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The Aging Network in Transition

Hanging in the Balance

Anne Montgomery and Elizabeth Blair

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Executive Summary

This white paper is the product of a forward-looking symposium commissioned by the Claude Pepper Center at Florida State University in Tallahassee and the National Academy of Social Insurance (NASI) in November 2014, together with support from the National Association of Area Agencies on Aging (n4a) and the National Association of States United for Aging and Disabilities (NASUAD). Its primary purpose is to spotlight transformative initiatives now underway in a key sector: the Aging Network (AN). Authorized under the Older Americans Act (OAA) and administered by the Administration on Aging (AoA), a division of the Administration for Community Living (ACL), the Aging Network is gradually becoming recognized as an essential component of health care service delivery for a burgeoning number of community-dwelling adults 65 and older. Driven by the large baby boomer cohort, this population will comprise one in five Americans in just 15 years. As they continue to age, the number of old-old Americans (those over the age of 85) will triple by 2050, ushering in a “longevity boom” that will be continued by younger generations – a permanent feature of U.S. society and many others around the world.

These sweeping demographic trends are already driving efforts to reengineer delivery of medical care and to expand availability of home and community-based services (HCBS) services. New delivery models include Medicare’s Accountable Care Organizations (ACOs), bundled payment initiatives and the Independence at Home (IAH) demonstration, which was extended in 2015 and may become permanent. The well-regarded Program of All-inclusive Care for the Elderly (PACE) is also poised for expansion with enactment of the PACE Innovation Act in November.¹ These and many other federal initiatives are designed to foster better integration of services across traditionally “siloed” provider programs and health care settings, while improving beneficiary outcomes and decreasing per-capita cost growth.

Within states, the growth of Medicaid long-term services and supports (MLTSS) programs represents an important trend. While MLTSS offers the AN potential new opportunities for contracting to provide health-related services, it also brings change and uncertainty, as many states shift from HCBS waiver programs – many of which have been historically administered by the AN – to Medicaid LTSS plans that are being required to assume responsibility for offering HCBS services to their enrolled populations. In light of these and other rapidly-unfolding policy shifts, the AN is working to reposition itself by building out and expanding its business expertise to include contracts with private-sector health care organizations, and by working to capture data that can demonstrate the value of supportive services to health care organizations. Over the next decade, the low-cost, community-anchored AN has an unparalleled opportunity to play a major role in building out a more cost-efficient, accountable, person-centered care system.

Accordingly, this paper broadly describes the role of the AN today. Despite the challenges of perennially low funding levels and the lack of federal investment in the development of infrastructure and technology for the AN, the Network is showing signs of significant progress in developing relationships with a diverse array of health care organizations. While detailed discussion of all programs with which the AN is involved is beyond the scope of this paper, the report covers key developments that are re-shaping the Network, including the Business Acumen Learning Collaborative (BALC), the Community-based Care Transitions Program (CTTP) and efforts to better measure the quality and value of its programs and services. The report also includes case studies highlighting the work of the AN in Florida, Massachusetts and California, discussion of quality initiatives and congressional actions, and concluding observations.

Introduction

When Lyndon B. Johnson signed the Older Americans Act into law on July 14, 1965, he established a clear vision:

The [law] clearly affirms our nation's sense of responsibility toward the well-being of all of our older citizens...Every State and every community can now move toward a coordinated program of services and opportunities for our older citizens. We revere them; we extend them our affection; we respect them.

By 1973, Area Agencies on Aging (AAAs) were established to fulfill this purpose, and other programs were created over time within the ambit of the OAA. Yet today, it is clear that much more work is needed to ensure the original bipartisan vision of Members of Congress who wrote the OAA can be sustained. During the Sixth White House Conference on Aging (WHCOA), which culminated in a day-long session held at the White House on July 13, 2015, President Barack Obama reflected on the achievements of the 50-year old “Great Society” programs – OAA, Medicare and Medicaid – while also noting that all need further reforms. “Protecting our seniors, dealing with the rising costs of an aging generation, ensuring we have enough home care workers looking out for our family members, maximizing the contributions that older Americans can make to our country – these challenges are just becoming more urgent,” he declared. The WHCOA final report, released in late December 2015, highlighted the urgency of doing more to support family and paid caregivers, to expand availability of nutrition services for low-income seniors, to expand primary care education to incorporate geriatrics, to promote public awareness of how to make communities “dementia friendly,” and to take various actions to better coordinate programs addressing housing, transportation, health care, and LTSS. The report did not, however, suggest policy proposals for comprehensive long-term care payment reform.²

Another key piece of the work that President Obama referenced was the need to reauthorize the OAA, which expired in 2011. During the current Congress, the Senate approved legislation in July of 2015 to extend the law, but the House of Representatives has not yet acted.³ Yet the reforms that the Aging Network is currently undertaking are not being driven by reauthorization, but rather by the urgency of rising demand among seniors and a pattern of flat funding during the last decade that has resulted in a significant decline in the purchasing power of OAA federal dollars.⁴ To address sharply increasing demand, the Aging Network is working to extend its reach beyond the traditional grants provided through the OAA to include funding from contracts with health care organizations. Concurrently, more medical professionals are gradually realizing the necessity of investing in social services and supports in order to address the socioeconomic determinants of health for older adults and other vulnerable populations.

At the November 2014 symposium, ACL Administrator and Assistant Secretary for Aging Kathy Greenlee discussed the importance of maintaining the AN’s “mission-driven work” to assist all older adults in need, while also urging attendees to embrace the broader challenge of transitioning into an evidence-driven, cohesive system. “The value base that we provide is lowering cost, improving care, and providing better health,” she declared. “There’s huge opportunity here for revenue, for stabilization of this network, for

What’s needed in every part of the country is a true community-based organization network.

— ACL Administrator/
Assistant Secretary for Aging
Kathy Greenlee

better outcomes.” Greenlee then issued a call to action: “What’s needed in every part of the country is a true community-based organization network,” she said. “So the payer, whether it’s a health system, a [managed care organization], or doctors, can call one person and get access to all the community-based services.”

This summons comes at a pivotal moment. Does the Aging Network – comprised of 623 AAAs, more than 500 Aging and Disability Resource Centers, 256 Title VI Native American aging programs, 56 State Units on Aging and an estimated 20,000 community-based organizations – have sufficient momentum to rapidly retool during the next decade to achieve this goal? Will there be enough support from the policy sector to help make these changes possible?

The Quest for Better Health Care Outcomes and Stabilized Costs

Before the next WHCOA convenes in 2025, the U.S. longevity boom will have produced a rolling transformation in the way most Americans think about growing old. Along the way there will be countless kitchen-table discussions, and ongoing policy and political debates about what longer lives mean for the health care system and for retirement, for older people who are committed to staying active in their communities alongside younger neighbors, and for the economy's priorities. Although the economic and social impacts will vary somewhat among communities and states, in general, millions of aging Americans will find themselves endeavoring to cope with chronic conditions and diminished physical and/or cognitive reserves. Over time, many will find they need hands-on assistance with daily tasks such as dressing, bathing and meal preparation, along with access to subsidized transportation and help with home adaptations and maintenance. Sophisticated forms of remote monitoring and telemedicine are expanding rapidly, a trend that will continue.

At the same time, new health care models (and adaptations of existing models) that aim to improve health care outcomes while constraining costs will be launched in the policy sector. The first and second generations of population-based health care models – Medicare ACOs – are a key evolutionary development. As presently structured, however, ACOs cannot proactively enroll and tailor services to cohorts of high-risk, high-need beneficiaries, sharply limiting their effectiveness (this may change if policy options announced by the Senate Finance Committee's Chronic Care Working Group in December 2015 are ultimately enacted). Nor are ACOs now responsible for the range of basic community supports and services. By comparison, Medicare health plans do enroll beneficiaries, but these plans currently lack strong incentives to ensure that their high-need, high-risk enrollees have ready access to community-based services – notably personal care, subsidized affordable housing and transportation and home-delivered meals.

Another model, the Medicare Independence at Home (IAH) program, delivers primary care to beneficiaries with serious chronic conditions in their own homes. IAH has succeeded in saving money and improving outcomes for Medicare beneficiaries, and has been extended. In addition, the Senate Finance Committee has recommended making the program permanent.⁵ While IAH providers educate and involve family caregivers and are encouraged to use telemedicine and remote monitoring technologies to facilitate decision-making and coordination of services, they are not held financially accountable for assuring that community-based social supports are readily accessible. In another larger set of initiatives, the Obama Administration is aggressively pursuing multiple bundled payment models. In one example, a hospital and physician services bundle announced for hip and knee replacements is scheduled to be implemented for hospitals in 75 geographic areas on a mandatory basis. But as with other bundled initiatives, the services involved represent a narrow slice of total care, are time-limited, and have no defined connection to social services and supports. Sustained success is likely to require a more comprehensive policy framework, along with significantly improved performance metrics and incentives for both achieving and reinvesting savings.

Another development occurred in January 2016 with the announcement of a new funding opportunity from the Center for Medicare and Medicaid Innovation for “Accountable Health Communities (AHL).” The initiative states that “although there is some evidence that existing programs may have improved connections between clinical and community services and begun to address health-related social needs, these programs vary widely in their screening strategies, enrollment criteria, availability, method of

delivering services, and degree of integration between clinical and community services....The underlying concept of this population-based model test is that identifying and addressing health-related social

needs has the potential to improve health care outcomes and reduce total cost of care.”The AHC program proposes interventions in three “tracks,” the most far-reaching of which will charge awardees with aligning services in the Medicare and Medicaid program that are delivered by “clinical delivery sites” with those provided by community service providers. However, the proposal does not contemplate providing additional funding for community-based services.⁶

Because the first half of the 21st century is a period when the number of workers relative to retirees will decline, it is likely that Congress and many state legislatures will increasingly focus on trying to constrain the growth of new spending on publicly-financed health care. In this environment, the low-cost Aging Network can play a pivotal role in building out a more efficient, accountable, person-centered care system.

