The Role of California Covered

Testimony of:
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For an informational hearing on:
Improving Outcomes through the Patient Centered Medical Home

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Chairman Pan, members of the California State Assembly Committee on Health, thank you for this convening this critically important and timely informational hearing. I appreciate the opportunity to testify before your committee on the Role that Covered California, the State's PPACA Health Benefits Exchange, in improving health outcomes and reducing the staggering burden of health cost inflation.

I'm Mark Blum, Managing Director of The America's Agenda: Healthcare Education Fund and convener of H.E.A.R.T, the "Health Exchange Advocacy and Responsibility Team." HEART is a statewide alliance of organizations representing millions of Californians from diverse backgrounds and sectors. Our member organizations include businesses, labor unions, patient groups, health providers (hospitals, physician groups, and allied health professionals), health plans, and payers. HEART members are united by a common commitment to the goals of optimizing patient outcomes, reducing growth in health care costs, and driving continuous improvement in the quality of care. We believe that a properly designed or "smart" California Health Benefits Exchange is an unprecedented opportunity to achieve these goals.

Structured Competition in the California Exchange

The design of California's Health Benefits Exchange amounts to creation, from scratch, of a new marketplace for individual and small group health insurance coverage. It is an enormous challenge and an historic opportunity to structure competition between insurance plans that can result in outcomes that lower, rather than raise health costs and drive continuous innovation in care delivery that improve the value and quality of care.

Health markets, including health insurance markets, do not have the fundamental attributes of a truly competitive market place. For a variety of reasons, imperfect competition in health care – or the complete absence of competition when some of the most important healthcare consumption decisions are made – leads to perverse economic outcomes like continuously rising health costs and insurance competition focused on risk selection, rather the kind of competition based on price or quality that would be expected in other markets. The predominant fee-for-service reimbursement system incents care providers to maximize the volume of medical services they provide, rather than incenting provision of the right care, at the right time, or in the most cost-effective setting.

There are no villains in this story. Just economic actors responding to financial incentives in the current health care marketplace. And health plans passing the rapidly rising costs on to Californians who pay the premiums.

If Covered California takes a pass on the historic opportunity that exists, right now, to structure competition in the State Exchange marketplace so that it can drive improvement in patient health outcomes and reign in increases in cost, then health care costs can only be expected to continue to rise at rates up to 4 times faster than

Californians' wages, as they have over the past decade. In this case, health insurance premiums would not remain affordable for Exchange beneficiaries, even with the income-based Premium Tax Credits, or subsidies, provided by the PPACA. In this scenario, sadly, the Covered California health insurance expansion will be short-lived.

On the other hand, if Covered California adopts the kind of structured competitive marketplace we call "smart" exchange design, there is a significant prospect that California Health Benefits Exchange Board (HBEX) will set in motion a virtuous cycle of aligned transformations in other California public programs, as well as in private sector commercial plans. This benefit of this kind of transformation will extend well beyond Covered California enrollees. It will benefit all Californians.

"Smart" structuring of the California Exchange marketplace is not particularly complex. The HEART member organizations have identified 3 principles of "smart" exchange design that, if applied, will harness the transformative power of competition among qualified California health plans to optimize patient outcomes, reduce growth in health care costs, and drive continuous improvement in the quality of care.

1) Robust competition among health plans – Robust competition over price and quality of care is critically important to containing growth in the cost of health insurance and to incenting innovation in cost reduction and quality improvement. To help ensure robust competition, Covered California should encourage participation by every California health plan that meets criteria and standards set by the Exchange Board. Waiting periods and other barriers to entry by qualified health plan innovators should be minimized.

2) Consumer access to transparent, accurate, meaningful, and easily comparable data on medical outcomes and costs - Such information allows consumers to compare cost and quality as the basis for making informed choices between health plans and the care delivery options (including medical homes) that each health plan offers.

3) An expeditious and realistic timetable should be adopted for every participating health plan and insurance carrier to offer all its exchange beneficiaries the option of "Team-based" or "medical home" care. – This will ensure robust competition in delivery of "Team-based" or "medical home" care.

