

STATEMENT BY DARRYL CARDOZA

Roundtable on Medicare Physician Payment Policy: Lessons from the Private Sector

**United States Senate Committee on Finance
June 14, 2012**

Darryl Cardoza
Chief Executive Officer
Hill Physicians Medical Group
San Ramon, CA 94583-0980
925-327-6710

ABOUT HILL PHYSICIANS

Chairman Baucus, Ranking Member Hatch, and members of the Finance Committee. Thank you for the opportunity to participate in this roundtable to discuss Medicare physician payment reform – it is a privilege and an honor. I believe this issue is an important ingredient to the financial solvency of Medicare and I commend the Committee in its efforts to hear from all stakeholders in the public and private sectors.

My name is Darryl Cardoza and I am the Chief Executive Officer of Hill Physicians Medical Group (“Hill Physicians”). Hill Physicians was formed in 1983 and is now one of the nation’s largest independent physician associations (IPAs). We have more than 3,500 participating primary care physicians and specialists across Northern California, serving 300,000 patients.

Hill Physicians’ organization is based on the “delegated model” framework, which has had good success in California. Under the delegated model, a health plan contracts with physician organizations on a capitated basis and delegates responsibilities to these organizations to arrange for the medical care of the plan’s enrollees. A delegated physician organization generally accepts responsibility for all physician services provided to enrollees that select the physician group for their physician services. Operating under this model, Hill Physicians’ services go beyond simply providing medical care. We use our organizational infrastructure to enable and encourage care coordination, credential physicians, ensure appropriateness in the provision of clinical services, drive quality improvement, and manage risk associated with population-based payments. Hill Physicians is responsible for paying its affiliated physicians for the services provided to patients assigned to us by the health plans. I will discuss below some payment innovations we use to encourage physicians to optimize value for the people we serve by providing quality services, while striving to improve affordability .

Hill Physicians has been committed to developing and operating a coordinated care model as the key to achieving an efficient, high quality health care delivery system. Hill Physicians has been operating under this principle and implementing a model to support this vision since its inception. As such, we believe that we serve as a good, real-world example of how an accountable care organization can achieve the goals of the Affordable Care Act.

Hill Physicians can be described as a “virtual physician organization,” in that we have organized a large number of independent, self- employed physicians into a single, accountable organization that is able to provide a specified scope of services for a specified price. Most of the physician practices that constitute our group are comprised of less than six physicians. In a country in which most physician practices are small and provide only a narrow scope of services, our organization creates an environment that enables integration and care management across a wide spectrum of services and providers so that the whole is greater than

the sum of its parts. Hill Physicians thus allows individual, small physician practices to be a part of a broad system of coordinated care.

Hill Physicians' organizational and management infrastructure has allowed it to be a nationally recognized leader in clinical quality, technological adoption, and the development of innovative healthcare delivery approaches such as Accountable Care Organizations (ACOs). Hill Physicians was among the initial organizers and proponents of the "Pay for Performance" program developed by the Integrated Healthcare Association in California and has consistently been rated as among the top performing medical groups in California by independent oversight organizations. In 2009, Hill Physicians became the physician organization component of an ACO to serve 40,000 members of CalPERS in the Sacramento area. This nationally watched program, a collaboration with Dignity Health hospitals and Blue Shield of California, reduced costs during the first year of operation by \$20 million. Those cost reductions have been sustained and even increased in years two and three, as the program continues.

PHYSICIAN COMPENSATION MODELS

As noted above, Hill Physicians receives a capitated per-member, per-month payment from health plans and is responsible for paying each participating provider. This has allowed us to use innovative physician payment models to reduce practice variability, improve quality and moderate escalation of costs. Hill Physicians' compensation plan for our physician network is primarily fee-for-service based, but with some material innovations as outlined below:

Primary Care Compensation

Hill Physicians pays primary care physicians using a hybrid model of fee-for-service and performance based compensation. The fee-for-service component encourages physician access and availability for our patients. The fee-for-service rate is lower than the Medicare fee schedule and less than what is generally regarded to be required to sustain a viable practice. However, this rate is supplemented by a quarterly primary care management fee ("PMF") that results in our network physicians being paid at an average rate that is considerably higher than Medicare. The amount of this fee earned varies based on individual practice performance. Performance metrics are established for quality of care, using industry standard, evidence-based measures, such as HEDIS measures, and for utilization performance, using measures based on services provided in the practice, referrals to specialists, use of diagnostic services, E.R. usage, and inpatient utilization. Additionally, physicians are evaluated based on their participation in activities that support care coordination and the Hill Physicians organization and infrastructure as a whole, including regular meeting attendance to review data, use of our e-solutions to foster communication and coordination of care, and continuing education.

A minimum of 200 Hill Physicians patients must receive care from a primary care physician to qualify for performance measurement and compensation. This helps to address concerns related to random statistical variation in results and the statistical credibility of the measures. The patient population is risk adjusted using industry-standard external software. Appropriate stop loss protections are in place to protect practices from uncontrollable factors. The program has worked well to encourage high quality and efficient care in our primary care network, and reduce practice variability, and sustain the viability of primary care practice.

Specialty Capitation:

While our specialists are generally paid on a fee-for-service basis, in our Sacramento region we have implemented a system of specialty capitation for selected specialties. We have contracted with certain group practices to make them our exclusive provider for their specialty. These practices are paid on a capitated, per-member, per-month basis. We monitor their practice patterns and include performance measures in our agreement with them. This system has worked well in this market.

Specialty Case Rate:

Two years ago, we developed a case rate pilot program in which our largest medical oncology practice volunteered to participate. Whereas capitated payment arrangements establish payments based on a population (i.e., on a per-member, per-month basis), a case rate typically reflects a set amount paid for a defined episode of care or set of services. In our oncology case rate program, payments are based on nine distinct “cohorts,” or cancer diagnosis groups. For example, the three most common cohorts are breast, lung, and colon cancers. A predetermined amount is paid to participating providers for each patient over a 36-month period. Case rate payments for each cohort mirror anticipated costs as they are incurred by participating providers for the total care provided to each cancer patient. Currently, approximately 50% of our oncology services are provided through this program.

The program has succeeded in maintaining quality, which is measured using certain American Society of Clinical Oncology metrics, while moderating the escalating cost trend for use of chemotherapy drugs. We are pleased with its results thus far, as are the oncology practices working with us in it. As we gain experience, we intend to expand our case rate program to other specialties in the future.

KEY STRENGTHS AND CHALLENGES

Our model has been successful for us, our physicians, our contracting health plans, our patients, and we believe the health care system overall. While we believe our model can provide benefits elsewhere, it is important to note that it may require some adaptation to work in a

different environment. I want to thus discuss some of the attributes of our model that have been the foundation of our success. As the Medicare program experiments with population and value-based payment models, it may be helpful to consider how these attributes are reflected or treated in a given model.

Infrastructure

A key component of Hill Physicians' ability to manage and foster high value care is our organizational framework and infrastructure, which is a distinguishing characteristic of the successful delegated model in California. The acceptance of population-based payments requires the use of sophisticated management, technology, intelligent use of data and interactive clinical-level communications, as well as a broad patient base, in order to effectively coordinate care, align incentives, and manage risk. Hill Physicians' infrastructure brings these resources and innovations to bear to create an enabling environment that encourages physician engagement and organization –an essential condition to creating an integrated and high value experience for patients.

Small Providers

While providing coordinated care requires a broad range of providers, small, independent practices can still contribute significantly to coordinated care efforts. The organizational structure of Hill Physicians allows small practices to participate in a larger, coordinated care system. As noted above, most of our practices have fewer than six physicians.

Network

Holding a network of providers accountable for the cost and quality of patient care becomes less viable to the extent that patients choose to seek care from outside of the network. Thus, there are significant challenges in developing a structure that enables providers to be accountable while also preserving the availability of unrestricted patient choice models such as broad network PPOs. Appropriate incentives need to be in place to encourage patients to stay within a given network while preserving their ability to have reasonable choices for where to get their care. We have been leaders in working with our health plan partners to determine the most effective methods for striking a balance.

Provider engagement

While our organization infrastructure provides significant support, Hill Physicians is driven by physicians, and physician engagement with our management support structure is key to our success. Physicians should be free to focus on doing what they do best – practicing medicine. To encourage physician engagement, we establish financial incentives for participation in care

management activities and maintain various outreach programs to educate physicians about their performance within the network. For instance, every primary care provider receives a quarterly report that details their performance relative to their peers. Our medical directors and staff hold numerous individualized and group meetings with physicians to review the data and discuss their performance and ways to improve.

CONCLUSION

Medicare is seeking to make greater use of population and value-based payment structures. There is something to be learned from the private sector and organizations like ours in understanding the conditions and investment in organization and infrastructure required for these models to succeed. Medicare Advantage is a well-established population-based payment model and we see value in efforts to explore the expansion of population-based payments to traditional fee-for-service Medicare.

However, across all these models, our experience is that certain variables need to be in place. Most importantly, organizing care on a population or value-based payment method requires significant infrastructure and technical expertise. Additionally, population and value-based care requires a strong network of providers who are engaged in the network. The goal of organizations like ours is to provide the necessary infrastructure and expertise upon which these models are built.

Again, I'm most appreciative for the opportunity to appear before you today, and I look forward to participating in the discussion today and in the future.

Thank you very much.