August 19, 2013

The Honorable Max Baucus
Chair
Senate Finance Committee

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee

The Honorable Dave Camp
Chair
House Ways and Means Committee

The Honorable Sander Levin
Ranking Member
House Ways and Means Committee

Dear Chairmen Baucus and Camp and Ranking Members Hatch and Levin:

LeadingAge appreciates the opportunity to contribute to the discussion among the Ways and Means and Finance Committees on policy challenges in Medicare coverage of post-acute health services.

To expand the world of possibilities for aging, LeadingAge members and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadingAge.org) includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. We promote adult day services, home health, hospice, community-based services, PACE, senior housing, assisted living residences, continuing care communities, nursing homes as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

We commend your committees' review of Medicare post-acute care payment policies and delivery systems. Our sector of the health care system too often is overlooked in healthcare policymaking. Post-acute care providers have an essential role to play in ensuring that Medicare beneficiaries receive the services they need when they need them in the setting most appropriate for the beneficiary.

This must be the ultimate goal of any revisions in present Medicare post-acute care policies. Providing the right services in the right setting, engaging beneficiaries in decision-making over their own treatment is the essence of the person-centered care in which we all believe. Post-acute care must be about services, not about settings.

To ensure a high-quality, cost-effective Medicare post-acute services system, it is essential to understand what services a beneficiary needs across the different settings in which the services might be provided. Delivery of services must not be driven by the present benefit structure or defined by current reimbursement systems.

Achieving well integrated, person-centered delivery of post-acute care will eliminate inappropriate use of expensive services, help to maintain beneficiaries' health rather than focusing on treating illness, and ensure effective transitions among the various levels of care. These reforms will result in greater cost-effectiveness in the Medicare programs as well as better health outcomes for beneficiaries.

We do not believe there is any need for Congress to panic over Medicare spending or jump to draconian cuts in coverage or reimbursement. The delivery system reforms being implemented under the Affordable Care Act already have had a beneficial effect on the trajectory of Medicare spending growth. In their most recent report, the Medicare trustees projected a two-year extension of solvency for the Medicare trust fund based on slower spending growth per beneficiary over the last two years. The CMS statement noted that:

> From 2010 to 2012, Medicare spending per beneficiary grew at 1.7 percent annually, more slowly than the average rate of growth in the Consumer Price Index, and substantially more slowly than the per capita rate of growth in the economy. Thanks in part to the cost controls implemented in the Affordable Care Act, spending is projected to continue to grow slower than the overall economy for the next several years. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-05-31.html

While there always is room for improvement and refinement of Medicare financing, the demonstration programs and other innovations initiated under health care reform provide a strong foundation for us to build on to improve post-acute care coverage.

Finally, we would challenge your committees to take a broader view of post-acute care. No discussion of our field is complete or accurate if it leaves out Medicaid, the most prominent public source of funding for long-term care. In testimony before the Long-Term Care Commission on August 1, Marilyn Moon, from the American Institutes for Research, pointed out the need to eliminate the artificial and counterproductive distinctions between the services covered by Medicare and those covered by Medicaid (http://www.ltccommission.senate.gov/Marilyn%20Moon%20Testimony.pdf). Unwillingness to taken Medicaid-covered services into consideration will continue the current cost-shifting between the two programs, between federal and state budgets and between consumers and providers.

Acute care providers, primary care and specialty care providers, and long-term services and support providers for years have provided services in their own care silos. This care vacuum leads to poor communication, mediocre care, and high hospital re-admission rates. It is during these transitional periods that older adults with chronic illnesses are most vulnerable.

The lack of integration between the Medicare and Medicaid programs creates a dilemma for many older people. Often, these individuals do not have enough income to pay for home and community-based services out of their own pockets. Yet, many have too much income or too many assets to qualify for home- and community-based services under Medicaid. Other payment

sources, such as Older Americans Act and Medicare funding provide only limited coverage for home- and community-based services. Waiver programs that allow states to use Medicaid dollars for home and community-based skilled care often have long waiting lists and strict eligibility requirements that prevent many Medicaid beneficiaries from receiving the home- and community-based services they need and deserve.

For care to be truly person-centered, individual needs must be assessed and met not only without regard to setting but also without regard to which program will fund the necessary services. Medicare and Medicaid today are silos and the distinctions between them must be broken down in the same way that silos separating hospital, residential, and home- and community-based services must be broken down. Only then will we have a truly cost-effective system of post-acute care.

Your committees also need to examine the services necessary to support Medicare beneficiaries in non-residential settings, especially following discharge from hospital care. It is true that post-acute services can often be provided outside of a hospital or skilled nursing facility. However, your committees need to take into consideration the family caregiving that makes it possible for services to be provided in a community-based setting without endangering a frail elder and risking rehospitalization. Medicare beneficiaries transitioning from hospital care frequently require social supports not funded by Medicare in order to remain at home. Family caregivers need training in complex medical care and other support in order to maintain their family member at home.

And the availability of affordable housing geared to the needs of frail elders also must be part of the long-term care equation. Without a place to live, Medicare beneficiaries cannot receive care and services "at home". The lack of affordable housing frequently is a barrier to discharging individuals from residential services into community settings.

