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CONGRESSIONAL TESTIMONY

**The Role of Long-Term Care in
Health Reform**

**Testimony before
Committee on Finance
United States Senate**

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My name is Dennis Smith. I am a Senior Research Fellow in Health Care Reform at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Long-term care is an important but all too often overlooked component of health care reform. The great challenges we face because of population changes between now and 2030 are well known and will require bold solutions. As the Committee's statement points out, "... Medicaid continues to be overwhelmed as the sole solution for long-term care ...".¹ All too often, Medicaid is called upon to fill missing pieces. Yet the federal government and the states are facing the reality that Medicaid in its current form is unaffordable and unsustainable.

About one-third of Medicaid spending, or about \$100 billion in FY 2007 went to long-term care.² Over the next 10 years, Medicaid long-term care spending is projected to grow at an average rate of 8.6 percent per year.³ At this rate, Medicaid will spend a cumulative total of \$1.7 trillion on long-term care between 2008 and 2017. Within Medicaid, there has been some shift in where long-term care dollars are spent. In FY 2000, 72 percent of Medicaid long-term care expenditures went to institutional care and just 28 percent to community based services.⁴ The overall distribution of FY 2007 expenditures had changed to 58 percent institutional and 42 percent community-based.⁵

The Committee's has asked the panel to address four questions which should help lead to the formulation of policies to create a system that is adequately prepared to meet the challenges of the 21st century. I will address them, however, in a different order as the policy decisions should lead sequentially from one to the next, ending with the financing question. From past experience, the financing is where consensus tends to fall apart. If you start with financing, chances are good that enthusiasm will wane before you discuss the policies of change. If agreement on policy can be reached, financing should follow.

How would better long-term care coverage affect overall health care access, quality and costs?

Long-term care coverage includes a mix of private and government sources. Better coverage should include the promotion of private sector options. Research from the National Bureau of Economic Research demonstrates that Medicaid has a large "crowd out" effect on private long-term care insurance.⁶

¹ Committee on Finance, hearing notice, March 20, 2008.

² Office of the Actuary, Centers for Medicare and Medicaid Services, 2008 Actuarial Report on the Financial Outlook for Medicaid, October 17, 2008, p. 10.

³ OACT, p. 17.

⁴ Suzanne Crisp, Steve Eiken, Kerstin Gerst, Diane Justice, Medstat, *Money Follows the Person and Balancing Long-Term Care Systems: State Examples*, prepared for the Centers for Medicare and Medicaid Services, September 29, 2003, Appendix 1, p. 15.

⁵ Brian Burwell, Kate Sredl, and Steve Eikern, Thomson Reuters, *Medicaid Long-Term Care Expenditures in FY 2007*, September 26, 2008, p.1.

⁶ www.nber.org/digest/jul05/w10989.html

We certainly see every day how poor quality increases costs. The journey into the long-term care system often begins with a senior who is on too many prescription drugs becomes disoriented, falls and breaks a hip. A person with a disability who did not get the properly equipped wheelchair is at risk for skin problems that can lead to pressure ulcers and hospitalization. In one study, the actuarial firm Milliman, Inc. estimated that 25 percent of hospitalizations for Wyoming's long-term care population were avoidable.⁷

More money does not mean better quality. Last month, the Nelson Rockefeller Institute of Government issued a report, *Medicaid and Long-Term Care: New York Compared to 18 Other States*. It concludes, “[u]nfortunately, New York’s broad range of services and higher spending have not produced a higher quality of care. The state is about average or slightly above average on measures of quality. The comparisons in this report show that New York has room to improve quality and lower costs.”⁸

The AARP Public Policy Institute has recently published its *2009 Across the States: Profiles of Long-Term Care and Independent Living*. Among its ten key findings, AARP estimates that, “[o]n average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based settings for every person in a nursing home.”⁹

Reform should offer more alternatives to Medicaid in order to divert people from needing Medicaid in the first place and Medicaid itself must be rebalanced. In this respect, Vermont provides a model for serious consideration. Patrick Flood, Deputy Secretary of the Vermont Agency of Human Services, has described how Vermont has abandoned the out-dated Medicaid structure of long-term care, and leveled the playing field between institutional and home care with the option of self-direction:

In 2005, Vermont received approval from CMS for an 1115 Waiver to re-design our Medicaid long term care system. The goals for the Waiver were to:

- Provide equal access to either a nursing home or home based care services
- Serve more people
- Manage the overall costs of long term care.

