Approved: 3-6-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 3:30 p.m. on February 17, 2003 in Room 234-N of the Capitol.

All members were present except: Senator Pete Brungardt, excused
Senator Paul Feleciano, excused

Committee staff present: Emalene Correll, Legislative Research
Ann McMorris, Secretary

Conferees appearing before the committee:
Mike Heim, Legislative Research
Janis DeBoer, Acting Secretary, Department on Aging
Barb Hinton, Legislative Post Audit
Janet Hierl, Heartland Homecare, Lawrence
Elaine Speck, Consumer
Jason Gallagher, Consumer
Jim Klausman, Kansas Health Care Association
Gina McDonald, Kansas Association of Centers for Independent Living (KACIL)
Debra Zehr , Kansas Association of Homes and Services for the Aging
Claude Thau, President, Thau, Inc.
David Landwehr, President, Long Term Care Solutions
Matt Hickam, Ombudsman, Long term care
Carolyn Middendorf, Kansas State Nurses Association
Kirk W. Lowry, Attorney, Topeka Independent Living Center
Bob Day, Department of Social and Rehabilitation Services

Others attending: See attached list

Presentations on Long Term Care

Mike Heim, Legislative Research, reported on the Task Force on Long-Term Care Services conclusions and recommendations (Attachment 1). In the Year Three Report, a study found that Kansas residents between the ages of 38 and 66 will, on average, face expenses that exceed income by at least $10,000 annually during their retirement years and the projected income deficit will be more than $20,000 annually for single women. By 2031, the aggregate annual deficit for retired Kansans could be in the $700 million range. The Task Force believes Form HCFA 2567 - a U.S. Department of Health and Human Services form that state inspectors use to record the results of their surveys or inspections of Kansas nursing homes is a major factor driving the increased liability insurance costs for nursing homes

- The Task Force recommends that legislation be introduced to amend KSA 39-709(g)(2)(B) dealing with recovery from estates of persons who had been receiving Medicaid benefits to shield from recovery the amount paid for long-term care by long-term care insurance purchased by the Medicaid recipient. The Task Force makes the above recommendation with the recognition that such legislation may not be permitted under federal law at this time.

- The Task Force recommends that a program be initiated where durable medical equipment which has been provided to Medicaid clients by the State of Kansas be recouped at the time the equipment is no longer needed or at the death of the client. The Task Force suggests further that any such equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles.

- The Task Force made a priority of establishing a long-term care system which promotes the need for healthy lifestyles; and which enables informed consumers to understand the possible outcomes of their choices.

Janis DeBoer, acting secretary, Department of Aging, reported on FY 2002 Funding Sources where Medicaid provided 57%, State General Fund 35% and other sources the remainder; on FY 2002

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM at on February 17, 2003 in Room 234-N of the Capitol.

Expenditures where Nursing Facility cost is 75%, access and in home is 20% and Nutrition 2% and Administration 3%; statistics on KDOA customers served, monthly Medicaid averages on customers served; monthly average Medicaid expenditures per customer; comparison of nursing facility and HCBS/FE customers and expenditures; the Level of Care (LOC) scores was very enlightening. Some seniors who are able to pay for nursing home care may choose to enter a facility regardless of their level of care score while other individuals with very high scores can function successfully in the community with the necessary supports, whether paid by public or private funds. The minimum score was 3 and the maximum was 125. The average score for a person starting to receive HCBS was 66 and the average score for a person entering a nursing facility was 74. (Attachment 2)

Barb Hinton, Post Audit, presented a summary of issues relating to long-term care paid for by the Kansas Medicaid Program. (Attachment 3) The audit found that Medicaid spending for long-term care increased $157 million going from $472 million in 1998 to $630 million in 2001. Of the $157 million increase $47 million was caused by higher reimbursement rates being paid to nursing facilities and $111 million was for long-term home and community based services. The audit recommended:

- Make it tougher for people to qualify for Medicaid funding. Kansas' financial eligibility standards are more lenient than other states. They allow Kansans to shelter a large portion of their assets and become eligible sooner than they would in other states. Also Kansas could make it tougher to qualify functionally by raising the score needed to qualify.

- Manage the care provided to the most expensive consumers. The elderly and disabled accounted for 94% of the increased long-term costs and 70% of the increased medical costs from 1998 to 2000.

- Cap the number of people who can receive Medicaid paid waivers (waiting lists)

- Institute spending cap. In 2001, the audit found 924 people received HCBS in the community that exceeded the cap and the State would have saved $9.2 million if those people had been served in a nursing home or other institutional setting.

- Help people take the step necessary to pay for their own long-term care through long-term care insurance. Kansas should consider offering a tax credit or deduction that is separate from currently available itemized deductions.

Janet Hierl, Pharmacist, reported on Heartland Homecare Services, located in Lawrence and Wichita, which services all consumers with the Medicine-on-Time (MOT) personal prescription System. She elaborated on an outline which touched on the various components of their service. She concluded by noting that evaluation of the Medicaid system is a complicated task. (Attachment 4)

Elaine Speck, consumer, Russell, KS., told of her experience in dealing with Medicaid since she became disabled and that she desires to have choices and make decisions about the quality of her life. She compared the cost to the State of Kansas of community based services versus nursing home care. She urged the HCBS program be funded as needed and the opportunity to access the HCBS program upon discharge from a nursing facility. (Attachment 5)

Jason Gallagher, consumer, Overland Park, told stories of disabled people and their lives and set forth what Medicaid services look like to those using or trying to use these services. He noted with people living longer, with technology making it easier for people with disabilities, and with home-care being the preferred long term setting, we are no longer in a mode of acute care but one of long term care. It is now about helping the disabled to live the most dignified, comfortable and productive life they can. He urged the task force to show the President we are serious about Medicaid reform in Kansas. (Attachment 6)

Jim Klausman, Kansas Health Care Association, indicated support of home community based services. He noted costs are out of control and there is a severe shortage of nurses.

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MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM at on February 17, 2003 in Room 234-N of the Capitol.

Gina McDonald, Kansas Association of Centers for Independent Living (KACIL) (Attachment 7) where people have the option of returning to employment and can keep their medical card for health insurance and pay a premium for their coverage. KACIL recommendations include:

- continue and expand the Medicaid Buy In Program
- review funding sources for people with developmental disabilities
- transitional living services under the PD waiver
- dollar follows the individual from institutions to the community
- review with insurance commissioner methods to make personal assistance services available, affordable and accessible through long term care and other insurance policies
- review potential for increasing the eligibility for obtaining health insurance through the medical card, identify methods which would allow people to pay premiums based on income

She concluded her testimony by stating: "We as a disability movement will never be free and equal as long as we depend on other people's money." Included with her written testimony was a glossary of terms/acronyms.

Debra Zehr, Kansas Association of Homes and Services for the Aging (KAHSA), recommended that the Division of Budget develop and update disability projections on at least 3-5 year basis. KAHSA supports a continuum of high quality, cost effective choices for persons with long-term care needs. Another option is adoption of the PACE model (Program of All-Inclusive Care for the Elderly). She mentioned strengthening of Medicaid care coordination (case management); increasing private and federal resources; and focus on provider supply and reimbursement. (Attachment 8)

Claude Thau, President, Thau, Inc. and very involved in designing the Federal Employee LTC program, noted advances could be given to cover LTC costs with the intention of recovering when an estate is settled. This should be provided outside the Medicaid Program. He suggested one tactic would be to stop putting people on Medicaid if they have assets which could fund their LTC. Such loans could be government-backed, but financed privately. (Attachment 9)

David Landwehr, President, Long Term Care Solutions, spoke on saving the long-term care system and noted their objective, reforms, and benefits. He reviewed the Medicaid LTC program and offered possible Legislative Medicaid solutions: (Attachment 10)

- Tax Credits
- Government/Private Sector Partnership Programs
- Eliminating unsustainable HCBS waivers
- Medicaid Reform using the citizen's home as collateral to provide quality services outside the Medicaid program
- Aggressive estate recovery programs

Matt Hickam, State Long-Term Care Ombudsman, noted that Medicaid pays for only one-seventh of all national health expenditures, but it pays for almost half of all nursing home costs. By comparison, private insurance covers about one-third of all national health expenditures but only 5% of long term care expenditures. (Attachment 11) He recommended any reform in the Kansas Medicaid program should

- Ensure that Medicaid is available for the neediest to pay for their long-term care needs
- Ensure that a spouse of a nursing home resident is left with enough assets and income to survive
- Ensure that nursing homes meet high care standards
- Ensure home and community services paid for by Medicaid are accompanied by enforceable standards of care.

Carolyn Middendorf, Kansas State Nurses Association, presented written testimony on long term care. (Attachment 12)

Kirk W. Lowry, attorney, Topeka Independent Living Center, noted the center helps people with disabilities move into and stay in their own home and receive appropriate and adequate support and services to live independent and safe lives. He suggested the state would save on administrative costs and be more efficient if there were one big waiver for all classifications of disability. (Attachment 13)

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Bob Day, SRS provided written material on Long Term Care issues (Attachment 14)

Considerable discussion on waivers, criteria for providers, skills, college student utilization for lower dormitory rates, and programs in other states.

The next meeting of the President's Task Force on Medicaid Reform will be on Monday, February 24 at 3:30 p.m. in Room 519-S with presentations and round table discussion by providers.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 14

Conferee recommendations

Mike Heim - reported the Task Force on Long Term Care Services

- Recommends that legislation be introduced to amend KSA 39-709(g)(2)(B) dealing with recovery from estates of persons who had been receiving Medicaid benefits to shield from recovery the amount paid for long-term care by long-term care insurance purchased by the Medicaid recipient. The Task Force makes the above recommendation with the recognition that such legislation may not be permitted under federal law at this time.

- Recommends that a program be initiated where durable medical equipment which has been provided to Medicaid clients by the State of Kansas be recouped at the time the equipment is no longer needed or at the death of the client. The Task Force suggests further that any such equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles.

- Made a priority of establishing a long-term care system which promotes the need for healthy lifestyles; and which enables informed consumers to understand the possible outcomes of their choices.

Barb Hinton of Legislative Post Audit

- Make it tougher for people to qualify for Medicaid funding. Kansas' financial eligibility standards are more lenient than other states. They allow Kansans to shelter a large portion of their assets and become eligible sooner than they would in other states. Also Kansas could make it tougher to qualify functionally by raising the score needed to qualify.

- Manage the care provided to the most expensive consumers. The elderly and disabled accounted for 94% of the increased long-term costs and 70% of the increased medical costs from 1998 to 2000.

- Cap the number of people who can receive Medicaid paid waivers (waiting lists)

- Institute spending cap. In 2001, the audit found 924 people received HCBS in the community that exceeded the cap and the State would have saved $9.2 million if those people had been served in a nursing home or other institutional setting.

- Help people take the step necessary to pay for their own long-term care through long-term care insurance. Kansas should consider offering a tax credit or deduction that is separate from currently available itemized deductions

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Elaine Speck, consumer
Urged the HCBS program be funded as needed and the opportunity to access the HCBS program upon discharge from a nursing facility.

Gina McDonald, KACIL
(1) continue and expand the Medicaid Buy In Program;
(2) review funding sources for people with developmental disabilities;
(3) transitional living services under the PD waiver;
(4) dollar follows the individual from institutions to the community;
(5) review with insurance commissioner methods to make personal assistance services available, affordable and accessible through long term care and other insurance policies; and
(6) review potential for increasing the eligibility for obtaining health insurance through the medical card, identify methods which would allow people to pay premiums based on income.

Debra Zehr, KAHSA
Recommended that the Division of Budget develop and update disability projections on at least 3-5 year basis

Claude Thau
- Noted advances could be given to cover LTC costs with the intention of recovering when an estate is settled
- Suggested one tactic would be to stop putting people on Medicaid if they have assets which could fund their LTC

David Landwehr noted possible Legislative Medicaid solutions:
(1) Tax Credits
(2) Government/Private Sector Partnership Programs
(3) eliminating unsustainable HCBS waivers
(4) Medicaid Reform using the citizen's home as collateral to provide quality services outside the Medicaid program
(5) aggressive estate recovery programs

Matt Hickam
Any reform in the Kansas Medicaid program should
(1) ensure that Medicaid is available for the neediest to pay for their long-term care needs;
(2) ensure that a spouse of a nursing home resident is left with enough assets and income to survive;
(3) ensure that nursing homes meet high care standards;
(4) ensure home and community services paid for by Medicaid are accompanied by enforceable standards of care.

Kirk W. Lowry
Suggested Kansas would save on administrative costs and be more efficient if there were one big waiver for all classifications of disability

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President's Task Force on Medicaid Reform

DATE: FEBRUARY 17, 2003

Name	Representing
Linda Lubensky	KS. Home Care
Nancy Pierce	Ks. Health Care Assn.
Jim Klausman	Ks. Health Care Assn.
Debra Zehr	KAHSA
Christy Lane	Ks Dept. on Aging
Janis DeBoer	Ks Dept. on Aging
Carolyn Middendorf	Ks St Ns Assn
Paul Johnson	PACK
Jennifer Schwartz	ASSISTIVE TECH FOR KANSANS
Mark McClaflin	Ks. Ins. Dept.
Linda Berndt	KHCA
Shannon Jones	SILCK
[illegible]	LINK
[illegible]	LINK
Elaine Speck	Individual
Jason Gallagher / Matt O'Connor	Individual / Independent

President's Task Force on Medicaid Reform

DATE: FEBRUARY 17, 2003

Name	Representing
Gina McDonald	KACIL
Claude Than	Than Inc
David Landwehr	LT Care Solutions
Janet Hiens	KPhA - Heartland Homecare Pharmacy
Ryan Schlinke	KPhA
Kathy Damron	Kansas Health Care Assoc.
Don Brown	KS INSURANCE Dept.

Task Force on Long-Term Care Services

YEAR THREE REPORT

CONCLUSIONS AND RECOMMENDATIONS

The Task Force reaffirms the six broad goals and the policy directions and strategies adopted in its first year of existence. The Task Force believes progress is being made on providing greater freedom of choice for recipients of long-term care services. Year three stands out as a year where major progress was made on compiling needed demographic and other statistical information for informed decision making regarding long-term care services.

Proposed Legislation: None

BACKGROUND

Long-Term Care Task Force Created

HB 2780 enacted by the 2000 Legislature and codified at KSA 65-6206 created a 20-member Task Force on Long-Term Care Services to study:

> ". . . state and federal laws and rules and regulations which impact on the services provided by the government and the private sector to citizens who are consumers of long-term care services, the financing of these services, both public and private, the effectiveness of partnering activities between state agencies and long-term care providers, and such other matters as relating thereto the Task Force deems appropriate."

The bill later defines long-term care as including a broad spectrum of supports, ranging from skilled nursing services to assistance with activities of daily living or help with instrumental activities of daily living.

Seven members of the Task Force are appointed by the Legislative Coordinating Council (LCC). Three of these appointees must be consumers of long-term care, three providers of long-term care, and one a trustee or board member of a long-term care facility. Of these seven, no more than two members may reside in any one congressional district.

The Chairperson and Vice Chairperson of the Task Force are appointed by the LCC from among the members of the Task Force. The Chairperson is to be a legislative member.

Two members are appointed by the President of the Senate and the Speaker of the House. Of the two appointments, one is to be a member of the Senate Committee on Ways and Means and one a member of the House Committee on Appropriations. The appointees must be from different political parties.

An additional two members are appointed by the Senate President, and the

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Minority Leader of the Senate is to appoint two members. In each case, one appointee must be a member of the Senate Committee on Public Health and Welfare and one a member of the Senate Committee on Financial Institutions and Insurance.

Two members are appointed by the Speaker of the House and two members are appointed by the Minority Leader of the House. In each case, one appointee must be a member of the House Committee on Health and Human Services and one a member of the House Committee on Insurance.

The Secretaries of Social and Rehabilitation Services (SRS), Aging, and Health and Environment (KDHE) or their designees make up the remaining members of the Task Force.

The Task Force is required to submit a report and recommendations to the Governor and Legislature on or before the second Monday of January each year through 2005, the year in which the statute creating the Task Force will expire. In developing recommendations, the Task Force is to consider creative, common sense solutions and approaches to problems that do not necessarily require additional expenditures.

Membership of the Long-Term Care Task Force

The current membership of the Task Force appears in the following box.

Legislative Members

Rep. Melvin Neufeld, Chairperson
Sen. Paul Feleciano
Sen. Janis Lee
Sen. Chris Steineger
Sen. Susan Wagle
Sen. Sandy Praeger, Vice Chairperson
Rep. Bob Bethell
Rep. Garry Boston
Rep. Nancy Kirk
Rep. Judy Showalter

Nonlegislative Members

Mark Baily, Via Christi Services
Evie Curtis, Kansas Advocates for Better Care
Linda Lubensky Kansas Home Care Association
Carol Moore, ANP (Gerontology) Mennonite Friendship Manor
Bob Smith, Alzheimer Association
Sister Beth Stover, North Central Flint Hills AAA
Ray Vernon, Wesley Towers
Janis DeBoer (Aging)
Martha Hodgesmith (SRS)
Patricia Maben (KDHE)

Task Force Activities

The Task Force met six days during calendar year 2002. A one-day meeting was held in July where results of the Employee Benefits Research Institute (EBRI) study regarding the income needs of elderly Kansans was presented to the Task Force and the Governor. The study was conducted jointly by EBRI and the Milbank Memorial Fund, an endowed philanthropic foundation. The study is described in a separate section.

A two-day meeting was held at the beginning of September. The first day was devoted to hearing from conferees concerning the increasing costs of liability insurance for long-term care providers.

Conferees who appeared included representatives of the Kansas Department on Aging (KDOA); the Kansas Association

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of Homes and Services for the Aging; a representative of a long-term care facility for the elderly; a Kansas insurer for long-term care; and representatives of the Irwin Siegel Agency, a national insurer for community based long-term care services for the disabled.

Conferees expressed concern that nursing home survey results were being used as an underwriting tool by insurance companies to determine insurance rates and as evidence in liability suits against nursing homes. Several conferees pointed out that increasing liability insurance premiums, a national issue, can be attributed in part to the declining stock market and the September 11, 2001 terrorist attacks. One conferee noted the insurance premium for his 169-bed facility will be $63,000. He said rising insurance rates were causing some facilities to go bare—without insurance. One conferee, among other things, suggested that the use of survey results in civil lawsuits should be prohibited, and that standards of care and qualified immunity should be codified.

Task Force members on the second day of the September meeting attended the Kansas Health Policy Forum where a representative of the Urban Institute of Washington, D.C., discussed issues regarding financing long-term care services.

Three meetings were held in early November over a two-day period. The meetings were held in Hays, Hutchinson, and Winfield, and consisted of a series of briefings as well as public forums. The briefings included the public release of the just completed "Kansas ElderCount 2002" report which is described in a separate section, briefings on Task Force activities and goals and briefings by representatives of SRS and KDOA.

More than 30 people representing a variety of groups and agencies which provide services to the elderly and the disabled addressed the Task Force during the course of the public forums in the three cities. Over 150 persons attended the meetings.

A variety of issues and ideas were presented to the Task Force which included the following:

- The importance, value and contribution to society made by the elderly and the disabled who need long-term care services;
- The need to fully fund programs that allow individuals to remain independent and to determine their own destiny;
- The problem which would be created by increasing the PASSAR (level of care) scores to decrease eligibility for services;
- The need for more respite care for family caregivers;
- The need to provide the less costly services in a timely fashion to prevent the need for more expensive entitlements services, *i.e.,* nursing home; and
- The value of socialization, nutritious meals, and senior centers; active lives and independence.

EBRI Study: Income Needs of the Elderly

A ground-breaking study that estimates total projected retirement income and expenses finds that Kansas residents currently between the ages of 38 and 66 will, on average, face expenses that exceed income by at least $10,000 during their retirement years, was presented to the Task Force and the Governor at the Task Force's July meeting. The study was

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conducted by the nonpartisan EBRI and the Milbank Memorial Fund. The study found that the projected income deficit in Kansas is more than $20,000 annually for single women; however, the category of married couples fairs the best. By 2031, the aggregate annual deficit for retired Kansans could be in the $700 million range.

See the full report that is available on the EBRI Website at:
www.ebri.org/pdfs/kansas.pdf

As the post-World War II baby boom generation begins to retire, the United States is expected to see a surge in the number of elderly over the next 20 years that will lead to significant cost increases in programs that retired Americans rely on Social Security and Medicare. This demographic problem is already acute in some other industrialized nations, however, the report indicates that the United States still has time to undertake actions before the financial crisis becomes acute.

For government, this could allow smaller changes now instead of bigger, more painful changes later. For business, early action increases the likelihood of future retirees having income and assets to spend in a consumer-driven economy. While the nation must face these issues as a whole, they also will present challenges for states and localities, and for public- and private-sector decision makers. Yet, analysis of future economic well-being of the retired population at the state level has been very limited due to the unavailability of the necessary data and models to perform the analysis.

EBRI and the Milbank Memorial Fund, initially working with the Oregon Governor's office, set out to see if this situation could be addressed for Oregon. The results released in 2001 made it clear that major decisions lie ahead if the state's population is to have adequate resources in retirement. Kansas was chosen as the second state to be assessed, and additional capabilities were added to the model for the Kansas assessment. Additional states will be analyzed in the future.

One of the key variables in the Kansas study affecting estimates for individuals is how house equity is allocated. The homes Americans own are often their most valuable financial asset. The elderly's housing equity was included in their retirement income sources and total expenditures were divided into expenses they all face each year (food, housing, and certain health expenditures), and those that only some elderly will experience in any given year (home-based health care and nursing facility care).

Results of the study are presented for three different assumptions on housing equity and Social Security benefit payments in the future. Housing equity is either assumed to be not liquidated, annuitized at normal retirement age (turned into a regular stream of income), or liquidated as needed. The Social Security benefits for retirees will be at current-law benefit levels, reduced benefits that could be fully funded from the current tax rate, or a combination of tax increases and increases in the normal retirement age (results also are given under different Social Security reform proposals).

Among the major findings of the EBRI/Milbank study:

- Assuming today's Social Security benefits, a single female Kansan in the 1936-1940 birth cohort would ulti-

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mately be expected to accumulate an average present-value deficit of $32,484 from age 65 until death, after paying for health and long-term care, food, and housing costs, if Medicaid pays in the future for custodial long-term care for the indigent what it pays for now (assuming the various thresholds are adjusted for inflation). Single males and both members of a married family would ultimately be expected to accumulate on average a present value deficit of slightly more than $19,000. If these same Kansans are assumed to annuitize their net housing equity at age 65 (perhaps by taking out a reverse mortgage that provides monthly income), the present-value of the aggregate deficits decrease to an ultimate value of $30,897 for single females and slightly more than $18,000 for single males and family members. However, if housing equity is assumed to be liquidated as needed, the present value of the ultimate deficits drops even further: $28,620 for single females, $14,198 for single males, and $10,212 for family members.

- Nominal annual deficits are simulated for all Kansas residents age 65 and over after Medicaid reimbursements, assuming status quo as well as current-law Social Security benefits, where current retirees are similar to the oldest cohort of workers. The results varied by housing equity scenario: the annual deficit for 2003 was estimated to be $168 million if housing equity is liquidated as needed to meet potential deficits, $263 million if all housing equity is annuitized at age 65, and $291 million if housing equity is never liquidated. By the year 2031, the corresponding values are estimated to have increased to be $478 million if housing equity is liquidated as needed to meet potential deficits, $659 million if all housing equity is annuitized at age 65, and $693 million if housing equity is never liquidated.

Although the actual values of the ultimate deficits are a function of the birth cohort, gender, family status, and choice of assumptions for Social Security and liquidation of housing equity, certain themes remain fairly constant across the scenarios:

- Single females can be expected to have a substantially larger ultimate deficit than either their single male or married counterparts—in some instances, nearly twice as much.
- Assuming that housing equity is annuitized at age 65 reduces the ultimate deficits, but not nearly as much as assuming that housing equity is liquidated when first needed to prevent a deficit.

Deficits are lowest under the current Social Security law assumptions. They increase somewhat under different Social Security reform proposals.

Kansas ElderCount 2002

The results of the Kansas ElderCount project was presented to the Task Force at its November meeting in Hays, part of a three-city public forum effort of the Task Force.

The mission of Kansas ElderCount is to collect and disseminate data describing the well-being of older adults for the enhancement of public policy, program planning, and general understanding.

The need for county data describing

older adults became clear at a spring 2000 meeting of the Kansas Task Force on Long-Term Care Services, moderated by Monsignor Charles Fahey of the Milbank Memorial Fund. During the meeting, a wall chart (*Aging in Kansas*) produced by the Center on Aging at the University of Kansas Medical Center was circulated. The wall chart contained social and demographic data from the 1990 census, at the county level. Task Force members from the Kansas House of Representatives and Senate began looking up their counties on the wall chart and comparing the data among counties. The data stimulated discussion and questions about the status of older adults. The Task Force chairperson and co-chairperson decided that the legislature, program planners, and the public needed an older adult version of Kids Count.

In the fall of 2000, The Kansas Health Foundation, a Wichita-based philanthropic organization dedicated to improving the health of all Kansans, awarded funding to the Center on Aging at KU Medical Center to spearhead the development of Kansas ElderCount. A statewide 32-member Advisory Committee was convened to help identify, prioritize, and secure data. This chart book and the accompanying wall chart can be found at: http://www2.kumc.edu/coa/eldercount.

Other project partners besides the Task Force, the KU Center on Aging and the Kansas Health Foundation are KDOA and the Milbank Memorial Fund, the latter of which provided money to publish the study.

The intended audience for Kansas ElderCount are:

- Program planners and community advocates seeking county-level data that will facilitate their ability to plan and deliver services on behalf of older adults.

- Educators wanting to share information about older adults and the communities in which they live, with students of all ages.

- Members of the Kansas State Legislature. State Senators and Representatives making important policy decisions, in particular, concerning the provision of long-term care services, as members of the Baby Boom generation (born 1946-1964) age into older adulthood. It is essential that current and high quality data are available to help legislators make informed policy decisions.

There are three ElderCount products: the chart book, a wall chart, and a Website. Data in ElderCount are grouped into five categories: population, economics, health, community living, and nursing homes. There are 36 indicators (variables) in the chart book reported for the 105 counties, 11 Area Agencies on Aging, and the State of Kansas.

