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All Together Now: Integrating Health and Community Supports for Older Adults

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The first waves of America's long-awaited "Silver Tsunami" have arrived, as 10,000 Baby Boomers are turning 65 each day.[1] And as they hit the shore, policy makers are facing the following critical questions about how to meet the requirements of an aging society: (1) How are needs changing? (2) What programs will best meet these emerging needs? (3) How should these programs be financed?

Three key trends will inform these policy decisions. First, research tells us that Americans prefer to "age in place," meaning that they want to stay connected with their support networks and find resources in the local communities of their choice. This preference is strong and growing.[2] Second, projections indicate that up to two-thirds of older Americans will likely need some form of extended long-term care.[3] And third, because of trends in geographic mobility, these individuals will have fewer family supports nearby to help meet their care needs.[4] Together, these trends suggest the need to re-examine current support programs and services to ensure that they will meet the coming needs of older Americans.

TRENDS INFORMING POLICY:

- desire to age in place
- long-term care needs
- family at a distance

This brief is the first in a two-part series about policies and programs that provide resources and services for aging in place. It reviews evidence indicating that public programs, as currently structured, are underfunded and fragmented, and it examines the evolving policy and funding landscape. It also documents promising changes in the delivery and integration of supportive services in public programs and makes recommendations to advance policies for aging in place. *The second brief explores community-based grassroots initiatives, assessing how they support individuals' goals to age in place and identifying public policies and programs that could sustain and expand similar initiatives.*

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1 Pew Research Center. (2010, December 29). *Baby boomers retire.* Retrieved from http://www.pewresearch.org/daily-number/baby-boomers-retire/

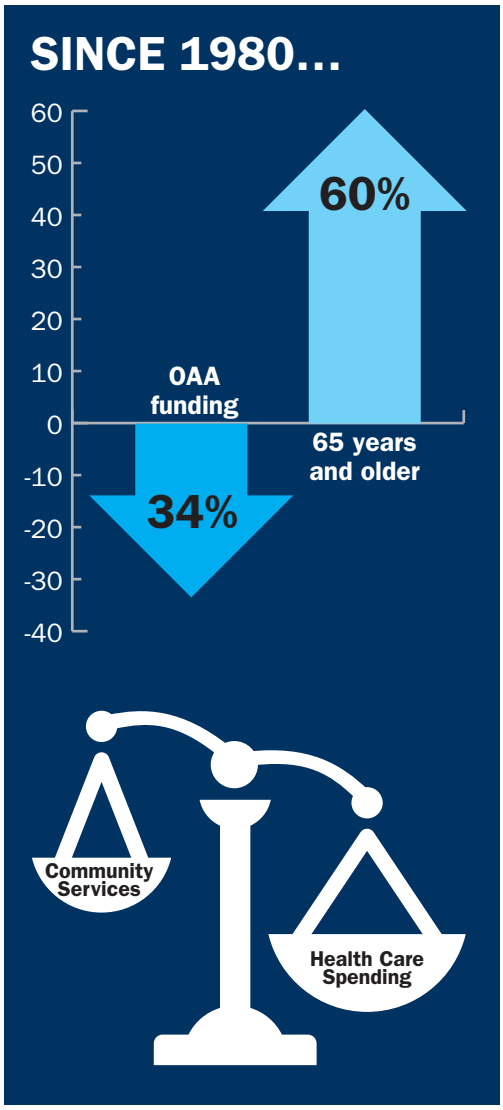
2 AARP Public Policy Institute. (2014, April). *What is livable? Community preferences of older adults.* Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/liv_com/2014/what-is-livable-report-AARP-ppi-liv-com.pdf

3 Ryan, J., & Edwards, B. (2015, September 17). Health policy brief: Rebalancing Medicaid long-term services and supports. In *Health Affairs* (p. 3). Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf423379

4 Redfoot, D., Feinberg, L., & Houser, A. (2013). The aging of the baby boom and the growing care gap: A look at future declines in the availability of family caregivers. *Insight on the Issues, 85*. Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf

Programs to Support Aging in Place Are Underfunded, Disjointed

The federally funded infrastructure that supports older Americans includes well-known programs like Medicare and Medicaid; lesser-known programs such as those funded by the Older Americans Act (OAA), including Area Agencies on Aging (AAAs) and senior centers; and smaller programs that provide assistance with nutrition, transportation, and housing.[5] Medicare provides for the acute health care needs of Americans over the age of 65 and younger disabled individuals. Medicaid provides additional resources to pay for health care for poor older Americans with annual incomes of less than $2,500 and includes long-term care (such as care in nursing homes and, increasingly, care at home). Programs funded by the OAA support nutrition and social needs and, unlike Medicare and Medicaid, have an explicit mandate to provide community-based services that support aging in place.[6]



