

ISSUE BRIEF: CARE COORDINATION

There has been significant emphasis in the last several years on care coordination's role in supporting older adults and in reaching the key aims of health care reform, namely improved patient outcomes, enhanced care experience, reduced costs, reduced provider burnout, and equity in outcomes.

This issue brief provides updates to the 2013 care coordination issue brief developed by Eldercare Workforce Alliance (EWA) and the National Coalition on Care Coordination (N3C).ⁱ It includes a synthesis of diverse strategies in use and a vision for how services could be improved.

Care coordination: what, why, who, where, and how?

What and why?

Care coordination is a methodical approach to care that facilitates better communication between and among individuals, family caregivers, and service providers. Care coordination is defined by the Agency for Healthcare Research and Quality (AHRQ) as the “deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.”ⁱⁱ

Well-designed coordination leads to improved outcomes, efficient care, and optimizes support systems for older adults and family caregivers. Care coordination models have designated protocol and guidelines that allow for consistency in approach, focus and scope of intervention, and workflow.

AHRQ describes the following activities typically included in care coordination:

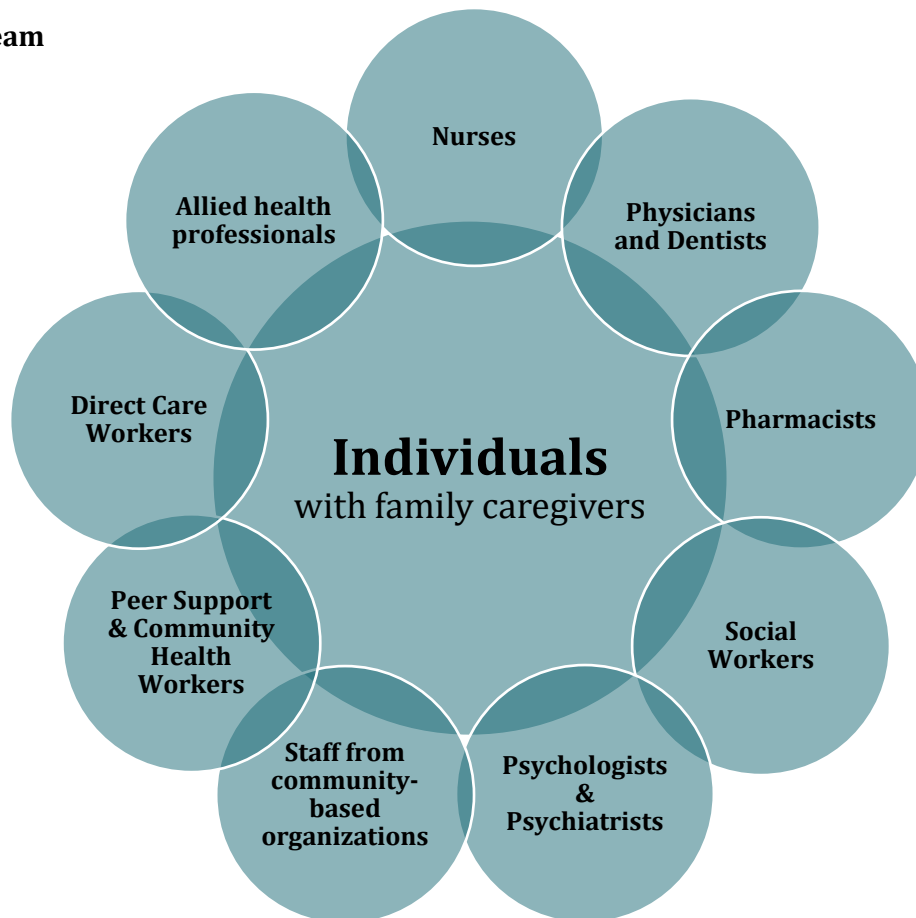
- Establishment of accountability or negotiation of responsibility
- Communication
- Facilitation of transitions between care settings and practitioners
- Assessment of needs and goals
- Creation of a proactive plan of care
- Monitoring, follow-up, and responsiveness to change
- Support of self-management goals
- Linkage with community resources
- Alignment resources with individual and population needs
- Medication management^{tiii}

Who?

