BIPARTISAN POLICY CENTER

January 29, 2016

The Honorable Orrin Hatch
Chairman
U.S. Senate Committee on Finance

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance

The Honorable Johnny Isakson
Co-chair, Chronic Care Working Group
U.S. Senate Committee on Finance

The Honorable Mark R. Warner
Co-chair, Chronic Care Working Group
U.S. Senate Committee on Finance

Submitted electronically to Chronic_Care@finance.senate.gov

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

The Bipartisan Policy Center (BPC) appreciates the opportunity to comment on the Senate Finance Committee *Bipartisan Chronic Care Working Group Policy Options Document* issued last month. Addressing the quality and cost of caring for persons with chronic illness is a major challenge, and we agree with the need to move forward to adopt evidence-based solutions to improve care for this vulnerable population. BPC commends the members of the Working Group for their commitment to finding bipartisan policy solutions and the open, thoughtful, and collaborative process they have undertaken.

In recent years, BPC's health program has released a number of reports that included recommendations to better organize and integrate our health care system to lower costs and improve quality of care.[1,2,3] Critical to these goals are efforts to provide higher quality and more efficient care to patients with multiple chronic conditions. Ongoing initiatives of BPC's health program related to this area include:

- **Health Project:**
  - Health care cost-containment and delivery system reform initiatives (2013-2015)
  - Long-term care financing (recommendations forthcoming February 1, 2016)

[1] *Recent reports include:*
Bipartisan Policy Center. *Transitioning from Volume to Value: Accelerating the Shift to Alternative Payment Models*. (2015). Available online at: http://bipartisanpolicy.org/library/transitioning-from-volume-to-value-accelerating-the-shift-to-alternative-payment-models/

[2] Bipartisan Policy Center. *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare*. (2015). Available online at: http://bipartisanpolicy.org/library/transitioning-to-organized-systems-of-care-near-term-recommendations-to-improve-accountable-care-organizations-in-medicare/

[3] Bipartisan Policy Center. *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment.* (2013). Available online at: http://bipartisanpolicy.org/library/health-care-cost-containment/

- Improving delivery of long-term services and supports (LTSS) and integration of LTSS with clinical care. This project, in collaboration with the Harvard School of Public Health and National Academy of Medicine, is building on existing research[4,5,6] to identify essential elements of delivery and reimbursement models for high-need, high-cost individuals in order to scale and spread successful models (recommendations forthcoming later this year).
  - Staff lead: Katherine Hayes, J.D., BPC Health Policy Director
- **Senior Health and Housing Task Force** (recommendations forthcoming May 2016):
  - Focused on the supply of affordable housing for our nation's seniors, home modifications and technologies to enable aging-in-place, improving collaboration across federal health and housing agencies, and improving access to, and coordination with, home- and community-based services.
  - Staff lead: Anand Parekh, M.D., M.P.H., BPC Senior Advisor
- **Health Innovation Initiative:**
  - Development of numerous reports including policy recommendations for using technology to improve health and the cost, quality, and patient experience of care (2011-2016).
  - Engagement of the employer community in taking actions to improve the health of individuals (including those with chronic conditions), the health of communities, and the health care system (2014-2016).
  - Staff lead: Janet Marchibroda, Director, BPC's Health Innovation Initiative and Executive Director, CEO Council on Health and Wellness
- **Prevention Initiative:**
  - The Prevention Task Force's recent recommendations focus on valuing prevention and improving population health through delivery system reform and clinical-community integration.
  - Staff lead: Lisel Loy, JD, Director, BPC's Prevention Initiative

With many of BPC's recommendations relevant to the Working Group still forthcoming, this document should be viewed as staff-level comments based on the research, expertise, and experience of BPC staff only. It is not endorsed by, and does not necessarily represent the views of, BPC's leaders, founders, or board. Finally, consistent with the principles of BPC's Health Project Leaders and senior BPC staff, recommendations should either be deficit neutral, or if the policies require increased federal spending, those costs should be offset to assure that changes do not add to the federal deficit.

