Improve

Health Through Community-Based Interventions

Recognize and protect the pivotal role that the Aging Network plays in addressing the social determinants of health and bridging the gap between acute care, behavioral health and long-term services and supports systems to improve health outcomes and reduce health care costs.

For nearly five decades, the Aging Network has developed local systems of coordinated services and supports that provide person and family-centered, home and community-based services (HCBS) for older adults and their caregivers. Services offered through AAAs include meals provided in the home and in community settings, in-home care, transportation, information and referral, evidence-based health and wellness programs, medication management, case management, caregiver supports and more.

The U.S. health care system is in the midst of a dramatic change as focus shifts from delivering volume to improving outcomes and value for patients. This evolution creates opportunities for health care organizations to work with AAAs and the Aging Network to better meet the health and wellness needs of our nation's aging population.

Both medical and social systems must prioritize partnership and collaboration, however, if we are to be successful. One sign of this increasing connection is that in recent years, as health care costs have continued to grow, the health care sector has taken a closer look at how social issues affect health—particularly individuals who have chronic conditions or other complications making them the most expensive to manage. These **social determinants of health (SDOH)**, also referred to as non-medical risk factors (NMRF), include, but are not limited to, access to housing, employment, nutritious food, community services, transportation and social support. Addressing these factors improves long-term health and

wellness outcomes. However, much work remains to fundamentally integrate historically disparate medical and community-based care systems.

As experts at providing services that address the social determinants of health, AAAs are increasingly partnering with health care entities to improve the health of older adults by engaging in innovative models of service delivery. In fact, AAA respondents to a 2018 n4a survey conducted in partnership with the Scripps Gerontology Center found that 44 percent already had contracts with health care entities.[23] However, there is ample opportunity to expand these efforts.[24] Specifically, Aging Network entities and other community-based organizations (CBOs) are evolving beyond individual partnerships with health care entities and developing regional and statewide networks of CBOs ready to fill any gaps and serve more people, thus enhancing their value as partners for health care organizations by improving the lives of their patients.

Policymakers in the Administration and Congress must prioritize proposals that preserve improvements in care delivery and promote advances toward better integrated, person and family-centered care. Community-based organizations—particularly AAAs—must be key partners in achieving this monumental change. Involving these on-the-ground experts is the best way to address the social determinants of health, provide more coordinated care for the way people live, and, ultimately, drive better health outcomes and save money.

n4a urges federal policymakers to recognize, engage and preserve the full potential of the Aging Network in improving health and reducing costs, particularly in the following areas.

Medicare

For more than fifty years, Medicare has provided vital acute health care coverage to older adults and people with disabilities. Currently, Medicare covers nearly 60 million beneficiaries—or nearly one out of every six Americans. Medicare is the country's largest health care payer, spending more than $731 billion in 2018, or roughly 15 percent of total federal expenditures.[25] While the rate of increase in Medicare spending has slowed since the Affordable Care Act and other cost-savings measures were implemented, as the population continues to age and more individuals become eligible for Medicare, costs will inevitably grow. On the current trajectory, annual Medicare spending is expected to top $1 trillion by 2026.[26] As a result, it is essential that Medicare be a driving factor in pursuing opportunities to provide better care at a lower cost, which includes incorporating access to community-based services that address SDOH.

While Medicare's primary role remains to provide acute health care in doctors' offices and hospitals to older adults and people with disabilities, health care outcomes and costs are driven, in large part, by SDOH, and Medicare must include and pay for opportunities to address these emerging realities.

Addressing SDOH through Supplemental Benefits in Medicare Advantage

Despite the growing awareness of the inherent value of social services that address SDOH and help older adults and caregivers get and stay healthy and independent, Medicare investments still do not reflect the growing need. Research has shown that non-medical risk factors in the physical environment and individual behaviors account for 80 percent of the factors that influence overall health.[27] Unfortunately, the vast majority of health care funding is directed toward acute care. In order to remedy this imbalance, health care payers and providers are increasingly shifting focus. For example, in April 2018, the American College of Physicians released a set of recommendations to improve patient care by enhancing services addressing SDOH,[28] including increased communication and collaboration with CBOs to treat patients who are at risk of being negatively affected by SDOH.

Historically, a wide gap has existed between social services and medical systems. In bridging this gap, it is imperative that intersections, partnerships, coordination processes and payment systems recognize the value that both bring to the table rather than medicalize social services, which will undoubtedly lead to higher costs and reduced consumer satisfaction.

Since 2018, the Centers for Medicare & Medicaid Services (CMS) began implementing an expanded definition of health-related supplemental benefits through Medicare Advantage (MA). This was an important first step to include critical high-need recipients of HCBS who may not otherwise have access to these services. Additionally, in its implementation of the 2018 Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, CMS expanded options for MA plans to address these non-medical risk factors for high-cost chronically ill beneficiaries by offering access to Special Supplemental Benefits for the Chronically Ill (SSBCI).

