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June 22, 2015

The Honorable Orrin G. Hatch  
Chairman  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
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The Honorable Johnny Isakson  
Committee on Finance  
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The Honorable Mark Warner  
Committee on Finance  
475 Russell Senate Office Building  
Washington, DC 20510

Dear Chairman Hatch:

Thank you for the opportunity to offer recommendations to the Senate Finance Committee Chronic Care Workgroup to discuss policies that support caring for the chronically ill. The American Medical Group Association (AMGA) represents multi-specialty medical groups and integrated delivery systems whose groups have already made the investments in people and infrastructure to manage this population of patients. While each medical group develops processes unique to its patients and communities, they share similar attributes including: multi-disciplinary care teams; electronic medical records (EMR) and analytics capability, and dedicated care managers who coordinate the patient’s care.

Given the long history medical groups have in developing care management processes, we believe their experience in the “real world” will provide valuable feedback to the Committee as it creates policies to incent population health management.

AMGA’s reply is divided into four sections: Section 1 describes current care management processes that are designed to treat the chronically ill; Section 2 details current impediments to treating the chronically ill; Section 3 provides recommendations for the financial and operational tools necessary to support the care for this vulnerable population; and Section 4 concludes the letter and briefly summarizes our recommendations.

**Care Management Processes**

Information Technology

Managing a population of patients, particularly those with chronic illness, is at the core of care process redesign. Care management lowers costs, improves the delivery of care, increases patient engagement and satisfaction, and shifts care settings from the inpatient to the ambulatory setting and in some cases to the home. Effective care management processes begin with an ability to identify and risk stratify patients with multiple chronic conditions. Clinical data is derived from medical group EMR systems and combined, when possible, with administrative claims data.

The data are analyzed and organized into action reports that give providers a clear picture of their patients, discover utilization and outcomes trends, and guide interventions to best treat and manage patients. This data is used in real time within the hospital setting to identify patients in need of more comprehensive discharge planning which may include a higher level of medication reconciliation, timely primary care follow-up and provision of in-home or community-based services. Moreover, sophisticated predictive analytic software is used to identify patients who will most likely have a hospital or emergency department (ED) admission within six months. These patients are pro-actively contacted and placed into appropriate care management programs to help improve their health, coordinate their care, and reduce costly hospital (re)admissions and ED visits.

While easy to describe, the information technology (IT) and staff needed to create the infrastructure necessary to identify and care for chronically ill patients is enormous. Functions, data definitions, and clinical activities must be standardized and integrated into the IT and provider workflow across the system. EMR fields must be developed to capture data, data from many systems must be integrated, dashboards must be built to demonstrate care gaps and performance, and consistent education and support teams must be in place. Importantly, medical group leadership must champion the change management effort.

### Outpatient Healthcare Navigators

On the patient side, medical group providers practice in multi-disciplinary teams that include primary and specialty care physicians, nurses, physicians' assistants, pharmacists, social workers, and other key allied health professionals. A critical component of the care team is the patient's health care coach/navigator/nurse that is in charge of coordinating the patient's care and creating personalized care plans. The nurse navigator works with the patient, family and primary care physician to help promote the optimal health outcomes for the patient. Special attention to patient populations that are affected by healthcare disparities is provided with novel approaches, such as, special outreach teams knock on the doors of new dual eligible high risk patients unable to be reached by traditional means. These intense efforts to reach at risk patients to engage them in their own health is just one example of grass roots tactics medical groups utilize to manage this population of patients.

Telehealth services and remote patient monitoring devices also play a key role in caring for the chronically ill in the outpatient/home setting. Understandably, for patients with chronic conditions, traveling to the physician's office is a difficult and tedious process. These patients often require specialty services that may not be available locally. Telehealth services allow providers to offer services in an office setting close to the patient's home or in the patient's home. Home monitoring devices are an effective triage mechanism, allowing the care navigator to review a patient's health status between office visits (e.g., are you short of breath today; have you gained weight this week), and provide for an appropriate level of care based on patient biometrics and reported symptoms.

Results of care navigator programs are impressive. Most medical groups report that hospital admissions and ED visits are significantly reduced when chronically ill patients are enrolled in care management programs. Patient satisfaction increases and importantly, patient engagement in their care also increases often resulting in increased wellness and ability to function in the community. Savings in individual large medical groups range from hundreds of thousands to millions of dollars.

