AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

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American Geriatrics Society Response – "Make Your Voice Heard" RFI
Submitted November 4, 2022

The American Geriatrics Society (AGS) submitted these comments in response to the Centers for the Medicare and Medicaid Services (CMS) *Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs* request for information (RFI). The AGS appreciates the opportunity to provide input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE).

Accessing Healthcare and Related Challenges

Access to Primary Care

Research shows that healthcare outcomes and costs in the U.S. are strongly linked to the availability of primary care physicians. According to the 20th report of the Council on Graduate Medical Education on Advancing Primary Care, studies have found that patients with access to a regular primary care physician have lower overall healthcare costs than those without one as well as improved health outcomes. Another study revealed that a higher proportion of PCPs in an area is associated with a lower level of spending. Specifically, states with a greater proportion of general practitioners had lower spending per Medicare beneficiary compared with other states. Most recently, research by Sanjay Basu et al. showed that greater PCP supply was associated with improved mortality. However, in the U.S. there is a workforce crisis, with a disappearing supply of PCPs, including geriatricians. According to the Health Resources and Services Administration (HRSA), there will only be 6,230 geriatricians by 2025, or approximately one for every 3,000 older adults that require geriatrics care, leaving thousands without access to these services. Additionally, rural populations have more limited access to primary care physicians than residents of urban areas, and generally are older, have a higher incidence of poor health, and face greater socioeconomic barriers to receiving care (e.g., transportation, internet access).

Long-Term Care Services and Supports (LTSS)

Ensuring older adults' access to a wider range of high quality and affordable long-term care options, including those that enable them to "age in place," in their own homes and communities, must be a priority. The overwhelming majority of older Americans want to remain in their homes as long as possible, but many lack needed home and community-based services or are unaware of these services. Even when long-term care services are available, many older adults lack the financial resources to pay out-of-pocket for these services for any extended period of time. Medicare covers very few such services (and provides no coverage for assisted living or non-skilled nursing home services). Medicaid remains the primary payer for both institutional and community-based LTSS, however in order to qualify for Medicaid many older Americans must "spend down" their assets. Family caregivers continue to provide the majority of long-term care for older Americans – often without sufficient training or support.

Medication Errors
Medication errors are a large contributor to poor outcomes, complications, and hospitalizations (and readmissions). Limited pharmacy support in the office setting in real-time complicates this issue and appropriate reviews of total medication lists should be required in all care settings with particular attention to care transitions. Medication Therapy Management (MTM) was to be the "cornerstone of Part D." Unfortunately, this has not been the case. While "price sensitivity" may be decreased with the annual Part D spending caps, it might trigger even more polypharmacy as well as medication-related problems. On average, Americans take more medicines and are less healthy than older adults in other countries and unlike Canada that advertises deprescribing ideas, pharmaceutical companies have a major presence in mainstream and social media. The only way to combat this rising public health problem is to provide and support *meaningful* MTM that ensures medicines do more good than harm. Much of the Part D-supported MTM is telephone calls from those hired by plan sponsors who are not known or trusted by Medicare beneficiaries.

Understanding Coverage Options
Many Medicare beneficiaries have limited digital literacy and/or access, which is problematic when coupled with the extremely complicated Medicare coverage options and related health insurance literacy challenges. Annual review of prescription and/or health plan coverage (Parts D and C, respectively) that can change dramatically every year is overwhelming enough for older adults and adults with disabilities. Support from high-functioning Senior Health Insurance Information Program (SHIIP) sites that have well-trained volunteers who are familiar with an efficient plan finder tool would be invaluable for these populations. The more administratively burdensome the Medicare plan finder tool is, the less likely those at SHIIP sites will be able to keep their volunteers engaged and happy. When the plan finder tool is not easy to navigate or seems incorrect – those helping beneficiaries lose faith that they are indeed making things better (improving access at a lower cost) for Medicare beneficiaries. In general, there are too many options and variables that grow more complex every year obscuring meaningful "choice." The plan finder tool should be beta tested 2 months before the Medicare open enrollment period and CMS should make tools available to help train volunteers.

