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

Dear Ms. Bassano:

On behalf of the National Association of Area Agencies on Aging (n4a), which represents the country's 622 Area Agencies on Aging (AAAs) and serves as a voice in the nation's capital for the more than 250 tribal aging programs, we are writing in response to the recently released Request for Information (RFI) from the Center for Medicare and Medicaid Innovation (Innovation Center) seeking feedback on a new direction for the Center.

The Innovation Center's aim of supporting the development and testing of innovative health care payment and delivery models is a worthy one. To meet the goals outlined in the RFI, it is essential to recognize that the nation is experiencing an unprecedented demographic shift, with our citizens aging faster and living longer than at any point in history. In fact, each day 10,000 people turn 65, and this population trajectory will continue to increase the financial demands on Medicare and Medicaid, which are the country's infrastructure for supporting health care and long-term services and supports to older adults.

We have two foundational premises and thus recommendations. As both Medicare and Medicaid serve this growing aging population, we understand that spending over the next 10 years for both programs is also expected to increase at an accelerated rate[i]. However, given the economic challenges that Medicaid and Medicare beneficiaries face—including the fact that half of all Medicare beneficiaries live on largely fixed incomes of less than $26,000[ii]—**expanded or new models of care must not shift costs to economically and medically vulnerable older adults** with no capacity to absorb additional financial burdens.

Furthermore, if the ultimate goal of the Innovation Center is to increase beneficiary choice and care quality while reducing costs and improving patient outcomes, then the implemented **models must include**

strategies to address the social needs of participating beneficiaries who often have complicated and chronic conditions and/or need help with one or more Activities of Daily Living (ADLs). We believe that managing those social or long-term services and supports needs drives better health and reduces costs over time

For decades, Area Agencies on Aging and Title VI aging programs have been cost-effective, trusted and proven resources for addressing the health-related social needs of older adults. Congress established AAAs in 1973 under the Older Americans Act (OAA) in order to create a local Aging Network entity responsible for planning, development and delivery infrastructure to respond to the home and community-based services and supports (HCBS) needs of Americans age 60 and over in every community in the country. Examples of these services include, but are not limited to, in-home supports—including personal care and chore services—as well as home-delivered and congregate meals, transportation, case management, caregiver assistance and support, and elder rights activities. Additionally, since their inception more than 40 years ago, AAAs have also evolved as important partners to a wide array of federal, state and local health care programs and initiatives—including Medicaid, Medicare and evidence-based health education and prevention programs.

Importance of the Aging Network in Successfully Linking Health Care and Community-Based Services Systems for Older Adults

Increasingly, evidence supports that the majority of health care costs are driven by factors outside of the clinical care environment, which studies suggest accounts for only 10 percent of total health care costs[iii]. Supported by federal initiatives to implement health care payment model reforms, a growing number of health care payers and providers are seeking opportunities to better address health-related social needs including, but not limited to, housing instability and quality, food insecurity, and utility and transportation needs. According to a recent study by the Robert Wood Johnson Foundation, nearly 90 percent of physicians indicated they see their patients' need for social supports, but unfortunately, 80 percent of doctors said they don't fully know how to connect their patients to community options[iv].

As the Innovation Center lays out the vision for a new direction, we strongly encourage agency leaders to build on existing successful models throughout the country, and seize the opportunity to foster further alignment and integration of the health care and social services sectors to improve cost-efficient, person-centered care within acute health care settings and in the patient's home and community—where the majority of health happens.

Aging Network entities, such as AAAs and their community-based service providers, are uniquely positioned to understand the importance of not only connecting patients and health-related services providers, but also ensuring adequate services are appropriately identified and available for beneficiaries in their community. As the Innovation Center identifies and invests in programs and models of care that follow the guiding principles referenced in the RFI, we encourage agency officials to support and expand upon existing successful pilot and demonstrations involving Aging Network entities and other community-based organizations (CBOs) that are already promoting many of the outlined guiding principles—principles that

address the health-related social needs of beneficiaries that exist—and should be addressed—beyond a clinical setting.

Current successful care models, many of which are referenced in n4a's comments and detailed in a response from the n4a-led Aging and Disability Business Institute, are already achieving the goals of improving care quality while reducing cost; delivering patient-centered and directed care; using evidence-based and data-driven insight to deliver cost-efficient and effective care; employing partnerships and collaborations among diverse stakeholders; and testing localized innovations with the intent of scaling best practices.

