



June 22, 2015

The Honorable Johnny Isakson
United States Senator
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senator
475 Russell Senate Office Building
Washington, D.C. 20510

Dear Senators Isakson and Warner:

The Healthcare Leadership Council (HLC) applauds the Senate Finance Committee's focus on improving care for Medicare Patients with Chronic Conditions and the formation of the bipartisan, full Finance Committee chronic care working group. Your leadership in this effort will be critical to paving the way for improved care for patients with chronic disease both inside and outside the Medicare program, because Medicare's size often drives the rest of the insurance market. The effects of such a transformation cannot be understated. As you noted in your request for information, treatment of chronic illness accounts for almost 93 percent of Medicare spending, and more than two-thirds of beneficiaries that have multiple chronic conditions. These costs are unsustainable and will worsen with the rapidly changing and growing Medicare population. The ideas offered below will make a meaningful difference to patients while also improving the long-term financial viability of the Medicare program. We urge you to consider us a partner as the working group moves forward with its efforts.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible to all Americans. Members of HLC--hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, and information technology companies--advocate measures to increase the quality and efficiency of healthcare by emphasizing wellness and prevention, care coordination, and the use of evidence-based medicine, while utilizing consumer choice and competition to enhance value.

HLC's membership is at the forefront of improving care for patients with chronic conditions. Based on decades of experience in implementing and developing policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs, we strongly believe in the results. Our signature compendium, *The Future Is Here* (www.hlc.org/compendium) outlines several important examples of ways that HLC members--as health providers, community leaders, and large employers--are demonstrating quantifiable health improvements and cost savings.

Policy Goals

HLC strongly supports the working group's goals to (1) increase care coordination across care settings for patients living with chronic diseases; (2) streamline Medicare's current payment systems to incentivize the appropriate level of care; and (3) facilitate the delivery of high quality care, improve care transitions, produce stronger patient outcomes, increase program efficiency, and contribute to an overall effort that will reduce the growth in Medicare spending.

Increase Care Coordination

HLC members are concerned with the long term sustainability of the Medicare program. The majority of people in Medicare have five or more chronic conditions, with more and more of them related to cognitive impairment or behavioral health. Also, with the entrance of the Baby Boom population into Medicare (the number of people enrolled in Medicare will nearly double in the next 20 years, from 47 million in 2010 to 80 million by 2030), it is vital to address chronic disease to maintain the viability of the program.

Care coordination is one of the most critical components of managing chronic conditions. The new addition of reimbursement for primary care coordination activities is an important first step, but does not automatically provide access or reimbursement for the suite of team-based care many patients need. We encourage the working group to think broadly about the members of a patient's care team and include all those who are involved both inside and outside the traditional health system. To move beyond the status quo, the working group should include nonphysician providers in any team-based models as well as incorporate community-based organizations, public health resources, and social services into supporting care coordination practices and policies to avoid lapses in treatment and compliance. The outsized role of caregivers in the health of patients should also not be overlooked.

Streamline Medicare Payment Systems

In order to maximize Medicare's current payment systems, it is important to create incentives for Medicare to more fully adopt prevention and early intervention measures that will enable beneficiaries to stay healthy longer, or begin managing chronic disease sooner. Diabetes is a clear example of how prevention, delivered in a low-cost community setting, can pay dividends for the health of seniors by reducing the prevalence of the disease while equipping those with or at risk for diabetes with the skills needed to manage their health, but this evidence based service is not covered by Medicare. Obesity, now classified as a disease by the American Medical Association (AMA), also offers a good example of where Medicare can shift to prioritize prevention rather than high-cost treatments as the condition worsens. Currently, Medicare covers intensive behavioral therapy (IBT) when provided in a primary care office and bariatric surgery (though fewer than 1 percent of beneficiaries have used the IBT benefit and surgery is only approved for those meeting certain criteria) but does not cover prescription medicines approved to treat obesity, nor the evidence based, low cost community setting IBT services. By covering such pharmaceutical therapies and evidence based community IBT services, Medicare would shift the emphasis away from

more dramatic surgery options and refocus on incremental weight loss as a way to stave off the complications and comorbidities of obesity.

