Center for
Medicare Advocacy
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January 29, 2016

The Honorable Orrin Hatch Chair, Committee on Finance United States Senate Washington, D.C. 20510	The Honorable Ron Wyden Ranking Member, Committee on Finance United States Senate Washington, D.C. 20510
The Honorable Johnny Isakson United States Senate Washington, D.C. 20510	The Honorable Mark Warner United States Senate Washington, DC 20510

Submitted electronically to: **chronic_care@finance.senate.gov**

Re: Comments on Chronic Care Reform

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

The Center for Medicare Advocacy (Center) is pleased to provide the Senate Finance Committee comments in response to the December 2015 request for comments on the Committee's Bipartisan Chronic Care Working Group Policy Options Document. The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality health care. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

We agree with the Committee that Congress should prioritize solutions to improve care quality for persons with multiple chronic conditions. The health care needs of older adults and people with disabilities should be at the center of these efforts.

We appreciate the Senate Finance Committee's bipartisan approach to addressing this important issue. However, we are disappointed that the Committee declared in the Policy Options Document that any future legislation stemming from the Committee must lead to savings or be budget neutral. Employing this strict budgetary framework significantly limits the ability of future legislation coming out of the Committee to meet the Committee's objective of improving care for the millions of Americans managing chronic illness. We urge the Committee to use this opportunity to create changes that truly address current gaps in coverage for beneficiaries and lead to improvements in care, coordination of services and outcomes.

In addition to responding to the specific policy proposals from the options document, below, we would like to underscore proposals we view as crucial to the development of a more effective approach to providing services to individuals with chronic conditions. As outlined in the Center's comments in response to the Workgroup's May 22, 2015 request for comments, we strongly urge the Committee to include full implementation of the *Jimmo v. Sebelius* settlement, the elimination of outpatient therapy caps and oral health in the health services provided in order to truly coordinate care and improve outcomes (see the Center's comments, available here: http://www.medicareadvocacy.org/center-comments-to-senate-finance-committee-regarding-chronic-care-reform/).

Fully Implement *Jimmo v. Sebelius* Settlement

The *Jimmo* settlement, the nationwide class action settlement with the Department of Health and Human Services, reaffirms the appropriateness of Medicare coverage of patients who need nursing and therapy services to maintain their functional level or to prevent or slow their decline or deterioration. The Court-approved settlement applies to nursing and rehabilitation services in skilled nursing facilities, home health settings, and outpatient therapy settings. Although the Settlement is not limited to patients with chronic conditions, it has obvious and special significance for people with chronic conditions since, by definition, these patients will not "recover" from their chronic conditions.

Assuring that Medicare patients get all the care and services they need to maintain their highest level of functioning is required by law, good policy, and likely to save public funds. The Settlement recognizes that enabling Medicare beneficiaries to maintain function helps them maintain independence and avoid more costly levels of care, such as hospitalizations.[1] Any changes proposed by the Committee to improve care for persons with multiple chronic conditions need to support full implementation of this settlement.

Eliminate Therapy Caps

Medicare coverage of outpatient therapy is currently capped on an annual basis at $1,940 for physical therapy (PT) and speech-language pathology (SLP) services combined, and $1,940 for occupational therapy (OT) services. These arbitrary caps are aimed at federal cost-savings rather than providing clinically appropriate services, and disproportionately affect the most vulnerable Medicare beneficiaries who require ongoing therapy services. As such, these caps should be repealed. While we urge full repeal of these caps, we understand that, in the past, the Committee drafted "replace" language that would replace the therapy caps with a form of prior authorization (PA). In general, we are concerned that PA often serves as a barrier to necessary care; more specifically, we are concerned that some of the language of the legislative replacement proposal would give the Secretary too much discretion to target certain medical conditions and inappropriately deny care. Should the Committee entertain therapy cap replacement language again, we ask that this language be revisited.