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[4] Hong, C.S., Siegel, A.L., Ferris, T.G. (2014). *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* Available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

[5] McCarthy, Ryan, Klein. (2015). *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis*. Available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/oct/1843_mccarthy_models_care_high_need_high_cost_patients_ib.pdf

[6] Taylor, L.A., Coyle, C.E., Ndumele, C., Rogan, E., Canavan, M., Curry, L., Bradley, E.H. (2015). *Levering the Social Determinants of Health: What Works?* Available online at: http://www.bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf

Receiving High Quality Care in the Home

Expanding the Independence at Home Model of Care:

BPC has supported development and expansion of alternative payment models (APMs) that tie incentives to greater levels of accountability for achieving better health outcomes and reducing costs. Thus we would generally support expansion of the Independence at Home (IAH) Model given it achieves these goals and holds promise for sustained results. In considering a permanent program, savings targets should take into account the following considerations for IAH demonstrations that serve patients whose chronic conditions are exacerbated by socio-economic needs:

Practices integrating Medicare and Medicaid services for dual-eligible individuals may incur added costs associated with unmet need, particularly for individuals with behavioral health diagnoses. For homeless individuals, health care provider groups often need to establish relationships with providers of housing, nutritional, and social services to homeless populations, such as shelters. Without these relationships, it can be difficult to identify and provide needed health care services. These practices often require a higher level of infrastructure investment, such as the need to address socio-economic factors not directly related to the costs of treating chronic conditions. Examples of these added factors include poverty, homelessness, inadequate nutrition, or other factors that require additional up-front investments.

Prior to nationwide expansion, the Working Group should consider:

1. Awaiting at least the second year of data to ensure cost savings are sustained and outcome measures are improved (including tracking whether nursing home stays have been averted).
2. Asking the Centers for Medicare and Medicaid Services (CMS) to perform subgroup analyses to determine characteristics of patients who gain the most from the intervention in terms of health improvements and cost savings.
3. Examining the physician eligibility criteria to gauge whether physicians who have less than 200 patients meeting eligibility are allowed to participate. A minimum number of patients is necessary; the exact threshold should be considered carefully.
4. Examining differences in practice patterns and costs for those that operate integrated care management for dual-eligible individuals.

Overall, the Independence at Home Demonstration is one of the few models tested by the CMS Center for Medicare and Medicaid Innovation (CMMI) that has shown cost savings. This is because it has, in general, successfully matched the intensity of the care intervention with the acuity of the patient. This is the most important factor in predicting cost savings. After a second year of data collection, if cost savings continue and outcome measures are improved:

1) CMS should provide subgroup analyses to inform whether patient eligibility needs to be adjusted. (In general, the more chronic conditions and the more functional limitations a beneficiary experiences, the more likely an intervention such as this will result in improvements in quality of life and reductions in preventable health care costs.) If adjustments are needed, use of hierarchical condition category (HCC)

risk scores could be considered, with special attention to presence of certain conditions such as mental illness, behavioral health and/or substance use disorders or dementia that can contribute significantly to patient outcomes. Furthermore CMS and/or Congress may wish to consider allowing practices that have proven successful in achieving quality and spending targets for the current population to expand to other high-cost, high-need beneficiaries.

2) As Congress and/or CMS consider HCC risk scores, they should consider providing flexibility in savings targets in the earlier years for certain practices serving a higher-than-average share of patients who require additional up-front investments. For these practices, achieving savings in the first year may be unrealistic. Permitting deficit neutrality over the first two years, and savings by the third year, for example, may help mitigate barriers to entry for providers serving patients in medically underserved areas, both urban and rural. Added costs for lower-income populations may include: establishing relationships with behavioral health providers and providers of services to homeless populations; and negotiating contracts with state Medicaid agencies or community-based organizations to provide services not covered by Medicare.

***Expanding Access to Home Hemodialysis Therapy*:**

BPC has advocated broader use of telehealth generally, which may in some cases, as in the case of home hemodialysis, require changes to geographic and originating site-of-service requirements. As BPC staff we would generally support broadening the originating site definition to include free-standing renal dialysis facilities located in any geographic area and the patient's home to enable patients to access their monthly visit with their clinician via telehealth. We believe this could enhance patient choice and quality of life. Patients and their caregivers should be thoroughly informed about the range of options in order to assess, in partnership with their clinicians, whether they may be well-suited for home hemodialysis. Whether an in-person visit with the patient's clinician should be required, and if so how frequently, could be tested and evaluated if necessary to assess impact on access to care, health spending, quality outcomes, and program integrity. The Congressional Budget Office (CBO) may "score" expanding access to home hemodialysis as increasing expenditures in the Medicare program. If so, we believe any costs associated with this expansion should be offset and not contribute to the deficit.

Advancing Team-Based Care

Providing Medicare Advantage Enrollees with Hospice Benefits.

