Enhancing the Health of Older Adults

Recognize and protect the pivotal role that the Aging Network plays in bridging the gap between the acute care, behavioral health and long-term services and supports systems to increase patient safety, improve quality of care and reduce health care costs.

The national network of Area Agencies on Aging (AAAs) and Title VI Native American aging programs are the community keystones in home and community based services (HCBS) coordination and delivery. AAAs and their provider networks are on the front lines of the country’s unprecedented demographic shift as 10,000 baby boomers turn 65 each day—a shift which is driving the growth in Medicare and Medicaid utilization and the need to better plan for, coordinate and deliver appropriate care to vulnerable and aging populations across care settings and payment models.

With the current health care paradigm shift that is both prioritizing integrated, person-centered, self-directed care, and rebalancing long-term care delivery away from institutionalization and toward in-home and community-based care options, community-based organizations (CBOs)—particularly AAAs—are key partners in achieving such monumental change. This shift—aimed at achieving the triple aim of better care for people, better health for communities and delivered at a lower cost—requires changes within a historically rigid and resistant medical model of health care delivery to realize and respond to the fact that a majority of an individual’s health and recovery happens at home and in the community.

The AAA 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 experience providing health-related services 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 administrative and legislative action by federal policy makers to recognize, engage and preserve the full potential of the Aging Network when transforming health care delivery systems, particularly in the following areas.

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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 long term services and supports (LTSS) for older adults and people with disabilities is not compromised. There is no “one size fits all consumers” 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. There are important steps that the Administration must take to ensure that the Aging Network can both continue to provide services to enable older adults to age at home and in the community and make critical infrastructure investments to leverage decades of expertise and be a key partner in enabling managed care organizations (MCOs) to meet their patient care goals.

Opportunities for Administrative Action

Promoting the Importance of the Aging Network: n4a appreciates recent recognition by the Administration, especially from the Centers for Medicare & Medicaid Services (CMS), of the value and importance of community-based organizations—in particular, AAAs and Aging and Disability Resource Centers (ADRCs)—in achieving positive patient health outcomes. However, we urge the Administration to support and fully implement changes in regulatory policy to ensure that CBOs are not only considered as part of the health care spectrum, but are fully engaged, included and compensated for the critical services they provide. For example, the recent draft Medicaid Managed Care regulations and Discharge Planning regulations, raise concerns about the possibility that MCOs will interpret these CMS regulations as an endorsement to leverage AAAs’ and ADRCs’ resources, support and services without any appropriate compensation. Given the limitation of federal OAA and ADRC funding, AAAs cannot be expected to extend their existing services and/or re-prioritize clients, especially if waiting lists exist, to accommodate MCO clients.

We urge CMS to implement final regulatory requirements that would ensure that the Aging Network entities are not only included as the long-standing, trusted community sources to bridge the gap between acute and community-based care settings, but also appropriately and adequately compensated for their roles in ensuring 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 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.

Preventing Disruption of Integrated, Efficient, Patient-Centered Care: AAAs have a long history of providing consumers with independent, conflict-free options counseling. For over 40 years, AAAs in particular have been a trusted resource for older adults and their caregivers and have developed well-defined, person-centered, user-friendly systems to develop, coordinate and deliver a wide range of home and community-based services that track consumer outcomes. In order to ensure that any potential conflict of interest is prevented, AAAs have established sophisticated and transparent firewalls between programs where it is necessary to ensure proper administration of programs and appropriate protection of beneficiaries’ interests.
However, there has been a recent push by CMS to review and reinforce a regulatory patchwork of conflict-of-interest requirements and subsequent changes in state efforts to ensure that systems are fully compliant. While we certainly appreciate and understand the importance of ensuring that patient assessment and access to care is free of conflicts, and realize the need to reexamine some systems where conflicts of interest exist, we are greatly concerned that well-functioning, appropriately firewalled, efficient systems will be undermined and dismantled, and that patient care will become ultimately more fragmented—unless CMS provides clarification and guidance to states about current conflict-of-interest requirements.

**Importance of Ombudsmen in Protecting Access to Care in an Integrated Health Care System:** n4a believes that it is essential for all Medicaid and Medicare consumers in managed care and other innovative health care delivery 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 CMS. 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) notification of consumer rights in clear and concise language easily understood by consumers; 2) information and assistance in pursuing complaints and appeals; 3) negotiation and mediation; 4) case advocacy assistance in interpreting relevant law; 5) reporting on patterns of non-compliance by plans as appropriate; and 6) individual case advocacy in administrative hearings and court proceedings relating to program benefits.

