National Council on Aging

June 22, 2015

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
Senator
Committee on Finance
United States Senate

The Honorable Mark Warner
Senator
Committee on Finance
United States Senate

Re: Senate Finance Committee Working Group on Chronic Care Request for information

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

Thank you for this opportunity to share our views on this critical, timely issue for the Medicare and Medicaid programs and the people that rely on them. Individuals with multiple chronic conditions have not been well-served under these programs and we believe that significant improvements should be made which can achieve strong bipartisan support.

The National Council on Aging (NCOA) is a respected national leader and trusted partner to help people aged 60+ meet the challenges of aging. Formed in 1950 as the first national organization to represent older Americans and those who serve them, our mission is to improve the lives of millions of older adults, especially those who are struggling. Through innovative community programs and services, online help, and advocacy, NCOA partners with nonprofit organizations, government, and business to improve the health and economic security of 10 million older adults by 2020.

NCOA has noteworthy expertise on chronic care issues and works in close collaboration with hundreds of community-based organizations that provide services to millions of older Americans on a daily basis. NCOA's **Center for Healthy Aging** supports the expansion and sustainability of evidence-based chronic care, health promotion and disease prevention programs in the community and online. We provide technical assistance, information, and resources to help organizations build capacity for implementing these programs. 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 national experts who could serve as excellent resources and hearing witnesses for the Committee.

Chronic diseases are the leading causes of death and disability in the U.S. and account for 75% of the nation's health care spending. Older adults are disproportionately affected; 80% have at least one chronic health condition, and more than half have multiple chronic conditions, which are especially difficult and costly to manage. With an aging population and unprecedented obesity rates (a risk factor for many chronic conditions), the burden of chronic disease is rapidly increasing and causing extraordinary challenges for the U.S. health care system.

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At the outset, as the Committee considers improving care for those with chronic conditions, it is critically important to understand and address the strong relationship between these conditions and **functional impairments, which drive the need for long-term services and supports** (LTSS) due to limitations in activities of daily living (ADLs). It is well documented that older adults with chronic conditions and functional impairment 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.[1] "Seniors with chronic conditions and functional impairment require acute care and LTSS from systems that are fragmented. The lack of coordination between acute care and LTSS may contribute to the unnecessary utilization of health services and higher spending on this population."[2]

If chronic care reform is to be effective, it must (1) understand that absent supports and services addressing functional impairments, improved health care coordination alone may not significantly improve quality or reduce spending; (2) emphasize models that strengthen community linkages and integrate chronic care with community-based LTSS; and (3) consider the social determinants of health.[3]

In general, **transparency** and reporting are critically important to any new policies intended to alter the delivery of care for those with multiple chronic conditions. We strongly encourage the Committee to create mechanisms to make publicly available data and information about any new or expanded programs to improve care for individuals with chronic health needs. As appropriate, we urge the Committee to request regular reports, analyses, and independent evaluations to continuously assess any new or expanded care models.

Another important threshold concern is **consumer engagement**, which must encompass mutually beneficial partnerships at every level of care. Carefully constructed education initiatives are essential to the design of any new or expanded care model. Individuals should be engaged at the community level in care design and redesign, as well as in policy and governance. Support for shared decision-making tools and processes should be emphasized through robust program requirements and quality measures. We encourage adoption of shared care plans, which are jointly maintained and updated by individuals with chronic conditions, family caregivers, and members of their care team.

In the management of complex conditions, self-direction, person-centeredness, and patient empowerment are key tools to sustaining and improving health. Individuals and families know best what will work for their lives. When they are in the driver's seat, they can work with their health care providers to develop a plan that has a much greater chance of success than a plan that fails to incorporate their perspectives and values. From a policy standpoint, this means that chronic care models should include patient involvement at the individual treatment and health plan level. We urge the Committee to adopt this framework as it develops new or expands existing care models for individuals with chronic care needs.

