AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

March 5, 2020

The Honorable Joaquin Arambula
Chair, the Assembly Budget Subcommittee #1 Health and Human Services
California State Capitol Room 5155
Sacramento, CA 95814

Re: **Support** of the Governor's Office of Health Care Affordability

Dear Assembly member Arambula:

America's Physician Groups is a not-for-profit, mission-driven association organized to assist accountable physician groups to improve the quality and value of healthcare provided to patients. America's Physician Groups represents and supports physician groups that assume responsibility for clinically integrated, comprehensive, and coordinated healthcare on behalf of our patients. In California, APG represents over 180 physician groups across the state. We support the Governor's proposed Office of Health Care Affordability and offer the following comments and suggestions.

The Role of the California Capitated-Delegated Model Physician Groups: Our members shared financial responsibility with payers generates better value and quality for Californians. California has led the nation in the use of capitated provider payment for the past three decades. Other states have faltered in the use of this payment model and just more recently rediscovered its value. California's managed care system has sustained the relationship between health plans and physician groups using per-member, per-month capitation, and more recently, percentage-of-premium capitation in global risk contracts between Medicare Advantage plans and Knox Keene licensed full-risk provider groups. The defining factor between our model and other states has been the addition of delegated claims payment to the provider groups by the HMOs, which is not common elsewhere. Delegation has driven greater alignment between the payer and the capitated providers to produce greater affordability coupled with better management of patient outcomes – particularly in avoidable hospitalizations and readmissions.

Performance Measurement of the Capitated-Delegated Model: The California Regional Cost and Quality Atlas has adopted the national total cost of care standard promulgated by the National Quality Forum (NQF) to compare performance of various health plans and provider delivery systems. The Atlas has reported data for measurement years 2013, 2015 and 2017, and will soon release data on 2019. In each measurement year, a single common theme pervades the data – clinical integration with risk-based provider payment outperforms all other coverage and delivery system models on cost, measured quality, and out-of-pocket exposure.

The Atlas reveals the definitive advantage of the use of the capitated-delegated model by payers over other delivery systems:[1]

- Lower total cost of care
- Lower member out of pocket costs
- Lower pharmacy costs
- Higher measured quality performance

In the California commercial HMO market our member's shared financial responsibility is estimated to control costs by more than $3 billion per year, according to a Milliman analysis published in July 2018.[2] The national insurer Humana also indicated that it saved $3.5 billion nationally in its Senior Medicare Advantage HMO by moving to value-based payments (in large part, full-risk capitation) within a short term period.[3] Humana reported a 20% reduction in medical costs. Finally, the Berkeley School of Public Health has published data indicated that California could save $110 billion over 10 years by simply increasing the use of clinically integrated delivery systems paid under risk-bearing models.[4] A subsequent analysis published in Health Affairs from these authors has further indicated:

> *We have just released a white paper which proposes an alternative path to move California towards universal coverage using a two-pronged approach: controlling high health care costs and employing novel sources of financing for universal coverage. This plan would provide health coverage to 3.55 million uninsured Californians, including low-income and undocumented persons, as well as those who receive only partial Medicaid benefits in line with the definition of insured used by the Congressional Budget Office.* ***The key element of this approach is the use of risk-based capitated care delivery models.***[5]

Other states have had trouble transitioning from fee-for-service based payment to more advanced models because of high levels of existing provider consolidation, corporate ownership of physicians, and lack of payer infrastructure to support models other than claims-based fee-for-service. California enjoys a great advantage over these other states given the existing infrastructure of capitated-delegated physician groups, and this will advance the Governor's objective for payment transformation.

