



January 26, 2016

By Electronic Delivery to: [Chronic\\_Care@finance.senate.gov](mailto:Chronic_Care@finance.senate.gov)

United States Senate Committee on Finance  
Bipartisan Chronic Care Working Group  
Policy Options Document

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Dear Chairman Hatch and Senator Wyden,

The Alliance of Dedicated Cancer Centers (“ADCC”) is pleased to submit the following comments to the Senate Finance Committee staff for consideration as the staff finalizes policies aimed at improving chronic care management, including the chronic condition of cancer.

The ADCC is comprised of eleven of the nation’s premier cancer centers focusing exclusively on the care of cancer patients (“Dedicated Cancer Centers”). Dedicated Cancer Centers are at the forefront of innovations in the field of cancer, with a shared commitment to discovering and implementing the most effective treatment strategies for patients living with or at risk for cancer.

We appreciate your attention to improving care for chronic conditions, and expect that cancer care is one of the chronic conditions that the Senate Finance Committee’s Chronic Care Working Group (CCWG) will address. We are supportive of the working group’s goals, which include: (1) increasing care coordination among providers across care settings treating individuals living with chronic diseases; (2) streamlining Medicare’s current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; and (3) facilitating the delivery of high quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiency, and contributing to an overall effort that will reduce the growth in Medicare spending.

In this letter, we discuss options for improving coverage and access for patients with chronic conditions, including for patients with cancer, while providing general support for many of the CCWG’s policy proposals. We appreciate the CCWG’s consideration of our comments. If you have any questions or require additional information, please contact me at [Karen.Bird@adcc.org](mailto:Karen.Bird@adcc.org), the Executive Director of the ADCC, or our consultant on technical matters, Ms. Jugna Shah at [jugna@nimitt.com](mailto:jugna@nimitt.com).

Sincerely,

A handwritten signature in cursive script that reads "Karen Bird".

Karen Bird  
Executive Director

## **Expanding the Independence at Home Model of Care**

The ADCC supports the Independence at Home (IAH) demonstration project created under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148). The ACA required the Medicare program to test a payment incentive and service delivery model that uses physician- and nurse practitioner-directed home-based primary care teams in an effort to reduce expenditures and improve health outcomes among selected Medicare beneficiaries with multiple chronic illnesses. The ADCC supports the expansion of the current demonstration into a nationwide program. We recommend, however, that legislation to create such an expansion clearly and explicitly indicate that the list of providers and suppliers that are qualified, per their state's scope of practice, to provide IAH services includes free-standing independent practitioners, group practices, hospital-based physicians, and non-physician practitioners. We also believe that specialty hospitals and groups (i.e., free-standing and hospital-based) should be allowed to provide these services for conditions such as cancer, diabetes, arthritis, and other chronic conditions.

We understand the CCWG is contemplating modifications to the existing IAH program, including the use of hierarchical condition categories (HCC) risk scores to identify complex chronic care beneficiaries for inclusion in the IAH program. HCC scores would replace the current criteria that an individual had a non-elective hospitalization within 12 months of his or her participation in the IAH program. While we support the Committee's desire to risk adjust, we do not believe that HCCs are an adequate tool for representing the severity and complexity of care related to cancer patients.

The version of HCCs in place in 2012 included only four cancer HCCs which means significant categories of cancers which are very different have been lumped together into four categories and some cancer codes are not included at all. HCCs are based on ICD-9 codes, which are very limited in their ability to identify cancer cases. Of the 864 cancer ICD-9 codes, 161 or 19 percent are not included in the HCCs. Importantly, both ICD-9 and ICD-10 codes describe the location of the cancer but do not capture the stage or intensity of the cancer which drives the level of treatment and severity of the cancer. Given this reality, we encourage the CCWG to look at additional tools that can better identify chronically ill beneficiaries.

The ADCC also recommends that communities be allowed to form separate entities for the purpose of providing these services, and to allow staff from member and non-member organizations to provide IAH services. For example, a community hospital and different physician practices could form an entity to provide IAH services, and the patient care staff could be comprised of voluntary and part-time staff from these member entities.

