



June 22, 2015

The Honorable Orrin Hatch  
Chairman, Committee on Finance  
United States Senate

The Honorable Ron Wyden  
Ranking Member, Committee on Finance  
United States Senate

The Honorable Johnny Isakson  
Member, Committee on Finance  
United States Senate

The Honorable Mark R. Warner  
Member, Committee on Finance  
United States Senate

Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner:

We appreciate the opportunity to provide comments to the chronic care working group of the Senate Finance Committee (“Committee”) as it considers solutions to improve care for Medicare beneficiaries living with multiple chronic conditions. The Advisory Board Company (“The Advisory Board”) applauds the Committee for its efforts to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs for this vulnerable population. We believe that realization of these goals hinges on changing the way the broader health care system pays for care to drive dramatic change in the delivery system. If effective, these incentives will lead to chronic care that is more comprehensive and coordinated and that better addresses clinical and non-clinical factors that impact health.

The Advisory Board is a global research, technology, and consulting firm, with expertise supporting health care stakeholders in their mission to provide high-value, high-quality health care to their patients and communities. Our membership includes more than 3,800 hospitals and health systems across the country, as well as physician groups, post-acute care providers, health insurers, device companies, employers, and states. Our technologies support health care providers in analyzing clinical, administrative, and financial data to improve quality and efficiency at the individual provider, health system, and population levels.

In our experience, providers indicate strong desire to improve the care that they furnish to patients with chronic disease. They work closely with us to identify and implement best practices in caring for this population. There are several critical elements to building best practice care models for patients with chronic disease: a holistic approach to caring for the patient; integration of mental health and socioeconomic services with primary care; care coordination across a broad range of providers; risk stratification to identify high-risk and “rising-risk” patients and allocation of resources to these groups; patient-specific care planning; and advanced patient engagement. While providers already adopt many of these elements, policy changes have the potential to facilitate faster, more effective implementation of delivery

system improvements that generate better care for patients with chronic disease and lower Medicare spending. This letter addresses five main opportunities for policy changes that support these efforts:

1. Realign incentives to move away from fee-for-service, reward better care for patients with chronic disease, and drive health system transformation
2. Increase provider access to data, funding, and training needed to implement effective chronic care programs
3. Enhance patient and provider access to resources that help address patients' non-clinical barriers to health
4. Improve means for engaging patients in high-value chronic care
5. Consider expanding waivers of certain payment restrictions to remove barriers to effective chronic care, particularly within APMs

**Opportunity #1: Realign incentives to move away from fee-for-service, reward better care for patients with chronic disease, and drive health system transformation.**

Although most providers want patients with chronic conditions to receive coordinated, multi-disciplinary care, Medicare's fee-for-service payment model poses the biggest barrier to such care. By paying health systems and physicians based solely on volume of discrete services, Medicare misses a huge opportunity to reward effective chronic care management. The result is a delivery system that provides siloed, inefficient, and—in some cases—appropriately avoidable care to patients with chronic disease. The incentives and delivery system do not address the growing need for providers to coordinate care across settings, episodes or illnesses. However, there are several options to optimize incentives and spur development of a more effective delivery system.

- i. Continue to expand fee-for-service rewards for chronic care through pay-for-performance and new billing codes:* Incremental improvements to the fee-for-service model may yield limited gains in care for patients with chronic disease. For example, adoption of pay-for-performance programs that adjust payments based on episodic quality and efficiency (such as the physician value-based payment modifier) may encourage providers to coordinate care across an episode. Similarly, CMS' recent introduction of codes for transitional care management (TCM) and chronic care management (CCM) services offers providers meaningful reimbursement for some care coordination and management activities. While it is too early to assess the impact of the CCM code, providers would benefit from further clarity on the types of providers that are allowed to bill the code and the required documentation. However, because these approaches retain the incentives of the fee-for-service model, the impact on care quality and cost may only be incremental as the broader delivery system remains largely unchanged.

