



20555 Victor Parkway
Livonia, MI 48152
tel 734-343-1000
trinity-health.org

January 29, 2016

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

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

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

Submitted via email to:
Senate Finance Committee Bipartisan Chronic Care Working Group
chronic_care@finance.senate.gov

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Senate Finance Committee Bipartisan Chronic Care Working Group:

Trinity Health appreciates the opportunity to provide comments and information on the Bipartisan Chronic Care Working Group Options Document. Our comments and recommendations reflect a strong interest in efforts that can support better health, better care and lower costs to ensure affordable, high quality and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 91 hospitals, 124 continuing care programs—including PACE, senior living facilities and home care and hospice services that provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns nearly \$1 billion to our communities annually in the form of charity care and other community benefit programs. We have 31 teaching hospitals with Graduate Medical Education (GME) programs providing training for 1,951 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 95,000 full-time employees, including 3,900 employed physicians, and have more than 11,100 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks across the country.

Trinity Health is an organization that is committed to rapid, measureable movement toward value in the delivery of and payment for health care. We wholeheartedly support the announcement of Secretary Sylvia Burwell to tie 30 percent of traditional or fee-for-service Medicare payments to quality or value through alternative payment models by the end of 2016; and 50 percent of payments to these models by the end of 2018. In fact, Trinity Health has committed to having 75 percent of our revenue in value-based arrangements by 2020 as a member of the Health Care Transformation Task Force.

Trinity Health also believes the transformation to alternative payment models requires an acceleration in the national movement to interoperability. A truly interoperable electronic medical record/electronic health record (EMR/EHR) – one which integrates data from different points of care, and is provided by different clinicians, into one meaningful record with a single patient portal – is critical to improving the care of all patients, especially those with chronic conditions.

Overall, Trinity Health believes that effective payment systems must hold providers accountable for better health, better care and lower costs. Without that accountability, reimbursement for care coordination and care management is merely another fee-for-service (FFS) opportunity that can be used to increase the volume of services provided to patients without assuring outcomes. Many of the policy options offered by the Working Group suggest enhancements to an antiquated and ineffective FFS system to allow payment for care management services. It is Trinity Health's strong belief that payment for care management services needs to be accompanied by a requirement to produce an outcome in order to guarantee results. The transformational change necessary for sustainable Medicare and Medicaid programs will only occur when payment models require accountability for episodes of care or populations, such as: bundled payment models, accountable care organizations (ACOs), global payment models, Patient-Centered Medical Homes (PCMHs) with incentives, and other future models with accountability.

I. Advancing Team-Based Care

Trinity Health agrees that payers, providers, caregivers and patients should be encouraged to expand collaboration to achieve integrated care. Using an Alternative Payment Model (APM) that requires accountability for outcomes, improving access to team-based care and facilitating collaboration and communication across the continuum of care should remain a priority for the Centers for Medicare and Medicaid Services (CMS).

Expanding the Independence at Home Model of Care

Trinity Health supports expansion of the Independence at Home (IAH) Model of Care because it does include accountability for outcomes. However, the nature of IAH is that it is targeted to specific individuals instead of entire populations. It is important to note that when programs are targeted at specific individuals there is a high risk of “cherry picking” beneficiaries for the program who require the least intervention, and leaving the more complex beneficiaries in traditional FFS. If, instead, the IAH model assigned a population to the program, it would reduce “regression to the mean” effect.

Following are additional recommendations for improvements to the program:

- Require Physician/Nurse Practitioner (NP)/Physicians Assistant (PA) groups to have a preferred network of Home Health Agencies (HHAs) in a model similar to a Next Generation ACO.
- Require a gainsharing exception with such agencies.
- Allow a home care agency to be a provider if they contract with or employ physicians/NPs/PAs.
- Allow physicians and other non-physician practitioners to provide in-home visits via telehealth technologies, and allow these providers to bill for those services.
- Enable IAH patients the opportunity to enroll in Programs of All-inclusive Care for the Elderly (PACE) on a temporary basis at a daily rate or on a per service basis when such services would be cost-effective (e.g., when the patient's other option would be a Skilled Nursing Facility (SNF) stay).

