Medicaid and Long-Term Care

New Challenges, New Opportunities

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Medicaid and Long-Term Care:

New Challenges, New Opportunities, and Implications for a Comprehensive National Long-Term Care Strategy

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# Table of Contents

Executive Summary .................................................................................................................. i

I. Study Purpose and Objective ......................................................................................... 1

II. Context .......................................................................................................................... 2
   A. What is Long-Term Care? ......................................................................................... 2
   B. Who Needs Long-Term Care? .................................................................................. 3
   C. Multiple Dimensions of the Long-Term Care Challenge ........................................ 5
   D. LTC Financing—The Strain of Long-Term Care Costs on Medicaid ....................... 6

III. Medicaid and LTC ...................................................................................................... 10
   A. Current State of Medicaid ....................................................................................... 10
   B. Increasing Costs of LTC—Impacts for Medicaid and for Individuals/Families .......... 15
   C. Different Segments of the LTC Population vis-à-vis Financing ............................... 21

V. Current Attempts to Reduce the Long-Term Care Strain on Medicaid .................. 25
   A. Partnerships for Long-Term Care Program ......................................................... 25
   B. Own Your Future ..................................................................................................... 26
   C. State Tax Incentives ................................................................................................. 26
   D. Government Employee Long-Term Care Insurance ............................................. 27
   E. Implications of the CLASS Program Provisions .................................................... 28

VI. Guidelines for a Comprehensive National LTC Strategy ..................................... 29
   A. Components of a Comprehensive National Long-Term Care Solution ............... 30

VII. Conclusion and Recommendations ........................................................................... 35

Appendix A: Medicaid Spending by State ....................................................................... 37
Appendix B: Map of State Activities to Encourage Planning for LTC ........................ 39
References ......................................................................................................................... 40
Executive Summary

A number of factors will likely result in dramatic changes to the financing and delivery of long-term care (LTC) services—an increasing population of older people and people with disabilities, a severe economic recession, the new national health reform law, and other recent developments. This study, conducted by The Lewin Group for Genworth Financial, synthesizes the latest available data on Medicaid and LTC trends; takes a new look at LTC financing challenges and possible solutions in light of these historic changes; and proposes guidelines for consideration in developing a comprehensive, national long-term care solution.

Over the last two decades, long term care moved beyond primarily medical and personal care assistance delivered in nursing homes, to include a wide range of health and human services to help people live more fulfilling, self-directed lives in an array of home, community, and residential care settings.

Recent opinion polls have shown widespread misconceptions about where LTC is provided, how much it costs and who pays for it. Most Americans do not plan for future long-term care needs or mistakenly believe they already have coverage.

Given this state of unpreparedness, Medicaid manifests as the default national LTC financing solution:

- Medicaid finances 49 percent of total LTC expenses today (Exhibit 3)
- Seven percent of Medicaid beneficiaries using LTC account for 52 percent of total Medicaid spending (Sommers and Cohen, 2006)
- LTC spending constitutes a substantial portion of state Medicaid budgets—one-third on average and ranging from 23 percent to 61 percent (Appendix A)

Based on current trends, both the number of people requiring LTC as well as those turning to Medicaid for coverage of LTC will continue growing significantly. The Lewin Group projects that:

- The total number of people age 65 and over requiring LTC will grow from 7.4 million in 2010 to 16.1 million in 2050 (Exhibit 4)
- Total national LTC spending for individuals age 65 and older of approximately $182 billion will nearly double by 2030 and increase to about $684 billion by 2050 (Exhibit 5)
- The number of people age 65 and older requiring Medicaid LTC will grow from 2.7 million in 2010 to 4.9 million in 2050 (Exhibit 4)
- Medicaid LTC spending is projected to increase from approximately $64 billion in 2010 to $101 billion in 2030 and $217 billion in 2050 (Exhibit 5)

From a broader public financing context, total spending for Medicaid, Medicare, and Social Security is projected to climb from 8.4 percent of GDP to 18.4 percent by 2050. In addition, Medicaid spending for health care for working age adults and children will greatly increase as a result of expansion of the Medicaid program to cover more uninsured people through the new national health reform law. In this time of increasingly strained federal and state budgets,
government spending on public programs must be cost-effective and sustainable over the long-term.

Although many states have responded to growing Medicaid costs by cutting services, these cuts could be more than offset by cost-shifting to other services and reductions in revenue from program elimination. On the other hand, investing in home and community-based services (HCBS) and improved coordination within Medicaid may bring long-term savings for state Medicaid programs.

The new health reform law includes several opportunities to enhance Medicaid LTC, focusing on incentives for states to expand coverage of services in the community.

Issues of LTC financing are closely intertwined with other challenges that will need to be addressed to meet the growing need for LTC in the United States, including supporting family caregivers, sufficient supply of the paid LTC workforce, promoting healthy aging, and ensuring access to quality services that meet people’s needs. Attempts to address these challenges have generally been fragmented and uncoordinated, focusing on one aspect of the problem or limited to a few providers or states. Findings from this paper emphasize the need for a comprehensive national solution to long-term care.

**Financing**

- Strengthen Medicaid LTC through efforts to expand HCBS and reduce unnecessary reliance on costly nursing home care, changes to improve care coordination, and initiatives to improve integration of Medicare with Medicaid
- Provide financial incentives to encourage people to plan for their LTC expenses by purchasing LTC insurance or other private financing options

**Healthy Aging**

- Conduct research to develop new ways to treat and prevent conditions and injuries driving the need for LTC, such as Alzheimer’s disease and hip fractures, could help reduce the need for LTC, save costs, and help people live healthier lives
- Institute care coordination and care transitions programs to improve health, reducing hospitalizations, and ultimately reducing health and LTC care costs

**Caregivers**

- Build and maintain an adequate, skilled, and diverse paid workforce by improving recruitment, retention, and training of the health and long-term care workforce to provide care for the growing population of older people and people with disabilities
- Support unpaid caregivers through individual counseling, organization of support groups, caregiver training, and respite care

**Education and Awareness**

- Enhance and expand existing efforts to educate people about their LTC options and help them make informed decisions
Fund Aging and Disability Resource Centers to provide community-level access to information, assistance and options counseling

Demand for LTC will become more significant around 2030 when the first wave of Baby Boomers turn 85. Hence, the next 20 years offer a window of opportunity to enact changes before the boomers enter late old age. Although this target may not seem to imply a sense of urgency for policymakers, achieving the goals for a comprehensive long-term care system and infrastructure (e.g., preparation of the LTC workforce; widespread dissemination of effective models of care; adequate personal planning for LTC needs) will require many years of effort. Hence, the time to act is now.

In assessing potential solutions, policymakers should consider the short-term and long-term impacts not only on the Medicaid LTC program, but also the broader impacts on federal and state budgets, and the effects on individuals and families in terms of access and quality of care and quality of life.
I. Study Purpose and Objective

The financing and delivery of long-term care (LTC) is in the midst of dramatic change, as a result of a number of factors—an increasing population of older people and people with disabilities, a severe economic recession, the new national health reform law, and other recent developments. In this study for Genworth Financial, The Lewin Group synthesizes the latest available information on Medicaid and LTC trends; examines LTC financing challenges and possible solutions in light of these historic changes; and suggests guidelines and recommendations for developing a comprehensive, national long-term care solution.

This report addresses the following key research questions:

- Who are the Americans who will need long-term care?
- What are the major dimensions of the long-term care challenge in the United States?
- What is the current state of LTC financing, and is it sustainable?
- What are the key drivers of the strain on Medicaid costs and of Medicaid financing of LTC in particular?
- What is required to create a more sustainable financing model for LTC and preserving and protecting Medicaid?
- What are the components of a comprehensive national LTC strategy?
II. Context

Long-term care (LTC)—services and supports to help people with a disability or chronic illness to live their everyday lives—is generally not covered by Medicare or other health insurance or disability insurance. Relatively few people have private long-term care insurance or can afford to self-pay for LTC for very long. As a result, Medicaid, the federal and state financed health and LTC program for people with low-incomes, currently picks up the majority of the national tab for LTC services.

Based on current trends, the number of people turning to Medicaid for coverage of LTC will continue to grow significantly. Increases in the numbers of people living with a disability or chronic illness, rising costs of long-term care services, and the worst recession since the Great Depression all will contribute to increased reliance on public programs and extremely pressured state budgets. At the same time, the new national health reform legislation brings many changes to Medicaid, notably new opportunities to develop solutions to Medicaid and LTC financing and initiatives to prepare to meet the growing need for long-term care in a way that better meets people’s needs.

From a broader public financing perspective, national spending for Medicaid, Medicare, and Social Security combined is expected to increase significantly over the next several decades. The Congressional Budget Office (CBO) estimates that all three entitlement programs will grow faster than the economy (CBO, 2009). The CBO predicts that Medicare spending, which as of 2009 constituted three percent of GDP, will increase to eight percent of GDP by 2035 assuming an extended-baseline scenario. While not growing as quickly as Medicare, by 2035 total Medicaid spending is expected to grow to five percent of GDP, from three percent in 2009. Medicaid and Medicare will continue to account for an increasing share of total health care spending, growing from 37 percent in 2009 to 41 percent in 2035. Longer retirements resulting from decreased mortality are expected to cause Social Security expenditures to increase from 4.3 percent in 2008 to 6 percent of GDP in 2035. In this time of increasingly strained federal and state budgets, it is important to ensure that government spending on public programs is cost-effective and sustainable over the long-term.

A. What is Long-Term Care?

Although in the past LTC was associated primarily with medical and personal care assistance delivered in nursing homes, today LTC includes a wide range of health and human services to help people live more fulfilling, self-directed lives in an array of home, community, and residential care settings. In recent years, states have been increasingly recognizing the importance of coordination across service populations and settings to develop effective solutions to long-term care challenges (Hewitt et al., 2008).

Depending on the setting and individual’s needs, LTC services might include: assistance with personal care activities such as bathing and dressing; assisting with household tasks such as...
meal planning and preparation and housekeeping; ensuring safety; monitoring health; assisting with medications; transportation assistance; facilitating recreational activities and community involvement; working with family members; providing companionship and support in developing and maintaining social relationships; and many other services (Hewitt et al., 2008).

B. Who Needs Long-Term Care?

Millions of Americans of all ages rely on LTC services due to disability or chronic illness. However, the financing solutions available for older and younger LTC users are quite different. Public and private efforts to address LTC financing challenges have focused primarily on the financing of elder care. Private LTC insurance is designed as a retirement planning product to help cover the costs of LTC that people may need as they age, rather than a solution for younger people with disabilities. In addition, people age 65 and over are covered by Medicare (which pays for short-term rehabilitation after a hospital stay, but does not cover LTC for an extended period of time). The personal financial circumstances of older and younger people are also very different, with older LTC users likely to be living on Social Security and retirement income and assets, while younger people with disabilities are more likely to be employed, attending school, or looking for work.

