The Voice of Accountable Physician Groups

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Building
Washington, DC 20510

The Honorable Johnny Isakson
131 Russell Building
Washington, DC 20510

The Honorable Mark Warner
475 Russell Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner,

On behalf of CAPG, I appreciate the opportunity to provide recommendations on legislative options for improving patient care for seniors with chronic conditions. CAPG is the largest professional association in the country representing physician organizations practicing capitated, coordinated care. CAPG members include over 190 multi-specialty groups and independent practice associations in 38 states, Washington, D.C. and Puerto Rico. CAPG represents a proven model of care that delivers patient-centered, coordinated and accountable care at the lowest cost with the highest quality.

The CAPG member model – prepaid capitation with clinical accountability and robust quality performance standards – is uniquely well suited to bring better care to the chronically ill. The payment model promotes an investment in the healthcare infrastructure needed to identify, treat, and prevent chronic disease. For patients with multiple chronic conditions, our coordinated delivery model is particularly essential.

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It works as follows. CAPG members are prospectively assigned a patient population and are paid a per-member, per-month amount to care for that population. CAPG members use robust health information technology tools to examine the characteristics of the patient population. Risk stratification requires the support of a strong technology backbone for physician organizations, along with disease registries that track the population. Strong, accurate clinical data supports the group's ability to identify and manage the population. Using this information, the population is divided into groups based on the degree and severity of illness.

Patient groups are then matched to appropriate care programs depending on the level and acuity of illness. For example, a patient with multiple chronic conditions and complex care needs might be assigned to a high risk clinic program. In the high risk clinic, treatment far beyond that available in a typical primary care office is provided. These clinics provide access to a social worker, pharmacist, behavioral support, and other community resources to care for the whole person. Information from the specialty clinics is shared with primary care physicians, specialists and family/caregivers, as appropriate. These programs are proven to be highly successful, and typically show a dramatic reduction in hospital utilization and a reduction in emergency department visits.

Specific examples of the interventions our members have made to improve patient health include:

New West Physicians (CO) Lowering Preventable Readmissions	Sharp (CA) Pursuing Optimal Primary Care and Prevention
New West Physicians put in place a Transitions of Care (TOC) program to reduce preventable readmissions for Medicare seniors. The TOC program assigns responsibilities to inpatient case managers, hospitalists, and mid-level providers to assess the patient's needs at discharge. Patients are evaluated on key metrics of their risk for a readmission and the transition out of the hospital and next steps for the patient's healthcare are carefully planned, implemented, and monitored. The Results: ▪ Medicare readmission rate of 6.6% (as compared to national Medicare 30 day all cause readmission rate of 18%)	Sharp has created an Advanced Primary Care (APC) Initiative to focus on prevention and on optimal care for certain chronic conditions. The APC assembles and empowers a care team to act on specific primary care goals, focusing on prevention, wellness, and treatment of chronic conditions. The Results: ▪ 10% increase in diabetes optimal care ▪ 23% increase in colorectal cancer screening ▪ 14% increase in glaucoma screenings
GEMCare (Bakersfield, CA) **Patient Centered Medical Home**	**WellMed (TX, FL)** **Palliative Care Program**
GEMCare created a primary care medical home to meet the comprehensive care needs of the 5% of patients that contributed to 55% of the cost of care. On average, these patients had 4-5 complex medical conditions. Today, these patients have access to a multidisciplinary care team. The care team includes doctors, pharmacists, nurse practitioners, health educators and social workers. The team works together to meet the patient's comprehensive care needs. The Results: ▪ 37% reduction in hospital admissions ▪ 31% reduction in readmissions ▪ 26% reduction in ER visits ▪ $2200 saved per year per person	WellMed created a palliative care program in 2013 to provide an extra layer of support for patients facing life limiting conditions. Our multi-disciplinary team collaborates with the patient's primary care physician to provide both in-clinic and in-home support to improve a patient and caregiver's quality of life. Our goals are to improve quality of life through comprehensive symptom management and ongoing treatments that are aligned with a patient's wishes. By bringing the care to the patient, we aim to decrease unnecessary trips to the emergency room and seamlessly transition patients to hospice when appropriate. **The Results:** • Decreased ER visits by 50% each quarter in 2014 • Decreased hospitalizations by 50% each quarter in 2014 • Average length of stay in hospice 110 days (national average 18 days) • Advanced care completion at 93% • Decreased PM/PM by 50% for patients in the home visiting program

