

*A LeadingAge CAST Report*

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STEPS ON THE ROAD  
TO LONG-TERM CHANGE  
*Strategies for Creating a  
Person-Centered Health Care System*

Proceedings of the CAST Commission Meeting  
March 16, 2014 | Washington, D.C.

# STEPS ON THE ROAD TO LONG-TERM CHANGE: Strategies for Creating a Person-Centered Health Care System



A program of LeadingAge

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## LeadingAge Center for Aging Services Technologies:

The LeadingAge Center for Aging Services Technologies (CAST) is focused on development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 5,400 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

For more information, please visit [LeadingAge.org/CAST](http://LeadingAge.org/CAST)

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## Executive Summary

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Do providers of long-term and post-acute care (LTPAC) need full-blown electronic health record (EHR) systems and top-of-the-line telehealth equipment before they can make a meaningful difference in the lives of older Americans?

Not necessarily, said CAST Chair Mark McClellan, MD, Ph.D., at the semi-annual meeting of the CAST Commissioners on March 16, 2014.

During a joint session with the LeadingAge Public Policy Congress and the CAST Commissioners, Dr. McClellan made it clear that technology-enabled services and supports are essential tools for any provider interested in participating in the reform of the nation's health care system. But he urged LeadingAge members not to put off implementation of those services because they can't afford to purchase the most comprehensive technology solutions on the market.

Instead, Dr. McClellan identified a number of short-term strategies that CAST and LeadingAge members could use to drive changes in health care reform. He urged members to follow the example of organizations, featured in several CAST case studies, which have adopted technology solutions, including those that are initially limited in scope but still allow for the collection and exchange of key health information.

In a meeting with CAST Commissioners following the Policy Congress presentation, Dr. McClellan discussed the challenges and opportunities that CAST and LeadingAge members will experience over the next several years. To meet the challenges, and take full advantage of the opportunities, he urged members to:

- Start getting ready to work with accountable care organizations (ACO), bundled payment programs and other risk-based care delivery models.
- Focus on a limited number of initiatives that can lead to better care at a lower cost.
- Use technology to promote care coordination with every member of a resident's health care team.
- Help the Centers for Medicare and Medicaid Services revise the quality measures it uses in new payment reform programs so they address the needs of frail older people with multiple chronic conditions.
- Participate in discussions and pilot programs to explore post-acute payment reform.

Commissioners spent the latter part of their March meeting developing technology policy priorities in three areas: EHRs and health information exchange (HIE); telehealth and telemedicine; and technology and housing.

Those priorities address ways to:

- Accelerate the adoption of EHRs and HIE so LTPAC providers can participate more fully in facilitating smooth transitions of care and in planning and implementing shared care.
- Provide financial support for technology adoption, particularly among smaller, stand-alone and rural LTPAC providers.

- Promote the use of telehealth and telemedicine as a way to help LTPAC providers deliver integrated and person-centered care and services that support the health and wellness of residents and clients across the continuum.
- Expand Internet connectivity among low-income older consumers so that a broad array of technology-enabled services can help support their health and wellness, reduce their loneliness and isolation, increase their quality of life and, ultimately, enhance their independence.
- Support housing plus services models that use technology to help low-and moderate-income seniors age safely and successfully in their homes and communities.

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## Part I

### **CREATING A PERSON-CENTERED HEALTH CARE SYSTEM: A CONVERSATION WITH THE LEADINGAGE PUBLIC POLICY CONGRESS**

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#### **Mark B. McClellan, MD, Ph.D.**

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*During the first part of its March 2014 meeting, the CAST Commissioners joined with members of the LeadingAge Public Policy Congress to hear a presentation from CAST Chair Mark McClellan. The presentation focused on opportunities that the Affordable Care Act offers to LeadingAge members and how those members could leverage their position as not-for-profit providers to drive changes in health care reform. Following is a synthesis of Dr. McClellan's presentation.*

The Affordable Care Act (ACA) is driving the current movement toward health care financing reform. But concerns about the rising per-capita costs of health care have been with us for decades.

Over the past 40 years, the rising cost of health care entitlements has accounted for most of the fiscal challenges facing the United States. Today, escalating health care spending is squeezing almost every other component of the federal and state budgets. All the while, the cost of health care programs keeps rising.

Despite these challenges, I don't believe we are likely to see a substantial reduction in health care



spending over the next decade. However, I do believe we will see continued pressure to implement meaningful payment reform.

### **A Person-Centered Financing System**

Traditionally, policy makers and payers have viewed health care as a collection of seemingly unrelated services that are purchased separately as if they were commodities. As our health care system becomes increasingly personalized and prevention-oriented, however, it makes less and less sense to use a day in the hospital, a day in the nursing home, a lab test or a prescription as the main currency of our health care system.

Instead, clinicians should be striving to deliver an integrated mix of services that meets the individual needs of each patient while achieving better results at a lower overall cost.

A person-focused health care system could help us accomplish this goal. Under this system, we wouldn't strive to pay the least amount of money for individual health services. Nor would we necessarily pay more for high-quality services. Instead, a person-centered payment system would reward providers—and, at the same time, hold them accountable—for delivering what matters most to patients: a higher quality of life and a better experience of care, all at a lower cost.

### **Accountable Care Organizations**

The risk-based payment model demonstrated by the accountable care organization (ACO) program is one way to achieve these person-centered goals. For that reason, ACOs have received a great deal of attention from the health care community in recent years.

When the Brookings Institution and Dartmouth launched the [ACO Learning Network](#) in 2008, we struggled to find five private insurers around the country that were willing to start a shared-savings ACO. Today, there are 300 private ACOs in the United States and more than 600 Medicare ACOs. Many of these ACOs were established in the last year or two, so the ACO program is still very much an evolving model.

Medicare reported recently on the first-year experience of its early ACO programs, which are part of the Medicare Shared Savings Program. Participants in this program get to keep a portion of the savings they bring to the Medicare system, provided they meet specific quality improvement benchmarks.

About 114 of the Medicare Shared Savings ACOs were launched in 2012. Of those ACOs, about 54 reduced health care costs by a significant amount during their first year. But only a minority of ACOs—about 29—actually reduced spending to a level that made them eligible to share in those savings. I suspect that more ACOs will share in Medicare savings in the next few years as they continue to hone their business models.

While the first-year results were preliminary, they did yield one interesting finding. Smaller, physician-led ACOs were more successful in saving money and sharing in those savings than larger, older and more sophisticated ACOs. Several factors contributed to their success.

- First, they used good data upfront to identify the needs of patients and to devise interventions to meet those needs.

