November 20, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Request for Information: Innovation Center New Direction

Dear Administrator Verma:

As the Innovation Center seeks to change direction to further foster an affordable patient-centered health care system, COPE Health Solutions and Montefiore Health System look to the Centers for Medicare and Medicaid Services (CMS) to continue to build on innovative approaches to improve the quality and cost effectiveness of health care. We appreciate the opportunity to respond to CMS' request for information on how to support innovative approaches. We offer suggestions below that we believe will help patients better manage their health, help physicians treat patients as whole persons and help reduce wasteful spending by decreasing regulatory burdens and streamlining existing programs. We believe the result of these initiatives would improve quality and lower health care spending in the United States.

Across the country, providers and health care companies are collaborating to improve how care is delivered, driving toward a more efficient system that provides patient-centered care at a higher quality and lower cost. We are one such collaboration. We represent a wide variety of health care providers and organizations—including premier academic medical centers, multispecialty physician groups, and multi-state integrated health systems—operating in urban and rural areas throughout the nation.

Together, we are creating networks of aligned hospitals, independent and employed physicians, other health care providers and community-based organizations, which have the capacity to assume financial accountability for improved coordination, quality and efficiency of patient care. These networks help patients take responsibility for their health by improving coordination and access to care, resulting in healthier people and more judicious spending.

Vision

We envision a health care system in which more health care dollars are directed toward patient care rather than administrative overhead and in which regulation does not perpetuate artificial silos that impede a patients-first model of care.

In this spirit, we propose a new model of accountability that aligns clinical, quality, financial and administrative requirements across federal and state programs, so that more health care dollars can be directed toward patients. Under this model, which we call Patients First, beneficiaries would have a single accountable care team responsible for coordinating all of their health care services, instead of receiving services and care management across a range of programs as they do today. If successful, the demonstration would serve as a model for the nation on how to incentivize providers and payors to manage patients holistically.

This model is responsive to several of the Innovation Center's new focus areas including: Increased participation in Advanced Alternative Payment Models (AAPMs); Medicare Advantage (MA) Innovation Models; State-Based and Local Innovation, including Medicaid-focused Models; and Program Integrity.

Current Challenges

Under the current environment, provider-based care coordination models such as Accountable Care Organizations (ACOs) are hampered in truly providing patient-centered care to drive quality and efficiency due to regulatory hurdles and the shortcomings of existing value-based payment opportunities.

- ***Current value-based models do not address fragmentation for patients who receive both Medicare and Medicaid (dual eligibles), limiting the potential for quality and value improvement.*** Dual eligibles face unique challenges in receiving quality care due to bifurcated benefit design and financing between the two government programs. The differences can exacerbate fragmentation and contribute to gaps in care by creating misaligned financial incentives among provider organizations, with each organization paid by a different payor for the same patient. Currently, many ACOs are responsible for dual eligibles' Medicare-covered services, but the patient's Medicaid-covered services fall outside the ACO's purview. This fragmentation creates challenges for physicians, hospitals and other providers that seek to deliver high-quality, coordinated care that treats each patient as a whole person.

  This fragmentation is especially concerning and counterproductive because the dual eligibles present the largest opportunity for care improvements and increased efficiency. Dual eligibles are 18 percent of the Medicare fee-for-service (FFS) population, but account for 32 percent of Medicare FFS spending. On average, total health care spending on

duals—including both Medicare and Medicaid—is more than twice the amount for other Medicare beneficiaries.[1]

- ***The promise of current Medicare ACO opportunities is limited in regions with high Medicare Advantage (MA) penetration, as Medicare ACO opportunities thus far have been limited to the fee-for-service population.*** While MA penetration is 33 percent on a national level, there is significant variation on the state- and county-levels.[2] While in New York City, 39 percent of all Medicare beneficiaries are enrolled in MA, 57 percent of Medicare beneficiaries in the Bronx are enrolled in MA.[3] Thus, Medicare ACO models for FFS beneficiaries are limited in their ability to address opportunities for cost-effective care delivery for all Medicare beneficiaries.

- ***Many patients participate in multiple care management programs, which weaken the effectiveness of the programs and increase operational expense.*** For example, a patient may be attributed to a Medicare ACO, enrolled in Medicaid managed long-term care and enrolled in a Medicaid Health Home. In this care, the patient may have three care managers and three different care plans. Duplicative care managers can weaken the effectiveness of the relationship with the patient and create administrative waste as each program as its own regulatory and administrative requirements.

- ***Demonstration projects often have opaque methodologies that are subject to change midstream.*** Under past Innovation Center models, methodologies were often difficult for providers to understand and model. As a result, it was difficult to gauge performance and understand if the provider was being successful. This issue was exacerbated when models were changed during the performance period.