In addition, Trinity Health recommends including a pilot program that would allow physicians to authorize services such as Lifeline (emergency response buttons), adult day care, respite care, and private duty even for non-waiver patients. In this model, a physician would be incentivized to only authorize what is needed as the dollars will impact her or his gainsharing.

Providing Medicare Advantage Enrollees with Hospice Benefits

Trinity Health believes that all Medicare patients should have access to hospice care, including patients enrolled in Medicare Advantage (MA) plans. However, there are several questions that surfaced regarding this particularly proposal. It is important that any policy changes increase beneficiary access to hospice services, and the coordination of those services with the rest of their care. In addition, policy changes should not produce unintended effects on beneficiaries, such as impeding access to hospice providers, or increasing their out-of-pocket costs. Key questions to be addressed include:

- Would MA plans allow beneficiaries to choose their hospice provider?
- What type of beneficiary cost-sharing requirements would exist?
- What types of prior authorization or other utilization management techniques would MA plans be allowed to use?

Trinity Health also urges the Working Group to consider a change in policy to make it more likely that patients who could benefit from hospice services are better able to take advantage of them. Under current policy, a beneficiary who elects the hospice benefit is required to forego curative treatment. The termination of curative treatment can discourage beneficiaries from electing hospice care, thereby forgoing the palliative care that can improve their quality of life.

Trinity Health suggests that the Working Group recommend revising Medicare policy to allow Medicare beneficiaries who are receiving hospice care to also receive concurrent treatment if they so choose. This means that a beneficiary would retain the option of electing the Medicare or Medicaid hospice benefit at any time, regardless of whether they are in MA or traditional Medicare, including dual eligible individuals. A targeted version – of this benefit design applicable to beneficiaries who have received certain diagnoses and who meet other qualifications – is currently being tested in select hospices under the Center for Medicare and Medicaid Innovation (CMMI) Medicare Care Choices Model. Trinity Health urges the Working Group to consider a policy change that would implement this policy to apply

program-wide. Giving Medicare beneficiaries the choice of whether or not to continue with treatment once they have elected to receive hospice services would likely lead to greater use of palliative care services, and a more cost-effective use of health care at the end of life.

Providing Continued Access to Medicare Advantage Special Needs Plans (SNPs) for Vulnerable Populations

Trinity Health is in favor of a long-term extension or a permanent authorization of the SNP plans. However, it is strongly recommended that any extension or permanent authorization be structured to allow providers to more easily compete for covered lives in SNPs, either through direct provider contracting with the Center for Medicare and Medicaid Services (CMS), provider-based SNPs, or other means. To be considered for contracting with CMS, these providers must develop a required skill set (e.g., paying claims, compliance expertise, etc.), meet the ACO financial reserve requirement, and establish a qualifying network of providers with which a health plan must contract. Allowing providers to participate as SNPs would enable even more CMS dollars to be used for care of members or be re-invested into the community.

Provider-sponsored special needs plans offer unique opportunities that improve beneficiary outcomes:

- Providers can better build upon the existing trusted provider/patient relationship.
- Providers (Integrated Care Team) can define protocols and care patterns with knowledge stemming from trusted relationships and hands on experience.
- Providers can leverage their proximity to data to more effectively provide immediate adjustments to care.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

Trinity Health supports payment for chronic care management in models where providers are held accountable for outcomes; for example: bundled payment models, ACOs, PCMHs that include risk sharing, or other models that are developed by CMS/CMMI. It is Trinity Health's strong belief that payment for care management services needs to be accompanied by a requirement to produce an outcome in order to guarantee results. All comments offered in this section are based on an underlying recommendation that these high-severity codes be used only in closed-loop systems as described above.

Managing multiple chronic conditions requires increased levels of patient-provider interaction beyond the typical in-person visit; and often includes an integrated care team, such as social workers, dietitians, nurses and behavioral health specialists.

Patient criteria – Trinity Health recommends that both chronic behavioral health disorders and chronic physical conditions be counted in determining what makes up the number of “multiple” chronic conditions necessary to bill a high-severity chronic care management code. This approach is consistent with mental health parity and a new systematic case review process in which Trinity Health uses the criteria of at least one chronic physical condition and one chronic behavioral health disorder.

