The Aging Network

A Balancing Act between Universal Coverage and Defined Eligibility

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The Older Americans Act (OAA) defines the primary mission of state and area agencies on aging as developing a comprehensive and coordinated service delivery system for older people. The act embodies values—for example, maximizing the independence of older people, supporting their preferences for receiving long-term care services at home, and empowering consumers with meaningful roles in program governance—that have served as guiding principles in advancing that mission for the aging network since the mid-1970s. And the service funds of the OAA have provided a basic foundation for financing the comprehensive delivery system envisioned in 1965 when the program was enacted.

Beyond these important contributions, however, the act is constrained in its ability to address the most intensive service needs of older people. This constraint is the result of two factors: (1) the obvious mismatch between the program’s relatively meager federal resources and its ambitious program goals, and (2) the myth, tenaciously sustained by many federal policy makers and national aging organizations, that the act can actually provide universal access to all older people, regardless of their income or functional need for services. In combination, these factors have yielded a distribution of resources to services that are provided in high volume at relatively low cost per recipient—useful, but thereby limiting the ability of the program to intensively serve those older people who have more complex needs.

Ironically, state agencies on aging have been best able to fulfill the act’s vision of a comprehensive delivery system through the use of other resources, ones that reject the OAA philosophy of universal access based solely on age, and instead use explicit eligibility criteria based on both functional and financial needs. Each state now has a Medicaid home and community care waiver program that provides a broad array of services to low-income older people whose disability levels would qualify them for admission to a nursing home. In addition, most states have programs funded by general revenues for people with comparable functional impairments who are required to pay varying portions of their service costs based on their incomes. These types of eligibility policies ensure that public resources are devoted to those most in need, and as a result, governors and state legislatures have been willing to commit substantial resources to home and community services. State and area agencies needed to convince policy makers that the network could judiciously allocate program resources to individuals based on explicit eligibility criteria rather than on the traditional, universal philosophy of the OAA. The delegation of responsibility to state agencies on aging for most programs funded by general revenues and for more than half of the Medicaid waiver programs indicates a recognition that they can be successful in this kind of endeavor.

So, one may ask, why are the paths taken by federal and state policy so different? A comparison of the political context within which the OAA operates at the federal and state levels yields some answers.

The Federal Policy Context

The promise of a universal program capable of serving all older people regardless of their functional status or income holds obvious political appeal. Advocates have increasingly referred to the OAA as an entitlement program, although neither its structure nor its funding level approximates that lofty policy status. As a further indication of the confused perception of the act’s status, proposals have been put forth during the past two reauthorizations that would have given older people the right to sue if they were unable to obtain OAA services.

The act provides a listing of priority target populations, which includes low-income minorities and a wide range of other groups—people who are frail, people who live in rural areas, and non-English speakers, among others. Further defining potential program recipients through the establishment of actual individually based eligibility
criteria rather than simply listing target populations is a notion that has rarely crept into the implementation of the OAA. Only two references to noneconomic eligibility criteria are made within the act: (1) Title III-C2 home-delivered meals, and (2) Title III-D, a small in-home services program that finances significantly fewer in-home services than does Title III-B, which lacks any reference to functional eligibility criteria. Since neither of these two eligibility references is underscored in congressional committee reports, floor statements, or other documents emphasizing legislative intent, they should not be viewed as a sign that policy makers have embraced the philosophy of defining access to a limited OAA service supply.

States have tried to focus OAA resources on services that help older people who have significant limitations in their ability to conduct activities of daily living. They have done so by using the authority contained in the act that allows states to transfer a certain percentage of funds among service categories. In particular, they have increased spending for home-delivered meals above the amounts appropriated by Congress and decreased spending on congregate meals. However, the political constraints of focusing too extensively on a frail population were underscored by the 1991 reauthorization of the act, which responded to the concerns of congregate meal providers by reducing the amounts available for transfer to home-delivered meals or to any other part of the program.

