June 22, 2015 via electronic submission

The Honorable Orrin G. Hatch
Chairman **Re: Chronic Care Working Group Request for Stakeholder Input**
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

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

Re: Senate Committee on Finance Chronic Care Working Group Request for Stakeholder Input

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Almost Family, Inc. (AFAM), we appreciate the opportunity to provide input to the Senate Committee on Finance (the Committee) chronic care working group on ways to improve care for the growing population of Medicare patients with chronic conditions.

This request for stakeholder input clearly puts patients where they belong, in the spotlight. We thank you for the opportunity to be a participant in the program and to offer our ideas, our perspectives and our commitment to be a part of the solution.

In August 2013 we provided a joint task force of the Committee and the House Ways & Means Committee with our views in response to a request for Post-Acute Care (PAC) reform. In that submission we called for a shift in focus from providers to patients as the central theme to renovating the Medicare program. We were thrilled to see that the latest SFC stakeholder request does exactly that. Much of our August 2013 response remains pertinent to this stakeholder request.

On the following page we provide an executive summary of our thoughts and expand upon those in the balance of the document.

Fundamental Gaps in Medicare Impacting Care the Chronically Ill – Must be Addressed

1. *Medicare was designed primarily to be a short-term benefit – yet chronically ill patients, by definition present long-term issues that, if not managed, become acute exacerbations driving higher costs to the Program.*
2. *The absence of objective assessment and care management processes in Traditional Medicare leaves the Program with the obligation to pay claims but with minimal opportunity to manage costs other than by managing provider categories and cutting rates.*

What We Propose – Establishing a Chronic Illness Program

1. *Establish a new benefit within Traditional Medicare specifically for the management of chronically ill patients (the Chronic Illness Program).*
2. *Upon recognition of the existence of qualifying disease states and indicators by medical professionals a comprehensive assessment would be used to identify and qualify patients at-risk for high costs for inclusion in the Chronic Illness Program.*
3. *Include a Care Management benefit*
   a. *Annual assessments and care planning – more frequent when patient conditions warrant.*
   b. *Patient engagement strategies with on-line information and education programs*
   c. *Encourage patient engagement and compliance with variable cost-sharing strategies*
4. *Turn the delivery system "upside-down":*
   a. *Move to Residence-Based versus Institutional-Based approaches*
   b. *To ensure Residence-Based approaches are utilized use a combination of provider attestations and financial incentives*
5. *Make assessments, claims and other clinical information available to patients and providers using the "Blue Button" or similar technology, include pharmacy data for reconciliation and compliance*
6. *Establish community-based response teams that provide an alternative to the "ER then Admit" default*
7. *Use assessment and care plan data at CMS to a) probe claims payments for program integrity and b) inform and encourage patients care plan compliance*
8. *For patients in the Chronic Illness Program renovate the Medicare Benefit:*
   a. *In home health, SNF and hospice care using care management, assessment and disease state information*
   b. *Use non-covered services just like the Medicaid "Waiver" services where they are shown to be more effective*
   c. *Integrate in-residence tele-monitoring and other technologies under the auspices of Medicare-certified home health agencies – especially important for rural patients*
   d. *Pay different payment rates to providers with different quality and cost outcomes*
9. *Make changes to improve viability of MSSP ACO's*
10. *Coordinate dual eligible benefits to eliminate gaps and duplications*

In the balance of this document we offer more detailed suggestions for how these ten summary points could potentially be implemented.

