A LeadingAge CAST Report

Leading by Example:

CAST's Role in Helping LeadingAge Members Turn Core Competencies into Sustainable Business Models

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LeadingAge™ CAST
center for aging services technologies

Leading by Example:
CAST's Role in Helping LeadingAge Members Turn Core Competencies into Sustainable Business Models

A program of LeadingAge

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LeadingAge Center for Aging Services Technologies:

The LeadingAge Center for Aging Services Technologies (CAST) is focused on development, evaluation and adoption of emerging technologies that will transform the aging experience. As an international coalition of more than 400 technology companies, aging-services organizations, businesses, research universities and government representatives, CAST works under the auspices of LeadingAge, an association of 5,400 not-for-profit organizations dedicated to expanding the world of possibilities for aging.

For more information, please visit LeadingAge.org/CAST.aspx

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Introduction

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At the October 2010 meeting of the LeadingAge CAST Commissioners, Chair Mark McClellan M.D., Ph.D. challenged CAST to take steps during 2011 to educate aging services providers about innovative business and operational models and to provide members with the tools they need to successfully implement those models. CAST has been working on several fronts for the past six months to meet that challenge.

CAST developed an 18-month work plan that calls for a multi-pronged effort to meet Dr. McClellan's challenge. Several steps in that work plan had already been accomplished by April 2011 when the CAST commissioners gathered in Washington, D.C. for their spring meeting. For example, we had recently completed a scenario planning process to define a vision of what the future will look like for aging services providers and to identify actions our members can take today in order to succeed in a future operating environment that promises to be challenging. That planning process helped CAST identify several delivery models that LeadingAge members could implement in the coming decade as well as the market forces that might cause those models to thrive or languish.

A second major component of our work plan, which is now underway, involves identifying specific components of future technology-enabled business models. Before year's end, we expect to share these business models with CAST and LeadingAge members through a report that will also include detailed case studies illustrating provider efforts to advance these models.

Finally, the business models and case studies that we are currently developing will be featured in a video that CAST will produce for viewing by LeadingAge members, their boards of directors and their community partners. The work plan's final stage will find CAST working to create an implementation guide that offers members a blueprint for how to move into the future using technology-enabled business models, in collaboration with CAST sponsors and members.

Discussions at April's CAST Commission meeting focused squarely on this work plan and the issues that should be addressed through our business model exploration and the subsequent development of our video and implementation guide. The following report captures the tenor of that discussion while outlining both the challenges and the opportunities that face CAST and LeadingAge members as the national movement to reform our health care system moves forward. Specific discussions, which are summarized in this report, include the following topics:

- **Payment Reform**. In his ongoing effort to educate LeadingAge and CAST members about the role they can play in the implementation of the Affordable Care Act, Mark McClellan provided more information about the evolving Accountable Care Organizations (ACO). Dr. McClellan also reviewed new performance-based payment options associated with heath reform and offered helpful recommendations for developing business models that incorporate these payment options.
- **Future Delivery Models**. CAST Vice President Majd Alwan reviewed the primary findings

of our scenario planning process, which identified key uncertainties about the future and delineated three categories of future business models.

- **Future Challenges and Opportunities**. The commissioners spent several hours identifying the major challenges that will face LeadingAge members in the future and exploring a number of strategies that CAST could pursue to help members address those challenges.

Part 1:

Payment Reforms: Incorporating Health Reform into Business Models

Mark McClellan, MD, Ph.D.
CAST Chair
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Leonard D. Schaeffer Chair in Health Policy Studies
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The convergence of health care reform and the fiscal pressures facing our country provide both challenges and opportunities to providers of long-term services and supports. CAST and its members need to find innovative ways to integrate promising technologies into our delivery systems so we can continue to provide the most vulnerable older consumers with the services and supports they need in the settings where they want to live. We need to pursue these goals while addressing the cost-related challenges that we currently face and that promise to become much more onerous in the future.

I'm optimistic that CAST and LeadingAge members can meet this enormous challenge and I'm convinced that health reform will give us a historic opportunity to do so. But we must act with a real sense of urgency.

During the next two years, we need to make a strong business case for technology-enabled services and supports and advocate for policy changes that connect the major technological tools available to us with the new care delivery models that are now beginning to emerge. Otherwise, the opportunities that health care reform might have afforded us will be lost.

