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# LONG-TERM CARE: STATES GRAPPLE WITH INCREASING DEMANDS AND COSTS

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BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

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# CONTENTS


| | Page |
|---|---|
| Opening Statement of Senator John Breaux | 1 |
| Statement of Senator Larry E. Craig | 3 |
| Statement of Senator James Jeffords | 4 |

PANEL I

| | |
|---|---|
| Hon. Howard Dean, M.D., Governor, State of Vermont, Montpelier, VT; accompanied by Patrick Flood, Commissioner on Aging and Disabilities | 6 |

PANEL II

| | |
|---|---|
| David W. Hood, Secretary, Louisiana Department of Health and Hospitals, Baton Rouge, LA | 26 |
| Ray Scheppach, Executive Director, National Governors Association | 40 |
| Richard Browdie, Secretary, Pennsylvania Department of Aging, on behalf of the National Association of State Units of Aging | 57 |

APPENDIX

| | |
|---|---|
| Statement of Karen A. Wayne, President/CEO Assisted Living Federation of America (ALFA) | 75 |

# LONG-TERM CARE: STATES GRAPPLE WITH INCREASING DEMANDS AND COSTS

**WEDNESDAY, JULY 18, 2001**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The committee met, pursuant to notice, at 10:07 a.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux (chairman of the committee) presiding.

Present: Senators Breaux, Craig, and Jeffords.

## OPENING STATEMENT OF SENATOR JOHN BREAUX, CHAIRMAN

The CHAIRMAN. The Committee on Aging will please come to order, and good morning, everyone. Thank you all for attending our hearing. We have a good opening witness who we look forward to hearing from, the Governor of Vermont, our good friend, Howard Dean. We have an interesting panel which I think is going to be very important in letting us know some of the developments and the questions of long-term care, particularly the Secretary of the Department of Health and Hospitals from my own State of Louisiana, David Hood, among others, who will be introduced at an appropriate time.

Today is the second in a series of hearings that the Aging Committee has embarked on, on the subject of long-term care. It is something that all of us are going to be hearing a great deal more about, particularly as the 77 million baby boomers—those folks born between 1946 and 1964—become eligible for senior programs like Medicare and others and also have to start making plans today about how they are going to spend their golden years when perhaps they may need additional help and additional care in dealing with some of their health problems brought on by the aging process.

But I can say that in our discussions as a committee and from personal experiences, the 77 million baby boomers do not want to be taken care of like the current Medicare beneficiaries and the seniors of today are being taken care of. For too many seniors in this country, long-term care means being housed in an institution. And I would argue that that is not the most effective and it is not the most efficient and in many cases it is not the necessary means of taking care of seniors.

My own father, who is in the category of approaching 80 years of age, has told me there is no way he is ever going to be put into a nursing home, that he would rather be dead. That may be an exaggeration, but it is certainly true that people who need medical

care in their golden years find that nursing homes serve a very valuable purpose. But there are many millions of others who find themselves housed in nursing homes when that type of institutionalized care is not needed, nor is it very efficient, nor is it very effective.

This country is now faced with a decision of the Supreme Court of the United States called the Olmstead decision, which basically makes a statement that the Americans with Disabilities Act actually prohibits States from discriminating against persons with disabilities, including those disabilities acquired through the aging process, that they cannot discriminate against those people by providing services in long-term care institutions when non-institutional care is recommended by a treating professional or is requested by the recipient of the services and would be a reasonable accommodation. So the States under this ruling can no longer just be comfortable with housing people in institutionalized care when it is not needed.

The final point I would make for purposes of the record is that my own State of Louisiana, to my regret, is ranked 49th in the Nation in the number of Medicaid waivers that they have requested and have been granted to use Federal, State Medicaid funds for purposes other than housing people in nursing homes. We rank 49th only because Arizona doesn't participate in the program; otherwise, I would fear that it would be even worse. We also rank 49th in the number of people who are served under Medicaid waivers. And so we need some attention, a great deal of attention being considered about how we operate in my home State.

[The prepared statement of Senator John Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Today's hearing is the second in a series on long-term care option for seniors and the disabled. The first hearing that we held last month with Tommy Thompson, Secretary of Health and Human Services, highlighted the Medicaid bias toward institutional care and efforts by the Department to shift funding away from institutional care and toward home and community based services.

Trying to shift Medicaid funds from institutional care to home and community based care may be as difficult as turning an ocean liner around, but we have to try. The 77 million baby boomers do not want to live in nursing homes when they are older and will strenuously resist leaving their homes to live in nursing homes. We are racing against a clock to develop other alternatives for baby boomers so they may "age in place."

Today we will hear from expert witnesses on the status of long-term care in the states. Some states have been aggressive in implementing the Olmstead decision and in creating a wide array of services for disabled citizens have created similar options for low-income seniors. Other states, like Louisiana, have not taken advantage of waivers available through the Department of Health and Human Services. Because most long-term care services are delivered through Medicaid and the state and federal government share in this funding stream, it is critical that we listen to what our witnesses have to say today so we can learn what is working well, what is working not so well and listen to suggestions for improvement by the federal government.

I now turn to Senator Craig for his comments.

Before I call on Senator Jeffords to introduce the Governor of his State, I would like to recognize our ranking Republican member, Senator Larry Craig. Larry.

**STATEMENT OF SENATOR LARRY E. CRAIG**

Senator CRAIG. Well, Mr. Chairman, thank you, and I apologize for running just a few moments late. But, again, let me recognize you for continuing what is now a three-part series on this committee's effort to understand and to build a record on long-term care. Our first hearing provided an overview of the challenges. Today, we are going to be examining some of the remarkable innovations that States have undertaken—and, Governor Dean, we are pleased you are before our committee. We will also be examining the obstacles the States continue to face.

Over the past decade, dozens of States have sought and received waivers from the Federal Medicaid program to creatively tackle long-term care challenges. In particular, the Federal Medicaid waivers have given States flexibility to provide seniors the option of receiving services in home and community-based settings rather than in nursing homes.

Nevertheless, much remains to be done. First, the waiver program remains just that—a waiver program. States must prepare and file detailed applications to the Federal Government each time they seek to depart from Washington's standard approach. Secretary Thompson is making great strides in speeding up that process but, still, the road to the State and the innovation remain cluttered with the kind of roadblocks that Federal approval sometimes develops.

Second, despite the progress in many States to shift the focus of long-term care toward home and community-based care, institutional nursing home care still consumes 3 times as many Medicaid dollars as home and community-based services, and that is unfortunate and troubling. I sense that is a substantial imbalance.

As we all know, the baby boomers will begin to retire in a few short years, Mr. Chairman. Both he and I find ourselves in that category, along with a lot of other citizens in our country, placing tremendous pressure on the current fractured, patchwork care services program. We owe it to them as well as to our current seniors, our children, and our grandchildren to tackle the hard problem, and I am pleased, Mr. Chairman, you are doing just that.

Governor, I think those of us who serve here and who had the opportunity of serving in State legislatures or serving at the State level oftentimes find the States served as marvelous incubators of thought and idea and program. The welfare reform that has benefited so many citizens across our country today was a product of State efforts. It was not something that was greatly envisioned here. It was that we took the good efforts of States and incorporated that into a national program. And so that is why we are anxious to hear from you and other States on the innovative practices they have used dealing with long-term care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Craig.

Let me recognize Senator Jeffords from Vermont for any comments he may have, as well as to present his Governor.

**STATEMENT OF SENATOR JAMES M. JEFFORDS**

Senator JEFFORDS. Thank you very much. There are few topics more important to our Nation's elders than the issue of long-term care, and I want to salute Chairman Breaux and Senator Craig for the priority they are giving to it for this committee.

This committee and its leadership has been at the forefront in responding to the needs of senior citizens. During the last Congress, Senators Grassley and Breaux were instrumental in drawing attention to the need for a national program for caregivers. The National Family Caregiver Support Program, which we included in the reauthorization of the Older Americans Act last year, is already providing $125 million to help support families and other provides of in-home and community-based care to older individuals. This program is helping not only our seniors but their families who are struggling to care for them in the home environment rather than the nursing home.

I raise the National Family Caregiver Program today only to point out that the focus of this committee is fertile ground where we can successfully plant the seeds of hope for our senior citizens. While the caregiver program will help many Americans, it is not itself enough.

Much has been said about the looming crisis facing our country as the baby boomers begin to age. During the first hearing on this topic, Secretary Thompson highlighted and defined that crisis. Today, people who are 65 years or older account for only about 13 percent of our total population. By the year 2030, they will account for about 1 in 5 Americans.

Today, Government funding accounts for about 60 percent of the funding for nursing home care. That is in part because our system is designed to direct people into nursing home settings. We will hear today why that may not be the only answer, and certainly it may not be the best answer.

I am especially pleased that Governor Howard Dean is here to advise the Aging Committee on Vermont's innovations in the area of providing long-term services because he has an important lesson to share, and I urge all of us to closely listen to Vermont's experience in establishing innovative approaches to the long-term care, the Federal regulatory problems, the State has confronted, and his advice for making the system work better.

I also want to welcome our other witnesses, Mr. David Hood of Louisiana and Mr. Scheppach of the National Governors Association and Mr. Rich Browdie, who is representing the National Association of State Units of Aging.

Let me go on to the introduction of my good friend. I have the special pleasure this morning of introducing my long-term friend and Vermont's long-term Governor, Howard Dean. Vermont has been at the forefront in providing our Nation's elders real choices, allowing them to live their lives in their homes. I know that my colleagues on the committee will want to listen closely to the lessons learned by Vermont and to the advice and recommendations that Governor Dean will offer.

Howard Dean brings to this discussion not only his experience as chief elected official of Vermont, but also as a physician who understands the needs of patients and the elderly.

Governor Dean received his bachelor's degree from Yale University in 1971 and his medical degree from Albert Einstein College of Medicine in New York City in 1978. He then completed his residency at the Medical Center Hospital of Vermont and opened an internal medicine practiced with his wife, Dr. Judy Spangler, in Shelburne, VT. He served in the Vermont House of Representatives from 1982 to 1986 and was elected assistance minority leader in 1985. He was elected Lieutenant Governor in 1986 and re-elected in 1988 and 1990.

On August 14, 1991, Dr. Dean's political career took a sudden and unexpected turn. He was treating a patient at his medical practice when a call came informing him that Governor Snelling had died of a sudden heart attack. Dr. Dean completed his patient's physical, called his wife and children, and drove to Montpelier to take the oath of office. He was elected to a full term in 1992 and has been re-elected by solid margins since that time.

Over his decade as Governor, he has shown himself to be a fiscal conservative with a social conscience. He has retired the State's deficit, built comfortable budget reserves, cut the income tax, improved the State's bonding rating, and reduced the State debt. Not bad.

In addition, Governor Dean has established Vermont as a national leader in the areas of children's disease prevention programs, health care reform, and welfare reform. He has also focused on improving public schools and helping Vermont families meet the cost of sending their children to college.

As we will hear today, he has been a leader in providing improved systems of care and programs for the elderly. In short, Governor Dean is an independent thinker, and all of us know that Vermonters cherish independent thinkers, and in that vein, I want to welcome him to the Aging Committee.

The CHAIRMAN. Well, thank you for that wonderful introduction, and Governor, we are delighted to have you. It is particularly appreciated by this committee to have you as Governor of the State come down and share your thoughts with us. What you have done is important. It is important for Vermont, but it is also important as a symbol for the rest of the country, and we are delighted to have you tell us about it. Governor, welcome.

**STATEMENT OF HON. HOWARD DEAN, M.D., GOVERNOR, STATE OF VERMONT, MONTPELIER, VERMONT; ACCOMPANIED BY PATRICK FLOOD, COMMISSIONER ON AGING AND DISABILITIES**

Governor DEAN. Thank you, Mr. Chairman. Thank you, Jim, for your kind words. I have with me Patrick Flood today, who is the Commissioner on Aging and Disabilities, who has done a wonderful job for us and gets a lot of the credit for some of the things that we have done, and he is certainly obviously a technical expert, and I thought I might refer some of the questions that you may have to him.

I have prefiled written testimony, which I am not going to read, so I am just going to kind of give you a general outline of what is going on.

As this committee is very much aware, our elderly population is growing. The fastest-growing age group in Vermont right now is those over 85 years of age. By 2025, 20 percent of the population will be elderly, and our current system of long-term, like many of our other systems for the elderly, will be supported by an increasingly fewer number of working-age people.

What we have done in Vermont is essentially used the waiver process, which we have been very successful at, to change our profile. In 1996, nursing home costs were 88 percent of our long-term care expenditures. Today, they are 74 percent. We had a nursing home population 4 years ago of 2,800; today, it is 2,300. At the same time, we have been able to use Medicaid dollars under a Federal waiver to take care of 1,000 people in their own homes. And this is really the crux of the message that I have for the committee today. Four years ago, we were able to take care of 400 people in their own homes. Today, we have more than doubled our ability to do that.

Older people want to be taken care of in their own homes. They don't want to go to a nursing home. I think the example you used of your own father is a very typical one that we hear from all kinds of people. And what we are trying to do in Vermont and what we need some help with and some flexibility with is to identify people early on who are potential candidates for a nursing home and get them enough services early on so they don't ever end up in a nursing home.

I think if I could distill my testimony today into perhaps one sentence, it is this: You should not need a waiver to be supported in your own home. And that is a position that Vermont and, of course, all the others States are in as well. We need a waiver to use innovative programs, and, of course, when the waiver has to be reauthorized, we have to jump through lots of hoops, and it makes it more and more difficult.

We are and have been able to keep some of the frail, vulnerable people in their own homes with as much as 30 hours of services a week. In the past, those people would have been sent to nursing homes.

We passed a few years ago something called Act 160, which is a mandate to reduce the number of nursing home beds and increase the number of people being taken care of in their own homes. Fortunately, we have been able to expand the Medicaid dol-

lars to do that; otherwise, it would be impossible. The State clearly can't pick up the tab for people who are no longer in nursing home beds.

The problem with the current system is essentially there is an entitlement to a nursing home bed, but there is no entitlement to any of the things that can keep you out of a nursing home. So one of the things we are interested in having the Federal Government do is to re-examine the entitlement so that the preferred choice is not immediately the nursing home bed. Families don't want that. The individuals don't want that. Of course, sometimes it is necessary. There are people who have enough needs that they can only be taken care of in an institutionalized setting.

Patrick and I were talking yesterday about my upcoming testimony, and he believes that we could reduce our present nursing home population easily by another 10 percent, and possibly more, so that the net reduction would have been almost one-third over a 4- to 6- or 8-year period, if we had enough flexibility from the Federal Government in terms of designing the program so that we could take care of people, identify people before they get into nursing homes, and never have to spend the $48,000 a year to keep folks in nursing homes.

Everybody is a winner with more flexibility. The senior citizen gets to stay in their own home or a more independent setting with support. The State saves money. The Federal Government saves money because an individual is less expensive. We can take care of more people, or for the same amount of money, if you are not as interested in the savings and more interested in spreading the care around, and the family likes it because they feel less guilty and it is less of a burden on them to keep somebody in their own home.

So, basically, that is what we are trying to do. What we are interested in is more flexibility without the need of a waiver, for prevention services, housing costs, flexible funds. We think that this committee ought to take a look at paying spouses in some instances, something that we are fooling around with. It is very hard to do those kinds of things, but certainly it is something that the committee might think about; and then covering nursing homes and home care during transition periods so we can get people into a more independent setting.

Again, I want to restate—and this is probably the most important thing I am going to say today. We need to somehow remove the bias toward institutionalized care. If we could do nothing else but that, that would be enormous, because the presumption is financially that when you are in a hospital and you are a senior citizen with a lot of disabilities caused by illness, that you are going to the nursing home; and anything that you do that is not about going to the nursing home requires a huge, jury-rigged, sort of innovative financial scheming to keep you at home and an enormous amount of work on the part of social workers and discharge nurses and so forth to keep that happening. So anything that we can do to remove the institutional bias and allow us to spend funds for people in their own homes, even to the extent that you would require for the financial, fiscal consideration a reduction in nursing home beds, that would be fine. Because we did that. We knew we

had to do that. We knew we couldn't afford simply to expand the program and keep the same amount of nursing home beds and then take care of more people in their home. And we have made that tradeoff under the waiver, and we are taking care of 600 more seniors than we were 4 years ago.

I think this goes without saying, and every advocacy group for seniors will tell you this, and I am sure they have: Everybody ought to have a voice in deciding where they are going to receive their care, and to empower the senior and their family, we need more flexibility at the Federal level.

I think that is really the—there are all kinds of things in here about money and other—a couple more things I want to say, because, you know, I am in the middle, Governors are in the middle. We come here and lobby you for more flexibility and more money, but we get lobbied by mayors for more flexibility for the local people and more money. So I am not going to beat you over the head with that because I am sure you hear it from everybody. But I would just like to make one or two more remarks, and then I will close my formal testimony.

The first is that one of the best things that could happen has actually nothing to do with or is only peripherally related to jurisdiction of the committee. We really badly need a prescription benefit with Medicare. You would not have designed the Medicare system today the way it was designed, the way you did it in 1964, because most decent health insurance has a prescription benefit. Medicare does not. If we had a prescription benefit piece of Medicare, in the Medicare program, it would enable us to keep people out of nursing homes because part of their problem is if they don't take their prescriptions, which they don't because they are too expensive—they take them half as much as they are supposed to or they don't take them at all so they can pay the rent—that cuts down on the kind of morbidity that sends people into long-term care.

Second—and on this I think I speak—I have pretty much spoken for most of the Governors as I have gone through this, and you are going to hear, I think, later from Ray Scheppach, who will officially do so. But the next piece is not speaking for all the Governors. Vermont, Rhode Island, and a few other States, I think Minnesota was one, really did not get much benefit out of S-CHIP. And if there is a way that when you look at your legislation that you could craft it so those States who are really trying to do a really good job and are ahead of the curve don't get penalized, as we did in S-CHIP, those States which were already giving children a large amount of health care never got any benefit out of S-CHIP. In fact, we have turned money back because we simply can't use the money because our benefit level—we are at such a high level, anyway. We insure people, kids up to 300 percent of poverty. We never had any benefit from S-CHIP money.

