

August 17, 2023



Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-5540-NC  
Mail Stop: C4-26-05  
Baltimore, MD 21244-1850

*Submitted electronically*

Dear Administrator Brooks-LaSure,

We appreciate the Center for Medicare and Medicaid Services (CMS) and the CMS Innovation Center (CMMI) continued efforts to test new payment and care delivery models to improve quality and lower costs to preserve the Medicare program for current and future generations. We view the Request for Information regarding Episode Based Payment Models (EPBM) (CMS-5540-P) as another step in this important work. While we are unable to provide detailed answers to every question contained in the 30-page RFI, we appreciate every opportunity to provide input to CMS/CMMI as they develop new payment and care delivery models and offer some additional items for them to consider as they continue to move providers and beneficiaries toward more accountable care relationships.

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging and disability services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

Our comments below reflect the perspective and experiences of providers of post-acute care, long-term services and supports, home and community-based services as well as affordable housing. We believe strongly that these providers play an integral role in delivering and coordinating care for Medicare beneficiaries and achieving improved outcomes for this population, and that these providers deserve to also benefit from the shared savings achieved by these models.

### **Concerns with EBPM elements**

LeadingAge agrees that all providers who provide care and services for Medicare beneficiaries should be engaged in accountable care to improve outcomes and lower unnecessary costs inherent in the fee-for-service (FFS) system. However, in our review of the RFI, we believe a 30-day EBPM for specialty care is at cross purposes with these goals.

First, much of specialty care for Medicare beneficiaries is about managing and supporting patients with chronic conditions. While chronic conditions can be treated, they are rarely curable. Chronic care

management is longitudinal in nature and requires more than 30 days of care to be effective. Therefore, it is not clear what would be achieved by a 30-day episode. We understand that a 30-day episode would reduce overlap with other accountable care models but to what effect? We understand CMS/CMMI envision the specialist under the EPBM would hand off the beneficiary to their primary care provider after the 30-days. It is silent on what continued, or more robust, role the specialist should have after the hand off. Ideally, a longer episode would be more appropriate. At the same time, we recognize a longer episode competes with the role of an accountable care organization to manage a beneficiary's care, making it less clear which entity -- the specialist or the ACO -- were responsible for improved outcomes and lowered costs. For these reasons, we would recommend CMS/CMMI abandon the 30-day episode except for time-limited specialty care.

We are also concerned that an EPBM focused on a singular chronic condition could reinforce the current fragmentation that the model seeks to eliminate. The majority of Medicare beneficiaries (68.4%) have 2 or more chronic conditions and 36.4% have 4 or more chronic conditions.<sup>1</sup> A narrowly focused approach to beneficiaries' care won't achieve the desired results. We need a comprehensive, whole person care management plan and supports. Ideally, this requires coordination, collaboration and communication across providers involved in the beneficiary's care.

For longitudinal chronic care management patients, we recommend CMS/CMMI consider some alternative approaches: incentivizing specialists' participation within ACOs by paying a monthly add-on payment in exchange for a more robust and comprehensive care management approach. The monthly payment could replace a series of individual billing codes and cover an array of services that must be provided. CMS/CMMI could outline a minimum set of interventions --health risk assessment related to the condition, care planning and navigation, more frequent patient engagement with higher risk patients, etc. --that specialists must provide for their chronic care patients. The goal would be to avoid exacerbations of the individual's chronic conditions or hospitalization, and to coordinate care with providers across the continuum to achieve these goals. This might also include specialists educating aging service providers on what situations warrant a call to the specialist versus an admission to the hospital. By using a single add-on chronic care management payment for a bundle of specified services (replacing existing codes), the new payment would be included in an ACOs total cost of care numbers or expenditures while the specialist would be accountable for managing the chronic condition and could even be eligible for a quality bonus based upon reduced hospitalizations achieved. We would argue that an array of providers should be eligible to manage chronic conditions of a population via such a chronic care management bundle, including nursing home providers who provide long term services and supports and other LTSS providers (e.g., home health, hospice, HCBS providers) who provide frequent care to a Medicare population.

### **Shift Focus to Achieving Savings Through More Robust Care Management and Prevention**

Beyond this RFI, we believe the time has come for CMMI to approach accountable care from a new vantage point. To date, ACO models and bundles have focused on care following a hospitalization. As the RFI notes, repeatedly, accountable models have reduced post-acute care (PAC) costs. If we are to take a more holistic, person-centered approach, we need to start with the person before they get to the

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<sup>1</sup> "Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010" by Kimberly A. Lochner, ScD; Christine S. Cox, MA. As accessed here: [https://www.cdc.gov/pcd/issues/2013/12\\_0137.htm](https://www.cdc.gov/pcd/issues/2013/12_0137.htm)

hospital. The person should have a single care navigator who is the first contact point for the beneficiary to get answers to questions, identify options for addressing their needs cost effectively and advise when a health concern arises. The navigator should work with an interdisciplinary team (IDT) of providers engaged in the care and services the individual receives. The navigator and IDT conduct a single comprehensive assessment and cooperatively develop a plan for addressing the individual's needs from medical to resources to pay for services to social determinants of health.

The navigator and IDT members should receive payment for this work, possibly through an add-on payment to current billing codes (similar to what is proposed in the Physician Fee Schedule rule (CMS-1784-P)) for certain coordination and collaboration behavior. These add on payments should not be limited to physicians and specialists but all providers who contribute to the care, management and support of the individual. This should include Medicare and non-Medicare providers and suppliers, such as a long-stay nursing home, assisted living, a home and community-based provider who delivers activities of daily living support, or possibly even an affordable housing service coordinator. The care, services and supports these providers deliver, if financially supported, can help a Medicare beneficiary avoid a hospitalization and manage their chronic condition(s). If we wait to address issues once someone is hospitalized, we have missed the ultimate opportunity to avoid the high cost of the hospitalization itself.

While the RFI sings the praises of bundled payment convenors and ACOs who have squeezed costs out of post-acute care, it fails to recognize those savings are only attainable because of how these providers are paid. The reality is the barrier to real change is the FFS system itself that pays for days of care in SNF or visits within a home health episode but pays a flat DRG payment to a hospital regardless of the days of care received.

We know the hospital cost is the big-ticket item therefore to change the trajectory we must either fundamentally change how hospitals are paid to lower that cost or avoid the hospitalization altogether. For example, managed care plans will use skilled nursing facilities in not only a post-acute situation to rehabilitate an individual who has been hospitalized but also directly admit individuals who perhaps have an uncontrolled chronic condition that requires supervision recognizing the skilled nursing care that can be provided in these settings as well as the 24/7 personnel who can monitor changing conditions, make adjustments to medications, and provide therapies so they can return home. Medicare Advantage plans are also looking at how to incentivize community-based providers, like palliative care, to do longitudinal care management of seriously ill beneficiaries that help keep them at home. There are limits to the savings that can be achieved by just reducing post-acute care services. The real opportunity is addressing an individual's needs before they are hospitalized.

**Recommendation:** In structuring future accountable care models to ensure improved integration, CMS should establish some basic person-centered expectations of the accountable care entity. For example, requiring the primary care and specialist to contribute to a single assessment of the patient. CMS could require interdisciplinary teams and support the development of them by identifying all providers who have delivered care to the beneficiary in the past year and providing this list to the accountable entity, care navigator or primary care physician. Successful models include: a single care navigator assigned to the beneficiary and serving as the beneficiary's chief point of contact, a routine health risk assessment, and an individualized care plan developed by an interdisciplinary team. CMS could establish these as

baseline expectations of future models.

**All providers must be engaged in both the care delivery reform and the financial rewards of accountable care.** As it is currently, ACOs assign or align beneficiaries based upon where they get their primary care, which while important, neglects perhaps from which providers they receive the bulk of their daily care needs versus a series of 15-minute office visits. Caregivers (e.g., RNs, LPNs, CNAs) in nursing homes, aides in assisted living, and nurses, therapists, and home care or personal care aides in a beneficiary's home have daily or more frequent interaction with the beneficiary than the overseeing clinician. As such, these professionals are well positioned to identify changes in condition early, address these changing needs or reach out to coordinate with primary care and/or specialty providers. By failing to recognize the important role of these providers, CMS/CMMI miss a great opportunity to truly bend the cost curve. Some aging service providers are not only able but are already successfully managing total cost of care through Institutional Special Needs Plans (ISNPs), and other contracting arrangements with payers. They should be permitted to be an accountable care organization or entity as well. We need to rethink how and what we pay them for.

**Recommendation:** CMMI to evaluate and test one or more ways to financially support care and services navigation and management. Possible approaches include: 1) Per Member Per Month amount for designated support navigators or on-site building service coordinators; 2) add-on payment for all providers who document conducting a certain level of communication, coordination and collaboration time with other providers and patients, including work on interdisciplinary care teams, and referrals to outside resources; and/or 3) Community-level support grants for those that establish a community-wide, all-provider connected community – no wrong door.

**One way to broaden accountable care engagement among providers is to make them eligible for value-based payments.** To ensure beneficiary access to aging service providers and the financial sustainability of these provider types, and simultaneously encourage aging service providers to partner in the goals of the APMs and managed care, they must be eligible for being paid for the performance and outcomes they achieve. Additionally, if we agree that providers do better under value-based arrangements vs. fee-for-service and that these arrangements create appropriate incentives, then CMMI and MA models should both be encouraged to pay providers under value-based reimbursement arrangements. FFS payments are particularly problematic for SNFs, who are paid on a per diem basis and whose bottom line suffers as they are impacted by changes in care delivery patterns (e.g., reducing lengths of stay). They just lose money every time they help achieve savings for APMs and managed care. However, in many cases, nursing home providers serve Medicare beneficiaries both through short-stay skilled care and long-stay nursing home care. We should be thinking about how to engage these providers to provide additional services and supports to their long-stay residents, consider how to use their skilled care expertise to stabilize individuals through direct admissions from the community not just how to limit their provision of post-acute care. Instead of thinking of paying for a day of service, how could we rethink payment. For example, it might include paying a nursing home provider a per person per month amount for more intense chronic care management, communication and coordination with accountable care entities. CMMI also recognizes in their strategic plan that it is more

than just health care that determines cost of care – our members deliver care at home, wherever the person calls home and are well positioned to deal with the holistic needs of patients and families that will actually reduce total medical spend. However, aging service providers are infrequently offered value-based arrangements with accountable care entities and managed care plans that would allow them to act on what they see in the field – from providing respite care to buying a new air conditioner to enhanced education. CMS/CMMI could change this.

**Recommendation:** Incentivize APMs and MA plans to contract or pay aging service providers for their contributions to care, services and outcomes for their aligned beneficiaries. Also consider creating alternative payment templates or guidance that make it easier for accountable entities to adopt these practices. These payment structures may include:

- FFS + performance bonus for quality measure performance.
- Episodic payments for defined service package tied to a condition or timeframe (60 or 90 day) that includes services beyond the site.
- Shared savings percentage beyond FFS

**Embed Value-Based Arrangements within ACOs:** The regulations around ACOs permit ACOs to share the savings they achieve with providers with whom they partner. However, to date, we have seen limited examples of where shared savings ever reach the post-acute care Skilled Nursing Facilities (SNFs) and Home Health (agencies that are often expected to make the changes in care delivery that result in the savings). We recommend CMS/CMMI take two steps in this area: 1) design value-based arrangement (VBA) templates – pay for performance bonuses to sub-capitated or bundled payments to a proportion of shared savings -- that ACOs can use to share the savings across contributing providers; and 2) require ACOs to utilize these VBAs with all providers contributing to ACO beneficiary outcomes. CMS/CMMI may also consider distributing value-based payments from its portion of the shared savings achieved.

**Pay all providers for collaboration and coordination time.** If we believe that we can achieve our goals for beneficiaries by providers working together, then all providers must be paid for the resources they dedicate to these activities. Deputy Administrator and Director Meena Seshamani highlighted the new codes in the Physician Fee Schedule proposed rule (CMS- 1784-P) on a recent webinar. She described the new codes as a mechanism to facilitate more providers to get into value-based care by reinforcing some of the building blocks of accountable care such as longitudinal care management. Similar add-on payments for care management and coordination should be created for other providers such as nursing homes, assisted living, home health, palliative care and other aging service providers who coordinate with other continuum providers and assist in longitudinal care management/coordination. This work is critical to improving outcomes and lowering costs but takes staff time and resources and is increasingly expected across payers and models. If we want providers to invest staff time and resources in these activities, we must reimburse them for it. Continually reducing certain providers' payments to reward other providers can only lead to closures and/or beneficiaries' access to certain services. All providers need adequate funding streams to support their involvement in improving care and be eligible for a portion of the total shared savings generated.

**Recommendation:** Establish HCPCS and CPT Codes or add-on payments for activities related to service coordination and collaboration with other providers (e.g., interdisciplinary team

meetings, communications with other providers to coordinate or consult on care or interventions needed).

**Test interventions that work in the VA and Medicaid in Medicare.** CMS is well aware that social determinants of health and non-medical services make a big difference in the ability of beneficiaries to remain in the care setting of their choice and reduce unnecessary medical utilization. Both Medicaid and the VA have offer more non-medical support services than Medicare. If CMS wants to make a dent in spending on high-cost services, it would be a boon to test whether Medicare payment for services like adult day, meals, transportation, and increased personal care have an impact on the cost and quality of Medicare services. Medicare Advantage plans have been given some flexibility to do this through the Value Based Insurance Design model and through supplemental benefits more broadly. We urge CMMI to be bold and test payment for a bundle of long-term care services and see the impact on Medicare spending.

**Data sharing and access can improve outcomes and provider coordination.** CMS can support providers who are required to participate in models by providing them with real-time data access on the beneficiaries assigned to them, developing and supporting processes for the electronic exchange of information and providing infrastructure payments to providers new to risk-based models so they can make appropriate investments. In addition, just like providers can look up what Medicare Advantage plan an individual is enrolled in, they should also be able to access a single portal to look up whether a beneficiary is assigned to an ACO, bundle, etc. This information alone could improve the ability to better coordinate care and communicate across the health system. Finally, each beneficiary should have an annual assessment conducted by an interdisciplinary team of providers, but that assessment and corresponding care plan should be accessible to other providers – Medicare, Medicaid, and private pay – who deliver services. Access to this information could thwart duplicative testing, and possible adverse outcomes. We need a single portal to access patient data. These items should be foundational to all models.

Thank you for the opportunity to contribute our thoughts and perspective on the development of future accountable care models. We would be happy to continue the conversation on any of the points we've made here or other questions CMS/CMMI has as we continue to strive for accountable care for all beneficiaries.

Sincerely,



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