Recommendations for how CMS can address these challenges through our policies and programs

Create Loan Repayment Programs for Geriatrics
Such programs would address the significant barrier that student loan debt creates for clinicians who want to pursue primary care careers in geriatrics, while helping to expand the workforce we need to care for the growing population of older Americans. Federally, the program would complement existing loan repayment programs offered by the HRSA for primary care medical, dental, and mental & behavioral health care providers. We urge the federal government to create loan forgiveness, scholarship, and financial incentive programs for professionals who enter geriatrics as recommended by MedPAC in its June 2019 report.

Ensure Competence of Our Workforce Caring for Older Americans
Funding for GME, while supported by Medicare, does not require that hospitals and other sites provide training that leads to a health professional workforce that is able to care for older adults with multiple complex and/or chronic conditions. GME reform is needed to address the gap between training

requirements and our country's need for a workforce that is prepared to care for us all as we age. MedPAC's 2010 report stated that institutions using Medicare dollars to support GME should be providing training to enable health professionals to develop competency in the care of older adults. Furthermore, the Institute of Medicine (IOM) has said that a geriatrics competent workforce will contribute to higher quality, safer, and more cost-effective care for patients. We believe that it is vital to mandate all Medicare-supported training to include geriatrics principles for all appropriate trainees in order to prepare a workforce that is competent to care for older people.

Support Direct Care Workers
Direct care workers are essential to assist older adults and ensure overall well-being, especially during public health crises. Jobs in aging services are highly skilled and complex, a fact not recognized in pay scales or reimbursement rates, while the work in these settings is physically and emotionally demanding. The COVID-19 pandemic exacerbated existing gaps in expertise and systemic weaknesses in health care service delivery for older adults particularly for the direct care workforce. We can better support the direct care workforce by strengthening the pipeline of direct care workers through the following actions: 1) Implement recruitment campaigns, particularly targeting displaced workers; (2) Provide funding for online training and competency evaluations; (3) Increase funding to direct care training providers to enhance the training infrastructure; and (4) Provide funding for in-person training following the PHE to increase and maintain direct care workforce capacity.

Strengthen Long-Term Care Services and Supports
Ensuring older adults' access to a wider range of high quality and affordable long-term care options, including those that enable them to "age in place," in their own homes and communities, must be a priority. We support policies to expand access to long-term care options, including in-home and other care that enables older adults to live independently as long as possible. We also support policies to better support and train family caregivers. We outline multiple potential action steps here AGS Comments on the HCBS Access Act Discussion Draft (americangeriatrics.org)

Ensuring Medication Safety
Pharmacy support may include, for example, an assessment of appropriate dose and duration of treatment as well as medications of particular risk for older adults (e.g., medications listed in the American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults). In general, interventions are needed to help avoid the use of potentially inappropriate medications among Medicare patients who are frequently on multiple medications. This will also help avoid the polypharmacy cycle (or prescribing cascade) where new medications are used to treat the side effects of currently prescribed medications, thereby saving costs on pharmaceuticals, reducing pill burden and its associated complications.

We need more support for medication reconciliation for community-based care given that most older adults see one or more specialists in addition to their primary care provider. State-based controlled substance monitoring programs have demonstrated the feasibility of internet accessible registries listing drugs that patients have filled at their pharmacy. On a national scale, an internet-accessible registry listing all drugs that a patient has filled would help in monitoring medication adherence and prevent drug interactions among patients seeing multiple prescribers. This registry must seamlessly interface

with the EHR so that clinicians can readily access the information as part of the routine workflow. This requires standards for electronic records as well as reporting to the registry and registry structure.

Understanding Provider Experiences

Key factors impacting provider well-being and the distribution of the healthcare workforce
While geriatrics has historically been a happier specialty (DOI:10.1186/1472-6963-9-166), there have been myriad challenges including the rising demands of the aging population, increased provider demands as well as complexity of payer markets with Medicare Advantage plans, inability to meet workforce needs, and maldistribution of geriatrics health professionals by region (HRSA Health Workforce Projections). Furthermore, as mentioned above, relieving student debt burdens for clinicians focusing on geriatrics may remove the barrier for trainee providers entering geriatrics training and in turn expand the healthcare workforce that is in high demand.

The challenges of provider well-being have been exacerbated since the beginning of the COVID-19 public health emergency and there have been substantial impacts on the well-being of providers leading to mental health challenges, such as posttraumatic stress disorder, depression, and burnout. A recent Mayo clinic report showed that burnout had risen from an unacceptably high baseline in the 30% up to 68% this year (DOI:10.1016/j.mayocp.2022.09.022). Other highlights include:

1. Burnout increased nearly 25% and depression increased 6.1%. This indicates the distress experienced by physicians is strongly related to work. Research also showed that lack of resiliency is not the driver for burnout.
2. The burnout risk for female providers was substantially higher than males, and this has implications for a field like geriatrics where 65.7% and 67.4% of recent geriatrics trainees in family medicine and internal medicine, respectively, are female (DOI:10.1001/jama.2021.13501).
3. The impacts of burnout were high in emergency medicine and family medicine.

Even more telling has been the longstanding statistic that we lose almost a medical school class (DOI:10.1001/jama.1977.03270290043024), approximately 300 physicians, to suicide each year (PMID: 31527944).

The AGS believes that functional status is a critically important outcome for older adults, especially those with multiple chronic conditions. Routine assessment of a person's physical function is critical to understanding changes in their ability to perform daily tasks and identify signs of early decline. Prevention of decline in functional status has the potential to increase quality of life and decrease emotional, social, and financial costs (DOI: 10.1056/NEJMoa020423; 10.1111/j.1532-5415.2004.52401.x). The AGS notes that there is a lack of meaningful functional status measures in the Quality Payment Program. Despite its importance, functional status remains a big gap in the data collected, resulting in a big gap in quality measures (DOI:10.1111/jgs.15595).

The 11 million older Americans who are dually eligible for Medicare and Medicaid are among the highest need populations in both the Medicare and Medicaid programs but often receive care that is fragmented and uncoordinated. Programs such as Programs for All-Inclusive Care for the Elderly and

Dual Eligible Special Needs Plans provide and coordinate the delivery of Medicare and Medicaid benefits, however, these programs are not always accessible to all who could benefit.

Additionally, older adults who are homebound are often underserved and likely to have unmet care needs. They are also more likely to be people of color or socially and economically disadvantaged. The opportunity to reach this vulnerable population is challenging due to lack of access to resources, dearth of providers or specialists, as well as social determinants of health that further impede access for this population, including education and socioeconomic status.

Virtual house calls would provide an opportunity for better care and can increase participation in care oversight, in particular for homebound older adults and other underserved populations. Telemedicine could provide an additional resource for health care professionals caring for vulnerable populations, eliminating some of the barriers for greater access to the healthcare system. By increasing clinician access to patients, we can provide remote management to help patients with multimorbidity, reducing prolonged wait times, and facilitating communication for coordinated care and services.

While the steps CMS has taken to reduce the location and technology restrictions on telehealth to help improve access to care overall, there are still individuals who lack access to broadband internet and devices to engage in audio-video visits. Given that there is an economic equity and rural access issue, the AGS believes telemedicine, including audio-only services, would be critically important in improving access for older adults with multimorbidity as well as reducing the burden on primary care practices.

Recommendations for policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations

A future where we work smarter, in teams, with the right data, at the right place, at the right time, and patient and family goals and needs are emphasized in that system may improve provider practices.

In large part, the shortage of primary care physicians is the result of underfunding of primary care, which has made careers in primary care medicine unattractive to graduating physicians because of the relatively low incomes they generate compared to other medical fields.

As described above in Topic 1, loan forgiveness programs would be a significant incentive for geriatrics care to eliminate the financial stressors of large student loan debts, while helping to expand the workforce we need to care for the growing population of older Americans. A *New England Journal of Medicine* article showing progress of an Ontario Primary Care Medical Home model emphasized that shifts in primary care may be possible when payment systems incentivize primary care practices to increase the workforce and that it is critical to ensure a work environment is desirable for healthcare professionals. Otherwise, there may be unnecessary hospitalizations and specialist visits where services could have been addressed in primary care (DOI:10.1370/afm.1228).

Furthermore, primary care also has greater levels of responsibility between visits, in quality reporting, and in dealing with the shortcomings of electronic health records (EHRs). The mismatch between payment and responsibility is as negative an incentive as the payment level itself.

Support Innovative Models of Care
Studies have shown that models providing coordinated and interdisciplinary geriatrics team-based care can make a critical difference, especially for persons with multiple chronic conditions, by preventing complications and enhancing the quality and efficiency of care provided across the healthcare continuum. We must incentivize innovative care models that value and support teams for complex high-cost patients. Many existing programs (Comprehensive Primary Care Plus (CPC+), Hospital at Home (HaH), and Programs for All-Inclusive Care for the Elderly (PACE)) show great promise but are limited in scope and not universally available. We need to support expanding existing programs shown to improve care while also continuing to learn about best practices in providing quality care for older adults with complex needs. In addition to providing better care, advanced primary care programs, like CPC+, help PCPs provide good care and be less overwhelmed with practice.

Improve Interoperability Between Health Systems
More must be done to enhance EHR interoperability among multiple providers and across different settings so that care coordination is more efficient, effective, and accurate. We also encourage innovations in health information technology (e.g., assessment tools, templates) that are specific to older adult care. EHRs have the potential to improve care of frail, older adults with multiple chronic conditions. To fulfill that potential, EHRs must have the capacity to capture key issues that affect care and well-being of older adults with chronic conditions, including, but not limited to, function, cognition, and patient's goals of care over time. This will aid providers in focusing on issues that address the overall goals of the patient, including function and maintaining independence.

Redesign the Electronic Record
Electronic record designs have greatly added to the burden in all practices, but especially primary care. Vendors and designers seem to have neglected assessment of human factors, realistic safety improvements, and practical workflow. Care must be redesigned around the record rather than the record supporting good care. The record system costs are now a staggering budget item for large health systems as well as small practices. Changing systems lose patient information and reduce productivity for a significant period of time and therefore is avoided whenever possible, also stifling improvements. Clinicians need standards that address usability at the point of care and cost. The record continues to have great potential and many positives have resulted, but it is time to revisit the processes and costs associated with these technologies.

Advancing Health Equity

CMS policies, programs, and practices that may help eliminate health disparities and used to advance health equity
Improving health equity across CMS programs requires a preventive as well as treatment perspective. Many beneficiaries of CMS programs have been experiencing disadvantages related to social determinants of health for years, even decades, prior to their eligibility. One prime focus of CMS programs should be to treat the health impact by addressing beneficiaries' social determinants of health. Social determinants, including inequality and injustice, create pathways through their interactions with biological processes in individuals and populations that result in greater disease burden and increased risk of poor health and well-being, referred to as the syndemics model of health (Centers for Disease Control and Prevention - Social Determinants of Health).

The most important interface may be a person-centric system of service coordination. Addressing a person's identified social determinants of health in isolation should not be the goal. The presence of the need is a signal that there are likely additional risk factors that need attention such as lack of access to support or health care and the conditions of the neighborhood and environment where people live, work, pray, and age. Meeting a need in isolation is a short-term stopgap that does not improve the various dynamics of social determinants.

Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs

The lack of access to high-quality healthcare in historically marginalized urban and rural communities is well-documented. An example of the consequences of a lack of community-based research infrastructures in 2020 was the lack of access to COVID-19 trials and therapeutics beyond large hospitals and academic medical centers (DOI:10.1136/bmjgh-2020-003188).

