Center for Medicare Advocacy

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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 Johnny Isakson
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Submitted electronically to: chronic_care@finance.senate.gov

Re: Comments on Chronic Care Reform

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

The Center for Medicare Advocacy (Center) is pleased to provide the Senate Finance Committee comments in response to the May 22, 2015 request for comments on chronic care reform. The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality health care. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

We agree with the Committee that Congress should prioritize solutions to improve care quality for persons with multiple chronic conditions. The health care needs of older adults and people with disabilities should be at the center of these efforts.

As articulated in the May 22 request for comments, the Committee has identified three overarching goals to guide the development of bipartisan legislation. These include: increased care coordination; streamlined payment systems to incentivize appropriate care; and improved quality, outcomes, and program efficiency. We have organized our comments, below, around these broad themes. As you draft policy, we ask that you consider the following principles related to each of the Committee's stated goals.

I. Increasing Care Coordination Across Care Settings

In the section below, we strongly urge Congress to establish a care coordination benefit within Traditional Medicare. We support full implementation of the settlement in *Jimmo v. Sebelius* and the addition of oral health to the comprehensive services provided to beneficiaries with chronic conditions. In addition, we identify a number of barriers that currently exist in the Medicare program that prevent individuals with chronic conditions from obtaining medically necessary care; in order to truly coordinate care across various settings, these barriers must be eliminated.

A. Care Coordination in Traditional Medicare

It is high time for a coordinated care benefit in Traditional Medicare; a benefit based on physician involvement, that recognizes the range of post-acute care needs of beneficiaries, and that provides adequate payment for care coordination. This is particularly true for Medicare beneficiaries with multiple chronic conditions, many of whom now see several physicians and other clinicians with little or no care coordination.

In March of 2002, the Center for Medicare Advocacy hosted a conference, sponsored by the Commonwealth Fund, to explore the development of a coordinated care benefit for the Traditional Medicare program. The resulting recommendations, agreed upon by consensus of the conference attendees, have been updated and are set out below, and remain relevant to the Committee's exploration.

- For more information about the 2002 conference and the resulting principles and recommendations, see: http://www.medicareadvocacy.org/establishing-a-coordinated-care-benefit-in-the-traditional-medicare-program/.

Guiding Principles

1. The primary, over-arching goal of a Medicare Coordinated Care Benefit is to improve care;
2. While cost-savings are important and likely an overall consequence of care coordination, they should not be viewed as the primary goal of such a benefit;
3. The Coordinated Care Benefit must be holistic in approach, considering the range of medical-social needs of Medicare beneficiaries;
4. The Medicare Coordinated Care Benefit is a voluntary benefit;
5. Election of this Benefit shall not preclude eligibility for all other Medicare benefits.

Eligibility Requirements

1. Eligibility shall be based on physician certification of:
   - Having three or more chronic medical conditions (to be determined taking into consideration multiple providers, high costs, and high use of services), or
   - Having a combination of clinically complex chronic conditions, including mental impairments, which would be amenable to coordinated care, or
   - Having multiple chronic conditions and mental and functional impairments which limit the ability of the individual to manage his or her chronic conditions;

2. Eligibility will be re-certified annually to ensure that each individual continues to receive the services that are appropriate to his or her situation. Individuals will not be denied continued eligibility if the services are necessary to maintain their current capabilities or to slow or prevent further deterioration of their chronic conditions;
3. Access to a Medicare coordinated care benefit shall be equally available to all beneficiaries regardless of income.

Elements of Care Coordination

1. A care coordination plan must be developed for persons eligible for the benefit and must be reflected in an individualized plan of care, consisting of two areas of coordination:
   - Coordination among the beneficiary's doctors about clinical/medical components of care, performed by medical personnel under the supervision of a physician;
   - Coordination of related health and social services, performed by a care coordinator;
2. Care coordination must include the coordination of medical care with related health and social services, including coordination among providers, and the education of physicians, patients, and families about specific patient needs;
3. The coordination of related health and social services must include physical, psycho-social, cognitive, family support needs, and risk assessment.

Care Coordinator Qualifications

Care coordinators may come from a variety of disciplines and must meet the applicable state and federal education, certification, and licensing requirements of those disciplines as a Condition of Participation in the Medicare program.

Payment

1. An adequate, prospective or bundled payment for coordinated care services should cover all payments for at least these reimbursable functions:
   - Initial and periodic, comprehensive, multi-disciplinary assessments, reimbursed on a fee-for-service basis;
   - Coordination of services, with payment determined on a prospective payment basis;
   - Ongoing monitoring, with payment determined on a prospective payment basis;
2. Payment should be prospectively determined, "per beneficiary/per 60 day episode of care," with adjustment for case complexity;
3. There should be no cost sharing to the beneficiary for care coordination services.

