October 15, 2023

Chairman Michael Burgess, M.D.
Health Care Task Force
House Budget Committee
2161 Rayburn House office Building
Washington, DC 20515

Dear Chairman Burgess,

Thank you for the opportunity to respond to the Health Care Task Force's request for information on actions Congress could take to improve outcomes while lowering health care spending. The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 mission driven aging services providers that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

We are pleased to see that the task force is interested in working to modernize and personalize the health care system, support innovation and increase patient access to quality and affordable care.

For older adults, it will be difficult to achieve these objectives until we first break down the government silos. Therefore, we recommend an important first step Congress can take is to instruct the White House to create an Office on Aging that can take a whole of government approach to the problems facing our aging population Sustainable long term care financing must be a part of this conversation as well.

We must acknowledge that there are drivers of health care spending that we cannot control like someone's genetics or the demographics. With 10,000 people turning 65 years old every day right now in the U.S, even if we control the per capita costs for these individuals through integration, coordination and early interventions, we as a nation will spend more through Medicare and Medicaid to provide the same services. Congress and regulators can, however, influence access to care, the models through which we deliver care, the services and supports that we pay for and the administrative burdens that regulation and other policies impose on providers. Below we outline some suggestions for tackling those health care drivers we can affect.

1. **Regulatory, statutory or implementation barriers that could be addressed to reduce health care spending.**
   It is important to balance appropriate safeguards for beneficiaries with the burden imposed by the regulation, statute or implementation of a requirement or program. Below we highlight areas where we believe that Congressional action could reduce health care spending in this area.

Nursing Home Staffing Mandate Will Drive Up Broader Health Care Costs in Plethora of Ways.

The first area where Congress could avert adding significant costs to the health care system would be to halt the implementation of the nursing home minimum staffing rule proposed by CMS. The nursing home **minimum staffing standards proposed rule** was published in the Federal Register on September 1, 2023, and proposes a 24/7 Registered Nurse (RN) requirement, minimum staffing for RNs and nurse aides, enhancements to the Facility Assessment requirements, and new Medicaid payment transparency provisions. The Centers for Medicare & Medicaid Services (CMS) estimates that nearly 79% of all nursing homes will need to add additional staff to meet either the 24/7 RN requirement or the minimum staffing standards. Though 38 states currently have staffing standards in place, the minimum staffing standards proposed in this rule exceed existing standards in all states for nurse aides and in all states except one for RNs.

CMS states that "long-term facilities would be expected to bear the burden of these costs, unless payors increase rates to cover costs." Noting that CMS is the predominant payer of nursing home services through Medicare and Medicaid, it would cost nursing homes serving dually eligible residents an average of $5.72 per resident per day to meet the 24/7 RN requirement and $13.96 per resident per day to meet minimum RN and nurse aide staffing requirements (**Table 19** and **Table 26**).

According to the federal Bureau of Labor Statistics, the nursing home and other care facilities' workforce shrunk 410,000 workers nationally between March 2020 and November 2021. While it began to rebound in February 2022, these nursing homes and other residential care facilities still have more than a 200,000-person deficit in their workforce.

CMS estimates the cost of meeting the proposed rule's staffing levels is $40.6 billion over 10 years with an average annual cost of $4.06 billion. Independent estimates of the cost impacts are even greater, including the analysis by LeadingAge using CMS administrative data estimating the annual cost at $7.1 billion. The costs of delivering quality care in nursing homes already far exceed Medicaid reimbursement levels[i], and this unrealistic mandate will force nursing homes to consider limiting admissions or even closing their doors for good, depriving older adults and their families care in their communities. This impact would trickle down to other settings – home health and hospice are also experiencing high levels of referral rejection and a staffing mandate would make these trends worse.[ii]

There simply aren't enough people to hire. As is true for most retail, food service, and hospitality businesses, a mandate will not solve the long-standing workforce shortages impacting nursing homes and the rest of long-term care continuum, particularly in rural and underserved areas. CMS estimates that approximately 75% of nursing homes will need to hire additional registered nurses (RNs) and certified nurse aides (CNAs) to meet the proposed staffing requirements. Many nursing homes have already been forced to utilize staffing agencies at prohibitive and unsustainable costs (this is true across our continuum and would get worse if the mandate were implemented as proposed).

