OPEN EXECUTIVE SESSION TO CONSIDER THE ''CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE ACT OF 2017''

THURSDAY, MAY 18, 2017

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 10:31 a.m., in room 215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Roberts, Cornyn, Thune, Burr, Isakson, Portman, Toomey, Cassidy, Wyden, Stabenow, Cantwell, Nelson, Carper, Cardin, Casey, Warner, and McCaskill.

Also present: Republican Staff: Chris Campbell, Staff Director; Mark Prater, Deputy Staff Director and Chief Tax Counsel; Brett Baker, Health Policy Advisor; Erin Dempsey, Health Policy Advisor; Jennifer Kuskowski, Health Policy Advisor; and Jay Khosla, Chief Health Counsel and Policy Director. Democratic Staff: Joshua Sheinkman, Staff Director; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Advisor; Matt Kazan, Health Policy Advisor; and Beth Vrable, Senior Health Counsel. Non-designated Staff: Joshua LeVasseur, Chief Clerk and Historian; and Jewel Harper, Deputy

Clerk.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The Committee will come to order. Today the committee has before it a Chairman's Mark of S.870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, as modified.

I would like to welcome everyone to this morning's executive session. Today the committee will consider and hopefully report legislation to improve the way Medicare serves patients with chronic conditions.

Given that we held a hearing on this very topic just two days ago, I will keep my initial remarks brief.

The legislation before us represents the hard work of the chronic care working group that I established along with Ranking Member Wyden, and is co-chaired by Senators Isakson and Warner.

We, as leaders of the committee, are very happy to cooperate with them. We formed this bipartisan group two years ago in hopes that we could advance important and much needed reforms for Medicare beneficiaries suffering from chronic conditions.

After two years of meeting with and receiving input from stakeholders in the health care community, including

850 formally submitted comments, the release of multiple public proposals and outlines, and good-faith negotiations, we have arrived to where we are today. The CHRONIC Care Act currently has 18 bipartisan cosponsors, 16 of whom sit on this committee.

The bill includes a number of policies that will improve care for the chronically ill through increased use of telehealth, including by giving Medicare Advantage plans and certain accountable care organizations enhanced flexibility to target telehealth services to Medicare patients with chronic conditions.

The bill also goes beyond telehealth by making improvements for beneficiaries who receive care across the Medicare spectrum, including fee-for-service, accountable care organizations, and Medicare Advantage. These are all important changes that will address the growing need to tailor treatments to those with chronic conditions.

Given the contentious nature of our nation's current health care debate, I think it is remarkable that we have been able to get to this point. While I would like to take credit for all of the successes we have enjoyed thus far, this endeavor has been the very definition of a team effort.

I want to, once again, thank Senator Wyden for his

commitment not only to this particular bill, but to the patients that will undoubtedly benefit once it is signed into law. I want to thank our distinguished co-chairs of the working group, Senator Isakson and Senator Warner who have really spearheaded this whole endeavor. And I want to thank the other Senators, on and off the committee, who have provided vital input and insight into this process and have helped shape this into a better legislative product.

Finally, I want to thank the advocates and stakeholders who have been so cooperative and helpful in providing feedback and expertise as this effort has moved forward.

Of course, now is not the time to celebrate anything. We have got work to do. Hopefully, we can move this legislation out of committee today, and then continue our efforts to get it passed on the floor.

Having said this, I will now turn to my colleague and friend, Senator Wyden for any comments that he would care to make at this time.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator Wyden. Thank you very much, Mr. Chairman.

I know it is the Chairman's plan to vote at 11:15. We have got colleagues here who want to make remarks, so I too will be brief.

I want to note two points relating to what the Chairman just said. If you were to tell people in a polarized political environment like this one where sometimes it seems that the Congress can hardly agree to order a 7Up, if you were to say we are about to pass major transformational Medicare reform, people would just look at you like you were hallucinating.

But the fact of the matter is, colleagues, that is what is going to happen. Senator Isakson, for example, was there at the takeoff. In fact, he was there before the takeoff, because Senator Isakson and I teamed up on The Independence at Home Program that was a part of the Affordable Care Act while Eddie Markey was doing it over in the other body. So we are very, very pleased to have Senator Isakson here this morning.

I am just going to begin my short remarks with this comment, and that is if you could bring back the lawmakers responsible for the creation of Medicare, the

people who created Medicare in 1965, and brought them to this hearing room in 2017, they would barely recognize the program that they created more than half a century ago.

As you and I talked about, Senator Isakson, everybody remembers Medicare. When it began it was Part A and Part B. And it was for surgeries like broken ankles and doctor visits like a bad case of the flu.

Today 90 percent of the Medicare dollar goes towards seniors who have two or more chronic conditions. We are talking about cancer, about diabetes, about heart disease, about strokes.

So it is my view from this day on, if somebody talks about health reform, both for the over 65 population, and the under 65 population and does not focus on chronic illness, that conversation is just not on the level because today we are talking about what health care has become, not just what it was in the past.

So this is, in effect, updating the Medicare guarantee. If you were to ask me to describe in one sentence what it is we are doing, if somebody asked Senator McCaskill of Missouri what is she up to, we are updating the Medicare guarantee.

Because Medicare has always been a promise, it has been a guarantee of defined benefits. It is not a

voucher. It is not slip of paper. It is not a coupon. It is a guarantee. And today, because of the good work on both sides under the leadership of our Chairman, we are updating that guarantee.

It is going to mean more care at home for vulnerable people left in institutions. We will be able to expand lifesaving technology as we heard from Senator Schatz and Senator Wicker.

It places a stronger focus on primary care. We all understand that for many people it is not really health care at all in America. It is sick care because we do not have enough prevention. We do not have enough primary care.

It empowers seniors however they get their Medicare, whether it is in fee-for-serve medicine, or Medicare Advantage, an accountable care organization, a kind of innovative program Senator Stabenow has in Michigan -- this is going to give those seniors the tools so that they can navigate this extraordinarily byzantine health care system.

I am going to close before we get some thank yous by saying we have got a lot of heavy lifting to do in the days ahead.

Most of the nation's older people today still do not benefit from having coordinated care. We had a witness

two days ago -- as you recall, Mr. Chairman -- who was talking about someone having a stroke in the middle of the night. They go to the hospital. They are there in the emergency room.

Perhaps they are released in a few days. But in much of America, when they are released, that hospital does not even know where to send the records for that patient so that there can be follow-up care.

So we have got a lot of heavy lifting to do. If I could literally go around the room, Senator Warner, of course, has done exceptionally important work in terms of promoting the discussion about end-of-life care. This is particularly important in Oregon where we consider ourselves pioneers. We are grateful to Senators Warner and Isakson for leading this effort.

And through the endless hours of work that went into writing this bill, our staff found time for multiple weddings, the birth of three children, and a handful of job changes. So big thanks to Karen Fischer, Hanna Hawkins, Lei Stuckard, Beth Vrable, and Matt Kazan. They are all from our team.

Senator Hatch had a terrific team, Jay Khosla, Brett Baker, Jen Kuskowski, Katie Meyer Simeon, and their chronic care lead, Erin Dempsey.

So I think, Mr. Chairman, today is about formal

recognition for how dramatic the changes have been to this program. I thank you and our co-chairs for their work. I know some colleagues want to talk, and that will be the end of my speechifying. Thank you.

The Chairman. Thank you, Senator Wyden.

Now I would like the co-chairs of the working group -- I want to give them an opportunity to deliver some remarks. So we will start with Senator Isakson, and then we are going to move to Senator Warner. We are so pleased with the work that they have done.

So Senator Isakson, let us take you first. Then, Senator Warner, we will go straight to you.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, A U.S. SENATOR FROM GEORGIA

Senator Isakson. Well Chairman Hatch, thank you very much for your support and for your vision in originating this effort which started over two years ago and has culminated today in what will be a marked improvement as America moves forward -- as Chairman Wyden has said -- in terms of health care for our seniors.

I want to thank you for what you have done, thank the Committee Chair and the Committee Ranking Member for their support. I want to particularly thank Mark Warner. I do not know that I have ever enjoyed working with anybody anymore in anything in my 38 years in public life than the Coordinating Care Working Group.

We have had some interesting forums. We have tackled some difficult issues. We have improved the outcome and lowered the cost of health care to seniors, and that is really what this is about today, improving the outcome and lowering the costs.

I want to particularly thank Jordan Bartolomeo of my staff who has worked countless hours and tireless hours for two and one-half years to help us get to this point. And on behalf of her, and the committee and myself, I

want to ask the Chair if I could by unanimous consent submit for the record over 40 letters of support from the industry all over Washington about the Chronic Care Working Group.

The Chairman. Without objection.

[The letters appear at the end of the transcript.]

Senator Isakson. Little did I know four months ago when I entered the hospital for an operation that I had two chronic conditions that I would need two doctors coordinating, or before we had this hearing today, I would have experienced firsthand the benefit of coordinated care.

I had back surgery in February and had to coordinate with my Parkinson's doctor -- they had to coordinate together because of the nature of the surgery. I found better results, lower costs, and a better outcome than I would have ever found had they not coordinated. I talked to both of those doctors during the course of my care and I am still doing some rehabilitation now.

About coordinating care and how much it helps -- I said the most important thing it does, it keeps you from replicating mistakes. It keeps the doctors from getting in each other's way. It is a seamless flow of information. It flows from one specialist to another to be sure that they are not doing things that are

counterproductive one to the other.

What the Chairman said is exactly correct. In the future, we will be saving more lives, improving the healthcare of more individuals, and saving more dollars than we would have ever done before we made this effort.

So to Senator Warner, I thank you for all that you have done and that we had the chance to work together. Senator Wyden, thank you for the things we did together, beginning with the demonstration projects on Care at Home. Senator Hatch, thank you as always for being a great Chairman and a great Member. And once again, Jordan Bartolomeo, thank you for being a great staffer that made me look good for a long, long time, and has made me look awfully good today.

With that, I will yield back.

The Chairman. Senator Warner?

OPENING STATEMENT OF HON. MARK R. WARNER, A U.S. SENATOR FROM VIRGINIA

Senator Warner. Well let me -- it is tough to follow Johnny Isakson on anything, but let me first start by thanking you and the Ranking Member, particularly for allowing someone that two years ago was -- even at that point -- still sitting at the kiddie table --

[Laughter.]

Senator Warner. -- to actually be part of such an important effort. Let me thank my staff, Marvin, and Johnny's staff, and all of the staff here. Over the last few years, I have had the opportunity to work with Johnny Isakson on Medicare Wage Index, on Home Infusion, on Care Planning, on a variety of other projects all culminating in the two years we have worked on this chronic care. I think I would not be chastened by any Member of the Senate to say there is nobody easier to work with, better to work with, and just kinder to work with. Kindness is not something we talk about here in the Senate.

So Johnny Isakson, I appreciate the chance to work with you. I am proud of the product we have got, and echoing what you said in your comments, that you have experienced care, the need for chronic care planning and chronic care management -- I usually revert back to

numbers, and I have got the numbers echoing what Senator Wyden said, 32 percent of the Medicare population has one chronic illness or less, they only account for 7 percent of the costs. Fourteen percent have 6 illnesses or more, they account for 46 percent of the costs.

It just makes absolute commonsense that if we can coordinate better care, you are going to end up with better quality of care, but you are going to end up with cheaper care as well.

So echoing what the Chairman has said as well, in a time when there is a lot of division here in this body, the fact that we are going to report out something that is a significant improvement and continuation of -- as Senator Wyden said -- the Medicare Promise is a great work. I am proud to have been a small part of it, and let us move on with the markup.

The Chairman. Well, thank you, Senator. Let us move on with the markup.

The committee has before it the Chairman's Mark on S.870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017.

We also have a modification which has been developed by a bipartisan staff which is hereby incorporating into the Mark unless there is objection.

[No response.]

The Chairman. There being no objection, we incorporate it.

The next order of business is to walk through the modifications in the mark and answer any questions. As is our usual practice, I recognize the bipartisan committee staffers, Erin Dempsey, Jen Kuskowski, Brent Baker, Beth Vrable, and Matt Kazan. So let us turn to you now.

Mr. Kazan. Thank you, Mr. Chairman. We will run through the modifications to the Mark.

The first modification to the Chairman's Mark in Section 101 drops the requirement that the Independence at Home practice receive an incentive payment as a condition of avoiding termination from the Independence at Home Demonstration.

The second modification to the Chairman's Mark in this section requires that the independent evaluation conducted at the conclusion of the Independence at Home Demonstration assess how participating practices use health information technology to provide more efficient care.

The next modification to the Mark makes an adjustment to the definition of conditions eligible to be covered under a Chronic Disease Special Needs Plan. This new definition describes conditions that would improve

the health and lower costs of patients with such a condition if a Chronic Disease Special Needs Plan is available to Medicare beneficiaries, or a condition that is either low prevalence in the Medicare population or a condition with disproportionately high per beneficiary spending.

The next modification to the Mark accepts the Casey/Portman amendment as modified. This amendment requires the Secretary of HHS to consider the impact of Medicare Advantage Plans that serve a high number of dually-eligible beneficiaries if the MA Quality Measurement System is done at the plan level rather than the contract level.

The next modification to the Mark accepts Cantwell Amendment Number 2 as modified. This amendment would add a requirement to a GAO study in the Chairman's Mark that would require an analysis of state's efforts to transition dually-eligible beneficiaries receiving long-term services and supports from institutional settings to home- and community-based settings.

Ms. Dempsey. Thank you, Mr. Chairman.

The next modification would modify Section 302, Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees. On page 9 of the Mark, Section 302 clarifies that for the purposes

of the GAO study on supplemental benefits, specified analyses of the listed topics would be conducted to the extent that data are available.

The next modification is in Section 303, Increasing Convenience for Medicare Advantage Enrollees Through Telehealth. On page 10 of the Mark, fix two spelling mistakes.

Also on page 10 of the Mark in Section 303, make a modification to the procedure by which the Secretary of JJS solicits feedback on what services should be available via Telehealth under Medicare Advantage.

And finally, on page 10 of the Mark in Section 303, clarify that under the Mark if a Medicare Advantage Plan offers the service via telehealth, the Medicare Advantage Plan must make the same services accessible in-person for the plan's enrollees and that the enrollees of the MA Plan would have the ability to decide whether to receive the service via telehealth or in-person.

The next modification is in Section 602, the GAO Study and Report on the Impact of Obesity Drugs on Patient Health and Spending. The modification to Section 602 would clarify that the GAO execution of the requirement elements of the study is contingent on data being available.

Finally, the Mark would accept as modified

Carper/Cassidy Number 3. This amendment would require the Secretary of HHS to conduct a study on the long-term cost drivers of Medicare, such as obesity, smoking, and mental illness. The study would require the Secretary to identify any barriers to collecting or analyzing this information and would be due no later than 18 months after the enactment of the Chairman's Mark.

Thank you, Mr. Chairman. That concludes the modifications to the Chairman's Mark.

The Chairman. Thank you. I want to note that Ms. Dempsey is here on a panel today, but she suffered terrible news recently surrounding her family. Her father, unfortunately, passed away earlier this week.

Erin has put in a great deal of work on this bill, and we are glad to have her here to help us. But, Erin, I think we all want to express our sincere condolences for your loss, and we know you and our family will be in our thoughts and prayers. So I want to thank you on behalf of the whole committee for being here today despite all that has gone on this week. We are very appreciative of you, and grateful to you.

Ms. Dempsey. Thank you, Mr. Chairman.

The Chairman. Now, to our entire staff and panel, will you briefly discuss the modifications to the Mark -- we have already done that. Okay -- so we have got that

done.

Do Senators have any questions regarding the Mark or the modifications?

Senator Wyden. Mr. Chairman?

The Chairman. I will recognize Senator Wyden if he has any comments to make.

Senator Wyden. Mr. Chairman, I do not have any comments. I know a number of our colleagues would like to speak on their contributions whenever you deem that appropriate.

The Chairman. Well I am ready to go, so --

Senator Grassley. Can you vote?

The Chairman. Do we have enough here to vote? If we could vote, and then we will take the speeches -- we do not have a quorum.

Senator Grassley. Can we have the vote on the floor?

The Chairman. Well we are just about close enough to get it if we can keep everybody here.

Senator Stabenow. Mr. Chairman?

The Chairman. Let us turn to Senator Stabenow for her comments, and we will keep moving ahead until we get -- I think we are just about to get it.

Senator Stabenow. Well thank you, Mr. Chairman.

I want to first lend my support and congratulations

to everyone involved. This is the way we should be doing health care, and I believe, every other issue in our committee -- two years' worth of bipartisan work, great leadership on both sides of the aisle.

I am pleased to have been involved in issues on Alzheimer's and caregivers and we have moved forward in a number of ways together.

So I want to congratulate you and urge that this is the way we do health care. And that we focus on bringing down costs for families, expanding coverage, improving quality, and that we do it in a way that no one loses their health insurance.

Mr. Chairman, I did want to just indicate offering and withdrawing one amendment that I will not ask for a vote on today, but I would appreciate an opportunity to speak on. That relates to another area where there is great bipartisan support, and that is access to mental health and substance abuse services.

We know that one out of five adults has a mental illness. We have worked together a number of ways. Senator Blunt and I have been working with many people on the committee since 2014 to pass a version of what we have called the Excellence in Mental Health Act.

The importance of that is that more than half of the people with mental illnesses today do not receive any

treatment. This is a critical health issue. The law that we passed in 2014 gave full reimbursement capability for eight states so that we are treating health care above the neck the same as health care below the neck, not with grants, but actually providing reimbursement for professionals that provide treatment, which is what we should be doing across the board.

When we put this in place, we created certified community behavioral health clinics, just like we have federally qualified health clinics with high standards. The clinics have to provide services like 24 hour crisis care, evidence-based integrated treatment for both mental illness and substance abuse, expanded peer support and counseling and services to address chronic problems.

So we, at this point, have eight states that -- because of the funding involved, only eight states that have been able to move forward with this funding, this comparable funding, mental health parity in the community. Nineteen states stepped forward to be able to do this, and Senator Roy Blunt and I are continuing to work to expand the demonstration projects to all 19 states.

So Mr. Chairman, and Ranking Member Wyden, and Members of the committee I look forward to working with you to take the next steps necessary to make sure that we

are not just treating mental illness and substance abuse with grants that run out, but that we reimburse for those health care issues like we reimburse for every other health care issue. It is critically important to families in the United States.

Mr. Chairman, I look forward to working with you on this.