Prepaid capitation is essential to providing the up-front payment to build this infrastructure to care for chronically ill patients. With this investment and alignment of incentives, we believe that this higher quality care model can be deployed across the country.

Our recommendations to ensure the availability of this delivery model are provided below in the answers to the Committee's questions.

1. **Improvements to Medicare Advantage for patients living with multiple chronic conditions.**

Recommendation: incentivize the use of alternative payment models (APMs) in Medicare Advantage (MA) in the same way that APMs are incentivized in Traditional Medicare.

CAPG agrees with Congress that value-based delivery models are required to provide high quality healthcare for Medicare beneficiaries. Specifically, upside and downside financial risk, including pre-paid capitation, paired with clinical accountability and robust quality measurement create the strongest incentives to improve population health. We have seen this play out in terms of improved outcomes, better rates of preventive services, and lower readmissions rates in MA as compared to fee-for-service (FFS).

To move to a better delivery model in Medicare, we believe that incentives must be aligned across all payers and particularly across Medicare: Traditional Medicare and MA. That is why we urge you to adopt a parallel incentive structure for APMs in MA to those incentives in Traditional Medicare.

It is well known that in MA, CMS makes a capitated payment to a health plan. It is less well known that the health plan then pays the downstream providers along a continuum: some plans pay physicians fee-for-service, some have ACO-like contracts, and some plans pay global capitation to downstream physician groups. While capitated payment models exist in MA today, their prevalence can be drastically increased with appropriate incentives to do so. Aligning the downstream payment to providers improves healthcare for seniors. Therefore, we believe that the same incentives to improve care delivery and health outcomes for Traditional Medicare must exist for the nearly 16 million seniors in Medicare Advantage.

CAPG encourages the Senate Finance Committee to create a level playing field for physicians and beneficiaries by making available a 5% bonus for physicians and physician groups participating in APMs in Medicare Advantage. Specifically, MACRA makes

available a 5% bonus payment for physicians and physician groups participating in APMs in Traditional Medicare. For the first two years, physician groups that have 25% of their Part B revenue in an APM receive a 5% bonus on 100% of their Part B claims. In later years, the threshold increases to 50% and then to 75%, the 5% bonus continues from 2019 to 2024.

Consistent with this framework, a 5% bonus should be made available to physician groups that have at least 25% of their MA contracts in two-sided risk bearing models, including capitation. The revenue threshold to qualify for the 5% bonus should increase over time to 50% and 75%, parallel to the incentive structure in Traditional Medicare.

Similar to the requirement in MACRA that APMs report MIPS-like quality measures, physician groups should be required to continue to report applicable 5 Star rating measures. Currently the vast majority of the 5 star quality measures program depends on the quality provided by the physician group, with a smaller fraction of the measures relying solely on health plan performance.

The 5% incentive should be paid to the physician group to allow the physician group to further invest in the type of clinical practice improvements that create better care for Medicare beneficiaries, in particular the chronically ill. Payment to the physician group will allow the type of investment in the delivery system infrastructure Congress and the Administration seek to create.

Recommendation: no further coding intensity reductions should be made to the MA program.

Because the most advanced alternative payment models, including prepaid capitation, exist only in Medicare Advantage today, Congress should take great care to protect this program from additional cuts that unfairly impact capitated medical groups. One area that we believe requires greater attention in this regard is coding intensity.

For background, federal law requires that the Centers for Medicare & Medicaid Services (CMS) apply a coding intensity adjustment that reduces MA payments. The adjustment is intended to account for differences in disease coding practices between MA and Traditional Medicare.

