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Chronic Care Working Group
U.S. Senate Finance Committee

Dear Members of the Chronic Care Working Group,

On behalf of Providence Health & Services, it is my pleasure to offer our recommendations on policy changes to the Medicare program to improve access and care for seniors living with chronic illness.

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence and its secular affiliates, including Swedish Health Services, offer a combined scope of 34 hospitals, 475 physician clinics, home health and hospice, senior services, supportive housing and many other health and educational services. The combined health system employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington.

As a large, integrated health care system providing services to patients across the continuum of care – from primary to acute care to home health and hospice – we are committed to clinical excellence with compassion. We know that quality of life improves when individuals and families have broad access to high-quality, patient-focused, affordable care. Together, Providence ministries and secular affiliates are working at scale to improve overall health in every community we serve through innovation in care delivery, new economic models and expert-to-expert collaboration.

Our mission and strategic focus call us to pursue new care delivery models to serve those in our communities who bear the burden of chronic disease. Providence is one of the original participants in the Program for All-Inclusive Care for the Elderly (PACE), as well as the Medicare Advantage program – both of which have proven to be highly effective in serving people with multiple chronic diseases.

Recommendations:

Support comprehensive primary care in traditional Medicare

Over the past few years, CMS has recognized the importance of developing specific codes for physicians and other Part B eligible providers to ensure payment for chronic care management. These codes include Transitional Care Management (TCM), which covers 30 days of transitional care provided to beneficiaries recently discharged from a hospital or skilled nursing facility. The TCM payment includes both in-person care, as well as non-face-to-face activities supporting beneficiaries' transition from an institutional to home setting.

In 2015, CMS began paying for a Chronic Care Management code, designed to support the ongoing, non-face-to-face management of patients with chronic conditions. This code does not require an in-person visit with the beneficiary.

Providence supports CMS continuing development and expansion of these new codes, particularly with the goal of aligning them with the patient-centered medical home model.

We urge CMS to expand this work and look to the success of the Comprehensive Primary Care initiative in providing aligned, multi-payer financial support to primary care practices that deliver more comprehensive primary care services. We encourage this committee to consider expansion of these efforts through a new provider designation in Medicare.[1] The provider designation and the accompanying payment reform (enhanced, prospective payment coupled with an opportunity to share in savings) should be available to primary care providers as a stand-alone, medical home arrangement in Medicare, or as part of a larger integration model like an accountable care organization.

Remove regulatory barriers to Medicare telehealth coverage and reimbursement

Presently, Medicare coverage and payment for telehealth and telemedicine services is limited to those services in which the originating site (where the patient is) is in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA), defined by HRSA and the Census Bureau, respectively. This originating site must be a medical facility and not the patient's home. Expanding coverage and reimbursement for telehealth services offers the potential to reach Medicare beneficiaries in rural areas and who are in need of chronic care management in a more effective and patient-centered fashion. As such, Providence supports the "Medicare Telehealth Parity Act," expected to be introduced in the House by Reps. Mike Thompson (D-CA) and Gregg Harper(R-MS).

Thompson's bill would expand telehealth coverage under the Medicare program implemented in three phases:

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[1] Baron, R., Davis, K., (2014) *Accelerating the Adoption of High-Value Primary Care — A New Provider Type under Medicare.* New England Journal of Medicine, DOI: 10.1056/NEJMp1314933.

- It would establish additional allowable sites of care when performed via telecommunications, would authorize remote patient management services for chronic health conditions, and would provide coverage under Medicare for these telehealth services
- It would amend the Social Security Act and the Communications Act of 1934 to expand access to and improve the quality of telehealth services by creating incentives and standards for quality measurement and reporting processes
- Would also recognize telehealth services and remote patient monitoring services as supplemental health care benefits that should be covered by ACOs and allow home telemedicine for patients with certain chronic conditions and remote monitoring

Expand the Independence at Home demonstration

Now in its third year having served 8,400 frail Medicare beneficiaries, the Independence at Home demonstration has saved an average of $3,070 per participating beneficiary, according to CMS. Currently, 17 organizations are participating in the demonstration, which provides chronically ill patients with a complete range of primary care services in the home setting. Medical practices led by physicians or nurse practitioners provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations.

