



LONG-TERM CARE

CHALLENGES AND SOLUTIONS FOR STATES

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

Kathleen Ujvari
Senior Strategic Policy Advisor,
AARP Public Policy Institute
Washington, DC

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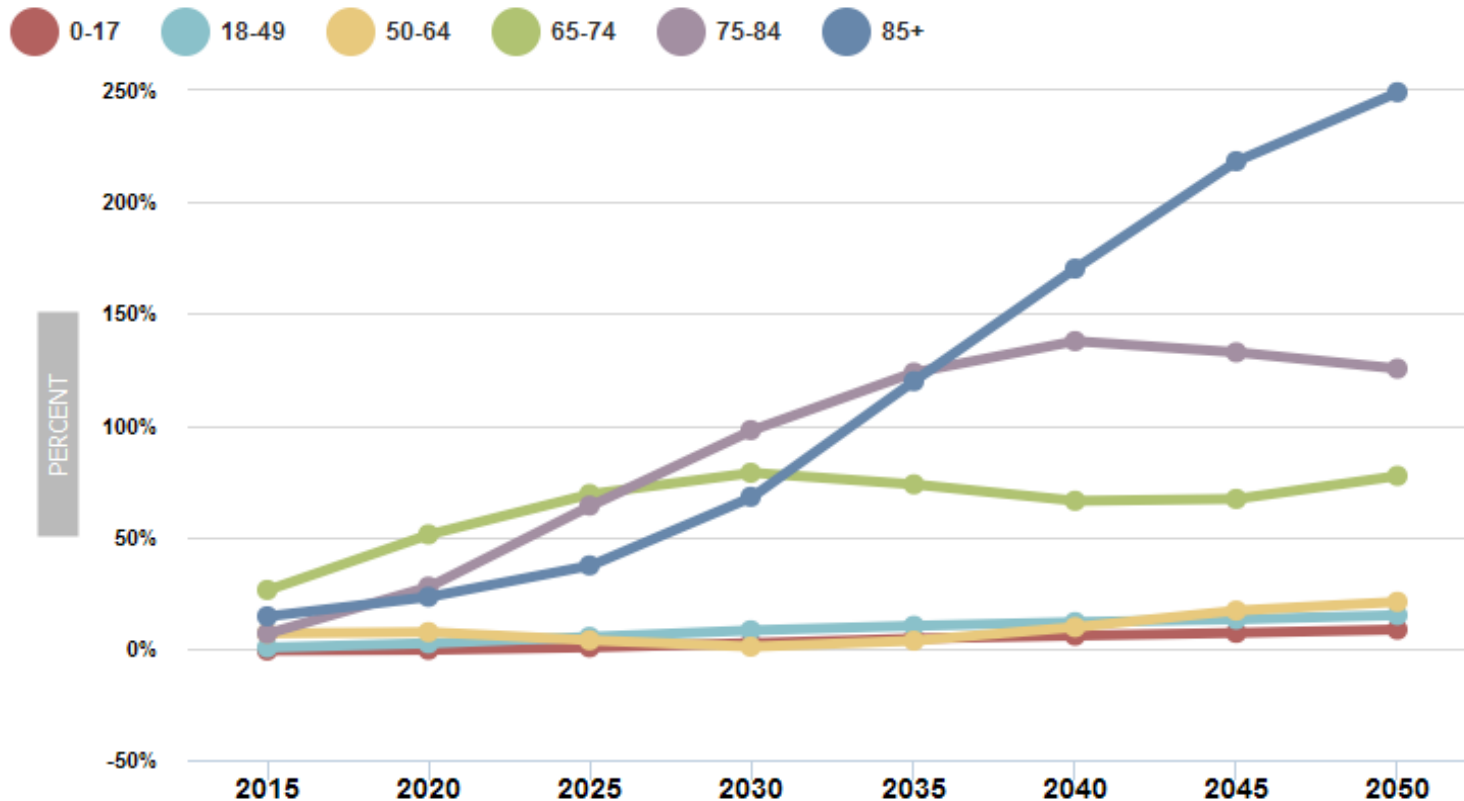
Short List of Issues – A Very Short List...

- 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

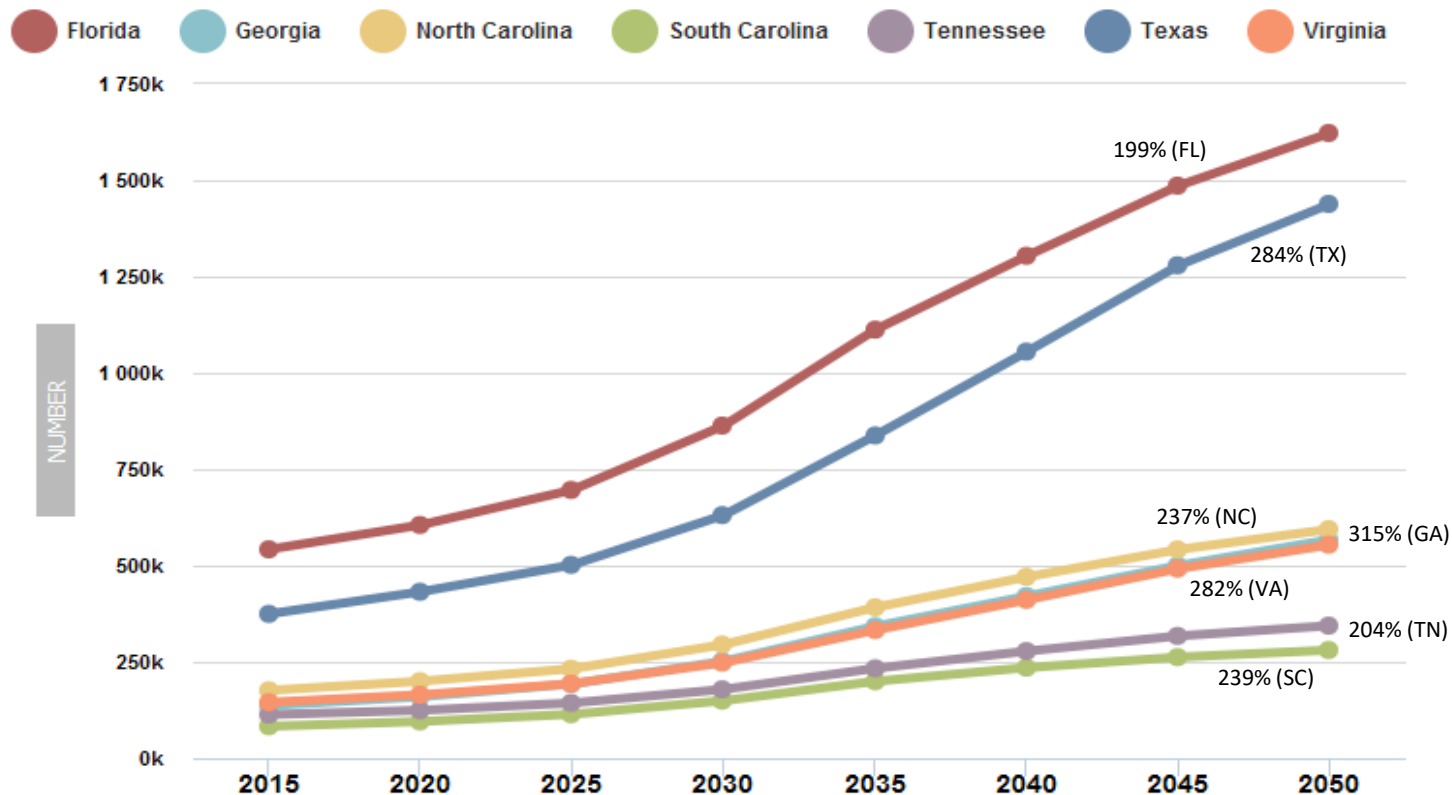
- Age 85 and older population is growing at a dramatic rate
 - Age group most likely to need LTSS to help with everyday tasks
 - Higher rates of disability than younger people
 - Prevalence of dementia
 - 32% of people age 85+
 - More likely to be living alone, without a spouse or other family member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



