Mass Home Care

Statement Regarding Improving Care for Medicare Patients with Chronic Conditions
Submitted to the U.S. Senate Financing Committee
Mass Home Care

June 19, 2015

U.S. Senator Orrin Hatch
Chairman, Committee on Finance

U.S. Senator Ron Wyden
Ranking Member, Committee on Finance

U.S. Senator Johnny Isakson
Committee on Finance

U.S. Senator Mark Warner
Committee on Finance

Re: Working Group on Chronic Care Request for information

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

Mass Home Care represents the 23 Area Agencies on Aging in the Commonwealth, as well as the 27 Aging Services Access Points (ASAPs), which manage a wide range of care coordination services funded by the state, and by MassHealth (Medicaid).

We submit the following comments regarding policies to improve care for patients with chronic conditions:

1. Creating integrated, independent, conflict-free care coordination across settings

In January of 1987, Representative Claude Pepper (D-FL) introduced H.R. 65, the Medicare Part C: Catastrophic Health Insurance Act. This legislation amended Medicare to add a new part C entitled "Program for Comprehensive Catastrophic Coverage, and Certain Preventive Benefits." Pepper's bill extended traditional Medicare coverage to provide, among other new benefits, "comprehensive long-term care services provided in the least restrictive environment."

Because this legislation never was signed into law, any discussion on the subject of improving Medicare's provision of services to individuals with chronic care needs must begin with the stark admission that Medicare cannot integrate care across settings because its scope of coverage barely addresses LTSS needs at all.

As Howard Gleckman of the Urban Institute recently pointed out:

> While older people with chronic conditions do need improved medical care, they also need better social supports, personal assistance, access to services such as transportation, and safe and affordable housing. Improving delivery of medical care without including social supports is like pumping air in a flat tire without first fixing the puncture….Those high cost enrollees don't just have multiple medical conditions. They also have functional limitations and often cognitive impairment. And often, it is the combination that drives high costs, not chronic illness alone…. without the services and supports to help address their functional limitations, even better coordinated medical care won't make huge improvements in their quality of life, and it may not save much money. (**1)**

Medicare was never designed to address what one physician has called "the ambush of social circumstances" that can have a major impact on individuals coping with multiple chronic conditions: lack of adequate housing, lack of adequate income, lack of accessible transportation, lack of proper diet and nutrition, etc. But as Gleckman reminds us:

> But remember that senior with heart disease, diabetes, and arthritis. Even with the best, well-coordinated medical treatments, how well is she going to do without an aide to help her get started in the morning, assistance taking her many meds, or a ride to the doctor? Without a grab bar in her shower, she could very well fall. And with very few exceptions, none of Medicare's managed care models provide any of those services.

Dr. Joanne Lynn of the Center for Elder Care and Advanced Illness, Altarum Institute, has described the fragmented, episodic approach we have taken with post acute care, and suggested a better path:

> A more reliable and efficient care system for frail elders must be integrated across multiple programs (e.g., Medicare, Medicaid, Older Americans Act [OAA], federal housing, and similar state and local initiatives) and service setting siloes (e.g., hospitals, nursing homes, home care, and housing modifications) that constitute health care and supportive and environmental services….[and] brings together health care practitioners, social services personnel, and organizations working on housing, transportation, and other community-based services in order to serve a complex population of older adults with chronic conditions and functional limitations. **(2)**

In Massachusetts, there is considerable precedent in the use of "conflict-free care management"—agents acting independently of the managed care organization. There is a well-established practice at the federal and state level in this kind of independent care coordination within the Medicaid program. Any managed care organization can benefit from this conflict-free care coordination.

In a 2010 report, the Center for Health Care Strategies stated: "One of the hallmarks of having a successful long term care program is the implementation of a needs assessment system that is independent of the agencies that directly provide services. This increases the likelihood that consumers are being assessed objectively, and that services are being provided to meet consumer needs rather than provider needs.

