



Working Together for an Affordable Future

June 22, 2015

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

The National Coalition on Health Care (NCHC) is a coalition of health care stakeholder organizations committed to promoting an affordable, high-quality health system in the United States. As the nation's oldest and most diverse group working to achieve comprehensive health reform, we represent more than 100 member organizations, including health care providers, purchasers, payers, and consumers. Collectively, our organizations represent, as employees, members, or congregants, more than 100 million Americans.

On behalf of NCHC's member organizations, I offer thanks for your pursuit of bipartisan chronic care legislation this year. As you have noted, chronic care accounts for the vast majority of health care costs in Medicare and the greater health care system. And with the cost burden on families and businesses increasing every year, waiting another two years to address the problem is unacceptable. Congress should act now to ensure that Medicare policy is aligned with and builds upon what is already working in the private sector, the states and successful federal initiatives.

Enclosed you will find a set of detailed policy recommendations, responsive to the specific issues raised in your letter of May 22, 2015. As the Finance Committee tackles the urgent national challenge of chronic care, NCHC and its member organizations look forward to doing all we can to support the effort. If NCHC can be of any assistance, please do not hesitate to contact

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myself at jrother@nchc.org or NCHC's Policy Director, Larry McNeely at lmcneely@nchc.org or 202-638-7151.

Sincerely,



John Rother
President and CEO

Improvements to Medicare Advantage (MA) for patients living with multiple chronic conditions

The MA program has the potential to advance transformative reforms to chronic care - reforms that may ultimately improve care and lower costs in traditional Medicare and systemwide. But this potential can only be realized in a policy environment that supports innovative, high-value chronic care.

Creating such an environment begins with a risk adjustment system that accurately accounts for the cost of treating chronically ill enrollees. *The Seniors' Health Care Plan Protection Act of 2015* (H.R. 2582), recently passed in the House of Representatives, would take a step in this direction by requiring the Centers for Medicare and Medicaid Services (CMS) to account for multiple chronic diseases and to evaluate other improvements to its risk adjustment policy. [NCHC supports HR 2582, The Seniors' Health Care Plan Protection Act.](#)

But additional risk adjustment improvements may be required. MA risk adjustment fails to fully account for the impact of fully dually eligible status on plan costs.¹ As a consequence, plans which enroll and assume responsibility for the care of the most vulnerable beneficiaries are punished financially. To correct this, [Congress should instruct CMS to adjust MA risk adjustment to reflect the costs associated with full dually eligible beneficiaries.](#) We note that more accurate risk adjustment in MA will also benefit enrollees in other programs which rely on MA risk adjustment such as the Program for All-inclusive Care for the Elderly (PACE) and Medicare-Medicaid Plans (MMPs) under the Financial Alignment Demonstration.

In addition to better risk adjustment, MA plans ought to have the opportunity to pursue exciting innovations in delivery and payment. Strategies such as specialized benefit packages for chronically ill enrollees,² delivery of care via telehealth technology,³ and integration of targeted home and community-based services with medical care have already proven their value, but Medicare rules now limit their use. When an entity such as an ACO or an MA plan has taken clinical and financial accountability for the cost and quality of care for a set of patients, regulations designed to limit utilization in a volume-centric, fee-for-service payment environment become unnecessary and should be waived. Specifically, Congress should

- [Permit all MA plans to propose benefit and cost-sharing improvements, an option currently only available in Chronic-Special Needs Plans \(C-SNPs\).](#) for enrollees with specified chronic conditions. For beneficiaries with chronic conditions like diabetes, this would enable plans to waive or eliminate copays on certain medications, provide additional transportation to individuals with

¹ Miller, M. "Testimony before the Senate Finance Committee: Improving Care for Beneficiaries with Chronic Conditions." May 14, 2015. Retrieved from <http://medpac.gov/documents/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-%28senate-finance%29.pdf?sfvrsn=0>

² Cohen, R., Lemieux, J., Schoenborn, J., and Mulligan, T. "Medicare Advantage Special Needs Plan Boosted Primary Care Reduced Hospital Use Among Diabetes Patients." *Health Affairs*. January 2012. Retrieved from <http://content.healthaffairs.org/content/31/1/110.full>

³ McCall, N., Cromwell, J., Smith, K., and Urato, C. *Evaluation of Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration: The Health Buddy Consortium (HBC)- Revised Final Report*. RTI International, April 2011. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/McCall_Eval_of_CMHCB_Demo_April_2011.pdf

more frequent medical appointments, or waive the copay for certain specialist visits based on an individual's health needs;

