Long-Term Care in Health Care Reform: Policy Options to Improve Both

Harriet L. Komisar, Georgetown University
Anne Tumlinson, Avalere Health, LLC
Judy Feder, Georgetown University and Center for American Progress
Sheila Burke, Harvard University
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Harriet L. Komisar, Anne Tumlinson, Judy Feder, and Sheila Burke*

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Executive Summary

Policymakers and the public widely recognize that policy reforms are needed to increase health care insurance coverage and create a more efficient health care system. A broad array of interested parties is engaged in discussion and debate about which specific reforms to adopt to achieve these goals.

Long-term care reform belongs in health care reform. The well-being and financial security of families depend not only on access to affordable medical services, but also on access to affordable, reliable long-term care—the daily assistance and supports that many individuals need because of serious medical conditions or disabilities.

This policy brief presents four policy options that merit serious consideration in the current health care reform discussions. We selected options that would address the most pressing needs in long-term care financing reform, help us achieve the goals of health care reform, and set the nation on a path to a better long-term care system in the future.

Proposals to Improve Long-Term Care in Medicaid

The first two options would improve long-term care for people with low incomes and limited financial resources. These options would modernize Medicaid in important ways, tailoring services better to individual needs and using resources more effectively.

- Expand Medicaid Support for Home and Community-Based Services
  The first option addresses a major shortcoming in Medicaid’s benefits—the limited, and highly variable among states, access to personal assistance in home and community settings.

* Harriet L. Komisar is a research professor at the Health Policy Institute, Georgetown Public Policy Institute, Georgetown University, Washington, DC. Anne Tumlinson is a Vice President at Avalere Health, LLC in Washington, DC. Judy Feder is a professor and former dean of the Georgetown Public Policy Institute, Georgetown University, and a Senior Fellow at the Center for American Progress. Sheila Burke is a faculty research fellow, Malcolm Wiener Center for Social Policy, John F. Kennedy School of Government, Harvard University, and a distinguished visitor, O’Neill Institute for National and Global Health Law, Georgetown University.
Key components of the proposal are the following:

- **Require—or provide strong financial incentives for**—states to expand home and community-based services.
- **Provide federal financial assistance to states through an enhanced matching rate to help finance expansions.**
- **Make home and community-based services eligibility available on an equal-footing with nursing home care**. Disability criteria and financial criteria for eligibility should be equivalent for across settings, including spousal impoverishment protection rules. To reduce unmet needs, a proposal could go further and give states the option of extending benefits to a broader population to include people who do not meet disability criteria for nursing home services.
- **Invest in workforce development** to assure people can obtain the type and quality of home and community-based services they need and want.

Legislation to accomplish some or all of these goals has been proposed in several recent congressional bills and in the Senate Finance Committee’s recent health reform proposals.

- **Improve Coordination of Medical and Long-Term Care for Medicare-Medicaid “Dual Eligibles”**

The second proposal aims to improve the quality and cost-effectiveness of services for people who rely on both Medicare and Medicaid by promoting the development and testing of integrated care programs for dual eligibles. Assuring capacity to deliver services appropriately and efficiently can be achieved by rewarding organizations that reduce Medicare or Medicaid costs, relative to projected performance, with a share of the savings. Similarly, states could be encouraged to develop and promote such organizations by sharing with them a portion of any Medicare savings (such as in reduced hospitalizations) from successful performance.

Key elements in integrated care models include the following:

- **A responsible entity**. One entity, such as a Medicare managed care plan or a state Medicaid program, would be responsible for assuring adequate, coordinated care.
- **Responsibility for coordinating the full set of acute and long-term care services covered by Medicare and Medicaid.**
- **Financial incentives for efficiency**. A mechanism that combines Medicare and Medicaid funding can promote efficiency gains by enabling savings in one program to be used to pay for services covered by the other—for example, savings from Medicare-covered hospital or other acute care services to be used to pay for home and community-based services or other non-Medicare services.
- **Mechanisms for assuring adequacy and quality of care, and data collection.**
- **Voluntary participation for dual eligibles**. If an integrated model is producing the coordinated care it should be, then it should be able to attract and retain voluntary participants. Further, it is important that dual eligibles, like other Medicare beneficiaries, retain the right to choose traditional Medicare fee-for-service benefits.

The recent Senate Finance Committee’s paper describing policy options for expanding health care coverage includes several options that would create new opportunities and incentives for states to develop coordinated care programs for dual eligibles. These could be strengthened by
also allowing a state to receive a share of any Medicare savings, relative to targets, achieved by a successful demonstration.

**Proposals to Improve Long-Term Care for the Broader Population**

The third and fourth options aim to strengthen long-term care protections for the broader population; one with better coordination of medical and long-term care for Medicare enrollees; the other by establishing insurance protection for people of all ages and incomes.

- **Improve Coordination of Medical and Long-Term Care for Medicare Enrollees with Chronic Conditions**

  The goal of the third proposal is to promote the innovation and diffusion of service delivery and payment models designed to improve quality and efficiency by coordinating the full range of medical and long-term services people with chronic conditions may need. The proposal would promote the development of demonstrations of care coordination models that address the need to coordinate both medical and long-term care for Medicare enrollees who need both.

  Within a flexible framework, demonstrations would need to meet certain broad requirements, which would include the following key elements:
  - Primary care “medical home” model.
  - Explicit responsibility for coordinating long-term care as well as medical care. Care coordinators would be responsible for determining long-term care needs and assisting the beneficiary and family members in locating care options and coordinating care; they would also play a critical role in planning transitions among care settings.
  - Communication with, and support and training for, family caregivers.
  - Payment system to support the model.
  - Option of targeting program to specific populations, such as Medicare enrollees who meet criteria indicating needs for both complex medical care and long-term care.
  - Data and evaluation.
  - Authority to expand successful care coordination demonstrations without new legislation.

The Senate Finance Committee’s recent document describing proposals to improve patient care and reduce health care costs includes proposals that would promote innovation and testing of chronic care coordination models. These policy improvements could be greatly strengthened by specifically encouraging the development and testing of models that include the coordination of long-term supports and services along with medical care.

- **Establish Public Insurance Protection for Long-Term Care for the Broad Population**

  In the fourth proposal, a public insurance program, financed by participants through premiums or taxes, would spread the risk across a broad population and offer protection to participants of all ages and incomes. The insurance could be designed to provide a core benefit that would be supplemented with private resources (including private long-term care insurance) and Medicaid.

  Key elements of a new public program include the following:
  - Ensure high participation among potential enrollees to spread risk widely to produce adequate revenues to pay benefits and keep enrollees’ contributions affordable.
- *Provide meaningful benefits* to ensure that people can obtain the services and supports they need and want.
- *Establish a financing mechanism that generates revenues dedicated to pay for future benefits.*

The *Community Living Assistance Services and Supports Act* (CLASS Act), included in the Senate Health, Education, Labor, and Pension (HELP) Committee’s proposed health care reform legislation, would create a premium-funded insurance program in which working-age adults could become eligible for a cash benefit after paying into the program for five years, and could maintain coverage throughout their lives by continuing to pay premiums. An alternative approach would be to create a new long-term care benefit in Medicare, financed with a surcharge on income taxes and available to people who are currently working-age when they become Medicare beneficiaries. Either approach would spread risk among a broad population and allow people to pay over time to insure for potential future needs. And, while neither approach would eliminate the need to rely on family care and personal resources or private insurance to assure full support, both would greatly enhance access to quality care and financial protection for people who need services.