- Second, they carried out a very limited number of initiatives. They used their data to choose initiatives they believed would help them reduce health complications, hospital readmissions and other service use.
- Third, they focused on the highest cost beneficiaries in specific subgroups of patients. This included people with congestive heart failure who were experiencing frequent hospital readmissions.

### **Becoming an ACO Partner**

Don't be surprised if you are not getting calls from ACOs who want to partner with you. Right now, they are trying to get their houses in order and figure out what is going on with their patients and what relatively easy steps they can take to get health care costs down.

There will be more opportunities to partner with ACOs in the future. But you will need to begin preparing now to be a good ACO partner.

Working with ACOs isn't easy. For many organizations, participating in these risk-based payment models requires nothing short of a complete culture change. To be successful, you must first adopt a person-centered mindset throughout your organization. You must support that new mindset by collecting specific data about residents, tracking residents and clients over time, and meeting specific performance measures that are truly meaningful to those residents and clients.

Technology can help get you ready to be an ACO partner. First and foremost, it can improve your ability to share key health information about your residents and clients with acute-care partners.

CAST has many resources that can help you explore how to use [electronic health records \(EHR\)](#) to collect and store that information and [how to use these technologies, including health information exchange \(HIE\), to drive quality and share that information with your health care partners.](#)

How can you get the attention of ACOs? You will need to provide your ACO partners with a simple, clear, compelling, quantitative and relevant case for partnering with you. ACOs are under the gun. They have taken on a new set of financial responsibilities, often without great data about their own patients. And they are expected to achieve savings in a short period of time. This is hard work.

You need to convince the health providers in your ACO that you can do a better job than they can with some of their highest risk patients. You also need to quantify how your participation on the care team would translate into savings for the ACO. The more you can present what you are doing in a quantitative and compelling way that fits directly into an ACO's business model, the more attractive you will be as an ACO partner.

I have to be honest, though. ACOs will be reluctant to pay you directly to offer these technology-enabled services and supports. You may need to look at your ACO relationship as the beginning of a long-term collaboration. At first, that collaboration may involve selective referrals and opportunities to provide long-term services and supports to ACO patients. Eventually the partnership could evolve into a long-term, shared savings contract. It may take some time to get to that point, however.

## Meaningful Quality Measures

As I mentioned earlier, ACOs must meet certain quality improvement benchmarks in order to qualify to share in Medicare savings. Currently, the ACO program is relying primarily on measures of quality that are not particularly relevant to your residents and clients.

For example, ACOs are tracking the hemoglobin A1C levels of their patients with diabetes. This is an important measure for patients with this disease. But if you have diabetes and four other conditions relating to frailty and cognitive impairments—like many of the people you serve—there are probably more important measures that your caregivers should be tracking.

We actually have the capacity to measure, on a regular basis, things that would be more meaningful for high-risk, frail patients. The information you collect during functional assessments of your residents is probably the most important information we have about how these patients are actually doing. But this information is not incorporated in a regular way into any of the current ACO quality measurements. This needs to change.

## Provider Engagement

Over the next year, the Centers for Medicare and Medicaid Services (CMS) will be envisioning the next version of the ACO program, including a revision of its quality measures. It is not too soon to think about how your comments might shape that program. It's important for long-term and post-acute care (LTPAC) providers to participate in this process to ensure that quality measures address the care of chronically ill and frail individuals.

This is also a good time for LTPAC providers to think about implementing pilot programs to test ways of developing payment reforms that improve quality and reduce costs. These pilot programs might be integrated with the work of the Center for Medicare and Medicaid Innovation at CMS, which is looking for ways to round out its portfolio of demonstration programs. There are also a number of state and regional efforts that are already implementing pilot programs involving post-acute and long-term care.

You might also think about launching a small initial pilot that is either self-funded or conducted in collaboration with an ACO, a bundled payment program or other person-level payment reforms. Check the [CAST website](#) regularly for information about potential partnership opportunities.

Finally, LTPAC providers need to get involved in post-acute payment reform. This reform is most certainly coming. The only question is how much of that reform will come in the form of across-the-board cuts and how much will be real reform that focuses on person-level, not site-specific, reimbursement.

As this reform period approaches, it's important that you convince policy makers that across-the-board cuts are not the easiest or the best way to save money. Instead, we need to selectively reduce funding for programs that aren't working and use those funds to sustain and expand programs that are working.

Meaningful quality measures would help us distinguish between programs that are working and those that are not. We need meaningful measures of patient experience, functional status and quality of life. This could enable the programs you value—like

the Program of All Inclusive Care for the Elderly—to convince policy makers and funders that they deserve increased funding so they can serve more older adults.

### **Consumer Engagement**

Up until now, we've focused almost exclusively on how health care and LTPAC providers can participate in reaching better outcomes at a lower cost. But what about consumers? Can they play a role in all of this? The Medicare Part D program offers an example of just how important a role they can play.

Medicare Part D started out as a standard drug benefit that followed a traditional insurance design. It had a deductible, a 25-percent co-payment, and catastrophic coverage on the back end. It also had the famous “donut hole” in between, which we thought would be more expensive than it turned out to be.

Today, no senior has this kind of traditional drug benefit through Medicare Part D. When given a choice, most seniors chose prescription drug plans with tiered-benefit designs that were tied to cost-effectiveness. To get the best savings from their tiered-benefit plans, seniors willingly shifted to generic drugs and preferred drugs. As a result, actual costs in the Medicare Part D program are running about 45 percent lower than were originally projected.

This type of consumer engagement has not yet come to the rest of health care delivery. Consumers don't view their post-acute and nursing care providers, or their hospitals, in the same way they view their drugs.

But what if we could convince consumers that they could get better care at a lower cost and share in the savings they helped create? I'm convinced that we would succeed with new payment models faster and more effectively.

### **Conclusion**

I like working with LeadingAge because you all are here for the right reasons. You don't do the work you do because it is the easiest way to make money. You do it because this is the way to make a real difference in the lives of real people.

The professionalism that is at the heart of LeadingAge organizations should be at the heart of health care reform. That reform should start with a culture that focuses on the person.

The solutions we seek to reform our health care system must come from you because those solutions must focus squarely on the people you serve and know best: older Americans who are going to face some significant difficulties if we don't get this right.

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## Part II

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### STEPS ON THE ROAD TO LONG-TERM CHANGE: AN EXCHANGE WITH THE CAST COMMISSIONERS

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#### Mark B. McClellan, MD, Ph.D.