Three years later, it is clear that the Waiver has succeeded beyond what Vermont hoped for. We are serving many more people than we could have under the old system. The number of new persons we can admit each year to our home based alternative programs has grown 2-3 times over what we could in the old system.

⁷ Bruce Pyeson, Kathryn Fitch, and Susan Panteley, *Medicaid Program Redesign: The Long Term Care and Developmentally Disabled Programs*, Milliman, Inc., September 15, 2006, p. 12.

⁸ The New York Health Policy Research Center, *Medicaid and Long-Term Care: New York Compared to 18 Other States*, prepared for the New York State Department of Health, February 2009, p. 14.

⁹ Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson, *AARP, Across the States: Profiles of Long-Term Care and Independent Living*, 8th Edition, p.17.

Nursing home use continues to decline gradually. Overall costs of the system have remained manageable.¹⁰

Flood summarized the Vermont experience: “The beauty of Vermont’s approach is that it turns out our theory is correct: more people, given the choice, will choose home based care, and less money will be spent on nursing homes. Thus we can shift money from the nursing home side of the ledger to the home based side and not spend more than was planned, but still serve more people overall.”¹¹

Millions of Americans served by Medicaid are also clients of other government programs such as the Supplemental Security Income (SSI) program, Food Stamps, housing assistance, mental health, aging, and even transportation programs. All of these programs are part of the long-term care continuum and we should view them as a cohesive system rather than individual, unconnected parts which is the way these programs are currently organized. Better coordination of current coverage would certainly increase access, improve quality, and lower costs. Milliman observes that, “[m]uch of the data collected and information reported about the LTC and DD programs are intended to demonstrate compliance with entitlement rules rather than support care management. A future that provides more efficient, better quality care will have strong capabilities to manage care processes.”¹²

In July 2008, the AARP Public Policy Institute published *A Balancing Act: State Long-Term Care Reform* which provides a good roadmap to reform. “Policy makers and researchers have attempted to identify successful practices. A review of the literature reveals several studies that analyze and identify key determinants that contribute to more balanced LTSS (long term services and supports) systems. But there is no magic formula that will accomplish system change without strong leadership and the political will to do so. ‘Success’ cannot be measured only by look at the allocation of state’s Medicaid dollars. An analysis of the hallmarks of a balanced system identified the components of an ideal LTSS system ...”¹³

The report describes 12 components of an “ideal” system as philosophy, array of services, state organization of responsibilities, coordinated funding sources, single appropriation (also called “global budgeting”), timely eligibility, standardized assessment tool, single entry point, consumer direction, nursing home relocation, quality improvement (which includes patient-defined measures of success), and integrating health and long-term care services.

These 12 ideal components suggest that from an organizational perspective, the current federal structure is out-dated and deficient. Reform should include a new

¹⁰ Statement of Patrick Flood at The Heritage Foundation, “Workable Solutions for Long-Term Care,” September 24, 2008.

¹¹ Ibid.

¹² Pyenson et. al., p.2.

¹³ Enid Kassner, Susan Reinhard, Wendy Fox-Grage, Ari Houser, Jean Accius, AARP Public Policy Institute, *A Balancing Act: State Long-Term Care Reform*,” July 2008, p. 12.

organization at the federal level to lead such change. The Centers for Medicare and Medicaid Services (CMS) is too big and too slow to make the changes that are needed. While people with disabilities want to self-direct, CMS is still arguing with itself over the “homebound rule” dealing with wheelchairs.

To support a system that can meet the challenges of the 21st century, the federal government should lead by example. A new federal agency would be created and agencies dealing with people with disabilities and the elderly would be consolidated under one roof. Experts from Medicaid, the Administration on Aging, vocational rehabilitation and other agencies and programs would be brought together to focus on the common mission. Various federal long-term care programs currently administered by the Social Security Administration and the Departments of Agriculture, Education, Health and Human Services, Housing and Urban Development, and Labor would also be consolidated and added to the new agency with a renewed emphasis on helping individuals with disabilities to achieve or maintain independence.

