



Leadership Council of Aging Organizations

The Growing Role of the Aging Network in Improving Health Care and Reducing Costs

During the 21st century, tens of millions of Americans are living into their 80s and beyond. This demographic shift is challenging our long-term care (LTC) and health systems, requiring that we re-examine the way we finance and provide services for older Americans. Given this reality, it is time to invest in the low-cost, community-based services that stabilize health care costs and enable older adults to remain in their homes and communities.

The Aging Network: A History of Supporting Aging in Place

The age wave presents both challenges and opportunities for communities supporting ever-larger populations of older adults and people with disabilities who seek to remain independent in their homes and communities. Currently, policymakers are making changes to the health care system.¹ Yet, for health care providers in pursuit of delivering better care, improving health and reducing costs, successful management of chronic conditions and functional limitations among this population requires embracing an array of health-related services that are meant to be delivered mainly at home—not within the walls of hospitals, physician's offices, and other conventional medical settings. This is where the Aging Network comes in.

Originally created by the Older Americans Act,² the Aging Network³ is comprised of 56 federally designated State Units on Aging, 622 local Area Agencies on Aging, 256 Title VI Native American aging programs,⁴ and the tens of thousands of private community-based organizations with which these agencies contract to provide critical social and nutrition services and supports for adults age 60 and older.

In July 1965, when Medicare, Medicaid, and the Older Americans Act (OAA) became law, Congress and the Administration envisioned a framework of basic supportive and health care services so that older adults would be enabled and empowered to age with health and independence for as long as possible. The OAA was therefore designed to meet a range of social and health-related needs, including home-delivered meals, transportation, and personal care; evidence-based health promotion and disease prevention; long-term care ombudsman and elder rights services; respite care and other services for family caregivers; and employment programs for older workers. The Aging Network provides these services in nearly every community across the country.

¹ American Health Care Act. 115th Congress, HR 1628

² The Older Americans Act (OAA) was first passed in 1965. The 1973 reauthorization established Area Agencies as part of a nationwide Aging Network to coordinate and deliver OAA services. Since 1965, the OAA has been amended or reauthorized 12 times, with the most recent reauthorization signed into law by President Obama in April 2016. More information on the OAA and details on the Act's titles and the services it supports is available on the Administration for Community Living (ACL)/Administration on Aging (AoA) website: <https://www.acl.gov/about-acl/authorizing-statutes/older-americans-act>

³ Administration for Community Living (ACL). Older Americans Act. April 2017. Retrieved from <https://www.acl.gov/about-acl/authorizing-statutes/older-americans-act>

⁴ National Association of Area Agencies on Aging (n4a). AAAs & Title VI Aging Programs. Retrieved from <http://www.n4a.org/aaastitlevi>

A Growing Nation and a Growing Need

The maturing of America's Baby Boomer generation is ushering in a long-term shift in the demographic composition of the country. With each passing day, an additional 10,000 Boomers turn 65, and by 2030, 74 million—or one in five—people in America will be 65 or older. By 2040, for the first time in the country's history, older adults will outnumber children under 18.⁵

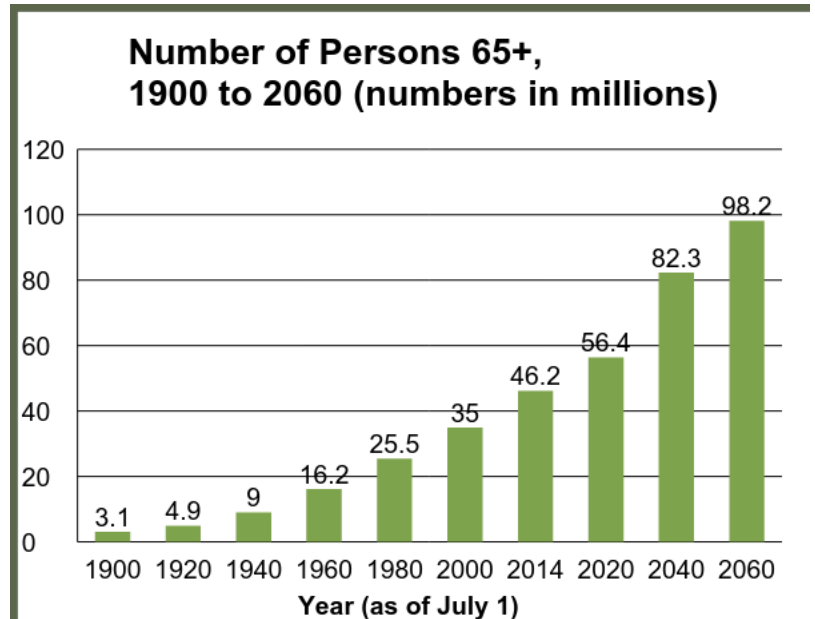
This unprecedented demographic shift to an older society has significant implications for the economy and many other aspects of life—including how we choose to age, and how we shape policy for support of older adults. Research consistently shows that over 90 percent of older adults want to age with dignity, independence and health at home and in their communities.⁶ However, nearly seven in 10 of us who reach the age of 70 will need help to stay independent as we age.⁷