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*After the LeadingAge Public Policy Congress meeting, CAST Vice Chair Kathleen Martin and CAST Executive Director Majd Alwan facilitated a far-reaching discussion between CAST Commissioners and CAST Chair Mark McClellan. The following is a summary of the question-and-answer session.*

#### Prioritizing Technology Tools

*What technologies should CAST prioritize as we try to facilitate and accelerate the participation of LeadingAge members in health reform initiatives?*

Thanks to CAST, we have a pretty good list of technologies that can actually help us improve care, save money and put the focus of our health care system where it belongs: on the person. CAST has produced very helpful case studies and examples organized around [particular technology areas](#) like electronic health records (EHR) and remote monitoring. In the next year CAST will produce similar tools around medication management.

These resources are helping providers become more aware of what technology solutions are available. That's a great first step. The next step is

helping organizations translate these new kinds of technology applications into a business model that is meaningful for them and takes into account both the needs of residents and clients, and the resources of the organization.

CAST is already contributing to this effort. [Several of its case studies](#) illustrate clearly that even targeted, limited approaches can still help us to make progress in providing better care at a lower cost.

For example, a case study of the [Norman Health System](#) in Norman, OK, suggests that an effective business model can be a very targeted one. Instead of investing in a full-blown EHR system and populating it with a comprehensive collection of data, for example, your organization might follow the Norman example and decide instead to share a few elements of the Continuity of Care Document (CCD) that you believe can help improve quality and lower costs for high-risk patients. CAST resources can help you clarify what the business case might be for exchanging specific CCD elements with health care partners so they can respond more quickly to changes in a patient's health and functional status.

By the same token, instead of waiting for the day when insurers will pay for telehealth technology, you might take a fiscally conservative approach to adopting that technology on your own. A CAST case study about [Jewish Home Lifecare](#) in New York shows that you don't need a high-speed Internet connection or high-resolution video links to transmit key information. Nor does telehealth have to involve fancy or frequent video contacts between clinicians and residents in order to improve care and lower costs.

A highly effective telehealth program might simply help patients with congestive heart failure send their daily weight to a clinician who can monitor and respond to changes. Or this technology might offer remote support to a person who has difficulty managing multiple medications.

### **Incentives for EHR Adoption by LTPAC Providers**

*What are the chances that Congress will authorize financial incentives to help long-term and post-acute care (LTPAC) providers make Meaningful Use of EHRs?*

The practical reality is that there is probably not going to be a lot of funding coming for further adoption of health information technology (IT). I have two reasons for saying this.

First, the current squeeze on the federal budget will make it very difficult to get Congress to approve new spending in any program area.

Second, our experience with the Health Information Technology for Economic and Clinical Health (HITECH) Act has been mixed. The 2009 HITECH Act authorized incentive payments to encourage physicians and hospitals in the Medicare and Medicaid programs to make Meaningful Use of EHRs. The incentive program has led to a fair amount of frustration on the part of clinicians who spent a good deal of money adopting EHR systems that met a federal checklist of requirements. The frustration came when those clinicians realized that their expensive EHRs were not necessarily leading to more coordinated care.

We are moving away from a time when it is acceptable to reward health care providers simply

for having EHRs that have certain characteristics and are *designed* to exchange information. We are moving toward a time when EHRs must actually help improve care through quality measures that are tied to better patient outcomes and more efficient care.

It is conceivable that the Centers for Medicare and Medicaid Services (CMS) could set up additional funding to accelerate EHR adoption among small LTPAC providers in rural areas. But CMS would most likely tie that funding to a provider's commitment to increase quality and reduce costs through participation in a bundled payment program or an accountable care organization (ACO). By the same token, loan programs could be established to accelerate EHR adoption, but those loans would likely be tied to participation in payment reform models. Providers are not likely to get federal funding or loans just for committing to use health IT.

### **What's in Store for CAST and LeadingAge Members?**

*What kind of changes do you think will impact CAST and LeadingAge members in the next few years?*

Providers of long-term and post-acute care cannot ignore ACOs over the next few years. The ACO program is already fairly large. It now includes 10 percent of Medicare beneficiaries nationwide and those numbers will increase substantially during the next two years.

Over the short term, you should be collecting hard data to demonstrate how you can help these organizations manage the care of their patients, reduce hospital readmissions and keep people out of the hospital altogether.

You might also begin exploring how you can collaborate with Medicare Advantage Plans and state programs that are currently working with CMS to provide integrated, capitated care for dual-eligible beneficiaries who receive both Medicare and Medicaid. These opportunities will depend on your local market.

### Personalized Care at a Lower Cost

*It seems counterintuitive to call for a system of high quality, personalized health services and still expect to deliver those services at a lower cost. Are you sure this is realistic and feasible?*

The entire economy—not just health care—is moving toward more personalized services that meet people where they are. But we are quickly learning that personalized health care services simply don't work in a fee-for-service payment environment.

The Brookings Institution is now examining our accountable care work in a global context. We are finding that most other countries have done a better job than the U.S. at keeping per-capita health care costs low. But many of these countries are achieving this goal simply by paying less for services. For example, people in Germany spend a lot more time in the hospital than we do. The government just pays less money per day for that care.

This approach doesn't represent a long-term quality solution.

ACOs and bundled payment programs represent a better solution because they move us from a provider-driven system to a person-driven system. They accomplish this by making sure payment essentially follows the individual. That is not easy

and it will take time. But I believe it will happen.

### Interoperability Challenges

*Some LTPAC organizations with different business lines have state-of-the-art EHRs for each business line. The problem is that these systems don't talk to one another, much less push data out to other organizations or pull data in from those organizations. If there isn't going to be any more money coming from the government, how will LTPAC providers ever be able to participate in health information exchange (HIE)?*

The lack of interoperability you're describing shouldn't surprise anyone. Many of the large EHR systems were designed initially for siloed health care organizations that purchased closed record systems they never intended to use for HIE. But that approach is almost certainly not going to work for health care over the long term.

CAST has collected many examples of providers who are actually finding ways to share information across different EHRs. But again, these providers are only sharing specific and limited data elements.

If you've got an EHR system with thousands of fields and 50 million lines of code, it may seem embarrassing to share only a patient's weight, discharge medication list and a few other vitals and lab results. But, believe me, that is a helpful start. And you can actually build a business case for targeting specific interventions with this limited amount of data.

Despite all the effort that has gone into developing standards and providing funding to promote health information exchange, the real solution to the challenge of information exchange may boil down

to a simple conversation. It's essential that you talk with your health care partners about what data elements you will share. Identify the workflows that will be necessary after your organizations exchange that data. This conversation must take place between senior leaders from both organizations.

It will be harder to have this conversation if your partners selected their respective electronic record platforms without exploring the ability of those platforms to exchange information. That's why CAST's [EHR whitepaper](#) emphasizes the need for strategic planning around the selection of an EHR solution. That was certainly the biggest challenge facing participants in the federal EHR Incentive Program. These participants invested in big EHR systems that met the requirements of the HITECH Act. It was only much later that they began exploring how to use those systems to exchange information as a way to improve patient care.

