



Snohomish County
Council on Aging

2009-2010
LEGISLATIVE AGENDA



ACKNOWLEDGEMENTS

We would like to acknowledge and thank members of the Council on Aging Legislative Committee who actively participated in the development and review of the issues.

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In addition, we appreciate the willingness of staff from a variety of agencies and programs to answer questions and provide updated information on their services.

We also would like to acknowledge and thank the LTC & A staff for their work on the 2009-2010 Legislative Agenda: Mike Manley, Administrator; Jerry Fireman, Supervisor; Stefanie Novacek, Program Manager; John Peterson, Program Manager; Susie Starrfield, Program Manager; Daniel VanArsdale, Long Term Care & Aging Intern; and Susan Foster-Breton, Senior Secretary.

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SNOHOMISH COUNTY COUNCIL ON AGING
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INTRODUCTION

The concerns of older people are broad. They worry about finding and affording quality health care. As they age, older adults want to maintain their independence and avoid outliving their retirement incomes. They wonder about the financial stability of programs like Medicare, Medicaid, and Social Security.

Older Americans also question what is being done to prepare for an aging society that will affect not only them but future generations. Snohomish County seniors express concerns the transportation system does not meet the needs of frail elders and individuals with disabilities; affordable housing is rapidly disappearing; and basic, affordable dental care is increasingly difficult to obtain.

Older Americans are not only wondering about these issues but advocating at the federal, state and local levels for innovative solutions and increased funding. Under the Older Americans Act, advocacy is a formal responsibility of the Area Agency on Aging. The Older Americans Act calls for the Area Agency on Aging to "serve as the advocate and focal point for older individuals within the community" (US Code, Title 42, Subchapter III, Part A, Section 3026(a)(6)(B)).

The Snohomish County Council on Aging, a citizen's advisory group, works to mobilize and empower older adults to become engaged in the political process. These legislative positions will guide our advocacy efforts throughout 2009-2010.

How to use this document

Each section of this document addresses a single issue, or a group of issues relating to a single subject. For each issue, a legislative goal is stated. For instance under "Medicaid", the first goal is "retain Medicaid as an entitlement," and then "Advocacy Priorities" presents arguments as to why and how this should be accomplished. "Background" information follows so the reader can understand how public and private services presently address the issue and where shortfalls lie.

The reader may then use this book to identify legislative issues of importance to Snohomish seniors; use the Priority statements to identify specific areas of legislative action desired; and use the Background information to gain an understanding of programs already in place. This should help in advocating for Snohomish seniors with the County Council, the State Legislature and Congress.

SUMMARY OF LEGISLATIVE GOALS BY TOPIC

Family Caregivers

Increase support to *unpaid family caregivers* enabling them to provide better quality and sustained service to a loved one.

Housing

Support, empower and mobilize families, senior citizens and people with disabilities to advocate for safe, affordable housing and residential options by narrowing the gap between housing needs and availability of affordable housing, thus allowing senior citizens and individuals with disabilities to age in place with dignity.

Long Term Care

Expand and sustain a continuum of long term care options that gives consumers choices, provides adequate and equitable funding and protects consumers' rights and dignity.

Long-Term Care Ombudsman Program

Improve the quality of life and care for people who live in licensed long-term care facilities such as nursing homes, assisted living and adult family homes and protect and promote the rights of these individuals.

Medicaid

Retain Medicaid as an entitlement.

Maintain funding for the Medicaid program as it currently exists.

Allow individuals applying for or renewing their Medicaid benefits to self-declare citizenship.

Increase the Medicaid income-eligibility level for adults who are elderly or disabled.

Medicare

Ensure the long-term financial stability of the Medicare program while meeting the needs of an aging population.

Standardize benefits and cost-sharing across Medicare Advantage Plans and Part D prescription drug plans.

Improve Medicare reimbursement rates and regulations surrounding the provision of mental health services.

Mental Health

Increase funding for preventative care and for expansion of services currently available to seniors.

Guarantee reasonable access to mental health services to all seniors, including those not on Medicaid.

Improve Medicare reimbursement rates and regulations surrounding the provision of mental health services.

Older Americans Act

Significantly increase Older Americans Act funding to respond to the growing population of older adults and the effects of inflation.

Planning for an Aging Society

Improve the well-being of older adults by supporting policies and programs that assist people as they age.

Social Security

Ensure Social Security's long-term solvency.

Transportation

Ensure a safe, accessible, unified transportation system is available throughout the county, meeting the needs of elderly citizens and people with disabilities.

FAMILY CAREGIVERS

Goal

Increase support to *unpaid family caregivers* enabling them to provide better quality and sustained service to a loved one

Advocacy Priorities

Based on funding in each of the last two legislative sessions, continue the increase in funding to the Family Caregiver Programs (that includes Respite) to:

- Enable Aging and Disabilities Services Administration (ADSA) to implement an evidence-based assessment system to better analyze and target interventions from the current Family Caregiver Support Program core services, and
- Enable Area Agencies on Aging to provide a full set of services appropriate for our local community.

Background

In Washington State an estimated 600,000 unpaid family caregivers provide long-term care support for people with disabilities; a significant portion of which would otherwise be paid for by the State. Their ability to continue care may be jeopardized due to the risks for both physical and mental illnesses from stress, self-neglect and exhaustion incurred by their caregiving role. Research has identified: high incidence of clinical depression (up to six times higher than normal for a caregiving spouse) from family caregiving; 63% higher mortality rate than non-caregivers; and the chronic stress family caregivers develop while caring for persons with Alzheimer's disease may shorten caregivers' lives by as much as 4-10 years.

