UNIVERSAL AMERICAN

A Healthy Collaboration®

June 22, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Johnny Isakson
Co-Chairman
Chronic Care Working Group

The Honorable Mark Warner
Co-Chairman
Chronic Care Working Group

Re: Request for Ideas to Improve Outcomes for Medicare Patients with Chronic Conditions

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

Universal American Corp. (UAM) appreciates the opportunity to submit ideas to inform the efforts of the United States Senate Committee on Finance to improve care for Medicare beneficiaries with chronic conditions.

UAM partners with PCPs to improve healthcare quality and reduce costs. We operate core Medicare Advantage (MA) plans in Texas, New York, and Maine, as well as 25 accountable care organizations (ACOs) in 13 states participating in MSSP. Our physician partner organizations are highly diverse and range from sophisticated, single-TIN integrated practices to multi-TIN independent practice associations and Federally-Qualified Health Centers. Under our model, we provide investment capital, care coordination, technology, and data analytics to improve the quality, efficiency, and cost-effectiveness of care provided to Medicare beneficiaries in both our MA plans and ACOs.

Given this experience, we are very excited to share our ideas with your Chronic Care Working Group. In this letter, we organize our responses according to six specific recommendations:

1. Center chronic care programs in the primary care practice
2. Leverage MSSP as a starting point for chronic care programs
3. Empower PCPs to integrate specialists into population health
4. Establish fair and equitable financial and/or benchmarking models
5. Provide the freedom to engage beneficiaries creatively

The remainder of this letter details each of these six recommendations and includes action items for each recommendation for consideration by the Working Group.

1. Leverage MSSP as a Starting Point for Chronic Care Management

Participating practices should be ACO providers. While the goals of the ACO model are similar to PCMHs, ACOs have a different payment model that supports and maximizes population health efforts. ACOs are also already identifying preferred provider networks and MSSP ACOs address potential patient panel and total cost of care concerns that may arise with standalone primary care practices. As our experience with MA demonstrates, standalone practices often have insufficient patient panel sizes to enter into risk-based contracts, which are essential for driving the care delivery changes necessary to manage the health of beneficiaries with chronic conditions. In contrast, ACOs assemble PCPs to achieve the beneficiary threshold necessary for population health management, with patient panels often far larger than the minimum.[1] Utilizing these large patient panels would also extend the reach of care delivery changes instituted for chronic care, including positive spillover effects for other ACO beneficiaries.

Evidence from MSSP demonstrates that ACOs are well-suited to manage and improve care outcomes for patients with chronic conditions. For example, Accountable Care Coalition of Texas (ACCT), one of our MSSP ACOs that joined the program in 2012, has decreased ambulatory care sensitive condition (ACSC) admissions for COPD/Asthma by 38 percent, from 11 discharges per 1,000 to less than eight, through the end of 2014. During the same period, ACSC admissions for bacterial pneumonia declined by 12 percent. Under independent PCP leadership, acute hospitalizations, 30-day readmissions, and emergency department visits have also fallen. Further, SNF utilization, which is significantly more likely for patients with chronic conditions, is also lower.[2] Our ACO has 31 SNF discharges per 1,000 patients, which is 55 percent lower compared to the average FFS population. These and other positive trends are also evident in the initial results for 2015, and indicate the early potential from leveraging MSSP for chronic care.

Action: The Working Group should streamline the administrative burden for ACO-based primary care physicians that bill the monthly Chronic Care Management (CCM) code 99490.

2. Empower PCPs to Integrate Specialists into Population Health

To reduce fragmented care delivery, PCPs should be empowered as the nexus for coordinating care with specialists. Beneficiaries with the greatest care needs often have multiple chronic conditions, and, for these individuals, treatment can mean visits with multiple specialists. Although each of these specialists may deliver high-quality care individually, they may not be aware of decisions and care plans developed by their peers, leading to adverse events (e.g., negative drug-drug interactions). Putting PCPs at the center of chronic care would help mitigate this problem. Many PCPs have already received PCMH recognition, which requires behaviors necessary for chronic care management, including coordination of follow-up care. A new model for chronic care would build on the PCMH principles, by holding PCPs accountable for the cost and quality care delivered to these beneficiaries by their specialists.

Any new model should allow PCPs formal opportunities to engage specialists. The Next Generation ACO model's preferred and affiliated provider agreements are an example of one way to facilitate more formal collaboration. Under these agreements, the PCP would analyze claims and other data to identify efficient partners based on the value, quality, and cost of the specialist episodes. Using that data, PCPs

[1] MSSP ACOs that completed their first performance year in 2013 had an average patient population of 16,706.
[2] Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Centers for Medicare & Medicaid Services. 2012.

would designate preferred specialists that accept the goals of improving chronic care, commit to following common care protocols, and participate in regular data sharing. We believe a key area of focus for these arrangements is the nephrologists and other specialties associated with the chronic kidney disease (CKD) and End Stage Renal Disease (ESRD) population segments in traditional Medicare.

We have experience identifying preferred providers in MA and MSSP. Our TexanPlus MA plan narrowed our skilled nursing facility (SNF) network from 44 to 12 facilities, based on key metrics such as readmission rates, patient experience, and clinical capabilities. These preferred facilities have driven a lower average length of stay, from 16 to 12 days, and a lower readmission rate, from 38 to 13 percent. The lessons from streamlining SNF networks could be applied to specialists to improve care coordination and outcomes.

Based on our experience across 25 MSSP ACOs, we believe a key area of focus for future preferred arrangements is with nephrologists and other specialists treating the chronic kidney disease (CKD) and End Stage Renal Disease (ESRD) population segments in traditional Medicare. Oftentimes these specialists are not included as ACO participating providers and it's very difficult to construct shared savings arrangements to incentivize the care coordination needed for CKD patients. The PCP should be positioned as the medical home with more tools to integrate preferred specialists that will improve treatment of this population's multiple comorbidities and chronic conditions.

Action: The Working Group should instruct CMS to require the development of ACO preferred provider sub-networks for the core specialists treating the CKD/ESRD population comorbidities.

3. Establish Fair and Equitable Financial and/or Benchmarking Models

To reduce total cost of care, primary care practices must be able to share in all savings from their efforts to better coordinate care for eligible beneficiaries with chronic conditions. In a capitated or shared savings ACO model, practices have the opportunity to share in Part A and B spillover savings. The opportunity to earn savings from avoiding unnecessary or preventable utilization outside of the primary care practice ensures that providers do not have an incentive to engage in undesirable behaviors.

The current MSSP financial model is not sustainable over the long-term, as historically efficient providers will have fewer opportunities to earn savings as their benchmark declines. Gradually replacing historical spending with a benchmark based on regional spending with adjustments for clinical risk will ensure that these efficient providers can continue to participate in the model. We urge the Working Group to include risk adjustment in benchmark methodology for any new, chronic patient-focused models to ensure financial viability for participants.

A significant investment in care coordination personnel will drive provider outcomes under chronic care models. Currently, our ACCTX team includes RN inpatient case managers, RN in-home (field) case managers, licensed vocational nurse (LVN) telephonic case managers, LVN home health coordinators, social workers, and support services coordinators. While evidence underscores the value of investing in these individuals, shared savings payments are ultimately not timely, limiting the opportunity for other physician practices to make similar investments. Accordingly, we recommend that the financial model account for these services. For example, the model could offer risk-stratified per member per month case management payments or population-based payments for more advanced participants. Risk-adjustment based on clinical severity is required to ensure appropriate capitation payments under any chronic care model. Further, as an additional bulwark against potential perverse incentives to increase

avoidable utilization or scrimp on necessary care, the model should stratify these payments based on quality performance, similar to the methodology used in Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract.[3]

Action: The Working Group should ensure 2-sided risk adjustment for multi-chronic condition patients.

4. Provide the Freedom to Engage Beneficiaries Creatively

To achieve better health outcomes and cost savings, participating PCPs must have the tools to encourage behavior change. First, beneficiaries should have cost-sharing incentives to seek care from participants in chronic care redesign. Specifically, beneficiaries should not have cost-sharing for five primary care evaluation & management codes (CPT 99211-99215) and the chronic care management code (CPT 99490). Eliminating cost-sharing for these codes will enhance the care coordination capabilities of PCPs by encouraging eligible beneficiaries to seek care as needed. Since the financial model would hold PCPs accountable to total cost of care, participating practices would not have an incentive to increase unnecessary utilization of these services.

We also recommend that the model permit participating PCPs to offer certain in-kind incentives to beneficiaries for receiving preventive care services. These incentives would encourage patients to receive certain approved services linked to beneficiaries' health goals. In particular, participating practices should be able to offer incentives for beneficiaries to complete their AWV. In-kind incentives would build off successful private sector experiences.[4,5] If well defined, in-kind incentives for preventive services will be a powerful tool for PCPs to engage beneficiaries.

One final incentive would be to offer beneficiaries an opportunity share in savings through reduced premiums, rebates, or another mechanism. For example, the model could adapt the planned coordinated care reward for beneficiaries aligned to Next Generation ACOs. Creating a direct financial incentive for beneficiaries would increase opportunities for patient engagement, with beneficiaries sharing an incentive to follow care plans, engage in positive behavior change, and seek care in appropriate settings (e.g., no longer visiting the emergency department for primary care).

Our experience has shown these changes work. In upstate New York, our Intensive Care Management (ICM) program targets MA plan members with multiple chronic conditions and significant barriers to care. The ICM program staffs over 40 nurse care managers and social workers on location to conduct over 14,000 at home visits and an additional 51,000 successful phone calls.[6] Long-term evaluation is ongoing, but initial results have shown that the program reduces medical spending, specifically hospital readmissions, without compromising patient outcomes. Even though our members do not have a copayment for these services, the ICM model has achieved budget neutrality by avoiding costly adverse events.

Action: For Medicare beneficiaries with significant socio-economic challenges, the Working Group should create special waivers that include transportation benefits to improve the PCP's ability to bring these patients to the clinic location and perform effective care management.

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[3] Massachusetts Payment Reform Model: Results and Lessons. Blue Cross Blue Shield of Massachusetts. October 2012.
[4] Keene N, et al. Preliminary Benefits of Information Therapy. January 2011.
[5] Chesser A, et al. Prescribing Information Therapy Opportunity for Improved Physician-Patient Communication and Patient Health Literacy. January 2012
[6] Internal UAM program evaluation.

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In conclusion, UAM strongly believe that PCPs play the most important role in improving quality and appropriately managing the cost-of-care for Medicare beneficiaries. We urge the Working Group to ensure that PCPs are at the forefront of care models for patients with chronic conditions, as these providers are best positioned to deliver patient-centered care. In our experience over two decades in population health, independent PCPs that are properly incentivized and held accountable under outcomes-based contracts can achieve industry-leading utilization rates, quality and outcomes. One key reason for this is that PCPs do not carry the burden of transitioning from fee-for-service (FFS) revenue sources linked to acute episodes, like facility-based providers.

UAM appreciates the opportunity to provide feedback to the committee. We would welcome any further discussions on our proposals with you and your staff, while continuing to work to improve quality of care for Medicare beneficiaries with chronic conditions.

Regards,

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