January 26, 2016

The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
215 Dirksen Senate Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
215 Dirksen Senate Building
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chair, Bipartisan Chronic Care Working Group
United States Senate
Washington, DC 20510

The Honorable Mark Warner
Co-Chair, Bipartisan Chronic Care Working Group
United States Senate
Washington, DC 20510

RE: United States Senate Committee on Finance, Bipartisan Chronic Care Working Group Policy Options Document, December 2015

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

Evolent Health appreciates the opportunity to comment on the Chronic Care Working Group Policy Options Document published by the United States Senate Committee on Finance in December 2015. We strongly support the Committeeôs focus on improving care for the millions of Americans managing chronic illness, and share the Committeeôs goals of changing the health of the nation, in part by changing the way health care is paid for and delivered.

Like the Committee, we recognize the difficulty of this task. Since our founding in 2011, we have actively worked with health systems across the country to implement value-based solutions, and have seen first-hand how difficult it can be to effect change at an individual and a health system level. In just over four years, our technology platform and care management programs have touched more than two million lives in 25 markets. We have deployed chronic care management programs that have proven successful at helping the chronically ill manage their care, leading to lower total cost of care while maintain or improving the quality of care. We support the Health Care Payment Learning & Action Network and are aligned with Category Fourð Population-Based Paymentð in the networkôs recently-released Alternative Payments Model Framework[1].

[1] Alternative Payments Model Framework. Health Care Payment Learning & Action Network. January 2016. https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf

At the same time, we experience daily the reality that the payment and policy landscapeð both public and privateð is still not optimized for the shift to value-based care; in fact, in many ways, it continues to actively prevent health systems from making the wholesale financial, clinical and operational changes necessary to support a value-based business. Health systems recognize that they are attempting to succeed in two diametrically-opposed landscapes at the same time; they are hesitant to make the significant investments required to stand up and support a population health-focused business until they are convinced it can be financially viable. Without an additional financial and operational push towards value-based care and alternative payments, they are unlikely to do so.

Therefore, we applaud the Committee for developing such an impressive array of forward-thinking policy modifications that would lead to better care at lower costs for individuals living with chronic diseases. However, Evolent Health believes that the most effective and sustainable way to improve the lives of the chronically ill is through a fundamental transformation of the health care delivery modelð to one that focuses, both clinically and financially, on managing population and community health. Therefore, we urge the Committee to focus on policies that leverage the unique market position of government-financed health programs to accelerate payment and delivery system change, and avoid proposals that would give the illusion of meeting these goals while simultaneously making them more difficult to reach.

Specifically, we focus our comments on the two broad categories of policy change that we believe would create a payment and delivery landscape under which successful coordination of care for the chronically ill is essential:

1. **Population-based risk sharing** that drives accountability for the total cost, quality and experience of care for a population of patients, both continuously and during discreet episodes that span multiple sites of care; and
2. **Benefit design modernization** that complements value-based payments to providers by engaging individuals and families in the coordination of their care without inappropriately shifting costs onto consumers.

Recognizing that the ultimate goal of the committee is to produce cost-neutral, bipartisan legislation in 2016, Evolent Health recommends three policy changes that could be enacted immediately:

1. Make the Next Generation ACO model a permanent option for MSSP participants, while allowing cost-sharing waivers for patients visiting in-ACO providers
2. Allow risk adjustment in MSSP Track 3
3. Allow MA plans to permanently use VBID in plan offerings

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Population-Based Risk Sharing
Population-based risk-sharing holds providers accountable for the total cost and quality of care for a population of patients, allowing them to share in any success by offering quality incentive payments or by sharing in any savings generated.

The use of population-based risk sharing is increasing in both the private and public sector. In the private sector, arrangements such as Blue Cross Blue Shieldôs Alternative Quality Contract, which rewards physicians for how well they care for patients, have proliferated across the country[2]. In the public sector, the Center for Medicare and Medicaid Services (CMS) and Center for Medicare and Medicaid Innovation (CMMI) have instituted a number of programs for both single, discrete care events (e.g., Coordination for Joint Replacement, Bundled Payments for Care Initiative) and for the total cost of care for Medicare patients (e.g., Medicare Shared Savings Program (MSSP), Pioneer Accountable Care Organization (ACO) Program).

A number of proposals outlined in the Chronic Care Working Group Policy Options Document make it easier for MSSP ACOs to recruit, retain, and care for beneficiaries using a population-based risk sharing methodology.

For example, one proposal, ñProviding Flexibility for Individuals to be Part of an Accountable Care Organization,òwould allow MSSP Track 1 ACOs to choose whether patients be retrospectively or prospectively attributed to their ACO, and would allow beneficiaries the opportunity to voluntarily elect to be assigned to the ACO in which their main provider is participating.

Evolent Health strongly supports both of these modifications to the MSSP. There is no one ñright answeròto the attribution question nationallyð retrospective and prospective attribution each have pros and consð so each ACO should be able to decide what is right for itself.

