NASUAD 2016 PRIORITIES

AGING AND DISABILITIES IN AMERICA

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The National Association of States United for Aging and Disabilities is the membership organization for state agencies that provide services and supports to seniors and people with disabilities. NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the promotion of state systems innovation, and the advancement of national policies to support home and community-based services for older adults, people with disabilities, and their caregivers. NASUAD provides policy analysis, technical assistance, and best practice dissemination to further the goals of our membership and to assist state agencies in enabling older adults and people with disabilities to receive services in home and community-based settings.

Programs that Support Older Americans and People with Disabilities

Many of the critical supports and services for older adults and persons with disabilities received increased or flat funding for FY2016, a positive development for some of our nation's most vulnerable citizens. However, these key programs will continue to face enormous pressure due to inflation as well as to the significant growth in the 65 and older population in the United States.[1] Therefore, additional investment and support remains necessary in order to allow older adults and people with disabilities to stay healthy and in their own homes, and avoid more costly institutionalization through Medicare and Medicaid.

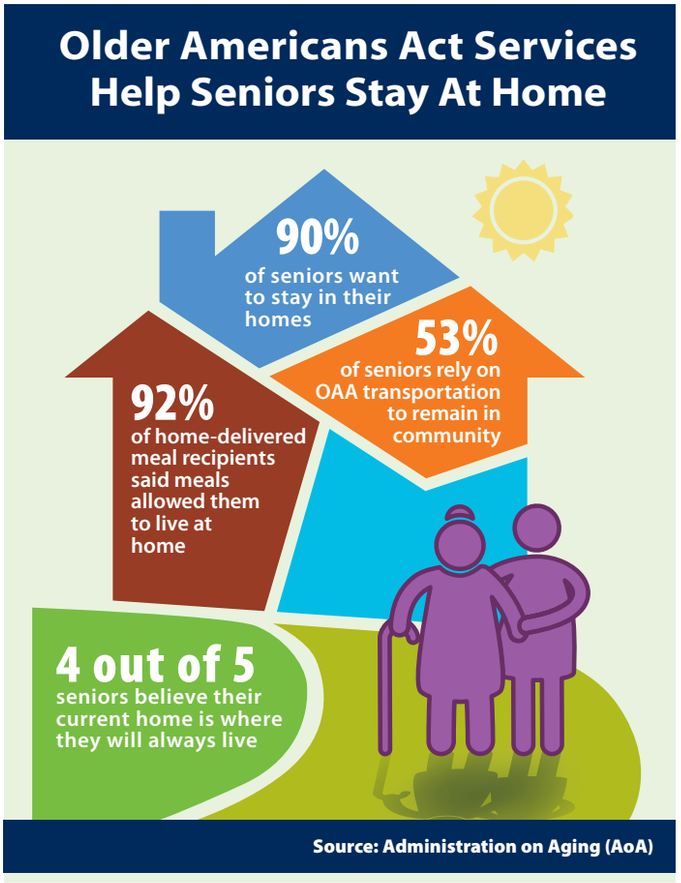
Reauthorize the Older Americans Act (OAA)

Background. The Older Americans Act (OAA, P.L. 109-365) is a vital component of our nation's long-term services and supports system, and is critical for supporting our nation's seniors. Passed in 1965, the OAA over the previous five decades has allowed American seniors to better age in place through mechanisms such as home-delivered meals, transportation, and supports for caregivers. The most recent OAA reauthorization occurred in 2006 and expired at the end of FY2011. The Senate and the House have passed a reauthorization package that was the result of several years of negotiation and includes a number of crucial bipartisan compromises. The legislation reauthorizes OAA for three years and provides crucial updates to terminology; streamlines program authorizations and operations; and improves important programs such as Elder Justice Initiatives.

Recommendation: NASUAD urges ACL to work with states in order to provide guidance and assistance with the implementation of the OAA amendments. NASUAD also recommends ongoing discussions with states, the Federal government, and Congress to determine ongoing improvements that can be incorporated into the next reauthorization, due in 2019.