## **Providing Medicare Advantage Enrollees with Hospice Benefits**

The ADCC supports this option. We believe that hospice is an important benefit for *all* Medicare beneficiaries, and that Medicare should provide hospice coverage under both Medicare Advantage (MA) and traditional Medicare plans.

We also believe that patient and family education about palliative care options is an important component to the successful adoption of hospice services. It is important that these conversations occur regularly with beneficiaries and their family members, so they are prepared at the earliest appropriate time to elect hospice care, if and when needed. Additionally, our understanding is that few hospice programs cover palliative radiation therapy or chemotherapy, feeding tubes, etc. We believe these

services can significantly improve the quality of life of terminally ill patients and should be offered and covered along with hospice care.

The ADCC appreciates CMS' recently promulgated coverage and payment policy for Advanced Care Planning (ACP services), which we believe will facilitate increased adoption of hospice for certain types of chronically ill patients, including cancer patients. To this end, we believe that CMS should allow for separate payment of ACP services under the OPPTS, even when these services occur on the same date of service as another procedure, service, or visit. ADCC member organizations schedule and organize care in such a manner to limit the number of separate trips the patient has to make the hospital. In other words, we schedule patients so they can receive multiple services in a given day, which eases their burden. Facilities should not be penalized from a reimbursement perspective due to organizing care in this manner.

### **Providing Continued Access to Medicare Advantage Special Needs Plans (SNPs) for Vulnerable Populations**

The ADCC agrees that MA SNPs enroll some of the most vulnerable and complex beneficiaries, including those with chronic diseases such as cancer. We agree these beneficiaries are likely to require higher levels of care, are dually eligible for Medicare and Medicaid, and have one or more chronic diseases. A long term extension of MA SNPs would allow for greater planning and investment in innovative care models for beneficiaries.

### **Improving Care Management Services for Individuals with Multiple Chronic Conditions**

The ADCC supports this option. We are concerned, however, that the addition of new and additional codes does not adequately support payment for high-quality care and positive or improved outcomes. To change this paradigm, we encourage the CCWG to develop a clear definition of a "high severity chronic care patient" and not limit this to patients with multiple chronic conditions only. We note that patients with certain single chronic conditions — such as cancer— may require more time and resources to treat, compared to other types of patients who may have multiple chronic conditions. The number of chronic conditions alone should not be the litmus test for defining a "high severity chronic care patient" as there are many factors that must be considered in defining a "high severity chronic care patient," including the time, resources, level and type of staff and services that are involved in the patient's non-face-to-face care.

### **Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries**

The ADCC supports options to allow all provider types to expand services and access to meet beneficiaries' behavioral health needs. Care coordination among hospitals, Community Mental Health Centers (CMHCs), and other care providers such as psychiatrists must be encouraged and covered. Additionally, care providers should be allowed to provide meals, coordinate transportation, and other supportive services without this being viewed as an inducement that would violate compliance rules. We also believe that, in addition to the supportive services listed above, CMS should cover medication therapy management (MTM) services that are provided by a licensed pharmacist. Keeping chronically ill patients on their medication regimes is a big challenge, particularly if they also have behavioral health issues. To this end, implementing Medicare coverage for MTM is a good example of expanding care integration and providing additional supportive care services to ensure patient health. We believe that inpatient admissions and ED recidivism could be significantly reduced if chronically ill patients, including cancer patients, could regularly come to the pharmacy to receive their medicines and check in with a pharmacist for medication management.

## **Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

The ADCC supports allowing MA plans to tailor their benefit packages to meet the specific needs of chronically ill patients, including cancer patients. This places the patient at the center of the care delivery model, which we fully support. Such patient-centered care will allow MA plans to provide the specific services their chronically ill members need rather than being required to provide standard, cookie-cutter care. The end result of such a shift, over time, is likely to be better outcomes and lower costs. Allowing MA plans this flexibility also aligns with Medicare's value-based purchasing goals.

