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January 28, 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

Re: ACS CAN Recommendations to the Senate Finance Committee's Chronic Care Working Group

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

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide comments on the Senate Finance Committee Bipartisan Chronic Care Working Group Policy Options document. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government. ACS CAN applauds the Senate Finance Committee, and the Bipartisan Working Group (Working Group), for a transparent and inclusive process and for your hard work to develop recommendations to transform Medicare to provide better care for individuals with chronic conditions such as cancer.

ACS CAN is pleased to offer comments that specifically address recommendations made in the policy options document. However, we are obliged to note concern that the Working Group's recommendations focus almost exclusively on changes to Medicare Advantage (MA) plans or new care models. While we fully support integrated approaches to care, we urge the Working Group to recognize that the majority of Medicare beneficiaries are still in traditional fee-for-service. Therefore, the Working Group recommendations should also focus on ways to improve care for beneficiaries remaining in traditional Medicare.

According to the Centers for Medicare and Medicaid Services (CMS) more than two-thirds of Medicare beneficiaries have two or more chronic conditions. This number will continue to increase as the population ages. And when it comes to cancer, age is a key factor. Roughly 78 percent of all cancer diagnoses are in people age 55 or older – many of whom are Medicare beneficiaries.

Beneficiaries with multiple chronic conditions are the heaviest users of health care – utilizing more physician, hospital, post-acute, and home health services – than other beneficiaries. In 2010, beneficiaries with two or more chronic conditions accounted for nearly 98 percent of Medicare hospital readmissions.[1] This excess utilization – and the associated increased costs to Medicare – could be reduced if the Medicare program changes the way it delivers and pays for services. To the extent the Medicare program can work better for beneficiaries with chronic conditions like cancer it will benefit all enrollees.

Medicare is the primary source of health care coverage for millions of Americans but as currently structured it does not encourage the kind of seamless care that beneficiaries with chronic conditions like cancer most need. There is little incentive for Medicare to foster integration across various sites of care or collaboration among providers. The program does not always utilize technology in ways that help to improve care. There are still gaps in coverage and Medicare is not yet a model of genuine patient-centered care.

The Center for Medicare and Medicaid Innovation (CMMI) is currently testing a number of payment and delivery models that could help to improve Medicare. Last year, the Department of Health and Human Services (HHS) Secretary announced the intent to move thirty percent of Medicare payments into alternative payment models. We applaud these efforts and believe that even more can be done to transform Medicare into a truly patient-centered program.

In our earlier comments to the Working Group we encouraged you to consider some guiding principles to help ensure that Medicare meets the needs of patients with chronic conditions. We still firmly believe that these principles should be the basis for the Working Group's final recommendations:

- Medicare delivery models should guarantee that patients with chronic illness like cancer have access to the full range of providers, practitioners, items and services required to address their healthcare-related needs;
- Medicare should remain affordable and protect patients from catastrophic out-of-pocket financial costs;
- Medicare's payment should incentivize practitioners to provide high quality care, encourage care coordination, patient navigation, palliative care and appropriate care transitions;
- New Medicare payment and delivery models should reduce inequities and disparities in care;
- Medicare delivery models should incentivize a greater use of technology to ensure seamless care;
- Medicare beneficiaries with chronic conditions should receive care that is consistent with the latest practice guidelines or comparable clinical standards;
- Medicare should provide comprehensive coverage of all evidence-based preventive services with no cost-sharing to the patient;
- Medicare should ensure that throughout the continuum of care, the patient is a partner in decisions about their treatment options, including the settings of care; and

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[1] Centers for Medicare and Medicaid Services, Chronic Conditions Among Medicare Beneficiaries. Chartbook, 2012 Edition. Baltimore, MD. 2012.

- Medicare should continue to systematically measure the success of new delivery and payment models and require high performance on both clinical quality and patient experience metrics that become more rigorous over time.

ACS CAN is pleased to offer comments that specifically address recommendations made in the policy options document. Our comments follow the order of the policy recommendations as they appear in the document.

Advanced Team-Based Care

Providing Medicare Advantage Enrollees with Hospice Benefits:
The Working Group is considering requiring Medicare Advantage (MA) plans to offer the hospice benefit provided under traditional Medicare. Under the proposal, the full scope of the hospice benefit, including the required care team and written care plan, would be required.

