

The Honorable Orrin Hatch
Chair, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

June 22, 2015

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

On behalf of the Center for Elder Care and Advanced Illness at Altarum Institute, we applaud the Senate Finance's Committee's formation of a chronic care working group and the opportunity to respond to your request for feedback on possible policy solutions.

As you consider developing innovative policy solutions, we urge you to think about the broader needs of the Medicare frail elderly population, mostly living with multiple chronic conditions and functional limitations, and who require *both* access to medical care and to social services and supports, including access to adapted affordable housing and transportation and assistance with basic life needs, often in the form of personal care. An estimated 5.9 million Medicare beneficiaries have such needs today, and this population will grow extremely rapidly as the baby boomer cohort continues to age and become less mobile, inevitably requiring greater levels of support to remain comfortable and living meaningfully in their own homes.¹ Unfortunately, today's fractured and inefficient program structures work against one another in certain respects, effectively requiring middle-income Medicare beneficiaries to "spend down" and become eligible for a poverty-related program -- Medicaid -- in order to have reasonable access to any form of long-term care. From a national, state and local policy perspective, this makes little sense.

Already, 80% of Americans over the age of 65 have two or more chronic conditions, and the majority of Americans who live to advanced old age will face an average of nearly 3 years of self-care disability.^{2,3} Policies that inhibit close coordination of existing programs that offer medical and long-term care (also known as social services and supports) will serve 21st century seniors poorly and, in doing so, will drive up costs of medical care in the form of repeated, unnecessary hospitalizations and emergency room visits, as well as premature long-stay nursing

home placements, particularly during the last several years of life. To avoid this, and cognizant of both the historic achievements, as well as the limitations, of Medicare, Medicaid and the Older Americans Act at their 50-year marks, we offer policy ideas for consideration.

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions.

We recommend that the operation of all Medicare Advantage (MA) plans be modified so that they can better serve the now rapidly-growing population of beneficiaries with multiple chronic conditions, disabilities, and frailty. This could be accomplished by establishing mechanisms that incentivize MA plans to broaden their scopes to take responsibility for ensuring that their enrollees can readily access supportive services in the community, notably personal care, subsidized affordable housing and transportation, and home-delivered meals. Now that the medical research is showing clear evidence that these supports significantly improve health outcomes and reduce medical costs,⁴ proactive policy steps are needed to guarantee that Medicare beneficiaries enrolled in managed care plans can safely and securely remain in their communities.

A second important way to achieve this end would be to require MA plans to ensure that their clinical teams develop and field comprehensive care plans across all treating providers that outline and track all of the services that a frail elderly or otherwise disabled beneficiary has been found to need in order to have what matters most to the elderly or disabled person himself or herself. Such care plans would move with the beneficiary across different medical settings and be accessible to service providers, as well as to the beneficiary and his or her family caregiver, as appropriate.

We further suggest that MA plans could be held accountable for reporting person-centered quality measures that reflect the efficacy of both medical and supportive services, as needed. For this to become a reality, CMS would need to provide financial support to researchers with geriatric expertise to develop, test and validate new quality measures that address the potentials and priorities of individuals within this high-need, complex population.

We have developed further details on such an approach in a demonstration proposal called “MediCaring Communities.”^{5,6}

2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures.

In addition to MA plan reforms (discussed above) Accountable Care Organizations (ACOs) have the potential to serve as a powerful platform for improving coordination of services for Medicare beneficiaries with complex chronic conditions and associated functional limitations – but are currently not doing so. As presently structured, ACOs are not permitted to proactively enroll and tailor services to beneficiary subpopulations. This sharply limits their effectiveness in coordinating services, ensuring consistent, high-quality care, and achieving cost-effectiveness targets for the high-needs elderly. To address these limitations, we recommend that special-purpose ACOs be chartered in diverse urban and rural communities across the country and that they be allowed to enroll high-need beneficiaries requiring a closely coordinated mix of geriatric medical care and long-term services and supports. Such ACOs would therefore serve a portion of the Medicare population in a given area – the highest cost and most service-intensive population in the program, and one which needs a somewhat different and carefully-tailored package of services. ACOs would be held accountable for meeting both quality and financial metrics. Savings realized from lower spending on medical care relative to benchmark projections would mostly be required to be reinvested in underfunded (and hence largely unavailable) long-term services and supports.

Again, we have proposed this under the title, “MediCaring Communities,” which we recommend that CMMI undertake as a multi-site demonstration. A number of communities are eager to undertake the work, and it would pave the way to implementing workable strategies for supporting the very large number of frail elders in the next dozen years.

3. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions.

We applaud CMS for their decision in the 2015 Medicare Physician Fee Schedule (MPFS) to establish two new codes for “care management” and “care transition” activities for beneficiaries with multiple chronic conditions, including the important role clinical staff play in carrying out these tasks. It is important to note that the scope of the covered care management elements and activities required will vary depending on the complexity of the beneficiary population. Elements that determine complexity include medical history, functional status, cognitive impairment, active psychiatric illness, substance use disorder, and socioeconomic factors such as lack of financial and/or social support, dysfunctional family, low health literacy, living alone, unsafe environment, and difficulty accessing transportation.

Additional policy reforms are needed to adequately incentivize appropriate care for the population of Medicare beneficiaries living with multiple chronic conditions. A single care management code is insufficient to address the breadth of complexity that exists among elders with multiple chronic conditions and functional limitations, and the varying degrees of treatment and monitoring that they require. Skilled clinicians should be providing more intensive management for a higher proportion of the most complex beneficiaries as the “age wave”

accelerates. This will not be possible with care management codes set only at a low average rate. Caring for many beneficiaries who have chronic conditions but low complexity may not require the development of a sophisticated care plan linked to the accompanying electronic health record (EHR) infrastructure in which a care plan can be shared across multiple providers, though these characteristics become essential for high-needs patients.

| | Standard CCM (Low) | Complex CCM (High) |
|--|---------------------------|--|
| Needs assessment | Routine | Comprehensive |
| Individualized care plan | No | Yes – based on goals & preferences |
| Goals | Focused | Multidimensional |
| Evidence-based guidelines | Yes | Often not appropriate or potentially harmful |
| Intensity of services | Less | More |
| Types of services & providers required | Fewer | Many |
| Facilitate access to needed services | Rare | Frequent, especially community services |
| Physician & clinical staff time | Less | More |

If such factors as those in the table above are not taken into account, differences in patient complexity may discourage providers from utilizing the code and from providing chronic care management services. Instead, many may just avoid taking on these patients or be unable to provide optimal care at inadequate fees. Therefore, creating at least an additional code for high levels of complexity would be beneficial to providers and would encourage them to engage in chronic care management for the range of patients in their care. Furthermore, an additional code should be created for care plan development. In order to bill for such a code, CMS should require that the plan has been developed in partnership with the person and his or her family, and that all health care services and social supports included are in accordance with the patient’s goals and wishes. Furthermore, as recommended by the Institute of Medicine (IOM) Report, “Dying in America,” we strongly encourage payment for the discussion of advance care planning.

Finally, we suggest that policy be developed that encourages further training of physicians in care of older adults with functional limitations. Medicare already pays for much of graduate medical education (GME), and could therefore require that all physicians enter practice with demonstrated competence in caring for complex Medicare beneficiaries. While creating a reimbursable code is an important first step in ensuring that people with multiple chronic conditions receive quality care, more could be done to ensure that providers have adequate training and knowledge to provide high-quality services to geriatric patients. Given the burgeoning number of older people with chronic conditions and functional limitations, medical education programs should prioritize coursework and training of both new healthcare providers and current healthcare providers on what makes care of frail older adults different.