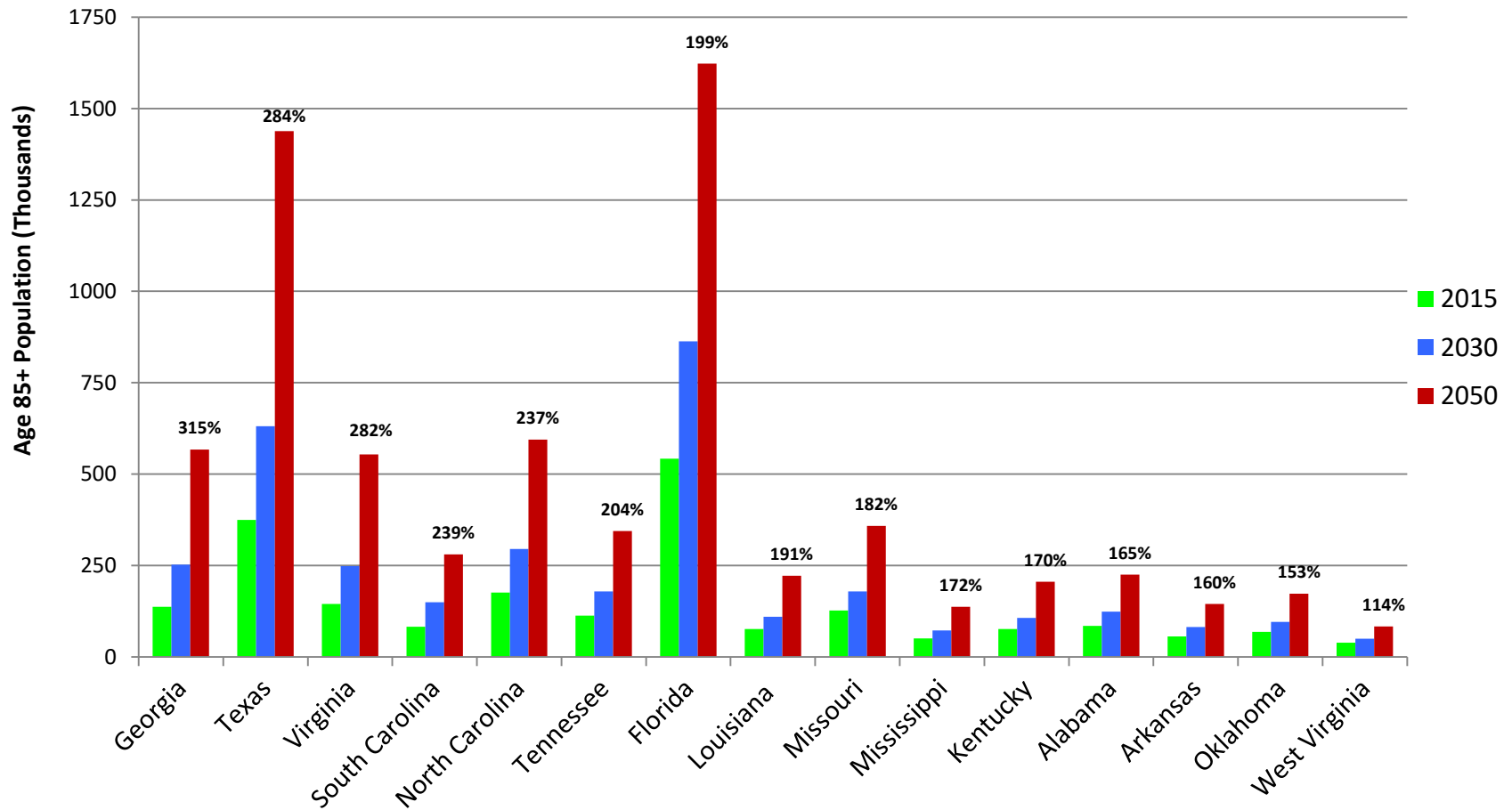
Source: AARP Data Explorer

Southern States with Largest Projected Percentage Change in Age 85+ Population, 2015 - 2050



