United States Senate Committee on Finance

Bipartisan Chronic Care Working Group
Policy Options Document

December 2015

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Introduction

Last year, the United States Senate Committee on Finance (Committee) took its first step in an important initiative to improve care for the millions of Americans managing chronic illness. On July 15, 2014, the Committee held a hearing entitled, "Chronic Illness: Addressing Patients' Unmet Needs." Senators heard compelling testimony from individuals battling multiple chronic medical conditions who are seeking more effective tools to help them navigate today's complex health care system. Senators also heard from providers, employers, and health plans about the challenges each face in trying to offer higher quality care at lower cost.

That first hearing helped the Committee begin to understand the problem. It also kick-started a longer term, transparent discussion with multiple stakeholders to understand the impact various chronic care coordination efforts might have on the Medicare program and those it serves. On May 15th, the Committee held a second hearing entitled, "A Pathway to Improving Care for Medicare Patients with Chronic Conditions." Senators heard testimony from experts at the Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC). The hearing gave members an opportunity to more closely examine how current chronic care coordination programs are working today, the challenges that remain, and possible solutions to improve health outcomes for Medicare beneficiaries.

During the May 15th hearing, Chairman Hatch and Ranking Member Wyden announced the formation of a bipartisan, Finance Committee chronic care working group (working group), co-chaired by Senators Johnny Isakson and Mark Warner. The working group was tasked with analyzing current law, discussing alternative policy options, and developing bipartisan legislative solutions that would be presented to the full Finance Committee for consideration.

To guide and inform this effort, the Chairman, Ranking Member, and Co-Chairs of the working group, issued a letter on May 22, 2015, formally inviting all interested stakeholders to submit their ideas, based on real world experience and data-driven evidence, on ways to improve outcomes for vulnerable Medicare beneficiaries living with multiple chronic health conditions. Later in July, Chairman Hatch and Ranking Member Wyden publicly released the 530 stakeholder recommendations that were submitted to the working group.

From August through October, the working group studied all 530 stakeholder comments and conducted 80 stakeholder meetings to discuss ideas that improve the way care is delivered to Medicare beneficiaries with chronic diseases. In reviewing all submissions, the working group outlined three main bipartisan goals that each policy under consideration should strive to meet:

1. The proposed policy increases care coordination among individual providers across care settings who are treating individuals living with chronic diseases;

2. The proposed policy streamlines Medicare's current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; and

3. The proposed policy facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency, and contributes to an overall effort that will reduce the growth in Medicare spending.

As the working group spent time with a wide variety of stakeholders to discuss policies submitted in response to the Committee's request, several broad themes began to emerge. However one overarching issue was clear: developing and implementing policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs is a formidable challenge. While we are committed to tackling this urgent matter head on, the Committee has repeatedly stated its intention to proceed thoughtfully.

Since the Affordable Care Act (ACA) became law, there has been an increased focus on programs like Accountable Care Organizations (ACOs) and medical homes that use disease management and care coordination tools to effectively target and better engage individuals with multiple chronic conditions. Recent ACO experience has initially shown promise, but these payment initiatives are still relatively new.

Recently, traditional fee-for-service Medicare has increased its focus on chronic care by implementing new billing codes in the physician fee schedule and by implementing alternative payment models. Yet traditional Medicare still struggles to properly align incentives to providers who engage in labor and time intensive patient care coordination. This underscores the inherent limitations of traditional Medicare's fee-for-service payment system – one that rewards providers for delivering increased volume of services, but doesn't incentivize them to coordinate medical care.

Based on these facts, the chronic care working group understands its difficult task. There are no easy answers. But all the members of the Committee, and their staff, have put in a tremendous amount of time and are dedicated to this process. Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner all believe this represents a strong, bipartisan desire to find real solutions.

The working group takes great pride in the open and transparent manner in which it has conducted its business. All efforts to date have helped frame the issues and identify policy options for the Finance Committee's consideration. At this stage in the process, the Chairman, Ranking Member, and Co-Chairs are pleased to release an options document summarizing key policy ideas we are considering as part of this thoughtful and deliberate process. Releasing this options document is intended to generate additional comments, feedback, and input from Finance Committee members and stakeholder groups as we work on a more finite list of policy ideas that the working group believes may have the greatest potential to improve care coordination in the Medicare program.

Release of the working group's options document, however, does not signal or imply that the Chairman, the Ranking Member, Senator Isakson, or Senator Warner have endorsed any or all of the policies contained herein. The document is simply the next step in a careful, thoughtful, and deliberative Committee process to help the working group determine which proposals deserve increased attention. Ultimately, a key factor in this process will be the involvement of the

Congressional Budget Office (CBO) in scoring proposals and their impact on federal spending. Although stakeholders, and sometimes even Congress, may disagree with how CBO views the impact of a certain Medicare policy option, consideration must be given to the impact new legislative proposals may have on the long term financial health of the Medicare program. As the Chairman and Ranking Member have consistently said, any future legislation must realize savings or it must be budget neutral.

Given these caveats, we are committed to moving forward with the next steps of our bipartisan process – including consideration of comments generated in response to this document. The working group remains united with a common goal: to develop policy options based on data-driven Congressional and stakeholder input that aids the Committee in producing a bipartisan legislative product that can be introduced and marked up next year.

To that end, we request that any individuals, researchers, businesses, organizations, or advocacy groups that are interested in submitting comments – specific to the content and questions outlined in this document – should send a letter or an email to the Senate Finance Committee chronic care reform mailbox at: chronic_care@finance.senate.gov.

The Committee's submission requirements are outlined below:

- All submissions must be made in the form of a PDF attachment. The attachment should be saved using the name of the organization and/or the individual submitting the recommendations.

- Please include the contact name, organization or organizations (if the submission is being submitted on behalf of a group or coalition), phone number, and email address in the body of the email. Please be advised that the Committee requests individual respondents refrain from including any personally identifiable information, such as private home addresses or social security numbers, in their submission.

- Submissions will be accepted through January 26, 2016. Please note that all submitted comments will be considered part of the record and will be made public at a later date.

Thank you for taking the time to provide feedback on these important ideas for chronic care reform in the Medicare program. We look forward to reviewing your feedback.

Receiving High Quality Care in the Home

Home-based primary care teams allow providers to spend more time with their patients to better coordinate health care services, perform medical and functional assessments in a familiar and safe environment, and accept increased accountability for all aspects of the patient's care plan. This approach seeks to improve patient outcomes while reducing health care costs – often accomplished by preventing the need for more expensive care in institutional settings.

