



January 29, 2016

The Honorable Orrin Hatch  
Chairman  
Committee on Finance  
United States Senate

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Johnny Isakson  
Committee on Finance  
United States Senate

The Honorable Mark Warner  
Committee on Finance  
United States Senate

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

The National Council on Aging (NCOA) appreciates this opportunity to provide comments on the Bipartisan Chronic Care Working Group Policy Options Document. We applaud the thoughtful, deliberate, bipartisan process and agree that effectively addressing the problems identified should be a high priority for Congress.

NCOA has noteworthy expertise on chronic care issues and works in close collaboration with various sectors across the health care continuum, including hundreds of non-medical, community-based organizations that provide services to millions of older Americans on a daily basis. NCOA's Center for Healthy Aging provides technical assistance, information, and resources to help organizations build capacity for implementing evidence-based community programs primarily targeting older adults with multiple chronic conditions. We also generate and disseminate new knowledge about best practices to improve outcomes. Our extensive work in this area has led to close collaboration with a number of nationally recognized experts across the country who are members of our Healthy Aging Policy Advisory Group. In addition to our Center for Healthy Aging staff, these nine leaders are available to serve as resources for the Committee.

Our comments are divided into two general areas: three policy recommendations that are not currently included in the options paper (a demonstration program on Integrated Self-Management, improving the annual Medicare Wellness Visit, and improving Medicare prescription drug plan decision-making), and our support for and views on seven proposals that are included.

Although there are a variety of thoughtful options in the paper that have some potential to improve Medicare chronic care, we are disappointed that, in general, the options fail to adequately address three significant concerns and opportunities that merit additional consideration and analysis:

- The fact that healthy behaviors improve health and reduce spending. Unfortunately, this is not a prevailing paradigm in the Medicare program. Medicare has failed to prevent older adults from acquiring new chronic conditions and adequately managing diseases and their complications. There is strong evidence that patients with chronic illnesses have better outcomes and lower costs when behavior changes are implemented, and these changes can be made only when patients have the confidence in their ability (self-efficacy) to effect change;
- The need for patients to be in charge of their health care and given the tools to make informed decisions based on their values and goals. Despite recent platitudes on "patient-centered care", there has been little focus by Medicare and health plans on the central role individuals play in proactively managing their health conditions. Providers and plans should be required to develop and implement evidence-based patient engagement and self-management support interventions, more strongly encouraged to partner with community-based programs, and measured and rewarded based on their success in meeting the needs identified by patients and family caregivers; and

- The ability of community-based aging services organizations, including the public health community, to address critical non-medical needs and social determinants of health that drive Medicare costs and affect health outcomes. There is an unfortunate bias in Medicare that only medical care providers and the medical care industry can improve beneficiaries' health. This strategy has had only modest success in bending the Medicare cost curve. To date, Congress and CMS have not sent needed signals that they expect and will pay for targeted community-based interventions that have been shown to improve health, self-efficacy and patient engagement, while lowering costs and improving quality of care.

We support and are pleased that some of these considerations are recognized under the option on developing quality measures, but believe much more can and must be done.

Our approach is rooted in the Wagner Chronic Care Model (CCM),<sup>1</sup> developed in the mid-1990s and refined in 1997, which is a widely accepted conceptual model for treatment and management of chronic disease and identifies the essential elements of a high quality health care system. These elements include not only the organization and delivery design of the health system itself, but also components that involve the community and self-management support, deemed critical for improving chronic disease management. A key feature of the CCM is its explicit attention to the need to empower and prepare patients to improve health outcomes through the use of community resources and self-management supports, existing outside of the medical setting and offered both in-person and online.