Policymakers need to recognize that even the sickest patients in the community interact with the health system and professionals for only a very small portion of their lives. Over 95% of the time they are left to manage chronic conditions largely on their own. **Self-management and behavior change** are key factors to reducing costs and improving outcomes from those with chronic care needs. Older adults with

[1] Avalere Health, LLC. Analysis of the 2006 Medicare Current Beneficiary Survey, Cost and Use file. Excludes beneficiaries who died during 2006.
[2] See http://www.thescanfoundation.org/sites/default/files/1pg_databrief_no22.pdf
[3] See http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health

chronic conditions face a number of barriers in terms of coping with their illness and optimizing their health, which include lack of social support, low skill levels for symptom management, and low confidence in their abilities to manage their conditions (self-efficacy). Self-management is heralded as a key component in the improvement of health outcomes associated with chronic disease. According to the Institute of Medicine, self-management is defined as "the tasks that individuals must undertake to live well with one or more chronic conditions." Through low-cost, easy-to-implement self-management education workshops, individuals with chronic health conditions can gain the knowledge, skills, and the support of others to make positive lifestyle changes that lead to improved quality of life.

The Importance of Chronic Disease Self-Management Education

Health care policymakers and practitioners have expressed continuing concern about inadequate chronic care management and treatment with the consensus that changes in primary, secondary, and tertiary care are needed to better serve this population and that health care providers should place a priority on slowing the progression of chronic disease.[4] Many strategies to improve care have been advanced, including better coordination of care and care transition among multiple care sites and providers, as well as innovative models of patient and family-centered care. Among the strategies advanced is greater attention to the dissemination of models of chronic disease self-management education (CDSME) to more Americans through both in-person and online programs.

Despite evidence that motivated and informed patients are more likely to have better health care outcomes,[5] the health care delivery system is oriented toward acute care rather than helping people to better manage the effects of chronic disease. Clinicians tend to see patients for very short periods of time, limiting their ability to discuss how lifestyles may affect their health or ways to self-manage chronic conditions. According to the Centers for Disease Control and Prevention (CDC), many people suffer from health risk behaviors that they themselves can change, such as improved physical activity and nutrition, decreased use of tobacco and alcohol, and control of high blood pressure and cholesterol.[6] Many experts believe that all of these issues could be addressed by helping individuals manage their symptoms. Self-management education has been identified by health care experts to be one of six models that successfully improve the lives of chronically ill persons and that integrate medical and community-based care.[7] Some payers and insurance plans have incorporated self-management education into patient care protocols, but adoption is not widespread.

The Chronic Care Model (CCM), developed in the mid-1990s and refined in 1997, is a widely accepted conceptual model for treatment and management of chronic disease that 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.[8] 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 support, existing outside of the clinical setting both in-person and online. See Figure 1.

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[4] Gerard Anderson, "Chronic Conditions: Making the Case of Ongoing Care."