Recognizing the Need to Adequately Support Community-Based Supports as Key Partners to the Health Care Community

Despite their critical role in supporting the health care outcomes of older adults, AAAs and the Aging Network are often constrained by federal, state and local funding limitations that are far different from the fiscal challenges that health care providers face. It's critical to note, therefore, that **to realize the full potential of meeting both a beneficiary's health care and social needs to improve outcomes and reduce costs will require entities within the social services sector to be fully included and appropriately compensated as care providers.** The other funding streams that the Aging Network has traditionally relied upon are increasingly limited and cannot be tapped for integrated care models or other health-care-funded efforts. To help save health care costs overall, community providers must be paid for their cost-saving work.

By embracing AAAs and other CBOs as valued and respected partners in meeting the health care and health-related needs of beneficiaries—which are equally important to improving health but often much less costly—of beneficiaries, the Innovation Center has an opportunity to improve care quality while curbing overall Medicaid and Medicare costs.

Building on Best Practices Within the Aging Network to Support Scaled Models of Care

CBOs across the country are already partnering with the health care sector to improve care for older adults—including a growing number of people with chronic conditions and disabilities who need community-based long-term services and supports to maintain their health outside of an acute-care setting. We encourage the Innovation Center to look to existing examples as indicators of the value of AAAs and their community-based provider partners to meet the health-related social needs and drive down costs for Medicare and Medicaid beneficiaries.

The Aging and Disability Business Institute has also submitted feedback in response to the Innovation Center's RFI, and we support the specific opportunities outlined in those comments. Specifically, we hope the Innovation Center will look to existing successful programs first as a foundation to build upon and expand improved models of care.

For example, the Medicare-Medicaid financial alignment initiative in Ohio demonstrates the positive outcomes that result from partnership between health care entities and AAAs. Additionally, for the particularly complicated and expensive needs of patients with dementia, we hope the Innovation Center will aim to emulate best practices underway in Texas, in which AAAs have been key partners in leveraging the expertise of the existing Alzheimer's Disease Supportive Services Program (ADSSP) to involve and train caregivers and to help improve care for dually eligible beneficiaries with Alzheimer's Disease and other dementias.

Considering that the current cost of Alzheimer's disease and other dementias is more than $250 billion annually, which is expected to skyrocket above $1 trillion over the next three decades, and that Medicare and Medicaid currently absorb 70 percent of that cost, it is essential that the Innovation Center make improving care for beneficiaries experiencing dementia a primary priority. We urge agency leaders to first look toward expanding existing successful models of care for these individuals that incorporate the broad range of home, community and caregiver supports available through AAAs and the Aging Network in scaling current best practices and developing innovative strategies.

We also recommend that the Innovation Center build upon existing successful demonstrations focused on improving care for Medicare and Medicaid beneficiaries with chronic conditions. According to the Centers for Disease Control and Prevention, $2.7 trillion, or nearly 86 percent, of the $3 trillion health care economy is spent on patients with one or more chronic conditions. Because patients with multiple chronic conditions, who are the most costly and complex patients to care for, still spend the majority of their time outside of the traditional health care system, it is even more important to involve health-related services providers, including AAAs and other CBOs, in strategies to manage—and also to prevent—chronic disease.

Consumers accessing these AAA programs have very high rates of chronic disease, including diabetes and cognitive impairments such as dementia, and this is a population our members know and serve well. In response, AAAs have evolved and broadened their service portfolios to include models focusing on meeting the complex needs of older adults with one or more chronic diseases. We urge the Innovation Center to identify scalable existing best practices, such as the evidence-based program HomeMeds, which has partnered with AAAs and other CBOs to focus on in-home medication management. Innovation Center leaders can also look to the Washington Health Home demonstration, which was deployed through the state's Aging Network to provide in-home medical assistance and care coordination for dually eligible beneficiaries with at least one chronic condition, saving CMS nearly $70 million in just the first two years of the demonstration.

