

Senate Finance Committee Chronic Care Working Group
Submitted via: chronic_care@finance.senate.gov



Dear Senate Finance Committee Chronic Care Working Group:

The Health Care Transformation Task Force¹ is pleased to respond to the December 2015 Chronic Care Policy Options document. We appreciate the thoughtful approach the Working Group has taken on this important topic and for the time and effort associated with the work that led to this comprehensive document.

The Task Force looks forward to continuing to work with policymakers to address the needs of this very important population of Medicare beneficiaries. Below, we outline our priority policy options from the comprehensive list provided, and our recommendations primarily focus on efforts that address the total cost, quality and care experience, and advance our members' collective goal of putting 75 percent of our business into value-based payment arrangements by 2020.

As part of the policymaking framework for addressing chronic care patients, the specific health needs and acuity of services for specific patients can change from time to time, and the particular focus of chronic care services should be tailored to the specific conditions of the patient at the time and subject the periodic reevaluation.

I. Advancing Team Based Care

The Task Force agrees that fostering collaboration among payers, providers, patients and caregivers, with a focus on integrated approaches to care, is key to improving quality of care, patient outcomes and experience, all while lowering costs. Improving access to team based care and facilitating collaboration and communication across the continuum of care should remain a Centers for Medicare & Medicaid Services (CMS) priority for the Medicare population.

¹ The Health Care Transformation Task Force (Task Force) is a group of private sector stakeholders that came together to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – currently including patients, payers, providers and purchasers – we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020. We hope to provide a critical mass of policy, operational and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

- **Senate Finance Committee (SFC) Option: Providing Medicare Advantage Enrollees with Hospice Benefits**

We support testing a hospice model that would give participating MA and MA-Prescription Drug (MA-PD) plans the option to offer hospice benefits concurrently with curative care to plan enrollees. The option to provide hospice benefits under MA would provide more flexibility, peace of mind, and cost savings to plan enrollees. As part of such a model, we recommend CMS monitor the following metrics: (1) hospice length of stay; (2) impact on acute, intensive care unit and emergency room utilization; (3) impact on medical cost; and, (4) member and family satisfaction (through FERC or similar survey instrument). We also emphasize that a model include the study of utilization of all services in the hospice population, particularly those services deemed “curative.”

Finally, we believe that MA plans that elect to include hospice care should liberalize the eligibility requirement of a six-month prognosis to a twelve-month prognosis. This change would better represent current end-of-life care standards.

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

Traditional Medicare fee-for-service (FFS) offers little comprehensive medical management infrastructure, including care management for the highest cost Medicare beneficiaries. The Task Force is fully supportive of efforts to increase and improve care management service for those individuals with multiple chronic conditions, as these are the beneficiaries who could benefit most from care management and improved care coordination across provider settings.

While a new high-severity chronic care management code may incentivize care management activities, CPT 99490 is already in existence for this purpose and underutilized for a variety of reasons. Many providers find the code administratively burdensome and do not believe that the reimbursement is sufficient to justify the time and resources necessary to bill under this code. We suggest that CMS reduce the administrative requirements for CPT 99490 and any new codes such as the high severity code proposed by the Committee.

For chronic care patients, the care team includes not just nurses and physicians, but social workers, behavioral health specialists, pharmacists, and/or community health workers. Advanced care coordination payments should be provided to the entire care team in recognition of the importance of behavioral health and the “non-clinical” needs of chronically ill patients.

To ensure effectiveness, we believe that the high severity code should be introduced temporarily while giving the Secretary of Health and Human Services authority to continue, discontinue, or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors (option (3) proposed by the Committee).

Finally, we believe that chronic care management payments should only be available to providers who are participating in alternative payment models (APMs) that provide incentives to deliver better outcomes at a lower cost. Any additional FFS payments should only be made within a context where providers are focused on, and held accountable for, improving patient outcomes. Without the supplemental infrastructure to focus attention on outcomes, chronic care management payments will neither improve health for patients, nor reduce the overall cost of care.