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[1] https://atlas.iha.org/story/risk. Accessed online 3/4/2020.
[2] Healthcare under the Delegated Risk Model in California: Lower cost, higher quality. July 16, 2018. Milliman Healthcare Town Hall. Accessed at: : https://www.healthcaretownhall.com/?p=9535#sthash.Bqnq5dIK.dpbs.
[3] Humana: Shifting Doctors from Fee-For-Service Cut Medicare Costs 20%
[4] Berkeley Healthcare Forum: A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives. SHORTELL, Stephen and Scheffler, Richard. (2014). Accessed at: http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/A-New-Vision-for-California%E2%80%99s-Healthcare-System.pdf.
[5] California Dreamin': Integrating Health Care, Containing Costs, and Financing Universal Coverage. Scheffler, Shortell, Annand and Arnold. Health Affairs Blog, February 8, 2019. Accessed at: https://www.healthaffairs.org/do/10.1377/hblog20190207.806149/full/. Whitepaper accessed at: http://petris.org/wp-content/uploads/2019/02/California-Dreamin_White-Paper_Feb-8-min.pdf

Accelerating the Transition from Fee-For-Service to Advanced Payment Models: We suggest these areas of focus for the new Office leadership to advance the transition away from fee-for-service provider payment:

- Reverse the 10-year trend away from capitated payment in the employer-sponsored coverage sector by transparently measuring the use of non-ffs provider payment by all payers in the state[6]
- Adopt the existing infrastructure of the California Regional Cost & Quality Atlas which currently reports total cost of care for 30 million Californians to speed the development of the OSHPD all-payer claims database
- Expand the public reporting and ranking of plans and providers under the Atlas
- Adopt policies that encourage payers to build the internal infrastructure necessary to operate using capitated provider payment rather than claims-based fee-for-service
- Adopt policies that publicly measure and report provider acceptance of non-ffs payment models against total revenue sources
- Advance the use of the IHA Symphony provider registry by all payers and providers in order to develop a true, accurate online multi-payer provider directory available to the public
- Adopt the findings of the DMHC-sponsored workgroup on encounter data reporting improvement
- Require all employers to offer at least one high-performing coverage option to employees during open enrollment, based on Atlas performance data, and transition toward more first-dollar coverage plans and away from lower-performing high-deductible plans
- Fund a statewide consumer education effort on total cost of care measurement, out-of-pocket exposure comparisons, coverage options, and high-performing provider networks
- Expand the reporting and use of the Align-Measure-Perform (AMP) system that is currently available on the Office of the Patient Advocate's website
- Enable the use of capitated provider payment in the self-funded employer and union trust fund payer sector (6 million+ lives) through reform of the Knox Keene Act.

Accelerate the Use of Telehealth Among Provider Networks to Increase Access: We suggest that the Office leadership can ensure the increased access to providers, increase competition among plans and providers, and decrease system cost by adopting policies that require the increased offering of telehealth and eConsult systems across California:

- Modify the current network adequacy standards and directory reporting standards to give credit to provider networks that include eConsult and telehealth access to patients and require public reporting of such capabilities in provider directories

[6] https://www.chcf.org/publication/as-commercial-capitation-sinks-can-californias-physician-organizations-stay-afloat/. Accessed online 3/4/2020: "California is seeing the decline of capitation — fixed prepayment for care of a defined population — particularly for commercial health insurance products."

- Adopt policies that encourage payers to create incentives for clinically integrated provider networks to build the internal infrastructure necessary to offer such access

Standardization of Regulation, Measurement of Performance, and Administrative Simplification: We suggest that the Office leadership consider the following initiatives to decrease system costs, increase efficiency, and improve transparency of performance:

- Commission a study of Insurance Code, Knox Keene Act and California Medi-Cal regulations and managed care contracting standards to determine where uniformity and conflict exist, and pursue harmonization of standards that apply to plans and providers
- Adopt joint auditing standards and processes between DMHC and DHCS in California Medi-Cal for the oversight of plans and delegated providers
- Encourage health plans and other payers to adopt common electronic infrastructure for use by contracted providers, such as the IHA Symphony provider registry. There are too many idiosyncratic portals, processes and formats for organized providers to cope with and the fragmentation results in poor reporting, administrative waste and roadblocks to standardized performance measurement. APG has suggested additional electronic infrastructure in the areas of claims payment reconciliation, encounter data reporting, and performance measurement metrics.

Conclusion: APG appreciates the opportunity presented by a strategic approach to statewide health system oversight presented by the Governor's proposal for an Office of Health Care Affordability. We look forward to supporting and assisting in the development of this initiative.

Sincerely,

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Please respond to wbarcellona@apg.org.

cc: Members of the Assembly Budget Subcommittee #1 Health and Human Services
Andrea Margolis, Consultant to the Assembly Budget Subcommittee #1
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