The community-based services provided through the aging network offer a low-cost way to keep some people at home, depending on their needs. Currently, 13,000 elderly individuals are on the statewide waiting list for home- and community-based services. Cuts to Medicaid will tax an overburdened aging network system, while leaving our most frail citizens without options for care.

North Carolina communities are witnessing a dramatic demographic shift toward an older population, which has been accompanied by an unparalleled increase in the costs of health care and long-term care. Between 2011 and 2031, the number of adults age 65 years or older is expected to grow by 78%, and those age 85 years or older by 71%, as the baby boomers age (Table 1). In contrast, the total state population is only expected to grow 21% during this same time period. As directors of 2 of the state’s 16 Area Agencies on Aging (AAAs), we would like to share our perspective on the impact that changes in Medicaid have had on the availability and cost of services for older adults. We are in the unique position of experiencing the effects of changes in Medicaid on our local health and social services systems even though we have no direct responsibility for managing Medicaid programs or funds. This is because there are connections between Medicaid and the programs provided through the AAAs, as we will explain.

The same year that Medicare and Medicaid were enacted, the Older Americans Act of 1965 [1] established a national aging network and charged it with helping to address a broad and ambitious agenda for promoting the well-being of persons 60 years of age or older. Amendments to the act, which were passed in 1973 [2], made states responsible for designating AAAs in multicity planning and service areas, and charged the AAAs with helping to develop comprehensive and coordinated local systems for providing home and community services that address the needs of active and frail older adults. Each of North Carolina’s 16 AAAs is part of its region’s Council of Governments, whose board is composed of local elected public officials within that geographic boundary. Through information and assistance providers, the AAAs work directly in each county with consumers and providers to help identify needs and service gaps. Our staff members see firsthand the consequences that public policies, or the lack thereof, have on seniors and their families.

AAAs provide a range of services for older adults, including home-delivered meals, in-home services, care management, transportation, senior center activities, family caregiver support, health and wellness education, adult day care, adult day health care, and legal services. The funding for many of these services goes to local providers, such as Councils on Aging, departments of health, social service agencies, and other nonprofit and for-profit organizations. There are no entitlement requirements for these services; the only prerequisite is that the recipient be at least 60 years of age. In many cases, we see seniors who do not qualify for Medicaid but who hover in near-poverty until a catastrophic health event forces them into a long-term care institutional setting such as a nursing home. By providing short-time or supportive services, such as transportation to the doctor, personal care support in the home, or 1 daily meal containing the recommended dietary allowance of all nutrients, our programs keep people at home longer, in a healthier state, at less expense.

Our funding is small relative to that of Medicaid programs. In 1992 the North Carolina General Assembly combined several state and federal funding sources that were serving the population of individuals 60 years of age or older into a single program known as the Home and Community Care Block Grant (HCCBG). This was done to offer greater local flexibility to respond to consumer needs. HCCBG services have been especially important to the “near poor”—those who have incomes just above the federal poverty level but are unable to pay privately for assistance. Nevertheless, our statewide resources for HCCBG (about $60 million) are tiny compared with the nearly $2.7 billion spent on Medicaid services for those 60 years of age or older during State Fiscal Year 2010-2011. HCCBG funds are made up of approximately 56% state tax dollars and 44% federal tax dollars. Local governments provide a 10% required match for these funds.

At the same time that AAAs are providing services that...
contribute to keeping the near-poor off of the Medicaid rolls, we are now seeing individuals who have been receiving Medicaid benefits in institutional settings being compelled to reenter the community-based delivery system without Medicaid resources. There are several policies that have led to this result. For instance, in 2009, in order to meet budget reduction goals, the North Carolina General Assembly froze the number of slots available for the Community Alternatives Program for Disabled Adults (CAP/DA), a Medicaid-funded program that provides resources making it possible for older North Carolinians to remain in the community through support services such as home care, transportation, meal preparation, and personal care. Without CAP/DA as a resource, adults with disabilities have had to fall back on HCCBG services or have been forced into long-term care facilities at greater cost.