Background on Health Reform

The long-term sustainability of our health care system – that is, its ability to deliver high-quality care to the people who need it the most at a cost we can afford—will depend on how long-term services and supports are integrated into the implementation of health reform. That's because our high healthcare costs are driven largely by the consumers that LeadingAge members encounter every day: frail older people who have multiple chronic conditions.

Fortunately, health policy makers have finally recognized that we can serve these at-risk individuals best and most affordably if we reduce care fragmentation and increase quality. To achieve these goals, health care reformers are attempting to encourage care coordination, bolster performance measures and align those measures with reforms in how providers are paid. We're seeing, for example, an emphasis on episode-based and capitated payment programs, as well as Accountable Care Organizations (ACO), which are groups of providers who share responsibility for managing and coordinating efficient, quality care for a specific patient population.

The basic themes of health reform should be familiar to LeadingAge members because these themes focus on promoting the holistic, person-centered approach to chronic disease management that has been a hallmark of their organizations. Therefore, CAST has the challenge—and the opportunity—to present a clear plan for how providers of health and long-term services and supports can help a reformed health system adopt this holistic, consumer-centered approach.

LeadingAge members that participate in ACOs, for example, will be well positioned to advance this ho-

listic approach while making meaningful contributions to health reform-mandated efforts to increase quality and reduce costs. Unfortunately, many new health reform initiatives, including ACOs, are not being designed to fully integrate long-term services and supports. Our challenge is to correct that oversight and gain a meaningful role for technology-enabled long-term services and supports in the implementation of this historic reform movement.

ACO Regulations

The proposed ACO regulations that the Centers for Medicare and Medicaid Services (CMS) released in April 2011 provide valuable insight into the direction and intent of health care reform. The regulations speak directly to the aspirations and strengths of long-term service and support providers. For one thing, they strongly reflect CMS's concern about that vulnerable segment of the older population that has high rates of frailty and chronic illness but very limited financial resources to pay for the substantial amount of care they require. In addition, the regulations include a variety of performance measures that encourage care approaches that many LeadingAge members have already implemented. These include the development of individualized care plans for older consumers, involvement of beneficiaries and their family members in care planning and decision making, and concerted efforts to help frail older consumers with medically complex conditions maintain their health and independence. The regulations also call for a variety of performance measures that address such issues as care coordination for frail older persons and the patient experience of care.

CMS has developed two approaches for how members of the ACOs will be paid for the coordinated care they provide. Significantly, both approaches are based on patient outcomes and depend on the close tracking of both care costs and the ACO's progress in meeting performance measures. Under one payment option, an ACO that lowers care costs while improving patient outcomes will share in the savings it creates for Medicare. Under the second payment option, called a two-sided risk version, ACOs gain higher rewards for lowering Medicare costs but also run the risk of losing some of their funding if the cost-per-beneficiary turns out to be higher than expected.

The 60-day comment period set aside for the ACO regulations ends in early June 2011. This comment period gives CAST and LeadingAge a good opportunity to support CMS's concern for vulnerable, frail Medicare beneficiaries and to recommend ways in which the regulations might be improved to better address the needs of a population that LeadingAge members know so well. In addition, LeadingAge and CAST can use the comment period to infuse their own values into health care reform's implementation. This can be accomplished by:

1. **Advocating for better measures of performance**. Our current system pays providers based on factors that are easy to measure, like what happens during a hospital stay or the acuity level of a nursing home resident. Unfortunately, we haven't done as good a job of measuring progress in reaching outcomes about which we care most, like whether care coordination is really working, whether medical complications are being prevented, or whether older consumers and their caregivers are happy with the care they receive. Providers of long-term services and supports want payment options and policies that support these issues. But that

won't happen unless we can measure this type of performance confidently and in ways that make sense to policymakers and consumers. The Long-Term Quality Alliance, a group that is supported by LeadingAge, is making progress in developing measures that can fill these gaps. But many other providers need to get involved in the process of developing and advocating for these measures.

