PROJECT 2020

Building on the Promise of Home and Community-Based Services

Overview of the Proposal

Project 2020's Goal:

Provide the resources to implement consumer-centered and cost-effective long-term care strategies authorized in the 2006 reauthorization of the Older Americans Act. Empower the Aging Services Network to implement these strategies through a three-pronged program encompassing person-centered access to information, evidence-based disease prevention and health promotion activities, and enhanced nursing home diversion services.

Even before the first baby boomer turned 60 years old in 2006, national spending for long-term care, especially under Medicaid, was placing significant strain on federal and state resources. In 2008, there are already more than 52 million Americans over age 60. By 2020, almost one in six individuals will be age 65 and older. The fastest growing segment of the aging population is individuals over 85, the most vulnerable older adults who tend to need long-term care and whose numbers are expected to double by 2020. These demographic trends make our current strategy for financing long-term care costs through the Medicaid and Medicare programs unsustainable.

The National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (n4a), conscious of the financial pressures facing states and the federal government, have developed a coordinated national long-term care strategy that will generate savings in Medicaid and Medicare at the federal and state levels while enabling older adults and individuals with disabilities to get the support they need to successfully age where they want to — in their own home and community.

Advocacy. Action. Answers on Aging.

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The strategy, which has evolved from long-term care initiatives of the U.S. Administration on Aging (AoA), the Centers for Medicare and Medicaid Services (CMS), HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE) and others, was incorporated into the reauthorized Older Americans Act (OAA) in 2006.

The strategy builds on the historic role of State Units on Aging (SUAs), Area Agencies on Aging (AAAs) and Title VI Native American aging programs (Title VIs). It is a comprehensive and integrated approach to enabling the elderly and individuals with disabilities to make their own decisions, to take steps to manage their own health risks, and to receive the care they choose in order to remain in their own homes and communities for as long as possible, avoiding unnecessary and unwanted institutionalization.

AoA, in cooperation with SUAs and AAAs, has been testing best practices in community-based long-term care that have been demonstrated to reduce the need for more expensive institutional care and prevent "spend down" to Medicaid for people of all ages with disabilities. n4a and NASUA have embraced these proven strategies as requirements for infrastructure development and participation in this program. This three-pronged approach will allow communities to provide services to this growing population at a lower cost to consumers and to Medicaid and Medicare. The key elements of this approach include:

1. **Person-Centered Access to Information**
2. **Evidence-Based Disease Prevention and Health Promotion**
3. **Enhanced Nursing Home Diversion Services**

For the long-term care strategies and solutions proposed, n4a and NASUA are seeking funding to support federal outlays of $2.4 billion over the next five years to be administered through the Aging Services Network of State and Area Agencies on Aging.

Funding will be administered by AoA through disciplined, performance-based grants that will have conditions of participation designed to ensure that the components are implemented in ways that have been proven to work best at the community level. The program seeks to build on and enhance — not supplant — the current system and network of SUAs and AAAs/Title VIs.

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For consumers, this program will empower individuals to make informed decisions and to better conserve and extend their own resources using lower cost evidence-based programs, including consumer-directed options for care in the community.

According to our initial estimates, the program has the potential to reach over **40 million Americans** and will **reduce federal Medicaid and Medicare costs by approximately $2.7 billion** over the first five years of the initial investment requested, resulting in a net savings to the federal government of over $300 million.

The program would also generate significant savings for state governments. Financial performance is expected to improve in years five through ten of the program, as all systems reach full scale operations nationally, with the **net federal savings over ten years reaching over $1.4 billion.**

Program Components

Person-centered access to information—

Due to the fragmentation in public programs and information asymmetry, too many individuals currently lack access to quality information on community-based long-term care services. This long-standing condition is a significant factor in over-utilization of institutional care.

Through the use of a single entry point system, such as the Aging and Disability Resource Centers (ADRCs) developed by the AoA and CMS, the Aging Services Network will provide individuals and their families with streamlined, comprehensive and reliable information that will help consumers make informed decisions about their long-term care.

ADRCs integrate outreach, information, and options counseling for home and community-based long-term care in the community. Forty-three states currently receive AoA grant funding to initiate ADRCs in their states. This component builds on the current nationwide network of SUAs and AAAs, as well as complementary programs such as AoA's Eldercare Locator.

Evidence-based disease prevention and health promotion—

Health and behavioral science has developed significant interventions for evidence-based disease prevention and health promotion that have been demonstrated to improve the health and well-being of elderly individuals, and do not require application through expensive medical and health care settings. Through this program component, individuals will be assisted with interventions provided by the Aging Services Network at the community level in areas such as falls prevention, physical activities, nutrition, chronic disease management and medication management.

Enhanced nursing home diversion services—

At any given time, a small, but critical, population of elderly individuals is at high risk of losing their independence and financial stability through nursing-home entry and spend down to Medicaid eligibility — individuals who would prefer to remain in the community if possible. Eligible individuals participating in this program component will be prescreened and receive intense case management through the single point of entry system to help coordinate personalized services and supports that will allow them to remain in their homes.

This needs-based portion of the program will provide home and community-based services such as home-delivered meals, homemaker services, personal care, medical transportation, home modification, assistive technology and adult day care. These traditional services provided by the Aging Services Network, when coupled with case management and the flexibility of consumer-directed models of care, provide an excellent alternative to nursing home care.