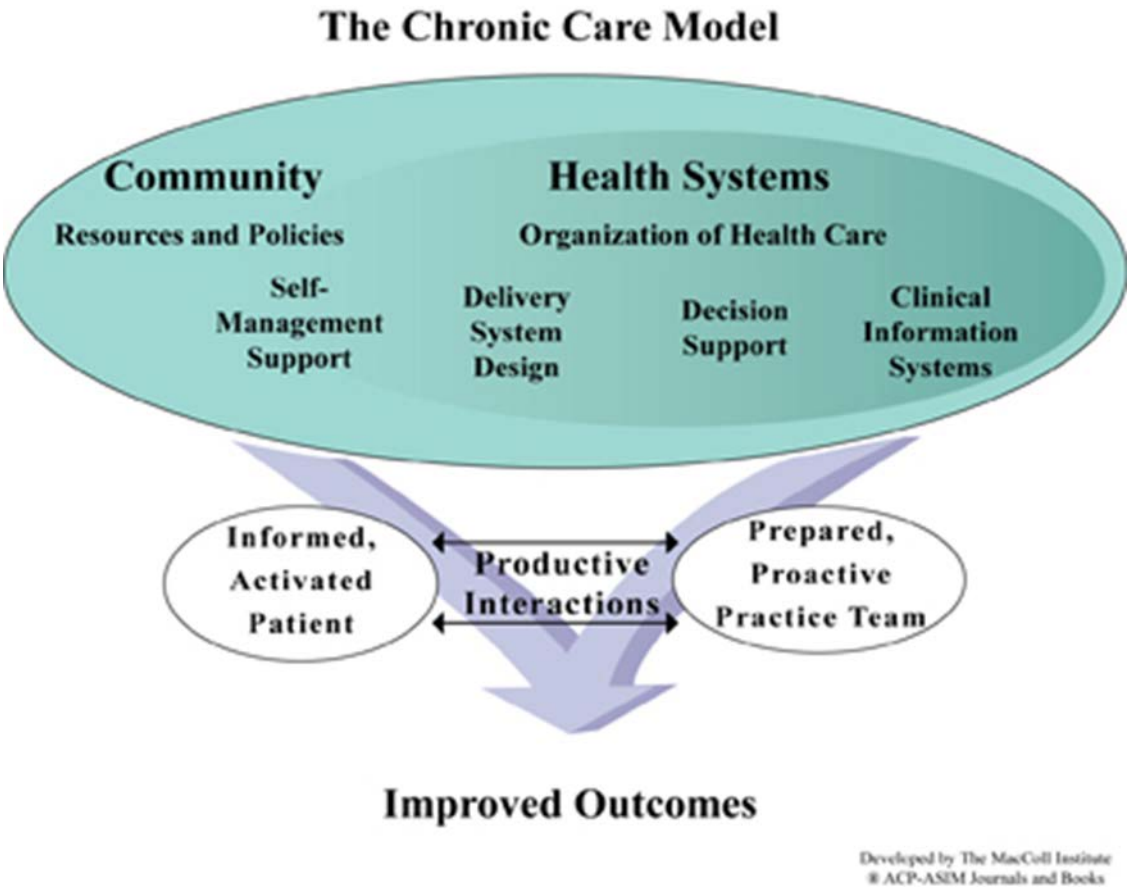
[5] David M. Mosen *et al.*, "Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions?" *Journal of Ambulatory Care Management*, 30, no. 1 (2007): pp. 21–29; and Thomas Bodenheimer, Kate MacGregor, and Claire Sharifi, "Helping Patients Manage Their Chronic Conditions," prepared for the California HealthCare Foundation, June 2005, available at www.chcf.org/documents/chronicdisease/HelpingPatientsManageTheirChronicConditions.pdf

[6] CDC, "Chronic Disease and Health Promotion." http://www.cdc.gov/chronicdisease/overview/index.htm#sec3

[7] Chad Boult and Erin K. Murphy," New Models of Comprehensive Health, Care for People with Chronic Conditions," in Institute of Medicine. *Living Well with Chronic Illness: A Call for Public Health Action*, January 31, 2012. The other models were: transitional care, caregiver education and support, interdisciplinary primary care. Care management, and geriatric evaluation and management. http://www.iom.edu/Reports/2012/Living-Well-with-Chronic-Illness.aspx

[8] Chronic Care Model. http://improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Figure 1



Effective chronic care systems emphasize the patient's central role in managing their health, as well as using effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving, and follow-up. “All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness.”[9]

Another key element of the model is mobilizing community resources to better meet patient needs. “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.”[10]

