OPTIMIZING HEALTHCARE FOR HIGH-NEED PATIENTS:
A PLAYBOOK

HEALTHCARE
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Optimizing Healthcare for High-Need Patients: A Playbook

Introduction

The Healthcare Leadership Council (HLC) is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable, high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, postacute care providers, home care providers and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Currently, 5 percent of patients account for 50 percent of healthcare costs in the United States. They typically experience three or more chronic diseases and a functional limitation in their ability to care for themselves or perform routine daily tasks.[1] Oftentimes high-need patients are seniors, but they are also younger, disabled adults.[2] As a consortium of leaders across all healthcare sectors, HLC members work to provide high-quality, efficient care, but there are roadblocks that obstruct our drive to optimal care. HLC members have designed and developed solutions to improve healthcare quality and efficiency, but they are often prevented from implementing these programs due to roadblocks set in law, regulations, or current guidelines and processes.

There are opportunities to serve people better across the continuum of care with forward-thinking, person-centered legislative and regulatory solutions.

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[1] Hayes, S.; Salzberg, C.; McCarthy, D.; Radley, D.; Abrams, M.; Shah, T.; and Anderson, G. Issue Brief: "High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?" The Commonwealth Fund, August 29, 2016.
[2] Kangovi S, Mitra N, Norton L, et al. Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities; A Randomized Clinical Trial. *JAMA Intern Med.* Published online October 22, 2018. doi:10.1001/jamainternmed.2018.4630

Action Items

Care for Those Who Need It Most

- Develop and disseminate tools that help providers and payers ask questions to screen patients for social determinants and identify the patients who need assistance.
- Incorporate the proven methods of Medicare Advantage in benefit design for high-need patients in traditional Medicare or those who are dually eligible for Medicare and Medicaid ("dual-eligibles").
- Facilitate beneficiary choice by making information about plan options transparent and easy to understand:
    - Offer newly eligible Medicare beneficiaries the explicit choice to enroll in Medicare Advantage or a fee-for-service plan.
    - Develop a Stars-like rating system for fee-for-service plan options so beneficiaries can make fully informed decisions across all available Medicare options.
    - Modernize the Medicare Plan Finder.

Prevention, Primary Care, and Preparedness

- Invest in wellness:
    - Revise U.S. Equal Employment Opportunity Commission regulations to conform to the standards established by the Affordable Care Act for employer wellness programs.
    - Offer wellness programs as a Medicare benefit.
    - Expand the definition of preventive services to include eligibility for Medicaid beneficiaries.
    - Pass the Preventive Health Savings Act to lengthen the Congressional Budget Office scoring window for preventive health and wellness programs.
- Expand proven disease-specific prevention programs:
    - Ensure that all Medicare beneficiaries with prediabetes have access to the Diabetes Prevention Program (DPP); facilitate that access through education and information, as well as through allowing qualified virtual providers to offer DPP.
    - Remove limitations to adequate medical care in mental health settings for all Medicare and Medicaid beneficiaries, including ensuring adequate length of stay and care coordination.
    - Allow reimbursement for a range of obesity treatments including medication.
- Ensure adequate disaster preparedness and rapid response:
    - Reauthorize and increase funding for the Assistant Secretary for Preparedness and Response in order to implement a regional disaster health system.
    - Enact the Good Samaritan Health Professionals Act.
    - Issue plans to ensure uninterrupted manufacturing and distribution of medicines, devices, and other healthcare supplies, and after-action reports that focus on disruption of access to care.

The Healthcare Workforce

- Ensure an adequate physician workforce:
    - Increase funding for Graduate Medical Education and increase the number of residency positions.

- o Pass the Resident Physician Shortage Act.
  - o Pass the Advancing Medical Resident Training in Community Hospitals Act.
  - o Pass the Opioid Workforce Act.
  - o Expand the Teaching Health Center GME program.
- Expand the training and development of allied health professionals and community health workers (CHWs):
  - o Standardize scope of practice guidelines for nonphysician healthcare providers across states.
  - o Expand the nurse licensure compact to all 50 states.
  - o Pass the Pharmacy and Medically Underserved Areas Enhancement Act.
  - o Cover CHW services under Medicare, Medicaid, and other health programs.

Optimizing Care for High-Need Patients

- Community-based care
  - o Pass the Community-Based Independence for Seniors Act.
- Incentivize coordinated care and care teams through payment, including value-based and other alternative payment models.
- Improve medication adherence and management:
  - o Give Medicare Part D prescription drug plans the flexibility to lower out-of-pocket costs for medications for high-need patients and to use clinical management tools to minimize waste.
  - o Enhance and optimize the Enhanced Medication Therapy Management (MTM) demonstration for Medicare Part D and offer benefits to all Part D members.
  - o Modernize and enhance the Standard MTM program.
- Expand access to telehealth and remote patient monitoring services to all Medicare and Medicaid beneficiaries by removing restrictions and expanding payment to all 50 states.
- Integrate care for dually eligible patients:
  - o Support the expansion of Dual-Eligible Special Needs Plans (D-SNP) and Fully Integrated Dual-Eligible Special Needs Plans; educate beneficiaries about the full range of plan options.
  - o Ensure that integrated contracting opportunities under D-SNPs are available to states.
  - o Expand the Program of All-Inclusive Care for the Elderly.
  - o Streamline and continue testing the Financial Alignment Initiative.
- Align regulations around substance use disorder treatment records with Health Insurance Portability and Accountability Act regulations and operations.
- Adopt the recommendations arising from HLC's National Dialogue for Healthcare Innovation for treatment of patients with substance use disorders.
- Encourage alternative methods of pain management through reimbursement.
- Expand NIH and FDA research into nonopioid pain management best practices.
- Incentivize states to use managed care to create networks that deliver long-term services and supports:
  - o Provide matching funds for services addressing social determinants of health.
  - o Permit states to use a State Plan Amendment to implement Medicaid LTSS programs.
  - o Reauthorize the Money Follows the Person grant program.

- Incentivize the appropriate use of hospice and palliative care:
  - Incorporate hospice benefits into the basic Medicare Advantage benefit package and extend eligibility to 12 months.
  - Eliminate restrictions that prevent the integration of curative care and use consensus-based quality measures to evaluate the benefit.
  - Initiate rulemaking to expand the list of Medicare practitioners who can be reimbursed for hospice and palliative care services, including under advanced payment models.
  - Revise Medicare Conditions of Participation to accommodate new and innovative hospice and palliative care models.
- Increase supplemental benefits and make them available to all individuals based on need and income level, including those in Medicare, Medicaid, employer-based, and ACA plans:
  - Nonemergency medical transportation
  - Home care
    - Make the CMS Independence at Home Demonstration permanent and expand to more sites and beneficiaries.
    - Support the Home Health Care Planning Improvement Act.
  - Home modifications
  - Nutrition
    - Pass the Preventing Diabetes in Medicare Act.
    - Encourage the use of nutrition-related, home- and community-based services.
    - Give state Medicaid health plans the opportunity to partner with community-based nutrition services organizations.