Federal funding for support services is miniscule compared with spending on health care. To illustrate, in fiscal year 2015, the federal government spent less than 2 cents on aging programs for each dollar it spent on health care for older Americans.[7] Moreover, funding for OAA has shrunk dramatically in recent decades, despite growth in the ranks of older Americans. According to an analysis by the National Association of States United for Aging and Disability (NASUAD), since 1980, OAA funding has dropped 34% when adjusted for inflation. Over the same period, the segment of the population 65 years of age and older has grown by 60%. The most recent driver of reduced funding was budget caps imposed through 2021 under the Budget Control Act of 2011. It is not surprising, then, that wait-lists for OAA-funded programs and unmet needs are widespread[8] across the country.

Area Agencies on Aging (AAAs) are the main local service organizations that administer many of the OAA community-based programs. Most AAAs have inadequate public funding and are seeking ways to sustain their services. Pressure on AAAs to seek new funding sources may be pulling the AAAs more squarely into

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[5] These include food assistance programs funded by the U.S. Department of Agriculture (USDA), transportation programs serving the elderly funded by the U.S. Department of Transportation (DOT), and Section 202 elder housing programs from the U.S. Department of Housing and Urban Development (HUD).

[6] OAA covers five core areas: supportive services (e.g., information and referral, outreach, transportation, legal services, in-home services, and others); nutrition (e.g., Meals-on-Wheels); caregiver support; health and wellness; and elder rights (e.g., Adult Protective Services). Funding is provided to local AAAs, which typically contract with local service providers and often provide subsidized services for low-income seniors.

[7] See Appendix A: $9.8 billion was spent across federal aging programs compared to $623.9 billion in Medicaid and Medicare expenditures on the aged population.

[8] Terzaghi, D., & White, E. (2014). *State of the states in aging and disability: 2014 survey of state agencies*. Washington, DC: NASUAD; and Government Accountability Office. (2015). *Older Americans Act: Updated information on unmet need for services* (GAO-15-601R). Retrieved from http://www.gao.gov/products/GAO-15-601R

the health care funding stream rather than bolstering health-related social and community needs.[9] Efforts to examine the right mix of services that will enable AAAs to foster essential links between health care services and community supports will help to frame new and emerging models.

Fewer public investments in community-based supports mean shifting responsibilities for assisting older adults to families, neighbors, and friends precisely when these informal supports are shrinking.

Fewer public investments in community-based supports mean shifting responsibilities for assisting older adults to families, neighbors, and friends precisely when these informal supports are shrinking. The scale of such informal, unpaid help is substantial when measured in terms of dollars. The Congressional Budget Office pegged the value of such help at $234 billion in 2011.[10] Looking toward the future, however, unpaid family caregivers cannot provide limitless support. The U.S. Census Bureau projects that by 2030, the population of those aged 65 and older will reach 72.8 million and represent 20.3% of the U.S. population. The population of those aged 80 and older, a subset of the total, will grow to 19.4 million over the same period. In contrast, the population of working-age adults (16- to 64-years-old) is projected to grow only nominally. The changing ratio of older-to-younger populations and the high mobility of the U.S. population results in fewer older adults having family support nearby.[11] Reductions in available informal support also put the aging population at risk for earlier institutionalization.

Beyond the problem of there being too few resources to support growing needs of older Americans, many programs are fragmented. At the national level, five federal agencies, spread across four departments, fund community services and supports for older Americans. A 2015 report from the Government Accountability Office (GAO) documented the need for better coordination across these agencies to ensure a more efficient use of resources and programs.[12] At the community level, consumers face a large and complex patchwork of programs and organizations that provide support services. The programs often serve a subset of the aging population, and only limited resources and tools are available to organize or explain the range of services provided.[13] Some states and localities assist with coordination, but the assistance is spotty. This complexity and lack of coordination detracts from the value of public and private programs.

Toward a "Big-Picture" Approach

Various grassroots, volunteer, and community-based models have emerged against this backdrop of underfunded and often disjointed public programs. AIR's companion report, *Community-Based Models for Aging in Place,* profiles three models that strive to provide a holistic, integrated, and less medically oriented approach to supporting the aging population. In combination with the emerging trends discussed below, such models could support an integrated pathway for expanding supports for aging in place.

