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January 26, 2016

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

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

The Honorable Johnny Isakson
United States Senate
131 Russell Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Building
Washington, DC 20510

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

Thank you for your continued efforts to improve the lives of chronically ill beneficiaries covered by Medicare. University of Wisconsin Health (UW Health) is an academic health system associated with the University of Wisconsin-Madison. It encompasses the research, education and patient care activities that take place at the UW School of Medicine and Public Health and within UW Hospitals and Clinics Authority. We share your belief that improved Medicare policy can contribute to better health outcomes for chronically ill beneficiaries, and with that goal in mind, offer our specific comments on a number of your proposed policy options below.

Advancing Team Based Care

Improving Care Management Services for Individuals with Multiple Chronic Conditions

UW Health supports the development of a new high-severity chronic care management (CCM) code that clinicians could bill under the Physician Fee Schedule. The advent of a billing structure for CCM holds huge potential for integrated care systems like UW Health. We provide the type of comprehensive care best suited for the chronically ill, and do so through interdisciplinary care teams that invest significant resources in developing and implementing care plans to maximize clinical outcomes. Those patients with the most demanding clinical needs often require investment beyond the twenty minutes outlined in the current CPT code for CCM services.
UW Health recommends that the high severity CCM code be limited to patients whose co-morbid diagnoses cross medical specialty areas, requiring the time and consultation of multiple physicians. We believe that the same providers should be eligible to bill the new code as are able to bill the current code – at UW Health, these are the physicians developing the care plan as well as the nurses and other qualified health care providers carrying out the management functions at the physician's direction. Finally, we believe that the code should be temporarily instituted while giving the Secretary of Health

and Human Services authority to continue, discontinue, or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors. We also recommend that CMS devote resources to technical assistance for the implementation of the code.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

As an Accountable Care Organization (ACO) that treats chronically ill beneficiaries with behavioral health issues, we believe addressing these individuals' needs is a critical policy area. We recommend that the Working Group explore one of two options: first, Congress could authorize ACOs to cover services that address behavioral health needs, such as transportation or support groups, but structure a fully capitated payment that maintains the ACO's acceptance of full risk for the beneficiary. UW Health believes that facilitating some targeted behavioral health services could assist in reducing overall spending per beneficiary. Alternatively, Congress could authorize Medicare to pay for an expanded set of mental health services for chronically ill beneficiaries, which would benefit a broader range of beneficiaries not enrolled in ACOs, but without the same level of financial assurances provided in a risk sharing arrangement.

Expanding Innovation and Technology

Providing ACOs the Ability to Expand Use of Telehealth

UW Health supports eliminating the originating site requirement entirely for ACOs, but does not believe that limiting the elimination to two-sided risk models is sufficient.

UW Health currently participates in the MSSP in the one-sided risk model, and perform among the top MSSPs in the country -- our annual cost per beneficiary for 2014 was $7,966, and our quality score was 94.3%. However, because we entered the program operating at a high level of efficiency, we face a challenge in achieving significant savings in the early years of our program. While we conduct additional evaluation, and continue to refine and improve our care models, the two-sided risk model is not a viable financial option for us. Therefore, until viable financial models for high performing (i.e., high quality/low cost) organizations are available, limiting the expansion of innovative care models to those under two-sided risk is counter-productive to the three-part aim.

Nonetheless, beneficiaries enrolled in our ACO can only benefit from further access to telehealth. E-consults and other remote monitoring activities are a growing component of our care model and are critical to distributing our physician resources efficiently across the UW system. Allowing patients to access a core set of services from physicians in real time – whether they are at home, or at an urban outpatient clinic with a nurse – will only help UW Health and similar systems further our work to find the maximum balance of high quality and efficient resource use.

Maintaining ACO Flexibility to Provide Supplemental Services

We support permitting ACOs participating in the MSSP program, like UW Health, to furnish a social service or transportation service for which payment is not made in fee-for-service Medicare. We believe this clarification will facilitate greater levels of service for Medicare beneficiaries participating in ACOs and improved financial and clinical success for the MSSP overall. Similarly, clarifying that ACOs may furnish remote patient monitoring is important for integrated systems like UW Health who service patients in rural locations and those who receive ongoing treatment in their homes.

Expanding Use of Telehealth for Individuals with Stroke

UW Health supports eliminating the originating site geographic restriction for the purpose of promptly identifying and diagnosing strokes. Expanding the availability of evaluation and diagnosis of acute stroke would not only facilitate stroke care generally, but also has the potential to significantly improve health outcomes. However, we would like to be sure the Working Group is aware of some of the limitations on building a successful telehealth program for stroke diagnosis and treatment under the current reimbursement model.