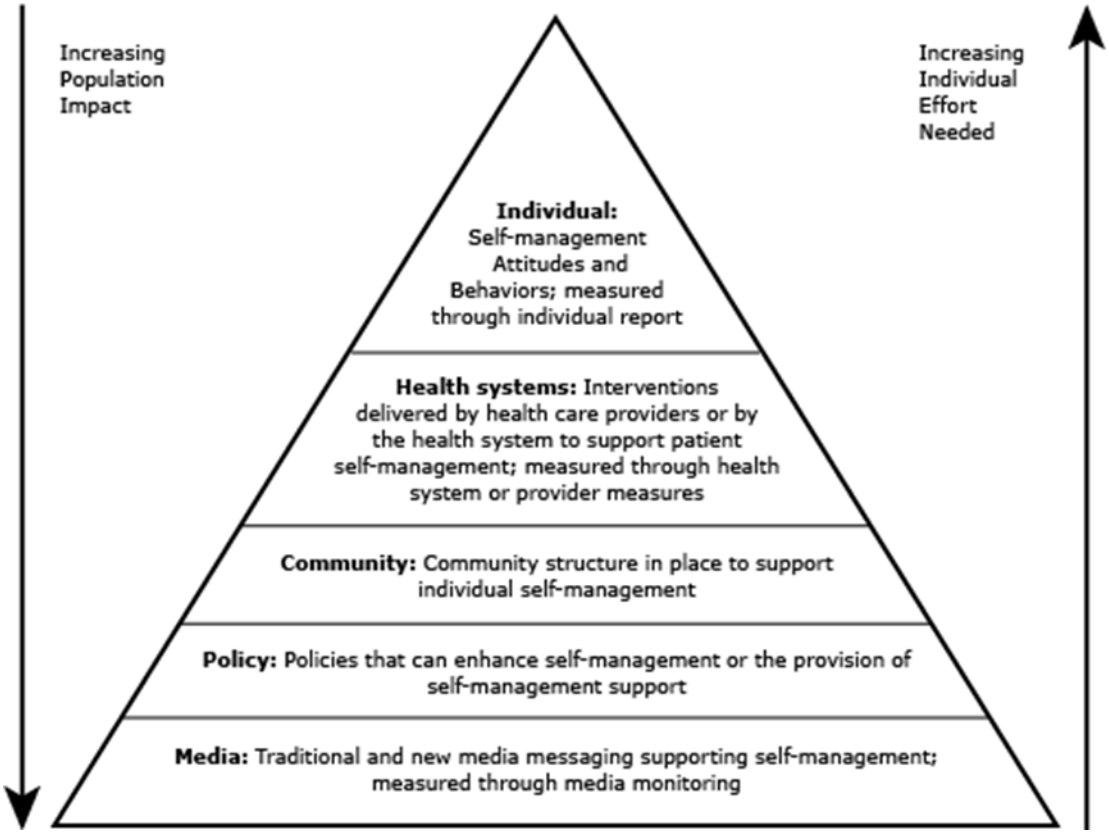
In addition to CDSME and falls prevention, other important evidence-based community programs include those for physical activity (EnhanceFitness, Healthy Moves for Aging Well, and Fit and Strong!), depression (PEARLS and Healthy IDEAS) and medication management (HomeMeds) programs.

[9] See http://www.improvingchroniccare.org/index.php?p=Self-Management_Support&s=22

[10] See http://www.improvingchroniccare.org/index.php?p=The_Community&s=19

Another helpful framework is an adapted version of Frieden's pyramid of public health impact[11], tailored to reflect self-management support[12]. This pyramid highlights the various domains that are collectively needed for self-management to have an impact at a population health level. These domains include media, policy, community, health systems, and the individual. These domains are organized on the pyramid by the contrast of population health impact with the level of individual effort needed. See Figure 2.

Figure 2



The Stanford Chronic Disease Self-Management Program (CDSMP), one of the most well-known and researched evidence-based programs, is a good model for people with multiple chronic conditions (MCCs), as research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and psychological health status, symptom management, and health care utilization.

Major published studies have found that CDSMP results in significant, measurable improvements in the health of people with chronic conditions, as well as cost savings:

- 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.[13]

[11] Frieden TR. A framework for public health action: the health impact pyramid. Am J Public Health 2010;100(4):590–5.
[12] Ruiz S, Brady TJ, Glasgow RE, Birkel R, Spafford M. Chronic Condition Self-Management Surveillance: What Is and What Should Be Measured? Prev Chronic Dis 2014;11:130328.
[13] http://www.ncoa.org/assets/files/pdf/center-for-healthy-aging/National-Study-Brief-FINAL.pdf

- A study published in *Medical Care* found a 2.5 visit reduction in ER and outpatient visits per participant over two years, and a 0.49 day reduction in hospitalizations in the first six months.
- Another study published in *Effective Clinical Practice* of CDSMP participants found that, over a one-year period, participants had a mean 0.97 day reduction in hospitalization and averaged 0.2 fewer ER visits. This suggests first year savings of about $1,000 per participant in the first year.

