The Changing Geography of Aging Services
How Advocacy Can Impact It

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The Political Landscape and Environment is Altering the Social Service System

- Political polarization
- Focus on the national debt and the economy
- Erosion of the social contract – 1960’s
- Everything is on the table for discussion, revision, and possible elimination
- The discussion and decisions made will forever alter the system to which we have become accustomed
- The role and responsibility of the Government is changing
- A central question is: what is the responsibility of the have for the have-nots?
Setting The Stage for Change

• How are the changes in the aging population influencing the issues our society faces?

http://www.theagingamericaproject.com/
Aging Issues and Policies: Critical Components

- **Demographics**
  - 10,000 Boomers reach 65 every day
  - The Fastest growing segment of the population is now those age 100+

- **Economics**
  - The model for service delivery: Institutional-biased model is not sustainable nor desirable
  - The costs of Medicare, Social Security, and Medicaid are fueling much of the political debate

- **Politics**
  - Limited government

- **Deficit Reduction**
Presentation Overview

- Review the history of the Older Americans Act
  - History
  - Evolution
  - Future
- Programs, Policies, and Politics
  - Medicaid
  - Medicare
  - Funding & Sequestration
- Advocacy
  - Defining the concept
  - Barriers and challenges
  - Important roles for social workers
Older Americans Act of 1965, P.L. 89-73, July 14, 1965

Lyndon Johnson signing the OAA, 1965.
1965 Older Americans Act (OAA): Historical Development

• 1965: Legacy of the Great Society
• The OAA is the foundation legislation for evolving public policy and services for seniors
• The mission of OAA is broad and it is based on a “bottoms up” approach
Older Americans Act

• Creation of Administration on Aging (AoA) as the federal focal point on aging issues and services
  • Provided grant to states for community planning, development, and coordination of services
  • Authority for research, training, and demonstration projects
OAA: Key Components

- The purpose of the Act is to help seniors maintain independence, provide services and to promote a continuum of care for vulnerable elderly
  - Creation of strategies, programs, and services to meet needs of older persons
  - Provision of tangible and intangible resources
  - Continuous identification of the changing needs of seniors
- Development of a nationwide aging infrastructure: State Units on Aging and Area Agencies on Aging
OAA: Key Components

• Recruitment of thousands of career professionals to field of aging
• Continual expansion of the scope, authority and responsibility of the State Units on Aging and the Area Agencies on Aging
• Decentralized model established
• Services are funded, developed, delivered and coordinated at the local level
OAA: Key Components

• Today there are 56 SUA, 629 AAA, 244 Tribal organizations and over 20,000 service providers that make up the Aging Network
• Emphasis on planning, coordination of a comprehensive service system and advocacy
• Provides for services for seniors and caregivers
OAA: Key Financial Components

- **Re-Authorization**
  - Act is reauthorized every 5 years
- **Appropriations Process**
- **Funding Levels**
  - OAA Services is Currently funded at approximately 1.4 Million dollars
  - Funding has remained stagnant
FIGURE 1
Major Services Authorized by the Older Americans Act

Aging Services Network

State & Area Agencies on Aging
56 State Agencies, 629 Area Agencies
Planning, Coordination, and Advocacy

Service Providers

<table>
<thead>
<tr>
<th>Access to Services</th>
<th>Nutrition</th>
<th>Home &amp; Community-Based LTSS</th>
<th>Disease Prevention &amp; Health Promotion</th>
<th>Vulnerable Elder Rights Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach, Information and Assistance Regarding Benefits</td>
<td>Congregate and Home-Delivered Meals, Nutrition Counseling and Education</td>
<td>Home Care, Chore, Personal Care, Adult Day Care, Family Caregiver Support</td>
<td>Examples: Physical Fitness, Nutrition Counseling, Immunizations, Evidence-Based Health Promotion</td>
<td>Long-Term Care Ombudsman, Prevention of Elder Abuse, Neglect, and Exploitation, Legal Assistance</td>
</tr>
</tbody>
</table>
OAA: Major Amendments

- 1972 – 1978 Beginning of Specific Service Initiatives
  - National nutrition program (1972)
  - Multipurpose senior centers (1973)
  - Community service employment (1973)
  - Priority (mandatory) services under Title III: home care, transportation, legal, residential repair (1975)
  - Separate authorization for home-delivered meals (1978)
OAA: Major Amendments

• 1978: Begin focus on elder rights issues
• 1984: Creation of long-term care ombudsman program
  • Authorized services to prevent elder abuse and required congressional report
  • Focus on special population: Alzheimer’s disease
• Addition of statutory requirements on targeting those in greatest need
OAA: Major Amendments