Individuals and family caregivers play integral roles in care provision, and their perspectives are central to the success of care coordination initiatives.

Older adults and families often work closely with health care teams composed of a range of disciplines—including, but not limited to, community health workers, direct care workers, nurses, pharmacists, physicians, and social workers—who lead and participate in care coordination initiatives. Care teams can live within a variety of settings, including community-based organizations [CBOs] that are part of the aging network.^{iv} CBOs can play a particularly key role in care coordination efforts, such as by helping to bridge clinical health care and social services, and by supporting self-care for chronic conditions. Local grassroots groups (such as volunteer networks, cultural communities, and faith-based organizations) can also support care coordination efforts.

The Care Team



Where?

Care coordination should be happening wherever and whenever care is provided. Care coordination efforts may be staffed within various settings: office-based primary care teams, house call programs, specialty care teams (such as oncology), hospitals (often staffed by discharge planners or transitional care coordinators), skilled nursing facilities, hospice and palliative care programs, aging network organizations, and housing programs. Insurance plans may have their own care coordinators as well, and approaches that integrate multiple types of care under one team (such as the Program of All-Inclusive Care for the Elderly and Accountable Care Organizations) may have care coordinators that span service settings.

How?

Care coordination activities can be intrinsic to a program—that is, part of the infrastructure—or external to a program—that is, a separate initiative built on top of other services. Although care coordination may be intrinsic to integrated teams, such teams still need to decide how they will work together on the tasks described above, who will take the lead on which tasks (and with which individuals served), and decision-making processes.

Two priorities are necessary to promote effective, efficient care coordination. First, the workforce must be prepared with appropriate knowledge, skills, and training. Second, care design must be streamlined so that coordination of care becomes intrinsic to service delivery.

Learning from care coordination efforts: Strategies and challenges

Care coordination efforts face a core tension: being effective and efficient at the same time. This historic example from early care coordination initiatives provides insight into this tension and the importance of relationships:

Based on successful pilot projects in the late 1990s that showed huge reductions in cost and dramatic improvement in health outcomes through aggressive case management, Medicare launched a national case management payment methodology. Large firms quickly developed with nurses calling assigned individuals to provide case management. By 2007, Medicare determined that the vast majority of these firms failed to deliver on either quality or cost parameters, and the program was essentially discontinued.

Follow-up analysis has shown that the few that did succeed — and the successful pilot projects — had one key element in common: first-name, caring, personal relationships in which the case manager was an advisory friend who got to know the individual and connected with him or her at a personal level. However, the majority of systems used nurses who had no personal connection to the individual, and the calls were often characterized by those receiving them as “harassment” rather than friendly coaching and facilitation.^v

In the years since, numerous strategies have been deployed to engage participants and provide coordinated, relationship-based care in a way that leverages technology and best practices. Standardized care models that leverage these skills can help address the tension of effectiveness vs. efficiency, and also help prepare for and address implementation barriers.

To learn more about specific care models, the Better Care Playbook highlights many specific initiatives in use across the country,^{vi} and the Social Interventions Research and Evaluation Network (SIREN) has a robust library of research related to interventions.^{vii} Moreover, the appendix of this issue brief includes numerous federally supported initiatives in which care coordination plays a central role, including many under the Center for Medicare and Medicaid Innovation (Innovation Center).