### Inpatient Care Managers

Care coordination in the inpatient setting is equally critical. The handoff between the hospital and home or subacute care can expose the patient to adverse events and poor coordination of services. Once identified as a high risk patient, inpatient care managers follow patients from day of admission to discharge. At discharge, the inpatient care manager is responsible for providing a detailed medication reconciliation of admission drugs and discharge drugs, often in consultation with a pharmacist, and scheduling follow-up visits with the patient's primary care physician. For the most fragile patients, some medical groups make next day home visits.

Again, such intense post-discharge management yields impressive results. One medical group reported that 40 percent of post discharge patients required an actionable event, such as a titration of medication, correction of a medication error, or the need to contact a physician for an unstable vital sign. Because of post discharge care management processes as described above, medical groups report significant reductions in hospital (re)admissions and unnecessary ED visits. Most importantly, the patient's health is improved and the wellbeing of the patient and their caregivers is better served.

### Behavioral Health Integration

Management of chronic health issues such as diabetes, hypertension, and coronary disease are often complicated by unrecognized or untreated mental illness, and depression and anxiety can be caused by chronic health conditions. Consequently, some medical groups have integrated behavioral health services in the primary care setting and others are moving in that direction.

Appropriate behavioral health integration (BHI) employs a team-based approach that addresses the mental and physical health of a patient. At the point of care, a primary care provider performs an initial mental health assessment. A mental health team which may include primary care providers, psychologists, psychiatrists, and master's level social workers then assess how to most appropriately address the patient's issues and provide an appropriate level of behavioral healthcare. BHI efforts have reduced admissions and ED visits as well as increased patient and provider satisfaction. Importantly, patients have responded positively to BHI integration because they are treated as a whole person rather than as a hand off to an outside mental health provider.

### **Impediments to Caring for the Chronically Ill**

Despite the positive results of these care management efforts, impediments to these activities are significant. Despite the millions of dollars these efforts can cost, they are largely not reimbursed in the fee-for-service (FFS) payment system. Ironically, the savings that result from these seven figure investments accrue to Federal and commercial payors and if the medical group owns a hospital, revenues are decreased as inpatient admissions and ED visits decline.

Consequently, to design a system that rewards value and incents the care of the chronically ill, Congress must offer providers the financial and operational tools necessary for success in managing populations of patients. Such tools include: financial support for care management infrastructure, timely access to all claims data, full cost and quality transparency, actionable data exchange; clear attestation models, and patient engagement and accountability.

These tools are lacking in Medicare and commercial FFS as well as Accountable Care Organizations (ACO) and potentially Alternative Payment Models (APM). Indeed, these tools are critical in the commercial risk setting as well and are necessary for providers to be successful in a value-based payment system. Without them, there is little incentive to effectively manage populations of patients, especially those with multiple chronic conditions.

### **Policy Recommendations**

#### Medicare Fee for Service

##### *Comprehensive Care Management Codes*

The Centers for Medicare and Medicaid Services (CMS) recognized the need to finance care management activities and took a significant step in that direction with the establishment of Comprehensive Care Management Codes (CCM). While medical groups appreciate CMS' effort, the Agency mandated various requirements that make use of these codes problematic. The primary obstacle to using CCM codes is the requirement that beneficiaries pay a 20 percent co-pay for the service. Medical groups have found it exceedingly difficult to ask beneficiaries to pay for services they had previously received free over the past several years.

Moreover, if a patient refuses to make the co-payment, the medical group will provide the service in any event. The co-pay requirement negates the sound principal behind the CCM codes. Eliminating the co-payment requirement is necessary to provide some incentive to offer care management services to Medicare beneficiaries.

Congress should consider going beyond the CCM codes to offer greater financial support for care management than the CCM code provides. The codes reimburse providers approximately \$40 for 20 minutes of care coordination activities per patient per month. This does not even approach full reimbursement for the infrastructure noted above. We do not request full funding, that is not fiscally possible. However, we recommend Congress provide higher Per Member Per Month (PMPM) payments to coincide with patient's health acuity. If a patient has six chronic conditions, providers should receive increased payments that reflect the complexity of the care needed for these patients. A smaller PMPM would be available for patients with two, three, four, or five conditions.

Finally, Congress should also consider separate payments for BHI activities. Even in the commercial setting, payment for coordinating mental health services is largely absent.