For Fiscal Year 2015, the Prevention and Public Health Fund provides $8 million for 22 states to offer CDSME on a limited basis. Profiles of these 22 state programs, including Utah, Oregon, Georgia and Virginia, can be found at http://www.aoa.acl.gov/AoA_Programs/HPW/ARRA/PPHF. Unfortunately, the number of states offering programs with this funding is scheduled to be reduced by one-half. The fact is, for these programs to be sustainable and available to those who need them, and for significant savings to be realized, Medicare and Medicaid will need to play a greater role.

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. For a description of CDSME success stories in 24 states, including Utah, Oregon, Georgia and Virginia, go to http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/cha-annual-meeting-2015/ALL_Success-Story-Formatted.pdf.

CDSME and other evidence based programs can address a number of the areas the Committee has requested for input on in the stakeholder letter. Without question, these proven programs will improve the health and quality of life for Medicare beneficiaries with multiple chronic conditions, including helping individuals to more effectively use their prescription drugs. In addition to community-based programs, there is an effective on-line version of CDSMP which would allow use of technology to spread self-management strategies with broader reach so that they are accessible to those not able to or interested in participating in group based, in-person programs.[14] There is also a self-study tool kit for CDSMP for those living in rural and frontier areas that do not have access to the internet or community programs. Each one of these options has been shown to be effective in improving self-management skills. These programs are the best option for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers. This will meet the goals of primary care providers and care coordination teams to maximize the health care outcomes for Medicare patients living with chronic conditions.

The Importance of Elder Falls Prevention

One in three Americans aged 65 and over falls each year.[15] In 2013, 2.5 million nonfatal fall injuries among older adults were treated in emergency rooms with more than 734,000 of these hospitalized.[16] Among older adults, falls are the leading cause of injury death. 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.[17] Medicare costs per fall averaged $14,306 and $21,270.[18] If we cannot stem the rate of

[14] For example, see Online Diabetes Self-Management: A Randomized Study at http://www.ncbi.nlm.nih.gov/pubmed/20299481
[15] 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.
[16] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online].
[17] Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. Injury Prevention 2006a;12:290–5
[18] 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.

increase in falls, it is projected that the cost in 2020 will be $67.7 billion, including Medicare costs estimated at about $48 billion.[19]

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%;[20] the Stepping On program reduced falls by 30%;[21] and the Otago Exercise Program reduced falls by 35% when delivered to adults 80 years of age and older.[22] A *Journal of Safety Research* special report from the CDC titled: "A cost-benefit analysis of three older adult fall prevention interventions"[23] 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.
- 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.[24]

NCOA Recommendations

In December 2010, the Department of Health and Human Services released Multiple Chronic Conditions: A Strategic Framework: Optimum Health and Quality of Life.[25] Goal 2 of the framework is to "Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions." Many of our suggestions below are closely aligned with and responsive to this goal, particularly Objective A on facilitating self-care management. 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.

[19] Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. Journal of Forensic Science 1996;41(5):733–46.
[20] 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.
[21] 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.
[22] 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.
[23] Carande-Kulis , VG, Stevens, JA, Beattie, BL & Arias, LA. Cost-benefit analysis of three older adult fall prevention interventions; Journal of Safety Research, 2015.
[24] 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.
[25] http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

Unfortunately, to date, 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. The following are ten NCOA recommendations to begin to address these and other concerns for older adults, particularly those with multiple chronic conditions:

1. Expand the Patient-Centered Medical Home (PCMH) self-management quality standards to other delivery models for Medicare

With respect to self-management, diabetes self-management training (DMST) and chronic disease self-management education programs have demonstrated success in improving health outcomes, promoting more appropriate health care utilization, and reducing health care costs for people with chronic conditions. The American Medical Association Physician Consortium for Performance Improvement-National Committee for Quality Assurance (NCQA) recommendations contain outcome and process measures to improve health status. Specifically, they include initiation of a DSMT program within 12 months of new diagnosis, and initiation of a DSMT program within six months before or six months after the start of insulin therapy. In addition, aspects of self-management are included in patient experience metrics on discharge (National Quality Metrics Clearinghouse [NQMC]: 005475), for behavioral health services (NQMC: 000850), and for disease-specific treatment plans.

