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**Chronic Care Working Group  
Electronic Submission**

Senator Mark Warner  
Senator Johnny Isakson  
Co-Chairs,  
Chronic Care Working Group  
US Senate Committee on Finance  
219 Dirksen  
Washington, DC 20510

Dear Senators Warner and Isakson:

On behalf of Wesley Enhanced Living, and the residents of senior living facilities we operate, thanks for your work to improve and sustain Medicare for the frail elderly who depend on it.

As you know all too well, although the Medicare benefit is quite comprehensive, our care delivery system often fails to deliver the right care, at the right time, in the right setting. Particularly for chronic care patients and those with multiple co-morbidities, care coordination is essential to improving outcomes and combatting the epidemic of “low-value care” that is described in Dr. Atul Gawande’s most recent New Yorker article:

<http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>

For beneficiaries and fiduciaries alike, Medicare must move away from volume-based payment, and experiment with new comprehensive payment models for care coordination. To help seniors get the right care - rather than the most care, Medicare should incorporate care coordination services where they can be most easily accessible and effective. Senior living communities offer the easiest and most powerful opportunity to provide care coordination because of the proximity of providers to patients, the critical mass of patients, and the frequency of their interaction.

We urge the Committee to move quickly to test promising new models of care coordination in a senior living communities known as Continuing Care Retirement Communities, or CCRCs, where seniors have the ability to “age in place.” **For the vast majority of seniors, residential care coordination could produce savings of at least 30% in Medicare and 20% Medicaid, promote personal responsibility and provide lifetime health and housing security.**

As you know, CCRCs are an extremely popular housing solution for seniors, with more than 2,000 operating around the country. While seniors normally enter the CCRC in the independent setting, the CCRC model provides assisted living, skilled nursing, and memory care services for residents on an “as needed” basis at no additional cost. The ability to easily offer needed services in a residential setting makes CCRCs the optimal setting for patients, providers and payors.

Because of outmoded geographic restrictions on Medicare Advantage plans; currently these senior communities are unable to offer a coordinated, comprehensive medical home model for their Medicare residents. **Instead of requiring each CCRC resident to manage and navigate their own health care issues, CCRCs should be allowed to provide on-site primary care in a payment system that reduces cost and improves outcomes by assisting Medicare beneficiaries to get the right care, rather than the most care.**

The SHIFT model described in the attachment would provide primary and non-acute services onsite, and coordinate and pay for acute and specialist care offsite as needed - - providing care coordination and disease management services to avoid hospitalizations and lower the total cost of care for seniors. Recent studies show that a residential care setting such as a CCRC is the ideal setting to integrate all of these cost containment strategies for Medicare seniors because of the near-constant interaction between staff and residents. This model offers the best chance of actually delivering comprehensive and coordinated healthcare and the only realistic opportunity of avoiding the “first” hospitalization.

Operationally, the SHIFT community would bear the risk and responsibility for providing comprehensive senior health and housing services to its residents in exchange for a reasonable entrance fee and a moderate monthly fee - - affordable to the vast majority of America’s seniors. The SHIFT community would utilize an interdisciplinary health care team led by salaried primary care physicians and advanced practice nurses to administer and coordinate comprehensive health care services for all SHIFT residents under a capitated, risk-adjusted Medicare payment.

**The attached actual Medicare cost data show that Medicare would save more than 30% for every SHIFT resident.** The reason is simple: the costs of primary care, skilled nursing care, long term care hospitals, home health, rehabilitation, medical transport and hospice represent about 30% of Medicare expenses for eligible seniors in a CCRC. The attached chart demonstrates that these silos of Medicare costs are *already paid for in the underlying CCRC cost structure of the SHIFT campus*. Although further savings are also likely to come from better health and better healthcare – these are not included in the 30% savings claimed. **Additionally, a 2009 study by Avalere Health showed that the SHIFT plan could result in Medicaid savings of 20%.** Medicaid payments for SHIFT residents who “spend down” into Medicaid would be much less than current nursing care costs, and residents will be able to stay in their CCRC home, and reducing state’s burgeoning Medicaid expenses for custodial nursing care.

A growing body of clinical evidence suggests that these savings forecasts are not only achievable, but are likely understated. Recent data from the U.S. Agency for Health Research and Quality shows that 60% of hospital admissions from all US nursing homes are “potentially avoidable”, and can and should be managed by a doctor onsite - - as proposed in SHIFT. Additionally, multiple studies point to various care-coordination practices resulting in savings to Medicare and Medicaid. Also, recent Commonwealth Fund reports point to care coordination savings in “low-value health care practices” and “overutilization of technology” which could be implemented quickly and easily in the residential care setting:

- <http://www.commonwealthfund.org/publications/in-brief/2015/mar/too-much-technology>
- <http://www.commonwealthfund.org/publications/in-brief/2013/jan/over-150-potentially-low-value-health-care-practices>

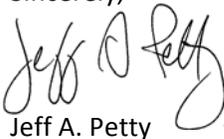
**S395/HR837 effectively addresses many of the key goals outlined by the Chronic Care Working Group:**

- most of the residents of senior living communities have multiple chronic conditions;
- at-risk comprehensive payment incentivizes providers to coordinate care for patients living with chronic conditions;
- comprehensive care coordination services on-site help promote effective use, coordination, and cost of prescription drugs;
- on-site care coordination teams offer Medicare patients the tools they need to meaningfully engage with their health care providers; and
- effectively utilizes primary care providers in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

Congress should move to provide seniors with better care at lower cost by demonstrating such reform models as soon as possible. S395/HR837 gives CMS explicit authority to test up to 5 different state projects for care coordination in a residential care setting, and immediately reduces Medicare payments by 10% for the providers who volunteer for the demonstrations.

We look forward to working with you to improve, reform and sustain the Medicare program for America’s frail elderly. Thank you for your work in this important area.

Sincerely,



Jeff A. Petty  
President/CEO

# SHIFT

## Potential Savings based on 2011 Medicare Data

### National

[http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV\\_PUF.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html)

Category of Service	Current FFS Medicare Spending			Minimum Savings Potential		
	2011 Avg payment/user	# Users per 1,000 beneficiaries	Total \$ for 1,000 beneficiaries	Rationale	%	\$
Hospital Inpatient	\$ 16,635	190	\$ 3,158,941	Save 19% - Dobson/Davanzo estimate <sup>(1)</sup> from care coordination	19%	\$ 600,199
Inpatient Rehab/LTCH	24,863	13	333,161	Save 100% - provided by existing SHIFT employees <sup>(2)</sup>	100%	333,161
Home Health	5,362	103	552,301	Save 100% - provided by existing SHIFT employees <sup>(2)</sup>	100%	552,301
SNF	16,314	59	959,257	Save 100% - provided by existing SHIFT employees <sup>(2)</sup>	100%	959,257
Hospital Outpatient	1,642	632	1,037,416	No savings claimed from improved outcomes	0%	-
FQHC/RHC	377	73	27,631	No savings claimed	0%	-
Ambulatory Surgical	807	105	84,780	No savings claimed from improved outcomes	0%	-
Evaluation & Management	1,001	896	896,415	60% of visits are primary care <sup>(3)</sup> - save 2/3 No savings claimed for 40% of visits to specialists	40%	358,566
Procedures	1,007	639	643,930	No savings claimed from improved outcomes or elimination of duplication in testing	0%	-
DME	710	290	206,177	No savings claimed	0%	-
Testing	332	798	264,985	No savings claimed from improved outcomes	0%	-
Imaging	371	705	261,257	No savings claimed from improved outcomes	0%	-
Other	1,111	361	400,512	No savings claimed	0%	-
Hospice	11,308	30	343,761	Save 100% - provided by existing SHIFT employees <sup>(2)</sup>	100%	343,761
Part B Drugs	556	548	304,489	No savings claimed	0%	-
<b>Total</b>			\$ 9,475,014			\$ 3,147,246
% savings						33%

<sup>(1)</sup> 19% savings based on experience of Veterans Administration which reduced bed days by 25%, also 17% reduction in hospital admissions due to care coordination found by Piekes et al at Mercy Hospital System.

<sup>(2)</sup> Existing staff of SHIFT can provide these services, not requiring additional providers or expense.

<sup>(3)</sup> MEPS, 2008

# The Medicare Residential Care Coordination Act of 2015

Directs the Secretary of Health and Human Services to establish and implement a demonstration project under titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act to evaluate the use of capitated payments made to eligible continuing care retirement communities for residential care coordination programs in up to 5 states. Fully at-risk capitated payment is 90% of expected Medicare fee for service cost of beneficiaries enrolled in the program.

**S. 395** introduced 2/5/2015

Original Cosponsors:

Senator Chuck Grassley, [R-IA]

Senator Robert Casey [D-PA]

Senator Bill Cassidy, M.D. [R-LA]

**HR 837** introduced 2/10/2015

Original Cosponsors:

Rep. Mike Fitzpatrick [R-PA-8]

Rep. Jenkins, Lynn [R-KS-2]

Rep. Barton, Joe [R-TX-6]

Rep. Buchanan, Vern [R-FL-16]

Rep. Kelly, Mike [R-PA-3]

Rep. Cartwright, Matt [D-PA-17]

Rep. Rothfus, Keith J. [R-PA-12]

Rep. Boyle, Brendan F. [D-PA-13]

Rep. Doyle, Michael F. [D-PA-14]

Rep. Brady, Robert A. [D-PA-1]

Rep. Fattah, Chaka [D-PA-2]

Cosponsors:

Rep. Meehan, Patrick [R-PA-7]

Rep. Scott Tipton [R-CO-3]

Rep. Brad Wenstrup, M.D. [R-OH-2]

# Potentially Avoidable Hospitalizations for Elderly Long-stay Residents in Nursing Homes

William D. Spector, PhD,\* Rhona Limcangco, PhD,† Christianna Williams, PhD,‡  
William Rhodes, PhD,§ and Donna Hurd, MSN§

**Background:** Hospitalizations of long-stay nursing home (NH) residents are common. The high estimates of potentially avoidable hospitalizations in NHs suggest that efforts to reduce avoidable hospitalizations may be effective in lowering health care expenditures as well as improving the quality of care for NH residents.

**Objective:** To determine the relationship between clinical risk factors, facility characteristics and State policy variables, and both avoidable and unavoidable hospitalizations.

**Method:** Hospitalization risk is estimated using competing risks proportional hazards regressions. Three hospitalization measures were constructed: (1) ambulatory care-sensitive conditions (ACSCs); (2) additional NH-sensitive avoidable conditions (ANHACs); and (3) nursing home "unavoidable" conditions (NHUCs). In all models, we include clinical risk factors, facility characteristics, and State policy variables that may influence the decision to hospitalize.

**Subjects:** The population of interest is a cohort of long-stay NH residents. Data are from the Nursing Home Stay file, a sample of residents in 10% of certified NHs in the United States (2006–2008).

**Results:** Three fifths of hospitalizations were potentially avoidable and the majority was for infections, injuries, and congestive heart failure. Clinical risk factors include renal disease, diabetes, and a high number of medications among others. Staffing, quality, and reimbursement affect avoidable, but not unavoidable hospitalizations.

**Conclusions:** A NH-sensitive measure of avoidable hospitalizations identifies both clinical facility and policy risk factors, emphasizing the potential for both reimbursement and clinical strategies to reduce hospitalizations from NHs.

**Key Words:** avoidable hospitalizations, nursing home, quality, transfers, elderly, risk factors, proportional hazard model

(*Med Care* 2013;51: 673–681)

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Hospitalizations of long-stay nursing home (NH) residents are common.<sup>1–3</sup> The rate varies by residents' health and demographic characteristics, the characteristics of the NH in which they reside, and State policies that influence the incentives to hospitalize residents.<sup>1,4–7</sup> Although transfers from NHs to hospitals are frequent, many hospitalizations have been identified as potentially avoidable; however, terminology and definitions vary.<sup>8,9</sup> Estimates vary greatly, ranging from 11% to 67%.<sup>2,8–12</sup> Generally, potentially avoidable hospitalizations (PAHs) for NH residents refer to hospital admissions that follow acute flare-ups of clinical conditions that could have been avoided if appropriate preventive care in the NH had been provided. Moreover, they include admissions for conditions that can be safely and effectively managed in the NH.<sup>12</sup>

The high estimates of PAHs in NHs suggest that efforts to reduce avoidable hospitalizations may be effective in lowering health care expenditures as well as improving the quality of care for NH residents. One approach to encouraging preventive care being used by the Centers for Medicare and Medicaid (CMS) is the NH Value-Based Purchasing Demonstration. It financially rewards NHs with low PAHs. Success will depend on how well the financial reward motivates staff to change clinical practice, whether staff can identify residents at risk for PAH, and the extent to which staff can improve preventive care. The ability to reduce PAHs also depends on resources available to the NHs, such as skilled staff, the quality of care provided, and State policies that provide financial incentives that affect hospitalization behavior.<sup>1,2</sup>

Estimates of potential cost savings and risk factors associated with PAHs in NHs have been mainly based on ambulatory care-sensitive conditions (ACSCs).<sup>2,3,13–15</sup> ACSCs include conditions for which hospitalizations are potentially avoidable when good outpatient care, not NH care, is provided. Although ACSCs were created for outpatient care, they identify a subset of conditions that can be treated in the NH and therefore miss some hospitalizations that can be avoided with better NH care. The reliance on the ACSC for NHs is partially because there is no consensus on measures for PAHs specific to NHs. Maslow and Ouslander<sup>16</sup> identify 10 studies that include a PAH measure for NHs. Most measures are based on ACSCs, and only a few studies provide the ICD9 details for their measures. An additional concern with using the ACSC measure for NHs is that the risk groups for these hospitalizations would likely be a subset of those at risk for a broader NH measure.