The nature of these needs is as unique as each individual who has them, but generally include assistance with one or more activities of daily life. This assistance comes in the form of services such as meal preparation, accessible transportation, exercise and socialization, household help, ensuring that medications are taken properly, and personal care such as bathing, dressing, toileting and transferring.

More creative investment and attention to our current system of community services will be required to provide support to a large and longer-lived population. When older adults are unable to successfully manage daily health-related tasks and other key activities of daily living, they are at much greater risk of experiencing a health crisis that can result in hospitalization or even institutionalization. These results are typically traumatic for individuals and families and expensive for taxpayers. Emergency medical interventions for frail elders are a significant Medicare cost driver, and publicly funded nursing home care now averages over \$90,000 annually per person. Sharp growth in nursing home costs have are projected to disproportionately⁸ contribute to Medicaid expenditures nearly doubling in the next ten years.⁹

Investing in Social Services Lowers Health Care Costs

Evidence shows that cost-effective services provided by the Aging Network keep elders out of crisis and from cycling in and out of hospitals and other high-cost settings. For example, a 2015 randomized control trial showed that older adults receiving nutrition assistance had fewer falls and hospitalizations, and reported less anxiety, isolation, and worry about living alone.¹⁰



⁵ U.S. Department of Commerce. Projections of the Size and Composition of the U.S. Population. March 2015. Retrieved from <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>

⁶n4a. Trends and New Directions: Area Agencies on Aging Survey. 2014. Retrieved from <http://www.n4a.org/files/AAA%202014%20Survey.pdf>

⁷ Bipartisan Policy Center. Healthy Aging Begins At Home. May 2016. Retrieved from <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/05/BPC-Healthy-Aging.pdf>

⁸ MACPAC. Report to Congress on Medicaid and Chip. Chapter 1: Medicaid Trends in Medicaid Spending. June 2016. Retrieved from <https://www.macpac.gov/wp-content/uploads/2016/06/Trends-in-Medicaid-Spending.pdf>.

⁹ Bipartisan Policy Center. Healthy Aging Begins At Home. May 2016. Retrieved from <https://cdn.bipartisanpolicy.org/wp-content/uploads/2016/05/BPC-Healthy-Aging.pdf>.

¹⁰ Thomas KS, Dosa D. More than a meal: Results from a pilot research study. For AARP. Retrieved from <http://www.mealsonwheelsamerica.org/theissue/research/more-than-a-meal>

In other research, states with higher spending on nutrition assistance report fewer “low-need” individuals who have transitioned to nursing homes, which saves taxpayers significant money.¹¹ Evidence-based falls prevention and chronic disease self-management programs, initially piloted under the OAA, are now common strategies to reduce emergency room visits, hospitalizations, and skilled nursing facility placements, therefore curbing health care costs.^{12,13} Other studies show that older adults who live in states with higher social services funding have better health outcomes on a variety of measures, including fewer people reporting activity limitations during the previous month.¹⁴ Chronic disease self-management programs that focus on creating individualized action plans to train older adults in managing their chronic conditions prevent avoidable hospitalizations and improve health outcomes.¹⁵ In combination with home-delivered or congregate meals, these programs sustain independent living.