Increase Flexibility for States

Background. The Older Americans Act enables States to provide numerous critical services for older adults, including home care, congregate and home-delivered meals, support for caregivers, case management, and transportation services. The ability for States to innovate by seeking waivers under the OAA, however, is limited to Sections 305, 306, and 307 under current law.



1 The number of adults age 65 and over is projected to grow from 40 million in 2010 to over 88 million in 2050. See: http://www.aoa.acl.gov/aging_statistics/future_growth/future_growth.aspx

Recommendation. NASUAD believes that Congress should amend the OAA in order to allow States to apply for waivers under additional sections of the Act, in order to perform demonstrations and explore innovative approaches to assist older adults. NASUAD also urges the Administration for Community Living (ACL) to work with states to approve alternate models of delivering care in order to test innovations that may lead to improved outcomes for participants. This would further enhance States' ability to find unique ways to deliver services to OAA recipients.

Support Programs that Assist Individuals to Age in Place

Background. The vast majority of Americans will not require Medicaid funded LTSS as they age in place but, instead, will be supported by a network of informal caregivers and a patchwork of services and supports. As a greater percentage of the U.S. population reaches the 65 and above age cohort, services under the Older Americans Act (OAA), such as home-delivered meals, will become increasingly important. Moreover, there is evidence that programs allowing older adults to live in the community can result in cost savings to states in terms of Medicaid LTSS spending.[2] Medicaid is a state-federal partnership, and thus savings accrued to the program can have positive impacts at both levels of government. NASUAD commends Congress for passage of the FY2016 omnibus appropriations bill, which allocates $448.3 million for congregate nutrition, and $226.3 for home-delivered meals—an increase of approximately $10 million for each program over FY2015 levels.

Recommendation. NASUAD believes that funding for Title III nutrition services should be modernized to remove the arbitrary allocations for congregate and home-delivered meals. Instead, there should be a single allocation for all nutrition services, and states should have the flexibility to allocate resources based upon the needs and preferences of individuals who use the program. Congress should also invest additional dollars in this program, as it is a crucial support for maintaining independence and health for seniors as they age in place.

Continue Investing in ADRCs

Background. Aging and Disability Resource Centers (ADRCS) play an important role in our nation's LTSS system, including support of state efforts to develop more efficient, cost-effective, and consumer-responsive systems of information. ADRCs were allotted $10 million in mandatory funding from 2010-2014 under the Affordable Care Act (ACA), which has now expired. ADRCs received $6 million in funding under the FY2016 omnibus, which represented a decrease of over 60% from the FY2014 levels. ADRCs are expected to do more for older adults and people with disabilities while receiving significantly less funding.

Recommendation. NASUAD proposes reinstatement of the appropriation of mandatory ADRC funding that expired in FFY '15.

Community Services Block Grant

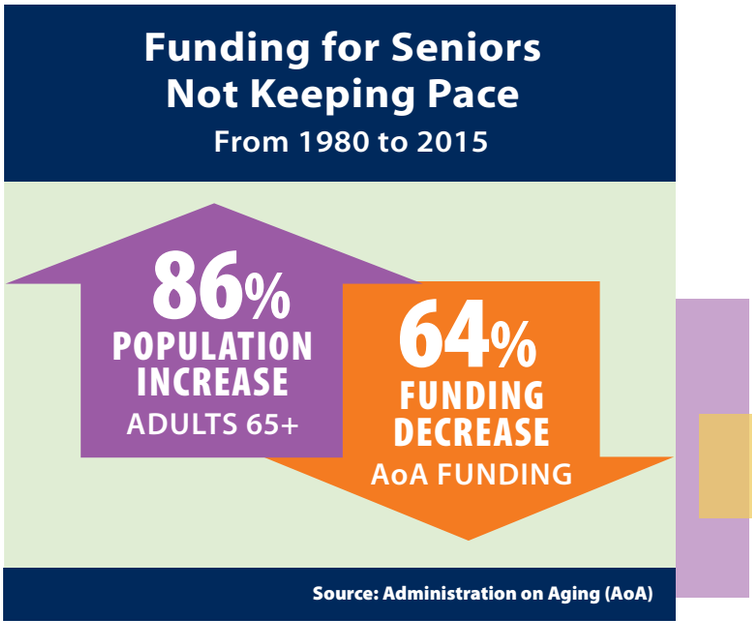
Background. Community Services Block Grant (CSBG) funds must be used for activities aimed at reducing poverty. By helping low-income individuals remain independent and in their communities, CSBG assists with controlling health care costs and reducing utilization of other federal services. CSBG received $674 million in FY2015, and NASUAD was pleased to see that funding under the FY2016 omnibus was increased to $751.3 million.