Defining Patient Categories

As we seek to address the needs of chronically ill patients we must also address the needs of the balance of patients. In this regard we suggest that the following will prove very useful in contemplating the management of patient populations:

Table 1 – A Suggested Framework for Contemplating Patient Populations	
Category 1: **Low Utilizers**	Patients who are generally healthy low utilizers of health resources. These patients generally don't require much attention.
Category 2: **Short Term Utilizers** Shorter term, procedurally "fixable conditions, or those more discreetly identifiable to a particular sentinel incident such as a heart attack or fall.	Patients who have some type of procedurally oriented needs from time to time but who do not have chronic conditions or needs. The easiest example to understand is the otherwise reasonably healthy senior who has a joint replacement. In these categories the acute care procedures largely "fix" the patient's issue and the patient recovers and returns to a normal life.
Category 3: **Chronically Ill** Longer-term, clinically more complex, "non-fixable" conditions that must be managed more comprehensively	Patients with disease states that will NOT go away. These conditions cannot be cured and instead must be managed. In many, if not most, of these cases an acute care inpatient stay is a part of the disease state progression that could actually have been avoided with the right kind of PRE-ACUTE care. The easiest examples to understand in this category are Congestive Heart Failure, COPD and Diabetes where an acute care stay is a manifestation of a failure to otherwise manage the patient in their own home. ***The key to managing costs for these patients category is to "stay ahead" of the disease state, manage the patients in their residences and to avoid the institutional care to start with.***

In our practice at Almost Family, we see a broad variety of patients. For those in Category 2, the existing Medicare benefit, including that for home health, generally works fine. For those in Category 3, however, the benefit is not well designed, particularly that for home health. With a redefined home health benefit for patients in a Chronic Illness Program, where we are not limited by home-bound status, skill needs and the six disciplines of care we could do a far more effective job in avoiding unnecessary hospitalizations and lowering costs to the program. We believe our patient populations are fairly representative of the population as a whole. Thus, contemplation of what we see should prove useful. While arguably somewhat simplistic from a clinical science perspective, we believe this type of contemplation of the needs of the patients, rather than how to reimburse specific providers will inform superior policy formation.

We think it is unlikely that a "one-size fits all" solution will work.

Our Overall Thesis for Cost Control – Residence-Based versus Institutional-Based Solutions

Consistent with the above summary of ten points we offer the following common-sense thesis regarding all patients and how we could achieve these objectives:

> ***<u>For patients, health care begins, and ends, at home.</u> We must recognize, and build our health care systems around the reality that patients start their health care journey at home, their principle place of residence wherever that may be. Whenever possible, we should seek to manage patients' care at home and whenever that's not possible, our goal must be to return patients to their homes at the earliest, safest, most economical point in their journey. Once returned to their homes, we should seek to keep them there and out of high-cost institutions.***

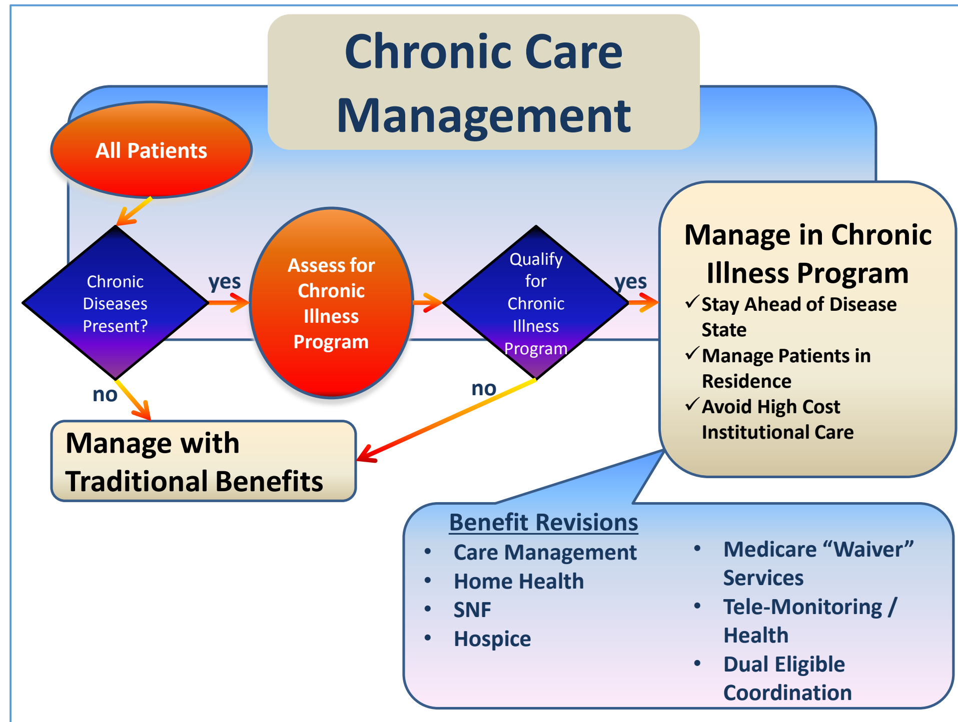
We believe a "patient-centric" perspective can reshape thoughts about the management of patient populations, further influencing movement to lower-cost Residence-Based rather than higher-cost Institutional-Based solutions. Because high resource utilization usually involves inpatient stays we believe the following perspective is useful:

Table 2 – A Suggested Framework for Contemplating Inpatient Hospital Stays and Categories of Patient Populations	
Category 2 Short Term Utilizers:	The initial admission: For this category of patients the in-patient stay is either a very positive step in "fixing" or curing a patient's condition or is a truly non-avoidable very appropriate intervention following a sentinel event such as a heart attack or fall. These admissions are generally a good use of health care resource dollars.
	Readmissions (30 day readmits): Avoiding readmissions for this group generally relies on the quality and success of the inpatient procedures along with a reasonable but not lengthy post-discharge rehabilitation period (in most disease states).
Category 3 Chronically Ill:	In this category of patients, given the chronic, non-curable conditions and the "frequent-flyer" nature of this population, in our view it is not useful or informative to good policy to try to separate admissions from readmissions. The key is to focus on reducing hospital admissions of all types, not just readmissions. These patients have acute care inpatient stays when attempts to manage the patients in their own homes have failed to contain the manifestations of the disease state.
	Hospitals, and all Facility-Based provider types, by their very nature can only really affect improvements in patient conditions while the patient is resident in their facilities. The key to managing this patient population is through routine interventions WHILE THE PATIENT LIVES IN THEIR OWN HOME.
	This can only really be accomplished through a coordinated effort lead by the patients' primary care physicians and physician extenders including nurse practitioners, physician assistants and home health agencies acting in concert as patient advocates.

The bold italicized sentences in the last two sections of Table 2 above are perhaps the most important sentences in the entire discussion of patient management at a lower cost.

For Chronically Ill Patients – Primary Care and Care Management are Critical to Cost and Quality

We offer the following framework that truly focuses on the needs of chronically ill patients.



Our view is to manage the patient rather the provider type with the following package of services:

1. **Primary Care.** The Primary Care Physician (or PCP) rather than the payer must ultimately be the central control point for utilization management and must be adequately trained, informed, empowered, protected, compensated and incentivized to act as such. To ensure efficient performance of this work, policies should encourage the use of physician extenders including Physicians Assistants (PA's), Nurse Practitioners (NP's), nurses, therapists, and other allied health professionals whether in the PCP's office or clinic practice, in the patient's home or in both, all under the supervision and control of the PCP.
2. **Care Management.** Case or Care management, using evidence-based clinical standards, must be integrated into the traditional Medicare program as an essential part of utilization management. <u>This is a feature largely lacking in the current system, and we make specific proposals for implementation into the traditional program in a separate section labeled "Chronic Care Management – A Model for Consideration" below.</u>
3. **Home First and Always.** Recognize that the home is both the start and the end of the health care journey for patients. At every step, treating clinicians must ask and answer: ***"How do I get this patient home as soon as safely possible?"***
4. **Low Cost Before High Cost.** Low cost alternatives should be evaluated and eliminated, or tried and exhausted, <u>FIRST</u> before patients can be admitted to higher cost service settings. At every step,

treating clinicians must ask and answer: ***"How do I safely care for this patient at the lowest cost possible?"***

