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Submitted electronically to [chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)

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, D.C. 20510

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

The Center for Consumer Engagement in Health Innovation at Community Catalyst respectfully submits the following comments to the Chronic Care Working Group's Policy Options Document.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

We applaud the Working Group on its commitment to identifying an impressive set of proposed policies that meet three goals, which we share:

1. Increasing care coordination among individual providers across care settings who are treating individuals living with chronic diseases.
2. Streamlining Medicare's current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases.

3. Facilitating the delivery of high-quality care, improving care transitions, producing stronger patient outcomes, increasing program efficiency and contributing to an overall effort that will reduce the growth in Medicare spending.

We hope the Working Group will consider one additional goal as it continues its work on behalf of beneficiaries with multiple chronic conditions: **reducing health disparities** among diverse populations, including racial and ethnic minorities, LGBT people, those with disabilities and other marginalized groups.

The policy proposals developed by the Working Group represent important steps in the right direction in the improved health and quality of life for Medicare and Medicaid beneficiaries with chronic conditions, who are among our nation's most vulnerable populations. We recognize the Committee's interests also extend to achieving savings for these critical public programs. However, we hope that the Committee will be guided by the wisdom of the so-called Triple Aim: achieving per capita cost **savings *only through improvements*** in the patient experience of care and in the health of populations.

Please note that the comments contained in this letter do not extend to every proposal contained in the Working Group's policy options document. Rather, we have selected those proposals we believe will have the greatest impact on the most vulnerable and underserved constituencies.

### **Providing Medicare Advantage Enrollees with Hospice Benefits**

We strongly support Medicare enrollees having full access to hospice benefits and recommend CMS test the concept of carving the benefits into Medicare Advantage through a demonstration. Hospice offers specialized care and support that helps to provide ease and comfort (physical, emotional and spiritual) for patients at the end of life and for their family members. There is a strong network of community-based hospice providers that offer person-centered, culturally-competent hospice care, and we believe it is essential to support these providers. While carving these benefits into Medicare Advantage may ultimately meet the goals we share with the Working Group for better coordinated care, we believe a wise incremental approach would be to test the concept through a demonstration. The results of such a demonstration would provide essential data on the carve-in's impact on quality and cost. Should the demonstration show positive results, it would also inform policymakers about the contracting requirements and safeguards necessary to protect beneficiaries' access to high-quality, community-based hospice services that honor people's wishes at the end of life.

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

We share the Working Group's strong interest in the integration of Medicare and Medicaid services for dually eligible beneficiaries. We believe that a long-term extension or permanent authorization of D-SNPs, particularly for those that are fully integrated, has the potential to improve the health outcomes and quality of life for many dually eligible beneficiaries, as well as to stabilize the program for states, health plans and providers. However, should this extension or permanent authorization be granted, we urge the Committee to ensure D-SNPs have the capacities and competencies to properly tailor their care management, provider interventions and partnerships with community-based organizations to the unique needs of the dually eligible

beneficiaries they serve. In particular, we believe that a number of the standards currently in place in some or all of the Financial Alignment Demonstration projects should become requirements for D-SNPs, namely:

- **Robust, trained and culturally-competent provider networks** that include a sufficient number of experienced providers able to meet the complex medical and support-service needs of members with multiple medical conditions and/or disabilities.
- The use of a **comprehensive assessment** of each beneficiary's needs that includes an evaluation of functional status, social and vocational needs, socioeconomic factors, personal preferences and the ability to obtain accessible services.
- The use of an **interdisciplinary care team** comprised of a beneficiary's primary care physician and other providers, as needed, to support the consumer; including but not limited to nursing, social work, behavioral health, long-term services and supports and pharmacy.
- **Contracts with existing community-based providers** of long-term services and supports.
- Offering all beneficiaries in need of personal care attendant services the **option for self-direction**.
- The use of an **independent long-term services and supports coordinator**.
- **Meaningful consumer representation** on D-SNPs' governing boards and advisory committees as well as the use of other means of soliciting member feedback, such as focus groups or member meetings.
- An easy-to-navigate and **integrated appeals and grievances** system.