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The Aging Network, the Older Americans Act, and Congress

As enacted in 1965, the OAA is based on the premise of a de-centralized network of funding for a community-anchored service delivery system. The objectives of the law are to ensure “adequate income in retirement; the best possible physical and mental health services without regard to economic status; suitable housing; restorative and long term care; opportunity for employment; retirement in health, honor and dignity; civic, cultural, educational and recreational participation and contribution; efficient community services; immediate benefit from proven research knowledge; freedom, independence and the exercise of self-determination; and protection against abuse, neglect and exploitation.”

To achieve these goals, the OAA charges the Administration on Aging (which is now part of the Administration for Community Living) with operating a variety of programs organized under five titles. The most widely known is Title III, which provides federal funding for State Units on Aging, created in 1965. In 1973, AAAs were established to develop, provide and contract for local services under provisions of a 1972 OAA reauthorization bill. Central OAA programs include:

- › The National Eldercare Locator Service, a toll-free call center to identify and connect older adults and caregivers to community resources

-
- › Support services (transportation, home care, legal aid, information and referral, case management and adult day care)
 - › Nutrition assistance programs (congregate meals served in group settings and home-delivered meal programs, commonly known as “Meals on Wheels”)
 - › National Family Caregiver Support Program (respite, education, training and counseling for family caregivers of older adults and older adults providing assistance to children)
 - › Health promotion services (education, counseling and consultation)
 - › Aging and Disability Resource Centers, which increasingly serve as portals for information about LTSS options and services for older adults and persons with disabilities of all ages
 - › The Senior Community Service Employment Program (SCSEP) program, which works with the Department of Labor to provide employment and volunteer opportunities for older adults
 - › Grants to tribal organizations
 - › The long-term care ombudsman program (chartered to assist frail elders in nursing homes, assisted living residences and, in some states, home- and community-based settings of care)
 - › Response to elder abuse, neglect and financial exploitation (education and referral services)

The AN’s core mission is to deliver services that are essential to keeping high-need populations safely at home and as stable as possible. But even a brief look at the AN’s budgetary capacity to provide services to a far larger population shows there are already large gaps in services, as measured by unmet need – suggesting that the gap between a need for basic support and actual availability of services will become a yawning chasm in future years unless a different policy course is charted. A 2015 Government Accountability Office (GAO) report found that nearly one-quarter of low-income adults over 60 are food insecure, and four out of five of this cohort (83%) did not receive meal services. The report also highlighted unmet need for personal care among older Americans, with more than a third of the 27% of older adults who have difficulty with one or more activities of daily living (ADLs) receiving either no assistance from formal or informal caregivers, or assistance with only some of their needs. Budgetary restrictions confronting Area Agencies on Aging were found to be an important factor, with 22% of agencies surveyed responding that they cannot serve all clients who need home-delivered meals.⁷

Over the last decade, these stark budgetary shortfalls have led to development of waiting lists. Today, waiting lists are common, even for home-delivered nutrition services. This was made plain in a three-arm study released in March 2015 by Meals on Wheels America (MOWA) with the AARP Foundation. Titled “More Than A Meal,” the report notes that “federal, state and local funding cuts, increased transportation and food costs, and the lingering effects of the economic downturn have had significant impacts.... Over the past several years, these compounding factors have resulted in hundreds of thousands of fewer seniors served, millions of fewer meals delivered, and a dramatic increase in waiting lists.” The report further notes that there is scant information in the public literature “of the demographic and socioeconomic makeup of the populations affected by these issues, particularly those individuals who self-identify as needing home-delivered meals but are placed on growing waiting lists due to insufficient resources.”

But the profile of elders revealed in the MOWA study shows deep vulnerability. Across the eight sites, the average waiting list for home-delivered meals was *six months or longer*. More than half of participating elders reported living alone, and 58% said they needed help from another person with personal care. Over a third of participants said that they did not have friends or relatives who would be willing and able to help them over a long period of time if they needed personal care. Among those with a chronic illness, nearly three-quarters said they had difficulty leaving home. According to the report, this suggests that “identifying loneliness and isolation as well as implementing interventions” in the home will “improve the health and well-being of older adults, particularly individuals that live alone, and decrease the influence of these modifiable risk factors on our healthcare system.” As might be expected, results of the study demonstrated that older adults receiving regularly delivered meals were better off (Box 1) compared to those who received no meals (the control group) and those who received frozen meals once a week, particularly for those living alone. More than 40% of participants receiving daily-delivered meals reported less worry at follow-up, compared to one-quarter of participants receiving weekly, frozen meals and under one-fifth of the control group.

Box 1

More Than a Meal Study⁸

The More Than a Meal study was a randomized, controlled trial with the objective of comparing the health and health needs of older adults on waiting lists for home-delivered meals with older adults living in the community, while also examining the differences in effects of two different meal-delivery methods.

The authors randomized 626 individuals on waiting lists of more than 6 months for home-delivered meals into 3 groups:

- › Remain on the waiting list
- › Receive frozen meals delivered weekly
- › Receive warm meals delivered daily

Compared with those on the waiting list and frozen meals groups, they found that those in the group receiving daily meals were more likely to exhibit:

- › Improvement in mental health
- › Improvement in self-rated health
- › Fewer Hospitalizations
- › Reduction in rate of falls*
- › Improvement in feelings of isolation among those living alone
- › Improvement in feelings of loneliness among those living alone*
- › Decreases in worry about being able to remain at home*

*= statistically significant compared with both control and frozen meals group

Table 1, below, reflects recent and current funding levels by program. Because OAA dollars have been on a declining trajectory in purchasing power as compared to the needs of a rising population of older Americans for a decade, the cumulative services gaps created by chronic underfunding are on track to create more substantial problems in the future as the population of homebound seniors grows, creating a new underclass of older adults with no meaningful access to the most basic of services and shifting costs to communities, charities and health care.

The Bipartisan Budget Act of 2015 approved by Congress in October 2015 will restore roughly 90% of spending reductions that would have otherwise been imposed under terms of the “sequestration” law (the Budget Control Act of 2011). The 2015 measure will add about \$80 billion dollars of funding back to discretionary programs for FY 2016, which include those funded through the OAA. Broadly, while the two-year budget deal will increase non-defense discretionary spending by \$40 billion over FY 2016 and FY 2017, total non-defense discretionary funding in 2016 remains on track to be 12% *below* spending levels in 2010, taking inflation into account. The result is that by 2017, non-defense discretionary spending is projected to fall to its lowest level as a share of the economy since 1962.^{9,10}

Table 1
FY 2016 Labor-HHS Appropriations As of December 16, 2015 (Dollars in thousands)

Notes: Increases over prior year are noted in BOLD. Decreases are noted in italics. Funding from mandatory sources in green; PPHF = Prevention and Public Health Fund

Older Americans Act and Other Key Aging Programs	FY 2010 Final Enacted	FY 2012 Final Enacted Dec. 2011	FY 2013 Final with Sequester March 2013 ¹	FY 2014 Omnibus Final Jan. 2014	FY 2015 Final Enacted Dec. 2014	FY 2016 President Budget Request 2.2.2015	FY 2016 Final Enacted Dec. 2015
Title III							
B: Support	368,348	366,916	347,724	347,724	347,724	386,182	347,724
C1: Congregate Meals	440,783	439,070	416,104	438,191	438,191	458,091	448,342
C2: Home-Delivered Meals	217,676	216,830	205,489	216,397	216,397	236,397	226,342
Nutrition Services Incentive Program	161,015	160,389	146,718	160,069	160,069	160,069	160,069
D: Preventive Health	21,026	20,944	19,849	19,848	19,848	19,848	19,848
E: Family Caregivers Support	154,220	153,621	145,586	145,586	145,586	150,586	150,586
Title IV	19,023	0	0	0	0		
Title V SCSEP (Dept. of Labor)	825,425	448,251	424,805	434,371	434,371	434,371	434,371
Title VI							
A: Grants to Indians	27,708	27,601	26,157	26,158	26,158	29,100	31,158
C: Native American Caregivers	6,389	6,364	6,031	6,031	6,031	6,800	7,531
Title II							
Aging Network Support Activities (including Eldercare Loc.)	44,283	7,873	7,432	7,461	9,961	9,961	9,961
Aging & Disability Resource Centers	10,000 (ACA mandatory funding)	16,457 (incl. 10,000 ACA)	15,585 (incl. 9,490 ACA)	16,119 (incl. 10,000 ACA)	6,119	20,000	6,119
Title VII Ombudsman/Elder Abuse	21,883	21,797	20,658	20,658	20,658	20,658	20,658
Elder Rights Support Activities		4,088	3,859	3,874	3,874	3,874	3,874
Adult Protective Services/Elder Justice Initiative (Non-OAA)		6,000 (PPHF)	2,000 (PPHF)	0	4,000	25,000	8,000

(1) FY 2013 column reflects roughly 5% sequester plus additional rescissions and transfers for a total of 5.6% from FY 2012 for ACL programs. Non-ACL programs listed at pre-sequester enacted levels are noted with a “ps.”