5. **Attestations and Incentives.** Two primary tools are available to the Program: 1) mandating certain provider actions including clinician attestations as to medical necessity and appropriateness and 2) establishing financial incentives that encourage desired behaviors. These can and should be embraced in concert to direct patients into the best and most appropriate care settings. Success depends on an appropriate blend of these tools; neither can be relied upon exclusively. Examples include:
   a. **Provider Actions and Attestations:**
      i. Establishing requirements and payments for PCP's and others for providing care management services.
      ii. Requiring all inpatient facilities to timely inform PCP's regarding admission and discharge processes thus enabling PCP participation in clinical decision making. ***Amazingly, this does not happen with consistency in practice today presenting one of the more significant obstacles to care transitions. Many of our referring PCP's commonly state that a primary problem in managing patient admissions, post-acute care and readmissions is that they often don't even know it is occurring until after the fact.***
      iii. Requiring clinical certification as a part of all admission attestations that in the ordering clinician's judgment the patient cannot be cared for in a lower cost setting.
      iv. Requiring the use of clinical "indicators" developed from empirical claims and assessment data to assist or guide ordering clinicians towards lower cost care settings.
   b. **Financial Incentives:**
      i. Maintaining no or low patient-responsible portions (cost sharing) in lower cost settings with directionally higher patient-responsible portions in higher cost settings.
      ii. Making bonus payments to PCP's for better risk adjusted outcomes relative to service utilization.
      iii. Enabling PCP's to share in the cost savings for their patient populations through ACO or ACO-like mechanisms.
      iv. Establishing higher payment rates or bonus payments to non-PCP providers with demonstrably higher success rates. (For example, HHA's or SNF's with lower risk-adjusted hospitalization rates should receive more payments than HHA's or SNF's with higher risk-adjusted hospitalization rates).
6. **Use Non-Covered Services.** Formal establishment of a Medicare "Waiver" program in which CMS approves the provision of otherwise non-covered services to patients with high case-management risk scores and specific chronic disease states where those services can be shown to reduce the overall costs of care and increase patients' ability to remain in their homes. This would help avoid the current reality in which physicians and providers MUST choose from list of Medicare covered services those which are the closest fit, even though much lower cost non-covered services could do.

7. **Renovate Home Health Benefit.** Renovate the Medicare home health benefit currently at section 1861m of the SSA to include:
    a. Bifurcation of the benefit based on patient types, disease states and assessed risk scores. Patients' with selected chronic disease states and risk scores would be eligible to receive a bundle of home health services paid on daily rate that varies with acuity. This would work like the hospice benefit, but better because payment rates would be based on disease states and the assessed risk scores. This could approach could also be applied to the hospice benefit
    b. Modify regulations to provide more flexibility regarding home-bound status and skill requirements again based on disease states and risk scores.
8. **Renovate Skilled Nursing Benefit.** Renovate the SNF benefit, in like fashion to home health removing arbitrary barriers such as the 3-day rule in cases where disease states and care management assessments, plus provider attestations indicate temporary exacerbations can be more efficiently managed through initial admission into the SNF setting rather than the current requirement to first route the patient through a high-cost acute care stay.
9. **Coordinate Dual-Eligible Benefits.** Coordinate Medicaid Benefits for Dually Eligible patients by transfer of Medicaid funds into the Medicare benefit for chronically ill patients much like the SLMB and QMB programs currently function. Require dually-eligible patients (and Medicaid programs) to use the same Chronic Care Management firm (see below) that the patient selects for Medicare-covered services. Medicaid programs would be required to make all claims data available to the Medicare program to facilitate coordination. If necessary, this could be accomplished via the "Blue Button" infrastructure.