### *Telehealth*

Medical groups recognize the promise that telehealth has in potentially transforming healthcare by improving access to care, patient engagement, and patient satisfaction. However, reimbursement for telehealth services is unnecessarily limited. AMGA supports expansion of the telehealth benefit and believes that these services could be very valuable to medical groups by promoting efficient and coordinated care whether in rural or non-rural areas. CMS is behind the private sector in its reimbursement of telehealth services. CMS should promote expansion of originating sites for telehealth services, and incent their expansion to providers with care management processes in place.

### *Accountable Care Organizations/Alternative Payment Models*

The participants in the Medicare Shared Savings Program (MSSP) and the Pioneer Accountable Care Organization Program (collectively, ACOs) have all made significant improvements in the delivery of high-quality care, especially to those with multiple co-morbid conditions. Indeed, ACOs are thought by many policy researchers to be well able to care for the sickest patients because they have invested in the infrastructure necessary to manage high-risk patient populations. However, though most of these entities have increased quality and achieved the goal of saving money for Medicare, program results have been uneven, at best. These entities have also encountered significant obstacles in program design that threaten not only their own success, but the future viability of these programs. ACOs need workable tools that adequately incentivize and operationalize this important work. These tools are described in detail below.

Related to this, Congress invested considerable time and energy in passing legislation repealing the Medicare Sustainable Growth Rate (SGR) mechanism. We sincerely thank you for this important achievement. However, the legislation relies on ACOs and other APMs to incentivize provider transition to value-based care. Unless the financing and operational models for ACOs and other future APMs are improved, we are concerned that the foundation for the new value based payment system in Medicare will be structurally unsound.

Because ACOs are considered a model for APMs, our comments related to ACOs apply equally to future APMs.

### *Beneficiary Attribution/In ACO Issue*

Medical group experience with ACOs has shown that up to 40 percent of patients attributed to the ACO actually receive their care outside the system. Physicians are willing to be held accountable under new payment models but to redesign care processes for patient populations requires an understanding of who those patients are.

An attribution methodology that holds an ACO accountable for costs that are not under their control is a significant obstacle to population health management, especially those with chronic conditions. Additionally, ACO performance on cost and quality metrics may be inaccurate because the patient attribution methodology does not accurately align patients who have not truly engaged with the ACO.

The ACO regulations place an emphasis on patient engagement, and place the responsibility for this on the ACO, while not permitting ACOs to incentivize their patients to seek care within the ACO. The Medicare Payment Advisory Commission (MedPAC) discussed this issue, among other ideas for improving ACOs, at their November, 2013 meeting. Among the ideas discussed was the possibility of incentivizing an ACO's attributed beneficiaries to seek their care in the ACO by permitting lower cost-sharing, or letting the beneficiary share in the savings generated by the ACO, since currently, patients may not understand they are in an ACO, or what that means for them.

In order to understand how "accountable" ACOs truly are, and to address a key issue that serves as a disincentive to enrolling as an ACO, we recommend that beneficiaries should select an ACO for all of their care, or at a minimum, identify their primary care provider (PCP), for a defined enrollment period. The designated ACO or PCP could be indicated on the beneficiary's Medicare card. We understand CMS and Congress' sensitivities to beneficiary freedom of choice which has been a hallmark of the FFS system. However, requiring providers to be accountable, while ignoring the need for accountability on the beneficiary side, provides significant barriers to success in the current ACO program and any future APM.

#### Timeliness/Quality of Data from CMS

There have been numerous issues surrounding the data ACOs receive from CMS. The timeliness and the utility of data have all been problematic. Some ACOs received data on their cohort's Hierarchical Condition Categories (HCC) scores more than a year after entering the program. Other ACOs have stated that the quarterly run-up data provided by CMS does not have the level of granularity needed for ACOs to make actionable changes.

The data file structures should be consistent, as well. Otherwise, it becomes necessary to involve the ACO's IT staff to convert the data into a consistent format, and the whole process becomes more resource-intensive and administratively burdensome. We believe a joint ACO/CMS/Center for Medicare and Medicaid Innovation (CMMI) committee should be formed that would work on creating a consistent format for data submissions and prioritize requested modifications to the standardized data set. The committee would also focus on other data-related matters such as improving its utility to both ACOs and CMS/CMMI. Standardizing the formatting process will improve APMs even before they are developed.

