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January 28, 2016

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, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Thank you for soliciting input from stakeholders regarding policy options identified by the Bipartisan Chronic Care Working Group to improve outcomes for Medicare patients with chronic conditions.

As noted in the comments Steward Health Care System, LLC (Steward) submitted to the Working Group in June 2015, Steward is New England's largest, community-based integrated delivery system. 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 one of the original participants in the Medicare Pioneer Accountable Care Organization (ACO) program, Steward 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 our rapid shift away from fee for service reimbursements. Our integrated care model was designed to deliver the highest quality care reimbursed under full risk, population-based payments. We are proud to be among 21 ACOs in the nation now participating in Medicare's Next Generation ACO program – just one of two in Massachusetts that will provide high-quality care under population-based payments.

Steward appreciates the three bipartisan goals the Working Group aims to achieve with these policy proposals. However, we encourage the Working Group to take a bolder approach to goal #2. Rather than "streamline Medicare's *current* payment systems" that perpetuate fee-for-service, we urge the Working Group to advance policies that transform the payment system toward one that rewards value, where Medicare pays for the highest quality care, in the most cost-efficient manner. As noted in our initial comment letter, all providers, especially the most advanced ACOs across the nation, need bold action to continue to innovate and incentivize providers to offer high quality, coordinated health care services in a cost efficient manner. Specifically, **we strongly urge you to (1) authorize a population-based payment program and to (2) amend existing laws and regulations that currently impede providers**

from offering highly integrated care at lower cost. Details on these proposals we previously submitted are included as Appendix A of this letter.

In addition to shifting the Working Group's overarching focus to transformative payment models, we offer the following specific comments and recommendations on several individual policies proposed in the Policy Options Document, listed below in the order in which they appear in the document:

Apply lessons learned from the Independence at Home Model of Care to global risk models.

While we support the underlying philosophy behind the Independence at Home Model of Care policy proposal, we believe that global risk arrangements, which reimburse providers with population-based payments for the total cost of care of their patients, are ultimately the model toward which Medicare should transition. Global risk arrangements incentivize many of the same activities as included in the Independence at Home model, including home visits and managing transitions of care, but reimburse providers for the total care needs of the patient, across the full continuum of care. Simply broadening this demonstration project will not achieve the Working Group's goals.

Apply Chronic Care Management billing code only to remaining Medicare fee-for-service beneficiaries.

The current chronic care management (CCM) billing code may conflict with ACOs reimbursed under global risk arrangements. We recommend maintaining CCM codes for the Medicare population that remains in fee-for-service arrangements, but transferring the budget or costs associated with chronic care management to the ACO (outside the medical expense budget) for chronically ill patients. Since an ACO provides care management services as a core function of its operation, any reimbursement Medicare provides for these services should be additive to an ACO's budget for their patient's total cost of care. Allowing the CCM code billed under the auspices of an ACO can lead to conflict between the ACO and its constituent providers. Moreover, the ACO should have precedence to determine how the CCM code is applied to beneficiaries for whom the ACO carries global risk. The principles described here also apply to the Working Group's policy proposal to "encourage beneficiary use of chronic care management services," which would waive beneficiary cost sharing for CCM services.

Integrate physical and behavioral health for chronically ill beneficiaries.

We strongly support the Working Group's proposal to improve the integration of care for individuals with both chronic physical illness and behavioral health needs. We offer three recommendations related to this priority:

1. *Ensure adequate reimbursement.* For providers to adequately support and coordinate care for these patients, additional reimbursement for behavioral health services and commensurate infrastructure needs should be factored into both an ACO's baseline budget, as well as risk adjustment methodologies. Unfortunately, under today's fee for service reimbursement chassis, many providers are reimbursed well below the actual costs of caring for such patients. ACOs should not be harmed by enhanced integration of physical and behavioral health.
2. *Integrate reimbursements in addition to care.* Integrating behavioral health into the total cost of care budget for ACOs will enable ACOs to care for patients in a truly integrated manner that delivers the best care outcomes possible.

3. *Remove federal barrier currently impeding integration.* The Working Group should strongly recommend removing specific federal barriers to the integration of physical and behavioral health data, such as the Confidentiality of Alcohol and Drug Abuse Patient Records rule (42 CFR Part 2). Such barriers impede providers' ability to access medical information about the "whole" patient and make it extremely difficult to coordinate patient care across multiple providers. Lifting many of such outdated rules – would significantly improve care coordination for chronically ill patients and would minimize administrative inefficiencies currently propagated by federal data-sharing barriers.

Encourage expansion and reimbursement of telehealth.

We recommend expanding the telehealth policy under consideration by the Working Group to explicitly allow telehealth as a covered, reimbursable service for all Medicare beneficiaries, not only for ACOs in the Medicare Shared Savings Program (MSSP), but also through waivers for ACOs participating in Next Generation ACO.

Ensure accurate payment for chronically ill individuals.

We support improvements to the Hierarchical Conditions Category (HCC) Risk Adjustment Model as delineated in the Policy Options Document. In particular, we believe including more than one year of data to establish a beneficiary's risk score will improve accuracy and predictability of the risk adjustment model and therefore, improve patient care. While we commend the Working Group's increased consideration of multiple chronic conditions and their interaction of behavioral health, we also believe that a beneficiary's risk score should capture factors such as social determinants of health, socio-economic status, functional status, etc. These enhancements will greatly improve the predictability of the costs associated with patient care and ultimately improve health care delivery.

Eliminate barriers to chronic care coordination under risk through cost-sharing waivers.

We applaud the Working Group's recommendation to allow ACOs in two-sided risk model to waive beneficiary cost sharing for items and services that treat the beneficiary's chronic condition. We recommend the Working Group allow ACOs to use their discretion when applying this waiver to beneficiaries. Empowering ACOs to waive beneficiary cost sharing when appropriate will ensure any service that a provider authorizes to improve the beneficiary's care or lower total cost of care can be eligible for the waiver. In addition, a broad waiver could have unintended consequences in increasing utilization if not carefully titrated by the ACO. We believe that waiving beneficiary cost sharing would be a powerful tool to incentivize appropriate utilization of services, especially when managing chronic disease.

Thank you for considering these comments and recommendations as you continue to 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

Appendix A – Additional Details From Letter Submitted in June 2015

(1) Population-Based Payments

A population-based payment (PBP) 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 Medicare Shared Savings Program (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.

(2) 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 SNFs 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.