Under the model, effective chronic care systems emphasize the patient's central role in managing their health, including self-management behavior change strategies such as assessment, goal-setting, action planning, problem-solving, and follow-up. Behaviorally sophisticated self-management supports needs to be available and give priority to increasing patients' confidence and skills so that they can be the ultimate manager of their illness. It is important to remember that the vast majority of patients spend 95% of their time outside of any interaction with medical care providers, making self-management critically important. Disease control and outcomes depend to a significant degree on the effectiveness of self-management. This includes the use of proven programs, particularly the Stanford Chronic Disease Self-Management Program (CDSMP), that provide education, emotional support, and behavioral change strategies for better living with chronic illness.

Another key element of the Wagner model is mobilizing community resources to better meet patient needs, specifically: "Community programs can support or expand a health system's care for chronically ill patients, but systems often don't make the most of such resources." Effective chronic care systems need to "form partnerships with community organizations to support and develop interventions that fill gaps in needed services."<sup>2</sup> New reimbursement strategies need to include these transformative interventions – the return on investment is clear and increasingly well documented.

The options paper also does not adequately account for or address a number of the important goals outlined in the December 2010 Department of Health and Human Services report: Multiple Chronic Conditions: A Strategic Framework: Optimum Health and Quality of Life.<sup>3</sup> For example, Goal 2 of the Framework is to "Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions." Specific strategies from the Framework in this area include:

- Strategy 2.A.1. Continually improve and bring to scale evidence-based, self-care management activities and programs, and develop systems to promote models that address common risk factors and challenges that are associated with many chronic conditions.
- Strategy 2.A.2. Enhance sustainability of evidence-based, self-management activities and programs.
- Strategy 2.A.3. Improve the efficiency, quality, and cost-effectiveness of evidence-based, self-care management activities and programs.

<sup>1</sup> Chronic Care Model. [http://improvingchroniccare.org/index.php?p=The\\_Chronic\\_Care\\_Model&s=2](http://improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2)

<sup>2</sup> See [http://www.improvingchroniccare.org/index.php?p=The\\_Community&s=19](http://www.improvingchroniccare.org/index.php?p=The_Community&s=19)

<sup>3</sup> [http://www.hhs.gov/ash/initiatives/mcc/mcc\\_framework.pdf](http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf)

We strongly encourage further consideration of additional options that will incorporate these strategies. In our view, this can best be accomplished by improving access to the in-person and on-line Stanford CDSMP, one of the most well-known and researched evidence-based programs in the world. Providing payment and other incentives under Medicare to make CDSMP and similar research-proven programs available to targeted beneficiaries who need them is the best starting point for moving forward in achieving the Framework goal and strategies above. Evidence-based self-management programs should be foundational pillars for improving chronic disease management. Over time, a certifying body (e.g., NCQA) should be positioned to determine whether specific new programs or approaches have enough science and experience with translation/replication, so that they are ready for certification and national distribution.

A number of research studies have demonstrated positive changes from CDSMP in self-efficacy, health behaviors, physical and psychological health status, symptom management, and health care utilization. For example, a 2013 national study supported by the Administration on Aging of 1,170 CDSMP enrollees found annual \$364 per capita savings in reduced emergency room visits and hospital utilization, with potential savings of \$6.6 billion if 10% of those with one or more chronic conditions participated in the program.<sup>4</sup> For a summary of national and state translational research studies that demonstrate how CDSMP has helped to achieve better health, better care, and lower costs, go to <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/Health-Outcomes-Evaluation-FINAL-DRAFT-022515.pdf>. Several studies have found long-term benefits beyond 12 months.<sup>5</sup> Strong results have also been reported for the Stanford Diabetes Self-Management Program (DSMP).<sup>6</sup>

In addition to community-based programs, there is an effective and research-proven on-line version of CDSMP which would allow use of technology to spread self-management interventions so that they are more widely and uniformly accessible to all who need them, especially those who might not be able to access a community-based program or who might not feel comfortable in a group setting.<sup>7</sup>

Currently, the Prevention and Public Health Fund has provided only \$8 million in discretionary funds per year for these programs, now available on a limited basis in only 8 states. For these programs to be sustainable and available to the millions of beneficiaries who need them, and for significant savings to be realized, Medicare and Medicaid will need to play a greater role. Chronic conditions are disabling, deadly, and epidemic in scale. They are the major driver of costs throughout the health care system. Investment in self-management interventions is critical to reducing the impact of chronic diseases, improving the nation's health, and lowering costs.