2. **Making a case for technology**. As we move away from Medicare's traditional fee-for-service payment system, it will become increasingly important to give policymakers and beneficiaries good reasons to believe in the role that technology can play in reducing costs and improving performance. CAST must find a way to describe promising technologies clearly, demonstrate that technology-enabled services are actually better services, and offer reassurances that technology enhances human interaction while enabling the kind of care coordination that is at the heart of health reform.

3. **Providing meaningful examples**. CAST won't get its message across by eloquently professing good theories about the efficacy of technology-enabled services and supports. Instead, we need to show concrete examples of the good outcomes that LeadingAge members are already achieving though technology-enabled services and supports. CMS needs to know that our members are successfully carrying out its care coordination goals, participating in new payment reforms, meeting performance goals, and achieving better outcomes at a lower cost for frail older people with chronic conditions.

Part II:

Scenario Planning: Looking into an Uncertain Future

Majd Alwan, Ph.D.
Vice President
LeadingAge Center for Aging Services Technologies, (CAST), Washington, DC

CAST began work in early 2011 on an informal scenario planning process aimed at developing a vision for the future of long-term services and supports. This process was designed to identify potential characteristics of the future operating environment, delineate categories of potential business models that could represent viable options for LeadingAge members, and evaluate how changes in the characteristics of the operating environment would affect these potential business models.

The first part of CAST's scenario planning process involved in-depth interviews with a variety of CAST Commissioners and LeadingAge senior staff, as well as input from members of the CAST Commission. *A Look into the Future: Evaluating Business Models for Technology-Enabled Long-Term Services and Supports* synthesizes these insights and, in the process, attempts to provide a "window into the future" that both CAST and LeadingAge members will find instructive and useful in their own strategic planning efforts. CAST is hopeful that members will use the report to imagine what the next decades could hold for providers of long-term services and supports and to take concrete steps now to begin preparing for the changes and challenges that may be ahead.

Key Uncertainties

Our scenario planning project identified two major uncertainties facing the field of aging services over the next decade: funding and provider adaptability.

Funding: Providers seeking funding for technology-enabled services will continue to be challenged by the fact that innovative payment models tend to lag behind innovative technologies and service models. It is possible that pay-for-performance reimbursement strategies included in the Affordable Care Act, or the willingness of states to reimburse for technology-related expenses, could speed up the development and adoption of technology-enabled service models. But it is also possible that funding for technology-enabled services could be severely curtailed in the unlikely event that health care reform is repealed or that public programs like Medicare, Medicaid and Social Security are cut back dramatically. Providers could respond to these less-than-ideal circumstances by changing the way they do business in order to make services more affordable. In this case, the field of long-term services and supports could see more competition and more use of technology.

On a related note, the lack of a robust private-pay market could delay the day when economies of scale make technology more affordable. On the other hand, the private-pay market could grow if consumers change their current aversion to planning, saving and paying for long-term services and supports.

Adaptability: The second primary uncertainty facing aging services providers is their ability to adapt to new business environments that are likely to emerge in the next decade. Providers who adapt successfully to those environments will find ways to work with acute-care and other partners to offer innovative, technology-enabled solutions for chronic care management or post-hospitalization rehabilitation for example. In order to build their capacity to take these actions, providers will need to strengthen their internal competencies and develop a thorough understanding of their operating environment.

Business Model Categories

In addition to identifying key characteristics of the future operating environment, the scenario planning process helped CAST identify three categories of business models which we believe have the potential to succeed in the future. These categories include:

- **Health-care related models.** These models feature local collaborative health organizations, like ACOs, which deliver integrated and coordinated health care and receive shared payments based on patient outcomes. To be successful, providers participating in these models must have the ability to manage higher acuity patients, offer pre-acute or sub-acute services, deploy technology, share data and partner with a variety of community stakeholders.
- **Community-based support models.** Models in this category include the "CCRC at Home," which delivers meals, services, activities, home maintenance and health care to consumers living in their own homes; home and community-based services delivered to Naturally Occurring Retirement Communities (NORCs) and other independent housing settings; and "village" models through which a membership group organizes and delivers programs and services so its members can

lead safe, healthy and productive lives in their own homes. The success of these community-based models will depend on the availability of reliable and easy-to-manage technologies, a robust private-pay market, providers' entrepreneurial spirit, and the ability of providers to demonstrate that their community-based and technology-enabled programs and services increase independence and reduce cost.

