THE AMERICAN HEALTH QUALITY ASSOCIATION

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The Honorable Orrin Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
The Honorable Johnny Isakson, Member
The Honorable Mark R. Warner, Member

United States Senate
Committee on Finance

January 25, 2016

Dear Senators:

I am writing on behalf of the American Health Quality Association (AHQA), which represents the Medicare-funded, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) and their subcontractors, now operating across the nation and in all U.S. territories. I wish to thank the Committee for the opportunity to provide written comments on the Chronic Care Working Group Policy Options Document. We applaud the committee for it's through work and careful consideration of the critical challenges regarding managing and treating chronic conditions, especially for Medicare beneficiaries. Our comments cover: Providing Medicare Advantage Enrollees with Hospice Benefits; Improving Care Management Services for Individuals with Multiple Chronic Conditions; Expanding Access to Prediabetes Education; and Increasing Transparencies at CMMI (and data).

Allowing Medicare Advantage Enrollees with Hospice Benefits

We applaud the policy proposals offered to ensure that Medicare Advantage (MA) hospice beneficiaries receive appropriate and high-quality care. Under current law, MA enrollees may elect to use hospice, but are either required to dis enroll completely from their MA plan or receive a combination of services from traditional Medicare and MA. These approaches to coverage do, in fact, lead to fragmented care delivery and disruptions in care, with consequent degradation in quality. A policy change to require MA plans to offer the hospice benefit presents a common-sense solution to this problem.

Coverage for hospice services by MA plans is, of course, an untested strategy and would require focused monitoring to ensure the services are of high quality. Patients and families, alike, suffer when end-of-life care is of suboptimal quality. The Quality Improvement Organization network has partnered with Centers for Medicare and Medicaid Services (CMS) on the PEACE Hospice and Palliative Care Quality Measures project to develop quality measures for hospice and palliative care that cover all domains of quality of care included in the National Consensus Project for Quality Palliative Care and endorsed by the National Quality Forum. This measure set could be used to inform an update to the MA five-star measurement system that ensures MA hospice beneficiaries receive appropriate and high-quality care.

Under the current Conditions of Participation for hospice organizations to begin and continue participating in Medicare, the hospice must develop, implement, and maintain an effective, ongoing quality assessment and performance improvement (QAPI) program. Requiring MA plans to maintain similar hospice-focused QAPI programs would be a potentially effective way to further ensure MA enrollees have access to high quality hospice services. The Quality Improvement Organization network has deep experience in supporting the development and implementation of QAPI programs across health services, including hospice organizations. Facilitating the development of effective, hospice-related QAPI programs by MA plans would be facilitated by enabling the CMS Quality Improvement Organization network to provide direct technical assistance with MA plans.

This would be of great value to Medicare beneficiaries to be able to align their care with current and future caregivers for patients transitioning to hospice. As the request is for measurements to assess effectiveness of hospice care giving, one also needs to assess the ability of Medicare Advantage plans to offer "goal of care" planning and identify patients that might benefit from a more extensive care continuum support.

There is a major study and program initiative spearheaded by Northwestern University with 10 hospitals and 20 to 30 post acute care providers in Illinois that are piloting a trigger tool that signals if a "goals of care" discussion should occur with the chronic care patient and their family. The providers have undergone several days of training on "Goals of Care" and the inclusion of the POLST and DNR forms. For patients that opt for palliative care and/or hospice care, the providers are tracking the level of support as patient transitions from one setting to another, including home. The goal of the project is to develop processes to ensure the patient and family wishes are honored for those that test positively to the trigger tool.

There are measurements being developed; however, it will be difficult to ascertain if Medicare Advantage patients are getting these interventions as there is no Medicare Advantage information available for research and analysis.

QIN-QIOs have experience working with providers on improving care along the continuum and could extend their work to include palliative and hospice care. Best practices and usage of trigger tools, goals of care, POLST and DNR forms, could all be a part of a positive hospice learning and action network to bring about consistency and respecting patient wishes during end of life care.

Improving Care Management Services for Individuals with Multiple Chronic Conditions.

As the United States Senate Committee on Finance chronic care working group has highlighted, meeting the needs of Medicare beneficiaries with chronic conditions and multi-morbidity have become one of the main challenges facing the US health care system. A large body of research has shown that Medicare beneficiaries with multiple chronic conditions experience uniquely unmet needs, but also that they experience a substantially higher level of health care utilization. Under the current fee-for-service system, payments are inadequately adjusted for complexity, including the CPT code (99490) for chronic care management services. We support the proposal to explore a new high-severity chronic care

management code to support team-based, coordinated care outside of a face-to-face encounter. We agree with the Med PAC testimony that these new codes need to be carefully defined, and rigorously tested prior to full implementation and permanent coverage under the Medicare Physician Fee Schedule.

With extensive experience in the development, validation and implementation of quality improvement measures, we offer the following four domains of measurement to assess the impact and effectiveness of this new payment construct:

1. cost,
2. unplanned episodes of acute care services,
3. rate of institutionalization, and
4. Functional decline.

The potential for the new construct is to delay functional decline and institutionalization, reduce unplanned acute care utilization, and remain cost neutral or cost saving.

