CONVERGENCE

Supplement to "Rethinking Care for Older Adults"

A Menu of Ideas for Administrative Actions

In December 2020, the Convergence Center for Policy Resolution published a Report summarizing a series of "brainstorming" conversations among experts on aging and caregiving for older adults. The conversations generated ideas for expanding opportunities for home and community-based care, advancing alternative business models in the institutional sector, and transforming the caregiving workforce.

Many of the ideas in the Report would require legislation or changes in business practice. But others could be advanced at least in part by administrative or regulatory actions at the federal, state, or local level. To further develop some of these latter ideas, Convergence invited experts from the original conversations, and some other experts, to flesh out their ideas for administrative actions consistent with the broad themes of the original conversations.

Like the ideas in the original Report, the proposals in this collection do not represent a consensus and they are not endorsed by nor represent the views of Convergence. Each proposal represents solely the views of the author. Convergence's purpose in publishing this collection is to spur productive conversation about the future of care for older adults.

This collection and the December Report were made possible by the generous support of the John A. Hartford Foundation.

May 2021

Section 1: Ideas for Administrative Actions to Make It Easier to Age at Home

Health-Housing Partnerships – HHS

Action Item: The Department of Health and Human Services should revise rules and launch demonstrations to encourage health and housing partnerships.

Objective: To make it possible for older adults living in a variety of housing models to more easily receive health services and supports.

Background and Action Steps

More options for a variety of living arrangements, such as shared living, clustered living, and sharing of personal care and other resources, would offer opportunities for older adults to avoid having to move to nursing homes (if they did not desire to do so), but not necessarily live alone. Unfortunately, many of the current waivers and state plan services under Centers for Medicare and Medicaid Services (CMS) rules may in some states not allow many living settings, depending upon how the state interprets the Home and Community Based Services (HCBS) Settings Final Rule; local zoning laws may also prevent even a small number of unrelated people living in the same abode. CMS should explore how to support more on-site supportive services, such as National Church Residences Project Based Health Assistance (PBHA) Model or the HUD IWSH Model[1].

To address the federal aspects of this limitation on an older person's preferred residential setting:

- The Administrator of CMS should undertake a review of all waivers and regulations to allow for unrelated people to live in the same abode. In light of the HCBS Settings Rule affecting provider-owned or controlled residential settings, the CMS administrator should clarify how persons who choose to live in groups or with unrelated persons can receive needed services.

- CMS should foster value-based programs such as PACE and Dual SNPs in CMMI demonstrations to encourage health plans and housing providers to partner with the housing units as the focal hub of care. Specifically, the CMS Administrator should direct the Center for Medicare and Medicaid Innovation (CMMI) to develop a grants program to demonstrate the degree to which organizations with medical and long-term care and services and supports (LTSS) global budgets can demonstrate medical and LTSS cost

[1] https://www.huduser.gov/portal/publications/IWISH_FirstInterimReport.html

savings by partnering with housing organizations. Some potential models could include but are not limited to:

  - Housing and a single health plan partner. In this model, all the participants in a housing community would be members of the health plan, either through a Medicare Advantage, special needs plan (SNP), or Program of All-Inclusive Care for the Elderly (PACE) contract, and a supportive housing partnership would be agreed upon with centralized shared services and a global medical and LTSS budget.

  - Onsite medical staff. CMMI could support medical practices at the housing sites caring for patients. The approach would be for the practices to partner with managed long-term services and supports (MLTSS) plans and services. PACE plans could be the onsite medical staff with a global budget. The Department of Housing and Urban Development (HUD) has pioneered this model with the Integrated Wellness in Supportive Housing (IWISH) program, as the state of Vermont has with the SASH model.

  - Housing and health plans that partner with multiple health plans at one housing property. In this model, HUD and the plans would create a shared services model for health plans to buy into services the way plans buy care in SNFs. Individual residents would also be able to obtain the services through their health plan or buy a la carte services from the centralized care management system based at the housing site. Funding and technical assistance would also be needed to help housing organizations become HIPAA-covered entities to the extent that care coordination and case management are offered by the housing owner. This would enable housing organizations to develop business associate agreements with plans, enable health plans to build electronic care plans in collaboration with housing organizations, and develop payment methodologies with health plans and create per member/per month (PMPM) or la carte services for their clients.

  - Matched control with three arms of PACE, SNPs, or MLTSS services. In this model, CMMI would fund a study to match participants from each group and compare total cost of care including LTSS services between the models. In the study, CMMI would compare service models to determine efficacy for diverse target populations.

- CMS should foster PACE and SNPS. In the same way that CMS has allowed Medicare plans to pay for certain services to address social determinants of health, CMS should allow PACE and Special Needs Plans (SNPs) to pay for housing from their global budgets to encourage innovation. In this arrangement, HHS-funded demonstrations would allow PACE or SNP providers to pay for housing-related services in joint projects between housing authorities and subsidized housing providers and PACE/SNP providers. The financial benefits for the housing authority and subsidized housing operators could be analyzed and measured; these would be

related to the percentage of residents in care coordination and case management with tenancy services, turnover and length of residency, and occupancy rates.

- CMMI should support localized health-housing partnerships. These partnerships between D-SNPS and senior or public housing developments allow local partners to develop an equitable and efficient cost model for integration of housing and services.

- Federal health care anti-abuse rules should be realigned to permit closer working relationships between affordable housing providers and health care providers. Under current HHS policies, selection preferences and referral mechanisms between housing owners and health plans create potential liabilities under anti-kickback and similar laws. While prevention of program abuse is important, concerns about liability make many affordable housing providers and their health partners reluctant to enter into partnership.

- Further expand housing related health services. HHS, with HUD, should encourage health care providers to subcontract with affordable housing owners for owner resident services staff to provide on-site services. The Social Security Act allows Medicare Advantage plans to provide special supplemental benefits for the chronically ill, and in recent years, CMS has expanded the scope of certain housing-related services that may be covered through HCBS programs. Many of these services, including, for example, tenancy sustaining services, structural modifications, transportation assistance, and food and nutritional supports, are items that affordable housing providers desire to provide through their own resident services staff, but tight project operating budgets and insufficient scale currently make it difficult or inefficient to offer them. Furthermore, CMS should encourage states to request Medicaid waivers and develop state plan services that would offer these supports to ensure that all who qualify can access services.

- Issue clearer guidance for the PACE innovation Act, enacted in 2018, to spur innovations to the Medicare Only PACE rules. This would make PACE a more viable choice for non-dual (Medicare/Medicaid) eligible individuals who live in subsidized housing.

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Health-Housing Partnerships – HUD

Action Item: The Department of Housing and Urban Development (HUD) should revise or reverse rules that discourage independent living in supportive housing for frail elders with significant disabilities.

Objective: To make it more possible for older adults with disabilities and other challenges to remain in their own homes rather than have to more to a nursing home.

Background and Action Steps

Older adults with disabilities who need long term supportive services (LTSS) often face significant challenges if they prefer to remain in HUD-supported community-based housing rather than enter a nursing home. For instance, capital and operating assistance for some public and subsidized housing does not adequately fund the addition of some of the safety and accessibility modifications needed to support people with motor disabilities to live more easily in such housing. Issues also arise regarding the availability of licensed persons who can provide medications to residents. Furthermore, HUD rules unfortunately restrict the regulatory flexibility necessary to address the wide range of disabilities and service needs of frail elders needing LTSS. Medicare Special Needs Plans and some Section 1115 Managed Long Term Care Services and Supports waivers often will pay for these kinds of safety equipment (grab bars, etc.) and other forms of housing-related services and supplemental benefits for the chronically ill as benefits. Fostering partnerships between housing owners and providers of community based LTSS will improve flexibility for the organizations managing these programs to pay for services not otherwise covered or routinely provided by housing managers. HUD can facilitate these collaborations and take further steps to make it easier for older adults with disabilities to stay in their homes.

- HUD should encourage state Medication Administrative Programs. To help address the challenge of managing medications, HUD should permit the project expenses associated with non-licensed medication management as an allowable cost for budget-based subsidy programs. HUD should also tie federal funding for HUD-supported housing to those housing organizations and the state developing programs to allow non-licensed staff to give medications through a state-developed Medication Administration Program (MAP). An example of a MAP regulation that states could adopt is in Massachusetts 105 CMR 700.000 and 105 CMR 700.004(C)(1)(i)). The Massachusetts regulations established a training and certification program for medication administration by non-licensed program staff and established standards to protect the well-being of individuals living in community programs who need assistance with administration of their medications.

- HUD should foster a wide range of housing options for older adults with disabilities. To help avoid older adults with disabilities having to move from community housing because of a lack of handicapped and accessibility units, additional capital and operating subsidy should be made available to finance supportive assisted housing with more than the

minimum proportion of accessible dwellings, and common space and dwelling units that are designed as visitable. In addition, funding should be available for a wide range of housing options to accommodate the need for community housing for people with dementia, Alzheimer's Disease and other conditions that involve cognitive decline, disorientation, and a high likelihood of wandering.

