STATEMENT FOR THE RECORD

SUBMITTED TO THE

SENATE FINANCE COMMITTEE

ON

REFORMING AMERICA'S HEALTH CARE DELIVERY SYSTEM

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AARP appreciates the opportunity to share with the Committee our priorities for delivery system reform in health care reform legislation. We commend Chairman Baucus and Ranking Member Grassley for their bipartisan leadership and commitment to enacting comprehensive health care reform legislation this year.

AARP has identified four primary goals for health care reform: ensuring Americans age 50 to 64 have a choice of affordable health care plans; strengthening Medicare for current and future generations by lowering health care costs and improving benefits; ensuring both the benefits and the cost of health reform is shared by Americans of all generations; and helping people to stay in their homes and out of often more costly institutions.

One out of every six dollars in our economy is for health care. Yet our health care system costs too much, makes too many mistakes, and gives us back too little value for our money. Patients face problems including medical errors, a lack of preventive care, duplicative and unnecessary tests, a lack of evidence to inform decisions about care, and expensive care. Payment systems are misaligned and do not encourage quality care. Fraud is too prevalent. Consumers may have poor health literacy skills, unhealthy behaviors, and not adhere to properly prescribed medications and other medical recommendations. Payers, providers, patients, and others all have a role to play in improving the health care system. Delivery system reform is critical to reducing skyrocketing health care costs and improving the quality of care. Bipartisan action this year is essential.

We are recommending delivery system reforms that include: a Medicare transitional care benefit; additional steps to strengthen and improve Medicare; nursing and other workforce improvements; comparative effectiveness research and other evidence-based improvements; payment reforms to improve quality; long-term care improvements; and better care coordination for those who are dually eligible for both Medicare and Medicaid.

Transitional Care and Hospital Readmissions

Better care coordination, especially for those with multiple chronic conditions, is an essential part of delivery system reform. Many gaps in care often occur at care transitions, as individuals move from one setting to another, such as from a hospital to home. A lack of coordination and follow-up care can lead to unnecessary hospital readmissions.

Unnecessary hospital readmissions mean unnecessary health care costs and poor quality of care for individuals, especially those with multiple chronic conditions who are high users of the health care system. A study published this month in the *New England Journal of Medicine* found that almost one-fifth of Medicare beneficiaries studied who were “discharged from a hospital were re-hospitalized within 30 days” and about one-third were re-hospitalized within 90 days. Additionally, one-half of the individuals re-hospitalized within 30 days after a discharge to the community had not visited a

physician since their discharge, indicating a lack of follow-up care. The study also estimated that Medicare spent $17.4 billion in 2004 on unplanned re-hospitalizations.

Too frequently, coordination and continuity of care do not occur and the quality of care breaks down, especially for individuals with multiple chronic conditions. They often experience multiple transitions across settings, seeing many different types of providers. For example, an eighty year-old woman with five chronic conditions is likely to see an average of 14 different physicians each year. In addition, if she is hospitalized, she will likely be cared for by multiple health professionals during her stay. She may be discharged to a skilled nursing facility for rehabilitation after the hospital stay and finally return home where she may receive some home health care or personal care to help ensure that she or she and her caregiver can take care of her needs.

Research has shown that she is vulnerable to breakdowns in care during each transition. Among the factors that contribute to gaps in care during critical transitions are poor or incomplete communication and transfers of information, inadequate education and support for older adults and their family caregivers, and the "absence of a single point person to ensure continuity," according to an article by Mary Naylor and Stacen Keating in the *American Journal of Nursing*. All too frequently, family members, partners, friends, or neighbors find that they are the sole care coordinators. In addition, individuals may have their medications changed by different physicians in different settings as they move across the care continuum, often contributing to adverse reactions, confusion for individuals and their caregivers, and patient noncompliance.