Strategies for engaging participants and providing coordinated, relationship-based care

Programs have taken a range of approaches to **identifying appropriate participants for care coordination** by targeting individuals:

- With high medical costs or frequent hospitalizations
- Who are at risk of incurring higher medical costs if their chronic conditions and health-related social needs are not managed appropriately
- Who are eligible for benefits under the Older Americans Act, Medicaid waivers, or other public benefit programs
- Who are referred directly by a provider
- With specific chronic conditions, clinical indicators, or who screen positive for unmet social or economic needs (such as hunger)
- At high risk for adverse outcomes by using predictive algorithms
- Within certain geographic areas (often using geography as a proxy for risk)

A **community-oriented approach is key for engaging hard-to-reach populations**, who may not interface often with the health care system due to access issues. Strategies include:

- Systematic screenings in the community (such as places of worship, health fairs, or libraries) to identify and engage individuals in care
- Implementing a no-wrong-door policy, so any interface with the health system or an aging network CBO opens the door to a coordinated system
- "Hot spotting," or using data to identify and target services (for example, identifying census blocks with high emergency department visit rates for falls and doing targeted outreach, education, and connection to primary care)

Findings to date have identified several key **characteristics that facilitate relationship building and more coordinated care**, including:

- Trusting team relationships^{viii}
- Provider commitment to and understanding of the program model
- Frequent touch points^{ix}
- Person-specific interventions
- Ability to effectively link individuals with services that address broad range of needs
- Use of empathetic language and gestures^x
- Anticipation of an individual's needs to support self-care
- Provision of actionable information
- Minimal handoffs

Implementation barriers

Over the years, several challenges to coordinating care have also been identified, including implementation. Implementing care coordination initiatives generally necessitates changes in workflow, changes in team dynamics, organizational culture, as well as developing new approaches to engage participants.^{xi}

Such changes can be prompted by the following questions:

- How do you reduce burden on interdisciplinary teams and fit your initiative with other initiatives in your service setting?
- How do you reach individuals who aren't engaged in their care or who may be apprehensive about disclosing relevant information or asking questions of their team?
- If your initiative uses a single point person as a care coordinator, how do you prevent the individuals and families served from becoming overwhelmed by an additional contact person?
- How can multiple care coordinators from different settings ensure role clarity and avoid duplication of efforts?
- How do you ensure quality when initiatives spread to other service settings or communities?

Involving multiple interdisciplinary team members and other stakeholders in the planning and implementation stages creates an environment in which these questions can be addressed in a collaborative way. Key stakeholders include individuals served, family caregivers, health care providers, home- and community-based service (HCBS) providers, the individual leading the care coordination process, leadership of the entity (such as a hospital or physician group) implementing the care coordination initiative, payers, and data and information systems teams. This collaborative approach helps identify systemic bottlenecks, promote team and community buy-in, and ensure interventions are informed by diverse strategies and perspectives.

In addition to engaging stakeholders, it is also critical to have a quality improvement from the beginning and throughout implementation. This will ensure the initiative is continually aligned with stakeholders' needs, and will inform best practices and sustainability.^{xii}

Financial sustainability

The move toward value-based care holds great promise for the expansion of care coordination initiatives. At the same time, creating business cases for care coordination efforts remains a challenge. While there is evidence that efforts to improve the service delivery system are slowing Medicare's cost growth,^{xiii} it is difficult to attribute improvements to any one initiative. In particular, care coordination programs have had a difficult time showing reductions on total cost of care, in large part due to care coordination's efforts to "correct underuse and ensure timely access to care."^{xiv}

"Focusing primarily on the financial return on investment from care coordination initiatives distracts from understanding the impact of care coordination on measures like quality of life for individuals served, financial strain for family caregivers, and job satisfaction for care teams."

Moreover, focusing primarily on the financial return on investment from care coordination initiatives distracts from understanding the impact of care coordination on measures like quality of life for individuals served, financial strain for family caregivers, and job satisfaction for care teams. For this reason, it is important to design for evaluation, using measures at baseline and ongoing follow-up that include participant-reported outcomes (such as functional ability^{xv}), process measures, and other costs related to care outside of utilization alone.

Workforce challenges

Although standardized guidelines are important for quality assurance purposes, the use of expert practitioners (from a variety of disciplines) who can “see the whole person” is important, especially in the care of older adults.^{xvi} As such, workforce availability, skillset, and scope of practice considerations have significant import for care coordination initiatives. The shortage of providers of all disciplines who are trained in geriatrics and gerontology continues to threaten the capacity of the health care system to meet the needs of older adults and families. Moreover, the lack of reimbursement mechanisms to support care coordination and to support home- and community-based services presents challenges to attracting the workforce needed now and in the future.

