

January 25, 2016

The Honorable Orrin Hatch
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
Co-chairman, Chronic Care Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
Co-chairman, Chronic Care Working Group
Finance Committee
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch and Senators Wyden, Isakson and Warner:

The undersigned organizations submit the following comments and recommendations to the Senate Finance Committee and its chronic care working group's December 2015 *Bipartisan Chronic Care Working Group Policy Options Document*. The signatories to this letter represent the largest and most preeminent healthcare organizations in the country whose members include physicians, hospitals, medical group practices and nearly all existing Medicare Shared Savings Program (MSSP) ACOs. Our recommendations reflect our unified expectation and desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for Medicare beneficiaries, reduce healthcare costs and improve quality in the Medicare program.

We provide the following feedback in support of a number of the working group's proposals, and we make further recommendations including that the chronic care working group should:

- **Enhance the ability of ACOs to provide home health by changing homebound definitions for ACOs**
- **Waive the Medicare telehealth geographic requirements and originating site restrictions for all ACOs**
- **Allow ACOs to provide supplemental social and transportation services and remote patient monitoring**
- **Account for an ACO's full growth in HCC risk scores across all contract years and consider additional changes to improve the accuracy of the risk adjustment methodology.**
- **Enable ACOs to select retrospective or prospective beneficiary assignment and permit beneficiaries to voluntarily elect to be assigned to the ACO in which their main provider is participating**
- **Waive beneficiary cost-sharing for Medicare chronic care management services**
- **Allow ACOs to waive beneficiary copays for primary care services delivered by primary care providers upon which ACO beneficiary assignment is based**

Receiving High Quality Care in the Home

The working group solicits feedback on how to help beneficiaries receive high quality care in their homes. Specifically, the working group is considering expanding the Independence at Home (IAH) demonstration into a permanent, nationwide program and requests feedback on program modifications to encourage additional practices to participate. We appreciate the working group's recognition of the value of providing care in a patient's home for beneficiaries with multiple chronic conditions. In addition to supporting the goals of IAH demonstration, we urge the working group to also address home health as it relates to ACOs.

Leaving aside the argument that health care decision-making ought to be made solely on the basis of medical care needs not payment rules, the IAH demonstration and the Veterans Affairs Department's Home-Based Primary Care program (HBPC) (after which IAH is modeled) have both shown positive results. Initial results from the IAH demonstration show that, on average, IAH has saved \$3,070 per participating beneficiary – totaling more than \$25 million in the demonstration's first performance year. The HBPC program has reduced the patient overall cost of care by 24% (\$38,000 v. \$29,000), reduced hospital cost of care by 63% (\$18,000 v. \$7,000) and nursing home care by 87% (\$10,000 v. \$1,400).

Enhancing Ability of ACOs to provide home health

Specifically related to an ACO's ability to provide home health, we recommend waiving the "home-bound" or the "confined to the home" requirement such that Medicare would pay for non-home-bound ACO beneficiaries to receive home health services. We recommend waiving the home-bound requirement for ACOs in all tracks and strongly believe all ACOs are incentivized to wisely use medical resources. Therefore, we support the use and benefit of this waiver for all ACO tracks for several reasons. Given the substantial evidence that home-based care independent of requiring "home confinement" has already been proven to be cost-effective, further requiring the ACO patient's health to deteriorate to the extent he/she is home-bound before eligibility for home-based services is unreasonable.

