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June 22, 2015

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 Jonny 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:

Thank you for the opportunity to provide input to the Committee on a range of critical policy issues that affect the provision and financing of care for the most vulnerable Medicare beneficiaries – those with disabilities and multiple chronic health conditions. Community Catalyst's mission is to ensure that consumer/community voice is at the table as we work to ensure quality cost-effective care for all. As such, it has extensive experience working with individuals and advocates on many of the issues before the Committee. For example, it served as the incubator for the Commonwealth Care Alliance, an innovative integrated delivery system that now serves nearly 17,000 adults with disabilities and chronic conditions. Community Catalyst also serves as the principal convener of *Voices for Better Health*, an initiative that works to ensure the voice of patients and their families are heard in the development and implementation of new integrated delivery systems in five states with Medicare/Medicaid Financial Alignment Demonstrations. *Voices for Better Health* partners closely with leaders in the geriatrics community – physicians, gerontologists, nurses, social workers and other providers and researchers – sharing best practices to improve efficiency, quality and outcomes in the demonstrations.

Policymakers, health care advocates and the public often view cost, quality and access as incompatible – that it is impossible to improve one of these parameters without having a negative impact on at least one of the other two. We question this perception. As more is understood about the dynamics driving spending among the small cohort of patients that account for most of the cost, it is clear much of it is attributable to sub-optimal care. Preventable hospitalizations and nursing home admissions, over-reliance on emergency rooms, inefficiencies in medication management, and adverse events that too often follow this care are largely at fault. And in many cases, these problems could have been prevented with timely, lower-cost interventions.

We believe it is possible to have care that is both better *and* more cost-effective. We also recognize, though, that getting from here to there is not easy and will take both time and effort. If new efforts are not well designed or implemented, there can be unintended effects that actually impede progress. With this in mind, we offer our thoughts on what we consider to be high-priority/high-leverage opportunities to improve care and outcomes for Medicare beneficiaries with multiple chronic conditions. Specifically, we address:

- Improvements to the Medicare Advantage program
- Improvements in policies related to Accountable Care Organizations (ACOs)
- Reforms in Medicare fee-for-service
- Improvements in the use, coordination and cost of prescription drugs
- Options for empowering Medicare beneficiaries

We also take this opportunity to share our views on the importance of addressing entrenched racial, ethnic, geographic and socio-economic health disparities in the Committee's policy deliberations. Finally, we conclude our input with some observations based on the experience of our partners who are engaged in the rollout of the Financial Alignment Demonstration in their respective states.

### **Improvements to Medicare Advantage**

Although a number of problems have plagued the program, including a history of overpayment to plans and persistent issues with improper coding to obtain higher reimbursement, Medicare Advantage (MA) plans have the potential to improve access to – and quality of – care, as well as stabilize costs for vulnerable beneficiaries. In order to better realize this potential we offer the following:

***Alter the risk adjustment approach so that it results in appropriate payments.*** The ability of MA plans to effectively manage the care of beneficiaries with multiple chronic conditions requires that they receive appropriate payment for doing so. Under the current risk adjustment system, MA plans are underpaid for beneficiaries with chronic conditions and overpaid for healthier beneficiaries.<sup>1</sup> While the Centers for Medicare and Medicaid Services (CMS) have stated their intent to address this issue in the most recent call letter,<sup>2</sup> it appears that the changes are likely to make the problem worse by collapsing some conditions into larger, more heterogeneous groupings. Failure to correct this will result in plans being unable or unwilling to serve those who could potentially benefit the most from coordinated care. We are hopeful that the forthcoming CMS study on the adequacy of the payment methodology for dual eligibles enrolled in MA plans will provide the data necessary to make these corrections.

***Support adjustment of the Five-Star Quality Rating System (Star System).*** The problem of inadequate risk adjustment is further exacerbated by flaws in the Star System that CMS utilizes to

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<sup>1</sup>Testimony of Mark E. Miller, Ph.D. before the U.S. Senate Committee on Finance, May 14, 2015.