Damaging chronic conditions are nearly epidemic in scale and driving major costs throughout the health system. Investments in these self-management interventions are key to reducing Medicare costs and improving national health.

Despite the long history and strong evidence behind CDSMP, there is only limited but growing penetration among Medicare Advantage (MA) plans. Currently, CDSMP is available through community partners in Kaiser Permanente, Group Health Cooperative, and dual eligible plans including Commonwealth Care Alliance, Senior Whole Health and the Tufts Health Plan. Some of the current barriers to growth include:

- There are no billing codes available to receive reimbursement for these programs.

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<sup>4</sup> <http://www.ncoa.org/assets/files/pdf/center-for-healthy-aging/National-Study-Brief-FINAL.pdf>

<sup>5</sup> See Lorig, et al, Online Diabetes Self-Management Program: A Randomized Study, *Diabetes Care*, Volume 33, Number 6 (2010); Lorig, et al, Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes, *Medical Care*, Volume 39, Number 11 (2001, pp. 1217–1223); and

Lorig, et al, Evidence Suggesting That Health Education for Self-Management in Patients with Chronic Arthritis has Sustaining Health Benefits While Reducing Health Care Costs, *Arthritis and Rheumatism*, Vol. 36, No. 4 (April 1993).

Copies available upon request

<sup>6</sup> Lorig K, Ritter PL, Villa FJ, Armas J, Community-based peer-led diabetes self-management: a randomized trial. *Diabetes Educator*, 35(4):641-651, 2009.

<sup>7</sup> For example, see Online Diabetes Self-Management: A Randomized Study at <http://www.ncbi.nlm.nih.gov/pubmed/20299481>

- There are insufficient incentives to offer evidence-based self-management education, health promotion, and behavior change programs that extend beyond clinic walls. Similarly, there are limited incentives for insurers to increase their enrollees' activation or provide formal education for their members that have chronic disease.
- MA plans want to offer similar benefits across their entire population and across state lines, but capacity does not yet exist in all communities and the absence of resources limits the availability of the on-line version. Although CDSMP has been scaling up, it has only reached critical mass in a small but increasing number of states.
- Most MA plans are still not prepared to embrace the value of community based services, in part because their administrative and medical leadership are not familiar with the programs that are available or the outcomes they can achieve. These leaders often do not react positively to evidence-based programs outside the medical care system until it is a regulatory imperative.
- MA plans are still in an early stage of assuming responsibility for behavior change and population health management.
- Plans often focus more on short-term, as opposed to longer term, cost savings. As is the case for a number of new initiatives with start-up and training expenses, costs may temporarily increase by a modest amount, but over the longer term, savings from community partnerships will be realized through reduced ER use, hospitalizations and readmissions.

Another area not addressed in the options paper that has significant potential to improve outcomes and reduce Medicare spending is improving access to evidence-based falls prevention programs. Falls are frequent, expensive, and largely avoidable. One in three Americans aged 65 and over falls each year.<sup>8</sup> In 2013, 2.5 million nonfatal fall injuries among older adults were treated in emergency rooms with more than 734,000 of these hospitalized.<sup>9</sup> In 2013, \$34 billion in direct medical costs was spent treating older adults for the effects of falls, with 78% of these costs reimbursed by Medicare.<sup>10</sup> Medicare costs per fall averaged \$14,306 and \$21,270.<sup>11</sup> If we cannot stem the rate of increase in falls, it is projected that the cost in 2020 will be \$67.7 billion, including Medicare costs estimated at about \$48 billion.<sup>12</sup>

A number of evidence-based programs are now available which have been shown to reduce falls and save money. When compared with controls, the Tai Ji Quan: Moving for Better Balance intervention reduced falls by 55%;<sup>13</sup> the Stepping On program reduced falls by 30%;<sup>14</sup> and the Otago Exercise Program reduced falls by 35% when delivered to adults 80 years of age and older.<sup>15</sup> A *Journal of Safety Research* special report from the CDC titled: "A cost-benefit analysis of three older adult fall prevention interventions"<sup>16</sup> found that:

- Tai Ji Quan: Moving for Better Balance had an average cost per participant of \$104.02, an average expected benefit of \$633.90, and an ROI of 509% for each dollar invested.