   We define team-based care as follows: A primary care practice model that enables a family physician or other qualified provider, working in an ongoing relationship with the patient and in concert with a multi-disciplinary team, to coordinate and deliver high quality health care across all settings (i.e. primary care, specialists, hospital, home).

Why is Team-based or Medical Home Care essential?

A compelling body of evidence has demonstrated that Team-based care delivery models – that is, the PCMH and similar advanced primary care models -- offer the greatest potential for reducing growth in health care costs and driving continuous improvement in quality of care[1] -- key goals of the Covered California. *Based on the evidence, we believe robust competition between health plans over innovation in delivery of Team-based care is vitally important to the success of the State Exchange.*

Moreover, the evidence shows this requirement would not be financially onerous for health plans. To the contrary, studies of team–based care delivery in thousands of diverse practice settings, have found generally positive net savings and relatively quick returns on investment in team-based care.[2]

No single care delivery model can be expected to flourish in every market environment or geographic region. HEART recognizes that a variety of team-based models, including the Patient-Centered Medical Home, share common functional characteristics that make them successful in reducing care costs and improving health outcomes. Variations in organizational structure enable each of these Team-based or Medical Home models to strengthen prevention and management of chronic disease that account for a full 75% of overall health care spending.[3] Team-based care models that generate outcomes comparable to the PCMH share the following attributes:

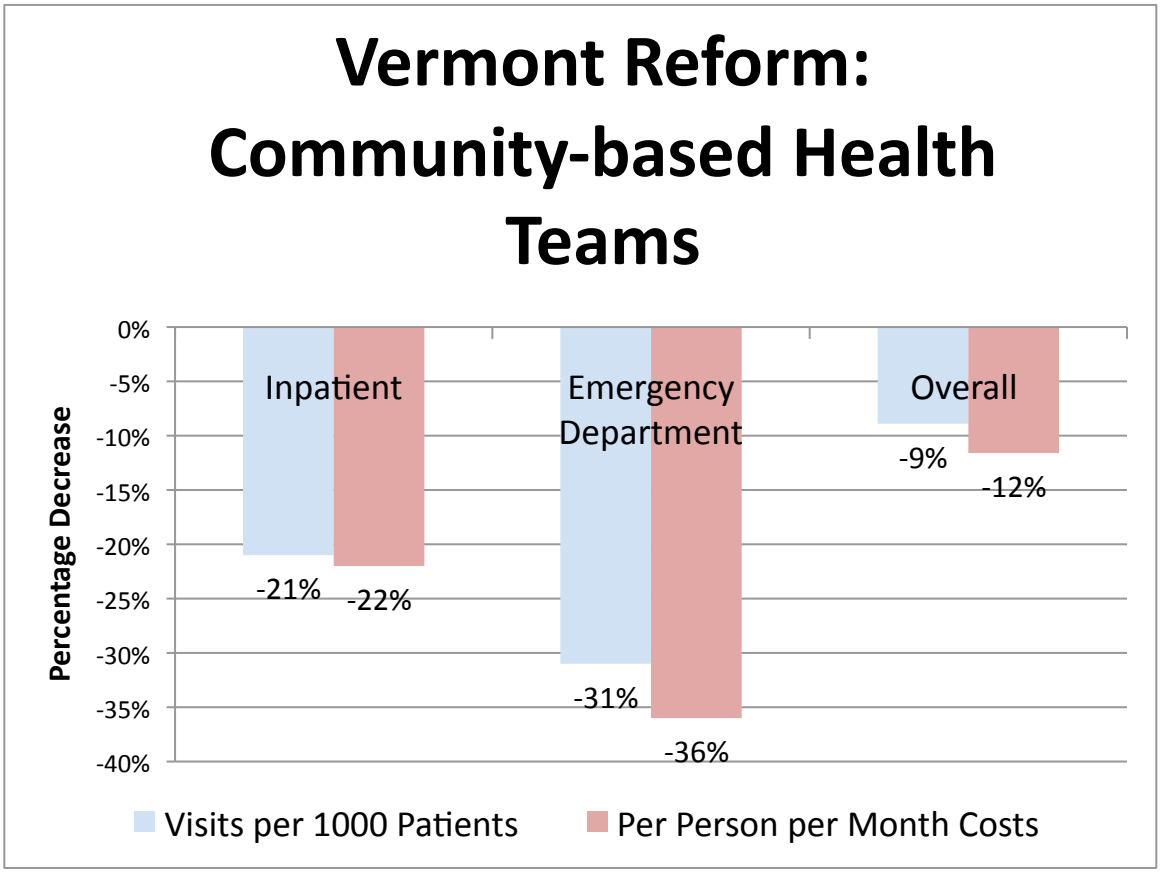
- a personal physician who takes overall responsibility for coordinating or delivering patient care across all care settings
- whole person orientation
- coordinated and integrated care
- safe and high-quality care through evidence-informed medicine
- appropriate use of health information technology
- emphasis on continuous quality improvements
- expanded access to care
- payment that recognizes added value from additional components of patient-centered care.