Mandating staffing requirements could decrease access to care across the continuum. Both the acute and post-acute care sectors are seeing workers exit the profession, leaving a void that cannot be filled without bold action. Nursing homes have already reported increasing demands on their

staffing resources, often leading to closures, which disproportionately affect rural areas. The existing workforce shortages are resulting in backlogs at acute care hospitals, which are unable to discharge patients due to reduced capacity in post-acute, long-term care facilities. Further, home health, hospice providers, and PACE providers – already navigating workforce challenges – will be short of even more workers if they move to nursing homes. Shuffling the relatively small number of care workers available between settings won't solve the problem.

Without congressional action to halt this proposed rule:

- **Wages will Increase Further.** Hourly wages will be driven higher to entice people to work. As these higher wages are reported on Medicaid cost reports, reimbursement will increase for these services. Higher Medicaid cost reimbursement will result in a need for more state dollars and more federal dollars to cover these costs.
- **Increase in Agency Staff.** Nursing homes who cannot find anyone to hire to meet the mandate will be forced to pay much higher wages for agency staff to fill these required positions for a time until they run out of funds.
- **Competition Across Health Care for Workers Could Increase Cost of Care.** The demand for nurses, due to the mandate, will further drive-up competition for nurses across health care settings from hospitals to in-home care, potentially placing upward pressure on wages throughout all of health care and resulting in across-the-board health care cost increases.
- **Health care system backups and reduced access.** Nursing homes faced with no one to hire or an inability to pay higher wages or hire agency staff will be forced to reduce the supply of available post-acute care and long-term care beds or will be forced to close because they are unable to generate enough revenue with the remaining beds. Hospitals in these areas and their patients will feel the pinch when these individuals cannot be discharged to a nursing home for rehabilitative care. Because they cannot discharge the person, that bed remains unavailable to the car accident victim or someone having a heart attack. In other cases, families will need to make the tough decision of someone leaving the workforce to care for their loved one.
- **Unfunded, unrealistic mandate versus value-based bonus.** The mandate, as it is proposed, provides no new funding to pay for the estimated 90,000 new staff that will be needed to meet the requirements. The estimated cost of adding these workers, according to LeadingAge analysis using CMS administrative data, is close to $7.1 billion more per year. Alternatively, instead of a stick approach CMS could instead opt to provide a bonus to those who are able to achieve the standards versus punishing them and the entire system for meeting an untenable proposal.

Medicare Advantage Costs Taxpayers More Than Original Medicare

Medicare Advantage (MA) costs more than original Medicare (a.k.a. Fee For Service-FFS). While MA offers Medicare-eligible individuals benefits such as capped out of pocket costs, reduced cost sharing and important supplemental benefits, these "advantages" cost taxpayers more. According to MedPAC, "Medicare spends 6 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $27 billion in 2023. This amount would be even larger if the favorable selection of beneficiaries in MA plans

were taken into account because beneficiaries who choose to enroll in an MA plan tend to be more profitable than beneficiaries who remain in FFS Medicare." It also notes, "The Commission remains concerned that the benefits from MA's lower cost relative to FFS spending are shared exclusively by the companies sponsoring MA plans (in the form of increased enrollment and revenues) and MA enrollees (in extra benefits). The taxpayers and FFS Medicare beneficiaries who help fund the MA program through Part B premiums do not realize any savings from MA plan efficiencies. Instead, Part B premiums are higher for all beneficiaries than they otherwise would be." MedPAC details the many reasons for these excess payments and recommendations for changing this practice. These recommendations for changing this situation warrant a look by Congress.

This overpayment of MA organizations (MAOs) is particularly concerning given that some of these MAOs are wrongfully denying care for Medicare-covered services to beneficiaries in their plans. They also pose a threat to beneficiary access to care due to inadequate payments and administrative burden.

