BIPARTISAN POLICY CENTER

June 22, 2015

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senator
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senator
Committee on Finance
United States Senate
Washington, DC 20510

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

On behalf of the Bipartisan Policy Center (BPC), thank you for the opportunity to provide input on improving care for Medicare patients with chronic conditions, and for your long-standing commitment to addressing these critical issues. We share your goals of improving the delivery of high quality care at greater value and lower cost without adding to the deficit.

Our comments are based on the considerable body of work produced through BPC's Health Project, Health Innovation Initiative, and Prevention Initiative, including:

- *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment* [Apr. 2013] and a series of four delivery system reform white papers focused on ways to accelerate the transition from fee-for-service to sustainable, higher-value alternative payment models (APMs). Recommendations are intended to build on early APM implementation, improve the viability of APMs, and make progress toward the long-term vision for the health care system presented in *A Bipartisan Rx*. [Aug. 2014 – Apr. 2015]
- Multi-stakeholder recommendations on connected care [Dec. 2013], and *An Oversight Framework for Assuring Patient Safety in Health Information Technology* [Feb. 2013]
- *A Prevention Prescription for Improving Health and Health Care in America* [May 2015]

In general, we believe the transition away from fee-for-service to more coordinated systems of care will benefit beneficiaries across the Medicare program, and particularly those living with complex, chronic conditions. With better payment incentives in place, APM providers are offering new services such as care coordination and patient education and are often focusing these interventions on those with multiple-chronic conditions and other identified risk factors to achieve quality and patient satisfaction targets and generate savings for beneficiaries and

the Medicare program. Below are our recommendations in response to the specific topic areas you have highlighted:

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

Medicare Advantage (MA) offers tremendous opportunity to coordinate care and improve outcomes and value for enrollees with chronic conditions. Furthermore MA special needs plans (SNPs) are allowed to specifically target enrollment to one or more types of special needs individuals including institutionalized, dually eligible, and/or individuals with severe or disabling chronic conditions. Based on recommendations in our 2013 report, *A Bipartisan Rx*, BPC recommends the following changes that would benefit those with chronic conditions in MA plans:

- *Replace the Medicare Plan Finder with a user-friendly, up-to-date Medicare Open Enrollment website that beneficiaries could use to make coverage selections upon enrollment and during the annual open-enrollment period.* The ability to more easily compare options side-by-side, including Medicare Advantage plans and a new generation of enrollment-based ACOs, could be particularly beneficial to beneficiaries with chronic conditions given they have a complex array of factors to consider in selecting the option that best meets their needs. Importantly, beneficiaries should be able to compare physician networks and the out-of-pocket cost for a primary-care-provider office visit.

- *Implement a budget-neutral reinsurance system for MA*, as is already in place for Medicare Part D and Medicare Advantage SNPs, to protect against high costs and improve the ability of MA plans to serve high-need, often high-cost individuals.

- *Incorporate a more accurate measure of functional status in Medicare's risk adjustment.* Functional status reflects an individual's ability to perform activities of daily living, which is a better predictor of risk than presence of chronic conditions alone. This has been a critical missing variable that should be included in risk adjustment across the Medicare program, including Medicare Advantage and new payment models. Functional status measure development and use is progressing, thanks in part to provisions in the IMPACT Act of 2014, and we encourage continued progress and prioritization of this measure at CMS and the National Quality Forum.

- *Require that all MA plans include prescription drug coverage.* While this change would affect all MA beneficiaries, it would be especially beneficial to those individuals with multiple chronic conditions who often have a greater need for prescription drug

coverage. In particular, this would ensure that plans have appropriate incentives to manage medication therapy and encourage drug adherence, which can lead to better outcomes and lower overall costs.

- *Permit plans to adopt tiered network designs.* Tiered network health plans include two or more tiers of in-network providers, which are sorted based on quality and cost. Beneficiaries pay lower cost-sharing when receiving services from providers in the preferred tier. This change could help MA plans promote greater value and efficiency in care delivery while ensuring affordable coverage.

