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May 15, 2009

Senator Max Baucus
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

VIA Email - Health_Reform-finance@dem.senate.gov

Dear Chairman Baucus,

As the nation's largest multi-disciplinary health professional organization dedicated to improving the health, independence and quality of life of older people through initiatives in clinical practice, research and professional and public education, the American Geriatrics Society (AGS) appreciates the opportunity to comment on the Finance Committee's "Proposals to Improve Patient Care and Reduce Health Care Costs."

With the number of Americans 65 and older expected to nearly double to more than 70 million by 2030, we believe there is an urgent and compelling need for Congress to advance and implement policies that address the unique health care needs of our nation's burgeoning elderly population. Our nation is facing an unprecedented increase in the number of older patients with complex health needs and, as detailed in the ground-breaking 2008 Institute of Medicine report, Retooling for an Aging America: Building the Health Care Workforce, we are woefully ill-prepared for the looming silver tsunami.

We appreciate the work of the Senate Finance Committee on health care reform. Many of the ideas presented in the Committee's paper will strengthen our health care delivery system by ensuring that we have an adequate primary care workforce and supporting well-coordinated care to all of our nation's citizens.

Our comments are provided to strengthen the ideas brought forward in the Committee's April 29th paper on improving patient care and reducing costs. We begin by sharing our comments on three key areas, and then offer more detailed comments on the entire document with the goal of assisting Congress in its efforts to create a high-quality, cost-effective system.

Three Key Reforms
We believe that there must be system-wide reforms that make the care of older adults more effective and economical, as our nation simply cannot sustain future growth in Medicare and private health care spending. As it pertains to this document, we support systemic changes that:

- Provide Support for the Primary Care Bonus;
- Address the Needs of Frail Older Adults with Multiple Chronic Conditions through Quality Initiatives and Care Coordination; and
- Increase and Enhance the Professional and Direct-Care Workforce.

Below we expand on several of these priorities and offer our views and recommendations regarding several of your health care proposals.

Support for the Primary Care Bonus

We appreciate the Committee's support for primary care and its call for a primary care bonus in order to improve recruitment into family, internal, and geriatric medicine. The need for geriatricians – those physicians who specialize in the care of older adults -- is great. The field of geriatric medicine is a subspecialty of internal or family medicine. These physicians who provide both primary and consultative care account for only a small portion of the total physician workforce – just 7,345 physicians are certified geriatricians. That number is declining at the same time as the number of persons who would benefit from geriatric expertise is rising. Shortages of primary care physicians are an increasing problem as well. In the United States, the number of medical students entering family practice training dropped by 50% between 1997 and 2005. In 1998, half of internal medicine residents chose primary care, but by 2006, over 80% had chosen to sub-specialize rather than pursue primary care.

Reimbursement rates are generally low for primary care codes, particularly compared with the procedural codes typically used by other specialists. Medicare and Medicaid reimbursement does not account for the fact that caring for frail older adults with complex care needs is time-consuming, and causes geriatric specialists to have fewer patient encounters and fewer billings (IOM Report, Retooling for An Aging America (April 14, 2008)(citing MedPAC, 2003)).

Accordingly, AGS is encouraged by the ideas introduced within the policy options paper that are supportive of bonus payments for primary care. At the same time, we believe that the 60% rule described in this document may allow many specialists to obtain the benefit of increased E&M reimbursement in such a way that will dilute the benefit of this "bonus". We strongly urge that the bonus be linked solely to being in one of the following categories: Geriatric Medicine, General Internal Medicine and Family Medicine. We believe that CMS should consider a credentials process that includes board certification as verification of training in primary care. We need to ensure that there is a method in place to identify that the services provided are consistent with primary care.

We ask that the Committee consider increasing the bonus amount to 10%. We believe that a 5% bonus will be insufficient to change the career choices of physicians-in-training away from primary care and into other specialties of medicine. As documented by the IOM, our nation faces a severe and growing shortage of geriatrics health care professionals. Also, among primary care physician specialties (general internists, family physicians and geriatricians) serving the Medicare population, geriatricians deliver the most primary care services, as a percentage of their services, under the fee schedule (MedPAC Report to Congress, June 2008). To achieve the dual objective of increasing payments to overcome the undervaluation of primary care services, and to provide incentives for physicians to specialize in geriatrics, we believe that a 10% increase is warranted.

AGS also encourages the Committee to include a permanent and comprehensive reform to the flawed and outdated SGR formula in its health care reform package, rather than the short-term proposals presented in the options paper. Absent major reforms to the SGR formula this year, we then ask that the Committee consider proposals that would provide a transition from SGR to a new payment reimbursement system, to be phased in over several years.

Address the Needs of Frail Older Adults with Multiple Chronic Conditions through Quality Initiatives and Care Coordination

<u>Quality Initiatives</u>

Since the Institute of Medicine released its ground-breaking report; Crossing the Quality Chasm: A New Health System for the 21st Century, in 2001, a great deal of energy has been focused on quality measurement and performance improvement. The goals of this work have been to promote higher quality care and create a

systematic approach for rewarding providers who provide quality care. Much of the emphasis and focus has been on developing quality measures that are specific to a single disease or condition with insufficient attention paid to developing measures for those with multiple chronic illnesses. In addition, some measures specifically exclude those age 65 and older (and diabetics age 75 and older) from being measured precisely because of the complexity they present. With the population of older Americans expected to reach 70 million by 2030, we support the development of a multi-stakeholder group to provide guidance to the Secretary on the development of measures that assess the quality of care of persons over the age of 75; those who are vulnerable and/or frail; and particularly those with multiple co-morbidities; and those who are receiving care near the end of life.

