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**COMMONWEALTH
FUND**

212.606.3800
1 EAST 75TH STREET
NEW YORK, NY 10021
WWW.COMMONWEALTHFUND.ORG

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The Honorable Johnny Isakson
Co-Chair

The Honorable Mark Warner
Co-Chair

Bipartisan Chronic Care Working Group
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Isakson and Chairman Warner,

Thank you for the opportunity to comment on the policy options for improving health outcomes for Medicare beneficiaries with chronic conditions laid forth in your December, 2015 document. The Commonwealth Fund applauds the working group's bipartisan, transparent, and inclusive efforts to identify policy options for the Committee's consideration.

The Commonwealth Fund is a non-partisan, private foundation that aims to promote a high performance health system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable populations. We achieve this goal by supporting independent research on health care and health policy issues, conducting internal policy analysis and survey work, and serving as a bridge between research and policymakers at the federal and state level.

As you are well aware, a disproportionate share of health care spending goes to the care of what the Commonwealth Fund refers to as "high-need, high-cost" patients (HNHC). With ten percent of all Medicare beneficiaries accounting for 53 percent of Medicare spending, the need for new approaches to providing care to our sickest and most vulnerable patients has never been more pressing. By preventing and better managing the chronic conditions that lead to high costs, we can enable people to live healthier lives and control the growth of health care spending. Based on our review of prior evidence and insights generated by our grantees, we offer four general framing comments and then address specific questions posed in your policy options document.

First, the focus on Medicare beneficiaries with chronic conditions—a large and increasing group—should be expanded to include those with functional limitations (such as difficulties with Activities of Daily Living). Commonwealth Fund analyses suggest that expanding the focus to include those with physical limitations or disabilities better positions payers and health systems to identify and improve the care of very sick, clinically complex patients who generate substantial health care spending. These patients are more likely to report higher out-of-pocket costs, greater fragmentation of care, more hospital visits, and twice the health care spending of individuals with multiple chronic conditions alone.

Second, high-need, high-cost patients are a heterogeneous population. “One-size” care management approaches cannot produce the same results for a frail elderly person living alone as they produce for an ambulating older adult with six complex chronic conditions. Identifying subgroups of patients with similar needs and challenges will enable insurers and providers to tailor interventions more effectively. Under the guidance of an external advisory group of health system leaders, the Commonwealth Fund is actively engaged in developing a framework and segmentation strategy to assist health systems, payers, and policymakers match promising programs and payment models to key subgroups. We believe that programmatic or policy improvements considered by the Committee should be mindful of potentially varying needs and opportunities to improve care of differing segments among Medicare beneficiaries with chronic conditions and functional limitations.

Third, as you noted in the policy options document, many of these critical changes to the health care delivery system are difficult to achieve under a fee-for-service payment system. If we as a nation are to improve the health of our most vulnerable, payment systems must be structured to incentivize and support delivery of coordinated, high-quality care. While fee-for-service remains the dominant payment approach in Medicare, we want to ensure that we do not further entrench the fee-for-service system with well-intentioned changes or new provisions. This would only send mixed messages to providers who are struggling to transition toward value-based payment and alternative payment models.

Finally, evidence suggests that interventions consistent with the Fund’s six principles for improving value for HNHC patients are the most likely to produce better care at lower costs. As you can see, there are significant areas of overlap between the six principles and the three bipartisan goals laid out by the working group: increased care coordination among providers treating individuals with chronic conditions; streamlining payment systems to incentivize the appropriate level of care and facilitating the delivery of high quality care; and improved care transitions and better patient outcomes.

The Commonwealth Fund’s Six Principles for Improving Value for High-Need, High-Cost Patients¹	
1.	The HNHC or chronically ill population is a heterogeneous group. In order to tailor appropriate interventions that improve care and constrain costs, we must identify subgroups of patients with similar needs and challenges.
2.	Shift the delivery of care for HNHC patients from institutional settings to home and community settings when possible. Institutional settings frequently fail to meet the needs of patients and caregivers while also being higher cost than a home or community-based setting.
3.	Integrate medical, behavioral and social services through the use of multidisciplinary teams of clinicians, behaviorists, case managers, and patients working together to better tailor treatments and address behavioral, social and medical needs.
4.	Streamline patient, caregiver and provider coordination and communication. Health care, behavioral health and social service enterprises could improve communication by taking full advantage of advances in consumer-friendly, secure digital options.
5.	Design and deliver care that meets goals set collaboratively by patient, caregivers and providers. Evidence suggests that health goals developed in a collaborative manner have a greater chance of being achieved.
6.	Payment systems should be flexible enough for providers to allocate resources as needed under a per-patient or outcomes-based payment system. Under such a system, they will be able to offer comprehensive services that can reduce health care spending and improve the lives of very sick, frail patients.

