Third Option Executive Summary

The nation is at a pivotal moment in the evolution of our health care system. An aging and increasingly chronically ill population continue to stretch dwindling health care resources, and our current fee-for-service reimbursement system, where clinicians are paid "per click" without an eye toward quality, cost or elimination of waste is inadequate to meet these needs or manage resources well. As such, it is critical that we move towards a new, alternative payment methodology of the future that reimburses clinicians based on the quality, efficiency, and patient outcomes.

New payment models have been introduced and tested in both traditional fee-for-services (FFS) Medicare and Medicare Advantage (MA). However, both systems have fundamental flaws that act as barriers to value. America's Physician Groups (APG) has drafted a new payment model that takes the best features of the ACO program in FFS Medicare and population based capitated payment arrangements in MA and combines them into a **"Third Option"** for Medicare beneficiaries.

The **Third Option** allows clinicians to better coordinate patient services and improve care while keeping costs in check – both for the system overall and the patient. The current FFS status quo does little to incent providers to practice the patient-centered, coordinated care we know is essential to improved health outcomes. America's seniors deserve better. We can and must do more to improve our nation's health care delivery system by enacting the Third Option today.

Executive Summary of APG's Third Option

- It features prospective population payments to physician organizations that include robust quality measurements with active beneficiary engagement through enrollment.
- It would allow the Centers for Medicare & Medicaid Services (CMS) to directly contract 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.
- To participate in this model, CIOs would have to meet current CMS and State requirements, similar to those required for existing Medicare Accountable Care Organization (ACO) participants such as a formal legal structure that allows the organization to receive capitated payment and pay contracted or employed providers.
- The model provides for the active enrollment by beneficiaries – a design element critical to the goal of achieving the full beneficiary engagement by selecting the program
- CMS would establish capitation rates including the standard Medicare Part A and Part B benefits, using methods and benchmarks similar to those used to establish rates for Medicare Advantage (MA) plans. The payments would be actuarially sound, risk adjusted, and updated annually. CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B FFS payments for enrolled beneficiaries, and the CIO would then be responsible for the payment for all professional and hospital services, whether provided in-network or out-of-network.

- Beneficiaries would be encouraged to stay in network by differential copayments and coinsurance, paying higher copayments for going out of the CIOs contracted or employed network, and lower or no copayments for services received in-network. Medicare supplement benefits would only be payable for services in network.
- Robust publicly reported quality and efficiency measures would be used similar to the MA Stars rating and could be used to make comparisons between the CIOs and FFS.
- CMS would contract with one or more Affiliated Service Organizations (ASOs) to provide a full range of necessary administrative services, including quality and data reporting, payment, financial and patient cost sharing tracking, enrollment, and all other back office functions. These ASOs would serve as fiscal and administrative intermediaries similar to those currently engaged by CMS and by self-insured employers