JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 28, 2016

The Honorable Orrin Hatch
Chair, 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 State Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Re: Bipartisan Chronic Care Committee Policy Options Document

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

Justice in Aging appreciates the opportunity to comment on the Bipartisan Chronic Care Working Group of the Senate Finance Committee's policy options draft. We commend the Committee for tackling the challenge of improving the health care delivery system for individuals with chronic medical conditions. With 6.4 million older adults[1] living in poverty and 90% of all older adults[2] living with at least one chronic condition, we are particularly concerned about the millions of poor seniors struggling to manage multiple chronic conditions. The Committee has taken an important first step to find solutions.

Justice in Aging, formerly the National Senior Citizens Law Center, uses the power of law to fight senior poverty by securing access to affordable health care. We have decades of experience with Medicaid and Medicare, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

Justice in Aging supports the Committee's three bipartisan goals of developing policies that increase care coordination, incentivize the appropriate level of care, and facilitate higher quality care. As the Committee moves forward, we recommend ensuring that all policies reflect two considerations:

1) **Beneficiaries with multiple chronic conditions will benefit from improvements to both traditional Medicare and Medicare Advantage.**
2) **Lessons learned from current integration demonstrations should instruct future Committee proposals.**

---

[1] Kathleen Short, "The Research: Supplemental Poverty Measure," (2012), available at: https://www.census.gov/prod/2013pubs/p60-247.pdf.

[2] AARP, *Chronic Conditions Among Older Americans,* available at: http://assets.aarp.org/rgcenter/health/beyond_50_hcr_conditions.pdf.

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Beneficiaries with multiple chronic conditions will benefit from improvements to both traditional Medicare and Medicare Advantage.

We appreciate the Committee's efforts to improve coverage and care for beneficiaries with chronic conditions, and we encourage these efforts to aid beneficiaries in both traditional Medicare and Medicare Advantage. We are concerned by the draft's substantial focus on the Medicare Advantage system and limited exploration of improvements in traditional, or fee-for-service (FFS) Medicare. We encourage you to ensure the final proposal places equal emphasis on both programs. The majority of Medicare beneficiaries (69%)[3] receive their coverage through the FFS system. These 38 million individuals should also be able to benefit from the Committee's innovations aimed at improving chronic condition management.

Individuals with chronic conditions often need an array of providers. Recently, more Medicare Advantage (MA) plans have started utilizing narrow networks as a cost containment strategy.[4] Unfortunately, these narrow networks can limit access to the providers that individuals with chronic conditions rely upon to coordinate care for their complex conditions. Due to the number of beneficiaries in traditional Medicare, and their need for robust provider access, we believe exploration into FFS Medicare improvements that enhance care coordination for chronic conditions should be a Committee priority.

Further, we caution against equating care coordination with managed care. The Centers for Medicare and Medicaid Services (CMS) are testing different models for care coordination, many of which operate within traditional Medicare. For example, the Medicare-Medicaid Coordination Office is testing both capitated and managed fee-for-service coordination models[5] as part of the Financial Alignment Initiative (FAI) known as the dual eligible demonstration. An initial evaluation report[6] indicates the FFS model has great promise for both beneficiary outcomes and payment efficiency.[7] We encourage the Committee to take a closer look at FFS innovations, in addition to MA innovations, so the Committee can better compare the two in terms of effectiveness and cost.

---

[3] Kaiser Family Foundation, *Medicare Advantage*, (June 2015), available at: http://kff.org/medicare/fact-sheet/medicare-advantage.

[4] Academy Health, *Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice*, (December 2014), available at: http://academyhealth.org/files/HCFO/RIBrief0315.pdf.

[5] Centers for Medicare and Medicaid Services, Financial Alignment Initiative, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[6] RTI International, *Measurement, Monitoring and Evaluation: Preliminary Findings from the Washington MFFS Demonstration,* (January 2016), available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf.

[7] Id. More than half of FFS focus group participants reported a significant improvement in their health or quality of life as a result of the demonstration's health home service (pg. 22). The savings for the first demonstration period were $21.6 million, representing over 6% savings to the Medicare program (pg. 26).

Lessons learned from current integration demonstrations should instruct future Committee proposals.

As the Committee reviews the draft proposal, we hope the Committee will take a closer look at existing Affordable Care Act demonstration projects and pilot programs tested through the Centers for Medicare and Medicaid Innovation (CMMI). For the last five years, states and the federal government have engaged in large and small scale testing of delivery system reform initiatives, many exploring improvements to chronic care management. CMS and its contractors are beginning to release early evaluations,[8] which provide helpful insight into lessons learned during program innovation, such as the importance of testing and fine-tuning programs before large scale implementation.[9] For example, in the dual eligible demonstrations, evaluators have found that states significantly underestimated the extensive financial investments and modifications of information management systems necessary for a large scale delivery system change.[10] Improving the health care delivery system for people with chronic conditions is a major task, and innovations should be approached with adequate resources, planning, and oversight.

Based on these experiences, we recommend the Committee approach many of the proposal initiatives (detailed below) as demonstration programs. We also recommend the Committee explore current program evaluations and incorporate those evaluation results in the chronic care coordination proposals.

Our comments on specific policy proposals follow below. We do not comment on all proposals in the policy paper.

Advancing Team-Based Care:

Providing Medicare Advantage Enrollees with Hospice Benefits:

We recommend the Committee explore this concept further, and that a demonstration project with beneficiary safeguard is the most appropriate format to test this model. We recognize that MA participants currently can face disruptions when entering hospice. For example, Medicare beneficiaries can face prescription drug interruptions when the beneficiary has to navigate prescription drug coverage transitions between the MA plan and hospice. An initiative that eliminates these types of complications would be a welcome improvement; however, we urge caution with the proposal to integrate hospice care into the benefit package. The needs of beneficiaries on hospice are complex, and hospice creates unique challenges for beneficiaries

[8] RTI International, *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative,* (October 15, 2015), available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf.
[9] Id. at 15.
[10] Id. at 9.

seeking an appropriate provider. We urge that any inclusion of hospice into MA ensure network adequacy and as much open access to providers as possible.

We echo the comments of other consumer advocates that any MA hospice demonstration must include well-defined appeals rights for any plan determination, including the right to appeal a plan of care to the Independent Review Entity on a 24-hour timetable. These appeal rights are needed for hospice in and out of managed care. Further, given the highly personal choices involved in hospice, incorporation of hospice in Medicare Advantage should not limit hospice choices for the plan member. If hospice becomes a plan benefit, members should also have a Special Enrollment Period in which an individual needing hospice could disenroll from the plan if the individual wishes to use an out-of-network hospice provider.

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

Permitting enrollment of individuals with ESRD into Medicare Advantage plans could help limit the high costs that many of these individuals now face in FFS Medicare. Our support is tempered, however, by our significant concerns about the capacity of many MA plans to take on the additional responsibility of ESRD beneficiaries. In any demonstration allowing plans to enroll ESRD members, it would be imperative that the demonstration include only those highest performing plans that have demonstrated full capacity to handle existing care coordination responsibilities. There also would need to be very rigorous readiness reviews of all aspects of plans' ability to serve this member population, including how plans would address the transportation challenges that many ESRD patients face in order to make their regular dialysis appointments.

To further improve options for individuals with ESRD, we encourage the Committee to consider providing for Medigap guaranteed issue or open enrollment rights for individuals with ESRD at the federal level, as exists for older adults who become eligible for Medicare at 65.

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

We agree that SNP enrollees are some of the most vulnerable and complex beneficiaries; however, we think it is premature to conclude that a long-term extension of and investment in SNP is necessarily the best path to care for these individuals. We recommend the Committee look closely at evaluations and data that are coming out of the current FAI dual eligible demonstrations, both to compare FAI performance with SNP performance and to get more information on elements of the managed care model that work best for complex populations.

In addition, we urge caution around the proposal to provide SNPs with greater flexibility in their benefit design. In fact, despite the multiple challenges the FAI demonstration faced in early

implementation, the evaluation cited the day-to-day health plan monitoring of compliance with federal and state policies as one of the demonstration's most important practices.[11]

Improving Care Management Services for Individuals with Multiple Chronic Conditions

We support the proposal to establish a high-severity chronic care management (CCM) code. We encourage the Committee to develop a proactive strategy for beneficiary and provider education as a part of any policy to introduce such a code.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries:

We recognize the importance of improving the coordination of care for those beneficiaries with chronic conditions and behavioral health needs. We support further study of options to integrate behavioral health services for individuals with a chronic illness, including the proposed GAO study.