The current fragmentation across agencies leaves individuals with disabilities trying to navigate the system frustrated and dilutes efforts to serve them. Fragmentation and duplication among dozens of different programs that each serves the same populations also drive up the costs of government, hidden from public view. This consolidation will reduce the size of the federal bureaucracy as duplicative support staff can be eliminated. To ensure savings, Congress should reduce funding for program operations for the effected agencies from current levels as part of consolidation. It will be a more nimble agency as well and return the focus of the various welfare programs to the most vulnerable populations. Decisions will be more timely and consistent and a new structure will provide a greater level of accountability.

The new agency would contain new centers for excellence for the populations to be served:

- Center for Excellence in Long-term Care and Supportive Service—Physical Disabilities
- Center for Excellence in Long-term Care and Supportive Services—Developmental Disabilities
- Center for Excellence in Long-term Care and Supportive Services—Behavior Health
- Center for Excellence in Long-term Care and Supportive Services—Seniors

Some will argue that Medicare and Medicaid must be kept together because of the “dual eligibles,” the 8 million low-income senior citizens and individuals with disabilities who are eligible for both Medicare and Medicaid. Some may think the missions of the two agencies are too intertwined to be separated. But the same argument was made in the past to keep Medicare and Social Security together and was ultimately put to rest. Although the programs were separated more than 30 years ago, the Social Security Administration (SSA) continues to administer major parts of the Medicare program including determining eligibility, collecting Medicare premiums, and explaining benefits.

Though there is overlap between the two programs, they can be neatly separated. Most people on Medicare will never cross over into Medicaid. Medicare does not provide long term care services. The role of Medicaid, for most seniors, is to pay bills, not make policy or deliver Medicare covered benefits.

Medicare is not the only program that has links to Medicaid. Development of Medicaid information systems requires interaction not with Medicare but with federal, state, and local officials who run other welfare programs--Food Stamps and the Temporary Assistance for Needy Families (TANF) program. The cost of eligibility workers and information systems are allocated among Medicaid, Food Stamps, and TANF. There are as many “dual eligibles” between Medicaid, Food Stamps, TANF and the Supplemental Security Income (SSI) program as there are between Medicaid and Medicare. Because Medicaid, TANF, SSI, and Food Stamps are means-tested programs, there are more eligibility policy issues among these programs than between Medicare and Medicaid.

Consolidation and reorganization will benefit recipients and taxpayers alike by focusing resources on services rather than bureaucracy, coordinating policies across programs that have the same mission, shrinking the size of the federal bureaucracy, reinvigorating federalism, and measuring results rather than process. It is not sufficient to engage in wishful thinking that by coordinating with greater intensity, frequency, or passion, significant improvements in outcomes will be achieved under the current organizational structures. The concentrated efforts will emphasize a person-centered approach rather than an institutional or provider-driven approach. Nor should taxpayers accept the current “watered-down” versions of performance measurements. Reorganization of the management at the federal level would be an important message about how serious the Medicaid problem is and how far the federal government is willing to go to solve it.

Are there different policy options for improving long-term care for the elderly in comparison to the disabled?

There clearly are differences between the elderly and people with disabilities in the use of long-term services and supports when we examine the length of time the two populations use LTSS and the array of services. However, policies for both populations should be the same: they should be person-centered and money should follow the person. Young adults with disabilities are more likely than seniors to be interested in supports that will lead to employment, for example. But at the federal level, we should avoid making artificial policy distinctions that could impede the choices and preferences of either population. Some current federal policies unnecessarily complicate the delivery of services to those who rely on them. For example, a person’s benefits can change solely because he had a birthday.

Community care for the developmentally disabled has progressed more rapidly than for the elderly and physically disabled. Community based care for the developmentally disabled now accounts for 63 percent of Medicaid long-term

expenditures on their behalf while 69 percent of long-term care expenditures for the elderly and physically disabled still go to institutions.¹⁴

Why has community care progressed more rapidly for the people with developmental disabilities than for our seniors? A better understanding of these changes and differences will assist in identifying how current policies should be changed.

First, the overwhelming credit goes to families. The shift from institutional care to community services reflects their preferences and demands. Families spoke and states responded, though some states faster than others. Long-term care should be properly viewed as a matter of personal liberty and freedom, a family issue, and a social issue as well as a health care issue. They have moved their loved ones out of institutions and, in many cases, on to self-direction. When long-term care is still viewed as a medical model, the progress has been slower. Choice and self-direction improves access and quality while lowering the cost. That is a successful formula that families embrace.

