AARP
Real Possibilities

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

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

AARP appreciates the opportunity to provide comments to the Senate Finance Committee's chronic care working group as you consider policy options and develop bipartisan legislative solutions. We commend the Committee's bipartisan approach to these important issues.

As the Committee pursues its work on chronic care, we urge the Committee to consider these overarching themes:

- Focus not only on Medicare beneficiaries with chronic conditions, but also Medicare beneficiaries with chronic conditions and long-term services and supports (LTSS) needs that can impact their health and well-being, as well as the cost of care;
- Provide person-and family-centered care that recognizes the role family caregivers play in providing and coordinating care and supports them as they assist their loved one; and
- Empower individuals (and their family caregivers, as appropriate) to actively participate in their care and help them make informed choices without inappropriately shifting burdens to them, or adding barriers to necessary care.

We expand on these briefly below, as well as in our response to the eight specific categories outlined in the Committee's letter to stakeholders.

High-Cost Medicare Beneficiaries with Chronic Conditions and LTSS Needs

As you note, significant numbers of Medicare beneficiaries have multiple chronic conditions, and beneficiaries with multiple chronic conditions account for a significant portion of Medicare spending. However, among Medicare beneficiaries with chronic conditions, many with the highest Medicare spending are those whose chronic conditions create the need for LTSS (that is, help with routine activities of life, such as bathing and preparing meals). The 15 percent of Medicare beneficiaries with both chronic conditions and LTSS needs experience disproportionately high Medicare costs and account for about one-third of Medicare's total spending. Medicare's average spending for beneficiaries with both chronic conditions and LTSS needs ($15,800 in 2006) is twice the average for beneficiaries with substantial chronic illness – as indicated by the presence of three or more chronic conditions without LTSS needs ($7,900). The pattern of higher Medicare spending for people with the combination of chronic conditions and LTSS needs is constant regardless of the number of chronic conditions.[1]

These high-cost beneficiaries can benefit greatly from better care coordination — and improving the coordination of their care has the potential to yield significant Medicare savings. Evidence from promising examples of primary care models that assess LTSS needs and coordinate a full range of services, including LTSS, show that it is possible to reduce hospital use, nursing home admissions, and costs, while improving quality of care.[2] It is important for these beneficiaries to receive the services they need, not just medical services, but also social and supportive services.

However, few current efforts to improve care delivery focus on high-cost beneficiaries with LTSS needs, or create incentives to coordinate the full range of services they need. In addition, a lack of quality measures currently exists for home and community-based services and supportive services and beneficiary and family caregiver's experience of care. We propose a few policy options below that would help fill these gaps and help lead to better quality at lower cost. Addressing these beneficiaries and the full range of their needs could help address the three identified bipartisan goals for policies.

Person-and Family-Centered Care and Supporting Family Caregivers

A person-and family-centered care (PFCC) approach is vital in looking at policy solutions for Medicare beneficiaries with chronic conditions, and especially those with multiple chronic conditions and LTSS needs. PFCC is an "orientation to the delivery of health care and supportive services that considers an individual's needs, goals, preferences, cultural traditions, family situation, and values. It includes the person and the family at the center of the care team, along with health and social service professionals and direct care workers. It also evaluates the person's experience of care. Services and supports are delivered from the perspective of the individual receiving the care, and, when appropriate, his or her family."[3] PFCC also means involving and respecting an individual's family caregivers, as appropriate, in supportive services planning and delivery. In addition, family

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[1] Komisar, Harriet L., and Judy Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*. Long Beach, CA: The SCAN Foundation, October 2011.
http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf

[2] Ibid.

[3] Feinberg, Lynn, *Moving Toward Person- and Family-Centered Care.* Washington, DC: AARP Public Policy Institute Insight on the Issues, March 2012.
http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/moving-toward-person-and-family-centered-care-insight-AARP-ppi-ltc.pdf

caregivers are integrated as partners in care and their needs and preferences are recognized and addressed.[4] We note the use of the term "person" and not "patient". AARP encourages the Committee to use terminology such as person, individual, or consumer, rather than patient, which is more limited to certain contexts and not appropriate in thinking about coordination across all settings and a PFCC approach to service delivery.

Person- and family-centeredness is important, not only because people want it, but also because consumers' experiences—across all care settings—can influence the effectiveness of treatment and health outcomes. More and more, professionals are encouraged to treat consumers and their family members as co-producers of health and as autonomous partners in treating, managing, and preventing disease. A useful catch phrase summarizes this concept: "Nothing about me without me." In addition, research suggests that person- family-centered care may improve health outcomes. For example, studies have found that consumers' whose treatment is deemed patient-centered are more likely to trust their clinicians, are more likely to adhere to treatment recommendations, and are less likely to die following a major event such as a heart attack.

There are about 40 million family caregivers currently, and in 2009, family caregivers provided an estimated $450 billion in unpaid care to adults with limitations in daily activities.[5] Family caregivers provide a broad range of assistance to any relative, partner, friend, or neighbor with whom they have a significant relationship and who has chronic or disabling conditions. Family caregivers assist with daily tasks such as dressing, eating, transportation, and managing finances; provide emotional support; coordinate care and communicate and advocate with health care and other providers; and perform medical/nursing tasks, such as wound care and managing multiple medications. According to a recent national survey, about 32% of family caregivers provide at least 21 hours of care a week, on average doing 62.2 hours of care weekly.[6] As the baby boomers age, it will be essential to recognize and support family caregivers in their caregiving roles. If family caregivers were no longer available, the economic cost to the US health and LTSS systems would increase astronomically. AARP's recommendations below help move us toward a more PFCC approach.

Empower and Support Individuals

Individuals value choice and control, and generally want to be active participants in or in charge of their care. However, they may need tools and information to help them actively engage in their care and make informed decisions. If individuals have family caregivers assisting them, those family caregivers may also need information to help them in supporting their loved ones. Whether it is information about treatment options, services, providers, quality, or cost, information is power.

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[4] Ibid.

[5] L. Feinberg, S. Reinhard, A. Houser & R. Choula, Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving 1, 3 (AARP PPI, 2011), available at http://www.aarp.org/relationships/caregiving/info-07-2011/valuing-the-invaluable.html.

[6] National Alliance for Caregiving and AARP, *Caregiving in the U.S. 2015*. Bethesda, MD: NAC, and Washington, DC: AARP, June 2015. http://www.aarp.org/ppi/info-2015/caregiving-in-the-united-states-2015/?cmp=CRGVNUSA_MAY21_015.

At the same time, it is important to ensure that consumers are not overwhelmed and have information they can understand and use, including in their own language. Care can also be improved, such as through better coordination and financial incentives to help individuals receive the coordinated and continuous care they need. For example, Medicare Advantage (MA) plans cap out-of-pocket expenses at different levels depending on the plan. MA plans also often provide additional services which fee-for-service (FFS) does not, including transportation to doctors' appointments and gym memberships. It is important that cost-sharing is not a barrier to necessary care. A JAMA study concerning children with chronic conditions showed that parents at or below 250 percent of the FPL with low cost-sharing levels were less likely to delay or avoid taking their children to a physician's office visit than those with high cost-sharing.[7] It is important to consider how to appropriately incent good care for people with chronic conditions, including those with LTSS needs.

Below we specifically address the eight categories where the Committee requested feedback.

1. Improvements to Medicare Advantage for Patients Living with Multiple Chronic Conditions

Medicare Advantage (MA) plans are well positioned to improve care and care coordination for individuals with chronic conditions, including those with multiple chronic conditions. MA plans already have several tools at their disposal, and in some cases may already leverage these tools to better coordinate care across providers and health care settings. These tools include:

- The ability to offer a range of plan designs, providing consumers with opportunities to select a plan that may best suits their needs, including the ability to provide lower cost sharing options or additional services beyond traditional Medicare;
- The ability to implement incentives for disease management and improved care coordination across providers and health care settings; and
- The requirement to cap out-of-pocket expenses to limit consumer financial exposure.

All MA plans should be encouraged to better utilize their tools and integrated care opportunities to better coordinate care for enrollees with chronic conditions. While MA plans have many tools already at their disposal to provide better care coordination, additional changes to MA can be made to further incentivize improvements. We offer the following suggestions:

- **Consider the promotion of plan designs more individually tailored to those with specific conditions or multiple chronic conditions.** Features may include:
  - Additional benefits;

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[7] Fung, Vicki et al., *Financial Barriers to Care Among Low-Income Children With Asthma: Health Care Reform Implications,* JAMA Pediatr. 2014;168(7):649-656. doi:10.1001/jamapediatrics.2014.79.

  - Reduced or waived cost-sharing structures to incentivize beneficiaries to access both high-value and preventative care that keeps them healthy and; and
  - Access to specialized provider networks with expertise in both specific chronic conditions and care coordination.

- **Encourage plans to improve care coordination for enrollees in all types of MA plans, not just Special Needs Plans (SNPs).** While SNPs have played an important role in providing a tailored MA option for individuals with chronic conditions, it is important that improvements be made to address care coordination for all MA plans as greater numbers of individuals with chronic conditions are enrolled in general MA plans rather than chronic condition special needs plans (C-SNPs).

- **Recognize that individuals with multiple chronic conditions are likely to have numerous care providers and may receive services in many different health care settings.** It is critical that care coordination efforts be streamlined in a person-centered manner and in a way that does not overwhelm or place obstacles in front of beneficiaries seeking necessary care.

- **Recognize the significant impact of even minimal cost-sharing changes on individuals with multiple chronic conditions.** This has a substantial financial impact on individuals, as well as impact on adherence and improved health outcomes. MA issuers should be encouraged to design plans that support minimizing out-of-pocket costs for those with chronic conditions and perhaps be rewarded for meeting specified health outcome measures.

- **Consider strategies to support greater individual adherence to care plans without creating penalties for non-compliance.**

- **Implement, where appropriate, principles of Value Based Insurance Design (VBID) in order to incentivize access to high-value services and treatments.** AARP endorsed legislation that passed the House Ways & Means Committee (H.R. 2581) which includes both important consumer protections and incentives for both plans and beneficiaries to utilize high-value care.

- **Require plans to utilize qualified providers such as advance practice registered nurses (APRNs) and physician assistants (PAs)** as a means of increasing access to care coordination, transitional care and other nurse-led chronic care management services.

- **Reward plans that perform well on quality measures** related to care for individuals with chronic conditions through the MA Star Ratings and payment system. Continuing to reward plans that demonstrate positive health outcomes for such individuals will encourage greater improvement in the program, and such measures should not be compromised.

- **Improve enrollees' experience** so that beneficiaries have readily available access to information they need to make enrollment decisions into a high quality MA plan that best meets their needs, including SNPs. This may include additional consumer and provider/State Health Insurance Program education to assist individuals with chronic care needs with enrollment decisions. Consumer tools should be provided to help individuals assess plan options and better match individuals with chronic conditions with plans that are most likely to meet their needs. Star ratings should be better explained and displayed to beneficiaries who often overlook this feature when choosing a plan.

- **Recognize that a high proportion of individuals** who have multiple chronic conditions also have LTSS needs. MA plans should be encouraged to improve care coordination for these LTSS needs. We suggest the following policy improvements:

    - Require MA plans to explicitly identify Medicare enrollees with LTSS needs and report data on this population. These data would include enrollment and dis-enrollment information, as well as information on service use. Performance measures should include:

        - Quality measures that assess the coordination of care for individuals during transitions from a hospital stay to home or another setting; and
        - Quality measures that assess the coordination of care for individuals with ongoing LTSS needs. Measures could examine whether the medical team helped identify support needs at home, helped arranged LTSS, and determine if people who needed LTSS received appropriate care that met their needs and preferences.

    - Direct resources to support development of quality measures for home and community-based services, supportive services, and beneficiary and family caregiver's experience of care. We also note that an integrated setting, such as an MA plan or an accountable care organization (ACO), would be a good place to test such measures because it is easier to identify who's accountable for providing the services needed for better care. These quality measures should also be publicly reported once they are developed and tested.

- **Strive for equitable payment and avoid under-compensating** for the cost of higher-cost individuals, including individuals with chronic conditions, and over-compensating for care for beneficiaries that are healthier in any changes made to the MA risk adjustment system. Any changes should ensure the adjustment accurately accounts for enrollees' chronic conditions. In order to avoid disincentives for enrollment of individuals with chronic conditions who have long-term service and support needs, the Committee may want to consider whether the inclusion of functional impairment in risk assessment would improve the accuracy of risk scores.

- **Improve SNPs**. SNPs have played an important role in providing an MA option for individuals with chronic conditions. While the Committee should consider improvements for all MA plans to better coordinate care, the SNP program should also continue to be improved to provide specialized care to their intended target population.

- **Strengthen oversight of MA plans.** CMS has limited resources to provide vigorous oversight of MA plans. That said, the financial and health implications for individuals with chronic conditions enrolled in plans that do not comply with Medicare rules is significant but, more importantly, does not meet the important health needs these beneficiaries require. We suggest the following:

  - Require and provide resources so that CMS can engage in strong plan oversight and swiftly take action against plans that are out of compliance;
  - Require CMS to ensure timely and accurate appeals process for claims denials;
  - Require that improvements made to MA plans related to chronic care management should undergo evaluation to ensure they are meeting their stated goals of providing better coordinated care for individuals with chronic conditions, including multiple chronic conditions; and
  - Provide additional options for individuals enrolled in MA plans to change to traditional Medicare, including the purchase of a supplemental policy and/or prescription drug plan if desired, when beneficiaries are faced with mid-year network changes leading to a plan that no longer meets their needs. As an alternative, AARP is supportive of legislation which passed the House Ways & Means Committee (H.R. 2581, cited above relating to VBID) that also includes the establishment of a new open enrollment period for beneficiaries already enrolled in an MA plan but who now wish to change due to unforeseen network changes and/or unanticipated plan dissatisfaction.

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

As noted earlier, Congress and CMS should make improving care for Medicare enrollees who need both LTSS and chronic medical care — a high-cost population that would benefit greatly from better-coordinated care — a priority in delivery reform by explicitly focusing on this population in initiatives such as ACOs, bundled payment, and performance measures. The Center for Medicare and Medicaid Innovation should also pay special attention to models or demonstrations which include the family caregiver as part of the care team or in other appropriate ways. Medicare beneficiaries with chronic conditions, and especially those with chronic conditions and LTSS needs, often have family caregivers providing or coordinating their care and communicating and advocating with health care and LTSS providers. Family caregivers are often the default care coordinators and can be a consistent presence with the individual they are assisting across different providers and settings. Appropriately engaging and supporting caregivers can improve care coordination and beneficiary outcomes. Care teams should include all relevant providers, including direct care workers, with the individual and the family caregiver, as appropriate, at the center of the care team. More specifically, we recommend Medicare:

- **Require ACOs to coordinate LTSS along with medical care, including family-provided, privately-purchased, or Medicaid-financed LTSS.** In documenting their designs, ACOs should explicitly address how they would coordinate care for this population, including practices such as assessing individuals' LTSS needs, identifying family caregivers, providing training for family caregivers as appropriate, helping to arrange for appropriate LTSS services, and coordinating with LTSS providers.

- **Adopt LTSS quality measures for Medicare ACOs and in the Bundled Payments for Care Improvement initiative.** Current performance measures for ACOs focus on medical care and patient experience with medical care, including disease management, but do not include the extent to which LTSS needs are met. The set of performance measures should be expanded to include:

    - Quality measures that assess the coordination of care for individuals during transitions from a hospital stay to home or another setting; and
    - Quality measures that assess the coordination of care for individuals with ongoing LTSS needs. Measures could examine whether the medical team helped identify support needs at home, helped arranged LTSS, and determined if people who needed LTSS received appropriate care.

  There is currently a lack of quality measures for home- and community-based services and supportive services, as well as beneficiary and family caregiver's experience of care. More resources should be directed to support development of these measures. As with all quality measures, they should be publicly reported and made available to consumers.

- **Require ACOs to develop programs to monitor the quality and performance** of their post-acute and LTSS partners and make this information publically available in a timely manner, so Medicare enrollees and their families can make informed decisions. ACOs must ensure that Medicare beneficiaries and their families are informed of their options and their ability to choose post-acute and LTSS providers that are not affiliated with the ACO.

- **Require ACOs to provide complete, consumer-friendly information** about what it means to participate in the ACO and what their rights are. It is important that individuals be able to talk with someone in person, especially with trusted professional staff in their doctor's office, about what participating in the ACO would mean for them, what data sharing means, and to indicate their choice to opt-out of data sharing if that is what they choose. Further, in order to make an informed choice about data sharing, beneficiaries need adequate information describing what data sharing within the ACO means and consists of; this needs to be of sufficient detail so it is clear what personal information will be available to whom. For example, this educational information needs to answer such questions as:

    - What data will be shared? Will the medical histories collected by my doctors be shared?
    - If I opt out of data sharing, will I still be in the ACO?

  - Will every medical encounter, every prescription, every test result, etc. be available to everyone who has access to the shared records? Will financial information, such as paid and unpaid coinsurance amounts, medical debts, etc. be included?
  - Who can see the data? Will every administrative and clinical staff person who works for any provider affiliated with the ACO be able to access my private information?
  - What privacy protections do beneficiaries have? If I decide to opt-out at a later date (e.g., a year from now), will previously-shared records become "closed" or will those always be available under data sharing?

- **Require each ACO to adopt user-friendly ways to allow Medicare beneficiaries to control which information is shared with which providers.** Right now, it is basically an all-or-nothing approach: share all data or opt-out. ACOs should be challenged to come up with more sophisticated, person-centered, ways to ensure that providers obtain the information they need without requiring beneficiaries to give up their privacy and right to control their private information. As ACOs expand their provider networks, a potentially larger and larger group of people may have access to private information, which could well include patients' acquaintances or relatives who work for affiliated organizations. Medicare beneficiaries who receive services from ACO providers need to have confidence that they can control their information and that their privacy will be protected.

- **Expand the EverCare Demonstration in Fee-For-Service Medicare.** In 2002, the Medicare EverCare demonstration showed that using nurse practitioners to provide front line primary care and care coordination for nursing home residents could improve quality of care, increase discharges to home and reduce hospital admissions and emergency room visits.[8]

  The EverCare demonstration was performed by a managed care organization that received capitation payments for the entire cost of care, including care coordination services. The evaluation found that Medicare savings outweighed the costs of care coordination. However, the MA plan retained all savings, rather than passing them through to Medicare.

  With only minor modifications, this model could be revised to capture savings for Medicare by expanding it to serve fee-for-service beneficiaries in nursing homes.

  The Medicare EverCare demonstration used a nurse practitioner to target Medicare MA plan enrollees who were nursing home residents. Most of these residents had multiple chronic conditions, including cognitive impairment. The nurse practitioner provided "intensive primary care" in the form of early symptom recognition and treatment. For example, this care included physical exam, ordering diagnostic tests and prescribing medications. The most common conditions that required intervention were infections,

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[8] Evaluation of the EverCare Demonstration Program Final Report (2002). Available at: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/Evercare_Final_Report.pdf.

exacerbation of chronic medical conditions, adverse drug events and side effects and acute events (i.e., heart attack and stroke).

In addition to spending about 35 percent of their time on direct patient care, the nurse practitioners spent time on indirect care activities, such as coordinating care with nursing home staff, primary and specialist physicians, pharmacists, and family members. The nurse practitioners also provided a comprehensive assessment, care plan and advance directive planning. In case of terminal patients, the nurse practitioners would plan and coordinate end-of-life and hospice care.

In a Medicare fee-for-service model, eligible nursing home residents could include any Part B beneficiary who was not in a Part A covered SNF stay. On average, this criterion would probably include about 80 percent of nursing homes residents. Based on other Medicare care coordination demonstrations, payment for nurse practitioner services should be based on a monthly capitation fee per resident.

EverCare should be offered as a program that pays a capitation fee only for care coordination services while other services are furnished on a fee-for-service basis. This would allow savings to accrue to Medicare. Nurse practitioner care coordinators could be self-employed or employed by the nursing home or third party entity, such as a home health agency or a medical home.

The Medicare EverCare demonstration found that a nurse practitioner could manage a caseload of about 85 nursing home residents. In 2002, the cost of one nurse practitioner was about $100,000 per year. At this rate, a caseload of 85 residents could support one nurse practitioner with per capita payments of about $98 per month.

Based on the EverCare demonstration, Medicare program savings could substantially exceed the level necessary to cover the cost of nurse practitioners. The EverCare evaluation found that hospital admissions were reduced by about half (about 24 admissions per year per 100 residents), emergency room visits were reduced by about half (about 36 visits per year per 100 residents), and use of rehab therapy services was reduced by almost half. While use of physician services increased, savings from reduced utilization of other services outweighed the cost of nurse practitioner services. The evaluation estimated net savings of about **$188,000 per nurse practitioner per year in 2002** (about $2,212 per nursing home resident per year).

If similar savings were attained for about 1.2 million FFS Medicare nursing home residents, aggregate savings could be substantial. In addition, the quality of care and clinical outcomes for nursing home residents would improve.

3. Reforms to Medicare's current FFS program that incentivize providers to coordinate care for patients living with chronic conditions.

The fee-for-service reimbursement system can lead to inefficiencies and segmentation along the care continuum. AARP recommends the following policy changes to better promote care coordination:

- **Waive beneficiary cost-sharing for Chronic Care and Transitional Care Management Services.** Beneficiaries with multiple chronic conditions may sign up to receive Chronic Care Management Services from their primary care physician. Their physician receives a fixed monthly payment for performing non-face-to-face services, including care coordination. Under current Medicare rules, beneficiaries are liable to 20 percent coinsurance for these services after paying the Part B deductible.

  Beneficiaries are also liable for cost sharing associated with post-discharge Transitional Care Management services following an inpatient admission. These services include non-face-to-face services such as assessing the patient's post-discharge needs, adjusting the plan of care, conducting medication reconciliation, educating the patient and/or family caregiver, coordinating care with other health care professionals, and assisting with arranging needed community services. Under the physician fee schedule, a physician or other qualified health professional, such as nurse practitioner, receives a fixed payment for delivering these services for 30 days following discharge.

  We recommend waiving the cost-sharing liability for beneficiaries receiving Chronic Care Management Services and Transitional Care Management Services. Out-of-pocket costs pose a barrier to eligible high-risk beneficiaries who could benefit from both of these services. Since beneficiaries with multiple chronic conditions tend to have high out of pocket spending for health care, any cost sharing burden that could discourage them from receiving these vital services should be removed.

- **Enact the bipartisan Improving Access to Medicare Coverage Act (S. 843/H.R. 1571)** to count the time a Medicare beneficiary spends receiving outpatient observation services toward the three-day inpatient hospital stay requirement for Medicare coverage of skilled nursing facility services. This could help beneficiaries in observation who need skilled nursing care get the care they need and help improve outcomes.

- **Expand the Independence at Home Demonstration.** The Independence at Home Demonstration is testing a service delivery and payment model that uses home-based primary care teams designed to improve health outcomes and reduce Medicare spending for beneficiaries with multiple chronic conditions. The primary care teams are directed by physicians and nurse practitioners who visit and care for patients in their homes ("house call") and are available 24 hours per day. The Independence at Home Demonstration awards incentive payments to providers who reduce Medicare spending and meet designated quality measures.

  Although the Independence at Home Demonstration evaluation is not yet available, similar but smaller programs have shown great promise by reducing Medicare spending by 17 percent without compromising quality of care.[9] Congress should review the Independence at Home Demonstration as quickly as possible and, based on demonstrated success, make home-based care available to high-risk beneficiaries as rapidly as feasible.

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[9] De Jonge KE et al. "Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders." J Am Geriatrics Soc;62:10, 1825-1831 (Oct 2014).

- **Consider how changes in Medicaid policies can positively impact Medicare outcomes for individuals and family caregivers.** For instance, removing Medicaid's institutional bias would enable individuals to live in their homes and communities. Additionally, assessing and addressing the needs of family caregivers when they are providing elements of a person-centered service plan will yield better care and outcomes.

4. The Effective Use, Coordination, and Cost of Prescription Drugs.

Prescription drug innovation plays a vital role in the health and financial security of the older population. For older adults, prescription drugs are critical in managing their chronic conditions, curing diseases, keeping them healthy and improving their quality of life. AARP recommends the following to promote better use, coordination, and cost management of prescription drugs:

- **Ensure that enrollee cost-sharing does not lead to cost-related non-adherence (CRN) and correspondingly higher health care costs.** Part D plans are increasingly using coinsurance, requiring enrollees to pay a percentage of a given drug's cost instead of a flat copayment. In addition, while Medicare Part D technically limits out-of-pocket spending, many enrollees find they are still responsible for substantial cost-sharing after they enter catastrophic coverage. For example, the widely used rheumatoid arthritis drug Humira still costs over $150/month in catastrophic coverage. Likewise, someone taking the hepatitis C drug Sovaldi for less than one year can face as much as $7,000 in cost sharing.

  Researchers have consistently linked high out-of-pocket costs with poor drug adherence and medication discontinuation. CRN can lead to adverse health outcomes, including deteriorating health and higher risk of hospitalization. Older adults with multiple chronic conditions are particularly at risk of CRN due to their high levels of medication utilization and correspondingly high out-of-pocket costs.

  There is evidence that the recent growth in Medicare Part D cost-sharing is having a negative impact on enrollees. More specifically, research has found that CRN is now increasing among elderly beneficiaries with four or more chronic conditions.[10] The research also has found evidence of reduced drug coverage generosity in recent years, as Part D plans increased their premiums and began to charge deductibles. Plans are also charging higher copayments and are increasingly applying utilization management techniques like prior authorization.

  Medicare Part D will only be successful if enrollees are able to maintain access to medically necessary medications. Any efforts to improve the effective use of prescription drugs must ensure that enrollee cost-sharing does not lead to CRN and correspondingly higher health care costs.

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[10] H. Naci, S.B. Soumerai, D. Ross-Degnan, F. Zhang, B.A. Briesacher, J.H. Gurwitz and J.M. Madden, "Medication Affordability Gains Following Medicare Part D Are Eroding Among Elderly With Multiple Chronic Conditions," *Health Affairs*, Vol. 33(8):1435-1443.

- **Integrate stand-alone Part D plans with prescriber incentives.** Patients typically use medications in conjunction with other health care services, yet prescription drugs are often isolated within the health care system. For example, CMS currently does not hold Medicare ACOs accountable for Part D costs. Likewise, Part D plans cannot share in any savings that they produce through better patient outcomes. Thus, even though many Part D plans have the capacity to encourage the effective use of prescription drugs, there is no financial incentive for them to do so.

  There are a number of ways to help address this challenge. For example, savings associated with improving adherence and reducing health care utilization and costs could be shared with Part D plans. Similarly, CMS could explicitly integrate accountability for Medicare Parts A, B, and D across ACOs and Part D plans.

  Providing plans with an opportunity to share in savings from avoided drug-related problems could also give Part D plans more incentive to invest in their medication therapy management (MTM) programs.[11] Such improvements could be further augmented by revisiting CMS' recent proposal to broaden enrollee access to MTM under Medicare Part D.[12]

- **Implement Value Based Insurance Design (VBID).** AARP supports the implementation, where appropriate, of Value Based Insurance Design (VBID) to incentivize the utilization of prescription drugs with demonstrated clinical value. By reducing financial barriers to essential medications, patients are more likely to adhere to their prescription drug regimens and potentially avoid expensive hospitalizations and emergency room visits.

  However, AARP is also mindful that payers may not have access to the amount and type of research that would allow them to determine which medications represent the best clinical value. Consequently, AARP strongly supports efforts to increase the availability of comparative effectiveness research to help guide payers' VBID decisions.

- **Consider how the high cost of prescription drugs limits the availability** of life-saving medications to those who are most in need of them. The growth in specialty drugs with remarkably high prices and correspondingly high out-of-pocket costs in particular has spurred debate about whether the costs associated with these products are sustainable. While Congress should look at appropriate ways to promote greater innovation, it must also take a serious look at policies that are driving the high cost of prescription drugs.

  Similarly, we must consider how costs impact access to new treatments under the Medicare Part D prescription drug program. A number of ideas have been put forward

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[11] N.L. Rucker, "Medicare Part D's Medication Therapy Management: Shifting from Neutral to Drive," AARP Public Policy Institute, June 2012.

[12] Centers for Medicare & Medicaid Services, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, Proposed Rule" January 10, 2014.

to expand access to medicines by making them more affordable for Medicare beneficiaries. For example, AARP has supported giving the HHS Secretary the ability to negotiate drug prices, which is particularly important where there is no price competition in the market. For example, even more limited authority -- such as allowing the HHS Secretary to negotiate drug prices when an innovative new drug therapy addressing a great need does not have an alternative on the market – would help to reduce the high cost of unaffordable new drugs.

Congress could also examine legislative solutions such as the Medicare Drug Savings Act, which would require manufacturers to provide Part D drugs to low-income people at the same prices they provide under Medicaid. In addition, Congress could consider medical shared savings approaches for high cost drug therapies, where a portion of the payment for the drug would be withheld to see if savings are gained to the Medicare program.

- **Create new levers to spur drug innovation and competition.** As more high cost drug therapies come on the market, it is clear that we must increase transparency in the marketplace to empower consumers with more information to place downward pressure on prices. Additionally, AARP believes there must be greater transparency of drug manufacturers' actual development costs than currently exists. Since the pharmaceutical industry routinely uses R&D costs to explain their high prices, increased transparency could provide much-needed clarity and a better understanding of the industry's pricing methods.

  AARP also believes the application of scientific evidence, or comparative effectiveness research, would inform clinical and patient decision making as well as the development of evidence-based guidelines and, in general, clinical practice and service delivery. Comparative effectiveness research would provide an objective basis for selecting appropriate procedures and interventions including prescription drugs and other new technologies. Countries that base their treatment and coverage decisions on clinical studies that compare new drugs to available alternatives have found that these efforts can help contain costs while promoting positive health outcomes.[13] AARP is also generally supportive of efforts to utilize new technologies and data to enhance the health care delivery experience for consumers by it making it more person-centered in nature.

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

Under current Medicare rules, physicians and other practitioners only get reimbursed for telehealth services to beneficiaries in rural and underserved areas. Moreover, telehealth communications must originate in certain specified locations, such as a hospital, federally qualified health center, or physician's office. They may not originate in a beneficiary's home. Communications must take place in a "real time" face-to-face interactive video conference. Interactions may not be delayed or recorded, nor simple e-mail

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[13] D. Bahr and T.Huelskoetter, Comparing the Effectiveness of Prescription Drugs: The German Experience, Center for American Progress, May 21, 2014.

communications. Medicare covers qualified communications within states and across state lines between beneficiaries and health professionals as well as consultations between health professionals. However, health professionals must be licensed to practice in each state in which the telecommunication takes place. State licensure requirements limit the use of telemedicine by a provider to diagnose or treat patients in a state in which the physician or nurse is not licensed. Individuals and their family caregivers could also benefit from the use of technology to share information and include both parties in communications or visits with health care providers. AARP recommends the following to better capitalize on technology:

- **Remove geographic restrictions on telemedicine services.** CMS has allowed Pioneer ACOs to provide telemedicine services without geographic restrictions. Congress should remove geographic restriction on Medicare FFS coverage for telemedicine services. Telemedicine should be available in all geographic areas, rural and urban alike. Previous legislation, such as the Medicare Telehealth Parity Act of 2014 (H.R. 5380 in the 113th Congress) would have made significant improvements.

- **Ensure family caregivers are part of electronic health records (EHR).** Family caregiver contact information should be included in an individual's EHR. Also, with the individual's permission, the family caregiver should have access to the health records. Family caregivers are key members of the care team, and should be fully incorporated.

- **Ensure interoperability across acute, post-acute, and LTSS settings**. Health information systems and EHRs need to be able to follow the individuals through the continuum of care.

- **Include the beneficiary's home as an acceptable site of service.** Beneficiaries should be allowed to receive telehealth communications in their home without having to travel to some other designated location. This would improve timely access to vital medical services for Medicare beneficiaries. In this way, telemedicine could improve patient outcomes, reduce hospital admissions and readmissions, and lower health care costs.

- **Broaden the scope of telemedicine services**. Medicare should cover delayed or recorded telehealth communications, such as recorded video, photographs, and e-mail.

- **Adjust payment rates for telemedicine services.** CMS should be authorized to adjust payment rates for telehealth communications to reflect the time and intensity of health care professionals' effort. For instance, a trial telemedicine program found that "virtual visits" which allowed patients to interact with physicians via e-mail were as effective as in-person visits for managing chronic conditions. However, virtual visits were five times faster than in-person visits (3.6 minutes vs 18 minutes) and physicians were paid only one-third the amount they would have received for an in-person visit.[14]

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[14] O'Rourke K. "Virtual Physician Visits Venture Into Mainstream Use." JAMA;311:24, 2468-2469 (June 24, 2014).

- **Encourage use of home monitoring equipment.** For beneficiaries with chronic conditions, Medicare should encourage the use of monitoring equipment in the home, such as remote monitoring systems to weigh and check the vital signs of patients with congestive heart failure. Currently, Medicare does not reimburse home health agencies for such remote monitoring costs.

- **Incentivize states to join the Nurse Licensure Compact and the Interstate Medical Licensure Compact** to more broadly use technology without legal hurdles. Incentives provided by Medicare or Medicaid could have two benefits: speeding up the legislative passage in pending states, and encouraging uninvolved states to join the compact. Nurses and physicians are being deterred from practicing telemedicine across state lines, despite the fact that telemedicine has been demonstrated to be a cost effective method of providing quality patient care.

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

Chronic care coordination is especially important in rural and frontier areas where access to providers and services is often limited. Technology has the potential to make high-quality care more accessible and more affordable in rural communities. Telemedicine could reduce the need to travel long distances for appointments, and reduce the costs associated with office or hospital visits. See our comments above on expanding the use of telemedicine. AARP recommends the following policy changes to better promote care coordination in shortage areas:

- **Incentivize states to modernize APRN scope of practice laws.** An example of such an incentive could be higher rates of reimbursement for chronic care management in states with full practice authority for APRNs. Only twenty one states currently allow APRNs to legally practice to the full extent of their training, despite the fact that APRNs can provide consumers and their caregivers with convenient, cost effective, and high quality care[15]. Although 25 percent of Americans live in rural areas, only 10 percent of physicians practice there. APRNs can fill this gap to assure greater access to care in rural areas. 23 percent of rural Americans are Medicare beneficiaries, compared to 20 percent of urban Americans[16]. NY Times Article *Doctoring without the Doctor* discusses the importance of increased scope of practice laws in Nebraska, where one third of the population lives in rural areas, and where it is more difficult to recruit physicians[17].This change has been recommended by the Institute of Medicine, National Governor's Association, Bipartisan Policy Center, American Enterprise Institute and Cato Institute.

- **Expand access to non-physician providers.** Previous legislation, the Seniors Mental Health Access Improvement Act, would provide greater access to health services in rural areas because it allows mental health counselors and marriage and family therapist services to be reimbursed under Medicare Part B, expanding the list of

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[15] "State Progress in Removing Barriers to Practice and Care." Future of Nursing: Campaign for Action. Accessed June 8, 2015.

[16] Gorsky, Mary Sue. *Advancing Health in Rural America: Maximizing Nurse's Impact.* Fact Sheet, Washington, DC: AARP Public Policy Institute, 2011.

[17] Tavernise, Sabrina. "Doctoring, Without the Doctor." The New York Times, May 25, 2015, Health sec.

covered providers who can deliver these needed services. Additionally, the Home Health Care Planning Improvement Act (S. 578/H.R. 1342) would authorize nurse practitioners, clinical nurse specialists, certified nurse-midwives and PAs as eligible health care professionals who can certify patient eligibility for home health care services under Medicare. This bill would allow APRNs, the group which currently coordinates the majority of skilled care for beneficiaries receiving home health, to certify Medicare patients for home health benefits. This critical change would improve access to important home health care services, including in rural and frontier areas, and potentially prevent additional hospital, sub-acute care facility and nursing home admissions—all of which are costly to the consumer, the taxpayer and Medicare.

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

Research shows that across all health settings, doing things to people instead of with them can be profoundly disempowering. It encourages consumers and their families to believe that professionals have all of the answers and that they lack the relevant knowledge and skills to have a legitimate role in decisions about their health care. Thus, we need to refocus every part of the health system on person- and family-centered care.

AARP is a strong supporter of evidence-based, person- and family-centered practices that will empower consumers to be active participants in their care across all sectors—population-based, primary care, acute care, and long-term services and supports—as long as they do not deny access to health care, make coverage or care unaffordable, or discriminate.

The individual should be at the center of any care plan, and be an active participant in its development. In order to better engage with health care providers, individuals and their family caregivers need to be informed, and providers need to take time to listen. Importantly, penalizing persons through increasing prices or cost-sharing does not result in better consumer decision-making or more involvement. AARP recommends the following actions to give individuals the tools they need to be engaged without creating barriers to care:

- **Make data on cost and quality more available.** To be an active participant in their own care, individuals need to understand their choices. Information on the cost and efficacy of various options are important to consumers. This information needs to be made available in a format that is easy to understand and user-friendly.

- **Enact provisions of the bipartisan Care Planning Act (S. 1549) to incentivize providers to coordinate care for individuals with multiple chronic conditions.** Medicare coverage of planning services engages an interdisciplinary team to help eligible beneficiaries understand disease progression, explore treatment options, and have a documented plan of care that reflects their goals, values, and preferences. The Advanced Illness Care Coordination Services demonstration builds on the planning services with assessment of the individual and their supports (including family caregivers), assistance with medications, in-home supportive services, emergency support, and importantly, coordination across health care and social service systems.

- **Incentivize hospitals and nursing homes to adopt models which promote interaction between patient and provider.** For example, *Transforming Care at the Bedside*, an initiative of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement, has demonstrated success in increasing nurse-patient interaction by 70 percent.[18]

- **Incentivize use of recommended person-centered medical homes.** The Person-Centered Medical Home (PCMH) is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical Homes can lead to higher quality and lower costs, and can improve consumers and providers' experience of care. PCMHs are driving some of the most important reforms in health care delivery today. A growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and emergency department visits, reducing health disparities, and improving patient outcomes.[19]

  The National Committee for Quality Assurance (NCQA) Person-Centered Medical Home Recognition is the most widely used way to transform primary care practices into Medical Homes. The NCQA awards the Recognition status to primary care practices that meet a variety of evidence-based requirements, including incorporating person-centered strategies. Person-centered requirements of the NCQA Medical Home Recommendation designation include:

  - Electronic access to health information;
  - Evidence-based consumer and family education and self-management support;
  - Training care teams to support self-management;
  - Self-care support;
  - Self-care and shared decision-making;
  - Measuring patient and family experience of care; and
  - Sharing performance reports with consumers.

  The federal government should create incentives for providers to obtain a recommended Person-Centered Medical Home designation from the NCQA. For example, the federal government could develop a bonus program for primary care practices that obtain the Medical Home designation. Alternatively, the federal government could provide grant funding to primary care practices to help offset the costs associated with meeting Medical Home requirements.

  Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The Clinical and Group CAHPS (CG-CAHPS) survey assesses patient-reported experience in primary care settings. The federal government should conduct a study to compare CG-CAHPS survey results for people in NCQA Recommended Medical

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[18] Rutherford P, Lee B, Greiner A. *Transforming Care at the Bedside.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004.

[19] See http://www.ncqa.org/Programs/Recognition/Practices/PCMHEvidence.aspx.

Homes with those not in medical homes to determine if there are differences in measures of beneficiary experience.

- **Require the federal government and providers to address health literacy.** One definition of health literacy is “a set of capacities that enable individuals to exert greater control over their health and the range of personal, social, and, environmental determinants of health.” This definition encompasses both clinical and public health arenas, and is preferable to one that focuses solely on clinical settings.

  Health literacy is essential for good health. If people cannot obtain, understand, and use health information, they will not be able to look after themselves effectively, navigate the health system without difficulty, and make appropriate health choices for their own, their family, and their community’s health. Improving health literacy is also a key underpinning for initiatives that seek to improve public health.

  There are myriad tools in the marketplace to assess health literacy,[20]but no single validated instrument that can be used across care domains and health conditions. Therefore, we urge the federal government to invest in the development of a valid and reliable tool for use across settings and conditions.

  We also urge the federal government to invest in testing interventions that improve low health literacy levels. In the interim, all provider types should be required to: (a) familiarize themselves with existing tools; (b) select a tool that they believe meets their needs; (c) implement the tool among their patient population; (d) use known interventions to address low literacy levels; (e) document findings; and (f) report summary findings publicly. Second, providers and public health officials should be required to use evidence-based standards for providing high-quality health information to consumers. The federal government should ensure that family caregivers with limited English proficiency be included in all efforts to improve health literacy, including making translation services available to them.

- **Require providers to provide meaningful opportunities for consumers and family caregivers to engage in shared decision-making.** There is considerable evidence that consumers want more information and greater involvement in decision making in partnership with their providers. Shared decision-making is a process in which consumers and family caregivers are active partners with professionals in clarifying acceptable treatment, management, and support options, discussing goals and priorities, and together, planning and implementing a preferred course of action. It operates under the premise that armed with good information, consumers can and will participate in decisions about their health. Consumers do this by asking informed questions and expressing personal values and opinions about their conditions and treatment options. Shared decision-making is appropriate in any situation when there is more than one reasonable course of action and no one option is self-evidently best for everyone.

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[20] See http://www.ncbi.nlm.nih.gov/books/NBK45386/.

Providers at all levels of the health system must give consumers and, when appropriate, their family caregivers opportunities to engage in decision-making throughout the health system. All levels of the health care system should be required to include consumers and/or their engaged family members in governance structures and on advisory committees. Consumer representation should reflect the diversity of consumers served by the provider type (e.g., older people, persons with disabilities, persons of color, etc.). Steps include:

  - The federal government should require providers at all levels of the health care system to provide appropriate orientation, onboarding, and support to promote meaningful consumer participation on governance structures and advisory committees.
  - The federal government should require all provider types to provide sufficient consumer (and family caregiver) education to support shared decision-making. This could take the form of face-to-face education as well as web-based consumer education application.
  - The federal government should routinely survey consumers on whether they had the opportunity to share in decisions about their health and long-term services and supports.
  - Providers should be required to document all efforts listed above and demonstrate to the federal government that they are engaging consumers and their family members, when appropriate, in shared decision-making.

- **Take a cautious approach to proposals that impose additional cost-sharing on consumers.** AARP strongly opposes any efforts to empower consumers using financial rewards or penalties that could result in loss of access to health insurance, undue cost burdens, and loss of access to needed services. This opposition holds across all settings of care, including workplace settings.

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.

Primary care is usually the entry point to the health care system and is also the focal point for management and coordination with other parts of the system. The numerous demands and range of skills and expectations of primary care suggest that it is best provided through a care team, with each professional member allowed to practice to the full extent of his or her license with a clear definition and understanding of roles and responsibilities.

All individuals benefit from well-coordinated care managed by a team of professionals with skills to serve their needs. In a person-centered system, an individual’s needs are the primary focus and are managed by a team whose members consult and coordinate with one another, as well as with the individual and/or caregiver. People with multiple chronic conditions particularly benefit from the skills of health professionals from a variety of disciplines. The team’s composition may vary according to individual needs, but it customarily includes physicians, nurses, social workers, pharmacists, nutritionists, and family caregivers, as well as the individual. When the individual has chronic conditions and LTSS needs, the team may include direct care workers, social service and LTSS providers.

It is also important that the care delivered is culturally competent and honors individuals' preferences, values, and circumstances. Providers and the care delivered needs to meet the needs of a diverse population, including those with limited English proficiency who may need language access services. It is beneficial for providers to be trained in the health care needs of older adults, and the Committee should consider recommendations in the 2008 Institute of Medicine report, "Retooling for an Aging America." Below are some additional recommendations from AARP, and we note some policy recommendations already discussed in other categories may also be relevant in this category.

- **Assure appropriate inclusion of Registered Nurses (RNs) and APRNs in care coordination.** In November 2014, Mercer released a report, *Integrated Patient Centered Management Care/Medicare Supplement Population,*[21] describing a pilot program focused on individuals in United Health Care's Medicare Supplement program and who had multiple chronic care conditions. The pilot tested using some of the ACO-type chronic care management interventions for this population. Registered nurses led the case management within a multi-disciplinary team that included physicians, social workers, and others. RNs also provided remote monitoring which significantly reduced re-hospitalizations. According to the study, the pilot saved $1.82 for each dollar spent, while improving care for each of the people in the pilot program, and 81 percent of this savings went to Medicare.

  A separate retrospective study of 826 patient records demonstrated that the addition of a nurse practitioner (NP) to coordinated care teams improved patient outcomes and reduced emergency room visits.[22] Another randomized controlled study of heart patients measured the effectiveness of APRNs as part of a coordinated care team in the transition from acute care to home care. This study showed that APRN patients reported fewer days in the hospital and a lower readmission rate, for a cost benefit savings of approximately $4,845 per patient.[23]

- **More effectively deploy RNs in chronic care management.** In a state-level scorecard on long-term services and supports, *Raising Expectations on Long-term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers,*[24] the research team identified a set of sixteen health maintenance tasks

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[21] Gold, Dan, and Kristin Parker. *Integrated Patient-Centered Care Management in the Medicare Supplement Population: A Viable Solution to Fragmented Care and Escalating Costs.* Washington, DC: Marsh and McLennan Companies, 2014.

[22] Robles, L., Slogoff, M., Ladwig, Scott, E., Zank, D., Larson, M. K., Aranha, G., & Shoup, M. (2011). *The addition of a nurse practitioner to an inpatient surgical team results in improved use of resources.* Surgery 150(4), 711-717.

[23] Naylor, M.D., Brooten, D.A., Campbell, R.L., Maislin, G., McCauley, K.M., Schwartz, J.S. (2004). Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. Journal of the American Geriatrics Society, 52(5), 675-684.

[24] Reinhard, S. C., Kassner, E., Houser, A., Ujvari, K., Mollica, R., Hendrickson, L.. (2014). Raising Expectations on Long-term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. http://www.aarp.org/home-family/caregiving/info-2014/raising-expectations-2014-AARP-ppi-health.html.

that registered nurses perform and can delegate to direct care workers. The research team identified these tasks with the support of the National Council of State Boards of Nursing. In AARP's 2014 study, nine states allowed RNs to delegate all sixteen tasks, up from six in 2011. The more tasks that RNs are allowed to delegate, the better the score a state obtains. Smarter deployment of RNs fosters more person-centered care in home- and community-based environments. Allowing RNs to better to use their full range of skills, including supervision of direct care workers, will increase access to care for all sixteen health maintenance tasks for Medicare beneficiaries living at home. This model helps assure a high quality of care and quality of life for Medicare beneficiaries and their family caregivers.

- **Expand the numbers of nurses trained with the skills necessary to effectively provide of care coordination, transitional care, and medication management.** Congress should expand the models established in the Medicare Graduate Nursing Education (GNE) Demonstration across the country. The program is completing the third year of a four-year $200 million demonstration testing the feasibility of Medicare support to train more APRNs. The test reimburses selected partnerships of hospitals, nursing schools, and community-based training sites for the cost of clinical training for APRNs, on the condition that 50 percent of the clinical training occurs at non-inpatient hospital sites such as retail clinics or federal qualified health centers.[25]

  A major goal of the GNE Demonstration is to provide training for APRNs to serve the Medicare population through person and family centered clinical care. APRNs in the GNE demonstration are trained to lead clinical teams designed to provide comprehensive care to individuals over age 65, including chronic care management, transitional care and medication management. APRNs can also assist with family caregiving in the home, which is particularly important as family caregivers take on increasingly complex medical tasks previously performed only in hospitals.

- **Extend nursing-led models, such as transitional care services, to all Medicare FFS beneficiaries with multiple chronic conditions upon discharge from hospitals and from SNFs.** Nurse care-coordination has been demonstrated as an effective tactic for increasing health outcomes while lowering costs in acute, transitional, and community care settings.[26] APRN's have increased flexibility to create individualized coordinated care plans based on patient needs.

- **Make the Independence at Home demonstration a permanent part of Medicare** if, as expected, the results from the demonstration show success.

- **Enact the bipartisan Home Health Care Planning Improvement Act of 2015 (S. 578/H.R. 1342)** as discussed above.

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[25] Quinn, W., Reinhard, S., Thornhill, Laura., Reinecke, P. *Improving Access to High Quality Care: Medicare's Program for Graduate Nurse Education.* Insight on the Issues, Washington, DC: AARP Public Policy Institute, 2015.

[26] Camicia, Michelle, et. al.. *The Value of Nursing Care Coordination*. Rep. Washington, DC: American Nurses Association, 2012. Print.

- **Medicare should incentivize states to modernize APRN scope of practice laws** to increase access to care, with higher rates of reimbursement for chronic care management.

- **Enact the bipartisan Care Planning Act (S. 1549)** which would also help meet the goals in this area, including maximizing health outcomes for Medicare beneficiaries with chronic conditions**.**

- **Test, support, and expand successful models of care delivery** that integrate care across primary, acute, chronic, and long-term care services and use interdisciplinary teams composed of health and LTSS professionals and others to deliver PFCC that supports the needs of the individual and their family caregiver. Evidence-based interventions should be used as appropriate.

- **LTSS care plans should be incorporated into electronic health records to enable providers to use a standardized care plan as consumers with LTSS needs move across settings.** This would also enable primary care providers and care coordination teams to access the LTSS care plan and better coordinate services to meet the individual's needs.

- **Conduct periodic assessment of an individual's clinical needs** (grounded in evidence-based protocols when available) and assessment of social and support needs and resources of both the individual and family caregivers, as needed.

Thank you for the opportunity to provide recommendations for chronic care reform in the Medicare program. If you have any questions, please feel free to contact me, or have your staff contact Ariel Gonzalez, Director of Federal Health and Family, at 202-434-3770 or agonzalez@aarp.org.

Sincerely,

Joyce A. Rogers

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Senior Vice President
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