Chronic Care Management – A Model for Consideration…

Establishing an integrated Chronic Care Management model within the Medicare benefit could be invaluable in the management of the chronically ill. Below are several of our ideas on how it could work. We also integrated the concept of a community-based response infrastructure that could provide a real and effective diversion of patient flow from the "Admit from ER" default that drives substantial cost to the Program:

a. A patient with qualifying chronic illness diagnoses would choose a care management provider following consultation with their PCP. The care management process would start with an annual PCP or NP-performed comprehensive health assessment fully informed by historical claims data. To avoid a seasonal crush, enrollment and annual cycles for these traditional enrollees would be tied to their birth dates.
b. The assessment would produce a risk score which, as it increases, would drive increased frequency reassessments (semi-annual, quarterly and monthly). Results of the assessment would be provided to treating providers to better inform their clinical decisions.
c. CMS would use the risk-assessment scores for program integrity safe-guard purposes where high utilization and low risk scores would trigger probe edits to provider payments and low utilization and high risk scores would trigger patient notifications that they should consult with their PCP more frequently.
d. The "Blue Button" technology and infrastructure would be incorporated and patients would be required to specifically authorize access to PCP's and PCP's would be required to review such information.
e. Care Management firms would provide patient education materials and reference sites for disease state management. Patients who complete disease-state management educational courses on-line or in person at their Care Management firm site, would be eligible for selected additional benefits and/or co-pay and deductible reductions. Patients who demonstrate high compliance rates would also be eligible for such additional benefits or co-pay reductions.
f. Care Management firms would be required to operate a network of community-based response resources that provide an alternative to the over-used "go to the ER" default treatment option. This would include communication protocols with primary care physicians and a team of rapid response nurse practitioners and home health nurses who would have access to assessment, care plan and claims records. When the patient does require a trip to the ER, one of these professionals, armed with the records would accompany the patient to the ER dramatically improving the ability of the ER physician to rapidly assess the situation and provide alternatives to the overused "admit through the ER" default treatment option.
g. Care Management firms would be paid a "per member per month" premium that would be a subset of the Medicare Advantage premium. Care Management firms would participate in a share of savings against a benchmark similar to ACO's but at a much lesser rate due to the premium funding. This would permit the Program, rather than Medicare Advantage plans to be the first and primary beneficiary of cost savings generated in the traditional Medicare program.
h. Careful consideration would need to be given to management of conflicting interests and biases such as MA plans potentially participating to convert patients to their plans.

Some Other Thoughts…

ACO's Show Great Promise – Success Depends on Integrating Recommendations

While Accountable Care Organizations (ACOs) are still in very early stages of development, we would like to express our current very positive thoughts with regard to the potential for their development long-term success. We believe that integrating our principle-based conceptual framework and the specific recommendations above into the existing ACO framework would be of great value for the Program and for beneficiaries. Additionally, we have made a number of specific recommendations for improving the viability of the Medicare Shared Savings ACO model under separate cover to CMS. <u>Primary among these is the need to provide a base level of funding to make it financially feasible to do the work necessary to generate real savings.</u> While we are actively pursuing the generation of savings in our eleven "Track 1" managed ACO's we have identified the lack of funding as the single largest impediment, followed closely by the need for information access parity with Medicare Advantage plans. Further, we recognize the convergence of the activities of properly funded ACO's with our vision of how Chronic Care Management could work. Competing models could be set up and analyzed to see which produces the better overall result.

Possible Extension of Assessment Process to All Patient Populations

Although it is outside the scope of the stakeholder request letter, consideration could be given to adding a broader assessment aspect to the overall Medicare Program. We believe thoughtful and appropriate management of patient populations should be built on a cornerstone of a high-quality objective assessment of patient needs. This could be accomplished by adding a primary-care based annual and interim comprehensive patient assessment for all Medicare patients. Building on the foundations of the relatively new "Annual Wellness Visit" and the "Health Risk Assessments" often sponsored by Medicare Advantage plans, fulsome datasets could be assembled on an annual basis for ALL Medicare beneficiaries independent of their Traditional or Advantage enrollment choices. In addition to providing meaningful program integrity advantages in both programs, the assessment data sets could be made available to physicians and other providers to more efficiently and fully inform care planning and management efforts. The results of the assessments combined with disease-state information could better inform risk assessments, pricing adjustments, claims processing and participation in specialty programs such as our proposed Chronic Illness Program.

