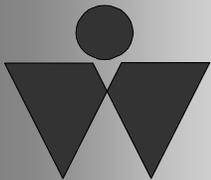


Long Term Care

- Background Paper on New York State's Long Term Care System
- New York State Vision for Long Term Care
- New York State's Response to the Olmstead Decision: The Most Integrated Setting Coordinating Council
- Aging Baby Boomers



LONG TERM CARE IN NEW YORK STATE

Background

New York's healthcare delivery system is large and varies greatly across the State and supports the healthcare needs of different regions, from the large urban centers such as New York City to the sparsely populated north country of the Adirondacks. A common characteristic of the system, however, is that it is dominated significantly by large institutions. Specifically, there are approximately 660 nursing homes in New York State with a total of more than 120,000 beds.

Yet the way in which long term care is delivered has been evolving rapidly. Many services previously available only on an inpatient or nursing home basis are now being provided and available in the community. This evolution has affected the nursing home industry and has resulted in a significant amount of excess institutional capacity in the State.

Nursing home occupancy continues to drop in most areas of the State to unprecedented levels. This drop has been driven by the growth of non-institutional alternatives such as assisted living, advances in medical technology, overall improvement in the health of potential consumers and caregivers, and increasing preference for less restrictive alternatives. The impact of initiatives aimed at compliance with the US Supreme Court Olmstead decision may further escalate these trends.

Competition for patients has caused long term care facilities to be very aggressive, as facilities struggle to regain the additional utilization needed to maintain acceptable operating margins. To provide for these business needs, most nursing homes now provide "sub acute" or short-term rehabilitation services. Other "niche" services such as ventilator beds, neurobehavioral, and dialysis continue to expand, as the market for more traditional chronic elderly clients shrinks.

The overall nursing home occupancy level has declined significantly in recent years and now stands at approximately 93%. An optimal occupancy level of 97% means there are approximately 7,000 excess nursing home beds in the State.

While occupancy has dropped, discharges/admissions have grown by 60% over the past four years, with virtually all growth in the short-stay rehabilitation categories of fewer than 90-day stays. Consequently, the average length of stay has diminished by at least 40%.

The inventory of pending Certificate of Need (CON) applications for facility infrastructure improvements is at an all-time high, with approximately \$1.4 billion in proposed construction. With the existing Medicaid reimbursement system essentially passing through capital costs, replacement of these homes will not

come cheaply for any payer, especially Medicaid. This situation is compounded by the recent retreat of the capital markets from the nursing home industry.

Demographic estimates completed for the recent nursing home bed need methodology update performed by the Department of Health (DOH) indicate flat growth in the number of consumers potentially requiring nursing home care (until approximately 2012 - 2015). After 2015, the nursing home eligible population is expected to spike upward as the large baby boomer segment begins to age.

Reforming the Long Term Care System

The current long term care system has developed incrementally over time and can be difficult to access, navigate, comprehend and manage for most New York residents -- whether receiving government assistance or not. The numerous long term care programs, administered and operated by a wide variety of entities, each have discrete statutory and regulatory requirements governing eligibility, target populations, scope of service and funding. Thus, the system lacks coordination, allows for duplicate services, is inefficient and expensive, and often fails to provide care that is optimum or appropriate.

In addition to the problems associated with a complex and arcane system, New York State is experiencing a dramatic growth in the demand for and cost of long term care services. The elderly population is increasing and the life expectancy of older New Yorkers continues to rise. This will place extraordinary demands on the long-term care financing and delivery system. The number of people in New York State aged 65 and older will increase from 2.3 million in 1995 to 3.3 million in 2025, while during the same time period the number of people aged 75 and older will grow from 1.07 million to 1.4 million.

Long term care spending includes skilled nursing facilities, home nursing services, home health aides, and personal care services. In State fiscal year 2005-06, gross New York Medicaid spending on long term care is projected to be \$11.84 billion, growing from \$10.87 billion in State fiscal year 2004-05. This represents a year-to-year increase of over 8.9 percent. In addition, informal caregiving – that provided by family members, friends and neighbors – has an estimated value of over \$11 billion per year.

The Olmstead decision, which requires that individuals receive care in the most integrated settings appropriate to their needs, provides an unprecedented opportunity to reshape our long-term care system to more effectively and affordably meet the needs of the disabled and elderly. Shifting the long term care system from an institution-based to a home- and community-based system parallels the desires of the disabled and the growing elderly populations to remain at home.