Managing an acute stroke is an extremely complex and high-stakes medical endeavor for an individual in a health care crisis. At UW Health, we consider these to be critical care services – specifically, the evaluation and management of a critically ill or critically injured patient. However, the Centers for Medicare and Medicaid Services (CMS) has not added the corresponding CPT code to its telehealth list, so even if the geographic restrictions were eliminated, the consult would be need to be billed at the relatively low level CPT code that can be billed via telehealth. For a health care system like UW Health to build a sustainable model providing stroke consults via telehealth, it would help to ensure that the physicians are being reimbursed according to the level of care provided and be able to bill these telehealth consults as the critical care services that they entail.

Under the current statutory and regulatory restrictions, UW Health has developed a subscription fee model, where eight partner institutions across the Wisconsin/Illinois region pay a small fee for access to the expertise of UW Health neurologists, and bill for professional services of their own staff. We would be glad to provide further information on this model and our experiences should it be of use to the Working Group.

<u>Identifying the Chronically Ill Population and Ways to Improve Quality</u>

Ensuring Accurate Payment for Chronically Ill Individuals

UW Health supports additional improvements to the CMS-Hierarchical Conditions Category (HCC) Risk Adjustment Model, and believes those outlined by the Working Group warrant consideration. However, UW Health recommends the Working Group also consider incorporating social determinants of health into the Risk Adjustment model, including, for example: stable housing and income; health literacy; and the stability of the individual's social relationships (i.e., whether the individual is subject to familial or other external stressors). We recognizing the difficulty of determining the appropriate set of these determinants, as well as integrating these types of data, which would fall outside of Medicare's databases. We hope that the work of the Institute of Medicine's Committee on Accounting for Socioeconomic Status in Medicare Payment Programs will provide the Working Group with concrete ideas for implementation.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

As an ACO participating in the MSSP Track One, UW Health would appreciate the option to assign beneficiaries prospectively. We support an upfront, collective payment for all services provided to the beneficiaries; we are interpreting the proposed policy to be a fully capitated payment, and recommend that the Working Group define it as such. Similarly, we would support a capitated payment for voluntary enrollees in the ACO.

We support freedom of choice for our patients, but do not believe that it is fully consistent with the capitated payment model envisioned in the Working Group's proposal. In our experience, the most efficient and successful risk models are those in which the providers bear full risk in exchange for a closed panel. Our private market risk bearing contracts operate in this fashion. Therefore, if a beneficiary is permitted to voluntarily elect to enroll in an ACO but retain the ability to receive services from non-participating providers, the Medicare program should retain some degree of risk. CMS can continue to reimburse the non-ACO provider under the traditional fee for service payment system, while retaining some ability to retrospectively reclaim a percentage of the capitated payment provided to the ACO. Given the inherent risks of such an arrangement, careful monitoring of the outcomes will be necessary and valuable as these new payment models are advanced, and CMS should consider risk corridors for those organizations willing to experiment with such models.

Empowering Individuals & Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services

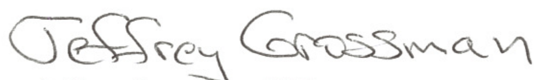
UW Health strongly supports the waiver of cost sharing for chronic care management services, as we agree that co-pays are currently a barrier to providing these services to eligible Medicare beneficiaries.

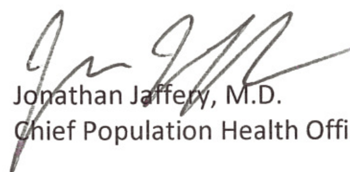
Eliminating Barriers to Care Coordination under Accountable Care Organizations

UW Health would appreciate the ability to waive cost sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease, but would like to raise the same concerns with the waiver of telehealth restrictions; such flexibility should be provided to ACOs in one-sided risk models as well, based on the difficulty some low-cost health care systems face in achieving financial savings great enough to benefit from a two-sided risk model. If the Working Group is reluctant to open the policy to a larger number of entities, alternative metrics could be used for inclusion, such as performance on certain quality metrics as tracked in the MSSP.

We appreciate your consideration of our comments. We would be pleased to answer any questions or discuss these policies further; feel free to contact Jonathan Jaffery, Chief Population Health Officer for UW Health, at jjaffery@uwhealth.org or (608) 821-4295.

Sincerely,





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