MA plans can be attractive to beneficiaries given their low or no premiums (69% of rural MA enrollees are in a $0 premium plan) and inclusion of supplemental benefits such as vision, dental and hearing. However, as recent OIG reports[iii], Congressional investigations (1, 2) and media accounts (1, 2)have shown, these plans do not always work well for beneficiaries when they need post-acute care services, often denying Medicare covered services. From a post-acute provider perspective, MA plans are typically paying skilled nursing facilities (SNFs) and home health agencies (HHA) providers less than Medicare FFS (often 60-80% of Medicare FFS rates) while imposing a significantly greater administrative burden. As MA enrollment rises, these providers lose any leverage to "negotiate" better rates with these MA plans with providers often signing contracts that initiate a financial death spiral because their choice is between providing services at a low rate or receiving no referrals at all. The result is lower revenues for these providers via not only lower per unit cost but also fewer units of service, and increased costs to hire additional FTEs to manage the costs associated with submitting prior authorizations and claims to the various MA plans. 91% of Medicare Advantage enrollees must get prior authorization to receive home health services and 99% must get prior authorization to receive SNF services.[iv] While plans indicate they are reducing health care expenditures, it is on the backs of post-acute care providers and beneficiaries who are wrongfully denied Medicare covered services based upon an artificial intelligence algorithm.

Considering Medicare FFS payments in a vacuum is simply not an option in this environment. We need Congress and its advisors (i.e., MedPAC) to recognize that provider margins cannot be examined in siloes. For example, in home health, while the current proposed CMS payment cuts are only in Medicare FFS, the reality is that the impacts of cuts in Medicare fee for service have ripple effects. In both the home health and SNF settings, MedPAC claims that payment must be adequate because providers accept contracts from Medicare Advantage – this interpretation does not reflect that providers must accept Medicare Advantage contracts to stay competitive in the market. Often our members must choose whether to limit access for Medicare Advantage patients due to the administrative and financial burdens of accepting MA – but this pattern limits access for patients. This pattern is even more alarming if you look at agencies that take Medicaid patients. Our members have no leverage to negotiate rates in either Medicare Advantage or in Medicaid.

It is not ideal that Medicare FFS is acting as a financial counterbalance to Medicare Advantage and Medicaid. The government needs to work on ensuring rate adequacy across all payers before disrupting overall access to care through further cuts to Medicare FFS. If policy options that ensure rate adequacy in both Medicare Advantage and Medicaid, smoothing of costs across payers might be appropriate. But in the current environment, continued reductions in Medicare FFS payment in conjunction with a shift of the population to MA and its inadequate provider payments will simply result in reduced access to care.

Medicare Advantage plans have received increases from CMS year over year – an 8.5% increase in CY2023 and a CY2024 increase of 3.32%– and rarely is any of that increase passed along to providers. **Congress should eliminate the non-interference clause** (Sec 1854 (6)(b)(iii) of the Social Security Act) in the Medicare Advantage law that prohibits CMS from intervening to set a Medicare FFS as the rate floor or to instruct plans to contract with providers through value-based arrangements that reward providers for delivering high quality outcomes. CMS should be permitted to ensure continued access to health care providers in rural and underserved areas through these types of measures but are currently handcuffed.

LeadingAge has outlined a number of areas where policy changes need to be made in MA in our white paper Medicare Advantage: Fulfilling the Promise including some administrative simplification measures.

Regulatory Burdens That Drive Up Costs

Reducing the regulatory burden on providers would free up resources to focus on beneficiary care, staff, and other critical aspects of operations. Oversight -- both for quality and for fraud and abuse – are important but in their current form, these tools are not having the desired impacts. We recommend the Committee look at ways to reduce burden and increase the efficacy of existing safety, quality, and oversight tools.

Congress should promote transparency and efficiency amongst CMS' audit contractors to shift the focus of current audit and recovery practices from obtaining large initial "overpayment" recoveries to halting billing practices and patterns that clearly reflect failure to comply with fundamental requirements of the program. We recommend:

- Re-focusing its audit contractors on patterns and practices characteristic of providers that aim to minimize or avoid therapeutic care and supportive services that are required under relevant Medicare programs.
- Placing emphasis on the education of providers rather than recovery of payments and ensuring there are clear definitions and standards communicated effectively to providers and that are applied uniformly in the audit process.
- Requiring substantive education and training for all auditors that is consistent with the education given to providers to minimize inconsistencies.
- Modifying the audit, recovery, and appeals processes to reduce the need for lengthy adjudication and reduce the burden for typically compliant providers. Included in this should be a procedure for centrally monitoring audits across all contractors to ensure a high bar for why a provider must go through multiple audits simultaneously. Additionally, there should be an opportunity for mediation with the MAC to explain the provider's justification for the billing and correct auditor errors before denial or recovery of claims are initiated; and

- Increasing transparency of CMS contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, and top denial reasons.