Source: AARP Data Explorer

Projected Percentage Change Age 85+ Population, All Southern States, 2015 - 2050

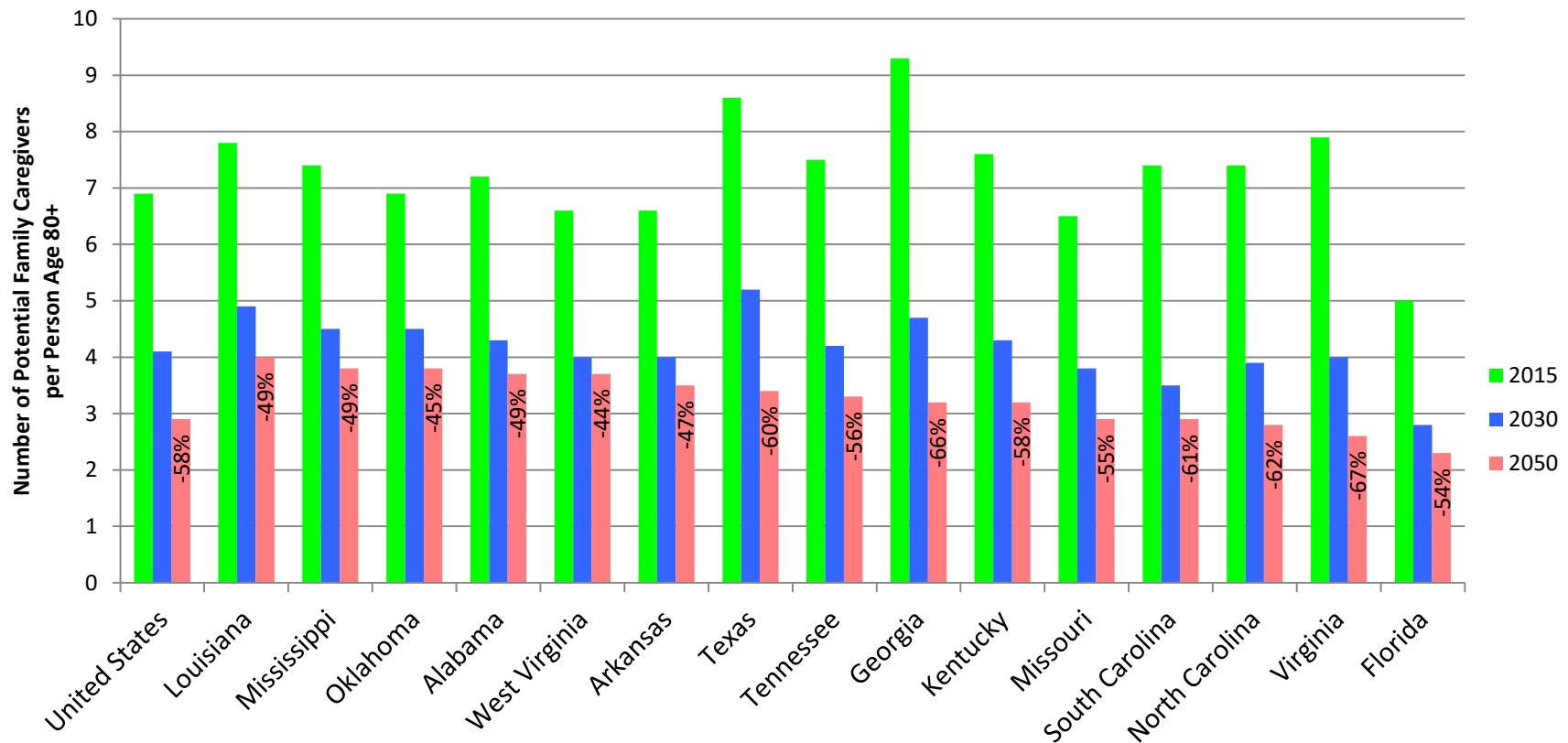


Source: AARP Data Explorer

“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



Source: AARP Data Explorer

Expanding HCBS... Why it Matters

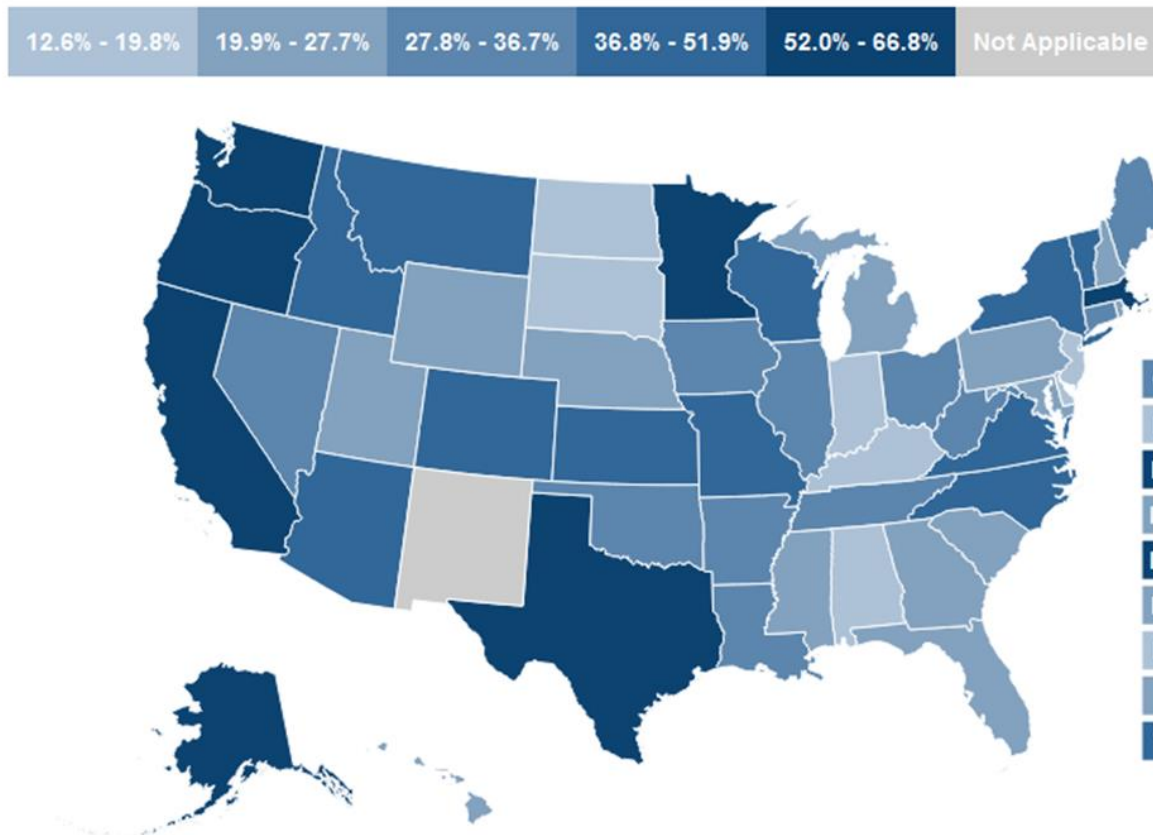
- Medicaid has an institutional bias
- Outdated and ageist prejudices
- 90% want to remain in their homes and community as they age
- Avoid unnecessary institutionalization by providing HCBS
 - In 2014, 12.2% of nursing home residents in southern states had low care needs (below the US national average)
 - 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!