The provision of hospice benefits under Medicare Advantage is not a policy BPC has examined to date. However, we concur with the Working Group's goals of reducing care fragmentation and disruption for patients who may be in need of and choose hospice care. We agree changes to MA payment and quality measures would be needed to ensure patients are receiving cost-effective, appropriate, high-quality care in accordance with their wishes. In considering whether to make hospice services available under MA, Congress should also consider the

impact of any interactions with patients dually eligible for Medicare and Medicaid who have access to Medicaid hospice benefits in states that have elected to offer it. Today hospice services for dually eligible beneficiaries are covered by Medicare, while Medicaid covers room and board in a nursing facility for individuals who otherwise qualify for Medicaid-covered nursing home care. With provision of hospice under MA, similar considerations should be made to ensure the full hospice benefit is provided, without duplication of services, for dually eligible beneficiaries.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations.

BPC has supported broader integration of Medicare and Medicaid services for dually eligible individuals. However, today states are not required to integrate care or to contract with Dual Eligible Special Needs Plans (D-SNPs), though D-SNPs must have a contract with the state Medicaid program in order to operate in that state. The Working Group has proposed requiring D-SNPs to integrate Medicare and Medicaid Services. Without a requirement that state Medicaid programs contract with D-SNPs, a new requirement for all D-SNPs to be fully integrated might become a barrier to broader adoption across states. However, a mandate for Medicaid to contract with D-SNPs is likely to attract political opposition. The following options might be considered:

1. Require D-SNPs to integrate Medicare and Medicaid services, with a phase-in of three-to-five years, but as is the case today, do not require states to contract with D-SNPs (though D-SNPs would still be required to contract with each state in which they operate). Additionally, recommend that CMS share with states wishing to contract with D-SNPs the model three-way contracts it is currently using as part of the Financial Alignment Demonstration to help facilitate the challenges of navigating multiple Medicare and Medicaid requirements.
2. If a state requirement is desired for broader adoption, consider limiting it to states that require Medicaid managed care for dually eligible beneficiaries.

Regarding whether to provide permanent authorization or a long-term extension of SNPs, we would concur with MedPAC's recommendations that Institutional SNPs (I-SNPs) be permanently authorized given their good performance on a number of quality measures, particularly reducing hospital readmission rates, and that Chronic SNPs (C-SNPs) be phased out, or the criteria significantly narrowed, if the Working Group proceeds with its proposed changes allowing MA plans to offer tailored benefits to individuals with chronic conditions more broadly. We would further recommend that D-SNPs be given a long-term extension to allow for the new changes (phasing in of Medicare-Medicaid integration, possibly with new three-way contracts and additional requirements) to take place and be adjusted if necessary.

Improving Care Management Services for Individuals with Multiple Chronic Conditions.

BPC supports a significant move away from fee-for-service payment and toward alternative payment models that provide better value. However, we recognize some providers may ultimately remain in the fee-for-service system, even if less financially attractive. Thus we would be open to changes to chronic-care-management (CCM) codes under the Medicare

Physician Fee Schedule to improve care for individuals with multiple chronic conditions and suggest that the Working Group consider one of the following two options:

1. Adding a second, more intensive CCM code which focuses on individuals at higher risk for poor outcomes and preventable health care costs. There is no magic number for chronic conditions; however, using 2014 CMS data, beneficiaries with 6+ conditions comprise 15% of fee-for-service beneficiaries or roughly 4.5 million people and result in 50% of total FFS Medicare spending and 75% of Medicare readmissions.[7] We would also suggest considering as one point of entry the combination of functional status impairment;[8] Alzheimer's disease and related dementias; or mental illness, behavioral health or substance use disorders with another chronic condition. Provision of this service to higher acuity patients should be reimbursed higher than $42 and reflect the increased Relative Value Units (RVUs) required to perform the tasks. Note also BPC's December 2014 recommendation that CMS should identify and revalue incorrectly valued codes under the physician fee schedule broadly, prioritizing the rebasing of the value of services in a way that does not add to federal spending.[9] OR
2. Scrapping the existing CCM code and replacing it with the first option above. Thus, there would be only one code, but it would be focused on a high-risk population that is the most likely to benefit from an integrated care plan, access to 24/7 care management services, and team-based care.

In addition, consider:

3. Reviewing the physician eligibility criteria and the billing requirements to ensure that they are not onerous for practitioners. Feedback from the physician community in this regard will be critical. The informed consent requirement, which is confusing, should be eliminated given that cost sharing should be waived for this service (see below).

The Working Group should consider waiving the beneficiary cost-sharing to incentivize beneficiaries to receive this service. Consistent with principles of value-based insurance design (VBID), high-value services such as chronic care management should be facilitated. Removing cost-sharing would increase patient acceptance and reduce physician confusion and burden to collect. This recommendation also pertains to the Working Group's proposal under "Encouraging Beneficiary Use of Chronic Care Management Services" on page 23 of the Options document.

