A Dozen Long Term Care Myths and Their Implications for Medicaid Reform

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A dozen myths related to …

- Financing of long term care (LTC)
- The role of Medicaid
- Medicaid eligibility
- Possibilities for the future
- Health promotion
- Quality

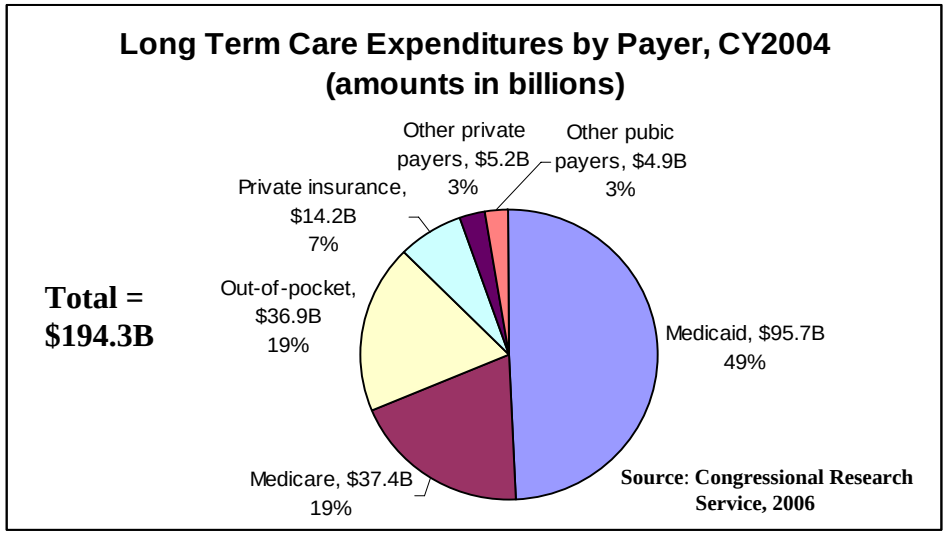
Myth #1:

Medicaid pays the vast majority of LTC costs.

Medicaid pays one-half of LTC, but out-of-pocket underestimated and informal not counted

Economic value of informal care estimated at $257B annually

- Paid services supplement, not supplant informal care



Implications for Medicaid LTC Reform

- Enhance supports for informal caregivers
  - Education and access to information
  - Tax subsidies or other incentives to encourage family responsibility
  - Consumer direction (individual budgets/"cash and counseling")
  - Respite benefits
  - Eliminate $^1/_3$ reduction in SSI benefits when live with others because it discourages informal caregiving arrangements

Myth #2:

Most people who require supports as a result of a disability live in institutions.

More Medicaid spending for institutions, but more people needing support live in the community

- Medicaid nursing facility 75% of LTC for aged/disabled and ICF-MR 42% for MR/DD
- Among elderly needing supports, 80% live in the community
  - 65% of these get unpaid support from family and friends only
  - 23% get both paid and unpaid supports
  - 10% get paid supports only
- Among non-elderly with disabilities, 95%+ live in the community
- People want community care and for most it can cost less

Implications for Medicaid LTC Reform

- Make home and community-based services an entitlement with equal status and ease of access as nursing facility care
  - Need more visible and easier avenues to gain access to public community-based programs

Myth #3:

Medicaid does not pay for housing.

Medicaid pays for nursing facility room and board costs

- Medicaid does not pay for community-based housing
- SSI benefits for those in the community with Medicaid supports becomes the primary means for paying for housing and other living costs
  - In 2006, federal SSI pays $603 per month ($7,236 annually) for an individual – often insufficient to maintain a household

Implications for Medicaid LTC Reform

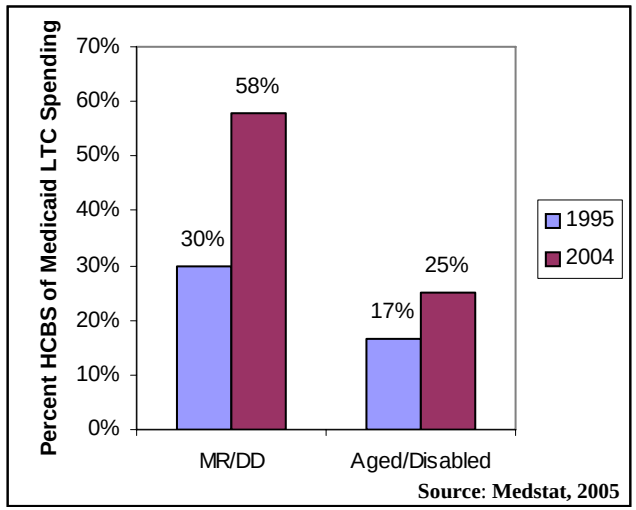
- For community options to be viable, SSI benefits need to adequately cover living expenses
- Efforts to shift to HCBS require coordination with affordable and accessible housing options

Myth #4:

States have made consistent progress in shifting to HCBS across disability populations.

