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**National Association of
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March 31, 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:

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 256 Title VI Native American aging programs, we are writing to raise several concerns about the Accountable Health Communities (AHC) Funding Opportunity Announcement (FOA) released on January 5, 2016.

While we are pleased to see the Centers for Medicare and Medicaid Services (CMS) Center for Medicare & Medicaid Innovation (CMMI) propose a model that recognizes that drivers of health care costs exist largely beyond the sphere of influence and scope of acute health care alone, we are concerned about the specific strategies deployed in the AHC model to address health-related social needs in the effort to reduce costs and improve care for all Medicare and Medicaid beneficiaries.

The goal of AHC to better facilitate the connection between Community-Dwelling Beneficiaries and available Community Service Providers to address health-related social needs that drive overall health care costs is an important one.

Our primary concern, however, with your approach is that building awareness about available community services and facilitating the connection between beneficiaries and services is only part of the equation toward achieving the goals outlined in the FOA. In order to achieve the outcomes CMMI is seeking through the AHC model, CMMI must ensure that there are *adequate and available services to meet beneficiary needs*.

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

n4a and our member AAAs and Title VI aging programs are uniquely positioned to understand the importance of not only connecting patients and health-related services providers, but also ensuring adequate services are available for beneficiaries. As an invaluable link in the National Aging Network established under the Older Americans Act (OAA) in 1973, AAAs were created to respond to the needs of Americans 60 and over in every local community. In this role, AAAs and other Aging Network entities have been providing a range of options that allow older adults, and increasingly people with disabilities, to choose the home and community-based services (HCBS) and living arrangements that promote health, dignity and independence in the home, outside of traditional health care systems. AAAs make it possible for older adults and people with disabilities to “age in place” in their homes and communities. For 40 years, AAAs have been a trusted resource for clients and their caregivers, and have developed well-defined, person-centered, user-friendly system to coordinate and deliver a wide range of HCBS that monitors consumer outcomes.

This means the 622-agency-strong AAA network brings 40 years of leadership experience in HCBS development, coordination and delivery, but the AAA network also acutely understands the financial limitations that community-based service providers face. ***Entities that deliver services critical to improved health outcomes are often constrained by federal, state and local funding limitations that are far different from the fiscal challenges that health care providers face.*** Furthermore, because AAAs are not simply service providers—delivering one or two services directly to consumers—but rather, they serve as coordinating agencies facilitating development and implementation of home and community based services for older adults and people with disabilities in communities across the country, they understand the important, complex and increasingly challenging role of ensuring alignment between needs and services for community-dwelling beneficiaries and for their caregivers. From our perspective, AAAs have, for decades, unofficially fulfilled the role defined for bridge organizations under the proposed AHC model for older adults and people with disabilities, the exact population that comprises a significant percentage of high-risk, high-cost Medicare and Medicaid patients targeted in the AHC model.

Specific Concerns Regarding the AHC Model

We appreciate that CMMI recognizes the critical role that community-based organizations (CBOs) play in improving health and reducing costs for Medicare and Medicaid beneficiaries. According to the FOA, the social, economic, behavioral and environmental factors account for 80 percent of the variation in health outcomes unrelated to clinical and acute health care. The AHC model could potentially provide important new evidence regarding the impact of community interventions on overall costs and outcome for Medicare and Medicaid beneficiaries. For this, we commend CMMI’s vision and goals. However, we believe the AHC model approach, as currently designed, will not achieve its intended aims of better alignment between systems. Our primary concerns include: lack of funding for health-related services; failure to account for

the diversity among Medicare and Medicaid beneficiaries; limitations on core health-related services assessments; lack of formal involvement of caregivers or assessment of caregiver support; and unrealistic expectations and evaluation criteria.

1. Lack of Funding for Health-Related Services

The hypothesis outlined in the AHC model is well-known and embraced by social services experts, if not yet rigorously proven: community services that address health-related needs have the potential to reduce health care utilization and costs. However, without supporting the actual services and adequately funding the community-based organizations (CBOs) that provide those services, facilitating access to organizations that don't have the capacity to meet demands jeopardizes the entire hypothesis and the overall system.

The FOA specifically states that the *“AHC model will test whether systematically identifying and addressing the health-related social needs of community-dwelling beneficiaries, impacts total health care costs and inpatient and outpatient health care utilization.”*

However, simply increasing awareness and even facilitating introductions to local community services does not ensure that beneficiaries' needs will be addressed. ***To fully address their needs, it is important to ensure that the community services are available and that beneficiaries are not being connected with organizations that have inadequate funding and/or long wait lists for services.***

Community-based organizations currently 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 often unable to meet current demand for services. In fact, a recent study conducted by Meals on Wheels and the AARP Foundation found an average waiting list of six months for home-delivered meals. And this pattern is not limited to nutrition services. Long wait lists for services throughout the country; inadequate federal, state and local funding; the recent economic downturn; and the unprecedented growth in the population of a vulnerable demographic—older adults, especially aged 85 and over—has left a nation-wide community services network, including AAAs and other Aging Network entities, scrambling and often unable to meet the current demand for home and community-based services of all kinds. Even if intervention strategies developed and implemented through the AHC model prove effective in reaching high-risk, community-dwelling beneficiaries and increasing awareness of and improving connections between the clinical care and community services systems, without funding the actual services, the model risks overloading an already strained and stressed network—and, more importantly, not meeting the beneficiaries' supportive services needs.