The Quality Improvement Organization network also has long history and great experience supporting programmatic changes to the Medicare program – especially those intended to improve quality of care. Small-scale tests of change would be considered a "best practice" in improvement science because they help determine whether an idea could result in sustainable improvement. Given the uncertainties that surround the development and implementation of this new payment construct, we recommend the code be temporarily instituted while giving the Secretary of the Department of Health and Human Services authority to continue, discontinue, or modify the code.

Expanding Access to Prediabetes Education

The diabetes self-management training (DSMT) benefit for Medicare Part B beneficiaries with diabetes was authorized by Congress in the Balanced Budget Act of 1997 (Section 4105). These DSMT services Medicare beneficiaries to cope with and manage their diabetes. It includes tips for eating healthy, being active, monitoring blood sugar, taking drugs, and reducing risks. The DSMT benefit covers up to 10 hours of initial training for a patient in a 12-month period and an additional 2 hours of follow-up training in each subsequent year. Evidence supports the effectiveness of self-management training to improve blood glucose (sugar) control in type 2 diabetes.

We support the policy consideration to expand access to prediabetes education. Prediabetes is a medical condition in which the blood sugar level is higher than normal, but not yet high enough to be classified as type 2 diabetes. People with prediabetes are at high-risk for the development of type 2 diabetes and are appropriate candidates for preventive interventions. Clinical trials have demonstrated the beneficial effect of lifestyle modification (predominantly exercise and weight loss) for the prevention of diabetes and the current medical standard of care is to counsel all patients with prediabetes on the benefits of weight loss and increasing physical activity. Regular reinforcement of these benefits is important for success. Prediabetes education programs, like the CDC's National Diabetes Prevention Program, and evidence-based diabetes self-management education (DSME) programs, like Stanford,

DEEP (diabetes education empowerment program) and Project Dulce, offer a programmatic construct to educate, motivate, and guide Medicare beneficiaries in lifestyle change to prevent diabetes.

Access to high quality DSMT and diabetes prevention training remains a barrier to optimal care, with gaps in the quality of care widening as the number of people with diabetes increases. One factor limiting this access is the limited set of providers eligible for DSMT coverage under the Medicare Program. Allowing prediabetes prevention programs and DSMT to be delivered by entities that are currently not providers under the Medicare statute could substantially improve Medicare beneficiary access to these services.

The Quality Improvement Organization network is currently partnering with CMS to expand access to DMSE services for Medicare beneficiaries with diabetes *and with* prediabetes, using the Stanford DSME, DEEP DSME, and Project Dulce DSME curricula. We are implementing and operationalizing train-the-trainer programs to expand the number of diabetes educators and empower community health workers to provide DSME. Our network is collaborating with a diverse spectrum of entities that are not providers under the Medicare statute, including faith-based centers, community health centers, departments of public health, state diabetes prevention control programs, and public housing authorities to expand access to these services and reduce the well-recognized disparities in diabetes care that result from the current state of limited access. CMS is currently exploring the opportunities in "Accountable Health Communities" that bridge health and community services. Expanding the coverage for high-quality prediabetes and diabetes self-management training to entities not currently providers under the Medicare statute would set the stage for a truly effective and accountable health community.

The working group also requested feedback on what conditions should be required for entities providing these DSME/diabetes prevention services to participate in coverage under the Medicare program. Again, the experience of the Quality Improvement Organization network can offer some insights. CMS could investigate and identify high-quality curricula to cover for beneficiaries. CMS has currently identified the Stanford Diabetes Self-Management Program, the University of Illinois at Chicago DEEP curriculum, and the Scripps Diabetes Institute's Project Dulce curriculum. These programs license and accredit entities to deliver their training programs. Entities would have to maintain their licensure and accreditation to participate in the coverage offered through the Medicare plan. A similar strategy of accreditation and maintenance of standards would be used for entities to participate as a covered health benefit as CDC-recognized diabetes prevention program.

Increasing Transparencies at CMMI and Data

While the trend is increasingly toward Medicare Advantage with fewer beneficiaries on Medicare Fee for Service, there is also a great need identified throughout the proposals on Medicare Advantage for performance assessment. However, it is becoming increasingly difficult to assess if Medicare Advantage initiatives are working as there is no claims data upon which to make that determination. As Medicare Advantage payment claims are made by providers to the Medicare Advantage plan, there is no single

source of data to do any type of comparative analysis or deep dive into Medicare Advantage program effectiveness and efficiency.

QIN-QIOs can utilize the data to identify gaps in performance and work with the Medicare Advantage plans to help close the gaps in care for beneficiaries that are on Medicare Advantage and Medicare Fee for Service plans. By having detailed data one can target QIN QIO quality improvement interventions for specific communities, plans, or individuals with various conditions or diseases.

In summation, AHQA is grateful for the opportunity to offer comments on polices regarding chronic care and stands ready to support the Committee by providing additional comments should that prove useful.

We commend the Committee for seeking input in this fashion and look forward to a national discussion on these critical issues.

Sincerely,

Colleen Delaney Eubanks

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