NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

January 26, 2016

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:

I write today to offer the National Coalition on Health Care's response to Senate Finance Committee Chronic Care Working Group's Policy Options Document and to urge you to advance meaningful chronic care legislation this year.

NCHC is the nation's largest, most broadly representative nonpartisan alliance of organizations focused on health care. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy—an affordable, high-value health care system for patients and consumers, employers and other payers, and taxpayers. Our members and supporters include nearly 90 of America's largest and leading associations of health care providers; businesses and unions; consumer and patient advocacy groups; pension and health funds; religious denominations; and health plans. Our member organizations represent—as employees, members, congregants, or volunteers—more than 150 million Americans.

NCHC's members are united in the conviction that we must do more to make health care affordable, and the belief that transformation of care for the chronically ill is central to that goal. In recent years, NCHC has worked with subject matter experts and our diverse member organizations to identify and advance a few common sense, yet powerful strategies to improve health care affordability.

The Policy Options Document strongly reflects three of those strategies: 1) engaging consumers in their own health and health care, 2) expanding care coordination for the highest cost, highest need beneficiaries, and 3) modernizing Medicare provider payment. In fact, the Coalition either supports outright or supports with certain qualifications each of the following policy options:

- Expanding the Independence at Home Model of Care
- Expanding Access to Home Hemodialysis
- Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations (long-term or permanent extension of SNP plans)
- Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (allowing non-SNP MA plans to provide tailored benefit packages to enrollees)
- Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees (such as social services, transportation and remote medical monitoring)
- Increasing Convenience for Medicare Advantage Enrollees through Telehealth
- Providing Accountable Care Organizations (ACOs) the Ability to Expand Use of Telehealth
- Maintaining ACO Flexibility to Provide Supplemental Services (such as social services, transportation and remote medical monitoring)
- Expanding Use of Telehealth for Individuals with Stroke
- Providing Flexibility for Beneficiaries to be Part of an ACO (prospective assignment and beneficiary attestation options)
- Accurate Payment for Chronically Ill Beneficiaries (changing the CMS-HCC Model to reflect number of conditions, behavioral health interactions, full dual status, and more than one year of data)
- Encouraging Beneficiary Use of Chronic Care Management Services (eliminating cost-sharing for CCM and TCM codes)
- Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness
- Eliminating Barriers to Care Coordination under ACOs (option for ACOs to waive certain cost-sharing for assigned beneficiaries)
- Expanding Access to Prediabetes Education

In the attached, we offer our detailed comments on the options and questions discussed in the Policy Options Document. Additionally, in recognition of the political and budgetary challenges associated with crafting legislation, we identify those options which, with your leadership, might be addressed through regulatory and administrative processes.

However, the Policy Options Document leaves other major barriers to better chronic care unaddressed. For example, Medicare's SNF and home health payments remain plagued with significant incentives for volume, despite repeated calls for reform by the Medicare Payment Advisory Commission. Policymakers have yet to address problems with the Hospital Readmission Reduction Program (HRRP), despite clear evidence that HRRP penalizes hospitals for serving lower-income populations. The persistence of these misalignments in Medicare's underlying provider payment policies can only undermine the progress in chronic care which you hope to

achieve. Congress can and should pursue bipartisan remedies to these problems, whether as part of this process or through future legislative efforts.

Nonetheless, NCHC urges the Finance Committee to mark up and advance chronic care legislation this year. As the CMS Office of the Actuary's 2014 National Health Expenditures reports revealed, health care spending growth has returned—a development that could, over the years ahead, erode the standard of living for millions of American families. And the forty-seven million Medicare beneficiaries themselves—particularly those facing chronic disease—need and deserve higher-quality, better coordinated care. Neither Medicare beneficiaries nor any American family should have to wait until the next Congress.

If the National Coalition of Health Care can be of additional assistance, please do not hesitate to contact myself at jrother@nchc.org or NCHC's Policy Director, Larry McNeely, at lmcneely@nchc.org.

Sincerely,

John Rother
President and CEO

Receiving High Quality Care at Home

Expanding the Independence at Home Model of Care

NCHC strongly supports expanding the Independence at Home Model, and establishing it as a permanent part of the Medicare program. Evidence continues to build that this model of care delivers better care at a much lower cost for the highest cost, highest need beneficiaries.[1,2, 3, 4]

In establishing the criteria used to identify patients who would benefit from this program, we suggest that the committee explore a range of options and select an approach that ensures IAH is broadly available to the segment of beneficiaries with the highest costs and highest needs.

