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SUBMITTED ELECTRONICALLY VIA
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Amy Bassano
Center for Medicare and Medicaid Innovation
ATTN: CMMI New Direction – Informal Request for Information
2810 Lord Baltimore Boulevard
Baltimore, MD 21244-2613

Re: CMMI New Direction – Informal Request for Information

Dear Ms. Bassano:

The American Geriatrics Society ("AGS") greatly appreciates the opportunity to comment on the Center for Medicare and Medicaid's Innovation's (CMMI) informal request for information (RFI) on its new direction. The AGS is a not-for-profit organization comprised of over 5,000 physician and non-physician practitioners who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to improve the health, independence, and quality of life of all older people.

Older persons with chronic illnesses and geriatric conditions frequently do not receive the recommended standard of care, and account for a disproportionate share of healthcare expenditures. Improved care for patients with multiple chronic conditions has been identified as one approach that has high potential for cost savings by reducing preventable hospitalizations as well as helping older adults with multiple chronic conditions have a higher quality of life and age in place. Studies have shown that models of geriatrics care can make a critical difference.

The RFI includes six guiding principles. We are especially supportive of those around provider choice, patient-centered care, transparency and participation among stakeholders, and testing of small scale models. Patient-centered care in particular is critical for our population and should also consider the importance of effective healthcare teams that include professionals with the expertise needed to provide this type of care. Coordination of care across settings is also key. Ultimately, the success of models tested by CMMI will depend not only on operationalizing these guiding principles, but also on the skills and training of healthcare providers delivering the care to older patients with complex conditions.

COMMENTS ON POTENTIAL MODEL AREAS DESCRIBED IN RFI

Physician Specialty Models

Older adults with complex and chronic conditions often suffer from overly fragmented, specialty-driven care. For this population, isolated physician specialty models do not have proven effect. Engagement between primary and specialty care and care planning are essential to high-quality care for older adults. ***CMS should prioritize models that promote collaboration between primary care providers and specialists.***

Prescription Drug Models

Pharmacists have been proven to be very effective in managing transitions from the hospital to the home by seeing patients in clinics, office practices, and in the home for post-discharge and/or post-acute care. These interventions help avoid the use of potentially inappropriate medications among Medicare patients who are frequently on multiple medications. ***CMS should pursue approaches that integrate appropriately trained pharmacists in healthcare teams outside of the pharmacy.***

Medicare Advantage (MA) Innovation Models

MA plans continue to be a focus of innovation initiatives and provide opportunities to improve the health and function of individuals who live with multiple chronic conditions. ***MA plans should engage geriatrics trained leadership for input in creating a business plan to incorporate geriatrics-specific approaches to care. Where possible these plans should adopt proven geriatrics models or key components of evidence-based models. MA plans could also be required to adopt payment policies that traditional Medicare deems valuable, such as payments that support Advanced Primary Care, whether through specific procedure codes or care management fees.***

State-Based and Local Innovation, including Medicaid-focused Models

The AGS welcomes opportunities to partner with states on developing local innovations, particularly for dually eligible populations such as nursing home patients. However, ***there is a need for support for carefully designed and implemented waivers to create opportunities for state and local innovations.***

Mental and Behavioral Health Models

Behavioral health needs are significant throughout life for many patients, and are especially important for older adults. Parity is a high priority for the AGS. Behavioral healthcare services 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 an option for these patients and others in rural areas. ***The AGS is part of the Leaders Engaged on Alzheimer's Disease (LEAD) coalition that has made recommendations around evidence-based models of dementia care that could be scaled and tested by the Innovation Center.***

GERIATRICS CARE MODELS

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. Models, for example, that reinforce the patient-provider relationship might prove superior to usual care and other new financial models that are potentially cumbersome for and confusing to older adults, their family caregivers, and their medical providers.

CMMI has already invested in the development of some innovative care models for geriatric patients. The Enhanced Care and Coordination Provider (ECCP) Initiative, for example, is focused on reducing avoidable hospitalizations for long-stay nursing home residents. The final evaluation report of Phase 1 describes positive results, particularly for those care models that directly provided services to residents. ***Following initial development and testing, CMMI should support approaches for scaling up models like the ECCPs to reach a greater number of frail older adults.***

In addition, ***we urge CMMI to identify and apply policy levers that support the market expansion or adoption into Medicare of other geriatrics care models that have been shown to improve care for beneficiaries with chronic conditions.*** Below we have highlighted a few of these models. This list is not meant to be comprehensive or prioritized. AGS leadership would welcome the opportunity to discuss these and other specific care models in further detail.