Providers eligible for billing high-severity chronic care management code – Trinity Health recommends that care managers—most often a nurse or social worker under supervision of a primary care physician or specialist—be allowed to bill the high-severity care management code.

Methodologies to measure impact, effectiveness and compliance – Trinity Health urges CMS to focus on a limited, manageable set (5-7 measures) of primarily outcomes-based measures – preferably patient-reported functional status metrics and metrics that can be derived from EHRs and submitted to CMS directly.

Permanence of the new code – Trinity Health recommends a new code be temporarily instituted while giving the Secretary of the Department of Health and Human Services authority to continue, discontinue or modify the code based on effectiveness; clinician and patient feedback; utilization of the code; and other factors. This approach would allow prudent modification based upon experience. Trinity Health discourages the Working Group from recommending that the code be made permanent.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

Trinity Health is pleased that the Working Group is considering policies to improve the integration of care for individuals with a chronic physical condition combined with a behavioral health disorder. Trinity Health supports payment for chronic care management in models where providers are held accountable for outcomes; for example, bundled payment models, ACOs, PCMHs that include risk sharing, or other models that are developed by CMS/CMMI. Trinity Health strongly believes that payment for care management services needs to be accompanied by a requirement to produce an outcome in order to guarantee results. All comments offered in this section are based on an underlying recommendation that payment for care management be used only in an outcome-based model.

Due to the shortage of behavioral health providers in the US, most individuals with behavioral health needs use their primary care doctor as their main source of care. This heightens the importance of integration behavioral health specialists with primary care providers. Collaboration between behavioral health specialists and primary care practitioners can have a significant impact on the ability of providers to deliver high-quality, people-centered care. An example is a primary care practitioner telephoning a behavioral health specialist to delve deeper into a patient's history to better understand current medical issues and determine the best treatment or management options for the patient. These interactions between providers are not uncommon scenarios and greatly enhance the care provided to a patient.

Collaborative care goes well beyond single provider-to-provider collaboration. Indeed, collaborative care is often team-based. For example, in the physician-led inter-professional case review conference, a multi-disciplinary care team – primary care physicians, specialists, pharmacists, nurse care managers, social workers, etc. – come together to discuss a patient's needs and treatment. Typically, however, only one professional can bill for this service even though the nature of multiple professionals contributing is what makes this care delivery model so valuable. Team-based collaborative care is critical to people-centered care delivery.

In considering how to pay for collaborative care in outcomes-based models, Trinity Health offers the following recommendations:

- Payment incentives should be available for both the primary care practitioner and the specialist.
- Other members of the care team are critical, including pharmacists, nurse care managers, social workers, etc.; and should, therefore, be eligible for payment incentives as well.
- Face-to-face patient encounters should not be required since the patient will often not be present during these interactions.
- The patient should be informed that a behavioral health specialist will be contacted on his/her behalf and informed of any implications regarding co-pays or other financial obligations that may result.
- Documentation requirements should not be so burdensome that they discourage providers from collaborating and seeking this reimbursement.
- By their very nature, psychiatric collaborations may take longer since they typically require detailed histories.

II. Expanding Innovation and Technology

Increasing Convenience for Medicare Advantage Enrollees Through Telehealth

Trinity Health supports broader use of telehealth services for Medicare Advantage enrollees. Telehealth has demonstrated a wide range of positive outcomes including better access to care regardless of the location of the patient, increased patient satisfaction, enhanced communication with providers and reduced costs. For these reasons, Trinity Health encourages expanded use of telehealth to promote health and well being across outpatient, inpatient and community-based settings regardless of the payer.

Telehealth provides an important opportunity to address our country's health care system's workforce challenges, particularly in providing better access to care for rural and inner-city patients. In these instances, telehealth importantly provides the opportunity for consultations with other health care professionals who are responsible for managing the patient at the originating site. Currently, however, there are few reimbursement opportunities for these critical provider-to-provider consultations (as opposed to provider-to-consumer). The Working Group should consider how its proposal can expand support for these important provider-to-provider consultations via telehealth.

