

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee

The Honorable Johnny Isakson
Co-chair
Chronic Care Working Group

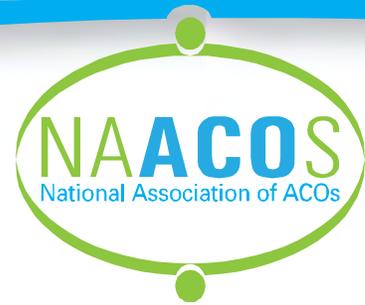
The Honorable Mark Warner
Co-chair
Chronic Care Working Group

Dear Chairman Hatch and Senators Wyden, Isakson and Warner:

We appreciate the opportunity to respond to the Senate Finance Committee and its chronic care working group's May 22nd letter requesting recommendations to improve chronic care management. The National Association of ACOs (NAACOS) is the largest Medicare Shared Savings Program membership organization in the US with approximately 150 MSSP and Pioneer ACO members. We are a member-led and member-owned non-profit organization. Our sole purpose is to improve the quality of Medicare delivery, population health or outcomes and cost efficiency.

The NAACOS looks forward to working with the other members of the Finance Committee chronic care working group as it continues its considerations to improve chronic care for the Medicare and Medicaid beneficiaries. Our comments below Address some of the issues the members of the working group will consider in developing proposals in this area. Fundamentally, the Medicare ACO programs are at the heart of improving chronic care. The ACO business model and clinical culture both mandate optimally treating patients with one or more chronic conditions. The ACOs are the fastest growing segment of Medicare FFS and in 2 years already serves half the number of beneficiaries as all of Medicare Advantage. There is not a better partner to your work group's efforts than the Medicare ACOs.

NAACOS, along with 17 other major ACO stakeholder organizations expressed its collective view of the MSSP program in its February 6th comment letter to CMS's proposed MSSP rule. Our letter is posted on the NAACOS website at: <https://www.naacos.com/pdf/MSSP-NAACOSJointCommentLetter020615.final.pdf>. While the CMS final rule marginally helps the ACO program, the final rules are woefully short in providing the tools and incentives needed for the Track 1 ACOs (99% of the program) to succeed. We hope your committee will consider in the context of improving chronic care, supporting a number of changes to the CMS MSSP program. We offer below both



recommendations on how to better equip the ACO program to treat chronic care patients and suggestions to your work group on important issues to consider.

1. Incentivize Providers To Better Coordinate Care

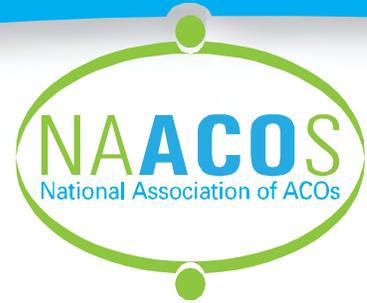
CMS should offer SNF, home health, telehealth, and post-acute referral waivers to all ACO participants regardless of track. These waivers in sum would appreciably help ACOs to better deliver and coordinate care for chronically ill Medicare beneficiaries.

2. Improve Use of Telehealth & Remote Monitoring

CMS's approval of telehealth service use is extremely milted. (It's estimated in 2011 the Medicare program reimbursed less than \$6 million in telehealth services.) Telehealth fundamentally changes or disrupts the way healthcare is delivered since they offer numerous methods and modalities to expand care delivery capacity/efficiency and improve health care outcomes particularly in under-served and rural areas. It 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 specialty and primary care providers and providers and patients.

Studies of telehealth's use in primary care show for example it is cost effective in reducing hospital admissions and re-admissions as well as reductions in both emergency visits and transfers between emergency departments. Studies also show telehealth services are less expensive, are not additive (they are moreover a substitute for in-person care) and are unlikely to induce utilization. Patient satisfaction via the use of telehealth, more specifically, interactive video, telephone consultations and remote monitoring has on balance been high.

Another essential use of telehealth is remote patient monitoring (RPM) as a way of providing secondary prevention for patients with chronic illness. RPM use to monitor 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. RPM use by the VA has also led to an 81% decrease in nursing home admissions and a 66% reduction in emergency department visits. The VA reports its telehealth programming generally has among other things reduced overall bed days for veterans by 58% and hospital admissions by 38%. Similar results in the use of so called consumer-facing technologies have been achieved in the private sector. Cardio-vascular disease patients in Boston's Partners Healthcare receiving RPM services experienced a 50% reduction in related hospital re-admissions. Similar results were achieved for Colorado patients enrolled in Centura's Health At Home program.



