



From the Point of Care

The Experience of California Physicians in the Medicare Advantage and Traditional Medicare Programs

A Report from the

California Association of Physician Groups

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In recent months, a significant debate has unfolded regarding the value that Medicare Advantage¹ (“MA”) plans provide to Medicare beneficiaries as compared to that provided through the traditional Medicare program. Critics of MA have asserted that MA plans provide less value to beneficiaries and to the federal government based almost exclusively on economic analysis that indicate that the cost of caring for Medicare beneficiaries is greater in MA plans than in traditional Medicare.

It is the experience of more than 150 physician groups in California and the 59,000 physicians who are part of these groups that they are able to provide better health care to their patients who are in Medicare Advantage plans than those in traditional Medicare.

This report is intended to share the perspective, one that comes from the point of care, of California physician groups and their physicians regarding MA and, by doing so, to contribute to the broader MA debate.²

I. Measuring Value

An assessment of the competing “values” of MA and traditional Medicare being realized by beneficiaries and the government must not only be economic. Such a value analysis must also consider other characteristics important to today’s beneficiaries and to sustaining the Medicare program, not just in the current fiscal year, but as the program confronts the enormous challenges that will come with the aging of the post-World War II generation. These other characteristics include:

- the delivery of quality health care,
- the efficiency of the care model,
- the capability of the care system to adjust to complex problems and innovate solutions in the technical aspects of care, access, financing and administration, and
- The ability of the system to improve the future health status of the population and thereby constrain future costs.

¹ Throughout this paper, references to Medicare Advantage or MA are intended to refer to coordinated care plans and are not intended to include Private-Fee-for-Service plans or Medical Savings Accounts.

² Direct quotes of physicians and physician group leaders are interspersed to provide their real world observations.

In the current debate regarding MA's value, there has been essentially no meaningful discussion on the comparative abilities of MA and traditional Medicare with regard to these and other characteristics essential to meeting the increasingly complex needs of an rapidly expanding population of seniors with extended life expectancy.

II. From the Point of Care: A Critical Perspective that Has Not Been Considered

No group of physicians caring for Medicare beneficiaries is better able to assess the comparative clinical value of MA and traditional Medicare than physicians who care for Medicare beneficiaries through physician groups which are members of the California Association of Physician Groups ("CAPG").

CAPG, the largest physician organization in California, is comprised of more than 150 of California's leading physician groups. These groups employ and/or contract with some 59,000 physicians who in turn provide coordinated health care services to approximately 12 million Californians within the managed care model, plus several million more in other product lines, including traditional Medicare. More than fifty percent of California's healthcare is delivered by physicians employed by or contracted with CAPG members.

Last year we served a Medicare Advantage patient with multiple medical problems whose prognosis was poor. The patient and his spouse were originally unrealistic about his prognosis and care needs. The entire inpatient and outpatient care teams have been involved to utilize services appropriately and efficiently and maintain optimum quality of life for both the patient and his spouse, who is the primary caregiver. Team members and services involved include the primary care physician (PCP), multiple specialists, nurse case managers (outpatient, acute inpatient, and SNF), social worker, palliative care nurse, Expanded Care Clinic, and Home Visit Program (PCP, specialist MD and mid-level home visits). Many team meetings have been called specifically to coordinate all aspects of the complex care needed for this patient. The spouse has concluded that her husband's care needs are beyond her abilities to sustain safely in their home. The patient has transitioned from acute to skilled level to custodial level care with assistance from all of the medical group's team members. We could not have provided this complex level of coordinated care under traditional Medicare.

CAPG's members play a critical role in the delivery of Medicare services. Under the California "delegated model", MA plans contract with CAPG members to not only deliver clinical care to enrollees, but also to administer many other elements of the health care system. MA, and the Medicare managed care structures that preceded it, have been present in the California market for more than 25 years. The most mature and sophisticated MA plans are based in California. California has the greatest number, 1.4 million, and proportion, 32.8 percent, of beneficiaries enrolled in MA. In major markets such as southern California and the San Francisco Bay Area, about fifty percent of Medicare beneficiaries have chosen to receive their Medicare benefits through MA plans and from the physician groups with which those MA plans contract. CAPG members and their physicians also care for millions of Californians in the traditional Medicare program.

These realities afford CAPG's members and their physicians with a critical perspective on what it means to practice medicine and to care for patients in MA as compared to traditional Medicare. It is not a perspective that is based on statistical analysis or econometric modeling.

It is a perspective from the point of care.