<http://www.finance.senate.gov/imo/media/doc/SFC%20chronic%20care%20testimony%20FINAL.pdf>

<sup>2</sup>See <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2016.pdf>

reward plans for providing better quality care. The effect of the Star System is that some MA plans with a higher percentage of low-income enrollees tend to receive lower bonuses. The combination of the Star System's methodology and the tendency in the MA system to pay less for enrollees who are both sicker and poorer undermines the ability of the MA program to effectively meet the needs of beneficiaries with multiple chronic conditions. We suggest that the Committee explore reimbursement and quality rating alternatives that address these shortcomings in its deliberations.

***Reduce cost sharing for beneficiaries with multiple chronic conditions.*** A more general concern is the cost-sharing that beneficiaries must contend with in MA plans. Although cost-sharing is lower in MA than in traditional Medicare (exclusive of supplemental insurance), cost can still be a barrier for medically fragile enrollees because they must use more services. While a generalized reduction in cost-sharing is likely to boost overall program costs, developing a mechanism for reducing cost sharing for MA enrollees with specific types or numbers of chronic conditions could both ease the financial burden of illness and also enhance effective treatment. This would make it possible to provide better care at lower cost to both beneficiaries and the Medicare program overall.

***Investigate the high rate of beneficiary benefit denials and appeals.*** Another concern that bears further scrutiny is the high rate of denials of first-round appeals for beneficiaries in MA plans. The high number of denials is a concern in itself, but these denials are more likely to affect sicker beneficiaries because they use more services. We believe there is a causal effect between these denials and the greater propensity for these sicker beneficiaries – who could benefit the most from coordinated care – to disenroll from MA.<sup>3</sup>

### **Improvements in Policies Related to Accountable Care Organizations**

Accountable Care Organizations (ACOs) – like MA plans – have significant potential to improve care for beneficiaries with multiple chronic conditions. We believe, however, that substantial improvements are needed to reach that potential. Experience with ACOs to date has been mixed, with a small number of systems accounting for the bulk of savings.<sup>4</sup> This may be attributable to what we see as an emphasis on quantity over quality. We concur with the statement in Mark Miller's testimony before the Committee on May 14, 2015 that "the goal should be to create conditions that will reward efficient ACOs that can create real value for the Medicare program, its beneficiaries and the taxpayers – not maximize the number of ACOs." With that in mind, we propose the following:

***Promote alignment of some program provisions across types of payment arrangements.*** In some cases, alignment is problematic. For example, the same risk adjustment issues that affect MA plans are also present in ACO reimbursement. They incorporate the same incentives to avoid patients with multiple chronic conditions. In other ways though, ACOs are treated less favorably

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<sup>3</sup> See e.g. Riley, GF, **Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service**, Medicare Medicaid Res Rev. 2012; 2(4): mmrr.002.04.a08.  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006478/>

<sup>4</sup> See <http://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>

than MA plans. We suggest that risk and rewards and quality reporting be aligned across the various types of payment arrangements. Specifically, we concur with MedPAC’s proposal that ACOs be eligible for quality bonuses in addition to shared savings, as MA plans already are.<sup>5</sup> Alignment of risks and rewards and quality reporting across types of payment arrangements (e.g. MA and ACO) would allow ACOs to achieve bonuses for quality in addition to shared savings.<sup>6</sup>

**Promote expansion of ACO accountability.** ACO accountability should also be expanded. First, ACOs – as integrated systems – can and should be held accountable for a broader set of potentially preventable events than are hospitals. Specifically, we recommend building on CMS’s current readmissions initiative and holding ACOs accountable for excessive rates of preventable (ambulatory-care sensitive) admissions and emergency room visits.