- ii. Articulate a clear transition path from fee-for-service to fee-for-value:* Broader success in improving care for patients with chronic disease and lowering spending on chronic disease requires dramatic realignment of incentives to drive complete system redesign. The most effective models for managing chronic disease require a focus on holistic outcomes rather than individual diseases or encounters; significant flexibility in care settings, provider type, and non-clinical supports; and shared incentives across a team of clinical and non-clinical providers. These models require significant health system transformation that will be achieved only through realigned incentives that pay providers on a per capita rather than a per encounter basis. Payment models must move beyond paying only for encounters with physicians to reward a team-based model of care. The Department of Health and Human Services' goal to move 50 percent of payments into alternative payment models (APMs) by 2018 and the recent legislation requiring an APM track under the Physician Fee Schedule recognize the importance of realigned incentives.
- iii. Reward advanced primary care practices for team-based, longitudinal care:* Paying primary care practices a supplemental per capita payment to cover ongoing chronic care management offers financial rewards for investments in team-based care and may begin a meaningful shift toward improved care. Population-based payment models for primary care practices should require the practices to demonstrate advanced capabilities including robust team-based care, substantial use of effective health IT, enhanced patient access, and advanced patient engagement. Early evaluations of some of these models—like the Comprehensive Primary Care Initiative—have suggested potential, though as the Committee notes various CMS demonstration programs around chronic care “have, at best, shown mixed results”. While payments to advanced primary care practices may drive some improvements in care, the impact of these models will remain limited because they don't change incentives for the broader health care delivery system.
- iv. Implement, evaluate, and scale APMs with accountability for total quality and costs:* Ultimately, payment models that hold providers accountable for total quality and costs have the greatest potential to drive improved care for patients with chronic disease. Although it is too early to evaluate fully the Medicare Shared Savings Program (MSSP) and similar initiatives, these types of shifts in provider incentives are necessary to generate meaningful delivery system transformation. Models in which providers bear financial risk if patient outcomes and Medicare spending miss benchmarks will be most impactful. It is critical that these models give providers flexibility to address clinical and non-clinical risk factors, utilize non-clinical staff, and allow clinicians to practice at the top of their license.



- v. *Foster multi-payer participation in value-based contracting:* Aligning incentives across payers is critical to establishing sufficient rewards for full investment in improved chronic care. If providers participate in APMs only through Medicare, the rewards to implementing advanced chronic care management programs will be limited. In research and financial modeling by The Advisory Board, we find that a majority of a providers' business—as much as 70-80 percent of total revenue—must be in APMs before the provider reaches a “tipping point” toward value-based care. Successful efforts to engage Medicaid programs and private payers in value-based payment models will lead providers to build more meaningful chronic care management capabilities.
  
- vi. *Develop effective quality measures and synchronize these across providers:* Developing effective quality metrics and synchronizing these metrics across payment models will enable providers to better focus chronic care initiatives and minimize administrative burdens. APM success hinges on effective quality measurement to ensure that patient outcomes are maintained or improved while costs are controlled. However, providers often face the daunting task of measuring and improving care across dozens or hundreds of quality metrics as they participate in value-based contracts with Medicare, Medicaid, and commercial payers. To alleviate this quality measurement burden and encourage broader participation in APMs, policymakers should work with stakeholders to harmonize quality metrics across programs and payers. This could be accomplished through a public-private partnerships, such as the Learning and Action Network, that seek to meet realistic and shared goals, and provide distinct benefits for all involved stakeholders. Public-private partnerships should address providers' concerns, create actionable initiatives for private entities, and streamline payment policies to assist all interested stakeholders in realizing collective business opportunities in APMs.