Finally, we recommend that the Medicare-Medicaid Coordination Office be granted expanded authority to align and oversee requirements for both plans participating in the Financial Alignment Demonstrations and D-SNPs.

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

We commend the Working Group for its proposal to build on the current policy of reimbursing for chronic care management (CCM) by establishing a new high-severity chronic care management code. We believe that the current policy is a step in the right direction and encourage the Working Group to pursue further action in this area. We concur with several commenters that current policy does not fully recognize the time and effort that may go into managing more complex cases. We would support payment for the existing code (CPT 99487) that better recognizes the level of effort required to coordinate care for patients with complex conditions.

If the Committee envisions a new code – mindful of MedPAC's caution that failure to carefully define new codes could lead to increased cost without improvements in care – we suggest the Working Group consider:

- Defining the use of the code so that it includes Medicare beneficiaries with two or more chronic conditions or one chronic condition with a significant functional impairment. We believe that the definition of a chronic condition should include mental health and substance use disorders, and that these conditions should be counted separately.

- Requiring an individualized plan of care developed with the patient and/or family caregivers.
- Implementing a geographic pilot, similar to the one developed for the Comprehensive Joint Replacement (CJR) initiative. This will make it possible to track spending outcomes and patient experience prior to making the policy both universal and permanent.

We also support the elimination of the 20 percent Part B cost-sharing associated with chronic care management services for beneficiaries with physical and/or behavioral health conditions (substance use disorder and mental illness). We believe that this will help overcome resistance from both patients and providers to accessing these services, particularly among lower-income beneficiaries. Such individuals may be both less likely to have supplemental coverage and more likely to have multiple chronic health conditions.

The Working Group requested feedback on whether the waiving of cost-sharing addresses the concern that beneficiaries may question CCM services that appear on “summary of benefit notices” because they do not involve a face-to-face physician encounter. Although it is likely to reduce beneficiary questions, we do not believe that eliminating cost-sharing alone will eliminate these questions. This issue is best addressed through the engagement of beneficiaries and caregivers in the creation of the plan of care, regular communication with beneficiaries and ongoing assessment of patient engagement or patient confidence.

Finally, we recommend that substance use disorders treatment providers and mental health providers be included among the clinicians eligible to bill for chronic care case management.

### **Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries**

We thank the Working Group for focusing attention on this important issue. In many cases, behavioral health conditions exacerbate other chronic conditions and vice versa. As you note, integration of care for mental illness and substance use disorders with treatment for other chronic conditions can improve outcomes for consumers and decrease costs.

We recommend the Committee consider the following Medicare policy changes to strengthen integration.

1. Promote the Collaborative Care Model,<sup>1</sup> which provides team-based care led by a primary care provider and a behavioral health care manager. The Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)<sup>2</sup> study is among those that have shown strong evidence of this model’s benefits in improving outcomes, increasing consumer satisfaction and reducing costs. Other studies have shown its effectiveness in reducing health disparities. A training model<sup>3</sup> is already well-developed for the Collaborative Care Model. The model can also be built out to add the community-based services and supports that are often needed to round out treatment. Medicare payment

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<sup>1</sup> Kennedy Forum. *Fixing Behavioral Health Care in America: A National Call for Integrating and Coordinating Specialty Behavioral Health Care with the Medical System*, December 2015. Available at [http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-BehavioralHealth\\_FINAL\\_3.pdf](http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-BehavioralHealth_FINAL_3.pdf).

<sup>2</sup> For more information about IMPACT, visit <http://impact-uw.org/about/research.html>.

<sup>3</sup> IMPACT Training Protocol. AIMS Center. University of Washington. Available at <http://impact-uw.org/training/>.

mechanisms that could be used to promote Collaborative Care include capitation, monthly case rates, bundled payments, and fee add-ons or enhancements.