In addition, the NCQA measures associated with patient-centered medical home (PCMH) certification include criteria for evaluating self-management skill-building within medical practices. Consideration should be given to taking current PCMH self-management quality metrics and applying them to the Physician Quality Reporting System (PQRS), Accountable Care Organizations (ACOs), Chronic Special Need Plans (SNPs), and Medicare Advantage Star Ratings. Specifically, NCQA's PCMH Standard on Care Management and Support (Standard Four) measures include 4B: Care Planning and Self-Care Support and 4E: Support Self-Care and Shared Decision-Making. These measures capture critical elements of care that support self-management for people coping with chronic illness.[26]

NCOA recommends that these Chronic Disease Self-Management quality metrics be included in standards for other Medicare providers, such as Medicare Advantage plans and ACOs.

2. Strengthen the Annual Medicare Wellness Visit to better promote healthy aging

Section 4103 of the Affordable Care Act provided Medicare coverage for annual wellness visits, which include a personalized prevention plan. 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 CDC's Stopping Elderly Accidents, Deaths, and Injuries (STEADI) tool;
- Develop billing codes for falls risk and patient activation assessments, as well as for referral to evidence-based programs;
- Develop standards for post-visit follow-up to better ensure compliance with the personalized prevention plan and referrals;
- Broaden the permissible circumstances under which visits can be conducted in a beneficiary's home.

[26] http://www.ncqa.org/Programs/Recognition/RelevanttoAllRecognition/RecognitionTraining/PCMH2014Standards.aspx

Electronic health records vendors are incorporating assessment tools into their software. For example, Epic, an electronic health records software system for medical groups, hospitals, and integrated health care systems, will release a an update of their tool that will include the STEADI algorithm for falls risk assessment. This electronic tool will provide a more streamlined approach for health care providers to integrate falls risk assessment into patient care.

3. Conduct a new demonstration on Integrated Self-Care Planning (ISP)

Self-management education and support 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 Planning (ISP), 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. 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. Practical protocols for team-based care planning would be developed that center on older adults' goals and results within individualized service integration. One option is for the Center for Medicare and Medicaid Innovation (CMMI) to conduct the demonstration.

Using the ISP 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. Periodic team meetings, supplemented with technology-based communications, would assess progress and then update the goals, plan and service mix. The ISP model would directly respond to the call from health systems, payers, and consumer advocates for integrating clinical and community-based support for self-care.

4. Extend funding for a modified version of the Community-Based Care Transitions Program (CCTP 2.0)

The Community-Based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tested models to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, improve quality of care, reduce readmissions for high-risk beneficiaries, and reduce Medicare spending. With some modifications and continued funding for successful demonstrations, these programs have significant potential to help in achieving the goals recently outlined by HHS Secretary Burwell to shift Medicare reimbursements from volume to value.[27]

Under the program, 102 participants in 40 states, primarily Area Agencies on Aging (AAAs), were awarded $300 million in grants from 2011 through 2015. NCOA worked closely on the provision with Senator Bennet and Dr. Eric Coleman, who developed the Care Transitions Program[28] at the University of Colorado. As we move forward, we must recognize that recalibration is inherent in and essential to successful innovation. With funding expiring, NCOA recommends that Congress take the lessons learned from the initial demonstrations to modify and improve standards, guidelines, and performance metrics, and extend CCTP 2.0 funding for up to 60 grantees for an additional three years.

[27] See http://www.hhs.gov/news/press/2015pres/01/20150126a.html

[28] See Eric A. Coleman, Susan A. Rosenbek, and Sarah P. Roman: "Disseminating Evidence-Based Care into Practice" in Population Health Management. August 2013, 16(4): 227-234 and http://www.caretransitions.org/

Getting these programs up and running took longer than originally anticipated, but there is much to be learned and replicated from a number of successful programs with strong results. Grantees incurred unreimbursed start-up costs averaging about $165,000, a substantial amount for most AAAs whose primary funding source – federal Older Americans Act discretionary appropriations – has been cut in recent years. These grantees have also expended significant time and effort establishing working relationships with hospitals, building electronic health record and billing systems, and training staff. Failure to extend a modified version of the program, just as many of these efforts are showing promise and results, ignores the significant progress and investments made and great potential for improved outcomes and cost savings.

