Current options being discussed by policymakers cannot yield the highly reliable, highly efficient service delivery system—inclusive of both health care and community-based supportive services—that the nation’s upcoming and transformative “age wave” will require. More far-reaching and rapid innovations in policy and health care delivery are essential. The MediCaring Accountable Care Community initiative is a comprehensive model that can deliver higher quality care for frail elderly Medicare beneficiaries at a lower per capita cost. The savings generated by adhering to established geriatric principles in the delivery of medical care would help fund community-based long-term services and supports (LTSS), using a modified Accountable Care Organization (ACO) known as an Accountable Care Community (ACC). A Community Board would monitor the quality and supply of services for frail elders, the most expensive phase of most lives. The constellation of improvements that form the basis of this model are congruent with the goal of improving access to LTSS, which is one of the 4 areas targeted by the Sixth White House Conference on Aging.

Key words: Long-term care, Community building, Reform, White House, Financing LTSS

“Between 2009 and 2012, the federal government recorded the largest budget deficits relative to the size of the economy since 1946, causing its debt to soar. The total amount of federal debt held by the public is now equivalent to about 74 percent of the economy’s annual output, or gross domestic product (GDP)…. If current laws remained generally unchanged…[by] 2039, federal debt held by the public would exceed 100 percent of
GDP.... Unless substantial changes are made to the major health care programs and Social Security, spending for those programs will equal a much larger percentage of GDP in the future than it has in the past...” – Congressional Budget Office (CBO), 2014 Long-Term Budget Outlook

Issued in July 2014, this solemn prognosis from one of the nation’s primary federal fiscal monitor and budgetary scorekeepers fueled partisan arguments in Congress leading up to the fall 2014 elections. As the dust settles, it appears that threading the needle will require improved bipartisan understanding of the issues fueling health care expenditure growth and broader agreement on balancing entitlement and discretionary priorities. More rigorous and far-reaching analyses are needed to illuminate how reforms in the U.S. service delivery system can produce high-quality results similar to those achieved in “lean manufacturing” processes (Womack, Jones, & Roos, 2007). This heightened awareness may be just in time; America’s “age boom” has begun. By the mid 2020s, the United States will be experiencing a demographically fueled surge in demand for both health care and long-term services and supports (LTSS) that will challenge communities, states, and the federal government as never before. Responding well in a constrained budgetary environment will require smarter development and more rapid dissemination of better-engineered models of care (Spillman & Lubitz, 2000). Can we actually achieve reductions in per capita health care costs, as CBO suggests we must, while making services more reliable and trustworthy? We contend that the United States has the capability to develop and implement sensible reforms to address these looming challenges. To succeed, policymakers, providers, researchers, analysts, and the public will have to adopt broader reforms in service delivery that maximize resources in current programs.

The Altarum Institute Center for Elder Care and Advanced Illness has constructed a model of care, known as MediCaring Accountable Care Communities (MediCaring ACCs), as a practical reform approach that can achieve sustainable costs while expanding availability of LTSS and also improving patient control over care decisions. For communities, the MediCaring model offers a population-based, pragmatic way to plan and build a more coordinated and well-managed eldercare system in anticipation of burgeoning demand.

The MediCaring ACC Service Delivery Model

A more reliable and efficient care system for frail elders must be integrated across multiple programs (e.g., Medicare, Medicaid, Older Americans Act (OAA), federal housing, and similar state and local initiatives) and service setting silos (e.g., hospitals, nursing homes, home care, and housing modifications) that constitute health care and supportive and environmental services. The redesign must start with a clear understanding of this population’s priorities and needs. The methods we propose build on the flexibility that providers, advocates, and local leaders can bring to revising the current service delivery system. These reforms entail building a collaborative care and governance process that focuses on elders’ individual goals. They also encourage explicitly changing the balance of public investments between supportive services and traditional medical services. This flexible approach can be quickly scaled up, does not require enactment of a new LTSS financing program, and can be implemented in time to respond effectively to the needs of our fast-growing population of frail elderly people.

