November 20, 2017

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

RE: CMMI New Direction Initiative/Request for Information

Dear Ms. Bassano:

LeadingAge appreciates the opportunity to respond to the Request for Information (RFI) by the Centers for Medicare & Medicaid Services (CMS) Innovation Center (the “Innovation Center” or “CMMI”) on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs and improve outcomes.

The members of LeadingAge and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadingAge.org) includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. LeadingAge promotes home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, nursing homes as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

Summary of Over-arching Considerations

There are some over-arching considerations for new models under the CMMI program which we have summarized below and on which we will elaborate infra:

- New models must empower beneficiaries (and their families) to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care across the continuum.

- LeadingAge believes it is important to promote competition based on quality outcomes and costs; therefore, it is important for CMMI to quantify outcomes based on the functional and clinical complexity of the medical condition of the individual.
being served in a particular model. Further, co-morbidities as well as socio-economic factors must be taken into account when determining quality and costs.

Model designs must reduce burdensome requirements and unnecessary regulations to allow providers to focus on providing high-quality healthcare to those they serve.

Data-driven insights should be used to ensure cost-effective care that also leads to improvements in beneficiary outcomes.

It is important to consider all costs when determining if a new model design is cost-effective. These may include Medicare Parts A, B and D expenses, Medicaid payments, as well as other costs for services through State funded programs.

Provider incentives should be determined based on the role the individual provider had in improving outcomes and reducing costs within the models.

What Works (And What Doesn’t Work) Today

New models should build upon what works (and address what doesn’t work) today.

- CMMI models have focused predominantly on Medicare with only limited consideration of the long-term services and supports (LTSS), prevention and wellness needs of older adults. If we don’t address the needs of the whole person, we cannot achieve the true potential of integration nor the three-pronged goal of achieving better care, better health and lower costs (the “Triple Aim”). Therefore, CMMI should explore models that pool not only Medicaid and Medicare funds, but also personal/private funds, Older American Act dollars and other public resources.

- Leadership of many of the CMMI models has been limited to physicians and acute care providers. LTSS and community-based service providers have more frequent interaction with older adults in their homes. By focusing on older adults in the community, there is greater opportunity to avoid unnecessary high-cost settings and services by providing the right services at the right time and in the right place. This does not mean we believe coordination shouldn’t occur with physicians and hospitals, where appropriate, but instead by ignoring the in-home service providers, we miss a critical opportunity to engage before an emergent issue occurs that requires more costly, and often unnecessary acute care when instead we could invest in wellness and prevention.

- LTSS providers are in an ideal position to initiate and take a leadership role in an integrated service model in conjunction with other community-based providers of services and supports. For example:
LTSS providers have regular, on-going interactions with older adults in their own homes. This onsite presence helps providers build trust and develop personal relationships with older adults.

LTSS providers witness firsthand the daily struggles, environmental challenges and changes in condition that older adults experience. This allows them to respond more rapidly to changes in the individual, and to communicate with that individual’s providers and caregivers. In contrast, physicians and hospital-based providers see an older adult outside the home and only for a short office visit or an episode of care.

LTSS providers ensure that the large proportion of older adults who live independently receive proactive and preventive services, including wellness and chronic disease management. These interventions can significantly lower health care costs by reducing the need for more expensive acute, post-acute and long-term care.¹

- LTSS providers engage in screening and early intervention. They also work to help mitigate more high-risk needs by taking steps to prolong individuals’ functionality, address their social determinants of health, and coordinate their medical, social and daily-living services.

Comments on Guiding Principles, Focus Areas

- As noted supra, it is important to promote competition based on quality outcomes and costs; however, CMMI also must use true measures of quality to quantify outcomes based on the functional and clinical complexity of the individual being served in a particular model. Today, CMS and CMMI use the 5-Star rating system as its quality guide. While we understand that this is an established program that is applicable across a variety of providers, we have concerns that it was originally designed for a different purpose and, as such, should be re-evaluated to ensure that measures reflect provider performance on outcomes related to a person’s function, goals and the clinical complexity of the individual’s medical condition. Our specific areas for concern related to the 5-Star rating system include the following:

  - 5-Star ratings are based on each nursing home’s performance as compared to others’ in the same state rather than to a national standard. There are no national criteria against which all nursing homes are measured. Therefore, a “five-star”

nursing home in one state may provide services and quality inferior to a three-star nursing home in another state.

- The 5-Star system grades nursing homes on a bell curve, which requires some nursing homes to be graded at the one- and two-star level and relatively few nursing homes to be graded at the four- or five-star level. No matter how well its nursing homes may perform, no state may have a preponderance of four- and five-star nursing homes. This punishes providers in states where excellence is the norm.

- While the 5-Star system was conceived as a tool to help consumers choose a nursing home, few consumers understand the actual meaning of the 5-Star ratings. In addition, the ratings have been applied to contexts for which they were never intended, such as partnership in accountable care organizations (ACOs), inclusion in managed care plans and distribution of revenues under state Medicaid value-based purchasing initiatives.

- Beginning on November 28, 2017, CMS plans to hold constant the current health inspection ratings on the Nursing Home Compare website for a period of one year. Nursing homes that commit time and resources to improving quality will be stuck with their current ratings. During this period, CMS will “highlight areas of quality concern” on nursing homes’ star ratings, and will also note any nursing homes that achieve deficiency-free surveys. However, no information will be posted on improvements nursing homes have achieved. This is of concern if the 5-star system will continue to determine which skilled nursing facilities (SNFs) are eligible for non-3-day-stay waiver admissions, as this could result in some SNFs being eligible that should no longer be eligible for such admissions, and other SNFs being penalized further even though they have improved their quality. Given these concerns, we would like to encourage CMMI to use a short-stay quality measure performance during the freeze period.

LeadingAge, consistent with the recommendations of the Government Accountability Office, will continue to request that CMS develop new national quality criteria upon which 5-Star ratings for all nursing homes would be based. This new national 5-star system should be achievable by every nursing home that strives for and delivers the established standard instead of the bell curve approach taken by CMS with respect to the existing ratings system.

- Model designs must reduce burdensome requirements and unnecessary regulations in order to allow providers to focus on providing high-quality healthcare to the individuals they serve. Sometimes this means there needs to be greater flexibility to meet an older
adult’s goals. Regulations that are too prescriptive hinder that person-centered approach to care and services.

- We are pleased that CMMI specified in the guiding principles that it intends to draw upon partnerships and collaborations with public stakeholders, and harness ideas from a broad range of organizations and individuals across the country.

- We agree with CMMI that new models must empower beneficiaries (and their families) to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care across the continuum. It is important to note, however, that limitations in eligibility and scope of services within the Medicaid, Medicare and Medicare Advantage programs serve as barriers at times to improving outcomes and reducing costs. For example, the homebound status eligibility requirement in home health, the 6-month time period for end of life care, the 3-day inpatient hospital stay requirement to be eligible for skilled nursing home care, the inability for Medicaid to cover the cost of affordable, safe senior housing and the inability for Medicare or Medicare Advantage to cover the costs of non-emergency medical transportation, nutritional meals and adult day services that could improve care outcomes for Medicare beneficiaries that are at high risk for emergency room visits, hospital admissions and re-admissions and long-term nursing home placement.

- LeadingAge agrees that CMMI should use data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes, but it is important to consider all costs when determining if a new model design is cost effective, such as Medicare Part A, B and D expenses, Medicaid payments, as well as other costs for services through State funded programs. We believe with all the data that CMS has, there is great potential for CMMI to examine ways to use this data to identify best practices, optimal clinical pathways and predictive analytics that could help all providers deliver the best possible care and services to the right people at the right time and ultimately reduce unnecessary costs. Specifically, CMS has a great opportunity to provide a full-view picture of the clinical pathways and outcomes of beneficiaries to providers and have a real effect on the quality delivered as CMS has all the fee-for-service Medicare claims data. While SNFs have access to real-time Minimum Data Set (MDS) data, this only provides a view within a particular organization.

LeadingAge recommends that CMS provide robust, confidential quarterly reports to SNFs, home health and hospice providers that help identify quality practices, and gives these providers the tools to conduct thorough root cause analysis. Specifically, these reports could include organization-specific trends data and top causes of readmission—if the goal is to improve performance, then CMS should leverage the claims data at its disposal to help provider organizations, especially those with more limited resources. By analyzing the available data,
CMS could provide reports to providers that display: their overall readmission rate, their readmission rate by diagnosis category (e.g., diabetes, respiratory, cardiac, dementia, etc.) and compare that to the average length of stay for those diagnoses, identify the main causes for readmissions, number of days between hospital admissions and possibly, optimal care delivery information (e.g., beneficiaries with an ALOS of X for condition Y had lower readmission rates than those with a shorter ALOS). This data could be provided and updated more quickly than any other source available to providers and, again, give providers a view into what happens to the individual after they leave their site of service. Individual provider-level trending information (e.g., facility’s performance by quarter and for the past three years) could also be beneficial. Each one of these data elements could help providers focus their attention based on these potential predictors and/or initiate conversations with providers in other parts of the care continuum to improve the care delivery and transition processes. Providing this information could also lead to real care transformation and do so more cost effectively than each facility paying a data vendor money to conduct this analysis with old data.

- Provider incentives should be determined based on the role the individual provider had in improving outcomes and reducing costs within the model, and recognize what is achievable based upon a patient’s medical condition and prognosis.

**Model Designs for Consideration as Part of CMMI**

LeadingAge has a number of ideas for models that CMMI should pursue. Some models are conceptual while others are more thoroughly fleshed out. All, however, are strongly aligned with many of the guiding principles outlined in the RFI on the Innovation Center’s future direction.

**Telehealth**

LeadingAge strongly recommends that CMMI launch the following two types of demonstrations:

**Chronic Care Management in the Community using Telehealth and Remote Monitoring**

This demonstration would involve the guiding principles of patient-centered care, small scale testing, benefit design and price transparency. The demonstration would be led by home health agencies (HHA), home care providers (HCPs), life plan communities (LPCs; also referred to as continuing care retirement communities or CCRCs), and housing with services providers (HSPs), and would explicitly encourage the use of telehealth and remote monitoring technologies.

Such a demonstration should test and evaluate the cost-effectiveness of a payment system similar to the payment methodology used in the Independence at Home Demonstration. Under this demonstration, home health agencies, life plan communities, assisted living (AL) providers, and
housing with services providers would receive annual incentive payments. Payment amounts would be based on a percentage of the Medicare savings (Parts A, B and D) achieved as a result of efficacy-proven telehealth services used to help older adults manage chronic conditions, improve health outcomes, and reduce hospitalizations, hospital readmissions, and transitions to higher levels or care (independent living to AL, or AL to skilled nursing).

Such a demonstration would be aimed at populations 60 years or older with two or more of five chronic conditions (diabetes, heart failure, hypertension, chronic obstructive pulmonary disease (COPD), and asthma), and living in the community including their own homes, independent living, senior housing, affordable housing, and assisted living communities as well independent living and AL levels of LPCs.

The payment model should allow home health care providers to bill for services such as monitoring, educating, triaging, and managing participants’ health, as well as coordinating with primary care or specialty providers when needed for additional interventions, like medication titration, change of medications, ordering laboratory tests, or modifying any other part of the care plan. The eligibility for payment should not be limited to rural areas.

Reducing Hospitalizations and Hospital Readmissions of Nursing Home Residents Using Two-way Video Conferencing Telemedicine and Telehealth

This demonstration would satisfy the guiding principles of patient-centered care and small scale testing and would be led by Skilled Nursing Facilities (SNFs) and LPCs. It would explicitly encourage the use of two-way video conferencing telemedicine, and telehealth.

Such demonstration would be aimed at testing and evaluating the cost-effectiveness of a payment system that would provide financial incentives to SNFs (and the skilled level of LPCs) participating in the demonstration to receive annual incentive payments based on a percentage of the Medicare savings (Parts A, B and D) achieved as a result of using two-way video conferencing telemedicine, and telehealth services to connect with physicians, hospitalists, psychiatrists, and other specialists help older adults residing in SNFs reduce unnecessary hospitalizations, hospital readmissions, improve health outcomes, and coordinate with hospitals and physicians if/when hospitalization or readmission is necessary.

The payment model should allow SNFs to bill for services such as assisting physicians in triaging, stabilizing and managing participants’ health as well as coordinating with physicians and hospitals when needed for additional interventions, like medication titration, change of medications, ordering laboratory tests, modifying any other part of the care plan, or transferring to a hospital. The eligibility for payment should not be limited to rural areas.
Affordable Senior Housing/Medicare Advantage Care Plan Partnership to Improve Care Coordination for Low-Income Older Adults

Over two million individuals aged 65 and over live in publicly-subsidized housing properties situated in urban, suburban and rural communities across the country. Findings from several studies conducted by The Lewin Group/LeadingAge research team and funded by HUD, DHHS/ASPE and the MacArthur Foundation, indicate that over 70 percent of these elderly residents are dual eligibles, have five or more chronic conditions, are taking multiple medications and incur higher Medicare and Medicaid expenditures than their dual eligible peers living in the community but not in subsidized congregate environments. This congregate housing setting, therefore, provides a unique platform for identifying low income older adults with various health care risks and targeting a range of preventative, chronic care management, care coordination and transitional care services to delay or avoid high cost utilization, including emergency department and hospital visits and nursing home placement. In addition to the economies of scale offered by having many low-income older adults living under the same roof, many of these HUD and/or state-subsidized sites have housing-based service coordinators dedicated to helping these residents age successfully in their communities.

Over the past decade, LeadingAge has documented a growing number of senior housing plus services programs designed to provide wellness services and service coordination. The most ambitious is the Seniors Aging Safely at Home (SASH) model that was developed in Vermont. Currently over 130 HUD 202, tax credit and public housing authority buildings are part of the SASH network and are directly linked to the medical homes and ACOs that were created by the state’s health care reform initiative.

Originally part of the 6-state Medicare Coordinated Care Demonstration Program, each property has a service coordinator and part-time wellness nurse per 100 residents who are dedicated to assessing the service needs and goals of individuals willing to participate in the program, developing individual and community-wide healthy aging plans, and engaging in evidence-based prevention and health promotion activities, health monitoring and coaching and care coordination with primary care providers and other health and social services providers. Findings from a four-year evaluation of this program, conducted by the LeadingAge and RTI research team and funded by ASPE/HUD, indicate ongoing reduction in the growth of Medicare expenditures for the SASH participants relative to non-SASH participants and another control group in New York.

These findings and promising results from several other studies, including a study of multiple senior housing properties that partnered with UPMC in the Pittsburgh area, prompted HUD to fund a $15 million randomized control trial of a service coordinator/wellness nurse model in 40 HUD 202/tax credit properties in 7 states. The Lewin Group and LeadingAge are currently

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2 Castle, 2009
assisting HUD in implementing this RCT; ABT Associates has been awarded the independent evaluation contract for this four-year demonstration.

One of the challenges to scaling this model is the lack of sustainable financing for this program. While HUD and/or housing operators currently support service coordinator positions in approximately 40 percent of housing properties nationwide, there is no such funding for nurses nor is the service coordinator support sufficient for the level of service coordination provided in programs like SASH or the HUD randomized control trial (RCT). SASH was able to access Medicare funding for their teams during the demonstration period and the state has continued to provide support through its health care reform effort. LeadingAge is currently working with LTQA and several Senior Care Organizations (Medicare Special Needs Plans for dual eligibles) in Massachusetts to explore the potential for SCOs to pull resources to fund a housing-based demonstration. Other states such as Oregon and Ohio have expressed interest in this type of model. We have also had discussions with a number of managed care plans and ACOs about the potential for them to partner with senior housing properties to more efficiently and effectively manage the care of Medicare beneficiaries living in their properties.

LeadingAge believes that there is great potential for affordable senior housing properties to partner with Medicare Advantage (MA) Plans to improve care coordination, address social determinants of health and reduce costs for the Medicare program. Last year, the Bipartisan Policy Center Senior Health and Housing Task Force recommended that the CMS launch an initiative that coordinates health care and LTSS for Medicare beneficiaries living in publicly-assisted housing to test the potential of improving health outcomes of a vulnerable population and reducing health care costs. LeadingAge would like to see CMMI support a targeted demonstration to explore how MA Plan benefits could be expanded to cover a wellness/service coordination function for elderly residents of affordable housing. Several options could be explored, including coverage only for individuals enrolled in MA Plans or a housing-based benefit that would be targeted to the property as a whole.

**Quality Survey Model for Long Term Care Facilities**

LeadingAge has always supported effective nursing home oversight and has encouraged its members to educate consumers so they can make informed decisions regarding care choices. However, the complicated, inconsistent and ineffective survey and certification system has caused many nursing home providers to question whether they want to continue in the field.

Presently, a new long term care survey process is being rolled out to providers. The goals of the new process are to improve quality of care and promote quality of life for residents who live in the nursing home, with the emphasis being on person-centered care. Nevertheless, the new survey process, like those before it, is built on the same dichotomy of either compliant or non-compliant conditions.
LeadingAge recognizes persistent flaws in both the current survey and certification process and the new process slated to take effect later this month:

- Lack of communication (except during surveys) and a consultative process between providers and surveyors that creates a punitive and defensive relationship which does not offer solutions to improve quality. Instead, visits done by surveyors are driven by fault finding.

- The complexity of the regulatory guidelines leads to inconsistency in oversight and enforcement. This complexity also inhibits true process improvement—where sustained quality management requires a focus on a small number of specific areas, and not dozens at one time.

- Lack of scientific evidence for many of the regulations hampers innovation and person-centered best practices.

LeadingAge would like to see a survey system that focuses on what works, and the dissemination of best practices. When issues are identified, surveyors should work with providers to identify potential, sustainable solutions. We believe that the survey process should embrace the principles of QAPI that are now part of the nursing home conditions of participation regulations. Further, as CMS moves forward with a new nursing home survey process, we would like to see the following:

- A more open and transparent communication style between surveyors and providers.

- Surveyors willing to look at innovative practices and provide meaningful input into areas of process improvement.

- Surveyors in all states adequately trained in both the interpretation of the regulations, but in communications skills as well.

- Survey training for providers as well as surveyors.

- Surveyor competency in the area they survey (e.g., nursing, dining).

When issues are identified during a survey visit, they should be shared with the providers—with a focus on how the provider might remedy or correct the deficient practice. Where possible, shared resources, such as a regional collaborative or Quality Improvement Organizations (QIOs), should be offered as resources for process improvement and best practices.
The Interpretative Guidelines for Surveyors should be reviewed annually, to make sure the
guidance is current with changing practice standards, and any changes to the guidance should be
communicated to providers as well.

Surveyors should be trained to be aware of culture-change initiatives that focus on person-
centered care, and be willing to work with the community to ensure compliance with regulations,
rather than immediately going to a citation, which stifles any willingness of providers to take
risks in developing innovative, culture-change practices.

CMS should make a clear distinction for consumers between deficiencies identified by complaint
and those that are self-reported by the provider.

Presently, nursing homes with deficiencies above certain levels automatically lose their authority
to train nurse aides for two years. This is often very arbitrary, applying even to previously high-
quality providers who have a deficiency that has been immediately corrected. Furthermore, those
providers that struggle with sustained quality challenges typically need MORE staff, not less.
And in many geographic areas, it is the training program that drives the workforce supply for the
providers. We believe that this remedy should be applied in more select cases, with the ability to
resume training when the deficient practice is corrected.

Lastly, in the event of a dispute between providers and surveyors, LeadingAge would like to see
the use of an Informal Dispute Resolution (IDR) process that is handled by an objective, reliable
third-party. This has already been successful in a number of states and should be instituted on a
national basis.

LeadingAge strongly believes that nursing home residents should receive the highest possible
quality of care, yet an enforcement system that merely focuses on finding errors and escalating
punishments does not lead to excellence. Rather, it merely serves to create defensiveness and
stifles any willingness of providers to explore new and innovative approaches to care. Nowhere
else in health care is such a complex and rigid system in place to determine “compliance,” while
serving as a disincentive to actual excellence.

We believe that CMMI is just the vehicle for creating an oversight and enforcement system that
ensures compliance and resident safety, but also helps drive providers to continue their journey
for performance excellence. Such an approach would improve the lives of millions of American
seniors and their families.

Integrated Services

LeadingAge believes it is time to redesign our current delivery system and clear away barriers so
the nation can more aggressively pursue integration models that respect older adults by taking a
more holistic approach to meeting their needs and achieving high-value results. While we have
made some progress in this area, we must move faster and do more to address the comprehensive needs of our aging population.

Our proposed model is for a person-centered, integrated service delivery model that views and addresses the needs of older adults in a holistic fashion, uses available public and private resources more efficiently, achieves better health outcomes, and helps Americans live better lives, regardless of age. We urge CMMI to initiate a large-scale, national demonstration to test, refine and encourage widespread adoption of this model for all older adults (as described below).

Our proposed integrated service model begins in the community with screenings and early interventions and is designed not only to identify and treat an individual’s health and chronic care needs, but also to understand the origins of high-risk conditions so their long-term impact on the individual’s health can be mitigated. By starting in the community, instead of the hospital or doctor’s office, we can:

- Keep people well and functionally able longer.
- Help people address such social determinants of health as financial security, nutrition, housing and transportation.
- Coordinate the foregoing early interventions with any needed medical care and social services. This approach can delay or prevent the need for emergency department (ED) or inpatient hospital care, post-acute care, and long-stay nursing home care. It can also promote appropriate and timely use of palliative and hospice care, and other essential services and supports.

The integrated service model described below would build on existing models like the Program of All-Inclusive Care for the Elderly (PACE) and Financially Integrated Dual Eligible (FIDE) Special Needs Plans (SNPs). But the new model would go further than these programs, and would achieve greater results because it would not start with a medical event. By taking an early, proactive and holistic view of the individual, the new integrated service model would optimize our use of available financial and workforce resources while achieving better outcomes for older adults. This new model would truly support all of us as we age, and enable all of us to live our best lives.

Overview

The integrated service model that LeadingAge envisions will address the needs of all older adults, not just those with high needs and high costs. The ultimate goal of this broader population
focus is to reduce the number of older adults who develop high needs and high costs, while also slowing the growth of Medicaid and other public financing.

As noted above, a key component of the integrated service model is its holistic approach to service delivery. The model would not view a person’s need from a narrow medical or symptomatic perspective. Rather, the model would deliver a comprehensive and coordinated set of services and supports at the community level to address the needs and goals of the whole person.

The integrated service model would be implemented by an organized, community-based “hub” of providers working collaboratively to deliver services and supports to individuals. The hub could be directed by any group of providers: not just a health plan, hospital, health system or doctor, but also a community-based LTSS organization. Providers in the hub would be financially aligned to work together across services and settings, and would employ a person-centered approach to addressing each person’s needs in a comprehensive way. The older adult would choose their community provider hub for integrating their care and services.

The integrated service model’s features would include:

Pooled Resources and Assumption of Risk
The success of the integrated service model depends on the ability of hub providers to pool all sources of funding – public and personal – and to be free from the existing fee-for-service structure. The model calls for payers to adopt and deploy risk-based payment methodologies that would incentivize groups of collaborating providers to integrate the full-range of services and supports necessary to help an individual maintain health and achieve personal goals. These pooled Medicare, Medicaid and personal funds would be deployed flexibly in service of a wide range of individual needs.

Hub providers would conduct comprehensive risk assessments and assume some portion of the risk for outcomes and total cost of care. This approach would encourage hub providers to be accountable for the total cost of care and services for the older adult, and to use the most cost-effective strategies to achieve optimal outcomes.

Inclusivity and Flexibility
The integrated service model would not place limits on which providers could lead the hub, and where services could be provided. Existing models like ACOs and SNPs can only be led by health plans, hospitals, health systems and doctors. The integrated service model would allow other community-based providers, including LTSS providers, to serve as the accountable entity/hub for older adults.
Single Point of Contact and Accountability

Integration is most successful when there is a single care manager, single care plan and single point of contact for individuals and their families. Therefore, the integrated service model would feature a single “service facilitator” who would be assigned to an individual by the community-based hub. Individual providers, health plans or sites of service would no longer employ their own care manager, thus eliminating the confusion and additional cost of this duplicative function.

The service facilitator would play a pivotal role within the hub. The role of this individual could be similar in purpose to a medical or health care home, but also might share some elements of the Medi-Caring Communities concept developed by Dr. Joanne Lynn.

The service facilitator would be:

- A resource who identifies and explains available care and service options to help older adults and their families proactively address the older person’s needs and understand the associated costs.

- A coach who engages older adults as active participants in their health. Older adults and their families have firsthand knowledge about the older adult’s needs, changes in condition, preferences and resources. Better health outcomes and compliance with the aging service plan are more likely to occur when older adults and their families are engaged in self-managing their chronic conditions and achieving the goals of their aging service plan.

- A translator who serves as a liaison among hub providers and between the individual and the hub’s interdisciplinary care team. The service facilitator obtains answers, clears up confusion and ensures optimal outcomes.

- A navigator who helps older adults and their families navigate health care and support systems by setting up appointments or arranging for selected services to ensure needs are met in a timely manner.

Comprehensive Assessment

The hub’s interdisciplinary provider team would perform a comprehensive assessment of each older adult. The assessment would ensure that current needs are addressed and changing

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conditions are caught early, before more costly services are necessary. This assessment would not only identify the older adult’s medical needs. It would also identify the individual’s:

- Functional and cognitive capabilities.
- Health-related social needs, including housing, transportation and nutrition.
- Current living and support environment.
- Existing providers engaged in addressing the older adult’s needs.

**Collaboration on the Aging Service Plan**
The hub’s interdisciplinary team, in collaboration with the older adult and his or her family, would use findings from the comprehensive assessment to develop a universal aging service plan. The plan would describe:

- The expected evolution of the older adult’s health and needs.
- Existing and potential resources to address those needs as they evolve.
- Any gaps or hazards that may be encountered.
- How these issues will be addressed.

The unified aging service plan would be developed, and modified as needed, in collaboration with the older adult, his or her family, and all identified current and new service providers. All hub providers would contribute to the plan for each older adult they serve. Providers, older adults and their families would work together as new situations arise, and would consider solutions that take into account the whole person and his or her service providers and support network.

**Timely Access to a Full Range of Services and Supports**
The hub would be allowed to offer any services and supports that “optimize health or functional status” for certain beneficiaries. Services and supports would not be limited to the current list of Medicare or Medicaid-covered services. Instead, Medicare and Medicaid or personal funds would be combined and used to pay for services that can be tied back to the needs identified in the individualized aging service plan.

The hub would be responsible for implementing the service plan. This would involve contracting with other providers of services and supports, facilitating the sharing of individuals’ health information across settings, and connecting older adults with service and support providers that could address emergent needs. Hub providers would establish ongoing communication channels and work together to create clinical pathways, best practices and protocols that follow the person across settings.

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Older adults would be able to access services and providers in a timely way so that unnecessary hospitalizations could be avoided. Services would be provided efficiently and, when possible, hub providers would use telehealth to address issues as they arise. The level of services and supports would increase and decrease to meet changing needs.

**Comprehensive Care Coordination**
Care coordination is a key strategy for improving the health care system’s effectiveness and outcomes for the older adult. But coordination must go beyond the medical to encompass all services and supports received by older adults. A 2015 Institute of Medicine report shows that poor communication among providers leads to diagnostic errors, and that today’s reimbursement models do not support needed care coordination.\(^7\)

Coordination of all services and supports would help to:

- Improve the older adult’s quality of life.
- Eliminate service duplication and unnecessary hospitalizations, thus reducing costs.
- Reduce poor outcomes from delayed services, conflicting care plans or poor communication.
- Ensure that individuals can access services and supports at the right place and time, and often for a lower cost.
- Identify the best interventions, based on the wisdom of the entire service team.
- Facilitate early assessment and intervention, which can extend an older adult’s independence, and help that person delay or avoid use of high-cost care settings and faster spend-down of their personal resources.

**Health Information Access and Sharing**
A 1999 Institute of Medicine report suggests that when individuals see multiple providers in different settings, and those providers don’t have access to complete information about the individual, “it becomes easier for things to go wrong.”\(^8\) To avoid this scenario, the integrated service model would give hub providers and families real-time access to health information and to an individual’s aging service plan. This access would:

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\(^8\) Institute of Medicine (November 1999). To Err is Human: Building a Safer Health System
Ensure continuity of services.
Avoid duplicative information collection and diagnostic tests.
Help providers make informed decisions about treatments, medications and daily supports based on a full picture of the individual.
Facilitate coordination and communication by helping providers consult with one another.
Make doctor visits more efficient by placing a focus on trends and changes in condition.

**Technology Tools**
Technology tools would be used within the integrated service model to help hub providers, older adults and their families:

- Achieve greater information sharing.
- Improve access to services and supports through virtual visits and tele-monitoring.
- Engage providers, older adults and families in activities to support wellness and independence.
- Facilitate predictive modeling to improve outcomes and identify best practices.
- Expand access to preventive and chronic disease management tools.

**Quality Assurance**
The integrated service framework would define measures of quality. At a minimum, these measures would gauge the satisfaction of the older adult and his or her caregivers. Measures would also be risk-adjusted, would account for socio-economic status, and would be tied to the achievement of the individual’s goals, as identified in the aging service plan.

The model supports CMMI’s proposed guiding principles including:

- Choice and competition in the market by providing more options for integration and more providers who could lead this approach.

- Provider choice and incentives: This voluntary model allows providers to decide and assumes that an array of financial options such as those available under the Next Generation ACO would be available as incentives for providers to collaborate, coordinate and communicate to fully integrate the services and supports their participants need.

- Patient-centered care: We would choose to say person-centered care but agree that empowering older adults, their families and caregivers to play a critical role in their own care will be integral to the success of this model.

- Small Scale Testing: Many LeadingAge members around the United States have firsthand knowledge of and demonstrated success offering integrated service models like
the one described above. Unfortunately, regulatory and financing barriers limit the ability of LeadingAge members to fully realize and scale these models.

LeadingAge believes this integrated service model approach represents both consumer-directed and market-based innovation models as it allows the individual consumer to select their “integrator,” be directly involved in the development of their aging service plan, and the model itself is designed to be led by the individual’s service providers in their community. We anticipate how the model is deployed and designed in each community will reflect individual market service availability, geographic challenges and advantages and provider and consumer preferences. The financial aspects of the model could be in the form of a bundled payment or use other financing approaches available under the Next Generation ACO or PACE models.

Additional information, including three LeadingAge member examples of an integrated service model can be found in our published paper.

A somewhat similar but more limited model--the Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program--is included in the Community Based Independence for Seniors Act. It moves Medicare beyond fee for service or MA. Specifically, MA plans would be allowed to enroll up to 1,000 eligible Medicare beneficiaries (including new enrollees) in the CBI-SNP program. Under this program, eligible Medicare beneficiaries would receive the LTSS benefits, such as homemaker services, home-delivered meals, transportation services, respite care, and adult day care services, as well as non-Medicare-covered safety and other equipment. Adding targeted home and community-based services (HCBS) not covered by Medicare for high-risk MA beneficiaries has the potential to postpone or prevent hospitalization and institutionalization.

With respect to potential demonstrations similar to CBI-SNP, CMS should work with provider associations to identify providers that are incorporating innovative practices to improve care outcomes and reduce costs. The existing work of innovative providers should be the starting point for the design of any new model. Further, it is important for CMMI to work with providers to ensure that the eligibility criteria for any care delivery model reflects the goals of that model. For example, the Medicare Care Choices Model was intended to provide a new option for Medicare beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers. Yet under current payment rules, Medicare and dually-eligible individuals are required to forgo curative care in order to receive services under the Medicare or Medicaid Hospice Benefit. This conflict was not resolved in the Medicare Care Choices Model, which, therefore, limits participation and effectiveness.

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9 Specifically, many of these members have participated in the Model 3 Bundled Payment for Care Improvement initiative and the Medicare Accountable Care Organizations program.
Additional Improvements for CMMI to Consider

LeadingAge strongly maintains that true reform of Medicare and Medicaid, and the broad development of integrated services, requires a single program and a single funding source that combines existing Medicare and Medicaid dollars so older adults can access a full range of services to address their medical, health-related, social and LTSS needs. We understand that such an approach is a long-term goal. Therefore, we share the following as a menu of interim steps that could be adopted or tested to support a move toward integration and incentivize providers to adopt a more holistic approach.