Finally, technology promises to improve the quality and efficiency of services and quality of life by enabling seniors to function more independently, whether in residential settings or in their individual homes. Public and private investment in technological solutions is essential to sustainability of the long-term services and supports system.

Options for reforming post-acute care

Thought leaders from different political perspectives have agreed that "Americans … face a choice. Payers could simply shift costs to individuals. As those costs become more and more unaffordable, people would severely restrict their consumption of health care and might forgo necessary care. Alternatively, governments could impose deep cuts in provider payments unrelated to value or the quality of care. Without an alternative innovative strategy, these options will become the default. They are not in the long-term interests of patients, employers, states, insurers, or providers."[1]

[1]Emanuel, *et. al*., "A Systematic Approach to Controlling Health Care Spending," August 1, 2012, at NEJM.org; http://www.nejm.org/doi/full/10.1056/NEJMsb1205901

LeadingAge recommends the following principles for post-acute payment reform:

1) **Medicaid and Medicare, alone and when combined (as in a capitated system for dually eligible individuals), should meet the same standard for adequate payment.**

- System inequities must be resolved. A uniform standard of payment would better ensure participation by quality providers and increase beneficiaries' access to services. It would eliminate the cost-shifting between Medicare and Medicaid and mitigate that between private pay (self-pay and private insurance) and public programs.

- A uniform standard for payment should be accompanied by streamlining conditions of participation, forms, codes and other administrative issues. The current system is inefficient and burdensome; it requires providers and beneficiaries to deal with confusing federal and state differences when seeking payment for care.

- Determining the best way to establish uniform payment standards should include consideration of federal legislation to provide for unified rate-setting, or a system of managed negotiation in which Medicare and Medicaid receive the same rates for the same services.

2) **Effective enforcement is necessary to ensure that adequate payment is not just an unfulfilled promise.**

3) **Payment must be adequate for *innovative,* efficient care; Medicaid must change to promote greater efficiency without compromising quality.**

- The way to the future for the nation and Medicaid lies with innovating our way to better care at a sustainable cost.

- For many years, low Medicaid rates have mandated frugality, but opportunities for better use of resources and better care can still be seen. New payment standards must include incentives to foster innovation (e.g., shared risk across the continuum) and provide services in the most appropriate setting. The standards also must encourage more preventive services and establish fair systems of accountability for quality.

4) **Scarce resources should spent on the services that are most related to quality (such as direct care).**

- How payment incentives are structured is just as important as the payment amount. In fee-for-service nursing home payments, "modified pricing" models have proven successful. These might be supplemented by appropriate "pay for performance" methods.

- In managed care rates, "partial capitation" can be used similarly to ensure appropriate spending on direct care and other services particularly related to quality.

5) Higher margins might be used as incentives for desired goals (with accountability for achievement) where service supply is limited and thus access is an issue, but otherwise may represent unnecessary public costs that should be reduced.

- At present, publicly owned nursing homes and, to a lesser extent, private nonprofits shoulder a disproportionate share of service delivery in places where investor-owned companies do not see profit opportunities.[2] This is a form of cross-subsidization. To redress geographic disparities in setting rates would be to apply standard economic principles in service of public goals.

- Extremely high margins—far more than needed to provide a reasonable return or induce appropriate supply—are appropriate targets for public savings.

[2] See, for example: Jeffrey Ballou, "Do Nonprofit and Government Nursing Homes Enter Unprofitable Markets?" *Economic Inquiry*, Vol. 46, Issue 2, pp. 241-260. April 2008.

QUALITY

Committee questions:

- How to align payment with quality, including improvement in care transitions
- Quality measures already in existence or development that can advance payment reforms
- What gaps in quality measures exist?
- Quality measures that can be applied across settings?

In the section on Value-Based Purchasing, below, we discuss our recommendations on aligning payment systems with quality and improving care transitions.

Skilled nursing facility quality measures

It is important to recognize that skilled nursing facilities already are subject to an extensive and detailed system of quality measures and oversight. The Nursing Home Reform Act, incorporated into the Omnibus Budget Reconciliation Act (OBRA) 1987, established a federal-state oversight system that has involved the development and implementation of quality measures for every aspect of nursing home operations. We are now 26 years into the implementation of this oversight system.

The oversight system is geared toward ensuring that nursing home residents receive whatever services are necessary to maintain the resident at the highest practicable level of functioning, whether or not the services are reimbursed by Medicare or any other program. The system is based on regular assessments of residents' condition and the services they need. It includes federal quality standards, surveys by state agencies at least annually, potential follow-up surveys by federal officials, specific sanctions for care deficiencies, and electronic publication of nursing homes' staffing, health inspection and quality measure performance on the CMS website.

LeadingAge and its members have a long history of initiatives that have achieved measurable improvements in the quality of aging services. Advancing Excellence has helped nursing homes improve performance on specific clinical measures including pressure ulcers and pain management. Quality First enables LeadingAge members to demonstrate better results across the continuum of services, from nursing home and home health care through affordable housing. These initiatives emanate from longstanding not-for-profit values of our members.

However, nursing homes continue to experience tremendous challenges with the current regulatory system. As shown in our report, *Broken and Beyond Repair*, the overwhelming burdens of the survey and certification process are punitive to providers, misleading to consumers and do little to measure or support quality improvement. Numerous Government Accountability Office reports have confirmed the inadequacy of this process, with one report finding even state regulators find the process overwhelming unwieldy and unmanageable.