I would hate to see that happen in whatever long-term care bill might occur. It would be possible, for example, to design a bill that would help those States that don't have much flexibility, but it wouldn't give us any more flexibility than we already have because we have a fair amount of it under our waiver.

So I would just put in a plea: For those States in the long-term care that are fairly far ahead of the curve—and I think we are one

of them—please don't pass a bill that addresses the bottom 10 States. Pass a bill that is going to help all the States. S-CHIP was not that bill for kids' health care, and we certainly don't want to have a repeat of that for the health care for seniors.

So, Mr. Chairman, let me thank you very much for your kind invitation to come down and talk. This is an area we have spent a lot of time on. This is an area Governors are going to be incredibly concerned about as we see our financial situation deteriorating, because this is a big piece of every single one of our Medicaid budgets.

In our State, we have, not including dual-eligibles, about 100,000 people, which is about 20 percent of our population, on Medicaid. Now, I have done that on purpose because I wanted to expand benefits to as many people as possible. Half of all the expenses—we have 100,000 people on Medicaid; 2,300 of those people use almost half of all the money that we spend on Medicaid, and that is the nursing home population. Every Governor has a profile like that, between 40 and 60 percent. So anything that you can do to help us expand the number of people we can cover for that 40 to 60 percent of our Medicaid budgets would be incredibly helpful. And we are just delighted to have the opportunity to come and share our views.

I would be happy to take questions or comments.

The CHAIRMAN. Well, thank you very much, Governor, for telling us about the Vermont experience and what you all have been able to do. I think that you really represent what the future hopefully will look like in all of our States with regard to how we treat and help seniors live a better life.

Tell us a little bit about how you were able to pass the Act 160, which, as your statement says, mandated the shifting of the State financial resources from institutional to the non-institutional services. What brought that about? How difficult was it to get done? I would imagine that nursing homes were strongly opposed to it. How did all of it take place, both politically as well as socially?

Governor DEAN. We put together, Mr. Chairman, a coalition of those in the disabled community and seniors, as well as the community providers—home health and so on—and tried to make it very clear that we thought we could get a lot more for our long-term money if we were more flexible, if they would be more flexible.

We particularly emphasized choice for consumers. Since most people prefer not to go to an institution, we found a great deal of resonance with that. What people want is opportunity to do things differently, and it turns out that the different opportunity is a lot cheaper for the State and, in this case, of course, the Federal Government, too, since you have a significant piece of money in the Medicaid budget.

It was extraordinarily cost-effective. Of course, the issue of what happens, you know, to excessive use of this benefit was raised, particularly by the nursing home lobby, but that turned out not to be true. In fact, we are able to serve a good many more people in circumstances that they prefer. So it is true that the nursing homes objected to this, but we were fortunately able to prevail. And as it turned out, we were correct. We have been able to decrease the

number of nursing home beds by a little under 20 percent and take care of about 150 percent more people in the system for that amount of money.

The CHAIRMAN. Have the nursing homes, for instance, been able to tailor their services so that some of them have actually been able to move into some of these different new services that are being provided on a home basis or day-care type of facilities?

Governor DEAN. We suggested that. That has not taken place as much as I might have thought. I do want to let Patrick have a crack at this question. Most of them were not nimble enough to do that, and, in fact, the hospitals took over some of the long-term care, the visiting nurses and so forth. There was some flexibility, not as much as perhaps there could have been, but I want to let Patrick just have a crack at that one as well.

Mr. FLOOD. Mr. Chairman, we made it clear to the nursing home industry in the beginning that we were ready and willing to help them change their services or do things more flexible. Adult Day is a perfect example. In fact, we had one nursing home in the State of Vermont that opened an Adult Day site.

But I have to tell you that, in retrospect, I think two factors are at work here. One is the nursing home industry has been doing business a certain way for a very long time, and they are not quick to change. And, in fact, they will tell you in their candid moments that they really expect that some of this emphasis that you are bringing here today will pass and that when the baby-boom generation comes——

The CHAIRMAN. You mean pass, go away?

Mr. FLOOD. It will go away; when the baby-boom generation comes, they are going to be back looking for nursing home beds. I don't believe that, but—so there is a certain inertia at work there where they are just unwilling to change.

But, second, as providers of service, they are pretty limited in what they can do. I don't know what nursing homes you have been in lately, but most of them look pretty much the same. You have buildings that are not easy to renovate, not easy to change into other use. So it is a pretty expensive proposition sometimes, too.

The CHAIRMAN. Today in Vermont, Governor, you say that all of the following services are available—and I take it that each one that you listed are the result of having to get a waiver from Health and Human Services, the old HCFA operation, to be able to provide those services. And that is another point about why you have to do that, because I think we have to make some changes up here so that we don't have a bias just for institutional care. They just say, we have money we want to have available to take care of seniors, and, let's design the best system that you can, make sure it is run right, but it doesn't have to be institutionalized so you don't need to have a waiver.

But you have home health aide services, homemaker services, personal care attendants, adult day-care services, case management services, assistive technology and home modification, and traumatic brain injury services.

My question is: Where did the people come from to provide those services? All of a sudden, you say, look—I guess it came about gradually, but all of a sudden, you say, look, here are some new

things that we can do with some of our seniors. Was the infrastructure there or did it—I guess it developed as you made the money available for it.

Governor DEAN. Let me answer that in a couple of ways.

The infrastructure was not there, although the advocacy groups were, and as money became available, these services became available. This is not, you know, a perfect world. It is wonderful for me to come to Washington and tell my story. We fight every day with people who want more of this and less of that, and that is just part of the political fabric of what happens when you make changes and what happens when you fight over resources. So I am not going to say that everybody is 100 percent satisfied customers. We have disagreements with people about what services they need, because if they could get any service they wanted, obviously we wouldn't be able to sustain the program.

We have built up as a result of this the sophisticated services needed to keep people in their own homes, and one of the very good things, in my view, that has happened is that we now have sophisticated services 4 or 5 years into this that we didn't have before, and so we can take care of much sicker people in their own homes and still it is much cheaper than it is in an institution.

The other point I would make about this and point out about the nursing home industry, in Massachusetts—I think this is a proper statistic, and Patrick should correct me if I am mistaken. I think one-quarter of all the nursing homes are in bankruptcy. In Vermont, that is not true. We do have a few financially troubled nursing homes. But I believe what this has done, coupled with the negotiation on our part with the nursing home community for adequate reimbursement, it is made the industry stronger. They are more careful. They take sicker patients. We pay nursing homes based on a case-mix formula now. So the sicker patients they have, the more they get paid.

I think you are going to have to do something like that if this is going to work because we can't expect to pay them at the usual rate if their case mix now—if they only get the sickest of all the patients and we are able to keep everybody at home.

So we think that the nursing home community can do OK out of this, although in our State they were kicking and screaming all the way. But it does require some new negotiating approaches on the part of the State as well.

The CHAIRMAN. Can you tell me, Patrick, what your reimbursement rate is for nursing homes?

Mr. FLOOD. As of July, the average nursing home rate in the State of Vermont would be approximately $130 a day, which puts it in the upper echelon.

The CHAIRMAN. Well, congratulations, Governor, for what you are doing.

Senator Jeffords, any questions of your Governor?

Senator JEFFORDS. Governor, thank you, an excellent statement, and I am proud of you and proud of Vermont in this area, as in many other areas.

I would like to further the inquiry that we are having here. What is Vermont's experience with the increased participation in new enrollees? Has there been a sharp increase in the expense of the pro-

gram, or have you been able to serve more elders with the funding available?

Governor DEAN. I would say it would be the second, but I would like Patrick to answer that one.

Mr. FLOOD. Absolutely, Senator. What we have been able to do by diverting people from nursing homes—the average cost is $48,000 a year in a Vermont nursing home on Medicaid. The average cost to keep someone at home on our waiver program is less than $20,000.

Senator JEFFORDS. Give me those figures again. I missed them.

Mr. FLOOD. The average cost for Medicaid, annual cost for Medicaid in a Vermont nursing home, is approximately $48,000 a year.

Senator JEFFORDS. $48,000.

Mr. FLOOD. To keep somebody at home on our waiver program averages less than $20,000 a year. So basically we can serve 2.5 people for the cost of 1 in a nursing home. So what we have been able to do is not only serve people who otherwise would have been in a nursing home, we have actually been able to take care of normal caseload growth. In other words, instead of building new nursing homes to take care of the population as it grows, we are building our waiver program where we can still afford it, and we have been able to use some of the other monies, as the Governor said, to buildup other infrastructure that is not necessarily covered by Medicaid, which is one of the problems here. There are very important services that don't get covered by Medicaid, and we have had to take some general funds and do that.

So we have been able to do all those three things with basically the same amount of money.

Senator JEFFORDS. I am glad you mentioned the lessons learned by Vermont through the S-CHIP program. Do you have any specific ideas to make sure responsible States are also rewarded? Would small-State minimum funding levels work?

Governor DEAN. I would say that certainly things like small-State minimum, but, you know, I am not an expert in how we get our money from the Feds on long-term care, so I think I would like Pat—I mean, the question was: What would we do so the S-CHIP experience isn't repeated on the long-term care?

Mr. FLOOD. Honestly, Senator, I think we are prepared to just start from where we are. We would like to just be able to use the same amount of money we have today in more flexible ways. We don't want to be penalized in any way, I think is the Governor's message here.

For example, when Medicare cutbacks occurred a few years back, the State of Vermont was probably the most cost-effective home health provider in the country, if not, the second. And when the prospective payment system started being put into place, we were severely penalized. Our already very low reimbursement was reduced even further, and we went through a very difficult time in the State of Vermont with home health. And that is just an example of what we want to avoid with a national approach.

I honestly think that if the Federal Government would just give us the opportunity to use available dollars more flexibly, that would be enough. Just be caution that in attempts to do this sort of thing that you don't cost shift away from a State that is already

doing a good job. That is the general theme. We have seen it happen, and we would prefer that it not happen again.

Senator JEFFORDS. Governor, you mentioned the importance of having a viable prescription drug benefit for our senior citizens. That is why we are working on the Finance Committee to make this program a reality this year.

Last year, we passed legislation based on advice we got from the Food and Drug Administration that would allow the reimportation of lower-cost drugs from countries like Canada. As the Governor of a border State, but also as a physician, can you tell me if Vermonters have benefited from their ability to get the lower-cost medicines for their personal use? And has there been any record of adverse events or abuses by this practice?

Governor DEAN. Well, Senator, I think the notion that somehow drugs that are made in America, shipped to Canada for sale there, and then come back into America are going to be less safe is ridiculous. The notion that the Secretary should have to sign off on some safety protocol makes absolutely no sense whatsoever. It is simply protectionist for the pharmaceutical industry.

In my view, reimportation, the more, the better. If we believe NAFTA is a good thing for the automobile industry, then why isn't NAFTA a good thing for the pharmaceutical industry? We have had zero safety problems with reimportation. Zero. We have an extraordinary program started by some doctors in Bennington which allows them essentially to buy drugs for personal patient use over the Internet. We not only had zero complications, since these drugs are made in the States, kept in their packages, go to Canadian pharmacies, and then come back to the States. But for the first year, 145 people used that program. The savings for those 145 people was $81,000. Now, that is an extraordinary savings for senior citizens principally on fixed income. And I would encourage you and the Senate to maximize our ability to reimport not only for individuals but also, frankly, if we want to do something for the local pharmacies, let the pharmacies and let the wholesalers reimport.

Again, if we are going to have an era of free trade and globalization, there isn't any reason that this particular industry should be exempted from it.

Senator JEFFORDS. Thank you.

The CHAIRMAN. That is another issue. [Laughter.]

Let me just ask one final question, Governor. I take it that what you are saying is that as a result of your efforts you have happier seniors and their family members are happier. And you are doing all of this for less cost.

I would imagine that some in the nursing home industry would make the argument, yes, but they are not getting the quality health care they need and they are at risk.

Can you comment on that?

Governor DEAN. Well, I think it is very clear—and I will comment as a physician not as a Governor on this one. I have taken care of a lot of people over the age of 65—over the age of 85, and it is very clear to me that the single most important way of keeping seniors happy and living longer is, in fact, keeping them happy. So I would actually disagree with anybody who said that the quality of care was going to be worse in the home, because by keeping

somebody with independence, that enhances their own sense of independence and allows them, A, to do more for themselves than they would in an institution, and, B, to feel much better about themselves. And, therefore, that alone will keep them living longer.

I doubt very much—I haven't seen studies on this, but I would be shocked if there was a lower incidence of people falling down and hurting themselves in a nursing home than there was in a properly supervised home. These folks who do the home care have plans, they have restrictions that they make very clear to the families what they have to be. So I don't think there is any kind of a safety issue, and my guess is that people do better in their own homes psychologically and, therefore, physically than they would in a nursing home.

Now, we are not talking about everybody. Remember, home health care is not for everybody. There are people who are so severely disabled that they must have institutional care, and we are not talking about doing away with all nursing homes. But there are an enormous number—in our State, for all we have done in expanding home health with the waiver, we still think that we have at least 10 percent of patients who are in institutions now who don't need to be there, and we can't get them out now because once you go in, you become dependent and you need even more services. So you have got to stop them from going in in the first place. Then they are not only happier, but they do better physically.

The CHAIRMAN. Patrick, any statistics on that?

Mr. FLOOD. Well, I can say, Mr. Chairman, that the Adult Protective Service Office is also within my department, so I see the complaints that come in about abuse and neglect and exploitation of elderly people. And I certainly have not seen any increase in the actual cases of abuse and neglect of people residing at home.

I agree 100 percent with the Governor's comments that if people are content, if people are happy, they tend to do better medically. And my experience—I have worked in nursing homes as well as in other settings, and my experience is an institutional setting, just by its nature, tends to cause problems that you wouldn't have at home. We have seen no indication, no statistics to indicate that there is any problem.

In fact, I would say unequivocally that people are better off and they are healthier and they are happier when they are being cared for at home. They have to have a system in place that manages that. We do have that in Vermont. Any particular client, any particular person at home, has probably two or three different kinds of services they are getting, and that provides a check and a balance in the system, which, in fact, is not something you necessarily see in an institution. That is the problem with institutions. They are separated.

In this case, the whole community is involved in the case of somebody so you get that check and a balance, and that, in fact, prevents the kinds of abuses people are worried about.

The CHAIRMAN. Well, thank you, Governor and Patrick, for sharing the Vermont experience with us, and hopefully it can be an example for others to follow. I think you all have done a wonderful job, and we appreciate your being with the committee.

Governor DEAN. Thank you, Mr. Chairman. Thanks, Senator.

Mr. FLOOD. Thank you.
[The prepared statement of Governor Dean follows:]

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**Testimony of Governor Howard Dean, M.D. (D-VT) to the Senate Special Committee on Aging**

**July 18, 2001**

Mr. Chairman and members of the Committee, my name is Howard Dean and I am Governor of the state of Vermont. I appreciate the opportunity to appear before you today to discuss – from a state perspective – an emerging health care issue with major ramifications for both the Medicare and Medicaid programs.

We are all acutely aware that our society is aging. In 25 years, the population over age 65 will represent 18.5 percent of all Americans, an increase from 12.6 percent today. People over 80, those most in need of long-term care, will grow by nearly one third. In the face of these trends, our current approach to long-term care simply will not meet the need. The cost for continuing business as usual will be enormous and unsustainable. We must instead develop a new fundamental structure for long-term care, one that emphasizes independence, dignity and choice for the people we serve, and which does so through creation of flexible programs and funding that are financially sustainable by the states.

Before expanding on these themes, I want to commend you for including representatives from the states in your planning activities. I am certain that we all share the same principles with respect to our nation's long-term care system – that it be efficiently operated, but also that it offer opportunities for self-determination among patients and their families and that it enhance the dignity and quality of life of those it serves. I also firmly believe that we can advance these principles only if the states and federal government – as the two major payers of long-term care—work together in partnership to reform the existing system.



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With these common principles in mind, I would like to begin today by talking briefly about the long-term care environment in Vermont and what we in our state see as the necessary components of any compassionate and financially rational long-term care system. I will describe how we have tried to put these components into place over the last several years, and the obstacles we have encountered. I will then conclude by offering some specific recommendations on how states and the federal government can work together to remove the obstacles that bar the path toward improving the quality of life for our frail elderly and disabled citizens.

**Long Term Care in Vermont**

While Vermont is smaller and more rural than many other states, our long-term care system is similar to what exists in the rest of the country. This is no accident, since much of the structure for long-term care has been molded over the years through federal regulation and entitlements.

If you are an elderly or disabled citizen of our state today, and in need of long-term care services, sooner or later you will most likely find yourself coming into contact with the Medicaid program. Even if you qualify financially, however, one of the first difficulties you will encounter is the way in which medical eligibility tests must be administered. Because it is an entitlement, traditional Medicaid exists as an "all or nothing" proposition for potential recipients. Take the case of a 65-year old widow who lives alone on a fixed income and wants to remain in the house where she and her husband raised their family. She is generally in good health, but to be able to stay, she needs some modifications made to her house, such as the installation of a wheelchair ramp. She also needs some light assistance with housekeeping. We can offer her these kinds of services through Medicaid only by qualifying her for the whole entitlement.

And the fact is, she may not qualify for the program. Long-term care eligibility in Vermont and other states is measured in one way or another against the yardstick of nursing home care. If you need assistance with activities of daily living to such an extent as to justify admission to a nursing facility, then and only then will you qualify for Medicaid long term care.