The working group should also explore streamlining the payment system and quality measure landscape. Currently, many measures for chronic conditions are misaligned or missing. Overlapping or contradictory quality measures should be harmonized across different Medicare payment programs so that patients and providers can work toward common goals. However, it is important to note that in the area of multiple chronic conditions, there are very few clinical guidelines to form the basis for quality measures. These gaps need to be addressed before quality measures can more fully be used as a tool in paying for value for patients with multiple chronic conditions. Furthermore, existing single condition guidelines may penalize providers providing customized care to a patient with multiple chronic conditions. (For example, a doctor may find that a patient with diabetes and another condition should not keep their blood sugar in the recommended range owing to the second condition.) Measures should be outcomes based, as opposed to process orientated and streamlined so as not to be overly burdensome.

Elevating Quality While Reducing Spending

While we understand the financial constraints facing Congress and the desire to focus on cost-saving options, we urge the committee to consider important investments in health and well-being that will pay dividends later. HLC supports viewing savings from wellness and prevention in a longer timeframe than the traditional 10 year “scoring window.” We also know that improved health has significant ramifications beyond the ledgers of federal health programs, and these effects--including the ability to remain in the community and continue working--should be considered as well.

Specific Recommendations

In response to your areas of inquiry, we offer the following suggestions:

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions.

Medicare Advantage (MA) plans offer seniors enhanced benefits such as choice of doctors, help managing chronic conditions, dental and vision coverage, and wellness and fitness services. This year, the Centers for Medicare and Medicaid Services (CMS) announced that MA enrollment has increased more than 40 percent since 2010 and premiums have fallen by nearly 6 percent from 2010 to 2015, and studies show that seniors are very satisfied with their MA plans. Peer-reviewed research has demonstrated that MA plans are more effective than traditional fee-for-service (FFS) Medicare at addressing chronic conditions.

MA plans need stability and predictability in order to offer beneficiaries coordinated, evidence-based care. In April, CMS released the 2016 Call Letter outlining MA changes. Although payment changes will affect plans differently depending on the characteristics of those plans, on average, plans should see a 1.25 percent payment

increase. HLC urges the working group to promote and advance high-quality, value-based healthcare by working with CMS to sustain the MA program at current levels in order to maintain choice and high value care.

To further improve MA, we suggest the following additional policies:

- *Fix the new CMS Risk Adjustment Model*
In this year's 2016 Medicare Advantage Final Call Letter, CMS fully implemented a new risk adjustment model, despite concerns expressed through the comment period about the negative impact this model would have on plans that had a significant number of higher acuity patients participating. The new model may undermine the ability of high-performing plans to continue to successfully deliver coordinated care and additional services to vulnerable beneficiaries. HLC hopes that the workgroup can direct CMS to reevaluate and change the risk adjustment model. Legislation that passed the U.S. House, the "Increasing Regulatory Fairness Act," (H.R. 2507), would focus on risk scores that take into account the number of chronic conditions, the impact of including two years of data to determine risk scores, and the impact of the removal of chronic kidney disease codes. We also support efforts to establish a separate risk adjustment comment period in advance of the annual rate notice, similar to what CMS currently does with the Star ratings program. Such a process would increase the transparency and improve the accuracy and credibility of the risk adjustment models. Taking into account the views of patients, providers, payers, and other thought leaders not only will result in better care, but also lead to greater stability to the annual rate notice process.
- *Community-Based Institutional Special Needs Plan (CBI-SNP)*
HLC supports the formation of a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration in five states to provide targeted community-based, long-term services and support (LTSS) to low-income Medicare beneficiaries who are functionally impaired. These individuals are at great risk of spending down their meager assets through nursing home placement and then becoming dually eligible for Medicare and Medicaid. Enabling these seniors to remain in the community could significantly improve their quality of life while simultaneously delivering savings to both states and the federal government. (Avalere Health has estimated the budget impact and found the demonstration would generate a total net savings of \$39.7 million for 5,000 initial participants, or \$8,085 per participant per year, over four years, through the reduction of hospitalizations and re-hospitalizations.) Senators Chuck Grassley (R-IA) and Ben Cardin (D-MD) have introduced legislation to this effect, "The Community Based Independence for Seniors Act" (S.704).
- *Additional Flexibility for MA Plans*
HLC recommends that the workgroup consider areas where MA plans can be allowed more flexibility to provide better coordinated or personalized care for their patients. One way Congress can do this is to follow the recommendation of

the Medicare Payment Advisory Commission (MedPAC) to allow the variation of benefits based on enrollee health needs. Additional flexibility would allow plans to do things like waive or eliminate copays on certain medications for one population, provide additional transportation for patients with frequent appointments, or waive the copay on a type of specialist visit based on an individual's health needs. The ability to tailor benefits to the specific needs of the individual will result in both increased access to care and higher adherence rates.