A Highly Functioning Healthcare Ecosystem

- Ensure access to high-quality plans:
  - Modify the Medicare Plan Finder to provide a complete picture of beneficiaries' financial obligations.
  - Update the Medicare Plan Finder to allow beneficiaries to indicate whether they have a Chronic Special Needs Plan condition and their plan options.
- Modernize payment models:
  - Incorporate socioeconomic status adjustments into quality measurement for alternative payment models.
  - Account for high-need patients in outcome-based payments under the Medicare Access and CHIP Reauthorization Act.
- Develop an accurate and meaningful approach to permanently address the impact of patients' socioeconomic status on Medicare Advantage Star ratings.
- Amend the Stark law and Anti-Kickback Statute to improve the effectiveness of value-based care models.
- Ensure access to state-of-the-art technological services and supports for Medicaid members and eliminate barriers to those services.
- Adopt technology-neutral interoperability initiatives.
- Resolve the technical difficulties in the CMS Medicaid Status Data File so the most vulnerable patients do not needlessly lose their Medicaid eligibility.

Care for Those Who Need It Most

Understanding who they are

The Bipartisan Policy Center (BPC) has defined high-need Medicare-only beneficiaries as those who have three or more chronic conditions, have functional or cognitive impairments, and reside in the community, not in an institutional or nursing home facility.[3] This definition does not include people who are ineligible for Medicare or those who are dually eligible for Medicare and Medicaid, and therefore excludes some of the highest-need individuals.

The National Academy of Medicine (NAM) uses the literature on these persons to outline a definition that includes total accrued healthcare costs, intensity of care utilized for a given period of time, and functional limitations.[4] This is a more complete definition that allows for the inclusion of more individuals. Ultimately, the classification of persons as high-need should be made by the healthcare provider or health plan. Overly restrictive criteria could limit access to needed programs and services.

The definition of high-need patients proposed by the Commonwealth Fund contains key distinctions: functional limitations on the patients' ability to care for themselves or perform routine daily tasks without supports and services. These limitations lead to the categorical distinction of high-need patients, but also comparatively contribute significantly to high costs. In fact, the Commonwealth Fund researchers found that these patients had average annual healthcare expenditures ($21,000) that were nearly three times higher – and which were more likely to remain high over two years of observation – and out-of-pocket expenses that were more than a third higher. Rates of hospital use for high-need adults were more than twice those for adults with multiple chronic conditions only; high-need adults also visited the doctor more frequently and used more home healthcare.[5]

> One in 20 adults in the United States, or about 12 million people,
> meet this definition of high need.[6]

The impact of social determinants of health

The impact of social determinants of health on high-need patients cannot be overstated. According to the Kaiser Family Foundation (KFF), "Social determinants of health are the conditions in which people are born, grow, live, work, and age that shape health."[7] These can include income, socioeconomic status, education, geographic location, employment, access to healthcare, transportation, food and nutrition, social isolation and many more broad categories but can also be specific social, behavioral, and functional limitations such as home-state/ home-safety, the ability to perform activities of daily living and the level of in-home support available to mitigate these limitations The KFF authors note, however, that access to healthcare is a weak determinant of health, and that addressing inclusion in the community and employment have a greater impact on prevention of exacerbated health conditions.

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[3] "Improving Care for High-Need, High-Cost Medicare Patients," Bipartisan Policy Center, April 2017.

[4] Long, P.; Abrams, M.; Milstein, A.; Anderson, G.; Apton, K.L.; Dahlberg, M.L.; and Whicher, D. editors. "Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health," Washington, D.C.: National Academy of Medicine, 2017.

[5] Hayes, S.; Salzberg, C.; McCarthy, D.; Radley, D.; Abrams, M.; Shah, T.; and Anderson, G. Issue Brief: "High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?" The Commonwealth Fund, August 29, 2016.

[6] Ibid.

[7] Artiga, S. and Hinton, E. Issue Brief: "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity," The Kaiser Family Foundation, May 2018.

One social determinant often overlooked is social isolation, which is closely linked, and often driven by, other social determinants of health.[8] Social isolation can have a profound negative effect on health outcomes. It is "on a par with high blood pressure, obesity, lack of exercise or smoking as a risk factor for illness and early death," says a prominent University of Chicago psychologist.[9] Three decades ago, researchers were warning of its effects, citing "increased risk of death among persons with a low quantity, and sometimes low quality, of social relationships."[10]

Providers and payers should screen people for social determinants to help identify those who are in need of supports and services. Research by Deloitte finds that 83 percent of hospitals are screening their "high-utilizer" populations (synonymous with "high-need") for social needs, but the researchers note that "some of this screening appears to be more occasional or ad hoc (26 percent)."[11]

CMS should disseminate and encourage adoption of screening tools – to be used in both clinical and non-clinical environments - that use questions and observations to identify risk associated with social determinants, including social isolation, that will then help hospitals, health systems, providers, and payers identify those who need assistance most and the type of assistance needed. Many of these tools are already in use. For example, the KFF authors report that in 2017, 19 states required Medicaid managed care plans to screen for or provide referrals for social needs. HLC member Change Healthcare identifies and assists Medicare Advantage and Medicaid and managed care organizations (MCOs). There is also a need for increased education about processes and resources available, allowing providers to connect individuals with the appropriate resources, services, and supports.

Leveraging proven methods

Medicare Advantage (MA) effectively provides healthcare coverage that generates cost efficiencies and improves clinical outcomes through use of value-based arrangements. Studies find that MA enrollees are less likely to end up in the hospital or emergency room for preventable conditions, spend fewer days in the hospital when they are admitted, on average, and are less likely to be readmitted than beneficiaries in traditional Medicare. Further, MA does a better job of managing chronic conditions. Some MA plans specialize in care for specific populations who can benefit from tailored and specialized care, such as individuals who are dually eligible for Medicare and Medicaid and those with certain chronic conditions. For example, diabetics enrolled in MA Chronic Condition Special Needs Plans (C-SNPs) experienced 19 percent fewer hospital days per enrollee than those enrolled in traditional Medicare.[12]

Given that Medicare is a substantial payer of services, it can have a reinforcing impact on private sector innovation. The withdrawal of the CMS regulation that would have implemented bundled payments in fee-for-service (FFS) plans shows that it can be difficult for the federal government to implement its own payment reform programs. However, MA continues to be a source of healthcare delivery reforms that improve quality and reduce costs. Under current policy, newly eligible Medicare beneficiaries who do not make an active enrollment choice are, by default, enrolled in Medicare FFS. When individuals become eligible for Medicare, they should instead have to make an explicit choice of enrolling in either

[8] Valtorta, N. and Hanratty, B. "Loneliness, Isolation and the Health of Older Adults: Do We Need a New Research Agenda?" *J R Soc Med* 2012 Dec. 105(12).

[9] https://well.blogs.nytimes.com/2013/05/13/shaking-off-loneliness/

[10] House, J.; Landis, K. and Umberson, D. "Social Relationships and Health." *Science*, vol. 241 no. 4865, July 29, 1988.

[11] Lee, J. and Korba, C. "Social Determinants of Health: How Are Hospitals and Health Systems Investing in and Addressing Social Needs?" Deloitte Center for Health Solutions, 2017.

[12] http://avalere.com/expertise/managed-care/insights/beneficiaries-in-specialized-diabetes-focused-medicare-plans-have-fewer-hos

an MA plan or FFS. CMS should test an alternative process that requires beneficiaries to make active enrollment selections when reaching Medicare eligibility. Should a beneficiary not make an active choice, under this demonstration a beneficiary would be enrolled into the highest value option available to them, either MA or FFS, based on quality and cost.