When providers across settings do not sufficiently and regularly communicate and coordinate among themselves and with individuals and their caregivers, quality of care suffers. Lack of communication and coordination produces quality problems, such as medical errors; duplicative or unnecessary tests; hospital readmissions; and adverse drug interactions. In addition, individuals and their caregivers may not always understand the information they receive from health professionals for a number of reasons, including poor communication, dementia or other conditions that impair understanding of the information, and language access or literacy barriers. Medicare beneficiaries report greater dissatisfaction related to discharges than to any other aspect of care that the Centers for Medicare & Medicaid Services (CMS) measures.

AARP believes that one key way to reduce unnecessary hospital readmissions, reduce unnecessary Medicare spending, and improve quality of care is to establish a transitional care benefit in the Medicare program. Such a benefit could be coupled with payment reforms to align payment incentives to discourage unnecessary hospital readmissions. This transitional care benefit would be specifically designed to support Medicare beneficiaries as they enter the hospital and move from the hospital to home or another setting, such as a skilled nursing facility or a rehabilitation facility. Congress could also consider expanding or giving the Secretary of Health and Human Services (HHS) the flexibility to expand the transitional benefit to include discharge from other institutional settings, such as a nursing home or rehabilitation facility.

The goals of such a benefit include reducing unnecessary hospital readmissions; ensuring that beneficiaries receive necessary follow-up services, supports, and education; ensuring communication among all members of the care team and management of medications; and supporting beneficiaries' family caregivers who coordinate their care. The benefit would be voluntary, evidence-based, and phased-in over time to ensure more effective and workable implementation. It would also complement efforts in 14 communities across the country to reduce re-hospitalizations under the Centers for Medicare & Medicaid Services (CMS) Care Transitions Project. The benefit could provide an infrastructure to further build on, disseminate, and implement evidence-based practices from the Care Transitions Project, as well as other research and experience over time. Valuable research has been conducted on improving transitions of care, such as the work by Dr. Mary Naylor, who pioneered the Transitional Care Model.

An effective way to structure this transitional care benefit has been rigorously tested and found to yield positive results. As we envision it, the benefit would at first be targeted at individuals at most risk for poor transitions and readmission to a hospital. For example, high-risk beneficiaries could have more than one characteristic such as serious chronic conditions, cognitive impairment, depression, or other potential characteristics that increase the likelihood of hospitalization; prior admission to a hospital within the past 30 days; and multiple admissions within a certain period of time. Attributes of high-risk patients might also be captured by an existing measure, such as a high Medicare Hierarchical Condition Category (HCC) score. Under existing models, which have been proven in the marketplace, nurse-led interdisciplinary teams assess the beneficiary (and his or her caregiver) at or close to the time the individual is admitted to the hospital and before hospital discharge. The nurse and other providers, in consultation with the beneficiary and caregiver, develop an individualized plan for appropriate follow-up during and after the transition.

Another approach to implement a transitional care benefit could target not only high-risk beneficiaries, but with appropriate targeting and risk adjustment, target middle- and lower-risk individuals for tiered evidence-based services of lower intensity. For example, a tiered approach could target three different levels of transitional care services to low, middle, and high-risk beneficiaries, based on meeting eligibility criteria for each level of services.

We believe a variety of evidence-based transitional care services could be made available to high-risk beneficiaries and their caregivers with services tailored to the specific needs of the individual. Examples of such services could include:

- Transition Care Coordinator – A trained health professional – a nurse in the evidence-based models -- with an interdisciplinary team that intervenes as needed;
- Geriatric Assessment – A comprehensive review of a beneficiary's physical and mental condition, including cognitive and functional capacities, medication regimen and adherence, social and environmental needs, caregiver needs and resources;

