New York State Office for the Aging

Aging in New York:
Building Capacity and Empowering Communities

41st Annual Conference of the State Society on Aging of New York

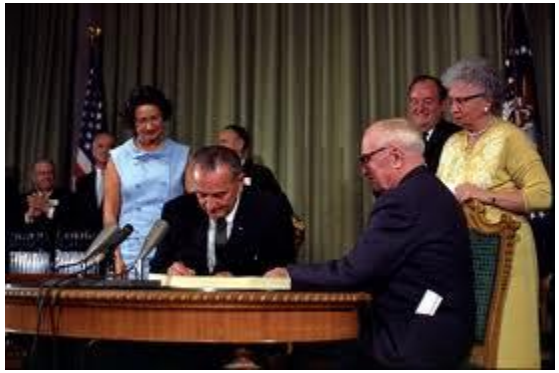
Wednesday, October 23, 2013
Gideon Putnam Hotel and Conference Center
Saratoga Springs, New York

NYSOFA Mission – Why We Exist

- The mission of the New York State Office for the Aging is to help older New Yorkers to be as independent as possible for as long as possible through advocacy, the development and delivery of person-centered, consumer-oriented, and cost-effective policies, programs and services which support and empower older New Yorkers and their families, in partnership with the network of public and private organizations which serve.

The Older Americans Act

"Countervailing Force" to Medicare and Medicaid



- Passed in 1965
- The primary federal discretionary funding source for home and community based services for older adults
- The goal: keep older adults healthy and independent, and living in the community.
- Established the Aging Services Network
- **Focused on multi-disciplinary partnerships at community level**

Older Americans Act

- 1965 – President Johnson signs the Older Americans Act.
  - "Countervailing Force"
  - Medicare and Medicaid pass Congress and signed into law
- 1969 – Areawide Model Projects were funded
  - FGP Program and RSVP Funded.
- 1972 – Amendments authorized
  - national nutrition program for the elderly funded;
  - national network of congregate nutrition projects.
- 1973 - Amendments established Area Agencies on Aging.
  - amendments added a new Title V, which authorized grants to local community agencies for multi-purpose senior centers
  - created the Community Service Employment grant program for low-income persons age 55 and older, administered by the Department of Labor.
- Comprehensive Employment and Training Act was enacted; included older persons.

1974

- Title XX of the Social Security Amendments authorized grants to states for social services. These programs included
  - protective services,
  - homemaker services,
  - transportation services,
  - adult day care services,
  - training for employment,
  - information and referral,
  - nutrition assistance, and
  - health support.
- Older Americans Act amendments added transportation under Title III model projects.
- Housing and Community Development Act enacted; provided for low-income housing for the elderly and handicapped, pursuant to the Housing Act of 1937.
- National Institute on Aging created to conduct research and training related to the aging process, and the diseases and problems of an aging population.
- Title V of the Farm and Rural Housing Program of 1949 expanded to include the rural elderly as a target group.

1975

- Older Americans Act Amendments authorized grants under Title III to Indian tribal organizations. Transportation, home care, legal services, and home renovation/repair were mandated as priority services.

1978

- OAA amendments required each state to establish a long-term care ombudsman program to cover nursing homes

1981

- Older Americans Act reauthorized; emphasized supportive services to help older persons remain independent in the community.
- Act expanded ombudsman coverage to board and care homes

1984

- Reauthorization of the Older Americans Act clarified and reaffirmed the roles of State and Area Agencies on Aging in coordinating community-based services, and in maintaining accountability for the funding of national priority services (legal, access, & in-home).

1987

The Nursing Home Reform Act (Omnibus Budget Reconciliation Act) mandated that nursing facility residents have "direct and immediate access to ombudspersons when protection and advocacy services become necessary." Simultaneously, the OAA reauthorization charged states to guarantee ombudsman access to facilities and patient records, provided important legal protections, authorized state ombudsmen to designate local ombudsman programs and required that ombudsman programs have adequate legal counsel.

1992

- Reauthorization of the Older Americans Act places increased focus on caregivers, intergenerational programs, protection of elder rights.
- OAA amendments added a new Title VII "Vulnerable Elder Rights Activities" which included the long-term care ombudsman; prevention of elder abuse, neglect and exploitation; elder rights and legal assistance development; and benefits outreach, counseling and assistance programs. The legislation emphasized the value of the four programs coordinating their efforts.

