

NATIONAL  
ASSOCIATION  
OF STATE UNITS  
ON AGING



1225 I Street, N.W.  
Suite 725  
Washington, D.C. 20005  
(202) 898-2578

NASUA

---

STATEMENT OF

Richard Browdie

Secretary, Pennsylvania Department of Aging

ON BEHALF OF

The National Association of State Units on Aging

PRESENTED TO

The Senate Special Committee on Aging

JULY 18, 2001

STATES UNITED FOR ACTION IN AGING

Good morning Mr. Chairman and members of the Committee, I am Richard Browdie, Secretary of the Pennsylvania Department of Aging and a member of the Board of Directors of the National Association of State Units on Aging (NASUA). The Association applauds the Committee for focusing congressional attention on the issue of long term care in America. The development of comprehensive home and community based systems of services for older persons and adults with disabilities has long been a policy and program objective of the Association. We are hopeful that this series of hearings you have undertaken will help move this critical issue in the lives of millions of older persons to the center of the national policy agenda.

States have moved aggressively in the last two decades to redesign state and local delivery systems and funding structures to respond to the chronic, long term care needs of older Americans and persons with disabilities, but NASUA believes that further progress is hindered by the absence of a comprehensive federal long term care policy for financing needed services.

As the public agencies charged by the Older Americans Act with determining the needs and preferences of the nation's older citizens, state units on aging, are acutely aware of the overriding fears expressed by older persons and their families regarding the risks associated with a need for long term care in this country. Once expressed somewhat vaguely as a fear of "losing independence," the concerns of increasingly knowledgeable older consumers have become focused on the realities of long term care in

America: likely separation from home and familiar persons, the inevitability of poverty, and the possibility of inadequate services or poor quality of care.

The inadequacies of long term care in America are built into the structure of the long term care system, whose foundation was laid in 1965 when Medicare and Medicaid were created as social insurance for elderly and poor people. Though obviously critically important to the lives of millions of older persons, these programs were drafted without extensive knowledge or experience with long term care needs of long-lived Americans. At that time, long term care services were viewed as simply an extension of medical care; we now know that medical services and long term care services are interrelated, but neither is simply an extension of the other. Each is associated with a distinct body of knowledge.

Medicare is a universal insurance program for the elderly (with substantial participation in costs by the beneficiaries), which does not pay for the major catastrophic cost of the elderly - long term care. Over its history, the division between acute and chronic care in Medicare has become more rigid. Because of its acute care focus, Medicare reinforces the medical model of care: physician dominated, nurse provided, in institutional or clinical settings. Medicaid, originally designed to follow suit, has been trying to change its approach, but as costs for institutional care grow, states are able to move only slowly.

Long term disability is a social problem, a functional problem, and a family problem. Medical and institutional care ought to be a support to a long term care system, not be the driving force. Regrettably, the Medicare system has

not addressed this issue but has instituted procedures which shift the problems and the costs from the federal financed health care system into the state and privately financed long term care support system.

Today, one quarter of the nation's elders are likely to experience multiple disabling conditions which render them dependent on others for long periods of time. Yet our nation's health insurance programs do not adequately assist older persons and their families to cope with this reality.

The cost of long term care is inescapable. The fastest growing segment of the population is the very oldest. Yet, what we purchase at enormous public and private cost is a patchwork of care which too often fails to meet the expectations of payer, provider and, most importantly, consumer.

The predominant and preferred focus of long term support is in the home. Yet government programs are structured to give most care in the most intensive and restrictive manner, in institutional settings. As you know, the bias toward institutional care in federal financing has required states to request waivers to divert some of these resources toward the preferred long term care setting - the home.

State systems of long term care were necessarily built on Medicaid in order to capture federal financial participation. Medicaid has become the nation's long term care insurance program. But the Medicaid long term care system exacts a high price for its benefits: it requires people to be or become poor to gain access; it requires individuals to separate from family members and relocate to institutions; it is organized through the medical care provider

systems; and it is not uniform in its benefits. While states have made significant progress in recent years in overcoming these obstacles through use of the Medicaid Home and Community Based Waiver authority, the predominate<sup>ANT</sup> bias in Medicaid remains institutional not home or community, medical not social. The Older Americans Act is the only piece of federal legislation that promotes comprehensive, coordinated systems of community care. But it falls woefully short in terms of financing and cannot meet all the needs of older people and their caregivers.