So there is not much we can do through Medicaid for this woman until her health further declines. Let us take the case of another elderly Vermonter, who is living at home with his wife and could remain there with the right combination of intensive medical and social supports. Absent these supports, the only recourse for his wife will be to place him in a nursing facility.

Here the prospects are a bit brighter. In 1996, we enacted a law in Vermont known as "Act 160". This law mandated the shifting of state financial resources on a defined timetable from institutional to non-institutional services. To my knowledge, it was one of the first laws of its kind in the country.

With Act 160 serving as a catalyst, we have worked to take maximum advantage of the home- and community-based services "waiver" option under Medicaid, to develop and fund an array of services designed to allow people to remain in their homes or other community settings when their only choice otherwise would have been a nursing facility.

Today in Vermont, all of the following services are available to qualifying individuals enrolled in our waiver program:

Home-health aide services – whereby a health care professional assists individuals in the home with specific health problems;

Homemaker services – including assistance with general household activities and housekeeping chores;

Personal care attendants – for assistance with basic needs such as bathing and dressing, as well as household activities like grocery shopping and paying bills. We also permit individuals to hire their own attendants;

Adult day care services – which involve transporting an elderly or disabled person to a center where they receive on-going attention and therapies before going home again for the night;

Case management services – to assist individuals to find and coordinate the various services they need;

Assistive technology and home modification – a limited benefit to help people obtain equipment or home modifications they need to remain independent and which are not covered by other sources;

Traumatic brain injury services – specialized services to assist people with traumatic brain injury remain out of an institution.

The average long-term care recipient living at home receives more than 30 hours a week of these kinds of services. We also have respite care available for spouses and other caregivers who, of course, continue to bear the brunt of the work associated with keeping a loved one at home.

And we offer full-time Residential care, for persons who are too medically fragile or disabled to remain at home, but who can safely live and age in place in a more private setting than one finds in a nursing home.

Our efforts to build a comprehensive home- and community-based service system were recognized by the federal government in 1999, when we were one of eight states selected to implement a pilot program to assist nursing home residents whose primary payer source is Medicaid to leave the nursing home and return to the community.

**Federal Obstacles**

As active as we have been in developing alternatives to nursing home care, the rules of the traditional Medicaid program have limited us in what we have been able to accomplish. That is because federal regulations are significantly biased toward institutional care. Nursing homes are identified as a basic service within Medicaid, but it takes a waiver for states to offer home- and community-based alternatives. The waivers themselves cap the number of people who can be offered waiver services. If others qualify, but the slots are filled, the only option we can offer is the nursing home.

We are also limited when performing our financial "test" to looking only at what Medicaid pays for and disregarding the effect of our actions on the other major public payer – Medicare. If we can intervene to improve the safety of the elderly woman's home, thereby preventing a fall and a hospitalization, we have saved a substantial amount

of money for Medicare. But the current rules do not allow us or you to recognize the value of our actions outside of the world of Medicaid, resulting in an incomplete picture of what we have achieved.

Finally, and perhaps most importantly, Medicaid rules today permit payment for supportive housing costs in a nursing home, but not in waiver or similar programs. This drastically limits what we can do without losing federal financial support.

How have these obstacles served to direct the flow of long-term care dollars away from home- and community-based services? In 1996, when Act 160 was passed in Vermont, 88 percent of our state's Medicaid long-term care budget was spent on institutional care and 12 percent on home- and community-based alternatives.

Since then, although the number of people served through our home- and community-based waiver program has more than doubled, last year we still spent 74 percent of our long-term care dollars on institutional services, and 26 per cent on home and community based care.

We are by no means out of the mainstream when compared to other states. Nationally, in 1999, 74 percent of Medicaid long-term care expenditures were for nursing home services and only 26 percent for home- and community-based alternatives[1].

While clearly I think we can do better, I should note that I am proud of our health care providers—both institutional and otherwise—and think they do an excellent job of delivering care to our elderly and disabled. I am also proud of the active grassroots coalitions of citizens that have formed in recent years and that work at the local level to reach out to those in need and help them to remain in the community or successfully make the transition to another living arrangement when they can no longer manage on their own. But I think with the proper restructuring of Medicaid regulations, we can accomplish much more.

**Components of Reform**

[1] Source – Health Care Financing Administration

I cannot help but observe that there is a strong parallel in the long-term care world to what is being discussed in Congress with respect to prescription drug coverage under Medicare. First, these two benefits are among the largest expenditure items in most state Medicaid budgets, including Vermont's.

Second, I have heard a number of people make the observation that if Medicare was being designed from scratch today, it would never exclude prescriptions. That is because what made sense thirty-five years ago no longer makes sense, given the advances in medicine and changes in society that have taken place.

I think the same observation can be made about how long-term care services are funded and delivered. If a long-term care system were being designed from scratch today, I do not think we would conceive of building a system in which a bias is shown for institutional care, rather than for services designed to keep people independent in their homes or the community. Nor do I think we would segregate funding into two different programs – Medicaid and Medicare – such that the financial ramifications of a change to one program are ignored in the other.

Allow me to propose four reforms of federal policy with respect to long-term care:

- *Reform 1 – Allow greater state flexibility.* Federal policies should permit states to offer flexible benefits, for example, by permitting us to begin helping frail elderly and disabled persons before their condition is severe and when our intervention could actually do the most good. We have made a careful study of the concept of early intervention in Vermont over the past several years and have used what we have learned to design a potentially groundbreaking program, known as "Home Front". Under this program, elderly and disabled persons who do not qualify for Medicaid, but whose quality of life and health could be enhanced through minimal interventions, would be enrolled for a limited package of services. These services would be tailored to a person's particular needs, and might include environmental modifications to their home, assistance with home chores and so forth.

Because most of these people would be on Medicare and have Part B, the program would also seek to engage their personal physicians in the design of the benefit package.

In order for us to offer a limited benefit package under existing federal regulations, the Home Front program would require a Section 1115a Medicaid waiver. This in turn means we would have to be able to demonstrate to HCFA that the program would be budget neutral to the federal government, i.e., that the federal government would spend no more on Home Front than it would have spent absent the waiver. That, unfortunately, is a difficult test to pass, when these people theoretically were costing nothing before – nothing, that is, if only Medicaid is considered.

For the Home Front program, and others like it to be implemented, one of two things must happen. Either the budget neutrality tests for persons with dual Medicare and Medicaid eligibility must be modified to look across both programs or states must be given the flexibility to offer these kinds of benefits without going through the difficulty of obtaining an 1115a waiver.

- *Reform 2 – Remove the bias toward institutional care.* In a letter to the states issued by HCFA last year in the wake of the Olmstead decision, HCFA said, "…no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.[2]" I endorse that position and would offer a shorter, "New England" re-phrasing: <u>No one should ever need a waiver from the federal government to remain in their home.</u>

  It is important to note that a leveling of the playing field between non-institutional and institutional care will not result in massive new federal spending. The good news is that home- and community-based services, the

[2] State Medicaid Director letter, January 14, 2000.

services people prefer, are actually cheaper. In Vermont, the average annual Medicaid cost for nursing home care will be $48,000, while the average cost on our home- and community-based Waiver will be less than $20,000. The evidence from federal studies confirms that home- and community-based services are cost-effective, in part because they give states greater leverage as a payer. For example, a GAO study in 1994 concluded, "Home- and community-based services have helped control growth in overall long-term care expenditures by providing an important alternative to nursing facility care, thus helping states exercise greater control over nursing facility capacity and use[3]." And this conclusion was reached without considering any potential savings garnered for Medicare.

- *Reform 3 – Emphasize self-determination and independence.* A great deal of energy has been devoted of late toward crafting a patient's bill of rights. In the world of long-term care, there can be no more fundamental right extended to patients and their families than to have a voice in deciding where an individual is going spend the rest of his or her life. Granting this right again is dependent on the flexibility available to state Medicaid programs – making certain that states can intervene early and offer multiple options for care.

- *Reform 4 –Re-examine public financing.* As you can tell from my earlier references to Medicare, I believe the Medicare and Medicaid programs are inextricably linked when it comes to the world of long-term care. Most long-term care recipients in Vermont and other states are covered by both programs, with Medicare serving as the primary payer and Medicaid the secondary.

  Since 1996, Vermont and five of our neighbors have studied Medicare-Medicaid crossover issues through a group known as the "New England States Consortium". Working with Medicare data provided by HCFA – and

[3] "Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs", GAO-HEHS-94-167

not normally available to states – we have been able to develop a complete profile of our dually-eligible populations. From the work done by the Consortium, I can tell you that while dual eligibles represent only 17 percent of all Vermont Medicaid beneficiaries, they account for nearly half – 46 percent – of our Medicaid budget. Similarly, the Medicare program spends nearly twice as much on each dual eligible as it does on Medicare-only beneficiaries.

Clearly, assuring the fiscal solvency of both programs in the future will require that long-term care dual eligibles be addressed in a holistic fashion. If there are things that can be done within Medicaid through early intervention and other measures to reduce costs in Medicare, they should be allowed and encouraged. And the savings should be recognized on both sides of the ledger.

**Federal Action**

There are several things that the federal government can do to advance the reforms I have outlined. First, it can act on the proposal for comprehensive re-structuring of the Medicaid program put forth by the National Governor's Association in February. This proposal, which was adopted unanimously at the NGA winter meeting, and which Governor Don Sundquist of Tennessee and I presented to Secretary Thompson in June, calls for elimination of the complex, multi-year research and demonstration waiver application process that serves to choke off innovation at the state level. The proposal also restructures the manner in which federal matching funds are distributed, to enable states to implement creative programs like Home Front.

Second, the federal government should begin to formally assess the impact of Medicaid policy changes on costs to the Medicare program, and vice versa. At the state level, this would mean allowing states to count savings generated for Medicare through Medicaid waiver programs, like Home Front, when assessing their cost effectiveness.

On the federal side, it would mean examining in advance the likely impact on states of new Medicare rules, and using that information when judging the ultimate merits

of proposed new policies. For example, when Medicare reduced payment rates for home health providers, this compelled many states, including Vermont, to raise our Medicaid rates to these same providers, to ensure adequate networks were maintained to serve the Title XIX program. Since the federal government pays for a share of Medicaid expenses, the net result was higher costs for the states and lesser savings for the federal government than would be assumed if one just looked at home health expenditures within Medicare.

Congress can determine with HCFA whether legislation would be required to permit this sort of comprehensive financial test. If so, the Title XVIII and XIX statutes should be amended to allow it. Eventually, I believe that the federal government and states are going to conclude that the only sensible approach for financing the care of dual eligibles will be to integrate the funding streams and manage patient needs and costs through a unified care management system. In the interim, however, updating the accounting rules would be a good first step.

Third and finally, is the subject of prescription drugs. While I mentioned this topic only in passing before, I want to take the opportunity to urge adoption of a prescription benefit for Medicare beneficiaries, and to ask that, if the final legislation places major responsibilities in the hands of the states for low-income seniors, that this be done in such a way as to allow for flexibility and to not penalize states that have been leaders in this area.

In Vermont, we have offered for many years a subsidized prescription drug benefit to low-income seniors who do not qualify for Medicaid. Part of the cost of this program is paid for with federal dollars under our 1115a waiver. If a Medicare benefit is adopted, this could naturally be of great help to us, particularly with regard to financing care for the long-term care population, which has among the highest of prescription costs. My concern, however, is that we not see a repeat of what occurred with the State Children's Health Insurance Program (S-CHIP).

When that program was enacted, Vermont already had some of the most generous eligibility standards in the country. Rather than being recognized for our achievements, we were restricted from using S-CHIP dollars in any meaningful way and so derived

almost no benefits. I would urge you not to take the same path in crafting a Medicare prescription benefit, but instead to incorporate enough flexibility for states that all can participate fully.

In closing, I want to return to what I stressed at the beginning of my remarks. Now is the appropriate time for the states and federal government to join in partnership to build the right long-term care system for the 21st century--one that is compassionate and fiscally responsible, and that will be equipped to serve the growing ranks of elderly and disabled in the years to come.

Thank you Mr. Chairman and members of the Committee for the opportunity to appear before you.

The CHAIRMAN. I would like to welcome our next panel of witnesses, including Mr. David Hood, who is the Secretary of the Louisiana Department of Health and Hospitals; Mr. Ray Scheppach, who is the Executive Director of the National Governors Association; and Mr. Rich Browdie, who is Secretary of Aging in Pennsylvania, who will be speaking on behalf of the National Association of State Units on Aging.

Gentlemen, we welcome you and look forward to hearing your testimony.

David, we have you listed first, so if you would go ahead and begin, we'd appreciate it very much. And thank you for being with us.

**STATEMENT OF DAVID W. HOOD, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS, BATON ROUGE, LA**

Mr. HOOD. Thank you, Mr. Chairman.

I am David Hood. I am the Secretary of the Louisiana Department of Health and Hospitals, and it is certainly an honor to be here to discuss this very important topic with you and the committee.

Governor Dean and Mr. Browdie, who is going to testify, I understand, I have read their written statements, and I was very impressed. I applaud them for the clarity with which they outlined the challenges and problems that are facing States today, and also the thoughtfulness of their proposed solutions.

It is apparent that all States are having difficulty in making the transition to a long-term care system that provides services our senior citizens need and want, both today and in the future. Louisiana, on the other hand, represents a group of States which are actually very similar to States like Vermont and like Pennsylvania in the types of challenges and problems that they face. But there is wide disparity between the rich and the poor States with respect to their resources and their ability to address these problems.

I think the demographics tell the story, and I will cite just a few of them.

In Louisiana, 23 percent of our total population is below the Federal poverty level; 24 percent of our elderly population is below the Federal poverty level. And in that respect, we are not unlike most Southern States.

If you look at Northeastern States, on the other hand, 11 to 14 percent of their total population and 8 to 11 percent of their elderly are below the Federal poverty level. So there is a significant difference there.

Louisiana has 20 percent of its population uninsured, and in the Northeast, it ranges from 11 to 15 percent, again, a significant difference.

The statistics, for several Southern States are even worse than for Louisiana.

I wish I could find some solace in the fact that these affluent and socially progressive States, while making progress, are still having tremendous difficulty reshaping their long-term care systems to meet the challenge of the baby-boomer generation. Instead the difficulties that those States are having make the challenges seem even more imposing for the poor States of this Nation, such as Lou-

isiana. I think Vermont and Governor Dean have certainly set a high standard for us and have provided us with a model that we could all follow. Progress so far has been slow in our State.

Louisiana has acknowledged that our health care system is in need of reform and revitalization if we are to meet the demands of the 21st century. We have made significant progress providing coverage for uninsured children and also for persons with disabilities in terms of providing community services. But progress has been painfully slow in providing more choices and better care for our elderly.

Louisiana did pass a bill in this recent legislative session to form an Olmstead Planning Group, so we do hope change will occur at a faster pace now. We have also established a trust fund for the elderly to provide some financing for these new community-based services that we hope will be expanded. And we will be expanding them this fiscal year. We hope to double, for example, the number of elderly waiver slots that we currently have.

Governor Dean indicated that 26 percent of Vermont's long-term care budget for the elderly goes to home and community-based services and 74 percent to nursing homes. In Louisiana, the situation is much different. We in Louisiana are far below Vermont's level. We hope to reach 10 to 15 percent for community services within the next few years.

There is a natural tendency to take care of the most urgent problems first, and I think Louisiana is no different in that respect. We tend to leave future problems for the future, and this is changing in some respects with our emphasis on primary care, coverage of children, and so forth. And we certainly need to quicken the pace with respect to our elderly population.

Nursing homes occupy nearly all of Louisiana's long-term care budget for the elderly. Nearly $600 million this year in direct payments to nursing homes will be made, plus $200 million for drugs, for physician services, and for various therapies and other services are paid separately. So we spend a total of about $800 million on our 25,000 or so nursing home recipients.

I think we would all agree that nursing homes are a vital part of our continuum of care, and they will be for the foreseeable future. Certainly this requires that we pay adequate rates to assure good quality of care in those nursing homes. Governor Dean mentioned $130 a day in Vermont. We pay about $80 a day in Louisiana, and that was after a recent very significant rate increase for our nursing homes. So there is a wide disparity there as well.

We also want to be certain that as much of the money as possible that we pay to nursing homes actually reaches the patient and that it goes to direct care for those patients.

One thing we need to do in Louisiana, like in Vermont, is to reduce overcapacity and to encourage our nursing home industry to diversify into other methods of delivering care to our elderly population. Our occupancy rate 15 years ago was about 95 percent. Today, it is about 80 percent. We are over-built. We have too many nursing home beds.

I would certainly agree with Governor Dean and Mr. Browdie that both Medicaid and Medicare need to be reformed and restructured with much thought given to what the impact of change in one

program might have on the other. For example, the Balanced Budget Act of 1997 implemented cuts in Medicare payments in many areas, including SNF care for the elderly, that had a direct impact on our Medicaid program in Louisiana.

I would summarize our recommendations for change with two words: funding and flexibility. We certainly would benefit in Louisiana from additional assistance in the form of enhanced match rates that would provide incentives to expand home and community-based services. In Louisiana, this provided an incentive for our LaCHIP program to expand, and in terms of enrollment, it is one of the best in the entire country. We think an enhanced match rate will work just as well for our senior citizens, and I totally understand what Governor Dean has said about not putting States that are ahead of the curve at a disadvantage here. But in Louisiana, the money would certainly be very helpful.

Waivers are administratively cumbersome and need to be simplified. Governor Dean suggests cost-effectiveness calculations should include the impact on Medicare, and we would wholeheartedly agree with that.

The concept of having to get a waiver at all simply proves that the medical model that forms the basis of Medicaid and Medicare law is outdated. It is expensive, and in the case of long-term care, it fails to meet the true needs of much of our elderly population.

However, waivers provide a mechanism for States to control entry into home and community-based services, which have high demand and long waiting lists in poor Southern States. If they were converted to State plan services, a State such as Louisiana would be overwhelmed. Everyone's needs would have to be met immediately. This needs to be taken into account as we consider reforms.