- HUD should reverse existing policies that are significant hurdles to affordable housing-health care partnerships. HUD continues to impose regulatory requirements dating from the period before the growth of Home and Community Based Services (HCBS), Program of All-Inclusive Care for the Elderly (PACE) and Special Needs Plans (SNPs). These often make it very difficult to operate affordable housing and health care partnerships. Specifically, HUD needs to:

    - Revise selection preferences. Most regulations for mainstream HUD programs currently forbid selection preferences based on the category of disability. These policies, related to the Fair Housing Act, effectively prohibit partnerships with HCBS providers serving people with significant disabilities, such as people with ID/DD, mental illnesses, traumatic brain injury and similar medical conditions. The current rules also do not foster partnerships with Dual Special Needs Plans (D-SNP), Chronic Condition Special Needs Plans (C-SNP) and similar Medicare Advantage programs that are targeted at elders with specific conditions like cardiovascular diseases, diabetes, end-stage renal disease or dementia.

    - Permit selection preferences in assisted housing for people using a specific health plan or provider where the provider has an agreement with the owner to deliver long term supportive services on-site. Current HUD policy does not allow a housing owner to develop housing with selection preferences for people served by specific providers. In part, this rule is an extension of the prohibition on preferences for people within a category of disability, but HUD has extended this view to bar partnerships with providers that are not identified by the category of disability, which would include a Senior Care Option plan or a Medicare Advantage plan. HUD should revisit these rules in conjunction with the Centers for Medicare and Medicaid Services (CMS); the inability to maintain such preferences makes it difficult for health providers to achieve the scale needed within a residential community to locate health services on-site.

    - Clarify data sharing rules and regulations. There needs to be more clarity and lass ambiguity regarding data sharing practices, so that the housing and health care sectors can, with resident consent, more easily share data to determine joint priorities.

    - Implement flexible policies regarding the percentage of units in a residential community that are set aside for people with disabilities. In a handful of programs, HUD has imposed a regulatory limit of no more than 25 percent, and this limitation operates as an unwritten rule of thumb in HUD programs where there is no

specified limit. The underlying policy goal of providing integrated, community-based housing and services is critically important. However, rigid limits do a disservice to a key Olmstead principle that supportive services be offered in a range of settings to accommodate the needs of people with a wide variety of disabilities whose condition require different degrees of support. Flexibility is crucial for people who may need and desire to live with other people with disabilities for peer support, or so that critical LTSS can be provided at the scale needed to sustain community-based living.

Authors

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Community Benefit

Action Item: The federal government should encourage nonprofit hospitals to help address supportive housing needs through community benefit activity.

Objective: To expand the supply of quality and affordable supportive housing for older adults by promoting such investments as a permissible community benefit activity.

Background and Action Steps

Increasing the supply of supportive housing would enable more older adults to remain in their own communities rather than move to a long-term care facility. While federal and state government funds are vital for the supply of supportive housing, nonprofit hospitals can also play a key role in expanding the supply. Adjusting the Internal Revenue Service (IRS) regulations for nonprofit hospitals could give them a greater incentive to do so.

Longstanding law requires that nonprofit hospitals and hospital systems seeking federal tax-exempt status under § 501(c)(3) of the Internal Revenue Code demonstrate that they provide a community benefit. The Nixon administration formalized this requirement in 1969,[2] but for 40 years the term remained undefined. State nonprofit tax law, which traditionally has paralleled federal tax law, also recognizes the concept of community benefit. Federal law sets no community benefit spending floors, while some state laws do.

Since 2009, IRS reporting rules in connection with hospital tax-exempt status has defined the term "community benefit" and has required hospitals to provide more detailed information on their community benefit spending. Information on hospital community benefit spending is publicly available through a special Schedule H that accompanies the annual 990 Form filed by tax-exempt hospital organizations.[3] Community benefit expenditures take two basic forms: financial assistance to individual patients and activities; and services considered "community health improvement" because they benefit the broader community. However, under current IRS policy, community health improvement is limited to services that benefit individuals (such as nutrition counseling or diabetes screening) as well as research and health professions education. The Affordable Care Act enhanced hospitals' interaction with their communities by adding a new requirement that tax-exempt hospital organizations conduct triennial community health needs assessments (CHNAs) that engage their communities and annually report on their progress in meeting priorities identified through their assessments.[4]

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[2] Revenue Ruling 69-545; see Sara Rosenbaum, Maureen Byrnes and Gary Young, 2016. Modifying Hospital Community Benefit Tax Policy: Easing Regulation, Advancing Population Health (Health Affairs Blog. December 1, 2016. https://www.healthaffairs.org/do/10.1377/hblog20161201.057691/full/#:~:text=In%201969%2C%20the%20Nixon%20Administration,whole%20as%20a%20charitable%20purpose.

[3] See Schedule H (Form 990) for the 2020 tax year, https://www.irs.gov/pub/irs-access/f990sh_accessible.pdf

[4] §501(r) of the Internal Revenue Code, added by § 9007 of the Affordable Care Act.

Extensive research suggests that community benefit spending remains quite low as a percentage of total hospital spending.[5] Research also suggests that although financial assistance to patients represents the vast majority of community benefit spending, the majority of such spending is for Medicaid "shortfall" (i.e., the difference between reported costs and Medicaid payments).[6] Relatively little is invested in direct financial assistance to uninsured and under-insured patients, and community health improvement expenditures are dominated by research and health professions education.

Hospitals make *de minimus* investments in community-wide health improvements that can address social conditions that affect health. One factor that may contribute to the insignificance of such investments is that community-*wide* health improvement efforts are classified not as community benefit spending but as *community-building*; hospitals that wish to report such expenditures as community health improvement must separately justify such investments, since they are not automatically recognized as community benefit spending. Additional justification may deter hospitals from making such expenditures out of legal compliance concerns.[7] Advocates and hospitals have attempted to encourage greater community-wide health improvement spending through tools that help hospitals document the countable nature of such spending as a community benefit, [8] but these efforts appear to have had only limited effect. A 2015 IRS policy acknowledges that housing can constitute community health improvement, but this policy exists only in an archived ruling, not as an automatic reporting line in Schedule H. States also have sought to promote community-wide health improvement as a permissible form of community benefit spending, [9] but hospitals may be deterred from doing so out of federal policy ambiguities.

Certain changes in the IRS regulations, together with parallel state action, could remove this ambiguity and encourage greater hospital funding of supportive housing for older adults and other households:

- The IRS should expressly classify supportive housing, along with other types of community-wide health improvements, such as investment in nutrition and neighborhood and environmental improvements, as specific types of community benefit spending under Schedule H. Rather than requiring separate justifications, investments that have been

[5] See, e.g., Bradley Herring et al., 2018. Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits. Inquiry. Available at https://journals.sagepub.com/doi/full/10.1177/0046958017751970

[6] Sara Rosenbaum et al., 2016. Improving Community Health through Hospital Community Benefit Spending: Charting a Path to Reform (GW). Available at https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1825&context=sphhs_policy_facpubs

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[8] Catholic Health Association, 2018. Housing and Community Benefit: What Counts? https://www.enterprisecommunity.org/resources/housing-and-community-benefit-what-counts-6230

[9] NASHP, 2018. States Work to Hold Hospitals Accountable for Community Benefits Spending. https://www.nashp.org/states-work-to-hold-hospitals-accountable-for-community-benefits-spending/; NASHP, 2020. Resources to Help States Maximize their Hospitals' Community Benefit Investments. Available at https://www.nashp.org/policy/population-health/community-benefits/

documented in the public health literature as related to health should become part of the automatically-recognized list of community benefit expenditures falling alongside other recognized categories on Schedule H, such as research and health professions training.

- States should take parallel steps to classify community-wide health improvements, including supportive housing, as recognized community benefit expenditures that do not require additional justification. This type of policy shift could parallel changes in federal policy, thereby underscoring the permissive nature of such expenditures.

- Hospital organizations should be required by the IRS to report community benefit expenditures, including community-wide health improvements, for each hospital within their systems. Current reporting rules allow systems to report such expenditures system-wide rather than specific to each hospital facility, which in turn deprives communities of the ability to measure the rate of local spending in their communities.

- Working with the CDC and public health experts, the IRS should develop community health needs assessment guidance for community-wide health improvements. Such guidance could help encourage hospitals to focus on interventions that improve health on a community-wide basis, along with investments that support services tied to clinical care for individuals. community-wide health improvements, as well as individual patient services.

- The IRS should scrutinize the extent to which hospitals are classifying Medicaid shortfall as a permissible community benefit expenditure. This expenditure is better understood as an insurance discount, not as a community benefit. To help communities more accurately measure the extent to which community benefit spending aids those in their communities, including elderly residents in need of services such as supportive housing, Medicaid discounts and other discounts for means-tested insurance payments should be removed as a community benefit.

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CAPABLE

Action Item: CMS should add CAPABLE to Medicare and Medicaid coverage and states should add the service to Money Follows the Person Programs.