Expanding the Independence at Home Model of Care

Background

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) created the Independence at Home (IAH) demonstration under the Medicare program to test a payment incentive and service delivery model that uses physician and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to applicable Medicare beneficiaries with multiple chronic illnesses. Medical practice staff are required to make in-home visits and to be available 24 hours per day, seven days per week to implement care plans tailored to the individual beneficiary's chronic conditions. Under the IAH demonstration, qualifying medical practices continue to receive traditional Medicare fee-for-service payments for services furnished but are eligible for incentive payments, subject to meeting performance standards on quality measures, if actual annual expenditures for applicable beneficiaries are less than the estimated spending target for the year. In the first performance year, 17 participating practices served more than 8,400 Medicare beneficiaries. The demonstration began on June 1, 2012, and will end on September 30, 2017.

Policy under Consideration

The chronic care working group is considering expanding the current IAH demonstration into a permanent, nationwide program. The working group is also contemplating additional modifications to the program. They include using hierarchical condition categories (HCC) risk scores as a way to identify complex chronic care beneficiaries for inclusion in IAH instead of requiring that the individual undergo a non-elective hospitalization within 12 months of his or her IAH program participation.

- The working group is soliciting feedback on any changes, should IAH be expanded nationwide, that could improve the current program design while still achieving savings. Are there specific modifications that could be made to encourage additional practices, beyond the 17 entities that participated in the first performance year, to choose to participate? Are more data needed to evaluate long term performance, outcomes, and savings potential?

- The working group is also seeking input on whether HCC risk scores are available for fee-for-service (FFS) beneficiaries, or if there are alternate methods in place to identify potentially eligible beneficiaries living with multiple chronic conditions.

Reason for Consideration

The IAH model is an example of how the coordinated, team-based care approach can improve health outcomes for Medicare beneficiaries. Although the IAH program’s first practice year data and preliminary performance results were issued only six months ago, the current demonstration

is showing positive results. On average, IAH has saved $3,070 per participating beneficiary – totaling more than $25 million in the demonstration's first performance year.[1]

Expanding Access to Home Hemodialysis Therapy

Background

Medicare requires that a beneficiary receiving dialysis treatment in his or her home receive a monthly clinical assessment with their clinician, often a nephrologist, to review lab work, check for complications, answer questions, and discuss the effectiveness of treatment. Beneficiaries can utilize telehealth to receive this visit only if it occurs in a) an authorized originating site (including a physician office and hospital-based dialysis facility) and b) the site is located in in a rural Health Professional Shortage Area (HPSA) or area county outside a Metropolitan Statistical Area (MSA).

Policy under Consideration

The chronic care working group is considering expanding Medicare's qualified originating site definition to include free-standing renal dialysis facilities located in any geographic area. This would give Medicare beneficiaries who receive dialysis therapy at home the option to go to a freestanding renal dialysis facility to have their monthly visit with their clinician via telehealth without geographic restriction. The beneficiary would retain the option to receive an in-person monthly visit with his or her clinician.

- The working group is soliciting feedback on whether any safeguards should be in place for beneficiaries who are undergoing home dialysis therapy and would be utilizing their expanded access to monthly visits via telehealth, such as a requirement that there be at least one in-person visit every three to six months.

- The working group is also soliciting feedback on whether the home also should be considered an originating site for this limited purpose, or reasons that the home would not be an appropriate originating site (*e.g.* whether the home lacks the necessary clinical equipment for the monthly visit).

Reason for Consideration

Approximately one in ten beneficiaries afflicted by End-Stage Renal Disease (ESRD) receive home dialysis. Adding free-standing renal dialysis facilities, and even a beneficiary's home, to the list of Medicare's approved originating sites, would provide greater flexibility and less travel for beneficiaries who choose to dialyze at home. According to a report published by the Government Accountability Office (GAO), "Studies have shown that patients who perform dialysis at home may have increased autonomy and health-related quality of life." This change in

[1] Centers for Medicare and Medicaid Services. June 2015. Press release. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-18.html.

policy regarding the monthly visit with a beneficiary's nephrologist could help to encourage patient independence.[2]

Advancing Team-Based Care

Surrounding chronically-ill beneficiaries with an interdisciplinary health care team is a model that, in certain settings and under specialized arrangements, can lead to stronger patient outcomes and reduced overall expenditures. Today many chronically ill beneficiaries, particularly those enrolled in traditional Medicare, may lack access to a proven, team-based care structure.

Providing Medicare Advantage Enrollees with Hospice Benefits

Background

Medicare Part A provides coverage for hospice care – care for a beneficiary's terminal illness and related conditions – if a beneficiary has been certified as having a life expectancy of six months or less, has accepted palliative care instead of curative treatment, and has signed a statement choosing hospice care instead of other Medicare-covered treatments for their terminal illness and related conditions. Medicare Advantage (MA) plans receive a risk-adjusted capitated payment that includes all Part A-covered items and services, except hospice care. Beneficiaries enrolled in a MA plan may elect the hospice benefit if they meet the benefit requirements; however, MA plans are not required to assume financial risk of their enrollees' hospice care. Rather, for beneficiaries enrolled in a MA plan who elect the hospice benefit, MA plans receive a reduced risk-adjusted capitated amount for health care items and services not related to the enrollees' terminal illness while Medicare Part A provides payment for the enrollee's hospice care.

Policy under Consideration

The chronic care working group is considering requiring MA plans to offer the hospice benefit provided under traditional Medicare. The full scope of the hospice benefit, including the required care team and written care plan, would be required. If a policy change is made, the current MA payment system would need to be adjusted to take into account this additional benefit. In addition, the MA five-star quality measurement system would need to be updated to include measures associated with hospice care. Such additional quality measures would include, but are not limited to, health outcomes (including patient satisfaction) and appropriate level of care.

- The working group is soliciting feedback on specific plan-level measures that could be used to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care.

[2] United States Government Accountability Office. October 2015. "Medicare Payment Refinements Could Promote Increased Use of Home Dialysis." Available at: http://gaonet.gov/assets/680/673140.pdf.

- The working group is soliciting feedback on other safeguards that should be in place to ensure MA enrollees have access to high quality hospice services.

Reason for Consideration

Under current law, MA enrollees may elect to use hospice, but are either required to disenroll completely from MA or receive a combination of services from traditional Medicare and MA. Both of these options lead to either a disruption in care or fragmented care delivery.