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[1] *Jimmo v. Sebelius*, No. 11-cv-17 (D.VT), filed January 18, 2011. Settlement approved January 24, 2013. For more information, see: http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

At a minimum, the therapy cap exceptions process should be permanently extended and revised. As you are aware, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 2017 and modified the requirement for manual medical review for services over the $3,700 therapy thresholds. Rather than letting the exceptions process expire, when there is no longer a larger SGR vehicle to address this policy through, absent repeal of the cap, the exceptions process should be permanently extended. Further, the review process for services that exceed $3,700 should be revised. In our experience, the manual review process imposed at $3,700 is extremely burdensome for providers. As a consequence, it creates a chilling effect on the willingness of many providers to use the exceptions process, resulting in beneficiaries with chronic conditions who are most in need of ongoing therapy, foregoing therapy services until the beginning of the next calendar year. As discussed above, the court approved settlement in *Jimmo v. Sebelius*[2] confirms the right of Medicare beneficiaries to therapy to maintain function, slow deterioration and prevent avoidable decline. Limiting Medicare reimbursement for therapy through arbitrary caps and a complicated exceptions process, while not in direct violation of this settlement, undermines beneficiaries' ability to receive medically necessary maintenance therapy services.

Include Oral Health

Any new efforts aimed at treating individuals with chronic conditions must incorporate oral health into the health care services that are provided in order to truly coordinate care and improve outcomes. Oral health is inextricably linked to the overall health of individuals. A 2011 Institute of Medicine and National Research Council report stressed the connection between oral health and overall health. ". . . [T]he mouth as a mirror of health or disease occurring in the rest of the body in part because a thorough oral examination can detect signs of numerous general health problems, such as nutritional deficiencies and systemic diseases, including microbial infections, immune disorders, injuries, and some cancers. Further, there is mounting evidence that oral health complications not only reflect general health conditions, but also exacerbate them. Infections that begin in the mouth can travel throughout the body."[3]

Poor oral health can lead to subsequent conditions, due to limited nutrition, vitamin deficiencies, pain, and limited social engagement. Additionally, incorporating oral health into comprehensive patient care lowers costs, as oral pain is a leading cause of emergency department visits.[4] A recent study published in the *Journal of the American Dental Association,* found that between 2008 and 2010, more than 4 million patients turned to hospital emergency departments due to oral health conditions, at a cost of $2.7 billion.[5] Not only are emergency department visits expensive, but they are also ineffective in resolving oral health care needs; patients entering

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[2] *Jimmo v. Sebelius*, No. 11-cv-17 (D.VT), filed January 18, 2011. Settlement approved January 24, 2013. For more information, see: http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

[3] Institute of Medicine and National Research Council, Committee on Oral Health Access to Services Board on Children, Youth, and Families Board on Health Care Services, *Improving Access to Oral Health Care for Vulnerable and Underserved Families*, pg 42, National Academy of Science, 2011, available at http://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf.

[4] *Lack of access to dental care leads to expensive emergency room care*, Association of Health Care Journalists, April 8, 2014, available at http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/

[5] "*Id.*

emergency rooms with oral health problems are often prescribed pain killers or antibiotics. "Research suggests that the vast majority did not receive dental procedures, but were instead treated with prescription medications."[6] Oral health must be included in any new efforts to address the care of those with chronic conditions in order to fully address patient needs, improve care coordination, and reduce costs.

General Comments on Policy Options Document

We note that a significant number of policy proposals in the Policy Options Document focus on expanding access to care for individuals with multiple chronic conditions who are enrolled in Medicare Advantage (MA) plans. While this goal is laudable by itself, we note that many of these proposals focus solely on the MA program, along with some targeted towards Accountable Care Organizations (ACOs), but few proposals relating to MA plans and ACOs have equivalents in the traditional Medicare program. Instead, we urge the Committee to focus on a level playing field between traditional Medicare and MA plans by ensuring that new policy proposals also apply in traditional Medicare.