Health care reform offers an opportunity to enact any or all of these initiatives—to improve the adequacy and quality of health and long-term care services for people who need both. We hope this opportunity will not be missed.
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I. Introduction

Policymakers and the public widely recognize that policy reforms are needed to increase health care insurance coverage and create a more efficient health care system. A broad array of interested parties is engaged in discussion and debate about which specific reforms to adopt to achieve these goals.

Long-term care reform belongs in health care reform. The well-being and financial security of families depend not only on access to affordable medical services, but also on access to affordable, reliable long-term care—the daily assistance and supports that many individuals need because of serious medical conditions or disabilities.

Currently, few Americans have insurance protection for the risk of needing extensive long-term care, at home or in other settings. Individuals and families must piece together a patchwork of supports which often means going without the services people need and want, depletion of financial resources, and lack of support for the family members and friends who provide extensive caregiving. The public program available to help, Medicaid, steps in only after financial resources are exhausted, and states’ Medicaid eligibility rules and benefits vary dramatically, especially for services at home and in community settings such as assisted living. Without improvements in long-term care policy, Americans will continue to experience unmet needs and financial devastation as they and their families struggle to pay for and provide needed services and supports.

Further, improving the long-term care system will advance the goal of using our health care resources more efficiently and effectively. Inadequate long-term care leads to worsening health conditions, unnecessary acute medical events such as hospitalizations, and greater demands on medical services. And poor coordination of services to meet a person’s combined medical and long-term care leads to wasteful inefficiencies, along with worse overall care. Improving the long-term care system will enhance the nation's efficient use of health care resources. These efficiency gains are essential to achieving the goal of controlling the future growth of health care spending while sustaining, or improving, quality.

Many opportunities exist to improve long-term care policy. This policy brief presents four policy options that merit serious consideration in the current health care reform discussions. We selected options that we think would address the most pressing needs in long-term care financing reform and help us achieve the goals of health care reform. The discussion is not exhaustive of the many ideas for improving long-term care financing that policymakers and analysts have proposed, such as the papers developed for the Georgetown University Long-Term Care Financing Project.¹ We focus on four policy options that will enhance the economic security of American families and improve the cost-effectiveness of health and long-term care, and that make sense now, in the current political and economic environment. These options set us on a path to a better long-term care system for the future.

The first two options would improve long-term care for people with low incomes who are eligible for Medicaid. These options would modernize Medicaid in important ways, tailoring services better to individual needs and using resources more effectively:
• **Expand Medicaid Support for Home and Community-Based Services.** The first option addresses a major shortcoming in Medicaid’s benefits—the limited, and highly variable among states, access to personal assistance in home and community settings.

• **Improve Coordination of Medical and Long-Term Care for Medicare-Medicaid “Dual Eligibles.”** The second proposal would improve care and reduce inefficient and unneeded services through better coordination of Medicare's mainly acute-care benefits and Medicaid's long-term care and other benefits for people enrolled in both programs.

The third and fourth options aim to strengthen long-term care protections for the broader population: one with better coordination of medical and long-term care for Medicare enrollees; the other by establishing insurance protection for people of all ages and incomes:

• **Improve Coordination of Medical and Long-Term Care for Medicare Enrollees with Chronic Conditions.** The third proposal would promote the testing and rapid adoption of service delivery and payment models designed to both improve care for Medicare enrollees and increase efficiencies in care delivery, through better coordination of the full range of medical and long-term care services people may need.

• **Establish Public Insurance Protection for Long-Term Care for the Broad Population.** In the fourth proposal, a public insurance program, financed by participants’ contributions, would spread the risk across a broad population and offer protection to participants of all ages and incomes. The insurance could be designed to provide a core benefit that would be supplemented with private resources (including private long-term care insurance) and Medicaid.

The four proposals could be enacted separately or together. Legislative action would not only be a major step toward building a stronger long-term care system for the future, but would also enhance major health and economic policy goals: improving the health and well-being of individuals, increasing the effectiveness and efficiency of health care delivery, and strengthening the economic security of American families.
What is long-term care and how many people need it?

Long-term care, also called long-term services and supports, refers to the services needed when a person’s ability to care for oneself has been compromised by chronic illness or disability. Long-term care consists predominantly of assistance from another person with routine daily activities such as bathing, getting around the house, preparing meals, or managing medications. The majority of long-term care is provided by family members and friends. People with disabilities are also supported by professional services provided in various settings including at home, and in assisted living facilities and nursing homes.

About 10 million people of all ages need long-term care (see Figure 1). A need for long-term care may arise from numerous causes, including chronic conditions, disease, injury, and developmental disabilities. Although the likelihood of needing long-term care increases steeply at older ages, about 40% of people with long-term care needs are under the age of 65. About two-thirds of people with long-term care needs are assisted solely by family members and friends, about one-fifth receive professional assistance at home or in other community settings (usually in combination with family help) and 14% receive support in nursing homes.ii

Approximately half of the adults with long-term care needs have a relatively high level of need, as indicated by a need for assistance with two or more activities of daily living (ADLs), substantial cognitive impairment, or nursing home residence.iii

Figure 1. People with long-term care needs, 2005

II. The Problem: Why the Current System Needs Reform

Our long-term care system falls far short of the access to care, choice, and quality that it should provide. The way long-term care is financed—and in particular, the lack of insurance protection for the risk of long-term care—is a major factor in these problems. Like the need for medical care, the need for long-term care is uncertain and varies widely among individuals. Some people will never need any. Some will rely solely on assistance, often extensive, from family caregivers. Some will need extensive long-term care, of a type or amount beyond what family caregivers can provide, and at an expense beyond what most families can afford. The cost of nursing home care—which averaged about $77,400 per year nationwide in 2008, and over $125,000 per year in several of the most expensive markets—or extensive services in other settings can quickly exhaust savings.

Few people, however, have insurance protection against the risk of long-term care. Although Medicare and most private health insurance plans cover rehabilitation and therapy services under some circumstances, they do not pay for the ongoing personal assistance with routine daily activities that constitutes most long-term care. Fewer than 3% of adults have private long-term care insurance.

The Medicaid program, administered by states and funded jointly by state and federal governments, is the nation's safety net for long-term services and supports. Medicaid pays for long-term care for people with few financial resources and for people who have exhausted their financial resources on medical and long-term care expenses. Although Medicaid’s safety net is crucial, it does not protect against financial catastrophe and, importantly, it does not provide the amount, type, or quality of long-term care services and supports people need and want. Medicaid's benefits and eligibility rules vary dramatically among states, leading to remarkably large differences in the availability of long-term care, especially home and community-based services, among states and among geographic areas within states.

Many individuals who need long-term care do not get the services they need, even if they are eligible for Medicaid, diminishing their quality of life and imperiling their health and safety. In the last national survey to explore the issue of unmet long-term care needs among people of all ages, one of every five individuals at home and in need of long-term care reported going without care they needed. Other research has found even higher rates—a survey of low-income seniors dually eligible for Medicare and Medicaid in six states found that more than half of those at home with long-term care needs had unmet needs.

An inability to obtain adequate care at home can cause some individuals to move to nursing homes in order to obtain needed care. A recent analysis estimated 5%-12% of long-stay nursing home residents, and a similar proportion of newly admitted residents (with a stay of at least 90 days), have relatively “low-care” levels of need, similar to need levels of people able to reside in community settings with adequate long-term services and supports.