Targeting Recipients

These initiatives do not create a new entitlement program but rather seek to serve more people in the community while helping to alleviate fiscal pressures on Medicaid and Medicare. The work of single point of entry information systems is to reach out to all consumers and caregivers who have the need for information on long-term care before they make irreversible decisions, ideally including younger adults who need to prepare in advance for their future long-term care needs. It is expected that the ADRCs will provide information, options counseling and referral to individuals who can and will finance their own care, as well as to those

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who may be eligible for support through the full array of programs available in the community.

The ADRC is a critical component of the program in that it will resolve the past systems limitations that: 1) denied consumers information about and access to the full range of long-term care options potentially available to them, and 2) caused fragmentation and inconsistency in information, processes, standards and other fundamental elements of access to care. Consumers and caregivers who need access to information regarding long-term care options will be served by a truly person-centered single entry point system. This program component is designed to help all who ask for assistance.

Participants in the evidence-based disease prevention and health promotion component will be targeted for disease management programs directed to their actual conditions and potential risk factors. Over time, services will be offered widely to elderly individuals and those with disabilities through evidence-based health interventions in an effort to reach those for whom the evolution of disease and negative impact of chronic disease can be delayed or avoided and/or those individuals who are at risk of sustaining injuries due to falls, thus suppressing costs even more.

The program component providing enhanced nursing home diversion services will be available to individuals who are at the same level of clinical need as Medicaid waiver eligibility but who have assets in excess of Medicaid financial eligibility, not exceeding an average of $25,000. (For most states this is equivalent to six months of nursing home care.)

These individuals fall outside of Medicaid eligibility, but due to their limited income and assets, they are the most likely to become Medicaid-eligible shortly after any institutionalization. While most states have effective home and community-based waiver programs for Medicaid-eligible people, only in very rare cases are they able to serve individuals whose assets are not below the $2,000 threshold. Older people with moderate incomes just above eligibility standards are routinely admitted to nursing homes, exhaust their assets, and become Medicaid eligible. Once these individuals have entered a nursing home setting, it becomes nearly impossible to return them to the community.

Shared Responsibility

Slowing the growth in the demand for Medicaid and Medicare services for the elderly will require a shared effort by federal, state, and local government entities. Funding for both the single entry point systems and the evidence-based chronic disease prevention programs would be funded through existing AoA grant mechanisms. States would continue to support the single entry point effort with 25 percent match and the evidence-based programs with a 15 percent match. Grants for the single entry point program and the evidence-based health promotion program would begin immediately upon passage of the legislation.

The grants for the enhanced nursing home diversion services component would be offered in three phases, with states best positioned to advance system changes being awarded grants first, followed by states that need additional time to prepare. The program would be administered through a series of competitive grants to the states. States would not be competing against one another, but rather against a set of performance-based criteria.

In order to ensure the success of the program and that both states and the federal government share in the expected savings, states would receive an enhanced Medicaid Federal Medical Assistance Percentage (FMAP) equivalent to an increase of 5 percent in return for their participation in the nursing home diversion portion of this program.

Technical assistance is planned for SUAs and AAAs to help them prepare for and implement each of the three facets of the program. A careful performance-based evaluation of the effort is also considered key to the success of the initiative.

Estimated Savings

Analysis has shown that these three components, when implemented across the country, effectively coordinated with existing activity of SUAs and AAAs, and targeted and managed properly, will cost less in the aggregate than if the aging services community maintains the current patchwork approach to services. This program will have all states engaged in implementation within three years of passage. Since federal savings, or "offsets," will be garnered by Medicaid and Medicare, this program is more than budget neutral and therefore in accordance with "pay-as-you-go" rules.

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The estimated gross federal savings for the program over five years total **$2.7 billion.** The initiative will also generate significant savings to the states, which with favorable match rates will realize savings at even higher rates. This is a significant aspect of the program, given the added fiscal pressures being put on states related to Medicaid long-term care financing. It is estimated that the total number of individuals who will be assisted under this initiative is just over 40 million individuals, most of these with little or no direct financial support through the ADRC information, assistance and options counseling services.

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Components of Program	Targeted Recipients	Estimated Number of Recipients (5 years)	Estimated Federal Savings (5 years)	Estimated Number of Recipients (10 years)	Estimated Federal Savings (10 years)
Person-Centered Access to Information	Provides information to anyone interested in long-term care	39 million	$324 million	105 million	$1.18 billion
Evidence-Based Disease Prevention and Health Promotion	Targets scientifically proven interventions to reduce chronic disease and disability to affected elderly individuals	1.2 million	$308 million	3.94 million	$1.24 billion
Enhanced Nursing Home Diversion Services	Provides consumer-directed community care to individuals at 300% SSI with approximately $25,000 in assets	118,000	$5 million	164,000	$159.4 million
Total Number Served		**40 million**		**108 million**	
Total Outlays *(includes federal, state, and local administration)*			$2.4 billion		$10 billion
Total Savings *(includes federal, state, and local)*			**$2.7 billion**		**$11.4 billion**

Based on calculations prepared by The Lewin Group, February 2008.