Similarly, Medicaid managed care organizations (MCOs) undertake activities to promote healthy behavior or address social determinants of health, according to the KFF survey of 2017 plans. MCOs cover nearly two-thirds of Medicaid beneficiaries nationwide.[13]

Leveraging these proven methods in benefit design for individuals in traditional Medicare, Medicaid, or those who are dually eligible will help to reduce utilization, lower costs, and improve outcomes.[14]

To increase transparency and support beneficiary choice, CMS should also develop a fee-for-service rating system similar to the MA Stars system, so that beneficiaries can make fully informed coverage, cost, and quality comparisons across all the Medicare options available to them.

CMS should modernize the Medicare Plan Finder to increase beneficiary awareness and understanding of coverage options. By enhancing this tool, CMS would be providing beneficiaries with the complete information needed to facilitate enrollment in the coverage best suited to meet their particular needs. CMS should undertake an enrollment demonstration in which beneficiaries would be free to change plans if they wanted. Testing this change would enable CMS to identify the best ways for ensuring that beneficiaries end up with the best care for them, and would likely improve engagement, satisfaction, and transparency, ultimately leading to improved outcomes and decreased costs.

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[13] https://www.kff.org/medicaid/report/medicaid-managed-care-plans-and-access-to-care-results-from-the-kaiser-family-foundation-2017-survey-of-medicaid-managed-care-plans/

[14] "Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare." Avalere Health, July 2018.

Prevention, Primary Care, and Preparedness

The first step in improving healthcare outcomes, increasing quality, and lowering American healthcare costs is access to preventive healthcare and services: providing services and supports to help people avoid developing conditions that put them in the high-need category. Although approximately 75 percent of total U.S. healthcare spending is on treatment for preventable diseases, only 3 percent of expenditures is invested in disease prevention programs, according to the American Public Health Association. Indeed, the entire budget for all chronic disease prevention activities at the Centers for Disease Control and Prevention is just $1.2 billion – an average of $4 per person per year. State public health spending averages only $32 per person per year.[15]

Prevention pays off. According to the U.S. Surgeon General:

- For every HIV infection prevented, an estimated $355,000 is saved in the cost of providing lifetime HIV treatment.
- A 5 percent reduction in the prevalence of hypertension would save $25 billion in five years.
- Annual healthcare costs are $2,000 higher for smokers, $1,400 higher for people who are obese, and $6,600 higher for those who have diabetes, than for nonsmokers, people who are not obese, or people who do not have diabetes.
- A 1 percent reduction in weight, blood pressure, glucose, and cholesterol risk factors would save $83 to $103 annually in medical costs per person.
- Increasing use of preventive services, including tobacco cessation screening, alcohol abuse screening and aspirin use, to 90 percent of the recommended levels could save $3.7 billion annually in medical costs.
- Reducing average population sodium intake to 2,300 milligrams per day could save $18 billion in healthcare costs annually.[16]

<p style="text-align: center; color: #4a7ebb;">The CDC estimates that if everyone in the United States received recommended clinical preventive care, we could save over 100,000 lives each year.[17]</p>

One of the best routes to prevention is primary care. But while representing 57 percent of patient visits, primary care accounts for only 6 to 7 percent of Medicare spending, and perhaps less for the rest of the population.[18] "Multiple investigators from various disciplines have assessed the effects of primary care and found that when people have access to primary care, treatment occurs before more severe problems can develop," Phillips and Bazemore wrote in *Health Affairs*. "People who receive primary care also have fewer preventable emergency department visits and hospital admissions than those who don't."[19]

The Healthcare Leadership Council believes that Congress and the administration should support the development and implementation of programs and services to keep Americans healthy, including:

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[15] "A Funding Crisis for Public Health and Safety: State-by-State Public Health Funding and Key Health Facts, 2017." Trust for America's Health. http://healthyamericans.org/report/136/

[16] National Prevention Strategy: America's Plan for Better Health and Wellness. National Prevention Council, Office of the Surgeon General, June 2011.

[17] https://www.cdc.gov/prevention/index.html

[18] Phillips, R. and Bazemore, A. "Primary Care and Why It Matters for U.S. Health System Reform." *Health Aff.* 2010;29 (5).

[19] Ibid.

- wellness programs,
- disease-specific prevention programs, and
- disaster preparedness and response.

Wellness programs

The RAND Workplace Wellness Programs Study sponsored by the U.S. Department of Labor finds that about half of employers with at least 50 employees, and more than 90 percent of those with more than 50,000 employees, offered a wellness program in 2012.[20] The success of these programs is proven. Studies have shown that medical costs are reduced by approximately $3.27 for every dollar spent on workplace wellness programs and that absenteeism costs are reduced by approximately $2.73 for every dollar spent.[21]

Individuals need access to comprehensive and evidence-based wellness programs that educate them on making healthy choices. These programs should be easily accessible, and wellness programs that are offered by, and available in, the workplace make them available to millions of American workers. Their success is often closely tied to incentives. Employers should be allowed to offer wellness programs that meet the Affordable Care Act (ACA)'s requirements, and the existing U.S. Equal Employment Opportunity Commission (EEOC) regulations should be conformed to the ACA standards. Left in limbo by the EEOC's failure to act since a judge vacated wellness program incentive limits in December 2017, the EEOC should provide guidance to employers looking to the future of these programs. Medicare should also offer wellness programs as a benefit.

The definition of preventive services should be expanded to incorporate interventions aimed at patient groups that include Medicaid beneficiaries.[22] Further, Congress should pass the Preventive Health Savings Act, which would allow Congress to request that the Congressional Budget Office lengthen its scoring window for preventive health and wellness programs. Without a more accurate way of knowing the longer-term cost savings associated with these programs, their implementation and effectiveness are limited.

Disease-specific prevention programs

Diabetes

Diabetes is one of the most prevalent chronic diseases, especially among the Medicare population. More than 26 percent of Medicare beneficiaries already has diabetes, and one out of every three Medicare dollars is spent on people with diabetes. Persons with diabetes comprise a large segment of the high-need population, but diabetes can be prevented and so can the associated costs. A multicenter clinical trial led by the National Institutes of Health (NIH) shows that the Diabetes Prevention Program (DPP) reduced the risk of prediabetic patients over the age of 60 becoming diabetic by 71 percent.[23] The Medicare demonstration program on diabetes prevention showed a savings of $2,650 per beneficiary in just 15 months.[24] Based on these results, CMS expanded the DPP into Medicare as of April 1, 2018.

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[20] https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/WellnessStudyFinal.pdf

[21] Baicker K.; Cutler D.; Song Z. "Workplace Wellness Programs Can Generate Savings." *Health Aff.* 2010;29 (2):304-311.

[22] Rosenbaum S.; Riley T.; Bradley A.; Veghte B.; Rosenthal J. "Strengthening Medicaid as a Critical Lever in Building a Culture of Health," Washington, DC: 2017, National Academy of Social Insurance.

[23] National Institute of Diabetes and Digestive and Kidney Diseases, "Diabetes Prevention Program," https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp.

[24] CMS, Center for Medicare and Medicaid Innovation, "Report to Congress," December 2016.