To reform the long term care system, it is important to structure the system to provide services that meet consumer needs. A new system must:

- foster social and physical wellness by keeping people functional and connected with their communities;
- make comprehensive and coordinated service options available in a wide variety of settings;
- support all persons to live as independently as possible as long as they desire and are able; and,
- support innovation through technology and new delivery and flexible financing models.

Integral to this process is creating a structure that:

- is easy for consumers and their caregivers to understand and use;
- respects consumer choice by providing unbiased comprehensive information about available long term care options and provider performance; and,
- involves consumers and their caregivers in planning, evaluation and decision making, so that supports are guided at all levels by consumer needs and preferences.

Most importantly, this system must be efficient and affordable.

Components of a Rebalanced and Reformed Long Term Care System

The components that are needed to re-balance and reform New York's long term care system include:

- Improving access to long term care services by establishing a single point of entry as well as a comprehensive Medicaid waiver to permit the State to provide more appropriate long term care services;
- Promoting personal responsibility by instituting Medicaid eligibility reforms and making long term care insurance more affordable and accessible;
- Promoting coordination between Medicare and Medicaid; and
- Reforming New York's nursing home system.

Improving Access: Single Point of Entry

- A key recommendation contained in the Health Care Reform Working Group Interim Report released in January of 2004 was to design and implement a single point-of-entry into the long term care system and focus on providing long term care services in community settings. The recommended Point of Entry (POE) system would provide unbiased, comprehensive and accurate information to individuals and families trying to access appropriate long term care services. The system would support

self-determination, promote personal responsibility, provide services that meet consumer needs, provide quality care, and ensure efficiency and affordability. The POE will reduce the need for, and delay entry into, more costly institutional care by encouraging the use of most integrated settings, recognizing and using informal supports in the home, better coordinating care and finding alternative non-medical services to reduce the need for more costly medical services.

More specifically, the Health Care Reform Working Group recommended a Point of Entry System that would provide:

- Comprehensive and unbiased information and assistance in all services and supports;
- The opportunity for consumers, regardless of payer source, to be screened to ascertain an individual's general social and medical needs and financial status and to direct them to available service options;
- A comprehensive needs assessment after an initial screening will identify the supports needed to maintain the highest level of functionality. It should be available for all individuals requiring it. The assessment will be mandated for those seeking publicly financed long term care services;
- All consumers, regardless of payer source, with assessments prior to, and as a condition of, nursing home placement;
- Service/care coordination and utilization management;
- A public education component that will assist consumers to prepare financially for their long term care needs; and
- An interdisciplinary team approach to more effectively coordinate and manage services for those individuals in the system.

Critically, the Report proposed that State guidelines be designed to guarantee statewide consistency.

As a result of the recommendations made by Governor Pataki's Health Care Reform Working Group, the Governor's office directed the New York State Office for the Aging (NYSOFA) and DOH to issue a Request for Information to gather input from stakeholders – consumers, caregivers, advocacy organizations, health care service and industry providers, support service providers, and trade associations on how to design and implement a Point of Entry System. A summary of the input may be found on the websites of both agencies.

Further information was gathered when NYSOFA conducted listening sessions across New York State during the summer and early fall of 2004 that were primarily focused on reform of our current long term care system.

Concurrent with these information gathering initiatives, NYSOFA and DOH has worked to formulate a plan to implement the HCRWG's recommendations. The agencies have found the RFI, Listening Sessions, and other forums in which

the Director of NYSOFA and SDOH Medicaid Director have presented the vision for long term care and sought input, to be instructive in the development of the plan.

Building upon the recommendations of the HCRWG, and incorporating what we heard from the strata of stakeholders, the framework for implementing a locally based but statewide point of entry (POE) system has been devised. The framework is as follows:

- The overarching goal is to implement a POE structure across all of New York State containing all the functions envisioned by the HCRWG.
- In recognition of the systems change that will be taking place, the POE should be rolled out statewide with the functions of Information and Assistance to provide unbiased information and assistance on all available services - nursing home, home care, PACE, LTHHCP, home delivered meals, adult day care services and other non-medical support services as well as other services available in the community. The POE would also conduct screening for appropriate needs and be a general information resource for planning for long term care needs. It would also provide information related to financing of services, albeit private pay, Medicaid or other State or Federally funded programs.
- During the same timeframe that NYSOFA and DOH are implementing these components, the agencies will work to specify the standards, requirements, outcomes and measures to be incorporated into an RFP for the fully functional POE.
- The POE will be a local entity that will operate under a contract with NYSOFA and adhere to statewide standards and requirements. A contracting approach shall be employed to ensure accountability as well as a consistent and unbiased program throughout the entire state. Local governments shall be given the first right of refusal in bidding to be the POE for their county.
- Additionally, a statewide contractor or contractors would, under the direction of NYSOFA and DOH, provide the infrastructure (e.g. IT/systems) support for, as well as program monitoring and training of, POE entities.
- Throughout the implementation process, the agencies will seek stakeholder/community input on the project.

