CALIFORNIA COLLABORATIVE FOR LONG-TERM SERVICES & SUPPORTS (CCLTSS)

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Amy Bassano
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Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-8016

Re: Innovation Center New Direction—Request for Information

Dear Ms. Bassano,

Thank you for the opportunity to comment on the Center for Medicare and Medicaid Innovation's (CMMI) request for information (RFI) on the Innovation Center New Direction.

The California Collaborative for Long Term Services and Supports is comprised of 34 statewide aging and disability organizations that promote dignity and independence in long-term living. Our members include advocates, providers, labor and health insurers and collectively we represent millions of California seniors and people with disabilities, their caregivers and those who provide health, human services and housing. Based on our collective expertise in serving the aging and disability populations, we offer the following input on both guiding principles and potential models to improve cost-effectiveness, access and quality of care.

1. GUIDING PRINCIPLES

A. Beneficiary Choice

I. Clarity in Communications

The first and second guiding principles in the RFI address choice and tools needed to exercise choice. We support beneficiary empowerment so they can make the best choices possible. To make that happen, all beneficiary communication about a demonstration, both at the start and throughout, should be in consumer-tested simple language, and accessible to individuals with disabilities and to those with limited proficiency in English.

II. Tools and Assistance

Among the guiding principles set out in the RFI is giving beneficiaries "the tools and information they need to make decisions that work best for them." To exercise informed choice, beneficiaries need easy-to-use and accessible tools that allow them to compare options. They also need to have free personalized assistance available to help them understand their options and their chosen coverage, something that is especially important for the many older adults and persons with disabilities who have difficulties using online resources.

III. Voluntary participation

The RFI stresses the importance of provider choice and incentives, favoring voluntary demonstrations. We urge that, more importantly, beneficiary participation in any demonstration that impacts their receipt of services should also always be voluntary. Demonstrations are, by their very nature, trials of untested systems meant to address deficiencies. Testing those systems should be a choice available to beneficiaries and not mandatory.

Beneficiaries with multiple chronic conditions have often spent months or years developing provider networks that work well for them. They should always be given the

option to keep their providers and not be required to disrupt their care to participate in a demonstration.

B. Define and Implement Person-Centered Care Principles

We believe that systems of care need to fully incorporate person-centered care characteristics that measure success by what matters most to individuals receiving services, including balancing complex care needs with an individual's daily living goals. We recommend that the Innovation Center incorporate person-centered care as a guiding principle and test models that prioritize person-centered care.

C. Standardize Assessment Questions Addressing Non-Medical Needs

Older adults with chronic conditions and function impairment have significantly greater medical spending than those with chronic conditions alone. We recommend that the Innovation Center test models that standardize and implement the use of functional assessment tools with a minimum set of care questions on function and other non-medical needs, building a process to coordinate these responses with other health-related information.

D. Implement Care Coordination for People with Complex Care Needs

Care coordination is a core element of a high quality system of care for people with complex care needs, implemented in partnership with individuals and guided by their needs and goals. There is evidence that care coordination models can provide a return on investment if assessments using function data are used to target services. We recommend that the innovation center test models that incorporate requirements for person-centered care coordination for people with complex care needs.

E. Incentivize Models of Care to Provide Optional Services

In order to meet the needs for social supports and services to people with multiple chronic conditions and functional or cognitive needs, we recommend that the Innovation Center test models that develop a clear structure and process on the use of optional services to enable health plans the flexibility to address unmet needs thru the use of optional services, and gather data that informs accurate rate setting methodologies.

F. Transparent Model Design and Evaluation

We strongly support transparent model design, including a broad stakeholder participation in in all stages of planning and implementation. Rigorous evaluations are also necessary to determine what is working well in a demonstration and what is not. In addition to looking at health outcomes and financial results, evaluations should include a beneficiary experience element. To be most useful, evaluation data should be made public as soon as possible and disaggregated so that impact on particular subpopulations can be assessed.

G. Consumer Protections and Robust Oversight

In addition to the guiding principles discussed in the RFI, a principle that should always be of prime importance is inclusion of consumer protections, along with oversight so that those protections are effective. All demonstrations should ensure that beneficiaries are not harmed by changes. Strong consumer protections must be in place, including effective appeals and grievance processes, adequate and genuinely available provider networks, and strong quality and safety standards. To be effective, these protections must be accompanied by oversight and enforcement. CMS has an overarching obligation to beneficiaries to provide robust oversight of providers and plans, an obligation that is even more important when new models are being tried and unexpected issues arise that could harm beneficiaries.

H. Ombuds

Having an ombuds program that can assist beneficiaries in navigating a demonstration and that also can identify and address systemic issues has proved effective in the past. We urge that an ombuds function, adequately funded, be part of every demonstration.

I. Systems Testing and Readiness Reviews

The start of any demonstration is the time when beneficiary access to care can be most at risk, and the issues often arise from systems errors: failure of data transfers to work correctly among participating entities, coding errors, unanticipated impact of demonstration changes on other systems or programs, etc. We strongly urge rigorous and extensive systems testing before the start of any demonstration. Robust readiness review procedures for participating providers and plans, states (if participating) and

CMS itself also need to be developed for each demonstration. Readiness review should address not just computer systems but personnel commitments to the demonstrations, provider understanding of the demonstration and all other elements.

J. Continuity of care

A related start-up concern is continuity of care. Even with notices, many beneficiaries are caught unaware when elements of their care delivery change. Having care continuity protections in place is essential so beneficiary health is not endangered. For protections to work, providers must be well educated on their mechanics. Further, the protections must be easy for both providers and beneficiaries to navigate.

2. POTENTIAL MODELS

A. Consumer Directed Care & Market-Based Innovation Models

Demonstrations that erode the universality of Medicare coverage by segmenting beneficiaries into those who can afford to pay additional amounts to providers and those who cannot do not advance the goals of the Medicare statute. Demonstrations that impose additional cost burden on struggling Medicaid beneficiaries or shrink their access to needed services do not advance the purposes of the Medicaid statute. We strongly urge CMMI not to pursue such models. Advocates are enthusiastic about instead working with CMMI to increase consumer-directed care and empower beneficiaries within models that provide positive incentives and that do not threaten bedrock principles in Medicare and Medicaid.

B. Support for the Dual Eligible Financial Alignment Demonstration

We ask that CMMI continue to support the Medicare-Medicaid financial alignment initiative (FAI), which is mid-stream in implementation. There has been a huge investment by stakeholders, plans, states, and MMCO in the design and implementation of the FAI, and much is being learned about what works and what does not, best practices, alignment of incentives and many other elements involved in the care of dual eligibles, who are disproportionately the highest need, highest cost beneficiaries for both the Medicare and Medicaid programs.

Several hundred thousand beneficiaries are currently enrolled in FAI state demonstrations. Shutting the demonstrations down just as the implementation phase is bearing fruit would cause significant disruption in their care. Further, the demonstrations in the participating states differ in significant aspects, providing a wealth of information and on-going learning as plans and states identify implementation challenges and develop responses. Much value would be lost if, after all the groundwork that has been laid, the demonstrations are not allowed to play out at this critical stage. Continuing to support the FAI will provide time for a thorough evaluation of the impact of the different state models on beneficiary outcomes and program costs.

C. Mental and Behavioral Health Models

We also encourage CMMI to develop models that focus on treating the whole person and improve coverage and integration of mental health and substance use disorders services into primary care. Mental health is a critical issue for older Americans, as one in five older adults has a mental health issue, and older men have the highest suicide rate of any group, according to the CDC. For dual eligibles, the issue is even more urgent. About 44% of older adults and persons with disabilities who are dually eligible for Medicare and Medicaid have at least one mental or cognitive condition, while more than half of all Medicare inpatient psychiatric facility patients are dual eligibles. The mental health needs of persons who are dually eligible are often overlooked in traditional medical settings, a costly intervention that also results in inadequate mental health care. Stigma and inadequate screening mechanisms prevent beneficiaries from accessing behavioral health services.

We strongly urge CMMI to promote integration of mental health and substance use disorder services in all models and build upon the existing efforts in the dual eligible demonstrations.

D. Mental and Behavioral Health Models for Persons with Dementia

An overwhelming majority of persons with dementia experiences psychotic symptoms or agitation, referred to as behavioral and psychological symptoms of dementia (BPSD).

Many such symptoms are the impetus to falls, weight loss, infection, incontinence, and nursing home placement, and cause considerable caregiver stress. Effective psychosocial interventions can dramatically improve affected individuals' quality of life and potentially save dollars spent on the complications noted above. Any intervention tested by CMMI should incorporate training and education for health professionals and family caregivers as many of these behaviors occur in the home and will be managed by caregivers. Additionally, multiple interventions and regular reevaluation should be included in any model since an affected person's needs--frequently expressed through behaviors--can change from day to day and across the disease spectrum. Finally, any model should be built around the quality of a beneficiary's life and be grounded in person-centered care.

E. <u>Implement the PACE Innovation Act</u>

Currently, Programs of All-inclusive Care for the Elderly (PACE) may only enroll beneficiaries who are at least 55 years of age and eligible for a nursing home level of care. Passage of the Pace Innovation Act now allows CMMI to pursue a number of PACE-like pilots that would allow other high-cost, high-need populations to enroll in pilot programs modeled on PACE and to benefit from the highly coordinated, fully integrated, patient-centered care for which PACE is well known. We recommend development of PACE-like pilots that could successfully serve a number of populations beyond the traditional PACE population, including:

- Medicare-only beneficiaries;
- Beneficiaries with mobility-limiting disabilities;
- At-risk medically complex beneficiaries;
- Beneficiaries with an intellectual or developmental disability;
- Beneficiaries with behavioral health conditions.

In particular, there is potential to explore adapted PACE models that would target "pre-PACE" populations, those with complex, recurrent and/or chronic medical and health needs who do not qualify for nursing home level of care. These models would be

designed to focus on beneficiaries with conditions that are manageable via early detection and interventions that lead to improved utilization and quality of life, and that employ core services that are part of the PACE model such as care coordination, transportation, supportive services and primary care. These "pre-PACE" models could be particularly adapted to serve Medicare-only beneficiaries, particularly those at risk of spending down to become Medicaid eligible, and Medicare, Medicaid eligible and dual beneficiaries with medically complex conditions who are at risk of needing nursing home care, as part of the At-Risk Medically Complex Beneficiary PACE-like pilots.
We also urge CMS to include provisions to address the sustainability of the models it decides to move forward with. We believe provisions that support the extension of successful pilots or demonstrations could make them more feasible and encourage more organizations to undertake them.

F. <u>Oral Health Integration and Models</u>

In addition to the potential models discussed in the RFI, we recommend CMMI test and promote models of care that provide comprehensive, integrated health care that includes integrated oral health services. Addressing a person's oral health needs is essential in ensuring improved health outcomes and is a necessary component of patient centered care. We urge CMMI to place an emphasis on developing models that focus on treating the whole person and improving integration of oral health services into all aspects of health care.

We also recommend that CMMI develop a demonstration that would offer oral health benefits through Medicare coverage. Currently Medicare covers very limited oral health care, with no preventive or routine dental care coverage. Consequently, Medicare recipients' oral health is neglected, which results in preventable tooth loss, increased emergency room use, and a decline in overall health and quality of life. One quarter of individuals age 60 and over no longer have their natural teeth, and twenty-three percent of older adults have severe gum disease, which increases their risk for aspiration pneumonia and other infections. Developing a model that adds dental care to

Medicare's Part B benefit would advance the goal of integrating oral health into total health care by incorporating the benefit administratively into the Medicare program that covers other health care providers.

G. Alternative Payment Models

We encourage CMMI to test models that integrate and deliver comprehensive medical and non-medical needs, beginning with early detection and diagnosis of Alzheimer's and related dementias. Individuals newly diagnosed with Alzheimer's have higher health care use and costs in the year prior to diagnosis and in the two years after diagnosis than those who do not receive this diagnosis. While more work is needed to understand the underlying causes of increased use of health care services immediately prior to and after receiving a diagnosis of Alzheimer's, it may be attributed to care for disability and injuries, such as falls, that might result from the early stage of the disease; treatments related to cognitive impairment or coexisting medical conditions; and costs of diagnostic procedures. Promoting early detection and accurate diagnosis can help to ensure that beneficiaries with dementia receive the most appropriate, highest quality of care.

