

SECURING THE FUTURE

Report of the Massachusetts Long-Term Care Financing Advisory Committee



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EXECUTIVE SUMMARY

Introduction and background

At the request of Governor Deval Patrick in early 2009, the Executive Office of Health and Human Services and the Executive Office of Elder Affairs convened the Long-Term Care Financing Advisory Committee to advise state policymakers on long-term care financing reform. The Advisory Committee is one of many initiatives stemming from the commonwealth's Community First Olmstead Plan, an action plan for the future of community-based long-term services and supports (LTSS) in Massachusetts.

This report describes the policy framework for the Advisory Committee's work, discusses the financing strategies the Advisory Committee considered, and presents a roadmap to universal access to LTSS coverage. The roadmap does not dictate a single route to the coverage goal, but rather presents short- and long-term options for making affordable LTSS financing mechanisms available to all Massachusetts residents.

The current system for financing LTSS is unsustainable, and a crisis is imminent. The solution lies in broader sharing of the responsibility for paying for LTSS and in creating more viable private financing options. Current trends indicate that LTSS costs in Massachusetts will increase at least 50 percent in the next 20 years and that the costs to the state Medicaid program will more than double. Taking action soon to broaden payment options is crucial, and the state should closely monitor progress toward the goal of universal access. If, over time, recommended strategies fall short of achieving necessary coverage, the Advisory Committee recommends development of a broad, state-sponsored, individual contribution program.

The need for LTSS affects nearly every family in Massachusetts. Approximately 10 percent of the population, or 630,000 individuals, have disabilities that require LTSS. LTSS refer to a wide variety of services and supports that help people with disabilities, including children, adults, and elders, meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing homes. Almost all of us at some point in our lives will need LTSS or will provide some of these services to a family member or friend.

Caring for loved ones is something most people want to do. Nationally and in Massachusetts, unpaid caregivers—including spouses, children, siblings, neighbors, and friends of care recipients—provide the bulk of LTSS and will continue to do so. Most report satisfaction with their caregiving role. However, many family and other unpaid caregivers assume significant and potentially long-term financial, physical, and emotional burdens in providing these LTSS. New financing strategies will address some of their challenges, but the Advisory Committee recognized that

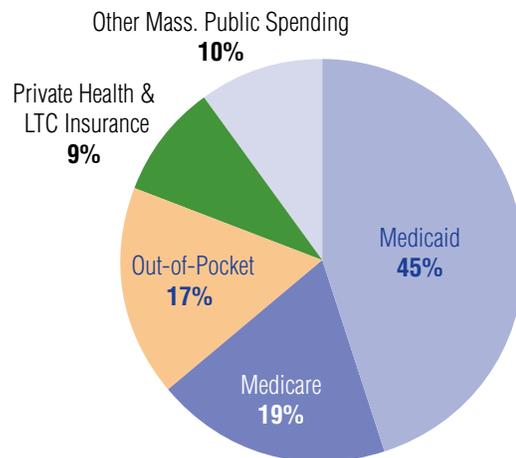
other public- and private-sector policies and programs—such as caregiver training, subsidized respite services, and employer-based family leave policies—will be critical to maintaining the ability of family members and friends to provide needed care.

When individuals with LTSS needs do not have access to unpaid caregivers or their caregivers cannot provide the level or amount of care required, they turn to paid caregivers. Because LTSS are often needed over an extended period, they can be quite costly and can quickly deplete an individual's or family's savings. Most health insurance, including Medicare, does not pay for most types of LTSS. Medicare covers only limited facility and home care services following a hospital stay. It does not provide for most LTSS that assist with daily routine tasks or self-care needs over a long period.

The primary public payer for LTSS is Medicaid (called MassHealth in Massachusetts), the health insurance program for low-income families, people with disabilities, and elders that is funded jointly by the state and federal governments. Medicaid pays for a variety of community-based and facility-based LTSS. State health and human services programs, federal veterans' affairs programs, private long-term care insurance, and out-of-pocket spending by individuals and their families also pay for LTSS. Figure A shows the distribution of spending for LTSS by payer in Massachusetts.

FIGURE A

Massachusetts Spending on LTSS by Payer (2005)



Source: Komisar and Thompson (2006), with adjustments made to Other Mass. Public Spending

Note: Medicare covers only limited-term services such as skilled nursing, therapy or skilled nursing facility care immediately following hospitalization. The Advisory Committee assumed Medicare would continue to cover these services but would not expand further into LTSS.

Aside from forgoing services, people who need to pay for LTSS have three primary choices for financing that care:

- Individuals can pay for LTSS out of their own pockets, at the time their need occurs.
- Individuals can anticipate the need for LTSS before it occurs and use one of a variety of insurance or savings mechanisms to set aside funds for later use. These mechanisms include traditional savings approaches, private long-term care insurance, certain life insurance policies, annuities, and reverse mortgages.
- Low-income individuals with limited assets can have needed LTSS paid for by Medicaid.

These three options leave significant gaps for consumers, particularly middle-income individuals. Out-of-pocket spending at the time services are needed is not a viable long-term option for many individuals with high LTSS needs. One out of six individuals turning age 65 will incur over \$100,000 in LTSS costs in his or her lifetime; for families with members who become disabled much earlier in life, the total expense can be even more. Most lower- and middle-income people do not have the financial resources to cover these costs. In addition, many of the private insurance-based mechanisms have historically been out of reach for most consumers, because products can be very expensive, especially to individuals who are not relatively healthy. These insurance products also often cover a limited amount of service, which may not meet an individual's full needs. More fundamentally, the savings and insurance products currently in the market are not well understood by or appropriately marketed to consumers, who are often unaware of the magnitude of the potential risk.

Medicaid's utility as a source of financing LTSS is also limited. To be eligible for MassHealth, most individuals must have a very low income and very limited assets. Middle-income individuals can only access MassHealth LTSS coverage by "spending down" their income and assets. In addition, access to MassHealth for people with similar LTSS needs and similar financial status is uneven. Because of MassHealth's patchwork financial eligibility and service coverage rules, people over age 65 must spend down to much lower income and asset levels than individuals under age 65 to access the same services. In addition, many low-income people under age 65 with disabilities have no access to comprehensive publicly paid LTSS.

The gaps left by these financing mechanisms not only leave individuals financially vulnerable but also can create enormous strain for unpaid caregivers. Further constraining individuals and their families is the fact that many of the available financing mechanisms offer insufficient coverage of community-based LTSS for those who wish to remain in their homes and communities.

There is a clear need to develop practical and affordable public and private financing solutions for LTSS, particularly given impending demographic changes that will exacerbate the problem. An aging population and longer life spans for people with disabilities, due in part to advances in medical

technology and treatments, will increase the demand for LTSS. These and additional factors such as smaller family sizes also will reduce the effective supply of unpaid family caregivers.

The lack of accessible financing options for LTSS represents a major gap in state and national social policy. Planning and financing mechanisms exist for retirement (Social Security, pensions, and retirement accounts), acute and ambulatory medical care (Medicare and employer-sponsored insurance), and estate planning (trusts); but there are few accessible options for planning or securing coverage for LTSS needs. The Massachusetts Long-Term Care Financing Advisory Committee was convened to recommend strategies to improve and expand the options for financing LTSS for people with disabilities and elders within the commonwealth. The Advisory Committee's recommendations are contained in this report.

The Advisory Committee's principles and scope

The Advisory Committee adopted six principles that guided its financing strategy development. In the Advisory Committee's view, a reformed LTSS financing system should

1. Ensure a strong public safety net for the poor and most vulnerable;
2. Assure quality of care and cost efficiency;
3. Limit financial pressure on the state financing system to preserve state funds for those most in need;
4. Encourage personal planning for financing LTSS;
5. Enable middle-income people to access LTSS without becoming impoverished; and
6. Better support unpaid caregivers.

Despite the economic constraints that existed in Massachusetts at the time of its work in 2009 and 2010, the Advisory Committee was determined not to lose sight of its long-term vision for a reformed system. While the budget context was one factor that informed how the Advisory Committee structured the roadmap, it did not temper the Advisory Committee's desire to advance a bold solution to the LTSS financing problem. As a result, the public and private LTSS financing strategies contained in the roadmap are progressive and comprehensive, while also being pragmatic and actionable. Additionally, Advisory Committee members felt strongly that taking action now to start putting these strategies into place would better prepare consumers and the government for future economic downturns.

The Advisory Committee selected the specific combination of public and private financing strategies included in the roadmap because they directly respond to the problems identified in the current financing structure, maximize the values underlying the six guiding principles, and maximize LTSS coverage.

The scope of the Advisory Committee's work was the financing of LTSS—how to pay for services—and not the many related issues of service delivery and supports necessary to meet the needs of people who typically use LTSS. However, the Advisory Committee identified several integrally related issues, such as affordable and accessible housing, access to employment opportunities, workforce capacity, and infrastructure development, which will be important in supporting the commonwealth's ability to meet its LTSS financing reform goals. These issues are discussed briefly later in this report; most of them are being addressed more thoroughly by other Community First Olmstead Plan workgroups and initiatives.

The financing work of the Advisory Committee coincided with other commonwealth efforts to increase care coordination and contain health care costs. A Special Commission on the Health Care Payment System recommended changes to how insurers pay for health care services. Through payment reform, the commonwealth is moving towards adopting more efficient, patient-centered methods of care that will affect all people, including people with disabilities and elders. Payment reform could provide incentives for traditional health insurance to use less costly, more appropriate services, such as home care, as a way to prevent the need for more costly facility-based services. Care coordination efforts, including those anticipated in the medical home model, hold great promise for more integrated use of LTSS.

The Advisory Committee's work also coincided with an important federal action—the creation of the Community Living Assistance Services and Supports (CLASS) program, part of the national health care reform legislation enacted in March 2010. CLASS provides a new mechanism for working people to plan ahead for their potential LTSS needs by making a voluntary contribution, through a payroll deduction, into a national trust fund. It will pay a daily cash benefit to those with an LTSS need after they have contributed to the fund for at least five years. CLASS is a significant step forward because it provides a common mechanism for financing LTSS for a broad population: working-age Americans. Its success and financial viability depend on the voluntary participation of young workers and those less likely to need LTSS in the near future. Evolving federal guidelines will be important in determining its utility.

The Advisory Committee's recommendations build on this context of expanding need and important federal and state reforms. The proposed strategies will improve the adequacy and fairness of LTSS financing and will require political leadership and effective community engagement to achieve.

The Advisory Committee's recommendations: Strategies for reforming Massachusetts' LTSS financing system

The Advisory Committee's long-term vision is for universal access to basic financial protection for Massachusetts residents with LTSS needs. The Advisory Committee believes that this vision is enormously important both for individuals and for the state. Individuals should be able to use LTSS

without impoverishing themselves, and the state faces an unsustainable trend in MassHealth costs for LTSS if other financing sources do not relieve that burden.

The Advisory Committee developed the roadmap to achieve this vision. Three core financing strategies include two that promote private/personal planning for one's LTSS needs, particularly for middle-income people who have some financial resources to contribute, and one strategy that improves the public safety net for low-income people.

The Advisory Committee's Recommended Core Financing Strategies

- Increase utilization of private LTSS financing mechanisms
- Expand MassHealth coverage to achieve equity in access to LTSS
- Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs

Each financing strategy consists of a set of discrete recommendations:

1. Increase utilization of private LTSS financing mechanisms

- Implement National Association of Insurance Commissioners (NAIC) model legislation that will provide for better regulation of LTSS insurance
- Promote life insurance with LTSS options
- Promote group coverage of LTSS insurance and portability of that coverage
- Develop a Long-Term Care Partnership Program that provides protection from impoverishment for individuals who purchase LTSS insurance if they eventually become eligible for Medicaid
- Promote the use of other private LTSS financing mechanisms, such as reverse mortgages, annuities, and LTSS savings accounts

2. Expand MassHealth coverage to achieve equity in access to LTSS

- Expand access to a *limited* package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs
- Subsequently expand access to a *comprehensive* package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs
- Expand eligibility for MassHealth coverage for LTSS for elders over age 65

3. Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs

- Educate employers and employees about CLASS and consider promoting their participation in the program if warranted.
- If other strategies do not achieve the goal of universal access to basic LTSS coverage, design and implement a state-sponsored individual contribution program that provides universal access to basic LTSS coverage for all Massachusetts residents. Private insurance and MassHealth could supplement this coverage for individuals with very high LTSS needs.

The Advisory Committee also articulated the following four **foundational strategies**, which are considered essential to successful reform and should be implemented in conjunction with the core financing strategies:

- Implement a comprehensive and multi-phase LTSS financing awareness and education campaign targeted to the public and to employers
- Maximize integrated financing and care coordination consistent with health reform and other system change efforts

- Expand support for unpaid caregivers' skills and well-being, particularly support for counseling programs, support groups, and training
- Extend additional support for unpaid caregivers' financial circumstances through workplace policies, tax incentives, and other means

The Advisory Committee recommends phasing in these strategies over a 10-year period. The Advisory Committee's proposal for phase-in is illustrated in Figure B.

The strategies in Phases I and II rely largely on making private savings and insurance mechanisms more attractive and persuading more people to use them voluntarily; additional expansions in the public safety net are recommended as state resources permit. While the Advisory Committee believes these efforts will increase coverage for LTSS, analyses available at the time of the Advisory Committee's work indicate that the Phase I and II proposals are unlikely to achieve the goal of universal access to basic LTSS coverage. Close monitoring and reassessment of incentives and coverage barriers will be important as each initiative is adopted; course corrections and ongoing actuarial and other analyses will be crucial.

FIGURE B

Phase-in of strategies to achieve universal access to LTSS coverage in Massachusetts

Phase I (Short-term: 1-3 years)	Phase II (Medium-term: 4-7 years)	Phase III (Long-term: 8-10 years)
<ol style="list-style-type: none"> 1. Implement multi-phase LTSS financing education and awareness campaign; expand support for unpaid caregivers. 2. Implement NAIC national consumer protection and insurance standards. 3. Improve/expand utilization of private insurance for LTSS, including adoption of LTC Partnership; promote the use of other private financing mechanisms. 4. Implement targeted MassHealth service expansion (limited package) for adults under 65 and expand eligibility for elders 65 and older. 	<ol style="list-style-type: none"> 1. Maximize integrated financing and care coordination consistent with health care reform opportunities and other system change efforts. 2. Implement additional MassHealth service expansions (comprehensive package) for adults under 65 with disabilities and self-care needs. 3. Educate employers and employees about CLASS. <ul style="list-style-type: none"> ■ Participate in federal rulemaking ■ Raise awareness of CLASS's existence and potential benefits ■ Promote employee participation if warranted 	<ol style="list-style-type: none"> 1. Extend additional support for unpaid caregivers' financial circumstances through methods such as <ul style="list-style-type: none"> ■ Programs to pay caregivers ■ Tax credits for training ■ Encourage supportive workplace policies in private sector 2. Design/implement mandatory state-sponsored individual contribution program that maximizes LTSS coverage for all Massachusetts residents. <ul style="list-style-type: none"> ■ Contingent on coverage gains from other strategies ■ Design to reduce adverse selection ■ Structure to complement CLASS and other financing options

Should the cumulative effect of the roadmap strategies fall significantly short of the goal of universal access, the Advisory Committee recognizes that the objectives of meeting expanding need and averting unsustainable individual and state fiscal impacts will not be met. If that proves to be the case, the Advisory Committee recommends requiring participation in a future state-sponsored individual contribution program. Should such a program become necessary, the Advisory Committee recommends that it be financed through contributions by as broad a base as possible of Massachusetts adults and that it be designed to cover most LTSS costs. A model for such a strategy is presented in this report. This state program could harness the collective economic strength of a broad-based insurance pool to meet the basic LTSS needs of the entire state, much as Social Security does for the basic retirement needs of the nation.

Estimated effects of the roadmap strategies

Over the next 20 years, as the population ages and LTSS needs and costs increase, the projected cost of LTSS in Massachusetts will increase at least 50 percent, to \$28 billion per year. With no changes in the structure of LTSS financing, much of that increase will be borne by MassHealth and by individuals purchasing services out of their resources at hand, with no financial protection, when the services are needed. Such a future would mean severe hardship for both state and family finances. The Advisory Committee's recommended strategies are projected to shift the financing of LTSS in a more sustainable direction, by relieving pressure on MassHealth and spreading the responsibility for private financing over longer time horizons and across more people.

If all roadmap elements were to be implemented, nearly half (46 percent) of LTSS costs could be pre-paid by individuals by 2030 through a combination of private insurance, the federal CLASS program, and a state-sponsored individual contribution program. This is in contrast to an estimate of just 14 percent prepaid by individuals absent the roadmap strategies. With the Advisory Committee's recommended reforms, individuals would be responsible for only 15 percent of costs at the time they need LTSS through out-of-pocket expenses, unpaid caregivers, and unmet need, rather than 38 percent without the roadmap. And Massachusetts state government's responsibility for LTSS would be reduced to 17 percent of LTSS care, rather than 21 percent under status quo policies, a difference of nearly \$1 billion. This would include a much smaller share paid through Medicaid and other state assistance programs and more paid as premium subsidies for a state-sponsored contribution program, which ultimately is funded by individual contributions.

The Advisory Committee believes that its array of strategies is consistent with its six principles. Implementation of these strategies will contribute greatly to increasing the kinds of LTSS financing options available and to improving the quality and attractiveness of options already available. Financing LTSS will remain a challenge, however, particularly as demographic trends contribute to a greater demand for LTSS. These strategies could go a long way toward more effectively using limited resources.

The existing system for financing LTSS in Massachusetts is unsustainable. Solving the problem of LTSS financing is imperative; doing it during a time of fiscal restraint in the commonwealth is a great public policy challenge. Massachusetts cannot wait for better times to address the problem, however. The Long-Term Care Financing Advisory Committee has proposed a multifaceted solution to this complex problem and recommends that it be implemented over 10 years. The strategies of the roadmap will shift more responsibility to individuals to plan for their futures; enable them to meet their LTSS needs without impoverishing themselves; relieve pressure on MassHealth while strengthening the public safety net; and support unpaid caregivers, whose participation in providing LTSS will continue to be essential. Successful implementation of the roadmap strategies will go far in helping people with disabilities, elders, and their families live as they wish, where they want, and within their means in the decades to come.

I. INTRODUCTION

A Overview of the issue and purpose of the roadmap

Long-term services and supports (LTSS) refer to a wide variety of services that help people with disabilities of all ages—including children, adults, and elders—meet their daily routine and self-care needs and improve the quality of their lives over an extended period. LTSS are provided predominantly in homes and communities, but also are provided in residential long-term care facilities.

The need for LTSS affects nearly every family in Massachusetts. In fact, approximately 10 percent of the population, or 630,000 individuals, have disabilities that result in the need for LTSS. Whether as a care recipient or caregiver, almost all of us at some point in our lives will need LTSS or will provide LTSS to a family member or friend.

Both nationally and in Massachusetts, unpaid caregivers—including spouses, children, siblings, neighbors, and friends of care recipients—provide the bulk of LTSS. When individuals do not have access to unpaid caregivers, or their caregivers cannot provide the level or amount of care required, individuals turn to paid caregivers for their LTSS needs. In many instances, people rely on both unpaid and paid caregivers.

Ninety-seven percent of people in Massachusetts have health insurance, due in part to the state's landmark 2006 health care reform initiative, but most health insurance does not pay for LTSS. Private health insurance, whether obtained through an employer or purchased individually, typically does not cover LTSS. Medicare, the federal health insurance program for America's elders and some younger people with disabilities, covers only short-term services.¹ Medicaid (called MassHealth in Massachusetts), the health insurance program for low-income people that is funded jointly by the state and federal governments, is the primary payer for LTSS, but most individuals must meet strict income and asset limits to qualify for benefits.

Because people often need these services over an extended period, LTSS can be quite costly and can quickly deplete an individual's or family's savings. Private insurance that expressly covers LTSS is available, but very few people have purchased it or set aside their own income or assets to pay for an eventual need for this care. Many middle-income individuals can only access LTSS by “spending down” their income and assets to become eligible for Medicaid. Some middle-class individuals transfer their assets years before they may need LTSS so they will not have to use them to finance LTSS in advance of Medicaid eligibility, but federal rules govern this practice and are quite restrictive.

Policy makers in the commonwealth recognize that the lack of accessible and affordable financing options for LTSS represents a major gap in state and national social policy. In January 2009, to address this issue, the Governor requested that the state's Executive Office of Health and Human Services (EOHHS) and Executive Office of Elder Affairs (EOEA) convene a Long-Term Care Financing Advisory Committee to advise state policy makers on ways to improve and expand the options for financing LTSS for people with disabilities in Massachusetts. Members of the state legislature strongly supported the creation of the Advisory Committee. The specific charge of the 24-member Advisory Committee was “to identify and prioritize short-term and long-term strategic options for reforming the financing system for LTSS for elders and individuals with disabilities in Massachusetts to support a range of LTSS and a sustainable mix of personal and familial responsibility, private financing mechanisms, and public assistance in a manner that maximizes independence and assures access to the necessary continuum of LTSS.”

This report will describe the policy framework for the Advisory Committee's work, discuss the financing strategies the Advisory Committee considered, and present a roadmap for providing meaningful LTSS financing options for all Massachusetts residents. The roadmap describes options within three core strategies and outlines a multi-phase approach for reform, which moves the state from simpler, short-term and low-cost options toward a long-term, comprehensive solution.

Staff to the Advisory Committee performed extensive analyses and modeling that informed the Committee's decision making. The data, assumptions, and models are included in the Appendices of this report. The Advisory Committee also solicited input from the public through a series of public meetings across the commonwealth.

B Massachusetts' Community First Olmstead Plan provides the policy framework for the Advisory Committee's work

The Advisory Committee developed its roadmap in the context of the commonwealth's “Community First” long-term care policy. Community First emphasizes maximizing independence for people with disabilities in home and community settings while assuring access to facility-based care when needed.

The framework for the Community First agenda is the state's Olmstead Plan, an action plan for the future of community-based LTSS in the commonwealth (Appendix A – Olmstead Plan Summary). The Patrick Administration established the Olmstead Plan in 2008 as a response to the U.S. Supreme Court ruling in *Olmstead v. L.C.*, which requires states to

¹ Medicare only pays for short-term use of skilled nursing facility and home health care services after a beneficiary's discharge from an acute care hospital.

provide services to people with disabilities in the most integrated settings appropriate. The plan is the result of collaborative efforts among EOHHS and EOE, advocates in the elder and disability communities, providers, and consumers.

The commonwealth's vision for Community First is to “empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice.” Specific objectives and timeframes for achieving this vision are aligned under six goals in the Olmstead Plan:

1. Help individuals transition from institutional (facility-based) care
2. Expand access to community-based long-term supports
3. Improve the capacity and quality of long-term supports in the community
4. Expand access to affordable and accessible housing and supports
5. Promote employment of persons with disabilities and elders
6. Promote awareness of long-term supports ²

Recognizing that this broad reform of the LTSS system in Massachusetts is “contingent upon the availability of re-aligned as well as new public and private long-term support funding,” the Olmstead Plan called for the creation of a long-term care financing advisory group to “determine a roadmap for public and private financing development.” To this end, EOHHS and EOE leadership convened the Advisory Committee in January 2009. The Advisory Committee's work was supported by the University of Massachusetts Medical School's Commonwealth Medicine Division³ and the Massachusetts Medicaid Policy Institute.

C Role of the Long-term Care Financing Advisory Committee

The Advisory Committee included 24 stakeholders from the public, private, and nonprofit sectors with a wide range of expertise and personal experience in the areas of LTSS policy development, service delivery, administration, advocacy, private insurance, Medicaid, consumer-directed care, and academic research. The Advisory Committee, which met 15 times between January 2009 and June 2010, reviewed and analyzed extensive information regarding the populations in Massachusetts that need and use (or may in the future need and use) LTSS, as well as literature about the gaps and limitations in the current public and private financing systems for LTSS (Appendix B – Bibliography of Select Literature). This information provided clear evidence that the current systems are inadequate to meet current

and projected LTSS needs. The Advisory Committee developed a problem statement (see text box on page 3) that guided its work in developing recommendations.

The Advisory Committee analyzed the coverage and cost implications of various public and private LTSS financing mechanisms, and developed comprehensive strategies for addressing the problem and for improving and expanding public and private LTSS financing options for all Massachusetts residents. The Advisory Committee developed its final roadmap of strategies by consensus despite the complexity of the problem, the number and diversity of its members, and the difficult budget environment in which the group worked.

The focus of the Advisory Committee's work was the financing of LTSS. The Advisory Committee, however, identified several important, related issues that will affect the commonwealth's ability to meet its LTSS financing reform goals:

- Affordable and accessible housing
- Employment
- Workforce capacity and development
- Transportation
- Administrative activities
- Public awareness and access to information
- Consumer choice

A description of these issues, most of which are being addressed by other Olmstead Plan or state workgroups or initiatives, is included in Section IV of this report.

The Advisory Committee supports ongoing activities and further work in these areas, and recognizes the importance of their success to the realization of a reformed financing system for LTSS that furthers the commonwealth's Community First goals.

² *Massachusetts Community First Olmstead Plan.*

³ Staff from the Center for Health Law and Economics, the Office of Long-term Support Studies, the Massachusetts Community First Systems Transformation Grant, and several consultants

Long-Term Care Financing Advisory Committee Problem Statement

The financing system for long-term services and supports (LTSS) in Massachusetts is

1. Fragmented among various public and private payers and informal caregivers
2. Centered on insurance-based programs that primarily cover services that are medically necessary, when most individuals' LTSS needs and preferences are for self-care and social supports that are community-based
3. Insufficient to support current and projected needs
4. Heavily dependent on state public assistance programs that have limited resources and base access to LTSS on an individual's income, age, or type of disability

Projected increases in the population of people with disabilities who will need LTSS, a projected decline in the availability of unpaid caregivers, and continued insufficient workforce capacity to provide LTSS will exacerbate these problems.

D Public input process provided critical feedback for development of the roadmap

From its inception, the Advisory Committee was committed to sharing information about its work with the public and collecting public input on the LTSS financing options it was considering. The state launched the Advisory Committee at a January 2009 public conference titled "Long-Term Care Financing in Massachusetts: Current Challenges, Future Trends & Policy Options." The Advisory Committee created a public website (www.mass.gov/hhs/communityfirst), where it posted all of its background, analytic, and meeting materials (Appendix C – Comprehensive List and Description of Advisory Committee Meeting Materials). The Advisory Committee also disseminated information to stakeholders through committees and workgroups related to the state's Community First Systems Transformation Grant.⁴

The Advisory Committee hosted public input sessions during February 2010 in three regions of the state to obtain input on the specific public and private financing strategies it was considering. Over 100 people attended these sessions, including LTSS consumers of all ages, working individuals, caregivers, and representatives from the state's Aging Services Access Points, Independent Living Centers, other elder and disability-specific organizations, community- and facility-based providers, behavioral health providers, long-term care insurers, and housing organizations. For those who could not attend, the Advisory Committee provided an opportunity to submit written comments.

The public input sessions included a presentation on the challenges the

commonwealth faces in financing LTSS and a description of the public and private financing options under consideration, small roundtable discussions to solicit input on each financing strategy, and a brief survey regarding participants' own experiences with LTSS and planning for their LTSS needs. Participants provided critical input regarding the following:

- The affordability of insurance products or program premiums
- The importance of mechanisms that protect an individual's savings and other assets
- Methods of increasing private long-term care insurance participation rates
- The pros and cons of a contribution model, such as the new federal Community Living Assistance Services and Supports (CLASS) program
- Ways to improve public financing of LTSS (particularly Medicaid) for low-income consumers

The Advisory Committee incorporated this feedback into its final roadmap strategies.

⁴ The Community First Systems Transformation Grant is a 2005 grant from the federal Centers for Medicare and Medicaid Services (CMS) designed to strengthen the system that provides community-based long-term services and supports for people of all ages with disabilities in Massachusetts, including elders. The grant focuses on ensuring quality care, effective nursing facility diversion strategies, accessible and affordable housing and optimal consumer choice.

II. DEFINING THE PROBLEM

LTSS FINANCING IN MASSACHUSETTS TODAY

A Background on current and future LTSS utilization and costs in Massachusetts

LTSS include a wide range of services

LTSS include non-medical and medical services, equipment, and supports that help people with disabilities of all ages meet their daily needs and improve the quality of their lives over an extended period (see Figure 1). Provided in homes, communities, and nursing facilities, LTSS include supports that help with everyday tasks (such as shopping, paying bills, cooking, cleaning the house) and self-care supports (such as eating, dressing, bathing, toileting).

LTSS can be quite costly, particularly for facility-based care. The average cost for a private room in a nursing facility in Massachusetts is \$115,000 per year, and the average cost of assisted living is \$51,000 per year.⁵

FIGURE 1

LTSS include a wide range of services and supports

Medical services	Support for everyday tasks	Support for self-care needs
Supports can include <ul style="list-style-type: none"> ■ Primary / preventive health care ■ Acute care ■ Post-acute care ■ Home health (post-acute) ■ Mental health ■ Hospice ■ Early intervention 	Supports can include <ul style="list-style-type: none"> ■ Homemaker ■ Chore ■ Laundry ■ Shopping ■ Meal preparation ■ Home-delivered meals ■ Bill payment ■ Emergency response ■ Transportation ■ Skills training ■ Care coordination 	Supports can include <p>Community</p> <ul style="list-style-type: none"> ■ Adult day health ■ Personal care attendant ■ Home health (long term) ■ Residential supports ■ Respite care <p>Facility-based</p> <ul style="list-style-type: none"> ■ Nursing facility ■ Intermediate care facilities/mental retardation ■ Chronic and rehabilitation hospitals
Education, employment, and housing services also are necessary components of successful community living for people of all ages with disabilities.		

Community-based LTSS, while usually less costly than facility-based services, can be expensive for individuals and families who have no coverage. For example, three hours per day of home health aide services three days a week costs over \$11,000 per year; five hours, five days a week costs over \$32,000 per year.⁶ LTSS costs in Massachusetts, particularly for facility-based care, are approximately 40 percent higher than the national average.⁷

People of all ages use LTSS in a variety of settings

Roughly 630,000 people in Massachusetts—10 percent of the state's population—currently use LTSS to meet their daily routine and self-care needs (see Figure 2).⁸ This diverse population includes children, adults, and elders with chronic illnesses or disabling physical, intellectual, or mental health conditions. Half of the people in Massachusetts who need LTSS are elders and half are under age 65, including young adults and children (see Figure 3).

⁵ MetLife Mature Market Institute, *The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*. (Westport, CT: MetLife, 2009).

⁶ Ibid.