- Enable MA plans to furnish covered services via telehealth and other remote access technologies, regardless of point of origin or setting of care, without the need for a supplemental benefit;⁴ and
- Build on the success of Institutional Special Needs Plans (I-SNPs): I-SNP's generally superior quality performance⁵ makes them a suitable platform for further innovation in benefits and care delivery. Congress should give I-SNPs the opportunity to furnish home and community based services to Medicare-only enrollees who are eligible for a nursing-home level of care, and provide a frailty factor payment (like that provided to PACE and FIDE-SNPs) to support those services. By allowing plans to furnish a home aide visit or safety equipment currently prohibited under Medicare rules, lawmakers would help more beneficiaries remain independent in their own home and delay or avoid the enormous costs to taxpayers associated with institutionalization.

NCHC also supports S. 1396 *the VBID Senior Copay Reduction Act*, which will establish a demonstration project testing whether reducing cost-sharing for high-value medical services, medications or high-value providers can improve quality and reduce costs. Similar legislation recently passed the House as part of H.R. 2570, *the Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015*.

Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures;

NCHC believes that the adoption of APMs could prove vital to the long-term affordability of Medicare and our health system as a whole. But it is important to realize that the most transformative step to promote APMs has already been enacted: granting the Center for Medicare and Medicaid Innovation (CMMI) the flexibility to test new approaches in traditional Medicare and scale up those approaches that achieve success. First and foremost, Congress must not undermine CMMI's funding and authority.

But Congress can do more to further accelerate the pace of change at CMS, by providing additional tools to participants in Medicare Shared Savings Program (MSSP) ACOs and CMMI initiatives like the Bundled Payment for Care Improvement Initiative (BPCI).

First, Congress should provide relief from restrictions intended to prevent unnecessary treatment. When an entity such as an ACO or an MA plan has taken clinical and financial accountability for the cost and

⁴ We note that tests of telephonic or remote disease management programs have often found them inferior to face-to-face assessment and care delivery for chronically ill patients, particularly high need patients. But the Health Buddies program, one of two highly successful sites under Medicare's Care Coordination for High-Cost Beneficiaries Demonstration, showed that telehealth and remote monitoring technology, deployed consistent with evidence-based practice, can effectively complement or improve face-to-face interactions for high-cost Medicare enrollees. MA Plans, ACOs or other entities which are clinically and financially accountable for patient care outcomes should have the flexibility to utilize telehealth technologies.

⁵ MedPAC. *Report to Congress on Medicare Payment Policy*. March 2013. Retrieved from <http://medpac.gov/documents/reports/chapter-14-medicare-advantage-special-needs-plans-%28march-2013-report%29.pdf?sfvrsn=2>

quality of care for a set of patients, regulations designed to limit utilization in a volume-centric, FFS payment environment become unnecessary and should be waived.⁶ Recent CMS rulemaking and CMMI initiatives have embraced waivers of the Skilled Nursing Facility 3-day rule for some ACOs. But Congress should ensure accountable entities, including at a minimum MA Plans, risk-based ACOs and BPCI participants, can access waivers of payment rules such as:

- The SNF 3-day rule
- The Home Health homebound requirement
- Home Health therapy frequency and duration restrictions
- Limits on preadmission home assessments
- Telehealth geographic and origination requirements
- Restrictions on providing outpatient dialysis for non-ESRD beneficiaries
- The prohibition of curative treatment for beneficiaries enrolled in hospice

Participants in risk-based payment models should also be able to apply for waivers granting the discretion to assign Low-Utilization Payment Adjustment (LUPA) status to those beneficiaries who may not require a full 60-day home health episode.

Second, Congress should explicitly permit beneficiaries to share in savings generated by APMs. This approach would entail allowing MSSP ACOs the option of waiving cost-sharing for primary care or other high-value services or providers and permitting BPCI participants to likewise offer patient incentives.

Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

Both APMs in traditional Medicare and Medicare Advantage can contribute to improving care for the chronically ill. But if Congress is serious about chronic care, reform cannot stop there.