<sup>8</sup> Tromp AM, Pluijm SMF, Smit JH, et al. Fall-risk screening test: a prospective study on predictors for falls in community-dwelling elderly. *J Clin Epidemiol* 2001;54(8):837–844.

<sup>9</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online].

<sup>10</sup> Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. *Injury Prevention* 2006a;12:290–5

<sup>11</sup> Shumway-Cook A, Ciol MA, Hoffman J, Dudgeon BJ, Yorston K, Chan L. Falls in the Medicare population: incidence, associated factors, and impact on health care. *Physical Therapy* 2009;89(4):1-9.

<sup>12</sup> Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. *Journal of Forensic Science* 1996;41(5):733–46.

<sup>13</sup> Li F, Harmer P, Fisher KJ, McAuley E, Chaumeton N, Eckstrom E, Wilson NL. Tai Chi and fall reductions in older adults: A randomized controlled trial. *Journal of Gerontology*. 2005 Feb;60A(2):187–94.

<sup>14</sup> Clemson L, Cumming RG, Kendig H, Swann M, Heard R, Taylor K. The effectiveness of a community-based program for reducing the incidence of falls in the elderly: A randomized trial. *Journal of the American Geriatrics Society*. 2004 Sep;52(9):1487–94.

<sup>15</sup> Campbell AJ, Robertson MC, Gardner MM, Norton RN, Buchner DM. Falls prevention over 2 years: A randomized controlled trial in women 80 years and older. *Age and Ageing*. 1999 Oct;28(6):513–8.

<sup>16</sup> Carande-Kulis , VG, Stevens, JA, Beattie, BL & Arias, LA. Cost-benefit analysis of three older adult fall prevention interventions; *Journal of Safety Research*, 2015.

- The Otago Exercise Program had an average cost per participant of \$339.15, an average expected benefit of \$768.33 for participants over age 80, and a return-on-investment (ROI) of 127% for each dollar invested for this group.
- Stepping On had an average cost per participant of \$211.38, an average expected benefit of \$345.75, and an ROI of 64% for each dollar invested.

In addition, the November 2013 Centers for Medicare and Medicaid Services (CMS) Evaluation of Community-based Wellness and Prevention Programs analysis found that participation in the A Matter of Balance (MOB) falls prevention program was associated with a \$938 decrease in total medical costs per year. This finding was driven by a \$517 per participant reduction in unplanned hospitalization costs, a \$234 reduction in skilled nursing facility costs, and an \$81 reduction in home health costs.<sup>17</sup>

While the concerns above merit additional discussion and exploration among leading experts in these areas, below are NCOA's specific comments and recommendations on the options paper.

### **1. Conducting a Demonstration Project on Integrated Self-Care Management (ISM)**

Effective management of chronic conditions requires more than medical care – it takes people and caregivers who consistently perform small actions, such as adherence to taking prescribed medications on time, checking blood pressure or glucose, dealing with depression or pain, communicating effectively with health professionals, eating well, and being physically active. Programs that enhance adoption of better self-management are crucial to managing risks from these conditions. Older adults with multiple chronic conditions need these types of services from the aging network. However, self-management education and supports in health systems and the community are highly fragmented, and neither sector has a practical process for integrating services at the patient/consumer level.