Source: National Association of Area Agencies on Aging, <http://www.n4a.org/legislativeupdates>

These budgetary constraints could cause serious difficulties for older adults who struggle with mobility, in combination with longstanding problems in coordinating services across health and social services providers. The story of an elderly veteran in North Carolina that quickly escalated to become national news in May 2015 illustrates the consequences. According to news accounts, a 911 call came in to dispatchers in Fayetteville, NC, on May 12th, 2015. Diagnosed with prostate cancer in 2008, Clarence Blackmon, 81, had returned to his home after several months of treatment. With the refrigerator empty and Blackmon too weak to leave the house, he told the operator that he needed “someone to get to the grocery store and bring me some food, because I need to eat something – whatever you can do to help. I can’t do anything.” The dispatcher responded by requesting assistance from local police, who went shopping at a local supermarket and delivered groceries to Blackmon along with the dispatcher. This sparked interest from local television outlets, and later national print and broadcast media, and shipments of food from concerned people around the country began to arrive, overwhelming the elderly veteran. Had the hospital that discharged Blackmon understood that arrangements for nutrition services and other appropriate supports needed to be in place for him when he arrived home – and if those services had been adequately funded – a crisis would have been avoided.

It is unclear whether policymakers at the national level have taken note of the experience of vulnerable older adults such as Clarence Blackmon. During a February 2014 hearing on the OAA, House Education and Workforce/Higher Education and Workforce Training Subcommittee chair Rep. Virginia Foxx (R-NC) observed: “As we work toward reauthorizing the Older Americans Act, we must acknowledge the law faces challenges...U.S. Census projections estimate the number of Americans age 65 and over will increase from 40 million in 2010 to 72 million in 2030....[and a]s a result, many are concerned that the Older Americans Act cannot effectively meet the needs of the rapidly growing senior population – especially amid current fiscal constraints.”

A parallel focus on curbing costs for vulnerable older adults was evident in congressional scrutiny of Medicaid at a hearing held in July 2015, when House Energy & Commerce Health Subcommittee chair Rep. Joe Pitts (R-PA) called the current trajectory of Medicaid spending “problematic.” Over the next decade, he noted, “program outlays are set to double. That means that, in a decade, Medicaid is going to cost federal taxpayers what Medicare costs today....this spending trajectory threatens the quality and access of care for the millions of vulnerable patients who depend on Medicaid.” Yet with no new social insurance program for LTSS on the immediate horizon, Medicaid’s dominant role in LTSS services – currently financing over 60% of public spending – seems unlikely to change unless service delivery reforms that bridge Medicare, Medicaid, the Older Americans Act and related programs are implemented in a framework that is both more coordinated, flexible and cost-effective.

Recent Developments in the Aging Network

These developments – including the rapid shift toward capitated financing for LTSS in HCBS settings – are also greatly impacting AAAs. Surveys conducted by the National Association of Area Agencies on Aging show that the proportion of AAAs’ overall budgets deriving from Medicaid is steadily increasing, rising from 21% in 2008 to 27% in 2013. In contrast, the portion of funding provided through the OAA, at 35%, has remained unchanged. Markwood noted that AAAs provide, on average, six different activities in their contracts with managed care plans. Common services include individual needs and program eligibility assessments, care management, caregiver support, care transition services from hospitals and

nursing homes to the home, development of service and care plans, participation in interdisciplinary teams, direct provision of home health and personal care services and conducting nursing home level of care determinations. The AN is also providing services to MCOs in the national demonstration for dually eligible beneficiaries. For example, Ohio has required MCOs to partner with the AN for care management services in its contract, and Massachusetts requires plans to contract with community-based organizations to provide long-term supports coordinators as members of the beneficiary’s care team.¹¹ “There is a value proposition here,” Markwood said. “We just need to build on it. In tracking AAAs across the country, we are seeing remarkably rapid growth in developing new lines of business, contracting with MCOs, expanding private pay programs and other healthy responses to the changing landscape.”

According to Roherty, the AN is rapidly broadening service delivery to include younger disabled persons. “I’ve had many commissioners and directors say there really isn’t a difference in a transportation broker finding transportation for somebody that’s a senior,” she said, as compared to “somebody that has a behavioral health challenge or somebody that has [an intellectual or developmental disability]. It’s pretty much the same job.”

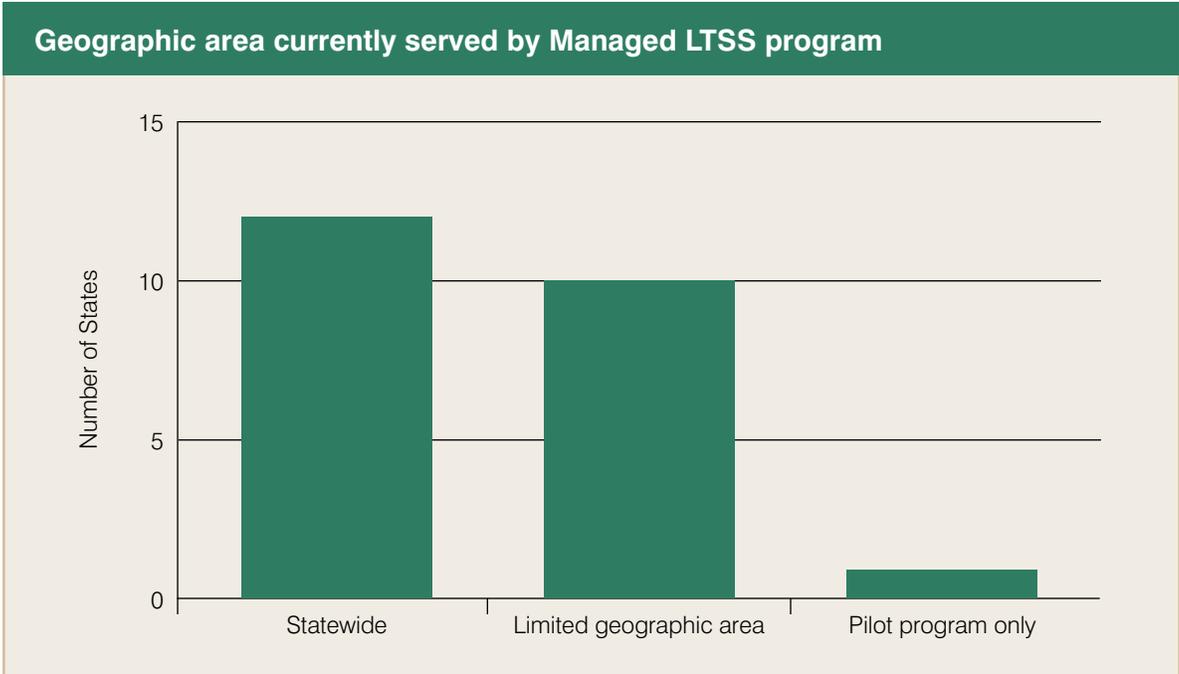
Although there is no budgetary mechanism in place to officially recognize the impact of social services spending on health care costs in the context of the federal budget, the close interrelationship between the sectors is beginning to be appreciated, with some analyses recognizing the AN’s impact on both quality and costs. To illustrate, Hennepin Health, a safety-net ACO in Hennepin, Minnesota, has used savings to hire navigators that connect Medicaid beneficiaries with vocational services, affordable housing, and other social services. In the process, the ACO has succeeded in decreasing emergency room visits by 9.1% and has an 87% patient satisfaction rate.¹²

With regard to recent developments in MLTSS, even as programs continue to roll out across the country – with 22 states now operating MLTSS and another 11 preparing to contract for delivery of services either to some or all of their Medicaid-covered populations in part of the state or statewide – beneficiary advocates worry that there’s no assurance that MCOs will provide the same services as those that have traditionally been available under waiver programs. Advocates worry that MCOs will choose to contract with larger providers to build new provider networks rather than utilizing smaller networks of community-based providers anchored by the AN, which have decades of experience in providing LTSS. In addition, MCOs frequently provide care coordination themselves, although many others contract with or share this role with Community-Based Organizations (CBOs).¹³

Recent reviews of state MLTSS evaluations show that outcomes are positive in some areas and mixed in others.¹⁴ At the 2015 NASUAD Home and Community-Based Services Conferences, Debra Lipson cautioned that due to wide differences in the way that states have chosen to implement MLTSS, one state’s experience with MLTSS does not easily compare with another’s. These differences include the way that capitation rates are set, whether enrollment is voluntary or mandatory, which populations are included, which services are covered, and whether or not the MCOs have any prior experience in providing LTSS.¹⁵ An influential survey of state LTSS systems produced by AARP, which ranks state LTSS systems on

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— Sandy Markwood, CEO, N4A



Source: NASUAD State of the States in Aging and Disabilities, 2014 <http://www.nasuad.org/hcbs/article/2014-state-states-aging-and-disabilities>

a number of quality indicators, includes high-performing states that rely entirely on the AN to provide LTSS services – such as Oregon and Washington – alongside states that are heavily reliant on MLTSS – such as Minnesota and Hawaii.¹⁶

Larry Polivka, Executive Director of Florida State University’s Claude Pepper Center, suggested at the November 2014 symposium that developments to date show the answer may vary across states. Recent surveys, he noted, have found that for-profit managed care plans with weak ties to the Aging Network are becoming dominant providers in the Medicaid home and community-based sector in more than half of all states^{17,18} – despite mixed evidence that MLTSS is more cost-effective.¹⁴ Polivka underscored that the Aging Network has a long history of providing cost-effective HCBS. For example, he noted, in a series of reviews of the AN’s performance in Florida, HCBS waiver programs run by the AN were found to be more cost-effective than the managed LTSS programs.^{19,20} The AN has had notable achievements in other states; for example, the Ohio AN has successfully delivered highly cost-effective HCBS over a 15-year period during which the 85+ population increased by 50%. Specifically, nursing home use in the elderly population dropped by 11%, while use of home and community-based services increased by 150%, and the total Medicaid LTSS budget increased by only 7%.²¹ Appendix A (page 31) provides a summary of the Aging Network’s successes in building community-based LTSS.

Yet to date, these and other successes have not necessarily proven predictive of what states are deciding to do in an era when the numbers of older adults needing community-based services is steadily climbing. Polivka observed that today, the Aging Network plays a relatively minor role in the HCBS sector in some states (Arizona, Texas and New Mexico) while in others (Oregon, Washington and Wisconsin) its role is stronger. In yet a third category, “mixed models” of Medicaid HCBS delivery may emerge, characterized by “extensive partnership” between managed care plans and the AN.