ACS CAN supports making hospice care available to all Medicare beneficiaries – regardless of whether the beneficiary elects to remain in traditional fee-for-service or chooses to enroll in an MA plan. Requiring MA plans to cover hospice services raises a number of operational issues, and changes to the program must be thoughtfully approached.

As the Working Group explores policy changes that would require MA plans to provide hospice to beneficiaries, a number of policy issues should be addressed and examined. For example, MA plans are permitted to restrict their provider networks if they meet certain network adequacy standards. Given the nature of the hospice program, it may not be appropriate for MA plans to be permitted to restrict access to these services. It would be important for beneficiaries to have a choice of available hospice providers.

The issue of cost sharing in connection with the hospice benefit would also need to be addressed, as well as prior authorizations, or other utilization management tools (above the current requirements for fee-for-service beneficiaries) to limit beneficiary access to the hospice benefit and/or steer beneficiaries to a particular hospice program.

Finally, we note that CMMI is currently testing the Medicare Care Choices Model, which would allow beneficiaries who have received certain diagnoses and who meet other qualifications and limited to certain hospices to receive hospice care and concurrent treatment if they so choose. ACS CAN supports this demonstration and urges the Working Group to consider adopting this demonstration into its final recommendations.

Improving Care Management Services for Individuals with Multiple Chronic Conditions:
The Working Group is considering establishing a new high-severity chronic care management code for clinicians who coordinate care for beneficiaries living with multiple chronic conditions. The new code payment would be higher to compensate providers who require more time with complex patients than is typically allotted time per month.

ACS CAN strongly supports this proposal. Cancer is a complex disease and its treatment involves multiple providers and specialties such as primary care providers, oncologists, radiologists, surgeons, palliative care providers, nutritionists, and mental health providers. Coordination of care becomes even more complicated when a cancer patient has other chronic conditions. According to National Cancer Institute Data, 25.2 percent of cancer patients have one comorbid condition, and 15 percent have two or more comorbid conditions. The most common comorbid conditions for cancer patients are diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure, and cerebrovascular disease.[2] Treating these patients is difficult and costly. Cancer patients and providers will benefit from this newly proposed high-severity chronic care management code.

In response to the Working Group's request for feedback on patient criteria for the potential new high-severity code, ACS CAN believes the criteria suggested in the proposal are too stringent and would prevent many patients who need this service from receiving it. ACS CAN urges the Working Group to finalize the proposal with eligibility criteria requiring patients to have 3 or more chronic conditions.

The Working Group asks for input on the types of providers who should be eligible to bill the new high-severity chronic care management code. ACS CAN supports allowing both primary care and specialty physicians to receive reimbursement for this new code. We also urge the Working Group to allow non-physician providers to be reimbursed for this code, such as nurses (RNs), nurse practitioners, clinical nurse specialists, nurse navigators, social workers, and patient navigators. These non-physician providers are often part of care teams and play significant roles in caring for beneficiaries with multiple chronic conditions.

Although the Policy Options Document references the Physician Fee Schedule, non-physician providers currently are limited in their ability to receive reimbursement under the Physician Fee Schedule unless they bill incident to a physician. Proper chronic care management often involves physician and non-physician providers working in tandem in the care of the beneficiary. ACS CAN urges the Working Group to require CMMI to create a demonstration program to better test ways in which Medicare can provide reimbursement – including direct reimbursement – to non-physician providers.

The Working Group also asks whether the new code should be temporary or permanent. ACS CAN encourages the Working Group to create the code and temporarily institute it while giving the Secretary of HHS authority to continue, discontinue, or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors.

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[2] Edwards, B. K., Noone, A.-M., Mariotto, A. B., Simard, E. P., Boscoe, F. P., Henley, S. J., Jemal, A., Cho, H., Anderson, R. N., Kohler, B. A., Eheman, C. R. and Ward, E. M. (2014), Annual Report to the Nation on the status of cancer, 1975-2010, featuring prevalence of comorbidity and impact on survival among persons with lung, colorectal, breast, or prostate cancer. Cancer, 120: 1290–1314. doi: 10.1002/cncr.28509.

Expanding Innovation and Technology

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees: The Working Group is considering giving MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees. This flexibility would allow an MA plan to provide tailored benefits that would reasonably be expected to improve the care and/or prevent the progression of the chronic conditions affecting MA enrollees.

