



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

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

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

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

June 22, 2015

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

Thank you for the opportunity to respond to your query on better care for Medicare beneficiaries with multiple chronic conditions. The Alliance of Community Health Plans is pleased to have this opportunity to share our ideas and approaches with you. We recognize how essential it is to take a whole-person approach to care for these patients, providing them not only with the highest quality medical care, but also addressing other factors that contribute to a better life.

In a 2011 survey of older people with multiple chronic conditions, 76 percent ranked independence as the most important health outcome from treatment, followed by pain and symptom relief.

Over the next 25 years, the number of Americans aged 65 and older will double to about 72 million, with roughly 10,000 Americans turning 65 every day from 2011-2031. ACHP members are caring for this growing population, realizing that their needs extend far beyond clinical care. Our member plans are working – primarily through the Medicare Advantage (MA) program – to keep frail seniors out of the hospital and where they feel most comfortable. Whether this is at home, in an assisted-care environment, or some sort of combination, our plans strive to make life in these seniors' final years as independent, dignified and personally fulfilling as possible.

We discuss below a number of principles and strategies that we have found effective for managing multiple chronic conditions.

FLEXIBILITY IN MEDICARE ADVANTAGE BENEFIT DESIGN: In developing care plans aimed at maximum function for each individual, we believe that it is important to consider social determinants of health and not to over-medicalize the services and benefits. This population (and their health status) benefits greatly from psychosocial supportive services including transportation, respite care, adult day care and light housekeeping. According to population health experts, most of a person's health status is determined not

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by medical care but by lifestyle and other social determinants. Flexibility in Medicare Advantage benefit design, both to encourage healthy behaviors and to allow for social supports, will be essential. Many of these services are also valuable to support prevention of chronic illness for healthier populations, so the possibility of inappropriately segmenting populations should be avoided.

Many ACHP member plans have innovative, patient-centered models that meet both the medical and psychosocial needs of their frail elderly MA members, including:

- **Fallon Health** (Worcester, Massachusetts) offers two coordinated care solutions that help older individuals who are eligible for Medicare or both Medicare and, Medicaid (the so-called dual-eligibles) live independently in the community. Both models offer insurance, medical care and social support in one package. **Summit ElderCare®**, a Program of All Inclusive Care for the Elderly (PACE) ¹ program, offers participants interdisciplinary medical care, socialization, recreation, counseling, rehabilitation therapy and meals at PACE adult day health centers, as well as home care, transportation and caregiver support. With **NaviCare®**, a dual-eligible special needs plan, enrollees receive a comprehensive assessment by health care professionals in their home. Results are reviewed with the enrollee's primary care physician and a care plan is shared with the enrollee. The care team and a "navigator" continue to partner with the primary care physician, enrollee and caregivers *to provide the best care to the enrollee*.

KEY SUCCESSES: Since its inception, NaviCare has shown 98 percent enrollee satisfaction rates. A full 100 percent of Summit ElderCare PACE participants are willing to recommend the program to others, and the program successfully kept 86 percent of participants in the community. CMS data show a 30-day readmission rate that is 14.7 percent lower than that for comparable patients in the region on traditional Medicare.

- **Geisinger Health Plan's** (Danville, Pennsylvania) Medically Complex Model uses care teams with a nurse and a community health assistant to treat elderly patients with complex conditions. Each team visits patients in hospitals or nursing homes to introduce itself and arrange post-discharge home visits. During home visits, the team assesses overall health, nutritional support, patients' medication management needs, safety in the home environment and the level of support patients receive at home. The team, which can also involve a pharmacist or social worker when needed, aims to help patients continue to live at home with the right resources and manage their health conditions proactively to avoid frequent visits to the emergency department.

KEY SUCCESSES: During the nine-month pilot, care teams closed an average of 14.8 gaps in care, such as medication adherence, and 2.8 safety-related gaps per patient, such as hazards in the home. After engaging in the program, members experienced a significant reduction in their volume of emergency department and inpatient hospital admissions.

- Kaiser Permanente's (Oakland, California) Proactive Assessment of Total Health & Wellness to Add Active Years (PATHWAAY) program is designed to help patients and physicians find ways to discuss topics such as cognitive impairment or urinary incontinence. These and other difficult topics are often left out of patient-physician conversations, leading patients to believe they aren't issues that can be addressed. PATHWAAY routinely screens members to identify risks for falls,

¹ The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits.

urinary incontinence, malnutrition, pain, frailty and mood disorders. After gathering information, a nurse collaborates with a primary care physician to create a Personalized Prevention Plan that outlines a specific, customized plan to mitigate risks specific to that member.