While we hear about this burden most frequently from our hospice members, we strongly recommend that the Committee consider implementing more transparency and accountability measures on audit contractors to ensure taxpayer dollars are being directed toward the right targets.

Another way to strengthen program oversight and reduce administrative burden on providers would be to standardize some MA processes from credentialing to a uniform prior authorization form and claim form, a single reporting portal for these processes.

2. Efforts to promote and incorporate innovation into programs like Medicare to reduce spending and improve outcomes.

Reduce costs by adopting interventions that work in the VA and Medicaid in Medicare. CMS is well aware that social determinants of health and non-medical services make a big difference in the ability of beneficiaries to remain in the care setting of their choice and reduce unnecessary medical utilization. Both Medicaid and the Veterans Administration offer more non-medical support services than Medicare. Congress could instruct CMS/CMMI to test whether Medicare payment for services like adult day, meals, transportation, and increased personal care have an impact on the cost and quality of Medicare services. Medicare Advantage plans have been given some flexibility to do this through the Value Based Insurance Design model and through supplemental benefits more broadly. In addition, we urge CMMI to be bold and test payment for a bundle of long-term care services and see the impact on Medicare spending. In the case of adult day services, studies show reductions in health care costs for those using adult day services due to the lower cost of adult day vs. a long0stay nursing home placement, and reductions in emergency room visits. (studies here: 1, 2,) Adult day services offer a broad range of services from socialization and activities to comprehensive skilled nursing tasks such as management of feeding tubes and wound care. For most participants, their ability to attend the day center allows a family caregiver to continue working and maintaining a home. Without availability of adult day services, most participants would need nursing facility placement. As the task force reviews ways to avoid the onslaught of Medicaid-paid nursing facility stays, policy innovations are necessary to support family caregivers and allow nursing facility eligible individuals to remain in their community homes. Adult day providers offer both respite to the family caregiver while also being a trusted source of knowledge and referral as the older adult's needs progress. Most participants at adult day centers have some limitations with their activities of daily living, while a very high percentage at most centers also have dementia. As dementia progresses, families and caregivers are faced with new challenges and seek counsel from adult day providers.

Healthcare Cost Driver: Lack of Affordable Senior Housing

The lack of affordable housing for older adults with very low incomes is key driver of U.S. healthcare costs.[i] In 2021, the most recent year for which data are available, 2.35 million older adult's renter households with incomes below 50% of their area median income spent more than half of their incomes for housing. As a result of this severe shortage of affordable senior housing, there has been

an alarming increase in homelessness among older adults. Between 2019 and 2021, the number of older adults with chronic homelessness living in shelters increased by 73%. People experiencing homelessness can be among the highest cost patients in the healthcare system.

Several years ago, the University of Illinois Hospital and Health Sciences System (UI Health) discovered that approximately 200 of its chronically homeless patients fell into the 10th decile for patient cost, with an annual, per-patient cost in the range of $51,000 to $533,000. Beginning in 2015, the University of Illinois Hospital, part of UI Health, worked to move 25 individuals experiencing chronic homelessness into affordable housing connected to services and supports. The health system saw a 42% drop in participants' health care costs almost immediately. On the utilization front, the hospital has seen a 35% reduction in use of the emergency department and an increase in patients accessing clinics for routine care.

We have become increasingly aware of the impact social determinants of health or social risk factors such as access to affordable, safe housing have on health care outcomes. And yet, we have yet to connect the efforts of HUD and HHS for older adults. In addition, Congress has not kept pace with the need to invest in affordable housing for the lowest income older adults. Today, HUD funds expand the supply of deeply affordable multifamily housing by around 1,200 apartments a year, through programs like HUD's trusted Section 202 Supportive Housing for the Elderly program, a far cry from the 2.35 million affordable senior housing apartments needed. Affordable senior housing connected to voluntary services and supports has been found to lower hospital usage, lower Medicare expenditure growth, increase visits with dentists and primary care providers, and result in fewer nursing home transfers. The cost of our underinvestment in affordable housing shows up in our nation's healthcare programs.