And, last, I would completely agree with Governor Dean and many others that a prescription drug benefit under Medicare in particular would keep people healthy, keep them out of nursing homes, out of hospitals, and we would certainly hope that will occur at some point in the near future. Otherwise, there will be tremendous pressure on States such as Louisiana and other poor States in the country.

Mr. Chairman, that concludes my oral remarks.

[The prepared statement of Mr. Hood follows:]

# Caring for Our Aging Citizens
## *The Louisiana Perspective*

Testimony of
**David W. Hood**
Secretary
Louisiana Department of Health and Hospitals

To the United States Senate
Special Committee on Aging
**Senator John Breaux, Louisiana, Chairman**

Wednesday, July 18, 2001

## I. Introduction

Senator Breaux and members of the Committee, thank you for inviting me to testify about issues facing older citizens in Louisiana, and the challenges before our State in meeting the changing needs of today's aging population.

As the head of the agency most responsible for setting health care policy and administering services in Louisiana, let me begin by briefing you about the overall state of health care in Louisiana. During the administration of Governor Mike Foster, the State of Louisiana has made significant strides toward improving health care for the citizens of the State. The first, and perhaps most important step, was to establish a solid base of financing in order to provide and enhance the health care services needed in Louisiana.

This was accomplished in the first year of this Administration when we had to balance our budget with one billion dollars less in federal funding than the previous year ... 1996. We have now stabilized our budget, while at the same time we focused our resources on programs and services that provide the most appropriate care and the best health outcomes to those we serve.

Since then, the thrust of our efforts have been to decrease the rate of uninsured children in Louisiana, and improve and increase services for our citizens with disabilities. In both of these cases we have been successful – we have created one of the nation's best Children's Health Insurance Program (LaCHIP) and we have made more community-based services available to people with disabilities.

Most recently, we have developed a comprehensive plan to *Fix the State's broken health care system* by increasing access to primary care to improve health outcomes. This is important because almost all health care in Louisiana centers around institutions ... including services for the elderly ... while the health care delivery system has moved increasingly to out-patient and community-based settings as a result of technological advances and financing changes.

But, the focus today is long-term care, and the challenges we face in Louisiana in order to develop a comprehensive continuum of long-term care for the citizens of our state.

I am pleased to be here today to testify about the state-of-the-state of long-term care in Louisiana, the steps we are taking to improve the system, the challenges we face, and make recommendations that we believe are necessary to help states such as Louisiana.

**II. Profile of Louisiana's Population (Age and Income)**

Let me describe Louisiana. Our state is not unlike many other poor states, particularly southern states that have a high percentage of people who are eligible for Medicaid. But, our population is aging much like the rest of the country. People over age 65 represent 11.6 percent of our total population, compared to 12.4 percent nationally. Our elderly population is also growing at a rate currently a little less than the national average – 10.2 percent compared to 12 percent.

But, it is anticipated that this rate will accelerate so that by the year 2020, the elderly population will increase by nearly 60 percent (over 300,000 more people).

The income levels of our citizens is an area where we see significant differences between Louisiana and many other states. By almost all measures, Louisiana's elderly are among the poorest and most vulnerable in the country. According to federal statistics, the percentage of older people with incomes below the poverty level is second highest in the nation.

The difference between Louisiana and the national average for poverty rates for seniors is almost double – 24.1 percent in Louisiana versus 12.8 percent nationally (Census 1990). And, we do not expect this statistic to get better. In fact, it is just the opposite – as our population ages, the number of those people living in poverty is expected to increase. This is also true for elderly people with disabilities.

What does this mean?

- First, we have a high proportion of people who are eligible for Medicaid. Louisiana is third in the number of elderly citizens receiving Medicaid (17.3 percent in Louisiana versus 11.1 percent nationally.)
- We have a high proportion of our elderly citizens who live alone.
- We have the second highest potential demand for publicly-funded long-term care.

# Profile of Age Characteristics for the United States and Louisiana

| Age Group | US Total | | | | | Louisiana | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1990 | 2000 | 2020 (Est.) | Percent Change | | 1990 | 2000 | 2020 (Est.) | Percent Change | |
| | | | | 1990 - 2000 | 2000-2020 | | | | 1990 - 2000 | 2000-2020 |
| **Total population** | 248,709,873 | 281,421,906 | 324,927,000 | 13.2% | 15.5% | 4,219,973 | 4,468,976 | 4,991,235 | 5.9% | 11.7% |
| **60 to 64 years** | 10,616,167 | 10,805,447 | 20,696,000 | 1.8% | 91.5% | 170,977 | 170,287 | 313,418 | -0.4% | 84.1% |
| **65 to 74 years** | 18,106,558 | 18,390,986 | 31,462,000 | 1.6% | 71.1% | 275,008 | 282,925 | 489,171 | 2.9% | 72.9% |
| **75 to 84 years** | 10,055,108 | 12,361,180 | 15,508,000 | 22.9% | 25.5% | 150,350 | 175,328 | 238,428 | 16.6% | 36.0% |
| **85 years and over** | 3,080,165 | 4,239,587 | 6,764,000 | 37.6% | 59.5% | 43,633 | 58,676 | 94,002 | 34.5% | 60.2% |
| **60 years and over** | 41,857,998 | 45,797,200 | 74,430,000 | 9.4% | 62.5% | 639,968 | 687,216 | 1,135,019 | 7.4% | 65.2% |
| **65 years and over** | 31,241,831 | 34,991,753 | 53,734,000 | 12.0% | 53.6% | 468,991 | 516,929 | 821,601 | 10.2% | 58.9% |
| **75 years and over** | 13,135,273 | 16,600,767 | 22,272,000 | 26.4% | 34.2% | 193,983 | 234,004 | 332,430 | 20.6% | 42.1% |

Source:
http://www.census.gov/population/www/projections/natdet-D1A.html
http://www.census.gov/population/www/projections/st_yrby5.html
http://www.census.gov/Press-Release/www/2001/sumfile1.html
able DP-1. Profile of General Demographic Characteristics for the United States: 2000 and 1999)

### III. The Changing Demographics

In less than 15 years, the Baby Boomers born between 1946 and 1964 will age into the status of senior citizens. As this incredible volume of Louisiana residents join the ranks of the elderly, the working population needed to support this fast growing older group will, instead, be declining.

When compared to other states, Louisiana is not gaining population at the same rate. In fact, for our younger, educated citizens who are seeking opportunities outside the state, the population is getting smaller. They are leaving to attend colleges in other states, with the likelihood that they will not return, or they are leaving for better paying jobs in other states once they complete their education.

Changes in the modern family structure will also have an impact. No longer is the two-parent, two-child family the norm. Census 2000 statistics show that single-parent families are rivaling the traditional parent family in Louisiana. As they age, these single parents who do not have family supports in place will face greater reliance on publicly-funded health care. Also, the increasing "never-married" population will not have the traditional family supports.

Research suggests that the two most important resources for Baby Boomers to take into their later years are income and education. But in Louisiana, these are scarce resources. Compared to Baby Boomers nationwide, that same group in Louisiana has lower household incomes and lower education levels.

When these facts are combined with the outward migration of an able-bodied, well-educated workforce, the increased life expectancy, high poverty rates, expenses associated with aging, increased health care costs and other factors, Louisiana is facing a critical future when it comes to caring for our older citizens.

### IV. Louisiana's Health Status

Compared to the rest of the nation, Louisiana continues to rank near the bottom for most key health indicators. Adjusted for age, we rank first in the death rates for diabetes and cancer, and we rank in the top 10 for other chronic diseases such as heart and cerebrovascular diseases.

As I mentioned earlier, over the past six years, we have taken some significant steps to address these poor health statistics, but these long-term strategies ... especially those targeted to our children ... will take time to show results.

There are a number of factors that contribute to our poor health status. Of course, our high poverty rate is the key factor. Other factors include:

- A continued lack of access to primary care – 6th to worst in the nation.
- A high rate of uninsured people – 4$^{th}$ highest.

- The fourth highest rate of people who rely on public insurance (Medicare and Medicaid).
- Very poor lifestyle factors: high rates of smoking and obesity, poor diets, poor rates of exercise.
- And, we're ranked 44th in the percent of people covered by private insurance.

### V. Current Long-Term Care Resources

The current state of long-term care in Louisiana revolves around nursing homes. Although other options exist, such as assisted living facilities, home and community-based services (waivers) and home health care, Louisiana still relies on nursing homes to almost the near exclusion of other options.

According to the Administration on Aging, overall, Louisiana has a rating of "below average" for its progress toward a Home and Community-Based Services system.

> *"Louisiana has a very high public demand on long-term care services. The state has the second highest number of nursing home beds per 1000 age 85+ in the nation; however, nursing home occupancy levels and resident acuity levels are both very low."*

Although we are making progress in this area, the above statement is true. In Louisiana, older residents who might only need intermediate care have few options other than admission to a nursing home.

In the Medicaid program, nursing home expenditures account for nearly $500 million yearly. Until it was recently eclipsed by the pharmacy program, for years this consumed the greatest portion of all Medicaid spending in Louisiana. As the chart below indicates, nursing home expenditures greatly exceed spending for all other community-based services for the elderly combined.

**Medicaid Spending on the Elderly and MR/DD Clients**
*(as reported March 2001)*

| Category | 1992/93 | | 1995/96 | | 1999/00 | | 2000/01 * | |
|---|---|---|---|---|---|---|---|---|
| | Spending (in millions) | People Served | Spending (in millions) | People Served | Spending (in millions) | People Served | Spending (in millions) | People Served |
| Private ICF/MRs (group homes) | $166 million | N/A | $159.5 | 3,786 | $169.9 | 3,602 | $175.1 | 3,627 |
| Nursing Homes | $500.4 | N/A | 503.4 | 26,206 | 491.9 | 25,197 | $490.9 | 24,621 |
| DHH Long-Term Care Facilities | $14.5 | 442 | $17.7 | 436 | $19.7 | 424 | $19.6 | 394 |
| State MR/DD Centers | N/A | N/A | $140.9 | 1,982 | $172.2 | 1,737 | $157.2 | 1,710 |
| MR/DD Waiver | $8.02 | N/A | $39.4 | 1,900 | $93.7 | 3,495 | $128.5 | 4,251 |
| Elderly Waiver | 0 | 0 | $2.5 | 156 | $4.08 | 366 | $4.9 | 679 |
| Adult Day Waiver | $1.3 | N/A | $1.4 | 217 | $2.23 | 328 | $2.4 | 500 |
| PCA Waiver | N/A | N/A | $1.5 | 115 | $1.8 | 113 | $1.8 | 121 |

** projected for end of FY 2000/01*

Although we have made small strides in providing more home and community-based care for our senior citizens, Louisiana still lags behind most other states. According to a study done by researchers at the University of California for the Health Care Financing Administration (1997 data):

- Louisiana ranks 49th of the 50 states in using home and community-based care services. But, since that time, we have expanded our use of the program for people with disabilities. We still need to provide more of these same opportunities to our aging citizens.

- Louisiana spent $109 per capita on nursing home expenditures versus only $1.33 per capita on community-based services.

- In 1995/96, we served 26,206 people in nursing homes but only 488 in the community.

Because of this over-reliance on nursing home care, there is an oversupply of nursing home beds while there are people who must wait years for community-based services.

Assisted living for Medicaid patients is still on the drawing board. Although we have developed an assisted living pilot project, budget deficits in the Medicaid program did not allow this

program to be implemented.

Also, changes at the federal level resulting from the Balanced Budget Act have greatly reduced the number of home health agencies operating in Louisiana. Home health is a vital component of the continuum of care for elderly citizens who do not want to utilize a nursing home when they get older and need some assistance in daily living activities.

### VI. Future Needs and Demands for Long-Term Care

For many elderly citizens, nursing homes have been the only option in Louisiana. And because there has not been a hue and cry from the elderly community, elected officials and policymakers have been slow to seek out and fund alternatives. This is about to change. Baby boomers represent a generation of people who are used to having choices when they are seeking services and getting what they want, even if they have to create it themselves. They are likely to continue demanding choices so that they can remain independent as long as possible.

This fact is readily apparent in the private pay arena where assisted living facilities are springing up like fire ant mounds after a good Louisiana rain. Although they are expensive, there is a great demand among those who are able to afford it.

But for lower income Louisianians ... for most Louisianians ... these are not options.

In addition, we anticipate demand for private rooms in nursing facilities, assistance in the home, transportation for the elderly who live in rural communities and foster care for the elderly.

### VII. Recommendations

The challenge for Louisiana, as well as for the rest of the nation, is to get ready, and get ready quick, in order to meet the needs of our aging citizens. We have been preparing to serve those needs by expanding choices for our elderly citizens, but progress has been slow. To some degree, we are getting ready. The Supreme Court's Olmstead decision has motivated states to make community-based services not only a choice, but a reality. While Olmstead will quicken the pace of progress it will not provide easy solutions for a state like ours.

Here are some examples of the progress we are making:

- Just this past Legislative Session, lawmakers approved a measure that requires advocates, policymakers, and health care providers to work together to plan for enhancing community-based alternatives and end Louisiana's institutional bias.

- We were also successful in getting help from Senator Breaux for additional federal funding that has allowed us to expand community-based services for the

elderly. Over the next 12 months, our slots for community-based services will increase by 600 slots to a total of almost 1300 slots.

- Our BluePrint for Health plan to improve our public health care system is designed to decrease the institutional bias in Louisiana. When fully implemented, we will have a healthier population that has greater access to primary care, and to more community-based services.

- We are examining the federal Program for All-Inclusive Care for the Elderly (PACE) that provides some community-based services and nursing home alternatives. Unfortunately, this program that pools Medicare and Medicaid funds relies on a managed care model, but Louisiana does not have much managed care penetration.

- We have applied for a Real Choice Systems Change grant that will allow us to accomplish the planning necessary to adapt Louisiana's long-term care system to the needs of the future by enhancing the infrastructure for community-based services.

- We must seek to ensure adequate rates to nursing facilities and other long term care providers to ensure that quality care is provided – whether in institutions or in community settings.

- We must encourage and create incentives for nursing facilities to diversify the services they provide to include other long term care services (subacute, assisted living, adult day health, etc.), thereby reducing excess capacity while increasing choice.

- We must work to build a continuum of quality long term care services that provides options to the elderly appropriate to their needs and desires – nursing facilities, assisted living facilities, adult day health care, in-home care as well as provide relief to family caregivers.

- We must seek the funding, and then begin to implement the recommendations of the Medicaid Assisted Living Task Force.

Meaningful change will also require federal intervention. Both Medicare and Medicaid were implemented in 1965, and for most intents and purposes have not changed significantly over the past 35 years. And, as I have pointed out, Medicare and Medicaid are designed on the medical model or institutional standard of care that is quickly becoming outdated.

Both Medicare and Medicaid must be restructured to conform to the changing health care needs

of our citizens, as well as to conform with the changing demographics of society ... more elders

living alone, lower birth rates that mean we'll have fewer able-bodied adults to support the aging population, more one-parent families with fewer children.

Should such a comprehensive restructuring take place, I would urge Committee members to see to it that changes are coordinated to occur within both programs. Attempting to reform only Medicare will result in significant and costly impacts to Medicaid, and therefore, to the budgets of all 50 states. Reform must be programmatic as well as fiscal to ensure the solvency of the Medicare Trust Fund while also maintaining the mission of providing care for our most vulnerable citizens.

Let me give you a few examples: Within the Medicare program, there is no option for non-medical services; therefore, the onus for community services falls upon the Medicaid program. And, because there is not a Medicare a prescription drug benefit, states and state Medicaid programs shoulder this burden.

With respect to the Olmstead decision, there is no role or responsibility born by Medicare ... with once again, the states shouldering the load.

Congress' reauthorization of the Older Americans Act last year will help tremendously in the efforts to address the needs of aging baby boomers. Additional assistance for the states in the form of enhanced match rates for long-term care and other community-based services not covered by Medicare would also be helpful. Just as has been done with children's health insurance, these enhanced match rates will make it more attractive for states to enact early and meaningful change in how they provide long-term care, especially community-based options. By providing such federal assistance, there are potential cost savings because people can choose to delay entry into institutional care.

Other recommendations include:

- Additional funding for research, planning and alternative policy for long term care services across the entire continuum of long term care.
- Provide tax credits for caregivers, and for long-term care savings accounts or the purchase of long-term care insurance.
- Support for workforce development initiatives that will assist in recruiting, training and retaining workers to provide long-term care services (such as nursing staff, personal care attendants, and others).
- Modification of Social Security earned income limits to permit the elderly to work

to meet their own needs.

- Reforms targeted at long-term care insurance (greater uniformity in benefits, greater affordability including subsidies for low and moderate income families, greater access through employers).

- Encourage affordable housing options, including paying room and board for nursing home alternatives.

### VIII. Summary

In conclusion, just as you and other members of Congress recognize the importance of reforming the Medicare program to meet the needs of our senior citizens, I would urge a more comprehensive look at the entire continuum of long-term care for seniors.

Louisiana's baby boomers have grown up with the concept of choice – choices in how they choose doctors, choices in what day care they use or where they send their children to school. To turn around and deny them choices when it comes to long-term care is counter to the way they have lived their entire lives.

These same individuals also desire to be in control. They do not want to give up their life savings just to become eligible for payment for nursing home care. Instead they want to work as partners with their families and medical professionals to determine their needs and how those needs can best be met.

Freedom. Control. Choice. Three simple concepts ... none of which are found in today's publicly-assisted long-term care programs. Yet, these concepts should form the basis for systemic and fundamental reform. Now is the time for a working partnership between the states and the federal government to design a long-term system of care that meets the needs of today's baby boomers – tomorrow's seniors.

The CHAIRMAN. Thank you very much, Secretary Hood.