**Opportunity #2: Increase provider access to data, funding, and training needed to implement effective chronic care programs.**

In response to realigned incentives, health systems will need to undergo a fundamental rebalancing of staffing, infrastructure, and health IT resources to develop capacity to provide high-value, coordinated care. Often, though, they lack resources necessary to make these critical changes. Policymakers may be able to mitigate some of these resource constraints through policy actions, including three significant levers:

- i. *Continue to expand provider access to data to ensure they have information necessary to provide effective chronic care:* Providers need seamless access to data from across the care continuum and need access to tools that enable efficient collaboration with other providers. Access to data is foundational to effective chronic care management as it

enables identification of gaps in care, risk stratification of patients, prioritization of outreach, and tracking of patient outcomes. Yet providers often lack access to necessary data from across the care continuum. The Committee might consider the following data-related policy options for enhancing chronic care:

- **Increasing interoperability:** Despite the EHR Incentive Program, providers continue to struggle with health data exchange across health systems and care settings. Enabling seamless interoperability would enable providers to send, receive, and analyze data critical to caring for patients and would facilitate coordination across care settings. Expanding the availability of application programming interfaces (APIs) and addressing business practices that restrict sharing of data are critical next steps to increasing interoperability.
- **Expanded access to claims data:** Providers use claims data in understanding patient populations and improving care delivery. CMS' recent changes to expand and simplify ACOs' access to claims data within MSSP will enable ACOs to provide more effective care to patients with chronic disease. Policymakers should continue to identify appropriate opportunities for sharing more claims data with providers.
- **Adoption of prospective attribution:** In Tracks 1 and 2 of MSSP, ACOs receive a list of preliminarily assigned beneficiaries at the beginning of a performance period, but don't know until after the performance period which beneficiaries ultimately will be attributed. This reduces ACOs' incentive to provide high-intensity chronic care services to patients. Prospective attributing patients to ACOs will give ACOs more confidence to invest in ongoing support for patients with chronic disease.
- **Improved data transparency:** Giving providers information about other providers' performance enables them to identify and collaborate with high-value partners in caring for patients with chronic disease. Efforts to expand data transparency should ensure that data is made available in user-friendly formats.

*ii. Consider targeted funding support to help small and/or rural organizations invest in chronic care more rapidly:* Many provider organizations, especially small and/or rural organizations, lack up-front capital necessary to invest in better chronic care services. Without the ability to invest in the health IT, physical infrastructure, and workforce development necessary to deliver high-quality coordinated care, these practices will be slower to participate in APMs and will face a longer transition to achieving the triple aim for patients with chronic illnesses. The Committee might explore models like CMMI's Advanced Payment Model for ACOs as potential approaches to provide financial support for these organizations in order to encourage a quicker transition to value-based arrangements.

*iii. Identify opportunities to change clinical culture through provider training in team-based care models and integration of non-clinical resources:* Because training on team-based

care models has not been a predominant part of medical education, many providers have not been trained to work effectively in a team-based environment that is a fundamental component of successfully delivering chronic care services. Training should help providers learn how to address behavioral health and socioeconomic needs as part of treating patients. In particular, many providers need to learn how to incorporate new team members—such as pharmacists, health coaches, and social workers—into care models. Although initiatives such as CMMI’s Transforming Clinical Practices Initiative and CMS’ Learning and Action Network may facilitate learning opportunities that lead to improved chronic care, preparing providers to work in a team-based care environment could also be addressed in the private sector beginning with medical school and residency training.

**Opportunity #3: Enhance patient and provider access to resources that help address patients’ non-clinical barriers to health.**

Efforts to improve care for patients with chronic disease will only achieve optimal success when reforms also target non-clinical barriers to health. Addressing these non-clinical barriers is key to improving management of chronic conditions and reducing related emergency department visits, and it can be as or even more impactful than providing outstanding clinical management. We suggest the Committee consider two key areas of policy to improve patients’ and providers’ access to non-clinical services:

- i. Expanded access to and integration of mental health services:* Many patients with chronic disease also face mental and behavioral health challenges that underlie and worsen their chronic disease. Often, these mental health issues are undiagnosed because of poor access to mental health services and poor integration of these services into primary care. Untreated, mental health conditions can undermine otherwise effective approaches to providing clinical care. The Committee should explore and identify policy options for expanding access to mental health services and facilitating integration of these services within advanced, team-based primary care practices.
- ii. Improving and integrating resources that address socioeconomic needs:* Providers who participate in APMs recognize that they often need to help patients with chronic disease address financial, education, and logistical barriers that hinder care efforts. While population-based payment models encourage providers to integrate socioeconomic support into their practice, many still lack knowledge of and/or access to critical services. Public sector support of models like New York’s Medicaid Health Home program ensure that critical services like housing, transportation, education, food, and employment services are provided alongside traditional medical services. Utilization of non-clinical staff, such as community resource specialists, in team-based models has



been shown to improve health outcomes and reduce costs.<sup>1</sup> Policies that promote innovative staffing models that leverage non-clinical staff should be further researched, scaled and promoted nationally to address Medicare beneficiaries across the country with chronic illnesses.

The Committee should evaluate the availability of socioeconomic supports for patients with chronic disease and consider opportunities to address gaps that may be identified. Aligning payment streams for housing, transportation and medical services could provide meaningful incentives for siloed stakeholders to collaborate with one another to improve care for patients with chronic illnesses. Some gaps may be best addressed through better coordination between federal, state, and local agencies and provider organizations. For example, the BUILD Health Challenge, a joint effort of The Advisory Board, the de Beaumont Foundation, the Colorado Health Foundation, the Kresge Foundation, and the Robert Wood Johnson Foundation, exemplifies how stakeholder partnerships can drive collaboration between hospital and health systems, community-based organizations and local health departments to improve the overall health of local populations. Policymakers' ability to convene stakeholders and encourage collaboration to address these issues could have an even more powerful impact beyond ongoing private sector efforts.

#### **Opportunity #4: Improve means for engaging patients in high-value chronic care.**

Improving chronic care requires a level of patient engagement beyond that usually achieved under traditional care delivery models. Addressing policy and operational barriers to patient engagement would allow providers to be more effective in building relationships with patients and in encouraging patient behaviors that lead to improved control of chronic disease.

- i. Increasing patient-level incentives to seek necessary, high-value care for chronic disease:* Many providers have expressed frustration that patients' financial incentives don't align with new payment models. Value-based insurance design (VBID) might be used to better encourage patients with chronic disease to receive high-value services and to choose high-value providers. For example, allowing providers to waive co-payments for visits with primary care physicians and/or services provided under the new CCM code might lead to more patients accessing these services, better control of chronic disease, and, ultimately, reduced utilization of emergency and acute care services. Similarly, rewarding patients in ACOs for choosing providers within the ACO—as CMMI is testing in the Next Generation ACO Model—may increase patients' choice of providers delivering high-value, evidence-based care. The Committee could consider

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<sup>1</sup> The Advisory Board Company. "Incorporating a Non-Clinical Care Team Member to Tackle High-Risk Patient Challenges." 2011.

opportunities to test and expand use of VBID among Medicare beneficiaries with chronic disease.

- ii. *Allowing providers to engage patients more actively in new payment and delivery models:* Current MSSP rules place limits on ACOs' ability to explain and promote the model to patients. Giving ACOs greater freedom to discuss these models with patients would help them engage patients. In addition, allowing beneficiaries to opt-in to attribution to a specific ACO based on their provider preferences would further patient engagement. This approach is being piloted in the Pioneer and Next Generation ACO programs and CMS expects to introduce a similar design in MSSP in the near future.
- iii. *Increasing patient access to meaningful data in useful formats:* Like providers, patients and caregivers with chronic conditions often struggle to access sufficient data from across the care continuum. Initiatives such as OpenNotes have been shown to increase patients' knowledge of their health and medical conditions and improve providers' relationship with patients.<sup>2</sup> Increasing secure access to patient data via publicly available APIs would spur rapid development of patient-facing apps that enable patients to access and interpret their data. The recently proposed rule for Stage 3 of the EHR Incentive Program would require providers to make data available to patients via APIs.