These initiatives are important first steps into a future of improved care integration and promoting access to services that promote health at home and in the community under Medicare, but many barriers continue to discourage widespread adoption of these important benefits. For example, MA plans serving rural areas where access to service providers is limited have been reluctant to include additional benefits in their plan offerings.

Additionally, MA plans report inconsistent and incomplete guidance from CMS on supplemental benefits has been challenging to work around.[29] To address these challenges and to give MA and CBO networks the time necessary to realize these opportunities, we encourage Congress and the Administration to continue promoting efforts to address SDOH through Medicare and accelerate the incorporation of existing social services infrastructures, particularly the Aging Network, into government and industry efforts that improve the health of older adults. Additional recommendations on SSBCI implementation should be considered by CMS and lawmakers, including the *Guiding Principles for New Flexibility Under SSCBI,* which n4a helped develop and has endorsed.[30]

Preserving and Expanding Care Options in Traditional Medicare

2020 provides an opportunity to develop forward-looking proposals for Medicare to ensure that a growing population of Medicare beneficiaries have access to comprehensive coverage options under original, Fee-for-Service (FFS) Medicare. Historically, FFS Medicare has not covered dental, vision or hearing care, despite the fact that these services are critical to maintaining health.

In 2020, policymakers should consider legislative solutions to remedy this historically myopic view of health care coverage under traditional Medicare and seriously consider opportunities to expand FFS Medicare to provide basic oral, hearing and vision care. Evidence shows that neglecting these medical needs can lead to deterioration in overall health, including an increased risk of dementia, social isolation and falls, resulting in potentially increased health care costs over the lifespan.

Additionally, Administrative and congressional action has primarily focused on expanding access to supplemental services through Medicare Advantage. However, the case for improving care integration is equally compelling for all Medicare beneficiaries, not just the roughly one-third who enroll in MA plans. We encourage policymakers to explore solutions that level the playing field between traditional FFS Medicare and MA to ensure that effective interventions are equally available to all Medicare beneficiaries.

Expanding Non-Biased Beneficiary Education and Enrollment Assistance

As Medicare grows more complex, it is essential that robust efforts are made to ensure that new and existing beneficiaries are as educated as possible about their benefits and how to use them. Existing efforts to provide **non-biased, person-centered assistance** through the State Health Insurance Assistance Program (see page 13) should be greatly expanded to ensure that those who need the most help selecting the best plan for themselves are able to do so. This is in the best interest of consumers, plans and the taxpayer. Additionally, further education on how to most effectively use plan benefits drives better health. The need is documented: a recent survey conducted by Anthem with n4a found that 59 percent of older Americans find navigating the health care system difficult, and more than half of non-retired older adults need more help understanding their benefits.[31] Nearly eight in 10 caregivers believe that they would be able to better help the person they care for manage their health if they better understood their benefits.[32] Given AAAs' existing role in providing Medicare education (two-thirds operate the local SHIP and nearly all provide basic education) and longstanding reputation for non-biased counseling, it's essential that any changes reflect this existing strength and resource.

Additionally, we encourage Congress to extend funding for trusted CBOs that provide Medicare outreach and enrollment activities to assist low-income Medicare-eligible beneficiaries in accessing benefits for which they are eligible (i.e., the LIS/Extra Help and Medicare Savings Programs). These bipartisan and longstanding Medicare education and enrollment activities enable AAAs, SHIPs and Aging and Disability Resource Centers (ADRCs) to work directly with beneficiaries to ensure that low-income older adults are provided with the information and support they need to make well-informed and cost-effective choices about their Medicare coverage. Originally funded for three years through the 2008 **Medicare Improvements for Patients and Providers Act (MIPPA),** funding for these activities was extended in the FY 2020 omnibus legislation through May 22, 2020. n4a calls on Congress to include a MIPPA extension in forthcoming health care extenders legislation, including increases specifically for SHIPs, AAAs and ADRCs to conduct this essential work.

Tap Into the Value of the Aging Network

n4a appreciates that in recent years, CMS has recognized the value and importance of community-based organizations—in particular, AAAs—in achieving positive patient health outcomes.

However, we urge the Administration (specifically CMS) and Congress to more effectively ensure that AAAs are not only included as longstanding, trusted community sources to bridge the gap between acute and community-based care settings, but that they are also appropriately and adequately compensated for the services they provide to ensure that health care providers meet patient care goals. Without fully recognizing and supporting the value provided by existing cost-efficient systems—such as AAAs managing Medicaid HCBS waivers or serving as the link between Medicaid and the nation's non-Medicaid LTSS system—any reforms will fail beneficiaries, unnecessarily undermine existing successful systems and potentially reduce the quality of care for the older adults who most need these services.