Now we will hear from Mr. Ray Scheppach, who is Director of the NGA.

**STATEMENT OF RAY SCHEPPACH, EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION, WASHINGTON, DC**

Mr. SCHEPPACH. Thank you, Mr. Chairman. I appreciate being here on behalf of the Nation's Governors.

The current health care system serving the Nation's elderly is a patchwork system built for another age. It no longer services our citizens, nor does it permit States to provide 21st century solutions. Medicare's coverage has many gaps: preventive care, prescription drugs, and long-term care. In their absence, States have filled the gaps with many small, innovative, but effective programs. Although we have done exciting and innovative things, the patchwork of programs and services that we have put in place is no substitute for a comprehensive vision of long-term care. And the programs are essentially getting much more costly.

Currently, Medicaid is about 20 percent of State budgets. It has now jumped up to be growing between 10 and 12 percent per year. It is squeezing out education funding. And as we look forward, we really don't believe States have the fiscal capacity to continue this funding, particularly when you look at the growth of the over–85 population between now and the year 2010 and, of course, the overall elderly population growth between 2010 and 2030.

States have been doing a number of innovative programs: home and community-based waivers. These allow States to provide alternatives to nursing home care through Medicaid. More flexibility, as has been previous mentioned, is needed in this area. Innovations, such as PACE and other programs, capitated rates which combine Medicare and Medicaid spending, are good experiments. There are a lot of information programs. State pharmacy assistance programs are now in 26 States, and States are spending over $400 million now on drugs for the elderly. We have cash and counseling programs in several States and partnerships for long-term care to help States work with the private sector and individuals to fund long-term care insurance. Many of these are being done with State-only dollars.

If you ask what the Federal Government can do, one thing I would like to say is that the Governors passed a very comprehensive policy at the last winter meeting that called for a fairly major reform of Medicaid. If you look at Medicaid, you find now that only about 40 percent of the funding is actually in entitlements for required populations. Essentially 60 percent of the funding in Medicaid is now for optional benefits and optional populations. Yet the problem is that once you include one additional individual, they have to get the complete menu of services. So allowing States a lot more flexibility in how they can mix and match those particular benefits of the program would go a long ways toward stretching the Medicaid dollars.

We also need help in Olmstead compliance. We need to work with other agencies such as HUD and Labor where we can develop more comprehensive programs with those agencies. We also could use an enhanced match for home and community-based care, and

also, although Secretary Thompson has been very, very good at expediting waivers during the last several months, he is limited by Federal law on the waivers, and perhaps an expanded waiver bill that would provide States with more flexibility for just the home and community-based case could be an effective strategy in the short run.

Thank you, Mr. Chairman, and I would be happy to answer any questions.

[The prepared statement of Mr. Scheppach follows:]

*Parris N. Glendening*
Governor of Maryland
Chairman

*John Engler*
Governor of Michigan
Vice Chairman

*Raymond C. Scheppach*
Executive Director

Statement of

RAY SCHEPPACH, EXECUTIVE DIRECTOR
NATIONAL GOVERNORS ASSOCIATION

before the

SENATE SPECIAL COMMITTEE ON AGING

on

STATE INNOVATIONS IN LONG TERM CARE

July 18, 2001

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Mr. Chairman and members of the committee, my name is Ray Scheppach, and I am the Executive Director of the National Governors Association. I appreciate the opportunity to appear before you today on behalf of the nation's Governors on the critical issue of long-term care.

**Introduction**

Increases in life expectancy and the aging of the baby boom generation are contributing to unprecedented growth in the population older than sixty-five. Similarly, improvements in medical technology are contributing to an increasing number of individuals with physical and other disabilities that are living longer, healthier lives. These growing populations are fueling an increasing demand for primary, acute, and long-term health care services. At the same time demographic and cultural changes are decreasing the availability of informal care. These factors will place a significant strain on our nation's current long-term care system, on beneficiaries and their families, and on current sources of public and private funding for these services.

One of the most important responsibilities of state and federal government is to protect and improve the health of our nation's citizens. The federal government, through Medicare and Social Security has been enormously successful in reducing the number of seniors living in poverty and in providing for some of the most basic health care needs of seniors and individuals with disabilities. However, there have always been significant gaps in Medicare's coverage. The most important gaps are for preventive care, prescription drugs, and long-term care. Additionally, there are significant beneficiary cost-sharing responsibilities. As a result, Medicare covers on average only about one-half of beneficiaries' health care costs.

Because Medicare does not fully address the long-term care needs of the nation, states (through Medicaid and state-financed programs) are facing an expanding range of long-term care challenges. Individuals and families, who already play a significant role in financing and delivering long-term care services, are under pressure to provide more assistance to their aging spouses and parents. There is a growing demand to increase the supply of long-term care providers and to develop new alternatives, services, and settings in long-term care. Moreover, there is an increasing need for government to integrate and streamline fragmented programs to be more client-friendly, cost-effective, and to assure quality service delivery.

Although these are significant challenges, we are confident that the answers are within our grasp. The Governors believe that greater flexibility for states and a new federal-state partnership are keys to developing innovative and improved systems of long-term care.

**State Innovations in Long Term Care**

To meet their long term care needs, states have undertaken a wide-range of innovations. The following sections will highlight certain categories of state innovation and initiatives in the area of long-term care and, where possible, identify examples of specific state programs and achievements.

Home and Community Based Care Waivers

Section 1915(c) of the Social Security Act, adopted in 1981, was intended to correct an "institutional bias" in Medicaid services for the chronically ill by providing states an alternative of offering a broad range of home and community-based care services to persons at risk of institutionalization. Prior to this, the only comprehensive long-term care benefit in Medicaid was care in a nursing home.

For 20 years, states have made these waivers the backbone of the delivery of home and community-based care. There are more than 250 programs now in operation and every state operates multiple programs providing a broad range of medical and important social services for frail seniors and individuals with physical, mental and developmental disabilities. Many states offer programs for other populations such as individuals with traumatic brain injuries, persons with HIV/AIDS, or children with mental illnesses. Essentially everything we have learned at the state level about the provision of home and community-based care has arisen from our experience with these programs.

Congress did not, however, authorize the states to provide these services with automatic approval. States were forced to make a special application to the HHS for each of their specific programs. These programs were time-limited and were paperwork and resource-intensive. Although the federal government has worked very closely with states to ease these burdens, there is still much that needs to be done to make the system better. At the core of that discussion is to what extent it makes sense for programs that are cost-effective, highly desired by beneficiaries and their families, and have been in operation for 20 years to still require waivers to operate.

Overcoming Barriers to Care

Several state initiatives are aimed at overcoming barriers to care for the 6.4 million seniors and individuals with disabilities dually eligible for coverage under the Medicare and Medicaid programs. Innovations in this area are designed to integrate Medicaid's long-term care benefits with Medicare's acute care coverage. Two kinds of programs have been adopted by numerous states: the Program of All-Inclusive Care for the Elderly (PACE); and the Medicare/Medicaid Integration Program (MMIP) sponsored by the Robert Wood Johnson Foundation.

- ***PACE*** projects provide for a full-range of acute and long-term care services, often in an adult day care setting, using a Medicare and Medicaid capitated payment system. The Balanced Budget Act (BBA) of 1997 provided for expansion of PACE projects nationwide. Twenty-five PACE sites are operating in 14 states and are planned for an additional 10 states.

- ***MMIP*** projects seek to integrate Medicaid's long-term care services with Medicare's acute services through managed care for the dually eligible. MMIP projects are currently underway in 13 states.

Addressing Workforce Issues

To address the ongoing shortage of nursing home and home health aides who are critical to meeting the long term care populations, states have undertaken a range of initiatives. Some examples of these efforts include:

- ***Iowa's*** Certified Nursing Assistant (CNA) Recruitment and Retention Project. Passed by the legislature and approved by the Governor, the project was conducted at eight nursing facilities. Its purpose was to reduce CNA turnover by providing programs and services that responded to the needs that direct care workers identified. Interventions were implemented at some facilities while other nursing homes served as a control group.

- ***Michigan's*** dedication of $1.7 million in tobacco tax funding to state innovation grants, formation of a state stakeholder commission, and funding for staff positions designed to address workforce capacity and quality issues.

- ***Oregon's*** ballot initiative mandating a commission to examine home care workforce issues.

"Cash and Counseling" and Family Caregiver Support Programs

Related to the home health and nursing home aide shortages, are consumer directed care and family caregiver support programs. To provide people of all ages with long-term disabilities with greater choice in selecting their own personal assistance workers, states have undertaken a variety of initiatives. Several states are involved with projects sponsored by the U.S. Deportment of Health and Human Services and the Robert Wood Johnson Foundation known as "Cash and Counseling projects." Additionally, to support caregivers providing ongoing long-term care assistance to family members, states have implemented a wide range of caregiver support programs.

- ***Cash and Counseling Programs*** exist in three states, Arkansas, Florida and New Jersey, and enable persons with long-term care needs to hire and retain their own personal care attendants. As part of the program, persons with long-term care needs are provided with a direct cash allowance to hire personal assistance workers (which may include friends and relatives) and are provided with counseling regarding bookkeeping and services management.

- ***Family Caregiver Support Programs*** exist in or are being planned for almost every state as a result of the enactment of the National Family Caregiver Support Program -- part of the Older Americans Act reauthorization last year. In addition to these federally supported programs, many states have initiated family support

programs using state general fund or tobacco tax revenues. Among the larger and older programs of this kind are family support programs operating in California and Pennsylvania. California's program provides information, education and support to caregivers of adults with a wide range of cognitive impairments. Pennsylvania has a similar program that also allows caregivers under the age of 60 to purchase new services or supplies to assist them in their caregiver responsibilities. For example, these supplies might include materials to make home modifications.

State Funded Program Innovations

To supplement federal/state funded programs such as Medicare, Medicaid and Older Americans Act programs that provide long-term care services, states have also implemented programs funded only with state and/or local revenue. Generally, state/locally sponsored programs offer a wide variety of long-term care services that enable individuals who need assistance to remain in their homes. They also provide services to individuals that would otherwise not qualify for means-tested programs like Medicaid. States have used a variety of state funding sources to finance these programs including general revenue, county property taxes, tobacco settlement funds, and state lottery funds. Examples of these kinds of programs can be found in California, Florida, Indiana, Ohio, and Pennsylvania.

State Pharmacy Assistance Programs

In response to the need to provide senior citizens in their states with assistance in meeting the high cost of pharmaceuticals, states have been leaders in developing pharmaceutical assistance programs. Almost half of the states have pharmaceutical assistance programs in operation, and many other states are developing programs. The majority of state pharmaceutical assistance programs provide benefits through direct subsidy or discounts. There are other options, however, including tax credits or measures that reduce retail prices, such as bulk or cooperative purchasing programs and drug buying pools. More recently, states are experimenting with Medicaid waivers (under Section 1115 of the Social Security Act) to provide the Medicaid prescription drug discount price to other residents, such as those eligible for Medicare.

In operation since the 1970's and 1980's, New Jersey, New York, and Pennsylvania's programs are three of the largest and oldest state-only pharmacy assistance programs. In 1999, enrollment in these three programs accounted for 71 percent of all state assistance program enrollees. All three states provide coverage to low to moderate-income beneficiaries age 65 or older through direct subsidy programs. Eligibility income levels range from $14,000 to $35,000 for singles and from $17,000 to $50,000 for married couples. While seniors are generally pleased with each program, they cover large populations and carry an annual cost of almost $400 million.

Retirement Planning Efforts

Several states have engaged in efforts to encourage their citizens to plan to meet their own retirement needs. These efforts include Partnerships for Long-Term Care and individual state efforts.

- ***Partnerships for Long-Term Care*** are programs that exist in Connecticut, Indiana, California and New York that represent public/private alliances between state government and insurance companies to create long-term care insurance programs.

  Originally sponsored by the Robert Wood Johnson Foundation, the programs use two approaches: the "Dollar for Dollar" model and the "Total Assets" model. Under the Dollar for Dollar model used in Connecticut, Indiana, and California, long-term care policies of varying length and scope are covered by the state's insurance division. Policies must provide at least one year of coverage at the time of issue. Once benefits under the private long-term care policy are exhausted, an application for Medicaid can be made using special eligibility rules. Every dollar paid out by an insurer through a certified policy is deducted from the resources counted toward Medicaid eligibility. Under the Total Assets model used in New York, once policies are certified by the state, they must cover three years in a nursing home or six years of home care. Once benefits under the private policy are exhausted, the Medicaid Eligibility process will not consider assets at all. While total asset protection is provided, individual income must be devoted to the cost of care.

  While successful, current federal law prohibits the expansion of these programs beyond these four models.

  - ***Individual State Efforts*** such as those undertaken in Michigan are aimed at increasing understanding of long-term care needs and the necessity to save for them. Michigan has dedicated $3 million in tobacco tax funding annually toward this goal. Accordingly, beginning in September, 2001, a media campaign including radio, TV, print media, a new web page and a toll-free telephone number will be launched to provide citizens aged 35 to 65 with information about a range of long-term care financing vehicles including long-term care insurance, annuities, and medical/retirement accounts.

Single Point of Entry Programs

A number of states have instituted single point of entry or "no wrong door" programs designed to assist seniors in obtaining the services they need regardless of income levels or where they first go to obtain help. For example:

- ***South Carolina's*** legislatively mandated Senior Access program provides a single point of entry system for seniors in 9 of 46 counties in need of long-term care services. Local Councils on Aging serve as the Senior Access agency receiving intake information on people seeking in-home services. Via an automated referral

system, financial eligibility for Medicaid waiver services is determined. Nurses make in-home functional assessments. If eligible, clients are enrolled for Medicaid waiver services. If ineligible, the council on aging enrolls clients for other appropriate federal and state funded services such as personal assistance and chore service.

- ***Indiana's*** single point of entry program utilizes the 16 Area Agencies on Aging covering all 92 counties in the state. Funding for this program that integrates 11 separate federal, state, and local funding streams has increased from $98.5 million to in 1995 to $237 million in 2001. Assessments are made for all in-home and nursing home services. Long-term care services are based on individual need and are available to people of all ages. If an individual can afford to pay for all or a portion or the cost of services they do so in accordance with a sliding fee scale. Developed in 1992, the infrastructure for this comprehensive approach is updated periodically to account for changes in law.

Increasing Assisted Living/ Housing for Low and Moderate Income Seniors

Several states have engaged in efforts to increase the number of available assisted living and senior housing units available to low and moderate-income persons. Innovations in this area include:

- ***Iowa's*** Senior Living Trust Fund, which provides financial assistance to nursing facilities to convert nursing home beds to assisted living programs. Participating facilities must serve at least 50% Medicaid clients and give up a certified nursing home bed for each assisted living bed created. Development grants are also available to any type of provider for developing alternative services (other than assisted living) such as adult day care, respite, home health, transportation and PACE. Grantees must demonstrate goals of providing alternative services to underserved populations and underserved areas of the state. In the first year, 76 applications were received, with $20,000,000 in funding available in the second year.

- ***Maine's*** state funded assisted living program, which supports 210 units of assisted living statewide. The program requires cost sharing by participants and takes into account not only income, but assets as well. Program costs run approximately $325,000 per unit, and $15,000 per person annually.

- ***The Coming Home Program*** of the NCB Development Corporation, in partnership with the Robert Wood Johnson Foundation, which provides three-year grants of $300,000 to nine states willing to make regulatory and reimbursement changes necessary to foster affordable assisted living for low-income seniors – usually in rural areas. Grantees are provided with technical assistance on state policy issues, a revolving loan fund, and assistance to local sponsors who wish to develop affordable assisted living.

- ***Michigan's*** Affordable Assisted Housing Project undertaken by Area Agencies on Aging, a two county regional center (both entities being designated to implement waiver services) and the State Housing and Development Authority. The project demonstrated the benefits of coordination between the Home and Community Based Waiver program and the Section 8 Rental Assistance program. Initial program participants were waiver clients on the state's waiting list for Section 8 rental assistance vouchers. The average value of combined public subsides was $1,540 per month, including $320 in housing vouchers and $1,220 in waiver services. Of elderly participants, the average age was 77 – with most choosing to remain in their existing homes.

Self-Sufficiency Efforts

Several states have encouraged seniors to remain physically self-sufficient through health promotion and disease prevention projects and via positive aging initiatives. Examples of these kinds of programs include:

- ***South Carolina's*** In-Home Prevention Services for Seniors (IHPSS) program, which targets seniors in 13 rural counties aged 65 and over who are willing and cognitively able to respond to individual health promotion and disease prevention plans. Public Information/Volunteer Coordinators provide community outreach and Registered Nurses (RNs) conduct in-home assessments and develop a plan of individually tailored priorities for the clients. Human Services specialists monitor clients and provide support through home visits. Volunteers provide assistance such as installing grab bars and helping clients exercise. Client evaluation occurs at the Department of Health and Environmental Control.

- ***Florida's*** Positive Aging and Self-Care Initiative media campaign, which encourages senior citizens to live life to its fullest, rather than focusing on disengagement. The campaign motto is "Aging in Inevitable. Living Life to Its Fullest Is an Option". This new program is aimed at encouraging learning new skills and participating in activities; taking responsibility for growing old well, accepting illness as a means of adapting to limitations and continuing to pursue life's pleasures, finding satisfaction in life-long experiences and accomplishments, and remaining eager to continuing to contribute. The campaign will feature Florida State football coach Bobby Bowden as spokesperson and will showcase role models who are proactive in managing the way they age.

**Implications of the Olmstead Decision**

The Supreme Court's decision in the L.C. v. Olmstead case addressed the issue of whether a state government discriminates against individuals with disabilities by treating people in an institution when it is determined that treatment in a more integrated setting in the community is "appropriate". The decision acknowledged that states must provide community placements when that can be "reasonably accommodated". States are not required to "fundamentally alter" any services or programs in order to meet this

requirement. Importantly the court also ruled that a state's budgetary constraints and the resources available to the state and the needs of others must be taken into account.

The Olmstead decision therefore does not constitute a mandate for complete and immediate deinstitutionalization. Instead Olmstead actually reaffirms what states have been doing for the past 20 years – moving individuals out of nursing homes and into the community – where doing so is appropriate. The Supreme Court decision clearly left states wide latitude in determining how to proceed with expanding home and community-based care. It required states to make "reasonable accommodations", and states are now in the process of meeting with providers, advocates and communities to develop plans to move people with disabilities into the community and to help those in the community stay out of institutions.

States cannot bear the burden of these decisions alone, and will need more assistance from the federal government. There are many things that our federal partners can do to assist states in assuring that the requirements of the Americans with Disabilities Act (ADA) are met. Congress and Federal agencies such as the Departments of Health and Human Services, Housing and Urban Development, and Labor can help with the housing, workforce shortage, and funding issues that remain.

**NGA's Health Care Reform Proposal**

One of the most important actions that the federal government can undertake in this area is to act on the health care reform proposal adopted by the National Governors Association in February. That policy (HR-32) calls for a number of improvements that will enable the states and the federal government to better anticipate, identify, and solve the long-term care challenges in this country.

The policy adopted by the Governors calls for strengthening the collegial and cooperative mindset between the states and the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). States have a unique role as funders and administrators of the Medicaid program, and it is critical to the health and well being of all 40 million beneficiaries that collaboration with our federal partners be encouraged. A stronger state-federal partnership acknowledging state flexibility will allow innovative programs to be implemented faster and in a more widespread fashion.

After twenty years of experience with home and community-based care waivers, we know that it no longer makes sense for good public policy to be implemented through the waiver process. Although HCFA has worked closely with states to improve the process, the greatest improvements would come through acknowledging that home and community-based care is best administered through the state plan process, and not through paperwork-intensive waivers.

In addition, in the Medicaid reform principles laid out in HR-32, there are important components for improving the long-term care system in this country. Under current law, Medicaid is essentially an all-or-nothing program. Financial and functional conditions will trigger eligibility for all the services currently offered by the program, but until those conditions are met, Medicaid is not allowed to pay for any services at all. States know

well that the provision of a few targeted services, such as respite care, home modifications such as a wheelchair ramp or bathtub railings, or personal care attendants can often maintain a high level of functioning in seniors or individuals with disabilities. These targeted services often prevent catastrophic events, prevent slow declines in functioning, and are a cost-efficient and critical component of good public health policy.

Unable to provide such targeted services through Medicaid, many states have taken to developing such programs with 100% state dollars. Allowing the federal government to partner in these types of programs would encourage some states to begin such programs, and allow the rest to expand and enhance what they currently provide. I've described some of the types of programs currently underway at the state level; it is critical that we as a nation find ways to encourage the continued to development of such programs. Furthermore, understanding that these state funded programs provide long-term savings for both Medicaid and Medicare, it is easy to see why allowing Medicaid to partner with the states is an important policy objective.

Our policy also calls on Congress and the Office of Management and Budget to relax the very stringent "budget neutrality" requirements that often serve to impede state innovation and the development of quality long-term care programs for seniors. We know that early intervention services in Medicaid are responsible for preventing hospitalizations for the elderly, thereby saving the Medicare program from additional costs. Similarly, state-funded respite care can prevent nursing home placements, thereby saving money for the Medicaid program. Funding for protease inhibitors for people who are HIV-positive will prevent the onset of AIDS and provide savings to a number of other health and social welfare programs. Currently, states are unable to factor in such cost savings when applying for Medicaid waivers. The flexibility to consider budget neutrality across federal programs would enable the Medicaid program to help people with disabilities return to the workforce, integrate and coordinate care for seniors, and prevent the onset of AIDS in people infected with HIV.

Finally, our policy acknowledges that there must be a reevaluation of the funding partnership in the Medicaid program. For the first time in its history, the combined federal state budget of the Medicaid program has exceeded the Medicare budget. This is due to a number of factors, but most importantly because Medicaid is increasingly being asked to carry burdens never dreamed of when the program was first created. In 1965, the Congress never could have imagined that Medicaid would become the single largest payer of long-term care services in the country, nor could they have foreseen the enormous budgetary pressures of providing prescription drug coverage, or even that one-third of the entire Medicaid program would be devoted to health care services for Medicare beneficiaries.

Given how the program has changed since its inception; given that Medicaid spending is growing faster than state per capita incomes and state tax revenues; and considering that so much of Medicaid spending is for Medicare beneficiaries, it is critical that some reevaluation of the funding nature of the program take place. The funding changes called for in our policy create a simple, yet elegant balance that will simultaneously help states that are facing severe fiscal crises but also provide sufficient incentives for states to expand eligibility and benefits to those who currently have nothing.

**Conclusion**

As you can see, Governors have been and will continue to be active in responding to the health and long-term care needs of the citizens in their states. Without a comprehensive national framework, however, it is likely that future services will be under funded and implemented on a state-by-state basis. This is why it is critical that states and the federal government commit now to developing a vision for long-term care in the 21st century. The most important thing that we can do is to create a comprehensive long-term care benefit at the federal level. Until then, the Governors have developed a plan that will enable the states to better meet the needs of seniors and individuals with disabilities.

Thank you Mr. Chairman and members of the Committee for this opportunity and I look forward to answering any questions you may have.

*Parris N. Glendening*
Governor of Maryland
Chairman

*John Engler*
Governor of Michigan
Vice Chairman

*Raymond C. Scheppach*
Executive Director

## HR-32. HEALTH CARE REFORM

This policy represents general consensus among the Governors, although additional discussions are necessary to refine the details. Governors and staff will continue to work with the President, the Secretary of the U.S. Department of Health and Human Services, the congressional leadership, and other key stakeholders in order to make these refinements.

**32.1 Preamble**

Governors traditionally have been the initiators of change and states have been the incubators of progressive ideas. Helping families move from welfare to work, expanding health care coverage to children outside the Medicaid population, and developing prescription drug programs for seniors are just a few examples of the innovations of states. Governors have been diligent in their efforts to maintain an appropriate balance between being strong partners with the federal government and being effective advocates and activists for the concerns of their states' citizens. Properly positioning themselves between these two points has given Governors the ability to succeed in uncharted territory. One example is health care.

Governors have heard their constituents' calls for affordable, accessible health care. They also have heard the need to be wise stewards of the public's money in reaching that goal. The nation's Governors have worked persistently to manage current programs and most have attempted to broaden coverage to those without affordable access. With that frame of reference to guide them, the Governors are currently assessing the entire health care system to find ways to improve its efficiency, quality, and accountability.

Americans obtain health insurance through Medicare, Medicaid and the State Children's Health Insurance Program (S-CHIP), as an employee benefit, and by purchasing individual coverage. The health care system is endangered by unsustainable increases in medical costs, burdensome program requirements, and counterproductive incentives.

**32.2 Goals**

Governors have identified a number of short-term and long-term reforms designed to realize these goals. Some of the longer-term reforms, such as improving Medicare, re-examining pharmaceutical coverage, and establishing the priorities for chronic care and long-term care may take months—or even years—to enact. However, we have identified a list of short-term achievable goals that could produce immediate improvements in the provision of health care. The long-term reforms are an equally high priority for Governors, but we recognize that more targeted reforms have a stronger likelihood of immediate passage.

The primary goals of the short-term reform effort are to:

- stabilize the current program;
- obtain maximum flexibility for states to manage optional populations and benefits while maintaining a guaranteed commitment to vulnerable populations;
- require the Health Care Financing Administration (HCFA) to collaborate with, rather than dictate to, states; and
- give states the tools and incentives to allow them to expand coverage to the uninsured.

While other improvements are also necessary, these are the reforms that are essential so that insured individuals continue to receive necessary health care and uninsured individuals may be able to obtain the coverage they need.

**32.3 Reforms**

**32.3.1 Rules.** Since the new Administration has delayed implementation of the most recently released regulations, the nation's Governors want to ensure that all of these regulations are reviewed carefully

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to reflect the concerns that we have expressed as an organization. Many hours of research and discussion were spent in developing our positions and outlining the areas that states anticipated as potential problems. We are interested in working with this Administration—as we have with past Administrations—in developing solutions together so that we can reach our mutual goals for a healthier America.

32.3.2 **HCFA.** It is essential to have a collegial and cooperative mindset between the states and HCFA. HCFA must acknowledge the unique role of states as funders and administrators of the Medicaid program rather than treating states as merely one of many stakeholders. For example, states need to have more options in running their programs, and HCFA needs to be more timely and responsive in working with states. Many states will not be able to continue their current optional programs without some regulatory relief. States are trying to operate programs that benefit people but they need the flexibility to operate programs in a cost-effective way. Many states are experiencing budget problems with their Medicaid programs and with their waiver programs. With enough flexibility, not only will states be able to continue to serve mandated populations, but they *may* be able to expand the base programs to provide health care coverage to others who do not have affordable access to it.

In order for Medicaid and S-CHIP to truly operate as state-federal partnerships, several changes are necessary in terms of the state plan amendment process, the waiver process, and also in terms of general communication and cooperation.

HCFA needs to be much prompter in reviewing and approving waivers and amendments to waivers and to state plans. The review also needs to be more limited.

- State Medicaid Director letters and regulations that undermine state flexibility should be reviewed to see if they are necessary and serve a constructive purpose. The entire process should be improved with an eye towards greater communication and partnership between HCFA and the states.
- HCFA should approach regulation of managed care with some sensitivity. The managed care approach in many cases has helped states maintain programs and expand coverage. If the bar is raised significantly higher for requirements for managed care programs than it is for fee-for-service programs, the states risk the loss of commercial managed care entities willing to participate in the program. HCFA should also recognize that managed care can be a tremendous benefit for individuals with special health care needs as it provides for better access to targeted services and coordination of care than the fee-for-service system.
- There should be much better coordination and communication among program jurisdictions within the U.S. Department of Health and Human Services (HHS) but also across federal agencies as well. Just as better coordination between Medicare and Medicaid can improve health care for frail seniors, better coordination between HCFA and the U.S. Department of Education can improve health care and education for children with disabilities in our schools.
- A more limited review and approval process should be adopted instead of the current Medicaid state plan and waiver review processes. This would help prevent lengthy delays and unnecessary bureaucratic entanglements. The state plan approval authority of the Secretary of HHS should be limited to certification that the plan includes all of the elements required by federal law. HCFA should continue to provide appropriate oversight for programs providing mandatory services to mandatory populations.

32.3.2.1 **State Plan Amendment Process.** States must be allowed wide latitude in submitting plan amendments. To the extent possible, the statute should be amended to allow innovative options without waivers. Beyond that, the following changes would improve the state plan amendment approval process.

- There should be a non-negotiable 45-calendar day period for HCFA to act; otherwise the plan amendment is approved automatically. There should not be an opportunity for HCFA to "stop the clock" on amendment applications.
- Federal funds should be available for the quarter starting with the submittal date.
- To prevent lengthy delays, the structure should limit the secretary's state plan approval authority to certification that the plan includes all of the elements required by federal law.
- States should be allowed wide authority to determine reimbursement methodology for providers.

- States should have wide latitude to self-certify their plans for optional services or optional beneficiaries.

32.3.2.2 **Waiver Approval Process.**

- Initial approval periods for all waivers should be five years.
- All waivers should become a part of the regular state plan after the initial period if the state has met the terms and conditions or goals of the waiver.
- There should be a non-negotiable 60-calendar day period for HCFA to act; otherwise the waiver or waiver amendment should be approved automatically. There should not be an opportunity for HCFA to "stop the clock" on waiver applications or not act in a timely manner on waiver amendments.
- The waiver application should contain certifications of state plans for the following areas: quality control, access, and appeals. States should be ultimately accountable and responsible for these measures.
- "Budget neutrality" must be redefined so that savings across federal programs can be recognized. At the very least, savings in programs throughout the Social Security Act should be considered together. For more innovative programs, such as those for the working disabled, savings or even federal revenue gains should be considered.

32.3.3 **Medicaid Improvements.** We believe it is essential that states be given the tools they need to stabilize their current Medicaid programs and to initiate and continue programs designed to broaden the span of health care coverage available in our communities. States should be able to determine, however, which approach best fits the needs of their citizens and their ability to pay. These reforms are intended to apply to the Medicaid program and not to S-CHIP.

This includes reforms in the Medicaid program as it applies to the U.S. Territories in order to increase federal funding for the legitimate and unique health care needs of the people of the U.S. Islands. For Americans in the Pacific and Caribbean territories, disparities in the health care system are due in large part to the cap on federal funding for the Medicaid program and the inequitable treatment of the territories in the determination of their federal match.

This also includes the principle that states who have "gotten ahead of the curve" with innovative reforms and expansions should not be penalized by maintenance-of-effort provisions.

32.3.3.1 **Greater Financial Flexibility.** States are having increasing difficulty in simply maintaining the fiscal integrity of current programs. This is particularly true in states that have expanded significantly beyond the traditional base program and are now having to react to higher rates of increase in inflation and utilization.

- States should be allowed to develop appropriate cost-sharing arrangements from non-mandatory eligibility groups and use these revenues to offset the state cost of program benefits.

32.3.3.2 **Restructure "All-or-Nothing" Approach of Medicaid.** The Governors believe that the current "all-or-nothing" structure of the Medicaid program should be restructured to provide greater flexibility with regard to Medicaid options. This would include giving states greater ability to design benefit packages for optional populations. The Governors are committed to honoring the commitment to maintaining the health care safety net for vulnerable populations. However, states should have more flexibility with optional benefits and optional populations.

The Medicaid program should be reformed to create three categories of coverage.

**Category I – Core Vulnerable Populations (mandatory).** Governors recognize that Medicaid provides a valuable role as a safety net for vulnerable populations and that the guaranteed entitlement to eligibility and benefits for this group should not be threatened. The federal government has essentially already defined this core group by establishing minimum standards below which no state is permitted to go. Therefore, for all of the populations covered under the federal minimum standards, states would guarantee both eligibility as well as the federal minimum requirements with respect to benefits.

No cost-sharing responsibilities on mandatory benefits for any individual in this category would be required. States would be permitted to impose reasonable cost-sharing on a sliding scale basis for

optional benefits. States would receive the regular federal match for all services provided to individuals in this category.

For Categories 2 and 3 below, more discussion is needed on the issues of populations, benefits, and cost-sharing.

**Category 2 – Additional Core Populations (state option).** Beyond the minimum guarantees established in Category 1, many states may wish to also guarantee eligibility and benefits for additional populations. At state option, states should be able to expand these guarantees to all individuals (regardless of category) up to a certain percentage of the poverty level. For all individuals in this category, states must provide a benefits package that is actuarially equivalent to the S-CHIP statutory model.

There should be an enhanced federal match (equivalent to the S-CHIP match) for all services provided to any individual in this category. This would provide the incentive for states to expand a guaranteed entitlement to a full benefit package. Cost-sharing for services for this population would be permitted using the S-CHIP statutory model (no more than 5 percent of a family's income).

**Category 3 – Full Flexibility Expansions (state option).** Either in addition to whatever expansions a state opted for in Category 2, or instead of a Category 2 expansion, states would be allowed to expand health insurance coverage to any population. States would be allowed to expand coverage to all individuals up to a certain level of income, or target services to at-risk individuals, as defined by the state. States would have maximum flexibility in determining the level of benefits and amount of cost-sharing provided to beneficiaries in this category.

Given the amount of state flexibility allowed under this category, states would only receive their regular federal match for all services provided.

**No Maintenance-of-Effort for States with 1115 Waivers or Other Expansions.** In order not to penalize innovation, states that have already significantly expanded coverage through an 1115 waiver would be allowed to drop their waivers and instead implement expansions through Categories 2 and 3. In order for these states to receive the enhanced match under Category 2, however, the original eligibility standards must be preserved and mandatory benefits must be maintained. Optional benefits and cost-sharing can be adjusted, but must remain overall at a level that is the actuarial equivalent of the benefits provided under the demonstration waiver design as approved by HCFA. Similarly, states that have expanded coverage without a waiver should be given the opportunity to take advantage of Categories 2 and 3 without maintenance-of-effort.

32.3.3.3 **Coordination with the Private Sector.** The Governors believe that seamless interactions between government-funded programs and private sector health insurance coverage, including reasonable cost-sharing requirements for higher-income populations and for subsidies to employer-sponsored insurance should be created.

As states expand Medicaid or S-CHIP to higher-income populations, there are interactions with the private sector that were never imagined by the designers of a 1965 safety net program. Some common-sense changes can help remove the welfare stigma of the Medicaid program and decrease the likelihood that public health programs crowd-out the private market. The changes include giving states the freedom to:

- set reasonable cost-sharing requirements; and
- use Medicaid funds to pay for part of the employee share of premiums.

32.3.4 ***Olmstead* Compliance.** States should receive more assistance from the federal government as they attempt to comply with the Americans with Disabilities Act and with the Supreme Court *Olmstead* decision. Our federal partners have participated for many years in the development of long-term care policy with their participation in the nursing home program. Now that states are looking forward to more home- and community-based care, a number of major challenges remain that will require significant fiscal and workforce investments. The federal government must increase its share of Medicaid expenditures devoted to achieving and maintaining compliance with the Supreme Court's *Olmstead* decision. This increased investment should include, at a minimum, the state option to provide Medicaid room and board support for individuals leaving institutional settings and an enhanced ability to cover community-based services for the mentally ill.

*Time limited (effective Winter Meeting 2001–Winter Meeting 2003).*
*Adopted Winter Meeting 2001.*

The CHAIRMAN. Mr. Scheppach, thank you.
Mr. Browdie.