Over the past decade, Massachusetts has moved forward to adopt an independent conflict-free care coordination framework for the provision of LTSS, both in accepting new federal financial incentives, and within state statute. Massachusetts has 11 years of experience with integrating medical and functional funding streams *and* settings for the elderly through the Senior Care Organizations (SCO) program. This insurance plan for dually eligible people age 65 and over is able to travel across the barrier of acute and post acute care by combining Medicare and Medicaid capitations---creating, in essence, the kind of unified insurance coverage that Congressman Pepper envisioned. The benefit plan in the SCO program reflects the bio/psycho/social needs of a "whole care" approach to care.

The SCO plan currently has 38,000 enrollees, and is operated by 5 separate plans, both for-profit and non-profit. It is voluntary enrollment, which allows members to "opt out" and return to traditional Medicare and Medicaid fee-for-service.

One of the unique features of this plan is that every senior with "complex care" needs has a Geriatric Support Services Coordinator (GSSC) on their team, who is not owned by the SCO, and functions as their independent agent for LTSS purpose. Under M.G.L. Chapter 118E, s. 9D, the GSSC is defined as:

> Geriatric support services coordinator, a member of a senior care organization primary care team who is employed by an aging services access point, is qualified to conduct and is responsible for arranging, coordinating and authorizing the provision of appropriate community long-term care and social support services… ASAPs under contract with SCOs shall employ geriatric support service coordinators, who shall be members of the primary care team and shall be responsible for: (i) arranging, coordinating and authorizing the provision of community long-term care and social support services with the agreement of other primary care team members designated by the SCO;

It is important in any Medicare reform plan that there is the capacity and funding necessary to provide such care coordination across all settings. The Massachusetts home care program, which receives $250 million in state and federal funding, has used non-provider, conflict-free ASAPs as its care coordinator since its inception in 1973. ASAPs are responsible for: (1) providing information and referral services to elders; (2**)** conducting intake, comprehensive needs assessments, preadmission screening and clinical eligibility determinations for elders seeking institutional and community care services from Medicaid or the home care program(3) arranging, coordinating, authorizing and purchasing community long-term care services called for in the comprehensive service plan; and (4) monitoring the outcomes of and making periodic adjustments to a service plan in consultation with service and health care providers. Under M.G.L. Chapter 19A, 4B, ASAPs are independent from providers:

> ASAPs shall not provide direct services except for case management; information and referral, and protective services as defined in regulations of the home care program…and the Older Americans Act, as amended…Except for the direct services provided by ASAPs pursuant to this section, no ASAP shall have a direct or indirect financial ownership interest in an entity that provides institutional or community long-term care services on a compensated basis

More recently, in October of 2013, Massachusetts statute created a second duals plan for people aged 18 to 64, the "One Care" plan, with enrollment of 17,600 members. This integrated Medicare and Medicaid plan also features on the core team an "Independent Long Term Support Coordinator (ILTSC). This care coordinator cannot be owned by a One Care plan. ASAPs and Independent Living Centers function as the ILTSC agent for plan members.

At the federal level, the Centers for Medicare and Medicaid Services (CMS) requires conflict-free case management policies in states using Medicaid funds from the Balancing Incentive Program, Community First Choice (1915 k), and 1915(i). It is also part of the Money Follows the Person requirements.

The CMS definition of conflict-free case management includes the following principles::

- Clinical determination of need is separated from direct service provision.
- The independent assessment is based on the individual's needs and strengths.
- Case coordinators are not related to the individual being assessed, their paid caregivers, or anyone financially responsible for the individual.
- A person-centered assessment including behavioral health, which will take into account the individual's total support needs as well as the need for the HCBS to be offered.
- The assessor must be independent; that is, free from conflict of interest with regard to providers, and to budgetary concerns.
- The person who assesses care needs does not provide the services to meet those needs

Conflict-Free Case Management exists in the following federal statutes:

- Balancing Incentive provisions in the Affordable Care Act
- Community First Choice provisions in the Affordable Care Act
- Final Rule CMS 2249F Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community- Based Services (HCBS) Waivers states that CMS emphasized the section 1915(i) of the Act requirement for conflict of interest standards at § 441.730(b). When a state proposes a state plan amendment to add section 1915(i) of the Act HCBS, CMS requires that the state specify the entity that will be responsible for the assessment, the qualifications of that entity, and how the state will meet the conflict of interest requirements at § 441.730(b).