To fill this gap, a demonstration program should be developed and implemented to test Integrated Self-Care Management (ISM), in which primary care and community service providers collaborate and integrate support to help older adults and their caregivers reach personal goals for aging well. Ideally, demonstrations would be conducted under both fee-for-service and capitated models. This new process would bring together older adults, caregivers, primary care providers, aging network providers, and public health organizations to develop and implement a shared pathway for managing each person's chronic conditions through CDSMP and other evidence-based programs (EBPs) in the community. The approach would span medical, community-based, and individual efforts to keep chronic conditions in check, reduce costs, and improve health and quality of life. Practical protocols for team-based care planning would be developed that center on older adults' goals and results within individualized service integration.

The ISM initiative would have two overarching goals:

- Improve health and quality of life outcomes for older people who have multiple chronic conditions (i.e., the target population); and
- Reduce preventable hospitalizations, readmissions and emergency room visits in order to lower per capita health care expenses for the target population.

Using the ISM process, a primary care provider and trained community coordinator from an aging network provider would help older adults and caregivers set and track personal goals and outcomes. Support and coaching would be provided to help overcome barriers to achieving the goals. This care team would draw on health system and community resources to guide the coordinated delivery of self-care education, programs and services from both sources. The ISM model would directly respond to the call from health systems, payers, and consumer advocates for integrating clinical and community-based support for self-care.

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<sup>17</sup> Report to Congress in November 2013: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act.

It is essential to apply clear criteria to determine which patients will likely benefit from new services/ interventions. Patient identification and monitoring are also critical to assure the criteria are being applied. The Secretary should be given discretion to determine the target population for receiving evidence-based services under the demonstration. Eligibility factors to consider include targeting patients with low activation or health confidence and the Hierarchical Condition Categories (HCC) model, currently used to adjust capitation payments to private health care plans for the health expenditure risk of their enrollees, and. While we recognize there are concerns regarding their accuracy in helping to adjust payment rates, they could still be useful in efforts to target services to populations in greatest need.

## **2. Strengthening the Annual Medicare Wellness Visit to Better Promote Healthy Aging**

NCOA recommends that this provision be strengthened to better address the needs of older adults with multiple chronic conditions, specifically:

- Improve requirements for screenings and referrals to CDSME and falls prevention interventions, including specific protocols, recommended best processes and practices, and use of the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) tool<sup>18</sup> developed by the CDC for falls prevention;
- Develop standards for post-visit follow-up to better ensure compliance with the personalized prevention plan and referrals; and
- Broaden the permissible circumstances under which visits can be conducted in a beneficiary's home.

Evidence-based programs (EBPs) should be more fully integrated into the personal action plans developed as a result of the wellness visits. Plans should focus more on self-management needs and improving patient activation and confidence. Follow up and referrals to evidence-based prevention and wellness programs offered by community-based organizations will maximize the opportunity presented during the visit to engage older adults in carefully planned next steps to improve their health. Plans should include not only a risk assessment in the required areas, but also follow-up action plans for issues such as falls, cognitive screening, depression screening, and overall physical activity.

Use of the STEADI algorithm and related tools can greatly enhance the opportunity to connect patients with community providers of EBPs. According to the CDC, for every 5,000 health care providers who adopt STEADI, over a 5-year period, savings of \$3.5 billion in direct medical costs could be achieved.<sup>19</sup>

## **3. Improving Medicare Prescription Drug Plan Decision-Making**

The success of the Medicare program depends on the ability of millions of consumers to make good decisions about complex insurance and plan options when they first enroll in Medicare and annually thereafter. Millions of beneficiaries struggle to make these decisions about Medicare Part D prescription drug coverage. Despite regular plan changes and growing out-of-pocket costs, inertia is commonplace. Focus groups conducted in 2014 by the Kaiser Family Foundation concluded: "Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive...and their inability to organize the information to determine which plan is best for them."<sup>20</sup>

There is clear and compelling evidence that most enrollees fail to review their Part D plan when they should or make ill-informed decisions that lead to higher Part D program and out-of-pocket health care costs. For example, while beneficiaries on average could save 30.9 percent of their spending by choosing the lowest cost

