Enhancing the Health of Older Adults

The national network of Area Agencies on Aging (AAAs) and Title VI Native American aging programs is poised to play significant roles in all health reforms that focus on helping older adults stay healthy and age in place. Supported by the State Units on Aging and joined by the tens of thousands of service providers and other community-based partners, the AAA and Title VI network offers a proven track record, well-established community partnerships, stability and a reputation as a trusted resource for older adults and caregivers in all communities.

AAAs have built on their long-standing track record of health-related services provided through the Older Americans Act (OAA) and Medicaid to develop relationships with acute health care providers and have shown positive results in improving patient safety, providing better outcomes and reducing health care costs.

n4a urges federal and state policy makers to recognize and engage the full potential of the Aging Network when transforming health care delivery systems, particularly in the following areas.

Aging and Disability Resource Centers
Aging and Disability Resource Centers (ADRCs) have proven to be a valuable “no wrong door” model for consumers in need of LTSS. Developed by AoA and CMS during the Bush Administration, these demonstrations were granted $10 million in mandatory funding for five years in the ACA. We believe ADRCs have proven their value and deserve a continued, stable funding source that, over time, will help grow the system nationwide.

Mandatory investments made through the ACA expired at the end of FY 2014, and the ADRC network stands to lose two-thirds of its annual federal funding if these investments are not restored in 2015. The 113th Congress did not bridge the gap created by expiring mandatory funding and FY 2015 discretionary appropriations for ADRCs is just $6 million. n4a supports the President’s FY 2016 budget, which includes $20 million in discretionary funding to continue supporting and expanding in ADRC “no wrong door” network development, but also supports larger, broader investments in the ADRC network to ensure that the vision of ADRCs to truly serve as a “no wrong door” network of information and access to LTSS is fully realized.

As detailed in n4a’s Recommendations for the 2011 Reauthorization of the Older Americans Act, it is important that the role of ADRCs be clarified vis-à-vis existing AAAs and their disability counterparts to ensure that advancements build upon existing systems and avoid redundancy.

Care Transitions and Care Coordination
AAAs have demonstrated their ability to partner effectively with health care systems and state quality improvement organizations to administer care transition programs that result in seamless transitions for consumers from acute care settings to home. This results in improved health outcomes and fewer re-hospitalizations.

The Affordable Care Act (ACA) established the Community-based Care Transitions Program (CCTP) to improve care for high-risk Medicare beneficiaries being discharged from the hospital to prevent unnecessary re-hospitalizations and avoidable health care costs. To receive funding from the program, which is administered by CMS as part of the Partnership for Patients, community-based organizations must partner with hospitals. AAAs have taken the lead in this initiative: AAAs have played a key role in approximately 90 percent of sites. More than 100 AAAs received initial CCTP funding.

However, n4a has serious concerns regarding how CCTP site performance was measured and evaluated by CMS. n4a is concerned that readmissions and enrollment metrics used to reflect program performance did not adequately or accurately capture site performance or impact. Therefore, n4a encourages Congress to pursue objective evaluation of the program. Furthermore, n4a is concerned that CMS’s ability
In order for reforms to be successful, we must tap the proven experience of AAAs in providing information, counseling, case management, services integration and other assistance to older adults.

Medicaid Managed Care Initiatives
As a majority of states have or are rapidly moving from fee-for-service to capitated managed care models for their Medicaid programs, it is critical that the Aging Network be the bridge to integrate acute and home and community-based services (HCBS) so that the quality of LTSS for older adults and people with disabilities is not compromised. There is no “one size fits all” approach to Medicaid LTSS and, as such, mandatory managed care initiatives need to be closely monitored to ensure they do not jeopardize access and quality of care. For example, outcome measures on quality should be as or more important than cost outcomes.

n4a urges states and the Administration to fully engage with the Aging Network as they consider and implement such reforms. In order for reforms to be successful, we must tap the proven experience of AAAs in providing information, counseling, case management, services integration and other assistance to older adults. If there is a rush to reduce costs without careful consideration of the value provided by existing cost-efficient systems—such as AAAs managing Medicaid HCBS waivers and AAAs serving as the link between Medicaid and the nation’s non-Medicaid LTSS system—the result will fail beneficiaries, unnecessarily undermine existing successful systems, and potentially reduce the quality of care for vulnerable populations.

