Avera Health (IA, MN, NE, ND, SD)

Ascension Health (AL, AZ, AR, CT, DC, FL, GA, ID, IL, IN, KS, KY, LA, MD, MI, MO, MN, MS, NY, OK, PA, TN, TX, WA, WI)

Carolinas HealthCare System (NC, SC)

Community Hospital Anderson (IN)

Erlanger Medical Center (TN)

Forrest General (MS)

Franciscan Missionaries of Our Lady Health System (LA)

Harris Health System (TX)

Hartford Hospital (CT)

Holy Name Medical Center (NJ)

Kaiser Permanente, Southern California Permanente Medical Group (CA)

Ohio Valley Health Services and Education Corporation (OH, WV)

Robert Wood Johnson University Hospital (NJ)

University of Pittsburgh Medical Center (PA)

January 26, 2016

United States Senate Committee on Finance
Bipartisan Chronic Care Working Group
Policy Options Document

Comments submitted: *Chronic_Care@finance.senate.gov*

Dear Chairman Hatch and Senator Wyden,

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers that formed over 12 years ago, whose members meet to generate comments on health policy proposals.

The Provider Roundtable (PRT) includes representatives from 14 different health systems, serving patients in 35 states. PRT members are employees of hospitals and or health systems, taking great interest in the operational and financial issues pertaining to provisions and reimbursement for in- and out- patient hospital services along with professional services performed.

Our members collaborated to provide substantive comments with an operational focus we hope Senate Finance Committee staff will consider as it finalizes policy options aimed at chronic care management. We appreciate the opportunity to provide our comments to the Chronic Care Working Group. A full list of the current PRT members is provided in **Attachment A.**

Please feel free to contact me at 314-733-6757 or via email at: *Kathi.Austin@ascensionhealth.org*.

Sincerely,

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Senior Business Analyst / Symphony MIC-Revenue Cycle
Ascension Health
12443 Olive Blvd, Suite 200
Creve Coeur, MO 63141

The Provider Roundtable (PRT) is pleased to offer comments on the Senate Finance Committee's Policy Option Document published by the Chronic Care Working Group (CCWG).

The PRT appreciates the research and thoughtfulness of the options presented by the CCWG. Our comments are presented based on our day-to-day operational experiences in provider settings across the country that service all patient types, and strive to reduce costs and improve both quality of care and overall quality of life.

Expanding the Independence at Home Model of Care

The PRT supports this policy and recommends any legislation explicitly state that Independence at Home (IAH) services may be provided not only by free-standing independent practitioner and group practices, but also by hospital-based physicians and non-physician practitioners, per their state's scope of practice. Furthermore, specialty hospitals and groups (i.e., free-standing and hospital-based) should be allowed to provide these services for conditions such as cancer, diabetes, arthritis, and other chronic conditions.

The PRT also recommends that communities be able to form separate entities for the purpose of providing these services, and that staff from member and non-member organizations be able to participate in providing IAH services. For example, a community hospital and different physician practices could form an entity to provide IAH services, and the patient care staff could be comprised of voluntary and part-time staff from these member entities. The initial implementation standards and polices will need to be more flexible and forgiving in the early years of implementation in order to provide all the facilities, providers, and physicians/non-physician practitioners listed above with the opportunity to learn and adapt to the new program. The implementation of the Medicare Value-Based Purchasing program is a good example of a program that followed those general principles.

Expanding Access to Telehealth

PRT members are actively involved in providing telehealth services. We have seen the benefit and power of this technology. We note, however, that the Medicare payment for the originating telehealth site fee is woefully inadequate to cover even a mere fraction of technology expenses, not to mention administrative expenses. The current payment amount represents a token that in no way is reasonable given the originating site's expenses to provide telehealth services. As part of any policy to expand telehealth to the Medicare and Medicare Advantage populations, we urge the Senate Finance Committee to review and update this payment amount to align it more reasonably with the originating site's costs to provide this important service.

In addition, we urge the Senate Finance Committee to permit telehealth services to be considered for network adequacy in cases where certain specialties are not readily available.