Persons with dementia and other complex beneficiaries need help managing their comorbid conditions, their behavioral health and safety challenges, long-term care options, and end-of-life preferences, among other concerns. Failing to meet these needs results in unnecessary and inappropriate health care costs. We believe there is significant potential for savings that could come with models that offer comprehensive, integrated services.

H. Implement Models to Increase Availability of Affordable Housing Options

The inability to access affordable housing is a significant barrier to community transitions, and many individuals experience inappropriate institutionalization solely due to the lack of affordable and accessible housing. Programs such as the Money Follows the Person demonstration have shown success in transitioning people from institutional settings to the community by assisting them to access housing. We recommend that the Innovation Center consider innovative ways to partner with the

U.S. Housing and Urban Development Department to test models to further affordable housing options that would allow persons with multiple complex conditions timely access to housing to prevent unnecessary institutionalization and the related costs.

I. Creating Access to Health Services in Housing

Today, over two million individuals age 65 and over live in publicly subsidized housing properties located in urban, suburban and rural communities across the country. Over 70 percent of these elderly residents are dually eligible for both Medicare and Medicaid, have five or more chronic conditions, are taking multiple medications and incur higher healthcare expenditures than their dual eligible peers living in the community, but not in subsidized congregate environments. This congregate housing setting 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 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.

We believe that by incentivizing Medicare Advantage (MA) Plans to enroll groups of low income seniors and individuals with disabilities living in affordable housing properties, embedding care management teams within senior housing, CMS will increase consumer- directed care, create informed prescription drug consumers, and bring mental and behavioral health supports to people at the most effective location - where they live.

We also see opportunity for CMS's Innovation Center to go beyond Fee-For-Service (FFS) and MA plans. By testing a multi-payer payment approach funded by public and private payers, CMS can evaluate how to increase participation in data-driven, voluntary care management programs designed to increase choice, improve care quality and reduce cost. A multi-payer pool will preserve consumer choice of providers and insurers.

J. Implement the Support and Services at Home (SASH) Model

The Support and Services at Home (SASH) model, developed in Vermont has demonstrated promising results including an ongoing reduction on the growth of Medicare expenditures for the SASH participants relative to non-SASH participants and another control group in New York. Currently, over 140 HUD 202, USDA Rural Development Section 515, tax credit and public housing authority buildings are part of the SASH network. The SASH network directly links these communities to the medical homes and ACOs that Vermont created during the state's health care reform initiative.

Each SASH property has a service coordinator and part-time wellness nurse for every 100 residents. The service coordinator and wellness nurse positions provide a number of services including: assessing the service needs and goals of individuals who are 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, coaching and care coordination with primary care providers and other health and social services providers.

SASH incorporates all six of CMS's guiding principles. SASH is a Patient-Centered model that is voluntary, protects provider choice, and provides the tools and information consumers need to make decisions that work best for them. For example, SASH has increased advance directives by 40 percent. SASH focusses on Mental and Behavioral Health by partnering with mental health agencies on programs such as the Zero Suicide initiative. Very low-cost interventions have led to a reduction in systolic blood pressure for 70 percent of the SASH Hypertension Management participants.

There is great potential for affordable senior housing properties to partner with Medicare Advantage Plans to improve care coordination, address social determinants of health and reduce costs for the Medicare program.

We would like to see CMMI support a targeted demonstration to explore options for expanding Medicare Advantage Plan benefits to cover a wellness/service coordination function for elderly and younger disabled residents of affordable housing. We hope that CMMI explores several options including coverage for individuals enrolled in Advantage Plans or a housing-based benefit that would be targeted to the property as a whole through a multi-payer approach. We strongly encourage CMS to discuss these new directions with HUD, LeadingAge, The National Well Home Network, affordable housing providers, other stakeholders and beneficiaries.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at 916-862-4903.

Sincerely,

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