However, analysis of the difference in coding between MA and Traditional Medicare has failed to look at the underlying causes of the differences between the two programs. In Traditional Medicare, with the exception of inpatient claims, FFS claim diagnosis data are not verified. Thus, the FFS data tend to be both inaccurate and incomplete. In contrast, in MA, health plans (and by extension downstream physicians) are required to

submit verified diagnosis data that can be supported by the medical record. The criticism is that the more accurate MA data yield higher risk scores than the CMS model would produce for the same patients were they still in FFS Medicare. However, the comparison is one of apples to oranges due to the different incentives across the two programs and high levels of inaccuracy in the Traditional Medicare program.

Coding in Medicare Advantage serves two important purposes. First, coding is a signal to the care team about the relative health and wellness or sickness of a patient. As part of the Medicare Advantage payment system, physicians use disease coding to signal to the care team that a patient has a chronic condition and/or progressive disease. The team can then work to prevent the progression of this disease.

Second, coding serves as a signal to the payer (CMS and then the health plan) that the patient requires additional resources to prevent the progression of a chronic disease or to improve the health status of a patient. Health plans in Medicare Advantage receive greater payments for sick patients and lesser payment for healthy patients as a function of "risk adjustment." Physician coding of patient illness signals to the payer the resources needed to treat this patient. Thus, the payment model in Medicare Advantage creates incentives for physicians to accurately code their patients' health.

Accurate coding is an essential part of identifying, treating and preventing the progression of disease in Medicare Advantage. Disease diagnosis and detection are critical ways MA is able to improve outcomes as compared to traditional Medicare. Punishing providers for the accurate detection and coding of disease in their populations by further cutting the program is the wrong direction for the future of high quality coordinated care.

The Affordable Care Act established a mandatory minimum adjustment beginning in 2014. Subsequent legislation increased the minimum adjustment. Current law gives CMS the authority to go above the minimum amount. To date, CMS has adhered to the statutory minimum adjustment.

Year	Minimum Coding Intensity Adjustment	Rate Notice Impact
2014	4.91%	-1.5%
2015	5.16%	-0.25%
2016	5.41%	-0.25%
2017	5.66%	TBD
2018 and beyond	5.90%	TBD

Over the past several years, pressure has been mounting to increase the coding intensity adjustment. This would result in a shortsighted cut to MA plans, which would be passed through directly to capitated providers and jeopardizes high quality care for seniors, particularly those that are chronically ill.

We recommend that the workgroup consider legislation to hold the coding intensity adjustment at current statutory levels. That is to say that the existing coding intensity cuts would take effect but that any additional coding intensity cuts would require an act of Congress and could not be unilaterally implemented by CMS. We believe that this is an important protection for capitated providers in Medicare Advantage and the beneficiaries that we treat. It also affords a more robust debate, discussion and evidence about coding practices rather than swift action by CMS through the rate notice process.

Recommendation: Congress should improve the CMS Medicare Advantage Risk Adjustment model to better account for patients with chronic conditions.

Appropriate risk adjustment represents a critical component of overall accuracy of payment in Medicare Advantage and is a driver of high quality care for seniors, particularly the chronically ill. We continue to believe that CMS is misusing the risk adjustment system to achieve an overall policy/political goal of cutting Medicare Advantage. This is not the proper purpose of risk adjustment and represents a critical, underlying flaw in the CMS 2014 HCC risk adjustment model (which the agency will fully implement in CY 2016). As an example, the CMS 2014 HCC model eliminates certain codes related to chronic kidney disease, diabetes and dementia.

As one example, CMS has removed chronic kidney disease (CKD) stages 1-3 from the CMS 2014 HCC model. CKD is progressive and while its progression can be slowed, the disease cannot be reversed. Removing the codes for early stage CKD is disruptive to clinical management of the disease. In essence, removing the HCC removes the incentives for coding. As described above, that code provides an important signal to the care team that this patient has a progressive condition that requires attention in order to slow disease progression. Eliminating both the signal and the resources to slow disease progression undermines the high quality coordinated care that our patients have come to expect. It further leads to the chance that patients with these types of conditions will progress to greater levels of illness before their conditions can be appropriately managed. In essence, the new model will increase advanced chronic disease rather than slow or stop it.