The PRT supports the concept of eliminating the requirement for rural designation for the originating site, and also urges CCWG to allow telehealth services to be permitted with no origination site restrictions. This would not only be for stroke telehealth, but also for long-term care and home telehealth services that are supported by mobile units and for other severe chronic or potentially chronic conditions such as ESRD patients, transplant patients, and cancer patients. This will allow patients to access the best specialist for their condition.

Furthermore, the PRT recommends that telehealth services be able to meet the requirement for direct supervision for outpatient hospital therapeutic services. Particularly in rural areas, telehealth can be very effective in providing supervision for lower-risk outpatient services.

The PRT supports the concept of expanded telehealth services via Accountable Care Organizations (ACOs).

The PRT supports the option to expand telehealth to allow a qualifying originating site to include any renal dialysis facility located in any geographic area – whether it is free-standing or hospital-based. The PRT opposes any health care policy expansion that excludes hospitals or hospital-owned and -operated clinics and providers from participating in covered service delivery.

Another option we urge the CCWG to consider is allowing coverage of telehealth services provided from a beneficiary's home. The PRT suggests that the visits can be video recorded and retained as part of the legal medical record. Home care and coordination of care are important value-based principles, and allowing visits with qualified professionals from the beneficiary's home would facilitate access as well as a surveillance of the home environment for safety purposes.

Providing Medicare Advantage Enrollees with Hospice Benefits

The PRT strongly supports this proposed option to require Medicare Advantage (MA) plans to offer the hospice benefit provided under traditional Medicare. Furthermore, we believe hospice is an important benefit and value-based strategy for the Medicare and Medicare Advantage programs. We believe that it would be strengthened by requiring an Advanced Care Planning (ACP) visit with a beneficiary at least one calendar day prior to election of hospice. Furthermore, for severe chronically ill beneficiaries, an annual ACP visit should be mandated. It is important these conversations occur regularly with beneficiaries and their families so they are prepared — at the earliest appropriate time — to elect hospice care and avoid unnecessary disruptions in their care at an inopportune time.

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

The PRT supports this option. We agree the MA payment amount will need to be adjusted appropriately.

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

The PRT supports this option with the addition of requirements for state Medicaid to also support and match Special Needs Plans (SNP) services and for MA plans to coordinate with state Medicaid programs. Without required coordination between SNPs and Medicaid, Medicare mandates for SNPs alone will not suffice in actual improved access, since most of these patients are dual-eligible beneficiaries.

Medicare Advantage Plans, Administrative Costs

The PRT supports Medicare Advantage Plans or Medicare Part C as an important option for beneficiaries. There are, however, significant administrative costs to the Medicare trust funds, Medicare Advantage Plans, and providers with regard to the administration of Medicare Part C. Each approved plan must select a Third Party Administrator (TPA) and purchase or create claims

processing/editing software to match or emulate CMS' software. CMS' payment system software for its various payment programs is complex. Providers frequently experience incorrect payments and claim edits from Medicare Advantage Plans that try to emulate CMS' payment systems, but do not succeed. A significant amount of administrative costs would be saved if Medicare was required to license or provide its software to an approved Medicare Advantage Plan so payment and claims processing were consistent whenever the MA program pays providers and suppliers based on standard Medicare payment programs and policies.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The PRT strongly supports this option in order to recognize the additional health care team resources required to successfully manage these more complex patients. We are concerned that the addition of more codes to be billed for payment continues to promulgate the mentality of fee-for-service versus coordination of care for improved value. The PRT urges CMS to develop a definition of a "high severity chronic care patient" and to commit to identifying these beneficiaries to health care providers who treat them.