- **Real-estate models.** This category contains continuing care retirement communities, independent living communities, formal housing-with-services programs, assisted living communities and nursing homes. Challenged by the depressed housing market, successful providers in this category will tap into new funding sources in order to use their campuses as launching pads for home and community-based services. Public funds and money available through the CLASS Act could help housing residents purchase services through these models. However, the potential growth of this model will be diminished considerably if funding streams for housing with services are eliminated, not developed or cut dramatically.

Models in each of these categories will use a host of enabling technologies, including teleheath, interoperable electronic health records and health information exchange. Providers will also use technology-enabled care coordination tools and forums, remote monitoring and assistive devices, technologies related to wellness and quality of life, and facility management technology where applicable.

Business Models and Case Studies

CAST is currently in the process of identifying specific business models within each category mentioned above and developing compelling case studies that illustrate these business models and showcase the impressive work that pioneering LeadingAge members are currently pursuing with local care and service partners. Several of these case studies will be selected to be featured in a video that CAST will produce for a provider audience. In addition, the Intel Corporation, a CAST sponsor, has expressed an interest in helping CAST develop blueprints and detailed implementation guides for select future models to help LeadingAge members adopt these technology-enabled business models. CAST will also be working with the LeadingAge Finance Cabinet to explore financing options for these models.

Part III:

Relying on Core Competencies to Gain Future Success

Discussion of CAST Commissioners

Long-term and post-acute care (LTPAC) providers are an important part of the health care system butgwe should participate more in discussions about how that system should be reformed. Education and advocacy is working and can goyfurther toward helping LeadingAge members gain a seat at the health reform table. But these strategies must be combined with member efforts to strengthen and promote the core competencies which, for decades, have set them apart from other health care providers.

These core competencies include (1) unsurpassed expertise in fostering strong relationships with older consumers and their families; (2) tested experience in providing high-quality, consumer-focused hospitality and wellness programs; and (3) a long tradition of engagement in their local communities. These competencies make long-term and post-acute care providers particularly skilled at serving the vulnerable consumers about whom health reformers are most concerned. When coupled with proven business models that address current and future operating challenges, these core competencies can ensure an organization's long-term sustainability. Without a doubt, technology will play a key role in allowing providers to continue offering efficient high-quality services that result in positive outcomes for residents and clients while saving health care dollars.

CAST can help LeadingAge members strengthen their core competencies and adopt proven business models. To reach those goals, it should consider:

- Educating providers of long-term services and supports about the value of looking into the future to identify business models and programs and assess which models and programs are likely to succeed in the future operating environment.
- Providing guidance to providers who are not adopting technology-enabled services and supports because current operating challenges prevent them from focusing clearly on future opportunities. To help these providers move forward, CAST might consider establishing a peer-to-peer consulting system through which CAST and LeadingAge members that have successfully adopted technology-enabled service models could share their hard-won expertise with providers interested in pursuing such adoption.
- Participating in policy discussions about new performance measures to ensure that those measures address areas of care that are important to LeadingAge and CAST members. New measures should reflect the valuable role of consumer-centeredness, wellness initiatives and social connectedness in helping vulnerable older people maintain health and independence.
- Identifying and promoting case studies that highlight how a cross-section of LeadingAge and CAST members has successfully adopted technology-enabled business models. These examples should illustrate how technology is helping members prevent isolation among residents, create an environment of hospitality, gather data on an ongoing basis to keep clients and residents safe, and create consumer-focused services and supports.
- Promoting technology as a way to support health reform goals. Our current health care system typically collects patient data only when medical episodes occur and often when the consumer is already in crisis. The use of monitoring technologies, on the other hand, can offer real-time information about consumer well-being that is collected on a day-to-day basis in the consumer's living environment. This continual stream of data allows health care professionals to intervene early with appropriate medications or treatments before a condition becomes serious, thus preventing avoidable hospitalizations, improving quality of life and saving healthcare dollars—all goals of health reform.

- Providing simple blueprints and implementation manuals to help providers adopt enabling technologies like electronic health records, monitoring systems and telehealth.
- Providing more complex blueprints that describe the steps an organization could take to develop new business models that respond to future markets by offering wellness, hospitality and consumer-focused services and supports that are enabled by technology.