Medicaid is the nation's largest funder of long-term care services, accounting for about 43% of national spending for long-term care in 2006 (see Figure 2). The federal government paid for more than half of Medicaid’s spending—the federal portion of Medicaid constituted about 25%
of national spending for long-term care, while the states’ share constituted about 18%. Private out-of-pocket spending was the second largest source of financing for long-term care, paying for 28% in 2006; and private insurance (consisting of both health and long-term care insurance) accounted for 7% of spending. These measures of spending vastly understate, however, the role of private resources in the form of unpaid family care and the indirect costs incurred by family caregivers. The overwhelming majority—85 percent—of total hours of care received by people living at home with long-term care needs are unpaid. Although Medicare represents 18% of national spending shown in Figure 2, Medicare is not designed to cover long-term care and most of this spending is for shorter-term, medically-related post-acute and rehabilitative services provided by home health agencies and skilled nursing facilities.

Our long-term care system lacks coordination among services to address health and long-term care needs. For people who have both complex medical needs and long-term care needs, the lack of coordinated care to meet their full range of needs is especially problematic, not only increasing the difficulty of arranging services but also leading to avoidable medical problems (and medical expenses) because of the lack of adequate support of the person’s daily needs for long-term care.

The four options we describe below would set us on a path to a better long-term care system for the future. They would improve access to needed long-term care and help control the growth of health and long-term care spending by using resources more efficiently and better coordinating care of both types. The first two options would address major shortcomings in the adequacy and coordination of care for people with the fewest financial resources; the second two would improve the adequacy of long-term care and coordination of care for the broader population.
III. Proposals to Improve Long-Term Care in Medicaid

A top priority in long-term care reform is to improve access, choice, and efficiency of long-term care services for people who are unable to pay for these services on their own because of their limited financial resources. Projections of health care spending growth make it clear that we must find ways to slow the growth of Medicaid and Medicare spending, as well as health care spending overall, by using resources more efficiently. The two options examined below would modernize Medicaid in important ways, tailoring services better to individual needs and using resources (medical and long-term care) more effectively.

Expand Medicaid Support for Home and Community-Based Services

This proposal aims to make personal care services in home and community settings more widely, and equitably, available in states’ Medicaid programs. This could achieve two important outcomes. First, more people would be able to obtain needed care in the setting they prefer, rather than having their choice limited to institutional services. Second, Medicaid long-term care programs could become more efficient over time by reducing use of higher-cost nursing home services relative to what it would otherwise be. Although expanding support of home and community-based services would require an initial investment, a recent review of research evidence concluded that it can be cost-effective over time for states to develop more balanced long-term care systems.

Of the $101 billion that Medicaid spent on long-term care in federal fiscal year 2007, 58 percent was for institutional (mainly nursing home) services. While the proportion of Medicaid's long-term care spending dedicated to home and community-based services has increased markedly in the past decade, an “institutional bias” in Medicaid coverage persists. Home and community-based services spending as a share of total long-term care spending grew from 19% to 42% between fiscal years 1995 and 2007, although the proportion varies among states. The majority of Medicaid long-term care spending goes towards institutional services in all but eleven states.

The wide variation in states’ investment in home and community-based services is an indicator of variation in the availability of these services. In 2005, home and community-based services spending per low-income person residing in the state (household income below 200% of the federal poverty threshold) in the five highest-spending states ($1,137) was nearly three times the national average ($383) and nearly eight times the average spent in the five lowest-spending states ($145) (see Figure 3).

The institutional emphasis originates in Medicaid law: federal law mandates that state Medicaid programs cover nursing home services, but gives states the option of covering personal care and other long-term care services in home and community settings. Although all states offer at least some home and community-based services, benefits and eligibility vary widely among states, and among geographic areas within some states. The avenues for covering these services are complex and vary in part because they have been added in patchwork over time to encourage states to shift their emphasis away from nursing home care, while at the same time reflecting a concern about constraining costs.
Differences in state policies can have serious consequences for people who need long-term care. A person who is financially eligible for Medicaid in one state might not be in another state, or might be eligible for Medicaid but not for Medicaid-financed home and community-based services. The result is a lack of access to needed care for many people—and inefficiency in Medicaid’s long-term care spending because some nursing home residents could be served as well, or better, in community settings at lower cost.

**Key Elements of the Proposal**

Different approaches could be implemented to increase access to home and community-based services in Medicaid. Key components of a proposal include the following:

- **Require—or provide strong financial incentives for—states to expand home and community-based services.** Mandating coverage of adequate levels of home and community-based services would make these services much more equitably available among states. To assure that services are meaningful, requirements could specify minimum benefits. If coverage of home and community-based services is not mandated, barriers to change will likely persist and protections for individuals will continue to vary widely among states, with people in some states having access to few home and community-based services benefits. If coverage is not mandated, then legislation should strengthen federal support for broadening access to home and community-based services.
• **Provide financial assistance to states to help finance expansions, through a higher federal matching rate.** Over time, better balanced long-term care systems are expected to be cost-effective—that is, to improve efficiency and yield good value for the dollar—but expansion will initially require higher expenditures. These expenses result from both the initial investments in establishing new benefits and the expectation that savings from lower nursing home use (compared with what it otherwise would have been) will be seen with a lag compared with spending for newly available home and community-based services benefits. Federal support to the states is therefore needed. Such support could be provided through a higher federal matching percentage for home and community-based services.

• **Make home and community-based services eligibility available on an equal-footing with nursing home care.** Both the disability criteria and financial criteria for eligibility should be equivalent for community-based and institutional services, including spousal impoverishment protection rules. For equivalence, people in community settings need enough financial resources to support community living. Raising the asset limits would allow people to keep sufficient resources to stay in their homes while receiving benefits.

A proposal could go further and extend benefits to a broader population to include people with a lower level of disability (that is, not meeting disability criteria for nursing home benefits), both to provide access to needed care (and thereby avert potential medical crises because of unmet need) and to prevent, or slow, deterioration to a more severe level of disability. This extension could be a state option, though perhaps encouraged with a financial incentive, such as with a higher federal matching percentage for the resulting expansion in services.

• **Invest in workforce development.** For the expansion of Medicaid coverage of home and community-based services to be fully effective, the delivery system for home-based care will need to expand. Potential investments in workforce development include support for training for direct care workers and training and support for family caregivers.

**Examples**

A recent Congressional bill offers one approach to making these changes in Medicaid. The *Community Choice Act* (S. 683, introduced by Senator Harkin, and H.R. 1670, introduced by Representative Davis) would require all states to make the option of personal attendant services in home and community settings available to people eligible for Medicaid nursing home services. The proposal provides states additional financial support for services for individuals requiring especially costly services, and for early implementation.