HLC urges CMS to ensure that all Medicare beneficiaries who are prediabetic and who could benefit from DPP have access to it, utilizing the Center for Disease Control's National Diabetes Prevention Program criteria. The information on available programs in the Medicare beneficiary area should be easily accessible on the CMS website, and CMS should undertake an education campaign to inform Medicare beneficiaries of this new benefit. Additionally, HLC asks CMS to allow qualified virtual (e.g., telehealth) providers to provide DPP. Doing so would ensure that Medicare beneficiaries in rural areas or who have mobility and transportation problems are still able to participate in the program. MA plans should be granted sufficient flexibility to implement this offering as well by being able to determine payment arrangements. The DPP should also be viewed as a potential model for other community-based programs, provided that appropriate clinical evidence is collected, to address such chronic diseases as obesity and asthma.

Obesity

Obesity is a top risk factor for diabetes with roughly 90 percent of people living with type 2 diabetes being overweight or having obesity. People who are overweight or have obesity have added pressure on their body's ability to use insulin to properly control blood sugar levels, and are therefore more likely to develop diabetes according to The Obesity Society. The number of diabetes cases among American adults increased by a third during the 1990s, and additional increases are expected. This rapid increase in the occurrence of diabetes is mostly attributed to the growing prevalence of obesity in the United States.

Obesity can be treated through dietary changes, increasing exercise and activity, behavior change, prescription weight-loss medications, and weight-loss surgery. Dietary changes can consist of cutting calories, making healthier choices, restricting certain foods, and incorporating meal replacements. Increased physical activity or exercise is an essential part of obesity treatment. Most people who are able to maintain their weight loss for more than a year get regular exercise, even simply walking. A behavior modification program can also help individuals to lose weight and keep it off. These programs include counseling and support groups.

In certain situation, prescription weight-loss medication may help. Weight-loss surgery for obesity may also be considered especially if other methods to lose weight have not worked. Weight-loss surgery limits the amount of food consumed or decreases the absorption of food and calories or both. The Affordable Care Act includes several provisions that promote preventive care including obesity-related services and coverage.

In addition to its serious health consequences, the estimated annual healthcare costs of obesity-related illness are $190 billion or nearly 21% of annual medical spending in the United States. Given the impact of obesity-related illness, research should continue into appropriate treatments and coverage. Currently the Medicare program does not cover prescription-related treatments or coverage for varied types of qualified healthcare providers. The "Treat and Reduce Obesity Act" (TROA) would provide CMS with the authority to expand the Medicare benefit for intensive behavioral counseling and would also expand Medicare Part D to provide coverage of FDA-approved prescription drugs for chronic weight management.

Osteoporosis

Osteoporosis is another disease that can be prevented, thus saving lives and costs. According to the National Osteoporosis Foundation (NOF), 54 million Americans – half of all adults age 50 and older – are affected by osteoporosis, low bone density, or both. The disease is responsible for an estimated 2

million broken bones per year; these bone breaks cost patients, their families, and the healthcare system $19 billion annually.

One study shows that in the United States from 2000-2011, the number of hospitalizations for osteoporotic fractures (43 percent) exceeded those for heart attack (25 percent), stroke (26 percent) and breast cancer (6 percent). Over 50 percent of the fracture hospitalizations are for hip fractures.[25] Up to 25 percent of hip fracture patients die within a year of their injury.[26] By 2025, experts predict that osteoporosis will be responsible for 3 million fractures, resulting in $25.3 billion in costs.

Osteoporosis is manageable, yet nearly 80 percent of older Americans who suffer bone breaks are not tested or treated for osteoporosis. The NOF estimates that about half of osteoporosis-related repeat fractures can be prevented with appropriate treatment. While Medicare offers preventive osteoporosis screenings for qualified individuals every two years or more frequently if medically necessary, evidence suggests that the rates of screening are declining.[27] HLC urges Medicare to encourage osteoporosis screening and provide adequate reimbursement for such services at a sustainable level.

Low bone density can be prevented from elevating to osteoporosis with diet, exercise, and medication. For example, researchers find that "net healthcare cost savings of $595.3 million per year and more than $4.76 billion cumulatively over the next seven years is potentially realizable after accounting for the cost of dietary supplementation [calcium, vitamin D, and magnesium]."[28]

Mental health

People with mental health conditions and substance use disorders use more medical resources, are more likely to be hospitalized for physical illness, and are readmitted to the hospital more frequently than those without these chronic health conditions. A lack of coordination between primary care and mental health results in inadequate treatment.

Further, Medicare and Medicaid reimbursement rules discourage adequate medical care in mental healthcare settings.[29] CMS should remove the 15-day limit for beneficiaries to stay in Institutions for Mental Diseases (IMD), allow for any number of days to be covered based on needs, and align standards with state and federal medical necessity laws.

Disaster preparedness and response

Persons with chronic conditions or functional limitations are especially vulnerable during disasters. The Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) is responsible for addressing the complex needs of these people during a disaster. HLC supports reauthorization of an increase in funding for ASPR so that it can implement a regional disaster health system that would direct grants to healthcare coalitions, academic medical centers, and other entities to be used by state and local governments without a request from the federal government. This will allow state and local governments to help address the unique needs of patients with chronic conditions during a disaster.

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[25] Singer A.J.; et al. Mayo Clinic Proceedings 2015. 90; 53-62.

[26] Burge R.; Dawson-Hughes B.; Solomon D.H.; Wong J.B.; King, A.; Tosteson, A. Incidence and Economic Burden of Osteoporosis-Related Fractures in the United States, 2005-2025. J Bone Miner Res 2007. 22(3): 465-475.

[27] Lewiecki E.M. 2016 Hip Fractures and Declining DXA Testing: At a Breaking Point? J Bone Miner Res 31 (Suppl 1).

[28] Shanahan, C. and de Lorimier, R. "Smart Prevention: Health Care Cost Savings Resulting from the Targeted Use of Dietary Supplements." Frost & Sullivan, September 2013. https://www.crnusa.org/sites/default/files/pdfs-hccs/SmartPrevention-fullreport0913.pdf

[29] https://www.nchc.org/wp-content/uploads/2016/06/care-coordination-fact-sheet-1.pdf

Congress should also enact the Good Samaritan Health Professionals Act, which would shield medical professionals who volunteer their services during a disaster from liability. This will encourage more providers to volunteer and it would also ensure access to primary and specialty providers.

After-action reports on governmental action during these disasters should include a focus on how access to healthcare can be restored when disrupted by the disasters. Additionally, these reports should discuss how best to continue the manufacturing and distribution of medicines, devices, and other healthcare supplies during and after a disaster in order to ensure uninterrupted access to therapies. It is also important to address the impact power outages have on individuals who are power-dependent. For example, certain durable medical equipment, such as ventilators or feeding pumps, may be inoperable during a disaster, which can have life-threatening consequences. Prolonged power outages also affect mobility.

The Healthcare Workforce

A well-trained, fully resourced, strategically deployed healthcare workforce is crucial for identifying, assessing, and treating individuals with chronic conditions or functional limitations. Care and health outcomes can be improved, and the costs of care reduced, through an adequate physician workforce and expanded training and deployment of allied health professionals and community health workers.

An adequate physician workforce

To ensure that physicians have the training they need, Congress should increase funding for Graduate Medical Education (GME) and increase the number of residency positions in both primary and specialty care. HLC urges Congress to pass the Resident Physician Shortage Act, which would increase the number of GME slots by 15,000 (3,000 per year). Additionally, Congress should pass the Advancing Medical Resident Training in Community Hospitals Act, which would raise the GME caps for hospitals that have inadvertently and unknowingly established medical resident training programs with artificially low levels. Legislation such as the Opioid Workforce Act that would increase the number of GME positions in addiction medicine should also be approved by Congress.

