FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

January 26, 2016

The Honorable Orrin Hatch
Chair, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

Families USA appreciates the opportunity to comment on the policy options document created by the Bipartisan Chronic Care Working Group of the Senate Finance Committee. Families USA is a national, non-profit, non-partisan consumer advocacy organization committed to securing affordable, high-quality health coverage and care for all in this country. We see developing policies that improve care and health outcomes for people with chronic conditions as absolutely critical to improving the overall quality and value delivered by our health care system, and reducing significant health disparities that exist in this country. We applaud the Committee for engaging in a transparent process to develop policies to improve care for Medicare beneficiaries with multiple chronic conditions, and we continue to support the identified goals of increased care coordination, aligned payment systems to encourage appropriate care, and enhanced health care quality.

Broadly, as the Committee moves forward, we encourage you to pursue innovation in both traditional Medicare and Medicare Advantage. The majority of Medicare beneficiaries are in traditional Medicare. As such, developing innovations that improve the care quality within traditional Medicare is absolutely essential to improving management of chronic conditions for the entire Medicare population. We also urge the committee to learn from ongoing demonstrations and test new care models through additional demonstrations. Considering these existing coordination efforts and their lessons on enrollment complexities, communicating with beneficiaries, and aligning acute and long-term services and supports will help shape well-informed policy.

We offer the following comments regarding specific proposals. We thank the Committee for the opportunity to comment on the policy options identified by the Working Group. We hope these recommendations will help the Committee fine-tune initiatives to improve the health and well-being of people with Medicare who have multiple chronic conditions. We welcome the opportunity to continue to engage with the Committee as you develop these concepts further. If you have questions concerning our comments or need additional information, please contact Lydia Mitts, Senior Policy Analyst at lmitts@familiesusa.org or (202)-628-3030

Sincerely,

Lydia Mitts
Senior Policy Analyst
Families USA

Improving Care Management Services for Individuals with Multiple Chronic Conditions

We supported the decision by CMS in the 2015 Medicare Physician Fee Schedule to establish a new code for chronic care management (CCM). Reimbursing clinicians for the time and labor involved in coordinating care for beneficiaries with multiple chronic conditions is necessary to ensure that these individuals receive quality care. Yet, for Medicare's most complex beneficiaries, additional care management support, beyond what is supported by the current CCM code, is necessary. These beneficiaries may need to see several specialists on a regular basis, to access various community and social services, and to have an individualized care plan developed. Without an additional code with higher reimbursement, health care providers cannot provide adequate care for these more complex beneficiaries, and may even choose to not take them on as patients.

As such, we support adding a new code for high-severity chronic care management, and agree that it is imperative that the population served and services provided under this code be well-defined. In order to increase uptake of both the current CCM and the new high-severity CCM code, CMS should waive the cost-sharing for these services, as even nominal cost-sharing can lead some individuals to forgo high value services. CMS should also develop strategies for both beneficiary and provider education about these codes.

While we support the addition of this code, we think it is critical that policymakers continue to support a transition away from fee-for-service and to alternative payments models that drive delivery of high -value care, improved care coordination and improved health outcomes. In the short term, it is important that providers be sufficiently reimbursed for care coordination using the new high-severity code, as we evaluate the impact of various alternative payment models to identify the best payment models for encouraging providers to invest and engage in care coordination. We support the new code being temporary. We encourage CMS to analyze the effectiveness of this code, and to combine these lessons with what is being learned from current Medicare demonstration projects to better incentivize care coordination for all beneficiaries.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

Greater integration of primary and behavioral health care is needed to provide optimal care for people with multiple health care needs, and we support efforts to encourage further integration. Despite its benefits for health outcomes and health care costs, Accountable Care Organizations (ACOs) have still encountered challenges in integrating primary care and behavioral health. Given this, we are supportive of the Government Accountability Office (GAO) conducting a study on the current status of primary care and behavioral health integration in all sectors of the health care system. Specific policy proposals for improving integration should draw from lessons learned from existing SAMHSA-HRSA and AHRQ BH-PC initiatives, and there should be continued investments in similar demonstrations to continue to learn best practices for better integration.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees:

Families USA strongly supports policies that expand access to and strengthen coverage of services to manage chronic conditions. As such, we strongly support creating more flexibility in Medicare to allow for reductions in cost-sharing for services that treat and help prevent the progression of chronic conditions. In order to improve care and health outcomes for those with chronic conditions, it is critical that policy action is taken to reduce unaffordable out-of-pocket costs that pose an insurmountable barrier to needed care for some patients. We also support allowing MA plans greater flexibility to provide additional benefits, such as non-health related transportation, that can assist beneficiaries in accessing supports to help manage their chronic conditions.