Two estimates of related, but not identical, proposals give a rough indication of the potential federal cost of the proposal. First, in a 2007 article, the authors estimated that requiring state Medicaid programs to provide personal assistance services to people with a nursing home level of disability would increase federal Medicaid spending by an estimated $1.4–$3.7 billion annually in 2006 dollars (and states’ Medicaid spending would increase by $0.6–$1.6 billion annually).xix A second estimate suggests a somewhat higher expense, though of roughly similar...
A different policy approach would be to encourage, but not require, states to make home and community-based services more widely available by giving them more flexibility in setting eligibility rules, along with financial incentives to shift toward more home and community-based services. This approach is proposed in a recent Senate Finance Committee paper describing proposals for expanding health care coverage.\textsuperscript{xxi} The Senate Finance Committee paper includes an option that would allow states to expand eligibility for home and community-based waiver services by eliminating the requirement that recipients have a nursing-home-equivalent level of need. The option would also permit states to broaden income eligibility criteria for home and community-based services offered in a state plan, up to the level now permitted for nursing home services and home and community-based waiver services (that is, income up to 300 percent of the Supplemental Security Income, SSI, benefit level). A second option in the Senate Finance Committee paper would encourage states to expand home and community-based benefits by increasing the federal matching percentage for these services. A third option would require states to apply spousal impoverishment protections (which are currently available for community spouses of nursing home residents) to spouses of people receiving home and community-based services (which states may optionally do now in some situations).

The \textit{Empowered at Home at Act} (S.434, introduced by Senator John Kerry) similarly would allow states more flexibility in setting eligibility criteria for home and community-based services. In states that take up the option, many more people could obtain home and community-based services, but states might not act on the option or might make only modest changes.

Alongside either a mandatory or optional approach, promoting workforce development would assist the service delivery system in meeting new demands. For example, the \textit{Retooling the Health Care Workforce for an Aging America Act} (H.R.468, introduced by Representative Schakowsky, and S. 245, introduced by Senator Kohl) includes several provisions to provide training for direct care workers and family caregivers.

\textbf{Improve Coordination of Medical and Long-Term Care for Medicare-Medicaid “Dual Eligibles”}

A second proposal focuses on measures to improve quality and efficiency of service delivery for acute medical as well as long-term care for people enrolled in both the Medicare and Medicaid programs, often referred to as “dual eligibles.” While dual eligibles constitute less than one-fifth of the enrollees in each program, they are high users on average of both Medicare and Medicaid services, accounting for 25\% of Medicare spending and 46\% of Medicaid spending in 2005 (see Figure 4). This high service use reflects their poor health status and greater likelihood of needing long-term care services. About one-third of dual eligibles use Medicaid-financed long-term care services in community or institutional settings.\textsuperscript{xxii}
The proposal focuses on the majority of dual eligibles who are eligible for full Medicaid benefits. Among the 8.8 million dual eligibles in 2005, 7.1 million were eligible for full Medicaid benefits; the other 1.7 million received Medicaid support to help pay for Medicare’s premiums and cost-sharing requirements but were not eligible for the full array of Medicaid benefits.xxiii

Together, Medicare and Medicaid provide a broad set of benefits for dual eligibles who are eligible for full Medicaid benefits. Medicare is the primary payer for services that both programs cover (mainly acute care). Medicaid pays the cost-sharing associated with Medicare benefits and also for Medicaid services not covered by Medicare, such as long-term care, dental, and vision services. Long-term care accounted for 58% of Medicaid spending for dual eligibles in 2005.xxiv

Although dual eligibles with long-term care needs typically use benefits of both programs, except in some demonstrations and waivers, neither program assumes responsibility for coordinating services across the programs. Neither program, for example, assures support services following a Medicare-financed hospitalization that might prevent a Medicaid-financed admission to the nursing home. And, if Medicaid were to invest in such support and prevent a hospital admission, its administrators often point out it is Medicare and the federal government that would reap the savings from lower hospital spending, while Medicaid and the state would bear the expense for in-home care.

The proposal would provide states with incentives to create, or expand, programs that coordinate the services paid for by the two programs—the mainly medical services covered by Medicare and the long-term care and other services covered by Medicaid. In doing so, states can build on the experiences of existing demonstration and waiver programs for integrated care, such as the
Program of All Inclusive Care for the Elderly (PACE), Wisconsin’s Partnership Program, Minnesota’s Senior Health Options, and New Mexico’s Coordination of Long-Term Services. xxv Better coordination of benefits has potentially large advantages for dual eligibles by improving the appropriateness and adequacy of care—and for the Medicare and Medicaid programs by using resources more efficiently through reducing duplication and inefficient “shifting” of responsibility between programs.

Key Elements of the Proposal

The proposal would promote adoption by states of programs to coordinate acute and long-term care services for dual eligibles. Although some options for offering coordinated Medicare-covered and Medicaid-covered services are available to states under current law, few programs currently exist. The goal of this proposal is to make a broader set of models available to states for integrated care programs, initially as demonstrations or waivers, with the potential for broader adoption. In addition, federal grants could be used to help states invest in developing new programs.

The objective in coordinated or integrated care is to have one organization or entity assume responsibility for coordinating the combined set of services covered by Medicare and Medicaid—and for the organization to have the incentive to provide care efficiently. To create an incentive for efficiency, an integration program needs to include a way for savings from services covered by one program to be applied to services covered by the other. Models in which a single organization receives a pre-set, risk-adjusted monthly payment per person from each program is one way to create this incentive, but other approaches are possible.

Most existing models use a managed care plan model, in which a health plan is responsible for providing all Medicare and Medicaid benefits, in return for a capitated payment (that is, a pre-set amount per person) from each program. xxvi For example, in Wisconsin, the Partnership Program is a voluntary program, available in some regions of the state, for dual eligibles who have a nursing home level of long-term care need. Participants receive integrated care from a health plan that has contracts with both Medicaid and Medicare. The plan receives a monthly per-person payment from each program for each dual-eligible participant; in turn, the plan is responsible for providing all Medicare-covered and Medicaid-covered services participants receive. xxvii

Although most existing models use a managed care design, other model designs could be used to achieve integrated care. The proposal would encourage states to experiment with different designs. Specifically, states that implement successful integrated care programs would receive a share of the Medicare savings, relative to a target, resulting from the adoption of integrated care.

Key elements in a coordinated care model include the following:

- **A responsible entity.** One organization or entity would be responsible for assuring adequate, coordinated care. The responsible entity could, for example, be a Medicare Advantage (managed care) health plan that receives payments from both Medicare and Medicaid. Alternatively, a state could be the responsible entity and either administer the program or contract with a health plan or other organization.
- **Responsibility for coordinating the full set of acute and long-term care benefits.** To eliminate incentives for shifting responsibility, the covered care must include the full scope of Medicare and Medicaid benefits including home and community-based services and institutional long-term care. A mechanism for coordinating care will be essential, but many different approaches are possible. Existing models illustrate some different designs for coordinating service delivery: for example, in Wisconsin’s program a multidisciplinary team that includes a nurse practitioner coordinates care; in Minnesota’s program, one person (a nurse or social worker) is responsible for coordinating care; and in Massachusetts’ program, a team of nurses and social workers coordinates care.xxviii

- **Financial incentives for efficiency.** A mechanism that combines Medicare and Medicaid funding can promote efficiency gains by enabling savings in one program to be used to pay for services covered by the other—for example to use savings from Medicare-covered hospital or other acute care services, to be used to pay for home and community-based services or other non-Medicare services. One potential approach is to use capitated payments—that is, a pre-determined monthly payment amount per person. Paying capitated payments to a health plan provides an incentive for efficiency because the plan can “profit” from finding ways to reduce costs. However, other mechanisms that provide a financial incentive for efficiency are possible, such as a shared-savings model (sometimes referred to as a “gain-sharing” model) in which, instead of a capitated Medicare payment, any Medicare savings (relative to a targeted amount) are shared between the Medicare program and the health plan (or the state).