### **The Future of mHealth in LTPAC Settings**

*How can LTPAC providers make the best use of mHealth?*

There's no question that mobile health care (or mHealth) provides opportunities to get information from patients more efficiently. Medicare doesn't currently reimburse for mHealth under its fee-for-service payment system. But one can imagine that such reimbursement would get more support within alternative, more person-focused business models.

In any case, it's not a good idea to start discussions about mHealth by simply saying, "We need more mHealth." Instead, let's talk about business models. How will the collection of mHealth data create a value opportunity for LTPAC providers over the short term? How can it put LTPAC providers

in a better position to help acute-care providers participate in alternative payment systems?

### **Taking Baby Steps**

*You are suggesting that we focus on short-term solutions. But these seem like baby steps. When will real change occur?*

Reforming the health care system isn't easy. But it's not impossible. Every year we encounter some huge obstacles. But every year, with leadership from all of you, we also take some real steps forward in terms of our ability to improve care and lower costs.

I remain firmly convinced that we are not going to reform health care in this country unless we do it in ways that center on the patients you serve. These are the most expensive patients in our health care system and, ironically, they are getting the least coordinated and least effective care of any patients in the system. They also offer us the greatest opportunities to improve the health care system by improving the care they receive.

Health reform isn't just about baby steps. We also need a clear vision of where we want health care to be in five years. But we can't ignore the short-term strategies either. Those short-term steps can help get us to our long-term vision. That's because they are easier to gain support for, easier to implement, and because they can work.

We can't downplay the big picture. But we also need a clear path of short-term steps to get us to that big picture. Remember, health care reform is a marathon, not a sprint. And I thank you all for sticking with it.



## Part III

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### RECOMMENDING OPTIONS FOR TECHNOLOGY POLICY: REPORTS FROM COMMISSIONER WORK GROUPS

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The CAST Commissioners spent part of their March 2014 meeting working together in three separate groups to develop recommendations for technology policy options that would address critical issues relating to the adoption and implementation of:

- Electronic Health Records and Health Information Exchange.
- Telehealth and Telemedicine.
- Technologies for Housing.

During their 45-minute work session, the Commissioners identified promising legislative and regulatory options that could support more widespread use of technology-enabled services and supports. They also identified potential research studies, education programs and awareness-raising strategies that they felt would help foster innovation and increase implementation and utilization rates in each technology category.

Following the work session, Commissioners heard a report from a representative of each workgroup. Those reports are summarized below. A summary of technology policy priorities appears at the end of this section.

### ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

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**Overview:** Federal and state policy makers could increase the number of long-term and post-acute care (LTPAC) providers adopting electronic health records (EHR) and participating in health information exchange (HIE) if they offered those providers financial assistance for EHR investments and mandated the development and use of uniform standards to govern HIE.

#### Financial Support for EHR Adopters

New sources of financial assistance—including grants, incentives and low-interest loans—would go a long way toward helping LTPAC providers invest in EHR systems. In addition, allowing LTPAC providers to share in the savings they create when they reduce hospital readmissions would help demonstrate to those providers the value of implementing EHRs and participating in HIE.

CAST Commissioners in this workgroup were realistic about the likelihood that new funding will be available for this purpose. Commissioners understand, for example, that the current budget climate will make it increasingly difficult for any provider of health care or long-term services and supports to secure promises of increased federal funding for any activity.

However, it was equally clear to Commissioners that many LTPAC providers will not be able to implement EHRs without some financial assistance.

This is unfortunate. Without basic EHR systems, LTPAC providers will not be able to participate in HIE. And, without the ability to exchange residents' health data, these providers will be unable to participate fully in efforts to reform the nation's health care system by increasing care coordination across primary, acute and post-acute settings. Lack of HIE participation by LTPAC providers makes care coordination more difficult for the entire care team.

Fortunately, current trends point to a steady decline in the cost of implementing EHRs in LTPAC settings. This trend has helped larger LTPAC providers find the funds necessary to purchase and implement electronic record systems. However, the average EHR price tag can still represent a stumbling block to some LTPAC providers. This is particularly true for smaller, stand-alone organizations, especially those operating in rural areas.

The U.S. must address these differences in EHR adoption rates so all health care consumers have access to coordinated and integrated care. One option is to target the shrinking pot of federal technology dollars to subcategories of LTPAC providers. Smaller, stand-alone and rural providers could make up top-priority subcategories because they are most in need of assistance.

### **Standards for Health Information Exchange**

Health Level Seven (HL7)—an international framework for the exchange, integration, sharing and retrieval of electronic health information—

offers some of the uniformity needed to enhance health information exchange. However, HL7 has its weaknesses, including the fact that it is not specific enough and is subject to significant interpretation by individual users.

More work is needed to create a uniform standard for electronic health information exchange so all providers are speaking the same language when they participate in statewide or regional health information networks. These uniform standards would ensure that all Continuity of Care Documents (CCD), pharmacy orders and medication reconciliation documents contain common data elements and use the same vocabulary. Such standards should be mandated. Otherwise, they are unlikely to be developed or implemented.

By the same token, government officials should review and adjust regulations that inhibit the seamless exchange of electronic information. For example, regulations in some states make it difficult to transmit pharmacy orders electronically due to regulators' discomfort with electronic signatures. In addition, regulations governing how patients consent to the exchange of their health information can create barriers to health information exchange.

### **Strategies for Raising Awareness about EHRs and HIE**

LTPAC providers need to hear more success stories from providers that have implemented EHRs and participate in HIE. These case studies should also explore the challenges that LTPAC providers faced during the implementation process.

Case studies about early adopters could:

- Raise provider awareness about the value of EHR adoption and HIE participation.
- Help LTPAC providers learn about how their colleagues faced and overcame adoption challenges.
- Help researchers and policy makers identify existing barriers to adoption and develop strategies to overcome those barriers.

Research on the return on investment of HIE, as well as its impacts on quality of care and services, should also be conducted in order to make the case for investment in HIE.

## TELEHEALTH AND TELEMEDICINE

### Charlie Hillman

*Chief Executive Officer*

*GrandCare Systems*

*West Bend, Wisconsin*

**Overview:** Telehealth and telemedicine are important technology solutions that can help LTPAC providers carry out their mission to deliver integrated and person-centered care and services that support the health and wellness of residents and clients across the continuum. These technologies are key enablers of strategic partnerships between LTPAC providers and hospitals, accountable care organizations (ACO) and other coordinated care delivery models. However, in order to promote delivery of the highest quality services and supports, LTPAC providers, their payers and regulators must stop viewing telehealth and telemedicine as a separate category of care delivery. Rather, telehealth and

telemedicine must be viewed as tools that providers use to deliver high-quality services and supports.