One suggestion to identify patients with multiple chronic conditions is to apply the Hierarchical Condition Categories (HCCs) to all beneficiaries annually. One of the significant limitations of this suggestion, however, is that the HCCs risk model does not sufficiently account for socioeconomic and demographic factors. Our suggestion to improve this limitation is to require all providers (i.e., hospitals, physicians, and other suppliers) to submit ICD-10 diagnosis codes related to socioeconomic factors (these are not currently required to be submitted). For example ICD-10 codes that are not currently required to be submitted include:

- Z59.0 Homelessness
- Z74.2 Need for assistance at home and no other household member able to render care
- Z74.1 Need for assistance with personal care
- Z74.3 Need for continuous supervision
- Z74.01 Bed confinement status
- Z73.6 Limitation of activities due to disability
- Z74.0 Reduced mobility
- Z75.1 Person awaiting admission to adequate facility elsewhere
- Z75.4 Unavailability and inaccessibility of other helping agencies
- Z91.1 Patient's noncompliance with medical treatment and regimen
- Z91.130 Patient's unintentional under-dosing of medication regimen due to age-related debility
- Z68.xx for Body Mass Index

Once CMS has these data, they can be incorporated into the HCC risk model. After CMS has identified these patients, an indicator could be placed in their eligibility record identifying the beneficiary as a "high severity chronic care patient." Then, a 271 HIPAA response to a 270 eligibility query would identify these patients immediately upon admission/access to the health care provider.

The PRT believes a program similar to the Comprehensive Joint Replacement program would be more conducive to incentivizing providers than applying additional HCPCS/CPT codes for Chronic Care Management (CCM). For example, hospitals and group practices could be incentivized to become CCM coordinators for these patients. CCM Coordinating entities should be incentivized to have agreements in place with other providers that treat these patients. CMS would track the total

cost of care and if either costs or the severity of chronic illness are reduced, the CCM Coordinating entity would get a percentage of the savings. This option would eliminate the need for providers to submit codes for payment, and would incentivize CCM coordination.

The CCWG is also seeking input on the types of providers that should be eligible for reimbursement under this new high severity chronic care code. The PRT recommends the code be limited to primary care providers, nephrologists (for patients diagnosed with chronic kidney disease), and oncologists (in cases of patients diagnosed with cancer). These eligibility restrictions would provide great incentives for care coordination that will ultimately lead to lower costs and higher quality.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

The PRT supports options to allow all provider types to expand services and access in order to meet beneficiaries' behavioral health needs. Patients with mental illness, substance abuse disorders, and complex chronic care conditions badly need improved, coordinated care. The vulnerability and pain of these patients cries out for immediate attention. They also account for a large portion of the explosive costs incurred in the existing system. One suggestion is to explicitly allow hospitals and Community Mental Health Centers to provide meals and transportation in their programs, and to report these costs separately to CMS via the cost reports. Provision of meals and transportation should not be considered to be an inducement or violation of any compliance rules.

We also recommend allowing the diagnosis of a behavioral health condition or dementia for a patient who has chronic care needs to be eligible for the availability of chronic care management services. We request that the CCWG consider allowing telehealth services to be used for this patient population. The allowable services will be offset by diminished readmissions and acute care costs.

One of the biggest issues with this population is ensuring that patients adhere to their medication regimes. The PRT strongly encourages the Senate Finance Committee to expand Medicare coverage to medication therapy management (MTM) provided by licensed pharmacists in all settings. (We offer additional comments regarding MTM below.) If these patients could regularly come to the pharmacy to get their medicines and check in with a pharmacist for counseling, it is likely that inpatient admission and ED visit recidivism that are associated with these conditions would be significantly reduced. This would, in turn, result in cost savings to the Medicare program, and offset the cost of MTM coverage.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees and ACO Members

The PRT supports allowing and encouraging MA Plans and ACOs to expand their supplemental benefits. We recommend that MA plans be allowed the flexibility to provide appropriate benefits to all enrollees, in cases where the basic benefit structure could be improved without requiring beneficiaries with multiple chronic diseases to purchase additional supplemental benefits. The MA program and the Next Gen ACO programs should be given the flexibility to determine how best to manage the delivery of care within the payment model and to also offer related non-clinical services. The flexibility within these bundled payment models should be broadly defined and also include psychosocial and other services that impact non-clinical determinants of care.