Part IV:

Conclusion and Next Steps

CAST has a great deal of work to do as it promotes its vision of person-centric wellness services that are supported by effective technologies and address the health needs of frail older people with multiple chronic conditions. In making our case for widespread adoption of this vision, CAST must and will lead by example.

- CAST will identify existing member programs that powerfully illustrate the key elements of care coordination and consumer centeredness that are currently missing in hospital-based, physician-based and acute-care based focus.
- CAST will promote the core competencies of LeadingAge members, who have a consumer focus, have unsurpassed expertise in providing services and supports in those communities, and can point to a proven ability to offer wellness and hospitality programs from which vulnerable older people can benefit greatly.
- CAST will share examples of our forward-looking members who make this vision concrete by developing and implementing technology-enabled care models that promise to lead the aging services field toward a secure future.

All of this work will take place in the context of health reform. CAST's goal over the next 18 months is to make all LeadingAge members aware of the new payment options that will soon be available to providers as well as the performance measures that will drive those options. At the end of this initiative, more LeadingAge members will be on their way to envisioning and implementing technology-enabled business models that allow them not only to survive, but to thrive, in our reformed health care system.

Appendix A: Updates on CAST Progress

Major CAST Accomplishments for Oct. 2010 – Mar. 2011

- Published "Bringing Aging Services to the Table: A Role for CAST in the Implementation of Health Reform" report of the Proceedings of the CAST Commission Meeting held Oct. 30, 2010, in Los Angeles, CA. The report summarizes ways in which CAST could frame its vision of aging services technologies in the context of health reform while continuing to help its members focus on their core values, capitalize on their competitive advantage in the marketplace, and adopt technologies that advance both.
- Published an analysis of state payments for Aging Services Technologies (AST). The analysis shows that 44 states reimburse for Personal Emergency Response Systems (PERS), 16 states reimburse for medication management and seven states reimburse for home telehealth/telemonitoring. Pennsylvania has the most comprehensive coverage for ASTs in its Telecare program, which includes home telehealth, activity/wellness monitoring, medication dispensing and PERS. New York, South Carolina, and South Dakota also have exemplary reimbursement programs.
- Partnered with Dixon Hughes, LeadingAge premier partner, on a whitepaper titled "Post-Acute/Long-Term Care Planning for Accountable Care Organizations". The whitepaper addresses post acute/long-term care organizations' uncertainty and concerns with the ACO concept and provide some tangible planning tools they can begin to use now without making huge resource commitments.
- Made Dixon Hughes' Strategic Comprehensive Organizational Readiness Evaluation (SCORE©) available to LeadingAge members. This on-line self-assessment tool was designed to help post-acute and long-term care providers evaluate their organizational and environmental readiness to participate in future integrated health care delivery models, such as ACOs. The tool, which is free, is designed for use by leaders of provider organizations.
- Continued to advocate for including long-term and post-acute care providers as active participants in Health Information Exchange activities and potentially other ARRA funded activities including state-designated Health Information Exchanges entities and Beacon Communities.
- Continued to provide guidance and successfully influence LeadingAge State-Affiliates and members in different states to become actively engaged in state HITECH Act initiatives.
- Supported an aging services technology demonstration in New York.
- Assisted in planning technology related educational sessions, where CAST commissioners provided educational presentations, at LeadingAge state affiliate conferences in Texas and Vermont.

- Kept CAST and its members mentioned in main media outlets including newspapers, magazines, trade and industry publications, both in print and electronic media.

HIT Standards Update:

- **LTPAC Certification Discussions**
  - Some confusion exists in the industry between meaningful use certification (not directly relevant to LTPAC, but essential to incentive eligible providers and therefore to those they may be partnering/exchanging information with) and EHR certification. Discussions are underway regarding how to ensure that the two certification approaches are complementary.