Yet as can be seen in Figure 1, since 2004, funding for social services that improve quality of life and reduce longer-term health care costs has been on a flat or declining trajectory. In 2015, the GAO estimated that 83 percent of older “food insecure” adults did not receive meal services, and two-thirds of older adults who reported difficulty with walking, dressing, bathing and other basic life activities received either no services or very limited help.¹⁶ Public funding continues to plummet relative to steadily rising need. In stark contrast, Medicare expenditures have doubled since 2004. Because most older Americans want to avoid living in a nursing home, the social model of assisted living has emerged and the number of assisted living facilities has grown exponentially in the last 20 years. As more people live in assisted living, they need the support of OAA long-term care ombudsmen to resolve problems and get the medical and social services needed to stay more independent and avoid unnecessary hospitalizations or a move to a nursing home.

These sharply diverging spending line items are on track to continue, unless a strategy to shift to lower-cost, community-focused service delivery systems is implemented during the next five to 10 years. If current spending distribution patterns are not re-thought, OAA funding—which is determined annually by Congress and not adjusted for the growing population or increasing costs—will buy fewer and fewer services. This ongoing disinvestment in social services that support long-term health and independence could ultimately contribute to acceleration of health care spending among older adults—particularly those whose needs extend beyond medical care to ongoing assistance with the basics of daily life.

Since the Budget Control Act (BCA) of 2011, and subsequent sequester in 2013, discretionary funding for home and community-based (HCBS) supports administered through the federal Older Americans Act has stagnated. Subsequent bipartisan budget agreements in 2013 and 2015 slightly eased topline budget pressures and alleviated some of the acute pain of additional sequester cuts, however overall domestic funding, including for OAA and other aging programs, has still fallen to historic lows as a share of the overall economy. For example, under sequestration, three-quarters of Meals on Wheels programs across the country cut the number of meals they served to older adults and waiting lists for meal delivery tripled,¹⁷ and ongoing stagnant funding since then means nearly 25 percent of local Meals on Wheels programs still maintain waiting lists. President Trump’s FY 2019 budget request to Congress would only deepen that disinvestment, which hits services that support low-income and vulnerable older adults particularly hard.

¹¹ Thomas KS, Mor, V. Providing more home-delivered meals is one way to keep older adults with low care needs out of nursing homes. *Health Aff (Millwood)*. 2013; 32(10):1796-802

¹² National Council on Aging (NCOA). Falls Prevention Programs: Saving Lives, Saving Money Infographic. 2017. Retrieved from <https://www.ncoa.org/resources/falls-prevention-programs-saving-lives-saving-money-infographic-3/>

¹³ NOCA. National Study of the Chronic Disease Self-Management Program: A Brief Overview. Retrieved from <http://www.ncoa.org/assets/files/pdf/center-for-healthy-aging/National-Study-Brief-FINAL.pdf>

¹⁴ Bradley EH, Canavan M, Rogan E, et al. Variation in health outcomes: The role of spending on social services, public health, and health care 2000-2009. *Health Aff (Millwood)*. 2016; 35 (5): 760-768.

¹⁵ Lorig K, Ritter, PL, Moreland C, Laurent DD. Can a Box of Mailed Materials Achieve the Triple Aims of Health Care? The Mailed Chronic Disease Self-Management Tool Kit Study. *Health Promotion Practice*. 2015; 16 (5): 765–774.

¹⁶ Government Accountability Office. Older Americans Act: Updated Information on Unmet Need for Services. 2015. Retrieved from <http://www.gao.gov/products/GAO-15-601R>

¹⁷ Meals on Wheels America. Sequester Survey Summary. 2013. Retrieved from <http://www.mowaa.org/document.doc?id=548>

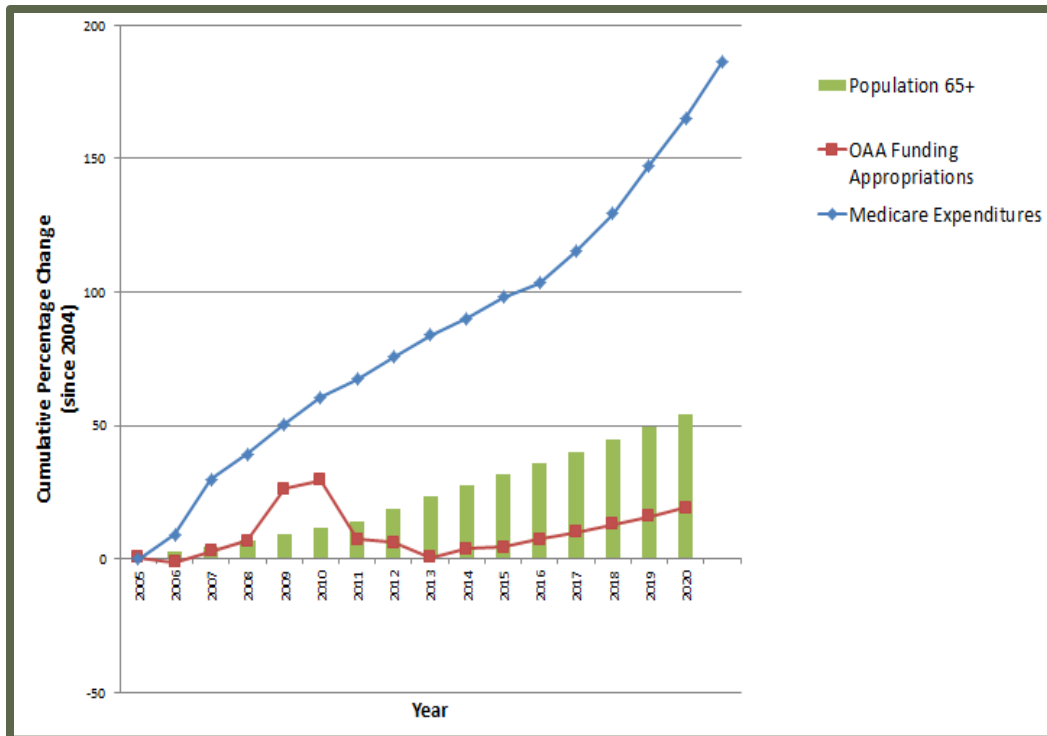


Figure 1: Source Adapted from Parikh RB, Montgomery A, Lynn J. *The Older Americans Act at 50—community-based care in a value-driven era.* *N Engl J Med.* 2015; 373 (5), pg.401. Values have not been adjusted for inflation.

Note: Medicare payments generally include mechanisms that adjust for the higher cost of inputs over time, i.e. wage growth and other increases in the expected cost of services.

Era of Unprecedented Threats to Health and Social Supports for Older Adults

In addition to concerns about federal discretionary funding for OAA programs and other aging programs, health care reform debates at the federal level have been exploring significant structural and financing changes to Medicaid. Since 1965, Medicaid has been the primary program covering long-term care. In 2016, Medicaid financed two-thirds of institutional and home and community-based long-term services and supports (LTSS) nationally at a cost of \$170 billion.¹⁸ Over 60 percent of Medicaid expenditures are for long-term care.

To improve quality and decrease per-capita costs, in recent years most states have moved toward providing more home and community-based services (HCBS) to older adults and people with disabilities as an alternative to more expensive nursing home or institutional care. As a result, in 2014, 53 percent of Medicaid-funded long-term care spending was on HCBS, the first time a majority of LTSS spending was for home and community-based services and a direct result of years of “re-balancing” policy efforts at the federal and state levels

Nearly all states use various Medicaid waiver authorities to provide HCBS services. Initiatives added to Medicaid over the last 30 years, including the Balancing Incentive Program, Money Follows the Person, and Community First Choice, have enhanced state flexibility and authority to offer HCBS services, which that surveys consistently show Americans greatly prefer over institutional services. Moreover, numerous

¹⁸ MACPAC. MACStats: Medicaid and CHIP Data Book. Retrieved from <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-12.-Historical-and-Projected-National-Health-Expenditures-by-Payer-for-Selected-Years-FYs-1970%E2%80%932025.pdf>

state and federal studies have demonstrated that meeting LTSS needs in the home and community is generally less costly on a per-person basis than institutionalization. A notable trend is the expansion of Medicaid Managed LTSS plans, which states are contracting with to manage the costs of HCBS service delivery.