Evidence has also shown the right supports delivered at the right time can relieve caregiver stress and allow family caregivers to continue to provide cost-effective care; *yet just over one-half percent of ADSA's long term care budget is devoted to such supports*. Evidence-based family caregiver research has demonstrated a combination of targeted interventions delayed placing a loved-one in a nursing home by approximately 18 months, compared to caregivers who did not receive interventions.

In recognition of the value of supporting family caregivers and improving the ability to target supports effectively, additional funding was provided in the last two legislative sessions to expand the number of families served, add depth to the respite program, and begin automation of an improved assessment and service planning tool.

HOUSING

Goal

Support, empower and mobilize families, senior citizens and people with disabilities to advocate for safe, affordable housing and residential options by narrowing the gap between housing needs and the availability of affordable housing, thus allowing senior citizens and people with disabilities to age in place with dignity.

Advocacy Priorities

Affordable housing for residents of all income ranges, ages, and mental and physical abilities is an essential foundation of a healthy, vibrant and diverse community.

Background

A rapidly growing elderly population that prefers to age in place presents a challenge to service providers and policy makers as they attempt to provide affordable and safe housing that will help the elderly maintain their independence and their dignity. The root of this challenge is that many elderly and persons with disabilities have incomes that are both limited and fixed. As demand has pushed housing and rent prices higher, seniors as well as lower income and fixed income people have increasingly sought affordable as well as subsidized housing.

An expanding and aging senior population requires an array of housing options be available to meet changing and diverse needs. The traditional focus of private senior housing providers has been housing and not convenience of neighborhood services. Elderly and non-elderly persons with disabilities also face these same problems, oftentimes due to either a newly acquired physical disability or a protracted illness. Stairs, windows, countertops, sinks and distances from other services create challenges for older adults and individuals with disabilities.

The provision of supportive services and affordable or subsidized housing allows older individuals the ability to age in place and prevents a premature move to a more restrictive setting. The U.S. Department of Housing and Urban Development (HUD) is beginning to recognize and support this concept. Local efforts are in place to help seniors “age in place” while enjoying the freedom and self-sufficiency to walk to the services they need. (For more information, please see Appendix).

LONG TERM CARE

Goal

Expand and sustain a continuum of long term care options that gives consumers choices, provides adequate and equitable funding, and protects consumers' rights and dignity.

Advocacy Priorities

- Provide consumers with choices that allow them to receive long term care services in the least restrictive setting. Offered services should include: In-home assistance, community services, a full range of supportive housing options, nursing facility care, and rehabilitative services.
- Increase reimbursement for persons under the Medicaid program who are living in assisted living facilities and adult family homes.
- Compensate contracted service agencies to cover the full cost of services provided. Pay long term care workers a truly livable wage.
- Ensure residents living in long term care facilities have access to Long Term Care (LTC) Ombudsman in order to protect and exercise their rights.

Background

Long term care is a blanket term for a wide range of services designed to meet medical, social, and personal needs in a variety of settings and locations. Such care is for individuals of any age.

Although most long term care is provided by families and friends on an unpaid basis, there is a continuing need for paid long term care in facilities such as nursing homes, adult family homes, and assisted living facilities. Because people prefer living in their own homes rather than placement in a long term care facility, there must be sufficient in-home and community residential services. For those persons whose health condition or disability requires 24-hour-a-day skilled nursing care, it is necessary to maintain an adequate supply of nursing facilities. Those facilities should be viewed as the last resort of residential choices.

Funding

The State appropriates general funds and federal Medicaid funds to purchase long term care services for the elderly and individuals with disabilities. The reimbursement to contracted agencies is intended to cover employee wages and fringe benefits, administrative costs and all other costs of doing business. Costs however continue to increase, while financial support from state and federal funds does not keep pace. In Washington State, the Senior Citizens Services Act (SCSA) is the primary source of state funding to develop, expand or maintain services that help older people remain in their homes. Between 1998 and 2007, SCSA funding increased by only 2% while the 60+age population grew by 24.5%. During this same time period, the Seattle Consumer Price Index grew 25.6%.

To create a stable, well-trained work force which will enable older persons to age in place, there must be significant increases in wages for home care workers, home health aides and certified nursing assistants. These individuals need and deserve a livable wage. Agencies providing home and community-based long term care services need increased reimbursement. Without these increases, there will be a decline in the state's ability to provide services that help the elderly and individuals with disabilities avoid or postpone the need for more expensive nursing home care.

Consumer Rights

From its inception in 1972, the Long-Term Care Ombudsman Program has used limited paid staff and relied heavily on volunteers to work with residents, families, friends, operators and facilities staff members to meet the needs and concerns of individuals living in nursing homes, assisted living facilities, and adult family homes. In Snohomish County, the Adult Family Home Initiative has enabled this program to dedicate a full time staff person to promote resident access to an Ombudsman. Under the Initiative, adult family homes visited by an Ombudsman have increased from 16% to 35%.

Continuation of the Initiative would allow outreach to continue. (For more information on the Long Term Care Ombudsman Program, see that section.)