- **Promote participation in Health Information Exchange organizations and activities**
  - CAST continues to promote and monitor LTPAC participation in HIE's across the country. In December, ONC unexpectedly released a challenge grant opportunity for LTPAC/HIE initiatives. Almost 15 states applied and four were awarded (Oklahoma, Colorado, Maryland, and Massachusetts were awarded). The Collaborative summit will highlights progress in these areas by both awarded and unawarded states.
  - The Direct project is an ONC initiative that has promising application for early LTPAC inclusion. Direct provides encrypted, authenticated provider to provider communication via state HIE infrastructures. Attaching structured documents to Direct messages, LTPAC, Hospital and Physician providers may be able to implement an "HIE lite" capability using existing infrastructure. CAST and the Collaborative is discussing the potential of this approach with various stakeholders.
  - CAST continues to support EHR adoption efforts by promoting use of HIT toolkits and other resources, doing adoption research and benchmarking where possible, and encouraging networking among adopters.

- **Continue shared policy and standards monitoring with the HIT Collaborative**
  - CAST is a founding partner and active participant in the LTPAC Health IT Collaborative. CAST supports shared policy monitoring and response, co-plans and ck-sponsors the annual summit and the HIE showcase, and co-monitors HIT standards, initiatives and regulatory developments with other LTPAC stakeholders.
  - Collaborative Summit Scheduled in Baltimore, June 13-14. http://www.ahima.org/Events/EventCalendar/Event.aspx?Id=93956e55-e542-40fa-a20d-4cbbc9519f9d . CAST is supporting the Interoperability Showcase at the summit.

- "A Roadmap for Health IT in Long Term and Post Acute Care (LTPAC): 2010-2012" http://www.leadingage.org/uploadedFiles/Content/About/CAST/Resources/2010-2012-LTPAC_HIT_RoadMap.pdf.
- Standards harmonization, implementation, and gap mitigation activities continue under the ONC sponsored S&I Framework. This framework includes harmonization of various CDA/CCD based specifications, and a Transfer of Care workgroup. CAST continues to monitor a variety of state and national transfer of care initiatives to ensure that they leverage existing electronic standards. The Direct project mentioned above has great potential to be a first step accelerator of standards based transfer of care.

CAST Research Update:

CAST continues its efforts to encourage and actively engage in outcome oriented evaluation of aging-services technologies as an essential element to more informed decision-making and wider adoption. Here is an overview of the new opportunities and on-going research initiatives:

AHRQ's Hypertension Study – The hypertension study has wrapped up. A manuscript of technical lessons learned has been accepted in the Journal of Telemedicine and E-Health, and is awaiting final publication. Once it is published it will be made available to the CAST Commission and CAST members. The study has been successful and can be replicated in other congregate settings. A final report is being prepared for AHRQ, and a brochure on this study has been designed, printed and will be distributed for providers and the nutrition center network. Copies of the brochure will be available at the CAST Booth at the Future of Aging Services Conference.

AHRQ's Active Aging Research Center – LeadingAge's application was evaluated. A decision has not been made due to budget uncertainty but we were informed that AHRQ may decide to fund two centers instead of one, with additional funding support coming from another Federal agency at a later date.

Aging Services Technology Study – CAST is responsible for three chapters: Medication Management, Functional Decline and Chronic Disease Management. All CAST chapters have been completed, reviewed by the technical advisory group, on which several CAST Commissioners serve. The National Opinion Research Center (NORC) at the University of Chicago, our partner on this study, submitted these chapters to the Task Order Officer at HHS.

HIT Incentives to other providers – This study is progressing. We reviewed the first two reports and provided input and guidance on the third report to NORC, our research partners on this project.

Evaluation of AOA's Aging and Disability Resource Centers – CAST's participation in this project has been completed which was done in partnership with the Lewin Group. We will see this report after the approval process within HHS. That report will be made available to Commissioners and there may be joint Lewin-CAST presentations on the findings.

Technology and Caregiving project – The National Alliance on Caregiving conducted a survey and those results have been published. CAST participated shaping the questions in that project and our participation was acknowledged.

iKOP project with the Utrecht University of Applied Sciences – CAST continues to participate in this project and CAST VP serves on the steering committee. The project aims to mainly engage students in demand driven research related to e-health in partnership with a number of SMEs. CAST suggested posting the findings of students' projects on the Internet to maximize the benefits to interested parties.

Intel's Scaling Independent Living Research (SILVR) – CAST continues to work with Intel on this project. We participated in a meeting at NIH where the outcome was very encouraging. There is interest from NSF, NIH, AHRQ and The Robert Wood Johnson Foundation in potentially participating in such a large scale research initiative. Intel is working on refining the research proposal which would lead to a planning grant, potentially from NSF and others.