Finally, provider usage of, and patient outcomes from, the new billing code should be rigorously evaluated to determine if the level of payment, eligibility criteria, and other

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[7] Centers for Medicare and Medicaid Services. *Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition*. Available online at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

[8] Komisar, H.L., Feder, J. (2011). *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services.* Available online at: *http://www.thescanfoundation.org/sites/default/files/georgetown_trnsfrming_care_2.pdf*

[9] Bipartisan Policy Center. (2015). *Transitioning to Organized Systems of Care: Medical Homes, Payment Bundles, and the Role of Fee-for-Service*. Available online at: http://bipartisanpolicy.org/wp-content/uploads/2015/01/BPC_Health_Transitioning-to-Organized-Systems-of-Care-Medical-Homes.pdf

regulatory standards are appropriate for achieving cost-effectiveness, better quality of care, and improved health outcomes for patients with complex needs.

Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries.

We commend the Working Group for its attention to the need for integration of care for individuals with a chronic disease combined with mental illness, behavioral health or substance use disorder. We suggest that the Working Group consider:

1. Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and other federal and private-sector stakeholders about modifying 42 CFR Part II, a regulation that protects the confidentiality of substance abuse user patient records. Though originally established as a way to remove the fear of prosecution for persons with substance use disorders seeking treatment and to reduce job discrimination, the regulation now has the unintended consequence of not allowing accountable care organizations (ACOs), among others, to obtain records for population health management. It is well known that beneficiaries with both physical chronic conditions and behavioral health conditions are at the highest risk for poor health outcomes and preventable health care costs. Without behavioral health information of beneficiaries, ACOs are currently limited in their ability to coordinate care and to develop integrated care plans for their assigned beneficiaries whose records are protected under 42 CFR Part II. There should be a middle-ground solution that both protects the privacy of those with substance abuse disorders but at the same time allows an accountable care team with access to the information they need to properly manage and coordinate the overall care of the beneficiary.
2. Allowing a mental illness, behavioral health or dementia diagnosis for a patient with another chronic illness to be a point of entry for the availability of payment for CCM services (as in the above policy option).

We support the Working Group's consideration of the Government Accountability Office (GAO) study on the integration of behavioral health and primary care across the various coverage programs and provider settings. We would suggest they include a survey of providers, including those participating in alternative payment models, on how these services are currently being integrated.

Expanding Innovation and Technology

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees.

The Working Group has proposed allowing MA plans the flexibility to tailor benefits to improve the care and/or prevent the progression of the chronic conditions affecting MA enrollees including: additional supplemental benefits not currently allowed that are related to the treatment of the chronic condition or the prevention of the progression of the chronic disease; reduction in cost sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease; adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic

condition or prevent the progression of the chronic disease; and care improvement and/or wellness programs specifically tailored for the chronic condition.

In general, we support the idea that MA and APMs that accept risk for achieving quality and financial targets should have greater flexibility to determine how best to manage care delivery, including the provision of non-clinical services within established spending targets. BPC is currently working as part of a collaborative effort with the Harvard School of Public Health (HSPS) and the National Academy of Medicine (NAM), formerly the Institute of Medicine, to identify and promote effective models of care for high-need, high-cost individuals. As part of that project, we will examine a broad range of delivery and payment models, and will provide recommendations on the inclusion of evidence-based benefits designed to address the needs of at-risk populations. The overarching goals of this additional flexibility, however should be to assure improvement in quality and value of services without increasing costs for the Medicare Trust Funds.

The Working Group should consider:

1. Using the principle of value-based insurance design to waive cost-sharing for the following high-value services:
    a. Evidence-based preventive services (screening & counseling), which is already the case under the basic Medicare fee-for-service benefit package and thus also MA plans but could be modified
    b. Evidence-based chronic care management practices/protocols (guidelines based)
    c. Generic medications for chronic care conditions whenever possible
2. Requiring evaluation and reports to Congress – by CMS or other entity in partnership with MA plans and ACOs – on the effectiveness of new plan features for chronically ill enrollees to help build the evidence base for effective models that could be replicated by other plans.
3. Eliminating C-SNPs, or significantly narrowing their eligibility criteria, if the proposed new supplemental benefit flexibility is to be applied broadly throughout MA.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees.

The Working Group is considering allowing MA plans to offer a wider array of supplemental benefits – medical or non-medical, social services – financed by rebate funds. In principle, BPC generally supports expanding the scope of benefits, provided they are evidence-based and would not increase federal costs. For dual-eligible individuals, we are identifying the barriers to the integration of Medicare and Medicaid services to expressly permit the use of Medicare Trust Fund dollars to supplement state spending on services covered by Medicaid, as well as services designed to address socio-economic factors that affect the health status of high-need, high-cost individuals. For "Medicare-only" populations, we plan to review existing law to identify statutory and regulatory barriers to the provision of a broader array of non-clinical evidence-based services. We will also identify the cost of providing added services to targeted populations and suggest a range of options to offset added cost, where needed.