In the wall chart, data are reported for counties and the state. The purpose of the wall chart is to facilitate comparison among counties (the data are presented in columns). There is overlap between the variables in the chart book and the wall chart (although not all chart book variables are on the wall chart). The wall chart also includes variables that are not in the chart book.

The Website contains the entire chart book and the wall chart for people to read on-line or download.

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Basic demographic data describing the age structure, sex distribution, and racial makeup of the State of Kansas is a backdrop to putting ElderCount information into perspective. With 2,688,418 people, the state of Kansas constitutes about 1 percent of the United States population. The population is dispersed among 105 counties. One-third of all Kansans live in two counties, Johnson and Sedgwick, each with 17 percent of the state's population. Wyandotte and Shawnee each contain 6 percent of Kansans. On the other hand, 68 counties have less than one-half of 1 percent of the Kansas population.

The majority (64) of Kansas counties contain fewer than 2,000 older adults and 34 counties have 1,000 fewer people age 65 or older. In fact, only five counties have more than 10,000 people age 65 or older:

1. Sedgwick 51,574
2. Johnson 45,069
3. Shawnee 23,341
4. Wyandotte 18,520
5. Reno 10,618

Many rural counties have been experiencing a steady decline in total population for decades. The challenges of maintaining independence and autonomy in older adulthood vary by geographic locale. Older adults in rural areas and their families face a unique set of challenges when it comes to accessing health care and receiving community-based long-term care services.

The following population data are reported in the ElderCount chart book:

- Population, 65+
- Race: nonwhite, 65+
- Hispanic, 65+
- Men and Women, 85+
- Registered to vote, 65+

The ElderCount chart book includes the following economic indicators:

- Labor force participation;
- Medium household income;
- Persons living in poverty;
- Medicaid enrollment;
- Total social security payments to persons age 65+; and
- Percentage of the area's total personal income from social security benefits to persons 65+.

The ElderCount book indicates the following health data:

- Mammography—annual rates;
- Hospitalization for cardiovascular care;
- Hospitalization for hip fracture; and
- Number of people 18+ per primary care physician.

The ElderCount book includes the following community living data:

- Percentage of 65+ living alone;
- Indicators of disability;
- In-home public long-term care services;
- Medicaid services for frail elderly;
- Medicaid average individual monthly payment; and
- Assisted living beds.

In regard to nursing homes, the ElderCount book contains the following:

- Beds (licensed) and occupancy rate;
- Residents, 65+;
- Residents (men and women reported separately), 75+;
- Residents, 65+ (total during 2000);

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- Medicaid, 65+ (total during 2000); and
- Medicaid average monthly payment.

YEAR THREE CONCLUSIONS AND RECOMMENDATIONS

The Task Force believes that progress is being made in regard to implementing the goals established by this Task Force in Year One; in regard to making Kansas more aware of long-term care needs of their fellow citizens, and in regard to bringing about a climate for needed change at the local, state, and federal levels.

The Task Force however, believes that much more must be done both in the short term and in the long term to bring about needed changes. The following are the specific recommendations of the Task Force as it concludes its third year of existence:

- The Task Force believes that there is a general perception that the makeup of the Task Force itself and its focus is primarily on the long-term care needs of elderly Kansans. The Task Force believes its makeup should be expanded to include one or more additional members that represent the interests of younger recipients of long-term care services, *i.e.* those persons other than the frail elderly. The Task Force asks the appropriate standing committee of the Kansas Legislature to introduce such a bill and that it receive favorable consideration by the 2003 Legislature.

- The Task Force on Long-Term Care is concerned about the federal forms and their use in the survey process (inspections) of Kansas nursing homes. The form (HCFA 2567) is a U.S. Department of Health and Human Services form that state surveyors (inspectors) use to record the results of their surveys or inspections. The federal regulations require that the statement of deficiencies is to be written in terminology specific enough to allow a reasonably knowledgeable person to understand the regulatory requirements that are or are not met. In the event there are no deficiencies cited, a statement to that effect is to be included on the HCFA 2567. If deficient practices are identified, the form (first column) contains a prefix tag (F Tag). The second column on the form is used to record a summary of the evidence of noncompliance and supporting observations. The documentation must be written in language specific enough to identify the scope and severity of the noncompliance. Surveyors are required to follow principles of documentation as set forth in the federal Health and Human Services manual. This federal manual was developed to ensure that the deficient practice statements would be strong evidence to use in administrative appeal hearings and court hearings.

The Task Force notes that representatives of the Milbank Fund have initiated a discussion with the U.S. Department of Health and Human Services about the nursing home inspections form and the inspection process to encourage a more collaborative model of inspection. In addition, several states have entered into similar discussions with the federal agency regarding this issue.

The Task Force believes the survey process and the HCFA 2567 form are a

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major factor driving the increased liability insurance costs for nursing homes.

The Task Force agreed that Senator Praeger, the Chairperson, should write a letter to the group of states discussing the survey process with the federal agency and offer the support and encouragement of the Task Force. Further, the Task Force authorized Senator Praeger to send a letter listing the Task Force concerns about the nursing home survey process and the use of HCFA 2567 to the Secretary of the U.S. Department of Health and Human Services.

The Task Force considered recommending legislation that would prevent the use of the survey form HCFA 2567 as evidence in civil liability suits against nursing homes. At least one state, Ohio, has enacted legislation prohibiting the use of survey results in civil lawsuits against nursing homes. The Task Force, after deliberation, rejected this idea.

- The Task Force recommends that legislation be introduced to amend KSA 39-709(g)(2)(B) dealing with recovery from estates of persons who had been receiving Medicaid benefits to shield from recovery the amount paid for long-term care by long-term care insurance purchased by the Medicaid recipient.

The Task Force makes the above recommendation with the recognition that such legislation may not be permitted under federal law at this time. The Task Force has requested KDOA and SRS to review the federal law on this issue to determine if this request for legislation should be pursued.

- The Task Force recommends that a program be initiated where durable medical equipment which has been provided to Medicaid clients by the State of Kansas be recouped at the time the equipment is no longer needed or at the death of the client. The Task Force suggests further that any such equipment that needs to be refurbished be sent to the Ellsworth Correctional Facility for refurbishing by inmates who now refurbish bicycles. The equipment could then be redistributed to other persons needing it by SRS. The Task Force asks that this recommendation be reviewed by the appropriate standing committee and that legislation be introduced if needed to implement this recommendation.

- The Task Force recommends that a loophole within the Medicaid recipient estate recovery law be closed regarding burial plots. Last year the Legislature closed a loophole regarding prearranged services with the passage of SB 513. The Task Force believes some savings also could be achieved by legislation which would prevent surviving relatives of deceased Medicaid recipients from opting for cremation or a less expensive burial plot and retaining the money saved by such action. The Task Force recommends the appropriate standing committee introduce this legislation for consideration by the 2003 Legislature.

- The Task Force recommends the appropriate standing committees review the top three data gaps that were identified in the *Kansas ElderCount 2002* study and consider the introduction of legislation, if needed, to fill these data gaps. These include:

  - **Abuse, Neglect, and Exploitation.**

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Currently, there are no county-level data available that describe the number of older adults who experience abuse, neglect, or exploitation. Without such data, it is not possible to target areas of the state for improvement.

Recommendation #1: SRS and the Kansas Department of Health and Environment (KDHE) should continue to work together in developing data collection systems that can report data on incidences of abuse, neglect, and exploitation in licensed health care settings and in the community. The data system should provide for the reporting of data at the county level.

- **Population Projections.** The State of Kansas needs an official set of population projections of the older adult population in order to plan appropriate services and set public policy.

  Recommendation #2: The Division of the Budget (DOB) should produce and disseminate county population projects for older adult men and women ages 65-70 and 80+. It also is recommended highly that the DOB produce and disseminate population projections for the 85-89 and 90+ age groups at the Area Agency on Aging level. The projections should be developed through the year 2040, and should be updated and disseminated every five years.

- **Difference between the Number of People Receiving Services and the Number Needing Services.** The need for nursing home care often can be prevented or postponed if older adults receive appropriate services in the community. The services can be provided by family members or friends (informal), or by community-based organizations (formal). (ElderCount reports the number of frail and low-income older adults receiving home and community-based care.) County data were not available, however, on the number of older adults in each county who wanted to receive services but did not, because they could not afford services, were on a waiting list for services, or services did not exist in their area. Such data are important for program planning.

  Recommendation #3: KDOA should collect and distribute county data describing the number of people who are eligible to receive HCBS/FE services but are not able to, and why.

- Additionally, the Task Force wants to remind the Legislature and the Executive Branch that the state should be aware that it is the major purchaser of long-term care services from providers in this state. The state by its purchasing decision can and does affect both the types of care and the quality of care that long-term care recipients will receive whether in the community or in a facility. Those decisions also can have a decided impact on the availability of services. Inadequate reimbursement not only affects the providers fiscal viability but also their ability to recruit and retain necessary staff.

The Task Force believes that there are a number of excellent long-term care services and facilities around the state.

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There are cultural changes being incorporated in the way these facilities operate, not only for the elderly but also for the disabled. Residents and recipients of care are given more freedom to choose how to spend their time, how to organize their daily activities, what and when they eat, and a number of other choices. The Task Force believes these changes should be encouraged and that contracts between the state as purchaser of long-term care services should reflect these freedom of choice options for persons needing long-term care services.

- The Task Force is aware of the *sometimes* major increases in liability insurance costs that long-term care facilities are being required to pay. The Task Force urges the 2003 Legislature to work closely with the Kansas Insurance Commissioner to arrive at legislative solutions, if needed, to provide relief from these increasingly burdensome costs.

- The Task Force wants the 2003 Legislature to be aware of the overwhelming majority of persons who testified before the Task Force this past year who expressed their preference for in-home and community-based services regardless of the age of the persons—in other words it was the same message from the disabled community as well as the elderly community. On the other hand, there was a consensus of concern about the potential program cuts and the impact of these cuts on people of Kansas who have very real needs that will occur if budgets of SRS and the KDOA are further cut.

Finally, the Task Force wants to commend the local committees who have joined together to provide creative ways of meeting the needs of the elderly and the disabled in spite of money shortages. The Task Force urges the 2003 Legislature to look for ways to meet the needs for more community-based and in-home services. This may entail looking at the possibility of closing one more of the state's remaining institutions providing care for the developmentally disabled. The Task Force recognizes that it is very expensive to operate parallel community based options with state institutions.

Year One Goals Reaffirmed

The Task Force reiterates the following definition of long-term care and its conclusions formulated as six broad goals and the policy directions, strategies, and immediate actions attached to each goal of the Task Force developed in Year One.

> Long-term care is defined as providing assistance to meet needs of persons who are limited in their ability to function independently over an extended period of time.
>
> Assistance includes the informal network of families, friends, and community services as well as formal services such as social service agencies, home health agencies, supportive day care, assisted and residential living, and nursing homes. Professional care coordination is a critical component of the long-term care system.

The Task Force, by consensus, arrived at six goals to be achieved by the end of 2005. The Task Force also determined an overall policy direction to be attributed to each of the goals. From each goal and policy direction several strategies were adopted to achieve the goal and one or more steps for immediate action to move toward achieving the goal were selected.

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The following is a listing of each of the six goals and the policy directives, strategies, and immediate action steps that attach to it. Steps that have been taken to date to achieve the goals, policy directions, and strategies are then described.

*I. **Goal No. 1. Establish a long-term care system which is understood and supported by Kansans; which recognizes the dignity and uniqueness of persons needing long-term care which promotes the need for healthy lifestyles; and which enables informed consumers to understand the possible outcomes of their choices.***

Policy Direction. All Kansans should have a right to access accurate, timely, and understandable information regarding the Kansas Long-Term Care System.

Strategies and Immediate Action

- Develop an interactive Internet website to permit access to information regarding long-term care services available in Kansas; develop and disseminate brochures and related publications informing Kansans of long-term care services available; and develop and promote public service announcements regarding the Kansas Long-Term Care System.

- Investigate the feasibility of establishing a 2-1-1 telephone system for Kansas by implementing a pilot project in two areas, one urban and one rural, with live operators to disseminate long-term care information in non-crisis situations.

- Direct SRS to develop comparable data to the ElderCount book to include persons with physical and mental disabilities.

- The University of Kansas Medical Center's Center on Aging in conjunction with the KDOA should continue to update the demographic profile of the future Kansas aging population and begin to develop models to project future long-term care costs to serve these populations. SRS should cooperate with the above entities and develop similar future demographic profiles of the disabled populations and models to project future long-term care costs to serve these groups also. Every effort should be made to integrate these efforts with the ElderCount project that is currently in progress.

Progress to Date. KDOA and SRS have both made numerous improvements to their websites.

- KDOA is tracking the 2-1-1 activity. According to the Alliance of Information and Referral Systems (AIRS) magazine for August 2002, over 10 percent of the United States population can now access information through 2-1-1. They are striving for 50 percent by 2005. AIRS is working with the United Way of America, who has enlisted the support of a marketing firm that has developed a new logo and is in the process of developing a marketing kit and awareness campaign. In Kansas, the 2-1-1 activity has been on hold for over a year while tariff rates are being set. The Kansas Corporation Commission (KCC) is involved in the rate setting procedure.

- The ElderCount project is completed, as noted in this report (Year 3). Updating the ElderCount information and developing comparable data to include persons with physical and

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mental disabilities remains a strategy of the Task Force.

- KDOA and SRS will review the federal law with regard to federal estate recovery legislation and determine if the request to amend KSA 39-709(g)(2)(B) can be pursued.

II. Goal No. 2. Provide an accessible, integrated, and comprehensive range of service options to meet consumer needs.

Policy Direction. An on-going process should be initiated that assesses the long-term care needs of Kansans and matches them with quality services whether publicly or privately funded.

Strategies and Immediate Action

- The Insurance Commissioner should be requested to examine the feasibility of an alliance between the State of Kansas and private insurers to offer long-term care insurance policies that are comprehensive and affordable to a broad range of individuals and report to the appropriate 2001 House and Senate standing committees.

Progress to Date. The Kansas Insurance Department submitted a report on the feasibility of an alliance between the State of Kansas and private insurers to offer long-term care policies. The report provides background on the issue, describes the State of Kansas long-term care insurance program for state employees, describes federal efforts to establish long-term care insurance for federal employees, describes certain problems and limitations in bringing about the proposed alliance, describes actions taken by the Kansas Insurance Department in this area, and discusses certain proposed incentives including state income tax incentives. The report concludes that there is no magic solution to creating one effective alliance between government and the insurance industry to provide long-term care insurance that is comprehensive and affordable to a broad range of individuals.

The Task Force was informed by SRS that long-term care insurance premiums are allowable against a person's spenddown for medical purposes just like health insurance premiums. It was noted that the state could create a program to pay for long-term care insurance coverage. The state would need to address the possibility that individuals who would likely be covered by such a program might be persons who expect to need services in the near future and the expense of a program could be considerable. Developing a program would have a number of challenges. It would be necessary to take into account the type of coverage offered as most long-term care insurance policies do not cover 100 percent of costs, have a number of limitations, and may be even more restrictive based on the age and medical condition of the potential insured person. Medicaid provides full coverage and likely would still be needed as a supplement for things like drugs.

III. Goal No. 3. Provide high quality long-term care.

Policy Direction. The management, funding, and regulatory functions of the Kansas long-term care system should be accountable for the achievement of desired, specified, and measurable outcomes.

Strategies and Immediate Actions

- A user friendly, understandable system should be created to identify quality outcomes, customer satisfaction, and provide effective dispute

resolution or grievance procedures for licensed facilities and agencies providing long-term care. KDOA is to be the lead agency in convening a group to include SRS, KDHE, the provider organizations, and advocacy groups.

- The survey process should be altered to insure the focus is on quality of care and consistency of the surveys (inspections) of long-term care facilities and agencies. The Task Force requests that a person from the Washington State Quality Assurance Nurse Program be brought to Kansas to present information to a joint meeting of the House and Senate Public Health and Welfare committees and the Task Force on Long-Term Care Services at the beginning of the 2001 Legislature.

- A study should be conducted by KDOA with the assistance of SRS, KDHE, and other appropriate parties including the Kansas Insurance Commissioner to determine the implication of survey results on liability insurance rate increases and nonrenewal of policies for long-term care facilities and agencies. The findings should be to the appropriate standing committees of the 2001 Legislature.

- The KDOA, as the lead agency, with SRS and KDHE, provider organizations, and advocacy groups, is requested to develop a proposal for a more formal system of continued coordination and monitoring of the long-term care services delivery system system continually reassesses the service needs of Kansans, evaluates the quality of services provided, and insures needed changes are made in a timely fashion. The proposal for the system should be presented to the Task Force.

Progress to Date. The Task Force notes that a report is being prepared by the KDOA and the Kansas Insurance Department regarding the impact of survey (inspection) results on nursing home liability insurance premiums. See Goal 3, Strategy 3 above.

IV. Goal 4. Provide effective, efficient, and affordable services.

Policy Direction. The Kansas long-term care system should provide the appropriate level of service emphasizing personal responsibility, prevention, and home and community-based care which supports the informal network of family, friends, and neighbors, and clearly establishes the locus of funding responsibilities.

Strategies and Immediate Action

- An analysis of the current licensed Home Plus system should be made to determine its cost effectiveness.

- A format shall be developed to independently assess the role, function, and effectiveness of point of entry state contractors and providers of long-term care services and the appropriateness of their placements.

- A system should be established to monitor cost effectiveness of long-term care services.

Progress to Date. Legislation was enacted in 2002 to increase the number of individuals allowed in a home plan facility from five to eight and allows an adult care home to convert a portion of one wing to a home plan facility as long as separate licensure is maintained.

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V. Goal No. 5. Support an adequate and effective work force.

Policy Direction. Incentives should be initiated that will assure adequate compensation, training, and career development to direct care workers in the Kansas Long-Term Care System.

Strategies and Immediate Actions

- The Task Force will examine the current reimbursement system at the beginning of the 2001 Legislative Session and make recommendations to the 2001 Legislature regarding modifications of the reimbursements for direct care workers in the long-term care delivery system.

- The Kansas Department of Human Resources (KDHR) should make an assessment of the successful training and retention programs that are available for long-term direct care workers in Kansas and nationally. In implementing this request of the Task Force, KDHR should make use of information obtained, under SCR 1606, passed by the 2000 Legislature. SCR 1606 requests the Governor to ask the various secretaries of Executive Branch agencies to examine the industrial training and retraining law and to identify funds available for training and retraining or continuing education of long-term care staff and report this information to the 2001 Legislature.

VI. Goal No. 6. Provide coordination and communication between the federal agencies, state agencies, and local agencies, and between the public and private sectors.

Policy Direction. Long-term care programs and policies should be developed through a broad-based, consensus building process involving all the key stake holders at all levels of government, the public and private sectors, as well as consumers and family members.

Strategies and Immediate Action

- Secure funding to hire a professional public relations firm to inform Kansans about long-term care needs and solutions.

- The Task Force should host a series of town meetings on the Kansas Long-Term Care System in the 2001 Interim. The town meetings will serve as a means to gather as well as to disseminate information about the need to further develop the Kansas Long-Term Care System.

Progress to Date. In regard to Goal No. 6, Strategy No. 2 calling for a series of town meetings on long-term care issues during the 2001 Interim, the Task Force did not undertake this strategy due to the cost of holding these meetings and the Task Force's recognition of tight fiscal constraints of the state.

The Task Force did undertake a series of three meetings in November 2002 in Hays, Hutchinson, and Winfield. See page 3 for more discussion of these meetings.

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Kansas Department on Aging

President's Task Force on
Medicaid Reform
February 17, 2003
Attachment 2-1

Long-Term Care Services: Nursing Facility and Home and Community Based Services for Frail Elderly

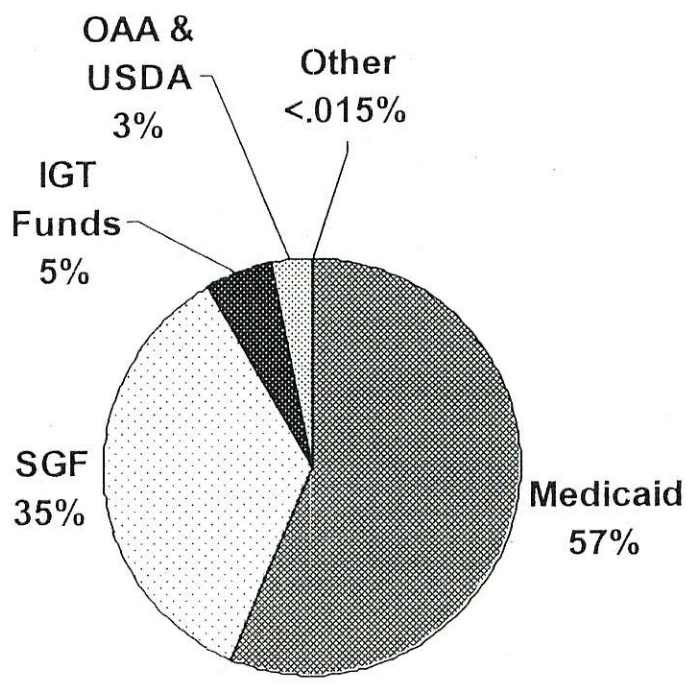
President's Task Force on Medicaid Reform
February 17, 2003
Janis DeBoer, Acting Secretary

For information contact:
Sheli Sweeney, Legislative Liaison
(785) 296-1299 or michelle@aging.state.ks.us

Doug Farmer, Assistant Secretary
(785) 296-6295 or dougf@aging.state.ks.us

Kansas Department on Aging FY 2002 Funding Sources

Medicaid	$223,272,190
State General Fund	$140,824,187
IGT Funds	$21,089,830
OAA & USDA	$11,312,578
Other	$328,013
Total	$396,826,798



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Kansas Department on Aging FY 2002 Expenditures

Nutrition **$8,840,080**

Congregate
Home Delivered Meals

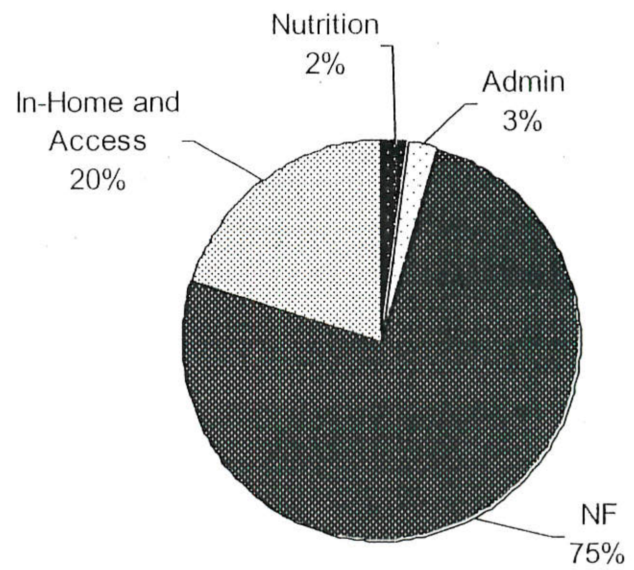
Access and In-Home **$78,881,780**

Older Americans Act (OAA)
Senior Care Act (SCA)
Income Eligible (IE)
Home and Community Based Services for Frail Elderly (HCBS/FE)
Targeted Case Management (TCM)
Senior Pharmacy Program
Partnership Loan Program

Nursing Facility **$298,201,922**

Administration **$10,249,130**

Includes Client, Assessment, Referral and Evaluation (CARE)



KDOA Customers Served FY 2002

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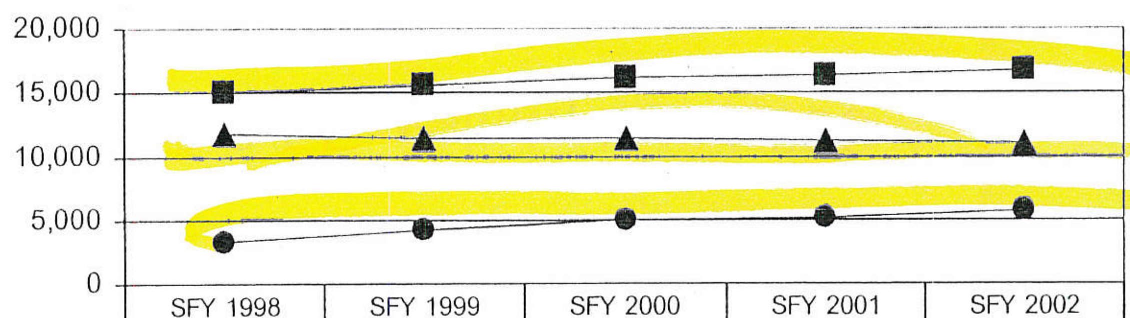
HCBS/FE	5,697	
Nursing Facility	10,979	56% of total services
CARE	13,324	

As of 1/31/03, HCBS/FE waiting list: 1,036

Monthly Medicaid Averages of Customers Served

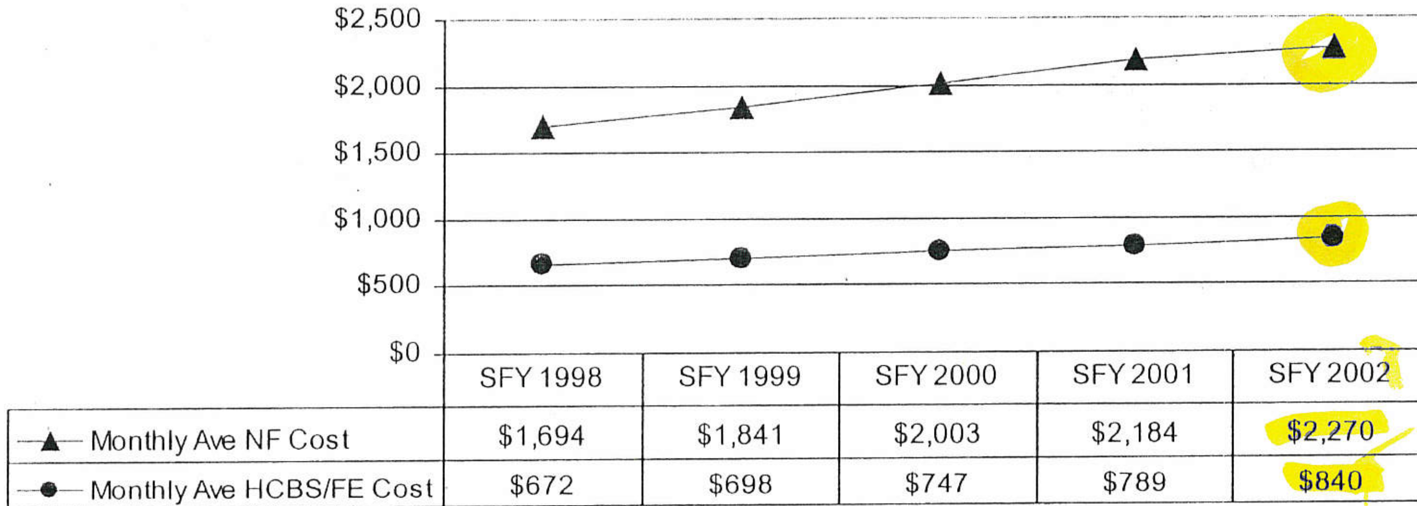


	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002
Total Average	15,120	15,624	16,271	16,399	16,676
Monthly Ave of NF	11,788	11,340	11,394	11,162	10,979
Monthly Ave of HCBS/FE	3,332	4,284	4,877	5,237	5,697
Total Customer % Yearly Increase		3.33%	4.14%	0.79%	1.69%

- For SFY 2002, the increase in the average monthly number of customers served on the HCBS/FE and Nursing Facility programs was 1.69%, which is slightly less than the population growth of 2.03% for the elder population, aged 80 and over.