Public oversight needs to be based on contemporary evidence, best practices, transparency, and a system that is consistent and timely. Those same principles should be used in developing oversight mechanisms for future services. The current nursing home regulatory process needs re-evaluation and overhaul through a credible independent entity.

The OBRA '87 nursing home oversight system was based on a landmark report by the Institutes of Medicine, "Improving the Quality of Care in Nursing Homes". According to recent findings by the IOM, the Government Accountability Office, and other watchdogs, nursing home care generally has improved over the last quarter century, but concerns about quality remain. Some homes fail to improve despite the detailed survey and enforcement system mandated by OBRA '87. The GAO continues to identify numerous issues with the way standards are enforced by state and federal agencies under this process, including wide variations in the way survey issues are treated in different areas of the country.

The CMS Nursing Home Compare website notes the limitations of the present oversight system in helping consumers determine quality of care in any particular nursing home:

- *Variation Among States:* There are some differences in how different states carry out the inspection process, even though the standards are the same across the country.
- *Medicaid Program Differences:* There are also differences in state licensing requirements that affect quality, and in state Medicaid programs that pay for much of the care in nursing homes.

http://www.medicare.gov/NursingHomeCompare/About/Strengths-and-Limitations.html

One of LeadingAge's greatest concerns about the present oversight system is that it measures only compliance with minimal standards of acceptable care. The system does not attempt to encourage excellence, nor does it reward innovative, high quality nursing home care. Even the five-star rating system on CMS's Nursing Home Compare website does not attempt to designate which nursing homes are truly excellent. According to CMS, a five-star home is not necessarily excellent; it is "much above average."

The long-term services and supports field has changed dramatically over the last generation. Residential and community-based choices have proliferated, with the result that nursing home residents often are more frail and nursing homes may provide more sophisticated services than in the 1970s and 80s. Post-acute care in nursing homes allows increasing percentages of residents to return to their homes and communities. In addition to the federal and state survey and enforcement system, the field itself has pursued numerous initiatives to improve quality of care and quality of life for residents – Quality First, Advancing Excellence, and culture change, including Green Houses and the Eden alternative to mention a few.

We need to update our view of the nursing home field and federal and state efforts to ensure quality. We must determine whether the oversight system put in place by OBRA '87 still effectively measures and improves quality of care for residents as well as ensuring compliance with Medicare and Medicaid requirements for nursing homes participating in those programs.

LeadingAge recommends:

The Institutes of Medicine or some other objective, credible third party should examine the present nursing home oversight structure for surveying and evaluating nursing homes. The IOM should examine the objectivity and accuracy of the nursing home survey process and its effectiveness in promoting sustained compliance with quality standards.

In addition, the IOM should look at the present survey system's ability to accommodate efforts by states, nursing homes and other stakeholders to engage in innovative ways to pursue quality improvement.

Before this study and evaluation is completed, LeadingAge would have serious concerns about the use of the present skilled nursing facility oversight system or quality measures derived from it as a basis for payment reform.

Oversight should do more than indicate whether a nursing home is meeting minimal standards of decency. The process should incentivize and reward innovation and excellence in meeting the needs of residents.

Home health care

The Outcome and Assessment Information Set (OASIS) is used to assess Medicare beneficiaries' home health care needs and to establish individual plans of care. OASIS is based on a decade of research and refinement by the Centers for Medicare and Medicaid

OASIS elements include rehospitalization within 30 days of discharge and hospital emergency room use. OASIS therefore already measures some of the key elements your committees are looking to address.

If your committees consider using OASIS as a basis for payment reform, we would urge you to take into consideration the greater degree of risk home health care providers assume than do hospitals or skilled nursing facilities. Home health care providers can develop care plans and provide the services the plans indicate, but they have far less control over their clients' compliance with the care plan than do hospitals and nursing homes. Home health clients may need to seek hospital care for reasons beyond the control or responsibility of home health care providers.

As with nursing home residents, home health care clients are among the frailest Medicare beneficiaries and often have multiple health conditions. As discussed below, we would be concerned about any rehospitalization initiative that would penalize long-term care providers for necessary and appropriate use of hospital services.

ASSESSMENT TOOLS

Committee questions:

- To what extent can OASIS, MDS or IRF be used or modified to be the foundation for broader payment reforms like bundling and site-neutral payments?

- To what extent is the CARE assessment tool useful in determining appropriate setting? How can its accuracy be improved?

- What other tools are available to ensure beneficiaries get the right care in the right setting?

LeadingAge response:

CMS needs to wait and analyze the impact of moving to OASIS C1 for Home Health, the changes in coding and move to ICD10 before instituting additional changes to data collection and changes to the assessment tool.

VALUE-BASED PURCHASING

Committee questions:

- Should existing post-acute care systems be transitioned to VBP and if so, how quickly?

- What performance measures should be used to assess providers' improvement?
- to assess providers' improvement?
- What payment model should be used? Should it be based on rewards or penalties?

The U.S. spends twice as much on health care per capita as other western countries but ranks in the lowest quartile on many quality measures. Such high costs and suboptimal health system quality are driving the search for solutions that will increase the *value* of health care.