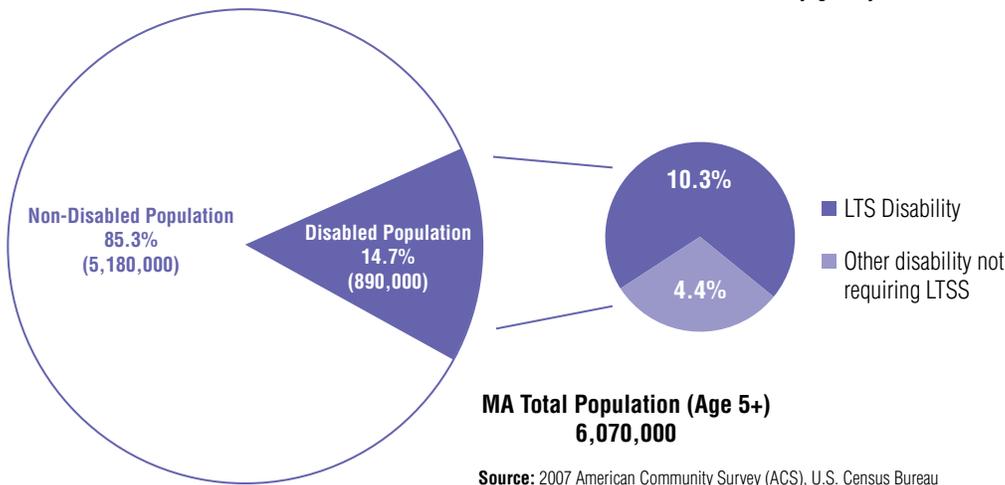
⁷ Ibid.

⁸ 2007 American Community Survey (ACS), U.S. Census Bureau. While nearly 900,000 people age 5 or over in Massachusetts (15 percent of the total population) identify themselves as having a disability, this report focuses on the majority of those individuals who need assistance with self-care or everyday tasks.

FIGURE 2

People with disabilities who need LTSS comprise 10 percent of the Massachusetts population

Massachusetts Population by Self-Reported Disability Status

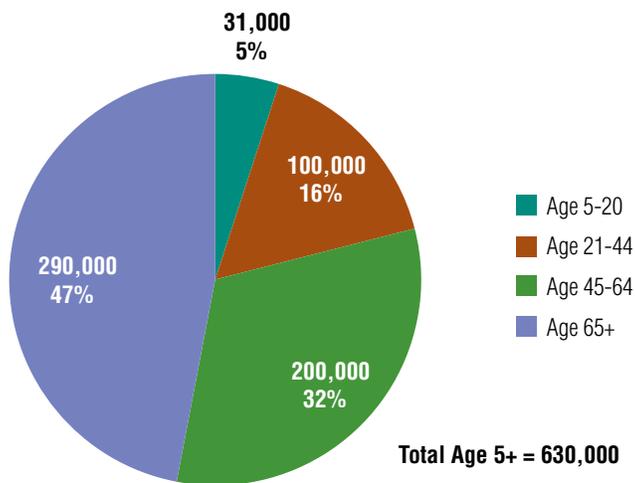


Source: 2007 American Community Survey (ACS), U.S. Census Bureau

FIGURE 3

People with disabilities who need LTSS are represented across all age groups

People with LTSS Disabilities in Mass., by Age Group (2007)



Source: 2007 American Community Survey (ACS), U.S. Census Bureau

Most people turning age 65 will need LTSS in their lifetimes but LTSS costs can vary greatly

While people of any age may need LTSS, the need tends to increase with age. Nearly seven in 10 people (69 percent) turning age 65 will need some LTSS in the future (see Figure 4). Projected LTSS spending, however, can vary greatly across individuals: four in 10 people (42 percent) turning age 65 will not spend anything on LTSS—either because they never need LTSS or because they only receive help from unpaid caregivers—but one in six people (16 percent) turning age 65 will have lifetime LTSS expenditures of \$100,000 or more (see Figure 5). It is difficult to predict who will need LTSS, the duration of the need, and the total cost of care. The absence of more comprehensive data on younger individuals needing LTSS makes it difficult to fully characterize their costs.

Most people (nearly 90 percent) in Massachusetts who use LTSS live in their own home or elsewhere in their community rather than in a nursing facility.⁹ This figure is consistent with national research that suggests that most people, regardless of age, who use LTSS prefer to receive services in the community.¹⁰ Although MassHealth and a variety of state agencies in Massachusetts provide a significant amount of community-based LTSS to people of all ages with disabilities, public spending on LTSS, particularly by MassHealth, still relies substantially on higher cost facility-based care.¹¹ Since 2003, the commonwealth has made a concerted effort to “rebalance” MassHealth LTSS spending toward community-based care and has seen a steady increase in both utilization of and spending on community-based LTSS (see Figure 6 on page 7). The commonwealth’s home- and community-based services (HCBS) waiver programs are some of the mechanisms by which Medicaid funds can be used to provide LTSS in community settings to eligible individuals who would otherwise require care in facility settings. Spending on these programs has been a significant factor in tilting the balance more in favor of community-based care. This shift in MassHealth utilization and spending from facility-based settings to communities reflects the success of the state’s Community First policy, as well as long-standing advocacy efforts by consumers and consumer advocates.

Many people with disabilities have unmet LTSS needs

While there is a large gap in the research in this area, particularly for children and non-elderly adults, several studies nationally and in Massachusetts suggest that many people with disabilities across all age groups have LTSS needs that are not being met through either paid or unpaid caregivers. People who have unmet need include those who receive some assistance with LTSS but need more help, and those who need LTSS but receive no assistance at all. The degree of this unmet need varies significantly by population and type of service needed. For example, a

⁹ 2007 American Community Survey (ACS), U.S. Census Bureau, tabulations by University of Massachusetts Medical School, Commonwealth Medicine.

¹⁰ Bayer, A. and Harper, L., *Fixing to Stay: A National Survey on Housing and Home Modification Issues Research Report*. (Washington, D.C.: AARP, 2000).

¹¹ This “institutional bias” is due in part to MassHealth eligibility and coverage rules that drive utilization toward facility-based care. For example, MassHealth members with a certain level of need and financial status are entitled to receive facility-based care, while most community-based LTSS are optional and access to them can be restricted.

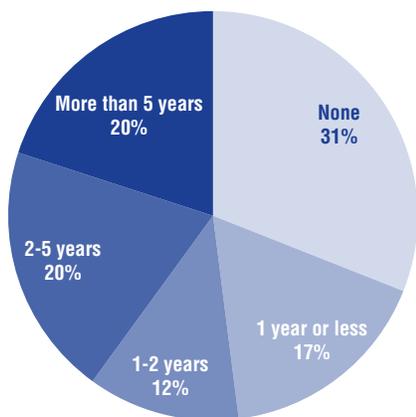
national study of community-based elders who qualify for both Medicaid and Medicare found that 58 percent of elders who need assistance with self-care have some unmet need.¹² A Massachusetts study of non-elderly adults with disabilities found that roughly half of all people who receive some assistance with specific everyday tasks, such as housework and meal preparation, need additional assistance; approximately one-third need additional assistance with self-care such as toileting, walking, and bathing.¹³

The implications of unmet need include lack of access to high-quality care, adverse health effects, increased risk of nursing facility admission, and diminished independence. The research on unmet need identifies inability to pay for LTSS as the primary reason for unmet need, but also suggests that inability to find help and not wanting to ask family or friends are contributing factors. In addition, some services can only be accessed through public programs; they cannot be purchased privately in Massachusetts because a private market does not exist. Additional research on unmet need is necessary to better understand the types of services that are needed and their costs. It is clear, however, that improved and expanded options for financing LTSS—including options that support unpaid caregivers—will help alleviate the problem.

FIGURE 4

Most people turning age 65 will need LTSS in their lifetimes

Projected need for LTSS by people turning 65



Source: Kemper (2005)

¹² H. L. Komisar et al., “Unmet Long-Term Care Needs: An Analysis of Medicare–Medicaid Dual Eligibles,” *Inquiry* 42 (Summer 2005): 171–82.

¹³ Massachusetts Department of Public Health. *Study of the Unmet Needs of Adults with Disabilities in Massachusetts, 2007*. (Boston: DPH, 2008).

Demographic changes will increase future LTSS demand and costs

Impending demographic changes will swell the number of people of all ages with disabilities who need and use LTSS. The related LTSS costs will place an increasing and unsustainable strain on state and federal financial resources, as well as on individuals and their families, making a solution imperative.

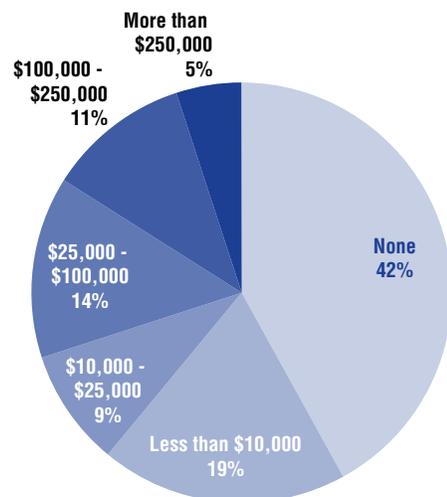
The population needing and using LTSS is expected to grow significantly in the coming decades as the nation’s 76 million baby-boomers begin to turn 65 in 2011 and people with disabilities live longer due in part to advances in medical treatments and technology. In Massachusetts, the population needing LTSS is projected to grow by 15 percent by the year 2020, compared to a growth rate of 6 percent for the general Massachusetts population.¹⁴

Total LTSS costs for these populations are projected to grow accordingly. In 2010, Massachusetts LTSS costs are estimated to be \$18 billion.¹⁵ This figure includes total LTSS costs, including LTSS spending or payments by individuals and third-party payers, and the value of support from unpaid caregivers and of unmet LTSS needs. Given the current population and expected trends, and absent interventions other than implementation of the

FIGURE 5

Projected lifetime LTSS costs for people turning age 65 can vary greatly

Estimated distribution of lifetime LTSS spending for people turning age 65



Source: Kemper (2005)

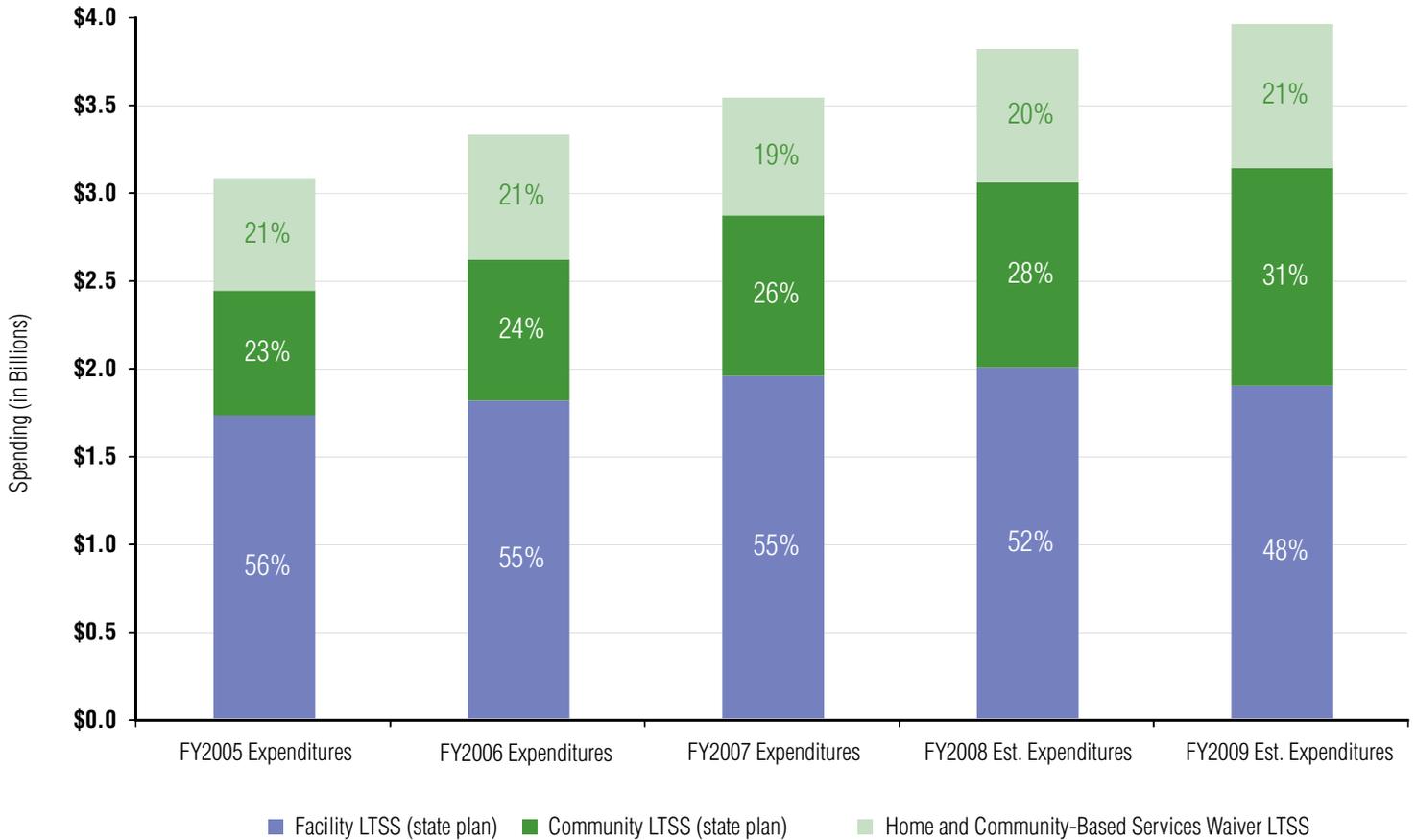
¹⁴ 2007 American Community Survey (ACS), U.S. Census Bureau, tabulations by University of Massachusetts Medical School, Commonwealth Medicine.

¹⁵ Estimate prepared by the University of Massachusetts Medical School, Center for Health Law and Economics using both national averages and Massachusetts-specific data. (See Appendix D of this report.)

FIGURE 6

The shift in MassHealth spending from facilities to communities reflects the state’s Community First policy

MassHealth Facility-Based, Community-Based, Waiver-Based Spending as a Percent of Total MassHealth LTSS Spending



Source: MassHealth Budget Office

federal CLASS program (described in Section II.C.2), total LTSS costs in Massachusetts are projected to increase by at least 50 percent over the next 20 years. MassHealth costs for LTSS will more than double.

Figure 7 illustrates the projected cost increase, as well as how those costs will be distributed across payers and programs, and across the funding sources—individuals and government. The colored blocks of Figure 7 show the current and projected costs of LTSS attributed to various payers and unpaid informal caregivers: Medicare, MassHealth, other Massachusetts state agencies, private insurance, CLASS, out-of-pocket spending by individuals, the value of care provided by unpaid caregivers, and the estimated cost of satisfying unmet needs.¹⁶ The costs are also allocated among two categories of government funding sources and two types of individual payments, represented by the areas between the dotted lines in the chart. The U.S. Government category includes Medicare and the federal share of MassHealth. The Massachusetts Government category includes the state share of MassHealth and other state spending. “Individual: pre-paid” refers to premiums and other contributions made to financing vehicles that insure against the risk of possible future LTSS needs. In contrast,

“Individual: at time of need” includes out-of-pocket payments directly for services, as well as the value of unpaid informal caregivers and the cost of satisfying unmet need. These distributions are discussed further in the next section.

B Financing of LTSS in Massachusetts is public and private, unpaid and paid

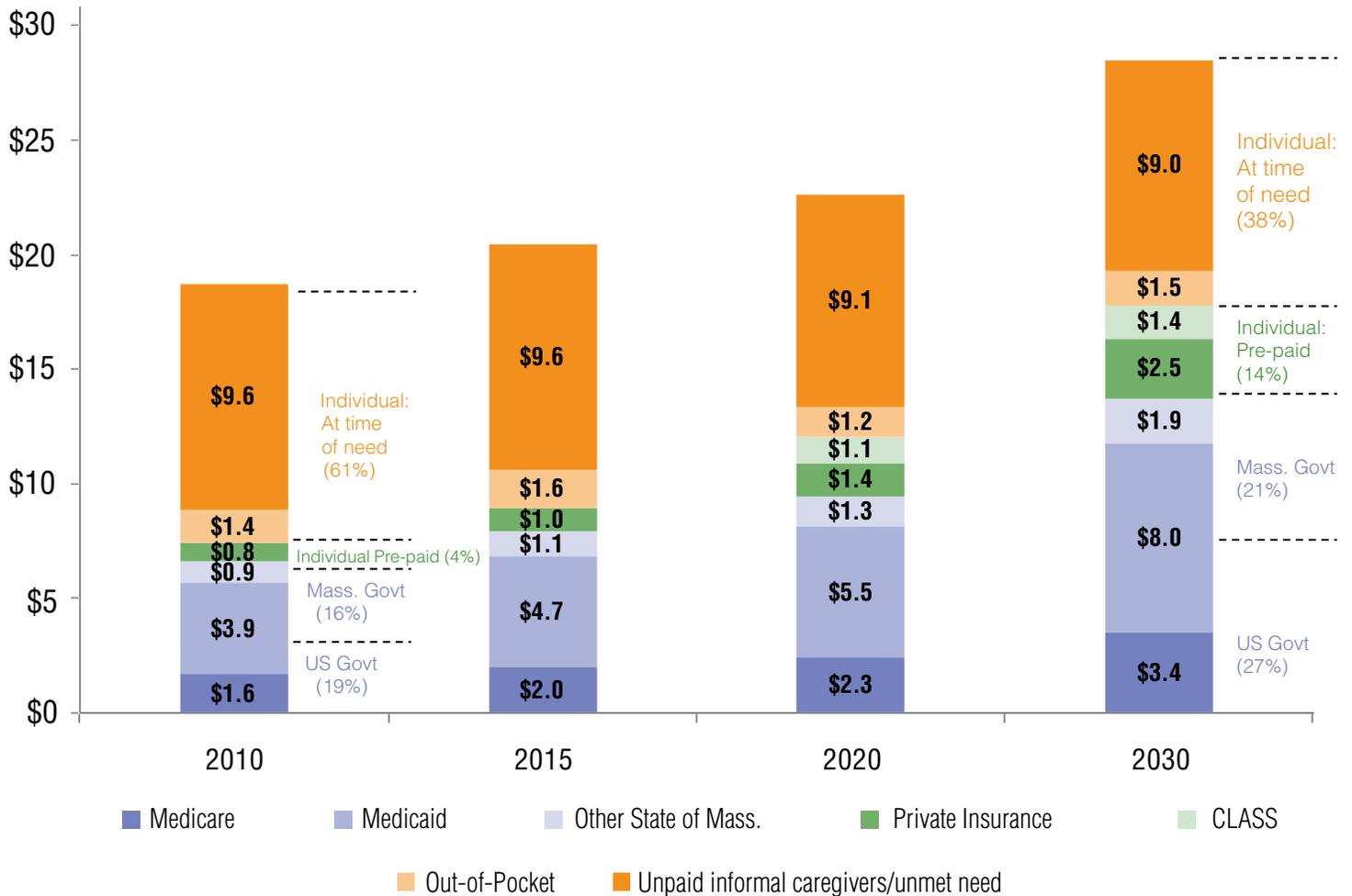
The three largest sources of support for LTSS in the current system—unpaid caregivers, Medicaid, and out-of-pocket spending by individuals and their families—are overburdened and may not be viable options for many people. For example, some people who need LTSS do not have family members or friends who are willing or able to serve as unpaid caregivers, particularly

¹⁶ The projected value of unpaid care and unmet need declines slightly from 2010 to 2030 because of a small projected increase in use of private insurance and the introduction of the federal CLASS program.

FIGURE 7

Total LTSS costs in Massachusetts are projected to increase by at least 50 percent in the next 20 years; MassHealth costs will more than double and government’s share of the burden will increase.

Projected cost growth of LTSS in Mass. in 2030 (in billions)



not for long periods of time. As shown in Figure 4 on page 6, an estimated 40 percent of people turning age 65 will need LTSS for more than two years. Families with children with developmental disabilities or a family member who experiences trauma or an adult onset disability will face even longer periods of LTSS need. Medicaid generally only covers people with limited income and assets and people who spend down their income to become eligible for the program.¹⁷ Additionally, because it is supported by state and federal tax dollars, Medicaid has finite resources and must compete with other state spending priorities, including education, public safety, and transportation. As for out-of-pocket spending, LTSS can quickly consume a family’s household income, savings, and other assets.

Unpaid caregivers are the backbone of the LTSS system, providing the majority of LTSS in Massachusetts. Roughly 700,000 people in Massachusetts provide nearly \$9 billion worth of unpaid LTSS annually to family members, friends or neighbors.¹⁸ Several factors—including people having fewer children, more women (who often are the primary caregivers)

in the workforce and the geographic dispersion of families—threaten the future availability of this critical source of support for LTSS needs. Many individuals also turn to paid caregivers for their LTSS needs. In many instances, people rely on both unpaid and paid caregivers. For example, even though many people in nursing facilities or assisted living facilities are paying for care, family members and friends continue to provide assistance with everyday tasks, such as shopping, bill paying, laundry, and transportation to medical appointments.

¹⁷ Through the MassHealth CommonHealth program, MassHealth allows certain categories of people at any income or asset level to “buy-in” to Medicaid. Sliding scale premiums apply to individuals at higher income levels. MassHealth CommonHealth is available to non-working individuals with disabilities under the age of 65 and working individuals with disabilities aged 18 or older with no upper age limit. This is explained in more detail in Section C.1.

¹⁸ M.J Gibson and A. Houser, *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update*. (Washington, DC: AARP Public Policy Institute, 2008). This number reflects the number of individuals providing LTSS at any given point in time. The estimated number of people providing informal care at any time during the year is 1,040,000.

LTSS are paid for through several public and private funding sources (see Figure 8), which are described in more detail below. **Medicaid** is by far the largest payer of LTSS both nationally and in Massachusetts. In Massachusetts, MassHealth pays for nearly half of all LTSS expenditures, totaling \$3.6 billion in 2008.¹⁹

Although **Medicare** was designed for elders and some younger people with disabilities, it provides only limited and short-term coverage of nursing facility and home care services.²⁰ Therefore, for purposes of this report and its analyses, the Advisory Committee did not consider Medicare as a payer of extended use of LTSS and did not assume any larger role for Medicare in its model projecting the effects of the proposed roadmap.

Out-of-pocket spending, which typically is the “first payer” for LTSS, includes direct payments that individuals and families make to providers of LTSS. Certain services, however, are not available for private purchase, regardless of one’s resources. Services such as individual supports and residential supports are available in Massachusetts only through MassHealth waivers (described in Section II.C).

Private health insurance and long-term care insurance together comprise only 9 percent of total LTSS spending in Massachusetts. Unlike acute health care, there is little employer or commercial insurance participation in financing LTSS. Nearly 97 percent of people with disabilities in Massachusetts have health insurance, but this coverage typically does not pay for LTSS. The exception is MassHealth, which covers certain LTSS for over 300,000 elders and younger people with disabilities. When insurance does cover some LTSS, they are often medical in nature and typically not the home- and community-based supports that most people with disabilities need.

Other public funds include discretionary spending by Massachusetts state agencies (other than MassHealth). These agencies, which spend close to \$1 billion on LTSS for elders, adults, and children with disabilities, include the state’s Executive Office of Elder Affairs, Department of Developmental Services, Department of Mental Health, Commission for the Blind, Commission for the Deaf and Hard of Hearing, and Department of Public Health. In particular, the Executive Office of Elder Affairs’ home care program pays for and coordinates a wide range of community-based LTSS for individuals age 60 and over. Subsidized services are targeted to low-income people, but there is no income restriction on who may purchase the services.

C The current public and private financing systems for LTSS in Massachusetts have gaps and limitations

1. MassHealth provides generous coverage of LTSS, but covers comprehensive community-based LTSS only for some members

MassHealth coverage of certain LTSS is generous for those who qualify

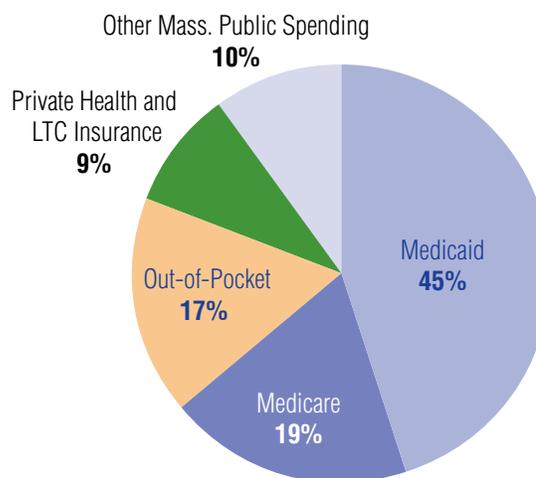
Medicaid (MassHealth in Massachusetts) is the primary payer for LTSS in the commonwealth and in the country. MassHealth provides broad coverage of LTSS for needy elders and most people with disabilities in Massachusetts. MassHealth’s eligibility rules are more generous than Medicaid programs in many states, particularly for children with disabilities, working people with disabilities, and non-working adults under age 65 with disabilities. These individuals can enroll in the MassHealth CommonHealth program regardless of their income or asset levels, with sliding scale premiums that apply to individuals with higher incomes.

MassHealth provides coverage for comprehensive, medically necessary LTSS through its Medicaid state plan,²¹ including many community-based LTSS that states have the option to cover. MassHealth also provides

FIGURE 8

Medicaid (MassHealth) is the primary payer for LTSS in Massachusetts

Massachusetts Spending for LTSS by payer (2005)



Source: Komisar and Thompson (2006), with adjustments made to Other Mass. Public Spending

Note: Medicare covers only limited-term services such as skilled nursing, therapy, or skilled nursing facility care immediately following hospitalization. The Advisory Committee assumed Medicare would continue to cover these services but would not expand further into LTSS.

¹⁹ MassHealth Budget Office. This figure includes spending on the state’s home and community-based services waivers.

²⁰ As noted earlier, Medicare only pays for short-term use of skilled nursing facility and home health care following a hospital stay. Medicare does not cover most LTSS that assist people with disabilities with their daily routine tasks or self-care needs over a long period of time.

²¹ A Medicaid state plan is a document that describes the nature and scope of a state’s Medicaid program to ensure it is in compliance with federal Medicaid rules. State Medicaid programs need a state plan approved by the Centers for Medicare and Medicaid Services (CMS) to receive federal reimbursement for program expenditures.

access to a wide range of additional community-based LTSS to roughly 20,000 people, a small subset of MassHealth members, through eight home- and community-based services (HCBS) waivers (see Figure 9 on page 11).²² HCBS waiver services in Massachusetts, however, are available only for certain targeted groups with a level of need that otherwise would qualify them for facility-based services: frail elders, adults with intellectual disabilities, adults with traumatic or acquired brain injury, and children with autism. The number of people who can participate in each waiver program is capped.

MassHealth maximizes all members' access to other health insurance coverage, including Medicare and employer-sponsored insurance, by providing premium assistance and other cost-sharing assistance for these individuals. For most of these individuals, MassHealth "wraps" the other coverage, meaning it pays for Medicaid-covered services, such as LTSS, that the other insurance does not cover.

MassHealth provides uneven LTSS coverage for low-income people with the same LTSS needs

Although MassHealth provides generous coverage of certain LTSS and uses innovative care delivery models, access to MassHealth-funded community-based LTSS is uneven for people who are similar in terms of financial resources and functional status. This inconsistency exists primarily because MassHealth's financial eligibility and service coverage rules evolved through decades of incremental program expansions, which base access to some or all LTSS on age or diagnosis, and clinical and functional level of care need. This patchwork approach leaves many low-income people, particularly non-elderly people with disabilities, without access to comprehensive publicly paid LTSS. Some non-elderly people with certain diagnoses or disabilities have access to a broader array of community-based LTSS through enrollment in a MassHealth waiver program. Enrollment in these programs is capped, however, so many MassHealth members who need these services cannot access them.

Another example of the disparity in access to LTSS in Massachusetts is seen in MassHealth's financial eligibility rules, which are more generous for people with disabilities under age 65 than they are for elders (Figure 10 on page 12). Primarily because of the availability of MassHealth CommonHealth, most people under age 65 with disabilities can access

MassHealth state plan LTSS at any income or asset level. Elders, however, generally must have incomes below 100 percent of the poverty level (\$10,830 per year for an individual, \$14,570 for a couple in 2010) and assets below \$2,000 for an individual or \$3,000 for a couple to access MassHealth state plan LTSS.²³ Elders with incomes above these levels can "spend down" their income to a set standard and become eligible for MassHealth. Frail elders age 60 and older with income below roughly 210 percent of the poverty level (close to \$23,000 per year) also may be eligible to enroll in a waiver to receive HCBS.

MassHealth innovations provide LTSS that improve quality and cost-efficiency

MassHealth has implemented several innovative care delivery models to ensure that people with disabilities receive the highest quality LTSS in the most cost-efficient manner. MassHealth is a pioneer in integrating Medicaid and Medicare financing and service delivery for elders who are dually eligible for both programs ("dual eligibles"). Different eligibility and coverage rules and separate provider networks usually result in parallel but uncoordinated systems of care for most dual eligibles and cost-shifting between the two programs. Through its voluntary **Senior Care Options** (SCO) program, MassHealth partners with Medicare to provide a comprehensive package of Medicaid- and Medicare-covered health and social services for over 10,000 low-income elders. SCO providers receive separate payments from Medicaid and Medicare and pool those payments to coordinate, provide, or arrange for the delivery of all necessary services for enrollees, minimizing incentives for cost-shifting. The commonwealth is in the process of developing a similar integrated care delivery system model for non-elderly people with disabilities who are dually eligible for MassHealth and Medicare.

Additionally, the commonwealth is exploring expanding its use of **consumer-directed care** models, which it employs in MassHealth and other state-funded programs for certain people with disabilities. These models encourage consumer independence, flexibility, and choice by allowing enrollees to manage their own LTSS budgets (with assistance if needed) and tailor the services they use to best meet their LTSS needs. Individuals can even use their funds to pay informal caregivers. There are several models of consumer-direction, including the national Cash & Counseling model, all of which put the decision-making in the hands of individuals and their families. Evaluations of consumer-directed care models to date indicate strong consumer satisfaction and improved quality of life. Although more research is needed in the area of cost-effectiveness, consumer-directed models may provide Medicaid with better value for its dollars (see Center for Health Care Strategies, Issue Brief 2007, Jessica Green, Ph.D., *State Approaches to Consumer-Direction in Medicaid*).

²² The Social Security Act provides authority for states to seek permission from CMS to "waive" certain provisions of federal Medicaid requirements to operate their programs in a way that differs from what the traditional Medicaid rules allow. Waivers allow states to cover services, such as HCBS, not authorized by traditional Medicaid rules in certain circumstances.

²³ Certain elders can be eligible for MassHealth services under less stringent financial criteria, including working elders with disabilities who are eligible for CommonHealth and elders who would not otherwise qualify for MassHealth due to income standards but require personal care attendant (PCA) services to remain in the community. Elders who require PCA services and are at risk of needing facility-based care without those services can be eligible for MassHealth services with an increased disregard to their income that raises the income standard to 133 percent of the Federal Poverty Level (FPL).