2000

- Older Americans Act Amendments of 2000 signed into law (P.L. 106-501), establishing the new National Family Caregiver Support Program, and reauthorizing the OAA for 5 years on November 13, 2000.

2001

- HHS Secretary Tommy G. Thompson released $113 million for first National Family Caregiver Support Programs grants to states on February 15, 2001.

2003

- Enactment of the Medicare Prescription Drug, Improvement and Modernization Act (MMA)

2006

- Medicare Part D Prescription Drug program (part of MMA) went into effect
- Enactment of the Lifespan Respite Care Act (administered by AoA)
- Older Americans Act Amendments of 2006 signed into law (P.L. 109-365), embedding the principles of consumer information for long-term care planning, evidence based prevention programs, and self-directed community based services to older individuals at risk of institutionalization.
  - Further embedded networks role in Screening for Mental health
  - Authorized ADRCs

2010

- Enactment of the Affordable Care Act

2011

- First of the nation's baby boomers turn 65.
- CLASS (Community Living Assistance and Supports) program, part of the Affordable Care Act, is designated to be administered by the Administration on Aging – later repealed

- Amended 19 times, about once every 3.5 years

- **Evolution of the role of the network over time**

WHY?
New York State
Trends in Demographics (2010)

Population Trends	2000	2008	2010	2015	2020	2025	2030
Total Population	19,000,135	19,460,969	19,566,610	19,892,438	20,266,341	20,693,354	21,195,944
Ages 5 and over	17,763,021	18,216,035	18,314,451	18,619,147	18,985,160	19,398,722	19,874,195
Ages 60 and over	3,211,738	3,558,460	3,677,891	4,027,480	4,499,549	4,962,734	5,302,667
Ages 65 and over	2,452,931	2,559,826	2,588,024	2,851,524	3,191,141	3,615,695	4,020,308
Ages 75 and over	1,180,878	1,281,459	1,259,873	1,242,577	1,332,145	1,561,652	1,815,879
Ages 85 and over	314,771	403,129	417,164	442,958	454,298	486,682	566,423
Ages 60-74	2,030,860	2,277,001	2,418,018	2,784,903	3,167,404	3,401,082	3,486,788
Ages 75-84	866,107	878,330	842,709	799,619	877,847	1,074,970	1,249,456
Minority Elderly, 60 and over	736,742	981,360	1,062,919	1,277,197	1,552,380	1,865,871	2,180,775
Ages 65 and over	506,282	674,022	716,078	872,889	1,058,974	1,296,349	1,574,537
Ages 75 and over	198,537	285,885	303,764	357,680	426,448	537,061	672,261
Disabled (ages 5 and over)	3,606,192	3,784,789	3,831,083	3,952,167	4,096,932	4,253,653	4,400,598
Ages 5 to 17	257,194	246,675	244,978	246,999	252,089	255,876	260,507
Ages 18 to 59	2,206,913	2,206,913	2,210,226	2,198,510	2,161,587	2,141,246	2,156,392
Ages 60 and over	1,201,431	1,331,201	1,375,879	1,506,658	1,683,257	1,856,532	1,983,699
Poverty,(1) Age 60+	352,835						
Below 150%	652,365						
Below 250%	1,201,110						
Housing (Own/Rent), 60+,(2)	158,860/92,900						

Source: NYS Data Book, 2010, © NYSOFA

Family Structure . . .

United States	
Married couple families	
Married couple families with children	
Single parent households	
Single person households	
Non-traditional households	

Federal and State Direction – Rebalance LTSS

- Olmstead Plan
- MRT
- Health Homes
- FIDA
- MLTC
- CFCO
- MFP
- CMMI Innovations
- Accountable Care Organizations
- Affordable Care Act

Federal Direction for Aging Network

2006 OAA Amendments, ARRA and ACA – Build and Strengthen Multidisciplinary partnerships – ADRC as Foundation

- ADRC Authorization
- CDSMP
- NHD/CLP
- Options Counseling
- ADRC Expansion Grants
- Veterans Directed
- Lifespan Respite
- Care Transitions
- Systems Integration - Part A and B
- CMS Innovations
- CDSME
- ADRC 2012 – Options Counseling
- Elder Abuse
- BIP
- NCI – Performance Standards
- Olmstead Implementation

New York State – Context for Change

We all recognize the need to address the issues of both physical and behavioral health:

- Both physical and behavioral health benefit from prevention efforts, screening tests, routine check-ups, and treatment.
- Many people have both physical and behavioral health illnesses.
- Increased mortality in those with behavioral health issues is largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and reluctance to access medical care.