Even when the workforce is available, other barriers stand in the way of full integration. For instance, while clinical psychologists are able to bill Medicare for the Health & Behavior Assessment & Intervention codes, in most states social workers are not able to do so because Medicare statute defines them solely as mental health providers, without recognition of the profession’s longstanding training and experience in discharge planning, case management, and other health care roles.

“The lack of reimbursement mechanisms to support care coordination and to support home and community-based services presents challenges to attracting the workforce needed now and in the future.”

Other systemic barriers

Focusing on care coordination initiatives alone also can miss the importance of addressing systemic challenges to comprehensive and coordinated care, such as:

- Lack of truly comprehensive care plans that span health care and long-term services and supports (LTSS)
- Lack of Regional Health Information Exchanges (HIEs) in many areas, creating a multitude of new vendors that are trying to fill the gap to coordinate care between different health systems and CBOs
- Lack of quality measures^{xvii} that capture what matters most to participants and their families, as well as a flawed readmissions metric that doesn’t incentivize reductions at the population level
- Lack of alignment among reimbursement incentives, which—despite the shift toward value-based care—often encourage volume over value
- Limited availability of resources or services (for example, resources that don’t exist in a given state or community, aren’t affordable, or for which long waiting lists or caps on clients served per year exist)
- Fragmentation exacerbated by care coordination efforts undertaken by multiple entities or by several disease-specific initiatives within one institution
- Barriers presented by data security and privacy requirements (such as HIPAA); although such concerns are necessary and important, they can make it harder for community-based organizations and some health care providers to participate in coordinated delivery efforts.

Care coordination in context

The focus on care coordination is not happening in a vacuum. The last decade has seen a tremendous focus on improving care for all people in the United States—including older adults—through delivery system and payment reforms prompted by the Affordable Care Act and other policies. Such changes include:

- Changing reimbursement mechanisms that incentivize focusing on quality measures like reducing hospital readmissions
- Federally funded demonstration projects that test out new models of care and financing (please refer to the appendix of this issue brief for additional information)
- Opening door for Medicare Advantage insurance plans to offer nonmedical benefits^{xviii}
- Aspects of some state Medicaid waivers that work toward more integrated, community-based health care and LTSS^{xix}
- Fee-for-service billable codes that support coordinated care,
- The use of HIEs, which have successfully allowed providers in many states to communicate with each other in real time

As a result of the ACA and some other policies, there is also an increasing focus among advocates and health care leaders on workforce roles, interprofessionalism, provider burnout, relationship-based care, equity, and implementation science.

At the same time, some systemic changes have reduced access to and quality of care. For example, some states have made it harder to qualify for and stay enrolled in Medicaid, and some Medicare Advantage plans have imposed copayments on home health care that don't exist in original (fee-for-service) Medicare.

“Ongoing efforts to improve the health care system for people with complex health and social needs present many opportunities for growth related to care coordination.”

Other national trends influencing care and care coordination include:

- Threats to long-standing aging services providers and other CBOs, posed by 1) hospitals and insurance plans that opt to build their own programs and services to coordinate care and social supports, rather than partner with and buy services from nonprofit CBOs who have long provided such services in the community—as well as by 2) competition from care management products offered by for-profit entities that are not grounded in local communities and often rely on centralized call centers or automation
- Consolidation (mergers and acquisitions) within the health care industry can either 1) combine different parts of the health care system through vertical consolidation (such as the merger of CVS and Aetna or of a hospital and skilled nursing facility) or 2) expand the reach of entities within their own industry through horizontal consolidation (such as one hospital acquiring another).
- Challenges with comparing quality and impact of “care coordination” initiatives; the term is often used interchangeably with “care management,” “case management,” and “service coordination.” The existence of various credentials and entities supporting care coordination and related practices can also pose a challenge.