CAPG's view is that of physicians and other clinicians striving to deliver the right care at the right time with the highest quality and greatest efficiency possible. It is a perspective drawn from caring for patients with complex health problems and with incomes sometimes below the poverty level. It is a perspective that comes from working within organizations built on systems of care using clinical teamwork, sophisticated information technology, constant self measurement, formalized quality improvement, and transparency of performance. It is a perspective that recognizes that health care is entering a new phase where providers and physicians will be held accountable to deliver the highest achievable quality of care at optimal levels of operational efficiency.

The most compelling benefit to Medicare managed care is the fact that care is delivered through a coordinated, structured network. The very nature of these networks focuses our attention as practitioners on quality metrics -- we are able to pay closer, more systematic attention to things like diabetes and cardiac care, as well as preventive services, because the managed-care tools we have available to us allow us to proactively reach out to patients who might otherwise "fall through the cracks." These kinds of methods are simply not available to us in the haphazard, informal delivery system of the traditional fee-for-service world.

As physicians, of course we try to do the right thing when the patient comes in to our office. We try to look through the chart and make sure all the needed things are addressed at the time of the visit. Absent the systematic prompts we get from managed-care organizations, we try the best we can to come up with flow sheets and other methods in our charts to keep track of these things. It is a daunting task. However, only through the reports and tools available to us through a managed-care network, we can address and manage whole populations, and can reach out to those patients that we wouldn't otherwise see (who need to be seen) and offer them care.

I can think of a patient, who is an elderly diabetic patient living alone, and who comes to the office when she remembers to or when she is feeling sick. Because of the lists and reports we get, we were able to see that she was past due for her lab tests, and we were able to call out to her and schedule her for care. Thank goodness we did, because her glycohemoglobin was elevated due to the fact that she forgot to renew one of her medications and it simply "dropped out of the picture." Catching this sort of thing helped prevent significant complications for her (and significant downstream costs), and deliver a better quality of health care.

It is a perspective that must be considered as federal policy makers debate the "value" of MA vs. traditional Medicare.

III. Lack of Comparative Performance Data Requires that Assessments Rely on Experience and Perspective

While the perspective of California's physician groups and their physicians is valuable in and of itself, the lack of valid, reliable and comparable data makes the groups' actual experience all the more important in this policy debate. It is simply not possible to statistically compare the care received by beneficiaries in MA as compared to traditional Medicare. For over a decade, enormous amounts of performance data have been collected on Medicare managed care plans. Only very recently, has pilot performance data has begun to be collected in traditional Medicare. Unfortunately, there are no data sets that permit true apples-to-apples comparison of how patients fare in the two different Medicare programs.

Thus, with regard to quality of care, efficiency of care, innovation, care coordination, and the use of information technologies in the health care setting, the best evidence is the observations, experience and anecdotes of those who deliver care through both settings.

IV. Assessing Value: Short Term vs. Long Term

The purpose of comparing the value of MA and traditional Medicare must not simply be to examine the performance of MA and traditional Medicare in meeting the needs of today's beneficiaries. An analysis that is only concerned with the near term cannot provide policy makers with information critical to preparing for the long term health care challenges that are rapidly approaching.

A fundamental consideration for policy makers must be the abilities of MA and traditional Medicare to meet the health care needs of Medicare beneficiaries in the coming years: the demographic tsunami now cresting as the post-World War II generation reaches the age of Medicare eligibility, the rapidly growing numbers of beneficiaries with multiple chronic illnesses, the looming health care work force shortage of primary care clinicians, the need for system flexibility and innovation to rapidly adjust to system stresses, etc.

In order to make a useful comparative value analysis, we must realistically assess the ability of MA and traditional Medicare to rapidly evolve in order to meet these long-term systemic challenges, to bring to bear technologies that lead to meaningful progress, to nimbly adapt business and care processes to regional needs, and to consistently deliver care with measurable high quality, efficiency, and accessibility.

V. Experience and Perspective of Physicians and their Groups are Indicative of MA and traditional Medicare performance

A. Disease Management and Chronic Care Improvement

The costs of chronic illness in America, measured in both human and financial terms, are staggering. As the American lifespan steadily extends, an increasing number of seniors live with multiple chronic conditions. For many chronic conditions, such as diabetes, congestive heart failure, atherosclerosis, and lung disease, modern medicine has an array of proven strategies to

minimize, delay, or entirely prevent complications. These services hold the potential to improve both comfort and productivity while reducing the huge costs of avoidable crisis interventions.

