



The Honorable Orrin Hatch  
Chair, Committee on Finance  
United States Senate  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member, Committee on Finance  
United States Senate  
Washington, D.C. 20510

The Honorable Johnny Isakson  
United States Senate  
Washington, D.C. 20510

The Honorable Mark Warner  
United States Senate  
Washington, D.C. 20510

June 22, 2015

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

Thank you for your attention to the importance of policy initiatives to facilitate the delivery of high quality care for Medicare beneficiaries living with multiple chronic conditions. Your working group is a critical step towards creating reforms in Medicare that will bring us closer to a health care system that delivers on the Triple Aim of better care, better outcomes, and lower cost. We appreciate the opportunity to offer recommendations to help shape the Committee's development of bipartisan policy to improve care for individuals with chronic conditions.

The National Partnership for Women & Families is committed to ensuring that new models of care delivery and payment provide the comprehensive, coordinated, patient- and family-centered care patients want and need while helping to drive down costs. The success of policy initiatives to improve care for individuals with multiple chronic conditions will rest on the ability of new delivery models to achieve all elements of the Triple Aim, including patient experience of care.

Delivering on all elements of the Triple Aim in turn requires partnering with patients and families at all levels of care. Such partnership must encompass meaningful, systemic collaboration with patient and family caregivers at the point of care, in designing new models of care delivery, in policy and governance, and at the community level. Supporting and engaging family caregivers is also critical; older adults living with multiple chronic conditions often depend on caregivers to help navigate the healthcare system.

We encourage the Committee to build new policy initiatives and models of care delivery or payment upon a strong foundation of robust consumer protections that ensure beneficiary needs are met and that beneficiary rights and access to care are safeguarded. Indeed, policies aimed at improving care for individuals with chronic conditions while lowering costs must also include accountability for improved patient health and experience of care, which requires inclusion of robust quality measures and meaningful consumer protections.

Thank you for the opportunity to provide feedback on specific policy issues that the Committee intends to address as part of its reform efforts; specific recommendations are included below. If you have any questions about our recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy at the National Partnership for Women & Families, at [lkennedy@nationalpartnership.org](mailto:lkennedy@nationalpartnership.org) or (202) 986-2600.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Ness", with a long horizontal flourish extending to the right.

Debra L. Ness  
President, National Partnership for Women and Families

## **Recommendations for Specified Issue Areas**

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

As the Committee contemplates new models for coordinated care for individuals living with chronic conditions, we strongly recommend considering the experience of current demonstrations being piloted by the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI). Lessons learned from existing coordination efforts, particularly with regard to enrollment complexities, communicating with beneficiaries, and aligning acute and long-term services and supports, will provide important background for future reform initiatives.

Overall, however, transformative policies to improve health outcomes for individuals with multiple chronic conditions should be built on a foundation of patient- and family-centered care. Delivering patient- and family-centered care in turn requires meaningfully engaging patients and family caregivers as partners in all levels of care delivery – at point of care, in care design and redesign, in policy and governance, and at the community level.<sup>1</sup> Engaging family caregivers, in addition to beneficiaries, is critical for this population, who are likely to rely on caregivers to access and navigate the health care system, including caregiver assistance with rides to appointments, trips to the pharmacy, and understanding Medicare benefits.

To ensure delivery of patient- and family-centered care, we recommend:

- ▶ Requiring alternative payment models (APMs), accountable care organizations (ACOs), Patient Centered Medical Homes (PCMHs), and other new models of payment and care delivery to demonstrate strong leadership commitment to delivering patient- and family-centered care (through, for example, creating a designated management position, dedicating specific resources to patient- and family-centered care in the budget, and consistently reinforcement of the value of partnering with patients and families to the organization).
- ▶ Requiring APMs, ACOs, PCMHs, and other new models of payment and care delivery to incorporate patient- and family-centered care criteria and principles not only into model design, but also into hiring practices, job descriptions, performance reviews, and compensation.
- ▶ Providing APMs, ACOs, PCMHs, and other new models of payment and care delivery with financial and technical support for skills development and training for providers and their staff on how to develop and sustain patient-centered practices.