Another area where additional flexibility could improve the MA program is the inclusion of telehealth services as part of the basic benefit package and not limited to the amount of supplemental benefit funds available.

Finally, the working group should consider ways to improve the 5-star rating system to more adequately account for the socio-economic status of Medicare beneficiaries. For example, we support efforts that would require CMS to announce cut-points prospectively, using historical performance to establish thresholds for the following measurement year. This way, MA plans can integrate performance targets for 4 and 5-star ratings into value-based provider contracts for the coming plan year. This will also enable beneficiaries to better use this information to assess plan quality.

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

As the healthcare system transitions toward paying for value of care rather than volume of services, Congress has legislated and the Center for Medicare and Medicaid Services (CMMI) has implemented alternative payment models (APMs) for the Medicare program. The Medicare Shared Savings Program (MSSP), in which Accountable Care Organizations (ACOs) participate, is a key part of this move. With two-sided risk, providers and payers are rewarded for doing more to improve population health and taking on patients that are most in need of care coordination. Many examples currently exist that the workgroup can examine to expand further APMs and enhance care for patients with chronic disease. HLC supports an increased emphasis on two-sided risk and awaits the progress toward the Department of Health and Human Services (HHS) goal of tying 30 percent of all traditional Medicare payments to APMs such as ACOs and bundled payments by the end of 2016 (and increasing to 50 percent by the end of 2018).

We are also optimistic about the move toward APMs brought about by the replacement of the Medicare physician payment sustainable growth rate. Replacement of the Medicare physician payment formula lets doctors pick from two ways to participate in that payment structure: 1) They can join the Merit-Based Incentive Payment System (MIPS), which rolls three incentive programs into one that gives doctors a quality score. If their scores meet a certain threshold, doctors' payment rates will increase; and 2)

They can sign up to be part of an APM payment arrangement that requires a group of doctors to band together and take a lump sum of money to care for a certain group of patients. If they can provide the care for less--and achieve certain quality metrics--they will share the savings. This legislation will do much to lay a clear path for providers and also change the system in ways that will make it more sustainable for the long term.

To further enhance MSSP, ACOs, and APMs HLC recommends:

- *Socioeconomic Status*
Shared-risk models that are based on the health of broad population should take care to factor in the socioeconomic status (SES) of the population. In areas where Medicare adjusts performance metrics and associated payment based upon clinical factors such as severity of the patient's illness, including the instance of multiple conditions or comorbidities, it is necessary to closely examine the adjustments so that no healthcare provider is penalized for accepting responsibility for the care of the sickest and most clinically complex patients. HLC believes that payment and performance metrics should also incorporate sociodemographic factors such as income, education, language proficiency, social support, living conditions, and available community resources. These variables can have a profound effect upon the patient's adherence to the treatment plan recommended by a medical professional. The current system, which does not account for these factors, creates an uneven playing field for performance measurement and subsequent performance-based payment. Furthermore, adjusted performance measures are critical for patients, payers, and others to make fair comparative conclusions about quality and value.

Alternatively, providers dealing with a population of high SES status may find it frustrating that once they addressed care transitions, "hot spots," and patient adherence and self-management, they saw a plateau in savings generated. It is important that Congress and CMS work together to develop incentives to encourage providers to continue to take on two-sided risk.

- *Allow APMs to Tailor Care to Specific Needs*
It is crucial that APMs be structured so that populations with complex needs are not locked into an incentive structure that limits the provider's ability to tailor treatment to the individual.
- *Privacy Policy and Coordinated Care Models*
It is also important to note that the management of chronic conditions, including mental health and substance abuse, requires the enablement of appropriate and sufficient information exchange among providers who treat individuals under these circumstances. As APMs proliferate, information exchange policy should keep pace with innovations in treatment and payment. HLC is pleased that the Substance Abuse and Mental Health Services Administration (SAMHSA) has solicited information about modernizing the Confidentiality of Alcohol and Drug Abuse Patient Records Regulations, found at 42 CFR Part 2. The regulations

governing the confidentiality of substance abuse treatment information guarantee the confidentiality of information for people who receive substance abuse treatment services from federally assisted programs. The programs may release identifiable information related to substance abuse treatment services only with an individual's express consent.

While the HIPAA Privacy Rule (mainly through HITECH) has been amended to align with advances in healthcare delivery and payment, the federal rules that govern the use and disclosure of alcohol and drug abuse treatment records have not changed since 1987. As such, HLC encourages the committee, in coordination with committees of jurisdiction, to call upon SAMHSA to update the confidentiality provisions for the use and disclosure of alcohol and drug abuse treatment records to enable easier and appropriate sharing between healthcare providers.

A major barrier under the current rules is the strict consent requirements that prohibit listing future unnamed providers on the consent form. Each time a new provider joins a coordinated care organization, such as an ACO, the organization needs to update the consent form. This stifles efforts to share important information among care providers working collectively to manage treatment.

Knowing about a patient's history of mental illness or substance abuse disorders and their past treatment is vital to proper and safe care. Sharing information on diagnosis, treatment, and care plans can help practitioners and families promote effective, comprehensive treatment plans to meet the needs and reduce the risk of medical error for those with certain chronic conditions, like substance abuse and addiction.

3. Reforms to Medicare's current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions.

As you noted in your request for information, there are inherent limitations in the FFS payment system that prevent the best care coordination. The Affordable Care Act (ACA) introduced some care coordination in Medicare, but much more can be done to help Medicare step toward better care coordination and ensuing health outcomes.

- *Maintaining Continuity of Care In the Transition to Medicare*
To aid care coordination for seniors entering Medicare, it will be important for Congress to address gaps of care patients face when moving from private insurance to Medicare. One particular example of such a disruption is continuous glucose monitoring technology (CGM). Despite the fact that it has been in use for over a decade, Medicare does not cover CGM technology.

By detecting glucose readings every five minutes and providing trending and alerts to warn of dangerous high or low blood glucose levels, this technology can provide life-saving information before it is too late. All leading diabetes

professional societies recognize the value of CGM and recommend it in their clinical guidelines, and 95 percent of private insurers cover CGM, including Federal Employees Health Benefits Program (FEHBP). Many diabetes patients rely on this technology to manage their care and unfortunately lose access when they turn 65. Numerous studies, including one by the Agency for Healthcare Research & Quality, show CGMs improve glucose control and health outcomes. As keeping blood glucose levels as close to normal can help prevent or delay diabetes complications, it is crucial that we allow patients to use the best tools for them to achieve their health goals. The “Medicare CGM Access Act of 2015” (S. 804) would provide Medicare coverage of CGM devices and therefore allow patients to transition to Medicare and continue to use the lifesaving products they are used to using.

Another area where Medicare lags behind private sector payers, and causes disruption among patients making the transition to the program is obesity drugs and evidence based community IBT. Today, patients in several federal health programs (including the Veterans Health Administration, the Indian Health Service, and FEHBP) as well as many private payors have coverage for pharmacotherapy and evidence based community IBT for weight loss, and these benefits should be able to be maintained as circumstances change and the patient enters Medicare. These disruptions in care will only grow as more insurers extend coverage for these therapies.

Congress should address both of these gaps in care to avoid setbacks in patient health when they enter the Medicare program. Additionally, the working group should consider the role of patient navigators and other ways that patients and caregivers can improve their interaction with the Medicare system so that valuable time spent with the physician can be focused on patient care and not red tape.

- *Annual Wellness Visit Improvements*
The annual wellness visit, established by ACA, provides seniors with annual visits to get preventive care. However, uptake of this benefit is woefully low. Congress should explore ways to educate patients and providers about the benefit. In addition, during the annual wellness visit, the provider should engage in managing the patients medication and synchronizing prescriptions, not just collect a list of medications and providers.
- *Screenings and Prevention*
By making beneficiaries aware of their health risks and conditions, the health system can help them take the first steps toward prevention, management, or treatment so that further complications are put off or avoided altogether. Diabetes is an excellent example of a chronic disease where early detection is crucial and intervention can make a meaningful difference. Screening for diabetes is a covered Medicare benefit but lack of awareness has contributed to a lack of uptake.

For those who are screened and diagnosed with diabetes or prediabetes, there are many barriers (including low provider awareness, program availability, and lack of reimbursement) to patients accessing treatment that would slow or stop the progression of the disease and its dangerous and costly complications (including cardiovascular disease, stroke, blindness, lower-limb amputation, and kidney disease). The “Medicare Diabetes Prevention Act,” (S. 1131) introduced in the House and Senate, would provide seniors access to the community-based National Diabetes Prevention Program (N-DPP) that has been proven to prevent and/or delay the onset of type 2 diabetes in seniors at high risk for the disease. The bill explicitly allows virtual N-DPP programs to be reimbursed as well as in-person programs, allowing seniors who cannot travel to easily access the program. A study commissioned by the American Diabetes Association, the AMA, and the YMCA of the USA from Avalere Health found that enacting the Medicare Diabetes Prevention Act will reduce federal spending by an estimated \$1.3 billion over ten years.

- *Coordinating care for Medicare’s sickest and most vulnerable beneficiaries*
As the Committee noted in its letter to stakeholders, according to MedPAC, the costliest 10 percent of Medicare beneficiaries accounted for almost 60 percent of annual FFS spending in 2010. This population is more likely to have chronic conditions, including chronic kidney disease, heart failure, and chronic obstructive pulmonary disorder (COPD). More than half (51 percent) of these individuals have five or more comorbid conditions. This population is also more likely to be dually eligible for both Medicare and Medicaid. We encourage the working group to direct CMS to test innovative models of care focused on the costliest 10 percent of Medicare FFS beneficiaries at a cost to the federal government that is lower than the current FFS system. In testing different approaches, the Committee’s chronic care working group should consider the development of models led by MA plans and provider-based ACOs. This approach requires flexibility and program design features not currently available under the MA, SNP, or ACO constructs.
- *Comprehensive Disease Management and Team Based-Care*
There needs to be better financing in FFS Medicare for the transition to team based care to happen more widely. Reimbursement models need to incentivize the incorporation of different types of providers into the team.

For example, the health of diabetes patients would greatly benefit from the addition of registered dietitians and diabetes educators to their team of providers. The “Preventing Diabetes in Medicare Act of 2015” (H.R. 1686) would provide Medicare coverage for medical nutrition therapy services to beneficiaries with prediabetes or with risk factors for developing type 2 diabetes. The “Access to Quality Diabetes Education Act of 2015” (H.R. 1726) would improve access to diabetes self-management training by authorizing certified diabetes educators to provide diabetes self-management training services, including as part of

telehealth services. These bills would provide beneficiaries with important tools to manage their disease, and therefore reduce costly future complications.

In addition to incorporating varied members of the care team, the comprehensive management of chronic disease also must include comprehensive solutions to chronic disease. Providers should be able to employ a wide range of tools to treat disease. For example, as mentioned above, Medicare currently limits the treatment of obesity--classified as a disease by the American Medical Association, and associated with, or a precursor to, more than 90 other chronic medical conditions including cardiovascular disease, diabetes, and cancer--to bariatric surgery and intensive behavioral counseling. However, a recent USA Today report found that fewer than 1 percent of seniors have used the new behavioral counseling benefit ushered in by the health reform law. With the introduction of several new FDA-approved anti-obesity drugs, it is important that providers and patients have access to the broad range of treatments for obesity. The "Treat and Reduce Obesity Act of 2015" (S. 1509) will provide Medicare beneficiaries and their healthcare providers with meaningful tools to reduce obesity by improving access to weight-loss counseling and by allowing coverage for new FDA-approved prescription drugs for chronic weight management. With 40 percent of adults between the age of 65 and 74 having obesity, it is important that comprehensive care as well as "all the tools in the toolbox" are able to be employed to combat the epidemic.

- *Socioeconomic Status*

One particularly relevant example of the effect of socioeconomic status in FFS is Medicare's Hospital Readmissions Reduction Program, which creates significant financial penalties for hospitals that exceed expected readmissions rates. More than any other hospital metric, readmissions are influenced greatly by factors beyond the hospital's control, and studies have demonstrated that sociodemographic challenges directly affect these outcomes and disadvantage providers who serve this population. HLC supports draft recommendations by the National Quality Forum (NQF) that NQF and others (such as CMS, Office of the National Coordinator for Health Information Technology, and the Agency for Healthcare Research and Quality) develop strategies to identify a standard set of sociodemographic variables for performance measurement and identifying disparities.

Our suggestions will help improve quality for patients and the system, but even these reforms will not be able to fully counteract many of the perverse incentives built into the FFS program. The addition of new codes (such as the new care coordination activities code for primary care providers) does not do enough to change the fact that incentives are based on volume and high-cost services, not prevention and care coordination-focused activities. Moving away from FFS to a value-based system will do the most to change this underlying condition.

4. The effective use, coordination, and cost of prescription drugs.

As the healthcare system continues to innovate, it is important that Congress recognize the value of prescription drugs in reigning in chronic disease epidemics from asthma to chronic kidney disease. However, even medications that provide large value are ineffectual if patients don't take them. For a wide variety of reasons (which needs further research and understanding), patients are frequently non-adherent to prescription drug therapies. The cost of this in the healthcare system is \$290 billion annually. Effective use of therapies in use now could make a substantial difference in addressing chronic disease and staving off future complications. We encourage the working group to develop a comprehensive plan to improve adherence and coordination of drugs, while keeping in mind that patients with multiple chronic diseases have complex (and often individualized) regimens that cannot be addressed with a "one size fits all" approach.

As part of our National Dialogue for Healthcare Innovation (NDHI), established in 2010 as a unique platform to bring together leaders from industry, government, academia, patient organizations, and all sectors of healthcare to discuss and develop consensus approaches to challenges affecting the course of healthcare innovation in the U.S., HLC has formed a patient engagement and adherence workgroup. The workgroup, comprised of NDHI summit participants, will examine the role of technology and system design that can result in better consumer involvement in healthcare planning and decisionmaking, helping to drive change throughout the healthcare system. The workgroup will meet throughout the summer to examine and profile how positive change can work to the benefit of individual patients, particularly those coping with chronic illnesses. We look forward to sharing our findings from this and other workgroups with you when they are finalized.

In addition to the recommendations that will flow from NDHI, we offer the following suggestions:

- *Provide Part D Plans Incentives To Improve Medication Adherence*
Medicare Part D plans have less incentive than their MA Part D counterparts to improve medication adherence among their members since stand-alone plans only see the costs of added utilization of medicines and not the offsets in other health service utilization that follows better management of chronic conditions. Reforms considered by the workgroup should include aligning incentives for better medication management and improved adherence through shared savings or other models that promote improved outcomes for patients.
- *Empower Pharmacists to Help Patients Manage Medications*
Since patients visit their pharmacist much more frequently than their doctor, this point of care is a valuable opportunity to engage with the patient to make sure that they understand and follow the medication regime provided by their provider. Pharmacists are also trained in the interactions between drugs, and can provide

a helpful check to ensure that drugs prescribed by different physicians don't overlap with harmful interactions.

- *Improved Medication Therapy Management*
HLC supports revising the current Medication Therapy Management (MTM) benefit to better serve patients and the healthcare system. Medicare MTM is currently limited to beneficiaries who have two or more chronic conditions and spend more than \$3,138 per year on drugs. This standard does not reach patients with the most to gain for MTM. For example, simply using high drug utilization as a criteria for MTM services would miss people with low drug utilization caused by poor adherence and people with high medical spending on ambulatory-sensitive conditions that would benefit from better medication management and adherence. We urge the workgroup to work in concert with House Energy & Commerce Committee colleagues to develop a solution that would ensure that MTM is provided to the patients who need it most.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology.

Poor health, treatment complexity, lack of access, the current (and projected) physician shortage, and even the cost of care can discourage patients from getting treatment that they need. In the case of chronic conditions, this is especially detrimental to health and health costs, since so much of chronic disease care is based on early intervention and management and care coordination. Telehealth is a substantial alternative to traditional healthcare to treat basic, episodic medical conditions as well as chronic disease. Benefits associated with telehealth can include improved patient access to healthcare, reduced medical costs through reduction in higher cost services, and improved patient satisfaction. Numerous studies have shown the effectiveness of telehealth both in terms of quality of care and cost; proper implementation can also support the move toward value-based reimbursement. HLC members have reached consensus-based principles supporting the healthcare workforce which include strong support for telehealth as a tool to expand the reach of the current healthcare system.

Despite the fact that private payers are increasingly employing telehealth to reach patients in a variety of settings and using a variety of technologies and rising consumer interest, Medicare lags far behind. Reimbursement is available for only a limited number of Medicare Part B services and is limited to live video (as opposed to other modalities such as store-and-forward, remote patient monitoring) as a substitute for an in-person encounter. It can also only occur when the originating site is in a Health Professional Shortage Area (HPSA), a county outside of any Metropolitan Statistical Area (MSA) or an Alaska or Hawaii demonstration project.

HLC members are pleased that CMS demonstrations include or have included interventions that use telehealth technologies, and we believe the results of those efforts warrant greater expansion of telehealth technologies throughout other CMS payment programs. While telehealth is already used effectively in MA, ACOs, and other

APMs, it is crucial that the workgroup take timely steps to begin building telehealth into FFS Medicare.

In order to expand telehealth to FFS Medicare beneficiaries, we suggest:

- *Eliminate Patchwork of State Laws that Limit Telehealth*
Currently, an uneven patchwork of state laws inhibits telehealth in several ways. First, each state has laws limiting the use of telehealth to certain modalities or imposing certain rules on prescription length, etc. Second, nurse practitioners and doctors can only practice medicine in the states where they are licensed. Attaining licensure for multiple states is burdensome and costly, and interferes with providers' ability to reach patients who may not be able to travel within their state, or those who need to see a far-away specialist. We recommend that Congress allow Medicare providers in one state to provide Medicare services via telehealth to beneficiaries located in a different state (TELE-MED Act of 2015).
- *Expand Reimbursement for Telehealth*
Even with the elimination of licensure and state-by-state barriers, telehealth will not be adopted widely in FFS Medicare until appropriate reimbursement is possible. We support eliminating 1834(m) requirements based on the originating site (geographic areas) and those based on site of service (where the patient is based at the time of service). Payment for telehealth services should always connect to the type of service being provided, not the method by which it is provided.
- *Remote Patient Monitoring*
Finally, we urge Congress to instruct CMS to create a remote patient monitoring (RPM) benefit. The same geographic and site restrictions do not apply to RPM, but the lack of common procedure terminology (CPT) codes for RPM activities and the requirement that RPM activities be bundled into payment for other basic services (e.g., an office visit provided the same day or other services incident to the service provided) prevent their widespread use. We encourage Congress to direct CMS to "un-bundle" RPM and allow the use of RPM for the monitoring of chronic disease.

The comments CMS received during the recent MSSP rule process underscore the rising importance of telehealth in both urban and rural settings for the improvement of accessibility and timeliness of needed care, increased communication between providers and patients, enhanced care coordination, and improved efficiency of care. In order to further improve telehealth in ACOs and other APMs, we offer the following comments:

- *Room for Innovation*
HLC believes that telehealth should be flexible enough to respond to advances in technology. (This is especially crucial for ACO contracts, which should be designed in a way that will not "lock in" certain types of technology.) In MA, HLC

believes that plans should have the ability to offer telehealth services as part of the basic benefit package and should not be limited to the amount of supplemental benefit funds available.

- *Alignment with Existing Quality Measures*

We urge Congress to avoid creating separate or additional telehealth-related quality measures. The type of service-delivery method should not detract from focusing on a small set of meaningful outcomes measures. Any statute should focus on the broad benefits of establishing connected care rather than restrictive reimbursement systems or parsing out a menu of connected care tools and approaches that may not keep up with current technology or best care practices.

- *Other Thoughts*

We are hopeful that use of telehealth by ACO primary care and specialty care participants will advance the process of breaking down regional barriers between independent health systems, which often obstruct telehealth and coordinated care. Government should encourage physician-to-physician and physician-to-patient consultations that are integrated into local outpatient and inpatient care alongside the local/regional healthcare organization. Finally, we urge the working group to instruct CMS to track and monitor the savings associated with telehealth in future models so that future models can build on those learnings.

6. Strategies to increase chronic care coordination in rural and frontier areas.

The chronic disease burden is especially prevalent in populations living in rural and frontier areas, making it even more critical to ensure that the policies the workgroup advances address those needs specifically. To provide better care coordination and access throughout the country, we offer the following suggestions:

- *Advance Telehealth Access*

For the reasons outlined above, telehealth is ideal for advancing health across a wide area. Where terrain, weather, distance or infirmity makes it difficult to travel, telehealth can help providers monitor and care for patients from a distance. We encourage the working group to collaborate with colleagues on the Senate Committee on Commerce, Science, and Transportation (particularly the Subcommittee on Communications, Technology, Innovation, and the Internet) to promote better internet access to ensure that once payment and licensure barriers are overcome, those living in rural and frontier areas can effectively access telehealth services.