- Care Plan – Develop a comprehensive care plan for the beneficiary and their family caregiver identifying problems, current therapies, and future services that may be needed;
- Face-to-face visits – Such visits would begin during hospital admission and resume after discharge at home or in the next care setting as needed during the episode – about 30-90 days – with the Coordinator able to work across settings
- Physician Visits – Accompany beneficiary to follow-up physician visits as needed;
- Medication Reconciliation -- Review medications to avoid adverse drug reactions, and teach the patient and caregiver how to organize, manage and take medications;
- Advice – Provide information and resources about conditions and care;
- Patient Navigation – Provide guidance on navigating the health care system;
- Patient Coaching – Advise beneficiary and caregiver how best to follow the clinician's instructions and how to best care for conditions;
- Provider Care Coordination - Educate and assist the beneficiary and their caregiver to arrange and coordinate provider visits and health care services;
    - Assure that providers are aware of services that have been ordered for and received by beneficiaries from other providers;
    - Work with providers to assure appropriate referrals to specialists, tests and other services.
- Support Service Coordination - Educate and assist beneficiary and their caregiver with arranging and coordinating support services (such as medical equipment, meals, homemaker services, assistance with daily activities, shopping, and transportation).

The benefit would <u>not</u>: provide transportation; pay for arranged services; limit access to physicians or other health care services; or require the beneficiary to follow the advice of the Transition Care Coordinator. We view the benefit as the glue or link in the chain that helps ensure continuity and quality of care for beneficiaries across the current silos of care.

Under existing models, participants are typically eligible to receive transitional care services during an admission and as needed during that episode -- about 30-90 days. It is critical that the model be team-oriented to ensure that care is properly coordinated. Interdisciplinary team members could include the primary care physician or practitioner, pharmacist, therapists, medical social worker, and other health care professionals as appropriate. The Transition Care Coordinator would be expected to collaborate closely with all the individual's physicians and other clinicians and have timely access to information about admissions and discharges to health care facilities. The Coordinator or other team member would also need to have knowledge of and access to community support services and payment options for appropriate health care and support services.

AARP believes a variety of payment mechanisms could be used for transitional care services. Indeed, we believe it is critical to get away from the silos of care that have contributed to these difficult transitions for patients. It is important for the services to

follow the patient. As long as they comply with participation criteria, the Transition Care Coordinator and any appropriate team members could be employed by an institutional care provider, a home health agency, a Medical Home (physician or other clinical practice), an insurer, a managed care organization, or other appropriate entity. Providers of transitional care services should be encouraged to use health information technology (HIT) with financial support available for start-up costs. If providers can effectively provide the transitional care services and coordinate care, the lack of HIT should not be a barrier to offering these services.

It is important that this new benefit be held accountable and be measured for quality. Performance measures should be used to evaluate the transitional care benefit and could include: admission rates to health care facilities; readmission rates; cost of transitional care and all other health care services; quality of transitional care experiences; measures of quality and efficiency; beneficiary, caregiver and provider experience; health outcomes; and savings to Medicare over time. However, realizing Medicare savings should not be the paramount factor for the adoption and continuation of a transitional care benefit. We note that this transitional care benefit could also be used in other public programs or in private health insurance.

Improving transitional care will also require mechanisms to provide information about national, state, and community-based resources for family caregivers upon a Medicare beneficiary's admission to or discharge from a hospital, post-acute care, or other setting. We urge the inclusion of such a provision, as in the Retooling the Health Care Workforce for an Aging America Act (S. 245), in the Committee's health care reform bill. Similar steps could also be taken beyond the Medicare program.

Strengthening and Improving Medicare

Strengthening and improving Medicare is a critical part of comprehensive health care reform. Medicare provides vital health care coverage to 44 million people. Yet, skyrocketing health care costs combined with an economic crisis are making the program's gaps ever more apparent. Today, people on Medicare spend about 30 percent of their incomes, on average, on out-of-pocket health costs – including premiums for supplemental coverage. This is six times greater than for people with employer-sponsored coverage and comes at a time when millions of Medicare beneficiaries have seen their retirement savings shrink and health care costs increase. We support reforms to improve quality of care for Medicare beneficiaries while lowering health costs by eliminating the waste and inefficiency that we cannot afford, and that often result in medical errors and poor care. We believe that payment reforms are necessary to improve the quality of care. The following are important Medicare improvements that should be included in comprehensive health care reform (in addition to the transitional care benefit):

- **Closing the Donut Hole and Lowering Rx Costs:** Taking steps to close the Part D coverage gap (donut hole) and lower drug costs through: gradually making the donut hole smaller over time; drug price negotiation; safe importation; expanding

access to generic drugs, including by creating a pathway for generic biologics; and requiring drug companies to provide Medicaid rebates for dual eligibles in Part D. Narrowing the Part D donut hole would reduce the amount of time that individuals have to pay premiums without getting insurance coverage and provide additional relief for those entering the coverage gap.