Ongoing efforts to improve the health care system for people with complex health and social needs present many opportunities for growth related to care coordination:

- Moving beyond replicating protocol to working on implementation and administrative concerns
- Leveraging the network of Geriatrics Workforce Enhancement Program sites and the workforce development programming produced by this network
- Scaling up successes from Medicare and Medicaid demonstration programs and advocating for permanent benefit changes to allow scalability and sustainability to communities across the country
- Expanding training in geriatrics and gerontology—including the possibility of requiring geriatrics training for physicians, given that Medicare is the leading funder of physician residency programs
- Development of quality measures and other ways of monitoring health and well-being, such as such as the Flourish index, an assessment method that measures 59 quality of care indicators across six determinants of health: biological, psychological, individual health behaviors, health services, environmental, and social^{xx}

It is worth noting that this brief is framed primarily in context of the health care system as it's currently structured. Many advocates argue that the system is fundamentally flawed; these advocates sometimes assert that care coordination initiatives create another layer of care, rather than redesigning the system to provide all care in a more coordinated manner. Such a redesign is the goal not only of federally funded demonstration projects, but also of private initiatives that are under way. In the meantime, health care and CBO leaders strive to improve care within existing systems, making incremental but significant progress toward more coordinated and effective care.

ⁱ http://eldercareworkforce.org/wp-content/uploads/2018/03/EWA_and_N3C_Care_Coordination_Issue_Brief_-_FINAL.pdf

ⁱⁱ <https://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf>

ⁱⁱⁱ <https://www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf>

^{iv} <https://www.aginganddisabilitybusinessinstitute.org/building-partnerships-with-primary-care-to-become-a-hub-for-service-delivery-for-older-adults-in-our-community/>

^v Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. <http://www.ihc.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx>

^{vi} <https://www.bettercareplaybook.org/>

^{vii} <https://sirenetwork.ucsf.edu/>

^{viii} <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5890872/>

^{ix} <https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.14086>

^x <http://www.annfamned.org/content/16/3/225>

^{xi} Helfrich, C. D., Sylling, P. W., Gale, R. C., Mohr, D. C., Stockdale, S. E., Joos, S., ... & Nelson, K. M. (2015). The facilitators and barriers associated with implementation of a patient-centered medical home in VHA. *Implementation Science*, 11(1), 24.

^{xii} <http://www.re-aim.org/about/applying-the-re-aim-framework/>

^{xiii} <https://www.politico.com/agenda/story/2018/09/12/medicare-spending-cost-budget-000692>

^{xiv} <https://www.nejm.org/doi/full/10.1056/NEJMp1610821>

^{xv} Kogan, A. C., Wilber, K., & Mosqueda, L. (2016). Person-centered care for older adults with chronic conditions and functional impairment: A systematic literature review. *Journal of the American Geriatrics Society*, 64(1), e1-e7.

^{xvi} <https://www.ncbi.nlm.nih.gov/m/pubmed/28196576/>

^{xvii} <http://www.nationalacademies.org/hmd/Reports/2018/implementing-quality-measures-community-based-care-serious-illness-proceedings.aspx>

^{xviii} Tumlinson, A., Burke, M., & Alkema, G. (2018). The CHRONIC Care Act of 2018: Advancing care for adults with complex needs. The Scan Foundation. Retrieved from http://www.thescanfoundation.org/sites/default/files/chronic_care_act_brief_030718_final.pdf.

^{xix} Graham, C. L., Liu, P. J., Hollister, B. A., Kaye, H. S., & Harrington, C. (2018). Beneficiaries Respond To California's Program To Integrate Medicare, Medicaid, And Long-Term Services. *Health Affairs*, 37(9), 1432-1441. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0452>

^{xx} <https://www.optimalaginginstitute.org/flourish-care-model>

Appendix: Federal initiatives and demonstration projects

Program of All-Inclusive Care of the Elderly (PACE)

PACE provides comprehensive medical and social services to certain individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care.