Monitoring, Enforcement, and Evaluation

1. Studies shall be performed to determine incentives to encourage eligible beneficiaries to participate in coordinated care;
2. Software and technology should be provided to care coordinators to facilitate care coordination, access to services, data collection, and payment requirements.

Beneficiary Protections

Legal safeguards shall include:

- The protection of patient confidentiality and privacy;
- The right to written notice when care coordination services are denied, reduced or terminated;

- The right to appeal a denial, reduction, or termination of care coordination services, including the right to an expedited appeal;
- The right to a review, before an appropriate agency as designated by the Medicare agency, of the quality of the care coordination services received;
- Written notice of voluntary/ involuntary disenrollment or termination of care coordination relationship rules;
- Disclosure of conflicts of interest of care coordinators with respect to referrals, disclosure of ownership and business relationships among care coordinators.

B. Assuring Full Implementation of *Jimmo v. Sebelius*

This nationwide class action settlement with the Department of Health and Human Services reaffirms the appropriateness of Medicare coverage of patients who need nursing and therapy services to maintain their functional level or to prevent or slow their decline or deterioration. The Court-approved settlement applies to nursing and rehabilitation services in skilled nursing facilities, home health settings, and outpatient therapy settings. Although the Settlement is not limited to patients with chronic conditions, it has obvious and special significance for people with chronic conditions since, by definition, these patients will not "recover" from their chronic conditions.

Assuring that Medicare patients get all the care and services they need to maintain their highest level of functioning is required by law, good policy, and likely to save public funds. The Settlement recognizes that enabling Medicare beneficiaries to maintain function helps them maintain independence and avoid more costly levels of care, such as hospitalizations.[1] Any changes proposed by the Committee to improve care for persons with multiple chronic conditions need to support full implementation of this settlement.

C. Need for Integration of Oral Health

Any new program aiming to treat individuals with chronic conditions must incorporate oral health into the health care services that are provided in order to truly coordinate care and improve outcomes. Oral health is inextricably linked to the overall health of individuals. A 2011 Institute of Medicine and National Research Council report stressed the connection between oral health and overall health. ". . . [T]he mouth as a mirror of health or disease occurring in the rest of the body in part because a thorough oral examination can detect signs of numerous general health problems, such as nutritional deficiencies and systemic diseases, including microbial infections, immune disorders, injuries, and some cancers. Further, there is mounting evidence that oral health complications not only reflect general health conditions, but also exacerbate them. Infections that begin in the mouth can travel throughout the body."[2]

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[1] *Jimmo v. Sebelius*, No. 11-cv-17 (D.VT), filed January 18, 2011. Settlement approved January 24, 2013. For more information, see: http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

[2]Institute of Medicine and National Research Council, Committee on Oral Health Access to Services Board on Children, Youth, and Families Board on Health Care Services, *Improving Access to Oral Health Care for Vulnerable and Underserved Families*, pg 42, National Academy of Science, 2011, available at http://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf.

Poor oral health can lead to subsequent conditions, due to limited nutrition, vitamin deficiencies, pain, and limited social engagement. Additionally, incorporating oral health into comprehensive patient care lowers costs, as oral pain is a leading cause of emergency department visits.[3] A recent study published in the *Journal of the American Dental Association,* found that between 2008 and 2010, more than 4 million patients turned to hospital emergency departments due to oral health conditions, at a cost of $2.7 billion.[4] Not only are emergency department visits expensive, but they are also ineffective in resolving oral health care needs; patients entering emergency rooms with oral health problems are often prescribed pain killers or antibiotics. "Research suggests that the vast majority did not receive dental procedures, but were instead treated with prescription medications."[5]

We urge the Committee to look to Oregon's ACOs as a model of integrating oral health into coordinated, patient-centered care. Through the Coordinated Care Organizations (CCO) initiative in Oregon, ACOs in Oregon were required to integrate oral health into the coordinated health team by July 1, 2014.[6] Oregon is currently the only state that requires its state-based ACOs to include dental services.[7]

A case study conducted by Leavitt Partners of dental care in ACOs, found that there were significant benefits to including oral health care in coordinated care.[8] One of the case studies examined Trillium Community Health Plan, an ACO serving Medicaid beneficiaries in Lane County, Oregon, as an ACO with recent integration of oral health care. The results of the case study show that, though information is limited due to the recent integration of oral health, the number of patients visiting the emergency department, primary care offices and urgent care centers with dental pain decreased.[9] This was in spite of the almost doubling of the patient population due to Medicaid expansion in the state. "Stories relate mostly to patients who, for the first time, have someone helping them make connections with the traditional physical health and the mental and dental resources now available to them. Additionally, Oregon's CCO program has built into it a heavy emphasis on reporting such that those with interest in the direction of the state's grand experiment can expect to have plenty of evaluation data as the program moves forward."[10]

