

The Honorable Orrin Hatch, Chairman  
The Honorable Ron Wyden, Ranking Member  
The Honorable Johnny Isakson, Member  
The Honorable Mark R. Warner, Member

United States Senate  
Committee on Finance

June 22, 2015

Dear Senators:

I am writing on behalf of the American Health Quality Association (AHQA), which represents the Medicare-funded, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) and their subcontractors, now operating across the nation and in all U.S. territories. I wish to thank the Committee for the opportunity to provide written comments regarding chronic care service delivery reform—improving quality while reducing the cost of services provided to the most vulnerable of our nation’s seniors is of paramount importance to all of our members.

As you indicated in your May 22 call for comments, the dramatic increase in the number of Americans between the ages of 45 and 64 who will soon be aging into Medicare-- many of them with multiple, chronic conditions -- will require widespread adoption of innovative care management strategies. Under our current 11<sup>th</sup> Scope of Work as outlined by the Centers for Medicare & Medicaid Services (CMS), QIN-QIOs are engaged in a number of important quality improvement and cost reduction initiatives, with an emphasis on supporting chronically-ill seniors.

I would like to take this opportunity to briefly highlight two of these current QIN-QIO activities and then to suggest additional policy innovations.

*Cost-Effective Self-Management Education for Vulnerable Seniors*

All fourteen QIN-QIOs are now engaged in formal, five-year programs offering diabetes self-management education (DSME), to Medicare beneficiaries, with an emphasis on working with disadvantaged rural and urban-dwelling seniors. QIO-led

programs emphasize evidence-based curricula using the Stanford and DEEP (Diabetes Education Empowerment Program) models. QIO-led pilots in West Virginia, New York, Texas that focused on rural, African-American and Hispanic/Latino senior populations demonstrated that formal DSME programs can result in measurable improvement in critical indicators such as HbA1c levels, weight control, eye exams and blood pressure management. These programs are consistent with the recently published joint recommendations: Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics DOI: 10.2337/dc15-0730

We urge CMS to expand Medicare's investment in cost-effective, evidence-based self-management education programs. As part of this commitment, Congress could authorize a substantial increase in federal support for "Train the Trainer" programs that use multi-lingual certified diabetes educators, community health workers, trained direct service workers and trained caregivers. CMS should consider extending the self-management teaching model to support patients with other chronic conditions including hypertension. Early research has demonstrated that high-risk individuals, with significant cardiovascular co-morbidities who enroll in Hypertension Self-Management Programs, can achieve substantial reductions in systolic and diastolic blood pressure without an increase in adverse events.

#### *Community Coalitions and Caregiver Training to Avoid Re-hospitalizations*

The problem of costly and often unnecessary return visits to acute care hospitals by seniors with multiple, chronic illnesses is now well documented. We know that aggressive medication reconciliation efforts and better communication among providers across settings can reduce the risk of re-hospitalization. But it is critical that provider organizations dedicate the resources necessary on a sustained basis to ensure that interventions are implemented and measured for improvement. The QIN-QIO model uses a community-based approach that crosses settings to create learning coalitions. These community coalitions engage in formal root-cause analysis led by independent quality improvement experts from the QIN-QIO, with the goal of identifying local, indigenous factors that are driving avoidable hospital readmissions. Over a recent three-year period, this community-based approach to care transitions led by QIOs has saved nearly \$1 billion.

We urge Congress and CMS to expand innovative approaches to reducing unnecessary re-hospitalizations, including expanding funding for community coalition-building. Using the Organizing for Health model, CMS can identify and champion communities that enhance care coordination across settings. In addition, Congress and CMS could expand incentives/resources for all provider settings to dedicate and train staff to assess caregiver health literacy and provide support and guidance during critical transitions.

Family members are often ill-equipped for the responsibilities of caring at home for a loved one with chronic illnesses and multiple co-morbidities. Lack of timely caregiver training is itself a risk factor for a senior's re-hospitalization.

In addition to these two areas of current QIN-QIO activity, AHQA wishes to briefly highlight additional topics we believe are worthy of the Committee's consideration. These include the following:

#### *Advancing the Patient-Centered Medical Home Concept*

As a community of quality improvement professionals, AHQA recognizes the importance of extending the patient-centered medical home model to chronically ill populations across the U.S. The team-based approach to care, emphasizing consistent primary care, care coordination and organized referral management, is a major advance from the fragmented, episodic care that too many seniors receive.

For this reason, our association supports the CMS chronic care management (CCM) payment code as an important step in recognizing the team-based approach to proactive care coordination.

#### *Emergency Services Reimbursement Reform*

Congress needs to reform Medicare to support emerging community based EMS programs that work with the high risk and "frequent readmission" patient cohort to offer care management services in the home. Currently, EMS services are only covered if the patient is transferred to the ER or another facility for care.

Reimbursement needs to be available for EMS services that prevent ER visits for high-risk patients with specified levels of co-morbidity. The current coverage bias results in too many patients presenting in the ER when high-quality, cost-effective services can be made available in the home.

#### *Revising Medicare Conditions of Participation*

We urge Congress and CMS to give strong consideration to revising current Medicare Conditions of Participation that require that all medical orders are created by physicians on staff at hospitals. Increasingly, advance care planning is being undertaken with community-based primary care physicians (PCPs), who are most likely to understand the needs of their patients. This is resulting in more Physician Orders for Life Sustaining Treatment (POLSTs) being completed. But, paradoxically, with the increasing reliance on hospitalists, it is becoming less likely that the PCP is on staff at the hospital where the patient is admitted. This increases the risk that the POLST will be declared invalid.

### *Recognition of Licensed Professional Counselors (LPCs)*

With the growing number of seniors with depression, dementia and substance use disorders, there is a substantial shortage of psychiatrists, licensed clinical social workers (LCSW), and PhDs available to provide psychotherapy (talk therapy) services. There are many evidence-based studies demonstrating that talk therapy is highly effective with or without medication. Medicare should recognize LPCs as practitioners equipped to treat seniors with mental illness and/or suffering from substance abuse.

### *Expanding Hospice-Based Palliative Care Coverage*

While substantial numbers of seniors suffer from symptoms that result from having a combination of chronic conditions, many of these patients are not terminal. Palliative care service coverage through hospice providers will greatly improve the quality of life for these individuals. The recent report from the Institute of Medicine, “Dying in America” outlines this deficit quite clearly. There is a pressing need for more workforce training in basic palliative care.

### *Improving Advanced Illness Planning*

We urge adoption of team-based care planning for seniors with advanced illness, along the lines of The Care Planning Act of 2015, as introduced by Senators Warner and Isakson. We view planning efforts that help patients articulate values and expectations as crucial to the emerging beneficiary-centered care movement. It is essential that service delivery reflects patients’ own planning priorities and that patients and families have the training they need to implement these care plans. We are persuaded that innovations like signed agreements between primary care physicians and chronically-ill Medicare patients outlining roles, responsibilities and expectations can offer real value in confirming treatment goals.

In summation, AHQA is grateful for the opportunity to offer comments on chronic case delivery system innovation and stands ready to support the Committee by providing additional comments should that prove useful.

We commend the Committee for seeking input in this fashion and look forward to a national discussion on these critical issues.

Sincerely,



Colleen Delaney Eubanks, CAE  
Executive Director