- **Mechanisms for assuring adequacy and quality of care, and data collection.** Quality monitoring is essential to protect dual eligibles from under-service. Regular and timely reporting of enrollees’ characteristics and service use are essential for quality monitoring and evaluation of the program.

- **Voluntary participation for beneficiaries.** Making participation voluntary, in contrast to mandatory, can also promote quality. If an integrated model is producing the coordinated care it should be, then it should be able to attract and retain voluntary participants. Further, it is important that dual eligibles, like other Medicare beneficiaries, retain the right to choose between fee-for-service Medicare and the option of enrolling in a Medicare Advantage plan.

Two distinct approaches to designing integrated care systems are: models that involve Medicare Advantage (managed care) plans; and models that do not use a Medicare Advantage plan platform.

- **Models involving Medicare managed care plans.** One approach for integrating care, available under current law, involves a contractual arrangement between the state and a Medicare Advantage Special Needs Plans (SNPs). SNPs (established by Medicare Modernization Act of 2003) are Medicare Advantage plans that target one of three categories of Medicare beneficiaries, one of which is dual eligibles. As a Medicare Advantage plan, a SNP receives a capitated payment from Medicare for each Medicare
beneficiary who enrolls in the SNP, and in exchange must provide the enrollee with Medicare benefits. SNP enrollment is voluntary for Medicare beneficiaries.

To create an integrated care program for dual eligibles, a state Medicaid program can contract with one or more SNPs so that for dual eligibles who choose to enroll in a SNP, the SNP will also provide their Medicaid benefits. Under this arrangement, the SNP would receive a capitated payment from Medicare, as well as payment from Medicaid. The payment from Medicaid could also be a capitated payment, but it does not have to be. An alternative potential design is for the state to contract with an organization to administer and coordinate Medicaid benefits for people enrolled in the SNPs operating in the state. Although a few states have adopted SNP-based integrated care programs, they are not widely available and not many dual-eligibles are enrolled in such plans. SNPs are not available in many states and locations within states; and regulatory and administrative differences can make it difficult for states and SNPs to integrate Medicaid and Medicare benefits in practice, such as differences in enrollment requirements and procedures to appeal claims.

Other models. Alternative integrated care arrangements that do not rely on a capitated payment from Medicare are also possible. As one example, North Carolina has proposed a demonstration that involves a shared-savings arrangement between the federal government and a non-profit organization connected to the state Medicaid agency. This organization—the Carolina Community Network—consists of a set of regional networks of physicians, hospitals, health departments and other community organizations. Under the demonstration, a financial incentive for efficiency would be provided by a shared savings (gain-sharing) arrangement. If actual spending for the Medicare benefits of participating dual eligibles is less than a target amount, then the Carolina Community Network will get a portion of the savings, subject to a specified cap.

Another approach would have states themselves take on responsibility for coordinating care, and providing the types of home and community-based services that can lower costs of hospital and other medical care (which are mostly borne by Medicare). States could administer coordinated care benefits or contract with private plans for that purpose.

Although some coordination has proceeded with reliance on capitation, other approaches could offer some distinct advantages in terms of assuring adequate service and could make integrated care available in geographic locations with no, or limited, availability of managed care plans. The goal of capitated payment is to encourage cost-effective, coordinated care. But capitation can reward an organization that delivers too little service—delivering less but not better care and simply reaping greater profits. Use of capitation rates on the assumption that the result will be greater efficiency can risk harming the people coordination is aiming to help.

Efforts to encourage coordinated care should therefore begin with the development and assurance of effective delivery arrangements—not with payment of a capitation rate. Providers and plans can be encouraged to develop those mechanisms through demonstrations, and be rewarded for reducing unnecessary services with mechanisms that pose less risk than full capitation—for example, the opportunity to share in and reallocate “savings” from lower than
projected use of hospital care. Even for a sophisticated organization, payment based on fixed budgets, which depend on the actual delivery of services (of whatever mix), may be preferable to payment of capitation payments, which are made whether or not services are delivered.

Despite its advantages in promoting value and quality, however, shared savings poses a problem in the timing of its efficiency rewards. Capitation payments, guaranteed in advance of services, provide organizations full flexibility to use resources as they deem most appropriate as they deliver services. By contrast, in shared savings approaches, organizations share in any savings relative to specified benchmarks or targets, with those savings determined retrospectively (for example, after a year). The entity providing coordinated care may therefore find it difficult to finance additional Medicaid services now, well in advance of receiving the reward. Thus, to encourage states and other organizations to take up this approach—and to encourage aggressive efforts by coordinated care programs to reduce acute-care needs by using Medicaid-covered services—it may be valuable for the federal government to make “start-up” funds available for new programs, for example through grants. (At a later time, up-front grants would be deducted from rewards determined when actual savings were known.) For established programs that want to expand, similar considerations would apply; in this case, the Centers for Medicare and Medicaid Services (CMS) might consider making funds available based on past performance, scaled to the number of enrollees.

Examples

The recent Senate Finance Committee paper describing policy options for expanding health care coverage includes three options that would create new opportunities and incentives for states to develop coordinated care programs for dual eligibles:

- **Establish a new Medicaid demonstration program for dual eligibles.** The proposal would create a new Medicaid authority allowing states to apply for demonstration waivers to test various approaches to coordinating care for dual eligibles. This proposal would potentially encourage experimentation with models of coordinated care for dual eligibles that do rely on a Medicare Advantage plan platform.

- **Allow use of Medicare savings in waiver cost-effectiveness test.** The proposal would let states’ waiver applications for programs to coordinate care for dual eligibles use Medicare savings to satisfy the requirement that the waiver program be cost-effective. This option applies specifically to section 1915(b) waivers; these types of waivers allow states to restrict Medicaid enrollees’ choice of providers, for example by requiring them to enroll in managed care plans. This proposal could encourage more states to contract with managed care organizations to provide coordinated care for dual eligibles.

- **Establish an “Office of Coordination for Dually Eligible Beneficiaries.”** The new office, established within CMS would provide leadership in identifying and creating ways to promote coordinated care for dual eligibles. A key role would be in leading efforts to align Medicare and Medicaid administrative and regulatory requirements to reduce complexity and barriers that occur in working across the two programs in coordinating care. This office would track and report on spending for dual eligibles.
These proposals could be strengthened by sharing Medicare savings that result from successful demonstrations with states that initiate them, as described above.

IV. Proposals to Improve Long-Term Care for the Broader Population

Strengthening the Medicaid safety net assists the most vulnerable people in need of long-term care—people who have limited resources and people whose needs have depleted their resources. But to best promote Americans’ health and economic well-being, attention to people’s long-term care needs requires broader policy reform. The third and fourth options address two major problems in the current long-term care system: the lack of coordination of medical and long-term care needs for people who need both; and the lack of insurance protection, regardless of income, for the risk of long-term care.

Improve Coordination of Medical and Long-Term Care for Medicare Enrollees

It is widely recognized that the health care system falls short on coordinating care among multiple physicians and providers, resulting in poor quality and wasted resources from avoidable hospitalizations and emergency room visits. Research on avoidable re-hospitalizations also suggests that better transition support for people returning home following a hospital stay could potentially reduce re-hospitalizations, improving care and saving money. A recent study found that one-fifth of Medicare beneficiaries discharged from the hospital were re-hospitalized within 30 days.