Investing in home modifications is another way to drive down healthcare costs. Community Aging in Place, Advancing Better Living for Elders (CAPABLE), which provides home repair and modifications relevant to individuals' functional goals along with other efforts to improve their self-care ability and functional goals, resulted in $867 less Medicaid spending per month in 2018, on average, for dual-eligible beneficiaries who are over age 65 and experienced difficulties with at least one activity of daily living (ADL). Another study found that the CAPABALE intervention reduced ADL disabilities by 30% in five months. Investments in affordable senior housing pay off in healthcare. There are more than 12.5 million dual eligibles. If we saved $867 per month for each dual eligible, **it could result in as much as $10 Billion + per month in savings or over $1T over 10 years.**

According to HHS, clinical care impacts about 20% of county-level variation in health outcomes, while social determinants of health (SDOH) affect as much as 50%. The lack of upstream affordable housing investment creates significant downstream healthcare costs.

Ensure All Providers are Rewarded for Value-Based Care. CMS has established a goal to have all Medicare beneficiaries and many Medicaid beneficiaries enrolled in an accountable care model by 2030. This is a solid goal, but it does not guarantee that all the providers who deliver care to these individuals are rewarded for the value they deliver within these accountable models. All providers need to be incentivized to communicate, coordinate and collaborate to improve the care delivered if we want to successfully reduce the cost of care. Accountable care is a team sport, but all must be financially incentivized to work toward the same goals. We have been working with CMMI, other

Post-Acute Care provider organizations and the Accountable Care Organizations (ACOs) to craft new models that allow other value-based arrangements such as a nested bundled payment to be part of an ACO so all providers who participate in a beneficiary's care are paid in a financially sustainable way.

Residential-based accountable care models should be permitted. We have seen examples of LeadingAge members who have successfully led risk-based or accountable care models in residential settings such as nursing homes and assisted living communities. However, the Medicare Shared Savings Program accountable care organization model prohibits any providers but hospitals, health systems and physicians from leading this model. The Medicare Shared Savings program statute should be amended to permit more provider types to lead these accountable care models. Residential-based settings have the benefit of daily interactions with the individuals for whom they provide supports and services. They also address their nutritional and transportation needs. This more comprehensive view of the older adult positions them to identify changes in condition earlier and intervene sooner to avoid higher cost settings. Models should test whether an ACO model could work in these settings where the residential facility coordinates services with primary and specialty care and other support services to avoid unnecessary hospitalizations and other high-cost settings and manage chronic conditions. Appropriate interventions like treating in place can reduce Medicare spending.

Administrative Burden

We think there are myriad ways to reduce the administrative burden imposed on providers by their participation in Medicare Advantage plans. As the *Improving Seniors' Timely Access to Care Act* envisions, electronic prior authorizations are one way to reduce costs and provider burden. However, we also think that standardizing some of the forms or portals used by the MA plans could result in reduced provider burden. Congress should encourage CMS to identify processes that could be standardized across Medicare Advantage plans that would result in reduced administrative burden for providers. For example, developing a standardized form for prior authorization requests for traditional Medicare benefits. If all plans must follow the same coverage criteria for traditional Medicare benefits and are not permitted to have additional internal criteria for these services, then it would follow that it would be most efficient for all providers to submit the same information to every plan. Therefore, this is a case where CMS could create a standardized form to ensure that all coverage criteria are followed for traditional Medicare and MA benefits. A standardized form would reduce the administrative burden on providers seeking approvals by eliminating multiple different forms and processes to obtain the needed prior authorizations. A standardized form could also streamline the approval process at the plan level as reviewers would know where to look for the critical information needed to decide whether the request complies with traditional Medicare criteria and eliminate the need to comb through volumes of data. This could reduce the time to make these decisions and speed beneficiary access to needed services. In addition, it increases the likelihood that decisions are made correctly the first time, because the necessary information is easier to be found by the reviewer. Correct initial decisions are good for the beneficiary as it expedites their access to needed care and could minimize their need to appeal. To date, post-acute providers have added FTEs to their organizations for the purpose of processing prior authorizations, claims, audits and other administrative burdens imposed by the fact that each MA plan has its own form, communication

channel and requirements that a provider organization must keep track of to get paid.

