AHCA
AMERICAN HEALTH CARE ASSOCIATION
NCAL
NATIONAL CENTER FOR ASSISTED LIVING

IMPROVING LIVES *by*
DELIVERING SOLUTIONS *for*
QUALITY CARE

June 22, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

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

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
75 Russell Senate Office Building
Washington, D.C. 20510

Senators Hatch, Wyden, Isakson, and Warner:

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) is pleased to submit comments for your consideration as you explore policy solutions to address the prevalence of chronic conditions in America. Through our representation of more than skilled nursing facilities (SNFs) just over one million beds, close to 200,000 assisted living beds (AL), as well as close to 10,000 intellectual and developmental disabilities (ID/DD) beds, AHCA/NCAL has extensive experience with chronic conditions and, based upon our work, we offer the ideas below in areas we believe we offer the most benefit to the Work Group.

1. ***Improvements to Medicare Advantage for patients living with multiple chronic conditions.*** AHCA/NCAL recognizes the importance of choice for Medicare beneficiaries both between Original Medicare and Medicare Advantage (MA) as well as

among MA plans. And, the Association believes that coordinated care (e.g., both provider lead or traditional health management organization (HMO) models) offers important support to persons living with multiple chronic conditions. To enhance the MA program, AHCA/NCAL suggests the following. First, little is known about how Original Medicare fee-for-service (FFS) and MA compare in terms of outcomes.[1] AHCA/NCAL strongly suggests that the Chronic Care Work Group avail itself of new CMS MA encounter data to better understand how MA plans are delivering care to persons with multiple chronic conditions, particularly in light of their still proprietary care models, and Medicare FFS approaches which also manage care (see below) as well as examine MA costs compared to Original Medicare. Second, increasingly, MA plans are contracting with downstream intermediaries to manage care for specialty populations and services. Of key interest to AHCA/NCAL is a growing market of post-acute care (PAC) benefit management entities. The MA statutory and regulatory language is insufficient to address plan coordination with these entities, providers and beneficiaries.[2] More concerning, the MA requirements do not require plans to disclose the introduction of these entities to beneficiaries or providers. AHCA/NCAL members report notable challenges with coordinating care when these unregulated parties are introduced. AHCA/NCAL recommends that the Chronic Conditions Work Group explore the role these entities in ensuring, or hindering, the delivery of care to persons with chronic conditions. Finally, the MA regulatory language requires MA plans to coordinate with physicians on care decisions. No other providers are mentioned.[3] AHCA/NCAL recommends the Work Group explore the addition of specialty providers as well as PAC and long term care providers to the list of providers with whom plans should consult when making care decisions for persons with chronic conditions.

2. ***Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures.*** AHCA/NCAL believes Senator Wyden's Better Care Program (BCP) concept included in his Better Care, Lower Cost Act of 2014 measure holds great promise in terms of an approach to better coordinate care for persons with multiple chronic conditions. Since the introduction of the Senator's bill last year, a number of initiatives have unfolded which the Association believes merit the Work Group's attention. These efforts hinge on the concept of provider lead entities (PLE) organizing

[1] ***The Wall Street Journal***, November 10, 2014 available at http://blogs.wsj.com/totalreturn/2014/11/10/medicare-vs-medicare-advantage-more-comparative-data-needed/
[2] [42 U.S.C. 1395w–25] and § 422.504 (i)(1)
[3] Ibid.

themselves around a particular population to deliver focused, coordinated care. First, the Center for Medicare and Medicaid Innovation (CMMI) has begun preliminary work on a Medicare-Medicaid Integrated ACO model. By definition, persons who are eligible for Medicare and Medicaid have chronic conditions. Second, three states are moving ahead with state-based legislation aimed at developing similar models – North Carolina, Alabama and Colorado. While Oregon also has its Care Coordination Organizations (CCOs), AHCA/NCAL believes these new initiatives bring fresh thinking. The Association's membership has been engaged in the development of these efforts. Regarding bundling and bundled payments, the Association has crafted a set of principles which we believe should be incorporated into any bundled payment arrangement. As noted above in regards to the people and families our members serve, these principles were crafted with an eye towards persons with complex, ongoing care needs.[4]

3. ***Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.*** The Affordable Care Act established the Medicare Spending Per Beneficiary (MSPB) measure which is integral to the Centers for Medicare and Medicaid Services (CMS's) Hospital Value-Based Purchasing (VBP) Program.[5] Beginning in fiscal year 2015, MSPB will account for 20 percent of hospitals' VBP payments. The MSPB measure also will be one of six cost measures in the 2016 Physician Feedback/Value- Based Payment Modifier Program. These measures are intended to address quality and efficiency but are as yet untested and some beneficiary groups have expressed concern about the potential negative impacts due to unintended MSPB market pressures. Additionally, when combined with implementation of the Protecting Access to Medicare Act of 2014 (PAMA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, both of which AHCA/NCAL supported, these initiatives present an array of substantial changes in the delivery of care to all Medicare beneficiaries but likely will disproportionately impact Medicare beneficiaries with chronic conditions. Related to the initiatives above, AHCA/NCAL recommends the Work Group explore how these efforts likely will impact persons with multiple chronic conditions and urges the work group to thoroughly explore CMS' implementation timelines and related beneficiary impact assessments before taking up additional changes. Additionally, AHCA/NCAL has invested considerable resources in the development of patient characteristics-based or

[4] Our principles were presented before the House Energy and Commerce Subcommittee on Health. To view the testimony, click here.

[5] To view the hospital measure, go to http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772053996

condition-based care and payment. The Association would be pleased to share this information with the Work Group.

4. ***Ideas to effectively use or improve the use of telehealth and remote monitoring technology.*** Before entering into discussion on telehealth and remote monitoring, AHCA/NCAL believes the Work Group first should consider the status of Health Information Exchange (HIE) among PAC and long-term care provider which are critical to a large subset of persons with multiple conditions. Such providers, including the Association's members, were excluded from the Meaningful Use program, and, therefore, had no incentives to build or conform PAC and long term care health IT systems to meet the functionality criteria outlined in the Meaningful Use program. To-date, many providers already have invested considerable resources to adopt certain health IT systems and then customizing them to meet their needs, which are often different from the needs of hospitals and physician practices who participate in the Meaningful Use program. Many of these systems are home-grown. If CMS were to enforce requirements that these systems meet certain certification criteria that is tied to the Meaningful Use program, it would place a tremendous burden on these providers, with a disproportionate amount of that burden falling on smaller and independently operated facilities. In addition, applying the same meaningful use program criteria to SNFs may result in costly changes that do not help with patient care given the population and purpose of SNF care. AHCA/NCAL recommends the Work Group explore CMS' ideas on PAC and long term care provider adoption of HIE and related health IT efforts such as telehealth and remote monitoring. Finally, AHCA/NCAL would be pleased to share member models of telehealth and remote monitoring. As noted above, many of our members have invested considerable resources in the development of such care tools in the absence of CMS guidance or support.

In closing, we laud the formation of the bipartisan Chronic Condition Work Group and welcome the opportunity to serve as a resource to the Work Group, its members and staff. Please contact Kim Zimmerman at kzimmerman@ahca.org or Michael Bassett at mbassett@ahca.org for more information.

Sincerely,

[Transmitted Electronically]

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