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[9] National Association of Area Agencies on Aging. (2014). *Trends and new directions Area Agencies on Aging 2014 survey.* Retrieved from http://www.n4a.org/files/AAA%202014%20Survey.pdf

[10] Congressional Budget Office. (2013, June). *Rising demand for long-term services and supports for elderly people* (p. 2). Retrieved from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf

[11] Redfoot, Feinberg, & Houser, 2013.

[12] Government Accountability Office. (2015, May). *Older adults: Federal strategy needed to help ensure efficient and effective delivery of home and community-based services and supports* (GAO-15-190). Retrieved from http://www.gao.gov/assets/680/670306.pdf

[13] U.S. Senate. (2013, September 30). *Commission on Long-Term Care report to Congress* (pp. 14–15). Retrieved from https://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf

Rather than contemplating these investments as constrained portions of a shrinking pie, they can be reframed as complementary strategies to enhance the well-being of older adults at a time when demographic and social change require fresh approaches. Although the tendency to compartmentalize programs is common, in reality, their outcomes overlap and should reinforce healthy aging and improved quality of life. Acute care spending is the lion's share of current total health care expenditures. However, "only 20% of the modifiable variation in health outcomes is due to clinical care, whereas 40% is due to social and economic determinants, 30% to health behaviors and 10% to physical environment."[14] If acute care expenditures concentrate on services that only affect 20% of outcomes, OAA and other federally funded community supports, private initiatives, and efforts to improve community environments and social supports (e.g., housing, transportation, food, social engagement, etc.) represent promising pathways to reduce the costs of Medicare and Medicaid by improving population health.

Emerging Trends Offer Some Encouragement

The idea of integrating community supports with health care services is not new. One of the earliest such programs, Medicaid's Program for All-inclusive Care for the Elderly (PACE), dates back to 1983. PACE was designed to offer a community-based alternative to nursing home care for eligible individuals by providing a combination of health and supportive services, such as home care; day programs; and integrated, coordinated care. Historically, annual PACE expenditures were less than $1 billion[15]—a very small component of Medicaid. Legislation in 1997 bolstered the status of PACE, making it a permanent provider under Medicare. More recently, innovation funding has been expanded to allow for-profit PACE programs. In 2015, the PACE Innovation Act allowed the Centers for Medicare & Medicaid Services (CMS) to support PACE programs that serve more and younger individuals. Traditionally, PACE's focus was clinically driven, but the new innovation flexibility may enable expanded, nonmedical services, such as meals, transportation, and companion care.

In a related initiative, for the past three decades, Medicaid has used home- and community-based services (HCBS) to provide long-term services and supports (LTSS) to reduce institutionalization and enhance aging in place. Initially, HCBS focused largely on younger individuals with disabilities rather than individuals who were eligible for both Medicaid and Medicare.[16] Since that time, many states have expanded the reach of their HCBS. As a result, in fiscal year 2013, for the first time, Medicaid spending on HCBS was higher than spending on nursing home care.[17] Initial research on the Money Follows the Person program and California's HCBS program found reduced overall health care spending resulted from transitioning to HCBS from institutional care.[18] To nudge states that have been less aggressive in rebalancing LTSS, the Affordable Care Act established incentives to move them toward community-based care.

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[14] Affordable Care Act Funding Opportunity Accountable Health Communities Funding Opportunity Number: CMS-1P1-17-001 CFDA: 93.650, Date: January 5, 2016, p. 4

[15] Eiken, S., Sredl, K., Gold, L., Kasten, J., Burwell, B., & Saucier, P. (2014, April 28). Table A. Medicaid expenditures for long-term services and supports: 2007–2012. In: *Medicaid expenditures for long-term services and supports in FFY 2012.* Retrieved from https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2012.pdf

[16] Such as the Olmstead decision regarding self-determination, Affordable Care Act provisions for the Money Follows the Person program, balancing incentive with no wrong door commitment, new HCBS design, improved waiver options, and the duals integration pilots.