Objective: To make a proven disability solution available to older adults that would help them age safely and more independently in their own homes.

Background and Action Steps

The vast majority of older adults report that they would like to age in their own homes and neighborhoods with adequate health care and social supports, however, there are currently not enough supports to reach this goal. CAPABLE is a program that supports aging in community by decreasing disability. It is an evidence-based, person-directed, goal attainment program with ten years of research demonstrating decreased disability, participant satisfaction, and cost savings. The program has been tested in clinical trials and as a demonstration project funded by the Center for Medicare and Medicaid Innovation (CMMI) and has produced significant cost savings (a 7:1 return on investment (ROI) for Medicare and an additional 3:1 ROI for Medicaid). A New England Journal of Medicine catalyst report estimated that CAPABLE could save Medicare $6.8 billion annually, even if only one-third of eligible patients participated and program savings were only half as much as shown in the original trial.

CAPABLE is a participant-driven, four-month intervention that reinforces an older person's self-identified goals, builds problem-solving skills and self-efficacy. The team-based approach deploys a registered nurse, an occupational therapist and a handy worker to address the home environment and uses the strengths of older adults themselves to improve safety and independence. On-demand training is available so that any qualified entity can provide the CAPABLE program. The CAPABLE team often works closely with the primary care team and focuses on how to support each older person to continue living in their home and community as they age.

CAPABLE was developed at the Johns Hopkins University and is now implemented in different parts of the country through a variety of funding mechanisms, including Accountable Care Organizations, health plans, health systems and Medicaid in limited ways throughout the country. Currently, there are programs in 34 sites in 18 states in the United States, and one in Australia. However, it is still available to less than 1% of Medicare beneficiaries. In 2019, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) unanimously recommended that the Centers for Medicare & Medicaid Services (CMS) consider testing CAPABLE to inform payment model development and recommended the program be given priority consideration as a traditional Medicare benefit. The CAPABLE program could be scaled and spread through three separate mechanisms: 1) it could be added to traditional fee-for-service (FFS) Medicare; 2) it could be promoted as a supplemental service/benefit in Medicare Advantage Plans; 3) it could be included as a service in state 1115 or 1915 Medicaid waivers, Money Follows the Person (MFP) or other authorities. Specifically:

- CMS should add CAPABLE as a covered benefit (new payment code) within traditional FFS Medicare. Assessment for the need for CAPABLE could be integrated as part of the Annual Wellness Visit or other existing Medicare programs/benefits (for example, CMS could explore expanding the home health benefit to include people with difficulty with at least one Activity of Daily Living who are not necessarily home bound could add CAPABLE as a covered home care service under regulations providing coverage for independent community living/social determinants of health). The eligibility criteria: adults over age 65 or age 70 who have difficulty with one or more activities of daily living (ADLs) such as bathing, using the toilet, eating, grooming, walking and transferring.

- CMS should promote CAPABLE as a supplemental service/benefit in Medicare Advantage (MA) Plans. CMS could do this by announcing that the CAPABLE portion of MA bids would be considered an important component of meeting MA's mission. CMS could provide template language to give plans guidance for adding the service to bids. MA plans could include coverage of non-medical services such as home modification. MA plans are currently able to include CAPABLE as a supplemental service or benefit, but they must use existing funds within their total budget to cover program costs. Eligibility criteria would be the same as for FFS coverage. Each MA plan would include language describing the CAPABLE program in their annual bids, and CMS would need to approve the addition of CAPABLE to each MA plan's group of services.

- CMS should track the impact of including CAPABLE as a benefit. Clinical outcomes and acute care utilization of older adults who enrolled in and completed the CAPABLE program should be compared with a similar cohort of older adults who did not complete CAPABLE (usual care). An evaluation of CAPABLE program results would become an element of the MA plan star rating and other quality measures, demonstrating program value.

- States could add CAPABLE to their Medicaid and other programs. Each state should consider including CAPABLE as a service in a state 1115 or 1915 Medicaid waiver, or in Money Follows the Person (MFP) or other programs. Alternatively, and similar to the recent Medicaid expansion language in the COVID relief bill, CMS could simply ask states to tell CMS they are adding CAPABLE rather than asking for permission through a waiver.

- Some states have already moved in this direction, and others could follow. In 2018, Massachusetts included language in their 1915c Frail Elder Waiver renewal that was approved by CMS. Other states could adapt that language as necessary to add CAPABLE as a service in their waiver renewals, they could amend current waivers, or they could include CAPABLE if they design and apply for new waivers, such as an 1115 Medicaid transformation waiver. In this approach, states would develop specific eligibility criteria: adults over age 65 or age 70 who have difficulty with one or more activities of daily living (ADLs) such as bathing, using the toilet, eating, grooming, walking and transferring.

  States could also add CAPABLE to MFP waiver requests. Adding CAPABLE to MFP programs would be an important step. MFP programs support people who have been in

SNF/NF or acute rehabilitation facilities and are returning to the community. Many of those individuals require health and social support at home. CAPABLE would help provide a smooth transition after a period of time when home health services end; CAPABLE has been shown to prevent Emergency Department transfers and rehospitalizations, and to lower acute care costs. In addition, CAPABLE are less likely to move to nursing homes than people who do not receive CAPABLE.

- Congress could leverage the Biden infrastructure plan as an opportunity to add CAPABLE to Title 18 of the Social Security Act to lessen the need for direct care workers and to strengthen the infrastructure of older adults being able to age in community.

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Villages

Action Item: States, cities and counties should scale and promote Villages as a focus for implementing a comprehensive array of services for aging-in-community.

Objective: To utilize the social capital and services of Villages to increase the ability of older adults to safely remain in their own homes and communities.

Background and Action Steps

We need to employ a variety of supportive services and social infrastructure to enable far more older adults and adults living with disabilities and frailties to remain successfully and safely in their neighborhoods – even if they have personal care needs and/or challenging medical conditions – rather than institutional care becoming their only option. The challenge with the home-based care approach is not only availability and cost of services; there is also a pressing need to enable personal engagement and connection. Social isolation and loneliness affect a significant proportion of the older adult and adults with disabilities populations. There is strong evidence that isolation puts the health of older adults at risk in many ways and has negative effects on quality of health, quality of life, and length of life. The recent National Academy of Medicine report on social isolation and loneliness states these are "topics of highest concern to both public health and clinical health care." It further notes these are community-wide problems and interventions will require the involvement of community-based social care providers.

Many communities have taken the initiative to address these needs by creating their own support infrastructure in the form of virtual Villages. Villages are intentional caring communities grounded on the principle of neighbor helping neighbor; reciprocity of action is a hallmark. Over 400 Villages have mobilized thousands of volunteers to manage operations, plan and execute programs, and provide supportive services when needed. Villages foster interpersonal connections and offer varied opportunities for members to age successfully. They organize a wide variety of activities based on member interests and offer a range of services, including transportation, help with shopping, and medical notetaking. Village members have consistently reported a significant positive impact on their personal well-being and quality of life as a direct result of Village membership.

Starting a standalone neighborhood-based Village is analogous to starting a small business. Many grassroots organizers lack needed skills. The average time to start this type of Village is about two years. The startup cost can be as much as $10,000 for incorporation and attaining tax-exempt status, insurance, background checks, computers, Internet connection and website. However, there are emerging sponsor-based Village business models that significantly reduce launch time and cost. The sponsoring organization provides the nonprofit status and "back office" business functions which enables the Village to focus on developing programs and services. This approach cuts startup time by more than half and eliminates most startup expenses. This is a Village business model that lends itself to replication and scalability.

Many jurisdictions are actively helping to create and support Villages. For instance, the New York State Office for the Aging, in partnership with the Albany Guardian Society, helps fund the Village Technical Assistance Center and the Capital Region Villages Collaborative, and also provides small seed grants to developing Villages. The District of Columbia provides grants to support Village programs. Montgomery County MD funds a full-time Village Coordinator staff position to promote the development and sustainability of Villages. Other jurisdictions should follow their lead.

There are several administrative steps that should be taken to expand and replicate Villages:

- Integrate into service delivery systems. States, Area Agencies on Aging (AAAs), cities and counties should integrate Villages into their service delivery systems by investigating how Village networks and services fit in the structure of services and supports for residents as the population grows older.

- Collect and analyze effectiveness data. Most Villages do not have the data needed to demonstrate savings in healthcare and other service costs. Thus, AAAs and jurisdictions, perhaps in partnership with universities, should help define the data categories and types of metrics they use for program evaluation and funding justification. In addition, they should promote compatible and consistent data collection with Villages. This would allow such analyses as comparing Medicare-reimbursed hospital patient stays and ER visits for Village members versus similar non-members, and the comparative effect on Medicare reimbursement penalties.

- Broaden communities of practice. AAAs and jurisdictions should collaborate with Villages to create broader communities of practice for evidence-based interventions such as falls prevention, chronic disease self-management, and Talking Circles, and collect consistent program evaluation data.

- Connect with senior centers. AAAs and jurisdictions should explore incentives for senior centers to sponsor or incubate Villages to achieve broader service area penetration and improved cost effectiveness.

- Offset membership fees. Cities/counties should explore providing grants to cover Village membership fees for low-income residents.

- Encourage MA and Medicaid reimbursement for services. The Centers for Medicare & Medicaid Services (CMS) should encourage state and local jurisdictions to develop procedures to reimburse Villages for Older Americans Act (OAA)-defined supportive home-based services, such as transportation and support for caregivers, under the provisions of current Medicaid waivers and Medicare Advantage programs.

- Encourage and evaluate partnerships between Villages and health-related service providers. CMS should encourage hospitals, federally qualified health clinics (FQHCs) and other health systems to develop partnerships with Villages and to evaluate the impact on

the quality and cost of care. In addition, CMS should conduct pilots to test the impact on Medicare and Medicaid costs of holistic medical and social interventions combining homecare/telehealth practices with non-clinical support from Villages, considering such factors as reduced emergency room visits, shortened hospital stays and expedited rehabilitation in home- based settings.

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Technology

Action Item: The federal government and states should take steps to improve broadband and encourage innovative telehealth solutions, coupled with digital literacy training and technology standards, to support the care and well-being of older adults.

Objective: To significantly reduce the digital divide and improve digital access in order to improve the quality of care delivered to older adults and to improve older adults' independence, engagement and quality of life.

Background and Action Steps

Broadband and telehealth are currently unable to meet the needs of older adults, family caregivers, and the workforce supporting older adults and persons with disabilities. However, broadband, telehealth, and digital technology are becoming increasingly critical to maintaining the independence and well-being of older adults. Broadband and digital technology play a significant role in helping individuals age in place by supporting 1) key activities of independent living (hygiene, nutrition, and medication), 2) cognition (monitoring, training, and financial security), 3) communication and social connectivity, 4) personal mobility, 5) transportation, and 6) access to healthcare.[10] Not only are broadband and telehealth resources and funding inadequate to meet the needs of older adults, broadband and telehealth also lack national standards and guidelines.

Technology-enabled interventions will be increasingly important in enabling older adults to remain at home and independent. In addition to the need to increase access to broadband and telehealth, older adults, as well as the work force supporting them, need expanded training to improve their digital literacy in order to reduce the digital divide that disproportionately affects vulnerable populations. Digital literacy training is key to technology being effective for both older adults as well as professionals and the direct care workforce across multiple long-term services and supports (LTSS) settings, including nursing homes, assisted living, and home care. Enhanced digital literacy will also expand access to lifelong learning, improve support for family caregivers, and assist older adults to remain in or re-enter the workforce. To meet this objective the following actions should be taken:

- The federal government should ensure that broadband be made universally available to support all health care, social services, and housing supporting older adults. Broadband needs to be made universally available for technology to be most beneficial to older adults. Broadband facilitates access to and exchange of information and knowledge that heavily impacts the economic, educational, and health care issues that are integral to the well-being of older adults. Limitations in high-capacity broadband accessibility, particularly in rural areas throughout the country, reveal the importance of expansion and affordability of broadband connectivity. The costs of broadband for users need to be reduced in order to support older adults in under-resourced communities, including affordable housing,

[10] Emerging Technologies to Support an Aging Population (United States Government) (2019).

home and community-based services, as well as all programs for low-income older adults. To fully address this need, Congress should consider establishing a program to achieve universal broadband availability, much as the Rural Electrification Administration was launched to ensure electricity services for all communities. But administrative actions are also required. For one thing, the Federal Communications Commission (FCC), in consultation with the Administration for Community Living (ACL), Housing and Urban Development (HUD), the Centers for Medicare and Medicaid Services (CMS), the Veterans Administration (VA), and other appropriate agencies should set minimum standards for broadband bandwidth to serve older adults in various care settings.

The Federal government should increase funding for the expansion, accessibility, and affordability of broadband in underserved, hard to reach areas and rural locations. The FCC should increase funding through existing initiatives that support the expansion of broadband, including the FCC's Emergency Broadband Benefit Program, Rural Digital Opportunity Fund, A-CAM Program, and the Connect America Fund Phase II Auction. The FCC should also expand the Digital Opportunity Data Collection initiative to help improve data collection that will further enhance broadband mapping to better inform the availability of broadband.

- **The federal government should adopt telehealth as a standard service delivery mechanism for older adults, including making waivers introduced under COVID-19 permanent.** Telehealth is a valuable tool that enables older adults to remain in their homes and, because of COVID-19, has expanded significantly. This expansion has demonstrated that telehealth should be fully integrated into the health care system and care of older adults. Through the rapid expansion of telehealth, for example, it has become clear that wearables and other remote monitoring devices have led to improved home-based monitoring of health conditions. In addition, "hospital at home" technology, supported by telehealth, is developing to the degree that many post-acute services and care for chronic conditions can be safely provided in a home setting. And general, smart home technology is making homes safer and more livable for people with serious health conditions, and technologies like virtual reality are helping to address social isolation and depression.

  As a result of this successful expansion of telehealth, Section 1135 public health emergency regulations and payments for telehealth platforms to address COVID-19 should be made permanent through CMS administrative changes (and where necessary through statute). This review should include making permanent the provision of services within an individual's home or "expansion sites" in the community, such as community centers and adult day centers. These regulatory steps would enhance the funding decisions made by Congress. In particular, Congress approved and allocated funds through the Coronavirus Aid, Relief, and Economic Security (CARES) Act to be used for initiatives that will provide immediate expansion of telecommunications services to support health care providers in staying connected with vulnerable and underserved populations. This allowed the FCC to launch the COVID-19 Telehealth Program in response to the inadequate access to health care that emerged with the onset of the pandemic. Through the Connected Care Pilot Program, the FCC further supports

initiatives that involve critical aspects of telehealth such as remote patient monitoring, increasing broadband access to low-income high-risk patients, and usability of video visits.

- The federal government should establish core digital literacy programs for older adults and standards for digital literacy for the workforce supporting older adults. Digital literacy training is essential for older adults to fully utilize the benefits of technology-enabled interventions as well as communications and information services. The Federal government should test models of technology training, with an emphasis on addressing differences in language and culture. The FCC should work with the National Institute on Aging (NIA) and ACL to conduct a study of older Americans to identify barriers to their adoption of technology-enabled services as well as gaps in technology applications and skill sets required to effectively use technology. Both informal and paid caregivers need continuous training in how to use more advanced technology. The Department of Labor and Department of Health and Human Services (HHS) – specifically CMS – should convene a joint task force to identify a national minimum set of core competency standards for digital literacy for the direct care and professional workforce in nursing homes, assisted living and other residential care facilities, and home care. In addition, HHS should assure that Older Americans Act funding is used to empower senior centers to provide technology access at the centers and to provide training and support for digital literacy.

- The federal government should establish guidelines for technology infrastructure and standardization of services. The FCC should set minimum standards for the infrastructure that supports technology-enabled programs for older adults. Guidelines are needed to ensure uniform technology infrastructure, including user-friendly technology interfaces, minimum technology standards for the built environment and Internet of Things (IoT), and seamless interoperability of devices that are used by older adults. Technology-enabled services should be standardized wherever possible, such as telehealth and remote devices, communication devices, and personal emergency response services. Single points of entry for services for older adults should be supported by an integrated technology infrastructure – Kaiser Permanente's Thrive Local Community Health is a model of such integrated systems.

- The federal government should support research and evaluation of core technology areas that will support older adults, family caregivers and providers. NIA and the National Science Foundation (NSF) should support research on technology innovation that supports older adults, including wearables, IoT, robotics, smart homes, virtual reality, and advanced predictive data analytics. Technology-enabled programs that include user design principals and ensure a simple user interface to enhance use by older adults and providers should be evaluated using standardized metrics. The Federal government should support demonstration projects through CMS, the Center for Medicare and Medicaid Innovation (CMMI), the Health Resources & Services Administration (HRSA) and ACL to evaluate technology-enabled models of care.

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Living with Dementia

Action Item: The federal government should improve the healthcare system through administrative actions to better address the needs of people living with dementia and their caregivers.

Objective: To achieve timely detection and diagnosis of dementia and improve delivery of dementia care services that enhance the quality of life for people living with dementia and their caregivers.

Background and Action Steps

The Milken Institute estimates 7.2 million people in the United States currently live with some form of dementia; this number is expected to reach nearly 13 million by 2040, disproportionately impacting women and racially and ethnically diverse communities. Alzheimer's, the most common form of dementia, is the most expensive disease in the US, and direct costs across Medicare, Medicaid, and private insurance, together with out-of-pocket costs to families impacted, are projected to reach $1.1 trillion by 2050. Family caregivers provide most dementia care, often damaging their own health and financial security. Thus, strategies to improve diagnosis and dementia care delivery must be an integral part of a national approach to improving care for older adults and their caregivers.

Early detection and accurate diagnosis of dementia can lead to actions that may slow disease progression and generate opportunities for better treatment and support for individuals and their caregivers. Individuals aware of their diagnosis can avoid behaviors such as smoking and excess alcohol consumption that are shown to accelerate cognitive decline and, instead, prioritize regular exercise and sleep, which can help prolong cognitive function. Certain drug treatments, such as cholinesterase inhibitors, can treat symptoms. Managing medications can help avoid adverse drug-to-drug interactions. Meanwhile, promising drug therapies in the pipeline may slow cognitive decline in patients with early signs of Alzheimer's. Thus, it is imperative that individuals living with dementia and their caregivers are aware of their disease as early as possible to take steps to extend quality of life and avoid lengthy or unnecessary periods of institutionalized care.

Administrative actions by federal government agencies to improve workforce and health system-level capacity can better prioritize routine cognitive assessments to detect dementia earlier, improve diversity and cultural competence in the dementia-capable workforce, and ensure coordination of care upon diagnosis. Building workforce and system-level capacity across the continuum of care will also reduce costs and improve quality of care. To meet these objectives, the Milken Institute Alliance to Improve Dementia Care recommends these steps:

- CMS should enhance access to cognitive screening and timely diagnosis: The Medicare Annual Wellness Visit (AWV) provides older adults a reliable, consistent annual opportunity for health checkups, but fewer than one-third of Medicare beneficiaries report receiving a structured cognitive assessment during their visit. The Centers for Medicare & Medicaid (CMS) guidelines encourage screenings by health providers to detect cognitive

impairment but do not require a specific screening tool. Structured cognitive assessments during primary care can establish a baseline of a patient's cognition, with annual assessment scores used to detect changes in brain health or cognitive decline. To improve rates of detection, CMS should require the use of a cognitive assessment tool within its guidelines during the AWV, such as the Mini-Cog©, Montreal Cognitive Assessment (MoCA), or the Saint Louis University Mental Status Examination (SLUMS), rather than relying on direct observation alone. Wider access and use of standardized assessment tools can also help build the evidence base needed to assess the balance of benefits and harms of screening for cognitive impairment required for the US Preventive Task Force (USPTF) to recommend annual cognitive screenings. Many researchers and clinicians believe the USPTF's recommendations to date, which do not endorse annual screenings, may have sharply discouraged physicians from administering them, even though they are a covered benefit under Medicare's AWV.

- NIH should expand the range of cohorts who can participate in clinical trials: Given that women, African Americans, and Latinos are disproportionately affected by dementia, efforts need to be made to facilitate their participation in clinical research studies where they are traditionally underrepresented. For example, only 2 percent of people in clinical studies assessing the efficacy of anti-amyloid drugs were African American, even though 20 percent of Alzheimer's patients are African American. The National Institutes of Health (NIH) should ramp up efforts to pursue culturally sensitive recruitment and retention efforts of those at greatest risk of dementia, including women, communities of color, and people with intellectual and developmental disabilities, in clinical trial research through tailored awareness and engagement strategies. To do this, NIH should encourage trial program leaders, such as academic or community-based medical centers, to broaden access and participation through tools like mobile clinical and research trial units, which can standardize the recruitment process in smaller communities, improve the experience of people participating in clinical trials, and increase retention among underrepresented populations.

  The NIH *All of Us* program targets underrepresented communities and prioritizes trust and transparency in clinical research methods to oversample African American, Latino, rural, and lower socioeconomic status participants. NIH should emphasize this approach in study sites that are conducting clinical trials on dementia, including workforce development, to recruit racially and ethnically diverse participants, and to obtain a more precise understanding of Alzheimer's disease pathologies among high-risk populations. Additionally, cohorts should be grouped in narrower age ranges (i.e., 65-70, 71-76, etc.) so participants age 65+ are not grouped together as one cohort.

- HRSA should strengthen the Geriatric Workforce Enhancement Program (GWEP): Even though the number of people with Alzheimer's disease is projected to triple by 2050, there is a shortage of physicians, nurses, and social workers with specialized training in geriatrics and complex dementia care. Funded by the Health Resources and Services Administration (HRSA), the GWEP was established in 2015 to better prepare the health-care workforce for age-friendly care. It provides education and training to patients,

families, caregivers, direct care workers, healthcare providers, health professions students, residents, fellows, and faculty on Alzheimer's disease and related dementias.

In 2019, and with additional foundation support, HRSA's GWEP program required its 48 grant recipients to educate and train the healthcare workforce on the Age-Friendly Health Systems (AFHS) framework. Evidence is mounting that the Age-Friendly approach to health care is making a difference in primary care practices that treat older adults. HRSA has developed two training curricula on Alzheimer's disease and related dementias (ADRD). The first curriculum educates the primary care workforce about dementia care. While the curricula have been widely used, HRSA needs to promote them to health professional and family caregivers and conduct additional research on the impact these trainings have on quality of care.

- CMS should expand access and improve equity in telehealth for older adults: To ensure that older adults living with dementia can receive a variety of services in their homes and communities, CMS should continue to expand reimbursement for different types of telehealth services and technology. Telehealth usage allows individuals living with dementia and their caregivers to access specialists and other medical services (such as occupational and physical therapy) at home, which can be less stressful, especially as the disease progresses and cognitive and physical function declines. While some codes allow for asynchronous and telephonic appointments as well as remote patient monitoring, CMS must ensure that reimbursement codes are robust enough to support promising new care delivery models as the US moves further towards home-based services. Only 62 percent of US older adults over age 70 use a smartphone, and 34 percent of low-income Medicare beneficiaries report no internet usage. Further, while Medicare Advantage (MA) plans are permitted to provide smartphones and tablets as supplemental benefits to facilitate access to telehealth services, CMS should consider expanding coverage of devices and connectivity to Medicare Fee-For-Service in support of technology-based care models. Together, these steps will yield greater access to telehealth among older adults at risk of and living with dementia and their caregivers for various types of clinicians and services.

Authors

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State Interagency Councils

Action Item: By executive order, states should establish an interagency council to coordinate the necessary programs, regulations, and financing streams to support home-based care and services.

Objective: To expand the range of older adult-friendly housing and communities by facilitating multi-level collaboration and coordination across multiple state departments, the federal government, local governments, providers, consumers, and other key stakeholders.

Background and Action Steps

Most Americans want to live independently and remain in their own homes and chosen communities as they grow older. Today, the vast majority of older adults live in the community and, as the U.S. population ages, the need for home-based care and services will continue to grow.

Over the past several years, many state-led efforts to support home-based care and services have focused on rebalancing their long-term care (LTC) systems so that older adults have greater access to Medicaid-funded Home and Community-Based Services (HCBS) as an alternative to nursing homes. States have utilized federal demonstration grants, Medicaid dollars, and state general revenue to strengthen their HCBS infrastructure, raise awareness among older adults about their LTC options, and expand access to HCBS for Medicaid-eligible individuals. States have also prioritized efforts to divert people from nursing homes and help people move out of nursing homes back into the community.

The COVID-19 pandemic's devasting effects on nursing home residents, including the staggering death toll, high infection rates, and increased prevalence of social isolation, further emphasized the need for states to rebalance their LTC systems and expand older adult-friendly housing and communities. While rebalancing efforts in many states have been successful in helping more older adults age in home and community-based settings, many state initiatives have been hindered by a singular focus on Medicaid, and by siloed activities, funding streams, and programmatic authority outside Medicaid. In order to make more rapid progress in expanding access to meet the rapidly growing need for high quality home-based care and services, states will need to better coordinate multiple funding streams and planning by different agencies and delivery systems.

Experience shows that state agencies and their external partners collaborate most effectively when two things occur. First, they need to be *required* to do so by the Governor so that agency heads know that it is a state priority. And second, a formal structure needs to exist that requires leaders to address specific challenges and identify concrete solutions, and that provides procedures and bodies for doing so. The creation of "children's cabinets" in more than half the states is an example of this two-part approach, in that case to coordinate programs for children. Interagency bodies have also been utilized to address climate change and disaster preparedness at the state and local levels.

- Governors should issue executive orders to establish an interagency council. Such councils would coordinate the necessary programs, regulations, and financing streams in order to expand the range of older adult-friendly housing and communities, support home and community-based services (HCBS) and increase choice in where people receive LTC services and supports.

- Membership. The council should at a minimum include representatives from the Governor's Office, State Department of Human/Social Services, State Medicaid Agency, State Department of Public Health, State Department of Aging, State Department of Labor and/or State Workforce Investment Board, State Housing/Housing Finance Authority, State Transportation Department, State Survey Agency, and State Association representing Area Agencies on Aging (AAAs).

- Structure and process. To be successful, the council should have a formal structure and a clearly defined operating process. The Executive Order should establish a charge for the council and identify skillful chairs who can lead the council's work. Further, the council should be adequately staffed and should regularly be held accountable for its work, preferably by the Governor directly.

- Use of data. As an early priority, the council should utilize census, demographic, and other existing data sources (e.g., community assessments conducted by AAAs, Community Health Needs Assessments conducted by hospitals, etc.) to develop supply and demand projections for home-based care and service needs on a community-by-community basis. These projections should inform a strategic plan that targets new investments in home-based care and service capacity in areas of the state with the largest gaps between supply and demand. The strategic plan should include overarching objectives, specific strategies and tactics that state agencies and/or external partners will implement to increase access and improve quality, measurable outcomes, and a process for assessing progress towards meeting outcomes.

- Implementation role. Once the strategic plan is created, the council should become the interagency implementation body. The council's role should be to collectively carry out the strategies and tactics in the strategic plan and continually evaluate and estimate the impact that the strategic initiatives are having in the state. In order to be successful, the Executive Order must provide clear authority to the council and implementing agencies for carrying out the strategic plan, and the Governor must require the council to take specific actions to meet the strategic plan goals.

Examples of strategic plan initiatives may include, but are not limited to:

    - Connecting people to information about long-term care services and supports by documenting what AAAs, senior centers, and other social service agencies are already doing, identifying gaps and areas of need, and supplementing current efforts with new initiatives. In some states, this may include developing and implementing an automated No Wrong Door (NWD) communications plan,

training state and external partners in how to utilize a NWD system, and developing tools to educate the public about HCBS generally and specific topics like spousal assessment and self-direction.

- Increasing transitions of long-term nursing home residents to the community by supplementing existing work that is already funded by Money Follows the Person demonstration grants. This may include innovative initiatives like a nursing home transformation grant program that provides funding to nursing homes to diversify their business model, de-license beds/reduce the number of beds in service, and begin reserving more beds for specialized resident needs.

- Building capacity in the home and community-based services workforce by aligning investments in publicly funded education and training programs to meet future projected HCBS needs. The council should support State Departments of Labor, State Workforce Investment Boards, and State Social Services Agencies in understanding where workforce shortages exist; the critical capacities, skills and training that job seekers will require to fill these jobs; and how to design training and career pathways programs that will build a robust and qualified home and community-based services workforce that can meet future projected needs.

- Closing service gaps, improving existing services, and identifying new services.

- Increasing access to affordable and accessible housing, especially for individuals with disabilities and other specific accessibility needs.

- Developing grant and/or waiver applications for federal funding to support specific programs, services and initiatives.

The American Rescue Plan Act of 2021 included an enhanced FMAP for Medicaid HCBS that states could potentially be utilized to fund strategic plan activities, including some of the examples outlined above. The 1-year, 10 percentage point FMAP increase for specified Medicaid HCBS expenditures takes effect on April 1, 2021 and lasts through March 31, 2022. States must enhance, expand, or strengthen HCBS and new funding must supplement, not supplant, state spending.

Examples of Similar Approaches

In Colorado, HB15-1033 created the Strategic Action Planning Group on Aging, which includes state departments, counties, providers, and advocates.

Connecticut's Strategic Rebalancing Plan is part of an initiative by Governor Ned Lamont and the General Assembly to expand long-term care options and help the nursing home industry diversify its business model to meet changing service needs. It represents exemplary collaboration and coordination across multiple state departments, the federal government, home health providers, nursing home administrators, consumers and other stakeholders. The plan is updated annually

and reflects Connecticut's proactive approach to address the anticipated, unprecedented demand for Medicaid-funded long-term care through 2040. The plan has informed new, innovative projects in the state, including the Connecticut Housing, Engagement and Support Services (CHESS) Initiative. If approved by CMS, the CHESS initiative will provide an evidence-based Medicaid supportive housing benefit to improve housing stability and health outcomes for an identified group of Medicaid members who have complex health conditions, have experienced homelessness, and tend to cycle through use of the hospital emergency department, inpatient admission and, in some cases, short-term nursing home stays, resulting in high Medicaid costs.

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Section 2: Ideas for Administrative Actions to Strengthen and Increase the Range of Nursing Facilities

Nursing Home Quality and Management

Action Item: By executive order, establish a national interagency task force to analyze the relationship between nursing home resident quality of care and financial management and staffing.

Objective: To coordinate federal data and agency action to enhance accountability for delivery of consistent, high-quality care across the nation's nursing homes.

Background and Action Steps

The COVID-19 pandemic exposed many underlying failures in the way we care for older adults and variations in the quality of care. Nursing homes faced enormous challenges, exacerbated by government decisions over testing priorities and the allocation of supplies, as well as structural underfunding by government of facilities and staff. Meanwhile, data collected at the federal level that may be related to other features of quality, such as ownership patterns, clinical outcomes and staffing, as well as responsibilities for analyzing and acting upon that data, are dispersed between different agencies and levels of government. Agency silos and a lack of focus undermine efforts to design appropriate quality measures and assess performance.

To help achieve a viable and high-quality nursing home sector, the federal government needs to combine steps to tackle funding and other structural issues with much closer attention to analyzing the available data on the relationship between staffing, financial management, and quality of care in order to develop more effective and reasonable standards of quality. In addition, federal agencies with oversight responsibilities need to work together much more closely, both to ensure quality standards are met and to identify longer-term actions to improve care and safety.

- The President should issue an executive order establishing an Interagency Taskforce to improve quality and support of residents in America's nursing homes. Federal agencies collaborate effectively only when required to do so by the White House: efforts at cooperation initiated by agency heads are rarely as successful. For this reason, the best course of action would be an executive order requiring agency actions.

- Membership. The Task Force should at a minimum include representatives of the Centers for Medicare and Medicaid Services (CMS) Administrator, the Health and Human Services (HHS) Inspector General, the Centers for Disease Control (CDC) Director, and the U.S.

Attorney General. The Task Force would consult with senior officials of the Administration for Community Living (ACL), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), and expert state-based authorities, including State Medicaid Fraud Control Units, state Long-Term Care Ombudsman and state surveyors.

- Data analysis. As its first priority, the Task Force should establish protocols to jointly analyze data and research on staffing, safety, quality, and spending patterns; review monitoring and enforcement efforts currently undertaken by agencies; and recommend immediate steps to improve coordination among federal agencies with regulatory oversight of nursing homes.

- Ownership patterns. The Task Force should propose steps to better examine ownership patterns and improve regulation of ownership changes. The COVID-19 experience indicates that nursing homes with the lowest quality of care have undergone more frequent ownership changes.

- Plan of action. The Task Force should develop strategies and coordinated action plans for addressing resident and staff quality issues that have been identified in research and analysis of federal data. It should engage with representatives of states and other levels of government to help develop coordinated or joint strategies.

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Nursing Home Staffing

Action Item: By executive order, require the Department of Health and Human Services (HHS) to amend nursing home regulations regarding staffing sufficiency and training requirements, and to amend Medicare prospective payments for skilled nursing facilities (SNFs) regarding direct care.

Objective: To address the problem of insufficient nursing and direct care worker staff in nursing homes and weaknesses in federal requirements for training, and to assure an appropriate level of Medicare prospective payments are spent on direct care.

Background and Action Steps

Studies of nursing homes indicate that quality of care and clinical outcomes are significantly negatively impacted when there are insufficient numbers of well-trained staff – a long-standing problem underscored during the COVID-19 pandemic. Research also shows that the availability of registered nurses (RNs), licensed practical or licensed vocational nurses (LPNs/LVNs) and certified nursing assistants (CNAs) is linked to quality. However, state training and staffing requirements vary widely and typically are inadequate. Federal requirements do not currently assure the appropriate level of staffing and training.

To improve nursing home quality, these shortcomings in staffing standards need to be rectified with adjustments in federal rules. An appropriate way to accomplish this would be for the President to issue an executive order requiring HHS to revise staffing standards and Medicare payment language. Specifically, such an order would:

- Assure sufficient staff. The order should require the HHS Secretary, with the Administrator of the Centers for Medicare and Medicaid Services (CMS), to amend nursing home regulations to clarify the definition for "sufficient staff" at a nursing home, including the availability of adequate RNs, LPN/LVNs and CNAs. Auditing requirements for reports of turnover and tenure of direct clinical staff would also be strengthened and regularly reviewed.

- Upgrade training. The order should require HHS to fast-track new federal requirements for CNA training, including upgrading training curricula and that the required minimum training should be at least 150 hours, with at least 12 hours of additional clinical training each year.

- Improve standards of care. Require CMS to develop evidence-based standards for the amount that SNFs/NFs will be reasonably expected to spend on direct care per resident.

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Small Houses

Action Item: The federal government and states should remove barriers to the growth of Small House facilities.

Objective: To increase the range of facilities available to all the adults needing care.

Background and Action Steps

Addressing the care needs for a growing older adult population requires significant investment in many existing nursing homes to upgrade facilities and expand staffing. But it also requires the expansion of a range of smaller facilities for residents who would thrive in other types of residence with different staffing arrangements.