Second, and of perhaps greater importance, is the need for a broader frame for ACO accountability. It is time for ACO accountability to move beyond the focus on third-party payers and more fully embrace accountability to patients and their representatives. Such a framework would include:

- Affirmative patient choice to affiliate with an ACO as opposed to retrospective attribution. Over time, retrospective attribution should be phased out.
- Shared savings/enhanced benefits for consumers. A key question for consumers is how their coverage/care will be better? Reduced cost sharing and enhanced benefits are key to answering that question, and they provide patients with an incentive to remain within an ACO referral system. That incentive is currently lacking, much to the frustration of providers who are accountable for cost and outcomes regardless of where care is received.
- Reinvestment of some ACO savings in the broader community. In addition to using savings to lower patients’ costs and/or enhance benefits, ACOs should engage their communities in discussions around how to reinvest a portion of savings in improving community health.<sup>7</sup>
- Increased utilization of Patient Reported Outcome Measures in quality measurement.
- Increased weight given to patient experience in assessing ACO performance, including patient activation.
- Expand and strengthen the role of patients/family members in governance and advisory bodies, with attention to the diversity of the patient population being served. This includes, but is not limited to, meaningful and effective participation of consumer representatives. It is especially important to engage patient/family representatives in reviewing patient-reported information such as complaints and grievances, and developing responses to that information.

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<sup>5</sup> See footnote 1.

<sup>6</sup> See footnote 1.

<sup>7</sup> In New Jersey, for example, the Medicaid Accountable Care Organization Demonstration Project (Public Law 2011, Chapter 114) requires Medicaid ACOs to develop gain-sharing arrangements, whereby any cost reductions achieved in the community are shared between participating providers, the state, and potentially, managed care organizations and other entities. Medicaid ACOs are also required to develop a process for engaging members of the community in design of the gain-sharing plan and provide a period for public comment on the plan.

## **Strengthening Primary Care and Care Coordination in the Fee-For-Service Program**

Integrated care systems appear to offer significant potential to moderate cost and improve quality of care.<sup>8</sup> However because many medical practices and health care systems still operate within a fee-for service context, it is important to consider what can be done to provide comprehensive, person-centered care beneficiaries with multiple chronic conditions within that environment. We offer a set of reforms that would address this need:

***Expand the use of high-quality case management programs.*** Although case management results to date have been mixed, research suggests that successful case management programs include the following features:

- Effective targeting, i.e. identifying those individuals who are most in need is key to ensuring a return on investment;
- “High touch” contact, including face-to-face interactions when needed, rather than exclusive reliance on telephonic outreach.
- Sufficient duration—quick touch is usually insufficient to stabilize high-need high cost patients and create new, more efficient and effective patterns of care
- Development of a plan of care based on the beneficiary’s goals
- Inclusion of a non-medical assessment and development of strategic interventions e.g. psycho-social, nutrition, home-safety.<sup>9 10 11</sup>

These features should be incorporated in the Patient-Centered Medical Home (PCMH) designation process and be required for enhanced reimbursement related to care coordination. They also should be required of ACOs regardless of which track they are participating in.

***Expand the care management/coordination team to include Community Health Workers.*** Community Health Workers (CHWs) should participate as team members in PCMHs, and especially in those that focus on providing care to underserved, racial and ethnic populations facing cultural and linguistic barriers to care. There is ample evidence that CHWs are effective in (1) assisting people to access and navigate the health care system and better manage their health conditions, (2) coordinating services for people with multiple chronic conditions, and (3)

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<sup>8</sup> See e.g. Mercer, Integrated Patient Centered Care Management in the Medicare Supplemental Population: A Viable Solution to Fragmented Care and Escalating Costs  
[http://www.mercer.us/content/dam/mercer/attachments/north-america/us/Revised\\_Mercer\\_H\\_B\\_Integrated\\_Care\\_Management\\_in\\_the\\_Medicare\\_Supplement.pdf](http://www.mercer.us/content/dam/mercer/attachments/north-america/us/Revised_Mercer_H_B_Integrated_Care_Management_in_the_Medicare_Supplement.pdf) Nov. 2014.

<sup>9</sup> Lynn J. Reliable and Sustainable Comprehensive Care for Frail Elderly People. JAMA. 2013;310(18):1935-1936.

