

May 10, 2016

Dr. Patrick Conway
Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Dr. Conway:

The undersigned organizations are writing to offer our reflections and concerns about the Accountable Health Communities (AHC) Funding Opportunity Announcement (FOA), released on January 5, 2016.

We commend the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI) for proposing a model that recognizes that many drivers of health care costs exist beyond the sphere of influence and scope of acute health care delivery alone and that the use of community services providers to bridge this gap is the best solution.

Yet as currently written, we believe the AHC model has severe limitations that will prevent CMS and partners from adequately addressing the health-related social needs of Medicare and Medicaid beneficiaries.

Our primary concern with the AHC approach concerns the lack of adequate funding for the community-based services at the center of the model. We do not believe that merely building awareness about available community services and facilitating the connection between beneficiaries and services will be sufficient to meet the goals outlined in the FOA. In order to achieve the outcomes CMMI is seeking through the AHC model, CMMI must also work to try to ensure that there are *adequate and available services to meet beneficiary needs*. Regrettably, the FOA does not address the dilemma faced by community services providers: chronic underfunding of social services and supports relative to rapidly rising need among community-dwelling older adults.

In addition to a lack of funding for health-related services, other potential pitfalls include a failure to take into account and adjust for the very substantial diversity that exists in Medicare and Medicaid beneficiary populations; limitations on core health-related services assessments; lack of involvement of family caregivers or assessment of their needs for support; and unrealistic expectations and evaluation criteria.

We ask you to consider and respond to the following challenges to the success of AHC.

No Funding for Community Services

In light of a growing body of research suggesting that factors influencing health are primarily mediated by social, environmental and behavioral factors, CMMI's recognition of the increasingly pivotal role that community-based organizations (CBOs) play in both improving health outcomes, and in reducing spending in high-cost settings for Medicare and Medicaid beneficiaries, is greatly appreciated. With adequate funding for CBOs, the AHC model has the potential to provide important new evidence regarding the impact of community interventions on overall costs and outcomes for Medicare and Medicaid beneficiaries.

Yet without appropriate resources for the CBOs that provide those services, we anticipate the FOA's hypothesis will be thwarted—limited to highlighting widening service gaps between the health care and social services sector, and heightening frustration among beneficiaries, many of whom will be unable to secure the services that screenings identify they need. Indeed, widespread screening combined with deep underfunding could serve to exacerbate current community service delivery scarcity. Community-based organizations addressing core health-related social needs—defined in the AHC model as housing instability and quality, food insecurity, utility needs, interpersonal violence and transportation need—are already struggling to meet current demands for services. Absent additional resources, many under the current proposal would primarily be navigating beneficiaries to waiting lists.

In fact, in [a recent study](#) conducted by Meals on Wheels America and the AARP Foundation, the community-based organizations that participated had an average waiting list of six months or longer for home-delivered meals. A Government Accountability Office report released last summer found that about 83 percent of food-insecure seniors and 83 percent of physically impaired seniors did not receive meals [through the Older Americans Act], but likely needed them.

Unfortunately, this pattern is not limited to nutrition services. A combination of factors—long wait lists for services throughout the country; inadequate federal, state and local funding; the recent economic downturn; and unprecedented growth in the number of older adults, especially those aged 85 and over—has left the nationwide community services network scrambling to provide more home and community-based services (HCBS) of all kinds on a deeply inadequate funding base.

A possible improvement in the proposal could be to require that both participating health care providers and social services providers be held *jointly accountable* for outcomes related to delivery of HCBS services post-screening. This could be done by requiring collecting data on outcomes metrics that assess whether the health-related services

identified as necessary were delivered; their quality and person-centeredness; the amount of resources available for provision of these services; and any differences in overall cost of care that can be linked to successful delivery of health-related services, as compared to situations in which such services that were identified during screenings were not provided.

One Size Does Not Fit All

We are concerned that the AHC model fails to account and adjust for the substantial diversity in needs, risk factors and vulnerabilities of Medicare and Medicaid community-dwelling beneficiaries. Without considering demographic factors such as age, disability, income, race, language barriers and more both medical providers and CBOs will face difficulties in identifying and delivering appropriate, cost-effective services. CMS is promoting person-centered care provision, yet failure to take a person-centered approach to targeting beneficiary services in the AHC model risks further congesting an already strained health-related services system. In particular, assigning the bridge organization to take a broad-stroke approach to screening beneficiaries risks missing important and specific beneficiary issues, needs and considerations. For example, the approach needed to address the challenges of food insecurity or interpersonal violence situations for an economically vulnerable single mother with young children may be entirely different than the approach required to properly evaluate the same situation for an 85-year-old dual-eligible beneficiary.

Lack of Acknowledgement of Caregiver in Assessment

For older adults and people with disabilities who comprise a large percentage of high-risk, community-dwelling Medicare and Medicaid beneficiaries, the role of family caregivers is often essential to meeting health-related social needs. A family caregiver is broadly defined as a relative, partner, friend or neighbor who has a significant relationship with, and provides a broad range of assistance to, an older person or an adult with a chronic or disabling condition. Yet the AHC model does not mention involvement of family caregivers in the assessment process, and does not require assessment of available caregiver support as part of the beneficiary's "core" health-related social needs assessment process. Failing to include family caregivers in both the assessment component and to account for support needs within the assessment eliminates evaluation and valuation one of the most important sources of health-related social services available.

Unrealistic Expectations and Evaluation Criteria

In the absence of federal investment in health information technology for CBOs, we fear it is unrealistic to require AHC model participants, in all tracks, to somehow rapidly acquire the administrative and technical infrastructure that must be ready to be deployed within the startup period; to screen and conduct interventions for tens of thousands of community-dwelling beneficiaries within the first year; and to double that footprint by the second year.

Based on past experience with care transitions programs, we believe the funds available in each of the tracks are too low to build the technical and network infrastructure necessary, *which must include CBOs as full and equal partners*. Additionally, since AHC funding is reevaluated annually, if participants are evaluated as not meeting (or exceeding) footprints, we are concerned that the AHC could be abruptly terminated, and that financially vulnerable CBOs would find they had lost resources that could have been focused on providing direct services.

Thank you for considering our feedback. Our organizations—and the millions of providers, advocates, older adults, people with disabilities and caregivers we collectively represent—look forward to working with you to ensure that the good intent in this program can be implemented upon a stronger foundation.

Sincerely,

Aging Life Care Association
Altarum Institute/Center for Elder Care and Advanced Illness
American Association on Health and Disability
Association of University Centers on Disabilities
Justice in Aging
Lakeshore Foundation
Lutheran Services in America
Meals on Wheels America
Medicare Rights Center
National Alliance for Caregiving
National Association of Area Agencies on Aging
National Association of States United for Aging and Disabilities
National Coalition on Care Coordination
National Committee to Preserve Social Security and Medicare
National Council on Aging
National Transitions of Care Coalition