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

Background

Individuals who are under 65 years old and are not receiving Social Security Disability Insurance (SSDI) benefits are entitled to Medicare if they are diagnosed with end-stage renal disease (ESRD) – permanent kidney failure – and meet limited work requirements. Beneficiaries who are entitled to Medicare solely on the basis of ESRD are prohibited from enrolling in a Medicare Advantage (MA) plan unless (1) a Medicare Advantage Special Needs Plan is available in the beneficiary's area or (2) the beneficiary is receiving health benefits through the same organization that offers a MA plan. Beneficiaries enrolled in a MA plan who are entitled to Medicare due to age or SSDI and subsequently develop ESRD, such beneficiaries may stay in the same MA plan or join a different plan offered by the same company. Additionally, an ESRD beneficiary who has had a successful kidney transplant and subsequently becomes entitled to Medicare due to age or SSDI may enroll in a MA plan.

Policy under Consideration

The chronic care working group is considering that all beneficiaries with ESRD, no matter when the condition began, be permitted to enroll in a MA plan. Payment to MA plans for beneficiaries with ESRD would be adjusted to take into account this change.

- The working group is seeking input on how MA benchmarks and bids would need to be adjusted to ensure accurate payment and not increase overall program costs.

- The working group is soliciting feedback on what quality measures are available to ensure that ESRD beneficiaries would have the information to make an informed choice when deciding whether to enroll in a MA plan.

Reason for Consideration

Beneficiaries who are enrolled in a MA plan may choose to stay in a MA plan or move to fee-for-service upon diagnosis with ESRD. However, there are a number of Medicare beneficiaries in fee-for-service when they are diagnosed with ESRD. Under current law, beneficiaries who are in fee-for-service are not permitted to enroll in a MA plan once they have been diagnosed with ESRD. Now that we have over a decade of MA program experience, it is unclear if this prohibition is still necessary.

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

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) established a new Medicare Advantage (MA) coordinated care plan to provide services for individuals with special needs. Special needs plans (SNPs) are permitted to target enrollment to one or more types of special needs individuals, including those who are (1) institutionalized, (2) dually eligible for both Medicare and Medicaid, or (3) living with severe or disabling chronic conditions. Among other changes, the Affordable Care Act extended SNP authority through December 31, 2013, and temporarily extended authority through the end of 2012 for dual eligible SNPs without contracts with state Medicaid programs to continue to operate, but in their current service areas. After 2012, dual eligible SNPs, new and renewing, were required to have contracts with state Medicaid agencies. Several subsequent laws have extended SNP authority without interruption; most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended SNP authority through December 31, 2018.

Policy under Consideration

The chronic care working group is considering either a long term extension or a permanent authorization of the SNPs, including SNPs that enroll beneficiaries in need of institutional level of care (I-SNPs), SNPs that enroll beneficiaries eligible for both Medicare and Medicaid (D-SNPs), and SNPs that enroll beneficiaries with certain chronic diseases (C-SNPs). The chronic care working group is also considering requiring D-SNPs to offer fully integrated Medicare and Medicaid services to their enrollees.

- The working group is soliciting feedback on what modifications should be made to C-SNPs should another policy be implemented that would allow general Medicare Advantage plans greater flexibility in their benefit design to treat chronically ill beneficiaries (see "Adapting Benefits to Meet the Needs Chronically Ill Medicare Advantage Enrollees").

- The working group is soliciting feedback on how much time is needed for states and D-SNPs to successfully integrate all Medicare and Medicaid services.

Reason for Consideration

SNPs enroll some of the most vulnerable and complex beneficiaries, many of whom have chronic diseases. SNPs enroll beneficiaries who have an institutional level need of care, are dually eligible for Medicare and Medicaid, or have a chronic disease. A long term extension of SNPs would allow for greater planning of and investment in successful care models that SNPs provide to these vulnerable beneficiaries. Congress's current pattern of short-term extensions limits the use and growth of SNPs.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

Background

The Centers for Medicare & Medicaid Services (CMS) has addressed chronic care management (CCM) in recent Medicare Physician Fee Schedule rules. The calendar year 2015 final rule established that Medicare would begin paying separately for CCM services under the Physician Fee Schedule effective January 1, 2015. The CPT code (99490) for CCM services may be billed when the following conditions are satisfied: "at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised or monitored."[3] The Centers for Medicare & Medicaid Services reimburses an average of $42 for the CCM code and beneficiaries are responsible for a 20 percent copayment of approximately $8.

Policy under Consideration

The chronic care working group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions. Managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit that often includes practice team members such as social workers, dieticians, nurses, and behavioral health specialists. The current chronic care management code covers a portion of that labor-intensive cost, the proposed new high-severity code payment would be higher to compensate providers who require more than the typical allotted time per month.

MedPAC has testified that unless new codes are carefully defined (this includes which beneficiaries are eligible, which providers are allowed to bill for the service, and what services can be offered), adding more codes – or modifying existing codes – may produce the unintended result of increasing Medicare payments without commensurate improvement in the quality of care provided to a chronic care patient.

- The working group is soliciting feedback as to the patient criteria for this potential new code. For example, beneficiaries that could be eligible could be those with five or more chronic conditions, one chronic condition in conjunction with Alzheimer's or a related dementia, or a chronic condition combined with impaired functional status.

- The working group is seeking input on the types of providers who should be eligible to bill the new high severity chronic care code. Clinicians who could be eligible to receive

[3] Centers for Medicare and Medicaid Services, Medicare Learning Network, Chronic Care Management Services, May 2015. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

advanced care coordination payments are those who offer comprehensive, ongoing care to a Medicare beneficiary over a sustained period of time.

- The working group is requesting input on methodologies to measure the impact, effectiveness, and compliance in relation to this new payment construct.

- The working group is also soliciting feedback as to whether the new code should be (1) made permanent, (2) temporarily mandated until CMS has sufficient time and data to analyze the effectiveness of the current CCM code as well as the proposed higher severity code and provide a report to Congress, or (3) temporarily instituted while giving the Secretary of the Department of Health and Human Services authority to continue, discontinue, or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors.