In addition to ensuring that funding is extended to those grantees who have invested in infrastructure resources and performed well, program modifications that incorporate lessons from experience should include: (1) improvements in evaluation metrics, based on analysis by the Altarum Institute;[29] (2) greater fidelity to the Care Transitions Intervention, which has shown strong results in reducing readmissions,[30] as well as the evidence-based HomeMeds and HomeMeds-Plus programs;[31] (3) more refined population targeting, including recognition of challenges presented by enrollment of beneficiaries with previously undiagnosed dementia or depression; (4) access to meaningful use Health IT funds currently limited to hospitals; and (5) clearer incentives for hospital participation, cooperation, and referrals.

5. Create a demonstration program on Medicare Diabetes Self-Management Training

Currently, Medicare Part B covers Diabetes Self-Management Training, which is designed to educate beneficiaries with a diabetes diagnosis about their disease and how to better manage it. The recent Quality Improvement Organization (QIO) 11th Statement of Work (SOW) recognized the importance of additional attention in this area, as physician and nurses need to step up and better engage patients. The benefit began in 2002 and provides compensation for up to ten hours of DSMT each year. To date, only three community-based organizations (CBOs) have made significant progress toward the goal of Medicare reimbursement for DSMT delivery. These early adopters reported that the process is more difficult than expected. Our hope was that their experiences would pave the way for others to follow, but this has not been the case. The path has been more tortuous than anticipated, and the returns somewhat disappointing given the level of effort and resources invested.

We recommend that a demonstration project be designed and implemented that would provide a simpler, more direct path for CBOs to offer evidence-based DSMT. Participants would need to comply with important Medicare standards while burdensome administrative barriers would be waived. One possibility would be to include the demonstration in the Medicare Diabetes Prevention Act (S. 1131), which NCOA supports. This would broaden the scope and strengthen the bill to provide evidence-based interventions after beneficiaries are diagnosed with diabetes.

6. Fund a Medicare demonstration modeled after the Medicaid Incentives for Prevention of Chronic Diseases Program

Section 4108 of the ACA created the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program for States to develop and implement evidence-based chronic disease prevention approaches to

[29] See http://altarum.org/health-policy-blog/initial-cms-evaluations-of-readmissions-have-serious-flaws
[30] See http://www.caretransitions.org/structure.asp
[31] Presentation by June Simmons, CEO of the Partners In Care Foundation at the National Readmissions Conference: "Care Transitions, Strategies that are Working" on May 7, 2014, and see http://www.homemeds.org/.

demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives must be comprehensive, evidence-based, widely available, and easily accessible. Ten states were awarded grants to test the use of incentives addressing at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes (or when there is a diagnosis or diabetes, improving management).

NCOA recommends that a similar Medicare demonstration program be designed and funded targeting high risk beneficiaries, including dual-eligibles. Properly constructed and based on recent learnings, evidence-based interventions and incentives to promote healthy aging and behavior change for this population have great potential to reduce Medicare spending and improve lives.

A relevant legislative proposal worth examining is the *Medicare Better Health Rewards Program Act of 2013* (S. 1228), introduced by Senators Wyden and Isakson. The demonstration would establish a point system to enable participant beneficiaries to receive up to $400 per year if they comply with the protocols developed by the Cleveland Clinic, including those for: (1) an annual wellness visit, (2) tobacco cessation, (3) Body Mass Index (BMI), (4) a diabetes screening test, (5) cardiovascular disease screening, (6) cholesterol level screening, and (7) screening tests and specified vaccinations. Evidence-based protocols related to chronic disease self-management should be added to the list.