In the MediCaring model (Table 1), the frail elderly cohort consists of people 65 years old or more who are dependent upon others for two or more activities of daily living or who also need nearly constant attendance because of cognitive impairment, along with people 85 years of age or older who recognize their limited physiological reserves and prefer to enroll in a well-designed, comprehensive program that matches their priorities. The model emphasizes development of an individualized, forward-looking care plan for each enrolled frail elder in a community, grounded in a comprehensive assessment of the person’s situation and likely future course, with shared decision-making about the services that best reflect the priorities and values held by each elderly person and family (or in some cases, a friend or surrogate). To be effective, care plans must actively guide all involved health care and social services providers and serve as the basis for achieving more satisfactory outcomes for individuals, for organizing services across different service providers, and for evaluating overall performance of the delivery system. Importantly, these longitudinal plans would reflect the treatment preferences and goals of care for enrolled frail elders and their family members and serve as a central linking document for coordinating medical care and LTSS, whether delivered by hospitals, physicians, family caregivers, home care agencies, nursing homes, social service and housing providers, or others.

The centralized care plan used in the MediCaring model effectively establishes a blueprint for building out a system

Table 1. Core Elements of the MediCaring Accountable Care Community Prototype

| 1. | Frail elders enrolled in a geographic community: |
| 2. | Longitudinal, elder-driven care plans |
| 3. | Medical care tailored to frail elders |
| 4. | Incorporating health, social, and supportive services |
| 5. | Core funding: shared savings from prudent geriatric care (a modified ACO) |
| 6. | Monitoring and improvement by a board representing community interests |

Note: ACO, Accountable Care Organization.
of care using existing programs and resources—one that brings together health care practitioners, social services personnel, and organizations working on housing, transportation, and other community-based services in order to serve a complex population of older adults with chronic conditions and functional limitations. Because the typical enrollee will be living in a private home, the model shifts the emphasis of service delivery from hospital and office settings to care in the home whenever doing so is medically appropriate and would optimize outcomes and costs. Key supportive services include safe housing, subsidized transportation, and home-delivered meals. Medical care decisions will be based on evidence and involve shared decision-making, including honest conversations about the likely impact of possible interventions and the merits of a supportive strategy for diagnosis and treatment. Evidence from research and demonstrations shows that this approach generally leads to substantial reductions in medical care expenditures (Boult, Karm, & Groves, 2008; Chang, Jackson, Bullman, & Cobbs, 2009; Counsell, Callahan, Buttar, Clark, & Frank, 2006; Ouslander, Bonner, Herndon, & Shutes, 2014).

To integrate financing from disparate programs and payers, MediCaring proposes to establish ACCs chartered at the local level. ACCs, a variant on current Accountable Care Organizations (ACOs), are in a prime position to be the focal point for organizing comprehensive care plan service delivery, including LTSS, in part because community-based organizations are the frontline providers of the mainly nonmedical services and supports that are so critical to the safety and stability of frail elderly people. In addition, MediCaring ACCs would be able to develop metrics concerning quality and the adequacy of service supply from locality-specific data sets and to display progress as part of locally managed dashboards. Such dashboards could use information from in-home meal delivery providers, for example, who can track certain kinds of service needs (such as the assistance of a social worker) for homebound (and mostly homebound) persons. Community-based providers arguably have a built-in interest in achieving quality results for participating elders, as well as the capability to seek greater efficiencies in organizing delivery of daily services. MediCaring ACCs can enhance these incentives—particularly if they must meet outcomes-driven metrics and transparency standards for public reporting and audits.

ACCs for frail elders could begin by gradually enrolling frail elders from senior nutrition programs, home care providers, referrals from other types of providers, and public education and information initiatives. Additionally, identifying elders who have an unplanned hospitalization would give the program a substantial population for initial outreach. If functional status information is available (e.g., from OASIS in-home care or medical records), then a highly enriched population can be the target of enrollment outreach. The aim is to offer enrollment to all eligible elders in a given geographic area or community, usually a city or county. In doing so, MediCaring ACCs would benefit from the considerable strengths of community-based organizations, which are familiar with conducting needs assessments and working with key service providers and civic leaders. Once established, MediCaring ACCs would become integrated into community planning and monitoring processes, which would continue to review their performance over time. In turn, good performance would help to maintain public and political support at the local level.

For participating providers, the model’s financial incentives are rooted in an ACO-type shared savings structure. Communities would establish a management and governance structure to monitor service supply and quality, track funding from various reimbursement programs and private sources, set prospective quality and spending targets, track and adjust expenditures on an ongoing basis, and allocate and invest resources where they are most needed, including managing the shared savings. The principal design modifications needed in order to use an ACO approach are that ACCs would need to be allowed to enroll all willing frail elders in the community to provide a comprehensive array of services and to manage savings that will be used in part for reinvestment in needed services for beneficiaries.