[17] Eiken, S., Sredl, K., Burwell, B., & Saucier, P. (2015, June 30). *Medicaid expenditures for long-term services and supports (LTSS) in FY 2013: Home and community-based services were a majority of LTSS spending.* Retrieved from http://www.balancingincentiveprogram.org/sites/default/files/Medicaid_Expenditures_LTSS_FY_2013.pdf

[18] Bohl, A., Schurrer, J., Miller, D., Lim, W., & Irvin, C. V. (2014, October 30). *The changing medical and long-term care expenditures of people who transition from institutional care to home- and community-based services* (The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program, Reports From the Field #15). Cambridge, MA: Mathematica Policy Research. Retrieved from https://www.mathematica-mpr.com/our-publications-and-findings/publications/the-changing-medical-and-long-term-care-expenditures-of-people-who-transition

The key to sustainable and affordable long-term care may be increased investment in community-based supports. Policies like Medicaid rebalancing and PACE recognize the benefits and cost-effectiveness of the HCBS programs. Yet there is substantial variability across state programs, and the jury is still out on how to determine the right mix of community-based services and what population characteristics indicate a need for these services while also maintaining or reducing overall health care costs. Proponents of community-based services emphasize that quality of life and an individual's preferences should be considered when assessing benefits and costs.[19]

Two recent funding announcements from the Center for Medicare and Medicaid Innovation (CMMI) and the U.S. Department of Housing and Urban Development (HUD) seek a similarly integrated approach. CMMI's Accountable Health Communities program seeks to fund community consortiums that will provide referral and support to community-based services for Medicare and Medicaid recipients for health-related social needs.[20] HUD's Supportive Services Demonstration for Elderly Households in HUD-Assisted Multifamily Housing program is designed to enable residents to age in place, improve their health, and delay institutionalization by placing a services coordinator and a part-time nurse inside HUD-supported housing facilities.

These initiatives, and others, show promise. They align better with the priorities of the aging population by connecting individuals with the support services that will enhance their ability to age in place. By integrating health care with nonmedical supports, these initiatives have the potential to improve health and drive cost savings. It should be noted that the more innovative programs (like those funded by CMMI and HUD) still represent small investments, and results have not yet been proven. But more established health programs, like PACE, are effective but limited in reach, as they focus exclusively on low-income seniors or high-risk, frail elderly. This leaves middle class, older Americans on their own to navigate the confusing patchwork described above.

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Next Steps: Reorienting and Retooling Investments in the Aging Infrastructure

Given the strong priority that Americans place on living in communities of their choice as they grow older, and the recognition that aging in place is both achievable and affordable, the time is right to rethink both the scale and scope of current programs that serve older Americans.

Given demographic realities, current funding for OAA programs is clearly inadequate to seriously improve the lives of seniors. New investments are needed to meet the needs of older Americans, their families, and their communities; many are struggling with unmet needs today. These investments should be informed by the best available evidence to ensure they are effective at meeting seniors' targeted needs. Thus, expanded research and rigorous evaluation are essential.

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[19] U.S. Senate. (2013, September 30). *Commission on Long-Term Care report to Congress* (p. 36). Retrieved from https://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf

[20] Booske, B., Athens, J. K., Kindig, D. A., Park, H., & Remminton, P. L. (2010, February). *Different perspectives for assigning weights to determinants of health* (County Health Rankings Working Paper). Madison, WI: University of Wisconsin, Population Health Institute. Retrieved from https://uwphi.pophealth.wisc.edu/publications/other/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf

In 2015, GAO called for the U.S. Department of Health and Human Services (HHS) to lead the development of a cross-agency federal strategy for home- and community-based services and supports.[21] This is a good start. Although the report focused on HHS, HUD, DOT, and USDA, it would be worthwhile to focus on *all* federal programs serving older adults by adding the U.S. Department of Labor (DOL), U.S. Department of Justice (DOJ), U.S. Environmental Protection Agency (EPA), and additional programs in HHS, such as the Centers for Disease Control and Prevention's (CDC's) Office of Disease Prevention and Health Promotion and the National Institutes of Health's National Institute on Aging. Similarly, at the local level, the labyrinth of services and organizations should be converted into a user-friendly system that can be more easily navigated by individuals and their families. Incentives should be incorporated into public programs for public *and* private organizations to pull together, become more engaged, and increase transparency about available services.

Recognizing that the acute-care focus of health care programs only impacts 20% of health care outcomes, more rigorous exploration is needed to determine whether careful, creative redirection of existing health care dollars toward supportive community-based services can improve health outcomes *and* quality of life by enabling individuals to remain in their communities of choice. One of the main challenges in redirecting dollars from existing programs is that they generally have fixed formulas or traditional expenditures that predetermine where money flows to the states—and then to agencies, counties, and towns—in a manner that leaves very little funding or flexibility. Redirected or new funding could be used in two ways:

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1. To reinforce successful programs, particularly where there are long wait-lists; and
2. To support new programs that promote community-based services that address the 50% of modifiable health outcomes related to social, economic, and environmental determinants.