FIGURE 9

LTSS covered by MassHealth

LTSS Covered by MassHealth State Plan *	
<ul style="list-style-type: none"> Adult day health Adult foster care Group adult foster care Behavioral health (mental health and substance abuse) Chapter 766: home assessments and participation in team meetings† Chronic disease and rehabilitation inpatient hospital Continuous skilled nursing Day habilitation Durable medical equipment and supplies 	<ul style="list-style-type: none"> Early intervention Home health Hospice Nursing facility Orthotics Oxygen and respiratory therapy equipment Personal care attendant Prosthetics Rehabilitation Therapy services: physical, occupational, and speech/language
LTSS Covered by MassHealth HCBS Waivers ‡	
<ul style="list-style-type: none"> Agency personal care++ Assistive technology Chore service Community transitions services Companion service Day services Extended habilitation—education Family support and training Grocery shopping and home delivery Home-based wandering response system Home-delivered meals Home/environmental accessibility modifications Home health aide Homemaker 	<ul style="list-style-type: none"> Individual goods and services Individual support and community habilitation Laundry Non-medical transportation Occupational, physical, and speech therapy++ Residential habilitation Respite services Skilled nursing++ Specialized medical equipment Substance abuse services Supported employment Supportive home care aide Vehicle adaptation

* The MassHealth state plan also includes primary, acute and other services available to members with disabilities across the lifespan. A complete list can be found in the MassHealth regulations at 130 CMR 450.105.

† Chapter 766 is the Massachusetts law that guarantees the rights of all young people with disabilities (age 3-22) to an educational program best suited to their needs.

‡ Additional services are provided to individuals enrolled in MassHealth HCBS Waivers. The services listed may be available through one or more of the following MassHealth HCBS waivers: Acquired Brain Injury Waivers, Autism Waiver, Frail Elder Waiver, Traumatic Brain Injury Waiver, and Developmental Disability Services Waivers. Service names may differ depending on the waiver.

++ Waiver service differs from state plan service in amount, duration, scope, and/or method of service delivery.

Finally, many elders who do not qualify for waiver services may be able to access state-funded care coordination and certain other LTSS through the Executive Office of Elder Affairs' Home Care program.

One effect of these disparate financial eligibility rules is that people with disabilities can lose their access to Medicaid-covered LTSS when they turn 65 and stop working. At that point, individuals must requalify for MassHealth using the more stringent financial eligibility rules for elders. The commonwealth has been working to address these and other inequities in access to LTSS for people with disabilities as part of its Community First agenda; the strategy involves adopting more holistic eligibility and coverage rules that only consider a low-income person's financial resources and LTSS needs. Consistent with this goal, the Advisory Committee committed

to developing financing options for low-income people who need LTSS regardless of their age or type of disability.

2. The private sector does not play a large role in financing LTSS in Massachusetts

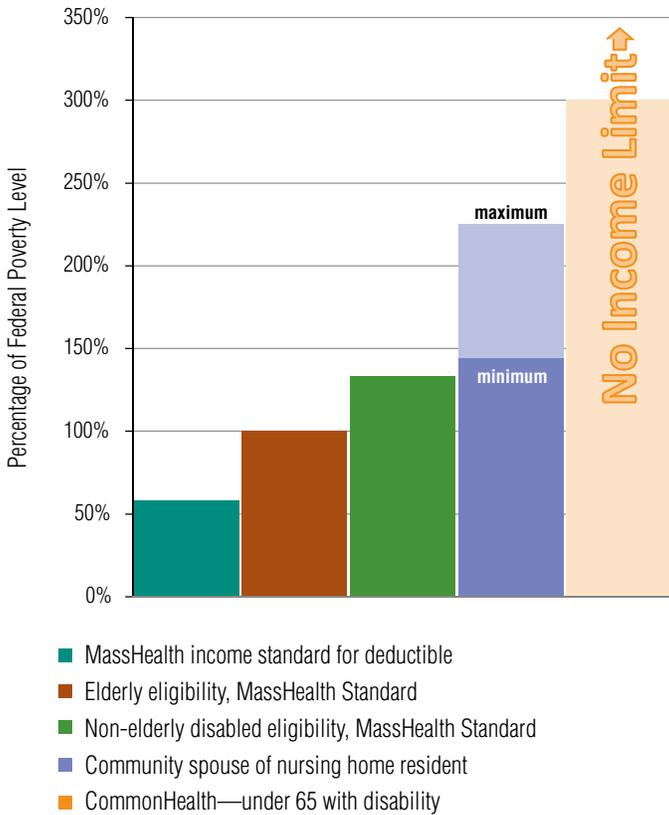
Private financing mechanisms for LTSS in Massachusetts are underutilized for several reasons

Private financing for LTSS is a small part of the current payer mix for LTSS, making up just 9 percent of current LTSS expenditures in Massachusetts, as shown in Figure 8 on page 9. This spending includes private long-term

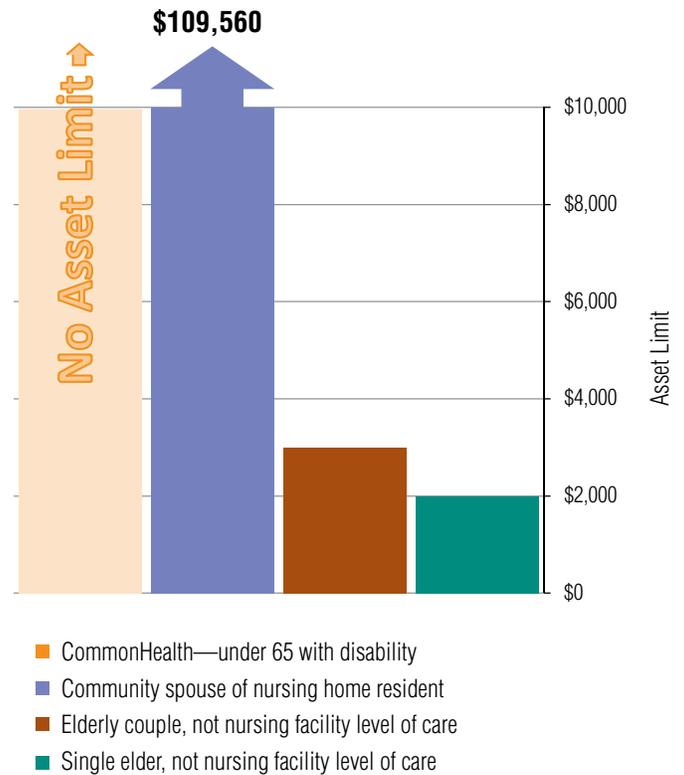
FIGURE 10

MassHealth financial eligibility rules create significant access inequities between elders and non-elderly people with disabilities

Income below which one is financially eligible for MassHealth



Maximum assets allowed for MassHealth eligibility



care insurance, as well as other private financial transactions and insurance products that can be used to pay for LTSS needs (see text box on page 13).

Long-term care insurance is the most commonly used of these private financing vehicles. Although the number of people purchasing long-term care insurance each year is growing, the overall take-up rate remains very low. The total number of Massachusetts residents with long-term care insurance in 2008 was roughly 153,000, or about 6 percent to 7 percent of eligible purchasers.²⁴ Of these, 64 percent purchase individual policies and 36 percent participate in group or employer-sponsored coverage. Other relevant facts about long-term care insurance in Massachusetts are in Figure 11 on page 14.

Existing private financing mechanisms for LTSS are underutilized for several reasons. Many people cite unaffordable insurance premiums (which can increase significantly from year-to-year) and fear of insurer insolvency when the benefits are needed (which can be decades after the policy is purchased) as primary barriers to purchasing insurance products. Massachusetts has a guaranty fund association that would offer a replacement policy from another company in the latter circumstance.²⁵ The availability of Medicaid may inhibit the purchase of private insurance for some people.²⁶ Long-term

care insurers also require applicants to undergo a health screen, leaving many people with chronic or disabling conditions who need LTSS unable to purchase a policy. Other financial vehicles can be confusing, be unregulated or under-regulated, and carry high transaction fees. Finally, many people are not even aware that these financing options for LTSS exist or mistakenly believe they do not need coverage because Medicare will cover their LTSS needs.

²⁴ Massachusetts Division of Insurance, 2010 *Report of Long-term Care Insurance in Massachusetts: Results of a 2008 Examination*. (Boston, MA: DOI, 2010)

²⁵ Mandated by M.G.L. Chapter 175, Section 146B, Massachusetts Life and Health Insurance Guaranty Association Law. The guaranty fund pays claims up to \$100,000 incurred before the policy-holder's next renewal date (but no shorter than 30 days or longer than one year). After that, the person has to enroll in a new policy, which may have higher premiums.

²⁶ D. G. Stevenson et al., "The Complementarity of Public and Private Long-Term Care Coverage," *Health Affairs*, 29: 1 (2010): 96-101.

Private LTSS Financing Vehicles

Long-term care insurance: Long-term care insurance pays for certain LTSS for premium-paying policy holders. Long-term care insurance typically covers specific services with a specified limited duration and/or maximum lifetime cost, after the policy holder reaches a defined level of disability.

Reverse mortgages on real property: Reverse mortgages allow homeowners to borrow against the equity in their home; the lender makes payments to the homeowner instead of the homeowner making payments to the lender. Borrowers can use the loan for any purpose, including for LTSS expenditures or long-term care insurance premiums.

Life insurance policies with long-term care options: Life insurance policies are contracts with an insurance company that allows buyers to plan for their beneficiaries in the event of their death. Buyers can purchase a **long-term care rider** that provides funds, in the form of either a monthly benefit or reimbursement for charges incurred, if long-term care is needed. If used for this purpose, the death benefit is reduced. Life insurance policies also can include provisions that allow the buyer to obtain **loans** on a policy or exchange a policy for cash value. Policies also can be sold to a viator for a cash payment. A viator or **viatical settlement** company may purchase a life insurance policy from a policy holder, who receives a lump sum cash payment from the viator that is a percentage of the policy's face value. This money can be used for LTSS expenditures.

Annuity contracts: Annuity contracts are contracts with an insurance company that pay the buyer monthly cash benefits during an established period of time or during the life of the buyer to help the buyer save for financial needs at the end of their lives. The buyer can purchase either a long-term care annuity that integrates long-term care insurance with an annuity, or a long-term care rider. A buyer with a long-term care rider who meets the policy's definition of requiring long-term care receives a monthly benefit to pay for care.

Massachusetts' existing incentives to use private insurance for LTSS can be strengthened

Massachusetts' Division of Insurance (DOI) regulates most products that provide insurance for LTSS, including individual and group life insurance policies with long-term care options, annuity contracts that provide funds to pay for LTSS needs, and individual long-term care insurance policies. Group coverage for long-term care insurance is not subject to DOI regulations.

DOI requires individual long-term care insurance policies to meet the following consumer protection standards:

- Are guaranteed renewable or non-cancellable
- Provide at least 730 days (or a comparable dollar amount) of coverage
- Do not include an elimination period (waiting period) of more than 365 days
- Provide benefits based upon a needs standard of no more than two Activities of Daily Living (ADLs)
- Include alternate care provisions allowing coverage for unspecified services if agreed to by the insured, insurance company, and health care practitioner
- Offer an applicant the opportunity to buy inflation protection and nonforfeiture benefits
- Offer at least one policy with home health care benefits and one that qualifies for certain MassHealth exemptions (see below)
- Limit any pre-existing condition clauses to no more than six months after the policy's effective date

- Do not limit benefit payments because an individual develops Alzheimer's Disease, mental illness, alcoholism, or other chemical dependency after the policy is issued²⁷

While these regulations provide some security for purchasers of long-term care insurance, Massachusetts is one of nine states that has not adopted broader consumer protection and insurance standards recommended by the National Association of Insurance Commissioners (NAIC). Expanded consumer protections, particularly around premium increases and insurer solvency, would encourage more people to purchase private insurance for LTSS. A bill to implement these broader standards was considered but not enacted during the past session of the Massachusetts legislature.²⁸ The NAIC standards, and differences between them and Massachusetts' existing consumer protections, are described in more detail in Section III of this report.

Since 1991, Massachusetts has provided certain exemptions from MassHealth eligibility and estate recovery rules for people covered by a long-term care insurance policy that meets the DOI coverage requirements outlined above. Ordinarily, for people to qualify for MassHealth coverage of LTSS, they must spend down all but a small portion of their assets. The MassHealth exemptions provide an incentive for people to purchase long-term care insurance by allowing them to keep more of their assets if they

²⁷ Massachusetts Division of Insurance, 2010 Report of Long-term Care Insurance in Massachusetts: Results of a 2008 Examination.

²⁸ Senate 2554, An Act to Establish Standards for Long-term Care Insurance. Massachusetts General Court, 186th Session.

FIGURE 11**Current participation in private long-term care insurance in Massachusetts**

2008 LTC Insurance Survey	Individual Market	Group Market
Number of people insured	97,644	55,214
Average annual premium*	\$2,696	\$513
Average age of member	65.3	50.4
Average daily nursing home benefit purchased	\$183	\$121
Average daily home health benefit purchased	\$178	\$93

* Premiums potentially reflect varying plan designs and enrollment demographics
 Source: Massachusetts Division of Insurance, 2010

1) use up all of their long-term care insurance benefits, and 2) apply for MassHealth because they still need LTSS coverage. Massachusetts' current exemptions are as follows:

- 1. Eligibility:** For Medicaid eligibility determination purposes, Massachusetts exempts from countable assets the former home of an institutionalized individual if that person is covered under a long-term care insurance policy that meets DOI's minimum coverage requirements.²⁹
- 2. Estate Recovery:** If a person is covered under a qualifying long-term care insurance policy when he or she enters a nursing home, MassHealth will not recover the costs of the nursing facility or other LTSS, if the person is permanently institutionalized and notifies MassHealth that he or she had no intention of returning home.³⁰

Though different in scope, Massachusetts' asset protection provisions related to qualifying long-term care insurance are similar to the Long-Term Care Partnership program, a national model that several states have adopted. Differences between the Partnership and Massachusetts' asset protection provisions are described in more detail in Section III of this report.

Securing private financing for LTSS requires action on the part of individuals and families; government can play a role in encouraging personal financial planning

Using private mechanisms to finance LTSS requires action on the part of individuals and families either to plan for potential future LTSS costs in advance of the need or to arrange for financing at the time of the LTSS need. Individuals in their 20s, 30s, and 40s may perceive the potential need to be nonexistent or too far in the future to act. Older consumers may be more

aware of the need to protect against future LTSS costs but may not be able to afford insurance premiums, which are higher for older purchasers, or may not have sufficient savings to cover the costs.

Although data on personal wealth beyond income data are sparse,³¹ it is clear that most families who wait to think about financing until a LTSS need arises will not be able to pay for extensive use of LTSS for themselves or a loved one out of income, savings, or other assets. Most people without current need have more pressing priorities, including housing expenses, daily living expenses, acute health care costs, and potentially college tuitions or debt, leaving few "rainy day funds" available for LTSS expenditures. Additionally, many low- and middle-income families do not have discretionary wealth and their only asset is the equity in their home, which they often are compelled to use to finance their LTSS needs. The recent economic recession has aggravated the situation by decimating people's wealth, including their income, retirement savings, and housing values.

One type of advance planning that some people undertake is to transfer valuable assets, so that they will not have to use them to finance LTSS before being able to qualify for Medicaid. While this practice does occur, strict federal rules governing asset transfers probably prevent it from being a very common path to Medicaid coverage.³² For example, transfers for less than fair market value may not occur within five years of applying for Medicaid, or a penalty that delays the start of Medicaid coverage will result. There are also strict rules governing the use of annuities to shelter assets, irrevocable trusts, and a number of other provisions.³³ It is important for government to monitor trends in this practice; if asset transfers become common, the practice would significantly undermine the economic appeal of other private financing mechanisms.

Earlier and better planning for financing LTSS needs is essential, as is the infusion of private dollars into the financing system for LTSS. Without such steps, many people will continue to face catastrophic LTSS costs with few options to pay for them except their own (often limited) income and assets and, when those are depleted, MassHealth. Acting on its consumer protection role and obligation to preserve finite public resources for those most in need, government should play a role in encouraging better planning, educating the public about financing options, and promoting the development and use of private financing mechanisms to pay for LTSS.

²⁹ MGL c.118E, §25; 211 CMR 65.00.

³⁰ MGL c.118E, §33; 130 CMR 515.011(B); 130 CMR 515.012(C); 130 CMR 515.014.

³¹ This is particularly true for non-elderly people with disabilities.

³² Joshua Wiener, prepared testimony before the U.S. Senate Committee on Finance Subcommittee on Health Care. Hearing on "The Role of Long-Term Care in Health Reform," March 25, 2009. The testimony cites a "rigorous research literature that finds that transfer of assets is relatively infrequent and usually involves quite small amounts of funds when it occurs."

³³ Center for Medicare and Medicaid Services, "Transfer of Assets in the Medicaid Program," January 8, 2008. (<https://www.cms.gov/DeficitReductionAct/Downloads/TOAbackgrounder.pdf>, accessed August 19, 2010).

The federal government took a step in this direction recently with the creation of the **Community Living Assistance Services and Supports (CLASS)** program in the national health care reform legislation President Obama signed on March 23, 2010.³⁴ The CLASS program provides a mechanism for working individuals to plan ahead for their potential LTSS needs by making a voluntary contribution, through a payroll deduction, into a national trust fund.

Active workers (including part-time workers) who choose to participate in CLASS must pay premiums for five years before they are eligible for CLASS's lifetime cash benefit. Employers can automatically enroll their workers into CLASS, but employees can choose to opt out of the program. Retirees can participate in CLASS as long as they were working for three of the five years and continue to pay premiums for all five years.

CLASS's monthly premiums are projected to be \$123 per month; low-income individuals and full-time students will pay significantly lower premiums.³⁵ Additionally, premiums will be age-adjusted so that younger enrollees will pay lower premiums than older enrollees. The average daily cash benefit, which can be used for any LTSS-related expense, including facility-based care, community-based care, and paying informal caregivers, is projected to be \$75. Policy makers and analysts expect this amount to cover at least a basic level of people's LTSS needs. There is no health screen for CLASS, so people with existing chronic conditions and disabilities are eligible to enroll.

Many features of CLASS are not yet defined, including employee premiums, the cash benefit level, and mechanisms for self-employed individuals and employees of non-participating employers to enroll in the program. The health care reform law gives significant flexibility to the federal Secretary of Health and Human Services to design the program, which will begin in 2011. The CLASS program is described in more detail in Section III of this report.

In addition to CLASS, several states currently provide state tax incentives to encourage the purchase of private insurance for LTSS, particularly by younger purchasers, with varying degrees of success. There is much more that both the state and federal governments can do to encourage or even orchestrate better financial planning for people's LTSS needs.

D The need to reform Massachusetts' LTSS financing system is evident

The information the Advisory Committee reviewed on current and projected LTSS needs, and the gaps and limitations of existing public and private LTSS financing options, highlight the urgency of the problem with the current LTSS financing system in Massachusetts. This is summarized as follows:

- LTSS include a wide range of often costly facility- and community-based services and supports.
- The population needing and using LTSS is diverse and represented within all age groups.
- It is difficult to know who will need LTSS and how much they will need, but most people cannot afford LTSS beyond short-term use.
- The number of people who need LTSS and the costs of providing LTSS are growing rapidly.
- Family members and other unpaid caregivers will continue to be an essential source of LTSS, but their availability will decline over time.
- Public dollars (primarily through Medicaid) disproportionately pay for LTSS compared to private dollars.
- Medicaid has limited funding and provides uneven coverage for low-income people with different personal characteristics (i.e., age, diagnosis) but who have the same LTSS needs.
- Private financing mechanisms for LTSS are not well-known or utilized.
- Private long-term care insurance is not advantageous, affordable, or available for everyone.

The complexity of LTSS financing issues and the diversity and size of the population needing LTSS require multiple solutions to the problem. Figure 12 is a schematic picture of the LTSS financing system that shows the financing options that currently exist. It does not portray the number of people covered by each option or the distribution of LTSS spending.

The accessible financing options depend on the extent of one's LTSS needs and financial resources (income, savings, and other assets), and—depending on an individual's particular circumstances—can quickly consume one's personal wealth or overwhelm one's family members or friends. In general, people with low income and few assets, regardless of LTSS need, are eligible for Medicaid (MassHealth). People with higher income and assets can purchase private insurance for LTSS, particularly to cover basic or moderate LTSS needs, and protect much of their wealth. The majority of people in the middle use personal resources to pay for or support their LTSS needs, eventually spending down to qualify for Medicaid coverage. This is particularly true for those with high LTSS needs or low to moderate financial resources. The Advisory Committee concluded that the status quo is not fair, efficient, or sustainable. In developing its roadmap for policy makers, therefore, the Advisory Committee recommends bold, proactive, and comprehensive strategies for solving the problem.

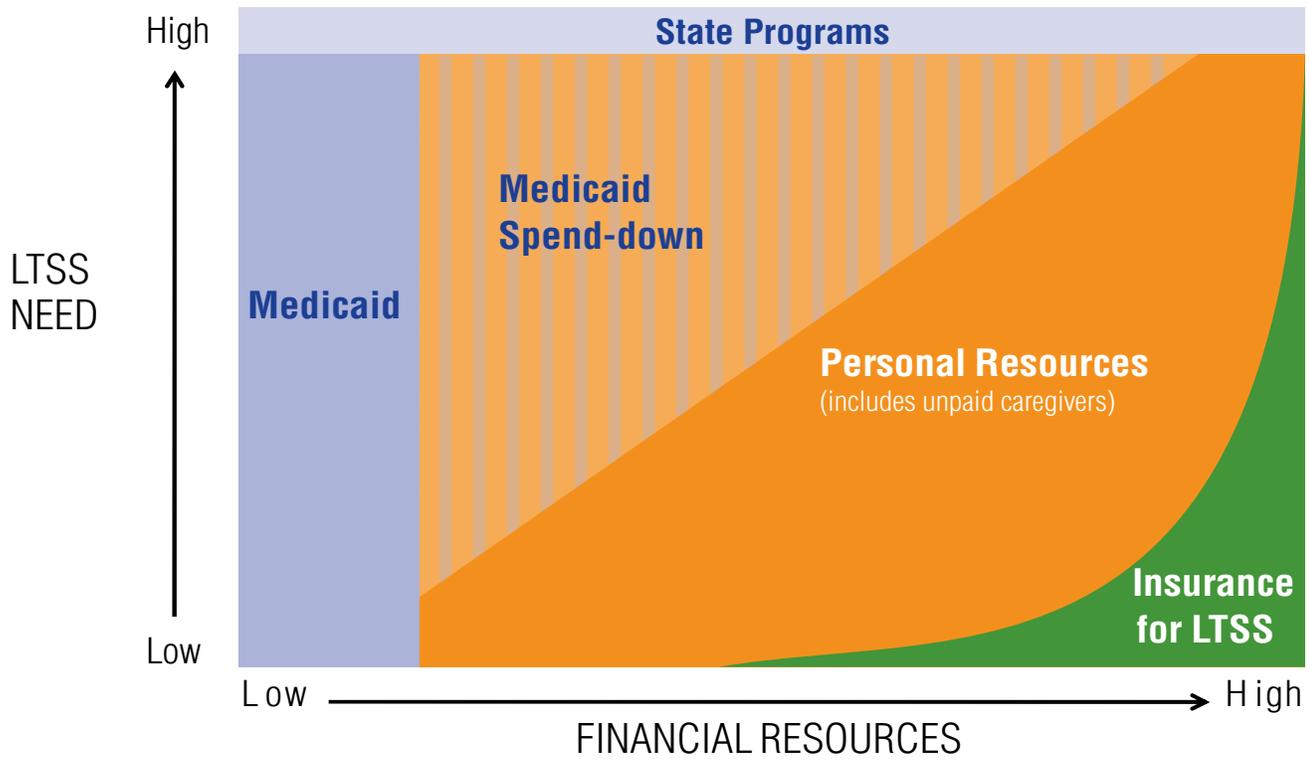
³⁴ Section 8002 of the Patient Protection and Affordable Care Act, Public Law 111-148, March 23, 2010.

³⁵ Paul Van de Water, *CLASS: A New Voluntary Long-Term Care Insurance Program*. (Washington, D.C.: Center on Budget and Policy Priorities, April, 2010).

FIGURE 12

Most people have few accessible and affordable options for financing LTSS in the current system

Schematic of current LTSS financing system



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III. A ROADMAP FOR REFORMING LTSS FINANCING IN MASSACHUSETTS

A A view toward a reformed LTSS financing system in Massachusetts

Moving toward access to universal coverage of LTSS

The Advisory Committee's roadmap includes strategies that move the current LTSS financing system from one that is accessible and affordable only for subsets of the population to a more seamless financing system that provides a broader array of financing choices to people with LTSS needs, regardless of age and financial resources.

From the outset, the Advisory Committee's long-term goal for a reformed financing system in Massachusetts has been to ensure universal access to a basic level of coverage for all people with LTSS needs. Without bold reform, the deficits in the LTSS financing system will worsen. Projected trends will increasingly burden individuals and families, government, and the LTSS system as a whole. Continued gaps in LTSS coverage will perpetuate the financial stress on individuals who must find a way to pay for services; the physical, emotional, and financial costs to unpaid caregivers; and the financial pressure on state Medicaid programs. For these reasons, the goal of achieving universal access to LTSS coverage dictated the Advisory Committee's analytic work and strategy development.

In developing its roadmap, the Advisory Committee considered strategies and incentive structures that would maximize participation in existing or new LTSS financing mechanisms. The Advisory Committee examined the merits of both voluntary and mandatory approaches to increasing participation and achieving universal LTSS coverage.

The roadmap's multi-strategy structure is described in this section of the

Massachusetts' reformed LTSS financing system will

1. Ensure a strong public safety net for the poor and most vulnerable
2. Assure quality of care and cost efficiency
3. Limit financial pressure on the state financing system to preserve state funds for those most in need
4. Encourage personal planning for financing LTSS
5. Enable middle-income people to access LTSS without becoming impoverished
6. Support unpaid caregivers

report. The implementation of the proposed array of strategies, phased in over approximately 10 years, will enable policy makers to monitor the state's progress in achieving universal access to LTSS coverage, and to gauge whether voluntary approaches are moving the system far enough along toward that goal before considering compulsory approaches described later in the roadmap.

Based on the specific problems it identified in the current public and private financing systems, the Advisory Committee adopted six principles for a reformed system that guided its strategy development (see box). As noted earlier, these principles relate to the financing of LTSS and represent only one area of work under the commonwealth's broader Community First Olmstead Plan.

The Advisory Committee selected the specific combination of public and private financing strategies included in the roadmap because they directly respond to the problems identified in the current financing structure, maximize the values underlying the six guiding principles, and maximize access to LTSS coverage.

Background on the methodology for the Advisory Committee analysis of financing strategies

In developing its roadmap, the Advisory Committee analyzed numerous public and private financing mechanisms, including those considered or adopted in other states and countries.³⁶ The analysis revealed that there is no quick fix or single solution that addresses the LTSS financing problems for all people who need or will need LTSS, and that multiple solutions are necessary to achieve the Advisory Committee's desired principles for a reformed LTSS financing system and its goal of universal access to coverage.

The Advisory Committee arrived at its final comprehensive set of strategies through analysis and debate. The Advisory Committee evaluated each financing mechanism based on several questions, including the following:

³⁶ For example, see Minnesota Department of Human Services, *Financing Long-term Care for Minnesota's Baby Boomers, A Report to the Minnesota Legislature*, January 2005; Washington State, Task Force on Long-term Care Financing and Chronic Care Management, *Interim Report*, January 2007 and *Final Report*, January 2008; and H. Gleckman, *Long-Term Care Financing Reform: Lessons from the U.S. and Abroad*. (Boston, MA: Center for Retirement Research at Boston College, 2010).

- Who would be eligible to participate?
- How many people would be covered?
- What incentives would increase participation?
- What would be the impact on and distribution of costs among various sources?

The substantive data analysis primarily focused on the strategies' individual and combined effects on increasing LTSS coverage and on cost to and spending by individuals, unpaid caregivers, and government. In order to project costs accurately, the model analyzes a point in the future when people who avail themselves of the proposed roadmap strategies would use them to finance their LTSS needs. All cost and spending estimates in this section of the report, therefore, are projected to 2030 dollars. These estimates assume that by 2030, the strategies will have been fully implemented and their long-term effects realized.

A detailed methodology for the Advisory Committee's analysis, including modeling, data sources, and assumptions, is in Appendix D.

B The Roadmap: LTSS financing strategies maximize coverage for all Massachusetts residents

1. Structure and overall impact of the roadmap strategies

The roadmap comprises three core financing strategies, each of which includes several discrete financing mechanisms (see Figure 13 on page 19). Two strategies promote private/personal planning for LTSS needs, particularly for middle-income people who have some financial resources available to contribute to their LTSS costs, while the third strategy improves the public safety net financing mechanism for low-income people. The three core financing strategies are as follows:

1. Improve or increase utilization of private LTSS financing mechanisms for existing or future LTSS needs
2. Expand MassHealth coverage to achieve equity in access to LTSS
3. Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs

Additional strategies are essential to successful reform and must be undertaken regardless of any further activity on the core financing strategies. The roadmap refers to these as "foundational" strategies. The specific strategies listed in Figure 13 are described in the following section of the report.

The combined strategies reform the LTSS financing system over time by realigning the LTSS funding mix, limiting excessive financial exposure for LTSS costs for individuals and their families, minimizing impoverishment of middle-income families, and strengthening the public LTSS financing system for low-income people.

More specifically, the strategies strive to achieve the following:

- Diversify the availability of affordable private LTSS financing options
- Promote the purchase of affordable private insurance for LTSS, particularly for younger people
- Increase the options for personal planning for future LTSS needs
- Ensure equity in access to publicly funded LTSS for low-income people with disabilities regardless of age or type of disability
- Promote cost efficiency with innovative financing and delivery models
- Provide both financial and non-financial support to unpaid caregivers

The strategies included in the Advisory Committee's roadmap are designed to expand access to coverage for community-based LTSS to all people with disabilities who need or will need them, and result in more integrated public and private LTSS financing options for people across the lifespan and financial spectrum. The roadmap strategies also significantly advance the commonwealth's Community First goals of consumer independence, flexibility, and choice.

2. The roadmap strategies

Foundational strategies

This section discusses four basic strategies that form the foundation for the core financing strategies that follow in the next section. The foundational strategies focus on raising general awareness of LTSS needs and costs in the coming years; promoting care coordination for those with LTSS needs; and supporting unpaid caregivers, the backbone of the LTSS delivery system.

F.1 Implement a comprehensive and multi-phase LTSS financing awareness and education campaign targeted to the public and to employers.

At the heart of any effort to improve and reform the system of financing LTSS must be a comprehensive awareness and education campaign. An effective campaign would increase utilization of private financing mechanisms and help people plan or save money earlier in life for future LTSS needs.