Reason for Consideration

Beneficiaries with multiple chronic conditions, or those with one chronic condition combined with a mental health impairment, often incur significantly higher costs than traditional fee-for-service (FFS) beneficiaries. These beneficiaries also have complex, time intensive, and labor intensive care management needs that extend beyond the time available during an in-person visit with a clinician. The current CCM code allows a provider to bill one patient, per month for a 20 minute time allotment spanning a 30 day timeframe. This structure may be insufficient to capture the time needed for a clinician to manage a complex patient's care.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

Background

Medicare provides coverage for treatment of mental illness and substance abuse disorders; however, the coverage is not as broad as it is for other services. Medicare will pay for a beneficiary to receive treatment for alcoholism and substance abuse disorders in both inpatient and outpatient settings. Mental health services and visits with psychiatrists or other doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, and physician assistants are covered by Medicare. For outpatient mental health services Medicare does not cover meals, transportation to or from mental health care services, support groups that bring people together to talk and socialize (though group psychotherapy is covered), or testing or training for job skills that are not part of the beneficiary's mental health treatment.[4] For inpatient mental health care, Medicare does not cover private duty nursing or a private room, unless medically necessary.

Policy under Consideration

The working group is considering developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Policies would

[4] Centers for Medicare & Medicaid Services. "Medicare & Your Mental Health Benefits." Available at: https://www.medicare.gov/pubs/pdf/10184.pdf.

encourage care integration whether the beneficiary elects enrollment in traditional Medicare FFS, a Medicare FFS Alternative Payment Model, or a MA plan.

- The working group is soliciting specific policy proposals to meet the goals stated above.

The chronic care working group is also considering a recommendation that the Government Accountability Office (GAO) conduct a study on the current status of the integration of behavioral health and primary care among private sector Accountable Care Organizations (ACOs), public sector ACOs, and ACOs participating in the Medicare Shared Savings Program (MSSP), as well as private and public sector medical homes.

Reason for Consideration

Behavioral health problems hinder the successful management of chronic conditions. Research has shown that the integration of behavioral health and primary care can improve care coordination and health outcomes while decreasing costs.[5] Stakeholders and researchers indicate that ACOs and other models face challenges integrating primary care and behavioral health services, despite the benefits of doing so.[6]

Expanding Innovation and Technology

Chronically-ill beneficiaries benefit from services and technologies that are tailored to address their unique needs. Innovation in benefit design and technology can increase beneficiary access to services that are critical to improve chronic disease management.

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

Background

Under Medicare Advantage (MA) private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll. Unlike original Medicare, where providers are paid for each item or service provided to a beneficiary, a MA plan receives the same capitated monthly payment regardless of how many or few services a beneficiary actually uses. The plan is at-risk if aggregate costs for its enrollees exceed program payments and beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing.

[5] Levey, Shandra M. B., Miller, B. F. & deGruy III, F. V. September 2012. "Behavioral Health Integration: an Essential Element of Population-Based Healthcare Redesign." *Transitional Behavioral Medicine: 2*(3): 364-371. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717906/pdf/13142_2012_Article_152.pdf.
[6] Lewis, V. A., Colla, C. H., Tierney, K., Citters, A. D., Fisher, E. & Meara, E. October 2014. "Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse with Primary Care." *Health Affairs: 33*(10): 1808-1816. Available at: http://content.healthaffairs.org/content/33/10/1808.abstract.

Policy under Consideration

The chronic care working group is considering giving MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees. This flexibility would allow a MA plan to provide tailored benefits that would reasonably be expected to improve the care and/or prevent the progression of the chronic conditions affecting MA enrollees.

Specifically, the chronic care working group is considering allowing MA plans to offer:

- Additional supplemental benefits not currently allowed that are related to the treatment of the chronic condition or the prevention of the progression of the chronic disease;

- Reduction in cost sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease;

- Adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic condition or prevent the progression of the chronic disease; and

- Care improvement and/or wellness programs specifically tailored for the chronic condition.

The working group is soliciting feedback on:

- Whether all MA plans should be permitted this flexibility, or if a subset of plans based on quality, experience, or other criteria should be eligible.

- The process by which chronic diseases would be identified for which MA plans benefits would be tailored.

- What other requirements MA plans should be required to meet to ensure changes to benefit design improve care for chronically ill beneficiaries and do not disrupt care for beneficiaries who do not have a chronic condition.

- What, if any, changes would need to be made to Special Needs Plans if this policy were implemented.

Reason for Consideration

Currently, MA plans must offer the same benefit package to all of its enrollees, despite the different health needs of these enrollees. Allowing MA plans to specifically tailor their benefit package to meet the needs of chronically ill individuals will help improve management of chronic diseases and/or prevent the progression of these diseases.

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

Background

All Medicare Advantage (MA) plans must offer required Medicare benefits (except hospice) and may offer additional or supplemental benefits. Mandatory supplemental benefits are covered by the MA plan for every person enrolled in the plan and are paid for either through plan rebates, a beneficiary premium, or cost sharing. Optional supplemental benefits must be offered to all plan enrollees, but the enrollee may choose to pay an additional amount to receive coverage of the optional benefit; optional benefits cannot be financed through plan rebates.

MA plans must adhere to specific rules regarding the supplemental benefits that they can offer. First, the MA plan cannot design a benefit plan that is likely to substantially discourage enrollment by certain MA eligible individuals (i.e., the antidiscrimination requirement.) Further, supplemental benefits (a) may not be Medicare Part A or Part B required services, (b) must be primarily health related with the primary purpose to prevent, cure, or diminish an illness or injury, and (c) the plan must incur a cost when providing the benefit. Items that are primarily for comfort or are considered social services would not qualify as supplemental benefits. Examples of supplemental benefits include the following:

(a) Additional inpatient hospital days in an acute care or psychiatric facility,
(b) Acupuncture or alternative therapies,
(c) Counseling services,
(d) Fitness benefit,
(e) Enhanced disease management, and
(f) Remote Access Technologies (including Web/Phone based technologies).

Policy under Consideration

The chronic care working group is considering allowing MA plans to offer a wider array of supplemental benefits than they do today. These additional supplemental benefits could be medical services or other non-medical, social services that improve the overall health of individuals with chronic disease. Any new supplemental benefits would continue to be paid by plans' rebate dollars.

- The working group is soliciting input on the criteria that could be used to determine what new supplemental benefits could be offered by a MA plan.

- The working group is soliciting input on whether safeguards should be put in place so that the offering of new supplemental benefits does not lead to abusive practices and/or inappropriate enrollment.

Reason for Consideration

A wide range of non-medical or social factors, such as nutrition, are important contributors to the health and costs of chronically-ill individuals. Currently, MA plans are able to provide some services not traditionally covered under fee-for-service Medicare. However, there are additional services that may particularly benefit chronically ill beneficiaries that are currently not permitted to be offered by MA plans as supplemental benefits.