- Formal coordination/integration with human services agencies for psychosocial supports lacking in design development.

FIDA, MLTC, HEALTH HOMES, BIP

Seek to integrate medical, behavioral, long-term support and services, and social needs in order to create person-centered, coordinated plans for Medicaid recipients.

Care Management for All =

- Accountability
- Holistic approach
- Person-centered
- Better outcomes
- Lower costs

Services Provided by the Aging Network

- Home delivered meals
- Congregate meals
- Nutrition counseling & education
- Long Term Care Ombudsman
- HIICAP
- Employment
- Medicare prevention, screening and wellness
- Options counseling, benefits and application assistance
- Legal Services
- Senior center programming
- EBI – CDSMP, fall prevention, etc
- Volunteer opportunities
- ADRC – aging and disability resource center
  - No wrong door – objective info and assistance on LTC
- Caregiver support services
  - Support groups
  - Training
  - Respite

Services Provided by the Aging Network

- Case Management
- Personal Care Level I and II (non-Medicaid)
- Ancillary services such as PERS, those that maintain or promote the individual's independence such as:
    - (i) purchasing/renting of equipment or assistive devices
    - (ii) purchasing/renting, maintaining and repair of appliances
    - (iii) personal and household items
- social adult day services
- transportation to needed medical appointments, community services and activities
- those that maintain, repair or modify the individual's home so that it is a safe and adequate living environment, such as:
    - (i) home maintenance and chores
    - (ii) heavy house cleaning
    - (iii) removal of physical barriers
- those that address everyday tasks, such as:
    - (i) house cleaning
    - (ii) laundry
    - (iii) grocery shopping, shopping for other needed items and other essential errands
    - (iv) bill paying and other essential activities

Systems Changes/reorganization in health care (Affordable Care Act) and long-term services and supports delivery (Olmstead, MRT, managed care for all, health homes, OAA reathorization) may provide an opportunity for aging services network to contract with:

- Medicaid Managed LTC
- Medicare Advantage
- Traditional Managed Care
- Veterans Administration
- Health Homes
- Private Insurers
- Private Pay Customers
- Businesses/Chambers of Commerce
- Other non-profits in human services

Managed Long Term Care

WHICH SERVICES ARE PROVIDED BY THE MLTC PLANS - Benefit Package of "Partially Capitated" Plans

MLTC Benefit Package (Partial Capitation) (Plan must cover these services, if deemed medically necessary. Member must use providers within the plan's provider network for these services).

- Home Care, including:
  - Personal Care (Home attendant or Housekeeping)
  - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Program
- Adult Day Health Care (medical model and social adult day care)
- Personal Emergency Response System (PERS),
- Nutrition -- Home-delivered meals or congregate meals
- Home modifications
- Medical equipment such as wheelchairs, medical supplies such as incontinent pads, prostheses, orthotics, respiratory therapy
- Physical, speech, and occupational therapy outside the home
- Hearing Aids and Eyeglasses
- Four Medical Specialties:
  - Podiatry
  - Audiology + hearing aides and batteries
  - Dental
  - Optometry + eyeglasses
- Non-emergency medical transportation to doctor offices, clinics (ambulette)
- Nursing home care

Federal Health Home Requirements

Section 2703 of the federal Patient Protection and Affordable Care Act (ACA) establishes authority for states to develop and receive federal reimbursement for a set of health home services for their state's Medicaid populations with chronic illness. Health home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care.

Health Home services include:

- comprehensive care management,
- health promotion; transitional care including appropriate follow-up from inpatient to other settings,
- patient and family support,
- referral to community and social support services,
- use of health information technology to link services.

Medicaid eligible individuals must have: (1) two chronic conditions; (2) one chronic condition and are at risk for a second chronic condition; or (3) one serious persistent mental health condition to qualify for health home services.

Systems Integration is Key

- 20% of older adults have a diagnosable mental disorder such as dementia, depression and anxiety
  - Medicare now pays for annual wellness visit, a variety of screenings, depression screening and alcohol and substance abuse screening
    - Primary care physicians are key
  - Virtually all of them have a chronic health condition

- 75% of ALL health care spending is spent on chronic conditions
  - Those ages 65 + - 91% have at least 1 Chronic condition
    - 73% have two or more

The next set of older adults – baby boomers

68% have at least one chronic condition

43% have at least 2

Other Costs Associated with Chronic Conditions

- Cost of an individuals independence and quality of life
- Costs for long-term care – exceed $500 billion nationally
- Out of pocket costs for individuals
  - Co-pays, premiums, deductibles
  - Prescriptions, then run risk of adverse interactions
  - Spend-down
  - DME
- Business costs – loss productivity and health spending
- Economic costs – local and state economy, income, assets

AAA's and Network Providing Services WHERE PEOPLE ARE

- Have a strong ground game – 59 AAA's and over 1,200 subcontractors
- Have extensive experience in working in and navigating complex systems
- Operate/administer myriad of programs and services – not a one trick pony
- Understand the valuable role caregivers play and work to maximize family support
- Understand public benefits, counseling and are seasoned in helping individuals and families with diverse applications for a myriad of programs
- Are mobile and can "go to" the client's home/other community setting
- Are adept at leveraging resources and building sustainable partnerships
- Have a culture of helping and are trusted locally
- Are positioned to be an important part of a new system that will:
  - Focus on prevention and preventive services and screenings
  - Manage chronic conditions through EBI's
  - Reduce reliance on Medicaid, maximize private pay
  - Better target those at risk and coordinate their care
- **Are an important part of economic development/sustainability**

What About Non-Medicaid Population?

Historical Funding

	OAA Funding	NYS
1993	$90.6 million	$57 million
2002	$102.5 million	$70.2 million
2012	$100 million	$113.9 million

With County, participant contribution, fundraising, cost sharing, etc – add an additional $250 million

Nursing Home Placement Indicators

To understand cost efficient programs and services, it is important to understand the risk factors associated with higher levels of care, particularly nursing home placement.

- ***Demographic characteristics:*** Older individuals and those who are non-Hispanic white.
- ***Socioeconomic status:*** Individuals with low incomes
- ***Health status and physical functioning:*** Those with certain health conditions (such as cognitive impairment, cancer, high blood pressure, diabetes, and a history of strokes and falls) and those who have difficulty performing activities of daily living (ADLs
- ***Prior health care utilization:*** Individuals who have spent time in the hospital or in a nursing home. In 2009, about 7 percent of state residents 65 or older had one nursing home stay and 23 percent of state residents 85 or older had one nursing home stay. (Source: Nursing Home Compendium 2010 from CMS)
- ***Living arrangements and family structure:*** Those who live alone (including widowed and divorced individuals), do not own their home, and have fewer children than their peers not in nursing homes.
- ***Availability of support:*** Individuals who lack caregiver support

NYSOFA Programs serve individuals at risk of nursing home placement and Medicaid spend-down

EISEP Case Management

Average age – 81.2
47% below 150% of poverty
85% difficulty in 3+IADL
30% difficulty in 3+ ADL
39% at nutritional risk
62% live alone
State Cost - $359
Local Cost - $119

EISEP Personal Care level I and II

Average age – 83.5
58% below 150% of poverty
91% difficulty in 3+IADL
45% difficulty in 3+ ADL
42% at nutritional risk
69% lived alone
State Cost - $2,369
Local Cost - $789

Home Delivered Meals

Average age 80.8
44% below 150% of poverty
77% difficulty in 3+IADL
23% difficulty in 3+ ADL
42% at nutritional risk
59% lived alone
$6.49 per meal

Social Adult Day Services

Average age - 81.5
32% below 150% of poverty
80% difficulty in 3+IADL
47% difficulty in 3+ ADL
22% at nutritional risk
24% lived alone
$9.72 an hour

Brown University - Older Americans Act Title III State Expenditures and Prevalence of Low-Care Nursing Home Residents

Objective. To test the relationship between older Americans Act (OAA) program expenditures and the prevalence of low-care residents in nursing homes (NHs).

Data Sources and Collection. Two secondary data sources: State Program Reports (state expenditure data) and NH facility-level data downloaded from LTCfocUS.org for 16,030 US NHs (2000–2009).

Study Design. Using a two-way fixed effects model, we examined the relationship between state spending on OAA services and the percentage of low-care residents in NHs, controlling for facility characteristics, market characteristics, and secular trends.

Principal Findings. Results indicate that increased spending on home-delivered meals was associated with fewer residents in NHs with low-care needs.