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted APMs underway at CMS, or by proposing new APM structures;

It is important to keep in mind that payment models focused too narrowly on a multiple-chronic-condition, high-risk, high-cost segment of the patient population – even with risk adjustment tools – may not allow participants (providers and plans) a sufficient ability to spread risk and achieve savings. Instead, a broader payment model including a mix of higher-risk and lower-risk beneficiaries can form the necessary infrastructure so that participants, as they assume greater accountability for outcomes and costs, will have a strong incentive to target or tier interventions with enrolled or assigned beneficiaries by level of need and intensity of service use. These payment reforms and the change in delivery system processes that they will motivate are essential to meaningfully improve care delivery and achieve quality and cost savings targets.

BPC has recommended an enhanced, enrollment-based APM concept called Medicare Networks. Similar to today's ACOs, Medicare Networks would be formed and led by health care providers who want to work together in a way that optimizes care coordination across care settings. The providers would be held responsible for the cost, quality, and coordination of care delivered to a defined group of beneficiaries. We believe beneficiaries with multiple chronic conditions have the most to gain from the coordination and integration inherent in these types of APMs; however, providers are still learning which interventions work best for certain conditions and segments of the population and how to best stratify risk and target services. With support from the Peterson Center on Healthcare, BPC's Health Project is currently collaborating with the Harvard T.H. Chan School of Public Health and the Institute of Medicine to identify and validate care models that can improve quality of care for high-need patients, lead to lower overall costs, and be scaled for adoption nationwide. *We will keep the Committee and Chronic Care Working Group apprised on our findings and recommendations as we continue this work throughout the year.*

Under BPC's Medicare Networks proposal and in response to proposed regulations on Medicare Shared Savings Program (MSSP) ACOs, BPC recommends the following:

- *Allow beneficiaries who utilize non-physician primary care providers, such as nurse practitioners and physician assistants, to be attributed to an ACO*. Based on current law and regulation, a beneficiary must receive at least one primary care service from a physician participating in the ACO as a preliminary step for determining assignment eligibility. BPC supports allowing ACO attribution based solely on use of at least one primary care service by a non-physician provider such as a nurse practitioner or physician assistant.

- *Transition all ACOs to prospective beneficiary assignment.* CMS's new Track 3 ACO model includes prospective, rather than retrospective, assignment of beneficiaries, which is a step in the right direction. We believe that in order for ACOs to successfully coordinate care and achieve better care and cost outcomes for the beneficiaries they actually serve, they should know for which patients they are responsible at the beginning of each contract year. Therefore, all ACOs should move to prospective beneficiary assignment.

- *Over time, transition to a patient-choice model in which beneficiaries have the opportunity to make an active decision to designate an ACO and would have incentives for doing so.* Using this approach, beneficiaries could designate an ACO and identify a primary care provider (physician, physician assistant, or nurse practitioner) that is part of an ACO member practice or in the ACO's network (providers that, in BPC's concept, could be affiliated with an ACO but would not participate in that ACO's governance and would not share in its savings/losses). ACOs should be allowed and encouraged to offer additional incentives to patients who opt-in. ACOs could choose which benefits to offer, such as cost-sharing waivers for ACO primary-care providers, a 24-hour nurse line, and extended primary-care office visit hours. Oversight will be needed to ensure benefits are not coercive or otherwise designed in a way that would inappropriately affect patient choice. Beneficiaries who designate an ACO could continue to see any Medicare provider, but these incentives (such as any waiver of cost-sharing for a primary care office visit) would be limited to services delivered by providers that are either members or in the network of the ACO. CMS would annually inform attributed beneficiaries of the opportunity to designate an ACO and any incentives. These incentives should not be available to beneficiaries who do not designate an ACO, even if they have been attributed. ACOs would be allowed, but not required, to promote designation opportunities to patients through marketing materials. Beneficiaries could change or cancel their ACO designation at the next annual selection period. This model could be

tested in Pioneer ACOs first and then scaled for implementation throughout all Medicare ACOs.