Expanding Access to Home Hemodialysis Therapy

NCHC supports allowing home-based dialysis patients to receive their monthly clinical assessment via telehealth. Furnishing monthly clinical assessments either at freestanding hemodialysis centers or other settings is consistent with NCHC's overall support for telehealth. In this case, as elsewhere, we believe appropriate use of telehealth can provide greater access for patients in a lower cost and likely more convenient setting.

Advancing Team-Based Care

Providing Medicare Advantage Enrollees with Hospice Benefits

Increased hospice election is commonly associated with higher quality care, member and family satisfaction, and less unnecessary care, particularly unnecessary acute care of little or no value.

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[1] Centers for Medicare & Medicaid Services. (2015). Affordable Care Act payment model saves more than $25 million in first performance year [Press release]. Retrieved from: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html

[2] Melnick, G.A., Green, L., & Rich, J. (2016). House calls: California program for homebound patients reduces monthly spending, delivers meaningful care. *Health Affairs, 35*(1): 28-35. Retrieved from: http://content.healthaffairs.org/content/35/1/28.abstract

[3] De Jonge, K.E., Jamshed, N., Gilden, D., Kubisiak, J., Bruce, S.R., & Taler, G. (2014). Effects of home-based primary care on Medicare costs in high-risk elders. *Journal of American Geriatric Society, 62*(10):1825-1831. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1111/jgs.12974/pdf

[4] Edes, T., Kinosian, B., Vuckovic, N.H., Nichols, L.O., Becker, M.M., & Hossain, M. (2014). Better access, quality and cost for clinically complex veterans and home-based primary care. *Journal of the American Geriatrics Society, 62*(10): 1954-1961. Retrieved from: http://onlinelibrary.wiley.com/doi/10.1111/jgs.13030/abstract

We support testing a hospice model that would allow participating MA and MA-Prescription Drug (MA-PD) providers to offer hospice benefits. The option to provide hospice benefits under MA would provide more flexibility, peace of mind, and cost savings to plan enrollees. Such a model should allow for testing of the provision of curative services concurrent with hospice.

To ensure policy changes do not produce unintended effects on beneficiaries, such as impeding access to hospice providers or adding to their out-of-pocket costs, adequate reimbursement will be critical. We further recommend that CMS monitor the following metrics: hospice length of stay; impact on acute, intensive care unit, and emergency room utilization; impact on medical cost; and member and family satisfaction. Finally, the testing of this MA hospice model should include the study of utilization of all services in the hospice population, particularly those services deemed "curative."

Providing Continued Access to MA Special Needs Plans for Vulnerable Populations

Special Needs Plans have served as incubators for promising innovation in care, enabling plans to develop new ways of managing chronic disease and coordinating care for some of the sickest Medicare enrollees. For example, a 2012 analysis by Avalere found that SCAN Health Plan's integrated care delivery approach has reduced rates of readmission among dual eligible beneficiaries by 25 percent[5] relative to fee-for-service beneficiaries. According to the 2013 SNP Alliance Profile Summary, Medicare beneficiaries enrolled in certain C-SNPs have experienced 50 percent fewer days in the hospital than a comparable group of FFS beneficiaries.[6] In fact, delivery and benefit innovations developed by SNPs are now proliferating elsewhere in the health care system. For example, the Center for Medicare and Medicaid Innovation is testing nurse-led care coordination for nursing home residents under the Initiative for Reducing Avoidable Hospitalizations among Nursing Home Residents. This innovation is similar to the work of Evercare, an I-SNP. Additionally, several states, including Minnesota and New Jersey, are contracting with D-SNPs as a means to integrate care and benefits for dually eligible beneficiaries.

Unfortunately, uncertainty about the future of the SNP program discourages plans from investing in these promising models of care and deters state Medicaid programs from exploring closer collaboration and integration with SNPs. Congress should end that uncertainty and enact permanent policy with respect to Medicare Advantage Special Needs Plans. At a minimum, legislation should provide for a permanent extension of I-SNPs and D-SNPs.