APMs and the MA plans can only achieve their full potential if coupled with reforms to the underlying FFS payment policies in traditional Medicare. After all, traditional Medicare’s reimbursement policies and rates remain critical components of the payment formulae for MA plans, ACOs, and the APMs now undergoing testing at CMMI. In any event, millions of chronically ill beneficiaries will rely on medical care reimbursed through traditional Medicare’s FFS payment arrangements for years to come—regardless of the rate of expansion of APMs and MA.

Therefore, NCHC recommends that Congress correct the incentives for unnecessary volume and intensity in traditional Medicare’s provider reimbursement policies, as described below.

⁶ In recommending these specific waivers, our aim is to promote better care management by ACOs and other APM participants which assume performance risk. Licensure, solvency and consumer protection standards for entities which assume full insurance risk should be maintained.

- Reform SNF Payment Reform: Provide a separate component for non-therapy services and base payment on patient characteristics, not payment volume, as recommended in a January 2015 report issued by MedPAC and Urban Institute.⁷
- Home Health Payment Reform: Establish a payment system based on patient characteristics and remove the number of therapy visits as a payment factor, as proposed in the March 2011 MedPAC report, Recommendation 8.3.⁸
- Readmissions Policies for Post-Acute and Other Providers: Establish a readmissions policy for home health providers, IRFs, long-term care hospitals (LTCHs), and Ambulatory Surgical Centers (ASCs)- similar to those for hospitals and skilled nursing facilities.

Even the physician payment bonuses enacted by *the Medicare Access and CHIP Reauthorization Act of 2015* to support a shift toward value retain some volume-based elements. Specifically, both the 5% bonus for Alternative Payment Model participation and the MIPS bonuses are calculated as a percentage of an eligible professional's FFS income. This means that, all other things being equal, Medicare will pay a larger bonus to clinicians who had billed more in the previous year. Congress should correct this technical flaw in the current statute by removing the volume-dependent elements of the APM and MIPS bonuses.⁹

Another critical area is the alignment of measures, including measures most germane to chronic care, across the public and private sectors. If public and private payers can agree upon a uniform and targeted, high value set of measures it will reduce redundant, burdensome data reporting, and simultaneously send a strong signal to providers about what are the most important areas to improve. To that end, NCHC supports the *Quality Measure Alignment Act of 2015 (S.1427)*, which would add a new duty to the role of the Consensus Based Entity (currently NQF) in facilitating measure alignment across the public and private sectors without incurring additional costs. To further ensure federal quality measurement policy is aligned with the most innovative private sector and public payers, the Finance Committee should explore ways to incentivize provider use of high-value, registry- or EHR-based outcome measures.

Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

1. Medicare policy must do a better job of helping beneficiaries take control of their own health-prior to the onset of chronic disease. To that end, NCHC supports S. 1131, the *Medicare Diabetes Prevention Act of 2015*. For pre-diabetic beneficiaries, this legislation would cover, under the

⁷ Carter, C., Bowen, G., and Wissocker, D. *The Need to Reform Medicare's Payment to Skilled Nursing Facilities is as Strong as Ever*. MedPAC and Urban Institute, January 2015. Retrieved from <http://medpac.gov/documents/reports/january-2015-medpac-and-urban-institute-report-the-need-to-reform-medicare-s-payments-to-skilled-nursing-facilities-is-as-strong-as-ever.pdf?sfvrsn=0>

⁸ MedPAC. *Report to Congress on Medicare Payment Policy*. March 2015. Retrieved from http://www.medpac.gov/documents/reports/Mar11_Ch08.pdf?sfvrsn=0

⁹ Although NCHC has not endorsed a specific approach to addressing this problem, a recent Brookings Institution Brief outlines how a fix could be structured. See Appendix in Berenson, R., Chernew, M., Kramer, W., Lansky, D. McClellan, M., and Milstein, A. "Medicare Physician Payment Reform: Securing the Connection Between Value and Payment." January 27, 2015. Retrieved from <http://pbgh.org/news-and-publications/pbgh-in-the-news/328-medicare-physician-payment-reform-securing-the-connection-between-value-and-payment>

Medicare Part B benefit, participation in the Diabetes Prevention Program- a cost-saving, community-based intervention that has been shown to reduce incidence of diabetes.¹⁰

2. Following onset of chronic disease, getting the correct medication regimen and adhering to that regimen are vital to a patient's ability to manage their own health. However, improper dosing, unforeseen medication interactions and avoidable side effects can create significant patient harm and expense. And non-adherence by chronically ill patients is linked to increased mortality and hospitalization rates.¹¹ Unfortunately, the incentives and regulatory structure makes addressing these problems more difficult than necessary for stand-alone Part D Prescription Drug Plans.