- The average age on the HCBS/FE waiver is 79 and the average age for residents in a nursing facility is 84.

Monthly Average Medicaid Expenditures per Customer



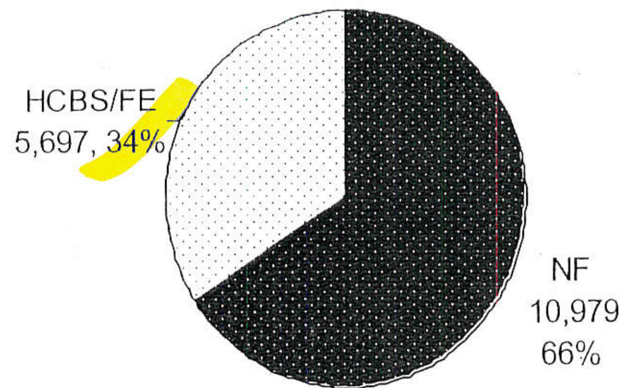
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002
Monthly Ave NF Cost	$1,694	$1,841	$2,003	$2,184	$2,270
Monthly Ave HCBS/FE Cost	$672	$698	$747	$789	$840

- In addition to the above analysis, the Department of Social and Rehabilitation Services conducted a study to determine the impact of HCBS/FE on nursing facility utilization (see Attachment A). The results from that study support KDOA's finding that HCBS/FE is a cost-effective alternative to nursing facility placement.

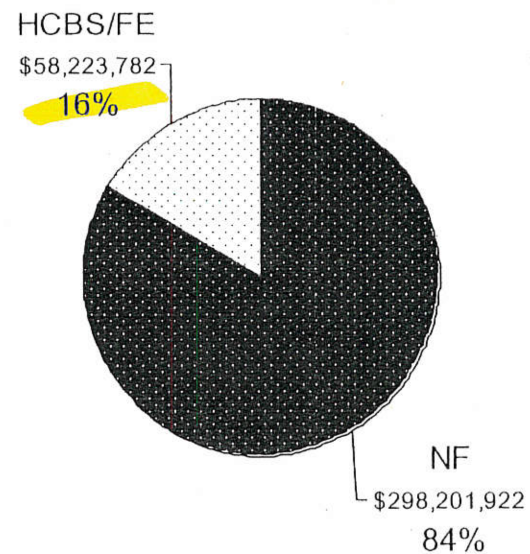
Comparison of Nursing Facility and HCBS/FE Customers and Expenditures

2-7

Monthly Average Served



Annual Expenditures



Attachment A

<u>University of Kansas - Abstracts</u>

Are Home and Community-Based Services Less Costly than Nursing Home Care?

TI Shireman, SK Rigler, KS Braman, RM Day. University of Kansas Schools of Pharmacy and Medicine, the Landon Center on Aging, and Kansas Dept of Social & Rehabilitative Services

Background: Kansas Medicaid covers home and community-based services (frail elderly (FE) program) as an alternative for older adults who are eligible for nursing home (NH) care but wish to stay in the community.
Objectives: To describe demographic and health characteristics of Kansas Medicaid enrollees receiving NH or FE services and to compare their relative Medicaid expenditures.
Methods: We compared one-year direct medical costs, from Medicaid's perspective, for a random sample of NH and FE recipients (n=1050 and n=1165, respectively), using mean monthly costs to adjust for enrollment time. We explored the influence of demographic factors and comorbidities on cost differences between the NH and FE groups using multiple linear regression models.
Results: The NH cohort was older than the FE cohort, (83.2 vs 76.9 years), more likely to be white (93.4% vs 82.0%), and more likely to have dementia (34.4% vs 5.6%) or psychoses (28.6% vs 10.4%). The FE cohort had a higher prevalence of major medical diagnoses and died at a higher rate than their NH counterparts. After adjusting for key demographic and clinical features, mean monthly total costs for the FE cohort were $1,147 ($p < 0.001$) lower than for the NH cohort. When we excluded direct NH and FE-specific costs, the FE cohort's mean monthly costs were $243 higher than for NH cohort ($p < 0.001$), reflecting higher use of inpatient and outpatient services.
Conclusions: FE program enrollment was associated with reduced total costs relative to NH care. When considered with a concurrent analysis of nursing home placement rates, results support the notion that these services are a cost-effective care alternative for frail older adults.
Supported by a grant from the Kansas Department of Social and Rehabilitative Services.

Do Home and Community-Based Services Reduce Nursing Home Placement?

TI Shireman, SK Rigler, KS Braman, RM Day. Pharmacy Practice, University of Kansas School of Pharmacy and Medicine, Landon Center on Aging, and Kansas Dept of Social & Rehabilitative Services

Background: Kansas Medicaid covers home and community-based services (frail elderly (FE) program) as an alternative for older adults who are eligible for nursing home (NH) care but wish to stay in the community.
Objectives: To determine whether FE services lowered the rate of subsequent NH admission.
Methods: Retrospectively, we identified a randomly selected cohort of community-dwelling, elderly Medicaid enrollees. Those enrolled in the FE program (n=963) were compared to those who did not receive any FE or NH services during the base year (n=2992). The outcome was any NH use during the subsequent year and modeled using logistic regression accounting for differences in demographic factors and comorbidities.
Results: Persons receiving FE services were more likely to be white (82% vs 78%), female (78% vs 70%), and older (78 yrs vs 75 yrs). The 3 most prevalent comorbidities for both groups were hypertension, arthropathies, and diabetes. Subsequent rates of NH use were 4.4% lower among FE enrollees than for the non-FE community-dwelling cohort. After adjusting for differences in age, race, gender and major comorbidities, non-FE community-dwellers were 1.49 (95% CI 1.16-1.92) times more likely to enter a NH as compared to FE enrollees.

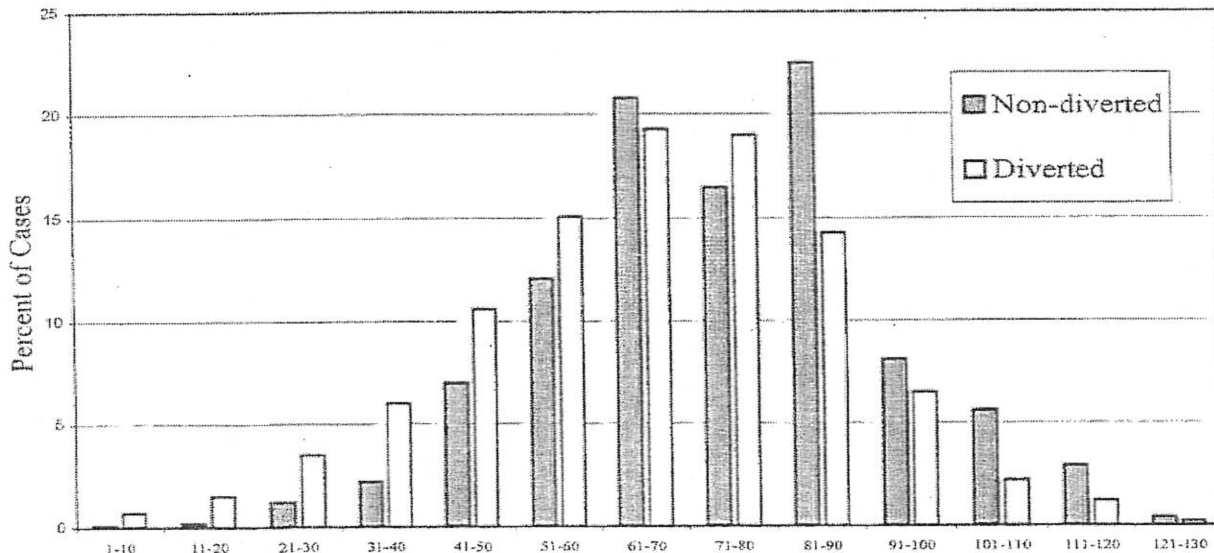
Conclusions: FE program enrollment reduced the likelihood of subsequent NH use among older Medicaid recipients. Combined with cost analyses reported elsewhere, results support the notion that these services are a cost-effective care alternative for frail older adults. Supported by a grant from the Kansas Department of Social and Rehabilitative Services.

Kansas Department on Aging
<u>**Level of Care (LOC) Scores**</u>
January 2003

The Kansas Department on Aging has funded research relative to determining a Long Term Care Threshold score that represents the level of care (LOC) at which an individual needs to receive long term care services. This concern is related to eligibility for Medicaid payment under either the Home and Community Based Services for the Frail Elderly or Nursing Facility Program. The Long Term Care Threshold score has been set at 26 since January 1, 1995. As a result of the allotment directives, SRS has changed the score to 30 effective February 1, 2003.

Researchers for the Kansas University School of Social Welfare have performed three studies related to residents who received a Client Assessment and Referral Evaluation (CARE). The focus of these studies was to follow a sample population and determine whether the individuals were diverted from nursing facility care. The researchers also looked at how long a person could be diverted if community based services were appropriate and available. This research is significant because it studies the sample population's choice of service options without regard to payor source.

The chart below, which appears in both the August 2001 and July 2002 reports, indicates that over half of the population studied had functional deficits which related to scores between 60 and 90. However, as the study points out: "The most important finding from this analysis is that some <u>non-diverted</u> customers with low LTC Threshold Scores entered NFs and some <u>diverted</u> customers with high LTC Threshold Scores were able to remain in the community." The <u>**average**</u> score for residents diverted from nursing facility care was 66. The <u>**average**</u> score for residents in the study, who entered a nursing facility, was 74. These scores are averages only. They would not be appropriate as a "threshold score."



Long Term Care Threshold Score
Non-diverted customers entered a nursing facility
Diverted customers were in the community with services at the time of the 30-day follow-up

2-10

As this research indicates, the Long Term Care Threshold Score must not be viewed as an absolute value. It is an indicator of the individual's level of impairment and need for long term care. The August 2001 study reports "the minimum score for both diverted and non-diverted customers was 3 and the maximum was 125." Seniors who are able to pay for nursing home care may choose to enter a facility, regardless of their LTC Threshold scores. This indicates that these individuals or their caregivers perceived a "need" for long term care. They were required to pay for this care from private funds because they did not meet Medicaid eligibility. On the other hand, individuals with very high scores can function successfully in the community with the necessary supports, whether paid by public or private funds.

The chart above suggests that individuals with lower scores are more likely to be able to receive services in the community. Those with higher scores are more likely to enter a nursing facility. Community services when available and appropriate have proven to be more cost effective to the Medicaid program. See Attachments 1 and 2.

Many other factors, besides those used in the LTC Threshold score calculation, influence a senior's ability to continue to function successfully without assistance. Support can be provided informally, by family or friends, or be a paid service, using either public or private funds. In the senior population, several elements, called "enabling factors," were identified in the 2002 KU study to influence an individual's choice of housing and service options. These include:

- Availability of care through institutions and agencies,
- Obtaining information on services and benefits,
- Availability of financial resources, and
- Informal supports.

Other elements called "predisposing factors" and "need factors" are explained in the June 2000 report, with a statistical analysis provided in the Technical Report of 2002. This research and other studies across the country continue to improve our understanding of what causes contribute to an individual's decision to enter the long term care delivery system.

Current research by the University of Kansas Medical Center suggests that the instrument being used to capture the LOC score could be enhanced to more accurately capture functional impairments and, in turn, be a better predictor of the need for long term care. Based on this research, we believe that the current instrument can be augmented and the scoring mechanism refined to be an improved measure of functional eligibility for Medicaid.

However, regardless of the instrument or scoring mechanism used, setting the value to be used for the Long Term Care Threshold score is a public policy decision. KDOA supports the Governor's recommendation that the threshold score be maintained at 26.

Summary of Issues Relating to Long-Term Car Paid for by the Kansas Medicaid Program
From the Performance Audit, *Medicaid Cost Containment: Controlling Costs of Long-Term Care*
President's Task Force on Medicaid Reform
Barb Hinton, Legislative Post Auditor
February 17, 2003

We found that from 1998 to 2001, Medicaid spending for long-term care increased $157 million, going from $472 million in 1998 to nearly $630 million in 2001.

<u>Of the $157 million dollar increase</u>:

$47 million was caused by higher reimbursement rates being paid to nursing facilities. Those rates increased because nursing facilities paid higher salaries to their caregivers (nurses, etc..) in 1998 than in 2001.

How to contain Medicaid spending for long-term care in nursing facilities? As you know, the Department on Aging limited nursing facility reimbursement rate increases for FY 2003 by delaying any increases in the rates until January 2003. Our August 2002 audit recommended pushing any increases back to June 20, 2003. It's our understanding the Department has done this to help address the budget allotments implemented in August and November 2002, which reduced the nursing facility SGF portion by $4.5 million.

The remaining $111 million of the $157 million spending increase was for long-term care services provided in the community. These services are commonly referred to as "waiver" or "HCBS" Home and Community-Based Services.

How to contain Medicaid spending for long-term care in the community? Most of the cost increase ($81 of the $111 million) was caused by <u>more people</u> getting waiver services, with the remaining $31 million caused by people getting more services per person in 2001 compared to 1998, and increases in reimbursement rates over that same time period.

<u>Because</u> most of the cost increase for long-term care waiver services was caused by <u>more people</u> getting services, the options that can do the most to contain costs related to limiting the number of people eligible for Medicaid-funded long-term care services. Here's how:

- **Make it tougher for people to qualify for Medicaid funding.** This can be done in 2 ways. Make it tougher for them to qualify <u>financially</u>, or make it tougher for them to qualify <u>functionally</u>. Applicants have to meet <u>both</u> requirements to get Medicaid funding help for long-term care.

  <u>Making it tougher to qualify financially</u>: from 1998 to 2001, SRS <u>made it easier</u> for people to qualify financially by loosening eligibility requirements. Further, an audit we did in March 2001 showed that Kansas' financial eligibility standards were more lenient than other states.. They allow Kansans to <u>shelter a larger portion</u> of their assets and <u>become eligible sooner</u> than they would in other states.

  <u>Making it tougher to quality functionally:</u> other surrounding states have either considered raising the score needed to qualify (Colorado has), or have <u>already raised</u> the score (Missouri has).

Our audit also recommended several options for paying less for long-term care. These options, although much more attractive than limiting eligibility, most likely won't produce costs savings as quickly, but they still should be implemented to help produce cost savings over the long-run. The first of these options, and the most important:

- **Managing the care provided to the most expensive consumers.** The elderly and disabled accounted for 94% of the increase in Medicaid-paid <u>long-term costs</u> from 1998 to 2001, and for 70% of the increase in Medicaid-paid <u>medical costs</u> from 1998 to 2000. Many elderly and disabled get both types of services.

Despite this, very few elderly and only and about half the disabled people getting services are in managed care–a program that could help ensure services are appropriate and necessary and that duplicate services are eliminated.

To effectively manage the care of these elderly and disabled clients, SRS must do a better job of analyzing and using data about Medicaid clients and the number and types of services they are receiving. Such information can help ensure that only the neediest people are getting services, and that they are getting only the services they need.

Some additional options we identified to help the State pay less for long-term care:

- **Cap the number of people who can get Medicaid-paid waiver services (waiting lists)**
- **Institute spending caps per consumer (cap spending at the average amount it would cost to provide services to these same people if the care were provided in an institutional setting.** For 2001, we found that 924 people receiving services in the community would have exceeded such a cap, and that the State would have saved $9.2 million if those people had been served in a nursing home or other institutional setting..
- **Recoup amounts paid in error.** We recommend that SRS do more of them, and then take the steps necessary to recoup the amounts that shouldn't have been paid to providers.
- **Help people take the step necessary to pay for their own long-term care.** LTC insurance isn't affordable for the people who need it most.

President's Task Force on Medicaid Reform
Long Term Care

February 17, 2003

Prepared by Janet Storey-Hierl R. Ph.

I. Introduction
   A. Pharmacist-In-Charge – Heartland Homecare Services, Lawrence, KS division
   B. Heartland Homecare Services operates 2 locations
      1. Lawrence
      2. Wichita
   C. Closed-door pharmacy
      1. Provide prescription management program targeting the LTC population
         a. Developmentally disabled
         b. Mentally retarded
         c. Behavioral management issues
      2. Service only those clients associated with or living in LTC facility
      3. Total clients served from both locations - 900
         a. Wichita – 350
         b. Lawrence – 550
      4. Prescription volume
         a. Wichita - 26,000 Rx's in 2002
         b. Lawrence – 31,416 in 2002
      5. Pharmacist FTE
         a. Wichita – 0.5 FTE
         b. Lawrence – 1.25 FTE
   D. All consumers are serviced with the Medicine-On-Time[R] (MOT) personal prescription system
      1. Features of MOT include:
         a. Individually tailored bubble pack system that packages multiple medications together according to time of administration
         b. Each bubble pack card is color-coded specific for time of day
         c. Client's medications are packaged in 28-day cycles
         d. The bubble pack system maintains the integrity of the product so that changes in medications allow for reuse of unused medications
      2. Advantages in utilizing MOT
         a. User-friendly system complete with detailed labeling
         b. Promotes compliance in drug therapy
         c. Reduces medication errors by support staff

d. Maintains independence to those that live independently from support staff
e. Reduces man-hours required by support staff

II. Routine Services Provided
   A. Maintain detailed patient profiles
      1. Perform drug interaction screens
      2. Detect poly-pharmacy
      3. Drug allergy alerts
      4. Therapeutic duplication
   B. Provide profile-generated MAR (medication administration record) to all recipients
   C. Obtain all refills for each client's medication
   D. Deliver medications to each location/residence
   E. Adjust and repackage medications as required
   F. Maintain dialog with caregivers, support staff, medical professionals as required for changes, alternative therapies, and potential untoward reactions/side effects
   G. Provide 24 hour call service for all clients, caregivers, and medical professionals

III. Medicaid Reform Issues
   A. Reimbursement strategies
      1. Current pricing structure
         a. Generics based on AWP – 27% + 3.40
         b. Brand name based on AWP – 13% + 3.40
      2. Suggested changes
         a. Increasing % reduction off AWP
         b. Establishing cost basis as AAC rather than AWP
      3. Potential outcome with relation to proposed changes
         a. Increasing % reduction of any one of the top 3 brand name drugs dispensed by our pharmacy will cause our business to close
         b. Using the cost basis of AAC rather than AWP is an inconsistent practice
            1) AAC is not the same for all pharmacies this lead to fewer independent pharmacy providers
            2) AWP cost basis is an established standard of practice and is the same for all pharmacies
         c. Slashing reimbursement practices or changing cost basis determination provides little or no incentive to help keep Medicaid costs down

B. Brand name drug limits

1. Proposal set to go into effect April 1, limits the number of brand name drugs for each patient to 5/calendar month
2. Some exclusions to this policy, only significant exclusion to the LTC patient is the atypical antipsychotic
3. Several drug classes important to this population were not included
   a. Antiepileptics
   b. Antidepressants
   c. Inhalers – COPD, asthma, emphysema
   d. Antibiotics
4. Limiting the number of brand name drugs provides little or no flexibility in cases of illness
5. Long term patients maintained on brand name drugs will result in more frequent hospitalizations, require more lab work, poor disease management, more support staff time allocations
6. Short term effects for cases of illness will be similar

IV. Conclusion

Evaluation of the Medicaid system as it relates to LTC is a complicated task. Prescription services are a significant portion of the budget for the LTC patient. Pharmacists are integral to maximizing patient care while minimizing drug costs to the Medicaid system. Slashing reimbursements, changing cost basis determinations, and limiting the number of brand name drugs for the established LTC patient is shortsighted. Fewer pharmacies will accept Medicaid recipients; more Medicaid dollars will be spent on hospitalizations, doctor visits, lab work and caregiver hours, and the pharmacists role in disease care management will suffer because his professional time has been devalued.

Senate Medicaid Reform Task Force
February 17, 2003
Testimony by
Elaine Speck

My name is Elaine Speck and I am 57 years old and have a physical disability. During this statement I hope to help you understand that just because I'm disabled, I like to have choices and make decisions about my quality of life, and by doing this I can live independently with minimal supports.

I have personally lived in a Nursing Facility for three months. I know first hand how quickly and formidable an individual's independence can be stripped from them, not to mention their freedom of choice relating to the simplest of things. Have you ever just felt like eating something on a particular day and not be able to do just that? Well I have, and not until I was admitted into a nursing facility did I experience that. In a facility there is no choice! How about if you want to stay up late and watch a movie? Well you can't do that because bedtime is at 9:00pm and the next morning according to someone else's schedule you have to be up and ready to eat breakfast at 6:00am. If you're lucky you can maybe get the once a week bath you are allowed to have on the day of your choice, instead of what the scheduler has listed on a piece of paper. I have to admit that I did raise hell about how and when they tried to plan out my bowel movement schedule and expressed it in I suppose a very inadequate way.

Acquiring my disability later in life, I know first hand how hard of a transition it is to accept. I'm not able to work, allowed a drivers license, and yes at one point in this process I was told I could not live any where except for a nursing facility to get quality care. I later learned about the physical disability waiver and Home and Community Based Services. I met some people from our area Independent Living Center, LINK. I was elated to learn about the program and an assessment was conducted, which is comparable to nursing facility admittance eligibility except more of a consumer directed program. This was such a pleasure to find out that I was eligible. BUT...there was only one problem – there was a waiting list of 6 months because adequate funding for this program was not available. I sank as quickly as I had risen with the thought that my life again would have some normalcy. The HCBS program is by far more cost effective than nursing facility warehousing.

My name came to the top of the list in November of last year after waiting 6 months. I understand that I was probably one of the last people to get on the PD waiver before it was frozen. I was finally able to receive services, instead of struggling every day to survive and living with the fear that the independence that I do have will deteriorate rapidly. **My plan of care was set up for 23 ½ hours a week and my assessment score is 47. My Personal Assistant whom I hired assists me with dressing, transferring, mobility, meal preparation, shopping, medication management, laundry, and housekeeping. I do get**

some informal supports from my sister with money management and transportation. My personal assistant does not get paid to sit around and supervise me, just to assist me with tasks that I am physically unable to do myself. The physical disability waiver does not pay for supervision, just task services. Basically the personal assistant is not paid except for services rendered. I direct this program because I know what my needs are and how to relay or explain to a personal assistant what type of help I need to live independently. **My total Plan of Care costs the state of Kansas $1391. The average Plan of Care for someone in a Nursing Facility is $2377, and there is not any individualized personal care.** I did not have my very own personal care attendant that was hired to take care of only me in the Nursing Facility. Why is it that if I would have decided to stay in the nursing home, the funding was there to pay for the nursing home care along with all but $30.00 a month of my SSDI benefit. Why couldn't funding just follow my decision to live independently with minimal supports at a more cost effective rate?

My SSDI check is $975. a month. I pay a client obligation of $310. a month, which leaves me $665. a month for rent, utilities, food, clothing, toiletry, etc. I am currently taking five different medications, which if I had to pay out of pocket would cost me over $600. a month. There is no way I could survive without medication coverage. Also I am a little concerned about switching from brand name to generic drugs. For some medications, this is not a problem, but I do take medications for seizures, which I have heard the generic drugs are not as effective as brand name drugs. Not controlling my seizures would cause many other problems that I would not want to think about.

I made the decision to leave the slamming of doors, the 6:00 am wake up calls, the constant alarms, and from the meals that were far from any type of nutritional value. I'm thankful that each day I have not smelled the wrenching smell of urine in the air and in my clothes, and I sometimes will ask company if my apartment smells like the nursing home because I can still smell it. I know of individuals that have died waiting for their name to come up on the PD waiting list and I don't believe that is right. We have all contributed to society in one form or another and all regardless of age should be able to choose where we want to live and where we want to die and what services we want in place to achieve this desire of choice. Most importantly, we can continue to contribute within our communities in a positive manner while living happily in our homes.

Why is it so hard for the State of Kansas to take a moment and do the math and compare the cost of facility care opposed to home and community based services? There is no need for the State of Kansas to pay an entity or an individual for services that I do not need assistance with. Just pay for services rendered and be-done with it. Not the thousands of dollars a month to a nursing home that provides no individualized personal care to any of the individuals that are abandoned and warehoused there for what ever reason with no voice or choice. Medicaid will not pay HCBS for supervision; lets not pay the nursing

facility except for individualized task based services. This is proof that the State of Kansas is paying nursing facilities for warehousing elderly and disabled individuals, because that is the State of Kansas' choice? What is wrong with this picture?

We as citizens of this United States have the God given right to freedom of choice. Too many have died waiting for their opportunity of choice. All we want is equality to choose to live and/or die in our own home with dignity and delight in the fact it was our choice, and that choice was honored and respected.

I am depending on this Task Force to let it be known what we, the disabled and elderly community, need, want and deserve to achieve and sustain independence. We want the HCBS programs to be funded as needed, and the opportunity to access this program as quickly as we can now access admittance to a nursing facility.

I thank you for your time, and I would be happy to respond to any questions you have.

