Johns Hopkins Medicine Comments on the
United States Senate Committee on Finance
Bipartisan Chronic Care Working Group Policy Options Document
January 26, 2016

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Topic Area: Receiving High Quality Care in the Home

- ***Expanding the Independence at Home Model of Care***
  Johns Hopkins Comments
  Using a risk scoring methodology as specified by CMS (HCC) to identify complex care beneficiaries for inclusion in IAH is hypothetically superior to using an entrance criteria of experiencing a non-elective hospitalization. Using HCC will likely target a larger population and potentially expose CMS to greater cost from a larger population, but be counterbalanced by potential avoidance of non-elective hospitalizations. CBO can score this tradeoff.

- ***Expanding Access to Home Hemodialysis Therapy***
  Johns Hopkins Comments
  There is an opportunity for CMS to shift hemodialysis from expensive free-standing facilities to home if the site definition were expanded (only for this particular service of monthly visits with the nephrologist) to "renal dialysis facilities, hospitals, clinics, SNFs, assisted living facilities, or beneficiaries' homes). By allowing the service component to be delivered remotely, this could further encourage beneficiaries to receive home hemodialysis services.

  This benefit should require at least one in-person visit every three months. Hemodialysis patients are by definition medically fragile. Legislation could include language for CMS to reassess this in-person visit frequency requirement every four years.

Topic Area: Advancing Team Based Care

- ***Providing Medicare Advantage Enrollees with Hospice Benefits***
  Johns Hopkins Comments
  Requiring MA plans to offer hospice benefits would provide a seamless transition from curative to palliative without disruption to members care delivery system. It would improve the care coordination across all member needs as part of their end of life care. The seamlessness could drive appropriate earlier adoption of hospice benefit. The current separation of service providers and accountability promotes fragmentation of care and is disruptive for beneficiaries, families and providers.

  Allowing for Hospice benefits under an MA plan would help to advance improved quality of care with greater access to Palliative Medicine and to encourage truly patient centered involvement in Advanced Care Planning.

Additionally:

- Plan level quality measures could include percent of members with life threating conditions enrolled in Hospice prior to death.
- We agree that "the current MA payment system would need to be adjusted to take into account this additional benefit". The adjustment needs to address the concurrent nature of the payment and its ability to risk-adjust based on the chronic condition driving the need for Hospice service.

- ***Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan***

  Johns Hopkins Comments

- The ESRD population, while a small segment of the overall beneficiary pool, disproportionately drives a health plan's financial performance due to its high cost. The variance in costs relative to reimbursement can be significant. Further study should be undertaken to understand this variance to develop an overall payment model that could mitigate the risk of having disproportionate share of this population before broadening the access can be considered.
- The ESRD population is medically complex and fragile. Frankly put, care delivery systems (IT infrastructure, business operational processes, clinical delivery optimization) is not at a point to support capitation (clinical and financial risk transfer) from the government to the private sector for this population in larger scale. Financial and clinical risk transfer for this population will be successful when delivery system transformation is more advanced. Until then, C-SNPs have a unique opportunity to build the expertise and industry know-how for the management of this population.

- ***Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations***

  Johns Hopkins Comments

- The SNP programs have offered some of the greatest rewards both in terms of improved patient outcomes, member satisfaction and cost savings. Changing the status of the SNP programs from essentially demonstration projects into permanently authorized plans would obviously allow for greater planning and would likely encourage further entry into this market by other health plans.
- The SNP programs by in large offer more comprehensive infrastructure and benefits than could easily be adopted by MAPD plans who would "adopt specific benefit enhancements for chronically ill" and therefore it should not require changes to the current SNP structure even if new the benefits for Chronically ill – benefit structure is implemented.

- ***Improving Care Management Services for Individuals with Multiple Chronic Conditions***

  Johns Hopkins Comments

  Caregivers are a critical component of the illness management of virtually any person with multiple chronic conditions. We recommend that if a new code is to be established, it allow for an **annual** planning visit of all patients and caregivers with three or more chronic conditions. The healthcare professional involved should include primary care providers who are in a position to direct the treatment of the patient and caregivers who are close relatives and those involved with the day to day management of the patient. This meeting should include an update on the current status of the individual in the current setting from the patient

and caregiver, including barriers and facilitators to treatment adherence as well as a routine planning component that includes a clear discussion of the status and prognosis of each of the clinical conditions and discussion of future needs such as home safety and adaptations, healthcare needs and preferences for management of disease progression.