Second, the financial relationships are different. Government needs to acknowledge that its own fragmentation of programs and philosophy of dependency in which providers, rather than people themselves are the decision-makers may be contributing factors as to why the majority of funding for the elderly and physically disabled still goes to institutional care. The institutional bias of Medicaid in which a nursing home bed is an entitlement but supports at home are optional are reinforced by financing advantages of institutions and relationships between institutions. In many states, institutions themselves help finance the cost of Medicaid through upper payment limits and provider taxes. Because they can be a source of the nonfederal share of the cost of Medicaid, they have an advantage when it comes to making budgetary decisions at the state level. Furthermore, institutions, especially in many rural areas in particular, nursing homes are major sources of employment, giving the mutual business interests of owners and workers a powerful political voice.

A third reason is the professionalization of community based services within the developmentally disabled community. Organizations have moved out of someone's basement or the church daycare into sophisticated operations. There are other reasons as well, but whatever the reason is, the central focus should be on leveling the playing field between institutional and non-institutional care. To achieve this, Title XIX itself will need to be amended and reorganized. Long-term care should have its own distinct part within Title XIX. The current distinctions between "mandatory" long term care services and "optional" long term care services should be eliminated. After more than 25 years of experience with home and community based waivers, it is time to recognize the obvious. Home and community based care works and states should not have to rely on waivers from Washington to provide it. However, the budget scorekeepers at the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) generally view

¹⁴ Burwell et. al., Table, "Distribution of Medicaid Long Term Care Expenditures for DD services, Institutional vs. Community-Based Services, FY 2007" and Table, Distribution of Medicaid Long Term Care Expenditures for A/D services, Institutional vs. Community-Based Services, FY 2007.

greater state flexibility in Medicaid will increase costs. Thus, flexibility will need to be coupled with financing reform as well.

How do we best achieve broad-based long-term care coverage, and why is this important for health reform?

Broad-based solutions will require improvement in all of the current efforts in long-term Medicaid, our retirement systems, and private long-term care coverage. Part of the solution to easing the pressures on Medicaid is for Americans to better prepare for their own retirement needs.

There is great attention to the aging of the “baby boomers” and to the rapidly growing population over the age of 75 where the need for long-term care increases. The age and functional abilities of the person are not the only determinant in whether a person will seek long-term care services and supports. What happens to someone else also matters. That is, family members are the greatest source of support, typically, one spouse caring for the other or an adult child caring for her parent. Broad based solutions should focus on keeping families together for as long as possible.

Better transition planning can lower costs. System redesigns should focus on delaying entry into institutional care or reducing the length of stay in an institutional setting. We should also help ensure a sense of security for families by helping a person with disabilities build assets for their future needs. Today, the message from Medicaid and SSI to individuals and families is don’t work, don’t build assets, don’t plan because if you do, you will lose eligibility. We should reverse this by creating special accounts for people with disabilities to build assets. The Bush Administration proposed such accounts called Living with Freedom, Independence, and Equality (LIFE) Accounts. LIFE accounts would be tax exempt and would not be counted in determining eligibility for Medicaid or SSI. Families could draw some funding out of the Account for incidental items, perhaps 10 percent annually, without penalty. The Account would then be used for future cost of care if the person needs to go into an institutional setting.

What is the range of distinct policy options for financing long-term care? What are the pros and cons of each?

Option 1: Expansion of Medicare Benefits to include LTC. Various interests have proposed that long-term care be added as a benefit to Medicare and that an increase in the payroll tax be added to finance the cost.

Adding new benefits to Medicare when the current program is already stressed does not make sense. Medicare will soon be liquidating assets in order to pay current benefits. The insolvency date of the Hospital Insurance Trust Fund is likely to be moved up when the Trustees report next month. Raising taxes on low-income workers for a benefit 50 years away makes no sense in the current economy. Small businesses would likely reject this as a threat to recovery and jobs and so should Congress.

Option 2: Federalization of LTC Under Medicaid. Federalization of Medicaid long-term care costs has been an official position of the National Governors' Association (NGA) for a number of years. The increased cost to the federal government has been an obvious impediment to the idea.

Option 1 and Option 2 suffer from similar deficiencies. First, the nature of long-term services and supports do not comport with Medicare. Medicare is a medical model and provider-driven entitlement model. Neither one of these is compatible with long-term services and supports which should be flexible and person-centered. Long-term care services and supports are as much social services as they are health care services. Housing is often a critical issue that needs to be addressed. Yet that is not an issue that can be equitably reduced to an actuarial value. While seniors typically use high cost long-term care for a relatively short period of time, many people with disabilities will rely on long-term care services and supports for a lifetime. What has been accepted as sound public policy for years may actually be counterproductive. For example, requiring a nursing home stay of some length has been viewed as a deterrent against the so-called "woodwork effect." But a person's ties to the community breaks down over time. Policies that protect the Medicare trust funds do not always work in the best interest of the individual.

Second, the cost of long-term care would increase substantially. The political pressure to increase provider reimbursement to the highest reimbursement levels possible would be significant. States also play an important role in the supply side of long-term care through the certificate of need process. Under Medicare or federalization of Medicaid, the cost of long-term care could double without any increase in real value. Finally, the federal government lacks the expertise to develop, support, and sustain a community based delivery system. Long-term services and supports are local and personal.

Option 3: LTSS Grant Under New Part B of Medicaid. I recommend that a third option be considered that will assist in the transformation of long-term care from institutional to person-centered supports and services. The current mandatory/optional services for long term care should be replaced by a new Part B of Medicaid under which long term services and supports (LTSS) are offered on an equal basis as under the Vermont model. States should be allowed to move away from the institutional level of care to a functional needs assessment system based on prevention, low, intermediate, and high needs. States should be required to offer families the opportunity to self-direct their long term services and supports. Federal rules on important policies such as spousal impoverishment protections, eligibility, and nursing home quality standards would be preserved to continue to hold providers and states accountable.

Medicaid long-term services and supports would be funded through a dedicated but capped LTSS grant that is stable, predictable, indexed, and guaranteed. States would have the incentive to adopt new delivery options through the conversion of the current

matching system to a maintenance of effort requirement (MOE). States therefore could improve service delivery and save state dollars without losing federal dollars.

States need a more flexible financing arrangement within existing funding levels to be able to level the playing field that also provides them with the ability to work outside the lines of current federal law and regulations. There can be good reasons to want to deviate from the current payment rules. For example, government generally does not want to pay providers for an empty bed. But to shift to community care while maintaining quality within institutions, a state would benefit from flexibility which would allow it to offer a funding stream that puts some nursing homes on a glide path to closure. The federal government would be more favorable to states experimentation with “pay for performance” if it did not have to take the risks connected with open-ended funding commitment.

The current match system works against the interests of what we should be trying to accomplish—greater value at lower costs. States are under tremendous pressure to maximize federal dollars. Medicaid needs a neutral approach in which states can reform their long term services and supports system but maintain a guaranteed stable and predictable source of financing from the federal government.

As part of this transformation, the federal government should create a new agency as previously suggested and increase, if necessary, support for discretionary programs that can divert or delay the need for long term care. The LTSS grant approach combined with the recommended federal reorganization will fulfill the AARP’s 12 “ideal” LTSS system. Investment in information and education will provide families with greater emotional security that there will be a continuum of care that supports the health, security, dignity, and individuality of their loved ones.

Funding for Medicaid acute medical care benefits for eligible individuals would continue under the current benefit structure under a new Part A in Medicaid. A child with a disability, for example, would remain eligible for the Medicaid early periodic, screening, diagnosis, and treatment (EPSDT) services.

Response to Concerns over Capped Funding. Over the years, criticism of and opposition to funding caps in Medicaid have generally focused on three areas:

1. states would be handicapped to respond to unforeseen events that would increase eligibility. Hurricane Katrina, SARS, and HIV/AIDS have been offered as reasons to oppose capped funding.
2. there could be medical breakthroughs that could be very expensive, putting states at risk for high cost technology.
3. states have little control over the cost drivers of health care making capped funding an unacceptable risk.

None of these objections particularly apply to the area of long-term care. These three reasons pose little risk in long-term care in which populations are stable and

predictable. Long-term care is more high touch than high tech. And in the area of long-term care, states have considerable control over how long-term care is delivered, which is why there are such great differences among the states in per capita spending and the distribution between institutional and community-based care.

Summary. The current Medicaid financing and benefit structure is an impediment to transformation of long-term care from an institution-based, provider-driven medical model to a person-centered, consumer-directed model. Reform should be focused on policies that can keep families together which will result in making Medicaid more sustainable and affordable. The current program costs taxpaying families approximately \$5,000 each. Promises to lower the cost of health care for the average American family should include modernizing Medicaid so they get the greatest value for government programs they support with their taxes.

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