Steward

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June 22, 2015

The Honorable Chairman Orrin Hatch
The Honorable Ranking Member Ron Wyden
The Honorable Senator Johnny Isakson
The Honorable Senator Mark R. Warner

Via Electronic Mail to chronic_care@finance.senate.gov

Dear Chairman Hatch, Wyden, Isakson, and Warner:

Thank you for soliciting ideas and input from stakeholders on policies to improve outcomes for Medicare patients with chronic conditions.

Steward Health Care System, LLC (Steward) is New England's largest, community-based integrated delivery system, caring for over 75,000 Medicare Pioneer Accountable Care Organization (ACO) beneficiaries and over 300,000 total members across commercial and Medicare risk-based contracts. Our provider network encompasses ten hospital campuses, nearly 3,000 physicians, as well as specialists, nurses, home health, behavioral health, and allied services professionals. Steward invested significant resources to create an integrated community care model that improves access to high quality, cost-efficient, community-based health care to the more than 1.2 million residents we serve annually.

As a participant in the Medicare Pioneer ACO program, Steward has delivered strong cost and quality results for Medicare beneficiaries. Steward generated the greatest savings in the nation in 2013 – $24.6 million – which represents 24% of the Pioneer program's total savings that year, and also improved overall quality by 21% while simultaneously improving patient satisfaction. One of the key factors in the success of our integrated care model was the shift away from fee for service reimbursements. Our integrated care model was designed to deliver the highest quality care under population based payments.

While Steward appreciates advancements made by the Center for Medicare and Medicaid Services (CMS) in both the recent Medicare Shared Savings Program (MSSP) rule and the Next Generation ACO program announcement, the most advanced ACOs across the nation need bolder action to continue to innovate and help providers offer coordinated health care services in the most cost efficient manner. Specifically, **we strongly urge you to authorize a population-based payment**

program and **to amend existing laws and regulations that currently impede providers from effectively offering highly integrated and lower cost health care**. Both of these approaches would rapidly and efficiently advance the Committee's three laudable goals:

1. Increase care coordination among individual providers across care settings who treat patients living with chronic diseases;
2. Streamline Medicare's current payment systems to incent the appropriate level of care for patients living with chronic diseases; and
3. Facilitate delivery of high quality care, improve care transitions, produce stronger patient outcomes, increase program efficiency, and contribute to an overall effort that will reduce growth in Medicare spending.

Population-Based Payments

A population-based payment program would achieve improved patient health care outcomes and lower costs in Medicare by reimbursing integrated providers using pre-paid, fully capitated global payments with no savings or loss cap. Population-based payments hold providers clinically and financially accountable for beneficiaries' care, and as importantly, incentivize providers to provide coordinated care to members in a manner that significantly lowers Medicare's costs, while improving patient care. Unlike existing demonstrations, a PBP reimbursement program would address many of the challenges faced by providers participating in MSSP and Pioneer ACO programs, challenges that the Next Generation ACO does not fully assuage. These existing ACO models need the following to improve patient care coordination:

- More flexibility in risk arrangements
- Greater financial predictability for providers
- Stronger beneficiary engagement tools for patients

Under a population-based payment program, Medicare would prospectively attribute beneficiaries to integrated providers – similar to the Pioneer ACO program – and waive federal rules that impede these providers from effective care management, such as using co-pays to directly engage patients, provide transportation, deliver care via tele-health in the home, and allow patients to receive care from skilled nursing facilities (SNF) without spending a minimum of three days inpatient first.

Medicare beneficiaries' medical care and providers' quality outcomes will improve. Providers reimbursed under population-based payments will have flexibility to provide beneficiaries care in a coordinated, seamless manner without limiting beneficiary choice. Patient satisfaction will improve, as program participants can coordinate all aspects of care for their patients, including transportation to and from appointments, or even bringing the provider to the patient through tele-health and medical monitoring equipment for home use.

A Medicare population-based payment program could save Medicare more than $25 billion and improve care for millions of Medicare beneficiaries. Placing providers at full clinical and financial risk for the medical care of their patients will save Medicare at least 2% in annual federal spending for the costs associated with Part A & Part B.

A Medicare population-based payment program could mitigate fraud
Adopting a population-based, global payment program has the potential to mitigate – or once fully implemented, eliminate fraud, waste and abuse (FWA) in the Medicare program. The existing fee-for-service system creates many opportunities for FWA, improper payments, or program ambiguity with each and every service that is billed. Conversely, a pre-paid, capitated global payment program would minimize fraud by incentivizing providers to manage total patient care needs and by meeting transparent quality metrics. There is less opportunity to take advantage of the system by "over billing", or related activities observed under fee for service. When clinical and financial incentives are appropriately aligned, providers can focus on meeting their quality benchmarks to achieve better health outcomes for patients.

Update federal laws and regulations that currently impede providers from effectively offering highly integrated and lower cost health care

Several federal rules currently impede providers from effectively coordinating medical care. For example, accountable care organizations may not use co-pays or other financial incentives to directly engage patients, provide non-emergency transportation, deliver care via tele-health in the home, or allow patients to receive care from skilled nursing facilities (SNF) without first spending a minimum of three days as inpatients. Specific recommendations for changes to federal law include:

- **CMS does not permit ACOs to provide financial incentives for beneficiaries to receive coordinated care** – Congress should expand ACO waivers for patient incentives to permit ACOs to waive co-payments and deductibles to encourage beneficiaries to receive coordinated care within the ACO;
- **CMS does not permit providers to provide routine transportation to patients, which is a burden for chronically ill beneficiaries** – Congress should permit ACOs to provide non-emergency transportation to chronically ill patients who require frequent engagements with the health care system, so as to avoid hospitalization;
- **Despite rapid improvements in digital technology, we have yet to realize the full benefits of tele-health** – Congress should change coverage rules to promote the delivery of care via tele-health technology in the home;
- **Medicare covered post-acute services are unavailable to many chronically ill beneficiaries** – Congress should amend coverage standards to cover stays in skilled nursing facilities after short-stay admissions and after observation care for selected diagnoses; and
- **Data needed for care coordination is not always available to ACOs** – Congress should require CMS to share with ACOs comprehensive data on all aspects of care provided to beneficiaries who suffer from chronic illness.

Thank you for considering this proposal as you review policies for chronic care reform in Medicare, and work with states to ensure that every American has access to sustainable health care services.

Sincerely,

David Morales
Chief Strategy Officer