- ***Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries***
  Johns Hopkins Comments
  Improved integration of behavioral health and other health care would be beneficial in encouraging the treatment of the whole patient. Psychiatric behavioral conditions which include mental health and substance use conditions are disproportionately prevalent in persons with multiple chronic condition and represent one of the greatest opportunities for improvement. Johns Hopkins has designed embedded behavioral health services in primary care. . Further study of the state of integration, conducted by the GAO and as proposed here, would provide valuable information to help guide policy recommendations. However, in the meantime, in order to improve this integration the following should be considered:

1. Eliminate high co pays for outpatient behavioral health services for all Medicare beneficiaries. The high non-parity co-pay is a significant barrier and disincentive to receive treatment and renders any embedded integrated care programs that attempt to finance through fee for service, impossible to sustain.
2. Develop and allow incentive systems that encourage full integration of medical care at the state and local level, and that discourage carve outs of behavioral health from other medical care. This could include health related material objects and payment and/or discounts on other co-pays or beneficiary cost sharing like what is suggested on page 25 of the CCWG Options Document, in the section entitled: "Eliminating Barrier to Care coordination under Accountable Care Organizations." (There is a clear evidence base for the powerful value of incentives when such systems are utilized).
3. Significant revisions or abolishment of the current federal confidentiality regulations for substance abuse treatment, which have been an impediment to care coordination and data analyses.
4. Greater flexibility in Medicare payments for mental health and substance use disorders (e.g., for coverage of transportation).
5. Medicare payments for bundling of methadone maintenance treatment, similar to approaches typically used with Medicaid.

Topic Area: Expanding Innovation and Technology

- ***Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees***
  Johns Hopkins Comments

- The concept of a "one-size fits all" approach to MA benefit structures has challenged the health plans ability to offer a benefit structure that would effectively meet the needs for the complex MA eligible population. The ability to adapt benefits to meet the need of chronically ill Medicare Advantage enrollees would allow greater access to targeted benefits in a coordinated care plan for chronically ill, without a need to switch health plans or to restrict beneficiary access to narrow benefit design around the chronic condition.
- The committee recognizes the complexity of adjusting benefit options based on health status and to that end allowing new plans to file for this flexibility in the bid should be at the

discretion of CMS based on individual health plan capabilities (I.e., Experience of parent organization etc.).

- The MAPD benefit structure is driven by the bid process. Flexibility in offering additional benefits and definition of the benefits available should be part of the bid process. The qualification for the benefits should be consistent across health plans to ensure a level playing field.

- ***Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees***

  Johns Hopkins Comments

- MA plans can and do offer Supplemental Benefits (I.e., Acupuncture/Fitness Benefits) and given the high popularity of the programs amongst the beneficiaries, will continue to do so. Redefining the criteria to allow beneficiary access to non-medical support services especially in the limited context of additional benefits for chronically ill as discussed above should be explored.
- The criteria for the service should be for the care of beneficiaries that will advance their physical wellbeing. Recognizing the innovation that is taking place in this area, the categories of services should be defined with potentially having a formalized process established to be able to have new categories considered and added.
- These benefits should be part of the bid filing for additional benefits for chronically ill to ensure appropriateness and transparency with CMS.

- ***Increasing Convenience for Medicare Advantage Enrollees through Telehealth***

  Johns Hopkins Comments

  The telehealth services provided by the plan should not be limited to those allowed under the traditional Medicare program. The MA structure – a competitive, regulated marketplace whereby plans compete on price and features – is one of the few places of true health plan product innovation. Medicare FFS unnecessarily restricts telehealth services by geography, site, visit medium, and scope of care. MA is a marketplace which allows health plans to engage in positive creativity to help Medicare beneficiaries.

  In addition, telehealth holds great promise and will quite likely reduce access problems and the chronic shortage of PCP/Behavioral Health providers in areas that need them the most. However, telehealth must be seen for what it is – a tool to help with the care and coordination of medical/behavioral/social services.

  Another idea is to consider including the following telehealth (or more broadly, Connected Health) technologies in the annual bid amount:

- Live audio-video, audio-only visits with Medicare providers and Medicare beneficiaries, without any originating site or distant site restrictions
- Secure e-messaging (i.e. secure email) messaging between Medicare providers and Medicare beneficiaries
- Remote daily, automated medication compliance monitoring
- Remote daily, automated weight monitoring for congestive heart failure patients
- Remote daily, automated blood sugar monitoring for insulin-dependent diabetics

Topic Area: Empowering Individuals & Caregivers in Care Delivery

- ***Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness***

  Johns Hopkins Comments

  Caregivers are a critical component of the illness management of virtually any person with multiple chronic conditions. We recommend that if a new code is to be established, it allow for an **annual** planning visit of all patients and caregivers with three or more chronic conditions. The healthcare professional involved should include primary care providers who are in a position to direct the treatment of the patient and caregivers who are close relatives and those involved with the day to day management of the patient. This meeting should include an update on the current status of the individual in the current setting from the patient and caregiver, including barriers and facilitators to treatment adherence as well as a routine planning component that includes a clear discussion of the status and prognosis of each of the clinical conditions and discussion of future needs such as home safety and adaptations, healthcare needs and preferences for management of disease progression.