PACE serve individuals who are age 55 or older, certified by their state to need nursing home care, able to live safely in the community (with PACE services) at the time of enrollment, and live in a PACE service area. While all PACE participants must be certified to need nursing home care to enroll in PACE, only about 7 percent of PACE participants nationally reside in a nursing home. If a PACE enrollee needs nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care. As of November 1, 2018, there were 123 PACE organizations in 31 states.^I

A U.S. Department of Health and Human Services (HHS) study found higher quality of care and better outcomes among PACE participants compared to clients receiving HCBS through HCBS section 1915 waiver programs. PACE participants reported better self-rated health status; better preventive care with respect to hearing and vision screenings, flu shots, and pneumococcal vaccines; fewer unmet needs, such as mobility and dressing; less pain interfering with normal daily functioning; less likelihood of depression; and better management of health care. Both PACE participants and the HCBS clients receiving care through 1915 waiver programs reported high satisfaction with their quality of life and the quality of care they received.^{II}

Moreover, the PACE care model is achieving these results for less than or the same amount of cost as other programs. In Medicaid, states pay PACE programs on average 16.5% less than the costs of caring for a comparable population through other Medicaid services, including nursing homes and home and community-based waiver programs.^{III} In Medicare, payments to PACE organizations are equivalent to the costs for a comparable population to receive services through the fee-for-service program.^{IV}

Medicare-Medicaid Coordination^V

The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals or Medicare-Medicaid enrollees. The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across federal agencies, states, and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. Focus areas include: coordinated care, cost-sharing, enrollment, fee-for-service benefits, appeals, quality, and access to care.

Home Based Primary Care (HBPC) (Veterans Health Administration)

Home Based Primary Care is health care services provided to Veterans in their homes by a VA physician and the health care team. Home Based Primary Care is for Veterans who have complex health care needs and for whom routine clinic-based care is not effective.

Veterans in the HBPC program receive case management and aid with activities of daily living such as help with bathing, dressing, fixing meals, or taking medicines. HBPC can be used in combination

with other HCBS. Isolated veterans or whose family is experience burden are also candidates for HCBS.^{vi}

Medicare Care Choices Model (MCCM)^{vii}

MCCM enables Medicare beneficiaries who are receiving life-extending or curative care for a terminal condition to receive supportive care services available the Medicare hospice benefit that cannot be separately billed under Medicare Parts A, B, and D. These services include nursing, social work, hospice aide, hospice homemaker, volunteer, chaplain, bereavement, nutritional support, and respite care services.

104 Medicare-certified hospices are participating in MCCM between 2016 and 2020. As of June 2017, 1,092 beneficiaries were enrolled in the model.

The first evaluation of MCCM included the following observations:

- Due to low enrollment, it was too early to measure the impact of the model on cost or other outcomes at the end of life. About half of MCCM enrollees were referred to the model by physician offices (most frequently primary care or oncology). Home health agencies (28%), hospitals (14%), emergency departments (6%), and skilled nursing facilities (1%) also referred enrollees.
- Nearly 40% of MCCM enrollees simultaneously received services from home health agencies while in the model. Enrollees received, on average, 4.1 home health visits per month, half of which consisted of speech, physical, or occupational therapy not covered under MCCM.^{viii}

Community-based Care Transitions Program (CCTP)^{ix}

Under CCTP, community-based organizations (CBOs) used care transition services to effectively manage Medicare beneficiaries' transitions and improve their quality of care. The CBOs were paid an all-inclusive rate per eligible beneficiary discharged from the hospital, based on the cost of care transition services provided at the beneficiary level and of implementing systemic changes at the hospital level. CBOs were paid only once per eligible discharge in a 180-day period for any given beneficiary.

103 collaborations across the country were funded starting in 2011, and 44 were extended through 2015, when the initiative ended.