A recent review of the evidence on promising models for high-need, high-cost patients was published by the Fund in November 2015.² Over the next few years, the Commonwealth Fund’s Health Care

¹ M. Abrams & E. Schneider, *Fostering a High-Performance Health System That Serves Our Nation’s Sickest and Frailest*, The Commonwealth Fund Blog, Oct. 29, 2015, <http://www.commonwealthfund.org/publications/blog/2015/oct/fostering-a-high-performance-health-system-sickest-and-frailest>.

Delivery System Reform program, in collaboration with other organizations, as well as our own Medicare and Cost Control initiatives, will be working to identify, evaluate, scale, and spread efforts to improve the care for the nation's sickest and frailest individuals.

Based on work that is currently underway by our grantees, we have the following comments on these specific policy options you are considering:

- Receiving High Quality Care in the Home
- Improving Care Management Services
- Behavioral Health Needs among Chronically Ill Beneficiaries
- Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations
- Providing Flexibility for Beneficiaries to be Part of an ACO and Maintaining ACO Flexibility to Provide Supplemental Services

Receiving High Quality Care in the Home

Based on early results released in June 2015, it is reasonable to expand the existing Independence at Home (IAH) program. Year One evaluation results showed \$25 million dollars in savings while improving quality and reducing 30-day hospital readmissions, as well as reducing hospital and emergency department costs. The program highlights the effectiveness of home-based, interdisciplinary primary care teams for frail Medicare beneficiaries cared for in the community.³

On the risk adjustment question, changes to the HCC model likely need to be made in order to more accurately predict the actual cost of complex frail elders with disabilities, an essential step in any shared savings program. The Fund has supported work by Bruce Kinoshian, MD, and colleagues at University of Pennsylvania Medical Center, which shows that the HCC model under-predicts costs of IAH enrollees by 17 percent when compared to similar, propensity-matched controls.⁴ The higher levels of mortality, frailty, and clinical instability in high-cost populations require additional adjustment (captured by a well-calibrated frailty adjuster) in order to reflect the additional costs associated with frailty compared to a model calibrated to a general fee-for-service Medicare population. The Penn team's analysis shows that the adjusters from the CMS PACE program (a unique capitated managed care benefit for frail elderly that provides comprehensive health and social services)—such as the PACE county rates, the PACE HCC model, and the PACE frailty adjusters—appear to capture the costs of this high-risk population nationally. Finally, the geographic adjustments need to be reconsidered since, based on the IAH experience, Dr. Kinoshian observed that there are large variations in the relative cost of high-cost beneficiaries, compared to the average beneficiary costs in low, medium, and high cost counties. While this puts providers serving high-cost patients in low cost counties at substantial disadvantage, the wide variation among the range of counties requires a local adjustment in order to accurately project the savings baseline in shared savings programs.

Improving Care Management Services

In response to the Committee's request for feedback on development of criteria for high-severity chronically ill patients, we agree that carefully constructed definitions for eligible patients are important. The Commonwealth Fund has supported recent analyses of high-cost Medicare