Learning from Past CMMI Demonstration Initiatives

Since CMMI's inception, AAAs and other CBOs have been key partners in several demonstration programs that have moved the needle toward improving alignment between community-based supports and the health care sector. Previous CMMI demonstrations—including, but not limited to, the Community-Based Care Transitions Program (CCTP), the implementation of Home Health programs, financial alignment initiatives for dually eligible beneficiaries and the

Accountable Health Communities models—have engaged AAAs and other CBOs as key partners to achieve the goals of improving alignment and care coordination between clinical and community care settings. However, in some cases, these previous demonstrations did not go far enough to address the systemic challenges preventing either sector from realizing the full potential of improved health care and social services integration.

For example, the CCTP demonstration did not recognize, or support, the substantial start-up costs that community-based agencies would encounter as they developed integrated, and often in-house, partnerships with area hospitals to transition Medicare beneficiaries from the hospital setting to home with the goal of reducing incidents of readmission. While community-based agencies participating in CCTP assumed substantial financial liability averaging more than $180,000 to participate in the demonstration, hospital participants were not required—nor often adequately incentivized—to be good-faith partners with their community partners. Additionally, the footprint and readmission goals were unduly ambitious and did not reflect the realities of the one-sided partnership between CBOs and hospitals. Therefore, while the majority of CCTP sites demonstrated significant cost savings to Medicare, the demonstration project was considered unsuccessful by some within CMMI when CBOs could not bring the effort to scale in a very short period of time.

However, had CMMI used the opportunity to recognize and address the challenges that community-based care transitions providers were facing, and be adaptable to rethinking and improving the AAA-hospital partnership, the program ultimately could have been a much larger success. We hope that in exploring a new direction the Innovation Center will modify the approach to administering and evaluating demonstration models to ensure that challenges are recognized and addressed, and, where possible, success emulated.

It's worth noting that in several areas where the CCTP model was particularly successful, the CBOs have been able to continue these care transitions efforts by working directly with multiple payers and participating hospital partners. After regionally reducing hospital readmissions from 23 percent to six percent among participating beneficiaries, the Eastern Virginia Care Transitions Partnership (EVCTP) was expanded into a statewide organization. This scaled care transitions model providing coordinated and transitional care for Virginia's Medicare and Medicaid Members demonstrates the potential of scaling successful demonstrations through Aging Network entities to improve care and care coordination and reduce costs for consumers with complex needs. With greater flexibility and commitment from the Innovation Center to using CBOs to drive down costs, the lessons learned from CCTP could inform the next evolution in care transitions innovation.

Addressing Current Barriers to Improving Integrated Care Options in Medicare and Medicaid

One systems-improvement area we urge the Innovation Center to address is removing current, albeit unintentional, barriers that are preventing improved integration between the health care and social services sectors. For example, in Medicaid in particular, a majority of AAAs have long played critical roles in the administration of Home and Community-Based Services (HCBS)

Medicaid waivers. For decades, AAAs in many states have been important partners in the implementation of a cost-effective and often preferred strategy for coordinating and delivering long-term services and supports for Medicaid beneficiaries in their homes and communities instead of institutional settings. In general, AAA roles have spanned from level of care determinations to assessments to case management to service coordination—and sometimes, AAAs have played more than one of those roles.

AAAs that have long played these multiple HCBS roles had appropriate firewalls in place to ensure that no part of their mission-driven work inadvertently created conflicts of interest. In order to ensure that any potential conflict of interest is prevented, AAAs have established sophisticated and transparent firewalls between programs where it is necessary to ensure proper administration of programs and appropriate protection of beneficiaries' interests. In fact, AAAs have excellent track records in providing consumers with independent, conflict-free options counseling while other departments simultaneously provide case management or service coordination.

However, we believe pre-2017 regulations and guidance from CMS may now needlessly restrict the ability of AAAs to fully meet the needs of the older adults they serve, putting vulnerable older adults served by Medicaid programs at risk and upending efficient systems already in place. Specifically, we believe that CMS's new approach to preventing conflict of interest within HCBS systems is overly restrictive. The problem is exacerbated as states add their own interpretation to the CMS regulations, further complicating efficient service delivery.

n4a and its members understand that federal and state systems must work to prevent conflicts of interest from potentially reducing a beneficiary's access to care or quality of care. We hope that the Innovation Center, in identifying new priorities for the agency, will use the opportunity to address current—albeit unintentional—barriers to coordinating and delivering person-centered care. In February 2016, n4a sent a letter to CMS detailing our concerns at that time, which have since expanded and evolved. We would be an enthusiastic partner in helping the Innovation Center both assess where these barriers are stymying currently successful programs and/or where they are preventing future system innovations and advancement. We would welcome new innovations initiatives aimed at alleviating current obstacles to cost-effective care coordination and delivery.