KEY SUCCESSES: More than 70 percent of members reported issues through the Total Health Assessment that they felt they would not have otherwise addressed during a regular visit with their primary care provider.

- **Presbyterian Health Plan's** (Albuquerque, New Mexico) Hospital at Home program allows patients who would traditionally be admitted to the hospital to receive care at home. Patients receive daily visits from an M.D. or nurse practitioner and one to two visits daily by a nurse. Early findings from the national Hospital at Home program found patients were better able to resume activities of daily living after discharge compared to patients who had been hospitalized. Upon discharge from Hospital at Home, patients continue to be followed by the same provider through Presbyterian's House Calls program if they are too frail to transition back to their primary care physician.

KEY SUCCESSES: Results include a shorter average length of stay in Hospital at Home compared to an inpatient stay (3.3 days vs. 4.5 days) and lower 30-day readmission rate of 3.2 percent vs. 9 percent nationally.

- **Priority Health** (Grand Rapids, Michigan) teamed with five local non-profit skilled nursing facilities and a local ambulance company to create the Tandem365 program. Emergency medical technicians check on patients in their homes and provide some treatment under the guidance of a medical director. Social workers, nurses and community organizations each play a role, accompanying patients to primary care physician appointments, providing care in the patient's home, taking them shopping and providing companionship. Volunteers from area church groups offer spiritual camaraderie.

KEY SUCCESSES: Results include a 38 percent decrease in inpatient stays and a 52 percent drop in emergency department visits.

ENSURE APPROPRIATE RISK-ADJUSTED PAYMENT: This is one of the most important components to ensure the success of any program aimed at individuals with multiple chronic conditions. Appropriate risk adjustment should recognize the intensity of services delivered not only to patients who have complex and multiple conditions, but also to those who may be at lower incidence of chronic illness. For the latter, risk-adjusted payment should recognize services provided by health plans to manage care and slow the progression of disease.

FIX THE MEDICARE ADVANTAGE BENCHMARK CAP: As part of the Affordable Care Act, Congress created MA Quality Incentive (MAQI) payments for MA plans with star ratings of 4 stars and above. At the same time, Congress set up a new payment methodology with a provision that MA payment benchmarks after passage of the Affordable Care Act (ACA) could not be higher than they would have been under pre-ACA methodology. This created the benchmark "cap."

Unfortunately, the benchmark cap has been interpreted to include the MAQI payments in the calculation of the benchmark. In some areas, the cap reduces or even eliminates the MAQI payments. ACHP plans – among the highest-quality plans in the country – will forego \$85 million in MAQI in 2015 as a result of the benchmark cap. Nationwide across all MA plans, the figure is \$415 million. This is money that would be

used for beneficiary benefits, including those related to care for patients with multiple chronic conditions, such as case management, transportation and patient education.

ALLOW COVERAGE OF TELEHEALTH SERVICES IN THE MEDICARE ADVANTAGE BASIC BENEFITS

PACKAGE: A combination of statutory and regulatory restrictions inhibits the use of telehealth (also referred to as remote access technologies) in both the traditional Medicare program and MA. ACHP believes that services provided by telehealth/remote access technologies should be recognized as covered services. We also believe that covered services should not be limited to those provided in a physical location or prohibited when the provider is remote from the patient.

ACHP members and many other health plans increasingly use telehealth to provide clinical care and strengthen coordination of services across settings; telehealth services have a particular use for beneficiaries with multiple chronic conditions, who are often home-bound or have transportation challenges. Our member plans are using electronic visits, video technology and remote monitoring to provide maintenance and preventive care for their enrollees, as well as diagnosis and treatment when it is clinically appropriate.

The plans are finding very high enrollee satisfaction with this approach and no degradation in the quality of care; in fact, remote technologies provide the opportunity for improvements in the quality of care because they increase the amount of interaction between the patient and health care team and the information available on the patient's health status.

Thank you again for the opportunity to provide comments. If you have any questions or need additional information, please contact Holly Bode, Director Public Affairs, at hbode@achp.org.

Sincerely,



Patricia P. Smith
President and CEO
Alliance of Community Health Plans