The extent to which the act should use economic criteria to define consumer need has been the subject of intense and continual debate throughout the evolution of the act (Hudson 1995). Two basic tenets are held by policy makers and advocates alike: (1) that, in its most colloquial form, the OAA is not a “welfare program” and thus should not use income to determine who should—and should not—receive services, and (2) that services should be targeted to those most in need, with particular attention to low-income minorities. Over time, these principles have come to be viewed as intellectually consistent by many involved with OAA policy—with the notable exception of state and local officials who must implement them.

Given the inability of most policy makers and advocates to come to grips with the limits on the act’s resources, it is not surprising that the issue of targeting resources to those in greatest need is framed in a somewhat abstract manner. The formula for the distribution of OAA funds within a state has become the debate’s focal point. Legislative language, court cases, and federal regulations have all focused on the question of which demographic factors should be used to allocate service funds among broad geographic areas—all of which avoids the real question of who gets served and, by default, who does not.

During reauthorization debates in both 1987 and 1991, state administrators of the OAA proposed a more specific and direct targeting strategy, which would have given states the option of using consumer cost sharing, through sliding-scale fees based on income, to allocate resources to an individual’s service cost. Certain access and advocacy services would have been exempted from sliding-scale fees. People with low incomes would not have been required to share costs; the service costs of others would have been subsidized based on their self-declared income level.

Cost-sharing policies have been used extensively within state-funded home and community care programs as a way of targeting resources based on income without excluding program participants through a means test. In state capitals, these policies received widespread support from consumers, advocates, and state legislators. However, inside the Washington beltway, reactions were quite different. Some advocates thought low-income people would be deterred from participation in OAA programs because they would be unable to understand that cost sharing would not apply to them. Others objected to any consideration of a recipient’s income, on the grounds that the OAA would become a “welfare program.”

The adoption of cost sharing was proposed during a congressional committee markup of the 1987 amendments to the OAA. Fifteen minutes later, a second set of amendments was introduced that also addressed targeting from the more traditional OAA perspective of referring to priority groups rather than from the perspective of individually based criteria. The committee’s reaction to each of these two approaches perfectly characterizes the debate.

The cost-sharing amendment specified that self-declaration of income would be used to calculate cost-sharing rates for program recipients and prohibited the application of cost-sharing policies to people with incomes below 125 percent of the poverty level. After discussing the general principle of using sliding-scale fees based on income, several members suggested that they might consider setting the income floor for the initiation of cost sharing at 300 or 400 percent of the poverty level but certainly not at the level used by most state programs. As either a measure of relative financial need or a criterion for resource allocation, the standard of 300 percent of the poverty level
falls far short of reality, since only 20 percent of older people have incomes above that amount. In any event, the majority of committee members did not give serious consideration to the concept, regardless of any particular income level, and therefore the proposal was dead for the 1987 reauthorization cycle.

In contrast, the second set of amendments that was introduced generated overwhelming support and was thought by most members to be a promising solution to this targeting dilemma. All components of the network—states, area agencies, and providers—would be required to set objectives for serving low-income minority older people, to describe their plans the methods they would use to achieve those objectives, and to report annually on the extent to which the previous year's targets were achieved. Press statements describing the committee's actions that day emphasized the advancements made in increasing targeting under the OAA through the adoption of these amendments. The committee's rejection of the amendment that would have more definitively targeted OAA resources was not mentioned.

By the time reauthorization of the act was considered again in 1991, cost-sharing policies were viewed in a somewhat more favorable light. The U.S. General Accounting Office (1989) had conducted a study mandated by the 1987 amendments and had found positive results from the use of cost sharing by states in other aging programs. While these findings and those of a similar study conducted by the Inspector General's Office of the U.S. Department of Health and Human Services persuaded some to reconsider their previous reluctance to support cost sharing, the preconceptions of many opponents were unchanged. Testifying at a congressional hearing, a witness representing a national aging organization reported learning through an informal survey she conducted of elderly residents of public housing that most of them would not seek OAA services if they were required to declare their incomes. No one questioned how people who would forgo public benefits rather than disclose their incomes had gained access to public housing, illustrating the extent to which this argument of participant deterrence had taken hold. Once again in 1991, cost-sharing policies were not adopted.

The State Policy Context

In the programs administered by the aging network beyond the OAA, the use of needs-based criteria, as opposed to the principle of universal coverage, is rarely debated. Functional need, defined by limitations in conducting activities of daily living, is used extensively in state home and community services programs funded with general revenues and in Medicaid home and community services waivers. This eligibility principle emerged in the late 1970s and early 1980s as states attempted to reduce growth in their Medicaid nursing home budgets by providing care to people living in their own homes who would otherwise require nursing home care. To implement this policy, aging networks established assessment procedures to measure need and determine eligibility, case management systems to develop individual care plans that authorize the amount and type of services to be received by each consumer, and methods for monitoring care plans to ensure that they are being implemented by providers in the manner authorized (Justice 1993).

In the state adult protective services/elder abuse programs, functional need is defined differently. In over half of the states, state agencies on aging administer the adult protective service system, which generally defines its target population as vulnerable adults who are unable to protect themselves from abuse, neglect, or exploitation by others because of a mental or physical impairment. The aging network has responded to this population by establishing administrative structures beyond home and community services programs—to the courts, law enforcement agencies, mental health systems, and guardianship procedures.

Financial need, in aging network programs other than the OAA, is determined through one of two methods, depending on source of funding. In home and community services waiver programs, financial need is obviously a creature of federal Medicaid eligibility policy. Within those limits, states have broad latitude to decide which eligibility options apply to home and community care, such as whether to apply the more generous institutional standard to community care, how much money recipients can retain after becoming eligible for the program, whether spousal impoverishment standards apply, and if people can qualify on the basis of having high medical expenses even if their income exceeds the eligibility threshold.

When state agencies on aging became involved in the administration of home and community services waiver programs, they immersed themselves in the arcane details of this complex web of Medicaid financial eligibility options, both to promote the adoption of state policies that would be most beneficial to older people and to implement
the eligibility rules that were ultimately enacted. In comparison, it is fairly straightforward to manage state general revenue programs that use cost sharing based on income. Developed as a way to eliminate income cliffs that lead to all-or-nothing eligibility for Medicaid, cost sharing allows states to serve people of all incomes yet still relate program expenditures to income.

The experiences of state agencies on aging in managing these programs based on functional and financial need led in almost half the states to their management of programs for younger adults with disabilities, further diminishing the principle of universal eligibility based solely on age. In assuming this responsibility, state agencies acquired new names, such as Office of Aging and Adult Services, that reflect their broader mission. But more important, they are now expected in state policy discussions to be the spokesperson for both elderly persons and adults with physical disabilities. Such changes are a somewhat natural evolution of state agencies on aging's role, given the comparable needs for home and community services by these two populations and the absence in many state governments of a focal point for policy coordination on behalf of adults with physical disabilities.

**Policy Implications**

The aging network has built the comprehensive, coordinated delivery systems envisioned by the Older Americans Act but with non-OAA resources, using functional eligibility criteria, which link income criteria to service support, and increasingly serving younger adults with physical disabilities. Why then has federal OAA policy remained so static? There are three possible reasons, with the first two reflecting differences between federal and state policy perspectives and the third applying to aging programs initiated by both levels of government.

The first factor distinguishing federal and state perspectives on needs-based programs is rooted in the classical principles of federalism, which suggest that policy makers who are in closer proximity to the decisions affecting people's lives are better able to effectively allocate program resources. Decisions made about program populations at the federal level are somewhat abstract, with the individuals they affect removed from direct observation. At the state level, outcomes are more visible. Here, refusing to acknowledge the limits of available funding is less feasible, because the inability of one program to adequately serve its intended recipients places more demand on other related programs. Given this interrelationship between human services programs, setting realistic guidelines for each becomes even more important. Some argue that the real reason that states are more willing to set program eligibility criteria based on functional or financial need is that they are stingy—refusing to fund programs as generously as the federal government. Yet in many states, the level of general revenue funding devoted to aging programs exceeds the state's federal OAA allocations U.S. Administration on Aging (1994).

The second reason for differing perspectives between federal and state officials toward needs-based aging programs lies in the nature of the programs that have historically been under their purview. The major federally administered programs for older people—Social Security and Medicare—are based on a social insurance model, with eligibility based on both age and work history. While both programs have certain features that relate incomes to benefits, they are predominantly characterized as universal programs that use age as the sole basis of need. In contrast, the federal programs administered by states are usually means tested; Medicaid, food stamps, and low-income energy assistance are primary examples.

These two distinct program traditions explain a large part of the differing reactions of federal and state policy makers to cost-sharing policies that require people to pay for part of their service costs based on their incomes. Federal officials and national advocacy organizations view cost sharing as a negative departure from universal access based solely on age—even though in the case of the OAA universal access was an unrealized philosophy. State officials and state advocacy groups, on the other hand, view cost sharing as a preferable departure from their means-tested programs, since it provides a vehicle for directly relating benefits to income but avoids denial of service on the basis of income.

A third factor, program size, influences both federal and state policy makers in an identical manner as they consider needs-based policies. In general, it appears more likely that large programs will use needs-based criteria than will smaller ones. This theory seems counterintuitive at first consideration, since lower levels of funding would imply a need for tighter allocation of program resources. However, if a program's budget is significantly less than the amount needed to fulfill its mission, policy makers are likely to conclude that the best political course of action is to avoid defining the size and characteristics of the population to be served. Any further specification of need criteria in
this circumstance would either narrow the size of the eligible population to a point that is politically unacceptable or highlight the degree to which program resources are inadequate. Conversely, a more adequate level of funding increases the probability of designing individual need criteria commensurate with available resources. Two examples, one each from federal and state policy, illustrate this point.

The president's health care reform plan, introduced in the fall of 1993, proposed the establishment of a new home and community care program for people of all ages with disabilities. Many of the program's features were drawn from state programs, including the use of functional eligibility based on inability to conduct activities of daily living and requirements for consumers to pay a portion of their care through cost-sharing scales based on income. As was not the case in the OAA debate, neither Congress nor advocacy organizations objected to the inclusion of these program features when the president's plan was discussed. There was some initial concern over the level of need proposed (for example, limitations in at least two or three activities of daily living, percentage of care costs that each income category should be required to pay) but not about the general principle of using these methods to quantify need. When fully implemented, federal funding for this program was expected to reach $36 billion annually. In contrast, OAA funding is a little over $1 billion a year. Neither program provided an individual entitlement that guarantees services to all who meet defined criteria for eligibility. Yet the eligibility criteria included in the president's proposal were consciously structured to match the number of potential program participants with the level of projected program funding.

Likewise, when home and community care programs funded by state general revenue expanded, needs-based eligibility criteria became more, rather than less, rigorous. In the 1970s, these programs mirrored the OAA, combining limited funds with universal eligibility. In the 1980s, as funding increased, states adopted specific eligibility criteria based on ability to perform activities of daily living, which was also the basis for the rapidly expanding Medicaid waiver programs.

The absence of opposition to both the administration's proposed eligibility criteria and comparable factors used in state revenue programs seems to suggest that, once program funding reaches a certain threshold, policy makers and advocates alike begin to realize that resources must be directed to people in need through specific standards. In contrast, policy makers may conclude that establishing functional and income-related criteria for the OAA would only highlight the extent to which its resources fall short of its promise.

Conclusion

The aging network has struggled to accommodate two divergent approaches to targeting the resources of the multiple programs they administer. The more traditional method is based on the universal coverage philosophy of the OAA, which avoids any consideration of individually based need criteria. The other method uses functional eligibility criteria and cost sharing based on income to target scarce resources to those most in need. This latter approach is likely to dominate both federal and state aging services programs as policy makers are forced to respond to the prospects of significantly reduced resources in the years ahead.

References