The final evaluation yielded the following information:

- CCTP participants from all 101 sites combined had lower readmission rates and Medicare Part A and Part B expenditures over periods in which these sites were active in the program, relative to comparable nonparticipants (matched comparisons). Medicare Part A and Part B expenditures were \$634 lower (\$7,064 vs. \$7,698; $p < 0.01$) for participants from the 101 CCTP sites than for matched comparisons.
- Impactful sites “successfully identified beneficiary needs, effectively linked participants with community-based services, and coordinated with post-acute care (PAC) providers. Specifically, successful sites responded to challenges with the provision of support services by identifying new service providers, sources of funding, and ways to connect participants with appropriate services in a timely manner.”^x

Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+)^{XI}

CPC was a four-year multi-payer initiative designed to strengthen primary care, running from 2012 through 2016. Under CPC, CMS collaborated with commercial and state health insurance plans in seven U.S. regions to offer population-based care management fees and shared savings opportunities to participating primary care practices, to support the provision of a core set of five “comprehensive” primary care functions (including many components outlined throughout this issue brief).

442 practice sites participated in CPC. In total, 2,188 participating providers served approximately 2.7 million individuals, of which approximately 410,177 were Medicare and Medicaid beneficiaries. Medicare expenditures for attributed beneficiaries grew less for CPC practices than for comparison practices, but the savings were not enough to cover Medicare’s CPC care management fees.^{XII}

CPC+ builds on CPC with a care management fee, performance-based incentive payments, and changing fee-for-service reimbursement for some participants. There are now 2,900 primary care practices participating in CPC+, in 18 states across the country; that initiative runs from 2017 through 2021).

CPC+’s first year has yielded the following findings:

- CPC+ integrates many lessons learned from CPC, including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, necessary health information technology, and claims data sharing with practices.
- 72% of practices establish collaborative care agreements with specialists (typically, cardiology, gastroenterology, and behavioral health).
- 90% of practices convened a patient and family advisory council.
- 85% of practices in Track 2 screened for unmet social needs.^{XIII}

Geriatrics Workforce Enhancement Program (GWEP)

GWEP is funded by the Health Resources and Services Administration (HRSA) within HHS under the Title VII and VIII Geriatrics Health Professions Programs.^{XIV} In 2018, HRSA funded 44 GWEP centers in 29 states with a specific focus on ensuring that primary care providers have the skills and knowledge to care for older adults. HRSA will be funding a total of 47 GWEP centers in 2019.

GWEP is the only federal program that develops a health care workforce that maximizes patient and family engagement while improving health outcomes for older adults.^{XV} The programs integrate geriatrics and primary care to transform clinical training environments to provide more coordinated and comprehensive care.

In academic year 2016–2017, GWEP centers provided training for 30,082 students and fellows participating in a variety of geriatrics-focused degree programs, field placements, and fellowships. These curricular activities reached a total of 131,293 trainees, 17% of whom were either family caregivers or patients. The majority of GWEP trainees received training in rural settings (69%) or medically underserved communities (84%).^{XVI}

Independence at Home

Independence at Home is a demonstration program under the Innovation Center. Medical practices deliver comprehensive primary care services at home to improve care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration will reward health care providers that provide high quality care while reducing costs.

14 sites across the country provide home-based primary care to targeted chronically ill beneficiaries for a three-year period. The program was set to end in 2018, but was extended by Congress for two additional years.

IAH saved an average of \$2700 per beneficiary per year in the first years. Total 10-year system-wide savings, before excluding cost-share savings, are anticipated to reach between \$2.6 billion to \$27.8 billion, depending on how many beneficiaries the program reaches over time. (Journal of the American Geriatrics Society)^{xvii}

At the same time, some EWA members are concerned that the core care team defined in the Independence at Home demonstration is limited to a narrow group of disciplines—and that the Innovation Center is not tracking staffing patterns as a factor in the success of demonstration sites.

Accountable Care Organizations (ACOs)^{xviii}

ACOs are groups of physicians, hospitals, and other health care providers who join voluntarily to provide coordinated, high-quality care to the Medicare beneficiaries they serve. When an ACO succeeds both in delivering high-quality care and in spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

The majority of Medicare's ACOs (561 of all 649 Medicare ACOs in 2018) are in the Medicare Shared Savings Program (Shared Savings Program or "MSSP"), which was included in the Affordable Care Act and launched in 2012. 10.5 million beneficiaries in Fee-for-Service Medicare (of the 38 million total Fee-for-Service beneficiaries) are in a Shared Savings Program ACO.

