January 26, 2016

Senate Committee on Finance Chronic Care Workgroup
219 Dirksen Senate Office Building
Washington, D.C. 20510

Submitted electronically to chronic_care@finance.senate.gov

RE: Bipartisan Chronic Care Working Group Policy Options Document

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

The National Health Council (NHC) appreciates the opportunity to submit comments on the proposed policy options in the Senate Finance Committee Chronic Care Working Group Policy Options Document. We commend Chairman Hatch and Ranking Member Wyden for their leadership. We also commend the Committee, particularly Senators Isakson and Warner, for their dedication to the chronically ill and for continuing to drive this important policy discussion forward.

The NHC is the only organization that brings together all segments of the health community to provide a united and effective voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, its core membership includes the nation’s leading patient advocacy organizations, which control its governance and policy-making process. Other members include professional and membership associations, nonprofit organizations, and representatives from the pharmaceutical, medical device, insurance, generic drug, and biotechnology industries.

As expressed in our June 2015 letter to the Committee, patient-centered care is care that respects a patient’s goals and aspirations, life experience, and medical needs. We feel that this concept is weaved throughout many of the policy options. Additionally, we support many of the policy options that are designed to better coordinate care for people with chronic conditions.

Receiving High Quality Care in the Home

Expanding the Independence at Home Model of Care
The NHC supports expanding the Independence at Home Model of Care into a permanent, nationwide program. Most individuals with serious chronic conditions would prefer to receive care at home rather than in a long-term care facility. We believe it is important to respect patients’ goals of remaining independent while receiving high-quality care. It is also typically less expensive for patients and the health system at large than institutionalization. Implementing this policy is an important first step to enabling patients to drive their care, as well as improving access to care for those who need it most.
Providing Medicare Advantage Enrollees with Hospice Benefits
The NHC supports the proposed policy of providing Medicare Advantage enrollees with full-scope hospice benefits. When Medicare Advantage first began, there was skepticism that these plans would provide appropriate care for seniors, leading to the carve-out of hospice benefits. However, we are long past that skepticism, and Medicare Advantage has proven itself to be a trusted, long-established coverage program for America’s seniors. Today, Medicare Advantage serves one-third of all Medicare enrollees, and this number is increasing.\(^1\) With the continued growth of enrollees in Medicare Advantage, hospice benefits should be included within these plans.

Further, expanding hospice benefits to Medicare Advantage plans would allow insurers the ability to create innovative hospice benefits or to expand existing programs from their commercial market to the Medicare Advantage population. For example, Aetna’s successful Compassionate Care Program allows beneficiaries to receive hospice benefits when they have a life expectancy of 12 months or less, as opposed to most plans which start hospice with a 6-month expectancy. Beneficiaries still have access to curative care, and their care is coordinated by a nurse practitioner, who serves as a case manager. Not only do patients and their families report increased satisfaction, but Aetna has reported decreased costs associated with acute care.\(^2\) The NHC encourages innovative strategies such as this and believes that allowing Medicare Advantage plans to offer hospice benefits would further this type of work.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations
The NHC supports extending Medicare Advantage Special Needs Plans (SNPs) for the most vulnerable and complex beneficiaries. These beneficiaries benefit from the specialized benefits received through SNPs. Further, authorizing these programs permanently removes uncertainty about the future of this program, both for the health plan carriers designing and implementing the plans as well as the beneficiaries relying on them. As we have previously stated, we believe SNPs should be consistently monitored and evaluated to ensure these plans are providing appropriate, high-quality care to beneficiaries.

Improving Care Management Services for Individuals with Multiple Chronic Conditions
We appreciate the proposed policy of implementing a billing code for care management and coordination for high-needs patients. The coordination of care for people with multiple chronic conditions is much more time intensive than for healthy individuals or those with less complex conditions. This proposal would more fairly compensate providers who offer this service, creating an incentive for them to coordinate care for Medicare’s sickest beneficiaries.

We would urge the committee to require CMS to continually monitor the usage of this payment code to examine whether the criteria to determine which populations are eligible should be modified.

Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries
The NHC applauds the Chronic Care Working Group for proposing care integration for individuals with a chronic disease combined with a behavioral health disorder, regardless of whether they are in an original Medicare or a Medicare Advantage plan. Research shows that behavioral illness and chronic disease are closely related and having both significantly decreases a patient’s well-being. In fact,

\(^1\) http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/
\(^2\) http://content.healthaffairs.org/content/28/5/1357.full.pdf+html
depression is found to co-occur in 51% of Parkinson’s disease, 42% of cancer, 27% of diabetes, and 23% of cerebrovascular disease patients.\(^3\) It is not enough or appropriate to treat each condition separately. Care must be coordinated to ensure a patient-centered approach that seamlessly addresses the total patient with health care needs.

The NHC also supports the proposal that the Government Accountability Office (GAO) conduct a study on the current status of the integration of behavioral health and primary care among accountable care organizations (ACOs) and medical homes. We believe this study will not only provide transparency of what is happening among these care models, but will also highlight best practices and areas for improvement.

**Expanding Innovation and Technology**

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

The NHC is pleased the Committee is considering broadening the services included in supplemental benefits for the chronically ill enrolled in Medicare Advantage. We strongly support the inclusion of social services for this vulnerable population. One example of such needed support is transportation to health care appointments. This is addressed in Medicaid by the non-emergency medical transportation (NEMT) benefit, which provides transportation to and from appointments for beneficiaries who otherwise would not be able to transport themselves.\(^4\) We believe a similar benefit should be offered to the chronically ill within Medicare Advantage plans. The NHC also supports including services such as social worker benefits or connecting beneficiaries to social programs they may eligible for.