The MediCaring Financing Model

The appeal of MediCaring’s financing derives from the observation that about half of a person’s lifetime health expenditures arise in the last period of long lives, with 49% of lifetime expenditures for the average person falling past age 65, and 36% of lifetime expenditures still ahead for those alive at age 85 (Alemayehu & Warner, 2004; Yu, 2006). In 2013, we undertook an analysis of how the model could work in four diverse communities: Akron, OH; Queens, NY; Milwaukee, OR (a suburb of Portland); and Williamsburg, VA. Clinical leaders and community-based organizations collaborated to produce estimates of enrollment, effectiveness, and timing of implementation of the model (MediCaring, 2013). The community leadership projected steady-state enrollment of 15,000 elders across the four communities. Based on estimates from research and demonstrations (especially, Beales & Edes, 2009; Boult et al., 2008; Chang et al., 2009; Counsell et al., 2006; Ouslander et al., 2014), the financing model conservatively projects a decrease of 20% from overall baseline medical costs and 5% from institutional long-term care costs, along with increases in home care and primary care. These savings correspond to a 91% return on investment (ROI) over the first year start-up period and a 249% ROI thereafter, with the program then projected to be able to sustain its financing from savings (Figure 1). Even very frugal baseline Medicare spending patterns, such as those that exist in Milwaukee, OR, showed savings sufficient to counterbalance the 18-month
start-up and the ongoing evaluation costs within 3 years. The total net cost of care savings over the first 3 years, as confirmed by independent actuarial assessment, was projected at $57 million (MediCaring, 2013). This model has to build on local experience and research evidence and the actual effects would differ, but the model does make it clear that substantial savings from prudent and patient-driven medical care are plausible, and that those savings could provide substantial buttressing of the social supports available in the community.

As the U.S. economy and social arrangements shift to accommodate greater longevity, reducing the per capita cost of certain types of medical care where this is desired and prudent—while simultaneously making greater investments in social supports to improve quality of life and reduce expenditures in health care—makes a great deal of sense. For example, improving lighting and hand rails is much less expensive than fixing broken bones and much better for the elderly person. Between now and 2025, the country would greatly benefit from structured public and leadership discussions about what elders and their families want and expect and how that can be achieved when tens of millions of Americans will be living to 85 years and beyond. In short, we will be experiencing a transformation of the same magnitude as the Industrial Revolution of the 19th century. The key difference is that the 21st century will have a Longevity Revolution. A thoughtful strategy will involve encouraging communities to test, adjust, and evaluate potentially transformative initiatives much more readily than we have in the recent past.

The Baseline: Policy Initiatives That Fail to Meet Frail Elders’ Needs

Arguably the most substantial change that reformers must confront is to turn away from the usual fragmented approach that are limited to a particular diagnosis, or a particular setting of care, or even a particular funding stream. Policy debates tend to focus mainly on high-frequency diagnoses or high-cost settings in the Medicare program and do not simultaneously consider similar patients in other programs and the key roles played by Medicaid and the OAA. Conversely, state officials focus primarily on Medicaid and pay less attention to Medicare. Often, Congress scrutinizes financing but is less involved in redesign of service delivery. Sometimes discussions turn to trying to control spending through per-beneficiary caps, block grants, and global budgets—but these approaches ignore the imperative to improve quality. Others focus on specific fiscal “carrot and stick” incentives, for example, for hospital readmissions—but these are too narrow to produce a lasting downward shift in spending.

On the social services side, the community-based elder-care network is largely supported by the OAA, which is appropriated annually. OAA services are unknown to most citizens until a family member needs meals delivered or a housing adaptation. The OAA is not a high priority for many Members of Congress, which is evident in lengthy delays that occur when the law comes up for periodic reauthorization, as well as its low funding levels. While the aged population grew by 30% from 2004 to 2014, OAA funding barely budged, from $1.8 billion in FY 2004 to $1.88 in FY 2014. Inflation-adjusted funding for key OAA nutrition programs such as “Meals on Wheels” shows a substantial decrease in purchasing power, from $1.04 billion in 1990 to $768 million in 2013 (Fox-Grage & Ujvari, 2014).