AGS commends the option of Maintenance of Certification as creating eligibility for PQRI initiatives. This process facilitates self examination and continuous performance improvement at the practice level. Because the PQRI is used to determine bonuses for providers who care for older adults, the bodies charged with measuring and ensuring quality should be encouraged to include geriatrics content that addresses the special expertise needed to care for those older adults. AGS is working with the American Board of Medical Specialties to improve the geriatric content in performance improvement modules offered by specialties.

CMS Chronic Care Management Innovation Center

AGS is very pleased that the Committee has included a number of proposals that would foster care coordination and multi-disciplinary provider collaboration. Geriatric care has long been synonymous with coordinated care. As patients age, the combination of conditions puts these patients at high risk of medical and social complications, requiring specific interventions tailored to the specific needs of each patient. These interventions include an array of services provided by a multidisciplinary team of providers and include coordination with other physicians, extensive family caregiver support, referrals for social supports, and high levels of medication management.

We are especially pleased with the specific language in Section 3 that encourages the wide-spread and facilitated testing of a care coordination model focused on high-cost beneficiaries with multiple chronic conditions, one of which may be dementia. This model is very similar to legislation, S. 1004/H.R. 2307 (RE-Aligning Care Act), which AGS strongly supports. Patients meeting the criteria under this legislation, sponsored by Senators Lincoln and Collins in the Senate and Representative Gene Green in the House, would be those most at risk of functional decline, and coordinated interventions would be designed to improve health outcomes and prevent hospitalizations, thereby potentially reducing health care costs. This high-risk population also accounts for a significant portion of Medicare spending. According to CBO, approximately 75% of Medicare spending pays for beneficiaries who have five or more chronic conditions.

One crucial element of this care coordination model not specifically listed in the Committee options paper is the comprehensive geriatric assessment. This assessment, performed by a multi-disciplinary team, is a comprehensive review of an individual's physical and mental condition. The assessment includes evaluations of cognitive and functional capacities, medication regimen and adherence, social and environmental needs, and caregiver needs and resources. For at-risk beneficiaries with complex conditions, this assessment is crucial since it serves as the basis for a comprehensive care plan for the individual. As the legislation is drafted, we ask that the Committee include language specific to geriatric assessments. AGS also looks forward to additional details from the Committee regarding the proposed Chronic Care Management Innovation Center under CMS.

Increase and Enhance the Professional and Direct-Care Workforce

Graduate Medical Education

We support the committee's recommendation that would increase the number of new slots; however, we strongly urge that geriatrics is part of primary care and that it be included in the 75% of new slots that will be allocated to primary care and general surgery. The addition of geriatrics is critical as there is already a well-documented shortage of geriatricians and an expansion of available training slots, in combination with enhancements to reimbursement proposed by Senate Finance in this document would help to increase the supply of geriatricians. The AGS Geriatrics Workforce Policy Studies Center predicts that we will need 30,623 geriatricians by 2030 in order to care for the 30% of the Medicare-eligible population that has multiple chronic conditions. Currently, there are 470 geriatric fellowship training slots available nationwide. With only 7,345 board certified geriatricians in practice, the number of available slots for geriatrics fellows would have to more than double to 1,172 to meet the projected need.

We also appreciate that the proposal would establish a re-distribution of currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery, however we strongly encourage that the language includes geriatric fellowships as well. While there are many geriatrics programs that do not fill their slots there are also a number of programs that could fill more positions if they had the funding. While we appreciate the finance proposal and believe that it is step in the right direction, it needs to go further if we are to really address the primary care shortages.

In addition, we strongly believe that DGME payments to hospitals for geriatric fellowship FTEs should be treated differently than others. The per-resident amount (PRA) paid to hospitals under DGME is multiplied by the percent of Medicare bed days over the total bed days for the institution. Hospitals with a high percent of Medicare business do better than those with large pediatric and obstetric volumes. Since geriatric fellows only take care of Medicare patients (or at least 99% of their patients) those positions should get the full PRA, not the discounted rate. The same mechanism could be used to provide incentives to hospitals to train those specialties that are needed. This would provide some leverage to shape the workforce. It may also be possible to create even steeper discounts for specialties for which there is an adequate workforce to offset the additional costs. If this were applied to just geriatric fellowship positions the cost would be very small and an offset may not be needed.

Promoting Greater Flexibility for Residency Training Programs

The AGS supports providing more flexibility to allow for training in non-hospital settings and strongly recommends that such flexibility and incentives be available in appropriate settings where older adults receive care, including nursing homes, assisted-living facilities and patients' homes. Training in such settings is specifically called for in the Residency Review Requirements for geriatrics fellowships. We also believe that for these settings there should be no geographic limitation imposed (underserved and/or rural) since our nation is facing a serious and growing shortage of geriatricians and other geriatrics health professionals in all states and all regions. The vast majority of geriatrics patients receive their care in settings other than hospitals and the 2008 IOM report, Retooling for an Aging America: Building the Healthcare Workforce, recommends that hospitals encourage the training of residents in all settings where older adults receive care.