Currently, the state is trying to address US Department of Justice (DOJ) allegations that it has been violating the Americans with Disabilities Act by allowing people with serious mental illness to be placed in adult care homes [3, 4]. If the majority of residents in such a home are determined to have been placed there because of mental illness, the home can be designated as an institution of mental disease, which will mean that it is no longer eligible to receive any reimbursement from Medicaid. Therefore many residents of adult care homes are facing relocation to another facility or relocation back to the community with loss of Medicaid benefits. As a result, long-term care ombudsmen from the AAA service system are receiving many requests for information and assistance from residents, families, and facilities.

In addition, as part of the DOJ settlement, eligibility requirements for personal care services (PCS) for residents of adult care homes are being tightened, which will result in loss of Medicaid benefits for some people. It has been reported that 62% of the almost 9,000 adult care home residents who have been found to no longer qualify for PCS are 55 years of age or older (39% were 65 years of age or older) [5]. These individuals will return without Medicaid coverage to their communities, where there are already more than 12,500 seniors statewide waiting for HCCBG services.

Another looming example of a change in Medicaid that would impact older adults is the proposed use of a brokerage system for Medicaid nonemergency transportation services. Expressing concern at that prospect, the North Carolina Association of County Commissioners has warned that “excluding Medicaid revenues from the consolidated model could lower human services transportation system funding by 20 to 50 percent, leading to job losses, higher state costs for other ridership services, and fewer transportation options for clients” (Thompson D, letter to Representative Nelson Dollar, October 12, 2012). This change in Medicaid policy has the potential to seriously reduce the availability of transportation to and from such locations as doctors’ offices and pharmacies.

We are especially concerned with the lack of funding for community based services to help people remain in their homes. Although we do not question the value of spending money on nursing home care for the frailest elderly people, we do worry that North Carolina exhibits a bias toward institutional care by inadequately funding community resources. For State Fiscal Year 2011-2012, the North Carolina Division of Medical Assistance paid $1,068,105,297 for nursing home care provided to 38,428 people, at an average cost of $27,795 per person [6]. In contrast, the state invested far fewer resources on those who were not yet Medicaid eligible, resources that could help them to remain in the community. For example, home-delivered meals were served to 18,689 persons on a daily basis at a cost of $14,226,679, or $761 per person, during the same time period. Adult day care was provided to 562 persons on varying days at a cost of $27,795 per person [6]. In contrast, the state invested far fewer resources on those who were not yet Medicaid eligible, resources that could help them to remain in the community.

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**TABLE 1. Projected Increases and Demographic Changes in the Population of North Carolina**

<table>
<thead>
<tr>
<th>Segment of Population</th>
<th>2011 No. (%)</th>
<th>2031 No. (%)</th>
<th>Percent Increase (2011-2031)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>9,669,244</td>
<td>11,729,907</td>
<td>21%</td>
</tr>
<tr>
<td>Age ≥60 yrs</td>
<td>1,851,124</td>
<td>2,988,476</td>
<td>61%</td>
</tr>
<tr>
<td>Age ≥65 yrs</td>
<td>1,289,618</td>
<td>2,296,795</td>
<td>78%</td>
</tr>
<tr>
<td>Age ≥85 yrs</td>
<td>155,718</td>
<td>265,686</td>
<td>71%</td>
</tr>
<tr>
<td>Baby boomers (born 1946-1964)</td>
<td>2,377,235</td>
<td>1,811,120</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

health status and functional abilities, thereby delaying or preventing the need for more costly care in a nursing home. Home- and community-based services can also extend the ability of families to continue their caregiving, thereby postponing or avoiding institutional placement.

These state funds, provided to local agencies through the North Carolina Division of Aging and Adult Services, and by the Division of Social Services, can help postpone or prevent nursing home placement and/or the need for Medicaid resources. In a recent Health Services Research article [7], Thomas and Mor concluded that “States that have invested in their community-based service networks, particularly home-delivered meal programs, have proportionately fewer low-care nursing home residents.” To us, the most important thing is that people prefer to age at home and in the community rather than in institutions.

