



January 26, 2016

Submitted via email at: chronic_care@finance.senate.gov

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Chronic Care Working Group, Co-Chair
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
Chronic Care Working Group, Co-Chair
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Bipartisan Chronic Care Working Group Policy Option Document

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

Blue Shield of California (BSC) appreciates the opportunity to provide comments on the Bipartisan Chronic Care Working Group Policy Option Document and thanks you for your commitment to improving care for Medicare beneficiaries with chronic conditions.

BSC is a non-profit health plan that offers health benefits coverage to individuals and groups throughout the State of California. Our mission is to ensure that all Californians have access to high quality care at an affordable price. In 2011, BSC was the first, and remains the only, health plan to voluntarily place a cap on its earnings. Since then, we have limited our net income to 2% of our annual revenue.

As a non-profit, Blue Shield's mission is to increase the number of insured Californians, improve health care quality, and provide higher-value care. BSC is dedicated to creating a health care delivery system that is worthy of our family and friends, a goal that can be better achieved through innovative approaches to care delivery.

We have focused our comments on several policy options that we believe have the potential to improve health care quality for individuals with chronic conditions.

Expanding the Independence at Home Model of Care

The Independence at Home model aligns with BSC's goal of enabling physician practices to provide home-based primary care to individuals who have multiple

comorbid conditions, are homebound, or would otherwise be unable to reach the physician's office due to complications with mobility. While we support the expansion of Independence at Home and hope that more practices will be able to participate, we propose the following changes to the model in order to further improve patient satisfaction and quality, while still lowering costs:

- The inclusion of a palliative care consultation for every beneficiary. All beneficiaries eligible for this model are eligible for a palliative care consultation and would benefit from having an advance directive or Physician Orders of Life Sustaining Treatment (POLST) document on file. In addition, we suggest that either the documentation of a medical surrogate or the documentation of an advance directive or POLST become a quality incentive, as they show a positive correlation with reduction of readmission rates, earlier acceptance of hospice, and an increase in patient and provider satisfaction.
- Allow inclusion of eligible commercial and Medicare Advantage beneficiaries to participate in the model. Many states in the Western United States have a higher rate of Medicare Advantage beneficiaries, leaving a smaller population to participate in these Medicare-specific pilots. Allowing these beneficiaries and the health plans administering the Medicare Advantage product to participate will make it more financially viable for physician practices to participate in the expanded Independence at Home program.
- Include hierarchical condition categories (HCC) risk scores in addition to non-elective hospitalization criteria. We support the expansion of the eligibility criteria to also include hierarchical condition categories risk scores to denote the evidence of progressive, complex chronic conditions. However, we suggest that a beneficiary can either qualify with a HCC risk score or with a non-elective hospitalization within 12 months. This would allow for those beneficiaries who have care gaps or have been inappropriately coded (with regard to HCC) to be eligible to qualify for in-home primary care.

Providing Medicare Advantage Enrollees with Hospice Benefits

BSC strongly supports the recommendation that Medicare Advantage plans can provide enrollees with hospice benefits. With the rise in long-term progressive conditions, it has become increasingly difficult for physicians to attest to a six-month eligibility requirement for hospice election. This, along with increased demand caused by the improved quality of life many patients receive in hospice, has caused the difficult and disruptive side effect of live discharge from hospice. The discontinuity of care with regard to hospice eligibility and service provision is not only difficult for the individual and their family, but it also makes it difficult for health plans and providers to develop a long-term shared care plan. With the management of a hospice benefit by the Medicare Advantage plan, accountability for the member will remain with the plan and there will be more incentive for the plan to transition the member earlier to hospice through the use of care coordination and transition management. In addition, providing hospice through the health plan would eliminate the need to create separate Medicare Advantage

contracts for hospice agencies providing palliative care services prior to a patient's election of, or eligibility for, full hospice care.

In order to maintain richness of benefits in all Medicare Advantage health plans providing hospice care, we propose the following plan-level measures:

- Establish minimum benefit requirements equivalent to the current Medicare hospice benefit, without the requirement for the six month physician attestation and annual recertification;
- Require the completion of an advance directive or POLST;
- Require an interdisciplinary care team, including: physician, advanced practice nurse, social worker, home health aide, and pharmacist;
- An additional requirement of a child life specialist for pediatric hospice cases;
- Require documentation of a care plan as well as a transition plan should the patient's condition improve and he or she graduate from hospice care;
- Require hospice or palliative care certification for case management teams interacting with the hospice patient and family;
- Require inclusion of grief and bereavement services for at least one year following the death of a patient on hospice;
- Require the ability to identify and document when a member died through data;

BSC also recommends that a taskforce be developed to identify and agree upon hospice measures to be included in the Medicare STARs rating system.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

BSC does not support the establishment of a new, high-severity chronic care management code. While we understand the need for additional reimbursement for provision of care to individuals with five or more chronic conditions or for more complex needs, reimbursement for this care management is not suitable for fee-for-service. We would instead recommend that individuals identified as high-severity be eligible for care reimbursed through bundled payment. These members are much better suited for a team-based approach to care, with an established care plan and the time to address multiple issues.

Developing Quality Measures for Chronic Conditions

BSC strongly supports the establishment of quality measures for all members with chronic conditions. All other measures identified by the Secretary of Health and Human Services, as required under the Medicare Access and CHIP Reauthorization Act of 2015, are highly critical for the delivery of appropriate, timely, and high-quality healthcare. In addition, the proposed measures on documentation of patient preferences at end of life, creation of shared care plans, and data collection on family experience of care, allows for a transformation in the provision of palliative and end of life care. This will allow individuals and their families to receive high quality care while improving patient satisfaction, avoiding overtreatment, and improving provider and family satisfaction. Standardized, patient-centric measures across all health plans and Medicare has the ability to accelerate transformation of care delivery and promote equity of quality care provision

for providers. With one set of measures, providers will be required to provide the same type of shared decision making and quality regardless of the patient's coverage.

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

BSC strongly supports the establishment of a one-time visit code post initial diagnosis of Alzheimer's/dementia or other serious or life-threatening illness. While we recognize the availability of physician consult codes and the advanced care planning visit codes, the documentation of an initial diagnosis of a serious illness would allow for better understanding of the progression of long-term serious illness. In addition, we are committed to the establishment of goals for care at the point of initial diagnosis of a serious or life-limiting illness, as it allows for improved care coordination and early referral to social and behavioral health support services for the individual and their family. Early intervention of palliative care and social support services has been proven to prevent initial admission while a patient is establishing an understanding of their newly-diagnosed condition. We strongly believe that the diagnosis of a serious or life-threatening illness warrants a planning visit, as there are additional population-health factors and comorbidities that must be considered upon initial diagnosis.

We recommend that the following condition categories be included for consideration of a Medicare-covered planning visit:

- Cancer
- Heart Failure
- Lung Failure
- Chronic Kidney Disease, stage III
- Neurodegenerative disease (MS, ALS, Parkinson's, etc.)
- Dementia, Alzheimer's, and other progressive neurocognitive impairments
- Cirrhosis
- HIV/AIDS

We recommend that the planning visit not focus solely on disease-specific elements but that the patient holistically be engaged in developing a care plan. Additionally, in order to identify the current and future medical and non-medical needs of the patient, we recommend planning visits include elements of the eight domains of quality palliative care in their assessment, as established by the National Consensus Project for Palliative Care's Clinical Practice Guidelines for Quality Palliative Care.¹ Since the focus of this visit is on planning and documentation of goals of care, it would not overlap with the chronic care management code that is dedicated to care coordination.

In closing, Blue Shield of California appreciates the opportunity to respond to the working group's policy options document, and we look forward to working with the committee and stakeholders to create a health care delivery system that best serves all enrollees, including those with chronic conditions.

¹ National Consensus Project for Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care, Second Edition*, pages 14-73.



Sincerely,

A handwritten signature in black ink that reads "N. Marcus Thygeson, MD MPH". The signature is written in a cursive style.

N. Marcus Thygeson, MD, MPH
SVP, Chief Health Officer