<sup>10</sup> [http://altarum.org/sites/default/files/uploaded-related-files/MedicaringCommunities\\_042815.pdf](http://altarum.org/sites/default/files/uploaded-related-files/MedicaringCommunities_042815.pdf)

<sup>11</sup> See e.g. Neighborhood Health Plan of Rhode Island news release 5/26/15: *Neighborhood's innovative new home-based care program for highly complex and costly members shows strong initial results. Health@Home claims data show a 26 percent reduction in Emergency Room visits and a 30 percent reduction in medical inpatient days. The Program is projected to save at least \$2.7 million in the first year.*

leading community-wide efforts to identify and address underlying causes of poor health.<sup>12</sup> Chronic care reform policy must include mechanisms for incorporating – *and* reimbursing – CHWs.<sup>13</sup>

### **Effective Use, Coordination, and Cost of Prescription Drugs**

Prescription drug costs for chronic care patients covered by Medicare are driven by the high drug prices paid by Medicare, the needs of beneficiaries, the clinicians' prescribing decisions, and the structure of Medicare plans, which influence patient and prescriber decisions. The high and rising costs of specialty drugs, which are projected to account for half of all prescription drug costs in the U.S. by 2018,<sup>14</sup> are playing an especially important role in drug costs for those with chronic conditions. These costs affect both Medicare program costs as well as out-of-pocket costs for beneficiaries, many of whom face coinsurances as high as 25 percent for drugs placed in specialty cost-sharing tiers. To begin to address these challenges, we suggest the following:

***Expand the Medication Therapy Management Program (MTMP).*** To improve the use of evidence-based, coordinated and cost-effective treatment, the Committee should support adoption of CMS's January 2015 recommendation<sup>15</sup> (that was not adopted in the final rule) to expand MTMP eligibility criteria to beneficiaries with two or more chronic conditions who take two or more Part D drugs *and* who have annual Part D drug costs of \$620/year (average cost of two generic drugs in 2015). Targeted community-based outreach on MTMP should be required for beneficiaries that receive the low-income subsidy, as well as those in racial and ethnic minority communities, to address documented disparities in access to MTMP. While 25 percent of Part D beneficiaries are theoretically eligible today, only 8 percent of patients are enrolled.<sup>16</sup>

***Address rising expenditures for specialty drugs.*** Costs are rising significantly due to increased need, lack of coordination, expanded uses of existing drugs, high prices, and provider "buy and bill" incentives for office-administered drugs.<sup>17</sup> We propose two policies to help address these challenges:

- Expand programs for episode-based bundled payments, which are one promising solution to implementing coordination and evidence-based treatment.
- Reform payment for Part B provider-administered drugs in the fee-for-service system, which currently are reimbursed at the Average Sales Price, plus six percent of drug costs,

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<sup>12</sup> NYS Health Foundation (October 2014). A Critical Link for Improving Health Outcomes and Promoting Cost-effective Care in the Era of Health Reform. <http://nyshealthfoundation.org/uploads/resources/community-health-workers-critical-link-october-2010.pdf>

<sup>13</sup> <http://content.healthaffairs.org/content/20/6/64.full.html>

<sup>14</sup> Lotvin et al., Specialty Medications: Traditional And Novel Tools Can Address Rising Spending On These Costly Drugs Health Aff October 2014 vol. 33 no. 10 1736-1744 <http://content.healthaffairs.org/content/33/10/1736.abstract>

<sup>15</sup> Centers for Medicare & Medicaid Services, Proposed Rule, Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs (January 10, 2014) available at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf>

<sup>16</sup> <http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf>

<sup>17</sup> Lotkin AM, Shrank WH et al. Specialty Medications: Traditional and Novel Tools Can Address Rising Spending on These Costly Drugs. Health Aff (Millwood). 2014;33(10).

which creates a significant incentive for overuse of the highest-price brand name drugs. Replace this methodology with a set fee, plus the cost of storage or, as proposed in the President’s FY2016 Budget, Average Sale Price plus 3 percent. The latter is projected to yield \$7.38B in savings during the period FY2016 – 2025.

We recognize that these policies will not entirely solve the problems associated with both mis-prescribing and high drug prices, but believe they are important steps in the right direction.

### **Empowering Medicare Beneficiaries**

Empowering beneficiaries is essential to any successful strategy to improve care for those with chronic conditions. Patients and family members must be seen as key members of the care team, *not* as passive recipients. Implementing programs to improve activation among patients with multiple chronic conditions, i.e. providing beneficiaries with the skills and confidence to become actively engaged in their health care, promises to be a relatively low-cost, but high-impact, way to address chronic disease treatment. A growing body of evidence shows that positive self-reported patient experience and increased activation are both correlated with better health outcomes and lower cost, particularly in patients who have chronic diseases.<sup>18 19 20</sup>

CMS has monitored patient activation within the Medicare population through the Medicare Current Beneficiary Survey (MCBS). Their analyses of these surveys have found that, while Medicare patients tend to self-report as moderately activated, there are disparities in activation based upon patient demographics.<sup>21</sup> Individuals who are dually eligible for Medicaid and Medicare are very likely to have low activation scores (46.2 percent, as are patients who self-report as less healthy (38 percent). Thus a threshold policy focus should be on increasing activation in these sub-populations that correlate with higher rates of chronic illness. We urge consideration of these improvements:

***Provide reimbursement for chronic disease self-management programs.*** This is a threshold requirement for an evidence-based intervention that has demonstrated its cost-effectiveness.<sup>22</sup> Reimbursement should extend to organized group programs as well as individual patient counseling and coaching, both of which are effective in helping patients develop personalized plans to manage their conditions, establish a more-healthy lifestyle, navigate the healthcare system, and better understand their diagnoses.<sup>23</sup> Patients may need encouragement to participate

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<sup>18</sup>Greene J., Hibbard JH, Sacks R, Overton V, Parotta CD. *When Patient Activation Levels Change, Health Outcomes And Costs Change, Too*, **Health Affairs (March 2015, Vol. 34, No.3)**.

<http://content.healthaffairs.org/content/34/3/431.short>

<sup>19</sup>Donald M, Ware RS, Ozolins IZ, Begum N, Crowther R, Bain C. *The role of patient activation in frequent attendance at primary care: a population-based study of people with chronic disease.*

<http://www.ncbi.nlm.nih.gov/pubmed/20598825>

<sup>20</sup><http://mcr.sagepub.com/content/early/2014/07/11/1077558714541480>

<sup>21</sup>[https://www.cms.gov/mmr/Downloads/MMRR2014\\_004\\_04\\_b02.pdf](https://www.cms.gov/mmr/Downloads/MMRR2014_004_04_b02.pdf)

<sup>22</sup><http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/CDSMP-Fact-Sheet.pdf>

<sup>23</sup> Heather D. Bennett, MD, Eric A. Coleman, MD, MPH, Carla Parry, PhD, MSW, Thomas Bodenheimer, MD, MPH, and Ellen H. Chen, MD, Health Coaching for Patients With Chronic Illness, *Fam Pract Manag.* 2010 Sep-Oct;17(5):24-29.

in these programs, and so their caregivers should be made aware of the potential benefits to be derived from activating their patients. Provisions should be made to develop programs specifically targeted to providers and other caregivers, as well as Community Health Workers, with a particular emphasis on programs that focus on reducing cultural or language barriers to activation (ex. low-English proficiency patients).

***Make quality measurement more salient and usable for beneficiaries.*** There is evidence that increased measurement of patient activation is associated with increased activation scores (even without other efforts specifically designed to increase scores).<sup>24</sup> Patients who have been asked questions about their level of activation and satisfaction by their care providers are more likely to take an active role in their care than patients who have not been asked. This suggests that patient activation can be improved within chronic care patients if there is a focused effort to include them in activation-related survey activities.

Making quality measurement more salient to patients is not limited to expanding the use of tools to measure and enhance patient empowerment in the clinical setting. Substantial overall improvements are needed in how we measure and report on quality to make quality measurement more salient and usable for patients. This includes both what we measure, i.e. greater reliance on outcomes over process measures – and specifically patient reported outcomes – and greater attention to how we display information.<sup>25 26</sup> In addition, even the best data is useless if people don't know it is there. Generally, patient awareness of quality information is low. A concerted effort is needed to expand patient awareness of quality information, but again, such an effort will be wasted if the information that is being presented is neither salient nor intelligible to patients and family members.<sup>27</sup>

Finally, while we strongly support encouraging consistent measurement of patient activation, we recognize that care must be taken in tying measures of activation to financial rewards for plans or providers. First of all, given the prevalence of cognitive impairment among the Medicare beneficiary population with multiple chronic conditions,<sup>28</sup> there are practical limits to strategies to improve activation. Also, lower income patients tend to score lower on the various scales of patient empowerment. Any connection of financial rewards to expanded measurement of patient activation would have to be risk-adjusted and might also have to exclude patients with certain diagnoses. Even if not attached to a financial incentive, promoting awareness of patient

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<sup>24</sup> *Asking questions: the effect of a brief intervention in community health centers on patient activation.* Deen D, Lu WH, Rothstein D, Santana L, Gold MR., *Patient Educ Couns.* 2011 Aug;84(2):257-60. doi: 10.1016/j.pec.2010.07.026. Epub 2010 Aug 25. <http://www.ncbi.nlm.nih.gov/pubmed/20800414>.

<sup>25</sup> See e.g. Cite recent IoM report on quality measurement? <http://www.iom.edu/Reports/2015/Vital-Signs-Core-Metrics.aspx>

<sup>26</sup> See for example the Health Care Compass developed by the quality compass and Massachusetts Health Quality Partners, a non-profit coalition of doctors, patients, health plans, and others who have come together to help improve the quality of healthcare services in the Massachusetts.

<http://healthcarecompassma.org/reports/office/index.php?subnav=c&entityid=102401&patients=adult>

<sup>27</sup> <http://www.ajmc.com/journals/issue/2015/2015-vol21-n3/are-healthcare-quality-report-cards-reaching-consumers-awareness-in-the-chronically-ill-population>

<sup>28</sup> <http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet/>

experience and patient empowerment scores is likely to improve patients' ability to identify high-quality providers and to elicit improved responses.

***Improve the data portals and digital information resources that give patients access to their health records and information.*** There is evidence that providing individuals (or family members, where appropriate) easy access to their personal health record and health information improves patients' ability to participate in their care.<sup>29</sup> Currently, CMS is engaged in efforts to improve the health information infrastructure in numerous states (ex. through State Innovation Models), but these should be expanded, and additional funding should be made available.

***Strengthen both patient due process rights and the ombudsman function.*** Beneficiary consumer protections suffer from lack of specificity. This is especially critical for beneficiaries with multiple chronic conditions. The rate of level-one denials referenced above suggests that there is a serious issue that needs to be addressed, both with respect to actual protections and education of providers/health plans. A good place to start would be requiring timely collection and analysis of data on denials, grievances and appeals, and public reporting of that data. Additionally, the following provisions should be adopted, at a minimum:

- Voluntary enrollment
- Easy disenrollment procedures
- Improved appeals and grievances processes<sup>30</sup>
- Establishment of a strong, independent ombuds program that not only helps individuals, but also tracks trends

## **Health Disparities and Individuals With Multiple Chronic Conditions**

Any policy that addresses health care costs, quality and access among the beneficiary population with multiple chronic conditions must include provisions that affirmatively address and mitigate the disparities that are endemic among racial, ethnic, geographic and socio-economic minorities. There are significant racial, ethnic and geographic disparities in the prevalence of chronic diseases. Blacks and Latinos have the highest prevalence of *six or more* chronic conditions,<sup>31</sup> and disparities in quality of care and health outcomes remain compelling and persistent for people in low-income households, including people of color. Indeed, some disparities related to chronic disease have actually grown larger over time.<sup>32</sup>

To achieve more equitable health care outcomes, it is crucial to incorporate disparity reduction goals into overall quality improvement goals and to adopt tools that support measuring disparities

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<sup>29</sup> <http://www.who.int/management/general/decisionmaking/WhereArePatientsinDecisionMaking.pdf>

<sup>30</sup> <http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2013CandDProgramAuditAnnualReport.pdf>

<sup>31</sup> Centers for Medicare and Medicaid Services (2012). Chronic Conditions among Medicare Beneficiaries, Chart Book 2012 Edition. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>

<sup>32</sup> Agency for Healthcare Research and Quality (May 2015). 2014 National Healthcare Quality And Disparities Report: Chartbook on Care Coordination <http://www.ahrq.gov/research/findings/nhqdr/2014chartbooks/carecoordination/2014nhqdr-care.pdf>

and undertaking interventions. We suggest the Committee incorporate the following strategies in their chronic care reform policy development:

***Improve data collection and reporting, including data stratified by race, ethnicity, primary language, gender identity and sexual orientation for measuring success.*** The quality of care individuals receive frequently depends on their race, ethnicity, gender identify, sexual orientation, age and language they speak. Therefore, stratified data collection and reporting must be a critical component of measuring health outcomes and patient satisfaction if disparities are to be reduced. The Committee should consider reinforcing the data collection requirements under section 4302 of the Affordable Care Act by offering a financial incentive for improved data collection.<sup>33</sup> Additionally, health care organizations should be required to use the new consensus metrics developed by the National Quality Forum (NQF) to assess cultural competency and language services.<sup>34</sup> Implementing these measures is critical in addressing provider biases, poor patient-provider communication, and poor health literacy.

Collection and reporting of data on the measures specified above will be an important contribution to creation of a long-term agenda for improving healthcare quality for populations experiencing disparities. We note that neither adjusting nor failing to adjust quality measurement or financial incentives for race/ethnicity or SES will actually reveal persistent disparities in treatment and outcomes. Improved data collection and reporting is essential for this purpose.

***Improve care coordination by integrating Community Health Workers (CHWs) in care coordination teams.*** As noted above, CHWs are ideally suited as members of the care coordination teams of patient-centered medical homes, particularly for underserved, racial and ethnic populations facing cultural and linguistic barriers to care. CHWs frequently are members of – or familiar with – the communities being served. As such, they bring a degree of empathy and credibility to the organization that fosters patient confidence and satisfaction.<sup>35</sup>

***Improve provider-patient communications by incorporating tools to assess, manage and reduce implicit biases among health care providers.*** Implicit bias among health care providers is a key contributing factor to health disparities because it negatively affects treatment delivery and medical interactions between providers and patients.<sup>36</sup> While race and ethnicity are two areas in which providers sometimes demonstrate implicit bias, a number of studies examining clinical decision-making suggest that implicit bias manifests in other areas, including gender and age. Further research is needed to identify effective strategies for mitigating implicit bias among health care providers, however an important first step is to equip health care providers with tools such as

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<sup>33</sup> We do not recommend imposition of financial penalties because the decision on whether to provide data rests with the patient.

<sup>34</sup> National Quality Forum (August 2012). Healthcare Disparities and Cultural Competency Consensus Standards. [http://www.qualityforum.org/projects/Healthcare\\_Disparities\\_and\\_Cultural\\_Competency.aspx](http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx)

<sup>35</sup> See, for example this recent media story. <http://www.providencejournal.com/article/20150526/NEWS/150529490>

<sup>36</sup> <https://www.iom.edu/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/PatientversionFINAL.pdf>

the Implicit Associate Tests (IATs)<sup>37</sup> to assess and manage their own biases.<sup>38</sup> We suggest that the Committee create incentives that reward health care providers who undergo implicit bias trainings and demonstrate perspective-taking and individuation when providing patient care.

