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January 26, 2016

Senator Johnny Isakson
Senator Mark R. Warner
Chronic Care Working Group
Committee on Finance
United States Senate
Washington, DC 20510-6200

Submitted electronically to chronic_care@finance.senate.gov

Re: Request for comments on committee plans to consider chronic care reform efforts

Dear Senators Isakson and Warner:

The American Nurses Association (ANA) welcomes the opportunity to provide comments in response to the Bipartisan Chronic Care Working Group (working group) Policy Options Document, released in December, 2015.

As the only full-service professional organization representing the interests of the nation's 3.4 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate and engage patients, their families and other caregivers as well as the public about various health conditions, wellness, and prevention, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[1]

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The Policy Options Document states that the group is considering options for improving care management services for individuals with multiple chronic conditions, including a "high-severity chronic care management code." As described in the paper, such a code would reimburse clinicians for coordinating care outside of a face-to-face encounter for the most complex beneficiaries living with multiple chronic conditions. The working group requests comments on patient criteria for such a code (for example, beneficiaries 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 also seeks input on the types of providers who should be eligible to bill for the new high severity chronic care code, and

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[1]The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

notes that eligible clinicians would be "those who offer comprehensive, ongoing care to a Medicare beneficiary over a sustained period of time."

We agree with the statement in the Policy Option Document that managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in-person visit with interactions from a wide range of health care providers. Further, as noted in the paper, the current chronic care management code covers only a portion of the labor-intensive costs. Therefore, we believe it may be appropriate to target such a code to individuals with four or more chronic conditions. We encourage additional analysis of this issue to ensure that a high-severity chronic care management code appropriately targets Medicare resources to beneficiaries with the greatest need for chronic care management. Our rationale for this request is based on the current system, which requires the presence of two or more chronic diseases, with nearly 70% of all beneficiaries eligible for this service. For more complicated beneficiaries (with four or more chronic conditions) Medicare spending per beneficiary is 50% higher than spending for those with only one or two chronic conditions. Beneficiaries with four or more chronic conditions also accounted for 90% of Medicare hospital readmissions. The absence of an appropriate code may inadequately address the health policy objective of improving care management with individuals with multiple chronic conditions.

With regard to the question of which types of providers should be eligible to bill for a high severity chronic care code, we note that nurses, including APRNs, serve a central role in diverse models of care coordination for people with complex illnesses across health care settings, and these providers have demonstrated impressive health care quality with lower costs in providing such care. Nurse-operated clinics manage patients with complex chronic conditions effectively and efficiently, ensuring that patients obtain necessary general and specialty care. APRNs should be appropriately compensated when they provide complex chronic care management services for their sickest and most complex patients. We strongly urge the working group to include APRNs as eligible clinicians to bill for a high severity chronic care code.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

The working group is 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 Accountable Care Organizations (ACOs) including private and public sector ACOs as well as those participating in the Medicare Shared Savings Program. ANA believes that it is essential to develop a comprehensive understanding of the extent to which behavioral health is integrated into primary care, and therefore supports a recommendation to have GAO undertake such a study.

Developing Quality Measures for Chronic Conditions

The working group's document states that the group is considering a requirement that the Centers for Medicare and Medicaid Services include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. Topics under consideration include the following: 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/Dementia, including measures for family caregivers, outcomes, affordability, and engagement with the healthcare system or other community support systems; and community-level measures in areas such as obesity, diabetes and smoking prevalence. The document notes that the working group is considering a recommendation that GAO evaluate appropriate measures for chronic care management.

We agree that it is essential to develop, implement and evaluate robust performance measures to identify and address effective and efficient chronic care coordination and stand ready to work with the Centers for Medicare and Medicaid Services on these efforts. ANA supports the recommendation to task GAO with developing a report on this topic. In directing GAO to develop this report, we urge the working group to task GAO with engaging the nursing community which remains fully committed and engaged in developing such measures.

Encouraging Beneficiary Use of Chronic Care Management Services

The Policy Options Document notes that the 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. Specifically, input is requested on the extent that waiving cost sharing would incentivize beneficiaries to receive these services.

ANA supports the proposal to waive co-payment for the current and contemplated chronic care management services. Increased patient and provider engagement is critical to improving and managing the health of those living with multiple chronic conditions. Improving access to these services by limiting or eliminating beneficiary cost sharing burdens may promote greater patient engagement in the plan of care and better, more cost-effective health outcomes.

We appreciate the opportunity to share our views on this matter. If you have questions concerning the discussion of beneficiaries currently eligible for chronic care services and spending associated with more complicated beneficiaries, please contact Peter McMenamin, Senior Policy Advisor-ANA Health Economist (peter.mcmenamin@ana.org). For other questions please contact Jane Clare Joyner, Senior Policy Advisor (janeclare.joyner@ana.org).

Sincerely,

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

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