Recommendation. NASUAD appreciates the additional funding for this critical program, and urges Congress to maintain this level of appropriations beyond FY2016.

Social Services Block Grant

Background. The Social Services Block Grant (SSBG) is a flexible source of funding that allows states to provide a variety of services to low-income children and families, including older adults and people with disabilities. SSBG received $1.7 billion in funding for FY2015, and funding remained flat for FY2016; however, SSBG is still subject to a reduction due to sequestration.

Recommendation. Congress should end sequestration and restore the full SSBG funding amounts.



2 Thomas, Kali S. and Vincent Mor. "Providing More Home-Delivered Meals is One Way to Keep Older Adults With Low Care Needs Out of Nursing Homes." *Health Affairs*. 2013.

Senior Community Service Employment Program

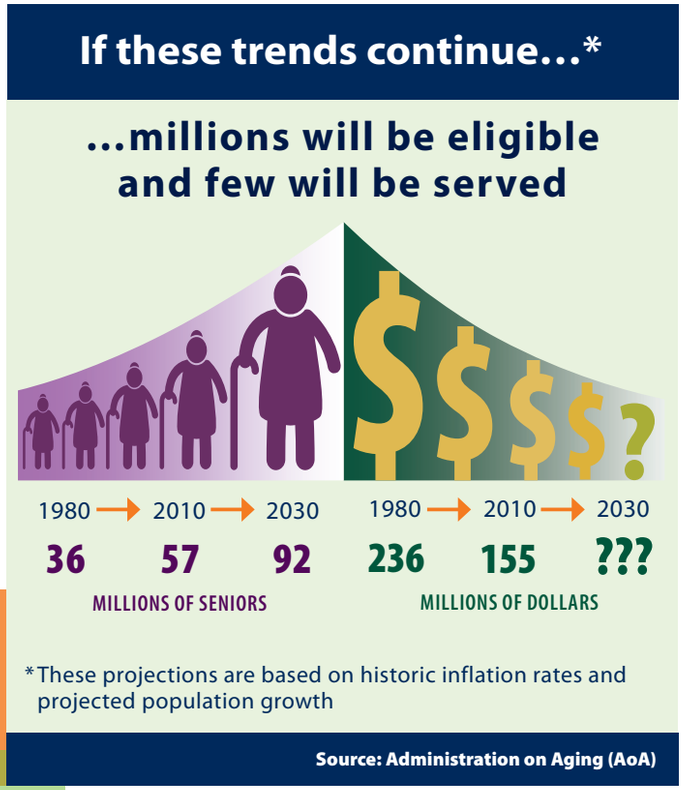
Background. The Senior Community Service Employment Program (SCSEP) assists low-income adults 55 and older with building skills, participating in community life, and earning a living. SCSEP received $434.37 million in FY2015, and this funding remained flat under the FY2016 omnibus bill.

Recommendation. NASUAD supports moving the SCSEP program from the Department of Labor to the Administration for Community Living (ACL). This would enable ACL to align SCSEP services with the broader array of community supports and better coordinate SCSEP services with State Units on Aging and best practices in serving older adults.

Low Income Home Energy Assistance Program

Background. The Low Income Home Energy Assistance Program (LIHEAP) provides energy assistance to low-income individuals and families by helping them pay ongoing heating and cooling costs. LIHEAP's funding remained flat from FY2015 at $3.39 billion.

Recommendation. NASUAD urges Congress to strengthen LIHEAP funding, which protects older adults and people with disabilities when they are most vulnerable to extreme conditions.



