



American Association on Health & Disability

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AAHD - Dedicated to better health for people with disabilities through health promotion and wellness



LAKESHORE

January 28, 2016

Re: Bipartisan Chronic Care Working Group Policy Options, Senate Committee on Finance

Chronic_care@finance.senate.gov

The Honorable Orrin Hatch
The Honorable Johnny Isakson
The Honorable Ron Wyden
The Honorable Mark Warner

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

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments and policy ideas to enhance interventions to assist persons with chronic conditions.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

We have coordinated our comments with members of the Consortium for Citizens with Disabilities (CCD) and Leadership Coalition of Aging Organizations (LCAO). We endorse the CCD comments submitted to the Committee. We also incorporate recommendations submitted to the Committee by Community Catalyst, the Medicare Rights Center, and No Health Without Mental Health.

Overarching Principles

We endorse the proposed principles submitted by the Medicare Rights Center:

“First and foremost, as the Committee moves forward, we encourage you to consider the following overarching principles:”

- Pursue innovations in both traditional Medicare and Medicare Advantage;
- Learn from ongoing demonstrations and test any new or revised care models;
- Couple targeted MA policies with system-wide MA improvements; and
- Incorporate robust, detailed, and specific beneficiary protections.

Finance Committee Policy Options Goals

As stated by Community Catalyst to the Finance Committee: “We applaud the Working Group on its commitment to identifying an impressive set of proposed policies that meet three goals, which we share:”

1. Increasing care coordination among individual providers across care settings who are 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.
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.

We fully endorse the Community Catalyst proposed 4th goal: **reducing health disparities** among diverse populations, including racial and ethnic minorities, LGBT people, those with disabilities and other groups facing disparities.

Providing Continued Access to MA SNPs for Vulnerable Populations

As preliminarily discussed within some in the disability community, we support an expanded and adapted SNP-PACE program, whose elements would include:

1. Person centered services – that reflect individual goals, priorities and situations
2. Functional independence – care planning focuses on prevention and supporting consumers in optimizing their physical and mental health and functional independence.
3. Comprehensive benefits – that includes all medical, social and supportive services
4. Interdisciplinary teams – that assess needs, and plan and deliver health care and LTSS
5. Intensive community based care –that serves individuals in their homes and communities
6. Capitated financing – that combines Medicare, Medicaid and private financing
7. Rigorous quality standards and performance measures – that assess and improve quality

We also support the Community Catalyst recommendations; any SNP program should include:

1. Robust, trained and culturally-competent provider networks that include a sufficient number of experienced providers able to meet the complex medical and support-service needs of members with multiple medical conditions and/or disabilities.
2. The use of a comprehensive and conflict-free assessment of each beneficiary’s needs that includes an evaluation of functional status, social and vocational needs, socioeconomic factors, personal preferences and the ability to obtain accessible services.
3. The use of an interdisciplinary care team comprised of a beneficiary’s primary care physician and other providers, as needed, to support the consumer; including but not limited to nursing, social work, behavioral health, long-term services and supports and pharmacy.
4. Contracts with existing community-based providers of long-term services and supports.
5. Offering all beneficiaries in need of personal care attendant services the option for self-direction.
6. The use of an independent long-term services and supports coordinator.
7. Meaningful consumer representation on D-SNPs’ governing boards and advisory committees as well as the use of other means of soliciting member feedback, such as focus groups or member meetings.
8. An easy-to-navigate and integrated appeals and grievances system.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

We support the integration of primary care into behavioral health settings and the integration of behavioral health into primary care settings. Any study and analysis should start with the lessons learned from the existing SAMHSA-HRSA and AHRQ BH-PC integration initiatives. These are multi-year, multi-million dollar investments, with dedicated federal and contractor specialist staff.

We agree with the observations of our sister organization, No Health Without Mental Health, submitted comments: “the separate, siloed BH payment and service delivery procedures lead ACOs to exclude active BH participation for logistical reasons. Policy proposals must be developed to overcome this systemic barrier preventing integrated care delivery.”

