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GEISEL SCHOOL OF MEDICINE AT DARTMOUTH

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The Honorable Orrin Hatch
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The Honorable Ron Wyden
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The Honorable Johnny Isakson
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The Honorable Mark Warner
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Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

We applaud the Committee for its leadership in addressing the policy issues surrounding chronically ill Medicare beneficiaries. By forming this work group, the Committee has taken an important step to begin to address gaps in current law and work towards alternative policy solutions.

The Committee has requested input from stakeholders on how it might improve outcomes for chronically ill Medicare beneficiaries. The Dartmouth Institute for Health Policy and Clinical Practice (TDI) has a long history of publishing research on variations in costs, utilization rates, quality, and other areas of health system performance, particularly for beneficiaries with chronic illness.

Target more than diagnoses, and we must go beyond health care

The Committee has defined the scope of the work around beneficiaries with multiple chronic illnesses. However, as the Request for Input notes, two-thirds of Medicare beneficiaries currently have two or more chronic disease diagnoses. The challenge of using diagnoses as the criterion for eligibility in a specific program is that the decision to assign a diagnosis to an individual patient is highly sensitive to both diagnostic intensity (how hard physicians look for disease) and to physician judgment (when is joint pain arthritis?) And over the course of their Medicare-eligible years, virtually all beneficiaries will acquire multiple such diagnoses. Finally, research by Dartmouth colleagues has shown that the frequency with which Medicare beneficiaries are diagnosed with a chronic condition varies by region, by up to two-fold, which cannot be explained by underlying differences in health.[1] This suggests the need to move away from targeting populations on the basis of a chronic disease *diagnosis* alone.

As noted during the May 15th hearing, previous efforts to improve outcomes for chronically ill beneficiaries have shown mixed results at best, often costing more money than is saved after accounting for the costs of the intervention. Several randomized controlled trials have called into question the value of adjuvant care coordination programs; others, with more comprehensive approaches, have been successful.[2-10] Two

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likely explanations for these mixed results are failures to target patients who are most likely to benefit, and interventions that do not address the problems faced by such populations. Beneficiaries who suffer from multiple chronic conditions *and* functional limitations fit this definition. 15% of Medicare beneficiaries have both chronic illness and functional status limitations, and these individuals account for 32% of total program spending. They spend twice as much as those beneficiaries who are characterized with only 3 or more chronic conditions. In the cohort of beneficiaries in the top 5% of Medicare spending, 61% reported they had both chronic illnesses and functional limitations, compared to just 32% with only 3 or more chronic illnesses.[11] These individuals have difficulty accomplishing "activities of daily living," such as bathing or dressing themselves, or getting groceries, or managing medications. They have basic and fundamental needs for comprehensive health care and long-term services and supports (LTSS), spanning both medical and non-medical settings.

Current law enables Medicare-eligible beneficiaries to enroll in either traditional Medicare, which reimburses providers on a fee-for-service (FFS) basis, or in private Medicare Advantage plans, paid a per capita rate per beneficiary. A third payment mode, "alternative payment models" (APMs) uses the FFS payment system but attributes patients to participating providers who agree to be held accountable for costs and quality outcomes. The Triple Aim improvements desired by the Finance Committee will require a bolder policy approach. Medicare will always reimburse for a hospitalization that averages tens of thousands in costs to the government that might have been avoided for want of a taxi ride to the pharmacy (which largely the program will not reimburse). We will need to build and strengthen linkages between health care and social services, target beneficiaries amenable to interventions, and structure our supports in such a way as to meet their needs. This has the potential to bolster the Medicare Trust Fund over the long term.