While we endorse recognition of a variety of Team-based or Medical Home models that have these characteristics, including the PCMH, we believe it is important for the Exchange Board to define clear criteria for recognition of team-based or medical home practices. In recent years, the term "Medical Home" has been used quite loosely as a marketing tool to describe practices that don't share the attributes that make team-based care models successful. Without clearly-defined Board standards for Medical Home recognition, self-identification of medical homes will not be particularly useful.

Below are two models of team-based care that have demonstrated impressive success in reducing overall costs of care while improving health outcomes:

Community Health Teams (CHT): SEC. 3502. of the Affordable Care Act directs the Secretary of HHS to establish a program with eligible entities to establish community-based interdisciplinary, professional teams (referred to as ''health teams''): "Such teams may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants." The community health team establishes contractual agreements with primary care providers to provide support services that enable them to function like patient-centered medical homes.

Community-based health teams were at the foundation of Vermont's Blueprint for Health Law (2006). Establishment of the Community-based health teams began in 2009. Data on the following graph demonstrates the success of the community-based health teams in delivering the right care, at the right time, in the right place, and at the lowest cost:



Direct Primary Care Medical Home (DPCMH): Rather than relying on physician management of a team of allied health professionals to coordinate patient care, the DPCMH reduces physician patient panel sizes to enable the physician more time to

develop a personal relationship with the patient and to participate more fully in delivering and coordinating the patients care. In the typical DPCMH office visit is 30-60 minutes, supplemented with scheduled phone visits, and e-communications. Like the PCMH, the DPCMH has extended and weekend hours and DPCMH physicians assume personal responsibility for coordinating care throughout all care settings. The direct practice model operates on the premises that productive physician-patient relationships take time to develop and that savings are garnered through physician effectiveness in motivating healthy changes in patient behavior that reduce patient demand for utilization of downstream services. DPCMH payments are typically based on a fixed per-member-per-month fees for comprehensive primary care services.

One of the most advanced DPCMH models is Qliance, a medical home model adapted particularly for scaling clusters of integrated primary care clinics in metropolitan areas. The graph below depicts reductions in unnecessary downstream (specialist and hospital) utilization for 2011 in Qliance's Seattle, WA group of 5 clinics:

Qliance

Direct Primary Care Medical Home:
Reduced Utilization of Unnecessary Downstream Medical Services

Type of Referral	Qliance # per year/ 1000*	Benchmark**	Difference	Savings PMPY***
ER Visits	73	158	-53%	$84
Hospitalizations (days)	155	184	-16%	$102
Specialist Visits	850	2000	-58%	$345
Advanced Radiology	273	800	-66%	$1054
Surgeries	28	124	-77%	$960
Primary Care Visits	4411	1847	139%	($818)
Savings PMPY	---	---	---	$1727

* Based on best available internal data, may not capture all non-primary care claims.
** Based on regional benchmarks from Ingenix and other sources.
*** Based on average costs in WA State.

Source: Qliance Medical Group insured patients under 65, 2011 (n=3011)

Qliance

2

Dr. Arnold Milstein, director of the Stanford Clinical Excellence Research Center, observes that the DPCMH practice model frees physicians to spend more time with their patients, particularly important for care of patients with chronic diseases. According to Dr Milstein, the DPCMH "tends to be more satisfying for the patient and much more satisfying [than conventional fee-for-service practice] for conscientious primary care physicians."[4]

Implementation by Covered California

To its credit, the California Exchange Board has identified Care Delivery Transformation as one its strategic objectives. Our recommendations have been well received, by and large, in discussion with senior Staff and Members of the Exchange Board (HBEX).