We agree with the suggestion of both Community Catalyst and No Health Without Mental Health: Promote the collaborative care model, which provides team-based care and has a growing research base. SAMHSA-HRSA-AHRQ have documented successes of this and similar models.

Many in the behavioral health field, and Community Catalyst in their submitted comments to the Finance Committee recommend: “Pay for peer support/recovery services as part of integrated care. There is growing evidence of the value of peer support and recovery services in the care of people with mental illness and substance use disorders. A number of Medicaid programs pay for peer services. Adding peers as a provider category in Medicare would help expand the services available for behavioral health.” Numerous studies exist, starting with SAMHSA’s Center for Mental Health Services. AAHD and Lakeshore Foundation fully endorse these ideas.

Developing Quality Measures for Chronic Conditions

We concur with the Finance Committee paper that the “top areas” for quality development should be patient (person) and family engagement, shared decision-making, care coordination, hospice-Alzheimer’s, and targeted conditions in “community-level” measures.

We strongly suggest that the Committee incorporate the 2013, reaffirmed in 2014 & 2015, National Quality Forum workgroup on persons dually-eligible for Medicare and Medicaid, recommendations to CMS concerning “high-priority measure gaps.” These are:

1. Goal-directed, person-centered care planning and implementation
2. Shared decision-making
3. Systems to coordinate healthcare with non-medical community resources and service providers
4. Beneficiary sense of control/autonomy/self-determination
5. Psychosocial needs
6. Community integration/inclusion and participation
7. Optimal functioning (e.g., improving when possible, maintaining, managing decline)

In its 2015 report to CMS, the NQF workgroup on persons dually eligible, shared a participant survey finding of priorities (which are also consistent with 2013-2014 gaps):

1. Beneficiary Experience
2. HCBS access and Rebalancing LTSS-transitions-care coordination
3. Health and general well-being (shift away from purely clinical outcomes)
4. Influence of social determinants of health

We also share with the Finance Committee, the Consortium for Citizens with Disabilities (CCD) Task Force on Long-Term Services and Supports July 2012 identified six gaps in existing quality standards as they directly relate to persons with disabilities. These are:

1. Consumer Choice and Participant-Directed Services
2. Satisfaction: Individual Experience with Services and Supports
3. % in employment or meaningful day activity

4. % in independent housing – Consumer choice, housing appropriateness, stability
5. Integrated primary and specialty care
6. Access to timely and appropriate care

Expanding the Independence at Home Model of Care

We endorse the CCD's observations supporting the expansion of the IAH's interdisciplinary primary care model. Expanding the current IAH demonstration into a permanent, nationwide program is the logical next step toward improving quality of care, eliminating inefficiencies in care delivery, and maximizing patient outcomes for those with chronic conditions. IAH would bring back "house calls" with 21st Century technology, quality measurement, and a team-based psycho-social approach to care much needed by some of Medicare's most vulnerable beneficiaries.

Promote Models to Combine Housing Plus Services for Low-Income Seniors.

We repeat a recommendation from the June 18, 2015 disability and aging collaboration submitted comments to the Finance Committee:

Low-income housing can be a platform for providing health and social services, reducing Medicare and perhaps Medicaid costs. Affordable housing properties linked with health and supportive services provide an option for meeting the varied needs of low-income older adults, while also helping address multiple public policy priorities. Low-income, dually eligible beneficiaries are the biggest users of health and long-term care services; housing with services enhances access to necessary services and supports, helping individuals to better manage their conditions and coordinate their care needs.

Housing Plus Services models focus on low-income seniors in subsidized housing, building on the existing infrastructure of housing, health, and community service networks. With the concentration of high-risk, high-cost residents, many of whom are dually eligible for Medicare and Medicaid, senior housing offers an economy of scale that can increase delivery efficiencies for providers and affordability for older adults. Older adults gain easy access to services, which encourages greater utilization and follow-through. We encourage the Committee to explore opportunities to integrate Housing Plus Services models in future legislation.