Today's pattern of facilities has been influenced by the 1954 Hill-Burton Amendments, which linked funding to skilled nursing facilities that met requirements based on hospital-like building standards. The passage of Medicare and Medicaid in 1965 further spurred such buildings and emphasized a clinical, institutional environment. Subsequent funding and regulation have also emphasized this type of facility. It is estimated that 51% of existing nursing home facilities in metropolitan areas are more than 40 years of age, and 72% are 30 years of age or older, according to data collected by National Investment Center, further calling for significant infrastructure improvement.

Since the 1990s, other household models have begun to emerge, are smaller and take a more person-centered approach. These smaller facilities typically house 10 – 24 residents in a more family style arrangement, with more customized private spaces. The Small House model, purpose-built to house and care for 8-12 residents, has shared living room and dining room space, open kitchens, and a consistent staffing model that includes a team of specially trained certified nursing assistants (CNAs) who function as versatile workers (i.e., with training in activities and food preparation as well as ADL supportive care) and who also work collaboratively as part of a team caring for those residents with clinicians.

The growth of these small models is hampered by many regulatory and funding approaches that are reminiscent of the earlier common model of care, and by a lack of encouragement from the federal government. For instance, certificate of need (CON) laws that exist in many states (roughly 36 states, including Washington, DC) require providers to get permission to build a new facility, which disincentivizes innovation. Regulations are also perceived as a barrier to person-centered approaches and oversight from regulators as punitive, which hinders providers from readily embracing these innovative models.

To encourage the growth of smaller facilities alongside more traditional housing with services, the federal government and states can and should take several steps:

- The federal government should encourage states to revise building codes and regulations for facilities. The Department of Health and Human Services (HHS) should provide

technical assistance and grants from existing funds to states to encourage them to review and revise regulations governing caregiving facilities for older adults, to expand Small House homes. HHS should ask states to provide the agency with data and other information on the impact of such revisions, in order to develop best practice guidance.

- The federal government should encourage states to apply to create more Small Houses under existing regulatory authority. Currently, some Small House homes are licensed as skilled nursing facilities, and some are licensed as assisted living residences. To accelerate this, the Centers on Medicare and Medicaid Services (CMS) should invite states to apply to build new Small House homes and provide planning grants for building them. If existing nursing facilities wish to transition from a traditional institutional design to also create spaces with Small House design in certain units or wings, CMS should encourage this with technical assistance to states for revising their Medicaid payment systems and guidance on cost-reporting and rate-setting options for combined traditional/Small House arrangements, as well as for Small House homes.

- States should consider eliminating the archaic CON process that hinders innovation in the nursing home sector. Departments of health should add a new sub-category of small house skilled nursing facilities and create regulations and licensing standards that support operationalizing the Small House model, as well as incentive payments for design, development and construction of innovative, community-embedded homes serving no more than 14 residents.

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Section 3: Ideas for Administrative Actions to Strengthen and Increase the Caregiving Workforce

Pay for Direct Care Workers

Action Item: States and the federal government should take steps to improve the pay of the direct care workforce.

Objective: To find ways of directly increasing the compensation levels of direct care workers or encouraging the market to do so.

Background and Action Steps

Our nation undervalues the 3.5 million nursing assistants, personal care aides, and home health aides who go to work each day in residential care settings and private homes across the country. These direct care workers help care recipients remain healthy, safe, and as independent as possible. Yet, many direct care workers struggle to make ends meet, earning an average wage of $13.36 an hour – about $475 a week. Undervaluing care contributes to the financial instability of direct care workers and their families, leads to chronic staffing shortages, decreased productivity, reduces quality of care, and it also adversely impacts the economic health of local communities.

State Medicaid programs increasingly use managed care to improve care coordination and manage costs for Medicaid populations with complex health care needs. By the end of 2020, 25 states operate managed long-term services and supports (MLTSS) programs, in which state Medicaid agencies contract with managed care plans to deliver long-term services and supports. This arrangement affords states and the Federal government some degree of power to move the market to pay higher compensation:

- States should encourage a minimum wage for caregivers. States should require – through the bidding and contracting process – that managed care organizations serving the LTSS population only contract with providers who pay a certain minimum wage level or make clear that their bids will be advantaged by making a commitment to contracting with providers paying a minimum wage level. This should be required by CMS of all new contracts beginning in 2024. To the extent that state arrangements include pay-for-performance provisions in contracts, the state should require that a minimum percentage of any bonus payments made when quality targets are met should be returned to the direct benefit of the care workforce.

- The federal government should specify how Medicaid rate changes should benefit workers. The Centers on Medicare & Medicaid Services (CMS) should require that state

Medicaid agencies explicitly specify how much of any recommended change to Medicaid rates be allocated to direct front line worker wages when the overall Medicaid budget is put forward to the legislature for approval. This will help to have a process in place that assures any rate change will likely include increased compensation to direct care workers. Require periodic audits to oversee the process and ensure that the percentage of provider reimbursement is going directly to pay direct care workers.

- MEDPAC should recommend a wage distribution formula for Medicaid rate increases. The Medicare Payment Advisory Commission (MEDPAC) advises Congress on Medicare payments to plans. When MEDPAC puts forward its recommendations regarding reimbursements for Medicare certified nursing homes and home health agencies, the recommendation should be explicit regarding the proportion of any recommended rate increase passed through directly to home health aides and certified nursing assistants. In addition, CMS should design oversight and audit mechanisms to ensure that these increases are passed on to this workforce.

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Licensing Direct Care Workers

Action Item: States and the federal government should permit aides to operate at the top of their license and encourage a team approach to care.

Objective: To demonstrate that an expansion in the tasks and activities that are delegated to care aides would not diminish the quality of care, would be a more cost-effective way to deliver care, and ensure that new roles and team responsibilities would be reflected in adjustments to payment systems.

Background and Action Steps

There is a widespread view that certified nursing assistants (CNAs) and home health aides could undertake activities that are currently delegated exclusively to nurses and that by so doing, these workers would be operating "at the top of their license," making them more valuable to the health care system. Currently state Boards of Nursing determine what is in the purview of a nurse's duties and so it is not surprising that states differ greatly in the tasks that they permit (and do not allow) aides to undertake. The current pandemic has shown that direct care workers are capable of completing tasks that may not have previously been part of their role. Greater delegation would enable such workers to play a more significant role in team-based care focused on both the medical and social service aspects of care. As such, expanding their role can potentially help to more efficiently meet care needs as well as increase the value, hence, associated compensation, of such jobs.

The following actions should be taken to accomplish this goal:

- CMMI should explore expanding care aide roles. Expanding nurse delegation and the roles beyond personal care tasks can support career development, contribute to increased retention, and save money for public payers by reliance on less expensive labor. The Center for Medicare and Medicaid Innovation (CMMI) thus should undertake demonstration projects that examine whether and if expansion in care aide roles affects the quality of care for recipients, worker outcomes, and cost of care by using less expensive labor.

- State boards should examine care aide roles. Nurse practice acts vary by state and the regulations determine which nursing services can only be performed by or under the direct supervision of a licensed nurse. Leaders of state boards of nursing need to be convened by, for example, the National Council of State Boards of Nurses (NCSBN) and/or the American Nurses Association (ANA) to explore the development of a common set of standards that would be used across states to expand care aide scope of work. Both of these organizations have acknowledged the potential of these actions.

- CMS should encourage Medicare Advantage plans to use aides in care teams. The Centers for Medicare & Medicaid Services (CMS) should encourage Medicare Advantage

plans to develop and test models that formally incorporate aides into care teams in nursing homes, assisted living, home health, and home-based primary care, including involving them in the development and ongoing oversight of care plans for older adults and younger people with disabilities. CMS and state policymakers should support demonstrations and evaluations that rigorously test the benefits of adding aides to integrated care teams. Studies should also explore the best strategies for integrating aides into the teams and the financial incentives that would motivate payers and providers to include aides as team members.

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Training Direct Care Workers

Action Item: States and the federal government should take steps to improve the training and skill level of the nursing home workforce.

Objective: To significantly improve the training of the direct care workforce to retain and develop them in order to improve the quality of care delivered by assuring that they are competent to do their jobs.

Background and Action Steps

The education and training of the direct-care workforce is insufficient to prepare these workers to provide quality care to older adults. Although there are a number of state and federal requirements related to training hours and knowledge/skills required for the education and training of nurse aides, home health aides, and personal- and home-care aides, these requirements are often inadequate or non-existent (in the case of home care aides/personal care aides), and they vary across occupational categories and settings of care as well as among states. Moreover, there may be different regulations emanating from both the federal government and states regarding the precise definition of a particular job classification. Finally, current approaches often require certain minimum number of hours of training to be completed to obtain certification status but do not specify the actual development of competencies.