## **Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

The ADCC encourages the CCWG to allow MA plans to expand their supplemental benefits. These additional benefits should include both medical and non-medical services, including social services, nutrition and dietary counseling, hospice and palliative care services, in-home care, telehealth, and transportation. Each of these can significantly improve the overall health of individuals who have chronic diseases, while impacting outcomes and costs in a positive manner.

## **Expanding Access to Telehealth**

ADCC members support expanding patients' access to telehealth services. We recognize the benefit and power of this technology, which includes efforts to provide on-going cancer care management to patients in their local communities. The ADCC is concerned, however, that the associated Medicare payment is inadequate to cover even a small proportion of the expense associated with telehealth technology. We believe that any policy to expand telehealth to the Medicare and MA populations must ensure adequate reimbursement. To this end, we urge the CCWG to review and update this payment amount to ensure it is more reasonably aligned with the originating site's costs to provide these important services.

The ADCC also supports the elimination of the requirement for a rural designation for the originating site for *all* severe chronic or potentially chronic conditions (i.e., not only for stroke patients), including cancer patients and patients requiring bone marrow transplants. The ADCC also supports the option to expand telehealth to allow a qualifying originating site to include any renal dialysis facilities located in any geographic area — whether free-standing or hospital-based — and to also expand this option to cancer care. We note that it is important for any healthcare policy expansion to include hospitals and hospital-owned and -operated clinics in addition to free-standing clinics and providers. Doing so is essential to remove artificial limitations that would prevent qualified providers from participating in expanded covered services.

## **Developing Quality Measures for Chronic Conditions**

The ADCC supports efforts to improve and expedite the development of quality care measures, including focused measure sets for chronic conditions. Priority should be given to the following:

- Measures that promote patient and family engagement, shared decision-making, improved care coordination, advance care planning, and superior management of complex comorbidities and psychosocial needs;
- Measures aimed at reducing healthcare and access disparities;
- Measures that promote efficient use of healthcare resources and reduced futile care; and

- Measures with a well-defined cost-benefit relationship.

Additionally, we believe a combination of cross-cutting measures and disease-specific measures should be developed, with an emphasis on measures that are capable of distinguishing high-value cancer care—in particular, outcome measures related to functional status and quality of life, recovery, and survival. Measure development should be guided by a formal long-term strategy, and measures should be organized into parsimonious disease-specific measure sets that are easily understood by patients. Where possible, measures should be validated across multiple care delivery settings.

We are engaged in this process for cancer care and continue to work among ourselves and with other stakeholders to develop meaningful outcome and patient satisfaction measures. Our first measure evaluates unplanned readmissions in cancer patients, which promotes patient safety and the delivery of more efficient health care. Currently, we are validating condition-specific outcome measure sets developed by the International Consortium for Health Outcomes Measurement (ICHOM) for early-stage prostate cancer and lung cancer.

Finally, as CMS continues to develop meaningful measures, we urge the agency to minimize provider administrative burden to the extent possible. One way to do this is to give measures available from structured data sources the highest priority, and to avoid use of chart abstraction measures as much as possible. Additionally, lack of data should not impede measure development. Rather, parallel efforts should focus on enhancing health information technology so that measure-related data elements are captured in a structured format.

### **Encouraging Beneficiary Use of Chronic Care Management Services**

The ADCC supports policies to reduce beneficiary out-of-pocket cost-sharing for chronic care and care coordination services. Such policies should not only include CCM services, but also extend to ACP services and prolonged evaluation and management visit services. In addition to waiving cost sharing, the ADCC encourages the CCWG to examine the existing reimbursement assigned to both the CCM and ACP services under both the Medicare Physician Fee Schedule (MPFS) as well as the Outpatient Prospective Payment System (OPPS). We believe that significant time and resources are expended on these services, yet current reimbursement levels are woefully inadequate. This may explain the low frequency that Medicare sees in its claims data for the existing CCM codes.