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

Background

Telehealth is the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, and other health care delivery functions. While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program recognizes and pays for only certain Part B telehealth services. These services must be either (1) remote patient and physician/professional face-to-face services delivered via a telecommunications system (e.g., live video conferencing), or (2) non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services in the case of any Federal telemedicine demonstration program in Alaska or Hawaii. Typically, Medicare coverage for remote face-to-face services includes payments (1) to physicians or other professionals (at the distant site) for the telehealth consultation, and (2) to the facility where the patient is located (the originating site).

While there is nothing to preclude Medicare Advantage (MA) from providing telemedicine or other technologies that they believe promote efficiencies, those services and technologies are not separately paid for by Medicare. MA plans may provide basic telehealth benefits as part of the standard benefit; for example, telemonitoring and web-based and phone technologies can be used to provide telehealth services. Medicare Advantage Prescription Drug (MAPD) may choose to include telehealth services as part of their plan benefits, for instance, in providing medication therapy management (MTM).

Policy under Consideration

The chronic care working group is considering permitting MA plans to include certain telehealth services in its annual bid amount. The use of these technologies would not be used as a substitute to network adequacy requirements.

- The working group is soliciting feedback on whether the telehealth services provided by the plan be limited to those allowed under the traditional Medicare program.

- The working group is also soliciting feedback on whether additional telehealth services be permitted and, if so, which ones.

Reason for Consideration

Currently, MA plans must use their rebate dollars to pay for telehealth services as a supplemental benefit. Telehealth technology is not necessarily an additional benefit, but rather an alternative mode of care delivery of mandatory benefits to an enrollee.

Providing ACOs the Ability to Expand Use of Telehealth

Background

While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program restricts telehealth payments by the type of services provided, the geographic location where the services are delivered, the type of institution delivering the services, and the type of health provider. While there is nothing to preclude ACOs from providing telemedicine or other technologies that they believe promote efficiencies, those services and technologies are not separately paid for by Medicare.

Policy under Consideration

The chronic care working group is considering modifying the requirements for reimbursement for telehealth services provided by ACOs in the Medicare Shared Savings Program (MSSP). The HHS Secretary would be required to establish a process by which ACOs participating in MSSP two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for telehealth services.

- The working group is soliciting feedback on whether to lift the originating site requirement entirely or to specify additional originating sites. For example, if the originating site is the beneficiary's home, what safeguards would be needed to ensure that proper clinical equipment is readily available?

Reason for Consideration

Traditionally telehealth has been viewed as a tool to improve access to services, but interest is growing to see if telehealth has the potential to reduce health care costs. Telehealth may have the potential to replace some face-to-face office visits, reduce emergency room visits, and prevent hospitalizations. Telehealth may also keep beneficiaries in closer, more consistent contact with providers. On July 29, 2015, the Congressional Budget Office (CBO) concluded that when telehealth services are clearly substituting for existing clinical services, then the potential to reduce Medicare program costs increases. However, when telehealth services appear to supplement existing provider services, or negatively alter patient and provider utilization incentives, then increasing telehealth service access are estimated to increase Medicare program costs.

The provision of telehealth services has the potential to improve access to care, lower costs, and improve health outcomes.[7,8] The chronic care working group previously received stakeholder feedback indicating telehealth services are an important tool at the ACO's disposal to improve quality and lower costs. Establishing this policy only for those ACOs participating in two-sided risk models may insulate against unnecessary utilization.

Maintaining ACO Flexibility to Provide Supplemental Services

Background

Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) participants are paid under Part A and Part B for services delivered to Medicare beneficiaries. In addition, the participating ACO may receive a shared savings payment if the quality performance standards are satisfied and the ACO has generated sufficient shareable savings under the performance–based payment methodology. Like other Medicare providers, ACOs are permitted to provide services not covered by Medicare if the ACO does not submit a claim to Medicare.

Policy under Consideration

The chronic care working group is considering clarifying that ACOs participating in the MSSP may furnish a social service or transportation service for which payment is not made under fee-for-service Medicare.

The chronic care working group is also considering clarifying that ACOs participating in the MSSP may furnish a remote patient monitoring service for which payment is not made under fee-for-service Medicare. These clarifications would enable ACOs to spend their own resources on a broader range of services and capabilities to best serve their patient population.

Reason for Consideration

A growing body of evidence suggests that the provision of social services in conjunction with health care services can lower health care use and costs, and improve health outcomes.[9] The working group has received feedback that the provision of social services and transportation services could assist ACOs in accomplishing their goal of improving health care quality and lowering costs.

The working group has also received feedback that ACOs benefit from retaining the flexibility to use remote patient monitoring services in accomplishing their goal of improving health care quality and lowering costs.

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[7] Noel, H.C., Vogel, D.C, Erdos, J.J., Cornwall, D. & Levin F. 2004. "Home Telehealth Reduces Healthcare Costs." *Telemedicine Journal and e-Health: 10*(2): 170-183.

[8] Uscher-Pines, L. & Mehrotra, A. February 2014. "Analysis of Teladoc Use Seems to Indicate Expanded Access to Care for Patients without Prior Connection to a Provider." *Health Affairs: 33*(2): 258-264. Available at: http://content.healthaffairs.org/content/33/2/258.abstract.

[9] Shier, G., Ginsburg, M., Howell, J., Volland, P. & Golden, R. March 2013. "Strong Social Support Services, Such as Transportation and Help for Caregivers, Can Lead to Lower Health Care Use and Costs." *Health Affairs, 32*(3): 544-541. Available at: http://content.healthaffairs.org/content/32/3/544.long.

Expanding Use of Telehealth for Individuals with Stroke

Background

Currently, Medicare pays for physician services involved in stroke treatment under the Physician Fee Schedule, with the hospital being paid under the Hospital Outpatient Prospective Payment System and Inpatient Prospective Payment System. While many of these physician services are furnished on-site when the beneficiary presents symptoms of stroke at the hospital emergency department, Medicare will pay a physician, at a distant site, for consulting on a patient experiencing acute stroke symptoms via telehealth if the originating site hospital, where the beneficiary is, is in a rural HPSA or a county outside an MSA.

Policy under Consideration

The working group is considering eliminating the originating site geographic restriction for the narrow purpose of promptly identifying and diagnosing strokes. This would provide every Medicare beneficiary the ability to receive an evaluation critical to diagnosis of an acute stroke via telehealth from a neurologist not on-site. Specifically, this would allow for individuals in urban areas to receive this form of care delivery.