Section 202 and Section 811 Housing

Background. Section 202 Housing for the Elderly Program and Section 811 Housing for Persons with Disabilities fund both the construction and operation of supportive housing for very low-income elderly households, including frail older adults, and very low-income people with disabilities, respectively. Both programs saw slightly enhanced funding in the FY2016 spending bill. Section 202 funding will see an increase from $420 million to $432.7, while Section 811 increases from $135 million to $150.6 million.

Recommendation. NASUAD urges Congress to continue to prioritize these projects and fund them accordingly.

Elder Justice

Background. The Elder Justice Act (EJA, P.L. 111-148) was signed into law in 2010, and represents the first time Congress authorized specific federal funding for Adult Protective Services. However, no specific funding has ever been appropriated to realize the goals of the EJA. In the FY2016 Omnibus the EJA did not receive standalone line-item funding; however, the omnibus proposal increases funding for elder rights support activities. The increase includes $8 million of funding that ACL is directed to disperse to states via competitive grants to identify and implement promising practices for elder justice initiatives.

Recommendation. NASAUD appreciates the $8 million in funding for elder justice initiatives appropriated under the FY2016 Omnibus, but urges Congress to fully fund the Elder Justice Act as enacted in 2010 in order to better protect our nation's older adults from all forms of abuse.

Title VII Services (including Long-Term Care Ombudsman Program)

Background. Title VII of the OAA authorizes the long-term care ombudsman program as well as a program to prevent elder abuse, neglect, and exploitation. The ombudsman program resolves complaints of nursing home residents and individuals in other institutionalized settings. Funding for these programs remained steady from FY2015 levels at $20.66 million in the FY2016 Omnibus.

Recommendation. NASUAD believes that protecting older adults from exploitation and abuse is of the utmost importance. With the significant expansion in the 65 and older population in the U.S., Title VII services will be put under increased pressure. Therefore, NASUAD believes Congress should appropriate enhanced funding for Title VII services.

Medicaid and Long Term Services and Supports

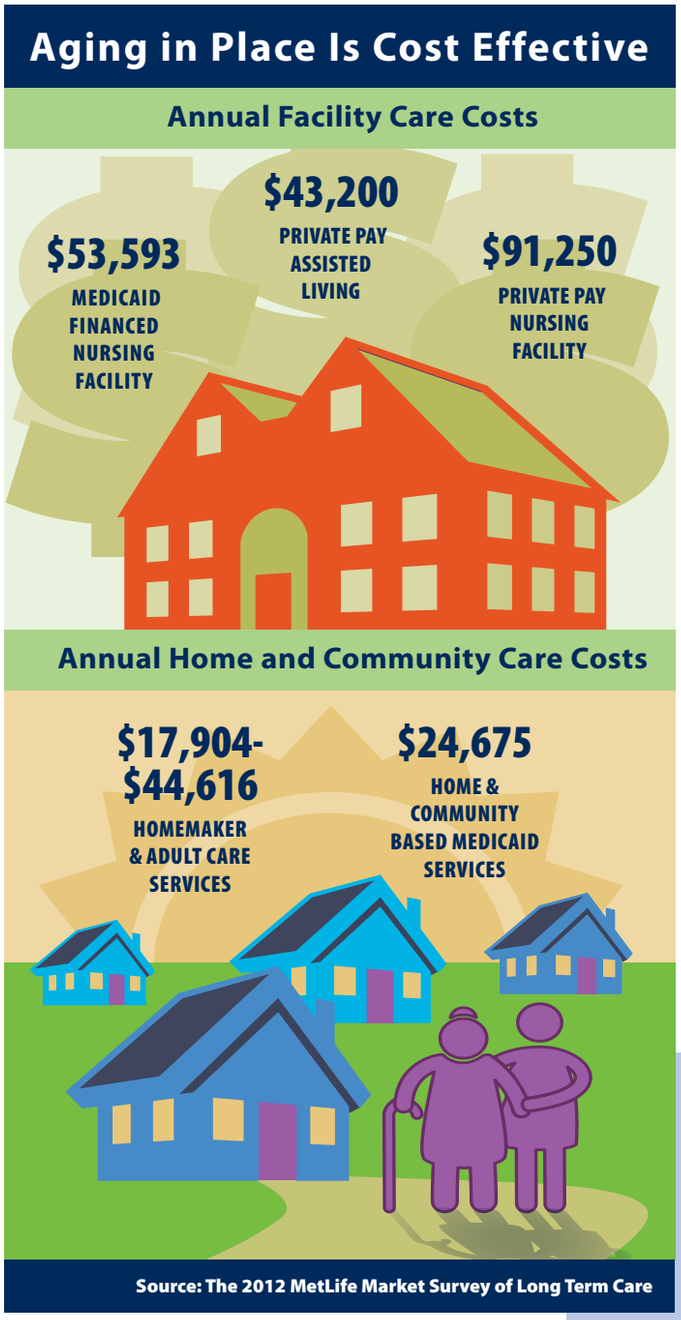
Long-term services and supports (LTSS) for older adults and people with physical disabilities are a significant component of national health care costs. In 2013, Medicaid spent approximately $146 billion on LTSS, with $75 billion of those funds spent on home and community-based services (HCBS) and $71 billion on institutional settings such as nursing homes or intermediate care facilities.[3] These costs are likely to rise, as the number of Americans needing LTSS at any one time is projected to more than double from 12 million today to 27 million by 2050. In the face of rising demand for and costs of LTSS, states and the federal government must develop innovative LTSS financing solutions, and improve both access to and affordability of LTSS, in part by exploring innovative partnerships, methods, and funding mechanisms.

