westhealth institute

November 20, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted electronically via CMMI_NewDirection@cms.hhs.gov

RE: Innovation Center New Direction – Request for Information

Dear Ms. Verma,

The Gary and Mary West Health Institute, a nonprofit, nonpartisan applied medical research organization dedicated to enabling successful aging for seniors, appreciates the opportunity to respond to your request for information on the agency's planned new direction for the Innovation Center and its opportunities to deliver new delivery and payment care models for Medicare beneficiaries.

General Sentiments

West Health's mission is *to enable seniors to successfully age in place, with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.* To realize this goal, West Health engages in research to develop data and systematically apply statistical and/or logical analytics to illustrate and evaluate how geriatric-specific acute and chronic integrated care models can help seniors age successfully age-in-place. Similar to CMS' Innovation Center, West Health has retained a talented and diverse group of researchers and professionals across healthcare delivery, policy, social science, data science, and medical professions, that continually explore opportunities to improve acute care for seniors in the emergency department, home, and community; chronic care settings for older adults that may need care at home; and supportive services, in order to avoid or reduce institutional care settings.

It is no secret that current projections for Medicare's financial solvency and the growing proportion of our nation's economy on health care puts the Medicare program in a ***state of extreme crisis***. Medicare trustees and the Congressional Budget Office (CBO) project Medicare spending to reach $1 trillion dollars by 2022, while tax-paying workers per beneficiary continue to decline. General tax revenues are paying for a growing share of Medicare spending, which takes away from other important federal spending needs, including education and infrastructure. Thus, the Innovation Center must be poised to ***demand*** efficiency, forwarding payment and delivery models that encourage value over volume. With new, thoughtful approaches to health care delivery and appropriate scaling of innovative models, including those fostered by West Health's applied medical research, ***solving the crisis is possible***. Like other

industries, providers should be held accountable for the cost, quality, and outcomes they deliver to beneficiaries, but not without appropriate incentives.

1.Do you have comments on the guiding principles or focus areas?

While we generally support CMS' guiding principles, we urge CMMI to better align its "Model Design Factors" with the evaluation criteria of the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

In addition, with regard to Small Scale Testing, we urge CMMI to consider revising to "Limited Scale Testing." We are concerned that small, rural, and otherwise underserved practices (that may be in urban areas), will be unable to engage in new, innovative models, given a lack of the requisite infrastructure, data and analytical capabilities, staffing, and capital to assume downside-risk. CMMI must ensure a resource differential does not limit these practices, which likely serve a beneficiary population in need of the most care, from participation in alternative payment and delivery models. CMMI should appropriately incent these practices, as well as provide ongoing technical assistance and data and analytics support.

Further, we strongly support the inclusion of the below principles:

Encourage beneficiary engagement in innovative care and delivery models. Innovative payment and delivery models should aim to increase and expand beneficiary access to high-value, highly coordinated medical care and treatment, which will result in improved beneficiary outcomes and quality of life. While beneficiaries should not be forced into models, we encourage the agency to make opt-ins readily available so beneficiaries have an increasing number of opportunities to engage in models that will improve their health and well-being. Incentives, such as reduced co-sharing or co-payments, could be used to encourage engagement.

Prioritize access to digital health applications. Based on the current inventory of alternative payment models (APMs), access to digital health applications, including telehealth and mobile health applications, is largely absent. We believe the inclusion of digital health technologies would expand access to critical health services for seniors – particularly those in rural and underserved areas – and vastly improve communication and engagement between patients and providers. Not only should the Innovation Center evaluate whether proposed models have included the use of digital health, we encourage it to prioritize those models. Frankly, we were disappointed to see that one model recently forwarded by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for limited-scale testing was not pursed by the agency because the technology used in the model concept was proprietary. It should be noted that an open-sourced product could have been used for the Innovation Center demonstration.

Promote the use of clinical data registries. The Medicare Access and CHIP Reauthorization Act (MACRA) specifically emphasized the use of qualified clinical data registries (QCDRs), which allow providers to deepen their understanding of quality and performance for relevant episodes of

care. An example is the American College of Emergency Physicians (ACEP) Clinical Emergency Data Registry (CEDR), which is "designed to measure and report healthcare quality and outcomes" and "provide data to identify practice patterns, trends and outcomes in emergency care." The data collected through these registries will spur important improvements in clinical care, and improve utilization and resource use, changing provider behavior at the point of care. CMMI must adopt and incorporate the power of clinical data registries in new models of care.

