



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

January 29, 2016

The Honorable Orrin G. Hatch  
219 Dirksen Senate Office Bldg.  
U.S. Senate Finance Committee  
U.S. Senate  
Washington, DC 20515

The Honorable Ron Wyden  
219 Dirksen Senate Office Bldg.  
U.S. Senate Finance Committee  
U.S. Senate  
Washington, DC 20515

The Honorable Johnny Isakson  
219 Dirksen Senate Office Bldg.  
U.S. Senate Finance Committee  
U.S. Senate  
Washington, DC 20515

The Honorable Mark Warner  
219 Dirksen Senate Office Bldg.  
U.S. Senate Finance Committee  
U.S. Senate  
Washington, DC 20515

Dear Senators:

The Consortium for Citizens with Disabilities (CCD) Health and Long Term Services and Supports Task Forces appreciate the opportunity to comment on the Senate Finance Committee's Bipartisan Chronic Care Working Group Policy Options Document. CCD is a coalition of national disability organizations working together to advocate for national public policy that ensures the self-determination, independence, employment, integration, and inclusion of children and adults with disabilities in all aspects of society.

Let us start by saying we would like to applaud the bipartisan approach that the Finance Committee is taking to this important issue. These matters affect everyone and the search for information leading to good policy is party neutral. We also would like to compliment the effort being made to seek input from stakeholders. There is much to be learned from the experiences of those who live with these conditions every day about where changes may be beneficial.

**Basic Principles**

- CCD would encourage the Committee to support improvements and advancements in both traditional Medicare and Medicare Advantage (MA). The option of managed care is a good one for many, but it is not the best choice for everyone. As innovative ideas are integrated into programs, CCD supports making sure that both types of Medicare benefit from the knowledge gained.
- CCD would encourage the Committee to learn from demonstration programs and to maximize the support for the Center for Medicaid/Medicare Innovation (CMMI).

Demonstration programs reflect the understanding that there may not be “one size fits all” and it is important to test and evaluate and be transparent with the outcomes.

- CCD would encourage making certain that strong consumer protections and beneficiary education are included in any model. Choice is a centerpiece of Medicare and it must remain so as changes are considered. Structures cannot be set up to support attracting healthier individuals and steering away individuals with health conditions. Information about the program, the changes, the operation, must be forthcoming and accessible.
- CCD requests that the Work Group consider inclusion of policy proposals that advance access to appropriate rehabilitation services and devices.

### Empowering Individuals and Caregivers in Care Delivery

CCD would like to encourage the support of waiving the associated beneficiary cost sharing. According to the Kaiser Family Foundation, 14 percent of people covered by Medicare have only traditional Medicare, they do not have supplemental coverage. This group includes a disproportionate number of Medicare beneficiaries that are under 65 who have disabilities and the near poor. We would caution, however, that just changing the cost sharing structures may not be sufficient, there is a general lack of beneficiary awareness which points to the need for outreach and educational initiatives.

As the evolution of Accountable Care Organizations (ACOs) continues it will be important to establish the process through rulemaking and educate beneficiaries about choices. Consistency across ACOs would make the educational efforts more efficient for beneficiaries and providers. CCD would support cost sharing being lowered or waived as an incentive, but not that costs could be increased as a deterrent. There is support for waiving deductibles to encourage improved access to care and particularly preventive care, as well as exploring whether waiving copayments or coinsurance when there is a proven clinical effectiveness would be viable. Whatever the determinations, the standards for deciding when and what cost sharing is waived should be transparent.

### Other Policies to Improve Care for the Chronically III

- As improvements are considered for CMMI, transparency will be critical and creates an opportunity for good input from multiple stakeholders. Details of model designs are essential to promote beneficiary awareness and engagement. It is important to strike the balance between opening the door to information and supporting high level, good quality innovation.
- Once demonstration programs have begun, information and discussion with stakeholders should continue both formally and informally. There should be input sought on course corrections or changes to the design even if it is midway through the demonstration. The involvement of stakeholders is not just at the beginning or at the end, but they should have input on how the project is working all the way through. Multi-stakeholder advisory committees may be one way to accomplish that ongoing stream of input.
- CCD supports the integration of primary care and behavioral health care and would point out that there are existing programs working towards that goal, including the

SAMHSA-HRSA and AHRC BH-PH integration initiatives. We urge the committee to ensure that any policy proposal or study utilize information and lessons learned from these projects and build on their successes..

- Low-income housing subsidies and the provision of services are starting points to providing effective health and social services, reducing Medicare and likely, Medicaid costs. Housing and service support enhances access to necessary services and the stability that people need to better manage their conditions and coordinate their care..