As the nation's largest source of LTSS funding, Medicaid is vital for people with significant disabilities who need assistance with activities and instrumental activities of daily living. Medicaid LTSS can be provided in facilities, such as nursing homes or long-term care hospitals; or in home and community-based settings, such as the individual's home or apartment; an assisted living center; or a group home.

Innovative Models for LTSS

Background. State agencies are working to develop innovative models that support individuals who require a wide range of health and social supports to live in various types of LTSS settings and to participate in the community to the maximum amount possible. Many prior state innovations, including shared-living arrangements, self-directed HCBS, and remote monitoring systems, have become commonplace and are crucial components of LTSS rebalancing. As states work towards these innovations, CMS should be an active and engaged partner and should encourage rapid implementation of new models of care.

3 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf



Yet, the 1115 waiver approval process that enables many innovations is an arduous, complex, and lengthy process. Similarly, the Federal government has often expressed a disproportionate amount of concern and resistance to the potential financial impact of proposals as well as adherence to strict regulatory compliance rather than to focus on partnerships and innovations that could improve care and HCBS. Furthermore, even though CMS provided guidance around expedited 1115 approvals, waivers that establish new types of HCBS are excluded from the expedited review.[4]

Recommendation. NASUAD believes that CMS should work with states to expedite 1115 waiver approvals that include LTSS policies. CMS should also look to maximize partnerships with states that test and disseminate innovative ways to expand access to HCBS and that provide support to individuals in the community. We note and appreciate that CMS has begun this process by identifying LTSS as a priority area of the Innovation Accelerator Program (IAP), and we recommend that lessons learned through the IAP be leveraged to continue partnerships towards LTSS innovation.

Support for Caregivers

Background. Informal caregiving is a crucial component of the nation's LTSS and HCBS systems, as many seniors and people with disabilities receive significant assistance with activities of daily living from their friends and families. According to estimates from the Congressional Budget Office, friends and family members acting as caregivers provided unpaid long-term services and supports that would have cost approximately $234 billion if the services were reimbursed during 2011. In comparison, all payments made to LTSS providers totaled $192 billion over the same time period.[5]

Serving as a caregiver often places large amounts of stress on an individual, as many caregivers forego their own needs in order to provide needed supports to their loved ones. Similarly, many caregivers are asked to provide these services without any training or instruction.

Recommendation. NASUAD believes that Congress, CMS, and the states should collaborate to increase the availability of supports and services to informal caregivers. This should include testing innovations in Medicaid to reimburse supports to caregivers, such as training, technical assistance, and ongoing resources. The initiative should also examine opportunities to provide supports to caregivers for individuals who are likely to qualify for Medicaid, but who are not yet eligible. The efforts should include an evaluation to determine whether caregiver supports can reduce the overall reliance on publicly-funded health programs.

