ is a multi-payer advanced medical home model that qualifies as an advanced APM under MACRA.

We knew that we wanted to be in the advanced APM track under MACRA and we had evaluated the model options available for our group. We believe that CPC+ would give us an opportunity to bring successful care management tools developed for our MA population to our fee-for-service population. This year we have 26,000 traditional Medicare beneficiaries and 180 physicians in CPC+. The model has several design elements that made it an attractive choice for our organization.

First, CPC+ reforms payment for our practice. Rather than relying solely on a flawed, volume-driven fee-for-service payment methodology, CPC+ combines prepaid, per-beneficiary-per-month payments with modified fee-for-service payments. We receive a care management fee calculated on a per-member-per-month basis. In addition, in CPC+, our fee-for-service payments are reduced. The withheld amount is instead paid to the group in lump sums on a quarterly basis. The pre-payment of funds allows us to invest in the infrastructure that we need to coordinate and manage care for our population. It has enabled us to bring successful care management models, like Transitions of Care (described below) to our fee-for-service population, resulting in better care at a lower cost.

Second, CPC+ uses robust performance based incentives that examine how well the practice performs on clinical quality, utilization, and patient experience. We know that performance measurement and accountability are essential in the movement from volume to value. CPC+ makes an upfront incentive payment for performance which is later reconciled against actual performance. If a participant falls below the performance standards, funds must

be repaid to the government. We believe that this is a critical element in a successful APM and will safeguard against concerns that may arise from the transition to advanced APMs.

Finally, the CPC+ program requires that its participants continue to build on the core competencies of population health management and improvement. For example, in the model, we identify and stratify our patient population. This means using data to identify the sickest patients and then tailoring our care processes and resources toward those patients. These patients often represent the most significant opportunity to improve care, reduce costs, and enhance quality. CPC+ provides the data and infrastructure for our FFS population to allow us to identify patients most in need and tailor services to those patients, to get them healthy and keep them healthy.

We are still relatively new to the CPC+ program, with this being the first year of implementation. What we already know is that this program provides the funding and payment model to allow us to bring our care management processes and tools to the FFS Medicare population.

#### **Examples of Success with APMs: COPC Transitions of Care Program**

Our Transitions of Care (TOC) nursing program is designed to create smooth transitions for patients who leave the hospital. When a COPC patient goes to the hospital, a TOC nurse will see the patient. From that point on the, TOC nurse will stay connected to that patient, through the time the patient leaves the hospital. The TOC nurse electronically schedules an appointment with the patient's primary care physician before the patient leaves the hospital. The nurse will also contact the patient 48 hours post discharge to check on the patient's health status, reconcile medications, and remind the patient about the follow up appointment. If the patient misses the appointment, the nurse will follow up with the patient and ensure the patient sees the primary care physician.

We know that this follow up appointment and the surrounding care coordination services work. The program has enabled us to keep our Medicare readmission rate to seven percent (as compared to a Medicare national average readmission rate of roughly 18 percent). The TOC program coupled with an expanded hospitalist program, care coordinators, visiting physicians and an expanded quality staff generated \$12 million in shared savings in 2016.

But, perhaps more importantly, this program has real life impact on our patients. In a fee-for-service system, a patient discharged from the hospital has little post-discharge planning. The patient may leave the hospital with instructions to call her physician, but there are few if any supports in place to ensure that visit happens. As a result, fee-for-service patients typically begin a vicious cycle of emergency room visits followed by post-discharge complications, landing the patient back in the hospital multiple times. Our TOC model, powered by the infrastructure of our APM participation, breaks this cycle.

### **The Importance of Advanced Alternative Payment Models**

COPC physicians are committed to APMs because we see what they can achieve for patients and for the healthcare system as a whole. We are working, across payer types, to move away from fee-for-service payment and ultimately, toward pre-paid, capitated models. We know that these models offer better quality for patients at a lower cost. Importantly for groups like COPC, we also know that these models will save the practice of primary care, by getting our primary care physicians off the treadmill of fee-for-service and enabling them to spend the time with patients that need the most attention and to be paid for keeping their patients healthy.