GME policies and teaching should reflect the team-based approach needed to care for persons who are chronically ill. Residency programs that focus on community-based care, such as the Teaching Health Center GME program, should be expanded and a portion of GME funding should be tied to the development of a curriculum focused on integrated team-based care.

> The United States could face a shortage of as many as 120,000 doctors by 2030.[30]

Allied health professionals

Currently, the scope of practice guidelines for nonphysician healthcare providers vary from state to state. This creates unnecessary barriers to the expansion of programs. Nurse practitioners, physician assistants, other advanced practice providers, and personal care attendants should be allowed to practice to the full scope of their training and should be reimbursed for their services. The practice requirements should also be standardized across states. Additionally, the nurse licensure compact should be expanded to all 50 states so that registered nurses and licensed practical and vocational nurses are able to practice in other states without having to secure additional licenses. This will give nurses additional flexibility in their careers and help reduce the nursing shortage.

The pharmacy workforce plays a critically important role in providing high-quality care. Pharmacists are both medication experts and clinicians[31] and should be recognized as such in federal policy. Congress should pass the Pharmacy and Medically Underserved Areas Enhancement Act, which would empower pharmacists to provide Medicare Part B services that are consistent with their education, training, and license. This legislation would let pharmacists assist in caring for persons with chronic diseases, especially those living in medically underserved areas. As pharmacists spend more of their time treating patients, pharmacy technicians could expand their role to handle the dispensing of medication.

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[30] "The Complexities of Physician Supply and Demand: Projections from 2016 to 2030," Special Report, Association of American Medical Colleges. Prepared by IHS Markit Ltd., March 2018.

[31] McInnis T.; Capps K. "Get the Medications Right: A Nationwide Snapshot of Expert Practices—Comprehensive Medication Management in Ambulatory/Community Pharmacy," Health2Resources, May 2016, 3.

Community health workers

Community health workers (CHWs) are referred to by many different names, including *promotores*, camp health aides, *colonia* health workers, lay health workers, outreach workers, community health representatives, indigenous or village health workers, and nontraditional health workers, but this playbook will refer to them as CHWs. These nontraditional and nonmedical service provider partners offer valuable and critical support. Regardless of their title, CHWs are frontline health workers who often come from the communities they serve and often have similar experiences that make them able to connect with people and engage them in their healthcare encounters. CHWs serve as a link between persons with chronic conditions, communities, and health and human service agencies and provide informal counseling, culturally competent health education, and advocacy.

Persons who received support from community health workers had

30 percent fewer hospital admissions in one year

compared with those who did not receive that support.[32,32]

CHWs are especially helpful in connecting people to services that assist with addressing social determinants of health, including transportation, affordable and accessible housing, and access to healthy food. They also help with scheduling appointments, addressing barriers to care, and serving as peer supports if they have similar experiences. These connections and assistance result in improved care and reduced costs, as shown in a study by HLC member Maxim Healthcare, which find that CHWs can help reduce hospital readmissions by 60 percent.[33] CHWs also serve a vital role as part of the telehealth team and by combining the two interventions, the impact of both interventions can be expanded.[34] CHW services should be covered by Medicare, Medicaid, and other health programs for persons who need assistance with accessing and addressing their healthcare and support needs.

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[32] Kangovi S.; Mitra N.; Grande D.; Huo H.; Smith R.A.; Long J.A. "Community Health Worker Support for Disadvantaged Patients with Multiple Chronic Diseases: A Randomized Clinical Trial." *Am J Public Health,* August 2017.

[33] Maxim Healthcare Services, "Community Based Care Management Programs: Maxim Healthcare's Proactive Approach to Reducing Hospital Readmissions," http://social.maximhealthcare.com/maxim-healthcare-cbcm.

[34]https://www.chlpi.org/wp-content/uploads/2013/12/Telehealth-and-CHWs_March-2018.pdf

Optimizing Care for High-Need Patients

Community-based care

HLC member SCAN Health Plan and the Coalition to Promote Medicare Independence have proposed a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration project that would prevent high-need patients from becoming high-cost. This plan would establish a demonstration program for home- and community-based care for low-income Medicare beneficiaries whose health needs put them at risk for nursing facility placement. The CBI-SNP program would prevent these beneficiaries from having to spend down their assets to qualify for Medicaid and would allow them to remain in their homes or communities. HLC urges Congress to pass the Community-Based Independence for Seniors Act, which would create this demonstration program.

Coordinated care

Coordinated care can improve health outcomes and overall quality of life. Different settings tackle coordination in different ways, but they generally rely upon patient-centered interdisciplinary collaboration and smooth transitions among providers. The National Academy of Medicine's special report, "Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health," suggests models typically fall into one of three broad categories:

- integrated care, relying on interdisciplinary teams that cover medical care as well as behavioral health services;
- transitional care, in which a single caregiver, usually a nurse, guides the patient among caregivers and care settings; and
- enhanced primary care, defined as primary care settings that make use of supplemental services and collaborations among caregivers. [35]

The authors emphasize that coordination, defined as "extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and [co-location] of teams,"[36] is a key delivery feature of successful care models.

Care teams that include a range of health professionals, including both physician and nonphysician providers, are critical to improving care and reducing costs. For example, HLC member Blue Cross Blue Shield of Tennessee provides patients with a support system that can help them improve their quality of life today and prevent costly, uncoordinated care in the future. Care managers and coordinators work with patients who have chronic health conditions, mobility challenges, mental health needs, or a recent hospital inpatient or outpatient stay, to improve outcomes and prevent readmissions.[37] Another HLC member, Aetna, has proposed a pilot program that would provide an interdisciplinary care management team and a dedicated health professional to seniors with complex medical conditions.

The deployment of care teams should be incentivized through payment. Support of value-based care and alternative payment models can help high-need patients get the coordinated care they lack.

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[35] Long, P.; Abrams, M.; Milstein, A.; Anderson, G.; Apton, K.L; Dahlberg, M.L.; and Whicher, D., editors. "Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health," Washington, D.C.: National Academy of Medicine, 2017.

[36] Ibid.

[37] Thompson, J. "Care Management: Improving Quality of Life While Reducing Medical Costs," Blue Cross Blue Shield of Tennessee News Center, April 12, 2018, https://bcbstnews.com/insights/care-management-improving-quality-of-life-while-reducing-medical-costs/.

Medication adherence and management

People with chronic conditions are often on multiple medications, each with different instructions and potential side effects. These issues can cause people to stop taking their medications or not take them as prescribed for fear of making a mistake or the embarrassment of not understanding, which can result in increased hospitalizations, exacerbated health conditions, and other healthcare costs. Medicare Part D prescription drug plans should have the flexibility to lower out-of-pocket costs for medications. They should also be given regulatory flexibility to use clinical management tools to minimize waste related to nonuse of prescriptions.

The Enhanced Medication Therapy Management (MTM) demonstration for Medicare Part D seeks to create incentives for robust investment and innovation in better MTM targeting and interventions. This program should be expanded and optimized, and its benefits offered to all Part D members. CMS should provide robust education to pharmacies and providers and should reconsider its stance regarding manufacturer and health plan collaborations to allow for appropriate interactions that will result in improved medication adherence.