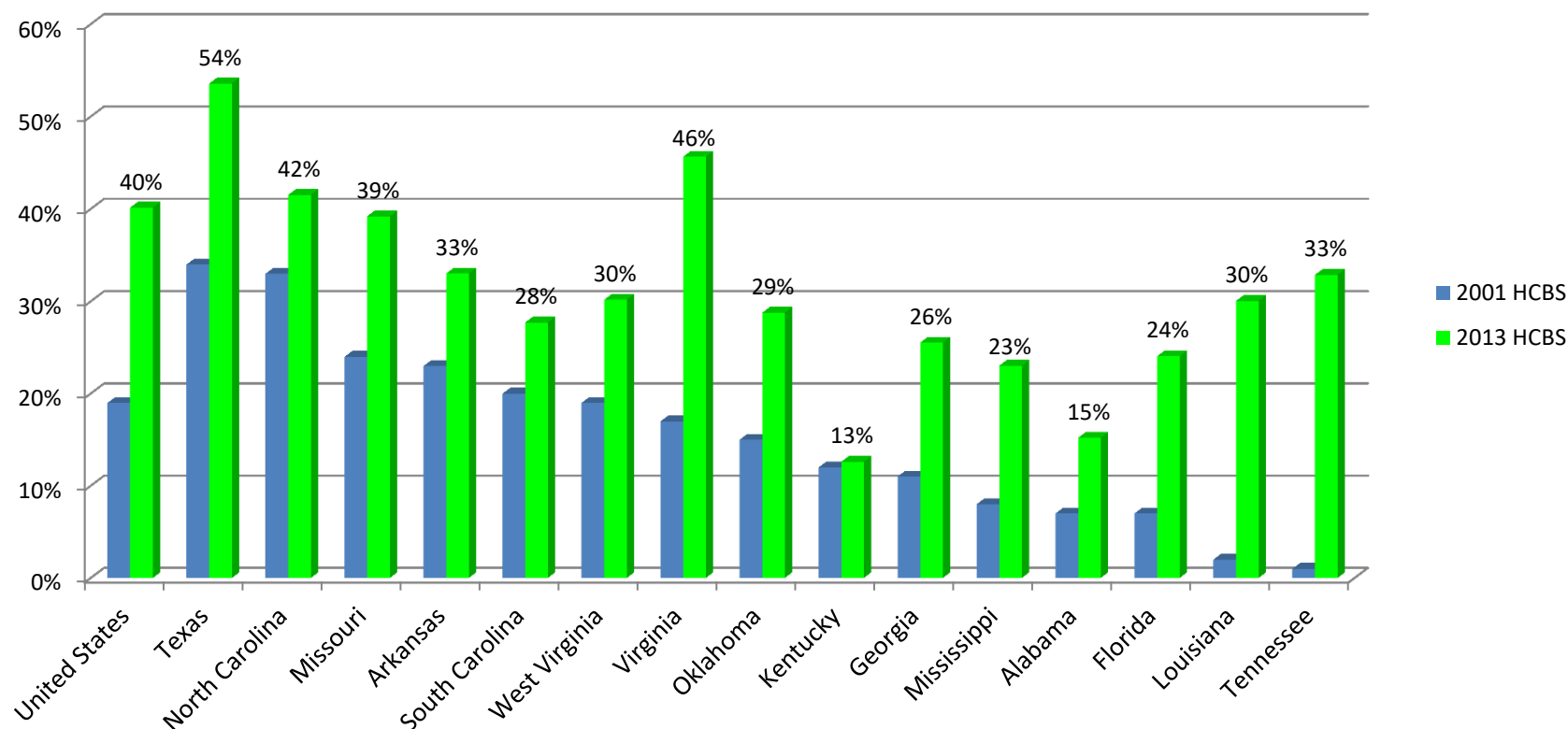
Medicaid LTSS Spending Balance: Older adults and adults with physical disabilities, 2013



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.

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

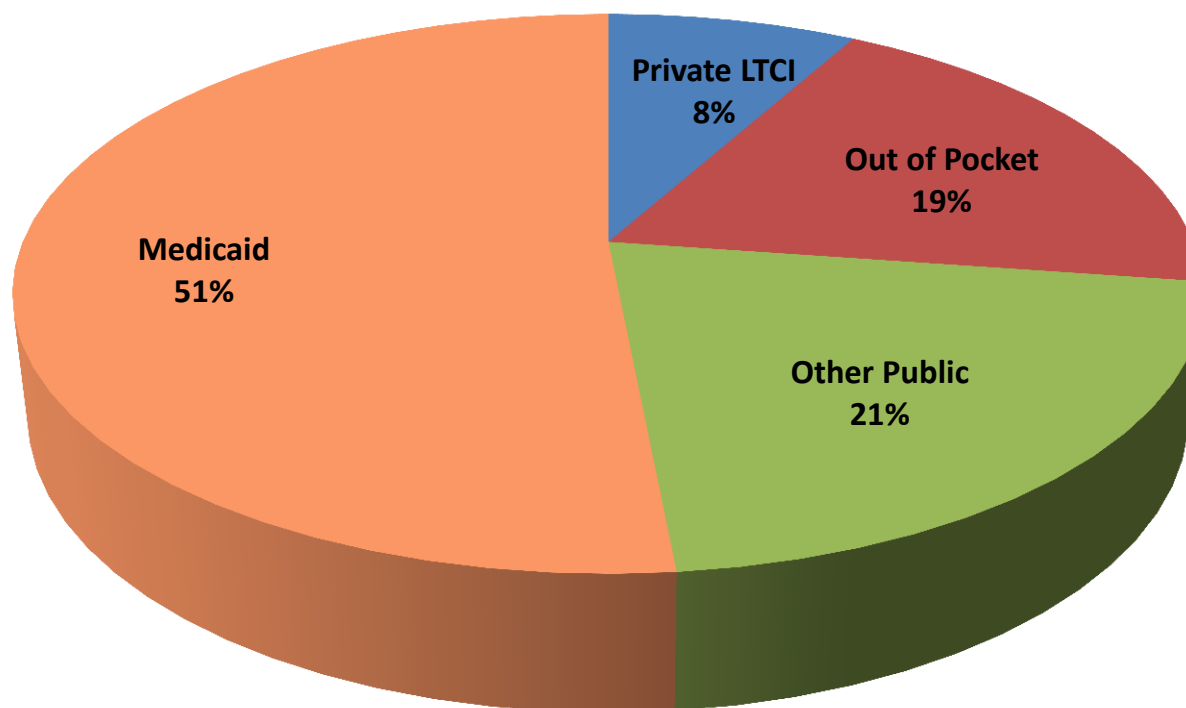


HCBS includes Aged/Disabled Waivers, Personal Care Services, Home Health, PACE, 1915j Self-Directed Services

Source: AARP Public Policy Institute

LTSS Financing: Primary Payer for LTSS – Medicaid

Total National LTSS Spending, 2013 = \$310 billion



SOURCE: The Kaiser Commission on Medicaid and the Uninsured (KCMU) estimates based on CMS National Health Expenditure Accounts data for 2013.

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!