RECOMMENDATION: Mass Home Care strongly urges the Senate Finance Committee to pursue the requirement for integrated, independent, conflict-free care coordination across settings in any managed care plan that covers LTSS.

2. Expand the use of independent Care Coordination For Transitional Care

According to a 2011 study of care coordination models for dually eligible beneficiaries by Emory University, there is a growing body of evidence that has identified the key functions performed by health plans and successful comprehensive team based care coordination models in managing chronically ill patients. The key design features of effective care models include:

- Coordination of care for all covered Medicare and Medicaid services

Utilizing a team based approach and a capitated payment from Medicare and Medicaid.

- Approaches that provide a whole-person focus on preventing disease and managing acute and mental health services tailored to the needs of dually eligible beneficiaries over age 65 and those under 65 with disabilities who reside in the community and in institutions.
- Medical advice from a care coordinator available 24/7.
- Assessment of patient risk and development of an individualized care plan
- Medication management, adherence and reconciliation
- Transitional care
- Regular contact with enrollees
- Centralized health records
- Close integration of the care coordination function and primary care (and specialist) physicians

The use of care transitions coordination in Massachusetts is a firmly-established model. Over the past several years, a number of CMS care transitions efforts, led by community-based ASAPs, have reduced preventable hospital readmissions.

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, has tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program. The Department of Health and Human Services planned to invest up to $1 billion in Affordable Care Act funds in the Partnership to reduce millions of preventable injuries and complications.

Care transitions occur when a patient moves from one health care provider or setting to another. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over $26 billion every year. Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible for, including the quality of care during the hospitalization and the discharge planning process. However, it is clear that there are multiple factors along the care continuum that impact readmissions, and identifying the key drivers of readmissions for a hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions.

The CCTP, launched in February 2012, runs for 5 years. Community-based organizations (CBOs) use care transition services to effectively manage Medicare patients' transitions and improve their quality of care. In Massachusetts, the CBOs are Aging Services Access Points (ASAPs). They are paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level. The three projects in Massachusetts are as follows:

Massachusetts Community Care Transitions Projects

Model Name	Organization Name			Area Served
Community-based Care Transitions Program	Elder Services of the Merrimack Valley, Inc. Lawrence, MA	Lawrence	MA	Operating in Massachusetts counties of Essex and Middlesex; New Hampshire counties of Hillsborough and Rockingham
Community-based Care Transitions Program	Elder Services of Worcester, Massachusetts Worcester, MA	Worcester	MA	Operating in counties of Hampden, Hampshire, Middlesex, Norfolk, and Worcester
Community-based Care Transitions Program	Somerville-Cambridge Elder Services Somerville, MA	Somerville	MA	Operating in Middlesex County

Care Transitions Coaching: A Case Profile

Ron is a 74 year old single man living alone in Amesbury. He has a past medical history that includes poorly managed diabetes, atrial fibrillation, hypertension, congestive heart failure, and obesity. Ron's health began to decline after he started to develop cellulitis on his lower right leg. He has had difficulty managing his health at home making him a perfect candidate for the Community Care Transitions Program.

Transition Coach Barbara became involved when the consumer was hospitalized due to complications of cellulitis. She helped the patient to establish a routine of taking his blood sugar daily and reducing his carbohydrate intake and coached him on ways to better manage his health at home. Ron was initially resistant to change and doubtful in his ability to control his chronic illnesses. He was again admitted to the hospital for undertreated cellulitis resulting in being placed on hospice due to his worsening skin infection and poor prognosis.

Barbara worked with the patient's Case Manager to get the consumer enrolled in the Community Choices program, allowing his home care services to increase from two hours of homemaking to 50 hours of home health aide assistance each week. The consumer's status improved as he was able, with the help of his Transition Coach, to begin to recognize changes in his skin condition and identify red flags that caused his cellulitis to worsen. Soon he no longer needed hospice services as his condition and outlook drastically improved.