Greater progress "rebalancing" LTC for MR/DD than aged and disabled

- Proportion of Medicaid LTC spending on HCBS for MR/DD nearly doubled over the past decade while A/D grew at half that rate
- Progress is also uneven by state



Implications for Medicaid LTC Reform

- Consistent effort on the A/D side needed to shift focus from nursing facility to HCBS – increased availability of HCBS
- DRA Money Follows the Person will move nursing facility residents to community
- Diverting entry requires intervention in critical pathways to nursing facilities (e.g., Aging and Disability Resource Centers)
  - Active and consistent pre-admission screening and counseling
  - Outreach to and coordination with hospital discharge planners, physician's offices, and others

Myth #5:

Many beneficiaries of Medicaid LTC qualify because they divested their assets.

Empirical evidence finds few Medicaid recipients use trusts or give away assets

- Little empirical evidence supports claims that large numbers of elderly plan their estates to gain access to Medicaid nursing home coverage (O'Brien, 2005).
- Older adults and younger individuals with disabilities generally have limited income and resources.
  - In 2004, 24.2% of non-elderly adults with disabilities had income below poverty (compared to 9.2% of the non-disabled)
  - 12.8% of elderly with disabilities had income below poverty (compared to 7.1% of the non-disabled)

Implications for Medicaid LTC Reform

- DRA has already lengthened the look-back period for penalties

Myth #6:

People on Medicaid contribute little to the cost of their care.

Medicaid nursing facility residents contribute nearly all their income

- Nursing facility residents with Medicaid financing contribute all of their income with the exception of a personal needs allowance ($30-$100/month)
  - On average, Medicaid nursing facility residents contribute 20% of their cost
- Many states also require cost-sharing for their HCBS waiver
- Medicaid rules protect the primary residence while the individual or their spouse is alive
  - OBRA '93 mandated estate recovery
  - In 2003, states recovered a total of $347.4 million – on average 0.5% of Medicaid LTC costs, however, Oregon recovered 2.2% (AARP, 2005)

Implications for Medicaid LTC Reform

- Allow alternative cost-sharing rules or income and asset tests for LTC
  - Sliding scale payments can allow those with higher incomes to access HCBS services and avoid nursing facility admission
- Encourage/require more effective estate recovery efforts

Myth #7:

Increasing HCBS will reduce Medicaid spending.

As a result of demographics, Medicaid LTC spending will invariably increase

- Expanding HCBS can increase the number of people served & could reduce the rate of increase.

Among A/D	1995	2005
% HCBS Users	54%	75%
% HCBS $s	18%	48%

- During the past decade, Washington State increased the number of A/D individuals served through Medicaid LTC by 30% and the rate of growth in the state's overall spending remained near the national average.

Implications for Medicaid LTC Reform

- Flexible, global budgets rather than line items by service
- Assessing severity of disability and availability supports key to successfully maintaining individuals in the community
  - Individualized budgets as a method to tailor benefits/$s to needs
- Technology can speed eligibility determination and help states monitor spending

Myth #8:

Baby Boomers recognize the need to plan for LTC in their future.

Few Americans plan ahead for LTC needs

- Less than 10% of those age 50+ own a long term care insurance policy
- Baby boomers had children later than any previous generation and worry more about college tuition than financing future LTC needs
- Women age 40-44 who never had children doubled from 1976-today (10% to 20%)
- About two-thirds of all Americans will likely need some type of supportive services after age 65

Implications for Medicaid LTC Reform

- Encourage planning for future LTC needs through education campaigns and individual counseling
  - DRA builds on Own Your Future campaign
- Create trusted places to obtain LTC information to help people plan ahead and deal with immediate crises.

