

The Academy Advisors

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance

The Honorable Johnny Isakson
Co-Chair
Chronic Care Working Group

The Honorable Mark Warner
Co-Chair
Chronic Care Working Group

Re: Chronic Care Working Group Stakeholder Feedback

Dear Chairman Hatch, Ranking Member Wyden, Co-Chairs Isakson and Warner:

We write to you under the banner of The Academy Advisors (“The Advisors”)ⁱ, a policy coalition associated with The Health Management Academyⁱⁱ. Our Leading Health System member partners are providers of integrated care delivery in 28 states across the country and have been committed to improving the lives of every member of the communities they serve. The Advisors systems are at the forefront of integrated care delivery with our health system members responsible for 1.5 million lives attributed to Medicare and commercial Accountable Care Organizations (“ACOs”).

We support the Senate Finance Committee’s bipartisan effort to improve the lives of individuals suffering from chronic diseases and appreciate the opportunity to respond with stakeholder input. Pursuant to the Committee’s request we write to provide feedback around a select set of issues that align with the priorities of our organization: reducing the barriers to delivering integrated care. While our response is limited to this perspective, we support the full efforts of the Chronic Care Working Group.

Issue Area 2 – Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to current or future APMs.

While many health care providers will respond to this inquiry with specific policies focused on care delivery, we would like to emphasize the importance of ensuring that any policy considered by the Committee to improve outcomes of patients with chronic disease through an APM must likewise be governed by the appropriate regulatory regime. Despite the uptick in APM participation over the past few years, the regulatory regime that governs Medicare payments is firmly rooted in fee-for-service. The current regulatory structure – much of which is designed to prevent inappropriate referrals and volume – was more logical when all Medicare payments were delivered via fee-for-service. However, as delivery models change and with a focus on coordinated care, regulatory flexibility is necessary.

The need for flexibility was apparent in the establishment of the Medicare Accountable Care Organization (“ACO”) program, which includes fraud & abuse waivers that allow coordinated care that would otherwise be prohibited. These waivers afford program participants the flexibility to engage in activities across the continuum of care that benefit patients, particularly those afflicted with chronic disease and need to interact with many facets of the health care delivery system. In November 2014, the Office of the Inspector General and the Centers for Medicare and Medicaid Services (“OIG”) extended the interim final rule (76 FR 67991) governing the fraud & abuse waivers for the ACO program for one year.

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We encourage the Committee to support a finalization of the waivers surrounding the ACO program. We also encourage the Committee to ensure a flexible regulatory regime permitting care coordination - while still providing protection against fraud and abuse – is established for any new chronic care APM that the Committee may pursue as a result of this Working Group.

Issue Area 3 – Reforms to Medicare’s current fee-for-services program that incentivizes providers to coordinate care.

Following up on our response to the previous Issue Area, the Working Group could make meaningful changes to Medicare fee-for-service that would incentivize coordinated care through regulatory relief. Specifically, the Stark Law and the Civil Monetary Penalties statutes could be revisited in light of the move away from fee-for-service toward coordinated care models that share risk, accountability and decision making.

The Stark Law was intended to establish bright-line rules for providers in order to prohibit arrangements that incentivize physician self-referrals. However, the drafting of the strict statute liability language in Stark creates greater uncertainty than clarity in coordinated care delivery arrangements. As a result, Medicare beneficiaries - specifically including those suffering from chronic conditions due to frequent contact with numerous providers and complex interactions with the health care system - are often unable to receive the greatest level of coordinated care.

We encourage the Committee to consider changes it can make to the Stark law to benefit patients afflicted with chronic conditions. Specifically, we recommend considering new Stark exceptions for non-ACO payment arrangements that address chronic care, are innovative and contain quality and performance conditions. Leading Health Systems are supportive of non-fee-for-service payment models for chronic care beneficiaries, but ensuring that an operational regulatory framework exists will be critical to participation.

Thank you for your continued efforts to seek bipartisan solutions in a balanced and constructive manner. We look forward to further engaging with the Committee in the construction of a transformative legislative solution to chronic care delivery.

If you have any questions please do not hesitate to contact either myself or Spencer Porr, Director of Health Policy & Federal Affairs (703.647.3195).

Yours sincerely,

The Academy Advisors



By: Nathaniel M. Bays, III
General Counsel & Executive Director, Health Policy

ⁱ The Academy Advisors is the policy affiliate of The Health Management Academy, working with Leading Health Systems on policy analysis and development.

ⁱⁱ The Health Management Academy provides executive education and advisory services to C-suite executives from integrated health systems across the United States. Our health systems membership can be found at <http://www.hmacademy.com>