This study focuses primarily on the challenges and potential solutions for financing LTC for older people, but also discusses the need to address the multiple dimensions of the LTC challenge.

Studies generally measure a person’s need for LTC by their ability to perform activities of daily living (ADLs) (such as eating, dressing, grooming, using the bathroom, and moving about) or activities of independently living (IADLs) (such as cooking, shopping, housekeeping, preparing meals, and managing medications). The need for long-term care affects groups of individuals differently. Older people are significantly more likely to need LTC, and women have a greater likelihood than men of needing LTC during their lifetimes (79 percent of women, 58 percent of men) (Kemper, Komisar, and Alecxih, 2005-06). Women are also more likely to be providing care to family members.

People turning age 65 in 2005 have a 69% chance of needing any long-term care, with women having a greater chance of needing LTC than men (58% for men and 79% for women).

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Kemper, Komisar, and Alecxih, 2005-2006

For planning LTC financing, it is useful to know a person’s likelihood of needing LTC in the future. A widely cited study estimated that people turning age 65 in 1990 had a 43 percent chance of using a nursing home at some point in their lifetimes (Murtaugh et al., 1990). However, this estimate was based on 1982-1984 data and does not reflect current nursing home utilization trends. According to the most recent research, using a microsimulation model, Kemper, Komisar, and Alecxih (2005-06) projected that of people turning 65 in 2005, 69 percent will need any long-term care and 35 percent will use a nursing facility in their lifetimes, spending an average of about nine months in a nursing facility. An estimated 13 percent of people turning 65 will spend time in assisted living facilities, 42 percent will use paid care at home, and 59 percent will get help from informal caregivers at home, with some individuals receiving services in multiple settings and from both informal and formal providers.
The microsimulation analysis by Kemper and colleagues (2005-06) showed that LTC use and spending will be unequally distributed. About 31 percent of people turning 65 are projected to have no need for LTC in their lifetimes, and many rely solely on family members and friends. At the other end of the spectrum, one in five (20 percent) people are projected to need LTC for five years or more, and five percent will spend more than five years in a nursing facility (Exhibit 1). This translates to great variation in the amount of LTC spending. Forty-two percent of older adults are projected to incur no LTC expenses in their lifetimes, and 19 percent will have expenses of less than $10,000, while 16 percent will have LTC needs costing $100,000 or more (Exhibit 2).

**Exhibit 1: Projected Average Years of LTC Need for Men and Women Turning Age 65 in 2005**

![Bar chart showing projected average years of LTC need for men and women turning age 65 in 2005.]

Source: Kemper, Komisar, and Alecxih, 2005-06.
As these projections illustrate, long-term care is a high-cost, relatively rare event. Many people will not need any paid LTC, while a small subset of the population will require an intensive level of paid care for an extended period of time. Hence, LTC is comparable to other types of risks that are typically covered by insurance, such as a car accident or damage to the home, where a small percentage of people will incur significant costs and need to use their insurance benefits. This contrasts with health care, which everybody needs, and where nearly everybody who has health insurance expects to use it.

C. Multiple Dimensions of the Long-Term Care Challenge

The LTC financing challenge intertwines with other dimensions of the LTC challenge, such as ensuring the quality and effectiveness of services, maximizing quality of life and autonomy, obtaining and maintaining housing, and providing access to an array of service options tailored to a person’s needs and preferences. The multiple dimensions create greater complexity, particularly when staff focused on specific areas, such as housing, are often unfamiliar with the other areas and unaccustomed to the different rules and requirements. Variation among states in rules and requirements, as well as coverage for services, also contributes to the challenge.

To meet the nation’s future LTC needs in an affordable and high-quality manner will require comprehensive strategies that address these multiple dimensions of the long-term care challenge.
D. LTC Financing—The Strain of Long-Term Care Costs on Medicaid

Despite increased spending on paid long-term care services, most long-term care services are provided on an unpaid basis by family members, friends, and other volunteer helpers (Kaye et al., 2010). The 22 percent paid for by Medicare primarily covers post-acute care. Medicaid finances the majority of LTC use (49 percent), with out-of-pocket spending by individuals and families the next largest source of payments (18 percent), and some long-term care insurance and other private sources (9 percent). Other public financing sources account for a tiny share of total LTC financing (Exhibit 3).

Exhibit 3: Total LTC Expenditures by Source, 2008 (billions)

Sources: National Health Policy Forum, 2010

National Health Expenditures by type of service and source of funds, CY 1960-2008 (ZIP, 41 KB), accessed June 7, 2010, from: National Health Expenditure Data
http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp

Seven percent of Medicaid beneficiaries who use LTC account for 52 percent of Medicaid spending. Sommers and Cohen, 2006

A small percentage of eligible individuals who need long-term care consume the majority of Medicaid expenditures and the number of these users will grow as the population ages. Medicaid's LTC users not only use LTC services, but they also use the program's acute care services more intensively than non-LTC users (Sommers and Cohen, 2006). According to the most recent available data, seven percent of Medicaid beneficiaries using LTC accounted for over half (52 percent) of all Medicaid spending in 2002 (Sommers and Cohen, 2006). Three-quarters of the
spending by these high-cost LTC users went towards LTC, and 25 percent went towards acute care and other supportive services. Half of these high-cost beneficiaries were age 65 or older, one-third were adults with a disability under age 65, and 11 percent were adults or children not classified as having a disability.

Much of the discussion about LTC financing has focused on addressing the future long-term care needs of the Baby Boom generation—Americans born between 1946 and 1965. This large cohort will begin to turn age 65 next year. Exhibit 4 shows that the projected number of elderly individuals using any long-term care services and Medicaid financed services will nearly double over the next 40 years.

Exhibit 4: Projected Elderly LTC Users


This increase in the older population with LTC needs is projected to lead to significant growth in LTC spending over the next few decades. The Lewin Group projects that total national spending for individuals age 65 and older of approximately $182 billion will nearly double by 2030 and increase to about $684 billion in 2010 dollars by 2050 when all of the Baby Boomers will be age 85 and older. Medicaid spending is projected to increase from approximately $64 billion in 2010 to $101 billion in 2030 and to $217 billion in 2050 (Exhibit 5).
Exhibit 5: Projected Total and Medicaid LTC Spending for the Elderly (amounts in 2010 dollars)


Boomer-driven demand for LTC will become more significant around 2030, when the first Boomers turn 85 (Redfoot and Pandya, 2002). Hence, the next 20 years offer a window of opportunity to enact changes before the Boomers enter late old age. Although this target may not seem to imply a sense of urgency, achieving the goals for a comprehensive long-term care system (e.g., preparation of the long-term care workforce; widespread dissemination of effective models of care) will require many years of effort (IOM, 2008).

A number of demographic, market, and policy trends will affect LTC use and spending over the next few decades (Redfoot and Pandya, 2002; IOM, 2008). The future elderly population will be more racially and ethnically diverse than today’s older adults, enjoy improved education and financial status, and differ in family structure. Older people are, on average, in better health than in the past and disability rates have declined (IOM, 2001, Manton et. al., 2006). At the same time, people are living longer and hence the number of years that people with disabling conditions require LTC is likely to grow, even if disability rates decline. Future trends in illness and disability, such as changes in smoking and obesity rates, may also influence the need for service. Medical and technological advances may

The Lewin Group projects that total national spending for LTC for individuals age 65 and older of about $182 billion will increase to nearly double by 2030 and increase to about $684 billion in 2010 dollars by 2050 when all of the Baby Boomers will be age 85 and older.
lead to more changes in how health care is delivered. Older adults of the future may also have different preferences for where and how care is provided.

Models of service delivery have also changed. The number of assisted living communities has increased substantially since the early 1990s, and Medicaid funding has gradually shifted to serve more people at home and in the community. Meanwhile, many nursing homes have shifted their service model to focus on rehabilitation or specialized care for specific chronic illnesses (Mehdizadeh, Nelson, & Applebaum, 2006).

Although current costs are lower for healthier older people than for those who are less healthy, healthier people actually incur higher total lifetime costs compared to unhealthy people because they tend to live longer (Moeller, 2010; Sun et al., 2010). This finding emphasizes the need to plan ahead for future health and long-term care needs.
III. Medicaid and LTC

A. Current State of Medicaid

1. Intention vs. Reality of Medicaid

The Social Security Act of 1965, the same legislation that created Medicare, established the Medicaid program. Medicaid was originally designed to provide health coverage for indigent parents, children, older people, and people with disabilities (CMS, “Public Programs that Pay for Long-Term Care,” 2010). Among the range of LTC services available under Medicaid today, states were only required to cover nursing facility services.

Congress provided states the opportunity to add most long-term care services after the original Medicaid legislation. States were first allowed to cover services in intermediate care facilities and facilities for people with intellectual/developmental disabilities (ICFs/MR) in 1971 (Kaiser, 2002, Appendix 1). Section 1915(c) home and community-based waiver services were added in 1981. Over time, Medicaid has grown dramatically in numbers of participants and costs, in large part due to growth in the number of recipients receiving LTC and the cost of providing those services.

Although most people prefer to receive services in their own homes, the majority of Medicaid spending for older adults and adults with physical disabilities goes to institutional services, which are generally most costly. Medicaid LTC’s bias towards nursing facilities is the result of unintended consequences rather than an organized plan for addressing the needs of low-income individuals who need LTC (Carder, Wright, and Jenkens, 2005, p. 18).

In addition, although Medicaid is intended as a safety net program for people living in poverty, it has also become the default LTC funding source for many older people who start their retirement years financially comfortable, but end up exhausting their assets and impoverishing themselves paying for LTC out-of-pocket. Often this spend-down is an unintended result of a lack of planning for LTC by individuals and families, as well as widespread misperceptions about LTC, such as the mistaken belief that it will be covered by Medicare or other health or disability insurance.

2. Strengths and Weaknesses of Medicaid LTC Structure

Features of Medicaid’s LTC structure that make it cost-effective can also have a negative impact on quality and access to care and quality of life for beneficiaries. Medicaid LTC is designed to minimize costs through high cost sharing (people in nursing homes pay nearly all their income for their nursing home care, estate recovery); very low reimbursement rates compared with private insurance and private pay rates, which makes it difficult for many providers to participate; eligibility restrictions; and other attempts to reign in spending. Medicaid is also
limited in the LTC services it will cover; for example it does not cover services in a private room in a nursing home, and relatively few assisted living facilities participate in Medicaid.

The good news is that opportunities exist for Medicaid LTC to achieve cost savings and improve quality and access to services at the same time, by addressing three major structural weaknesses in the program (UnitedHealth Center for Health Reform & Modernization (UHC), 2010):

1) An “institutional bias” which favors nursing home care and makes it more difficult to provide services in the community. A major focus of Medicaid LTC reform over the past decade has been on ending the bias in favor of institutional services and improving access to services in the home and community. Several studies in the 1990s and 2000s (Mollica et al., 2009; Kaye et al., 2009; Senecal, 2009; Weissert et al., 1997; GAO, 1994; Alecxih et al., 1996) have found evidence that states that invest in comprehensive systems of home and community based LTC experience long-term reductions in Medicaid spending. In these states, the expansion of HCBS was often accompanied by other efforts to transform state long-term care systems, which may also contribute to cost savings.

2) A lack of care coordination for people who receive LTC services. The limited research on case management and care transition programs suggests these programs can be effective in reducing health utilization and costs (Lewin, “UHC Gaps in Care…,” 2010). In addition, the value of interdisciplinary teams, in which practitioners with different areas of expertise work together to provide health care and social services for a single individual, for improving the care of older adults with complex care needs has been increasingly recognized in recent years (IOM, 2008). However, team training is not currently a focus in the curriculum for many providers and they may be unfamiliar with this practice style, which could impede the spread of such teams.

3) A lack of coordination with Medicare. A few states have used programs that integrate Medicaid and Medicare to improve access to community-based LTC and improve care management (UHC, 2010). These models allow more flexibility to ensure that a person’s needs are met regardless of which system is responsible. Integrated LTC also minimizes unnecessarily shifting costs and unnecessary use of hospitals, nursing homes, and other medical services.

In addition to these structural issues, Medicaid also suffers from consistently low reimbursement rates which can lead to poor quality, and it requires participants to become impoverished to qualify.
Medicaid and the “Great Recession”

The U.S. is in the midst of the worst recession since the 1930s, which has caused the steepest decline in state tax receipts on record (McNichols and Johnson, 2010). In January 2010, the national unemployment rate was 9.7 percent, and over 8.4 million people have lost their jobs since the start of the recession in December 2007 (Kaiser, “State Fiscal Conditions and Medicaid,” 2010). At least 46 states face or have faced shortfalls for fiscal year 2011 (McNichol and Johnson, 2010).

The economic crisis and rising unemployment have led to higher demand for public programs, including Medicaid, and continue to strain state budgets (Kaiser, “State Fiscal Conditions and Medicaid,” 2010). About 4.8 million more people are expected to enroll Medicaid and the Children’s Health Insurance Program (CHIP) as a result of the recession.

States have already undertaken a range of aggressive cost containment actions in recent years, and these conditions have led more than half the states (29) to report that additional Medicaid cuts would either be likely mid-way through FY 2010 or had already been implemented (Kaiser “Medicaid’s Continuing Crunch…”, 2010b). Fifteen other states suggested that cuts could be possible. Twenty-one states said that Medicaid cuts were most likely to come from reductions in provider rates, while the other eight states were looking to reduce or restrict program benefits. Provider taxes were also being considered by some states as a way of maintaining provider rates and program benefits. While enhanced federal reimbursement (see below) for Medicaid expenditures through the American Recovery and Reinvestment Act of 2009 (ARRA) has temporarily shifted a portion of the cost burden to the federal government, state governments are anticipating significant budget shortfalls once the provision sunsets at the end of 2010. Though a six-month extension was expected, as of June 21, 2010, Congress is continuing to debate the measure (McKnights, 2010). In the absence of an extension of the program, the FY 2011 aggregate budget gap for all states is expected to climb to $102 billion and as high as $180 billion (Kaiser Commission, 2010a). This will likely put increased pressure on further Medicaid cuts. While an economic recovery will relieve some of this pressure, the inevitable growth in the population of people who need LTC and the declining working-age population to both support and provide financing requires not only short-term solutions, but purposeful preparation for the long term.

4. Implications of PPACA for Medicaid

Medicaid plays a leading role in the Patient Protection and Affordable Care Act (PPACA) health reform legislation, signed into law on March 23, 20101. The Congressional Budget Office (cited

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1 The Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010, included some changes to the PPACA.
in Rosenbaum, 2010) projected that of the 32 million people who will gain health coverage by 2019, half are expected to obtain their coverage through Medicaid and its smaller companion program, the Children’s Health Insurance Program (CHIP) (Rosenbaum, 2010).

The PPACA fundamentally alters Medicaid’s eligibility structure (Rosenbaum, 2010). Prior to the reform, states generally could not use Medicaid to cover low-income adults who had neither children nor a disability (Kaiser, “Explaining Health Reform…”, 2010). The law expands Medicaid significantly to cover millions more low-income, uninsured people, primarily working-age adults (Kaiser, “Optimizing Medicaid Enrollment…”, 2010). It creates a mandate for Americans to obtain health care coverage and designates Medicaid as the coverage pathway for low-income uninsured Americans. Most notably, the PPACA expands Medicaid eligibility to cover nearly all people earning 133 percent of the federal poverty level ($14,404 for an individual or $29,327 for a family of four in 2010) by January 1, 2014 (Kaiser, “Financing New Medicaid Coverage…”, 2010). The law provides states with increased federal resources to expand coverage.

A recent Kaiser Commission on Medicaid and the Uninsured study (Holahan and Headen, 2010) projected that, due to large increases in federal matching rates, the federal government will bear about 95 percent of all new Medicaid spending from expansion under the PPACA. Federal spending is projected to increase by $443.5 billion and state spending is projected to increase by $21.1 billion between 2014 and 2019 due to the reform (Holahan and Headen, 2010). This represents a 22.1 percent increase in federal spending, compared with a 1.4 percent increase in state spending, and a 13.2 percent increase in total Medicaid spending over baseline from 2014 to 2019. Enrollment in Medicaid is projected to rise by 27.4 percent by 2019. The projected impact of the law varies across states, based on differences in current levels of coverage and federal match rates, from a decrease in spending of 2.1 percent in Massachusetts (which has a low share of uninsured citizens at baseline) to a projected increase in spending of 4.8 percent in Mississippi.

However, these estimates are imprecise and the outcomes for Medicaid spending and enrollment could vary significantly depending on how the reform is implemented (Holahan and Headen, 2010). For example, greater increases in enrollment could result if the federal government, states, and community organizations conduct aggressive outreach and enrollment campaigns, while participation could be lower if states are slower to implement reform or face implementation barriers.

The new health reform law includes several opportunities to enhance Medicaid LTC, focusing on incentives for states to expand coverage of services in the community, including a new voluntary program to help pay for LTC in the community (CLASS).

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The health reform law also includes many measures to improve quality, access, and efficiency in the Medicaid program (Kaiser, “Medicaid and Children’s Health Insurance Program Provisions in the New Health Reform Law,” 2010). These include increases in provider payments, testing of new payment and service delivery models to improve quality and efficiency, and new funding for pilot programs for medical homes and accountable care organizations. The law also establishes a new federal office to improve coordination of care for older people and people with disabilities who are receiving both Medicare and Medicaid (“dual eligibles”).

In addition, the PPACA includes a number of provisions related to Medicaid and long-term care, which focus on financial incentives for states to expand Medicaid coverage of community-based long-term care and reduce over-reliance on nursing homes (Kaiser, “Medicaid and Children’s Health Insurance Program Provisions…”, 2010):

- Establishes the Community First Choice Option in Medicaid, which will allow states to provide community-based attendant supports and services to people with incomes up to 150 percent of poverty who require an institutional level of care through a state plan amendment and provides an enhanced federal match for the program
- Provides states new options to extend coverage of home and community-based services under the state plan
- Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of LTC services provided in the community
- Extends the Money Follows the Person Rebalancing Demonstration program through 2016 to help Medicaid participants in nursing homes who would like to move to the community
- Allocates new funding to continue Aging and Disability Resource Center programs, which provide assistance with information and access to the full range of available LTC services
- Provides new protections against impoverishment for spouses of Medicaid recipients who are receiving services in the community
- Includes a statement that Congress should address long-term services and supports in a comprehensive way that guarantees older people and people with disabilities care they need, available in both the community and institutions
- Establishes a new national, voluntary program to pay for long-term services and supports in the community (CLASS) (discussed later in this paper)

5. Future of the Current Medicaid Program

The future of the Medicaid program will depend largely on how financing challenges are addressed. The recession and growing Medicaid costs have led many states to make or propose cuts in services (Kaiser, “Medicaid’s Continuing Crunch…”, 2010b). However, these cuts appear to be short-sighted. For example, Lewin’s analysis of a proposal to eliminate coverage of adult day health care from California’s Medicaid program estimated that the $135 million saved from the cut would be more than offset by cost-shifting to other services and reductions to state
revenue from program elimination, resulting in a net $51 million loss to the state in 2010-11, and losses growing in the future as the population ages (Lewin, “Projected Economic Impact…,” 2010).

More promising approaches will focus on modernizing the structure of Medicaid LTC financing to spend limited resources more wisely while improving access and quality of care. In addition, initiatives to help people plan to privately finance their long-term care could help more people get the care they need without reliance on Medicaid.

B. Increasing Costs of LTC—Impacts for Medicaid and for Individuals/Families

Over the past decade, Medicaid long term care spending has slightly outpaced total health care spending -- 7.6 percent annually for Medicaid LTC spending from 1998 to 2008 compared to 7.0 percent annually for total health spending (Centers for Medicare & Medicaid Research, 2008; Burwell, 2009). Given the rapid growth in the oldest old during this period (3.1 percent annual growth in the population age 85 and older), the modest growth is somewhat unexpected. Significant declines in the use rate for nursing facility services among the oldest old contributed to holding down Medicaid spending increases (Alexxih, 2006).

Medicaid spending overall will continue to increase due to the economic decline and health reform. Although, long term care has not driven recent growth in Medicaid spending, the growing cost of LTC and growing population of people who need LTC will further stress state Medicaid budgets in the future. The cost of LTC for individuals and families paying privately has also been increasing in recent years.

1. Aggregate Cost of Medicaid Long-Term Care

Appendix A provides the most recent data on state-by-state spending on Medicaid LTC services. State Medicaid LTC expenditures in 2008 averaged $105.9 billion – 33 percent of total Medicaid spending (Burwell, 2009). Our calculations show that Medicaid LTC services accounted for 3.1 percent of all state expenditures. The states with the smallest proportion of their budgets going to Medicaid LTC at three percent were Alabama, Alaska, and Utah. The states where LTC Medicaid consumed the largest portion of state budgets were Pennsylvania (5.0 percent) Minnesota (5.1 percent), New Hampshire (5.6 percent) and New York (8.0 percent).

In 2008, Medicaid long-term care spending accounted for 33 percent of all Medicaid spending and 3.1 percent of total state expenditures.

More recently, enrollment and spending growth in the Medicaid program overall, which were originally budgeted to increase at an average of 6.6 and 6.3 percent respectively for FY 2010, have increased at a rate of 7.5 and 7.9 percent nationally (Kaiser Commission “State Fiscal Conditions and Medicaid”, 2010a). Furthermore, in the first three quarters of 2009, state revenues experienced double-digit losses which represented the largest decline on record, and 41 states are facing a mid-year budget shortfall totaling an estimated $35 billion.
The Federal Medical Assistance Percentage (FMAP) is the federal government’s share of a state’s Medicaid expenditures. Under Section 1905(b) of the Social Security Act, FMAP rates can vary from a minimum of 50 percent to a maximum of 83 percent. The match rate is determined by a state’s per capita income relative to the national average, and is calculated annually (Grady, 2008). Actual FMAP rates for FY2009 ranged from 50 to 75.84 percent. As part of ARRA, the FMAP has been temporarily increased by 6.2 percent from October 1, 2008, to December 31, 2010 (Lav et al., 2009). In addition, states which have experienced a significant rise in unemployment are eligible for an additional FMAP increase of 5.5, 8.5, or 11.5 percent. Under ARRA, the Government Accountability Office (GAO) estimates that the total federal expenditures attributable to the enhanced FMAP will be $87 billion. As mentioned, the PPACA also includes increases to the FMAP to cover the cost of expanding coverage to the low-income uninsured through Medicaid.

As of 2007, the federal government paid $190 billion (about 57 percent of the total cost) for Medicaid (Truffer et al., 2008). Factoring in the annual GAO estimates for the enhanced FMAP, the projected federal share of Medicaid costs for FY 2009-11 are $232.5 billion, $263.9 billion, and $262.8 billion (Lav et al., 2009). Medicaid spending accounted for 7.0 percent of the federal budget in 2007 and is projected to account for 8.4 percent by 2013 (CMS, 2008).

2. Private Pay Costs

Genworth’s 2010 annual Cost of Care study surveyed LTC providers nationwide about the costs of services in home care, adult day health care, assisted living, and nursing homes (Genworth, 2010). The price of assisted living showed the highest five-year annual growth rate (nearly seven percent) of all services included in the study. Despite this fact, the median annual cost of assisted living was half ($38,220) that of semi-private nursing home rooms ($67,525) and private nursing home rooms ($75,190), both of which grew at a rate of about five percent (Exhibit 6). A contributing factor to these increased costs is that many facilities have evolved to provide a more appealing living environment and more levels of care (AHIP HI-WIRE, 2010). Other factors driving increased costs in LTC facilities likely include increases in U.S. health care costs, labor costs, and the shortage of nurses.

The median annual cost of homemaker ($41,184) and home health services ($43,472) grew at the slowest rate (about 2 percent). The annualized growth rate over the last five years was not
available for adult day health care, but the median annual cost ($15,600) was significantly lower than other LTC services.

Exhibit 6. Median Cost of Private Pay Long-Term Care Services and Growth Rate, 2010

<table>
<thead>
<tr>
<th>Service</th>
<th>Median Cost (per hour/day/month)</th>
<th>Median Annual Cost</th>
<th>5-Year Growth Annual Rate</th>
<th>Growth 2009-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Services</td>
<td>$60/day</td>
<td>$15,600</td>
<td>(not available)</td>
<td>12.0%</td>
</tr>
<tr>
<td>Assisted Living base rates</td>
<td>$3,185/month</td>
<td>$38,220</td>
<td>6.7%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Homemaker/Companion</td>
<td>$18/hour</td>
<td>$41,184</td>
<td>2.4%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$19/hour</td>
<td>$43,472</td>
<td>1.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Nursing Home - semi private</td>
<td>$185/day</td>
<td>$67,525</td>
<td>4.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Nursing Home - private room</td>
<td>$206/day</td>
<td>$75,190</td>
<td>4.5%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>


Program costs across all LTC services have increased much faster over 2009 than over the previous five years. Assisted living and adult day health care rates increased 12 percent over 2009, semi-private nursing home rooms increased 5.7 percent, private nursing home rooms grew by 5.1 percent, homemaker services by 3 percent, and home health aide services by 2.7 percent.

Costs varied significantly by state. For example, the median annual rate for a stay in a private room in a nursing home ranged from $51,191 in Missouri to $202,210 in Alaska (See Exhibit 7 for the 10 most expensive and 10 least expensive states).

---

4 Assisted living base rates often do not cover all of the total needed assisted living services. Communities vary on the services they include in their base rate.
### Exhibit 7: Nursing Home Private Pay Trends from the 10 Most Expensive and 10 Least Expensive States: (private room)

<table>
<thead>
<tr>
<th>10 Most Expensive States</th>
<th>Median Daily Rate</th>
<th>Median Annual Rate</th>
<th>Percent Growth Past 5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>$554</td>
<td>$202,210</td>
<td>3%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>$376</td>
<td>$137,058</td>
<td>5%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$321</td>
<td>$116,983</td>
<td>3%</td>
</tr>
<tr>
<td>New York</td>
<td>$320</td>
<td>$116,800</td>
<td>3%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>$315</td>
<td>$114,975</td>
<td>4%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$301</td>
<td>$109,865</td>
<td>4%</td>
</tr>
<tr>
<td>Maine</td>
<td>$278</td>
<td>$101,302</td>
<td>5%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>$276</td>
<td>$100,740</td>
<td>6%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$269</td>
<td>$98,185</td>
<td>3%</td>
</tr>
<tr>
<td>Vermont</td>
<td>$262</td>
<td>$95,630</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 Least Expensive States</th>
<th>Median Daily Rate</th>
<th>Median Annual Rate</th>
<th>Percent Growth Past 5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah</td>
<td>$175</td>
<td>$63,875</td>
<td>3%</td>
</tr>
<tr>
<td>Illinois</td>
<td>$174</td>
<td>$63,601</td>
<td>4%</td>
</tr>
<tr>
<td>Georgia</td>
<td>$170</td>
<td>$61,926</td>
<td>5%</td>
</tr>
<tr>
<td>Texas</td>
<td>$161</td>
<td>$58,765</td>
<td>3%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>$155</td>
<td>$56,575</td>
<td>6%</td>
</tr>
<tr>
<td>Iowa</td>
<td>$155</td>
<td>$56,393</td>
<td>4%</td>
</tr>
<tr>
<td>Kansas</td>
<td>$155</td>
<td>$56,575</td>
<td>6%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>$143</td>
<td>$52,104</td>
<td>4%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$140</td>
<td>$51,056</td>
<td>6%</td>
</tr>
<tr>
<td>Missouri</td>
<td>$140</td>
<td>$51,191</td>
<td>3%</td>
</tr>
</tbody>
</table>

| National Average           | $206             | $75,190           | 5%                        |

Source: Genworth Financial, 2010

#### 3. Medicaid Costs

States have discretion in setting Medicaid rates for services, which are generally much lower than private pay rates. In a classic free market, industries can respond to worker shortages by adjusting prices and improving wages, benefits, and other job attributes until enough workers are willing to fill the positions. However, in the long-term care industry, which is funded primarily by Medicaid, little room is left for the market to adjust (IOM, 2008). This is especially true for nursing facilities in the two states (Minnesota and North Dakota) with a “rate equalization” law dictating that nursing homes cannot charge private pay residents more than the Medicaid rate.

Exhibit 8 shows state Medicaid rates for nursing facilities, home health, and personal care. Over half the states reported either no nursing home rate increases or a decrease for FY 2010, compared with an average annual increase of 3.1 percent over the past two years (Eljay, 2009).
A study conducted for a nursing home provider association (Eljay, 2009) found that in 2009, Medicaid reimbursed 92 cents for every allowable cost incurred by nursing facilities.

### Exhibit 8: Medicaid Rates for Nursing Facility, Home Health, and Personal Care

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>169.36</td>
<td>21.00</td>
<td>11.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>27.63/hour</td>
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<tr>
<td>Arkansas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14.25</td>
</tr>
<tr>
<td>Arizona</td>
<td>159.56</td>
<td>9.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>162.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>188.15</td>
<td>34.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>220.42</td>
<td>24.40/hour</td>
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</tr>
<tr>
<td>District of Columbia</td>
<td>250.36</td>
<td>76.00</td>
<td>17.90/hour</td>
<td>17.80</td>
<td>14.50</td>
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<td></td>
<td></td>
<td>30.80/hour</td>
<td>19.80</td>
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<tr>
<td>Florida</td>
<td>180.05</td>
<td>24.65</td>
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<td>9.70</td>
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<tr>
<td>Georgia</td>
<td>135.59</td>
<td>61.32</td>
<td>61.32</td>
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<tr>
<td>Hawaii</td>
<td>229.22</td>
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<tr>
<td>Idaho</td>
<td>180.85</td>
<td>127.81</td>
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<td>16.38</td>
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<td>117.09</td>
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<td>62.76</td>
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<tr>
<td>Indiana</td>
<td></td>
<td></td>
<td></td>
<td>29.05</td>
<td>20.07/hour</td>
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<tr>
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<td>121.34</td>
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<td></td>
<td>34.67</td>
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<td>135.82</td>
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<td>23.68</td>
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</tr>
<tr>
<td>Kentucky</td>
<td></td>
<td></td>
<td></td>
<td>34.13</td>
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<td>25.13</td>
<td>14.00</td>
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<td>176.94</td>
<td>85.95</td>
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<td>Maryland</td>
<td>218.25(^1)</td>
<td>54.61/hour</td>
<td>35.22/day</td>
<td>35.22/day</td>
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</tr>
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<td>192.01</td>
<td>24.60/hour</td>
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<td>13.16</td>
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<tr>
<td>Michigan</td>
<td>195.03</td>
<td>81.45</td>
<td>51.72</td>
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<td>7.35</td>
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<td>Minnesota</td>
<td>162.58</td>
<td>68.98</td>
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<td>15.76</td>
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<td>64.15</td>
<td>16.96</td>
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<td>Montana</td>
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<td>Nevada</td>
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<tr>
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<td>25.87/hour</td>
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<td>New Mexico</td>
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<tr>
<td>New York</td>
<td>217.59</td>
<td>29.76/hour</td>
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<td>19.16</td>
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<tr>
<td>North Carolina</td>
<td>155.69</td>
<td>49.65</td>
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</tbody>
</table>
### Medicaid and Long-Term Care Final Report

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<td>67.00</td>
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<td>Ohio</td>
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<td>112.87</td>
<td>10.56/hour</td>
<td>7.30/visit</td>
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<td>46.32</td>
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<td>144.73</td>
<td>39.71</td>
<td>63.36</td>
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<td>Wyoming</td>
<td>160.37</td>
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<td><strong>National Average</strong></td>
<td><strong>$167.02</strong></td>
<td><strong>$73.30</strong></td>
<td><strong>$48.68</strong></td>
<td><strong>$18.11</strong></td>
<td><strong>$10.64</strong></td>
</tr>
</tbody>
</table>

Note: The nursing facility rates for Maryland do not reflect a rate reduction of approximately $5 per patient day effective August 1, 2009.

**Sources:**
- Nursing facility rates are from ElJay, 2009.
- Home health and personal care rates are from Kaiser, “Medicaid Home and Community-Based Service Programs,” 2009, Table 12.

Although Medicaid rates have been found to fall short of costs in nursing facilities, the situation is even bleaker for assisted living and adult day services. Medicaid rates for services in assisted living are more difficult to compare across states because of variations in the services covered, the rate methodology (flat or tiered), and different policies regarding caps on how much participating facilities can charge residents for room and board (Mollica, 2009). All but two states (Alabama and Kentucky) cover or plan to cover services in assisted living residences. Seventeen use flat rate reimbursement with rates ranging from $35.04 a day in Georgia to $69.75 a day in Utah. Other states pay tiered rates based on the needs of the resident. Unlike nursing facilities, federal regulations do not allow Medicaid to reimburse for room and board (shelter and food) in assisted living, and the low Medicaid reimbursement for services also makes it difficult for many providers to participate. Providing affordable assisted living for lower income older adults is a challenge.
people with disabilities is a complex undertaking that requires merging two disconnected solutions: providing affordable housing and providing affordable services (Carder, Wright, and Jenkens, 2005). Meeting the growing demand for new affordable service-based housing will require coordinated efforts to combine programs, policies, and expertise.

Rates for adult day services are similarly difficult to compare across states because of differences in services covered and whether the state pays a flat daily rate, hourly rate, or tiered rates for different levels of care. As of 2006, all states funded some form of adult day services through Medicaid (O’Keeffe and Siebenaler, 2006). In an ASPE study of adult day services in five states, nearly all of the providers received a significant percentage of their operating revenue from Medicaid, and all said that the reimbursement rate did not cover their costs. For example, in North Carolina, the statewide median cost for adult day service programs offering a combination of social and health care services was $51 a day, but the Medicaid waiver program paid only $36.51 a day. To stay afloat, therefore, adult day service providers had to turn to other funding sources including state and local program funds, Veterans Administration funds, the Social Services Block Grant, and Older Americans Act funds. Several programs minimized costs by using part-time and on-call staff. In addition, several providers set their private pay rate higher than cost to subsidize the lower than cost reimbursement from public programs. Several programs relied on substantial in-kind contributions, volunteers, subsidies from parent organizations, and charitable donations.

C. Different Segments of the LTC Population vis-à-vis Financing

In terms of financing sources, the major segments of the LTC population include: self-insurers, LTC insurance buyers, those who are indigent and Medicaid eligible, and those who spend down to Medicaid.

1. **Self-financing (and other private financing) population**

The self-financing population refers to those who plan to use a portion of their retirement assets to pay for their LTC. Self-financing may be a good option for people who do not qualify for LTC insurance because of a pre-existing condition and for those who plan to use their retirement savings for their care, do not want to pay premiums for a LTC insurance policy they might not need, and are not concerned about preserving assets for their families (HHS, 2010).

A number of financing options are available for older people who plan to self-finance their LTC using their assets, including annuities, reverse mortgages, sale of the home, continuing care retirement communities, trusts, and life

---

**Segments of the LTC Population by Source of Financing:**

- **Self-financers:** may need Medicaid if incur very high LTC costs and exhaust money saved for LTC
- **LTC insurance buyers:** may need Medicaid if incur very high LTC costs that exceed the limits of the policy
- **Indigent:** Medicaid eligible and near-eligible
- **Unplanned spend-down to Medicaid:** exhaust savings, become impoverished, and turn to Medicaid due to lack of planning or misperceptions about LTC
settlements (sale of life insurance policy) (HHS, 2010). Programs that encourage self-insuring for LTC could help people prepare for their futures and reduce the number of people who need to rely on Medicaid LTC.

All but the most wealthy, however, may be at risk of eventually depleting their LTC savings fund, impoverishing themselves, and needing to turn to Medicaid if they require an intensive level of services for a long period of time, such as the five percent of Americans turning 65 who are projected to spend more than five years in a nursing facility (Kemper, Komisar, and Alexih, 2005-06).

2. Long-term care insurance financing population

Long-term care insurance is a type of insurance developed to protect against the financial risk of LTC (HHS, 2009). LTC insurance is like other types of insurance policies, in that all policy holders pay premiums and only a portion will need LTC and use their benefits. A great variety of policy options are available. The benefit amount can range from $50 a day to up to $500 a day. Most policies today provide comprehensive coverage in a range of settings, such as at home, adult day centers, assisted living communities, and nursing homes. Facility-only policies are also available and may be a lower-cost option for people who plan to receive any care at home from unpaid family members and friends. People may obtain the insurance individually or through their employer if their employer offers a LTC insurance benefit. The average buyer between ages 45 and 54 paid $1,900 annually for their coverage in 2009, according to a survey by the American Association for LTC Insurance (AALTCI, 2010c). An advantage of LTC insurance is that it is a defined benefit, whereas much of Medicaid LTC is discretionary spending subject to possible cuts every state fiscal year.

Although LTC insurance has been available since the late 1970s, it remains a small share of long-term care financing, with approximately six percent market penetration in 2004 according to the Congressional budget Office (2004). The typical LTC insurance purchaser: is age 45 to 65, has financial assets of $100,000 or more, identifies the risk of long-term care, has a strong desire to avoid the risk and “not be a burden” to their families, and is willing to purchase LTC insurance as a solution. LTC insurance is not an option for every American, due to the cost of premiums and medical underwriting.

Others may be hesitant to purchase LTC insurance because they do not want to pay a premium for many years for LTC coverage they may never use. An alternative option for people who have an annuity or retirement savings that could be converted to an annuity is asset-based long-term care insurance, i.e., a product linking either a life insurance policy or an annuity with long-term care insurance (AALTCI, 2010b). The primary advantage of these products is that the buyer will still get some benefit (life insurance or an annuity) even if they do not need LTC. Of people with non-qualified annuities age 64-plus, 76 percent say they intend to use their annuity savings in case of catastrophic illness or nursing home care (Gallup, 2009). Half of annuity.
holders in the survey were concerned that long-term care costs could bankrupt them in retirement. Asset-based LTC insurance buyers tend to be age 55 to 75, with financial assets of $300,000 or more, concerned about long-term care costs yet do not like the idea of paying premiums for something they may never use under traditional LTC insurance, and plan to self-insure with retirement savings (AALTCA, 2010c). The Pension Protection Act (PPA) of 2006 established new tax advantaged opportunities for purchasing these products for long-term care planning (Pension Protection Act, 2006). Prior to January 1, 2010, long-term care insurance benefits and charges from annuity-LTC insurance were taxable; effective January 1, 2010, benefits and LTC insurance rider charges against the account are not taxable.

Programs that provide some funding for LTC insurance—such as the LTC Partnership program, group insurance for government employees, and tax breaks—can reduce the number of people who need to exhaust their assets and spend down.

Policies specify the total amount of time or dollar amount up to which benefits will be paid, for example two years, five years, or $1 million dollars. Because most LTC insurance policies do not provide unlimited lifetime coverage to beneficiaries, policyholders may eventually need to turn to Medicaid if their care needs exceed the benefits of the policy. However, data from the LTC Partnership program show that few people with Partnership policies (292 Partnership policyholders out of 190,000, about 0.15 percent) had exhausted their benefits since the program began (GAO, 2007, p. 42). GAO noted that most Partnership policy holders purchase policies that are likely to cover all or most of their LTC expenses needed during their lifetimes (GAO, 2007, p. 40).

3. Indigent population

Medicaid is the safety net insurance program for the indigent population. To receive benefits, applicants must show that they meet very stringent financial guidelines in addition to having a health or functional need for services. In 2010, the federal income limit was $674 per month, but states can and often do set higher income limits (Kaiser, “Medicaid and Long-Term Services and Supports,” 2009; CMS, 2010). The asset limit is generally $2,000 for an individual and $3,000 for a couple in most states, although the limit is higher for the community spouse of a nursing home resident and in some states, Medicaid waiver beneficiaries receiving services in home and community based settings. The PPACA mandates that, beginning in 2014, all states apply spousal impoverishment protections to spouses of Medicaid beneficiaries receiving home and community based services (Justice, 2010).

Medicaid LTC beneficiaries are allowed to retain assets of only about $2,000, and they must contribute most of their income towards their care. They are subject to Medicaid’s “estate recovery” policy and limited in choice of service providers. Thirty-five states and D.C. allow people who are “medically needy” to become eligible by subtracting the cost of their medical and long-term care bills from their incomes. Those applying for Medicaid coverage of nursing home care are subject to a “look back” period of five years to prevent people from giving away their resources in order to qualify for Medicaid, rather than using them to pay for their medical care and long-term care. This leaves many people with modest financial means who are not eligible for Medicaid, yet unable to afford to pay privately.
People receiving Medicaid coverage of nursing home care must spend nearly all of their income (saving only a small “personal needs allowance”) towards the cost of their care, with Medicaid covering the rest, and are subject to Medicaid’s “estate recovery” policy of seeking reimbursement from the participants’ estate of Medicaid monies spent on their behalf. In addition, Medicaid participants are limited in their choices of services to those that covered by Medicaid.

4. “Tip-over” population (spend down to Medicaid)

Many people have not planned ahead for the costs of LTC, because they are confused about LTC costs and how it’s paid for, are uncomfortable thinking about the topic, or other reasons. When they need LTC, they may be surprised at how much it costs and that it is not covered by Medicare or health insurance. Given their high cost, paying for LTC services can present a daunting challenge for those who have not aside savings for this purpose or purchased LTC insurance, especially for those who develop a need for intensive services for an extended period of time.

Limited data is available about the “tip-over” population of long-term care users who begin paying privately and then spend down their resources and turn to Medicaid for assistance. Most of the studies are outdated and have focused on nursing homes. An Ohio study examined spend-down among private pay nursing home residents from 2001 to 2004 (Mehdizadeh, Nelson, and Applebaum, 2006). After six months, 12 percent of private pay nursing home residents had shifted to Medicaid; after one year, just under a third were using Medicaid. Medicaid use jumped for private pay residents who remained in the nursing home for longer stays. After two years, over half (55 percent) of private pay residents had converted to Medicaid, and at three years nearly two-thirds (64 percent) had spent down to Medicaid. The literature lacks any studies that include recent estimates of Medicaid spend down among the community population.

Family members often supplement paid services with unpaid care and/or pitching in to help pay LTC costs. In a national survey of assisted living residents, family members were the primary payment source for 10.6 percent of assisted living residents and the secondary payment source for 24.1 percent (AAHSA et al., 2009). Costs associated with family caregiving include costs to caregivers of lost wages and benefits, lost productivity to businesses, spending by caregivers on travel, and other out-of-pocket expenses associated with caregiving (FCA, 2005).

The federal Own Your Future campaign to educate people about LTC and encourage planning, and initiatives that encourage the purchase of private LTC and other private financing options, can help individuals and families plan for their LTC needs and could reduce the number of people who exhaust their life savings paying for LTC and need to turn to Medicaid. In addition, programs to assist family caregivers can help people stay at home longer and avert the need for more costly nursing home care.
V. Current Attempts to Reduce the Long-Term Care Strain on Medicaid

The federal government and states have initiated several strategies to encourage planning for LTC, with the hope that the cost of these programs would be offset by reductions in Medicaid spending for LTC. The programs described in this section fall under the overarching umbrella of initiatives to provide LTC education and awareness and incentives for LTC planning.

A. Partnerships for Long-Term Care Program

The Long-Term Care Partnership program is a collaboration between states and private insurers to encourage consumers to purchase LTC insurance (CHCS, 2007). The program allows insurance buyers to access Medicaid services while protecting and retaining more of their assets. The Partnership program was developed in the late 1980s with support from the Robert Wood Johnson Foundation as a demonstration in four states (California, Connecticut, Indiana, and New York). In theory, the program would attract people who were at risk of future reliance on Medicaid to cover LTC needs and would not otherwise have bought private insurance (CHCS, 2007). Consumers would be protected from impoverishment, and Medicaid would save money by having people obtain private insurance coverage for the initial phase of their long-term care.

The Deficit Reduction Act of 2005 allowed for the expansion of Partnership programs to other states (CHCS, 2007). The law also requires Partnership policies to include certain consumer protections, particularly the provisions of the National Association of Insurance Commissioners’ Model LTC regulations, in addition to inflation protection when purchased by a person under age 76. Thirty-seven states now offer Partnership policies, and many other states are in the process of participating (Thomson Reuters, 2010). See Appendix B for a map of state participation in Partnerships and other long-term care financing activities.

Although the program clearly benefits consumers by enabling them to rely on private insurance and Medicaid to pay for their long-term care instead of their assets, the long-term impacts on Medicaid spending are too early to be determined. A GAO study of the four initial Partnership states suggested that the programs were unlikely to generate Medicaid savings, because most of the Partnership policyholders either would have purchased insurance anyway or had sufficient assets that they would not have needed Medicaid any sooner in absence of the program (GAO, 2007). However, GAO’s methodology included some simplifying assumptions which lowered the possibility of cost savings (Meiners, 2009). In addition, the four initial states sent letters to GAO stating they were
confident that the Partnership Program would result in short-term and long-term savings to Medicaid (GAO, 2007). Ultimately, the cost-effectiveness of the program is highly dependent on how well it is marketed to people who could benefit from the policies, especially those with more modest assets, who are most likely to help achieve cost-effectiveness (Meiners, 2009). A recent report from the Connecticut Partnership program showed promising results, with the state reporting Medicaid savings of $8 million and projected savings of $170 million by 2016-2020 (State of Connecticut, Office of Policy and Management, 2010).

B. Own Your Future

The “Own Your Future” Long-Term Care Awareness Campaign is the first large-scale government effort to increase awareness of the need to plan for long-term care. The campaign was initiated in 2005 by three entities within the Department of Health and Human Services (HHS) — CMS, AoA, and the Assistant Secretary for Planning and Evaluation (ASPE) — in partnership with five states (HHS, 2006, 2008). As of February 2010, the program had expanded to 24 states and Washington D.C. (HHS, 2010) (see Appendix B). Participating states send a letter from the Governor to residents between the ages of 45-70 and hold a press conference to promote the Campaign. Campaign states often conduct additional awareness activities, including public service announcements and development and dissemination of state-based information and resources. A National Clearinghouse for Long-Term Care Information supports state campaign activities and a website where consumers can read information about long-term care and order a free Planning Kit (http://www.longtermcare.gov/).

An evaluation of the initial five states found that about eight percent of households receiving the mailing responded and ordered the Planning Kit (Long Term Care Group & LifePlans, 2006). People from all demographic groups ordered the kit. Those most likely to respond were: closer to the time when they might need long-term care (e.g., age 65-69 as compared to age 55-59); people who believed in the value and benefits of planning and were concerned about how they would pay for LTC; and people who had a close family member who needed LTC or who knew someone who had used up their savings paying for LTC. The study also found that people who received the Planning Kit were nearly twice as likely to buy LTC insurance or take other planning actions (e.g., evaluating their existing insurance coverage to see if it covered LTC, consulting with a financial planner, or looking into a reverse mortgage). Additional resources that would have allowed follow-up mailings may have resulted in a higher proportion of those contacted requesting the Planning Kit and as a result more individuals purchasing long-term care insurance or taking planning actions.

C. State Tax Incentives

For people who itemize deductions on their federal taxes, premiums for a tax-qualified LTC insurance policy count as a medical expense, and medical expenses are deductible if they exceed 7.5 percent of Adjusted Gross income. In addition, a growing number of states—as of 2008 29 states plus the District of Columbia—offer state tax incentives for the purchase of LTC insurance (See Appendix B for chart of which states) (Kaiser State Health Facts, 2008). Eighteen
states plus the District offered tax deductions, nine states offered tax credits, and two states offered both a deduction and a credit. Tax credits potentially benefit more taxpayers, because they are not limited to people who itemize their deductions (Stevenson, Frank, and Tau, 2009). Tax deductions, in contrast, provide a greater tax benefit for insurance buyers with higher incomes.

As with other programs that encourage planning for long-term care, the idea is that the program will not only help people reduce the financial risk of LTC, but will also save the government money by achieving savings in Medicaid LTC spending. Stevenson et al. (2009) analyzed the effects of state tax incentives and other factors on the take-up rate for private LTC insurance from 1996-2005 in all 50 states and D.C. The model indicated that state tax incentives were responsible for only a small portion of the growth in LTC insurance over the 10-year study period. Both types of tax incentives can be useful for increasing awareness of LTC, especially when provided in combination with other efforts to increase awareness. In terms of increasing the take-up rate for private insurance, however, tax credits were associated with a small increase in take-up rate for LTC insurance, but state tax deductions were not associated with any significant change. Most state tax benefits are small in size, and larger size tax incentives may have made a larger difference in insurance purchase rates.

D. Government Employee Long-Term Care Insurance

The federal government and a growing number of state governments (see Appendix B) offer group long-term care programs as a voluntary employee benefit (HHS, 2010). The employer typically does not pay a portion of the premium (as they do with health insurance), but they often offer a favorable group rate.

The Federal Long Term Care Insurance Program is the largest LTC insurance program in the nation, sponsored by the U.S. Office of Personnel Management for Federal employees (OPM, 2010). The program is financed entirely by enrollee premiums, with no government contribution. The program is medically underwritten, and people can be denied coverage if they have existing medical conditions. The plan provides a comprehensive benefits package covering services at home and in adult day centers, assisted living residences, and nursing homes. It also provides coverage for care provided by family members, friends, and other caregivers who are not working for an agency. Enrollees also have access to consultative services to help with decision-making and care coordination services to assist people who are beginning to need LTC with understanding their benefits and available LTC options. Twenty-nine states plus D.C. offer LTC insurance for public employees (HHS, 2010).
E. Implications of the CLASS Program Provisions

The PPACA establishes a new national, voluntary long-term care services financing program, the Community Living Assistance Services and Supports (CLASS) program. The program will be paid for through voluntary payroll deductions, and all working adults will be automatically enrolled unless they choose to opt-out (Kaiser, “Questions about Medicaid’s Role,” 2010). Premiums will be subsidized for certain groups of participants, with students and people at incomes up to 100 percent of poverty level paying just $5 a month (Rosenblatt, 2010).

The CLASS program requires a five-year vesting period before a person can claim benefits, and it provides people with functional limitations a modest cash benefit averaging at least $50 a day\(^5\) to purchase services and supports needed to live in the community (Kaiser, “Medicaid and Children’s Health Insurance Program Provisions,” 2010; AHIP HI-WIRE, 2010). This is a more limited benefit than that provided by most private insurance policies (AHIP HI-WIRE, 2010). If the benefit is $60 a day, this would cover about 3 hours of home health aide care a day or daily care in an adult day center (about 6 to 8 hours a day), based on median costs from the Genworth 2010 cost of care survey. Individuals who need more intensive assistance would need to rely on family members and friends or purchase the additional care privately, and they might eventually spend down their savings and need to apply for Medicaid.

Many details about the program have yet to be established, including eligibility requirements, premiums, and how to include people who are self-employed or work for non-participating employers (AHIP HI-WIRE, 2010). Over time, it is hoped that CLASS will help reduce Medicaid costs for nursing home care (Kaiser, “Questions about Medicaid’s Role,” 2010). However, because of the lack of medical underwriting, this unique insurance program is at risk of premiums becoming unaffordable if participation is low or if it attracts people who are primarily less healthy and more expensive to cover (AHIP HI-WIRE, 2010; Ng, 2010). In this scenario, the CLASS program would essentially benefit people who cannot obtain LTC insurance coverage in the commercial market, but would not receive broad support (Ng, 2010). A more pessimistic possibility is that CLASS might reduce the purchase of private insurance and worsen the situation for Medicaid and individuals.

Another expected outcome of the CLASS program is that it will also make Americans more aware of the limitations of Medicare and Medicaid coverage for long-term care and the need to plan ahead for their LTC needs.

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\(^5\) The amount of the cash benefit has yet to be specified but is likely to be $50 or $75 a day (Rosenblatt, 2010).
VI. Guidelines for a Comprehensive National LTC Strategy

Given the current economy and increases in the need for and cost of long-term care, a consensus has emerged acknowledging the need for solutions addressing the multiple dimensions of the LTC challenge—improving information and options for private LTC financing, modernizing Medicaid, and promoting the goals of quality of care, quality of life, healthy aging, access to an array of services that meet consumers’ needs and preferences, and support for paid and unpaid caregivers. However, attempts to address these challenges have generally been fragmented and uncoordinated, focusing on one aspect of the problem or limited to a few providers or states. Findings from this paper emphasize the need for a comprehensive national solution to long-term care financing. Guidelines for developing a national, comprehensive LTC financing strategy that meets people’s needs include:

Guidelines for a Comprehensive National LTC Solution:
- Combination of private and public financing
- Sustainable over the long-term
- Coordinated, integrated, and person-centered
- Address multiple dimensions of the LTC challenge

Mix of a strong private and public financing systems—A fair system of long-term care financing for all should include solutions that help people finance their care privately without become impoverished, in combination with a strong safety net to cover services for those who need it. In a recent national survey of over 1,000 LTC consumer advocates, provider representatives, public officials, policy experts, and other experts, most respondents (83.6 percent) favored the view that paying for LTC should be a shared responsibility, as opposed to a responsibility primarily of government, employers, individuals, or adult children (Miller, Mor, and Clark, 2010).

Long-term solutions—Solutions that focus only on immediate cost savings are short-sighted and often result in inefficiencies over the long-term. To meet the long-term care needs of today and the future will require making investments in services and structural changes that will pay off in long-term cost-savings and improved quality of care and quality of life for service participants.

Coordinated, integrated, and person-centered solutions—Traditionally, pieces of the long-term care challenge have been addressed separately—by funding stream (Medicaid, Medicare, private pay), caregiver population (family caregivers, paid caregivers), service recipient population (aging, mental health, adults with physical disabilities, people with intellectual/developmental disabilities, children with disability or chronic illness), or service setting (home, nursing facility, hospital, residential care). More integrated solutions that address similar challenges across “silos” offer potential to achieve wider-ranging results and make better use of limited resources. The best solutions look at people holistically and provide information and assistance to help link a person with the various community resources that can help meet their needs for not only long-term care services, but also their health care, social services, and economic/financial needs (Girsham, 2010).
Comprehensive solutions that address multiple dimensions of the LTC challenge — As discussed in the section below, in addition to LTC financing, a comprehensive solution must also address the need for healthy aging and prevention programs, a strong supply of prepared formal and informal caregivers, and education and awareness about LTC.

A. Components of a Comprehensive National Long-Term Care Solution

To achieve a comprehensive LTC solution will require building a strong infrastructure that includes the following components:

1) healthy aging / prevention programs,
2) a strong supply of well-prepared and supported caregivers (formal and informal)
3) education and awareness about LTC options, and
4) public and private financing solutions that meet people’s needs.

1. Healthy aging

A comprehensive LTC strategy should include efforts to prevent the need for LTC by promoting health and wellness and interventions to treat and prevent disabling conditions. The PPACA provides new federal support for prevention and wellness through the following measures (Kaiser, “Summary of New Health Reform Law,” 2010):

1) establishes a national strategy for prevention, wellness, and public health activities by creating a National Prevention, Health Promotion and Public Health Council; a Prevention and Public Health Fund; and a grant program to support the delivery of evidence-based and community-based prevention and wellness services
2) Expands coverage of preventive services in Medicare and Medicaid
3) Provides support for employer-based wellness programs, including grants to small employers that establish wellness programs and technical assistance to evaluate employer-based wellness programs.

Healthy aging initiatives offer to help reduce the need for LTC services and expenditures, as well as improving peoples’ lives. Healthy aging involves not simply a program or service, but a systems change strategy that aims to: 1) support optimal physical, mental, and social health of older adults, 2) ensure that physical environments and communities are safe and support wellness-promoting attitudes and behaviors, and 3) effectively use community programs and health services to prevent or manage the impact of disease on function (Whitelaw, 2008). The healthy aging movement aims to foster the widespread use of evidence-based health promotion programs for older adults, and to engage public and private organizations across the finance and service sectors, research, advocacy, and public agencies to create systems changes to support healthy aging.
An example of an evidence-based healthy aging program is Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) (NCOA, 2008). The program integrates depression awareness and management into existing case management programs serving older adults. Demonstrated impacts for older adults include fewer symptoms of depression, decreased physical pain, improved ability to self-manage depression, and improved well-being through achievement of personal goals. On the service provider level, the program increases service provider capacity to assist clients with depression. On the community level Healthy IDEAS resulted in increased connections between community mental health programs and other agencies and expanded opportunities for helping underserved older adults.

The literature shows older people with economic hardships such as homelessness or housing insecurity, energy insecurity, or food insecurity are particularly at risk of health problems and disability (The Lewin Group, “UHC Gaps in Care…,” 2010). This suggests that efforts to promote healthy aging for disadvantaged populations may need to combine health promotion services with linkages to other supports to help reduce risk factors for poor health.

Research to develop new ways to treat and prevent conditions and injuries driving the need for LTC, such as Alzheimer’s disease and hip fractures, could also help reduce the need for LTC, save costs, and help people live healthier lives. A recent report for the Alzheimer’s Association estimated that a treatment breakthrough that delays the onset of Alzheimer’s by five years — similar to the effect of anti-cholesterol drugs on preventing heart disease — would result in an estimated reduction in the number of people with Alzheimer’s of 1.3 million in 2020 and 5.3 million in 2050 (Alzheimer’s Association, 2010). This hypothetical treatment would lead to Medicaid costs savings for nursing home care of people with Alzheimer’s of 20 percent in 2020, and 44 percent in 2050. This equates to projected savings of $8 billion in 2020 and $66 billion in 2050.

Care coordination and care transitions programs have been gaining attention and also show potential for improving health, reducing hospitalizations, and ultimately reducing health and LTC care costs. Care coordination or case management is an interdisciplinary approach in which a care coordinator or case manager assists with accessing and using the health care and social support services needed to meet a person’s individual needs and preferences (Berenson and Howell, 2009). Care transitions provide short-term, intensive services after discharge from a facility. Several care coordination and care transitions models serving diverse populations have demonstrated evidence of reduced health care utilization and cost savings (Lewin, “UHC Gaps in Care…,” 2010). Additional research is needed to elucidate the most effective models and approaches to care coordination and transitions.

Several studies suggested that health promotion programs, including programs to help participants managing chronic illness and workplace wellness programs, may have positive effects on health (Lewin, “UHC Gaps in Care…,” 2010). For example, a study of the Lifetime Fitness Program (now known as EnhanceFitness), a group-based community exercise program in Washington State, found that program participation by those over the age of 65 resulted in substantial reductions in health care costs and risk of hospitalization (Ackermann et al., 2003). EnhanceWellness (EW), formally known as the Health Enhancement Program, is a patient-centered disease self-management program for community-dwelling elders at risk for functional decline which has been implemented in several states. Evaluations of the program
found that it reduced disability risk factors among participants, including reducing physical inactivity, increasing social activity, reducing depression, and improving self-reported health status (Phelan et al., 2002; 2006).

2. Caregiving

A comprehensive LTC solution must also recognize the need to ensure a sufficient supply of home health aides, nursing assistants, personal care assistants, and other LTC workers, in addition to informal caregivers, to provide services. Although paid and unpaid caregivers have traditionally been treated separately in policy discussions and public programs, their worlds intersect and people often receive support from both family and paid caregivers at the same time (Better Jobs Better Care, 2005). Initiatives that take a more integrated approach and acknowledge and support the needs of both family and professional caregivers could help to build effective care teams and optimize limited resources for caregiver education and support.

Addressing the nation’s future LTC needs will require building and maintaining an “adequate, skilled, and diverse” paid workforce (IOM, 2001, p. 11). A 2008 Institute of Medicine (IOM) study found that the health and long-term care workforce is inadequate on all these counts to meet the needs of older adults (IOM, 2008). Care providers trained in geriatrics are scarce, and significant shortages exist, particularly among direct service workers who support people living at home (IOM, 2008, p. 5). The Bureau of Labor Statistics projects that between 2008 and 2018, the third and fourth fastest growing occupations in the country will be home health aides and personal and home care aides (PHI, 2010).

These and other direct service workers face a host of serious challenges, including the status and image of caregiving work, shortages and high turnover, low wages and lack of health insurance or other benefits, insufficient training and education, limited career growth opportunities, difficult relationships with supervisors, and lack of respect in some workplace cultures (Lewin, 2008). Long-term care workers also face alarmingly high risk of workplace injuries. In 2008, nursing and residential care facilities experienced 12.5 nonfatal occupational injuries and illness cases per 100 full-time workers, the ninth highest rate of any occupation, coming in just behind sawmill manufacturing and outranking animal slaughtering (BLS, 2010). Common hazards for nursing and residential care workers include sprains and strains, overexertion, falls, assaults and violent acts, and slips and trips (NIOSH, 2008).

A number of federal agencies, states, and private entities have sponsored numerous programs to improve recruitment, retention, and training of the health and long-term care workforce to provide care for the growing population of older people and people with disabilities. Initiatives focused on the direct service workforce (e.g., nursing assistants, personal care assistants, home health aides, direct support professionals) include the National Direct Service Workforce Resource Center, direct service worker associations, worker registries, the Community College Caregiver Training Initiative, the High Growth Training Initiative, Cash and Counseling, Better Jobs Better Care, Real Choice Systems Change Grants, Money Follows the Person Grants, and Community-Integrated Personal Assistance Services and Supports (CPASS) (The Lewin Group,
Medicaid and Long-Term Care Final Report

Efforts focused on the professional health workforce (e.g., nurses, doctors) include the Comprehensive Geriatric Education Program, the National Health Service Corps, the Indian Health Service Loan Repayment Program, and the National Institutes of Health loan repayment program, to name a few (IOM, 2008, p. 176-181).

The PPACA provided new funding for the development of initiatives to strengthen the direct care workforce, including a national training curriculum for personal and home care aides, career ladder programs, and state comprehensive health workforce strategies (Regan, 2010). The PPACA also called for the establishment of a Personal Attendants Workforce Advisory Panel within the Department of Health and Human Services. This panel is responsible for examining and advising the Secretary of HHS and Congress on workforce policy issues including the adequacy of the number of personal care attendants, salaries, and wages and benefits. The health care provisions of the law will also benefit long-term care workers, many of whom are uninsured.

While many caregivers report caring for a family member to be rewarding, it also causes stress and financial hardship for many caregivers. Programs and policies that assist family caregivers—such as tax credits, respite services, paid time away from work, referral services, counseling, and promoting technologies to assist caregivers—can help caregivers continue to provide valuable support and could avert greater spending for paid providers (National Alliance for Caregiving, 2009).

3. Education and awareness

Consumers and their families seeking aging and disability services are often unaware of their options. Many nursing facility placements result from a lack of knowledge about community alternatives (Engelhardt, 2009).

Recent opinion polls show that misconceptions abound about where LTC is provided, how much it costs, and who pays for it. A 2006 AARP national survey of Americans age 45 and older found that little had changed since 2001 regarding the confusion over long-term care costs and financing (Barrett, 2006). Eight percent of respondents correctly estimated the monthly cost of a nursing home within 20 percent of the national average cost, and 23 percent were within 20 percent of the correct monthly cost of assisted living. Twenty-nine percent claimed that they had purchased long-term care insurance, while in reality less than 10 percent of Americans in that age group have coverage. Most respondents (59 percent) thought that Medicare would pay for an extended nursing home stay, but it does not. Long-term care is a top retirement concern of people age 55 and older, yet many people have not talked with their family members about how they would finance future LTC expenses (Genworth Financial, 2010b).