Rehabilitation Services and Devices

We repeat the CCD observation that the Policy Options Document makes no reference to rehabilitative services and devices. Rehabilitation is key to the ability of beneficiaries with chronic conditions to maintain their functional status and independence while managing their comorbid illnesses or conditions. Maximizing functional status and independent living for beneficiaries with chronic conditions will save Medicare significant dollars in the long term. We request that the Work Group consider inclusion of policy proposals that advance access to

appropriate rehabilitation services and devices. CCD has offered to share ideas with the Committee.

Increase Funding for State Health Insurance Assistance Programs (SHIPs):

We endorse the Medicare Rights Center recommendation: Adequate funding for SHIPs nationwide is absolutely vital to ensuring that people with Medicare are supported in making plan decisions. Sustained by federal, state, and local funding, SHIPs are the go-to resource for people with Medicare and their families who have questions about Medicare and related programs.

Improve Beneficiary Notices:

We endorse the Medicare Rights Center recommendation, urging the Committee to advance needed improvements to standard beneficiary notices, both to encourage people with Medicare to evaluate their coverage options and to make plan comparisons easier. Most importantly, we encourage the Committee to support policies to strengthen the Annual Notice of Change (ANOC) through the addition of individually tailored content. We continue to advocate for an individualized ANOC to better serve beneficiary needs, specifically one that details which specific providers are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, where utilization management tools will be newly applied, and so forth—customized according to the actual providers, services, and prescription drugs that an individual beneficiary utilizes.

Improve the Beneficiary Experience with MA Denials and Appeals:

We endorse the recommendations of the Medicare Rights Center: As the Committee continues to develop policy options related to MA, we urge you to explore opportunities to improve the beneficiary experience with denials of coverage, appeals, and grievances as part of any legislative package to improve care delivery for those with multiple chronic conditions. Options to improve the MA appeals process include:

- Increased transparency and public data on how MA plans manages denials, appeals, and grievances;
- Strengthened support for beneficiaries, SHIPs, and other professionals to assist with MA appeals;
- Enhanced CMS monitoring and enforcement of plan requirements related to appeals; and
- More proactive involvement by MA plans and health care providers in the management of appeals.

Importantly, we believe the Committee's efforts should complement initiatives already underway at CMS to improve the Part D appeals process, including planned enhancements to beneficiary

denial notices and strengthened data collection at each stage of the appeals process. In addition, we encourage the Committee to draw on lessons learned from a recent CMS pilot initiative examining how plan outreach to prescribers and collaboration with pharmacists can facilitate improved beneficiary access to needed prescription drugs, without requiring the beneficiary to formally request coverage after a rejection at the point of sale.

Incorporate Robust, Detailed, and Specific Beneficiary Protections:

We agree with the Medicare Rights Center recommendation: Naming adequate consumer protections is vital to the design of any new or revised care model intended for individuals with multiple chronic conditions. Protections related to enrollment, marketing, grievances, and complaints as well as denials and appeals must be incorporated. Public reporting, rigorous oversight, and independent evaluations are also essential.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkross10@comcast.net.

Sincerely,



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Member, National Quality Forum (NQF) workgroup on persons dually eligible for Medicare and Medicaid and NQF population health task force (<http://www.qualityforum.org/>) and NQF representative of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports (<http://www.c-c-d.org/>). 2015-2016 and 2014-2015 NQF duals workgroup liaison to the NQF PAC/LTC workgroup. Member, ONC (Office of the National Coordinator for Health Information Technology) Health IT Policy Committee, Consumer Workgroup (<http://www.healthit.gov/policy-researchers-implementers/federal-advisory-committees-facas/consumer-empowerment-workgroup>). Member, SAMHSA Wellness Campaign National Steering Committee – January 2011-September 2014. (<http://promoteacceptance.samhsa.gov/10by10/>).

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