### Changing Our Language

Changing our language could be an important first step in fully integrating telehealth and telemedicine into LTPAC settings. The terms “telehealth” and “telemedicine” should no longer be used to refer to the services that LTPAC and other providers deliver remotely. Instead, these services should simply be described as “health” and “medicine.” After all, we don’t label a medical intervention as “pharmaceutical” simply because it involves the use of pharmaceuticals.

A more careful use of language, by providers and regulators alike, would make it clear that residents and clients receive the same high-quality health and wellness services, whether those services are delivered in person or using telehealth/telemedicine tools. Universal acceptance of this view could help:

- Remove barriers to reimbursement by public and private payers who would be encouraged to pay for telehealth and telemedicine in the same way they pay for in-person care.
- Increase consumer acceptance of telehealth and telemedicine technologies as legitimate care-delivery tools.
- Give LTPAC providers the flexibility they need to use every tool at their disposal to provide individualized, person-centered care and to employ the most appropriate caregiver—including nurses and certified nursing assistants—to deliver those services remotely.

CAST Commissioners in this workgroup acknowledged that any change in language will take time and should ultimately be embraced by regulators and payers to ensure success.

### **Payment**

When all providers are rewarded for health outcomes, rather than reimbursed for individual episodes of care, telehealth and telemedicine will become a very valuable tool to increase access to care, allow early detection of emerging conditions, and help residents and clients stay healthier and avoid costly health complications, hospitalizations and emergency department visits.

Payers and ACOs can play an important role in moving us closer to this reality and should be involved in these discussions.

### **Raising Awareness**

Wide distribution of case studies to LTPAC providers is the most effective way to raise awareness about telehealth and telemedicine solutions. These case studies should illustrate why and how investments in technology will support the mission of aging services providers.

Examples of how LTPAC providers are using telehealth and telemedicine to partner with hospitals, ACOs, bundled payment programs, insurance providers and other payers would be particularly helpful. These case studies should also illustrate the strengths that LTPAC providers bring to health reform initiatives: specifically, their expertise in managing health and wellness in vulnerable populations.

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## **TECHNOLOGY FOR HOUSING**

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### **Marcia Conrad-Miller**

*Senior Director*

*Research and Development Competency Centers and Global Technology Operations*

*Philips Home Monitoring*

*Framingham, Massachusetts*

**Overview:** Technology can be used effectively to support healthy aging among residents of a variety of independent housing settings, including federally subsidized housing communities, independent living communities and private homes. Basic Internet connectivity is an essential requirement for delivering this support. When such connectivity is made available, a broad array of technology-enabled services—including telehealth, telecare and social connectedness—could be provided to support health and wellness, reduce loneliness and isolation, increase quality of life and, ultimately, enhance independence among senior housing residents.

### **Connecting Low-Income Consumers to the Internet**

Lack of Internet connectivity is one of the primary barriers keeping older adults from accessing valuable technology solutions. The Federal Communications Commission (FCC) may play an important role in breaking down this barrier.

Since 1985, the FCC's Lifeline program has provided a discount on telephone service to qualifying low-income consumers. The program is designed to ensure that all Americans have the opportunities and security that come with basic telephone service. To participate in the program,

consumers must have an income that is at or below 135% of the federal Poverty Guidelines or participate in a qualifying state, federal or Tribal assistance program.

A similar program aimed at providing low-income individuals with Internet access would greatly expand consumer access to many in-home technologies and to technology-enabled services. These technologies, coupled with resident assessments and delivery of appropriate services, could help older adults remain healthy and independent for longer and could save health care dollars by improving access to preventative care.

Several technologies could enrich the housing environment:

- **Remote monitoring of chronic conditions:** These telehealth technologies might range from health-monitoring kiosks in the lobbies of congregate housing communities to individual digital devices that help older adults regularly collect and transmit data about their vital signs to clinicians.
- **Daily check-ins with nurses or other clinicians:** Housing residents could use telehealth devices to answer daily questions about their health and wellbeing. In turn, a clinician could respond with early interventions when the resident's answers to those questions indicate an emerging health condition.
- **Medication management:** Medication adherence programs are particularly critical to maintaining the health of older adults who may have difficulty managing multiple prescriptions. Technology can play a key role in helping older people carry out this often confusing and error-prone task.
- **Computer software:** Older adults could learn to use computer programs that deliver health education or help them improve their brain fitness.

### Potential Barriers

A number of potential barriers must be addressed before housing-based technologies can reach their full potential.

**Lack of utilization:** Initially, housing providers may have difficulty convincing residents to participate in technology programs that are based in their properties. Older housing residents may have limited experience with technology or may not understand the importance of measuring vital signs or using monitoring devices. These barriers can be reduced through:

- **Assessment:** Technology deployment is likely to be most successful if it is preceded by individual assessments of residents' health and functional status. Residents will be more likely to use technologies that they believe are meeting a specific, identified need.
- **On-site support:** Service coordinators, health navigators, wellness nurses, clinical social workers and staff of onsite health clinics in various housing settings could play a significant role in assessing residents, educating them about technology, offering them health and wellness recommendations, and referring them to technology-enabled

interventions. The onsite team could also offer training on the use of health- and wellness-related technologies.

**Staffing requirements:** A potential barrier to medication management technologies is the requirement, enforced by many states, that registered nurses carry out onsite medication management administration in housing environments. State efforts to eliminate or relax these requirements could help make medication management technology more widely available.

**Need for more research:** Additional research could help break down some of the barriers to technology-enriched housing. That research could:

- **Quantify technology-related cost savings.** Researchers could explore cost savings that can accrue from technology-enabled services, or from remote monitoring devices that help older consumers manage their chronic diseases or take their medications. Providers could use this research to build a case for establishing innovative care and payment models that are supported by Medicare, Medicaid, managed care organizations and others. These models would provide coverage and appropriate incentives to reduce health complications, hospital admissions and readmissions.
- **Shed light on the ability of Housing Plus Services models to contain health care utilization costs.** Pioneering research demonstrations could feature partnerships between congregate housing properties and physician-based ACOs or managed care companies. Studies and pilot programs could explore the

business case for establishing onsite wellness clinics that provide health services to residents while using technology to help residents self-manage and monitor their health and wellbeing between visits with clinicians.

### Advocacy for Technology-Enriched Housing

LeadingAge already supports the delivery of health and supportive services within affordable housing properties. In particular, the [LeadingAge Center for Housing Plus Services](#) was established in 2013 to serve as a national catalyst for the development, adoption and support of innovative affordable housing solutions that enable low- and modest-income seniors to age safely and successfully in their homes and communities.