According to CMS, the demonstration has shown that beneficiaries on average:

- Have fewer hospital readmissions within 30 days
- Have follow-up contact from their provider within 48 hours of a hospital admission, hospital discharge, or emergency department visit
- Have their medications identified by their provider within 48 hours of discharge from the hospital
- Have their preferences documented by their provider
- Use inpatient hospital and emergency department services less for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection

Providence Health & Services is currently in the early stages of offering a home visit service to our communities in King County, Washington. At present, our providers are not able to serve Medicare beneficiaries due to regulatory restrictions related to conditions of payment for services typically provided in a clinic setting. As a well-established primary care network, Providence is in a position to significantly improve access to care for chronically ill seniors in our communities if allowed to be reimbursed for services provided to Medicare beneficiaries.

We applaud the Senate passage of the "Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015" (S. 971), and we urge the House to quickly adopt this legislation as well.

Medicare reimbursement for Advance Care Planning

Last year, the American Medical Association (AMA) through the Current Procedural Terminology (CPT) Editorial Panel developed two new codes – 99497 and 99498 – that describe complex Advance Care Planning. Complex ACP involves one or more meeting(s), lasting 30 minutes or more, during which the patient's values and preferences are discussed and documented, and used to guide decisions regarding future care for serious illnesses. These consultations are voluntary on the part of the patient and the patient's preferences, including the involvement of family members and caregivers, is paramount.

We strongly recommend that Congress support the adaptation of CPT codes 99497 and 99498 by CMS. ACP is especially valuable for Medicare beneficiaries with multiple chronic illnesses as many receive care at home from family and other caregivers, and their children and other family members are often involved in making medical decisions. This policy, supported by both the Centers for Disease Control and the Institute of Medicine, is long overdue and will empower Medicare beneficiaries to personalize their care and improve their end of life experience.

Accelerative delivery system reform for Accountable Care Organizations:

The Accountable Care Organization model, established for Medicare by the Affordable Care Act, provides an opportunity for participating provider organizations – hospitals, physicians, post-acute care providers and others – to manage and create models of care for a defined population of patients. We believe with certain regulatory improvements in the Medicare ACO programs, participating ACOs can more effectively serve beneficiaries with chronic illness and purse more innovative care management structures.

First, we recommend that CMS continue to move forward in expanding models that can prospectively attribute beneficiaries who are being served by an ACO. Doing so would allow ACOs to focus their care coordination efforts on those beneficiaries with multiple chronic disease conditions.

Second, CMS should use the large cohort of current MSSP ACOs to conduct demonstrations and pilot programs that waive traditional fee for service payment and program requirements for providers operating within an ACO. While Providence supports CMS testing four payment and program waivers within the Next Generation ACO model and making the 30-day skilled nursing facility rule available for waiver in Track 3, these are still quite narrow in scope.

Current barriers and areas that are ripe for piloting payment waivers and other regulatory flexibility for ACO participants include:

- Beneficiary cost sharing requirements
- Restrictions for billing and payment for telehealth services
- Homebound requirement for the provision of home health services
- Requirement that hospice beneficiaries forgo curative services
- Program requirements relating to discharge planning

CMS should create a process for ACOs to apply for and receive waivers for Medicare payment and program rules, such as those listed above, that are barriers to care improvement and coordination. All risk tracks in MSSP should be permitted to apply and "make the case" for why the waiver is necessary and how the ACO will use the waiver. If necessary for monitoring or oversight, CMS could create waiver

pathways, so that ACOs that apply and receive similar waivers could be part of shared learning and technical assistance.

As of right now, the ACO financial models put forth by CMS do not provide sufficient regulatory flexibility to truly reform the delivery of care. CMS needs many more concurrent tests to get underway so that 2-3 years, they will be able to expand these areas of regulatory flexibility to complement the higher levels of risk.