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Jason Gallagher
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jason@ibelievedesign.com

RE: Written Testimony for Medicaid Reform Taskforce

February 17, 2003

Senator Clark and Members of the Taskforce:

My name is Jason Gallagher and I am here today to tell you stories of people and their lives, and to give you an idea of what Medicaid services look like to those of us using or trying to use these services.

First I want to tell you my story. Currently, I am happy, I am receiving HCBS services, and can now live comfortably in my Overland Park apartment. I am living independently making the choices that 22 year-olds make. I have the ability to work my part time job at Johnson County Community College where I am a math tutor. I have the ability to take classes at JCCC or any other college I chose, or to just be able to hang out with friends.

Despite this, it hasn't always been so simple. When I graduated from High School I did not have the services I needed to help me to be independent and enjoy the life my peers took for granted. I had limited PCA hours (2 hours a day) that I had for what I needed while I was in school. When I requested more hours because my situation had changed, I was denied. My mom had to quit her job to take care of me, at a time in my life when I wanted to leave home, not have to spend all day with my mom. Together we spent a year and a half fighting SRS for the services I needed. It got to the point where my parents were in financial peril and the only choice was going to be to put me in a nursing home. PUT A 19 year old in a nursing home???? It took nothing less than the threat of a lawsuit from Kansas Protective Services to get the PCA hours I needed so my mom could work, I could be independent and to stay out of a nursing home.

So yes, now, I am able to have my dignity, my freedom, and my independence. I was hoping that others would not have to go through what I did, but it pains me to say things are worse now. There are people all across this state that aren't getting the full services they need. There are many who can't afford to stay in the community because of the protected income level. Even worse, there are thousands who aren't getting services at all. Numerous more are in the nursing homes trying to get out.

These are stories that I heard first hand when I put together this booklet, Living by Chance, not Choice, that you have seen. These are stories like Veronica Patterson who is in a similar situation as I was in. A 20 year-old woman who has been WAITING for 8 months, and wants nothing more than to be able to live independently and to get her undergraduate degree and eventually her Masters degree at Pittsburgh state. After that she will get a job that will allow her to be give back for the services she needed in the

way of taxes, and business activity. However, now she has to rely on her mom and sister just to stay out of the nursing home. Her sister and mom having to give up their jobs or reduce their hours to be there for her. What is wrong with this picture?

These are stories like Robert Jarman who lost his truck to repossession and had to borrow money for health care and to pay for his home because he lost his job due to his disability. He is on the waiting list now, and without Home and Community Services his family will have to choose between his wife staying home to help him with care or going into the nursing home. His biggest fear being that his children will see him in a nursing home, and will have to remember him that way!

Stories like Roger Carter who was able to get out of a nursing home, and now is happy to be able to take his wheelchair to watch the ducks at the pond. Yet, his freedom is being threatened because the protected income level is making it hard for him just to be able to afford his basic necessities like rent, utilities, and FOOD. This is a man who worked his whole life then lost his life savings to pay for his own care, and then was thrown into a nursing home. Now he is struggling to stay away from the one place that haunts him.

I talked to many of these people on the phone, and had a chance to meet a couple of them in person on Friday. These are people who aren't asking for much. All they want is to live in their own home, to be able to buy semi-descent clothes, to be able to afford shampoo, to have dignity, and have a life. These people aren't getting rich off Medicaid and Social Security, nor will they ever. I am not rich, but I can live comfortably, but these people aren't even getting that opportunity. These are people who are choosing between food and medicine, living off of bread and water, whose families are giving up their lives to help them, and who are scared for their lives they will lose what little freedom they have to a nursing home.

If you want to help these people, if you want to change the Medicaid system for the better, if you are TRULY serious about Medicaid reform, you need to think in a new direction. The world has changed. With people living longer, with technology making it easier for people with disabilities, and with home-care being the preferred long term setting, we are no longer in a model of acute care, but one of long term care. No longer is it about fixing people because something is "wrong" with them, it is about helping them to live the most dignified, comfortable, and productive life they can. It shouldn't be anymore about "illness" as Bob Deigh was telling us on Thursday, but instead about wellness. The health-care paradigm has changed, and now it is time for Medicaid to change with it.

First and foremost we need to get Veronica and Robert, and the thousands of others off the waiting list, and into their homes. The waiting lists need to be fully funded. We need to raise the protected income level, or even better yet change the way people pay for their health care. Social Security says Substantial Gainful activity is $800 a month, and the Federal Government puts poverty level at $748 a month, and yet the state of Kansas expects persons on Medicaid to live on $645??? Once the immediate problems have been solved we must move in a new direction. We need to no longer make nursing home an

entitlement, and make HCBS an equal choice. We need to give consumers choice over how their Medicaid dollars are spent. We need to promote programs like working healthy, and change guidelines so they encourage people to go to work, instead of discourage, as they do now. We need to consider wellness and preventative care over illness and emergency care.

Once you see that the Medicaid system is outdated, that there is a major need for a paradigm shift, you will also see that when you move people out of nursing homes, and give consumers choice it will cost the state considerably less in money in the long run. You will see that the quality of care will be significantly enhanced. You will see individuals who will thrive in their community and will be able to give back by paying taxes, filling jobs, contributing ideas, and being helpful, faithful, and productive citizens.

NOW is the time to get people off waiting lists and out of nursing homes. NOW is the time to change. Now is the time for Kansas to show that it cares about its citizens in need and to make Kansas a leader in Medicaid policy. Let us show the President that we are serious about Medicaid reform.

I have faith that together we can make new ideas a reality, and make Kansas a better place for everyone to live, work, and participate productively in family and community.

Thank You.

Gina McDonald
President/CEO

Member Agencies:

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LINK, Inc.
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Resource Center for Independent Living, Inc.
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Topeka Independent Living Resource Center
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Presentation to
President's Task Force on Medicaid Reform
Senator Stan Clark, Chair
February 17th, 2003

Thank you for the opportunity to present before you today. My name is Gina McDonald and I am the President of the Kansas Association of Centers for Independent Living (KACIL). KACIL represents 13 Centers for Independent Living around the state. Our mission is to work for the rights of people of all ages who experience disabilities.

I want to start by thanking this committee for your interest and work on Long Term Care issues. As you well know, the average age of citizens in this state and in this country continues to rise. As we age, it is likely that many of us will experience disabling conditions that will cause us to have to make changes to our lifestyle.

But Long Term Care is not just about Senior Citizens. Young people also experience catastrophic illnesses, accidents and births of children with disabilities which will also require long term care. It is no surprise to you as you review the states budget that much of the funding for long term care goes to services for people with developmental disabilities, (MR/DD Waiver), physical disabilities (PD Waiver), Head Injuries, (HI Waiver) and children with Technology assistance needs, (TA Waiver).

In the coming years, many of us will have need for supports which will allow us to remain in our homes. Many of us want that option. KACIL agrees that there should be mechanisms other than dependency on the state to ensure all citizens have the option of remaining in place as we age and/or acquire disabilities.

For many individuals who experience significant disabilities, there are few options. Many individuals we have asked to testify before committees over the years have been people who thought they had prepared for accidents, illnesses and other events by saving money, having health care insurance and some even had long term care insurance. Many people had good paying jobs prior to their accident or illness.

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But with one catastrophic illness or injury their insurance capped out. They reached their lifetime limit of $1,000,000.00. They soon depleted their savings accounts. They could not go back to their former employment because of real or perceived limitations. They depended on their families for as long as possible, but the strain was too much on families who had both spouses working and children to raise. Or, because of the mobility of individuals there often is no family member within close proximity to provide care.

The other group is individuals who are born with severe disabilities. They have a 78% unemployment rate. They are most likely to be eligible for services.

And so for many individuals, the only option is to look to the state for support. The options the state has are entitlement services in institutions, where study after study has proven that costs are higher than community based services, or Home and Community Based Services (HCBS) Waivers. These are programs that support individuals in the community and the state "waives" serving people in institutions so long as the state can prove that it remains less costly in the aggregate for people to get services in the community.

HCBS waiver services are not entitlement programs and so, large waiting lists have built up over the last ten years. People are waiting an average of six months on the PD Waiver to get services. Some die waiting, some get worse due to lack of care and some use informal supports until that runs out and they wind up in a nursing facility with much greater needs and more cost.

We've heard suggestions about using volunteers or neighbors to provide needed home and community-based services. Imagine how you'd feel about waiting in bed for a volunteer or a neighbor to get you out of bed. If they didn't feel like coming, you are stuck in bed all day and all night. Most of us don't even invite our neighbors into our homes anymore. Imagine having to ask your neighbor to assist you in getting on and off the toilet.

It is our opinion that the State, in an effort to maximize federal funds, has made "Medicaid Junkies" out of many people with disabilities and families. Just as with the welfare system, we have designed a safety net that traps people and makes them believe they can do little to improve their situation.

KACIL suggests that in this time of budget crisis, we determine what we can do to empower people, rather than trapping them into dependence. Advocates, consumers, the state and legislators need to work together to develop solutions that are based on the dignity and ability of disabled people, not on their deficits.

We need to redesign systems so that they provide supports when needed and teaching tools whenever possible to minimize or eliminate dependency on the system and maximize independence.

Kansas Association of KACIL Centers for Independent Living

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Our hero in the independent living movement, Justin Dart Jr. said that "Empowerment is when we say no to the primitive illusion that society, government, the free market; the public media are some sort of paternalistic super gods that can give us truth, equality and prosperity."

Our freedoms will come not only when we are released from nursing facilities, but when we are employed with health care and do not have to worry about our services being cut because the state is short of funding. We, the disabled community must work with you to change systems that discriminate, and minimize us and we must work together to ensure that systems are there as supports that move us toward independence, not nets that trap and keep us in costly programs.

How do we accomplish these grand objectives? The answers will not be achieved today or tomorrow, but we can take steps to the solutions. KACIL recommendations include:

1. CONTINUE AND EXPAND THE MEDICAID BUY IN PROGRAM

This legislature is to be commended for the great success of the Medicaid Buy In program where people have the option of returning to employment and can keep their medical card for health insurance and pay a premium for the card, based on their income. According to the Working Healthy program, as of January 2nd, 2003, 510 Kansans are taking advantage of the program which began last July. 56% of those people are paying a premium for their coverage. Most were not previously working and now are paying taxes.

SRS and advocates have been working together but have been unable to include Personal Assistance services as an optional service that people can use under the medical card for this program. That means that people who use wheelchairs or need an assistant for other reasons cannot use the program yet. When we can include personal assistance as a covered service, the number of people using the program will increase dramatically. That's good news. That means they'll be working and paying taxes. They'll be paying premiums on their medical card.

One of the main barriers to including PAS is that the federal government will not allow the State to define "work". We are advocating that the definition of who is eligible to receive PAS under this program be people who work in an integrated work setting for at least 40 hours a month.

Without that definition, a person on the waiting list for HCBS services could apply to the Medicaid Buy In program, work one hour a month and be eligible for PAS services. As advocates we recognize that would put the budget in danger and we are opposed to such a situation. We will advocate for a change in Federal Regulations, but we ask that this body write to our Senators and Congressmen

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and to CMS and to Social Security Administration and request that they allow for a definition of work as part of the Medicaid Buy In program that will define work as at least 40 hours per month.

2. REVIEW FUNDING SOURCES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.

There continues to be strong disincentive for people with mental retardation and other developmental disabilities to become independent. The majority of all funding is tied up in matching the waiver using Title XIX funds. The regulations written around that funding source give very little options for community providers to be reimbursed for teaching people to become independent. Rules and regulations encourage and support dependency models.

KACIL recommends a review of programs that were implemented by community providers prior to the development of the current funding systems. There were programs out there that fostered independence. Direct SRS to provide funding for model programs that are effective at promoting independence. They work, but they must be funded. KACIL believes that current funding can be used. It will require a change in regulations and in thinking.

We must also look at the invasive and sometimes discriminatory regulations used as part of the DD Reform Act that prevent Community Based Agencies from being reimbursed for providing real integrated services for people with developmental disabilities. There must be more freedom for people with developmental disabilities to take risks without the provider agency being held responsible for all actions of consumers. People learn from their mistakes, yet for people who we assume have the most difficult time learning, people with developmental disabilities, don't have that option. We reward protection and control and by doing so, minimize the individuals ability to learn, grow and become more independent.

KACIL is working with Kansas University, SRS, Community Developmental Disability Organization's and Self Advocates Coalition of Kansas to look at ways to create more self directed programs for people with developmental disabilities. We received a grant from Health and Human Services under President Bush's New Freedom Initiatives. We have high expectations that we can be successful in identifying some of the barriers that keep people in programs and do not encourage outcome based services.

This grant only deals with services for attendants. We hope that SRS will review all regulatory language and create ways to ensure people have the greatest opportunities for success and that providers of services are rewarded for outcomes.

7-4

3. TRANSITIONAL LIVING SERVICES UNDER THE PD WAIVER.

KACIL has discussed the option of adding a service called transitional living to the PD Waiver. This service would allow the opportunity for people to receive training for a period of time to learn to complete tasks for themselves and then complete waiver services. This will not work for every individual, but we believe that some people could reduce their hours of Personal Assistance Services and some may even be able to leave waiver services.

However, we continue to identify the need to allow individuals to keep their medical card for health care needs. If we don't create that option, people will not be able to leave the services. The Medicaid Buy In program could be a model for how to implement this option.

By offering transition services to people for 6 months with the intent of teaching them to do tasks themselves or getting OT or PT evaluations to determine equipment which would allow them to do tasks themselves we will be helping people off the system instead of teaching them to be dependent on the system.

4. DOLLAR FOLLOWS THE INDIVIDUAL FROM INSTITUTIONS TO THE COMMUNITY.

This concept is based on the Olmstead decision by the Supreme Court which says that services should be paid for in the most integrated setting. If people with disabilities who are in facilities can benefit from and want to receive services in the community, they should have the option of moving to the community.

Currently there is about a six month waiting list for home and community based services. Even though she has restored cuts made in the SRS budget, the Governor's '04 budget for HCBS has no new dollars to decrease the size of the waiting list. So we can anticipate it increasing substantially.

There is no waiting list for institutional services. If you are in an institution, the state is paying for your care already, on an average, at a greater rate than what would be required for services in the community.
This concept would allow people to move to the community and the dollars would follow them without having to wait on a waiting list.

It is very difficult to become independent of the system while living in the community. Your Public policies such as Medicaid Buy In and HCBS Waivers have made it easier.

Over a year ago, the State of Kansas was awarded a Real Choice Systems Change grant from HHS for $1.4 million dollars. The purpose of the grant is to redesign long term care service delivery system. The grant could address waiting list issues and design a better diversion program before entering a N.F. It should also address the implementation of the Dollar Following the Individual.

Kansas Association of KACIL Centers for Independent Living
1423 West Crawford ◆ Salina, KS 67401 ◆ Voice/TT: 785/825-2675 ◆ Fax: 785/825-7029

It is impossible to become independent from a Nursing Facility Bed. Please study the benefits of the Dollar Following the Individual to free people who want to move home.

Both Texas and Missouri have passed similar laws.

5. REVIEW WITH INSURANCE COMMISIONER METHODS TO MAKE PERSONAL ASSISTANCE SERVICES AVAILABLE, AFFORDABLE AND ACCESSIBLE THROUGH LONG TERM CARE AND OTHER INSURANCE POLICIES.

As our population grows older and as Medical Science becomes better at keeping us alive and saving us from accidents, illnesses, the need for Long term Care will only increase. We have done a dis service for years by talking about Personal Assistance Service and Long Term Care as something outside and separate from the realm of Health Care. And so we considered it only for elderly and disabled.

We now need to redirect our efforts to consider Long Term Care including, but not limited to Personal Assistance Services as Health Care.

We need to work with Insurance companies, the State, consumers and advocates to identify the barriers to getting and keeping Long Term Care Insurance today, and develop methods to make it more affordable, accessible and desirable to people.

As the population of "Baby Boomers" grows older, they want to "age in place." That is they want to remain in their homes and continue to be contributing members of society. Medicare won't pay for all the costs. Medicaid as we've seen is killing the State budget.

But Long Term Care Insurance is unaffordable for people who are just making ends meet. It many times is very limited in the services and length of time it will provide those services.

Surely there is a way to solve these major obstacles to people getting the care they need so they can remain at home, if they choose.

Let's create some method of getting everyone to the table to address the issues and develop a plan.

6. REVIEW POTENTIAL FOR INCREASING THE ELIGIBILITY FOR OBTAINING HEALTH INSURANCE THROUGH THE MEDICAL CARD. IDENTIFY METHODS WHICH WOULD ALLOW PEOPLE TO PAY PREMIUMS BASED ON INCOME.

1423 West Crawford ◆ Salina, KS 67401 ◆ Voice/TT: 785/825-2675 ◆ Fax: 785/825-7029

Without health insurance, many individuals will continue to use costly programs such as waivers and institutional care. With access to medical cards, we believe many individuals would not need other services.

This could also be considered for individuals who are now called the 'working poor', or people who cannot afford traditional health insurance, but could pay a premium to a larger pool and have health care.

These seven recommendations will move people with disabilities to less dependence on the system that will and can not always be there.

We as a disability movement will never be free and equal as long as we depend on "other people's money". The Independent Living philosophy is one of consumer control, not government control. KACIL wants to assist in any way we can to offer incentives and support to assist people with disabilities to achieve the same American dream that we all have.

Thank you for the opportunity to present to you today. I would be happy to stand for questions.

1423 West Crawford ♦ Salina, KS 67401 ♦ Voice/TT: 785/825-2675 ♦ Fax: 785/825-7029

GLOSSARY OF TERMS/ ACRONYMS

AARP	American Association of Retired Persons
ADA	Americans with Disabilities Act
ADAPT	Americans Disabled for Attendant Programs Today
ADL	Activities of Daily Living
AMI	Alliance for Mentally III
A/N/E	Abuse/Neglect/Exploitation
APS	Adult Protective Services
AT	Assistive Technology
ATK	Assistive Technology for Kansans Project
CAP	Client Assistance Program
CIL's	Centers for Independent Living
CMS	Centers for Medicare and Medicaid Services (Previously HCFA)
CMHC	Community Mental Health Center
CDDO	Community Developmental Disability Organization
DD	Developmental Disability
DME	Durable Medical Equipment
DOA	Department On Aging
HCBS	Home and Community Bases Services--the waiver alternative to institutionalized care under Medicaid

HCBS/FE	Home and Community Based Services for the Frail Elderly
HCBS/HI	Home and Community Based Services for the Head Injured
HCBS/ MRDD	Home and Community Based Services for Mental Retardation and Developmental Disabilities
HCBS/PD	Home and Community Based Services for Physical Disabilities
HCBS/TA	Home and Community Based Services for Technology Assisted Children
HCFA	Health Care Finance Administration (Health & Human Services see CMS)
HHA	Home Health Agency or Home Health Aide
HHS	Health and Human Services (Department of)
IADL's	Instrumental Activities of Daily Living
ICF/MR	Intermediate Care Facility for the mentally retarded--a Medicaid funded residential setting
IDEA	Individuals with Disabilities Education Act
IL	Independent Living
INTERHAB	Association of Rehabilitation Facilities serving people with developmental disabilities
KACIL	Kansas Association of Centers for Independent Living
KAMI	Kansas Alliance for the Mentally Ill
KAPS	Kansas Advocacy & Protective Services
KCDD	Kansas Council on Developmental Disabilities
KCDC	Kansas Commission on Disability Concerns
KCDHH	Kansas Commission for the Deaf and Hard of Hearing
KDHE	Kansas Department of Health and Environment
KDOA	Kansas Department on Aging

KHIA	Kansas Head Injury Association
K-PASS	Kansas Personal Assistance Services and Supports
KRS	Kansas Rehabilitation Services
LOC	Level Of Care. Can refer to the score used to determine eligibility for Title XIX services
MH&DD	Mental Health and Developmental Disability
NF	Nursing Facility
PA or PCA	Personal Attendant or Personal Care Attendant
PAS	Personal Assistance Services
PIL	Protected Income Level – the amount of money a person who is getting services is allowed to keep before services can be rendered.
SILCK	Statewide Independent Living Council of Kansas
SRS	Social and Rehabilitation Services (Department of)
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
UAI	Uniform Assessment Instrument. Screening tool used to determine eligibility for Title XIX services and to determine Level of Care score.

KANSAS ASSOCIATION OF
HOMES AND SERVICES FOR THE AGING

To: Senator Stan Clark, Chair, and Members,
President's Task Force on Medicaid Reform
From: Debra Zehr, RN, MA, Vice President
Date: February, 17, 2003

Medicaid Long-Term Care: Improving Services while Controlling Costs

Thank you, Chairman Clark and Members of the Task Force. The Kansas Association of Homes and Services for the Aging is the trade association representing 160 not-for-profit long term care provider organizations that serve over 15,000 older people around the state. Our members include faith-based, fraternal, civic group and government sponsored nursing homes, retirement communities, assisted living facilities, senior housing and community-based service providers.

In order to understand and plan for long-term care in the future we must have sound population projections. While **the ElderCount Project provides a good foundation for** program and policy planning now and in the very near future**, we would recommend that the Division of Budget develop and update disability projections on at least 3-5 year basis**. And while these projections are important, we know they cannot take into account the great unknowns. For instance, if a cure or effective treatment for Alzheimer's Disease or spinal cord injury is found, our need for long term care will plummet.

Medicaid is the healthcare safety net for vulnerable Kansans. As a society, we have an obligation to make sure it performs effectively and efficiently. There have been a stack of reports generated on methods to control or contain Medicaid expenditures in the past few years. Generally these methods break down into three broad strategies: 1) reform the system, 2) increase private and federal resources and 3) "other" strategies. I'd like to take a few minutes to highlight some of the particulars of these strategies related to long-term care.

REFORM
KAHSA supports a continuum of high quality, cost-effective choices for persons with long-term care needs. Kansas has made significant progress in the past several years to move this concept toward reality. We applaud the efforts of the Legislature, the previous Administration, and the Departments of SRS and KDOA toward this end. **Reform of the system usually has meant increasing the availability of home and community-based services** as a way to provide choice and decrease use of facility-based (nursing home) care. Kansas has adopted this reform and, as a result, the number of HCBS/FE consumers has steadily increased as the number of nursing home residents has declined. Another option **is adoption of the PACE model, or Program of All-Inclusive Care** for the Elderly, in which an organization receives a flat, capitated payment to deliver and coordinate all needed preventive, primary, acute and long-term care services to persons who are eligible for nursing home care. Last year the state entered into an agreement to

President's Task Force on
Medicaid Reform
February 17, 2003
Attachment 8-1

217 SE Eighth Street
Topeka, Kansas 66603-3906

3-7443
3-9471

pilot PACE with Via Christi. Other methods of reform include strengthening of **Medicaid care coordination** (case management) to assess need, authorize services, allocate resources, and provide for ongoing reassessment.

INCREASE RESOURCES

A second set of strategies involves **increasing private and federal resources**. Many states, as well as the federal government, have put policies in place to **encourage increased use of private long term care insurance**, such as tax credits. So far, these measures have shown minimal results. Attempts to **reduce Medicaid estate planning** have also been largely unsuccessful to this point. Some states have successfully **maximized federal Medicaid match**, but this approach seems to be drying up as the federal government is experiencing its own set of challenges and new priorities. Another option that has not been explored is changing statute to allow for the creation of **nursing home or long-term care districts** similar to our current hospital district structure. This would allow for injection of local mil levy to support continued delivery of long-term care services in rural areas.

OTHER

Other strategies focus on **provider supply and reimbursement**. Most states, excluding Kansas, limit the supply of nursing home beds through a **Certificate of Need program or moratoria** on all but replacement beds. However, even without a CON or moratorium, nursing home beds and occupancy have steadily declined in Kansas over the past six years. Perhaps the state could look at providing incentives for providers to **merge or close**. This would result in more efficient use of Medicaid dollars overall. We believe that **provider reimbursements**, which have already been squeezed in our current economic environment, must be adequate to ensure high quality care. Unfortunately, our members are facing a number of escalating costs that do not directly contribute to quality care. Chief among these is skyrocketing insurance costs. Other cost drivers include increased staffing, increased acuity of residents, new federal requirements related to HIPAA, OSHA and Life Safety Code, and increased utility costs. We agree with the Department on Aging that there should be an examination of ways to **incent providers toward increased quality of care**. For instance, facilities might receive additional reimbursement if they 1) have a staff retention above the 50 percentile, 2) demonstrate substantial survey compliance, 3) have high resident satisfaction rates, or 4) provide a relatively high number of nursing hours. Another possibility for cost savings would be to reinstitute the 85% occupancy rule on all but smallest facilities.

KAHSA welcomes this opportunity to be part of the discussion about Medicaid reform. As a member of the Big Tent Coalition, we support adequate funding for services for the frail elderly and other vulnerable populations.

Thank you. I would be happy to answer questions.

An earlier version of this article was first published electronically under the title "How to Save Medicaid LTC" on 24Oct02 by the Center for Long-Term Care Financing. Information regarding the Center for LTC Financing can be found at http://www.centerltc.org.

Medicaid Reform Suggestion, by Claude Thau

Through Medicaid, we do two wonderful things for people who need long-term care (LTC). First of all, we all pay taxes so that indigent people can get commercial LTC that they otherwise would not be able to afford. We should all feel proud to contribute to that cause.

Secondly, we provide support to people who are NOT indigent. If people were to sell their homes in order to pay for LTC, and then were to recover, they could no longer return home. To avoid such an undesirable result, we give them advances (loans) to cover their LTC costs, with the intention of recovering when their estate is settled.

Not only do we pool our money to provide a loan to such people, we provide that loan on an interest-*free* basis! And it is a *long*-term loan as it does not require repayment until the care recipient dies. And if the recipient's spouse is living in the house, the loan does not have to be repaid until the spouse dies. If disabled or minor children live in the house or if adult children who were care-givers for a couple of years live in the house, the loan continues until they die or sell the house.

It is wonderful that we provide such loans, but such loans should be provided OUTSIDE the Medicaid program. When we do it through Medicaid:

- Loan recipients feel the sting of being "on welfare". These people have been independent since their youth and have saved in order to maintain their independence. Why should they be placed on Medicaid when they are not indigent?
- Being on Medicaid, they are restricted to Medicaid-certified LTC providers. They cannot select the facility of their choice; nor can they have a private room; nor can they select an assisted living facility, commercial home care or reward relatives or friends for providing care. Why should their use of their money be restricted?
- LTC providers, such as nursing homes, are paid the government Medicaid reimbursement, which is inadequate. Why should they not receive full cost?