Kathleen Ujvari

kujvari@aarp.org

The Case for Financing Older America's Long-Term Care Need



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INNOVATIONS

A Risk We All Face

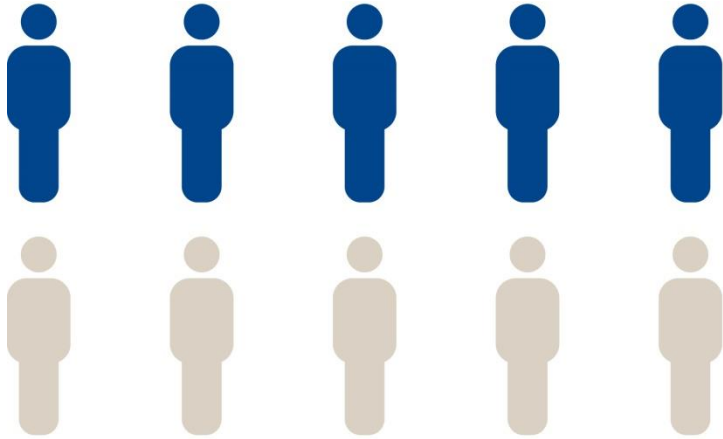


**Half of Adults Age 65+ Will Need a
High Level of Care at Some Point**

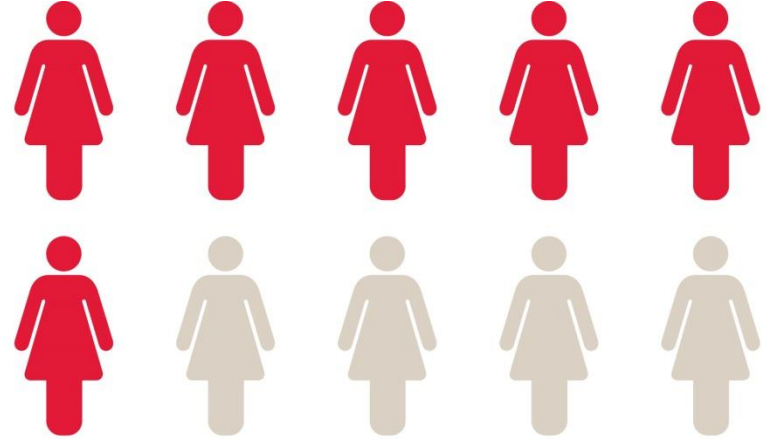
Favreault & Dey (2015), Table 1



Women Face Higher Lifetime Risk



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



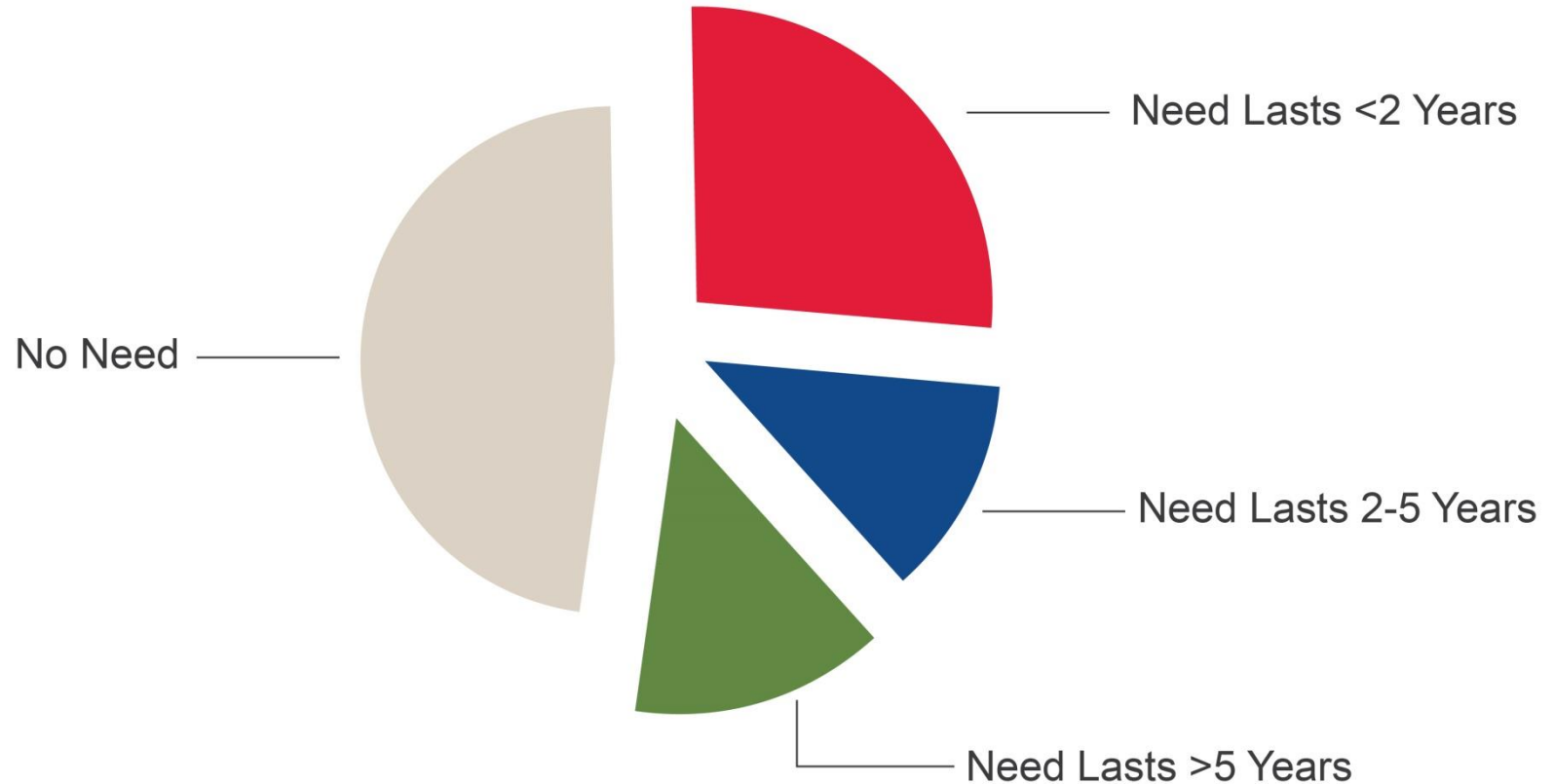
60% of Women Age 65+ Will
Face High Levels of Need