- **SFC Option: Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries**

Chronically ill patients face many non-physical health challenges. We support the Committee's proposal of integrating behavioral health care as part of a chronic care management program. Care management and wellness services have a psycho-social axis that colors all interactions that patients have with the health care system. We believe a comprehensive approach to physical and mental health forms the foundation of patient-centered care.

II. Expanding Innovation and Technology

- **SFC Option: Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

Provider networks and Medicare Advantage plans should be able to tailor care to beneficiaries who are chronically ill in ways that best meet their needs. These types of flexibility will improve clinical outcomes, slow disease progression, and minimize barriers to quality care. We support the Committee's proposal to allow Medicare Advantage plans to provide targeted supplemental benefits based on the specific chronic conditions faced by beneficiaries. This will reduce barriers to providing additional services to high need individuals who are likely to benefit from these services.

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

The use of supplemental benefits for chronically ill Medicare Advantage enrollees is a patient-centered approach to care that the Task Force supports. Enhanced benefits not

currently covered under the Medicare program that would be especially beneficial include those that address barriers to effective treatment. Important examples include transportation, meal services, and exercise and wellness programs.

- **SFC Option: Providing ACOs the Ability to Expand Use of Telehealth**

Telehealth is an innovative way to increase beneficiary access to provider services. We believe that telehealth payments should not be restricted geographically. We believe that the originating site requirement should be eliminated entirely for ACOs and other similar risk-bearing entities. With the assumption of risk, ACOs and other entities are held accountable for unnecessary utilization and waste, and therefore should not be restricted in their ability to provide telehealth services due to fears of overutilization.

- **SFC Option: Maintaining ACO flexibility to Provide Supplemental Services**

As noted by the Committee, the provision of social and transportation services is integral to consistent, high-quality, and continuous care for patients. We believe that ACOs and other similar risk-bearing entities should have the flexibility to provide social and transportation services as deemed necessary for specific patients. The services need not be required for all patients, but should be accessible for targeted patients who would most benefit from them. We also support the use of “remote patient monitoring systems” as a supplemental benefit, but recommend that this term be interpreted to include a variety of support tools and services such as patient portals and applications, not just telehealth services.

III. Identifying the Chronically Ill Population and Ways to Improve Quality

Identifying the chronically ill population is important in reducing health care costs that are concentrated in a very small patient subpopulation. Since the top 5% of patients, ranked by individual health care dollar spent, are responsible for almost half of the nation’s total personal health care dollars spent, finding and managing care for this group of patients can be an efficient and effective way to increase quality and reduce costs more generally.

- **SFC Option: Ensuring Payment for Chronically Ill Individuals**

Chronically ill beneficiaries often have disproportionate health expenditures and thus are susceptible to adverse selection problems. Robust risk adjustment that properly compensates for these outsized expected costs can ensure adequate resources and reimbursement for care provided to chronically ill beneficiaries. We agree that the current Hierarchical Condition Category (HCC) model used in Medicare may need fundamental improvements. We specifically support refinement of the HCC model to account for interactions between behavioral and mental health conditions and physical health outcomes.

- **SFC Option: Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization**

Allowing Medicare FFS beneficiaries to voluntarily elect to be assigned to the ACO, or other similar risk-bearing entity, in which their main provider is participating will increase the number of beneficiaries participating in the program, and the amount of care subject to value-based payment arrangements. Given Task Force members are committed to transitioning away from fee-for-service, we support increased participation in ACOs and other risk models. Voluntary alignment is an important component of a robust attribution model, which itself is necessary for accepting accountability for a population of patients. A robust attribution model is one that reflects a patient declaration “Yes, this is my provider group” and a provider group declaration “Yes, this is our patient.” Robust attribution makes a population “more known” and if ACO attribution is maintained and shared by a payer (including Medicare), it can be used to support information exchange, optimize care coordination, and align incentives across all providers.

- **SFC Option: Developing Quality Measures for Chronic Conditions**

Innovation in care delivery for the chronically ill should be driving toward the end goal of improved value: higher quality care at a lower cost to patients and the health care system overall. To that end, it is important to monitor the success of care delivery reforms and value-based payment arrangements to ensure that patients are indeed receiving high quality care. We urge CMS to use existing measures that fill this need, as well as test patient-reported outcomes measures (PROMs) and other measures that use patient-generated health data.

While the Task Force supports the Committee’s proposal to require CMS to develop measures that focus on health care outcomes for individuals with chronic disease, it is our position that quality measurement should become more focused on a small number of metrics that emphasize patient-reported and patient-generated data. We believe that the measures outlined by the Committee are important for ascertaining the full picture of the needs of the chronically ill population and whether those needs are being met. To that end, while there are many more detailed measures of particular aspects of care for chronic disease, we believe that the use of PROMs is the best way to gauge overall success.

Existing infrastructure such as the Health Care Transformation Task Force, the Health Care Payment Learning and Action Network, and the Center for Healthcare Transparency, can support CMS and accelerate the adoption of new chronic care measures (including PROMs). We believe that collaboration with public and private sector stakeholders to design, test, and spread these measures, is key for measure development and adoption.

IV. Empowering Individuals and Caregivers in Care Delivery

To comprehensively care for high need, high-cost patients and improve health outcomes for this population, it is critical that individuals and caregivers be considered as partners at all levels of care delivery. Ultimately, partnership with patients and family caregivers is the best way to empower patients and ensure that care is aligned with patient needs and preferences, and is the best way to encourage optimal patient and family engagement in the care and self-management process. While the Committee emphasizes the importance of empowering individuals and caregivers to be engaged in their care, the proposed policies focus on engaging patients at the point of care alone. Meaningful engagement, however, means supporting patients and family members as equal partners not just in decisions related to their care, but also decisions related to care delivery design and governance of provider organizations. In addition, patients and caregivers are valuable resources for forming partnerships between providers and communities.

- **SFC Option: Encouraging Beneficiary Use of Chronic Care Management Services**

Waiving the beneficiary co-payment associated with the current chronic care management code and the proposed high severity chronic care code described by the Committee will help to align incentives between providers and patients in order to increase beneficiary access to chronic care management services. The Task Force supports any efforts by the Committee to promote access to valuable care management and care coordination activities given their proven benefit to patient health and the reduction in unnecessary health care costs that can be achieved through streamlined, coordinated care. We agree that reducing the administrative burden of collecting a care management co-payment will incentivize providers to engage in more collaborative, patient-centered care. However, we believe that these waivers should occur within the broader context of accountability created by APMs.

- **SFC Option: Eliminating Barriers to Care Coordination under Accountable Care Organizations**

We believe that the integrated approach of ACOs, and the accountability fostered through the assumption of risk, protects against overutilization and waste. Therefore, we support the elimination of all beneficiary cost-sharing (co-payments, co-insurance, and deductibles) for chronic care management activities. The benefits of care coordination far exceed the nominal fees paid by beneficiaries for these activities, and with aligned incentives across an ACO, beneficiaries can be provided the highest quality care possible. We also emphasize, however, that meaningfully engaging beneficiaries as partners in care and delivering patient-centered care that meets the needs of patients and families is the best way

to encourage beneficiaries to consistently seek care within their ACO and access preventive care or disease management as needed.

V. Other Policies to Improve Care for the Chronically Ill

- **SFC Option: Increasing Transparency at the Center for Medicare & Medicaid Innovation**

The Center for Medicare & Medicaid Innovation (CMMI) does incredibly important work and is effectively the laboratory for the transformation to value-based care arrangements. CMMI. CMMI makes a significant amount of information available about its programs, yet the Task Force believes it should be required to put all of its alternative payment models out for public comment before “going live.” These models represent the payment mechanisms of the future and it is important for stakeholders to provide input throughout the policy development process. While CMMI often provides these opportunities to stakeholders, we believe a specific requirement for this would be appropriate public policy.

Thank you for the opportunity to provide this comment. Please contact Task Force Executive Director Jeff Micklos (jeff.micklos@leavittpartners.com) or (202.774.1415) with any questions.

Sincerely,

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