As the Center has noted in previous comments to the Committee[7], current MA and Part D plan enrollees face challenges accessing care that must be addressed if delivery system reforms on behalf of those with chronic conditions are to be truly effective. For example, our own experience helping MA enrollees who have been denied care by their plans underscores the ongoing, alarming trends concerning beneficiary denials and appeals. Individuals with chronic conditions are more likely to need multiple services and prescription drugs, and are therefore more likely to face coverage restrictions and utilization controls, most notably in MA and Part D plans. Annual audit findings by CMS suggest significant room for improvement by MA and Part D plans in the administration of utilization management tools and beneficiary appeals processes.

In addition, as we also urged in previous comments, we recommend closer scrutiny of how individuals with chronic conditions currently fare in MA plans, particularly before holding the MA program up as a model for care coordination and delivery. For example, recent studies by the Kaiser Family Foundation, *Health Affairs* and CMS together suggest that individuals who are poorer and sicker tend to disenroll from MA plans at a disproportionately high rate, which is troubling because such individuals tend to have greater health needs.[8] Further, before exploring additional payment to MA plans based upon an individuals' socio-economic or other status, the Medicare program should ensure that payments to MA plans is accurate, and the billions of dollars that are inappropriately paid to MA plans through inappropriate manipulation of risk adjusted payment ("upcoding") should be recouped.

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[6] *Id.*

[7] See http://www.medicareadvocacy.org/center-comments-to-senate-finance-committee-regarding-chronic-care-reform/.

[8] See, e.g., Kaiser Family Foundation (November 2014), available at: http://kff.org/medicare/report/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program/; Gerald F. Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Services", CMS, Medicare & Medicaid Research Review (MMRR) Vol. 2 No. 4 (2012), available at: http://www.cms.gov/mmrr/Articles/A2012/mmrr-2012-002-04-a08.html; and *Health Affairs*, January 2015 *vol. 34 no. 1 48-55;* and *Health Affairs, October 2015 vol 34, no.10:1675-1681.*

Finally, with respect to proposals that would immediately ramp up new policies for application at the national level, we would like to emphasize that when considering a new policy proposal, we encourage the Committee to explore the option of demonstration programs to test new policies, as they allow for the careful, targeted design of consumer protections and mid-course corrections.

Our comments addressing the specific policies in the options document are below.

Receiving High Quality Care in the Home

Expanding Independence at Home Model of Care

We support the option to expand the IAH demonstration. We are pleased that the demonstration's initial results have been quite positive. It is an excellent model for complex, frail patients who have difficulty leaving their homes even with transportation support. We have two suggestions for modifying the program: (1) improve incentives for integration with community-based agencies to improve patient health and well-being beyond the current medical model; and (2) before taking this nation-wide, review the current targeting strategy to ensure scalability.

Expanding Access to Home Hemodialysis Therapy

The Center believes that there is an added risk for telehealth beneficiaries in that an in-person assessment is bound to be more accurate in early detection of problems. "Virtual" assessments in the form of Q&A with the beneficiary or the caregiver should only be utilized when there is either a trained clinician with the beneficiary to perform any hands-on skilled assessments as needed during the telehealth visit (e.g at an MD office, hospital, AND/OR the proposed free-standing dialysis center).

If the home were to be considered an "originating site" for the purposes of telehealth visits, we believe that in the interest of patient safety and accuracy of the assessment, that the beneficiary and/or caregiver(s) be considered for the appropriateness of being an originating site on a case-by-case basis. In determining whether a particular beneficiary's home should be considered an originating site (and appropriate for telehealth visits *without* a clinician nearby) certain areas should be assessed: compliance, capacity, successful demonstration of proper techniques for both the dialysis process as well as assessment of the dialysis port/site. If the beneficiary/caregiver is deficient in any of these areas then telehealth might not be the best option and the visit would need to be done in some sort of clinical setting.