The Assessment process would be informed by access to the Medicare claims data sets currently provided including, in particular, Part D Prescription Drug data and present a significant opportunity to improve medication reconciliation and compliance, a key factor in many hospitalizations. This Assessment Benefit could operate on a stand-alone basis with information passed on to other providers or it could operate in a more integrated fashion with a Chronic Care Management Benefit as we described in more detail above. In either event it could provide the cornerstone or baseline dataset on which clinical decisions could be based and against which improvements and declines could be measured.

Questions and Answers

We believe we have addressed the most important concepts throughout our text above. However we have a few additional thoughts and cross-references in response to the specific categories of questions in your stakeholder letter:

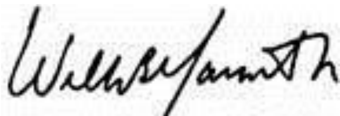
Category	Responsive Comments
1. Improvements to Medicare Advantage	Consideration should be given establishing a separate Assessment Benefit for all Medicare enrollees regardless of enrollment choice. This would provide important program integrity benefits and levelize the playing field between MA plans, MSSP ACO's and the Traditional enrollees.
2. Transformative Policies such as ACO or Alternative Payment Models (APM)	We also propose the establishment of a Chronic Illness Program for patients with selected disease states and risk assessments. Proper qualification and assessment for participation can provide appropriate program controls to facilitate benefit design changes
3. Reforms to current FFS Program	In conjunction with the above we propose significant specific renovations to current FFS benefit designs in the areas of home health, SNF, hospice and ACO programs. Additionally, we propose coordination of dual eligible benefits through the assessment and care management benefits and fund transfers from Medicaid to Medicare.
4. Prescription drugs	We propose inclusion of medication reconciliation through the assessment and care management processes and by making claims data accessible to authorized providers.
5. Telehealth	We propose inclusion of in-residence telehealth benefits under the auspices of the home health benefit.
6. Rural Areas	The inclusion of in-resident telehealth and telemedicine benefits seems especially important for rural and frontier residents
7. Patient Engagement	We propose encouraging patient engagement and participation through the provision of additional benefits and/or lower cost-sharing for completion of accredited on-line or in-person disease-state education program and for compliance with the Chronic Illness Program.
8. Primary Care Providers	As we stated above the Primary Care Physician is still the key to appropriate patient care. We believe our proposed benefit and ACO changes would significantly strengthen the ability of Primary Care to achieve its objectives.

Closing

As we said in our preface, we at Almost Family feel we have a responsibility as citizens both corporately and individually, and as advocates for the needs of America's seniors, to work together with the public sector to evolve good policy that protects and strengthens the promise of Medicare for our patients.

In the pages that follow we provide *Exhibit I -- Highlights about Almost Family that inform our perspectives and establish the context for our comments and Exhibit II -- Pillars of Good Program Benefit and Payment Designs – A Principles Based Approach.*

We thank you for the opportunity to be heard and to be included as part of the solution. We look forward to working with you in more detail in the evolution of these ideas.



William B. Yarmuth
Chief Executive Officer

C. Steven Guenthner
President

Exhibit I -- Highlights about Almost Family that inform our perspectives and establish the context for our comments...

Our Core Business. Since our August 2013 stakeholder letter to the SFC & WM we have continued our growth trajectory and our enterprise-wide mission of Senior Advocacy which has led-us to our position as the nation's fourth largest provider of Medicare home health services and one of the nation's leaders in the provision of home and community based services primarily to the elderly and disabled enrolled in Medicaid programs. Our 12,000 employees service over 100,000 patients a year and interact with tens of thousands of physicians, hospitals, SNFS and other provider types coordinating efforts to maintain patients in their homes.