4. The effective use, coordination, and cost of prescription drugs.

Errors in the use of medications are astonishingly common, especially for persons living with multiple chronic conditions, moving through multiple settings of care, or living with the challenges of aging.⁷ We have been working with a CMS-funded innovation project in Hawaii that engages the skills of hospital-based pharmacists for inpatients and regular community pharmacists (with special training) in working with high-risk patients after discharge. Pharmacists have also been integrated into interdisciplinary care teams in a large delivery system in Minnesota. The results have been striking, with drug therapy problems cut by more than half.⁸ Without this sort of pharmacist involvement, substantial medication errors affect about one-quarter of hospital discharges.⁹ Sustained medication management substantially reduces expenses for hospitalizations.

The problems that the pharmacists identify are roughly divided between inadequate dosages, inappropriate medications, serious interactions or side effects, untreated indications, and patient access or adherence. Note that the current Medicare program for medication management under Part D can identify only a small part of these problems, and it operates mostly to reduce costs by substituting generics and watching for redundancy. In order to substantially improve medication management, the pharmacist or physician doing the review must know a great deal about the patient's situation and goals. It is perfectly appropriate for an elderly and frail diabetic to have medications managed just to avoid dangerously low or high blood sugar, for example, rather than managed to avoid long-term complications; but one cannot know that without knowing the patient's situation and goals.

Optimal medication management requires substantial physician education, activation of patients and families to manage medications well, enabling of pharmacists to be an important part of the service delivery team, and having decision support tools built into electronic medical records. Medicare fee-for-service creates barriers to all of these.¹⁰ CMS could require better physician education as part of the GME program, encourage better patient self-care by supporting

programs to encourage chronic illness self-management, and specifically encourage broader utilization of the trained pharmacist workforce by, for example, providing better payment for chronic care management that involves a pharmacist, or which can demonstrate very low rates of drug therapy problems.¹¹

In addition, public policy must confront the remarkable price escalation of medications, both new drugs and old ones. The pharmaceutical industry has no real incentives to keep prices low, and Medicare has no capability to negotiate on price. Medicare could beneficially follow the Veterans Health System's lead on price negotiation and could be given the authority and responsibility to limit the use of very high cost medications. For example, Medicare could require quite explicit informing and consent for instances where a medication has predicted small effects despite very high prices. Medicare should have the authority to bar use of certain high-cost medications among beneficiaries with very limited prognosis for survival. The Working Group should consider whether the current permission for Federally Qualified Health Centers (FQHCs) to purchase medications at Veterans Health System prices should extend to all Medicaid patients, regardless of provider.

5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology.

Telemedicine and remote monitoring technology have the potential to provide enormous benefit to older people with multiple chronic conditions, many of whom have limited mobility or access to transportation. Increasingly, delivery of services in the home will become an important component of care for frail elderly Medicare beneficiaries, because moving frail elders to a physician's office or to the hospital can pose additional risks in some cases, including a decline in function.¹² Ongoing research and evaluation will be needed to assess the efficacy, safety, and cost-effectiveness of telemedicine-delivered chronic care management. While some studies show savings for use of telemedicine interventions in chronic care management, and stakeholders have noted that telemedicine technology has the potential to improve care coordination for people with chronic disease, evidence is mixed overall.^{13,14}

More widespread use of telemedicine must contend with certain challenges, particularly with regard to payment policy. Current reimbursement of telemedicine services in Medicare is largely limited to rural areas. In order to be covered, the originating site must be in a rural Health Professional Shortage Area (HPSA) as defined by the Health Resources and Services Administration (HRSA).¹⁵ Further, inconsistency in definitions of terms with regard to the scope of telemedicine and areas designated as rural results in a lack of coordination between the 26 federal agencies involved in setting telemedicine policy.¹⁶ The focus on rural areas also excludes the majority of older people living in suburban and urban areas with disabilities who have limited mobility, or for whom leaving home to see a medical professional may be disruptive. At a 2012 Institute of Medicine workshop on telemedicine, Spero Manson of the

University of Colorado’s Centers for American Indian and Alaska Native Health remarked that broader definitions of rural could incorporate factors of isolation within a larger community, such as a disenfranchised part of a city.¹⁷ Similarly, the Department of Health and Human Services could consider reexamining current limitations on the definition of “originating site” to prioritize areas where elders have difficulty accessing reliable primary care and medical services.