Reason for Consideration

Using telehealth to identify individuals experiencing a stroke can facilitate in the diagnosis and aide in prevention of debilitating effects associated with delayed treatment, particularly in areas of the country that lack the clinicians most experienced in diagnosing acute stroke.[10] Currently, this type of care delivery model is only available to individuals in a rural area due to Medicare's originating site geographic restrictions. Prompt, accurate diagnosis leads to timely treatment that can dramatically improve patient outcomes.

Identifying the Chronically Ill Population and Ways to Improve Quality

Plans and providers that participate in the Medicare program should be appropriately paid for and evaluated on the care that they provide to chronically ill Medicare beneficiaries. Plans, providers and beneficiaries all benefit from policies that ensure these goals are met.

Ensuring Accurate Payment for Chronically Ill Individuals

Background

Payments made to Medicare Advantage (MA) plans are risk adjusted using the Centers for Medicare & Medicaid Services (CMS)-Hierarchical Conditions Category (HCC) Risk Adjustment Model are risk adjusted to take into account the demographic and health history of those who actually enroll in the plan. The size of the adjustment takes into account the severity

[10] Hess, D.C. & Audebert, H. J. "The History and Future of Telestroke." May 2013. *Nature Review Neuroscience 9*: 340-350.

of a beneficiary's illness and the accumulated effect of multiple diseases, as well as interactive effects – instances where having two or more specified diseases or characteristics results in expected health care expenditures that are larger than the simple sum of the effects. While demographic information alone explains less than one percent of the variation in the health care expenditures of Medicare beneficiaries, the addition of health history information increases the amount of variation in spending that is predicted by the model to over 12 percent of spending.

Policy under Consideration

The Chronic Care Working Group is considering making changes to the CMS- HCC Risk Adjustment Model. Specifically these changes to the CMS-HCC Model would take into account the following:

- Any changes in predicted costs associated with the total number of conditions of an individual beneficiary, including any cumulative impact of a large number of conditions;

- Any changes in predicted costs associated with the interaction between behavioral/mental health conditions with physical health conditions;

- The differences in costs associated with beneficiaries who are dually eligible for both Medicare and Medicaid through different eligibility pathways; and

- The use of more than one year of data to establish a beneficiary's risk score.

The Chronic Care Working Group is also considering a study to examine whether the use of functional status, as measured by activities of daily living or by other means, would improve the accuracy of risk-adjustment payments. The study could also examine the challenges in providing and reporting functional status information by MA plans, providers and/or by the CMS.

- The working group is soliciting feedback on what other potential changes to the HCC model should be considered.

- The working group is also soliciting feedback on which changes, if any, should be differentially applied to CMS payment models, such as Medicare Advantage or Accountable Care Organizations.

Reason for Consideration

The purpose of risk adjustment is to predict costs associated with different types of beneficiaries. Research shows that the current HCC risk adjustment model under-predicts high cost, complex individuals. Accurate risk adjustment is imperative to ensuring that providers and plans are fairly paid for the costs they incur for providing care to chronically ill individuals.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

Background

Medicare fee-for-service beneficiaries are assigned to Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) based on their utilization of primary care services provided by a physician who is an ACO provider/supplier. Beneficiaries currently do not have the option of choosing to participate directly in an ACO (aside from seeking care from a particular provider), but are notified if their primary care provider is an ACO participant. Beneficiaries who receive at least one primary care service from a primary care physician within the ACO may be assigned to that ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO.

Beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO but who receive at least one primary care service from any physician within the ACO are assigned to that ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians.

Policy under Consideration

The chronic care working group is considering recommending that ACOs in MSSP Track One be given the choice as to whether their beneficiaries be assigned prospectively or retrospectively.

Also, the Chronic Care Working Group is considering recommending that Medicare fee-for-service beneficiaries have the ability to voluntarily elect to be assigned to the ACO in which their main provider is participating. The Secretary would be required to establish a process by which beneficiaries could voluntarily elect to be assigned to a MSSP ACO while still retaining their freedom of choice to see any provider.

The working group is soliciting feedback on whether:

- A beneficiary who voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO.

- ACOs that are assigned beneficiaries prospectively should receive an upfront, collective payment for all services provided to the beneficiaries in the ACO.

- ACOs that provide services to beneficiaries who voluntarily elect to enroll in the ACO should receive an upfront collective payment for all services provided to these beneficiaries.

Reason for Consideration

The manner in which Medicare fee-for-service beneficiaries are assigned to an ACO affects how the ACO can tailor care for its beneficiaries and how the ACO is evaluated. Under current Centers for Medicare & Medicaid (CMS) rules, Medicare determines the method of beneficiary

attribution, rather than giving ACOs the option to choose the assignment methodology that best fits their model of care. Medicare fee-for-service beneficiaries can be assigned to an ACO either retrospectively or prospectively depending on the ACO's track.

Prospective assignment allows ACOs to identify beneficiaries for whom they will be held accountable and proactively take steps to connect these beneficiaries to appropriate care, but also holds ACOs accountable for the spending for these beneficiaries even if the ACO providers do not provide the care. Retrospective assignment ensures that ACOS are held accountable for the spending only of those beneficiaries who receive most of their primary care services from ACO providers, but they may not know who those beneficiaries are until the end of the year.

In addition, Medicare fee-for-service beneficiaries are currently assigned to an ACO using claims data. Beneficiaries may have relationships with ACO primary care providers that are not captured through baseline or plan-year claims.

Developing Quality Measures for Chronic Conditions

Background

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Title XVIII of the Social Security Act was amended to require the Secretary of Health and Human Services to develop a plan for the development of quality measures. Under such plan, the Secretary is required to address how measures used by private payers and integrated delivery systems could be incorporated in Medicare; describe how coordination, to the extent possible, will occur across organizations developing such measures; and take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures. In developing the plan and funding measure development to execute it, the Secretary is required to give priority to outcome measures (including patient reported outcome and functional status measures), patient experience measures, care coordination measures, and measures of appropriate use of services (including measures of over use).

Policy under Consideration

The chronic care working group is considering requiring that Centers for Medicare & Medicaid Services (CMS) include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. Topic areas related to chronic conditions that the working group is specifically considering include:

- Patient and family engagement, including person-centered communication, care planning, and patient-reported measures;

- Shared decision-making;

- Care coordination, including care transitions and shared accountability within a care team;

- Hospice and end-of-life care, including the process of eliciting and documenting individuals' goals, preferences, and values, quality of life, receipt of appropriate level of care, and family/caregiver experience of care;

- Alzheimer's and dementia, including measures for family caregivers, outcomes, affordability, and engagement with the healthcare system or other community support systems;

- Community-level measures, in areas such as obesity, diabetes and smoking prevalence.