Another barrier to building a more efficient system is the rise of private entrepreneurs in the post-acute care (PAC) time period (the 90 days after hospital discharge). Companies sometimes referred to as “efficiency contractors”
have initiated a growing number of contracts with managed care organizations, bundled payment awardees, and ACOs, using nontransparent, proprietary protocols to streamline Medicare-covered PAC services aggressively. Their success highlights, and may help to eliminate, the wastefulness of current practices. One contractor has announced that the company can save, on average, 45% of Medicare spending in the 90-day PAC period, a time period amounting to 23% of Medicare expenditures (Scully, 2014). If permitted to continue unabated, these public dollars will disappear from Medicare with no accompanying reinvestment in meeting other needs, such as building capacity for community-based supportive services during the “age boom.” This suggests that policymakers and citizens may wish to carefully consider the desirability of efficiency contractors realizing large gains from a public program at a time of budgetary austerity and steadily growing demand for services (Lynn, 2014).

Another area of current emphasis that has a relatively modest impact on the frail elder population is healthy aging and prevention strategies. These interventions do contribute to well-being and should always be included in quality metrics—for example, reduction of caregiver stress, reduction of falls risk, and improvements in mobility—but every person’s physiology eventually fails and this leads to functional losses, worsening chronic conditions, and dying. Therefore, illness prevention and healthy aging initiatives do not substantially alter the costs of the last phase of life.

Established quality monitoring and improvement systems fail to address the fact that some tests and treatments are unhelpful to and may be undesired by frail elders (e.g., mammograms for 90-year-old women). The importance of little remaining time is very salient to the decision-making of a frail elder but is virtually absent from guidelines, quality measures, and practices that have been developed for a somewhat younger population. These practices sometimes persist because neither physician nor patient is eager to confront the closeness of death (Boul, Counsell, Leipzig, & Berenson, 2010). But precisely because frail elderly people have much less time to benefit from many prevention strategies, or from certain strenuous or difficult treatments such as cardiac surgery and chemotherapy, treatment protocols need to be re-examined. In addition, frail elder physiology generally tolerates disruptions and challenges much less well than earlier in life. Recognizing this, many small programs have shown that we can deliver much better care at lower cost if we adopt geriatric principles and also work harder to provide adequate housing, food, nutrition, and support of family caregivers (Counsell et al., 2006; Hirth, Baskins, & Dever-Bumba, 2009; Romo et al., 2013). Regrettably, these initiatives have often been viewed as “outside of” mainstream medical care and have not had broad implementation. In a Medicare system that has largely rewarded procedures, underpaid for counseling and decision-support, and excluded supportive and environmental services, having a robust medical care supply and an inadequate support system is not surprising (Simon et al., 2013). To tackle this situation, policymakers and stakeholders would do well to focus on optimizing the broader service array that the very large Boomer cohort will need (Kaye, Harrington, & LaPlante, 2010; Robison, Shugrue, Fortinsky, & Gruman, 2014).

**Promising Reforms That Could Be Components of MediCaring**

To date, most research projects, demonstrations, and improvement innovations have focused on interventions that change the dynamic of the health care system only modestly. Many managed care plans, hospitals, and ACOs, for example, have incorporated a care navigator, care coordinator, care manager, or similar person into their systems, who is meant to create efficiencies by being knowledgeable about available services and arranging what the patient needs. Elders and family members going through this part of life often need a knowledgeable professional friend, and many different professionals claim this role, including social workers, nurses, and trained nonclinicians. But as typically configured, this popular option often takes the job of coordinating services across settings and programs away from clinical teams and the elder and family—which then makes them even less likely to participate in negotiating comprehensive, practical care plans that reflect the elderly person’s own treatment preferences and remaining life goals. Furthermore, neither care navigators nor clinical teams typically take responsibility for assuring adequate follow-up and timely provision of needed support services. Medical homes, with their focus and skills, are also finding it difficult to coordinate care for their complex elderly and mentally ill patients (Croghan & Brown, 2010). While there is appeal in having a single go-to person, tests of the care navigator concept to date have shown modest progress at best (Brown, 2013; Brown, Peikes, Peterson, Schore, & Razafindrakoto, 2012).

We need bolder innovations. In a more accountable delivery system, the role of care coordinators would be closely aligned with those set forth in a longitudinal care plan accessible to all service providers. A care coordinator would then be enabled to align services provided by the medical team with those provided by social services providers and could also influence the availability and even the supply of community-based supportive resources. In addition, the care manager and the clinical team would be more attuned to, and accountable to, quality metrics that reflected whether the services delivered actually met the
treatment preferences of elders and comport with their goals. This is a set of metrics that no one has yet developed and set forth as a standard. If enough communities can launch MediCaring ACC pilots, their experience would establish new baseline targets and benchmarks for appropriate care for tens of millions of Boomers.