The Chairman. Well thank you. I look forward to it too.

Are there any other amendments --

Senator Carper. Mr. Chairman?

The Chairman. Senator Carper?

Senator Carper. Yes, thanks so much.

Let me preface my remarks about the amendment that Senator Roberts and I will be offering together. This is rather extraordinary in that Congress is pretty dysfunctional. The federal government looks pretty dysfunctional to be able to develop this kind of consensus.

Usually, I find that leadership is real helpful in making that happen. So I just want to commend both you and Senator Wyden for providing that leadership. To Johnny and to Mark, my thanks to you for the very impressive way that you provided a good example for all of us to find common ground on some really important

issues.

I spoke at a hearing earlier this week on chronic care, and I talked about my mom. I talked about my mom in her last years of life, taking 15-16 different medicines. Doctors prescribed and never talked to, never coordinated that. That is not an uncommon situation, I suspect, for all of us.

Senator Roberts and I have been working -- I want to thank my staff Lynn Sha and Sun Moon Shine (phonetic). But I also want to really thank the people at this table who have worked with us, with Lynn and the staff of Senator Roberts, but you helped us a lot with the amendment that Senator Cassidy and I worked on with regard to the GAO study on obesity and smoking. We appreciate that. You have been terrific in helping us get through this.

Poor medication adherence -- I am told -- across our country cost something like thousands of lives and up to $300 billion each year -- $300 billion each year and we need to get our arms around this problem.

The amendment that Senator Roberts and I are offering today eliminates barriers for information sharing, increases care coordination between hospitals, doctors, and Part D drug plans to improved medication adherence, to improve patient health, and at the same

time to reduce costs by -- could be quite a bit of money.

We just heard back from CBO this morning that there is no cost to this amendment. We request a vote.

I yield to Senator Roberts and just thank him and his staff for working with us on this.

Senator Roberts. I thank the Senator for yielding.

I might note with interest that Tom Carper and Johnny Isakson tied for the nicest guy award in the Senate as of this year. It is the third year in a row that they have done that. So if you just hook onto the Isakson bill or the Carper bill, you will have success.

Research indicates that suboptimal medication use, taking too much or not taking enough prescribed medication leads to avoidable annual health care costs of almost $300 billion -- $300 billion due to additional health care utilization such as emergency room visits, hospital readmissions, or post-acute care. The example that Tom used of his mom is right on spot. The situation with my mom was a very serious situation with a lack of coordination and actually caused her to pass on.

But at any rate, if we want to truly bend the health care cost curve and improve health care around the nation, we must proactively address the public health issue of non-adherence. Adherence is also the lowest among the chronically ill, which is why Senator Carper

and I saw an opportunity to help address this issue in the context of the chronic care legislation.

Like he said, I want to thank both the Chairman and the Ranking Member for this bill.

Our amendment directs the Department of Health and Human Services to establish a process by which Medicare prescription drug plans can request Parts A and B claims data to promote the appropriate use of medications and improve health care outcomes.

Under a CMMI Demonstration Program on medication therapy management, certain plans can already request this information to assist with identification and care coordination of individuals at risk of medication related problems. Our amendment builds upon this to allow all drug plans access to this data for these same purposes while ensuring we protect the security of personal health information.

I want to again thank Senator Carper and his staff for working on this issue with me. And kudos to my staff member, Emily Mueller. I would request our colleagues certainly support this amendment.

Thank you, Mr. Chairman.

The Chairman. Well thank you.

Senator Cantwell?

We have a quorum. Okay, voice vote the amendment.

All those in favor of the amendment say aye.

[A chorus of ayes.]

The Chairman. All those opposed will say no.

[No response.]

The Chairman. The ayes have it. The amendment is adopted.

Now we will turn to Senator Cantwell. Then we will call up the Mark. Are you okay?

Senator Cantwell. Call the vote. Vote.

The Chairman. Okay. Let us call the vote.

[Laughter.]

The Chairman. The clerk will call the vote.

The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Crapo?

The Chairman. Aye by proxy.

The Clerk. Mr. Roberts?

Senator Roberts. Aye.

The Clerk. Mr. Enzi?

The Chairman. Aye by proxy.

The Clerk. Mr. Cornyn?

Senator Cornyn. Aye.

The Clerk. Mr. Thune?

The Chairman. Aye by proxy.

The Clerk. Mr. Burr?

Senator Burr. Aye.
The Clerk. Mr. Isakson?
Senator Isakson. Aye.
The Clerk. Mr. Portman?
Senator Portman. Aye.
The Clerk. Mr. Toomey?
The Chairman. Aye by proxy.
The Clerk. Mr. Heller?
The Chairman. Aye by proxy.
The Clerk. Mr. Scott?
The Chairman. Aye by proxy.
The Clerk. Mr. Cassidy?
The Chairman. Aye by proxy.
The Clerk. Mr. Wyden?
Senator Wyden. Aye.
The Clerk. Ms. Stabenow?
Senator Stabenow. Aye.
The Clerk. Ms. Cantwell?
Senator Cantwell. Aye.
The Clerk. Mr. Nelson?
Senator Nelson. Aye.
The Clerk. Mr. Menendez?
Senator Wyden. Aye by proxy.
The Clerk. Mr. Carper?
Senator Carper. Aye.

The Clerk. Mr. Cardin?
Senator Cardin. Aye.
The Clerk. Mr. Brown?
Senator Wyden. Aye by proxy.
The Clerk. Mr. Bennet?
Senator Wyden. Aye by proxy.
The Clerk. Mr. Casey?
Senator Casey. Aye.
The Clerk. Mr. Warner?
Senator Warner. Aye.
The Clerk. Mrs. McCaskill?
Senator Wyden. Aye by proxy.
The Clerk. Mr. Chairman?
The Chairman. Call Mr. Crapo first.
The Clerk. Mr. Crapo?
Senator Crapo. Aye.
The Clerk. Mr. Chairman?
The Chairman. Aye.
The clerk will report the vote.
The Clerk. The final tally is 26 ayes, 0 nays.
The Chairman. It looks to me like it has passed.
Senator Cantwell. Mr. Chairman, if I could just --
The Chairman. Senator Cantwell?
Senator Cantwell. -- enter into the record, thank you for including language on rebalancing so that we show

that community-based care is more cost effective than nursing home care, particularly for the dual-eligible population.

I want to thank Senator Grassley for joining me on the Lymphedema Treatment Act that is so important because it is such a debilitating chronic care condition affecting 3 million Americans. We want to continue to work with you and the Ranking Member on inclusion in this at a future time.

Thank you.

Senator Nelson. Mr. Chairman?

The Chairman. Let me ask unanimous consent that the staff can take care of all technical amendments and other amendments and we need to add that.

Senator Nelson first, and then Senator Cardin.

Senator Nelson. Mr. Chairman, I am going to offer an amendment and then withdraw it --

The Chairman. Okay.

Senator Nelson. -- just to put it on the record, and I will insert my statement.

The Chairman. Thank you.

Senator Nelson. But this involves the cost sharing that seniors have to do on highly specialized drugs, and they do not have the ability to appeal a certain type of these drugs like they can appeal the costs of so many

other drugs.

So this would allow that appeal for all of those Medicare Part D prescription drug plans using the tiering system.

Thank you.

The Chairman. Thank you.

Senator Portman?

Senator Nelson. And I ask consent to insert this into the record.

The Chairman. Without objection.

[The prepared statement of Senator Nelson appears at the end of the transcript.]

The Chairman. Senator Portman, and then we will go to Senator Cardin. He will be our last speaker.

Senator Portman. Thank you, Mr. Chairman.

So Senator Bennet and I have an amendment that we filed. We are not going to offer it because we think that CMS can give us some more technical advice and we are looking for a better CBO score.

It has to do with a Medicare program linking coordinated services or PLUS Act. We filed this knowing that we still had work to do on it, but we think that it is incredibly important for the committee to move forward on this idea.

MedPAC has now reported that the costliest 10

percent of Medicare fee-for-service beneficiaries account for about 60 percent of the program's cost.

This legislation would establish pilot programs to improve the care for those highest risk Medicare fee-for-service beneficiaries most in need of services through the use of comprehensive and effective care management.

So it is a pilot program that would allow selected organizations like Medicare Advantage and Medicare Advantage Plans or accountable care organizations to offer benefits and services to these highest risk folks in these selected areas.

We believe strongly that it is going to save money, but also help with regard to these patients who are struggling to manage their chronic care conditions, such as dementia, heart failure, and those suffering from opioid addiction combined with mental illness which is increasing in our country.

So we look forward to working with the committee on that and hope, Mr. Chairman, that you and Senator Wyden work with us on that. I also want to thank you, both of you and Senators Isakson and Warner for including in the CHRONIC Care legislation some of the work that was talked about earlier by the staff, first for including an extension of the Independence and Home Program within the CHRONIC Care Act.

As you know, I wanted it to be permanent. We got a two-year extension. We only ever do a two-year extension, frankly, because I think the CBO score is misleading. I think it does not take into account the fact that we know Independence and Home is going to save money, and for another two years of having this program in place will help for us to get the data to be able to provide it to CBO to convince them that we are right.

This program currently is a demonstration program that operates in 17 areas across the United States, including many of the states with Members represented here in this committee -- 8,500 Medicare beneficiaries. It uses home-based primary care teams to focus on quality of care for patients in their homes, keeping them out of more expensive institutional settings. It has worked really well.

In Ohio, particularly with the Cleveland Clinic, we have got great results -- as an example of how coordinated team-based approach can both improve health care outcomes and save a lot of money. In the first performance year, on average, this program saved over $3,000 per beneficiary, totaling more than $25 million.

Again, we have seen this benefit in Ohio, but also in many of your states.

The current demonstration, again, expires at the end

of September. So I really appreciate your putting it in the CHRONIC Care Act and continuing it for another two years. Otherwise, we would have not been able to continue the program.

Again, my hope is that we can get CBO to recognize the cost savings that comes from this home-based program. This data will be helpful.

I also want to thank the Chairman for working with me to include a provision Mr. Kazan mentioned earlier that I championed with Senator Casey to ensure that the most vulnerable Medicare beneficiaries, low income, disabled, dual-eligible seniors are able to maintain access to high-quality Medicare Advantage Plans. I appreciate Senator Casey working with me on that, and thank you for including it in the Mark today.

And finally, I want to bring to the committee's attention something that Senator Wyden and I have worked on over the years, which is preventive care in Medicare. This is a really exciting opportunity for us, in our view, and our Better Health Rewards Program is not included here in its entirety, but there is here in the Mark today a step in the right direction in my view because you concluded that the accountable care organizations can have within the CHRONIC Care Act part of the Better Health Rewards Program we worked on.

Basically, it creates an incentive to focus on prevention by providing better health care through rewards -- in this case, some payments upfront to incentivize seniors to set goals and meet health targets.

So I thank you for including that and I hope Senator Wyden and I can move forward on this broader issue, saving Medicare a lot of money and improving health care outcomes through better preventive care upfront with the annual physicals that are already required under Medicare.

So thank you, Mr. Chairman, and thank you Senator Wyden.

Senator Wyden. Mr. Chairman, if I could --

The Chairman. Let me turn to Senator Wyden, and then I am going to turn to Senator Cardin, and then wrap it up with Senator Cardin.

Senator Wyden. I want to tell my colleagues I appreciate their courtesy and I am going to be very brief.

Senator Portman is making a number of important points, and just two that I want to touch on. First, I very much share your view that we have to relentlessly focus on getting Independence at Home made permanent, because it is on the right side of history giving older people more of what they want, which is to be at home

with a real opportunity to save dollars.

It also has a very strong intersection with technological innovation, because we are seeing more and more companies providing the kinds of services and products at home that is so essential.

The last point I would make very quickly is when Senator Portman talks about the importance of prevention in Medicare, this is right at the heart of sensible policy for both people over 65 and under 65, because diabetes is one of the key concerns we have had in writing the CHRONIC Care bill that we passed unanimously today, and I think Medicare being the flagship health care program for this country, now putting a focus on chronic illness is going to give us an opportunity to advance what you are talking about, which is more emphasis on preventing the chronic illness in the first place.

So thank you and I thank my colleagues for letting me chime in.

The Chairman. We will go to Senator Cardin, and then Senator Carper, and then we are going to go to Senator Cassidy.

Senator Cardin. Thank you, Mr. Chairman. I first want to thank you for accommodating this legislation. It is a very important piece of legislation. It makes a

great deal of sense so people can get the health care in the venue that is the most cost effective, efficient and comfortable. That is certainly true in dialysis, and I thank you for the provisions that are included in this bill for dialysis patients.

It is also true for encouraging more telemedicine, which is critically important for rural areas that do not always have the type of specialists that are needed for timely care.

So this bill is very, very important. I had intended to offer an amendment. I was going to withdraw it, but let me just talk about it because I am pretty passionate about our need to get the therapy cap done permanently.

It was policy that was part of the Balanced Budget Act of 1997 that made no sense whatsoever. I know that because I was in the Ways and Means Library at the time when we were talking about it, and I asked Chairman Thomas what was meant by this, and he had no idea. He said it is a placeholder for a dollar amount of savings that CBO scored.

It never had any policy behind it. And it makes no sense whatsoever, and it does impact where people can get there therapy services, more expensive areas they can get it. It also discriminates against those who had the

greatest need, stroke victims, et cetera.

Now we have taken steps along the way to make sure it does not take effect. And we paid for it a dozen times over. And we have the votes to pass a permanent repeal of the therapy cap. We have that support in both the House and Senate. We just cannot seem to find a vehicle to get it done.

So I am just imploring the leaders of this committee to find a way that we can get this done. And I know the wisdom of our Chairman and Ranking Member, and I just urge them to find a way that we can get rid of this policy that makes no sense at all.

The Chairman. Thank you, Senator.

We will go to Senator Carper, and then we are going to go to Senator Cassidy, and that should wind it up, I hope.

Senator Carper. Thank you, Mr. Chairman.

A couple of years ago I was driving to the train station to come down here, and I was listening to NPR, the news at 7:00. They reported on a survey that had been taken -- thousands of people around the world, and the question that was asked in the survey was what is it you like about your job? That was it -- what do you like about your job?

Interestingly enough, most people said they like

getting paid.

[Laughter.]

Senator Carper. A lot of people said they like having fringe benefits, a pension, health care, vacation. Some people said they like the folks they work with. Others said they like the environment where they work.

But actually the answer that most people agreed on was the thing that they liked the most about the job was they realized that the work that they did was important, and they felt like they were making progress. They felt the work they were doing was important, and they believed they were making progress.

Sometimes -- almost every day -- the work that we do is important, but probably rarely more so than today. And it has got to be too bad the whole country could not observe what is taking place here today because we have done work that is important, and we are making progress on a variety of fronts, on a human front with people who are Medicare providers, but also the taxpayers, help pay for this stuff.

I am encouraged that if we can find bipartisan solutions, and a variety of them here today, to improve Medicare, just maybe, just maybe we can find a bipartisan path forward to reform our individual and our small business health insurance markets.

Months ago when President-elect Trump took office, he promised a variety of things and pledged really a kind of a three-part pledge, health insurance for everybody. It would be better insurance. It would be less expensive.

But in my own state last week, Aetna announced that they are going to exit the individual insurance market in Delaware. We now have just one insurer in our marketplace and premiums will, as a result, be a good deal higher than they ought to be.

Aetna did not give us any specific reasons for leaving Delaware, but insurers around the country have pointed to this administration's refusal to make cost sharing reductions permanent, along with a series of actions that are designed to discourage healthy individuals, largely young people, from joining the insurance rolls as a cause for 40 percent premium increases and unmanageable market instability.

Before the Trump Administration assumed office, independent analysis like Standard and Poor's found that individual insurance markets were gradually improving over the past three years. S&P went back to 2014, they looked to see how much the health insurance companies lost in the market places. They lost their shirts. They raised their premiums, copays, deductibles -- 2015 was

better. They raised their premiums, their copays, their deductibles -- 2016 was better, for some a breakeven year, others got close to breakeven, some still lost a fair amount of money.

But now several states, including my own state, face the prospect of having just one health insurer, and insurance premiums that are far higher than they ought to be.

My guess is none of our constituents care all that much about who wins points with the next health care bill that we pass. They just want access to a good health insurance plan that does not cost an arm and a leg. I do not think that is an unreasonable request.

While today's Markup of our bill before us is a very encouraging step, it is just the first of many steps that we need to take, and we all know that. I hope it will be followed by holding bipartisan hearings and a commitment from all of us to begin working across the aisle, across party lines to fix our insurance market, and to make real the President's promise to provide all Americans with quality, affordable health insurance.

Thank you.

The Chairman. Thank you.

Senator Cassidy, you will wrap it up.

Senator Carper. And I want to just say, if I

could, Mr. Chairman, a pleasure working with Senator Cassidy. He may mention another issue that we worked on, but I want to thank Bill for that.

Senator Cassidy. Yes, I thank Senator Carper because this is a bill that he and I have worked on. I congratulate the Chair and the Ranking Member on you all putting together this bipartisan work.

The fact is if you look at what is driving chronic disease in our nation, it is obesity, and we cannot address this burden of chronic disease without first addressing this.

That is why Senators Carper, Grassley, and I introduced the Treat and Reduce Obesity Act. This bipartisan legislation provides Medicare beneficiaries access to the full complement, the armamentarium of evidence-based obesity reduction approaches, including obesity drugs and intensive behavior therapy.

Mr. Chairman, I am hopeful we can move forward with the legislation in the future. To do that, we need a cost estimate from CBO. I would ask that you and your staff work with us to get a score for this bill so that we can have the thoughtful conversation about how to get individuals the care they need. My ask this morning is if the Chair would agree that we achieve this score?

The Chairman. I thank you, Senator.

Senator Toomey, we will list your vote as you being here. Is that okay?

Senator Toomey. That is good.

The Chairman. Okay. We will make that in the record.

Well I want to thank you all for attending and participating in this process. Once again, this really is an important piece of legislation that will hopefully care for those suffering from chronic illness.

I really want to congratulate my colleague, Senator Wyden, and of course Senators Isakson and Warner for today's success. And I want to thank them once again for their hard work and their leadership on this committee, and on this particular bill.

Furthermore, I would like to thank all of you staff members who just do a tremendous amount of work for us and get very little compliments for it, I think, sometimes. But we really love and appreciate all that you do and are grateful to you. You spend countless hours making this happen.