A comprehensive public awareness and education campaign will bring LTSS into the forefront of individuals' planning for their future and make them aware of the options that exist. Specific efforts must be made to educate individuals, employers, health care providers, and policy makers about the costs of LTSS; the likelihood of needing LTSS; the roles of MassHealth, Medicare, and health insurance; unpaid caregiving, its supports, and challenges; and the roles of long-term care insurance and other private financing mechanisms. New initiatives, such as those included in this report, will also have to be incorporated into any awareness campaign.

FIGURE 13

Specific financing strategies to expand access to and coverage of LTSS

Core Financing Strategies			
	1 Increase utilization of private LTSS financing mechanisms	2 Expand MassHealth coverage to achieve equity in access to LTSS	3 Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs
S P E C I F I C S T R A T E G I E S	1.1 Enact the national consumer protection and insurance standards recommended by the National Association of Insurance Commissioners (NAIC)	2.1 Expand access to a <i>limited</i> package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs	3.1 Participate in the federal process of specifying the details of CLASS; educate employers and employees about CLASS; consider promoting participation of employees and employers in CLASS if warranted when details are known
	1.2 Improve and expand the purchase of private insurance for LTSS <ul style="list-style-type: none"> ■ Promote life insurance with LTSS coverage options ■ Promote group coverage/portability of private insurance for LTSS ■ Develop LTC Partnership program (with provisions for protecting Massachusetts residents who have already purchased LTC insurance) 	2.2 Expand access to a <i>comprehensive</i> package of community-based LTSS to this targeted group	3.2 If other strategies do not achieve the goal of universal access to basic LTSS coverage, then <ul style="list-style-type: none"> ■ Design and implement a state-sponsored individual contribution program that provides universal access to basic LTSS coverage for all Massachusetts residents ■ Private insurance and MassHealth would provide supplemental coverage for individuals with very high LTSS needs
	1.3 Promote the use of other mechanisms to support private financing for LTSS (e.g., reverse mortgages, annuities, and LTSS savings accounts)	2.3 Expand eligibility for MassHealth coverage for LTSS for elders over age 65	
Foundational Strategies			
<ul style="list-style-type: none"> ■ Implement a comprehensive and multi-phase LTSS financing awareness and education campaign targeted to the public and to employers ■ Maximize integrated financing and care coordination consistent with health care reform opportunities ■ Expand support for unpaid caregivers' skills and well-being, particularly support for counseling programs, support groups, and training ■ Extend additional support for unpaid caregivers' financial circumstances through workplace policies, tax incentives, and other means 			

The commonwealth will be able to build upon existing efforts to developing a LTSS awareness campaign. In January 2010, Governor Patrick launched a public awareness initiative called “Embrace Your Future,” overseen by the Executive Office of Elder Affairs, which was designed to build awareness around the importance of financial, legal, home modification, health, and other planning options. There are also a number of targeted initiatives that educate consumers on the Massachusetts LTSS system. These include the federally funded Serving the Health Information Needs of Elders (SHINE)

program at the Executive Office of Elder Affairs; information and referral units of state agencies and community organizations, including Independent Living Centers, Aging Services Access Points, Aging and Disability Resource Consortia, and Councils on Aging; and database resources, such as 800AGEINFO and the Massachusetts Aging and Disability Information Locator (MADIL).

There are likely to be new resources available to the commonwealth in its development of a comprehensive awareness and education campaign. As the new national health care reform law (the Patient Protection and Affordable Care Act) is rolled out, there are a number of efforts underway to educate the public about the new programs and benefits that will be available, including those available through CLASS. The commonwealth should continue to monitor federal funding opportunities that might be available for further education about federal reforms.

F.2 Maximize integrated financing and care coordination consistent with health care reform opportunities and other system change efforts

This strategy begins to improve access to LTSS for elders, despite continued service and eligibility inequalities between elders and non-elderly individuals with disabilities. Many elders with insufficient time and income to prepare for their future or current LTSS needs will still have limited alternatives to “Medicaid spend-down” and safety net services.

A combination of expanded access to care coordination through opportunities in the federal health care reform legislation and other pilot projects and continued investment in Aging and Disability Resource Consortia (ADRC) would increase options for elders to locate and access coordinated LTSS. To receive the full array of MassHealth state plan services or enroll in a HCBS waiver, non-working elders must meet asset and income criteria, as well as clinical criteria.³⁷

The Advisory Committee recommends investigating a number of options to enable elders to locate and access coordinated LTSS:

- **Pursue and maximize opportunities that arise due to the Patient Protection and Affordable Care Act (ACA) that result in integrated and coordinated care.** Over the next several years, new pilot programs, demonstration projects, and grants that are part of the ACA will be available to states. The commonwealth should review all opportunities and apply for funding that will increase opportunities for integrated and coordinated care. See Appendix E for a list of available opportunities.
- **Expand funding of the Massachusetts ADRCs.** ADRCs are key access points that provide elders and individuals with disabilities with LTSS information, referral, and assistance; streamlined access to eligibility for publicly funded programs; benefits and options counseling; evaluation of needs; and service planning coordination. With expanded funding, these 11 regionally based consortia can continue to help elders and individuals with disabilities learn about LTSS options and locate services and supports. This strategy provides opportunities both for individuals who have done some advanced planning for LTSS but need some additional assistance or information and for individuals who are having difficulty preparing for their future LTSS needs due to age or financial status. The commonwealth currently

has a three-year grant (ending in 2012) from the Administration on Aging to enhance and strengthen ADRC programs and statewide systems development. The commonwealth should pursue future grant opportunities and seek additional state appropriations when grant funding ends to maintain ongoing services and coordination and to continue to develop a comprehensive statewide ADRC system.

F.3 Expand support for unpaid caregivers' skills and well-being, particularly support for counseling programs, support groups, and training.

Caring for loved ones is something that most people want to do. Nationally and in Massachusetts, unpaid caregivers—including spouses, children, siblings, neighbors, and friends of care recipients—provide the bulk of LTSS to family members and friends and will continue to do so. Most report satisfaction with their caregiving role.³⁸ However, many family and other unpaid caregivers assume significant and potentially long-term financial, physical, and emotional burdens in providing these long-term supports. In order to maintain and possibly expand this critical source of support for LTSS, the commonwealth should expand its investment in supports for unpaid caregivers.

There are a number of programs to increase unpaid caregivers' access to training, counseling, and supports that are funded by both federal and state sources, including resources from the Administration on Aging through the Older Americans Act. With the following additional investments to bolster these supports, the commonwealth could sustain the efforts of this critical source of LTSS:

- **Encourage increased federal funding of programs that support family caregivers.** The Lifespan Respite Care Act was enacted in 2006 to expand and enhance respite services, and improve coordination, access, and quality at the state level. The program has not been funded at recommended levels since its passage. The commonwealth should urge Congress to appropriate full funding at authorized levels. The National Family Caregiver Support Program (Title III E of the Older Americans Act) provides information and assistance, counseling, support and training programs, respite, and limited supplemental services to caregivers through Area Agencies on Aging. The President's 2011 budget increases this program's level of federal funding, which has been nearly stagnant over the last several years, by \$50 million. Increased funding of this program will ensure additional families can provide quality care.

³⁷ Non-medicare elders have access to many services, including case management, through the Home Care Basic program and Home Care Enhanced Community Options program (ECOP); however, eligibility for this program does not entitle them to the full array of MassHealth state plan services. Neither program has an asset tests but both require sliding scale fees based on income.

³⁸ K. Donelan et al., “Challenged to Care: Informal Caregivers In A Changing Health System,” *Health Affairs*, 21:4 (2002): 222-231.

- **Promote increased awareness and utilization of existing caregiver supports.** Information and referral (I&R) services currently are available in Massachusetts through a number of state agencies and community provider and referral organizations.³⁹ I&R assists unpaid caregivers in finding the supports they need, as well as additional LTSS to supplement the care they provide to care recipients.
- **Increase availability of training programs.** Many unpaid caregivers provide assistance with activities that were once typically provided by trained professionals in hospitals or other facilities, such as changing dressings, assisting with administering medications, and helping with equipment.⁴⁰ Formal training will improve the quality of care unpaid caregivers can deliver and the ability of caregivers to continue providing this care.
- **Increase availability of support groups and counseling programs.** Support groups and counseling programs can help unpaid caregivers with depression and can improve feelings of satisfaction, well-being, and quality of life. In some cases, interventions have significantly delayed nursing facility utilization of the care recipient, suggesting that modest investments can yield substantial savings of public dollars through Medicaid cost avoidance.⁴¹
- **Increase use of evidence-based programs.** A one-size-fits-all approach to caregiver supports is less effective than targeted evidence-based interventions. Organizations such as the Rosalyn Carter Institute for Caregiving offer information on numerous interventions. These resources can be useful when developing new targeted interventions and evaluating current ones.

F.4 Extend additional support for unpaid caregivers' financial circumstances through workplace policies, tax incentives, and other means.

Some caregivers face economic insecurity if they need to reduce their own work hours or stop working altogether to accommodate their caregiving activities. In addition to expanding programs that provide training and counseling to unpaid caregivers, the commonwealth should consider offering financial supports, such as direct cash payments or tax credits, to caregivers to preserve this critical source of LTSS, and should urge the private sector to do the same. Strategies include efforts such as these:

- **Create specific tax credits for unpaid caregivers.** Tax incentive options include offering income tax credits to caregivers who provide specific LTSS or tax deductions to offset a percentage of LTSS costs incurred by the caregiver. Tax incentives can also be used to motivate caregivers to complete training programs. Half of all states have implemented a type of tax credit or tax deduction for caregivers, including dependent care tax credits and caregiver tax credits ranging in value from \$500 to \$2,400.⁴²
- **Expand programs that pay caregivers.** Current Massachusetts programs, such as the Adult Foster Care and Personal Care Attendant programs, permit payment for providing medically necessary LTSS

to friends and to certain non-legally responsible family members. Other programs, such as peer counseling and skills training, are only sporadically funded. Additional programs can increase access to these and other consumer-directed program models that either directly pay caregivers or provide funds to the care recipient for purchase of LTSS from a provider of their choice.

- **Encourage employers to provide assistance and offer improved leave policies to employees who provide care to family members.** Caregivers are vital members of the workforce; seven in 10 caregivers report working while providing care to a loved one. To juggle family and work priorities, most caregivers must make changes in their work schedules to accommodate these sometimes competing responsibilities. Two-thirds (66 percent) of caregivers report starting work at a later time, leaving work early, and taking time off from work.⁴³ The commonwealth can promote workplace policies that enable caregivers to remain in the workforce while providing care in various ways, including the following:
 - ◆ Ensuring LTSS public awareness and education campaigns include information for employers about establishing programs and policies to support workers who are also caregivers
 - ◆ Convening statewide and regional conferences with state agencies, advocacy organizations, providers, stakeholders, and corporations to discuss best practices and options for supporting caregivers in the workforce
 - ◆ Considering expansion of Family and Medical Leave Act (FMLA) policies at the state level including applying leave provisions to employees in workplaces with fewer than 50 employees and extending the time periods for leave

Core financing strategies

This section reviews the three core financing strategies and the specific recommendations that fall within each one. There is a short description of each specific strategy, followed where appropriate by the strategy's estimated effects on coverage and on costs and spending, as well as likely advantages

³⁹ Examples of information and referral resources include the Aging Services Access Points, Independent Living Centers, Councils on Aging, Aging and Disability Resource Consortia (ADRC) and state agencies through services such as 1-800-AgeInfo (Elder Affairs), the Massachusetts Aging and Disability Information Locator (MADIL), and FamilyTIES (Department of Public Health).

⁴⁰ K. Donelan et al., "Challenged to Care: Informal Caregivers in a Changing Health System," *Health Affairs*, 21:4 (2002): 222-231

⁴¹ M. Mittleman, W. Haley, O. Clay, D. Roth, Improving caregiver well-being delays nursing home placement of patients with Alzheimer's disease." *Neurology* 67 (9) 2005: 1592-9.

⁴² Dependent care tax credits are limited to direct expenses incurred by a caregiver to pay someone else to care for a child or dependent while caregiver tax credits include both direct and indirect caregiver expenses. Alzheimer's Association. State and Federal Tax Credits and Deductions. Retrieved from: http://www.alz.org/national/documents/topicsheet_taxcreditsdeducts.pdf

⁴³ National Alliance for Caregiving in collaboration with AARP. Caregiving in the U.S. 2009.

and challenges. The estimated effects of the strategies are based on analyses available at the time of the Advisory Committee's work. Close monitoring and reassessment of incentives and coverage barriers as each initiative is adopted, along with further actuarial and other analyses, will allow the state to make appropriate course corrections over time.

Core Strategy #1: Increase utilization of private LTSS financing mechanisms

1.1 Enact the national consumer protection and insurance standards recommended by the National Association of Insurance Commissioners (NAIC).

Description: In the 1980s, the NAIC developed its Long Term Care Insurance Model Act and Regulation to “encourage stronger state legal protections, expand the authority of regulators, and guide state regulators in overseeing rates.”⁴⁴ The model legislation promotes the availability of insurance coverage, protects applicants from unfair or deceptive sales or enrollment practices, facilitates public understanding and comparison of coverage options, and facilitates flexibility and innovation in the development of long-term care insurance.⁴⁵ The ultimate goal is to better protect consumers through rate stabilization.⁴⁶ The NAIC model legislation, updated most recently in 2006, has been used as a guide in many states to develop state-specific legislation. Massachusetts is one of nine states that have not enacted the NAIC model legislation.⁴⁷

Massachusetts' existing regulations around insurance for LTSS (which includes individual long-term care insurance policies, annuities and life insurance policies with long-term care riders) contain many consumer disclosure provisions that are consistent with the NAIC model regulation. Other items in the NAIC model (most notably sections pertaining to rate review) are not adopted in Massachusetts. The NAIC model legislation clarifies and expands on the consumer protection and insurance standards that currently exist in Massachusetts in several ways. Adopting the NAIC standards would bring Massachusetts' long-term care insurance market in line with nationally accepted standards. Implementing the NAIC model legislation also is a required step in the development of a long-term care partnership program (see Strategy 1.2).

1.2 Improve and expand the purchase of private insurance for LTSS, particularly for middle-income and younger adults.

Description: There are a number of strategies that could increase utilization of private insurance for LTSS, including the following:

1. Improve insurance products for LTSS

As noted in the previous section, increasing consumer protections could increase consumer confidence in private insurance products for LTSS. Another improvement is for Massachusetts to license “linked products” as other states now do. These linked products are insurance policies for both LTSS and life insurance through which the insured individual can use the

benefits for LTSS if needed; if not, the beneficiary would receive the life insurance benefit after the insured's death.

2. Promote the appropriate use of insurance for LTSS, including life insurance policies with accelerated death benefits or long-term care insurance riders and linked products.

Massachusetts' LTSS awareness and education campaign (see Strategy F.1) could promote the use of these products as an element of individual planning for the future, and encourage employers, including the state Group Insurance Commission, to offer group coverage for LTSS as an employee benefit. Employees might be more likely to take up and maintain employer-sponsored insurance for LTSS if the employer's plan required “like plan” portability; that is, if upon leaving employment, the employee had the option to purchase an individual plan with a similar premium and similar benefits.

3. Develop a Long-Term Care Partnership program

A Long-Term Care Partnership program is a collaboration between private long-term care insurance and state Medicaid programs that is established in federal law.⁴⁸ As noted above (see Strategy 1.1), states must have the NAIC consumer protection standards in place to pursue a Long-Term Care Partnership program. Partnership programs are designed to

1. Expand private financing for LTSS by encouraging the purchase of private long-term care insurance policies
2. Preserve Medicaid dollars by delaying or preventing people from spending down or transferring their assets to become eligible for Medicaid⁴⁹

⁴⁴ M. Kofman and L. Thompson. *Consumer protection and long-term care insurance: Predictability of premiums*. (Washington, DC: Georgetown University, 2004).

⁴⁵ T. Query, “An Update on Public Policy Changes Affecting Long-Term Care.” *The Journal of Financial Planning*, (2004).

⁴⁶ M. Kofman and L. Thompson. *Consumer protection and long-term care insurance: Predictability of premiums*. (Washington, DC: Georgetown University, 2004).

⁴⁷ Legislation (S. 2476) currently pending in the state's legislature would implement the NAIC model act with slight modifications to account for existing consumer protection policies in Massachusetts. If this legislation is enacted, the state's insurance commissioner would need to promulgate regulations (likely based on NAIC's model regulations) to implement the legislation.

⁴⁸ The Robert Wood Johnson Foundation developed the original Long-Term Care Partnership model in the late 1980s as a grant program for states. Four states (California, Connecticut, Indiana, and New York) have been operating Partnership programs since the early 1990s. Over 30 states now have implemented or are pursuing Partnership programs since the Deficit Reduction Act of 2005 removed a technical barrier Congress placed on the development of additional Partnership programs. See Center for Health Care Strategies. *Long-Term Care Partnership Expansion: A New Opportunity for States: Issue Brief*. (May, 2008).

⁴⁹ Research on Partnership programs is limited and mixed about the success of these programs in significantly expanding utilization of private long-term care insurance and delaying or avoiding future Medicaid spending. Drawing definitive conclusions either way may be premature as many early Partnership participants are only now starting to use their long-term care insurance benefits. See U.S. Government Accountability Office, *Long-term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings*, GAO-07-231. (Washington, DC: Author, May, 2007). Congressional Research Service, *Medicaid's Long-term Care Insurance Partnership Program*, Order Code RL32610, (January, 2005).

The Partnership provides an incentive for middle-income people to purchase long-term care insurance by allowing those who exhaust their insurance benefits but still have LTSS needs to receive Medicaid benefits without first spending down all of their assets. In a Partnership program, individuals who purchase long-term care insurance policies that meet certain coverage requirements can later apply for Medicaid using special eligibility rules.

Under these circumstances, the individual can receive Medicaid benefits and keep assets equal to the amount of insurance coverage paid out through the Partnership policy (called a “dollar-for-dollar” methodology). The Medicaid program will not count these assets toward its asset limit when determining Medicaid eligibility, and the Medicaid program will not recover these assets from the individual's estate after the individual's death. States with Partnership programs may establish reciprocal agreements with other Partnership states so that individuals can maintain the Medicaid asset protection if they move to another Partnership state.

Massachusetts has similar Medicaid exemptions in place for individuals purchasing qualifying long-term care insurance. Massachusetts is not a Partnership state, however, because its asset protection provisions differ from those in Partnership states.

The Partnership's dollar-for-dollar asset protection method encourages middle-income individuals to purchase some long-term care insurance, even if they cannot afford to purchase an insurance product with sufficient benefits to qualify for the current Massachusetts exemptions. The Partnership also protects any type of asset, while Massachusetts current provisions only protect the home. As a result, the Partnership allows people with LTSS needs to keep this asset protection when they move from their house to a rented apartment, assisted living facility, or a family member's home.

Additionally, the Partnership's asset protection takes effect at the time that an individual purchases the long-term care insurance policy. In Massachusetts, an individual must hold a qualifying long-term care insurance policy at the time of admission to a nursing facility. This is a disadvantage for consumers who used up insurance benefits prior to entering a nursing facility to the extent that the remaining benefits no longer meet the state's minimum coverage requirements on the date of admission.⁵⁰ Qualifying policies under the Partnership model also must cover community-based LTSS. In Massachusetts, there is no requirement that qualifying long-term care insurance policies do so. Finally, because Massachusetts is not considered a Partnership program, there is no reciprocity in Medicaid asset protection between Massachusetts and Partnership states.

⁵⁰ S. 309, a bill pending in the Massachusetts legislature's Elder Affairs committee, would amend Massachusetts' estate recovery exemption rule for qualifying long-term care insurance [MGL c.118E, §33] to require MassHealth to look at the minimum coverage requirements that exist at the time the LTCI policy was purchased rather than when the person entered the nursing facility. This change would eliminate one of the differences between Massachusetts' provision and the Partnership model.

The Advisory Committee recommends developing a Partnership program, with some choice for individuals currently holding long-term care insurance policies that qualify under existing Massachusetts rules. Some people may have purchased a long-term care insurance policy under Massachusetts' current provisions and prefer to keep their current asset protection, which protects the total value of their house. As part of this strategy, the commonwealth should create a mechanism that allows these individuals to choose whether to retain the current asset protection or move to the asset protection provided by the Partnership program. Some individuals may prefer to protect their home, because it is their most valuable asset and because they want to continue living in it. However, many individuals with LTSS needs move to an assisted-living facility, an accessible apartment, or a family member's home. If the individual no longer has a house to protect, the Partnership's more flexible dollar-for-dollar protection would be more beneficial.

Effect on coverage: These changes could increase the number of people with qualifying long-term care insurance from 9 percent to 12 percent of those eligible to purchase such coverage.

Effect on cost and spending: Implementing this strategy could reduce Medicaid spending by up to \$80 million per year, of which \$40 million is state Medicaid spending and \$40 million is federal Medicaid spending. This estimate is based on an assumption that 10 percent of new spending by private insurance for LTSS would offset Medicaid costs, while 45 percent would replace other out-of-pocket spending, and 45 percent would replace informal care and unmet need. [Cost and spending estimates are in 2030 dollars. Estimates assume that all of the strategies have been fully implemented and their long-term effects have occurred.]

Advantages: This strategy provides incentives to consumers to protect themselves from high LTSS costs and allows people who need LTSS to retain some of their assets or pass them on to their heirs.

Challenges: Individual consumers who already have purchased policies that qualify for Massachusetts' existing asset protections may prefer these rules (e.g., their house might be worth more than what they could afford under dollar-for-dollar coverage) or may prefer the Partnership's dollar-for-dollar asset protection rules (e.g., it protects other types of assets). To protect all consumers, the commonwealth would need to implement a mechanism to allow these individuals to choose to either maintain their current Massachusetts asset protection or convert to a Partnership policy.

1.3 Promote the use of other mechanisms to support private financing of LTSS.

Description: Besides insurance for LTSS—a dedicated policy or a rider to a life insurance policy—other vehicles that are widely used for private financing of LTSS include reverse mortgages and annuity contracts. Typical

users for whom these vehicles are attractive are older (the minimum age for a reverse mortgage is 62) and have significant assets, either in the form of home equity or cash.

A **reverse mortgage** can be an attractive option because high home values in Massachusetts allow many people to fund all of their care this way, and because it is a source of financing that may be available when other sources have been exhausted. The state should make this a more solid option by expanding certain consumer protections and information. For example, lenders should be required to make closing costs more transparent by making them publicly available in a standard, comparable format. Closing costs should also be limited by regulation to no more than a set percentage of the total loan amount.

Annuity contracts can be an attractive alternative to insurance for LTSS for people who want to leave some of their assets to heirs, because annuity investments are tax deferred and the buyers (or their heirs) receive some benefit from their premiums even if they never need LTSS. Annuities also are an option for people who would not qualify for insurance for LTSS because they did not pass the health screen, for example. Annuity contracts provide a flexible, cash benefit, but there is a risk that the account may not be adequate to fund all future LTSS costs. The state should make annuities a more reliable financing mechanism by creating safeguards for consumers around issues such as company insolvency, and should include the advantages and pitfalls of annuities in its LTSS education and awareness campaign.

Hypothetical LTSS users: Carlos and Maria, ages 83 and 82, middle- to higher-income

Carlos and Maria, both retired, spent years fixing and improving their home and hope to leave it to their three children. Maria receives a pension and the couple receives rental income from an apartment in their two-family home.

Carlos was diagnosed with rheumatoid arthritis, a chronic and debilitating disease. Now, he needs help walking and transferring, and Maria cannot assist him by herself. Their children stop by in the mornings and evenings, and Maria hired a personal care attendant during the day. Recently, Carlos suffered third-degree burns from a cooking accident, and a visiting nurse comes by every other day to perform ongoing treatment. Maria was surprised to learn that Medicare and her Medigap insurance policy did not fully cover these services. Carlos and Maria are spending their savings much faster than they had planned, and they do not want to lose their house.

Monthly income: \$6,000 (pension, apartment rental, and Social Security)

Current assets (including their house): \$425,000

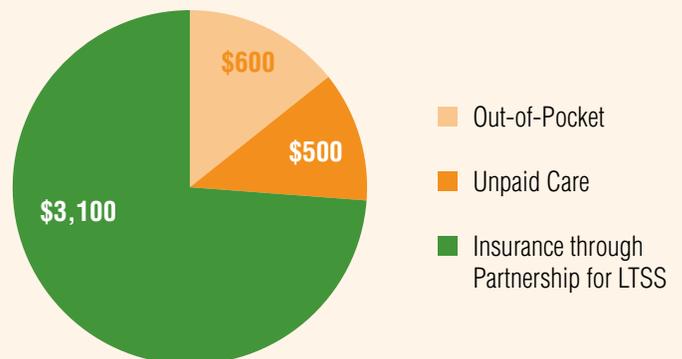
Current monthly minimum LTSS needs: \$2,200 (one visiting nurse 10 hours a week and one Personal Care Attendant (PCA) 10 hours a week)

Impact of Core Strategy #1 on payment for LTSS:

Current system (monthly)



Core strategy #1 (monthly)



With increased efforts to get Massachusetts residents to use private financing mechanisms for LTSS, we assumed that Carlos and Maria would purchase coverage while they were working. Based on their level of need, Carlos and Maria would have about 74 percent of their needs covered by insurance and they would reduce their out-of-pocket costs by \$1,600 per month.

An alternative, as yet hypothetical, mechanism for private financing of LTSS would be a **savings account for LTSS** analogous to a Health Savings Account (HSA)—that is, a tax-advantaged account for meeting LTSS needs that accumulates value as a financial asset and can be passed on to heirs. This mechanism might be an attractive vehicle for younger people who, as a result of an education and awareness campaign, understand the need to save for future LTSS needs. This type of account would need to be authorized by state legislative action and would affect only state taxes, unless the federal government took a similar step.

Effect on coverage: Improvements in consumer protections for existing financing vehicles would result in only a small increase in coverage. Creating a new savings vehicle would also increase coverage only by a small amount, at least initially.

Effect on cost and spending: Similarly, these enhancements likely will have only a small effect on overall spending.

Advantages: Making private financing vehicles safer and more attractive would increase the options available to people who want to plan for future LTSS needs and have the financial resources to do so.

Challenges: Challenges for implementing this strategy include increasing awareness of the need to plan for financing LTSS and of these planning options, as well as providing enough information so that people will be able to judge which vehicle would work best in their individual circumstances.

Core Strategy #2: Expand MassHealth coverage to achieve equity in access to LTSS

This core strategy includes several specific strategies designed to help eliminate inequities in access to MassHealth coverage for LTSS described in Section II.C.1 of the report. The core strategy would expand financing options available to low-income people who need LTSS regardless of their age or type of disability.

2.1 Expand access to a *limited* package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs.

Description: This strategy would expand access under MassHealth to a limited package of community-based LTSS to a targeted group of adults with disabilities and self-care needs.⁵¹ This expansion would address one inequity in access to LTSS for people below age 60. Currently, elders over age 60 with self-care needs have access to a broad range of community-based LTSS (through the Frail Elder HCBS waiver and through programs administered by the Executive Office of Elder Affairs), while very few people under age 60 and over with similar needs can access these publicly funded services.

A limited package of LTSS could include the following:

- Case management
- Family support/Community habilitation
- Grocery shopping/delivery
- Home-delivered meals
- Homemaker services
- Individual support/Community habilitation
- Laundry services
- Respite care
- Supportive employment
- Peer counseling

Effect on coverage: These services would expand covered benefits for a targeted group of adult MassHealth members with disabilities and self-care needs.

Effect on cost and spending: Providing a limited package of community-based LTSS to a targeted group of 10,000 adults with disabilities would increase MassHealth expenditures by approximately \$260 million per year. The state share of this cost would be \$130 million, assuming the federal government continues to fund 50 percent of state Medicaid expenditures. [Cost and spending estimates are in 2030 dollars. Estimates assume that all of the strategies have been fully implemented and their long-term effects have occurred.]

Advantages: This strategy begins to address long-standing inequities in LTSS access and coverage in the MassHealth program.

Challenges: This strategy would not achieve full equity in access to publicly funded LTSS for all low-income people with disabilities. Some of these individuals, however, may be eligible for other private financing mechanisms included in the roadmap. This strategy would also require additional or redirected state spending, which would come from the savings (i.e., the freed-up state dollars from MassHealth cost avoidance) resulting from the roadmap's private financing strategies that delay or prevent a person from using MassHealth-covered LTSS. While designing expansions, the commonwealth should also consider mechanisms that allow for more effective care coordination and integrated acute and LTSS care delivery and financing (see Section IV – Integrally Related LTSS Activities)

2.2 Expand access to a *comprehensive* package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs.

Description: This strategy improves on Strategy 2.1 by providing a more comprehensive set of community-based LTSS to the targeted group of adult MassHealth members with disabilities and self-care needs.

⁵¹ The American Community Survey (ACS) identifies 40,000 people with disabilities and self-care needs in Massachusetts between the ages of 19 and 64. Roughly 10,000 of these individuals currently receive a broad range of community-based LTSS through one of MassHealth's HCBS waivers, leaving roughly 30,000 people in this group without access to these services. To better manage its costs, the Advisory Committee recommends beginning the expansions with a targeted group of people and a targeted benefit package.

A comprehensive package could include the following services:

- Assistive technology
- Agency personal care
- Behavioral health services (for those who currently do not have access to these services)
- Case management
- Chore services
- Companion services
- Continuous skilled nursing
- Day services
- Environmental adaption
- Expanded counseling
- Family support/Community habilitation
- Grocery shopping/delivery
- Home-based wandering service
- Home-delivered meals
- Home health aide
- Homemaker services
- Individual support/Community habilitation
- Laundry services
- Medical management
- Non-medical transportation
- Peer counseling
- Respite care
- Supportive employment
- Specialized medical equipment
- Supportive home care aide

Currently, these services are available only to a small number of individuals who meet certain diagnosis-specific criteria through HCBS waivers. Providing these services to a larger number of individuals with disabilities and self-care needs would help them to live independently in a community setting.

Effect on coverage: These services would further expand covered benefits to a targeted group of adult MassHealth members with disabilities and self-care needs.

Effect on cost and spending: Providing a comprehensive set of LTSS to a targeted group of 10,000 MassHealth members would increase MassHealth expenditures by approximately \$210 million per year (in addition to the \$260 million for the limited package). The state share of this cost would be \$105 million. [Cost and spending estimates are in 2030 dollars. Estimates assume that all of the strategies have been fully implemented and their long-term effects have occurred.]

Advantages: This strategy would enable low-income people with disabilities and self-care needs to live independently in the community and could reduce unmet need and the use of facility-based care. It builds on Strategy 2.1 to address long-standing inequities in LTSS access and coverage in the MassHealth program.

Challenges: As with Strategy 2.1, this strategy would not achieve full equity in access to publicly funded LTSS for all low-income people with disabilities, and would require additional or redirected state spending.

2.3 Expand eligibility for MassHealth coverage for LTSS for elders over age 65.

Description: This strategy would raise financial eligibility limits for MassHealth for elders, age 65 and over, with self-care needs. The income limit for this population would be raised from 100 percent to 200 percent of the Federal Poverty Level (FPL) and the asset limit would be raised from \$2,000 to \$10,000. This eligibility expansion addresses one inequity in access to LTSS for people above age 65.

Currently, people with disabilities who are under age 65 can access MassHealth state plan services at any income and asset level via the CommonHealth program, though they may be required to pay a sliding scale premium and one-time deductible. Non-working people age 65 and over, however, do not have access to CommonHealth and generally must meet strict income and asset limits in order to access MassHealth state plan services.

Effect on coverage: Approximately 10,000 elders over age 65 with self-care needs would become eligible for MassHealth state plan services.

Effect on cost and spending: Raising MassHealth financial eligibility limits for elders would increase MassHealth expenditures by approximately \$230 million per year. The state share of this cost would be \$115 million. [Cost and spending estimates are in 2030 dollars. Estimates assume that all of the strategies have been fully implemented and their long-term effects have occurred.]

Advantages: This strategy provides a viable financing option for community-based LTSS for elders between 100 percent and 200 percent FPL, and begins to address long-standing inequities in LTSS access and coverage in the MassHealth program.

Challenges: Though an important step, this strategy still would not achieve full equity in access to publicly funded LTSS for all people with disabilities regardless of age (CommonHealth would still be available to non-elderly members further up the income scale who need state plan services). This strategy would also require additional or redirected state spending.

Core Strategy #3: Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs

3.1 Participate in the federal process of specifying the details of CLASS; raise awareness of CLASS's existence and potential benefits for employers and employees; consider promoting employee participation in CLASS if warranted when details are known.

Description: The Community Living Assistance Services and Supports (CLASS) program provides a new mechanism for the private financing of some LTSS. Effectively, CLASS is a broad-based social insurance program

Hypothetical LTSS user: Phil, age 34, low-income with high service needs

Phil is a 34 year-old man with cerebral palsy, type 1 diabetes, and autism who lives with his mother, and his adult sister and her husband. Phil is able to live in the community with MassHealth personal care attendant services and extensive assistance from his mother and sister.

Phil's mother recently lost her stable job and is only working an irregular part-time schedule, and his sister is moving out-of-state because her husband was transferred to another office. Phil's family can no longer provide for his unpaid supports. Because of the changes to his family environment, Phil is at risk of needing facility-based care. Phil's mother doesn't know how she can continue to work without her daughter at home providing support to Phil.

With the expansion of a limited package of community-based LTSS, as recommended in strategy 2.1, Phil would receive the additional services he needs to live in his community. He would be able to access the individual supports, case management, and respite care that he needs given his changed informal support system. A more comprehensive package of services, as recommended in strategy 2.2, would also assist him and enable him to work by providing medication management, supportive employment, and non-medical transportation. These services would also enable Phil's mother to re-enter the full-time workforce with confidence.

with the potential to reduce reliance on public programs and to give people more flexibility in purchasing LTSS and receiving those services in the community. Workers will be able to begin contributing premiums in 2011, and the first benefits will be paid in 2016.

It is not yet clear whether CLASS will be an attractive option for Massachusetts residents. CLASS's financial viability depends on the early participation of younger people who are unlikely to require LTSS in the near future and whose premiums will help to seed the benefit fund and finance benefits for people with more immediate LTSS needs. Premiums will need to be set at a level that encourages this group's participation; without it, it may be difficult to set premiums at a reasonable level for everyone else.

The U.S. Department of Health and Human Services (HHS) will develop the details of CLASS over the next two and a half years. Massachusetts should actively engage with the federal government in the development of the program and should review and officially comment on proposed rules as they are issued, so that the state has as much input as possible into efforts to make the program something that many Massachusetts workers would want to use.

CLASS is a voluntary program for workers as well as their employers. The most direct way for employees to participate in CLASS is through a payroll deduction, but their employers must agree to undertake the administration of the deduction for this mechanism to work. Federal officials will establish an alternative mechanism to allow employees of non-participating employers and the self-employed to participate, but widespread participation depends on the ease of the payroll deduction. Massachusetts, therefore, should ensure that its broad-based education and awareness campaign (see Strategy 1.1) includes detailed information about CLASS to encourage employer participation. Federal funding supporting the implementation of health care reform may be available to states for this activity. The commonwealth also can set an example as an employer by making payroll deduction for CLASS available to state employees through the Group Insurance Commission.

Beyond these activities, the state should wait until more is known about the features of the program. If it appears that CLASS premiums will be affordable and the benefits attractive for people over a broad range of ages and functional status, then the state should undertake an organized initiative to encourage workers to participate.

Because CLASS enrollment is only available to employed individuals, it is important to increase opportunities for individuals with disabilities and elders to join and remain in the workforce and enroll in CLASS. In 2006, the labor force participation rates for individuals age 16 and older in Massachusetts with and without disabilities were 29.6 percent and 75.2 percent, respectively. Efforts to increase the lower rate will provide new financing opportunities for individuals with current LTSS needs (see Section IV – Integrally Related LTSS Activities).

Effect on coverage: National estimates are that 3 percent to 6 percent of eligible workers will participate in CLASS. Massachusetts may be toward the higher end of this range because the population's higher-than-average incomes could make some workers more willing to put aside money for long-range purposes.

Effect on cost and spending: When CLASS is fully implemented it could save MassHealth an estimated \$140 million per year, \$70 million of which is the state's share of the cost. This estimate is based on an assumption that 10 percent of new CLASS spending on LTSS would offset Medicaid costs, while 45 percent would replace out-of-pocket spending, and 45 percent would replace informal care and unmet need. [Cost and spending estimates are in 2030 dollars. Estimates assume that all of the strategies have been fully implemented and their long-term effects have occurred.]

Advantages: CLASS will be available to all working people, and its large insurance pool will create a potential opportunity to broaden the segment of the population able to plan for private financing of LTSS. The payroll deduction contribution mechanism, similar to health insurance premiums,

is easy to use to the extent that employers agree to participate. The cash benefit is flexible and would cover at least a basic level of LTSS needs for most people.

Challenges: Young workers with no foreseeable LTSS needs likely will place less value on LTSS coverage than older or functionally impaired workers, but a key to sustaining CLASS's financial solvency is that young workers contribute as older workers leave the workplace and begin accessing services. Official estimates of participation are fairly low across all age groups, though higher numbers could enroll if design features and pricing encourage participation by employers and employees. Many features of CLASS are not yet defined (e.g., employee premiums, cash benefit level, mechanism for self-employed and employees of non-participating employers), so a determination of whether the state should encourage participation will not be possible for one to two years.

3.2 Design and implement a state-sponsored individual contribution program that provides universal access to basic LTSS coverage for all Massachusetts residents; private insurance and MassHealth would provide supplemental coverage for individuals with very high LTSS needs.

Description: The Advisory Committee's recommendations are driven by its long-term vision of universal access to coverage for LTSS. This goal is enormously important both for individuals and for the state. While individual and family contributions to meeting LTSS needs are important, people should be able to use LTSS services without impoverishing themselves, and the state faces an unsustainable trend in MassHealth costs for LTSS if other financing sources do not relieve that burden.

The strategies already discussed—strategies that make private insurance more attractive, that improve the reach of MassHealth, and that encourage participation in CLASS—will enable more people to obtain LTSS coverage. The Advisory Committee's analysis of currently available information, however, indicates that these voluntary (i.e., not mandatory) strategies will likely result in only small increases in coverage for LTSS.

Currently, only about 9 percent of LTSS provided in Massachusetts is paid by private insurance. Strategies to improve and increase utilization of private LTSS financing mechanisms could increase the share of LTSS paid by private insurance to 12 percent by 2030. Federal budget officials estimate that 3 percent to 6 percent of eligible individuals will enroll in the new federal CLASS program.⁵² Even when both of these strategies are fully implemented, only 17 percent of LTSS costs will be pre-paid by individuals. And further increasing the burden on MassHealth would harm the state's financial health.

Moreover, voluntary approaches often result in adverse selection, where only those people who are at high risk of needing and using the LTSS benefit participate. Younger people without disabilities often choose not

to participate because the cost is not worth the perceived benefit. Adverse selection threatens the solvency of voluntary products and programs because the predominantly high-risk participants drive up costs to a level that is unaffordable to lower- and middle-income individuals.

The Advisory Committee therefore concluded from the available analyses that voluntary approaches would increase coverage for LTSS, but were unlikely to achieve the goal of universal access to coverage, in which case the objectives of meeting expanding need and averting unsustainable individual and state fiscal impacts will not be met. If that proves to be the case, the Advisory Committee recommends requiring participation in a future state-sponsored individual contribution program. Should such a program become necessary, the Advisory Committee recommends that it be financed through contributions by as broad a base as possible of Massachusetts adults and that it be designed to cover most LTSS costs. The Advisory Committee envisions a program that would cover the full LTSS costs for the approximately 80 percent of the state's population who have low to moderate LTSS needs, and would pay a significant share of the LTSS costs of the 20 percent who have high LTSS needs. The program could be funded through payroll deductions, as CLASS will be, through a surcharge on health insurance premiums, or through another assessment mechanism. The program should include public subsidies for people with low incomes in order to maximize enrollment. The state could seek federal Medicaid matching funds for these subsidies.

With this contribution program covering basic LTSS costs, other private and public insurance could provide supplemental catastrophic coverage. Private insurers would likely begin to offer supplemental long-term care insurance at much lower rates than products currently available. Similarly, MassHealth's role would shift from paying for virtually all LTSS to merely supplementing the benefits of the contribution program for low income people; this shift would enable MassHealth to pay for catastrophic LTSS for more people and still realize cost savings.

This state program would harness the collective economic strength of a broad-based insurance pool to meet the basic LTSS needs of the entire state, much as Social Security does for the basic retirement needs of the nation. As with Social Security, this program's effectiveness depends on universal participation. To reach universality, the state might consider these options for structuring a mandatory contribution program:

- Negotiate with the federal government to establish a Massachusetts-specific version of CLASS with mandatory enrollment (with subsidies as described above)
- Require Massachusetts residents to participate in a contribution program, around which CLASS would wrap. The federal government would authorize this program, with lower CLASS premiums for Massachusetts
- Require Massachusetts residents to have a minimum level of LTSS coverage with various options (CLASS, private, and state-level options) for satisfying the requirement

⁵² Douglas Elmendorf, "Additional Information on CLASS Program Proposals," (Washington, DC: CBO, November, 2009).

Effect on coverage: The state-sponsored individual contribution program would provide universal coverage for a basic level of LTSS need.

Effect on cost and spending: Sliding scale premium subsidies based on a participant's income would cost approximately \$1.1 billion, financed by participants' contributions; the state could potentially receive federal matching dollars to help defray this cost. This estimate assumes that individuals with family income under 200 percent FPL would contribute 0.5 percent of their income, individuals with family income 200 percent to 299 percent FPL would contribute 1 percent of their income, and individuals with family income 300 percent FPL or higher would contribute 2 percent of their income. A program structured in this way would reduce MassHealth spending on LTSS by \$3.2 billion (the state share of this cost would be \$1.6 billion).

The state could use a portion of these savings to expand MassHealth to provide catastrophic wrap-around LTSS coverage for all individuals with family income up to 300 percent FPL who need such coverage. This MassHealth expansion would cost approximately \$500 million. [Cost and spending estimates are in 2030 dollars. Estimates assume that all of the strategies have been fully implemented and their long-term effects have occurred.]

Advantages: A broad-based contribution program would achieve the Advisory Committee's goal of universal access to coverage.

Challenges: Requiring participation in an LTSS coverage program would be a public policy challenge and probably unpopular now, given recent health insurance mandates at the state and federal levels and current

Hypothetical LTSS users: Alan and Christine, ages 74 and 72, middle-income

Now retired, Alan worked as a truck driver for many years until he suffered a stroke. Immediately following the stroke, Alan did not have self-care needs, but he could not drive, remember shopping lists, or manage his finances. As a consequence of Alan's stroke, Christine retired from her position as an administrative assistant to care for Alan. They sold their home and moved into a more accessible apartment, which they pay for using their retirement savings and monthly Social Security benefit.

Christine began to show signs of dementia at age 70, but with help from family, friends, and neighbors, they were able to stay in their apartment. Recently, Alan fell and required hospital and rehab visits due to a broken hip. Christine's cognitive abilities quickly spiraled downward. It was necessary for both Alan and Christine to move into a nursing facility because their unpaid caregivers could not provide the necessary additional care. Christine and Alan were unable to afford constant supervision and cueing for Christine, self-care for Alan, their monthly medication, and rent. The couple spent their entire savings within two months in the nursing home. Based on their level of need and financial position, Alan and Christine enrolled in MassHealth Standard.

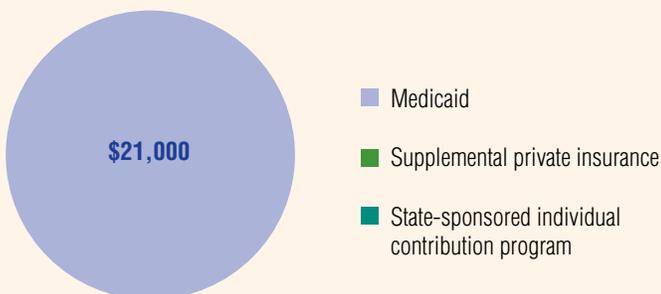
Monthly income: \$2,000 (Social Security) under 200 percent FPL

Current assets: \$0

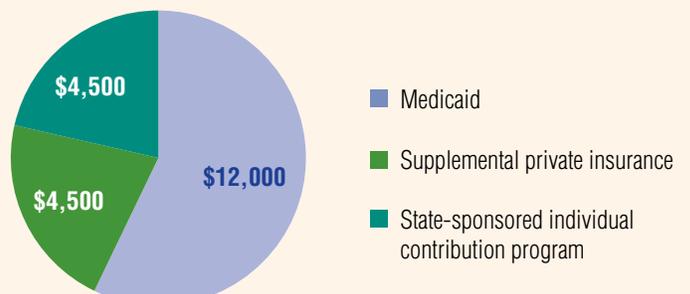
Current monthly minimum LTSS needs: \$21,000 (monthly cost for two people in a nursing facility)

Impact of Core Strategy #3 on payment for LTSS:

Current system (monthly)



Core strategy #3 (monthly)



Currently, Alan and Christine do not pay for services because they are on MassHealth; however, using initiatives under Core Strategy #3, the cost of their care is shifted to the state-sponsored individual contribution program. With the contribution program paying the first \$75 per day for each of them, Alan and Christine would be able to purchase affordable supplemental private insurance to defray some additional cost. As a result, MassHealth costs would decline by \$9,000 monthly.

economic conditions. The requirement may become more feasible in the future when, as a result of other efforts, a larger percentage of the population will have some form of LTSS coverage.

C Short-, medium-, and long-term options for LTSS financing reform

The Advisory Committee's roadmap for reforming LTSS financing in Massachusetts is a multi-faceted, long-term solution, which includes a series of public and private financing options that strategically move the current LTSS financing system toward the Advisory Committee's end goal of a reformed system that maximizes affordable LTSS coverage for all residents. This section discusses how the Advisory Committee recommends that the various elements included in the roadmap be incorporated over time. Specifically, the recommended implementation is structured in three phases: short-term (Years 1–3), medium-term (Years 4–7), and long-term (Years 8–10).

The phases are not additive in the sense that the recommendations in one phase are a prerequisite for those in another. Instead, the recommendations in each phase reach progressively further in terms of the number of people with LTSS needs who would be covered, the financial impact on individuals and/or the government, the political challenges policy makers may face in implementing the strategy, and the complexity of implementation (e.g., longer-term phases include options requiring changes in state law or regulation or more intensive negotiations with federal oversight agencies). In at least one instance, the scope of a strategy in one phase likely will be affected by the success of a strategy in an earlier phase: the participant profile and take-up rate in CLASS may affect how the state designs a state-level individual contribution program to reach its goal of universal coverage. Ultimately, the combined strategies in all three phases build the structure for universal coverage of all people in Massachusetts with LTSS needs.

1. Current System for Financing LTSS

Figure 15 shows how LTSS are financed at different levels of need and financial resources today. For example (looking at Figure 15), a person, represented by the dotted line, with moderate income and/or assets (i.e.,

FIGURE 14

Phase-in of strategies to achieve universal access to LTSS coverage in Massachusetts

Phase I (Short-term: 1-3 years)	Phase II (Medium-term: 4-7 years)	Phase III (Long-term: 8-10 years)
<ol style="list-style-type: none"> 1. Implement multi-phase LTSS financing education and awareness campaign; expand support for unpaid caregivers 2. Implement NAIC national consumer protection and insurance standards 3. Improve/expand utilization of private insurance for LTSS, including adoption of LTC Partnership; promote the use of other private financing mechanisms 4. Implement targeted MassHealth service expansion (limited package) for adults under 65 and expand eligibility for elders 65 and older 	<ol style="list-style-type: none"> 1. Maximize integrated financing and care coordination consistent with health care reform opportunities and other system change efforts 2. Implement additional MassHealth service expansions (comprehensive package) for adults under 65 with disabilities and self-care needs 3. Educate employers and employees about CLASS <ul style="list-style-type: none"> ■ Participate in federal rulemaking ■ Raise awareness of CLASS's existence and potential benefits ■ Promote employee participation if warranted 	<ol style="list-style-type: none"> 1. Extend additional support for unpaid caregivers' financial circumstances <ul style="list-style-type: none"> ■ Programs to pay caregivers ■ Tax credits for training ■ Encourage supportive workplace policies in private sector 2. Design/implement mandatory state-sponsored individual contribution program that maximizes LTSS coverage for all Massachusetts residents <ul style="list-style-type: none"> ■ Contingent on coverage gains from other strategies ■ Design to reduce adverse selection ■ Structure to complement CLASS and other financing options
<p>————— Ongoing assessment of progress toward universal coverage for LTSS —————→</p>		

in the center of the horizontal axis) and a low level of need (towards the bottom of the vertical axis) might rely at first on a private insurance policy. At a higher level of need, though, private insurance might not be sufficient and that person might need to call on personal resources and informal care. Eventually, as need increases, personal resources are no longer sufficient, and this person might spend down to become eligible for Medicaid (MassHealth). Some state programs exist to support those with the greatest need regardless of their resources.

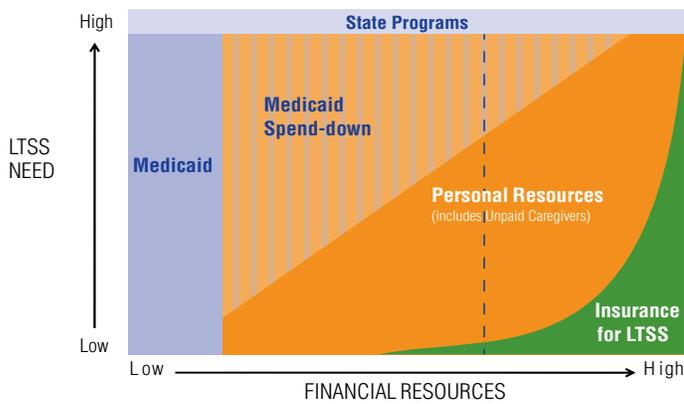
Subsequent diagrams show how reliance on these LTSS financing mechanisms would shift as the phases of the roadmap are implemented.

2. Phase I

Phase I is the first three years of implementation. During that time, the Advisory Committee recommends relatively low-cost strategies, such as an

FIGURE 15

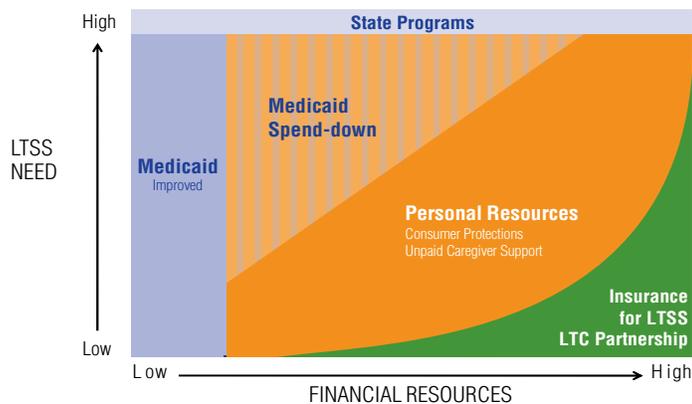
Current LTSS financing system



© Center for Health Law and Economics, University of Massachusetts Medical School

FIGURE 16

Future LTSS system after Phase I



© Center for Health Law and Economics, University of Massachusetts Medical School

education and awareness campaign and support for unpaid caregivers, as well as strategies intended to increase individuals' use of private savings and insurance vehicles to plan for future LTSS needs. Targeted MassHealth expansions also are part of Phase I.

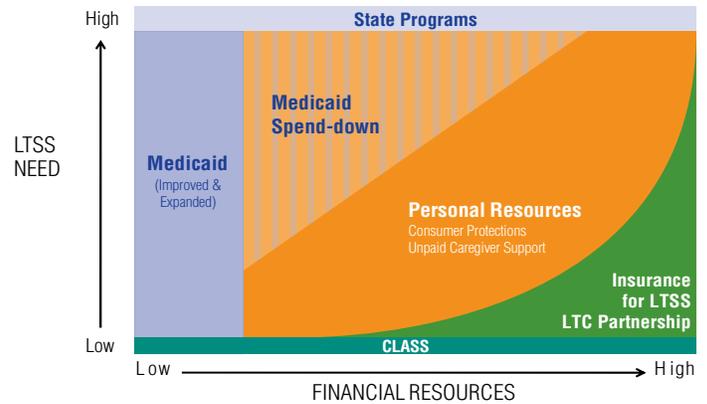
Figure 16 shows how LTSS would be financed at different levels of need and financial resources if the strategies of Phase I were implemented. In Phase I, private insurance would provide somewhat more support than it does currently.

3. Phase II

Phase II (Figure 17) covers Years 4–7 of roadmap implementation. In this phase the roadmap calls for efforts to educate employers and employees about the federal CLASS program as it is implemented. A financially stable CLASS program would provide a basic level of coverage up and

FIGURE 17

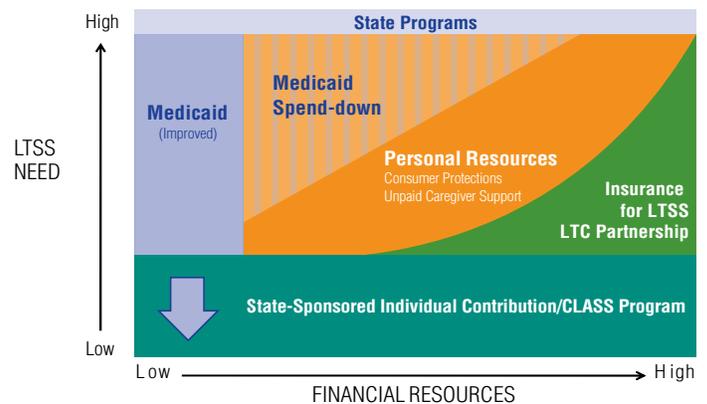
Future LTSS system after Phase II



© Center for Health Law and Economics, University of Massachusetts Medical School

FIGURE 18

Future LTSS system after Phase III (full roadmap implementation)



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down the resource spectrum (contributions would be subsidized for lower-income people), and would supplement other private coverage. In addition, targeted programs to expand opportunities for elders to locate and access coordinated LTSS would help to delay spending down to Medicaid eligibility.

4. Phase III

Phase III (Figure 18) implementation would occur in Years 8–10. This phase introduces the state-sponsored individual contribution program as a companion to federal CLASS. With this coverage available, combined with the modest increase in private insurance coverage from previous phases, financing of LTSS shifts considerably (compared with the status quo) from paying for services at the time of need to planning for future needs. Out-of-pocket expenses would be reduced, as would the burden on the Medicaid program.

5. Cost Projections

Figure 19 shows how the distribution of the projected cost of LTSS will shift if implementation of the roadmap proceeds with all strategies through all three phases. If no changes are made (“status quo”), Medicaid will continue to dominate as a payer and there will be a significant level of unpaid informal care and unmet need, as there is today. With full implementation of the roadmap, the Advisory Committee projects that Medicaid’s obligations will shrink considerably, as will unpaid informal care and unmet need, and a large share of the costs of LTSS will be absorbed by individuals’ participation in new federal and state social insurance funds.

Figure 19 shows both the costs borne by specific payers and care providers in each phase (colored bars), as well as the share of the total cost burden that is pre-paid by individuals, borne by individuals at the time of need, paid with state government funds, and paid with federal funds (percentage labels).

All of the dollar figures included in Figure 19 are as of 2030, when all of the strategies would be fully implemented. The 2030 cost figures demonstrate the effects of the various financing mechanisms at a time when people who access the financing mechanism require LTSS. The model includes assumptions about the anticipated characteristics of individuals who would purchase private insurance, enroll in CLASS, or access another financing mechanism, in terms of age, income, assets, and need for LTSS. The model then projects the numbers of people who would access benefits at specific time intervals. Appendix D details the methodology and assumptions used in this financial model.

Figure 19 depicts LTSS costs if nothing changes compared to the LTSS costs when each phase of strategies is implemented. This graph highlights that, if there are no policy changes (“status quo”), the share of LTSS costs pre-paid by individuals will increase somewhat from 2010 levels because of a slight projected increase in private insurance coverage and the introduction of the federal CLASS program. Still, only 14 percent of

LTSS costs (\$3.9 billion) will be pre-paid by individuals by 2030 through private insurance and the federal CLASS program. Thirty-eight percent of costs (\$10.5 billion) will be absorbed by individuals at the time they need LTSS through out-of-pocket expenses, unpaid caregivers, and unmet need. Massachusetts state government funds will pay for 21 percent of LTSS costs (\$5.9 billion) through the Medicaid program and other state programs.

In contrast, if all Phase III elements are implemented, 46 percent of LTSS costs (\$12.9 billion) could be pre-paid by individuals by 2030 through a combination of private insurance, the federal CLASS program, and a state-sponsored individual contribution program. Individuals would be responsible for only 15 percent of costs (\$4.0 billion) at the time they need LTSS through out-of-pocket expenses, unpaid caregivers, and unmet need. Massachusetts state government’s responsibility for LTSS would be reduced to 17 percent of LTSS care (\$5.0 billion), with a much smaller share paid through Medicaid and other state assistance programs, and more paid as premium subsidies for a state contribution program.

D Next steps for launching the roadmap

The Advisory Committee is adjourned upon the release of the roadmap. The preceding subsection of this report recommends, however, that systematic implementation of the roadmap strategies take place over 10 years. Successful action on the recommendations will require effort focused on developing public policy, communicating and collaborating with stakeholders, building public support and understanding, and monitoring and reporting on progress toward the goal of universal coverage for LTSS. Additional data collection, analysis, and research also will be needed.

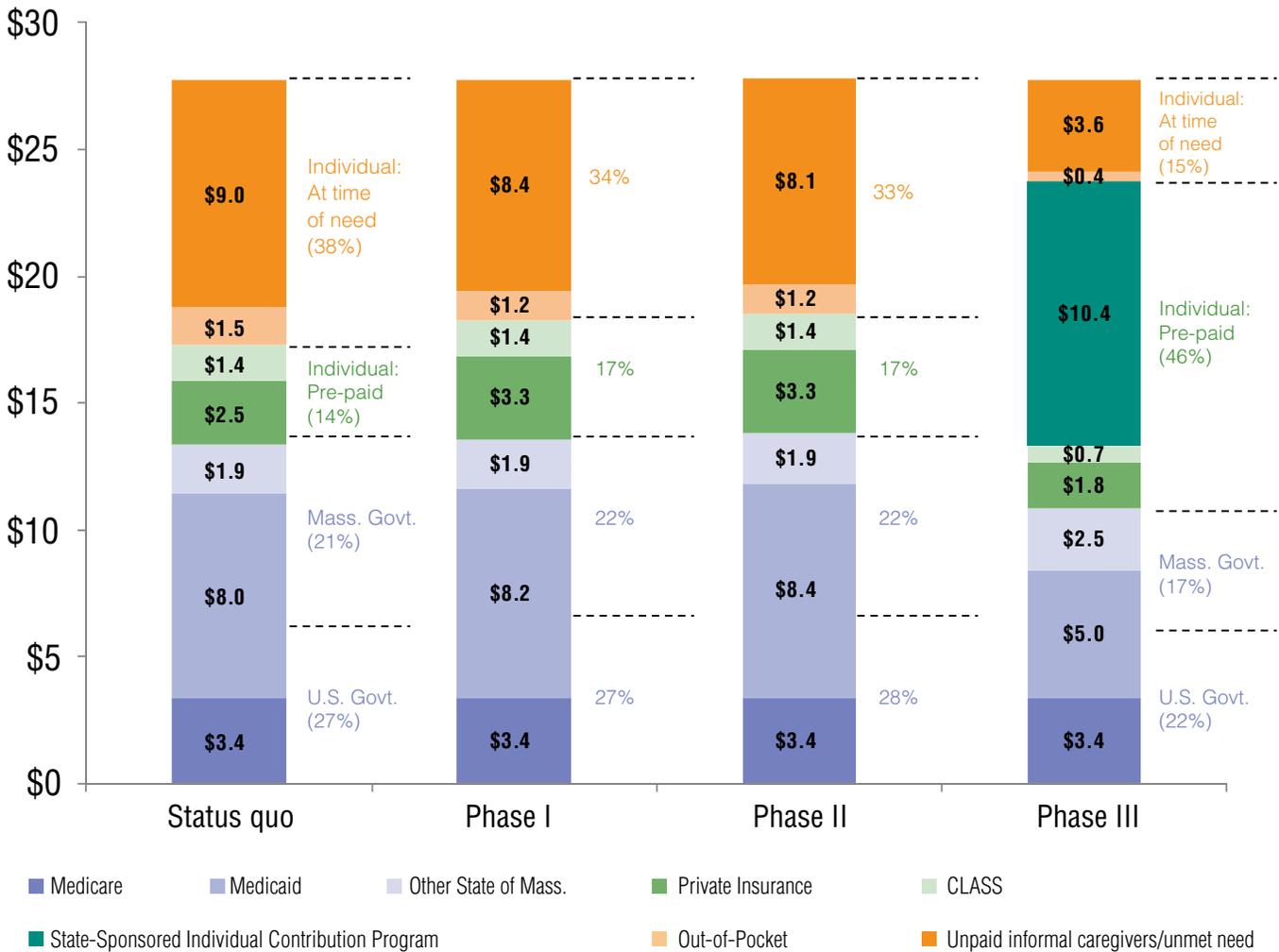
In order to ensure sustained action on the strategies, the Advisory Committee recommends the immediate designation of a public or quasi-public entity with ongoing responsibility for implementing the roadmap, in partnership with public and private stakeholders. Among its important functions should be to arrange for the continued research, actuarial and economic analysis, and modeling work needed to align the elements of the roadmap so that their features and incentives interact in a way that promotes universal LTSS coverage. Section V of this report details some of these additional research and data needs. This body would also engage with the federal government (HHS) regarding potential interaction among the roadmap strategies—for example, coordination of CLASS with the state contribution program, or the use of residual resources from the federal “Own Your Future” campaign to support targeted awareness and education efforts. This implementation board should be required to report on progress, at least annually, to the Governor, the Legislature, and the people of Massachusetts.