The working group asks for feedback on whether ñA beneficiary who voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO.òWe believe that a patient who elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO, but we believe providers should also have the ability to reduce cost-sharing for in-ACO providers. This preserves freedom while recognizing the needs of the ACO.

[2] Song, Z. et al. "Changes in Health Care Spending and Quality Four Years into Global Payment." New England Journal of Medicine, October 30, 2014. http://www.nejm.org/doi/full/10.1056/NEJMsa1404026

The working group also asks for feedback on whether "ACOs that are assigned beneficiaries prospectively should receive an upfront, collective payment for all services provided to the beneficiaries in the ACOò and whether ñACOs that provide services to beneficiaries who voluntarily elect to enroll in the ACO should receive an upfront collective payment for all services provided to these beneficiaries.òEvolent Health strongly supports prepayment for ACOs. A population-based prepayment allows the ACO to efficiently invest in the hard and soft population health infrastructure required to fundamentally change the way it cares for its chronically ill population. It also gives the ACO a tool to help develop and align its provider network, which would help ensure attributed patients have access to the right provider at the right time.

A number of policy proposals outlined in the Bipartisan Chronic Care Working Group Policy Options Document center on the addition of Physician Fee Schedule codes for various chronic conditions and providers. While the goals of these new codes are laudable, the policy options are unlikely to create the payment environment necessary to transform clinical practiceð and in fact are likely to hinder progress towards that transformationð for two reasons.

First, it isnôt clear that adding a spate of individual, fragmented billing codes will alter payment incentives enough to fundamentally alter provider behavior; the codes simply extend the existing fee-for-service system without foundationally shifting providers to a focus on managing total cost, quality and experience of care. As noted by the committee, this is at odds with CMS, which has committed to shifting 50% of all Medicare payments to alternative payment models by 2018.[3]

Adding additional billing codes to the Physician Fee Schedule gives the illusion of progress towards a payment system that is optimized to support those with chronic conditions, when in reality it further entrenches a fee-for-service system that is, in many ways, incompatible with better managing the care of the chronically ill.

Second, the new set of fragmented billing codes do not provide the predictable and consistent revenue necessary to justify the investment in people, processes, and technology necessary to effectively and efficiently coordinate care. These investments are expensive but ultimately critical to creating a health system that can properly manage the care of chronically ill individuals.

[3] "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." Centers for Medicare and Medicaid Services. January 26, 2015. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

Ultimately, fragmented care coordination-focused billing codes fail to offer providers the incentives or resources to fundamentally transform how they practice medicine; in providing an insufficient solution, they may paradoxically make true care coordination more difficult. Only once providers are truly incented to both the quality of care and to reduce the total cost of that care are we likely to experience the fundamental transformation of care for the chronically ill.

Benefit Design Modernization

A one-size-fits-all benefit design cannot accommodate the needs of a diverse patient population, and is not best suited to enable health plans and providers to care for the chronically ill. We expect that modernizing benefit design in a way that complements a value-based payment methodology will lead to higher quality and more cost-effective care. Such modifications would include, but not be limited to: reduced cost-sharing for high-value services and, coverage of supplemental benefits, and reduced cost-sharing for visiting high-valuable providers within a Medicare Advantage network. We believe that these or other thoughtful, positive modifications of benefit design will lead to better patient and familial engagement in the coordination of chronic care without inappropriately shifting cost onto them.

As with population-based risk sharing, this is already happening in both the private and public sector. In the private sector, health plans are creating insurance products that are tailored specifically to certain chronic diseases. Aetna, for example, has created a plan tailored to diabetic patients that includes lower co-pays for specialists that diabetic patients are likely to see, and that offers financial incentives for getting an HbA1C test twice a year[4]. In the public sector, CMMI recently launched a Value-Based Insurance Design demonstration for Medicare Advantage that will test whether the flexibility to offer clinically-nuanced VBID elements in plan design will lead to higher quality and more cost-efficient care for targeted enrollees with specific chronic conditions[5].

A number of policy options proposed by the working group address benefit design modernization. For example, ñAdapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrolleesòwould potentially allow supplemental benefits, cost-sharing reductions for items/services that treat a

[4] Andrews, Michelle. "Now There's a Health Plan That Zeroes in On Diabetes Care." National Public Radio Shots. November 17, 2015. http://www.npr.org/sections/health-shots/2015/11/17/456255470/now-theres-an-aetna-heath-plan-that-zeroes-in-on-diabetes-care

[5] "Medicare Advantage Value-Based Insurance Design Model." Centers for Medicare and Medicaid Services. January 5, 2016. https://innovation.cms.gov/initiatives/vbid/

chronic condition, and adjustments to provider networks. Evolent Health strongly supports modifications to the Medicare Advantage benefit design because we believe they will offer the flexibility necessary for providers to implement disease-specific offerings to their beneficiaries. We believe this can be done without placing undue risk or cost on the patient.