The working group is also considering recommending that Government Accountability Office (GAO) conduct a report on community-level measures as they relate to chronic care management. The report would discuss appropriate measures in this domain and provide recommendations for holding providers accountable to community-level measures, linking provider payment to these measures, and encouraging the use of these measures.

Reason for Consideration

Improvement in health care delivery for individuals with chronic disease is facilitated in part by the development of quality measures that specifically target the unique needs of these individuals. The current quality measurement landscape does not have sufficient measures that can be used to monitor the quality of care for individuals with multiple chronic conditions.

Empowering Individuals & Caregivers in Care Delivery

Providing timely, accurate tools and information can empower Medicare beneficiaries to better manage their chronic diseases. These strategies can improve health care quality and outcomes, and reduce costs to both beneficiaries and the Medicare program.

Encouraging Beneficiary Use of Chronic Care Management Services

Background

The calendar year 2015 final rule established that Medicare would begin paying separately for chronic care management (CCM) services under the Physician Fee Schedule, effective January 1, 2015. The current chronic care management code, as described in the section, "Improving Care Management Services for Individuals with Multiple Chronic Conditions", may be billed when services provided satisfy the following condition: "at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised or monitored." The Centers for Medicare & Medicaid Services reimburses an average of $42 for the CCM code and beneficiaries are responsible for a 20 percent copayment of approximately $8.

Policy under Consideration

The chronic care working group is considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code described above.

- The working group is soliciting input on the extent that waiving cost sharing would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provides supplemental coverage.

- The working group is soliciting feedback as to whether waiving cost sharing addresses the concern that beneficiaries may question CCM services that appear on summary of benefit notices because they do not involve a face-to-face physician encounter.

Reason for Consideration

Waiving the beneficiary co-pay may encourage some providers, who find the approximately $8 monthly co-payment confusing and burdensome to collect, in order to bolster the chronic care code take up rate.

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

Background

Currently there is no specific payment code for a one-time visit to discuss issues associated with a diagnosis of a serious or life-threatening illness, such as Alzheimer's/Dementia.

Policy under Consideration

The chronic care working group is considering requiring that Centers for Medicare & Medicaid Services (CMS) implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a diagnosis of a serious or life-threatening illness, such as Alzheimer's/Dementia. The purpose of this visit would be to discuss the progression of the disease, treatment options, and availability of other resources that could reduce the patient's health risks and promote self-management.

- The working group is soliciting feedback on the scope of diseases that would be considered a serious or life-threatening illness and, thus be eligible for a Medicare-covered planning visit.

- The working group is soliciting feedback on whether the nature of certain illnesses is more conducive to dedicated, covered planning visits upon diagnosis than other serious, chronic conditions.

- The working group is soliciting feedback on whether a planning visit should have different required elements for each illness, and, if so, the extent that per-illness requirements are manageable for physicians who diagnose multiple serious or life-threatening illnesses.

- The working group is soliciting feedback on how the requirements of this payment code should interact with the requirements of the current chronic care management code or the high severity chronic care code under consideration in order not to duplicate payments.

Reason for Consideration

Diagnoses of serious or life-threatening illnesses, such as Alzheimer's/Dementia, are devastating to Medicare beneficiaries and their families. Some of these illnesses do not have a predictable disease progression, do not have an arsenal of treatment options that can be immediately deployed, and symptoms may not manifest for years. These circumstances make it imperative that a discussion between the patient and their doctor occurs upon diagnosis.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

Background

Accountable Care Organizations (ACOs) were conceived as collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, and others. ACOs in the Medicare Shared Savings Program are intended to provide incentives to providers to manage care across the continuum by reducing health care costs while meeting performance standards on quality of care. The Centers for Medicare & Medicaid Services notes that the coordinated care provided through ACOs may help to ensure that patients, especially the chronically ill, "get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."[11] Beneficiaries who are assigned to ACOs continue to have standard Medicare Part A and B cost-sharing responsibilities, including deductibles and coinsurance payments.

Policy under Consideration

The chronic care working group is considering allowing ACOs in two-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease.

- The working group is soliciting feedback on whether the items/services eligible for reduction should be defined through rulemaking or be left to the discretion of the ACO.

[11] Centers for Medicare & Medicaid Services. "Accountable Care Organizations (ACO)." Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/Aco.

- The working group is also soliciting feedback on the type of cost sharing that could be waived, such as copays, coinsurance, or deductibles.

- The working group is requesting input on the extent that waiving cost sharing would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provide supplemental coverage.

Reason for Consideration

A broad body of research has shown that individuals often make decisions about their health care based on the cost of services. In some cases, cost sharing at the point of service may discourage individuals from seeking out care they need, including preventive care or chronic disease management. Delaying or forgoing preventive care or care related to chronic disease management may lead to increased costs and poor health outcomes. ACOs are accountable for the health outcomes and costs of their attributed beneficiaries, and ACO beneficiaries may be more likely to seek out preventive care or chronic disease management if the cost of accessing those services is low. Providing this option under a two-sided risk model will allow ACOs to best determine whether waiving cost sharing will lead to higher quality care and achieve increased savings for both the ACO and the Medicare program.

Expanding Access to Prediabetes Education

Background

Diabetes self-management training (DSMT) is a covered service under Medicare Part B for beneficiaries who are at risk of complications from diabetes. The training includes a variety of techniques, including instruction on how to self-monitor blood glucose level; education of proper diet and exercise habits; creating a patient-specific insulin treatment plan; medication adherence; and motivating the patient to follow through on these activities to manage their diabetic needs. DSMT covers up to 10 hours of initial training for a patient in a 12-month period and an additional 2 hours of follow-up training in each subsequent year.

Policy under Consideration

The chronic care working group is considering recommending that Medicare Part B provide payment for evidence-based lifestyle interventions that help people with prediabetes reduce their risk of developing diabetes. The Secretary would be required to establish criteria for this program in accordance with the standards under the National Diabetes Prevention Program established by the Centers for Disease Control and Prevention.

- The working group is requesting feedback on whether to allow such a program to be delivered by entities that are currently not providers under the Medicare statute, such as non-profit organizations and departments of health; and if so, what requirements these entities should be required to meet.