LONG-TERM CARE OMBUDSMAN PROGRAM

Goal

Improve the quality of life and care for people who live in licensed long-term care facilities such as nursing homes, assisted living and adult family homes and to protect and promote the rights of these individuals.

Advocacy Priorities

Sustain the Long-Term Care (LTC) Ombudsman Adult Family Home (AFH) Initiative funding which will continue to provide residents with resources, supports and access to an Ombudsman on a regular basis

Background

The Long-Term Care Ombudsman Program was initiated by former President Nixon through his 1971 Eight Point Initiative to improve the quality of care in America's nursing homes and respond to complaints submitted to the White House and the Department of Health, Education and Welfare regarding abuse and neglect of nursing home residents. In 1987 amendments to the Older Americans Act considerably strengthened the Ombudsman Program and elevated the Nursing Home Ombudsman Program to a statutory level. The statute and subsequent regulations required all state agencies to establish an Ombudsman Program.

The Ombudsman Program works with residents, families, friends, operators and facility staff members to meet the needs and concerns of individuals living in nursing homes, assisted living facilities and adult family homes. Using limited paid staff and relying heavily on volunteers, ombudsmen are resident-centered. The program provides public education to promote a better understanding about the use of long-term care facilities. It also helps residents, family, staff and operators of facilities establish a resident or family council.

There are many reasons residents and their families need an Ombudsman:

- Many frail and vulnerable residents cannot speak up for their needs and desires
- Some residents are alone and have no close relatives or regular visitors
- Long-distance caregivers appreciate knowing someone is looking out for their loved ones
- Residents are intimidated by the idea of appearing, in any way, to criticize a facility
- Most residents do not know they have rights or what their rights are in a facility

In Snohomish County, the Adult Family Home Initiative has enabled the Ombudsman Program to dedicate a full time staff person to promote visitation and increased resident access to an Ombudsman. Under the Initiative, adult family homes visited by an Ombudsman have increased from 16% to 35% and continuation of the Initiative would allow outreach to continue.

MEDICAID

Goal

Retain Medicaid as an entitlement.

Advocacy Priorities

Guarantee a federally protected and enforceable right to adequate health care benefits to any individual who meets the Medicaid financial and other eligibility criteria.

Background

Medicaid is the means-tested, state-administered health care program for people with low income. It is funded by matching federal and state contributions but its specific financial eligibility and benefit decisions are largely a matter of state policy.

Medicaid is structured as an entitlement program, meaning states have a duty to provide assistance to persons who are eligible under the law. Individuals must meet financial requirements and belong to certain groups considered “categorically eligible” for the program i.e. children, parents of dependent children, pregnant women, people with disabilities, and the elderly.

Medicaid should be retained as an entitlement. An individual meeting the Medicaid eligibility requirements should be able to apply at any time during the year without fearing funds may be depleted or a waiting list started.

Goal

Maintain funding for the Medicaid program as it currently exists.

Advocacy Priorities

Maintain the access of low-income residents to primary and specialty care, prescription drugs, long term care, mental health, substance abuse treatment and prenatal care.

Background

One in five Americans relies on Medicaid for health care coverage. During economic downturns, enrollment in Medicaid traditionally soars as individuals lose jobs and incomes fall. Cutting Medicaid harms the state’s most vulnerable residents: children, pregnant women, and elderly and disabled individuals with very low incomes. A number of studies documented uninsured Americans who delay or forego needed care may develop more costly medical problems or even die.

In addition, cutting Medicaid causes states to lose federal funding. The federal government, using a formula, matches state Medicaid spending on a percentage basis. According to Families USA (a national health care advocacy organization) “for every dollar a state cuts from its Medicaid program, it saves only 24 to 50 cents” (Families USA July 2008, 2). Medicaid also plays a role in stimulating state business activity and state economies through a multiplier effect. Not only does the state purchase Medicaid services from businesses but the employees of those businesses have salaries to spend. Medicaid cuts can actually reduce business activity, jobs and wages during an economic downturn.

In order to maintain access to health care, Medicaid must avoid cutting reimbursement rates to providers and increase rates if possible. A medical coupon is worthless if providers refuse to accept it.

Goal

Allow individuals applying for or renewing their Medicaid benefits to self-declare citizenship.

Advocacy Priorities

Simplify the Medicaid enrollment and renewal process so low-income Americans can receive the benefits they are entitled to.

Background

The Federal Deficit Reduction Act (DRA) of 2005 requires states to document the citizenship and identity of all applicants and recipients of Medicaid. This means individuals applying for Medicaid will need to prove citizenship by showing documents such as a U.S. passport or an original U.S. birth certificate, before becoming eligible for Medicaid. Prior to this requirement, applicants were allowed to self-declare citizenship, a practice proven effective in improving access to health care services (with very little fraudulent activity identified).

The Kaiser Commission on Medicaid and the Uninsured determined that nationally, the citizenship documentation requirements have delayed needed medical services and most state Medicaid directors cited them “as a factor in the 2007 decline in Medicaid enrollment, the first drop in a nearly a decade” (Kaiser Family Foundation 2007). More than likely, these individuals will remain uninsured and not receive the care they need. Care will be sought at local emergency rooms, overwhelming local communities and providers trying to meet the need.