FIGURE 19

Estimated distribution of the costs of LTSS in 2030 if no policy action, or partial or full implementation of LTSS financing roadmap

Projected cost of LTSS in Massachusetts in 2030 (in billions)

(Note: CLASS is included in status quo and Phase I as it will exist in 2030 regardless of other interventions.)



IV. INTEGRALLY RELATED LTSS ACTIVITIES THAT COULD AFFECT THE ADVISORY COMMITTEE'S FINANCING REFORM GOALS

The Advisory Committee recognizes that the commonwealth's goal of maximizing access to and coverage of LTSS cannot be met through improved and expanded financing alone. Successful implementation of the Advisory Committee's roadmap is contingent upon the realization of related initiatives that expand access to affordable and accessible housing, employment opportunities, and transportation, for example, for all people with disabilities. A reformed LTSS financing system also depends on a well-trained and professional direct care workforce, an accessible administrative infrastructure that benefits from the latest technologies, and a well-informed public that is empowered to make health care decisions for themselves and their families.

While the Advisory Committee's charge and work focused on developing LTSS financing strategies, it strongly supports ongoing initiatives and activities in these other areas, which also are part of the commonwealth's Community First Olmstead Plan. Therefore, the Advisory Committee endorses the following initiatives and activities that support its financing reform goals and principles:

- Increasing the availability of **affordable and accessible housing**, including housing that meets needs along the care continuum
- Promoting **employment** of elders and people with disabilities and encouraging the commonwealth to lead this effort by becoming a model employer
- Promoting a high-quality and stable direct care **workforce** that is adequate to meet LTSS needs and permit consumer choice through activities such as initial and on-going professional training, career ladder development, and review of regulatory and policy decisions designating the types of professionals allowed to provide specific types of care
- Increasing the availability and coordination of local **transportation** options for people with disabilities and elders
- Enabling more effective care coordination through **administrative and infrastructure improvements** that expand usage of health information technologies and build capacity for information exchange
- Promoting public health activities and research and demonstration projects that result in **prevention and lifestyle changes** that decrease future LTSS needs
- Increasing **consumer choice** in the LTSS delivery system

V. ADDITIONAL RESEARCH AND DATA NEEDS

The Advisory Committee developed a series of financing strategies based on analysis and modeling of currently available data. During its work, the Advisory Committee identified several gaps in the existing data related to LTSS financing. The absence of data in the following areas affected the project staff's ability to adequately model specific interventions. Data on specific populations across the lifespan are particularly sparse. The commonwealth will need to collect these and other data to support implementation of the Advisory Committee's roadmap and to improve the LTSS financing and delivery systems.

As improved data become available, a comprehensive biennial report that describes the Massachusetts-specific state of LTSS needs and how they are being met should be developed and disseminated. The report could be a complement to the commonwealth's annual household health insurance survey and biennial employer survey on health insurance.

Data on the population in Massachusetts needing and using LTSS

The Massachusetts population data used throughout this analysis was primarily from the 2007 and 2008 American Community Survey (ACS), sponsored by the U.S. Bureau of the Census. As the 2008 ACS was released in mid- to late-2009, it was necessary to use the 2007 ACS in early analyses presented to the Advisory Committee. The 2007 ACS asked a detailed series of disability-related questions that were used to determine Massachusetts residents with self-care needs and independent living needs. With the release of the 2008 ACS, staff attempted to incorporate the new data into presentations; the 2008 ACS, however, did not provide the same detail for determining disability status.

ACS administrators explicitly state that the two versions of the survey should not be used when comparing disability data. As a consequence of this change in methodology, this analysis uses 2007 ACS data to determine the number of Massachusetts residents with self-care needs and independent living needs. The analysis uses 2008 ACS for aggregate population and income data, as these questions were consistent with the 2007 approach. The Advisory Committee should request of the Census Bureau that the ACS return to using the disability questions from 2007 in future iterations of the survey to more completely capture the LTSS status of state residents.

Additionally, there is a lack of comprehensive data on non-elderly people (i.e., adults and children) with disabilities, particularly those who do not use MassHealth services. It is difficult to accurately gauge the need levels and current LTSS spending and utilization from this population, as well as the source of services. Furthermore, in the wake of the recent economic downturn, it is difficult to project how well LTSS needs are being met; individuals and families now have less income but potentially more time

to provide informal care due to unemployment or underemployment. To accurately capture the total LTSS need in Massachusetts further analysis would require detailed demographic, financial (income and asset), and LTSS utilization data for elders and younger people with disabilities.

Data on unmet LTSS need in Massachusetts

To conduct this analysis, staff developed a “Profile of Service Users” using state and ACS data. Staff identified the number of people with disabilities and elders living in the commonwealth and the number of people currently using government-sponsored services. However, it is difficult to estimate the number of people who could benefit from LTSS but are currently going without necessary services. Additional research and data collection should be conducted to understand more about the unmet needs in the commonwealth, and an appropriate framework should be developed for measuring unmet need in the service system. Among the questions that should be answered are the following:

- What LTSS needs are currently not being met by the service system?
- Do certain populations have disproportionate unmet needs?
- Are certain services better at meeting needs than other services in the delivery system?
- Are there certain needs that are not being met in the community that result in individuals having no alternative but to seek institutional care?
- What barriers prevent needs from being met?

Data on Massachusetts LTSS spending and utilization trends

Due to various service expansions in MassHealth, and to Massachusetts residents receiving LTSS services from a variety of sources (some unpaid), it is difficult to appropriately gauge the real cost of LTSS utilization. Future analysis would require the following spending and utilization data:

- Improved capture and characterization of spending in state agencies—where it is, what it is, how to spend differently to ensure maximizing efficiency and leverage federal dollars
- Claims data experience from private LTC insurance companies to capture and characterize private spending for LTSS
- Survey data on which services are best provided informally and the actual financial cost of these services as they relate specifically to LTSS cost (i.e., not forgone income)

Analysis to support development of a state-sponsored individual contribution program

The state would need to conduct in-depth analysis in order to develop this type of program.

- Actuarial analysis of expected spending and utilization under a contribution program
- Twenty-year projection of annual LTSS costs to establish self-sustaining premium rates
- Economic impact analysis to understand the effects of the contribution by individuals on individuals, as well as the effects of new money to support unpaid caregivers

Data on programs that integrate care management, acute and LTSS financing, and delivery of care

- Cost effectiveness of programs and models
- Member satisfaction of programs and models
- Analysis of the impact of global payments on LTSS spending

Data on successful programs that provide support to unpaid caregivers

The roadmap includes options that increase supports for unpaid caregivers, the backbone of the LTSS system. As these options are implemented, the Advisory Committee recommends additional research and data collection on programs targeting caregivers, including the following:

- Research on return on investment for caregiver support programs. Programs with a higher rate of return should be prioritized.
- Research on the annual cost of unpaid care that considers economic conditions, individual financial situations of families, and market conditions for providing services.
- Research on evidence-based caregiver support programs and prioritization of effective programs.

VI. CONCLUSION

The existing system for financing LTSS in Massachusetts is unsustainable and a crisis is imminent. Many individuals do not plan adequately for future needs—because they do not fully appreciate the likelihood of such needs, because they are under the misconception that Medicare or private health insurance will pay for the services they need, or because of limitations within the current private financing system. Private financing options, which spread the risk of LTSS costs across an insurance pool or offer convenient ways for individuals to save, are insufficient and often financially unattractive. As a result, MassHealth stretches to cover services for formerly middle-income people who must spend virtually all of their income and assets before they can qualify for benefits. This financial pressure on MassHealth also weakens the safety net for those with low incomes and minimal assets who have no other options.

Gaps in coverage are projected to widen over the next two decades. Overall aging of the population, lengthening life expectancies, and improved treatments for disabling conditions will increase the aggregate level of LTSS needs. At the same time, it will become increasingly difficult for the unpaid, informal caregivers on which the system depends for a large portion of community-based services to keep pace with the need. MassHealth, the predominant payer, does not supply all needed services to all of its members, restricting some based on age, functional status, or diagnosis.

Solving the problem of LTSS financing is imperative; doing it during a time of fiscal constraint in the commonwealth is a great public policy challenge. Massachusetts cannot wait for better times to address the problem, however. The Long-Term Care Financing Advisory Committee has proposed a multi-faceted solution to this complex problem and recommended that it be implemented over 10 years. The combined strategies of the proposed roadmap will shift more responsibility to individuals to plan for their futures, enabling them to meet their LTSS needs without impoverishing themselves; relieve pressure on MassHealth while strengthening the safety net for individuals with LTSS needs; and support family members and other unpaid caregivers, whose participation in providing LTSS will continue to be essential. Successful implementation of the roadmap strategies will go far in helping people with disabilities, elders, and their families live as they wish, where they want, and within their means in the decades to come.

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VIII. APPENDICES

A Massachusetts Olmstead Plan Summary ⁵³

A vision for the future

Empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, are high in quality, and provide optimal choice.

What is an Olmstead Plan?

In 1999, the U.S. Supreme Court rendered a favorable decision in *Olmstead v. L.C.*, a case that challenged the state of Georgia's efforts to keep people with mental disabilities institutionalized. The Court interpreted the Americans with Disabilities Act (ADA) to require states to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Additionally, the Court indicated that each state should develop an Olmstead plan to demonstrate efforts to be consistent with the ruling.

Why is an Olmstead Plan important to Massachusetts?

The elder and disabled populations in Massachusetts are growing. They are diverse groups of individuals, many of whom depend on state-supported programs. With a broad array of home- and community-based services, including case management, housing supports, and transportation, many can live in less restrictive, and sometimes less expensive, community-based settings where they would prefer to live.

- Massachusetts has a total population of over 6.4 million people, including approximately 13 percent (roughly 832,000) who are 65 years and older.
- In Massachusetts' general population, the likelihood of having a disability varies by age. For people between the ages of 16 and 64 years of age, 11 percent (more than 470,000 individuals) report having a disability. For those individuals over the age of 65, the percentage of people who report having a disability is 36 percent (close to 300,000 individuals).ⁱ
- As of August 2008, there were approximately 25,000 children with disabilities, 203,000 adults under the age of 65 with disabilities, and 107,000 seniors enrolled in MassHealth.
- On any given day, the average number of MassHealth clients (over the age of 18) residing in nursing homes is approximately 28,300.ⁱⁱ
- The current federal and state long-term care financing system was originally designed for institutional rather than community care, and as

a result, it has tended to favor institutional over community care.

- Among elderly and disabled MassHealth members living in the community, as well as among those who are not MassHealth members, there is a desire for more access to home and community-based supports.
- Employment opportunities, critical for supporting elders and people with disabilities in leading self-sufficient and independent lives, are limited in Massachusetts, as they are elsewhere.
- People with disabilities in Massachusetts are almost three times as likely to be unemployed as their non-disabled peers.
- Access to sufficient affordable and accessible housing is often one of the greatest challenges to successful transition from institutional care to independent living.
- The ability of elders and people with disabilities to choose community over institutional care is affected by the availability of community options.

How was the plan developed?

Governor Patrick established an Olmstead Planning Committee in 2007. A large group of representatives including providers, consumers, and advocates, as well as elders and individuals with disabilities (see Appendix), worked collaboratively with state agency staff to develop the current framework and implementation strategies for the Administration's plan. The original People's Olmstead Plan, produced by a group of consumer advocates in 2002, was the starting point for the discussions. Using the goals of the People's Olmstead Plan as a foundation, the Olmstead Planning Committee reviewed prior and current EOHS Olmstead-related initiatives and objectives and identified gaps in service and policy development. The Committee identified six overarching goals and short-term action steps that are the basis of this 18-month implementation plan.

The Community First Olmstead Plan

The overall purpose of the Massachusetts Olmstead Plan is to maximize the extent to which elders and people with disabilities are able to live successfully in their homes and communities.

The following are the six major goal areas included in the state's Olmstead Plan. Detailed objectives and timeframes for each area are included in the Community First Implementation Plan, which can be accessed at www.mass.gov/hhs/communityfirst.

1. Help individuals transition from institutional care.

This goal is at the heart of the Supreme Court decision and is the core focus of the Olmstead Plan. Identifying institutionalized individuals who want to move back home or to other community settings can be challenging.

⁵³ Created by the Massachusetts Olmstead Planning Committee, October 2008. The full plan is available at <http://tinyurl.com/2umkmxu>.

Disability and elder-related organizationsⁱⁱⁱ, in addition to EOHHS staff, currently work to engage individuals in transition processes. However, a more systematic approach would further greater success. Implementation of the Long-Term Care Options Counseling process^{iv}, and initiation of the transition services components of the planned Community First 1115 Waiver program^v, the Hutchinson settlement, and the alternative Rolland settlement^{vi} will provide important ingredients toward success in moving individuals to community settings. Ongoing assessment of the effectiveness of these transition interventions will provide a basis for continuous quality improvement.

2. Expand access to community-based long-term supports.

Among the efforts to improve access to home- and community-based services will be activities to expand access to case management, medication management, behavioral health, caregiver supports, assistive technology, and accessible transportation for elders and persons with disabilities.

At the same time, efforts will be made to improve transition services for adolescents with disabilities who are leaving the education system.

The Olmstead Plan will also focus on increasing the access that elders and people with disabilities have to community-based long-term resources.

The primary means of achieving this objective during the Olmstead Plan's initial implementation period will be the launch of the Community First 1115 Waiver program. Specifically, by the end of the 18-month implementation period following federal approval, we anticipate that 15,600 people will be enrolled in the Community First Waiver program. In addition, during this same period, EOHHS will also engage in activities to meet the obligations of the Rolland court settlement. The state will also work to expand Medicaid community support coverage options by exploring the feasibility of options such as those permitted by the federal Deficit Reduction Act.^{vii}

The Olmstead Plan also refers to several current program review processes which will, when completed, offer solutions to removing other access barriers. For example, one workgroup is focused on identifying and implementing effective ways to improve the MassHealth Personal Care Attendant program's operations. There is also a cross-agency initiative modifying the way EOHHS coordinates planning to assist severely disabled young adults who are turning 22 and "aging out" of educational services.^{viii}

3. Improve the capacity and quality of community-based long-term supports.

A core principle of the Olmstead Plan is choice. To promote choice, agencies will emphasize consumer empowerment and person-centered planning and decision-making. This emphasis on choice will be complemented by improvements in current guardianship, regulatory, and administrative practices.

Ongoing and new efforts will concentrate on developing mechanisms to sustain and expand the skills of a high-quality, appropriately trained community workforce. The Personal Care Attendant (PCA) Quality Workforce Council, established by the state Legislature in 2006, is one

such mechanism that makes it easier for individuals with disabilities to find and hire PCAs.^{ix} The objective of initiatives such as the Community First Waiver program will be to increase financing options and service choices, including residential supports that allow people to live in the community in a variety of settings, including group homes, foster care, and individual apartments. Additional projects will help to define the quality and measure the performance of the long-term support systems.

4. Expand access to affordable and accessible housing with supports.

Affordable, accessible housing is critical to a system that successfully supports elders and people with disabilities who either remain in the community or move to the community from an institutional setting. To develop more accessible housing, EOHHS will collaborate with the Department of Housing and Community Development (DHCD) in efforts to develop affordable housing while renovating existing housing stock. EOHHS will also focus on raising citizens' awareness about accessible housing, promoting the Mass Access Housing registry^x and the state's home modification and assistive technology funding options.

5. Promote employment of persons with disabilities and elders.

Efforts must include greater access to employment opportunities, including employment support services, for elders and individuals with disabilities, increased access to vocational rehabilitation services and career planning for individuals with disabilities, and evaluation of the effectiveness of employment initiatives.

Newly established EOHHS employment goals as well as several federal grant initiatives^{xi} provide both the framework and the support for re-tooling employment services for the target population. Expanded collaborations with the state Department of Elementary and Secondary Education (DESE) and the state Executive Office of Labor and Workforce Development (OLWD) will improve vocational training services for transition-aged youth, employer engagement strategies, market-based skill development, and job retention support. Improved monitoring of employment outcomes holds the promise of continuous quality improvement.

6. Promote awareness of long-term supports (LTS)

A strategy must be developed for educating clinicians in community practices and institutions, as well as residents of the commonwealth, about availability and viability of community-based LTS options.

Implementation of the Long-Term Care Options counseling processes will go a long way toward ensuring that elders and individuals with disabilities have better information about their options when contemplating long-term support decisions. Finally, efforts will be made to reach community members to make them more aware of both institutional and non-institutional support options. These efforts will include promotion of available online information resources in addition to a broad outreach and education strategy.

Appendix
Olmstead Planning Committee Members

OLMSTEAD PLANNING COMMITTEE MEMBERS	
Al Norman	Massachusetts Home Care
Annette Shea	Office of MassHealth
Arlene Korab	Brain Injury Association of Massachusetts
Betty Sughrue	Massachusetts Rehabilitation Commission
Bill Allan	Disability Policy Consortium
Bill Henning	Boston Center for Independent Living
Blair Cushing	AIDS Housing Corporation
Carol Menton	Massachusetts Commission for the Deaf and Hard of Hearing
Carol Suleski	Elder Services Plan of the North Shore (Senior Care Options (SCO)/ Program of All Inclusive Care for the Elderly (PACE))
Cindy Wentz	Massachusetts Rehabilitation Commission
Courtney Nielsen	AIDS Housing Corporation
Daniel J. Greaney	Stavros Center for Independent Living
Ed Bielecki	Mass Advocates Standing Strong
Elissa Sherman	Mass Aging Services Association
Elizabeth Fahey	Home Care Alliance
Ellie Shea-Delaney	Department of Mental Health
Gigi Alley	Advocate
John Chappell	Massachusetts Rehabilitation Commission
John Winske	Disability Policy Consortium
Katherine Fox	Briarcliff Lodge Adult Day Health Center
Keith Jones	Soul Touchin' Experiences
Lisa Gurgone	Massachusetts Council for Home Care Aides
Lisa McDowell	MassHealth Office of Long-term Care
Loran Lang	Massachusetts Commission for the Blind
Maggie Dionne	Massachusetts Rehabilitation Commission
Margaret Chow-Menzer	Department of Developmental Services
Maria Russo	The May Institute
Martina Carroll	Stavros Center for Independent Living
Nancy Alterio	Disabled Persons Protection Commission
Pat Kelleher	Home Care Alliance
Paul Lanzikos	North Shore Elder Services

Paul Spooner	MetroWest Center for Independent Living
Rick Malley	Massachusetts Office on Disability
Rita Claypoole	Advocate
Rita Barrette	Department of Mental Health
Robert Sneirson	Disability Policy Consortium
Sue Temper	Springwell
Valerie Konar	Massachusetts Assisted Living Facilities Association (Mass-ALFA)

OLMSTEAD PLANNING COMMITTEE STAFF LEADS

Eliza Lake	Systems Transformation Grant Lead for Diversion Committee
Jean McGuire	EOHHS-Disability Policies and Programs
Laurie Burgess	EOHHS-Disability Policies and Programs
Mason Mitchell-Daniels	EOHHS-Disability Policies and Programs
Michele Goody	Office of MassHealth
Peter Ajemian	EOHHS-Disability Policies and Programs
Ruth Palombo	Executive Office of Elder Affairs
Sandra Albright	Executive Office of Elder Affairs
Shannon Hall	University of Massachusetts Medical School-Project Management Office

Endnotes for Appendix A:

- i** General population demographic data is based on information from the American Fact Finder, an online tool that reports on the American Community Survey. The American Community Survey is an ongoing survey that provides data on communities every year and is administered by the U.S. Census Bureau. Numbers in this report are estimates for 2007.
- ii** MassHealth nursing facility data is from claims paid for state fiscal year 2007.
- iii** These organizations include Aging Service Access Points (ASAPs) and Independent Living Centers (ILCs), networks of providers that work with elders and people with disabilities in the community.
- iv** The Long-Term Care Options Counseling process was developed pursuant to a 2006 state statute. This statute, Chapter 211 of the Acts of 2006, specifies long-term care options counseling requirements.
- v** The Medicaid program is a medical assistance program operated under federal and state law. The Medicaid statute lays out the rules about what can be a covered service and who can be covered. Federal law allows for the federal government to waive some of those statutory rules and provide for different rules requested by the state and specified by the terms of the waiver (i.e., the waiver program). The planned Community First 1115 Waiver is an example of such a Medicaid waiver program, which is intended to reduce barriers to accessing MassHealth-funded home and community-based services (HCBS) in the community and help individuals, who can do so safely and beneficially, to return to community living from nursing facilities. The Community First 1115 Waiver application is currently awaiting federal approval.
- vi** Under the Rolland Settlement, the commonwealth agreed to either provide certain services to individuals who are Rolland class members and residing in nursing facilities or to place these individuals into community-based programs. Under the Hutchinson Settlement, the commonwealth agreed to establish a Home and Community Based Waiver program for individuals with Acquired Brain Injuries.
- vii** The federal Deficit Reduction Act (DRA) was passed in 2005 and established several law changes related to long-term care. Several of the changes presented new options for states to offer new or expanded programs for people needing long-term care services.
- viii** This effort is called the “Turning 22 Initiative.”
- ix** Chapter 268 of the Acts of 2006 is the state statute that created the PCA Quality Workforce Council.
- x** The Massachusetts Accessible Housing Registry is a free program that helps people with disabilities find rental housing in Massachusetts, primarily accessible and barrier-free housing. www.massaccessshousingregistry.org
- xi** The Medicaid Infrastructure and Comprehensive Employment Grant (MICEO) is intended to increase the number of people with disabilities who are employed while improving the quality of jobs. This grant is intended to build on the work of the previous 2001 Medicaid Infrastructure grant and is defining employment services outcomes by working with the EOHHS Strategic Task Force on Employment.

B Bibliography of Select Literature

AARP. (2008). *State Long-Term Care Reform in Massachusetts*. Washington, DC: Author. Retrieved from: http://assets.aarp.org/rgcenter/il/2008_10_ltc_ma.pdf

Summary: Two-page fact sheet on Massachusetts rebalancing and policies.

Alzheimer's Association. (2006, May). *State and Federal Tax Credits and Deductions*. Retrieved from: http://www.alz.org/national/documents/topicsheet_taxcreditsdeducts.pdf

Summary: More than seven out of 10 people with Alzheimer's disease live at home, where family and friends provide almost 75 percent of their care. The remainder is "paid care" costing an average of \$19,000 per year. Because caregivers pay for most of these expenses out of pocket, they may be eligible for tax credits or deductions.

Bayer, A. and Harper, L. (2000). *Fixing to Stay: A National Survey on Housing and Home Modification Issues Research Report*. Washington, D.C.: AARP. Retrieved from: http://assets.aarp.org/rgcenter/il/home_mod.pdf

Summary: This report presents the results of a national telephone survey of Americans aged 45 and over. The study examines the opinions and behavior of older Americans regarding their current and future housing situations, with emphasis on home modifications that enable people to remain independent and that increase the safety and convenience of their home.

Center for Health Care Strategies. (2008, May). *Long-Term Care Partnership Expansion: A New Opportunity for States: Issue Brief*. Retrieved from: http://www.chcs.org/usr_doc/Long-Term_Care_Partnership_Expansion.pdf

Summary: This brief provides a background and history of Long-Term Care Partnership programs, information about reforms in the Deficit Reduction Act of 2005, and an overview of issues states should consider when developing LTC Partnership programs.

Citizens for Long Term Care and Paraprofessional Healthcare Institute. (2003, January). *Long-Term Care Financing and the Long-Term Care Workforce Crisis: Causes and Solutions*. Retrieved from: <http://www.longtermcarersa.org/images/Long%20Term%20Care%20Financing.pdf>

Summary: This paper explores the interrelationship between the current LTC financing system, the quality of direct care jobs, and the resulting decline in long-term care availability. It includes recommendations for LTC finance reforms.

Cohen, M.A., Miller, J., & Weintraub, M. (2001). Patterns of Informal and Formal Caregiving Among Elders With Private Long-Term Care Insurance. *The Gerontologist* 41 (2):180-187. DOI: 10.1093/geront/41.2.180

Summary: This report provides basic descriptive information on community-dwelling, disabled, private long-term care (LTC) insurance policyholders who have accessed policy benefits, including how benefits are used, whether claimants feel they are getting appropriate value from their policies, and what the patterns are of formal and informal service use.

Cohen, M., Kumar, N. and McGuire, T. (1992, Fall). Financing Long-Term Care: A Practical Mix of Public and Private. *Journal of Health Politics, Policy, and Law*, 17(3):403-424. DOI:10.1215/03616878-17-3-403.

Summary: This article outlines proposals in Congress and makes recommendations that Congress should consider a program that enhances Medicaid; improves consumer education; assists states in regulating long-term care policies, so as to enhance consumer protection and confidence; and clarifies taxes on long-term care insurance to encourage workers and the elderly to protect themselves against catastrophic expenses.

Cohen, M. (2003). Private Long-Term Care Insurance. *Journal of Aging and Health*, Vol. 15, No. 1, DOI: 10.1177/0898264302239015.

Summary: This paper summarizes and synthesizes what is known about the private long-term care insurance market and its impact on public expenditures, policyholders, their families, and providers.

Cohen, M. (2006). *Long-Term Care Planning and Insurance*. [PowerPoint slides] Retrieved from: <http://aspe.hhs.gov/medicaid/mar/MarcCohen.pdf>

Summary: This PowerPoint presents background information on long-term care (LTC) planning, provides information on how LTC insurance fits into the planning picture, and provides data on the impact of growth in the LTC insurance market on consumers and on Medicaid expenditures.

Cohen, M. A., Weinrobe, M., Miller, J., and Ingoldsby, A. (2005). *Becoming Disabled After Age 65: The Expected Lifetime Costs of Independent Living*. Washington, DC: AARP Public Policy Institute. Retrieved from: http://assets.aarp.org/rgcenter/il/2005_08_costs.pdf

Summary: The purpose of this analysis was to estimate, for persons 65 and over, the remaining lifetime probability of developing a disability and needing long-term care services, the service-related costs associated with avoiding nursing home placement and remaining at home while receiving

appropriate quality care, and the costs associated with supporting currently institutionalized older persons in the community. This report does not analyze persons who developed disabilities before the age of 65.

Congress of the United States Congressional Budget Office. (2004). *Financing Long-Term Care for the Elderly*. Retrieved from: <http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTermCare.pdf>

Summary: This Congressional Budget Office paper summarizes the current state of financing for long-term care, identifies some of the issues affecting it both now and in the future, and considers policy alternatives that address the mix of private and governmental sources of financing for LTC costs.

Congressional Research Service. (2005). *Medicaid's Long-term Care Insurance Partnership Program*, Order Code RL32610. Retrieved from: <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3261001212005.pdf>

Summary: This report provides a summary of the experiences of the four states in implementing the partnership program, including data and analysis of participation, policies purchased, and the market for long-term care insurance. It also attempts to evaluate the extent to which the asset protection promised under the partnership program is sufficient and necessary to encourage more persons to purchase long-term care insurance, and discusses other key issues raised by policymakers and stakeholders concerning the expansion of the partnership program to the national level. Legislative proposals are also described.

Connecticut Long-Term Care Planning Committee. (2007). *Long-Term Care Plan: A Report to the General Assembly*. Retrieved from: <http://www.cga.ct.gov/AGE/LTC%20Plan-2007%20Final.pdf>

Summary: This plan was produced to educate and provide recommendations to policymakers regarding what steps Connecticut should initiate and continue to take in order to meet the long-term care challenges of the next several decades.

Crisp, S., Eiken, S., Gerst, K., & Justice, D. (2003, September). *Money Follows the Person and Balancing Long-Term Care Systems: State Examples*. Washington, DC: Medstat. Retrieved from: <http://www.cms.hhs.gov/PromisingPractices/Downloads/mfp92903.pdf>

Summary: Many states have successfully developed and implemented strategies that improve the balance between spending for institutional and community-based services. Developing a balanced long-term care system in which "money follows the person" requires, at a minimum, changes in the state's policies and procedures. State successes have included many common elements. This paper discusses those elements.

Crowley, J.S. (2008). Washington, DC: O'Neil Institute for Nation and Global Health Law. Retrieved from: www.hcbs.org/moreInfo.php/doc/2452

Summary: This paper identifies potential administrative and legislative actions that could be taken to bolster the capacity of Medicaid and Medicare to meet the needs of people with disabilities and chronic conditions. Policy options are listed in four key areas: eligibility and enrollment; access to services; program management and delivery system issues; and, financing.

Donelan, K., et al. (2002). "Challenged to Care: Informal Caregivers In A Changing Health System." *Health Affairs* 21 (4) 2002: 222-231. Retrieved from: <http://content.healthaffairs.org/cgi/reprint/21/4/222>

Summary: This report is from a 1998 national survey of informal caregivers. It includes caregiver demographics, activities, barriers to providing assistance, challenges, and rewards.

Disability Policy Consortium. (2005). *Long Term Supports and Medicaid Information*. Boston, MA: Author. Retrieved from: <http://www.dpcma.org/LinkClick.aspx?fileticket=vkXpYe4DSh0%3d&tabid=423&mid=1146>

Summary: This paper is a compilation of reports and articles about long-term supports, including a glossary and list of acronyms.

Elmendorf, D. (2009). *Additional Information on CLASS Program Proposals*. Washington, DC: Congressional Budget Office. Retrieved from: http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf

Summary: This letter from the Congressional Budget Office director provides information on the budgetary effects of the CLASS program.

Feder, J., Komisar, H.L., and Niefeld, M. (2000). *Long Term Care in the United States: An Overview*. *Health Affairs*, 19 (3), 40-56. Retrieved from: <http://content.healthaffairs.org/cgi/reprint/19/3/40.pdf>

Summary: This paper reviews key long-term care issues, describes the population that needs long-term care, financing mechanisms, patterns of service use among elders, and policy implications and issues.

Feder, J., Komisar, H.L., and Freidland, R.B. (2007, June). *Long-Term Care Financing: Policy Options for the Future*. Washington, DC: Georgetown University. Retrieved from: <http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf>

Summary: This report describes the current long-term care financing partnership and reasons why it needs improvement. It presents proposals for change and the impacts of each proposal.

Galston, W. A. *Reviving the Social Contract: Economic Strategies to Promote Health Insurance & Long-Term Care*. Washington, DC: The Brookings Institute. Retrieved from: http://www.brookings.edu/~media/Files/Projects/Opportunity08/PB_SocialInsurance_Galston.pdf

Summary: This paper provides suggestions for consideration regarding the social contract. Suggestions include mandating long-term care insurance and making small-group and individual health insurance more affordable.

Gibson, M.J., Gregory, S.R., and Pandya, S.M. (2003). *Long-Term Care in Developed Nations: A Brief Overview*. Washington, DC: AARP Public Policy Institute. Retrieved from: http://assets.aarp.org/rgcenter/health/2003_13_ltc_dv.pdf

Summary: This report provides a brief overview of many of the key long-term care policy trends that cross national boundaries in developed nations in two ways: trends in delivering and organizing formal and informal long-term care services, and on financing long-term care, specifically, the movement toward universal (not means tested) public programs for long-term care.

