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November 29, 2016

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

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

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

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

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

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

We also see potential opportunities to improve the legislation prior to introduction and as it moves through the legislative process. AARP appreciates your inclusion of some of our recommendations in the draft bill. In addition, we understand the bill would include offsets to ensure that it is budget neutral. It is important that those offsets are reasonable and do not harm Medicare beneficiaries. We appreciate the Senate Finance Committee Chronic Care Working Group's transparent process that has allowed for stakeholder input and feedback.

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

- Extending the Independence at Home Demonstration;
- An easily navigable unified grievance and appeal process for dual eligible special needs plans (SNPs) that adopts important enrollee protections, the continuation of benefits pending appeal, and the integration of behavioral health services into specialized Medicare Advantage (MA) plans (D-SNPs);

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

- Expanding the use of telehealth in MA plans; and

- Improvements to the MA risk adjustment model that improves the accuracy of payments to plans based on enrollee's health and demographics, and the proposed GAO study on how to most accurately measure the functional status of MA plan enrollees and whether such use would improve the accuracy of MA risk adjustment payments.

As the bill moves forward, we suggest further improvements including:

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

- In Section 202, consider annual public reporting on types of grievances and appeals, include language making it clear that low English proficiency (LEP) enrollees are entitled to oral interpreters through every step of the grievance/appeal process;

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

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

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

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

- Expand use of telehealth in fee-for-service. In particular, consider allowing remote patient monitoring in conjunction with chronic care management and transitional care management codes. Also, consider creating secretarial authority to lift restrictions on telehealth services based on evidence, on a service-by-service basis;

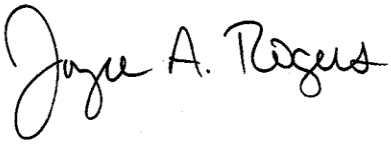
- Clarify the time period during which an accountable care organization (ACO) can opt to have beneficiaries prospectively assigned for a specific agreement period (e.g., at least

90 days before the agreement period begins) and potentially clarify how often a beneficiary can voluntarily align to the ACO in which the beneficiary's main primary care provider is participating; and

- In Section 501, certain ACOs would be allowed to offer a flat incentive payment of up to $20 per qualifying primary care service directly to a Medicare beneficiary. While we support testing the concept of financial incentives in principle, the impact of financial incentives needs to be carefully evaluated. We urge you to add a provision requiring a rigorous independent evaluation of financial incentives. We also suggest including a separate section directing CMS to waive beneficiary cost sharing for chronic care management and transitional care management services.

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

Sincerely,



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