Advocacy for Housing Plus Services models should continue. In addition, LeadingAge should advocate for legislative and/or regulatory changes designed to ensure that the services and supports delivered in affordable housing settings meet the same quality standards required of ACOs, home health agencies and health care providers in other settings.

Finally, LeadingAge should encourage federal agencies—including the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Housing and Urban Development (HUD)—to work together to make Housing Plus Services models a reality in more housing properties. HUD, CMS and other agencies should challenge each other to play a meaningful role in creating a regulatory and funding environment that would support these models.

## TECHNOLOGY POLICY PRIORITIES

Following is a summary of the Technology Policy Priorities discussed by the CAST Commissioners:

1. **Accelerate adoption:** LTPAC providers are important partners for acute care providers. However, the success of these partnerships will depend on the ability of LTPAC providers to use health information technology (IT) and to exchange relevant health information electronically. LTPAC providers with this capability will be able to participate more fully in facilitating smooth transitions of care and in planning and implementing shared care. LeadingAge and CAST would continue to advocate for inclusion of LTPAC settings in national health IT initiatives, including the development, adoption and use of interoperability standards, the certification of IT products, and the engagement of LTPAC providers in health information exchange activities. This exchange of health information would take place both directly and through health information exchange entities.
2. **Financial support:** LeadingAge and CAST would advocate for the establishment of initiatives to encourage and accelerate the adoption of interoperable EHRs, particularly among smaller, stand-alone and rural LTPAC providers. Such initiatives might include state and federal legislation authorizing grants or low-interest loans to assist with initial health IT investments. Regulatory agencies would be encouraged to provide ongoing payment incentives to LTPAC providers that adopt these technologies and demonstrate that they meet certain quality and cost measures.
3. **Telehealth and telemedicine:** Telehealth and telemedicine can help LTPAC providers carry out their mission to deliver integrated and person-centered care and services that support the health and wellness of residents and clients across the continuum. These technologies are key enablers of strategic partnerships between LTPAC settings and hospitals, ACOs and other coordinated care delivery models. LeadingAge and CAST would continue to advocate for legislation, including the Fostering Independence Through Technology (FITT) Act, which provides payment incentives for the use of telehealth and telecare when costs are reduced and care quality outcomes are improved. In addition, CAST and LeadingAge would advocate with agencies of the U.S. Department of Health and Human Services, including CMS and its Center for Medicare and Medicaid Innovation, for more demonstration projects focusing on health IT in general, and telehealth in particular. These projects—including demonstrations set in service-enriched housing settings—would engage, or be led by, LTPAC providers.
4. **Internet connectivity:** Basic Internet connectivity is an essential requirement for delivering technology-enabled care and support services. When such connectivity is made available, a broad array of technology-enabled services—including telehealth, telecare and social connectedness—could be provided to support health and wellness, reduce loneliness and isolation, increase quality of life and, ultimately, enhance independence among senior housing residents. LeadingAge and CAST would advocate with the Federal Communications Commission for a program

aimed at helping low-income individuals obtain Internet access. This initiative would greatly expand consumer access to many in-home technologies and to technology-enabled services. These technologies, coupled with resident assessments and delivery of appropriate services, could help older adults remain healthy and independent for longer and could save health care dollars by improving access to preventative care. Similarly, advocacy with HUD would facilitate and support Internet access in congregate low-income and affordable housing.

5. **Housing Plus Services:** LeadingAge and CAST would advocate to encourage federal agencies—including CMS and HUD—to work together to make Housing Plus Services models a reality in more housing properties.



## Appendix A:

### MAJOR CAST ACCOMPLISHMENTS FOR OCT. 2013 – MARCH 2014:

- Completed and published the first CAST Technology Adoption and Utilization Survey, which gauged technology adoption and use among organizations included in the 2013 LeadingAge Ziegler 100 (LZ 100). The effort was accomplished in partnership with Ziegler.
 

[http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/LZ100\\_Technology\\_Survey\\_2013.pdf](http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/LZ100_Technology_Survey_2013.pdf)
- Published *HIGH-TECH QUALITY IMPROVEMENT: Using Information Technology to Support Quality Improvement in Long-Term and Post-Acute Care Settings*, the Proceedings of the CAST Commission Meeting held on Oct. 26, 2013, in Dallas, TX.
 

[http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/High-Tech\\_Quality\\_Improvement.pdf](http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/High-Tech_Quality_Improvement.pdf)
- Succeeded in including S. 596, known as the Fostering Independence through Technology Act of 2011 (FITT), as an amendment in legislation adopted by the Senate Finance Committee in the ongoing congressional efforts to repeal the sustainable growth rate (SGR) and make changes to Medicare physician payments. Sen. John Thune (R-SD) and Sen. Amy Klobuchar (D-MN) introduced the bipartisan FITT Act. The bill would create a pilot program under Medicare to provide incentives for home health agencies to use home monitoring and communications technologies to improve access to care and help beneficiaries remain in their own homes.
- Continued to advocate for including long-term and post-acute care providers as active participants in health information exchange (HIE) activities and possibly other activities funded by the Health Information Technology for Economic and Clinical Health (HITECH) Act. These activities include state-designated HIE entities and Beacon Communities. The HITECH Act was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.
- Continued to provide guidance and successfully encourage LeadingAge state affiliates and members in different states to become actively engaged in state HITECH Act initiatives.
- Continued to support LeadingAge state affiliates in their efforts to conduct technology education, technology surveys aimed at gauging technology adoption among providers, and other technology-related activities, including technology policy and advocacy efforts.
- Promoted news about CAST and its members in mainstream print and electronic media outlets, including newspapers, magazines, trade and industry publications.

## **CAST RESEARCH UPDATE – MARCH 2014:**

CAST continues its efforts to encourage and actively engage in outcome-oriented evaluation of aging services technologies as an essential element to more informed decision-making and wider adoption. Here is an overview of the new opportunities and ongoing research initiatives:

- Technology Adoption and Technology Spending Surveys:** In partnership with Ziegler, CAST completed and published the first Technology Adoption and Utilization Survey, which gauged technology adoption and use among organizations included in the 2013 LeadingAge Ziegler 100 (LZ 100). We worked with Ziegler to update the Technology Spending Survey we developed and fielded to the Ziegler CFO Hotline last year. We are in the process of collecting new data. We also updated the technology adoption questions and integrated the vast majority of these questions into the new LZ 100 Survey for 2014.
- Stratis Health HIT PAC Project:** This project, funded by the Centers for Medicare and Medicaid Services (CMS), is wrapping up. It aims to study and encourage health information exchange between hospitals and nursing home partners in two Minnesota communities. CAST is a partner with Stratis Health on the project. CAST Executive Director Majd Alwan serves on the project's advisory group and is an expert consultant on the project. The Stratis

Health team has developed a Health Information Exchange (HIE) toolkit that complements the Stratis electronic health record (EHR) implementation tools. These tools served as a basis for the CAST EHR initiative and are currently being updated. CAST will share the research findings with members. It also plans to incorporate the new HIE toolkit in the CAST EHR initiative when it is updated in 2014. This toolkit should be particularly useful to all LeadingAge members.