Despite gains over recent decades to expand access to in-home community supports to meet LTC needs and reduce costs, currently the 115th Congress and the Trump Administration are considering proposals to dramatically restructure Medicaid from a federal-state financial partnership based on eligibility requirements at both the federal and state level, to a system of per-capita caps that are designed to reduce federal funding contributions by 25-40 percent over 10 years. In a rapidly aging society, the responsibility for states to pick up a larger share of the costs of covering individuals who need LTSS could result in significant budget pressures. Because older adults and people with disabilities represent the majority of Medicaid spending, restricting the federal contribution to Medicaid has the potential to sharply limit access to these services among older Americans.¹⁹

An Evolving Health Care and Social Services Landscape

Notwithstanding drastic policy changes to Medicaid under consideration in Congress and by the Administration, the current policy landscape for both Medicare and Medicaid is changing rapidly as Congress and states push toward value-based payment systems that aim to measure provider performance more precisely, as well as patient outcomes and satisfaction. This shift is spurring innovations in health care delivery that include, but are not limited to, Accountable Care Organizations, managed LTSS plans and programs, bundled payment programs, expansion of the Program of All-Inclusive Care of the Elderly, and flexibility for Medicare Advantage plans to provide individually tailored supplemental services to their enrollees (i.e., non-Medicare covered services, such as social supports provided by the Aging Network) and other initiatives.²⁰

These developments show that policymakers and stakeholders are increasingly recognizing the value proposition of aligning health care with social services and community supports.

In this evolving environment, the Aging Network has a clear opportunity to demonstrate its value in maintaining the health and stability of older adults who choose to age in place. For example, a key initiative, the Community-Based Care Transitions Program (CCTP), demonstrated that AAAs are effective partners in serving high-risk Medicare beneficiaries and improving coordination during transitions from hospitals to the home. Overall, the program reduced 30-day all-cause hospital readmissions by over six percent, with some sites achieving much higher reductions.²¹

Through the CCTP and other initiatives, the Aging Network is well-positioned to coordinate the planning and delivery of social and health-related services for older adults.²² However, investment in the Aging Network's data and analytics capabilities will be necessary in order to be able to report on and demonstrate the impact of supportive services on the health of older adults. Notably, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 provided billions of dollars to medical providers to support adoption of Electronic Health Records and health information technology. Because the post-acute, LTSS, and social services providers were excluded, community service providers have struggled to connect with and to exchange data with health care providers. However, in July 2016, the Center for Medicare and Medicaid Services (CMS) announced an initiative to expand HITECH funding to a broad array of additional providers, including community-based Medicaid providers.²³

¹⁹ Community Catalyst. The Impact of Medicaid Per-Capita Caps on LTSS. March 2017. Retrieved from <http://www.communitycatalyst.org/resources/publications/document/Impact-of-Medicaid-Per-Capita-Caps-on-LTSS.pdf>.

²⁰ Such as the Senate Finance Committee's Chronic Care Working Group: <https://www.finance.senate.gov/chairmans-news/hatch-wyden-isakson-warner-release-proposals-to-improve-treatment-for-chronic-illness>

²¹ The San Diego Care Transitions Partnership, for example, showed a 27 percent reduction in 30-day readmissions for their CCTP enrollees. Staff estimates overall health care savings, net of program payments, at \$9.6 million through January 2015.²¹

²² <https://www.acl.gov/node/571>

²³ Montgomery A, Slocum S, Morgan L. Information Technology and the Aging Network: Opportunities to Enhance Information Technology Capacity. 2016. <http://altarum.org/sites/default/files/uploaded-publication-files/IT%20and%20the%20Aging%20Network->

The importance of aligning IT systems in order to coordinate care across the health and HCBS systems cannot be overstated. In a recent survey, 45 percent of responding AAAs reported that there are organizations with which they would like to share IT systems or data but do not or cannot.²⁴ The most common reasons cited for this were the need for a new or upgraded system, incompatible data formats, or concerns about their data. In addition, two-thirds of responding AAAs reported that up-front cost was a barrier to implementing better IT systems. These technological barriers prevent data exchange with providers, and make it difficult for community-based organizations to capture data that demonstrates the impact of their programs. Spurred by HITECH funding and growing recognition of the role that community services can play in tempering overall costs and improving quality, this is set to change.