4 http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB07242015-Fast-Track.pdf
5 https://www.cbo.gov/publication/44363

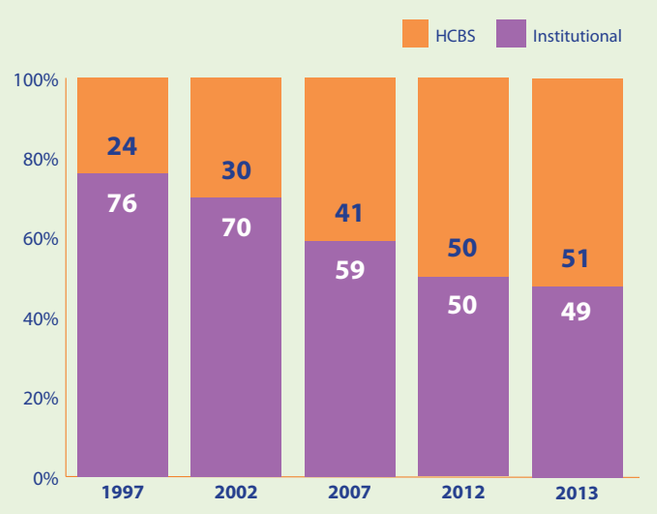
Home and Community-based Settings

Background. On January 16, 2014, the CMS released a Medicaid final rule establishing new standards for HCBS programs (CMS 2249-F/CMS 2296-F). In part, the final regulation defines the characteristics that a home and community-based setting must exhibit in order to receive Medicaid funds. The standards are rigorous and much of the implementation work has focused primarily on ensuring that all buildings demonstrate strict compliance, rather than ensuring that there are options to provide meaningful choice of residence based upon the needs and preferences of each individual.

The rule also requires that all states be compliant with this requirement by 2019. This deadline, while several years away, is likely to be very challenging for many states due to the significant changes to the entire HCBS system. The need to be in compliance with the regulation coupled with the fact that the rule does not allocate any additional funding to support this massive overhaul will highlight capacity and financial issues.

While the rule is based upon laudable goals of increasing the community integration for individuals who receive Medicaid-funded HCBS, the actual implementation of the rule has established a strict rigidity that risks undermining the ability to provide services on an individualized basis. It instead creates challenges to ensuring that the health and welfare of some individuals are appropriately addressed. Certain community-based settings are at risk of becoming excluded from Medicaid reimbursement, which may have the

Medicaid Spending on Long-Term Care Has Been Shifting Toward Community-Based Care



Source: Centers for Medicare & Medicaid Services

unintended consequence of reducing the choices of settings and services available to individuals receiving LTSS.

Recommendation. CMS should allow additional transition time beyond the current 2019 deadline. CMS should also refocus the subregulatory guidance and implementation activities to emphasize meaningful choices based upon the needs and preferences of individuals instead of assessing individual buildings against a set of rigid federal standards. Congress should allow states to use the Money Follows the Person program to support modifications to their HCBS programs in order to come into compliance with the rule.