Programs for All-inclusive Care for the Elderly (PACE) is a managed-care program that was developed to enable individuals to live independently in the community, rather than a nursing home, with a high quality of life. Several evaluations of the program have shown PACE to be effective in creating cost-savings and improving quality of life for frail older adults.

There is an opportunity now for CMS to move forward without delay on innovative PACE-like models that could address the needs of multiple populations and align with CMMI's future direction. The AGS supports the following recommendations submitted by and outlined in further detail by The National PACE Association (NPA).

- PACE-like Pilot: At-Risk Medically Complex Beneficiaries
  NPA recommends that CMS implement a PACE-like pilot to address the needs of medically complex Medicare and/or Medicaid beneficiaries who are at-risk of needing nursing home level of care. NPA shared a framework for this pilot—*At Risk Medically Complex*—with CMS in September 2016. Such a pilot would aim to delay nursing home eligibility and improve other patient-centered outcomes, such as function and mental health, by streamlining care delivery for at-risk medically complex beneficiaries, through the integration of medical care and long-term services and supports (LTSS), thereby creating efficiencies for states.

- PACE-like Pilot: Medicare-only Beneficiaries
  NPA has also outlined a pilot program focused on expanding Medicare beneficiaries' access to PACE in states that have not elected PACE as a Medicaid option. Expanding access to PACE would provide Medicare beneficiaries with a more coordinated, integrated, and cost-effective alternative to existing LTSS options. This pilot also has the potential to delay Medicare beneficiaries' spend-down to Medicaid thus creating savings for states.

- PACE as an Advanced Alternative Payment Model (APM)
  NPA recommends that CMS recognize PACE as an Advanced APM. CMMI should use its demonstration and waiver authorities to recognize the PACE model as currently configured as an Advanced APM and to allow PACE contract clinicians to apply their PACE patient care towards reaching Qualifying Participant status.

Patient-Centered Medical Homes (PCMHs) for Older Adults actively engage patients and their caregivers in care provided by clinicians in primary care practice. Studies show that PCMHs have many benefits, including better quality, patient experience, continuity, prevention, and disease management. For more information visit: https://pcmh.ahrq.gov/

A PCMH model for older adults could focus on medically underserved communities, rural areas, and primary care providers' practices. In addition to total costs of medical care compared to usual FFS (or MA) medical care, important metrics would include patient satisfaction, quality of life, mental health, hospital admissions/readmissions, utilization of subspecialty consultations, and physical functioning and independent living of beneficiaries. Higher payments to providers (e.g., as planned under MACRA) would create a financial incentive for small group practices or alliances of solo practitioners to participate in the PCMH and patients could be incentivized to participate based on the additional services and benefits offered (e.g., pharmacist consultation). More information about PCMHs for older adults can be found in a recent White Paper entitled *Patient-Centered Medical Homes and the Care of Older Adults*.

The Independence at Home (IAH) Demonstration model provides home-based primary medical care to older adults with severe chronic illness and disability. An interdisciplinary team coordinates all medical and social services, providing better clinical care and patient experience. Each program delivers 24/7 medical care to help avoid preventable emergency room visits and hospitalizations. In 2012, CMS launched the Medicare IAH demonstration which was active through September 2017 in 16 sites around the country and had enrolled over 10,000 beneficiaries. CMS found that IAH practices saved over $35 million during the first two performance years. Years 1 and 2 cost savings is 11 percent annually, produced by the IAH demonstration that saved money. CMS accrued $19 million in IAH demonstration savings and almost $17 million in savings were earned by 9 out of the 17 programs that saved more than 5 percent. Year 5 concluded on September 30, 2017. Legislation to extend the demonstration passed the Senate (S.870), and advanced out of the full House Energy and Commerce Committee (H.R.3263) in September 2017. We look forward to the two year extension included in these bills and are working with the American Academy of Home Care Medicine and others on legislation to convert the IAH demonstration into a permanent, national Medicare program. For more information visit: https://innovation.cms.gov/initiatives/independence-at-home/.