Additionally, even if the home is considered appropriate for the purposes of conducting telehealth visits, we agree with the document example indicating that there should be guidelines for how often an in-person clinical assessment should be performed. An accurate assessment of an A/V fistula for function and signs of clotting or infection needs to be in person. Using touch for feeling the "thrill" indicating blood flow and for warmth/heat which could indicate infection or clot, sound via stethoscope to listen to "bruit" which indicates a functioning fistula as well as close visual inspection for hematoma or edema, which could indicate a problem. So, we agree that a minimum of at least one in-person clinical assessment should be performed every 2-3 months when the home is otherwise used as the originating site AND the caregiver/patient is appropriate to act on-site during telehealth visits. This would allow the trained-but-non-clinical person to monitor the patient's dialysis needs throughout the month and review via telehealth every 1-2 months, and an in-person assessment by a trained clinician alternating every 2-3 months in the interest of patient safety and earlier detection of potentially life-threatening issues.

Advancing Team-Based Care

Providing MA Enrollees with Hospice Benefits

We agree with the Committee that the current provision of hospice services for MA enrollees who elect the hospice benefit can lead to fragmented care delivery. We have significant concerns, though, about incorporating the hospice benefit into the MA program, and urge policy changes related to the hospice benefit that would improve access to care for all hospice beneficiaries, including those enrolled in MA plans.

There are a couple of potentially positive changes that might arise from "carving in" the hospice benefit to the MA program relating to beneficiary cost-sharing and appeal rights. First, when an MA enrollee currently elects hospice and proceeds to obtain services relating to their terminal condition from traditional Medicare, such enrollee usually has no secondary coverage, such as a Medigap, by virtue of being in an MA plan. In other words, such individuals are usually subject to full cost-sharing amounts in traditional Medicare (for example, 20% coinsurance for Part B services). If an MA plan had to cover hospice services, presumably cost-sharing would be structured the same as that for other benefits received through the MA plan thus out-of-pocket liability would be more limited (and a cap on out-of-pocket expenses, or the MOOP, would apply).

Second, if MA plans became responsible for covering hospice services, there would be an opportunity to create appeal rights where they don't currently exist for beneficiaries and their families when they are denied care by the hospice. Currently, there is no expedited appeal right within the hospice benefit unless a hospice provider is terminating services altogether. If an individual takes issue with elements of the hospice plan of care, for instance, with drugs prescribed or the frequency of aid visits but the hospice provider refuses to change services accordingly, there is little recourse for the hospice patient. If a hospice provider contracted with an MA plan, though, the plan could intervene, or, more importantly, such services could be subject to an organization determination by the plan, which would trigger an appeal right if the plan denied a beneficiary's request. Such appeal rights would have to be clearly articulated within the MA program.

We urge the Committee to address these issues – particularly the lack of a meaningful appeal right within the hospice benefit – without necessitating a "carve-in" of hospice in to the MA program. As discussed next, our concerns about adding hospice to the MA benefit outweigh the potential benefits.

As a threshold issue, incorporating the hospice benefit into the MA program raises concerns about beneficiary autonomy with respect to making the decision to elect hospice services. Hospice is legally and by "hospice philosophy" supposed to be a choice. One elects the benefit. Some, when diagnosed with a terminal illness, choose to "fight" the disease, opting to undergo whatever treatment is necessary, with the hope of cure or extension of life. Others choose to focus on quality of life rather than cure. One wonders if MA plans, in their efforts to "promote coordination of care," might have too much power and potentially erode the Medicare beneficiary's right to choose the first option - continued treatment. What will happen when the oncologist recommends hospice? Maybe the person won't elect care - but will this mean that all further curative treatment will be denied coverage by the MA plan as not medically reasonable and necessary - thus forcing the hospice "choice"? If an individual does elect hospice, will plans inappropriately restrict coverage of Part B services not related to the terminal condition by deeming them medically unreasonable and necessary? If an MA plan is fully capitated for the range of Medicare services, including hospice, what financial incentives does an MA plan have to limit curative treatment and instead steer people towards hospice? In order for a hospice election to be meaningful, it must remain a real choice for each Medicare beneficiary.