#### Risk Adjustment

Accurate risk adjustment is an important aspect of the evaluation of an ACO's performance. At present, the CMS HCC prospective risk scores may be lowered if the ACO's continuously assigned patient population shows an improvement in health status or if coding is not maintained at its prior level. Conversely, HCC scores are not increased if an ACO's patient's health acuity increases. This leads to a scenario where historical benchmarks can only decrease and ACOs are left to chase a dropping reimbursement figure. As a result of this recalculation, many ACOs lost shared savings on their interim payment calculation.

We understand CMS' concern that ACOs might utilize more accurate coding to augment risk scores and increase the expected cost for a given patient population. However, it is axiomatic that caring for patients with multiple chronic illnesses requires greater utilization of healthcare services, and consequently, higher costs.

Arbitrarily capping HCC scores ignores this obvious truth. Moreover, HCC codes are used to understand the underlying patient population's chronic disease state. ACOs need to be allowed to accurately code risk in all programs so physicians have a full understanding of a patient's status.

To the extent there is concern related to fraud and abuse issues involved in HCC coding, most ACOs have sophisticated in-house counsel and compliance officers, as well as outside counsel. This legal infrastructure scrutinizes internal coding issues to better ensure compliance with Medicare billing rules.

If an ACO's patient population's HCC scores increase, CMS needs to adjust for the health status of this population using the higher risk score. We also recommend creating a CMS/ACO task force to more fully consider this issue.

### *Financial Benchmarks Transparency*

We applaud CMS' decision in its ACO Final Rule stating that it will consider adopting alternative benchmarks in the MSSP program. AMGA believes that MSSP participants should have the choice to transition to benchmarks based on regional FFS expenditures instead of national FFS expenditures, or use a blend of regional and national FFS expenditures. Many AMGA member medical groups have indicated that use of a regional component in the benchmarking process for their ACOs could make a positive difference in their ability to meet the Minimum Savings Rate.

Under the current benchmarking methodology that takes into account an ACO's historical costs, benchmarks vary considerably among ACOs. As a result, historically low-cost ACOs may have more difficulty in achieving shared savings, or simply elect to not participate in the MSSP program at all. Given the goals of the MSSP program to incentivize improvements in population health while slowing the growth of Medicare expenditures, the benchmarking framework should provide a way for high-quality, low-cost ACOs to succeed financially.

### *Access to Claims Data/Transparency/Standardization*

#### *Claims Data*

Healthcare data, and its transparent use, is a critical tool in caring for the chronically ill. Data has the potential to better educate the patient and drive significant change and improvement in the delivery system as described above. However, transparency is not as transparent as it seems. Currently, data is fragmented among provider, payor and government silos and often jealously protected. This non-system of measurement was barely adequate in a FFS system where providers were not at risk and the system was largely focused on procedures and acute care visits. And, patients generally, enjoyed low cost sharing obligations. It is completely inadequate in a value based system which focuses on managing patients to keep them out of the inpatient setting and where patients are increasingly responsible for paying a greater share of their care.

While medical groups with EMRs are able to review their own clinical information, adjudicated claims data, which covers office visits, tests, procedures, lab results, medications, hospitalizations, ED visits, etc., is critical to painting a fuller picture of the patient. Claims data is needed for providers to understand the care that happens outside of the medical group office. Claims data is also needed to better predict risk and identify chronically ill and high cost patients. In other words, medical groups need both clinical and claims data to manage a patients' care and their costs. However, access to claims data is uneven. Some commercial payors will share its claims data with providers while many will not. CMS shares its Medicare claims data with ACOs but there are limits to the effectiveness of this data share effort. The data is delivered in ever changing formats, which needlessly takes up hours of administrative time to reformat it, and is not timely delivered. For medical groups that are not in the MSSP program, there is limited ability to access claims data.

AMGA recommends the development of a central data warehouse, coordinated by a trusted party that would house administrative claims data from a variety of sources (e.g., Federal healthcare programs, commercial payors, labs, pharmacy benefit managers, etc.). Examples of data warehouses already exist.

The Organ Procurement and Transplantation Network collect data on every organ transplant in the country and have helped improve transplant care. Specialty physician societies have created sophisticated disease registries and dozens of states have implemented or are implementing all payor claims data bases.

However, we believe a central database is needed to avoid fragmentation. Providers would be able to request data from this warehouse as needed, instead of the current practice of receiving data at a certain designated time (i.e., monthly, quarterly, etc.). At a minimum, Congress should require CMS to provide its claims data, including Part D drug data, to a central warehouse. Congress should also consider requiring commercial payors to submit their claims data to the warehouse.