2. Providing grants to cover start-up costs for developing team-based care. These might be coordinated with ACO initiatives or other Center for Medicare and Medicaid Innovation projects.
3. Pay for peer support/recovery services as part of integrated care. There is growing evidence<sup>4</sup> of the value of peer support and recovery services in the care of people with mental illness and substance use disorders. A number of Medicaid programs pay for peer services. Adding peers as a provider category in Medicare would help expand the services available for behavioral health.
4. Where fuller integration is possible, promote the PCMH model of integration. This model is being used in the Massachusetts Financial Alignment Demonstration, including by the Commonwealth Care Alliance.<sup>5</sup>

We also urge you to commission the GAO study on integration in ACOs and medical homes that the Working Group mentioned in its Policy Options Document. Having this additional information will be very useful in identifying and addressing barriers to integration.

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

Community Catalyst generally supports allowing plans to adapt benefit design to better meet the needs of beneficiaries with chronic conditions, within certain limits. Mindful that greater flexibility in benefit design could be used not only to improve care for enrollees with chronic conditions, but also to discourage or discriminate against such beneficiaries, we believe that as a safeguard CMS should create a menu of approved evidence-based supplemental benefits and cost-sharing reductions related to improved treatment of specific chronic conditions from which plans might select.

### **Maintaining ACO Flexibility to Provide Supplemental Services**

We support the Working Group's proposal to allow ACOs the flexibility to provide social services and transportation services. As noted in the policy options paper, there is evidence that suggests linking social services with health care services improves health outcomes and lowers costs.<sup>6,7</sup>

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<sup>4</sup> Davidson, et al., *Peer support among persons with severe mental illnesses: A review of evidence and experience*. World Psychiatry 2012; 11(2): 123- 128; Reif et al., *Peer recovery support for individuals with substance use disorders: assessing the evidence*. Psychiatr Serv. 2014 Jul;65(7):853-61.

<sup>5</sup> See [Massachusetts Three-way Contract](https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/massachusettscontract.pdf) for Capitated Model. Appendix L. Available at <https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/massachusettscontract.pdf>.

<sup>6</sup> See Hostetter, M. and Klein, S., *In Focus: Using Housing to Improve Health and Reduce the Costs of Caring for the Homeless*, October/November 2014. Available at <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/october-november/in-focus>.

<sup>7</sup> See Waters, M., *Notes from the Frontline - Organizing to Make a Change*, August 20, 2015. Available at <http://www.communitycatalyst.org/blog/notes-from-the-frontline-organizing-to-make-a->

We caution the following when considering this policy:

- Since ACOs would be required to spend their own resources to provide a broader range of services, it will be critical to **understand their capacity and the availability of local resources to actually provide social services and/or transportation services.**
- **Upfront investments** may be needed to ensure broader adoption of this model.

### **Ensuring Accurate Payment for Chronically Ill Individuals**

Community Catalyst greatly appreciates the Working Group’s interest in and focus on the risk adjustment model for Medicare Advantage plans. Risk adjustment that accurately reflects the needs and “costliness” of members is critical for ensuring that plans are appropriately paid for the services they provide. Given the experience of plans serving dual eligible members to date, Community Catalyst has strongly supported CMS’ proposal to change its risk adjustment model to include six separate community segments based on age, dual eligible status and disability status. In addition, we strongly support the Working Group’s focus on disease interaction terms, particularly the interaction of behavioral health conditions with physical health conditions. In addition to the suggested changes, we recommend that the Working Group consider a frailty adjuster, such as that used in the Program of All-inclusive Care for the Elderly (PACE). We also believe it is important to examine the impact of socioeconomic factors, such as homelessness. Understanding the impact of these factors will be critical for ensuring plans don’t have an incentive to avoid taking on patients with complex care needs.

We would be remiss if we did not use this opportunity to raise the importance of improving risk adjustment for hospitals as well as for health plans. There is increasing evidence that the current Medicare methodology is not capturing key factors that contribute to the risk of a readmission. Notably, new research has demonstrated that a patient’s baseline functional status (not included in readmission risk prediction models) predicts increased risk of readmission.<sup>8</sup> Another recent study found that clinical and social characteristics not included in Medicare’s current risk adjustment methods explained much of the difference in readmission risk between hospitals with higher versus lower readmission rates.<sup>9</sup> Income, race, educational attainment and being dually eligible for Medicaid and Medicare were all strongly correlated with higher readmissions rates, as were self-reported health status and difficulties with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). The study concluded that hospitals with high readmission rates may be unfairly penalized, largely based on the patient populations they serve.