In addition to the choice surrounding whether or not to elect hospice, choice about from whom hospice services will be obtained is a critical one. Most MA plans provide services through restricted or limited networks of providers. The lack of choice of potential hospice providers, should MA plans be required to provide hospice services, is of significant concern. The choice of hospice provider is a critical right for those electing hospice, who, along with their family and caregivers weigh a number of factors which can include geography, philosophy of particular providers, religious preference, range of services, quality of provider and the ability to changes providers in an effort to obtain the right fit. By design, MA plans would likely limit such choice.

Should the Committee move forward with this policy proposal, we urge doing so only with a limited pilot or demonstration program that incorporates robust consumer protections, including free choice of provider.

Allowing ESRD Beneficiaries to Choose an MA Plan

Currently, individuals with ESRD face the most restrictions, as a group, regarding their choices of how they wish to access their Medicare benefits. As noted by the Committee, they are largely prohibited from enrolling in MA plans, and face restrictions on purchasing Medigap policies. While we encourage expansion of choices for ESRD beneficiaries through the right to enroll in MA plans, such a right should be coupled with heightened oversight of access to services and providers within MA plan for this population, including network adequacy and design of plan benefits, including cost-sharing for dialysis and other services regularly used by those with ESRD. In addition, in order to maximize choices for this group of people, federal rights concerning purchase of Medigap plans should be expanded to individuals with ESRD.

Providing Continued Access to MA SNPs for Vulnerable Populations

The Committee suggests continuing access to Special Needs Plans for vulnerable populations. However, we are concerned that only limited details were provided in the options document regarding the possible permanent extension of these programs. We also have concerns regarding what implications this extension would have on the ongoing state-level demonstration on managed care integration of Medicare and Medicaid.

With these demonstrations still ongoing and only preliminary evaluation results released, we are concerned it is premature to advance proposals that would require Medicare-Medicaid integration and/or expand models still in the testing phase. In particular, we expect the demonstrations will yield valuable lessons with respect to network design, beneficiary and provider education and uptake, reimbursement structures, appropriate supplemental benefits, incentive structures, and adequate beneficiary protections. The demonstration programs vary in regard to geographic area, target population, enrollment timelines and processes, care delivery models, financing, the scope of benefits, and beneficiary protections. We encourage the Committee to learn from the lessons of the duals demonstrations, and review the first evaluation released by CMS on January 22nd, and subsequent evaluations on the demonstrations, as they are made available, before advancing this concept.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

We applaud CMS for their decision in the 2015 Medicare Physician Fee Schedule (MPFS) to establish two new codes for “care management” and “care transition” activities for beneficiaries with multiple chronic conditions, including the important role clinical staff play in carrying out these tasks. It is important to note that the scope of the covered care management elements and activities required will vary depending on the complexity of the beneficiary population. Elements that determine complexity include medical history, functional status, cognitive impairment, active psychiatric illness, substance use disorder, and socioeconomic factors such as lack of financial and/or social support, dysfunctional family, low health literacy, living alone, unsafe environment, and difficulty accessing transportation.

Additional policy reforms are needed to adequately incentivize appropriate care for the population of Medicare beneficiaries living with multiple chronic conditions. A single care management code is insufficient to address the breadth of complexity that exists among elders with multiple chronic conditions and functional limitations, and the varying degrees of treatment and monitoring that they require. Skilled clinicians should be providing more intensive management for a higher proportion of the most complex beneficiaries as the “age wave” accelerates. This will not be possible with care management codes set only at a low average rate. Caring for many beneficiaries who have chronic conditions but low complexity may not require the development of a sophisticated care plan linked to the accompanying electronic health record (EHR) infrastructure in which a care plan can be shared across multiple providers, though these characteristics become essential for high-needs patients.