I look forward to tackling more challenges in the future with the help of my colleagues and here on the Finance Committee. It is a pleasure to work with Senator Wyden who is always open to good ideas and we have developed a very rare and good friendship, bipartisan

friendship that I think is a good example for our Senate and maybe the whole Congress.

Senator Wyden. Thank you.

The Chairman. Well thank you, Senator for your kindness.

With that, I am going to close this down today and we will recess until further notice.

[Whereupon, at 11:21 a.m., the meeting was adjourned.]

I N D E X

Statement of Senator Bill Nelson

Millions of seniors on Medicare are living with chronic or life-threatening health conditions and rely on prescription drugs for coping with their chronic disease.

In recent years, seniors have seen dramatic changes in their cost-sharing options in the Medicare Part D program as many drug plans now require patients to pay a percentage of a drug's list price.

This can lead to ridiculously high out-of-pocket costs for our nation's seniors, especially if a patient requires a drug on the most expensive, or specialty tier.

As many of you know, Medicare Part D prescription drug plans use a "tiering" system where each tier has a different copayment.

Since 2015, all plans have adopted a specialty tier that requires seniors to pay as much as 33 percent of the cost of the drug.

More and more drugs are being placed on these specialty tiers – forcing many seniors on Medicare to decide between bankruptcy and life-sustaining treatments.

The Part D program has a "tiering exception," which allows seniors on Part D to appeal to cover a drug at the lower "preferred drug" cost-sharing level if it is deemed medically necessary.

Beneficiaries can request a tiering exception on every tier in their plan except for drugs on the specialty tier, where the highest-cost drugs are located.

Last Congress, I introduced a bill that would give seniors on Medicare the right to appeal for a lower copay for the highest cost specialty drugs, when a doctor determines them as medically necessary.

The Medicare Part D program works best when seniors can choose from several options to find a plan that best fits their needs without hurting their pocketbooks.

I look forward to working with the Committee on this bill to strengthen the Part D program to make sure it works for all seniors.

ASN LEADING THE FIGHT AGAINST KIDNEY DISEASE

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p 202.640.4660 • f 202.637.9793 • www.asn-online.org

April 17, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden and Co-Chairs Isakson and Warner:

On behalf of the American Society of Nephrology's (ASN) nearly 17,000 physicians, scientists, nurses, and other health professionals, thank you for your leadership in sponsoring the CHRONIC Care Act of 2017. ASN commends your continued bipartisan commitment to improving the lives of all Americans suffering from chronic diseases, including the 40 million Americans living with kidney diseases.

In particular, ASN strongly supports the legislation's proposal to designate the dialysis facility as an originating site for telehealth services for home dialysis patients. Home dialysis—in the form of peritoneal dialysis (PD) or home hemodialysis (HHD)—is an important treatment option that, for some patients, offers significant clinical and quality of life advantages. By expanding home dialysis patients' flexibility to use telehealth technology to interface with their nephrologists, this bill may help increase access to this important treatment option for patients with kidney failure.

As highlighted by a January 2017 Government Accountability Office (GAO) report, nearly 40 million Americans—roughly 17% of the US adult population—live with kidney diseases. Of these individuals, over 680,000 live with kidney failure, a life-threatening condition that must be managed by dialysis or a kidney transplant. Patients with kidney failure are among the most complex and most expensive patients in medicine, costing Medicare over $103 billion annually.

The policies outlined in the CHRONIC Care Act of 2017 that permit the utilization of new and innovative technologies like telehealth, and the elimination of barriers to coordination of care, will provide for improved outcomes of individuals managing kidney diseases, and will also reduce the burden of kidney diseases on the economy.

ASN and the professionals it represents are committed to the goals outlined in this act of improving management of chronic diseases, streamlining care coordination, and improving the quality outcomes for this population of vulnerable citizens. We believe this legislation is a crucial step in improving the access of Americans living with kidney diseases to optimal quality care, regardless of socioeconomic status, geographic location, or demographic characteristics.

Again, thank you for your time and dedication. To discuss ASN's position on this legislation further, please contact ASN Director of Policy and Government Affairs Rachel Meyer at rmeyer@asn-online.org or at (202) 640-4659.

Sincerely,

Eleanor Lederer, MD, FASN
President

cc: Senator Bennet
Senator Cardin
Senator Thune
Senator Casey
Senator Cornyn
Senator Crapo
Senator Grassley
Senator Carper
Senator Stabenow

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April 7, 2017

Senate Committee on Finance
Chronic Care Working Group
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch, Ranking Member Wyden, Sen. Isakson, and Sen. Warner:

The American Academy of Neurology (AAN), the world's largest association of neurologists representing 30,000 professionals, is strongly committed to improving the care and outcomes of persons with neurologic illness in a cost-effective manner. We would like to express our strong support for the reintroduction of the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act*.

The CHRONIC Care Act, if enacted, will significantly improve care for Medicare's most complex patients suffering from chronic diseases, including neurologic conditions such as Alzheimer's disease, Parkinson's disease, stroke, epilepsy, traumatic brain injury, ALS, multiple sclerosis (MS), and headache. Patients with these neurologic diseases often represent a large portion of the high-need, high-cost Medicare beneficiaries.

The AAN supports the intent of the CHRONIC Care Act to expand innovation through technology. In particular, the Academy strongly supports the elimination of the originating site geographic restriction on reimbursement for telestroke services. Removal of this barrier to telestroke care will increase stroke care coordination, improve patient outcomes, and ultimately reduce Medicare and Medicaid expenditures.

In addition to removing the originating site requirement for telestroke services, the Academy appreciates the increased authority and flexibility provided to accountable care organizations (ACOs) and Medicare Advantage plans regarding telehealth services. These changes will significantly improve patient care and help drive health care innovation.

Thank you for your leadership on this critical issue and we look forward to working with you to advance this critical legislation. Please contact Mike Amery at *mamery@aan.com* if you have questions or request additional information.

Sincerely,

Terrence L. Cascino, MD, FAAN
President, American Academy of Neurology

April 19, 2017

L.A. Care
HEALTH PLAN

John Baackes
Chief Executive Officer

The Honorable Orrin Hatch
U.S. Senate
Washington, DC 20510
The Honorable Johnny Isakson
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
U.S. Senate
Washington, DC 20510
The Honorable Mark Warner
U.S. Senate
Washington, DC 20510

Subject: S. 870, CHRONIC Care Act of 2017

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

On behalf of L.A. Care Health Plan, a public health plan, serving over two million Medicaid and Medicare enrollees, I thank you for the introduction of S. 870, Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017.

L.A. Care participates in California's Cal MediConnect program, under the Centers for Medicare & Medicaid Services Financial Alignment Initiative to test integrated care and financing models for dual eligible beneficiaries. L.A. Care has approximately 15,000 dual eligibles enrolled in our plan. The CHRONIC Care Act would make all SNP types permanent, which will strengthen and improve the SNP program and enable it to fulfill its mission of providing specialty care to millions of our nation's most vulnerable beneficiaries with multiple chronic conditions and socio-economic needs.

We are pleased that the legislation also strengthens the role of the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services (CMS). By making this office a point of contact for states and enabling it to develop regulations and guidance for a unified grievance and appeals process, it will improve care delivery for the millions of beneficiaries who are dually eligible for Medicare and Medicaid, whom as you know, are the most costly and complex group of beneficiaries in our nation.

California's program has achieved significant reductions in long-term care days, inpatient days, and emergency room visits. This program is working in California and has improved the care of this very vulnerable population and has delayed institutionalization for many enrollees. In California, there is a high rate of satisfaction among beneficiaries in the program.

We thank you for your leadership on this important policy and look forward to working with you to pass this important legislation.

Sincerely,

John Baackes

American College of Physicians
Leading Internal Medicine, Improving Lives

April 20, 2017

The Honorable Orrin Hatch
Chairman, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
Co-Chairman, Chronic Care Working Group
U.S. Senate
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

On behalf of the American College of Physicians, I am writing to express our support for S. 870, *The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*. This legislation is the result of your bipartisan effort that started in 2015 with the release of a chronic care policy options document that was developed with the guidance and input of stakeholders, including ACP. We commend you for introducing this legislation in the 115th Congress. This letter will provide our views on the legislation concerning specific provisions that we support, as well as detail our suggestions for additional sections that would strengthen services provided to patients with chronic illness.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP-SUPPORTED PROVISIONS

We would like to highlight several important provisions in the legislation that are consistent with ACP policy and thank the committee for having included, in some cases, specific ACP recommendations from prior communications.

- **Section 101- Extending the Independence at Home Model of Care**

  The Independence at Home Model of Care is a demonstration project under Medicare to test a payment incentive and service delivery model that uses physician and nurse practitioner-directed home-based primary care teams for Medicare beneficiaries with multiple chronic illness. This section would extend this demonstration for an additional

two years. ACP is supportive of this model of care and supports expanding this demonstration project if results continue to be positive.

- **Section 303- Increasing Convenience for Medicare Advantage Enrollees Through Telehealth**

  This section would allow a Medicare Advantage plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B. ACP is supportive of this policy as it would expand the role of telemedicine as a method of health care delivery that may enhance patient care.

- **Section 305- Expanding Use of Telehealth for Individuals with Stroke**

  This section would expand the ability of Medicare beneficiaries presenting with stroke symptoms to receive a timely consultation via telehealth to determine the best course of treatment, beginning in 2018. ACP is supportive of this policy as we support lifting the geographic restriction for the purposes of identifying and diagnosing strokes through telehealth.

- **Section 401- Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization**

  This section would give Accountable Care Organizations (ACOs) in the Medicare Shared Savings Plan the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. ACP is supportive of this section as we encourage giving ACOs the choice to have retrospective or prospective assignment of beneficiaries and allowing beneficiaries to voluntarily align with their main doctor for ACO assignment.

ACP RECOMMENDATIONS FOR IMPROVEMENT

We would also like to provide our recommendations for two additional sections that we respectfully request that you add to the bill that will improve care management codes for individuals with chronic conditions and encourage the use of chronic care management services.

Improving Care Management Codes for Individuals with Multiple Chronic Conditions

This legislation does not address the issue of new chronic care management codes, as was initially referenced in the Chronic Care Working Group Options Document. While we acknowledge this was likely due to the fact that CMS did address it in the FY 2017 Final Rule on the Physician Fee Schedule, we believe this warrants attention by the

committee within legislation because there is a 40 minute time gap for chronic care management services not recognized by the existing CCM codes in the final rule.

As you are aware, the 2017 Medicare Physician Fee Schedule Final rule established a new Complex Chronic Care Management code for doctors that provide Complex Chronic Care Management services to patients that last at least 60 minutes in length and for each additional 30 minutes thereafter, which ACP supports. CMS currently provides a code for Chronic Care Management services that last at least 20 minutes but has failed to initiate any new codes for these services that last between 20-40 and 40-60 minutes. ACP remains concerned that the fee schedule fails to adequately value chronic care services between 20-60 minutes, which could lead to more barriers to care for chronic care patients.

ACP Recommendation

We urge the Committee to include a section on Improving Care Management for Individuals with Multiple Chronic Conditions that would require CMS to establish two new codes (perhaps initially as G codes) that would recognize the value of care for clinicians who treat patients with chronic care conditions between 20-40 minutes and 40-60 minutes.

Encouraging Beneficiary Use of Chronic Care Management Services

ACP is disappointed that this legislation does not address the issue of beneficiary cost-sharing, as was initially referenced in the Chronic Care Working Group Options Document. This proposed policy would waive the beneficiary co-payment associated with the current chronic care management code as well as the complex chronic care management code that was recently approved by CMS. We believe waiving this beneficiary co-payment is critical in the effort to improve care to individuals with chronic conditions and it would require a legislative remedy to do it, as explained by CMS.

Waiving beneficiary cost-sharing, both the co-insurance and deductible, will incentivize beneficiaries to receive these CCM services. Currently, physicians are required to get authorization from patients to initiate CCM services—this is a means of ensuring that these patients are aware of these services and remain engaged partners. As a part of the discussion around this authorization, physicians notify patients that they will be responsible for the co-payment amount associated with CCM. At the time of this discussion, the physician is likely unaware of any supplemental coverage that the patient may have so they must inform the patient that he or she may be required to pay the copayment amount. If the discussion of a co-payment were no longer required because of the elimination of beneficiary cost-sharing, physicians would be more likely to have the discussion with beneficiaries about providing the CCM services that the patient needs. Further, waiving cost-sharing would eliminate any unintended

discriminatory impact on beneficiaries of modest means, who more likely will not have any supplemental coverage.

ACP Recommendation

We urge the Committee to include a section that would move chronic care management services to the preventive services category under Medicare FFS to eliminate any beneficiary cost sharing associated with these services. Alternatively, you could insert a provision in this bill that would allow CMS to give physicians the option of routinely waiving the copay for chronic care management codes for patients with chronic conditions.

In conclusion, ACP appreciates your sustained effort to improve the quality of care provided to patients with chronic illness. We look forward to working with you to improve and advance this legislation and welcome the opportunity to provide feedback whenever needed. Should you have any questions regarding this letter, please do not hesitate to contact Brian Buckley on our staff at bbuckley@acponline.org or by phone at 202-261-4543.

Sincerely,

Jack Ende, MD, MACP
President

HEALTHCARE
LEADERSHIP
COUNCIL

April 13, 2017

Senator Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Senator
Committee on Finance
United States Senate

The Honorable Mark Warner
Senator
Committee on Finance
United States Senate

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

Thank you for your leadership of the Senate Finance Committee Chronic Care Working Group. The introduction of S. 870, the "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act," represents an important step forward in strengthening and improving health outcomes for Medicare beneficiaries with chronic conditions.

The Healthcare Leadership Council (HLC) is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies—advocate measures to improve the quality and efficiency of healthcare by emphasizing wellness and prevention, care coordination, and the use of evidence-based medicine.

Like the Working Group, HLC's members share a strong commitment to improving care for Medicare beneficiaries with chronic conditions. Our members are at the forefront in implementing and developing policies designed to manage disease, streamline care coordination, and reduce Medicare costs. We strongly believe in the results of these programs.

HLC was pleased to have been part of the Working Group's efforts, and we are happy to see many of our recommendations included in the CHRONIC Care Act. We are glad to support this legislation.

Thank you again for your work on behalf of Medicare beneficiaries with chronic conditions. HLC applauds your leadership on this important issue, and looks forward to continuing to work with you. If you have any questions, please do not hesitate to contact Debbie Witchey at 202-449-3435.

Sincerely,

Mary R. Grealy
President

SNP Alliance
A National Nonprofit Leadership Organization
The National Voice for Special Needs and Medicare-Medicaid Plans

The Honorable Orrin Hatch
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
U.S. Senate
Washington, DC 20510

April 18, 2017

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

I am writing on behalf of the 27 members of the Special Needs Plan (SNP) Alliance to thank you and your staffs for the introduction of S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. I know this proposal reflects countless hours of work from you and your staffs as well as a great deal of input from a wide range of stakeholders, including the SNP Alliance. Your commitment to finding a bipartisan approach to improving how chronically ill Medicare beneficiaries are cared for is laudable and one that I believe is a powerful example to us all.

While there is much in the proposal of interest to the SNP Alliance, there are two provisions that we want to highlight. The first is permanent authorization of all SNP types. This policy has been the cornerstone of our advocacy efforts for over a decade, and we commend you for including it in the proposal. Ensuring that the most vulnerable Medicare beneficiaries have continued access to needed specialty care is essential to improving how we deliver chronic care.

The second provision that we want to underscore would strengthen the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services (CMS) so that it is "a dedicated point of contact for States to address misalignments that arise with the integration of specialized MA plans for special needs individuals," with responsibility for "developing regulations and guidance related to the implementation of a unified grievance and appeals process." We believe that this is essential in the ongoing effort to providing seamless, quality care for beneficiaries who are dually eligible for Medicare and Medicaid, the most costly and complex group of beneficiaries in our nation.

Again, there are other provisions of interest to the SNP Alliance, and we look forward to continuing to engage with you and your staffs in discussion about them. But we wanted to take this opportunity to express to you our gratitude for your continued persistence and commitment to these important issues.

Best regards,

Rich Bringewatt
President and CEO
SNP Alliance

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APRIL 28, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

The Better Medicare Alliance (BMA) is pleased to support your bipartisan bill, the "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017" (S. 870).

BMA is a broad alliance of more than 80 organizations, including doctors, hospitals, health systems, aging service agencies, business groups, health plans as well as beneficiaries, who support and advocate for Medicare Advantage and the innovative, quality care it delivers. As the private managed care option within Medicare, Medicare Advantage's fully-capitated, risk-adjusted framework encourages a focus on care coordination, early intervention, care transitions, and effective secondary interventions for seniors with chronic disease.

We commend your leadership in advancing a broad range of new policy options for improving the way care is delivered to Medicare beneficiaries with chronic conditions. Your legislation could not be more timely or necessary: In 2010, according the Centers for Medicare & Medicaid Services (CMS), 14% of Medicare beneficiaries with six or more chronic conditions accounted for 46% of Medicare spending.

The CHRONIC Care Act is a welcome step in the right direction, with provisions to better enable Medicare Advantage to deliver high value, quality, cost-effective health care to beneficiaries with multiple chronic illnesses. It would expand successful models of care within Medicare Advantage, including expanding telemedicine and support for beneficiaries to receive care in their homes.

Specific provisions in the CHRONIC Care Act that would bolster Medicare Advantage's proven successes in providing preventive services and coordinated care, improving chronic disease management, and pioneering value-based models include:

- **Expanding the Center for Medicare & Medicaid Innovation (CMMI) Medicare Advantage Value-Based Insurance Design (VBID) Model to all states:** The VBID model allows Medicare Advantage plans to offer supplemental benefits or reduced cost sharing to enrollees with specified chronic conditions, focused on the services that are of highest clinical value to them. The model tests whether this can improve health outcomes and lower expenditures for Medicare Advantage enrollees.

- **Permanently Extending Medicare Advantage Special Needs Plans (SNPs):** SNPs enable improved team-based care by coordinating benefits for dual-eligible, chronically ill, and institutionalized beneficiaries. Some policy changes are proposed to the SNP program,

such as requiring greater coordination for chronically ill enrollees and dual-eligible beneficiaries. Current SNP authorization expires December 31, 2018.

- **Expanding Supplemental Benefits in Medicare Advantage:** The bill would give Medicare Advantage plans greater flexibility to offer a wider array of supplemental benefits (using rebate dollars) to address chronic conditions starting in 2020. Currently, Medicare Advantage plans may offer supplemental benefits that are considered primarily health related, but other services that can help address chronic illness cannot be included, such as healthy meals and transportation to medical appointments.