## *Standardization*

Different payors require providers to submit different quality measures in different formats, at different times, with different inclusion/exclusion criteria etc. This fragmented quality measurement system takes up resources on the provider end and diverts attention from building the infrastructure necessary to effectively manage population health.

From a consumer perspective, this lack of standardization means the same physician can be ranked “good” by one payor and “poor” by another. Without apples to apples comparison system, consumer interpretation of the “data” is literally left up to the imagination of the reader, making a truly informed choice challenging at best.

Of course, different measures do apply to different populations. For instance, measures for the Medicare and Medicaid programs must address different priorities, given the different populations served by these programs. However, standardizing the collection, submission and reporting formats for these programs is essential to allow providers to focus on redesign care processes and providing consumers with real actionable information that lets them make informed choices.

Congress, along with the healthcare industry should examine the larger issue of whether the current measurement system truly measuring and improving quality? Currently, there are large measure gaps in the National Quality Strategy that should include measures in the care coordination and patient safety domains. Overuse and underuse of services for costly disease states are not covered by current measurement regimes. Acute care measures such as admissions, length of stay, days in the Intensive Care Unit may be good measures of quality. H.R. 2 contains provisions requiring the examination of quality measures and AMGA applauds this important review.

As mentioned earlier, AMGA recommends that Congress require CMS to convene a stakeholder group to discuss, develop and agree on a consistent format and process for the collection, submission, reporting and exchange of data.

## Medicare Advantage

Many medical groups and health systems have their own Medicare Advantage (MA) plans, or treat patients who are MA beneficiaries. Approximately thirty percent of today’s Medicare beneficiaries are enrolled in an MA plan and enrollment continues to grow each year due to the popularity of the program. MA programs are known for incentivizing high-quality care through the management of chronic conditions that result in healthier beneficiaries, in addition to reductions in avoidable hospitalizations. The payment structure utilized by MA incentivizes the team-based approach of multi-specialty medical groups and the provision of the right care, at the right time. The MA program moves the financing system away from a FFS model and toward one that emphasizes and incentivizes integration, value, and care coordination.

AMGA recommends Congress require MA plans to offer incentives to patients to participate in care management programs. Such incentives can include payment waivers or cash back rewards for meeting health goals. Relatedly, Congress should require MA plans to reimburse providers for care management processes. Reimbursement could be targeted to reward structural measures, such as having inpatient managers/outpatient navigators or if providers meet outcomes measures such as reduced (re)admissions, length of stay days, improved patient satisfaction scores.

Measurement of MA plan success in addressing the chronically ill would include measuring the percentage of eligible patients in care management programs as well as improved quality metrics, such as better control for people with diabetes or hypertension.

## **Conclusion**

Medical groups have long invested in the processes designed to identify and care for patients with multiple chronic conditions. These investments in technology and people are expensive and largely unreimbursed. The FFS payment model has been traditionally focused on paying for acute care and the financing system must be transformed to one that rewards population health management. Financial and operational tools are necessary to incent and operationalize this new type of care.

Importantly, these tools must be available in both Federal and commercial settings, and in FFS and risk products. Consequently, AMGA offers Congress the following recommendations:

1. **Care management incentives.** Provide financial incentives to invest in care management tools designed to care for patients with multiple chronic conditions. CCM codes need to be changed to spur greater adoption and increased PMPM reimbursement should be available for treating patients with multiple (2+) conditions.
2. **Beneficiary attestation.** Providers cannot manage a chronically ill patient population without knowing who their patients are. In an accountable payment system, patients need to select a medical group, ACO, etc., for their total care. At a minimum, patients need to select a primary care provider who is responsible for their care.
3. **Access to full claims data.** Providers must have full access to all claims data. A centralized data warehouse should be developed that providers can access on an as needed basis.
4. **Data Exchange.** Data exchange from CMS and all payors must be timely, actionable and accessible.
5. **Data standardization.** Data submission, reporting and feedback must be standardized.
6. **Risk Adjustment.** Risk adjustment must reflect increases and decreases in patient acuity levels.
7. **Financial benchmarks.** MSSP participants should be able to choose the financial benchmark best suited for its circumstances.
8. **Medicare Advantage.** Medicare Advantage plans should reimburse providers for care management activities and provide incentives for MA beneficiaries to engage in them.

We thank you for your consideration of our recommendations. If you have any questions regarding this letter, please contact Chet Speed, at [cspeed@amga.org](mailto:cspeed@amga.org).

Sincerely,



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