Notes

1 U.S. Census Bureau, *2017 National Population Projections Tables;* https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.
2 AARP Research, *2018 Home and Community Preferences: A National Survey of Adults Age 18-Plus;* https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html.
3 U.S. Department of Health and Human Services, *How Much Care Will You Need?;* https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html.
4 U.S. Census Bureau, *Older People Projected to Outnumber Children for First Time in U.S. History;* https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html.
5 U.S. Census Bureau, *2017 National Population Projections Tables.*
6 AARP Livable Communities, *Aging in Place: A State Survey of Livability Policies and Practices;* https://www.aarp.org/livable-communities/learn/research-trends/info-12-2012/aarp-aging-in-place-state-survey.html.
7 U.S. Department of Health and Human Services, *An Overview of Long-Term Services and Supports and Medicaid: Final Report;* https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report.
8 Community Living Policy Center, *Improving Home and Community-Based Services Infrastructure: A Policy Proposal Based on the Balancing Incentive Program;* https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/HCBS%20Infrastructure%20Brief%2010.21.19_0.pdf.
9 Medical Transportation Access Coalition, *The Value of Medicaid's Transportation Benefit: Results of a Return on Investment Study;* https://mtaccoalition.org/wp-content/uploads/2018/08/NEMT-ROI-Study-Results-One-Pager.pdf.
10 Julianne Holt-Lunstad, Timothy B. Smith, and J. Bradley Layton, *Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Medicine;* https://doi.org/10.1371/journal.pmed.1000316.
11 AARP, *The High Price of Social Isolation;* https://www.aarp.org/health/medicare-insurance/info-2017/isolation-higher-medicare-fd.html.
12 AARP Public Policy Institute, *Valuing the Invaluable: 2019 Update — Charting a Path Forward;* http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html?cmp=RDRCT-VALUN_JUN23_015.
13 Congressional Budget Office, *Medicaid—CBO's April 2018 Baseline;* https://www.cbo.gov/system/files?file=2018-06/51301-2018-04-medicaid.pdf.
14 Alzheimer's Association, *Alzheimer's Disease Facts and Figures;* https://www.alz.org/alzheimers-dementia/facts-figures.
15 U.S. Department of Health and Human Services, *Elder Justice Coordinating Council (EJCC),* https://acl.gov/programs/elder-justice/elder-justice-coordinating-council-ejcc.
16 AARP Public Policy Institute, *Valuing the Invaluable.*
17 Congressional Budget Office, *Medicaid—CBO's April 2018 Baseline.*
18 Bureau of Labor Statistics, *Unpaid Eldercare in the United States—2017–2018 Summary: Data from the American Time Use Survey;* https://www.bls.gov/news.release/elcare.nr0.htm.
19 National Council on Aging, About Evidence-Based Programs; https://www.ncoa.org/center-for-healthy-aging/basics-of-evidence-based-programs/about-evidence-based-programs/.
20 RAND Corporation, *Multiple Chronic Conditions in the United States;* https://www.rand.org/pubs/tools/TL221.html.
21 Milken Institute, *The Cost of Chronic Diseases in the U.S.: Executive Summary;* https://assets1c.milkeninstitute.org/assets/Publication/Viewpoint/PDF/Chronic-Disease-Executive-Summary-r2.pdf.
22 Centers for Disease Control and Prevention, *The State of Aging and Health in America 2013;* http://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf.
23 National Association of Area Agencies on Aging, *Measuring the Value of AAA Services: Making the Case to Health Care Partners;* https://www.n4a.org/files/n4a_ROI_Report_July2018_Final.pdf.
24 Health Affairs, *Health Care And Community-Based Organizations Have Finally Begun Partnering To Integrate Health And Long-Term Care;* https://www.healthaffairs.org/do/10.1377/hblog20180130.620899/full/.
25 Kaiser Family Foundation, *The Facts on Medicare Spending and Financing;* https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.
26 Ibid.
27 National Academy of Medicine, *Social Determinants of Health 101 for Health Care: Five Plus Five;* https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.
28 The American Journal of Managed Care, *Physicians Call for Action on Social Determinants of Health;* https://www.ajmc.com/newsroom/physicians-call-for-action-on-social-determinants-of-health.
29 HealthPayerIntelligence, *Challenges of Creating Medicare Advantage Supplemental Benefits;* https://healthpayerintelligence.com/news/challenges-of-creating-medicare-advantage-supplemental-benefits.
30 Anne Tumlinson Innovations and Long-Term Quality Alliance, *A Turning Point in Medicare Policy: Guiding Principles for New Flexibility Under Special Supplemental Benefits for the Chronically Ill;* https://annetumlinsoninnovations.com/wp-content/uploads/2019/07/2019-07-24_GuidingPrinciplesForSSBCI.pdf.
31 National Association of Area Agencies on Aging, *8 in 10 Older Americans Believe They Are Prepared to Age Well, But Need Help Understanding Their Benefits and Navigating the Health Care System;* https://www.n4a.org/content.asp?admin=Y&contentid=1002.
32 Ibid.