Further, CMS should enhance the Standard Medication Therapy Management model. Improvements should include:

- establishing predetermined standard eligibility criteria;
- taking into account in program evaluations, the population served and the plan type; and
- removing disadvantages to plans that have more beneficiaries in the Standard MTM program.

Personalized medicine

Individuals can benefit from more effective, targeted treatments. Maintaining and strengthening the commitment to the Precision Medicine Initiative can break down barriers to research and continue facilitating private-sector involvement in leading this effort.

Telehealth and remote monitoring

Individuals may encounter challenges getting to their medical appointments, whether due to functional limitations, lack of transportation options, or geographic barriers. In these situations, telehealth can facilitate connections with providers. HLC commends Congress for passing the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act whcih expanded telehealth and remote patient monitoring sites in Medicare, including the addition of home dialysis sites as originating sites for those patients and the lifting of evaluation restrictions for telestroke. HLC believes that telehealth should be expanded to more areas of medicine beyond the ones outlined in the CHRONIC Care Act, and all Medicare beneficiaries should have access to these services. HLC urges Congress to expand the use of telehealth to all Medicare beneficiaries by lifting its current restrictions on the service, including patient location restrictions, communication technology restrictions, and coverage (1834(m)) restrictions.

CMS and Congress should also lift the restrictions on remote patient monitoring (RPM). RPM can be an effective tool. However, only 22 states have Medicaid programs that reimburse for RPM.[38] The small cost of providing this monitoring would be offset by the reduction in office visits and ER utilization. In

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[38] "State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and District of Columbia," Center for Connected Health Policy, National Telehealth Policy Resource Center, April 2017.

fact, a remote patient monitoring pilot study find that home monitoring can yield more than $8,000 in savings per patient annually.[39]

Integrated care for persons dually eligible for the Medicare and Medicaid programs

In 2015, only 20 percent of people dually eligible for Medicare and Medicaid were enrolled in programs that blended medical and social services.[40] Persons who are dually eligible often need medical care and social supports and services; Medicare spends twice as much for a person who is dually eligible as it does for a Medicare-only beneficiary.[41] Total spending on dual-eligibles in 2013 was $312.4 billion.[42] To reduce these costs and improve their care, the federal government, states, and health plans should support the expansion of Dual-Eligible Special Needs Plans (D-SNPs) and Fully Integrated Dual-Eligible SNPs (FIDE-SNPs), and Medicare-Medicaid Plans (MMPs) participating in the Financial Alignments Initiative (FAI).

In D-SNPs, FIDE-SNPs, and MMPs, CMS, states, and health plans work together to ensure persons who are dually eligible are served in the most integrated and coordinated way possible. This has resulted in contracts that include requirements for service coordination and has led health plans to develop new and innovative tools and processes. HLC urges CMS to educate Medicaid beneficiaries about the full range of Medicare plan options available to them when they are eligible for the program.

CMS should ensure that integrated contracting opportunities under the D-SNP model are available to states in 2021 when new Bipartisan Budget Act (BBA) statutory requirements related to integration and grievance and appeals processes will become effective. In developing these BBA rules, CMS should:

- support the move toward integrated products, including FIDE-SNPs, D-SNPs, and Medicare Managed Plans, while accounting for state differences in Medicare and Medicaid integration levels and allowing states to retain the flexibility to define programs, such as populations to be served and services to be provided;
- unify Medicaid and Medicare grievance and appeals requirements for D-SNPs to the greatest extent possible, including timelines and processes, while allowing state flexibility;
- reduce complexity for beneficiaries and minimize administrative burdens on participating entities; and
- work with states to aid in the development of a common nomenclature and materials and create tools that can be used to educate all stakeholders.

Aligning and improving these processes and services would enable individuals and their family members to better navigate their care. Additionally, the Program of All-Inclusive Care for the Elderly (PACE) should be expanded by increasing funding for nonprofit providers who wish to develop new PACE daycare sites or expand existing sites.

The Financial Alignment Initiative has provided important opportunities to test the delivery of integrated services and benefits to persons who are dually eligible. It includes several critical components of integration, including more coordinated and flexible coverage of Medicare and Medicaid services and

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[39] https://www.geneia.com/news-events/press-releases/2016/june/geneia-study-finds-remote-patient-monitoring-could-save-more-than-8000-dollars-per-patient-annually
[40] Long, P.; Abrams, M.; Milstein, A.; Anderson, G.; Apton, K.L.; Dahlberg, M.L.; and Whicher, D., editors. "Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health," Washington, D.C.: National Academy of Medicine, 2017.
[41] "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid," Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, January 2018.
[42] Ibid.

benefits under a single entity, coordinated grievance and appeals processes, and common insurance identification cards. However, HLC recommends that testing and improvements continue within the FAI. For example, the marketing approval process for member materials should be streamlined so that Medicare and Medicaid do not have two separate review processes, which prevents health plans from providing their members with information in a timely manner. We also recommend increased transparency of the MMP payment rate development process and actuarial soundness per Medicaid managed care regulations, supporting the viability of MMP and ongoing provision of high-quality care. Continuing to test this and other proposals within the FAI will help improve quality of care, value, and access to a meaningful package of services for dual-eligibles.

Substance use disorders

People with substance use disorders often experience other chronic conditions. The complete medical records of these patients must be accessible to their healthcare providers, with appropriate protections in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Having all the information necessary for safe, effective, high-quality treatment and care coordination that addresses all of an individual's health needs is vital to support prevention, treatment, and recovery. Current federal regulations governing the confidentiality of drug and alcohol treatment and prevention records (42.C.F.R. Part 2 (Part 2)) limits the disclosure of information among healthcare providers and payers. This includes information regarding the completeness or incompleteness of a shared record of information about similar treatment that is recent or ongoing. HLC strongly believes that substance use disorder treatment records should align with HIPAA to allow the exchange of patient information in order to deliver holistic care. HLC supports legislation to align Part 2 with HIPAA for the purposes of healthcare treatment, payment, and operations, with appropriate protections.

HLC's *National Dialogue for Healthcare Innovation (NDHI)* convened a diverse group of healthcare stakeholders, government leaders, and others to develop additional suggestions for the treatment of individuals with substance use disorders. These recommendations include:

- expanding access to evidence-based substance use disorder treatment;
- developing sustainable payment systems to support treatment;
- emphasizing opioid misuse prevention strategies and community partnerships;
- utilizing a person-centered, team-based approach that includes a wide range of healthcare providers, including peer and recovery supports;
- improving supply chain security and opioid disposal practices; and
- creating opportunities for healthcare leaders to share knowledge and best practices.

NDHI participants also recommend expanding access to nonopioid, evidence-based nonpharmacological pain management. Alternative methods of pain management should be encouraged, and HLC applauds CMS's guidance that includes nonopioid pain management in the supplemental benefits allowed to MA beneficiaries. The National Institutes of Health (NIH) and the Food and Drug Administration (FDA) should be incentivized to expand research to assess best practices and treatment effectiveness to better enable the offering of alternative therapies.