Prevention and Wellness
We urge Congress to maintain funding for the Prevention and Public Health Fund (PPHF), which represents a critical investment in promoting wellness and preventing the diseases that are a main driver of health care costs. Supporting evidence-based prevention and wellness programs for older adults is imperative, given the nation’s aging population and growing rates of chronic disease. More than 80 percent of Americans age 65 and older have at least one chronic condition, and half have at least two. Costs, both in terms of health care dollars and disability rates, are staggering. Among older adults, chronic conditions account for nearly 95 percent of health care expenditures and limit the activities of millions of people, decreasing their productivity and ability to live independently.

Lawmakers and administrators should build upon proven, cost-effective evidence-based health promotion and disease prevention programs for older adults at the community level, including chronic disease self-management and falls prevention programs provided by the Aging Network under the Administration for Community Living (ACL) leadership. These programs deliver proven results and reduce Medicare and Medicaid costs. n4a supports the Administration’s FY 2016 proposal to allocate $8 million of the PPHF to ACL for the Chronic Disease Self-Management Program, and we encourage Congress to again fund AoA falls prevention activities through the PPHF, at least meeting FY 2015’s level of $5 million.
Other Vital Issues

Health Care Ombudsman

n4a believes that it is essential for all Medicaid and Medicare consumers in managed care systems to have an independent advocate who will provide individual assistance and represent enrollees on larger systemic issues in front of plans, the state and the Centers for Medicare and Medicaid Services. While states will want to develop ombudsman models that best suit their needs, we recommend these key elements be included in all ombudsman programs: (1) information and assistance in pursuing complaints and appeals; (2) negotiation and mediation; (3) case advocacy assistance in interpreting relevant law; (4) reporting on patterns of non-compliance by plans as appropriate; and (5) individual case advocacy in administrative hearings and court proceedings relating to program benefits.

Veteran Directed HCBS

The growth of the veteran aging population and the desire of veterans of all ages to self-direct their care has led to the rapid expansion of the Veteran Directed Home & Community-Based Services (VD-HCBS) Program at the Department of Veterans Affairs (VA). Area Agencies on Aging are key partners in VD-HCBS provision in many communities, and these programs have achieved nearly universally positive outcomes for participating veterans. These investments must continue to ensure access to options for self-directed care, and respect veteran preference to receive HCBS over more costly, often unwanted, nursing home care.

Medicare Low-Income Outreach

Since 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) has helped hundreds of thousands of Medicare beneficiaries access $2.3 billion in health care benefits. With dedicated MIPPA funding, AAAs, State Health Insurance Assistance Programs (SHIPs) and ADRCs have conducted outreach and assistance for low-income Medicare beneficiaries to access Part D Low Income Subsidy (LIS/Extra Help) and the Medicare Savings Programs (MSPs). Additionally, MIPPA grants have helped Medicare beneficiaries access and take advantage of the free preventative services authorized under the ACA. Congress should implement continued, stable funding for these crucial activities.

Money Follows the Person and Balancing Incentive Program

The Medicaid Money Follows the Person (MFP) Rebalancing Demonstration Grant and the Balancing Incentive Program (BIP) have played a crucial role in state efforts to rebalance Medicaid long-term care systems and increase access to non-institutional LTSS. According to CMS, over 40,500 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs as of December 2013. Additionally, BIP provides new ways for states to serve more people in home and community-based settings. The ACA both strengthened and expanded MFP and created BIP, and both should be reauthorized, extended and improved to ensure Medicaid beneficiaries have access to HCBS.