- Significant Amendments since 2000
- National Family Caregiver Support Program
- Title V restructuring
- Cost-sharing
The Mandated Responsibilities of the Area Agencies on Aging

- Be the leader
- Grass roots organization
- Coordinate and work with a network of providers
- Advocacy
- Plan for the current and future needs
Since 1965 Older Americans Act Has:

- Stimulated and supported the development of new and improved services
- Provided grant funds (seed money) to states and the Aging Network
- Energized research on aging issues
- Supported and reinforced the continual identification of needs of seniors and caregivers
- Established expectation
  - Responsibility of federal, state and local governments
Figure 1. Current OAA Service Clients and Potential Eligible Population

- Number of Persons Eligible for OAA Services (Age 60 and above)
- Age 60 and above & Below 250% FPL
- Age 60 and above & Below 200% FPL
- Number of Persons Receiving OAA Services
Landscape Changes Impacting the OAA and the Aging Network

- The movement to a medical model
- The focus on outcomes and data
- Move to evidenced based programming
- Emphasis on care transitions
- Lack of growth in funding
- Desire for uniformity across the system
- Need for AAA’s to develop new revenue streams
- Managed care and its impact on AAA’s role in Medicaid
- Consolidation of AAA’s
- Changes in State Units on Aging across the nation
- ADRC’s – 2003 Initiated, included in ACA
- Sequestration and the impact of funding reductions
Landscape Changes Impacting Medicaid, Medicare and AOA

- CMS granting States authority to pilot new models for the dual eligible's
- Medical care is being altered as focus moves towards outcomes rather than units of care
- Focus on re-hospitalizations and unnecessary hospitalizations
- Quality of care rather than quantity of care
- Personal responsibility and prevention
- SUA are reorganizing and reducing staff
  - 70% of States have consolidated
  - NASUAD 2012
- ACLS- AOA change January 2012
- ADRC’s
Factors Influencing Change

• The continual increases in Medicaid and Medicare expenditures
• The continual growth in population needing services
• Affordable Care Act- New models, expansion of Medicaid, grants for pilot projects
• Changes at CMS- Medicare-Medicaid Integration Division
• States are making changes to how Medicaid is managed and services are provided
  – States are moving to managed care models
  – Kansas has moved in a way that no other State has previously done- Continuing their role as being a leader in Medicaid services
Medicaid Has Many Vital Roles In Our Health Care System

Health Insurance Coverage
31 million children & 16 million adults in low-income families; 16 million elderly and persons with disabilities

Assistance to Medicare Beneficiaries
9.4 million aged and disabled — 20% of Medicare beneficiaries

Long-Term Care Assistance
1.6 million institutional residents; 2.8 million community-based residents

Support for Health Care System and Safety-net
16% of national health spending; 40% of long-term care services

State Capacity for Health Coverage
Federal share can range from 50 - 83%; For FFY 2012, ranges from 50 - 74.2%
Comprehensive Medicaid Managed Care Penetration by State, October 2010

U.S. Overall = 65.9%

0% - 50% (9 states)
51% - 65% (15 states)
66% - 80% (17 states and DC)
80%+ (9 states)

NOTE: Includes enrollment in MCOs and PCCMs. Most data as of October 2010.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.
Medicaid Financing of Safety-Net Providers

Public Hospital Net Revenues by Payer, 2008
- Medicare: 21%
- Commercial: 26%
- State/Local Subsidies: 13%
- Medicaid: 33%
- Other: 3%

Total = $40 billion

Health Center Revenues by Payer, 2008
- Medicaid: 37%
- Federal Grants: 20%
- State/Local/Other: 20%
- Other Public: 7%
- Private: 7%
- Self-Pay: 3%

Total = $10.1 billion

Percent Distribution of National Health Expenditures, by Type of Sponsor, 1987, 2000, 2010

Notes: Starting with the 2009 NHE data, CMS expanded their focus on spending by Type of Sponsor, which provides estimates of the individual, business, or tax source that is behind each Source of Funds category and is responsible for financing or sponsoring the payments. "Federal" and "State & Local" includes government contributions to private health insurance premiums and to the Medicare Hospital Insurance Trust Fund through payroll taxes, Medicaid program expenditures including buy-in premiums for Medicare, and other state & local government programs. "Private Business" includes employer contributions to private health insurance, the Medicare Hospital Insurance Trust Fund through payroll taxes, workers' compensation insurance, temporary disability insurance, worksite health care. "Household" includes contributions to health insurance premiums for private health insurance, Medicare Part A or Part B, out-of-pocket costs. "Other Private Revenues" includes philanthropy, structure & equipment, non-patient revenues.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group at https://www.cms.gov/NationalHealthExpendData (see Historical; NHE Web tables, Table 5).
Medicaid provides support for providers and services in the health care system