**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 transitions programs that provide seamless transitions for consumers from acute care settings to home. This results in improved health outcomes and fewer re-hospitalizations. We need to expand and improve the level of coordination in our nation’s health and LTSS systems with care transitions and care coordination, and ensure that there are clear roles for AAAs to play in those activities.

**Opportunities for Administrative Action**

**Community-Based Care Transitions Program (CCTP):** 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. AAAs largely took the lead in implementing this program creating CBO–hospital partnerships that have ultimately demonstrated cost savings and improved care for Medicare beneficiaries. Following an unanticipated $200 million cut in funding for the five-year program, which undermined the ability of CMS to accurately track and assess site performance, funding for a majority of the more than 100 initial sites was discontinued, and all program funding will end in 2017.

n4a is very concerned that the key improvements in post-acute care models tested and proven through CCTP will be lost if CMS does not take steps to ensure that remaining, successful sites are continued through either short or longer-term funding extensions that will enable successful, still emerging, models to work toward strategies for sustainability beyond CCTP. We are also concerned with that CCTP site performance, measured and evaluated by CMS, uses stringent and inaccurate readmissions and enrollment metrics that do not accurately reflect individual site and program performance, impact, cost savings and patient care improvements.
Additional Opportunities to Support Care Transitions and Care Coordination Activities: Beyond funding for the CCTP program, we urge CMS to ensure that hospitals and other health care providers are including AAAs, ADRCs and other CBOs in their discharge planning and care transition efforts. It is critical that the improvements in patient care and cost-saving infrastructure that was developed through CCTP are not lost or merely rolled into hospital discharge planning activities without CBO involvement and investment.

We encourage CMS's Center for Medicare and Medicaid Innovation to seed new partnerships between the medical community and the Aging Network. New efforts in this area have the potential to better integrate health care and community services through models such as Medical Homes, Medicaid Health Homes and new demonstration projects that better coordinate care to dually eligible individuals.

Opportunities for Congressional Action

Support Care Transitions in New Legislative Strategies to Address Care for Individuals with Chronic Conditions: We appreciate recent efforts by the Senate Finance Committee to explore legislative solutions to better achieve the triple aim—especially as it relates to improving care for high-risk Medicare beneficiaries who have multiple chronic conditions. As lawmakers evaluate strategies to providing better care at lower cost with improved patient health outcomes, we encourage Congress to take steps to formally incorporate and incentivize collaboration and compensation for CBOs. Recognizing and involving agencies, such as AAAs, in future legislation addressing these important issues will endorse the key role that the Aging Network plays in improving health and strengthen the ability of the network to be a critical partner in the health care paradigm shift. Specifically, n4a also encourages Congress to explore legislation that would make care transitions activities reimbursable under Medicare and incentivize hospitals to work with AAAs and other community-based organizations to more efficiently and safely facilitate patient transitions from acute health care settings back to the home and community.

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. Since that time, ADRCs have proven their value and deserve a continued, stable funding source that, over time, will help grow the system nationwide.

Opportunities for Congressional Action

Reinstate ADRC Funding Through Annual Appropriations: Mandatory investments made through the ACA expired at the end of FY 2014, and as of 2015, the ADRC network lost two-thirds of its annual federal funding because these investments were not restored through appropriations. 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 2017 budget, which includes $8.1 million in discretionary funding to continue supporting and expanding the 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. And we encourage
Congress to restore, at minimum, previous levels of federal funding to continue strengthening investments in ADRC infrastructure.

Additionally, we encourage Congress to explore legislative strategies—through initiatives such as Money Follows the Person and Balancing Incentive Program reauthorization—to support and bolster the key roles that ADRCs play in supporting seniors, people with disabilities of all ages, and their caregivers to explore and determine best-aligned LTSS options.

Other Vital Issues

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 LTSS and increase access to non-institutional options. 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.

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’s (ACL) leadership. These programs deliver proven results and reduce Medicare and Medicaid costs. n4a supports the Administration’s FY 2017 proposal to allocate $8 million of the PPHF to ACL for the Chronic Disease Self-Management Program, and we encourage Congress to again fund ACL falls prevention activities through the PPHF, at least meeting FY 2016’s level of $5 million.

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.

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