Aging and Disability BUSINESS INSTITUTE

Amy Bassano
Acting Deputy Administrator for Innovation and Quality &
Acting Director, Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

via electronic submission

Dear Acting Director Bassano:

Thank you for the opportunity to provide feedback and input into the new direction of the Center for Medicare and Medicaid Innovation. Our comments will primarily address the important role of community-based organizations, and their expertise in addressing social determinants of health, in the health care system. We will focus on state, local and Medicaid models, behavioral health models and Medicare Advantage.

The importance of social supports, such as housing, nutrition, transportation and personal care, in maintaining the health and independence of older adults as well as people with chronic conditions and disabilities has become increasingly clear. Research demonstrates that the social supports that community-based organizations (CBOs) provide, including care coordination, care transitions programs, and evidence-based programs, improve health outcomes and reduce health care spending by allowing older adults and people with disabilities to remain in their communities and out of high-cost hospital and nursing home settings. [1,2] Recent research has also found that functional limitations are associated with higher Medicare spending, further emphasizing the necessity of addressing them.[3]

The Aging and Disability Business Institute (Business Institute) is led by the National Association of Area Agencies on Aging (n4a) in partnership with the most experienced and respected organizations in the aging and disability networks. The Business Institute works with aging and disability CBOs to help them

[1] Thomas KS and Dosa, D. More than a Meal: Results From A Pilot Randomized Control Trial Of Home-Delivered Meal Programs. Meals on Wheels America and Brown University School of Public Health, 2015. https://www.mealsonwheelsamerica.org/theissue/research/more-than-a-meal/pilot-research-study
[2] Bradley EH, Canavan M, Rogan E, et al. Variation in health outcomes: The role of spending on social services, public health, and health care 2000-2009. Health Aff (Millwood). 2016; 35 (5): 760-768.
[3] Windh J, Mulcahy J, Wolff J, Willink A, Kasper J, Atkins G. L. Medicare Spending on Older Adults Who Need Long-Term Services and Supports. Washington, DC: Long-Term Quality Alliance, 2017. http://www.ltqa.org/medicare-spending-on-older-adults-who-need-ltss/

adapt to a new, value-driven health care environment by providing them with tools and resources to better contract with health care partners. The overarching vision of this initiative is to improve the health and well-being of America's older adults and people with disabilities through improved and increased access to quality services and evidence-based programs. Building the business capacity of aging and disability CBOs so that they can effectively contract with health care payers will ultimately lead to improved quality of life for older adults and people with disabilities through better integration and coordination of a wide array of medical and social services and supports.

Given the growing evidence described above, we urge you to ensure that CBOs, and the social supports and services that they provide, are central to the design of models that CMMI develops. CBOs, which have decades of experience reaching vulnerable populations to provide needed services, are a vital part of the health care system. They are central to the creation of patient-centered reforms that drive quality, reduce costs and improve outcomes. CMMI must commit to strategic and flexible engagement of CBOs as it seeks to develop new models.

CBOs across the country are already partnering with the health care sector to improve care for older adults and people with chronic conditions and disabilities. Additional flexibilities and considerations could enhance the ability of CBOs to effectively and efficiently work with health care partners.

Medicare Advantage Innovation

We agree that added flexibility for Medicare Advantage (MA) plans to provide additional benefits would promote the health and well-being of older adults and people with disabilities. Medicare Advantage plans could be encouraged to include nutrition, transportation or other services as supplementary benefits, and should have the ability to target these services to the beneficiaries with complex chronic conditions who would most benefit. This approach is consistent with the recommendations of the Bipartisan Policy Center's report, *Improving Care for High-Need, High-Cost Medicare Patients*[4], as well as proposals in the Senate Finance Committee's Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which was recently passed by the Senate.[5]

In addition, future models could clarify that care transitions programs fall under the quality improvement activities of the medical loss ratio. Currently, such services are classified as administrative, which limits the ability of MA plans to provide them in partnership with CBOs.

State-Based/Local/Medicaid

CBOs are uniquely positioned to address social determinants of health in their communities by helping individuals manage their chronic conditions, and providing services that prevent hospital admissions and readmissions. We believe that CMMI should consider further development of models that encourage collaboration and partnership between CBOs and the health care sector at the local level. CMMI has

[4] Bipartisan Policy Center. Improving Care for High-Need, High-Cost Patients. 2017. https://bipartisanpolicy.org/library/improving-care-for-high-need-high-cost-medicare-patients/

[5] Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, S.870, 115th Cong. (2017).

developed and promulgated two such models in the past: the Community-Based Care Transitions Program (CCTP) and the Accountable Health Communities initiative addressed the significant role of social determinants in health and health spending.

While n4a and its partner organizations applauded CMMI's attention to the important issue of unmet social needs, we had concerns about the design of the AHC model, particularly regarding the lack of additional funding for community-based organizations and services. Such community programs are often underfunded, and many have lengthy waiting lists for access. These problems are likely to be exacerbated by enhanced screening, which will result in greater numbers of referrals to organizations that do not have the resources to address greater numbers of individuals in need. Any model designed to address social needs should also ensure that these needs can be properly addressed by the community, which will require additional funding for CBOs. As CMMI considers the development of new models that link health and community-based services, it should allow the use of funds to ensure that community-based services are adequate to address the needs of participants.

The impact of the CCTP program was limited by a short ramp-up time for implementation, and by a lack of access to timely data. Many CBOs lack the sophisticated data and IT systems required for partnership with the health care sector, and were not provided with sufficient time to develop and implement them. Significant up-front costs associated with the program further inhibited CBOs from meeting enrollment benchmarks. Nevertheless, many CCTP sites showed significant reductions in both hospital readmissions and admissions, resulting in significant savings to Medicare. The CCTP was highly valuable in creating partnerships between CBOs and hospital systems to address the social needs of high risk patients. Future models that encourage health system collaboration with CBOs would benefit from ensuring that participants have adequate ramp-up time to implementation, and that CBOs have appropriate data access.