- **Increasing Telemedicine Benefits in Medicare Advantage:** The bill would allow a Medicare Advantage plan to offer additional, clinically appropriate telemedicine benefits in the annual bid, above and beyond the services currently reimbursed under Medicare Part B starting in 2020. Currently, Medicare Advantage is constrained to the limited amount of telemedicine services included in Traditional Fee-For-Service Medicare, and is not able to include other innovative telemedicine services in bids. Medicare Advantage plans can choose to provide additional telemedicine benefits via supplemental benefits (using rebate dollars) with CMS approval.

Medicare Advantage is leading the way on coordinating care, reducing costs for those with chronic conditions, and empowering patients. Medicare Advantage offers an option that meets the goals of more integrated care, more patient engagement, and improved health outcomes for Medicare beneficiaries. BMA believes that the above-cited provisions will advance your goals of facilitating the delivery of high quality care, increased program efficiency, improved care transitions, better patient outcomes, and cost containment in Medicare spending.

Thank you for the thoughtful and deliberative process by which you sought stakeholder ideas in crafting the CHRONIC Care Act. We look forward to working with you and your colleagues on both sides of the aisle to enact this needed legislation.

Sincerely,

Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

Cc: The Honorable Michael Bennet
The Honorable Sherrod Brown
The Honorable Richard Burr
The Honorable Maria Cantwell
The Honorable Ben Cardin
The Honorable Tom Carper
The Honorable Bob Casey
The Honorable Bill Cassidy
The Honorable John Cornyn
The Honorable Mike Crapo
The Honorable Michael Enzi
The Honorable Chuck Grassley
The Honorable Dean Heller
The Honorable Claire McCaskill
The Honorable Robert Menendez
The Honorable Bill Nelson
The Honorable Rob Portman
The Honorable Pat Roberts
The Honorable Tim Scott
The Honorable Debbie Stabenow
The Honorable John Thune
The Honorable Patrick Toomey

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April 26, 2017

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

On behalf of Senior Whole Health and the low-income seniors that we serve, we want to thank you for introducing S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017.

Senior Whole Health provides services to over 13,000 residents of New York and Massachusetts through our Dual Eligible Special Needs Plan (SNP). We strongly support the CHRONIC Care Act, which would provide permanent authorization for Dual Eligible SNPs. This will strengthen the SNP program by providing our beneficiaries with critically needed program stability. Permanent authorization will allow our organization to continue offering specialty care to economically disadvantaged individuals with multiple chronic conditions.

We are pleased that the legislation also strengthens the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services (CMS). We, as an organization, encouraged Congress to establish this office as a point of contact for States. Coordinating both Medicare and Medicare is complex. This office encourages the development of regulations and guidance for a unified grievance and appeals process and works to ensure improved care delivery for the millions of beneficiaries who are dually eligible for Medicare and Medicaid. We believe this office should continue to coordinate care for those who are dually eligible – the most costly and complex group of beneficiaries in our nation.

We have sent letters of support to our Senators in New York and Massachusetts as well. We look forward to working with you to pass this important legislation.

Best regards,

Wayne Lowell, Chairman & CEO
Senior Whole Health

May 2, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
131 Russell Senate Building
Washington, D.C. 20510

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
475 Russell Senate Building
Washington, D.C. 20510

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

On behalf of the HealthCare Chaplaincy Network (HCCN) and its affiliate the Spiritual Care Association (SCA), I am writing to applaud your introduction of S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We commend your leadership in advancing this important legislation, which seeks to improve care for Medicare beneficiaries with chronic conditions, expand innovative care models, and facilitate telemedicine coverage. In anticipation of the Senate Finance Committee's consideration of S. 870, we also wanted to share our thoughts on potential amendments to further strengthen the legislation.

Specifically, we believe the permanent extension of the successful Independence at Home (IAH) program would help provide concrete evidence that person-centered, team-based care models—like IAH— provide better outcomes, increase efficiencies and save care resources. As a demonstration project, IAH has proven success in providing high quality care services—with greater efficiency—to Medicare beneficiaries with chronic conditions, including dementia. Moreover, two peer-reviewed studies[1], have shown IAH to reduce care costs for this vulnerable population by 12 to 17 percent. We respectfully urge the Committee to consider adopting a permanent extension of the IAH program as the legislation moves forward.

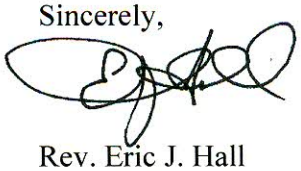
In addition, for far too long, spirituality has been disregarded and degraded as part of our health care delivery system. Yet the role spirituality plays in a person - with a chronic or fatal condition - is vital in increasing overall fulfillment, finding satisfaction in their care plan and facing the adversities that these conditions provide in both body and mind. Moreover, services and counselling provided by spiritual care professionals provide assistance not only to the individual, but to their family caregivers as well.

[1] *See*, "Better Access, Quality and Cost for Clinically Complex Veterans and Home-Based Primary Care", Journal of the American Geriatrics Society 62:1954-1961, 2014; "Effects of Home-Based Primary Care On Medicare Costs in High Risk Elders", Journal of American Geriatric Society, 62:1825-1831, 2014.

We were encouraged that the latest version of S. 870 again includes a Government Accountability Office (GAO) longitudinal study on effective care management for those with chronic conditions. To make certain that spiritual health is addressed as part of the study, we look forward to working with the Committee and with the GAO to ensure that the definition of interdisciplinary teams includes chaplains and other spiritual health specialists.

We stand ready to work with you and the other members of the Senate Finance Committee to ensure the role of spiritual health is properly incorporated in new models of care designed to strengthen care management and care delivery to Medicare beneficiaries with chronic conditions. Further, we would welcome the opportunity to serve as a resource on spiritual health issues as the Committee considers additional policies related to the treatment of persons with chronic conditions. Thank you again for your consideration of our views, and please do not hesitate to contact me directly if I may provide any additional information or assistance. I can be reached at 212-644-1111 x110 or ejhall@healthcarechaplaincy.org.

Sincerely,



Rev. Eric J. Hall
President and Chief Executive Officer
HealthCare Chaplaincy Network *and*
Spiritual Care Association

EJH:pac

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May 3, 2017

The Honorable Orrin Hatch
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
U.S. Senate
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
U.S. Senate
Washington, DC 20510

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

SCAN Health Plan (SCAN) applauds the Senate Finance Committee and the Bipartisan Chronic Care Working Group for reintroduction of the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017* (S.870). We strongly endorse this legislation and encourage the Senate Finance Committee and Congress as a whole to consider the comprehensive package in an expeditious manner.

We are pleased to see many of SCAN's recommendations included in the legislation. SCAN is a not-for-profit health plan that serves seniors through Medicare Advantage (MA) plans, including all forms of special needs plans (SNPs). Approximately 185,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California, making it the fifth largest not-for-profit MAPD plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high-quality care to the most vulnerable Medicare beneficiaries – those who live with multiple chronic conditions, who are eligible for nursing home care, who experience difficulty performing activities of daily living, and who may also qualify for Medicaid.

Many provisions in the bill will strengthen the Medicare Advantage program and make it easier to serve the chronically ill. In particular:

- **Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations –** The CHRONIC Care Act permanently reauthorizes all three types of Special Needs Plans (SNPs), and specifies needed structural improvements. SCAN has offered SNPs since their inception, and we thank the Committee for recognizing their value to vulnerable populations.

- **Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees** – The CHRONIC Care Act expands the testing of the CMMI Value-Based Insurance Design (VBID) Model to allow an MA plan in any state to participate in the model during the testing phase. The VBID demonstration will allow MA plans to offer supplemental benefits or reduced cost sharing to enrollees with specified chronic conditions. We believe the ability to further tailor benefits to the specific needs of beneficiaries will result in increased access to care, higher adherence rates and greater ability to remain living in the community.

- **Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees** – The CHRONIC Care Act allows an MA plan to offer a wider array of supplemental benefits, including non-medical services, to chronically ill enrollees. This new flexibility will allow health plans the ability to tailor services to the unmet needs of the individual and address multiple factors like functional and socio-economic status.

- **Ensuring Accurate Payment for Chronically Ill Beneficiaries** – The CHRONIC Care Act directs the Secretary of the Department of Health and Human Services to make changes to the Risk Adjustment Model to improve accuracy for beneficiaries with multiple chronic conditions. It is imperative for MA plans to be accurately and fairly

compensated, and we are optimistic the changes to risk adjustment described in the legislation will better reflect the true cost of serving this population.

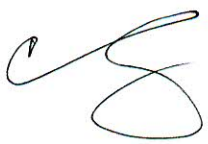
- **Increasing Convenience for Medicare Advantage Enrollees through Telehealth** – The CHRONIC Care Act allows a MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount. Expanding access to telemedicine in a responsible manner makes sense because it improves access to care for beneficiaries and gives medical providers real-time data about their patients, thus improving care.

- **Allowing End-Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan** – The CHRONIC Care Act would allow individuals with ESRD to enroll in any MA plan beginning in 2021. Access to the quality care management services provided by MA plans should be afforded to individuals with ESRD – especially those without access to an ESRD C-SNP.

- **Extending the Independence at Home Model of Care** – The CHRONIC Care Act extends the successful Independence at Home (IAH) demonstration for an additional two years and expands the number of beneficiaries involved. The model is proving that connecting providers to home with social support services not only saves money but provides better, more integrated care.

We appreciate the many years of hard work the Committee and Workgroup have invested, and remain hopeful that Congress as a whole takes up this legislation as soon as feasible. Thank you for the opportunity to be included in this thoughtful process.

Sincerely,



Chris Wing
CEO
SCAN Health Plan

AMGA
Advancing High Performance Health

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May 8, 2017

The Honorable Orrin G. Hatch
Chairman
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221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
475 Russell Senate Office Building
Washington, DC 20510

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

I am writing on behalf of AMGA to thank you and offer our support for the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, S. 870, a bipartisan bill to strengthen and improve health outcomes for Medicare beneficiaries living with chronic conditions. AMGA is a trade association leading the transformation of health care in America. Representing multispecialty medical groups and integrated systems of care, we advocate, educate, innovate, and empower our members to deliver the next level of high performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. More than 175,000 physicians practice in our member organizations, delivering care to one in three Americans.

We appreciate the time and effort the Senate Finance Committee and the Chronic Care Working Group devoted to this proposal. This bill includes a number of policy options that AMGA recommended to advance team-based care. For example, the bill allows Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) in track 1 to choose prospective or retrospective attribution. It is important that all MSSP ACOs have the option of prospective assignment so our members can know who their patients are and can develop the administrative, clinical, cultural and financial competencies necessary to eventually assume downside financial risk.

The bill would also waive the originating site requirement to allow for expanded use of telehealth services for downside risk ACOs only. As this bill moves forward, we recommend waiving the originating site requirement for all ACOs regardless of track. There is substantial evidence via the Veterans Administration, the Indian Health Service, state Medicaid programs and commercial health plans that telehealth services reduce hospital admissions and re-admissions, hospital bed days of care, and emergency department use. More generally, telehealth services also improve timely access, quality and care coordination, patient engagement, and reduce costs. Applying this wavier to the ACOs not in Track 1 needlessly limits the benefits of this technology to a very small subgroup of ACO patients. We believe all ACO beneficiaries should benefit from this important technology.

Additionally, we support provisions intended to expand supplemental benefits within the Medicare Advantage (MA) program to improve treatment of chronic conditions. We also support the provision to expand telehealth services in MA.

AMGA strongly endorses the CHRONIC Care Act of 2017 and greatly appreciates your leadership on this issue.

Sincerely,

Donn Sorenson
Chair, Board of Directors
AMGA

CareSource™

The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

May 4, 2017

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

On behalf of CareSource, I wanted to thank you for the introduction of S. 870, the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*. We would like to offer the following comments for your consideration as you further refine the proposal and address other policies that impact the most vulnerable Americans.

As you know, through the MyCare Ohio demonstration program, CareSource operates as a Fully Integrated Dual Eligible Special Needs Plan (FIDE- SNP) in Ohio, serving over 26,000 dual eligible beneficiaries. Ohio is one of the largest fully integrated dual eligible demonstrations in the nation, with over 100,000 dual eligible members currently enrolled in managed care. FIDE-SNPs and D-SNPs improve access to care and integration of services for vulnerable dual eligible beneficiaries with complex care needs.

The lynchpin to successfully caring for dual eligible beneficiaries is to not only provide for a more flexible, responsive Medicare program, but to equally provide for an adequately funded and integrated Medicaid program. While the *CHRONIC Care Act* takes steps to improve the former, the Medicaid financing policies contemplated under the *American Health Care Act (AHCA)* cause us concern. These proposals will inevitably lead to increased state fiscal pressure, which will result in difficult choices for states about eligibility, benefits and provider payments. CareSource is an advocate of bending the health care cost curve for those with chronic conditions, but we should do so by driving integrated care delivery and coverage models.

While we urge Congress to take steps to ensure the Medicaid program's future viability, we highlight several key components of the *CHRONIC Care Act* that enhance our efforts serve Americans with complex care needs:

- Section 201 of the *CHRONIC Care Act* would make all SNP types permanent, and by 2022, require D-SNPs to integrate Medicare and Medicaid long-term services and supports and/or behavioral health service. These welcome and needed policies will strengthen and improve the SNP program--enabling plans to fulfill their mission of providing cohesive specialty care to millions of our nation's most vulnerable beneficiaries with multiple chronic conditions and greater socio-economic needs. This section also strengthens the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services (CMS). By making this office a point of contact for States and enabling it to develop regulations and guidance for a unified grievance and appeals process, it will improve care delivery for the millions of beneficiaries who are dually eligible for Medicare and Medicaid, whom as you know, are the most costly and complex group of beneficiaries in our nation.

- Section 301 of the bill will allow Medicare Advantage (MA) plans like CareSource to participate in the Center for Medicare and Medicaid Innovations (CMMI) Value-Based Insurance Design (VBID) Model. We have advocated for an expansion of the model to allow for new participants and appreciate this opportunity to offer innovative, flexible MA plan designs across all of our markets.

- Finally, we appreciate section 302 of the bill that contemplates an expansion of Medicare Advantage plans' supplemental benefit offerings to allow for non-medical, social service-related benefits to be considered. Given that non-medical services contribute a significant impact to consumers' health outcomes, we support any effort to more fully integrate physical, mental/behavioral, and social determinants of health across all of our health plan product offerings. For instance, we have taken steps within our Medicaid offerings to establish a program, *Life Services,* which integrates these services with support from case managers and life coaches. We holistically address any need (including such things as housing adequacy, nutrition, or transportation) preventing a consumer from moving off of government subsidies and into a life of self-sufficiency. Under section 302, such a program could be adapted to meet a wider array Medicare recipients' needs, providing them with a more comprehensive, effective pathway to wellbeing.

We look forward to working with you to pass this important legislation.

Best regards,

Anthony D. Evans

Anthony D. Evans
Senior Vice President, Integrated Care and Home Health Services

American Heart Association | American Stroke Association
life is why

Advocacy Department
1150 Connecticut Ave., NW | Suite 300 | Washington, DC 20036
P 202-785-7900 | F 202-785-7950 | www.heart.org

May 9, 2017
Senate Committee on Finance
219 Dirksen Senate Office
Building Washington, DC
20510-6200

Re: Chronic Care Act of 2017

Dear Chairman Hatch, Ranking Member Wyden, Sen. Isakson, and Sen. Warner:

On behalf of the American Heart Association, including the American Stroke Association and our more than 30 million volunteers and supporters across the country, we congratulate members of the Finance Committee for the significant effort they have given to the goal of improving health outcomes for Medicare beneficiaries living with multiple chronic conditions.

Our organization is dedicated to building healthier lives, free of cardiovascular disease (CVD) and stroke. While we have made tremendous progress towards achieving this goal, we know that many in the Medicare population still live with high blood pressure, high cholesterol, coronary heart disease, heart failure, or stroke – with many beneficiaries suffering from more than one of these and other conditions. That is why we remain committed to working with you to address these leading causes of death and disability and to ensure that patients suffering from these diseases receive high quality, coordinated care.

Your legislation, if enacted, would allow patients to receive care that meets their unique chronic health care needs, as well as create incentives for the provision of coordinated care services to high-cost Medicare beneficiaries. This represents an important step forward in moving the Medicare program away from a system based on episodic care to a more responsive and comprehensive health care program. We are particularly grateful that Congress included a provision that would expand the use of telehealth for individuals with stroke.

Expanding the Use of Telehealth for Individuals with Stroke
We thank Congress for including our recommendation to expand access to telestroke for Medicare beneficiaries. Telehealth can make care more accessible and affordable while reducing widespread access disparities,

particularly those attributable to geography or provider shortages. Telehealth is particularly valuable to vulnerable patients with CVD or stroke who, because of their geographical location, physical disability, advanced chronic disease, or difficulty with securing transportation, may not otherwise access specialty healthcare services. As we described in our June 2015 letter, allowing Medicare to reimburse for telestroke services that originate in urban and suburban areas, as well as in rural areas, increases stroke care coordination among providers; incentivizes the appropriate level of care for stroke patients; and, facilitates the delivery of high quality care and improves patient outcomes all while reducing Medicare spending. Despite the many benefits, telehealth continues to be underutilized for the management of CVD and stroke. This bill takes a significant step towards improving both the quality and timeliness of care for stroke patients through telemedicine.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

We also appreciate Congress' recognition of the role that telehealth can play in increasing the accessibility and effectiveness of care for patients with other chronic conditions and the attention paid to it in several of the proposed policy options. We support permitting Medicare Advantage (MA) plans to include certain telehealth services in its annual bid contract. In doing so, the services offered should not be limited to those allowable under traditional Medicare, but instead include additional services, such as on-line internet assessments, critical care (i.e. telestroke), computerized clinical data analysis, the collection and interpretation of physiological data (i.e. "store and forward" and remote patient monitoring technologies), and mobile health technologies such as smartphone applications, biosensors, and wireless implantables.