Additionally, we strongly support using a variety of incentives, payment adjustments and requirements to support health information exchange and improve interoperability. Under

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<sup>1</sup> For a thorough definition of meaningful engagement and what it entails, please refer to the framework described in the Health Affairs article: “A Framework for Understanding the Elements and Developing Interventions and Policies” available at <http://content.healthaffairs.org/content/32/2/223.abstract>.

the current fragmented fee-for-service payment model, there are few incentives to share data. Interoperability is a key component of broader efforts to move toward a value-based health care system, and health information exchange is fundamental to achieving the improved quality, care coordination, patient-centeredness and cost reduction goals of many new models of care delivery and payment.

Going forward, new models of care delivery and payment should be required to demonstrate how they are using (or planning to use) interoperable technology to advance health information exchange in care coordination and quality improvement. Evaluation of programs should also include providers' performance on quality measures that are indicative of whether or not care was coordinated and information was exchanged electronically.

We particularly support efforts to ensure that individual beneficiaries, their family caregivers, and providers can send, receive, find and use clinical data. To this end, we encourage CMS to strengthen and expand requirements for ACOs and APMs that mandate that individuals be able to view, download and/or transmit their own health information and electronically exchange secure messages with their providers. Consistent with current requirements for the "Meaningful Use" Electronic Health Record (EHR) Incentive Program, ACOs and APMs should be accountable for having at least 5 percent of their patients accessing their health information online.

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

Medicare and Medicaid fee-for-service programs should reimburse for nonmedical services and better support efforts to integrate community supports into care delivery. Care for vulnerable populations will be better coordinated if there are stronger linkages with the community and reimbursement for wraparound services and a delivery models that take a multi-disciplinary approach to health. Indeed, ACOs and other APMs should be required to integrate community resources – including community-based organizations, community health workers, mental health peer wellness specialists and non-clinical social supports – into their networks and care coordination teams.

Promising examples of such integration are already emerging in Medicaid. For example, Hennepin Health in Minnesota was created specifically for a population of new Medicaid beneficiaries with high medical and social service needs. The model relies on nonclinical supports which are typically unavailable in a fee-for-service arrangement. To care for its high-needs population, Hennepin invests in a health care workforce that can meet the physical, behavioral, social, and economics needs of patients. Care coordinators, community health workers, pharmacists, dentists, behavioral health professionals, and social services navigators are all employed by Hennepin, in order to ensure that the Hennepin care delivery system is equipped to target and address social determinants that drive poor health. Early evaluations demonstrate the success of the program: fewer emergency department visits, better care for patients with chronic care, high patient satisfaction, and financial savings.<sup>2</sup> Hennepin Health is just one example of this approach, but it acts as a

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<sup>2</sup> DeCubellis, J., Erikson, C., Garrett, N., Johnsrud, K., Linzer, M., Owen, R., Sandberg, S., Shimotsu, S., Soderlund, D., & Vickery, K. (2014, November). *Hennepin Health: A Safety-Net Accountable Care Organization For The Expanded Medicaid Population*. *Health Affairs*. Retrieved 12 June 2015, from <http://content.healthaffairs.org/content/33/11/1975.abstract>

proof of concept for designing alternative payment models to reimburse for services that meet the nonmedical needs of patients.

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

The National Partnership for Women & Families supports policies that allow for the expanded use of telehealth services to improve patient care, and believe effective use of telehealth services has potential to improve communication between providers and patients and families; to facilitate more timely treatment and support; and to address access barriers for certain populations.

We do note, however, that there are times telehealth may not be appropriate; for example, when there is a cognitive impairment, when diagnostic testing is needed, when the condition is severe, when a hands-on examination is needed, or if there is an uncertain diagnosis. With regard to telehealth services, it is also important to consider how language barriers and the potential loss of nonverbal cues may affect the delivery of some types of care by telehealth services. While we believe telehealth could significantly improve care and access for beneficiaries, we are concerned about potential for abuse. Thus, we support implementing enhanced monitoring and auditing of telehealth services and programs. For example, policies should include monitoring and oversight mechanisms that evaluate how telehealth is supporting or diminishing care for more vulnerable beneficiaries, especially dually eligible beneficiaries.

Finally, we note that data collected via remote monitoring technologies from patients' implantable and wearable devices are becoming an increasing part of telehealth efforts. These and other health data generated and shared by patients and families complement clinical data to provide a more complete picture of patients' health, and thus help to inform care decisions. Greater use of remote monitoring technologies, specifically policies to incorporate this data into EHRs for clinical use, may pave the way for the incorporation and use of other important types of patient generated health data, such as goals, preferences, and values.

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

Chronic care coordination in rural and frontier populations requires innovative new thinking about how to provide primary care to underserved communities. Currently, about one-fifth of the U.S. population lives in a rural area, but only about 10 percent of the nation's physicians are located in rural areas.<sup>3</sup> As a result, rural areas depend heavily on a full range of non-physician primary care professionals. It is therefore critical to define health care professionals to include non-physician primary care providers, such as physician assistants and nurse practitioners, to meet the medical needs of beneficiaries in rural areas. Any new policies put in place should recognize the need for non-physician professionals as integral to care for rural populations.

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<sup>3</sup> National Conference of State Legislatures. (2011, August). *Closing the Gaps in the Rural Primary Care Workforce*. Retrieved 12 June 2015, from <http://www.ncsl.org/research/health/closing-the-gaps-in-the-rural-primary-care-workfor.aspx>.

Additionally, we note that rural populations greatly benefit from strong linkages between providers and community based organizations and resources, which help fill gaps in access to medical providers. Thus, care delivery models for individuals with multiple chronic conditions should be required to demonstrate intent to engage and partner with community based organizations and resources and should place strong emphasis on facilitation of seamless transitions from acute care settings to long-term support services and/or community based resources.

### **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with the health care providers.**

As previously noted, improving health outcomes for individuals with chronic conditions while lowering costs requires meaningful engagement with beneficiaries and caregivers at all levels of care. Beneficiary engagement goes beyond a consumer focus group or survey; rather, it must encompass mutually beneficial partnerships at every level of care – at point of care, through care shared decision-making and care planning; in care design and practice redesign; in governance and policy; and at the community level.<sup>4</sup> Further, we encourage the Committee not to think about “consumer engagement” as merely consumer “education” – but as systematic and meaningful involvement of consumers in all decisions concerning transforming how care is delivered and paid for, and at every level.

The National Partnership for Women & Families’ believes that patients can play a greater, more-empowered role in their health and health care when they are involved in shared decision-making and care planning. Indeed, individualized care plans are a core element of effective care coordination, and we continue to support an emphasis on care planning in all new models of care delivery. We encourage the Committee to think of care plans as “shared care plans,” which are jointly maintained and updated by patients, family caregivers, and members of their care team. We urge the Committee to consider policies that would encourage greater utilization of shared decision-making tools and shared care-planning processes. Incentives for greater engagement at point of care can be incorporated through robust program requirements, quality improvement strategies, and required public reporting of performance on quality metrics.

Accomplishing the goals of shared care plans, shared decision-making, and patient engagement requires that a beneficiary’s health information be shared between the beneficiary and his or her provider. Therefore, we strongly support requirements that give beneficiaries – and their designated family caregivers – the ability to view, download, and transmit their health data in a manner consistent with the “Meaningful Use” Electronic Health Record (EHR) Incentive Program.

Offering patients real-time, electronic access to their health information also has been shown to support greater levels of patient engagement. Data from a 2014 National Partnership for Women & Families’ survey clearly shows that online access has a positive impact on a wide range of activities that are essential to better care and improved health outcomes, including knowledge of health and ability to communicate with providers. Significantly, the more often individuals access their health information online, the more

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<sup>4</sup> For a thorough definition of meaningful engagement and what it entails, please refer to the framework described in the Health Affairs article: “A Framework for Understanding the Elements and Developing Interventions and Policies” available at <http://content.healthaffairs.org/content/32/2/223.abstract>.

they report that it motivates them to do something to improve their health – 71 percent, compared with 39 percent who used online access less frequently.<sup>5</sup>

Online access is particularly important for those with chronic conditions, as they are significantly more likely to use online access frequently (one – two times per month) than those without chronic conditions. Individuals with chronic conditions are also more likely to say that online access improves desire to do something about their health: 65 percent as compared to 53 percent.<sup>6</sup>

This frequency of access clearly has profound implications for engaging patients and improving their health status. As such, we encourage the Committee to ensure that electronic access to personal health information is included in any new policy or program aimed at improving care for those with chronic conditions and to support preservation of the patient and family engagement requirements in Meaningful Use regarding view/download/transmit and secure messaging.

Finally, we also emphasize the importance of supporting caregivers, who in turn play a critical role in facilitating beneficiary engagement. Caregivers are often the backbone of our nation’s long-term services and supports—with 43.5 million adults having provided unpaid care to an adult or a child in the prior 12 months. On average, caregivers spend 24.4 hours a week providing care and usually become de facto care coordinators for care recipients.<sup>7</sup> In 2009, it was estimated that caregivers provide the equivalent of \$450 billion in uncompensated care annually—saving federal, state, and local governments millions of dollars.<sup>8</sup>

As the Committee develops legislation, we urge you to explicitly address needed supports for family caregivers. Areas of the highest need include identification of caregivers most at risk for deteriorating health and financial security; paid sick days and paid family and medical leave for caregivers; training for caregivers performing activities of daily living, medical/nursing tasks, and interacting with formal care providers; and planning for future needs, like end-of-life care.<sup>9</sup>

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

The health system often fails to adequately coordinate care across a fragmented system of providers. With half of Medicare beneficiaries being treated for five-or-more conditions and chronically ill patients seeing a median of seven different physicians per year, the benefit of improved care coordination is obvious.

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<sup>5</sup> *Engaging Patients and Families: How Consumers Value and Use Health IT*, from <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>.

<sup>6</sup> *Engaging Patients and Families: How Consumers Value and Use Health IT*, from <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>.

<sup>7</sup> AARP Public Policy Institute and National Alliance for Caregiving, “Caregiving in the U.S.,” (June 2015), available at: <http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-us-research-report-2015.pdf>

<sup>8</sup> Feinberg, L., Reinhard, S.C., Houser, A., and R. Choula, “Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving,” (AARP Public Policy Institute: 2011), available at: <http://assets.aarp.org/rgcenter/ppi/lc/i51-caregiving.pdf>

<sup>9</sup> AARP Public Policy Institute and National Alliance for Caregiving, “Caregiving in the U.S.,” (June 2015), available at: <http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-us-research-report-2015.pdf>

While the idea behind care coordination – that the care patients receive is coordinated between across all health care providers and settings – is simple, care coordination as a model is multifaceted and does not have a universally adopted framework. Thus, the first step towards addressing the development of care coordination teams is producing a framework. We recommend the following:

- ▶ Multi-disciplinary teams coordinate care obtained from multiple providers and facilities, and patients and families are treated as integral members of the care team.
- ▶ Providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- ▶ Patients and families are encouraged and supported in participating in care and decision-making at the level they choose. For example, patients, families, and providers work together to develop shared care plans that aim to reach clinical and personal health goals. Shared decision making processes are routinely implemented.
- ▶ Processes are in place to effectively monitor and manage all tests, referrals, and procedures.
- ▶ Medications are actively managed and reconciled to avoid adverse interactions.
- ▶ Care team is available by phone, email, or in-person during evenings and weekends, and in-office appointments are scheduled promptly.
- ▶ Patients are asked who, if anyone, they want involved in their care and define who is considered family. Practices respect that choice and actively encourage family involvement.
- ▶ Practices foster strong linkages with community resources, including those that provide non-medical services and supports to vulnerable populations.
- ▶ Practices robustly utilize health information technology (HIT) and health information exchange infrastructure. HIT is a foundational element of improving a practice's ability to share.

Policies that seek to better coordinate care for individuals with chronic conditions should build on these elements to ensure they are providing high quality care and meeting the needs of the patient and family caregivers. Additionally, we note that a critical element of assessing effective care coordination is the patient's experience; patients and family caregivers can provide valuable insight on whether or not their care was coordinated. Care coordination models should capture patient experience and ensure that such data is incorporated into quality improvement initiatives.

Thank you for the opportunity to provide feedback on specific policy issues that the Committee intends to address as part of its reform efforts. If you have any questions about our recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy at the National Partnership for Women & Families, at [lkennedy@nationalpartnership.org](mailto:lkennedy@nationalpartnership.org) or (202) 986-2600.