Federal Legislative Update:

While 2010 marked one of the most extraordinary years in history with the passage of comprehensive health reform (the Affordable Care Act), the controversy that characterized the debate over health reform continued. Coupled with the equally historic election in November which returned the House of Representatives to Republican control and reduced the Democratic majority in the Senate, the last quarter of 2010 and first quarter of 2011 have proved to be equally contentious.

Lame Duck Session: November-December 2010

1. In the period between the election and installation of the 112th Congress, the 111th completed key business that affects both Medicare providers and senior housing; all three of these provisions were AAHSA priorities:
   - **a. Medicare:**
     - i. The exceptions process that allows Medicare beneficiaries to be compensated for more than $1700 in outpatient therapy was allowed to continue through 12/2011.
     - ii. The RUGS-IV payment system was implemented in full (repealing a portion of the Affordable Care Act that had bifurcated implementation)
   - **b. Housing:**
     - i. S. 118, which improves the HUD 202 program for existing properties and creates a new category, enriched housing, as a prelude to incorporating services in senior housing (which could include technology), passed, the only housing legislation in the entire 111th Congress.
2. 112th Congress: January-March 2011
   - **a. Health Reform Update**
     - i. As was noted in the Legislative Update prepared for CAST's October 2010 meeting, there were a number of provisions in the Affordable Care Act that either directly or indirectly addressed technology for aging services providers. These included:

1. Creation of a certified EHR Grant Program for Long-term Care Facilities in FY 2011

2. Implementation of a Demonstration Project for Use of HIT in Nursing Homes by March 2011

b. Continued controversy over health reform has delayed or put on hold the various demonstration programs and grants—no funds have been appropriated to implement these programs and it is hard to say when this will happen, given the current environment.

c. CLASS Insurance Program Update

i. This national, voluntary insurance program for long-term services and supports has been LeadingAge's major public policy objective since 2006. Once implemented, CLASS will provide a nationally-managed and administered insurance benefit available to employed adults regardless of health status, which will provide cash benefits for insureds that develop the need for assistance with activities of daily living. One of the specific uses for the cash benefits that is mentioned in the legislation is assistive technology, which could include home modification as well as use of personal technology.

ii. The Department of Health and Human Services (HHS) has delegated responsibility for developing and implementing CLASS to the Administration on Aging, under the leadership of Assistant Secretary Kathy Greenlee.

iii. Greenlee has brought in an exceptional team to develop this unique program. Regulations are expected by October 2012.

iv. As was reported in October, LeadingAge and many of the advocacy organizations that originally supported CLASS have launched AdvanceCLASS, a non-profit educational organization designed to promote and support implementation of CLASS.

v. Controversy that dogged the program during the debate over health reform has not abated, and there is continuing effort by opponents to kill the CLASS Act, including as of March 18, a bill introduced in the House to repeal the Act. An updated Q&A describing the CLASS Act and responding to the various attacks on it was distributed to Commissioners.

vi. Both implementation of CLASS and preventing its premature demise remain major policy objectives for LeadingAge.

d. Budget and Deficit Reduction Battles

i. The 111th Congress unfortunately never completed a budget for FY 2011; the federal government has been operating on short-term "continuing resolutions"

since October 2010. The current CR expires April 8.

ii. The battle over completing a budget for the remainder of FY 2011 has dominated the first three months of the 112th Congress, with new members, who came in on an anti-government, anti-spending platform, driving an effort to reduce discretionary funding such as housing funds, transportation, technology.

iii. The budget for FY 2011 will form the base for the budget for FY 2012.

iv. In addition to struggling to find common ground to enact a budget for FY 2011 (and soon, FY 2012), Congress and the Administration are trying to figure out how they are going to address the more difficult question of how to reduce federal funding so that the federal deficit can be reduced. This battle will address Medicare and Medicaid, and likely Social Security.