NASUAD executive director Martha Roherty noted at the symposium that “[Medicaid] managed care and managed long-term services and supports are marching across the states and the nation,” in part because they view managed care plans as being able to provide states with greater budget predictability. “We no longer have wild swings,” Roherty said. “We’re seeing waiting lists go down in a lot of states -- states that had massive waiting lists for home and community-based services.” At the same time, Sandy Markwood, chief executive officer of n4a, observed that funding sources for the AN are diversifying well beyond Medicaid, the OAA and state general revenues to include transportation programs, initiatives with the Department of Veterans Affairs (VA) and Medicare, as well as contractual partnerships with hospitals, managed care plans, disability organizations, evolving integrated care initiatives and consumer-focused private pay programs. The AN, she concluded, has a variety of avenues for expansion during the next 10 years.

In an effort to promote greater consistency, in May 2013, the Centers for Medicare and Medicaid Services (CMS) issued guidance governing states’ implementation of MLTSS, which the agency proposes to codify in regulation; a proposed regulation was released in June 2015. The guidance requires that MLTSS beneficiaries be offered conflict-free education and enrollment and disenrollment assistance. As a result, the AAAs and community-based organizations within the AN that wish to contract with MCOs to offer services will need to decide whether they will continue to provide direct services or whether they will provide front-end assessment or enrollment assistance to MLTSS enrollees.²²

Other major regulatory changes affecting the AN include a regulation governing all Medicaid HCBS providers – ranging from assisted living to adult day, home and personal care agencies and others – as well as provisions governing participation in the Balancing Incentive Program.^{23,24} To assist the AN in understanding this swirl of activity and to be able to leverage new opportunities for partnering with health care organizations, ACL launched the Business Acumen Learning Collaborative (BALC) in 2013.

Business Acumen Learning Collaborative

Launched as a public-private partnership between ACL and the John A. Hartford Foundation, the BALC provides targeted technical assistance to selected networks of community-based organizations – including AAAs, Centers for Independent Living and other community-based organizations – that jointly apply to be part of a learning collaborative. ACL’s technical assistance takes the form of in-person consultations, webinars, written materials and peer-to-peer learning in an effort to develop the business capacity required to contract with health care organizations, ranging from Medicaid managed care plans, Medicare Advantage plans, ACOs, hospitals and more. Grant funding from the private foundations supports in-person meetings and training sessions for the collaborative. The first collaborative concluded at the end of 2014 and ACL launched a second wave in 2015 (Box 2). The overarching goal is to boost the business capacity of community-based aging and disability organizations to market their community-based care networks to partnering health care providers, including MCOs.

Several other initiatives are also working to develop and enhance the business acumen of the AN. For example, ACL also funds the “Aging and Disability Partnership for Managed Long-Term Services and Sup-

We’re seeing waiting lists go down in a lot of states — states that had massive waiting lists for home and community-based services.

— Martha Roherty,
NASUAD Executive Director

ports,” a collaboration led by n4a that includes the National Disability Rights Network, Justice in Aging, Disability Rights and Education Fund and Health Management Associates. The stated goal of the Partnership is to ensure the delivery of efficient, high-quality MLTSS to both older adults and younger people with disabilities. The SCAN Foundation also launched the “Linkage Lab” program in 2013, an initiative that focuses on preparing community-based organizations in California to contract with health care entities. The first Linkage Lab cohort, consisting of 6 CBOs, reported signing 27 contracts with health care partners as of early 2015.²⁵

Box 2

Business Acumen Learning Collaborative Grants	
Round 1 Network Leads (2013 Launch)	Round 2 Network Leads (2015 Launch)
Partners in Care Foundation (CA)	County of San Diego, Health and Human Services Agency Aging & Independence Services (CA)
San Francisco Department of Aging and Adult Services (CA)	Alameda County Aging, Disability, and Resource Connection (CA)
Healthy Aging Regional Collaborative (FL)	Indiana Association of Area Agencies on Aging, Inc., and the Indiana Aging Alliance, LLC (IN)
Elder Services of the Merrimack Valley (MA)	Aging and Disability Resource Consortium of the Greater North Shore, Inc. (MA)
The Senior Alliance and the Detroit Area Agency on Aging (MI)	St. Louis Metropolitan Integrated Health Collaborative (MO)
Minnesota Metro Aging and Business Network (MN)	Center on Aging and Community Living (NH)
AAAs of Erie and Niagara counties (NY)	INCOG Area Agency on Aging and Ability Resources, Inc. (OK)
PA Association of AAAs, Inc. in partnership with the PA Centers for Independent Living (PA)	The Arc Tennessee (TN)
North Central Texas Council of Governments (TX)	Vermont Association of Area Agencies on Aging (v4a) and the Vermont Community-Based Collaborative (VT)
	Aging and Long Term Care of Eastern Washington (WA)
	Wisconsin Institute for Healthy Aging (WI)

Source: Administration for Community Living, Center for Integrated Programs, Office of Integrated Care Innovations.

In general terms, the AN is aiming to offer “value-added” services, including beneficiary self-management programs for chronic diseases to improve quality of life outcomes for older adults. Other interventions include falls prevention and wellness initiatives for at-risk Medicare beneficiaries. At the November 2014 symposium, NASUAD’s Roherty challenged attendees “to stop...giving stuff away. Start realizing that what you’re doing has a value and start figuring out what the value is so that you can go out and sell it... You’ve got to step up or you’re going to get stepped on, because somebody else is going to figure out the value of that and they’re going to sell it.”

The AN believes that its deep community knowledge and expertise in social services and supports for older adults will increasingly be recognized as essential to the ability of the health care sector to execute sustainable strategies for serving medically complex people at home. In this context, services packages, Roherty noted, can be geared to specific purposes and targeted to enrolled Medicaid populations, including interventions designed to prevent hospital readmissions, manage chronic conditions, activate and empower beneficiaries in self-care, and assist with transitioning elders out of nursing homes into community settings. One of the primary services now being offered by the AN is case management, which may be billable as a Medicaid administrative service, according to ACL staff.

Billable services for fee-for-service Medicare beneficiaries can also be constructed for diabetes self-management and other chronic conditions, as well as for wellness services. Being able to bill for services and contract with health care providers, however, involves meeting standards, including clinical supervision requirements, and the ability to measure quality according to measures that managed care plans (and increasingly other types of providers) are required to report. A major difficulty confronting the AN is that it lacks the technological infrastructure for billing and tracking performance. Social services organizations also have less experience with privacy requirements of the Health Information Privacy and Protection Act (HIPAA) and did not receive federal funding to offset the cost of purchasing (or linking to) HIPAA-compliant electronic medical records systems.

Other AN services that can be negotiated into contracts include nutrition counseling and provision of meals, education about Medicare’s preventive benefits, caregiver support, environmental modifications, person-centered planning and personal care, transportation, benefits outreach and enrollment, falls prevention and mental health services.

The goal of the initial BALC pilot program, running from May 2013 through December 2014, was to enable networks of community-based organizations to establish at least one new contract with an integrated care entity by the end of 2014. Results were promising, with 14 contracts signed. In addition to devising pricing strategies for services, major challenges identified in the pilot included a lack of infrastructure for “back office” functions such as billing, tracking outcomes and the information technology required to perform these functions. In response, one network of CBOs formed a Management Services Organization (MSO) to assist in these functions. In the 2015-2016 collaborative, some CBO networks are examining how to create brokerage hubs for referrals of payers to HCBS providers, as well as brokerages that also include direct provision of services, e.g., assessment and short-term service coordination (generally over 30 days). Achieving consistent quality across these types of new networks is an ongoing challenge, along with building capacity for performance measurement (e.g., managed care Healthcare Effectiveness Data and Information Set, or HEDIS) and meeting accreditation requirements.

The ultimate goal of ACL's Business Acumen Learning Collaborative is that participating community-based networks will be able to contract and negotiate services packages with risk-based private sector health care organizations. AAAs can also create programs with appropriate clinical staff (e.g., a registered dietician or nurse) to provide services such as diabetes self-management, which can be billed on a fee-for-service basis under Medicare. In so doing, ACL reasons, the AN can also readily expand its reach to non-OAA populations who are eligible to receive services through various programs, including adults with disabilities under 60, veterans and caregivers of all ages. According to n4a's Markwood, in some communities, the AN has already expanded its footprint to serve 30-40% of the population base of older and vulnerable adults, and some AAAs are launching business lines serving individuals outside traditional OAA service populations through MLTSS, Medicare and private-pay programs.

The BALC program received a boost in the omnibus budget bill enacted late in 2015 with inclusion of report language in the Labor/HHS appropriations section stating that Congress "supports ACL in the development of the Business Acumen Learning Collaborative and the successful partnerships between its network of home and community-based service organizations. The collaborative aims to reduce hospital admissions and readmissions, improve care coordination, improve access to social services and supports and lower overall health expenditures in the future. The Committee urges ACL to continue these efforts and collaborate with CMS to maximize further cost savings."²⁶

"There is widespread awareness that change is coming" in the AN, he said. "It's more of a challenge to get it done."

— Tim McNeill,
RN, MPH, ACL Consultant

One of ACL's top technical assistance contractors for the BALC is Tim McNeill, a U.S. Navy-trained RN with a long background in research coaching at Federal Qualified Health Centers. For the last six years, McNeill has crisscrossed the country, training AN organizations. "There is widespread awareness that change is coming" in the AN, he said. "It's more of a challenge to get it done." Today the AN has 15 accredited diabetes self-management programs up and running, and there are challenges with convincing managed care plans that the services offered are worth paying for. "Managed care plans don't want to contract with tiny, non-technologically savvy organizations," he said, adding that "it's critical that the AN define its 'value add,' and report it out." McNeill noted that ACL is pushing individual CBOs to come together as a

broad coalition and not try to make the many necessary transitions individually; to become "clinically integrated systems of care." Larger networks have already formed in San Diego, Dallas, and other areas serving 70 to 80,000 older adults each month, he noted, and there is growing interest in using Aging and Disability Resource Centers (ADRCs) to help broker services and establish lasting networks capable of providing services to large numbers of people.

There is also an accelerating push in the health care industry, and from the federal government, to rapidly develop and expand value-based purchasing initiatives, which involve taking risk. In Pennsylvania, the AN is in the process of forming a for-profit limited liability company with Independent Living Centers in order to be able to do this. Yet McNeill also observed that other types of organizations are equally interested in providing evidence-based chronic disease management programs, community-based services and health-related services. For example, St. Louis-headquartered MTM, Inc. has grown from a local broker of non-emergency medical transportation services in the St. Louis, MO area - acting as a liaison between recipients and subcontracted transportation providers as well as facilitating trip scheduling,

service oversight and payment – to a multi-state for-profit company that offers multiple services. Those include ambulance claims management (i.e., standardized payments and processes, utilization control and contracting with a network of providers), call center services (i.e., provision of information to enrollees on behalf of health plans about their health benefits), and assessment of transit needs for special populations. MTM’s clients include Medicare, Medicaid, private health plans, state and local government agencies, third party administrators and various health care providers.

Nonprofit organizations with a research base are also offering services that may overlap somewhat with some of what the AN wishes to pursue. For example, Health Quality Partners, a non-profit health care quality research and development company based in Pennsylvania, is contracting with ACOs and managed care plans to provide advanced preventive care services, using nurse care managers to work with Medicare beneficiaries and their primary care providers to provide assessment and monitoring, support for medication management, education, self-management coaching and care transitions.

BALC: Florida, Case Study #1

AAAs in some states are seeking to acquire provider status in the Medicaid and Medicare programs, partnering with private foundations to acquire a working knowledge of how to design, price, negotiate and bill for distinct, value-added services; to establish or interface with systems that can collect and report data on performance metrics; to train staff in working closely with health care providers who are striving to achieve good performance on required quality metrics; and to devise and implement strategies for achieving financial targets. In Florida, for example, Martha Pelaez is the director of the Healthy Aging Regional Collaborative, of the Health Foundation of South Florida (HFSF), a conversion foundation serving Broward, Miami-Dade and Monroe Counties that opened its doors in 1993, following the sale of a majority interest in Cedars Medical Center of Miami to Columbia/HCA Corporation. Seven years ago, the Foundation decided to underwrite a Healthy Aging Initiative based on a collaborative of community-based organizations and AAAs to offer evidence-based wellness programs in four areas: chronic disease self-management education, falls prevention, physical activity and depression.

According to Pelaez, to date more than 38,000 services have been delivered through the initiative. At the end of the fifth year, the Foundation’s board voted to shift the focus to building infrastructure for an aging services network anchored in south Florida. “There was a lot to build,” Pelaez noted, including technology, clinical connections and billing capacity. The Foundation created Florida Health Networks (FHN), a not-for-profit limited liability company, to serve as the MSO for the AN in South Florida. The Foundation also decided to seek and contract with a third-party administrator (TPA) that has the capacity to provide health information technology that meets “Meaningful Use” standards and can operate an integrated population health model that includes health care professionals and community health workers working as a team. The TPA also has the ability to bill for Medicare and Medicaid-reimbursable services.

The overarching goal, Pelaez said, is to create a statewide infrastructure across Florida’s 11 planning service areas using ADRCs as the network hub in each planning area. Together, the network will aim to deliver clinically-driven, community-based, technology-enabled services to Medicaid agencies, MCOs, ACOs and other organizations as part of a broad strategy to position the AN as a partner for managing population health for value-based contracts, i.e., programs predicated on pay-for-performance/quality,

bundled payments, shared savings and partial and full risk. In this process, the role of the AN in relationship to its health care partners is broadly defined as follows:

Aging Network: ADRCs continue to contract with service providers to deliver a broad range of wellness and prevention services. In addition, the ADRCs play a central role in ensuring population health services for older adults, including community health workers, who are trained in multiple evidence-based programs. ADRCs have a “network agreement” with the Foundation, which provides back-office services as an MSO.

Florida Health Network: Coordinates activities with all participating ADRCs, and is also responsible for coordinating business development, including negotiating and executing contracts with health plans and other health care organizations. FHN contracts with the TPA to deliver technology services, billing services, clinical staff and other administrative and reporting services.

Third Party Administrator: Provides 1) technology services for the services and programs delivered by FHN and the ADRCs; 2) billing and credentialing services as required, and interface with CMS; and 3) licensed clinical staff as required to support specific programs.

A principal challenge that the Foundation has faced in building out the FHN, Pelaez said, is to ensure that all stakeholders are prepared to work together in different environments and arrangements than they have historically, and that they deliver services in accordance with strict CMS rules. For example, AAAs and ADRCs must transition from relying on volunteers to utilizing a workforce of well-trained community health workers, she explained, who can work with health care providers as part of a coordinated team but also remain true to serving the broader community of elders in need. “We are building a network of community health workers who are working with clinical personnel in the provision of care coordination and patient activation programs, including diabetes self-management and falls prevention.”

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— Martha Pelaez, Director
Healthy Aging Regional Collaborative,
Health Foundation of South Florida

FHN is now positioning itself to work with physician groups and ACOs in supporting chronic care management and wellness care plans, so that health care providers who conduct annual wellness visits can refer patients to prevention programs in the community by working with the AN. Key goals of FHN are to have neighborhood sites offering evidence-based prevention programs for older adults and adults with disabilities, to receive physician referrals for targeted population and to use HIT with a care coordination platform.

Although Medicare Advantage plans currently have incentives to work with the AN providers, Pelaez said, this could change. “It is a moving target,” she observed. “Will Medicare Advantage plans build their own programs or contract with the AN? Will comprehensive managed care plans for dual eligibles recognize the value of the AN? So far [the Medicaid plans] all think they can do it all themselves and that the Aging Network can provide ‘free’ services.” Pelaez also noted that some dually eligible beneficiaries can have “as many as three different billable partners,” requiring complex contracting among different systems. “Moving towards an integrated system is the goal of the triple aim; however, we’re not there yet,” she said.

Going forward, Pelaez continued, “our target population is the 15% [of older adults who are] at risk of becoming the most costly 5%, in a given population; those who are in danger of having a fall; and who have multiple chronic conditions, including diabetes and depression.” She noted that one of the many challenges is that seniors in this 15% are “not in a senior center...they are the hardest to find and are at the greatest risk.” Still, the AN is likely to succeed, she maintained, precisely because it has decades of experience working in communities with older adults, and because AAAs and associated community-based organizations are trusted by older adults. Without the AN, achieving improved outcomes for older adults with complex chronic conditions will remain an elusive goal for many health care providers, Pelaez asserted. She predicted that initiatives in Florida that are being undertaken by the AN in collaboration with FHN will demonstrate a solid, sustainable return on investment (ROI).

BALC: Massachusetts, Case Study #2

Another program that is doing pioneering work is the Healthy Living Center of Excellence in Merrimack Valley, Massachusetts. There, Elder Services of Merrimack Valley (the AAA) has partnered with Hebrew Senior Life, a company focused on LTSS services. Launched with funding from the Tufts Health Plan Foundation and the John A. Hartford Foundation, the Center is a virtual entity. Services include care coordination, care transitions and “Care at Hand” coaching services for elders that can be accessed through information kiosks. These kiosks also offer information about chronic disease self-management – e.g., pain self-management, diabetes, cancer thriving and surviving and behavioral management – and how to access more focused training and assistance programs. A primary goal of the Center is to gradually expand to create a statewide hub encompassing all AAAs in a single cohesive provider network.

According to Jennifer Raymond with Hebrew Senior Life and Joan Hatem-Roy with the AAA in Merrimack Valley, the diabetes self-management program is billable to Medicare fee-for-service in Merrimack Valley, but not elsewhere so far. To tackle managed care, the Center is working to build referral relationships with the Massachusetts Senior Care Options (SCO) plans, which are focused on providing services to dually eligible beneficiaries. For example, the AAAs provide geriatric case managers for the plans, and are currently in contract discussions about providing care transitions services for the SCOs that are based on the model developed by Eric Coleman of the University of Colorado.²⁷ With regard to ACOs, the Center is exploring the feasibility of conducting a pilot for high-risk diabetes patients. To accomplish this, the ACO has created a registry of such patients who can be referred to the Center’s programs. This concept could, Hatem-Roy said, be expanded to hospitals, other managed care plans such as PACE plans and even large physician groups.

Greater Lynn Senior Services (GLSS) is an AAA that also delivers para-transit and other transport services and a principal partner in the region’s Aging and Disability Resource Consortium (recently re-named the Greater North Shore Link). Located in Lynn, Massachusetts, GLSS collaborates with the Healthy Living Center in Merrimack Valley on the delivery of health self-management programming. Firmly believing that “health happens in the community” and that the key to lasting health care reform lies in the “transformation of information into inspiration” for both consumers and providers, GLSS has championed, designed and implemented a number of consumer engagement initiatives.