Require coordination and collaboration across provider types. To meaningfully impact the health care spend, and improve quality, outcomes and patient experience, providers must actively coordinate and collaborate during episodes of care. To accomplish this, access to enabling technologies, including interoperable electronic health records and clinical decision supports, will be essential. These technologies should include access to shared decision-making tools, provider directories, and comparative cost and quality data, including data on the financial impact of various services and procedures on beneficiaries. This would help providers connect their patients with high-value providers at a reasonable price. In 2015, CMS required Accountable Care Organizations (ACOs) to describe how they will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries, which may include electronic health records (EHRs). This requirement should be consistent across other alternative payment and delivery models forwarded by the Innovation Center. As a reminder, while standards development and adoption are not in the direct purview of the Innovation Center, it must press federal partners, including the Office of the National Coordinator for Health Information Technology (ONC), for speedy action in the development and adoption of data, usability, and interoperability standards.

Emphasize coordination with community-based organizations. To facilitate more seamless transitions for beneficiaries with complex needs that extend beyond the traditional health care delivery system, the Innovation Center must emphasize coordination with community-based organizations (CBOs). Community-based organizations could assist alternative payment and delivery models with establishing processes to quickly identify attributed beneficiaries that will need community-based services, and begin coordinating needed services, in conjunction with appropriate personnel, immediately. While the Innovation Center began testing the Accountable Health Communities (AHC) Model, the vast majority of models in the Innovation Center's inventory, as well as those that have been considered by PTAC, fail to recognize the importance of community based organizations for beneficiaries that are unable to manage their care independently. This is particularly true for beneficiaries that live alone and do not have family or another caretaker available to assist during times of health care crisis. Consistent with the agency's sentiments above, alternative payment and delivery models should emphasize coordination with community-based organizations.

2. What model designs should the Innovation Center consider that are consistent with the guiding principles?

Emergency Department Innovations

Advances in medical technology and changes in public policy continue to demonstrate the viability of diversion from the ED or avoidance of ED in some acute care instances as a realistic option for delivering high-quality, cost-effective health care to Medicare beneficiaries who prefer care outside the ED. In fact, a growing body of medical literature suggests that alternatives to ED care can be more cost effective than care provided in other health care settings, with better associated recovery experiences.

Unfortunately, access to home health services are generally offered to patients being discharged from the inpatient hospital or nursing home setting – not the emergency department (ED). For certain cohorts of patients, a discharge from the ED with home health care would improve quality, outcomes, and patient satisfaction, as well as reduce the provision of unnecessary care and services, thus lowering costs. To that end, we urge the Innovation Center to rapidly test this alternative delivery model.

As we have suggested in prior comments, CMS should update the Outcome and Assessment Information Set (OASIS) instrument to allow HHAs to indicate when referrals come from EDs, which will produce useful data for tracking and demonstrating the value of these referrals. We also encourage CMS to lift any restrictions that would prohibit ED physicians from "steering" patients to high-value HHA providers.

Geriatric EDs

Seniors are projected to make up 19% of the population of California by 2030, up from 12% in 2012 . This poses challenges to the healthcare system given the more complex medical and social needs seniors may have. As a result, seniors are increasingly turning to the emergency department (ED) for their healthcare needs, in part due to convenience and shortage of primary care providers (PCPs), but also because the acute care needs of seniors are often beyond the scope of a PCP.

In addition to clinical and physical enhancements, GEDs focus on the non-medical needs of seniors. Typically, seniors would visit the ED and either be admitted to the hospital (which is costly), or discharged with limited resources to help transition home (often resulting in return ED visits), because access and knowledge of available community resources are either lacking or non-existent. GED protocols emphasize connecting patients to the appropriate resources, both within and beyond the ED.

GEDs serve as a model consistent with the shift towards value-based care, where accountability for medical and non-medical needs of patients are considered. This is especially relevant for dual e

eligible, which can present with complex medical and social issues making them among the most vulnerable segments of our population.

GEDs represent an innovative model to address the unique care needs of vulnerable underserved populations, where medical and social issues play major roles in their healthcare. This analysis will provide a first look at their results in California.

Early evidence from existing models of geriatric emergency care—ones that promote best clinical practices for older adults and create a more positive and sensitive physical environment, for example—shows they have the potential to improve health outcomes, better coordinate care, and reduce costs.

3. Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models.

- Fee-free data sharing among the HHS departments would facilitate the ability to evaluate models with cross-department jurisdiction
- Data sharing which includes financial impact on beneficiaries

4. What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?

Medicare Advantage (MA) Innovation Models

CMS wants to work with Medicare Advantage (MA) plans to drive innovation, better quality and outcomes, and lower costs. CMS seeks to provide MA plans the flexibility to innovate and achieve better outcomes. CMS is currently implementing an MA plan model, the Medicare Advantage Value-Based Insurance Design (VBID) model, that provides benefit design flexibility to incentivize beneficiaries to choose high-value services; but this model could be modified to provide more flexibility to MA plans and potentially add additional states. More generally, CMS is interested in more models in the MA plan space and regulatory flexibility as necessary for purposes of testing such models. CMS is potentially interested in a demonstration in Medicare Advantage that incentivizes MA plans to compete for beneficiaries, including those beneficiaries currently in Medicare fee-for-service (FFS), based on quality and cost in a transparent manner. CMS is also interested in what additional flexibilities are needed regarding supplemental benefits that could be included to increase choice, improve care quality, and reduce cost. Additionally, CMS seeks comments on what options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as alternatives to FFS and MA.

PACE 2.0

The PACE 2.0 initiative would build on the PACE Innovation Act, legislation passed by Congress that allows for PACE pilots that develop innovations supporting PACE's ability to serve a larger

number and wider range of adults with high health care needs. A demonstration could identify underserved subpopulations currently eligible to enroll in PACE as well as new unserved populations, that could benefit from the PACE model. To meet the needs of these individuals, the demonstration could support the development of strategies to scale PACE operations and spread it to more communities by adapting the model. The goal would be to provide care to more people and spread to more communities and potentially achieve a five-fold increase in those served by PACE and promote implementation of the strategies developed.

5. How can CMS further engage beneficiaries/stakeholders in development of these models and/or participation in new models?

We urge CMMI to prioritize models that have been developed with broad input from stakeholders, and specifically payers. Payers have been testing models for many years in an effort to contain costs for their insureds. Many of their ideas are being shared through the Health Care Payment Learning and Action Network (HCPLAN), an initiative launched by the

Department of Health and Human Services (HHS) in 2016, as well as the Health Care Transformation Task Force (HCTTF), a private initiative that aims to drive value-based contracting in the private sector

6. Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?

Further exploration of the application of telehealth in MA plans would yield insightful data regarding the appropriate deployment of telehealth as a replacement to a face-to-face encounter for specific cohorts of beneficiaries. Currently, MA plans are paid a per person monthly amount. As CMS understands, the Secretary determines a plan's payment by comparing its bid to a benchmark. A bid is the plan's estimated cost of providing Medicare-covered services (excluding hospice but including the cost of medical services, administration, and profit). In general, the Secretary has the authority to review and negotiate plan bids to ensure that they reflect revenue requirements. A benchmark is the maximum amount the federal government will pay for providing those services in the plan's service area. If a plan's bid is less than the benchmark, the
plan's payment equals its bid plus a rebate. The rebate must be returned to enrollees in the form of additional benefits, reduced cost sharing, reduced Medicare Part B or Part D premiums, or some combination of these options.

An MA plan may provide basic telehealth benefits as part of the standard benefit. For example, telemonitoring ,web-based and home technologies can be used to provide telehealth services. Medicare Advantage Prescription Drug plans may choose to include telehealth services as part of their plan benefits, for instance, in providing medication therapy management. However, MA plans that want to provide telemedicine or other technologies to promote efficiencies beyond what is covered in the traditional Medicare program must receive approval to provide them as a supplemental benefit, and must use their rebate dollars for those services.

There is a legislative proposal to address the issue. West Health believes, support from CMMI to test the model would help to advance the access to telehealth for beneficiaries and enable aging-in-place policies. The reported bill would allow an MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. The Secretary would be required, no later than November 30, 2018, to solicit comments on what types of items and services (including those provided through supplemental health care benefits) should be considered to be additional telehealth benefits and the requirements for the provision or furnishing of such benefits (such as licensure, training, and coordination requirements). The costs of telehealth benefits included in the bid would not include capital and infrastructure related costs or investments. If an MA plan provides a service as an additional telehealth service, the MA plan must also provide access to the service through an in-person visit (and not only as an additional telehealth visit), and the beneficiary would have the ability to decide whether or not to receive the services via telehealth. This section would not affect the requirement that MA plans must provide enrollees with all benefits under Parts A and B of Medicare (except hospice).