Long-term services and supports

People can become dually eligible for Medicare and Medicaid because of their need for long-term services and supports (LTSS). Medicaid spending for managed LTSS more than doubled in three years

from fiscal year 2012 to fiscal year 2015, and growth is expected to continue as states implement new programs.[43]

The shift to providing care and services in home- and community-based settings should continue to be required and expanded. Medicaid managed care organizations play an important role in partnering with states to develop a sustainable system that builds capacity to deliver these services to people seeking access to LTSS services. Congress and the administration should incentivize states to use managed care to design, build, and coordinate networks that deliver LTSS. For example, the federal government should provide matching funds for services addressing social determinants of health to enhance opportunities for people to live in and receive services in their homes and communities. States should also be allowed to use a State Plan Amendment to implement Medicaid LTSS programs. The CMS Money Follows the Person grant program has also been beneficial in assisting states in improving access to home- and community-based services, and this program should be reauthorized.

Hospice and palliative care

HLC supports policy changes that incentivize the use of hospice and palliative care. Hospice benefits should be made part of the basic MA benefit package. Additionally, Medicare hospice eligibility should be extended from six to 12 months. Predicting the length of decline for a terminally ill patient is often difficult; extending the hospice benefit would make it easier for beneficiaries to utilize these services and more likely that providers would refer their patients to hospice. Introducing palliative care earlier in the continuum of care can create more quality of life for patients and caregivers. Medicare hospice services should integrate curative care as well as palliative care. Current restrictions on these services for hospice patients mean that many do not choose to enter hospice. Coordinated care that includes palliative, curative, and hospice care would result in better care and improved patient experience. As CMS defines and tests these new models of end-of-life care, HLC recommends that the agency use consensus-based quality measures to evaluate the benefit.

Hospice and palliative care should use an interdisciplinary team of providers, including social workers, chaplains, nurses, and case managers. CHWs can also play an important role for patients who wish to cease treatment and die at home. However, Medicare does not currently reimburse for the services of these providers. CMS should initiate rulemaking that expands the list of Medicare practitioners who can be reimbursed for hospice and palliative care services, and advanced payment models should also include the use of these providers.

NDHI's opioid recommendations include ensuring appropriate access to treatment for hospice and palliative care patients. Pain at the end of life is particularly hard to treat and manage.

Another barrier currently in place for hospice and palliative care is the Medicare Conditions of Participation (COPs). The barriers created by the COPs "make the arrangement of services logistically complicated and impede the continuity in team-based care that people with advanced illness and their families need."[44] These COPs should be revised to accommodate new and innovative hospice and palliative care models.

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[43] Eiken, S.; Sredl K.; Burwell B.; and Woodward, R. "Medicaid Expenditures for Long-Term Services and Supports in FY 2015," prepared for the U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Cambridge, MA: Truven Health Analytics, part of IBM Watson Health, 2017.

[44] "Policy Barriers to Advanced Illness Care Models: Exploring the Obstacles to Implementing Innovative Clinical Models," Coalition to Transform Advanced Care, May 2018.

Supplemental benefits

Social determinants of health create lack of access to healthcare; additional services and supports are often necessary and must be reimbursed. CMS recently allowed for more flexibility on the type of supplemental benefits MA plans can offer. The benefits mentioned by CMS in its guidance include adult day care services, home-based palliative care, in-home support services, support for caregivers, medically approved nonopioid pain management, memory fitness benefits, home and bathroom safety devices and modifications, transportation, and over-the-counter items and medications.

HLC supports the use of all these supplemental benefits, and this playbook recommends the use of these services and supports to address social determinants. HLC asks that these benefits be made available to all Medicare beneficiaries, tailored to their state of health, level of disease severity, and income level. Additionally, HLC believes that these services should be offered to persons who are not Medicare-eligible, including individuals covered by Medicaid, employment-based plans, or ACA plans.

There is a growing focus on addressing social determinants of health to better serve individuals holistically and improve health outcomes and cost effectiveness over time. CMS should examine ways for the health system to coordinate effectively with the broader system of community supports, including housing, employment, and education supports, nutrition, and nonmedical transportation.

Transportation

A key benefit that CMS included in the guidance on supplemental benefits for MA plans was transportation, access to which can be a social determinant of health for many high-need patients. High-need patients visit the doctor an average of 9.6 times a year,[45] but they may face barriers to transportation, including availability and accessibility, disability, income, and geographic location. This problem is especially evident in rural areas that lack access to public transportation, but even in urban areas, public transit may not be accessible.

State Medicaid agencies should ensure that eligible, qualified beneficiaries have access to nonemergency medical transportation (NEMT); that CMS continues to offer NEMT as a mandatory benefit in Medicaid; and CMS offers this supplemental benefit to Medicare beneficiaries, as well. The Bipartisan Policy Center estimated that the average cost per enrollee of providing Medicare beneficiaries with NEMT would be $50 per month. However, when spread across all enrollees in an MA plan, the cost for this type of transportation would only be $1.75 per beneficiary per month.[46] This small cost would be offset by an increase in provider efficiency and reduction in poor health resulting from "no-show" appointments. Additionally, opportunities may exist to use ride-sharing services to reduce the cost of providing this transportation. A pilot program for California CareMore MA and dual-eligible beneficiaries used Lyft to offer transportation services. This program resulted in an average reduction of per-ride NEMT costs from $31.50 to $21.30.[47] Using ride-sharing companies addresses the barriers to volunteer provision of NEMT, such as background checks, bonding, and lack of liability insurance.

Home- and community-based services

Home- and community-based services (HCBS) assist individuals who continue to live in their homes, increasing quality of life and resulting in lower hospital and nursing home costs and decreased utilization. Homecare workers assist individuals with activities of daily living such as bathing, dressing,

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[45] Hayes, S.L.; Salzberg, C.; McCarthy, D.; Radley, D.; Abrams, M.; Shah, T.; and Anderson, G. Issue Brief: "High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?" The Commonwealth Fund, August 29, 2016.

[46] "Improving Care for High-Need, High-Cost Medicare Patients," Bipartisan Policy Center, April 2017.

[47] KPMG Government Institute, "Investing in Social Services as a Core Strategy for Healthcare Organizations: Developing the Business Case," March 2018, 26.

meal preparation and eating, transportation, and light housework. They also provide companionship, which addresses the detrimental emotional and health effects of loneliness. They "work with family members, community agencies, and medically trained professionals like doctors and nurses to broaden the scope of care for seniors and provide better health outcomes."[48]

Homecare providers, as part of the overall support team for family caregivers, can also relieve the stress of caregivers who struggle with caring for their relatives with high needs. The Coalition to Transform Advanced Care (C-TAC) find that 69 percent of these family members represent a net negative experience with caregiving, and this work harms their state of mind, social life, finances, and their own health.[49] Homecare professionals and community-based services such as adult daycare centers are valuable services offered to both the patient and the family to alleviate stress and improve or maintain cognitive functions.

CMS's Independence at Home Demonstration is an example of a successful home-based program for Medicare beneficiaries. In the second year of this demonstration, the program saved a net of $7,821,374, an average of $89 per beneficiary. This program's success should be replicated. Congress should make it a permanent program, extending it to additional sites and more beneficiaries, including those in FFS Medicare. HLC also asks Congress and the administration to reduce barriers to home care by supporting legislation such as the Home Health Care Planning Improvement Act, which would allow nurse practitioners, certified nurse specialists, certified nurse-midwives, and physician assistants to certify that their patients need home healthcare.

Home modifications

Often, home care must be accompanied by modifications to make homes safer and more accessible. Low-cost solutions such as installing bathroom grab bars and removing rugs or other trip-and-fall risks can help to keep people safe and prevent costly injuries. Savings could be significant: The National Council on Aging estimates that the total cost of fall injuries in 2013 was $50 billion, 75 percent of which was paid by Medicare.[50] CMS should permit the reimbursement of these services as supplemental benefits.