For example, in addition to providing traditional AAA services such as information and referral, nutrition, caregiver supports, advocacy, protective services, case management, money management and more, GLSS offers mobile mental health, specialized domestic violence interventions for older women, hoarding supports, a “homeless elders” breakfast program, mobility management (including travel training), care

transitions supports, a comprehensive falls prevention program and habilitation training. As a leadership member of the Greater North Shore Link, GLSS delivers options counseling, housing search and nursing home-to-community transition services funded by the federal “Money Follows the Person” program. GLSS is also pioneering an enhanced LTSS coordination function for some providers participating in One Care, the Commonwealth’s demonstration program for dually eligible beneficiaries. The enhanced LTSS Coordinators are hired through GLSS, which oversees the staff and tracks outcomes. GLSS serves about 30,000 consumers across five communities north of Boston and over 100,000 consumers annually through its roles both as a para-transit provider and as a key leader in the region’s incorporated Aging and Disability Resource Consortium.

Paul Crowley, Executive Director, and Valerie Parker Callahan, Director of Planning and Development, explained that GLSS information kiosks are permanently sited at certain community “pulse-points” (e.g., libraries, housing sites, senior centers, etc.) and also “rove” to additional sites across the region in concert with special events. The kiosks are developed and funded by GLSS and sponsored by Link partners in their catchment areas. Their programming offers engaging, instructional materials and activities on a broad range of subjects through a variety of platforms, including interactive assistive technology, as well as programs that are designed to work individually or in small groups with staff specialists and trained kiosk advisors. Among the subjects are driving safety, mobility planning, travel training, cognitive assessments and memory strengthening, employment counseling, options counseling, falls risk assessments and prevention, cardiac health education and monitoring, and activities for groups (karaoke, chair yoga, story-telling, games and various online or “virtual programs”). Home visits to follow up on key health and wellness issues, including habilitation training, can also be arranged.

We are trying to create portals of entry [for services] that are not necessarily an institutional door.

— Valerie Parker Callahan, Director of Planning and Development, Greater Lynn Senior Services

In addition, the kiosks promote a program known as “Passport to Health,” which invites older adults to create an advanced directive and to record critical directions for how to notify certain medical providers and family members if a medical emergency occurs. These include instructions for the care of pets, caretaking of the home and how to make new arrangements for supporting an already-ill or disabled loved one. Medications, prior conditions and previous emergencies are listed in each individual’s Passport, which is generally tacked up on the consumer’s refrigerator and readily available for presentation to medical personnel in the event of an emergency. According to Parker Callahan, tools like the Passport reflect the kiosk’s significance in helping elders create effective community services linkages for those who wish to

age in place and rebound swiftly and with greater stability if emergencies do occur. The program further urges older adults to request a transitions coach well before discharge from the hospital. “We are trying to create portals of entry [for services] that are not necessarily an institutional door,” she said.

Finally, the Greater North Shore Link aims to develop a strong business infrastructure (e.g., referral, billing, resource coordination, staff training, consistent protocols, tracking outcomes) to serve AAAs and to provide seniors with better LTSS access to community-based, person-directed, and enhanced supports via a “no wrong door” system. Similar to Florida, there is interest in using the ADRC-based entity as an avenue for both organizing and brokering LTSS. Another area that is similarly inclined is San Diego, California, which is also the site of the largest Community-based Care Transitions Program in the country.

Community-based Care Transitions Program

Some of the most forward-looking emerging partnership arrangements between the AN and the health care sector focus on Medicare beneficiaries who have an increased risk of hospitalization. Under Section 3026 of the Affordable Care Act, the CCTP is charged with assuring safe transitions between care settings, preventing the health and emotional toll of hospital readmissions and reducing health care costs. Designed as a five-year demonstration, the CCTP is structured as a risk-based business contract between participating hospitals with high readmissions rates and community-based organizations that are part of the AN. Starting in February 2012, “high-risk” Medicare beneficiaries at 101 sites with a history of multiple readmissions, cognitive impairment or complex chronic conditions were enrolled during several phases. Working with hospitals but with care transition services anchored in communities and provided mainly by AAAs, CCTP sites utilize coaching along with a variety of other interventions, including medication review and management, training of beneficiaries and their family caregivers in self-management of chronic conditions and varying short-term supportive services following discharge from the hospital, such as personal care, transportation to medical appointments and home-delivered meals.

A pioneering program, the CCTP has produced a solid record of success at some sites, while others have encountered challenges ranging from slow enrollment, poor access to hospital patient data and high start-up costs. These were exacerbated by the Aging Networks’ lack of access to information technology that is compatible with, and comparable to, what hospitals and physicians have acquired during the last several years, in part with federal incentive payments. The CCTP program in San Diego is a standout. It is anchored by Aging & Independence Services (AIS), an AAA that is the lead agency for San Diego County’s ADRC (the other entity sharing the ADRC is the local Independent Living Center).

The San Diego Care Transitions Partnership (SDCTP) is a partnership between the County of San Diego Health and Human Services Agency’s Aging & Independence Services, Palomar Health, Scripps Health, Sharp HealthCare, and the University of California San Diego Health System (a total of 13 hospitals that together serve 92% of the fee-for-service (FFS) Medicare population). San Diego started receiving CCTP grant funding in January 2013, serving more than 38,000 high-risk patients. It offers a care transitions intervention based on the Coleman model (self-management of medications, creation of a personal health record maintained by the patient, timely follow-up with primary or specialty care and a list of “red flag” indicators indicating a worsening condition)²⁰ and a care enhancement intervention.

To date, the program has demonstrated a 27% reduction in 30-day all-cause readmission for CCTP enrollees. Relative to all Medicare FFS beneficiaries in the 13-hospital system, readmissions risk declined 9%. AIS notes, however, that total inpatient hospital utilization declined by around 13% during the same time period, suggesting that the program had a positive effect in lowering not only readmission rates, but admission rates as well. With regard to lowering Medicare spending on hospitalization, San Diego CCTP staff calculate that estimated savings, net of program payments, totaled \$9.6 million through January

In San Diego, estimated savings, net of program payments, totaled \$9.6 million through January 2015. If the concomitant drop in hospital admissions is also factored in, estimated savings jump to more than \$50 million.

2015. If the concomitant drop in hospital admissions is also factored in, estimated savings jump to more than \$50 million. The program was recently awarded an additional six months of funding which will extend the program through June 2016; in the years thereafter, how AIS and San Diego hospitals will work together to prevent re-hospitalizations has yet to be negotiated.²⁸

Concurrently, AIS has been collaborating with a California-based non-profit, Partners in Care Foundation, for some years on evidence-based programs for vulnerable older adults, including chronic disease and diabetes self-management. Partners in Care provides a broad array of social supports for vulnerable populations – older adults, infants and families at risk – offering services ranging from services for new mothers to training health care providers and families about pain management and end of life supports. Partners provided seed funding to form a collaborative of nine CCTP programs in southern California and then built a regional provider network – an MSO that includes the CCTP collaborative. Similar to other MSOs being formed to assist the AN, a leading goal is to contract with public and private managed care plans and other health care organizations to provide care transitions services, complex care management, medication management and evidence-based program services to individuals who are referred.

Not all CCTP programs have fared as well as San Diego's program. Many of the initial participating programs dropped out or were terminated in the first two years, most frequently due to difficulties in achieving rapid enrollment. The evaluation contractor for CMS, Econometrica, concluded in its first report that only four of the 47 CCTP programs reduced all-cause readmission rates by the target of 20%.²⁹ Yet prominent critics of the readmissions measure have pointed out that the metric is blind to the real impact of CCTP interventions. For example, Dr. Joanne Lynn, director of Altarum Institute's Center for Elder Care and Advanced Illness, observed that "nearly everything [that CCTP programs do to reduce readmissions] in the first 30 days will continue to have a positive effect for much longer, and *better support arrangements and care planning in the community will end up reducing index admissions*" [emphasis added].³⁰ Reducing admissions causes the denominator to shrink, given that CMS uses readmissions/discharges as the key quality measure. If the numerator and denominator shrink at the same rate, the quality measure will not show improvement.

Lynn further noted that no measures were included to look specifically at what the impact of the CCTP interventions has been from the perspective of enrolled beneficiaries.³⁰ Similarly, a blog written by Christopher Langston for the John A. Hartford Foundation called the Econometrica evaluation "premature and very confusing," in part because it did "not look at what happened to the patients who got the treatment, specifically." Langston noted that "the thing that is most innovative about CCTP is not the interventions to reduce readmissions themselves...[but rather] the creation of new partnership arrangements between community-based organizations, largely Area Agencies on Aging, and hospitals – arrangements where only CBOs could get paid."³¹

Initiatives to Measure and Demonstrate Better Value and Quality of Life

Until recently, the AN did not fully embrace the challenges of collecting and reporting detailed data that can highlight and demonstrate the value of its services to the health care sector and to state and federal policymakers. Nor has the health care sector made a significant investment in understanding the value of community-based services for patients that are most often provided in the home, effective

at stabilizing vulnerable individuals, and, in so doing, can reduce total care costs. The result is a dearth of measures that are appropriate for examining and analyzing the cumulative impact of services rendered by health and social services providers on outcomes for those who need a mix of medical and LTSS, and cost.