[5] Wing, C. (2012). Improving care and controlling health costs for dual eligibles [Powerpoint]. Retrieved from: http://www.nchcbeta.org/wp-content/uploads/2012/10/June-21-Forum-Presentation-Chris-Wing-SCAN-Health-Plan-.pdf

[6] Lewin Group. (2012). SNP Alliance annual profile and advanced practice report. Retrieved from: http://www.nhpg.org/media/14847/2011%20snp%20alliance%20profile%20&%20%20advanced%20practice%20report%20final.pdf

We support the CCWG's interest in extending condition-specific benefit flexibility, currently available only to C-SNPs, to all MA plans. However, until such a change has been implemented and evaluated, it would be premature for Congress to sunset C-SNPs.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

NCHC supports enhanced care management for high-severity chronically ill patients. Alternative payment models like ACOs, global payment, and advanced medical homes generally must rely on high-severity care management if they are to be successful. Yet given the continued importance of fee-for-service payment for the majority of Medicare providers, the establishment of high-severity care management codes in the Physician Fee Schedule is appropriate at this time.

However, establishment of such codes is within CMS' current statutory authority and could be addressed in the CY 2017 Physician Fee Schedule rulemaking cycle. The CCWG may wish to consider to leveraging the regulatory process, rather than establishing such a code through statute.

We note also that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are currently ineligible for the existing Chronic Care Management (CCM) codes, since they do not bill under the Fee Schedule. We urge the Committee to ensure that FQHCs and RHCs are able to utilize the existing CCM codes as well as any new high-severity care management codes.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

NCHC supports an integrated approach to the delivery of behavioral health and other health care services. We believe the following policy changes, discussed elsewhere in NCHC's comments, would help support such integration.

Benefit Flexibility: Expansion of MA supplemental benefits could enable plans to furnish mental health and substance abuse services not currently covered by Medicare. Similarly, clarifying that ACOs can provide non-covered benefits enables ACOs to target these services to the assigned beneficiaries who need them.

Better Risk Adjustment: Accounting for the interactions between behavioral and physical health conditions and providing additional HCCs for substance abuse and mental health services would better support plans and ACOs that enroll and serve beneficiaries facing behavioral health challenges.

Expanding Innovation and Technology

Adapting Medicare Benefits to Meet the Needs of Chronically Ill Beneficiaries

NCHC supports allowing Medicare Advantage plans to provide tailored benefit improvements, specialized provider networks, and cost-sharing reductions to subsets of enrollees with certain identified chronic conditions, similar to the benefits furnished by C-SNP plans today.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill MA Enrollees

Improving health outcomes for chronically ill individuals frequently requires provision of services that are not traditionally considered clinical in nature, particularly when social determinants of health—such as lack of transportation, insufficient nutrition, and inadequate housing—hinder access to the full range of needed care or otherwise impact how patients respond to care. Research indicates that clinical care comprises only 20 percent of the factors that drive health outcomes, while social, economic, and physical environmental factors make up 50 percent.[7]

Preventing the adverse consequences of social determinants can pay off in the form of better health outcomes and care experiences for individuals, improved population health, and lower health care spending—the attributes of the Triple Aim. If the health care system does not account for and support activities that address the social determinants, poor health outcomes will persist and culminate in health and health care disparities—ultimately leading to the perpetuation of otherwise avoidable expensive health care.

Given the substantial impact that non-clinical factors have on a person's health and health care outcomes, NCHC supports allowing MA plans to furnish non-medical or social service supplemental benefits that improve the overall health of individuals with chronic disease. Examples of such services should include, but need not be limited to, non-covered transportation, nutrition, in-home support services, behavioral health services, home improvement, communication devices, caregiver training, assistive devices, and remote patient monitoring systems. Consistent with our recommendation on adapting benefits to meet the needs of chronically ill beneficiaries above, plans should be permitted to target these services to those enrollees who most need them.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

MA Plans, ACOs, or other entities which are clinically and financially accountable for patient care outcomes should have the flexibility to utilize telehealth technologies to deliver health care services in the most effective and efficient manner. Therefore, NCHC supports permitting MA plans to include telehealth services in their annual bid amounts.

[7] County Health Rankings. (2015). *Rankings background.* Retrieved from: http://www.countyhealthrankings.org/about-project/rankings-background.

As the Policy Options Document suggests, telehealth should not be considered just another supplemental benefit; it ought to be considered a means of delivering a broad range of Medicare benefits. For this reason, NCHC opposes limiting MA telehealth services to the current Medicare telehealth benefit.

In fact, Medicare's own experience demonstrates that telehealth can be a cost-saving, quality-enhancing means of care delivery. 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.[8]

Providing ACOs the Ability to Expand Use of Telehealth

As stated above, MA Plans, ACOs, or other entities which are clinically and financially accountable for patient care outcomes should have the flexibility to utilize telehealth technologies to deliver health care services in the most effective and efficient manner. NCHC supports the waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services for MSSP ACOs.