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[3] *Lack of access to dental care leads to expensive emergency room care*, Association of Health Care Journalists, April 8, 2014, available at http://healthjournalism.org/blog/2014/04/lack-of-access-to-dental-care-leads-to-expensive-emergency-room-care/

[4] "*Id.*

[5] *Id.*

[6] *Dental Care in Accountable Care Organizations: Insights from 5 Case Studies*, Leavitt Partners, June 9, 2015, page 24, available at, http://leavittpartners.com/2015/06/dental-care-in-accountable-care-organizations-insights-from-5-case-studies/

[7] *Adding Dentists to the team: ACO costs go down, care up*, Politico Pro, Erin Mershon, June 16, 2015, Available at, http://khn.org/morning-breakout/some-acos-save-money-by-adding-dentists/

[8] *Dental Care in Accountable Care Organizations: Insights from 5 Case Studies*, Leavitt Partners, June 9, 2015, page 2, available at, http://leavittpartners.com/2015/06/dental-care-in-accountable-care-organizations-insights-from-5-case-studies/

[9] *Id. at* 26-27.

[10] *Id*. At 27

The report found in addition to providing needed oral health care, another benefit of including oral health into an integrated team of providers, is that dentists often interact more frequently with patients, and are therefore able to reinforce healthy habits and encourage additional preventive (non-oral health) screenings. ". . . [D]entists were a critical patient touch-point, interacting more frequently with patients than other health care providers, and achieved remarkable success in utilizing dentists to close patient-care gaps."

Realizing the central role that oral health plays in a person's overall health, Virginia also plans to incorporate oral health into its ACOs. The state is currently studying how to achieve better care, and better outcomes for patients at lower costs. The Virginia Center for Health Innovation included an oral health planning committee in its Virginia Health Innovation Plan design process that is providing recommendations for the ACOs in Virginia.[11] Improved oral health is among the initiative's listed population health goals: "Better care for selected mental and oral health conditions through improved integration with primary care."[12] Though Virginia is in the early planning stages, we urge the Committee to monitor the analysis and recommendations of this initiative, as it maintains a holistic approach to patient-centered care.

Oral health must be included in any new chronic care program in order to fully address patient needs, improve care coordination, and reduce costs.

D. Removing Current Barriers to Care

There are a number of policy changes that should be made within the Medicare program to remove current barriers to care and improve coverage for individuals with chronic conditions.

1. Eliminate outpatient therapy caps

Medicare coverage of outpatient therapy is currently capped on an annual basis at $1,940 for physical therapy (PT) and speech-language pathology (SLP) services combined, and $1,940 for occupational therapy (OT) services. These arbitrary caps are aimed at federal cost-savings rather than providing clinically appropriate services, and disproportionately affect the most vulnerable Medicare beneficiaries who require ongoing therapy services. As such, these caps should be repealed. While we urge full repeal of these caps, we understand that, in the past, the Committee drafted "replace" language that would replace the therapy caps with a form of prior authorization (PA). In general, we are concerned that PA often serves as a barrier to necessary care; more specifically, we are concerned that some of the language of the legislative replacement proposal would give the Secretary too much discretion to target certain medical conditions and inappropriately deny care. Should the Committee entertain therapy cap replacement language again, we ask that this language be revisited.

At a minimum, the therapy cap exceptions process should be permanently extended and revised. As you are aware, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015

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[11] Virginia Center for Health Innovation, available at, http://www.vahealthinnovation.org/what-we-do/the-virginia-health-innovation-plan/regional-accountable-care-communities-information/ (last visited June 21, 2015).
[12] Virginia Center for Health Innovation, available at, http://www.vahealthinnovation.org/what-we-do/the-virginia-health-innovation-plan/regional-accountable-care-communities-information/ (last visited June 21, 2015).

(MACRA) extended the therapy caps exceptions process through December 31, 2017 and modified the requirement for manual medical review for services over the $3,700 therapy thresholds. Rather than letting the exceptions process expire, when there is no larger SGR vehicle to address this policy through, absent repeal of the cap, the exceptions process should be permanently extended. Further, the review process for services that exceed $3,700 should be revised. In our experience, the manual review process imposed at $3,700 is extremely burdensome for providers. As a consequence, it creates a chilling effect on the willingness of many providers to use the exceptions process, resulting in beneficiaries with chronic conditions who are most in need of ongoing therapy, foregoing therapy services until the beginning of the next calendar year. As discussed above, the court approved settlement in *Jimmo v. Sebelius*[13] confirms the right of Medicare beneficiaries to therapy to maintain function, slow deterioration and prevent avoidable decline. Limiting Medicare reimbursement for therapy through arbitrary caps and a complicated exceptions process, while not in direct violation of this settlement, undermines beneficiaries' ability to receive medically necessary maintenance therapy services.