The Better Care, Lower Cost Act is a great start

In the prior Congress, Ranking Member Wyden and Senator Isakson unveiled the "Better Care, Lower Cost Act," which would empower providers to form "Better Care Plans" to enroll chronically ill beneficiaries to provide all Medicare Part A, B and D services under capitated payment. We applaud the refinement of eligible patient criteria beyond applying diagnostic criteria alone. As introduced in the legislative text, patients shall be eligible if they are "medically complex given the prevalence of chronic disease that actively and persistently affects their health status, and absent appropriate care interventions, causes them to be at enhanced risk for hospitalization, limitations on activities of daily living, or other significant health outcomes."[12] This language fundamentally recognizes two key design elements for a successful program: (1) the need for a clinically precise definition of "medical complexity" and/or functional limitations; and (2) the importance of going beyond narrowly defined clinical services to include social or behavioral services that will provide the best possible care at the lowest overall cost for at-risk beneficiaries.

To address these challenges we see two plausible paths forward. One would be to develop a program that was able to target populations of beneficiaries who could be precisely identified based on functional or clinical characteristics that are associated with prolonged high costs and enable providers with demonstrated competencies in care for such patients to prospectively enroll patients under a capitated or shared risk model. I am not confident this will be possible, but the experience of the Commonwealth Care Alliance – a Medicare Advantage plan with a similar aim/approach – suggests that it might be.[13] Several more reasons to be concerned about such a "carved out" approach, however, include: the possibility of regression to the mean (if patients are identified during high cost episodes); scaling to meaningful numbers of beneficiaries; and the unfortunate effect if they do scale, that they would remove from Accountable Care Organizations (ACOs) a population where real savings are possible.

It is for these reasons that we think a more successful approach would be to accelerate the expansion of the ACO model, perhaps embedding such programs within ACOs. The advantage of the population-based approach taken by ACOs is that these organizations have the incentives both to keep patients from declining in health or function and to provide the best care for patients regardless of whether their disability or high cost is short or long term. We discuss steps that could be taken to accelerate the adoption of this model in the next section.

ACOs are the right vehicle, but improvements still needed

Therefore, we believe strongly that one APM in Medicare, the Accountable Care Organization, is a potent vehicle for improvements in care and cost growth sought by the Committee, and for which it sought detailed comments. Under the Medicare methodology, ACOs are responsible for the total cost and quality of all Part A and B services for the population attributed to their care. There are several ACO vehicles in Medicare, including the Medicare Shared Savings Program (MSSP), the Pioneer ACO model, and the recently announced Next Generation ACO model. ACOs have strong incentives to pursue robust care coordination and invest in personnel and technology – all of which can make a difference in patient outcomes. At Montefiore Medical Center, a Pioneer ACO in New York City, that meant investing in supportive housing for some high utilizing homeless beneficiaries to break the cycle of non-adherence with medical care, clinical decompensation, and the resulting expensive, avoidable trips to the emergency department and costly admissions. This approach at Montefiore, which saved $24.5 million in its first performance year in Pioneer, demonstrates the potential of the ACO model to target the high cost, high need beneficiaries of most interest to the Committee.[14]

All told, nearly 8 million Medicare beneficiaries are receiving care through one of these models. Early results from the ACO programs show encouraging results – over just two

years in Pioneer, we see lower costs than in FFS and better patient experience.[15-17] The MSSP findings from the first performance year are still to be validated, but it too seems to demonstrate small gains relative to FFS.[18]

In June, CMS finalized a rulemaking process that will fundamentally change some aspects of the MSSP, the largest ACO program in Medicare. We applaud many of these changes, which were responsive to ACO needs while balancing the needs of the Medicare Trust Fund. These changes included: giving Track 1 ACOs (upside risk only) an additional 3-year contract period at equal sharing rates (50%), which they had proposed be lowered to 40% to encourage movement to two-sided risk ACOs; reforming the benchmark formula in a 2nd contract by equally weighting the years from which a new benchmark will be derived; adding back into the new benchmark any savings up to and including minimum savings rates; a new Track 3 that contained higher risk/reward ratios with up to 75% sharing rate, prospective attribution, and a payment waiver of the 3-day admission rule for skilled nursing facility admission; more data sharing elements with ACOs for the specific purposes of performance improvement; and including non-physician providers in the attribution methodology that aligns beneficiaries to ACOs based on their primary care patterns.