Recent attention has focused in particular on individuals with multiple chronic conditions and high medical costs for whom better coordination and transition support could be most beneficial, both in terms of improving health and well-being and improving the efficiency of care delivery. Many Medicare beneficiaries with long-term care needs have complex medical care needs, high Medicare spending, and could benefit greatly from better care coordination, including better transitional care. Among Medicare enrollees age 65 and older residing in community settings (that is, not in nursing homes), the 14% who received assistance with activities of daily living had average Medicare spending in 2005 that was more than three times the average for those who did not need assistance with activities of daily living (see Figure 5).

The objective of this proposal is to make coordinated care that addresses both medical and long-term care needs more widely available to Medicare enrollees, in particular enrollees with complex needs including management of multiple chronic conditions. The proposal would create financial incentives in Medicare for care coordination support that spanned both medical and long-term care domains. The proposal would not alter financial responsibility for paying for medical and long-term care services. Thus, individuals and their families (and Medicaid for eligible people) would continue to be responsible for paying for long-term care services, with care coordination assisting individuals in using their private resources effectively to meet their needs.
New demonstrations could build on the experiences with existing models. One example is the Guided Care model, developed and piloted by Chad Boult and colleagues at Johns Hopkins University. In this model, a specially-trained registered nurse, based in a primary care physician practice, works with clinicians and patients. Activities include: assessing needs and developing plan of care, providing information and support for patients and family caregivers, and coordinating transitions among sites of care. Results of the program are promising; they indicate both improved quality of care and reduced medical care costs from fewer hospital stays and emergency room visits.xxxvii

**Key Elements of the Proposal**

The proposal would explicitly promote development of coordinated care models that include long-term care within an aggressive demonstration and implementation program in Medicare designed to stimulate innovation and experimentation in service delivery. Coordinating long-term care requires particular knowledge and skills: good care coordination involves understanding the patient’s and family’s needs, preferences, and caregiving capacity, as well as knowledge of the types of services and supports available in the local market. The aim of the proposal is to encourage development of care coordination models that effectively coordinate across medical and long-term care services.

Within a flexible framework, demonstrations would need to meet certain broad requirements, including the following key elements:
Primary care “medical home” model. The proposal calls for chronic care coordination models that are designed to provide enrollees with a primary care medical home—a physician or group practice with which the person has a long-term relationship and that serves as a place of first contact for new medical concerns, coordinates care with specialists, and supports communication among patient, family and other caregivers, and providers. Experts have found that effective designs rely on teams for delivery of care; coordination could be the responsibility of a single coordinator or a team.

Explicit responsibility for coordinating long-term care as well as medical care. A care coordination program would not be required to pay for the long-term care services that are not included in Medicare benefits, but the care coordinator or coordination team would have explicit responsibility for assessing the patient’s long-term care needs and assisting the patient and family members in locating care options and coordinating care. The care coordinator would play a critical role in planning transitions among care settings and in making care arrangements, for example in arranging for rehabilitation services and home care after a hospital stay.

Communication with, and support and training for, family caregivers. When desired by patients, family caregivers would be involved in consultations with members of the care team. Care coordination activities would also include education and training for family caregivers to assist them in providing long-term care support. In addition, coordination services would assist individuals and their family caregivers in assessing needs for, and to locate and arrange for, long-term care services.

Payment system to support the model. Medicare payments for coordinated care need to provide appropriate incentives to support the model’s goals of patient-centered, coordinated, quality care. The demonstrations would permit testing of innovative methods.

Option of targeting program to specific populations. Demonstrations would have the option of being designed specifically for Medicare beneficiaries with certain health characteristics; for example, Medicare enrollees who meet specified criteria indicating that they have complex health care needs and require an array of services from different providers and potentially in various settings, or Medicare enrollees who meet specified criteria indicating needs for both complex medical care and long-term care support.

Data and evaluation. It is essential that data be reported that can be used to monitor programs and evaluate their effects on beneficiaries and program costs. Uniform reporting requirements should apply to all participating providers and organizations, including collection of cost information and outcome measures on a timely basis.

Authority to expand successful demonstrations without new legislation. Allowing the Secretary to expand successful demonstration designs without new legislation would promote rapid diffusion of innovations designed by CMS or private organizations.
The proposal would be strengthened by expanding it to include benefits, limited in scope, to assist family caregivers and thereby assist beneficiaries in remaining at home. For example, one benefit could provide a capped amount of respite services to support family caregivers. Another potential benefit could provide training and counseling assistance to a family caregiver, for example through a maximum number of appointments with appropriate professionals, such as a social worker or a nurse.

**Examples**

The Senate Finance Committee’s recent document describing proposals to improve patient care and reduce health care costs includes two proposals that would promote innovation and testing of chronic care coordination models. xxxviii

- **Extend the Medicare Health Care Quality Demonstration program.** This proposal would permanently extend the Medicare Health Care Quality Demonstration, which was established as a five-year program by section 646 of the Medicare Modernization Act. The demonstration program allows physician and other provider groups to use alternative benefit and payment designs to test approaches to improving patient care. Although the Senate Finance Committee does not specifically identify care coordination as a focus of the reauthorization of this demonstration, experts have suggested that this demonstration could be used to test innovative payment designs for chronic care coordination.xxxix

- **Establish a “Chronic Care Management Innovation Center” in CMS.** This proposal could complement the one above by supporting CMS-initiated chronic care models. The new center would initiate, and evaluate, pilot programs to test different models and approaches to improving care coordination, including testing payment methods. Target populations are not restricted, but the proposal would encourage development of models for patients with multiple chronic conditions and long-term care needs.xl

These policy improvements could be greatly strengthened by specifically encouraging the development and testing of models that include the coordination of long-term supports and services along with medical care.

A different approach—creating a Medicare payment specifically for chronic care coordination—was proposed in the *Reaching Elders with Assessment and Chronic Care Management and Coordination Act* (or the *RE-Aligning Care Act*, S.1004, introduced by Senator Lincoln, and H.R. 2307, introduced by Representative Green). This proposal would establish Medicare payments to physicians (and other authorized professionals) to cover costs of conducting assessments for fee-for-service Medicare enrollees with multiple chronic conditions and expected high Medicare expenditures (and who are not nursing home residents)—and of care coordination services for those determined in the assessment to be eligible for them. A single chronic care manager (physician or other authorized professional) would be responsible for coordination activities such as: managing referrals and conferences among different providers, providing educational and counseling support for patients and their family caregivers, providing information and referrals for community-based long-term care services, and coordinating transitions among settings.
Establish a New Public Long-Term Care Insurance Program

Until we address the greatest gap in long-term care financing—the lack of widespread insurance protection—individuals and families will continue to be at risk of unmet long-term care needs and financial catastrophe. We currently lack any vehicle that serves to spread the financial risk of long-term care throughout the population and provide a reliable funding source for the care some people will need. While Medicaid acts as a safety net for individuals with few resources or whose resources have been exhausted by out-of-pocket medical and long-term care costs, most people have little protection against the possibility of impoverishment. And state budgets are strained by the lack of widespread insurance coverage with more than one-third of Medicaid spending devoted to long-term care for people who had neither insurance nor the resources to pay for all of their care out-of-pocket.xli

Despite federal and state efforts to create a more robust private long-term care insurance market, relatively few adults have purchased this type of coverage. The cost and complexity of private long-term care insurance limit the ability of many consumers to purchase it.xlii In addition, the private market has struggled to price products, keep premiums steady for existing policyholders, and provide benefits flexible enough to serve needs that may arise decades after purchase. And private long-term care insurance simply is not available to people with disabilities, including younger people with disabling injuries or health conditions.