3. CBOs modeling capabilities on health care policies, including limitations or improvements to such analyses and processes.

LeadingAge has observed that the Congressional Budget Office does not include cost savings in its estimate of the cost of new policies. In health care, substitutions of care and care avoidance have shown to reduce costs to the health care system. CBO's failure to include such cost savings or offsets of costs due to a proposed policy change creates an incomplete picture of the true costs of a policy. Congress should instruct CBO to amend their current practices to include cost savings and offsets in their calculation of the net impact of a policy on health care spending.

4. Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long term health costs.

Many LeadingAge members are innovators. They see a need in their communities and seek ways to partner to address it. Below are a few examples of programs that LeadingAge members participated in and/or lead the development of that provide strong examples of how we can improve health outcomes for individuals in the community through the right interventions and save money.

TANDEM365[1]

TANDEM 365 was established in 2009 by two LeadingAge members seeking to reduce hospital readmissions by closing service gaps for older adults who are age 55 and have complex care needs and high costs. Today, this in-home integrated care model is delivered by four LeadingAge members who are competitors, and a local ambulance company.

Like LeadingAge's proposed integrated service model, TANDEM365 takes a team approach to customizing care for the older adult. The model also provides a single point of contact – a nurse or social work navigator – who helps the older adult access needed services and supports so he or she can remain at home. Like the LeadingAge model, TANDEM 365 features an aging service plan (called a "life plan") that the interdisciplinary team develops in collaboration with the older adult.

TANDEM365 delivers non-traditional services that are not typically reimbursed by insurance plans. These include:

- Meals.
- Transportation.
- Telehealth.
- Personal emergency response systems.
- Personal care.
- Navigators who attend doctor visits or meet an older adult in the ED, when necessary.
- Round-the-clock rapid-response support from an emergency medical services team.

[1] http://tandem365.com/

Commercial payers have acknowledged TANDEM365's three primary values: lower cost, satisfied members and improved outcomes. One payer, PriorityHealth, initially helped pilot the program among plan members whose health care spending exceeded $25,000 per year. PriorityHealth paid $625 per month for every member participating in TANDEM365.

The initial pilot showed these results for the program's high-touch, in-home services:

- Inpatient hospital stays reduced by 38%.
- Emergency Department visits reduced by 52%.
- Overall total cost of care lowered by 35%.[2]

In subsequent years, TANDEM365 reports average health care costs are down 30.2% for participants and Emergency Room visits are down 46.2%.

Following the successful pilot, PriorityHealth penned a three-year contract to continue its partnership with TANDEM365 through a new, risk-sharing arrangement. TANDEM365 was also asked to pilot its program with Blue Care Network of Michigan. For more information about TANDEM365: https://tandem365.com/.

SASH

The Supports and Services at Home (SASH) program was created by LeadingAge member Cathedral Square Corporation in collaboration with multiple health and aging services provider organizations. Launched in 2011, SASH is an affordable, housing-based care coordination program that serves as an extender to community health teams (CHT) supporting Vermont's statewide medical home model.

Teams composed of housing-based care coordinators and wellness nurses work with dedicated representatives of community-based service agencies (Area Agencies on Aging, Visiting Nurse Associations, and mental health agencies) to support participating residents in one or more affordable housing communities. The teams may also serve Medicare recipients living in the communities surrounding the housing properties.

SASH teams:

- Conduct comprehensive assessments of residents to identify any health- and wellness-related needs.
- Help those residents access and arrange services to address identified needs.
- Provide onsite wellness and prevention programs.
- Coordinate with the CHTs to assist individuals who have complex needs and monitor those individuals in the community.
- Work with local hospitals to help support and monitor transitions home after a hospital stay.

[2] http://tandem365.com/wp-content/uploads/2014/01/T365-PlanteMoran-Report.pdf

Initially, the SASH care coordinator and wellness nurse were primarily supported through Medicare's Multi-Payer Advanced Primary Care Practice demonstration.[3] The care coordinator/wellness nurse team currently continues to receive Medicare support through the states Vermont All-Payer ACO Model.

Across Vermont, approximately 5,000 individuals living in more than 100 housing properties and in the surrounding communities are participating in the SASH program. An ongoing evaluation has found that SASH is slowing the growth of total annual Medicare expenditures for participants in early-launching housing properties by an estimated $1,227 per beneficiary per year, compared to non-participating individuals.

The SASH program is another example of how integrated service models are most successful when they start with the needs of individuals where they live and connect and surround those individuals with needed services through an accountable group of providers.

Rural Connected Communities

What we hear from both rural and underserved areas is that funding and flexibility to bring community partners together is one of the keys to promoting innovative practice. It involves putting older adults and their families at the center of the system. Our system as currently constructed does not reimburse for the time needed to form the relationships that lead to effective interventions nor to provide services like transportation, maintenance in the home, care coordination, socialization and others that have proven effective in keeping people in the setting of their choice for longer.

We recommend the task force explore ways to reimburse for these aspects of providing services and supports. One example where this type of approach is working is the Connected Communities Grant Project being run by our state partner, LeadingAge Minnesota. Each Connected Community pilot includes the area hospital(s) and/or health system(s), nursing homes, home health agencies, assisted living providers, local area agencies on agency and tribal agencies, home and community-based service providers, social services, physicians, local public health, and area health plans (the payers). What is unique, is that the effort is coordinated by an aging service provider that has proximity to consumers, clinical providers, and community systems. It really is a whole system, person-centered approach. While the details are community-informed, each pilot agrees to address community planning, care coordination, quality improvement, and social engagement as part of their initiatives. To date, the program is seeing the development of deeper relationships across the participating partners resulting in shared problem solving and resources to meet community needs, greater identification and interaction with community individuals before they need care, and the creation of a comprehensive inventory of available services and supports in the community.

This type of approach is local but there are aspects that are replicable including creating a local coalition to lead this community-based work and break down barriers across sectors, completing a comprehensive review, taking a population health approach, engaging older adults in healthy aging, and

[3] Several care coordinators are also funded wholly or partially as service coordinators through the U.S. Department of Housing & Urban Development. The program also receives support from Medicaid, other state agencies and foundations.

building a community-specific care management model that can address needs unique to that geographic area, especially in rural areas.

While programs like Connected Communities and similar initiatives, require upfront investments to support the effort, we believe the f early interventions, connecting community-swelling beneficiaries to needed services before an emergency and not duplicating efforts but addressing community gaps and needs jointly through a non-siloed approach will reap longitudinal savings for Medicare and Medicaid. Congress can support such developments through upfront planning and implementation funding, creating new payment structures for longitudinal population health management and other sustainable funding streams for services that help people stay in the community.

5. **Recommendation to reduce improper payments in federal health care programs**

Today, Medicare and Medicare Advantage claims, provider credentialing, appeals, and quality measurement, etc. occur through separate processes. By standardizing this data collection via a single portal, policymakers would be more easily be able to identify situations where multiple claims are made for the same service, compare quality and value delivered by the two programs on a per capita basis, and reduce provider costs associated with the administrative burden of needing to report into a variety of payer systems all demanding different information.

Thank you for the opportunity to contribute our thoughts and perspective on ways to modernize health care and reduce health care spending. We would be happy to continue the conversation on any of the points we've made here or other questions you may have.

Sincerely,

Nicole O. Fallon
Vice President, Integrated Services & Managed Care
LeadingAge
nfallon@leadingage.org

[i] MACPAC. (2023, January 6). *Estimates of Medicaid Nursing Facility Payments Relative to Costs : MACPAC*. https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/

[ii] https://homehealthcarenews.com/2023/07/referral-rejection-rates-patient-complexity-in-home-health-care-reaching-all-time-highs/ and https://hospicenews.com/2022/02/18/referral-rejection-rate-for-hospice-reaches-all-time-high-of-41/

[iii] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

[iv]https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

[i] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf