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THE FUTURE OF LONG-TERM CARE: SAVING MONEY BY SERVING SENIORS

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THE FUTURE OF LONG-TERM CARE: SAVING MONEY BY SERVING SENIORS

WEDNESDAY, APRIL 18, 2012

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:03 p.m. in Room 216, Hart Senate Office Building, Hon. Herb Kohl, chairman of the committee, presiding.

Present: Senators Kohl [presiding], Whitehouse, Udall, Manchin, and Corker.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. Good afternoon to everyone, and thank you so much for being here. Today we're looking at the question of how best to provide and finance long-term care services for the millions of Americans who need them, while also balancing our debt, our deficits, and our overall financial picture.

As we look ahead, we're going to have to do more with less. We all know that. In fact, we must find better and more efficient ways to provide care because the money simply will not be there.

We're here today to talk about some of the ways to save money without doing material damage to long-term care. The costs of long-term care services, more than $300 billion a year, are already massive for both taxpayers and families, and left unchecked, this burden will continue to grow as our rapidly aging population requires more long-term care.

Medicaid alone projects $1.9 trillion in long-term care costs over the next 10 years, with an annual average cost increase of 6.6 percent, and we are seeing similar increasing cost trends for Medicare and in some sectors of the long-term care insurance industry.

Unfortunately, there is no easy answer. While our two largest publicly-financed health care programs, Medicaid and Medicare, currently pay for the bulk of long-term care, they are limited in scope, and private long-term care insurance has the potential to play a larger role, but the market is facing challenges, and some consumers have been skeptical about purchasing a policy that is both worth the cost and represents a secure and sound investment.

To help us meet this challenge, our witnesses will discuss some promising strategies for improving services while at the same time restraining costs. Particularly, I look forward to hearing about the savings we would achieve by reducing unnecessary hospitalizations, by delaying or avoiding institutionalization, and by increasing the use of home and community-based services. As we will hear

today, these solutions have already achieved some success and could be expanded across the country.

As we work to develop policies that enable seniors of all incomes to plan for and access long-term care, we will need the best ideas, and we will need to work together in a bipartisan manner. So we look forward to today's hearing, to the testimony and the ideas that we will hear from our witnesses.

And now the witnesses. Mr. John O'Brien is Director of Healthcare and Insurance for the U.S. Office of Personnel Management, where he oversees the Federal Employees Health Benefit Program; and more importantly for this hearing, the Federal Long Term Care Insurance Program. This program is the largest private long-term care insurance program in the country.

Mr. Loren Colman is Assistant Commissioner of the Minnesota Department of Human Services. With more than 25 years of experience with long-term care facilities, Mr. Colman oversees a host of programs for older adults and is a leading force behind Minnesota's Transform 2010 program, which is designed to help the state prepare for retirement of the Baby Boomer generation.

Dr. Holtz-Eakin is President of the American Action Forum. He was Chief Economist with the Council of Economic Advisors from 2001 to 2002, and he served as a Director of the Congressional Budget Office from 2003 to 2005.

Professor Judy Fader has had a long and distinguished academic career, serving as Dean of the Georgetown Public Policy Institute in Washington, D.C. from 1999 to 2008. Today, she is a professor at Georgetown University, a Fellow at the Urban Institute, and an elected member of the Institute of Medicine.

We also have Dr. Bruce Chernof with us today. He is the President and CEO of the SCAN Foundation, based in Long Beach, California, an organization that is dedicated both to research and to dissemination of knowledge that improves the health of older adults. Dr. Chernof also served as Director and Chief Medical Officer for the Los Angeles County Department of Health Services.

We thank you all for being here. And before we go to your testimony, we will hear from the distinguished Ranking Member of this committee, Senator Corker.

STATEMENT OF SENATOR BOB CORKER

Senator CORKER. Mr. Chairman, thank you. I know you had a conflict until 10:00. I came at the perfect time. I don't give opening comments much. I thank you for calling the hearing, and I look forward to listening to our witnesses. So thank you so much, I appreciate it.

The CHAIRMAN. Thank you.

All right.

Mr. O'Brien.

STATEMENT OF JOHN O'BRIEN, DIRECTOR OF HEALTHCARE AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT, WASHINGTON, DC

Mr. O'BRIEN. Chairman Kohl, Ranking Member Corker, members of the committee, thank you for the opportunity to testify today on long-term care insurance. The Office of Personnel Management

oversees numerous benefit programs, including long-term care insurance for Federal employees, annuitants, and family members.

Long-term care is divided into people who need help with activities of daily living or who need supervision due to severe cognitive impairment. It can be provided at home, in an adult daycare center, assisted living facility, or nursing home. Most health insurance plans, including the Federal Health Benefits Program, do not provide coverage for long-term care services. This unmet need led to the creation of the Federal Long-Term Care Insurance Program.

Long-term care insurance is an important benefit because people are living longer, and the likelihood of needing long-term care services increases with age. After age 65, Americans have a 70 percent chance of needing some form of long-term care during their lives. Long-term care is also provided to people under age 65 who need help taking care of themselves due to diseases, chronic conditions, injury, developmental disabilities, or severe mental illness.

Long-term care insurance is also important because services can be very expensive for the average American family. In 2011, the average cost of a semi-private room in a nursing home was over $75,000, and the average cost of home care was roughly $31,000.

In 2000, Congress passed the Long-Term Care Security Act, which authorized OPM to contract with qualified carriers to provide long-term care coverage for Federal employees, U.S. Postal employees, members of the uniformed services, annuitants and their qualified family members. In March 2002, OPM introduced the long-term care program to the Federal workforce.

This is the 10th year for the program, and it is the largest employer-sponsored long-term care program in the country. The long-term care program is a 100 percent employee-paid benefit. Through the long-term care program, the Federal Government uses its leverage in the marketplace to offer private, long-term care insurance to Federal employees and their qualified family members.

The initial contract to provide long-term care insurance for Federal employees was with Long Term Care Partners, a joint venture of John Hancock and Metropolitan Life. The benefit became available to Federal employees in 2002, and by February 2003, 187,000 individuals were enrolled. By the end of the initial 7-year contract term, enrollment had increased to approximately 224,000 enrollees.

At the end of the initial contract term in 2009, OPM awarded a second contract to John Hancock. As part of the new contract, John Hancock added a new benefit option with increased home health care reimbursement, new benefit periods, higher daily benefit amounts, and increased payment limits for informal care provided by family members.

The long-term care program provides coverage for nursing home stays, assisted living facilities, hospice stays, home care, and other services. In addition to Federal civilian and uniformed service employees, other qualified family members who are eligible to apply for the coverage include spouses, same-sex domestic partners, surviving spouses, members of the uniformed services, parents, and adult children.

Although enrollees can customize the benefit, the vast majority, over 99 percent, opt for one of four pre-packaged options. The pre-packaged plans offer variations in the daily benefit amount, the

benefit period, the maximum lifetime benefit amount, waiting periods, and inflation protection options. The package includes comprehensive care coordination, portability of coverage, international benefits with no war exclusions, and guaranteed renewability. Enrollees can change their coverage options as their needs change and have a variety of premium payment options.

Since the new contract offered new covered options that were not previously available, in 2011 OPM held an open season for the long-term care program. I should note that an individual can enroll in the long-term care program at any time. But outside of an open enrollment period or within 60 days of their hiring as an employee, they are subject to full medical underwriting.

What we have referred to as "open season" allows employees and their spouses to apply with abbreviated underwriting, which means applicants answer fewer questions about their medical history. I should also note that during the 2011 open season, same-sex domestic partners of Federal employees had the option to apply with abbreviated underwriting. This inclusion of same-sex domestic partners followed President Obama's June 2010 memorandum directing agencies to extend benefits to same-sex domestic partners of Federal employees, consistent with existing law.

Educational efforts for the 2011 open season began in fall of 2010. OPM, along with Long Term Care Partners, worked to increase awareness about the benefits of long-term care insurance for the Federal workforce. Direct mail, email campaigns, workshops, webinars, advertisements, payroll notices, and other tools educated the Federal workforce about long-term care insurance. Additional information was available on the Federal long-term care website, including the ability to apply for coverage online. Clarity and transparency were top priorities of the educational campaign, and care was taken to assure that benefits and features of the long-term care product were clearly understood.

The educational efforts were very successful at increasing awareness among the eligible population that the program is a valuable and cost-effective way to protect against the high costs of long-term care. The success of the effort was borne out by the numbers. We received over 45,000 applications during the 2011 open season, and total program enrollment increased 20 percent, from 224,000 to approximately 270,000 members.

As the long-term care insurance market continues to evolve, we believe the Federal long-term care program is well positioned to offer a variety of benefit choices with relatively low cost to enrollees. OPM is working to maintain the long-term viability of the program by pursuing policies that will protect current and future enrollees. For example, we are interested in pursuing participation in state/Federal long-term care partnerships which provide asset protection as an incentive for enrollment. We are also continuing to assess plan benefit options to ensure that they are attractive to enrollees.

Long-term care insurance provides a cost-effective way for individuals making average incomes, like most Federal employees, to protect themselves against the financial catastrophe that a long-term illness or injury can cause. The long-term care insurance market is still relatively young and uncertain, and OPM will need to

closely monitor the market to make certain the program meets the current and future needs of the Federal family. Our goal is to provide enrollees with insurance protection, mitigate their potential costs for long-term care services.

Thank you for the opportunity to testify today and I am happy to address any questions you may have.

The CHAIRMAN. Thank you, Mr. O'Brien.

Mr. Colman.

STATEMENT OF LOREN COLMAN, ASSISTANT COMMISSIONER, MINNESOTA DEPARTMENT OF HUMAN SERVICES, ST. PAUL, MN

Mr. COLMAN. Thank you, Mr. Chair, and members of the committee. On behalf of Commissioner Jesson, I thank you for this opportunity to share with the committee the efforts that Minnesota is making to provide the best possible long-term care system for older adults and persons with disabilities.

Minnesota has a strong infrastructure, built over many years, of long-term care services and supports for older adults and people with disabilities. Last fall we were very proud and gratified to see the quality of Minnesota's long-term care system recognized by the AARP and the SCAN Foundation.

Minnesota ranked number one among all states in the first-ever AARP Scoreboard on Long-Term Care Services and Supports for Older Adults, People with Disabilities and Family Caregivers. The report validates the direction that Minnesota has been moving for the past 25 years, to reduce reliance on institutional care and encourage access to services in home and community-based settings. It acknowledges Minnesota's efforts in providing comprehensive phone and web-based information and referral resources for seniors and their families and people with disabilities, as well as providing evidence-based support for family caregivers.

Not that long ago, most people that were served by Medicaid in Minnesota received long-term care services in an institution. Over time, we've developed the supports needed to serve people in their own homes and communities. Today, 63 percent of the older adults receiving Medicaid long-term care services get that care in their home or in community settings, and 95 percent of persons with disabilities receiving medical assistance long-term care services are in community settings.

We are also proud of Minnesota's system of nursing facilities as the state and facilities have worked in partnership toward improved quality and care. Several years ago we launched a Nursing Facility Report Card to give consumers and family members access to comparative information on quality and consumer satisfaction. We have promoted innovation in care through performance incentive payments. The median length of stay in Minnesota nursing facilities is now less than 30 days as services become rehabilitative in nature. Successful collaborations with the industry have contributed to right-sizing the number and distribution of nursing facilities in the state.

In Minnesota, a healthy synergy results from having the policy areas for aging and adult services, disability services, nursing facility rates and policy, and the Minnesota Board on Aging consoli-

dated into the part of the Department of Human Services that I oversee.

We have worked very hard over the years to ensure a solid alignment of services delivered under Medicaid and the Older Americans Act. These services, on a continuum, become the critical safety net that seniors use as they become more frail. By aligning them much more closely in how seniors transition among each service, we ensure that the system works in a more cost-conscious manner and delivers care better to seniors and their caregivers.

The Older Americans Act is a critical resource in our long-term care system and supports. The Senior LinkAge phone line, which annually serves 89,000 older Minnesotans and their families, and the complementary Disability Linkage Line and Minnesotahelp.info website, are valuable foundations to our services.

These services comprise a statewide virtual call center that allows for a single toll-free access with routing to local communities. Trained professionals answer questions about all types of insurance and Medicare products, including our state's long-term care partnership policies and other long-term care options. They are well positioned to answer inquiries from people seeking to understand the basics and options about housing and other long-term care services as they age.

Under new legislation, these counselors also are involved in expanding long-term care consultation that helps individuals considering assisted living to become fully informed consumers. We have found that good information as early as possible can also delay the need for more expensive services or the need to access Medicaid.

Linkage Line Services have expanded under Lt. Governor Yvonne Prettner Solon to be a "one stop shop" for seniors and their families for direct contact with all state agencies on issues that they may have with any area of our state government.

Similar to many states, Minnesota is significantly challenged in meeting the anticipated demand for long-term care services and supports, especially as Boomers age. We are currently working on a request for a Medicaid waiver that would redesign the program to offer benefits based on the need of the individual, so that they get the right levels of services based on their needs, from lower needs to higher needs.

We know that the preference of most older Minnesotans is to remain in their home. We want to further empower older Minnesotans to make those choices by making home and community-based services the norm in Minnesota and institutional care the exception.

As Minnesota has worked successfully to rebalance our long-term care system, we also have had our eye on the coming age wave. And now, we are on the verge of launching the "Own Your Future" campaign in Minnesota to encourage people to plan, especially those in the 40 to 65-year-old range. We're building on what other states have done in partnership with the federal government, and we're adding some new elements:

A public awareness campaign that includes marketing via the Web using contemporary messaging such as Internet ads;

Development of more affordable products for middle-income people;

Better alignment of the incentives within Medicaid to support private financing of long-term care. The Long Term Care Partnership is a start, but it's not the end;

Targeted outreach to employers as a credible source of information about long-term care and financing options. Employers benefit from offering workers a sense of control and peace of mind that a long-term care plan can provide.

The Minnesota business community has expressed a strong interest in working with us.

Our goal for "Own Your Future" is not only to raise awareness of the financial risk of not preparing for long-term care needs. We want to improve the quality of life for Minnesotans in their later years by increasing the number of those who have taken action to own their future and maintain choices. I can provide more details on the campaign if time allows today.

Thank you for the opportunity to testify.

The CHAIRMAN. Thank you very much, Mr. Colman.

Professor Feder.

STATEMENT OF JUDY FEDER, PROFESSOR OF PUBLIC POLICY AND FORMER DEAN, GEORGETOWN PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Dr. FEDER. Chairman Kohl, Ranking Member Corker, I am delighted to be with you today to discuss the—thank you.

I still am delighted to be with you today to discuss ways to improve the quality and efficiency of services for people who need long-term care.

Chairman Kohl, you started by asking about ways we can reduce unnecessary hospitalizations for this population, and that is the focus of my testimony. I specifically want to explain why it is so important that the Medicare program give top priority in delivery reform initiatives to people, beneficiaries, who need long-term care, and that those initiatives extend care coordination beyond medical care to include the coordination of long-term care services.

The data that I present in my testimony, developed with the support from the SCAN Foundation, will tell you why this is so important, and I'm hoping that you have my testimony in front of you. But if you don't, I'm going to tell you what to look for in the data, when you have that, when you look at the pictures.

The first slide that we show you, Figure 1, shows that despite the fact that we are focusing so much on people with chronic conditions as a source of high Medicare spending, when we look at the data, it is not the people with chronic conditions alone who are driving high Medicare spending. It is people whose chronic conditions create the need for long-term services and supports. In fact, what we show you in the first figure is that it is the 15 percent of Medicare beneficiaries with chronic conditions and long-term care needs who account for close to a third of all Medicare spending.

The second figure brings this down to per-capita spending, per-beneficiary spending, and it shows us how disproportionate that spending is. Average per-person spending for enrollees with chronic conditions and functional limitations, average spending is at least double the average for enrollees with chronic conditions only. Medi-

care spends almost $16,000 per beneficiary for functionally impaired beneficiaries and much less for everybody else.

The third figure in my testimony shows us that this pattern—higher spending for chronically ill people who have functional limitations relative to chronically ill people who don't—holds true no matter how many chronic conditions people have. So even the per-capita spending for people who have as many as five chronic conditions is lower than for a beneficiary with only one chronic condition but also long-term care needs. So again, it's long-term care that's driving high spending.

The result is that it is beneficiaries with long-term care needs who rank among the highest Medicare spenders, and you can see that in Figure 4. Nearly half the beneficiaries in the top 20 percent of Medicare spenders, and 61 percent of the top 5 percent of spenders need long-term care along with having chronic conditions.

Now, where is the extra spending going? That takes us to the hospitalizations. The data show us that enrollees who need long-term care are much more likely than other beneficiaries to be using hospitals, to have hospital stays, and to use hospital emergency departments.

We also find that it is higher hospital and post-hospital spending in skilled nursing facilities, short-term spending in skilled nursing facilities and by home health agencies, that is the largest source of the extra spending that I've described to you for people with long-term care needs.

The good news is that using new authorities in the Affordable Care Act, the Center for Medicare and Medicaid Services is promoting delivery innovations that, through care coordination, aim to reduce precisely this kind of excessive hospital, and with it post-hospital, service use. But past experience tells us that without effective targeting to beneficiaries most at risk of inappropriate and high-cost hospital use, such as the long-term care users I've been describing, the coordination is not likely to produce significant savings. That's why it's so important that Medicare target its innovations to people with chronic conditions and functional limitations and coordinate the full range of their service needs.

Although limited in number, programs that do this exist all around the country, but are small in number, and they have shown promise in reducing hospital use, nursing home admissions, and cost for selected patient groups, while improving the quality of care. CMS can build on these organizations' experiences by encouraging interventions that accommodate the various sizes and capacity of primary care physician practices, and by improving upon, but not replacing, the fee-for-service payment system, by paying monthly amounts per enrolled patient sufficient to support care coordination and other currently uncovered care management services, and by holding participating providers accountable for savings that offset the costs of coordination.

Dual eligibles, beneficiaries served by both Medicare and Medicaid, represent about half of the beneficiaries that I've been talking about. But despite the potential I've shown you for Medicare savings from coordinating Medicare-financed care, to date policymakers have focused overwhelmingly on states and Medicaid rather than Medicare as primarily responsible for improving care to

dual eligibles. The absence of Medicare leadership is particularly odd given that 80 percent of the dollars that are spent on dual eligibles—and you can see this in Figure 7—80 percent of the dollars spent on dual eligibles are Federal dollars, more than two-thirds of which flow through the Medicare program.

To improve care and reduce costs for Medicare-Medicaid beneficiaries, dual eligibles, along with the roughly equal number of Medicare-only beneficiaries who need long-term care, it is essential that Medicare exert its leadership rather than simply shift responsibility to the states. And a major way they can do that is, as I've described, is to give priority in delivery reform to people who need long-term care and to coordinating their long-term care, as well as their medical services.

Thank you.

The CHAIRMAN. Thank you very much.

Dr. Chernof.

STATEMENT OF BRUCE CHERNOF, PRESIDENT AND CEO, SCAN FOUNDATION, LONG BEACH, CA

Dr. CHERNOF. Thank you, Chairman Kohl, Ranking Member Corker, for the opportunity to testify at this critical hearing today. My name is Dr. Bruce Chernof, and I serve as the President and CEO of the SCAN Foundation, an independent, non-profit foundation devoted to creating a sustainable continuum of quality care for all seniors.

We envision a society where seniors receive integrated medical care and supportive services in a setting most appropriate to their needs and with the greatest likelihood of contributing to a healthy and independent life.

Americans today are living longer than in previous generations, often with chronic conditions and functional impairment at older ages, which increases the number of people who will need long-term services and supports. Most Americans are not aware of the high likelihood of needing long-term services and supports at some point in their lives, and have few tools to plan for this reality. The cost of this care is substantial, impacting both family financial resources and the ability for family caregivers to engage in the labor market. When individuals and families have exhausted their personal resources and can no longer shoulder these costs on their own, they have to depend on Medicaid for help. Those who qualify for Medicaid long-term services and supports generally need this assistance for the rest of their lives.

Medicaid is fundamental to the current financing and delivery of long-term services and supports for low-income Americans. It's the largest purchaser of long-term services and supports, and it is the backdrop for all vulnerable older Americans who need this level of care after spending their resources.

Medicaid has evolved over the years from paying exclusively for nursing home care to funding critical services in the community that allow for low-income individuals with substantial daily needs to live in the place that they call home. Several states have taken or are currently taking strides to bolster their Medicaid long-term services and support systems, with the goal of providing high-qual-

ity, person-focused, and cost-effective care to their residents, including states represented by members of this committee.

So, for example, in our recent Scorecard that we put together with the support of the Commonwealth Fund and completed by AARP comparing all states on having a high-performing long-term services and support system, Wisconsin ranked fifth in the nation. Additionally, we funded technical assistance to 21 states that seek to evolve their Medicaid long-term services and support systems. Tennessee is a frontrunner in this group given their experiences with the Choices program.

Current laws and regulations, including many positive provisions in the ACA, already exist, giving states the flexibility to upgrade their operations, create more integrated, person-centered care, with strong beneficiary protections.

Under these arrangements, states must increase the quality monitoring and oversight rules to ensure that individuals have appropriate access and that quality protections are incorporated into purchasing contracts and are strictly upheld in practice.

States seeking only to solve what they perceive as a cost problem in Medicaid, without giving sufficient attention to improving person-centered access and care delivery, have a great potential to create undue harm to some of the country's most vulnerable residents.

We believe that more person-centered care delivered in organized systems will generate savings in Medicaid. These savings, however, are necessary but not sufficient given that there will be a net increase in need. Medicaid is poised to take on more long-term services and support costs due to the trifecta of increasing life expectancy, increasing prevalence of chronic conditions and functional limitations at older ages, and finally low savings rates among Baby Boomers. Some states will experience the impacts of these factors on their Medicaid programs faster than others. Policy options are needed to minimize the disparity among states to absorb these costs through already-constrained resources, those same resources that face potential cuts as part of entitlement reform discussions. One possibility is to provide enhanced Federal support to states that are experiencing the most rapid patient aging.

We also think that there is a lot of almost mythology about what is or isn't happening in the Medicaid program, and Medicaid crowd-out is, frankly, one of those areas that is more theory supported with scant evidence than proven fact. Many other organizations have done polling work, and we've done polling work ourselves that documents that the vast majority of Americans have no idea who pays for long-term care, long-term services and supports, or they believe that Medicare will cover them when the time comes.

Furthermore, no one looks forward to being on Medicaid because it carries a public perception as being a welfare program.

So American families deserve affordable, accessible, comprehensive solutions in order to plan for their future long-term services and supports needs without having to spend down to Medicaid, if possible. Policy options in the public sector, but also in the private realm, should be thoroughly explored to meet these aims so that Americans can receive high-quality services provided with dignity, respect, and transparency.

Thank you so much.

The CHAIRMAN. Thank you very much, Dr. Chernof.
Dr. Holtz-Eakin.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM, WASHINGTON, DC

Dr. HOLTZ-EAKIN. Chairman Kohl and Ranking Member Corker, thank you for the privilege of being here today. Let me just pick up on some points that have been made by the panelists before me, and then I'll be happy to answer your questions.

The first is, obviously, this is a very difficult problem whose scale will grow rapidly in the years and decades to come, and there are really two separate aspects to it. The first is going to be the nuts and bolts costs of long-term care services driven by a greater number of individuals who will require those services and an increasing cost per person, and there are really two things that the committee can think about on dealing with that fundamental problem, which is the cost.

One is those kinds of preventive actions that could be taken to either defer or eliminate the need for long-term care services, and there, the things that stand out are the increasing prevalence of Alzheimer's and dementia, which lead to extremely costly cases, and to the extent that research and other efforts can make progress on that, I think that's something that should be within the scope of the discussion.

And the second is the models of delivery which actually are more efficient, and thus given the state of the condition of any beneficiary, would lower the cost on actually delivering those services, and there I think the real moral is going to be picking very flexible strategies because we know that the current models, largely informal care provided by family members, can't survive the need to work and the increasing number of people needing the services, and we're going to have to have a lot of flexibility in the delivery of these services as we try to learn about what works.

So avoiding building into some sort of program a rigid structure I think is the first order of business, given the cost problems that are going to face us.

Then the second aspect is the financing of the cost of those services. Again, I think we're going to have to do things very differently. I at least believe that an enormous effort should be placed on enhancing the private-sector financing of these services as the top priority, and doing everything possible—and I understand this is not easy—to have private long-term care insurance take a greater role in the financing of this.

I say that for two major reasons. I mean, the first is we know the current and projected strains on the Federal budget. They are, quite frankly, daunting, and in my years at the CBO and my career spent studying congressional budget problems, I've never seen anything like the position we find ourselves in. It is simply not a time at which we can commit the taxpayer to additional mandatory spending commitments without thinking very hard about it. I mean, right now the cash flow gap between premiums and payroll taxes coming into Medicare and the spending going out is approaching $300 billion a year. It is an unsustainable trajectory. So if we can enhance the private sector pick-up of these costs before

we put them on the Federal budget, everyone comes out ahead, I think.

The second reason is we've never pre-funded the costs of these services. If we had private insurance reserving premiums and pre-funding the payment for the cost of that care, we would, in fact, address some of our national saving issues and have a benefit there of delivering better overall growth and economic performance at a time when we're going to need every national dollar to meet the variety of demands on both the public and the private sector for the resources to meet the standards of living for both the elderly and the working population.

So I think the strategies have to be flexibility and prevention on the costs, and private sector first on the financing, and I'd be happy to continue the discussion. Thank you.

The CHAIRMAN. Thank you very much.

So we'll go to questions and comments at the moment. There appear to be three areas where there is strong evidence that we can indeed save money while at the same time not damage the effectiveness of long-term care, and you have all referred to these three: number one, by keeping people out of the hospital in the first place; number two, by not sending people to a nursing home until they absolutely need to be there; and number three, by rebalancing or shifting nursing home residents who don't really need to be there to a home or a community setting where their costs are lower.

So moving from here on forward, addressing these three things, how can we do better? Do you have some particular thoughts and ideas on how we can improve on our cost of long-term care while not damaging the product?

Mr. O'Brien.

Mr. O'BRIEN. I think OPM is incredibly interested in sort of continuing to improve the products that we're offering. Just to clarify where we are, it is still a relatively young product for us. The experience of folks who are actually getting the services is relatively small relative to the total population that is in.

One of the things we are monitoring very closely with our contractor as we go forward is as advantages are made in the delivery of the service, we will work with our contractor to make sure that those are applied to our program, and we are very interested in hearing what those on the cutting edge of these programs are as what the best way forward is.

The CHAIRMAN. Mr. Colman.

Mr. COLMAN. I think initially we have to look at what does the consumer want and what does the consumer have the ability to have as choice, and the number-one thing we hear from older people in Minnesota is they want to remain in their homes. And if we can provide low-cost interventions, we can delay the need for more expensive services for some period of time, and that's what we're really focusing on, is delaying the need for more expensive services.

We have a tracking in Minnesota. Ninety-two percent of long-term care in Minnesota is provided by families right now, and they want to continue to do so, and the more we can support families to continue to help their older family member, again it will conserve dollars for those that truly have higher needs.

The CHAIRMAN. Does that 92 percent lead the nation? Do you know, or do you——

Mr. COLMAN. Mr. Chairman, I don't know. I don't know what other states are tracking. We——

The CHAIRMAN. Are you imagining—because you've been in this field a long time—that that's among the very highest in terms of percentage?

Mr. COLMAN. I think it is probably, Mr. Chair, on the higher end of the spectrum. But I think family members throughout the country want to support their family members. They need the tools, they need the information, they need some additional support in order to do so, but I believe there are people across the country who are committed to helping their family members.

The CHAIRMAN. I think you and the others on our panel have said that a key is keeping people with long-term care needs in their homes as long as possible, keeping them out of hospitals, out of nursing homes, and in their homes. Is that right?

Mr. COLMAN. Mr. Chair, that's correct.

The CHAIRMAN. What about you, Professor Feder?

Dr. FEDER. Chairman Kohl, you asked about reducing hospital use as one of your goals. My testimony was directed at that through improved coordination of care, enhanced primary care targeted to this population, and coordinating their long-term care needs, as well as their basic medical needs.

But I would add to that in preventing unnecessary hospitalization. We have tremendous evidence of inappropriate, unnecessary, and potentially preventable hospital use by long-term nursing home residents who are not getting enough nursing care in the nursing home. And I would urge attention to holding nursing facilities, skilled nursing facilities—again, you can do this through Medicare—holding them accountable for providing that good care and thereby preventing unnecessary hospital admissions, whether for bedsores or dehydration, things that we know can be handled in the nursing home.

And a third area for Medicare initiatives would be greater accountability for good-quality care, including preventing unnecessary hospitalizations, in the SNPs, the special needs plans, the Medicare Advantage plans that are directed at dual eligibles. MedPac tells us that we don't know very much about what goes on in those plans, and we could do a far better job of holding them accountable for delivering appropriate care.

Now, when you ask about promoting more home and community-based care, I would answer with what not to do. Making major cuts in Medicaid financing and Federal financing for Medicaid, or turning over more responsibility to the states I believe would put home and community-based care in particular in danger, and nursing facilities have a great deal of political power in the states, and I think that if resources are constrained, particularly as needs are rising, to cut what's coming in from the Federal Government would particularly put home and community-based services at risk.

I would similarly pick up on a caution that I heard in Dr. Chernof's testimony about any initiatives that are moving to managed care for dual eligibles or managed long-term care that are primarily budget, not quality driven. There, too, I think we have to

be very mindful of whether we will be getting appropriate home and community-based along with other services for those beneficiaries.

And then finally, I would endorse another comment or suggestion of Dr. Chernof's, regarding the future as the population ages. I'm rooting for those improvements in preventing Alzheimer's. It's not only in my personal interest it is clearly in the nation's interest. But we are likely to see an increased demand or need for finance for formal long-term care services, and unlike Dr. Holtz-Eakin, I'm not a believer that we will make great progress through private long-term care insurance. We can do better with private long-term care insurance, especially on its quality, but I do not see that as the financing solution for the problem, whether we have it now or we have it in the future.

In that area, enhanced Federal support, as Dr. Chernof said, with an enhanced match, or with the federalization of the program, I think, is going to be critical to getting appropriate access to care at home and in the community, as well as in nursing homes as the population ages.

The CHAIRMAN. All right.

Dr. Chernof, how can we do better without spending more?

Dr. CHERNOF. Chairman, a couple of observations. First, I'd suggest that you're asking a specific question about what can we do better now, and I would observe that there is also this other question, which is how do we plan better for the long term. And so I want to address my comments specifically to your question, which is what is it that we can do with current systems to really improve them given what we know.

I would observe, if you were to look at our long-term services and supports scorecard, looking all across the country, and then the roadmap work that we completed with the Center for Health Care Strategies looking at the steps to improving systems, whether it begins with rebalancing, moving to managed long-term services and supports, or creative models around duals, we should be heartened by the fact that there are really good models out there, some of them represented by folks on this committee, and that we should be building on what we know.

So the notion that we're starting from scratch is certainly not accurate. There are really good models, and we should build on those experiences.

To Dr. Holtz-Eakin's point, which I strongly agree with, flexibility is really important, because how we're going to meet the needs of families and delivery systems is very locally based. It's based on the assets on the ground, on family structures and other kinds of resources.

So the solution I think to your three points resides in organized, accountable systems of care that have the flexibility to meet the needs of families and are responsive to the assets that are available. I would offer that those flexible, accountable systems have four key characteristics.

The first is that they begin by focusing on the quality and coordination of care. The notion of targeting the right services to the right folks is incredibly important in how you get the efficiencies you're looking for.

The second point would be that they have rebalancing at their core, which means we are going to focus on helping folks stay in the communities of their choice, that we're going to work against the tyranny of the bricks and mortar. I'm a physician. I grew up in hospitals. I've cared for people in nursing homes. Bricks and mortar drives so much of the financing of health care, but what we're really talking about is a system that begins and resides with the focus being in the community.

The third key point would be this notion of self-direction and choice. It's hard for clinical providers to do that. I hold myself amongst them. We really start by talking with patients and families about what they want and then try to achieve that, because that will often be the most cost-effective choice, and it will often be one that keeps the family, the individual, even when they are a patient, in the driver's seat.

And the fourth characteristic is that any of these changes really do need to be efficient systems. They need to generate cost savings that can be used to support the system, that they generate outcomes that improve quality. So that notion that you measure what you're doing, that we're not just building systems that are more expensive because they're better, but we're building better systems that are actually more efficient and are much better stewards of the public resources that we use in these programs.

The CHAIRMAN. Thank you.

Dr. Holtz-Eakin.

Dr. HOLTZ-EAKIN. Yes. So I think the important things to echo are that there are models and examples that appear promising at the moment for, in particular, doing the coordination in many cases across what are traditionally separated long-term care and health services.

Our experience when I was at CBO was that successful small-scale models don't often scale successfully. So what I would urge you to do is think hard about scaling things up, in particular if you're going to go past something that looks like a demo, pilot, example, and focusing on the states as the vehicle for scaling makes a lot of sense because they have the capability of running large-scale programs like Medicaid, they have flexibility in how they implement things, and you can learn from the different state experiences. So I think a focus on the state level actually makes a lot of sense from that point of view.

We also know that many states have been very successful in the health area using managed Medicaid approaches with adequate quality controls for outcomes. To the extent that we wanted to try some more coordination through that vehicle, I think that would be a sensible first step in this area and see what kind of results we actually get on larger populations.

The CHAIRMAN. Thank you.

Senator Corker.

Senator CORKER. Thank you, Mr. Chairman, and thank all of you for your testimony.

As you look at the issue and just look at overall financing for health care in general, it's obviously a major train wreck that's out on the horizon. I was this weekend visiting a couple of neighbors in a long-term care facility, and it's just incredibly expensive. All

of us either have loved ones or friends or neighbors that have had Alzheimer's. We see more and more of that coming. So the financing component of it is just incredibly difficult and a national issue, and moving to a national crisis.

How are the private institutions that you've dealt with that are actually insuring long-term care on the private side, how are they actuarially doing? I mean, it seems to me it would be very difficult at this juncture, knowing so many changes demographically but also larger occurrences of Alzheimer's, obviously much larger costs, how in the world, how are the private institutions faring that are actually in the long-term care business, and are there concerns about their solvency down the road?

Do any of you want to—I know some of you don't really like private, so I'll ask you some public. Go ahead.

Dr. HOLTZ-EAKIN. I think we've seen both some private failures where they have not adequately managed those risks, and we've seen some people leave the long-term care insurance market as a result, but we've also seen some of the institutions both understand the interactions with Medicaid better, have taken advantage of the partnership opportunities, offer policies that protect against up to 5 percent inflation risk to the beneficiary and still manage their finances well enough to stay in business.

So there are still people in the business and being successful. If we get more examples like OPM, where there are more employers providing the gateway to large pools of individuals buying this insurance, I actually think they would have a much brighter future. When you look at the kinds of things that matter for making private insurance more successful and a bigger part of this—and I want to emphasize for Professor Feder's sake, I don't think private insurance is going to pay every dollar going forward. Most is in families. That's the bulk of it. We ought to get every dollar we can in private insurance because the demands on the public sector are going to be enormous, and we just ought to do these things.

So I think awareness, start with awareness campaigns. I think there is a lot of ignorance about the need for this care late in life and who is going to pick up the tab. Get wherever you can employer offer as part of the package so that people can see it there, and enroll——

Senator CORKER. You mean in a cafeteria?

Dr. HOLTZ-EAKIN. If at all possible, yes. I mean, it's not perfect for everything. Deal with the Medicaid coordination issue. I mean, there is a research literature suggesting that Medicaid crowds out private long-term care insurance. I think it deserves serious consideration. It's not the only reason that there's trouble. You could consider some things for the tax code. None are magic bullets.

But again, since we have a saving need, and we have a long-term care financing need, products that come with annuities for long-term care insurance, innovative financial products that are favored by the tax code might be part of the solution. And if you go back to the literature on how do you get people to save and buy health insurance, you could have opt out. Start with private long-term care insurance as part of a package and then opt out of it if you don't want it.

So, none of those are, in and of themselves, fabulous. None of them are, in and of themselves, going to solve it. But I think all of them merit some consideration.

Dr. FEDER. Senator Corker, it's not that I don't like private long-term care insurance.

Senator CORKER. I was going to ask you about public.

Dr. FEDER. I'd be happy to talk about that as well, but it's not that I don't like it. It's that it is—and Doug has couched his suggestions, suggestions—it's a neutral term, "advocacy"—in terms of recognizing that it's part of the solution. It's not the solution.

And my concern is that as long as I've been working on this issue, and it's getting close to long enough to need long-term care, long-term care insurance has been called a fledgling industry. It is very challenging for this industry to grow. It's serving about the same number of beneficiaries today as it was 10, 20 years ago. It's just not growing. And several of the companies, or certainly some prominent ones, have stopped offering the product.

I don't know that it's because they're going out of business, but they're having difficulty making money on it and making it grow. The way they keep from going out of business is that they set limits on the lifetime benefits and are careful in selecting their beneficiaries and, when necessary, they increase the premiums even after people have been paying for many years.

So it is a product that is particularly limited—and I know that Senator Kohl has been quite interested in promoting strong quality standards for insurance. If it's a good product, it's good that people with means can afford it. But the number who can is modest, and the industry itself recognizes that.

So my concern with a strategy to make it better, I think making it better is great. My concern with any strategy that would, say, put tax incentives into it to support it, that's actually spending public dollars or foregoing revenues, as Doug well knows, and if I'm choosing, I would rather see those dollars strengthen support for those least able to afford care, not for those who are most able to afford care, because we know historically that those subsidies do, in fact, go to people who probably would have bought it anyway.

Senator CORKER. That's interesting. I do think the environment here is moving more towards tax reform that doesn't incent, that actually does away with many of the $1.2 trillion in tax breaks that we give each year. So I understand that's a suggestion that maybe calls for there to be greater uptake. At the same time, I think the momentum right now is in a very different direction, and I think everybody acknowledges that.

Doctor.

Dr. CHERNOF. Just to add one observation, more from a clinical place than the folks on each side of me, I guess the challenge that I see in front of us is that we've failed as a country to achieve a social policy goal of getting people to plan effectively for their long-term service and support needs as they age, given that 70 percent of folks are going to need them.

So even when you look at things like the Partnership Program, which is a nice incremental step, the reality is that it's an open question whether the Partnership Program actually covers new people or whether it covers people who were predisposed to buy

long-term care coverage, which is still a good thing. I mean, every person covered is a good thing.

So those sorts of challenges suggest that what we have is kind of a boutique or a niche product and that many of the solutions we've looked at sort of build in a very incremental way, and I think the challenge or opportunity in front of us may be to look at larger-scale solutions that get us to broader forms of coverage, whether they're in the public or the private space. But we need to get to a place that has people more engaged and that there are cost-effective choices in front of them.

Senator CORKER. Professor Feder, I know that you were, I think, a pretty major champion of not necessarily the Class Act but something like that, where there was public financing in place. If you look at where we are today, where in today's dollars the average American family making average wages puts about $119,000 into the Medicare program over their lifetime in today's dollars, and that same family takes out of Medicare over their lifetime in today's dollars $357,000, as we all know, you cannot make that up with volume, and yet a lot of volume is on its way, over this next 10 years in particular.

I mean, knowing that we're not particularly good at making those things work in the public sector, we always want to give people what they wish without asking them to pay for it. I mean, that's kind of the way politics has been in Western democracies.

Is there a way for us to effectively design, in your opinion, a public plan that addresses the concern you're talking about, that we're all talking about?

Dr. FEDER. Well, I think there is. I think that, unfortunately, there's a lot of resistance to that at the current time. But let me just——

Senator CORKER. And I think a lot of it is because of the way we've handled some of these other programs.

Dr. FEDER. Well, let me address that. First, I think it's useful to consider and we've heard a couple of times, accurately, that 70 percent of people who are turning age 65 are likely to need long-term care. The reason that we're talking about insurance, whether public or private, is because there's a lot of unpredictability for individuals about where they're going to fall.

So on the 70 percent, that means 30 percent aren't going to need it at all, and I think we all root for that, live to a ripe old age and then say goodbye, healthy. That would be the best. But there are also, even within the 70 percent, about 17 percent use less than a year of intensive long-term care services. At the other end of the spectrum—excuse me, 20 percent use more than 5 years. So there's variation, and that's why we talk about insurance, because savings alone, you can't do it.

Senator CORKER. That's right.

Dr. FEDER. It's just not doable. So that's the first thing.

On your Medicare point, the problem there is rising health care costs. Can we contribute during our working years at the rate of growth we've seen on health care costs? First of all, we only contribute during our working years to cover Part A, mostly hospital costs, which is only about half of costs. The rest we pay through premiums and general revenue. So in that pre-funding, there's such

an imbalance because we aren't controlling health care costs, and it's not that Medicare is doing worse than the private sector. The whole system is not controlling health care costs. If anything, Medicare is doing slightly better, has done historically over most of history slightly better in controlling costs.

Now, going forward, because we are moving toward more integrated care, we're looking to have Medicare lead the whole system in making that more efficient. So I wouldn't share a negative view toward Medicare. I think we need to do better in all of our health care spending.

And then what you're raising really is whether we——

Senator CORKER. I wasn't giving a negative view. I was just stating the facts. We're spending three times as much as we're taking in, and I'm just saying that as politicians, we have difficulty aligning those things. I agree with you that both on the public and private side, health care costs have not been controlled. I agree with that. I'm not making a differentiation between public and private.

Dr. FEDER. Good. Okay.

Senator CORKER. We just haven't handled this program or the other entitlement program particularly well.

Dr. FEDER. Well, I'm not sure we agree on that, but that's okay. We can move on from that. What I would say is that what I thought you were talking about is looking for a way to pre-fund.

Senator CORKER. That's correct.

Dr. FEDER. And I actually would be happy to provide for the record a proposal that was developed by Len Berman, who used to run the Urban Institute Brookings Joint Tax Center, and a colleague of his at the Urban Institute that actually put forward a design for the pre-funding of services for that. I think that can be done, challenging, pre-funding it all, which Medicare was never designed to be. That's what I was really saying earlier. Pre-funding it all is challenging because we do, when we take it in as a federal government, we tend to lend ourselves that money.

Senator CORKER. That's right.

Dr. FEDER. And if we really want to put it away, that's a challenge for us. But I'd be happy to share that proposal.

Senator CORKER. I'd love to see it. Thank you.

Sorry for taking so long.

The CHAIRMAN. Thank you so much.

I know Senator Udall has to leave. Do you want to ask a couple of questions, make a comment? Go ahead.

Senator UDALL. I think Senator Manchin arrived before I did.

The CHAIRMAN. All right. Go ahead, Senator Manchin.

Senator MANCHIN. Thank you so much. I appreciate that. Very kind of you.

Mr. Colman, we all know that Medicaid was never intended to be the primary provider of long-term care coverage, yet Medicaid is the largest payer of long-term care services, with long-term care accounting for almost half of national long-term care spending. As a former governor, I know that giving our states the flexibility and resources they need to innovate is a first and critical step toward controlling spending in the Medicaid program and improving long-term care outcomes.

We will never achieve quality and savings with a one-size-fits-all approach that ignores the differences in the Medicaid population from state to state. As you noted in your testimony, Minnesota is applying waivers under Medicaid to improve the way to deliver and pay for services and to make sure that services go to the most in need, which I agree with.

With that being said, sir, what steps could Congress take to improve an increase in flexibility in states like West Virginia and Minnesota to help maximize the value of long-term care in their Medicaid programs?

Mr. COLMAN. Thank you for the question. I, too, believe that the states can manage the programs effectively, and I think Minnesota is an example of if you have a vision, if you have a goal, and if you plan appropriately, you can achieve that. But it takes some prerequisites. You can't have a home and community-based system unless you plan to have a home and community-based system, unless you have the infrastructure for communities to retain people of all ages in their communities.

I think we have to not only move away from a one-size-fits-all philosophy so that all states will look alike but also that the waivers have to look identical. We've had this partnership with the Federal Government that begins with the assumption that the institution, because of the way the programs were initiated, the institution is the entitlement, and then you have to seek permission to do things differently, which is always contrary to my thinking, why we have to ask permission to do things differently that the consumer wants.

Again, I'll repeat. People want to stay in their homes, and that's why we're redesigning a system whereby the most expensive care, the most expensive services, the waiver so to speak, will be available to those with the highest needs where it cannot be provided elsewhere.

But beyond that, we want strategies to maintain independence, again low-cost strategies to maintain independence, low-cost strategies to encourage transition back to the community, and we've had some success with that. Transition to communities of people who have been in nursing homes longer than 90 days are proving very successful. But it takes a person-by-person strategy to achieve that outcome. We can't just declare that that's what we're going to do. It takes resources, which is what Minnesota is doing.

So if we dispense with the waiver, and then everyone has that full menu, as opposed to targeting based upon individuals' needs where in the system they best can use their——

Senator MANCHIN. You believe in health care waivers, correct?

Mr. COLMAN. I do, sir, yes.

Senator MANCHIN. Mr. Chernof, if you would, the same kind of comment on the waivers. How do the states have a little bit more flexibility, and do you believe that's important?

Dr. CHERNOF. Thank you, Senator. Building on what was already said, I think that there needs to be a valid, reliable delivery system in place. So to get from where you are to where you want to be really depends on the resources that are currently available, and if you don't have everything you need, then you need to give the time to grow those resources, and that's why, to my mind, some of

these flexibilities are really important. If you're going to encourage folks to remain in their home or in their community, there have to be valid, reliable, observable, accountable resources that can be there to help those families when they need that little bit of help.

So I think where the flexibilities come in is I do agree that moving away from the only entitlement being the nursing home and actually getting to a place where folks get home and community-based services as a right, not as a waiting list but as a right. That's a huge step in the right direction, and that's an important piece of flexibility.

But then what the states need to be able to demonstrate is that there's really a valid system that's there to meet the needs of folks as we make that transition.

So I think what the states need to be able to demonstrate to ask for that flexibility is that there really is a demonstrable system where quality is being measured, where there is a way that, if folks are having a problem, beneficiary issues, they can be addressed. But we need to move away from the tyranny of bricks and mortar.

Senator MANCHIN. If I can just very quickly ask Mr. Holtz-Eakin, in your testimony it's a common misconception that Medicare covers long-term care, and many more simply never save for it or plan for it, for long-term care services and supports. What do you think can be done, or what should be done for us to educate the public? Because there are so many people falling through. They just have nowhere to turn to.

Dr. HOLTZ-EAKIN. I'll be honest, I don't know that there's a magic public education program. We have enormous problems in Federal programs and their costs, and it's difficult to educate the American public about the scale of that problem. But there have been some Own Your Future initiatives which were mentioned. I think those are the kinds of things you ought to look and see what kinds of successes we get from them. They are relatively small scale. If they turn out to be a good investment, you do a project evaluation, they've improved awareness and they don't cost much, that would be great.

I think the more you can do through the employer community, who are often very effective at reaching their employees about various financial management issues, I think those are the two things to do.

Senator MANCHIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Udall.

Senator UDALL. Thank you, Mr. Chairman. Thanks to you and the Ranking Member, Senator Corker, for holding this important hearing. I think this discussion has been very, very helpful on a macrocosmic level. I've got a couple of questions that are a little more focused.

But before I turn to those, I wanted to acknowledge that, Dr. Chernof, I think you're sitting between those two advocates——

[Laughter.]

——Intentionally.

Chairman Kohl and Chairman Corker have very astute staffs. But thank you all for your great and spirited conversation.

Mr. Colman, let me turn to you and follow up a little bit on what Senator Manchin pursued, with a particular focus—and I'm going to turn to Dr. Feder as well—on rural parts of the country. In Colorado, of course, the eastern reach of our state is very rural. We produce a lot of food and fiber and fuel for the country. We also have western reaches in Colorado that are very rural.

What have you found are some of the unique challenges in providing those long-term services into those parts of your state?

And then, Dr. Feder, I'd like you maybe to follow on with how Medicare itself could work with that dynamic.

Mr. COLMAN. Again, Minnesota has Greater Minnesota also, where the population density is certainly a challenge in providing services to older adults and people with disabilities. What we've found, though, is that we need some flexibility, that again, relying upon the communities and the community infrastructure with which to base long-term care services and supports, we need to acknowledge the drive time, the differences that we need to accommodate in our policies to allow for people to have some choice, but they may not have as much choice.

It's a challenge to devise policies that accommodate those kind of distinctions or differences, but it can be done.

We're also learning the value of technology and the fact that every day there is more to be learned from how we can support people in their own homes with the use of technology via the Internet, via other lifeline-like systems and monitoring systems for people who are some miles away from services.

Senator UDALL. Dr. Feder, would you like to——

Dr. FEDER. Yes. I would reiterate and I think reinforce the emphasis on technology to connect people who are dispersed to resources that can serve as supports and have people who can check in on people who are impaired and be able to—Skype is a wonderful thing. I'm sure we've got better than that, but there are I think mechanisms that can make people feel connected and supported and keep them connected to caregivers, by which I mean medical technicians in urban areas.

But you asked about Medicare. I think that Medicare, in terms of developing integrated delivery systems, I think Medicare is in the process of doing this. We need not look to states, or we need not look only to states. Medicare can do a great deal, and is, in this regard. By trying to support physician practices, small physician practices in rural areas, and using personnel who can serve several practices as care coordinators, who are able to connect—using both visits and technology—to people who are in their own homes and enable them to connect to resources for supports, I think Medicare can do a lot in that regard.

Senator UDALL. So you perhaps could be making house calls using technology without actually being on site.

Dr. FEDER. I'm confident it's not exactly the same, but I think you could greatly enhance support for people both in terms of monitoring their conditions and in terms of helping them—keeping track of people so that you know when a crisis is occurring. That's what coordinators, what we're looking at with social workers and nurses and other professionals, to help identify when people need interventions and try to connect them to the resources, the infra-

structure we're talking about, that Bruce is talking about building, so that they can stay at home, so it doesn't become a crisis and we don't have an unnecessary hospitalization.

Senator UDALL. Both my parents were very stubborn. I'm sure I won't be stubborn and my children will think I'm very flexible. But they both wanted to live in their own homes in their later years. Imagine that. And they both took falls. There were not people there, and both of them lay in the bathroom and kitchen, respectively, for half a day or longer, and then the result of those falls ended up in their deaths ultimately. So I wonder if there couldn't be that sort of monitoring, although you have privacy concerns and so on.

Dr. FEDER. But we can do way better. I don't think there's any question about that. If you think about things that cause unnecessary hospitalization, like dehydration, having somebody checking in on you that you're eating properly, taking your medications, all those things can very much improve quality of life and quality of care for people, and prevent the use of expensive services.

Senator UDALL. Dehydration actually contributed to the conditions that both my parents developed.

Let me go back to, if I might, long-term care insurance. I know, Dr. Holtz-Eakin, you spoke to this. I know I've got my little pamphlet that the FHEBP has sent me sitting in my home office, suggesting I ought to buy long-term care insurance. I haven't responded yet. I keep thinking, well, I'll find a moment where I want to do that.

Mr. O'Brien, I know that in the Federal program we have one long-term care insurer, I think. Is it John Hancock? What are you doing to think about attracting more carriers? And then if there's a little bit of time left, I might ask Dr. Holtz-Eakin how we further use market forces and market psychology to get us aging Baby Boomers to participate.

Mr. O'BRIEN. I actually think you've identified one of the challenges that we see for the Federal long-term care program going forward, is that in recent years the number of insurers who are actively participating in this market has gone down. I'm not so concerned that we have one provider of the long-term care program right now. I think that for the way we've done it, that's the way we do life insurance. It's not like the health insurance where people are changing yearly.

What I am more concerned about is that when we re-upped our contract, we only had one active bidder to provide that service. So we are looking very carefully. At the moment we have a provider that's doing a good job, but a concern long term for this program is that there are enough active participants, insurers out there trying to actually provide that service.

I think the point was made earlier today that the market has stayed relatively static over a number of years, and it's not growing rapidly. We are very happy in the fact that, when the contract opened up again, that we actually increased enrollment by roughly 20 percent, which we thought was very positive. But it is one of the challenges on the horizon for us.

Senator UDALL. I could help those numbers if I'd sign up.

Mr. O'BRIEN. You can sign up any time.

[Laughter.]

You can do it in the hearing now.

[Laughter.]

Senator UDALL. Doctor, would you have any further observations?

Dr. HOLTZ-EAKIN. I think it's very important to harness market forces literally from the ground up. You've heard talk about the technologies. You've heard talk of the need for flexibility, and markets are very, very good at that. There are roles for government in this, and they are on both sides, both good and bad. I mean, you care about privacy. You care about having quality personnel going into someone's home and delivering services. But if you regulate too tightly what a person can and cannot do, then you're not going to get the benefits of bundling the different kinds of services.

So a thorough review at the ground level in every state about the ability to provide these services more cheaply is going to make the care cheaper, and that's going to help make the insurance cheaper. You just can't get around that. Having very expensive underlying care makes insurance a lot harder to sell.

And then you have to be able to make money or you're not going to stay in the insurance business, and I think we've had too little awareness and too little education for people to sign up. There's an old saying that says insurance is sold and not bought, and we might need to sell more of this. So I think that's a big part of it. And to the extent that the experience of the Boomers in caring for their parents drives this, I think that's one thing we might see be very different in the future than in the past.

Senator UDALL. Thanks again. Thanks to the Chairman.

I think President Clinton once remarked this is a high-class problem we have because of the extension of our lifespans, but nonetheless it is a real challenge. Thank you all.

The CHAIRMAN. Thank you very much, Senator Udall.

Dr. Holtz-Eakin, you've expressed some optimism about the private long-term care insurance market. The individual market has not thrived, as you know, in recent years, with premium increases sometimes as high as 90 percent.

On the other hand, a Wisconsin company that I'm very proud of, the Northwestern Mutual, has never had a premium increase.

In your opinion, or in your view, how can we succeed with the long-term care insurance market in keeping the premiums reasonable and getting people to participate in long-term care insurance?

Dr. HOLTZ-EAKIN. Again, as I mentioned to Senator Udall, ultimately the costs are driven by the underlying costs of long-term care services. So step number one is work on those to the extent possible. And then step number two is pool as effectively as you can and make sure that you can get broader pools. That's always been a problem in the individual markets, and this is a very thin individual market at the moment. Ways to enhance the pooling, particularly by having individuals able to buy through their employer, I think is the key to making that more successful.

The CHAIRMAN. Senator Corker.

Senator CORKER. I think I'm good. I look forward to seeing Professor Feder's document, and I thank all of you for testifying. This is a very massive problem. I mean, people are not thinking in ad-

vance of those kind of things down the road. I mean, people, candidly, have difficulty just sort of seeing daily and yearly activities through. I think the comment, Doug, that you made about insurance being sold and not bought, the fact is that it's just not on—by the way, I haven't signed up either, and I may not.

But it's a big problem, and the cost associated with this—and again, I hate to go back to that. I really do appreciate, Dr. Chernof, your comments about customizing and making this very customer or patient centered. I agree with that. We were very aggressive, as you know, in Tennessee in seeking waivers and really moving to community-based solutions. By the way, that was done by people on both sides of the aisle through the years, and I think it's worked out very well for us.

But this is a massive, massive problem, one that the Finance Committee and others here all need to be involved in dealing with, and no doubt there is a public sector role. And at the same time, I have to tell you, on the private side I think that trying to—again, this sounds like Northwestern Mutual, who I do have a policy with—has done a good job of it. But the actuarial issues of being able to take in premiums now and know that that's going to deal with situations down the road is really, really tough.

Anyway, I thank you all for educating us today and coming here from other places, and look forward to seeing you again.

The CHAIRMAN. Any other comments from members of the panel?

[No response.]

We thank you so much for being here. It is clearly complicated, vast, and terribly important, and you've shed a lot of light, and thank you for coming.

Thank you, Bob.

Senator CORKER. You too, sir. Appreciate it. Good hearing, very good hearing.

[Whereupon, at 3:24 p.m., the hearing was adjourned.]

APPENDIX

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

STATEMENT OF
JOHN O'BRIEN
DIRECTOR OF HEALTHCARE AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

before the

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

on

"The Future of Long-Term Care: Saving Money by Serving Seniors"

April 18, 2012

Chairman Kohl, Ranking Member Corker, and Members of the Committee:

Thank you for the opportunity to testify today on long-term care insurance. As the Federal agency responsible for recruiting, retaining and honoring a world-class workforce, the Office of Personnel Management (OPM) oversees numerous benefit programs, including long-term care insurance for Federal employees, annuitants and their family members.

Long-term care is personal care and other related services provided on an extended basis to people who need help with activities of daily living or who need supervision due to a severe cognitive impairment, such as Alzheimer's disease. It can be provided at home, in an adult day care center, assisted living facility, or nursing home. Most health insurance plans, including those in the Federal Employees Health Benefits Program, do not provide coverage for long-term care services. This unmet need led to the creation of the Federal Long Term Care Insurance Program (FLTCIP).

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Director of Healthcare and Insurance
U.S. Office of Personnel Management

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Long-term care insurance is an important benefit because individuals are living longer, and the likelihood of needing long-term care services increases with age. After age 65, Americans have a 70% chance of needing some form of long-term care during their lives.[1] Long-term care is also provided to people under age 65 who need help taking care of themselves due to diseases, disabling chronic conditions, injury, developmental disabilities, and severe mental illness. In addition, long-term care insurance is important because long-term care services can be very expensive for the average American family. In 2011, the national average cost of a semi-private room in a nursing home was $75,555 and $39,240 for care in an assisted living facility. The average cost of home care was roughly $31,000 per year or about $20 per hour.[2] .

History of the FLTCIP

In 2000, Congress passed the Long-Term Care Security Act (Public Law 106-265), which authorized OPM to contract with qualified carriers to provide long-term care coverage to Federal employees, including U.S. Postal Service employees, members of the uniformed services, annuitants, and their qualified family members. In March 2002, OPM introduced the FLTCIP to the Federal workforce. This is the tenth year for the FLTCIP, which is the largest employer-sponsored long-term care insurance program in the nation. As a voluntary, 100% employee-paid benefit, coverage is provided for long-term care services for Federal employees to protect

[1] U.S. Department of Health and Human Services, National Clearinghouse for Long-Term Care Information. www.longtermcare.gov/LTC/main_Site/index.aspx

[2] John Hancock 2011 Cost of Care Survey
www.jhltc.com/uploadedFiles/Marketing_Materials/Education_Awareness/ltc_1167.pdf

against having inadequate assets to cover the substantial costs needed to pay for long-term care. Through the FLTCIP, the Federal Government utilizes its leverage in the marketplace to offer private long-term care insurance to Federal employees and their qualified family members. Initially, OPM contracted with Long Term Care Partners, LLC, which was a joint partnership of John Hancock Life Insurance Company (John Hancock) and Metropolitan Life Insurance Company, to manage the application process and claims administration. Both John Hancock and Metropolitan Life Insurance Company provided long-term care insurance for the initial contract term. In February 2003, 187,000 individuals were enrolled and by the end of the initial seven year contract term in April 2009, enrollment had increased to approximately 224,000 enrollees.

The Long-Term Care Security Act requires that the long-term care insurance contract be for a term of seven years, unless terminated earlier by OPM in accordance with the terms of the contract. In 2009, the initial contract term ended and, effective May 1, 2009, OPM awarded the second contract to John Hancock. As part of the new contract, John Hancock added new benefit options with increased home health care reimbursement, new benefit periods, higher daily benefit amounts, and increased payment limits on informal care provided by family members. Long Term Care Partners continues to administer the program on behalf of John Hancock.

Features and Benefits

The FLTCIP provides coverage not only for nursing home stays but for assisted living facilities, hospice stays, respite care, caregiver services, home care, and adult day care services. In addition to Federal civilian and uniformed services employees, other qualified family members who are eligible to apply for coverage include spouses of Federal employees or annuitants, same-sex domestic partners of Federal employees, surviving spouses of active or retired members of the

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uniformed services, parents, parents-in-law and stepparents of living Federal employees and adult children of living Federal employees or annuitants.

Enrollees have the option of four pre-packaged plans (i.e., Plan A, B, C, and D) or can customize the benefits that meet their needs. The four pre-packaged plans offer a variation to the daily benefit amount (the maximum amount the insurance will pay for a single day), the benefit period (the length of time the insurance will last), the maximum lifetime benefit amount, waiting periods and inflation protection options. All four pre-packaged plans have a 90 calendar day waiting period. In addition, there are two methods of inflation protection. The first inflation protection option is the automatic compound inflation option, which increases benefit levels by either 4 or 5 percent each year without a corresponding rise in premiums. The second inflation protection option is the future purchase option, which allows enrollees to obtain benefit increases based on the Medical-Consumer Price Index every two years.

Other benefits of the FLTCIP include the flexibility for enrollees to change coverage as their needs change, various payment options for premiums such as payroll/annuity deduction, comprehensive care coordination, portable coverage, international benefits with no war exclusions, and insurance coverage that is guaranteed renewable.

2011 Open Season

In 2011, OPM announced the program's second open season for FLTCIP. The FLTCIP is medically underwritten and individuals can apply throughout the year. However, open season allows employees and their spouses to apply with abbreviated underwriting, which means the applicant answers fewer questions about their medical history. In addition, newly hired

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employees to the Federal Government and their spouses have 60 days to apply for long-term care coverage with abbreviated underwriting standards. Employees, retirees, and qualified family members who apply outside of an open season, the full underwriting standards apply.

Also, during the 2011 open season, same-sex domestic partners of Federal employees had the option to apply with abbreviated underwriting, providing the same rights as other qualified family members for purposes of applying for coverage. This inclusion of same-sex domestic partners resulted from President Obama's June 2010 memorandum directing agencies to take action to extend benefits to the same-sex domestic partners of Federal employees, consistent with existing law. During the 2011 open season, over 300 applications were submitted by same-sex domestic partners of Federal employees.

OPM along with Long Term Care Partners used numerous methods of communication to provide awareness about the benefits of long-term care insurance to the Federal workforce. Direct mail campaigns, direct email campaigns, onsite workshops, webinars, advertisements, payroll notices, and public relation efforts were all utilized to educate the Federal workforce about long-term care insurance. Educational efforts for the 2011 open season began in fall 2010. The educational campaign focused on reaching all eligible employees multiple times through multiple channels. Webinars were used heavily during this open season and an online decision tool was available. Increased information was available on the website, including the ability to apply for coverage online for both full and abbreviated underwriting. The educational campaign sought to provide a high degree of transparency for people considering purchasing long-term care insurance by clearly outlining the features and benefits of the FLTCIP, demonstrating the impact of inflation

on long-term care costs, and effectively communicating to all employees the potential for future rate increases should they be necessary for the health of the FLTCIP. The public relations plans raised awareness of both long-term care insurance in general and the FLTCIP. News releases and appearances on Federal radio programs such as *Federal Drive, For Your Benefit,* and *Your Turn with Mike Causey* delivered the message to Federal family members that the FLTCIP is a valuable and cost-effective way to protect against the high costs of long-term care.

Overall, Long Term Care Partners received over 45,000 applications during the 2011 open season. The breakdown of the approved applications was 55 percent female and 45 percent male. For active civilian enrollees the average age was 53 and for active uniformed services enrollees the average age was 47 during the open season. The most frequently purchased plan options included: a 3-year benefit period elected by 43% of the applicants and the most popular daily benefit amount was $150 also elected by 43% of the applicants. In addition, 70 percent of the enrollees selected the automatic compound inflation option with 58 percent of enrollees selecting the 4 percent automatic compound inflation option and 12 percent of enrollees opting for the 5 percent automatic compound inflation option. The communication efforts during the 2011 open season were very successful as enrollment increased 20% from 224,000 to approximately 270,000 enrollees.

Future of the FLTCIP

As the long-term care insurance market continues to evolve, we believe the FLTCIP is well positioned to offer a variety of benefit choices with relatively low cost to enrollees. In addition, we have taken steps to address potential premium risk. The National Association of Insurance Commissioners (NAIC) 2000 model long-term care insurance regulations established guidelines

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that carriers must meet when setting premium rates. In its Request for Proposals (RFP) for both contracts, OPM stated that carriers must follow NAIC's model regulation by including a margin for moderately adverse conditions when setting premiums for new enrollees. To ensure continued stability of the FLTCIP, in its RFP for the second contract, OPM stated that carriers should adjust premiums for existing enrollees to ensure that they were adequate, but that premium increases for existing enrollees should not exceed 25 percent per enrollee.

OPM is working to maintain the long term viability of the FLTCIP by pursuing policies that will help protect current and future enrollees. For example, we are interested in pursuing participation in state Long Term Care Partnerships which provide asset protection as an additional incentive for enrollment. We are also continuing to assess plan benefit options to ensure they are not only attractive to enrollees but also limit risks that would tend to increase future premiums.

Long-term care insurance provides a cost effective way for individuals making average incomes, like most Federal employees, to protect themselves against the financial catastrophe that a long-term illness or injury can cause. However, the long-term care insurance market is still relatively young and uncertain. OPM will need to closely monitor the market to make certain the FLTCIP meets the current and future needs of the Federal family. Our goal is to administer the FLTCIP as an on-going program that will provide enrollees with insurance protection to mitigate their potential costs for long-term care services.

Thank you for the opportunity to testify today and I am happy to address any questions you may have.

Senate Special Committee on Aging
Testimony by Loren Colman, Assistant Commissioner,
Continuing Care, Minnesota Department of Human Services
2 p.m., Wednesday, April 18, 2012

Good afternoon.

I am Loren Colman, Assistant Commissioner for Continuing Care in the Minnesota Department of Human Services. Today I am representing Minnesota Human Services Commissioner Lucinda Jesson.

Thank you on behalf of Commissioner Jesson for this opportunity to share with the Committee the efforts that Minnesota is making to provide the best possible long-term care system for older adults and persons with disabilities.

Minnesota has a strong infrastructure, built over many years, of long-term care services and supports for older adults and people with disabilities.

Last fall we were very proud and gratified to see the quality of Minnesota's long-term care system recognized by the AARP.

Minnesota ranked Number One among all states in the first-ever AARP Scorecard on Long-Term Services and Supports for Older Adults, People with Disabilities and Family Caregivers.

The report validates the direction that Minnesota has been moving for the past 25 years – to reduce reliance on institutional care and encourage access to services in home and community based settings.

It acknowledges Minnesota's efforts in providing comprehensive phone and web-based information and referral resources for seniors and their families and people with disabilities as well as providing evidence-based support to family caregivers.

Not that long ago, most people that were served by Medicaid in Minnesota received long-term care services in an institution. Over time, we've developed the supports needed to serve people in their own homes and communities.

Today, 63 percent of the older adults receiving Medicaid or Medical Assistance (MA) long-term care services get that care in their home or in community settings, and 95 percent of persons with disabilities receiving MA long-term care services are in community settings.

We are also proud of Minnesota's system of nursing homes as the state and facilities have worked in partnership toward improved quality and care.

- Several years ago we launched a Nursing Home Report Card to give consumers and family members access to comparative information on quality and consumer satisfaction.
- We have promoted innovation in care through performance incentive payments.
- The median length of stay in a Minnesota nursing home is now less than 30 days as services become more rehabilitative in nature.
- Successful collaborations with the industry have contributed to right-sizing the number and distribution of nursing facilities in the state.

In Minnesota, a healthy synergy results from having the policy areas for aging and adult services, disability services, nursing facility rates and policy and the Minnesota Board on Aging consolidated into the part of the Department of Human Services that I oversee.

We have worked very hard over the years to ensure a solid alignment of services delivered under Medicaid and the Older Americans Act. These services, on a continuum, become the critical safety net that seniors use as they become more frail.

By aligning them much more closely in how seniors transition among each service – we ensure that the system works in a more cost conscious manner and delivers care better to seniors and their caregivers.

The Older American Act is a critical resource in our long term care system and supports. The Senior LinkAge phone line, which annually serves 89,000 older Minnesotans and their families, and the complementary Disability Linkage Line and Minnesotahelp.info website, is a valuable foundation to our services.

These services comprise a statewide virtual call center that allows for a single toll-free access with routing to local communities.

Trained professionals answer questions about all types of insurance and Medicare products, including our state's long-term care partnership policies and other long-term care options. They are well positioned to answer inquiries from people seeking to understand the basics and options about housing and long term care services as they age.

Under new legislation, these counselors also are involved in expanded Long Term Care Consultation that helps individuals considering assisted living to become fully informed consumers. We have found that good information as early as possible can also delay the need for more expensive services or the need to access Medicaid.

Linkage Line Services have expanded under Lt. Governor Yvonne Prettner Solon to be a One Stop Shop for Seniors and their families for direct contact with state agencies on issues they may have with any area of state government.

Similar to many states, Minnesota is significantly challenged in meeting the anticipated demand for long term care services and supports, especially as the boomers age.

A project called Aging 2030 began 15 years ago to increase the understanding of all sectors in the state about the need to transform our infrastructures, policies and services to prepare for a permanent shift in the age of our state's population. The emphasis has been on strategies that increase economic security and family and community supports for older people.

We are currently working on a request for a Medicaid waiver that would redesign the program to offer benefits based on the need of the individual, so that they get the right levels of services based on their needs, from lower need to high need.

We know that the preference of most older Minnesotans is to remain in their home. We want to further empower older Minnesotans to make that choice by making home and community-based services the norm in Minnesota and institutional care the exception.

As Minnesota has worked successfully to rebalance our long-term care system, we also have had our eye on the coming age wave.

And now, we are on the cusp of launching the "Own Your Future" campaign in Minnesota to strongly encourage people, especially those 40 to 65 years old, to plan for their long-term care.

We are building on what other states did earlier in partnership with the federal government, and we are adding new elements:

- A public awareness campaign that includes marketing via the Web using contemporary messaging such as internet ads
- Development of more affordable products for middle-income people

- Better alignment of the incentives within Medicaid to support private financing of long-term care. The Long Term Care Partnership is a start but not the end.
- Targeted outreach to employers as a credible source of information about long-term care and financing options. Employers benefit from offering workers a sense of control and peace of mind that a long-term care plan can provide. The Minnesota business community has expressed a strong interest in working with us.

Our goal for "Own Your Future" is not only to raise awareness of the financial risk of not preparing for long-term care needs. We want to improve the quality of life for Minnesotans in their later years by increasing the number of those who have taken action to "own their future" and maintain choices.

Thank you again for the invitation to testify today.

I am happy to respond to questions.

TESTIMONY BEFORE THE

SPECIAL COMMITTEE ON AGING

U.S. SENATE

APRIL 18, 2012

BY

JUDITH FEDER, PH.D.

PROFESSOR OF PUBLIC POLICY and FORMER DEAN

GEORGETOWN PUBLIC POLICY INSTITUTE

GEORGETOWN UNIVERSITY

AND

INSTITUTE FELLOW, THE URBAN INSTITUTE

Chairman Kohl, Senator Corker and other members of the Committee, I am delighted to be with you today to explore ways to improve the quality and efficiency of services for people who need long-term care. My testimony builds on long-term care policy research I've conducted over many years with colleagues at Georgetown University and presents findings from recent work with Harriet Komisar, supported by the SCAN Foundation, [1] to emphasize that

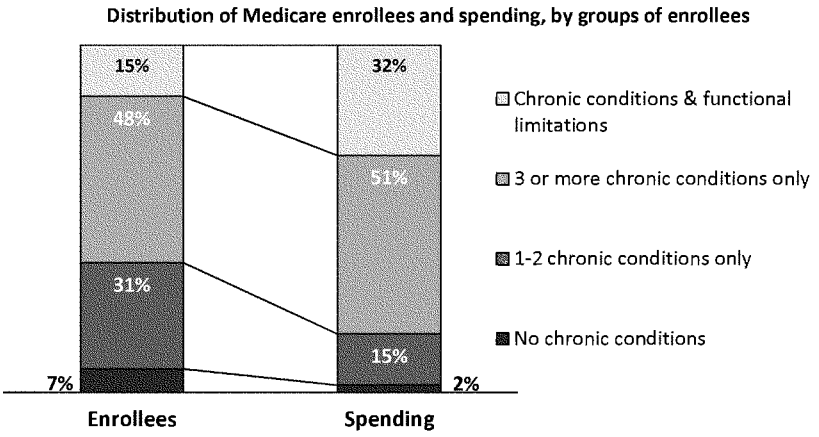
- It is beneficiaries with chronic conditions and functional limitations, not chronic conditions alone, who are disproportionately high Medicare spenders;
- Better coordinating their care—across the spectrum—can achieve significant savings as well as quality improvement; and therefore,
- Medicare should give top priority to delivery reform initiatives that both target beneficiaries with functional impairments and extend care coordination to encompass long-term care.

Although people with chronic conditions are front and center in the movement for delivery reform, that movement risks missing the mark. It is people with chronic conditions and the need for long-term care needs (that is, help with routine activities of life, like bathing and preparing meals), not people with chronic conditions alone, who account for disproportionately high per person Medicare costs. Specifically, the 15% of Medicare beneficiaries who have both chronic illness and long-term care needs account for about a third of all Medicare spending (**Figure 1**). In comparison, enrollees with substantial chronic illness—as indicated by the presence of 3 or more chronic conditions—represent roughly equal shares of the Medicare population and Medicare spending. That means it is the high cost associated with enrollees with the combination of chronic illness and functional limitations—and not the cost of those with

[1] Komisar and Feder, "*Transforming Care for Medicare beneficiaries with Chronic Conditions and Long-term Care Needs: Coordinating Care Across All Services*", The SCAN Foundation, October 2011 http://www.thescanfoundation.org/commissioned-supported-work/transforming-care-medicare-beneficiaries-chronic-conditions-and-long%E2%80%90

multiple chronic conditions alone—that drives the disproportionate share of Medicare spending associated with enrollees with multiple chronic conditions.

Figure 1: Chronic conditions and functional limitations, not chronic conditions alone, explain high per person Medicare costs

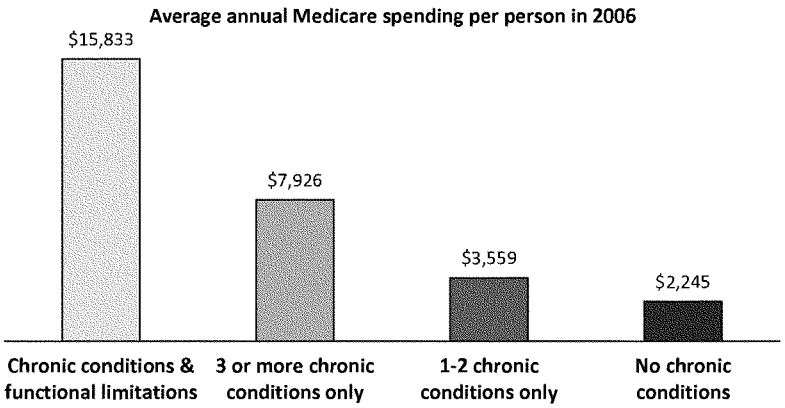


Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.

That it is beneficiaries who have functional limitations in conjunction with chronic illness, not chronic illness alone, that explains high spending is apparent from the comparison of average per beneficiary spending (**Figure 2**). Average Medicare spending for chronically ill beneficiaries with functional limitations is twice as high as for beneficiaries with 3 or more chronic conditions and no functional limitations—about $15,800 compared with $7,900 in 2006. This level is more than four times the average spending for enrollees with 1 or 2 chronic conditions and no functional limitations ($3,600 in 2006). While about a quarter of Medicare beneficiaries with chronic conditions and functional limitations reside in nursing homes, the

majority do not—and for both groups, Medicare spending is significantly higher than for beneficiaries with 3 or more chronic conditions and no functional limitations.

Figure 2: Average per person spending for enrollees with chronic conditions and functional limitations is at least double the average for enrollees with chronic conditions only

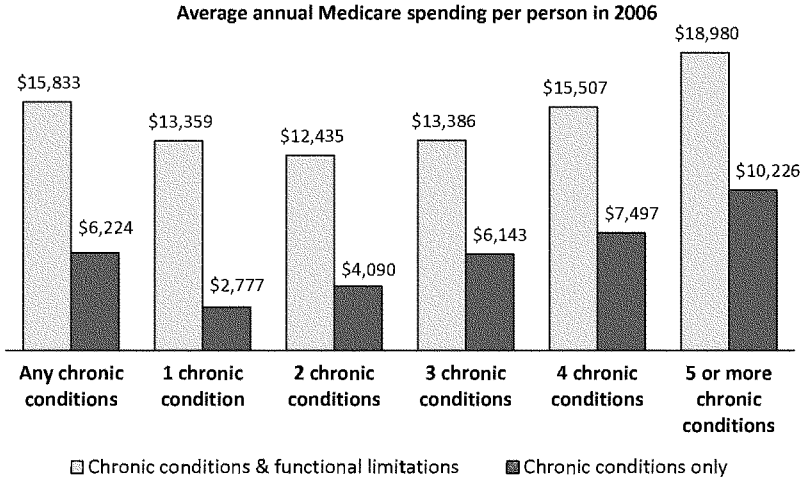


Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.

The pattern of higher spending for chronically ill people with limitations than for chronically ill people without holds true no matter what the number of chronic conditions (**Figure 3**). Among enrollees with chronic conditions only (that is, without functional limitations), average annual spending in 2006 ranged from $2,800 (for people with 1 chronic condition) to $10,200 (for those with 5 or more chronic conditions). In comparison, the amount for those with functional limitations ranged from about $13,000 for those with 1 to 3 chronic conditions to nearly $19,000 for those with 5 or more chronic conditions—about (or more than) twice as high as those without functional limitations at every level of chronic illness. Indeed,

average spending for beneficiaries with 5 or more chronic conditions and without functional limitations ($10,200) was lower than average spending for beneficiaries with only one chronic condition who also have functional limitations (about $13,400).

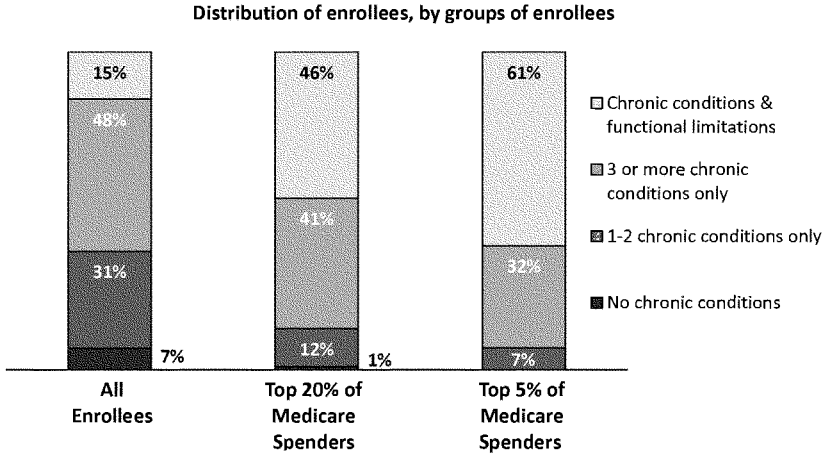
Figure 3: Medicare enrollees with chronic conditions and functional limitations have higher spending per person than enrollees with chronic conditions only



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.

Not surprisingly, beneficiaries with long-term care needs rank among Medicare's highest spenders. Nearly half the beneficiaries in the top 20% of Medicare spenders have functional limitations as well as chronic conditions (**Figure 4**). Among Medicare's top 5% of spenders, the proportion is even higher. Three out of five of these highest-cost Medicare beneficiaries are chronically ill people who need long-term care.

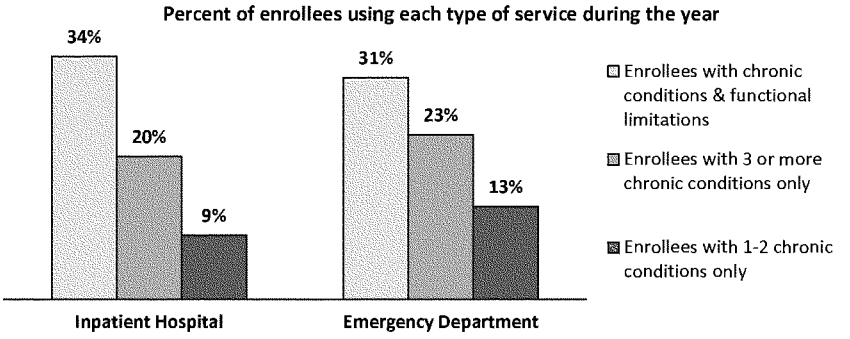
Figure 4: Medicare enrollees with chronic conditions and functional limitations are over half of Medicare's highest spenders



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.

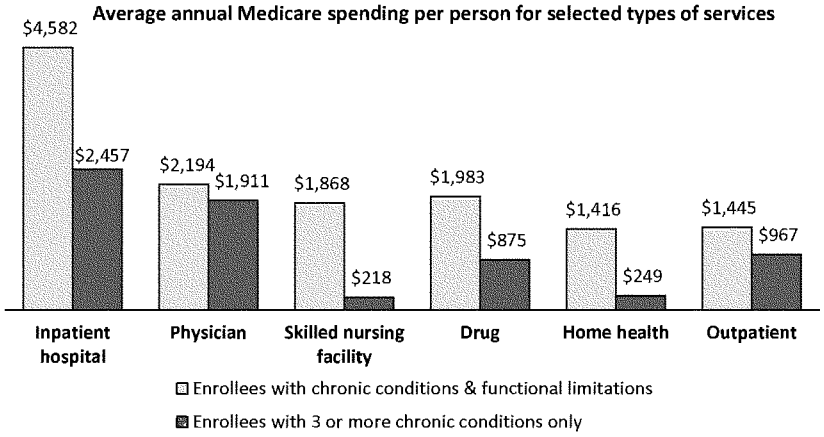
Enrollees with the combination of chronic conditions and long-term care needs are far more likely than other beneficiaries to use both hospital inpatient and emergency department services (**Figure 5**). One-third had hospital stays in 2006, compared with 20% of enrollees with 3 or more chronic conditions without functional limitations and 9% of enrollees with 1-2 chronic conditions only. As a result, average spending per person on hospital services was nearly double for enrollees with chronic conditions and functional limitations, compared to those with 3 or more chronic conditions only—$4,600 compared with $2,500 in 2006 (**Figure 6**). Higher hospital and post-acute spending are the largest sources of the overall difference in average spending between these groups.

Figure 5: Enrollees with chronic conditions and functional limitations are more likely to use hospital inpatient and emergency department services



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.

Figure 6: Higher hospital and post-acute spending are the largest sources of higher spending for enrollees with chronic conditions and functional limitations



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, The SCAN Foundation, October 2011.

The Centers for Medicare and Medicaid Services are actively engaged in using new authority for innovation under the Affordable Care Act to promote delivery innovations, aimed largely at reducing unnecessary hospital costs. But past experience tells us that without effective targeting to beneficiaries at high risk of inappropriate and high cost hospital use, care coordination is unlikely to produce significant savings. Targeting innovations to people with chronic conditions and functional limitations—and coordinating the full range of their service needs—offers a path to achieving the cost savings and quality improvements that policymakers aim to achieve.

Although limited in number, programs with these characteristics exist and have shown promise in reducing hospital use, nursing home admissions and costs for selected patient groups while improving quality of care. Key elements of these models include:

- A core of comprehensive primary medical care;
- Assessment of patients' long-term service and support needs, plus caregiver assessment;
- Coordination of long-term care as well as medical care (same person or team involved in coordinating both);
- Ongoing collaboration between care coordinators and primary care physicians;
- An ongoing relationship between care coordinators and patients and families;
- Attention to supporting patients during transitions between care settings;
- Commitment to "person-centered" care; and
- Monthly per-person payments to cover coordination costs Medicare does not cover.

CMS can build on these organizations' experience by encouraging delivery innovations that focus on people who need long-term care and coordinate services across the continuum to take account of their long-term care needs along with their medical needs. And CMS can

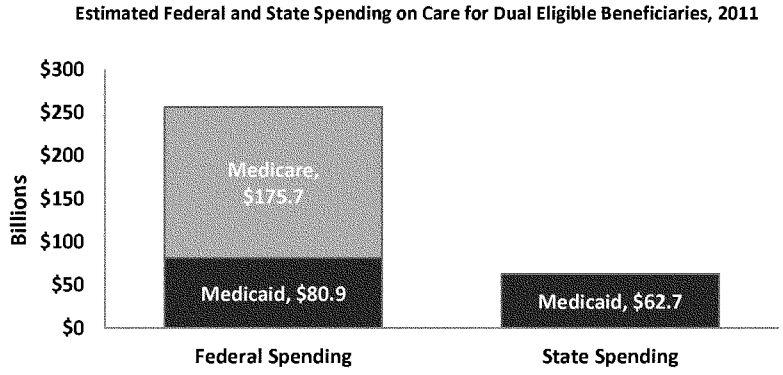
facilitate adoption of these practices by encouraging interventions that accommodate the varied size and capacity of primary care physician practices and improve upon, but do not replace, the fee-for-service payment system. These interventions would:

- Zero in on people most at risk of preventable hospital use, in order to maximize impact on reducing unnecessary and costly care;
- Allow different approaches—both networks that hire and manage care coordinators and coordinators employed by physicians' practices—in order to maximize provider participation;
- Pay monthly amounts per enrolled patient, sufficient to support coordinators and other currently uncovered care management services;
- Hold participating providers accountable for savings that offset these care coordination payments and pay providers—who satisfy quality standards—a share of savings if spending is less than projected; and
- Encourage state participation for dual eligibles provided states, like participating providers, actually invest in delivery improvement.

About half (48%) of the beneficiaries who would benefit from interventions like these are "dual eligibles"—beneficiaries of both Medicare and Medicaid. At 40% of Medicare's and of Medicaid's costs, the 9 million dual eligibles are a focus of efforts to slow growth in spending. But to date policy-makers have focused on states and Medicaid, rather than Medicare, as primarily responsible for improving care delivery to this vulnerable and expensive population. The absence of Medicare leadership is particularly odd, given that the dollars spent on dual eligibles are overwhelmingly federal. Of the $319 billion estimated as spent on dual eligibles in 2011, 80% ($256.6 billion) are federal dollars, more than two-thirds of which flowed through Medicare (**Figure 7**). Further, it is Medicare, not Medicaid, that finances dual eligibles' medical care, including the inappropriate hospital use that is the target of coordination efforts and the expected source of savings from delivery reform. Medicaid's role for dual eligibles focuses

overwhelmingly on long-term care and states lack experience in managing dual eligibles' medical care.

Figure 7: Federal government finances 80 percent of spending on dual eligibles



Source: Feder et al. 2011. "Refocusing Responsibility For Dual Eligibles: Why Medicare Should Take The Lead." Washington, DC: The Urban Institute, http://www.urban.org/health_policy/url.cfm?ID=412418

To improve care and reduce costs for Medicare-Medicaid beneficiaries, along with the roughly equal number of Medicare-only beneficiaries who need long-term care, it is essential that Medicare exert its leadership rather than simply shift responsibility to the states. Priority in delivery reform that coordinates care for beneficiaries with chronic conditions and long-term care needs is fundamental to Medicare's assuming responsibility for reducing the inappropriate service use that the program is now paying for. And that leadership should extend to other measures likely to reduce costs and improve care for people receiving long-term care—like holding skilled nursing facilities accountable for inappropriate hospital admissions of long-term nursing home residents and holding Special Needs Plans (SNPs) accountable for quality care.

For Medicare-Medicaid beneficiaries and for Medicare-only beneficiaries who need long-term care, fiscal pressure requires, and new legislative authority enables, Medicare to remedy the program's longstanding inattention to the costs and care of people whose chronic conditions create a need for long-term care. By so doing, the Medicare program can not only improve the quality of care to its most vulnerable beneficiaries, but also most effectively pursue the cost savings that are so vital to Medicare's future.

Testimony for Bruce A. Chernof, M.D.
President & CEO, The SCAN Foundation
Senate Special Committee on Aging
The Future of Long-Term Care: Medicaid
April 18, 2012

Executive Summary

Americans today are living longer than in previous generations, often with chronic conditions and functional impairment at older ages, increasing the number of individuals who will need long-term services and supports (LTSS). The percentage of the "oldest old," or those age 85 and above, is expected to increase over 25 percent by 2030, and LTSS needs are highest among this age group.[1] Most Americans are not effectively prepared for the high likelihood of needing LTSS at some point in their lives. When individuals and families have exhausted their personal resources and can no longer shoulder LTSS costs on their own, they have to depend upon Medicaid for help. Those who qualify for financial assistance through Medicaid for LTSS generally need this support for the rest of their lives.

Medicaid, the federal-state program that provides health care to millions of low-income Americans, is fundamental to the current financing and delivery of LTSS. Of the nearly 70 million individuals enrolled in Medicaid in FY 2011, nearly 6 million were over the age of 65 and almost 11 million were people with disabilities.[2] Individuals age 65 and older represented about eight percent of Medicaid enrollees, but account for 20 percent of all program expenditures.[3] Medicaid paid for over 62 percent of total U.S. spending on LTSS in 2010, representing almost one-third of all Medicaid spending.[4] Slightly more than half (53%) was for institutional care.[4]

This testimony describes Medicaid's critical role as this country's LTSS safety net and describes delivery system and financing opportunities to ensure its continued role to provide person-centered, quality care for low-income Americans with substantial daily needs. Current laws and federal regulations already exist that allow for states to upgrade their operations and administrative structures to create more integrated, beneficiary-protected, and efficient care. Savings generated by delivery system reforms, however, are necessary but insufficient to compensate for what will likely be a net increase in LTSS need in the future. Some states will experience the impact of population aging on their Medicaid LTSS programs faster than others. Policy options are needed to ensure that there is not a growing disparity among states to absorb these costs through already constrained resources, those same resources that face potential cuts as part of a larger entitlement reform discussion.[1]

Medicaid is poised to take on more LTSS costs due to the trifecta of increasing life expectancy, increasing prevalence of chronic conditions and functional limitations at older ages, and low savings rates among baby boomers. American families deserve affordable, accessible, and comprehensive solutions in order to plan for their future LTSS needs without having to spend down to Medicaid. Policy options in the public and private realms should be thoroughly explored to meet these aims so that Americans can receive high-quality services provided with dignity, respect, and transparency.

Introduction

Long-term services and supports (LTSS) is defined as assistance with activities of daily living (ADLs, including bathing, dressing, eating, transferring, walking) and instrumental activities of daily living (IADLs, including meal preparation, money management, house cleaning, medication management, transportation) to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more. LTSS include such things as human assistance, supervision, cueing and standby assistance, assistive technologies, and care and service coordination for people who live in their own home, a residential setting, or an institutional setting such as a nursing facility. LTSS also include supports provided to family members and other unpaid caregivers.[5]

Seventy percent of Americans who reach the age of 65 will need some form of LTSS in their lives for an average of three years.[6] Most individuals desire to receive these services in their homes and communities rather than in an institution, such as a nursing home.[7-9]

The cost of LTSS is substantial, impacting family financial resources and their potential to engage in the labor market. Private market costs of LTSS can far exceed most families' resources, particularly for families of older and disabled Americans.[10,11] In 2011, personal care at home averaged $20 an hour, or about $21,000 annually for part-time help. Adult day care services cost an average of $70 per day, or about $19,000 on an annual basis for five days of services per week. For people who need extensive assistance through nursing home care, the average annual cost is $78,000 for a semi-private room.[12]

When the need for LTSS arises, individuals and families initially finance this care by utilizing their own resources. Families draw on their income and assets, and family caregivers provide a substantial amount of unpaid care. In 2009, nearly 62 million family caregivers in the United States provided care to an adult with LTSS needs at some time during the year. The estimated economic value of their unpaid contributions was approximately $450 billion in 2009, up from an estimated $375 billion in 2007. Businesses in the United States lose up to $33 billion per year in lost productivity from full-time caregiving employees.[13] Private long-term care insurance plays a small role in financing LTSS, as about 6 to 7 million private policies are in force.[4]

When individuals and families have exhausted their resources and can no longer shoulder the costs of LTSS on their own, they reach to Medicaid for help. Individuals who qualify for financial assistance through Medicaid for LTSS generally need this help for the rest of their lives. This testimony will describe Medicaid's critical role as this country's LTSS safety net and describe delivery system and financing opportunities to ensure its continued role to provide person-centered, quality care for low-income Americans with substantial daily needs.

What is Medicaid and How Does it Relate to LTSS?

Overview of the Medicaid Program

Enacted in 1965, Medicaid is the federal-state jointly funded program that provides medical services and LTSS to millions of low-income Americans across the 50 states, the District of Columbia, and the Territories. Title XIX of the Social Security Act (SSA) outlines the operational structure of the program and authorizes funding to states to finance services. The Medicaid program is the responsibility of both the states and the federal government, with states having primary responsibility for how the program is administered. Within national guidelines, each state can establish its own eligibility standards for the program; determine the type, amount, duration, and scope of services that will be provided; and set payment rates for these services. However, Medicaid is an entitlement program, meaning that states must provide certain mandatory services to specified populations in order to receive federal funding. While participation is voluntary, all states in some fashion currently participate in the program and provide these benefits to their residents.[3]

Medicaid financing is a shared responsibility of the federal and state governments. States incur Medicaid costs by making payments to service providers and performing administrative activities and are then reimbursed by the federal government for the "federal share" of these costs. The amount of the federal contribution to Medicaid relative to state dollars is termed the "federal medical assistance percentage" (FMAP) and is determined by a statutory formula set in law that establishes higher FMAPs for states with per capita personal income levels lower than the national average and lower FMAPs for states with per capita personal income levels that are higher than the national average. An FMAP of 50 percent is the statutory minimum. For fiscal year 2012, state FMAPs ranged from 50 percent to 74 percent.[3,14]

As required by Section 1902 of the SSA, each state operates its Medicaid program under a state plan, which describes the populations the state intends to cover as well as the nature and scope of services it plans to offer. Each state plan is subject to the approval of the Centers for Medicare and Medicaid (CMS; the federal agency responsible for the federal portion of Medicaid), and serves as a state's agreement that it will conform to the SSA requirements and the official Medicaid-related issuances from CMS.[15] To qualify for Medicaid coverage, an applicant's income and assets must meet program financial requirements. States are required to serve select groups of individuals, also known as "categorically needy" populations, as part of their state plans. At their discretion, states may choose to cover additional "categorically related" groups beyond those required by law.[3] For the purposes of this document, we will focus on individuals who are included in the following groups:

Categorically needy as defined by law:[3]

- low-income individuals who are age 65 and older, or blind, or under age 65 and disabled who qualify for cash assistance under the Supplemental Security Income (SSI) program.

Categorically related as defined by each state:[3]

- individuals who are ages 65 and over, or blind, or under age 65 and disabled whose income exceeds the SSI level (about 75 percent of the federal poverty level (FPL) nationwide) up to and including 100 percent FPL;
- certain children with disabilities who live at home but need the level of care provided in an institution;
- individuals who are living in institutions (e.g., nursing facilities or other medical institutions) with income up to and including 300 percent of the maximum SSI benefit (about 220 percent FPL); and
- the "medically needy" or individuals in categories selected by the state (e.g., age 65 and above, the disabled, families with dependent children) whose income is too high to qualify as categorically needy.

In addition to covering certain populations, states must also provide certain services as part of their participation in the Medicaid program (See Table 1). These consist of a basic set of mandatory medical care services and institutional LTSS. States may choose to offer optional services, which vary by state, as part of its Medicaid state plan.[16]

Table 1. Examples of Mandatory and Optional Medicaid State Plan Services

Mandatory Service Examples	*Optional Service Example*
• Inpatient hospital services • Outpatient hospital services • Physician services • Nursing facility services for persons age 21 or older • Home health care for persons eligible for skilled nursing services • Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other setting • Rural health clinic services • Laboratory and x-ray services	• Diagnostic services • Clinic services • Rehabilitation and physical therapy • Home- and community-based services to certain persons with functional impairments; • Intermediate care facilities for the intellectually disabled • Nursing facility services for children under age 21 • Transportation services • Hospice care • Targeted case management services • Prescribed drugs and prosthetic devices • Optometrist services and eyeglasses • Dental services

Source: *Office of Retirement and Disability Policy, U.S. Social Security Administration. Annual Statistical Supplement, 2010: Medicaid Program Description and Legislative History. 2010*

States may also apply to CMS to waive certain Medicaid requirements in order to modify their Medicaid programs and implement new approaches in the delivery and payment of services. Medicaid waivers allow states to limit the following elements: services to specific geographic areas; the amount, duration, and scope of services; and the number of individuals served or target services to certain populations. Medicaid waivers also allow federal matching payments to state investments that would otherwise not be matched under existing Medicaid rules. These waiver provisions are codified in several sections of the SSA.[17] Specifically, states can request to waive the following core Medicaid provisions:[17]

> ***Comparability:*** Medicaid benefits must be comparable across the entire eligible population. This provision prohibits states from offering different services to individuals within specific eligibility groups or limiting services based on diagnosis, type of illness, or condition.
>
> ***Statewideness:*** States are generally required to make Medicaid benefits available to all eligible individuals, regardless of their geographic location within the state.
>
> ***Freedom of Choice:*** Medicaid beneficiaries are guaranteed the freedom of choice of providers to ensure access to services.

Medicaid waivers consist of Section 1115 research and demonstration waivers, as well as 1915(b) and 1915(c) program waivers. Section 1115 research and demonstration waivers offer the broadest form of waiver authority that exists and permit the U.S. Secretary for Health and Human Services (HHS) to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid program. Section 1915(b) and 1915(c) program waivers are intended to allow states administrative flexibility to operate their programs while managing costs. Specifically Section 1915(b) waivers permit states to waive the freedom of choice provision and require eligible beneficiaries to receive services from a limited set of providers, a mechanism often implemented using managed care models. Section 1915(b) waivers also allow states to waive comparability and statewideness provisions, affording states the ability to target specific populations in certain parts of the state. Section 1915(c) waivers allow states to provide home- and community-based services (HCBS) to individuals who would otherwise require care in an institutional setting, such as a nursing home. HCBS can include personal care services, homemaker services, case management, environmental modifications, and respite care. Section 1915(c) waivers allow the HHS Secretary to waive comparability and statewideness provisions, waive certain income and asset rules, and allow states to use enrollment caps to limit the number of beneficiaries that can be served by the waiver program.[17]

LTSS and Populations in Medicaid Who Use These Services

As noted above, LTSS services covered by Medicaid include institutional services such as those provided in a nursing facility or intermediate care facilities for the mentally retarded (ICFs/MRs). LTSS that are provided outside of institutional settings, such as nursing homes, over an extended period of

time are referred to collectively as HCBS.[16] Non-institutional LTSS covered by Medicaid include home health, private duty nursing, rehabilitative services, personal care services, Program for All-inclusive Care for the Elderly, and a variety of HCBS provided through Medicaid waivers.[4,18]

Nationally, Medicaid is the primary payer of LTSS for millions of Americans. Of the almost $208 billion in total U.S. spending on LTSS in 2010, Medicaid paid for over 62 percent ($129.3 billion). These payments represent almost one-third of all Medicaid spending. Of Medicaid LTSS spending for FY 2010, slightly more than half (53%) was for institutional care.[4] This proportion of spending on institutional care relative to HCBS varies across states. In FY 2010, the percentage of Medicaid spending that went towards HCBS for older adults and people with disabilities ranged from 62.1 percent in Washington to 12.1 percent in North Dakota.*,[18]

Of the nearly 70 million individuals enrolled in Medicaid in FY 2011, 10.7 million were people with disabilities and 5.7 million people were over the age of 65.[2] That year, individuals with disabilities represented approximately 15 percent of Medicaid enrollees, but accounted for 41 percent of Medicaid expenditures, the largest share across all groups.[3] Additionally, individuals age 65 and older represented about 8 percent of Medicaid enrollees, but about 20 percent of all program expenditures.[3]

As Americans continue to live longer than in previous generations, often with chronic conditions and functional impairment, the number of individuals needing LTSS is expected to increase. The percentage of the "oldest old" or those age 85 and older is expected to increase by more than 25 percent by 2030 and it is among this population that the LTSS need is most substantial. Approximately 30 percent of those age 85 and older have moderate to severe LTSS needs – three times the proportion among those 75 to 84 years old.[1] Many Americans are not effectively prepared for the likelihood of needing these services at some point in their lives, increasing the potential that the high cost of LTSS will deplete personal resources and leave them to rely on Medicaid to finance these services.

The Medicaid LTSS landscape is highly fragmented, resulting from differing funding streams or authorities. For example, nursing home care is a mandatory state plan benefit but HCBS is not. Additionally, the eligibility criteria, limited capacity, and limited geography of most HCBS offered through waivers restrict equal access. Across the country, there are over 300 Medicaid 1915(c) waivers for HCBS alone.[19] Furthermore, the broader service infrastructure that includes services provided under the Older Americans Act through the Aging Network is not always linked to the Medicaid-funded LTSS. This structure results in fiscal and administrative inefficiencies at the state level. It also forces consumers, particularly those requiring a variety of different services, to navigate a complex maze of programs to receive the care they need. Programs such as Money Follows the Person, which can support individuals who wish to leave an institution and return to the community, as well as care

* Selected states with a high penetration of Medicaid managed LTSS are excluded from this figure: Arizona, Florida, Massachusetts, Minnesota, New Mexico, New York, Rhode Island, Tennessee, Texas, Vermont, and Wisconsin.

coordination programs provided through Medicaid waivers and sometimes through state funds or the Aging Network are successful in helping the consumer to navigate the labyrinth of services and cobble together the supports they need to live as independently as possible. However, these programs are small due in part to the intensive nature of the work and the available resources to fund them.

Improving Medicaid LTSS via the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) includes several provisions to improve LTSS provided through Medicaid. First, these provisions seek to rebalance the Medicaid-funded LTSS system in the states toward increased use of HCBS and away from institutional settings. Secondly these provisions seek to improve the operational efficiency of state LTSS systems to plan, implement, and monitor the quality and cost of these services. The goal of these initiatives is to encourage a broader range of available services. However, none are part of the mandatory entitlement and do not fundamentally recalibrate the financial imbalance that currently favors institutional care services over HCBS.

Key ACA provisions to improve Medicaid-funded LTSS include:[20-22]

- ***Community First Choice State Plan Option (CFC):*** CFC is a new Medicaid State Plan option that provides community-based attendant services and supports to those meeting nursing facility eligibility criteria, which includes a six percent FMAP increase.

- ***State Balancing Incentive Payments Program (BIPP):*** BIPP provides enhanced federal matching funds to states that adopt strategies to increase the proportion of their total Medicaid LTSS spending devoted to HCBS and implement delivery system reforms that will increase consumer accessibility to needed services and supports, including: 1) the establishment of a "No Wrong Door— Single Entry Point System" that creates a statewide system of access points for LTSS; 2) adoption of conflict-free case management; and 3) application of core standardized assessment instruments for determining eligibility for non-institutional services and supports used in a uniform manner throughout the state.

- ***Medicaid Home- and Community-Based Services State Plan Option (1915(i)):*** Section 1915(i) of the SSA permits states to both extend HCBS enrollment to individuals with incomes up to 300 percent of SSI and offer the full range of Medicaid benefits to all eligible individuals receiving services through the 1915(i) option. Additionally, the law requires that these benefits be available statewide.

- ***Spousal impoverishment protections for Medicaid HCBS:*** The ACA requires states to apply spousal impoverishment rules to beneficiaries who receive HCBS for a five-year period beginning on January 1, 2014.

- ***Money Follows the Person (MFP):*** MFP helps to facilitate the relocation of eligible individuals receiving ongoing care in institutions back to the community. MFP provides a 75 percent FMAP for HCBS provided to individuals in the first year following relocation from an institution. The ACA reduced the institutional length of stay requirement from six months to 90 days and extended this demonstration through 2016.

- ***Health Homes:*** As of January 2011, states have the option to enroll Medicaid beneficiaries with chronic conditions into a health home to better coordinate care across health care, and potentially LTSS, providers. States who take up this option will receive an enhanced FMAP of 90 percent for two years.

- ***Medicare-Medicaid Coordination Office (MMCO) & Center for Medicare and Medicaid Innovation (CMMI):*** MMCO is a new office within CMS that is working to better align Medicare and Medicaid for those who are eligible for both programs. A primary goal of MMCO is to ensure full access for this population to seamless, high quality health care and to make the system as cost-effective as possible. The CMMI is also another new office within CMS, which was created to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care within Medicare and Medicaid. MMCO and CMMI are partnering to test financial models to support state efforts to coordinate care for individuals eligible for both Medicaid and Medicare.

Special Emphasis on Those Eligible for Medicaid and Medicare

There are over 9 million individuals that are eligible for both Medicaid and Medicare ("dual eligibles").[23] While dual eligibles account for a smaller percentage of enrollees in both programs, they account for a disproportionate share of the costs. Duals represent 15 percent of Medicaid enrollees but account for 39 percent of Medicaid costs.[24] These individuals are universally acknowledged to be an extremely vulnerable and medically fragile group. Thirty-three percent of dual eligibles have one or more of the following chronic conditions – diabetes, stroke, dementia, and/or COPD – that often result in functional limitations and may require the use of personal care and supportive services.[25] They are more likely to have multiple chronic conditions, use more health services, and have higher per capita spending than Medicare-only beneficiaries.[26,27]

While dual eligibles are generally sicker and use more health services and LTSS than Medicare-only beneficiaries, there is still substantial heterogeneity among this population. Dual eligibles are all low-income, but there are both aged and younger disabled populations; 41 percent of dual eligibles are under the age of 65.[28] Approximately 17 percent of dual eligibles live in institutional settings and those who live in the community may or may not use LTSS.[26] Approximately one-third of dual eligibles have a mental illness and 24 percent require help with three or more ADLs.[26] What these data suggest is that the only common element in this population is their eligibility for Medicare and Medicaid. Dual eligibles are a special population with varied health and LTSS needs and they would benefit

substantially from a more person-centered system of care that evaluates their needs in a uniform manner and matches high quality services to their needs and preferences.

For these individuals, the Medicare and Medicaid programs were meant to complement each other, with Medicare covering medical services, while Medicaid provides assistance with Medicare premiums and cost sharing and providing coverage for LTSS. However, misalignments between the two programs often make it challenging for dually eligible individuals to access needed services in a timely and customer-focused manner.[29] Regulatory inconsistencies between Medicare and Medicaid have been articulated and solutions are being sought within CMS. In 2011, MMCO launched its Alignment Initiative, the goal of which is to "to identify and address conflicting requirements between Medicaid and Medicare that potentially create barriers to high quality, seamless and cost-effective care for dual eligible beneficiaries." As part of the Alignment Initiative, MMCO identified 29 "alignment opportunities" in six broad categories: coordinated care, fee-for service benefits, prescription drugs, cost sharing, enrollment and appeals.[29] In May 2011, MMCO published its Opportunities for Alignment list in the Federal Register and made it available for public comment.[30]

Changing Role of States in the Medicaid Program

Across the states, Medicaid programs are evolving from direct payers and operators of services to purchasers of coordinated services.[31] A growing trend in states is to contract with managed care entities and mandatorily enroll Medicaid populations in these plans for their medical services. The proportion of Medicaid beneficiaries enrolled in managed care increased from almost 57 percent in 2001 to 72 percent in 2010 nationwide.[32] As of June 2010, all but three states (Alaska, New Hampshire, and Wyoming) had enrolled at least part of their Medicaid populations in managed care; 29 states have Medicaid managed care penetration higher than the national average.[33] Another more recent and growing trend among states has been to purchase LTSS through managed care plans. As of 2009, 13 states used managed care purchasing strategies to deliver LTSS to their Medicaid beneficiaries, although only a few states broadly employ managed care for all LTSS provisions.[34] In addition, another 11 states recently reported that they are planning for the implementation of managed LTSS.[35]

The establishment of the MMCO and CMMI in the ACA created the infrastructure to better align Medicare and Medicaid for those dually eligible for both programs. Last year, 15 states were awarded design contracts of up to $1 million from CMS to develop new approaches to better integrate the full range of services including primary, acute, rehabilitative, and behavioral health services, as well as LTSS. In addition to those 15 states, another 23 states submitted letters of interest to CMS indicating their intent to develop integration models as well. Of the 38 states indicating interest, 27 states are considering managed care as the vehicle to integrate the full range of medical and supportive services

available through Medicare and Medicaid for the dually eligible population.[36] Already, 13 states among these 38 have submitted proposals for comment at the state/federal levels.[†,36]

While managed care entities and the states that monitor these entities have experience providing quality care for a general Medicaid population, which largely consists of children and women of child-bearing age, this is not the case for serving adults across the age span who have substantial disabilities and require LTSS. As states increase the purchasing of LTSS from managed care entities for their Medicaid populations, states must also increase their quality monitoring and oversight roles of these entities to ensure that beneficiary access and quality protections are incorporated clearly in the managed care contracts and are strictly upheld in practice.[37] States seeking only to solve what they perceive as a cost problem in their Medicaid LTSS programs without giving sufficient attention to improving person-centered access and delivery of care have great potential to create undue harm to some of the country's most vulnerable residents under these new arrangements.

The Need for System Transformation in Medicaid LTSS

Given the opportunities available through the ACA and spurred by the rapid transformation of Medicaid through managed care, states have many opportunities to maximize the value of care delivered to those receiving Medicaid-funded services now and into the future. States will need to transform their LTSS systems in many ways to achieve a sound, person-centered LTSS system for seniors and persons with disabilities. The SCAN Foundation has identified five core elements or "pillars" of system transformation that are building blocks to achieving a more person-centered system. These five pillars of LTSS system transformation are:[38]

- Administrative reorganization;
- Flexible accounting practices;
- Uniform assessment;
- Integrated information systems; and
- Quality measurement and quality assurance.

Currently in many states, multiple departments or agencies have a role in administering LTSS. Similarly, LTSS are funded by multiple siloed funding streams, even among services funded by Medicaid. The result of the fragmented administration and funding streams is an inefficient system that is very difficult for consumers and providers alike to navigate and utilize most appropriately. Furthermore, the siloed funding streams create barriers to establishing a person-centered system for consumers in which they can access the services they need and prefer, which are most often in their

[†] The following states have released their proposal for state (S) comment or have completed their state comment period and have posted their proposal for federal (F) comment: California (S), Illinois (S), Massachusetts (F), Michigan (F), Minnesota (S), New York (S), North Carolina (S), Ohio (S), Oklahoma (S), Oregon (S), Vermont (S), Washington (S), Wisconsin (S).

homes and communities.[39] Solutions include creating more streamlined administrative structures in states, for example having all state staff with management and oversight responsibility for LTSS under one administrative unit. Also, states can utilize flexible accounting practices that seek to allocate existing funding in ways that better respond to the needs of persons who receive LTSS. Flexible accounting practices consist of budgeting practices and contractual language that incentivize the use of less-expensive HCBS, which can result in savings that can be reinvested into the HCBS system to further reduce the use of institutional services. Administrative reorganization and flexible accounting practices are tightly linked to each other given that organizing the administrative and financing activities related to LTSS under one "roof" can create greater efficiencies and reduce the fragmentation that currently plagues state LTSS systems.

A uniform assessment can be defined as a common assessment tool or process to assess an individual's functional capacity and needs that is used across programs and services to guide care planning and resource utilization.[40,41] The value of a uniform assessment is that it enables a process to identify individual needs and preferences, and then connect that individual to the appropriate services that can best meet his or her needs. Furthermore, it provides information about a population of people served across multiple programs to facilitate service planning, resource allocation, and quality monitoring at the person, program, and state levels in a standardized way.

Integrated information systems are the technological framework in which the uniform assessment lives and support the transmission of information from the case manager to the program, county, and/or state levels for purposes of planning, evaluation, and quality monitoring. Uniform assessment and integrated information systems are also tightly linked, as having common ways to evaluate need and preferences across LTSS programs (i.e., uniform assessment) and having a mechanism to share that information at the consumer, program, and state levels can go a long way to better understanding who is served and support quality measurement and monitoring.

Finally, quality measurement and quality assurance is critical to ascertaining the extent to which the system provides services for "the right people, in the right place, at the right time," as well as whether the program or policy achieves intended outcomes. Quality assurance systems require a common measurement approach, a systematic approach to data collection, data systems and analytic processes to interpret measures, and leadership to promote policy/programmatic change. Critical to the establishment of a quality measurement/quality assurance system is both the uniform assessment and integrated information systems, as these provide the vehicles through which a core set of quality indicators can be consistently measured and evaluated. Without uniform assessment and integrated information systems in place, quality efforts may be substantially hamstrung. The inability to develop quality measures that can be used across programs and populations with a common definition derived from common data points creates an incomplete and inconsistent approach to program and policy improvement.

Given the increasing trend in states toward responsibility for oversight and quality assurance, system transformation elements are necessary to ensure high quality and value of service for beneficiaries. States that have implemented some or all of these system features have stronger functioning LTSS systems.[5]

Profiles in State Innovation on Improving LTSS

Several states have taken strides to bolster their Medicaid LTSS systems with the goal of providing high-quality, consumer-focused, and cost-effective care to their residents. These have sought to transform their systems of care through either upgrading the state's traditional fee-for-service model, or opting for a managed care model. The overarching desired outcome from both models is to ensure the most person-centered and effective use of Medicaid LTSS expenditures with an emphasis on improved access to quality HCBS. Below is a description of the lessons learned from some leading states using one of these two service platforms based on analysis completed by the Center for Health Care Strategies.[42]

Rebalancing LTSS using a Fee-For-Service Approach[43]

Four states – Georgia, Oregon, Vermont, and Washington – have succeeded in creating innovative LTSS systems and are pioneers that learned by trial and error how to build and improve their programs. These pioneering states have achieved dramatic shifts away from institutional care and toward the home and community settings that maximize independence and are preferred by most beneficiaries. These four profiled states each have different approaches to rebalancing care toward greater use of community-based services in a variety of geographical and political environments, and in programs initiated in the 1980s as well as those launched more recently. Lessons learned that are described below clarify the key elements that other states seeking to rebalance their LTSS systems should adopt:

1. Communicate a clear vision for LTSS and identify a champion to promote program goals.
2. Bridge the gaps between state officials responsible for medical assistance and LTSS.
3. Engage stakeholders to achieve buy-in and foster smooth program implementation.
4. Embrace a "No Wrong Door" philosophy for all HCBS to help consumers fully understand their options.
5. Deploy case management resources strategically.
6. Use a uniform assessment tool, independent of provider influence, to ensure consistent access to necessary LTSS.
7. Support innovative alternatives to nursing homes.
8. Expand the pool of personal care workers to increase the numbers of beneficiaries in home and community settings.
9. Take advantage of initiatives that help people move out of nursing homes and into the community.
10. Analyze relevant data to track quality of care metrics that reflect the vision of the long-term care program.

Transforming LTSS using a Managed Care Approach[44]

Five innovative states – Arizona, Hawaii, Tennessee, Texas, and Wisconsin – with expertise in managed care approaches for individuals with long-term care needs were identified and lessons learned were gathered through interviews and in-depth site visits. While these featured states each have different approaches to managing the full spectrum of long-term care needs, they are joined by the common vision of providing higher quality and more cost-effective LTSS. These lessons learned illuminate the key elements that states seeking this transformation pathway should adopt:

1. Communicate a clear vision for managed LTSS to promote program goals.
2. Engage stakeholders to achieve buy-in and foster smooth program implementation.
3. Use a uniform assessment tool to ensure consistent access to necessary LTSS.
4. Structure benefits to appropriately incentivize the right care in the right setting at the right time.
5. Include personal attendant care and/or paid family caregivers in the benefit package.
6. Ensure that program design addresses the varied needs of beneficiaries.
7. Recognize that moving from a 1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing and plan accordingly.
8. Develop financial incentives to influence behavior and achieve program goals.
9. Establish robust contractor oversight and monitoring requirements.
10. Recognize that performance measurement is not possible without including LTSS-focused measures.

Considerations for States Integrating Care for Dual Eligibles

As noted above, states are actively considering mechanisms to better integrate care for their dually eligible population with the goal of high-quality, consumer-focused, and cost-effective care. A third state Profile report[45] created in 2010 from interviews with seven states – Arizona, Hawaii, New Mexico, Oregon, Tennessee, Texas, and Vermont – offered guideposts for improved integration of care for dual eligibles. This report offered three strategies that states should consider when deciding what direction to choose for designing integrated programs for dual eligibles based on their current state strengths and capacities:

1. States that have a strong managed care system for medical services, but lack a robust LTSS program, should consider building on their existing managed care system to serve dual eligibles.
2. States that have a strong system for LTSS, but lack a strong managed care system for medical services, should consider broadening their LTSS system to include managed medical services for dual eligibles.

3. States with both a strong medical care system and a strong LTSS program should consider bridging these systems to integrate services.

Considerations to Reinforce the Medicaid LTSS Safety Net

Medicaid is the major payer of LTSS and, without a more comprehensive and affordable mechanism to help people plan for the high cost of care, this reality will remain so. This is increasingly true given the known trends of population aging and the fact that individuals in the highest age brackets have the greatest need for LTSS among all age groups. LTSS costs will also increase over time given historic trends,[46] so the likelihood that all payers – individuals and families as well as Medicaid – can absorb these costs without a policy intervention is minimal.

For LTSS (and medical care), Medicaid is also the payer of last resort. It accepts the responsibility of fulfilling vital daily care needs that are beyond the financial capacity of most American families. Medicaid is also beholden to the outcomes of a Medicare-funded care delivery system that favors acute care episodic services over a person-centered continuum of quality care. There are a number of models and mechanisms to improve the efficiency and effectiveness of state Medicaid LTSS systems while decreasing pressure on federal and state budgets. These solutions generally rest in four interrelated categories:

1. Structural and delivery system reforms in state Medicaid programs;
2. Structural and delivery system reforms that improve the interface between Medicaid and Medicare;
3. Improvements in Medicaid's responsiveness to increasing LTSS need via targeted FMAP enhancements; and
4. Creation of more accessible, affordable, and comprehensive solutions for individuals and families to plan for likely LTSS needs in the future.

Federal and state stakeholders should support the systems transformation efforts articulated in the first two options as long as the goal of creating high-quality, person-centered care is paramount. We believe that coordinated care delivery in state Medicaid LTSS programs, as a standalone effort or part of integrating LTSS with medical care, has great opportunity to meet the illustrious "triple aim" of health care – improved personal experience of care, improved population health, and reduced per capita costs.[47]

While calculating the cost savings that each state can achieve depends upon a number of endogenous and exogenous factors, most states choosing to improve their LTSS systems estimate savings over time usually from an overall reduction of institutionally-based care. However, savings generated by delivery system reforms are necessary but not sufficient to compensate for what will likely be a net increase in LTSS need created by population aging. Some states will experience the impact of population aging on

their state Medicaid LTSS programs faster than others. This situation will create a growing disparity among states to absorb these costs through already constrained resources, those same resources that face potential cuts as part of a larger entitlement reform discussion.[1] Given Medicaid's substantial role in financing LTSS, without policy intervention, these individuals will experience the greatest impact of federal and/or state budget cuts to Medicaid.

Beyond gaining cost savings through state efforts at system transformation and minimizing future cuts to Medicaid, there are federal level policy options to improve Medicaid's responsiveness to increasing LTSS need by making some targeted FMAP enhancements. One option is to provide an enhanced federal match for Medicaid LTSS provided in the community that would be tied to a state's rate of population aging over a defined period of time.[1] This strategy could provide some relief to states that will experience the effects of rapid population aging and its associated impact on LTSS need. A second option is to create an FMAP enhancement that accounts for the intensity of chronic conditions and functional limitations among its Medicaid population. The current FMAP calculation may be appropriate for covering expenditures for a healthier categorical group, but it is potentially insensitive to wide variation of needs and costs for those individuals who have serious chronic illness burden and concordant functional limitation. The current categorical aid codes provide a very limited risk adjustment to states for certainly high use populations, and therefore a more nuanced approach to reimbursing states in accordance with their population characteristics may be merited.

Finally, right now Medicaid is poised to take on more LTSS costs due to the trifecta of increasing life expectancy, increasing prevalence of chronic conditions and functional limitations at older ages, and low savings rates among baby boomers. American families deserve affordable, accessible, and comprehensive solutions in order to plan for their future LTSS needs without having to spend down to Medicaid. Policy options in the public and private realms should be thoroughly explored to meet these aims so that Americans can receive high-quality services provided with dignity, respect, and transparency.

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Appendix

1. AARP: *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers—Fact Sheet*

2. The SCAN Foundation: *DataBrief No. 27: Medicaid Managed Care and Long-Term Services and Supports Spending*

3. The SCAN Foundation: *DataBrief No. 26: Dual Eligibles, Chronic Conditions, and Functional Impairment By Age Group*

4. Center for Health Care Strategies: *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*

5. Georgetown University: *The Importance of Federal Financing to the Nation's Long-Term Care Safety Net*

Challenges in the Future of Long-Term Care

Testimony for the Senate Special Committee on Aging

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April 18, 2012

I thank Emily Egan, Shanez Hendrick, Michael Ramlet and Cameron Smith for their assistance. The views herein are mine alone and do not represent those of the American Action Forum.

Chairman Kohl, Ranking Member Corker, and Members of the Committee thank you for the opportunity to be here today to discuss the demand for, cost, and financing of long-term care (LTC) services. Long-term care is the personal assistance that enables people who are physically or mentally impaired to perform daily routines (called Activities of Daily Living or ADLs) such as eating, bathing, and dressing. LTC is a pervasive part of the life cycle; an individual who turned 65 in 2005 has a nearly 70 percent chance of needing long-term care at some point in their lifetime.[1]

The provision of LTC will like increase, both absolutely and as a fraction of our economy, over the next 40 years. According to estimates of the Census Bureau, the number of elderly people (those ages 65 and older) in the United States will increase by two and a half times between 2000 and 2050. This is significant for LTC as 19 percent of seniors have some degree of chronic impairment. Among those aged 85 and older, impairment is even higher, 55 percent are impaired and need assistance with ADLs.[2]

Currently much of the LTC in the United States is supplied by spouses and adult children and labeled donated, or informal, care. However, demographic changes will reduce the supply of informal care. Smaller families, lower fertility rates, and increasing divorce rates may make donated LTC services less common in the future. The size of the average family has declined, reducing the number of adult children available to care for their elderly parents. Family size fell from 3.8 members in 1940 to 3.1 members in 2000; if current trends continue, it will decline to 2.8 people by 2040. At the same time, the rate at which women participate in the labor force will probably continue to grow, further reducing the availability of donated care. Those family-related trends, in sum, could further stimulate the demand for formal, or paid, services.

Paid LTC is very expensive. Although there is wide geographical variation for all long-term care costs, the 2012 Genworth Cost of Care Survey provides the most recent average costs: in 2012, nursing homes cost $81,030 for private rooms. Assisted living averages $39,600. Unskilled home health aides cost an average of $19 per hour and, for the average care time of 17 hours per week, annual costs are $16,800.

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[1] *Kemper, Komisar, and Alecxih, 2005-2006*

[2] Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004)

Paying for Long-Term Care

Because the informal caregivers are essentially payers as well as providers, they are an important source of financing costs. The donated care is very hard to quantify- but estimates range from $50 billion to $350 billion. The informal caregivers not only forego wages and therefore investment and retirement income for themselves, caregivers also suffer from higher rates of depression and other potentially expensive health problems.

Turning to formal care, Medicaid accounts for the highest percentage of paid care- roughly 50 percent.[3] Jointly funded by the federal and state governments, Medicaid is a means-tested program that pays for medical care for certain groups of people, including seniors with impairments who have low income or whose medical and LTC expenses are high enough that they allow those seniors to meet Medicaid's criteria for financial eligibility. Within broad federal guidelines, the states establish eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment; and administer their own programs. The share of each state's Medicaid expenditures that is paid by the federal government is determined by a statutory formula. Medicaid generally pays for services provided both in nursing facilities and in the home, although the specific benefits that the program provides differ from state to state, as do patterns of practice, the needs and preferences of beneficiaries, and the prices of services.

Many people who are not eligible for Medicaid while they live in the community become so immediately or shortly after being admitted to a nursing facility because of the high cost of institutional care. One study demonstrated that one-third of discharged nursing home patients who had been admitted as private-pay residents became eligible for Medicaid after exhausting their personal finances; nearly one-half of current residents had similarly qualified for coverage.[4] Medicaid coverage is especially common among nursing home patients who have been institutionalized for long periods.

State Medicaid directors have been given more flexibility in recent years to design their long-term care programs to help seniors stay in their homes as long as possible, by allowing payment for non-traditional services such as home modifications. This has caused spending on home-based services to rise faster than spending on institutional services but leads to lower aggregate spending and patients generally prefer to stay in their homes as long as possible.

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[3] Congressional Research Service. *"Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

[4] Joshua M. Wiener, Catherine M. Sullivan, and Jason Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington, D.C.: AARP Public Policy Institute, June 1996)

Medicare, the health insurance entitlement for those ages 65 and over, covers some services considered LTC as well. Medicare pays roughly 23 percent of aggregate long-term care costs.[5] However, while Medicare pays for nursing home stays after acute episodes and has home health benefit providing post-acute care and skilled services to homebound seniors, it does not cover the ongoing, unskilled care and assistance with the Activities of Daily Living that many seniors need for an indefinite period of time.

The remainder of paid long-term care is provided by out of pocket spending (20 percent) and private long-term care insurance (7 percent).[6] The data on private LTC insurance generally capture payments that insurers make directly to providers but do not always pick up insurers' reimbursements to policyholders for covered services that policyholders initially pay for out of pocket. Thus, estimates of LTC insurance payments—and of out-of-pocket spending—should be interpreted with caution because the former may be underestimated and the latter overestimated.

The Future of Financing LTC

The picture that emerges is one in which an increasing demand for LTC services will arise over the next several decades. At the same time, the dominant form of provision and payment - informal care - will be squeezed by demographic and labor market trends. The result will be a relative shift toward paid care.

But who will pay?

To date, the answer has not been private LTC insurance. Exactly why is a bit of a mystery since since insurance is used as the dominant solution for both health care and disability costs. While a large part of that may have to do with "crowd-out" from Medicaid (see below), there may be as well a disconnect between the likelihood of needing long-term care and people's beliefs about their risk. Adults are largely unaware of their future LTC needs and do not adequately prepare for them. They are also surprised to find out just how expensive it is. Other adults are under the false impression that if they get sick and need constant care, that Medicare will cover it.

At the same time, it appears unwise to reflexively add a new LTC payment stream to the demands facing the U.S. taxpayer. At present, we face both a sluggish economy and rapidly escalating health care costs. The US currently runs annual deficits of over one trillion and

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[5] Congressional Research Service. *"Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

[6] Congressional Research Service. *"Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

our national debt is over $15 trillion. This is not the time when we can afford to dramatically expand our health insurance entitlement programs. The current mix of financing for LTC, in which a significant share of financing comes from government programs, already adds to the pressures that the federal budget will experience with the aging of the baby-boom generation. Contributing to the strains that government LTC programs will face are incentives created by those programs that diminish the attractiveness of using private resources—especially private insurance—as a means for seniors to finance their care.

Medicare is quickly becoming insolvent and there is substantial concern about how the program will cover just the medical care needs of the baby boomers, let alone their LTC needs. Medicaid, which is scheduled to dramatically expand enrollment as a result of the Affordable Care Act, is already placing more and more pressure on state budgets and eating into funding for education, infrastructure and other necessary programs.

In addition, because Medicaid and Medicare both generally pay lower fees for services than those paid by private payers, beneficiaries may not receive the same quality of care that private policyholders receive. Both entitlement programs are less flexible in the types of services they cover as private insurance would be; a person who has private coverage has a broader choice of providers and types of care than an individual on Medicare or Medicaid. Furthermore, both Medicare and Medicaid do not make adequate use of lower cost settings to provide care. Generally home health is less expensive and preferred by patients; however we continue to spend billions on institutional care.

In contrast, private long-term care insurance (LTCI) pays out a daily benefit and the beneficiary can choose to spend that money on the care that best meets their needs. 43 percent of private LTCI beneficiaries choose to spend their benefits on home care, 35 percent use the benefits for assisted living and only 25 percent chose nursing homes.[7] Seniors with functional limitations are not a one-size-fits-all population. They have diverse health needs, differing abilities, and varying amounts of support from their spouse, family or community. LTCI not only offers many options, these are also associated with care management that assists caregivers in implementing and monitoring an individualized plan of care. The individual is best served by a flexible program tailored to their unique situation.

[7] American Association for Long-Term Care Insurance, 2008 LTCi Sourcebook.

Long-Term Care Insurance

As mentioned above, LTCI pays only 7 percent of aggregate long-term care costs in the US, as fewer than 10 percent of adults hold a policy.[8] Policyholders typically become eligible to collect benefits when they reach a specific minimum level of impairment, usually defined as being unable to perform two or three Activities of Daily Living (ADLs) or having a cognitive impairment significant enough to warrant substantial supervision. The vast majority of plans pay over $100 per day and 21.5 percent pay over $200 per day.[9]

The majority of Americans with health insurance coverage are insured on group policies provided by their employer. Unlike health insurance, LTCI is largely an individual market although employers are increasingly offering employees LTCI benefits. In the 1990's, employer-sponsored LTCI represented less than 3 percent of all policies but by 2007 they had grown to one-third of the market.[10] Federal government employees are one of the largest purchasers of large group LTCI through an employer-sponsored group LTCI plan. Indeed, employer-sponsored is a somewhat misleading term as employers usually do not contribute to the premiums. Employees can take advantage of the larger group pooling for discounted premiums but most often pay 100 percent of the cost.

The LTCI market has been consolidating rapidly in the last decade. While previously there were over 100 firms selling LTCI, the market dropped to 45 companies in 2006, with only 10 firms selling over 80 percent of all new policies.[11] The LTCI companies are diversifying their products and creating new hybrid policies that combine with annuity income or life insurance. Long-term care insurance is not a one-sized fits all market. In fact, the Pension Protection Act of 2006 created tax incentives permitting long term care coverage to be offered as a component of life insurance and annuities. Such products are expected to have strong appeal with retiring members of the baby-boom generation.

Challenges for the LTCI Market:

Challenges exist for LTCI market on both the supply and demand side. On the supply side, the key appears to be broader use of purchase through employers. The costs of marketing to and enrolling groups are about half those for individuals. On average, administrative costs as a percentage of premiums are likely to fall in the future as group policies make up a

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[8] Congressional Research Service. *"Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

[9] American Association for Long-Term Care Insurance, 2008 LTCi Sourcebook.

[10] Congressional Research Service. *"Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

[11] Congressional Research Service. *"Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress"(2011)*

larger share of the private LTC insurance market. A second challenge in the current environment is the low rate of return on reserves, which is likely to be resolved only through better macroeconomic performance.

There are also significant issues with demand for LTCI. Certainly, cost is a factor. Additionally, LTCI may be unattractive to some consumers because it does not, in general, insure against the risk of significant price increases for long-term care. Most policies promise to provide contractually specified cash benefits in the event that a policyholder becomes impaired. To protect themselves against LTC price inflation, consumers can purchase a rider to their policy under which the policy's benefits grow at a specified rate each year (usually 5 percent); however, such riders offer no protection against additional costs if prices rise at a faster pace. Concerns about price increases of that kind are not unjustified: Medicaid's average reimbursement rates for nursing facilities grew at an average annual rate of 6.7 percent from 1979 to 2001.[12]

Although Medicaid's coverage differs in many respects from that of private insurance, it nevertheless reduces the demand for private policies. Research has shown that the availability of Medicaid constitutes a substantial deterrent to the purchase of private insurance, even for people at relatively high income levels.[13] Medicaid's rules for financial eligibility affect people's decisions to purchase private LTC insurance as well as how much insurance they buy because the rules offer a low-cost alternative (by allowing people to qualify for the program's benefits) to making personal financial preparations for possible future impairment. People who buy private insurance or accumulate savings substantially reduce the probability that they will ever qualify for Medicaid's benefits, thereby forgoing the value of the government provided benefits that they might otherwise have obtained. Thus, the availability of Medicaid raises the perceived cost of purchasing private insurance or of saving. That increase is small for relatively wealthy people who have little likelihood of ever qualifying for Medicaid coverage, but it can be substantial for others. One study in particular found that the availability of Medicaid was a key factor for why two-thirds of the wealth spectrum did not hold a LTCI policy.[14]

Since private LTCI insurance is largely an individual market, it is not a tax-free benefit like employer provided health insurance. While employer provided LTCI benefits are treated by the federal tax code as untaxed income, very few employers who offer LTCI plans

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[12] Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004)

[13] Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

[14] Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

contribute to them. States vary in their tax treatment, with some providing tax deductions or credits to individuals or tax credits to employers who offer policies. However, with state income tax being generally low, these benefits do not appear to make a large difference in the decision to purchase or forego long-term care insurance.

Reform Options

There are several options for increasing LTCI participation rates. One program that has been successful is the "Long-Term Care Partnership Program." It was originally crafted in the 1980s, halted in 1993 and re-started in 2006.[15] This demonstration project was designed to make private LTCI more desirable by altering Medicaid eligibility rules for those holding policies that cover up to a certain dollar-amount of benefits. If further benefits were needed, the policyholder became eligible for Medicaid without the stringent spend-down requirements. For example, the program allows individuals who hold a policy with $150,000 to become eligible for Medicaid with $150,000 of their assets protected from the traditional asset test.[16]

Another option would be to incentivize LTCI via the tax code. While states have had modest success, a federally implemented tax deduction or tax credit may be more effective at incentivizing individuals to purchase policies. These options included cafeteria plans and the use of flexible spending accounts to cover LTCI. Additionally, as the market has been so limited by Medicaid crowd-out, tightening the limits for Medicaid eligibility may drive more demand for private policies.

In any case, the public clearly needs additional information about this issue. The public is woefully unaware of their likelihood of needing LTC at some point in their life. Among those that acknowledge that they may need ongoing care, many mistakenly assume they are covered by Medicare or supplemental insurance or believe their families will be able to care for them. Generally the country is uneducated about the costs of paid care and is likely to be unaware of what LTCI products exist and how the benefits work. Thus education and better retirement planning resources are an integral part of any reforms that aim to boost LTCI use. The LTC Information Clearing House is the only federal funding for LTC awareness and planning; spending only $3 million annually.

Conclusion

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[15] The National Conference of State Legislatures, *A Guide to Long-Term Care far State Policy Makers: The Long-Term Care Partnership Program* http://www.ncsl.org/issues-research/health/archive-the-long-term-care-partnership-program.aspx

[16] The National Conference of State Legislatures, *A Guide to Long-Term Care for State Policy Makers: The Long-Term Care Partnership Program* http://www.ncsl.org/issues-research/health/archive-the-long-term-care-partnership-program.aspx

Currently, elderly people finance LTC services from various sources, including both private resources and government programs. Incentives inherent in the current financing structure have led to increased reliance on and spending by government programs and may have discouraged people from relying on private resources (savings, private LTC insurance, and donated care) to prepare for potential future impairment. The demographic changes projected for the coming decades will bring increased demand for long-term care and heightened budgetary strains.

Expanding the entitlement programs is not the answer-instead we need to look to the potential of a larger and more robust private long-term care insurance market, a mechanism we rely on for nearly all other healthcare financing. A LTCI market allows for both flexibility in the plan selection and, if needed, utilization of plan benefits to their unique medical needs, financial reality and family situation. A successful solution in this vein would return Medicare and Medicaid to their original functions, to provide medical care and a safety net, respectively.

The Importance of Federal Financing to the Nation's Long-Term Care Safety Net

Judy Feder and Harriet L. Komisar
Georgetown University

February 2012

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Exhibits

The Importance of Federal Financing to the Nation's Long-Term Care Safety Net

Judy Feder and Harriet L. Komisar*
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I. Introduction

Long-term care is rarely mentioned in political discussions of deficit reduction. But the financing that supports it is most definitely on the table. Medicaid, along with Medicare and Social Security, is an "entitlement" targeted for "cuts", "swaps," or "caps" in numerous deficit-reduction proposals, both Republican and Democratic. And Medicaid—most often characterized as the federal-state health insurance program for low and modest income people—is, in fact, the nation's only safety net for people who need extensive long-term care services. A third of Medicaid spending goes toward that safety net, paying primarily for personal assistance in nursing homes and at home for people who need help with the basic tasks of daily life. Whether publicly recognized or not, deficit-reduction measures that aim to limit federal funding for Medicaid threaten the long-term care safety net.

But deficit pressures are not the only threat. Reliance on state-based financing—even when matched by federal funds—has produced a program with glaring inadequacies and inequities, which is poorly equipped to deal with future, let alone current, challenges in serving a growing elderly population. Policy "solutions" that would limit the federal commitment to long-term care financing without regard to the underlying challenge would increase, not decrease, these shortcomings. To equitably meet last-resort long-term care needs for people of all ages and incomes—across the nation—will inevitably require greater, not reduced, federal responsibility.

Accordingly, this brief reviews Medicaid's importance and limitations when it comes to long-term care and makes the case for strengthening Medicaid's safety net in one of two ways—assumption of full federal responsibility for Medicare beneficiaries who also rely on Medicaid (so-called "dual eligibles") or an enhanced federal match for Medicaid long-term care services. Each approach carries with it a federal commitment to bear the brunt of a growing elderly population—a burden that varies considerably across states. The difference between the two is whether to assure (the first approach) or to encourage (the second) greater equity and adequacy of services for low-income people across states. Either way, federal action is essential both to remedy current limitations and variations in Medicaid's long-term care safety net, and to assure its adequacy and equity into the future.

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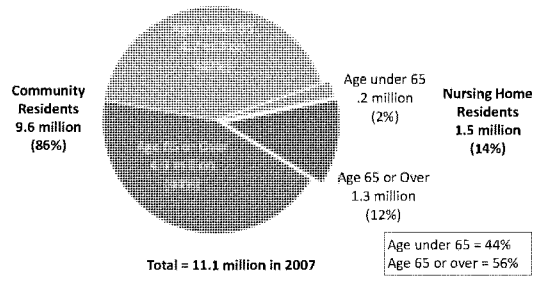
II. Medicaid's Long-Term Care Safety Net is Essential but Flawed

Why do people rely on Medicaid for long-term care? Simply put, because they lack the resources to manage on their own. Critics of Medicaid's safety net role argue that Medicaid reduces families' responsibility to save, purchase insurance, or provide for their own long-term care needs. But such arguments misjudge people's ability to plan for long-term care needs and the resources they have available if needs arise.

First, the need for long-term care is a risk, not a certainty. Although the risk of needing long-term care rises at older ages, people of all ages are at risk—and even at older ages, whether and the extent to which a person may need long-term care varies widely among individuals. Among people under the age of 65, less than two percent have long-term care needs,[1] but they constitute nearly 5 million of the 11 million people who need long-term care (**Figure 1**). Among people now turning age 65, an estimated three in ten will not need long-term care during the rest of their lives, while two in ten will need five or more years of long-term care (**Figure 2**).[2] Most people who need long-term care (over 80 percent of people with long-term care needs living at home) rely solely on family and friends to provide it and do not receive paid services.[3] But families cannot always provide the full amount, intensity, or type of care that is needed.

Figure 1

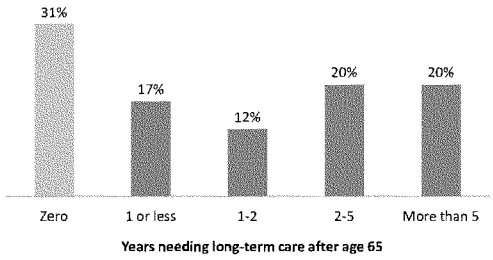
People with long-term care needs, 2007



Source: Authors' estimate based on Kaye, Harrington & LaPlante (2010) analysis of data from the 2007 National Health Interview Survey and the 2004 National Nursing Home Survey.

Figure 2

Percentage of people now age 65, by estimated years of needing long-term care after age 65



Source: P. Kemper, H. Komisar and L. Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42(2) (Winter 2005/2006): 335-350.

When paid care is necessary, its costs can far exceed most families' resources. In 2011, personal assistance at home averaged $20 an hour, or about $21,000 annually for 20 hour per

week of assistance, and adult daycare center services cost an average of $70 per day, or about $19,000 on an annual basis for 5 days of services per week (**Table 1**). Assisted living services averaged about $42,000 for a basic package of services. For people who need the extensive assistance provided by nursing homes, the average annual cost is now $78,000 for a semi-private room, but varies widely among markets and averages over $100,000 in many of the country's most expensive areas.[4]

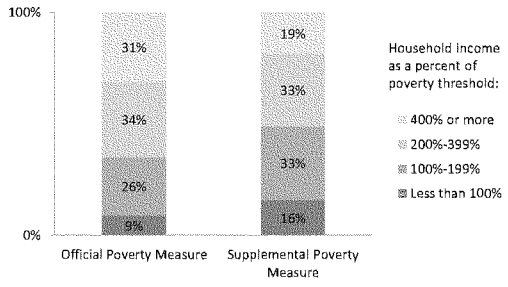
Table 1. Average national prices for long-term care services, by type of service, 2011

Nursing Home	$78,110 annually, semi-private room $87,235 annually, private room
Assisted Living	$41,724 annually for basic package
Home Care	$20 per hour 20 hours per week = $20,800 annually
Adult Day Services	$70 per day 5 days per week = $18,200 annually

Source: The MetLife Mature Market Institute, *Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, October 2011.

The mismatch between the costs of these services and the resources of the people who need them is dramatic. Focusing on the older people who are most at risk of needing long term care, findings from the Census Bureau allow us to see this in two ways (**Figure 3**). Using the traditional or "official" measure of poverty, fewer than a third of people age 65 and over have incomes equal to or greater than four times the federal poverty level—or about $42,000 for an individual age 65 or older, or $53,000 for a senior couple.[5] Most people's incomes are clearly well below what is necessary to pay for institutional care and insufficient to make intensive care in the community affordable.[6] The new "supplemental poverty measure" indicates that even fewer older people have income sufficient to support care needs.[7] By this measure, which, along with other adjustments, takes out-of-pocket spending for medical care into account, the proportion of people with incomes greater than four times the poverty threshold falls from almost one in three to one in five.

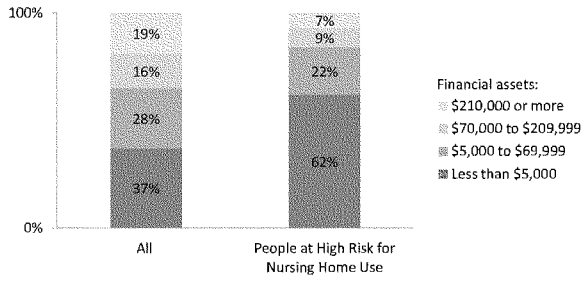
Figure 3
Distribution of people age 65 and over, by income relative to poverty threshold, 2010



Source: K. Short, *The Research Supplemental Poverty Measure: 2010*, U.S. Census Bureau, November 2011.

Although, in theory, savings can help fill the gap between income and service costs, in practice, savings are inadequate to the task. For people of working age who need long-term care, their disability often comes well before they have a chance to accumulate savings that might help pay for long-term care costs. Most older people also lack assets sufficient to finance extensive care needs. In 2005, only one in three seniors living in the community had savings of at least $70,000 (equivalent to the average cost of a year in a nursing home in 2005) (**Figure 4**). That proportion fell to 16 percent among seniors most likely to need nursing home care. Numerous seniors have low savings—more than one-third (37%) had less than $5,000 in savings in 2005.

Figure 4
Distribution of people age 65 and older living in the community, by financial assets, 2005



Source: B. Lyons, A. Schneider, and K. Desmond, *The Distribution of Assets of the Elderly Population Living in the Community*, Kaiser Commission on Medicaid and the Uninsured, 2005. People at high risk of nursing home use were defined as those age 85 or older, with no spouse, and who need assistance because of functional or cognitive limitations.

Given the unpredictability and catastrophic nature of extensive long-term care needs, heavy reliance on savings to finance them is never likely to work. Insurance is the best way to protect against the risk of unpredictable, potentially catastrophic expenses. But private insurance for long-term care has never really gotten off the ground. Only about 6 to 7 million people are estimated to currently hold any type of private long-term care insurance,[8] and most purchasers have relatively high incomes.[9] Unfortunately, many people in their 50s and early 60s are accumulating insufficient resources to cover basic living expenses in retirement, let alone to finance potential long-term care needs.[10] In addition, available long-term care insurance policies offer limited and uncertain benefits—raising questions about the wisdom of purchase. Policies limit benefits in dollar terms in order to keep premiums affordable, but therefore can leave policyholders with insufficient protection when they most need care; and policies have often lacked the premium stability that can assure purchasers of their ability to continue to pay in year after year, in order to receive benefits if and when the need arises.

Policies to promote or subsidize the purchase of private long-term care insurance (sometimes accompanied by consumer protection requirements) are intermittently proposed to encourage more people to purchase this type of insurance. But analysis shows that such subsidies are more likely to benefit people already able to purchase insurance on their own than to extend the market.[11] Further, without market reforms, these policy options are unlikely to create a dependable insurance marketplace. We need only look at experience in the non-group market for health insurance—plagued by risk selection, high marketing costs, benefit exclusions, and other problems— to recognize that reliance on that market for long-term care insurance will be grossly inadequate to assure most people sufficient protection.

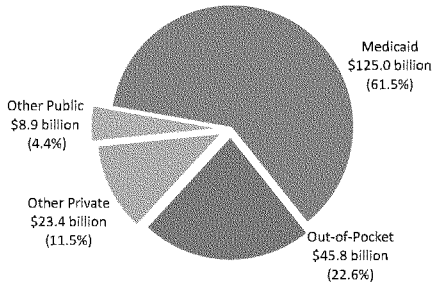
The Community Living Assistance Services and Supports (CLASS) Act—included in the Affordable Care Act—was intended to establish public, rather than private, long-term care insurance as a core means of protection against the risk of long-term care needs.[12] CLASS was designed to provide a limited daily cash benefit to people with functional impairments who make at least five years of payments beginning during their working years (and continue to pay premiums thereafter). CLASS relies on voluntary participation and is required, by law, to be fully premium financed. However, in October 2011, the Secretary of the Department of Health and Human Services suspended implementation of CLASS.[13] Although CLASS has not been repealed, its future as a basis for public long-term care insurance is tenuous, at best.

Medicaid pays for most long-term care expenditures but its protections are limited and vary across states

Given long-term care costs and the absence of insurance, it is not surprising that when people need extensive care, they often rely on Medicaid to help pay for it. In 2009, Medicaid financed 61.5 percent of national long-term care spending ($203 billion) **(Figure 5)**.[14] Medicaid paid in part or in full the costs of about two-thirds of the nation's 1.5 million nursing home residents.[15] An estimated 2.3 million people received Medicaid-financed home and community-based services during 2007.[16] Spending on long-term care services accounts for a full third of all Medicaid spending,[17] and for 70 percent of Medicaid spending on the 9 million people who are "dual-eligibles" (that is, beneficiaries of both the Medicare and Medicaid programs).[18]

Figure 5

National expenditures for long-term care, by source, 2009



Total = $203.2 billion

Source: C. O'Shaughnessy, *The Basics: National Spending for Long-Term Services and Supports*, National Health Policy Forum, March 2011.

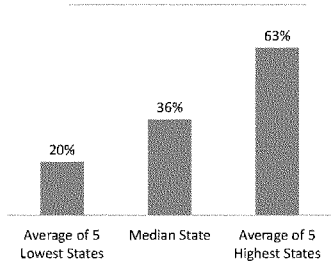
To qualify for Medicaid protection, individuals must have low income and savings to begin with, or exhaust the resources they have in purchasing medical and long-term care.[19] Given how high service costs can be, the opportunity to qualify for Medicaid when the costs exceed an individual's income and savings is essential to assure that people have access to care. Most nursing home users age 65 and older who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission.[20] But about 14 percent of nursing home users age 65 and older begin their nursing home stays by spending only their own resources and then become eligible for Medicaid when their financial resources are exhausted.[21] Medicaid recipients in nursing homes are required to spend all of their income on their nursing home care (subject to limits for people with spouses at home), except for a small "personal needs allowance" of $30 to $60 in most states.[22]

Some argue that people "transfer" their assets in order to qualify for Medicaid rather than exhaust their assets before they qualify, allowing even well-to-do people to qualify for Medicaid benefits. But evidence shows the following realities: 1) few older adults have the income or wealth that would warrant such transfer; 2) people in poor health are more likely to conserve than to exhaust assets; 3) for the elderly population as a whole, transfers that occur are typically modest (less than $2000); and 4) transfers associated with establishing eligibility are not significant contributors to Medicaid costs.[23]

Despite Medicaid's importance, its protections vary considerably from state to state and, in most if not all states, fall short of meeting people's needs. Variation takes multiple forms. The first variation is in the breadth or narrowness of its eligibility requirements and the share of people in need of care each state's program serves. To estimate the "reach" of states' Medicaid long-term care programs, a recent study by the AARP measured the ratio of the number of people receiving Medicaid long-term care services in each state to the state's number of low-income adults with difficulties in activities of daily

living (an estimate of the number of people with long-term care needs).[24] This ratio provides an approximate measure of the proportion of low-income adults with long-term care needs who receive Medicaid long-term care services. The states with the most extensive coverage are estimated to reach about two thirds of low-income adults with long-term care needs—about three times the share in the states with the least extensive programs (**Figure 6**). Half the states reach only about a third of this population.

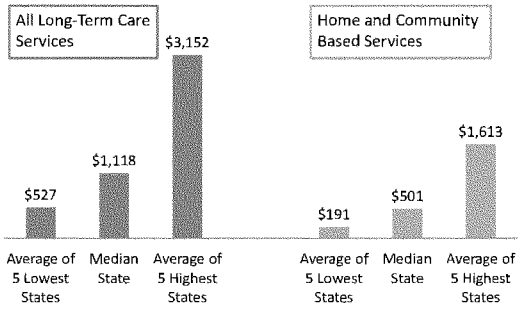
Figure 6
Estimated percentage of low-income adults with long-term care needs who receive Medicaid long-term care services, 2007



Note: Estimated in each state as the ratio of the approximate number of people receiving Medicaid long-term services and supports to adults age 21 or older who reside in a nursing home or who reside in the community with income at or below 250% of the federal poverty level and have difficulty with bathing or dressing.
Source: S. Reinhard et al., *Raising Expectations: A State Scorecard on Long-Term Care Services and Supports for Older Adults, Adults with Physical Disabilities, and Family Caregivers*, AARP Public Policy Institute, 2011.

Even greater variation among state programs is apparent when comparing states' Medicaid long-term care spending per low-income state resident. This measure reflects the combined effect of a state's breadth of eligibility with the generosity of services it provides (**Figure 7**). Medicaid long-term care spending per low-income state resident in the highest spending states (averaging $3,000 in federal fiscal year 2009 in the 5 highest states) is about six times the amount of the lowest spending states (averaging $500 in the 5 lowest states). The range is still larger—from about $1600 to about $200, or eight to one—for Medicaid's non-institutional long-term care services for people in the community, the setting where most people with long-term care needs reside.

Figure 7
Medicaid long-term care spending per state resident with income below 200% of poverty level, 2009



Source: Authors' estimates based on: S. Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update*, Thomson Reuters, October 31, 2011, for Medicaid expenditures in federal fiscal year 2009; and U.S. Census Bureau, "POV46: Poverty Status by State: 2010", last revised September 13, 2011, for number of state residents with income below 200% of the federal poverty level in 2010.

Low spending on community-based care relative to institutional care reflects Medicaid's historical emphasis on nursing homes as the primary locus of long-term care support. Over the past two decades, states have moved toward greater balance. In 2009, 44 percent of Medicaid long-term care spending nationwide was for home and community-based services, up from 18 percent in 1995.[25] But this overall trend obscures disparate treatment within the Medicaid population, as well as across states. Home and community-based services constitute a significantly larger share of spending on long-term care services for people with developmental disabilities (66 percent nationwide) than for older adults and people with physical disabilities (36 percent nationwide). One source of this difference is that community-based long-term care services for people with developmental disabilities are more likely to consist of 24 hours per day of support (for example, provided by group homes). For older people and people with physical disabilities, nursing home and other institutional services continue to dominate spending in most states, with substantial variation across the nation (**Table 2**). Half the states direct more than 70 percent of their long-term care spending on this population to nursing home and other institutional services. But the community-based services' share of long-term care spending in the most community-oriented states was almost six-fold the share in the states that were most institution-oriented (63 percent on average in the five highest states compared with 11 percent on average in the five lowest).

Table 2. Percentage of Medicaid long-term care spending on services for older adults and people with physical disabilities that is for non-institutional services, 2009

Lowest state	4%
Average of 5 lowest states	11%
Median state	28%
Average of 5 highest states	63%
Highest state	79%

Source: Authors' calculations based on data from S. Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011. Amounts are for federal fiscal year 2009.

This variation in the availability of home and community-based care services across states, particularly for older people and people with physical disabilities, has enormous consequences in terms of access to adequate care. Unlike most Medicaid services, which the law requires be made available to all people eligible, home- and community-based care is subject to enrollment caps. Most states have limits on enrollment and establish waiting lists for care at home.[26] Most people who have long-term care needs are, in fact, at home—and dependent primarily on family for the services they need. But surveys have shown that many people living at home are receiving insufficient care and, as a result, are at heightened risk of negative consequences—like falling, soiling themselves, or going without bathing or eating. Analysis indicates that the prevalence of unmet needs for long-term care, though significant across the country, is lower in states with greater availability of services at home.[27]

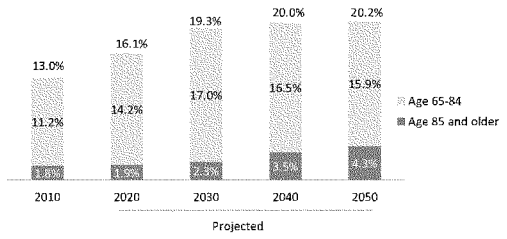
III. Challenges and Choices for the Future

Medicaid's challenges in meeting the needs of its eligible population are not limited to long-term care. The deep and extended economic recession is seriously squeezing Medicaid resources at the same time it increases the demand for services—particularly among low-income families. The availability of an enhanced federal match from 2009-2011 alleviated some of this financial burden. But the extra match ended in June 2011, and the squeeze continues—affecting all Medicaid beneficiaries, whether or not they need long-term care.

The threat to Medicaid's ability to address long-term care needs goes beyond the business cycle. The aging of the population affects Medicaid just as it affects Medicare and Social Security. Having more older adults—especially very elderly people—will increase the need for long-term care. The percentage of the population aged 85 and older is expected to increase by more than one-quarter by 2030 (from 1.8 percent in 2010 to 2.3 percent in 2030) and to more than double by 2050 (to 4.3 percent) (**Figure 8**). It is among this population that the need for long-term care is most substantial. Nearly 3 in 10 people age 85 years or older have moderate to severe long-term care needs—three times the proportion among 75-84 year-olds (**Figure 9**). As the baby boom generation ages, more people will need more long-term care.

Figure 8

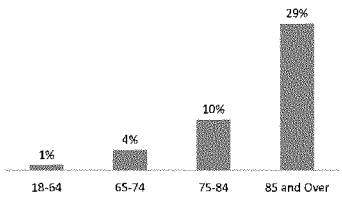
Percentage of the population that is age 65 and older, 2010 to 2050



Sources: 2010 from C. Werner, *The Older Population: 2010*, U.S. Census Bureau, November 2011. Projections for 2020-2050 from U.S. Census Bureau, "Table 3. Percent Distribution of the Projected Population by Selected Age Groups and Sex for the United States: 2010 to 2050," August 14, 2008.

Figure 9

Percentage of people in each age group who have moderate to severe long-term care needs, 2005

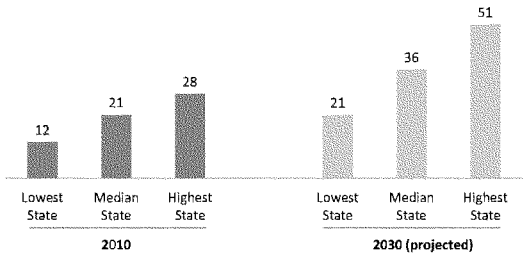


Note: Based on community residents needing assistance with activities of daily living and nursing home residents.
Source: Authors' estimate based on data from: Centers for Disease Control and Prevention, Health Data Interactive, www.cdc.gov/nchs/hdi.htm; and Centers for Disease Control and Prevention, National Nursing Home Survey, 2004 Current Resident Tables, June 2008, http://www.cdc.gov/nchs/nnhs/nnhs04_tables.htm.

States are aging at different rates and the adequacy of their resources varies considerably

Figure 10

Range among states in the number of people age 65 and older per 100 people ages 18-64 (2010 and 2030)

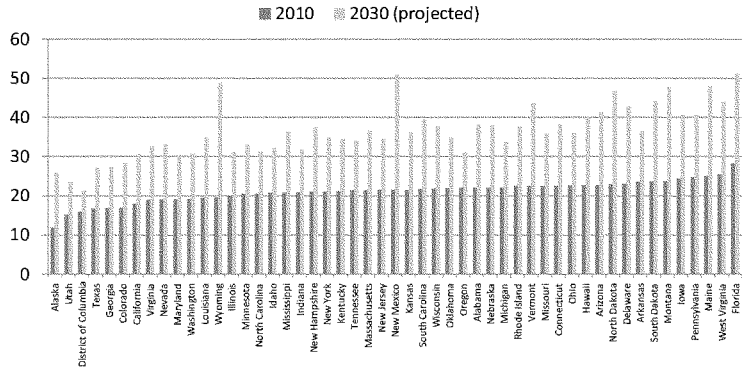


Source: Authors' tabulations of data from: L. Howden and J. Meyer, *Age and Sex Composition: 2010,* U.S. Census Bureau, 2010 Census Briefs, May 2010; and U.S. Census Bureau, "File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July 1, 2004 to 2030," 2005.

The population is aging in every state. But the effects—and the burdens—of an aging population will be larger in some states than others. Key to the adequacy of public resources to support the needs of older people will be the availability of working people to generate resources—measured as the ratio of one age group to the other. In 2010, the number of people aged 65 per 100 people aged 18-64 ranged from 12 in the "youngest" state to 28 in the oldest state (**Figure 10**). By 2030, this ratio is projected to grow in all states and the range to expand from 21 in the youngest states to 51 in the oldest. In 2030, more than half of the states will have a ratio greater than the highest state has today. On the whole, the "oldest" states today will continue to be among the "oldest" in 2030 (**Figure 11**).

Figure 11

Number of people age 65 and older per 100 people ages 18-64, by state (2010 and 2030)



Source: Authors' tabulations of data from: L. Howden and J. Meyer, *Age and Sex Composition: 2010,* U.S. Census Bureau, 2010 Census Briefs, May 2010; and U.S. Census Bureau, "File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July 1, 2004 to 2030," 2005.

It is uncertain whether any state has the capacity to deal with the needs of an aging population.[28] What is certain is that the greater the imbalance between the older population and the working age population, the greater challenge states will face in sustaining, let alone improving, the adequacy of long-term care services. As a result, the inadequacy and inequity that already characterizes Medicaid long-term care services across the states is likely to grow substantially worse in the years to come. To address today's insufficiencies and to build a better and more equitable system for the future, a change in financing is required.

Medicaid's current matching approach leaves inequities and inadequacies in place for the future

Medicaid's inadequacies and inequities at least partially reflect the influence of its financing mechanism—an open-ended federal match of state spending. The federal match varies, from a minimum of 50 percent to a high of 74 percent, based on a formula that provides a larger federal share to states with lower per capita incomes.[29] The purpose of the formula is to facilitate spending in poorer states and, in general, to encourage spending.

In practice, however, providing lower-income states' greater incentives to spend has not offset variations in state incomes in shaping Medicaid spending. A 2001 Urban Institute analysis of thirteen states found that a 1 percent increase in per capita income was associated with about a 2 percent increase in state Medicaid spending per low-income person.[30] For example, a state with 10 percent higher average income than another state would spend 20 percent more per low-income resident. As a result, even with higher Medicaid matching rates for low-income states, low-income states had total (federal and state) Medicaid spending per low-income resident that was substantially less than in higher-income states.

The aging of the population is only likely to exacerbate this variation—as the share of the population likely to need services grows relative to the working-age population needed to support them.[31] As the population ages, only an expansion of federal responsibility for financing long-term care services is likely to prevent or reverse growing inadequacy and inequity in the availability of Medicaid support for long-term care.

Enhanced federal support is needed for an equitable and sustainable long-term care safety net

At least two approaches of enhanced federal support are worthy of exploration. First is the full federal financing of a federally-defined long-term care benefit for dual eligibles (that is, low-income seniors and people with disabilities who are eligible for both Medicare and Medicaid)—which from its inception, assures greater equity in service availability across states, as well as absorbing from the states responsibility for financing care to a growing elderly population. Second is a substantially enhanced federal match for Medicaid long-term care, tied to the aging of the state's population, which encourages rather than assures greater equity but, like the first option, largely shifts the financial burden of aging to the federal level.[32]

Full federal financing of long-term care for dual eligibles

The first—and the most straightforward approach to promoting both equity and adequacy—is replacement of the federal-state matching formula with full absorption of financing for a standard package of long-term care services for dual eligibles at the federal level. This option would establish nationally-uniform standards for eligibility and long-term care benefits for low-income Medicare beneficiaries of all ages (that is, seniors and younger people eligible for Medicare because of disabilities). This option could be designed as a uniform long-term care benefit incorporated into the Medicare program. Alternatively, as a program targeted to low-income people, it could be achieved by establishing a nationally-uniform minimum benefit with federal financing that states could enhance with federal matching funds. Because we are focusing on the safety net rather than a universal program (like Medicare, providing coverage to all who qualify without regard to income), we explore the latter approach here. Implementation of the benefit would be handled at the state level, enabling the program to benefit from state initiatives in service delivery and care coordination that are now being promoted.[33] Federalizing long-term care financing for dual eligibles in this way would resemble the establishment of the Supplemental Security Income program for low-income older adults and people with disabilities in 1972, which replaced federal matching grants to states with a federally-financed, federal-state administered, "floor" of income protection.[34]

A new federally-financed long-term care program for dual eligibles would set a nationally-uniform benefit standard for dual eligibles, designed to fall somewhere in the middle of the range of state long-term care programs today. To achieve equity and control spending growth, the benefit would be nationally defined—with specific benefits assigned based on an individual's needs, as determined by a standardized assessment process. In addition, payment rates to providers would be federally defined and adjusted for geographic variation in input costs, like Medicare payment rates. States would have the option of providing additional services to supplement the federal benefit, and could receive federal matching funds for those services.

States would be required to contribute toward the costs of the new federal benefit, as they currently are to the Medicare prescription drug benefit[35]—specifically, states would be required to pay the federal government an amount initially equivalent to either their current long-term care spending on dual eligibles or, for state's whose current programs are "more generous" than the federal standard, an amount equivalent to what it would cost them to offer the uniform federally-defined benefit. The state payment amount would be increased annually by an index measuring inflation (as measured by wage growth or the consumer price index, for example) and growth in the state's population. The population adjustment increases the state's contribution as its revenue capacity increase. The index holds states "harmless" for disproportionate growth in the dually-eligible population in need of service (that is, for growth in the dually-eligible population that exceeds the rate of growth of the overall population). The result is that as states get older, they would pay less than under current arrangements to maintain the same level of service. The federal government, on the other hand, would pick up the costs of expansion to the federally-defined benefit level in states now below it, and most of the costs of a growing number of dual eligibles in all states. Federal matching funds would continue to be available to states providing additional benefits beyond the federally-defined standard.

By establishing and sustaining a nationally-uniform benefit floor across all states, this proposal has the potential to "uplift" a substantial portion of the population to a higher level of service—enhancing both adequacy and equity into the future. Arguments for this proposal include the fact that the federal government is already financing roughly 80 percent of dual eligibles' acute and long-term care—financing nearly all their acute care, through Medicare, and more than half their Medicaid long-term

care services.[36] Were the federal government to pick up the rest, it would bring an end to current incentives to shift responsibilities and costs from one program to the other and, if well managed, encourage federal coordination of services across the full spectrum of an individual's care needs.

Aging-based enhancement of federal match for long-term care services

A different approach to strengthening the long-term care safety net would be a substantial increase in federal financing through an enhanced matching rate, tied to the proportion of a state's population who are low-income seniors. Such an approach would resemble the recent enhancement of state matching rates to reflect states' unemployment levels,[37] that is, increasing federal responsibility for a national challenge—in this case, the aging of the population. However, it would differ from the unemployment approach in its permanence and its design to have the federal government bear most of the burden of an aging population over time. Unlike the previous approach, the enhanced match would leave it to states to determine benefits and payment, much as they do today. Further, this approach would affect all Medicaid recipients of long-term care, rather than applying only to dual eligibles.

Under this approach, the federal government could adopt a range of matching enhancements for long-term care spending depending on the "age" of the state; for example, the enhancements could initially range from perhaps an addition of 5 percentage points to the current federal share for states that are now the "youngest" to an addition of 10 or 15 percentage points for states that are now the "oldest." A state's "age" would be measured based on the ratio of its population age 75 or over with incomes below 300 percent of the federal poverty level (the population most likely to need Medicaid long-term care services) to its working aged population (the population providing the bulk of the financial resources in the state).

Some might advocate that the enhanced match apply only, or differentially, to home and community-based services, in order to encourage "rebalancing" away from institutional care. But aging will challenge states' capacity to deliver both institutional and non-institutional services. Focusing enhanced federal support only on community services could put adequacy of institutional care at risk. An enhanced match applying to all long-term care services will facilitate the increased emphasis on community-based services that is already occurring.

To assure that enhancements expand service and eligibility levels—rather than replace state funds—states would be required to spend enhancement dollars on long-term care and to sustain at least their current eligibility and benefit standards (or initial spending levels). Over time, the enhanced matching rates would partially relieve the states of the burden of an aging population with increasing long-term care needs. A state's "age" would be periodically recalculated and the federal enhancement would increase with the increase in a state's "age" (that is, ratio of people age 75 or older with income below 300 percent of poverty to the working age population). The relationship between the ratio and the enhancement would be fixed, so as states age, the maximum enhancement would also rise (as ratios increase in all states), subject to a maximum enhancement of 20 or 25 percent.

Unlike the previous option, which targeted federal financing to the least generous states, this second option would initially focus enhanced federal financing on states with the largest shares of residents likely to need help paying for long-term care services. This option's different approach to targeting, along with the absence of the previous option's nationally-defined benefit and payment schedule, will likely mean continued wide variation in service availability across the states. Tying the availability of federal financing to the share of a state's population that is older and unable to afford services will likely enhance the adequacy of the safety net in all states.

IV. Conclusion

Forty years ago, Congress enacted the Supplemental Security Income program to promote greater adequacy and equity in income support for low-income older people and people with disabilities. The Supplemental Security Income program replaced federal matching grants to states with full federal financing of basic income support. Now is the time to take a similar step with respect to long-term care financing in Medicaid.

The current Medicaid long-term care safety net, though invaluable to people who rely on it, leaves too many people who need services without them and makes the adequacy of services a function of where people live. Today, variations in adequacy are considerable. Half the states reach only about a third of the low-income population with long-term care needs, and the least generous states achieve only about a third the reach of the most generous. Long-term care spending per low income person in the state—which reflects not only who gets served but how much service they get—varies even more: six-fold from the most generous to the least generous states for all long-term care services and eight-fold for services at home or in the community. Limited service is associated with reports of greater "unmet need"—or going without—among people who rely on others for help dressing, toileting, eating and performing other basic tasks of daily life.

Over the next two decades, the aging of the population will double the share of the population that is over age 85, the age group most likely to need long-term care. All states will experience the increase, but some states will face greater challenges than others—measured by the growth in the ratio of the older population to the working age population. States already strapped in their ability to provide long-term care services will find themselves more strapped over time, and both inadequacy and inequity of service across the nation will likely increase.

Neither the inequity nor the inadequacy of Medicaid long-term care services across states is a problem likely to be solved with greater "flexibility" in states' use of existing resources and admonitions to pursue greater efficiency. Although long-term care at home has the potential to serve more people at lower cost than current reliance on nursing homes for the bulk of care to older adults in need, currently low levels of service resources mean that greater resources will be essential to meet the needs of a growing elderly population.

The fundamental problem is not inefficiency; rather it is basic demographics and distribution of resources. With a growing older population dispersed unevenly across states, deficit reduction proposals that would take the federal government out of the financing picture or reduce its role would clearly worsen, rather than improve, current long-term care financing deficiencies. Block grants or other financing mechanisms to arbitrarily limit growth in federal financing will lock inadequacy and inequity in place and worsen it over time. Even Medicaid's open-ended federal matching grants, designed to provide greater assistance to more hard-pressed states, will increasingly fall short in establishing a decent floor of long-term care protection across the nation.

Achieving an equitable, adequate, and viable long-term care safety net clearly requires greater, not lesser federal financial involvement is required. To that end, we have proposed two options. Full federal financing of long-term care for dual eligibles would, like enactment of the Supplemental Security Income program, replace federal matching grants to the states with a new uniform standard of eligibility and benefits. States would continue to share in benefit costs but would be "held harmless" from the burden of an aging population—which would be absorbed by the federal government. The second option, similar to the recent enhancement of the federal match to help states cope with severe unemployment,

would retain federal matching rates but increase the federal share as the state's "age" increases (as measured by the ratio of low-income older people to people of working age in the state).

An enhanced match for long-term care services would leave in place more variation and inequity across states (at lower federal cost) than full federal financing of long-term care for dual eligibles. But by "cushioning" states from the costs of providing services for a growing older population, enhanced federal matching rates would sustain greater adequacy of long-term care services in all states.

Achieving greater equity and adequacy of long-term care service—along with state fiscal relief—will carry a significant price in increased federal spending. It is hard to be optimistic that the nation will be willing to pay this price, given political battles around financing even current service commitments. But this brief documents that a failure to adequately finance a long-term care safety net also carries a price: the inevitable deterioration in care for growing numbers of people unable to care for themselves. Whether this is a price the nation can tolerate is a question yet to be squarely addressed.

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Notes

[1] Authors' estimate based on data from: H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (January 2010): 11-21; and U.S. Census Bureau, "Table 1. Population by Age and Sex: 2007," May 2009, http://www.census.gov/population/www/socdemo/age/age_sex_2007.html.

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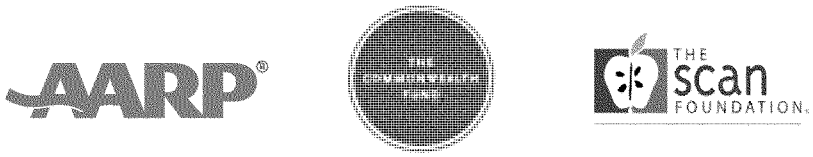


Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers is the first of its kind: a multi-dimensional approach to measure long-term services and supports (LTSS) system performance at the state level, both overall and along four key dimensions.

Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers, consumers, and other private sector forces also affect state performance, both independently and in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

The *Scorecard* examines state performance across four key dimensions of LTSS system performance:

- Affordability and Access
- Choice of Setting and Provider
- Quality of Life and Quality of Care
- Support for Family Caregivers

Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Overall state rankings, including each state's quartile of performance in each of the four dimensions, are displayed below.

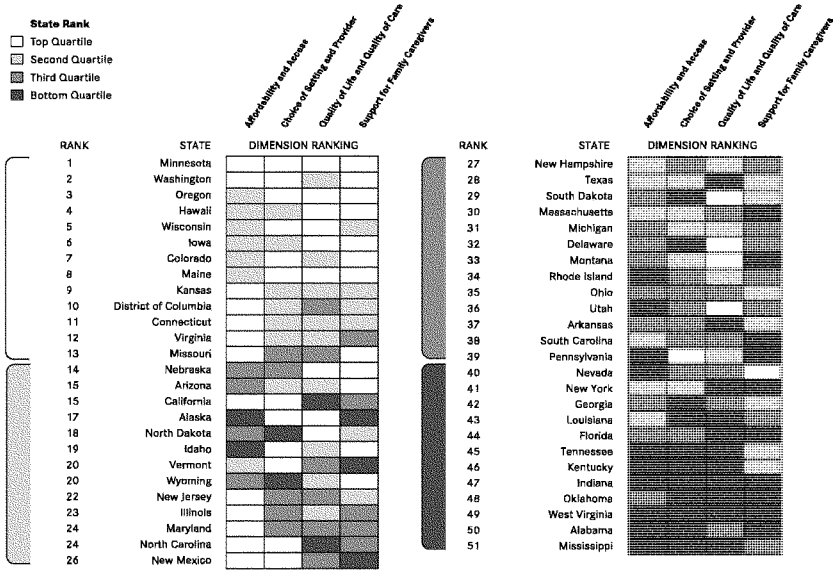
Major Findings: High-level findings of the Scorecard include:

- Leading states often do well across dimensions, but all have opportunities to improve.
- Wide variation exists within dimensions and indicators.
- State Medicaid policies dramatically affect consumer choice and affordability.
- Support for family caregivers goes hand in hand with other dimensions of high performance.
- The cost of LTSS is unaffordable for middle-income families.

How to Get the Full Report: The full report is available at www.longtermscorecard.org

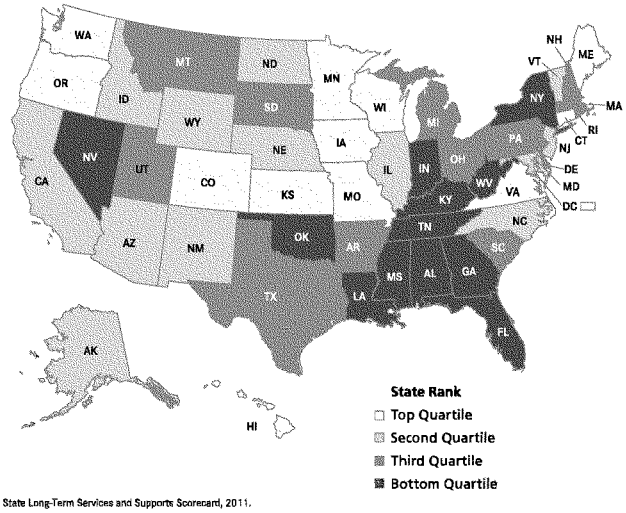
To order hard copy of the report, contact the AARP Public Policy Institute at (202)434-3890 or email jgasaway@aarp.org.

State Scorecard Summary of LTSS System Performance Across Dimensions



Source: State Long-Term Services and Supports Scorecard, 2011.

State Ranking on Overall LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2011.

THE SCAN FOUNDATION.

DataBrief: Medicaid Managed Care and Long-Term Services and Supports Spending

Did you know...

In 2009, 13 state Medicaid programs used managed care to deliver long-term services and supports?

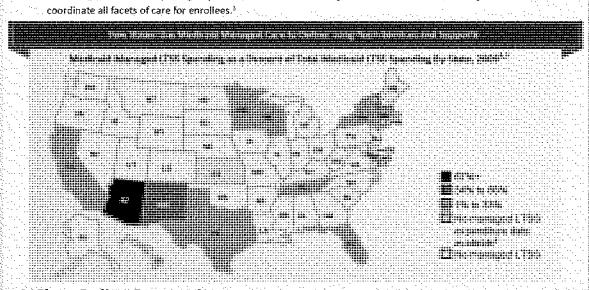
About the data:

This analysis is based on 2009 data collected by Thomson Reuters on Medicaid managed care spending on LTSS, as well as 2009 data reported in the CMS Form 64 and published by Thomson Reuters, which details each state's Medicaid expenditures. Thomson Reuters identified 13 states using Medicaid managed LTSS and polled state departments to determine how much they spent on managed LTSS and in what categories. Each of the 13 states, except Hawaii and Kansas, reported expenditures.

In this analysis, spending on LTSS includes spending on nursing facilities; intermediate care facilities for the mentally retarded; home- and community-based services (HCBS) expenditures authorized under Sections 1915(c) and 1915(j) of the Social Security Act; the home health benefit; the optional personal care benefit; the Program of All Inclusive Care for the Elderly (PACE); and select HCBS spending authorized under Section 1115 of the Social Security Act. HCBS expenditures authorized under Section 1915(i) of the Social Security Act are not included.

Analytics powered by Avalere Health LLC

- Medicaid is a state and federal partnership program that covers medical care and long-term services and supports (LTSS) for low-income individuals.
- In most parts of the U.S., the provision of LTSS is highly fragmented. Furthermore, this fragmentation can lead to lower quality care and inefficiencies in care delivery.[1]
- Although most Medicaid LTSS is paid as fee-for-service, some states provide these services to beneficiaries through managed care plans. These predominantly private plans receive a set payment per month and are responsible for providing all necessary services to their enrollees.
- In 2009, 13 states delivered LTSS through managed care ("Medicaid managed LTSS") to individuals with disabilities.
  - The 13 states were: Arizona, California, Florida, Hawaii, Kansas, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Vermont, and Wisconsin.
  - In three states, Medicaid managed LTSS accounted for over 40 percent of total Medicaid LTSS spending.[2]
- Increasingly, states are exploring ways to expand Medicaid managed care to include LTSS, making it easier to coordinate all facets of care for enrollees.[3]



A Clear Policy Connection

As LTSS costs continue to account for a growing proportion of Medicaid spending, states have shown significant interest in using managed care to improve care coordination and reduce costs, particularly for seniors and people with disabilities who have complex medical and LTSS needs.

Many states are quickly expanding their managed LTSS programs and several states are also pursuing the integration of LTSS with medical services. However, only 13 states have experience with Medicaid managed LTSS programs upon which to build. Given that this is a new venture for many states, there are a number of issues they should consider. Managed care infrastructures—specifically, networks of physicians, hospitals and LTSS providers—take time to build. Though some states have built similar infrastructures for other Medicaid populations, they will need to modify them to ensure that networks can meet the needs of seniors and people with disabilities.[3] Additionally, states should seek to incorporate best practices that include: communicating a clear vision for managed LTSS to promote program goals; engaging stakeholders to achieve their buy-in for program implementation; and ensuring that benefits are designed to meet varying beneficiary need by encompassing the full array of LTSS.[7] States can also benefit from requiring the use of a uniform assessment tool as part of their managed LTSS programs. These assessment tools can ensure consistent evaluation of need and provide for the development of LTSS-focused measures to evaluate program performance and quality of care provided to individuals.[7]

[1] The SCAN Foundation. DataBrief No. 21: Dual Eligibles, Chronic Conditions and Functional Impairment. 2011. Accessed September 28, 2011 at: http://www.thescanfoundation.org/foundation-publications/databrief-no-21-dual-eligibles-chronic-conditions-and-functional-impairment.
[2] Kaiten J, Eiken S, Burwell B. Medicaid Managed Long-Term Services and Supports Expenditures. 2011. Accessed September 30, 2011 at: http://www.hsbc.org/files/205/12013/MedicaidManagedLTSSExpenditures.pdf.
[3] Kaiser Family Foundation. Examining Medicaid Long-Term Service and Support Programs: Key Issues to Consider. October 2011. Accessed October 15, 2011 at http://www.kff.org/medicaid/upload/8243.pdf
[4] Data collected and published by Thomson Reuters. See Kaiten J, Eiken S, Burwell B. Medicaid Managed Long-Term Services and Supports Expenditures. 2011.
[5] Total percentages of state long-term services and supports spending in managed care: Arizona 87%, California 4%, Florida 1%, Massachusetts 5%, Minnesota
[6] Hawaii and Kansas have Medicaid managed LTSS programs, but did not provide data on program expenditures.
[7] Lind, A; Gore, S; Barnetto, L; Somers, S. Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. Center for Health Care Strategies. November 2010. Accessed January 5, 2012 at: http://www.thescanfoundation.org/sites/default/files/MLTS_Roadmap_0.pdf.

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DataBrief: Dual Eligibles, Chronic Conditions, and Functional Impairment By Age Group

Did you know...

In 2009, 29% of dual eligibles under age 65 and 37% of duals age 65 and over had both functional impairment and chronic conditions.[2]

About the data:

This analysis is based on the 2009 Medicare Current Beneficiary Survey (MCBS) Access to Care file, an annual, longitudinal survey of a representative sample of Medicare beneficiaries enrolled for the full year. The MCBS collects information on Medicaid eligibility, chronic conditions, and functional impairment.

In this analysis, individuals who either self-reported that they had Medicaid coverage or who were identified by the Centers for Medicare and Medicaid Services as having Medicaid coverage were considered to be dual eligibles. Individuals who indicated that they received help or standby assistance with one or more Activities of Daily Living (ADLs) and/or three or more Instrumental Activities of Daily Living (IADLs) were considered to have functional impairment. This analysis included respondents residing in the community and in institutions.

Individuals who indicated that they had ever been diagnosed with any of the following conditions were considered to have a chronic condition: arthritis, Alzheimer's Disease, broken hip, cancer (excluding skin), congestive heart failure, depression, diabetes, hypertension, mental illnesses (excluding depression), myocardial infarction and other heart conditions, osteoporosis, Parkinson's Disease, pulmonary diseases such as emphysema, asthma and Chronic Obstructive Pulmonary Disease, and stroke.

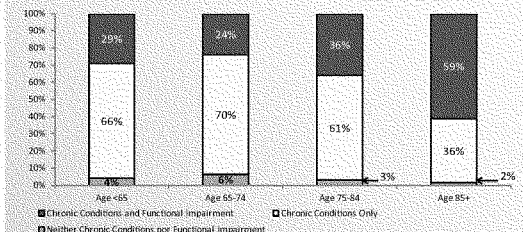
This analysis excludes Medicare beneficiaries who enrolled or died during 2009.

Analytics powered by Avalere Health LLC

- "Dual eligibles" are low-income individuals who are eligible for both Medicare and Medicaid benefits. They are often in poor health and among the most costly patients to both programs.[1]
- Most beneficiaries qualify for Medicare at the age of 65, though some younger people also qualify if they have disabilities, end-stage renal disease, or amyotrophic lateral sclerosis.[2] If these individuals fall below certain income and asset limits, they can also qualify for Medicaid.[3]
  - In 2009, 41% of duals were under age 65, compared to 10% of Medicare-only beneficiaries.
- Dual eligibles have higher rates of chronic conditions than their Medicare-only counterparts. In particular, they have higher rates of mental illness and cognitive impairment than Medicare-only beneficiaries.[4] In addition to chronic conditions, they more often have functional impairment and require long-term services and supports (LTSS) to assist with daily activities such as eating, bathing, and dressing.[4] These factors make duals a complex population to care for.
- In 2009, 33% of duals of all age groups had both chronic conditions and functional impairment. This varied by age group, reflecting the diverse care needs of this population.[4]

Dual Eligibles Are a Diverse Population with Differing Long-Term Services and Supports Needs

Dual Eligibles by Age Group, Number of Chronic Conditions, and Functional Impairment, 2009*



* N = 3,279,733 duals age <65, 2,140,048 duals age 65-74, 1,692,792 duals age 75-84 and 942,033 duals age 85+.
Note: Totals may not sum to 100% because duals with functional impairment only are not shown in this chart among all duals. 1% have functional impairment only. Among the age groups, 1.1% of <65, 0.44% of 65-74, 0.19% of 75-84, and 3.34% of 85+ duals had functional impairment only. Also, 4% of dual eligibles under age 65 have neither chronic conditions nor functional impairment as defined in this analysis, but may have qualified for Medicare due to a condition not included in the current definition of chronic disease (e.g., end stage renal disease or amyotrophic lateral sclerosis).

A Clear Policy Connection

Dual eligibles across all age groups have high rates of both chronic conditions and functional impairment and may require both medical services and LTSS to meet their care needs.[4] Experts agree that the coordination of medical care and LTSS could help improve duals' quality of life and reduce expenditures for Medicare and Medicaid. However, this population is very diverse. For example, younger duals with functional impairment and chronic conditions may have significantly different preferences for how they receive LTSS than seniors.[1]

Section 2602 of the Affordable Care Act created the Medicare-Medicaid Coordination Office (MMCO), responsible for coordinating Medicare and Medicaid benefits to improve quality of care for this population.[5] In April 2011, the MMCO awarded contracts to 15 states to develop new models of care for duals that integrate primary care, acute care and behavioral health services, as well as LTSS. For care models targeting dual eligibles to significantly impact health outcomes and reduce costs, they must go beyond a disease-centered focus and address functional impairment in a person-centered manner. The MMCO opportunity provides states a platform from which to accomplish this objective.

1 Kaiser Family Foundation, Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. July 2009. Accessed September 29, 2011 at: http://www.kff.org/medicaid/upload/8061.pdf.
2 Social Security Administration. 2011 Red Book: Overview of Our Disability Programs. Accessed September 29, 2011 at: http://www.ssa.gov/redbook/eng/overview-disability.htm. Examples of disabling conditions include chronic heart failure, chronic kidney failure, Down syndrome, severe cancers and other severe illnesses that typically cause a person to be unable to work.
3 The SCAN Foundation. Policy Brief No. 11: Eligibility Pathways for Dual Eligibles. 2011. Accessed November 15, 2011 at: http://www.thescanfoundation.org/foundation-publications/databrief-no11-eligibility-pathways-dual-eligibles.
4 Avalere Health, LLC. Analysis of the 2009 Medicare Current Beneficiary Survey, Access to Care File.
5 Centers for Medicare and Medicaid Services. "About the Medicare-Medicaid Coordination Office." September 2011. Accessed January 17, 2012 at: https://www.cms.gov/medicare-medicaid-coordination/.

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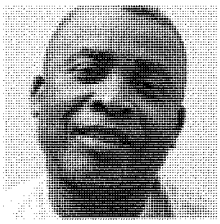

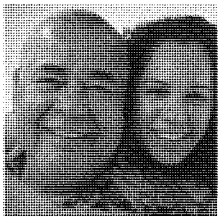

Profiles of State Innovation:
Roadmap for Managing Long-Term Supports and Services

November 2010

Funded by The SCAN Foundation.

www.chcs.org

Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services

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Acknowledgements

We are grateful to The SCAN Foundation for supporting this effort to uncover best practices from across the country for better managing long-term supports and services. In particular, we recognize Rene Seidel and Gretchen Alkema for their dedication and passion in improving vital services for millions of adults with disabilities and the elderly. The states featured in this roadmap — Arizona, Hawaii, Tennessee, Texas, and Wisconsin — are true pioneers in designing new ways to provide care for this high-need population. We are indebted to our advisory group of state staff, other national experts, and colleagues at the Centers for Medicare & Medicaid Services (see appendices for the advisory group list) for providing insights and guidance along the way. We hope that additional states embark on their own journeys to transform the state of managed long-term supports and services across the country.

The **Center for Health Care Strategies** is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries.

For more information, visit **www.chcs.org**.

A. Lind, S. Gore, L. Barnette, S. Somers. *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services.* Center for Health Care Strategies, November 2010.

Foreword

The Affordable Care Act of 2010 presents national policymakers and state leadership across the country with the opportunity to improve quality outcomes for low-income adults receiving long-term supports and services (LTSS). Even prior to its passage, a number of states had developed successful long-term care models, particularly in the home- and community-based service area. The SCAN Foundation wanted to create an opportunity for all states not only to learn about these various model programs, but also to provide a specific roadmap for states interested in implementing similar programs. Key issues include what concrete steps state officials need to consider within their own state as well as how to best interface with the Centers for Medicare & Medicaid Services to implement these options.

To this end, the Center for Health Care Strategies (CHCS) has developed three ***Profiles of State Innovation*** roadmaps to help states explore and understand emerging options, best practices, and proven models of success in three areas: (1) rebalancing LTSS care options to support home- and community-based services; (2) the development and implementation of a managed LTSS program; and (3) integrating care for adults who are dually eligible for Medicaid and Medicare.

The mission of The SCAN Foundation is to advance the development of a sustainable continuum of quality care for seniors. The ***Profiles of State Innovation*** roadmaps outline ways to achieve a more balanced, integrated, and efficient LTSS system. The information included in each roadmap has the potential to ensure that older adults and people with disabilities can age with dignity, choice, and independence while remaining in their homes or in the environment they prefer.

We thank all of those who have contributed to this series, especially the state and program innovators profiled, and members of the project's National Advisory Group, who gave so generously of their time and expertise. We also acknowledge the dedication and hard work of the CHCS staff: Stephen A. Somers, Alice Lind, Lindsay Barnette, Suzanne Gore, and Lorie Martin.

Bruce Chernof, MD
President & CEO
The SCAN Foundation

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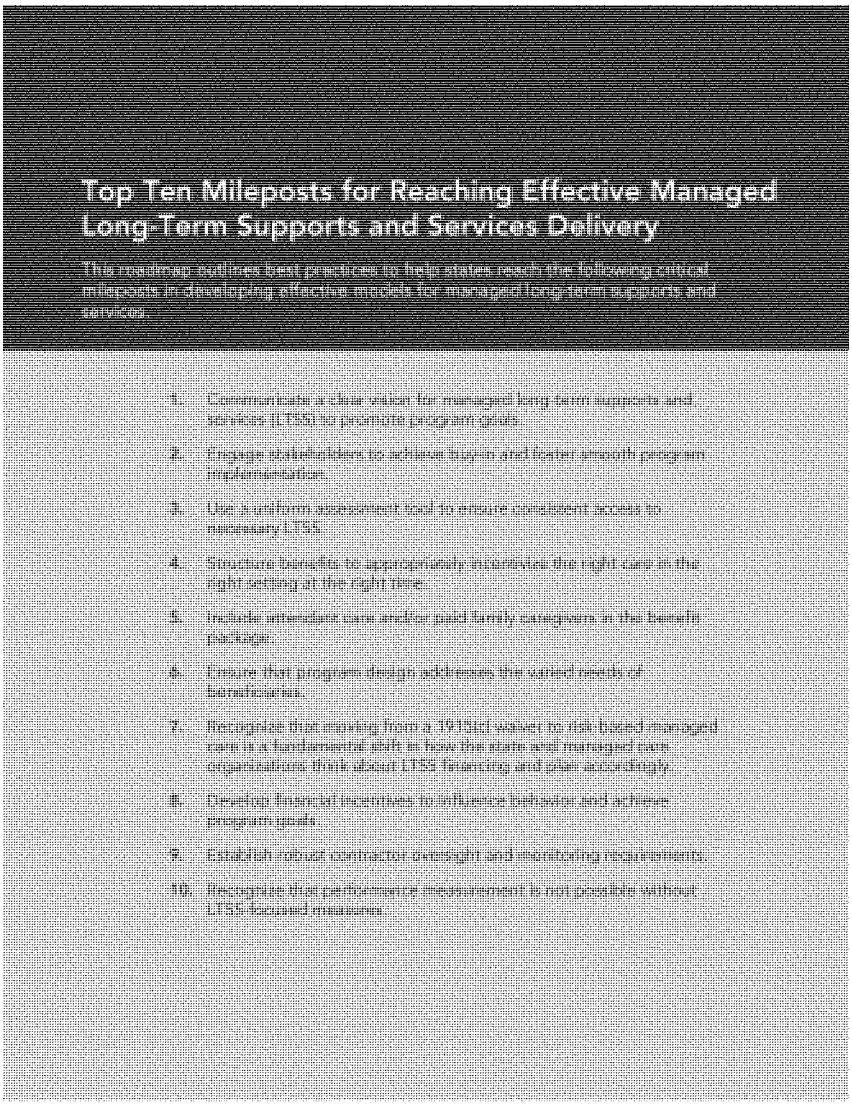

Top Ten Mileposts for Reaching Effective Managed Long-Term Supports and Services Delivery
This roadmap outlines best practices to help states reach the following critical mileposts in developing effective models for managed long-term supports and services.
1. Communicate a clear vision for managed long-term supports and services (LTSS) to promote program goals.
2. Engage stakeholders to achieve buy-in and foster smooth program implementation.
3. Use a uniform assessment tool to ensure consistent access to necessary LTSS.
4. Structure benefits to appropriately incentivize the right care in the right setting at the right time.
5. Include attendant care and/or paid family caregivers in the benefit package.
6. Ensure that program design addresses the varied needs of beneficiaries.
7. Recognize that moving from a 1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing and plan accordingly.
8. Develop financial incentives to influence behavior and achieve program goals.
9. Establish robust contractor oversight and monitoring requirements.
10. Recognize that performance measurement is not possible without LTSS-focused measures.

Introduction

The passage of the Affordable Care Act (ACA) left a fair amount of unfinished business in the U.S. health system in the long-term supports and services arena. It may be some time before Congress takes on major legislation on long-term care, but there is little doubt that demographics and economics will compel policymakers to consider more dramatic changes in how the nation organizes, finances, and delivers long-term supports and services (LTSS). In the meantime, with the exception of the Community Living Assistance Services and Support (CLASS) Act and some more modest features of ACA, the onus for rethinking publicly financed LTSS delivery will reside at the state level, particularly in Medicaid, which finances more than 40 percent of LTSS in America.[1]

Fortunately a good number of states have made genuinely innovative and robust investments in this arena over the past several decades. These efforts can be grouped into three areas:

- Rebalancing LTSS to provide more home- and community-based services (HCBS) options as well as nursing facility alternatives;
- Developing and implementing a managed long-term supports and services (MLTS) program; and
- Integrating care for adults who are dually eligible for Medicare and Medicaid.

IN BRIEF

Medicaid pays for more than 40 percent of the nation's long-term supports and services (LTSS) costs. Although costs for LTSS represent almost one-third of all Medicaid spending, these services are often disconnected and financially misaligned. Overhauling the delivery of long-term care offers significant opportunities for states to improve health care quality, control costs, and enhance the quality of life for millions of Americans. Health reform legislation extends new funding options for states to achieve a more equitable balance between institutional and home- and community-based care.

This roadmap culls from state best practices across the country to outline key elements for managing LTSS that provide high-quality, consumer-focused, and cost-effective care.

Through support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) conducted an environmental scan to identify state best practices in each of these three critical areas. The resulting *Profiles of State Innovation* series culls lessons from state LTSS pioneers to create roadmaps for other states to follow as they develop new or improved systems of LTSS.

For this report, CHCS, with assistance from an advisory group of state staff and other experts,[2] identified five innovative states — Arizona, Hawaii, Tennessee, Texas, and Wisconsin — with expertise in managed care approaches for individuals with long-term care needs (see sidebar for selection criteria). The lessons herein were gathered through interviews and in-depth site visits with these pioneering states. CHCS also drew from its extensive work with additional states in pursuing MLTS programs and integrating care for duals. While the featured states each have different approaches to managing the full spectrum of long-term care needs, they are joined by the common vision of providing higher quality and more cost-effective long-term supports and services.

[1] Kaiser Commission on Medicaid and the Uninsured estimate based on CMS National Health Accounts data, 2008.
[2] See appendix for list of advisory group members.

State Environment

Today, 94 percent of Medicaid beneficiaries needing LTSS receive their care through the fragmented fee-for-service (FFS) system.[3] LTSS costs continue to account for greater proportions of Medicaid spending and the nation's aging population is generating increasing need for services. This is motivating many states to look for ways to offer consumers broader access to home- and community-based options, while at the same time better managing overall long-term care spending. Thus, more states are interested in pursuing managed care approaches for these types of services.

Interviews with the states indicated that they sought to implement an MLTS program to:

- Build upon existing managed care experience and/or infrastructure, as in Arizona and Tennessee;
- Use managed care organizations to decrease and/or end waiting lists for home- and community-based waiver services, as in Hawaii, Texas and Wisconsin;
- Provide a more flexible set of benefits and more choice than typically found in Medicaid FFS, particularly for community-based care;
- Achieve a more cost-effective long-term supports and services system;
- Strengthen the quality of care; and/or
- Take an important step toward fully integrating the delivery and financing of the full range of acute and long-term supports and services for those needing long-term care.

State Selection Criteria

To identify state innovators, CHCS and the advisory group members referenced several information sources on state progress in improving LTSS systems, including the Kaiser Family Foundation's and Thomson Reuters' reports on waiver expenditures, and an AARP report that breaks out LTSS expenditures by eligibility category.[4]

General criteria:

1. State's system for assessment, determination of need, and case management of LTSS is independent of providers.
2. State collects and analyzes data for performance measurement, and mines data to track utilization and program impacts on costs.
3. Consumers and other stakeholders are engaged in program design and quality monitoring.
4. State is committed to continuous quality improvement of its LTSS towards statewide system that supports multiple populations.
5. State has formal and informal bridges across medical/LTSS systems.

Criteria for managed LTSS states:

1. State has regulatory and/or legislative support for non-FFS approach to LTSS.
2. State engages consumers in program implementation.
3. State relies on cross-agency integration to blend financing and delivery systems.
4. State has commitment to evaluate along multiple dimensions.
5. The managed care system in the state is replicable.

Prevailing wisdom tells us that if "you've seen one Medicaid program, you've seen one Medicaid program." There is no aspect of the program wherein this is more true than in the design of MLTS programs. These programs vary dramatically from one state to the next in terms of target populations, covered benefits, enrollment options, and contracting. The decisions states make in the design of MLTS programs are dependent on their individual histories and context, including existing infrastructure (both in terms of managed care as well as LTSS) and the political support for and stakeholder concerns about managed

[3] P. Saucier. "Overview of Medicaid Managed Long-Term Care." Presented at the National Health Policy Forum on Medicaid Managed Long-Term Care, April 25, 2008.

[4] B. Burwell, et al. "Medicaid Long-Term Care Expenditures in FY 2008." Thomson Reuters, December 1, 2009 (available at **http://www.hcbs.org/moreInfo.php/doc/2793**); T. Ng, C. Harrington, M. O'Malley-Watts. "Medicaid Home and Community-Based Service Programs: Data Update." Kaiser Commission on Medicaid and the Uninsured, November 2008 (available at **http://www.kff.org/medicaid/upload/7720_02.pdf**; and E. Kassner, et al. "A Balancing Act: State Long-Term Care Reform." AARP Public Policy Institute, July 2008 (available at **http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf**).

care. While Figure 1 (see pages 8-9) provides detailed information on the key characteristics of the MLTS programs found in the states interviewed, there are a few distinctions worth highlighting:

- While most states have a broad inclusion policy (all adults age 65 and over as well as people with physical disabilities are eligible to enroll), some states (Arizona and Tennessee) have chosen to focus on those at risk for or at the nursing home level of care. Wisconsin includes people with developmental disabilities in its program in addition to other eligibility categories. Hawaii includes all age groups, which means that medically fragile children are served under the MLTS program as well as frail elderly.
- Contractors in Arizona, Hawaii, and Tennessee are responsible for providing the full-range of Medicaid acute and long-term supports and services to the population being served, while Wisconsin's program includes Medicaid long-term supports and services only. While Texas includes both acute and LTSS, its STAR+PLUS program does have some notable carve-outs including hospital and nursing facility care.
- Arizona, Hawaii, Tennessee, and Texas have elected to make their MLTS programs mandatory for eligible beneficiaries while Wisconsin's Family Care program is voluntary.
- Hawaii, Tennessee, and Texas have chosen to include large, national managed care organizations among their contractors, while Wisconsin uses "public" managed care organizations (MCO), composed of consortia of counties, as well as private plans. Arizona has more of a hybrid approach, contracting with a mix of large, national plans as well as local, home-grown or county-based MCOs.
- The majority of states have created an MLTS program that is separate from the managed care program providing acute care to the broader Medicaid population. Tennessee is the exception — it chose not to have a separate procurement for MLTS contractors and instead chose to amend contracts with their existing MCOs to bring LTSS into the mix.

Three of the five states interviewed have been operating their respective MLTS programs for more than 10 years. As a result, these states are focused primarily on expanding or improving upon the existing program infrastructure. For example, the Arizona Long Term Care System (ALTCS) program was established in 1989. Texas is in the midst of expanding its STAR+PLUS program into the Dallas/Fort Worth area, which will bring the total of those with LTSS needs in managed care to approximately 45 percent. Similarly, Wisconsin is in the process of expanding Family Care statewide. As of summer 2010 the program, which began as a five-county pilot, was operating in 55 of the state's 72 counties. Hawaii and Tennessee are relative newcomers; Hawaii implemented its program statewide in 2009, and Tennessee completed implementation of its CHOICES program in August 2010.

Figure 1: State Managed Long-Term Supports and Services Program Dashboard

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Implementation Date	1989	2008	2010	1998	2000
Medicaid Authority	1115	1115	1115	1915 (b)/(c)	1915 (b)/(c)
Eligibility	Medicaid aged (65+), blind and disabled beneficiaries who need a nursing home level of care. Includes dual eligibles.	Medicaid aged and disabled beneficiaries of all ages, including those on spend-down.	Three target groups: (1) Medicaid beneficiaries receive care in nursing facilities (NF); (2) Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities who need a nursing home level of care; (3) Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities "at risk" of institutionalization.	Medicaid beneficiaries who receive SSI and/or qualify for certain waiver services. Includes dual eligibles.	Medicaid beneficiaries with long-term care needs, including frail elders, people with physical disabilities, and people with developmental disabilities.
Enrollment	Mandatory	Mandatory	Mandatory	Mandatory	Voluntary
Beneficiaries Served	49,501	41,500	Almost 30,000	155,000	30,013
Geography	Statewide	Statewide	Statewide	Limited geographic areas	Limited geographic areas (in process of expanding statewide)
Covered Benefits	Medicaid acute, behavioral health, and LTSS (including HCBS and NF).	Medicaid acute medical and behavioral health, LTSS (including HCBS and NF).	Medicaid acute, behavioral health, and LTSS (including HCBS and NF).	Medicaid acute, limited behavioral health, and home- and community-based services.	Medicaid LTSS (including HCBS and NF).
Integration with Medicare for Dual Eligibles	Contractors are not currently required to be special needs plans (SNPs) but many are, allowing for integration of care for beneficiaries who chose to receive both sets of services from single plan.	Contractors are not currently required to be SNPs.	Contractors are not currently required to be SNPs.	Contractors in the STAR+PLUS expansion area (Dallas/Ft. Worth) will be required to be SNPs in order to fully integrate care for dual enrollees. Contracts in other areas of the state are not currently required to be SNPs but many areas, allowing for some integration.	Wisconsin has a separate program (Family Care Partnership) that uses SNPs and provides fully integrated acute, primary and long-term Medicaid/ Medicare services for dual eligibles.

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Care Management Overview/ Innovations	Require MCOs to use the following case manager/ beneficiary ratios: • 1:48 in home; • 1:60 in assisted living; and • 1:120 in NF In-home visits are required every 90 days.	Mandatory ratios of case manager to beneficiary based on eligibility status. In-person visits are required.	State requires that care management be vested within the MCOs. In-home visits are required quarterly with monthly contacts. Focus on managing transitions—inpatient admissions must be reported to MCOs in order to trigger immediate discharge planning.	State requires MCO service coordinators to be able to authorize services, including waiver services and adult family home. States does not mandate a case manager to client ratio, but has an expectation that the case manager will be able to meet the client's needs, working with community resources.	Each beneficiary is assigned both a care manager and a registered nurse. In-home visits are required every 90 days. Care planning and service decisions are decided by beneficiary and care team. RNs are required to coordinate with acute care providers as well.
Performance Measurement Overview	23 acute care HEDIS measures. Also measure annual initiation of HCBS.	HEDIS, CAHPS measures.	HEDIS, CAHPS and select 1915(c) CMS performance measures regarding applicable waiver assurances.	State tracks quality of care, process measures, complaints and appeals; annual surveys conducted on access and satisfaction.	MCOs required to report on several quality indicators including continuity of care, vaccinations, and dental visits. State also measures personal experience outcomes through state-specific tool.
Contractors	Contractors at risk for all covered benefits. Includes large, national managed care organizations (MCOs) as well as local, public (county-based) plans.	Contractors at risk for all covered benefits. Includes large, national MCOs but HI-focus.	Contractors at risk for all covered benefits. Include large, national MCOs and plans with national affiliations.	Contractors at risk for everything except inpatient and NF care. Include large, national MCOs.	Contractors at risk for all covered LTSS services. Include primarily local and/or public (county-based) plans.

	Arizona Long Term Care System	Hawaii QUEST	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Rate Structure Overview	Blended capitation rate based on experience of health plan enrollees. Historically rate cells are defined by contract type. In FY 2007, separate capitation rates for (1) Dual; (2) Non-Dual; (3) Acute Care only; and (4) Post Period Coverage, were developed.	Moving to blended capitation rates.	Blended capitation rate with built in assumptions regarding expected utilization (e.g., mix of HCBS/NF use) and level of care provided. Two rates: (1) Duals and (2) Non-duals.	LTSS portion of capitation rate is based on HCBS waiver experience. Rate cells include: (1) Other Community Care Medicaid Only; (2) Other Community Care Medicaid/Medicare; (3) Community-based Alternatives Medicaid Only; (4) Community-based Alternatives Medicaid/Medicare.	Capitation rates built for individual beneficiaries based on functional status and level of care needed in prior year. Rate development starts with base rates for NF level of care and non-NF level of care.
Evaluation	Yes, McCall 1996 and 1997.[5]	Yes, Health Services Advisory Group is the EQRO.	Planned components include EQRO annual reports and NCQA Accreditation Survey reports.	Institute for Child Health Policy, External quality review organization annual report.[6]	Yes, APS Healthcare 2003.[7]

[5] N. McCall and J. Korb. "Utilization of Services in Arizona's Capitated Medicaid Program for Long-Term Care Beneficiaries." *Health Care Financing Review* 19 (2): 119-34, 1997. McCall, N., C.W.Wrightson, J. Korb, M. Crane, W.Weissert, and J.Wilkin. *Evaluation of Arizona's Health Care Cost Containment System Demonstration*. San Francisco: Laguna Research Associates, 1996.

[6] Texas External Quality Review Annual Report Fiscal Year 2006 for Medicaid Managed Care and Children's Health Insurance Program. Prepared by Texas External Quality Review Organization Institute for Child Health Policy, University of Florida. January 2008. Available at:
http://www.google.com/url?sa=t&source=web&cd=2&sqi=2&ved=0CBsQFjAB&url=http%3A%2F%2Fwww.hhsc.state.tx.us%2Freports%2F2006_External_Quality_Review_Annual_Report.pdf&rct=j&q=Texas%20Star%20Plus%20CHP&ei=a4zITMqpJYOglAesrIz1Cw&usg=AFQjCNF-0pxvro5dRIE_fc_MbWOtDLwulw

[7] APS Healthcare, Inc. 2003. *Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness for Calendar Year 2002*. Available at http://www.dhfs.state.wi.us/

Implementation Mileposts

Based on the experiences of Arizona, Hawaii, Tennessee, Texas, and Wisconsin, CHCS identified 10 critical mileposts that states interested in pursuing MLTS approaches should strive for in the development and implementation of their programs.

1. Structure MLTS program around a vision/goal that addresses the needs of the state/community and communicate that vision to the broader stakeholder community.

Health Reform Intersections: The ACA, in §2402, expresses Congressional intent to expand the provision of home- and community-based long-term supports and services. States where legislatures have expressed similar vision have greatly benefited from the transparency and stakeholder involvement that passing such legislation required.

Each of the states interviewed began its respective program with a similar purpose — to provide Medicaid beneficiaries with additional options for receiving care in their homes and communities. Each state then tailored that goal around the specific concerns of the state and its stakeholder community. For Wisconsin and Texas, the emphasis was on ending waiting lists for waiver services, while Tennessee and Arizona focused on providing consumers with additional choices and diverting and/or transitioning consumers from institutional settings to home and community settings where appropriate. It is critically important to start the program design and planning process with a clear idea of where the state wants to go in terms of overall program outcomes. In Hawaii, the goal of increasing HCBS use by 5% was established early in the program design of QExA (see sidebar for additional details). Having a clear vision to guide MLTS program development provided additional clarity to state staff as well as the stakeholder community at large.

States have communicated the identified vision or overarching program goals in various ways. Tennessee and Wisconsin each pursued legislation for the implementation/expansion of MLTS programs. In both states, legislative authority was not required to advance the development and implementation of an MLTS program. However, each state felt that the process of getting legislative approval was an important opportunity to ensure that the state's vision for MLTS was communicated and understood in a very public way. This transparent process helped build buy-in and support for the program from policymakers and stakeholders alike.

Transparency was also critical for success in Hawaii. Two months prior to the go-live date, the legislature expressed concern about implementation of QExA, and state staff began frequent informational briefings with legislators that lasted through the implementation period. One key product of this intensive communication was a QExA Dashboard that allows key indicators to be shared regularly with stakeholders.

Hawaii: Expanding Managed Care to Serve the Users of Long-Term Care

Hawaii created the QExA program to serve seniors 55 and older and beneficiaries of all ages with disabilities. With program implementation, most 1915c waivers were absorbed under a new 1115 demonstration waiver, so that most home- and community-based services could be delivered by a managed care delivery system. Services under QExA include service coordination, outreach, and enhanced quality of health care services. QExA established these goals for the program:

- Improve the health status of seniors and people with disabilities;
- Establish a "provider home" through the use of primary care providers;
- Empower beneficiaries by promoting independence and choice;
- Assure access to high-quality, cost-effective care that is provided, whenever possible, in the homes and/or communities of beneficiaries;
- Coordinate care, including primary, acute, behavioral health, and long-term supports and services; and
- Ensure that beneficiaries are able to receive needed care in their choice of settings.

By establishing a statutory basis for the MLTS program, Wisconsin was able to codify key program features, such as entitlement and duties of the health plans and the state, which helped protect the integrity of the program design over time. Likewise, Tennessee embedded a series of guiding principles for LTSS in its authorizing statute, including "a global budget for all long-term care services for persons who are elderly or who have physical disabilities that allows funding to follow the person into the most appropriate and cost-effective long-term care setting of their choice, resulting in a more equitable balance between the proportion of Medicaid long-term care expenditures for institutional, i.e., nursing facility, services and expenditures for home and community-based services and supports" and a mandate for the state to rebalance the overall allocation of funding for Medicaid-reimbursed long-term care services by expanding access to and utilization of cost-effective home and community-based alternatives to institutional care for Medicaid-eligible individuals.

Establishing a viable long-term vision for MLTS goes far beyond an initial buy-in campaign, however. States that have implemented successful MLTS approaches have done so by allowing the established vision to permeate the very fabric of the program, from concept to implementation and beyond. Wisconsin has worked very hard to ensure that its vision of providing cost-effective support to achieve consumer-identified outcomes was at the core of Family Care's program design. Three of the most important aspects of the program — rate-setting, resource allocation, and performance measurement — have been designed with that goal in mind. Because the program is built on the premise of truly person-centered care, Wisconsin builds capitation rates on a *person-by-person* basis, factoring in individual needs and previous utilization. In addition, care planning is done using a resource allocation decision process that focuses on providing cost-effective services to meet the consumer's desired outcomes. As a result, the consumer and his/her family or caregivers are at the center of the planning and decision-making process. In order to ensure that individual outcomes are being met, the state has developed a new tool — the Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) — to evaluate outcomes from the member perspective.

Similarly, although Arizona already "rebalanced" its LTSS system through its ALTCS program, it remains committed to transitioning beneficiaries out of institutions whenever possible. Notwithstanding Arizona's dramatic accomplishment of serving 70 percent of its seniors and population with disabilities in home and community settings (as opposed to nursing facilities), the state continues to pursue additional strategies to serve beneficiaries in the community. One recent program enhancement expanded the HCBS workforce by allowing spouses to serve as paid caregivers and establishing a self-directed attendant care program. As a result, the state has continued to see a 1-2 percent increase in people residing in home and community settings every year.

2. Engage stakeholders early and often to achieve buy-in and ensure smooth implementation and sustainability of program.

States that have successfully implemented MLTS have found it necessary to work with a variety of stakeholders both during the early stages of the design process and on a continuing basis thereafter. This is particularly true when a state faces significant opposition to managed care. Proactively addressing the concerns and/or needs of individual stakeholder groups can ease apprehension and support stakeholder buy-in.

Tennessee: A Framework to Support MLTS Program Implementation

Concerned about getting buy-in from a wide variety of stakeholder groups, Tennessee spearheaded its efforts to transform LTSS by establishing a long-term vision for the program. In doing so, the state looked at the challenges with its current fragmented long-term care system that provided consumers with limited choices and/or decision-making opportunities and resulted in the inefficient use of the state's limited resources. To restructure the LTSS system, the state sought to improve access to the system as a whole, while providing increased service options particularly at the community level.

With the public support of Governor Bredesen, the state initiated stakeholder meetings to solicit input on what the restructured LTSS system should look like. The state met with key advocacy and provider groups, establishing close partnerships to help guide the best approach for improving access and community choices. Based on stakeholder recommendations, the state established a framework that was formalized through the passage of the Long-Term Care Community Choices Act of 2008. An illustration of the broad support the state garnered for this legislation is that it passed unanimously in both the House and Senate of the Tennessee General Assembly without a single "no" vote in any committee. This was a critical step in achieving necessary buy-in for the CHOICES program from community stakeholders.

By initially focusing on the end goal — e.g., providing greater choices for receiving care in the community — rather than the method for getting there, the state could build support for the overall program before having to address potential stakeholder concerns regarding managed care. The Governor also played a critical role in moving the program forward as did the unanimous passage of legislation that helped shore up initial support for the program.

Hawaii used multiple mechanisms for gathering stakeholder input. At the request of advocacy organizations representing consumers and family members, the agency implemented a QExA Advisory Committee including advocates for the developmental disabilities community, provider associations, state agencies, the medical school, family organizations, and faith-based organizations. The group met monthly for two years prior to and one year following program implementation. Focus groups were conducted with an array of consumers on different islands. QExA Roundtables were held quarterly to provide a forum for communication with providers and beneficiaries. An ombudsman program was also developed, resulting in a contract with the Family to Family Health Information Center that provides information, referrals, and assistance in navigating the QExA system.

All of the states interviewed conducted extensive initial stakeholder outreach during the program design process. States consistently reached out to both advocacy groups and provider organizations, noting that the latter often foment and/or financially support opposition from the former. They found that provider groups are often the most apprehensive when it comes to transitioning to a new LTSS system since it can result in changes to roles, how they are paid, etc.

Texas: Working with Stakeholders in "HealthCare Matters"

In the early days of STAR+PLUS, advocates in Texas had concerns about managed care, so the state decided to engage consumers to be partners in the design and implementation of its proposed MLTS program. The Texas Health and Human Services Commission (THHSC) contracted with Healthcare Matters in 1998 to conduct a series of consumer focus groups to provide feedback to THHSC on STAR+PLUS. Four focus group meetings were held in Houston, to address a variety of topics including access, quality of care, complaints, coordination, and provider choice.

In addition, Healthcare Matters assisted the STAR+PLUS Program with consumer, provider, and community trainings, and brokered a meeting of MCOs and small providers. Over time, Healthcare Matters developed a close working relationship with the Texas HHSC, and helped to ensure that consumer advocacy input was included in plans, materials, and media products.

As advocates were given the opportunity to learn more about what the program could do (e.g., eliminate wait lists and provide additional benefits), they became STAR+PLUS champions, taking responsibility for working to alleviate the concerns of potential beneficiaries.

In Tennessee, for example, state staff worked with Area Agencies on Aging and Disability (AAADs) to identify what role they should play in the new MLTS system. This entailed discussing what the AAADs thought they were doing well in their previous role as operators of the HCBS waiver program and what responsibilities they would be comfortable transitioning to managed care contractors. Based on the discussion, the AAADs continue to serve as the point of entry into the Medicaid MLTS system, but some of their previous responsibilities for building provider networks and facilitating provider reimbursement are now handled by MCOs. In addition, Tennessee realized it was important for the state to address providers' financial concerns and design incentives to ensure provider participation. In particular, the state decided that it would set provider rates for the first few years of the program so that providers would not have to worry that the MCOs were going to reduce costs simply by cutting provider reimbursement rates.

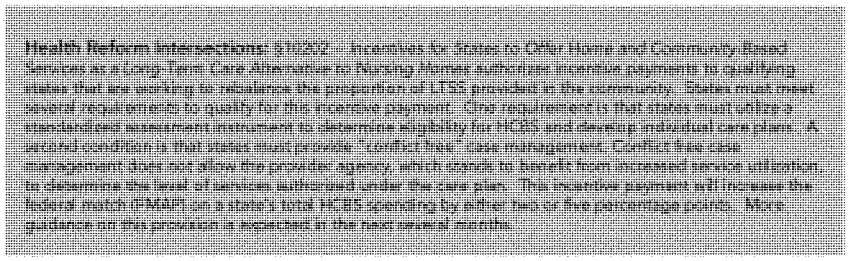
Engaging stakeholders not only entails working with policymakers, providers, and/or the advocacy community, but also with managed care contractors. Successful MLTS states have sought to create a culture of collaboration with their plan partners. This collaborative partnership has allowed the states to ensure that plans fully understand the state's program goals and vision and have a vested interest in seeing the MLTS programs succeed.

During the design phase of the CHOICES program, Tennessee met with its MCOs every week for six to eight months to ensure that the policies and procedures being developed were understood and agreed upon by all those involved. Such collaboration can also lead to the development of innovative processes as a program matures. Arizona, for example, wanted to implement a standardized assessment tool for determining level of care and worked with its plans to develop an agreed-upon approach based on their collective experiences.

To truly ensure that the needs of the beneficiaries are being met on an ongoing basis, it is important for stakeholder engagement to happen at the MCO level as well. In Wisconsin, for example, several of the Family Care contractors have developed their own committees that include consumer and provider

representatives to make sure that local stakeholder needs — e.g., high quality care or sufficient reimbursement rates — are being addressed.

3. Use a uniform assessment tool that is conducted independently from providers.



One of the hallmarks of having a successful long-term care program is the implementation of a needs assessment system (including level of care) that is independent of the agencies that directly provide services. This increases the likelihood that consumers are being assessed objectively and that services are being provided to meet consumer needs rather than provider revenue needs. In some states, as in Wisconsin, this tool can also serve as the basis for capitated rate setting and provide consistent, reliable data for program review and analysis. The states that participated in this project were selected, in part, because of their use of a uniform assessment tool.

Most MLTS states rely on MCOs to perform assessment functions, with MCOs' built-in incentives to align care serving to eliminate conflict. In Hawaii, service coordinators who are employees or contractors of the health plans are responsible for conducting health and functional assessments annually. These assessments are the basis of care plan and service arrangements, determined in collaboration with the beneficiary and their family. In addition, service coordinators conduct the nursing facility level of care functional eligibility review, using the state's standard tool. Once completed, the tools are transferred to the external quality review organization, which reviews them on behalf of the state.

In addition to offering examples of best practices that can be used to guide MLTS programs, the states interviewed also shared missteps that other states may want to avoid. One of the concerns with Tennessee's previous LTSS system was that it had an inadvertent institutional bias. Because the state's nursing facility level of care criteria was extremely low, it essentially served as an open door to nursing homes. As a result, those whose care could have been safely provided in a home or community setting were often entering nursing facilities. The state is now struggling to "tighten the door" by raising level of care requirements, targeting nursing facility services to those with higher acuity needs, while at the same time allowing individuals with lesser levels of need (i.e., at risk of institutionalization) to receive HCBS. Unfortunately maintenance of effort requirements in the American Resource and Recovery Act and, more recently, the Patient Protection and Affordable Care Act are unintentionally creating obstacles for the state. Because of these requirements, states that raise eligibility standards — e.g., by tightening the nursing home level of care requirements in Tennessee's case — may no longer be eligible for enhanced federal matching funds.

Wisconsin: Screening Tool for Determining HCBS Eligibility

With input from stakeholders, consumers, and providers, Wisconsin developed a uniform web-based assessment tool in 2001 to determine eligibility for HCBS waivers in Family Care pilot counties. The resulting Long Term Care Functional Screen (LTCFS) offers an automated and objective way to determine the long-term care needs of elders and people with physical or developmental disabilities throughout the state. The LTCFS has multiple uses including: establishing level of care for Family Care eligibility; providing information to help people making decisions about how to meet their long-term care needs; informing the development of capitation rates; and evaluating the program.

The LTCFS inventories needs across key areas affecting an individual's risk/need for institutionalization, including:

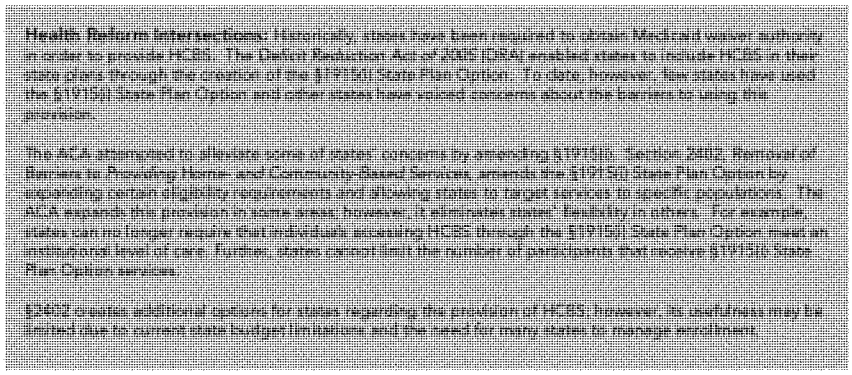
- Activities of daily living (ADLs) such as bathing, dressing, toileting, transferring, mobility, and eating;
- Instrumental activities of daily living (IADLs) such as meal preparation, using the telephone, medication management, and money management;
- Diagnoses and health-related services or tasks;
- Communication and cognition (e.g., memory loss, decision-making ability);
- Behaviors and/or mental health (e.g., wandering, substance abuse); and
- Available transportation or employment.

Upon completion, the clinical professional who administered the screen can instantly see the consumer's level of care and eligibility for Family Care and/or other available LTSS programs. To ensure the quality of the information that is collected through the LTCFS, the state has developed the following requirements:

- Provide all screeners with a single online training program;
- Test and certify all screeners with a single online certification test;
- Provide all screeners with a single written instruction manual;
- Conduct routine and ad hoc monitoring of submitted screens; and
- Schedule regular statewide skills and knowledge testing.

Additional information on Wisconsin's LTCFS can be found at: http://dhs.wisconsin.gov/flcare/FunctionalScreen/index.htm.

4. Structure a benefit package that will appropriately incentivize the right care in the right setting at the right time, including coordination with acute care.



States often vary in deciding what services to include in their MLTS benefit packages. However, among the states interviewed for this project, all agreed that it is critical that the benefit package be structured to align incentives to ensure that beneficiaries receive the right care in the right setting at the right time. Arizona, Hawaii, and Tennessee all felt that the success of a managed long-term care program relies heavily on the development of a comprehensive benefit package that includes all relevant acute and LTSS services, including nursing facility care. These states felt that the only way to truly align all of the incentives was to place the plans at risk for the full array of Medicaid acute and LTSS services so that there would be a greater focus on keeping consumers in the community for as long as appropriate.

While Wisconsin chose not to include acute care in its Family Care program, it has still taken great pains to ensure that the acute and long-term supports and services are coordinated as closely as possible for beneficiaries. The decision to focus solely on LTSS was due, in large part, to the feeling among many Wisconsin advocates that the integration of acute and LTSS would lead to more of a "medical model" focused primarily on the underlying diagnosis and medical/acute care treatment rather than providing the social supports and community-based services often needed to keep people out of institutions. As a result, the state decided that at a minimum, managed care organizations should be responsible for all institutional and community-based LTSS and have specific requirements and/or incentives to actively coordinate with acute care and/or other services not included in the benefit package. For example, the Family Care team includes a registered nurse who is responsible for contacting a member's acute care providers within the first 90 days of enrollment to set up a plan for coordinating care. The plan includes a system for sharing test results, prescriptions, and/or other information that would potentially have implications for the member's overall health. The nurse is also responsible for working with physicians and pharmacists on medication reconciliation every six months. Generally speaking, the state has found this process to work well. However, the nurses often need to educate acute care providers about how Family Care's resource allocation system works when beneficiaries come away from office visits with "prescriptions" for items such as scooters or other LTSS-related services.

Where and how care coordination/case management is provided also varies among state MLTS programs. In some states services are provided by an entity separate from the health plan, generally through a sub-contract between the plan and the organization providing the care coordination/care management services. Such arrangements can help quell stakeholder concerns that a managed care entity will deny costly services even if such services are believed to be needed and appropriate. However, both Wisconsin and Tennessee felt that it was critical that care coordination/case management be vested within the managed care entity in order to ensure that a single organization is responsible for the totality of care provided to a consumer. These states believe that is the only way in which care can truly be integrated and incentives aligned. They assert that if managed care entities are at risk for the full range of services that may be needed by the member, the care coordinator working for the MCO will be able to ensure that members receive the care they need to live safely in the community, and avoid the more costly institutional setting.

Tennessee: Use of Existing Infrastructure to Facilitate MLTS Approach

During Tennessee's initial stakeholder process, the state examined a variety of LTSS delivery system options to achieve its overall goal of improving access and choices for consumers needing LTSS. Given that the state's Medicaid acute care system has long relied on managed care, the state was concerned that a separate LTSS program would only perpetuate the fragmentation that characterized its current LTSS system. After much deliberation, the state concluded that the best vehicle was to integrate the long-term care system within TennCare — its existing managed care delivery system. The state felt that this was the only way to truly align all parts of the Medicaid system.

Once this decision was made, the state began working with its existing managed care contractors (several of which are national plans with experience in managing LTSS in other states). Together, they designed ways to provide a single set of Medicaid services to covered beneficiaries, expand access to HCBS in order to divert nursing home placement, and transition beneficiaries out of nursing facilities and into HCBS where appropriate. In addition, the state began working with stakeholders to address concerns that providers and/or advocates might have with managed care and to build strong consumer protections into the program.

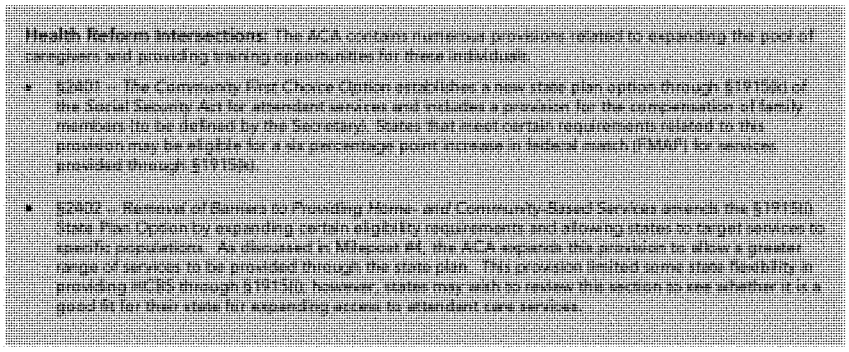
Today, the three TennCare managed care organizations are responsible and at-risk for providing the full continuum of LTSS services, including nursing facility and HCBS, in addition to all primary, acute, and behavioral health services for eligible members. Care coordination is provided by the health plans, and focuses on support for member preferences regarding services and settings as well as intensive management of transitions between care settings. Tennessee is one of the few states with experience in integrating all services, including behavioral health, into managed care. This integration positions the state for undertaking a unique demonstration of how to integrate all care for adults who are dually eligible.

A state's MLTS benefit package is often influenced by the needs and concerns of the broader stakeholder community including providers, policymakers, and advocates. While it is important to listen to and address these concerns whenever possible, states should balance those concerns with their own vision for MLTS and the program's long-term sustainability. During the development of the STAR+PLUS program, Texas faced significant opposition from the nursing home industry which did not want to participate in managed care. After months of negotiations, the state carved nursing facility care out of the benefit package for fear that the initial STAR+PLUS pilot would never get off the ground if it placed plans at risk for those services. More than 10 years later, the state is finding that it is difficult to incentivize greater use of HCBS options when institutional care is carved-out of the program. Over time, the state hopes to adjust its MLTS program to include more of the risk for institutionalization.

Texas' experience with institutional care highlights another important lesson for states pursuing MLTS programs — if possible, states should include all desired benefits and/or program design elements at the start of an MLTS program. Hawaii's leadership was emphatic about this as well, saying that if they had implemented acute care only, "we would still be here two years later planning to include long-term care

benefits." State experience demonstrates that it can be more difficult to add things in or make substantial changes to existing MLTS programs. This may mean taking more time during the planning stage to work with relevant stakeholders or to develop systems for implementation, but it is usually time well-spent that will save states resources in the long-run.

5. Include attendant care and/or paid family caregivers within the benefit package as these services often play an important role in keeping consumers out of institutions.



Health Reform Intersections: The ACA contains numerous provisions related to expanding the pool of caregivers and providing training opportunities for these individuals.

- §2401 – The Community First Choice Option establishes a new state plan option through §1915(k) of the Social Security Act for attendant services and includes a provision for the compensation of family members (to be defined by the Secretary). States that meet certain requirements related to this provision may be eligible for a six percentage point increase in federal match (FMAP) for services provided through §1915(k).
- §2402 – Removal of Barriers to Providing Home- and Community-Based Services amends the §1915(i) state plan option by expanding certain eligibility requirements and allowing states to target services to specific populations. As discussed in Milepost #4, the ACA expands this provision to allow a greater range of services to be provided through the state plan. This provision limited some state flexibility in providing HCBS through §1915(i); however, states may wish to review this section to see whether it is a good fit for their state for expanding access to attendant care services.

One of the first things a state can do when trying to shift care away from institutions toward more home- and community-based settings is to focus on the development of in-home programs. By starting with the expansion of in-home services, a state can build upon existing systems rather than invest considerable resources in developing new and/or additional infrastructure (e.g., alternative residential settings). In addition, it is typically far less complicated to build programs aimed at keeping consumers out of nursing facilities than transitioning them out of institutions. As a result, it may make sense for a state to start with diversion and move toward transition and relocation once more community-based services and options are in place.

For many states this may mean starting with the development or expansion of attendant care programs as part of the overall MLTS benefit structure. Attendant care is a term that usually covers a variety of services that are provided in a consumer's home as an alternative to nursing facility care. These services may include homemaking, personal care, general supervision, and/or companionship. Hawaii includes personal assistance services (level 1 chore services), which were previously covered as a state-only benefit, in its 1115 waiver. By doing so, the program has been able to double the number of clients receiving these benefits since QExA was implemented. All of the states interviewed include attendant care in their respective MLTS programs. In the majority of the interviewed states, attendant care may also be provided through consumer-directed programs offered in conjunction with an MLTS program. In this scenario, consumers are given the opportunity to directly hire, fire, and supervise their own attendant care providers without going through a home care agency. In addition, consumers have the ability to make decisions about how best to get their needs met, including who will provide services and when the services will be provided.

Many states have found that allowing family members, neighbors, and friends to participate in attendant care programs is a way to increase the available direct care workforce. States vary in how they implement this benefit. In Tennessee, the consumer direction benefit offers a formal pathway for hiring family members (excluding spouses) as well as others with whom a consumer has a close personal relationship. All consumer-directed care providers in Tennessee are required to undergo background checks, even family members. In Hawaii, the employment of family members reinforces the traditional value of family-centeredness, and allows families to maintain close living arrangements preferred by many ethnic subcultures in Hawaii (e.g., Native Hawaiians, Asian Americans, etc.). In Arizona, family caregivers can participate both in the self-directed attendant care program as well as the traditional attendant caregiver program (see sidebar for more detail).

Arizona: Providing Options for Family Caregivers

Arizona, which has one of the highest percentages of consumers receiving care in home- and community-based settings in the country, attributes much of its success in keeping consumers out of institutions to the inclusion of family members as paid caregivers in its attendant care program. However, the state has developed a series of requirements and protocols to ensure the quality of care.

To be eligible for the benefit, the person needing care must qualify medically and financially for ALTCS. Family members providing the care must be trained and hired by a qualified home health or attendant care agency. The training, which lasts only a couple of days, provides the new caregiver with knowledge and training in CPR, basic first aid, and infection and disease control. Once the training is complete and the family member is certified by the agency, the family caregiver is paid an hourly rate by the home health or attendant care agency for care authorized for the consumer. The care manager and home health agency are still involved in determining the types of services and number of hours that will be provided through the ALTCS program.

Notably, Arizona recently added the Spouse as Paid Caregiver option to its overall attendant care program. Under this option, the ALTCS consumer's husband or wife can be compensated to provide up to 40 hours a week of attendant care or similar services. The state believes that allowing spouses to serve as paid caregivers will help reduce the challenges of ensuring an adequate caregiver workforce and allow additional ALTCS consumers to remain at home.

6. Ensure that the program design sufficiently addresses the varied needs of MLTS consumers.

Health Reform Intersections: §1915(i) – Incentives for States to Offer Home- and Community-Based Services as a Long-Term Care Alternative to Nursing Homes authorizes incentive payments to qualifying states that are working to rebalance the proportion of LTSS provided in the community. States must meet three specific conditions to qualify for this incentive payment. One condition is that states must use a core standardized assessment instrument to determine eligibility for HCBS and to develop individual service plans to address identified needs. To ensure that all of an MLTS consumer's needs are adequately addressed in his or her service plan, states should consider incorporating behavioral health assessment questions into the standardized assessment instrument.

More than 10 million Americans currently need some type of long-term supports and services to assist them with life's daily activities.[8] While much of the LTSS population is elderly, almost 42 percent are under age

[8] Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long Term Services and Supports," February 2009. Available at http://www.kff.org/medicaid/upload/2186_06.pdf.

65. These younger beneficiaries include both children and adults with disabilities, encompassing individuals with physical as well as behavioral or developmental disabilities. While there may be some overlap in the type of care provided from one group of beneficiaries to the next, the needs and preferences of a 30-year-old with paraplegia differ significantly from those of an 85-year-old with multiple chronic conditions in need of a hip replacement. Given the population's heterogeneity, a one-size-fits-all approach to the benefit package will not meet the varied needs of every MLTS beneficiary. It is important that states recognize this from the outset and ensure that all aspects of the MLTS program — from the benefit structure to the care management approach to the provider networks — are designed with commensurate flexibility.

One area often overlooked or inadequately addressed by states is the intersection of LTSS and behavioral health. The majority of the interviewed states indicated a need to focus attention on the behavioral health issues of beneficiaries. Tennessee has fully integrated behavioral health benefits into its MLTS program. Hawaii includes treatment for chemical dependency and acute behavioral health services in its MLTS system. In some states, among them Wisconsin, more than half of the beneficiaries receiving LTSS also have a mental health diagnosis.

As Wisconsin's Family Care has expanded to additional counties, the state has seen a significant increase in the number of consumers previously served primarily by the local mental health system enrolled in the program. For many managed care entities serving as Family Care contractors this is a significant challenge since they have had little prior experience in providing care to consumers with severe mental illness and, in many areas, community-based resources are lacking. The state has begun to address this concern by providing web-based trainings to MLTS staff around mental health diagnoses, related needs, and available resources. In addition, Wisconsin is working with its contracted MCOs to find creative ways to provide psycho-social rehabilitation services to help deter acute psychiatric hospitalization for those with mental health diagnoses or developmental disabilities.

Arizona: Interdisciplinary Care Teams Focus on Behavioral Health Needs

Given the prevalence of mental health diagnoses among many of its beneficiaries needing LTSS, Arizona believes that the appropriate placement of consumers with severe mental illness is critical. To that end, the state has ensured that the ALTCS program has sufficient flexibility to allow its managed care contractors to establish additional services.

For example, Mercy Care Plan has developed an interdisciplinary team (IDT) model for consumers identified as high-need and high-cost who have had two or more inpatient admissions for behavioral health issues in the past 30 days and/or other internal or external referrals. Members of the IDT include the consumer's case manager as well as the plan's medical director, a variety of nurses, and the behavioral health medical director and behavioral health coordinator. The IDT meets on a regular basis to discuss participating consumers' needs, preferences, barriers to care, etc. and make recommendations for a care plan that will prevent future hospitalizations/ED visits and increase overall health and satisfaction outcomes. Consumer readmissions are monitored at 30-, 60-, and 90-day intervals. In addition, Mercy Care has 12 certified behavioral health care managers to assist in care coordination for consumers with behavioral health needs.

Bridgeway Health Solutions, another ALTCS contractor, also employs an IDT model for its enrollees and includes a behavioral health specialist on the team. In addition, because medication often plays such a critical role in the treatment of certain mental illnesses and because behavioral health providers may not be as connected to the acute or LTSS community, Bridgeway includes a pharmacist as part of the IDT to address poly-pharmacy issues.

Another way that the varied needs of the LTSS population can be addressed is to require the use of interdisciplinary (or multidisciplinary) care teams as part of the care planning and care management

processes. Several of the states interviewed require that managed care entities use an interdisciplinary team to develop an individualized plan of care based on each beneficiary's needs and preferences and to help ensure that care is being properly coordinated across all aspects of the system (e.g., acute, LTSS, behavioral health, etc.). Although the composition of these teams varies depending on the level and type of care needed by individual beneficiaries, teams typically include the following mix of professionals: physicians; nurses; social workers; community resource specialists; certified case managers; pharmacists; and other specialists.

Building a program that is designed to meet the varied needs of all eligible beneficiaries may mean establishing clear linkages between the MLTS program and other systems in the state that affect it. For example, Wisconsin has worked to develop close ties between Family Care and Adult Protective Services as well as the mental health system outside of what is covered by Medicaid. As the benefit design in Texas wavered between including and excluding behavioral health services, health plans actively worked to maintain bridges to the mental health system. In 2007, Tennessee moved to full integration of behavioral and physical health services in the managed care delivery system. Tennessee MCO's contracted with existing Community Mental Health Centers in order to ensure the stability of the mental health system and continuity of care for members.

7. Recognize that moving from a 1915(c) waiver system to risk-based managed care represents a fundamental shift in how both the state and managed care entities think about LTSS financing.

Implementing a managed care system can be a significant challenge for many states, often requiring the development of additional infrastructure and skill sets at the state level. For example, in the fee-for-service setting providers are paid based on a pre-determined rate for every unit of service provided. These rates may be in place for a number of years before any adjustments are made. In a managed care setting, states must set rates for multiple contractors, usually on an annual or semi-annual basis. In setting these rates, states must make assumptions about the types and amount of services beneficiaries will use in the future. In order to effectively set rates, states must often invest in new data systems and infrastructure to analyze encounter data from managed care entities as well as information regarding the functional status or acuity of the target population.

In addition, managed care also introduces new requirements such as actuarial soundness to ensure that Medicaid managed care entities are adequately reimbursed based on predicted health care expenditures for the populations served. Most states have elected to engage actuarial firms to assist in the development of MLTS rates, at least until this internal capacity set can be developed.

As a state's knowledge of and comfort with the rate-setting process grows, it can take on more responsibility in-house. In Wisconsin, for example, the state has taken a shared actuarial approach in which its staff adjusts pre-established rates, but relies on its independent actuary to provide an un-biased, outside perspective. Arizona now employs its own in-house actuary to develop rates more efficiently and effectively. Arizona does acknowledge, however, that this would not have been possible in the early years of the program. It is important to note, however, that relatively few actuarial firms are experienced in setting capitated rates for LTSS, so states and their actuarial partners may be on a learning curve together.

In some states, pre-existing HCBS waivers have operated at a local level with community organizations or county-based entities responsible for the day-to-day management of the LTSS system. As these states move toward a more standardized, statewide approach via an MLTS program, they may be faced with payment variations among provider groups in different parts of the state. Wisconsin has faced such challenges. Prior to Family Care, the LTSS system was run out of county-based entities with each responsible for setting its own rates. Now that Family Care is expanding statewide, the state seeks to develop a standardized set of rates for the various HCBS provider groups.

Texas: Building In-House Expertise in Rate-Setting and Financial Oversight

It is important for states to hire staff with both technical rate-setting knowledge as well as a comprehensive understanding of how MCOs operate on a business level. Texas, for example, has a financial group comprised of staff who primarily come from the private sector and know the MCO business model. By knowing where to look, these state staff have found examples of inaccurate data and aggressive accounting techniques, saving the state millions of dollars.

For example, it is a useful skill for state staff to be able to comprehend and compare health plan reports submitted to the Securities and Exchange Commission with other financial reports filed with the state. Texas also has the contract teeth to back up its demand for accurate encounter data, which is used to validate service utilization. Payment withholds are applied for inaccurate data. They have achieved a 95 percent accuracy rate across their encounter data, which is used to set rates going forward.

Given the fact that relatively few states have implemented MLTS to date, accepting risk for LTSS can represent a change for the managed care entities as well. Three national firms have extensive experience with managed LTSS — United, AmeriGroup, and Aetna/Schaller Anderson. National firms like Molina and Centene as well as regional entities such as Massachusetts' Community Care Alliance and Wisconsin's Family Care organizations, are also becoming significant players in MLTS. States will need to work closely with their selected plans to develop and implement successful programs. However, even for national plans that have experience with MLTS, states have found that ongoing collaboration between the state and managed care contractors is critical for ensuring that the state's program goals and financial incentives are aligned in the rate-setting process. Wisconsin, for example, meets with health plan staff on a monthly basis during the rate-setting process each year. Hawaii is moving to blended rates in the next contract cycle in order to improve its incentive structure.

8. Develop financial performance incentives to achieve the stated goals of the program.

State MLTS programs should use contractual incentives to achieve their goals. In Tennessee for example, the capitation rates are being set with the expectation that the CHOICES program will result in a fundamental shift in how and where LTSS care is provided. In order to promote movement away from institutional cate and toward more home and community options, Tennessee factors in assumptions about the impact the CHOICES program will have on the mix of institutional and HCBS services provided to LTSS beneficiaries. In determining these assumptions, which include a three to four percent decrease in institutional care over two years, the state has had to find a balance between incentivizing appropriate HCBS use while being realistic about what plans can do in relarively short periods. The state plans to reassess these assumptions on an annual basis. In Hawaii, incentive payments are incorporated into contracts to reward increasing the use of HCBS and decreasing institutional care.

Arizona uses a similar process to encourage greater reliance on home- and community-based options through the development of its rates. As in Tennessee, the state uses an HCBS-nursing facility mix to help set the rates. However, if a given contractor provides HCBS to a greater number of beneficiaries than projected, it is rewarded in a reconciliation process at the end of the year.

Despite the nursing facility carve-out, Texas has incorporated a number of disincentives into the STAR+PLUS program to prevent potentially avoidable institutionalizations. The state structured the contract so that plans face a financial penalty if they go above the nursing home occupancy baseline based on the previous year. As a result, the state has reduced nursing facility utilization month by month.

Texas: Incentives to Support HCBS

In 2001, Texas became one of the first states to implement a Money Follows the Person program. Over the years, the state's managed care STAR+PLUS program has had great success using this program to divert beneficiaries and disillend from nursing home care. In fact, more consumers within managed care have chosen consumer direction than those in traditional fee for service. In STAR+PLUS service areas, MCO representatives are required by contract to visit beneficiaries when they are admitted to a nursing facility to identify opportunities to transition individuals back into the community. In addition, through a separate budget, the state provides some financial incentives to consumers to help them move out of institutions and into the community.

Since the MFP program began, more than 20,000 individuals have been relocated to the community. A pilot project in San Antonio, including the state, MCOs, the Center for Independent Living, and the behavioral health agency, is providing services beyond those in the 1915c waiver to ease transition. Beneficiaries and their families are prepared for what it will like to be back in community, and are given post-relocation assistance for 365 days. Keys to success in Texas include the availability of specialized providers, housing alternatives for beneficiaries with complex needs, transportation, and financial support for rent deposits.

9. Establish robust contractor oversight and monitoring requirements to maintain and improve the MLTS program.

In working with large national plans, states, including Arizona, Tennessee, and Texas, have found it necessary to be very prescriptive, particularly during the early program stage, to ensure that contractors are providing a state-specific model rather than an off-the-shelf product. To that end, they have taken a "manage or be managed" approach and have developed very specific contracts that set clear standards and expectations for plan performance. To ensure these expectations are being met, states have established robust mechanisms for monitoring performance, including monthly/quarterly reports and program dashboards.

Arizona believes that its significant oversight of the program during the early years was a key factor to its success. State staff believe that by working very closely with the plans during the two to three years it took for the ALTCS program to completely transition from fee-for-service to managed care, the state was able to gain a better understanding of how the program would really work, what the challenges were, and what it would take to resolve them. As the managed care entities got their models in place and case managers gained experience, the state was able to cut back on some of its initial requirements — including a 60-page audit guide — and focus on the most important issues. At the same time, since the program's inception the

state has seen a shift from local, non-profit plans to large national, for-profit plans that would prefer to use their own standardized care models. The state has held firm in its specific contracting requirements (e.g., maximum case manger ratios, etc.) and has developed additional requirements. An example is a network development plan designed to examine network capacity over the long-term in order to keep contractors "on their toes." Texas and Tennessee have taken similar approaches in developing specific contract requirements with consequences for failure to meet specified standards.

Even in states like Wisconsin that contract almost exclusively with local managed care entities, robust contract and monitoring requirements help ensure that consumers are receiving comparable benefits from plan to plan. This is particularly important as the state continues to move away from local, county-based long-term supports and service systems in expanding Family Care statewide.

Tennessee: Electronic Alert System Ensures HCBS Care Accountability

Careful monitoring to assure that consumers receive needed care on a timely basis is essential, particularly when care is provided outside of more formal care settings. Tennessee implemented an electronic visit verification (EVV) system that provides the state, managed care organizations, and home care agencies with real-time information regarding when consumers are receiving needed HCBS and when they are not.

HCBS providers log into the EVV system when they arrive at the consumer's home to deliver pre-determined/scheduled care and log-out upon their departure. The phone-based system can track where the call originated. When a provider does not log into the system on schedule, a notification is immediately generated and sent to both the home care agency and managed care organization which can then arrange for back-up care. This enhances the ability of both entities to detect and resolve problems. In addition, a claim can be generated from each login, thus facilitating timely payment for providers. The EVV is used both for formal HCBS providers and those hired by consumers in the self-directed option included under CHOICES.

To further ensure accountability for HCBS services the state receives a monthly report from each managed care organization outlining service gaps and delays in service delivery. These are assessed against managed care performance standards and benchmarks. The system helps ensure financial accountability by ensuring that only services provided are reimbursed, and moreover, improves quality of care by quickly identifying and resolving gaps in care. MCOs benefit from the system because it ensures that consumers get services and providers get paid.

Hawaii initially focused on overseeing provider network adequacy to ensute access to care. In taking a patient-oriented approach, the state built in many reporting requirements for health plans to demonstrate their provision of all medically necessary care and appropriate denial of inappropriate services. The contracts have prescriptive requirements for the handling of grievances and appeals, and an on-site visit occurted to verify compliance. Additionally, an active quality strategy committee reviews health plan quality reports.

Strong, standardized requirements help providers acclimate to a managed care program. For example, Texas requires that all STAR+PLUS contractors use a uniform billing process with the same set of forms across plans and providers. Not only does this make the billing process easier for providers, the plans, and the state, it also allows the state to offer training and technical assistance across plans. Similarly, Tennessee has chosen to take on some of the traditional managed care duties in the first few years of the CHOICES program to ensure a smooth transition from fee-for-service. In particular, the state elected to set all nursing facility and home-and community-based provider rates and even required that plans offer contracts to all currently operating nursing facilities to ensure some control over the initial provider networks and maintain stability in the system during the transitional years of the program.

10. Recognize that performance measurement is not possible without LTSS-focused measures.

Health Reform Intersections: [illegible] Adult Health Quality Measures directs the Secretary to release an initial set of quality measures for Medicaid-enrolled adults no later than January 1, 2011. This provision further directs the Secretary to work with states to develop a standardized format for reporting information based on the selected measures by January 1, 2013. This provision does not specifically include LTSS-focused measures; however, this may provide an opportunity for states to help develop national LTSS benchmarks.

Performance measurement is a critical element of any managed care program, giving states, providers, consumers, and the managed care entities themselves valuable information about the quality and utilization of care provided. This information can be used to track performance over time, identify areas for improvement, facilitate comparisons across plans, and determine priorities for special initiatives.

States are addressing this barrier in a number of ways. For instance, Arizona and Wisconsin have developed additional tools and/or measures of their own with which to assess health plan performance. In Arizona, ALTCS contractors are required to examine the initiation of home- and community-based services for elderly and physically disabled members on an annual basis. This measures the percentage of newly placed HCBS ALTCS members who receive specific services within 30 days of enrollment.[9] In 2009, the performance standard for this measure was 92 percent. In Hawaii, the state partnered with both of its health plans to develop an evaluation tool to objectively and consistently assess need for HCBS.

Wisconsin: Person-Centered Performance Measurement Approach

Wisconsin's Family Care program seeks to provide cost-effective care to achieve individual consumer-identified outcomes. In 2004, Wisconsin contracted with the University of Wisconsin's Center for Health Systems Research and Analysis to develop its own method to identify individuals' desired outcomes. The resulting Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) is structured around 12 domains:

1. Living in a preferred setting;
2. Making one's own decisions;
3. Deciding one's own daily schedule;
4. Maintaining personal relationships;
5. Working or pursuing other interests;
6. Being involved in the community;
7. Having stable/predictable living conditions;
8. Being treated fairly and with respect;
9. Having the amount of privacy desired;
10. Being comfortable with one's health situation;
11. Feeling safe; and
12. Feeling free from abuse and neglect.

The interview tool was completed in June 2008 and has been validated. Because Wisconsin Family Care focuses on providing cost-effective support to achieve a consumer's desired outcomes, PEONIES was a critical step in ensuring plan and case management performance.

[9] http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/ALTCS-HCBS-2009.pdf

Conclusion

Developing and implementing a managed long-term supports and services program can be challenging. Success depends on a variety of factors including state leadership, existing state infrastructure and/or familiarity with managed care in general, as well as an appetite for managed care among stakeholders. Despite the challenges, however, by following in the footsteps of Arizona, Hawaii, Tennessee, Texas, and Wisconsin (while avoiding some of the landmines that befell them on their own roads to success), states should feel that MLTS is within their reach. While this roadmap can serve states as a guide to the stops along the way as they go down the path toward MLTS, it is important that those interested in doing so move forward *not* expecting to be able to "replicate" existing programs to the last detail. Every state is different and programs will need to be developed according to the needs of the local environment. Medicaid agencies can, however, borrow heavily from the elements that have worked in existing programs and incorporate them into their own — new models of MLTS.

Appendix A: List of State and Plan Interviewees

Arizona

Arizona Health Care Cost Containment System (AHCCCS) Staff:
Kate Aurelius, Deputy Director
Kim Elliot, Administrator, Clinical Quality Management
Alan Schafer, ALTCS Manager

Bridgeway Health Solutions Staff:
Duane Angulo, Director of Pharmacy
Richard L. Fredrickson, Chief Executive Officer
Robert Krauss, MD, Medical Director
Nicole Larson, Vice President of Operations and Compliance
Mary Reiss, Director of ALTCS Case Management

Mercy Care Plan Staff:
Kathy Eskra, Vice President of Long Term Care for Aetna Medicaid
Chad Corbett, Director Long Term Care
Mark Fisher, President and Chief Executive Officer

Yavapai County Long Term Care Staff:
Leona Brown, Compliance/Program Development Manager
Jesse Eller, Director

Hawaii

Hawaii Department of Human Services Med-Quest Division:
Patti Bazin, Health Care Services Branch Administrator

Evercare Hawaii:
Dave Heywood, Executive Director
Bill Guptail, COO
Jeri Kakuno, Director of Operations, MDX Hawaii
Mary Campos, Director, Field Clinical Services
Debbie Hughes, Director of Operations
Cheryl Ellis, MD, Medical Director

Ohana Health Plan
Erhardt Preitauer, President, Hawaii Region
Linda Morrison, Senior Director, Operations and IT
Wendy Morriarty, Senior Director, Field Clinical Programs
Jayme Pu'u, Senior Manager, Network Management
James Tan, MD, Senior Medical Director

Tennessee

TennCare Bureau of Long Term Care Staff:
Carolyn Fulghum, Director of Quality and Administration for Elderly and Disabled Services
Keith Gaither, Managed Care Director
Jarrett Hallcox, Director of Long Term Care Project Management
Patti Killingsworth, Assistant Commissioner and Chief of Long Term Care
Julie Johnson, LTC Appeals Manager
Casey Dungan, Assistant Director, Fiscal/Budget

Texas

Texas Health and Human Services Commission Staff:
Pam Coleman, Former Deputy Director for Managed Care Operations (has since retired from state)
Joe Vesowate, Deputy Director for Managed Care Operations
David "DJ" Johnson, STAR+PLUS Project Specialist
Ivan Libson, Implementation Coordinator Managed Care operations
Scott Schalchlin, Director for Health Plan Operations
Rich Stebbins, Manager of Finance
Paula Swenson, Director of Health Plan Management
Marc Gold, Special Advisor for Policy and Promoting Independence, Texas Department of Aging and Disability Services

Evercare of Texas:
Leah Rummel, Vice President, Strategic Account Development
Catherine Anderson, Vice President, Business Development

Beth Mandell, Regional Executive Director

Superior Health Plan:
Cindy Adams, Chief Operating Officer
Ceseley Rollins, Vice President, SSI

Amerigroup:
Cathy Rossberg, Chief Operating Officer

Wisconsin

Wisconsin Department of Health and Family Services
Division of Long Term Care Staff:
Fredi-Ellen Bove, Deputy Administrator
Susan Crowley, Administrator
Monica Deignan, Managed Care Section Chief
Charles Jones, Family Care Program Manager
Tom Lawless, Fiscal Management and Business Systems Section Chief
Kathleen Luedtke, Planning and Analysis Administrator
Karen McKim, Quality and Research Manager
Alice Mirk, Care Management Services Manager

Portage Aging and Disability Resource Center:
Janet Zander, Director
Cindy Pitrowski, Assistant Director

Community Care of Central Wisconsin Staff:
Darren Bienvenue, Director of Service Coordination
Jim Canales, Chief Executive Officer
Dana Cyra, Director of Quality Management
Rick Foss, Director of Service Coordination
Mark Hilliker, Chief Operations Officer
Julie Strenn, Director of Provider Network Services

Appendix B: National Advisory Group Members & CMS Participants (in addition to State Interviewees)

Joseph Caldwell
Director, Long-Term Services and Supports Policy
National Council on Aging

Mike Cheek
National Association of State United for Aging and Disabilities

Sara Galantowicz
Senior Research Leader, Thomson Reuters Research Department, Community Living Systems Group

Cyndy Johnson
Independent Consultant

Diane Justice
Senior Program Director, National Academy for State Health Policy

Enid Kassner
Director, Independent Living/LTC
AARP Public Policy Institute

Harriet L. Komisar
Senior Research Analyst, University of Maryland, Baltimore County, The Hilltop Institute

Barbara Lyons
Vice President, Deputy Director KCMU
Kaiser Family Foundation

Anne H. Montgomery
Senior Policy Advisor, Senate Special Committee on Aging

Martha Roherty
Executive Director, National Association of State United for Aging & Disabilities

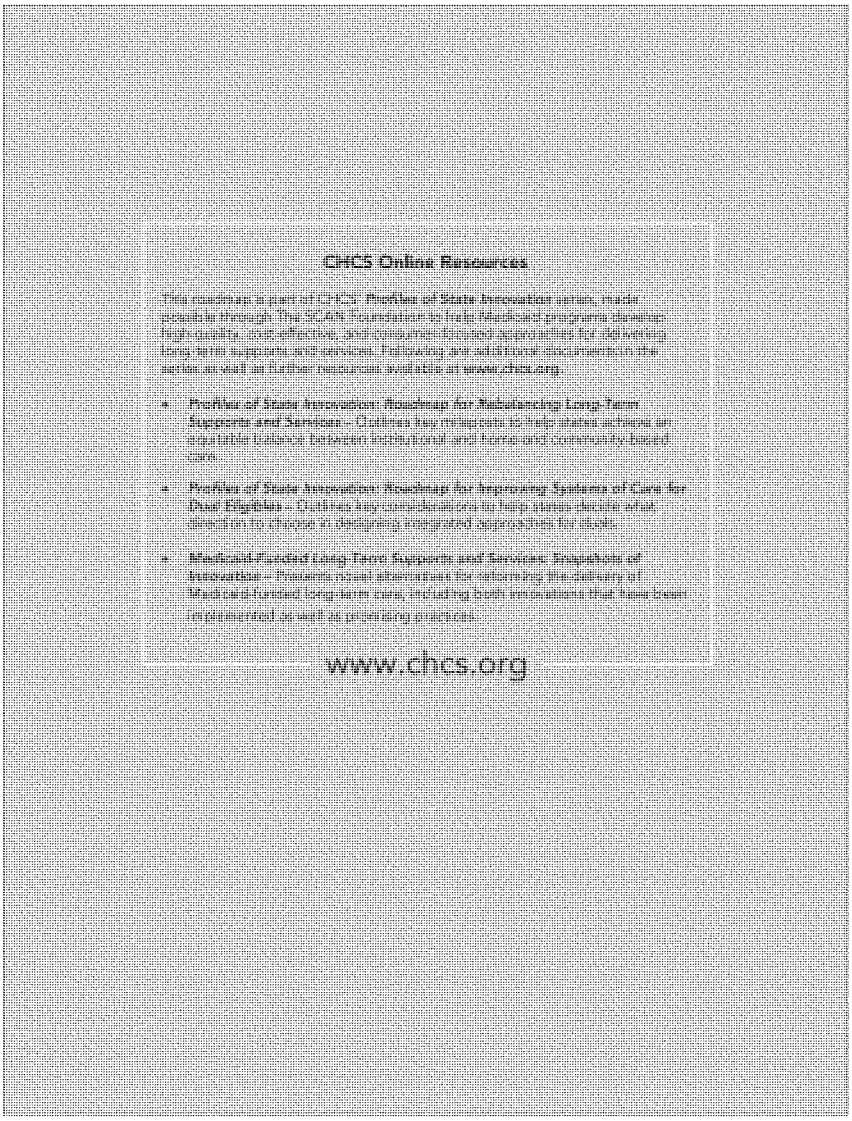
James M. Verdier
Senior Fellow, Mathematica Policy Research, Inc.

Centers for Medicare & Medicaid Services

Linda Peltz
Director, Division of Coverage and Integration

Carrie Smith
Technical Director, Division of Coverage and Integration

Mary Sowers
Director, Division of Community and Institutional Services
Center for Medicaid, CHIP & Survey Certification
Disabled and Elderly Health Programs Group


CHCS Online Resources
www.chcs.org

Statement for the Written Record of

Susanne Matthiesen, MBA
Managing Director, CARF-CCAC and Aging Services

Before a Hearing of the Senate Special Committee on Aging on

The Future of Long-Term Care:
Saving Money by Serving Seniors

The Importance of Accrediting Providers of Long Term Services and Supports

United Stated Senate
Hart Senate Office Building
Room 216
Washington, DC
April 18, 2012

Submitted May 2, 2012

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Chairman Kohl and Members of the Senate Special Committee on Aging:

On behalf of the Commission on Accreditation of Rehabilitation Facilities (CARF), I am pleased to submit this statement for the written record in connection with the hearing held on April 18, 2012 entitled, **"The Future of Long-Term Care: Saving Money by Serving Seniors."** I am Susan Matthiesen, MBA, Managing Director of CARF-CCAC and Aging Services.

CARF has been a leading, independent, nonprofit accrediting body of health and human service programs since 1966. We have a long-standing track record in accrediting providers of post-acute rehabilitation, long term services and supports including home and community services, assisted living services, as well as complementary programs involving behavioral health care, mental health, substance abuse, and employment and community services.

With active participation and expertise from stakeholders in the program areas that CARF accredits, including providers, funders, and, most importantly, the persons receiving services and their families, we develop consensus-based standards that are focused on outcomes and the experience of persons served by CARF accredited programs. CARF accreditation is a consultative process where CARF-trained peers with expertise in the program area being assessed conduct a comprehensive site visit of the program under review. During these site visits, information is exchanged and best practices are explored for potential adoption by the provider.

CARF accreditation means that a program has been personally and comprehensively examined by experienced peers, assessed based on well-developed and widely accepted standards, and found worthy of accredited status for a defined period of time not to exceed three years without recertification. In this manner, CARF helps ensure that its accredited programs are accountable, transparent, deliver high quality services, and meet the needs of persons served.

CARF thanks you and the Members of the Senate Special Committee on Aging for holding this important hearing. We applaud your leadership in continuing to highlight the critical issue of long term care and long term services and supports in America. I write on behalf of CARF to assert the value of non-profit, private accreditation undertaken by third-party accreditors in the effort to control government spending on long-term care and health services while ensuring accountability, transparency, and the quality of services provided. We believe that a significant way the government can help ensure quality and cost-effectiveness in programs offering long term services and supports is through private accreditation.

As the U.S. population continues to age and rely more heavily on long-term care services as well as home and community-based services, the demand and urgent need for independent, objective performance evaluation of our government-supported programs increases. In addition, as states and federal programs reform delivery systems to reduce costs, these reforms could result in reduced quality of care if Congress fails to establish, or fails to encourage the establishment of, safeguards to preserve accountability, transparency and quality for long term services and supports delivered both in facility-based settings and in the community.

This is one reason why CARF has been a leader in the development of standards around home and community based long term services and supports, which can have a dramatic impact on reduction of facility-based, and often more costly, long term care alternatives. In keeping with the U.S. Supreme Court's decision in the Olmstead case, CARF has strived to accredit a wide range of services from traditional long term care to long term services and supports provided in the least restrictive setting possible. In fact, CARF has developed home and community based standards in all health and human services settings in which it accredits programs. For the purposes of this hearing today, CARF's standards involving long term services and supports in the home and community setting are the most relevant.

Both the U.S. government and individual taxpayers deserve to know that investments in Medicare and Medicaid, as well as the private health and long term care markets, improve the health and well being of beneficiaries and reduce system inefficiencies. One of the most effective ways to monitor quality of services and measure consumers' experiences with providers of long term care services and supports is through a non-bureaucratic, non-profit, private accreditation model, much like CARF employs.

Long term services and supports ranging from home and community-based programs to traditional nursing homes can utilize accreditation to support an infrastructure that encourages a person-centered focus on outcomes. For example, accreditation can foster programs that have systems in place to meet the needs of individuals transitioning from a hospital to a nursing home to their home or community-based setting. Private accreditation can also help a program develop and evaluate its risk management strategy, which is particularly important for both facility-based and home and community-based long term services and supports which, by definition, may need to be provided to the same persons for many years into the future. The accreditation process can help ensure a service provider commits to prudent fiscal procedures, a strong administrative foundation, and an emphasis on quality improvement, all with an overarching goal of creating good, sustainable outcomes for the end users of the program's services.

The Importance of Meeting the Needs of Persons Served

CARF's model of performance improvement and its measurement tool known as "uSPEQ" (pronounced "You Speak") incorporates both consumer and employee satisfaction as primary factors in assessing the success of a program. uSPEQ is a psychometrically tested and validated set of measures that directly gauges the outcomes of programs from the end users' perspective. It is confidential and anonymous. uSPEQ has proven to be a valuable tool that can be used by multiple programs to assess their competencies in successive years and in comparison to other similar programs.

Currently, a number of agencies—namely the U.S. Department of Health and Human Services (HHS), the Department of Veterans Affairs (DVA), and the Social Security Administration (SSA)—either utilize uSPEQ or are in the process of implementing the use of this measurement tool to evaluate their programs from a consumer perspective, without adding to the federal workforce and without relying on indirect surrogates for quality measurement.

There is a growing demand for monitoring and evaluating the health and long term care services that the aging population receives. ***CARF recommends that the Committee on Aging seriously consider the importance of the use of non-profit, national accreditation bodies that are equipped to monitor and assist in improving long term care/long term services and supports programs, whether they be federally financed or privately funded.*** We encourage the Committee to make recommendations to the Senate's legislative committees to utilize private accreditation as a key strategy for helping to ensure accountability and quality in long term services and supports.

Once again, Chairman Kohl, thank you for your leadership on this vital issue and for the opportunity to submit this written statement for inclusion in the hearing record. If you have any questions or would like additional information, please contact me at smatthiesen@carf.org or Peter W. Thomas, CARF's Washington counsel at (202) 466-6550 or peter.thomas@ppsv.com.

The Future of Long-Term Care: Saving Money by Serving Seniors
Senate Special Committee on Aging
April 18, 2012
2:00 p.m.

Statement for the Record
Toby S. Edelman
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The Center for Medicare Advocacy suggests that huge savings in the cost of care in nursing facilities could be achieved if facilities eliminated the inappropriate use of antipsychotic drugs and provided sufficient staff to meet their residents' needs. The Center commends the Senate Special Committee on Aging for holding a hearing on April 18, 2012 – The Future of Long-Term Care: Saving Money by Serving Seniors – to call attention to the connection between high quality of care and lower costs to the Medicare and Medicaid programs.

Antipsychotic Drugs

Each day, hundreds of thousands of nursing home residents are given antipsychotic drugs,[1] even though, as documented by the Department of Health and Human Services's Office of Inspector General in May 2011,[2] these drugs are inappropriate and life-threatening for the vast majority of residents to whom they are given. Antipsychotic drugs are also extremely expensive. The Inspector General reported that for the six-month period, January 1-June 30, 2007, erroneous drug claims for atypical antipsychotic drugs for nursing home residents cost $116 million.[3] This report underestimates the costs of antipsychotic drugs because it looked only at atypical antipsychotic drugs (not conventional antipsychotic drugs as well) and because it looked only at nursing home residents (not other care settings, such as hospitals and assisted living).

The harm that antipsychotic drugs can cause people for whom they are inappropriate is well-established. In 2005 and 2008, the Food and Drug Administration issued Black Box warnings about atypical[4] and conventional[5] antipsychotic drugs, advising that these drugs

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[1] *The New York Times* reported that approximately one-quarter of all nursing home residents regularly take antipsychotic drugs – nearly 350,000 people. Duff Wilson, "Side Effects May Include Lawsuits," *The New York Times* (Oct. 2, 2010), http://www.nytimes.com/2010/10/03/business/03psych.html?_r=1&scp=1&sq=Duff%20Wilson%20%22Side%20Effects%20May%20Include%20Lawsuits%22&st=cse.

[2] Office of Inspector General, Department of Health and Human Services, *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150(May 2011), http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf.

[3] *Id.* ii.

[4] In April 2005, the FDA issued "black box" warnings against prescribing atypical antipsychotic drugs for patients with dementia, cautioning that the drugs increased dementia patients' mortality. FDA, "Public

can cause the death of older people who have dementia. Antipsychotic drugs are also included on the Beers List of drugs that are inappropriate for most older people.[6]

There is no dispute that these drugs provide little or no benefit to most nursing home residents[7] and that they can lead to many poor resident outcomes, such as hospitalizations and falls.

High Cost of Poor Care

The single most important predictor of high quality of care and high quality of life for nursing home residents is nurse staffing. Since 1990, federal law has required, and paid, nursing facilities to have sufficient numbers of staff to meet the needs of their residents.[8] Yet more than a decade ago, the Centers for Medicare & Medicaid Services reported that more than 90% of nursing facilities did not have sufficient staff to prevent avoidable harm to nursing home residents or to meet their residents' needs in compliance with federal standards of care.[9]

There is a widespread belief that the United States cannot afford to pay for adequate staffing at nursing facilities. The truth is that the United States pays enormous amounts for nursing home care, but that too much of the money is misspent. Redirecting payments to care would result in better care at lower cost.

Health Advisory: Deaths with Antipsychotics in Elderly Patients with Behavioral Disturbances" (April 5, 2005), http://www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/ucm053171.htm.

[5] In June 2008, the FDA extended its warning to all categories of antipsychotic drugs, conventional as well as atypical, and directly and unequivocally advised health care professionals, "Antipsychotics are not indicated for the treatment of dementia-related psychosis." FDA, "Information for Healthcare Professionals: Conventional Antipsychotics," FDA Alert (June 16, 2008), http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm.

[6] The American Geriatrics Society 2012 Beers Criteria Update Expert Panel, "American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults," *Journal of the American Geriatrics Society* (2012).

[7] *See* Clive Ballard, M.D., Professor of Age Related Diseases, King's College, London, England, and Director of Research, Alzheimer's Society (United Kingdom) (speaker, CMS's Technical Expert Panel, April 10, 2012) (powerpoint attached); testimony of Toby S. Edelman before Senate Special Committee on Aging, "Overprescribed: The Human and Taxpayers' Costs of Antipsychotics in Nursing Homes" (Hearing, November 30, 2011), http://www.aging.senate.gov/events/hr240te.pdf.

[8] 42 U.S.C. §§1395i-3(b)(4)(A), (C), 1396r(b)(4)(A), (C), Medicare and Medicaid, respectively; 42 C.F.R. §483.30.

[9] Centers for Medicare & Medicaid Services (CMS), *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I* (Summer 2000), *Phase II* (Winter 2001), found 97% of facilities failed to meet one or more staffing requirements (1.15-1.3 hours licensed staff; 2.4-2.8 hours aide), and 52% failed to meet all staffing requirements, to prevent avoidable harm to residents. Simulation found 91% lacked sufficient nursing staff to meet five key care processes required by Reform Law (dressing/grooming, exercise, feeding assistance, changing wet clothes and repositioning, toileting). .More than 40% of facilities would need to increase aide staff by 50% or more; more than 10% of facilities would need to increase aide staff by more than 100%.

The Centers for Medicare & Medicaid Services (CMS) pays skilled nursing facilities very high Medicare rates[10] – so high that the Medicare Payment Advisory Commission, which reports that margins exceeded 10% for the tenth consecutive year (in 2010, margins exceeded 18.5% for freestanding nursing facilities and were 20.5% for for-profit facilities),[11] recommended again in March 2012 that skilled nursing facilities not receive any increase in their Medicare rates this year.[12]

Nursing facilities have not spent Medicare reimbursement specifically intended for staffing on staffing. When Congress increased Medicare rates by 16.6% in 2000, specifically for the nurse staffing component of Medicare rates,[13] the Government Accountability Office found that skilled nursing facilities increased their nurse staffing by less than two minutes a day[14] – virtually no change at all.

The common claim that Medicaid rates are too low should also be viewed with skepticism. An investigative report by *U.S. News & World Report*, "The New Math of Old Age; Why the nursing home industry's cries of poverty don't add up," found considerable related-party and self-dealing transactions in the nursing home industry, involving facilities' sending profits to their corporate parent, paying rent to related companies, and paying management or consulting fees to related parties.[15] Many "costs" are actually profits by another name.

The problem is not low reimbursement rates, but that government payment programs allow nursing facilities to spend their reimbursement in whatever way they choose.

When they permit nursing facilities to divert their reimbursement from care of residents to corporate overhead and profits, facilities are understaffed. The human toll is enormous. Residents suffer terrible health care outcomes and deaths that could have been avoided with better care.

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[10] Medicare rates for skilled nursing facilities fiscal year (FY) 2012 are 3.4% higher than FY 2010 rates, even with an 11.1% reduction that corrected the "unintended excess payments" that occurred in therapy-related reimbursement for FY 2011. For FY2012, the highest rates per resident per day are $737.08 for urban facilities and $754.11 for rural facilities. 76 Federal Register 26,364, at 48,501, Tables 4 and 5, respectively (Aug. 8, 2011).

[11] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* page 183 (March 2012). http://medpac.gov/documents/Mar12_EntireReport.pdf.

[12] *Id.* page 170, Recommendation 7-1: "The Congress should eliminate the market basket update and direct the Secretary to revise the prospective payment system for skilled nursing facilities for 2013. Rebasing payments should begin in 2014, with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare's payments are better aligned with providers' costs."

[13] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub.L. No. 106-554, App. F, §312(a), 114 Stat. 2763, 2763A-498.

[14] Government Accountability Office (GAO), *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, GAO-03-176 (Nov. 2002), http://www.gao.gov/new.items/d03176.pdf, found that although Medicare rates were increased 4-12% (on top of prior increases), staffing remained virtually stagnant (1.9 minutes increase in nurse staffing, but less RN, more LPN and aide time). The GAO concluded, "increasing the Medicare payment rate was not effective in raising nurse staffing" (page 4).

[15] Christopher H. Schmitt, "The New Math of Old Age; Why the nursing home industry's cries of poverty don't add up," *U.S. News & World Report* (Sep. 30, 2002).

The health care system also incurs enormous financial costs as it tries to undo the bad outcomes that were avoidable and should have been avoided. For decades, research has documented the high cost of poor care,[16] including the following:

Avoidable hospitalization

Large percentages of the hospitalizations of nursing home residents are considered avoidable. In March 2010, the Medicare Payment Advisory Commission (MedPAC) reported that in 2005, "potentially avoidable readmissions cost the [Medicare] program more than $12 billion" and that "In 2007, more than 18 percent of SNF stays resulted in a potentially avoidable readmission to a hospital."[17] A primary cause of hospitalizations from nursing homes, discussed in the research literature for more than 20 years, is the inadequate nurse staffing levels in nursing facilities.[18]

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[16] More than 20 years ago, the Subcommittee on Aging of the Senate Committee on Labor and Human Resources identified the high cost of poor care. *Nursing Home Residents Rights: Has the Administration Set a Land Mine for the Landmark OBRA 1987 Nursing Home Reform Law?*, 102nd Cong., 1st Sess. (June 13, 1991) described "what happens if we don't give good care." "Explosively expensive care is required to redress the effects of poor nursing care for residents in nursing homes. Inadequate numbers of nursing assistants, poorly supervised by licensed nurses, lead to breaks in care or inappropriate care. Basic care, food, fluids, cleanliness, sleep, mobility and toileting, when not carried out, leads to devastating outcomes for residents and additional expense for the government." Subcommittee on Aging of the Senate Committee on Labor and Human Resources, *Nursing Home Residents Rights: Has the Administration Set a Land Mine for the Landmark OBRA 1987 Nursing Home Reform Law?*, 102nd Cong., 1st Sess., page 175 (June 13, 1991). The Staff report identified a few of the poor care outcomes, their causes and their estimated costs: "Lack of toileting leads to urinary incontinence," which leads to "skin irritation, decubitus ulcers, urinary tract infections, additional nursing home admission and hospitalization" and is estimated to cost $3.26 billion annually; "Poor hydration, nutrition, mobility and cleanliness lead to pressure ulcers," whose treatment costs are estimated to range between $1.2 and $12 billion; Use of chemical restraints is a major cause of falls, including hip fractures, which are estimated to cost $746.5 million' and "Poor care leads to excess hospitalizations," costing nearly $1 million.

In 2011, the National Consumer Voice for Quality Long-Term Care updated its earlier work on the high cost of poor care, which it originally issued in 2001. *The High Cost of Poor Care: The Financial Case for Prevention in American Nursing Homes* (April 2011),

http://www.theconsumervoice.org/sites/default/files/advocate/action-center/The-High-Cost-of-Poor-Care.pdf.

[17] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* 167 (March 2010), http://medpac.gov/documents/Mar10_EntireReport.pdf.

[18] J.S. Kayser-Jones, Carolyn L. Wiener, and Joseph C. Barbaccia, "Factors Contributing to the Hospitalization of Nursing Home Residents," *The Gerontologist* (1989). *See also* two recent papers for the Kaiser Family Foundation, Henry Desmarais, "Financial Incentives in the Long-Term Care Context: A First Look at Relevant Information," (Oct. 2010), http://www.kff.org/medicare/8111.cfm, and Michael Perry, Julia Cummings (Lake Research Partners), Gretchen Jacobson Tricia Neuman, Juliette Cubanski (Kaiser Family Foundation), "To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care facility Residents; A Report Based on Interviews in Four Cities with Physicians, Nurses, Social Workers, and Family Members of Residents of Long-Term Care Facilities (Oct. 2010), http://www.kff.org/medicare/8110.cfm.

Many emergency department visits are also avoidable. The Centers for Disease Control and Prevention reported in 2010, that in 2004, 8% of nursing home residents nationwide – 123,600 individuals – had an emergency department (ED) visit in the prior 90 days and that 40% of the ED visits, involving 50,300 residents, were preventable.[19]

Pressure ulcers

The Agency for Health Care Research and Quality reported in January 2009 that in 2006, 2604 patients were admitted to hospitals from nursing homes with primary diagnosis of pressure sores and that the cost to treat them was almost $44 million; that in 2006, 40,056 people were admitted to hospitals from nursing homes with secondary diagnosis of pressure sores and that the cost to treat them was more than $800 million.[20]

Conclusion

Eliminating the inappropriate use of antipsychotic drugs and improving nurse staffing in nursing facilities would go a long way towards saving money and improving care for residents.

The Center for Medicare Advocacy is a private, non-profit organization, founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help older people and people with disabilities obtain necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and health care rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

[19] Christine Caffrey, CDC, "Potentially Preventable Emergency Department Visits by Nursing Home Residents: Untied States, 2004," NCHS Data Brief, No. 33 (April 2010), http://www.cdc.gov/nchs/data/databriefs/db33.pdf. CDC found that 104,900 residents (85%) had one ED visit in the prior 90 days and 18,400 residents (15%) and two or more ED visits.

[20] Agency for Health Care Research and Quality: "Pressure ulcers are increasing among hospital patients," *Agency News and Notes* (Jan. 2009), http://www.ahrq.gov/research/jan09/0109RA22.htm; AHRQ, "Hospitalizations Related to Pressure Ulcers among Adults 18 Years and Older, 2006," (Statistical Brief #64, Dec. 2008), http://www.hcup-us.ahrq.gov/reports/statbriefs/sb64.jsp.

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National Center for Assisted Living

STATEMENT

Of

The National Center for Assisted Living

For the

U.S. Senate Special Committee on Aging Hearing:

"The Future of Long-Term Care: Saving Money by Serving Seniors"

April 18, 2012

The National Center for Assisted Living (NCAL) represents approximately 3,000 assisted living providers nationwide, and is the assisted living voice of the American Health Care Association (AHCA). NCAL commends the U.S. Senate Special Committee on Aging Chairman Herb Kohl of Wisconsin and Ranking Member Bob Corker of Tennessee for convening this hearing. As the nation emerges from a deep and lengthy recession and faces difficult debates over levels of national spending and taxes, it is imperative that we explore cost-effective ways to help finance long term care for seniors and people with disabilities in ways that meet their needs, provide choices of care settings, and ensure person-centered care. AHCA/NCAL strongly believes that public policy should support a wide range of long term care choices that are affordable for all

Americans, including both those who pay privately and those needing assistance through government programs.

Assisted Living: A Cost-Effective Long Term Care Option

Once a novel concept, assisted living has grown to be a major – and very cost-effective – option for seniors and people with disabilities needing long term care services and supports. Seniors and their families opt for assisted living because of its emphasis on empowering residents' freedom to live their lives as they wish, with dignity and privacy, while providing them with needed services and supports. Assisted living continues to grow and focus on consumers' individual wants, needs, and preferences.

According to the 2010 National Survey of Residential Care Facilities, more than 733,000 Americans lived in state-licensed assisted living/residential care communities with more than 139,000 (or about 19 percent) of these receiving services under the Medicaid program. The study found that more than half of assisted living residents are age 85 and over and almost 40 percent receive assistance with three or more activities of daily living, with bathing and dressing being the most common.[i] Forty two percent of assisted living residents have Alzheimer's disease or other dementias. Other common chronic conditions among residents include: high blood pressure (57 percent of residents), heart disease (34 percent), depression (28 percent), arthritis (27 percent), and diabetes (17 percent).

Assisted living compares very favorably to other types of long term care in terms of cost. Genworth's "2012 Cost of Care Survey," for example, recently reported that the median annual cost of a single-occupancy assisted living unit was $39,600 compared with a median annual costs of $81,030 for care in a private room in a nursing home; $73,000 annually for care in a semi-private nursing home room; and $43,472 annually for home care provided by licensed home health aides. [ii]

Medicaid Coverage and Assisted Living

Last March 15, this Committee convened a roundtable discussion exploring a wide variety of issues concerning assisted living. One of the few areas of consensus was that the nation needed to develop many more assisted living units that were affordable for low-income people, both within the Medicaid program and for people of modest incomes who did not qualify for Medicaid. Unfortunately, even though Medicaid is the principal financing vehicle that makes assisted living affordable for people of this population, the growth of Medicaid coverage for assisted living has been curtailed by many structural and political factors.

Medicaid coverage in assisted living is much more limited than Medicaid coverage for nursing homes. While nursing home coverage is a mandated benefit under Medicaid, states have the

option to cover assisted living services under the program. Furthermore, under Medicaid waivers, states can limit assisted living Medicaid coverage to a geographic area or to a certain number of slots or aggregate expenditure target. This is not the case for institutional settings. Under the Medicaid program, assisted living is considered a home and community-based (HCB) setting and consequently Medicaid does not pay the cost of room and board, including utilities and food. These gaps in Medicaid financing mean that states must consider a number of design decisions to finance costs that Medicaid does not cover. As a result, financing streams for assisted living receiving Medicaid tend to be very complex and funding for residents receiving Medicaid tends to be much lower than private-pay funding.

The latest study detailing national and state-by-state Medicaid payment and policy for assisted living was prepared by independent researcher Robert Mollica in 2009.[iii] Entitled "State Medicaid Reimbursement Policies and Practices in Assisted Living," the report updated previous research done by the U.S. Department of Health and Human Services and outlined the wide variation in how states determine Medicaid payment levels for assisted living communities and other related policy issues. The report describes how states respond to the lack of Medicaid funding for room and board costs in determining a variety of policies, including whether or how much states supplement payments for room and board; whether states allow families and individuals to supplement room and board payments for Medicaid beneficiaries; and whether states allow beneficiaries to share apartments and under what conditions.

Among the major findings were the following:

- Thirty-seven states provided coverage under §1915 (c) HCB services waivers to cover services in residential settings; thirteen states provided coverage directly under their state Medicaid state plan; four included services in residential settings under §1115 demonstration program authority; and six used state general revenues. States may use more than one funding source.

- Tiered rates were the most common methodology for reimbursing assisted living providers. Nineteen 19 states used tiered rates while 17 states used flat rates.

- Twenty-three states capped the amount that may be charged for room and board.

- Twenty-four states supplemented the beneficiary's federal Supplemental Security Income (SSI) payment, which states typically use as the basis for room and board payment. SSI payments combined with state supplements ranged from $722 to $1,350 a month depending on the state. Some states provide no supplement.

- Twenty-five states permitted family members or third parties to supplement room and board charges.

- Twenty-three states required apartment style units; 40 states allowed units to be shared; and 24 states allowed sharing by choice of the residents.

While Medicaid does not pay for room and board in assisted living settings, payment rates for Medicaid services are typically lower than private market rates. Gaps in the funding system drive many of the other problems facing Medicaid coverage in assisted living. Room and board typically comprises about 40-50 percent of the cost of assisted living and the SSI payment is often inadequate to cover room and board costs, even in instances where states supplement SSI.

Given the core economic issues described above and the realities of Medicaid underpayment, providers must have flexibility to manage their level of Medicaid involvement. In addition, NCAL believes that families should be able to supplement room and board payments for residents receiving Medicaid coverage so that they can afford single-occupancy units.

Despite these concerns, and even though the current political climate makes it difficult to propose new public funding streams, it is imperative for policymakers to consider ways to help states cover the gaps around Medicaid funding. Policies that could be considered include making housing vouchers available to low-income assisted living residents including Medicaid beneficiaries, providing increased public financing for construction of affordable assisted living, and expanding incentives and mechanisms for families to save for future long term care costs. As Congress and the newly formed Administration for Community Living consider ways to make long term care more cost effective, research should be done to determine how wrap-around subsidies for housing in assisted living for low-income populations could save money in overall long term care costs. For example, a $5,000 assisted living housing voucher could facilitate the placement of a Medicaid beneficiary in a HCB setting in which services cost tens of thousands of dollars less than an institutional setting.

Evaluations of the Money Follows the Person grant program have found that major barriers to transitioning people from nursing homes to the community include "insufficient supply of HCBS providers and services" and "inaccessible and/or unaffordable housing."[iv] Even though the definition of a qualified setting in the Money Follows the Person program's authorizing legislation made it difficult for assisted living providers to participate in the program, it is noteworthy that nine percent of the Medicaid beneficiaries transitioning to the community under the program went to live in an assisted living community. The percentage would have been much higher if the program's rules had allowed assisted living settings to participate to a greater degree and if there were supplemental funding to cover the costs of room and board.

CMS Attempt To Define HCB Settings, Combine Waivers Raises Concerns

NCAL and many other stakeholders have grave concerns that the continuing effort by the Centers for Medicare & Medicaid Services (CMS) to define Medicaid HCB settings for the first time has the potential to exclude many assisted living providers from the Medicaid program, thereby dramatically reducing access to needed housing and services to low-income individuals. The proposed rules ("Medicaid Program: Community First Choice Option," *Federal Register*, Feb. 25, 2011 and "Medicaid Program; Home and Community-Based Services Waivers" *Federal Register*, April 15, 2011) would significantly reduce long term care options for Medicaid beneficiaries while potentially raising the cost of providing Medicaid coverage for the federal and state governments. If these proposed rules are not changed, they would force the majority of the more than 139,000 Medicaid beneficiaries currently living in assisted living communities to be transferred to a nursing home or other institutional setting.

Both proposed rules would disqualify a community-based provider, such as assisted living or a group home, from participation in Medicaid by virtue of being on or near a property containing an institutional setting. Many seniors choose to live in settings offering multiple levels of care (e.g., continuing care retirement communities), and states have chosen to allow Medicaid to pay for these.[v] Especially at a time when the senior population is growing rapidly, CMS should not restrict the options available to seniors and the states.

The several other conditions that assisted living communities would be required to meet in order to qualify as a Medicaid community-based setting under the April 15, 2011 proposed rule would decrease access and choice for Medicaid beneficiaries. Of great concern is the requirement that the residents have a lease. In most states assisted living communities use resident agreements because they offer a unique combination of services and housing. This and the other requirements, such as having lockable doors and forbidding settings targeted to a particular diagnosis, could disqualify assisted living communities in several states from delivering care for the most vulnerable seniors, particularly those with Alzheimer's disease.

While we agree with the intent to integrate Medicaid beneficiaries into the larger community and have person-centered care, the proposed definitions would have the opposite effect. Many of these older Medicaid beneficiaries do not have the option of returning to their home because their needs can no longer be met through home health care alone. Others may no longer have a home to return to. Denying access to assisted living and group home settings would force older low-income residents into nursing homes and other institutional settings because, in most cases, there would be no other options.

NCAL believes that any definition of HCB settings should include all types of assisted living communities participating in Medicaid. Indeed, under the logic of the landmark Olmstead decision, depriving Medicaid beneficiaries of a major type of housing with services, such as assisted living, would be the opposite of a reasonable accommodation, especially for those

seniors who prefer to live in assisted living and those for whom assisted living is the least institutional option available based on their clinical needs. NCAL agrees that care in HCB settings should be resident-centered and continues to work with federal agencies to operationalize that goal in a way that does not arbitrarily restrict choice.

AHCA/NCAL also continues to have concerns regarding CMS' proposal to provide states with the option to combine or eliminate the existing three permitted waiver targeting groups. As we have noted in our comments on the proposed rules, combining target populations such as persons with mental illness with persons with developmental disabilities or frail seniors in waivers may increase the risk of inappropriate placement of vulnerable individuals as well as create safety issues.

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[i] "Residents Living in Residential Care Facilities: United States, 2010," Christine Caffrey, Manisha Sengupta, Eunice Park-Lee, Abigail Moss, Emily Rosenoff, and Lauren Harris-Kojetin, NCHS Data Brief No. 91, April 2012, U.S. Dept. of Health and Human Services.

[ii] "Genworth 2012 Cost of Care Survey," Genworth Financial, Inc., and National Eldercare Referral Systems, LLC (CareScout).

[iii] "State Medicaid Reimbursement Policies and Practices in Assisted Living," Robert Mollica, National Center for Assisted Living, Washington, D.C., October 2009. Information for the report was obtained from two primary sources. Baseline information on state assisted living reimbursement policies and practices was obtained from previous studies sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Policy and Evaluation, and RTI International in 2002, 2004, and 2007. The information was updated through an electronic survey and telephone calls with state officials responsible for managing Medicaid services in licensed assisted living/residential care settings. Information was also obtained from state websites when available. Responses were received from 45 states and the District of Columbia. Information for states that did not respond to the survey was obtained from previous reports and material found on state web sites. Data were collected between March and June 2009. To obtain a copy of the report, visit *www.NCAL.org*.

[iv] "Money Follow the Person Demonstration: Overview of State Grantee Progress, January to June 2011," Noelle Denny-Brown, Debra Lipson, Matthew Kehn, Bailey Orshan, and Christal Stone Valenzano, Mathematica Policy Research, December 2011.

[v] For example, CMS' proposed rule implementing the Community First Choice Option states "that certain settings are clearly outside of what would be considered home and community-based because they are not integrated into the community . . . home and community settings would not include a building that is also a publicly or privately

operated facility which provide inpatient institutional treatment or custodial care; or in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual's diagnosis that is geographically segregated from the larger community, as determined by the Secretary." (See "E. Setting" section on page 10740 of the Feb. 25, 2011 *Federal Register*.) Depending on how such language might be interpreted, it could exclude assisted living communities currently operating in proximity to institutional facilities, on a campus or otherwise, as well as assisted living units in Continuing Care Retirement Communities. Many seniors choose this campus model over freestanding models.

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