2. Eliminate the three day prior hospitalization requirement for coverage of post-acute skilled nursing facility (SNF) care

Since this three day requirement was created along with the Medicare program in the 1960s, medical advances have shortened hospital stays, making this arbitrary barrier to SNF coverage even more unnecessary and outdated. Even with repeal of this technical requirement, Medicare coverage of SNF services would still have to meet medical necessity requirements, including the need for daily skilled care. Managed care organizations have the option to waive the three-day hospital requirement and the overwhelming majority of them do. Accountable care organizations and various CMS demonstrations have also tested waiver of the hospital requirement. It is time to modernize the Medicare program to recognize that a three-day hospital requirement should not be a prerequisite to Part A coverage of a SNF stay.

At a minimum, however, count all days in the hospital – including those spent in "observation status" – towards the three day requirement.[14] The increased use of observation status in the hospital (when someone is deemed to be an "outpatient" rather than in "inpatient") has led to many people who spend three or more days in the hospital being denied Medicare coverage of subsequent SNF stays.[15]

3. Need to Integrate Medicare Part D Prescription Drug Plans

Access to prescription drugs is vitally important to the health and well-being of individuals with multiple chronic conditions, and any attempt to adequately coordinate care for these individuals must address their medication needs. Stand-alone Part D prescription drugs plans are not well-

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[13] *Jimmo v. Sebelius*, No. 11-cv-17 (D.VT), filed January 18, 2011. Settlement approved January 24, 2013. For more information, see: http://www.medicareadvocacy.org/medicare-info/improvement-standard/.

[14] A bill currently before Congress would count all days spend in a hospital towards the three day stay requirement: "Improving Access to Medicare Coverage Act" (H.R. 1571, S.843).

[15] For more information about observation status and the impact on Medicare beneficiaries, see Center for Medicare Advocacy website: http://www.medicareadvocacy.org/medicare-info/observation-status/.

positioned to participate in care coordination activities given that, by design, they lack relationships with health care providers and access to data about their enrollees' health needs.

Yet, Part D plans are critically important to individuals with Traditional Medicare and their involvement will be vital to any successful effort to enhance care coordination for individuals with multiple chronic conditions—facilitating communications among prescribers, pharmacists, and beneficiaries. As such, we urge the Committee to pursue avenues to integrate stand-alone Part D plans into any new or expanded care models.

E. Incorporate Lessons Learned from Ongoing Demonstrations and Test New Models

As the Committee contemplates new models for Medicare coordinated care, we strongly recommend considering the experience of current demonstrations. In particular, the Affordable Care Act (ACA) authorized the Centers for Medicare & Medicaid Services (CMS) to develop demonstrations to align the financing and delivery of Medicare and Medicaid benefits for dually eligible individuals.[16] In 10 states, these demonstrations are testing capitated payment models and their ability to pay for care coordination and enhanced long-term services and supports. States are in the early stages of implementing these demonstrations. Understanding these existing coordination efforts and their lessons on enrollment complexities, communicating with beneficiaries, and aligning acute and long-term services and supports provide important background for future coordination efforts.[17]

In addition to drawing on lessons learned from existing demonstrations, we urge the Committee to ensure that any new models of care are adequately tested. The Center for Medicare & Medicaid Innovation (CMMI) provides an existing venue for such testing. As the Committee develops legislation, we urge that you carefully pilot test any care initiatives not yet thoroughly vetted.

II. Streamlining Payment Systems to Incentivize Appropriate Care

While we recognize that payment systems within Medicare must evolve in order to incentivize appropriate care, we urge caution with respect to the potential impact of some of these new payment models on Medicare beneficiaries. As stated previously, we recommend that new payment systems be tested in demonstration form before being adopted wholesale, and that any adoption be based on evidence that better care actually results from changes in payment models. As discussed below, there is some evidence that some of the most frequently discussed payment system reforms have had unintended negative consequences for beneficiary care and access to services.

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[16] For more information on these demonstrations, see: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[17] Medicaid Payment and Access Commission (MACPAC), "Experiences with Financial Alignment Initiatives Demonstration Projects in Three States," (2015), available at: www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf

A. Value Based Purchasing

There is certainly appeal to the theory of value-based purchasing (VBP) – paying more for better care, but the reality has not yet matched the promise of the theory. As noted by CMA in 2007, "there is little evidence that pay-for-performance systems leads to significant improvements in quality of care for patients … and some evidence that unintended negative consequences occur." See "Value Based Purchasing in Medicare: Just Another Gimmick?" CMA Weekly Alert (2/07/08) (available at: http://www.medicareadvocacy.org/InfoByTopic/QualityOfCare/QualOfCare_07_02.08.PayForPerformance.htm).

An analysis of the CMS demonstration of VBP in skilled nursing facilities between 2009 and 2012 found that VBP "did not directly lower Medicare spending and improve quality for nursing home residents." L&M Policy Research, Evaluation of the Nursing Home Value-Based Purchasing Demonstration, page 50, Contract No. HHSM-500-2006-0009i/TO 7, http://innovation.cms.gov/Files/reports/NursingHomeVBP_EvalReport.pdf.

Some of these unintended consequences of VBP and bundling include "increased incentives for selection of the most profitable patients, withholding of patient care, so-called upcoding (that is, coding patients' conditions so that they trigger higher reimbursements), and fraud, along with the technical difficulties of adjusting for the severity of patients' illnesses and measuring and monitoring quality." Vincent Mor, et al., "The Revolving Door of Rehospitalization From Skilled Nursing Facilities" Health Aff January 2010 Vol. 29 no. 1 57-64, available at http://content.healthaffairs.org/content/29/1/57.full.

B. Bundled Payments

Hospitals receiving a bundled payment that includes post-hospital care for 30 days (or more) following discharge should be motivated to conduct good discharge planning and to identify the appropriate setting. However, as noted by Judy Feder, bundled payment for a set of services "potentially promotes skimping on care or avoidance of costly patients." Feder, J., "Bundle with Care – Rethinking Medicare Incentives for Post-Acute Care Services" *New England Journal of Medicine*, August 1, 2013, available at: http://www.nejm.org/doi/full/10.1056/NEJMp1302730.

As noted above under Value Based Purchasing, some of the unintended consequences of VBP and bundling include "increased incentives for selection of the most profitable patients, withholding of patient care, so-called upcoding (that is, coding patients' conditions so that they trigger higher reimbursements), and fraud, along with the technical difficulties of adjusting for the severity of patients' illnesses and measuring and monitoring quality." Vincent Mor, et al., "The Revolving Door of Rehospitalization From Skilled Nursing Facilities" Health Aff January 2010 Vol. 29 no. 1 57-64, available at http://content.healthaffairs.org/content/29/1/57.full.

Any bundling proposal needs to preserve patients' rights; to assure that the full range of post-acute services and providers are included in the bundle and are available to patients; to eliminate,

or at least reduce to the extent possible, conflicts of interest between patients and holders of the bundles; and to consider the costs to the Medicaid program. CMA, "Bundling Payments for Post-Acute Care" (Alert, May 14, 2015), http://www.medicareadvocacy.org/articles/weekly-update-archive/.

C. Site Neutral Payments

Site neutral payments may be especially harmful for people with chronic conditions, who may need, in the short run, more expensive post-acute care but who may, in the long run, have better outcomes at less overall cost to the health care system. The Medicare Payment Advisory Commission (MedPAC) has recommended site-neutral payments between inpatient rehabilitation hospitals (IRHs) and skilled nursing facilities. CMA, "No Site Neutral Payments for Inpatient Rehabilitation Facilities and Skilled Nursing Facilities" (Alert, Dec. 11, 2014), http://www.medicareadvocacy.org/no-site-neutral-payments-for-inpatient-rehabilitation-facilities-and-skilled-nursing-facilities/ (citing studies showing better outcomes for patients in IRHs, cost-shifting to Medicaid).

We are wary of site neutral payments in the post-acute care setting, and our concerns clearly translate to individuals with chronic conditions who need care in such setting. A main premise of site neutral payments is that the same level and quality of care is provided to the same individuals across different care settings with the same outcomes achieved and therefore payment, regardless of setting, should be the same. We disagree with this premise.

As CMA noted in a Weekly Alert earlier this year regarding a site neutral payment proposal in the President's FY2014 Proposed Budget, equalizing payments between IRHs and SNFs is poor policy. Rate equalization will result in Medicare beneficiaries being denied medically necessary care and is unlikely to achieve the cost savings anticipated. Although IRHs and SNFs may treat some patients with similar conditions, the care that they provide, and their patient outcomes, are different. Compared to patients in SNFs, patients in IRHs have shorter lengths of stay and better outcomes at discharge and are more likely to be discharged to home (rather than to another health care setting).[18] Recent reports by the Inspector General[19] and the Department of Justice's intervention in litigation against SNFs for fraudulent billing of therapy[20] underscore SNFs' overbilling Medicare and the frequent inadequacy of therapy in the SNF setting. See "The Impact of the President's Budget on People Who Depend on Medicare and Social Security" CMA Weekly Alert (April 11, 2013) http://www.medicareadvocacy.org/the-impact-of-the-presidents-budget-on-people-who-depend-on-medicare-and-social-security/.