## **LEADINGAGE LEGISLATIVE UPDATE – MARCH 2014:**

### **FY 2014 Omnibus Spending Bill**

In Jan. 2014, the President signed H.R. 3547, an omnibus spending bill to fund federal agencies for the remainder of this fiscal year. This bill marked the first time in many years that Congress and the President have agreed to top line budget numbers for discretionary funding. The bill also marked a loosening of sequestration. Not only did the omnibus address FY 2014, but it also provides top line budget numbers for FY 2015. In many respects, this legislation indicates at least some interest in moving the government forward in a less crisis-like manner.

The good news is that the omnibus provides a 2.6 percent increase in total discretionary spending levels over fiscal 2013. This means that most of the funding that senior housing and services programs lost to sequestration last spring has been restored.

**Medicare and Medicaid:** This bill does not affect

Medicare or Medicaid, which are not subject to the appropriations process. Under the budget deal passed by Congress in Dec. 2013, Medicare payments to health care providers will continue to be subject to 2-percent sequestration.

**Older Americans Act Home and Community-Based Services Programs:** The higher spending cap especially benefitted Older Americans Act programs, which will receive a total of \$1.6 billion. This funding will include:

- **Senior Meals:** The bill includes \$815 million for senior nutrition programs, which provide congregate meals and Meals on Wheels to needy seniors so they can remain healthy and independent. This amount fully replaces the cuts imposed on the program in the FY 2013 sequester. This includes a \$41 million increase for the elderly nutrition programs, including the Home-Delivered Meals (“Meals on Wheels”) program.
- **Community Services Block Grant:** The bill includes \$674 million for the Community Services Block Grant (CSBG), a \$39 million increase over the fiscal year 2013 level. The CSBG is a critical, flexible source of funding that helps local community-based organizations provide a variety of assistance to low-income populations.
- **Pay for Success:** The bill includes new authority and \$14 million in funding for the Corporation for National and Community Service to test models of financing that pay for outcomes, rather than activities. Modeled after Social Impact Bonds, which were developed in

the United Kingdom, Pay For Success pilots will leverage private resources by reimbursing entities for accomplishing the desired outcome. This differs from the current system of awarding a grant to an entity for future activities that are believed to accomplish the same outcome.

- **Social Services Block Grants:** Social Services Block Grants will be funded at \$1.7 billion. Many states use these funds to provide home and community-based services.

**Senior Housing:** The news here is mixed. Section 8 and Section 202 did receive increased funding. However, the additional funding for Section 8 may not be sufficient to prevent short funding of contracts. The omnibus potentially allows \$1.5 million for a housing with services demonstration.

- **Section 202:** A total of \$383.5 million to include Project Rental Assistance Contract (PRAC) renewals, amendments, and existing congregate services grants; \$72 million for service coordinators and an “elderly project rental assistance demonstration.”
- **Project-based Section 8:** \$9.5 billion. Since the amount needed to provide 12-month contracts for all renewals is estimated at \$11.3 billion, this amount pretty much guarantees that there will be short funding of contracts. The Department of Housing and Urban Development (HUD) said earlier last year that it needed \$11.4 billion. We will continue working with HUD to ensure that senior housing providers

have the resources they need for optimal operation of their facilities.

### Other Issues

- **Therapy Caps:** Each year we deal with the expected imposition of financial caps on outpatient therapy resulting from legislation passed in 1997. The caps have never gone into effect because they would create a terrible financial burden for seniors and persons with chronic disabilities. This is the same legislation—the so-called Sustainable Growth Rate (SGR) formula that mandated reductions in payments to physicians—that has also not gone into effect. Each year Congress passes legislation to avoid the cuts to physicians and imposition of the caps. This year, it looks like there may be legislation to address SGR permanently. The Senate Finance Committee has passed legislation that does restructure Medicare payments to physicians, and there are at least two bills in the House that address a permanent “fix.” The Senate legislation also repeals therapy caps and replaces caps with a system requiring pre-authorization. This proposal is generally acceptable to our large coalition. We are waiting to see what happens in the House. One of the big barriers to addressing SGR has been the expected cost. While the emphasis has been on agreeing to policy, payment for repealing SGR is unsettled.
- **S. 596:** LeadingAge has actively supported the Fostering Independence through Technology Act for 2013 (FITT), which creates pilot projects to encourage home health providers to use remote patient monitoring services, at a reduced cost to Medicare. Language implementing FITT was included in the Senate Finance SGR bill discussed above, and we are hopeful it will be included in final legislation. We continue to search for a member of the House of Representatives to introduce a companion bill.
- **S. 597/H.R. 1179:** This bipartisan legislation authorizes counting all overnight hospital stays toward the three-day stay required for Medicare eligibility for skilled nursing facilities. Currently beneficiaries may be billed as “outpatients” (called observation) despite being in the hospital for many nights. There is significant support for, and no opposition to, the substance of the legislation. However, there are concerns about its price tag. We are part of a large coalition of consumers and providers advocating for the bills.
- **Medicare Post-Acute Care Reform:** As we have noted before, last summer the Senate Finance and House Ways & Means committees requested comment on “options to reform” Medicare post-acute care (skilled nursing, home health, long-term care hospitals, and inpatient rehabilitation facilities). LeadingAge submitted extensive comments based on the work of our Public Policy Congress and our long-standing positions on Medicare and Medicaid payment, delivery system and reform. It is not clear what will happen with this request; it is far-reaching and ambitious. In addition, the chair of the Senate Finance Committee, Max Baucus, resigned to become Ambassador to China. Sen. Ron Wyden from Oregon is expected to take over the chairmanship, which will bring new leadership and interests to the committee. Sen. Wyden is

interested in coordinating care, which is clearly of interest to us as well. But it is not clear what, if any, agenda he has for post-acute sector.