Nutrition

High-need patients at risk for or living with chronic diseases such as diabetes should have access to Medical Nutrition Therapy (MNT), providing them with diagnostic, therapy, and counseling services that help them prevent and manage their diseases. HLC urges Congress to pass the Preventing Diabetes in Medicare Act to give Medicare beneficiaries with prediabetes or risk factors for developing type 2 diabetes access to this program. This would reduce healthcare costs and usage by preventing beneficiaries who are already high-need from becoming even more so.

People may have difficulty preparing nutritious foods due to functional limitations and mobility issues, or constraints such as living in a "food desert," or lacking sufficient funds to buy them. According to the Commonwealth Fund, more than half of adults with high needs have low incomes. CMS should encourage the use of nutrition-related, home- and community-based services such as "home-delivered meals, congregate meals, nutrition education, diet modification, adaptive eating devices, and nutrition

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[48] "Caring for America's Seniors: The Value of Home Care," Home Care Association of America and Global Coalition on Aging.

[49] Family Caregiver Research, Coalition to Transform Advanced Care.

[50] https://www.ncoa.org/news/resources-for-reporters/get-the-facts/falls-prevention-facts/

counseling"[51] that help support high-need patients who want to remain at home and decrease institutional placements due to lack of access to nutritious meals. State Medicaid agencies should reimburse Medicaid health plans to partner with community-based organizations that provide these nutrition services.

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[51] Gibbs, S. and Herr, A. "Providing Home- and Community-Based Nutrition Services to Low-Income Older Adults: Promising Health Plan Practices," Center for Health Care Strategies Brief, April 2018.

A Highly Functioning Healthcare Ecosystem

High-quality plans

Medicare beneficiaries can use the Medicare Plan Finder tool to assess the MA, Part D, and Medigap options available to them in their area. While the tool enables beneficiaries to tailor their search based on which drugs they take or whether they receive Extra Help, the Medicare Plan Finder does not support more custom searches.

CMS should modify the Medicare Plan Finder to give beneficiaries a complete picture of their financial obligations under various coverage options. Today, when beneficiaries are comparing FFS to MA, the Plan Finder does not include the costs associated with a standalone Part D Plan (PDP) or Medigap plan, both of which enrollees commonly purchase in FFS, and neither of which is separately needed by beneficiaries choosing an MA Prescription Drug (MA-PD) plan. Therefore, beneficiaries do not see a true apples-to-apples comparison of their costs under each coverage option.

Additionally, CMS should make simple updates to the Medicare Plan Finder so that beneficiaries can indicate whether they have one of the 15 designated C-SNP conditions and learn if specialty care through a C-SNP is an option for them. If a consumer identifies as having diabetes, for example, any diabetes C-SNPs located in that individual's region could be flagged in the results list with a special symbol. A brief pop-up note could explain what a C-SNP is and the options for enrolling.

Payment

Policymakers must ensure that physicians, other healthcare providers, health plans, and hospitals are paid appropriately for the services they provide. Quality measurement should better incorporate socioeconomic status adjustments to incentivize alternative payment models in areas of high need, and efforts to move to outcome-based payments under the Medicare Access and CHIP Reauthorization Act (MACRA) should properly represent people with chronic conditions. Without these adjustments, efforts to reward high-performing providers may result in lower funding for providers who serve many high-need persons. HLC supports the use of a limited number of standard vetted measures under MACRA, capturing variance in patient populations and urging CMS to synchronize these measures.

Quality

CMS must continue to work with stakeholders to identify a meaningful, long-term solution to the impact that characteristics of socioeconomic status (SES) and disability status have upon the MA Star ratings. Beneficiary-level characteristics have a meaningful impact on Star ratings, which is critical to allow health plans that care for the program's most vulnerable beneficiaries to compete on an equal playing field. CMS currently uses a Categorical Adjustment Index (CAI) that adjusts for disparities associated with the percentages of beneficiaries who receive a low-income subsidy, are dual-eligible or have disability status. The CAI is insufficient to address this important problem. CMS has also acknowledged that the CAI has a very small impact on plan ratings. CAI is a temporary solution, and CMS, working closely with stakeholders, must develop an accurate and meaningful approach to address permanently the impact of SES characteristics on the Star ratings, working closely with stakeholders.

Value-based payment models

HLC believes that Congress and the administration should remove barriers to the adoption of value-based payment models. This should include modernizing the physician self-referral ('Stark") law and Anti-Kickback statute, regulatory barriers that were initially implemented to discourage overutilization and inappropriate influence on provider decision making in a FFS environment. However, these laws now inhibit the adoption of value-based payment models. While exceptions and safe harbors exist,

those protections are too narrow in scope. Modernizing these laws will allow providers to deliver more cost-efficient, higher quality care. Congress should amend the Stark law and Anti-Kickback statute to allow waivers for stakeholders in alternative payment arrangements, as well as create general exceptions to protect Accountable Care Organizations (ACOs) and other alternate payment models that meet certain criteria, regardless of whether they participate in a Medicare-sponsored project. Congress should also expand the exceptions for the donation and financial support of electronic health information products.

Maximizing technology

Medicaid and MA consumers have substantially greater access to and utilization of technology (e.g., computers, smartphones) than in previous years. Medicaid managed care organizations leverage this access and utilization through innovative disease and care management activities designed to improve the health outcomes and experience of members. Examples include text message appointment reminders, outbound call campaigns about coverage renewals, and email messages soliciting updated contact information. Despite the modernization of technology, federal law still prohibits the use of new tools that would enhance how plans communicate with members. CMS should recognize the importance of the use of technology in ensuring access to state-of-the-art services and supports for Medicaid members and work with the Federal Communications Commission (FCC) to eliminate non-marketing communication barriers that negatively affect all stakeholders, including consumers, plans, and states.

In order for the healthcare community to utilize technologies to help this population, CMS must provide data in a complete and timely manner. Without the right information, healthcare stakeholders are unable to help Medicaid patients maintain their eligibility when it is time to renew coverage. This can result in people losing coverage, even though they remain eligible. HLC urges CMS to resolve the technical difficulties contained in its Medicaid Status Data File (MSDF) so the most vulnerable patients do not needlessly lose their Medicaid eligibility.

Interoperability

High-need patients often consult multiple providers, each of whom may be part of a different health system. It is critical that patient record systems be interoperable so their healthcare information is seamlessly transferred among providers, irrespective of their location or affiliation. HLC opposes all forms of information blocking within the exchange of healthcare information and endorses the flow of information across all entities. These interoperability efforts should be led by the private sector with a limited role for government. Any interoperability initiatives by the federal government should be "technology-neutral" and focused on outcomes, which will promote accessible and rapid innovation in health information connectivity. This interoperable health system also needs to correctly identify patients and match them to their data.

It is critical that patient records be both interoperable and easily accessible to patients and their caregivers, to further the important goals of patient education, empowerment, and better management of health conditions.

"Integrating medical, behavioral health, and social services;
better linking caregivers with health systems; and
fostering relationship-centered care would be consequential
for millions of high-need patients and might also lead
to broader solutions for our delivery system as a whole."[52]

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[52] Chokshi, D. MD. "A Bipartisan 'Moonshot' in Health: Improving Care for High-Need Patients," *JAMA* Forum post, July 19, 2017.