**STATEMENT OF RICHARD BROWDIE, SECRETARY, PENNSYLVANIA DEPARTMENT OF AGING, ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE UNITS OF AGING**

Mr. BROWDIE. Good morning. I am Richard Browdie, the Secretary of the Pennsylvania Department of Aging and a member of the Board of Directors of the National Association of State Units on Aging. The association applauds the committee for focusing congressional attention on the issue of long-term care in America.

The development of comprehensive home and community-based service systems for older persons and adults with disabilities has long been a policy and program objective of the association. We are hopeful that this series of hearings that you have undertaken will help to move this critical issue in the lives of millions of older persons to the center of the national policy agenda.

As the public agencies charged by the Older Americans Act with determining the needs and preferences of the Nation's older citizens, State units on aging are acutely aware of the overriding fears expressed by older persons and their families regarding the risks associated with a need for long-term care in this country. Once expressed somewhat vaguely as a fear of losing independence, the concerns of increasingly knowledgeable older consumers have become focused on the realities of long-term care in America: likely separation from home and familiar persons, the inevitability of poverty, and the possibility of inadequate services or poor quality of care.

The inadequacies of the long-term care system in America are built into the structure of the long-term care system, whose foundation was laid in 1965 when Medicare and Medicaid were created as social insurance for the elderly and poor people. Though obviously critically important to the lives of millions of older persons, these programs were drafted without extensive knowledge or experience with long-term care needs of long-lived Americans. At that time, long-term care services were viewed as a simple extension of medical care. We now know that medical services and long-term care services are interrelated, but neither is simply an extension of the other. Each is associated with a distinct body of knowledge.

Long-term disability is a social problem, a functional problem, and a family problem. Medical and institutional care ought to be a support to the long-term care system, not be the driving force. Regrettably, the Medicare system has not addressed this issue but has instituted procedures which shift the problems and the costs from the federally financed health care system into the State and privately financed long-term support system.

State systems of long-term care were necessarily built on Medicaid in order to capture Federal financial participation. Medicaid has become the Nation's long-term care insurance program. But the Medicaid long-term care system exacts a high price for its benefits: it requires people to be or become poor to gain access; it requires individuals to separate from family members and relocate to institutions; it is organized through the medical care provider systems; and it is not uniform in its benefits. While States have made sig-

nificant progress in recent years in overcoming these obstacles through the use of the Medicaid home and community-based waiver authority, the predominant bias in Medicaid remains institutional not home or community, medical not social. And as the costs of institutional long-term care continue to grow, States have been inhibited in their ability to move quickly because of the rising costs.

The Older Americans Act is the only piece of Federal legislation that promotes comprehensive, coordinated community-based systems of care, but it falls woefully short in terms of financing and cannot meet all the needs of older people and their caregivers.

Despite these handicaps, States have moved aggressively in the last two decades to organize and rationalize long-term care systems, by coordinating, financing, and designing systems which more closely meet the needs and preferences of their older citizens.

States have taken deliberate and aggressive action to constrain the growth in nursing home utilization and divert savings to community services, as you have heard; provide substantial State and local funds to develop more comprehensive and systematic approaches to serve persons who do not meet the financial eligibility of Medicaid and are unable to pay privately for needed services—and if I might divert, Pennsylvania is a strong example of that kind of initiative—develop a variety of services in in-home, adult day care, assisted living, and other services designed to meet the needs of diverse populations of older people; reorganize local services systems to provide standardized assessments of needs for both institutional and community-based long-term care services, and in some States single points of entry systems; provide consumers with choice of services and providers suited to their individual needs and preferences; develop equitable cost-sharing policies to extend services to an even broader population; and pursue standards of quality which monitor the achievement of outcomes sought by the consumer: comfort, security, and dignity.

These efforts have resulted in a vastly improved array of service options, increased involvement of family and community in-service systems, and permitted a more judicious management of resources—but only for a small segment of population requiring care. Current structuring and financing of long-term care is not adequate to meet the current need, much less the future growth in the long-term care population.

The solution is a national long-term care policy which provides a predictable, uniform long-term care benefit which older people, their families, State and local governments, private insurers, and providers can plan on. Knowing what Federal policy is committed to provide will enable these other actors in the system to anticipate and plan for the additional resources and services which will be required.

NASUA believes that the system older persons deserve will be most equitable and responsive to their individual needs if it is federally financed, State administered, locally managed, and consumer directed.

We are very encouraged by a number of recent Federal policy and program initiatives which are providing States with new resources and flexibility to reform the current long-term care system.

First, the field of aging worked with Congress and the administration to authorize and fund the National Family Caregiver Support Program. As you know, the majority of people with chronic disabling conditions rely on friends or family members for their primary source of assistance. This new program supports caregivers in their stressful roles with an array of services and supports that may delay or prevent the need for institutionalization. We look forward to working with you and the Administration to expand the reach of this new program.

Second, we applaud Congress and the Administration in providing States with new opportunities, flexibility, and resources to respond to the Olmstead decision. We are hopeful that Congress will continue to support these new Federal initiatives which provide States with resources to build on the work of the past two decades.

Third, NASUA also applauds and supports the efforts of Secretary Tommy Thompson in streamlining and expediting the Medicaid waiver process for States and providing leadership on the new Family Caregiver Support Program and the Systems Change Grants. We were greatly encouraged by his testimony before this committee last month that underscored the administration's support for State innovations in long-term care.

Having said this, we do continue to believe that a more fundamental restructuring of the long-term policy is needed and warranted. NASUA looks forward to working with this committee to clarify existing Federal policies and support additional legislation, including Medicaid reform, to enable States to expand home and community-based services and long-term care programs for persons with disabilities, regardless of age, and to promote Federal policies that foster consumer dignity and respect through consumer choice and control.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Browdie follows:]

NATIONAL
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STATEMENT OF

Richard Browdie

Secretary, Pennsylvania Department of Aging

ON BEHALF OF

The National Association of State Units on Aging

PRESENTED TO

The Senate Special Committee on Aging

JULY 18, 2001

*STATES UNITED FOR ACTION IN AGING*

Good morning Mr. Chairman and members of the Committee, I am Richard Browdie, Secretary of the Pennsylvania Department of Aging and a member of the Board of Directors of the National Association of State Units on Aging (NASUA). The Association applauds the Committee for focusing congressional attention on the issue of long term care in America. The development of comprehensive home and community based systems of services for older persons and adults with disabilities has long been a policy and program objective of the Association. We are hopeful that this series of hearings you have undertaken will help move this critical issue in the lives of millions of older persons to the center of the national policy agenda.

States have moved aggressively in the last two decades to redesign state and local delivery systems and funding structures to respond to the chronic, long term care needs of older Americans and persons with disabilities, but NASUA believes that further progress is hindered by the absence of a comprehensive federal long term care policy for financing needed services.

As the public agencies charged by the Older Americans Act with determining the needs and preferences of the nation's older citizens, state units on aging, are acutely aware of the overriding fears expressed by older persons and their families regarding the risks associated with a need for long term care in this country. Once expressed somewhat vaguely as a fear of "losing independence," the concerns of increasingly knowledgeable older consumers have become focused on the realities of long term care in

America: likely separation from home and familiar persons, the inevitability of poverty, and the possibility of inadequate services or poor quality of care.

The inadequacies of long term care in America are built into the structure of the long term care system, whose foundation was laid in 1965 when Medicare and Medicaid were created as social insurance for elderly and poor people. Though obviously critically important to the lives of millions of older persons, these programs were drafted without extensive knowledge or experience with long term care needs of long-lived Americans. At that time, long term care services were viewed as simply an extension of medical care; we now know that medical services and long term care services are interrelated, but neither is simply an extension of the other. Each is associated with a distinct body of knowledge.

Medicare is a universal insurance program for the elderly (with substantial participation in costs by the beneficiaries), which does not pay for the major catastrophic cost of the elderly - long term care. Over its history, the division between acute and chronic care in Medicare has become more rigid. Because of its acute care focus, Medicare reinforces the medical model of care: physician dominated, nurse provided, in institutional or clinical settings. Medicaid, originally designed to follow suit, has been trying to change its approach, but as costs for institutional care grow, states are able to move only slowly.

Long term disability is a social problem, a functional problem, and a family problem. Medical and institutional care ought to be a support to a long term care system, not be the driving force. Regrettably, the Medicare system has

not addressed this issue but has instituted procedures which shift the problems and the costs from the federal financed health care system into the state and privately financed long term care support system.

Today, one quarter of the nation's elders are likely to experience multiple disabling conditions which render them dependent on others for long periods of time. Yet our nation's health insurance programs do not adequately assist older persons and their families to cope with this reality.

The cost of long term care is inescapable. The fastest growing segment of the population is the very oldest. Yet, what we purchase at enormous public and private cost is a patchwork of care which too often fails to meet the expectations of payer, provider and, most importantly, consumer.

The predominant and preferred focus of long term support is in the home. Yet government programs are structured to give most care in the most intensive and restrictive manner, in institutional settings. As you know, the bias toward institutional care in federal financing has required states to request waivers to divert some of these resources toward the preferred long term care setting - the home.

State systems of long term care were necessarily built on Medicaid in order to capture federal financial participation. Medicaid has become the nation's long term care insurance program. But the Medicaid long term care system exacts a high price for its benefits: it requires people to be or become poor to gain access; it requires individuals to separate from family members and relocate to institutions; it is organized through the medical care provider

systems; and it is not uniform in its benefits. While states have made significant progress in recent years in overcoming these obstacles through use of the Medicaid Home and Community Based Waiver authority, the predomin~~ate~~ant bias in Medicaid remains institutional not home or community, medical not social. The Older Americans Act is the only piece of federal legislation that promotes comprehensive, coordinated systems of community care. But it falls woefully short in terms of financing and cannot meet all the needs of older people and their caregivers.

Despite these handicaps, states have moved aggressively in the last two decades to organize and rationalize long term care systems, by coordinating, financing and designing systems which more closely meet the needs and preferences of their older citizens.

States have taken deliberate and aggressive action to:

1. Reorganize state functions and coordinate state level efforts;

2. Develop an array of funding sources including Medicaid state plan services, the Medicaid Home and Community Based Waivers and the 1115 Waivers, state and local general revenues, Social Services Block Grant and Older Americans Act;

3. Constrain the growth in nursing home utilization and divert savings to community services;

4. Provide substantial state/local funds to develop more comprehensive and systemic approaches to serve persons who do not meet the financial eligibility of Medicaid and are unable to pay privately for needed services;

5. Develop a variety of services (in-home, adult day care, assisted living, etc.) designed to meet the diverse needs of older persons;

6. Reorganize local delivery systems to provide a standard assessment of service needs for both institutional and community based long term care and in some states single points of entry;

7. Provide case managers to guide access to services and monitor individual service needs over time;

8. Provide consumers with choice of services and providers suited to their individual needs and preferences;

9. Develop equitable cost-sharing policies to extend services to an even broader population; and

10. Pursue standards of quality which monitors the achievement of the outcomes sought by the consumer: comfort, security, and dignity.

These efforts have resulted in a vastly improved array of service options, increased involvement of family and community in service systems, and permitted a more judicious management of resources--but only for a small

segment of the population requiring care. Current structuring and financing of long term care is not adequate to meet the current need, much less the future growth in the long term care population.

The solution is a national long term care policy which provides a predictable, uniform long term care benefit which older people, their families, state and local governments, private insurers and providers can plan on. Knowing what federal policy is committed to provide will enable these other actors in the system to anticipate and plan for the additional resources and services, which will be required.

NASUA believes that the system older persons deserve will be most equitable and responsive to their individual needs if it is federally financed, state-administered, locally managed, and consumer-directed.

We are very encouraged by a number of recent federal policy and program initiatives which are providing states with new resources and flexibility to reform the current long term care system. First, the field of aging worked with Congress and the Administration to authorize and fund the National Family Caregiver Support Program. As you know, the majority of people with chronic disabling conditions rely on friends or family members for the primary source of assistance. This new program supports caregivers in their stressful roles with an array of services and supports that may delay or prevent the need for institutionalization. We look forward to working with you and the Administration to strengthen and expand the reach of this new program.

Second, we applaud Congress and the Administration in providing states with new opportunities, flexibility and resources to respond to the Olmstead decision. A prime example is the Systems Change Grants for Community Living which will allow enhanced state creativity and innovation in reforming their long term care systems. States are in the process of developing proposals to the Centers for Medicare and Medicaid Services for resources to assist in the development of long term care systems that offer consumer choice and emphasize home and community based alternatives to institutional care. We are hopeful that xxx Congress will continue to support this new federal initiative which will provide states with resources to build on the state initiatives of the past two decades outlined above.

Third, NASUA also applauds and supports the efforts of DHHS Secretary Thompson in streamlining and expediting the Medicaid waiver process for states and providing leadership on the new National Family Caregiver Support Program and the Systems Change Grants. We were greatly encouraged by his testimony before this Committee last month that underscored the Administration's support for state innovations in long term care.

Having said this, we do continue to believe that a more fundamental restructuring of long term care policy is needed and warranted. Xxx NASUA looks forward to working with this Committee to clarify existing federal policies and support additional legislation, including Medicaid reform, to enable states to expand home and community based long term

care programs for persons with disabilities, regardless of age; and to promote federal policies that foster consumer dignity and respect through consumer choice and control.

*The National Association of State Units on Aging was founded in 1964, as a national non-profit membership organization comprised of the 57 state and territorial government agencies on aging. The mission of the Association is to advance social, health, and economic policies responsive to the needs of a diverse aging population and to enhance the capacity of its membership to promote the rights, dignity and independence of, and expand opportunities and resources for, current and future generations of older persons, adults with disabilities and their families. NASUA is the articulating force at the national level through which the state agencies on aging join together to promote social policy in the public and private sectors responsive to the challenges and opportunities of an aging America.*

The CHAIRMAN. Thank you very much, gentlemen, for your testimony and for being with us and sharing your thoughts.

Secretary Hood, in our State of Louisiana, looking at the waivers we have for non-institutionalized care for seniors, it seems we have only one which has 500 slots. So everything else that we have for seniors is really institutional-based nursing homes. The rest of them that you have, four waivers that you receive, but they are not targeted to seniors. One is for a group of 18 to 55; another one is for people with disabilities from 0 to 65 years of age; and another one is for adults over the age of 21; and I guess for elderly and disabled. I guess that would include potentially some seniors, but it is also for young adults as well. There is one then that is targeted just for seniors.

I guess the question is why. You make the point in your statement—and I understand it and I agree with it—that we have a lack of resources. But it would seem to me that if a State has a lack of resources and is a relatively poor State, this would mean that they would aggressively try to move into a different way of delivering services for seniors other than using institutionalized care.

For example, you point out that we spend $109 per person in Louisiana for nursing home services and only $1.33 for home and community-based services. And Governor Dean pointed out that it was spending $48,000 a year for a person to be in a nursing home and less than $20,000 a year to serve a person who is elderly in a home and community-based setting.

So it would seem to me that the argument that we have lack of resources is an argument in support of moving to something other than nursing homes, institutionalized care, not a reason not to do it.

Can you comment on that?

Mr. HOOD. Yes, sir, and, Senator, just one minor correction. Most of the elderly waiver slots are for the elderly. There are a few disabled adults who are not elderly.

The CHAIRMAN. I want you to get to the main question. But I understand we have four—one, two, three, four waivers that have been approved for Louisiana. One is the personal care attendant waiver, which offers services to individuals between 18 and 25—excuse me, 18 and 55 who have lost sensory or motor functions. We have one for mental retardation and developmental disability waivers for people with disabilities between the ages of birth and 65. And we have an elderly and disabled waiver for adults over the age of 21. And there is only one that is granted specifically for elderly. Is that not correct?

Mr. HOOD. That is correct, and as I said, the elderly waiver is predominantly people over the age of 65, with very few adults who are under 65.

The CHAIRMAN. So getting back to my main point, if we are a State that is relatively poor, why are we not moving to something that is less expensive in treating elderly?

Mr. HOOD. Right, and, you know, I wish I could say that it was strictly a financing problem. It is not. There is also what I would say is a lack of resolve that we have had in the past. This is only now beginning to change. Now we have, as I said, an elderly trust fund that we can use to finance some additional services. We have

an Olmstead Planning Group and a process that we will use to try to plan for those services.

The CHAIRMAN. What is the elderly trust fund, and how much money do we have in it?

Mr. HOOD. Well, there is a significant amount of money in that particular fund, and one-third of the interest earnings from that money will be used for community-based services for the elderly. The other two-thirds will go to nursing home care and will be used to increase or enhance the quality of care in our nursing homes.

So that is a significant step in the right direction. I think we are——

The CHAIRMAN. It would seem like if two-thirds is going to institutionalized care and one-third is going to new and less expensive services, that is a step in the wrong direction.

Mr. HOOD. Well, many people would say that. I would only point out that our nursing homes are not particularly well reimbursed in terms of rates compared to other States.

The CHAIRMAN. The statistics show me that we are the 7th most profitable nursing homes in the country in Louisiana. Is that not correct?

Mr. HOOD. Those statistics have been published, and the publisher of those statistics has informed me now that they were in error, that they were not 7th in the Nation. I frankly don't know exactly what they are.

The CHAIRMAN. If we are not 7th, we must be something else. He didn't tell you what the other number was?

Mr. HOOD. No. They are no longer citing that particular statistic in their most recent report.

The CHAIRMAN. Well, if the report said that we were the 7th most profitable nursing home system in the Nation and now they are saying we are not, they must be saying that we are something else. They don't say what else we are?

Mr. HOOD. My guess is that we are probably in the top 25 for sure, and the reason is that not only do we have low rates, but we also have low cost.

The CHAIRMAN. What has been the position of the nursing homes in Louisiana with regard to these waivers?

Mr. HOOD. I think they are in a mode of basically maintaining of the status quo, tolerating the movement toward waivers and community-based services.

The CHAIRMAN. They support the waiver?

Mr. HOOD. As I said, they are reluctantly accepting the existence of these types of services. I would not say that they have embraced them at all.