The CCWG is also considering a recommendation to reduce cost-sharing for items and services to treat chronic conditions or prevent chronic disease progression. The PRT agrees that it is appropriate

to reduce cost-sharing in order to increase patient engagement and adherence in certain circumstances. We believe, however, that this flexibility should be offered for *all* benefits and services within the MA and Next Gen ACO bundled payment models. Consistent with this approach, we agree with the CCWG proposal that MA Plans should be able to adjust their provider networks to include providers and non-clinical professionals that are needed to efficiently and effectively manage the chronic illness. Further, we recommend this flexibility be offered to all MA plans and ACOs.

Developing Quality Measures for Chronic Conditions

The PRT supports improvement in quality care measures for chronic conditions. We caution, however, that additional measures should be vetted to ensure that they not only measure outcomes of care, but also are implemented in a manner that does not increase administrative burden. Chart abstraction measures should be avoided as much as possible. We recommend a phase-in approach for the measures to maximize the opportunity for providers to learn and adopt best practices over time.

Encouraging Beneficiary Use of Chronic Care Management Services

The PRT supports policies that reduce beneficiary out-of-pocket cost sharing for coordination services. These services include both CCM and ACP services. A cautionary approach with regard to this proposal is necessary to evaluate the current chronic care management code and determine if its cost-sharing is a driving factor for its utilization, or if other factors — such as the payment amount itself — is a more significant factor. Either of these options adds costs to the program. Waiving cost-sharing would incentivize beneficiaries to utilize services (just as it would for any service where cost-sharing is waived or lowered). Given the high proportion of Medicare beneficiaries with Medigap or supplemental policies, the CCWG will also want to evaluate whether the cost-sharing coverage under the Medicare Supplemental plans might mitigate the impact of lowering or eliminating cost-sharing on a significant number of beneficiaries. We believe that, if cost-sharing for these services is waived, beneficiaries must be notified in the Medicare Summary Notice.

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

The PRT supports the concept that additional time is needed with patients and families who experience a devastating diagnosis, traumatic event, and/or other life-threatening illness such as cancer. It is our experience that patients and families often cannot absorb all the information at a single prolonged visit. CPT already has prolonged visit and Advanced Care Planning (ACP) CPT codes that appropriately and adequately provide for the necessary additional time. Therefore, the PRT urges the CCWG to ask CMS to develop a National Coverage Determination (NCD) to recognize coverage of these existing CPT codes for certain diagnoses and for such frequency that will benefit patients, their care, and their disease management.

For this additional payment option to have the intended effect, the criteria should be comprehensive and flexible. This would allow for assessments of multiple factors that may affect treatment outcomes, such as living situations, depression, environmental hazards, transportation needs, and other social and environmental factors.

Expanding Access to Prediabetes Education

The PRT supports the CCWG proposal to extend benefits for self-management to include patients who test positive for pre-diabetic conditions. The Working Group is also considering covering and paying for services to be delivered by entities that are currently not providers under the Medicare statute, including non-profit organizations and of Health Departments. We question the value of adding this to the Medicare program for a single disease state. Rather than focus on single diseases for early stage interventions, we recommend that Medicare cover appropriate interventions that may prevent the onset or progression of chronic diseases such as congestive heart failure, chronic kidney disease, COPD, and Type II diabetes. If non-traditional providers are considered for the program, we recommend requiring an appropriate credentialing process as a requirement for being reimbursed for these services.

Medication Therapy Management (MTM) and Medication Synchronization & Obesity Drugs

The CCWG is considering requiring a study to determine how Part D prescription drug plans (PDPs) can coordinate the dispensing of prescription drugs in order to improve medication adherence so, to the extent feasible, multiple prescriptions can be dispensed to a beneficiary on the same day. Such a policy change would enable medication synchronization and foster improved comprehensive medication reviews. The PRT supports medication synchronization and believes that a vital way to accelerate its adoption would be for CMS to cover medication therapy management (MTM) by qualified pharmacists.

We also believe that obesity drug prescriptions could be monitored by qualified pharmacists through MTM to ensure that patients are adhering to their medication regimens. This would help alleviate the significant cost concern stemming from coverage and continued prescription refills for patients who do not comply with medication regimens and other supportive treatments for weight management.

We appreciate the opportunity to provide our comments and appreciate the CCGW's consideration of them.

Attachment A: 2016 Provider Roundtable Members

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