Value-Based Purchasing, also known as Pay for Performance (P4P), one of several strategies being tested and implemented for Medicare, bases payment to providers partly on meeting selected performance standards. The Centers for Medicare and Medicaid Services (CMS) is developing a similar payment strategy for skilled nursing that *may* be implemented in 2014; several states are experimenting now.

P4P, if well designed, should be part of the transformation of Medicare; the goal is to improve patient care. However, given the mixed results to date, ***well-designed*** is the critical challenge.

<u>LeadingAge proposes the following principles for performance measures:</u>

1) **Pay for performance must measure the right things.**

    - Medicare should reward high quality, patient-centered health care.

    - Performance measures should take into account quality of life and environmental factors that have been clearly demonstrated to make a difference in quality of care and life.

    - If nursing home survey data are used as part of the quality measures:

        – Only extremes on the negative side (e.g., immediate jeopardy/widespread) should be included.

        – The data must be standardized to factor out states' differences in surveyor practices.

    - Direct care staffing, case-mix adjusted, is a good proxy measure of quality, since considerable research has found staffing and quality consistently related.

2) **Performance measures must recognize differences among provider types (e.g., skilled nursing and home and community-based services).**

- Ideally, at least some core quality measures should be applicable to many different care settings.

- Setting-specific measures should take into account differences in the providers' goals and the people served.

3) Developing P4P systems for nursing homes requires coordination across Medicare and Medicaid and must take state Medicaid differences into account.

- Since the majority of nursing homes are certified for both Medicare and Medicaid, a federal P4P system for Medicare and a state's P4P system for Medicaid must not conflict (that is, do not judge a home's quality "poor" by one standard and "excellent" by another).

- As more states develop P4P systems, Medicare may need to consider state-specific quality measures, particularly when using survey results.

4) Performance measures must be credible, reliable and validated.

- Measures must be developed or ratified by an objective, qualified third party that operates transparently.

- Measures should not just be developed by a CMS contractor, then applied to payments without third-party scientific review and validation studies and a transparent, objective, fair process for adoption.

<u>LeadingAge proposes the following principles for rewarding performance:</u>

1) Pay for Performance must be structured to distribute rewards appropriately to achieve goals.

- The shared-savings bonus approach is a good reward system model. The bonus pool comes from total Medicare savings related to an episode of care (including all providers involved in it) with savings shared between Medicare and the participating providers.

- The P4P system should not include potential payment losses (below what payment would be if not participating) as long as the provider meets certification standards; meeting those standards is what the current payment is for. There is already a system of fines for deficient care in nursing homes.

2) Payment must be sufficient to make achievement of performance goals plausible.

- If the P4P system will require new investment by providers to qualify for a reward, then the reward should be reasonably related to the investment cost. System designers need to take into account the fact that nursing homes have been operating under severe financial pressures for years.

- The system could be Medicare budget neutral while still affording the potential for increased payments for demonstrated higher quality and ensuring that total Medicare system savings (from fewer unnecessary hospitalizations, for example) are shared with high-performing nursing homes.

LeadingAge proposes the following principles for implementation:

1) The administrative burden on providers must be minimized.

- Data collection should incorporate relevant, existing, quality-related databases to the degree possible.
- Data collection should focus on evidence-based, scientifically provable behaviors, processes and outcomes.

2) Successful implementation requires an appropriate infrastructure (such as electronic records).

- Information technology must support quality care and include efficiencies that allow for *more time dedicated to direct care.*
- Information technology should support the ability to link quality measures to actual performance, separate from survey or customer satisfaction data.
- Similar to Medicare P4P for physicians and hospitals, P4P for nursing homes should include added compensation for meaningful use of technology, particularly for small, rural providers.
- System infrastructure should be designed to support the ability to communicate across settings.

3) A feasible, credible validation process is required.

- The validation process must be standardized and uniform across states.

4) An appropriate public reporting system must be developed.

- Just as the individual P4P measures must be credible, reliable and validated, with a transparent process governing their adoption, so too must be the system for public reporting of performance results.
- Developing a valid public reporting system requires more meaningful expert and stakeholder participation than has been the case with the "Nursing Home Compare" reporting system.

Home health care

For Medicare coverage of home health care, the pay-for-performance demonstration has shown us that savings can be achieved when an incentive system is established that rewards home health agencies for providing quality services.

The report on value-based purchasing still leaves us with questions as to how such a payment system would work. CMS needs to continue to obtain stakeholder feedback on value based purchasing, and move forward to implement a value-based purchasing payment system for home health. This type of payment system discourages inappropriate utilization of home health services.

For hospice, we agree with MedPAC that a u-shaped curve type of payment system that pays the hospice a higher payment during the initial period of hospice, decreases payment after the care plan and services are in place, and has a retroactive payment when hospice services are discontinued to cover the more expensive end of life care services. It is important that CMS move forward with a new payment system for hospice that covers the cost of care for individuals on hospice that have diverse clinical needs.

We also encourage Congress to move forward with the demonstrations from the Affordable Care Act that are showing savings to Medicare. We are especially interested in seeing outcome results from the Community-Based Transitions program and the Independence at Home program. We believe that these two demonstrations could have a major impact on improving the quality of care transitions from the hospital to home.

HOSPITAL READMISSIONS

Committee questions:

- Should there be a broad readmissions program for all post-acute care providers or only certain types?

- What payment model should be used, shared savings or penalties?

- What measures should be used – all-cause or exceptions for non-preventable admissions (like accidents)? How well-developed are these measures? Should any condition-specific measures be used?

- How soon should the program begin?

- What are the pros and cons of a SNF readmissions program as called for by MedPAC and the President's budget?

LeadingAge response:

We see the expansion of the present hospital readmissions initiative that focuses on hospital care to one involving post-acute care as a likely progression.

We would favor a shared savings approach over penalties. Shared savings are a positive incentive for providers. In addition, improving performance may involve investments in staffing and technology that are costly to the individual provider while ultimately resulting in savings to the system as a whole. We see it as only fair that providers who have invested in improving their performance should share in these savings.

We would point out that Medicare beneficiaries receiving skilled nursing facility or home health care are more likely than the general population to have a number of health care conditions, any one of which can require hospitalization. We don't feel that hospitalizations for unrelated health conditions or events should count against a provider that has performed acceptably.

Before a readmissions program could begin, CMS would have to complete research and evaluation, similar to what has been done for the acute care sector.

In the meantime, several initiatives are under way to improve transitions between acute and post-acute care, integrating services in order to prevent rehospitalizations. We see these more comprehensive approaches as more promising than a change in Medicare payment policies alone as a means of both preventing hospitalizations and ensuring that beneficiaries receive essential services:

Transitional Care Nurse Model

Mary D. Naylor, Ph.D., R.N., Director of the New Courtland Center for Transitions and Health at the University of Pennsylvania, School of Nursing, developed the "Transitional Care Nurse" model.

This model designates staff to follow enrolled patients from hospitals into their homes, and using an evidence-based care coordination approach, provides services designed to streamline plans of care and interrupt patterns of frequent acute hospital or emergency department use and health status decline. The transitional care nurse collaborates with patients' physicians in the implementation of tested protocols with a unique focus on increasing patients' and caregivers' ability to manage their care. The transitional care nurse is an expert in providing comprehensive care to the chronically ill, versed in national standards of care delivery, and experienced in providing both acute and community-based services. Transitions from acute to community and transitions in health status are monitored and managed to improve patient care and outcomes. Each nurse is in charge of a caseload of 15 to 20 patients, with an average of 18 patients. The nurse also helps the patient's family/caregivers to achieve their goals as a caregiver.

Project BOOST

Another promising model is the "Better Outcomes for Older Adults through Safe Transitions" (BOOST) program. Project BOOST helps hospitals reduce re-admission rates by providing them with proven resources and expert mentoring to optimize the discharge transition process, enhance patient and family education practices, and improve the flow of information between inpatient and outpatient providers. BOOST has four key components:

1. A comprehensive intervention based on the best available evidence.
2. A comprehensive BOOST "Implementation Guide" that provides instructions and project management tools to help multi-disciplinary teams to plan, implement and evaluate the intervention.
3. The BOOST "Mentoring Program" is provided courtesy of a grant from the John A. Hartford Foundation, and includes face-to-face training for hospital staff and a year of expert mentoring and coaching to revise the discharge process and implement BOOST.
4. The BOOST "Collaborative" has been established so staff at BOOST sites are able to communicate with and learn from each other via the BOOST Listserv, online community site, and quarterly all-site teleconferences.

This program was initiated in Sept. 2008. Early reports from Project BOOST sites are promising.

- At Piedmont Hospital in the Atlanta area, the rate of re-admission among patients under the age of 70 participating in BOOST is 8.5 percent, compared with 25.5 percent among non-participants. The re-admission rate among BOOST participants at Piedmont over the age of 70 was 22 percent, compared with 26 percent of nonparticipants.

- When St. Mary's Medical Center in St. Louis implemented BOOST at its 33-bed hospitalist unit, 30-day re-admissions dropped to 7 percent from 12 percent within three months. Patient satisfaction rates also increased markedly, from 52 percent to 68 percent.

Guided Care

The Guided Care™ program, developed at Johns Hopkins University in Baltimore, Maryland, strives to meet the growing challenge of caring for older adults with chronic conditions and complex health needs. At the center of the model is a "Guided Care Nurse," who works with the older consumer's primary care physician to assess the consumer and caregiver at home, create an evidence-based care plan, monitor the consumer's condition, coordinate care transitions and promote patient self-management through coaching, education and access to community resources. A pilot study found that Guided Care™ resulted in greater consumer satisfaction and lower insurance costs. In a pilot study, patients who received Guided Care rated their quality of care significantly higher than usual care patients. The average insurance costs for Guided Care patients were 25 percent lower over a six month period.

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Medicare Medical Home

The Medicare Medical Home Demonstration, authorized under the Tax Relief and Healthcare Act of 2006, tested a re-design of the primary healthcare delivery system to provide targeted, accessible, continuous and coordinated, patient-centered care to high-need populations. The Medical Home is a good example of collaborative efforts on the provider level that help older people manage their chronic conditions and avoid hospitalizations.

A consumer's medical home is centered in a primary healthcare setting, where a partnership develops between the patient, his or her family, and the primary healthcare practitioner. These partners work together to access all medical and non-medical services the consumer needs. To promote coordination and continuity of care, the Medical Home maintains a centralized, comprehensive record of all health-related services. It is conceivable that an ACO could consist of a group of medical homes partnering with a hospital.