- *Adjust ACO payment methodology to aid in the transition to models with increasing levels of accountability.* BPC has proposed several improvements to the payment methodology for Medicare ACOs, including:
    - Use of prospective spending benchmarks and a five-year transition to regional, risk-adjusted benchmarks. There are substantial drawbacks to provider-specific, historical benchmarks, as they provide little incentive for relatively efficient providers to participate, and they may allow relatively inefficient providers to maintain such inefficiency for long periods without penalty. To the degree that benchmarks are rebased, they undermine the providers' business case for investing in improved delivery.
    - Allowing ACOs to receive partial shared-savings bonuses for reducing spending and achieving significant, relative quality improvement in certain areas, even if they are not yet able to meet all of the national quality standards.
    - As in the Medicare Access and CHIP Reauthorization Act (MACRA), BPC proposes tying annual fee schedule updates to participation in APMs. In a January 2015 paper, BPC made two recommendations that would go beyond MACRA's differential update policy (higher annual payment-rate updates for APM providers, lower updates for FFS providers). The first recommendation is to create a middle tier of updates for providers that adopt one-sided-risk APMs; the highest annual payment-rate updates would be reserved for providers at two-sided risk, slightly lower updates would be available for providers at one-sided risk, and FFS providers would receive the lowest annual payment-rate updates. Second, BPC proposes expanding differential updates beyond physician-fee-schedule providers to all Medicare providers. Under this approach, all Medicare providers would have stronger incentives to adopt APMs with increasing levels of risk. *Importantly, in BPC's vision for the future of APMs, providers and patients alike are incentivized to participate in a model of care that improves quality while reducing the growth in Medicare spending.*

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

BPC is focused on advancing models of care that improve quality and value. The current Medicare fee-for-service payment system rewards the fragmentation of care and does not promote integrated care delivery for all patients across different settings. Particularly for those individuals with chronic and comorbid conditions, fee-for-service does not effectively meet their needs.

BPC has recommended that higher annual payment-rate updates be reserved for providers that participate in APMs – similar to the approach that will be implemented under MACRA – including PCMHs, bundled payments, and ACOs – relative to fee-for-service. As we accelerate the transition towards the Medicare Network model, the PCMH model can function within the traditional fee-for-service system in order to improve value and better coordinate care, especially for those individuals with chronic conditions who require a more integrated approach to care. Additionally, the PCMH can be used as a means of educating providers on APMs, incentivizing the coordination among individual providers in order to provide better care, and thus accelerating the approach towards alternative payment models such as ACOs and Medicare Networks. The PCMH model is especially promising for individuals with chronic disease due to the increased focus on the coordination of care. The PCMH model reimburses single primary-care provider or practice to better coordinate patient care, noting opportunities for improved quality and efficiency. Specifically, the Comprehensive Primary Care Initiative (CPCI) is CMMI's multi-payer PCMH initiative that includes Medicare, Medicaid, and privately insured patients. CPCI provides a per-member, per-month payment in addition to fee-for-service reimbursements, but also hold participating practices accountable for quality to share in savings. While there have been many private and public approaches to the PCMH model, CPCI appears particularly promising. The upside-risk PCMH model should be considered an APM eligible for the higher fee-schedule payment-rate updates (such as in MACRA, or a larger differential) to incentivize the better coordination of care for Medicare beneficiaries, especially those with chronic conditions.

Bundled payment models, such as CMMI's Bundled Payment for Care Improvement (BPCI) model, involve a provider or group of providers who are paid based on an episode of care. Bundled payment has shown some promise for improving quality and lowering costs for specific conditions or specialties, such as oncology. However, there are limitations given the difficulty of reimbursing chronic care management on an episodic basis. Bundled payment is useful within, and in the transition to, models with greater accountability for population health outcomes and costs, such as ACO or PCMH models. Given their focus on chronic disease management and coordination across multiple providers and settings, they are better suited for individuals with multiple-chronic conditions than bundled payment alone.

