Area Agency on Aging 1-B

THE ADVOCATE

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FEDERAL FUNDING FOR SENIOR PROGRAMS AT RISK
Debt Ceiling Deal Includes a Look at Entitlements

Congress narrowly averted default on paying the nation's current obligations by passing compromised legislation that includes both immediate and future spending cuts in exchange for raising the national debt ceiling. The Budget Control Act of 2011 calls for discretionary spending caps spread over 10 years which will affect aging policy and funding in both the short and long-term. Senior advocates anticipate that all programs which make up the safety net for older Americans, including entitlement programs Social Security, Medicare and Medicaid will be scrutinized. The Act does not work to pay down the $14.3 trillion national debt, but slows the growth of the debt. Here is how the decisions will be made and how they may impact seniors and adults with disabilities:

Phase 1: To find $917 billion in savings over 10 years, Congress will reduce appropriations for domestic programs such as those funded through the Older Americans Act. Medicare, Medicaid and Social Security are exempt from cuts in this phase. For the first two years, the cuts must be divided evenly between security (including defense) and non-security programs. However after the second year, non-security programs may be subject to enormous cuts. For FY 2012, spending will be cut by $21 billion.

Phase 2: Congress will appoint a 12-member bipartisan committee which will be tasked with creating another package of savings, worth $1.2—$1.5 trillion, by November 23. Everything will be considered – cuts to discretionary programs, cuts to entitlements and increases in revenues. The committee will present a recommendation to Congress for a simple up or down vote, without amendments. If the committee does not include revenue increases, cuts to discretionary spending alone may be insufficient and significant cuts to Social Security, Medicare and Medicaid may be necessary.

Possible Phase 3 – If the committee cannot agree on Phase 2 measures or if Congress fails to act by December 23, $1.2 trillion in across-the-board cuts will be automatically triggered, starting Jan. 1, 2013. Social Security, Medicare and Medicaid are exempt from automatic cuts, but Medicare payments to providers may be included. Half of the automatic cuts must come from security and defense programs to prevent unfair routing of non-security programs.

The National Association of Area Agencies on Aging points out that "with the (spending) caps in place for 10 years, there is no immediate relief in sight from reduced or frozen funding levels that do not take into account population growth, human need or other factors that increase demand for programs and services."

Select programs that may face long-term funding cuts:

- Older Americans Act Programs:
  - Supportive Services
  - Nutrition Services
  - Vulnerable Elder Rights
  - Preventative Health
  - Training and Research
  - National Family Caregiver Support
- Community Living Assistance and Supports Program (CLASS)
- Aging and Disability Resource Centers
- Community Service Block Grants
- Low-Income Home Energy Assistance Program (LIHEAP)
- Social Services Block Grants
- HUD Section 202 – Supportive Housing for the Elderly Program

MICHIGAN HEADS TOWARD INTEGRATED CARE FOR INDIVIDUALS RECEIVING BOTH MEDICARE AND MEDICAID

Michigan's Department of Community Health is currently developing a plan to transform the way medical services are administered for the approximately 220,000 individuals who participate in ***both*** Medicare and Medicaid. Development of an integrated care system is one way states are being encouraged by the federal government to improve the quality of health care for its low-income residents, achieve administrative efficiencies and lower state-funded health care spending. The plan is expected to be complete by April 2012. One state official estimated publicly that the plan, if approved by the Centers for Medicare and Medicaid Services (CMS) could be implemented beginning in 2014. Projected savings from the change are included in the state's 2012 budget.

The proposed integrated care model covers both Medicare and Medicaid services and benefits, including inpatient and outpatient acute care, skilled nursing facility services, nursing home care, behavioral health services, hospice, home health care, durable medical equipment and prescription drugs. It will likely be administered by a single managed care organization. All dually-eligible Medicare/Medicaid individuals will be automatically moved into the new system with the choice to opt-out.

At a recent public forum in Southfield, consumers, health care providers and advocates met with officials to learn about the proposed model and to offer input on how it can best serve the unique needs of the "dual-eligible" population. Officials presented a list of proposed elements to the new model, but stressed that the final plan will consider the recommendations of all stakeholders, especially consumers themselves.

The following proposed program elements serve as a starting point for the plan:

- All core Medicare and Medicaid services, with the potential for additional social supports
- A comprehensive provider network across the continuum of services
- A single standardized assessment tool to identify participant needs
- A single care coordinator to assist in the development of person-centered plans
- Person-centered medical homes
- Family caregiver involvement
- Strong home and community-based long-term care options
- Plan performance metrics to evaluate effectiveness
- Quality management strategies and measurements not available in the current fee-for-service system
- Data sharing among providers across the continuum of care
- Automatic enrollment with ability to opt out
- Consumer protections, including grievance and appeal processes that meet the standards required by Medicare and Medicaid

Public forums are one of several ways officials are reaching out for stakeholder input. Consumers and advocates are strongly encouraged to learn more about the plan and send in comments and suggestions. For regular updates, go to the Michigan Community Health Department's website: http://www.michigan.gov/mdch or contact Ann Langford at AAA 1-B at (248) 262-1282 or alangford@aaa1b.com.

Mail written comments to:

Integrated Care Project, Medical Services Administration, 400 S. Pine, Lansing, MI 48909.