CAPG encourages the Senate workgroup to partner with physicians and particularly capitated physician groups to better understand how risk adjustment changes impact patient care and what improvements to the risk adjustment model could be made to facilitate better care for chronically ill Medicare seniors.

2. **Transformative policies that improve outcomes for patents living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models currently underway at CMS, or by proposing new APM structures.**

Earlier this year, Congress enacted and the President signed into law the Medicare Access and CHIP Reauthorization Act (MACRA). Beginning in 2019, MACRA includes a 5% incentive payment for physicians and physician groups that take financial risk in Traditional Medicare. Physicians must have a certain percentage of their revenue in a risk-bearing financial model and the revenue threshold increases over time.

CAPG believes that Medicare Accountable Care Organizations (ACOS) including the Medicare Shared Savings Program (MSSP), Pioneer ACO program, and Next Generation ACO program, will be the main ways that a physician group can qualify for this incentive to take on financial risk.

On the one hand, we believe that CMS has made substantial progress in pursuing and advancing the Medicare ACO program. Over 400 organizations are participating in the available Medicare ACO structures. CAPG has long viewed the ACO program as the on-ramp to greater levels of financial risk and clinical accountability. The potential of the ACO program is to advance physicians and physician groups into greater levels of risk, including capitated arrangements, with all of the many care coordination improvements that flow to beneficiaries. CMS recently announced a Final Rule governing the Shared Savings Program that we believe goes a long way toward securing the pathway to financial risk. The rule allows organizations a second contract cycle in upside only financial models (a total of six years without any liability for financial losses for ACOs). The rule then makes the risk-bearing ACO options more attractive, by giving the ACO the choice of its own minimum savings and minimum loss rate, making prospective assignment available for organizations that take risk, and exploring the waiver of certain Medicare rules for organizations that take financial risk. At nearly the same time, CMS announced that it would be testing a capitated ACO through the Next Generation ACO model run through the CMS Innovation Center. All of this is substantial progress and we believe sets up the ACO program to flow directly into the MACRA incentive program in terms of the timing of taking financial risk (for example, an 2013 start date ACO would engage in upside only risk arrangements from 2013-2018 and would begin taking

financial risk in 2019, the same year the 5% incentive begins for risk-bearing organizations). The ACO program appears to be on a path forward toward greater levels of financial risk).

On the other hand, we have seen with our own members' experience that quality improvement and cost savings are possible in the ACO program, and yet performance in both areas falls short of what is possible in fully capitated arrangements in Medicare Advantage. Therefore, we believe that Congress should continue to focus on two areas: improving the existing ACO program and building a fully capitated delivery model with appropriate quality incentives in Traditional Medicare.

Recommendation: Improve Medicare ACO program to better drive high quality care and the evolution to risk-based contracts

We recommend that the Committee pursue the following improvements to the Medicare ACO program.

Align Quality, Benchmarking, and Risk Adjustment in Medicare ACO Program with the MA Program

CAPG believes that revisions to the ACO program should be made with an eye toward greater alignment with the Medicare Advantage program. In Medicare Advantage, physician groups contract with plans for capitated payments or other risk-based payment models. As the ACO program continues to develop, there could be meaningful comparisons between risk-based provider contracts in Medicare Advantage and risk-based provider contracts in Medicare Part B. Over time, we believe that beneficiaries should be able to elect the best option for their individual circumstance – fee-for-service, Medicare Advantage or an ACO. Ideally, a beneficiary would be able to judge the available options based on the value presented by each option.

Building the foundation for these meaningful comparisons will require revisions to the ACO program in three areas: benchmarks, risk adjustment, and quality measures. We would like to emphasize the importance of aligning quality measures for physician organizations across ACOs and physician groups receiving capitation or risk-based payments in Medicare Advantage. We believe there is a significant opportunity to create alignment between the ACO quality measures and the 5 Star Rating Program measures that apply to physician groups in Medicare Advantage. In addition, the agency should work toward reporting these measures consistently for beneficiaries, using Physician Compare.