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<sup>18</sup> See <http://www.cdc.gov/steady/>

<sup>19</sup> See [http://www.cdc.gov/steady/pdf/make\\_fall\\_prevention\\_part\\_of\\_your\\_practice-a.pdf](http://www.cdc.gov/steady/pdf/make_fall_prevention_part_of_your_practice-a.pdf)

<sup>20</sup> <http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/>

plan available, only 12.2 percent do so.<sup>21</sup> Pilot programs that support beneficiary choice by sending simplified and personalized information on plan costs have been found to generate savings for beneficiaries.<sup>22</sup>

Choosing the right Part D plan is a difficult process. Not only must enrollees consider an average of about 30 plans, but they must compare plans along multiple, complex dimensions. These include premiums, cost-sharing, whether their drug is on the formulary, pharmacy networks, and the application of utilization management tools such as prior authorization. The complexities and consequences are particularly challenging for beneficiaries with multiple chronic conditions who, as one would expect, take more prescription drugs than those without. In the treatment of patients with multiple medical problems, adherence to disease-specific guidelines often requires the use of 10 or more medications.<sup>23</sup> According to William Lang, vice president of policy and advocacy for the American Association of Colleges of Pharmacy “There’s an increasing number of people with chronic illnesses, and the primary management tool available for dealing with chronic illness is medication”<sup>24</sup>.

NCOA is working to address these concerns through a diverse, multi-sector Advisory Group that is collaborating to improve public policies, build public-private partnerships, and foster and develop marketplace innovations. We are combining the knowledge of key experts and interest groups, as well as the on-the-ground experience of those who work with beneficiaries on a daily basis. The Advisory Group is identifying barriers to consumer engagement and marketplace innovations, analyzing potential policy options and innovative solutions (legislative, regulatory, administrative, and private sector), and working collaboratively to bring the best consensus and bipartisan solutions to scale nationwide.

We would welcome the opportunity to engage with the Committee on these issues to identify policies that would advance needed improvements in beneficiary choice and decision-making. Areas of particular interest include: (1) improving beneficiary notices and mailings, especially the Annual Notice of Change (ANOC); (2) addressing concerns with the Medicare Plan Finder; (3) making cost sharing tiers simpler and less burdensome for beneficiaries; (4) addressing Part D problems for low-income subsidy eligible beneficiaries paying expensive premiums unnecessarily; (5) improving Prescription Drug Plan (PDP) Star Ratings; and (6) providing resources for pilot programs and consumer testing to support this work.

#### 4. **Developing Quality Measures for Chronic Conditions**

NCOA strongly supports this option on pages 22-23 of the paper. We would welcome the opportunity to continue to engage with the Working Group to provide additional details regarding the first three bullets (which we believe should be the highest priority on the list), specifically:

- Patient and family engagement, including person-centered communications, care planning and patient-reported measures;
- Shared decision-making involving patient goal-directed care; and
- Care coordination, including care transitions, and shared accountability within a care team.

NCOA’s Center for Healthy Aging has analyzed many of the metrics developed for the management of chronic conditions and has concluded that the most thoughtful, reliable measures were developed by NCQA for Patient Centered Medical Homes (PCMH). Specifically, PCMH Standards 4 and 5 should be more uniformly applied to other entities serving similar chronically ill populations, such as Accountable Care Organizations (ACOs), Chronic Condition Special Need Plans (C-SNPs), and Medicare Advantage plans. It makes no sense to apply

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<sup>21</sup> [Abaluck, Jason, and Jonathan Gruber](#). 2011. “Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program.” *American Economic Review*, 101(4): 1180-1210.

<sup>22</sup> [Kling, Jeffrey R., Sendhil Mullainathan, Eldar Shafir, Lee Vermeulen, and Marian V Wrobel](#). 2012. “Comparison Friction: Experimental Evidence from Medicare Drug Plans.” *Quarterly Journal of Economics*, 127 (1): 199-235.