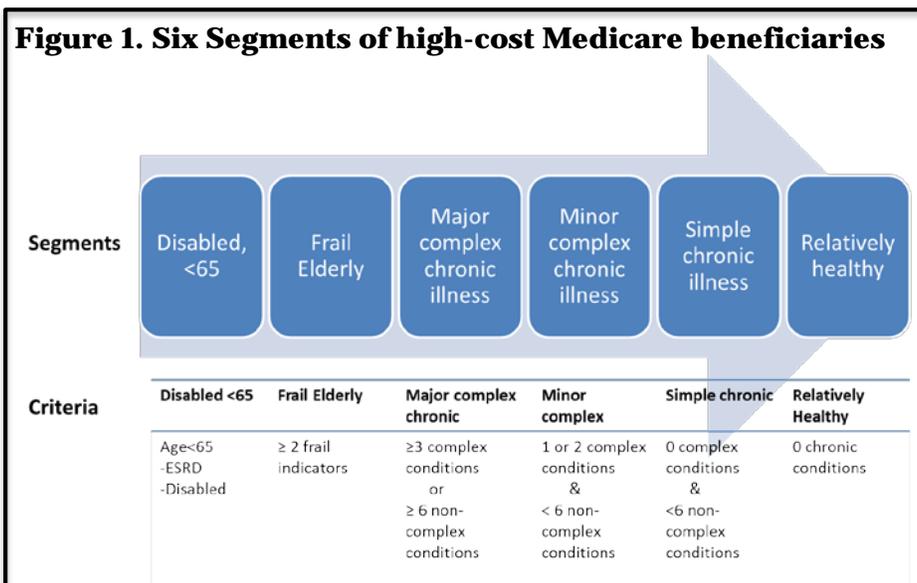
² D. McCarthy, J. Ryan & S. Klein, *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis* (New York, N.Y.: The Commonwealth Fund, Oct. 2015, <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/care-high-need-high-cost-patients>).

³ Centers for Medicare and Medicaid Services, "Affordable Care Act payment model saves more than \$25 million in first performance year," June 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html>.

⁴ B. Kinoshian, P. Bolin, G. Taler and D. Gilden. "Expected Costs for Medicare's Frailest Beneficiaries," Memo to The Commonwealth Fund, March 21, 2015; S. Bollampally, D. Gilden, E. Dejonge, G. Taler, P. Boling and B. Kinoshian. "Home Based Primary Care Significantly Reduces Costs Among Independence at Home Eligible Medicare Beneficiaries," Poster Presentation at the AcademyHealth Annual Research Meeting, June 15, 2015.

beneficiaries' characteristics and patterns of care by a team led by Ashish Jha, MD, MPH of the Harvard School of Public Health that provide a useful framework for identifying such beneficiaries and structuring appropriate interventions.

Using Medicare claims data, the Harvard team has empirically derived six segments of high-cost Medicare beneficiaries that health systems and payers can use to identify and manage patients with high-cost and complex needs (see Figure 1). Since 63.1 percent of Medicare beneficiaries have chronic conditions, Dr. Jha's team further subdivided this group into three distinct segments based on the specific type and number of chronic conditions. Based on these analyses, we suggest that the "major complex chronic" segment is likely to most closely align with the questions raised by the Committee about how best to define a "high-severity" chronically ill patient population.⁵ This has important implications for selecting and applying the right interventions primarily because it narrows the population to those most likely to benefit from intervention and can thus save precious resources.



Behavioral Health Needs among Chronically Ill Beneficiaries

Chronically ill individuals with behavioral health problems are at increased risk of serious medical complications and premature death. The coexistence of chronic disease and behavioral health problems (mental health condition or substance abuse disorder) also dramatically increases costs. High-need, high-cost Medicare beneficiaries are two to three times more likely to have a behavioral health problem than other Medicare beneficiaries.

Incentives to spread effective models integrating behavioral and physical health care, particularly in primary care, is a priority for the high-need, high-cost population. Promising models with solid evidence exist. For example, the Collaborative Care model, which was initially developed for a geriatric population by a team at University of Washington with support from the John A. Hartford Foundation, has demonstrated cost savings in high-risk, low-income populations with medical comorbidities, compared to traditional health care.⁶ Nonetheless, there have been few incentives to improve the link between general and behavioral health practitioners and to scale best practices.

⁵ The nine conditions identified as "complex" by Jha et al. are: Acute Myocardial Infarction / Ischemic Heart Disease, Chronic Kidney Disease, Congestive Heart Failure, Dementia, Chronic Lung Disease, Psychiatric Disease, Specified Heart Arrhythmias, Stroke, and Diabetes.