Barbara worked with the local VNA to get a social worker involved and advocated for the primary physician to perform a thorough medication reconciliation and to authorize a nurse to perform medication teaching. Ron became confident in self-managing his medications. At the conclusion of Barbara's involvement, Ron's lower leg cellulitis had healed, allowing him to increase his independence and improve his walking, enabling him to safely live at home with an improved quality of life.

Care Transitions Coaching: 2nd Profile

Henry is a 70 year old with two hospitalizations within the past two months. Henry lives alone and is wheelchair bound due to car accident that resulted in an amputated left leg. Henry had a home health aide four times a week and Home Delivered Meal services from his ASAP. Henry has chronic renal and prostate issues. He is alert and oriented, and on palliative care. Patient was given a Foley catheter during his most recent hospitalization due to his urinary retention.

A Transition Coach went out to see Henry in his home the day after he was discharged from the hospital. Henry reported to the Coach that he was experiencing a burning sensation while urinating. The Coach alerted her Nurse Coordinator, who contacted the VNA to report the symptoms and requested a VNA nurse be sent out

the same day. The Nurse Coordinator then advocated to have Henry's urologist follow-up appointment pushed up to an earlier date, since Henry's appointment wouldn't be for another two weeks. The Nurse then put in a wellness call to the Henry over the weekend to check in. During the follow-up call, Henry mentioned to the Nurse that he felt his catheter was leaking, as he was experiencing wetness when he had the urge to urinate. His primary VNA nurse did not work on the weekends. The Nurse Coordinator called the VNA and another nurse was able to see Henry to flush and change the device. The Transition Coach followed up with Henry a few days after the episode, and Henry reported he did not have any new or worsening signs and symptoms of a UTI after his catheter had been changed.

Close coordination of care prevented Henry's re-hospitalization. In the past, Henry had only limited access to community supports. Coaching allowed him to have regular wellness check-ins to target any signs and symptoms of his worsening state before they progressed to a point that he needed to go to the hospital. Henry has become an active participant in his own care. The ASAP care manager and Coach worked together to get an increase in home health aide from four times a week to 8 under the Community Choices program.. Without Coaching assistance, Henry would have waited until his primary nurse was next scheduled to come out to see him, putting him at further risk for developing a UTI. The wellness check-ins allowed for the establishment of a good rapport with his care team. Without the regular check-ins, Henry might not have felt comfortable with letting the Nurse know of his change in status, and might have left out certain details of the catheterization that were critical in leading the Nurse to believe that Henry was experiencing the start of a UTI. The increase in home health aide service will assist Henry in maintaining good personal care to avoid UTI's.

Outcomes: The CCTP Project in Massachusetts

- One CCTP project has enrolled 3,782 hospital patients on Medicare into their Transition Coaching program. For the period December 1, 2012 to July 31, 2014, this Care Transitions project reduced the hospital readmission rate from 25% for this target population to 19.5%---a decrease of 37% in the readmissions rate.
- Another CCTP project using trained transitions coaches supported by tablet-based software enrolled community-based Care Transitions Program patients, and after six months, found that a subset of admissions they were tracking saw hospital readmissions dropped from 24% to 14%--a 39.6% reduction. There was a net savings to Medicare of $567,071 during the six months. (Source: AHRQ)
- As of March, 2015, two of the CCTP projects are in the top 8 performing projects in the country. One project has served over 10,000 patients since mid-2012. This site targeted patients at high risk of readmission and has achieved more than a 50% reduction in the 30-day Readmission Rate among its CCTP Participants.

These Care Transitions outcomes have demonstrated that independent, community-based care coordination entities, the ASAPs, are an evidence-based approach that can result in substantial reductions in the readmissions rates at their hospital partners. Massachusetts has the advance of an existing LTSS care coordination infrastructure capable of achieving impressive outcomes.

As the Massachusetts Health Policy Commission has noted:

"Transitional care focuses on improving care transitions – such as when a patient is discharged from a hospital into a post-acute care setting – through better in-hospital planning and post–discharge follow-up. Such efforts target acute hospital and ED use and health status decline, emphasizing coordination and close clinical management among all involved parties. Care management activities can also play a role in better coordination of care for high-cost patients across multiple conditions. In addition, other geographically targeted programs have focused on high-cost patients dealing with socioeconomic challenges. This strategy, popularly referred to as "hot-spotting," often targets patient populations with interventions that convene providers and community groups to solve problems in a more holistic manner. While some of the factors driving high-costs are clinical,

others are socioeconomic, such as education, and delivery system-related, such as fragmented care or high-priced providers."

As one health plan noted: "Their [health coaches] job is to help patients with health needs that are not medical — diet changes, tracking down the right supportive socks, finding free senior transportation vans that can transport them to office visits or exercise classes." (New York Times 3/22/15)

The Care Transitions benefit also includes access to community living coaches who can focus on non-medical social factors that impact health care, and evidence-based wellness programs, which are now widely lead by ASAPs to increase patient engagement and education on managing chronic diseases. The Healthy Living Center of Excellence, sponsored by an ASAP and medical provider, has created a integrated and coordinated statewide network of providers for evidenced based wellness programs. By working with health care insurers, physician groups and other health care providers they can help to identify high risk members and refer to locally lead programs.

RECOMMENDATION: Medicare and Medicaid should provide funding for community-based, independent care transitions coordinators based on the CCTP project model found in section 3026 of the Affordable Care Act.

3. Expand and fund self-management as a key component in the improvement of health outcomes associated with chronic disease.

The ASAPs and AAAs in Massachusetts are actively involved in disseminating chronic disease self-management programs as part of a statewide Healthy Living Center of Excellence, which was initiated by one of our member agencies, Elder Services of Merrimack Valley, and Hebrew Senior Life. There has been very little focus by health plans, including Medicare and Medicaid, on the role of the individual in proactively managing their health conditions and taking more responsibility for improving their personal behaviors that will result in improved health outcomes and lower costs. Most consumers have received no training in self-care and chronic care management. There are many self-management trainings now out in the community, and they represent the most innovative models of patient- and family-centered care, because they actually engage members in maintaining their own wellness. Greater focus should be paid to the dissemination of models of chronic disease self-management education (CDSME) to more Americans of all ages, in groups, in one-on-one settings, and online programs.

We recommend support for Medicare beneficiaries to have access to evidence based self- management programs for chronic disease, pain management, fall prevention and physical activity. We believe this will result in improved quality of care, improved disease management and lower per capita costs. Mass Home Care supports Medicare funding for the Stanford Chronic Disease Self Management Program (CDSMP) for older adults with chronic disease. Research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and psychological health status, and symptom management as well as reducing per capita costs of health care.

The Center for Medicare and Medicaid Innovation (CMMI) should be directed to develop and test Integrated Self-Care Planning (ISP), to integrate primary care and community service providers to help older adults and their caregivers reach personal goals for aging well.

Mass Home Care also recommends that Medicare billing codes for Chronic Care Management (CCM) services include the provision of chronic disease self management education (CDSME). Community providers should be able to bill for those members who attend a CDSME workshop either in-person or online at the recommendation of their physician.

RECOMMENDATION: We urge the Chronic Care Workgroup to recommend CDSMP and CDSME be provided by community based organizations to all health care providers, organization and

systems as the fundamental self management approach for Medicare beneficiaries with one or more chronic diseases.

Notes:

1. Howard Gleckman, the Urban Institute: http://www.forbes.com/sites/howardgleckman/2015/05/15/senators-would-improve-medicare-for-seniors-with-chronic-disease-but-are-ignoring-half-the-problem/
2. Joanne Lynn, Center for Elder Care and Advanced Illness, Altarum Institute, Washington, District of Columbia. http://gerontologist.oxfordjournals.org/content/55/2/278.full

Thank you for the opportunity to submit this statement,

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