However, traditional Medicare's fee-for-service reimbursement system has been structured and providers are incentivized to deliver episodic, acute services on a hit-and-miss basis. This approach does not accommodate the care coordination needs of people with illnesses that require daily attention over years or decades. Embarrassingly, multiple studies have pointed out that many patients in traditional Medicare receive chronic care oversight in a sporadic and incomplete fashion—as much as half in the recent condemning RAND study.³

Mr. Q.S. is a 92 year old gentleman with multiple diagnoses, including congestive heart failure, history of pulmonary embolism, hypertension, ataxia and chronic gastrointestinal hemorrhage. Although he lives with his son, his son does not usually participate in his healthcare needs. The primary care doctor attempted to provide quality care to this gentleman, but unfortunately the patient was not proactive in contacting his doctor or follow-up with specialists. His preferred action was to call 911 to take him to the hospital for much of his primary care needs. Because of frequent emergency room visits and in-patient hospitalizations, we as the medical group evaluated his needs and identified him as a frail elderly at risk. Our case management team communicated with him on a regular basis to make sure his healthcare needs were being met. Our continuity of care case manager would see him in the hospital to assist with discharge planning and assure that continuity of care occurred post discharge. We placed him in our homecare program where a nurse practitioner was assigned to evaluate him at his apartment home. This entire ambulatory care was managed by our high risk program director and the case management team facilitated both in-patient and outpatient care. This included facilitating and assisting in transportation to doctor's appointments. An integral part of this team approach was communication with the primary care doctor. As a result, his primary care doctor was much more involved in the overall care of the patient, his outpatient care was better coordinated and he was no longer receiving the bulk of his ambulatory services in the emergency room. The end result is that the patient became more proactive in his healthcare and had a significant decrease in his emergency room use and in the number of hospitalizations.

Organized delivery systems serving MA beneficiaries in California have confronted this challenge by embracing the Chronic Care Model.⁴ In order for the Chronic Care Model to work, a fundamental redesign of care delivery and provider incentives must be employed, and these innovations are being actively deployed for California's MA patients.

The first challenge in caring for both individuals and populations alike is to know who needs what care and when—a simple concept, but one that cannot be realized in traditional Medicare.

³ McGlynn et al, New England Journal of Medicine, 348: 26, June 26, 2003. See also: Asch SM, McGlynn EA, Hogan MM, Hayward RA, Shekelle P, Rubenstein L, Keeseey J, Adams J, Kerr EA. Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. Ann Intern Med. 2004 Dec 21;141(12):938-45; and Asch SM, Kerr EA, Keeseey J, Adams JL, Setodji CM, Malik S, McGlynn EA. Who is at greatest risk for receiving poor-quality health care? N Engl J Med. 2006 Mar 16;354(11):1147-56.

⁴ The Chronic Care Model was originally presented by Edward H. Wagner, M.D., The Center for Health Studies, Group Health Cooperative of the Puget Sound.

Computerized, centralized registries allow California medical groups to know which patients have certain diagnoses, when their services are due, what are their lab results and personal measures, and when those results indicate the need for intervention. These systems, considered leading edge for sophisticated clinics just five years ago, are widely deployed in California physician groups, both large and small. In MA chronic care models, registries allow the medical group to deliver information to independent physician offices and to their opportunities as well as track their performance in caring for their patients.

For the sake of organized approaches, there may be 3 levels of clinical care for chronic illness:

A first level is early recognition and intervention for people at risk but who do not feel symptoms. Osteoporosis is one example where systematic approaches to identify middle aged and senior patients with this treatable problem can prevent catastrophic problems several years or even decades later. Osteoporosis screening initiatives in California medical groups are already reducing the economic and clinical consequences of spinal and hip fractures.

In the context of MA, California's physician groups are incentivized to provide anticipatory care through the continuum of life. Pneumococcal and influenza immunizations, prompted by medical groups which systematically reach out to all their candidate patients, particularly those with chronic illnesses, are a prime example of preventive care. Such proactive care is rare and inconsistent in traditional Medicare, typically depending upon patient initiative and word of mouth.

A second level of care management involves patients who have a known illness but may consider themselves temporarily relatively well. These patients all too often wait until an avoidable crisis to come to attention. California medical groups, in collaboration with MA plans, don't wait. They stratify patients into risk categories and reach out to engage these patients. An inconvenient and costly trip to a doctor's office is frequently not necessary to succeed with the questions, prompts, and supports to stay comfortable and productive. Chronically ill patients in higher risk categories receive disease management services involving regular monitoring of the patient's health status, coupled with a system which alerts providers when clinical warning signs are present. Disease management programs for people with congestive heart failure have provided exceptional value to both patients and the MA program by substantially reducing the number of avoidable emergency room visits.