**Opportunity #5: Consider expanding waivers of certain payment restrictions to remove barriers to effective chronic care, particularly within APMs.**

In order to protect the integrity of the Medicare program, Congress and CMS have instituted a variety of policies limiting reimbursement for specific services. Many of these regulations were established to ensure that providers did not abuse the fee-for-service system. However, as the health care system shifts towards APMs, some of these payment requirements may no longer be necessary since new payment models already include incentives to discourage inappropriate utilization of services. Adjusting payment policy in these cases might improve efficiency by giving providers more flexibility to deliver the most appropriate care regardless of setting or provider type. To that end, the Committee might consider the payment policies outlined below for opportunities to enhance providers' ability to care for patients with chronic disease.

- i. *Removing the three-day inpatient stay requirement for skilled nursing facility (SNF) coverage for patients within APMs:* CMS will allow ACOs participating in the new Track 3 of MSSP to apply for a waiver to the three-day inpatient stay SNF requirement. This will allow ACOs to provide care in the most appropriate setting, in some cases allowing patients with chronic disease to bypass hospitalization at an acute care facility.

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<sup>2</sup> The Advisory Board Company. "A New Level of Transparency: Doctors Should Give Patients Access to Their Notes"

- ii. *Revising post-acute care referral requirements for providers in APMs:* CMS recently considered allowing ACOs in MSSP flexibility to encourage beneficiaries in the ACO to choose high-value post-acute care providers. High variation in spending for post-acute services makes this an area of opportunity for ACOs to reduce spending, and building partnerships with high-value providers is a key strategy. CMS expects to test waivers to post-acute referral requirements through CMMI before introducing the option more broadly in MSSP.
- iii. *Ensuring option to bill Medicaid for physical and behavioral health services provided on the same day:* Medicaid payment policies often prohibit same-day billing for physical and behavioral health services. Revising policies to allow for same-day billing of these services would help providers address medical and behavioral issues in a more coordinated manner.
- iv. *Broadening and clarifying reimbursement for telehealth services:* As providers take on additional responsibility in managing patients' chronic illnesses, they need flexibility to deliver care from a distance via telemedicine. However, current regulations limit providers' ability to deliver effective chronic care through the technology. Revisions to current telehealth reimbursement and delivery policies would enable providers to better coordinate patients' chronic conditions.

For example, Medicare currently does not reimburse for telehealth services provided to patients in their homes. This policy does not support patients who may not have access to transportation or would prefer to consult with their provider from the comfort of their own home. Allowing home-based access to live video would be especially impactful in rural and underserved areas where patients may not be in close proximity to a provider. For providers participating in APMs with financial risk, the structure of the payment model would prevent overutilization of telehealth services.

Revised regulations around telehealth should also clarify how payments should be billed and distributed between originating and receiving telehealth sites. This information would be helpful in encouraging providers to integrate behavioral or mental health telehealth services directly into their clinical practice, improving access for patients with chronic conditions. This could also serve as a mechanism for provider-to-provider consultations, allowing for better coordination between providers.

Finally, policymakers should consider adding reimbursement for the use of asynchronous "store and forward" telehealth technology. This form of telehealth can utilize provider time more efficiently, provides meaningful information to the patient and would be a great resource in rural areas. Demonstration programs underway in



Alaska and Hawaii may provide insights on policies for supporting effective use of asynchronous telehealth models.

We appreciate the opportunity to comment and look forward to working with the Committee as it moves forward in its efforts to address these important issues. We would welcome further dialogue around any of the opportunities outlined above or other areas where we can be helpful.

Sincerely,

Piper Nieters Su  
Vice President, Health Policy