



Improve

Health by Addressing the Social Determinants

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

For 45 years, the Aging Network has developed local systems of coordinated services and supports that provide person-and-family-centered, home and community-based services (HCBS) for older adults. Services offered through AAAs include meals provided in the home and in community settings, in-home care assistance, transportation, information and referral, evidence-based health and wellness programs, medication management, case management and more.

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

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

Key national leaders recognize the inherent value in addressing these social determinants of health.

According to Health and Human Services Secretary Alex Azar:

The root cause of so much of our health spending [is the] social determinants of health. Social determinants would be important to HHS even if all we did was health care services, but at HHS, we cover health and human services, all under one roof. In our very name and structure, we are set up to think about all the needs of vulnerable Americans, not just their health care needs.¹⁰

As experts at providing services that improve the social determinants of health, Area Agencies on Aging are increasingly partnering with health care to improve the health of older adults by engaging in innovative models of service delivery. In fact, AAA respondents to a 2018 n4a survey conducted in partnership with the Scripps Gerontology Center found that 41 percent already had contracts with health care entities.¹¹ However, there is ample opportunity to improve these efforts.¹²

Policymakers in the Administration and Congress must prioritize proposals that preserve improvements in care delivery and promote advances toward better integrated and person-and-family-centered care. Community-based organizations—particularly AAAs—must be key partners in achieving this monumental change. Involving these on-the-ground experts is the best way to address the social determinants of health, provide more coordinated care for the way people live, and, ultimately, drive better health outcomes and save money. For instance, a home health demonstration in Washington State used AAAs as community-based care coordinators to serve the population of people who are dually eligible for Medicaid and Medicare. Early results show tremendous savings to Medicare—\$107 million over three years¹³—and spotlight the value of experienced care coordinators at the community level.

As our nation considers improvements to health care delivery systems, n4a urges federal policymakers to recognize, engage and preserve the full potential of the Aging Network in improving health and reducing costs, particularly in the following areas.

Medicare

For more than fifty years, Medicare has provided vital acute health care coverage to older adults and people with disabilities. Currently, Medicare covers nearly 60 million beneficiaries—or nearly one out of every six Americans. Medicare is the country's largest health care payer, spending more than \$702 billion in 2017, or roughly 15 percent of total federal expenditures.¹⁴ While the rate of increase in Medicare spending has slowed since the ACA and other cost-savings measures were implemented, as the population ages and more individuals become eligible for Medicare, costs will inevitably grow. On the current trajectory, annual Medicare spending is expected to top \$1 trillion by 2026.¹⁵ Despite these fiscally troubling trends, there is no reason to panic. Medicare is not going broke and there are commonsense strategies that policymakers can promote to further reduce costs under Medicare without jeopardizing access to care for often economically vulnerable beneficiaries.

Medicare's primary role to provide acute health care in doctors' offices and hospitals to older adults and people with disabilities has historically overlooked the fact that the vast majority of factors that influence individual health exists outside of traditional medical settings. Health care outcomes and costs are driven, in part, by SDOH.



Addressing SDOH through Supplemental Services in Medicare Advantage

Unfortunately, investments in social services that address SDOH and keep older adults and caregivers healthy and independent do not reflect the value and growing need. Physicians and other health care providers often do not know how to connect their patients to community-based options. According to the Robert Wood Johnson Foundation, nearly 90 percent of surveyed physicians indicated they see their patients' need for social supports, but unfortunately 80 percent said they do not fully know how to link patients to these networks.

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

In 2018 and 2019, The Centers for Medicare and Medicaid Services (CMS) proposed expanding access to Health-Related Supplemental Benefits through Medicare Advantage. The Administration took an important first step in expanding the definition of health-related supplemental benefits to include critical HCBS that evidence shows improve the health outcomes for high-need beneficiaries who may not otherwise have access

to these services. Additionally, in 2018 Congress passed, as part of its Bipartisan Budget Agreement, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, which includes opportunities to improve care integration, particularly for high-need Medicare beneficiaries.

These initiatives were important forays into a future of improved care integration and promoting access to services that promote health at home and in the community. We encourage Congress and the Administration to find additional policy opportunities to accelerate the incorporation of existing social services infrastructures, particularly the Aging Network, into government and industry efforts that improve the health of older adults.

For example, we encourage policymakers to consider incorporating and promoting the cost-saving potential of care transitions programs in the panoply of available primarily health-related services and supports, which assist consumers as they leave acute care or institutional settings and head home. Often, making the transition from hospitals or skilled nursing facilities to home can be difficult and cause problems if not managed properly. Unnecessary re-hospitalizations and negative health outcomes are frequently the result, driving up health care costs. AAAs have demonstrated their ability to partner effectively with health care systems and Medicare quality improvement organizations to administer care transitions initiatives. These programs have demonstrated improved health outcomes and

fewer re-hospitalizations by providing assistance with nutrition, transportation, caregiving and other in-home supports, all social determinants.

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



Medicaid Home and Community-Based Services

Recent developments have opened new opportunities for Medicare beneficiaries to access supplemental services in Medicare Advantage that help provide access in the home and community to benefits that promote health and independence.

Traditionally, however, Medicaid has been the primary provider of these services through the Medicaid Home and Community-Based Services (HCBS) waiver program. The OAA philosophy of providing the social services and supports needed to maintain the independence of older adults also drives the federal-state Medicaid HCBS system. Historically, two-thirds of AAAs play a key role in their state's Medicaid HCBS waiver programs, often performing assessments, leading case management or coordinating services. In general, their roles spanned from level-of-care determinations to assessments to case management and service coordination.

The following recommendations reflect that expertise and experience and urge Congress to strengthen Medicaid HCBS to better improve beneficiaries' health.

Rebalancing to Save Money

As the largest public funding source for long-term services and supports (LTSS), Medicaid will be indisputably affected by the rapid growth of the country's population of older adults. Rebalancing efforts—designed to correct for Medicaid's inherent bias toward more expensive, less-desired institutional care—must be supported and expanded, and at the very least preserved.

Giving consumers access to the most appropriate services in the least restrictive setting should be the priority. That's not only what consumers want and need, but also what makes the most financial sense for taxpayers. Studies have shown that HCBS is more affordable and thus more cost-effective than institutional care.¹⁶ Additionally, supporting older adults in their communities ensures that they are also economically contributing to those communities.



n4a recommends reauthorizing the following re-balancing efforts:

- **Money Follows the Person (MFP)** is the longest-running effort to support people transitioning from a nursing home back to the community; it expired in 2016 and should be reauthorized immediately. n4a endorses the bipartisan plan that was introduced in the 115th Congress, S. 2227/H.R. 5306, the EMPOWER Act, which would reauthorize MFP for five years. While we applaud the 116th Congress for passing a short-term extension, we urge lawmakers to swiftly pass a long-term extension or permanent solution for MFP.
- **Balancing Incentive Payment Program (BIP)**, part of the Affordable Care Act's rebalancing efforts, provided take-up states with enhanced flexibility and new funding to reform and rebalance their LTSS systems. BIP expired in 2016 and should be updated and reauthorized in 2019.

Managed Care Considerations

As a majority of states have moved from Medicaid fee-for-service to managed care models in recent years, it is critical that the Aging Network be the bridge to integrate acute health care and HCBS; this will ensure that quality is not compromised.

With private and federal encouragement and support, n4a is driving change within the Aging Network by equipping trusted local providers with cutting-edge business acumen skills to better work with Managed Care Organizations (MCOs) and other health payers to

support person-centered, coordinated and cost-effective care for older adults and people with disabilities.

There is no one-size-fits-all-consumers approach to Medicaid LTSS and, as such, mandatory managed care initiatives must be closely monitored to ensure that the older adults and people with disabilities who rely on these programs receive access to them and that quality of care remains at or exceeds current standards. There are important steps that the Administration must take to make critical infrastructure investments to support the systems that promote independence as people age. These steps must include ensuring that the Aging Network can continue to provide services that enable older adults to age at home and in the community and be partners in enabling MCOs to meet their patient care goals.

Non-Emergency Medical Transportation (NEMT)

Unfortunately, despite Administration comments embracing the importance of addressing SDOH in health care programs, recent state and agency actions have directly contradicted these assertions. For example, while policymakers have identified access to

transportation as a key SDOH,¹⁷ CMS is considering proposals that would reverse the mandatory provision of Medicaid Non-Emergency Medical Transportation (NEMT) services.

Because Medicaid covers health care services for low-income Americans—many of whom face chronic diseases, mobility challenges and lack access to personal transportation—services that ensure transportation to regular medical care are essential to preserving individual health and independence in the community. Non-Emergency Medical Transportation (NEMT) often prevents treatable conditions from escalating into more serious and expensive conditions.

According to an August 2018 study, NEMT pays for itself as part of a care management strategy for people with certain chronic conditions.¹⁸ Federal rules require states to provide no or low-cost NEMT for most Medicaid beneficiaries, but a few states have received waivers to curtail the benefit, and some others are considering doing so.

Actions like this have the potential to hurt Medicaid beneficiaries, as well as Medicaid providers, and cost taxpayers more money in the long-run. n4a members are key partners in coordinating and providing NEMT in communities across the country. We encourage Congress and the Administration to preserve and expand NEMT, rather than sanction efforts in some states to undermine access to critical transportation benefits that improve health and independence for medically vulnerable Medicaid beneficiaries.

Tap Into the Value of the Aging Network

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

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