### Developing Quality Measures for Chronic Conditions

The hope of putting new programs in place for people with chronic conditions can only be successful if there are quality measures to determine what success looks like and when it is achieved. CCD would suggest that the “high-priority measure gaps” that were first identified in 2013 and reaffirmed in 2014 and 2015 through the National Quality Forum workgroup on people dually-eligible for Medicare and Medicaid would be a set of recommendations to spark the discussion. They are:

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

We also would like to note that the CCD Task Force on Long Term Services and Supports, in July 2012, identified six gaps in existing quality standards as they directly relate to people with disabilities and while some of these issues have been mentioned, they may be important to keep in mind. They are:

- Consumer choice and participant-directed services;
- Satisfaction – individual experience with services and supports;
- Percent of population in employment or meaningful day activities;
- Percent in independent housing – consumer choice, housing appropriateness, stability;
- Integrated primary and specialty care; and
- Access to timely and appropriate care.

CCD recognizes that the policy options document clearly recognizes the concept of function as important to the Medicare population in need of chronic care. However, functional decline is only one component of full recognition of the concept of function. The CCWG should strongly consider broadening its definition of chronic care management to more fully include recognition of an individual’s functional status as a key measure in chronic care delivery. In addition, while the concept of functional improvement is critical, the Jimmo v. Sebelius settlement dictates that maintenance of functional status, and prevention of deterioration of function, are also important instances

when Medicare must cover skilled therapy and skilled nursing services. These concepts should be recognized and incorporated into the definition of chronic care management and addressed throughout the chronic care proposals being advanced in the CCWG's legislative package.

A focus on function would also include a permanent solution to the long-standing problem of the Medicare outpatient therapy caps, along with the related "exceptions process," which uses Recovery Audit Contractors (RACs) to review all claims that exceed the caps. The caps and current exceptions process deny rehabilitation services to the very Medicare beneficiaries who need the services the most. A one-size-fits-all outpatient therapy benefit simply does not meet the needs of some Medicare beneficiaries, particularly those with chronic or multiple conditions. We believe that any legislation that is designed to address chronic conditions should include meaningful efforts to finally and permanently eliminate the outpatient therapy caps.

#### Expanding the Independence at Home Model of Care

CCD understands that the Working Group is seeking to advance innovative ideas to increase care coordination including promotion of appropriate levels of care for the most complex beneficiaries, discouraging overuse of services, and providing better outcomes and improved patient/caregiver satisfaction. IAH's interdisciplinary primary care model, quality measures and patient involvement, requirement for mobile Electronic Health Records and continuous access, and its targeted approach to people with chronic conditions appear to meet these goals.

We note that the Working Group has asked for input specifically on ways to "improve the current program design while still achieving savings" as well as the best means to determine eligible populations. The current program design has worked well and has achieved savings. Therefore, we have no comments for improvement of the design of the IAH model.

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

#### Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan

CCD supports the provision in the Policy Options Document to allow Medicare beneficiaries with End Stage Renal Disease (ESRD) to join Medicare Advantage (MA) plans. Currently, ESRD beneficiaries must stay in the fee for service system, but MA plans may offer better coordination and less cost-sharing for this highly vulnerable population. Barring ESRD patients from access to MA plans is one of the last explicitly permitted forms of insurance discrimination based on disability status and it should be eliminated on principle alone.

## Rehabilitation Services and Devices

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

For instance, one very specific proposal that could have a major impact on non-ambulatory beneficiaries with chronic conditions would be to clarify Medicare coverage of seat elevation in wheeled mobility devices. Currently, this is considered non-covered, but seat elevation allows Medicare beneficiaries who cannot ambulate the ability to transfer safely from surface to surface and perform mobility related activities of daily living (MRADLs). Performance of MRADLs is the cornerstone of the current National Coverage Determination (NCD) on Mobility Assistive Equipment and, yet, CMS has established a coverage policy that runs contrary to this NCD. Coverage of seat elevation would be a dramatic benefit to many Medicare beneficiaries with chronic conditions who are not able to ambulate in their homes without wheeled mobility. CCD encourages the Working Group to consider inclusion of this and other proposals that advance access to appropriate rehabilitation services and devices.

Thank you for your consideration of our comments. If you have any questions please contact Mary Andrus, Easter Seals ([mandrus@easterseals.com](mailto:mandrus@easterseals.com)) or Peter Thomas ([Peter.Thomas@PPSV.COM](mailto:Peter.Thomas@PPSV.COM)), with the CCD Health Task Force.

Sincerely,

American Association on Health and Disability  
American Network of Community Options and Resources  
American Occupational Therapy Association  
American Therapeutic Recreation Association  
Association of University Centers on Disabilities  
Autism Speaks  
Bazelon Center For Mental Health Law  
Brain Injury Association of America  
Christopher & Dana Reeve Foundation  
Dialysis Patient Citizens  
Disability Rights Education and Defense Fund  
Easter Seals  
Epilepsy Foundation  
Justice in Aging

National Alliance on Mental Illness  
National Association for the Advancement of Orthotics and Prosthetics  
National Disability Rights Network  
National Multiple Sclerosis Society  
Tourette Association of America  
The Arc of the United States  
United Spinal Association