Dr. Eric Coleman, of the University of Colorado, developed the Care Transitions Program. The model has the following components:

• A patient-centered record that consists of the essential care elements for facilitating productive interdisciplinary communication during the care transition.
• A structured list of critical activities designed to empower patients before discharge from the hospital or nursing facility.
• A patient self-activation and management session with a Transition Coach™ in the hospital, designed to help patients and their caregivers understand and apply the first two elements and assert their role in managing transitions.
• A Transition Coach™ who will make follow-up visits in the skilled nursing facility and/or in the home and make accompanying phone calls designed to sustain the first three components.

Dr. Coleman focuses the intervention with the patient on what he calls The Four Pillars™:

1. Medication self-management: A patient is knowledgeable about medications and has a medication management system. A "Medication Discrepancy Tool" helps remedy transition-related medication problems.
2. Use of a dynamic patient-centered record: A patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure the continuity of the care plan across providers and settings. The patient or informal caregiver manages the PHR.
3. Primary care and specialist follow-up: A patient schedules and completes follow-up visits with the primary care physician, or specialist physician, and is empowered to be an active participant in these interactions.
4. Knowledge of red flags: A patient is knowledgeable about indications that their condition is worsening and knows how to respond.

http://www.caretransitions.org

Stanford Self-Management Program

The Stanford Patient Education Research Center has developed, tested, and evaluated self-management programs for people with chronic health problems. All of these programs are designed to help people gain self-confidence in their ability to control their symptoms and how their health problems affect their lives. This model uses small-group workshops that generally meet for six weeks. Meetings are held once a week, lasting about two hours, and are led by a pair of lay leaders with health problems of their own. The meetings are highly interactive, focusing on building skills, sharing experiences and support. Kaiser Permanente and Group Health Cooperative of Puget Sound have adopted the Stanford Chronic Disease Self-Management Program.

BUNDLED PAYMENT EPISODES AND MANAGED CARE FOR AGING SERVICES

Committee questions:

- Pros and cons of the 4 bundling models undertaken by CMMI?
- Other models?
- How to ensure providers in bundling situations don't stint on care or upcode?
- What factors should be taken into account in determining payment?

LeadingAge response:

Environmental pressures are driving changes in payment and service delivery systems. Federal and state budget pressures require effective cost containment. Yet, if cost containment drives down quality and access, beneficiaries and providers all suffer. The challenge is to achieve greater value by creating better systems of care and improving outcomes through person-centered best practices.

LeadingAge proposes the following principles, applicable to Medicare, Medicaid and private sector services:

1) **Systems must be driven by empirical evidence and study of best practices at every stage of development and operations. The urgency for system improvement must be matched with vigorous study, evaluation and dissemination of evidence-based solutions and best practices.**

a. **System developers must take the long view of system improvements. They must take the time needed to figure out how to achieve difficult reforms and implement appropriate monitoring systems.**

- New models can spur needed changes in coordinating care, improving quality, and measuring and rewarding good performance. But rushing headlong into uncharted waters, seeking quick budget fixes, risks missing the longer-term goals of achieving better systems and patient outcomes.

- It is not yet apparent how adding an insurance company or other entity (with its need for profit and overhead) between Medicaid/Medicare and service providers will lead to lower costs without harming beneficiaries. So far, Medicare Advantage has cost more than fee-for-service, and states' limited experience with Medicaid managed care for long-term services and supports (LTSS) has shown that better care is possible, but difficult, while state savings have been elusive.

- When implementing these new systems, states should "communicate a clear vision for managed [LTSS] to promote program goals," and "recognize that moving from a

1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing, and plan accordingly."[3]

- Two core areas states should focus on when implementing Medicaid managed care systems that include an entity such as a managed care organization (MCO) between Medicaid and the service providers are: " rate setting, including paying MCOs rates that are 'enough but not too much' to ensure the rates do not create incentives for MCOs to restrict or deny care; and contract monitoring and performance improvement, including the use of software or on-site audits to review MCO submission of required data as well as financial incentives or bonuses to MCOs that meet or exceed performance targets."[4]

b. New models must preserve access and quality for individuals and families.

- The care delivery system should be focused on person-centered, person-directed care; it should be rational and comprehensible.

- Patient choice and patient responsibility must be part of the process.

- We need to work toward a better, common understanding of the essential characteristics of quality that can be formally evaluated around specific criteria. Study and dialogue must include perspectives from across the care continuum with acute care learning from aging services and vice versa.

- When implementing Medicaid managed care systems, "states need to ensure that enrollees and their caregivers have access to a wide range of services and that the care is coordinated across many types of providers and care settings."[5]

- When implementing these new systems, states should "ensure that program design addresses the varied needs of beneficiaries" and "includes attendant care and/or paid family caregivers in the benefit package." States should "recognize that performance measurement is not possible without LTSS-focused measures" and should "establish robust contractor oversight and monitoring requirements."[6]

- Three of the five core areas that states implementing Medicaid managed care should focus on are: "provider networks and access to services, including visits to providers and 'mystery shoppers' to ensure that all providers on MCO network lists are available and accessible to enrollees; quality assurance and improvement,

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[3] "Top ten mileposts for reaching effective managed long-term supports and services delivery: best practices for states," in *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, SCAN Foundation, November 2010.