Medicaid as a share of national health care spending:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Total National Spending (billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Services and Supplies</td>
<td>17%</td>
<td>$2,186</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>19%</td>
<td>$814</td>
</tr>
<tr>
<td>Professional Services</td>
<td>8%</td>
<td>$689</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>32%</td>
<td>$143</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>8%</td>
<td>$259</td>
</tr>
</tbody>
</table>

NOTE: Includes neither spending on CHIP nor administrative spending. Definition of nursing home care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. SOURCE: CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditure Accounts, 2012. Data for 2010.
Percent Distribution of Source of Funds for Selected Personal Health Care Services, 1970 and 2010

Notes: Medicare and Medicaid were enacted in 1965; by January 1970, all states but two were participating in Medicaid. "Out-of-Pocket" includes direct spending by consumers for all health care goods and services not covered by insurance, except for health care premiums. "Priv. Health Ins." includes premiums paid to health insurance plans and the net cost of private health insurance (administrative costs, reserves, taxes, and profits or losses). "Other" includes Other Public Health Insurance Programs (CHIP, Dept. of Defense and of Veterans Affairs) and Other Third Party Payers (e.g., worksite health care, other private revenues, workers' compensation, maternal/child health, other state and local programs, etc.).

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group at https://www.cms.gov/NationalHealthExpendData/ (see Historical; NHE Web tables, Tables 7, 8, 11, 12).
Medicaid plays a critical role for selected populations

Percent with Medicaid coverage:

All Nonelderly Individuals
- Poor: 43%
- Near Poor: 26%

Families
- All Children: 34%
- Low-Income Children: 59%
- Low-Income Adults: 22%
- Births (Pregnant Women): 45%

Aged & Disabled
- Medicare Beneficiaries: 20%
- People Living with HIV/AIDS: 47%
- Nursing Home Residents: 70%

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of ASEC Supplement to the CPS; Birth data from Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007; National Governors Association, 2006; Medicare data from USDHHS.
Medicaid Enrollees and Expenditures, FY 2009

Enrollees
Total = 62.6 million

Expenditures
Total = $346.5 billion

NOTE: Percentages may not add up to 100 due to rounding.
SOURCE: KCMJ/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.
Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2009

Enrollees
Total = 62.6 million

Expenditures
Total = $346.5 billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.
Dual eligible beneficiaries are a diverse population

- Age 85+ 14%
- Age 75-84 21%
- Age 65-74 26%
- Under Age 65 39%

- Age

- Community 87%
- Facility 13%

- Type of Residence

- No Mental Impairments 51%
- Mental Impairment 49%

- Mental Impairments

- 4 or more Chronic Conditions 35%
- 3 Chronic Conditions 20%
- 2 Chronic Conditions 20%
- 0 or 1 Chronic Conditions 25%

- Number of Chronic Conditions

NOTE: Mental impairments were defined as Alzheimer’s disease, dementia, depression, bipolar, schizophrenia, or mental retardation.
Dual eligible beneficiaries account for a substantial share of Medicaid spending

Medicaid Enrollment, 2009

- Children: 49%
- Adults: 26%
- Other Aged & Disabled: 15%
- Duals: 10%

Total = 63 Million

Medicaid Spending, 2009

- Prescribed Drugs: 0.4%
- Other: 2%
- Acute: 7%
- Long-Term Care: 25%
- Other Aged & Disabled Spending: 28%

Total = $359 Billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012. MSIS FY 2008 data were used for MA, PA, UT, and WI, but adjusted to 2009 CMS-64.
Dual eligible beneficiaries comprise 20% of the Medicare population and 15% of the Medicaid population in 2008.