At the same time, CMS sidestepped some of the most challenging questions, suggesting it will push forward with a separate rulemaking process to determine how benchmarks shall be calculated in 2nd contracts later this summer. This is particularly important because, in the absence of savings and/or a plausible path to achieving them, the other well intended changes contained in the June rule do not matter. Evidence has begun to accumulate that ACOs are more likely to win (e.g. earn shared savings) under the current methodology if they start from a relatively high baseline.[15,19] This may pose challenging questions for historically efficient providers that are considering whether to form a Medicare ACO, both in the initial contract as well as any subsequent contracts.

We agree with the conceptual approach outlined by MedPAC and others to begin setting benchmarks using ACO specific historical spending, but in a 2nd agreement, to use a regional comparison, or a blend of both historical and regional factors.[20] These two elements are critical to creating an attractive and sustainable ACO program for all types of provider groups – both historically efficient and inefficient providers. Furthermore, regionally derived benchmarks may enable more accurate information about spending targets *prospectively*, something that the current methodology is challenged to do. Some questions need to be resolved such as the cadence of this transition and how the regions might be defined, but these are technical specifications that CMS has the expertise to address.

There is some additional potential for refinement that may improve the ability for ACOs to recoup the costs of their investment as well as introduce more equity in the program. As we outlined in a recent commentary and simulation, varying the rates at which savings

are shared between CMS and the ACO would give a greater share of the savings to ACOs from earlier savings, and more to CMS as savings grew.[21] This approach – which we term *graduated savings distributions* – may be particularly desirable, if the goal is to increase certainty among providers forming ACOs that they will be more likely to achieve some level of shared savings bonuses, and secondly, to moderate some of the potential for windfall gains using a benchmark derived from prior inefficient FFS spending.

What remains unclear is the budgetary impact if CMS were to embrace graduated savings distributions among ACOs. Our simulation used certain thresholds and modified sharing rates that would, using 2012-2013 results from the MSSP, give more money to ACOs and less to CMS, resulting in about $150 million less for the Medicare Trust Fund. However, if over the long term, the graduated savings approach induced more ACO formation and sustained participation at lower cost than would have been experienced in FFS, there may still be significant savings opportunities for the federal budget. The Committee should partner with CMS to evaluate this approach more robustly, with all available data, in order to determine whether it is an attractive one for the ACO program, which may require certain statutory changes.

Current risk adjustment methodology is flawed and must be improved

In order to improve the care experienced by the chronically ill, we believe it is also critical to address the methodology used by CMS to adjust payments for beneficiaries, depending on their health status. Currently, CMS uses the Hierarchical Condition Category (HCC) methodology, which was introduced in 2006 to incorporate diagnosis as well as demographic information payments to private Medicare Advantage plans, which previously had only adjusted for demographics. It is also used now in the Medicare ACO programs, as well as elsewhere in Medicare.

For chronically ill beneficiaries, who are more costly than average beneficiaries, how well or how accurately the risk adjustment methodology compensates those who are responsible for their care is vital. Without adequate risk adjustment, there are incentives to selectively avoid such costly beneficiaries (an insurance concept known as “adverse selection”); on the contrary, risk adjusted payments that are too generous will generate significant overpayments at taxpayer expense.

The HCC methodology assigns a risk score to a given beneficiary based on the combination of diagnosis and demographic factors correlated to expected Medicare expenditures for the coming year. A beneficiary risk score of 1.0 would indicate that this beneficiary would be expected to cost exactly the average amount Medicare spends per capita. A higher risk score will thus increase payments from CMS, and in this way, creates incentives to subvert the “true” financial risk associated with the care for a given beneficiary.

We see evidence in Medicare of both adverse selection resulting from inadequate risk adjustment and of gaming risk adjustment to increase payment. Prior to the introduction of the HCC methodology in 2006, when payments were adjusted only by demographic information, private MA plans had strong incentives to avoid sicker beneficiaries; after the introduction, these incentives were decreased[22]. These incentives still exist, if as MedPAC analysis has found, the HCC methodology overcompensates for lower cost beneficiaries and undercompensates for high cost beneficiaries.[23] A recent study in the National Bureau of Economic Research found that MA enrollees have 6 – 16% higher HCC risk scores than would be expected for the same beneficiaries in traditional Medicare, resulting in as much as $10 billion in additional payments, supporting other recent work.[24] Currently, CMS factors in a legislatively proscribed "Coding intensity adjustment," but this may not recoup all overpayments.