2. Failure To Account for Diversity Among Medicare and Medicaid Beneficiaries

We are concerned that the AHC model fails to account for the diversity in needs, risk factors and vulnerabilities of Medicare and Medicaid community-dwelling beneficiaries. Involving beneficiaries without considering demographic factors such as age, disability, income, race, language barriers, etc., risks ineffectively, inefficiently and inappropriately aligning

beneficiaries with services. CMS has promoted person-centered care provision, yet this failure to take a person-centered approach in targeting beneficiary participation 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. If one organization—the bridge organization—is serving as an information and referral assistance funnel for an incredibly diverse and complicated Medicare and Medicaid population, the necessary nuances that a more individualized approach would accommodate may be missed. For example, the approach to assessing the status of core health-related social needs such as food insecurity or interpersonal violence situations for a economically vulnerable single mother with young children may be entirely different than the approach to evaluating the same situation for an 85-year-old dual-eligible beneficiary.

There are information and referral assistance services provided by agencies, such as AAAs, Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CILs) and others, that specialize in meeting the needs of individuals across the spectrum of beneficiary diversity. Dismissing, consolidating or recreating those existing pathways jeopardizes expertise developed over decades of serving vulnerable populations with very specific needs and requirements for care.

3. Limitations on Core Health-Related Services Assessments

We appreciate that CMMI recognizes the importance of housing security, food security, ensuring access to utility support and transportation services, as well as assessing interpersonal violence, for high-risk, community-dwelling beneficiaries. However, we are concerned that these are the only health-related social needs defined as “core” needs, and that all remaining health-related services are described as “supplemental.” We are further concerned by the fact that screening for “supplemental” services is optional for AHC model participants. We would argue that even if the five “core” health-related social needs are met, it fails to guarantee that others gaps don’t exist that could significantly affect health outcomes of community-dwelling beneficiaries. Additionally, we would argue that even if one of those “core” needs is not met—which would indicate a poor outcome under the AHC model—other “supplemental” health-related social needs could compensate for that unmet need.

For example, if an older beneficiary has all five needs met, but lives in complete isolation without emotional support from friends or family, health outcomes are likely to be affected. Similarly, if a homebound beneficiary has no access to or need for transportation, but has substantial caregiver and home care support to meet their in-home needs, health outcomes would not likely be affected—despite failing to fulfill access to transportation. We believe that requiring assessment of only those five “core” health-related social needs without requiring review and assessment of other factors fails to maintain a person-centered, individualized approach to care.

4. No Formal Involvement of Caregivers or Assessment of Caregiver Support

For older adults and people with disabilities who comprise a large percentage of high-risk, community-dwelling Medicare and Medicaid beneficiaries, the role of caregivers is often essential to meeting health-related social needs. Yet the AHC model fails to involve caregivers in the assessment process, which is often a critical step in ensuring an accurate account of available social supports, especially for beneficiaries with cognitive and behavioral disorders. Furthermore, the AHC model provides no required assessment of available caregiver support as part of the beneficiary's "core" health-related social needs assessment process.

At last estimate, 40 million informal caregivers provided \$470 billion worth of care to parents, spouses, partners and other adult loved ones in 2013. This surpassed total Medicaid spending and reflects that over 10 percent of the nationwide population serves as a caregiver in some capacity. Failing to include caregivers in both the assessment component and to account for support within the assessment, completely eliminates evaluation and valuation one of the most important sources of health-related social services available.

5. Unrealistic Expectations and Evaluation Criteria

The requirements that AHC model participants, in all tracks, build the administrative, technical and community network infrastructure within the startup period, screen and conduct interventions for a footprint for tens of thousands of community-dwelling beneficiaries within the first year and double that footprint by the second year, are unrealistic. Furthermore, based on past experience, we believe the funds available in each of the tracks are insufficient to build the technical and network infrastructure necessary. Additionally, funding is reevaluated annually, and if AHC participants are not meeting or exceeding footprints, we fear these investments may be pulled altogether, and that already financially vulnerable CBOs could lose resources that could have been focused toward providing direct services.

This was the experience of many AAAs involved in the Community-based Care Transitions (CCTP) program funded through CMMI, which had more robust investments, more reasonable expectations and a more focused objective—and yet still agencies sometimes lost their own private investment dollars in trying to make the model work financially. We believe the AHC model should have been more informed by the relevant CCTP successes, as well as the hard lessons learned.

In summary, the AHC model seeks demonstrate the importance of addressing unmet health-related social needs to improve outcomes and reduce costs. We are fully supportive of this approach, but it needs to occur with the full scope of support for community-based services, take into account the unique and diverse needs of vulnerable Medicare and Medicaid populations and, realistically and accurately, assess program performance. There is not one easy way to align these disparate systems, but common-sense investments in current best practices will have a

lasting impact toward a holistic, person-centered approach to care that accounts for both clinical and social health care needs.

We respectfully request that CMS and CMMI pause on implementing the AHC model and take into account feedback from providers of health-related social services before widespread deployment of this funding opportunity. We strongly feel that with an intensive and thoughtful engagement process of all relevant stakeholders in the AHC model, CMMI could achieve the intended objectives. In the worst-case scenario and without needed changes to AHC, CMMI risks undermining the gains that have already been made to better align acute health care and community-based care systems.

Thank you for considering our feedback and we look forward to a continued dialogue on this and other issues related to the health, wellness and independence of older adults.

Sincerely,

A handwritten signature in cursive script that reads "Sandy Markwood". The signature is written in black ink and is positioned below the word "Sincerely,".

Sandy Markwood
Chief Executive Officer