Conclusion:

LeadingAge, CAST and other stakeholders continue to work collaboratively to raise the profile of the long term and post acute care community before Congress and the Administration, focusing on interoperability and availability of technology across the health care spectrum. This past summer the collaborative wrote to both the Secretary of HHS and the chair and ranking members of the Energy and Commerce Committee strongly urging that unspent funds from the American Recovery and Reinvestment Act of 2009 (ARRA) be made available to LTPAC providers, noting that "[f]ully incorporating the long term care sector of the health care community in the nation's effort to promote HIT and health information exchange is critical to transforming the health care delivery system. Excluding LTPAC will not only slow the adoption of interoperable HIT, but it risks harm to our most vulnerable citizens as they migrate through the health care system with numerous providers during single episodes of care and over time across multiple episodes of care."

CAST and LeadingAge will continue to support funding for implementation of the grants and demonstration programs in the Affordable Care Act, so that LeadingAge members remain informed and participate. In addition, we continue to work to advance the efforts of the LTPAC collaborative, and seek opportunities to include providers of long term services and supports in any new legislation advancing the use of technology in the health care system.

LeadingAge's Public Policy Objectives for the 112th Congress were shared with Commissioners.

CAST State Policy Update:

CAST Whitepaper: Analysis of State Payments for Aging Services Technologies (AST)

In January 2011 CAST completed a state-by-state analysis of available reimbursement for aging services technologies through Medicaid waiver and other programs. This "living" document will serve as a resource for CAST members and others that will be updated with current information and expanded to insurance reimbursement policies and other relevant payment sources such as tax credits

as such information is made available. The paper shows that 44 states provide reimbursement for personal emergency response systems, 16 states provide for medication management services, and seven states provide for telehealth services while Pennsylvania covers all of the above plus telecare services.

States that cover both telehealth and medication management include Connecticut, Kansas, New York, South Dakota, Wyoming and South Carolina. California, Colorado, Iowa, Minnesota and New Hampshire, New Jersey, Ohio, Utah, Vermont, Virginia, and Washington reimburse for medication monitoring technology services. Wellness activity monitoring is only officially reimbursed in Pennsylvania. Delaware, Arkansas, and Texas are considering expanding their coverage of Aging Services technologies but are frozen due to budget issues. New York, South Carolina, and South Dakota have exemplary reimbursement programs but Pennsylvania seems to have the most comprehensive coverage of Aging Services technologies.

We hope that all the states follow PA's example in not only expanding the Medicaid waiver program to cover a broad range of technologies, like wellness activity monitoring, but also offer coverage of these types of technologies and technology-enabled services through their state options programs to a broader segment of the population.

Cost savings should be the argument used in trying to get the state legislators and governments to expand these types of reimbursements for these types of technologies, programs, and services.

These cost savings will be recognized through the reduction in person visits, hospital readmissions and unnecessary hospitalizations. There would be an extension in independent living and a reduction in institutionalization.

The paper is available at the following link on the CAST website:

http://www.leadingage.org/uploadedFiles/Content/About/CAST/About_CAST/CAST_State_Paymen_%20Analysis.pdf

State Challenge Grant Applications

CAST was pleased to see the ONC's HIE Challenge Grant with one of the focus areas (area two) being on Health Information Exchange with Long-Term and Post Acute Care provider to improve health outcomes around transitions in care.

A number of LeadingAge affiliates, members as well as CAST members and sponsors partnered with their states' HIE and submitted an application under the aforementioned focus area. These affiliates/states include Florida, Rhode Island, Oregon, and California with several receiving support from CAST. Four state HIEs were awarded one to two million dollars to engage long term and post acute care providers in HIE Activities. The awardees were Oklahoma, Colorado, Maryland, and Massachusetts.

Providers and affiliates that partnered with the state HIE on grant applications have fostered good relationships and elevated the importance of participation from providers around HIE activities. For example, RI HIE is now working to enroll 100% of nursing homes in the state in the state's HIE.

Aging Service Technology Policy Updates

New York: Feb. 28 Technology Demo Day at the

State Capital involving the Homecare Association. Vendors will be set up for legislators to stop by and learn about the technologies. CAST supported NYAHSA's efforts.

Texas: There is pending legislation that was proposed to amend the existing telemedicine bill to expand coverage to home telehealth.

California: California is preparing to do a legislative briefing this Spring at the state capital on these technologies and make policy recommendations while providing resources.

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