[http://www.leadingage.org/Recommendations\\_for\\_Post\\_Acute\\_Payment\\_Reform.aspx](http://www.leadingage.org/Recommendations_for_Post_Acute_Payment_Reform.aspx)

- **Tax Reform:** The chairs of the Senate Finance Committee (Sen. Baucus, MT) and House Ways & Means Committee (Rep. Dave Camp, MI) toured the country seeking comments from businesses and others about reforming the Internal Revenue Code. Sen. Baucus and Sen. Orrin Hatch, the ranking member of Finance, also asked their fellow Senators for suggestions for tax credits and deductions they support. LeadingAge wrote each member of the Senate urging them to include low-income housing tax credits and full charitable deductions in their response to the Committee. It is definitely not clear where this is going. The committee had to publicly promise that Senators' responses would be kept confidential for 50 years to encourage Senators to identify their favored tax deductions. Changes in committee leadership, and the fact that this is an election year for the House and a third of the Senate, make it unlikely that there will be significant changes to the tax code.

### Future-Casting

- **Budget:** The President will be issuing his proposed budget for FY 2015 in March, which is about a month later than it is supposed to be issued. However, because the omnibus provides for FY 2015, we expect that the appropriations committees will begin work on the FY 2015 budget shortly. Our major

advocacy on the budget will be directed toward HUD and affordable senior housing, and we are in the process of finalizing our position.

- **Medicare Legislation:** The major bill being debated is the SGR repeal. We will continue to look to that bill as the vehicle for the legislation described above, including FITT, therapy cap repeal, and observation stays.
- **Long-Term Care/Services Financing:** LeadingAge's Finance Cabinet II issued its post-CLASS Act report. We are looking for champions in Congress to support continuing efforts to find the best way to address financing of long-term services and supports, as well as ways to bring the conversation on financing care and services to the broader public.

## CAST STATE TECHNOLOGY UPDATE – MARCH 2014:

### State-level Technology Activities

In its continuing effort to track technology activities in the states, CAST held one conference call prior to preparing this update. The call included a presentation by CAST Executive Director Majd Alwan on the results of the CAST-Ziegler Technology Adoption and Utilization Survey. The next call was scheduled for Feb. 26 and featured a presentation on "Oklahoma Health Information Exchange and Engaging Long-Term and Post-Acute Care (LTPAC) Providers" by Dr. Brian Yeaman, president and chief executive officer of Yeaman Consulting.

## State Updates

- **California:** California, Oregon and Washington organized a technology conference with AgeTech West. Members engaged with vendors and thought leaders and it was a very successful conference.
- **Massachusetts:** Massachusetts hosted a technology symposium. CAST Commissioner Chip Burns delivered a keynote address emphasizing the importance of electronic medical records (EMR) and technology infrastructures to support providers. The Massachusetts Health Information Exchange/Massachusetts Highway (MeHI) offered a well-received presentation on two ways of connecting to hospitals.
- **New York:** LeadingAge New York (NY) conducted a technology adoption survey among its members in 2011. There was an 80-percent response rate, although it was not easy getting members to respond. LeadingAge NY found that less than half of its members had adopted EMRs. It expects that the numbers have increased significantly since the survey was administered. LeadingAge NY is currently contacting Regional Health Information Organizations (RHIO) in an attempt to gauge the level of health information exchange (HIE) among members and the level of engagement between the RHIOs and LTPAC providers. To date, survey respondents have voiced a great deal of frustration about HIE. Providers with multi-service systems cannot exchange health information within their own systems. They

attribute this lack of interoperability to a problem with various electronic health records.

LeadingAge NY is also researching funding sources for members who wish to adopt technology. One source is a revolving loan funds for health information technology (IT) adoption. CAST referred LeadingAge NY to the Minnesota loan fund and suggested following up with Darryl Shreve from Aging Services of Minnesota.

## STANDARDS UPDATE – MARCH 2014:

- There has been significant industry conversation in response to news that the Office of the National Coordinator of Health Information Technology (ONC) and the federal Standards Committee are exploring potential certification approaches related to meaningful use for long-term and post-acute care (LTPAC) health information technology (IT). Our understanding is that current sentiment is leaning toward voluntary, modular-based certification programs. LeadingAge and CAST are supportive of such a program.
- The LTPAC Health IT Collaborative will hold its 10th Annual Summit on June 23-24 in Baltimore, MD. The summit will explore and refine the themes for the collaborative's biannual technology roadmap, which it will publish later in 2014. Preliminary themes focus on "connected patients," "connected workers," "connect providers," "health intelligence and quality," and the "evolving

business landscape,” including the new entrepreneurialism.

- We continue to see informal and ad-hoc initiatives focus on partners, products and services that expand health information exchange (HIE). At the same time, national, state and regional HIE networks continue to explore models to sustain their services.

## **Appendix B:**

### **PRINCIPLES FOR MANAGED LONG-TERM SUPPORTS AND SERVICES – 2014**

LeadingAge represents over 6,000 non-profit organizational members who provide services across the aging span of long term services and supports (LTSS). We recognize the importance of creating population health strategies, and know that, for many with chronic care needs, this includes the full continuum of LTSS. We realize the myriad of environmental pressures driving the States to explore and implement managed LTSS programs. We are concerned that many of these programs are being developed without adequate stakeholder input, thus impacting large numbers of vulnerable and high risk beneficiaries, for whom many of these managed care health plans have had little or no experience. The statements below represent LeadingAge members’ core set of principles that are elemental to effective, efficient and equitable delivery of managed LTSS that will ultimately lead to sustainable programs for the States, the providers of these services and the individuals they serve. LeadingAge member organizations believe that managed long term supports and services must adhere to the following core principles:

#### **Access**

- Individuals have access to the services that they need and, whenever possible, in the setting they choose, and effective uniform assessment tools are utilized.

- Services are coordinated across settings and based on individual assessment-based needs.
- Enrollment is expanded only when there is evidence of success and adequate capacity of services to meet the needs of the population enrolled in Managed LTSS.
- Person-centered programs are in place and adequately funded to ensure the core functions of individual advocacy, systemic monitoring, early intervention, and consumer education

#### **Quality**

- Managed LTSS programs develop consistent quality measures that apply to long term services and supports, including measures that address consumer experience, measures of direct workforce, integration of services, and quality of life measures.
- Enrollment should include “opt-out” provisions when services or networks are not adequate for individual needs or do not include current provider or services that individuals find essential to their care.

#### **Transparency**

- Managed LTSS contracts are developed through an open and transparent process with the managed care health plans, the state Medicaid offices, providers and consumers

#### **Finance**

- Medicaid and Medicare, alone and when combined (as in a capitated system for dually eligible individuals), meet the same standard for adequate payment.
- Uniform standards for payment are accompanied by streamlining conditions of participation, forms, codes and other administrative issues.
- Payments are adequate for innovative, efficient care: Recognizing Medicaid must change to promote greater efficiency without compromising quality.





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