Key Elements of the Proposal

The proposal would establish a new public long-term care insurance program for a broad population. Under such a program, private insurance and Medicaid would likely continue to play a role by “wrapping-around” a core set of benefits provided by the new public program. Designing a public long-term care insurance program requires a policy design that includes several key elements:

- **Ensure high participation among potential enrollees.** High participation spreads risk widely, thereby producing adequate revenues (through premiums or taxes) to pay benefits while at the same time keeping the enrollee contribution affordable. Other than mandating participation, policymakers could consider a mechanism that automatically enrolls employed individuals, requiring them to choose explicitly not to participate (referred to as “opt-out”). Subsidizing premiums for people with low-incomes and offering tax incentives would also encourage participation in a voluntary system. If participation is mandatory, subsidies for low-income people would be important to make their contributions affordable.

- **Provide meaningful benefits.** To achieve its goals of improving access to needed care and providing financial protection for the risk of having long-term care needs, the program must provide benefits that are significant and flexible. Under these broad criteria, the program design could reflect any number of policy choices. The program could contain what is referred to as an “indemnity” structure, where specified types and amounts of services are covered and benefits are tied to actual service use. Or, alternatively, it could use a “disability” structure where the presence of a disability
triggers specified benefits that are not tied to specific service use and could be used to purchase a wide range of services or supports. Some advocates argue that given the nature of long-term care (where so many needs are personal and highly individualized), the flexibility of a disability structure would better meet people’s needs.

Within either approach, policymakers must decide on the extent of the public program’s benefits. For example, in most private long-term care insurance policies, the policy’s payment of benefits is limited to a maximum dollar amount of expenditures for covered services (on average about $150 per day) and to a certain amount of time (the majority of buyers choose between three and five years of coverage, although policies with lifetime coverage are available). These amounts are determined by the policyholder at the time of purchase; as an option, purchasers can buy inflation-protection which increases the benefits annually by a specified rate. Policymakers have the option of following this type of benefit structure or providing a different design, such as a smaller benefit amount over a longer period of time. They could also decide to pay benefits immediately upon the advent of disability or after a period of time or a certain amount of privately-financed service use (deductible). All of these decisions have implications for the amount of the premium or tax as well as the roles of Medicaid and private insurance.

- **Establish a financing mechanism.** Any public long-term care insurance program must specify a way to generate revenue to pay for all or most of the program’s costs. The program can generate revenue through the collection of premiums by participants. Alternatively, policymakers could choose to finance the program through taxes, such as a payroll tax like Medicare Part A or some type of income tax surcharge. Some offsetting savings would likely be available, over time, from reductions in expenditures by other programs, especially Medicaid. Savings would be generated when the public insurance program’s benefits enable individuals who would otherwise be eligible for Medicaid benefits to avoid (or delay) relying on Medicaid.

**Examples**

Two public insurance proposals illustrate the potential variations in policy design options. The first, the *Community Living Assistance Services and Supports Act (CLASS Act)*, included in the Senate Health, Education, Labor, and Pensions (HELP) Committee’s recent proposed health care reform legislation, would establish a premium-funded insurance program that pays flexible cash benefits and promotes participation by deducting premium contributions from wages unless employed individuals opt out of enrollment. The second, a proposal to finance long-term care services through Medicare developed by Leonard Burman and Richard Johnson for the Georgetown University Long-Term Care Financing Project, would establish a Medicare-based program that covers services financed through a surcharge on federal income taxes.

We explore the key features of these two proposals below:

- **Participation.** The CLASS Act would permit an employed individual and spouse age 18 and older to enroll in the new program and pay monthly premiums. (A person who later becomes unemployed or retires can stay in the program by continuing to pay premiums.)
The proposal adopts an “opt-out” approach to enrollment of working-age adults, which has been applied to employment-based savings programs.\textsuperscript{xlvi} To also encourage participation, the CLASS Act subsidizes premiums for people with low incomes.

The Medicare expansion, in contrast, provides insurance protection to all individuals included in the program (people under a specified age when the new program begins) at the time they become Medicare enrollees (that is, at age 65 or at younger ages if eligible based on significant disabilities). Therefore, there is no explicit decision to enroll; rather, nearly everyone is automatically enrolled.

Both the CLASS Act, and the Medicare expansion begin collecting revenue from a working-age population and allow this revenue to accumulate, initially for a five-year period before the program begins to pay benefits, but more importantly over time before the people covered by the new program reach the older ages at which long-term care risk is highest. By financing with revenues collected from a broad population consisting initially of working-age people, both programs offer a way for people to pay over time to obtain insurance protection for potential future needs. However, because they exclude people who are now older from coverage, the problems of inadequate insurance coverage would remain for a long time.

- **Benefit structure.** The CLASS Act would provide a “cash” payment—recipients would receive specified amounts in a funded account which they could draw upon for qualified non-medical services and supports, including personal assistance services (including those provided by family caregivers), home modifications, and assistive technology devices.

  The benefit levels would vary by disability level, with the minimum eligibility level set at 2 or more limitations in activities of daily living (ADLs) or a similar level of disability due to cognitive impairment. The number of benefit levels for varying levels of disability could range from two to six, to be determined by the program. The initial benefit amounts would average at least $50 per day (among people with varying benefit levels). There is no time or dollar limit on the total benefits a person can receive—benefits are payable for the duration of disability until death (that is, lifetime benefits). Benefit amounts would increase over time to reflect inflation.

  Under this benefit structure, beneficiary liability is not capped if costs exceed benefit amounts. Therefore, supplemental private insurance would be necessary for individuals interested in protecting themselves against high long-term care costs. Alternatively, individuals could rely on out-of-pocket payments or Medicaid (if eligible).

  A cash benefit would provide considerable flexibility for beneficiaries to tailor services and other purchases to suit their particular needs—including the ability to pay family caregivers, make home modifications, or make other eligible expenditures on non-medical services and supports that a pre-specified package of services might not accommodate. In contrast, service benefits are less flexible and have to be adjusted as new modes of care delivery evolve.
Demonstrations using cash or vouchers within Medicaid suggest the importance of accompanying a cash benefit with information and counseling to help people identify and arrange their hiring or purchases, as well as with arrangements to assure that workers are both qualified and adequately paid. Any cash program will need to ensure that consumers have the information they need to make appropriate use of the funds. Regulations may be needed to help protect consumers from paying too much, receiving poor quality, or fraud.

One other issue with a cash benefit is that differences in the cost of long-term care services and supports among locations mean that fixed dollar amounts of benefits will buy different amounts of services in different places. For example, in 2008, the average hourly cost of home health aide services was $16 or less in several of the least expensive markets and $25 or more in several of the most costly markets—thus, a $50 daily benefit could purchase more than 3 hours of home health aide services in some markets, and 2 or fewer hours in others. In contrast, if the government purchased pre-specified services on behalf of an insured individual, it assumes the risk for these geographic differences.