Although those of us who work for AAAs are certainly among the strongest proponents of home and community living, we are also realists about what is possible with existing resources. One trend of late that concerns us greatly is the diminished ability of local governments to shore up insufficient state and federal funding. Reduced funding from United Way is compounding the problem for some of these providers. We are therefore advocating well-planned, well-orchestrated, and well-supported changes in public policy. We are also calling on the larger community not only to engage in the debate about what should or should not be done, but also to contribute to helping resolve individual and community challenges with regard to identifying or developing additional resources.

Irrespective of particular situations that will surely arise affecting individuals, organizations, and communities—such as the current crisis with regard to adult care homes—North Carolina faces a demographic future over at least the next 30 years that will test our creativity, resourcefulness, and resolve (Table 1). With some of the oldest of the nearly 2.4 million North Carolinian baby boomers (born between 1946-1964) already tapping entitlements and needing other services, we can only imagine the effect of this group on every aspect of society as we move forward—including, of course, the need for health care and human services.

We must do more than imagine; we must be deliberate and inclusive in our planning and in the development of strategies for more effectively managing health care and long-term care needs. We cannot afford to operate in silos or to be narrow or overly short-term in our thinking. In North Carolina we have convened commissions and established task forces to provide blueprints for our future. In 1993, the North Carolina Division of Aging published volume 3 of the North Carolina Aging Services Plan, which was titled A Unified Social and Health Services System for Older Adults [8]. And in 2001, the North Carolina Institute of Medicine published A Long-Term Care Plan for North Carolina [9], which was updated most recently in 2007 [10]. We have witnessed some progress over the past 20 years; however, there are still many compelling reasons to continue coordination and collaboration. We must improve the continuity of care for the increasing number of older adults with chronic conditions by better integrating social and health services. This can be done through technology, training, person-centered approaches, collaborative case management, and dialogue—physicians and hospitals need to have discussions with providers of community services.

The AAAs are currently involved in a number of efforts to promote better management for quality and cost-savings. They are supporting the emergence of Programs of All-inclusive Care for the Elderly (a Medicare program and a Medicaid state option). In addition, they are helping persons who are dually eligible for Medicare and Medicaid to connect to medical homes. The AAAs are also increasing their efforts to improve the transitions of dually eligible patients to and from hospitals and long-term care facilities. As coverage of the dually eligible by Community Care of North Carolina (CCNC) expands, there will be an increasing amount of overlap between the networks, and the AAAs will collaborate with CCNC to build a stronger bridge between medical care and community supports.

The health and wellness evidence-based training being provided by many AAAs across the state is being expanded. These programs empower seniors to change behaviors in order to live a healthier, longer life. The AAAs are also actively participating in transition projects for seniors moving to and from hospitals and long-term care facilities. AAAs use existing community partnerships, hospitals, medical homes, CCNC, and local service providers to reduce readmissions and strengthen overall health outcomes. The AAAs also want to expand relationships with the Veterans Administration to ensure access and quality of care for older veterans.

Our appeal to the health care community is simple—recognize, link to, and invest in our aging network. Doing so will truly pay major dividends for patients and practices. Although conceptually there is growing awareness that the well-being of older persons goes beyond the quality of their medical treatment to include personal safety, spirituality, and the strength of family caregiving, we have still not reached a point of sufficient confidence and sufficient connectedness between the health system and the social services system. In both systems, early intervention and support have the potential to reduce future need for Medicaid services for the near-poor and for those returning to the community.

There is not one simple answer. Through creativity, innovation, leadership, and a strong commitment to collaboration, North Carolina will find effective solutions to greatly enhance quality of life for North Carolinians.


Acknowledgments

Thanks to Dennis Streets, Director of the North Carolina Division of Aging and Adult Services, for his contributions to this article.

Potential conflicts of interest. K.D.B. and G.S.W. have no relevant conflicts of interest.

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