Despite these handicaps, states have moved aggressively in the last two decades to organize and rationalize long term care systems, by coordinating, financing and designing systems which more closely meet the needs and preferences of their older citizens.

States have taken deliberate and aggressive action to:

1. Reorganize state functions and coordinate state level efforts;
2. Develop an array of funding sources including Medicaid state plan services, the Medicaid Home and Community Based Waivers and the 1115 Waivers, state and local general revenues, Social Services Block Grant and Older Americans Act;
3. Constrain the growth in nursing home utilization and divert savings to community services;

4. Provide substantial state/local funds to develop more comprehensive and systemic approaches to serve persons who do not meet the financial eligibility of Medicaid and are unable to pay privately for needed services;
5. Develop a variety of services (in-home, adult day care, assisted living, etc.) designed to meet the diverse needs of older persons;
6. Reorganize local delivery systems to provide a standard assessment of service needs for both institutional and community based long term care and in some states single points of entry;
7. Provide case managers to guide access to services and monitor individual service needs over time;
8. Provide consumers with choice of services and providers suited to their individual needs and preferences;
9. Develop equitable cost-sharing policies to extend services to an even broader population; and
10. Pursue standards of quality which monitors the achievement of the outcomes sought by the consumer: comfort, security, and dignity.

These efforts have resulted in a vastly improved array of service options, increased involvement of family and community in service systems, and permitted a more judicious management of resources--but only for a small

segment of the population requiring care. Current structuring and financing of long term care is not adequate to meet the current need, much less the future growth in the long term care population.

The solution is a national long term care policy which provides a predictable, uniform long term care benefit which older people, their families, state and local governments, private insurers and providers can plan on. Knowing what federal policy is committed to provide will enable these other actors in the system to anticipate and plan for the additional resources and services, which will be required.

NASUA believes that the system older persons deserve will be most equitable and responsive to their individual needs if it is federally financed, state-administered, locally managed, and consumer-directed.

We are very encouraged by a number of recent federal policy and program initiatives which are providing states with new resources and flexibility to reform the current long term care system. First, the field of aging worked with Congress and the Administration to authorize and fund the National Family Caregiver Support Program. As you know, the majority of people with chronic disabling conditions rely on friends or family members for the primary source of assistance. This new program supports caregivers in their stressful roles with an array of services and supports that may delay or prevent the need for institutionalization. We look forward to working with you and the Administration to strengthen and expand the reach of this new program.

Second, we applaud Congress and the Administration in providing states with new opportunities, flexibility and resources to respond to the Olmstead decision. A prime example is the Systems Change Grants for Community Living which will allow enhanced state creativity and innovation in reforming their long term care systems. States are in the process of developing proposals to the Centers for Medicare and Medicaid Services for resources to assist in the development of long term care systems that offer consumer choice and emphasize home and community based alternatives to institutional care. We are hopeful that xxx Congress will continue to support this new federal initiative which will provide states with resources to build on the state initiatives of the past two decades outlined above.

Third, NASUA also applauds and supports the efforts of DHHS Secretary Thompson in streamlining and expediting the Medicaid waiver process for states and providing leadership on the new National Family Caregiver Support Program and the Systems Change Grants. We were greatly encouraged by his testimony before this Committee last month that underscored the Administration's support for state innovations in long term care.

Having said this, we do continue to believe that a more fundamental restructuring of long term care policy is needed and warranted. Xxx NASUA looks forward to working with this Committee to clarify existing federal policies and support additional legislation, including Medicaid reform, to enable states to expand home and community based long term

care programs for persons with disabilities, regardless of age; and to promote federal policies that foster consumer dignity and respect through consumer choice and control.

*The National Association of State Units on Aging was founded in 1964, as a national non-profit membership organization comprised of the 57 state and territorial government agencies on aging. The mission of the Association is to advance social, health, and economic policies responsive to the needs of a diverse aging population and to enhance the capacity of its membership to promote the rights, dignity and independence of, and expand opportunities and resources for, current and future generations of older persons, adults with disabilities and their families. NASUA is the articulating force at the national level through which the state agencies on aging join together to promote social policy in the public and private sectors responsive to the challenges and opportunities of an aging America.*