Create flexibility for Medicare Advantage

As described by the Medicare Payment Advisory Commission, Medicare Advantage plans are currently required by law to provide a uniform benefit package to all of their enrollees, making it difficult to tailor specific benefit plans and programs for certain chronic disease conditions. By allowing MA plans to modify their benefit structure to permit variation in the benefits offered, plans can better focus on their individual enrollees' health care needs.

This is currently the design of chronic condition Special Needs Plans (C-SNPs) and has proven successful, albeit on a smaller scale, in serving Medicare beneficiaries with diabetes in particular. Extending the C-SNP model to all MA plans offers the potential to greatly improve the care delivered and health status of MA enrollees by providing coverage for various non-Medical support services, such as transportation, nutrition counseling and other services – similar to those provided through the PACE program.

Providence supports legislation introduced in both the Senate (The Value-Based Insurance Design Seniors Copayment Reduction Act S. 1396) and House (Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act, H.R. 2570) that would establish demonstration programs through the Medicare Advantage Program to allow plans to establish Value-Based Insurance Designs in their offerings to enrollees.

In addition to adopting legislation to create these demonstrations, Providence supports the following additional policy proposals:

- Provide MA plans with opportunities to test VBID models on the *full* range of conditions that are currently being addressed in the commercial marketplace.

- MA plans should be permitted to target VBID programs to specific individuals, thus allowing benefit packages to be customized for patients with multiple chronic conditions.

- The VBID demonstration should allow a variety of design features including incentives to encourage MA enrollees to participate in disease management, wellness programs, and other health improvement activities. Cost sharing incentives and additional benefits should exist in the form of rewards and not limits to Medicare-covered services.

Improve risk adjustment for MA plan payments

MA payment policy should promote improving the overall health of the population of seniors who

choose it as their Medicare option, in alignment with national policy goals and to make care coordination available to all Medicare beneficiaries, including the most vulnerable populations. The MA risk adjustment system is a key element in ensuring that plans can achieve this goal. Studies demonstrate MA plan investments in activities that identify chronic conditions at their earliest stages and implement care management protocols that slow the progression toward more advance disease states are improving access to preventive care, reducing unnecessary hospital readmissions, and resulting in more appropriate use of services than in traditional Medicare.

However, recent changes to the system announced by the Centers for Medicare & Medicaid Services (CMS) move in the wrong direction. The Agency's decision to fully phase in the 2014 CMS-HCC risk adjustment model in 2016 removes key codes for early stage chronic kidney disease (CKD). A recent Oliver Wyman analysis found a 23 percent reduction in plan payments for individuals with CKD under this approach. This is a significant problem, considering that 56 percent of the population with a CKD risk adjustment code in the 2013 risk adjustment model would no longer have a code for this condition under the 2014 risk adjustment model. As a result, MA plans will have fewer resources for investing in activities that identify chronic diseases at their earliest stages and for implementing care management protocols that slow the progression toward more advanced disease states.

The MA payment system, including its risk adjustment model, should support the goal of delivering high quality, coordinated care for Medicare beneficiaries, particularly those with high-cost, high-burden chronic conditions who can benefit the most from early identification and care management services offered by MA plans. Payment policies should ensure that MA plans can continue to innovate and offer services for enrollees with chronic conditions that are generally unavailable for beneficiaries in the fee-for-service program. Provisions in H.R. 2579, the "Securing Care for Seniors Act of 2015", would take an important step in recognizing the importance of making changes to the risk adjustment system that appropriately address the needs of beneficiaries with multiple chronic conditions. We urge CMS to work with MA plans in an open and transparent manner to ensure future changes to the system are consistent with these goals.

We thank you for the opportunity to share these comments and look forward to participating with the Finance Committee as these ideas are further refined and legislation is developed. For more information, please contact Ali Santore at Alison.Santore@providence.org.

Sincerely,

Rod Hochman, MD
President and Chief Executive Officer
Providence Health & Services