Maintain Strong Incentives for Two-Sided Risk Arrangements

CAPG believes that the incentives for organizations to take two-sided risk need to be very strong. Earlier this year, CMS had proposed four waivers of existing fee-for-service payment rules for ACOs that elected to participate in certain risk-bearing ACO arrangements: (1) waiver of the SNF 3-day rule; (2) waiver of restrictions on telehealth services; (3) waiver of the homebound requirement for home health services; and (4) waiver of restrictions on ACOs specifying post-acute care providers for certain ACO beneficiaries. In its recent Final Rule, CMS announced that it would make the SNF 3-day waiver available for Track 3 (risk-bearing) ACOs. Other waivers will be studied and may eventually be adopted in later years.

We encourage further exploration of all of these waivers and how they can be more timely implemented for risk-bearing ACOs. We caution that all waiver opportunities should be considered in light of achieving parity in flexibility for risk-bearing physician groups in MA and ACOs. That is to say that payment rules that are lifted or improved upon in Traditional Medicare for ACOs should also be lifted and improved upon for capitated physician groups in MA.

Benchmarking in the ACO Program

Benchmarking remains one of the largest potential barriers to continuing ACO participation. The benchmarking methodology has proven a barrier to success for ACOs, even for those organizations with a long, established track record of success in coordinated care and population management. CMS has not yet fully addressed major benchmarking methodology complaints from the ACO community.

CMS recently indicated that it would release a proposal on benchmarking later this summer. We encourage the workgroup to carefully monitor benchmarking developments and to work with industry to ensure that concerns are being addressed.

Modifying beneficiary cost sharing and other incentive opportunities

A number of ACO stakeholders, including CAPG members, have repeatedly cited the issues of beneficiary engagement and “stickiness” to the ACO network as a major barrier to success in the program. CAPG member ACOs see a tremendous amount of leakage of their ACO beneficiaries – that is to say that many ACO beneficiaries are receiving care outside of the ACO network.

We recommend that ACOs in two-sided risk models be permitted to use financial and/or other incentives to encourage beneficiaries to see providers affiliated with the

ACO. This may include lower cost sharing for visits within the ACO as compared to visits outside of the ACO. Legislation introduced in the House of Representatives last Congress (H.R. 5558, the ACO Improvement Act) would have allowed ACOs the additional flexibility to design incentive programs for beneficiaries, subject to the approval of the Secretary of HHS. We encourage the workgroup to consider making these tools available to ACOs in the future.

Recommendation: create a new, capitated APM structure called the Third Option.

As discussed above, we believe that Congress should pursue additional options to qualify for the APM track established in MACRA. CAPG has developed the below Third Option design, intended to afford another risk-based option for providing coordinated care to seniors. The Third Option provides an alternative to fee-for-service without enrolling in Medicare Advantage.

Clinically Integrated Organizations

Under our proposed Third Option, CMS would contract directly with clinically integrated organizations ("CIOs"). CIOs may be existing physician organizations or newly formed entities.

The CIO would be explicitly physician group centric. However, other providers could take ownership stakes, or could accept a measure of risk and accountability through affiliation agreements. This could include a broad spectrum of health care providers, including physicians, hospitals, nursing homes, home health organizations and other entities wishing to be accountable for the delivery of coordinated care to a defined population across the continuum of care. The CIOs would feature team-based care, led by primary care physicians and supported by other primary care providers operating at the top of their licenses (e.g., nurse practitioners, physicians' assistants, pharmacist, social workers).

Active Beneficiary Enrollment

Beneficiaries could enroll in a CIO at any time throughout the year. Beneficiaries would have a choice among traditional fee-for-service Medicare, Medicare Advantage, and a CIO. When the beneficiary elects the CIO, the beneficiary would also elect a primary care physician associated with the CIO. The beneficiary would then commit to receiving services in the CIO model for one year. Experience has taught us that active, intentional enrollment by an engaged and informed beneficiary is vastly superior to the retrospective attribution models that CMS has experimented with in the MSSP and Pioneer ACO programs.