In sum, the October 2014 ONC noted in a paper titled, "Health Information Technology Infrastructure To Support Accountable Care Arrangements," remote monitoring would produce as much as \$200 billion in cost savings over the next quarter century.

3. Empowering Medicare Patients

One way to "empower" Medicare patients is to allow them to "attest" they're participants in an ACO. Another way to "empower" chronically ill Medicare patients is to make more available to them social service supports. Medicare spending is not driven by the number of patients with chronic conditions but moreover by patients with chronic conditions and functional limitations. While 48 percent of Medicare enrollees have three or more chronic conditions, they drive only 51 percent of Medicare spending. Fifteen percent of Medicare enrollees have chronic conditions and functional limitations however they drive 32 percent of Medicare spending.

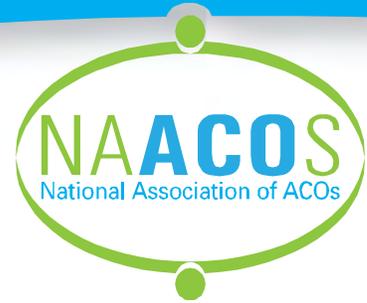
(http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf)

Add to this the fact compared to OECD countries in sum, the US spends comparatively a disproportionate amount of money on health care versus social services. Among other OECD countries for every \$1 spent on health care, \$2 is spent on social services. US spending is the opposite. For every \$1 spent on health care, \$0.55 is spent on social services. The Medicare program needs to "empower" Medicare beneficiaries to seek and receive social support services.

We would be remiss if we did not note as well empowering Medicare beneficiaries should also mean improved advanced care planning (including POLSTs or Physician Orders for Life Sustaining Treatments) and greater recognition of, and support for, family caregivers. We are supportive of Senator Warner and Senator Isakson's Care Planning Act of 2015.

4. More Effectively Utilize PCP and Care Coordination Teams

In order for providers to work effectively in care coordination teams it is necessary provider teams have the ability to share confidentially patient records. Federal regulations however currently prohibit the release of identifiable information related to substance abuse treatment services without the patient's prior express consent. This regulation, 42 CFR Part 2 and 42 CFR 2.31 and commonly referred to as "To Whom" consent, dates to 1987 or before the development and wide use of HIT and EHRs. In June 2014 SAMHSA held a public listening session because SAMHSA recognized the regulation prevents patients from "fully participating in integrated care efforts even if they are willing to provide consent." (NAACOS provided comments that are of public record.) SAMHSA has not to date made formal comment about updating this regulation and it is unknown if and when SAMSHA will. While we full well recognize the importance of maintaining patient confidentially it is practically impossible for providers wanting to improve care coordination for patients with substance abuse problems when



the patient is required to provide prior written consent, that is both the provider group and the patient be required to know in advance future un-named ACO clinicians that may treat the patient.

5. **Increase Chronic Care Coordination in Rural and Frontier Areas**
Community Health Workers (CHW) are being re-discovered for their ability to provide effective peer support. The New England Journal of Medicine last week published a brief overview of CHW's last week (<http://www.nejm.org/doi/pdf/10.1056/NEJMp1502569>). We also note New Mexico's successful use of CHW's in providing support for, among others, patients with diabetes (<http://nmhealth.org/about/phd/hsb/ochw/>). See also the Academy of Family Physicians Foundation's "Peers for Progress" work lead by U. of North Carolina Professor Ed Fisher (<http://peersforprogress.org/>).
6. **Prescription Drugs**
Beyond noting the drug costs above, we well realize Medicare will have to include Part D in its MSSP and other Alternative Payment Model programming. However, we advise this be done cautiously and carefully and via rulemaking. ACOs are ever-increasingly recognizing the role of pharmacists in improving care delivery via medication therapy management in all forms since in part only an estimated 33 to 50 percent of patients with a chronic disease adhere to their prescribed medication therapies over time. Pharmacists can be/are particularly effective in providing preventive health and caring for patients with diabetes, heart failure, CAD, COPD and osteoporosis. The Congress should encourage the integration of pharmacists in Medicare's Alternative Payment Model programming. We also well recognize the epidemic in the over use and misuse of prescription (opiod) pain medication. That said the Congress should not over correct for this problem such that it causes further the under treatment of pain. The IOM estimates over 115 million Americans suffer from chronic pain.

Thank you again for considering our comments. We believe the nation's 400+ ACOs can make a huge contribution to improving chronic care and we look forward to continued discussions on this important topic. If you have any questions or need further information, please contact Jill Dowell, at jdowell@NAACOs.com or (202) 650-7084.

Sincerely,

Clifton Gaus
CEO