- **Keeping Medicare Affordable:** Ensuring total premiums and out-of-pocket costs do not become excessive.

- **Helping the Most Vulnerable:** Improving the patchwork of programs that help low-income Medicare beneficiaries afford to pay for their prescriptions, premiums, deductibles, and other health costs. First, raising the income threshold for assistance to 150 percent of poverty, ideally making the standard the same across programs. Second, eliminating the stringent asset tests that prevent people who did the right thing and saved a small nest egg for retirement from receiving vital assistance. Third, making sure beneficiaries know that these low-income assistance programs exist and simplifying the application process to ensure our most vulnerable are getting the help they need.

- **Reducing Racial and Ethnic Disparities:** Taking steps to address racial and ethnic disparities in health care so all Americans receive high quality care, such as: issuing comprehensive federal requirements for the collection of racial and ethnic data; strengthening the capacity of the Office of Civil Rights and providing the resources to enforce existing federal language access requirements; ensuring adequate reimbursement for the provision of language services in Medicare fee-for-service and Medicare Advantage; and, increasing cultural diversity and competencies in the health workforce.

Congress must act now to address affordability and solvency, or Medicare will not be able to effectively serve current or future beneficiaries. Commonsense ways to help put Medicare on stable financial ground include:

- Revising the way Medicare pays doctors and hospitals to reward high quality care rather than how much care is provided, including through "medical home programs";
- Promoting care coordination programs for people with multiple chronic conditions, such as through individualized assessments and care plans (as in the Independence at Home Act), and improving care at the end of life;
- Reducing overpayments to private insurance companies;
- Reducing waste, fraud and abuse, while protecting beneficiaries; and,
- Lowering drug prices by allowing Secretarial negotiation and importation as well as creating a pathway for generic versions of biologic drugs – medications that treat diseases such as cancer and multiple sclerosis.

Models, such as the medical home, have the potential to improve the quality of care and care coordination, increase access to care, improve payments for primary care and care

coordination, and possibly reduce costs. A number of states are also embracing the medical home concept and some states, including North Carolina, have reported reduced costs through a medical home project. More broadly, effective practice models that emphasize, encourage, and improve primary care should be expanded and incentives should be created to encourage individuals to practice in primary care. Interdisciplinary care teams should be encouraged, as they can provide quality care for individuals and recognize the valuable role and contributions of multiple care providers. The workforce should also be adequately prepared and trained to address the needs of an aging population. Strengthening the primary care workforce is an essential part of ensuring the provision of quality affordable health care for all.

Nursing Workforce

Congress should take some important steps to help ensure a nursing workforce that is prepared to address the needs of those with chronic conditions and long-term care needs and the growing aging population more broadly. AARP recommends a new approach to funding nursing education to better prepare and ensure a highly-skilled nursing workforce to meet the needs of Americans.

Congress should modernize Medicare funding to prepare advanced practice registered nurses with the skills to care for Medicare beneficiaries with chronic conditions. Currently, Medicare pays hospitals to prepare nurses at the basic education level. This is based on the predominant way nurses were educated in 1965 at the inception of Medicare, but it is outdated and does not adequately prepare nurses to care for Medicare beneficiaries. We propose that Medicare's nursing education dollars be dedicated to graduate nursing education costs for the preparation of advanced practice registered nurses with the skills necessary to provide primary and preventive care, transitional care, chronic care management, and other nursing services in interdisciplinary teams for the Medicare population. Under this approach, hospitals would still accept the Medicare dollars but would be required to pass them to affiliated schools of nursing to cover the costs of such educational activities. This would ensure that nurses educated in part by Medicare funds would be trained to provide the services that Medicare beneficiaries will need in the settings where they will be provided.