ACS CAN is supportive of the MA program. However, we are concerned the proposed policy changes could unintentionally disadvantage beneficiaries who remain in traditional fee-for-service Medicare. These tend to be the very the beneficiaries who could most benefit from improvements in chronic care. The Working Group's proposals – e.g., adding supplemental benefits that are related to the treatment of the chronic disease or prevention; reducing cost-sharing for items or services that treat chronic disease or prevent the progression of chronic disease; and care improvement or wellness programs specifically tailored for the chronic condition – are benefits that should be provided to all Medicare beneficiaries, not limited to those who enroll in an MA plan.

For example, with respect to supplemental benefits designed to prevent chronic disease, we urge the Working Group to consider legislation to ensure that beneficiaries who receive a screening colonoscopy that results in the removal of one or more precancerous polyps are not assessed a copayment. Under current Medicare rules the removal of the polyp is considered a diagnostic – not screening – procedure. While this loophole has been fixed for individuals enrolled in qualified health plans, Congressional action is required to ensure that this barrier to colonoscopies is removed for Medicare beneficiaries as well. We urge the Working Group to include the bipartisan Removing Barriers to Colorectal Cancer Screening Act (S. 624) in its final recommendations.

In addition, we are concerned with the policy proposal to allow MA plans to have different provider networks to treat enrollees with chronic conditions. Under this policy, an MA plan could have multiple provider networks for the same plan, but only certain beneficiaries would be permitted access to those providers. It is unclear whether these MA plans would be permitted to market this enhanced provider network. We are concerned that if MA plans were permitted to engage in such marketing, it would undoubtedly create beneficiary confusion. Moreover, enhanced provider networks should not be necessary. If the Working Group is concerned that the MA plans' provider networks are insufficient to meet the needs of beneficiaries with chronic care needs, then the Working Group should revise the existing provider network standards to require MA plans to contract with specific providers. To permit an MA plan to offer an enhanced provider network to only a select group of beneficiaries could result in restricted provider access to non-chronically ill beneficiaries, which is not the intent of the policy proposal.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees:
The Working Group is considering allowing MA plans to offer a wider array of supplemental benefits than they do today. These additional supplemental benefits could be medical services or other non-medical, social services that improve the overall health of individuals with chronic disease. Any new supplemental benefits would continue to be paid by plans' rebate dollars.

ACS CAN agrees that non-medical or social factors can be important contributors to the health and costs of chronically ill beneficiaries. For example, nutrition counseling for cancer survivors can help reduce the risk of cancer recurrence. However, we are concerned about the extent that MA plans are permitted to provide supplemental benefits not available to beneficiaries in fee-for-service Medicare. To the extent that some beneficiaries have access to significantly more benefits, it creates an uneven playing field between the MA program and fee-for-service Medicare. Therefore, if the Working Group is inclined to permit MA plans to provide additional supplemental benefits, we would encourage the Working Group to direct CMS – whether through the Office of the Secretary or through CMMI – to determine the extent to which these benefits should be provided to all Medicare beneficiaries as a mandatory service.

Providing ACOs the Ability to Expand Use of Telehealth:
The Working Group is considering modifying the requirements for reimbursement for telehealth services provided by Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP). The HHS Secretary would be required to establish a process by which ACOs participating in MSSP two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

Approximately one-fourth of all Medicare beneficiaries live in isolated or rural areas and many confront formidable barriers to quality cancer care.[3] Individuals with cancer – particularly those in rural or frontier areas – often have challenges accessing specialists due to geographic limitations. Telehealth services have the potential to help cancer patients overcome geographic limitations to access specialist care and allow patients the opportunity to receive services without having to incur additional travel costs. Some providers and health care systems are testing models specifically targeted to cancer patients[4,5] especially for delivering palliative care, pain management and patient navigation services;[6,7,8,9] and the findings from these models should help to inform changes in Medicare's reimbursement of telehealth.

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[3] Medicare Payment Advisory Commission, A Data Book: Health care spending and the Medicare program. June 2015.

[4] Doolittle GC, Spaulding AO. Providing Access to Oncology Care for Rural Patients via Telemedicine. J Oncol Pract. Sep 2006; 2(5): 228-230.

[5] Doorenbos, A.Z., Demiris, G., Towle, C. et al. Developing the Native People for Cancer Control Telehealth Network. Telemed J E Health. 2011; 17: 30–34.

[6] Alaska Native Tribal Health Consortium. AFHCAN telehealth solutions. http://www.afhcan.org/. Accessed June 21, 2012.