By allowing enrollment throughout the year, this program would permit CIOs to efficiently employ their own sales staffs. This will enhance the accountability of the organization to its beneficiaries, from the point of sale onward.

To facilitate the election of the Third Option, quality and service information about available CIOs would be made available to the beneficiary. This CIO level information would be developed by stakeholders, including physicians, approved by CMS, and then disseminated by both CMS and the CIO to allow consumers to make fully informed choices about their care. Beneficiaries would be empowered with information regarding the package of services available under each of the three models, including any additional care management programs or benefits.

Benefits

The Third Option would cover the standard Medicare Part A and Part B benefits. CIOs would have the option to work with a Medicare drug plan to offer Part D benefits as well, but CIOs would not be required to offer pharmacy benefits. If the CIO did not offer Part D benefits, such benefits would continue to exist alongside the Third Option.

Premium

In the Third Option, the Part B premium would be reduced for beneficiaries that (1) select the Third Option for a fixed one year period; and (2) actively select a primary care physician within the CIO who will be charged with coordinating all aspects of the enrollee's care. The percentage to be waived is to be determined with the aim of providing sufficient incentive for beneficiaries to select our proposed Third Option while at the same time providing sufficient funding for the program. This partial waiver of premium, coupled with the provisions relating to Medicare Supplemental insurance below, should make the Third Option an attractive alternative for seniors.

Beneficiary Alignment

As with Original Medicare, beneficiaries would be free to access services from any Medicare contracted physician. However, to incentivize beneficiaries to access care in-network as directed by their chosen primary care physician, services rendered by out-of-network providers would be subject to higher out of pocket costs. Prior authorization for certain high cost services would be required. The higher cost-sharing for use of services outside the CIO is designed to achieve the twin goals of allowing freedom of choice but incentivizing the efficiencies and higher quality that can be obtained by consistently accessing a highly organized, financially aligned, and electronically connected network of team-based providers. To encourage beneficiaries to seek needed

care, including preventive care services, beneficiaries would not need to pay a deductible and would have no copayments for preventive services. To provide beneficiaries with additional incentives to access service in-network, Medicare supplemental insurance policies sold to CIO beneficiaries would be required to provide coverage for in-network services only. Beneficiaries would remain free to access services out-of-network, but would do so without the benefit of supplemental insurance coverage.

Payment to CIOs

Using regional historical Part A and Part B cost information, CMS would each year establish an actuarially sound, risk adjusted, global capitation payment to be made to the CIO for the entire population assigned to the CIO through the beneficiary selection process described above. CIOs would be free to accept these cap rates, or elect not to enter into a contract with CMS. The capitation amount would be published in advance, to allow CIOs to decide whether to continue participation, and to permit an orderly transfer of beneficiaries to other options if the CIO found that the proposed capitation was inadequate.

CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B fee-for-service payments for those beneficiaries, thus creating the alignment and incentives to produce lower cost trend and higher quality than experienced in the past. The CIO would be responsible for the payment for all professional and hospital services, whether provided in-network or out of network.

In addition to base capitation, CIOs would be eligible to receive incentive payments for meeting certain quality targets much as Medicare Advantage organizations do in the Medicare Advantage 5 Stars program. Importantly, the incentives would be paid to the CIO organization, not to individual physicians or health plan intermediaries. This will foster alignment of incentives with high performing physicians within the CIO.

Administration and Operations

Rather than building expensive health plan infrastructure and capacity, CMS would, at its expense, contract with one or more highly capable Affiliated Service Organizations ("ASOs") to administer the eligibility and enrollment process, make the global capitation payments, receive encounter data from the CIOs, operate the quality and incentive bonus program, and conduct all other functions necessary to operate the Third Option. In particular, the ASO will be necessary to handle the complexities associated with administering differential cost sharing for the out-of-network benefit. CMS may elect to contract with one or more national insurance carriers with the existing infrastructure

and systems necessary to rapidly implement this program at scale. The expectation is that the use of national health plans in this ASO, non-risk bearing capacity will result in lower cost for these services than currently experienced within Medicare Advantage. This ASO model will mimic the use of an ASO by self-insured employers in the commercial context.

