



June 19, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Johnny Isakson
United States Senator
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Mark R. Warner
United States Senator
Committee on Finance
United States Senate
Washington, DC 20510-6200

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

The SCAN Foundation welcomes the opportunity to submit comments to the U.S. Senate Committee on Finance (Committee) on how to improve outcomes for Medicare beneficiaries with chronic conditions.

The SCAN Foundation (Foundation) is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence. The Foundation envisions a future where high-quality, affordable health care and supports for daily living are delivered on each person's own terms, according to that individual's needs, values, and preferences. The ideal system of care would consist of medical providers who are knowledgeable about long-term services and supports (LTSS) partnering with community-based organizations (CBOs) to coordinate care (primary, behavioral, LTSS, etc.).

Over the last two decades, significant investments have been made based upon the premise that chronic illness alone drives health care use. While some tangible improvements have been achieved through national demonstrations, there is little evidence that “fixing” the chronic disease only will directly result in better care and health outcomes at a lower cost. The missing piece of these strategies is how chronic disease(s) coincides with a person’s daily living, which requires a more robust discussion of functional status.

Addressing both the patient and the underlying person is the key to more effective targeting for care coordination services. Roughly 110 million people in the United States live with chronic illness and nearly 32 million have serious functional limitations. Of key interest to The SCAN Foundation is the overlap in these demographics, accounting for 27 million people. In 2011, the Foundation [commissioned an analysis](#) of this cross-section between chronic illness and functional status from a federal payer perspective and found powerful results. Over 30 percent of older Medicare beneficiaries in the top spending quintile have both chronic conditions *and* functional limitations. On average, Medicare spends almost three times more per capita on seniors who live with chronic health conditions and functional impairment compared to seniors with chronic conditions alone. Individuals with chronic conditions and functional impairment were nearly twice as likely to have a hospital stay compared to individuals with chronic conditions alone.

These data clarify that a chronic disease perspective to care delivery is simply too broad an assumption for good targeting. The Foundation believes that in order to adequately address the challenges of improving health care quality and reigning in rising costs, the Committee should develop policies and programs that give equal consideration to a person’s health and functional status.

Below are the Foundation’s responses to six of the eight items for which you are seeking input. The responses include policy recommendations that highlight standards of practice that could lead to coordinated service delivery across the continuum of care, better quality care, and more efficient use of health care resources by:

- Focusing on people with chronic conditions combined with functional limitations;
- Using risk assessment tools to identify this target population;
- Elevating the importance of and sustainability of person-centered care coordination; and
- Creating quality measures that account for person-centered care.

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

- A [report](#) from Avalere Health commissioned by the Foundation explores how gathering and using non-medical data to better coordinate care for high-risk Medicare beneficiaries can improve person-centered care and be cost effective. Avalere looked closely at how health risk assessments (HRAs) that include LTSS needs can provide a broader picture of the person receiving care, and in turn, allow health plans to best

target care coordination and transitions programs. The committee should consider policy requiring a functional assessment as part of the HRA.

- Avalere’s analysis shows that when effective care coordination models are employed to address the medical and non-medical needs of targeted Medicare beneficiaries, their quality of care and daily living improves, leading to decreased use of high-cost medical services. We recommend the health risk assessments (HRAs) Medicare Advantage plans complete for each beneficiary be used to target individuals who would benefit from further needs assessment, care planning, and care coordination. When Medicare Advantage plans report to CMS, they should include information on how the HRA is being used to connect people with care coordination.
- The [National Health and Aging Trends Study](#) (NHATS) has been gathering information on the functioning of Medicare beneficiaries ages 65 and older. NHATS data can provide an understanding of trends in late-life functioning. The Committee should consider how the NHATS data can be used to identify the most high value items for identifying functional need. This could inform what functional data to collect in HRAs, and which values are most effective for targeting care coordination.

2. Transformative policies that improve outcome 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.

- As previously mentioned, the [report](#) from Avalere Health looked closely at how HRAs that include LTSS needs can be a tool for health plans to better target care coordination and transitions programs. We recommend that providers participating in ACOs and other alternative payment models be similarly required to implement a health and functional assessment to target care coordination and more effectively address the functional and health needs of individuals with chronic conditions.