First, APMs are demonstrated to improve quality and reduce cost. A recent study by the Integrated Healthcare Association (IHA) examined the health care quality and cost across the state of California. Looking at results for 24 million patients, IHA found that:

- Capitated commercial contracts outperform fee-for-service commercial products on cost and quality. The capitated model outperformed the fee-for-service model on five of six quality measures and cost, on average, \$200 less per patient annually;
- Statewide emergency department visits, all cause readmissions, and inpatient bed days were all between 50 percent and 75 percent higher in fee-for-service than in capitated, coordinated Medicare Advantage;
- A coordinated care delivery system is a key factor in the success of capitated payment models.<sup>1</sup>

A recent study in the American Journal of Managed Care compared two physician organizations in Medicare Advantage, one where the MA plan paid its downstream physicians with fee-for-service, the second where the MA plan paid its downstream physician organization a capitated payment. The capitated group had higher quality and generated cost savings.

Specifically, the patients in the capitated (advanced APM) group had a six percent better survival rate and a 32.8 percent lower risk of dying as compared to the FFS group. The capitated group reduced emergency department visits and inpatient hospital admissions by 11.2 percent and 11.9 percent respectively. The reduction in ED visits resulted in an estimated savings of \$100,915. The reduction in inpatient admissions resulted in a savings of \$1,756,869.

In our view, these improvements to quality and patient experience flow from a payment and delivery model that encourages physicians and other care team members to focus on providing the right care for their population. In APMs, incentives are re-aligned toward team-based care, a focus on preventing illness and disease progression, and providing care in the right

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<sup>1</sup> Integrated Healthcare Association, Benchmarking California Health Care Quality and Cost Performance (2016), available at <http://www.iha.org/sites/default/files/resources/issue-brief-cost-atlas-2016.pdf>.

place at the right time. Participating in models like CPC+ brings us one step closer to this ultimate end-goal.

It is no secret that the healthcare system faces serious challenges in the years to come. Baby boomers are aging into Medicare at a rate of about 10,000 per day, seniors are living longer, and often with multiple chronic conditions. These demographic shifts necessitate a more robust primary care work force. I believe that our country is already facing a crisis in primary care and that these challenges could exacerbate the problem.

Along with other policy changes, the shift to advanced APMs can help save primary care. In a fee-for-service payment model, physicians are on a treadmill of sorts. Over the last 6-8 years programs such as PCMH, PQRS and Meaningful use have slowed the delivery of care due to increased documentation requirements. The electronic health record you have incentivized is a better record but it is much more difficult to complete a visit. Current delivery models have already curtailed volume so it is imperative we continue to move forward and pay for value. Without pay for value the only way a primary care physician can maintain their compensation is to see more patients. This can lead to burnout, frustration, and a feeling that the physician does not have time to have meaningful interactions with patients.

APMs can get our doctors off that treadmill. We pay our doctors to keep their patients healthy, we reward our physicians for their performance on quality and efficiency metrics, not the volume of services provided. The result is two-fold, they are less focused on volume, to be sure. But our physicians also see that their patients are getting the care they need and are healthier as a result. In all, we believe that APMs are key to a more satisfying, sustainable way to practice medicine. We think that APMs are one piece of the puzzle for saving primary care in this country.

### **Medicare Advantage APMs**

Clearly, MACRA's incentives for advanced APM participation have played a role in driving us into new models in advanced APMs. This is true for other CAPG members as well. We believe it is equally important to have these incentives for risk contracting (advanced APM participation) in Medicare Advantage as well. As you know, a third of all seniors are enrolled in Medicare Advantage. In some parts of the country, more than half of the senior population is enrolled in an MA plan. MA has reached a size and strength where its role in delivery system and payment reform simply cannot be ignored.

We were thrilled to see that CMS announced its intent to create an advanced APM demonstration in MA. In the MACRA final rule for 2018, the agency says that participants in such a demo can qualify as advanced APM participants for 2018 through 2024. This is a crucial step forward that will allow additional doctors to participate in advanced APMs and will also align incentives across Medicare. We thank all the Members of Congress, including those present at today's hearing who encourage CMS to move forward with this important policy change.

## **Conclusion**

Thank you for the opportunity to testify today. I hope this testimony has been helpful as you consider the status of the value movement and the role MACRA has played to accelerate delivery system transformation. I am pleased to answer any questions.