Quality and Efficiency Measurement

To ensure that the CIOs have a strong business case for the delivery of high quality care, CIOs would be required to maintain a pay-for-excellence program to incent their downstream providers to deliver high quality care. The compensation payable to providers under these programs would be paid by the CIO from the global capitation it receives, and would not be deducted or withheld from the capitation paid by CMS to the CIO. Under this program, incentive compensation of as much as 15% of total provider compensation will be tied to high performance on quality measures, a model which has been demonstrated to successfully drive provider behavior. Individual CIO performance would be publicly reported. Quality measures would be developed, tested, and rolled out consistent with accepted practices. These measures would apply and be reported at the level of the CIO, rather than individual provider level.

CIO performance on these quality measures would be publicly reported so that beneficiaries will be able to make informed decisions during enrollment. These measures should be the same as, or align closely with, measures in Medicare Advantage Stars program and Original Medicare so that beneficiaries can readily compare the three options.

Organization Eligibility

CIOs that wish to participate in the Third Option must be credentialed and certified by an independent third party organization. We believe that the criteria for certification should include: (1) ability to accept and distribute globally capitated, population-based payments; (2) care management processes; (3) health information technology; (4) patient centered care; (5) primary care team-based approach; (6) physician leadership; and (7) meeting state licensing requirements and solvency standards.

3. **Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions**

In recent years, CMS and Congress have worked to incorporate additional codes in the Physician Fee Schedule that incentivize primary care, particularly for beneficiaries with chronic conditions. Most recently, CMS through the regulatory process and Congress

through the legislative process adopted codes creating payment for care management services furnished to Medicare beneficiaries with two or more chronic conditions.

CAPG supports the movement in fee-for-service to focus on primary care, care management, and care coordination, particularly for the most vulnerable Medicare beneficiaries. In general, we support the direction of driving fee-for-service reimbursement toward prevention of disease, slowing the progression of chronic diseases, and coordinating services of the chronically ill. We encourage the committee to consider these types of improvements for those physicians and patients that remain in the Traditional Medicare program.

4. **Effective use, coordination, and cost of prescription drugs;**

Encouraging and proliferating the adoption of capitated, coordinated care delivered through multi-specialty physician organizations can improve the use, coordination, and cost of prescription drugs. Many of our CAPG members use robust internal quality performance programs to encourage the use of appropriate generics. In addition, organized physician practices are the best suited to employ appropriate measures to use high cost specialty drugs.

5. **Ideas to effectively use or improve the use of telehealth and remote monitoring technology**

Recommendation: Congress should expand access to telehealth services by including the telehealth benefit as part of the basic benefit package in Medicare Advantage and through the use of waivers for risk-bearing ACOs.

CMS is proposing to waive certain restrictions on coverage of telehealth services in the ACO program. CMS states in the Proposed Rule that it would likely waive the originating site requirements that limit telehealth payment to services furnished within specific types of geographic areas or demonstration sites. CAPG supports the expanded use and coverage of telehealth technologies in the ACO program. Telehealth has tremendous potential to improve care and has been successfully deployed by physician groups to the great satisfaction and convenience of our patients. Telehealth technology is increasingly being used by our members to supplement face-to-face interactions between physicians and their patients. We support the agency's proposal to waive limiting requirements for two-sided risk ACOs.

CMS has often stated in the context of Medicare Advantage that the agency is confined to the statutory parameters for telehealth services covered by fee-for-service Medicare for purposes of the basic benefit package. As a result of this limitation, in Medicare

Advantage, plans use their rebate dollars to cover telehealth as a supplemental benefit. CAPG has encouraged CMS to consider ways that it can include a broader array of telehealth technologies in the basic benefit package. We encourage Congress to allow MA plans to include broader telehealth technologies in the basic benefit package (rather than as a supplemental benefit).