Maintaining ACO Flexibility to Provide Supplemental Services

As noted above, non-clinical factors, including social determinants of health, have a substantial effect on health and health care outcomes. NCHC supports clarifying that ACOs participating in the Medicare Shared Savings Program may furnish services for which payment is not made under fee-for-service Medicare. Examples of such services should include, but need not be limited to, non-covered transportation, nutrition, in-home support services, behavioral health services, home improvement, communication devices, caregiver training, assistive devices, and remote patient monitoring systems.

This policy change would also enable ACOs to provide palliative care services at any age and any stage in a serious illness. A study released this month showed that cancer patients with comorbid conditions who received a palliative care consultation within two days of admission had overall hospitals costs reduced by 22-32 percent.[9]

[8] McCall, N., Cromwell, J., Smith, K., & Urato, C. (2011). Evaluation of Medicare Care Management for High Cost Beneficiaries (CMHCB) demonstration: the Health Buddy Consortium (HBC), revised final report. 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

[9] May, P., Garrido, M.M., Cassel, J.B., Kelley, A.S., Meier, D.E., Normand, C., et al. (2016). Palliative care teams' cost-saving effect is larger for cancer patients with higher numbers of comorbidities. *Health Affairs, 35*(1): 44-53. Retrieved from: http://content.healthaffairs.org/content/35/1/44.abstract

Expand Use of Telehealth for Individuals with Stroke

NCHC supports eliminating the originating site geographic restriction for the purpose of promptly identifying and diagnosing strokes. Adding telestroke services to the Medicare benefit will ensure more timely and therefore more effective care for stroke patients.

Identifying the Chronically Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically Ill Individuals

NCHC supports the proposed changes to the CMS-HCC model to better account for the impact of multiple chronic conditions, the interaction of behavioral health conditions, and fully dual eligible status. We also support the use of more than one year of data to establish a beneficiary's risk score and a study exploring the feasibility of adjustments for functional limitations.

The Chronic Care Working Group may also wish to consider establishing additional HCCs for substance abuse conditions and mental health conditions, such as depression and anxiety, and using these conditions in behavioral health-physical health interactions.

We note that CMS has signaled that it will propose changes to the risk adjustment model in this year's Part C and D call letter process. Prior to final legislative action on this issue, the Committee should consider the outcome of the regulatory process.

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

NCHC supports offering MSSP Track One ACOs choice of retrospective or prospective assignment of beneficiaries and allowing voluntary beneficiary attestation.

The Policy Options Document requests comment on whether assigned beneficiaries should be allowed to seek care outside the ACO. NCHC recognizes the challenges that arise for providers and plans when beneficiaries elect to seek care from non-participating providers. Steps can and should be taken to reduce such leakage, including better information for beneficiaries or reducing cost sharing for services within the ACO. However, today, every Medicare beneficiary remains entitled by law to seek care from any participating provider. This is commonly recognized with respect to enrollees in traditional Medicare, but Medicare Advantage enrollees also retain the right to seek care from non-network providers at the same cost-sharing levels provided by traditional Medicare. Proposals to eliminate this underlying entitlement to seek care from all Medicare providers would raise concerns for consumer advocates, providers, and beneficiaries and undermine the chances of advancing significant chronic care legislation this year.

The Policy Options Document also requests feedback on the possibility of upfront collective payment for ACO beneficiaries. NCHC supports offering a global payment option as provided for in the Next Generation ACO Model, but we have reservations about applying upfront collective payment in all ACO tracks.

The provider payment responsibilities associated with upfront collective payment could be a significant burden for organizations in the first stage of their journey toward risk. We also note that state laws often require important licensure, solvency and consumer protection standards for organizations assuming insurance risk. The establishment of three tracks within the Medicare Shared Savings Program, along with the Pioneer and Next Generation ACO Models, allows provider organizations to work toward more advanced payment methodologies in a more appropriate, gradual manner.

Developing Quality Measures for Chronic Conditions

NCHC would welcome additional measure development in the areas of patient and family engagement, shared decision-making, care coordination, end of life care, Alzheimer's/dementia, and community level measures.

However, given the already significant burden on the measure development and endorsement processes, additional funding should accompany this proposal. It will also be vital that new measure development efforts are properly aligned and integrated with the measurement initiatives enacted as part of MACRA and the IMPACT Act.

NCHC supports instructing the Government Accountability Office (GAO) to report on community-level measures as they relate to chronic care management.