Maximizing Independence (MIND) at Home intervention is designed to systematically assess and help address unmet needs that may be barriers to persons with Alzheimer's disease or related dementias remaining in their home, while maintaining their health and wellbeing and that of their caregiver. MIND at Home links people with dementia and their caregivers to community-based agencies, medical and mental healthcare providers, and community resources. The model is delivered by a Memory Care Coordinator and an interdisciplinary team who use six basic care strategies—resource referrals, attention to environmental safety, dementia care education, behavior management skills training, informal counseling, problem-solving—as well as ongoing monitoring, assessment and planning for emergent needs. Research studies funded by an innovation grant from CMMI and multiple private foundations have shown improvements in patient and caregiver outcomes related to this intervention. For more information visit: http://www.mindathome.org/

GRACE Team Care™ provides home-based, integrated geriatric care by a nurse practitioner and social worker who work with the office-based primary care physician and a larger interdisciplinary team to develop an individualized and person-centered care plan incorporating chronic disease management and protocols developed for the treatment of 12 targeted geriatric conditions (e.g., dementia, depression, falls, etc.). GRACE has improved care quality and outcomes, and lowered the cost of care in

high-risk Medicare beneficiaries by reducing emergency department and hospitalization rates. The GRACE program has been successfully applied to a variety of health systems and health plans such as MA, ACOs, medical groups, and VA Medical Centers around the country. For more information visit: http://graceteamcare.indiana.edu/home.html

Guided Care is driven by a highly skilled registered nurse in a primary care office, who assists three to four physicians in providing high-quality care for patients with complex and chronic conditions. Under the program, the nurse provides eight services including: assessing, planning care, monitoring, coaching, chronic disease self-management, educating and supporting caregivers, coordinating transitions between providers and sites of care, and access to community services. A one year pilot study in urban Baltimore, Maryland, found that Guided Care recipients experienced more improvement in the quality of their care compared to similar patients who received usual care. In addition, insurance claims revealed that the costs of healthcare were lower for the Guided Care patients than for the usual care patients. For more information visit: http://www.guidedcare.org/

Acute Care for Elders (ACE) is an interdisciplinary service that generally incorporates a modified hospital environment (e.g. safe mobility and a homelike atmosphere); early assessment and intensive management to minimize the adverse effects of hospital care; early discharge planning; and patient-centered care protocols. Over the last two decade, these units have been introduced in hospitals nationwide. Research evaluating outcomes for older adults admitted to ACE versus usual care has shown improved processes of care, prescribing practices, physical functioning, restraint rates, and patient and provider satisfaction as well as reduced nursing home placement, length of stay, costs, and readmissions. For more information visit: http://www.uhhospitals.org/cleveland/services/geriatric-services/services/acute-care-for-the-elderly

The Hospital Elder Life Program (HELP) is a comprehensive, evidence-based, patient-care program that provides optimal care for older persons in the hospital. HELP was originally designed to prevent delirium among hospitalized older adults but multiple studies have demonstrated that the program also prevents functional and cognitive decline and decreases length of stay and nursing home placement. HELP does this by keeping these patients oriented to their surroundings, meeting their needs for nutrition, fluids, and sleep and keeping them mobile within the limitations of their physical condition. The program has also shown cost savings. For more information visit: http://www.hospitalelderlifeprogram.org/

Home-Based Primary Care Model is a healthcare service provided to Veterans with complex healthcare needs and for whom routine-clinic based care is not effective. Under the model, a VA physician supervises the healthcare team that provides skilled services, case management, and help with activities of daily living (e.g., bathing, dressing, fixing meals, or taking medicines). This program is also for Veterans who are isolated or their caregiver is experiencing burden. For more information visit: https://www.va.gov/GERIATRICS/Guide/LongTermCare/Home_Based_Primary_Care.asp

A strong home-based community support system is as essential a resource as the hospital or doctor's office and must be recognized as such. This area has the greatest potential and policy need. The Home-Based Primary Care model should be replicated outside of the Veterans Health Administration as similar models have shown to improve care for non-VA patients. For example, the ElderPAC program at the University of Pennsylvania linked house call teams with a local Area Agency on Aging. Their goal was to improve care for older individuals with multiple chronic conditions and complex social needs. Seniors who were managed in this program were more likely to remain independent in their homes; had lower long-term nursing home use; had lower mortality rates; and had lower Medicare and Medicaid costs.

