LONG-TERM CARE
CHALLENGES AND SOLUTIONS FOR STATES

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Long-Term Care in the United States: A short list of issues

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Southern Legislative Conference of
The Council of State Governments
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Short List of Issues – A Very Short List...

- Demographics – The aging population is growing at a dramatic rate

- Supply of family caregivers - The backbone of LTSS unlikely to keep pace with future demand

- Expanding HCBS – Shifting Medicaid spending away from institutional care and toward HCBS alternatives

- Financing LTSS – Solutions are needed to address potentially catastrophic costs of LTSS
Dramatic Growth of the Aging Population

- Age 85 and older population is growing at a dramatic rate
  - Age group most likely to need LTSS to help with everyday tasks
  - Higher rates of disability than younger people
  - Prevalence of dementia
    - 32% of people age 85+
  - More likely to be living alone, without a spouse or other family member to provide them with assistance

- Baby boomers turn 85 in just 14 years

- States are making significant changes in the way they deliver and fund LTSS
  - But, will states be equipped to address the needs of the growing aging population in the not too distant future?
Skyrocketing Rate of the Age 85+ Population

Source: AARP Data Explorer
Southern States with Largest Projected Percentage Change in Age 85+ Population, 2015 - 2050

- Florida: 199% (FL)
- Georgia: 315% (GA)
- North Carolina: 237% (NC)
- South Carolina: 282% (VA)
- Tennessee: 204% (TN)
- Texas: 284% (TX)
- Virginia: 239% (SC)

Source: AARP Data Explorer
Projected Percentage Change Age 85+ Population, All Southern States, 2015 - 2050

Source: AARP Data Explorer
“You Take Care of Mom, But Who Will Take Care of You?”

- Family caregivers provide the majority of LTSS

- Supply of family caregivers unlikely to keep pace with future demand

- Projected family caregiver support ratio in the US
  - In 2015, almost 7:1 ratio
  - In 2030, ratio declines to 4:1
  - In 2050, further decline to just under 3:1

- Rising demand and shrinking families to provide LTSS call for new solutions to the financing and delivery of LTSS and family support
Projected Family Caregiver Support Ratio: Southern States, 2015 - 2050

<table>
<thead>
<tr>
<th>State</th>
<th>2015</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>6.26</td>
<td>5.78</td>
<td>5.55</td>
</tr>
<tr>
<td>Louisiana</td>
<td>5.84</td>
<td>5.52</td>
<td>5.49</td>
</tr>
<tr>
<td>Mississippi</td>
<td>5.39</td>
<td>5.17</td>
<td>5.14</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>5.14</td>
<td>4.92</td>
<td>4.88</td>
</tr>
<tr>
<td>Alabama</td>
<td>4.91</td>
<td>4.70</td>
<td>4.66</td>
</tr>
<tr>
<td>West Virginia</td>
<td>4.77</td>
<td>4.56</td>
<td>4.52</td>
</tr>
<tr>
<td>Arkansas</td>
<td>4.63</td>
<td>4.42</td>
<td>4.39</td>
</tr>
<tr>
<td>Texas</td>
<td>4.50</td>
<td>4.29</td>
<td>4.25</td>
</tr>
<tr>
<td>Tennessee</td>
<td>4.37</td>
<td>4.16</td>
<td>4.12</td>
</tr>
<tr>
<td>Georgia</td>
<td>4.24</td>
<td>4.04</td>
<td>3.99</td>
</tr>
<tr>
<td>Kentucky</td>
<td>4.11</td>
<td>3.91</td>
<td>3.86</td>
</tr>
<tr>
<td>Missouri</td>
<td>3.98</td>
<td>3.78</td>
<td>3.73</td>
</tr>
<tr>
<td>South Carolina</td>
<td>3.85</td>
<td>3.65</td>
<td>3.61</td>
</tr>
<tr>
<td>North Carolina</td>
<td>3.72</td>
<td>3.52</td>
<td>3.48</td>
</tr>
<tr>
<td>Virginia</td>
<td>3.59</td>
<td>3.39</td>
<td>3.35</td>
</tr>
<tr>
<td>Florida</td>
<td>3.46</td>
<td>3.27</td>
<td>3.23</td>
</tr>
</tbody>
</table>

Source: AARP Data Explorer
Expanding HCBS... Why it Matters

- Medicaid has an institutional bias
- Outdated and ageist prejudices
- 90% want to remain in their homes and community as they age

Avoid unnecessary institutionalization by providing HCBS
- In 2014, 12.2% of nursing home residents in southern states had low care needs (below the US national average)
  - Nursing home diversion or taking steps to transition back to community may be limited due to insufficient alternatives

- HCBS are less costly than institutional services
Expanding HCBS – Shifting to a More Balanced LTSS System

- Balancing LTSS delivery systems
  - Expanding access to HCBS and reducing dependence on institutional care

- Dial is moving to shift Medicaid spending away from nursing homes to HCBS alternatives
  - Much room for improvement!
Medicaid LTSS Spending Balance: Older adults and adults with physical disabilities, 2013

Source: Source: Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Truven Health Analytics, June 2015.