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

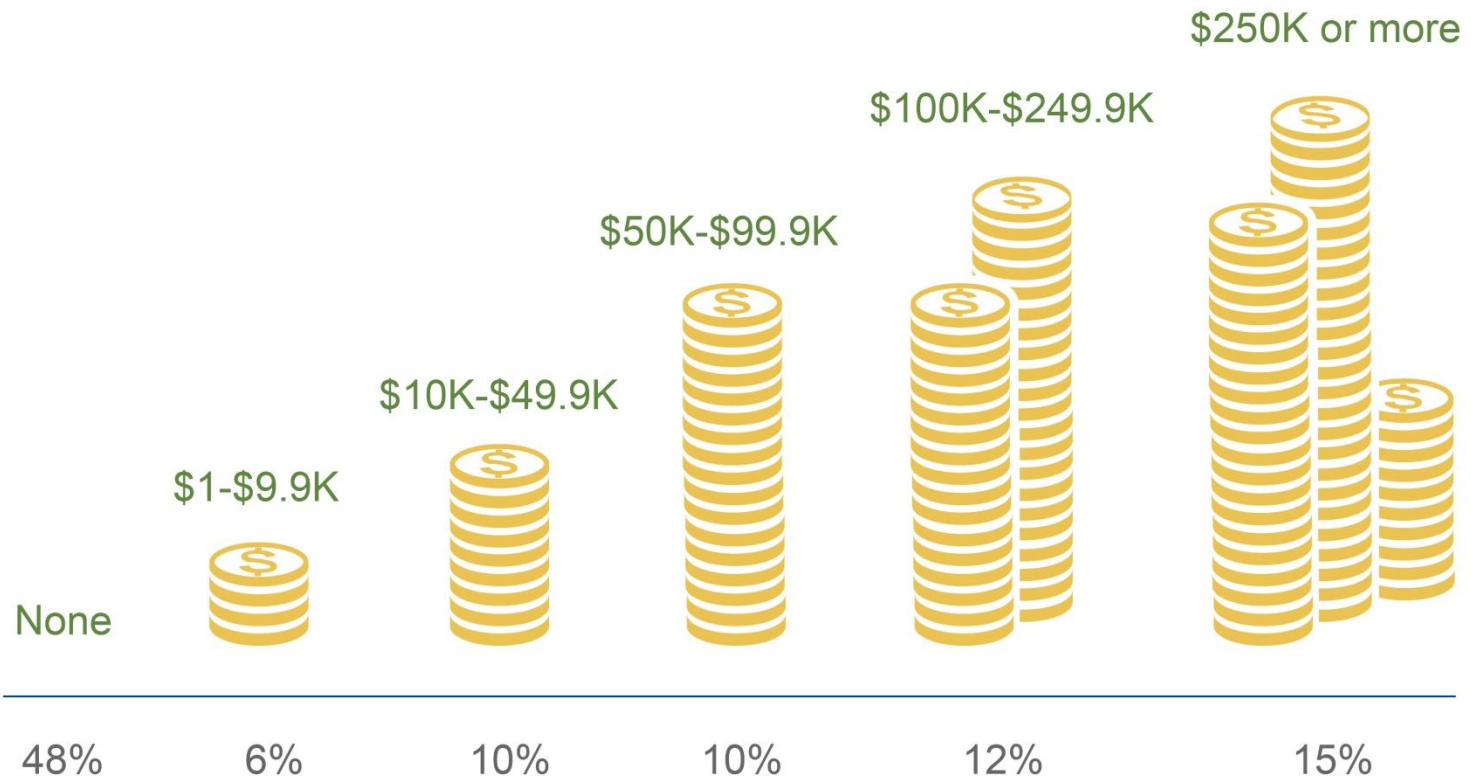
52% of Adults Age 65+ Have High Need



Favreault & Dey (2015), Table 1



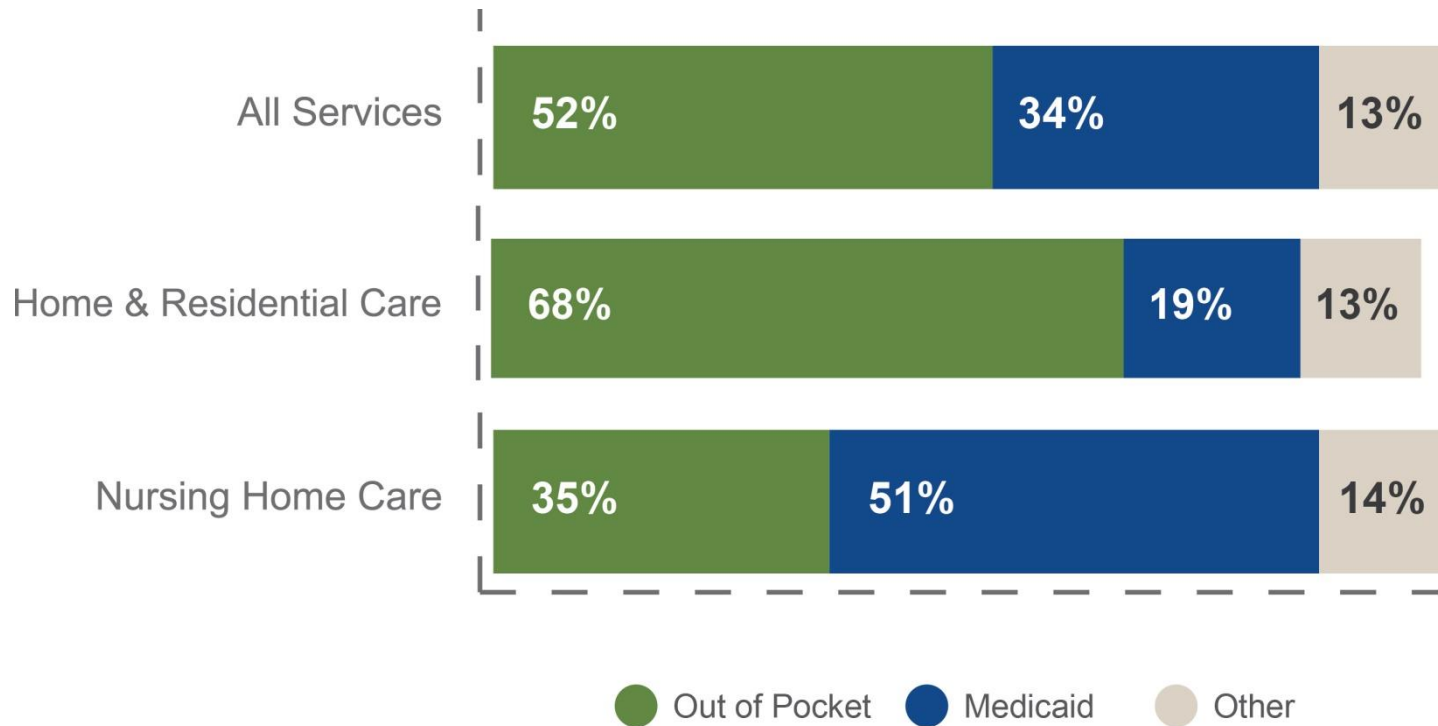
And Risk VERY High LTC Costs Over Lifetime



Favreault & Dey (2015), Table 5



Much of Which is Covered by Families Through Out of Pocket Spending



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



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Federal Policy Consensus: A Role for Private Insurance

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

BPC	Leading Age	The Collaborative
Specific recommendations to establish a lower cost, limited benefit product	Supports innovations in the private insurance market that emphasize consumer choice and flexibility	Suggests a series of initiatives to revitalize private sector specifically to cover front-end risk



With Public Catastrophic Coverage

SUMMARY

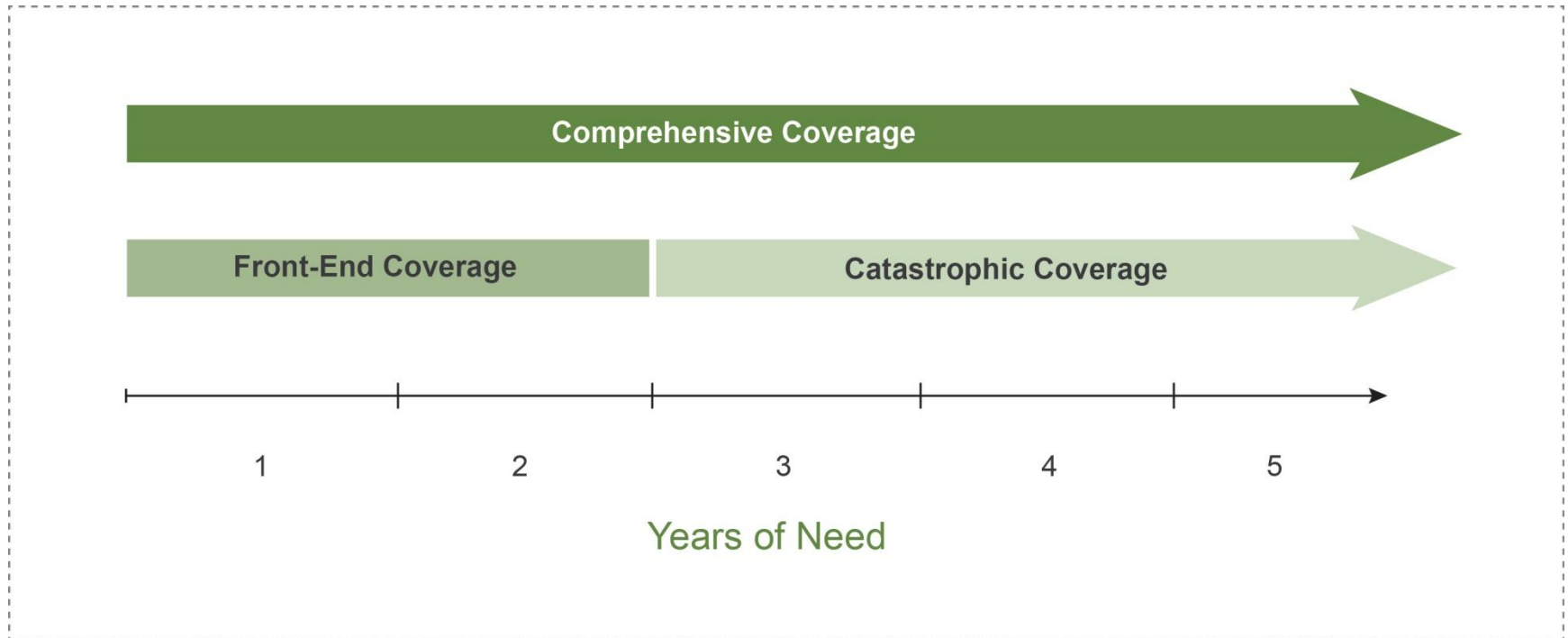
Protect everyone against the risk of high LTSS need that occurs over long periods of time.