Expanding Innovation and Technology:

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

We believe the proposal to allow flexibility in benefit design, cost sharing, and provider networks has potential merit, when combined with adequate consumer protections. Reduction in cost sharing as an inducement to promoting consumer behavior is a particularly effective technique, especially for individuals with limited incomes.

We recommend, as with most of what is proposed in the policy paper, that flexibility should be accorded only to plans that have a demonstrated track record of providing core benefits effectively and at a high level of quality. Further, the concept needs to be tested in a demonstration, drawing on lessons learned in current demonstrations, with broad stakeholder engagement, before being adopted broadly.

Finally, marketing would need to be carefully controlled to ensure the MA plan's choice of supplemental benefits is appropriately driven by effectiveness in meeting member needs, and not on marketing appeal.

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

We agree with the Committee that enhanced social supports and non-medical services can benefit older adults with chronic care needs. We believe there is great value in testing systems

[11] RTI Evaluation report at 7: "interviewees in capitated model demonstration States noted the importance of the role of the joint CMS-State Contract Management Team (CMT)," and "CMS and State concur in their view that the CMT has been a very successful vehicle for joint oversight of MMP performance."

that could provide needed supports and that such systems should be tested both in Medicare Advantage and in FFS Medicare. In designing such systems, it is important to incorporate protections to both ensure equitable access and to prevent abuse by plans, providers or beneficiaries. In particular, with regard to cost-sharing, we agree with the Committee that only reductions and waivers in cost sharing, not increases, should be considered. Further, there should be extensive evaluation to determine what supplemental benefits are actually being delivered, and which are effective in improving and maintaining health. As with the prior proposal, marketing would need to carefully restricted.

Empowering Individuals and Caregivers in Care Delivery:

Developing Quality Measures for Chronic Conditions:

We strongly support the proposal that the Government Accountability Office (GAO) conduct a report on community-level measures as they relate to chronic care management. We also support the requirement that CMS include the development of measures that focus on the health care outcomes for individuals with chronic disease in its quality measure plan. We agree with the six outlined topic areas, and suggest the inclusion of a seventh topic area--rebalancing. CMS has indicated one goal of the shift to managed care delivery model for long-term services and supports is to rebalance public spending on LTSS by increasing access to home and community-based services. State-specific measures on rebalancing[12] and HCBS access currently exist, and CMS has proposed including rebalancing measures in future quality strategies,[13] but we believe a requirement in the CMS quality measure plan is an important component of measuring progress on chronic care management.

Empowering Individuals & Caregivers in Care Delivery:

Encouraging Beneficiary Use of Chronic Care Management Services:

We support waiving the Part B coinsurance associated with the recently introduced Chronic Care Management (CCM) codes. For a chronic care management benefit to be implemented in a meaningful manner, it must be implemented without an additional financial burden for beneficiaries. Beneficiaries already dedicate a significant portion of income to Medicare expenses. Out-of-pocket health care spending is the greatest for those with incomes between 100-200% Federal Poverty Level (FPL). For example, those with incomes between 100%-150% FPL spent 26% of their income on health care. Further, Medicare beneficiaries who are in fair or poor health spent a median 20% of their income on health care costs, compared to 14.2% for

[12] See "Is it Working? Recommendations for Measuring Rebalancing in Dual Eligible Demonstrations and MLTSS Waivers," (January 2013), available at: http://dualsdemoadvocacy.org/wp-content/uploads/2014/01/Rebalancing-in-MLTSS-and-Dual-Eligible-Demo_01.13.14.pdf.

[13] See: Medicare-Medicaid Plan Quality Rating Strategy, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalMMPQualityRatingsStrategy110615.pdf.

those in very good or excellent health.[14] Cost-sharing forces beneficiaries to determine, with insufficient information, whether chronic care management care is necessary or beneficial for them. Providing the benefit without additional cost allows more consumers to experience quality care coordination and for all stakeholders to reap the benefits.

Thank you for the extensive outreach the Committee and its staff have conducted in developing the draft proposal. We appreciate the thought and dedication the Committee and its staff have placed on understanding the challenge of chronic illness, and the bipartisan collaboration to determine solutions for higher quality care. If you have any questions concerning these comments, I can be reached at JGoldberg@JusticeinAging.org.

Sincerely,

Jennifer Goldberg
Directing Attorney

[14] AARP, *Insight on the Issues: Medicare Beneficiaries Out of Pocket Spending for Health Care*, (2013), available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/medicare-beneficaries-oop-spending-AARP-ppi-health.pdf.