While Trinity Health supports expanding the list of covered services to be as comprehensive as possible – to include such services as: teleradiology, teleneurology, telecardiology, and telepharmacy for example) – Trinity Health also recognizes that there is a shortage and poor distribution of nearly all specialties in various communities across the country. Therefore, the Working Group is encouraged to think creatively about how the reimbursement structure for telehealth might better evolve to incorporate emerging resource needs as opposed to the less systematic approach today of adding telehealth codes service-by-service.

Providing ACOs the Ability to Expand Use of Telehealth

Trinity Health is pleased that the Working Group is considering modifying the requirements for reimbursement for telehealth services provided by all tracks of ACOs in the Medicare Shared Saving Program (MSSP). Trinity Health believes that there should be a process by which all tracks of ACOs in the MSSP may receive a waiver of the geographic component of the originating site requirements. Such a waiver will allow the ACO to use its extensive knowledge of local resources to align the service

to the needs of the area. The MSSP presents an opportunity for the Medicare program to learn more about the potential value of telehealth in a more integrated environment, such as substituting these services for more difficult to obtain specialty visits. To protect against any abuses, ACOs can be monitored for outliers of these services that do not achieve savings. Thus, we support the waiver of the originating site policy under the telehealth benefit for all tracks of the ACOs in the MSSP program.

Maintaining ACO Flexibility to Provide Supplemental Services

Trinity Health believes that clarifications should be made to regulations so that all tracks of ACOs in the MSSP may furnish a social service or transportation service for which payment is not made under FFS Medicare. Experience demonstrates that care management initiatives have the potential to achieve meaningful improvements in quality and reductions in cost. CMS should be directed to grant flexibility to authorize non-covered Medicare benefits – such as transportation for specific clinical purposes or a remote patient monitoring system. CMS should also be directed to substitute alternative benefits for specific sub-populations or individuals—when doing so is expected to result in better care or outcomes at a better cost, and is offered as an option to the beneficiary. Often these services can be instrumental in providing care to a member at home, rather than an institution. This can benefit both the patient, by providing care in the comfort and safety in their home as well as to the system in potential cost savings.

In addition to the supplemental services described by the Working Group (social services or transportation services), Trinity health urges that the policy provide for sufficient flexibility to allow all tracks of ACOs to provide palliative care services, including those services provided by non-physician providers, which may not be directly reimbursed under the Medicare program. In conjunction with this policy, the Working Group and subsequent legislation developed by the Senate Finance Committee may want to direct CMMI to evaluate the extent to which ACOs are providing these services and determine what, if any, cost savings are attributable to the use of these services by non-physician providers. Moreover, CMMI should determine whether it may be possible to scale these services to the broader Medicare fee-for-service population.

Expanding Use of Telehealth for Individuals with Stroke

Trinity Health believes that public and private payers should provide telehealth reimbursement regardless of the origination site. Eliminating the originating site geographic restriction for promptly identifying and diagnosing strokes—as being considered by the Working Group—is a step forward in the right direction; but again, Trinity Health supports lifting the origination site restriction for all services.

Trinity Health has significant experience using a remote-presence robot, which allows stroke network physicians to provide two-way consultation and interaction to patients in different geographic locations. These specialists also use the technology in the following remote capacities:

- Provide bedside consultation for the patient's physician and family.
- Perform a neurological assessment, including the ability to visualize the size and shape of the patient's pupils if necessary.
- Review diagnostic tests performed on the stroke patient such as computerized tomography (CT) scans, electrocardiogram (EKG) monitoring, and laboratory results.

- Incorporate these results into the electronic health record at the source hospital, supporting seamless and more efficient care of patients on an ongoing basis.

Using this telehealth technology, stroke network patients have received effective intervention during the crucial early moments of a stroke. The end result for the patients has been better quality of life and significantly lower need for costly rehabilitation services.

III. Identifying the Chronically Ill Population and Ways to Improve Quality

Providing Flexibility for Beneficiaries to be Part of an ACO

Trinity Health recommends the following order of precedence for assigning beneficiaries to ACOs:

- Beneficiary choice through attestation at any time during the year.
- Prospective assignment regardless of which Track.
- Retrospective assignment in Tracks 1 and 2.

Trinity Health believes this creates the most stable population for the ACOs, while first honoring beneficiary choice.

Receiving services from non-participating ACO providers

Trinity Health also believes that all tracks of ACOs should be allowed to incentivize beneficiaries with lower co-pays and cost sharing to use participating providers, particularly primary care providers. Experience demonstrates that well-coordinated and connected care results in higher quality care and lower costs. However, Medicare beneficiaries will retain the ability to receive services from non-ACO providers, albeit at higher cost.

Developing Quality Measures for Chronic Conditions

Innovation in care delivery for the chronically ill should be driving toward the end goal of improved value: higher quality care at a lower cost to patients and the health care system overall. To that end, it is important to monitor the success of care delivery reforms and value-based payment arrangements to ensure that patients are indeed receiving high quality care. We urge CMS to use existing measures that fill this need, as well as test patient-reported outcomes measures (PROMs) and other measures that use patient-generated health data.

While the Trinity Health supports the Work Group's proposal to require CMS to develop measures that focus on health care outcomes for individuals with chronic disease, it is our position that quality measurement should become more focused on a small number of metrics that emphasize patient-reported and patient-generated data. We believe that the measures outlined by the Working Group are important for ascertaining the full picture of the needs of the chronically ill population and whether those needs are being met. To that end, while there are many more detailed measures of particular aspects of care for chronic disease, we believe that the use of PROMs is the best way to gauge overall success.

Existing infrastructure such as the Health Care Transformation Task Force, the Health Care Payment

Learning and Action Network, and the Center for Healthcare Transparency, can support CMS and accelerate the adoption of new chronic care measures (including PROMs). We believe that collaboration with public and private sector stakeholders to design, test, and spread these measures, is key for measure development and adoption.

Socio-demographic Implications

Trinity Health strongly believes that when using measures to reward and penalize a provider, the context within which providers are working must be considered. We believe that every patient who seeks care should expect the same outcome; however, it is also important to understand the increase or decrease in outcome risks associated with socio-demographic factors that are outside of the control of the provider. Use of these factors in risk-adjustment allows for fair cross-provider comparisons and does not penalize one provider over another or convey one provider is lower quality simply due to their willingness to treat any patient, despite that patient having an increased risk in poor outcomes due to endogenous factors that are captured in proxy measures such as socio-demographic variables. The lack of risk-adjustment can create a perverse cycle, wherein resources are denied – both payment penalties and income by discouraging beneficiaries from using these providers; to providers, who care for such patients, subsequently leading to unequal care for those patients due to lack of equal resources to treat them.

IV. Empowering Individuals & Caregivers in Care Delivery

To comprehensively care for high need, high-cost patients and improve health outcomes for this population, it is critical that individuals and caregivers be considered as partners at all levels of care delivery. Ultimately, partnership with patients and family caregivers is the best way to empower patients and ensure that care is aligned with patient needs and preferences, and is the best way to encourage optimal patient and family engagement in the care and self-management process. While the Working Group emphasizes the importance of empowering individuals and caregivers to be engaged in their care, the proposed policies focus on engaging patients at the point of care alone. Meaningful engagement, however, means supporting patients and family members as equal partners not just in decisions related to their care, but also decisions related to care delivery design and governance of provider organizations. In addition, patients and caregivers are valuable resources for forming partnerships between providers and communities.

Encouraging Beneficiary Use of Chronic Care Management Services

Trinity Health recommends that chronic care management services be covered similarly to preventative care—at no cost to the beneficiary. Trinity Health supports waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high-severity chronic care code described above. The success of managing chronic conditions directly relates to patient engagement. Copays and co-insurance are barriers to patient engagement. Eliminating barriers to patient engagement will result in better-managed chronic conditions.

These services are very new to the patient experience and often require patient education prior to acceptance of this model and desired increased patient engagement. This results in patients undervaluing these services at the outset of the care management relationship. However, once the relationship is established, patients are better able to understand and describe the value of the services

that they receive. Both government-funded projects and commercial payers have demonstrated successful outcomes when chronic care management services are provided without beneficiary cost sharing.

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

Trinity Health supports payment for chronic care management in models where providers are held accountable for outcomes; for example, bundled payment models, ACOs, PCMHs that include risk sharing, or other models that are developed by CMS/CMMI. Trinity Health strongly believes that payment for care management services needs to be accompanied by a requirement to produce an outcome in order to guarantee results. All comments offered in this section are based on an underlying recommendation that payment for care management be used only in an outcome-based model.

Trinity Health appreciates the Working Group’s recognition that certain diagnoses require extraordinary amounts of provider time to work with the patient and patient’s family. We suggest that this type of visit should not be limited only to times when the patient is physically present, but it also should be available when the patient is not present. For example, it is common for a family practitioner caring for a geriatric patient with dementia to have a one-hour visit with the patient followed by another one or two-hour visit with the family/caregiver. Almost by definition, the cognitive impairment of the patient usually necessitates a separate visit with the family/caregiver, and sometimes requires that this visit be conducted without the patient present, given the emotional challenges of the subject matter.

This situation is particularly common for providers caring for dual-eligible beneficiaries where there is a high percentage of disabled persons who have significant care management and support needs. Similar to the geriatric population with dementia, providers may meet with the family/caregiver separately from the patient. During the family/caregiver visit, the physician can explain the diagnosis, various treatment options, behaviors exhibited by the patient to monitor and next steps in treatment and management of the patient. These visits help the provider to optimize the management of the patient and thereby improve the patient’s treatment, enhance the capacity of the family/caregiver to manage the patient, and potentially reduce unnecessary care with improved outcomes.

As far as specific questions asked in the Working Group draft, Trinity Health requests clarity as to how this type of one-time payment would differ from the newly introduced advanced care-planning code. If this code is intended to help care for patients with life-threatening illnesses, the overlap is confusing.

Eliminating Barriers to Care Coordination under ACOs

Trinity Health supports allowing all tracks of ACOs to waive beneficiary cost sharing—such as copayments—for items/services that treat a chronic condition or prevent progression of a chronic disease. The private sector offers examples of successfully implementing such incentives. As well documented in benefit design, people respond to even small increases and decreases in cost-sharing under their health coverage. CMS should consider how ACOs should be able to leverage this effect to provide better care coordination. An example of such services is the new Chronic Care Management code which requires \$8 a month in co-insurance. This co-insurance may serve as a barrier to accessing care and prevent beneficiaries from using a service that would improve health outcomes and generate

savings opportunities. Thus it would make financial sense for ACO participants to waive the co-insurance. Similarly, with respect to encouraging beneficiaries to stay within the ACO when seeking care, an ACO may find it beneficial to waive co-insurance for primary care providers. We encourage CMS to carefully consider the possibility of this type of flexibility.

V. Other Policies to Improve Care for the Chronically Ill

Increasing Transparency at the Center for Medicare & Medicaid Innovation (CMMI)

Trinity Health would not support requiring formal rule-making for CMMI. Adding this type of requirement would go against the intent of CMMI and slow down the process of transformation—which needs to move faster not slower.

We agree with the comments offered recently in the Health Affairs article titled “[Expanding The Meaning Of Community Health Improvement Under Tax-Exempt Hospital Policy.](#)”¹

In the Patient Protection and Affordable Care Act of 2010, Congress created the new CMMI, designed to be up and running within CMS by 2011. Its purpose is “to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing quality of care.”

Study on Medication Synchronization

Trinity Health recommends that the Working Group pursue the study to improve medication adherence. Experience shows that patients with multiple medications are challenged to manage them, so easing that burden would increase compliance and improve outcomes.

Study on Obesity Drugs

Trinity Health recommends that the Working Group pursue the study to determine the use and impact of obesity drugs in the Medicare and non-Medicare populations. Trinity Health also supports a study that evaluates various interventions, which could include intensive nutritional counseling with a trained nutritionist and other pharmaceutical interventions.

Opportunities to Expand PACE

As you know, PACE provides a proven, comprehensive medical care that is fully integrated with long term services and supports to frail, elderly individuals, a large majority of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals coordinates and provides care to PACE participants with the goal of supporting their ability to remain in the community, as an alternative to permanent nursing home placement.

Trinity Health is the nation’s leading PACE provider with 11 programs in 8 states – comprising 10% of all PACE programs. Trinity Health respectfully urges the Working Group to consider adding these PACE proposals to the next draft of legislation planned for release:

¹ [Expanding The Meaning Of Community Health Improvement Under Tax-Exempt Hospital Policy](http://healthaffairs.org/blog/2016/01/08/expanding-the-meaning-of-community-health-improvement-under-tax-exempt-hospital-policy/), Health Affairs Blog, 1/8/16 <http://healthaffairs.org/blog/2016/01/08/expanding-the-meaning-of-community-health-improvement-under-tax-exempt-hospital-policy/>

Authorize PACE organizations in states without PACE or with limited geographic access to PACE to move forward under a contract with Medicare – PACE organizations can operate only in states that have added the PACE program to their state Medicaid plans and that agree to enter into three-way PACE agreements with PACE organizations and CMS. Currently, 18 states have not elected PACE as a state option; and, in these states, no Medicare beneficiaries have access to the program. Further, there are states that have added PACE to their Medicaid plans but that are not authorizing new PACE programs to serve additional communities. As a result, in these areas, access to PACE is unnecessarily limited for Medicare-only beneficiaries.

Allow Medicare-only beneficiaries who enroll in PACE to choose a distinct Part D plan, rather than require them to enroll in the PACE organization's Part D plan – because PACE is required to provide all Medicare and Medicaid benefits. A Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for his/her prescription drug coverage. Medicare-only beneficiaries—unlike dual-eligible beneficiaries—are required to pay a monthly premium for their Part D coverage and should be able to use their resources to select the Part D plan of their choice. Greater choice and flexibility will help Medicare beneficiaries by allowing them to receive the coverage and prescription drug access that is best suited to their medical and financial needs.

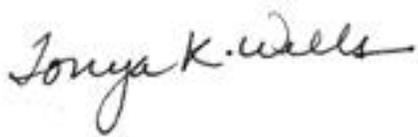
Allow PACE organizations more flexibility in determining the premiums charged to Medicare-only beneficiaries – the existing regulations limit PACE organizations' ability to establish the premiums charged to Medicare-only beneficiaries by requiring them to be set in accordance with the Medicaid rates paid for dual-eligible beneficiaries. This limits PACE organizations' ability to establish rates that reflect consumers' interest in differentiated rates based on the range of care needs within the nursing home level of care population. With few exceptions, PACE Medicaid rates for dually-eligible individuals are not adjusted for risk or need. The Working Group's stated goals are to increase care coordination among individual providers, streamline payment systems to incentivize the appropriate level of care, facilitate the delivery of high quality care, improve care transitions, produce stronger patient outcomes, maximize efficiency, and reduce growth in Medicare spending. The Working Group can achieve each of these objectives by encouraging greater access to PACE for Medicare beneficiaries at capitation rates that are more attuned to their needs; and, as a result, more competitive in the market place.

Conclusion

As an organization that is strongly committed to advancing better health, better care and lower costs, Trinity Health appreciates the opportunity to provide comments to the Senate Finance Committee Bipartisan Chronic Care Working Group draft. Many of the policy options offered by the Working Group suggest logical improvements to an antiquated and ineffective FFS system. These recommendations to the FFS program are likely to result in better care for beneficiaries with chronic conditions. However, these improvements system still reward volume and are not transformational. The transformational change occurs when payment models require accountability for episodes of care or for populations – such as bundled payment, ACOs, or global payment models. It is only these types of reimbursement changes that will assure that our Medicare program is delivering better health, better care and lower costs.

If you have any questions about our comments, please feel free to contact me at 734.343.0824 or wellstk@trinity-health.org.

Sincerely,

A handwritten signature in black ink that reads "Tonya K. Wells". The signature is written in a cursive, flowing style.

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health