HCBS Requirements for Person Centered Planning and Conflict of Interest

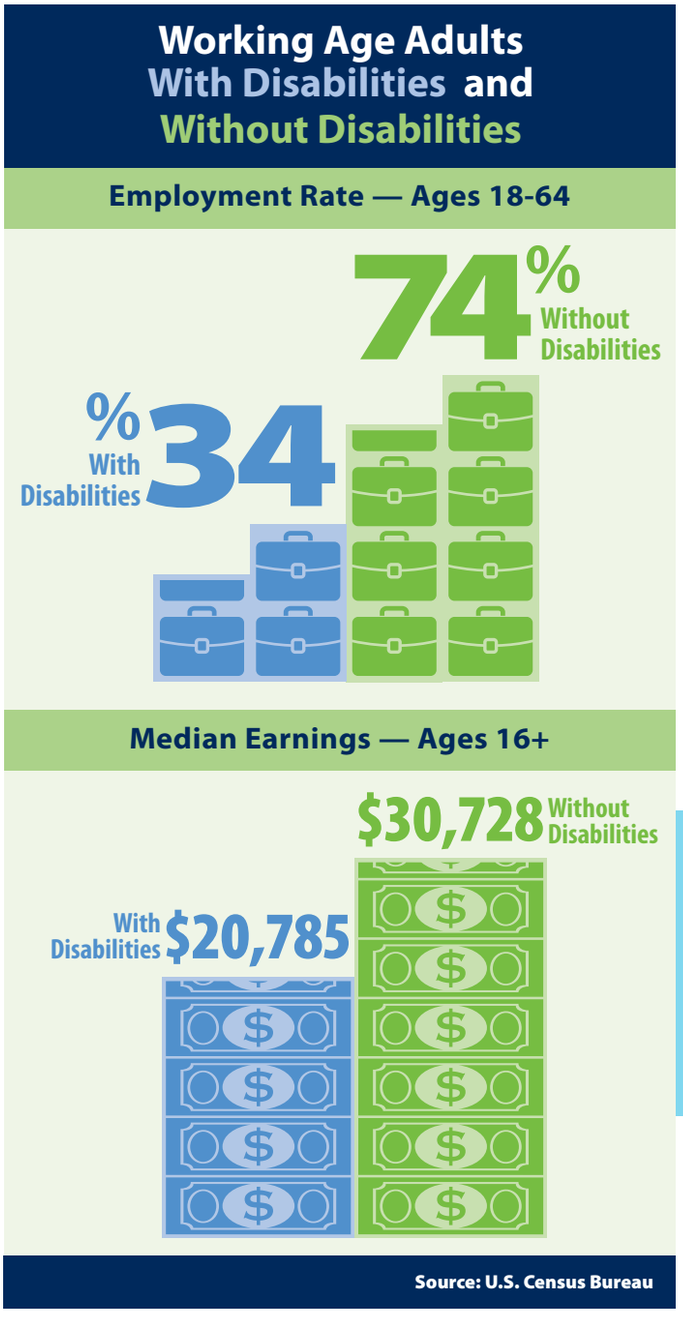
Background. In addition to the new standards on HCBS settings, the Medicaid HCBS final rule also includes provisions that establish guidelines for person-centered planning and mitigating conflict of interest in the program. These provisions became effective in March of 2014 and, unlike the settings requirement, do not have any transition period for states to come into compliance. Both provisions establish stringent new requirements that necessitate significant changes to State HCBS programs, but the conflict of interest provisions may be especially challenging as they prohibit entities from providing an individual with direct services if they also provide case management or, in some cases, do functional assessments. Many state systems previously had entities responsible for both of these functions due to a lack of alternative providers; the expertise needed to serve nuanced populations; or the specific knowledge of service provision that assessments require. Despite the major changes imposed by the regulation, and the effective date in 2014, CMS has not issued clear guidance on the expectations regarding these provisions. States are working to come into compliance, but have specific technical questions about how policies should be developed to ensure that providers and the HCBS system meet the regulations.

Recommendation. CMS should articulate a clear and consistent message about the person centered planning requirements as well as the conflict of interest provisions so that states can ensure compliance. In addition, CMS should develop a robust training and technical assistance program for States and stakeholders to ensure actual movement in the service delivery system.

Employment for Seniors and People with Disabilities

Background. As more individuals receive LTSS in the community, there is an increased need to provide opportunities for meaningful, integrated employment. Employment is a core component of community living, as it provides income that enables individuals to engage in activities that they choose and purchase items to personalize their home and life. Employment also offers socialization and the ability to make meaningful friendship and develop other relationships. In the past, CMS has collaborated with states through the Medicaid Infrastructure Grants and the Medicaid Buy-in programs to improve opportunities for employment. However, additional work is necessary to ensure that policies of the Social Security Administration, workforce development system, state vocational rehabilitation programs, and Medicaid are in alignment. Similarly, CMS and states should continue to collaborate regarding policy and programmatic innovations to support workers with disabilities.