Medicaid reimbursements pay LTC providers less than the cost of LTC. When state budgets are tight, as they are now, legislators and governors propose slashing such payments even further. Meanwhile government pushes provider costs upward with a variety of mandates, such as quality controls, mandatory staff training, etc.

Because of low reimbursements, LTC providers cannot afford a competitive salary. So when they train staff, the newly-trained person secures a higher-paying job in a hospital or elsewhere. The vacancy not only reduces the quality of care in the facility, but the facility incurs cost seeking and hiring a new employee, who typically is less experienced than the person who left.

The best staff leave, as they are most in demand, but providers get stuck with their hiring mistakes. Surely, they should fire these weak performers, right? Unfortunately, it is not easy to fire anyone when you are understaffed! Of course, as time goes on and they suffer 100% annual turn-over (some jobs turn over more than once; others not at all), the labor pool quality, as regards care-givers, likely deteriorates. Even outstanding NH management has an extremely difficult time providing excellent care in such an environment.

Private-pay LTC recipients in Medicaid-certified facilities get "taxed" in three ways to support this system: 1) they pay income taxes to support Medicaid; 2) they pay higher fees to LTC providers (subsidizing the costs of Medicaid recipients); 3) they suffer from inferior care in facilities which have many clients "on Medicaid".

Therefore, some savvy private payors now refuse to enter Medicaid-certified facilities. Instead of being seen as a badge of honor, Medicaid "certification" may be viewed as a public announcement that cost transfer will occur and that care might be inferior.

Another problem occurs when we, the tax-payers, try to recoup our loan. Various parties bewail the plight of "poor Sarah" who wanted to leave her house to her children, but whose estate had to sell the house because it was partially encumbered by a government lien. Of course, recouping payments from the "indigent" sounds questionable.

However, those people were ***not*** "indigent". The critics never mention that we all gave Sarah a 20-year interest-free loan and all we are trying to do is to recover the principal (no interest) so that we can lend the money to someone else.

So, how can we get out of this mess? One key tactic would be to stop putting people on Medicaid if they have assets which could fund their LTC. Instead, such loans could be government-backed, but financed privately. This simple change would have ***dramatic*** impact:

a) Such care recipients would no longer feel the indignity of being "on welfare".
b) Care recipients would have flexibility to use these loans to purchase the kind of care they want, from whomever they want. Their buying decisions would encourage consumer-driven efficiency in the marketplace.
c) Many more care recipients would remain "private payors" rather than being on Medicaid. Providers would benefit from the resultant higher fees.
d) The additional provider revenue would lead to reduced cost transfer from Medicaid LTC recipients to private-pay clients and/or improved care.
e) Because fewer people will go on Medicaid, tax-payer money will be saved. We could afford higher reimbursements for Medicaid patient care.
f) We avoid the whole concept of "repaying Medicaid" and "government liens".

From a State Budget point-of-view, this proposal has several positive aspects to it:

1) There will be many fewer people on Medicaid, so Medicaid payments for LTC will decrease substantially (recoveries will disappear, but recoveries do not offset the up-front payments and come many years later).
2) Significant savings can occur in determining Medicaid eligibility and processing Medicaid payments.
3) The entire administrative effort for recoveries can be dropped.
4) In addition to the substantial savings in expenses mentioned above, there is an increase in revenue! The additional income of LTC providers will be taxable.

The State also benefits because there will be more investment in LTC services and more consumer control of the selection of their LTC provider. Furthermore, there will be more incentive for family care-giving. These changes should increase choice, improve care and reduce cost.

An alternative loan program already exists, although it does not provide government-backed loans and is limited to $50,000. Formerly known as "Grannie Mae", the program is now called ElderLife Financial (www.elderlifefinancial.com). Unfortunately, I found the following quote on the Grannie Mae web-site: "Currently, Grannie Mae's Passports primarily accommodate families seeking Assisted Living Community or Continuing Care Retirement Community, needs respectively." Why is that? Apparently because CMS and the states are treading on its responsibilities, ElderCare is only effective making loans for providers not covered by Medicaid.

We need to continue to provide LTC to the indigent, but we should attempt to improve the quality of care. This can be accomplished indirectly if we continue to provide loans to people who need LTC but lack liquid assets, but do so through a private lending, government-backed program rather than through Medicaid.

The author can be reached as follows:

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Thau Inc. was established to help create a **sound** long-term care insurance industry in the U.S.A. It works in 3 areas:

a) Consulting for LTCI companies, providers of services, employers, associations, insurance agencies, etc.
b) Wholesaling LTCI by training and servicing insurance brokers across the country.
c) Advocacy work.

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2000-: **President**, Thau, Inc. (a Long-Term Care Insurance consulting firm)

Provides LTCI consulting to the federal government, employers, associations, insurance companies of all sizes, providers, and other parties, domestically and internationally.

Unlike most LTCI consultants, Claude has significant, current sales experience.

1994-99: **Senior Vice President**, Transamerica Occidental Life Insurance Company
Senior Officer, Long Term Care Insurance (LTCI), TOLIC

Created strategies/plans and built staff to develop this new business. Restructured strategies and staff several times to respond to internal/external conditions.

Launched industry-leading LTCI products, with numerous innovative concepts.

Tripled sales two years in a row. Grew 5 times as fast as the LTCI industry each of 3 consecutive years despite internal disruptions, increasing market share from 0.4% to 3.2% (estimated).

Involved in selling several major accounts such as Los Angeles Country Employees' Retirement Association, Regence Health Care, MN State Chamber of Commerce

1991-93: **Chief Operating Officer** (and SVP), Transamerica Assurance Company (TAC)

Reduced Group Term Life insurance Loss Ratio from 80% to 65% in 1 year, saving nearly $2,500,000 annually.

Established plan to increase stagnant earnings by 60% in 1992 over 1991; exceeded plan by 10%. Also exceeded planned increase of 50% for 1993 over 1992.

Created product modifications, adding many $millions of value to each year's sales.

1987-93: **Senior Officer**, Transamerica **Travel Insurance** Services
1989-91: **Senior Officer**, Transamerica **Pacific Operations**
Senior Officer, Transamerica **Group Insurance** Services

Built each unit from scratch with combined staff of only 6 people.

Conceived of new group and travel insurance coverages to differentiate from commodity products sold by the rest of the industry.

First recipient of TLC Award for teamwork, leadership and commitment.

1971 to 1987: Earlier Actuarial and Project Management roles

Claude and his wife, Tina, have been married for 30 years. Their son, Andrew, is a law student at NYU and their daughter, Tracy, is an undergraduate at Northwestern University. Claude is involved in non-profit activities with a variety of organizations. For example, he serves as the Chairman of the Board of the Center for Long-Term Care Financing and works with the American Stroke Foundation and Midwest Bio-ethics Center. (publications on back)

9-4

Selected LTCI articles and speaking engagements (including commitments)

Jan03: Two-part National Underwriter series re: Limited Pay LTCI Regulations
Society of Actuaries LTCI conference, speaking in 4 sessions, including:
LTCI Quote Engines: pros/cons of letting others have your rate files
Enrolling Extended Relatives and Spouses
Nov02:AALTCI Symposium (St.L): "The Great Debate: Indemnity vs. Reimbursement"
Also: NTQ vs. TQ LTCI policies and the Association Market: Approaches that Work
Oct02: LTC Bullet: Board Chair Claude Thau on How to Save Medicaid LTC
Sep02: 5 presentations scheduled between 12Sep02 and 27Sep02.
Jul02: LTC Bullet: Board Chair Claude Thau on Medicaid Planning
Jul02: Video tape released: "How You Can Protect Your Clients from LTCI Rate Increases"
Jun02: ProfitZone Radio: LTC and LTCI
AALTCI Teleconference call regarding association LTCI business
Apr02: National Underwriter: "LTCI Policy Changes"
Amer. Soc. on Aging/NCOA: "Why Areas of Aging (et. al.) should care about LTCI"
AALTCI Symposium (TX): "The Group Association Market for LTCI" (many times)
Quoted extensively in Best's Review. Ron Panko "Hope for a Healthy Marketplace"
Mar02: Sales Strategies Interview "Winning Formulas for an Association Endorsed Program"
38 Pediatric Hospital HR Executives: "How Mature is the Group LTCI Market?"
Feb02: Kansas Department of Insurance Institute: "How to Protect Your Clients from Premium Rate Increases in LTCI" (Also given many times elsewhere)
Jan02: Society of Actuaries LTCI conference: "Group Long-Term Care Insurance Transfer Considerations" and "LTCI: How Consumerist Are We?"
Dec01: Milliman/LOMA/LIMRA meeting: "Long-Term Care Actuarial Issues for Marketers"
Sep01: Missouri Association of University and College Personnel Association
Jun01: NCFA actuaries meeting: "LTCI for Fraternal Organizations"
May01:National Underwriter, "Two Little Words Can Spell All The Difference In LTC Contracts"
Mar01:AALTCI LTC Symposium (CA): "Ways to Minimize Your E&O Risk"
Feb01: Life & Health Advisor: A New Proposal to Provide Health Insurance to More People
Jan01: Society of Actuaries conference moderator and/or speaker for:
"Death on our own terms: How will changing end-of-life culture impact LTCI"?
"Hot Topics in Pricing LTCI" and "Avoiding Design Disasters"
Nov00 CA Broker: The CA NTQ vs. TQ Disclosure Form: Good Idea but Faulty Design?
AALTCI LTC Symposium (TX): TQ vs. NTQ: the Ultimate Debate
Sep00: Ingram's Magazine: Financing Long-Term Care
Jul00: Audio interview on Mr. LTC web-site (http://www.mrltc.com/RealAudio/thau.ram)
Apr00.:Life & Health Advisor: Profile of this Month: Claude Thau
LTC Forum: 1 of 3 keynote speakers (LTCI training conference in Scottsdale AZ)
Nov98:CA Broker: The California Partnership—Why Aren't You Selling It?
Speaker at First National Long-Term Care Insurance Forum's closing panel
Oct98: National Underwriter: Insurers Can Simplify LTC & Offer Flexibility
Sep98: NAHU LTC Conference: spoke as part of the CEO panel
Mar98:Health Insurance Underwriter: The Myth of Role Reversal
Feb97: Health Insurance Underwriter: Should You Sell Non-Qualified Products?
Feb96: Health Insurance Underwriter: Liability
Feb95: Health Insurance Underwriter: Suitability

Mr. Thau has given many Continuing Education seminars in various states, as well as speaking to business, consumers and other groups. He has been on 7 radio shows re: LTCI.

From: Center for Long-Term Care Financing [ltcbullets@centerltc.org]
Sent: Thursday, September 05, 2002 7:11 PM
To: Recipient list suppressed
Subject: LTC Bullet: Medicaid Planning Full Disclosure

LTC Bullet: Medicaid Planning Full Disclosure

LTC Comment: LTC Bullets readers frequently send us examples of flyers and web sites promoting easy access to Medicaid nursing home benefits. Complaints about Medicaid planning are just as likely to come from state and federal welfare administrators as they are to come from insurance agents and financial planners. Over the years, eight Congresses and three Presidents have struggled to discourage the widespread practice of artificial impoverishment to qualify for Medicaid. The government even went so far as to make it a crime: "Throw Granny in Jail" (repealed) and "Throw Granny's Lawyer in Jail" (unenforceable). Nothing seems to work. Now come Ross Schriftman, Associate Chair for Long-Term Care, and the National Association of Health Underwriters (NAHU) Long-Term Care Committee with a fascinating idea they have under consideration. Why not require Medicaid Planners to disclose the nature, consequences, and suitability of the self-impoverishment products they offer just as insurance agents and carriers must do for the legitimate financial products they market? You'll find the proposal that the NAHU folks are considering below the following announcements. Contact Ross Schriftman at mailto:ross@ktbenefits.com if you have any comments or suggestions.

*** Heads up! Please make a note. The Center for Long-Term Care Financing has dropped our rotary phone number at our old Bellevue, WA location (425-467-6840 is gone). Please put our new phone numbers and mailing address in your address files:

Stephen A. Moses, President, 206-283-7036, smoses@centerltc.org
Amy Marohn-McDougall, Executive Director, 425-377-9500, amy@centerltc.org
Damon V. Moses, Administrative Coordinator, 206-283-7036, damon@centerltc.org

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Stay in touch. We appreciate your comments and suggestions. ***

LTC BULLET: MEDICAID PLANNING FULL DISCLOSURE

Following is the proposal submitted by Ross Schriftman which is under consideration by the NAHU LTC Committee as referenced in the LTC Comment above. Material in brackets [ ] has been added for clarification by the LTC Bullets editor.

"MEDICAID PLANNING FULL DISCLOSURE TALKING POINTS

"As agents, we have to carefully explain the products and services we provide including disadvantages. This applies to advertising, sales presentation and on-going service.

9-6

"Unfortunately, I don't see the same kind of due diligence in the advertising that is done by the Medicaid Planning industry. For example, here are some lines from advertising pieces that are sent regularly to my Mother who is 77 years of age and a homeowner:

"'Protect Your Estate from Catastrophic Illness and Nursing Homes Without Purchasing Nursing Home Insurance and Which Assets are Exempt from a Nursing Home.' (Sponsored by Extension Education Senior Security Enrichment Workshop. Free continental breakfast)

"'Find out Why Experts Say Destroy Your Will. Don't Lose Your Estate to a Nursing Home.' (Sponsored by Senior Informational Services. Free Seminar. Space is limited.)

"'Avoid Medicaid Trap: How to Protect Your Assets from Catastrophic Illness and Nursing Homes.' (Senior Financial Survival Workshop. Free seminar)

"Are You Gambling with Your Retirement Stability? Topics include: How to avoid losing your [nest] egg to long term care expenses, WITHOUT buying long term care insurance.' (Sponsored by Serve our Seniors. Free breakfast) [Emphasis in the original]

"What should be disclosed [by Medicaid planners] is the following:

o The purpose of Medicaid (assist the poor and indigent)

o The fact that transfers are permanent and irreversible losing control over those assets.

o The fact that assets are [placed] in other people's names (i.e., adult children) and are subject to their creditors and/or divorce agreements.

o The fact that assets in an adult child's name could jeopardize grandchildren's chances of qualifying for financial aid for college.

o The restrictions on the type of services and facilities available [from Medicaid].

o The low reimbursement rates that have created bankruptcy and low quality of care in Medicaid facilities.

o The shortage of nursing staff for community as well as facility care that may [impede access to Medicaid-funded care at any level].

o The loss of other resources such as most of a person's Social Security check to offset Medicaid expenditures. [Medicaid requires recipients to contribute all of their personal income, including Social Security benefits, toward their cost of care except for a small personal needs allowance, usually between $30 and $60 per month.]

o Estate recovery requirements upon death that can severely damage family inheritance. [Recovery of benefits paid from the estates of deceased recipients has been mandatory since the Omnibus Budget Reconciliation Act of 1993, although this requirement is not uniformly enforced and Medicaid planners routinely circumvent it for their clients.]

o The cost to taxpayers and future generations that is taking money away from other programs.

"REGULATORY CONSIDERATIONS

"Who regulates this [Medicaid planning] industry?

"Who would police this and make sure information is accurately provided? (As we know in the insurance and investment field, home offices have compliance departments that must approve advertisements.)

"What penalties would be levied against planners who are not fully disclosing the advantages and disadvantages of their planning techniques?

"What should state and federal regulators be doing to properly inform the public?

REASONS THIS IS NEEDED

"'Buyer beware.' Unless the public understands the ramifications of [Medicaid planning] in advance, they may spend a lot of time and money (i.e., legal fees) and then realize all the negatives before they stop the process. This is unfair and therefore up front full disclosure in advertising material is needed.

"Truth in advertising is something that is part of most industries today. The financial planning/ legal advice industry should not be an exception. In fact it is probably more important [in this field than in others]. If someone has a bad experience purchasing a refrigerator or even a more expensive item like an automobile, the financial, personal and emotional consequences are far less severe than a bad experience creating a financial plan that locks in for the rest of his or her life.

"Although a legal option, this type of planning is hurting communities, providers and shifting scarce government dollars away from other important priorities such as education, the need for a prescription [drug] program, and defense. It also hurts the government's ability to focus Medicaid dollars on those whom the program was designed for, the poor.

"Only through proper disclosure can people make an informed decision if they want to pursue such a course of action.

"Promoters [of Medicaid planning], by implication, have made the idea of buying long term care insurance [seem like] a foolish choice for consumers with such statements as 'Find out how you can get the government to pay for your nursing care without buying long term care insurance.' This is contrary to government policy which is now encouraging private insurance as a solution to the Medicaid budgetary crisis.

"Other financial products such as bank accounts, credit cards and insurance are promoted with a regulatory authority approving or denying the use of certain advertising. There are also disclosure documents for nearly every financial product at the time of sale as well.

"Since a Medicaid Plan includes trusts which are legal documents, the courts have authority to regulate this activity.

"RECOMMENDATIONS:

"Through regulatory authorities, promoters should be required to submit advertising for approval before distribution.

"Just as insurance agent seminars are periodically monitored for content, regulatory authorities should monitor 'Medicaid Planning' seminars to determine if the content is deceptive or hype rather than accurate and full disclosure of the advantages and disadvantages of the product and services being promoted.

"There should be a regulatory approved disclosure form at the initial consultation with the advisor disclosing the advantages and disadvantages of such planning. The prospective client signs and receives a copy of this form. The planner must keep this document on file for possible audits by regulatory authorities.

"Upon completion of the plan, the advisor must have the client sign another document listing the advantages, disadvantages and recommendations of the planner. The client receives a copy of this document as well. This document would be signed and maintained by the planner for future audits by regulatory authorities."

A formatted version of today's LTC Bullet is available at www.centerltc.org/bullets/current/383.htm.

*** Forward freely; encourage subscribers! ***

The Center for Long-Term Care Financing is a 501(c)(3) charitable non-profit organization dedicated to ensuring quality long-term care for all Americans.

Right now, you can show your support with an online donation through a secure server connection at http://www.centerltc.org/support/index.htm .

Contributions are tax-deductible. If you get value from our LTC Bullets, our web site, our reports, our speeches or our public policy advocacy, please consider making a donation. Even small contributions are very much appreciated. Visit our website at www.centerltc.org/needhelp.htm or contact Amy Marohn at amy@centerltc.org for more details.

This e-mail is the latest installment of "LTC Bullets" - the Center's periodic online news service covering the latest information and trends in long-term care financing. We welcome responses to the material presented.

Unsubscribe by simply using your reply button to send a request. Please put your e-mail address and name in the body of your message. Your e-mail address will be deleted from the Center's mailing list before our next mailing. We apologize for any inconvenience. We do not intend our "LTC Bullets" to reach anyone not interested in receiving them.

S-1097.1

SENATE BILL 5730

State of Washington **58th Legislature** **2003 Regular Session**

By Senators Deccio, Thibaudeau, Parlette, Rossi, Keiser and Winsley

Read first time 02/10/2003. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to eligibility for long-term care services under
2 the medical assistance program; adding new sections to chapter 74.39A
3 RCW; creating a new section; providing an effective date; and declaring
4 an emergency.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** (1) The legislature finds that access to
7 care for people who need long-term care services is in jeopardy because
8 of the difficulty in providing public funds to finance the medical
9 assistance program. It also finds that eligibility policy for the
10 medical assistance program, for people needing long-term care services,
11 has evolved in such a way that it provides eligibility to some people
12 who have the ability to pay for the care they need from their own
13 resources.
14 (2) It is the intent of the legislature that eligibility for
15 medical assistance, for the provision of long-term care services, be
16 limited to people who do not have the ability to pay for the care they
17 need, and that eligibility for medical assistance be set at the minimum
18 threshold, with regard to assets, required for participation in the
19 federal medicaid program under Title XIX of the social security act.

9-10

1 It is also the intent of the legislature to establish a process for
2 offering information and referral to private sector financing
3 mechanisms that will allow people to draw upon their fixed assets to
4 finance their long-term care service needs. It is the further intent
5 of the legislature that by taking these measures, eligibility for the
6 medical assistance program will be reserved for the people in greatest
7 financial need, and that we will be better able to afford to provide
8 good quality care to those who are eligible.

9 NEW SECTION. **Sec. 2.** A new section is added to chapter 74.39A RCW
10 to read as follows:
11 (1) The department is directed to conform its medical assistance
12 eligibility requirements, for those who commence to receive long-term
13 care services on or after July 1, 2004, to the minimum level permitted
14 by Title XIX of the social security act with regard to any exemptions
15 for assets.
16 (2) The department is directed to periodically review, and adjust
17 as necessary, its eligibility requirements to counteract the effects of
18 anyone attempting to obtain eligibility by concealing or divesting
19 assets or income.
20 (3) The department is directed to seek waivers from the federal
21 government from requirements that the state exempt from eligibility
22 determination the value of an applicant's home or other real estate.
23 (4) The department is directed to report to the legislature
24 regarding federal actions on the requested waivers, and to identify any
25 changes in federal statutes required to carry out the intent of this
26 act.

27 NEW SECTION. **Sec. 3.** A new section is added to chapter 74.39A RCW
28 to read as follows:
29 The department is directed to establish an information and referral
30 process, for people seeking medical assistance for long-term care
31 services who appear to have sufficient assets in the form of a home, to
32 financial institutions that can arrange a home equity conversion
33 mortgage designed by the United States department of housing and urban
34 development and insured by the federal housing administration.

9-11

1 NEW SECTION. **Sec. 4.** This act is necessary for the immediate
2 preservation of the public peace, health, or safety, or support of the
3 state government and its existing public institutions, and takes effect
4 July 1, 2003.

--- END ---

9-12

Coalition to Reform Long-Term Care Financing

LTC CHOICE: Saving the Long-Term Care System

Objective: To prevent the collapse of Washington's long-term care system by returning Medicaid to its original purpose as a program to finance care for those who do not have the resources to pay for their own care. Without strong action, the state will be unable to maintain necessary long-term care funding as the "baby boomer age wave" leads to a doubling of the elder population over the next 20 years.

Ending the defacto Medicaid entitlement that has been created and reducing the current heavy reliance on Medicaid to finance long-term care services has the potential, to save as much as $250 million in state funds each biennium once the reforms are fully implemented. If only as few as 10% of the future Medicaid caseload can be shifted to a self-pay basis, this alone will save $50 million each biennium. This approach will also give consumers greater control over their care and allow for adequate funding to support the best possible quality of care for the elderly and people with disabilities.

Reforms: 1) Return Medicaid to its original purpose of financing care for those indigent individuals who cannot pay for their own care. Require individuals who are able afford it to utilize their personal assets to finance the LTC services they require.

2) Develop a mechanism to enable individuals to obtain financing based upon their assets and to be paid by their estates only after both the individual and any surviving spouse have died.

3) Educate the public on each individual's responsibility for meeting his or her long-term care needs.

Benefits: **Long-term care consumers** will have more choices and better access to the services they want as more of them enter the market as private buyers.

Long-term care providers will see their costs met and be able to meet changing consumer preferences in a market that is two-thirds private.

State budget writers will experience a significant drop in demand for scarce public resources.

Medicaid-sponsored residents will receive better care because government payers will be able to pay on a more adequate basis since they will responsible for fewer eligible people.

Long-term caregivers and other employees will benefit by higher wages that providers will be able to pay as they become less dependant on public funds.

Recipients, providers and caregivers will all benefit from enhanced quality of care when greater reliance on private financing provides the resources necessary to improve staffing.

Taxpayers will benefit because they will no longer be required to subsidize the care for people who can afford to pay their own way.

Contact: ***David Landwehr (316) 945-4827 dlandwehr@landwehrl*** [illegible]

President's Task Force on
Medicaid Reform
February 17, 2003
Attachment 10-1

Medicaid LTC Problem

In 2020, (only 17 years from now!) projections show 150 million people will be on government assistance. Baby Boomer retirees, their long living elders, and pre-retiree welfare recipients will comprise this huge number. The most expensive of these government recipients will be the people needing assistance with LTC claims. Public policy decisions made today will influence the depth of the problem we will face. Currently 6 to 8% of the population has LTC insurance as contrasted to 80 to 90% policyholders for car, home, and acute health insurance. Since the risk of a $100,000 to $150,000 lifetime claim is higher than the combined risk for the other three, we need to change the percentages. Last year LTC insurance paid over $1 billion in claims or .6% of LTC costs. We need to accelerate that participation.

I have provided an example of a typical good quality LTC plan. In my opinion, the premiums would be affordable for 50 to 80% of 40 to 59 yr olds. If we could provide the right climate encouraging purchase, the Medicaid LTC problem could be radically reduced.

Possible Legislative Medicaid Solutions

- Tax Credits for purchase would provide incentives for lower and middle income citizens to purchase. (Probably Fiscal Note currently prevents.)
- Government/Private Sector Partnership Programs have provided a road map to a better approach. (See Partnership for Long-Term Care Program Attachment and Project Proposal: Controlling Medicaid Long-Term Care Costs).
- Eliminating unsustainable HCBS waivers, as currently conceived, would encourage purchase. It is fraudulent to mislead people into believing that they can expect government to provide these benefits in the future. Unsustainable government programs like the currently implemented HCBS encourage people to ignore risk. (I actually received this response from a prospective client. " I don't need to take personal responsibility, I can dump my problem on future taxpayers and get home care. I can use an attorney to hide assets. Only suckers buy LTC insurance.") Another perspective is: If people see others getting taken care of, they don't perceive that a need exists. They might not know how the need is being addressed, but they know that a lot of people are not bemoaning the fact that they chose not to buy LTCI. HCBS costs could be greatly reduced with the next alternative.
- Medicaid Reform using the citizen's home as collateral to provide quality services outside the Medicaid program is an excellent idea. See Medicaid Reform packet.
- The HIPPA act required states to for aggressive estate recovery programs. Elder law attorneys make this a joke. Aggressive changes need to be made to supplement your carrot approach with a stick. Medicaid Planning Full Disclosure requirements would help citizens know the risks of Medicaid Planning. (See attached **Medicaid Planning Full Disclosure)** Stock Brokers, Insurance Agents, Financial Planners, etc. must provide clients with disclosure statements. Client disclosure statements would go a long way to help in correcting this particular problem.