- *Provider Access Bill*

Millions of Americans, including children and seniors, lack adequate access to primary care services – especially in underserved communities. In coordination with other healthcare providers, pharmacists can provide underserved Medicare beneficiaries with the care they need and deserve. “Pharmacy and Medically Underserved Areas Enhancement Act” (S. 314) would amend Medicare so

pharmacists can be reimbursed for delivering care to Medicare beneficiaries in medically underserved communities. The legislation would build upon existing law that allows nurse practitioners (NPs) and physician assistants (PAs) to be reimbursed by Medicare by covering services delivered by pharmacists. Pharmacists could be reimbursed for providing services that would otherwise be provided by physicians as long as such activity is permitted by the laws and regulations of the state in which the pharmacist practices. Similar to the law for NPs and PAs, the Pharmacy and Medically Underserved Areas Enhancement Act would limit rates to 80 or 85 percent of what would be paid to physicians, helping limit Medicare spending while expanding access.

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

One of the key discussions of our latest NDHI summit was the necessity of patient engagement to achieve the best health results. When patients are actively participating in managing their health and meaningfully engaging with their healthcare providers, the greatest strides in health are possible. We strongly support any efforts to encourage patients to play a greater role in managing their health and engaging with their healthcare providers.

To optimize this interaction, we suggest:

- *Recognize the Importance of Intensive Behavioral Counseling*
Intensive behavioral counseling (IBT) for certain patients with obesity is a benefit provided by Medicare but is often underutilized. Since IBT is often a lower cost, lower risk route of care, we need to ensure that it is more widely used as part of the overall suite of therapies available to providers and patients. Patient and provider outreach and education can raise awareness of the benefit. Providing the benefit outside of the traditional clinical setting would help, since physicians often do not have time in their visits to administer the counseling or the necessary training. The Treat and Reduce Obesity Act contains provisions to improve access to weight loss counseling by expanding the types of eligible providers that can offer the benefit outside of the primary care setting. This would also strengthen team-based care, because the Act requires that any nonphysician provider or instructor furnishing the therapy must communicate any recommendation or treatment plan for an individual to the individual's primary care physicians or practitioner.
- *Improve Patient Self-Management Skills*
Allowing referrals and reimbursement for evidence-based self-management services would empower and enable Medicare beneficiaries to manage their own health. Congress should explore ways to help educate patients on their health before their chronic disease escalates. For example, though Medicare Part B covers diabetes self-management training, it does not cover self-management training for chronically ill patients without diabetes. Medicare should also do

more to increase the utilization of existing preventive care services such as screenings, vaccinations and the annual wellness visit.

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

HLC strongly supports initiatives designed to more effectively utilize primary care providers as part of a team providing coordinated care to a patient. In addition to strengthening and empowering primary care providers, we urge the workgroup to consider models that incorporate nonphysician providers such as nurse practitioners, nurse assistants, community-based providers, pharmacists, and trained health educators as an integral part of the healthcare delivery system. Health services provided by nonphysician providers are an important way for the current healthcare system to be more productive and efficient because the services they provide are often lower cost to the patient and supplement the care given in a traditional healthcare setting. Additionally, providers of this type are critical to the development of team-based care. HLC believes that in order to meet the needs of a growing and aging population, we need dramatic reform of how the healthcare workforce incorporates nonphysician providers. Nonphysician providers should be allowed to deliver the care that they are trained to provide in collaboration with health teams. Reimbursement and regulatory gaps or barriers should be addressed so this type of care is accessible by more patients.

- *Improve Care Transitions*
Care coordination teams can make a major impact on patient health in the transition from one care site to another. HLC encourages the workgroup to examine and the potential of transitional care teams to help patients move from one point of care to another. As you are aware, hospitals have started partnering with pharmacists, nurses and other professionals to assist with care transition upon patient discharge. One example of such a program is the Walgreens Well Transitions program. This type of program is especially important for patients managing multiple chronic diseases that require strict adherence to drug regimens that become increasingly complicated during periods of care transition.

HLC appreciates the opportunity to provide input to the working group and we look forward to working with you on developing policy solutions. If you have any questions, please feel free to contact HLC's Executive Vice President, Debbie Witchey, at dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President