Gibson, M. J., and Houser, A. (2008). *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update*. Washington, DC: AARP Public Policy Institute. Retrieved from: http://www.hcbs.org/files/149/7404/economic_value_caregiving_2008.pdf

Summary: This paper estimates the economic value of family caregivers' contributions and summarizes findings about the costs to caregivers. Informal caregiving helps to improve the quality of health and LTC and reduce the use of nursing home and inpatient hospital care.

Gibson, M.J. and Satyendra, K. V. (2006, December). *Just Getting By: Unmet Need for Personal Assistance Services Among Persons 50 or Older with Disabilities*. Washington, DC: AARP Public Policy Institute. Retrieved from: http://assets.aarp.org/rgcenter/il/2006_25_disability.pdf

Summary: This report provides information about individuals who receive some help and still have unmet personal assistance needs and individuals who receive no help at all. It also identifies changes that would improve quality of life, explores preferences regarding who provides personal assistance, and identifies factors that are most predictive of unmet need.

Gleckman, H. (2007, April). *Medicaid and Long-Term Care: How Will Rising Costs Affect Services For An Aging Population?* Boston, MA: Center for Retirement Research at Boston College. Retrieved from: <http://www.globalaging.org/health/us/2007/rising.pdf>

Summary: This brief explores trends in Medicaid spending on long-term care and the implications of its rapid growth for taxpayers and for the needs

of an aging population. It discusses Medicaid's financing role and impact on state budgets and also examines policy efforts to decrease Medicaid spending.

Gleckman, H. (2007, June). *Financing Long-Term Care: Lessons from Abroad*. Boston, MA: Center for Retirement Research at Boston College. Retrieved from: http://crr.bc.edu/briefs/financing_long-term_care_lessons_from_abroad.html

Summary: This brief reviews the long-term care experiences of Germany, Japan, France, and the United Kingdom and highlights potential lessons for the United States.

Gleckman, H. (2008, June). *How Can We Improve Long-Term Care Financing?* Boston, MA: Center for Retirement Research at Boston College. Retrieved from: www.hcbs.org/moreInfo.php/doc/2315

Summary: This brief reviews several options for LTC change including enhancing private long-term care insurance, replacing the current welfare-based system with a public social insurance program, and introducing a hybrid public-private system.

Gleckman, H. (2010, February). *Long-Term Care Financing Reform: Lessons from the U.S. and Abroad*. The Commonwealth Fund. Retrieved from: <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Feb/Long-Term-Care-Financing-Reform-Lessons-from-the-US-and-Abroad.aspx>

Summary: This paper reviews the long-term care financing systems in France, Germany, Japan, the Netherlands, and the United Kingdom and identifies lessons learned.

Gleckman, H. (2007, September). *The Role of Private Insurance in Financing Long-Term Care*. Boston, MA: Center for Retirement Research at Boston College. Retrieved from: http://crr.bc.edu/briefs/the_role_of_private_insurance_in_financing_long-term_care_2.html

Summary: This brief discusses the potential benefits of long-term care insurance, reviews its current structure and status, and explores possible explanations for low take-up rates. Also, it considers future issues surrounding the role of this product.

Hendrickson, L. and Reinhard, S. (2004). *Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choices*. NJ: Rutgers Center for State Health Policy. Retrieved from: http://www.hcbs.org/files/52/2599/State_policy_in_practice.pdf

Summary: This paper explores states' use of "global budgeting" to promote a public policy of supporting consumers' long-term care choices. This report defines global budgeting in the context of long-term care, provides

five state models, and offers lessons learned about determining what is “in the globe,” legislative and administrative language to advance it, and how it can be implemented.

H. L. Komisar et al., (2005, Summer). Unmet Long-Term Care Needs: An Analysis of Medicare–Medicaid Dual Eligibles. *Inquiry* 42, 171–82. Retrieved from: <http://www.inquiryjournalonline.org/inqronline/?request=get-document&issn=0046-9580&volume=042&issue=02&page=0171>

Summary: This paper examines how well the medical and long-term care needs of dually eligible community-based elderly are being met under the current combination of Medicare and Medicaid policies.

Johnson, R.W., Toohey, D., and Wiener, J.M. (2007). *Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions*. Washington, DC: The Urban Institute. Retrieved from: http://www.urban.org/UploadedPDF/311451_Meeting_Care.pdf

Summary: This study projects the number and percentage of people ages 65 and older with disabilities and their use of long-term care services through 2040. The projections show how changes in disability levels, financial resources, children’s availability, and other characteristics will affect the future demand for paid and unpaid long-term care services.

Kaiser Commission on Medicaid and the Uninsured. (2009). *Dual Eligibles: Medicaid’s Role for Low-income Medicare Beneficiaries, Fact Sheet*. CA: Author. Retrieved from: http://www.kff.org/medicaid/upload/4091_06.pdf

Summary: This fact sheet provides information about the 8.8 million Americans enrolled in both Medicare and Medicaid. It describes the services that are available to the “dual-eligible” population and policy challenges.

Kaiser Family Foundation. (2007). *Medicare: A Primer*. Menlo Park, CA: Author. Retrieved from: <http://www.kff.org/medicare/upload/7615.pdf>

Summary: Overview of Medicare with rules and regulations as well as statistics from 2006.

Kofman, M. and Thompson, L., (2004). *Consumer protection and long-term care insurance: Predictability of premiums*. Washington, DC: Georgetown University. Retrieved from: <http://ltc.georgetown.edu/papers.html>

Summary: This policy brief highlights a consumer protection issue regarding consumers’ expectations on premiums.

Kronick, R.G., Bella, M., Gilmer, T.P., and Somers, S.A. (2007). *The Faces of*

Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions. Hamilton, NJ: Center for Health Care Strategies, Inc. Retrieved from: http://www.chcs.org/usr_doc/Full_Report_Faces_II.PDF

Summary: The Faces of Medicaid II answers the following questions: What is the prevalence of chronic conditions within the Medicaid population? Are there patterns or clusterings of these conditions that could inform the development of more appropriate guidelines, care models, performance measurement systems, and reimbursement methodologies?

Mahoney, K.J., Meiners, M.R., Shoop, D.M., and Squillace, M.R. (2002). Consumer Direction in Managed Long-Term Care. *The Gerontologist*, 42, 32-38. Retrieved from: <http://gerontologist.gerontologyjournals.org/cgi/content/abstract/42/1/32>

Summary: This report presents results of a survey of the attitudes and practices of managed care organizations (MCOs) concerning consumer direction. The study focused on understanding several alternative measures of consumer direction and the factors that are associated with the MCOs concerning those measures.

Massachusetts Department of Public Health and the Center for Survey Research. (2007). *Study of the Unmet Needs of Adults with Disabilities in Massachusetts*. Boston, MA: Author. Retrieved from: http://www.mass.gov/Eeohhs2/docs/dph/behavioral_risk/unmet_needs_adult_disability.pdf

Summary: This study includes interviews with over 570 adults with disabilities in Massachusetts. This report describes their health, the extent and nature of disability, health insurance, employment, and demographics. The report also presents findings on unmet and insufficiently met needs.

Massachusetts Division of Insurance. (2009, January). *Your Options for Financing LTC: A Massachusetts Guide*. Boston, MA: Author. Retrieved from: http://www.mass.gov/Eoca/docs/doi/Consumer/HealthLists/LTCare_Guide.PDF

Summary: This guide was prepared by the Massachusetts Division of Insurance for citizens of the commonwealth to provide them with basic information about the various types of long-term care services available in Massachusetts.

Massachusetts Division of Insurance. (2010). *2010 Report of Long-term Care Insurance in Massachusetts: Results of a 2008 Examination*. Boston, MA: Author. Retrieved from: http://www.mass.gov/?pageID=ocaterminal&L=7&L0=Home&L1=Consumer&L2=Insurance&L3=Health+Insurance&L4=Health+Care+Access+Bureau&L5=Group+Products+and+Plans&L6=Report+on+Long+Term+Care+Insurance&sid=Eoca&b=terminalcontent&f=doi_Consumer_css_health_LTCare_Survey_Results_2008&csid=Eoca

Summary: The Massachusetts Division of Insurance surveyed the market

for long-term care insurance to understand the products that Massachusetts and national insurers purchase in the individual and group markets and the ways that carriers offer products. DOI identified trends and areas that may require further action.

Massachusetts Extended Care Foundation. (2003). *Challenging the Myths about Long-Term Care in Massachusetts*. Newton Lower Falls, MA: Author.

Summary: This paper attempts to dispel some common myths about nursing homes in Massachusetts. These myths revolve around the high cost and low necessity for nursing homes as well as the myth that there are cheaper or better available alternatives.

Master, R.J., and Eng, C. (2001, November/December). Integrating Acute And Long-Term Care For High-Cost Populations. *Health Affairs*. 20 (6) 161-172. Retrieved from: <http://healthaff.highwire.org/cgi/content/full/20/6/161>

Summary: This report presents several “boutique” initiatives to integrate acute and long-term care. These initiatives share most of the following characteristics: prepaid, risk-adjusted financing; integrated Medicare and Medicaid funding streams; a flexible array of acute and long-term benefits; well-organized, redesigned care delivery systems that tailor these benefits to individual need; a mission-driven philosophy; and considerable creativity in engaging government payers. The experience of these “boutiques” illustrates both the obstacles to, and the opportunity for, meaningful, widespread care delivery reform for vulnerable chronically ill populations.

MetLife Mature Market Institute. (2009, October). *The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*. Westport, CT: Author. Retrieved from: <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf>

Summary: This market survey contains daily private-pay rates for private and semi-private rooms in licensed nursing homes, monthly base rates for assisted living communities, hourly rates for home health aides from licensed agencies and agency-provided homemaker companion services, and daily rates for adult day services across the United States.

Merlis, Mark. (2004, April). *Long-Term Care Financing: Models and Issues*. National Academy of Social Insurance Study Panel on Long-Term Care. Retrieved from: http://www.nasi.org/usr_doc/Merlis_LongTerm_Care_Financing.pdf

Summary: This paper provides an overview of policy choices to be made in designing a financing system; gives examples of the possible approaches in each issue area; and summarizes equity issues or other policy concerns raised by the options.

Minnesota Department of Human Services. (2005, January). *Financing*

Long-term Care for Minnesota's Baby Boomers, A Report to the Minnesota Legislature. St. Paul, MN: Author.

Retrieved from: <http://www.leg.state.mn.us/docs/2006/Mandated/060704.pdf>

Summary: This report examines the issue of financing long-term care in the future as the number of older Minnesotans needing long-term care dramatically increases. It describes a variety of public and private financing options that may have some potential for addressing this critical issue, and offers recommendations to the State of Minnesota for actions that should be taken to prepare for these long-term care challenges.

Mittleman, M.; Haley, W.; Clay, O.; Roth, D. (2006). Improving caregiver well-being delays nursing home placement of patients with Alzheimer's disease. *Neurology* 67 (9), 1592-9. Retrieved from: <http://www.neurology.org/cgi/content/abstract/67/9/1592>

Summary: A randomized controlled trial was conducted in order to determine the effectiveness of a counseling and support intervention for spouse caregivers in delaying time to nursing home placement of patients with Alzheimer disease and identify the mechanisms through which the intervention accomplished this goal.

Mollica, R. (2003, February). Coordinating Services Across the Continuum of Health, Housing, and Supportive Services. *Journal of Aging and Health*. 15 (1), 165-188.

Summary: This article describes trends in three areas of state long-term care policy for elderly low-income Medicaid beneficiaries—providing home care services to residents in subsidized housing and assisted living; offering nursing home residents opportunities to relocate to community settings; and integrating acute and long-term care services for beneficiaries who are dually eligible for Medicare and Medicaid. Multiple initiatives responding to consumer preferences and fragmentation of the delivery systems were identified. Key components were consumer demand; the availability of nursing facility alternatives; and state priorities for controlling expenditure growth.

National Alliance for Caregiving in collaboration with AARP. *Caregiving in the U.S. 2009*. Retrieved from: http://assets.aarp.org/rgcenter/il/caregiving_09_fr.pdf

Summary: This study, which is based on data from quantitative telephone interviews, compares family caregivers in 2009 with caregivers in 1997 and 2004.

National Association of State Medicaid Directors. (2007). *State Perspectives on Emerging Medicaid Long-Term Care Policies and Practices*. Washington, DC: Author. Retrieved from: <http://www.nasmd.org/resources/docs/LongTermCareRpt1007.pdf>

Summary: The purpose of this survey analysis is to provide the states with

an overview of the implementation of these Deficit Reduction Act changes across the country. This paper specifically reviews the Deficit Reduction Act changes in Long-Term Care services and the steps the states have taken with respect to the changes.

National Council on Disability. (2005). *The State of 21st Century Long-Term Services and Supports: Financing and Systems Reform for Americans with Disabilities*. Washington, DC: Author. Retrieved from: http://www.ncd.gov/newsroom/testimony/2005/novak_12-15-05.html

Summary: This report provides a broad overview of and recommendations regarding LTSS issues including supporting family caregivers, addressing workforce shortages, improving the quality of LTSS services, and improving access to transportation and housing.

O'Brien, E. (2007). *Long Term Care Partnerships: An Update*. Washington, DC: Alliance for Health Reform. Retrieved from: http://www.allhealth.org/publications/long-term_care/long_term_care_partnerships_53.pdf

Summary: This brief describes the history of Long-Term Care Partnership programs, changes following the Deficit Reduction Act, and possibilities for the future.

O'Keefe, J. (2008, October). *Self-Direction Programs and Policies: A Handbook*. [PowerPoint slides]. Retrieved from: http://www.nasua.org/pdf/hcbs_08_final_presentations/Monday_9-29-08/945am_workshops/Self-Direction%20Programs%20and%20Policies%20Handbook-Presentation.ppt.pdf

Summary: This presentation provides an introduction to self-direction including information about key features of self-directed programs, the legal authority under Medicaid to offer self-direction, and basic elements of a self-directed program including individual budgets, counseling, and fiscal management services.

Query, T. (2004). An Update on Public Policy Changes Affecting Long-Term Care. *The Journal of Financial Planning*. Retrieved from: <http://www.fpajournal.org/BetweenTheIssues/LastMonth/Articles/AnUpdateonPublicPolicyChangesAffectingLong-TermCare/>

Summary: This paper explores the influence of regulatory and legislative changes over time, as well as forthcoming proposals that financial planners need to be informed about to better serve their clients.

Scanlon, W. (2004) *Long-term care and the policy agenda*. Washington, DC: Georgetown University. Retrieved from: <http://ltc.georgetown.edu/pdfs/remarks.pdf>

Summary: This is an edited version of conference remarks made by William

Scanlon, long-term care policy expert and Director, Health Care Issues, U.S. General Accounting Office. Dr. Scanlon offers his views on long-term care's place on the policy agenda and presents his perspective on ways to think about long-term care financing in the future.

Seifert, R. (2008). *The Basics of MassHealth*. Boston, MA: Massachusetts Medicaid Policy Institute. Retrieved from: <http://bluecrossfoundation.org/~media/MMPI/Files/The%20Basics%20of%20the%20Massachusetts%20Medicaid%20Program.pdf>

Summary: This fact sheet introduces the MassHealth program, describing its basic structure, who receives benefits and what those benefits are, and how enrollment and spending have changed over time. It explains how MassHealth fits into the programs created by the 2006 reform law. It concludes with a discussion of some of the current policy issues and challenges facing the program.

Senior Agenda Coalition and Rhodes to Independence. (2007). *Reforming Long-Term Care for Rhode Island: Best practices from other states*. Providence, R.I.: Author. Retrieved from: <http://rhodestoind.startlogic.com/docs/Reforming%20LTC%20in%20RI.pdf>

Summary: This report provides examples of initiatives launched in different states to rebalance their long-term care services to allow greater access to home- and community-based services. It also discusses the implementation of The Perry Sullivan Reform Act and the Real Choices System Transformation Grant strategic planning process.

Shirk, C. (2006). *Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program*. Washington, DC: National Health Policy Forum. Retrieved from: <http://www.nhpf.org/library/details.cfm/2510>

Summary: This paper reviews the background of the Medicaid home and community services (HCBS) waiver program and the contribution of the HCBS waiver program toward improving access to community-based care for Medicaid beneficiaries who are elderly and disabled.

Shostak, D. & London, Paul. (2008). *State Medicaid Expenditures for Long-Term Care 2008-2027*. Retrieved from: <http://www.ahip.org/content/default.aspx?docid=24597>

Summary: This report includes long-range forecasts and baseline projects for Medicaid LTSS expenditures by state.

Silverstein, M. & Parrott T.M. (2001). Attitudes toward Government Policies that Assist Informal Caregivers. *Research on Aging*, 23 (3), 349-374. doi: 10.1177/0164027501233004

Summary: National survey data was used to determine American preferences for three public program policy options that assist caregivers: directly paying caregivers, granting tax credits to caregivers, and requiring that employers grant time off without pay to caregivers.

Simon-Rusinowitz, L. et al. (2005). Paying Family Caregivers: An Effective Policy Option in the Arkansas Cash and Counseling Demonstration and Evaluation. *Marriage & Family Review*, 37 (1/2), 83-105. DOI: 10.1300/J002v37n01_07 Retrieved from: http://www.cashandcounseling.org/resources/20060222-111538/View_EText1.pdf

Summary: This article reports findings from the Cash and Counseling Demonstration and Evaluation (CCDE) in Arkansas, in which consumers receive a cash allowance to purchase personal assistance services. In this comparison of consumers who hired family vs. non-family workers, consumers who hired relatives received more service and had equal or superior satisfaction and health outcomes, as compared to those who hired non-relatives. Findings are further clarified by drawing from worker focus group reports and program experience, and policy issues are specifically addressed.

Stevenson, D.G., Frank, R.G., Tau, J. (2009). Private Long-term Care Insurance and State Tax Incentives. *Inquiry* 46(3), 305-321.

Summary: This paper uses national data to study tax incentives for long-term care insurance. It concludes that the market take-up for long-term care insurance increased over the last decade, but state tax incentives were responsible for only a small portion of this growth.

Stevenson, D., and Wiener, J. (1997). *Long-Term Care for the Elderly and State Health Policy*. Washington, DC: The Urban Institute. Retrieved from: http://www.urban.org/UploadedPDF/anf_17.pdf

Summary: This policy brief discusses three broad strategies that states could use to control spending for Medicaid long-term care services for the elderly: increase outside resources, system reform, and strategies to control spending. It also provides an overview of utilization and expenditures associated with long-term care for the elderly.

Stevenson, D. (2008). Planning for the Future—Long-Term Care and the 2008 Election. *New England Journal of Medicine*, 358(19), 1985–1987.

Summary: This article explains the need for long-term care reform despite its lack of attention during the 2008 election. Three key questions about reform are identified: How should long-term care be viewed within the larger context of the delivery and financing of health care? Should long-term care services that are publicly financed continue to be administered through a welfare-based strategy or should we move to a more universal approach? Should reforms of long-term care place greater emphasis on public programs or private provision?

Stevenson, D.G., Cohen, M.A., Tell, E. J., Burwell, B. (2010). The Complementarity of Public and Private Long-Term Care Coverage. *Health Affairs*, 29(1), 96-101. Retrieved from: <http://content.healthaffairs.org/cgi/content/abstract/29/1/96>

Summary: This report explores reasons for the modest size of the private long-term care insurance market, including the perceived value gap, role of Medicaid, and consumer confidence. It also explores the effects of public policy on the insurance market, including Medicaid crowd-out.

Stevenson, D., & Wiener, J. (1998). State Policy on Long-Term Care for the Elderly. *Health Affairs*, 17 (3), 81-100. Retrieved from: <http://content.healthaffairs.org.ezproxy.umassmed.edu/cgi/content/abstract/17/3/81>

Summary: This report focuses on state strategies to control long-term care spending, including offsetting state spending with increased private and federal contributions, making the delivery system more efficient, and using traditional cost-control mechanisms, such as controlling the nursing home bed supply and cutting Medicaid reimbursement rates.

Sum, A., Khatiwada, I., Tobar, P., Palma, S., & McLaughlin, J. (2006). *The Adult Disabled Population (16-74) in Massachusetts: Its Size and Demographic/Socioeconomic Composition in 2003-2004*. Retrieved from: http://www.clms.neu.edu/publication/documents/first_mrc_report_in_2006.pdf

Summary: This report provides a comprehensive array of estimates of the recent size of the adult disabled population in Massachusetts, a profile of their demographic/socioeconomic backgrounds, and projections of the future size and age composition of the state's population of people with disabilities.

Summer, L. (2005, October) *Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. Retrieved from: <http://www.kff.org/medicaid/upload/Strategies-to-Keep-Consumers-Needing-Long-Term-Care-in-the-Community-and-Out-of-Nursing-Facilities-Report.pdf>

Summary: This report reviews policies and practices in states that are most successful at keeping people in community settings. The most successful states made systemic changes to increase the capacity for community-based care and provide options counseling and assistance for making choices about care.

Thompson, L. (2004, March) *Long-term Care: Support for Family Caregivers*. Washington, DC: Georgetown University. Retrieved from: <http://ltc.georgetown.edu/pdfs/caregivers.pdf>

Summary: This brief provides information about the role of family caregivers, demographics of caregivers, the amount of care provided, the

challenges of family caregiving, and methods of supporting family and informal caregivers. Suggestions for support include information and assistance services, technology, education and training, support groups and counseling, respite care, financial support, comprehensive support initiatives, and formal care for people with disabilities.

Tumlinson, A., Aguiar, C., and O'Mally, Watts, M. (2009, June). *Closing the LTC Funding Gap: The Challenge of Private LTC Insurance*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. Retrieved from: <http://www.kff.org/insurance/7879.cfm>

Summary: This policy brief examines the fundamentals of long-term care insurance, and describes the results of a study exploring how consumers purchase policies, what they are buying, how much the insurance costs, how policies cover services, and how regulations work to protect consumers. The brief also explores some of the key challenges policymakers face in increasing the role of private long-term care insurance in financing long-term care.

University of Massachusetts Medical School, Center for Health Policy and Research. (2006). *Diversion and Transition Services in the U.S. Promising Practices and Options for the Future*. Retrieved from: http://hcbs.org/files/84/4184/DiversionInventory_NationalReport.pdf

Summary: This report provides a variety of recommendations for states to consider in addressing the barriers and strengthening efforts to divert and transition individuals from nursing facilities.

University of Massachusetts Medical School, Center for Health Policy and Research. (2008). *Integrating Medicare and Medicaid Benefits for Adults with Disabilities. Literature Review and Interview Summary*. Boston, MA: Author.

Summary: This report describes findings from academic and policy literature and key informant interviews with program officials from selected state integrated programs related to critical design and implementation issues on Medicare and Medicaid integration using special needs plans.

University of Massachusetts Medical School, Center for Health Policy and Research. (2007). *Community First PASRR Study: Understanding Individuals with Mental Health Conditions who are Screened by the Pre-Admission Screening and Resident Review Process in Massachusetts*. Boston, MA: Author.

Summary: This paper presents data from the Pre-Admission Screening and Resident Review process in Massachusetts. Findings include a description of the demographic profile, a clarification of service needs necessary for preventing or delaying nursing facility admission, and case studies.

University of Massachusetts Medical School, Center for Health Policy and Research. (2004). *Promising Practices: Managing the Care of*

People with Disabilities. Boston, MA: Author.

Summary: This report reviews promising practices for serving and managing the care of people with disabilities in the arenas of planning; implementation; eligibility; funding and authority; contracting; delivery system and services offered; care management and care coordination processes; evaluation and outcomes; and replication.

University of Massachusetts Medical School, Center for Health Policy and Research and Massachusetts Medicaid Policy Institute. (2004). *Understanding MassHealth Members with Disabilities*. Boston, MA: Author. Retrieved from: http://www.umassmed.edu/uploadedfiles/MMPI_Report_June2004.pdf

Summary: The goal of this policy report is to promote a better and broader understanding of non-elderly MassHealth members with disabilities.

U.S. Department of Health and Human Services. (2008). *A Profile of Medicaid Institutional and Community-Based Long-Term Care Service Use and Expenditures Among the Aged and Disabled using MAX 2002: Final Report*. Washington, DC: Author. Retrieved from: <http://aspe.hhs.gov/daltcp/reports/2008/profileMAX.pdf>

Summary: This study evaluates the potential of using MAX Person Summary files to examine how successfully states have rebalanced their long-term care systems and how Medicaid enrollees who utilize community-based long-term care services differ from people in institutions.

U.S. Government Accountability Office. (2007, May). *Long-term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings*, GAO-07-231. Washington, DC: Author. Retrieved from: <http://www.gao.gov/new.items/d07231.pdf>

Summary: This report examines several aspects of Partnership programs including the benefits and premium requirements of Partnership policies as compared with those of traditional long-term care insurance policies; the demographics of Partnership policyholders, traditional long-term care insurance policyholders, and people without long-term care insurance; and whether the Partnership programs are likely to result in savings for Medicaid.

Van de Water, P. (2010, April). *CLASS: A New Voluntary Long-Term Care Insurance Program*. Washington, D.C.: Center on Budget and Policy Priorities. Retrieved from: <http://www.cbpp.org/files/4-16-10health.pdf>

Summary: This report explains the CLASS Act, as created through health

care reform legislation, including benefits, financing, and why it is needed.

Washington State Task Force on Long-term Care Financing and Chronic Care Management. (2008, January) *Final Report*. Retrieved from: http://www.governor.wa.gov/lctcf/reports/ltc_task_force_final_report.pdf

Summary: This is the final report of a task force that was established by legislation to “develop recommendations for the Governor and appropriate committees of the Legislature to improve the State’s ability to support the delivery of long-term care services that meet the current and future need of its citizens.”

Wiener, J. (April 2009). *Long-Term Care: Options in an Era of Health Reform*. Washington, D.C.: Author. Retrieved from: <http://www.thescanfoundation.org/sites/default/files/AllianceLTCPaper.pdf>

Summary: This paper reviews the main issues of long-term care reform and examines the principal reform options available to policymakers. Financing, service delivery, and quality assurance are all discussed.

C Comprehensive List and Description of Long-Term Care Financing Advisory Committee Meeting Materials

Meeting Schedule and Materials

All PowerPoint presentations are available online at www.mass.gov/hhs/communityfirst.

January 30, 2009

Public Forum: “Long-term Care Financing in Massachusetts: Current Challenges, Future Trends & Policy Options”

Objective: Highlight LTSS issues facing Massachusetts and beyond and available policy options for consideration to a broad audience. Feature presentations by

- JudyAnn Bigby, MD, Massachusetts Secretary of Health and Human Services
- Judy Feder, PhD, LTSS policy expert
- Paul Harrington, PhD, economist
- Patricia Jehlen, state senator
- Keith Jones, consumer advocate

Distributed materials:

- I. Long-Term Care in Massachusetts: Facts at a Glance (Original report)
- II. Advancing the Community First Agenda: The EOHHS Long-Term Care Financing Advisory Committee (About the Committee)
- III. Long-Term Care Financing Advisory Committee membership list
- IV. Participant biographies

Advisory Committee Meeting #1

Objective: Introduce members of the Advisory Committee and discuss the work plan and critical questions.

Distributed materials:

- I. Proposed work plan
- II. Principles of the Massachusetts Community First Olmstead Plan
- III. Suggested readings
 - a. *Long-Term Care Financing: Policy Options for the Future*
 - b. *Long-Term Care Financing: Growing Demand and Cost of Services are Straining Federal and State Budgets*
 - c. *The Role of Private Insurance in Financing Long-Term Care*
 - d. *How Can We Improve Long-Term Care Financing*

- e. *Financing Long-Term Care: Lessons from Abroad*
- f. *Improving Health Coverage for Americans with Disabilities: Policy Options for the president-elect and 111th Congress*

March 5, 2009

Advisory Committee Meeting #2

Objective: Provide an overview of the LTSS system, including a high-level view of the current and future population with LTSS needs and current and projected spending by payer type. Provide information about the Advisory Committee's role within the framework of the commonwealth's Olmstead Plan and related Community First activities. Discuss the problem statement, critical questions, goal, and framework for reform.

Distributed materials:

- I. Long-Term Supports in Massachusetts (PowerPoint presentation)
- II. The Massachusetts Community First Olmstead Plan
- III. Suggested Readings
 - a. *Long-Term Care Financing: Policy Options for the Future*
 - b. *Long-Term Care Financing: Models and Issues*

April 17, 2009

Advisory Committee Meeting #3

Objective: Provide in-depth research and data analysis on the populations needing LTSS and implications for Advisory Committee consideration. Information should include current and projected population estimates, utilization, unmet need, and spending by payer.

Distributed materials:

- I. Profile of Massachusetts Populations Needing Long-Term Supports: Implications for Financing Solutions (PowerPoint presentation)
- II. Suggested readings
 - a. *Kennedy says Health Reform Must Include Long-Term Care*
 - b. *Specifics of the Class Act Bill*

May 15, 2009

Advisory Committee Meeting #4

Objective: Provide information on the public sector role in financing LTSS including in-depth look at Medicaid, state agency and other federal funding. Information should include eligibility and coverage rules, limitations and policy innovations including waiver options, care coordination, consumer-direction, and long-term care partnerships.

Distributed materials:

- I. The Role of the Public Sector in Financing Long-Term Supports (PowerPoint presentation)
- II. Long-Term Supports in Massachusetts: A Profile of Service Users (Original Report)
- III. Draft letter in support of LTSS in Health Care Reform to Massachusetts Congressional Delegation

May 22, 2009

CLASS Act presentation and Q&A with Dr. Connie Garner, Policy Director for Disability and Special Populations for Senator Edward M. Kennedy

June 18, 2009

Advisory Committee Meeting #5

Objective: Provide information on the private-sector role in financing LTSS, including in-depth look at current and future capacity for private financing through informal support, financial/insurance products, income, and wealth. Continue to discuss individual, familial, and public responsibility, sustainable distribution of the financing burden, and policy intersections.

Distributed materials:

- I. The Role of the Private Sector in Financing Long-Term Supports (PowerPoint presentation)
- II. Private Financing of Long-Term Services and Supports in Massachusetts by Christine Bishop, Brandeis University (PowerPoint presentation)
- III. Financial/Insurance Products to Fund the Costs of Long-Term Care by Kevin Beagan, Massachusetts Division of Insurance (PowerPoint presentation)
- IV. Final letter in support of LTSS in Health Care Reform to Massachusetts Congressional Delegation
- V. Information recommended or requested by members of the Long-Term Care Financing Advisory Committee

July 23, 2009

Advisory Committee Meeting #6

Objective: Review and synthesize findings from public and private financing presentations. Discuss strategy development and framework for final recommendations, including review of the work of other states in this arena.

Distributed materials:

- I. Policy Synthesis & Strategy Development Framework (PowerPoint presentations)
- II. Public Financing Strategies (Draft)

III. Private Financing Strategies (Draft)

September 10, 2009

Advisory Committee Meeting #7

Objective: Provide additional information on array of financing mechanisms and discuss “straw man” financing proposal.