We contend further the Medicare home health home-bound requirement is inconsistent with the Medicaid program, which does not require states to have a home-bound requirement in providing home health services, and is therefore a source of confusion for ACOs with dual eligibles attributed to them. There are no eligibility restrictions whatsoever for Medicaid home health services. This double standard is made worse by the fact that the Medicare home-bound requirement has caused numerous states to erroneously require their Medicaid beneficiaries be home-bound before qualifying for Medicaid home health. Concerning the administration of a home health home-bound ACO waiver, ACOs should describe the staff and procedures involved in the clinical management of beneficiaries under this waiver. *Ultimately, we emphasize that a home-bound waiver should be available to ACOs in all three tracks.*

Providing ACOs the Ability to Expand Use of Telehealth

The working group is considering modifying the payment policy for telehealth services provided by MSSP ACOs. Under the working group's proposal, the Secretary of Health and Human Services would be required to establish a process by which ACOs participating in MSSP two-sided risk models would be able to receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services. The working group also solicits feedback on whether to lift

the originating site requirement entirely or to specify additional originating sites and asks for feedback on necessary safeguards to ensure that proper clinical equipment is readily available.

We strongly support waiving the Medicare telehealth geographic requirements and originating site restrictions for all ACOs, regardless of track. Studies have shown certain medical services delivered using telecommunication technologies can be substitutable, cost effective, quality improving and preferred by beneficiaries. More importantly, given the ACO care coordination and infrastructure that facilitates team-based communication, there are important patient protections inherent in this health care delivery model that may not be in place outside of the ACO model.

The working group recommends limiting the telehealth waiver to ACOs participating in two-sided risk models to protect against unnecessary utilization. We understand the concern about unnecessary utilization, but we urge the working group to provide the waiver for ACOs in all tracks and establish other safeguards to avoid unnecessary utilization. Every Track 1 ACO has substantial risk through their investment of startup costs and ongoing operating costs so that it would be foolish to allow their providers to over utilize these services and miss their savings opportunity. Further, to ensure the appropriate use of telehealth services, an ACO should be required to: outline a plan on how it will use telehealth services particularly to improve chronic care management; have a mechanism in place to electronically transmit a record of the telehealth encounter to the patient's primary care provider if the eligible telehealth provider is not the patient's primary care provider; and, publicly post their use/approval of the waiver. We also recommend allowing CMS to deny or revoke a waiver as well as monitor an ACO's billing under the payment waiver to reduce possible abuse.

The statutorily-imposed limitations on the use of Medicare telehealth services must be modernized. (In 2011 it is estimated the Medicare program reimbursed less than \$6 million in telehealth services.) There is a well-established evidence demonstrating that certain telehealth services fundamentally improve healthcare by expanding care delivery capacity/efficiency and enhancing health care outcomes particularly in under-served and rural areas. Telehealth offers the ability to enhance consultations between patients and providers, enable remote monitoring, improve the transmission of medical information, help support patients' self-management and generally improve communication and education between providers and patients. In an ACO primary care delivery model, telehealth may help prevent or manage numerous leading causes of illness, disability and death. Studies with a focus on chronic disease management have shown that certain telehealth services improve access, quality, and cost. Patient satisfaction via the use of telehealth, more specifically, interactive video, telephone consultations and remote monitoring, has, on balance, been high. Further, studies show that telehealth is cost effective in reducing hospital admissions and re-admissions as well as reducing both emergency visits and transfers between emergency departments. In sum, telehealth services facilitate prevention, coordination and cure and deserve to be available to all beneficiaries in all ACOs.

Two positive examples of telehealth include work done by the Veterans Administration (VA) and the Indian Health Service (IHS). As of 2013, the approximately one million veterans used some type of VA telehealth offering, and the VA expects this number to increase to over four million, or two-thirds of all veterans receiving some form of VA health care, in the near future. VA use of telehealth includes counseling services, prosthetic and other check-ups, remote patient monitoring (RPM) and sharing electronic medical record access for veterans' family caregivers. RPM for VA patients with chronic obstructive pulmonary disease, congestive heart failure, diabetes and other chronic conditions showed a

reduction in hospital bed days of care in excess of 40% on pre-enrollment figures and led to an 81% decrease in nursing home admissions and a 66% reduction in emergency department visits. The IHS telehealth efforts have improved Native American health in particularly remote locations. The IHS has been successful in improving diabetes control by significantly lowering low-density lipoprotein cholesterol and hemoglobin A1c levels through the use of telehealth, and the IHS has also used the technology to consult with specialists throughout the country to improve its delivery of specialty care.

Telehealth also promises significant financial benefits. An October 2014 paper by the Office of the National Coordinator for Health Information Technology (ONCHIT), titled “Health Information Technology Infrastructure to Support Accountable Care Arrangements”, stated that remote monitoring would produce as much as \$200 billion in cost savings over the next quarter century if properly deployed with patient protections that ensure care coordination, support communication among the patient’s medical team and the patient. Despite considerable favorable evidence for certain medical service and technology combinations, telehealth remains largely a promise more so than a reality in the Medicare program. *Expanding Medicare coverage for telehealth for all MSSP ACOs is urgently needed to help scale the services and patient-centered care. ACOs are particularly well-suited to the deployment of telehealth services given the structural patient protections of this health care delivery model.*

Maintaining ACO Flexibility to Provide Supplemental Services

The chronic care working group is considering clarifying that MSSP ACOs would be able to furnish social or transportation services and would be permitted to use remote patient monitoring services, none of which are paid under fee-for-service Medicare. We support allowing MSSP ACOs to provide social and transportation services, which could assist ACOs in accomplishing their goal of improving health care quality and lowering costs. We also support allowing ACOs to use remote patient monitoring to enable better patient access to care and to ease burdens that may hinder patients’ ability to receive adequate care to manage their health. These clarifications would enable ACOs to devote resources to a broader range of services and capabilities to best serve their patient population.

Ensuring Accurate Payment for Chronically Ill

The working group is considering making changes to the CMS HCC Risk Adjustment Model and outlines a number of possible modifications to the CMS HCC Model. We underscore the importance of the HCC Risk Adjustment Model and the critical role it plays in whether MSSP ACOs are able to achieve success in the program. We continue to believe the current methodology inadequately captures the risk and cost associated with ACO beneficiaries. *For all three tracks, we urge Congress to consider additional changes to increase the accuracy of the risk adjustment methodology.*

For the continuously enrolled population, the HCC scores are capped at the ACO’s baseline risk. CMS only allows an *increase* in the risk adjustment based on demographic changes (e.g., the aging of the population), not on changes in the acuity of the population. On the other hand, CMS allows *reductions* in the risk adjustment based on demographic factors *or* HCC scores for the continuously enrolled. We are concerned that by only counting HCC scores that work against the ACO for the continuously enrolled population, the current policy actually disadvantages ACOs that take on the management of the sickest populations with greater medical need.

This policy stems from a concern that the ACOs will receive higher payments due to improved documentation and coding. However, ACOs do not have the same tools at their disposal as MA plans to improve coding. MA plans are able to use a separate process to submit the “one best medical record” that supports each beneficiary’s HCCs identified for validation from a hospital inpatient, hospital outpatient, or physician medical record. ACOs generally have a more limited number of settings within their participant network and lack access to other facilities’ or settings’ coding practices. Correct ACO coding merely serves to ensure that providers are paid appropriately and willing to take the sickest patients. In addition, this artificial cap applies a perverse incentive in which those ACOs that meet the goal of improving their patients’ health and reducing costs through coordinated care management and other long-term strategies will be penalized. These organizations will see a decrease in acuity for well-managed patients that will count against them, while they will not receive credit for caring for patients whose acuity worsens, whether or not the patients’ illnesses were preventable. ACOs should get full credit for any increase in HCC risk scores for the first year the beneficiary is in the ACO. This will give the ACO some time to ensure that all of the beneficiaries’ diagnoses have been captured on claims before the score is frozen. *While we believe ACOs should have the full growth in HCC risk scores across all contract years, at a minimum we urge Congress and CMS to recognize the full growth for beneficiaries in their first year of assignment to the ACO. In addition, further research is needed on alternative risk adjustment models.*

The working group is also considering a study to examine whether the use of functional status, as measured by activities of daily living or by other means, would improve the accuracy of risk-adjustment payments. The study could also examine the challenges in providing and reporting functional status information by MA plans, providers and/or by the CMS. We strongly support conducting this study and recommend that in addition to functional status, it also examine the effect on risk adjustment from economic and socioeconomic status as well as from behavioral and mental health.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

The working group is considering recommending that ACOs in MSSP Track 1 be given the choice as to whether their beneficiaries be assigned prospectively or retrospectively. Also, the working group is considering recommending that Medicare fee-for-service beneficiaries have the ability to voluntarily elect to be assigned to the ACO in which their main provider is participating. The Secretary would be required to establish a process by which beneficiaries could voluntarily elect to be assigned to a MSSP ACO while still retaining their freedom of choice to see any provider.

We support allowing ACOs to select using either retrospective or prospective beneficiary assignment. A retrospective assignment model can be beneficial for some ACOs. For example, a small ACO may be worried about dropping below the 5,000 beneficiary minimum and thus prefer a model where it could add beneficiaries throughout the year. Under the prospective model as currently defined by CMS, the ACO will only lose beneficiaries. However, by the time an experienced ACO selects a more advanced model design, a prospective model would most likely be preferred. With substantial risk required under this track, an ACO would want a very stable beneficiary population to avoid unexpected changes in its benchmark. Moreover, these more advanced ACOs would want to employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible.

Based on discussions with participating ACOs, we believe that prospective assignment can be valuable across all tracks to stabilize the beneficiary population, which also aids in establishing stable

benchmarks. As we note above, there are different reasons an ACO might prefer retrospective or prospective assignment that may not relate to level of risk. Moreover, some ACOs may prefer having the ability to get accustomed to prospective assignment under a one-sided risk model before moving to a two-sided risk model. Adding the prospective assignment to other models may also give CMS more confidence in providing broader payment waivers as the population to which the waivers would apply would be easier to define. Thus, all ACOs should have the option of choosing prospective assignment. Similarly, ACOs should be allowed to move from retrospective assignment to prospective assignment at each recertification.

We also support the working group's proposal to allow beneficiaries to voluntarily elect to be assigned to the ACO in which their main provider is participating. We recommend this beneficiary attestation process be available for all MSSP ACOs, regardless of track. This process would allow beneficiaries to attest that they consider a particular provider responsible for coordinating their overall care. An attesting beneficiary would be attributed to the ACO with whom that provider is affiliated. Although CMS would retain its current stepwise attribution process, beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed. Furthermore, the beneficiary would remain attributed to that ACO until the beneficiary enrolled in Medicare Advantage, moved out of the ACO's service area, attested to a provider affiliated with another ACO, or the beneficiary otherwise indicates that they receive their care elsewhere.

Providing beneficiaries with the opportunity to voluntarily align with an ACO would balance the important considerations of beneficiaries' freedom to choose their providers, with ACOs' interest in reducing turnover, which would help provide a more defined and stable beneficiary population up front. This, in turn, would allow ACOs to better target their efforts to manage and coordinate care for beneficiaries for whose care they will ultimately be held accountable. In addition, allowing beneficiaries to attest to the provider they want to manage their care may help increase beneficiary engagement in that care.

Encouraging Beneficiary Use of Chronic Care Management Services

The working group solicits input on the extent that waiving cost-sharing for chronic care management (CCM) would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provides supplemental coverage.

We support waiving beneficiary cost-sharing for Medicare CCM services. The cost-sharing, which includes an \$8 co-pay for months when the service is furnished and applicable deductible payments, is a deterrent for beneficiaries to receive this service. Waiving the cost-sharing would address beneficiary confusion about receiving a bill during a month when the beneficiary did not have a face-to-face visit with the provider billing for CCM. Additionally, it often costs more for practices to collect the \$8 co-pay than the amount of the co-pay itself. We urge the working group to treat chronic care management services like other preventive services, for which Medicare waives the beneficiary co-payment and pays 100% of the Fee Schedule amount.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

The working group is considering allowing ACOs in two-sided risk models to waive beneficiary cost sharing, such as copayments, for items/services that treat a chronic condition or prevent the progression

of a chronic disease. The working group solicits feedback on whether the items/services eligible for reduction should be defined through rulemaking or be left to the discretion of the ACO.

We believe there is opportunity for several additional waivers that would both help MSSP ACOs improve care delivery and encourage beneficiary health-seeking behavior. Our strongest recommendation is waiving certain primary care copays for all ACO tracks. We offer this proposal for four reasons. First, by waiving the copays for primary care services, the ACO can encourage patients to get the most appropriate and time-sensitive care. The waiver offers the possibility of further engaging beneficiaries in their health and their healthcare by helping ensure necessary preventative screenings are provided, chronic conditions are kept from unduly progressing, and preventing new conditions or exacerbations of existing conditions.

Second, unstable beneficiary assignment is a well-recognized MSSP problem. Michael McWilliams and his colleagues found in a 2014 *JAMA Internal Medicine* study that unstable assignment was as high as 33% and that “much of the outpatient specialty care for patients assigned to ACOs, particularly higher-cost patients with more office visits and chronic conditions, was provided by specialists outside of patients' assigned organizations, even among more specialty-oriented ACOs.” CMS noted in its December 2014 proposed ACO rule that unstable assignment or “churn rate” is 24% on average. We believe a copay waiver would reduce unstable assignment and “leakage,” or where ACO-assigned patients' office visits occur outside their ACO.

Third, because we propose to limit the copay waiver to five specific primary care (CPT) Evaluation and Management codes (99211-99215), Transitional Care Management codes (99495 and 99496) and the Chronic Care Management (CCM) CPT code 99490, we believe this will produce the greatest benefit for the least amount cost to the ACO. Without an out-of-pocket (OOP) cost, the ACO patient can seek care without having to decide presumptively whether care is essential or not. For the ACO provider, the waiver will, again, help reduce year-over-year assignment instability and leakage. The copay waiver would also serve the ACO provider and patient equally well since more timely appointments and greater adherence to care would minimize the possibility of greater downstream costs due to higher intensity care. The waiver would both motivate and reinforce beneficiary-provider attestation (offered in the Pioneer ACO model and discussed in the working group's policy options document).

Lastly, we recognize the concern that waiving OOP costs can drive over- or unnecessary utilization, i.e., the concern over the “offset effect.” To address that concern, we recommend limiting the waiver to a discrete number of primary care codes delivered by primary care providers upon which ACO beneficiary assignment is based. The waiver would also only benefit a discrete number of ACO patients since about 25% of Medicare beneficiaries have Medigap insurance and a much larger percentage have supplemental coverage via employer-sponsored plans and other policies that typically provide first dollar coverage. We also know beneficiaries without secondary coverage are poorer in health, lower in income, have higher out-of-pocket costs and stint on care. Finally, we know that waiving the primary care copays will result in lower revenue for the ACO physicians and we recommend that the waiver be optional to an ACO, and in order to implement it, the ACO would need to have advanced consent of all primary care providers through their ACO participant agreements. We further recommend that the ACO be able to reimburse the physicians for the forgone revenue associated with waiver of the copays.

In sum, we believe waiving a discrete list of primary care service copays for all three ACO tracks would encourage the use of primary care services, improve patient outcomes over time and further patient centered care. This recommendation is consistent with MedPAC's 2010 technical panel's finding that lowering cost sharing services for preventive services is a way to encourage the use of high-value, high-quality health care.

CONCLUSION

On behalf of the undersigned organizations, we thank you for the opportunity to provide feedback on the chronic care working group's policy options document. We are hopeful that our constructive comments on improvements to the program are helpful and welcome any questions you may have.

Sincerely,

American College of Physicians
American Medical Association
American Medical Group Association
Medical Group Management Association
National Association of ACOs
Premier healthcare alliance