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[18] This Weekly Alert cites to the CMA Weekly Alert from 3/8/07, referenced above.
[19] Office of Inspector General, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009*, OEI-02-09-00200 (Nov. 2012), https://oig.hhs.gov/oei/reports/oei-02-09-00200.asp.
[20] *United States of America v. Life Care Centers of America*, Civil Action No. 1:08-CV-251, Civil Action No. 1:12-CV-64 (E.D. Tenn. Nov. 28, 2012), https://oig.hhs.gov/fraud/enforcement/criminal/2012/Life_Care_Complaint_Intervention_11.28.2012.pdf.

D. Value-Based Insurance Design (V-BID)

We strongly encourage the Committee to proceed carefully as it considers any changes to beneficiary cost sharing, whether in MA plans, Traditional Medicare, or otherwise. Some academics, health plans, and others suggest that cost-sharing should be altered on the basis of value or clinical nuance, known as value-based insurance design (V-BID).

In general, we support eliminating or lowering cost-sharing to facilitate access to needed, high-value health care services, such as the policies advanced through the ACA that eliminated Medicare cost-sharing for select preventive care. Yet, we urge the Committee to avoid any policies allowing cost-sharing increases intended to steer older adults or people with disabilities away from perceived low-value care. At the same time, should the Committee adopt V-BID concepts as part of a legislative package, we urge transparency, accountability, and educational initiatives be incorporated in the design of any such program. For example, assertions about which care counts as "high-value" should be supported by an evidence-base that is made publically available, in formats accessible to beneficiaries and their health care providers.

III. Facilitating Delivery of High Quality Care

In order to achieve the articulated goal of delivering high quality care, improving care transitions, and producing stronger patient outcomes, reforming Medicare coverage for all beneficiaries, and in particular those with chronic conditions, must place primary focus on the beneficiary perspective. Shifting additional costs onto beneficiaries, as some Medicare reform proposals would do, would slow, rather than foster, these important goals. Further, before private Medicare Advantage plans are looked to as a model of care coordination of those with chronic conditions, and such plans seek increased payment and altered quality measurement based upon enrollment of such individuals, greater scrutiny of MA plan performance is necessary. Finally, quality of care across settings must not only be measured, but enforced.

A. Protect People with Medicare from Cost-Shifting

Any legislative proposal to reform the provision of care to individuals with chronic conditions must not be paid for by shifting costs to Medicare beneficiaries. We urge Congress to first, do no harm: do not increase costs on Medicare beneficiaries. Many of the Medicare "redesign" proposals offered by various entities over the last several years have included provisions that would shift additional costs on to Medicare beneficiaries, including further income-relating Part B and D premiums, and increasing the Part B deductible. Most people with Medicare cannot afford to pay more for health care. Half of all people with Medicare—nearly 25 million—live on annual incomes of $23,500 or less, and one quarter live on annual incomes of $14,400 or less.[21] Health care costs are already a significant expense for Medicare beneficiaries and are increasing. In 2010, Medicare premiums consumed 26% of the average monthly Social Security benefit

[21] Kaiser Family Foundation, "Income and Assets Among Medicare Beneficiaries: Now and in the Future" (January 2014), available at: http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2013-2030/.

compared to only 7% in 1980. Today the average Medicare household spends 15% of their income on health care, three times that of non-Medicare households.[22]

Some of the most potentially devastating cost-shifting proposals, particularly applicable to individuals with chronic conditions, are those that seek to impose cost-sharing or otherwise restrict coverage in the home health setting. Such cost-shifting undermines the policy goal of rebalancing long-term services and supports, which seeks to support and encourage care in non-institutional settings. Enabling people to remain at home and receive the health care services they need is far cheaper for health care payors than placing unnecessary barriers to home care and limiting necessary care to institutional settings.

1. Do not impose home health copays or otherwise restrict home health coverage

Congress should oppose any copay proposal for Medicare home health services. Congress eliminated the home health copayment in 1972 for the very reasons that it should not be imposed now – such out-of-pocket costs would deter care at home and create incentives for more expensive institutional care.[23] Further, Congress should also oppose any proposal to cap payments for episodes of care that would reduce beneficiary access or otherwise restrict the number of home health visits to which beneficiaries are entitled. The *Jimmo* settlement requires that nursing and therapy services covered by Medicare may be provided in the home to maintain a patient's function or to prevent or slow a patient's decline or deterioration.

2. Ensure beneficiaries are held harmless from payment adjustments

Because beneficiary premiums and cost sharing are based on overall Medicare expenditures, provider payment adjustments should not lead to increased Medicare spending. Instead, innovative reimbursement and delivery models should be implemented, which reduce Medicare expenditures by incentivizing quality and value, rather than quantity and volume.

3. Focus incentives on providers

Many Medicare redesign or reform proposals seek to change both provider and beneficiary incentives to access higher value and lower cost services. Most proposals that aim to "encourage more appropriate use" or selection of services by beneficiaries unduly place the burden on beneficiaries to reduce health care costs by making wiser choices. Such proposals often overlook the fact that once beneficiaries seek care and are engaged in the health system, doctors

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[22] Kaiser Family Foundation, Policy Options to Sustain Medicare for the Future (January 2013). *Also see* Leadership Council of Aging Organizations (LCAO) Fact Sheet "Medicare Beneficiary Characteristics and Out of Pocket Costs" (June 2014), available at: http://www.lcao.org/issue-brief-medicare-beneficiary-characteristics-pocket-costs/.

[23] See Leadership Council of Aging Organizations (LCAO) Issue Brief "Medicare Home Health Copayments: Harmful for Beneficiaries" (February 2015), available at: http://www.lcao.org/lcao-home-health-copayments-issue-brief/.

and other medical providers, not patients, generally drive the number and types of services that are delivered.[24]

B. Improve Access to Care in Private Plans – Medicare Advantage and Part D

As the Committee expressly requests recommendations for improvements to Medicare Advantage (MA) for patients living with chronic conditions, we ask that you address a number of challenges currently faced by MA and Part D enrollees, including denials of coverage, appeals, and grievances as part of any legislative package to improve care delivery for such individuals.

First, we ask the Committee to address alarming trends concerning beneficiary denials and appeals. Individuals with chronic conditions are more likely to need multiple services and prescription drugs, and are therefore more likely to face coverage restrictions and utilization controls, most notably in MA and Part D plans. Annual audit findings by CMS suggest significant room for improvement by MA and Part D plans in the administration of utilization management tools and beneficiary appeals processes.[25] Our own experience helping MA enrollees who have been denied care by their plans bears these findings out.

Second, we recommend closer scrutiny of how individuals with chronic conditions currently fare in MA plans, particularly before holding the MA program up as a model for care coordination and delivery. For example, the Kaiser Family Foundation recently released a literature review of research evidence on health care access and quality in Medicare Advantage and Traditional Medicare published between 2000 and 2014. While the report notes that there are substantial limitations on available evidence, it does highlight some key findings. For example, on the one hand, available evidence indicates that Medicare HMOs "tend to perform better than Traditional Medicare in providing preventive services and using resources more conservatively." On the other hand, the report notes that "beneficiaries continue to rate traditional Medicare more favorably than Medicare Advantage plans in terms of quality and access …. [and] Among beneficiaries who are sick, the differential between traditional Medicare and Medicare Advantage is particularly large (relative to those who are healthy), favoring traditional Medicare."[26] Even more alarming, CMS' own research concludes that disenrollment by individuals from MA plans back to traditional Medicare "continues to occur disproportionately among high-cost beneficiaries, raising concerns about care experiences among sicker enrollees

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[24] See, e.g, National Association of Insurance Commissioners (NAIC), Senior Issues Taskforce, Medigap PPACA (B) Subgroup, "Medicare Supplemental Insurance First Dollar Coverage and Cost Shares" (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

[25] For an explanation of recent audit findings and sanctions, see this October 2014 letter from consumer advocates to the Medicare Payment Advisory Commission (MedPAC): http://www.medicarerights.org/pdf/101014-medpac-part-d-appeals.pdf; For the most recent audit findings, see: Centers for Medicare and Medicaid Services (CMS), "The 2013 Part C and Part D Program Annual Audit and Enforcement Report," (2014), available at: http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2013CandDProgramAuditAnnualReport.pdf

[26] Kaiser Family Foundation (November 2014), available at: http://kff.org/medicare/report/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program/.

and increased costs to Medicare."[27] Similarly, a recent article in *Health Affairs* found, among other things, that "People dually eligible for Medicare and Medicaid ("dual eligibles") and Medicare beneficiaries under age 65 and disabled disenrolled from Medicare Advantage at higher than average rates, a trend worth exploring because these beneficiaries tend to have significant health care needs."[28]

Finally, we urge the Committee to address wasteful spending in the MA program before further altering MA payment based upon enrollees' health condition or other factors, as discussed in the next section. The Center for Public Integrity recently conducted an investigation of Medicare Advantage payment and "found that billions of tax dollars are wasted every year through manipulation of a Medicare payment tool called a 'risk score.'"[29] The Medicare program should ensure that payments to MA plans is accurate, and the billions of dollars that are inappropriately paid to MA plans should be recouped.

C. Preserve Integrity of Part C and D Star Ratings System

It is essential that any program designed to serve individuals with multiple chronic conditions maintain the integrity of the quality ratings system. Therefore, we alert the Committee to our concerns regarding risk adjustment of quality measures for individuals with complex conditions.

The Center has serious concerns regarding incorporating socioeconomic status (SES) and sociodemographic status (SDS) like income, education, race and ethnicity, in quality performance measures, and performing risk adjustment for these factors in accountability applications. Though we believe it is an error to conflate quality measures and payments, it is clear that as payments are increasingly tied to quality performance scores, the two areas are linked. We agree with CMS that performance measures should aim to identify disparities in care and strive to eliminate these disparities.

Quality measurements are designed to reveal disparities in care, and spur changes in order to address those disparities. We are concerned that risk adjustment will mask these disparities and disincentivize healthcare units from making the changes that could equalize care, making quality analysis and quality ratings useless. Altering quality measures based on sociodemographic factors risks masking existing disparities in care, and could create two divergent standards of care, while concealing the actual cause of these disparities through the inflation of performance scores.

Research suggests that individuals from under-resourced communities are more likely to receive poor care.[30] However, the data do not indicate that disadvantaged patients cause poor quality

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[27] Gerald F. Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Services", CMS, Medicare & Medicaid Research Review (MMRR) Vol. 2 No. 4 (2012), available at: http://www.cms.gov/mmrr/Articles/A2012/mmrr-2012-002-04-a08.html.

[28] *Health Aff January 2015 vol. 34 no. 1 48-55;* http://content.healthaffairs.org/content/34/1/48.abstract.

[29] See "Medicare Advantage Money Grab" available at: http://www.publicintegrity.org/health/medicare/medicare-advantage-money-grab.

[30] Agency for Healthcare Research and Quality (AHRQ), "National Healthcare Disparities Report," (last modified Nov. 3, 2014), available at http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/highlights.html

ratings. As there is little publically available data demonstrating a causal link between SES/SDS factors and lower quality measure scores for MA and Part D plans, suggestions that dual enrollment in a plan causes low performance are anecdotal and do not reflect conclusions based on supporting data. Without these data, it is premature to make changes to the Star Ratings program. Efforts by CMS are underway to explore the link between sociodemographic factors and quality scores.[31] We believe this inquiry should continue and that the agency's findings should inform the development of policy in this area.

Because the Star Rating system encourages continuous quality improvement, we urge the Committee in developing new models of care, to refrain from incorporating any changes to performance measurement that would lead to masking disparities and harming disadvantaged patients.

D. Quality

As the Committee considers ways to improve care for Medicare patients with chronic conditions, we encourage you to address ways to ensure high quality of care in all settings.

With quality measurement, a market-based approach to ensuring quality, the expectation is that patients will be given information and will choose for themselves where they want to receive health care. In addition, however, we also need to ensure that care in all settings paid for by the Medicare program is of high quality. A regulatory approach that relies on the government to set and enforce quality of care standards is equally essential.

The federal government sets and enforces quality of care and quality of life standards for nursing facilities. *See Smith v. Heckler*, 747 F.2d 583, 589 (10th Cir. 1984):

> After carefully reviewing the statutory scheme of the Medicaid Act, the legislative history, and the district court's opinion, we conclude that the district court improperly defined the Secretary's duty under the statute. The federal government has more than a passive role in handing out money to the states. The district court erred in finding that the burden of enforcing the substantive provisions of the Medicaid Act is on the states. The Secretary of Health and Human Services has a duty to establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the Act. These requirements include providing high quality patient care. This duty to be adequately informed is not only a duty to be informed at the time a facility is originally certified, but is a duty of continued supervision.

This language was codified and expanded by the federal Nursing Home Reform Law enacted in 1987. 42 U.S.C.§§1395i-3(f)(1) (Medicare). The Medicaid statute is virtually identical. *Id.*

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[31] For example, regarding star ratings for MA plans, see: Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, April 6, 2015, Duals discussion pgs 101-105: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

§1396r(f)(1) ("It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.")

State courts as well recognize the important of the government setting and enforcing standards. See *California Association of Health Facilities v. Department of Health Services*, 16 Cal.4th 284, 940 P.2d 323, 65 Cal.Rptr.2d 872, 885 (1997) ("the primary responsibility for enforcing compliance with statutes and regulations governing long-term health care facilities has been given to the Department through its licensing inspection, and citation regime").

Conclusion

We appreciate the opportunity to provide feedback on reforming Medicare's coverage of and payment for individuals with chronic conditions. We urge Congress to place the needs of beneficiaries, as discussed above, at the forefront of any reform efforts.

Sincerely,

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