- Medicare: 37 million
- Dual Eligible Beneficiaries: 9 million
- Medicaid: 51 million

Total Medicare beneficiaries: 46 million  Total Medicaid beneficiaries: 60 million

National Spending on Nursing Home and Home Health Care, 2006

**Nursing Home Care**
- Private Insurance: 7%
- Other: 6%
- Medicaid: 43%
- Out-of-Pocket: 26%
- Medicare: 17%

**Total = $124.9 billion**

**Home Health Care**
- Private Insurance: 11%
- Other*: 6%
- Medicaid: 34%
- Out-of-Pocket: 11%
- Medicare: 38%

**Total = $52.7 billion**

Note: Medicaid percentage includes spending through SCHIP. Other includes private and public funds.
SOURCE: Kaiser Commission on Medicaid and the Uninsured, based on Health Affairs January/February 2008, CMS, National Health Accounts.
Growth in Medicaid Long-Term Care Services Expenditures, FFY 1990-2009

In Billions


$32 $54 $75 $92 $100 $109 $115 $122

13% 20% 30% 32% 37% 41% 59% 57%

87% 80% 70% 68% 63% 41% 42% 43%

Institutional Care  Home and Community-Based Services

Note: Home and community-based care includes home health, personal care services and home and community-based service waivers. Institutional care includes intermediate care facilities for the mentally retarded, nursing facilities, and mental health facilities.

SOURCE: KCMU and Urban Institute analysis of HCFA/CMS-64 data.
Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2009

NOTE: Totals may not sum due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on FY 2009 MSIS and CMS-64 data.
These Realities in Expenditure Growth and Trends Have Resulted In:

• In 209 70% of Medicaid population was in managed care

• In 2012 21 States are in or are moving into Managed Care LTSS models

• 36 States submitted letters of interest to participate in Medicare's Dual Eligible Program

• Pilot projects to address rehospitalizations of Medicare population: community and NF
Key considerations for testing new models of managed care for dual eligible beneficiaries

- The current landscape offers room for improvement
  *The current system is fragmented; coordination will help to improve care*

- One size will not fit all
  *Various approaches are needed to address each subgroup’s unique needs*

- Building expertise and plan capacity takes time
  *Few health plans and states have experience managing both populations*

- Proceed with caution
  *Infrastructure needs to be in place; transitions are difficult*

- Don’t count your savings before they are hatched
  *Many are laying claim to savings, few results to date have shown cost savings*

- Accountability matters: who will be in charge?
  *Oversight needs to protect beneficiary rights and evaluation needs to be dynamic*

SOURCE: Dx For A Careful Approach To Moving Dual Eligible Beneficiaries Into Managed Care Plans. Health Affairs, June 2012. http://content.healthaffairs.org/content/31/6/1186.full?jkey=AQVp04z5Izzy6&keytype=ref&siteid=healthaff
The Changing Role of the AAA Network

- Others are taking notice of the unique and valuable infrastructure of the AAA's:
  - Veterans Administration, FEMA, CMS, FCC
- The AAA infrastructure is unique
- The Network is working to remain relevant, to expand funding streams and to revise service models
The Changing Role of the Network

- It is evolving
- Striving to maintain a primary role
- The goal: Improved access, and information
- The right service, at the right time
- Assisting across the populations to help people plan for their long term care needs
Advocacy
What is it? How does it work?

We are all born Advocates
...the baby who cries when it wants fed
...the toddler who throws a tantrum when they don’t get their way

Advocacy
...making your wants known
Advocacy is Critical

• In the Changing Geography of Aging Services the discussion has changed
  – Ageism is alive and well
  – Programs for seniors are now seen as entitlements
  – The 47% includes retirees
  – The cost of Medicare, Social Security and Medicaid are aging issues
Advocacy Barriers for Aging Issues

• We live life forward and understand it backwards

• The impulse to the positive as we age

• The heterogeneity of older adults
  – If you interest is children, it doesn’t change when you turn 65

• Caregiving is time limited
  – Nursing Facility example
Different Types of Advocacy

- Self Advocacy
- Individual Advocacy
- Systems Advocacy
- Issues Advocacy
Advocacy: Important Elements

- Be honest
- Know the topic and the details
- Be polite and don’t argue
- Develop relationships with the decision makers
- Make yourself a resource for information and facts on the topics you’re interested in
What is Advocacy?

- It is simply using resources to influence others:
  - Policy makers
  - Leaders
  - Decision makers
- Advocacy involves ACTION
What is Advocacy?

