

December 14, 2017



The Honorable Paul Ryan
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Re: Support for Bipartisan Medicare Legislation that Improves Care for Patients with Chronic Conditions

Dear Speaker Ryan and Minority Leader Pelosi:

The recent passage of the Senate's *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017* (S. 870), which passed under a unanimous consent agreement, is a strong indicator of widespread bipartisan support for measures that can improve the quality of care while lowering costs. Specifically, provisions such as an expanded Value-Based Insurance Design model, improvements to Medicare Advantage special needs plans, broader telehealth access, and flexibility in Accountable Care Organization (ACO) beneficiary assignment, have the potential to greatly improve care delivery.

We strongly encourage the House to expeditiously move the components of this important legislation forward, either through existing individual component bills or through a single bill that serves as a complement to S. 870. We acknowledge that these bills are in various stages of review, and commend committee leadership for continuing to advance these critical issues. The Task Force has identified areas for further enhancement in the pending legislation, described below.

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

H.R. 1995

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. We support the proposal to expand the CMMI VBID Model to allow an 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. 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.

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

H.R. 3044

The Task Force supports the patient-centered approach of using supplemental benefits to better serve chronically ill Medicare Advantage enrollees. Enhanced benefits that would be especially valuable include those by addressing barriers to effective treatment. Many of these benefits are not currently covered under by Medicare 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 as examples of supplemental benefits that should be available in the MA program under the current proposal.

The Task Force also asks that MA plans be allowed 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 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.

Extension of Special Needs Plans and Improvements to Severe/Disabling Chronic Condition Special Needs Plans

H.R.3168

Special Needs Plans (SNPs) play a vital role in allowing high-cost, high-need MA enrollees to access targeted care. The Task Force supports the proposal to extend SNPs and improve integration of dual-eligible SNPs (D-SNPs). The Task Force also supports improvements to severe/disabling chronic condition SNPs, particularly in care management requirements. These individuals are often the sickest and most costly patients, and often have social needs (such as transportation) that may impede access and/or adherence to medical care. The Task Force encourages more specificity around requirements for care management, including extension of services to address the social determinants of health.

Promoting Communication between Part D Plans and Medicare Fee-for-Service

H.R. 3447

Adequate information flow is critical to beneficiary care management. The Task Force therefore supports allowing Medicare Parts A and B data to be shared with Part D prescription drug plans. The Task Force strongly believes that the sharing of data can better support medication management and improve care coordination.

Expanding the Use of Telehealth

H.R. 2556

The Task Force 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 making care more affordable.

Additional Considerations for Alternative Payment Models

In addition to the specific commentary above, the Task Force recommends that the following alternative payment model-related provisions be included in any final bill:

- **Flexibility for beneficiaries to voluntarily join an accountable care organization.** Allowing Medicare 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 is necessary for accepting accountability for a population of patients.
- **Elimination of barriers to care coordination under accountable care organizations.** S. 870 includes a proposal for a flat rate payment to Medicare FFS beneficiaries under the ACO Beneficiary Incentive Program. The Task Force supports legislation that lowers the out-of-pocket cost burden for beneficiaries, but believes that these supports should reflect the amount and level of acuity of care e.g., waiving cost-sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease). The Task Force supports this approach, as it more directly addresses the needs of those with chronic illness by correlating with each patient's out-of-pocket burden.
- **Extension of telehealth waivers to all accountable care organizations.** The Task Force supports the extension of the Next Gen ACO telehealth waiver to all MSSP tracks, so that providing telehealth services under value-based payment arrangements is not unnecessarily limited. We believe that telehealth payments should not be restricted geographically. 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.

Thank you for the opportunity to provide comments on this important legislation. 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

Cc:

The Hon. Pat Tiberi
Chairman
Ways and Means Subcommittee on Health

The Hon. Michael Burgess
Chairman
House Energy Subcommittee on Health

The Hon. Sander Levin
Ranking Member
Ways and Means Subcommittee on Health

The Hon. Brett Guthrie
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House Energy Subcommittee on Health

The Hon. Gene Green
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