We recommend that the Committee include beneficiary education in the development of new codes. We also encourage the Committee to waive the associated cost-sharing for such visits. The copayment is a burden for both patients and providers and eliminating it will increase uptake in the current use of the code and make the use of a new code for more complex patients better received. If we believe this is a beneficial population-health tool, then we should provide an incentive to use it, as we do for preventive services.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

We strongly support the identified proposal to study the need for behavioral health services among individuals with a chronic illness and support the proposed GAO study. We often observe that behavioral and mental health care is underutilized among seniors and people with disabilities, and we believe these critical services can provide significant relief to people with Medicare who need them.

Expanding Innovation and Technology

Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees

The Center agrees that reduced cost-sharing, expanded provider networks, and technology-driven care improvement/wellness programs could provide greater access and services to those with chronic conditions. Caution should be employed before allowing all Medicare Advantage plans to use a flexible benefit structure, however, as safeguards should be in place to ensure plans are providing appropriate access to coverage. For examples of such safeguards, we encourage the Committee to analyze CMS' proposed MA value based insurance design (VBID) model, which includes an allowance for only lowered cost-sharing and additional benefits for high-value services and care, prohibits marketing of incentive (VBID) programs, and the retention of MA anti-discrimination rules.[9]

Rather than initially apply a flexible benefit structure to all MA plans, the Center recommends a demonstration with a well-monitored subset of MA plans to determine what is – and is not – working well. The subset should be inclusive of MA plans with proven quality, consumer satisfaction, experience, and a high level of proven administrative organization and operational transparency. With a limited launch, a comparison subset of MA plans should be used to study the impacts on those with chronic conditions and to measure results. Consideration should be given to using the CMS Chronic Care Disease Data Warehouse compiled through the traditional Medicare program to initially identify needs. Other requirements for implementing this should include: consumer need and satisfaction surveys (inclusive of care coordination, responsiveness, and outcomes), examination and evaluation of appropriate resources used to accomplish goals, and assurances that proper training of MA personnel has been done to ensure needs of those with chronic conditions will be properly understood and addressed.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill MA Enrollees

Given advances in technology, the definition of "reasonable and necessary" health care for those with chronic conditions necessarily takes on a revised meaning when considering expansion of

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[9] See CMA Comments re: Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model September 17, 2015, available at: http://www.medicareadvocacy.org/cma-comments-re-medicare-advantage-ma-value-based-insurance-design-vbid-model/.

benefits for those with chronic conditions. There must be an understanding that care coordination and care management is paramount and includes non-medical services, such as social services. Services that should be covered are those that are reasonable and necessary to the comprehensive health care of those with chronic conditions. What is considered to be “primarily for comfort” for most Medicare beneficiaries might instead be definitively reasonable and necessary for someone with a chronic condition, e.g. a paralyzed person having the ability to control a light switch in a bedroom by using only his eyes (it may be medically recommended for him to sleep in the dark to get proper restorative sleep). This illustrates that there should be a different standard for criteria of what is reasonable and necessary as it applies to the specific needs of the individual with chronic conditions who has a reduced functional capacity.

There should always be safeguards to prevent abusive practices and/or inappropriate enrollment. This may be avoided if there is first an identified need for the enrollment in a chronic care program and then a reasonable and necessary standard is applied that is understood to be reasonable and necessary for the specific chronic condition involved.

Maintaining ACO Flexibility to Provide Supplemental Services

The Center believes this option provides an important opportunity to address the access to evidence-based prevention and wellness programs through the connection to primary care screening and referral. ACOs should have a population-based strategy for patient engagement that is evidence-based that improves health confidence and self-management capacity. In general, we suggest clarifying that ACOs participating in the MSSP be able to furnish evidence-based prevention and wellness programs, transportation and other social services, including programs for chronic disease self-management, falls prevention, diabetes management, pain management, and caregiver support.

Identifying Chronically Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically Ill Individuals

The Center would like to stress the importance of accurate payment for chronically ill individuals. CMS recently released broad proposals regarding adjusting models in order to more accurately predict costs for different types of beneficiaries. CMS plans to provide more detailed information regarding models and how the costs of care will be predicted in the Call Letter in the spring. Therefore, we urge the committee to review and consider comments from a broad range of stakeholders in response to the Call Letter when determining the accurate metric for risk adjustment.

