

**Johns Hopkins Medicine Comments on the
United States Senate Committee on Finance
Bipartisan Chronic Care Working Group Policy Options Document
January 28, 2016**

ADDENDUM

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ACOs and Tele-Health

Johns Hopkins Medicine believes that tele-health services are an important potential tool to improve access as well as efficiency of care. We would advise not restricting tele-health payment to those in 2 sided ACO models to allow for those in 1 sided ACO models. We would also favor flexibility with respect to the originating site, and at least inclusive of in-home services or place-of-employment opportunities.

ACO Flexibility and Supplemental Services

Johns Hopkins Medicine supports the ability to use its own resources to provide additional services for patients that are not covered by Medicare, or are otherwise prohibited under the Civil Monetary Penalties law which prohibits providers from providing Medicare patients with certain beneficiary inducements (such as social services, transportation, or remote monitoring). In order to mitigate the potential for Program abuse, the CMS might consider limiting the additional services to ACO population members with certain chronic disease diagnosis codes and/or certain types of visits. For example, an ACO would be permitted to provide transportation services to diabetes patients to their primary care provider's office, and/or to dialysis centers.

Allowing ACOs to provide patients with remote monitoring equipment/capabilities is supported by the recently enacted Value-Based Insurance Design (VBID) for Medicare Advantage Plans. Adopting this policy for ACOs would be consistent with that program.

Flexibility for Beneficiaries to be a Part of ACOs

Johns Hopkins Medicine believes that a beneficiary who elects to be assigned to an ACO should still be allowed to receive services from non-ACO providers. Although possibly not ideal from the network perspective, it helps to ensure patient choice. In addition, beneficiaries who voluntarily align to an ACO (regardless of where they've received the plurality of their PCP services) most likely have a strong connection to an ACO provider (or providers). These beneficiaries should not be 'punished' by restricting their right to seek care outside the network. Such a policy may have the unintended effect of discouraging beneficiaries from enrolling/participating in any ACO. It also seems duplicative of the Medicare Advantage

program where patients are restricted to using in-network providers. CMS should instead adopt a policy similar to that under the NGACO (Next Generation ACO) program allowing patients to voluntarily align without any restrictions on provider access. This would further ensure that ACOs focus on improving quality/reducing costs for all ACO attributed beneficiaries, not just those who self-attribute.

Johns Hopkins Medicine believes that allowing ACOs to determine whether they would be assigned beneficiaries prospectively or retrospectively would be advantageous. If pursuing prospective assignment, receiving some upfront payment to help support associated operational expenses would be advantageous, should the ACO elect for this. This payment should be in the nature of an ACO operational support payment akin to that under the NGACO program, and should not be a partial or full capitation for services rendered. The latter may discourage ACOs which are inexperienced with population health and managing risk from enrolling in the MSSP—which seems to contradict CMS’ recent decision to allow Track I ACOs to renew under Track I. The support, as under the NGACO program would be repayable from any ACO savings, regardless of whether it generated sharable savings, i.e. savings in excess of the MSR.

Allowing beneficiaries to determine their attribution by an attestation of primary care rather than just relying on retrospective claims history would be advantageous. In this case, receiving some upfront payment to help support associated operational expenses would also be beneficial, should the ACO elect for this. For the same reasons as stated above, we support an ACO operational support payment, rather than a full or partial capitation payment for these beneficiaries.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

Johns Hopkins Medicine would support provisions which allow increased flexibility for ACOs in all 3 Tracks to waive beneficiary cost shares for targeted populations. While we recognize that ACOs with downside risk have even greater reasons to control spending, we feel Track I ACOs are just as likely to effectively implement such programs with the goal of achieving as much savings as possible. Allowing ACOs to determine patients for which they can waive co-payments would maximize flexibility. It would seem important for CMS to know whether a co-payment was actually collected on a particular case to make a proper determination of the total cost of care. Use of specified standards in rule-making could reduce that flexibility.

Similarly, maximizing flexibility for ACOs to determine which payments may be appropriate to waive in particular circumstances would be advantageous. Such an approach is consistent with the flexibility afforded MA Plans participating in the VBID model. As with MA plans, ACOs have better insight into the cost barriers which inhibit its chronic disease patients from accessing needed care. Therefore, ACOs should have the discretion to determine which cost shares should be subject to waiver.

There is good reason to believe that waiving cost sharing would incentivize beneficiaries to receive relevant services. Studying this differential impact within the ACO model based on patient demographic and/or social factors would be advantageous. While we do not know the exact percentage of Medicare beneficiaries who have Medigap policies, it is our belief that CMS’ concern here is outweighed by the likely program improvements (and savings) which would result from making care more affordable and accessible to all beneficiaries through waiving certain cost shares, regardless of the patient’s Medigap status. Alternatively, CMS could implement approach where the waivers are applied selectively to those not covered under

Medigap policies. We further believe that CMS' recent restriction on the sale of so called "1st dollar" Medigap policies adequately addresses CMS' concern here.