Recommendation. Congress should enact programmatic improvements to Medicaid Buy-in programs. Notably,



the Buy-ins should be modified to allow individuals who worked while receiving HCBS to retire and retain their LTSS without impoverishing themselves. The Federal government, including ACL, CMS, and the Department of Labor, should reconvene employment focused activity groups, particularly as a component of the Money Follows the Person rebalancing demonstration and the HCBS settings regulation.

Expanding the Workforce

Background. The number of senior citizens and people with disabilities in our country continues to increase substantially, creating a strain on the availability of sufficient providers to meet their LTSS needs. By 2030, projections indicate that nearly 20% of the population will be over the age of 65.[6] This will inevitably exacerbate the challenges placed upon the network of LTSS providers.

Recommendation. CMS, ACL, and Congress should work to expand the availability of LTSS providers across the country. This may involve expanding the utilization of telemedicine for HCBS or funding research on innovative ways to provide HCBS with less human assistance. The Federal government should work with states to implement defined strategies and programs that leverage Workforce Innovation and Opportunity Act (WIOA) workforce centers to establish a pipeline between job seekers and LTSS providers. This should also include grants to states for professional development, as well as for evaluating and implementing ways to ensure that professionals are practicing at the top of their practice.

Medicare

Background. Enrollment in Medicare continues to grow in tandem with the overall aging of the population. Over a ten year period, Medicare enrollment increased by approximately 25 percent, from the 41 million individuals enrolled 2003 to 52 million enrollees in 2013. Simultaneously, Medicare services are evolving in conjunction with the changes occurring throughout the broader health care system, with emphasis on accountable care, value-based payments, and increased coordination of health and social supports. Additionally CMS has launched an initiative, called the Accountable Health Communities Model, to evaluate the impact of improving coordination between health care providers with social services.

Delivery changes have also included expanded managed care. Enrollment in Medicare Advantage plans more than doubled from 5.3 million enrollees in 2003 to 14.4 million individuals in 2013. This rate of growth significantly outpaced that of traditional Medicare, and has implications on the way that services are delivered, as well as the out-of-pocket costs for

enrollees. Through CMS's Financial Alignment Initiative, the federal government and states are collaborating to integrate care for dual eligibles—individuals who are enrolled in both Medicare and Medicaid. Under this program, dually-eligible beneficiaries receive coordinated care through either a capitated managed care plan or a fee-for-service model. States share in the savings that accrue to Medicare and Medicaid as a result of this approach, but must also invest significant time and resources. Similarly, the inclusion of Special Needs Plans for individuals in institutions or for dual eligible individuals will drive broader changes to health care delivery and will require increased collaboration with states.

Recommendation. CMS should continue to work with states to develop, test, and implement innovative programs to coordinate services and supports between Medicare, Medicaid, and other LTSS. CMS should focus on methods that promote and support state innovations and should provide states with the maximum amount of flexibility possible in order to effectuate change. CMS should also ensure that Medicare savings resulting from state investments in LTSS infrastructure are shared with state agencies.

Background. Medicare does not cover routine dental care, preventive dental services, or restorative dental procedures. Consequently, some estimates indicate that over two-thirds of older adults lack coverage to dental benefits.[7] Without coverage, individuals must either pay for dental services out-of-pocket, which can be quite costly, or go without care, which can lead to significant health problems. The Centers for Disease Control and Prevention note that diseases of the mouth and gums are common among older adults, especially for individuals who grew up in eras without fluoridated water or access to routine dental care. These diseases frequently increase in severity as individuals increase in age; however, the incidence and prevalence of oral health diseases varies widely across different states in the country.[8]

Recommendation. NASUAD supports the addition of oral health care services as a covered benefit under Medicare.

6 http://www.pewresearch.org/daily-number/baby-boomers-retire/
7 Oral Health America. *State Of Decay*. http://www.dentistryiq.com/content/dam/diq/online-articles/documents/2013/10/OHA_State_of_Decay_2013.PDF
8 http://www.cdc.gov/OralHealth/publications/factsheets/adult_oral_health/adult_older.htm

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