AARP Data Explorer
Rebalancing Medicaid LTSS Institutional Spending Toward HCBS

Percentage of Medicaid LTSS Spending for Older Adults and Adults with Physical Disabilities Going to HCBS: Southern States, 2001 and 2013

- HCBS includes Aged/Disabled Waivers, Personal Care Services, Home Health, PACE, 1915j Self-Directed Services
- Source: AARP Public Policy Institute
LTSS Financing: Primary Payer for LTSS – Medicaid

Total National LTSS Spending, 2013 = $310 billion

- Medicaid: 51%
- Private LTCI: 8%
- Out of Pocket: 19%
- Other Public: 21%

Financing LTSS

- Solutions are needed to address potentially catastrophic costs of LTSS
  - High outlay of public expenditures, individuals are ill prepared for high out-of-pocket costs, skyrocketing 85+ population, and fewer family caregivers

- New sources of both public and private financing are needed
  - Need a mix of financing sources that include social insurance, private insurance, and savings, plus strong safety net protections

- Government and individuals to share responsibility

- Progressive, broad-based, stable, affordable, and capable of growing with enrollment
Thank you!

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The Case for Financing Older America’s Long-Term Care Need
A Risk We All Face

Half of Adults Age 65+ Will Need a High Level of Care at Some Point

Favreault & Dey (2015), Table 1
Women Face Higher Lifetime Risk

50% of Men Age 65+ Will Face High Levels of Need
60% of Women Age 65+ Will Face High Levels of Need

Note: Percentages in picture are approximate. Actual values are 46.7% of men, and 57.5% of women. Favreault & Dey (2015), Table 1
Older Adults Risk Many Years of High Need

52% of Adults Age 65+ Have High Need

- Need Lasts <2 Years
- Need Lasts 2-5 Years
- Need Lasts >5 Years
- No Need

Favreault & Dey (2015), Table 1
And Risk VERY High LTC Costs Over Lifetime

Favreault & Dey (2015), Table 5
Much of Which is Covered by Families Through Out of Pocket Spending

- **All Services**: 52% Out of Pocket, 34% Medicaid, 13% Other
- **Home & Residential Care**: 68% Out of Pocket, 19% Medicaid, 13% Other
- **Nursing Home Care**: 35% Out of Pocket, 51% Medicaid, 14% Other

Note: The estimated remainder of spending (Other) includes a combination of private LTC insurance and Medicare. Favreault & Dey (2015), Table 3A
And Unpaid Family Caregiving

Nearly 2/3 of Older Adults with LTC Needs Living at Home Receive All Help from Unpaid Family and Friends

Note: Excludes individuals living in nursing homes
Freedman & Spillman (2014), Table 2
New Insurance-Based Options for Financing LTC
SUMMARY

Reform the private insurance marketplace to provide lower priced policies of limited duration (ideal for front end risk)

- Limited duration products (e.g., 2 years)
- Auto-enroll through employer
- Expanded use of retirement accounts to purchase products

<table>
<thead>
<tr>
<th>BPC</th>
<th>Leading Age</th>
<th>The Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific recommendations to establish a lower cost, limited benefit product</td>
<td>Supports innovations in the private insurance market that emphasize consumer choice and flexibility</td>
<td>Suggests a series of initiatives to revitalize private sector specifically to cover front-end risk</td>
</tr>
</tbody>
</table>
With Public Catastrophic Coverage

SUMMARY

*Protect everyone against the risk of high LTSS need that occurs over long periods of time.*

Groups will continue to work on details, including how to define catastrophic risk and how to finance it.

<table>
<thead>
<tr>
<th>BPC</th>
<th>Leading Age</th>
<th>The Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A public insurance approach for catastrophic expenses is worthy of consideration</td>
<td>Supports concept of universal insurance as having the biggest impact</td>
<td>Recommends a universal catastrophic insurance program</td>
</tr>
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</table>
Mandatory & Voluntary: Three Approaches to Covering Risk

Years of Need

1  2  3  4  5

Comprehensive Coverage

Front-End Coverage

Catastrophic Coverage
Mandatory Option Creates Largest Medicaid & Out-of-Pocket Savings

Favreault & Johnson (2015), Table 15
Impacts of Mandatory Approaches

<table>
<thead>
<tr>
<th></th>
<th>Front-End</th>
<th>Catastrophic</th>
<th>Comprehensive</th>
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<tbody>
<tr>
<td>Out-of-Pocket Reduction</td>
<td>14%</td>
<td>16%</td>
<td>24%</td>
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<tr>
<td>Medicaid Reduction</td>
<td>8%</td>
<td>28%</td>
<td>32%</td>
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Favreault & Johnson (2015), Table 15
New Mandatory Approaches Shift Spending in Different Ways