Beginning November 2008, the Washington State Medicaid Program estimates approximately 1,500 people will be denied Medicaid coverage each month because they cannot immediately prove their citizenship. Although 80 percent will eventually find the necessary documents, they may go for months without medical coverage. Since the citizenship requirement became effective on July 1, 2006, the Department of Social and Health Services (DSHS) unit of 27 workers verifying citizenship of 500,000 people found only one person receiving Medicaid who was not a U.S. citizen (Turner 2009).

Goal

Increase the Medicaid income-eligibility level for adults who are elderly or disabled.

Advocacy Priorities

- Ensure the Washington State Legislature appropriates sufficient funds to raise the CNIL to 80 percent of the federal poverty level in 2009 and to 100% in subsequent biennia.
- Increase the MNIL in parity with increases to the CNIL.

Background

In Washington (unlike many other states) the Medicaid income-eligibility level for elderly or disabled adults is set *far below* the federal poverty level (FPL) (Greenfield 2008). The FPL for one individual is currently \$867 a month; the Medicaid income-eligibility level for one adult is currently \$637 a month – less than 75% of the FPL. (A higher level applies for nursing home and other institutional care). As a result, thousands of disabled or low income Washington residents go without timely and appropriate medical care; receiving care only when their deteriorating health lands them in emergency rooms or hospitals.

In 2008, the Washington State Legislature took a small positive step by adopting (and the Governor's signing) legislation increasing the "categorically needy income level" (CNIL) to 80% of the federal poverty level. The increase will be in effect in July of 2009 if sufficient funds are appropriated.

The medically needy income level (MNIL) also needs to be increased to maintain parity with the CNIL. When someone is eligible for Medicaid in all other respects, but has too much income, he or she may qualify for benefits during a three or six month period by "spending down" either three or six months' worth of "excess income." "Excess income" here means income in excess of the MNIL.

If the CNIL were increased to the federal poverty level and the MNIL remained static, individuals with excess income would continue to have a spend-down requirement based on the lower MNIL. Allowing the MNIL to drop below the CNIL would produce irrational and unjust results.

MEDICARE

Goal

Ensure the long-term financial stability of the Medicare program while meeting the needs of an aging population.

Advocacy Priorities

Identify and enact financing solutions that are equitable, broadly based, and affordable to all individuals.

Background

In 2007, the Medicare program covered 44.1 million people, spent \$432 billion and represented 16 percent of all federal spending (Centers for Medicare & Medicaid Services 2008 and Kaiser Family Foundation 2008). In 2006, the most recent year available, Medicare spending accounted for 19 percent of national health expenditures. Nationally, the Medicare program pays for about one-third of all hospital stays.

From 2000 to 2030 the number of people on Medicare is projected to rise from 40 million to 78 million. The Congressional Budget Office predicts net federal spending on Medicare will grow from \$331 billion in 2006 to \$524 billion in 2011. The 2008 Medicare Trustees Report estimates the Hospital Insurance Trust Fund that pays for Part A services will be insolvent by the year 2018. The Medicare Program and our society must collectively and creatively face the challenge of financing care for an aging population with a declining ratio of workers to beneficiaries.

Goal

Standardize benefits and cost-sharing across Medicare Advantage Plans and Part D prescription drug plans.

Advocacy Priorities

Make it easier for consumers to understand and compare their Medicare choices across plans.

Background

Medicare has four parts:

- Part A (Hospital Insurance) pays for inpatient care in hospitals, skilled nursing facilities, hospice care and some home health care
- Part B (Medical Insurance) covers doctors' services and outpatient care and some home health
- Part C (Medicare Advantage) offers a choice of private health plans as an alternative to the traditional fee-for-service Medicare program and
- Part D covers prescription drugs.

In recent years Medicare Advantage (MA) choices have expanded to include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, medical savings accounts (MSAs) and special needs plans (SNPs). Part D Prescription Drug Plans may be included as part of MA Plans or may be stand alone plans; each with a different formulary of covered drugs.

“In 2006, the typical Medicare beneficiary had approximately twelve MA Plans to choose from; five percent of the beneficiaries had 40 or more plan choices” (O’Brien and Hoadley April 2008, 2). In Snohomish County, people with Medicare could choose from 48 stand alone Prescription Drug Plans and 66 Medicare Advantage Plans in 2009.

Each Medicare beneficiary needs to carefully consider whether a particular Medicare Advantage Plan, Prescription Drug Plan or Original Medicare will best meet his or her health care needs. Comparing options however is not an easy task as “the proliferation of private plans and dimensions along which they differ has made it increasingly difficult for beneficiaries to become informed about, understand, and compare the available alternatives” (O’Brien and Hoadley April 2008, 2). It is particularly difficult to evaluate and compare out-of-pocket costs.

In 1992 federal legislation required private insurers offering Medigap policies (insurance designed to fill the gaps in traditional Medicare coverage) to standardize benefits according to twelve different policy types. A precedent was set for standardizing benefits in order to help consumers understand and evaluate their Medicare options.

Goal

Improve Medicare reimbursement rates and regulations surrounding the provision of mental health services.

Advocacy Priorities

People with Medicare as their primary form of insurance should be able to access mental health services.

Background

In July 2008 Congress passed legislation providing for mental health parity in Medicare. Previously, Medicare covered 80 percent of the approved amount for outpatient physical health services and only 50 percent for outpatient mental health services. Over several years the legislation will end this inequity by phasing in higher payment levels for mental health services until Medicare pays 80 percent of the approved amount for both outpatient physical and mental health services.