Building a Foundation for Holistic Service Delivery

- Take a broader look at needs: Expand the existing Medicare wellness visit benefit to include a comprehensive assessment that evaluates an older adult’s need for services and supports to foster independence and manage health and wellness. The American Geriatrics Society supports this concept.

- Expand the list of reimbursable services: Permit Medicare and Medicaid reimbursement for any services that optimize the health or function of an older adult as long as he or she is part of an integrated service model, has received a comprehensive risk assessment, and has a corresponding care and service plan.

Facilitating Coordination among Providers

- Foster health information sharing: Reexamine the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to identify actual barriers to health information sharing among health and service providers. Once these barriers to integration are identified, seek appropriate legislative or regulatory changes, and educate providers about the types of sharing that HIPAA allows.

- Align expectations of providers across the continuum: Include performance measures for primary care physicians and hospitalists in the Merit-based Incentive Payment System track of the Quality Payment Program to encourage and assess their level of coordination with LTSS and post-acute care providers.

Expanding the Pool of Providers Who Can Lead Integrated Models

If we are serious about transforming service delivery and lowering cost, we must pursue models that originate in the community and engage with individuals before a hospitalization occurs. Achieving this goal requires the participation of a variety of providers. LeadingAge, therefore, encourages CMMI to expand its thinking about what types of providers can lead models
currently being tested as well as proposed models. If we truly seek to change the spending trend, we must approach the needs of a person as a whole person not exclusively by payer source. It is this siloed thinking that has brought us to the current day.

- Medicare: Reimburse LTSS or community-based organizations responsible for coordinating care for Medicare beneficiaries or individuals who are dually eligible for Medicare and Medicaid. To facilitate reimbursement, Medicare should also develop a corresponding code, similar to the Medicare Chronic Care Management Current Procedural Terminology code available to physicians.

- Demonstration programs: Amend existing ACO and other CMMI demonstration language to:
  
  - Expand the definition of providers that can lead these integrated service models. Include LTSS, post-acute, and other community-based organizations and providers in this definition.
  
  - Allow these providers to apply for the Advanced Investment Model ACO so they can obtain an “advance” on their projected shared savings. Providers can use that advance to make the upfront infrastructure investments needed to pursue such integrated service models.

- LTSS providers: CMMI should launch a demonstration to test a voluntary, national, fully-integrated service model like the one described in this document. The model, led by post-acute and/or LTSS providers, would allow Medicare funds to be pooled with Medicaid and/or private funds. It would also leverage technologies that have been demonstrated to effectively support integrated service models in addressing older adults’ needs. It could utilize funding options available to Next Generation ACOs or PACE programs.

- Medicare Advantage: Broaden the definition of “provider” so senior living and assisted living providers could develop and deliver provider-sponsored MA plans. In addition, consider revising MA plan requirements, including reserve requirements, for provider-sponsored plans so they are similar to the requirements governing PACE programs.

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Removing Limitations on Service Delivery

- Eliminate minimum hospital stay requirements for obtaining needed care or services: Waive the three-day inpatient hospital stay requirement for all integrated service models when a comprehensive care or service plan is in place and a care coordinator or service facilitator is involved. Eliminate the observation status under Medicare fee-for-service for the purposes of determining nursing home eligibility for post-acute care. This is already permitted under MA plans and some alternative payment models.

Creating a Flexible Framework

- Build on other models: Create and test a regulatory framework for the new integrated services model that builds on PACE and FIDE SNP. At a minimum, the framework should require a community-based hub of providers to conduct a comprehensive risk assessment, develop an aging service plan, coordinate services through a single service facilitator, and consolidate and integrate funding for older hub participants. Provider payment options might look like those available under the Next Generation ACO model.

- Deliver services in the right place: Eliminate the requirement that service provision be limited to a certain site of service or source of payment. Instead, allow for service provision to be governed by provider scope of practice and qualifications so services can be provided in homes, congregate housing communities, AL communities, or another location, as long as that care can be provided safely. This change would help address workforce shortage issues, ensure that older adults receive timely access to care where and when they need it, and potentially reduce unnecessary emergency room visits and health care utilization.

- Allow consumer choice: Permit older adults to choose the group of providers that receives and utilizes all available public and private funding to provide them with cross-continuum coordination of services. This “integrator” could be a health plan, ACO, integrated service hub, medical home or health care home. The integrator would only be chosen by a third party if an individual did not make a selection.

LeadingAge would like to thank CMMI for opening a new direction to promote patient-centered care. As we have stated in our response to this RFI, by focusing on older adults in the community and by using true measures of quality to evaluate outcomes, there is greater opportunity to avoid unnecessary high-cost settings and services by providing the right services at the right time and in the right place.
Ms. Amy Bassano  
November 20, 2017  
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Please do not hesitate to contact us with any questions you may have about the models discussed in this response to the RFI.

Sincerely,

Katie Smith Sloan  
President & CEO  
LeadingAge