Tax Qualified Long Term Care Insurance

Individual Policy Series GCPRO III TQ 197

Underwritten by Life Investors Insurance Company of America

Sample Pricing

Presented by: David Landwehr - (316)945-4827

LTC Workplace Solutions - Bronze - Kansas

February 02, 2003

Nursing Home, Assisted Living	
Policy Maximum	$75,000.00
Maximum Daily Benefit - Nursing Home	$100.00 per Day
Maximum Daily Benefit - Assisted Living	$100.00 per Day
Elimination Period	90 Days
Home Health Care	
Policy Maximum	See Above
Maximum Daily Benefit - Basic Services	$60.00 per Day
Maximum Daily Benefit - Adult Day Care	$60.00 per Day
Maximum Daily Benefit - Professional Services	$120.00 per Day
Elimination Period	0 Days
Optional Features (Additional premium required)	
Benefit Increase Option	5% Simple or 5% Compound
Payment Options	
Premium Payment Period	Lifetime
Premium Payment Mode	Monthly

Age	Quantity	Married Deferred	Married 5% Simple	Married 5% Compound	Single Pref Deferred	Single Pref 5% Simple	Single Pref 5% Compound
18-40	1	7.51	12.77	17.14	8.23	14.00	18.78
41	1	7.51	12.77	17.14	8.23	14.00	18.77
42	1	8.23	14.00	18.78	9.82	16.72	22.40
43	1	9.10	15.49	20.76	9.83	16.72	22.41
44	1	9.10	15.49	20.76	10.55	17.95	24.06
45	1	9.82	16.72	22.40	10.55	17.95	24.05
46	1	9.82	16.72	22.40	11.27	19.18	25.70
47	1	10.55	17.95	24.06	11.27	19.17	25.70
48	1	10.55	17.95	24.06	11.27	19.17	25.70
49	1	10.55	17.95	24.06	11.27	19.17	25.70
50	1	11.28	19.18	25.71	12.86	21.87	29.33
51	1	11.27	19.18	25.70	13.58	23.10	30.97
52	1	12.86	21.87	29.33	14.31	24.33	32.63
53	1	13.58	23.10	30.97	15.03	25.56	34.27
54	1	14.31	24.33	32.63	16.62	28.26	37.90
55	1	16.63	28.27	37.41	18.07	30.72	40.65
56	1	17.35	29.49	38.68	18.79	31.95	41.89
57	1	19.65	33.21	43.04	21.09	35.65	46.19
58	1	21.10	35.44	45.58	23.41	39.33	50.57
59	1	23.41	39.10	49.39	24.85	41.50	52.43

A Word About Your Premium Rates. The Policy allows the company to adjust premiums as needed, with the prior approval of your state insurance department. We cannot increase your premiums during your rate guarantee period, if applicable. We cannot single you out for a premium rate increase, but we can change your premium based on our experience with all insureds in your same premium class. However, once we issue your coverage, we cannot cancel your Policy as long as you pay your premium on a timely basis.

This is for illustration purposes only. Benefit availability may vary by state. Please use the outline of coverage and/or sales brochure for a description of benefits, exclusions, limitations and the terms under which the policy may continue in force. Premium and benefit amounts will vary depending upon the plan selected and are subject to underwriting approval.

This is an illustration, not a contract.

10-3

Tax Qualified Long Term Care Insurance

Individual Policy Series GCPRO III TQ 197

Underwritten by Life Investors Insurance Company of America

Sample Pricing

Presented by: David Landwehr - (316)945-4827

LTC Workplace Solutions - Bronze - Kansas

February 02, 2003

Nursing Home, Assisted Living	
Policy Maximum	$75,000.00
Maximum Daily Benefit - Nursing Home	$100.00 per Day
Maximum Daily Benefit - Assisted Living	$100.00 per Day
Elimination Period	90 Days
Home Health Care	
Policy Maximum	See Above
Maximum Daily Benefit - Basic Services	$60.00 per Day
Maximum Daily Benefit - Adult Day Care	$60.00 per Day
Maximum Daily Benefit - Professional Services	$120.00 per Day
Elimination Period	0 Days
Optional Features (Additional premium required)	
Benefit Increase Option	5% Simple or 5% Compound
Payment Options	
Premium Payment Period	Lifetime
Premium Payment Mode	Monthly

Age	Quantity	Married Deferred	Married 5% Simple	Married 5% Compound	Single Pref Deferred	Single Pref 5% Simple	Single Pref 5% Compound
60	1	24.86	41.02	51.21	27.89	46.02	57.46
61	1	27.89	45.46	56.62	30.92	50.41	62.78
62	1	30.92	49.78	61.53	34.69	55.85	69.03
63	1	33.96	54.01	65.88	37.72	59.98	73.18
64	1	37.72	59.60	71.28	41.47	65.53	78.38
65	1	41.47	64.69	76.72	45.96	71.70	85.02
66	1	45.96	71.24	83.18	50.44	78.18	91.28
67	1	51.31	79.01	91.33	56.50	87.01	100.57
68	1	55.78	84.78	97.60	62.58	95.12	109.51
69	1	62.57	93.86	107.00	69.36	104.05	118.60

A Word About Your Premium Rates. The Policy allows the company to adjust premiums as needed, with the prior approval of your state insurance department. We cannot increase your premiums during your rate guarantee period, if applicable. We cannot single you out for a premium rate increase, but we can change your premium based on our experience with all insureds in your same premium class. However, once we issue your coverage, we cannot cancel your Policy as long as you pay your premium on a timely basis.

This is for illustration purposes only. Benefit availability may vary by state. Please use the outline of coverage and/or sales brochure for a description of benefits, exclusions, limitations and the terms under which the policy may continue in force. Premium and benefit amounts will vary depending upon the plan selected and are subject to underwriting approval.

This is an illustration, not a contract.

10-4

Tax Qualified Long Term Care Insurance

Individual Policy Series GCPRO III TQ 197

Underwritten by Life Investors Insurance Company of America

Sample Pricing

Presented by: David Landwehr - (316)945-4827

LTC Workplace Solutions - Silver - Kansas

February 02, 2003

Nursing Home, Assisted Living	
Policy Maximum	$150,000.00
Maximum Daily Benefit - Nursing Home	$100.00 per Day
Maximum Daily Benefit - Assisted Living	$100.00 per Day
Elimination Period	90 Days
Home Health Care	
Policy Maximum	See Above
Maximum Daily Benefit - Basic Services	$100.00 per Day
Maximum Daily Benefit - Adult Day Care	$100.00 per Day
Maximum Daily Benefit - Professional Services	$200.00 per Day
Elimination Period	0 Days
Optional Features (Additional premium required)	
Benefit Increase Option	5% Simple or 5% Compound
Payment Options	
Premium Payment Period	Lifetime
Premium Payment Mode	Monthly

Age	Quantity	Married Deferred	Married 5% Simple	Married 5% Compound	Single Pref Deferred	Single Pref 5% Simple	Single Pref 5% Compound
18-40	1	13.74	23.36	31.33	14.54	24.72	33.15
41	1	14.55	24.73	33.17	15.35	26.10	35.00
42	1	14.54	24.73	33.16	15.35	26.10	35.00
43	1	15.35	26.10	35.00	17.77	30.20	40.50
44	1	16.96	28.83	38.66	18.58	31.58	42.35
45	1	17.77	30.20	40.50	18.57	31.57	42.33
46	1	18.58	31.58	42.35	19.38	32.94	44.18
47	1	18.58	31.58	42.35	20.19	34.32	46.03
48	1	18.58	31.58	42.35	20.19	34.32	46.03
49	1	19.39	32.95	44.19	20.19	34.32	46.02
50	1	19.39	32.95	44.19	22.62	38.45	51.57
51	1	22.61	38.45	51.55	23.42	39.82	53.40
52	1	23.42	39.82	53.40	25.04	42.58	57.09
53	1	24.23	41.20	55.24	27.46	46.68	62.62
54	1	27.45	46.67	62.60	29.07	49.43	66.29
55	1	29.07	49.42	65.42	32.31	54.94	72.69
56	1	32.31	54.93	72.04	33.92	57.68	75.64
57	1	33.92	57.32	74.27	37.96	64.15	83.12
58	1	37.95	63.75	81.98	42.00	70.55	90.71
59	1	42.00	70.13	88.60	44.42	74.17	93.71

A Word About Your Premium Rates. The Policy allows the company to adjust premiums as needed, with the prior approval of your state insurance department. We cannot increase your premiums during your rate guarantee period, if applicable. We cannot single you out for a premium rate increase, but we can change your premium based on our experience with all insureds in your same premium class. However, once we issue your coverage, we cannot cancel your Policy as long as you pay your premium on a timely basis.

This is for illustration purposes only. Benefit availability may vary by state. Please use the outline of coverage and/or sales brochure for a description of benefits, exclusions, limitations and the terms under which the policy may continue in force. Premium and benefit amounts will vary depending upon the plan selected and are subject to underwriting approval.

10-5

Introduction

The Partnership for Long-Term Care Program was conceived as a noble experiment. It boldly attempted to reconcile the seemingly irreconcilable arguments and advocates for public versus private financing of long-term care. The idea of linking government and private enterprise in a common effort to solve an intractable social problem quickly captured the imagination of many politicians, public administrators, and insurance executives. For a while, as the Partnership approach snowballed, it looked like a huge success was in the making. After a decade of trial, however, the consensus of thoughtful analysts and critics is that the Partnership for Long-Term Care Program has failed to achieve its main objectives. The purpose of this chapter is to examine why the Partnership program failed and to suggest an approach that can empower it to succeed.

Background

Mark Meiners and Hunter McKay wrote an article titled "Private Versus Social LTC Insurance: Beware the Comparison" in the spring 1990 issue of *Generations*. In this seminal piece, they debunked the "myth … that social insurance and private insurance are competing strategies for solving this country's long-term-care financing problems" (Meiners and McKay, 1990). They observed that social insurance, by helping everyone at the expense of all, was seductively attractive but unaffordable and politically infeasible. This was a reasonable conclusion given that the Pepper Commission proposals had recently failed and the Medicare Catastrophic Coverage Act of 1988 had just been repealed. On the other hand, they noted that private insurance, by appealing to the self-interest of individuals to protect themselves, could relieve the burden on public programs of providing long-term care but that it would never be a

general solution. Unfortunately, they explained, private insurance is voluntary, expensive, limited in coverage, and available only to those who can qualify medically. Meiners and McKay concluded that neither public nor private financing of long-term care could succeed independently. Would it be possible, they asked, to combine the benefits of a public financing approach with the benefits of a private financing approach to neutralize the negatives associated with both systems?

They decided that such a partnership was not only possible, but also highly desirable. At that time, "individuals and their families [paid] nearly half the cost of nursing home care out-of-pocket with the other half covered by the Medicaid program but only after an individual has become impoverished" (Meiners and McKay, 1990). Clearly, America already had a public/private partnership for long-termcCare based on a more or less equal balance between catastrophic spend-down and means-tested public assistance. "In effect," the analysts noted, "people who need long-term care are faced with a deductible equal to most of their assets and with co-payments equal to most of their income if Medicaid is to be their long term care insurance program" (Meiners and McKay, 1990). Could it be, they wondered, that embedded here, deep among the roots of the problem, was the germ of a solution?

Perhaps more people could be encouraged to insure privately if they were offered, in exchange for taking on this personal responsibility and expense, some forgiveness of their obligation to spend down into impoverishment. If part of the long-term care financing burden were taken over by Medicaid, maybe more people could afford private insurance because they would not need to buy as much coverage. On the other hand, if more people had at least some private insurance protection, Medicaid would benefit significantly because fewer people would come to need its expensive services. Such was the crux of the Partnership origins.

From this simple idea grew some ambitious objectives. As summarized in the same *Generations* article, the Partnership program's goals were to:

- Assist elders in avoiding the impoverishment required by Medicaid for those using long-term care services;
- Promote greater access to insurance protection by working with insurers to develop products affordable to a large segment of the elderly population;
- Encourage development of coordinated long-term care delivery systems that combine both private and public funding sources;
- Allow elders to plan for their long-term care needs in a manner that maximizes personal choice;
- Encourage development of a unified long-term care system in which all elders are treated equally;
- Conserve public resources for those truly in need by alleviating middle-class elders' reliance on Medicaid; and
- Remove the incentives for elders to transfer assets or otherwise "game" the system to gain Medicaid eligibility (Meiners and McKay, 1990).

It would be unreasonable to expect the Partnership program to have solved all of these problems and to have reached all of these goals in the past ten years. Nevertheless, we are justified in asking to what extent these grand objectives were actually achieved by America's long-term care service delivery and financing system during that period. Answering this question may help shed some light on how the Partnership program could be modified to accomplish these goals more effectively.

Evaluation

Other chapters in this volume examine whether and to what extent any or all of the Long-Term Care Partnership Program's goals were achieved in the individual states where the program was implemented. The purpose of this section is to observe that none of the problems addressed in the Partnership's goal statement has been resolved at the national level as of the end of 1999.

America's long-term care service delivery and financing system remains fragmented and dysfunctional despite an avalanche of literature and programs intended to address these difficulties. Access and quality problems are commonplace despite constantly rising public and private expenditures. Institutional bias in favor of nursing home care prevails despite most seniors' preference for home- and community-based services. Medicaid and Medicare's share of nursing home costs has increased while the share contributed by private out-of-pocket expenditures has declined, despite the conventional wisdom that widespread catastrophic spend-down is wiping out many older Americans' savings (HCFA, 1999). Medicaid estate planning, the practice of artificially impoverishing a senior to achieve Medicaid eligibility, remains commonplace, despite concerted efforts by three presidents and eight Congresses to discourage the practice. The American public remains in denial and largely ignorant about the risk and cost of needing long-term care, despite a growing barrage of media coverage and insurance marketing addressing this issue. Private long-term care insurance has penetrated less than 10 percent of the senior market and virtually none of the critical baby boomer market, despite the well-documented fact that its cost has dropped and its quality has improved significantly[1] (Moses, 1999)

Why have we failed to correct these problems? What can we learn from the Partnership for Long-Term Care Program to help us plot a better course? How should we proceed to build

on the proud, but shaky, foundation of the Partnership? These are the questions the remainder of this chapter will attempt to answer.

Flawed Logic

The fundamental premise of the Partnership for Long-Term Care Program was that consumers would be more likely to purchase private long-term care insurance if they received in exchange a reduction in their spend-down liability for Medicaid eligibility. This assumption underlay all of the program's goals and strategies. The reasoning was explicit. Coordinating private insurance benefits with Medicaid eligibility was expected to:

- Reduce the cost of long-term care protection for the middle class;
- Capture the public's attention for an education campaign about long-term care risk and cost;
- Encourage private insurers to offer high-quality, government-approved, private long-term care insurance;
- Diminish the lure of Medicaid estate planning; and
- Contribute to solving the crisis in long-term care service delivery and financing.

One could hardly fault the Partnership's reasoning that these objectives could be achieved if the underlying premise were correct. Who would pass up the carrot of subsidized long-term care protection while confronting the stick of catastrophic spend-down?

If it were not true, however, that Medicaid requires impoverishment before providing free or deeply discounted long-term care benefits, all of these presumed benefits of the Partnership program would disappear. For example, what if most Americans could ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever needed formal long-

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term care, and still obtain Medicaid and Medicare benefits without spending down their savings? If this were true, sensible consumers would see no incentive to purchase private long-term care insurance in the promise to forgive a spend-down liability that did not exist. Their sensitivity to the risk and their interest in the subject of long-term care would not increase. The popularity of Medicaid planning would not decline. The problems in the long-term care system would not improve. In other words, if the Partnership's assumption about the catastrophic nature of nursing home spend-down were mistaken, then the reason for the program's failure would be obvious and clues to its rehabilitation nearly self-evident. Was the Partnership for Long-Term Care Program based on a false assumption?

The Myth of Medicaid Spend-Down

In the late 1980s, when the Partnership for Long-Term Care Program was conceived, most experts assumed that America faced an epidemic of catastrophic nursing home spend-down. One often read in those days that half to three-fourths of all persons in nursing homes on Medicaid had begun as normal middle-class people, but had spent down their life's savings before qualifying for medical assistance benefits. Congress promulgated the estimate that an average family spent down into impoverishment within thirteen weeks if confronted with long-term nursing home expenditures. In 1990, I argued in a *Gerontologist* article titled "The Fallacy of Impoverishment" that these doleful statements about Medicaid spend-down were highly dubious (Moses, 1990). My argument was based on reasoning logically from the explicit generosity and elasticity of Medicaid eligibility rules: Why would people need or want to spend down? To support this reasoning, I supplied extensive anecdotal evidence that Medicaid nursing home eligibility was much easier to achieve than most people assumed or the law seemed to

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require. Unfortunately, at that time we had no hard, empirical data to prove or disprove any conclusions about the impact of catastrophic spend-down.

Today, however, we know much more about the spend-down question. More than two dozen formal academic studies have concluded that Medicaid nursing home spend-down is much less significant than originally assumed. (Arling et al., 1988; Branch et al., 1988; Burwell, Adams, and Meiners, 1990; Deane, 1990; Liu, Doty, and Manton, 1990; Short et al., 1992; Spence and Wiener, 1990). For example, the data from one study showed that 72.9 percent of single people, 85.4 percent of married people, and 77.7 percent of all people are already eligible for Medicaid when they enter a nursing home (Sloan and Shayne, 1993). On average, the spend-down studies found that only 15 to 25 percent of Medicaid nursing home residents had begun as private payers and converted to Medicaid — less than a third of the former spend-down estimates. Furthermore, not one of these so-called spend-down studies distinguished between people who had spent down the old-fashioned way — by writing big checks to nursing homes for many months — and people who had spent down the new-fashioned way — by artificially impoverishing themselves with or without the help of an attorney. In other words, as small as the percentage of nursing home residents who converted from private pay to Medicaid is, it includes everyone who qualified without actually spending down assets by taking advantage of loopholes in Medicaid's eligibility rules.

If people are not spending down their life's savings for nursing home care in huge numbers, however, where is the money coming from to pay America's large and growing nursing home bill? The popular literature on long-term care still frequently reports that nursing home expenditures come half from Medicaid and half from patients' pockets. This has not been true for many years. As of 1997, according to the Health Care Financing Administration

(HCFA), Medicaid still paid 47.6 percent of nursing home payments (HCFA, 1999) (almost unchanged from 47.2 percent in 1985[2)] but Medicare's share has jumped to 12.3 percent (up 10.8 percent since 1985). Total state and federal government expenditures for nursing home care are up from 51.2 percent of total nursing home costs in 1985 to 62.2 percent in 1997 (HCFA, 1999). The truly startling development, however, is the change in out-of-pocket nursing home expenditures. They have declined from 44.3 percent in 1985 to 31.1 percent in 1997 (HCFA, 1999). Even this huge drop in patients' private expenditures understates the actual decline in out-of-pocket costs, however. Upward of 40 percent of expenditures reported by HCFA as out-of-pocket are actually Social Security income received by Medicaid recipients and contributed toward their cost of care as required by law[3] (Lazenby and Letsch, 1990). This "spend-through" of Social Security benefits, reasonably estimable at 12 percent of total nursing home expenditures nationally, is technically an out-of-pocket cost, but it is definitely not a spend-down of assets as that term is usually interpreted. What does all this mean?

Clearly, public and private roles in financing nursing home care in the United States have turned upside down in the past twelve years. Today, direct government payments (Medicaid, Medicare, and the Department of Veterans Affairs) plus indirect government payments (Social Security spend-through) account for almost 75 percent of all nursing home payments nationally. Out-of-pocket expenditures (excluding Social Security spend-through) have dropped to less than 20 percent of the total, and a considerable portion of this remainder represents spend-down of personal income, not assets. In summary, based on official government data for 1997, there is no basis to assume that spend-down of residents' savings contributes more than 10 to 15 percent at most of nursing home payments in the United States. That is hardly enough to excite a lot of worry among the populace about spend-down risk. Nor is it enough to arouse a great deal of

interest in private long-term care insurance protection, whether provided by a Partnership plan or any other kind of privately underwritten policy.

How Medicaid Really Works

Clearly, nursing home spend-down is not as big a factor in America's long-term care financing system as the Partnership program originally presumed. No wonder people did not leap at the opportunity to avoid a spend-down liability that probably would not occur for many years, might not occur at all, and would likely be inconsequential anyway. Before we can explore a way to correct this situation, however, a big question about nursing home spend-down remains: How do people qualify for Medicaid, a means-tested public assistance program, without spending down their assets? By answering this question, we may reveal the key to unleashing the full potential of the Long-Term Care Partnership Program.

Practically every article on long-term care financing that mentions Medicaid refers to the program as though it covers only "low-income" or "impoverished" people. For the program's acute care benefit, this is true. In fact, Medicaid covers only two-thirds of the elderly poor and less than half of poor children for acute, preventive, or emergency care. For the program's long-term care benefits, however, neither income nor assets are an obstacle to eligibility for most people who qualify medically. In most states, the "medically needy" are eligible for Medicaid nursing home benefits if their medical expenses, including private nursing home care, exceed or approximate their income. In other states, an "income cap" applies but may be circumvented easily by means of a "Miller income trust" as authorized by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). For couples, income eligibility is even easier still. A community spouse may retain up to $2,049[4] per month of income as of 1999 without affecting the

institutionalized spouse's eligibility. The median income of older persons in 1997 was $17,768 for males and $10,062 for females (AARP, 1998). Less than 6 percent of people age 65 and over have incomes in excess of $50,000 per year (U.S. Census, 1998), which would barely cover the annual cost of private nursing home care. Income, therefore, does not interfere with Medicaid nursing home eligibility except for the very-highest-income elderly.

Ostensibly, assets are a huge obstacle to Medicaid nursing home eligibility. By law, a Medicaid recipient may retain only $2,000 in nonexempt assets.[5] This fact gives rise to the commonplace presumption that most people must be spending down catastrophically for nursing home care before they qualify for Medicaid. Both the popular and the academic media usually fail, however, to emphasize that Medicaid nursing home recipients may also retain unlimited exempt assets. For example, one home of any value including all contiguous property is exempt. A business of any value, including the capital and the cash flow, is exempt. One automobile of any value is exempt as long as it is used for the benefit of the recipient. An irrevocable burial trust fund of any value is exempt. Certain kinds of annuities are exempt. People who own a little too much nonexempt wealth can easily convert it to one of these exempt categories and are frequently encouraged to do so by Medicaid eligibility workers, financial planning professionals, and especially by public and private Medicaid estate planning attorneys. Of course, anyone can give away the equivalent of the average cost of a private nursing home every month without incurring any transfer of assets penalty. For Medicaid nursing home applicants who possess hundreds of thousands of dollars more than the program's asset eligibility limit, more sophisticated artificial impoverishment techniques are readily available by retaining counsel. These include self-canceling installment notes (SCINs), life care or personal care contracts, irrevocable income-only trusts, guardianships, spousal refusal, transfer of the home with reserved

special powers of appointment, charitable remainder trusts, various creative gifting techniques, and many others. As a last resort, elder law attorneys often suggest divorce as a means to impoverish the institutionalized spouse for purposes of qualifying for Medicaid benefits. The widespread practice of Medicaid estate planning has been thoroughly documented in a series of studies by Brian Burwell (Burwell, 1991, 1993, 1995) and in the "Magic Bullet" state-specific studies conducted by the author in Illinois, New Jersey, Maryland, Florida, and several other states (Moses, 1994, 1995a, 1995b, 1996).

The Long-Term Care Partnership Program's assumption that forgiveness of the Medicaid spend-down "requirement" would be a big incentive for the public to buy long-term care insurance was wrong. It was wrong because spend-down is not as big a problem as originally believed. Ironically, if it were, no additional incentive would be necessary to persuade the public to purchase long-term care insurance. People would seek out the protection if faced with genuine financial risk. Congressman Henry Waxman, D-California, sensed this fact when he pushed through legislation that terminally hamstrung the partnerships. He did not think that scarce public welfare resources, desperately needed to ameliorate conditions for the poor, should be used to indemnify upper-middle-class people against a predictable and insurable risk of growing old. Therefore, Congressman Waxman successfully persuaded Congress in OBRA '93 to deny the Partnership program an exemption from mandatory Medicaid estate recovery. When assets protected by the Partnerships' spend-down feature became vulnerable to recovery from the Medicaid recipient's estate, the program's only unique incentive for purchasing its plan, however illusory, was rendered ineffectual.

Coordination of Benefits

The Partnership program's link with Medicaid contributed to its failure in another important way. Medicaid is a means-tested public assistance program. It is welfare. The program has an inferior and deteriorating reputation for access, quality, reimbursement, discrimination, and institutional bias. Gerontological literature is full of evidence substantiating (1) the difficulty Medicaid recipients and their families often face in finding open beds; (2) the quality of care problems frequently presented by nursing facilities with the highest Medicaid caseloads; (3) the program's low reimbursement rates, on average only 80 percent of private-pay rates; (4) the vulnerability of Medicaid recipients to discrimination regarding admission and services as compared to private payers; and (5) the continuing focus of Medicaid on nursing home care instead of on the home care, community-based services, and assisted living that seniors prefer[6] (Moses, 1999). Undoubtedly, many potential purchasers of Partnership plans looked askance at the idea of relying on public assistance to supplement their private insurance. Private insurance carriers must have wondered about the wisdom of coordinating their contractually guaranteed benefits with the political promises of a welfare program on the verge of bankruptcy. Finally, consumers and carriers alike shared a concern about the lack of portability of Partnership plans. Privately insured beneficiaries can receive their benefits anywhere, but Partnership policies tie clients to their Medicaid home state. In short, virtually every aspect of the Long-Term Care Partnership's relationship with the Medicaid program turned out to be problematical.

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What Went Right With the Partnerships?

In spite of these problems, the Partnership for Long-Term Care Program has made a very important contribution to the long-term care financing issue by encouraging the public and private sectors to cooperate on a potential solution. Although the Partnership's long-term care insurance policies have been criticized as having benefits too rich and premiums too high, the process of developing and negotiating the policies has forced government staff and insurance company employees to learn about each other's expectations and constraints. Today, the public officials who were involved in developing the Partnerships have a better understanding of the legitimate underwriting and marketing issues that influence insurance companies. Similarly, industry staff who worked on the Partnership plans have a better conception of the political and advocacy issues that public officials must take into account. Next time these groups work together, the results can reasonably be expected to be easier to achieve.