<table>
<thead>
<tr>
<th>APPROACHES</th>
<th>SPENDING BREAKDOWN</th>
<th>AVG LIFETIME SPENDING</th>
<th>PAYROLL TAX RATE</th>
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<tbody>
<tr>
<td>Current</td>
<td>2% 56% 41%</td>
<td>$135,000</td>
<td>—</td>
</tr>
<tr>
<td>Front-End Mandatory</td>
<td>19% 46% 36%</td>
<td>$144,600</td>
<td>0.60%</td>
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<tr>
<td>Catastrophic Mandatory</td>
<td>30% 43% 27%</td>
<td>$147,900</td>
<td>0.75%</td>
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<tr>
<td>Comprehensive Mandatory</td>
<td>38% 37% 25%</td>
<td>$154,300</td>
<td>1.35%</td>
</tr>
</tbody>
</table>

Favreault & Johnson (2015), Tables 1 and 16
Sources


#LTCFinancing
Managing LTSS Spending in Virginia’s Medicaid Program
Virginia LTSS spending has been increasing and shifting toward community-based services.

Note: Spending data not adjusted for inflation.
Reliable functional screenings ensure equitable access for only eligible recipients

- Individuals must meet medical and functional criteria to be eligible for LTSS
- Screenings need to be consistent and reliable to ensure equitable access to services
- Recipients choose community-based or institutional care once they are determined to be eligible
Results of eligibility screenings vary significantly across screening teams

NOTE: Teams that screened at least 100 individuals in FY16.
LTSS eligibility screening process creates risk of unreliable results

- Training for screeners is not consistent or mandatory
- No inter-rater reliability testing to validate consistency between screeners
- Recent oversight efforts in Virginia focused on improving timeliness of screenings, not reliability
Virginia is taking several steps to ensure reliable screenings

Proposed legislation in the current Virginia General Assembly would:
- Develop a single, comprehensive training curriculum and require screeners be trained and certified
- Implement an inter-rater reliability process
- Provide funding for improved oversight of the reliability of screenings
Serving recipients in lower-cost, community settings presents opportunity for savings

- Annual cost per recipient for community-based services is $12,000 less than nursing facilities, on average

- Research indicates that recipients have better health outcomes when served in the community
Shift towards HCBS driving down per recipient LTSS spending in Virginia Medicaid

<table>
<thead>
<tr>
<th></th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
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<tbody>
<tr>
<td><strong>Institutional</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Average enrollment</td>
<td>19,944</td>
<td>19,783</td>
<td>19,441</td>
<td>19,246</td>
<td>19,332</td>
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<tr>
<td>Spending per enrollee</td>
<td>$51,916</td>
<td>$53,443</td>
<td>$55,413</td>
<td>$55,415</td>
<td>$50,685</td>
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<tr>
<td><strong>HCBS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Average enrollment</td>
<td>29,552</td>
<td>32,530</td>
<td>35,952</td>
<td>38,880</td>
<td>42,414</td>
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<tr>
<td>Spending per enrollee</td>
<td>$34,893</td>
<td>$34,289</td>
<td>$33,956</td>
<td>$33,990</td>
<td>$32,417</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average enrollment</td>
<td>49,496</td>
<td>52,313</td>
<td>55,392</td>
<td>58,126</td>
<td>61,746</td>
</tr>
<tr>
<td>Spending per enrollee</td>
<td>$41,752</td>
<td>$41,533</td>
<td>$41,486</td>
<td>$41,084</td>
<td>$38,137</td>
</tr>
</tbody>
</table>

Note: Spending data not adjusted for inflation.
80% of hospital screenings in Virginia are recommended for nursing facility care.
Hospitals recommend more institutional placements for several reasons

- Difficult to assess individuals’ long-term needs when they are hospitalized for acute conditions
- Difficult to assess individuals’ ability to function safely in the home without screening at home
- Hospital staff are focused on discharging patient efficiently to a safe setting
Blended capitation rates provide strongest rebalancing incentive for MLTSS programs

- CMS recommends a blended rate, which pays MCOs based on an expected percentage of recipients in the community-based care.
- Blended rates create strong, long-term incentive to shift toward community-based services.
- Virginia used a blended rate for its dual-demonstration program, but did not establish a target mix.
Virginia is taking several steps to encourage further rebalancing

Proposed legislation in the current Virginia General Assembly would:

- Provide funding for Virginia to assess if hospital screenings lead to unnecessary institutionalizations and develop solutions
- Require Virginia to use a blended capitation rate with a target mix to incentivize MCOs to continue progress
Contact Information

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