7. Include CDSME in new Medicare billing codes for complex chronic care

NCOA recommends that Medicare billing codes for Chronic Care Management (CCM) services include the provision of CDSME. Considering that the vast majority of chronic condition management takes place outside of the health care setting, providers should be able to bill for those patients who attend a CDSME workshop either in-person or online. These workshops are available throughout the country, with more than 256,000 participants to date.

8. Add second falls as a Hospital Readmissions Reduction Program measure

The Hospital Readmissions Reduction Program, mandated by the ACA, requires CMS to reduce Medicare payments to inpatient prospective payment system hospitals with excess readmissions. This program went into effect on October 1, 2012. This is a penalty program that reduces the base diagnosis related group (DRG) payments for discharges as result of performance on specific readmission measures. Such measures currently include unplanned 30-day readmissions for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty. In 2017, CMS will add a measure for 30-day unplanned readmissions for coronary artery bypass graft surgery. NCOA recommends that a measure be added for readmissions due to a second fall and could include fractures, brain injuries, and other related injuries.

9. Provide assistance to states on how to incorporate evidence-based healthy aging programs within their Medicaid programs

Several states have successfully incorporated evidence-based healthy aging programs within Medicaid. Some states have included CDSME in 1915(c) Home and Community-Based Services (HCBS) waiver programs. Others have sought to include evidence-based healthy aging programs within Medicaid managed care and duals integration demonstrations. States have a great deal of flexibility to incorporate evidence-based programs and related supports for participation (e.g. transportation) through various

Medicaid HCBS authorities and programs, such as the 1915(c) HCBS waiver programs, 1915(i) State Plan Option, Health Homes, and Money Follows the Person Demonstrations.
Some of these options could provide an enhanced federal match. For example, the Medicaid Health Home benefit allows states to receive an enhanced federal match to implement Health Homes to support an integrative, whole-person approach to care for individuals with two or more chronic conditions, those with one who are at risk for a second, and those with a serious and persistent mental health condition. Services can include care management and coordination, health promotion, transitional care follow-up, and help connecting community and social support services. States could better utilize this option to target and provide evidence-based healthy aging programs. NCOA recommends that CMS be directed to provide technical assistance and guidance to states on incorporating evidence-based healthy aging programs within Medicaid. The Medicaid Innovation Accelerator Program could provide a platform for assistance on these issues to states, along with clear metrics and data on impact and success.

10. Enhance access to CDSME and Family Caregiver Support for veterans and federal employees

The average age of the federal workforce is also increasing. Many workers are living with multiple chronic conditions which are costly in terms of absenteeism, loss of productivity, and health care claims. Furthermore, chronic diseases have a negative effect on quality of life for the employee and can lead to disability and premature death if not appropriately managed. The Department of Health and Human Services has invested in evidence-based programs and supports national dissemination of proven healthy aging programs, such as the suite of CDSME online and community-based programs.

Building Better Caregivers is an online workshop aimed to equip caregivers with knowledge, skills, and peer support to boost confidence, reduce feelings of burden and stress, and improve overall mental and physical health. The program is currently available to family caregivers through the Department of Veterans Affairs. Since 2012, over 1,400 caregivers have participated in workshops. However, recruitment efforts to date have primarily focused on caregivers of younger, post-9/11 veterans with traumatic brain injury and post-traumatic stress disorder. In partnership with the aging services network, additional outreach and recruitment should be undertaken to reach family caregivers of older veterans with disabilities who could also benefit from this program.

As the country ages, increasing numbers of workers are juggling work and family caregiving responsibilities. Businesses lose up to $33.6 billion annually in work productivity and absenteeism due to caregiving responsibilities of full-time employees. Businesses also face about 8% higher health costs for employees with eldercare responsibilities, potentially costing an estimated $13.4 billion per year.

The federal government should be a model employer by promoting the availability evidence-based health programs to federal workers. As such, NCOA recommends that the Office of Personnel Management provide federal employees with access to coverage for CDSME and family caregiver support programs for federal employees. Access for federal contractors should also be considered.

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 our Vice President for Public Policy and Advocacy Howard Bedlin at howard.bedlin@ncoa.org.

Sincerely,

James Firman
President and CEO