7. **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers**

We believe this is an area of significant opportunity for the workgroup to substantially improve care for seniors with chronic conditions. Today, the majority of Medicare patients have at least one chronic conditions and many Medicare beneficiaries have multiple chronic conditions. Medicare beneficiaries are living longer than they did when the program was enacted, their conditions are more complex, and the available technology and innovations have expanded exponentially over the past 50 years. And these issues are widely expected to continue to grow as baby boomers age into the Medicare program.

The complexities of treating today's Medicare beneficiary require a better model – one that is coordinated, integrated, and aligned toward treating all of a patient's needs. Beneficiaries should be both empowered to choose their care providers and incentivized to engage with their selected care team. The empowerment piece requires getting beneficiaries accurate, useful information and comparisons of their physicians across all components of Medicare – fee-for-service, ACOs, and Medicare Advantage.

The second piece relates to beneficiary incentives to engage with a defined care team. We believe that this is essential to improving the quality of care for beneficiaries with chronic conditions. Without a care team that is communicating all aspects of a patient's care, there is too much risk for error, lack of communication, and a continuation of fragmented and wasteful healthcare utilization and spending. To truly control the cost of care and provide a better quality experience, we believe that the Committee must consider ways to incentivize patients to seek care within defined teams. This effort is already underway in the commercial market as well – defining high quality teams of providers and incentivizing patients to seek care from those sources.

Specifically in the ACO context, a number of ACO stakeholders, including CAPG members, have repeatedly cited the issues of beneficiary engagement and "stickiness" to the ACO network as a major barrier to success in the program. CAPG member ACOs see a tremendous amount of leakage of their ACO beneficiaries – that is to say that many ACO beneficiaries are receiving care outside of the ACO network.

We understand that CMS is committed to upholding the fee-for-service nature of the program and allowing beneficiaries to maintain free choice of providers. Therefore, to balance these two concerns, we recommend that CMS work to develop a proposal that allows ACOs in two-sided risk models to use financial and/or other incentives to encourage beneficiaries to see providers affiliated with the ACO. This may include lower cost sharing for visits within the ACO as compared to visits outside of the ACO. In addition, legislation introduced in the House of Representatives last Congress (H.R. 5558, the ACO Improvement Act) would have allowed ACOs the additional flexibility to design incentive programs for beneficiaries, subject to the approval of the Secretary of HHS. We encourage the agency to use its regulatory authority to begin to test such a model as soon as possible.

8. **Ways to more effectively use primary care providers and care coordination teams to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.**

Successful care coordination requires the creation and deployment of advanced primary care teams. We believe that the primary care infrastructure is one essential element of a high functioning delivery system that prevents and slows the progression of chronic disease.

CAPG has developed a survey tool that sets out the attributes required for sophisticated healthcare systems to deliver accountable, value-based care. The survey, the Standards of Excellence™ (SOE), describes the elements of a successful advanced primary care practice. For example, the advanced primary care domain of the survey examines the primary care practice's integration of chronic illness and preventive medicine prompts to primary care providers; how the primary care offices communicate with other care professionals; and whether the organization provides a central case manager for patients with complex care needs. We encourage the Committee to consider how these attributes can be further incentivized to build the primary care infrastructure for coordinated care.

In addition, we believe that the workgroup has an opportunity to hear from and showcase high functioning primary care practices. A number of CAPG members have started on a journey to transform their primary care practices to improve clinical quality and health outcomes. We believe that the Committee has a unique opportunity to learn more about this journey toward a higher value delivery system and to share the successes and challenges of this transformation with the rest of the country. CAPG would be pleased to serve as a resource by connecting the Committee to our member physician organizations who can share these experiences.

Conclusion

We appreciate the opportunity to provide comments to the Committee. We are pleased to answer any questions you may have.

Sincerely,

DONALD H. CRANE
President & CEO