The CHAIRMAN. What is the biggest problem as to why we are 49th or dead last in the number of home-based community services for elderly?

Mr. HOOD. Because, as I said earlier, I don't think there has been the resolve. It is not just a funding issue, and it is not just a flexibility issue. It is also——

The CHAIRMAN. How do we solve the resolve issue?

Mr. HOOD. I think through the activities of this committee, for example. Certainly you yourself have brought many of these issues to light, and I think that that will have a demonstrable effect in

Louisiana. And there is certainly a sign that our legislature is showing some indication that we need to change as well.

I think we are taking the long view now instead of looking just one year down the road at a 1-year budget horizon. So through programs such as LaCHIP, for example, which obviously is for children, but it will have some long-term effect. Primary care initiatives have been discussed in Louisiana, and, you know, we have a plan to do something about the lack of access to primary care.

I think the elderly problem is also on the radar screen, and I believe that we will make significant progress in the near future.

The CHAIRMAN. Well, you and I have worked together very well, and I commend you for it. I think that your heart is in the right place on these issues, and I know it has not been easy, and part of the problem, I think, is political and getting some of these things accomplished, because people have interests and they don't want them shaken up.

I don't, for the life of me, understand why people who are in the nursing business can't wake up and move into the 21st century and recognize that the baby-boom generation is not going to want to go to their facilities. I am going to Baton Rouge this weekend to participate in the Senior Olympic Games, and there are going to be 9,000 seniors there. And I bet you if I took a poll as to whether any of them would prefer being in a nursing home institutionalized when they need health care or whether they would rather be in a home or a community-based setting receiving adequate care if they, in fact, are not seriously ill, I bet I don't find one person that would have difficulty in saying they prefer home and community-based services.

This industry is going to have to wake up and realize that the 21st century is not going to be like the 19th century and the 20th century. They have to adjust their delivery of services and health care for elderly to something that fits the needs and the requirements of the upcoming baby-boom generation. And what they have now is simply not going to be where it is going to be in the next 50 years.

I would argue to them, look, you can make money doing other services, too. I mean, you are going to have to pay for these services, but they are different services. And people are going to have to recognize that change is coming, and, in fact, in Vermont, we have heard that it is here. And you heard Governor Dean say, look, we have got happier people, happier seniors, happier family members, and we are doing all of it for less cost, which is—you know, how can you beat that deal? I mean, particularly for a poor State that doesn't have a lot of resources, if we can take care of people for substantially less in a better setting and bring about happier results for people, this is what it is all about.

Mr. HOOD. And, Senator we are encouraging the nursing home industry to think in those terms, that this is not necessarily a lose-lose situation to them.

The CHAIRMAN. It is not.

Mr. HOOD. Some of them have diversified. Some of them provide, for example, adult day health care. Some also provide assisted living services. I think we need to move more rapidly in that direc-

tion. Diversification I think is the future for the nursing home industry.

The CHAIRMAN. You know, we have got to get away from the thought—I mean, it is all of us in society, out of sight, out of mind. I think that unfortunately some people feel if they have a grandparent or a parent in a nursing home they don't have to be as involved. And that is a tragic statement, because it is probably easier for them, but it is really not the best for everybody involved. And that is a cultural thing, and we have to recognize that.

Well, let me talk to the other gentlemen about what we need to do as a committee, because we heard Governor Dean talk about, you know, why do I have to do all these waivers? If this is the right thing to do, why do I have to go plead with the Federal Government to please let me do it? Why don't we just—I mean, would you recommend that we have an act of Congress that says that States can provide care for elderly citizens in the best setting that they determine to be best for the people in their State? They would probably have to submit a plan to us to make sure that the money is being spent appropriately. We are not going to just toss the money out and say go use it somewhere, but give them almost total flexibility. Design a day-care center, design a home health care delivery system, and show us what it looks like and how it is going to be run, and then you can go do it. Is that something we should do, Ray?

Mr. SCHEPPACH. Well, it would be nice. I don't know whether Congress, in all honesty, both sides, would be willing to do that. We do believe that Medicaid needs to be reformed. As I said, there is so much money in optional services and optional benefits when States have no flexibility. And all you have to do is look back at welfare reform when States had a fair amount of flexibility. You know, they moved 50 percent of the caseload into self-sufficiency. So I think they now have a track record where they have done a lot in a program that they had flexibility.

If you can't get something like that one, what I do think would be important would be expanded waiver authority so that you could get a broader definition of what would be allowed——

The CHAIRMAN. All right. I am going to ask you all to do something for us. Submit to this committee, if you can, a proposal for the committee from a legislative standpoint. You don't have to worry about doing it in legislative form. Just give me the Governors' ideas about how they would like to see this part of the Medicaid program written in order to give them the flexibility that they need. And I think that would be very helpful to us.

Let's see. I have some other questions I know might be of interest.

Ray, again, the NGA, National Governors Association, in February—you referred to H.R. 32, a health care reform proposal that the Governors adopted. Can you tell me a little bit more about that? What was the most important element of that proposal, do you know?

Mr. SCHEPPACH. Well, what we did is we basically protected the entitlement nature of it. So anybody under the current legislation that was entitled to get certain benefits, that was continued. But

then there was a second component of it that allowed States to designate other vulnerable populations that the States would entitle.

We did ask for an enhanced match on that particular component, but then the rest of the money, which is really basically in optional benefits and optional services, States would have a lot more flexibility to utilize that funding.

So, for example, States would get flexibility to increase the copays. They would be able to work with the private sector to perhaps pay for coverage of children through parents' programs. So it is really focusing on that 50 to 60 percent of the money that is optional, but the problem is you can't—you have no ability to mix and match that money. That is the policy and we would like to work with Congress on it.

The CHAIRMAN. I thank all of you. The goal of this committee is to try and help establish a system that provides better long-term care in this country for seniors that is not only better but is more efficient economically. We spend about $50 billion a year under the Medicaid program as a Federal share that goes to nursing homes. All of those people do not need to be there. Some do and they get great service, and I think that there is a percentage—and it is a large percentage—who do not need to be in that type of an institutional setting in order to be taken care of because of their conditions. And I think that if we can provide better services to allow people to be happier and more content and families to be happier and more content and do it all at a less cost than we currently do it, that is a win-win situation.

I know the problems and the pitfalls and the politics of it, but that is not a reason for us not to do what I think is right. And, David, I think that you understand that, and I think you are giving it your best, and I think people are starting to recognize what we have been preaching and what you have been preaching. And I want to work with you to help our people understand that.

This can be a win for everybody, including the nursing homes, if they wake up and recognize that the care they give today is not going to be the care that they are going to be called upon to give tomorrow. It is a changing world. I thank you, all three of you, for your contribution and for being with us.

That will recess the hearing for the moment.

[Whereupon, at 11:27 a.m., the committee was adjourned.]

# A P P E N D I X

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**WRITTEN STATEMENT OF**

**KAREN A. WAYNE, PRESIDENT/CEO**

**ASSISTED LIVING FEDERATION OF AMERICA**
**(ALFA)**

**FOR**

**SENATE SPECIAL COMMITTEE ON AGING**

**HEARING ON**

***LONG TERM CARE: STATES GRAPPLE WITH INCREASING DEMANDS AND COSTS***

**SUBMITTED FOR HEARING RECORD**

**JULY 18, 2001**

Chairman Breaux and members of the committee, I am Karen A. Wayne, President and CEO of the Assisted Living Federation of America (ALFA). On behalf of ALFA I am pleased to submit the following statement for the record of your July 18, 2001 hearing on "*Long Term Care: States Grapple with Increasing Demands and Costs*".

ALFA's 7,000 members include for-profit and not-for-profit providers of assisted living, independent living and other forms of senior housing and services. Founded in 1990 to advance the assisted living industry and enhance the quality of life for the consumers it serves, ALFA broadened its membership in 1999 to embrace the full range of senior housing and care providers who share ALFA's consumer-focused philosophy of care. The primary mission of ALFA is to promote the interests of assisted living, senior housing and care providers dedicated to enhancing consumer choice and quality of life.

ALFA applauds the Committee for today's hearing. This very important topic—addressing state initiatives to shift Medicaid services away from institutional care and toward community-based services—has been a top priority for ALFA and our members. ALFA strongly supports the right of seniors to receive care in the community-based setting of their choice and the development of ways to make it easier for residents of non-institutional settings to obtain reimbursement traditionally reserved for nursing homes.

Through ALFA's *Informed Choice* campaign, we wholeheartedly endorse making certain that state law preserves the right of seniors to receive care—and reimbursement for that care—in the least institutional, most community-integrated setting possible, where the emphasis is on empowering consumers to make their own decisions about their lives and circumstances. The importance of this right will only grow as today's "Baby Boomers" reach their upper years and require more care.

ALFA has long supported making Medicaid "portable" so that publicly funded consumers can choose where they will receive care and who the care provider will be. This allows publicly funded consumers to have the same options as those who can pay their own way. I am pleased to provide the Committee with the attached concept paper on "*ALFA's Medicaid Consumer Account Program: A New Model for Reimbursement of Home and Community Based Services.*"

The ALFA Medicaid Consumer Account Program builds upon successful state programs that provide Medicaid reimbursement in residential-care settings. Features of the ALFA Program are:

- Maintains budget neutrality and will not add to current and projected costs of maintaining the current long-term care system.
- Emphasis on consumer-directed decision making and independence while maintaining the fiscal integrity and accountability of the Medicaid program.
- Funding that is "portable" because it will reimburse the consumer rather than the assisted living provider. Portability is the cornerstone of the Program.
- Applies the same eligibility criteria for beneficiaries as that used for consumers receiving services under a state plan or a Home and Community Based Services waiver.
- States determine the value of the consumer account based on each individual's functional assessment, medical requirements and type of service needed.

Thank you Mr. Chairman for holding this important hearing and for the opportunity to add our testimony to the written hearing record. We look forward to working with you on this important issue.

# ALFA Medicaid Consumer Account Program

## A New Model for Reimbursement of Home and Community Based Services

### INTRODUCTION

The limitations of the country's long term care system are well known. While upper income consumers have a variety of private insurance, home care and residential alternatives to nursing homes, low-income consumers have few choices because of the nature of the Medicaid program.

Nursing home services are part of the "state plan" and therefore are considered an entitlement for all those who require such care. By contrast, community-based alternatives such as assisted living and in-home services are most often covered by a Medicaid waiver. Waiver programs have caps on the amount that may be reimbursed by the federal government. As a result, when states reach their cap, consumers who qualify for home and community-based services under Medicaid are placed on waiting lists. Yet if they seek nursing home placement, they are given immediate access to Medicaid coverage. Correcting this imbalance requires new approaches that create a level playing field among a range of services and settings and allow consumers more choices.

A number of states have designed strategies to address this imbalance. Prompted by rising nursing home costs, demographic changes and consumer preferences, states are implementing or considering policy options. A 1994 report by the General Accounting Office described systems changes in three states in which home and community-based programs were expanded to control rapidly increasing Medicaid expenditures for institutional care. The report concluded that the expansions allowed states to serve more beneficiaries than would otherwise have been possible because of the lower costs associated with residential settings and community-based alternatives. Residential settings such as assisted living have been an important component of initiatives in Maine, Oregon, and Washington to create a balanced system and to reduce reliance on institutional settings. Policy changes adopted or under development by states are possible because of the flexibility in the Medicaid waiver program.

ALFA's proposed Medicaid Consumer Account Program gives state policy makers another option. The ALFA Program has the following benefits:

1. Budget neutrality. The program will not add to present or future costs of maintaining the current long-term care system.

2. Emphasizes consumer-directed decision-making and independence while maintaining the fiscal integrity and accountability of the Medicaid program.

3. Funding is portable—it will allow the consumer to authorize payment to a qualified provider of his/her choosing. Portability allows publicly funded consumers to choose where they will receive care and who the care provider will be. It allows them to have the same options as private-pay consumers.

4. Applies the same eligibility criteria for beneficiaries whether receiving services under a state plan or Home and Community-Based Services waiver.

5. States determine the value of the consumer account based on the individual's functional assessment, medical requirements and type of service needed.

## ALFA MEDICAID CONSUMER ACCOUNT PROGRAM

Under the ALFA Medicaid Consumer Account Program, states would combine funding for nursing home, home health, personal care, and home and community-based services to provide a level playing field for all service options. Consumers would be assessed to determine their functional eligibility and level of need for long term care. Once financial and functional eligibility was determined, a "Consumer Account" would be created for the beneficiary and funds would be credited to the account that can only be used to purchase long term care services.

With the assistance of a consumer care advisor, consumers would review their needs, determine which services or combination of services best meet those needs, and select providers to deliver services. The consumer would present a "coupon" or "authorization" to the service provider. The coupon might specify the type of service, the number of units to be purchased and the schedule for delivering care, the cost per unit, and the duration of the "purchase." The provider would obtain the consumer's signature when services were delivered and submit an invoice to receive payment.

## ENROLLMENT – ESTABLISHING CONSUMER ACCOUNTS

Consumers would apply for a Consumer Account through state agencies, single entry point agencies or provider agencies, depending upon the structure of the state's system. States currently use one of these approaches, or a combination of the three, to determine functional eligibility for long term care and to authorize services. Instead of completing the assessment and authorization placement in a nursing facility or a home and community-based care plan, the entity would establish an "account" with a maximum obligation. The amount of the obligation could be a flat amount for all consumers or varied based on the individual needs of the consumer. Tiered obligation amounts, case mix systems or risk-adjusted methodologies could be developed to determine how much should be credited to an individual's account.

There are two approaches to determining the amount credited to an individual's account: 1) The credit could be determined based on the level of need regardless of the setting in which care is

delivered. This would create incentives for the consumer to use the least expensive services in the least restrictive setting in order to maximize the amount of care received. However, this may create barriers to accessing some services. Since the historical cost of nursing home, assisted living, and home care services vary, a flat credit may not allow a consumer to access a nursing home. Meanwhile, if the credit were set at the average cost of a nursing home, states might end up overpaying for care to consumers who elect non-institutional options.

2) States could determine the amount based on a mix of the level of need and the service setting. Depending on the state's nursing home payment system, a credit range may be established for consumers electing nursing home care or a maximum that reflects the mix of facilities and rates in the geographic area.

In the case of assisted living, the credit could be set as percentage of the cost of nursing home care or an average of an appropriate sample of facilities in the area. If the credit amount is lower than the monthly fee charged by a specific assisted living community, the consumer account might be supplemented by family members or other sources available to the consumer. Credit amounts for community care plans might also be set as a percentage of nursing home care, which is currently done is some states, or using a tiered approach based on the number, type, and intensity of functional and health needs.

Whichever approach is used, consumer choice and access must be ensured. Developing a credit amount that is too low to gain access to a provider type creates barriers that are found in the current system. On the other hand, creating a system that encourages the use of more costly services or more intense service plans than are needed places states at risk of higher costs.

Services would be debited to the account as they are purchased by the consumer or a consumer care advisor. Managing the account is clear-cut for consumers who select a nursing home or assisted living community, since the cost of their care is more predictable each month. However, consumers who remain in their own homes may need a mix of services from a variety of providers such as personal care, home health, skilled nursing, transportation, or home delivered meals.

Implementation of a tracking system to monitor spending against the consumer account is important. If a consumer's needs change, the account would be modified after a re-assessment by a care advisor. Spending that could possibly exceed the amount credited to an individual's account would need to be reviewed and adjustments made to the care plan in subsequent months if an adjustment to the credit amount is not warranted. Provisions would be needed when consumers continue to authorize care that will exceed the credit. Criteria for monthly, rather than quarterly or bi-annual, account credits could be developed, or the option could be removed for those consumers who are not able to manage the account.

## PAYMENT PROCESS

There are several options for administering the payment process. The provider could submit an invoice to the state Medicaid agency or the state aging department, a single entry point agency that also provides care advisory services, a fiscal intermediary contracting with the Medicaid program or provider organization designated to perform this function.

## ROLE OF THE CONSUMER

The ALFA Medicaid Consumer Account Program emphasizes consumer control. It would provide consumers who are willing and able with the opportunity to organize and implement their plan of care, and to make decisions about the type of care and the providers of that care. Not all consumers will want to perform these tasks. While family members or other designees may perform them, the system should provide for care advisors who will handle the care planning, service authorization and monitoring functions for those with dementia who are not capable of making such decisions, or others who choose not to do so themselves. States could continue to authorize and pay for services under their current systems for consumers who do not want or are unable to manage a consumer account.

## CONSUMER CARE ADVISORS

A key part of the ALFA Program is the role of the consumer care advisor. The consumer advisor represents a revision of the case management functions now performed in many states. This new function highlights the role of the consumer taking charge of their own care needs, and the supportive and advisory role of the consumer advisor. In some cases, the consumer advisor will function in the traditional case management style.

## AUTHORITY

The ALFA Medicaid Consumer Account Program shares some of the same objectives and benefits of the Cash and Counseling Demonstration/Evaluation (CCDE). The CCDE is a large-scale public policy experiment in four states to test the feasibility and assess the advantages of a consumer-directed approach to financing and delivering personal care services.

However, the CCDE is a cash benefit experiment and Medicaid law does not permit direct cash benefits to consumers. The state Medicaid programs participating in the Cash and Counseling Demonstration must obtain special "1115" research and demonstration waivers from the Health Care Financing Administration.

By contrast, the ALFA Medicaid Consumer Account Program can be implemented using existing federal authority. The specific authority or combination of authorities--Prepaid health plan, § 1115, § 1915 (a), § 1915 (b), or § 1915 (c) -- will be determined by the approach selected by the state.

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**The ALFA Medicaid Consumer Account Program was developed under the auspices of *ALFAcares*, the affordable housing initiative of ALFA. Under the banner of *ALFAcares* Public and private sector leaders are actively supporting state, federal, and industry partnerships that will expand affordable housing opportunities for low-and-moderate income seniors.**

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