We urge you to consider policies that will encourage prudent expansion of telemedicine technologies to facilitate care coordination of services across providers working in disparate settings; to enhance communication between care team members; and to facilitate the delivery of medical care, and ongoing monitoring, for frail elderly Medicare beneficiaries at home. Telemedicine and remote monitoring technologies have potential to engage patients and their family caregivers in their health care, and to empower them with the information they must have to effectively navigate transitions between providers and ongoing changes in their conditions. It is certain that these technologies will play a significant role in the care of a fast-growing number of older Americans, particularly as the number of family caregivers decrease.¹⁸ Because evidence on efficacy and cost-effectiveness is mixed and will continue to evolve, we strongly suggest that you support research initiatives to further assess the use of telemedicine technologies for people with chronic disease, and build in requirements for ongoing evaluation of telemedicine interventions into future initiatives aimed at reforming and improving Medicare.

6. Strategies to increase chronic care coordination in rural and frontier areas.

Chronic care coordination in any setting entails the following components:

- a. Patient/family education for self-care;
- b. Adequate back-up for questions, complications, and new problems;
- c. Comprehensive care planning, across specialists, primary care, social supports, and personal care – negotiating goals and strategies that prioritize what matters most to the patient/family and that are achievable; and
- d. Adequate supply and quality of services in the area – medical care and behavioral health as well as food, housing, transportation, caregiver support.

Clearly, each of these is more challenging in rural and frontier areas, especially when the scarcity of providers and transportation barriers are complicated by poverty, as they often are. However, we can now use technology to bridge distance gaps, such as telehealth and home monitoring to support the goal of safely aging in place. Education of both providers and patients can be done using distance education techniques. Using audio-visual connections, care planning can engage all relevant providers and lead to a shared understanding of what the patient and family need in the home. All involved can be honest about the realistic possibilities for in-home care and transportation. Relatively infrequent in-home visits by designated provider team members can establish relationships, set up remote monitoring and communication, enhance self-care

education, and watch for neglect or other problems that require revision of the care plan. Rural and frontier communities can often be more supportive about palliative care and death at home than can urban and suburban areas. Sparsely populated areas will greatly benefit from better-organized, consolidated service delivery arrangements for home care, so that travel times between patients are minimized. In many parts of the country, this has evolved naturally, since only a single community-supported Visiting Nurse provider and one primary care practitioner is available. Hospice, skilled home care, and palliative care services may need enhanced payment in order to be reasonably available in areas where travel times are long and in-person care is essential. These natural and encouraged arrangements should be monitored for quality and cost as a public trust. Local and regional government entities could take on the quality review and regulatory barriers that make it difficult to establish accountable care organizations or managed care organizations in these areas. In order to encourage greater investments of high-quality care systems in rural and frontier areas, local and regional governance could enable investment of savings in buttressing otherwise scarce supportive services, such as respite care for family caregivers and in-home personal care.

7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.

Care plans are a crucial tool with which to engage Medicare beneficiaries and their caregivers in their health care. Care plans should guide all involved health care and social services providers and serve as the basis for achieving more satisfactory outcomes for individuals, for organizing services across different service providers, and for evaluating overall performance of the delivery system. Older people and their family caregivers would be engaged in the development of comprehensive and forward-looking, goal-oriented care plans, and the care team would be held accountable for the quality and reliability of the full spectrum of services provided. Care plans would be based on comprehensive assessment of the elder and the family caregiver, including questions about the health status of the family caregiver and his or her ability and willingness to provide support, and whether the family caregiver is able to locate and secure necessary resources and help, such as hands-on training or access to respite services.