Geriatrics health professionals focus their clinical attention on the 5Ms of geriatrics: Multimorbidity, What Matters, Medication, Mentation (cognitive function), and Mobility (physical function) (https://www.thecanadiangeriatricssociety.wildapricot.org/Geriatric5Ms/). This forms the basis for the age-friendly health systems framework that is centered on ensuring that all older people, including underserved older adults, have access to this type of coordinated care, while also making sure personal needs, values, and preferences are at the heart of that care.

The healthcare workforce shortages and need to close geographic and demographic gaps must be addressed to increase access for historically marginalized communities. In order to have meaningful improvement for patients, particularly underserved communities, crucial health outcomes to consider include reduced symptom burden, effects on cognition and physical function, sustained health-related quality of life, as well as the reduced negative impacts of social determinants of health.

The COVID-19 PHE underscored and exacerbated the structural inequities experienced by older adults of color. Older adults and in particular older adults of color faced disproportionate adverse effects such as reduced face-to-face interactions with clinicians, gaps in access to essential supplies while in isolation, and physical and mental consequences of social isolation (DOI:10.1080/08959420.2020.1759758; DOI:10.18502/ijph.v49i12.4810). Examples from the pandemic include a lack of trust in local healthcare leaders to have the best interest of historically marginalized populations when offering vaccination in communities of color (KFF COVID=19 Vaccine Monitor: December 2020).

Recommendations for how CMS can promote efficiency and advance health equity through its policies and programs

It is important to invest in addressing the underlying structural and social determinants of health as the cause of increased risk for historically marginalized groups and reduce the impact of health-related social risk factors. Doing so will foster healthier individuals and communities, producing fewer beneficiaries with disadvantages influenced by social determinants of health, and less cost to health care programs. This requires fundamental changes in the diversity of the healthcare workforce; training and support for the next generation of health professionals from diverse backgrounds; and all aspects of healthcare with the perspective of the intersection of ageism not only with racism but also with other

forms of bias and discrimination (DOI:10.1111/jgs.18105). This may support realizing a just healthcare system in which being part of one or more groups does not affect the quality of care that is delivered and ensure that all of us receive timely, high-quality care that is responsive to our individual needs and offered with cultural humility (DOI:10.1111/jgs.18105).

Interventions to address social determinants of health require support of and a meaningful interface with non-medical social infrastructure in the communities where beneficiaries live, work, pray, and age. Identification of need and referral for services should be embedded in health care practice. However, the provision of social services is not and should not become a responsibility of health care practice. Referrals alone do not mitigate needs, services do. Unless greater resources are made available through direct or indirect payments to the agencies and organizations that provide social services, increasing the number of referrals will further clog the already overburdened social service system. Investing in social service agencies, organizations, and communities would improve the effectiveness, efficiency, and financial stability of social programs.

There is also a need to improve the data and information interface between health care entities and other systems that support individuals who are negatively impacted by social determinants of health. The providers of health care services and social service agencies and organizations can work collaboratively to ensure effective and efficient care and service coordination and information sharing to improve referral processes as well as appropriate consideration of medical situations while providing services and support.

Successful sustainable improvement in health equity requires a new approach to fund social services, one that is not dependent on the provision of individual health care services. It requires the development of person-centered processes in communities that are empowered to deliver coordinated services to individuals, families, and neighborhoods financed by a stable and secure flow of funds to communities to identify and reduce the impact of health-related social factors.

Health care payers such as CMS should be one source of these funds as when effectively managed, the result will be a decrease in disease burden and long-term costs. Cost savings will also accrue to other payers of the consequences of social dysfunction, such as the systems of justice, penal, education, and commerce. These payers should also contribute as might businesses, philanthropy, and others.