We also applaud the Committee for recognizing safeguards are necessary for the implementation of this policy. Increasing the numbers and types of supplemental plans creates the risk that Medicare Advantage plans may move many medically necessary benefits into a supplemental plan, driving up total costs for people who need those services. Additionally, all benefits included within the supplemental benefits should be of value to all chronically ill patients, not solely catering to a specific sub-population within Medicare Advantage. The NHC believes it is sound policy to ensure that all benefit designs prevent any form of discriminatory practices.

**Maintaining ACO Flexibility to Provide Supplemental Services**

The NHC supports allowing ACOs to provide supplemental services. Similar to our comments above, we recommend including social services such as transportation, social worker access, and connecting beneficiaries to other social programs. As health care systems shift toward value-based models, such as ACOs, we believe it is important to ensure access to services remain consistent and robust in all models of care.

**Identifying the Chronically Ill Population and Ways to Improve Quality**

**Ensuring Accurate Payment for Chronically Ill Individuals**

The NHC firmly believes that accurate and appropriate risk adjustment is essential to the operations of health plans in order to reduce plans’ incentive to only enroll those patients with the lowest health needs. When risk adjustment fully accounts for the complicated care and coordination required for people with

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multiple, complex conditions, plans are not absorbing the risk that comes from offering coverage and care to these individuals. With many years of utilization and payment data, the accuracy of the risk adjustment model to ensure that plans are paid fairly is a matter of correcting known issues within the system. A recent study by Avalere Health shows that the existing risk adjustment model does not adequately compensate Medicare Advantage plans for the increased cost of covering people with multiple chronic conditions. Thus, the NHC strongly supports the Committee’s consideration of addressing the current risk adjustment model to more accurately identify chronically ill patients and more fairly compensate Medicare Advantage plans that enroll them.

**Developing Quality Measures for Chronic Conditions**
The NHC appreciates the working group’s initiative to incorporate quality measures specific to the chronically ill population. As previously stated, we believe that the best care for people with chronic conditions is when providers customize care based on a person’s aspirations, life experience, and medical needs.

However, because existing measures are largely based solely on clinical outcomes, they may punish providers for offering customized care that may not be considered standard but best helps a patient achieve desired outcomes. Thus, we are very pleased to see that the Committee is considering requiring CMS to develop quality measures that can truly help ensure patients are fully engaged in their care and achieving their preferred outcomes. We are particularly interested in the following three proposals that were listed in the Committee’s policy options:

- Patient and family engagement, including person-centered communication, care planning, and patient-reported measures;
- Shared decision-making; and
- Hospice and end-of-life care, including the process of eliciting and documenting individuals’ goals, preferences, and values, quality of life, receipt of appropriate level of care, and family/caregiver experience of care

These potential measures are very similar in aim and nature, and could be married into a single quality measure set, assessing whether or not patients and family caregivers have been fully engaged in the care planning process, expressing and achieving their goals, preferences, and experiences. While hospice and end-of-life care is a prime example of a chronic care setting that would benefit from this type of elicitation and documentation, it is not the only time it would be beneficial. Thus, a core measure set addressing these issues could be used universally across various care settings.

**Empowering Individuals & Caregivers in Care Delivery**

**Encouraging Beneficiary Use of Chronic Care Management Services**
The NHC is pleased to note that the Committee is considering waiving the copayment for the chronic care management code and the proposed high-severity chronic care code. We believe it is important to remove all barriers to care for this vulnerable population. Research tells us that reducing copays for the chronically ill increases medication adherence, which is important to managing chronic diseases.  

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Furthermore, research has shown that copays are a burden for many chronically ill patients and do not achieve their intended results of reducing health care expenditures.  

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer’s/Dementia or Other Serious or Life-Threatening Illness  
The NHC applauds this proposed policy to implement a one-time payment to providers who are discussing with patients and families important issues regarding Alzheimer’s disease/dementia or other serious or life-threatening illnesses. These are critical, necessary, and time-consuming conversations. The NHC encourages the Committee to consider establishing protocols that will ensure all patients with serious chronic conditions receive this care by properly compensating providers for the time consumed by these activities.

The NHC strongly encourages the Committee to create an incentive for conversations between the provider or care team and the patient and/or their family caregiver to discuss care management, care planning, formal or informal caregiving, goals and priorities of the patient, and other relevant topics to the disease or patients’ wishes. This may be an in-person visit or a remote conversation, depending on the preference of the patient.

In addition to this discussion, the provider must develop a care plan, which should include immediate next steps. Criteria should be created to ensure that care plans are developed in a way that is understandable and clearly incorporates the feedback of the patients and their families. Furthermore, we caution the Committee of developing a set of criteria to determine when this planning visit is medically necessary. We strongly believe that if a provider deems that this conversation is necessary then the patient should have access to this service.

Thank you again for including our comments in your discussion to improve care for all people with chronic diseases and disabilities. We believe that people with chronic conditions are best served by a health care system that provides access to quality health care, respects their personal goals and aspirations, and is designed around the patient experience. All three elements are essential to promote an individual’s best possible health outcomes. We look forward to working with the Committee to turn the outlined policy options into meaningful policies that meet these goals.

Please do not hesitate to contact Eric Gascho, the NHC’s Vice President of Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,

Marc Boutin, JD
Chief Executive Officer

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9 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442363/