The decade of the Partnership's existence has seen a vast improvement in the quality, coverage, cost, and popularity of private long-term care insurance in general. The program's unstinting publicity efforts regarding the risk of long-term care and the value of private insurance surely have contributed to these advancements. Many insurance agents and executives have observed that it is often the Long-Term Care Partnership's educational efforts and reputation that open a client's door, even if the insurance policy ultimately written is not a Partnership plan. Finally, the large and ever-growing popularity of the Partnership concept among politicians, public administrators, and private insurance personnel alike has built an extraordinary foundation on which to construct a more successful program. The big question remains, then, how should the Partnership for Long-Term Care Program be modified so that it can achieve its full potential?

Recommendations and Analysis

The Partnership for Long-Term Care Program was based on one false and one correct assumption. The assumption that appreciably more people would buy long-term care insurance to avoid Medicaid spend-down and to qualify for Medicaid nursing home benefits proved to be false. The assumption that public and private organizations working together could contribute toward the improvement and public awareness of long-term care insurance products proved to be true. The way to save and improve the Partnership program is to drop the portions of it that are based on its false assumption and to build on the portions based on its correct assumption. Fortunately, that will be fairly easy to do by implementing the following suggestions.

- Eliminate the Partnership's Medicaid spend-down forgiveness feature;
- Terminate the Partnership's coordination of benefits between private long-term care insurance and Medicaid;
- Modify the Medicaid program to create a total, but less immediately onerous, spend-down requirement;
- Educate the public that everyone must either buy long-term care insurance or commit to spending down all assets as a requirement for receiving public assistance;
- Mitigate the immediate financial impact of spending down by empowering uninsured seniors to purchase long-term care services in the private marketplace with a line of credit on their estates;
- Maintain and expand the cooperation between private insurers and state/federal officials;
- Retain the government's seal of approval on quality LTC insurance products;

- Permit a wider range of products to qualify for government approval by allowing inexpensive, basic coverage as well as expensive, comprehensive coverage; and
- Convert the Partnership from a state-by-state to a fully national program.

These recommendations are not as radical or unrealistic as they may seem. Dropping the Partnership's spend-down forgiveness feature will not detract from the program's effectiveness. The forgiveness feature did not work because Medicaid spend-down is not a common or serious problem. If it were, spend-down forgiveness would not be necessary because people would buy insurance to avoid having to spend down catastrophically. In the presence of a strong spend-down liability, affordability of private insurance will not be a problem because new premium funding sources, such as home equity conversion and contributions from potential heirs, will be drawn to long-term care insurance. The word will get around quickly that private insurance is a necessity if estates and inheritances are genuinely at risk.

Terminating the Partnership's coordination of benefits between private insurance and Medicaid will remove one of the most serious and valid criticisms of the program. No longer will scarce public resources be used to indemnify middle-class people against the risk of long-term care while Medicaid fails to provide adequately for the acute and preventive care needs of the truly poor. No longer will people have an incentive to buy less private coverage than they really need, while leaving themselves vulnerable to an inadequately financed welfare program in the end. More people will buy long-term care insurance. Fewer people will need Medicaid. Here again, nothing important is lost and many benefits are gained.

Eliminating the Partnership's links with Medicaid will require creating a new and stronger reason for people to buy private insurance. No later than age 65, at a time when the public is highly sensitive to retirement issues, the public and private Partnership should (1)

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educate everyone about long-term care risk and cost; and (2) require either (a) proof of private long-term care insurance coverage or (b) a signed affidavit acknowledging that all assets including the home are at risk before Medicaid will pay for long-term care. Establishing a real Medicaid spend-down liability will provide a strong incentive for people to purchase as much private long-term care insurance as they can afford.

What about people who cannot or will not buy insurance even when faced with a true spend-down liability? They should have a better option than to qualify for a welfare nursing home by means of real or artificial impoverishment, which is the fate they face today. Why not permit them to spend down gradually for top-quality home care, assisted living, or nursing home care purchased in the private marketplace? Let them use their estates as collateral for a government-backed but fully collateralized line of credit to supplement their income so they can afford these services. Deduct public expenditures from the ledger of their estates and recover the balance plus interest after the last surviving exempt relative dies. This approach assures access to quality care at the appropriate level for anyone with too much income and assets to qualify for Medicaid but not enough cash flow to pay privately for long-term care without help. Simultaneously, this option creates a new incentive for families to pull together and find creative ways to avoid spend-down by purchasing long-term care insurance early.

With these changes in place, all objections to making the Long-Term Care Partnership into a national program would fall away. Unburdened of its ties to Medicaid, the program could focus on what it does most successfully. Such priorities include educating the public about long-term care risk and cost, facilitating development and certification of high-quality long-term care insurance products, and fostering cooperation between public officials and private companies in enhancing the market for private coverage. Medicaid, on the other hand, unburdened of its role

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as long-term care re-insurance for the middle class and girded with a real spend-down liability, will be reinvigorated financially and able to focus its scarce resources on the genuinely needy. No one will be hurt by this change. Those with income and assets, but no insurance, will spend down gradually through a line of credit on their estates. Those with little income or assets will qualify for Medicaid as before. But the newly established real risk of actually having to spend down savings and home equity will cause most people to opt for private insurance while they are still young, healthy, and affluent enough to afford it.

Conclusion

The Partnership for Long-Term Care is a great idea scuttled by one bad assumption. The program's founding hypothesis, that consumers would buy a lot more long-term care insurance if they did not have to worry so much about Medicaid spend-down liability, was mistaken. In the first place, most people were not worried about Medicaid spend-down because their elderly friends and relatives usually qualified for Medicaid nursing home benefits without spending down. In the second place, the prospect of going on welfare and dying in a nursing home was not a consummation most people wanted to include as part of their long-term care planning. To reinvigorate the Partnership program, it will be necessary to sever its ties with Medicaid. This can be done by establishing a strong Medicaid spend-down liability mitigated by a new program to empower seniors to spend down gradually by means of a line of credit on their estates. With this new incentive in place to take the risk and cost of long-term care seriously, the public will be much more receptive to the Long-Term Care Partnerships' educational efforts and much more likely to purchase its approved and certified long-term care insurance policies.

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End Notes

1 All of the assertions in this paragraph are thoroughly discussed and documented in a new report published by the Center for Long-Term Care Financing titled "The Myth of Unaffordability." See References.

2 Although Medicaid pays less than half the cost of nursing home care, the program contributes at least some portion of the payment for over two-thirds of all nursing home patient days in the United States. The difference comes from Medicaid recipients who must contribute most of their income, usually Social Security benefits, toward their cost of care.

3 According to HCFA, "An estimated 41 percent ... of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." See also Lazenby and Letsch, 1990, in References.

4 This amount increases with inflation each year. It was originally established at $1,500 per month in the Medicare Catastrophic Coverage Act of 1988.

5 A community spouse of an institutionalized Medicaid recipient may retain up to an additional $81,960 in otherwise nonexempt assets as of 1999. This Community Spouse Resource Allowance (CSRA) was originally established at $60,000 in MCCA '88 and it too increases annually with inflation.

6 Comprehensive discussion and citations to the evidence in the gerontological literature for these propositions is provided in the Center for Long-Term Care Financing's "Myth of Unaffordability" report. See References.

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Project Proposal: Controlling Medicaid Long-Term Care Costs

Submitted to the Kansas State Legislature
by
Stephen A. Moses, President
Center for Long-Term Care Financing

I. **Objective**: Produce a step-by-step plan to save the State of Kansas $47 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for rich and poor citizens alike across the whole spectrum from home and community-based to nursing home care.

II. **Problem**: Medicaid nursing home expenditures in Kansas almost doubled from $117.8 million in 1989 to $232.5 million in 1995. This rapid cost increase severely impairs the state's ability to maintain generous Medicaid nursing home eligibility criteria, to expand the home and community-based services often preferred by seniors, and to sustain adequate financing for other critical state services such as corrections, education, and highways.

III. **Diagnosis**: Generous Medicaid nursing home eligibility rules in Kansas (and elsewhere), although well-intentioned and politically popular, have gradually converted a means-tested public assistance program (welfare) into an expensive, defacto long-term care entitlement program. Consequently, private out-of-pocket and insurance financing of home, community-based, and nursing home care have languished while Medicaid costs for these programs have sky-rocketed. The public policy dilemma is to contain Medicaid long-term care spending without incurring the wrath of voters by increasing taxes or cutting benefits.

IV. **Treatment**: The solution to this quandary, proposed in a long series of reports by the DHHS Inspector General, the General Accounting Office, and LTC, Incorporated, is to retain generous Medicaid eligibility criteria while restricting asset transfers and shelters, enhancing estate recoveries, and encouraging private long-term care financing alternatives. The difficulty with this solution, however, is that it is complicated to achieve and it is often opposed by various long-term care interest groups. Therefore, a two-fold public policy intervention is needed: the Medicaid program must assure that (1) every federal and state statutory, regulatory and administrative remedy is fully employed to target public assistance resources to the most needy while diverting more prosperous people to private financing options and (2) every stakeholder in the long-term care financing issue understands the benefit to its constituency of implementing the necessary measures. These are the specific goals that this project would seek to achieve.

V. **Work Plan**: To achieve the objective and goals of this project, we propose the following activities (estimated hours by project staff in parentheses):

A. Examine Medicaid nursing home eligibility criteria in Kansas with attention to federal and state statutory, regulatory and policy guidelines. Thoroughly study and review all relevant state and federal statutes, regulations and policy manuals and compare them to eligibility policies in other states. Provide recommendations for state legislation, program policy changes and federal waivers to achieve a stronger and tighter asset control methodology. (30 hours Moses; 20 hours Rosenfeld)

B. Review the state's implementation of OBRA '93 (Omnibus Budget Reconciliation Act of 1993), HIPAA '96(Health Insurance Portability and Accountability Act of 1996) and BBA '97 (Balanced Budget Act of 1997) authorities. Interview responsible state staff and study existing plans, proposed legislation, and policy options under consideration. Recommend ways that the State of Kansas can take full advantage of this powerful federal legislation. (20 hours Moses; 15 hours Rosenfeld)

C. Appraise the status of Medicaid estate planning (the artificial impoverishment of frail seniors to qualify them for publicly financed nursing home benefits) throughout the state. Review the legal literature on Medicaid planning in Kansas and interview five or more key, influential elder law attorneys. Recommend measures to control Medicaid estate planning and to encourage attorneys, financial planners, accountants and other senior advisers to suggest private long-term care financing alternatives while their clients are young and healthy enough to afford them. Assess the effect of criminalization of Medicaid transfer of assets advice in BBA '97 on the practice of Medicaid estate planning. (40 hours Moses; 25 hours Rosenfeld)

D. Plan and conduct site visits to at least four local Medicaid nursing home eligibility local offices (urban, suburban, and rural). Interview supervisors and eligibility workers; review eligibility policies and procedures; examine a judgmental sample of Medicaid nursing home eligibility case records; compile examples of Medicaid estate planning techniques; explore the potential impact of possible alternative solutions on affected field staff; and obtain ideas and recommendations from front line workers. (30 hours Moses; 30 hours Rosenfeld)

E. Analyze Kansas's lien and estate recovery strategy including statutory authorities, regulations, administrative policies, program activity, and collections. Interview key program staff; analyze procedures; examine the integration of front-end eligibility controls with back-end collection efforts; estimate maximum recovery potential; research best practices from other states and explore the possibility of applying them in Kansas. Recommend initiatives to maximize non-tax revenue to the

State of Kansas from lien and estate recovery programs. (36 hours Moses; 36 hours Rosenfeld)

F. Study long-term care insurance regulation in Kansas. Interview representatives of the State Insurance Commissioner's office; review laws, regulations and policies governing the content and sale of long-term care insurance products in the state; interview agents and brokers who market home health and nursing home insurance policies concerning the obstacles they face; compare policies and practices in Kansas with other states; and analyze the chilling effect of easy Medicaid eligibility on the marketability of private insurance alternatives. Recommend statutory, regulatory and policy changes to enhance early planning for private long-term care insurance as an affordable, high quality alternative to reliance on Medicaid nursing home benefits by default. (20 hours Moses; 20 hours Rosenfeld)

G. Interview and brief key long-term care stakeholders: e.g., senior and consumer advocates, Governor's staff, key legislators and staff, proprietary and non-proprietary nursing home, assisted living and home health providers, long-term care insurers, Medicaid planners, taxpayer representatives, the Chamber of Commerce and other business interests, Medicaid management, line and legal staff, and any other group which the state believes would be appropriate. It is critical to meet with each group separately to avoid adversarial confrontations between groups and to target each group's special interests. The purpose of these meetings is to discern the prevailing attitudes of the various interested parties, both public and private, in the long-term care area and to introduce them to the consensus strategy described in the Inspector General's reports and LTC, Incorporated's Florida, Montana, Wisconsin, Illinois, Maryland, South Dakota and New Jersey reports. We will conduct two-hour presentations for each interest group with a stake in the long-term care financing issue. Presentations will include a summary of the problem, an historical perspective on how we got into the fiscal and political predicament we are in, a summary of recommendations from the DHHS Inspector General and other government agencies on how to resolve the situation, and an explanation of why it is in the best interest of each group to work cooperatively with the others on the proposal under consideration to the mutual benefit of all. Each respondent will receive an information pack of articles and reports on the topic similar to the one enclosed herewith. (60 hours Moses; 60 hours Rosenfeld)

H. Examine the overall social impact (upon the elderly population, families, etc.) from the transfer of resources and assets. We propose to explore every aspect of the potential ramifications for seniors of the transfer of assets and resources issue and to provide relevant recommendations on each. For example, what effect does Medicaid estate planning have on the state's ability to finance and the nursing homes' ability to provide access to quality long-term care? Will closing loopholes

discourage vulnerable seniors from seeking needed care? Does the easy availability of Medicaid benefits discourage advance planning and purchase of private long-term care insurance products or continuing care retirement community contracts? To what extent are middle class people on Medicaid consuming state tax revenues needed to fund other public needs such as education, highways, and prisons? Are there ways to divert the middle class to other financing mechanisms while making Medicaid benefits more readily available to the poor than ever before? We will address all of these questions and many more similar ones in the final report of this project. (16 hours Moses; 12 hours Rosenfeld)

I. Prepare and submit an interim report mid-way through the project summarizing current status, problems encountered, solutions proposed, work remaining, preliminary findings, etc. (16 hours Moses; 14 hours Rosenfeld)

J. Analyze all data; write the final report including the action plan implementation strategy; and submit five original bound copies to the state. The final report will be entirely substantive, clear and readable as evidenced by our previous work products, samples of which are available upon request. The goal is to prepare a document suitable for presentation to the State Legislature as a game plan to improve long-term care access and quality, benefit seniors, reduce Medicaid expenditures and enhance the fiscal responsibility of state government. (80 hours Moses; 60 hours Rosenfeld)

K. Subsequent to publication of the final report, the principal author will be available in Kansas for one week at the Legislature's convenience to present state legislative testimony, advise on implementation strategy, conduct media briefings, present findings to key interest group representatives, and provide any additional follow-up work desired by the state. (40 hours Moses)

L. The preceding time estimates are based on the assumption that the state will provide a desk, phone, and meeting space during our site visits and will assist us in obtaining necessary documentation, contacting appropriate respondents, scheduling interviews, and making other arrangements essential to the successful completion of the project. This kind of shared responsibility has worked very well in previous projects with other states. We estimate the total state staff time necessary to perform these functions during the entire project to be approximately 120 to 160 person hours.

VI. **Site Visits**: We anticipate the need to spend approximately 20 work days in Kansas during this project for the purpose of conducting interviews and briefings, visiting local eligibility offices, analyzing current policies and procedures, conducting legal research, etc. In addition, we have allowed and budgeted

for a post-project visit of five days for follow-up, testimony, briefings, etc.

VII. **Schedule**: We recommend beginning this project by May 1, 1998 and completing it by October 1, 1998.

VIII. **Deliverables**: One interim status report of several pages and five copies of a formal, bound final report reflecting all of the commitments made within this proposal.

IX. **Business Proposal**: We propose to conduct the work described in this proposal for the following compensation:

Moses: $175 per hour times 388 hours equals $67,900

Rosenfeld: $115 per hour times 292 hours equals $33,580

Travel expenses: 20 days for two-member project team @ $300 per person per day including all air and ground transportation equals $12,000. Plus one week follow-up for project director is five days @ $300 per day equals $1,500.

Total: $114,980

This bid covers all fees and charges by the contractor to the State of Kansas incidental to this project.

X. **Experience and Credentials**: All tasks related to this project will be performed by Stephen A. Moses or David M. Rosenfeld of the Center for Long-Term Care Financing (unless another arrangement is requested by the Center and accepted by the State of Kansas) as delineated below:

A. The Center for Long-Term Care Financing is a private organization dedicated to the study of public and private long-term care financing.

B. As to the competence and *bona fides* of Stephen A. Moses, Director of the Center for Long-Term Care Financing, to conduct this research, Mr. Moses served for nine years with the Health Care Financing Administration as a Medicaid State Representative. In this capacity, he conducted periodic reviews of Oregon's long-term care eligibility system, asset control methodologies, and estate recovery program; he directed a feasibility study of closing eligibility loopholes and implementing estate recoveries in Idaho; and he surveyed every Medicaid eligibility system, lien and estate recovery program in the country (*The Medicaid Estate Recovery Study*, Region 10, November 1985).

In 1987, Mr. Moses joined the Office of Inspector General of the U.S. Department of Health and Human Services where he was the national project director and author of another national study of

Medicaid nursing home eligibility, Medicaid estate planning, and asset and resource divestiture problems entitled *Medicaid Estate Recoveries*, June 1988. He also directed and authored *Transfer of Assets in the Medicaid Program: A Case Study in Washington State*, May 1989 for the Office of Inspector General. Both of these projects delved deeply into all of the topics proposed for review in Kansas. Mr. Moses advised the General Accounting Office on all aspects of its study entitled *Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs*, March 1989. He briefed then-incumbent Secretary Otis Bowen of USDHHS and Administrator William Roper of HCFA on the growing national problem of Medicaid asset/resource divestiture and the need for Medicaid estate recoveries and he wrote the Inspector General's contribution to the report to Congress on these subjects that was mandated by the Medicare Catastrophic Coverage Act of 1988 (*Medicaid Estate Recoveries: A Management Advisory Report*, December 1988.)

Since leaving federal service in 1989, Mr. Moses has published over seven dozen articles on Medicaid estate planning, nursing home eligibility, transfer of assets, liens and estate recoveries; he has consulted on these subjects in over 25 states and spoken at innumerable national conferences; and he has testified before two dozen state legislatures. As Director of Research for LTC, Inc., Mr. Moses directed and authored studies on Medicaid nursing home eligibility, asset and resource transferring techniques, methods to control divestiture, estate recoveries, and how to implement OBRA '93 in numerous states, e.g.: *Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness*, December 1990; *The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin*, June 1992; *Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses*, March 29, 1993; *Long-Term Care in Montana: A Blueprint for Cost-Effective Reform*, September 23, 1993; *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, April 21, 1994; *The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois*, February 1, 1995; *The Long-Term Care Financing Crisis: Danger or Opportunity? A Case Study in Maryland*, September 15, 1995; *The Heartland Manifesto: How to Finance Long-Term Care for Middle America*, August 1, 1996; *The Jersey Share: How to Pay for Long-Term Care with Less Federal Money*, March 31, 1997. Of closely related significance is *Medicaid Loopholes: A Statutory Analysis with Recommendations*, which Mr. Moses presented to the minority staff of the United States Senate Committee on Finance in 1991 and *Medicaid Estate Planning: An Analysis of GAO's Massachusetts Report and Senate/House Conference Language*, presented to The United States Senate Committee on Finance and Special Committee on Aging, July

30, 1993. Any or all of these reports and publications are available for review upon request.

Assisting Mr. Moses in the conduct of this study is David M. Rosenfeld. Mr. Rosenfeld is a graduate of Case Western Reserve University Law School and is admitted to the bar in Washington State. He also has a Masters of Social Work degree. David Rosenfeld is the author of several published articles in the field of study covered by this project. He has given presentations on long-term care financing issues to professional associations throughout the United States.

XI. **References**: The following persons may be contacted concerning the projects referenced above:

A. New Jersey Project Coordinator: Susan Reinhard, Deputy Commissioner, Department of Health & Senior Services, John Fitch Plaza, CN-360, Trenton, NJ, 08625-0001, 609-292-7874.

A. South Dakota Project Coordinator: Richard J. Reding, Executive Director, South Dakota Health Care Association, 804 N. Western Ave., Sioux Falls, SD, 57104, 605-339-2071.

B. Maryland Project Coordinator: Joe Coble, Director of Legislative and Government Relations, Health Facilities Association of Maryland, 229 Hanover St., Annapolis, MD, 21401, 410-269-1390.

C. Illinois Contract Officer: Jan Boone, Assistant Bureau Chief, Bureau of Long-Term Care, Illinois Department of Public Aid, Third Floor, 201 south Grand Avenue East, Springfield, Illinois, 62763, 217-524-7211.

D. Florida Contract Officer: Susan Ahrendt, Medical Health Care Program Analyst, Agency for Health Care Administration, Office of Medicaid Program Analysis, 1317 Winewood Blvd., Building 6, Room 235, Tallahassee, FL, 32301, 904-488-9350.

E. Montana Contract Officer: Terry Frisch, TPL Manager, Department of Social and Rehabilitation Services, 111 North Sanders Street, Box 4210, Helena, Montana, 59604, 406-444-4162.

F. Wisconsin State Contact: Gene Kussart, Executive Assistant, Department of Health and Social Services, P.O. 7850, 650 One West Wilson St., Madison, WI, 53707, 608-266-9622.

G. Inspector General contact: Michael Mangano, Principal Deputy Inspector General, Office of Inspector General, Room 5246 Cohen Building, 330 Independence Ave., S.W., Washington, DC, 20201, 202-619-3146.

H. U.S. Senate Contact: Roy Ramthun, Professional Staff Member, Senate Finance Committee, 203 Hart Building, Washington,

DC, 20510, 202-224-5315.

I. Massachusetts State Contact: John Robertson, Acting Deputy Associate Commissioner, Medical Assistance, Essex Station, P.O. Box 68, Boston, MA, 02112, 617-348-5375.

TESTIMONY of
MATT HICKAM
STATE LONG-TERM CARE OMBUDSMAN
before the
PRESIDENT'S TASK FORCE ON MEDICAID REFORM
February 17, 2003

Chairman Clark, Members of the Task Force.

My name is Matt Hickam and I serve as the State Long-Term Care Ombudsman for Kansas. In this position I oversee the Office of the State Long-Term Care Ombudsman, an independent state agency charged with advocating for residents of long-term care facilities across the state. I am pleased to have this opportunity to share with you my views on Medicaid reform and its impact on long-term care facility residents.

Nearly 25,000 Kansans live in Medicaid-certified nursing homes or similar facilities. About half of Kansans 65 and older who are in a nursing home receive help paying for at least part of their care from Medicaid.

With regards to long-term care, any reform to the Kansas Medicaid program should:

1. **Ensure that Medicaid is available for the neediest to pay for their long-term care needs.** Contrary to popular belief, one need not be impoverished to qualify for Medicaid. In Kansas, income and/or asset based qualifications are easily avoidable with the right lawyer. Indeed, a whole cottage industry exists that teaches seniors how to qualify. This gaming of the system by middle and upper class seniors is grossly unfair to those low-income seniors who truly need Medicaid.

2. **Ensure that a spouse of a nursing home resident is left with enough assets and income to survive.** Currently, a spouse of a nursing home resident on Medicaid can retain enough of the couple's resources, including the family home, to meet their own needs. An elderly spouse should not face dire poverty when they can no longer care for their loved one at home. All Kansans should be encouraged to purchase long-term care insurance so that this tragedy does not occur.

3. **Ensure that nursing homes meet high care standards.** Kansas should be allowed flexibility by the federal government in its Medicaid design, but Kansas should ensure that nursing homes comply with quality of care standards, residents' rights protections, and inspection and enforcement procedures.

4. **Ensure home and community services paid for by Medicaid are accompanied by enforceable standards of care.** Medicaid support of home and community services

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must be accompanied by assurances that the services meet the health care and other needs of nursing home-eligible people. It will not work if the purpose is only to move people to less expensive settings and not to provide viable choices among appropriate services. People who qualify for Medicaid long-term care services have multiple medical problems, often including dementia. The state regulatory entity overseeing home and community services should have adequate funding to ensure that beneficiaries do not lose access to services and protections they need.

Medicaid pays for only one-seventh of all national health expenditures, but it pays for almost half of all nursing home costs. By comparison, private insurance covers about one-third of all national health expenditures but only 5 percent of long-term care expenditures. Combine the rapid aging of the population with the fact that those over age 85 are the fastest growing part of our elderly population and the financial picture for taxpayers is bleak.

By 2030 when the baby boomers are retired, Medicaid long-term care costs will increase at least fourfold in real dollar terms. This is a disaster for Medicaid and for all other statewide programs that will be crowded out of the state budget. As a matter of equity, permitting the middle class to abuse Medicaid's long-term care eligibility requirements at the expense of the poor is inexcusable. By continuing this abuse, Medicaid will eventually absorb almost all state revenue. This means that if a Legislator's primary concern is education, Medicaid must be reformed. If it is highways, Medicaid must be reformed. Reforming Medicaid is crucial for Legislators if they wish to fund any other issue in a generation.

Thank you. I am pleased to stand for questions.

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The Voice and Vision of Nursing in Kansas

Terri Johnson M.S.N., A.R.N.P.
President

Terri Roberts J.D., R.N.
Executive Director

TO: Presidents Medicaid Task Force

FROM: Carolyn Middendorf M.S.N., R.N.

DATE: Monday, February 17, 2003

SUBJ: Long Term Care

In an attempt to make this information "real", we contacted a registered nurse in western Kansas who is a long term care director of a swing bed area located in a small hospital. The area for which she is responsible is licensed and certified for Medicaid, but not for Medicare. Approximately 50% of the beds in this facility are utilized by consumers whose care is funded by Medicaid; the remaining 50% of the consumers have care funded by "private pay". In most of the facilities, the percentage of beds for Medicaid range from 45-55%.