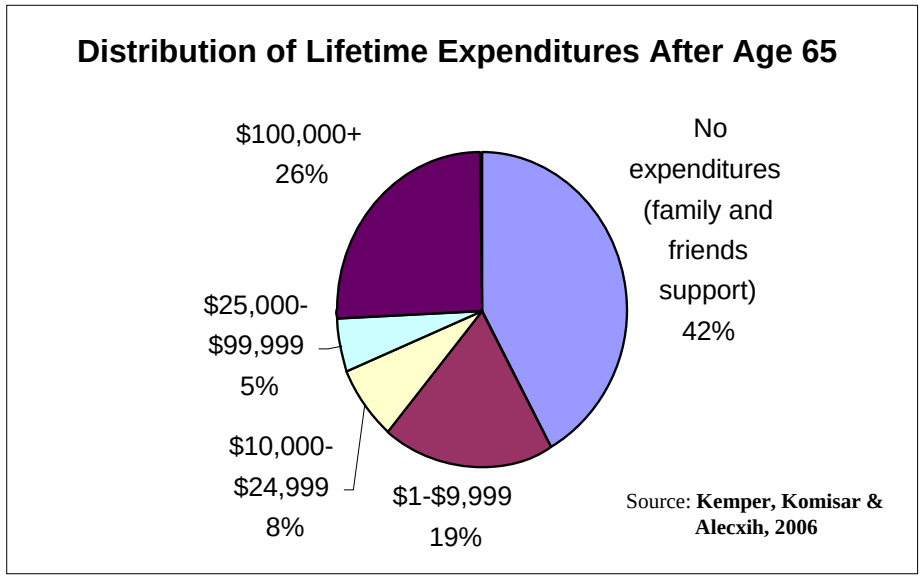
Myth #9:

Individuals can save enough to cover their LTC costs.

While most could save enough, over 25% would face expenses over $100,000

- 2000 median net worth among elderly was $110,000, but only $25,000 excluding home equity

Average lifetime per capita at age 65 = $47,000



Implications for Medicaid LTC Reform

- Without a broader social insurance approach, Medicaid needed as a safety net
- Need to encourage early saving and/or remove potentially perverse incentives regarding Medicaid eligibility
  - Possible vehicles through medical savings accounts or retirement accounts

Myth #10:

LTC insurance & reverse mortgages can solve the financing dilemma.

LTC insurance & reverse mortgages can increase the LTC options for a subset of Americans

- But these private sources are not a silver bullet
- Long term care insurance policies can be expensive and may be unaffordable for many middle-income Americans.
- Because of the limited nature of the benefits offered and fairly high lapse rates, despite increased purchase, the role of long term care insurance in financing services in the future may not grow much.
- Older adults own nearly $3 trillion in home equity, yet few take advantage of methods to tap this resource.

Implications for Medicaid LTC Reform

- Encouraging purchase at younger ages would be the most effective policy for increasing the role of LTC insurance.
- Public-private LTC insurance partnership expanded through DRA.
- Policies to use home equity need to overcome older adults' strong desire to leave an inheritance.
- Standardizing the reverse mortgage process could promote the use and/or access to assistance for care planning when using personal assets.

Myth #11:

People with disabilities would not benefit from health promotion activities.

Health promotion can provide significant benefits to those with disabilities

- Two thirds of individuals with a disability also have a chronic condition
- The Stanford Chronic Disease Self-Management Program significantly improves participant health status while reducing the use of hospital care and physician services.

Implications for Medicaid LTC Reform

- Providing individuals with information and tools to manage their chronic illness and create incentives for the consistent application of practice guidelines in all settings can improve quality of life and reduce health care expenditures
  - Chronic disease self-management, physical activity and falls prevention
  - Reminders for practice guidelines
- Eliminate barriers for coordination between Medicare and Medicaid services
- High cost beneficiary case management with a health promotion component

Myth #12:

Quality care can be assured through process requirements.

Workforce quality and responsiveness to the individual are more critical

- Process measures alone have failed to significantly improve quality in nursing homes
- Recent efforts to incorporate outcome measures for both nursing facilities and HCBS
  - Quality of life, functional independence, staffing, health and wellness
- CMS demonstration of pay for performance for nursing facilities

Implications for Medicaid LTC Reform

- Continue efforts to focus on outcomes
  - Resident centered initiatives
- Need to encourage workforce retention

Top Five Medicaid LTC Recommendations

1) Eliminate the barriers and actively encourage Medicare and Medicaid integration.
2) Make HCBS an entitlement with equal access as NF care, which means active intervention into critical pathways.
3) Enhance supports to family and friends as caregiver.
4) Effective, consistent, person-centered service coordination that goes beyond medical or LTC specific, but does both plus heath promotion, housing, transportation and others that enables productive community living.
5) Institute individualized budgets, consumer direction and cash and counseling.

Two Non-Medicaid LTC Recommendations

- Efforts to encourage people to plan ahead for LTC.
- Sufficient SSI payments or additional housing supports to realistically live in the community.