The beginnings of a more far-reaching approach are arising in the national demonstration for dually eligible beneficiaries (Medicare-Medicaid Coordination Office, 2014). In this program, federal and state agencies have increasingly recognized the complexity of encouraging reform that is tailored to different populations (e.g., developmentally disabled adults, physically disabled adults, frail elders, and persons with serious mental illness or substance abuse) receiving services in varying health care systems (e.g., with different penetration of managed care or hospital utilization) and have accordingly allowed more innovation at local and regional levels, while also adhering to a set of core standards and quality metrics (Eiken, Sredl, Burwell, & Gold, 2010; Zainulbhai, Goldberg, Ng, & Montgomery, 2014). Over time, this approach will help build a more efficient and reliable care system, though best practices will require incorporating social services providers like Meals on Wheels, and providers of environmental supports including adapted housing, as part of comprehensive elder care.

The 12 states participating in the national dual eligible demonstration (as of July 2014) are testing various capitated and managed fee-for-service models covering about 1.5 million beneficiaries (Medicare-Medicaid Coordination Office, 2014). The negotiated Memorandums of Understanding feature multiple quality metrics, more than 70 of which are “core” federal measures that apply to demonstrations in all participating states. Very few of these measures apply to LTSS delivered in the community or focus on quality of life. Missing are measures such as the alignment of the care plan with the priorities of the frail elderly person and the ability to choose a suitable living arrangement. A worthy care system for dually eligible frail elderly persons should be able to expand to include frail elders who are not yet poor enough for Medicaid. Doing that requires sustainable financing, which the MediCaring ACC model proposes (Lynn, 2013; MediCaring, 2013).

Another sign of progress is the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) (113th Congress, 2014). Enacted in September 2014, the law requires Medicare to establish a common PAC assessment tool and requires PAC provider organizations—skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, and long-term care hospitals—to report standardized assessment data, including functional limitations. IMPACT also calls for new quality measures (which would follow from the standardized assessment tool) on functional status, skin integrity, medication reconciliation, incidence of major falls, and patient preference. The law will galvanize improvements in data that will allow predictions of the effects of various combinations of services and beneficiary situation, as well as assessment of the quality of care. By 2022, the IMPACT bill requires the Medicare Payment Advisory Commission and the Centers for Medicare and Medicaid Services to submit recommendations for redesign of a PAC payment system “that establishes payment rates according to individual characteristics instead of the setting where the patient is treated,” according to a summary (113th Congress, 2014).

A Meeting of Many Minds – A Commitment to Testing a MediCaring Approach?

To some, discussions about how we can we assemble some of the pieces of our health care puzzle to reduce per capita costs while doubling the system’s capacity may seem improbable in this hyper-partisan era. Yet in 2014 and 2105, the outgoing Obama Administration is trying to jumpstart richer discussions on retirement security, LTSS, healthy aging and elder justice in various states and localities as part of the Sixth White House Conference on Aging (WHCOA). The first WHCOA, held in 1961 during the Administration of John F. Kennedy, resulted in a far-reaching report with hundreds of recommendations. Some of these were aimed at various levels of government and some were even meant to be taken forward by private citizens. The initial conference focused most of its attention on health care and income issues and worked to spur interest in development of seminal policy: Medicare, Medicaid, and the OAA, all enacted in 1965.

Fifty years later, the challenge of expanding the ability of existing programs to fund LTSS for the nation’s burgeoning population of the old-old is at the heart of the MediCaring ACC model. But to organize and implement community-based systems of comprehensive care will require a remarkable level of strategic leadership and cooperation across traditional boundaries, and a meeting of many minds at multiple levels of government. Just as the Sixth WHCOA is intended to look 10 years ahead and create a blueprint for action that the nation can embrace, a plan to redesign the care system for the fastest growing and most costly population of all, the frail elderly phase of life, will necessitate new types of agreements and operational flexibilities, both across the workforce and across programs that were not originally envisioned as working in tandem. For now, the most important work—the essential spark—starts with a community’s desire to have a different and better care system for its residents who are living with the disabilities
and health challenges associated with advanced age. But progress depends upon federal policy that encourages substantial innovation and testing and allows that community to move ahead.

**Funding**

This work was supported in part by grants from the Milbank Fund for Rehabilitation and from the Stern Family Foundation, as well as core support from the Altarum Institute.

**Acknowledgments**

The authors gratefully acknowledge the support and help of many people who have shared in developing the MediCaring model and especially the work of leaders in the four communities who helped to create the estimates of enrollment and effectiveness in predicting the financing for MediCaring.

**References**