We are particularly concerned that the impact of Medicare’s payment policy on hospitals that disproportionately care for socially and clinically complex patients is to redirect resources away from these facilities. We strongly support a comprehensive review of risk adjustment across Medicare hospital payment policies and revision of risk adjustment methodologies to properly account for a fuller range of the social and clinical factors that contribute to risk.

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[change?source=email#.Vpk2LporJeh](#) (reinforcing the importance of coordination between the health care system and the community-based services network in order to provide support services to beneficiaries).

<sup>8</sup> Greysen, et al., Functional impairment and hospital readmission in Medicare seniors. *JAMA Intern. Med.* 2015; 175(4):559-565.

<sup>9</sup> Barnett, et al., Patient characteristics and differences in hospital readmission rates. *JAMA Intern. Med.* 2015; 171(11): 1803-1812.

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

We are pleased to see the Working Group's support for providing beneficiaries flexibility to be part of an ACO and urge it to place **emphasis on choice and active engagement of beneficiaries**. To further strengthen this policy option, we recommend the following:

- Beneficiaries should be able to voluntarily choose to be part of an ACO as opposed to retrospective attribution. Over time, retrospective attribution should be phased out.
- Beneficiaries should be able to receive services from providers of their choice without fear of being locked into a specific ACO with access to providers limited to that entity.

Successful voluntary alignment will also require a robust, coordinated beneficiary education and outreach effort. We recommend:

- Utilizing the strong infrastructure already in place to address beneficiary questions and concerns, including well-trained State Health Insurance Assistance Programs (SHIPs). CMS is also a trusted source for information about ACOs.
- Active collaboration with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, around education and outreach. Beneficiaries are more likely to trust CBOs, which will in turn create more buy-in to join/stay in the ACO.
- ACOs provide detailed information about their participating providers and how care will be better coordinated within their integrated systems. Information should be provided in ways that are accessible and understandable by beneficiaries, including in different languages as needed, based on the beneficiary population.<sup>10</sup>
- A clearly described process for opting-out of alignment with a provider; this process should be clearly delineated from separate opt-out procedures for data sharing.
- CMS issue additional guidance on the types of educational materials ACOs and providers will be permitted to give to beneficiaries. CMS also should provide clear guidance on the role it will play in reviewing ACO and provider-developed materials sent to beneficiaries, to ensure the materials are neither misleading nor coercive.<sup>11</sup>

Provider incentives should be clearly communicated as part of beneficiary rights and consumer protections, including a clear explanation that alignment does not change a beneficiary's rights,

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<sup>10</sup> The Social Security Administration provides its materials in 18 languages. See <http://ssa.gov/multilanguage/>. The U.S. Justice Department has a safe harbor provision for HHS recipients in meeting written translation requirements by providing written translations for each language group that represents 5 percent or 1,000 people, whichever is less, of eligible individuals. See <http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf>. Additionally, the Department of Labor requires that certain plans covered under ERISA provide summary plan descriptions in languages, where the lesser of 500 people or 10 percent of plan participants speak the same non-English language. See 29 CFR 2520.102-2(c)(2).

<sup>11</sup> See Coalition for Better Care, Comments on Next Generation Accountable Care Organization Model Request for Applications, May 18, 2015. Available at <http://www.nationalpartnership.org/research-library/campaigns/campaign-for-better-care/coalition-for-better-care-comments-on-next-generation-aco-model.pdf>.

such as freedom of choice of Medicare provider, ability to seek a second opinion or file a complaint. Also, CMS will need to carefully monitor direct outreach and communication with beneficiaries in order to protect against gaming.