4. The effective use, coordination, and cost of prescription drugs;

To improve care outcomes and value for dually eligible beneficiaries, BPC supports building on current demonstrations underway for this population, and consideration of integrating prescription drug coverage under Medicare Part D along with broader Medicare and Medicaid service integration. Furthermore BPC's proposed Medicare Networks would be allowed, but not required, to partner with a preferred Part D Prescription Drug Plan (PDP), which could lead to efficiencies and lower costs for plans and beneficiaries. Analyses by MedPAC and the

Congressional Budget Office (CBO) have indicated that drug adherence for certain conditions can generate overall Medicare savings due to reduced acute care utilization. However, because better drug adherence increases spending in Part D and generates savings in Parts A and B, the incentives are not aligned across programs to encourage these initiatives. Partnerships between BPC's proposed Medicare Networks or existing ACOs and PDPs, which could include shared savings arrangements, could facilitate better management of prescription drugs, better patient outcomes, and lower overall costs. Medication Therapy Management (MTM) can be an important tool for individuals with chronic conditions. In its MA and PDP proposed regulations for contract year 2015, CMS raised concerns regarding low MTM uptake and uneven application of eligibility criteria by PDP sponsors. While the agency has to-date not finalized new eligibility criteria as proposed in 2014, it has encouraged plans to use existing criteria appropriately to increase MTM uptake among eligible Medicare Part D beneficiaries.

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

Telehealth, which includes remote monitoring technology, can be used to improve access to and convenience of care (particularly for the elderly and those living in rural areas) as well as lower costs, for example through reductions in hospital readmissions and transportation costs. As an eligibility criterion for Medicare ACO participation, CMS now requires ACOs to describe in their applications how they will use enabling technologies to coordinate care, including electronic health records (EHRs), telehealth, and remote patient monitoring. Furthermore, as an incentive to participate in performance-based risk arrangements, CMS will test allowing providers to use telehealth in CMMI's Next Generation ACO model and, after rulemaking with notice and public comment period, is expected to allow telehealth waivers in MSSP no earlier than January 1, 2017. These changes represent positive steps forward in addressing reimbursement barriers to that prevent many providers from taking advantage of telehealth to improve cost and quality outcomes, as we highlighted in our 2013 policy dialogue on connected care.

6. Strategies to increase chronic care coordination in rural and frontier areas;

Many providers continue to report challenges in obtaining capital to fund the considerable start-up costs associated with forming an ACO. We appreciate that to address these challenges CMMI is rolling out an ACO Investment Model of pre-paid shared savings, building on experience with the Advance Payment Model. However, loan capital should also be more broadly available. Existing private-sector lenders and public-sector lending programs have historically focused on facilities and equipment acquisitions supported by the fee-for-service business model; whereas, the business model of taking risk for quality outcomes and the cost of services requires a different sort of infrastructure to support care coordination. Moreover, historical ACO program design (e.g., using historical benchmarks that are rebased) has undercut the attractiveness of ACOs to investors and lenders. Under the most recent MSSP

regulations, MACRA and BPC's recommended changes, ACOs should become more attractive to investors.
Some provider organizations already have the financial wherewithal to make these investments, and more will have access to capital if the design changes recommended here are implemented. Nevertheless, others still may not because the purpose of ACOs is in part to break new ground and to provide networked services in less commercially viable areas, such as some rural locations. Because beneficiaries and the public will be best served by the formation of a diverse array of ACOs in a wide range of locations, temporary, targeted efforts to help newly forming ACOs obtain access to capital may well be warranted. BPC recommends two approaches:

- Authorize the Secretary of Health and Human Services to provide additional technical and financial resources, such as low-interest loans, to help ACOs form in rural areas, or
- Establish a federal loan-guarantee program for multi-specialty or primary care physician-led organizations seeking to form an ACO.

These efforts would complement other approaches to improve the viability of the ACO model in rural and other areas where they are slower to form such as waivers for two-sided-risk ACOs that utilize telehealth to improve care coordination.