CMMI is in the process of implementing a demonstration allowing for MA plans in seven states to implement plans that incorporate reductions in cost-sharing for chronic condition services. We believe the experience and best practices from these demonstrations should inform how best to provide this flexibility across all MA plans. We also urge the working group to consider additional policies to extend these added benefits to individuals in traditional Medicare, which currently serves 70% of Medicare beneficiaries. Developing policies that improve access to and affordability of chronic care services for the broader Medicare population is imperative to meeting the needs of the full Medicare population.

Broadly, any tailored benefit designs that MA plans are allowed to implement should be evidence-based and shown to improve health outcomes for people with chronic conditions. For this reason, we have significant concerns with the proposal’s inclusion of wellness programs among the benefits that MA plans would be allowed to offer. We strongly oppose allowing MA plans to offer wellness program models that require beneficiaries to complete certain activities or meet certain health-related goals in order to access additional benefits or reductions in cost-sharing. We also strongly oppose allowing MA plans to use wellness programs that adjust beneficiaries’ premiums based on their completion of certain activities or health goals. Programs that adjust enrollees’ health care costs or benefits based on completion of certain requirements are not evidence-based, have not been shown to be effective at producing long-term improvements in health behaviors or outcomes, and have a history of being used in a discriminatory manner to deny affordable health care benefits to people with chronic conditions.

Furthermore, we have significant concerns that lower-income and vulnerable populations can face disproportionate barriers to completing required wellness activities. For example, programs that require completion of online health assessments or courses can be difficult to complete for individuals without reliable and consistent computer and internet access, and for individuals with limited English or internet proficiency. Many lower-income workers may be balancing hourly jobs that provide little flexibility to take time off or that require them to work evenings. This can make it difficult or impossible to complete in-person or telephonic health coaching common to such programs. In sum, these types of programs can actually create more barriers to accessing affordable care for the most vulnerable populations that already face disproportionate barriers to accessing the supports they need to manage their chronic condition. We strongly recommend that the Committee not pursue policies to allow for these types of wellness programs in MA.

Maintaining ACO Flexibility to Provide Supplemental Services

We strongly support clarifying that ACOs participating in the Medicare Shared Savings Program may furnish social and transportation services. Many social needs, including housing quality and security, transportation, and food security have an enormous impact on overall health. These issues can prevent beneficiaries from actively engaging in their own care and cause unnecessary health complications, leading to poorer outcomes and preventable and costly utilization of health care services. We believe that is critical that ACOs partner with existing social service providers and trusted community based organizations in furnishing these supports. The working groups should consider additional policies that could help foster collaboration and partnership between ACOs and these community providers. This could include requirements that ACOs includes such providers within their governance.

While addressing these needs is essential for ACOs to deliver on their goal of improving health care quality and lowering costs, some ACOS may still not have adequate resources to provide such services under the current shared savings model. This is particularly true of ACOs that serve disproportionately lower-income, more vulnerable communities. CMMI’s Advance Payment ACO model demonstration may provide important lessons regarding how best to provide adequate upfront resources to these ACOs. Based on the results of this Advance Payment model, we recommend that the Work Group consider additional policies aimed at supporting newer, smaller ACOs that may not have shared savings available to invest in these services immediately.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

We support allowing beneficiaries the flexibility to voluntarily elect to be assigned to a specific ACO. However, it is critical that individuals who use this flexibility maintain their freedom of choice of providers and are allowed to seek care from providers outside of their assigned ACO. Preserving beneficiaries’ right to seek care outside of an ACO is an important mechanisms for holding ACOs accountable for delivering high quality, patient centered care. This creates an incentive for ACOS to improve quality and patient experience so that beneficiaries voluntarily seek care from within the ACO. If beneficiaries are locked-in to receiving care only from within the ACO, this removes such an incentive to continually improve patient experience and creates potentially adverse consequences where beneficiaries are locked into a network of providers that is not responsive their needs.