### **Developing Quality Measures for Chronic Conditions**

Community Catalyst strongly supports the Working Group’s proposal that CMS include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. We support all of the topics listed, including: patient and family engagement; shared decision-making; care coordination; care consistent with patient’s goals, values and preferences; family/caregiver experience; dementia care; and community-level measures. We believe that quality measurement must start by measuring what matters most to patients. We suggest the Institute of Medicine’s *Vital Signs* report<sup>12</sup> as a possible starting point for a parsimonious set of measures that captures many key domains of health. We also encourage the Working Group to promote the improved collection of data, stratified by race, ethnicity, language, sexual orientation and gender identity since these factors often affect the quality of care that beneficiaries receive.<sup>13</sup>

### **Encouraging Beneficiary Use of Chronic Care Management Services**

We appreciate the Working Group’s commitment to supporting policies that aim to empower Medicare beneficiaries and their caregivers to be active and confident participants in ensuring that health care decisions match their goals, preferences and needs.

We appreciate and strongly encourage the Working Group’s consideration to waive the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity code. Please refer to our related comments above, under “Improving Care Management Services for Individuals with Multiple Chronic Conditions.” Not only does this policy have potential to incentivize beneficiaries to receive these services, but the elimination of any confusion from, or financial burden on, the beneficiary may also incentivize providers to offer and encourage care management services. Furthermore, while a generalized reduction in cost-sharing is likely to boost overall program costs initially, investing in chronic care management services is an evidence-based intervention that has demonstrated its cost-effectiveness.<sup>14</sup> Services such as counseling and coaching are effective in helping patients develop personalized plans to manage their conditions, establish a more healthy lifestyle, more smoothly navigate the health system and better understand their diagnoses<sup>15</sup> – all of which offer strong potential to result in better health outcomes and lower costs for both beneficiaries and the Medicare program overall.

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<sup>12</sup> Institute of Medicine, *Vital Signs: Core Metrics for Health and Health Care Progress*. April 2015. Available at [http://iom.nationalacademies.org/~media/Files/Report%20Files/2015/Vital\\_Signs/VitalSigns\\_RB.pdf](http://iom.nationalacademies.org/~media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_RB.pdf).

<sup>13</sup> See Agency for Healthcare Research and Quality, *Disparities in Healthcare Quality Among Racial and Ethnic Groups*, September 2012. Available at <http://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr11/minority.pdf>. See also Center for American Progress, *How to Close the LGBT Health Disparities Gap*, December 2009. Available at [https://cdn.americanprogress.org/wp-content/uploads/issues/2009/12/pdf/lgbt\\_health\\_disparities.pdf](https://cdn.americanprogress.org/wp-content/uploads/issues/2009/12/pdf/lgbt_health_disparities.pdf).

<sup>14</sup> National Council on Aging, *The Value of the Stanford University Chronic Disease Self-Management Program*. August 2012. Available at <https://www.ncoa.org/wp-content/uploads/Value-of-Stanford-Chronic-Disease-Self-Management-Program.pdf>.

<sup>15</sup> Bennett, et al., *Health Coaching for Patients with Chronic Illness*, *Fam Pract Manag.* 2010 Sept-Oct;17(5):24-29.



## **Eliminating Barriers to Care Coordination under Accountable Care Organizations**

We strongly support the Committee's interest in allowing ACOs in two-sided risk models to waive beneficiary cost-sharing for treatment of chronic conditions. We believe that – given the health and cost benefit of appropriate treatment of chronic conditions – they should be covered in the same manner as preventive services under Medicare: pre-deductible and without cost-sharing. We support a balanced approach in the use of rule-making to establish guidelines and safeguards, while providing some flexibility, in order to reflect evolving best practices and guidelines.

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We strongly support the Working Group's efforts to develop proposals that will improve the health of some of the most vulnerable Medicare and Medicaid beneficiaries. We greatly appreciate this opportunity to offer comments on these proposals and invite you to contact me at [ahwang@communitycatalyst.org](mailto:ahwang@communitycatalyst.org) with questions.

Sincerely,



Ann Hwang, MD  
Director, Center for Consumer Engagement in Health Innovation