Currently, there are very few LTSS quality measures in use by states participating in the demonstrations for dually eligible beneficiaries, and of those that are in use, most are focused on nursing facilities.³² Overall, there is a lack of recognition in the medical literature that good social supports and services modulate the sustained success of many health care interventions.³³⁻³⁵ Yet awareness that quality outcomes in the health care sector are influenced by non-health factors (e.g., socioeconomic status factors) is beginning to build. For example, Vermont's Support and Services at Home (SASH) program, which is a part of the state's Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), and Vermont's Blueprint for Health provide care coordination for older adults living in affordable housing. SASH was initiated by the Cathedral Square Corporation – a provider of independent and shared affordable housing for seniors – due to concerns that frail residents in its properties did not have enough support to live safely in their homes. SASH provides a comprehensive health and wellness assessment, the creation of an individualized care plan, on-site nursing coaching, care coordination and health and wellness group programs. The SASH team consists of a SASH coordinator and wellness nurse along with local service provider organizations, including AAAs. The first evaluation of the program found that participants in the early panels of SASH had slower growth in Medicare spending and post-acute care spending relative to two comparison groups: individuals residing in non-SASH House and Urban Development (HUD) properties participating in MAPCP, and individuals not participating in either program.³⁶

In Washington State, one study examined the impact of a Chronic Care Management Program for enrollees in the Washington State Medicaid Program, which built upon existing AAA case management and service delivery infrastructure. The program provided care management, care coordination and patient education in self-management skills to high-risk Medicaid beneficiaries with functional limitations who received in-home personal care. The program was found to produce significant savings in inpatient hospital costs of \$318 per member per month.³⁷

Joseph Ruby, president and CEO of the AAA “Direction Home” in Akron, Ohio, has urged AAAs to become closely involved in planning committees at hospitals, ACOs, physician groups and on-the-ground efforts of other key stakeholders in order to ensure their involvement in health initiatives. At the November 2014 symposium, Ruby noted that there are “plenty of common interests” in the form of ongoing delivery system reform initiatives, many aimed at reducing utilization – such as hospital admissions, emergency department use and lengths of stay. These offer the possibility of aligning activities and strategic opportunities to get community-based organizations involved in “thinking beyond medical model boundaries.”

Some of the quality measure domains called for in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) may help to accelerate such thinking, with uniform measures called for in the following eight domains:

- › Functional status, cognitive function and changes in function and cognitive function;
- › Skin integrity and changes in skin integrity;

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- › Medication reconciliation;
 - › Incidence of major falls;
 - › Communicating the existence of and providing for the transfer of health information and care preferences;
 - › Discharge to community;
 - › Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates;
 - › Resource use, including total estimated Medicare spending per beneficiary.

IMPACT's initial measures must be selected and implemented through regulation by 2017 for use in post-acute care (PAC) settings, generally those covering up to 90 days of services following hospital discharge. PAC providers include skilled nursing facilities, inpatient rehabilitation facilities, home health agencies and long-term care hospitals. The measure domains start to recognize factors that are specific to individuals, notably in the care preferences domain, but arguably fall short of person-centeredness goals for HCBS services that encompass quality of life, and which aging and disability advocates favor developing and disseminating.³⁸

By comparison, revised standards for person-centered planning and written service plans issued by CMS in a final rule for HCBS Medicaid waiver services in January 2014, and which will be phased in through March 2019, are markedly person-centered. Among numerous requirements, the regulation requires all states, and plans and providers contracting with Medicaid programs, to have a "person-centered planning process" in place that ensures consumers are in charge of directing this process to the maximum extent possible. Beneficiaries must be empowered to make "informed choices" about services and providers, and the consequences of making particular choices, and the written service plans must reflect the "identified need and individual preferences of consumers." NASUAD's Roherty urged AAAs, ADRCs and community-based organizations "to really participate in understanding what home and community-based services 'writ large' will look like in your state" in the years ahead. "Participate in your transition planning effort that each of the states are conducting," she said. "Get to know, as Aging and Disability Network professionals... what's included in your transition and what steps are needed to ensure that your current operations are still going to be maintained... or if they're not, what steps you're going to take" to continue to expand HCBS programming.

Together, these policy developments suggest a need for greatly accelerated measures development that can more fully and accurately reflect the value of social services in improving (or maintaining) the quality of care and quality of life for older adults living in the community. New or adapted measures are essential for assessing the effectiveness of AN providers and the cost of specific (or bundled) AN-delivered services in a population that has both chronic conditions and functional limitations. As states continue to shift toward capitation, and Medicare fee-for-service spending increasingly shifts to "value-based" and "alternative payment models," greater priority may be given to developing and testing new metrics for community-delivered services.

The Department of Health and Human Services (HHS) is already moving in this direction with creation of the Community Living Council, a multi-agency collaborative that also encompasses the Office of the

Assistant Secretary for Planning and Evaluation (ASPE), the Agency for Health Care Research and Quality (AHRQ) and CMS. ACL staff note that while quality has been an ongoing conversation, the focus has shifted to identifying specific measurement gaps and developing strategies to address them. The council has established a strategic partnership with the National Quality Forum (NQF) and is working through a multi-stakeholder committee over a two-year period to develop recommendations for community-based LTSS measurement. To date, the NQF committee has issued the first of three interim reports defining HCBS services and 11 quality domains. These differ from the IMPACT law domains, covering workforce, consumer voice, choice and control, human and legal rights, system performance, full community inclusion, caregiver support, effectiveness/quality of services, service delivery, equity and health and well-being. A December 2015 report on measuring HCBS quality further notes that “numerous potential subdomains for measurement exist under each of the domains.”³⁹ Ultimately, person-centered planning may drive conversations about quality of life measures, and care planning processes may span providers working in disparate settings.

Elsewhere within HHS, work is being done on HCBS quality measurement with Medicaid-managed LTSS plans in mind. Comments submitted by the National Council on Aging on a proposed managed care regulation issued by CMS in May 2015 urged the agency to require states to greatly expand participation by beneficiaries, providers and consumer representatives – including Area Agencies on Aging and Centers for Independent Living – in their Medicaid-managed LTSS advisory committees.

Separately, NASUAD has partnered with the Human Services Research Institute and the National Association of State Directors of Developmental Disability Services to develop the National Core Indicators-Aging and Disability Survey (NCI-AD). This survey project, which began collecting data in 14 participating states in June 2015, is designed to help states assess their HCBS programs by addressing quality of life, person-centered services and community integration.⁴⁰ In addition to measuring quality, NCI and NCI-AD measures can be used to assess compliance with CMS’ new Home and Community-Based Services regulations, which were issued in March 2014.⁴¹ Recently, ACL announced tightened standards for its evidence-based programs. The agency has historically used a three-tiered definition of “evidence-based,” allowing Title III-D funds to be used for programs meeting minimal, intermediate and top tier criteria. Beginning in October 2016, programs must show their services have:

- › demonstrated effectiveness through evaluation at improving the health and well-being or reducing disease, disability and/or injury among older adults;
- › proven effective with an older adult population, using experimental or quasi-experimental design;
- › published research results in a peer-review journal;
- › fully translated in one or more community site(s); and
- › created dissemination products that are available to the public.⁴²

In another important quality development, the 2014 Quality Improvement Network-Quality Improvement Organization (QIN-QIO) statement of work includes a specific requirement to address health disparities relevant to diabetic outcomes. QIN-QIOs work with Medicare beneficiaries, providers, and communities on data-driven initiatives that increase patient safety, improve community health and clinical quality, and better coordinate post-hospital care. Specifically, each QIN-QIO is now charged with implementing diabetes self-management training programs that target Medicare beneficiaries in the

following high-risk groups: African Americans, Latino Americans, Asian/Pacific Islanders and individuals living in rural areas.

This initiative offers the prospect of expanded opportunities for the AN to work with Medicare contractors and local providers treating beneficiaries with diabetes. CMS instructions for the QIN-QIOs require development of “sustainable” programs, and stipulate that billing for the classes through Medicare must be clearly delineated (i.e., not billed twice) in collaborations with community-based organizations.

A wide-ranging Academy Health paper issued in April 2015 notes that “things that do seem to be effective at improving quality have to do with organizational structure, leadership, value structures and decision-making processes.”⁴³ Based on a February 2015 symposium held in Washington, D.C., the Academy’s analysis suggests that quality measures should be tailored to maximize functional outcomes, independence and quality of life, while reducing family caregiver stress. In this regard, in addition to measuring the impact and outcomes of current evidence-based practice programs such as falls prevention and diabetes self-management programs, the AN is well-positioned to play a role in collecting and analyzing data for measures of the availability of safe and adapted housing; the availability (or lack thereof) of family caregivers and voluntary support for homebound elders; access to personal care and home-delivered medical services; availability of reliable transportation; and availability of assistance to seniors and individuals with disabilities to navigate benefits, personal finances and legal help. The report also warns that time is of the essence, observing that the “train has left the station on delivery system reforms that have the potential to reshape HCBS – without agreement on standardized measures that might be used to assess changes in the quality of services provided.”

Concluding Observations

The Aging Network’s transformation is enormously challenging. At stake is not only the fate and future of AAAs, ADRCs and their community-based partners, but also the capacity of communities across the country to successfully field an adequate supply of “aging in place” services to growing elderly populations and younger individuals with LTSS needs. At this juncture, less than a decade remains for the AN to transform itself into a business-oriented enterprise that can brand, broker and deliver its services as measurably value-based and delivered in the context of contractual arrangements with health care organization partners and to older adults as direct consumers. Achieving success requires the AN to establish an array of new capabilities. The longstanding pattern of low appropriated funding levels in an era when the number of seniors is increasing by 10,000 each day underscores that the AN cannot rely on OAA dollars alone to finance needed new infrastructure. To date, no public funding has been provided to aid the AN in creating a far more robust, sophisticated technological infrastructure that can support collection and reporting of quality metrics that link to electronic health records, and which can be used to analyze the combined impact of health and social services on beneficiary outcomes. Also needed, but lacking so far, is public and private funding to develop and steward performance metrics that can accurately capture the role of AN services in changing (and hopefully reducing) total care costs.

Yet the AN already has considerable strengths to build on. One is that AAAs and ADRCs are already a trusted point of access and provider of services in communities across the country. James (Jay) Bulot, director of the Georgia Division of Aging Services, noted that “access to services that we provide for the public is really crucial, whether it’s through a health plan, a health system, or through the AAA. So if we

tie this to public awareness of what's out there and how to get there," and then conduct "some sort of consistent outreach, and make sure that folks know it's appropriate to come to that ADRC for assistance, that really is kind of how you get to the 'no wrong door.'"