Developing Quality Measures for Chronic Conditions

We agree with the Committee that care for beneficiaries with chronic conditions would be improved by the development of quality measures that address the specific needs of this group, such as the development of individualized care plans, care coordination, and support for care transitions. We encourage the Committee to consult the recommendations made by the National Quality Forum to CMS in 2013 and reaffirmed in 2014 and 2015 on high-priority measure gaps for people dually-eligible for Medicare and Medicaid. These gaps include:

- Goal-directed, person-centered care planning and implementation
- Shared decision-making
- Systems to coordinate health care with non-medical community resources and service providers
- Beneficiary sense of control/autonomy/self-determination

- Psychosocial needs
- Community integration/inclusion and participating
- Optimal functioning (e.g. improving when possible, maintaining, managing decline)

Providing high-quality care also requires engaging patients and their families, which can be reflected in measures addressing person-centered communication and other patient experience measures. However, in order to truly transform the care provided, patient and family engagement must go beyond just the point of care. Patients and their families should be included at higher levels of care design, such as by serving on advisory councils, and measures should be developed to reflect the degree to which patients and families are being engaged in this manner.

Finally, we support the GAO producing a report on community-level measures. In order to determine the most appropriate community-level measures and how such measures can be used to incentive the improvement of care, we believe more study and guidance is needed. Such measures hold significant promise for determining how the health care and social service systems can prevent and better manage chronic conditions at the community-level.

Encouraging Beneficiary Use of Chronic Care Management Services

We strongly support policies that would waive beneficiary cost-sharing for chronic condition management services. As discussed early, even nominal cost-sharing can be a barrier to individuals obtaining necessary care. Removing cost-sharing for high value services like chronic condition management services is good for both patients and the system. It ensures that this service is affordable and accessible to all beneficiaries and can help promote greater utilization of a service that could help prevent costly duplicative care or avoidable complications in the future.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

We support providing Accountable Care Organizations flexibility to waive cost-sharing for services to treat a chronic condition. This allows ACOs to address affordability problems that may prevent some of their patients from fully adhering to treatment plans necessary to best manage their chronic condition. However, we do think such flexibility must be implemented in a consistent, transparent manner across ACOs and that implementation of such flexibility should be defined through rulemaking or guidance. Leaving implementation to ACO discretion could result in immense diversity across providers in implementation of this flexibility and could result in immense confusion among beneficiaries regarding the benefits of seeking care through an ACO. formal guidance or rule making is necessary to ensure that beneficiaries, caretakers, and their advocates understand patient rights and benefits under the ACO model.

Expanding Access to Prediabetes Education

Currently, 1 of every 3 American adults—86 million people—have prediabetes. Without effective intervention, up to 30% of these individuals will progress to having type II diabetes within five years, putting them at increased risk for kidney disease, heart attack, and stroke, among other complications. These complications can significantly decrease beneficiaries' quality of life and cost the health care system billions of dollars. Fortunately, evidence-based interventions, such as the National Diabetes Prevention Program have been shown to successfully prevent or delay the transition from prediabetes to type II diabetes. Providing payment under Medicare Part B for such an effective program would make it easier for more beneficiaries to take part in such a program.

We recommend that non-profits and community-based organizations be eligible to receive payment for delivering these programs, as many such organizations have already been successfully delivering the NDPP and other prevention programs to their communities for many years. Furthermore, given their role as trusted partners, these organizations are likely best suited to reach out to and effectively engage with those beneficiaries who are at risk. Partnering with these organizations is particularly important in underserved communities, where additional barriers exist between the health care system and the most vulnerable beneficiaries.

Increasing Transparency at the Center for Medicare & Medicaid Innovation

The Center for Medicare & Medicaid Innovation (CMMI) is playing a crucial role in furthering our understanding of how to improve the delivery of and payment for health care to better improve care and lower costs. In order to best fulfill this mission, CMMI should seek the input of a diverse group of stakeholders. The need for stakeholder input and transparency is especially important in designing the beneficiary education and engagement for a model or demonstration project. Beneficiaries who are fully informed of the models they can or do participate in are best equipped to take advantage of the presented opportunities to improve their health. We recommend that multi-stakeholder advisory committees be established at the outset of a project's design process, and that this committee be maintained and consulted throughout the duration of the project, particularly when course-corrections are warranted mid-demonstration.

We understand and support the need for CMMI to be flexible and innovative, and we encourage the Committee to balance these priorities with the need for stakeholder engagement and transparency. To do so, we recommend that all demonstrations have a 30-day comment period. Maintaining relationships with a diverse array of stakeholder groups on an ongoing basis, through the recommended advisory committees and other mechanisms, will allow CMMI to better incorporate the recommendations of these stakeholders into initial designs and to quickly distribute comment opportunities to relevant stakeholders to receive and incorporate their feedback.

Finally, it is important for CMMI to rigorously evaluate the results of all models and demonstration projects and to publish these results in an accessible manner, including those demonstrations that ended early or changed significantly in the middle of the demonstration due to unsatisfactory results. In order for these evaluations to have maximum impact, they must also be disseminated among a variety of health system partners and made easily accessible to the public.