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

BPC	Leading Age	The Collaborative
A public insurance approach for catastrophic expenses is worthy of consideration	Supports concept of universal insurance as having the biggest impact	Recommends a universal catastrophic insurance program



Mandatory & Voluntary: Three Approaches to Covering Risk



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



Favreault & Johnson (2015), Table 15



Impacts of Mandatory Approaches

Front-End

Catastrophic

Comprehensive



Out-of-Pocket
Reduction

14%

16%

24%



Medicaid
Reduction

8%

28%

32%

Favreault & Johnson (2015), Table 15



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New Mandatory Approaches Shift Spending in Different Ways

APPROACHES	SPENDING BREAKDOWN	AVG LIFETIME SPENDING	PAYROLL TAX RATE
Current	<ul style="list-style-type: none"> Insurance 2% Out of Pocket 56% Medicaid 41% 	\$135,000	—
Front-End Mandatory	<ul style="list-style-type: none"> Insurance 19% Out of Pocket 46% Medicaid 36% 	\$144,600	0.60%
Catastrophic Mandatory	<ul style="list-style-type: none"> Insurance 30% Out of Pocket 43% Medicaid 27% 	\$147,900	0.75%
Comprehensive Mandatory	<ul style="list-style-type: none"> Insurance 38% Out of Pocket 37% Medicaid 25% 	\$154,300	1.35%

Insurance
 Out of Pocket
 Medicaid

Favreault & Johnson (2015), Tables 1 and 16



Sources

Favreault, M. M., & Dey, J. (2015). Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Retrieved from <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief> (Favreault & Dey, 2015)

Favreault, M. M., Gleckman, H., & Johnson, R. W. (2015). Financing Long-Term Services and Supports: Opinions Reflect Trade-Offs for Older Americans and Federal Spending. *Health Affairs*, 34(12). Retrieved from <http://content.healthaffairs.org/content/early/2015/11/13/hlthaff.2015.1226.full> (Favreault, Gleckman & Johnson, 2015)

Favreault, M. M., & Johnson, R. W. (2015, November). Microsimulation Analysis of Financing Options for Long-Term Services and Supports. *Research Report for The SCAN Foundation*. Retrieved from http://www.thescanfoundation.org/sites/default/files/nov_20_revised_final_microsimulation_analysis_of_lts_report.pdf (Favreault & Johnson, 2015)

Freedman, V. A., & Spillman, B. C. (2014). Disability and Care Needs Among Older Americans. *The Milbank Quarterly*, 92(3), 509-541. (Freedman & Spillman, 2014)

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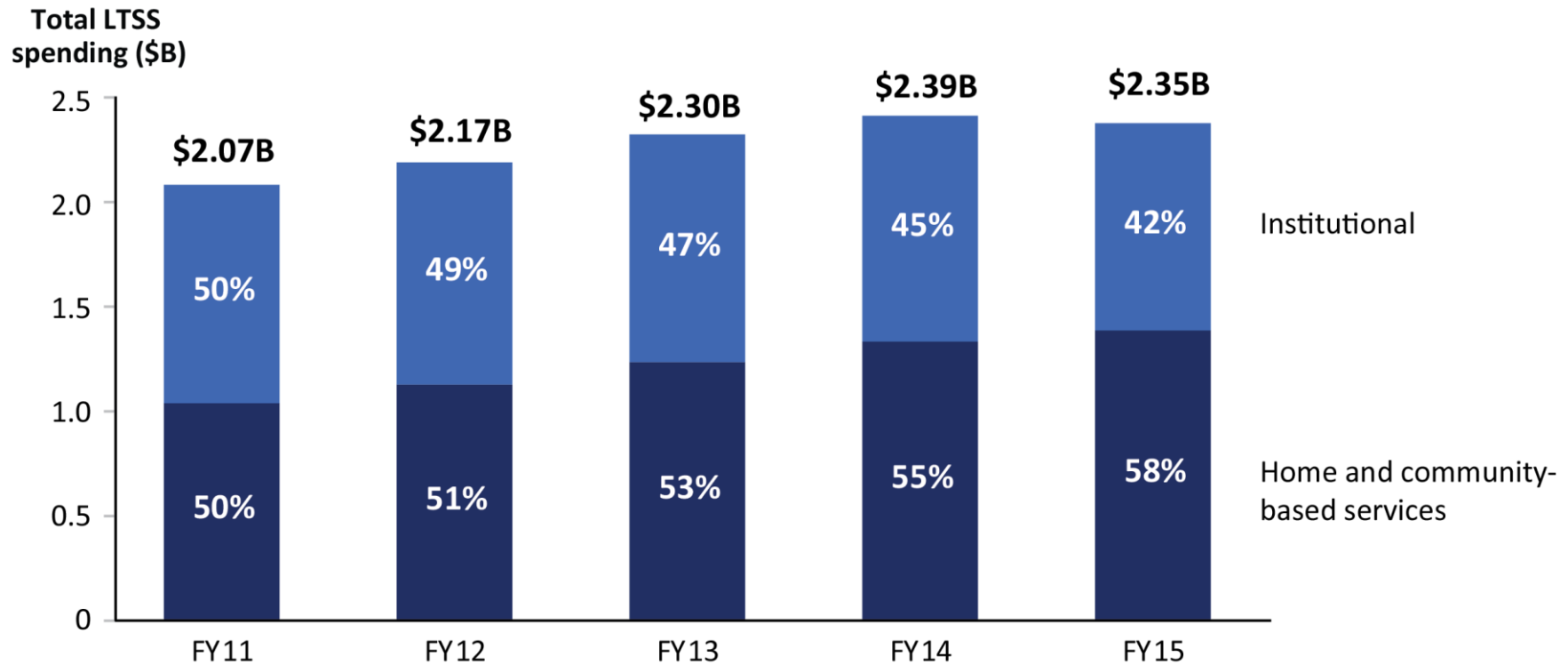