States and local communities play critical roles in advancing policies for aging in place. Their responsibilities for much of the local service delivery, most of the built environment, and existing resources for assisting with services navigation and coordination place them uniquely at the integration point of health care and community-based services. State budgets and the same acute clinical focus as the federal government have often made this less of a priority. Pilot programs in the states or communities with the largest populations of adults aged 65 and older may help to identify new state and community models.

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Maximizing health and engagement in communities is a near universal priority, but the ability to meet these objectives will be determined in large part by federal and state policy priorities and available resources. Research on the health outcomes and cost impacts of PACE and HCBS programs reinforce the benefits of advancing more community-based options. A more productive direction for policy is emerging, but there is still a long way to go. Greater emphasis on support services and better integration of those services with other programs will advance the goal of sustaining policies and programs related to aging in place.

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[21] Government Accountability Office. (2015, May). *Older adults: Federal strategy needed to help ensure efficient and effective delivery of home and community-based services and supports* (GAO-15-190). Retrieved from http://www.gao.gov/assets/680/670306.pdf

Appendix A: Comparison of Funding for Federal Aging Programs vs Health Expenditures on the 65+ Population

Agency/Program	Funding ($ millions)
FEDERAL AGING PROGRAMS (Fiscal Year 2015)	
Administration for Community Living (ACL)	
Aging Network Support Activities	10.0
Supportive Services and Senior Centers	347.7
Congregate Nutrition	438.2
Home-Delivered Nutrition	216.4
Nutrition Services Incentive Program	160.1
Preventive Health	19.8
Program Innovations	-
National Family Caregiver Support Program	145.6
Native American Nutrition and Supportive Services	26.2
Native American Caregivers Support	6.0
Protection of Vulnerable Older Americans	20.7
Elder Rights Support Activities	7.9
Chronic Disease Management Education	8.0
Elder Falls Prevention	5.0
Aging and Disability Resource Centers	6.1
Senior Medicare Patrol	8.9
State Health Insurance Assistance Programs	52.1
Alzheimer's Disease	18.5
Lifespan Respite Care	2.4
Department of Labor	
Senior Community Service Employment	434.4
Department of Health and Human Services	
Low Income Home Energy Assistance Program*	480.4
Social Services Block Grants*	240.9
Community Services Block Grant*	95.5
Centers for Disease Control and Prevention	
Elder Falls Prevention	2.1
Corporation for National and Community Service	
Senior Corps	202.1

Agency/Program	Funding ($ millions)
Department of Housing and Urban Development	
Section 202 Housing for the Elderly	420.0
Housing Counseling	47.0
U.S. Department of Agriculture	
Supplemental Nutrition Assistance Program (SNAP)**	6,372.5
Commodity Supplemental Food Program*	30.0
TOTAL FEDERAL AGING PROGRAM FUNDING	**9,824.5**
HEALTH EXPENDITURES ON THE 65+ POPULATION	
Medicare expenditures on 65+***	542,204.0
Medicaid expenditures on 65+****	81,700.0
TOTAL HEALTH EXPENDITURES ON THE 65+ POPULATION	**623,904.0**
FEDERAL AGING PROGRAM FUNDING AS % OF TOTAL HEALTH EXPENDITURES	**1.6%**

* Authors' calculations. Expenditures estimated using share of persons aged 65 and older at or below 2 times the federal poverty level as a proportion of the total (14.17%). U.S. Census Bureau. (n.d.). Table 5 People With Income Below Specified Ratios of Their Poverty Thresholds by Selected Characteristics: 2014. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf.

**Fiscal Year 2013 data. Expenditures reported are for individuals aged 60+.

*** Authors' calculations using calendar year 2015 data. Expenditures estimated using share of beneficiaries 65+ as a proportion of total beneficiaries per Trustees Report.

**** Fiscal Year 2014 data. Includes home- and community-based waiver services for elderly, which combine health care and supportive services.

Sources: National Council on Aging. (Year). FY17 aging program funding table. Retrieved from https://www.ncoa.org/resources/federal-budget-fy17-aging-program-funding-table/; U.S. Department of Agriculture, Food and Nutrition Service, Office of Policy Support. (2014). *Characteristics of Supplemental Nutrition Assistance Program households: Fiscal Year 2013.* Washington, DC: Retrieved from http://www.fns.usda.gov/sites/default/files/ops/Characteristics2013.pdf; The Boards of Trustees, Federal Hospital insurance and Federal Supplemental Medical Insurance Trust Funds. (2016). *2016 annual report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2016.pdf; U.S. Department of Health and Human Services. (2015). *Actuarial report on the financial outlook for Medicaid.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf.

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