

June 22, 2015

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

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
U.S. Senate
Washington D.C. 20510

The Honorable Johnny Isakson
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

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

On behalf of Montefiore Health System (MHS), I commend the Senate Finance Committee's efforts to improve care and reduce costs for Medicare patients with chronic illnesses. MHS is a large integrated delivery system, a successful accountable care organization, and one of the nation's leading Pioneer programs serving the New York metropolitan region, including the Bronx, where patients suffer from the highest rates of diabetes, asthma, and COPD hospitalizations in our region. For years, we have been singularly focused on the best approaches to managing care for those with complex chronic diseases.

MHS' value-based payment portfolio accounts for over 400,000 lives in full risk and shared savings arrangements across every single payer (Medicare, Medicaid, and Commercial). These arrangements include both direct risk with the government, such as the FFS-based Pioneer ACO program, and risk contracts with health plans, such as Medicare Advantage (MA) Plans and Medicaid Managed Care plans. These value-based arrangements account for approximately half of the revenue that flows through MHS. We have creatively used resources through these arrangements to invest in care management and social supports for our highest need patients in order to improve the outcomes and contain the costs associated with chronic illnesses. As our portfolio demonstrates, even within our own marketplace there is no one-size fits all model for patients with complex needs. **We therefore urge the committee to support provider flexibility to choose from a variety of value-based strategies, recognizing that different markets, providers and patients will require varying approaches.**

With this overarching point in mind, we offer the following feedback:

Incorporate services and supports for chronically ill populations into total population health models

As the committee contemplates strategies for addressing Medicare beneficiaries with chronic conditions, we believe that it is critical for program and policy options to align with existing models, such as ACOs, that hold systems accountable for total population management. MHS has unique perspective to share on this count, having participated in CMS' Physician Group Practice Demonstration, which provided fees for managing high cost patients only and in the Pioneer ACO program, which incents more integrated care delivery for a broad population of Medicare FFS beneficiaries.

Under our ACO and other shared savings programs and through delegated relationships with MA plans, we have developed comprehensive care management, disease management, and pharmacy and other support programs that serve patients with complex needs. In our experience, the value of programs that hold providers accountable for broad populations is that we can flex and contract resources to address not just the chronically ill, but those who are at risk of developing chronic illnesses or advancing to multiple comorbidities. While we have established a sophisticated suite of services, our patients would absolutely benefit from additional flexibilities in reimbursable services under Medicare and further supports targeted to particular chronic diseases.

For this reason, we suggest that any services and supports being considered by the committee, such as enhanced care management fees, reduced cost sharing, new risk adjustment methodologies, and the like, be available not simply through new specialized programs limited to the chronically ill, but also to programs that serve broad populations, many of whom will progress to become chronically ill.

Ensure that payment and accountability models reflect comprehensive medical and social needs

Many of our most complex patients not only suffer from multiple comorbidities, but also from social challenges that impact health outcomes. The Bronx alone is home to 70,000 dually eligible individuals, many of whom are chronically ill, elderly and face functional limitations. Because of this circumstance, we have found that changing healthcare behaviors requires our system to expend enormous effort to address social issues like housing instability, food insecurity, limited transportation, exposure to violence and more. While we are able to support some of these services through reinvestments and community partnerships, the failure to account for the added challenge of serving patients of lower SES in Medicare Advantage payments or quality outcomes, seriously limits our abilities to effectively intervene. As the committee weighs new strategies for amending or adjusting MA risk adjustment, we strongly encourage the consideration of other risk adjustment or stratification methodologies to account for SES and the frailty of populations with chronic illnesses, and to do so across all value-based models.

As another option, the committee may consider new benefit package designs that enable reimbursement for services typically not reimbursable under the Medicare program, but that benefit patients with chronic illnesses. Such services could include remote patient

consults via telemedicine platforms, expanded home visitation services, transportation for defined clinical purposes, remediation to address environmental or living circumstances exacerbating illness (e.g. insufficient cooling/heating systems), or housing support services. Finally, as many of the most complex patients face terminal illnesses, we believe revisiting policies around hospice and palliative care is sorely needed. Specifically, the committee should contemplate the use of hospice care concurrently with curative care and expanding eligibility requirements to encompass a broader range of patients with significant needs, such as allowing individuals with a 12 month prognosis to access the hospice benefit.