Improving the Capacity of Social and Community Supports to Meet the Needs of an Aging Nation

The Aging Network has a decades-long history of delivering home and community-based services that enable older adults and their caregivers to age in place with health and independence for as long as possible. In a rapidly changing health care and social services landscape, it is critical to preserve the long-standing, trusted, efficient and effective networks and infrastructure that have successfully served older adults in every community. However, it is also essential that policymakers recognize and invest in opportunities to improve coordination between our health care and social services sectors with the aim of reducing spending and improving health outcomes by meeting the non-medical, health-related social needs of a rapidly aging population. In addition, for those older adults who need care in the assisted living and nursing home settings, the OAA State Long-Term Care Ombudsman Program helps resolve complaints and protects the rights of those vulnerable residents, thereby playing an integral part in improving the quality of care and reducing unnecessary spending. With those goals in mind, we recommend that policymakers prioritize the following actions.

- 1. Funding for discretionary federal programs that support aging at home and in the community must be increased and better aligned to grow with a growing population.** For decades, federal funding for OAA programs has not kept pace with population growth or the cost of services. Lawmakers should reassess budgetary policy priorities with regard to the OAA to ensure that funding is better aligned with demographic realities of an older adult population. Robust investments in discretionary OAA programs are needed to restore recent cuts. Additionally, in the future, we believe that appropriated funding must take into account information on the population growth of older adults adjusted by measures of unmet need and demographics.
- 2. Preserve the federal-state guaranteed partnership of Medicaid and expand opportunities to shift LTSS toward the home and community.** Reject current proposals to restructure Medicaid and reduce the federal share of Medicaid funding. While policy solutions to address the rapidly increasing need and cost of providing long-term care should be prioritized, these solutions must not consider limiting the federal share of these costs or shifting costs and risks onto states.
- 3. Capture the value of social services and supports to older adults' health and independence and effect on overall health care costs.** Demonstrating the value of meeting the social and community health-related social needs for older adults is essential in policy discussions to expand access to HCBS under federal discretionary and health care programs. Achieving this will require the social services and health care sectors to improve data collection and integration. One important solution that policymakers can promote to make progress on this objective is to ensure that states and Area Agencies on Aging are able to apply for existing HITECH funding available through 2021 to support IT development for community and public health providers.²⁵

[Opportunities%20to%20Enhance%20IT%20Capacity.pdf](#)

²⁴ n4a and Scripps Gerontology Center at Miami University. Information Technology in Area Agencies on Aging: Report from the 2015 National AAA Survey. Retrieved from <http://www.n4a.org/publications>

²⁵ Montgomery A, Slocum S, Morgan L. Information Technology and the Aging Network: Opportunities to Enhance Information Technology Capacity. <http://altarum.org/publications/information-technology-and-the-aging-network-opportunities-to-enhance->

4. Leadership at federal agencies, including the Administration for Community Living (ACL) and CMS, should collaborate to further integrate social services and health care delivery.

As the importance of meeting health-related social needs through home and community-based supports becomes increasingly mainstream, the social services and health care sectors must improve communication and collaboration. This shift toward understanding and cooperation must be reflected at all levels of policymaking and be modeled at the federal level. To this end, CMS must ensure that leadership and staff have a commitment to promoting the value of non-medical, health-related, community-based services in achieving better health outcomes. With growing evidence demonstrating the impact of social services on the health and quality of life of older adults, CMS and other agencies that have a common mission to serve older adults must take steps to understand the role that social supports play in their initiatives.

The bottom line: If older adults and people with disabilities do not receive the social supports they need, hospital readmissions and costly stays in nursing homes will continue to drive Medicare and Medicaid spending up. Bending the overall health care cost curve, in part through greater investment in the Aging Network, is sound policy. New and creative solutions to help tens of millions of Americans age in place are needed. Now is the right moment to invest in strengthening the vital—but until recently, too often overlooked—social and community services sector.