



June 9, 2017

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

STATEMENT FOR THE RECORD: Examining Bipartisan Medicare Policies that Improve Care for Patients with Chronic Conditions, May 16, 2017

Health Care Transformation Task Force
601 New Jersey Ave. NW, Suite 450
Washington, DC 20001

The Health Care Transformation Task Force¹ applauds the Chronic Care Working Group for its efforts in advancing bipartisan Medicare policies to improve care for beneficiaries with chronic conditions. In particular, the Task Force supports the recently reintroduced *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 (S.870)* as a stepping stone to improved quality of care through value-based payment arrangements.

In previous correspondence with the Working Group (February 2016)², the Task Force indicated its support for refinement of the CMS-Hierarchical Conditions Category (HCC) model to account for interactions between behavioral and mental health conditions and physical health outcomes. The Task Force is encouraged by the implementation of this policy as well as the implementation of additional provisions of the Working Group's Discussion Draft.

The following comments focus on our priority policy options within the *CHRONIC Care Act of 2017*, with a particular focus on efforts that advance our members' collective goal of putting 75 percent of our business into value-based payment arrangements by 2020, and promote the broader private sector movement toward value-based care. We encourage the Committee to continue this important work and look forward to additional legislation that would provide for more impactful improvements to Accountable Care Organizations than the provisions included in the current bill.

¹ The Health Care Transformation Task Force (Task Force) is a consortium of private sector stakeholders that to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – currently including patients, payers, providers and purchasers – we share a common commitment to transform our respective business and clinical models to deliver the high quality, person-centered care at a lower cost. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020. We hope to provide a critical mass of policy, operational and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

² <http://hcttf.org/resources-tools-archive/2016/2/1/task-force-letter-to-senate-finance-committee-on-chronic-care-policy-options>

I. Expanding Innovation and Technology

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

Provider networks and Medicare Advantage plans should be able to tailor care to beneficiaries who are chronically ill in ways that best meet their needs. These types of flexibilities will improve clinical outcomes, slow disease progression, and minimize barriers to quality care. We support the Committee’s proposal to expand the testing of the CMMI VBID Model to allow a MA plan in any state to participate in the model by 2020, and also ask that this expansion apply to Employer Group Waiver Plans (EGWPs) within Medicare Advantage. Achieving savings without negatively impacting quality is a core goal of the transformation to value-based payment arrangements, and the VBID Model shows promise in this space. The testing phase will be important to determine if the supplemental benefits offered under the VBID model not only reduce barriers to care for high need individuals, but stimulate positive health outcomes while reducing overall costs. To that end, the Task Force also supports increased flexibility within the VBID model to allow MA plans to make positive benefit changes mid-year in order to best meet the needs of their chronically ill beneficiaries.

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

The use of supplemental benefits for chronically ill Medicare Advantage enrollees is a patient-centered approach to care that the Task Force supports. Enhanced benefits that would be especially beneficial include those that address barriers to effective treatment. Many of these benefits are not currently covered under the Medicare program given that they are not primarily health-related services (*i.e.*, social services). Important examples of supplemental benefits that address the social determinants of health and reduce barriers to care include transportation, meal services, and exercise and wellness programs. All of these approaches have been known to improve health and overall function as specified by the proposal. We encourage specific inclusion of these services in the bill as examples of supplemental benefits that would be able to be offered in the MA program under the current proposal.

We also ask that the Committee consider allowing MA plans to offer “benefits in lieu of benefits” (*i.e.*, substituting a needed benefit for an unnecessary one, as already offered under commercial plans). This type of flexibility would incentivize use of VBID within Medicare Advantage, and would allow plans to offer enhanced benefits to targeted enrollees. This policy is well-aligned with the Committee’s proposal to expand supplemental benefits in MA, as it encourages plans and providers to work together to meet the needs of chronically ill individuals in the most efficient and effective way possible.

c. Providing Accountable Care Organizations the Ability to Expand Use of Telehealth

Telehealth has moved beyond an innovative approach to beneficiary access to provider services, and has become a part of routine care models. The Task Force therefore supports the extension of the Next Gen ACO telehealth waiver to all MSSP tracks, so that provision of telehealth services under value-based payment arrangements is not unnecessarily limited. We believe that telehealth payments should not be restricted geographically. We also believe that the originating site requirement should be eliminated entirely for ACOs and other similar risk-bearing entities. With the assumption of risk, ACOs and other entities are held accountable for unnecessary utilization and waste, and therefore should not be restricted in their ability to provide telehealth services. Further, ACOs and other similar entities are held accountable for quality of care of their attributed patient population, and are therefore incentivized to provide face-to-face encounters with patients when it is clinically necessary.

The Task Force also supports the provision of telehealth services to patients in their home, as this reduces barriers to care for many patients who have mobility or transportation limitations. Bringing care to patients where they are follows a patient-centered approach that will likely improve clinician-patient relationships and increase adherence to treatment/therapy plans, all while lowering the cost of care. We recommend that the *CHRONIC Care Act* reference the language and principles included in the *CONNECT for Health Act* (S. 2484/H.R. 4442), which was informed by the experiences of multiple provider organizations.

II. Identifying the Chronically Ill Population

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

Allowing Medicare FFS beneficiaries to voluntarily elect to be assigned to the ACO, or other similar risk-bearing entity, in which their main provider is participating will increase the number of beneficiaries participating in the program, and the amount of care subject to value-based payment arrangements. Given that Task Force members are committed to transitioning away from fee-for-service, we support increased participation in ACOs and other risk models. Voluntary alignment is an important component of a robust attribution model, which itself is necessary for accepting accountability for a population of patients. A robust attribution model is one that reflects a patient declaration of “Yes, this is my provider group” and a provider group declaration of “Yes, this is our patient.” Robust attribution makes a population “more known,” and if ACO attribution is maintained and shared by a payer (including Medicare), it can be used to support information exchange, optimize care coordination, and align incentives across all providers. Simply allowing patients to voluntarily elect to be part of an ACO is not enough, however. ACOs must actively engage in outreach and education that will help patients better understand the benefits and implications of participation.

III. Empowering Individuals in Care Delivery

a. Eliminating Barriers to Care Coordination under Accountable Care Organizations

The Task Force emphasizes that meaningfully engaging beneficiaries as partners in care and delivering patient-centered care that meets the needs of patients and families is the best way to encourage beneficiaries to consistently seek care within their ACO and access preventive care or disease management as needed. As proposed, a flat rate payment to Medicare FFS beneficiaries under the ACO Beneficiary Incentive Program would not effectively impact the highest-need, highest-cost population. The Task Force supports policies that lower the out-of-pocket cost burden for beneficiaries, but believes that these supports should reflect the amount and level of acuity of care. For example, a previous proposal by the Chronic Care Working Group contemplated waiving cost-sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease. The Task Force is supportive of this approach, as it more directly addresses the needs of those with chronic illness by correlating with each patient's out-of-pocket burden.

Thank you for the opportunity to provide this comment. Please contact Task Force Executive Director Jeff Micklos (jeff.micklos@hcttf.org, 202.774.1415) or Caitlin Sweany, Director of Transformation Facilitation and Support (caitlin.sweany@hcttf.org, 510.506.8972) with any questions.

Sincerely,

The Health Care Transformation Task Force