The care plan should serve as a central document for coordinating medical care and long-term services and supports; and all providers involved in the person's care, including hospitals, physicians, family caregivers, home care agencies, nursing homes, social service and housing providers, and the elderly person himself or herself should have access and feedback. The care plan must move with the person across settings and time, be accessible to all providers, be revised as situations change and at planned intervals, and be evaluated for achievement of goals. Care plans place the person and their family at the center of the care team, ensuring that their goals and preferences drive the decisions of which health care services and social services they will receive.

8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

In considering the goal of maximizing health care outcomes, it is important to consider that the quality metrics for older Americans often pay no attention to their goals and wishes. Current quality metrics are often actually contraindicated in an older, frail population. Quality metrics for this population should assess the degree to which the services a person is receiving actually help that person meet his or her life goals and treatment preferences as recorded in a comprehensive care plan (discussed above on p. 8).

In addition, we would like to submit the following- policy recommendation that addresses most of the topics above.

Comprehensive Proposal: Establishing and Testing Community-Anchored, Multi-Payer Multi-Provider Plans

The Center for Elder Care and Advanced Illness has developed a community-anchored, mixed-payer model that would use current program funds from Medicare, Medicaid, and private resources to provide coordinated and comprehensive services, including both health care and social supports. This model would reinvest health care savings, harvested primarily from reduced hospitalization and emergency room use, into providing the long-term services and supports that are so vital to the well-being of this population.

Along with reinvestment of shared savings into social supports, these plans offer a mix of “geriatricized” medical care and social services and supports in accordance with each person’s life goals and treatment preferences and create transparent performance metrics that can be used to guide ongoing operations. Services are guided by a comprehensive, longitudinal care plan, which follows comprehensive assessment and incorporates the preferences and goals of each older adult. Often inappropriate, undesired, and excessive medical testing and treatment would be replaced by medical care that is guided by the care plan and adjusted as necessary, with prudent testing and treatment, plans for hospital use and end of life care, and support of family and paid caregivers. In addition, more medical services would be provided in the home, generating substantial savings as well as better medical care.

These plans can be readily based on existing financing and service delivery platforms with appropriate modest modifications. These include an ACO, a Medicare managed care plan such as a Special Needs Plan or a PACE plan (Program of All-Inclusive Care for the Elderly), or comprehensive bundled payment programs as they are developed. A plan in a given community would be allowed to offer enrollment to all qualifying frail elders, defined as those with 2 or

more limitations in activities of daily living (ADLs) or cognitive impairments, or those who are 85 years old or more, across a defined service area.

While these reforms can be implemented under existing Medicaid and Medicare waiver authority, assembling the right package of waivers is an immensely complex and time consuming process, and thus a daunting task for many communities that are working today to coordinate comprehensive services people need while living with serious chronic conditions. We urge you to call upon the Department of Health and Human Services to put forward a waiver and demonstration application template that would provide a clear roadmap for communities that would like to move forward with these reforms.

As the quality measures available are largely inappropriate for older adults, CMS will need to invest in the development of new quality metrics for this population. We also urge you to encourage the Department of Health and Human Services, in implementing the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, and moving towards value-based payments in 90% of Medicare dollars, to develop quality measures that respond to individuals' values, goals, and quality of life.

This plan meets all three of your proposed policy goals as outlined in your request for comments. By ensuring that the person's treatment preferences are followed, as well as reducing hospitalizations and nursing home admissions, these plans deliver high quality person-centered care at a lower cost and enhance coordination between health and social service providers across care settings.

Thank you for the opportunity to comment on this critically important topic. We would be happy to discuss any of these ideas in further detail, and look forward to working with you.

Sincerely,

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