• Effective advocacy is a combination of stories, life experiences, data and statistics that demonstrate the nature of the problem and needs
• Advocacy includes asking for changes in policies, programs, and funding
• Advocacy directly relates to the work of Social Workers
Advocacy Basics

1. Tell your story and personalize it
2. Value your experience
3. Speak from your knowledge and training
4. Be succinct in your communication
5. Do your homework and know the issues
6. Keep it simple
7. All politics are local
Advocacy Basics

8. Tell the truth
9. Know your opponents
10. Build coalitions
11. Thank those who helped you
12. Think big, but know your bottom line
13. Don’t let perfect become the enemy of good
You Can Influence Congress... Without Even Leaving Home

• There are actions you can take to influence policy, funding, and programs at the national level
  • Nature abhors a vacuum - being at the table versus being on the table
  • Members of Congress need information from constituents about the issues, it is critical that they have data and stories from “back home”
You Can Influence Congress Without Even Leaving Home

• Make the effort
• Don’t be afraid or intimidated
• Get others involved
• Be creative

Remember these important advocacy axioms

• “Honesty is not the best policy, it is the **ONLY** policy”
• “Today’s opponent may be tomorrows ally”
• “You don’t make peace by talking to you allies”
Vote: Every Vote Counts!

One Vote

✓ ... made Texas part of the United States (1845)
✓ ... saved President Andrew Johnson from impeachment (1868)
✓ ... saved the Selective Service System 12 weeks before Pearl Harbor (1941)
✓ ... was John F. Kennedy’s margin of victory over Nixon in 1960 by less than 1 vote per precinct in Illinois, Missouri, New Jersey & Texas
Examples of Successful Advocacy

• Sedgwick County Mill levy Reduction for 2013 FY
• Senior Care Act funding increase for 2012
• OAA Placemats Initiative
• KanCare letter
• Sequestration and OAA Program funding
The Last Supper - it Could Happen to You

Your lunch and other services for seniors are on the chopping block.

This message sponsored by:

KAART
Meeting the Needs of Older Kansans

and your local Area Agency on Aging

Insert your logo here

Did you know your meal is funded by federal funding through the Older Americans Act?
You and over ___ people in our local community receive

TAKE ACTION NOW

Contact your congressional representative to tell them you don’t want your meal or services for seniors cut. For information on how to reach your congressperson call 1-866-457-2364.

Today adults over 60 are over 57 million strong! You can make a difference. Be heard.
Your Meal Could be on the Chopping Block

Your lunch and other services for seniors could receive major cuts.

This message sponsored by:

Meeting the Needs of Older Kansans

and your local Area Agency on Aging

Insert your logo here

Did you know your meal is funded by Older Americans Act which is Federal funding?

You and over ____ people in our local community receive a daily lunch.

TAKING ACTION NOW

Contact your congressional representative to tell them you don’t want your meal or services for seniors cut.

Please call 1-800-998-0180 to be connected to your congressperson.

Today adults over 60 are over 57 million strong! You can make a difference. Be heard.
Your Lunch Could be up in the Air

Your lunch and other services for seniors could get tossed.

This message sponsored by:

Kansas Area Agency on Aging
Meeting the Needs of Older Kansans

and your local Area Agency on Aging

Insert your logo here

Did you know your meal is funded by federal funding through the Older Americans Act?
You and over ___ people in our local community receive a daily lunch.

TAKE ACTION NOW

Contact your congressional representative to tell them you don’t want your meal or services for seniors cut. For information on how to reach your congressperson call 1-866-457-2364.

Today adults over 60 are over 57 million strong! You can make a difference. Be heard.
"Sequestration" Has a Face!

Since the early 1970's the Federal Older Americans Act (OAA) has been the impetus for a system of cost-effective community services to meet the most basic needs of our oldest citizens. Information about services, assistance with bathing and other personal care needs, meals-on-wheels & transportation are components of this Aging Network.

While all parts of the network do not touch all older adults, services exist that provide "just enough" assistance to direct our older citizens toward independence, dignity, and self-determination. In addition, services have expanded to provide training, assistance, and support for their families, neighbors, and other unpaid caregivers who provide 80% of the long term support in our country. While this care comes at no cost to taxpayers, the personal cost is high for those who make sacrifices in their own lives to care for aging parents, neighbors, and friends.

"Sequestration" – the automatic 9% across-the-board spending cutback coming in January if Congress cannot agree on a budget - will unravel years of service development and weaken the structure of the Aging Network. This will happen just in time for the largest increase in aging Americans in our country's history! Levels of aging services in Washington State have increased in spite of relatively flat funding due to strong community support of these programs, but cuts at this time will, without a doubt, have serious consequences to the strong service system established over many years.
People who think they can change the world are the ones who do.
Presentation Summary

• Older Americans Act is the foundation legislation for Aging Services and it has evolved over the last 47 years

• The changing demographics, increasing need for services, the recession and its lingering impact are fueling changes in Medicaid, Medicare and public policy

• The political focus on Aging issues is altering the perception of programs serving seniors

• Advocacy is Critical
Questions?

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