⁶ J. Unutzer, W. Katon, C.M. Callahan, et. al. "Collaboarative care management of late-life depression in the primary care setting: a randomized controlled trial," *Journal of the American Medical Association*, December 11, 2002 288(22): 2836-2845. <http://jama.jamanetwork.com/article.aspx?articleid=195599>.

The Fund has supported Dr. Jürgen Unützer, MD, MPH, MA, of University of Washington, Edward Wagner, MD, MPH, of Group Health Cooperative, and Jonathan Sugarman, MD, MPH, of Qualis Health to review the evidence and, in collaboration with providers, develop an “implementation guide” to assist with successful integration of behavioral health in primary care.⁷ The team defined and developed a practical approach for achieving integrated care, including worksheets, metrics, and concrete examples. While the work focused on low-income patients served by community health centers, the lessons are transferrable to all primary care practices, including those serving Medicare beneficiaries.

Harold Pincus, MD, MPH, at Columbia University Medical Center, has argued that one key to applying the implementation of these integration strategies is the development of meaningful and valid measures that assess the quality of ambulatory care-behavioral health integration, especially for chronically ill, complex patients.⁸ Such measures could be used in future value-based purchasing to drive organizations to deliver care that better integrates behavioral health services. Dr. Pincus is in the process of developing a framework to classify existing measures and will engage in a consensus process with national experts to identify the best available quality measures that are feasible and assess a range of key issues (e.g., access, patient experience, provider experience, efficiency). We expect results to be available by May 2016.

Regarding the specific question about current status of behavioral health integration among Medicare ACOs, the Fund has supported two relevant studies. First, a study by a team at Dartmouth, based on a national survey of ACOs, shows that integration of behavioral health care and primary care remains low, with most ACOs pursuing traditional fragmented approaches to physical and behavioral health care and only a minority implementing innovative models. Contract design and contextual factors appear to influence the extent to which ACOs integrate behavioral health care. Nonetheless, the authors conclude, “our findings suggest that ACOs can promote improved care for behavioral health conditions and better integration with physical care.”⁹ The second study, led by a team at The Johns Hopkins University, examines behavioral health integration in the Alternative Quality Contract, an early ACO model from Blue Cross Blue Shield of Massachusetts. The analysis, led by Colleen Barry, PhD, showed that ACO enrollees were slightly less likely to use mental health services and among the users, there was decline in total health care spending, but not a decline in mental health spending.¹⁰ To our knowledge, there exists no comprehensive review of cost and utilization of mental health services among public sector ACOs.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

The Commonwealth Fund is supporting the Center for Health Care Strategies to lead two collaboratives—one with 17 states engaged in the Financial Alignment demonstration and one with 8 special needs plans—to integrate and improve care for individuals who are dually eligible for Medicare and Medicaid. Some lessons that are relevant to the questions raised in the policy options document:

- Integration of behavioral health for chronically ill beneficiaries would have a significant impact on the health status and spending of the dually eligible population. A number of states are moving from “carve out” models to “carve in” models where managed care plans are responsible for both behavioral and physical health services.

⁷ BH Implementation guide, 2015. <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Behavioral-Health-Integration.pdf>

⁸ M. L. Goldman, B. Spaeth-Rublee, and H. A. Pincus, “Quality Indicators for Physical and Behavioral Health Care Integration,” *Journal of the American Medical Association*, Aug. 2015 314(8):769–770.

⁹ V. A. Lewis, C. H. Colla, K. Tierney et al., “Few ACOs Pursue Innovative Models that Integrate Care for Mental Illness and Substance Abuse with Primary Care,” *Health Affairs*, Oct. 2014 33(10):1808-1816.

¹⁰ C. L. Barry, E. A. Stuart, J. M. Donohue et al., “The Early Impact Of The ‘Alternative Quality Contract’ On Mental Health Service Use And Spending In Massachusetts,” *Health Affairs*, Dec. 2015 34(12):2077–2085.

- Permanent status of D-SNPs under the Medicare Advantage program might provide much-needed stability to states when engaging stakeholders to develop plans for advancing integrated care products for duals.
- Improvement in payment through more accurate risk adjustment is needed, especially to reflect the individual's functional limitations. The complexity and heterogeneity of the dual eligible population suggests that risk adjustment should reflect patients' needs and not be a single adjustment to cover all duals.
- Given the extensive social service needs that directly affect health status and spend of dually eligible beneficiaries, states and MA plans need flexibility to offer a wider array of supplemental benefits to cover non-medical services.