TANF Health Professions Competitive Grants

We believe that these competitive awards for research and demonstration projects to provide disadvantaged parents with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand should include family caregivers and/or direct care workers as well. The 2008 IOM report states that public, private, and community

organizations should provide funding and ensure that adequate training opportunities are available in the community for informal caregivers. It also states that direct-care workers are the primary providers of paid hands-on care and emotional support for older adults, yet the requirements for their training and testing are minimal. The demonstration projects will help us to do more to ensure the competence of personal-care aides.

Proposal on Development of a National Workforce Strategy

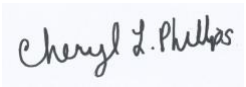
Recommendation 1-1 of the 2008 IOM Report, Retooling for an Aging America; Building the Health Care Workforce calls for Congress to require an annual report from the Bureau of Health Professions to monitor the progress made in addressing the crisis in supply of the health care workforce for older adults. AGS and the Association of Directors of Geriatric Academic Programs have been tracking the status of the geriatric medicine workforce since 2000.

Little attention, however, has been paid to tracking other sectors of the workforce caring for older adults and we believe that there is a need for a national workforce commission or, in the alternative, a permanent Healthcare Workforce Center so policymakers will have more comprehensive and ongoing information about all sectors of the health care workforce. Given the projected growth in the number of direct care workforce jobs, we believe it is important to track the direct care workforce so that can have a better understanding of this sector. We are pleased that you are collaborating closely with the Health, Education, Labor and Pensions Committee to develop a national workforce strategy. As you work to address this issue, we ask that you give serious consideration to including provisions from S. 245 (Retooling the Health Care Workforce for an Aging America Act of 2009), sponsored by Senator Kohl, which would implement key recommendations from the IOM report on the geriatrics health care workforce.

Following this letter, we offer more detailed comments on the entire document with the goal of assisting Congress in its efforts to create a high-quality, cost-effective health care delivery system. Please consider the American Geriatrics Society as your resource on issues of aging and health care as well as geriatric education and research. If there are any additional resources/information that you would find helpful, please do not hesitate to contact Alanna Goldstein at agoldstein@americangeriatrics.org or 212-308-1414.

We look forward to working with you.

Best regards,



Cheryl Phillips, MD
President, American Geriatrics Society

The American Geriatrics Society
Comments on Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs

May 15, 2009

Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems

Linking Payment to Quality Outcomes

Establishment of a Hospital Value-Based Program (VBP)

Senate Finance Language - Page 3, 1st Paragraph (beginning line7)

AGS Recommendations/Additions (underlined/yellow highlight)

Certain hospitals would be excluded from the VBP program, including those who fail to report quality measures under the RHQDAPU program; those that have been cited by the Secretary for deficiencies that posed immediate jeopardy to the health or safety of patients during the performance period; and hospitals for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply. Small and rural hospitals, safety net, and large tertiary hospitals with high risk-score patients are all potentially disadvantaged under VBP. Reports to evaluate vulnerable hospitals should begin immediately with a plan in place if such hospitals are disadvantaged. Measures for the hospital Value-based Purchasing Program would be selected from the measures used in the RHQDAPU program. The measures would focus on the same areas that are the focus of the RHQDAPU program: heart attack (AMI); heart failure; pneumonia; surgical care activities; and patient perception of care. Beginning in 2013 and beyond, the Secretary would have the authority to expand the measurement areas beyond those listed above and should also consider evaluation of competing measures for appropriate performance.

AGS Rationale

Some hospitals that are eligible for VBP stand to be disadvantaged under the program, and therefore, any legislative package should include language that provides those hospitals the opportunity to correct the situation, by first receiving some type of report informing them that they are vulnerable to being disadvantaged under VBP, and then being afforded time or opportunity to correct the problem through some means.

Senate Finance Language - Page 3, 2nd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

Measures for the hospital Value-based Purchasing Program would be selected from the measures used in the RHQDAPU program. The measures would focus on the same areas that are the focus of the RHQDAPU program: heart attack (AMI); heart failure; pneumonia; surgical care activities; and patient perception of care.

Data on co-morbidities should be collected so that programs can be evaluated for adverse effects on access for frail, minority, and disadvantaged populations by reviewing case mix before and after implementation.
Beginning in 2013 and beyond, the Secretary would have the authority to expand the measurement areas beyond those listed above. Priority should be given to measures that target geriatric syndromes and functional outcome and to developing measures that look at patient outcome after an episode of care that involves several locations, e.g., acute, then SNF, then home health (e.g., what % of patients are institutionalized permanently).

AGS Rationale
Disease-specific mortality rates are poor indicators for quality unless adjusted for age, acuity and frailty in the aging population. Not only do local demographics make a significant impact in mortality rates, but there is also an unexpected impact of positive ambulatory care models. For example, in a community with a successful heart failure care coordination program, the overall admission rate for heart failure might well be lower than expected. However, the mortality rate for those who are admitted would most likely be higher, since the acuity of those persons who did need admission and could no longer be managed in the community would be much higher.

Senate Finance Language - Page 3, 5th Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)
Performance standards that reward hospitals based on either attaining a certain performance standard or making improvements on performance relative to a previous performance period would be established. Hospitals that move from one quartile into the next higher quartile would be eligible for an incentive payment to be determined by the Secretary based on a linear sliding scale. Hospitals would be rewarded based on whichever level is higher, attainment or improvement.

AGS Rationale
While rewarding by quartile performance seems the most logical, such a model rewards those institutions that are already likely good performers and that may well have adequate resources to continue to perform well. Thus, there is very little overall change in quality across the system. A more meaningful measure of system improvement is demonstrated when a hospital actually improves from one quartile to the next. Perhaps such change should be rewarded as much as those who remain in the top group.

Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans

Senate Finance Language - Page 5, 5th Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)
The Secretary would be directed to complete Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively. Each plan would include consideration of the following issues: (1) The on-going development, selection, and modification process of measures of quality and efficiency that account for frailty, disease burden and end-of-life status as well as for patient-centered preferences; (2) The reporting, collection, and validation of quality data; (3) The structure of value-based payment adjustment, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for the value-based bonus payments; and (4) The disclosure of information on performance. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in each setting.

AGS Rationale
Measures of process and quality must take into consideration certain characteristics of patients, such as frailty, disease burden and end of life status, as well as patient-centered preferences. It is critical to recognize that these providers do not serve a homogenous population. The measures of quality of care may be very different for a 67-year-old recovering from a knee replacement, as opposed to an 88-year-old with advanced dementia with multiple chronic conditions and functional impairments**.**

Physician Quality Reporting Initiative (PQRI) Improvements and Requirement

Senate Finance Language - Page 6, 1st Definition

AGS Recommendations/Additions (underlined/yellow highlight)
1. Qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program would and mean a continuous assessment program to advance quality care and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice. The Secretary will work with certifying Boards to insure that attention is paid to ensuring competency in care of older adults across the components of maintenance of certification programs.

AGS Rationale
AGS commends the option of Maintenance of Certification as creating eligibility for PQRI initiatives. This process facilitates self examination and continuous performance improvement at the practice level. Because the PQRI is used to determine bonuses for providers who care for older adults, the bodies charged with measuring and ensuring quality should include requirements that address the special expertise needed to care for those older adults. AGS is working with the American Board of Medical Specialties to improve the geriatric content in performance improvement modules offered by specialties.

AGS Would Like to See the Following Definitions Added:

4. The Secretary should consider Maintenance of Certification Programs, or similar programs applicable to the discipline, for measuring the quality of care provided by other professionals (e.g. nurse practitioners) that meet all of the criteria outlined in 1-3 above for use in the PQRI.

AGS Rationale
Disciplines that are certified by a process that includes of the components of the MOC program that has been developed and adopted by medical specialty boards should be eligible to have those processes used under PQRI.

Promotion of Adherence to Appropriateness Criteria for Imaging Services

Senate Finance Language - Page 9, 2nd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)
The Secretary would establish a Diagnostic Imaging Exchange Network (DIEN) in five regions of the country, beginning in 2011. The DIEN would assist physicians in determining the necessity, safety and appropriateness of ordering an imaging study, with the intent of minimizing duplicative scans and radiation exposure to patients.

Using the Nationwide Health Information Network (NHIN) infrastructure and existing HIT standards, the Secretary would establish an information exchange network that would equip physicians and providers with HIT-enabled systems to access a patient's entire imaging history prior to ordering an imaging study. Starting in 2013, the Secretary would offer support from a radiology benefits manager (RBM) for outlier physicians as a method to build appropriateness criteria into the practices. Penalties for outlier physicians would not start until such time as DIEN or RBM programs were in place.

AGS Rationale

It is critical to build appropriateness criteria into the practice of ordering diagnostic imaging. The proposed Diagnostic Imaging Exchange Network would provide assistance to physicians in determining the appropriateness of ordering imaging studies by adding medical decision support to electronic records and health information systems. Radiology benefits managers could eliminate outliers by a prior authorization process. The 5% conversion factor penalty is potentially disproportionate to ordering providers who do not self-refer without such methods in place that will facilitate improvements.

Medicare Inpatient Rehabilitation Facility and Long-Term Acute Care Hospital Quality Reporting

Senate Finance Language - Page 9, 1st Paragraph in section

AGS Recommendations/Additions (underlined/yellow highlight)

The Secretary would be directed to establish quality reporting programs for inpatient rehabilitation and long-term care hospital providers. Under this policy, the Secretary would be required to select quality measures for inpatient rehabilitation facilities and long-term acute care hospitals by 2011 and implement mandatory quality measure reporting programs for both types of providers by 2012. Selected measures would be endorsed by a consensus-based entity that the Secretary is directed to identify and contract with under the Social Security Act. The selected measures would take into account the trajectory of certain chronic conditions and geriatric syndromes and cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care.

AGS Rationale

In post-acute and long-term care settings, a patient's ability to be successfully rehabilitated may be affected by the presence of multiple, chronic conditions, particularly for older, more frail individuals. Quality measures that take into account the trajectory of certain chronic or geriatric conditions will inform the provider of service as to treatment goals that are realistic or feasible.

Primary Care

Primary Care and General Surgery Bonus

Senate Finance Language - Page 10, 2nd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

Certain Medicare providers (family, general internal and geriatric medicine physicians) would be eligible for a primary care services bonus payment. Such Providers ~~who furnish at least 60 percent of their services in~~

~~specified ambulatory settings~~ would receive a bonus of at least 10 ~~5~~ percent over the fee schedule amount for providing certain evaluation and management services, defined as follows: office visits (codes 99201–99215); nursing home and domiciliary visits (codes 99304–99340); and home visits (codes 99341–99350). The bonus would apply to services furnished to both established and new patients. The provision would be in effect for five years, from January 1, 2010 through December 31, 2014. The Secretary shall develop a method to collect and verify training in primary care (defined as family, general internal, and geriatric medicine) and a method to identify that the services provided are consistent with primary care.

AGS Rationale

Reimbursement rates are generally low for primary care codes, particularly compared with the procedural codes typically used by other specialists. Medicare and Medicaid reimbursement does not account for the fact that caring for frail older adults with complex care needs is time-consuming, and causes geriatric specialists to have fewer patient encounters and fewer billings (IOM Report, Retooling for An Aging America (April 14, 2008)(citing MedPAC, 2003). Accordingly, AGS is encouraged by the ideas introduced within the policy options paper that are supportive of bonus payments for primary care. At the same time, we believe that the 60% rule described in this document may allow many specialists to obtain the benefit of increased E&M reimbursement in such a way that will dilute the benefit of this "bonus." We strongly urge that the bonus be linked solely to being in one of the following categories: Geriatric Medicine, General Internal Medicine and, Family Medicine. We recognize that CMS will need to develop a credentialing process for determining which clinicians are eligible for this bonus payment. CMS could potentially look to the certifying Boards, lead by the American Board of Medical Specialties, for this data.

We also ask that the Committee consider increasing the bonus amount to 10%. We believe that a 5% bonus will be insufficient to change the career choices of physicians in training away from primary care and into other specialties of medicine. As documented by the IOM, our nation faces a severe and growing shortage of geriatrics health care professionals. Also, among primary care physician specialties (general internists, family physicians and geriatricians) serving the Medicare population, geriatricians deliver the most primary care services, as a percentage of their services, under the fee schedule (MedPAC Report to Congress June 2008). To achieve the dual objective of increasing payments to overcome the undervaluation of primary care services, and to provide incentives for physicians to specialize in geriatrics, we believe that a 10% increase is warranted.

Finally, AGS encourages the Committee to include a permanent and comprehensive reform to the flawed and outdated SGR formula in its health care reform package, rather than the short-term proposals presented in the options paper. Absent major reforms to the SGR formula this year, we then ask that the Committee consider proposals that would provide a transition from SGR to a new payment reimbursement system, to be phased in over several years.

AGS look forwards to working with the Committee on crafting a workable and equitable payment reimbursement system for physicians and other health care professionals who specialize in delivering high-quality and cost-effective care of older adults. As the Congress moves forward on SGR reform, we encourage the Committee to consider the establishment of payment mechanisms that reflect increases in physicians' and other health professionals' practice costs (including the cost of creating an effective health care team) as well as adequate recognition of the work related to care and care coordination for Medicare's most complex beneficiaries.

Payment for Transitional Care Activities

Senate Finance Language - Page 11, 1st Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

Under this option, Medicare would reimburse physicians and other eligible providers (as defined in the fee schedule) for certain care management activities performed by nurse care managers (or other qualified non-physician professionals, such as diabetes educators). Qualified activities would include providing in-person care assessment and management, coaching, education, and self-management support to patients. To be eligible for reimbursement, physicians could directly hire qualified care managers or contract with care managers in their community. These services would only be paid for beneficiaries who have been discharged from the hospital within the previous six months for a stay classified by a DRG related to the following major chronic diseases:

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Asthma
- Diabetes
- Depression
- Alzheimer's and Other Dementia
- Delirium
- Stroke

Medicare would also pay a modest supplemental fee to a primary care practice or other eligible provider for each patient who (1) has been discharged from the hospital after a stay classified in a DRG for one of the major chronic diseases, (2) receives at least one currently covered evaluation and management service or one of the newly covered care management services within 30 days after discharge, and (3) is not readmitted to a hospital for a stay classified as a chronic disease DRG within 60 days after the initial discharge. The Committee is seeking input on whether this policy should be expanded to include care coordination payments for beneficiaries with high-cost, chronic illness who are at highest risk for hospitalization (those proactively identified should be done so using a simple validated risk assessment measure).

AGS Rationale

We strongly support including the call to expand the policy to include those at highest risk for hospitalization. AGS supports the Committee's proposal for transitional care activities. We also urge the Committee to also expand eligibility for payment for transitional care activities to beneficiaries with chronic conditions who are at risk of re-hospitalization. We are concerned that the Committee's list of six DRGs does not include other high cost/high risk conditions. At a minimum, the Committees list of DRGs should include other conditions that are prevalent in the geriatric population, such as Alzheimer's and other dementias, delirium and stroke.

Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

Chronic Care Management

CMS Chronic Care Management Innovation Center

Senate Finance Language - Page 12, 3rd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

To be considered for wide-scale testing, care models must focus on patients with multiple chronic conditions including those who are at highest risk for institutional placement, hospitalization or readmission, as well as those with cognitive or functional impairment . CMIC would have flexibility in targeting patient populations most appropriate for care management interventions but would be encouraged to include: (1) high-cost beneficiaries with multiple chronic conditions; (2) beneficiaries with cognitive impairment, including dementia; (3) beneficiaries with an inability to perform 2 or more activities of daily living (i.e. homebound patients). In addition, CMIC would be encouraged to include the testing of models that use a comprehensive geriatric assessment to qualify high-risk chronically ill patients for comprehensive care coordination services.

Rationale/Additional Recommendations

As proposed by the Committee, the inclusion of chronically ill older adults with complex medical conditions (including dementia) in the testing of models is absolutely essential to determining which models improve health outcomes through the delivery of high-quality and cost-effective care to these high-risk and high-cost patients. These results will build on the findings of recent studies suggesting that models with greatest potential for improving the quality and outcomes of chronic care and with the potential for widespread diffusion include elements of the Chronic Care Model, including teams of qualified health professionals (see: Boult, C. et al. Successful Models of Comprehensive Health Care for Multi-Morbid Older Persons: A Review of Effects on Health and Health Care. A Paper Commissioned by the Institute of Medicine, National Academy of Sciences, for its 2008 Report: "Health Care Workforce for an Aging America" and Boult C. et al. Improving Chronic Care: *The "Guided Care" Model*. The Permanente Journal/ Winter 2008/ Volume 12 No. 1: 50-54.) We added additional language above to fully capture those beneficiaries at risk who are most likely to benefit from care coordination services.

For at-risk beneficiaries with complex conditions, a geriatric assessment is an important tool since it serves as the basis for a comprehensive care plan for the individual, that is then implemented by the care coordination team (see: Reuben DB. Principles of Geriatric Assessment. In: Hazzard WR, Blass JP, Ettinger WH, Halter JB, Ouslander JG, editors. Principles of Geriatric Medicine and Gerontology, 4th ed. New York: McGraw-Hill, Inc.; 1999.). Generally performed by a multi-disciplinary team (e.g. geriatrician, geriatrics nurse practitioner, social worker, pharmacist, mental health professional), the geriatric assessment is a comprehensive review of an individual's physical and mental condition. The assessment includes evaluations of cognitive and functional capacities, medication regimen and adherence, social and environmental needs, and caregiver needs and resources.

AGS recommends that the Committee's proposal regarding CMIC be amended to include the following key elements for care coordination models under consideration. The RE-Align Care Act (S. 1004), introduced by Senator Lincoln and cosponsored by Senator Collins, embodies these key elements of care coordination, and we

ask that the Committee include the legislation (or the pilot proposal based on the language) in the Committee's final health reform legislation.

1. Targeting high risk beneficiaries with multiple chronic conditions, including dementia. These conditions often lead to functional impairment and interventions, that if coordinated by the care team, can both improve health outcomes and potentially reduce hospitalizations.
2. Multidisciplinary team approach to care, with a team of qualified health professionals and social care service providers experienced in managing the care of older adults with complex conditions;
3. Comprehensive geriatric assessment for at-risk beneficiaries;
4. Involvement of patients (or designated caregivers) in their own care;
5. Predominately face-to-face contact between providers, patients, and designated caregivers, as well as ongoing coordination and monitoring the care between visits

Hospital Readmissions and Bundling

Bundling Policy

Senate Finance Language - Page 15, 2nd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

The bundled payments would be calculated as the inpatient MS-DRG amount plus post-acute care costs of treating patients in that MS-DRG. This bundled payment amount would be adjusted to capture savings from the expected efficiencies gained from improving patient care and provider coordination within the bundled payment system. Also included in the bundled payment would be expected or planned readmissions within the 30-day post-acute timeframes. The revised MS-DRG should be appropriately revalued to account for expected medically necessary post acute services. A monitoring system will be established to detect changes in post acute services to ascertain whether hospitals are limiting referrals for necessary services. Hospitals or other eligible entities would receive the bundled payment for each patient served, regardless of whether the patient receives post-acute care services. No additional payments would be made to the hospital or organizing provider for readmissions during this timeframe and Medicare would no longer make separate payments to post-acute providers for care initiated within 30 days post-discharge.

AGS Rationale

We recommend revisions to prevent creation of a disincentive for referral of patients that require post-acute care. We believe the primary goal is to prevent premature discharge, inappropriate cost shifting and readmission. While we recognize these aims, we have concerns that such a policy would negatively impact the frail elderly, particularly those who are disadvantaged and minority. Any new payment policy should improve care coordination and ensure that patients receive the information they need to transition safely from the hospital to post-acute care when necessary, but should not result in unintended consequences that could harm patients. In order to achieve these goals, there must be a better understanding of what works and what does not, based on sound evidence, so that patient safety and health care quality are maintained under a reformed system.

Moving From Fee-for-Service to Payment for Accountable Care

Medicare Shared Savings Program (i.e. Accountable Care Organizations)

Senate Finance Language - Page 18, 2nd Paragraph

AGS Recommendations/Concerns

To qualify, an organization would have to meet at least the following criteria: (1) agree to a minimum two-year participation, (2) have a formal legal structure that would allow the organization to receive/distribute bonuses to participating providers, (3) include the primary care providers of at least 5,000 Medicare beneficiaries, (4) provide CMS with a list of the primary care and specialist physicians participating in the organization, (5) have contracts in place with a core group of specialist physicians, (6) have a management and leadership structure in place that allows for joint decision making (e.g., for capital purchases), and (7) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care.

AGS Rationale

We have concerns about criteria #5 (underlined above), which is that a group of primary care physicians who qualify by the attribution methodology for 5,000 Medicare members might well be able to demonstrate savings to the Medicare program. This process inherently discriminates against primary care and essentially places them in a position of dependence on ACOs as structured in the proposal. While savings rebates would obviously have to be restructured compared to an ACO that has to pay specialists in contracts, primary care groups should at least be able to compete in a demo as they met all of the other parts of the definition of an ACO.