7. Are there any other comments or suggestions related to the future direction of the Innovation Center?

Examples of State-Based and Local Innovation, including Medicaid-focused Model designs the Innovation Center might consider that are consistent with the guiding principles

Consideration of an implementation/scaling strategy included in the original proposal
States play a critical role in innovation and delivery of high quality care. CMS wants to partner with states to drive better outcomes for people based on local needs. CMS and the Innovation Center have worked with states on a variety of initiatives including the State Innovation Models, Innovation Accelerator Program, Strong Start and Medicaid Incentives for the Prevention of Chronic Diseases Model. These efforts and a variety of successful State-led models provide lessons learned for advancing innovation. Through this model focus area, states could drive reform and innovation. Healthcare providers and states would work with CMS to develop state-based plans and local innovation initiatives to test new models. Models would vary based on the needs and goals of each state for improving care and lowering costs, but could include providing states with more flexibility for multi-payer reforms as well as increasing opportunities for physicians serving Medicaid and CHIP populations to participate in value-based payment models. Models specific to Medicaid populations would also be considered. CMS would rely on authority under sections 1115 and 1115A of the Act in developing and implementing such models.

Senior Wellness Center
The Gary and Mary West Senior Wellness Center, funded by the Gary and Mary West Foundation, was unveiled to the community in 2010 as an innovative, integrated solution to

promoting independence and healthy living for seniors. Through the Wellness Center, seniors receive daily hot meals, access to on-site health professionals including oral health, social services management, community activities, and classes. The unique center was over-built with the specific purpose of allowing ample space for collaborative partners to provide important on-site services in an effort to expand and strengthen the multi-disciplinary approach to senior wellness. Today, through the innovative senior center model, more than 5,000 people are served annually, making the Gary and Mary West Senior Wellness Center the leading provider of services to high-risk seniors living in San Diego.

We believe the Innovation Center should consider the Gary and Mary West Senior Wellness Center for a demonstration project and nationwide scaling.

Senior Dental Center

To further enhance the breadth of services available to seniors, the Gary and Mary West Foundation launched a state-of-the-art, integrated geriatric dental center, which serves an estimated 1,200 seniors a year. There is growing scientific evidence that untreated oral disease, particularly periodontal disease, can be associated with chronic conditions such as cerebral vascular disease, coronary artery disease, and diabetes. In fact, our data collection activities to date show that 40 percent of illnesses for seniors in San Diego stems from oral healthcare

problems making it a significant public health issue. To help avoid expensive interventions, the Senior Dental Center focuses on improving care and lowering costs by integrating oral health with primary care and providing high-touch care coordination and wrap-around services. The Senior Dental Center also collects robust data using a Comprehensive Geriatric Assessment (CGA) tool that is shared with local healthcare providers as part of an existing health information exchange. Our Institute is conducting research to test the impact quality oral health services has on overall healthcare costs and health outcomes. To that end, we believe the Innovation Center should consider the Senior Dental Center for a demonstration project and nationwide scaling.

Gary and Mary West Geriatric Emergency Department

Launched in 2016, the Gary and Mary West Senior Emergency Care Unit, a state-of-the-art senior emergency care unit housed within the Emergency Department at Jacobs Medical Center, will enhance care for older adults and enable a multi-year medical research initiative. The services focus on geriatric medicine, acute care screening, urgent care, case management, and social and psychiatric care, as well as facilitate home- and community-based care options when possible. The research will focus on identifying best practices in senior emergency care, building the evidence for geriatric emergency care protocols, connecting clinical and social resources to provide home and community-based care and addressing the training needs of a multidisciplinary workforce.

We believe the Innovation Center should consider the Gary and Mary West Senior Emergency Care Unit for a demonstration project and nationwide scaling.

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We appreciate the opportunity to provide comments on the aforementioned issues of importance to West Health and America's seniors. We are hopeful that our comments herein will move the Innovation Center toward addressing some of the most pressing issues facing the Medicare program. We would be pleased to meet with you and share some of our research in the aforementioned areas.

Sincerely,

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