Providing Flexibility for Beneficiaries to be Part of an ACO and Maintaining ACO Flexibility to Provide Supplemental Services

As mentioned above, the Commonwealth Fund is supporting a team at Dartmouth to conduct a national survey of ACOs about their systems, structure, staff, and processes. These data are linked to Medicare claims data so that Carrie Colla, PhD, and Elliot Fisher, MD, MPH, can then assess the relationship between structural features of the organizations that may be associated with better beneficiary outcomes and more efficient use of resources.

In response to the Committee's question about impact of different ACO attribution methods, the Fund supported the Dartmouth team to study this question, which was published in a paper in *Health Affairs* in 2013.¹¹ Results show that "retrospective attribution" (where the ACO waits until the end of the performance year and then assigns patients to an accountable care organization based on their use of services in the completed performance year), more fully and accurately reflected an ACO's patient population than "prospective attribution" (when patients are assigned to an ACO for the upcoming performance year based on each patient's use of services in the prior year). With retrospective attribution, an ACO may be better positioned to achieve shared savings.

Regarding the cost of ACO development, the Dartmouth team found that the Advanced Payment Model ACO, in which rural MSSPs were awarded upfront investments to assist with ACO formation, was associated with significantly better performance in both disease prevention and wellness screening measures.¹²

ACOs may need more flexibility in terms of selection and streamlining quality measurement requirements. One provider participating in the Pioneer ACO program described facing 219 unique metrics across 6 risk-based contracts forcing choices about where to direct early organizational efforts and surfacing concerns about burdensome measurement.

Many of the policy options considered by the Committee seek to give ACOs more flexibility to determine what best meets the needs of chronically ill patients. At this time, there is still much to learn about the best ways for ACOs to organize, structure, and deliver care. Thus far, the evidence points to a wide variety of organization types and various levels of technical capability (e.g. formal care management, IT) to both produce savings and deliver high-quality care. Therefore, we agree that promoting flexibility in ACO regulation is important to promote continued experimentation and ongoing assessment and evaluation.

Given that we know that Medicare patients with complex chronic conditions have considerable behavioral health and social service needs, we support giving ACOs flexibility to test ways to

¹¹ V. A. Lewis, A. B. McClurg, J. Smith et al., "Attributing Patients To Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests," *Health Affairs*, March 2013 32(3):587–595.

¹² B. B. Albright, V. A. Lewis, J. S. Ross et al., "Preventive Care Quality of Medicare Accountable Care Organizations: Associations of Organizational Characteristics With Performance," *Medical Care*, Jan. 2016 [Epub ahead of print].

coordinate and integrate with social service agencies and are supporting a lot of work in this space. For example, under the direction of Ruben Amarasingham, MD, at Parkland Clinical Care Innovations (PCCI), a research team has conducted an environmental scan of shared savings models with social service organizations. While not limited to Medicare beneficiaries (there is much to be learned from Medicaid on this question), Dr. Amarasingham's team has identified 300 innovative programs that either incorporate a financial arrangements of two or more health and non-health entities (e.g., financial contract); coordinate care between medical and non-medical organizations; or (least likely) involve risk-sharing among medical and non-medical organizations. The PCCI team is currently conducting a survey with these organizations to understand the structure of the arrangements. And based on input from several experts, the PCCI team has created a typology of domains and elements that need be considered in designing shared savings models between health care and social service agencies. Another project, with Robyn Golden, MSW, at Rush University, is evaluating a new social service integration model in which social workers are placed in primary care to assist patients over 55 years old with non-medical needs.

We are pleased to discuss any of these issues further or to connect you to the researchers we've referenced in this memo as you move forward on select policy options. Thank you for the opportunity to comment and for your commitment to improving care for high-need, high-cost patients.

Sincerely,

Rachel Nuzum, M.P.H.
Vice President, Federal and State Policy
The Commonwealth Fund

Melinda K. Abrams, M.S.
Vice President, Delivery System Reform
The Commonwealth Fund