### **Lessons Learned From Implementation of the Medicaid/Medicare Financial Alignment Demonstration in Five States**

In conclusion, we would like to share with the Committee some observations derived from our work with partner organizations in five states that are engaged with implementation of the Financial Alignment Demonstration (FAD). In addition to offering a view of challenges on the ground, these observations also have relevance to the other initiatives targeted to beneficiaries with multiple chronic conditions.

***Consumer and provider education are critical.*** A key lesson learned to date through the FAD is the importance of outreach to – and education of – both consumers and providers. Lack of this education has created a number of early implementation challenges for those states pursuing a FAD. On the consumer education front, many consumers were not aware of the FAD, its purpose or how it would affect them. This was especially concerning for those enrollees who were auto-enrolled into the FAD and, as a result, experienced lapses and delays in care. Similarly, providers did not know of the changes. As a result, many providers turned away patients or were unclear about their roles and responsibilities.<sup>39</sup> The Committee must ensure that outreach and education to consumers and providers is a central component of chronic care reform policy *from the very beginning*

***Rigorous evaluation and public reporting is essential.*** The Committee should ensure rigorous evaluation and transparency of performance data in any chronic care reform policy. The FAD includes an evaluation, but there has been virtually no reporting of data necessary to inform the public regarding how well this initiative is performing. This is particularly true with regard to the provision of long-term services and supports. Any chronic care reform policy should ensure the collection and transparent reporting of data on hospitalizations and re-hospitalizations, emergency room visits, patient functionality, spending on community-based long-term services and supports, as well as patient-reported outcome measures (as noted above).

***Continuity of care is of the highest priority.*** If Medicare beneficiaries are enrolled in new programs, they must have the right to continue services they are receiving at the time of enrollment without interruption. They also have the right to continue seeing their current providers and to continue taking the same prescription drugs they are currently taking. These provisions serve as a critical safeguard for beneficiaries, many of whom have longstanding

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<sup>37</sup> Implicit Association Test is a computerized measurement tool designed to measure the strength of automatic associations people have in their minds. This tool has been used to measure implicit bias in physicians <https://implicit.harvard.edu/implicit/iatdetails.html>

<sup>38</sup> US National Library of Medicine National Institutes of Health (November 2013). Physician and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities <http://www.ncbi.nlm.nih.gov/pubmed/23576243>

<sup>39</sup> MACPAC Report on “Experiences with Financial Alignment Initiative Demonstration Projects in Three States”. Retrieved: <https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf>

provider relationships and for whom an interruption of that relationship would cause harm. Despite these safeguards, we have seen numerous violations of these rights in the FAD.<sup>40</sup> The Committee must ensure that continuity of care for beneficiaries remains foundational to any reform policy implemented.

***Stakeholder capacity and coordination are imperative.*** The Committee must ensure appropriate coordination among all initiatives that emerge from this effort. The FAD implementation was vastly complicated by the fact that the participating states, CMS and a broad range of stakeholders on the ground had to manage the roll-out of multiple health reform initiatives simultaneously, e.g. Medicaid expansion, Medicaid managed care, ACOs, etc. Given how many health system transformation initiatives are currently underway, any new initiative must be premised on an accurate appraisal of the capacity of all relevant stakeholders to implement the reforms. Any new initiative should: ensure the capacity to assess, manage and coordinate the full spectrum of beneficiaries’ needs; ensure the inclusion of providers with expertise in managing the unique needs of beneficiaries with multiple chronic conditions; and ensure strong linkages with community resources, including those that provide non-medical services and supports.

Thank you again for the opportunity to provide this input. We look forward to partnering with the Committee as it advances this important work.

Sincerely,



Robert Restuccia  
Executive Director

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<sup>40</sup> MACPAC Report on “Experiences with Financial Alignment Initiative Demonstration Projects in Three States”. Retrieved: <https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf>