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United for Aging and Disabilities

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VIA ELECTRONIC SUBMISSION

Amy Bassano
Acting Director, Center for Medicare & Medicaid Innovation
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Acting Director Bassano:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing in response to the Center for Medicare & Medicaid Innovation's (CMMI) Request for Information (RFI) regarding new directions for the Center. NASUAD is a nonpartisan association representing the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and individuals with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including Medicaid long-term services and supports (LTSS), the Older Americans Act (OAA), and a variety of other health and human services programs. Together with our members, we work to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability and for their caregivers.

We appreciate the opportunity to comment on this RFI and are pleased with the emphasis on collaboration and partnership with states that CMS leadership has articulated in various public events and conversations with our members. We encourage CMMI to embrace this philosophy, as we believe that strengthened partnerships with the states will lead to stronger programmatic designs, particularly around demonstrations that impact older adults, people with disabilities, and individuals who require LTSS. Some demonstrations, notably the Accountable Health Communities Model and the Financial Alignment Demonstration, would have had more effective designs if state agencies had been given the opportunity to provide meaningful input prior to formulation. State involvement would have identified a number of potential barriers that hampered program implementation, as well as existing resources that the models could leverage.

There are many opportunities to implement programs that enhance the ability of states and CMMI to collaboratively address the needs of this population. Below, we provide recommendations for models and concepts to consider for CMMI's new direction. These

recommendations are centered on Focus Area 6: State-Based and Local Innovation, including Medicaid-focused Models.

Enhanced Integration for Dual Eligible Enrollees

Beneficiaries who are dually eligible for both Medicare and Medicaid make up a disproportionate share of expenditures under both programs, totaling about one third of the costs of each program. The proportion of dually eligible enrollees is expected to grow rapidly over the next ten years driven by the aging of baby boomers. At this critical time, states, health care advocates, health plans, providers and CMS must maximize their shared responsibility for improving the costs, efficiency and quality of care for this highly complex and costly special needs population. Prior demonstrations and models to serve dual eligible individuals have maintained a rigid structure that continues to create barriers between Medicare and Medicaid services.

We recommend that CMMI establish a new demonstration for dual eligible individuals that enables a state to serve as the integrating entity for Medicare and Medicaid funding. In this proposed model, the state would serve as the point of accountability to CMS for the provision of care and for ensuring the health and welfare of program participants regardless of whether it uses a fee-for-service (FFS) or capitated delivery model. This could be accomplished by providing states with a risk-adjusted per capita payment to cover the Medicare supports for each dual eligible individual, using the Dual Eligible Special Needs Plan payment structure. The state would administer both the Medicare and Medicaid benefit either directly (using a FFS model) or through contracted health plans (with a comprehensive capitation payment made for both Medicare and Medicaid benefits).

Under this model, states would be able to truly integrate supports for dual eligible individuals and to address inconsistencies in coverage, payment, and outcomes measurement for the population that necessarily arise from operating two separate programs. We know of at least one state – which was not able to take advantage of the Financial Alignment Demonstration – which would be immediately interested in applying for such a demonstration.

Extend and Enhance the Financial Alignment Demonstrations

There have been incremental successes arising from CMMI's Financial Alignment Demonstrations. With either the capitated or managed FFS models, various administrative and service-delivery improvements could be enacted to better align supports and services to dual-eligible beneficiaries and to focus on overall improvement of health. Preliminary findings from the analysis of Washington State's managed FFS model indicate that this approach can yield savings across the health care system.[1] Additionally, a recent ASPE study on the long standing integrated FIDE-SNP based Medicare-Medicaid program in Minnesota shows that enrollees were:

- 48 percent less likely to have a hospital stay, and if so, had 26 percent fewer stays.

[1] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalMedicareCostYr1FinalYr2Preliminary072817.pdf

- 6 percent less likely to have an outpatient ED visit, and if so, had 38 percent fewer visits.
- 2.7 times more likely to have a PCP visit, but if so, had 36 percent fewer visits.
- No more likely to have a long-term nursing home admission.
- 13 percent more likely to have any HCBS.[2]

However, we note that these outcomes have not yet been universally found across the demonstrations. One factor cited that contributes to the potential challenges was the lengthy lead-in time required for effective implementation of the demonstrations.[3] The need for a slow and methodical approach of such a significant demonstration comports with our experiences in other systems change initiatives. We have found that initiatives such as these require a long period of time to ensure that there are meaningful changes in both participant and provider behavior, to collect data and evaluate outcomes, and to determine programmatic changes that could improve the overall system of care. Such changes should then be implemented and evaluated as part of an iterative process improvement approach to the demonstration. Because of this, ***we recommend providing extensions of the demonstration to states that wish to extend their program. We also recommend allowing additional states to establish an alignment demonstration, such as those who have implemented, expanded, or gained additional experience with managed long-term services and supports (MLTSS) in the period since the initial demonstrations were established.***

We also believe that additional flexibilities and programmatic efficiencies could be implemented that would lead to better outcomes for participants. For example, states with experience operating an MLTSS program should have increased flexibility to work with its health plans to coordinate operational aspects of serving dual eligible, including streamlined enrollment, assessments, model of care development and network development. Additionally, the "state as an integrator" model discussed in our previous comment would provide an opportunity to strengthen the integration of services and supports for individuals served by this demonstration. Finally, while CMS has made great strides in providing additional Medicare data (Parts A, B, and D) to states to fill in gaps for dually eligible beneficiaries, states are currently unable to access data for Medicaid enrollees in Medicare Advantage plans. CMMI should make it a priority to provide states with as much data as possible to effectuate integration in an unintegrated system.

We also recommend that states have the option to mandate that beneficiaries enroll in the demonstration, provided that participants have meaningful choices regarding demonstration plans. The Medicaid Managed Care regulations[4] regarding choice, beneficiary protections, and mandated enrollment would provide a good example of ways to implement a mandatory enrollment policy while ensuring that the health, rights, and autonomy of individuals are protected.

Lastly, we recommend providing the Medicare-Medicaid Coordination Office (MMCO) with increased regulatory authority over this model. MMCO has provided strong leadership and direction around programs to integrate services for dual eligible individuals; however, the regulatory

[2] https://aspe.hhs.gov/basic-report/advancing-integrated-care-lessons-minnesota
[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf
[4] https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html

authority to implement such integration has remained within the respective Medicare and Medicaid Centers at CMS. MMCO should have the authority to implement the necessary changes that enable the alignment demonstration and other initiatives, such as PACE, which are focused on dual eligible individuals, to fully reach their potential. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of dual eligibles.

Strengthening Medicare Post-Acute Transitions

After a Medicare-eligible individual experiences an acute event that results in a hospital stay, rehabilitation and other post-acute services are generally provided in an institutional setting such as a Skilled Nursing Facility (SNF) or an Inpatient Rehabilitation Facility (IRF). The experience of our members indicates that many of these individuals never return home, particularly those older Medicare beneficiaries with significant health care conditions. These individuals often stay in the facility after their Medicare post-acute stay ends, either as a Medicaid-funded resident or as an individual who spends down their assets on the path to Medicaid eligibility. In many cases, this post-acute and spend down period has led to a deterioration of the person's community supports (both formal and informal) as well as their housing situation. The end result is that Medicaid first encounters many individuals when they are living in a facility with little resources or opportunity to return to the community.

NASUAD recommends implementing a demonstration project that examines the efficacy of prioritizing community-based post-acute care in lieu of facility-based care. This could enable Medicare post-acute care to be provided in an intensive, holistic, and community-based fashion, beyond what is currently available through the Medicare home health benefit. We believe that it could provide greater opportunities to serve individuals in the community and prevent long-term institutionalization. This would require a demonstration to convert the Medicare post-acute benefit into an array of home and community-based services (HCBS) that meets the varied needs of individuals in the community. Any demonstrations or projects enacted under this proposal would also need strong links between the existing aging and disability networks, as well as coordination to ensure that there is no duplication with Medicaid-funded HCBS.

We recognize that CMMI has begun to address community-based interventions through initiatives such as community care transitions program (CCTP), which has since been discontinued, and the accountable health communities (AHC) model. However, we believe that stronger engagement with the aging and disability network as well as with state LTSS officials prior to finalizing the programmatic design would have strengthened their ability to meet the holistic needs of LTSS participants. ***Therefore we further recommend that such a demonstration is designed and implemented in collaboration with states, who can identify potential barriers to successful implementation.***

Finally, as we noted in our feedback about the AHC demonstration, we strongly urge CMMI to consider providing additional targeted funding to those community-based services which are insufficient to provide services to current individuals who need LTSS.