Although this change represents a significant improvement, the 44 million people who rely on Medicare as their primary form of health insurance continue to have difficulty accessing mental health services. Low Medicare reimbursement rates and burdensome regulations relating to mental health services continue to discourage mental health providers from accepting Medicare as payment. Medicare requires outpatient mental health services to be delivered by staff with Masters Degrees but does not reimburse community mental health agencies at rates high enough to enable them to hire individuals with these qualifications. The program also requires extensive documentation of the services delivered. In Snohomish County few mental health providers accept Medicare.

The shortage of trained personnel represents another barrier to receiving appropriate treatment. In Snohomish County community mental health providers report difficulty in hiring geriatric mental health specialists. The American Geriatrics Society documented the national shortage of geriatricians and the even greater shortage of geriatric psychiatrists. By 2030 there will be only one geriatrician for every 4,254 Americans 75 years and older and only one geriatric psychiatrist for every 20,195 Americans 75 and older.

MENTAL HEALTH

Goal

Increase funding for preventative care, and for expansion of services currently available to seniors.

Advocacy Priorities

- Enact the 1/10th of one percent sales tax initiative, and dedicate a portion of the revenue to geriatric mental health services.
- Build on successful mental health programs already existing in Snohomish County targeting older adults such as Geriatric Depression Screening, Senior Peer Counseling, and Day Services for Mentally Ill clients attending adult day health programs.
- Advocate for more funds to expand Hope Options for seniors who have mental health issues and are in housing crisis.

Background

Mental health problems are not a normal part of aging. Twenty percent of Americans have a diagnosable mental disorder during any given year. Untreated mental health disorders in older adults can lead to diminished functioning and alcohol abuse; older adults have the highest suicide rate in the country. In addition, only half of older adults who discuss specific mental health problems with a physician receive any treatment. Mental health problems can appear late in life due to a stroke, dementia, cancer, arthritis and some medications.

In Snohomish County there are 90,000 seniors and approximately 18,000 of them will experience a mental health disorder; yet only one percent of those seniors will access mental health services. Research shows untreated mental health disorders can increase the likelihood of severe illnesses, requiring expensive institutionalized care. Early identification and treatment of mental health needs of older adults in the community will not only help them maintain their independence and dignity, it will also decrease the number of seniors needing long-term, institutionalized care.

Goal

Guarantee reasonable access to mental health services to all seniors, including those not on Medicaid.

Advocacy Priorities

- Provide training for mental health care managers in order to assist adult family home providers with residents who suffer from a mental illness.
- Promote collaborative care programs so trained care managers work with the elder persons' regular doctor to better treat depression or other mental disorders.

Background

The public mental health community outpatient system is intended to serve individuals who meet the medical standard of need and have insufficient resources to receive treatment outside the public system. Older persons whose income and/or assets are above the threshold for Medicaid eligibility cannot obtain service from the publicly funded system. Older persons whose mental health problems appear late in life and have no prior history of severe mental illness, fail to meet the "access to care standards" required for persons seeking publicly funded mental health services.

Goal

Improve Medicare reimbursement rates and regulations surrounding the provision of mental health services.

Advocacy Priorities

People with Medicare as their primary form of insurance should be able to access mental health services.

Background

In July 2008, Congress passed legislation providing for mental health parity in Medicare. Previously, Medicare covered 80 percent of the approved amount for outpatient physical health services and only 50 percent for outpatient mental health services. Over a several year period legislation will end the inequity by phasing in higher payment levels for mental health services until Medicare pays 80 percent of the approved amount for both outpatient physical and mental health services.

Although this change represents a significant improvement, the 44 million people who rely on Medicare as their primary form of health insurance continue to have difficulty accessing mental health services. Low Medicare reimbursement rates and burdensome regulations relating to mental health services continue to discourage mental health providers from accepting Medicare as payment. Medicare requires outpatient mental health services be delivered by staff with Masters Degrees but does not reimburse community mental health agencies at rates high enough to enable them to hire individuals with these qualifications. The program also requires extensive documentation of the services delivered. In Snohomish County, few mental health providers accept Medicare.

The shortage of trained personnel represents another barrier to receiving appropriate treatment. In Snohomish County, community mental health providers report difficulty in hiring geriatric mental health specialists. The American Geriatrics Society documented the national shortage of geriatricians and an even greater shortage of geriatric psychiatrists. By 2030 there will be only one geriatrician for every 4,254 Americans 75 years and older and only one geriatric psychiatrist for every 20,195 Americans 75 and older.

THE OLDER AMERICANS ACT

Goal

Significantly increase Older Americans Act funding to respond to the growing population of older adults and the effects of inflation.

Advocacy Priorities

- Enable older Americans to remain as independent as possible in their homes and communities.
- Preserve and strengthen the existing aging network.
- Sustain the commitment to serving diverse populations and protecting the most vulnerable.

Background

The Older Americans Act (OAA) of 1965 created a network of federal, state, and local agencies and organizations that provide services to, or represent the interests of, older persons living in their homes and communities. Nationally, the aging network consists of 56 State and Territorial Units on Aging, 655 Area Agencies on Aging, 240 Indian Tribes and Native Organizations, and more than 29,000 service providers.

The U.S. Administration on Aging allocates OAA funds to the State Units on Aging (SUA). The SUAs then distribute them to the Area Agencies on Aging (AAAs) who, in turn, contract with local providers. In Washington the Aging and Disability Services Administration is the State Unit on Aging. There are thirteen designated AAAs including Snohomish County Long Term Care & Aging and its citizen's advisory board, the Council on Aging.

The OAA's primary objectives are to enable people age 60 and older to live independently and to provide a continuum of care for vulnerable elderly individuals. Services supported by the OAA in Snohomish County include congregate nutrition, home delivered meals, case management, information and assistance as well as legal assistance. As part of the National Family Caregiver Support Program, the OAA also authorizes services that support family caregivers including kinship caregivers (e.g. grandparents raising grandchildren.)

In 2006, OAA Programs served 9.5 million clients nationwide. Over 98 million meals were served to almost 1.7 million individuals at congregate meal sites and 140 million home-delivered meals were served to almost one million homebound elders in fiscal year 2006.

Funding for the OAA has lost ground over the past 20 years due to our rapidly increasing, frail, older population and the relative level of federal funding that has not kept pace with inflation. According to the National Association of Area Agencies on Aging (NAA), in 2008 56% of the programs surveyed made cutbacks in the services they provide due to rising food, fuel or other operating costs. The survey also showed 90% of AAAs expected to make reductions in 2009.

PLANNING FOR AN AGING SOCIETY

Goal

Improve the well-being of older adults by supporting policies and programs that assist people as they age successfully.

Advocacy Priorities

To implement “age sensitive” policy structures as well as physical and service infrastructures that support older adults.

Background

- Between 2005 and 2030, Washington State will find itself in the midst of a global demographic challenge--a major growth in the population of its older citizens.
- During this period, Washington State’s population is expected to grow by 36%, from 6,250,000 to 8,500,000.
- During this same period, the 65 and older population is expected to grow by over 133%, from approximately 710,000 to 1,660,000;
- Washington ranks 11th of all states in projected growth of population 65+ by the year 2025.

Why should we care?

We should care because this demographic shift will have a tremendous impact on every facet of our lives:

- It will redefine our ideas of work, retirement, and leisure;
- It will alter our housing, transportation, land use, and living arrangements;
- It will challenge our health and long term care systems, public safety; and
- It will reshape our economy and plans for economic development.

Changes in population present opportunities as well as challenges in meeting the needs of county residents. *By looking at “Aging Readiness” in a holistic manner, we can begin to develop communities that:*

- Encourage people of all ages to prepare for life as an older adult.
- Develop “age sensitive” community infrastructures that support people as they age.
- Establish and adapt existing services to recognize and accommodate the needs of older adults and adults with disabilities.
- Build and adapt physical infrastructures that support people throughout the life span.
- Promote creative ways for the area’s older adult population to utilize their talents, skills, and experiences in both paid and un-paid roles.
- Promote flexibility in the workplace to accommodate and support the vital role played by an increasingly aging pool of workers as well as family caregivers.

Successful advocacy and policy on aging should involve a number of criteria that must include a sense of:

- Security and Safety: which comes from stabilized housing, adequate nutrition, access to help when needed, and freedom from abuse and exploitation.
- Connectedness: where the aging are involved with family and community.
- Meaningfulness: where lives are valued and respected and where individuals can make contributions to their community, family and friends.
- Wellness: wherein all can maintain and manage their level of health and well-being.

SOCIAL SECURITY

Goal

Ensure Social Security's long-term solvency.

Advocacy Priorities

- Oppose privatization and the establishment of private accounts.
- "Do no harm" to the vulnerable groups that rely on Social Security.
- Recognize that relatively modest changes can dramatically impact the program.
- Encourage Americans to actively plan and save for their retirement years, recognizing that Social Security payments need to be supplemented by private savings and pensions.

Background:

Social Security is the single largest U.S. Government program paying out nearly \$614 billion in benefits to more than 54.7 million people in 2008. Since its inception in 1935, Social Security has been structured as a social insurance program to which workers contribute financially and earn entitlement to certain benefits.

The Social Security system collects payroll taxes, earns interest income from its trust fund and holds its trust fund assets in the form of Treasury bonds. According to projections in the 2008 Trustees Report, benefit payments will begin to exceed Social Security tax revenues in 2017 requiring the program to start using some of its interest income. After 2026, Social Security would begin redeeming the bonds in the trust fund in order to raise the additional funds needed to pay full benefits. Using a combination of tax revenues, interest earnings, and income from the redeemed Treasury bonds, the program would be able to continue paying full benefits until 2041.

In 2041 the trustees project the Trust Fund will be exhausted. However, Social Security's tax revenue will be sufficient to pay 78 percent of promised benefits. By 2082, the percentage would fall to 75 percent.

As these numbers show, Social Security does not face an immediate financial crisis but will eventually confront a significant imbalance.

Social Security has played a significant role in reducing poverty among older people. Ninety percent of people over the age of 65 receive Social Security benefits. Without these benefits approximately 40 percent of older Americans would have fallen below the poverty line in 1999. Social Security benefits are an essential income source for many older retirees. Among elderly Social Security beneficiaries, 20% of married couples and about 41% of unmarried persons rely on Social Security for 90% or more of their income.

Many people are unaware three out of every ten Social Security checks do **not** go to retirees (Shelton 2007). Disabled workers receive benefits as well as the children and spouses of deceased, retired, or disabled workers. For an average wage earner with a spouse and two children, Social Security provides the equivalent of \$350,000 in disability insurance and \$400,000 in life insurance.

TRANSPORTATION

Goal

Ensure a safe, accessible, unified transportation system is available throughout the county, meeting the needs of the elderly and of people with disabilities.

Advocacy Priorities

- Assure the availability of transportation services to older persons and persons with disabilities; especially those who have low-incomes, are frail, or live in rural areas.
- Move toward a unified public transportation system to serve the entire county.
- Ensure paratransit services are comprehensive, coordinated, reliable and responsive to the needs of older people and people with disabilities.
- Simplify the application process for paratransit services.
- Design routes to meet the needs of the elderly and disabled.
- Ensure adequate funding so transit authorities do not have to choose between adequately funding paratransit or accessible fixed-route services.

Issues

Public transportation in Snohomish County does not meet most seniors' transportation needs.

Background

Access to transportation services can be confusing and disappointing for the frail senior citizen or younger disabled person who simply needs a dependable ride.

Snohomish County is served by several transit systems. The following chart indicates distinctions in service between Everett, Community Transit and areas not covered by either company:

Snohomish County & Public Transit Benefit Area

<u>Everett Transit</u>	<u>15% Outside PTBA</u>	<u>Community Transit</u>
<ul style="list-style-type: none"> ▪ 15% of Snohomish County residents live within Everett Transit PTBA. ▪ Serves the City of Everett, (and some limited areas near the city). ▪ Receives funds from the City of Everett to provide fixed route and paratransit services. ▪ Uses Community Transit to transport consumers from ET's areas to destinations in CT's areas. 	<ul style="list-style-type: none"> ▪ 15% of Snohomish County residents live entirely outside both ET & CT areas. ▪ Areas include: North of Stanwood, parts of Arlington/ NW Granite Falls, a small section of Lake Goodwin, the Machias area, Lake Roesiger, and NE Bothell/SW Monroe. 	<ul style="list-style-type: none"> ▪ 70% of Snohomish County residents live in Community Transit's Public Transit Benefit Area (PBTA). ▪ Provides fixed route & paratransit service to many, more densely populated areas of Snohomish County. ▪ Senior Services of Snohomish County (SSSC) operates CT's paratransit and Dial-A-Ride-Transportation (DART) services. ▪ Used by ET to transport area paratransit customers to outside area destinations.

Most regular fixed-route buses, available through Community Transit and Everett Transit, depart between 6 AM and 8 AM, and 4 PM to 6 PM. Seniors travel most frequently between 9 AM and 4 PM, and current bus schedules are ineffective in meeting the needs of seniors. Elderly consumers and senior citizen advocates have consistently expressed the following frustrations regarding transportation services within Snohomish County:

- Large portions of the County are unserved by either bus system.
- The application for paratransit services is lengthy and confusing, with no sharing of eligibility between the two systems.
- Paratransit trips are shared rides usually requiring one-day advance reservations.
- Bus routes are designed to serve commuters rather than senior citizens.

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APPENDIX

This appendix contains additional background information and/or advocacy priorities for some of the preceding sections.

Housing

Housing Programs

The following are housing programs that provide a direct or indirect benefit to low-income renters:

HUD Section 202

Funds are granted to private non-profit organizations for the purpose of constructing apartments for seniors age 62 and older. The tenants pay no more than 30 percent of their income and HUD pays the remainder (up to a pre-established market rent.) Applicants must apply for housing and meet strict income and other federally mandated criteria. Due to the demand for this type of housing, a priority system may be in place in an attempt to house those with the greatest needs first.

HUD Section 811

Similar to the Section 202 Program, however, only for persons with disabilities.

HUD Section 221

Federally funded units made available through HUD to private, for-profit builders, offering those who meet eligibility criteria an opportunity to rent at reduced levels.

Farmers Home Administration Section 515

Offers programs to non and for-profit developers to build affordable housing for elderly persons meeting low-income and other criteria. Waiting lists for these units are very long as they offer deep subsidies and universal affordability. Developers receive low interest rates on long term loans.

HUD Section 8

From its inception in 1974 the Section 8 Housing Assistance Program has provided both project-based and tenant-based rental assistance. Project-based programs provide owners with federal assistance for both rental subsidies and mortgage insurance. Tenant-based programs provide low-income persons with certificates or vouchers to pay the difference between 30 percent of the tenant's gross income and market rent for the area and unit size as determined by HUD.

Public Housing Programs

There are over 800 units of public housing in Snohomish County. These units were built by the local Housing Authorities using loan or grant funds from HUD. The Housing Authorities rent them to eligible persons. In addition to the rents collected, the authorities receive subsidies from HUD to cover the operating and debt service costs.

Tax Credit Program

A complex federal program administered at the state level by the Washington State Housing Finance Commission provides credit or reduction in tax liability for owners or investors in low-income rental housing. Non-profit or for-profit low-income housing developers "sell" the tax credits to investors, who contribute equity to the project in exchange for an ownership position allowing them to use the tax credits. The equity contribution helps reduce the

amount of other financing needed to develop the project and subsequently lowers the amount of rent charged to qualified tenants.

HOME Funds and Housing Trust Funds

Programs provide funding and general guidelines to states and local governments, allowing them to design and tailor affordable housing strategies to address local needs and housing conditions. HOME funds are federal. State and county trust funds are funded by the state and county, respectively.

Federal Low Income Housing Preservation and Residential Home Ownership Act, Title VI

Provides an incentive for non-profits to acquire housing that is in danger of being “lost” due to prepayments, refinancing, or other reasons.

Medicaid

Additional legislative priorities for the Medicaid program include:

- Preserve the “due process” rights currently available to Medicaid beneficiaries and applicants.
- There should not be an increase in the burden families assume in order to provide or finance long term care services.
- Maintain the current Nursing Home Quality standards for health care received by nursing home residents.
- Increase efforts to identify and stop Medicaid fraud.
- Maintain eligibility protections for all currently protected low-income groups i.e. pregnant women with infants, children, disabled individuals (as defined by Social Security), and the elderly. Phase-in eligibility for all poor children, providing coverage until they reach the age of 18.

There must be a benefit package sufficient in amount, duration, and scope to reasonably meet the complex needs of beneficiaries.

- Due to the limited financial resources of beneficiaries, few or no additional cost-sharing requirements should be imposed. Spend down is a form of cost sharing. Cost-sharing or a sliding-fee scale could be used as a way to expand eligibility to the population whose income is just above the currently protected low-income groups.
- States should be allowed to supplement the Medicaid benefit package and encouraged to provide certain services regarded as optional, e.g. dental care.
- States should give the same services to all eligible individuals and should not be allowed to arbitrarily deny or reduce services to an otherwise eligible individual due to type of illness or condition.

Medicare

Additional advocacy priorities for the Medicare program include:

Financing

Ensure long-term financial stability of the Medicare program while meeting the needs of an aging population. Any financing solutions should be equitable, broadly based, and affordable to all individuals.

Cost

Structure reimbursement to providers and Medicare managed care organizations so Medicare payments are set at appropriate levels; promote cost containment, encourage efficient service delivery and compensate providers fairly. Recognize provider reimbursement is closely linked to the ability of Medicare beneficiaries to access doctors. Protect Medicare beneficiaries, especially those on low and fixed incomes, from cost-sharing increases beyond current law and from programmatic changes driving up their overall health costs.

Means-Testing

Means-testing (adjusting premiums, deductibles and coinsurance on a sliding-fee scale based upon the person's income and/or assets) would only be acceptable if fair and can be done in a cost effective manner. Care must be taken to avoid increasing administrative complexity or eroding the popular support of Medicare.

Consumer Rights

Appeal procedures and standards for decision-making should be simple, understandable, and incorporate standards of due process; including the right to an in-person hearing.

Choice

Preserve genuine beneficiary choice of plans and health care providers, including fee-for-service and managed care options. Provide understandable and objective information so the public can make informed choices. Congress must provide adequate funding to help persons on Medicare make informed decisions regarding their choices.

Managed Care

Strengthen consumer protections for Medicare beneficiaries enrolled in managed care, including disclosure of information needed by beneficiaries to make informed decisions about their health care options; protections for due process and appeal rights; and plan enrollment and disenrollment.

Prescription Drug Coverage (Part D)

There should be comprehensive structural reform whereby drug coverage is fully integrated into the benefit packages of health insurance plans. The reform should include the following:

- Negotiating directly with the pharmaceutical companies for lower drug prices.
- Prices that Part D plans pay are transparent.
- Standardize the plans.
- Eliminate the donut hole.
- Safeguards for beneficiaries.
- Greater protections for dual eligible individuals including the elimination of co-pays
- Intensify efforts to enroll those eligible for "Extra Help".
- Eliminate the assets tests for low income beneficiaries.
- Establish one standard, simplified process for coverage determinations and appeals, including Prior Authorizations and Exceptions that all Part D plans must follow.

Social Security

Additional Information on Social Security's Structure

An estimated 164 million people or 96% of all workers are covered under Social Security. Workers pay a flat tax of 6.2 percent of their wages up to \$106,800 with their employers contributing an equal amount. Self-employed individuals pay both shares. If a worker pays into the system for at least 40 quarters or 10 years, the individual will receive benefits at the minimum retirement age. Social Security also provides survivor and disability benefits after a worker earns a minimum number of work credits.

Inflation protection and progressive benefits are other important safeguards within the Social Security system. Unlike most private pensions, Social Security benefits are adjusted annually to protect against inflation. Benefits are also progressive with benefits for low-wage earners replacing a larger percentage of their average income than for high-wage earners.

Transportation

Additional Paratransit Information

Once an individual has been determined eligible for paratransit services through either DART or Everett ParaTransit, their eligibility does not guarantee a ride. For DART, consumers must make a request by 3:00 pm the day before the trip. DART has not declined a ride request for five years if it was submitted by this deadline. For the Everett ParaTransit Service, consumers may request up to seven days in advance as well as the day of service.

Paratransit service is limited to trips beginning and ending within 3/4 mile of local fixed routes. In addition, paratransit rides are shared rides, requiring consumers to be flexible in their pick-up times and be able to tolerate lengthy trips.

To become eligible for paratransit services, the disabled elderly consumer must complete separate ADA application forms for Community Transit's DART and Everett's ParaTransit.

- DART's ADA application is eight pages long and requires a physician's statement. There is a 21-day review period with most applications being processed within 5½ days.
- The Everett ParaTransit ADA application is also eight pages long and may require a physician's statement. Most applications are processed within 10 days.

In addition, potential paratransit consumers must also obtain a Regional Reduced Fare Permit to purchase paratransit bus tickets/passes at a reduced rate.

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