We are also concerned that 5,000 patients and 50% shared savings may be too few patients and too little gainshare to incentivize physician groups to do this. These and several other design features are very different from the current PGP demo and thus have not really been tested. MedPAC has discussed a voluntary ACO model, consisting of at least one hospital, primary care physicians and specialists, but also has said that the incentives are probably not strong enough to encourage the participation of physicians. This proposal jumps straight to an ACO model without testing it first or demonstrating that it will work. We do believe that properly structured ACOs are promising. A key feature must be a requirement for leadership by primary care physicians. For Medicare, there should be requirements for geriatrics services access. Lessons learned from Medicare Advantage should be applied.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

Comparative Effectiveness Research

Senate Finance Language - Page 24

AGS Recommendations

AGS has not formulated a position yet on the establishment of an Independent Institute, so we do not have any specific language changes to the proposal. AGS strongly supports comparative effectiveness research initiatives and, as the Committee moves forward on fashioning a proposal, we ask that it give serious consideration to the following recommendations:

- Significant resources under the Comparative Effectiveness Research program be targeted to address the unique medical needs of our nation's elderly population.
- Health professionals and medical researchers with experience in the care of older adults be represented in the Comparative Effectiveness stakeholder process, including boards and advisory committees.
- Comparative effectiveness research should include a sufficient number of older adults in clinical trials. Older adults, with their multiple chronic conditions, have long been under-represented in clinical research (for example: Hutchins LF, Unger JM, Crowley JJ, et al: Underrepresentation of Patients 65 Years of Age or Older in Cancer-Treatment Trials. New England Journal of Medicine 341:2061-2067, 1999). For this reason, particular attention should be paid to research activities that help us to better understand care for this population which will, ultimately, result in better quality care and enhanced savings under Medicare.
- Comparative effectiveness research, including that conducted by NIH, should include a reference to older adults as a special population in a manner similar to how women, children, and minorities are referenced.

Nursing Home Transparency

Senate Finance Language - Page 33, 4th Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

Study and report on training required for certified nurse aides and supervisory staff. The Secretary would be directed to increase the required minimum training standards for all certified nursing assistants. At the same time, the Secretary would be directed to further study and prepare a report to Congress on the content of certified nurse aide and supervisory staff training and whether the number of required training hours is adequate, and if not, what the training level should be.

AGS Rationale:

The 2008 IOM Report, Retooling for an Aging America; Building the Health Care Workforce calls for, in recommendation 4-2, "All licensure, certification, and maintenance of certification for health care professionals should include demonstration of competence in the care of older adults as a criterion." Currently, the federal minimum of 75 hours of training for nurse aides has not changed since it was mandated in 1987. A number of states have higher numbers of required hours. The IOM report also calls for (recommendation 5-1) states and the

federal government should increase minimum training standards for all certified nursing assistants and home health aides to at least 120 hours and should include demonstration of competence in the care of older adults.

Workforce

Redistribution of Unused GME Slots to Increase Access to Primary Care & Generalist Physicians

Senate Finance Language Page 34, 2nd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

The Secretary would be authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application addressing the criteria below, by such number determined by the Secretary. Seventy-five percent of new slots would be allocated toward geriatrics fellowship, primary care or general surgery residency training positions for at least 5 years. Teaching hospitals would be allowed to request up to 50 resident FTE positions from the pool of re-distributed slots. Programs applying to receive the slots will be prioritized based on certain criteria, which may include, but not be limited to: sponsoring institutions located in a Primary Health-Health Professional Shortage Area (HPSA), as determined by the Health Resources and Services Administration; sponsoring institutions located in rural areas; sponsoring institutions located in urban areas with a population of a million or less; sponsoring institutions located in states with a higher proportion of medical graduates relative to number of available residency slots within the state; and states with higher than average population growth. Hospitals that qualify for additional resident slots would display a demonstrated likelihood of filling the positions within the first three cost reporting periods and would be involved in an innovative delivery model.

AGS Rationale

Geriatricians are primary care doctors who undergo an additional year of fellowship training focused on the unique health care needs of older adults. There is a well-documented shortage of geriatricians and an expansion of available training slots, in combination with enhancements to reimbursement proposed by Senate Finance in this document would help to increase the supply of geriatricians. The AGS Geriatrics Workforce Policy Studies Center predicts that we will need 30,623 geriatricians by 2030 in order to care for the 30% of the Medicare-eligible population that has multiple chronic conditions. Currently, there are 470 geriatric fellowship training slots available nationwide.[1] With only 7,345 board certified geriatricians in practice, the number of available slots for geriatrics fellows would have to more than double – to 1,172 to meet the projected need.[2]

Senate Finance Language - Page 34, 3rd Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)

Slots would be redistributed among teaching hospital sponsors. For a sponsoring institution to receive additional residency slots, they must maintain the level of primary care residency positions at a level that is at least equal to the average number of primary care positions over the past 3 fiscal years. However, if the primary care positions

[1] Reference to current number of fellow slots: AMA and AAMC National GME Census data compiled by the Status of Geriatrics Workforce Study

[2] ADGAP Status of Geriatrics Workforce Study. Figure 1.3, Available at www.ADGAPstudy.uc.edu

cannot be filled through the National Resident Match Program over that period of time, the hospital would be allowed to transfer the slot to a different specialty. The redistributed resident slots would be subject to the same IME and DGME payment formulas as is used to reimburse hospitals' previous residents with the exception of various specialties such as geriatrics whose per-resident amount payment differs under DGME in a revised formulation. Revisions shall be implemented so that the per resident amount (PRA) shall more accurately reflect the proportion of patients treated by the specialty that are Medicare beneficiaries.

AGS Rationale

DGME payments to hospitals for geriatric fellowship FTEs should be treated differently than others. The per-resident amount (PRA) paid to hospitals under DGME is multiplied by the percent of Medicare bed days over the total bed days for the institution. Hospitals with high percent of Medicare business do better than those with large pediatric and obstetric volumes. Since geriatric fellows only take care of Medicare patients (or at least 99% of their patients) those positions should get the full PRA, not the discounted rate. The same mechanism could be used to provide incentives to hospitals to train those specialties that are needed. This would provide some leverage to shape the workforce. It may also be possible to create even steeper discounts for specialties for which there is an adequate workforce to offset the additional costs. If this were applied to just geriatric fellowship positions the cost would be very small and an offset may not be needed.

Promoting Greater Flexibility for Residency Training Programs

Senate Finance Language - Page 35, 1st Paragraph

In order to promote training in outpatient setting and to ensure the availability of residency programs in rural and underserved areas, the Committee is considering ways to provide more flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Proposals being considered include counting time for certain non-patient care activities, such as didactic and scholarly activities in a nonhospital setting for purposes of calculating GME payments, removing current disincentives placed on training programs that rely on volunteer supervisory physicians to provide training in outpatient settings and providing flexibility in the operation of residency programs involving more than one teaching hospital. The Committee looks forward to continuing to receive input on these topics.

AGS Recommendation/Rationale

The AGS supports providing more flexibility to allow for training in non-hospital settings and strongly recommends that such flexibility and incentives be available in appropriate settings where older adults receive care, including nursing homes, assisted-living facilities and patients' homes. Training in such settings is specifically called for in the Residency Review Requirements for geriatrics fellowships. We also believe that for these settings there should be no geographic limitation imposed (underserved and/or rural) since our nation is facing a serious and growing shortage of geriatricians and other geriatrics health professionals in all states and all regions. The vast majority of geriatrics patients receive their care in settings other than hospitals and the 2008 IOM report, Retooling for an Aging America: Building the Healthcare Workforce, recommends that hospitals encourage the training of residents in all settings where older adults receive care.

TANF Health Professions Competitive Grants

Senate Finance Language - Page 35, 4th Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)
The Secretary of Health and Human Services (HHS), in consultation with the Secretary of Labor, shall make competitive awards for research and demonstration projects to provide disadvantaged parents, family caregivers or direct care workers, with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand. .

AGS Rationale
See IOM Recommendation 5-1 of the IOM Report referenced above. In addition, Recommendation 6-2 states that public, private, and community organizations should provide funding and ensure that adequate training opportunities are available in the community for informal caregivers. Direct care workers are the primary providers of paid hands-on care and emotional support for older adults, yet the requirements for their training and testing are minimal. The demonstration projects will help us to do more to ensure the competence of personal-care aides.

Proposal on Development of a National Workforce Strategy

Senate Finance Language - Page 36, 5th Paragraph

AGS Recommendations/Additions (underlined/yellow highlight)
Several studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology, improving care of older adults, and increasing access to primary care services.

AGS Rationale
The inclusion of this language would implement a key recommendation from the IOM. Recommendation 1-1 of the 2008 IOM Report, Retooling for an Aging America; Building the Health Care Workforce calls for Congress to require an annual report from the Bureau of Health Professions to monitor the progress made in addressing the crisis in supply of the health care workforce for older adults. AGS and the Association of Directors of Geriatric Academic Programs have been tracking the status of the geriatric medicine workforce. Little attention has been paid to tracking other sectors of this workforce, including direct care workers, and we believe that there is a strong need for such a center in order for us to have a better understanding of the overall workforce.

As the Committee works in cooperation with the Senate Committee on Health, Education, Labor and Pensions to develop health care workforce policies, we urge your positive consideration of legislation introduced by Senator Kohl, S.245, the Retooling the Workforce for an Aging America Act. This legislation, co-sponsored by Senator Lincoln, would implement a number of key recommendations from the IOM report, including reforms of Title VII and Title VIII programs that would: (1) expand Geriatric Education Centers (GECs) to offer short-term intensive courses (mini-fellowships) in geriatrics, chronic care management and long-term care to faculty members of medical schools and other health professions schools; (2) expand the Geriatric Academic Career Awards (GACA) program to include junior faculty in nursing, social work, clinical psychology, and other allied health disciplines approved by the Secretary; (3) authorize a Geriatric Career Incentive Awards (GCIA) program to provide financial support for Masters-level clinical social workers and psychologists pursuing advanced degrees in geriatrics, long-term care or chronic care management; (4) expand the Nursing Comprehensive Geriatric Education Program to support additional training in geriatrics for nurses and nursing faculty.

Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management

Linking Payment to Quality

Senate Finance Language - Page 37, 6th Paragraph

AGS Recommendations/Additions (underlines/yellow highlight)

Under any proposed payment option, some portion of payment to MA plans should be tied to performance on quality measures such as care management and care coordination for the chronically ill. As previously mentioned, current law already requires MA plans to report on certain quality measures on an annual basis in order to participate in the Medicare program. These measures are recognized by the NCQA, a national, independent accrediting body. CMS compiles performance on these measures, along with consumer satisfaction data, into a 5-star ranking system. This widely available ranking system could be used to determine a portion of MA payments so that higher ranked MA plans receive an increase compared to lower ranked plans.

AGS Rationale

Quality care for those complex patients with multiple chronic conditions requires development and implementation of individualized, coordinated plans of care. Such plans of care often call for further evaluation, treatment, referrals and patient or caregiver education or both.

If you have any questions or if AGS can provide any additional resources/information, please contact Alanna Goldstein at agoldstein@americangeriatrics.org