- ***Statutory hurdles often prohibit services from being provided in the most appropriate setting.*** One example is a statutory provision called the Medicaid Institution for Mental Disease (IMD) exclusion that prohibits federal Medicaid reimbursement for IMD patients aged 21 to 65. This exclusion applies to both inpatient care and other benefits provided to IMD patients both inside and outside the IMD. Because Medicaid will not pay for the provision of these services, this creates a disincentive for physical health providers to provide care in IMDs and to accept IMD patient referrals.

- ***As a result of these challenges, the gains of accountable care models are limited and health care dollars are unnecessarily spent on administrative requirements rather than patient services.***

---

[1] Medicare Payment Advisory Commission, *A Data Book: Health care spending and the Medicare program,* June 2017

[2] *Ibid.*

[3] Greater New York Hospital Association, *Medicare Managed Care Enrollment –By County and Plan September 2017-September 2017,* October 2017.

Recommendations

As the Innovation Center considers its new direction, we recommend CMS takes the following steps to unlock the potential of provider-based care management models:

- ***Test a new "Patients First" model that allows select ACOs with deep experience in risk-transfer arrangements to become accountable for a regional population of Medicaid, Medicare and dual eligible beneficiaries.*** This model would test improvements in patient health status and savings generated through combining numerous Medicare and Medicaid programs into a single, seamless program with a single regulatory standard. Beneficiaries, who today receive services and care management across a range of programs, would now have a single accountable care team responsible for coordinating all of their health care services, available to those with demonstrated needs. The accountable care team, situated within a single integrated delivery system, would collaborate closely with payors and providers to generate a unified care plan, reflecting all health care needs and relevant social supports. This model would foster patient engagement by building strong relationships between patients and their care teams, to help patients make informed choices and actively promote their own health.

- ***Expand existing ACO models to include dual eligibles' Medicaid benefit.*** We recommend that CMS partner with ACOs to refine existing models in order to allow qualified ACOs to voluntarily assume additional risk for dual eligibles' Medicaid benefit. CMS should use its authority to support these refinements as appropriate, including but not limited to 1115 waivers or state plan amendments, to incorporate Medicaid financing for ACO models.

- ***Leverage local innovation and increase opportunities for participation in AAPMs by allowing Medicare to participate in state-based initiatives.*** CMS should build partnerships with state governments to give states the flexibility to test new approaches with specific patient populations or regions. For example, New York State designed and is implementing the Value Based Purchasing (VBP) Innovator Program to improve quality and reduce costs for Medicaid managed care patients. This unique risk-sharing arrangement allows experienced provider organizations to take on additional financial accountability for their patients as they assume delegated functions from the insurance plan, including care management and utilization review. The state developed the program in partnership with provider organizations and Medicaid managed care plans.

  CMS has the opportunity to expand the impact of state-driven approaches such as the VBP Innovator Program, by incorporating Medicare financing and by providing states with additional regulatory flexibility to promote innovation. CMS support for state-based initiatives would help physicians, hospitals and other providers use similar contracts across all lines of business, to increase operational efficiency, reduce waste and allow more funding to be used for patient care.

- ***Provide incentives for MA plans and other payors to participate in risk-based arrangements with ACOs.*** By increasing the number of patients in a region in similar risk-based arrangement, fewer dollars need to be spent on building distinct and redundant administrative models. As in the previous recommendation, this will allow more funding to be used for patient care and will generate additional savings for government programs. CMS should allow and encourage voluntary participation from multiple payors in newly designed approaches, including MA plans, commercial payors and self-insured employer groups**.** This regulatory flexibility would foster innovation among private payors and provider organizations, to improve quality and reduce overall costs of care.

- ***Give flexibility to ACOs to provide care in the most appropriate setting.*** While CMS currently provides flexibility provided to ACOs through waivers such as the telehealth originating site expansion, the waiver of the skilled nursing facility three-day stay waiver and post-discharge home visits, this flexibility should be expanded to include waiver of the IMD exclusion and further use of telehealth.

- ***Use models that are easily understandable and offer stability.*** Providers need to understand their performance in order to improve upon it. The Innovation Center should test new models with transparent and easily replicable methodologies, which are stable over the course of the project or have predictable changes.

Thank you for your consideration of our perspectives on the CMS Request for Information: Innovation Center New Direction. We welcome the opportunity to work with CMS to build on the innovative approaches outlined in this brief.

For questions or more information, please contact:

Allen Miller
Chief Executive Officer
COPE Health Solutions
213-542-2234
amiller@copehealthsolutions.com

Lynn Richmond, NP, MS
Executive Vice President & Chief Strategy Officer
Montefiore Medicine
718-920-6474
lrichmon@montefiore.org

Bill Wing
President
Adventist Health

Richard J. Gilfillan, MD
Chief Executive Office
Trinity Health, Livonia Michigan

Susan L Turney, MD, MS, FACP, FACMPE
Chief Executive Officer
Marshfield Clinic Health System