Providing ACOs the Flexibility to Expand Use of Telehealth

Similarly, we support the provision to increase Accountable Care Organizations (ACO) flexibility to expand the use of telehealth. Eighty percent of Medicare beneficiaries reside in a Metro area. Medicare's current requirement falsely presumes that individuals automatically have access to care if they live within a "big city" and this limitation also aggravates current racial disparities in the healthcare system. Because telehealth technologies have been shown to reduce unnecessary hospital visits for heart disease and stroke patients, it is vital that current geographic and originating site barriers be removed. A waiver from section 1834(m) would be a significant policy change that would go a long way in providing more ACOs with the flexibility to provide telehealth services for heart disease and stroke patients who otherwise would not receive care. In this way, we support removing the geographic requirement for currently-reimbursable originating sites, and including those which lie in a metropolitan country.

Adapting and Expanding Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

We support proposals that would give MA more flexibility to vary benefit structures based on chronic conditions and offer a wider array of supplemental benefits than they currently do, by allowing plans to encourage beneficiaries to select high quality, cost effective health care services. Designing plans that offer preventive care, wellness visits, and certain high value treatments, such as medications to control blood pressure at little or no cost to beneficiaries can promote prevention, healthy behaviors, and treatment adherence, all of which may save money by reducing future costly medical procedures.

Study on Medicare Synchronization

We believe the GAO study of the feasibility of implementing medication synchronization programs in Medicare and its findings can play a key role in developing more effective medication adherence programs. There is an array of reasons why patients with heart disease do not take their medicines as prescribed, and these patients are more likely than adherent patients to have adverse health events that increase costs to them and the health care system. Policies that seek to reduce barriers and increase adherence for patients with a chronic disease must be tailored to the unique needs of each patient and medication synchronization is a promising mechanism to do that. Therefore, we support the inclusion of language that would require a study to examine the feasibility of implementing medication synchronization programs in Medicare.

Study on Obesity Drugs

We also support the inclusion of a study on obesity drugs in the final policy proposal. Obesity is a primary target for the American Heart Association's efforts to improve the cardiovascular health of all Americans by 20 percent by 2020. We believe that the type of research proposed in this policy option is critical to informing efforts to bring about reductions in obesity across all ages, races, ethnicities, and genders. To this end, we are offering a few suggestions as to how to best structure the study so that it is most effective for these efforts.

A complex disorder, obesity is a major health risk factor linked to increased CVD, stroke, cancer, hypertension, diabetes, and early death. Obesity is also costly. In 2010, the estimated nationwide cost for obesity was $315.8 billion. If current trends continue, the costs of obesity could reach 16 percent to 18 percent of U.S. health expenditures by 2030.

Obesity drugs can be an important complement to lifestyle and behavior changes that should be the focus of obesity treatment regimens. The drugs may produce weight loss by biologic means or reinforce behavior change. They may also have health benefits beyond weight loss. It is necessary, therefore, that the report's research protocol account for and address these different levels of impact and roles for obesity drugs. Given the significant economic impact of the condition, an economic analysis on cost-effectiveness as part of the research would also be very informative.

We applaud the Finance Committee for addressing the challenging issues related to caring for Medicare patients with multiple chronic conditions. We greatly appreciate the thought and deliberations that went into the development of this bill and we thank you again for the opportunity to express our strong support. If you have any questions or would like to discuss any of these comments further, please contact Madeleine Konig at madeleine.konig@heart.org or Stephanie Curtis at stephanie.curtis@heart.org.

Sincerely,

Steven R. Houser
President

TELADOC

May 10, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden,

We are writing today to offer our strong support for S. 870, the "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017." The CHRONIC Care Act represents an important bipartisan milestone in federal efforts to expand telehealth services to patients. It includes many of the telehealth initiatives that we have recommended and that the Senate Finance Committee's Chronic Care Working Group included in earlier draft versions of this legislation.

Teladoc, the nation's largest and oldest telehealth company in the United States providing high quality 24/7 access to primary care services, specifically supports the CHRONIC Care Act's provisions to: (1) expand telehealth services to beneficiaries enrolled in Medicare Advantage Plans (MA) by including telehealth in the MA bid amount; (2) expand telehealth benefits to beneficiaries participating in Accountable Care Organizations (ACOs); (3) allow remote patient monitoring through telehealth for patients with chronic conditions, such as those with end-stage renal disease, through both ACOs as well as the traditional fee-for-service Medicare program; and (4) eliminate Medicare's overly restrictive originating site geographic restrictions for stroke patients and certain patients with ESRD who are receiving treatments in their homes. Taken together, these initiatives would represent significant bipartisan progress to improve access to quality coverage for millions of Medicare beneficiaries.

We understand that many of the sponsors of the CHRONIC Care Act support even broader expansion of telehealth services, but are constrained by current Congressional Budget Office conventions to limit the bill's telehealth expansions primarily to portions of Medicare that are at-risk. To that end, Teladoc looks forward to continuing to work with you and your colleagues to make the same high-quality, cost-effective telehealth services that are now widely offered in the commercial market, such as behavioral health services and primary care for simple non-emergent illnesses, available to all Medicare beneficiaries.

Thank you for your commitment to improving Medicare for chronically ill beneficiaries. Teladoc appreciates the opportunity to inform the creation of the Chronic Care Act through comment letters and in person and looks forward to continued collaboration with the Senate Finance Committee and your colleagues throughout Congress to help advance concrete

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initiatives that will improve the lives and health of beneficiaries by making telehealth services more widely available.

Sincerely,

Claudia D. Tucker
Vice President Government Affairs
Teladoc

cc:

The Honorable Johnny Isakson
The Honorable Mark Warner
The Honorable Michael Bennett
The Honorable Benjamin Cardin
The Honorable John Thune
The Honorable Robert Casey
The Honorable John Cornyn
The Honorable Michael Crapo
The Honorable Chuck Grassley
The Honorable Thomas Carper
The Honorable Debbie Stabenow
The Honorable Claire McCaskill
The Honorable Pat Roberts
The Honorable Bill Cassidy

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May 12, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

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

The Association of American Medical Colleges (AAMC) applauds the continued bipartisan approach of the Senate Finance Committee to improve care and outcomes for Medicare patients with chronic conditions and welcomes the reintroduction of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. As the organization that represents the central care providers for the nation's most challenging and complex patients, the AAMC supports the underlying tenants of the bill to streamline Medicare's payment system to incentivize the appropriate level of care, increase care coordination among individual providers across care settings who are treating individuals living with chronic illnesses, and to facilitate the delivery of high quality care.

The AAMC is a not-for-profit association representing all 147 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 residents.

Academic medical centers (AMCs), which include clinical faculty providing care to patients at both inpatient and outpatient clinic settings, are leaders in providing care for clinically complex and vulnerable patients while also performing innovative research and training for the next generation of clinicians. Although they comprise only 5 percent of hospitals, AMCs provide 20 percent of hospital inpatient services to Medicare beneficiaries, 25 percent of all Medicaid inpatient care, and 33 percent of all hospital-based charity care. Often located in urban areas, AMCs care for a disproportionate share of medically underserved patients including those who lack health insurance or are covered by Medicaid, or, though insured, are residents of low-income areas. The nation's teaching hospitals are perhaps best known for providing the world's most advanced medical care to patients who are diagnosed with serious or rare illnesses, as well as those patients who have multiple, complex conditions.

The AAMC appreciates the committee's recognition of the importance of advancing team based care, expanding innovation and technology, and identifying the chronically ill population to ensure better care.

In addition, empowering individuals and caregivers in care delivery is critically important—when patients are involved and invested in their care, they often experience better outcomes.

Again, the AAMC appreciates and supports the committee's efforts to improve care for Medicare patients with chronic conditions. We look forward to continuing to engage with you to address these challenges and ensure all Americans get the care they deserve. If you would like to discuss this issue in further detail, please contact Leonard Marquez, AAMC director of government relations, at lmarquez@aamc.org or 202-862-6281.

Sincerely,

Karen Fisher, JD
Chief Public Policy Officer
Association of American Medical Colleges

CC: Leonard Marquez, director of government relations

BETTER MEDICARE ALLIANCE

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MAY 12, 2017

The Honorable Orrin Hatch
Chairman
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The Better Medicare Alliance (BMA) applauds your leadership and work with the Senate Finance Committee to improve outcomes for beneficiaries with chronic conditions by permanently authorizing Medicare Advantage Special Needs Plans (SNPs) in the bipartisan "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017" (S. 870).

BMA is a broad alliance of 85 organizations, including doctors, hospitals, health systems, aging service agencies, business groups, retiree organizations, and health plans, as well as beneficiaries. Collectively, we support and advocate for Medicare Advantage and the innovative, quality care it delivers. As the private managed care option within Medicare, Medicare Advantage is the preferred mode of health care delivery for more than 18.5 million beneficiaries. The fully-capitated, risk-adjusted framework of Medicare Advantage incentivizes innovative delivery of care focused on preventive services, primary care, chronic disease management, and integrated health services that deliver the right care in the most appropriate setting. This includes the use of new technology and care in the home, as well as partnerships with community organizations to address beneficiaries' needs and improve health outcomes.

We strongly support permanent authorization of Institutional Special Needs Plans (I-SNPs), Dual Eligible Special Needs Plans (D-SNPs), and Chronic Condition Special Needs Plans (C-SNPs), and thank the Senate Finance Committee for including this provision in S. 870. Established in 2003, SNPs are a type of Medicare Advantage plan that have the authority to provide specialized care to serve beneficiaries who are dually-eligible for Medicare and Medicaid (D-SNPs), have certain chronic conditions (C-SNPs), or receive long-term care in an institutional setting such as a Skilled Nursing Facility (I-SNPs). In addition to providing all Medicare Part A and Part B benefits, SNPs must also exceed these core benefits by providing reduced cost sharing, individualized care plans, and other tailored benefits related to mental health, social services, and wellness.

More than 2.3 million beneficiaries are enrolled in nearly 600 SNPs nationwide. SNP enrollees often have lower income, less support, and more complex medical conditions than other Medicare beneficiaries. This is why SNPs are so critical to our high need populations: they provide care tailored to high-need, complex beneficiaries through care management tools, such as care managers, interdisciplinary teams, specialized provider networks, enhanced home and community-based services, and data sharing across health plans and providers.

BETTER MEDICARE
ALLIANCE

SNPs have proven their value to beneficiaries and our health care delivery system by lowering rates of hospitalizations and readmissions. A 2012 study found that people with diabetes in C-SNPs—particularly nonwhite beneficiaries—had lower rates of hospitalization and readmission than their peers in Traditional Fee-For-Service Medicare.[1]

Permanently authorizing the SNP program will furnish health plans and providers a stable environment to allow for greater planning of and investment in the successful care models that SNPs provide to high need beneficiaries.

BMA thanks you for your dedication to furthering policies that will better enable SNPs, and Medicare Advantage to focus on prevention, coordinated care, better management of chronic conditions, and new provider payment models that reward value over volume. As a result of these innovative delivery models, Medicare Advantage is enhancing Medicare beneficiaries' health and well-being, while driving improvements in care delivery. Passage of your legislation will help to build on these successes.

We stand ready to support you and your colleagues as you work to advance the important policies in the CHRONIC Care Act.

Sincerely,

Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

cc: Members, United States Senate Committee on Finance

[1] Robb Cohen, Jeff Lemieux, Jeff Schoenborn, Teresa Mulligan, "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients," *Health Affairs*, January 2012 vol. 31 no. 1 110-119.

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May 12, 2017

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

via Electronic Submission

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Re: Letter in Support of S.870—CHRONIC Care Act of 2017

Chairman Hatch and Ranking Member Wyden:

On behalf of Almost Family, Inc. (AFAM), we appreciate the opportunity to write in support of S.870, Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We compliment the chronic care working group's efforts to improve care for the growing number of Medicare beneficiaries with chronic conditions and appreciate its consistent outreach in soliciting stakeholder input in the evolution of policy. To date we have submitted three comment letters on this subject and presented before joint Senate Finance Committee staff in October 2015. As strong supporters of the bill, we are grateful for this opportunity to reengage the Committee and look forward to future discussions around these and other topics.

Our company brings a unique perspective to the chronic care management discussion due to significant involvement in the following areas:

- Our provision of skilled in-home nursing care helps add value to Medicare by keeping beneficiaries in their own homes and shortening or avoiding costly admissions to hospitals or SNFs.
- Our provision of personal care services gives us valuable experience caring for patients with long-term care needs and dual-eligibles, while they remain in their own homes.
- Our recently announced joint venture agreement with Community Health systems is the nation's largest such partnership and affords us the opportunity explore new ways to promote greater clinical alignment between home health and hospital systems.
- Ingenios Health, an AFAM subsidiary, provides comprehensive in-home health risk assessments, primarily for MA payers. We believe repurposing, or dual-purposing, this service platform could be invaluable in addressing the needs of the chronically ill.

- Imperium Health Management, another AFAM-owned subsidiary, provides strategic management services to 15 accountable care organizations (ACOs) in 10 states, linking primary care physicians with homecare for the purpose of delivering savings to Medicare.

Our unique experiences and capabilities give us valuable insight into all three categories of Medicare: Traditional Medicare, Medicare Advantage and MSSP ACOs. In the remainder of this document we discuss specific areas we support in S.870 and offer minor suggestions for ways we think it can be improved.

Sec. 101—Extending the Independence at Home Demonstration Program

We support extending the Independence at Home (IAH) Demonstration Program. IAH allows chronically-ill patients to be cared for in their own homes, which is the patient-preferred and lowest-cost delivery setting. As we have written before, the focus of our healthcare delivery system should be on providing treatment to patients while they remain in their own homes whenever possible. When not possible, the objective should be to return these patients to their homes at the earliest, safest and most cost-effective point in their journey. Once back home, the goal should be to keep them there and out of higher-cost institutional settings for as long as possible. We support extension of IAH as a meaningful step in the right direction.

Sec. 201 & Sec. 302—Select Proposals Related to Medicare Advantage Plans

A. Sec. 201—Providing continued access to Medicare Advantage special needs plans for vulnerable populations.

We support providing continued access to MA special needs plans (SNPs) for vulnerable populations. In addition, we propose authorizing community-based institutional special needs plans (CBI-SNPs), in line with legislation introduced in the 114th Congress by Senators Grassley and Cardin that would establish a demonstration project to provide eligible beneficiaries enrolled in select MA plans with certain community-based long-term services and supports. Such services and supports include bathing, dressing, housekeeping, transportation and respite for a primary caregiver. The objective behind CBI-SNPs is to allow patients to age in place for as long as possible. We support providing continued access to SNPs for the approximately 30% of seniors who elect MA coverage, including CBI-SNPs, but encourage the working group to consider adopting similar proposals for the remaining 70% who choose Traditional Medicare.

B. Sec. 302—Expanding supplemental benefits to meet the needs of chronically-ill Medicare Advantage enrollees.

We support proposals to allow MA plans to expand supplemental benefits to meet the needs of chronically-ill patients, but encourage the working group to consider testing demonstrations that mirror these objectives within the Traditional Medicare population, as well. MSSP ACOs, for example, are working to coordinate care for beneficiaries enrolled in Traditional Medicare and create savings for the Program. We believe beneficiaries participating in MSSP ACOs should have the same access to supplemental benefits as beneficiaries enrolled MA plans.

Sec. 304, Sec. 401, Sec. 501—Proposals Related to Accountable Care Organizations

We strongly support and compliment the working group's focus on strengthening MSSP ACOs. With the proper adjustments, ACOs have shown great promise and potential for long-term success in improving

quality and achieving savings for Medicare. As we have written before, reforms in this space should emphasize the management of patients through routine interventions in their own homes, so as to prevent worsening of chronic conditions that may otherwise result in costly institutional admissions. Instead of focusing on systems to reduce hospital readmissions, adoption of cost-effective homecare interventions can greatly reduce hospital admissions before they occur.

A. Sec. 304—Providing accountable care organizations the ability to expand the use of telehealth.

We strongly support expanding the use of telehealth for ACOs, but recommend it be done for both one-sided and two-sided risk models. In 2016, of the total 433 ACOs participating in the MSSP, 411 (95%) had chosen one-sided risk.[1] While there is an important role to play for two-sided risk ACOs, we do not believe all answers lie in a two-sided risk solution. At this early stage in the program, we believe policymakers should focus on fostering greater physician engagement through development of a viable one-sided risk model. In our experience, the innovative physicians participating in our ACOs are only willing to graduate to two-sided risk when they are confident they can compete, and win, under one-sided risk first.

B. Sec. 401—Providing flexibility for beneficiaries to be a part of an accountable care organization.

We strongly support providing greater flexibility for beneficiaries to participate in ACOs. While we maintain the single greatest impediment to the success of MSSP ACOs is lack of funding, allowing the choice of prospective assignment, assignment based on voluntary identification and creation of a notification process for beneficiaries participating in ACOs are meaningful steps in the right direction.

C. Sec. 501—Eliminating barriers to care coordination under accountable care organizations.

We strongly support eliminating barriers to care coordination under ACOs by establishing an incentive program to encourage beneficiaries to obtain medically necessary primary care services. However, we believe any such incentive program should be available to both one-sided and two-sided risk models. Our physician-led ACOs are constantly looking for new ways to engage patients and incentivize healthy behaviors. Allowing them to reward patients who obtain medically necessary primary care services is one way to achieve this goal. Since there is no additional federal funding offered under the incentive program, the cost of opening it to one-sided risk models would be revenue-neutral, while the benefits could potentially be significant.

Sec. 502—GAO Study and Report on Longitudinal Comprehensive Care Planning Services under Medicare Part B.

We strongly support commissioning a GAO study and report on establishing a new payment code for longitudinal comprehensive care planning services under Medicare Part B. This proposal mirrors an idea we presented in two submissions and in-person meetings with the Committee to establish a new benefit within Traditional Medicare, specifically for the management of chronically-ill patients.

[1] David Glass, Jeff Stensland and Sydney McClendon, Medicare Payment Advisory Commission (MedPAC), "Status Report on Medicare Accountable Care Organizations (ACOs)." Oct. 6, 2016, slide 4. Retrieved from: http://www.medpac.gov/docs/default-source/meeting-materials/statusreportonmedicareaccountable_oct16_pres_sec.pdf?sfvrsn=0.

Under our proposal, medical professionals would use a comprehensive assessment to screen at-risk patients for inclusion in the "Chronic Illness Program." As part of the program, participants would have access to a "care management benefit," which would include annual assessments, long-term care planning services, patient engagement tools and wraparound services to provide medically necessary care to chronically-ill patients in their communities.

We believe a GAO study and report on longitudinal comprehensive care planning services is a significant step in the right direction and applaud the working group's efforts to explore ways to meet the long-term care needs of chronically-ill Medicare beneficiaries.