The implementation of fully functioning POE entities, which provide critical assistance to individuals and their families enabling them to make informed choices to meet their long term care needs, is vital to restructuring New York's current long term care system. In addition to the reasons already noted, it is

important to keep in mind that the magnitude of the impact of our changing demographics is barely being felt yet. The impact will take hold in a few short years, which is why we must work to restructure the system now to more appropriately meet the long term care needs of the State's population.

Improving Access: Comprehensive Medicaid Waiver

Federal waivers give states the option to institute some flexibility with their Medicaid programs. Waivers allow states to create programs that provide services not traditionally covered by Medicaid (e.g. home modifications, home-delivered meals) and that "waive" certain federal requirements.

An array of services and supports are needed to meet the needs of individuals with chronic illnesses and disabilities. Public and private sources fund a range of health, social service, housing, mental health, nutrition, and transportation programs. The system restructuring will curtail artificial limitations that payer sources currently impose on service configurations.

Current State Plan services serve as entitlements with modest restrictions on quantity, cost, or length of service. The Plan operates under different dynamics than capped or privately financed programs with limited benefits. Financial caps and service limitations can influence program managers and consumers to maximize informal supports, use other appropriate and potentially less costly services and negotiate services within defined spending limits.

Modifying New York's State Plan services and waivers will produce a more rational approach to care and utilization management under the Medicaid program which will complement the coordinated care approach envisioned as part of the Point of Entry.

Promoting Personal Responsibility: Medicaid Eligibility Reforms

Many of the individuals who use long term care services, with the assistance of attorneys, place their assets out of the reach of the Medicaid program. The most commonly used asset protection methods include transferring assets to a third party and individuals refusing to support the spouses with whom they reside. By closing the eligibility loopholes, the perception of Medicaid as "the easy way" to fund long term care services will be altered.

Promoting Personal Responsibility: Affordable and Accessible Long Term Care Insurance

As important as changing the perception of Medicaid as the primary financier of long term care is guaranteeing the availability of a wide range of options for non-Medicaid financing of long term services. By modifying the state's Long Term Care Partnership Plan, stimulating the Non-Partnership long term care insurance market; creating a government funded long term care reinsurance mechanism, introducing long term care savings accounts, encouraging/incentivizing employer and labor union participation, and making

state and federal tax incentives available to family members who purchase long term care coverage on behalf of another family member, the options for financing long term care without using publicly-funded services will be enhanced. Activities are underway at both the State and federal levels to make some of these changes.

Coordinate the Medicare and Medicaid Programs

Medicaid is also the primary financier for the majority of long term care consumers who are dually eligible for Medicare and Medicaid. Medicare generally pays for their primary and acute care services; Medicaid generally pays for long term care service needs. There are more than six million individuals nationally and almost 600,000 individuals in New York State who are dually eligible for both Medicare and Medicaid. The dually eligible tend to have more serious and complex medical and long term care needs than other Medicaid and Medicare eligibles. Having coverage divided between two payers has resulted in fragmented care and misaligned financial incentives.

The complexity of care delivery for dual eligibles has led both state and federal governments to search for better ways to coordinate their care. The primary goals have been to integrate both the delivery and financing of acute and long term care services. The primary vehicles for accomplishing this is using the managed care model. Beginning in 2005, dual eligibles in New York can now join a managed care plan that provides services supported by both programs.

Reform New York's Nursing Home System

Review of the industry reveals a delivery system undergoing unprecedented change, which, despite receiving spiraling government payments, finds itself facing significant fiscal problems. Meanwhile, state and local governments face the daunting challenge of balancing the competing pressures of escalating health care costs with other needs, while striving to maintain reasonable property and income tax rates. Thus it is necessary to regain control of costs and development of incentives to rightsize and rationalize the long term care continuum of services.