ADDITIONAL CONSIDERATIONS FOR MODELS

Beneficiary Engagement

CMS asks how they can further engage beneficiaries in model development. We ask that CMS consider the addition of beneficiary/surrogate engagement as a required component of innovations grants. One option would be an assessment tool for all practices to assess their model and best practices. Metrics should be public and known to all peers and patients.

The AGS also 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 healthcare systems. We also encourage CMS to move to use of the patient relationship categories and codes to help define the mutual expectations of physicians and patients.

Flexibility

Flexibility is important as we continue to form innovative partnerships and break down the silos of health care. For example, hospitals and skilled nursing facilities (SNFs) are partnering to improve communication and care quality. These partnerships could involve more resource sharing that could raise the level of care for patients in both settings, although for this to be feasible a hospital needs to be discharging a concentrated number of patients to a smaller number of SNFs. Interpretation of regulations around limited discharge options are a barrier to expanding high value networks between hospitals and post-acute care settings. While hospitals should not limit a beneficiary's options, it would be helpful for CMS to explicitly allow promotion of these "high value" networks to encourage strengthening of these partnership arrangements.

Telehealth

Geriatrics health professionals are not available to everyone based on geography and other barriers – thus greater flexibility is needed with telehealth and other waivers for innovative ways to extend the reach of specialized medical care. Telehealth has the potential to improve outcomes for chronically ill, multi-morbid patients, including homebound older adults and those living in underserved areas. Patients often have to travel long distances to reach a provider and this can be especially challenging for older adults who may have multiple medical appointments and difficulty traveling. Telehealth support has also shown to improve care for patients in SNFs and assisted living facilities by decreasing emergency department utilization and hospitalization. Home health monitoring systems have shown similar improvements and better compliance and patient satisfaction.

Qualification as an Advanced Alternative Payment Model (APM)

These models all require investment of resources to implement. The AGS believes the investment of such resources should qualify as meeting risk thresholds to allow these models to qualify as Advanced APMs under MACRA. However, CMS's current interpretation of the financial risk criterion is not aligned with its policy goals to encourage development of, and participation in, APMs. Given the relatively small number of APM entities and clinicians participating in such entities, CMS could better achieve its goals by developing inclusive policies regarding Advanced APMs that encourage the development of, and participation in APMs generally. CMS should be encouraging these activities not only for large healthcare networks that can take on significant financial risk immediately, but also for smaller organizations and a variety of provider types, who, relative to their size and structure, are taking on

substantial risk in their own right. In addition, CMS should commit to ensuring that comparable opportunities and risks exist for physicians in all parts of the United States to participate in Advanced APMs. High-quality, patient-centered care can come in all shapes and sizes, and CMS should not limit its ability to promote transformative care by so narrowly defining payment models that will meet the definition of Advanced APMs. The AGS urges CMS to include additional ongoing projects as Advanced APMs and to continue to work collaboratively with the provider community to develop new models.

Rigorous and Transparent Evaluation of Models

The evaluation of models is both critical and complex. Sometimes the best ideas do not prove to be effective when implemented. Metrics should be clearly identified prior to program initiation and systematically assessed during implementation. The identification of appropriate metrics, with systematic and synthesized input from consumers, stakeholders, and researchers should be part of the development of RFPs and independent from the funded implementation. Consistent with the flexibility principle indicated above, the implementation team should be encouraged to identify additional measures and engage stakeholders during the work. Whenever possible, comparator groups should be identified prior to the start of implementation. Appropriately de-identified results and data, both positive and negative, should be publicly available in order to ensure full learning from the investment of public resources. Finally, all evaluations should systematically consider adherence to the proposed intervention to allow better understanding of reasons for positive or negative findings and to allow learning for future efforts.

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Thank you for the opportunity to submit these comments. We would be pleased to answer any questions you may have. Please contact Alanna Goldstein, agoldstein@americangeriatrics.org.

Sincerely,

Debra Saliba, MD, MPH, AGSF
President

Nancy E. Lundebjerg, MPA
Chief Executive Officer