As we have discussed, we support the idea that MA and APMs that accept risk for achieving quality and financial targets should have greater flexibility to determine how best to manage care delivery, including the provision of non-clinical services within established spending targets. We will continue examining what successful models are doing today and how to address unnecessary barriers, avoid unintended consequences, and assure improvement in quality and value without increasing costs for the Medicare Trust Funds.

Increasing Convenience for Medicare Advantage Enrollees Through Telehealth.

BPC agrees that telehealth, including remote patient monitoring, offers great promise for improving access to care (particularly for the elderly and those living in rural areas); reducing the cost of care, for example through reductions in hospital readmissions and transportation costs; and increasing the convenience of care for patients and their caregivers. However, several barriers exist to broader use of telehealth, including those related to reimbursement, regulatory restrictions, and state licensing. Under capitated MA and APMs with risk-sharing arrangements (such as ACOs), telehealth could be used as a means to provide better care at lower costs. In fact, as an incentive to participate in performance-based risk arrangements, CMS is now testing allowing providers to use telehealth in CMMI's Next Generation ACO model and, after rulemaking with notice and public comment period, is expected to allow telehealth waivers in MSSP no earlier than January 1, 2017. We would propose that the Working Group consider:

1) Authorizing CMMI to test allowing MA plans in some states to include telehealth in their bids with the goals of improving care quality, outcomes, and value. This test could inform the range of telehealth services that should be permitted if the model is deemed eligible for expansion to a permanent, nationwide feature of the MA program.
2) Eliminating today's originating site requirements to ensure broader access and flexibility to help plans achieve these goals.
3) Encouraging more states to adopt the Interstate Medical Licensure Compact, which can streamline medical licensure to help facilitate innovations in health care such as telehealth. To-date, 26 states have enacted or proposed legislation to enact the Compact.[10]

Providing ACOs the Ability to Expand Use of Telehealth.

We would support the ability of two-sided risk Medicare Shared Savings Program (MSSP) ACOs to receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services. MSSP ACOs should be given the flexibility to provide remote-patient-monitoring services. Further we hope stakeholder input to the Working Group on this topic will inform CMS's forthcoming rulemaking on allowing telehealth waivers in MSSP, particularly as to whether any safeguards should accompany removal of the originating site requirement. Quality and payment incentives in this model should be aligned such that it would be in the ACO's best interest to ensure beneficiaries have the appropriate equipment and that the telehealth services provided are evidence-based.

[10] Federation of State Medical Boards. *Interstate Medical Licensure Compact*. Available online at: http://licenseportability.org/index.html

Maintaining ACO Flexibility to Provide Supplemental Services.

The Working Group is considering clarifying that ACOs participating in the MSSP may furnish a social service, transportation service, or remote monitoring service for which payment is not made under fee-for-service Medicare. We would generally support this kind of flexibility and believe it could be even broader to encompass other non-medical items and services that could improve health outcomes and reduce costs (e.g., home modifications to help prevent falls). This is something we hope to look into further through BPC health program initiatives. The Working Group should also consider offering this flexibility only to MSSP ACOs participating in two-sided risk models as an incentive to greater accountability for cost and quality.

Expanding Use of Telehealth for Individuals with Stroke.

We would support removal of the originating site geographic restriction for the purpose of identifying and diagnosing strokes (i.e., allowing a specialist consultation via telehealth to beneficiaries regardless of their geographic location).

Identifying the Chronically Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically Ill Individuals.

We appreciate the Working Group's attention to improving risk adjustment in Medicare, specifically the Hierarchical Conditions Category (HCC) Risk Adjustment Model. Consistent with BPC's recommendations, we support the inclusion of functional status, as measured by ability to perform activities of daily living, in risk-adjustment for Medicare Advantage and also for ACOs (i.e., risk adjustment factors should be the same for MA plans and ACOs). The Working Group should consider work currently underway at CMS to standardize measurement of functional status (e.g., implementation of the IMPACT Act of 2014), as well as the National Quality Forum, and whether it could be built upon as opposed to launching a new study.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization.

BPC has recommended an enhanced, enrollment-based APM concept called Medicare Networks. Similar to today's ACOs, Medicare Networks would be formed and led by health care providers who want to work together in a way that optimizes care coordination across care settings. The providers would be held responsible for the cost, quality, and coordination of care delivered to a defined group of beneficiaries. We believe beneficiaries with multiple chronic conditions have the most to gain from the coordination and integration inherent in these types of APMs; however, providers are still learning which interventions work best for certain conditions and segments of the population and how to best stratify risk and target services. As previously noted, BPC is working in collaboration with HSPS and NAM, with support from the Peterson Center on Healthcare, to identify and promote the spread and scale of care delivery and reimbursement models that can improve quality of care for high-need, high-cost patients, lead to lower overall costs, and be scaled for adoption nationwide. We will

keep the Committee and Chronic Care Working Group apprised on our findings and recommendations, which are slated for release in 2016.

Under BPC's Medicare Networks proposal, BPC has recommended the following:

- *Allow beneficiaries who utilize non-physician primary care providers, such as nurse practitioners and physician assistants, to be attributed to an ACO*. Based on current law and regulation, a beneficiary must receive at least one primary care service from a physician participating in the ACO as a preliminary step for determining assignment eligibility. BPC supports allowing ACO attribution based solely on use of at least one primary care service by a non-physician provider such as a nurse practitioner or physician assistant.

- *Transition all ACOs to prospective beneficiary assignment.* CMS's new Track 3 ACO model includes prospective, rather than retrospective, assignment of beneficiaries, which is a step in the right direction. We believe that in order for ACOs to successfully coordinate care and achieve better care and cost outcomes for the beneficiaries they actually serve, they should know for which patients they are responsible at the beginning of each contract year. Therefore, all ACOs should move to prospective beneficiary assignment, with an exception for beneficiaries who move into or out of the service area during the year.

- *Over time, transition to a patient-choice model in which beneficiaries have the opportunity to make an active decision to designate an ACO and would have incentives for doing so.* Using this approach, beneficiaries could designate an ACO and identify a primary care provider (physician, physician assistant, or nurse practitioner) that is part of an ACO member practice or in the ACO's network (providers that, in BPC's concept, could be affiliated with an ACO but would not participate in that ACO's governance and would not share in its savings/losses). ACOs should be allowed and encouraged to offer additional incentives to patients who opt-in. ACOs could choose which benefits to offer, such as cost-sharing waivers for ACO primary-care providers, a 24-hour nurse line, and extended primary-care office visit hours. Oversight will be needed to ensure benefits are not coercive or otherwise designed in a way that would inappropriately affect patient choice. Beneficiaries who designate an ACO could continue to see any Medicare provider, but these incentives (such as any waiver of cost-sharing for a primary care office visit) would be limited to services delivered by providers that are either members or in the network of the ACO. CMS would annually inform attributed beneficiaries of the opportunity to designate an ACO and any incentives. These incentives should not be available to beneficiaries who do not designate an ACO, even if they have been attributed. ACOs would be allowed, but not required, to promote designation opportunities to patients through marketing materials. Beneficiaries could change or cancel their ACO designation at the next annual selection period. This model could be tested in Next Generation ACOs first and then scaled for implementation throughout all Medicare ACOs.

- *Adjust ACO payment methodology to aid in the transition to models with increasing levels of accountability.* BPC has proposed several improvements to the payment methodology for Medicare ACOs, including:
    - Use of prospective spending benchmarks and a five-year transition to regional, risk-adjusted benchmarks. There are substantial drawbacks to provider-specific, historical benchmarks, as they provide little incentive for relatively efficient providers to participate, and they may allow relatively inefficient providers to maintain such inefficiency for long periods without penalty. To the degree that benchmarks are rebased, they undermine the providers' business case for investing in improved delivery.
    - Allowing ACOs to receive partial shared-savings bonuses for reducing spending and achieving significant, relative quality improvement in certain areas, even if they are not yet able to meet all of the national quality standards.
    - As in the Medicare Access and CHIP Reauthorization Act (MACRA), BPC proposes tying annual fee schedule updates to participation in APMs. In a January 2015 paper, BPC made two recommendations that would go beyond MACRA's differential update policy (higher annual payment-rate updates for APM providers, lower updates for FFS providers). The first recommendation is to create a middle tier of updates for providers that adopt one-sided-risk APMs; the highest annual payment-rate updates would be reserved for providers at two-sided risk, slightly lower updates would be available for providers at one-sided risk, and FFS providers would receive the lowest annual payment-rate updates. Second, BPC proposes expanding differential updates beyond physician-fee-schedule providers to all Medicare providers. Under this approach, all Medicare providers would have stronger incentives to adopt APMs with increasing levels of risk. *Importantly, in BPC's vision for the future of APMs, providers and patients alike are incentivized to participate in a model of care that improves quality while reducing the growth in Medicare spending.*

Developing Quality Measures for Chronic Conditions.

We applaud the steps taken in MACRA to address coordination in measure development and prioritizing outcome measures (including patient-reported outcome and functional status measures), patient experience measures, care coordination measures, and measures of appropriate use of services (including measures of over use). BPC has proposed significantly consolidating and aligning a core set of measures across public and private payers and programs, as well as prioritizing outcomes and patient experience measures.[11]

Bearing in mind BPC's support for prioritization of a smaller set of core outcome- and patient-centered measures, we would generally support the Working Group's proposed topic areas for inclusion, including measures focused on patient and family engagement, shared decision-making, care coordination, care transitions and care planning; hospice and advanced care; Alzheimer's disease; and dementia; and community-level measures in areas such as obesity,

[11] Bipartisan Policy Center. (2015). *Transitioning from Volume to Value: Consolidation and Alignment of Quality Measures*. Available online at: http://bipartisanpolicy.org/wp-content/uploads/2015/04/BPC-Health-Quality-Measures.pdf

diabetes and smoking prevalence. To bend the health care cost curve, we need to not only improve care coordination for patients with one or more chronic conditions, but also focus on ways to reduce the prevalence of risk factors associated with chronic conditions as well as reduce the incidence of chronic conditions (e.g., heart disease, depression, diabetes). ACOs and MA plans should be accountable for not only ensuring that chronic conditions are managed well but also for ensuring their beneficiaries don't accrue *new* conditions in the first place. Based on our work with the Prevention Task Force, we believe that the inclusion of "population health" quality measures supports the type of upstream prevention efforts that are necessary to see these outcomes.[12]

Empowering Individuals & Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services.

As stated in our comments above (page 6), the Working Group should consider waiving beneficiary cost-sharing to incentivize beneficiaries to receive these covered chronic care management services. Consistent with principles of value-based insurance design (VBID), high-value services such as chronic care management should be facilitated. Removing cost-sharing would increase patient acceptance and reduce physician confusion and burden to collect. BPC has recommended cost-sharing discounts as an incentive to participate in Medicare Networks, our version of ACOs, and we have recommended changes to first-dollar coverage under supplemental plans, including Medigap and employer-sponsored insurance, that would reduce the "blunting" effect that occurs when supplemental plans fill in all cost-sharing and render waivers or reductions moot as incentives.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

The Working Group is considering requiring that CMS implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer's disease and other dementias. This is an interesting concept; however, we are not convinced it is necessary, and it may be duplicative of current medical practice and billing codes (e.g., chronic care management or advance care planning) or the high severity chronic care code under consideration.

Eliminating Barriers to Care Coordination under Accountable Care Organizations.

CMS recently announced funding for testing of the Accountable Health Communities Model. This is an important step forward, and reflects one of the recommendations of BPC's Prevention Task Force, which called for greater connectivity between clinical and community-based services. Under this cooperative agreement, applicants will form a consortium within

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[12] Bipartisan Policy Center. (2015). *A Prevention Prescription for Improving Health and Health Care in America*. Available online at: http://bipartisanpolicy.org/wp-content/uploads/2015/05/BPC-Prevention-Prescription-Report.pdf

their target geographic area that includes the State Medicaid agency and relevant health care and community health entities to address health-related social needs through enhanced clinic-community linkages as a means to improve health outcomes and reduce costs. Results from these models should be used to inform to better coordinate care in ACOs not only between health care providers but between clinical and community services.

Regarding waiver of cost-sharing by MSSP ACOs accepting two-sided risk, the Working Group should consider using the principle of value-based insurance design to waive cost-sharing for the following high-value services:

a. Modifications to eligible evidence-based preventive services (screening & counseling).[13]
b. Evidence-based chronic care management practices/protocols (guidelines based).
c. Generic medications for chronic care conditions whenever possible.

Expanding Access to Prediabetes Education.

We support the Working Group's proposed policy to allow diabetes prevention programs to be offered by non-profit organizations, health departments, and other qualified entities, regardless of their current status as providers under the Medicare statute. Many such entities are already providing diabetes prevention programs and achieving excellent results.

To determine eligibility requirements, Medicare can: (1) study the characteristics and results of entities such as the YMCA, Omada Health, and others that currently offer diabetes prevention programs; and (2) work with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)—the original developers of the national diabetes prevention program—to determine the types of educators and administrative requirements that would be necessary to implement a diabetes prevention program that aligns with models that have been shown to be successful

The Working Group should consider:

1. Allowing the Diabetes Prevention Program to be delivered to pre-diabetic Medicare beneficiaries by entities that are not currently providers under the Medicare statute. As has been done with diabetes self-management training (DSMT), Medicare should identify an accrediting body (in this case, the Centers for Disease Control and Prevention's National Diabetes Prevention Program), to certify community-based entities that could offer this program to beneficiaries. The results of a current CMMI Innovation Award to the YMCA should help inform this new Medicare Part B payment.
2. Allowing additional community-based prevention and wellness programs that are evidence-based to be delivered by entities that are not currently providers under the Medicare statute. Under Section 4202 of the Affordable Care Act, CMS is currently conducting a prospective study of community-based programs to assess whether

[13] For example: under current law, mammography screens are not covered as prevention services without cost-sharing for women with a prior diagnosis of breast cancer because the screening is a higher-level screen. Likewise, when during a colonoscopy a polyp is found and removed, Medicare rules do not clarify that the colonoscopy should be treated as a preventive service without cost-sharing, as is the case with qualified health plans.

beneficiaries using these services experience improvements in health outcomes and reductions in costs.[14,15] Programs such as the Chronic Disease Self-Management Program, A Matter of Balance (falls prevention program), and Enhance Fitness (physical activity promotion) have all shown promising results in retrospective analyses. CMS should identify the best of these programs and task a private sector organization such as the National Council on Aging (NCOA) or a federal agency such as the Administration on Aging (AoA), now part of the Administration for Community Living (ACL), to act as a certifying entity for these programs.

3. Clarifying in the interim that under page 18, **Maintaining ACO Flexibility to Provide Supplemental Services**, ACOs are allowed to furnish such community-based prevention and wellness programs although there is not currently a payment made under fee-for-service Medicare.

Increasing Transparency at the Center for Medicare & Medicaid Innovation.

The Working Group is considering modifications that would either require CMMI to issue notice and comment rulemaking for all models that significantly affect Medicare spending, providers or beneficiaries, or require CMMI to issue notice and comment rulemaking for all mandatory models and at least a 30-day public comment period for all other innovation models. We would have concerns that these requirements, while well-intentioned, could significantly slow the process and reduce CMMI's flexibility to innovate, test, and respond quickly as models are developed, tested, evaluated, and improved over time. Transparency and private-sector input and engagement is critical to CMMI's work. However, we would encourage the Working Group to explore whether there are federal requirements that can be eased (while maintaining the appropriate level of oversight and program integrity) in order to improve transparency and incorporation of stakeholder input, rather than adding new federal requirements that could further tie CMMI's hands. We would recommend having an open dialogue with the agency and relevant private-sector stakeholders about what CMMI truly needs to be more responsive, inclusive, transparent, and achieve better results more rapidly.

Study on Medication Synchronization.

The Working Group is considering requiring a study to determine how Part D prescription drug plans (PDPs) can coordinate the dispensing of prescription drugs in order to improve medication adherence and comprehensive medication reviews so that, to the extent feasible, multiple prescriptions can be dispensed to a beneficiary on the same day. This seems to be a worthy goal, which we would generally support.

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[14] *Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act*. (2013). Available: http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf

[15] Colligan, E. M., Tomoyasu, N., & Howell, B. (2014). Community-Based Wellness and Prevention Programs: The Role of Medicare. *Frontiers in Public Health*, *2*, 189. Available online at: http://doi.org/10.3389/fpubh.2014.00189

Study on Obesity Drugs.

When the Medicare Part D statute was signed into law in 2003, FDA had not yet approved any drugs designed to treat obesity, and obesity was not a formally recognized disease. Since then, FDA has approved several such drugs for weight loss and weight management and the American Medical Association has declared obesity a disease. We support studying the use and impact of obesity drugs as a way to inform whether or not obesity drugs should be removed from the Medicare Part D exclusion list. The Treat and Reduce Obesity Act (H.R. 2402, S. 1509), among other provisions, proposes to allow FDA-approved weight-loss drugs under Part D. This legislation currently has 124 cosponsors in the House and 10 in the Senate, up from 115 and 5 when the legislation was proposed in the 113th Congress.

Thank you again for the opportunity to submit feedback to the Senate Finance Committee's Chronic Care Working Group. We again commend your bipartisan leadership on improving care for Americans with chronic conditions. If you have questions or wish to discuss BPC's comments, please contact Ashley Ridlon, Senior Manager at the Bipartisan Policy Center Advocacy Network (BPCAN), at (202) 714-7309 or aridlon@bipartisanadvocacy.org.

Sincerely,

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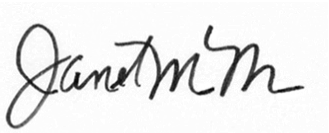

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