A third level of care involves patients with more active and life-engulfing care. This level requires more intense interactions and a high degree of individualization, coupled with systematic supervision from an expert care manager working in conjunction with the physician. This level of care cannot "cure" advanced chronic illnesses, but it may be able to avoid threatening, painful, and costly complications.

Examples of this specialized outreach and oversight would include patients using anticoagulants, patients with frail and unstable conditions, patients entering complex phases of care with many providers, and patients approaching the end of life. These care management services are possible only in the context of the MA program and are virtually non-existent in traditional Medicare.

Living in a small trailer that he shared with his wife in a destitute area, John A. was virtually bed bound. A double amputee from his poorly controlled diabetes, his days were spent lying in a small bed with hardly a window to look out of.

I met him for the first time as he lay in a hospital bed after an ambulance had rushed him to the emergency room. He had his second amputation just a few months before at another hospital but had never been able to keep up with his follow up care. Indeed, as he was being discharged from our hospital, he assured me there was no way for him to follow up at my office as an outpatient, the same as he had done with his previous physicians.

Fortunately, he had just enrolled as a senior managed care member of my local IPA. I was able to enroll him immediately in our High Risk program. A nurse case manager coordinated visiting nurse care in his home. While I would be obligated to my patients in the office, our high risk program physician started making regular home visits to coordinate his care and follow up. All of these coordinated services would not be available if it were not for the efforts of the delegated model of Physician Associates, IPA, and John's ability to enroll in a managed care program.

We weren't able to reverse the damage of years of uncontrolled diabetes, but through coordinated care, we were able to give John a level of care otherwise not available. He received the compassionate care with dignity that I would not be able to provide on my own. He had been "managed" by a team that cares.

B. Quality Improvement and Value-based Incentives (Pay for Performance)

California medical groups in collaboration with MA plans and others have led the nation in the development of clinical performance measurement programs and economic incentives which reward high-performing providers. Under the auspices of the Integrated Healthcare Association (www.ihc.org) these efforts have set the foundation for California's annual Pay for Performance ("P4P") bonus payment system. MA plans have rewarded California medical groups achieving high standards with \$145 million in bonuses over the last three years. These bonuses have created economic incentives which have resulted in health care improvement strategies being implemented across the entire state.

California's P4P program has been widely studied by other states and the Centers for Medicare & Medicaid Services to determine which components can be exported to geographic areas where traditional Medicare payment methodologies predominate. Two characteristics seem essential to a successful P4P program: 1) medical groups need to be effectively integrated with their local provider community and 2) population-wide care improvement is the criterion for a financial reward.

The benefits of California's P4P program are demonstrable in the MA program, resulting in a new culture of measurement, public reporting, annually improving quality, an objective assessment of efficiency, and better personal experiences and clinical outcomes for MA beneficiaries. There is no comparable P4P program in traditional Medicare and, given the importance of organized systems of care and population based measures, P4P in traditional Medicare is likely to be unsuccessful in stimulating meaningful changes in practice patterns.

C. The Use of Healthcare Information Technologies to Improve and Manage Care

California's physician groups and their physicians, working with MA plans, are making better and more frequent use of healthcare information technologies ("HIT") than their traditional Medicare counter parts. The structure of the MA program in California and its reliance on physician groups and other organized systems of care, with the movement to competition and compensation based on quality and efficiency of care, has propelled the deployment and utilization of HIT.

The coordinated care inherent in the Medicare Advantage Model enables the physician to keep pace with these ever accelerating changes in the practice of medicine. Within a few days of the New England Journal of Medicine article reporting significant cardiovascular risks of a widely prescribed diabetic medication, all of our medical group's primary care physicians had the necessary information to help them determine the best course of action for their patients on the medication. The medical group intranet coupled with the electronic health record enabled the decision support team to develop physician specific patient lists of those prescribed the medication and the endocrinologists to disseminate clear and concise consensus recommendations to guide greater than 40 primary care physicians. As a result, an intelligent, coherent, uniform and expert opinion based recommendation was available to all Medicare Advantage patients in our organization. Without a well-structured medical group willing and able to invest in information technology infrastructure, this would not be possible. Without Medicare Advantage, it is unlikely that such highly coordinated medical care would continue to exist.