Additionally, given how the ADCC members schedule and deliver care, we believe it is important that CMS allow for separate payment under the OPPS for ACP services, rather than making these services only conditionally payable. This means that ACP services should generate separate reimbursement even if they are provided on the same date of service, such as chemotherapy or some other scheduled visit or procedure.

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

The ADCC supports the concept that additional time is needed with patients and families who have received the devastating diagnosis of a traumatic or other life-threatening illness. We believe that patients with life-threatening illness, including those with cancer, can benefit from care management, advanced care planning, and other similar types of services that recognize the additional time and additional services required to help patients and families process information (i.e., treatment options, prognosis, change in treatment options, etc.). Certain existing codes/services, such as the CCM and ACP codes, are a step in the right direction, but we agree that creation and use of an additional one-time

prolonged visit code would be useful in providing even more resources and care management services to patients with life-threatening illnesses. The ADCC encourages the CCWG to work with CMS to develop a National Coverage Determination to recognize coverage of such a new code for certain diagnoses.

Additionally, the ADCC requests that the CCWG request that CMS allow existing codes — such as CCM, ACP, prolonged visits, etc. — to be covered at a frequency that ensures patients and their families are able to absorb the information needed for on-going care and disease management. We also request that beneficiary cost-sharing be eliminated for the proposed new one-time visit code for post initial diagnosis of serious or life-threatening illness.

### **Increasing Transparency at the Center for Medicare & Medicaid Innovation**

The ADCC supports the Center for Medicare and Medicaid Innovation (CMMI) and understands its purpose is to test innovative payment and service delivery models to reduce program expenditures while preserving and/or enhancing quality of care. In selecting models to test, we recognize the Secretary of Health and Human Services (HHS) gives preference to models that improve the coordination, quality, and efficiency of health care services. We encourage the CCWG to finalize modifications that would require CMMI to issue notices and comment rulemaking for all models that affect a significant amount of Medicare spending, providers, and/or beneficiaries. We also recommend that CMMI be required to issue notice and comment rulemaking for all mandatory models with at least a 60-day public comment period.

Given the number of new initiatives being tested, we believe it is important for CMS to obtain public input and to increase transparency around any care models that are implemented. In addition to formal rulemaking, we believe policy and other subregulatory documents are key to providing notice about the types of models that are being considered. Providers typically need more than 60 days to read, digest, formulate, vet, and submit thoughtful comments that address both operational issues and overall impact. Therefore, we would appreciate efforts by CMMI to provide information to the community in advance of formal rulemaking.

### **Medication Therapy Management (MTM), Medication Synchronization, Obesity Drugs, & Behavioral Health**

ADCC members have extensive experience with medication management. It is our experience that successful medication management that addresses serious polypharmacy risks must be supported by qualified pharmacists in addition to the patient's treating physicians. Qualified pharmacists as directed by a treating physician provide critical expertise to the healthcare team that not only supports and implements medication synchronization, but also reduces overall pharmacy costs and the risk of adverse side effects. Pharmacists are also key stakeholders in the development of innovative strategies for medication management for patients who have chronic conditions and behavioral health issues. For example, cancer patients often experience behavioral health issues associated with the stress of coping with their diagnosis, along with the treatment therapies and their side effects, which can be difficult to manage. For this reason, we urge the CCWG to consider Medicare and MA coverage and payment for MTM by qualified pharmacists. Pharmacists are critical to the successful management of polypharmacy and can be key drivers for achieving high-quality care and outcomes for patients with chronic illnesses, such as cancer and dementia.

## **Conclusion**

Thank you in advance for your consideration of our comments. If you have any questions or would like to discuss these comments, please do not hesitate to contact me, [Karen.Bird@adcc.org](mailto:Karen.Bird@adcc.org); our outside counsel, Jorge Lopez, [jlopez@akingump.com](mailto:jlopez@akingump.com); or our technical consultant, Jugna Shah [jugna@nimit.com](mailto:jugna@nimit.com).