Savings for Decreased Rehabilitation Services

A related, but somewhat distinct, issue to the expansion of HCBS in post-acute settings is the interaction between Medicaid supports and Medicare rehabilitation services. The current system of care includes significant disconnects, given that Medicaid is often responsible for providing comprehensive HCBS that prevents or reduces readmissions to the hospitals. This not only leads to reduced hospital expenses, but also to a reduction in post-acute rehabilitative expenditures as well. Medicare is responsible for the payment of both of these services for dual eligible individuals, yet state Medicaid programs finance a significant portion of HCBS and LTSS that can reduce hospitals, readmissions, and the resulting post-acute services. States that have already established robust systems to reduce the need for these services have struggled to secure shared savings through either the managed FFS or the capitated financial alignment demonstrations. This occurs largely due to the lower baseline of utilization already established prior to the demonstration which skews the capitation and FFS shared savings calculations. ***We believe that CMMI should establish demonstrations where states can receive credit and shared savings for both hospitalization and rehabilitation savings achieved as a result of their HCBS interventions, even if robust systems existed prior to the establishment of the demonstration.***

Durable Medical Equipment Coordination on a Timely Basis

Medicaid often pays for durable medical equipment (DME) that does not meet the criteria set by Medicare. This occurs for a number of reasons, such as different medical necessity standards, different coverage definitions, or broader availability of DME for purposes of community integration in HCBS waivers. However, due to Medicaid's statutory role as payer of last resort, programs must first receive a Medicare denial prior to paying for the Medicaid-covered DME. Oftentimes, this denial is delayed or is not sent to the Medicaid office, thus creating significant hardship on the individuals who are awaiting their medical supplies. This is particularly true for individuals leaving a NF or hospital as a vendor cannot be paid for items under HCBS programs until the individual leaves the institution. The current process also creates payment insecurity with vendors causing hesitancy to supply items with no guarantee of payment and some vendors may unduly influence the item that is supplied based on what is covered by Medicare. Access issues are also created by the Medicare procurement process. For example, the competitive bid process limits the number of vendors that participants (and the state) may work with, reducing participant choice. The procurement process reduces business for vendors who do not win the bid, which may also reduce the number of available vendors in an area, since smaller vendors (who do not win the bid) may go out of business. Due to inconsistent requirements between Medicare and Medicaid, some DME vendors who win the competitive bid decline to work with Medicaid or decline social service authorizations. ***We recommend piloting a project to expedite DME coordination for both Medicare copayments covered by state agencies, as well as for Medicare denials of equipment that the state may ultimately provide.***

Social Determinants of Health

There is an increasing recognition that many of the factors which impact the health of individuals fall outside the realm of the traditional medical system.[5] The focus on "social determinants" that impact the health of participants and communities is driving policymakers to think about new and innovative interventions that can address individuals in a person-centered manner. We noted earlier that the CMMI AHC model represented an initial foray into these issues; however, we have previously noted some shortcomings with the programmatic design. NASUAD recommends that CMMI collaborate with state Medicaid and Aging and Disability agencies to design additional initiatives that could strengthen interventions which address the social determinants of health. Two areas where CMMI could prioritize such interventions include enhancing employment supports for persons receiving LTSS and addressing housing-related issues, such interventions regarding chronic homelessness, affordability and accessibility of housing.

Employment

NASUAD believes that there are a number of opportunities to enhance the availability of employment-related supports to older adults and people with disabilities. Our research indicates that many participants in LTSS programs who are not working would like to be employed, including almost one in four older adults.[6] Increased employment has also shown to result in a reduction of Medicaid expenditures for individuals with disabilities, and could also lead to higher income and less reliance on other state and federal social services programs.[7]

There are a number of proven models for providing individualized, customized, and/or supported employment opportunities for individuals who have significant disabling conditions. NASUAD's experience with employment supports indicates that several core items must be addressed:

- Person-centered models to ensure that participants receive the necessary initial and ongoing support to obtain, maintain, and advance in employment;
- Maintaining access to crucial supports, such as LTSS, which are not provided by most private insurance plans, including once the participant retires;
- Ensuring that individuals have accurate and timely information about the interaction between their employment income and public benefits; and
- Follow-along supports to assist the individual when circumstances change.

Given Administrator Verma's strong emphasis on providing Medicaid beneficiaries with opportunities to become gainfully employed, we believe that there are opportunities within CMMI to test models of care that integrate these types of supports and ensure that older adults and people with disabilities are able to maximize their potential in the workplace. ***We recommend that***

[5] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[6] https://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf
[7] http://ppc.uiowa.edu/sites/default/files/mepd.pdf

CMMI build upon the successes and lessons learned from the Medicaid Infrastructure Grants[8] to implement projects that incorporate the following components:

- ***Eligibility criteria that de-links Medicaid from the receipt of social security benefits and promotes employment;***
- ***Asset disregard policies that enable participants who work and accrue retirement income to remain on Medicaid once their employment ends;***
- ***Supported and customized employment services that assist individuals with significant disabilities obtain, maintain, and advance in employment;***
- ***Strong work incentives and options counseling to assist participants understand the impact of earnings on their overall situation; and***
- ***Evaluation to demonstrate the impact of increased employment on Medicare and Medicaid health expenditures as well as expenditures on other social services.***

Housing

State experiences with the Money Follows the Person deinstitutionalization program demonstrate that a lack of affordable, accessible, housing is one of the most significant barriers to community-based living for many individuals with disabilities and older adults.[9] This challenge is exacerbated by policies that require states to cover the cost of institutional nursing facilities, including room and board expenses, but prohibit payment of these expenses in a noninstitutional setting. These inconsistent policies undermine our nation's policy goals as well as the desires of program participants, both of which strongly prioritize HCBS as the favorable setting of care. Additionally, HCBS is a less expensive setting of care than nursing facilities and other institutions. ***NASUAD recommends that CMMI establish a demonstration in partnership with states to enable Medicaid programs to pay for certain housing related expenses, up to and including room and board. This pilot should include strong research to assess whether the total expenditures under the demonstration is cost-effective compared to institutional care.***

Enhanced Medication Reviews and Monitoring

Older adults, especially those with significant cognitive issues such as dementia, frequently receive significant numbers of prescription drugs, including antipsychotic and opioid medication. Though some initiatives have attempted to identify instances of inappropriate prescriptions or adverse interactions, these have often been targeted to residents of nursing facilities. While the defunct CCTP took steps in that direction, there remains a need for programs that identify potential issues across a wide range of older adults in a variety of settings. This is particularly important since older adults are one of the demographics most significantly impacted by the opioid crisis in the United States. In fact, a recent report by the HHS Inspector General found that one-third of all Medicare

[8] https://www.mathematica-mpr.com/our-publications-and-findings/publications/what-were-the-top-outcomes-of-state-medicaid-infrastructure-mig-grants

[9] https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf

Part D beneficiaries received a prescription for opioids during 2016.[10] ***We recommend that CMMI evaluate opportunities for demonstrations that establish a cadre of dedicated, qualified professionals who can assess the array of prescriptions provided to older adults through the Prescription Drug Plans (PDPs) who deliver the Part D benefit in order to identify potential instances of inappropriate prescriptions or contraindications.*** This could be done by requiring the PDPs to provide such assistance or a separate intervention that works collaboratively with the PDPs.

Addressing Opioid-Related Issues

In addition to efforts to monitor and reduce inappropriate prescriptions, there are other opportunities to address participants who are experiencing opioid abuse and addiction issues. One such opportunity is to ensure that proper coordination occurs for individuals receiving treatment who transition from Medicaid to Medicare at age 65. Our members have reported a significant disconnect between the prescription coverage delivered through Medicaid and what is currently available and considered medically necessary by the PDPs. ***CMMI should consider instituting a program that ensures Part D plans accept any prescriptions accompanying medication assisted treatment interventions when individuals become eligible for Medicare.***

Measuring Quality

Quality measurement is a crucial component of all health care delivery programs. NASUAD strongly supports CMMI initiatives that would strengthen the information available regarding the outcomes and quality of care delivered to participants across Medicare and Medicaid. We note that many quality initiatives have focused on clinical measures, such as A1C screenings, but have overlooked the role of the LTSS system in ensuring quality of life for the participants served. We strongly recommend that CMMI take a broader view of 'patient experience' which looks beyond clinical practice.

To fill this gap, states agencies collaborated with NASUAD and the Human Services Research Institute (HSRI) to develop the National Core Indicators – Aging and Disabilities (NCI-AD)™ survey, which collects a wide range of information on experience of care and quality of life for older adults and people with physical disabilities in publicly funded LTSS programs. The NCI-AD™ program provides states with valid and reliable data they can use to tailor LTSS innovations and policy solutions to that state's unique need.[11] This survey is the counterpart to the National Core Indicators survey, which collects similar information for individuals with intellectual and developmental disabilities. These surveys provide valuable information that drive policy and program improvements, resulting in enhanced delivery of care to individuals.

NASUAD suggests that CMMI demonstrations incorporate quality metrics, such as NCI-AD™, that assess program outcomes as well as measuring person-centered experience of care in order to ascertain the true impact of supports and services provided to individuals. This holistic approach to quality measurement will be especially important given the increasing emphasis on social

[10] https://www.npr.org/sections/health-shots/2017/07/13/536873912/extreme-opioid-use-and-doctor-shopping-still-plague-medicare
[11] https://nci-ad.org/

determinants of health and the understanding of how non-clinical interventions can drive improvement in the overall health of populations.

Oral Health

We recommend CMMI test and promote models of care that provide person-centered and holistic interventions, which includes oral health services. Inadequate access to oral health care leads to a wide range of negative outcomes for older adults and people with disabilities.[12] NASUAD's membership has endorsed including dental and oral health services in Medicare. While we recognize that expansive adoption of a benefit would require a statutory change, we believe that CMMI has an exciting opportunity to evaluate the impact of providing dental services to Medicare beneficiaries. Such a demonstration project could assess fiscal savings associated with reduced medical costs, such as emergency room visits, as well as increase in overall health of participants. Demonstration projects to include oral health supports within Medicare interventions should focus on fully integrated services and payment models, which includes collocated services; integrated referral systems; and value-based payment models that promote healthy outcomes for physical and oral health.

Caregiver Support

NASUAD believes that supporting caregivers is a crucial component of a cost-effective LTSS system. Nationally, unpaid caregivers provided services that were valued at an estimated $470 billion in 2013 – an amount that far exceeds funds spent on LTSS in Medicaid and Medicare.[13] Loss of these unpaid supports would likely result in a greater number of institutional placements, deterioration of health, and increase in overall program expenditures for both Medicare and Medicaid.

In the FY2018 Physician Fee Schedule, CMS finalized adoption of comprehensive care planning for individuals with chronic conditions. This includes CPT code 96161, which provides for: "Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient."[14] We believe that this is an important step forward that CMMI can build upon. We note that Washington State has also begun experimenting with models to provide targeted supports to unpaid caregivers in a manner that can reduce overall LTSS expenditures.[15]

NASUAD recommends that CMMI develop a pilot project that uses the results of the Medicare caregiver health risk assessment to provide targeted supports and services that reduce stress on the caregiver and enable individuals with LTSS needs and chronic conditions to remain in the home. The exact interventions should be designed in coordination with state aging and disability agencies, but could include a combination of respite care and adult day services for the participant as well as depression and stress management interventions for the caregiver.

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[12] http://www.nasuad.org/sites/nasuad/files/NASUAD%20Oral%20Health%20in%20America.pdf
[13] https://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf
[14] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-01.html
[15] https://www.hca.wa.gov/about-hca/healthier-washington/initiative-2-long-term-services-and-supports

Conclusion

We appreciate the opportunity to comment on the wide range of issues discussed in this RFI. Our nation's population is aging, individuals are living longer, and new technology and medical advances are allowing individuals with disabilities to live longer and more fulfilling lives in the community. We believe that CMMI has a unique opportunity to evaluate models that can enhance the overall health and well-being of individuals in the Medicare and Medicaid programs. We look forward to engaging with CMS as you review the responses to this RFI and develop strategies to enhance the provision of services and supports for all of individuals that we serve.

If you have any questions, please feel free to contact Damon Terzaghi of my staff at (202) 898-2578 or dterzaghi@nasuad.org.

Sincerely,

Martha A. Roherty
Executive Director
NASUAD