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

In the transition away from fee-for-service and toward more coordinated systems of care, providers should be incentivized to use evidence-based models to improve patient self-management and patient activation. Additional technical assistance and peer-to-peer learning collaborative-style learning may be needed to spread adoption of these evidence-based models.

Health IT, including mobile applications, can also play an important role in patient engagement. BPC has proposed a risk-based regulatory framework to ensure patient safety of health IT without stifling innovation. While federal agency action has moved in a positive direction, legislation is still needed to provide greater regulatory certainty for health IT developers and providers.

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

As Medicare still relies upon fee schedules for provider payment, continued congressional and agency efforts to increase payment for primary care while reducing the utilization of other services in an appropriate manner promotes the success of organized systems of care with the expectation of reducing costs overall. In addition to extending higher payments for primary-care office visits, the PCMH model should be considered as another way to increase payment to primary-care practitioners, as recommended by MedPAC in their June 2014 report. A strong system of primary care and team-based care is critical for prevention and better treatment, coordination, and outcomes for individuals with chronic disease.

Prevention and its relation to improving chronic care delivery and payment in Medicare

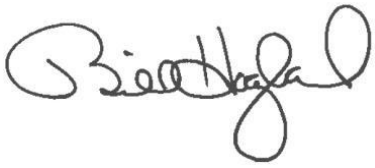
While more patient-centered and efficient treatment of individuals with chronic disease is critical, health care payment and delivery reforms should also take into account the value of, and support, effective strategies for chronic disease prevention. BPC's Prevention Task Force has proposed a framework that recognizes preventable chronic conditions are widespread and costly, that much of the work of effective prevention strategies must occur outside the doctor's office, that the current understanding of what approaches are effective in non-clinical settings is limited, that problems as complex as obesity and chronic disease will require multiple interventions to show impact, that accomplishing a shift toward disease prevention and wellness will require new kinds of integrated entities and financing mechanisms, and that it will be important to test the effectiveness of these new strategies and entities. Medicare-relevant recommendations include:

- CMS should *require economic or cost-effectiveness analysis* in funding opportunity announcements to help build cost-related evidence from public health and clinical interventions; should *integrate at least two population health quality measures into the next ACO iteration*; should *invest in testing an accountable health community model with scalable/sustainable funding mechanisms* that can establish a concrete framework for improving population health while leveraging the existing delivery-system infrastructure; and should *support efforts, infrastructure, and analyses needed to spread and scale what works*. In addition, CMS should *consider including requirements for translating and disseminating findings and results in the RFP process*.
- Congressional budget committees should *direct the CBO to use "present discount accounting" to bring long-term savings from prevention "up" in time and to align better with CBO's current 10-year scoring window*; these changes will help ensure that CBO is accounting for benefits that might be seen 20–25 years out.
- Communities, public health officials, and hospitals should collectively explore ways to improve Community Health Needs Assessments and better use these assessments as a tool for aligning goals and implementation plans. At the same time, communities, public

health officials, and hospitals should engage with other stakeholders to identify existing organizations at the state, regional, or local level that could function as *integrators across public and private programs including Medicare,* potentially with additional support from national-level organizations (e.g., the National Association of Counties, the National Association of County and City Health Officials, the Centers for Disease Control and Prevention, and the American Heart Association).

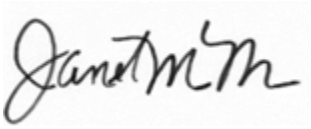
Thank you again for the opportunity to submit comments; we look forward to continuing to work with you on this important effort.

Sincerely,



G. William Hoagland
Senior Vice President
Bipartisan Policy Center

Katherine Hayes, J.D.
Director, Health Policy
Bipartisan Policy Center



Janet M. Marchibroda
Director, Health Innovation
Executive Director, CEO Council
on Health & Innovation
Bipartisan Policy Center

Lisel Loy, J.D.
Initiative Director, Prevention Initiative
Bipartisan Policy Center