Innovation in our Business. Our perspectives continue to evolve as we learn more. Since August 2013 we have invested significantly in becoming one of the nation's leading ACO enablement companies with 11 ACO's and 85,000 Medicare lives under contract with an aggregate annual benchmark of nearly $1 billion. This puts us in direct daily interaction with over 80 physician practices and 1,000 thought-leading individual practitioners all seeking ways to drive spending down and quality up. We have formed a "Healthcare Innovations" segment within our business. We are co-invested with Obama administration former Chief Technology Officer Aneesh Chopra and Microstrategies co-founder Sanju Bansal in an enterprise that seeks to bring technology solutions to health care to improve patient engagement and more informed clinical decision making thus lowering costs and improving quality. We continue to seek more such opportunities.

Our Mission. We believe passionately in our mission to be advocates for our patients, primarily seniors, nearly all of whom are Medicare-covered and many of whom are dually-eligible for Medicaid services. These patients, whether of the Greatest Generation or Baby-Boomers, all strongly desire to age-in-place, in their own homes, and wish truly to burden no one with excessive costs. Our simple yet incredibly powerful mission, embodied in our "Senior Advocacy" mission statement, guides all our actions. We seek to create value for all four of our key stakeholder groups, our patients, our employees, our payers and our capital sources, in that order, by providing real solutions to the healthcare needs of our nation's seniors.

Our Obligation. We believe just as passionately that we have an obligation as Americans to help our government fulfill its statutory commitment to provide healthcare to all seniors in the most efficient manner possible thus preserving the Medicare Trust Funds and the promise of Medicare for future generations. Our Obligation extends to the promise of Title 19 Medicaid programs which are incredibly important to the topic of caring for the chronically ill. According to the CDC, 65% of the dually eligible have two or more chronic conditions and 35% have four or more. Addressing the current inconsistencies, overlaps and gaps in these programs is critical to a well-designed and efficient chronic care management solution.

Program Integrity and Trust. Program integrity controls that ensure only appropriate services are provided are absolutely key to establishing the Trust that is necessary between providers and payers. Almost Family has for years now been proactively pressing for program integrity reforms to achieve that trust and minimize abuse drains of public funds by bad actors. We are on-record with SFC and W&M, CMS, MedPac and others publicly with specific proposals to help eliminate fraud and waste. We feel

obligated to point out that our proposed program integrity controls, which we have been actively pressing since 2011, highlight the exact areas of focus in the recently announced large enforcement actions. While our proposals may not be perfect we believe they would have prevented at least some of the financial harm to the Program.

Commonality of Interests. As a tax-paying entity, we are effectively your joint-venture partner in all we do. We return roughly 40% of any earnings we generate back to the public treasuries from which our revenue sources are largely derived. Our capital sources return similar portions of their earnings to the treasuries. We have long been puzzled by what appears to be a significant bias of policy makers toward the influences of non-tax paying organizations. We respectfully suggest that embracing the fact that we are a capitalist society and designing payment programs to generate desired outcomes rather than "align payments with costs" will actually help us solve our problems faster. Like all providers, public or private, tax-paying or not, we must generate reasonable returns to our capital sources that provide the financial capital necessary to pursue this Mission and fulfill this Obligation. In order for us to achieve that we must be able to generate reasonable operating margins – a concept that is absent from current rate setting formulas. We believe this absence hinders rather than helps the Program's ability to achieve its own goals and objectives. Improving upon this will improve results for the Program.

Public Transparency. We are public in virtually every way. We serve the public in their communities and homes across the nation, providing services funded by the public treasuries. As a publicly-traded entity we are owned by the public with our shares traded and valued on a daily basis by the investing public. Much of our ownership is in the invested savings, retirement and pension funds of everyday Americans. When we succeed financially, the largest single beneficiary is the public treasury where we return 40% of any earnings. The balance inures to the benefit of our public shareholders. As a publicly-traded company we are bound by law to provide the highest level of transparency through the filing of our detailed financial results with the SEC and these are made available for all to see. We suggest that this model is actually more beneficial than any other to the public interests.