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

- Recognizing the importance of a full assessment (health and functional needs) to properly coordinate care, we recommend that quality measures take a person (rather than the current provider or health system) centered approach, including the need to incorporate an assessment of the patient's functioning and utilization of that information into care plan. The Foundation is currently working with the National Committee on Quality Assurance (NCQA) to identify quality measures for person-centered care, which could be the basis for building person- centered quality metrics into the future physician Merit-Based Incentive Payment System. An earlier [report](#) from NCQA elevates a quality framework for integrated care, and could be a starting place for identifying quality measures.

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

- The [Center for Technology and Aging](#) (CTA) focuses on projects aimed at improving the well-being of older adults, chronic care management, and patient engagement through technology solutions. Remote patient monitoring (RPM) technologies have been shown to be effective in helping to manage chronic disease, post-acute care, and monitoring the safety of the older adult population. RPM technologies can help older adults slow the progression of chronic disease and ensure continued recovery after being discharged from an acute care setting. CTA has developed an [overview](#) of various technologies that support older adults aging in the community, as well as a [fact sheet](#) and [toolkit](#) for remote patient monitoring. Information in these resources could also be useful in addressing care coordination in rural and frontier areas addressed in item number six of the Chronic Care Working Group letter.
- While the Senate Committee on Finance is seeking specific comment regarding the use of telehealth and other technologies for care coordination, an element of face-to-face interaction should be maintained when incorporating telehealth into health system care delivery processes. A report from [Avalere](#), as well as an evaluation from the [Medicare Coordinated Care Demonstrations](#), describe the value of targeting services based on a comprehensive assessment and implementing person-centered care coordination that involves face-to-face engagement. Some degree of face-to-face interaction in the care coordination is critical to success.

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

- Person-centered care is an approach to health care and supportive services in which care is directed by the individual needing care and allows him or her to identify their goals, preferences, and desired outcomes in an effort to improve their overall quality of life. The Foundation believes care coordination models that are grounded in principles of person-centered care increase an individual's engagement in his/her care and create better health outcomes. It is critical that there be a common understanding of person-centered care as well as how to develop and implement these concepts through the health care delivery system. American Geriatrics Society will release a suite of reports defining and operationalizing person-centered care this summer, building on a philosophical framework described in a [report](#) from the Foundation. We recommend the Committee develop policy that more clearly defines person-centered care and establishes it as a core principle in service delivery.
- Conversations and opportunities to think about function should be included in every encounter in the health care process in order engage individuals in thinking about their day-to-day functioning and how it relates to their health. One example would be to incorporate a simple questionnaire at check-in that screens for function, followed-up by

a conversation with the provider during the appointment. We recommend that the Committee aggregate and highlight practical ideas similar to this one so that innovative health systems can share their learnings with the broader health care community on engaging Medicare beneficiaries.

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.

- Effective care coordination is grounded in an assessment of the individual’s health condition, social and functional needs. Accordingly, services must be coordinated across both medical and non-medical services in order to meet the individual’s range of needs. As previously referenced, a [report](#) from Avalere Health confirms the notion that when older Medicare beneficiaries have non-medical characteristics, such as functional limitations, or self-reported fair or poor health, their risk for health care utilization increases dramatically, leading to higher costs. Avalere identified that assessments that include LTSS needs can provide a broader picture of the person receiving care, and in turn, target care coordination and transitions programs. When effective care coordination models are employed to address the medical and non-medical needs of targeted Medicare beneficiaries, their quality of care and daily living improves, leading to decreased use of high-cost medical services. A suite of fact sheets highlights utility of an enhanced HRA that includes functional assessment to target care coordination resulting in a cost-effective use of health care dollars.
- In order for person-centered models of care to succeed, they must be sustainable. In partnership with Avalere, the Foundation has developed a sustainability [blueprint](#) for health plans to be able to analyze the sustainability of their model and communicate its value. The Committee may be able to use this blueprint to think through funding mechanisms that prioritize and better support person-centered care coordination.

Thank you for the opportunity to provide input on how to improve outcomes for Medicare beneficiaries with chronic conditions. The Foundation believes that targeted care coordination and person-centered care are essential components to addressing the needs of older adults and people with disabilities receiving services through Medicare. Ensuring the individual is at the center of the process and the proper infrastructure is created to support care coordination is vital to the success of any Medicare program.

Sincerely,

A handwritten signature in black ink, appearing to read 'B. Chernof', written in a cursive style.

Bruce A. Chernof, M.D.
President and CEO