Developing Quality Measures for Chronic Conditions

We concur with the Finance Committee that the “top areas” for quality development should be patient (person) and family engagement, shared decision-making, care coordination, hospice-Alzheimer’s, and targeted conditions in “community-level” measures.

We strongly suggest that the Committee incorporate the 2013, reaffirmed in 2014 & 2015, National Quality Forum Committee on persons dually-eligible for Medicare and Medicaid, recommendations to CMS concerning "high-priority measure gaps." These are:

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

In its 2015 report to CMS, the NQF Committee on persons dually eligible, shared a participant survey finding of priorities (which are also consistent with 2013-2014 gaps):

1. Beneficiary Experience
2. HCBS access and Rebalancing LTSS-transitions-care coordination
3. Health and general well-being (shift away from purely clinical outcomes)
4. Influence of social determinants of health

Although developing quality measures that are focused on physicians is important, we urge the Committee to look at measure development in other areas as well. Progress has been made in the use of palliative and end-of-life quality measures, especially in hospice care, but these tools remain underused in a variety of care settings. For example, Long-Term Care Hospitals currently do not have measures that assess the quality of palliative or end-of-life care, despite the high mortality rate of patients in those facilities.[10] Accordingly, we strongly encourage the Committee to promote the development of quality measures for physicians, acute providers like hospitals and post-acute providers like home health agencies.

Specifically, The Center suggests that the Committee consider directing CMS to develop measures for the post-acute providers enumerated in the *Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)*. Although that statute requires CMS to develop measures for the post-acute setting, it does not specify that this work should include palliative and end-of-life measures. Adding those specific areas to the law's current requirements will ensure that CMS implements measures on advanced illness and end-of-life quality for all post-acute providers.

Empowering Individuals & Caregivers in Care Delivery

Establishing a One-Time Visit Code Post Diagnosis of Alzheimer's/Dementia

While it is our hope that practitioners currently take the time necessary to adequately explain new diagnoses to their patients, we support the establishment of a One-Time Visit Code Post

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[10] Proclamation No. 224, 80 Fed. Reg. 72724, (Nov. 20, 2015).

Diagnosis of Alzheimer's/Dementia as a means to stabilize families and individuals after a diagnosis in order to put them on the right path for future conversations with their provider. We would urge that cost-sharing be waived for this visit.

Also, we believe that this type of visit should not be limited for Alzheimer's/Dementia. This type of post diagnosis visit should be available for other serious and life threatening diseases.

Expanding Access to Prediabetes Education

As supporters of the Medicare Diabetes Prevention Act of 2015 (S. 1131/ H.R. 2102), we encourage the Committee to include expanding access to prediabetes self-management services among the policy options considered moving forward.

Other Policies to Improve Care for the Chronically Ill

Increasing Transparency at CMMI

Though we strongly support high levels of transparency, and the opportunity for vigorous stakeholder engagement, we are aware that CMMI is able to move more quickly with proposals than other agencies. We would like to urge the Committee to strike a balance between transparency, and the ability of CMMI to maintain a high pace of innovation. Therefore, we would encourage the Committee to establish consistent stakeholder involvement, and to create standards for demonstrations, particularly when models change during the demonstration period.

Conclusion

We appreciate the opportunity to provide feedback on reforming Medicare's coverage of and payment for individuals with chronic conditions. We urge Congress to place the needs of beneficiaries, as discussed above, at the forefront of any reform efforts. If you have questions concerning our comments or need additional information, please contact Kata Kertesz, Policy Attorney at kkertesz@MedicareAdvocacy.org or David Lipschutz, Senior Policy Attorney at dlipschutz@MedicareAdvocacy.org or 202-293-5760.

Sincerely,

Kata Kertesz
David Lipschutz