Streamline reporting/documentation requirements for new CCM codes

We very much appreciate CMS' efforts to expand support for care management services by paying for care coordination when a patient transitions from an institutional setting and new policies to reimburse providers for chronic care management (CCM) services. We are concerned, however, that the administrative burden associated with the new CCM codes and some of the prohibitions around when and which providers can bill, will limit their use and utility. As a part of the committee working group's mandate, we urge an expert stakeholder engagement process to identify areas where the CCM structure could be streamlined and improved, while still maintaining program integrity.

Examine policies to enhance information exchange and other enabling technology related to management of complex populations

Given the multi-faceted needs of patients with chronic illnesses, it is critical for healthcare providers to be able to access comprehensive data about patients with relative ease, so as to enable early identification of unique patient needs and challenges, prevent duplication of services and ease care transitions. To that end, we recommend that the committee evaluate and where appropriate, amend policies governing information exchange.

A specific example would be limitations on non-behavioral health providers' ability to view behavioral health information about patients in order to coordinate care. In particular, 42 CFR Part 2 substance abuse confidentiality regulations are well intentioned and made sense when they were first enacted. However, they create real problems in risk-based models of care, where one of the most important elements of managing the population is understanding what underlying health conditions might be affecting their success and addressing them. In the current environment, if a provider is at-risk for a patient's health and their care manager asks for all of the patient's information on file, they are blocked from seeing any substance abuse-related information. Particularly in the post-ACA environment, where individuals can no longer be discriminated against by insurers for a preexisting condition, nor priced out of the marketplace because of it, it seems as if the benefits of permitting this information to travel between providers and

care managers involved in population health initiatives outweigh the risks. MHS can speak further to our experience with this law as an impediment to better care within our Pioneer ACO population, but we recommend that the Committee consider this regulation and support the enactment of changes that balance the need to preserve a patient's privacy with the ability of both providers and patients to be successful in risk-based models of care.

Related, the committee should encourage incorporation of other types of data related to socio-economic challenges (e.g. data pertaining to food stamps, homelessness, incarceration, etc.) into health information exchange entities to support comprehensive care management. Given the clear connection between socioeconomic factors and challenges in achieving success in health outcomes, providers are more likely to be successful in long-term improvements in health if they understand the full picture of a patient's life and challenges, and are able to deploy appropriately tailored resources to address those challenges. As such, the Committee should consider ways to align Medicare data with other federal and federally-funded data bases. Further, we suggest that the committee take steps to advance interoperability of IT platforms and common standards for electronic clinical information, such as those articulated in the Office of the National Coordinator's Nationwide Interoperability Roadmap.

We also support the committee's continued interest in expanding the use of telemedicine platforms to enable remote visits between patients and providers in ways that are maximally accessible for both parties. MHS recently received a CMMI grant to support the integration of behavioral health services into primary care, using a telemedicine platform that will allow psychiatrists to both remotely confer with on-site primary care providers as well as patients. We are confident that this demonstration, along with other such efforts across the country, will continue to underscore the utility of telemedicine not simply in rural settings, but also in urban environments. We believe this technology is of crucial value in addressing the needs of individuals with multiple chronic illnesses, many of whom are home bound or struggle to access transportation. We support efforts to explore the use of telemedicine platforms and are happy to share lessons learned through our CMMI demonstration with the committee.

Advance regulatory reforms that facilitate complex care management

Effective care management for patients with chronic illness will require not simply new care models, reformed reimbursement structures, and supportive IT, but also a regulatory environment that enables patients to receive multiple services in a single environment. Regulations and policies such as those that prohibit Medicaid reimbursement for behavioral health services in non-behavioral health clinics, undermine the ability of service providers to co-locate services and make care easier and more accessible for patients. As a part of the working group's charge, we urge an evaluation of regulations that may impact and undermine co-location and integration of multiple service types.

Thank you again for the opportunity to provide this input and for the committee's focus on this important area. I am available to follow-up on any of these issues. In addition, please feel free to have your staff reach out to my staff, Kate Rose, Vice President for Public Policy and Government Relations at karose@montefiore.org or by phone at (718) 920-6647.

Sincerely,

A handwritten signature in black ink, appearing to read "Steven M. Safyer", is enclosed in a thin black rectangular border.

Steven M. Safyer, MD
President and CEO