The training of the direct care workforce needs to be re-oriented toward a universal worker approach, which focuses on the development of a core set of competencies that can be applied by direct care workers across multiple long-term services and supports (LTSS) settings, including nursing homes, assisted living, and home care. This will not only enhance worker mobility across care settings, but also assure that as the system evolves workers can more easily be retained in the field. To meet this objective, the following actions should be taken:

- The federal government should establish core competency standards. The Department of Health and Human Services (HHS) – specifically the Centers for Medicare & Medicaid Services (CMS) – and the Department of Labor (DOL) should convene a joint task force to identify a national minimum set of core competency standards across settings (e.g., nursing homes, assisted living and other residential care facilities, and home care.) CMS can mandate the core competencies for Medicare and Medicaid-certified providers. While the federal government would set minimum standards, the states would determine how to deliver the training to meet these federal standards.

- Certification should be strengthened. Certified Nursing Assistant (CNA) certification typically lasts two years and is renewable with evidence of employment during the period and the payment of a fee. Certification requires a national training requirement and states can develop their own programs that meet or exceed federal guidelines. As part of the setting of minimum standards, ongoing competency exams should be required as a mechanism to support continued education and training focused on the development of

competencies. As well, the Institute of Medicine recommendations of 2008 set out a 120-hour minimum training requirement, which should also be part of the national CNA standard. The number of training hours should be based on the competencies defined for the workers and the time needed to train the workers in the knowledge and skills required to demonstrate each competency.

- STAR ratings should include more workforce metrics. CMS is charged with setting quality standards related to the workforce providing certified Medicare home health and skilled nursing care. As part of its STAR ratings system, more workforce-related metrics related to competencies and turnover should be included in the aggregate measure. CMS should make available to all states guidance on the adoption of such measures so that there can be greater synergy in cases where states undertake their own quality measurement.

- Medicare Advantage plans should focus more on workforce metrics. CMS should encourage Medicare Advantage plans to contract with entities that are scoring highly on workforce quality measures by adding such measures to Healthcare Effectiveness Data and Information Set (HEDIS) metrics. This will provide an incentive for plans to contract with organizations investing in competency-based workforce development.

- The DOL Apprenticeship program should emphasize direct care. The Administration should direct DOL to focus resources allocated to the Department's Apprenticeship program toward the training, development and matching of direct care resources. This would represent a reallocation of existing resources within the program. These apprenticeship programs should focus on career advancement beyond nursing, including social work, human resources management and other professions related to managing staff and resources.

- HHS should evaluate caregiver training models. HHS should support demonstration projects through CMS, the Center for Medicare and Medicaid Innovation (CMMI), the Health Resources & Services Administration (HRSA) and the Administration for Community Living (ACL) to evaluate caregiver-training models to determine under what circumstances they are successful, impact on worker and resident/client outcomes, and how they can be scaled up.

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Health Profession Opportunity Grant Program

Action Item: Encourage every state to create a Health Profession Opportunity Grant Program, targeting recruitment and training into certified nursing assistant (CNA) jobs with action by CMS to address local shortages of workers.

Objective: To support nursing homes in meeting their demand for CNAs and reduce turnover, which will improve the safety and quality of nursing home care.

Background and Action Steps

The U.S. Bureau of Labor Statistics is projecting job growth for certified nursing assistants (CNAs) at twice the average rate compared with other occupations over the next decade.[i] Despite this projected demand and unlike other parts of the health care industry, nursing homes, including skilled nursing facilities and residential care facilities, have experienced a downward trend in employment over the past year with 300,000 fewer jobs compared to right before the start of the pandemic.[ii] The supply of nursing home staff is limited in part due to high turnover rates, estimated at 130% in the average nursing home before the pandemic,[iii] as well as the difficulties of recruiting during the health crisis. But the problem is long term; high turnover in nursing homes has been tied to burnout, lack of promotion opportunities, and lack of employee assistance programs such as childcare.[iv,v,vi,vii] Increasing CNA staffing levels has been associated with better quality of care in nursing homes.[viii,ix]

The Health Profession Opportunity Grant Program (HPOG), run by the Administration for Children and Families (ACF) within the US Department of Health and Human Service (HHS), has demonstrated success at increasing recruitment and retention of health care workers, including CNAs, by targeting the underlying factors related to turnover. The problem, however, is that not every state has an HPOG program. Currently HPOG operates 32 sites within only 21 states.[x] The program has been administered by ACF since 2010 and was originally designed to support individuals on the Temporary Assistance for Needy Families (TANF) program. It has expanded over time to support other low-income individuals in a health care career. Although CNAs are one of the most common occupations supported by the program – given the low barriers to entry into the occupation – HPOG nevertheless does not require or have dedicated sites to support CNAs. Another challenge is that under the current HPOG design, the program does not have the statutory power to increase wages for workers, and it can only provide wraparound support services. Currently, funding for HPOG expires at the end of FY21 unless it is extended by Congress.

Despite HPOG's limitations, a randomized control trial funded by the Office of Planning, Research, and Evaluation in ACF found that HPOG participants had 12 percentage points higher employment rates in health care three years after initiating the program compared with a control group of individuals not participating in the program.[xi] Other statistically significant improvements seen among HPOG participants compared with a control group were increased rates of training completion, confidence in career knowledge, career progress, and financial stability, including having a job that offers health insurance. Each site has flexibility in how the program is designed

and the eligibility criteria to fit local community need. Typical HPOG programs offer training, tuition assistance or waivers, free course materials, supplies, and uniforms, fee assistance for exams, license, and certifications, career counseling, case management, peer support, and personal and family supports (e.g., childcare and transportation assistance). [xii]

Congress will need to consider whether to extend or make permanent funding for HPOG by the end of this fiscal year. Meanwhile, several administrative steps should be considered to expand HPOG as a tool to increase recruitment, and to improve the governance and operation of the program:

- ACF should require all HPOG programs in areas of CNA shortages to dedicate funds to support training of CNAs. One legislative proposal to make HPOG permanent (H.R. 3398) would create two demonstration projects with 25 percent of funds focused on training individuals into careers related to pregnancy, childbirth, or postpartum, and training individuals with an arrest or conviction record. Given CNA shortages, ACF should modify its rules to require no less than 25% of funds to be focused on training CNAs.

- The Centers for Medicare and Medicaid Services (CMS) should review its reimbursement rules for HPOG programs supporting CNAs. HPOG operates in a complex reimbursement system and has little influence on wages. Wage increases would need to come from adjustment in CMS regulations governing how nursing home reimbursements from Medicaid and Medicare are used, preferably together with an increase in funding for nursing homes. To help address locations with HPOG programs and severe CNA shortages, CMS should explore opportunities to adjust CNA wages.

- All states should establish HPOG programs. Currently only 21 states have an HPOG program. Yet nursing homes often operate across state lines, and all states are likely to be experiencing nursing home staff shortages. States currently lacking sites should create them under the program and ACF should encourage them to do so. If every state were to have a HPOG program, the effect would be to increase the supply of CNAs and help achieve an equitable improvement in nursing homes across states. While that would require an increase in congressional funding for HPOG, ACF can and should indicate its support for state programs.

- The Secretary of HHS should require the coordination of HPOG activities, including funding of HPOG between ACF and the Bureau of Health Workforce in the Health Resources and Services Administration (HRSA). HPOG currently sits in ACF because the program's original target was TANF participants and has been considered a poverty alleviating program. While successful at accomplishing that task, as the program has evolved and grown it now serves to improve the supply and skills of caregivers across health professions and provides the first steps of a health career ladder. Thus, it would make sense for HPOG to be administrated by the same agency that oversees other health professional training programs targeting underserved communities, such as the National Health Service Corps (NHSC) housed in HRSA. Pending any statutory action to transfer the program to HRSA, the Secretary of HHS should require HRSA and ACF to coordinate

their approaches to HPOG. In particular, ACF's rigorous evaluation should continue whether HPOG moves to HRSA or the two agencies coordinate the program's management. The Maternal, Infant, and Early Childhood Home Visiting Program has a similar arrangement – HRSA administers that program and ACF evaluates it.

- HHS and DoL should create a joint office on the caregiving workforce. The President should direct HHS and the Department of Labor (DoL) to establish a joint, high-level Long-Term Care Workforce Office that would be charged with examining and reporting on all federal workforce programs that can be harnessed to help create an adequate and well-distributed LTC workforce throughout the nation. The Office should recommend steps to strengthen the LTC workforce. The Biden Administration has indicated its support for significant funding for the workforce. The Office would help ensure that such funding helps both to address local shortages and to assure that HPOG becomes an integral part of a larger federal initiative with a clearer focus of reducing shortages and improving working conditions, including wages, benefits, and training.

With nearly 2.3 million leisure and hospitality workers made unemployed by the pandemic, the HPOG program could provide a needed opportunity for these and other workers to be retrained and employed in health-related services for older adults. The support services offered through HPOG are critical elements to retain health care workers and could be especially important for rural communities who may otherwise not have the resources to recruit for high demand occupations such as CNAs.[xiii] These services are also important to retain a diverse pipeline of health care workers given that minority populations are more heavily represented in entry-level positions rather than in higher skilled positions.[xiv] To provide high-quality care to patients, we need a high-quality health workforce. The HPOG program has a proven track record that is built on evidence, and with expanded investments, has the potential to strengthen our pipeline of health care workers in areas of greatest need.

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