In addition to the Shared Savings Program, the Center for Medicare and Medicaid Innovation (Innovation Center) has developed other ACO initiatives, including the Next Generation ACO Model and the Comprehensive ESRD Care Model. ACOs in the Innovation Center's models generally take on greater levels of risk than ACOs in the Shared Savings Program.^{xix}

There are numerous evaluations of the various ACO initiatives on the CMS website and in the literature.

Accountable Health Community (AHC) Initiative^{xx}

Over a five-year period, AHC will provide support to community-based "bridge" organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (specifically, housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs). Funds for this model support the infrastructure and staffing needs of bridge organizations and do not pay directly or indirectly for housing, food, violence intervention programs, utilities, transportation, or other community services. Participating sites are in one of two tracks:

- Assistance Track—Bridge organizations provide navigation services to assist beneficiaries at high risk of housing instability, food insecurity, interpersonal violence, lack of utilities, or insufficient transportation in accessing services to address these health-related social needs.

- Alignment Track—Bridge organizations encourage partner alignment to ensure that community services are available and responsive to the needs of the beneficiaries.

31 sites are participating in the CHC demonstration between 2017 through 2021. No findings have been released to date.

^I <https://www.npaonline.org/>

^{II} Leavitt, M. (2009). *Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.*

^{III} NPA analysis of PACE Upper Payment Limits and Capitation Rates,

<http://www.npaonline.org/sites/default/files/NPA%202016%20UPL%20Paper.pdf>

^{IV} The Effect of PACE on Costs, Nursing Home Admissions and Mortality: 2006-2011, Mathematica Policy Research evaluation prepared for the US Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy (2014)

^V <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>

^{VI} https://www.va.gov/geriatrics/guide/longtermcare/home_based_primary_care.asp

^{VII} <https://innovation.cms.gov/initiatives/Medicare-Care-Choices/>

^{VIII} <https://innovation.cms.gov/Files/reports/mccm-fg-firstannrpt.pdf>

^{IX} <https://innovation.cms.gov/initiatives/CCTP/>, critique <https://medicaring.org/2015/01/26/evaluation-flaws/>

^X <https://downloads.cms.gov/files/cmml/cctp-final-eval-rpt.pdf>

^{XI} <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>

^{XII} <https://downloads.cms.gov/files/cmml/CPC-initiative-fourth-annual-report.pdf>

^{XIII} <https://innovation.cms.gov/Files/reports/CPC+2017-Summary.pdf>

^{XIV} http://eldercareworkforce.org/wp-content/uploads/2018/03/GWEP_AdvocacyToolkit_FINAL_115th_Congress_Update_2.pdf

^{XV} http://eldercareworkforce.org/wp-content/uploads/2018/03/GWEP_OnePager_v2.pdf

^{XVI} <https://bhw.hrsa.gov/health-workforce-analysis/research/projections>

^{XVII} <https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.15314>

^{XVIII} <https://innovation.cms.gov/initiatives/aco/>

^{XIX} "Pathways To Success: A New Start For Medicare's Accountable Care Organizations," Health Affairs Blog, August 9, 2018. DOI: 10.1377/hblog20180809.12285

^{XX} <https://innovation.cms.gov/initiatives/ahcm/>



*The **Eldercare Workforce Alliance (EWA)** is a group of 34 national organizations, joined together to address the immediate and future workforce crisis in caring for an aging America.*
www.eldercareworkforce.org

*The **National Coalition on Care Coordination (N3C)** is a platform to identify & advocate for policies & practices that advance coordinated & integrated care. N3C is a national membership coalition and is housed by the **Center for Health and Social Care Integration (CHaSCI)** at **Rush University Medical Center** in Chicago.*
www.chasci.org

The positions of the Eldercare Workforce Alliance reflect a consensus of 75 percent or more of its members. Statements reflect the consensus of the Alliance and do not necessarily represent the position of individual Alliance member organizations. The Alliance is a project of the Advocacy Fund.