[7] Hennemann-Krause L1, Lopes AJ1, Araújo JA2, Petersen EM2, Nunes RA1. The assessment of telemedicine to support outpatient palliative care in advanced cancer. Palliat Support Care. 2014 Aug 27:1-6.

Over the past five years, new technological advances and increased broadband connectivity across remote and rural settings in the U.S. allow many of these models to connect patients with their health care providers beyond the traditional brick and mortar health care setting.[10] As the Working Group contemplates whether to eliminate the originating site requirement or specify additional sites to the accepted list, we believe it would be premature to make a recommendation given the lack of scientific evidence supporting either option. We do, however, recommend the Working Group direct CMMI to conduct pilot telemedicine demonstrations to better determine whether the originating site requirement could be eliminated or specify additional sites that would qualify.

Identifying the Chronically Ill Population and Ways to Improve Quality

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization:
ACS CAN supports the ACO program. However, we are concerned with the Working Group's proposal to allow Track One MSSPs to prospectively assign beneficiaries. In implementing the ACO program, CMS grappled with whether beneficiaries should be assigned on a prospective or retrospective basis. Many consumer and patient groups urged CMS to adopt a retrospective basis due in large part to concern over an ACO's ability to cherry pick the beneficiaries aligned with the ACO. Ultimately CMS agreed to adopt a retrospective assignment.

We are concerned that allowing some Track One MSSPs to prospectively assign beneficiaries creates the potential for beneficiary confusion. Most beneficiaries are unaware of the ACO program and much consumer education is needed to inform them of the benefits of this model. Unfortunately, to date this education has not yet occurred. We are concerned that without broader, comprehensive beneficiary education, the proposed voluntary beneficiary election will amount to nothing more than a form provided at the point of service and will fail to provide the beneficiary with an opportunity to request additional information and/or discuss any concerns she may have.

We therefore urge the Working Group to direct HHS to provide better beneficiary education about the broader ACO program before enacting policies that would alter beneficiary assignment to an ACO. ACS CAN is willing to work with the Working Group, HHS, and other stakeholders in the developing and testing of beneficiary educational materials as well as dissemination of these materials.

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[8] Pruthi S., Stange K.J., Malagrino Jr. G.D., Chawla K.S., LaRusso N.F., Kaur J.S. Successful implementation of a telemedicine-based counseling program for high-risk patients with breast cancer. Mayo Clinic Proceedings, 88 (1), pp. 68-73.

[9] Holland DE1, Vanderboom CE, Ingram CJ, Dose AM, Borkenhagen LS, Skadahl P, Pacyna JE, Austin CM, Bowles KH. The feasibility of using technology to enhance the transition of palliative care for rural patients. Comput Inform Nurs. 2014 Jun;32(6):257-66.

[10] Federal Communications Commission. *2015 Broadband Progress Report*. https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2015-broadband-progress-report.

Developing Quality Measures for Chronic Conditions:
The Working Group is considering requiring that CMS include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease.

ACS CAN fully supports requiring CMS to include chronic care measures in its quality measures plan. We support the emphasis on patient and family engagement, including person-centered communication, shared decision-making, care planning and patient-reported measures. Medicare beneficiaries with chronic conditions have considerable experience with the health care system. Capturing their experiences through patient reported outcomes measures can be a valuable tool for improving the program.

For patients with chronic conditions like cancer, engaging in care decisions can make an enormous difference in the treatment outcome. Cancer patients often want to share in decisions about their care. These patients want to be assured that they are making treatment decisions based on the best information available and they want to fully understand the risks and benefits of their treatment options. This is why shared decision making and good practitioner-patient communication is so essential and needs to be effectively measured.

ACS CAN also supports the Working Group's recommendation for measure development for care coordination. Medicare beneficiaries with cancer see a myriad of providers – oncologists, primary care physicians, nurse practitioners, radiologists, cardiologists, surgeons, and others – and they need to know that these practitioners are talking to each other and fully understand all of their needs. Unfortunately, most Medicare patients are currently left to cobble together their care and act as their own care managers.

Equally problematic is the lack of seamless transitions of care. For many cancer patients the transition from oncology back to primary care – following the end of cancer treatment – is disjointed. Many of these patients do not have a survivor care plan and are not fully clear about their next steps. New alternative care models – like ACOs and Patient Centered Medical Homes – purport to provide better care management and care transitions so it is critical that the effectiveness of the services being offered are measured to ensure that they deliver on the promise of better care.

Finally, ACS CAN supports the development of measures related to hospice and end-of-life care – particularly how well the beneficiary's goals, preferences and values are elicited and documented.

Empowering Individuals & Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management (CCM) Services:
ACS CAN strongly supports the proposal to waive the beneficiary co-payment associated with the current chronic care management code as well as the proposed high-severity chronic care code described above. As the Policy Options document notes, this service takes place amongst providers, and not necessarily in the presence of the patient. Therefore, many patients do not understand why they are being charged a co-payment for the service (approximately $8 per month for the current chronic

care management code), and providers find it difficult to collect. These difficulties may discourage some providers from using the code and performing the service. Removing the current co-payment, and not requiring one for the proposed new high-severity code, are important steps to increase usage of the codes and delivery of these vital services.

The Working Group notes that many Medicare enrollees have Medigap or employer retiree coverage that supplements Medicare and may already allow the patient to avoid paying this co-payment. The Working Group suggests that because of these supplemental policies, this proposal will not affect use of chronic care management services. However, according to the Kaiser Family Foundation, 14 percent of Medicare enrollees in 2010 did not have any type of supplemental coverage[11] and thus would definitely incur the beneficiary cost-sharing. In addition, it is important to note that to the extent that supplemental policies cover the cost of this co-payment; this cost-sharing will ultimately be borne by enrollees in the form of higher premiums for supplemental policies. ACS CAN encourages the Working Group to implement this proposal and remove cost-sharing for chronic care management services.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness:
The Working Group is considering requiring that CMS implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness like Alzheimer's/Dementia. The purpose of this visit would be to discuss the progression of the disease, treatment options, and availability of other resources that could reduce the patient's health risks and promote self-management.

ACS CAN supports this proposal. We note that cancer patients benefit greatly from time with their healthcare providers, and the current evaluation and management codes are insufficient to provide reimbursement for the necessary time it may take a provider to have a meaningful discussion with a beneficiary, or family member of a patient who is newly diagnosed with a serious or life-threatening illness. Separate payment for this service under the Medicare Physician Fee Schedule would allow providers to have more lengthy encounters, develop a detailed patient care plan, and discuss the availability of community resources for assistance. This new code could also serve as a precursor to use of the (current and proposed) chronic care management codes.

The Working Group asks for feedback on the scope of diseases that would be considered serious or life-threatening, thereby qualifying a patient for use of this new code. ACS CAN encourages the Working Group to refrain from listing specific diseases in conjunction with the code. We are concerned the Working Group's singling out of Alzheimer's/Dementia in its proposal will discourage the code's use for patients with other diseases like cancer. This code can help many types of patients and should not be associated with a single disease. Rather than focusing on specific disease diagnosis, ACS CAN encourages the Working Group to focus on serious illness more broadly, and clearly define the term.

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[11] Kaiser Family Foundation. "Medigap Reform: Setting the Context for Understanding Recent Proposals." January 13, 2014. http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/.

The Working Group asks for feedback on whether a planning visit should have different required elements for each illness. As ACS CAN encourages the Working Group to not single out specific diseases, we do not support requiring different elements of the visit for different diseases. We support the description of the elements of the visit in the Working Group's current proposal: "The purpose of this visit would be to discuss the progression of the disease, treatment options, and availability of other resources that could reduce the patient's health risks and promote self-management." However, ACS CAN strongly supports the addition of one element: development of a care plan. This is perhaps implied in the current list, but we encourage the Working Group to make the development of a care plan a specific requirement. Developing a care plan based on the patient's needs and preferences helps cancer patients express their goals of treatment to providers, and leads to receipt of important services like palliative care.

The Working Group solicits feedback on how the requirements of this payment code should interact with the (current and proposed) chronic care management codes. If, as we encourage above, a care plan is required to be developed at this visit, this will be a useful pre-cursor to provider use of the chronic care management codes. However, patient care plans, goals, and available resources are not static throughout treatment of a serious disease. The course of treatment might cause the patient to change her goals (for example, from curative treatment to alleviation of pain), or side effects of treatment might require a new conversation about treatments or community resources to alleviate these side effects. Allowing multiple visits under this code will allow providers to better respond to patient needs. The care plan can serve as a basis for organizing these chronic care management services, and can identify the providers involved in these future services.