[4] AARP: *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*, July 2012. See: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf

[5] "Keeping Watch…"

[6] "Top Ten Mileposts…."

including using real-time service-monitoring tools such as electronic visit verification systems to monitor home care delivery; and member education and consumer rights, including ombudsman programs specifically aimed at investigating and resolving enrollee problems."[7]

c. New systems must incorporate reasonable expectations for risk taking, and include meaningful opportunity for providers to participate in system design.

- These systems should include shared risk based on an empirical model that takes into account the complexity of aging services for people with multiple needs and co-morbid conditions.

- While it is essential to personalize care, better quality and use of resources can be achieved by standardizing many processes based on research and best practices.

- For risk to be reasonable, systems must provide for tracking outcomes and improving processes.

- When implementing these new systems, states should "engage stakeholders to achieve buy-in and foster smooth program implementation."[8]

2) New models must promote innovative relationships between hospitals and the full continuum of aging-services providers.

a. Public payment program rules must create a level playing field so aging-services providers can share in appropriate risks and rewards.

- There should be shared incentives for all providers that participate in an individual's care. Physicians, hospitals, residential care providers, home and community-based services—all are important to success.

- Goals should be mutual, not conflicting; incentives must be aligned across all providers to promote optimal transitions and services.

- When implementing these new systems, states should "develop financial incentives to influence behavior and achieve program goals" and "structure benefits to appropriately incentivize the right care in the right setting at the right time."[9]

b. New systems should include technical assistance and development of tools (by the public and private sectors) to help those in rural and underserved urban areas participate.

[7] "Keeping Watch…"
[8] "Top Ten Mileposts…"
[9] "Top Ten Mileposts…"

- Just as it is important that providers across the continuum (from acute care to community aging services) be included, so too is it important that intense focus on change not leave behind those providing critical services in less advantaged areas.

c. **Emphasize development and dissemination of interoperable electronic health records and other technologies that include aging services across the continuum.**

- LeadingAge and many member providers are currently leaders advancing this field, but the issue is so critical it mandates mention in this list of principles.

- When implementing these new systems, states should "use a uniform assessment tool to ensure consistent access to necessary LTSS."[10]

[10] "Top Ten Mileposts…"

SITE NEUTRAL PAYMENTS

Committee questions:

- Are some post-acute settings more ready for this than others?
- Pros and cons of MedPAC's site neutral approach between long-term care hospital and inpatient payment systems?
- Pros and cons of President's site neutral proposal between SNF and IRF reimbursement?
- Aside from MedPAC and President's proposals, any other site-neutral policies close to ready for prime time?
- What criteria should be used to assess appropriateness of payment for the site and condition?
- Pros and cons of either equalizing payments between two different settings or narrowing the gap?
- Do any policies validate differences in reimbursement between settings?

LeadingAge response:

The Committee's questions about site neutral payments include two asking for comments (e.g., pros and cons) on various proposals related to site neutral payments between SNFs and IRFs (inpatient rehabilitation facilities).

LeadingAge's view of that was very well stated by Dr. Barbara Gage (a noted researcher on the topic) at an August 1 2013 public hearing of the Federal LTC Commission. One of the Commissioners asked Dr. Gage "Do you have an opinion on site-neutral payment, where you are paid on the services delivered instead of necessarily the setting?"

In response, as recorded in the transcript, Dr. Gage said:

"Site-neutral payment is a very loaded term that has come out of those interested in post-acute care, and I would define it first, to say that if we are talking about site neutrality of the [part of a per case or per diem] rate associated with the case mix, then it makes sense. Why would you pay a different amount for a PT under home health than you pay for that PT in the outpatient department? There are additional facility-specific costs that also need to be taken into account. And when people talk about site-neutral, they often throw all that into one. Those [i.e., the facility-specific part of the rate] should not be standard [i.e., the same for all]."

LeadingAge does not support site neutral payment proposals (that we have seen to date) regarding neutrality between SNFs and hospitals (i.e., PPS hospitals, IRFs, or any such entity that is required to meet hospital-level conditions of participation). There are meaningful

differences among such entities (facilities), with regard for example to physician and other staffing that affect cost but are not well measured in current "resource utilization" research—they are excluded in "case-mix" payment differences. Many of the factors that affect those (unmeasured in case-mix) facility costs are important to quality. But one cannot assume that most, and certainly not aspects of quality are captured in the still primitive quality indicators we have now.

In brief, LeadingAge does not support the proposals we have seen, urges the Committee to look at any submitted with particular care and recommends that established independent experts be asked for their advice as well.

OTHER ISSUES

- What is the ongoing role of fee-for-service?

Leadingage Response: Fee-for-service will, for a long time, be the basis for payment of much of health care. To meet the triple aim of quality, improving population health and reducing costs, fee-for-service payment models must 1) include balanced incentives that do not merely drive volume as the single reward; 2) link payment in some fashion to measures of individual and population care quality; 3) reward activities that are time-consuming, person-centered and as yet not recognized for reimbursement – such as team-based conversations with patients about advanced illness planning and care preferences.

Considering the general health status of Medicare beneficiaries in post-acute care, it is especially important that payment systems not create disincentives to serving people with complex chronic care needs.

- What percentage of reimbursement should be put at risk to incentivize participation in alternatives to fee-for-service? What entity should manage payments?

