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June 22, 2015

**National Association of Area Agencies on Aging**

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The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On behalf of the National Association of Area Agencies on Aging (n4a), which represents the country's 623 Area Agencies on Aging (AAAs) and serves as a voice in the nation's capital for 256 Title VI Native American aging programs, we are writing in response to the Senate Finance Committee's request for input on policy initiatives to facilitate the delivery of high-quality and cost-effective care for Medicare beneficiaries living with multiple chronic conditions. We applaud the Committee for seeking stakeholder input on legislative proposals to address well-known and long-standing challenges to improving care for vulnerable populations.

AAAs and Title VI programs are on the frontlines of the country's unprecedented demographic shift as every day, 10,000 baby boomers turn 65 and become Medicare beneficiaries. By 2030, on average one in five Americans will be 65 or older, and in some areas, that statistic will be much higher.

**Area Agencies on Aging: Local Leaders in Aging and Community Living**

AAAs were established under the Older Americans Act (OAA) in 1973 to respond to the needs of Americans 60 and over in every local community. By providing a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best, AAAs make it possible for older

adults to "age in place" in their homes and communities. AAAs tap into private, local, state and federal funding streams to provide person-centered care for their clients. Federal funding sources most commonly used by AAAs are OAA, Medicaid home and community-based waivers, Prevention and Public Health Fund (PPHF) evidence-based health and wellness programs (such as falls prevention and chronic disease self-management programs), and State Health Insurance Assistance Programs (SHIPs). Increasingly, AAAs are adapting to Medicaid Managed LTSS and expanding into care transitions partnerships with local health care entities.

Our members reach millions of older adults and their caregivers every year and they do so by supporting them in ways that acute health care systems do not, cannot and, arguably, should not. AAAs support their clients' lives by providing the wrap-around services needed to ensure successful aging, whether that is transportation, home-delivered meals, chore services, in-home care, caregiver education, support and respite, or even help selecting a Medicare Part D plan. That's why we believe it is critical to recognize the pivotal role that the Aging Network (state units on aging, AAAs and providers) plays in any discussion of coordinated care for seniors.

**Coordination Must Involve the Home and Community**

We appreciate that Senate Finance Committee members recognize the need to better engage consumers with chronic conditions in their own care coordination, delivery and outcomes, and that there is a growing commitment to look beyond acute health care providers in order to achieve the triple aim of better health and better care at lower costs.

Given that patients—even the most costly and vulnerable population who each have more than six chronic conditions—still spend the vast majority of their time outside of the traditional health care systems, it will be impossible to achieve this triple aim without committed, thoughtful, strategic and flexible engagement of community-based organizations (CBOs), including AAAs, which have a 42-year history of providing health and social supports to individuals and their caregivers in their homes and communities. Also, because AAAs operate a complex service delivery system that provides access, community-based, in-home and elder rights services, they must play a crucial role in helping to achieve the goals to improve patient health and the Medicare bottom line.

With new opportunities and innovations emerging on a regular basis to provide better coordinated, cost-effective and more successful care, AAAs have flexibility that serves their clients well. **Today, 90 percent of AAAs offer evidence-based health and wellness programs, up from just over half in 2007.** For instance, 70 percent of AAAs offer Chronic Disease Self-Management Education (CDSME) programs, two-thirds of AAAs are involved in institutional transition and diversion programs, and over half of all AAAs are part of an integrated care delivery system of some kind (e.g., Community-Based Care Transitions, Veteran-Directed HCBS, Managed LTSS, Duals Demos, etc.). However, it will be necessary for Congress and the Administration to continue to support and build upon these efforts. AAAs and other CBOs should be key partners to identify and expand best practices and act on opportunities to improve integrated care delivery that improves health and reduces costs.

***In order to achieve the three overarching goals identified by the Committee to***

***guide the development of bipartisan legislation, there must be broad stakeholder engagement that includes not only of traditional health care providers, but also the agencies and organizations, such as AAAs, that serve patients where they live at home and in the community.***

**Recommendations**
As you draft policy, we ask that you consider the following recommendations related to the Committee's goals to increase care coordination across care settings; improve quality outcomes and care transitions; increase program efficiency and contribute to an overall effort to reduce the growth in Medicare spending.

- **Improve Care Transitions and Care Coordination by Better Integrating the Aging Network and Community-Based Organizations**

  **Care Transitions:** AAAs have demonstrated their ability to partner effectively with health care systems and state quality improvement organizations to administer care transition programs that result in seamless transitions for consumers from acute care settings to home. This results in improved health outcomes and fewer hospital admissions and preventable 30-day re-admissions.

  The Affordable Care Act (ACA) established the Community-based Care Transitions Program (CCTP) to improve care for high-risk Medicare beneficiaries being discharged from the hospital to prevent unnecessary re-hospitalizations and avoidable health care costs. To receive funding from the program, which is administered by CMS as part of the Partnership for Patients, community-based organizations must partner with hospitals. AAAs have taken the lead in this initiative: AAAs played a key role in approximately 90 percent of sites. More than 100 AAAs received initial CCTP funding, and in an October 2014 n4a survey, over 90 percent of respondents (n=82) said they were achieving positive results by reducing readmission and/or saving Medicare money. However, n4a has serious concerns regarding how CCTP site performance was measured and evaluated by CMS. n4a is concerned that readmissions and enrollment metrics used to reflect program performance did not adequately or accurately capture site performance or impact. Therefore, n4a has encouraged Congress and CMS to pursue objective evaluation of the program. Furthermore, n4a is concerned that CMS's ability to accurately track and capture site performance was undermined when $200 million was cut from CCTP's budget in the final FY 2013 spending package.

  Outside of CCTP, however, AAAs are still working with hospitals and health care providers to support care transitions, and n4a encourages the Congress and CMS to explore options to make care transitions activities reimbursable under Medicare and to specifically incentivize hospitals to work with AAAs and other community-based organizations to more efficiently and safely facilitate patient transitions from acute health care settings back to the community/home.

  **Bridging Health and LTSS:** Furthermore, we need to improve the level of

coordination between our nation's health and LTSS systems. As with care transitions, there are clear roles for AAAs to play in those activities and the wisest and most cost-effective approach is to involve the Aging Network (and other CBOs as appropriate) from the start, rather than having health systems attempt to reinvent an already successful model of home and community-based services and supports by building new systems themselves.

For example, we encourage CMS's Center for Medicare and Medicaid Innovation to seed new partnerships between the medical community and the Aging Network. New efforts in this area have the potential to better integrate health care and community services through models such as Medical Homes, Medicaid Health Homes and new demonstration projects that better coordinate care to dually eligible individuals.

- **Prioritize Prevention and Wellness**

  The Prevention and Public Health Fund (PPHF) established under the Affordable Care Act represents a critical investment in promoting wellness and preventing and managing chronic diseases that are a primary driver of health care costs. Supporting evidence-based prevention and wellness programs for older adults is imperative given the nation's aging population and growing rates of chronic disease. Lawmakers and administrators should build upon proven, cost-effective evidence-based health promotion and disease prevention programs for older adults at the community level, including chronic disease self-management and falls prevention programs provided by the Aging Network under the Administration for Community Living (ACL) leadership. These programs deliver proven results and reduce Medicare and Medicaid costs. n4a supports the Administration's FY 2016 proposal to allocate $8 million of the PPHF to ACL for the Chronic Disease Self-Management Program, and we encourage Congress to again fund AoA falls prevention activities through the PPHF, at least meeting FY 2015's level of $5 million. Additionally, we support CMS initiatives to identify, expand and replicate best practices in chronic disease self-management and falls prevention to further advance the evidence base for these effective programs.

We also support the following recommendations that our colleagues have submitted in response to your request for information and that we believe will also help you to achieve the bipartisan goals identified.

- **Include CDSME in New Medicare Billing Codes for Complex Chronic Care**

  Medicare billing codes for Chronic Care Management services should include the provision of Chronic Disease Self-Management Education (CDSME). Considering that the vast majority of chronic condition management takes place outside of the health care setting, Aging Network and other providers should be able to bill for those patients who attend a CDSME workshop either in-person or online. These workshops are available throughout the country, with more than 256,000 participants to date.

- **Create a Demonstration Program on Medicare Diabetes Self-Management Training**

  Currently, Medicare Part B covers Diabetes Self-Management Training (DSMT), which is designed to educate beneficiaries with a diabetes diagnosis about their disease and how to better manage it. The benefit began in 2002 and provides compensation for up to 10 hours of DSMT each year. To date, only 2-3 CBOs have made significant progress toward the goal of Medicare reimbursement for DSMT delivery. Our understanding is that these early adopters reported that the process is more difficult than expected, and we share the recommendation that these important efforts can be streamlined to offer a simpler, more direct path for CBOs to offer evidence-based DSMT. Participants would need to comply with important Medicare standards while burdensome administrative barriers would be waived.

**Importance of Seeking Solutions beyond Medicare**

Lastly, while we strongly support and appreciate the Committee's efforts to look at strategies to reduce Medicare costs for individuals living with multiple chronic conditions while improving the quality and efficacy of that care, we also strongly encourage lawmakers to look beyond policy solutions that focus exclusively on Medicare payment for acute services.

Again, we strongly recommend that policy options better and more effectively integrate acute care and LTSS. As evidenced by recent proposed regulations for Medicaid managed care, the health care landscape is changing, and there is an enhanced focus on aligning health care systems. We urge the Committee to adopt a holistic approach to services, incorporating LTSS and removing outdated restrictions that prevent Medicare from utilizing a broad array of home and community-based services in coordination with Medicaid.

Thank you for your commitment to exploring innovative and bipartisan strategies aimed at creating and improving policy to better achieve the triple aim. We look forward to working with you to further identify common-sense and cost-effective solutions to serve the health and social needs of Medicare beneficiaries and to identify opportunities to better align acute care and community-based LTSS systems.

Sincerely,

Sandy Markwood
Chief Executive Officer