

January 26, 2016

The Honorable Orrin Hatch  
Chairman, Committee on Finance  
United States Senate  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member, Committee on Finance  
United States Senate  
Washington, D.C. 20510

The Honorable Johnny Isakson  
United States Senate  
Washington, D.C. 20510

The Honorable Mark Warner  
United States Senate  
Washington, DC 20510

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

The American Geriatrics Society (AGS) appreciates the opportunity to comment on the “Bipartisan Chronic Care Working Group Policy Options Document.” The AGS is a national not-for-profit health professions organization comprised of over 6,000 physician and non-physician practitioners and researchers who specialize in the care of the elderly – the most vulnerable and the most affected by chronic diseases. Our members are trained to meet the complex medical and social needs of this growing population.

The AGS supports the three main bipartisan policy goals outlined by the working group. We believe that the first goal to increase care coordination for individuals living with chronic diseases, the highest continuous cost Medicare beneficiaries, will not only improve the quality of care that these individuals receive, but will increase beneficiary satisfaction and reduce the growth in Medicare spending – both desired results of the third goal. To achieve the second goal, we believe that Medicare’s current payment system must be redesigned to support this focus on care coordination and to fund the transformation through utilizing fee-for-service payment, changing Medicare Advantage rules, and improving beneficiary access to alternative care models. We also strongly believe that the healthcare workforce must have the skills and training in geriatrics, including team-based chronic care management, to meet the needs of our nation’s unprecedented number of older adults. Competencies in geriatric medicine and clinical gerontology, in combination with the use and dissemination of proven models of geriatric care, are essential to the success of all three goals.

The AGS advocates for person-centered care, which is directed to the individual's values and preferences, and involves coordinated care by an interdisciplinary team of professionals. The care should address the comprehensive needs of those with multiple chronic conditions, including medications, behavioral health, and social needs/function. An interprofessional panel convened by the AGS in collaboration with the University of Southern California and with support from The SCAN

Foundation recently conducted a research project to define person-centered care. The definition can be found at: <http://geriatricscareonline.org/toc/person-centered-care-a-definition-and-essential-elements/CL020>. Further, the chronic care model described by Edward Wagner and colleagues provides a conceptual framework for policy development. Finally, we recognize the importance of the family caregiver in providing support and resources to assist loved ones with chronic and often complex conditions.

The AGS is enthusiastic about policies that advance the continued evolution of the healthcare system to support coordinated, person-centered care that multi-morbid geriatric patients need. We look forward to working with the committee on this important effort. Below we provide feedback on several of the sections outlined in the policy options document.

## **RECEIVING HIGH QUALITY CARE IN THE HOME**

### ***Expanding the Independence at Home Model of Care***

The AGS greatly appreciates the working group's focus on high-quality home care and the value of home-based primary care teams. The Independence at Home (IAH) demonstration has a strong evidence base and we support the proposal to expand it nationwide. We encourage strategic initiatives to disseminate the IAH model and funding support strategies to assist healthcare systems to adopt the model. A successful example of geriatric practice model dissemination is a program called the Medicare Innovations Collaborative led by Dr. Al Siu at Mount Sinai Medical Center and Dr. Bruce Leff at Johns Hopkins Bloomberg School of Medicine. In this program, multiple health systems worked together with national experts to support the implementation of best practice strategies at each site. There are a total of 17 practices that participate in the IAH demonstration including ones in Oregon, Texas, North Carolina, Ohio, Pennsylvania, New York, Michigan, Florida, and Virginia.

To further monitor and evaluate the IAH program, we recommend including performance measures evaluating patient and primary caregiver satisfaction. In addition, measures from the CARE Item Set assessing patients' performance of activities of daily living (ADLs) and those for community mobility such as the Life Space Assessment instrument should be included.

We believe that using Hierarchical Condition Categories (HCC) risk scores is *not* a sufficient method for identifying complex chronic care beneficiaries for inclusion in IAH. Patients that require home-based or complex care interventions often have medical issues (e.g. functional, cognitive, etc.) that are beyond a diagnosis and not recognized in the HCC model. We recommend that IAH programs adopt PACE's (Program of All-Inclusive Care for the Elderly's) patient eligibility criteria. It is important to note that PACE uses HCC risk scores for payment, not eligibility. Eligibility criteria could also be informed by the Department of Veterans Affairs' (VA's) robust evidence on Home-Based Primary Care and other models which have been successfully implemented in the VA system.

### **Expanding Access to Home Hemodialysis Therapy**

Overall, the AGS supports policies and regulations that expand the number of telehealth services covered by Medicare, and therefore agrees with the proposal to expand the list of Medicare’s approved originating sites for End-Stage Renal Disease (ESRD) beneficiaries dialyzing at home to receive their monthly clinical assessment via telehealth.

## **ADVANCING TEAM-BASED CARE**

### **Providing Medicare Advantage Enrollees with Hospice Benefits**

The AGS encourages optimal access to hospice services for Medicare beneficiaries who are enrolled in Medicare Advantage (MA) programs. There are several key points which deserve emphasis. The end of life is a vulnerable time for Medicare beneficiaries and their family caregivers. Efforts should be made to decrease the “red tape” regarding health insurance during this time. These efforts should lessen the burden for these individuals and improve access to services. Additionally, there is a solid evidence basis supporting improved care for individuals who receive hospice care at the end of life. The challenge for any proposal moving forward is that it translates into access to the specific hospice and palliative care providers and programs that can demonstrate they are providing excellent care and meeting the needs of patients and families.

The AGS also recommends that the Centers for Medicare and Medicaid Services (CMS) be required to consider specific quality measures to ensure that enrollees receive the same type of hospice services that have been shown to lead to higher quality of life and higher patient and family satisfaction. These quality measures should support better care coordination among interdisciplinary team members (nursing, pharmacy, social workers, and physicians), encourage communication between physicians and family, encourage the coordination of care towards the patient's goals/preferences, and assure attention to medications at end of life – avoiding adverse drug events in the context of end of life care.

### **Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan**

The AGS supports the proposal to offer MA to all ESRD beneficiaries. This change would provide ESRD beneficiaries with better or additional services at a lower cost and better coordinate care across the many providers that such patients see regularly, including dialysis facilities, nephrologists, endocrinologists, podiatrists, and primary care.

### **Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations**

The AGS encourages the use of evidence-based models to support the further development and implementation of Special Needs Plans (SNPs). Where possible these plans should use evidence-based models such as GRACE (Geriatric Resources for Assessment and Care of Elders), Guided Care, Care Management Plus, and Chronic Disease Self-Management Programs. Through rule-making CMS may be able to establish incentives and requirements with respect to plans adopting proven models or key components of evidence-based models. We continue to learn the best methods in caring for the most complex and frail. The AGS also supports permanent authorization for SNPs.

The working group also solicits feedback on modifications made to the C-SNPs should another policy be implemented that would allow MA plans greater flexibility in treating this population. We do believe

that there is some degree of redundancy between the goals of the SNPs and other models of care that have been successful including PACE and GRACE. We recommend that legislation make efforts to move closer to services similar to those found in these programs. We also recommend that consideration be given to a “Frailty” C -SNP for persons with two or more ADL dependencies and multiple chronic conditions rather than the list of individual chronic conditions.

**Improving Care Management Services for Individuals with Multiple Chronic Conditions**

The AGS strongly supports the need for a high-severity chronic care management code and appreciates the working group’s proposal to reimburse clinicians for coordinating non-face-to-face care for complex Medicare beneficiaries living with multiple chronic conditions. We urge CMS to recognize CPT code 99487 (complex chronic care management services, at least 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with specified required elements) in addition to 99490. The 20 minutes of clinical staff time in the chronic care management code currently reimbursed by Medicare is inadequate given the needs of the chronically ill Medicare population potentially eligible for this service. We are also presenting codes to CPT and discussing concepts with CMS about fee-for-service payments that would better address care management as an alternative to hospitalization, when requiring substantial professional work or when caring for a beneficiary with a single highly complex disease.

We appreciate the risk of providing payment for patients that are not complex, but in reality it is not likely that substantial services of this type are to be delivered without need, especially if provided by the usual care providers or by community supported organizations. For most medical services there is a presumption of necessity and these are no different than many others. Any criteria will miss those who might benefit or specify eligibility for those who do not need services. With this in mind AGS supported language in CPT regarding patients who need complex chronic care management, as follows: Typical patients have one or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. Patients may have medical and psychiatric behavioral co-morbidities (e.g., dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support weaknesses or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are expected.

However, we would be pleased to work with Senate Finance or CMS to use the expertise and practical knowledge of our member professionals and researchers to refine criteria as needed. We believe multiple illness, multiple providers, multiple medications, historical high cost, ADL impairment, anxiety, and weak social supports define the patients most in need of care management by a team with geriatrics competencies.

### **Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries**

The AGS supports the working group's focus on integrating primary care and behavioral health services for chronically ill beneficiaries. Behavioral health needs are significant throughout life for many patients, and are especially important for older adults. Consideration of evidence-based models in behavioral health should be primary goals; for instance, the Advancing Integrated Mental Health Solutions Center has tested and disseminated several models for collaborative psychiatry and behaviorist integration into primary care with significant results. Another mechanism we support to facilitate these models' integration into primary care is the Collaborative Care Model (CoCM) for psychiatric conditions. The CoCM is a defined set of evidence-based psychiatric services that ensure that patients seen in primary care settings and diagnosed with a mental health or substance use disorder have access to psychiatric services through their primary care provider, including access to non-face-to-face psychiatric consultation and collaborative psychiatric care management. Behavioral health should be integrated into primary settings of care wherever possible, with specific training for the needs of older adults. Telehealth solutions, like online cognitive behavioral therapy, may be options for older adults and others in rural areas.

Coupled with behavioral health is the need to consider addiction services, including substance abuse screening, intervention, referral and treatment with access to evidence-based approaches including cognitive behavioral therapy, medication assisted therapy, and other treatments.

## **EXPANDING INNOVATION AND TECHNOLOGY**

### **Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

The AGS encourages innovations in practice models which would be available to Medicare beneficiaries. An example of such flexibility which has led to improved care is in a model called CAPABLE (Community Aging in Place, Advancing Better Living for Elders). This program provided a nurse, an occupational therapist, and a handy man to evaluate and assist a home-bound elder. The preliminary outcomes showed improved function for vulnerable home-bound seniors. In short, flexibility of MA plans may lead to better health outcomes, as noted by the novel approach in CAPABLE.

While there have been many successful models implemented for Medicare beneficiaries with chronic conditions through MA plans, there has also been mixed experience to date regarding their ability to offer complex care management and intensive need services themselves. We recommend proceeding with caution and as noted in the proposal create eligibility criteria such as quality and experience prior to permitting this flexibility.

### **Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

The AGS encourages consideration of expanding supplemental benefits which may increase beneficiaries' access to services that are either not covered, or covered only on a limited basis, by traditional Medicare and that better address the social determinants of health. For example, Medicare's durable medical equipment (DME) benefit provides limited coverage of parenteral and enteral nutrition therapy for beneficiaries who meet certain criteria, among them that the condition causing the need for nutrition therapy is permanent, not temporary. There is substantial medical evidence suggesting that adequate nutrition therapy contributes to improved outcomes for elderly surgical patients. Reducing

nausea and vomiting, managing fluids and maintaining adequate levels of key nutrients are important goals of geriatricians. Indeed, the AGS and the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) recently released a new collaborative best practices guideline for optimal care of older adults immediately before, during, and after surgical operations that includes recommendations for nutrition. The guidelines can be found at:

<http://geriatricscareonline.org/ProductAbstract/optimal-perioperative-management-of-the-geriatric-patient/CL022>. MA plans should have additional flexibility to pay for nutrition therapy within a supplemental benefit category in circumstances where it will improve patient outcomes.

***Increasing Convenience for Medicare Advantage Enrollees through Telehealth  
Providing ACOs the Ability to Expand Use of Telehealth***

The AGS is pleased to see that the working group has highlighted the importance of telehealth services throughout this document. As mentioned in our June 22, 2015 comment letter, telehealth has the potential to improve outcomes across the board for chronically ill, multi-morbid patients, including homebound older adults and those living in underserved areas. Likewise, we support the working group's proposal to expand the number of telehealth services provided by MA plans and Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MMSp). However, we strongly believe that all Medicare beneficiaries should have access to telehealth services, and that increased flexibility to provide such services should be afforded to other payment models as well. This includes Medicare fee-for-service which currently has a gap. The current requirements address shortage areas, however do not adequately value the potential efficiency gains for beneficiaries, caregivers and providers that can be achieved through technology. As technology advances greater monitoring, more useful "touches" and the delivery of special expertise can be achieved. In addition, the AGS encourages further development of an evidence-base on which to support these policy recommendations.

***Maintaining ACO Flexibility to Provide Supplemental Services***

The AGS believes that the working group's proposal enabling MMSp ACO participants to use their own resources to provide social services and/or transportation services is appropriate.

***Expanding Use of Telehealth for Individuals with Stroke***

The AGS would like to reiterate its support for the expansion of telehealth services and its ability to bring timely expertise to patients and families. We agree with the proposal to eliminate Medicare's originating site geographic restriction to receive an acute stroke evaluation via telehealth.

**IDENTIFYING THE CHRONICALLY ILL POPULATION AND WAYS TO IMPROVE QUALITY**

***Ensuring Accurate Payment for Chronically Ill Individuals***

The AGS supports the working group's proposed changes to the CMS-HCC Risk Adjustment Model. The current model under-predicts high cost, complex individuals, and thus the MA plans and ACOs generally try to steer away from these patients.

We strongly support the working group's recommendation to study the use of functional status, as measured by activities of daily living. We believe this would help improve the predictive accuracy of the model. In addition, we urge the working group to look further at geriatric syndromes such as dementia,

depression, falls, and urinary incontinence which are often big drivers of cost. Functional status and other proposed changes should be applied equally to MA and ACOs and must be tested before they are included in the CMS-HCC Risk Adjustment Model.

The AGS also notes that methods to ensure accurate payment are often linked to quality measurement. This is explored in the National Quality Forum's (NQF's) report, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. We urge the working group to consider the potential unintended consequences, including lowering incentives to improve care for chronically ill individuals, if the most complex patients are likely to degrade the "performance" of the providers. We believe that the continuous improvement of performance measurement and risk-adjustment should be recognized. Simultaneously, payment changes should be consistent with stimulating and funding positive transformation without upending the financial stability of those who care for the most challenging populations.

#### **Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization**

The AGS urges CMS to develop a plan to encourage beneficiaries to designate a primary care provider (PCP). We recommend that CMS educate its beneficiaries that having a regular source of primary care is an important part of care, and that for most people high quality health care starts with having a relationship with a trusted PCP. Primary care is a key feature of all high-performing health care systems.

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

The AGS is very concerned that functional outcomes are not mentioned in the working group's list of proposed topic areas related to chronic conditions for CMS to include in its quality measures plan. As noted in the background section of this policy proposal, the Secretary of Health and Human Services under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) is required to give priority to outcomes measures, including functional status measures. We believe that basic functional outcomes such as ADLs are important to patients and families, predict other outcomes such as death and institutionalization and are assessed in many care settings, e.g. hospitals and nursing homes. If this data was reported, it could provide tremendous information to catalyze improvements in quality for beneficiaries with multiple chronic conditions. Additionally, we recommend that a requirement for studies of validity and feasibility are included in the development of new quality measures for chronic conditions.

#### **Encouraging Beneficiary Use of Chronic Care Management Services**

The AGS strongly supports waiving the beneficiary co-payment associated with the current chronic care management codes as well as the proposed high severity chronic care code described on page 11. The current co-payment is a real and psychological barrier to adoption of CCM both from the patient perspective (why should patients pay more for appropriate care management and coordination) and the provider (billing for co-payment).

**Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness**

The AGS supports the general goal of this proposal, however, believes that it is missing a key component by not bundling the assessment of Alzheimer's/dementia with counseling following initial diagnosis.

The AGS, along with support from the American Psychiatric Association (APA) and the American Academy of Neurology (AAN), recently submitted an application for a new CPT code that would address issues related to caring for patients with cognitive impairment such as dementia, management of symptoms, assessment of decision-making capacity, addressing caregiver stress, and other factors important to providing competent and comprehensive care. We urge CMS to adopt payment for such a service as described below.

Comprehensive assessment of and care planning for the patient with cognitive impairment, office or other outpatient, home or domiciliary or rest home, requiring an independent historian, with the following required elements:

- Comprehensive cognition-focused evaluation including a pertinent history and examination
- Medical decision making of moderate or high complexity
- Functional assessment (e.g., Basic and Instrumental Activities of Daily Living), including decision-making capacity
- Use of standardized instruments for stage dementia
- Medication reconciliation and review for high-risk medications
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s)
- Evaluation of safety (e.g., home), including motor vehicle operation
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
- Advance care planning and addressing palliative care needs
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (e.g., adult day programs, support groups) shared with the patient and/or caregiver with initial education and support

**Eliminating Barriers to Care Coordination under Accountable Care Organizations**

The AGS believes this is a complicated issue and while we believe that such changes to waive beneficiary co-payments are promising, we recommend that any changes be made through the rule-making process.

**OTHER POLICIES TO IMPROVE CARE FOR THE CHRONICALLY ILL**

**Study on Medication Synchronization**

Overall, the AGS supports the proposal to require a study to determine how to improve medication synchronization within Medicare Part D prescription drug plans (PDPs). Medication errors are a large contributor to poor outcomes, complications, and hospitalizations (readmissions), especially for Medicare patients who are frequently on multiple medications and see one or more specialists in addition to their primary care provider. We believe that synchronizing beneficiaries' medications to a



single refill date will help provide community pharmacists with the information that they need to raise potential red flags (e.g. Beers Criteria) and reconcile medications to avoid duplication.

However, we are concerned that beneficiaries will be charged the full co-payment for less than a one-month supply of a drug when they first request medication synchronization and therefore will be dissuaded from participating. For example, we have heard that patients offered to pick up their medications all at once through CVS's ScriptSync program are often interested until they learn that they will incur additional charges. We recommend that such a program in Part D PDPs adjust beneficiaries' co-payment for any drugs dispensed for less than the standard refill amount for the purpose of synchronizing medicines.

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The AGS greatly appreciates the opportunity to comment on proposals to improve the care of individuals with chronic and often complex conditions. Please do not hesitate to contact us, or AGS' Director of Public Policy Alanna Goldstein ([agoldstein@americangeriatrics.org](mailto:agoldstein@americangeriatrics.org)), if we can provide any additional information or assistance.

Sincerely,



**Steven R. Counsell, MD, AGSF**  
President



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