Hence, a comprehensive solution to LTC should include efforts to educate people about their LTC options and help them make informed decisions. A major national initiative to improve information and access to LTC is the Aging and Disability Resource Centers (ADRC) program, a joint effort of the
U.S. Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS). The ADRC initiative supports states to develop “one-stop shops” in communities where people can make informed decisions about their LTC options and access the services and supports they need (AoA, 2009). One of the key functions of ADRCs is to provide “options counseling” to help people understand their LTC options. The Own Your Future Long-Term Care Awareness Campaign (discussed above) is a federal-state initiative to increase Americans’ awareness of the importance of planning for future long-term care needs (HHS, 2008). As part of this effort, the Department of Health and Human Services created the website LongTermCare.gov to provide information and resources to help individuals and their families plan for future long-term care (LTC) needs.

A number of other initiatives also focus on educating consumers about their LTC options and helping them make more informed choices. For example, CMS created the “Nursing Home Compare” website (http://www.medicare.gov/NHCompare/) to help people find and compare nursing homes in their area. The Assisted Living Disclosure Collaborative, a project of the Agency for Healthcare Research and Quality (AHRQ) in partnership with the Center for Excellence in Assisted Living, is developing tools to help consumers make better choices based on improved information about costs and services in assisted living (CEAL, 2010). Many states have established worker registry websites which match people who need direct support or personal assistance at home or in the community with caregivers looking for work (DSW Resource Center, 2009). Educational materials such as the “Find Choose, Keep” toolkits (http://rtc.umn.edu/ildspworkforce/), a product of the Illinois Direct Support Professional Workforce Initiative, help consumers and their families learn skills to hire and manage their own workers.

4. LTC financing

LTC financing for elder care, the core focus of this paper, is a central component of a comprehensive national LTC strategy. The amount and structure of financing systems will affect the ability to achieve all the other components discussed above. Efforts to strengthen LTC financing should include both 1) steps to modernize the financing structure of Medicaid LTC, and 2) education and incentives to encourage people who to plan for their LTC needs by purchasing LTC insurance, setting aside funds in an annuity, or other private financing options.
VII. Conclusion and Recommendations

Fragmented and uncoordinated attempts to address long term care challenges to date generally focused on one aspect of the problem or on only a few providers or states. Findings from this paper emphasize the need for a comprehensive national solution to long-term care financing. Given the current economy and increases in the need for and cost of long-term care, solutions need to focus on the multiple dimensions of the LTC challenge:

Financing

- Preserve Medicaid as a safety net insurance program. Modernize Medicaid’s financing structure to provide more cost-effective, better quality care for people with low-incomes and for those who exhaust their private LTC financing resources by expanding HCBS and reducing unnecessary reliance on costly nursing home care, improving care coordination, and integrating Medicare with Medicaid.

- Provide financial incentives to encourage LTC insurance and other private LTC financing options. Financial incentives could include tax credits or deductions, more employer offered LTC insurance, and development of additional public-private funding solutions such as establishing LTC insurance pools to help lower the cost of LTC insurance for people who are self-employed or whose employers do not offer LTC insurance as a benefit for employees or retirees.

Healthy Aging

- Fund research to prevent disease and develop evidence-based interventions. Investing in new ways to treat and prevent conditions and injuries driving the need for LTC, such as Alzheimer’s disease and hip fractures, could also help reduce the need for LTC, save costs and help people live healthier lives. Ensure that Prevention and Wellness provisions in PPACA such as preventive services and pilot programs address key chronic issues.

- Implement effective care coordination and care transitions programs. Identifying timely and proven interventions to improve health, reduce hospitalizations, mitigate chronic conditions and ultimately reduce health and LTC care costs should be targeted to those who might benefit the most.

Caregivers

- Build and maintain an adequate, skilled and diverse paid workforce. Improve recruitment, retention, and training of the health and long-term care workforce to provide care for the growing population of older people and people with disabilities.

- Support unpaid caregivers. Offer individual counseling, support groups, caregiver training, and respite care to family and friends that provide care to individuals unable to care for themselves.

Education and Awareness

- Promote education, awareness and planning for LTC. Solutions that promote education, awareness, and planning for LTC can help individuals and families choose the options...
that best meet their needs and preferences, in addition to reducing the number of people who need to rely on Medicaid to help pay for their care. This should include continuing and expanding the existing programs such as Own Your Future and the LTC Partnership program.

- Fund Aging and Disability Resource Centers. ADRCs provide community-level access to information, assistance, options counseling, and eligibility for long term care services.

Over the next 20 years, in advance of the first baby boomers turning 85 in 2030, the United States has a window of opportunity to enact meaningful long term care changes. Although this target may not seem to imply a sense of urgency, achieving the goals for a comprehensive long-term care system and infrastructure (e.g., preparation of the LTC workforce, widespread dissemination of effective models of care, adequate personal planning for LTC needs) will require many years of effort. Hence, the time to act is now.

In assessing potential solutions, policymakers should consider the short-term and long-term impacts not only on the Medicaid LTC program, but also the broader impacts on federal and state budgets, and the effects on individuals and families in terms of access and quality of care and quality of life.
## Appendix A: Medicaid Spending by State

<table>
<thead>
<tr>
<th>State</th>
<th>FY 2008 Medicaid LTC Expenditures (in millions)</th>
<th>FY 2008 Total Medicaid Expenditures (in millions)</th>
<th>Total FY 2008 State Expenditures (in millions)</th>
<th>FY 2008 State Medicaid LTC Expenditures (in millions)</th>
<th>Medicaid LTC Spending as a Percent of All State Expenditures</th>
<th>Medicaid LTC Spending as a Percent of All Medicaid Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$1,289</td>
<td>$4,066</td>
<td>$40,159</td>
<td>$417</td>
<td>1.0%</td>
<td>32%</td>
</tr>
<tr>
<td>Alaska</td>
<td>$332</td>
<td>$963</td>
<td>$12,322</td>
<td>$158</td>
<td>1.3%</td>
<td>35%</td>
</tr>
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<td>Arizona*</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Arkansas</td>
<td>$1,032</td>
<td>$3,350</td>
<td>$16,899</td>
<td>$279</td>
<td>1.7%</td>
<td>31%</td>
</tr>
<tr>
<td>California</td>
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<td>$33,539</td>
<td>$194,276</td>
<td>$5,013</td>
<td>2.6%</td>
<td>30%</td>
</tr>
<tr>
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<td>$1,168</td>
<td>$3,187</td>
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<td>2.3%</td>
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</tr>
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<td>Connecticut</td>
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<td>29%</td>
</tr>
<tr>
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<td>29%</td>
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<td>$36,762</td>
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<td>28%</td>
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<tr>
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<td>$11,160</td>
<td>$174</td>
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<td>33%</td>
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<tr>
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<td>33%</td>
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<tr>
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<td>$11,675</td>
<td>$46,877</td>
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<td>3.4%</td>
<td>27%</td>
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<tr>
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<tr>
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<tr>
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<tr>
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<td>3.0%</td>
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<tr>
<td>Massachusetts</td>
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<td>$44,146</td>
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<td>28%</td>
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<tr>
<td>Michigan</td>
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<td>$9,763</td>
<td>$43,982</td>
<td>$956</td>
<td>2.2%</td>
<td>23%</td>
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<tr>
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<td>$15,599</td>
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<td>25%</td>
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<tr>
<td>Montana</td>
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<td>$99</td>
<td>2.2%</td>
<td>40%</td>
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<tr>
<td>Nebraska</td>
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<td>$1,584</td>
<td>$8,712</td>
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<td>3.2%</td>
<td>42%</td>
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<tr>
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<tr>
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<td>39%</td>
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<td>Oklahoma</td>
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<td>$3,526</td>
<td>$19,962</td>
<td>$383</td>
<td>1.9%</td>
<td>33%</td>
</tr>
</tbody>
</table>
## Medicaid and Long-Term Care Final Report

### FY 2008 Medicaid LTC Expenditures (in millions)

<table>
<thead>
<tr>
<th>State</th>
<th>FY 2008 Medicaid LTC Expenditures</th>
<th>FY 2008 Total Medicaid Expenditures</th>
<th>Total FY 2008 State Expenditures</th>
<th>FY 2008 State Medicaid LTC Expenditures</th>
<th>Medicaid LTC Spending as a Percent of All State Expenditures</th>
<th>Medicaid LTC Spending as a Percent of All Medicaid Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>$1,104</td>
<td>$3,191</td>
<td>$22,644</td>
<td>$432</td>
<td>1.9%</td>
<td>35%</td>
</tr>
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<td>Pennsylvania</td>
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<td>40%</td>
</tr>
<tr>
<td>Rhode Island</td>
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<td>South Carolina</td>
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<td>25%</td>
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<td>Vermont*</td>
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<tr>
<td>Virginia</td>
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<td>$5,365</td>
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<td>33%</td>
</tr>
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<td>Washington</td>
<td>$2,029</td>
<td>$6,400</td>
<td>$31,732</td>
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<td>32%</td>
</tr>
<tr>
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<td>$221</td>
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<td>38%</td>
</tr>
<tr>
<td>Wisconsin*</td>
<td>$1,915</td>
<td>$5,179</td>
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<td>2.2%</td>
<td>37%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>$208</td>
<td>$486</td>
<td>$4,958</td>
<td>$104</td>
<td>2.1%</td>
<td>43%</td>
</tr>
<tr>
<td><strong>National Total</strong></td>
<td><strong>$105,912</strong></td>
<td><strong>$323,105</strong></td>
<td><strong>$1,477,771</strong></td>
<td><strong>$46,450</strong></td>
<td><strong>3.1%</strong></td>
<td><strong>33%</strong></td>
</tr>
</tbody>
</table>

*Note: Arizona does not report long term care spending through the Medicaid MSIS system because the State covers these services under a capitated program. Vermont and Wisconsin also have substantial portions of their spending missing from this table as a result of a managed LTC program.


Appendix B: Map of State Activities to Encourage Planning for LTC

Sources:
- Partnerships for LTC: http://www.dehpg.net/ltcpartnership/map.aspx
- Own Your Future: http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/State/index.aspx
- LTC insurance tax incentives: http://www.statehealthfacts.org/comparetable.jsp?ind=381&cat=7
- LTC insurance for state employees: http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Private_Programs/LTC_Insurance/index.aspx
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http://www.alz.org/documents_custom/trajectory.pdf


http://www.urban.org/uploadedpdf/1001316_chronic_care.pdf
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