The HBEX solicitation for Qualified Health Plan applicants included several questions regarding the capacity of health plan applicants to provide medical home delivery and coordination of care, although the solicitation did not include a clear definition of what it considers a medical home to be. HEART has been invited to advise the Board staff on its response to application, with a view toward strengthening health plan proposals to offer medical home care.

This interest in promoting team-based care is encouraging. We recognize the enormous challenge the Exchange Board and its staff faces in getting Covered California online and operational by January 1, 2014. The clock is ticking. But the questions remains to be answered: Will Covered California require participating health plans to offer beneficiaries the choice of Team-based or Medical Home care on the exchange by some specified time in the future?

If the answer is "yes," Covered California stands to fulfill its promise to transform the delivery of health care and make high quality health care affordable for all Californians.

If the answer is "no," Covered California may be on time only to launch a new market for the same old insurance products, but an historic opportunity will have be lost.

Strong Demand for Team-based Care Among Exchange-Eligible Californians

I will close with encouraging evidence of powerful demand among prospective Covered California beneficiaries for new models of team-based care. Two separate public opinion polls have revealed strong interest in having a choice of team-based care among low-income and exchange-eligible Californians:

A poll of Californians below 200% of the federal poverty level commissioned by the Blue Shield of California Foundation[5] last summer found:

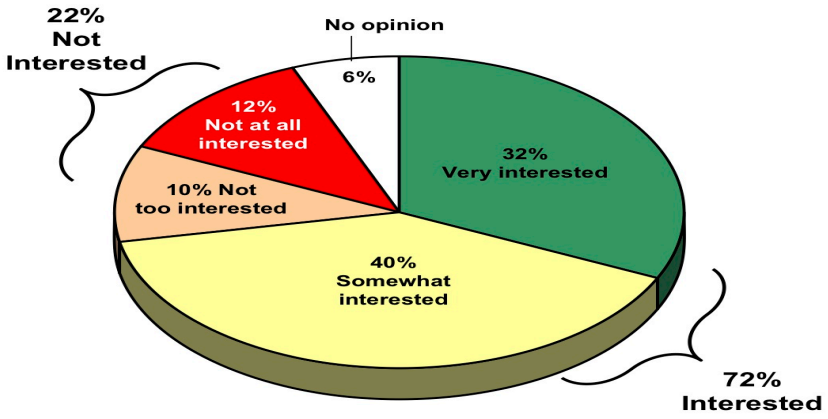
> Low-income patients want their care to be provided by a doctor, but they are very open-minded to other options, especially a team-care model. Among low-income Californians who do not have team-based care now, 81 percent say they'd be willing to try it. Among those who currently have a care team, a nearly unanimous 94 percent like it.

This finding resonates with the findings of a Field Poll commissioned by America's Agenda and HEART in March 2012[6] that showed nearly three in four California voters

(72%) are interested in making health plans available based on a physician-led personal health team approach to care:

Table 1a

High level of voter interest in having insurance companies make available health plan options based on a physician-led personal health team approach