Unique Perspective. Home health clinicians and para-professionals do their work in the homes of hundreds of thousands of patients a year providing us with a perspective no other industry can match both in interaction with primary care physicians but also with the many home and community based support systems upon which the chronically-ill so necessarily rely.

Exhibit II -- Pillars of Good Program Benefit and Payment Designs – A Principles Based Approach…

- ***Principle #1: Focus on The Bigger Picture.*** We must always maintain focus on managing the entire Medicare spend, rather than just fixing silo issues. Initiatives to address the "issue of the day", whether it is the SGR fix, PAC reform, or in this case caring for chronically ill patients can, if not managed carefully, actually replicate the very problems they seek to alleviate. Accordingly, in our comments below we address improvements in managing the entire Medicare patient population rather than just the chronically ill.
- ***Principle #2: Patients Matter More than Providers.*** The focus of the Program must be on managing the health care needs of patient populations rather than on managing categories of providers. Accordingly, payment programs should be contemplated in terms of the types of patients we seek to serve and the results we seek to achieve. Additionally, all the benefits available to patients must be coordinated to prevent gaps and overlaps which may result in underserving and/or overspending. We must address coordination of Medicare and Medicaid coverages.
- ***Principle #3: The Need For Trust.*** We must address program integrity and what we view as the insidious impact of a fundamental lack of trust between the Program and providers. We often hear this articulated as "Providers all game the system." As your staff can attest, we seek to play a leadership role in working with the Program to implement program integrity solutions to build a foundation of trust between the Program and providers. Appropriate safeguards, guardrails, and systems of checks and balances must be in place to protect patients and the treasuries from abuse. Then care venues can be selected in the best interests of patients and the Program worry-free from "gaming" or abusive practices.
- ***Principle #4: Payment Design Matters.*** Historically, payment models have sought to "align payments with providers' costs" which presumes provider costs have historically been appropriate. We must shift this to a new definition in which "payments align with value received by the program". Value received by the Program is better evaluated in terms of money saved by the program than in terms of money spent by providers. We must be far more interested in driving better outcomes at lower costs over time, more interested in the value we receive for the payments we make, than we are in framing payment accuracy in terms of alignment with costs. By their very nature the historical approach, and the term "reimbursement", hamper progress and reform, by encouraging providers to continue historical practices. Payment systems must provide incentives to produce the best outcomes and allow providers to earn reasonable returns to reward the capital put at risk to produce those outcomes. At the same time payment models must be founded in economic realities of margins and returns. Earnings optimization models that result from policy designs need to be consistent with and not contrary to these goals – determine what we want payers and providers to do and pay them to do that thing, more when they do it well, and less when not as well.
- ***Principle #5: Historical Biases Impede Progress.*** Historical biases that certain provider-types are inherently good or bad, or that tax-paying status defines inherent good or bad must be broken

down and reset through balance and diversity in perspective and representation. Playing fields must be levelized between different parties attempting to achieve the same goals. For examples ACO, must have access to exactly the same information as Medicare Advantage plans, and must receive some amount of up-front payments to fund the work they must do to generate savings.

- ***Principle #6: Traditional Medicare Must Be Maintained.*** Maintaining the viability of Traditional Medicare is important, turning the program over to the insurance companies does not solve the problem. Instead it defers and replaces old problems with new problems. Traditional Medicare must be wrapped in a care-management model that ensures that patients' needs are properly assessed, care plans are appropriately established, and actual care is delivered by and through the oversight of primary care physicians and their extenders including specifically nurse practitioners and home health professionals.
- ***Principle #7: Health care must begin and end at home.*** Perhaps the most important point of all, each individual's physical existence is centered in their primary place of residence – their home. Patients nearly always choose to remain at home whenever possible and there can be no debate that patients in their own homes consume health care resources at a lower rate than those in inpatient settings.