<sup>23</sup> Mary E. Tinetti, M.D., Sidney T. Bogardus, Jr., M.D., and Joseph V. Agostini, M.D. Potential Pitfalls of Disease-Specific Guidelines for Patients with Multiple Conditions. *N Engl J Med* 2004; 351:2870-2874.

<sup>24</sup> See <http://www.webmd.com/news/20140514/prescription-drug-use-continues-to-climb-in-us>

key chronic care quality measures to some entities but not others. Alignment across these entities will provide improved data on comparative performance, inform policy reforms, and result in better outcomes for patients.

The followings PCMH measurers capture critical elements of care that support coordination and self-management for beneficiaries coping with chronic illness:

Standard 4: Plan and Manage Care

- A. Identify Patients for Care Management
- B. Care Planning and Self-Care Support
- C. Medication Management
- D. Use Electronic Prescribing
- E. Support Self-Care and Shared Decision-Making

Standard 5: Track and Coordinate Care

- A. Test Tracking and Follow-Up
- B. Referral Tracking and Follow-Up
- C. Coordinate Care Transitions

The intent of PCMH 4 is that plans systematically identify individual patients and manage and coordinate care based on need. This includes tracking and following up on all lab and imaging results and important referrals, and coordinating the care patients receive from specialty care, hospitals, other facilities and community based organizations.

In our view, for beneficiaries with multiple chronic conditions, most important among the standards above are 4B and 4E:

PCMH 4B: Care Planning and Self-Care Support

Care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in 4A.

- 1. Incorporates patient preferences and functional/ lifestyle goals.
- 2. Identifies treatment goals.
- 3. Assesses and addresses potential barriers to meeting goals.
- 4. Includes a self-management plan.
- 5. Is provided in writing to patient/family/caregiver.

PCMH 4E: Support Self-Care and Shared Decision-Making

The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:

- 1. Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients.
- 2. Provides educational materials and resources to patients.
- 3. Provides self-management tools to record self-care results.
- 4. Adopts shared decision-making aids.
- 5. Offers or refers patients to structured health education programs, such as group classes and support.
- 6. Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates.
- 7. Assesses usefulness of identified community resources.

Standards should also specify the types of programs, education, resources and tools that need to be utilized, including that they must have an evidence base. We support the development of new measures that would focus

on the percentage of patients who engage in evidence-based self-management programs, and measures that would improve health confidence, such as the Wasson Health Confidence Measure.<sup>25</sup>

## **5. Improving Care Management Services for Individuals with Multiple Chronic Conditions**

NCOA supports this option on pages 11-12 to establish a new high-severity Medicare chronic care management (CCM) code. By itself, the current management code is insufficient to address the breadth of complexity that exists among elders with multiple chronic conditions and functional limitations, and the varying degrees of treatment and monitoring that they require. Skilled clinicians should be providing more intensive management for a higher proportion of the most complex beneficiaries. For example, patients with complex chronic care needs should have a more comprehensive needs assessment, a sophisticated care plan linked to the accompanying electronic health record infrastructure that is shared across multiple providers, as well as stronger incentives for facilitated access to needed community services.

Differences in patient complexity may discourage providers from utilizing the code and from providing chronic care management services. Instead, many may just avoid taking on these patients or be unable to provide optimal care at inadequate fees. Therefore, creating at least an additional code for high levels of complexity would be beneficial to providers and would encourage them to engage in chronic care management for the range of patients in their care.

Unfortunately, few providers are using the current CCM benefit. CMS has reported that about 35 million Medicare beneficiaries are eligible to receive these billable care-management services, but the agency has received reimbursement requests for only about 100,000. This is largely because of the qualifying criteria, the fact many physicians believe the \$42 per member per month is insufficient, and the 20 percent Part B monthly copay requirement. In addition, 20 minutes per month is not the way chronic care is provided – because of the up-and-down nature of disease management.

NCOA strongly supports waiving beneficiary copayment for these services. The copayment is a burden for both patients and providers and eliminating it will increase uptake in the current use of the code and make the use of a new code for more complex patients better received. If we believe this is a beneficial population-health tool, then we should provide an incentive to use it, as we do for preventive services.

With regard to patient criteria for the new code, consideration should be given to the aforementioned HCC scores, which can help stratify more complex needs that drive the highest costs and help protect against avoidable declines.

With regard to the types of providers who should be eligible to bill the code, this should reflect the importance and power of team-based care. A Care Manager (RN) or social worker is likely the most appropriate team member to be working with complex, high risk patients.

With regard to the question on the new code asked in the last bullet on page 12, we favor their option 3 - giving HHS authority to “continue, discontinue or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors.”

## **6. Maintaining ACO Flexibility to Provide Supplemental Services**

NCOA believes the option outlined on page 18 provides an important opportunity to address access to evidence-based prevention and wellness programs through the connection to primary care screening and referral. ACOs should have a population-based strategy for patient engagement which is evidence-based that improves health confidence and self-management capacity. We suggest clarifying that ACOs participating in the MSSP be able

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<sup>25</sup> See [https://www.hcfama.org/sites/default/files/health\\_confidence\\_policy\\_brief\\_final.pdf](https://www.hcfama.org/sites/default/files/health_confidence_policy_brief_final.pdf)

to furnish not only transportation and social services, but long-term services and supports (LTSS) and evidence-based prevention and wellness programs, including programs for chronic disease self-management, falls prevention, diabetes management, pain management, and caregiver support. Comparable flexibilities should be afforded to C-SNPs.

Providing this clarification is particularly important because of the strong relationship between chronic conditions and functional impairments, which drive the need for LTSS. It is well documented that older adults with chronic conditions and limitations in Activities of Daily Living (ADLs) have significantly higher Medicare spending than those with chronic conditions only. In 2006, Medicare spent about \$17,500 for beneficiaries with both chronic conditions and functional impairment and approximately \$5,960 on those with chronic conditions and no functional impairment.<sup>26</sup> The lack of coordination between acute care and LTSS contributes to the unnecessary utilization of health services and higher spending on this population. Partnering with community-based organizations can contain costs not only by reducing readmissions and related ER visits, but by enhancing independence at home and delaying or avoiding expensive nursing home care.

### **7. Providing Flexibility for Beneficiaries to be Part of an ACO**

If an ACO elects prospective assignment and provides services to beneficiaries who voluntarily elect to enroll, the options paper proposes that ACOs should receive an "upfront, collective payment for all services provided to these beneficiaries" (pgs. 21-22).

NCOA supports this proposal, as it would enable ACOs to use the collective payment for a wider array of services beyond those covered under FFS, including those CMS has chosen not to waive for Track 1 ACOs. These might include expanded LTSS and evidence-based prevention and wellness programs (see #6 above), as well as telehealth, remote monitoring and home visits. The collective payment offers providers the opportunity to lower delivery costs that provides a greater opportunity for savings and provider participation/program sustainability.

### **8. Expanding the Independence at Home (IAH) Model of Care**

NCOA supports the option on pages 6-7 to expand the IAH demonstration. We are pleased that the demonstration's initial results have been quite positive. It is an excellent model for complex, frail patients who have difficulty leaving their homes even with transportation support. We have two suggestions for modifying the program: (1) improve incentives for integration with community-based agencies to improve patient health and well-being beyond the current medical model; and (2) review the current targeting strategy to ensure scalability before taking this nation-wide.

Finally, NCOA also generally supports the options on pages 28 and 29 of the paper to increase transparency at CMMI and conduct a study on medication synchronization.

Thank you again for this opportunity to share our views. If you have any questions or if we can be of any further assistance, please contact me at [howard.bedlin@ncoa.org](mailto:howard.bedlin@ncoa.org).

Sincerely,

Howard Bedlin  
Vice President for Public Policy and Advocacy

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<sup>26</sup> Avalere Health, LLC. Analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file. Excludes beneficiaries who died during 2006.