E-mail comments to: integratedcare@michigan.gov

The Area Agency on Aging 1-B believes that any new model should build upon the strengths of the aging network and ensures access to home-and-community based services. Currently AAA 1-B is engaged in a joint study with The Senior Alliance (AAA 1-C) and Valley Area Agency on Aging to examine the impact of integrated care on Michigan's consumers, health care providers and the aging network. Results of the study will be released in October.

REDUCING SENIOR HUNGER
THROUGH OLDER AMERICANS ACT NUTRITION PROGRAMS

In the United States, almost 1 million seniors go hungry because they cannot afford to buy food. Additionally, it is estimated that 50 percent of all diseases impacting older Americans are directly connected to lack of appropriate nutrition intake. These findings come from a report from the US Senate Subcommittee on Primary Health and Aging titled *Senior Hunger—The Human Toll and Budget Consequences*, which links the growing hunger crisis among seniors to the increased burden on the long-term care and health insurance systems.

The Older Americans Act (OAA) authorizes federal funding for nutrition services and these dollars are leveraged with state and local funding to provide meals for over 2 million individuals who cannot afford quality nutrition or are unable to shop or prepare their own meals. OAA nutrition programs serve those at a greater risk of nursing home placement—those who are isolated, lack support needed to assist with activities of daily living, are low-income and may suffer from chronic health conditions like diabetes.

As Congress examines Older Americans Act (OAA) programs in preparation for its reauthorization in 2012, members are increasingly demanding that federal programs prove their worth and demonstrate measurable outcomes for the dollars invested. According to *Senior Hunger*, the cost of a one-year supply of home-delivered meals is roughly equal to the cost of one day in a hospital. Hunger amoung seniors is not only a moral problem, it's an economic one as well and investments in nutrition services play an important role in slowing the growth of health care spending.

VALUE FOR THE MONEY: MICHIGAN'S MEALS-ON-WHEELS PROGRAM

The Area Agency on Agency 1-B (AAA 1-B) recently completed a study examining Michigan's Meals-on-Wheels programs and reports positive outcomes for Michigan seniors, families and taxpayers:

Meals-on-Wheels…

- **Feed the Malnourished**—The number of participants who eat fewer than two meals per day dropped 57%
- **Make Food Affordable**—Seven percent of participants went from being unable to afford food, to having enough money to buy food
- **Saves Lives**—Providers find a fallen participant, and potentially save their life, once per day on average.
- **Leverage Other Resources**—Providers leverage an additional $1.50 for every dollar of state or federal funds allocated
- **Save Seniors Money**—Joint liquid meal purchasing by Michigan Meals-on-Wheels providers saved almost $1 million on Ensure purchases
- **Create and Retain Jobs**—The average Meals-on-Wheels provider employs the equivalent of 27 full time employees
- **Uses Volunteers**—The average Meals-on-Wheels provider has 159 volunteers who contribute 4,235 hours valued at over $31,000 annually
- **Provide Comprehensive Assessments**—Participants receive an in-home assessment that would cost $265-$365 at market rates
- **Provide Exceptional Quality and Value**—Meals exceed quality standards at 33% to 42% less cost than private market home-delivered meal alternatives.

To read the complete study, click on Home Delivered Meals for the Elderly Program or contact Ann Langford at (248) 262-1282 or alangford@aaa1b.com.

CONSUMER ADVISORY TEAM GETS DOWN TO WORK: IMPROVING SERVICE AND ADVOCATING FOR CHANGE

For several years, a group of committed MI Choice participants have met regularly at AAA 1-B as the Consumer Advisory Team (CAT). The CAT team is the go-to group when agency planners want feedback on programs and procedures that impact its MI Choice and Care Management clients. Members regularly review the agency's quarterly service quality assessments and make recommendations for service improvements. They have also been instrumental in developing the new Self-Determination model where clients are able to hire their own caregivers.

Recently the team provided comment on the agency's plan to examine and restructure the roster of Direct Service Purchase providers. They agreed with the plan to strengthen the eligibility criteria for providers and suggested that providers be required to adhere to stringent quality-assurance principles.

Members are also invited to participate in work groups and receive training to enable them to use their experiences to help develop better programs. One member recently completed the Peer Mentor Master Trainer training in Lansing. She will soon train volunteers to mentor and assist new MI Choice participants. "I will use my skills to help other people," she told the team at a recent CAT meeting.

In July, two members attended a public forum to learn more about the state's work on developing an integrated care model for dually-eligible Medicare/Medicaid individuals. The CAT team plans on remaining involved with this project and offering their recommendations for improving the current system.

The CAT team also provides important advocacy help as well. Some members travel to legislative hearings and others have submitted written testimony. During the recent state budget deliberations, one longtime member shared with legislators how the MI Choice program allowed her to remain living at home instead of relying on more costly institutional care. "Because of being at home," she wrote, "I can participate in helping this state financially."

The CAT team is open to MI Choice participants who are dedicated to improving the quality of long-term care and being the voice of individuals who cannot advocate on their own behalf. Teleconferencing is available for members who choose to call-in to the meetings from home. Contact Barb Lavery, Special Projects Coordinator at (248) 262-9945 or blavery@aaa1b.com for more information about joining the CAT team.

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If you are willing and able to receive
The Advocate by e-mail, please let us know!

Area Agency on Aging 1-B
Advocacy • Action • Answers on Aging

The Area Agency on Aging 1-B (AAA 1-B) is a nonprofit agency serving the needs of older adults in Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw counties. For more information about the Senior Advocacy Network SAN) or to receive future editions of The Advocate, contact Ann Langford at (248) 262-1282 or alangford@aaa1b.com.