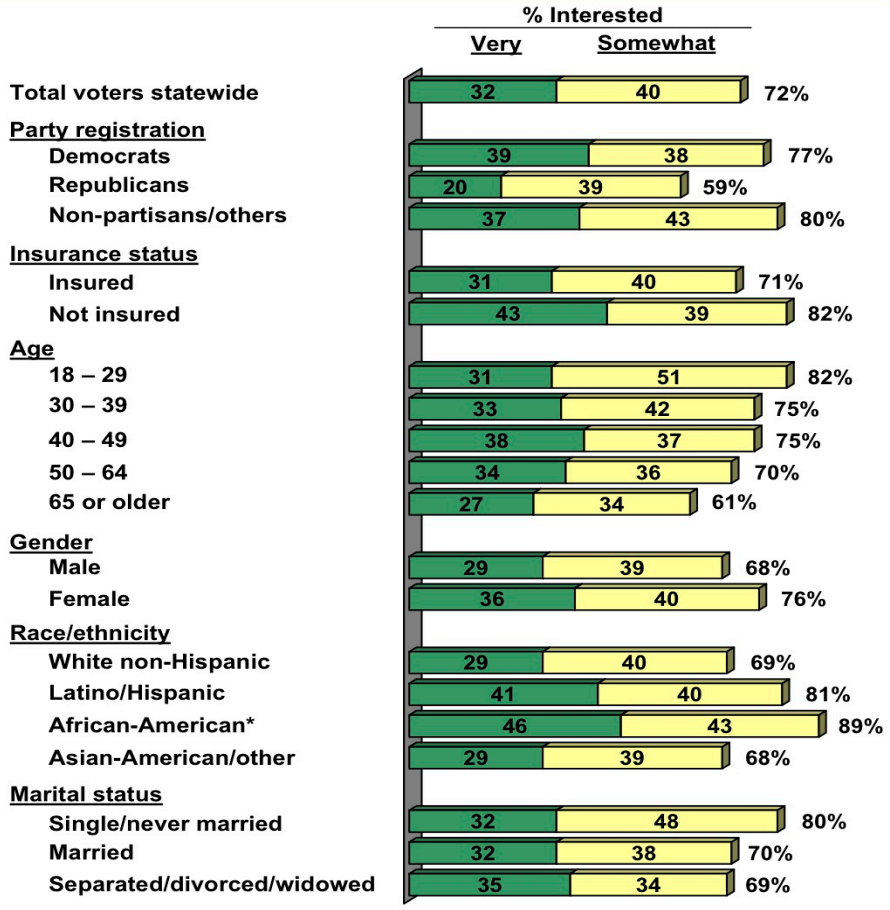


Even more interesting, the poll showed that attraction of personal health teams was most intense among the states key target audiences for coverage expansion:

See next page…

Table 1b

Greatest interest among many of the state's key target audiences for coverage expansion (i.e., the young, non-white ethnic voters, singles and the uninsured)



** Small sample base.*

Field Research Corporation 4

Some have expressed concerns that requiring health plans to provide medical home care may discourage the health plans from participating in the Exchange.

The opinion research tells a different story. Two independent public opinion polls tells us there is significant untapped demand for team-based care, *and* this demand is especially strong among Exchange- eligible Californians . If the State assures that team-based care choices are offered on the Exchange, California-Covered consumers will choose it.

And health plans will chose to participate in the State Exchange, too, to fulfill the demand for team-based care.

Covered California has an enormously important role to play in the transformation of California health care delivery. If the State seizes its the opportunity to adopt a "smart" exchange marketplace, now, all Californians stand to benefit from lower costs and continuous improvement in the quality of their care.

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[1] Gilfillan RJ, Tomcavage J, Rosenthal MB, et al. Value and the medical home: effects of transformed primary care. Am J Manag Care. 2010 Aug;16(8):607-614.

[2] Grumbach, K, Grundy, P., Outcomes of implementing patient centered medical home interventions: a review of the evidence from prospective evaluation studies in the United States. Patient-Centered Primary Care Collaborative. 2010 Nov 16. Available at: http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf

[3] Center for Disease Control and Prevention, "Chronic Disease Prevention and Promotion, Updated August 12, 2012. Available at: http://www.cdc.gov/chronicdisease/index.htm

[4] Dr. Arnold Milstein, director of the Stanford Clinical Excellence Research Center, "'Direct Primary Care' A New Option For The Uninsured," interview on *All Things Considered*, NPR, May 30, 2012, 3 PM. Available at: http://www.npr.org/2012/05/30/154012196/direct-primary-care-a-new-option-for-the-uninsured

[5] Blue Shield of California Foundation, "New Research: Low-Income Californians Ready for New Models for Their Health Care," July 9, 2012. Available at: http://www.blueshieldcafoundation.org/news/archives/20120706/new-research-low-income-californians-ready-new-models-their-health-care

[6] Healthcare Exchange Advocacy and Responsibility Team, *California Voter Views about Health Plan Choices, Personal Health Teams, and Design of the California Health Insurance Exchange*, March 2012. Available at: http://heartca.org/downloads/heart_report_amended_3-20-12.pdf