Medication management can be an effective part of patient-centered, team-based care, especially when focused on outcomes that are aligned with patients' care plans and goals of therapy. But without access to enrollees' medical claims, PDPs are limited in their ability to identify enrollees who are most likely to benefit from interventions (i.e. those with frequent hospitalizations or doctor visits). And because improving medication use can sometimes increase a beneficiaries' Part D spending even as it decreases Part A and B spending, PDPs have little incentive to prioritize medication management services (e.g. currently covered Medication Therapy Management (MTM) services or Comprehensive Medication Management services provided by a clinical pharmacist). Finally, medication management services are generally classified as an administrative cost and counted against a plan's medical loss ratio (MLR), creating another disincentive to invest in them.

We hope the Finance Committee will explore a range of policy options to address these challenges. As an initial step, Congress should classify medication management services as quality-improving activities for the purposes of calculating MLR.

3. When chronic disease evolves into serious or advanced illness, it is particularly critical that patient's own preferences and choices determine the course of treatment. This can only occur if care planning is an integral part of the Medicare benefit. Specifically, provided measures are in place to prevent fraudulent billing, NCHC supports adequate reimbursement for the following services:
 - care planning upon diagnosis of Alzheimer's disease or dementia, and
 - advanced care planning for patients with serious or advanced illness as provided for in S. 1549, The Care Planning Act of 2015.

Ideas to effectively use or improve the use of telehealth and remote monitoring technology; Strategies to increase care coordination in rural and frontier areas

Telehealth and remote monitoring technologies have potential to curb costs while continuing to deliver quality care to patients, wherever they may reside. As discussed above, NCHC supports enabling Medicare

¹⁰ Diabetes Prevention Program Research Group. "10 year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study." *Lancet*. October 29, 2009.

¹¹ Ho, P.M., Magid, D.J., Masoudi, F.A., McClure, D.L., and Rumsfeld, J.S. "Adherence to cardioprotective medications and mortality among patients with diabetes and ischemic heart disease." *BMC Cardiovascular Disorders*. Dec 15, 2006. Sokol, M.C., McGuigan, K.A., Verbrugge, R.R., and Epstein, R.S. "Impact of medication adherence on hospitalization risk and healthcare cost." *Medical Care*. June 2005.

Advantage plans to furnish covered services via telehealth and other remote access technologies, regardless of point of origin or setting of care, without the need for a supplemental benefit. Congress should also allow participants in risk-based payment models to apply for a waiver of telehealth restrictions.

The effective use, coordination, and cost of prescription drugs

Current drug pricing trends, particularly in the specialty drug sector, threaten the affordability of health care in the United States. Patients and purchasers are already paying upwards of \$100,000 a year for some medicines. Left unchecked, the application of current unsustainable pricing models to new cancer, cholesterol, multiple sclerosis, and diabetes drugs will leave our health system with an untenable choice: reduce access to medications needed to manage chronic disease or shoulder increasingly unaffordable cost burdens.

NCHC is currently engaged in a dialogue with stakeholders, industry, and the American public to identify a better approach that promotes value, transparency and effective competition in the pharmaceutical sector. And while we recognize a resolution of this issue may be beyond the purview of the Chronic Care Workgroup, we wish to communicate our strong interest in working with the Finance Committee on this important issue moving forward.

Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions

Advanced medical home models have enormous potential to engage the full range of health care professionals in improving care and lower costs for chronically ill Medicare beneficiaries. NCHC supports continued testing, and expansion, if warranted, of such models, including the Comprehensive Primary Care Initiative and the smaller Intensive Outpatient Care Program, now a Health Care Innovation Award grantee.

But there are also additional steps which Congress can take now. Initial results from Medicare's Independence at Home Practice Demonstration, team-based primary care model delivered in an enrollee's home, has demonstrated broad quality improvement and an average per beneficiary savings of \$3057.¹² Yet under current law, the Secretary of Health and Human Services lacks the statutory authority to expand this particular demonstration without further Congressional action. Any chronic care legislation should include a voluntary, nationwide expansion of the Independence at Home Demonstration

¹² Centers for Medicare and Medicaid Services. "Affordable Care Act Model saves more than \$25 million in first year." Press release. June 17, 2015. Retrieved from <http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html>