Another, ñProviding ACOs the Ability to Expand Use of Telehealth,ò would waive geographic restrictions on telehealth, bolstering the set of tools available to ACOs to care for their beneficiaries. We strongly support efforts to provide ACOs the freedom to care for their patients in whatever care setting they feel is appropriate. Broadening the telehealth geographic restriction waiver by lifting the originating site requirement entirely would help providers reach chronically ill patients in new and efficient ways. Many ACOs, for example, would not have the requisite chronically patient density to support a nurse care manager at every provider office, but could support a telephonic care manager to care for its geographically-dispersed patients. Such a telephonic care manager could make check-in calls with patients from a remote location, helping to support the care of patients from their own homes.

Finally, ñEliminating Barriers to Care Coordination under Accountable Care Organizationsò would allow ACOs in two-sided risk models to waive beneficiary cost sharing, and give ACOs the latitude to determine what items or services would be eligible for cost-sharing reductions. Evolent Health is strongly in support of this proposed policy, and recommends that the eligible items/services be left to the discretion of the ACO. ACOs are best positioned to know what modifications would best enable patients and providers to work together to manage chronic illnesses, and ACOs could draw on each group to develop their own payment infrastructure.

Immediate Recommendations

We believe the above recommendations are substantively and politically viable today, but recognize that creating the payment environment necessary to transform care for the chronically ill while require a multi-year commitment from the public and private sectors. Therefore, appreciating that the near-term goal of the committee is to produce cost-neutral, bipartisan legislation in 2016, Evolent Health recommends three policy changes that could be enacted immediately:

1. **Make the Next Generation ACO model a permanent option for MSSP participants, while allowing cost-sharing waivers for patients visiting in-ACO providers**

For the reasons cited above, we believe the Next Generation ACO model is more attractive to health systems than Track 1, Track 2, or Track 3. It allows providers to fund, build, and operate their ACOs with significantly more freedom than any of the previous tracks, and is a more financially-viable option than the other tracks. It has been met with interest from health systems across the country, as evidenced by the 21 chosen to participate in 2016[6], with a similarly large cohort expected to begin in 2017.

While the Next Generation ACO model is new, the general concept underpinning it is not, and ACOs are now recognized as one model that health systems can use to reduce the total cost of caring for a community while maintaining a high quality of care. There was, and will continue to be, interest from health systems across the country to join the Next Generation program, and we believe that CMS should make the model a standard component of the MSSP.

Additionally, Next Generation ACOs should have the freedom to use cost-sharing waivers and other benefit design methods to incent beneficiaries to see in-ACO providers. This is good for beneficiaries, as it will reduce financial barriers that can be a hindrance to seeking necessary care, and is good for the ACOs, as it will give them a tool to promote the coordinated care experience offered by the risk-bearing ACO while still promoting a patientôs freedom to choose her provider.

2. Allow risk adjustment in MSSP Track 3

Currently, MSSPôs Track 3 does not allow for negative changes in a patient populationôs health over time through risk adjustment. This makes it more difficult for participants to care for their patient population and can reduce the otherwise inherent incentive in a population health model to seek out and improve care for the riskiest, highest-cost patients. In our experience, provider organizations are highly dubious of assuming any significant level of downside risk without a minimally-viable risk adjustment mechanism.

Allowing risk adjustment ï beginning with the approach taken in the Next Generation ACO model ï would make the program look more attractive, likely increasing the number of participants. Any increase in payments based on risk score increases would likely be outweighed by decreases in total medical spend by a larger, more stable set of participating ACOs.

[6] Next Generation ACO Model. Centers for Medicare and Medicaid Services. January 11, 2016. https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

Ultimately, CMS will need to shift the MSSP to a model that rewards attainment and not simply improvement, moving away from health system-specific historical benchmarks and towards regional comparisons where risk adjustment will be equally if not more essential. Allowing risk adjustment in Track 3 will provide CMS the opportunity to begin to analyze the effects of such a shift.

3. Allow MA plans to permanently use VBID in plan offerings

We believe that the Medicare Advantage Value-Based Insurance Design demonstration should transition into a permanent fixture of the program, and that MA plans should be able to incent beneficiaries to use high-performing sub-networks of their total network. We expect that this modification would lead to higher quality care at a lower cost for chronically ill beneficiaries of MA plans.

This modification would be good for both providers and patients. High-performing providers would be rewarded for their excellence with additional patient volume, and low-performing providers would be incented to become more effective and more efficientð which will improve the overall performance of the network for beneficiaries.

Taken together, we believe that the recommendations outlined above would help the working group meet its stated goal of improving care for the millions of Americans managing chronic illness. Additionally, we believe they would also help prevent millions of Americans from developing a chronic illness in the first place, which would have a material effect on both the aggregate cost of healthcare in America but, more significantly, would have a material effect on the lives of millions of Americans.

If you have any questions, or would like to follow-up on any part of this letter, please contact Mike Miesen at mmiesen@evolenthealth.com or (312) 898-3113.

Sincerely,

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