The overpayments are likely a result of how intensely physicians tend to diagnose and treat, which varies by up to two-fold by hospital referral region, despite little evidence of underlying differences in illness.[1] That the frequency of being diagnosed with a chronic condition varies by region, but is not connected to differences in health status is a challenge for any risk adjustment model that relies on diagnosis-based information. Because more diagnoses result in higher risk adjusted payments, there is thus the opportunity to game the claims-based HCC model, biasing the payments towards more intensive plans, regions, and physicians. We also see that when beneficiaries move their residence from the least observationally intensive regions to the highest intensity regions, their risk scores also grow significantly.[25] This is strongly suggestive that the burden of underlying illness is not responsible for these changes in risk scores.

The claims-based HCC model could be modified to make use of more information, or different information, in an attempt to improve its accuracy. A recent MedPAC analysis evaluated three alternatives, but found that further accuracy might come at the expense of weakening incentives for plans or providers to control costs. Therefore, it may be more attractive to move risk adjustment towards a model that sits outside of the influence of providers/plans.[23]

Dartmouth colleagues have identified a potential approach worth pursuing further. Comparing the HCC method's ability to predict mortality and spending against an exogenous measure of population health (taken from self-reported measurement of obesity, smoking, and general health status at the community level, as well as combined with claims-based incidence of stroke and hip fracture, which are not likely to vary upon observational intensity), the HCC method performed worse on mortality, and after being corrected for visit intensity, worse on spending than did the population health measure.[26] While this approach is not suitable for individual risk adjustment due to its reliance on community-level measurement, it highlights the possibility of using exogenous factors less sustainable to gaming. Advancing a risk adjustment model that collects patient-reported data at the individual level (perhaps using an annual wellness survey and

confirming reported risks via biometric screening) holds potential to improve the validity and reliability of the model.

Congress has an obvious interest in improving risk adjustment and in funding the development of a new model. Even with the blunt coding intensity adjustments, MedPAC estimates that coding differences contribute an additional 3% of annual costs beyond the costs of traditional Medicare.[27] In comparison to the overpayments in Medicare Advantage, the funding needed to advance a better risk adjustment model is relatively small, but its impact will be enormous. Therefore, we urge the Committee partner with CMS and other Congressional stakeholders to ensure further funding is available for this critical area of research.

Further steps to enhance the attractiveness of the ACO model.

We strongly applaud several of the steps taken by Congress in the legislation replacing the Sustainable Growth Rate model.[28] In particular, the bonus for physicians participating in ACOs/APMs – an additional 5% per year for 5 years starting in 2019 – and the eventual differential introduced in 2026 between growth rates in the fee schedule for physicians in APMs (updated at 0.75% per year) vs. those who remain in FFS (updated at 0.25% per year). To further accelerate the adoption of ACOs, Congress should consider moving up the date at which that differential will be introduced. Only when physicians in fee-for-service practice realize that change is definitely coming will the growth of alternative payment models be assured.

We look forward to continuing to work on these matters with the Committee and the work group. Please do not hesitate to reach out with any questions.

Sincerely,

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References:

1. Welch H, Sharp SM, Gottlieb DJ, Skinner JS, Wennberg JE. Geographic variation in diagnosis frequency and risk of death among medicare beneficiaries. *JAMA.* 2011;305(11):1113-1118.
2. Nelson L. *Lessons from Medicare's demonstration projects on disease management and care coordination.* 2012.
3. Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *Jama.* 2009;301(6):603-618.
4. Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. *Health Affairs.* 2012;31(6):1156-1166.
5. Counsell SR, Callahan CM, Buttar AB, Clark DO, Frank KI. Geriatric Resources for Assessment and Care of Elders (GRACE): A New Model of Primary Care for Low-Income Seniors. *Journal of the American Geriatrics Society.* 2006;54(7):1136-1141.
6. Counsell SR, Callahan CM, Clark DO, et al. Geriatric care management for low-income seniors: a randomized controlled trial. *Jama.* 2007;298(22):2623-2633.
7. Meret-Hanke LA. Effects of the program of all-inclusive care for the elderly on hospital use. *The Gerontologist.* 2011;51(6):774-785.
8. Boult C, Wieland GD. Comprehensive primary care for older patients with multiple chronic conditions:“Nobody rushes you through”. *Jama.* 2010;304(17):1936-1943.
9. Boult C, Reider L, Leff B, et al. The effect of guided care teams on the use of health services: results from a cluster-randomized controlled trial. *Archives of Internal Medicine.* 2011;171(5):460-466.
10. Boult C, Leff B, Boyd CM, et al. A matched-pair cluster-randomized trial of guided care for high-risk older patients. *Journal of general internal medicine.* 2013;28(5):612-621.
11. Komisar HL, Feder J. Transforming care for Medicare beneficiaries with chronic conditions and long-term care needs: coordinating care across all services. *Report from Georgetown University.* 2011.
12. Better Care, Lower Cost Act. 113th Congress. 2014.
13. Meyer H. A new care paradigm slashes hospital use and nursing home stays for the elderly and the physically and mentally disabled. *Health Affairs.* 2011;30(3):412.
14. Paquette D. The surprising health care experiment that saved taxpayers 24 million last year. *The Washington Post.* 10/6/14, 2014.
15. McWilliams JM, Chernew ME, Landon BE, Schwartz AL. Performance Differences in Year 1 of Pioneer Accountable Care Organizations. *New England Journal of Medicine.* 2015.

16. McWilliams JM, Landon BE, Chernew ME, Zaslavsky AM. Changes in Patients' Experiences in Medicare Accountable Care Organizations. *New England Journal of Medicine.* 2014;371(18):1715-1724.
17. Nyweide DJ, Lee W, Cuerdon TT, et al. ASsociation of pioneer accountable care organizations vs traditional medicare fee for service with spending, utilization, and patient experience. *JAMA.* 2015.
18. Medicare ACOs continue to succeed in improving care, lowering cost growth. Centers for Medicare and Medicaid Services; 2014.
19. Heiser SF, Elliott; Colla, Carrie. Unpacking The Medicare Shared Savings Proposed Rule: Geography And Policy. *Health Affairs Blog.* 2015.
20. *March 2015 Report to the Congress: Medicare Payment Policy.* MedPAC; 2015.
21. Colla CH, Scott; Tierney, Emily; Fisher, Elliott;. Balancing Goals in the MSSP: Consider Variable Savings Rates. *Health Affairs Blog.* 2015.
22. Newhouse JP, Price M, Huang J, McWilliams JM, Hsu J. Steps to reduce favorable risk selection in Medicare Advantage largely succeeded, boding well for health insurance exchanges. *Health Affairs.* 2012;31(12):2618-2628.
23. *Report to the Congress: Medicare and the health care delivery system.* MedPAC; 2014.
24. Geruso M, Layton T. Upcoding: Evidence from Medicare on Squishy Risk Adjustment. *National Bureau of Economic Research Working Paper Series.* 2015;No. 21222.
25. Song Y, Skinner J, Bynum J, Sutherland J, Wennberg JE, Fisher ES. Regional Variations in Diagnostic Practices. *New England Journal of Medicine.* 2010;363(1):45-53.
26. Wennberg DE, Sharp SM, Bevan G, Skinner JS, Gottlieb DJ, Wennberg JE. A population health approach to reducing observational intensity bias in health risk adjustment: cross sectional analysis of insurance claims. *BMJ: British Medical Journal.* 2014;348.
27. Zarabozo C. *Issues in Medicare Advantage.* Medicare Payment Advisory Commission; November 5, 2014 2014.
28. The Medicare Access and CHIP Reauthorization Act of 2015. 114th Congress. 2015.