At this time, Medicaid is reimbursing the facility $95/day for an individual's care. "Private pay" customers are paying $90/day. Semi-private rooms cost $90/day while those in Private rooms are charged $100/day. Medicaid reimbursement of $95/day would mean that the cost to Medicaid would be $2,850.00 for a month of care. This facility receives some local support in the form of mill levy monies directed for operating expenses. This facility also does "fund raising" to assist them in providing care/services/niceties beyond the necessities of life for the residents. The facility has not resorted to cost shifting at this time.

A very recent survey conducted on the care and services provided indicated that actual care was costing $110.00 for consumers of both types of funding, prompting the director to state, "we shall have to look at that." The Board of Directors has been very reluctant to raise the rates, although the survey shows that private pay consumers have been undercharged.

The fact that this facility has been able to manage at all is most likely due to the fact that labor costs in the western part of the State are less than in the long term care facilities in the eastern part of Kansas. This facility and others in the area are paying CNAs $8.20/hour. Competition for CNAs in other parts of the State likely make the cost of labor much higher. How long can a facility absorb or cost shift to accommodate individuals for whom the reimbursement is inadequate to pay for necessity? The concern for providers is another topic.

Medications are billed for separately. In recent months, individuals have been limited to only five (5) brand name prescriptions and must have prior authorization for drugs like Vioxx or Celebrex. While a number of drugs are available in generic form, some individuals would respond more successfully to the specific brand name drugs, which may include more than five drugs. Thyroid replacement hormone which cost $11/100 tablets fifteen years ago now costs $57.90/100 of the generic drug. Payment for over the counter drugs (OTC) is included in the cost per room and board.

According to the Medicaid Manual, the $95 paid to facilities for Room & Board should cover these items/services:

any supplies needed to carry out the client's care

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any suppled needed for personal care; shampoo, .lotion
incontinence products
products for open skin lesions; decubitus, torn skin
mobility aids; wheel chair, walker
overlay products; disposable protective "chux"
OTC drugs

There can be separate billing for durable medical equipment (DME); oxygen, pharmaceuticals.

At this time, Medicaid does not reimburse for beds in Assisted Living, although there has been some monies allowed with the HCBS funds. Individuals who might not need to be house in long term care are forced by their circumstanced to live in the more expensive residence. Although some individuals have qualified for HCBS, there are apparently inadequately staffed home health agencies with providers to deliver the care that would keep consumers out of the nursing home.

Services which could be provided by a home health agency would be meals, perhaps even some meal preparation, light housekeeping, personal hygiene, such as bathing and dressing. This list is not an inclusive list. The individual who needs treatment, such as Physical Therapy and/or Occupational Therapy may qualify for Skill Nursing Care/Medicare.

Although this specific facility is attached to a hospital, three residents there now have depleted their own resources and had to apply for Medicaid. The time to run through their assets averaged two years–at approximately $34,000/year. One recent admission was due to the reduction in state monies available to keep them in their own home. This director expects four to six admissions in the near future due to the loss of meals delivered to person's homes. While these individuals most likely have other health care or personal needs, the cost of meals daily is going to force them into a facility at the cost of over $34,000/year.

The future of Medicaid funds is highly unpredictable. The number of older adults is growing. People are living longer, and those attaining 65 years in the next forty years will continue that trend. Many retirees and near retirees have taken losses–some small, some huge–in the investments they thought would carry them through their late years. Some individuals have lost most, if not all, they had counted on for those years.

The point we want to make is that the $100-150 needed to assist individuals to stay at home longer will ultimately relieve the State of higher nursing home costs. The profile of a nursing home resident is an elderly female who has few resources. She may have never worked outside her home, does not have retirement income of her own. Even if there are resources or a family who assists in affording care, it is not likely there is unlimited resources–as is born out by the stories of most older adults.

It is regretful that Medicaid federal dollars have been lost through the lack of the State's Maintenance of Effort, or matching funds.

We believe the State has a responsibility to assist these individuals, and ultimately itself, with the lesser dollars.

TOPEKA INDEPENDENT LIVING RESOURCE CENTER
Kirk W. Lowry
Attorney
501 S.W. Jackson Street
Topeka, Kansas 66603-3300
(785) 233-4572, TDD (785) 233-1815, Fax (785) 233-7196

February 17, 2003

The Honorable Stan Clark
Chair, President's Task Force on Medicaid

Re: Long Term Care

Dear Senator Clark and members of the committee:

The Topeka Independent Living Resource Center is a private non-profit organization that advocates for the human and civil rights of people with disabilities. The center helps people with disabilities move into or stay in their own home and receive appropriate and adequate support and services to live independent and safe lives. The center acts as payroll agent for people who are on the Physical Disabilities Waiver, Frail Elderly Waiver, and the Developmental Disabilities Waiver. Moreover the center provides peer counseling, benefits counseling, independent living skills counseling, workforce training, and legal representation.

Medicaid Has Successfully Improved Public Health

1. For over three decades, Medicaid has offered insurance coverage to millions of people who would otherwise be uninsured because they cannot afford to pay for private insurance, their employers do not offer insurance, or their chronic conditions have been deemed uninsurable by insurance company underwriters. Currently Medicaid covers 40.1% of all children, 26.1% of the elderly, and 20% of persons with disabilities in America.

2. Medicaid has improved and protected public health. Medicaid has helped the United States achieve near universal protection against debilitating, communicable childhood diseases. Moreover, Medicaid has played a major role in reducing infant mortality rates.

3. Medicaid has provided essential services for people with disabilities that are not generally available through private health insurance. Medicaid Home and Community Based Waivers allow States to offer personal care attendant services and other community services that enable people with substantial disabilities move into their own home or stay in their own home instead of in an institution.

4. Medicaid has created work incentives for people with disabilities. Kansas has a medically needy program that allows people to qualify for Medicaid with income up to 300% of poverty and spend that income down to $645 on medical bills. Moreover, Kansas has passed a Medicaid Buy-in that allows people to work and pay premiums to keep Medicaid.

Long Term Care Spending in Kansas

1. People with Developmental Disabilities (Page 74 of Gov. Budget)

Institutions: KNI: $24,247,416 for 181 consumers = $133,963 per person
Parsons: $20,361,666 for 185 consumers = $110,063 per person
Total: $44,609,082 for 366 consumers

MR/DD Waiver: FY 02 $189,468,000 for 5,539 consumers = $34,206 per person

2. People with Physical Disabilities (Pages 74 and 79 of Gov. Budget)

Institutions, Nursing Facilities: FY 02 $298.2 Million for 10,979 people = $27,161 per person

PD Waiver: $60,528,000 for 3,747 people = $16,154 per person
FE Waiver: $58,200,000 for 5,697 people = $10,216 per person

The waivers are more cost effective, cover substantially the same people, and there is very loading effect from people who refuse to be institutionalized.

Recommendation:

One Big Waiver

The State would save on administrative costs and be more efficient if there were one big waiver for all classifications of disability. Now, there are six waivers: physical disability, developmental disability, head injury, technology assisted, frail elderly, and severe emotionally disturbed. Long term care should be cross-age/cross-disability.

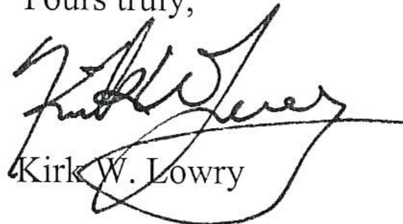
President Bush's Medicaid Reform Proposal

Our center is opposed to the new Medicaid reform proposal. The proposal would entice states with up front money but leave states with the risk of increasing enrollments and medical costs in years seven through ten. It is too risky for the states to give up their federal matching rate and accept all the risk of the baby boom generation long term care needs.

Olmstead Concerns

The Supreme Court held in *Olmstead*, that unnecessary institutionalization is discrimination against people with disabilities. Right now there are people in institutions who are on a waiting list for a waiver. The state does not have a formal Olmstead plan. We have asked the state and the secretaries to make an Olmstead plan. The state has an obligation to ensure that not one single person with a disability that is in a nursing home or state institution who is on a waiting list remains there.

Yours truly,



Kirk W. Lowry

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

President's Task Force on Medicaid Reform
February 17, 2003

Long Term Care Issues

Division of Health Care Policy
Robert Day, Director of Medical Policy/Medicaid
785.296.3981

For additional information contact:
Office of Planning and Policy Coordination
Marianne Deagle, Director

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Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

President's Task Force on Medicaid Reform
February 17, 2003

Long Term Care Issues

Chairman Clark and members of the Task Force, thank you for the opportunity to present to you today. My name is Robert Day. I am the Director of Medical Policy/Medicaid for the Division of Health Care Policy in Social and Rehabilitation Services. I am pleased to present to the Committee information regarding two of the home and community based services waivers that provide long term care to persons with disabilities and how the growth of these waivers has affected institutional services in Kansas.

Background

Medicaid waivers are federally approved requests to waive certain specified Medicaid rules. For instance, federal Medicaid rules generally allow states to draw down federal Medicaid funds for services provided in institutions for persons with severe disabilities. But many community supports and services provided to persons with disabilities are not covered by the regular federal Medicaid program. Home and community based services (HCBS) waivers give the state federal approval to draw down federal Medicaid matching funds for community supports and services provided to persons who are eligible for institutional placement, but who choose to receive services that allow them to continue to live in the community. The Center for Medicare and Medicaid Services (CMS) requires that the cost of services paid through HCBS waivers be, on the average, less than or equal to the cost of serving people in comparable institutions. States who receive these waivers must also assure CMS that the people served on the waivers remain healthy and safe. However, CMS does not require that states monitor the safety and health of the persons on waivers using rigid, federally mandated standards, as they do for institutional services. CMS also allows states to manage access to waivers. So HCBS waivers are not entitlements like institutional services. Finally, states are given broad latitude in establishing reimbursement rates for waiver funded services. Kansas has experienced great success in using the flexibility provided by HCBS waivers to serve many people with severe disabilities in community settings in a cost effective manner. I would like to briefly review the successes of the two waivers that provide long term care for persons who are developmentally disabled (DD) and persons who are physically disabled (PD).

Developmental Disability Waiver

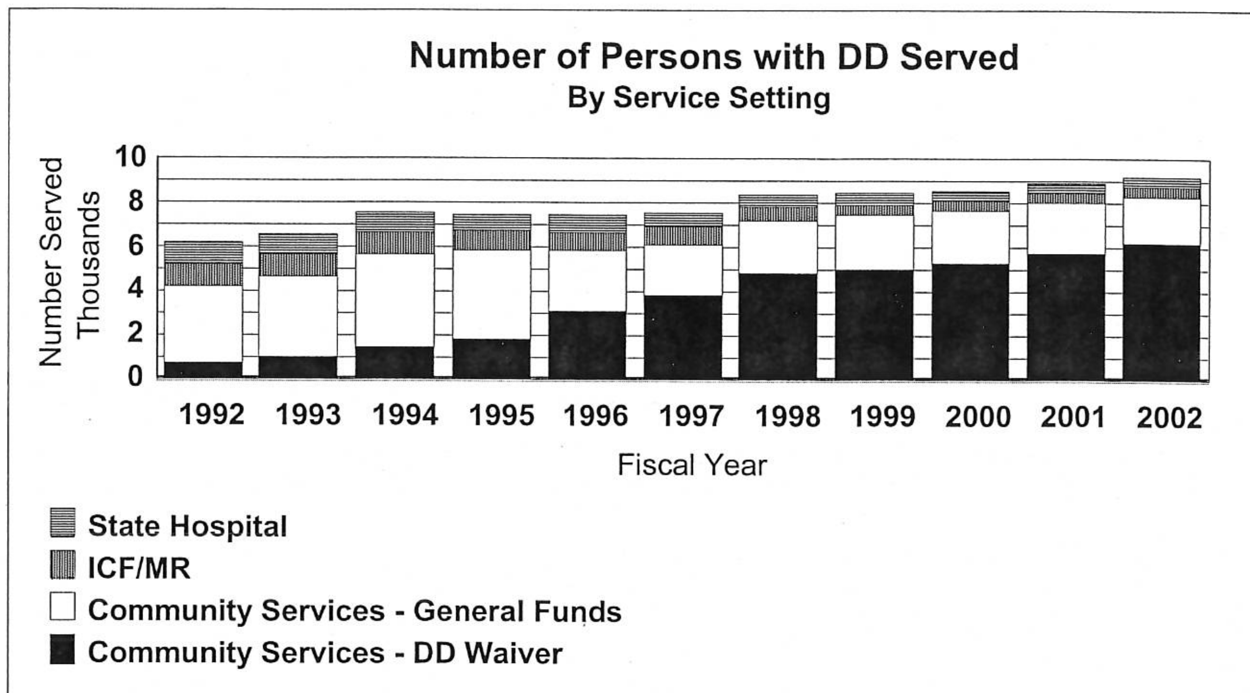
The DD Waiver provides Medicaid funding for persons who are eligible for admission to state or private institutions called intermediate care facilities for the mentally retarded (ICFs/MR). Over

the years, Kansas has used the DD Waiver for several purposes. First, it is used to help pay for the costs of placing persons from state hospitals and private institutions into community-based service settings. In the late 1980s the waiver was used to help pay the cost of community services for persons being placed from Norton State Hospital. Then, in 1992 Kansas began using the flexibility of the DD Waiver to more aggressively offer people living in state hospitals and their families the choice to move to community services through a process called the Community Integration Project. As a result of these efforts enough Kansans moved from state hospitals to allow the closure of Winfield State Hospital. In addition, in the last 10 years, nine of ten large private ICFs/MR have closed and many of the persons they once served are now being served in the community with DD Waiver funding.

Second, Kansas has used the DD Waiver to draw more federal funds for the cost of services for persons whose services were previously funded with only general funds. Beginning in FY 1994, SRS and Community Developmental Disability Organizations (CDDOs) began moving people whose services were funded with only state general funds onto the DD Waiver so additional federal Medicaid matching funds could be obtained for their services. The savings from this effort were used to serve people from the community DD waiting list and, in 1996 when the waiting list was eliminated for a short period of time, savings were used to provide a rate increase to community service providers. Through this process Kansas expanded eligibility for DD Waiver services to what is believed to be the maximum extent feasible.

Third, DD Waiver funding has allowed Kansas to access federal Medicaid matching funds to serve literally thousands of people who were waiting for community DD services. Since 1991, this has included supports for families whose children with DD continued to live at home. Without the federal matching funds made possible by the DD waiver, nearly 3/5ths of those removed from the DD waiting list, or about 1,800 people, would still be unserved or living in institutions.

The chart on the next page graphically displays the numbers of people with DD served from these various funding streams:

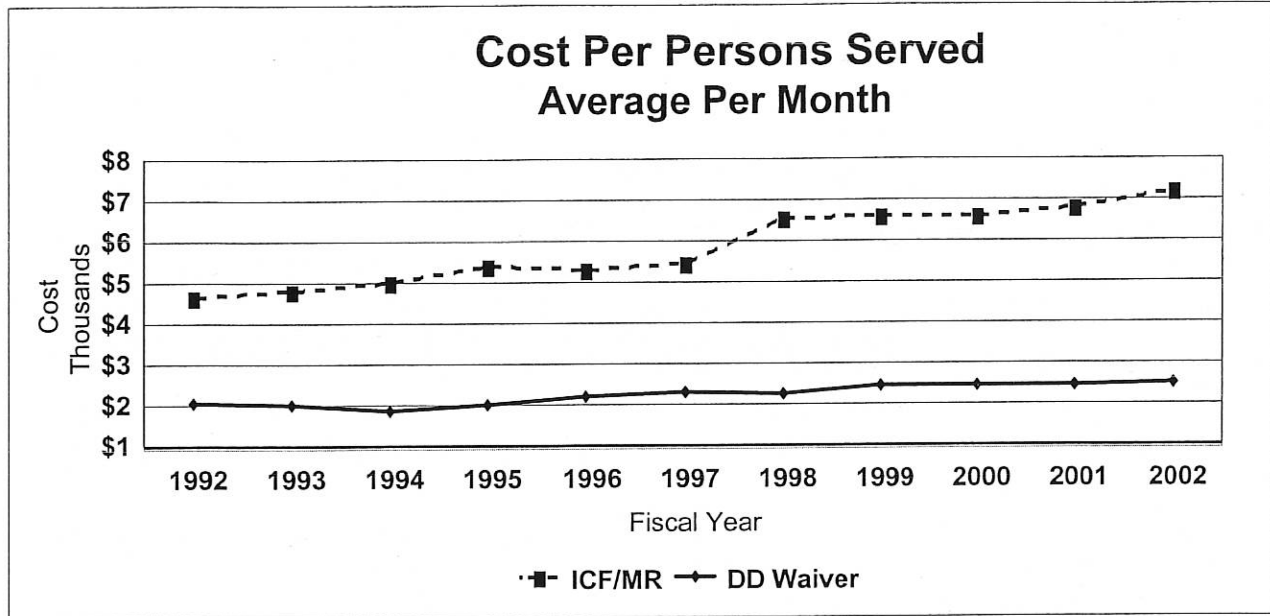


As the chart shows, the number of persons with developmental disabilities (DD) served in Kansas by the DD waiver increased by 5,469 from FY 1992 through FY 2002. Included in this number are about:

- 3,000 people taken off community waiting lists,
- 1,130 people who chose to move from state or private institutions, and
- 1,280 people who were served in the community with state general funds, but who were moved to DD waiver funding.

The waiting list for community DD services, however, continues to be a concern. Currently, there are 661 unserved persons waiting for community DD services. The FY 2004 GBR contains $5,082,592 to serve additional people from the DD waiting list. But, the demand for services continues to rise. So, even with this additional funding, the DD waiting list is projected to reach 931 persons by the end of FY 2004.

Occasionally, the question arises regarding the cost of serving persons in community settings. It would only be speculation to project what the cost of serving people in institutions would be if Kansas did not have a DD waiver. However, the chart on the following page shows the average per person cost of serving persons through the DD Waiver and public and private ICFs/MR:



The average costs of serving persons through the DD Waiver have risen far more slowly than the average rates paid for private and public ICFs/MR.

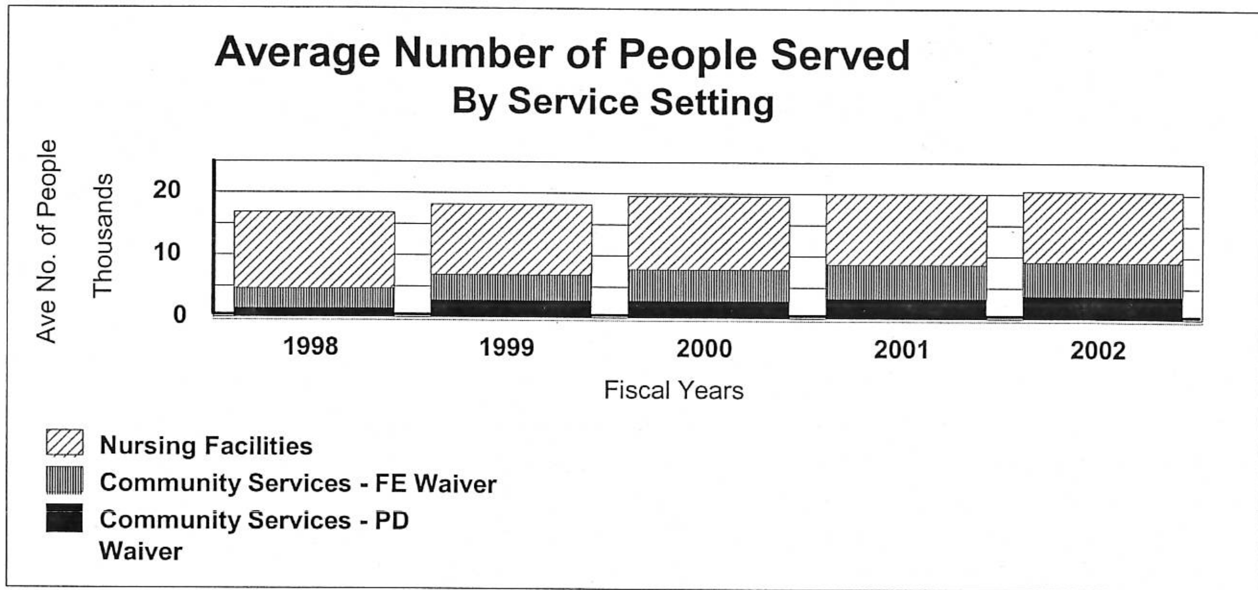
- The average monthly cost for serving people on the DD Waiver increased by about $550 from FY 1992 through FY 2002.
- The average monthly cost of serving people in public and private ICFs/MR increased by $2,560 per month from 1992 through FY 2002.
- The percentage increase of average monthly costs for the DD Waiver has been 21.8% over 10 years, or 2.2% per year.
- The percentage increase of average monthly costs for ICFs/MR has been 55% over 10 years, or 5.5% per year.

The DD Waiver has provided a cost effective means to allow people to move from public and private institutions to community based services. It has also allowed a significant number of people whose services were funded with all state general funds to generate federal Medicaid matching funds to defray the cost of their services. Savings from this funding shift allowed people to be taken from the DD waiting list and to give providers a rate increase. Finally, it has provided a way to more aggressively address the community DD waiting list. All of this was accomplished through controlled access, without establishing a new entitlement and with a very modest increase in the cost per person.

Physical Disability Waiver

In 1997, SRS began a home and community based services waiver specifically for persons with physical disabilities (PD Waiver). The PD Waiver funds community based services to persons with severe physical disabilities who are eligible for nursing facility placement, but who choose

to remain in their home. The PD Waiver was designed to fund the kinds of supports that are unique to generally younger persons with physical disabilities. Since 1998 the number of persons served through the PD Waiver has risen steadily. The following chart shows the overall growth of the PD Waiver, FE Waiver, and number of persons in nursing facilities paid by Medicaid. The FE Waiver is shown on this chart so that all waivers related to nursing facilities are seen together. I want to make clear however, the PD Waiver and FE Waiver serve people with significantly different needs.

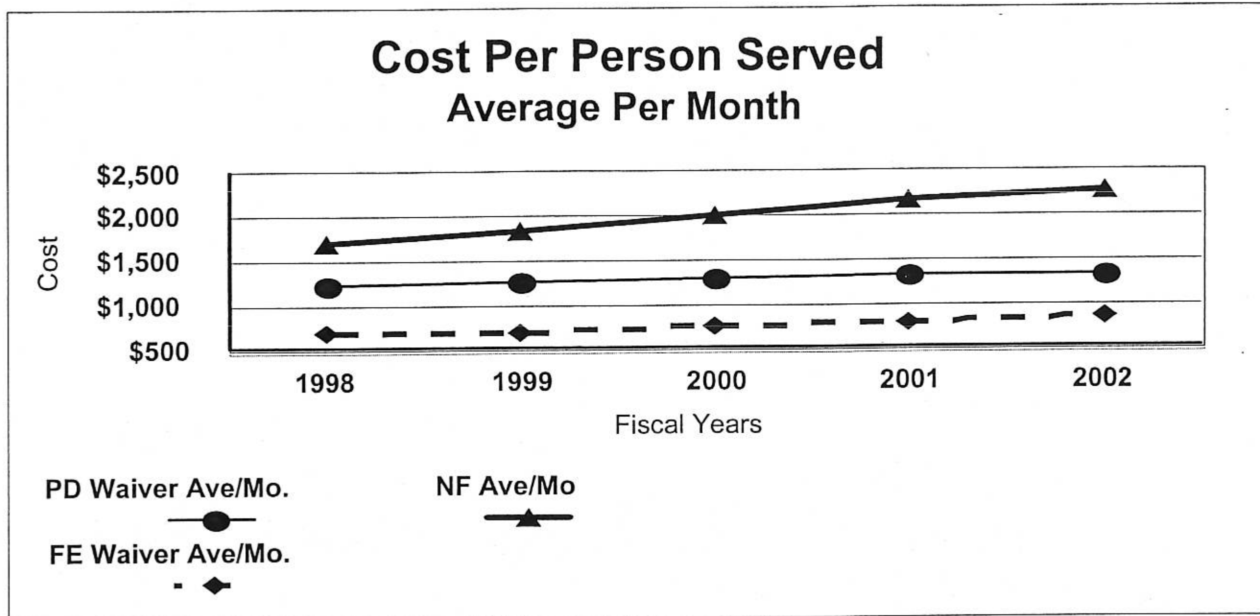


The data shows the following:

- The number of persons served through the PD Waiver has grown an average of 31.5% per year,
- The number of persons served through the FE Waiver has grown an average of 17.7% per year, and
- The number of persons that Medicaid funds in nursing facilities has declined an average of 1.72% per year.

This data seems to clearly indicate that the availability of the PD and FE waivers have provided community based alternatives to people with disabilities and limited the growth of nursing facilities.

The PD Waiver waiting list, however, remains a concern. Currently, there are 744 persons on the PD Waiver waiting list. The FY 2004 GBR includes $2,541,296 to serve additional persons from the waiting list. But, the demand for services continues to rise. So, even with this additional funding, the PD Waiver waiting list is projected to grow to 1,925 by the end of FY 2004.



The average cost of serving persons with physical disabilities in community settings is much less than the average cost of nursing facilities. In addition the increase in waiver costs have been much less than the increases experienced by nursing facilities.
The costs of serving all of these persons has risen in recent years, but the increase in costs for persons on the PD Waiver has risen less than the other two programs.

- The increased costs of the PD Waiver for this time period have averaged 2.1% per year
- The increased costs of the FE waiver for this time period have averaged 6.25% per year, and
- The increased costs of nursing facilities for this time period have averaged 8.5%.

Summary

The DD and PD Waivers provide a safe and cost effective way for people with severe disabilities to be served in their own homes and communities. These waivers have allowed Kansas to greatly reduce its reliance on expensive and highly federally regulated institutions. The waivers also allow Kansas to secure significant federal funds to pay for these services. But most importantly, the HCBS waivers allow people to live the kind of life they want to live, near their family and friends, in their own homes. Over the years SRS and others have compiled many stories about the lives of people who are on the waivers. More than the facts and figures I presented today, these stories tell of the true success of the HCBS waiver programs in Kansas.

Thank you for letting me present to you today. This concludes my formal presentation and I would be happy to stand for questions.