Conclusions. States that have invested in their community-based service networks, Particularly home-delivered meal programs, have proportionally fewer low-care NH residents.

Value of Aging Network

Nursing Home Diversion and Transition Program and the Community Living Program:

- Targets individuals at imminent risk of Medicaid spend-down and nursing home placement. Allows individuals to maintain their independence and remain in their communities by offering consumer directed models of care, which allow individuals to be more involved and have more control over the types of services they receive and how they receive them.
  - Outcomes data shows that 81% of program participants were diverted from nursing home care resulting in savings of $643,250 per month ($7.7 million per year)

Value of Aging Network

- **ADRC Evidenced-Based Care Transitions Program:** Assists older adults with the transition from hospitals to home through evidenced based models, specifically, the Coleman model. The grant builds on the ADRC model which is an essential required component.

  - Program Data: From April to September 2011 (this reporting period), the Albany NY Connects engaged in care transitions activities with 293 in-hospital patients (Albany Memorial Hospital, Samaritan Hospital, and Seton Hospital collectively). Of those 293 individuals, 228 went on to complete the 30 day Care Transitions Intervention and 3 individuals to complete the 90 day CTI-Plus. Of all individuals who completed the program (either 30 or 90 days), 7.8 % (18) were readmitted within the first 30 days after their hospital discharge, far exceeding the baseline rate by an approximate 50% further reduction in readmission.

Value of Aging Network

Chronic Disease Self Management Program: Served over 5,000 community living older adults with chronic disease, engaged providers already delivering CDSMP in a statewide system, and built a regional infrastructure to offer and sustain high quality deliveries adhering to the fidelity of the CDSMP and other evidenced-based health programs. Among the deliverables is integration with NY Connects as a referral source.

- Results - overall health increased, fatigue was reduced, pain was reduced, there was a reduction in those reporting shortness of breath, physicians visits, ER visits, hospitalizations and hospital nights were all reduced, generating significant savings.
  - Savings - $600-$800 per year, per person who completes at least 4 of the 6 sessions

Value of Aging Network

- **Medicare Improvement for Patients and Providers Act for Beneficiary Outreach and Assistance** : *Expand, extend and enhance outreach efforts to increase participation in the Medicare Savings Program and Low Income Subsidy Program, provide assistance with Medicare Part D and increase the use of preventive services for beneficiaries***.** Collaboration between the State Health Insurance Program (known as HIICAP in NYS), Area Agencies on Aging (AAA) and Aging and Disability Resource Centers (**NY Connects**) are required.
  - Outcomes data shows that HIICAP involvement with helping individuals access "Extra Help" applications generated $70 million in benefits to low-income individuals that they would not have otherwise had, freeing up this amount to meet other daily needs.

Value of the Aging Network

While Older Americans Act and state funded programs do not serve Medicaid clients, the aging services network plays a very important role with Medicaid recipients and dual eligible's or those who are not currently participating but are eligible for Medicaid.

Examples of tasks performed by area agencies on aging and subcontractors include

- application and recertification assistance,
- screening,
- assistance with applying for Medicare Savings Program and Low Income Subsidy
- HEAP assistance,
- Food Stamps,
- assistance to duals on Medicare Part D,
- assistance to nursing homes regarding Part D,
- targeting and outreach to dual regarding prevention and health and wellness benefits,
- providing congregate and home delivered meals, social adult day services,
- non-medical transportation,
- caregiver support and training,
- training for DSS, hospitals, nursing home staff on Medicare Part D,
- counseling on meeting Medicaid spend-down,
- falls prevention education,
- chronic disease self management,
- senior center programming,

How do We Increase Service Capacity – Non-Medicaid?

Federal appropriators hostile towards discretionary funds

NYS closing multi-year structural deficits

- Expand Access to SNAP and other federal benefit (LIS/MSP, etc) – avg benefit $175/month = 27 meals per month full pay, 44 meals if paying $4 contribution
- Need More Volunteers – Prep, delivery, etc.
- Private Foundations/Community Health Foundations
- New Financing Mechanisms for Network
  - Independence Savings Accounts/Family Accounts – i.e. ITN
  - Independence Insurance
  - Independence Home Equity Line of Credit
- Governors Advisory Council
  - Private Pay Development
  - Cost Sharing for OAA
- Medicaid Administration Pursuit
  - NY Connects
  - LTCOP

Questions?