Comparative Effectiveness Research

AARP strongly believes that one of the fundamental building blocks of a reformed health care system is the availability of scientifically valid, objective, comparative information about treatment options. According to some estimates, less than half of all medical care is based on or supported by adequate evidence about its effectiveness. AARP is pleased with the down payment of $1.1 billion for comparative effectiveness research (CER) included in the American Recovery and Reinvestment Act (P.L. 111-5). However, we need a long-term and robust investment in CER. AARP supports the creation of an independent entity that would conduct and disseminate comparative effectiveness research.

Long-Term Care and Helping People Live at Home

AARP believes that all Americans should have the choice to get needed care at home, since 89 percent of Americans age 50+ want to remain at home as long as possible. Yet home and community-based care is often unaffordable or unavailable. Many with long-term care (LTC) needs – including those with multiple chronic conditions – rely on Medicaid, the largest payer of long-term care in this country. But Medicaid has an institutional bias – institutional care is a mandatory service, while home and community-based services are provided at the state's option. Nationally, 75 percent of Medicaid LTC spending for older people and adults with physical disabilities pays for institutional services, with only 25 percent going to the home and community-based services that people prefer. Yet states that invest in HCBS can, over time, slow their rate of Medicaid spending on LTC. In addition, on average, Medicaid dollars spent on HCBS can support nearly three older adults and individuals with disabilities for every person in a nursing home, according to a report released by AARP last year. Congress should make changes to expand access to HCBS and work to end Medicaid's institutional bias.

Family caregivers are also critical to the health and LTC systems in this country. At any given point, about 34 million family caregivers help loved ones live at home. These caregivers provide and coordinate care, risking their own health and financial security while providing unpaid assistance with an estimated economic value of about $375 billion in 2007, according to AARP's Public Policy Institute. Family caregivers reduce Medicare inpatient expenditures of single older persons, as well as expenditures for home health and skilled nursing facility care. Assistance by family caregivers also delays or prevents the use of nursing home care.

We urge Congress to include in comprehensive health care reform important improvements in Medicaid HCBS and support for family caregivers to enable more individuals to live in home and community-based settings and not in often more costly institutional settings. Specifically, Congress should:

- Raise the income eligibility level, broaden the scope of covered services, and make other improvements in the Medicaid HCBS state plan option, as in the Empowered at Home Act (S. 434);
- Provide an enhanced Medicaid match to states to expand HCBS;
- Require spousal impoverishment protections in Medicaid HCBS (just as they exist in institutional care), as in the Empowered at Home Act (S. 434); and
- Establish a state plan option or requirement to assess all HCBS beneficiaries' family caregiver needs and connect them to supports, as in the Retooling the Health Care Workforce for an Aging America Act (S. 245).

Dual Eligibles

Finally, as part of improving coordination of care, Congress should focus on improving the quality of care and reducing costs for individuals eligible for both Medicare and Medicaid – the dual eligibles. Individuals who are dually eligible are often in poor health

and have long-term care costs. The high costs of their care increase both Medicaid and Medicare spending. According to a recent report by the Kaiser Family Foundation, almost nine million dual eligibles accounted for 18 percent of Medicaid enrollment and 46 percent of all Medicaid expenditures for medical services in fiscal year 2005. Significantly, 1.6 million of these dual eligibles "who had per capita Medicaid spending of $25,000 or greater in 2005 accounted for more than 70 percent of all dual eligible spending."

Congress should improve care coordination for the dual eligible population by:

- Establishing a Medicare and Medicaid pilot to integrate care and financing for dual eligibles;
- Improving Special Needs Plans, including through contracts with state Medicaid programs; and
- Requiring or providing incentives for sharing information regarding dual eligibles, such as claims and Part D utilization data, between Medicare, Medicaid and other health plans.

Conclusion

We stand ready to work with members of the Finance Committee, and others on both sides of the aisle in the House and Senate, and the Administration to enact comprehensive health care reform this year that includes the important system delivery reforms we have outlined. System delivery reform is essential to reducing health care costs, improving quality, and providing affordable coverage for all Americans.