A series of changes designed to realign capacity with the ever-changing needs of consumers of long term care, which entails a more rational distribution of scarce fiscal resources designed to continue quality care at a more affordable price, is needed. Concomitantly, we need to monitor and assist the multi-billion dollar nursing home industry in transitioning itself into a fiscally responsible system offering the highest quality of needed long term care services.

NEW YORK STATE'S VISION FOR LONG TERM CARE

We envision an accessible, coordinated and person-centered long term care system in New York State that: Supports Self-Determination; Promotes Personal Responsibility; Provides Services that Meet Consumer Needs; provides High Quality Care; and Ensures Efficiency and Affordability.

SUPPORTS SELF-DETERMINATION AND PROMOTES PERSONAL RESPONSIBILITY

SUCH A SYSTEM:

- EMPOWERS AND CREATES OPPORTUNITIES FOR CONSUMERS AND THEIR CAREGIVERS* TO MAKE INFORMED CHOICES ABOUT THEIR LONG TERM CARE THAT BALANCE COST, ACCESS AND QUALITY.
- IS EASY FOR CONSUMERS AND THEIR CAREGIVERS TO UNDERSTAND AND USE.
- RESPECTS CONSUMER CHOICE BY PROVIDING CONSUMERS AND THEIR CAREGIVERS WITH UNBIASED COMPREHENSIVE INFORMATION ABOUT AVAILABLE LONG TERM CARE OPTIONS AND PROVIDER PERFORMANCE.
- IS SENSITIVE TO CONSUMER PREFERENCES AND THEIR WILLINGNESS TO ASSUME PERSONAL RISK.
- INVOLVES CONSUMERS AND THEIR CAREGIVERS IN THE PLANNING, EVALUATION AND DECISION MAKING FOR LONG TERM CARE, SO THAT SUPPORTS ARE GUIDED AT ALL LEVELS BY CONSUMER NEEDS AND PREFERENCES.

*UNPAID CARE AND SUPPORT PROVIDED TO THE CONSUMER BY FAMILY, FRIENDS, NEIGHBORS AND OTHERS IN THE COMMUNITY.

PROVIDES SERVICES THAT MEET CONSUMER NEEDS

SUCH A SYSTEM:

- SUPPORTS SOCIAL AND PHYSICAL WELLNESS BY KEEPING PEOPLE FUNCTIONAL AND CONNECTED WITH THEIR COMMUNITIES.
- MAKES COMPREHENSIVE AND COORDINATED SERVICE OPTIONS AVAILABLE IN A WIDE VARIETY OF SETTINGS.
- SUPPORTS ALL PERSONS TO LIVE AS INDEPENDENTLY AS POSSIBLE AS LONG AS THEY DESIRE AND ARE ABLE.
- SUPPORTS INNOVATION THROUGH NEW DELIVERY AND FLEXIBLE FINANCING MODELS, AND THROUGH THE USE OF TECHNOLOGY.

PROVIDES HIGH QUALITY CARE

SUCH A SYSTEM:

- ENSURES REASONABLE ACCESS, HIGH QUALITY AND AFFORDABLE CARE.
- PRODUCES OUTCOMES, RECOGNIZING EXCELLENT PERFORMANCE AND IMPROVEMENTS IN PERFORMANCE.
- SUPPORTS A MOTIVATED, STABLE WORK FORCE THROUGH ADEQUATE COMPENSATION, WORK FORCE TRAINING AND CAREER DEVELOPMENT OPPORTUNITIES.
- PROVIDES PROTECTIONS FOR THE VULNERABLE, INCLUDING THOSE LACKING IN FAMILY AND OTHER INFORMATIONAL SUPPORTS, AND THOSE UNABLE TO MAKE DECISIONS.
- PROMOTES QUALITY THROUGH OBJECTIVE PERFORMANCE ASSESSMENT, TIMELY AND APPROPRIATE RESPONSE TO CONSUMER COMPLAINTS AND CARE DEFICIENCIES, AND PROTECTION OF CONSUMER RIGHTS.

ENSURES EFFICIENCY AND AFFORDABILITY

SUCH A SYSTEM:

- SUPPORTS THE INFORMAL CARE SYSTEM, INCLUDING FAMILY, FRIENDS, VOLUNTEERS, AND EXISTING COMMUNITY RESOURCES, AND TAKES NO ACTION THAT ERODES IT.
- ENCOURAGES EFFICIENCIES AND PRODUCTIVITY, INCLUDING USE OF LABOR-SAVING TECHNOLOGY THROUGHOUT THE SYSTEM.
- PROMOTES FISCALLY RESPONSIBLE PLANNING TO MEET LONG TERM CARE NEEDS.

Olmstead Decision

Background

Commonly referred to as the “Olmstead Decision,” *Olmstead v. LC, EW, et al*, was decided by the US Supreme Court in July 1999. In the case, Olmstead was the Commissioner of the Georgia Department of Human Resources and LC woman in the State’s care diagnosed as mentally retarded and schizophrenic. The case was brought on the grounds that Olmstead, in his official capacity, was violating Title II of the Americans with Disabilities Act (ADA) by confining LC (among others) in the Georgia Regional Hospital (GRH) in Atlanta.

Title II of the ADA states “Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by any such entity.”

LC contended that treatment professionals concluded she could be cared for appropriately in a community-based program, yet she remained placed at GRH. LC brought suit to US District Court to force the State to place her in appropriate community-based program, and the State responded that inadequate funds existed to provide such placement and such placement would “fundamentally alter” the State’s programs. The District Court rejected both claims, concluded under Title II that unnecessary institutional segregation constitutes discrimination per se and cannot be justified by lack of funding. The Eleventh Circuit Court of Appeals upheld the judgment, but remanded for reassessment the cost-based argument to the High Court.

The Decision

In July 1999, the Supreme Court issued the Olmstead decision, upholding the 11th Circuit opinion.

The Court affirmed that, pursuant to Title II of the Americans with Disabilities Act (ADA) and corresponding Department of Justice implementing regulations, States must provide services and treatment to individuals with disabilities, “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”

In this decision, the Court held specifically, that to avoid discrimination, States may be required to place individuals with disabilities in community settings, rather than institutional, if:

- The State’s treatment professionals determine that community placement is appropriate
- The transfer from institutional to a less restrictive setting is not opposed by the affected individual, and

- The placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with similar disabilities.

Implications

Subsequent actions by States and the corresponding litigation regarding such actions have set forth a “blueprint” for compliance with Title II of the ADA and the Olmstead Decision. Such a blueprint typically consists of a definitive plan developed by the State, for services to the disabled, including:

- Establishing a process for assessing individuals with disabilities placed in institutional settings
- Identifying appropriate less restrictive settings for placement
- Transitioning a declared number/percentage of institutionally-placed individuals in said less restrictive settings, as a reasonable pace, based on State resources and needs of others with disabilities.

In New York, the current process being undertaken to comply with the Olmstead Decision is the implementation of the Most Integrated Setting Coordinating Council (MISCC). Legislation enacting the MISCC, while somewhat inconsistent with the actual Olmstead Decision, has produced a forum for which individuals with disabilities could speak directly to policy-makers about their needs for services. MISCC was established and began meeting in the winter of 2003, holding regular meetings through winter of 2004, including several constituent forums around the State. Currently, preliminary draft reports have been prepared by 4 subcommittees, and one ad hoc committee. Those draft recommendations are being marked up with the consultation of external advocates and individuals with disabilities and will be presented to the full MISCC this summer for review and submission.

AGING BABY BOOMERS: The Demographic Imperative

Nationally:

The number of older persons and their lifespan will increase dramatically over the coming 30 to 50 years:

- Nationally, the number of persons 65 and older will nearly double between 2000 and 2030 (from 11 to 20 percent). In 2030, one in five Americans will be over age 65.
- Of this group, the oldest old (85 and older) will grow nearly five times by the year 2040 (4.3 million to 19.4 million).
- Older Americans will also be living longer. By the year 2050, older men will live to age 86 on average (compare to age 73 now) and older women will live to age 92 (compared to age 79 now).
- **There will be three times the number of moderately or severely disabled older persons in 2040 compared to 1986 (increasing from 5.1 million to 22.6 million).**

Health and Social Services: With these increases, health and social costs will increase in the next 10 years:

- For every dollar spent on health care in the U.S. now, all but 10 cents (90 percent) is spent on the care of persons 65 years of age and older. Economists project that health care costs will reach \$3.1 trillion by the year 2012 (compared to \$1.4 trillion today), the equivalent of \$10,000 per year for every American.

Labor Force: There will be major shifts in the labor force with potentially a negative economic impact over the next 50 years:

- The number of working age persons contributing to the nation's economy will drop compared to the number of older, non-working adults. This 'elderly dependency ratio' (the number of persons 18-64 versus 65 and older) will fall 40 percent (6.5:1 to 3.5:1) between 2000 and 2050.

Racial, Ethnic, and Cultural Profile: The next generation of elderly will be very different from that of the current older population. The younger, working age population is also increasingly diverse, an interactive affect with our aging population:

- Older adults like the U.S. overall will become increasingly diverse. Racial and ethnic elderly subgroups will represent 34 percent of the older population by 2050 compared to 15 percent in 1995.
- The number of older Hispanics will increase over three hundred fold (328%) between the year 2000 and 2030, the number of older Asians and Pacific Islanders will increase nearly 200 fold (185 percent), and the number of older African Americans will increase over 100 fold (131 percent).

Baby Boomers: Research shows that incoming cohorts of older persons, the 'baby boomers,' will have different needs and desires than older persons today.

- Boomers will be more likely than the preceding cohort to enter old age without spouses and more will be childless or parents of only children.
- The delay in marriage and child bearing for this cohort will mean a longer span between the generations than that experienced by today's elderly.
- Most women boomers will enter old age with, like men, a work history spanning all their adult lives.
- Boomers may not want to retire fully; they may have more expendable income, time and energy, and may wish to pursue other educational or workplace opportunities.

New York State:

New York's population is getting older.

Age Structure: The State's median age increased from 30.3 years in 1970 to 32 years in 1980 and now exceeds 36 years. This increase is due to the aging of the baby boom, the leading edge of which (those born in 1946) has now reached the early retirement age of 55. Baby Boomers will have a significant impact on the aging of our population for the entire first half of this century. Projections follow:

- The proportion of the population age 0 to 19 will remain relatively stable between 2000 and 2015 making up approximately 27 percent of the total population in both years.
- The population 20 to 44 years old will decline from 37 percent of the total to 33 percent by 2015 as the tail end of the baby boom leaves this cohort.
- The youngest of the baby boom will be over 50 years old by 2015 while the oldest will approach 70 years old. This group will increase from 18 percent in 2000 to nearly 24 percent by 2015.

New Yorkers Age 85 and older:

- In the year 2000, there were 311, 488 New Yorkers who were 85 or older. (2000 Census)
- The percent change in this age group between the years 1990 to 2000 was 25.5%; a change of 248,173 in 1990 to 311,488 in 2000.
- It is projected that by 2015, 416,640 New Yorkers will be over age 85.
- When we reach age 85, one in two of us require the assistance of another to meet daily living needs.

New York's age distribution is approaching a more mature and stable structure than many states experiencing rapid growth and high rates of in-migration.

- The proportion of the population age 0 to 19 will remain relatively stable between 2000 and 2015 making up approximately 27 percent of the total population in both years.
- The population 20 to 44 years old will decline from 37 percent of the total to 33 percent by 2015 as the tail end of the Baby Boom leaves this cohort.
- The youngest of the Baby Boom will be over 50 years old by 2015 while the oldest will approach 70 years old. This group will increase from 18 percent in 2000 to nearly 24 percent by 2015.

Counties:

Age Structure:

In the year 2015, it is projected that elders, age 60 and over, will be:

- 20 percent or more of the population in 55 of NYS counties
- 25 percent or more of the population in 19 of NYS counties
- 30 percent or more of the population in 2 NYS counties (Delaware- 32 percent and Hamilton – 37 percent).

Upstate's large senior citizen population increased in size and share.

- Fourteen percent of Upstate's residents in 2000 were age 65 and older, compared to 12 percent nationwide.
- Western New York had the largest share of seniors, at 16 percent, up from 15 percent in 1990.

Implications for New York State and its Counties:

- The implications of these demographic and social trends are significant across sectors yet communities are largely uninformed and unprepared.
- Health promotion and independent living will become essential goals if communities are to afford the economic consequences of increased illness and disability.
- The decrease in working age relative to older aged persons will require creative approaches to employment to offset a shrinking labor force and new approaches to care giving for frail elderly.
- Increased diversity will require that services be provided in culturally and language sensitive ways.
- Communities will need to create living environments that attract aging baby boomers if they are to maintain a viable tax base and business marketplace.
- Of particular concern to New York State and local governments are projected, significant increases in health care costs, and Medicaid costs specifically.
- Other trends with important implications for communities relate to labor force ratios and caregiver burden.
- The dependency care ratio (persons 85 years and older versus those 45 to 65 years of age) in New York will increase by over 70 percent between 2000 and 2050, impacting the human resources needed to support a growing population of elderly.
- The population support ratio (persons 85 years and older versus those of working age, 18 to 64 years) will decrease by 40 percent over the same time period, impacting the economic resources available to sustain aging communities.
- The number of persons age 65 and older relative to the number of homecare workers will increase from 7 elderly persons per caregiver to 24 per caregiver by 2050.

Sources:

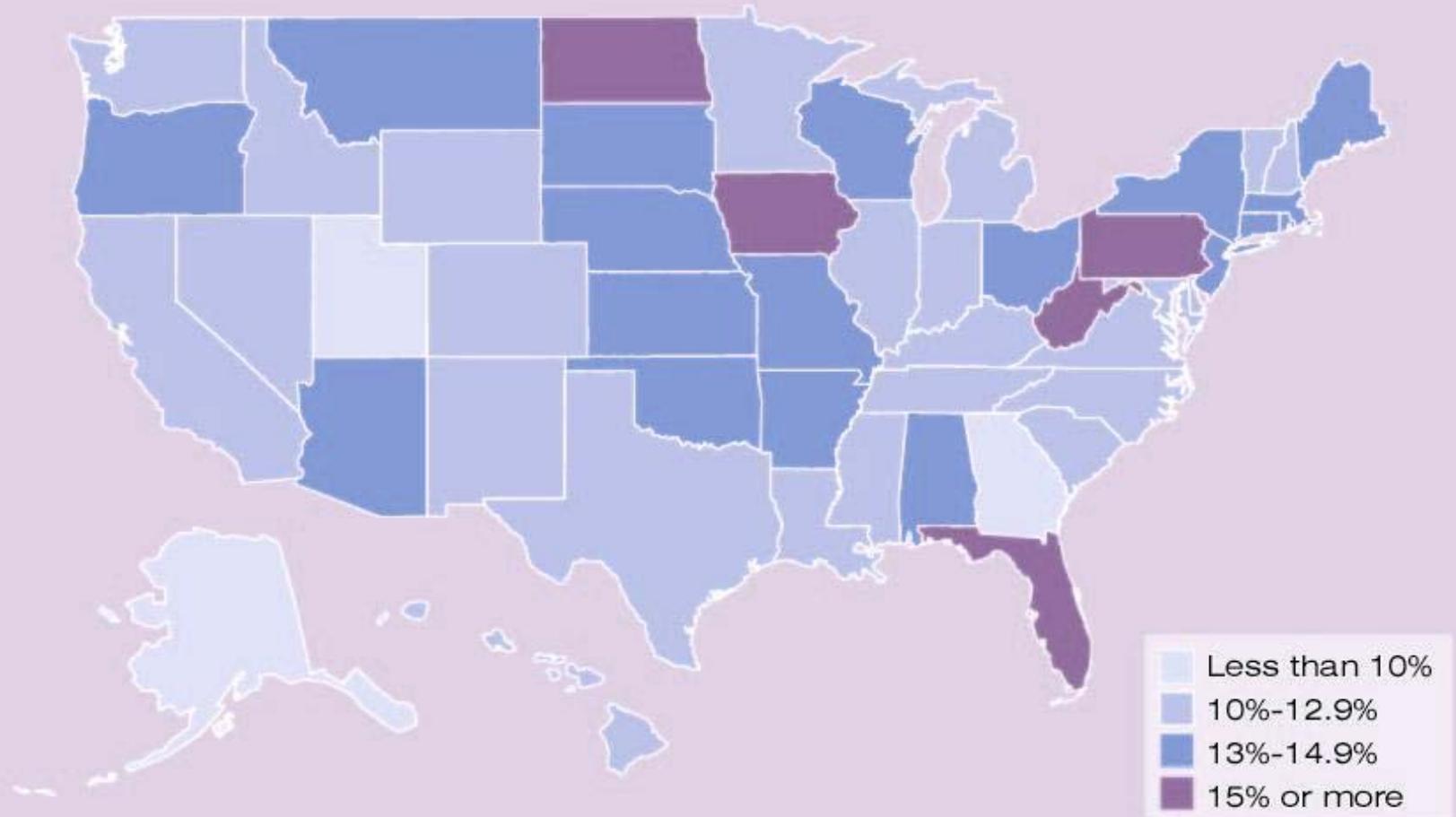
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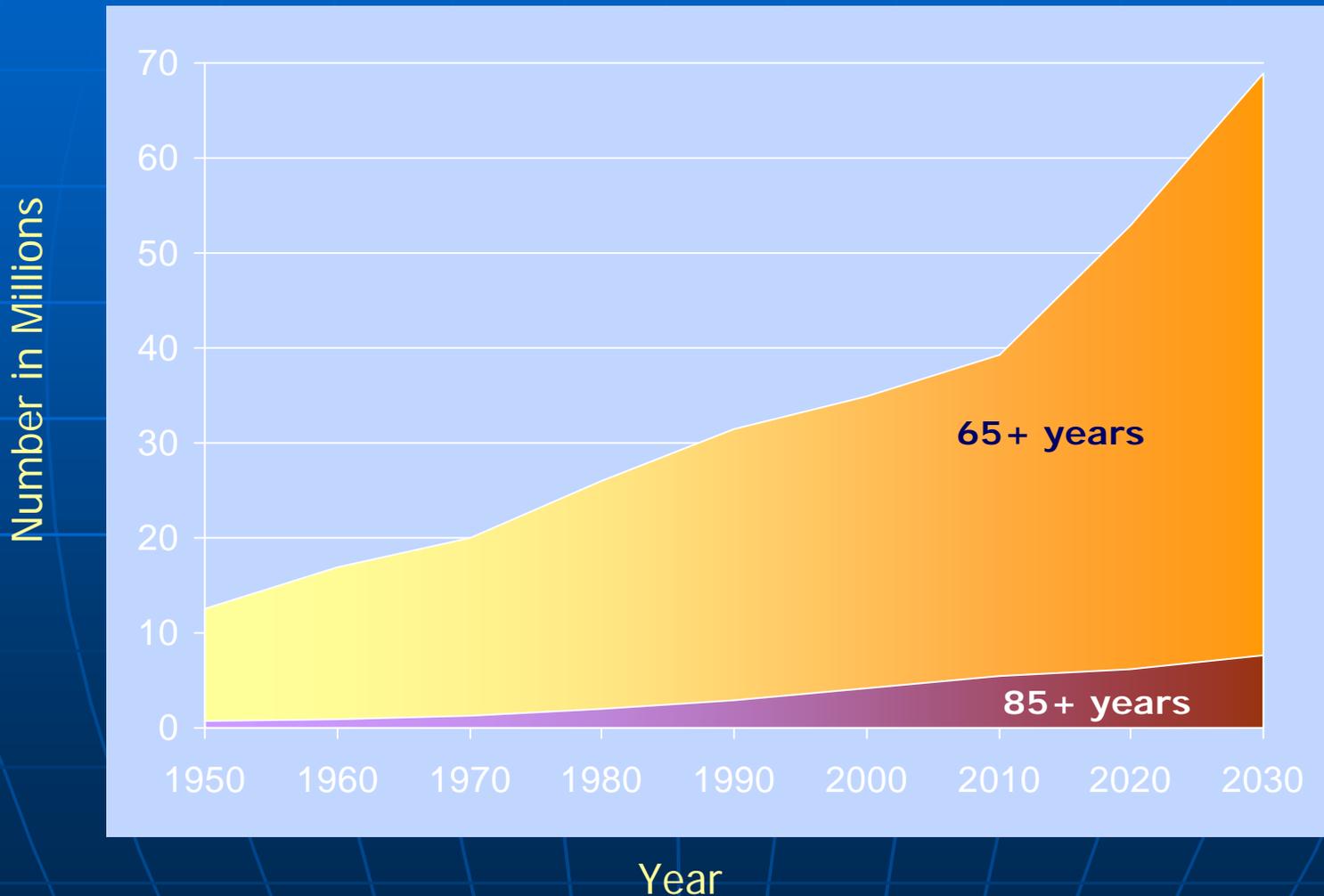
AGING BOOM DATA

Percentage of the population age 65 and older, by state, 2000



Note: Data for the year 2000 are middle-series projections of the population.
Reference population: These data refer to the resident population.
Source: U.S.Census Bureau, Population Projections.

The Graying of America 65+ Population 1950-2030



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The Graying of America 65+ Population 1950-2030

2000 -- **12%** of the US population
age 65+

2030 -- **20%** of the US population
will be 65+

The Graying of America 65+ Population 1950-2030

2000 - 2015:

Most rapid growth of population --

85+: ↑ 28 %

Impaired: ↑ 17 %

2000 - 2040:

85+ population –

↑ from 4 million to **19 million**

***AGING* - Baby Boomers**

2024 – All Boomers in Elder Cohort

Oldest Boomers

2006 – age 60

2031 – age 85

Youngest Boomers

2024 – age 60

2049 – age 85