AGS | THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.

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June 22, 2015

The Honorable Orrin Hatch
Chair, Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

On behalf of the 6,000 multidisciplinary geriatrics health professionals that comprise the American Geriatrics Society (AGS), we thank you for the opportunity to submit feedback on ways to improve care for Medicare beneficiaries with chronic conditions.

Geriatrics is a specialty dedicated to care of the medically and socially complex older person. Medicare, fundamentally remains a program based upon insurance principles of the 1960's with an acute care, hospital based focus. Despite key modernization steps such as coverage for preventive services and prescription medication, the current system remains a passive, fee-for-service (FFS) program. For the most part care is delivered when the beneficiary is able to get to the site of care. This includes Medicare Advantage.

Under FFS, payments are inadequately adjusted for complexity, including the new chronic care management services. Organizational payments are not necessarily directed in a more favorable method, although incentives are created to more effectively manage chronic illness. While the Medicare Access and Children's Health Insurance Program Reauthorization Act includes many improvements, more fundamental changes are needed which will require input from many stakeholders. Despite the efforts of Congress and others, primary care specialties, including geriatrics, still face severe shortages and are not rebounding. Exacerbating the problem is the impending expiration of the primary care incentive payment (10 percent), which will cut payments for the most high volume primary care services.

We encourage the Senate Finance Committee to explore all mechanisms: benefit changes, payment reform, support of new structures, workforce investment to address shortages in geriatrics and other primary care specialties, and requirements that programs and funding be directed by those with geriatrics competency. Federal policies and programs should create strong incentives and opportunity for states to leverage federal resources to pay for services that are not covered by Medicare, such as community based support services. The overarching aim should be to support person-centered chronic care management:

- Identify the high risk beneficiaries and as needed, provide outreach and services in the site of care that is most appropriate.
- Use effective healthcare teams that include professionals with the expertise needed to provide person-centered care (i.e., some will need a physician and a nurse while others will need a physician, nurse, social worker, and therapist).
- As Medicare moves to value-based payments (VBP) recognize that existing quality metrics have the high potential to degrade the quality of care for the multi-morbid chronically ill and to exacerbate deterrence factors for healthcare workers to enter the field of geriatrics.
- Support convening experts to create measures of quality as performance measurement and improvement is important. Measure only at the appropriate level, not an individual clinician.
- Provide intensive services for the most high risk and high cost, who frequently only access the system via the emergency department.
- Invest in training the workforce in the care of older adults, including physicians, nurse care managers, medical assistants, community healthcare workers, direct care workers, and others.
- Incentivize accepting the challenge of caring for the most complex patients, reversing current disincentives.
- Induce and support change by community providers rather than paying for additional layers of administrative activities or creation of disconnected entities that move into a niche market for short term profit.
- Require electronic health records to set standards that incorporate data elements relevant to identifying the high risk population and make interoperability a high priority. EHR standards should be streamlined so that providers do not have to sift through excessive data and text to locate what is clinically relevant.

## (1) Improvements to Medicare Advantage (MA) for patients living with multiple chronic conditions

Medicare Advantage (MA) provides key opportunities to improve the health and function of individuals who live with multiple chronic conditions. Chronic care models are based on productive interactions between informed and empowered patients and families and a prepared and proactive practice team of health providers. We outline our concerns about the current MA structure and recommendations towards "best practice." We agree that when Medicare delegates substantial management and resources to Medicare Advantage plans that there must be risk adjustment and quality metrics. But the very high stakes of the 5 Star program have had some unfortunate consequences for those with multiple chronic conditions and the professionals who care for them. For example, the use of the AGS Beers Criteria in Part D has led plans to supersede clinical judgment. For over two decades, the Beers Criteria has served as a guideline for healthcare professionals listing potentially inappropriate medications for older adults. The Criteria was last updated by the AGS in 2012, and the new edition will be released this year.

### Improve Guidelines for Chronic Disease Management (DM)

Medicare Advantage plans often dictate that providers follow guidelines for chronic disease management without consideration for frailty status, age and prognosis, and estimated life expectancy. Plans drive providers toward benchmarks, which often represent inappropriate goals for this population. The over-reliance on these benchmarks leaves providers who care for this population at risk for poor performance evaluations and payment cuts and discourages person-centered care. This is especially

concerning given the current workforce shortage of these providers. DM is not sufficient and often inappropriate for the very population of concern in the Finance Committee request.
***We recommend that chronic care guidelines (e.g. hypertension) be modified to include specific recommendations for frail elders.*** Such a change would directly improve appropriate use of resources by not pushing patients with advanced disease such as cancer or dementia towards obligatory and burdensome testing (e.g. colonoscopy, mammography). Guidelines for geriatrics providers should be appropriate and achievable, with a strong focus on improving the care and quality of life for the patient.

AGS's Choosing Wisely® recommendations are one example of clinical guidance that help make geriatrics principles relevant, accessible, and actionable. Another example is the recently released MCC Geriatrics & Evaluation Management Strategies App that supports clinicians who are caring for individuals with multi-morbidity by guiding through a step-wise approach to providing person-centered care that is consistent with an individual's goals for care.

Hierarchical Conditions Categories (HCC)
***We recommend that Medicare explore mechanisms to add functional status to the HCC methodology.*** Risk adjustment supports care for the chronically complex. Risk adjustment could be improved by collecting data from those who have personally evaluated the beneficiary. For example, functional impairments are known to correlate with cost yet are not captured in the HCC methodology. Electronic records could facilitate capturing this information.

***We recommend that Annual Wellness Visit (AWV) services be limited to teams that also are capable of providing chronic care management for the beneficiary.*** The current focus on wellness in the AWV makes it less likely to be performed in the target population. AWV is not consistently being performed by primary care providers. As a result, those best positioned to provide chronic care management for beneficiaries that take into account all of their diseases and conditions are not doing the screening. This has a negative impact on the beneficiary when it comes to coordinated follow-up care. Condition identification by primary care will improve care, risk adjustment, and prepare the providers for risk sharing.

Professional Payments
MA plans could be required to adopt payment policies that traditional Medicare deems valuable, as Medicare improves. For example, payment policies providing for chronic care management or primary care incentives. Medicare may better value services such as home care and, in turn, MA plans would need to pass those payment incentives to providers. We appreciate the desire to allow flexibility and innovation, but as Medicare more appropriately funds the services to improve care, it would be appropriate for Congress to require MA plans to do the same.

**(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**

***Workforce:*** All programs for the complex Medicare beneficiary should have a requirement for geriatrics trained leadership or meaningful and authoritative input, just as Part D does today on formulary committees. Geriatrics training is useful for addressing the younger dual eligible, but programs for this population may also warrant a similar requirement for behavioral health training.

***Payment:*** For dual eligible there are very successful models (see below) that utilize savings from Medicare Part A to fund the services necessary to produce the savings. There should be strong incentives to create shared funding and eliminate the siloed payment that has long plagued these two programs. For example, states could be given funding for nursing home payments that would otherwise be ineligible for federal funding, if the resident is enrolled in a dual program. Better yet, the funding could vary by whether the facility has a medical director with demonstrated geriatrics competency and training, whether the facility participates in programs such as IMPACT[1] and whether there is physician or non-physician providers (NPP) available daily for a minimum time period. While non-institutional care is preferred, for those that need institutional care, the care is improved.

***Care Teams:*** Team care and community health team approaches are not the expectation, although some more sophisticated entities have recognized the value. Expenditures for team care must be allowable costs in any accounting that occurs. Access to the multidisciplinary team for appropriate patients should be required to ensure there is expertise in designing care plans that often span both medical and social service needs of a beneficiary. We need further experience before a specific benefit level can be set. Programs, including MA plans, should be able to create flexible benefits unless such programs are determined to be unambiguously discriminatory.

## (3) Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

AGS strongly supported FFS payment for chronic care management. However, we do not support solely using the CMS designed CCM code CPT 99490 alone. This service is not truly applicable to the target population. Twenty minutes a month may be appropriate to help bring a diabetic individual with poorly controlled hypertension to better health. However, it is not an adequate amount of time to manage and coordinate care for those with 6 or more conditions, functional disability and other factors that make them high utilizers. CPT did create and the RUC did value higher level services, but CMS elected to give them "B" status. This is a failure of CMS to adequately recognize the resources used for such care.

There is some inherent conflict with FFS and more bundled or organizational payments, but we encourage Medicare to continue to participate in valuation of services as they are used in payments internal to organizations receiving bundles. We believe home care is undervalued in part because real resource inputs such as travel are not allowed. Additionally, the RBRVS system uses intensity as a factor and may discount time spent showing the beneficiary dignified courteous treatment as being worth less than other time spent. In reality, providers only have so much time, so the impact is to reduce the worth of services that are essential for the target population.

Medicare should consider allowing payment for home visits by qualified teams and team members such as nurse practitioners on a FFS basis. Many individuals with complex chronic conditions could benefit from a nurse and/or social worker home visit that need not be part of, nor be eligible as a skilled home care service, nor be a mental health service. A team based service could be paid to an eligible provider. Medicare could create a FFS code or codes or ask CPT to do so. Once covered this service will be more widely performed and better described and valued.

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[1] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html

Hospital readmission, post-acute bundled payment, hospital acquired conditions and other such policies do improve the recognition of the value of primary care and care coordination, but unless payments are redistributed within a financially at risk organization, the FFS payments remain inadequate. Medicare could help to model the value (not resource inputs) of such services.

## (4) The effective use, coordination, and cost of prescription drugs

***Pharmacy support across the continuum of care should be emphasized —either directly with a pharmacist on site or available in real time via telehealth—to assist in prescribing decisions and counseling.*** Medication errors are a large contributor to poor outcomes, complications and hospitalizations (and readmissions). Limited pharmacy support in real time in the office setting complicates this issue, although appropriate reviews of total medication lists should be required in all care settings – with particular attention to care transitions. Pharmacy support may include, for example, an assessment of appropriate dose and duration of treatment as well as medications of particular risk for older adults (e.g., medications listed in the Beers Criteria).

Additionally, pharmacists have been proven to be very effective in managing transitions from the hospital to the home by making home visits. This is beyond the Part D covered Medication Therapy Management (MTM) services and is more significant in saving Part A/B resources by education, improved adherence and other factors than by simply better drug use (although that too will occur). Pharmacists should be able to have a Part B provider status when working in a team of other Part B providers. The judicious use of appropriately trained pharmacists in healthcare teams outside of the pharmacy has the potential to be one of the largest innovations in care.

***Community pharmacies should be incentivized to play a key role in raising potential red flags (e.g., Beers Criteria) and reconciling medications to avoid duplication. A national Medicare drug registry is necessary for safety, cost containment, and quality.*** While hospitals are also expected to reconcile medications, there needs to be a more accurate and robust effort that supports reconciliation for community-based care given that most older adults see one or more specialists in addition to their primary care provider. State-based controlled substance monitoring programs have demonstrated the feasibility of internet-accessible registries listing drugs that patients have filled at their pharmacy. On a national scale, an internet-accessible registry listing all drugs that a patient has filled would help greatly in monitoring medication adherence and prevent inadvertent drug interactions among patients seeing multiple prescribers.

Overall, these interventions will help avoid the use of potentially inappropriate medications among Medicare patients who are frequently on multiple medications. They will also help avoid the polypharmacy cycle (or prescribing cascade) where new medications are used to treat the side effects of currently prescribed medications, thereby saving costs on pharmaceuticals, reducing pill burden and its associated complications.

***Address high drug costs.*** The high cost of prescription drugs is a pressing issue that needs to be addressed since it drives up health care costs and reduces access to much needed medications. This is a complex ship to right and may involve review of FDA processes, disallowance of copay waiver programs and other factors.

## (5) Ideas to effectively use or improve the use of telehealth and remote monitoring technology

***Enact changes to expand the number of telehealth services covered by Medicare, especially services that will improve home-based care for frail older adults and those in rural and other underserved areas.*** Telehealth has the potential to improve outcomes across the board for chronically ill, multi-morbid patients, including homebound older adults and those living in underserved areas. Web-based consultations using telehealth, or shared imaging between rural primary care providers, geriatricians and specialists not in practice within the patient's catchment area, for example, would help ensure that the 62 million Americans living in these communities receive the best care possible. Patients often have to travel long distances to reach a provider and this can be especially challenging for older adults who may have multiple medical appointments and difficulty traveling.

Telehealth support has also shown to improve care for patients in skilled nursing facility (SNF) and assisted living facilities by decreasing emergency department utilization and hospitalization. Home health monitoring systems have shown similar improvements and better compliance and patient satisfaction. Telehealth can also be used to train and educate primary care providers and other specialists with the geriatrics competencies needed to adequately treat beneficiaries with multiple chronic conditions.

We recognize that access to the resources needed to provide these services, including telehealth equipment and staff to coordinate care, makes feasibility challenging but believe that these challenges could be addressed by Congress.

This field is rapidly changing, and today many telehealth parties come from entrepreneurial technology organizations. Medicare should have a standing mechanism to evaluate new technologies for coverage, coding and payment within a broader context than current coverage would allow. This mechanism would help address costs and also support the economic development of these services globally.

Improvements to Electronic Health Records (EHR)

***Enhance electronic health records (EHRs) interoperability among multiple providers and across different settings so that care coordination is more efficient, effective, and accurate; and encourage innovations in health information technology tools that can be used to improve health care in rural and other underserved areas. Require EHR vendors to work with stakeholders to address inclusion of assessment tools and templates specific to care of older adults.*** EHRs have the potential to improve care of frail, older adults with multiple chronic conditions. To fulfill that potential, EHRs must have the capacity to capture key issues that affect care and well-being of older adults with chronic conditions, including, but not limited to, function, cognition and patient's goals of care over time. This will aid providers in focusing on issues that address the overall goals of the patient, including function and maintaining independence.

In the future, apps, smartphones, tablets and telecommunications advances will need to be integrated with EHRs to further support coordinated care for those with chronic illnesses. Both improved access to telehealth equipment and care coordination will contribute to higher quality care, including reducing hospitalizations and complications for the multi-morbid patient.

## (6) Strategies to increase chronic care coordination in rural and frontier areas

***The* Graduate *Medical Education (GME) program should allow for more flexibility in the sites where residents train (e.g. community-based settings).*** Currently, teaching hospitals are often located in large, urban areas resulting in minimal training in rural settings. Physicians often decide to practice in the communities where they are trained. Programs such as the Teaching Health Centers (THCs) and Rural Training Track (RTT) encourage medical students to receive primary care training in rural and other underserved areas. A recent study of RTT graduate outcomes found that at least half RTT graduates were located in rural areas after graduation, two to three times the proportion of family medicine residency graduates overall.

***Encourage the dissemination of innovative programs and models designed to increase the existing workforce capacity to care for rural patients with complex, chronic conditions.*** One example is Project ECHO (Extension for Community Healthcare Outcomes), a program that has successfully established links between primary care providers in rural communities and expert specialists in academic health centers to help manage patients who have chronic conditions through the use of videoconferencing to conduct virtual clinics. Another example is the Colorado MESA (Medicare Experts/Senior Access) Initiative, which is a geriatric model that implements a team-based approach to care that includes physicians, social workers, nurse specialists and geriatric pharmacists for patients throughout the state of Colorado. Models like MESA are critical in rural areas where physicians do not have the resources necessary to individually treat each patient, especially those with chronic conditions who need more time and care.

***Add incentives or requirements for insurers to provide care coordinators, or support for providers to hire coordinators.*** In addition to increased support for providers to implement teleheath and other innovative ways of caring for patients at a distance, supporting providers to hire care coordinators will improve the quality care for rural patients living with chronic conditions. If the coordinators are provided remotely, they must be able to easily communicate with both the patient and providers to prevent miscommunication and errors, and help develop a reliable relationship. Telehealth equipment would also help improve adherence with this type of program and outcomes.

## (7) Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their healthcare providers

<u>Encourage Advance Care Planning (ACP)</u>

***Support two CPT codes –99497 and 99498—that will value the time-intensive conversations that are needed for advance care planning (ACP).*** High quality ACP gives patients and healthcare providers an opportunity to discuss the patient's values and preferences regarding future care for serious illnesses. ACP is particularly important for Medicare beneficiaries with multiple chronic conditions, and therefore, these time intensive conversations should be a valued activity for healthcare providers, many of which already engage in this service. The Centers for Medicare and Medicaid Services (CMS) are considering these codes for payment beginning in 2016. There is also legislation that was recently introduced and supported by AGS that would also provide reimbursement for this service, the Care Planning Act of 2015 (S. 1549) (Senators Warner D-VA and Isakson R-GA). AGS also supports bipartisan House legislation, the Personalize Your Care Act, introduced by Representatives Blumenauer (D-OR) and Roe (R-TN) last Congress.

Enabling and encouraging patients to have frank and open discussions with their providers about their care preferences over the near and longer-term is essential to providing high-quality, person-centered care. These conversations also allow family who are often involved in making medical decisions and caregivers to understand and honor patients' wishes should they be unable to make a decision for themselves. Furthermore, research shows that ACP leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression and loss of productivity.

Support Person-Centered Care

We would like to highlight two programs that are targeted specifically for individuals with chronic conditions to help them learn how to manage and improve their own health. Both programs seek to realign care around patients' self-identified health goals.

***Chronic Disease Self-Management Program*** sets up workshops for people with different chronic conditions that are held once a week for six weeks in community settings such as senior centers, churches, libraries, and hospitals. These interactive workshops are facilitated by two trained non-health professional leaders, one or both of whom have chronic diseases themselves. The subjects covered (e.g., techniques for dealing with problems such as fatigue and isolation, exercise and nutrition, medication use, etc.) aim to give participants the confidence to maintain an active and fulfilling life while living with chronic disease.

***CaRe-Align*** will create a new health care model that puts patients' health-outcomes goals and preferences at the center of their care, and aligns primary care and specialty care to focus on these goals and preferences. CaRe-Align moves to a standard of care that is goal attainment-based, rather than solely disease-based, offering the opportunity to improve care, health outcomes, and health care value. This new care paradigm was developed through the joint support of the John A. Hartford Foundation and the Patient-Centered Outcomes Research Institute (PCORI) with the input of over 100 stakeholders, including patents, caregivers, providers, policy makers, researchers and payers. Plans are being developed to test this new approach to care with continuing support from the Hartford Foundation.

Promote Community Engagement

***Create incentives (e.g. discounts) through Medicare for older adults to utilize community-based programs, such as those found in senior centers.*** Senior centers offer a wide variety of benefits, including but not limited to meals, transportation, social engagement, fitness classes, support groups, enrichment programs (e.g. computer training), and volunteer opportunities. Research shows that older adults who participate in senior centers can learn to manage and delay the onset of chronic diseases and experience measurable improvements in their physical, social, spiritual, emotional, mental, and economic well-being. In addition, these programs help empower older adults to live independently in their own homes and communities for as long as possible.

Provide Access to Electronic Health Records (EHRs)

***We believe that patients and their representatives, when appropriate, should have access to their health records, including important information such as medication lists, problem lists, and allergies.*** The intention is to inform and empower the patient and their family as they interact with the healthcare team. Patients should also have the ability to input their unique goals and preferences for care. The

industry should facilitate mechanisms for appropriate access and effective communication with patients.

While not currently available in most EHRs, additional tools such as chronic disease self-management apps, caregiver support apps, and links to community resources will allow patients to manage their health and coordinate their care in the context of their chronic illness.

**(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.**

***Support further expansion and adoption of geriatric models of care that have been shown to improve care for Medicare patients with chronic conditions.*** Studies have shown that various models of geriatrics care can make a critical difference by providing coordinated and interdisciplinary geriatrics team-based care, especially for persons with multiple chronic conditions, which prevents complications and enhances the quality and efficiency of care provided across the healthcare continuum.

***Program of All-Inclusive Care for the Elderly (PACE)*** is a managed-care program that was developed to enable individuals to live independently in the community, rather than a nursing home, with a high quality of life. The PACE model uses an interdisciplinary team of healthcare professionals to provide and manage care in the community, and serves approximately 34,000 enrollees, 90 percent of which remain in this setting. Research has shown that PACE provides better health outcomes when compared to traditional services for seniors with chronic care needs. While beneficiaries with Medicare and/or Medicaid can join PACE, which is currently available in 32 states (114 programs in total), current policy has kept these programs siloed and has made adoption challenging.

***GRACE Team Care™*** is a cost-effective team-care model that has been shown to improve the health of frail older adults with multiple chronic conditions by working with patients in their homes and communities to manage health problems, track changing care needs, and leverage needed social services. GRACE provides home-based, integrated geriatric care by a nurse practitioner and social worker who work with the office-based primary care physician and a larger interdisciplinary team to develop an individualized and person-centered care plan incorporating chronic disease management and protocols developed for the treatment of 12 targeted geriatric conditions (e.g., dementia, depression, falls, etc.). GRACE has improved care quality and outcomes, and lowered the cost of care in high risk Medicare beneficiaries by reducing emergency department and hospitalization rates. The GRACE program has been successfully applied to a variety of health systems including health plans such as Medicare Advantage plans, ACOs, medical groups, and VA Medical Centers around the country. To date, several thousand older adults and hundreds of primary care physicians have benefited from the GRACE model. Payment for nurse practitioner and social worker home visits when they are working in collaboration with an office-based primary care physician would help make this model of care and associated Medicare cost reduction available to patients in the traditional FFS program.

***Guided Care*** is driven by a highly skilled registered nurse in a primary care office, who assists three to four physicians in providing high quality care for patients with complex and chronic conditions. The model aims to improve quality, access, and self-care for these high-risk patients. Under the program, the nurse provides eight services including: assessing, planning care, monitoring, coaching, chronic disease self-management, educating and supporting caregivers, coordinating transitions between providers and

sites of care, and access to community services. A one year pilot study in urban Baltimore, Maryland, found that Guided Care recipients experienced more improvement in the quality of their care compared to similar patients who received usual care. In addition, insurance claims revealed that the costs of healthcare were lower for the Guided Care patients than for the usual care patients.

***Acute Care for Elders (ACE)*** is an interdisciplinary inpatient hospital service designed to meet the special needs of older patients with an emphasis on the continuity, coordination, quality, and dignity of care provided. Over the last two decade, these units have been introduced in hospitals nationwide. The ACE unit model generally incorporates a modified hospital environment (e.g. safe mobility and a homelike atmosphere); early assessment and intensive management to minimize the adverse effects of hospital care; early discharge planning; and patient-centered care protocols. Research evaluating outcomes for older adults admitted to ACE versus usual care has shown improved processes of care, prescribing practices, physical functioning, restraint rates, and patient and provider satisfaction as well as reduced nursing home placement, length of stay, costs, and readmissions.

***Patient-Centered Medical Home (PCMH)*** model improves health care by transforming how primary care is organized and delivered. An effective PCMH encompasses five principle functions and attributes: patient-centered, comprehensive care, coordinated care, superb access to care, and a systems-based approach to quality and safety. PCMHs require a team of care providers that might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. More than 10 percent of U.S. primary care practices, almost 7,000 altogether, are recognized as PCMHs by the National Committee for Quality Assurance (NCQA), which has the nation's largest PCMH program. Studies show that PCMHs have many benefits, including better quality, patient experience, continuity, prevention and disease management. In addition, studies show that PCMHs lower costs from reduced emergency department visits and hospital admissions. There is a need for support for these programs. A geriatrics patient-centered medical home would go beyond these requirements and implement services such as complex chronic care management.

***Home-Based Primary Care Model*** is a health care service provided in the home for Veterans with complex health care needs and for whom routine-clinic based care is not effective. Under this model, a VA physician supervises the healthcare team that provides care for Veterans who need skilled services, case management and help with activities of daily living. Examples include help with bathing, dressing, fixing meals or taking medicines. This program is also for Veterans who are isolated or their caregiver is experiencing burden. Home-Based Primary Care can be used in combination with other home and community-based services. The ElderPAC program at the University of Pennsylvania linked house call teams with a local Area Agency on Aging. Their goal was to improve care for older individuals with multiple chronic conditions and complex social needs. Seniors who were managed in this program were more likely to remain independent in their homes; had lower long term nursing home use; had lower mortality rates; and had lower Medicare & Medicaid costs. This area has the greatest potential and policy need. A strong home-based community support system is as essential a resource as the hospital or doctor's office and needs to be recognized as such.

***Independence at Home (IAH) Demonstration,*** conducted by the Center for Medicare and Medicaid Innovation, as part of CMS, is a voluntary program that provides chronically ill Medicare beneficiaries with home-based primary care services. The IAH Demonstration is active at 15 sites around the country and enrolled 10,000 beneficiaries in the three-year interval from 2012-2015. In its first year, the demonstration saved the Medicare program more than $25 million and provided higher quality care to

homebound patients. ***The IAH Demonstration recently expired, and therefore we urge Congress to pass the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015 (H.R. 2196).*** This legislation will make it possible to continue testing new approaches for treating these Medicare beneficiaries in their homes. Specifically, it will extend the IAH Demonstration two years while analysis of the program continues.

Workforce Competency

***Requires that the healthcare workforce be trained in the unique and complex needs of the sickest Medicare beneficiaries.*** The Institute of Medicine (IOM) underscored the need for the entire workforce to be competent in its 2008 report, *Retooling for an Aging America: Building the Health Care Workforce.* ***We believe that the GME system is one avenue for achieving this goal.*** Several agencies, advisory bodies, and foundations (including AHRQ, MedPAC, COGME, and the Macy Foundation) expressed concern that the training provided by the GME system is not adequately preparing residents to provide high quality care to older patients. We firmly believe that improvements in quality or efficiency of care will not be fully realized without a concomitant commitment to ensuring that GME training programs are teaching these unique skills. Furthermore, reports indicate that the current mix of physician specialists is failing to meet the complex needs of our current population. We have made several recommendations around reforming the GME system and would be pleased to speak with you further about these changes. Legislation, supported by AGS, from the 113th Congress would also serve as a first step in building the healthcare workforce including the Training Tomorrow's Doctors Today (Representatives Schock (R-IL) and Schwartz (D-PA)) and the Community-Based Medical Education Act (Senator Murray D-WA). AGS is also encouraged by the provisions included in legislation introduced last Congress by Senator Wyden (D-OR) (Section 7 of the Better Care, Lower Cost Act) providing for curricula requirements for direct and indirect GME payments, notably the requirements concerning team-based care and chronic care management.

In addition to those trained under GME, we are equally concerned that those educated outside the GME system are not being trained in the competencies needed to appropriately care for older adults. For example, mental health services are very important for the treatment of common age associated diseases like depression and behaviors associated with dementia; however few are trained in the geriatrics competencies needed to provide adequate care. Treatment of mental health conditions has shown lower rates of hospitalization, substance abuse and institutionalization (nursing home) of Medicare patients.

Team Care Training

***Medical education funding should transform education and training.*** Today, few primary care graduating residents would join a small practice without an EHR, no more than would an emergency medicine doctor want to work in a facility that did not have 24x7 CT imaging. In the near future, we hope that all clinicians will seek to join organizations where the unique role of every provider is recognized, efficient use is supported (practicing to the top of a license) and systems and processes of care are built around coordinated teams. This takes training and is no less critical than learning many knowledge points of clinical science and procedures. We should make the "Primary Care Team" our standard term in word and action.

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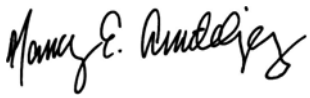
The AGS greatly appreciates the opportunity to comment on proposals to improve the care of individuals with chronic and often complex conditions. Please do not hesitate to contact us, agoldstein@americangeriatrics.org, if we can provide any additional information or assistance.

Sincerely,



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