Another possible area of strength for the AN is that its mission and services can be adapted to fit not only traditional HCBS waivers and managed Medicaid LTSS, but also other types of innovative arrangements and financing models. In this regard, a key trend is the recent rise in interest among states to develop Medicaid ACOs. Although it is early days for Medicaid ACOs, these large integrated systems are designed to explicitly include community-based providers in order to cost-effectively serve large and growing populations of vulnerable beneficiaries, including complex and high-risk patients.

A recently published "ACO Business Planning Toolkit" from the Center for Health Care Strategies (CHCS) argues that "because there are significant inefficiencies in the current health care system including delayed exchange of patient information, lack of preventive care, poor access to care, unaddressed social and behavioral factors, redundant tests and improper financial incentives... well-designed ACOs can improve sharing of patient information, support better management at the point of care and tap community resources to provide much-needed social supports such as housing, nutrition, translation and transportation services." The toolkit, which was designed for New Jersey, further notes that "other benefits of an ACO are improved individual and population health, and the potential to reduce overall health care costs by promoting primary and preventative care and lessening the need for expensive services."⁴⁴ Some of the specific requirements for establishing a Medicaid ACO in the state include identification of a "designated area;" inclusion of 5,000 or more beneficiaries (either fee-for-service or managed care or both); participation of 75% or more of qualified Medicaid primary care providers and at least four behavioral health care providers in the designated area; a governing board with a mechanism for shared governance, including representation of health and social services providers and consumer organizations; a "gain-sharing" arrangement "where any cost reductions achieved in the community are shared between participating providers, the state, and potentially managed care organizations and other entities;" a detailed quality plan; and a process for "engaging members of the community."

At the national level, there are hopeful signs that policymakers are beginning to realize that reliable community-based LTSS is essential to keeping Medicare beneficiaries with complex chronic conditions from repeatedly cycling in and out of high-cost health care settings. The Senate Finance Committee's move to charter a bipartisan chronic care working group, chaired by Sens. Johnny Isakson (R-GA) and Mark Warner (D-VA), requested stakeholder to provide ideas for "transformative policies" in March 2015 and subsequently issued a policy options document in December (comments on the options document are due by January 26, 2016). The Committee's current recommendations include making IAH permanent, as well as expanding supplemental benefits (such as enhanced disease management) to chronically ill Medicare Advantage enrollees. The document further observes that "a wide range of non-medical or social factors, such as nutrition, are important contributors to the health and costs of chronically-ill individuals."

In conjunction with development, testing and refinement of ACOs and other new and evolving alternative payment models (APMs), slowing spend-down to Medicaid in the population of Medicare beneficiaries who have modest incomes (the "pre-duals") is likely to become a highly salient issue during the next decade. If effective policies are not implemented to slow the rate of spend-down, the resulting Medicaid cost burden for state economies - as well as the federal government, which pays on average

57% percent of Medicaid costs – could become difficult to manage during the boomer-driven peak of the U.S. “age wave.” What is certain is that the number of Medicare beneficiaries with both chronic conditions and functional limitations who need a coordinated, seamless combination of medical care and LTSS will increase steadily during the next 15 years and beyond. As such, a primary focus may be how quickly and effectively current programs can be adapted to deliver better-tailored services to many more beneficiaries at significantly lower per-capita costs.

Absent thoughtful, careful reforms in service delivery, both Medicare and Medicaid are at high risk of ballooning costs as tens of millions of boomers move steadily toward “old-old” age (over 85), when needs for care and support are often at their most intense. Older adults who require, but do not receive, reliable community-based social services in order to remain out of crisis will be at high risk of multiple hospital readmissions. This is likely to become increasingly difficult for hospitals to manage due to financial penalties for readmissions. In addition, Medicaid is already at high financial risk due to its role as the default payer for nursing homes, and the current dearth of affordable private coverage for LTSS. Broader scaling of cost-effective models of service delivery that hold providers accountable for tightly coordinated medical care and the health-related supports that are the hallmark of the AN represents a prudent investment. If successfully implemented, they could also help keep health care expenditures for older adults from crowding out other needed societal investments.

Given these factors, experts at the Claude Pepper Center-NASI symposium agreed that expanding the mission of the AN over the next decade to serve millions of additional vulnerable older adults in need of basic, low-cost community supports is likely to yield broad benefits to society in the form of stabilized overall costs and higher quality of life for millions of long-lived Americans. ACL technical assistance contractor Tim McNeill summed up possibilities for the AN’s future in this way: “We’re going in one of two directions – either [the Network] grows, strengthens and becomes more cohesive, and works with payers to show the intrinsic value of services through [jointly developed] quality measures...or they’re going to shrink” as payers and for-profit entities push prices down. “We will embrace and lead change, and lead development of standards,” he said, or “quality [of services] will drop.”

ACL Administrator Greenlee agreed, predicting that “adequate quality measures across all the domains can really help us, because once we deliver this value base that people want to buy, and we can show this outcome, everybody can kind of move in that direction, and those outcomes can then drive what we should be delivering. It’s going to take some time, because we’re so far behind in terms of quality measures. But if we can do six or seven things really well and show the outcomes from that – not just output – I think that will shape by itself the nature of where the network will go in the next 10 years, because we will be able to sell that to a whole variety of payers [based on] the value add that we can demonstrate.”

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Appendix: Successes of the Aging Network

AARP’s “Long-Term Services and Supports Report Card” is published periodically and assesses the performance of state LTSS systems – according to domains of affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers and effective transitions – perfectly highlights the breadth and strength of the AN and its longstanding successes in building LTSS systems across the country.¹⁶ High-ranking states utilize a variety of delivery and financing models in their Medicaid LTSS systems. Some states have some or all of their LTSS populations in MLTSS, while others are administered entirely by the Aging Network through waiver programs. This chart summarizes AN successes in key areas in selected states. All data from the table below are from the Scorecard except where noted.

Selected Aging Network Successes in LTSS	
Percent of Medicaid and Other State Spending on HCBS	The Aging Network has been successful in rebalancing Medicaid spending in favor of preferred home and community-based services. The five highest ranked states on this indicator – New Mexico, Minnesota, Washington, Alaska and Oregon – averaged 62.5% of LTSS spending on HCBS for older adults and persons with disabilities. Total Medicaid spending for HCBS has increased from 18% in 1995 to 51% in 2013.*
Percent of New Medicaid LTSS Users First Receiving Services in the Community	In the top five states – Alaska, Minnesota, New Mexico, the District of Columbia and Idaho – an average of 77.6% of new LTSS users were served in HCBS settings, with Alaska having the highest rate of 81.9%.
Nursing Home Residents with Low Care Needs	States that have a high proportion of nursing home residents who have low care needs may not be taking appropriate steps to transition these residents to these alternatives. The top five states on this indicator – Maine, Hawaii, Utah, South Carolina and Pennsylvania – average 5% NH residents with low care needs. Maine has the lowest percentage at 1.1%.
Percent of People with 90+ Day Nursing Home Stays Successfully Transitioning Back to the Community	A high-performing LTSS system helps nursing home residents who would prefer to live in the community to transition. The top states were Utah, Oregon, Arizona, Nevada and Washington. These states transitioned an average of 13.1% of long-stay nursing home residents to community setting. Utah, the highest performer, transferred 15.8%.
Aging and Disability Resource Center Functions (ADRCs)	ADRCs are highly visible and trusted places where people of all incomes and ages can turn for information on long-term services and support options, and serve as single point of entry for access to public long-term support programs and benefits. The LTSS Scorecard found that New Hampshire, Florida, Minnesota, Indiana and Wisconsin had the most complete ADRC programs as measured a composite score of the extent to which the ADRC provided each of six core components, and the statewideness of the ADRC’s reach.

* Eiken S, Sredl K, Burwell B, and Saucier P. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Truven Health Analytics; 2015. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/long-term-services-and-supports.html>

Acronym Glossary

AAAs: Area Agencies on Aging

ACO: Accountable Care Organization

ADLs: Activities of Daily Living

ADRCs: Aging and Disability Resource Centers

AHC: Accountable Health Communities

AHRQ: Agency for Health Care Research and Quality

AIS: Aging and Independence Services

AN: Aging Network

AoA: Administration on Aging

APMs: Alternate Payment Models

ASAP: Aging Services Access Point

ASPE: the Office of the Assistant Secretary for Planning and Evaluation

BALC Business Acumen Learning Collaborative

CBOs: Community-Based Organizations

CCTP: Community-based Care Transitions Program

CMS: Centers for Medicare and Medicaid Services

FFS: Fee for Service

GAO: Government Accountability Office

GLSS: Greater Lynn Senior Services

HCBS: Home and Community-Based Services

HEDIS: Healthcare Effectiveness Data and Information Set

HFSS: Health Foundation of South Florida

HHS: Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act

HIT: Health Information Technology

HUD: Department of Housing and Urban Development

IAH: Independence at Home

IMPACT: Improving Medicare Post-Acute Care Transformation Act

LTSS: Long-Term Services and Supports

MAPCP: Multi-Payer Advanced Primary Care Practice Demonstration

MCO: Managed Care Organization

MLTSS: Managed Long Term Services and Supports

MOWA: Meals on Wheels America

MSO: Management Services Organization

N4A: National Association of Area Agencies on Aging
NASI: National Academy of Social Insurance
NASUAD: National Association of State Units on Aging and Disability
NCI-AD: National Core Indicators-Aging and Disability Survey
NQF: National Quality Forum
OAA: Older Americans Act
PAC: Post-Acute Care
PACE: Program of All-Inclusive Care for the Elderly
QIN-QIO: Quality Improvement Network-Quality Improvement Organization
ROI: Return On Investment
SASH: Support and Services at Home
SCSEP: Senior Community Service Employment Program
SCO: Senior Care Options
SDCTP: San Diego Care Transitions Partnership
TPA: Third-Party Administrator
VA: Department of Veteran's Affairs
WHCOA: White House Conference on Aging

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