We appreciate this opportunity to share our comments and look forward to continuing to work with you and your staff on these and other reforms. We welcome the opportunity to participate in further stakeholder discussions and/or legislative hearings on improving the lives of Medicare beneficiaries living with chronic conditions. If you have any questions, please do not hesitate to contact me by phone at 502-891-1000 or email at denisfleming@almostfamily.com.

Sincerely,

Denis Fleming
Vice President of Government Relations
Almost Family, Inc.

CC: William Yarmuth, Chairman and CEO, Almost Family, Inc.;
Steve Guenthner, President, Almost Family, Inc.

NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

May 12, 2017

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

Dear Chairman Hatch & Ranking Member Wyden:

I write today to offer the National Coalition on Health Care's support for key provisions of S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, and to suggest steps to further strengthen the legislation as it moves forward.

NCHC is the nation's largest, most broadly representative nonpartisan alliance of organizations focused on health care. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy—an affordable, high-value health care system for patients and consumers, employers and other payers, and taxpayers. Our members and supporters include nearly 90 of America's largest and leading associations of health care providers, businesses and unions, consumer and patient advocacy groups, pension and health funds, religious denominations, and health plans. Our member organizations represent—as employees, members, congregants, or volunteers—more than 150 million Americans.

NCHC applauds the introduction of this legislation and commends your efforts on chronic care, an issue that is vital to affordability in Medicare and across our health care system. We are pleased to support the following provisions:

- Section 201, Providing Continued Access to Medicare Advantage (MA) Special Needs Plans for Vulnerable Populations: MA Special Needs Plans have served as incubators for promising delivery and benefit innovations, enabling plans to develop new ways of managing chronic disease and coordinating care for some of the sickest Medicare enrollees. This important provision ensures that they can continue to play that role.

1111 14TH STREET, NW, SUITE 900, WASHINGTON, DC 20005 | (202) 638-7151 | NCHC.ORG

- Section 301, Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees: NCHC supports the expansion of the MA VBID demonstration to all fifty states and U.S. territories. As currently implemented, this demonstration includes important beneficiary protections, including the requirement that cost-sharing is reduced rather than increased and uniform notice requirements. The national expansion of this model test can better inform the development of future reforms to align benefit structures with ongoing value-based provider-payment reforms and lower cost barriers to needed care.

- Section 302, Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees: This important provision will ensure plans can deploy services that may not be covered under Medicare but can improve health outcomes and lower costs. Examples of such services should include, but need not be limited to, non-covered transportation, nutrition, in-home support services, behavioral health services, palliative care services, home improvement, communication devices, caregiver training and support, assistive devices, and remote patient monitoring systems.

- Telehealth Provisions: Certain telehealth provisions of the CHRONIC Care Act are consistent with NCHC-supported telehealth legislation—the CONNECT for Health Act (S. 1060). We are pleased to support the following provisions:
    - Section 102, Expanding Access to Home Dialysis Therapy
    - Section 304, Providing Accountable Care Organizations the Ability to Expand the Use of Telehealth
    - Section 305, Expanding Use of Telehealth for Individuals with Stroke

- Section 401, Providing Flexibility for Beneficiaries to be Part of an ACO: This provision makes needed improvements to the Medicare Shared Savings Program, including the option to assign beneficiaries to ACOs prospectively in all MSSP tracks and through beneficiary attestation. Should the voluntary attestation provision be enacted, we hope that you will work closely with CMS to ensure a robust coordination and outreach effort that extends beyond mere notification. Properly implemented, Section 401 represents an initial down payment on the reforms that are needed to ensure ACOs realize their potential to improve Original Medicare.

As a whole, the introduced legislation has potential to improve health outcomes and lower costs over time. But given the scope of the chronic disease challenge, the Committee can and should do more—particularly with respect to the highest-cost, highest-need beneficiary populations. To that end, we urge improvement in three specific areas of the bill:

- Broaden the Expansion of Independence at Home: The expansion of the Independence at Home Practice Demonstration from 10,000 to 15,000 beneficiaries, included in Section 101, would be a constructive step. But given the success of home-based primary care in the IAH

Practice Demonstration[1] and previously at the Veterans Health Administration,[2] the Committee should not delay a broader expansion. NCHC supports the Independence at Home Act (S. 464), which converts IAH to a nationwide, voluntary program within Medicare. If it is impossible to include full conversion, the Committee should, at a minimum, expand the IAH Practice Demonstration to 50,000 beneficiaries and five years. This would allow providers in additional geographies to gain experience with this transformative care model and broaden the evidentiary base for its formal evaluation.

- Incorporate Bipartisan Steps to Support Advanced Illness Care: Advanced illness care is an important part of chronic care. During the last Congress, NCHC expressed support for S. 1549 Care Planning Act. We understand that an updated version of that legislation is nearing introduction. At a minimum, we would urge incorporation into the CHRONIC Care Act of provisions supporting advanced illness quality measure development, updating the Medicare and You handbook, and testing an Advanced Illness Care Model. Together, these policy changes can deliver meaningful improvements in outcomes and care experience for Medicare beneficiaries living with advanced stages of cancer, Alzheimer's, dementia, renal disease, heart failure, or other conditions.

- Permit MA Plans Flexibility to Invest in Non-covered Telehealth Services: As introduced, Section 303 of the CHRONIC Care Act is an important step forward, but we believe the language should be strengthened to better align with that of the NCHC-supported CONNECT for Health Act (S. 1060). Telehealth is not a separate and distinct service, but rather a modality that enables providers to deliver already covered care in a way that improves health and lowers the cost of care without increasing utilization. An overly prescriptive approach that lists specific services that are and are not permitted may limit innovation and investment in telehealth interventions with potential to achieve significant outcome improvements and cost savings.

Finally, we reiterate NCHC's support for providing ACOs and other alternative payment model entities increased clarity on their ability to furnish other upstream interventions that Medicare typically does not cover, such as social services, transportation, nutritional therapy, or remote patient monitoring. We regret that the Committee's interest in this vitally important issue, discussed in the December 2015 Policy Options document, was not directly reflected in the introduced legislation. If this issue remains unaddressed in S. 870, we would encourage the Committee to quickly turn to this topic in subsequent legislative efforts this year.

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[1] "Independence at Home Demonstration Corrected Performance Year 2 Results," Centers for Medicare & Medicaid Services, January 19, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19.html.

[2] Thomas Edes et al., "Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care," http://c.ymcdn.com/sites/www.aahcm.org/resource/resmgr/News_Room/Better_Access,_Quality,_and_.pdf.

If the National Coalition of Health Care can be of further assistance on these or other issues, please contact NCHC's Policy Director, Larry McNeely, at lmcneely@nchc.org.

Sincerely,

John Rother
President and CEO

MASSACHUSETTS

Andrew Dreyfus
President and Chief Executive Officer

April 28, 2017

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Chronic Care Working Group, Co-Chair
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
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The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
Chronic Care Working Group, Co-Chair
Senate Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

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

On behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA), I would like to congratulate you on the introduction of the CHRONIC Care Act of 2017, and offer our support for this important legislation. We applaud the Committee's thoughtful efforts to develop bipartisan legislation that will achieve our shared goals to facilitate the delivery of high quality care for beneficiaries living with chronic conditions.

BCBSMA is a not-for-profit organization that was founded seventy-five years ago by a group of community-minded business leaders. Our history – and our future – is one of collaborating with the community to improve the health and quality of care that our members, and all citizens of the Commonwealth, receive. At BCBSMA, our vision is a transformed health care system that provides safe, timely, effective, affordable, patient-centered care for all.

As a nationally-recognized Medicare Advantage health plan, we are proud of our achievements in delivering high quality products and service to our members. CMS awarded our Medicare Advantage HMO Plan and our Prescription Drug Plan the highest rating of 5 Stars. Furthermore, we are always looking for ways to innovate and improve the products we offer to our members. For example, this year, we became a pioneer participant in the Centers for Medicare and Medicaid Innovation Medicare Advantage Value-Based Insurance Design Model, and have applied to continue in 2018.

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MASSACHUSETTS

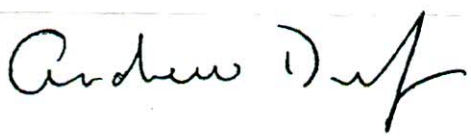
Andrew Dreyfus
President and Chief Executive Officer

One key component of our value-based benefit offering is to reduce cost share for members with a particular clinical condition. We believe that removing the cost barrier to certain medications may lead to increased compliance and medication adherence, which in turn, could improve health outcomes while also avoiding inpatient admissions. We are committed to exploring innovative benefit designs, and applaud the Committee for proposing to expand the testing of the Model through the CHRONIC Care Act.

In addition, based on our experience researching and developing our value-based insurance design, we support the Committee's proposal to allow Medicare Advantage plans the flexibility to provide targeted supplemental benefits to chronically ill enrollees. For example, all too often, Medicare beneficiaries that suffer from chronic conditions are in need of surgical interventions. A key aspect of their recovery is a nutritious diet, both from a nutritional perspective as well as a therapeutic perspective as it correlates to medication effectiveness and tolerance. For some beneficiaries, access to nutritional meals is challenging either due to financial constraints or the right level of support in their home. As a result, we recommend that Medicare allow health plans to provide supplemental benefits, under a specific set of criteria, to meet the needs of Medicare beneficiaries who require specific support at a specific time in their recovery to prevent hospital readmissions. We applaud the Committee for exploring policies to improve access to this type of high-value care for beneficiaries living with chronic conditions.

In conclusion, I want to thank the Senate Finance Committee for its leadership and true commitment to addressing the challenges facing Medicare beneficiaries with chronic conditions. We look forward to continuing to work with you to improve the health and quality of care for our nation's seniors.

Sincerely,



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Altegra Health

May 15, 2017

The Honorable Orrin Hatch, Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden, Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Johnny Isakson
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Mark Warner
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

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

On behalf of Altegra Health, I am writing to offer our support for S 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. Altegra Health commends the Senate Finance Committee and the Chronic Care Working Group for including proposals that will improve care delivery and overall quality of life for Medicare Advantage (MA) low-income beneficiaries, particularly those with socio-economic challenges.

Altegra Health supports S 870 because it provides more flexibility to provide benefits that are more tailored to their beneficiaries, particularly those with chronic conditions. In particular, S 870 would allow a MA plan in any state to participate in the Centers for Medicare and Medicaid Innovations' (CMMI) Value-Based Insurance Design (VBID) Model. Additionally, S 870 would allow a MA plan to offer a wider array of supplemental benefits to chronically ill beneficiaries beginning in 2020.

As outlined in its letter to the Finance Committee and the working group on June 22, 2015, Altegra Health helps identify and enroll MA low-income beneficiaries into Medicaid as a dual eligible, the Part D Low-Income Subsidies (LIS), and more than 13,000 community programs to which they may qualify through its COMMUNITY Link™ product. As you may know, MA low-income beneficiaries are more likely to have multiple chronic conditions. Altegra Health's experience has shown that these benefits can positively impact a MA beneficiary's overall health and well-being, as well as deliver financial assistance to those in need of these services. Additionally, MA low-income beneficiaries are more likely to be satisfied with their MA plan when their socio-economic challenges are addressed, which positively impacts the MA plan's STAR ratings.

The strongest evidence of the positive impact of Altegra Health's assistance to MA low-income beneficiaries is plan tenure. When Altegra Health calculated the average period of MA plan enrollment for over 19 million beneficiaries for the last 15 years, it found that plan tenure for those assisted with community program enrollment increased 42 percent. When those MA beneficiaries with slightly higher incomes were assisted with community program enrollment, their plan tenure increased 25 percent. Additionally, MA beneficiaries who were assisted with Medicaid enrollment remained with their MA plan 10 percent longer when assisted with community program enrollment. Community program

enrollment assistance clearly has a positive impact beyond the direct effect on an individual's care and condition profile.

Additionally, Altegra Health studied more than 7 million MA beneficiaries available for Altegra Health's community program enrollment assistance in 2016. Community program participation rates for the MA disabled population were 2.8 times higher than those for the MA aged population. Altegra Health's analysis also indicates a more severe condition profile (as expressed by total risk score) for those MA beneficiaries assisted with community program enrollment compared to those not assisted. Furthermore, those assisted with enrollment in programs that specifically targeted the beneficiary's individual needs had a higher severity medical condition profile.

As already mentioned, Altegra Health supports the bill's efforts to allow MA plans more flexibility to meet the socio-economic challenges of their low-income beneficiaries. Altegra Health urges the Senate Finance Committee to advance efforts that provide more resources for MA plans to help these beneficiaries meet these challenges. Altegra Health commends Congress for including language in the 21st Century Cures Act that would adjust the Centers for Medicare and Medicaid Services-Hierarchical Condition Category (CMS-HCC) Risk Adjustment Model by directing the Secretary of Health and Human Services (HHS) to take into account the total number of diseases, multiple years of data, and dual eligibility status; as well as require the Medicare Payment Advisory Commission (MedPAC) and the HHS Secretary to provide a study of any adjustments. Other related efforts from Congress and HHS include, but are not limited to:

- The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), as instructed by law, is studying the effect of socio-economic status on MA quality measures. As expressed in the December 2016 report, incentivizing MA plans to meet the socio-economic challenges of their low-income beneficiaries is a strategy that can improve how plans manage the care of this population.
- The Accountable Health Communities model will test whether systematically identifying and addressing the health-related social needs of beneficiaries' impacts total health care costs, improves health, and quality of care.
- S 309 would direct the HHS Secretary to establish a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program to provide home and community-based care to eligible Medicare beneficiaries age 65 or older.

Altegra Health urges the Senate Finance Committee to advance opportunities such as these where appropriate and collaborate with HHS and CMS to provide MA plans with the resources to tailor benefits for their low-income beneficiaries.

Thank you again for introducing S 870. Altegra Health believes it can be a strong resource to the Senate Finance Committee as it aims to meet the socio-economic challenges of MA low-income beneficiaries. Please feel free to reach out to me or our team if we can be of further assistance.

Sincerely,

Kevin C Barrett

Kevin C. Barrett
Senior Strategy Advisor

Clover

The Honorable Orrin G. Hatch
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

May 15, 2017

Re: Clover Health's Support of the CHRONIC Care Act

Dear Chairman Hatch and Senator Wyden:

I am writing today to offer Clover Health's ("Clover") support for provisions related to expanding supplemental benefits in S. 870, the "Creating High-Quality Results and Outcomes Necessary to Improve (CHRONIC) Chronic Care Act of 2017." We would also like to thank the Senate Finance Committee and staff for your bipartisan efforts to improve the care of Medicare beneficiaries with chronic conditions, and for your engagement with health plans and other key stakeholders throughout this multi-year process.

As background to our interest, Clover is a Medicare Advantage ("MA") insurance plan that is dedicated to advancing the way Medicare beneficiaries are cared for via capturing and analyzing data to identify at-risk beneficiaries, and proactively intervening with our care management teams and our provider network to improve health outcomes, fill care gaps and reduce avoidable costs. The Clover business model is designed to rapidly generate new care delivery approaches and test their real-world effectiveness. We began offering MA plans in 2013, and, to date, have grown to manage over 25,000 beneficiaries.

We offer our support of Section 302, related to expanding supplemental benefits to meet the needs of chronically ill MA beneficiaries. Studies show that certain key social determinants of health—social support, food and transportation—have a significant impact on health outcomes, and especially so with seniors. We believe that allowing MA plans the ability to design supplemental benefits that address social determinants of health would materially enhance beneficiary care. We also support MA plan flexibility to develop tailored interventions for chronically ill beneficiaries. With appropriate oversight from the Centers for Medicare and Medicaid Services ("CMS"), MA plans could construct customized programs to meet the specific needs of beneficiaries with multiple chronic conditions and improve health outcomes by making clinical care more individualized and more coordinated.

Clover is prepared to assist with additional information, if needed. If you have any additional questions, please do not hesitate to contact me by phone or email (415-238-1750/ brady.priest@cloverhealth.com) or Erica Pham (415-894-5701/ erica.pham@cloverhealth.com).

Sincerely,

Brady Priest
General Counsel
Clover Health

CalOptima
A Public Agency
Better. Together.

May 15, 2017

Senator Orrin Hatch
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Ron Wyden
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Support for the CHRONIC Care Act (S. 870)

Dear Chairman Hatch and Ranking Member Wyden:

I write to you in strong support of the "Creating High-Quality Results and Outcomes Necessary to Improve Care (CHRONIC) Act of 2017" and am especially pleased to see that the Act includes permanent authorization of Special Needs Plans for beneficiaries dually eligible for Medicare and Medicaid benefits (D-SNPs).

Operating in Orange County, California since 1995, CalOptima is a not-for-profit, community-based health plan that ensures delivery of high-quality, cost-effective health care to nearly 800,000 Medicaid beneficiaries. In September 2016, the National Committee for Quality Assurance (NCQA) named CalOptima the top rated Medi-Cal plan in the state for the third year in a row and among the best plans in the nation.

Since 2005, CalOptima has operated a D-SNP known as OneCare, which today covers more than 1,300 low-income seniors and people with disabilities. These enrollees are part of a highly vulnerable population, which includes the frail elderly, the disabled, and those with multiple chronic or mental health conditions. Enrollees have language barriers, limited family or social networks, and housing needs. To ensure that OneCare enrollees are well served, personal care coordinators work with them to complete health risk assessments that identify their acute, chronic, behavioral health, long-term support services and care coordination needs.

Unfortunately, D-SNPs are currently only authorized through the end of 2018, and this lack of long-term certainty about the future of the program causes concern among D-SNP enrollees, plans, providers and states. Permanent authority for D-SNPs would:

- Give confidence to enrollees and their families that the plans they chose will not sunset;
- Give certainty to states that D-SNPs will continue as a reliable option for advancing Medicare-Medicaid integration over the long term; and,
- Provide stability for plans like CalOptima so that they can continue to offer D-SNPs and invest in enhanced care coordination.