LeadingAge response: Part of this first question relates to what the incentive program is and who has developed it…is it valid? Does it create other unintended negative consequences? Can providers all equally participate or does the incentive skew to particular providers or groups? Initially, immature and untested incentives should not be greater than 5% and probably more structured and tested incentive plans should not exceed 30% - based on earlier health plan physician pay for performance experience. Ideally a third party who has access to the data, but no conflicts that bias results should be the managing entity.

- What patient and facility data are needed to design payment systems?

LeadingAge response: Meaningful process and outcomes data – both at an individual AND at a population level. Such data should include not only cost and negative events, but measures of patient experience and effective care coordination. Data sets need to be developed to capture what is meaningful for different populations (eg: HEDIS measures of health care prevention have little value to providers who focus on patients of advanced age or at end of life). Currently we are driven by the data we can easily collect administratively through claims – and thus our measurement drives our care. We need to identify what data we REALLY need to change care delivery and then identify mechanisms to collect it (eg; patient experience of care).

- To what extent do related policies like the three-day stay rule, anti-kickback statutes, etc. need to be modified to accommodate payment reform (away from fee-for-service)? Would providers be willing to take more financial risk in exchange for modification of these policies? Any existing policies that must remain in place if the remnants of fee-for-service remain?

LeadingAge response: There will always be a need for criteria for payment and qualifications for services and settings, as well as for protecting the Medicare program, beneficiaries and the

taxpayer. In the meantime, it is important that problems with the current system continue to be addressed by Congress, including revising the 3-day stay rule so that observation days are counted (S. 569, H.R. 1179) and either eliminating restrictions on outpatient therapy (S. 367, H.R. 713) or continuing the therapy caps exceptions process.

- How will payment reforms lower federal spending? What types of efficiencies can be expected?

LeadingAge response: Care that is based in informed-decision making WITH the patient and the providers, care that reduces redundancy and wasteful duplication, care that reflects individual preferences towards end of life, care that minimizes costly errors, and care that meets individuals' needs in the setting where they need to be (rather than the setting reimbursement dictates) is better care and CONSIDERABLY less expensive.

BENEFICIARY PROTECTIONS

Committee questions:

- How to ensure beneficiaries get care in the appropriate setting?

  LeadingAge response:

  Aging and Disability Resource Centers, managed care case coordinators, and hospital discharge planners all should educate Medicare beneficiaries leaving the hospital as to what services they need to reduce the chance of a hospital re-admission.

- Should beneficiary preferences be accommodated, and if so, how?

  LeadingAge response:

  We believe that the beneficiary needs to be aware of all the provider options that are available for them. Beneficiaries need adequate, impartial information to make responsible, informed decisions. While the beneficiary's preferences are important, there need to be appropriate medical criteria for eligibility for care in a skilled nursing facility, home health, or hospice.

- How to prevent incentives for cherrypicking or inappropriately reducing care?

  LeadingAge response:

  Developing a payment system for both hospice and home health that is not tied to the number of visits, rewards quality, contains a risk adjustment factor for individuals requiring more clinically complex care would reduce the incidences of home health and hospice agencies from cherrypicking cases or inappropriately reducing care.

- How should beneficiary cost-sharing be addressed under new payment systems?

  LeadingAge response:

  There needs to be research on cost sharing for Medicare home health before implementing a new copay for Medicare beneficiaries. Our concern is that cost sharing could lead low-income Medicare beneficiaries who are not eligible for Medicaid to refuse needed skilled home health services because they are unable to afford a copay.

  We also are concerned that state Medicaid programs may not pay the co-pays for dually eligible beneficiaries, as happens with skilled nursing care. This could lead some home health agencies to deny services for these individuals.

- How to encourage beneficiaries to more appropriately choose post-acute services other than by cost-sharing?

LeadingAge response:

We believe that programs such as medical home and other programs that provide a care manager to assist the beneficiary in the process of obtaining the most appropriate post-acute service is the key to more cost-effective decisions on what type of services to use after a hospital stay.

It would be useful for the committees to look at the Program of All-Inclusive Care for the Elderly (PACE) program as an example of cost-effective post-acute and long-term services.

PACE organizations use capitated payments from Medicare, Medicaid and, to a limited extent private payers, to create a pool of funds that meet the needs of their participants. These funds allow PACE to provide all the care and services covered by Medicare and Medicaid, as approved and coordinated by a PACE interdisciplinary team.

As a flexible model of care, PACE can also provide medically-necessary care and services that are not covered by Medicare and Medicaid. Since PACE organizations assume the full financial risk for care, the program has built-in financial, quality, and consumer choice incentives. For example, PACE provides preventive care as a way to avoid a more expensive level of care, such as a nursing home placement, down the road.

The all-inclusive component of PACE means that clients receive a coordinated package of care and services that combines primary and acute medical services with institutional and community-based long-term services like adult day and in-home services, meals, and transportation. While housing is not part of the PACE benefit package, many PACE organizations have developed partnerships with housing providers in order to maintain frail seniors in the community.

CONCLUSION

LeadingAge greatly appreciates the opportunity to comment on these issues that will have a far-ranging impact on the long-term services and supports field.

If you have questions on any of our comments or would like to discuss them further, please contact Marsha Greenfield, Vice President for Legislative Affairs, mgreenfield@leadingage.org.