We support the use of this new code working in conjunction with the proposed chronic care management codes (discussed above) to provide patients additional time to consult with their health care provider to better understand their new diagnosis for a serious or life-threatening disease. However, we note that the new chronic care management codes proposed by the Working Group are only available to patients with multiple diseases. A patient with only one serious or life-threatening disease should not be limited to only one planning visit. We urge the Working Group to ensure that these individuals also are able to receive the care coordination services needed for their diagnosis.

ACS CAN also would like to call attention to the need for more health care providers to be trained in providing such guidance to patients with a serious life threating illness and believe that palliative care could provide such a model. Providers must have adequate skills to be able to have goals of care conversations, and address the needs of patients with multiple chronic conditions. In recognition of this need, we urge the Working Group to consider three policy issues that need to be addressed in order to ensure that Medicare beneficiaries are provided better quality of care through greater access to palliative care services. These three policy issues involve the need to train more physicians, nurses, social workers, and other health professionals in the medical subspecialty of palliative care; the need to educate the public and providers about the availability of palliative care; and the need for a greater investment in evidence-based research specific to palliative care and symptom management.

As part of our effort, ACS CAN continues to encourage the enactment of the Palliative Care Hospice Education and Training Act, H.R. 3119 (a Senate companion measure is expected to be introduced shortly). While we recognize that this legislation is outside the jurisdiction of the Senate Finance Committee, we believe these issues are important to consider in context with establishing a policy for such visits post initial diagnosis of a serious or life-threatening illness.

Other Policies to Improve Care for the Chronically Ill

Increasing Transparency at the Center for Medicare & Medicaid Innovation (CMMI):
The Working Group is considering modifications that would either require CMMI to issue required notice and comment rulemaking for all models that affect a significant amount of Medicare spending, providers or beneficiaries; or require CMMI to issue notice and comment rulemaking for all mandatory models and at least a 30 day public comment period for all other innovation models.

Transparency in the CMMI process is incredibly important, particularly as the Center implements new models and payment systems. We believe CMMI benefits from hearing from all interested stakeholders prior to finalizing policies that will greatly impact enrollees, providers and health systems. CMMI should be required to seek, receive and respond to input and feedback from all stakeholders when implementing new policies. All stakeholders should be given a chance to submit comments on CMMI models.

We note that individuals who are dually eligible for the Medicare and Medicaid programs often have chronic conditions. We urge the Working Group to ensure this transparency applies to any future models that focus on Medicaid. Transparency is perhaps even more important for models involving Medicaid because of its combined federal/state funding and administrative structure and the vulnerability of beneficiaries who are dually eligible for both programs.

The Working Group asks for feedback on whether instituting these types of requirements would impact CMMI's ability to "rapidly modify models or terminate models that are not working." Requiring notice and comment rulemaking upon implementation of a model will not at all affect proposals to change or stop using the model. ACS CAN believes that the increased transparency and ability for stakeholders to give adequate feedback outweighs any delays this requirement might cause in implementation. A shorter 30-day comment period for changes or removal of models should not cause unreasonable delay for changes to a model – and would actually help in making the relevant providers, systems and patients aware of the upcoming proposed change.

Study on Medication Synchronization:
The Working Group is considering requiring a study to determine, in order to improve medication adherence, how Part D prescription drug plans (PDPs) could coordinate the dispensing of prescription drugs so that, to the extent feasible, multiple prescriptions can be dispensed to a beneficiary on the same day, providing greater opportunity for the beneficiary to receive comprehensive counseling from a pharmacist.

ACS CAN supports this proposal. Individuals with chronic conditions and those in active cancer treatment often have to juggle multiple medications, many of which have different dispensing dates. As a result, a patient may often have to make multiple trips to the pharmacy in a given month – or week – in order to fill her prescriptions. This can impose an undue burden on patients – particularly for someone who may be immunocompromised as a result of chemotherapy.

As part of the study, ASC CAN urges the Working Group to explore specific policies to ensure that beneficiary cost-sharing does not increase under the policy.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to provide comments to the Senate Finance Committee Chronic Care Working Group's Policy Options Document. If you have any questions, please feel free to contact me or have your staff contact Keysha Brooks-Coley, Director of Federal Relations at Keysha.Brooks-Coley@cancer.org or 202-661-5720.

Sincerely,

Christopher W. Hansen
President
American Cancer Society Cancer Action Network