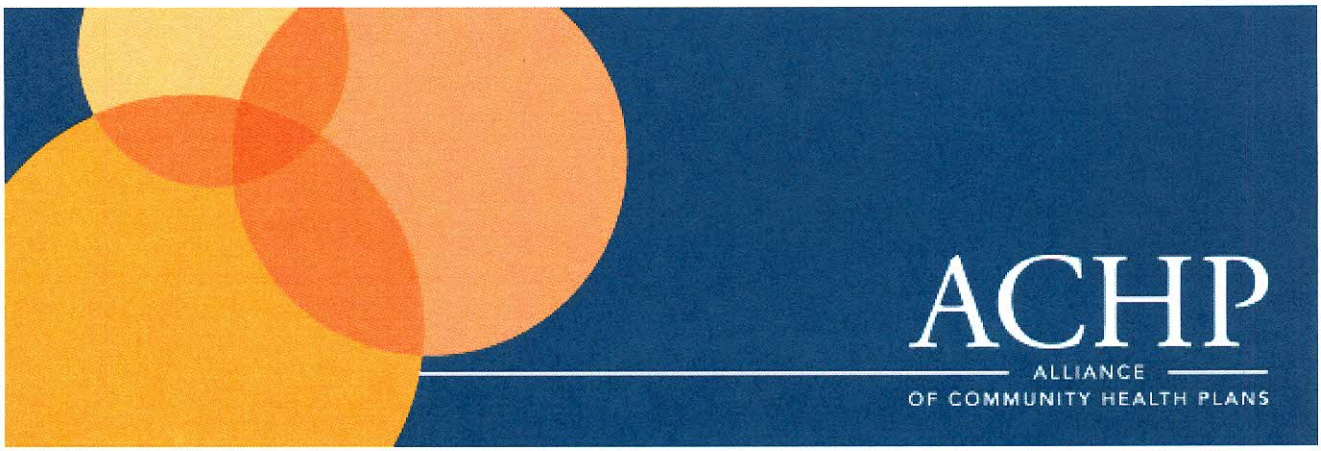
CalOptima strongly supports permanent authorization of D-SNPs and applauds the Senate Finance Committee for including this provision in the CHRONIC Care Act.

CalOptima stands ready to answer any further questions you may have about OneCare and looks forward to working with you toward ensuring certainty for D-SNP enrollees, plans, providers and states.

Sincerely,

Michael Schrader
Chief Executive Officer

cc: Senator Kamala Harris
Senator Dianne Feinstein
Representative Lou Correa
Representative Darrel Issa
Representative Alan Lowenthal
Representative Mimi Walters
Representative Ed Royce
Representative Dana Rohrabacher
Representative Linda Sanchez



May 16, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

The Alliance of Community Health Plans (ACHP) applauds the introduction of S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We thank the Senate Finance Committee and the Chronic Care Working Group for your efforts and commitment to improving the care of Medicare beneficiaries with chronic conditions. We believe this legislation makes important changes to the Medicare program which will encourage innovative and cost effective approaches to patient care delivery that will improve health outcomes.

ACHP is a national organization bringing together innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for more than 18 million Americans across 27 states and the District of Columbia, including 2.4 million Medicare beneficiaries.

ACHP supports provisions in the CHRONIC Care Act that would permanently reauthorize special needs plans, expand the MA Value-Based Insurance Design Model and expand supplemental benefits to meet the needs of chronically ill MA enrollees.

We applaud and strongly support the provision that allows MA plans to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B. We also urge the committee to reconsider language that may be unnecessarily limiting, given the pace of technological change. This language would require the Secretary to solicit comments on what types of telehealth services offered to enrollees as supplemental benefits should be considered as additional benefits. This could ultimately limit what telehealth services are included in the basic bid. Telehealth is not a separate and distinct service, but rather a modality that enables providers to deliver already covered care in a way that improves health, increases consumer convenience and lowers

the cost of care without increasing utilization. We caution against an approach that is overly prescriptive in listing specific services that are permitted and not permitted, and which may not keep up with changing technology and innovations that improve care and patient access.

Initial evidence from ACHP member plans indicates that the use of telehealth-based services does not increase costs and may, in fact, lower them. For example, in its testimony for the May 16, 2017 committee hearing, UPMC Health Plan states that a 2014 analysis of its e-visit program, "Anywhere Care," found no evidence that e-visits or other telehealth initiatives added to costs. In fact, "data indicated that members who utilized an e-visit had a lower overall cost of care for the conditions treated than members who sought the same care in an emergency room, urgent care center, primary care office, or retail clinic."

Another area of concern for ACHP is the language that states the Secretary may consider implementing the quality star rating system at the plan level for special needs plans and all MA plans. Applying the star ratings at the plan level instead of the contract level would cause beneficiary and market confusion when plans have several benefit packages in the same area. Reporting of data at the plan level will lead to small denominators for smaller, community plans like ACHP members and could cause unwarranted variations in ratings. In addition, reporting HEDIS, CAHPS, and HOS data at the plan level would lead to increased administrative burden and cost. We do not believe this issue furthers the goals of this legislation and hope that the committee will exclude this language as the legislation proceeds in the Senate.

Thank you again for introducing this important legislation. Our plans stand ready to work with you and Senators of both parties to develop market-tested solutions based on many years of experience improving the health of communities across the nation and the American health care system as a whole. As always, if you or your staff have any questions, please do not hesitate to contact me at cconnolly@achp.org or 202-785-2247.

Sincerely,

Ceci Connolly

Ceci Connolly
President and CEO
Alliance of Community Health Plans

THE MICHAEL J. FOX FOUNDATION
FOR PARKINSON'S RESEARCH

May 17, 2017

The Honorable Orrin G. Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: S. 870 CHRONIC Care Act

Dear Chairman Hatch and Senator Wyden,

On behalf of The Michael J. Fox Foundation for Parkinson's Research (MJFF), I write to express my support and appreciation for your legislation, S. 870, the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*. It is estimated that 1 million people in the United States have Parkinson's disease (PD). As the world's largest nonprofit funder of PD research, MJFF is dedicated to accelerating a cure for Parkinson's and developing improved therapies. In providing more than $700 million in research to date, the Foundation has fundamentally altered the trajectory of progress toward a cure.

With more than 80 percent of individuals with PD relying upon Medicare, the Medicare and Medicare Advantage programs play a vital and irreplaceable role in ensuring adequate access to quality healthcare for the Parkinson's population. MJFF supports the extension of the Independence at Home (IAH) demonstration under the Medicare program and supports the expansion of telehealth under S. 870.

The MJFF applauds you for your authorship of this important piece of legislation and thanks you for your continued commitment to the protection of the Medicare program and Medicare beneficiaries. Should you have any questions, please feel free to contact me at tthompson@michaeljfox.org or by phone at 202-638-4101 ext. 382.

Sincerely,

Ted Thompson, JD
Senior Vice President, Public Policy
The Michael J. Fox Foundation for Parkinson's Research

KIDNEY CARE
PARTNERS

May 17, 2017

Senate Committee on Finance
219 Dirksen Bldg.
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden and Senators Isakson and Warner,

Kidney Care Partners (KCP) applauds the introduction of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 (S. 870) and appreciates your continued efforts to improve care delivery for individuals living with chronic conditions. Proper management of chronic conditions will improve the health and quality of life for millions of individuals, while reducing system-wide health care costs.

KCP is an organization of patient advocates, nephrology professionals, dialysis providers, and manufacturers whose mission is ensure that l) individuals with chronic kidney disease (CKD) and end-stage renal disease (ESRD) receive optimal care and are able to live quality lives, 2) dialysis care is readily accessible to all those in need, and 3) research and development lead to enhanced therapies and innovative products. ESRD is an irreversible failure of kidney function that is fatal without a kidney transplant or dialysis treatments. There are more than 26 million adults living with CKD, which can lead to kidney failure if untreated. More than 636,000 Americans are living with kidney failure with about 430,000 of these individuals relying on dialysis. The number of individuals suffering from ESRD is expected to double over the next decade.

KCP supports the inclusion of policies in the CHRONIC Care Act that expands access to home dialysis therapy and permanently authorizes Special Needs Plans (SNPs).

Expanding Access to Home Dialysis Therapy

We are pleased that the legislation expands the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth. The policy will expand the number of originating sites from which the beneficiary can have a telehealth assessment with the nephrologist to include freestanding dialysis facilities and the patient's home and enables these telehealth visits to be conducted from the expanded list of sites without geographic restriction.

KCP believes the use of dialysis clinics as originating sites will increase the pool of individuals who can properly and effectively use home dialysis, particularly in rural and underserved areas. Home dialysis requires a special commitment to care, and for those individuals with the capability and support necessary to dialyze at home, the ability to use technology to have a virtual visit with their physician can improve the quality of care and quality of life for ESRD beneficiaries.

KIDNEY CARE
PARTNERS

Permanently Authorizing SNPs

We are pleased that the legislation permanently authorizes SNPs. KCP believes the tailored benefits and specific expertise of SNPs play an integral role in caring for the ESRD population. Permanent authorization of SNPs would bring a degree of certainty needed to allow these plans to evolve to best serve the needs of vulnerable populations.

Thank you again for your commitment to improving care delivery and outcomes for Medicare beneficiaries with chronic conditions. The CHRONIC Care Act will lead to a more efficient health care system and improved quality of care and quality of life for millions of Americans, and KCP looks forward to working with you in advancing this legislation.

Sincerely,

F W Maddux MD

Dr. Frank Maddux
Chairman
Kidney Care Partners

KIDNEY CARE
PARTNERS

Mission Statement:

Members of the kidney care community have formed an alliance – Kidney Care Partners. Their goal is to involve patient advocates, care professionals, providers and manufacturers. Their mission, individually and collectively, is to ensure:

- Chronic kidney disease patients receive optimal care;
- Chronic kidney disease patients are able to live quality lives;
- Dialysis care is readily accessible to all those in need; and
- Research and development leads to enhanced therapies and innovative products.

Coalition Members:

AbbVie
Akebia
American Kidney Fund
American Nephrology Nurses' Association
American Renal Associates, Inc.
American Society of Nephrology
American Society of Pediatric Nephrology
Amgen
AstraZeneca
Baxter Healthcare Corporation
Board of Nephrology Examiners and Technology
Centers for Dialysis Care
DaVita Healthcare Partners, Inc.
Dialysis Clinic, Inc.
Dialysis Patient Citizens
Fresenius Medical Care North America
Fresenius Renal Therapies Group
Greenfield Health Systems
Hospira, a Pfizer Company
Keryx Pharmaceuticals
Kidney Care Council
National Kidney Foundation
National Renal Administrators Association
Nephrology Nursing Certification Commission
Northwest Kidney Centers
NxStage Medical
Renal Physicians Association
Renal Support Network
The Rogosin Institute
Sanofi
Satellite Healthcare
U.S. Renal Care

Kidney Care Partners • 601 Thirteenth Street NW, 11th Floor • Washington, DC 20005 • 703.273.3830

AARP®
Real Possibilities

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May 17, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, DC 20510

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

AARP thanks you for your continued bipartisan leadership and collaboration that has resulted in the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (S. 870). We support the legislation, and believe that it would take some important steps to improve care for the millions of Medicare beneficiaries with chronic conditions.

We also see potential opportunities to improve the legislation as it moves through the legislative process. AARP appreciates your inclusion of some of our recommendations in this bill prior to introduction. Furthermore, we appreciate the Senate Finance Committee Chronic Care Working Group's transparent process that has allowed for stakeholder input and feedback. If any offsets are needed as this bill moves forward, it is important that those offsets are reasonable and do not harm Medicare beneficiaries.

AARP supports a number of provisions in the CHRONIC Care Act, including:

- Extending the Independence at Home Demonstration;
- An easily navigable unified grievance and appeal process for dual eligible special needs plans (SNPs) that adopts important enrollee protections, the continuation of benefits pending appeal, and efforts to improve integration of long-term services and supports and behavioral health;

- Allowing Medicare Advantage (MA) plans to offer a wider range of supplemental benefits to improve or maintain the health or overall function of a chronically ill enrollee; and

- Expanding the use of telehealth in MA plans and accountable care organizations (ACOs).

As the bill moves forward, we suggest building upon the bill's strong foundation with the following improvements:

- Expansion of the Independence at Home Demonstration Program to a nationwide program in Medicare;

- In Section 201, consider annual public reporting on types of grievances and appeals, and include language making it clear that low English proficiency (LEP) enrollees are entitled to oral interpreters through every step of the grievance/appeal process;

- Further strengthen current provisions to require quality measurement at the plan level for all MA plans, including SNPs;

- While AARP has been supportive of the Center for Medicare & Medicaid Innovation's (CMMI) efforts to test Value Based Insurance Design (VBID) in the Medicare Advantage Program -- and believes such plan designs may have the potential to improve care for people with chronic conditions -- we recommend not directing CMMI to expand testing as quickly as the bill would, since it would be too soon for the pilot demonstrations to show improvements in quality of care or savings to the Medicare program. We also recommend that the bill should not unnecessarily restrict CMMI's authority to modify or even terminate the demonstration based on findings of the test, as it currently would do;

- In Section 302, consider support for family caregivers, in addition to the beneficiary, when considering types of additional supplemental benefits;

- As MA plans are permitted to offer additional telehealth services, CMS should monitor carefully to ensure that quality of care is maintained and quality reporting should be required. CMS should ensure that plan savings as a result of telehealth are returned to the program and that additional costs associated with providing telehealth options are not born by the beneficiary or used to justify higher MA payment rates;

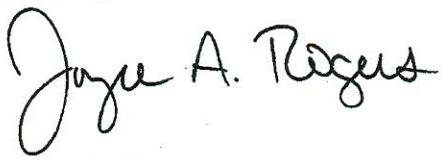
- Clarify the time period during which an ACO can opt to have beneficiaries prospectively assigned for a specific agreement period (e.g., at least 90 days before the agreement period begins) and potentially clarify how often a

beneficiary can voluntarily align to the ACO in which the beneficiary's main primary care provider is participating; and

- In Section 501, certain ACOs would be allowed to offer a flat incentive payment of up to $20 per qualifying primary care service directly to a Medicare beneficiary. While we support testing the concept of financial incentives in principle, the impact of financial incentives needs to be carefully evaluated. We appreciate the inclusion of an evaluation by the Secretary of Health and Human Services, and suggest that in evaluating health outcomes, the Secretary should include examination of short-term measures, such as blood pressure control and blood sugar control. We also suggest including a separate section directing CMS to waive beneficiary cost sharing for chronic care management and transitional care management services.

Thank you for the opportunity to provide feedback on this legislation. AARP looks forward to continuing to work with the Chronic Care Working Group and the Finance Committee more broadly as this legislation moves forward. If you have any questions, please feel free to contact me, or have your staff contact Rhonda Richards at 202-434-3770 or rrichards@aarp.org.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

May 17, 2017

The Honorable Orrin G. Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chair
Senate Committee on Finance
Chronic Care Working Group
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
Co-Chair
Senate Committee on Finance
Chronic Care Working Group
219 Dirksen Senate Office Building
Washington, DC 20510

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

On behalf of the physician and medical student members of the American Medical Association (AMA), I applaud your leadership and your dedication to advancing the interests of some of the most vulnerable patients in our nation among the Medicare population by developing legislation that would provide a clear pathway toward new delivery models that are patient-centered and will improve health outcomes and value. S. 870, the "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017," represents the strong consensus that addressing chronic conditions in a comprehensive and coordinated fashion not only improves the quality of care and patient experience, but also produces demonstrable cost savings to the health system. The AMA is pleased to support this legislation and looks forward to working with you as S. 870 progresses through the legislative process.

Currently, physicians and other health care providers are expending significant time and resources to modernize how medical care is delivered. The AMA supports the provisions in the legislation that would remove barriers to care coordination and enhance beneficiary flexibilities to be a part of an accountable care organization (ACO).

The AMA continues to support extending and expanding the Independence at Home (IAH) Demonstration Program, which has already produced savings to the Medicare program as well as improved health outcomes among a beneficiary population that is medically fragile with high acuity. The comprehensive approach and flexibilities provided by the IAH Demonstration have established a proven method for providing care in less costly settings that enhance the quality of patient care. Notably, IAH teams that include a physician and have an established relationship with a hospital are able to provide the most comprehensive, coordinated care, particularly for patients with complex comorbidities.

While other federal health programs, state Medicaid programs, and private health plans have allowed adoption of telehealth and remote health services, current Medicare restrictions have impeded the uptake of now well-established service delivery methods. Increased access to telehealth and remote patient

monitoring services is urgently needed to effectively address the looming demographic health demands that will be placed on the Medicare program and health care providers in the near future. Telehealth is particularly important for patients with chronic conditions as it removes barriers to adherence and improves access to care in less costly sites of care. The AMA supports the inclusion of telehealth coverage for certain ACOs and Medicare Advantage (MA) plans, as well as for patients who are suffering from acute stroke or need dialysis. The AMA also appreciates the important patient access protections that would ensure that telehealth would not be used for network adequacy determinations for MA plans. As the telehealth provisions in S. 870 were incorporated and updated in the recently introduced S. 1016, "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2017," the AMA would urge the committee to update the current language by incorporating the parallel telehealth provisions in S. 1016. Specifically, we urge adoption of provisions contained in S. 1016 that ensure adherence to important state laws relevant to enforcing the oversight of medical practice laws.

Furthermore, as S. 870 moves through the legislative process, we urge you to consider the inclusion of section 11 of the "CONNECT for Health Care Act" that would establish a meaningful pathway to expand Medicare coverage of telemedicine and remote patient monitoring services while addressing concerns regarding the potential for increased expenditures. Specifically, the Secretary of the U.S. Department of Health & Human Services would be given the discretion to waive the current Medicare restrictions on telehealth (subject to applicable state medical practice and licensure laws) if the Centers for Medicare & Medicaid Services Chief Actuary certifies that such a waiver would: (1) reduce spending without reducing the quality of patient care; or (2) improve the quality of patient care without increasing spending.

Thank you for your leadership on the chronic care issue. We look forward to working with you to advance this legislation in the Senate.

Sincerely,

James L. Madara, MD

ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

April 21, 2017

The Honorable Orrin G. Hatch
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Dear Chairman Hatch and Senator Wyden,

The Association for Community Affiliated Plans (ACAP) is writing to express our strong support for the provisions related to Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs) in S.870, the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*.

ACAP is an association of 60 not-for-profit, community-based Safety Net Health Plans located in 26 states. Our member plans provide coverage to almost seventeen million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Advantage Dual-Eligible SNPs. Nationally, ACAP plans serve almost half of all Medicaid managed care enrollees. Twenty-four of our plans are D-SNPs, and 14 of our plans participate in the Financial Alignment Demonstration, accounting for over 30 percent of all enrollment in the Demonstration.