With these adjustments, we believe that future models could have a much stronger impact on health care spending and outcomes.

The financial alignment demonstrations in Ohio and Texas demonstrate the positive outcomes that result from partnership between health care entities and CBOs. In Ohio's MyCare demonstration, health plans are required to contract with Area Agencies on Aging (AAAs) to provide waiver service coordination to beneficiaries over 60. In addition, two of the five managed care organizations have chosen to contract with AAAs for fully delegated care management. These two MCOs have the highest market share for the waiver population, demonstrating the value of the AAA role to consumers.

California and Texas utilized Alzheimer's Disease Supportive Services Program (ADSSP) grants to provide dementia expertise to the duals plans in their financial alignment demonstrations. In these models, CBOs work with the plans to provide evidence-based programs and supportive services to participants with dementia and their families. The CBOs also provide technical assistance to the plans in the identification of cognitive impairment and identification and support of family caregivers. Preliminary evidence from California indicates that plans are significantly more likely than at the launch of the

program to have involved the caregiver in development of a care plan, and to refer the person with dementia or their caregiver to available home and community-based services.[6]

Behavioral Health Models

CMMI should consider testing models designed to improve care for people with Alzheimer's and other dementias. Dementia is a major driver of health care expenditures, and care for people with dementia comes at a tremendous cost to family caregivers. A recent analysis of Health and Retirement Study data found that average per-person health care spending for people with dementia in the last five years of life was more than a quarter-million dollars, 57 percent greater than costs associated with death from other diseases such as cancer and heart disease.[7]

Family caregivers are critical in allowing people with dementia to live safely and independently in the community. Indeed, family caregiver burnout is one of the largest predictors of nursing home entry for individuals with dementia.[8] Community-based organizations, particularly the Aging Network, have deep expertise in working with the individual and family, utilizing evidence-based models which improve caregiver stress and well-being. As seen in the California and Texas Financial Alignment Demonstrations, the expertise of CBOs in providing person-centered services and evidence-based programs to this population can save tax payer dollars by preventing nursing home entry and hospitalization, and has the potential to greatly improve the quality of life of people with dementia and their caregivers.

Additional Suggestions

Many CBOs are contracting to provide case management for health care partners. We appreciate the importance of conflict of interest rules preventing case-managers from steering individuals towards services that they or their organizations also provide. However, these rules often present significant barriers to CBOs playing multiple roles, many of which are often the only providers of vital services in their community. Preventing CBOs from serving clients to whom their organization also provides case management or planning would significantly reduce consumer choice in areas with few service providers. Many CBOs have successfully created firewalls and other systems to ensure that there is no conflict of interest in providing services. In Ohio, firewalls ensure that case management is provided by a distinct work unit within the AAA, separate from screening and assessment and provider network management and reporting up a separate supervisory chain.

The Business Institute also strongly encourages the expansion of evidence-based programs. Such programs prevent hospital readmission and improve health at lower cost than clinician-driven

[6] Cherry DL. Dementia Care Management within the Federal Financial Alignment Demonstrations. Presentation at National Research Summit On Care, Services And Supports For Persons With Dementia And Their Caregivers. National Institutes of Health Bethesda, MD. October 16–17, 2017. https://aspe.hhs.gov/pdf-document/research-summit-dementia-care-federal-financial-alignment-demonstration

[7] Kelley AS, McGarry K, Gorges R, Skinner JS. The Burden of Health Care Costs in the Last 5 Years of Life. Ann Intern Med. 2015; 163(10): 729–736.

[8] Eksa K, Graessel E, a Donath C, Schwarzkopf,L, Lauterberg J Holleb R. Predictors of Institutionalization of Dementia Patients in Mild and Moderate Stages: A 4-Year Prospective Analysis. Dement Geriatr Cogn Dis Extra. 2013; 3(1): 426–445.

programs,[9] while allowing nurses, social workers and others to perform at the top of their licenses. These programs are available across the country through more than 1,000 community-based organizations and health care delivery systems and reach over 150,000 people each year.

One prominent example is HomeMeds, which is based on a comprehensive in-home medication inventory with additional questions regarding adherence and possible adverse effects. It also includes a computerized risk assessment and alert process with pharmacist follow-up to resolve potential medication-related problems. HomeMeds facilitates medication reconciliation after hospitalization, fits well with care transition coaching, identifies adherence problems, and addresses medication-related risks for falls and hospital readmissions while reducing the use of high-risk medications. Currently, 28 Area Agencies on Aging across the country utilize HomeMeds, and more than 14,000 medication assessments were completed in 2016 and 2017 across all HomeMeds sites.

A recent review of data by a major academic medical center showed that when paired with a thorough psychosocial and functional assessment (called HomeMedsPlus) for a high-risk group being discharged, population-level readmission levels were brought down by 3 percentage points. The pre-post results for the high-risk group showed readmissions were reduced from 30 percent to 10 percent.

Thank you for the opportunity to provide feedback into the new direction of the Innovation Center. Please contact the Business Institute's Deputy Director Mary Kaschak at mkaschak@n4a.org for more information, or if you have any questions.

Sincerely,

Nora Super

Director, Aging and Disability Business Institute
Chief, Programs and Services, National Association of Area Agencies on Aging

[9] NCOA. National Study of the Chronic Disease Self-Management Program: An Overview. https://www.ncoa.org/wp-content/uploads/National-Study-Brief-FINAL.pdf