Managing LTSS Spending in Virginia's Medicaid Program

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Virginia LTSS spending has been increasing and shifting toward community-based services

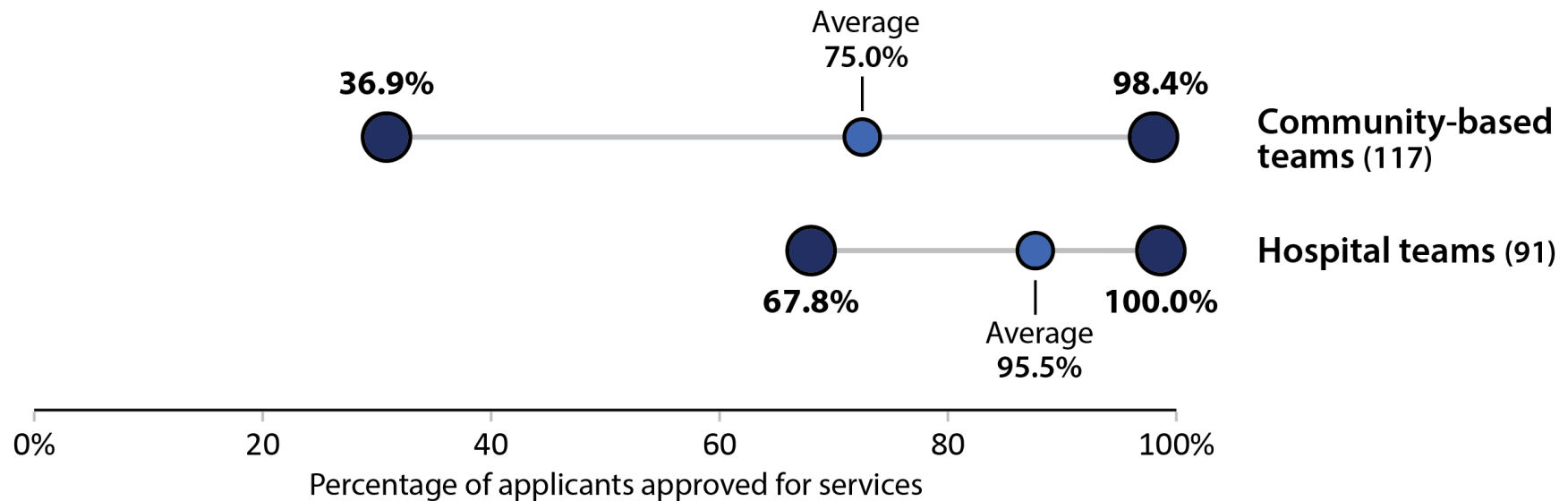


Note: Spending data not adjusted for inflation.

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

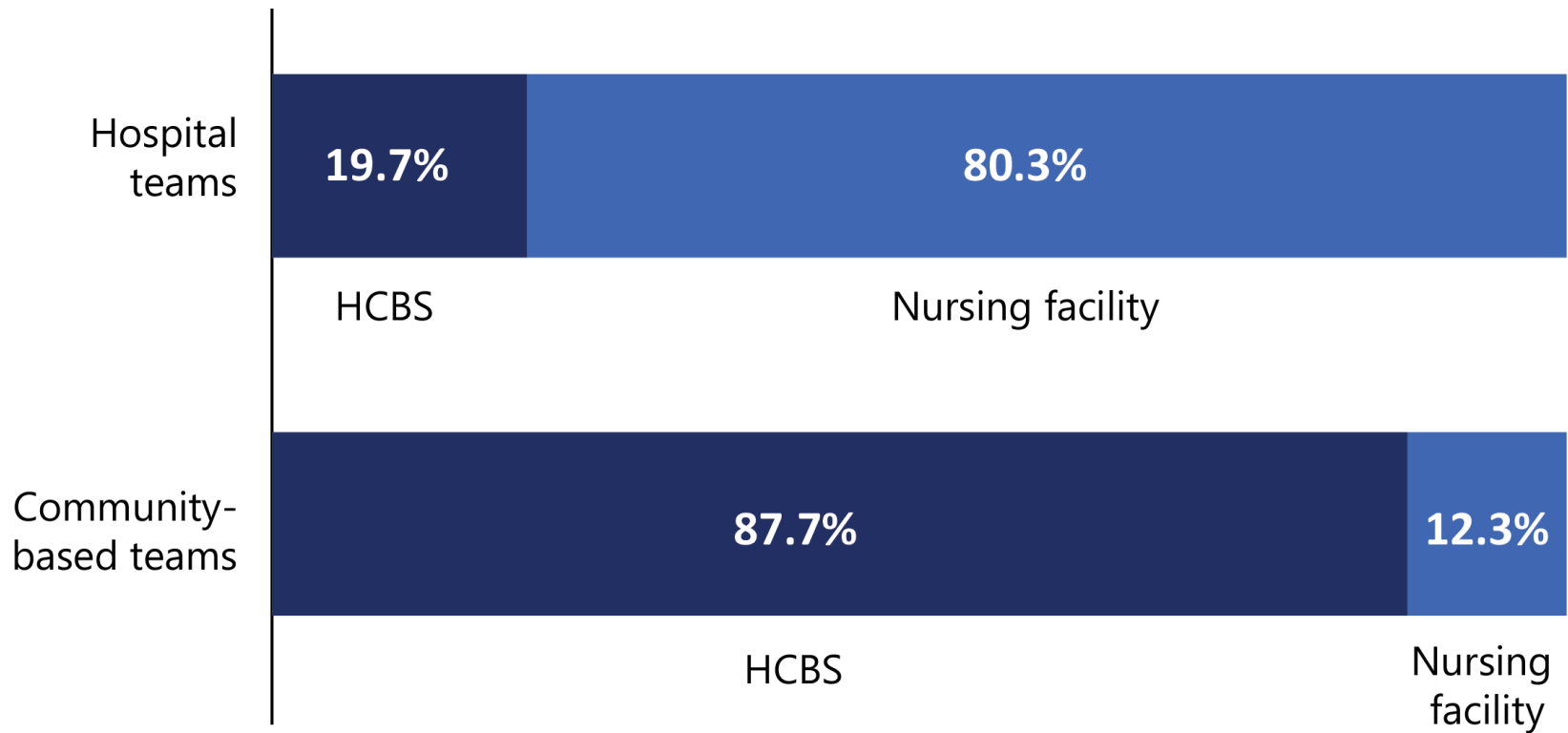
- Annual cost per recipient for community-based services is \$12,000 less than nursing facilities, on average
- Research indicates that recipients have better health outcomes when served in the community

Shift towards HCBS driving down per recipient LTSS spending in Virginia Medicaid

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

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

Jeff Lunardi

804-371-4581

jlunardi@jlarc.virginia.gov