The Innovation Center Must Not Implement Care Models that Shift Costs to Beneficiaries or Undermine Successful Demonstrations

n4a fully supports the goals of the Innovation Center to test and scale approaches that improve health care and care coordination while reducing costs and enabling Medicare and Medicaid beneficiaries to age with independence and dignity in their homes and communities. However, we cannot support any proposals or intent outlined in the RFI that would fundamentally restructure Medicare into a premium support or voucher program. According to the Congressional Budget Office, a voucher program would significantly increase costs for Medicare beneficiaries by failing to cover the growing costs of health care as people age, causing costs to go up substantially.

Additionally, we oppose any model that would require Medicare or Medicaid beneficiaries to privately negotiate pricing with their health care providers. At a time when the population of medically and economically vulnerable older adults is increasing, the Innovation Center should be focused on simplifying the current system of care and improving integration and communication between acute health care and social services care providers, not requiring beneficiaries—especially those with complex, chronic care needs—to learn the intricacies of a complicated, difficult health care system.

Furthermore, we encourage the Innovation Center to continue improving on years of lessons learned and best practices developed in the Medicare-Medicaid financial alignment initiative, which is mid-stream in implementation. After significant investment by health care payers, states and federal agencies, stakeholders at every level are gathering invaluable data about how to improve care for dual eligibles, who are the highest-cost and highest-need Medicare and Medicaid beneficiaries. Taking steps to roll back ongoing initiatives serving dual eligible beneficiaries would erode years of knowledge and value in improving care for a critically important population that's a major driver of Medicare and Medicaid costs.

The Importance of Empowering Caregivers in Developing Care Models

Caregivers provide over $400 billion annually in uncompensated care to older adults and people with disabilities[v], yet are often an afterthought, at best, in health care coordination and delivery. We urge the Innovation Center to explore supporting models of care that fully assess, include and account for the caregivers available in the beneficiary's life. AAAs and their CBO partners in the Aging Network have decades of experience in meeting both the service and support needs of millions of caregivers.

Building upon a foundation initially established through the National Family Caregiver Support Program, AAAs are better equipped than medical professionals to facilitate many activities of assessment and care planning for patients and caregivers. These activities include, but are not limited to, conducting a functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity; evaluation of home safety; identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks; providing education, support or advance care planning; creating of an HCBS care plan and referral to community resources as needed; and sharing a care plan with a patient's caregiver(s). Therefore, we urge the Innovation Center not only to include caregivers as a critical component in expanding upon existing successes and developing new models of care and but also to ensure that CBOs, such as AAAs, are a key partner in fostering and supporting caregiver integration.

Conclusion

n4a appreciates the Innovation Center's call for stakeholder feedback in developing its a new direction. We sincerely encourage, and would be enthusiastic partners with, Innovation Center

leadership to support ongoing opportunities to improve integration between community-based services provided by the AAAs and other Aging Network partners with acute health care providers and payers. We support an approach that builds upon the challenges and successes from previous demonstrations that incorporated AAAs, CBOs and other key community stakeholders, and that realistically and thoughtfully identifies opportunities to address existing barriers between the social services and health care sectors.

There is continued opportunity for the Innovation Center to improve care for Medicare and Medicaid beneficiaries by considering and capitalizing on the traditional HCBS infrastructure and supporting the inclusion of AAAs and other CBOs. As trusted resources with a long history in the community, AAAs have important knowledge of the targeted population and skill sets that can complement those of traditional acute care providers and help the Innovation Center realize the guiding principles outlined in the RFI. We look forward to working the Innovation Center to ensure that these goals are met, and that the critical role of AAAs and other CBOs in improving beneficiary health through community services and supports is preserved and strengthened.

Sincerely,

Sandy Markwood
Chief Executive Officer

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[iii] Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. (2010). County Health Rankings http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf.

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