ACAP strongly supports permanent authorization of D-SNPs and commends the Senate Finance Committee for including permanent authorization in S.870. D-SNPs can tailor their care management, provider interventions, and partnerships with community-based organizations to the unique needs of their dual-eligible enrollees. D-SNPs have been reauthorized numerous times, but only in a series of short-term extensions, and are currently authorized through the end of 2018. The lack of a long-term authorization destabilizes the program for beneficiaries, states, health plans, and providers. ACAP supports permanent authorization of D-SNPs because doing so would provide certainty to plans, beneficiaries, and states and would foster longer term partnerships and investments in care management and integration with Medicaid. We also commend the Committee for defining an integrated D-SNP in a way that reflects the numerous ways in which states work with D-SNPs to integrate Medicare and Medicaid benefits for dual-eligible beneficiaries.

ACAP is prepared to assist with additional information, if needed. If you have any additional questions, please do not hesitate to contact Christine Aguiar Lynch at (202) 204-7519 or clynch@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer

cc: Members, Senate Committee on Finance

KAISER PERMANENTE®

May 17, 2017

The Honorable Orrin G. Hatch
The Honorable Ron Wyden
The Honorable Johnny Isakson
The Honorable Mark Warner
Committee on Finance
United States Senate
Washington, D.C. 20510

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

We are writing to thank you for the leadership you have demonstrated by introducing the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We commend you for bringing this thoughtful and responsible package of provisions to the Finance Committee for markup on May 18, 2017, and appreciate the inclusive and lengthy process you have undertaken to bring the legislation to this point.

Kaiser Permanente believes that expanding the availability of telehealth and related technologies in Medicare is a key policy change that would improve the quality and enhance the availability of care for patients with chronic conditions. These technologies are becoming more prevalent in care delivery across the country and have been shown to improve patients' access to and timeliness of care, enhance communication between providers and patients, and improve care coordination.

With these benefits in mind, we support the Chronic Care Working Group's inclusion of provisions that would permit Medicare Advantage plans to offer their enrollees the option of accessing covered services (e.g., physician office visits) by way of telehealth technologies as part of their basic Medicare coverage, rather than as a supplemental benefit. This flexibility will make it possible for a substantial portion of the Medicare population to access care in the way that best meets their clinical needs and care preferences. We also appreciate the continuing process that the Working Group is engaged in to refine the details of these provisions to ensure appropriate protections while enhancing access to telehealth.

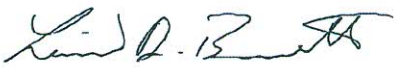
As the largest private integrated health care delivery system in the country, Kaiser Permanente delivers health care to more than 11 million members in eight states and the District of Columbia, including 1.5 million Medicare patients. Our mission is "to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve." Since our founding in 1945, Kaiser Permanente has been innovating to provide our members the highest quality care that optimally meets their clinical needs and care preferences, including a focus on prevention, primary care, and well-coordinated, continuously managed care for members with chronic conditions.

900 7th Street, NW., Suite 590
Washington, D.C. 20001
(202) 216-1900

Kaiser Permanente has improved our effectiveness in preventing and managing chronic conditions by leveraging our integrated structure, physician-led interdisciplinary teams, advanced electronic health record and associated digital tools, commitment to evidence-based care, and capitated payment model. Many of our initiatives and clinical programs for addressing chronic diseases can be linked to lower rates of hospitalization and readmission, suggesting that they achieve the "triple aim" of improved care for populations as well as for individual patients, while making care more affordable. We believe the CHRONIC Care Act takes important steps in the same direction.

Thank you for the attention you are giving to the complex issues associated with improving care for individuals with chronic conditions. We look forward to continuing to work with you as this legislation moves forward and further refinements are considered.

Sincerely,



Laird D. Burnett
Vice President, Government Relations

900 7th Street, NW., Suite 590
Washington, D.C. 20001
(202) 216-1900

America's Health
Insurance Plans

Marilyn Tavenner
President &
Chief Executive Officer

May 17, 2017

The Honorable Orrin Hatch
United States Senate
104 Hart Building
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Building
Washington, D.C. 20510

The Honorable Ron Wyden
United States Senate
221 Dirksen Building
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
475 Russell Building
Washington, D.C. 20510

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

On behalf of America's Health Insurance Plans (AHIP), I am writing to express our support for your bipartisan legislation (S. 870), the "Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017." As noted in our response to the Policy Document released in December 2015 by the Senate Finance Committee's Chronic Care Working Group, and in an earlier letter responding to the Working Group's request for input, AHIP and our members strongly support this effort to increase care coordination among plans and providers serving individuals with chronic diseases, develop payment systems to incentivize the delivery of higher quality, more efficient services to this vulnerable population, and improve outcomes while reducing health care costs.

AHIP's members are strongly committed to serving Medicare beneficiaries under the Medicare Advantage (MA) and Part D programs, and continuing to provide cost-effective, high-quality, and accessible health care. Today, more than 18.5 million Americans – about 32 percent of Medicare beneficiaries – have chosen to enroll in the MA program, and 16.6 million of them receive drug benefits through their plan. An additional 25 million Americans receive drug coverage through a stand-alone Prescription Drug Plan (PDP).

The innovative chronic care management programs developed by MA and Part D plans are serving as a foundation for changes promoted by the Congress and others to foster delivery system reforms throughout the Medicare program. Plan benefit designs use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. By focusing on prevention, early detection, and care management, health plans are working to mitigate the personal and social harm caused by chronic illness.

We strongly support the provisions in your legislation that build upon these innovative care management programs by expanding the current Value-Based Insurance Design (VBID) Model for the MA program, permitting plans the flexibility to offer additional supplemental benefits to

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better serve individuals with specific health care needs, and broadening the use of telehealth in delivering basic Medicare benefits to enhance value and reduce premiums for their enrollees. We also strongly support provisions that would permanently reauthorize MA Special Needs Plans (SNPs) and establish a unified grievances and appeals process for individuals enrolled in dual eligible SNPs (D-SNPs). The legislation will enhance the MA and Part D programs and the services provided to beneficiaries, and address current legislative and regulatory barriers to continued innovations.

Thank you for your leadership on these important issues, and throughout the debate on this legislation. We look forward to working with you to build support for passage of your bill.

Sincerely,

Marilyn B. Tavenner

Marilyn B. Tavenner
President and CEO

CAPG
The Voice of Accountable Physician Groups

May 18, 2017

The Honorable Orrin Hatch
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators Hatch, Wyden, Isakson, and Warner:

CAPG applauds the reintroduction of S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We thank the Committee for its commitment to improving care for chronically ill Medicare beneficiaries.

CAPG represents nearly 300 physician organizations across 44 states, Washington, DC, and Puerto Rico. Our members are distinguished by their commitment to fostering healthier populations while delivering services within a defined budget. This model reduces waste while improving quality and affordability. Coordinated, accountable care is essential to meet the needs of an aging and increasingly chronically ill population.

The policies contained with the CHRONIC Care Act of 2017 support the advancement of our model. In particular, we are pleased to support the following specific components of the bill.

Medicare Advantage Provisions

Section 201: providing continued access to MA Special Needs Plans (SNPs) (section 201). MA SNPs enable health plans and delegated, capitated physician groups to provide new ways to manage chronic and complex conditions for the sickest patients. The CHRONIC Care Act of 2017 would permanently authorize SNPs. This provision will give much needed certainty to SNP participants, including plans, providers, and beneficiaries. SNPs across the country are partnering with sophisticated physician organizations to offer high quality coordinated care to specific patient populations. This successful model should be encouraged and strengthened going forward. We appreciate the Committee's recognition of the program's importance and success.

Section 301: adapting benefits to meet the needs of chronically ill MA enrollees. MA plans are currently required to offer the same benefit package to all enrollees. The Innovation Center is currently testing the Value-Based Insurance Design (V-BID) model to allow MA plans greater flexibility to meet the needs of chronically ill individuals. The CHRONIC Care Act of 2017 would expand the testing of the VBID model to allow an MA plan in any state to participate in the model by 2020. We support this expansion of the current VBID model to provide additional flexibility for physician groups that care for MA beneficiaries.

Section 302: expansion of MA supplemental benefits to meet the needs of chronically ill enrollees. The CHRONIC Care Act would allow MA plans to offer a wider array of supplemental benefits to chronically ill enrollees beginning in 2020. Plans would be permitted to provide targeted supplemental benefits to specific chronically ill enrollees. This provision will allow plans and their contracted networks of physicians additional tools and ability to care for patients with chronic conditions.

Section 303: increasing convenience for MA enrollees through telehealth. This section would allow an MA plan to offer additional telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. Our member groups are constantly innovating in the telehealth space to improve care coordination and convenience for beneficiaries. We support this approach which would encourage the use and development of technology that both improves the coordination of care and patient health.

Traditional Medicare Accountable Care Organization Provisions

Section 304: Expanding the use of telehealth for ACOs. This section would apply the Next Generation ACO telehealth waiver criteria to the Medicare Shared Savings Program Tracks 2 and 3 and Pioneer ACOs. We support the expansion and encouragement of the use of telehealth for the ACO population. As with the MA population, we see tremendous population to incorporate telehealth into the delivery system to improve coordination and convenience for patients.

Section 401: providing flexibility for beneficiaries to be part of an ACO. This section would allow MSSP ACOs the choice to have beneficiaries prospectively assigned and would give the beneficiary to option to voluntarily align to the MSSP ACO in which the beneficiary's main primary care provider is participating. Beneficiaries would retain freedom of choice to see any provider. We support this provision and note that it is consistent with the policy announced in last year's final physician fee schedule rule. Beneficiary engagement in accountable care models is essential for the success of these models over the long-term.

Section 501: eliminating barriers to care coordination for ACOs. This provision would allow two-sided risk ACOs to offer up to $20 per qualifying service directly to the beneficiary. The ACO would not be provided additional reimbursement to cover these costs. We support this provision which would give accountable care organizations another tool to engage patients. This flexibility would better enable ACOs to encourage the use of primary care services and to increase stickiness to the ACO, all of which is necessary for the sustainability of the ACO program.

Additional Areas for Consideration

As you move forward with your work in this area, we encourage the Committee to consider two additional areas of opportunity to improve care for the chronically ill.

First, we encourage the Committee to press forward with payment change in traditional Medicare. While the ACO programs in traditional Medicare have started the nation on a path toward greater levels of clinical and financial accountability, these models have not gone far enough to transform the way care is delivered and paid for in traditional Medicare. We believe that the next frontier is a pre-paid budget made directly to physician groups in traditional Medicare. When combined with appropriate quality measurement and other features, we know that this model can be successful and represent a destination for today's delivery system reform efforts.

Second, we know that the next frontier for coordinated care is to address social determinants of health. Today, there are barriers for physician organizations trying to address the social determinants of health in their patient populations. Our member physician organizations witness firsthand the importance of addressing social determinants in improving overall population health outcomes. Particularly in situations where capitated physician groups are working with a health plan to improve the health of the population, there should be the flexibility to address the social determinants of health. We know the importance and value of making home visits, providing nutritional support, and providing caregiver support, but are largely prevented from providing these services given existing restrictions. Pilot projects have consistently shown that large advances in quality and population health can be achieved by addressing social determinants. Providing only medical services does not sufficiently address many of the most impactful underlying drivers of cost and morbidity. We know this from empirical experience. Our efforts to lower cost, improve quality, and increase beneficiary satisfaction must be sensibly expanded into the social area to continue to expand the success of the MA program.

Conclusion

CAPG congratulates the Senate Finance Committee's Chronic Care Working Group on their CHRONIC Care Act, and advocates for its swift passage. We are committed to continuing our work with Congress to improve our nation's health care system.

Sincerely,

DONALD H. CRANE
President and CEO

Kindred Healthcare

May 18, 2017

The Honorable Orrin Hatch
Finance Committee, Chairman
SD-219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Finance Committee, Ranking Member
SD-219 Dirksen Senate Office Building
Washington, DC 2510-6200

Dear Senators,

On behalf of Kindred Healthcare and our more than 100,000 dedicated teammates, thank you for your leadership in advancing *The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*. I applaud your bi-partisan collaboration and your involvement of stakeholders in developing this important legislation. As a post-acute care provider and care manager, we appreciated the opportunity to submit our perspective and ideas as you developed new policies.

At Kindred, we recognize the need for real, actionable policy solutions to address the unique care needs of a rapidly growing Medicare-eligible population who are increasingly chronically ill with multiple medical conditions. We believe that the *CHRONIC Care Act of 2017* represents an important first step in creating care solutions for this difficult to treat patient population.

The aging population and rapid increase in the number of chronically ill and medically complex beneficiaries presents significant challenge for families and caregivers, and for the Medicare program. Of the 1.9 million Medicare hospital readmissions in 2010, beneficiaries with two or more chronic conditions accounted for 98 percent of these readmissions. This trend underscores the need for reforms in our healthcare system in order to align care interventions across the entire continuum in order create better patient outcomes, reduce hospital readmissions and mortality rates, and keep patients in the setting they most desire – their home.

Independence at Home

We are particularly pleased that the *CHRONIC Care Act of 2017* includes an extension of the Independence at Home (IAH) demonstration project. We firmly believe that providing the right care in the right place allows us to create care models that support wellness and prevent the need for a hospital admission. In-home physician services play an important role in maintaining a patient's independence and more effectively delivering coordinated care for chronically ill patients. Expanding the successful IAH demonstration will allow more patients' ability to access to this approach to care, which has been shown to demonstrate significant value to patients and payors alike.

Kindred is currently participating in the IAH demonstration in community with great patient need. Several years ago, we developed Kindred House Calls in order to bring high-quality, physician-based house call services to homebound patients who are at high risk for hospitalization and cannot easily access traditional outpatient services. Through our team-based approach, we are providing comprehensive care services resulting in improved clinical outcomes, preventing emergency room visits and hospital stays, and creating positive patient experiences. Kindred House Calls is one of the largest home-based

primary care practices in the nation, with approximately 100 practitioners providing care to more than 10,000 patients annually in 12 markets in five states.

Next Steps in Chronic Care Management Policies
We are encouraged by the *CHRONIC Care Act of 2017*, and support many of the policies within the legislation, and view this bill as a first-step in developing a more comprehensive policy solution that ensures coordinated care management for some of our nation's most costly and complex patients. We look forward to working with you to build upon this policy foundation, so that we may develop the next steps in effective chronic care management solutions for patients we serve each day.

On an ongoing basis, we are committed to working with you to advance effective reforms that have real and lasting impact on the lives of Medicare beneficiaries with multiple, complex chronic illnesses.

Sincerely,

Benjamin A. Breier
President and Chief Executive Officer
Kindred Healthcare

commonwealth care alliance

May 17, 2017

The Honorable Orrin Hatch
Chairmen – Senate Finance Committee
United States Senate
104 Hart Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member – Senate Finance Committee
United States Senate
221 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Commonwealth Care Alliance, I am writing to express our strong support for the bipartisan Senate Bill 870, the CHRONIC Care Act of 2017.

Commonwealth Care Alliance (CCA) is an integrated health care system serving the comprehensive health care needs of dual eligible beneficiaries in Massachusetts, with a particular focus on the most complex cases and hardest to serve members. We have been serving the over age 65 dual eligible population in the Senior Care Options program, a D-SNP, since 2004. We have been serving the under age 65 disabled dual eligible since 2013 in One Care, Massachusetts' financial alignment demonstration. Enrollment has been increasing, currently CCA covers over 8,000 Senior Care Options members and over 12,000 One Care members. Since its inception, CCA has focused its efforts on providing high quality cost effective care for poor, frail, disabled enrollees with complex chronic conditions served by the Medicare and Medicaid programs.

We greatly appreciate the Committee's consultation of CCA throughout the development process of the CHRONIC Care Act. This bill addresses critical elements in our Medicare system that have required attention for many years. Given our role in serving Medicare/Medicaid dual eligibles, we believe that the CHRONIC Care Act's provisions related to D-SNPs and for dual eligibles, and in particular the permanent authorization of D-SNPs, will have a long-term positive impact on the vulnerable populations we serve. D-SNPs have been reauthorized through a number of short-term extensions, the most recent of which will expire at the end of 2018. We believe that the lack of a long-term authorization destabilizes the program for beneficiaries, states, health plans, and providers. By removing the D-SNPs from frequent and periodic reauthorization, the CHRONIC Care Act reduces uncertainty for plans, states, providers, and beneficiaries and helps to ensure continuity of care for dual-eligible enrollees.

In addition, we see great benefit in the bill's consolidated grievance and appeals procedures. The ability for the Secretary to waive notification requirements when a service is covered by either Medicare or Medicaid creates a necessary level of simplification and understanding while simultaneously creating administrative efficiencies. We fully support the provisions codifying these sound practices and policy decisions.

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Finally, we believe that requiring the Comptroller General to carefully study the inclusion of longitudinal comprehensive care planning services within Medicare Part B will demonstrate the benefits of including such services within Medicare Advantage. As a national leader in the effort to incorporate end of life care into Medicare Advantage, we would like to share our positive experience on the benefits of voluntary, shared decision-making after a member has been diagnosed with a serious or life-threatening illness. We have found that integrating end of life care into our plan has fostered innovations; including our Community Paramedicine program. In addition, it has enabled members to avoid many of the barriers related to hospice, such as the frequent need to switch primary care providers to Hospice medical directors and the need to sign Hospice enrollment forms, which often feels like abandonment for the responsible family member.

Aggressive treatment can coexist much more easily with palliative care when end of life care is imbedded within Medicare Advantage. At CCA, we put no restrictions on what type of care patients receive at the end of life. Members are not on "Hospice" or aggressive care – they are on individualized care plans that strive to deliver the best of high quality, patient and family-centered care. By eliminating the dichotomies of hospice versus aggressive care, we have found that patients enter into palliative/end of life care much sooner, spend fewer days in ICUs, and more frequently die in the home rather than an unknown or uncomfortable setting.

Lastly, keeping end of life care within the health plan eliminates much of the front-end costs for durable medical equipment, intensive nursing, case management and medications that hospices typically absorb for very short stays. Continuity of insurance, as well as the care team, is essential to good end of life care. We believe strongly that Medicare members and their loved ones should not have to face a decision to change their coverage and care team at a time when they are most under stress and vulnerable.

Given the importance of providing certainty and continuity of coverage to dual eligibles, we believe that S.870 provides an important underpinning for care to America's Medicare/Medicaid population.

In advance, thank you for your time and consideration of this important piece of legislation. If you have any additional questions, please do not hesitate to contact me.

Sincerely,

Christopher Palmieri
President & Chief Executive Officer

CC: Senator Elizabeth Warren
Senator Edward Markey

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