CMS can play an important role in advancing a preventive approach to inequities in a manner similar to its investment in preventive medicine. Prevention is a proven strategy in health care; immunizations, screenings, and public health interventions–such as seat belts and antismoking campaigns–have demonstrated benefit to individuals, populations, and communities. Preventive services to support reducing the impacts of social determinants of health are likely to provide similar benefits in addressing inequity.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

The AGS is appreciative of the waivers and rules that CMS has made since the start of the COVID-19 pandemic to expand coverage for Medicare telehealth services. The importance of telehealth during this pandemic cannot be understated and providers and patients have been utilizing these services in

overwhelming numbers. We believe that telehealth services, when appropriate, should continue to play an important role in expanding access to health care services once the COVID-19 pandemic ends.

In particular, audio-only telehealth services (e.g., telephone calls without the need for video) have been especially important for older adults. The AGS believes that audio-only E/M services are important tools for caring for certain patients, particularly older patients and patients who are low income, both of whom may not have access to more advanced audio-visual technology such as smartphones or computers. Patients with cognitive impairment and/or low vision face additional barriers that can prevent use of more advanced technology for telehealth services. We note that audio-only E/M services are not simple phone calls directing the patient to schedule an in-person visit but can often involve prolonged conversations and evaluation.

Recommendations for CMS policy and program focus areas to address health disparities and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE

Audio-Only Communications and Other Telemedicine

During the PHE, CMS has considered the telephone E/M services (99441 - 99443) to be a replacement for in-person E/M services. CMS added those codes to the Medicare Telehealth Services List and pays them at the same rate as an in-person E/M services for the duration of the PHE. CMS has also created codes to describe virtual check-in services of 5-10 minutes (G2251) and 11-20 minutes (G2252) that can be used to report audio-only services and has valued those based on RVUs for the comparable telephone E/M service codes, which is considerably lower than the rate paid for the telephone E/M services during the PHE. 99441 - 99443 has not been added to the Medicare Telehealth Services List on a Category 3 basis meaning that these codes will no longer be considered Medicare telehealth services 151 days after the end of the PHE. At that time, the codes will no longer be separately payable.

As noted above, the AGS believes that audio-only E/M services are important tools for caring for certain patients and urges CMS to continue paying for audio-only services after the end of the PHE. The AGS also recommends that CMS revisit the payment for these services to make sure they appropriately reflect the physician work and practice expense associated with these services.

During the PHE, CMS suspended frequency limitations for telemedicine in the skilled nursing facility and nursing facility services. Medically necessary care should not be arbitrarily limited so long as the required in-person services are provided after the end of the PHE. We ask that CMS not reinstitute clinically irrelevant frequency limitations on telemedicine services.

Access to Vaccines

The AGS also urges CMS to consider additional steps that could be taken to promote equitable access to preventive vaccines. We believe that the additional payment for the provision of the COVID-19 vaccine to beneficiaries in their home has expanded access to that vaccine. We urge CMS to consider extending the additional payment for vaccines administered in the home after the end of the PHE and expanding the availability of additional payment to the other preventive vaccines covered under Medicare furnished in the home.

Planning for Pandemics and Other Disasters

The current COVID-19 PHE underscored the gaps in our planning for a pandemic resulting in a disproportionate impact on older Americans, particularly older Americans of color. It is critically important to ensure that CMS identifies all essential health care workers (e.g., certified nursing assistants, social workers, and dietary aides) and settings (e.g., nursing homes and other congregate housing) so that they also receive assistance and resources. We emphasize the importance of including the expertise of geriatrics health professionals, nursing home and long-term care leadership teams, and hospice and palliative care experts. Scientists and public health experts are best positioned to lead efforts to educate all Americans on the state of the science and serve as trusted information sources for Americans on what they can do to protect themselves and others.

It will be vital to invest in solutions that address the health, social, and economic disparities that contributed to people of color and older adults being among the hardest hit by the COVID-19 pandemic. For example, investments are needed in Federally Qualified Health Centers so that they are equipped to provide care via telehealth during both times of pandemic and normal times. In Opportunities for Medicaid to Address Health Disparities, Shilipa Patel and Tricia McGinnis have outlined a number of recommendations for how Medicaid could be changed that would reduce the health disparities that contributed to the greater impact of COVID-19 on communities of color (DOI:10.1377/forefront.20200527.351311).