Under the Medicare expansion proposal, beneficiaries would be eligible for nursing home services and up to 100 hours of home care services per month. This program would pay benefits when the enrolled individual is assessed to need assistance with 2 or more ADLs or to have severe cognitive impairment. In contrast to the CLASS Act, the program caps beneficiary liability (for covered services) at $5,500 per year ($500 deductible plus $5,000 in copayments), but its service benefits structure would not allow for as much flexibility as a cash benefit structure.

- **Financing.** The CLASS Act would be primarily self-financed through a premium paid by participants. Some offsetting savings would be available through reductions in Medicaid spending when the program begins paying benefits for people who would otherwise qualify for Medicaid long-term care coverage.

The CLASS Act authorizes the Secretary to set premium amounts, subject to specified requirements. Premiums are allowed to vary by age at the time of enrollment and would be subsidized for people with low incomes. The legislation indicates that the Secretary should aim to set premiums in the first year so they average no more than $65 per month, but the average can be higher if needed.

The new Medicare benefit would be financed by a combination of revenues from a dedicated income tax surcharge and general tax revenues. The role of each source would be gauged so that the income surcharge approximately replaced private financing, and the general tax revenues replace the proportion of funding that would otherwise come from Medicaid. An income tax surcharge provides progressive financing; people with the highest incomes (and highest taxes) would contribute the most; people with no income tax liability would pay nothing.
V. Conclusion

Enactment of health reform to assure affordable, meaningful health insurance will be an enormous accomplishment. Its impact on the health and economic security of our nation’s families will be substantially enhanced if it includes provisions that improve access to long-term supports and services along with medical care. This paper has proposed specific measures to achieve that end.

Expanding Medicaid support for home and community-based services would enable more people to obtain needed care in the setting they prefer. Over time it also has the potential to build a more efficient long-term care system by reducing the use of high-cost nursing home services relative to what it otherwise would be. Requiring all states to provide these services at specified levels would eliminate tremendous inequities across states—improving care for eligible people regardless of where they live. Short of requirements, federal support to give states a strong incentive to further expand home and community-based care would reduce gaps in availability.

Improving the coordination of medical and long-term care for Medicare-Medicaid dual eligibles can achieve both better quality and enhanced efficiency in serving people who rely on both Medicare and Medicaid services for their extensive health and long-term care needs. Organizations capable of providing both sets of services—whether enhanced Medicare managed care plans or Medicaid delivery arrangements—can be paid by both programs to address the full array of beneficiaries’ needs. Assuring capacity to deliver services appropriately and efficiently can be achieved by rewarding organizations that reduce Medicare or Medicaid costs, relative to projected performance, with a share of the savings. Similarly, states can be encouraged to develop and promote such organizations by sharing with them a portion of any Medicare savings (such as in reduced hospitalizations) from successful performance.

Improving coordination of medical and long-term care for Medicare enrollees with chronic conditions can provide beneficiaries at all income levels with better support to sustain health and avoid preventable hospitalizations and other expensive care. Demonstrations to reward provider arrangements that coordinate medical care (through medical homes and chronic care management) are high on the list of delivery reforms likely to be included in health reform legislation. However, a focus on coordinating medical care alone will lead these initiatives to fall short. Assuring that new service models are designed to coordinate long-term supports and services as well as medical care, and holding them accountable for achieving that coordination, has the potential to achieve far more in terms of quality improvement and efficiency than focusing only on coordination of medical care.

Establishing public insurance protection for long-term care for the broad population is essential to truly assure access to affordable, quality long-term care for people of all incomes and ages. The CLASS Act, included in the Senate Health, Education, Labor, and Pension (HELP) Committee’s proposed health reform legislation would create a premium-funded insurance program in which working-age adults could become eligible for a cash benefit after paying into the program for five years, and could maintain coverage throughout their lives by continuing to pay premiums. An alternative approach would be to create a new long-term care Medicare
benefit, financed with a surcharge on income taxes paid by people who are currently working age and available to them when they become Medicare beneficiaries. Either approach would spread risk among a broad population and allow people to pay over time to insure for potential future needs. And, while neither approach would eliminate the need to rely on family care and personal resources or private insurance to assure full support, both would greatly enhance access to quality care and financial protection for people who need services.

Health reform offers an opportunity to enact any or all of these initiatives—to improve the adequacy and quality of health and long-term care services for people who need both. In recommending these proposals, it is our hope that this historic opportunity will not be missed.

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Notes

i The papers and a report analyzing them can be found at: http://ltc.georgetown.edu.
iii Ibid, based on analysis of 2005 data from the National Health Interview. Estimate is based on six ADLs: bathing or showering, dressing, eating, using the toilet, getting into and out of a bed or chair, and getting around inside the home.
vi Feder, Komisar, and Friedland, Long-Term Care Financing: Policy Options for the Future.
vid Ibid.
ix Vincent Mor et al., “Prospects for Transferring Nursing Home Residents to the Community,” Health Affairs 26, no. 6 (November/December 2007): 1762-1771.
x The federal government paid for approximately 57% of Medicaid spending for long-term care. Christine Scott, Federal Medicaid Assistance Percentage (FMAP) for Medicaid, Congressional Research Service, March 2005.
We have not included options for promoting private long-term care insurance. Although private long-term care insurance can play a significant role for some individuals, we concluded in previous research that this type of insurance would not be purchased by a majority of people, even with policy changes that make it more attractive, would mainly be taken up by people with relatively higher incomes, and therefore we do not consider promoting private long-term care insurance to be a priority for investment of public resources. Not only does the cost of private insurance present a barrier to purchase, but private long-term care insurance is not available people with current long-term care needs or those with health conditions that, as determined by medical underwriting, put them at higher risk of needing long-term care in the near future. See Feder, Komisar, and Friedland 2007.


Feder, Komisar, and Friedland, *Long-Term Care Financing: Policy Options for the Future*.


States mainly use two optional ways to cover personal care and other long-term services in home and community settings. First, the majority of Medicaid’s spending for home and community-based services is through home and community-based services waivers, which also serve more people than the other types of home and community-based service benefits. These waivers allow states to provide personal assistance and other services to people who have a nursing home level of need (that is, meet functional eligibility criteria for nursing home or other institutional care)—and, in contrast to other Medicaid services, allow states to limit the number of people receiving services and use waiting lists. Second, about three-fifths of states offer a personal care benefit in their Medicaid programs; eligibility rules do not require a nursing home level of need, but financial eligibility criteria are usually more restrictive than for waiver services. This option does not allow states to use waiting lists, but they can control spending by limiting services. Burwell, Sredl, and Eiken, *Medicaid Long-Term Care Expenditures in FY 2007*; Ng, Harrington, and O’Malley, *Medicaid Home and Community-Based Service Programs: Data Update*; Jeffrey S. Crowley, *Medicaid Long-Term Services Reforms in the Deficit Reduction Act*, Issue Paper (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006).


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Ibid. As of March 2009, the North Carolina program was under federal review for approval.


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A link to the bill can be found at: http://help.senate.gov/Maj_press/2009_06_09.pdf.


Feder, Komisar, and Friedland, *Long-Term Care Financing: Policy Options for the Future*. 
For more information contact:

**The SCAN Foundation**

Bruce A. Chernof, M.D., President & CEO  
René Seidel, Vice President Programs & Operation  
3800 Kilroy Airport Way, Suite 100  
Long Beach, CA 90806  
Phone: (888) 569-7226  
E-mail: info@thescanfoundation.org  
www.thescanfoundation.org