In general, NCHC advocates that health care quality measurement should move over time toward a parsimonious set of core outcome measures, with a focus on patient-reported experience and functional outcomes. Wherever possible, such measures should be endorsed by a multi-stakeholder process to ensure they are evidence-based and meet the needs of all stakeholders. Incentives should be offered to providers who utilize the highest-value measures, such as more advanced registry or EHR-based quality outcome measures, and patient-reported outcome measures (PROMs), addressing patient experience, the level of functional restoration or improvement, and quality of life.

Empowering Individuals & Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services

NCHC strongly supports waiving the cost-sharing for chronic care management and transitional care management codes, as well as the proposed high-severity chronic care management codes.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

NCHC supports a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer's/dementia.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

NCHC supports the proposal to allow ACOs to waive beneficiary cost sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease.

Expanding Access to Prediabetes Education

NCHC strongly supports coverage of Diabetes Self-Management Training for pre-diabetics under Medicare Part B.

We note that the Diabetes Prevention Program has relied on peer-led programming delivered by nonprofit organizations and departments of health, and by doing so has successfully delayed onset of diabetes over the short- and long-term. Any expansion of DSMT coverage must continue to allow this benefit to be provided by nonprofit organizations and departments of health.

Other Policies to Improve Care for the Chronically Ill

Increasing Transparency at the Center for Medicare & Medicaid Innovation

NCHC and the broader stakeholder community view rapid cycle testing and refinement of alternative payment models as indispensable to the successful transition away from volume-based payment in general and the implementation of MACRA's Alternative Payment Model provisions in particular**.**

Therefore we urge the Committee to exercise extraordinary caution in crafting policy related to the Center for Medicare and Medicaid Innovation (CMMI). Although we agree that greater transparency and public comment on the CMMI's important work is important, the Committee can most readily make progress by working collaboratively with the Department of Health and Human Services to address these goals.

In the event that a statutory change proves necessary, legislation should focus solely on carefully tailored, bipartisan solutions that contribute to rather than undermine CMMI's important work. Requiring notice and comment rulemaking upon initial establishment of a new, large-scale mandatory model could be one such solution. However, NCHC would oppose any legislation that reduced CMMI's capacity to rapidly stand up new models, make mid-course corrections to models to accommodate beneficiary or provider needs, or terminate models that are not succeeding.

Study on Medication Synchronization

The Policy Options document proposes a study exploring how Part D prescription drug plans (PDPs) could coordinate the dispensing of prescription drugs so that, to the extent feasible, multiple prescriptions can be dispensed to a beneficiary on the same day. Medication Synchronization is a promising approach to improving adherence, that merits testing and study in the Medicare context. If the Committee moves forward with a study of Medication Synchronization in Medicare, such a study should carefully monitor the demonstration's impact on beneficiaries' cost-sharing and adherence to needed medication- particularly for lower income beneficiaries.

As a separate, additional step toward improved medication management and adherence, NCHC supports expanding the recent Medicare Part D Enhanced MTM Demonstration to include MA-PD plans.

Rural Health

With 23 percent of Medicare beneficiaries residing in rural areas, a Medicare chronic care strategy can only be successful if it reaches this important population. Rural Americans are older, sicker, and poorer than their urban counterparts. Specifically, they are more likely to suffer with a chronic disease that requires monitoring and follow-up care. This makes convenient access to care crucial for ensuring patient compliance with the services that are necessary to reduce the overall cost of care and improve the patients' outcomes and quality of life. Yet, many rural Americans live in areas with limited health care resources, restricting their available options for care.

Premier and National Rural Healthcare Association, both members of the National Coalition on Health Care, have proposed an approach that engages Critical Access Hospitals (CAHs) in the transformation of care in rural areas. Their Critical Access Hospital Value-Based Purchasing proposal would implement payment incentives tied to performance on evidence-based care, mortality, safety, patient experience, care coordination, and spending, with an emphasis on heart failure, cardiovascular disease, diabetes, stroke, behavioral health, obesity, and chronic obstructive pulmonary disease. Through this program, CAHs would earn up to 2 percent bonuses on inpatient and outpatient services if they meet quality, patient experience, and efficiency targets during the first and second years of the program. If, after three years, it can be demonstrated that the group of CAHs as a whole reduced total Medicare spending for the population they serve then

a share of those savings would generate a pool for incentive payments to be distributed back based on related performance.

NCHC believes the CAH Value-Based Purchasing concept complements the CCWG's other proposals and merits consideration for inclusion in any legislative package.