- The working group is also soliciting feedback on whether there is evidence to support coverage of services analogous to DSMT for beneficiaries who are at risk of complications from other chronic conditions.

Reason for Consideration

Under current law, only Medicare fee-for-service beneficiaries who have been diagnosed with diabetes and are at risk of complications for diabetes are eligible to receive diabetes self-management training. Individuals who are at risk of developing diabetes ("prediabetes") are not eligible to receive this type of self-management training. Furthermore, DSMT may currently only be delivered by a limited set of providers. Preventing the progression of prediabetes to type one or two diabetes is better for individuals and the nation's health care spending.

The National Diabetes Prevention Program is a well-established, evidence-based program. This model could be adapted within the Medicare program to include other diseases in addition to diabetes.

Expanding Access to Digital Coaching

Background

Currently, the Centers for Medicare & Medicaid Services (CMS) uses its www.Medicare.gov website and the 'Medicare Learning Network' to deliver information regarding benefits, coverage, and programs, along with resources for the health care professional community. The "Medicare and You" Handbook provides similar information to beneficiaries.

Policy under Consideration

The working group is considering requiring the Centers for Medicare & Medicaid Services (CMS) to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-management of their own health. There would need to be a mechanism to ensure the information is valid and up-to-date.

- The working group is soliciting feedback on whether Medicare.gov is an appropriate site for this information or whether beneficiaries have other venues to obtain valid, reliable information.

- The working group is soliciting feedback on whether this activity should be conducted by an outside entity and, if so, what level of oversight is required to ensure individuals receive accurate and reliable information.

- The working group is soliciting feedback on what type of information would be most beneficial for beneficiaries.

Reason for Consideration

Reliable information about a chronic disease and ways to manage that disease will help individuals and their families. However, there are myriad websites containing health care information and there are no assurances that the information is accurate or up-to-date. The Medicare.gov website is a trusted source of information for Medicare beneficiaries on benefits and coverage and could be a valuable tool to provide important health care information for beneficiaries.

Other Policies to Improve Care for the Chronically Ill

There are other specific topics beyond those outlined above that affect individuals with chronic diseases. In particular, there are certain gaps that should be studied in further depth due to their potential high impact on chronic disease management.

Increasing Transparency at the Center for Medicare & Medicaid Innovation

Background

Section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) established within the Centers for Medicare & Medicaid Services (CMS) the Center for Medicare and Medicaid Innovation (CMMI). The purpose of CMMI is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP) while preserving or enhancing quality of care. In selecting these models, the Secretary of Health and Human Services (HHS) is required to give preference to models that improve the coordination, quality, and efficiency of health care services. In its most recent report to the Congress (December, 2014), CMS reports that since the Innovation Center was established in 2010, it has launched 22 payment and service delivery initiatives that currently involve over 2.5 million Medicare, Medicaid, and CHIP beneficiaries and more than 60,000 providers.[12]

Policy under Consideration

The chronic care working group is considering modifications that would either require CMMI to issue required notice and comment rulemaking for all models that affect a significant amount of Medicare spending, providers or beneficiaries, or require CMMI to issue notice and comment rulemaking for all mandatory models and at least a 30 day public comment period for all other innovation models.

- The working group is soliciting input on the types of models that would require rulemaking.

[12] Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation, December 2014. "Report to Congress." Available at: https://innovation.cms.gov/Files/reports/RTC-12-2014.pdf.

- The working group is soliciting input on how often rulemaking should be required. For example, should Congress mandate that rulemaking occur any time changes are made to a model? What impact, if any, would this have on CMMI's ability to rapidly modify models or terminate models that are not working?

Reason for Consideration

CMMI is testing a number of initiatives. Many of these concepts are complex and large in scope. Collecting robust public input is key to ensuring the success of these demonstrations. While CMMI did use rulemaking to collect stakeholder feedback in relation to the Comprehensive Care for Joint Replacement (CCJR) Model and the Home Health Value-Based Purchasing Model, doing so is not explicitly required by law. Mandating public notice and comment would increase transparency in the development of CMMI initiatives and ensure public input into all payment and delivery reform models.

Study on Medication Synchronization

Background

In April 2012, the Centers for Medicare & Medicaid Services (CMS) finalized a rule requiring daily cost-sharing requirements for Medicare Part D prescription drugs. Beginning in 2014, CMS requires that Part D sponsors establish and apply a daily cost sharing rate whenever a prescription is dispensed by a network pharmacy for less than 30 days' supply, unless the drug is exempted by regulation. This rule applies regardless of the setting in which the applicable drugs are dispensed. The daily cost-sharing rule does not address how pharmacy dispensing fees are to be negotiated, calculated, or paid and the rule does not require the proration of pharmacy dispensing fees.

Policy under Consideration

The chronic care working group is considering requiring a study to determine, in order to improve medication adherence, how Part D prescription drug plans (PDPs) could coordinate the dispensing of prescription drugs so that, to the extent feasible, multiple prescriptions can be dispensed to a beneficiary on the same day, providing greater opportunity for the beneficiary to receive comprehensive counseling from a pharmacist. The study could look at current barriers to coordination and best practices used by commercial drug plans, with an assessment of the feasibility of such medication synchronization programs in Medicare.

Reason for Consideration

Individuals with chronic diseases often take multiple prescriptions that are prescribed by different clinicians. Because most prescriptions have a standard length (*i.e.*, 30-days) and are prescribed on different days, the individual is required to pick up prescriptions at various times during the month. Alignment of dispensing could improve medication adherence by individuals with chronic diseases.

Study on Obesity Drugs

Background

Historically, Medicare Part D has not covered drugs used for weight loss or gain, or for cosmetic purposes. Some Medicare Advantage prescription drug plans (MA-PDs) are permitted to cover these drugs as a supplemental benefit.

Policy under Consideration

The Chronic Care Working Group is considering requiring a study to determine the use and impact of obesity drugs in the Medicare and non-Medicare populations. The study could: specifically detail the utilization of such drugs and any subsequent impact on medical services that are directly related to obesity, including by subpopulations determined by the extent of obesity; examine medical interventions for individuals not taking obesity drugs; and examine the experience of MA-PDs that cover obesity drugs as a supplemental benefit.

Reason for Consideration

Obesity is a serious problem that is often directly related to or exacerbate chronic diseases. Prescription drug treatments may be an effective policy intervention, but more information is needed to better understand the impact on quality and overall costs to the Medicare program.