As a consequence of the rapid expansion of HIT utilization, California's organized systems of care now are widening the application of electronic health registries. Earlier, we described the key utility of electronic registries for the management of chronic illnesses, particularly those requiring cyclical oversight for maximum benefit. Registries are also being used to assure routine screening and preventive services such as mammography, cervical cancer screening, colorectal cancer and screening for other treatable illnesses.

Beyond registries, California's medical groups are deploying electronic health records ("EHR") well ahead of the national trend. CAPG's member groups are using EHRs widely in ways that directly benefit MA beneficiaries. The application of EHRs to the senior population has resulted in the following:

- Physicians managing multiple simultaneous conditions with complete access to the clinical information necessary for the best medical decision,
- Electronic prescribing and subsequent tracking to assure accuracy, continuity, and safety,
- Coordination of care among multiple providers with instantaneous sharing of information to support clinical decision making and to avoid redundancy, missed opportunities, and mistakes, and

- Providing patients with portable access to critical medical records when away from home.

The use of EHRs, electronic registries, electronic prescribing and other HITs is not nearly as prevalent in traditional Medicare.

D. Narrowing the Variation of Care by Delivering Evidence Based Medicine

Dr. Jack Wennberg's work has demonstrated extensive variability in the performance of tests and procedures based upon non-scientific influences of provider preference and supply-driven utilization. Beyond the obvious financial cost and the potential liability of providers who may occasionally follow non-scientific motivations, there is personal danger to patients in inappropriate and excessive care. As Dr. Wennberg has made clear, the highest utilizing areas are also the areas with the poorest clinical outcomes.

California's medical groups, working in the context of the MA program, have spent 15 years learning to avoid inappropriate utilization by focusing on scientifically justifiable clinical decisions. Physicians who are part of physician groups routinely submit clinical rationale and justification for procedures, especially those with "gray areas," clinical controversy, or complex choices. This insistence upon clinical dialogue does not replace a physician's clinical judgment, nor is it an excuse to thwart necessary care, but rather a quest to deliver the right care...at the right time...at the right place. California's medical groups review patterns of care, engage practitioners with exceptional patterns in a non-judgmental fashion, and use the power of peer engagement to identify respectful, safe, and efficient alternatives. Objective, scientific, and ethical oversight is the cornerstone of the efficient use of finite resources in a costly environment. Traditional Medicare is structurally incapable of such discipline.

This ability to scientifically direct care correctly the first time and avoid unjustifiable care, is a central trait of California's organized physician group systems, and it is a bedrock foundation for our MA plans. No fee-for-service system, including traditional Medicare, can remotely approach this level of engagement. In fact, attempts to do so typically create inflammatory reactions, consuming time and money with adversarial appeals processes and quixotic outcomes that serve neither the Medicare program nor the patient.

VI. Connecting the Dots: The Experiences of California Physicians and Physician Groups Delivering Care in MA and traditional Medicare.

California physicians who practice as part of a physician group recognize that practicing medicine in the context of Medicare Advantage permits a level of quality and efficiency that is not possible in traditional Medicare. MA encourages organized systems of care supported by EHRs, decision support tools and electronic registries effectively deliver care to the chronically ill and those in relatively good health in ways that are not possible in traditional Medicare. The assurance of access to care as a "medical home" through physician groups working with MA plans cannot be found in traditional Medicare. The systematic approaches to patients with special needs made possible by MA are not possible in traditional Medicare. Consistently high quality care and clinical efficiency increasingly differentiate MA from traditional Medicare. The ability of MA to respond to new medical challenges, the continued development of new

drugs and devices, and meeting the challenge of caring for a burgeoning population of seniors with chronically illnesses cannot be remotely equaled by traditional Medicare.

A Medicare member was referred from his PCP to pulmonology for evaluation and treatment of End Stage COPD [chronic obstructive pulmonary disease]. During the initial consultation it was determined that the member no longer desired active and aggressive treatment. The pulmonologist had access to the Medical Group's social worker, palliative care nurse, and case management team who are located on site for best coordination of care opportunities. The Social Worker met with the member and his spouse while they were still in the exam room to answer questions, begin re-defining the patient's advanced directive, and to begin the process for evaluating how continued care could best be provided. The Social Worker consulted with other members of the case management team, the PCP and the specialist. A plan was identified and implemented timely and efficiently that met the needs of the member, his spouse, and the care management team. Additional undesired services and hospitalizations were avoided and the patient's quality of life was optimized.

CAPG and its members urge Congress to carefully monitor the MA program. In doing so, Members of Congress must consider not only the economic performance of MA, it must also consider the contribution MA is making in creating systems which routinely provide superior care with optimal efficiency in an increasingly complex population.