Distributed materials:

- I. Developing Massachusetts’ Roadmap for LTS Financing Reform (PowerPoint presentation)
- II. Financing Mechanism Fact Sheets (w/check list)
- III. “Straw Man” LTS Financing Proposal

October 15, 2009

Advisory Committee Meeting #8

Objective: Provide overview of informal caregiver support, services available to informal caregivers, and possible policy actions. Discuss two possible models for Massachusetts: LTC Partnership and Contribution Program and their impact on Medicaid.

Distributed materials:

- I. Addressing the Challenge: Public and Private Solutions for Long-Term Services & Supports (PowerPoint presentation)
- II. Handout: Connecticut Case Study 101

November 12, 2009

Advisory Committee Meeting #9

Objective: Discuss refined “straw man” financing proposal including analysis of LTC Partnership, Contribution Program and impact on Medicaid. Review population impact, coverage, and cost and savings analysis. Announce LTSS public awareness campaign.

Distributed materials:

- I. Building a Roadmap for Financing Long-Term Services and Supports: Melding Private Insurance, a Contribution Program and Medicaid into a Cohesive Proposal (PowerPoint presentation)
- II. Partnership vs. Massachusetts Current Quasi-Partnership Comparison
- III. Appendix Tables

December 10, 2009

Advisory Committee Meeting #10

Objective: Discuss related issues that are integral to the availability and accessibility of LTSS but outside the scope of the Advisory Committee’s charge and endorse other initiatives and activities seeking to resolve the issues. Provide analysis of Medicaid expansion costs and cost avoidance from LTC Partnership and Contribution Program. Provide a preliminary roadmap of short- and long-term activities.

Distributed materials:

- I. Building a Roadmap for Financing Long-Term Services & Supports: Melding Private Insurance, a Contribution Program and Medicaid into a Cohesive Proposal—Part II (PowerPoint presentation)
- II. Intersecting Activities and Initiatives Related to Financing of Long-Term Services and Supports

January 13, 2010

Advisory Committee Meeting #11

Objective: Discuss goals and format of public input sessions and legislative briefing. Discuss refined Medicaid eligibility and service expansion proposals. Discuss layering and sequencing of roadmap for financing LTSS.

Distributed materials:

- I. Building a Roadmap for Financing Long-Term Services & Supports: Refined MassHealth Expansions and Layering of our Proposals (PowerPoint presentation)

January and February, 2010

Public Input Sessions—Boston, Northampton, Shrewsbury

Distributed materials:

- I. Long-Term Care Financing Advisory Committee (PowerPoint presentation)
- II. Long-Term Services and Supports Survey
- III. Questions for discussion

February 25, 2010

Advisory Committee Meeting #12

Objective: Discuss themes from public input sessions. Review scenarios of public and private LTSS options, including payer shifts and coverage impacts. Review interaction and sequencing of LTSS financing options. Begin discussion of final report.

Distributed materials:

- I. Building a Roadmap for Financing Long-Term Services & Supports: Layering and Sequencing of our Financing Options (PowerPoint presentation)
- II. Quick Comparison of the Three Future Scenarios (handout)
- III. Detailed Assumptions
- IV. Themes from the Public Input Sessions in Boston, Northampton and Shrewsbury

March 25, 2010

Advisory Committee Meeting #13 (Conference Call)

Objective: Discuss final report draft outline and process outline.

- I. Draft outline of final report
- II. Draft process timeline

April 29, 2010

Advisory Committee Meeting #14

Objective: Discuss comments on introduction and “defining the problem” sections and roadmap strategy. Discuss necessary steps for launching the roadmap.

- I. Finalizing the Roadmap Strategies (PowerPoint presentation)
- II. Sections of the draft final report

June 4, 2010

Advisory Committee Meeting #15

Objective: Discuss visuals for final report. Discuss final sections of the report, including roadmap for reforming LTSS Financing in Massachusetts, integrally related LTSS activities, and additional research and data needs.

- I. Finalizing the Roadmap (PowerPoint presentation)
- II. Sections of the draft final report and appendices

D Detailed Methodology

Introduction

This Appendix details the methodologies and assumptions used to develop the analysis presented in section III of the report, “A Roadmap for Reforming LTSS Financing in Massachusetts.” It first presents the data and trend assumptions that form the basis for the analysis. The following sections detail the methodology for establishing 2010 baseline costs by data source and for trending that baseline forward to 2030. The final section explains the assumptions and methods used in modeling the effects of the various financing strategies identified by the Advisory Committee.

Data sources and initial assumptions

This analysis relied on LTSS expenditure and utilization data from state sources, state-level estimates of demographic data derived from the American Community Survey (ACS), asset data from the U.S. Census Bureau, national averages for LTSS spending, and national projections published by the Congressional Budget Office (CBO).

The methodological challenge was to identify and integrate data from a variety of sources that together encompass all the sources of LTSS coverage for Massachusetts residents (including unmet need and unpaid care). Chart 1 of the Appendix illustrates the baseline cost components and various data sources used to compile baseline LTSS cost projections, while Chart 2 highlights the assumptions to project forward to 2030.

The analysis used the best and most timely public data wherever possible to quantify spending in the current and future environments. As the data analysis is primarily based on historic projection and spending, any new data assumptions should be incorporated into this analysis. What follows in the remainder of the methodology is the detail to the estimation (2010 LTSS cost/spending) and projection (2030 LTSS cost/spending for the baseline and Phases I, II, and III) assumptions and methods.

2010 Baseline Cost/Spending for LTSS in Massachusetts

The analysis used three steps to determine projected 2010 LTSS costs:

Step 1: To determine the cost and spending of LTSS 2008 Medicaid costs from **Chart 1 were projected forward** to 2010 based on the Medicaid trend assumption in **Chart 2** above (see trend formula in Section IV). Based on projected 2010 Medicaid cost of \$3.87 billion, projected total 2010 LTSS spending was based on the assumption in **Chart 1** where Medicaid represents 48.9 percent of LTSS spending. This assumption projects total 2010 LTSS spending to be \$7.93 billion.

Step 2: National percentages of total spending for Medicare, out-of-pocket expenditures, private insurance, and other private coverage (displayed in **Chart 1**) were applied to the projected 2010 total LTSS spending of \$7.93 billion to estimate the spending by each of these sources.

Step 3: The analysis used actual data provided in **Chart 1** for other public/state programs; this raised projected 2010 LTSS spending to \$8.63 billion. Similarly, assumptions in **Chart 1** were applied for unpaid care and unmet need and these were not trended based on the assumptions in **Chart 2**. **Chart 3** illustrates projected 2010 cost and spending.

2030 baseline cost/spending for LTSS in Massachusetts

Baseline 2030 LTSS costs were projected by trending forward the cost components displayed in **Chart 3** using the annual trend assumptions displayed in **Chart 2** and the Trend Formula below. The 2030 projection was adjusted to include the CLASS program, based on the assumption that CLASS will be fully implemented by 2030.

Trend Formula:

$$\text{Projected 2030 LTSS Cost} = \text{Sum of (2010 Cost Component * (1 + Utilization Trend + Cost Component Trend) ^ (Years of Trend))}$$

Projected 2030 LTSS costs are displayed in Chart 4.

CHART 1

Baseline LTSS cost components, assumptions, and data sources

LTSS Cost Component	Data Used	Data Source
MassHealth (Medicaid) ¹	\$3,600,000,000	Spending based on: MassHealth Budget Office (2008 data)
Other public/state programs ²	\$906,000,000	Spending based on: MassHealth Budget Office and Massachusetts EOHHS (2010 data)
Unpaid caregivers	\$8,900,000,000	Annual cost projection for Massachusetts based on: AARP Public Policy Institute; Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update
Unmet need	\$678,000,000	Annual cost projection based on: Massachusetts Department of Public Health; Study of the Unmet Needs of Adults with Disabilities in Massachusetts, 2007 (see assumptions in Appendix Section VI)
Medicaid Medicare Long-term care insurance Other private coverage Out-of-pocket Other public	% of LTSS spending: 48.9% 20.4% 7.3% 2.7% 18.1% Calculated separately based on actual data	Percentage of 2010 LTSS spending based on distribution from: Komisar and Thompson; National Spending for Long-Term Care, Georgetown University Long-Term Care Financing Project, Feb. 2007 (2005 data)
Massachusetts demographic data	Disability Population size and Income Asset data	Disability status based on: 2007 American Community Survey (ACS), U.S. Census Bureau Population status based on: 2008 American Community Survey (ACS), U.S. Census Bureau Asset data based on: 2002 Net Worth and the Assets of Households: 2002, U.S. Census Bureau

1. Includes claims for nursing facility, community services and home and community-based waiver services.

2. Includes discretionary LTSS spending by state agencies (other than MassHealth) in Massachusetts, including the state's Executive Office of Elder Affairs, Department of Developmental Services, Department of Mental Health, Commission for the Blind, Commission for the Deaf and Hard of Hearing, and Department of Public Health.

CHART 2

Trend assumptions and data sources used in LTSS analysis for 2030 projections

LTSS Cost Component	Annual Percentage Increase	Data Source
Annual utilization	1.0%	Assumption based on: Long-Term Care in Massachusetts: Facts at a Glance, available at http://www.mass.gov/Eeohhs2/docs/eohhs/ltc_factsheet.pdf
Medicaid/Medicare/ Other public/State programs	2.8%	Assumption based on: Congressional Budget Office; CBO Memorandum: Projections of Expenditures for Long-Term Care Services for the Elderly, 1999.
Private insurance/Other private	5.0%	Assumption based on: Congressional Budget Office; Financing Long-Term Care for the Elderly, 2004. Based on projected premium increase.
Out-of-pocket	1.0%	Assumption based on: Congressional Budget Office; CBO Memorandum: Projections of Expenditures for Long-Term Care Services for the Elderly, 1999. Source document presents an annual increase of less than 1%, for purposes of this analysis it was adjusted to 1%.
Unpaid caregivers	0.0%	Assumption based on: Congressional Budget Office; Financing Long-Term Care for the Elderly, 2004. No financial growth was assumed in unpaid care due to smaller family sizes and increased burdens on unpaid caregivers.
Unmet need	0.0%	Assumption based on: No growth in the share of unmet need was assumed.

Additional assumptions:

It was assumed that the underlying cost of care changes when a new payer, such as CLASS, pays for care that formerly was paid or provided by one or more other sources. For this model, assumptions were made about the share of spending that was formerly paid or provided by each source, as follows:

- CLASS
 - ◆ CLASS participation will pay 5 percent of 2030 Massachusetts LTSS costs
 - ◆ Spending offsets:
 - 10 percent of CLASS spending replaces Medicaid costs
 - 45 percent of CLASS spending replaces out-of-pocket expenditures
 - 45 percent of CLASS spending replaces unpaid caregiver costs
- State program changes
 - ◆ Comprehensive public and employer education/awareness campaign
 - ◆ Provide training, support, and respite for unpaid caregivers
 - ◆ Implement national consumer protection and insurance standards (NAIC model act and regulations)
 - ◆ Support other private mechanisms for financing LTSS
- Improve/expand various aspects of private coverage and create a LTC Insurance Partnership

2030 projected cost/spending on LTSS in Massachusetts (Phase I, II and III)

2030 projected cost/spending on LTSS in Massachusetts – Phase I

Phase I includes three major changes to the projected baseline 2030 Massachusetts LTSS system:

CHART 3

Projected 2010 LTSS costs and expenditures

Cost Component	Final 2010 projection of LTSS costs	Percentage of 2010 LTSS expenditures	Basis of estimate
Medicaid	\$3,878,000,000	21.3%	Massachusetts data
Medicare	\$1,618,000,000	8.9%	National average amount paid relative to Medicaid
Out-of-pocket expenditures	\$1,435,000,000	7.9%	National average amount paid relative to Medicaid
Private insurance	\$579,000,000	3.2%	National average amount paid relative to Medicaid
Other private	\$214,000,000	1.2%	National average amount paid relative to Medicaid
Other public/State programs	\$906,000,000	5.0%	Massachusetts data
Unpaid caregivers	\$8,900,000,000	48.9%	National data
Unmet need	\$678,000,000	3.7%	Massachusetts data
Total	\$18,208,000,000	100.0%	

- Targeted Medicaid expansions

- ◆ Expand eligibility for elders with self-care needs from 100 percent to 200 percent FPL and increase the asset limit from \$2,000 to \$10,000
- ◆ Provide **limited** HCBS packages to a targeted group of 10,000 non-elderly people with disabilities with self-care needs who currently do not receive services

- ◆ Privately purchased coverage/other private increase to 12.0 percent of total LTSS costs

- ◆ Spending offsets:

- 10 percent of new LTC insurance spending replaces Medicaid spending
- 45 percent of new LTC insurance spending replaces out-of-pocket spending
- 45 percent of new LTC insurance spending replaces unpaid care/unmet need

Projected 2030 LTSS costs after Phase I are displayed in Chart 5.

- State program changes

- ◆ Marketing campaign and support for unpaid caregivers creates \$26 million in new state program LTSS spending
- ◆ Support for unpaid caregivers would reduce Medicaid costs by 3 percent
- ◆ Spending offset:
 - 100 percent of increased unpaid care replaces Medicaid spending

- Elder Medicaid coverage expansion

- ◆ Approximately 10,000 elders with self-care needs in Massachusetts would be newly eligible for coverage
- ◆ Projected 2010 per member per year (PMPY) cost of \$13,000 trended forward to 2030 using the trend formula from section IV and the annual cost component increase from Chart 2
- ◆ Spending offset:
 - 100 percent of new Medicaid spending replaces unpaid care/unmet need cost

- LTC Partnership and improvements to insurance

CHART 4

Projected 2030 LTSS costs and expenditures (without CLASS and with CLASS)

Cost Component	Initial 2030 projection of LTSS Costs/Spending	2030 projection of LTSS costs (w/ CLASS)
Medicaid	\$8,176,000,000	\$8,037,000,000
Medicare	\$3,411,000,000	\$3,411,000,000
Out-of-pocket expenditures	\$2,132,000,000	\$1,507,000,000
Private insurance	\$1,857,000,000	\$1,857,000,000
Other private (membership programs)	\$686,000,000	\$686,000,000
Other public (state programs)	\$1,910,000,000	\$1,910,000,000
Unpaid caregivers	\$8,900,000,000	\$8,276,000,000
Unmet need	\$678,000,000	\$678,000,000
CLASS	\$0	\$1,388,000,000
Total	\$27,750,000,000	\$27,750,000,000

- Non-elder Medicaid service expansion
 - ◆ 10,000 non-elderly people with disabilities with self-care needs in Massachusetts would be newly eligible for coverage
 - ◆ Project 2010 PMPY cost of \$15,000 trended forward to 2030 using the trend formula from section IV and the annual cost component increase from Chart 2
 - ◆ Spending offset
 - 100 percent of increase in Medicaid spending replaces unpaid care/unmet need
- State program changes
 - ◆ Comprehensive public and employer education/awareness campaign
 - ◆ Provide training, support, and respite for unpaid caregivers
 - ◆ Implement national consumer protection and insurance standards (NAIC model act and regulations)
 - ◆ Support other private mechanisms for financing LTSS
- Improve/expand various aspects of private coverage and create a LTC Insurance Partnership
- Targeted Medicaid expansions
 - ◆ Expand eligibility for elders with self-care needs from 100 percent to 200 percent FPL and increase the asset limit from \$2,000 to \$10,000
 - ◆ Provide comprehensive HCBS packages to a targeted group of 10,000 non-elderly people with disabilities with self-care needs who currently do not receive services
 - ◆ Develop opportunities to enable elders to access coordinated LTSS

Additional data sources:

- Projected 2010 PMPY for elders and non-elders expansions provided by MassHealth Budget Office
- 2030 projection of eligible elders based provided by MassHealth Budget Office and assumptions from **Chart 2**

2030 Projected Cost/Spending on LTSS in Massachusetts – Phase II

This Phase II includes three major changes to the projected baseline 2030 Massachusetts LTSS system:

CHART 5

Projected 2030 LTSS costs and expenditures – Phase I

Cost Component	Baseline 2030 Projection of LTSS Costs/Spending	Projected 2030 LTSS Costs/Spending—Phase I
Medicaid	\$8,037,000,000	\$8,203,000,000
Medicare	\$3,411,000,000	\$3,411,000,000
Out-of-pocket expenditures	\$1,507,000,000	\$1,151,000,000
Privately purchased coverage/Other private	\$2,543,000,000	\$3,333,000,000
Other public programs/State programs	\$1,910,000,000	\$1,936,000,000
Unpaid care/Unmet need	\$8,954,000,000	\$8,354,000,000
CLASS	\$1,388,000,000	\$1,388,000,000
Total	\$27,750,000,000	\$27,776,000,000

Projected 2030 LTSS costs after Phase II are displayed in Chart 6.

■ State program changes

- ◆ Marketing campaign and support for unpaid caregivers costs \$26 million in new LTSS spending
- ◆ Support for unpaid caregivers would reduce Medicaid costs by 3 percent
- ◆ Spending offset:
 - 100 percent of increased unpaid care replaces Medicaid spending

■ LTC Partnership and improvements to insurance

- ◆ Privately purchased coverage/Other private increase to 12 percent of total LTSS costs
- ◆ Spending offsets:
 - 10 percent of new LTC insurance spending replaces Medicaid spending
 - 45 percent of new LTC insurance spending replaces out-of-pocket spending
 - 45 percent of new LTC insurance spending replaces unpaid care/unmet need cost

■ Elder Medicaid coverage expansion

- ◆ Approximately 10,000 elders with self-care needs in Massachusetts would be newly eligible for coverage
- ◆ Projected 2010 Per Member Per Year (PMPY) cost of \$13,000

trended forward to 2030 using trend formula and annual cost component increase in Chart 2

◆ Spending offset:

- 100 percent of new Medicaid spending replaces unpaid care/unmet need cost

■ Non-Elder Medicaid service expansion

- ◆ 10,000 non-elderly people with disabilities with self-care needs in Massachusetts would be newly eligible for coverage
- ◆ Project 2010 PMPY cost of \$27,000 trended forward to 2030 using Trend Formula and Annual Cost Component increase in Chart 2

◆ Spending offset

- 100 percent of increased in Medicaid spending replaces unpaid care/unmet need cost

■ Geriatric Case Management

- ◆ Approximately 10,000 elders up to 300 percent and assets up to \$50,000 (over 200 percent FPL) in Massachusetts would utilize the program and reduce unpaid caregivers/unmet need
- ◆ 2006 PMPM costs for Case Management is \$210; rates were trended forward at the same rate as Medicaid increases

- ◆ Spending offsets:
 - 80 percent of reduced unpaid care/unmet need increases Medicaid spending
 - 20 percent of reduced unpaid care/unmet increases out-of-pocket spending

Additional data sources:

- Projected 2010 PMPY for elders and non-elders expansions provided by MassHealth Budget Office
- 2030 Projection of eligible elders for expansions and buy-ins based 2008 ACS and 2002 U.S. Census Bureau asset data

2030 Projected Cost/Spending on LTSS in Massachusetts – Phase III

Phase III includes three major changes to the projected baseline 2030 Massachusetts LTSS system:

- Implement state-sponsored individual contribution program to provide a CLASS-like benefit to all Massachusetts residents
- Improve/expand various aspects of private coverage and create a LTC Insurance Partnership as a supplement to the State Contribution Program
- Medicaid program provides a supplement to State Contribution Program for low-income Massachusetts residents with very high LTSS costs

Projected 2030 LTSS costs after Phase III are displayed in Chart 7.

Phase III assumptions:

- Detailed 2030 Medicaid Cost Projection
 - ◆ Distribution of current 2010 Medicaid costs (\$3.6 billion):
 - Facility-based care: 61 percent
 - Community services: 12 percent
 - Waiver services: 27 percent
- Distribution of projected Medicaid enrollment (368,000 people)
 - ◆ By age:
 - Elders: 37 percent
 - Non-elders: 63 percent
 - ◆ By service type:
 - Facility-based care: 10 percent
 - Community services: 85 percent
 - Waiver services: 5 percent
- Annual cost increase – **See Chart 1**
- Aggregate annual member utilization increase:
 - ◆ Facility-based care: -0.04 percent
 - ◆ Community services: 4.47 percent
 - ◆ Waiver services: 1.00 percent
- State-sponsored individual contribution program assumptions
- Massachusetts residents over 25 years of age pay a percent of income toward LTSS coverage program:

CHART 6
Projected 2030 LTSS costs and expenditures – Phase II

Cost Component	2030 projection of LTSS costs	Projected 2030 LTSS Cost/Spending—Phase II
Medicaid	\$7,796,000,000	\$8,452,000,000
Medicare	\$3,411,000,000	\$3,411,000,000
Out-of-pocket expenditures	\$1,507,000,000	\$1,161,000,000
Privately purchased coverage	\$2,543,000,000	\$3,333,000,000
State of Massachusetts	\$1,936,000,000	\$1,936,000,000
Unpaid care/Unmet need	\$9,195,000,000	\$8,095,000,000
CLASS	\$1,388,000,000	\$1,388,000,000
Total	\$27,776,000,000	\$27,776,000,000

- › Below 200 percent FPL: 0.5 percent
- › 200 percent to 299 percent: 1.0 percent
- › 300 percent FPL and above: 2.0 percent
- ◆ 2008 Massachusetts population over age 25 increases at 0.5 percent annually
- ◆ 2008 Massachusetts resident income increases at 4 percent annually
- ◆ Monthly premium or premium equivalent would be approximately \$200 per month per covered resident
- ◆ The State Contribution program would cost approximately \$11.5 billion in 2030
 - › The Commonwealth of Massachusetts would provide \$1.1 billion in subsidies to low-income residents
 - The federal Medicaid program would provide 50 percent of subsidy dollars
- ◆ Spending offsets:
 - › 35 percent of State Contribution Program spending replaces spending on existing Medicaid members
 - › 45 percent of State Contribution Program spending replaces unpaid care/unmet need from increased utilization by existing Medicaid members and care utilized by Massachusetts residents who would only incur unpaid care costs
 - › 19 percent of State Contribution program spending replaces Private LTC insurance spending
 - › 1 percent of State Contribution program spending replaces state spending
- Private LTC insurance as a supplement to the State Contribution program
 - ◆ Supplemental coverage pays 5 percent of LTSS costs
 - ◆ Spending offsets:
 - › 80 percent of increased new LTC insurance spending replaces out-of-pocket spending
 - › 20 percent of increased new LTC insurance spending replaces unpaid caregiver/unmet need cost

CHART 7 Projected 2030 LTSS costs and expenditures – Phase III

Cost Component	Baseline 2030 projection of LTSS Costs/Spending (without CLASS)*	Projected 2030 LTSS Costs/Spending—Phase III
Medicaid	\$8,176,000,000	\$5,007,000,000
State	\$4,088,000,000	\$2,230,000,000
Federal	\$4,088,000,000	\$2,777,000,000
Medicare	\$3,411,000,000	\$3,411,000,000
Out-of-pocket expenditures	\$2,132,000,000	\$383,000,000
Privately purchased coverage	\$2,543,000,000	\$1,748,000,000
State of Massachusetts	\$1,910,000,000	\$2,458,000,000
Unpaid care/Unmet need	\$9,578,000,000	\$3,633,000,000
CLASS	\$0	\$694,000,000
State-Sponsored Individual Contribution Program	\$0	\$10,416,000,000
Total	\$27,750,000,000	\$27,750,000,000

* CLASS is excluded due to the potential interaction with the Mandatory State-Sponsored Individual Contribution program that provides a similar benefit

- CLASS for Massachusetts residents who are not vested in State Contribution program
 - ◆ CLASS pays 2.5 percent of LTSS costs
 - ◆ Spending offsets:
 - 80 percent of CLASS spending replaces out-of-pocket spending
 - 20 percent of CLASS spending replaces unpaid caregiver/unmet need cost
- Targeted Medicaid supplemental coverage expansion
 - ◆ Provide supplemental coverage for Massachusetts residents up to 300 percent FPL with self-care needs at a cost of approximately \$500 million
 - ◆ Spending offsets:
 - 20 percent of new Medicaid spending replaces out-of-pocket spending
 - 80 percent of new Medicaid spending replaces unpaid caregiver/unmet need cost
- Percentage of people who have additional monthly need of care who currently receive some LTSS: 14.4 percent
 - ◆ Percentage of people with disabilities who have additional monthly need of care who currently receive some LTSS by amount of need:
 - 1-2 hours per week: 7.4 percent
 - 3-5 hours per week: 28.7 percent
 - 6-10 hours per week: 27.4 percent
 - More than 10 per week: 36.4 percent
- Average monthly need of care for individuals who receive no LTSS:
 - ◆ A few times a month: 3 hours
 - ◆ 1-2 hours per week: 6 hours
 - ◆ 3-5 hours per week: 16 hours
 - ◆ More than 5 hours per week: 32 hours
- Average additional monthly need of care for individuals who receive some LTSS:
 - ◆ 1-2 hours per week: 6 hours
 - ◆ 3-5 hours per week: 16 hours
 - ◆ 6-10 hours per week: 32 hours
 - ◆ More than 10 per week: 50 hours

Additional data sources:

- **Disability status based on:** Data provided by MassHealth Budget Office
- **Population and income data based on:** 2030 projection of eligible elders for expansions based 2008 ACS
- **Mandatory Contribution program premiums:** Based on analysis conducted by EBD Consulting

Additional data source:

- The Massachusetts Department of Public Health; *Study of the Unmet Needs of Adults with Disabilities in Massachusetts*. (2007).

Additional information

Unmet need projection development

Unmet need assumptions:

- Estimated unmet need by applying the rate per hour to the estimated number of hours of unmet need
- Children and elders have the same level of unmet need as adults age 18-59 (the study only included adults age 18-59)
- One hour of care costs: \$18
- Percentage of people with disabilities who receive no LTSS: 4.2 percent
 - ◆ Percentage of people with disabilities who receive no LTSS by amount of need:
 - A few times a month: 40.2 percent
 - 1-2 hours per week: 22.2 percent
 - 3-5 hours per week: 30.8 percent
 - More than 5 hours per week: 6.8 percent

E Federal Funding Opportunities

The federal Patient Protection and Affordable Care Act (ACA) includes a number of funding opportunities related to long-term care, including the following. State policy makers should consider which funding opportunities would be most beneficial for Massachusetts.

Medicaid Money Follows the Person (MFP) Long-Term Care Demonstration (Sec. 2403)

- Extends the MFP rebalancing program through September 2016.
- Allocates \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives (FYs 2010-2014).

Planning Grants to Provide Health Homes for Chronically Ill Patients (Sec. 2703)

- Secretary awards grants to states to develop state plan amendments to provide health homes for patients with two chronic illnesses, one chronic illness and risk factors for another, or a serious and persistent mental health condition.
- States will include in the state plan amendment methodologies for tracking hospital readmissions or calculating savings from improved care coordination, and a proposal for using health IT in providing health care home services.
- The state shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects the provider or team.
- The Secretary pays each eligible state an amount each quarter equal to the federal medical assistance percentage of expenditures in the quarter. During the first eight fiscal year quarters that the state plan amendment is in effect, the federal medical assistance percentage applicable to such payments shall be equal to 90 percent.
- Funding: \$25 million or less per state.
- Secretary must report to Congress before Jan. 1, 2017. Demonstrations will begin Jan. 1, 2012, and end on Dec. 31, 2016.

Independence at Home Medicare Demonstration (Sec. 3024)

- Create demonstration program to provide high-need Medicare beneficiaries with primary care service in their home, delivered by physician- or nurse practitioner-directed primary care teams.
- Allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes and efficiency of care, reduce the cost of health services, and achieve patient satisfaction.

- Funding: \$5 million per year for FYs 2010-2015. Effective Jan. 1, 2012.

Community-based Care Transitions Program (sec. 3026)

- Funding will be provided to hospitals with high admission rates and certain community-based organizations that improve care transition services for “high-risk Medicare beneficiaries” defined in federal statutory provisions.
- Program will be conducted for five years beginning on Jan. 1, 2011.
- Funding: \$500 million for FYs 2011-2015.

Making the Senior Housing Facility Demonstration Permanent (Sec. 3208).

- Service area of a Medicare Advantage Senior housing facility plan can be limited to a specific geographic area.
- Medicare Advantage Senior housing facility plans offer primary care services onsite and have a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate; provide transportation services for beneficiaries to specialty providers outside of the facility; and have participated (as of Dec. 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than one year.

Community Transformation Grants (Sec. 4201)

- A state agency, local government agency, national network of community-based organizations, a state or local non-profit organization, or an Indian tribe can apply for money for implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.
- Funding: appropriations for FYs 2010-2014.

Training Opportunities for Direct Care Workers (Sec. 5302)

- Award grants to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes, assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home- and community-based settings.
- Grants will be awarded to universities that have established public-private educational partnerships with the institutions mentioned above.
- Use grants to offset fees and tuition for individuals in this workforce.
- Funding: \$10 million for FYs 2011-2013.

Geriatric Workforce Development (Sec. 5305)

- Secretary will award grants or contracts to entities that operate geriatric education centers. These centers will provide short-term courses that focus on geriatrics, chronic care management, and long-term care and provide supplemental training for faculty members in medical schools and other health professions schools. These courses will count toward continuing medical education credits. Also offer at least two courses per year for family caregivers.
 - ◆ Funding: Awards are \$150,000 per center and no more than 24 awards may be given; \$10.8 million for FYs 2011-2014.
- Geriatric Career Incentive awards for individuals who will teach or practice in the field of geriatric medicine for at least five years.
 - ◆ Funding: \$10 million for FYs 2011-2013.
- Expansion of eligibility for geriatric academic career awards; payments go to medical schools.

Grants for cultural competency, prevention, public health, and work with individuals with disabilities (Sec. 5307)

- Award grants for development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.
- Funding: Necessary appropriations authorized for FYs 2010-2015.

Revisions to Payment Bundling Pilot (Sec. 10308)

- Applies pilot to continuing care hospitals for full episodes of care, which is defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from the hospital.
- Continuing care hospitals are those that demonstrate the ability to meet patient care and patient safety standards and provide under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units, long term care hospitals, and skilled nursing facilities.

Grants to support the Long Term Care Ombudsman Program and adult protective services (Sec. 6703)

- “Sec. 2046”: Rule of Construction, grants to survey skilled nursing facilities.
 - ◆ Grants to state agencies that perform surveys of skilled nursing facilities. Design and implement complaint investigation systems that optimize collaboration between providers, consumers, and authorities and respond promptly and effectively to complaints.

- ▶ Funding: \$5 million each year for FY 2011-2014.

- “Sec. 2042”: Adult Protective Services

- ◆ The HHS Secretary will provide funding and technical assistance to state and local adult protective services agencies; collect and disseminate data annually about abuse and exploitation of elders; develop information about best practices and provide training opportunities.
 - ▶ Funding: \$3 million for FY 2011 and \$4 million for each FY 2012-2014.
- ◆ Establish an adult protective services grant program to award annual grants to states and local governments.
 - ▶ Funding: \$100 million for FYs 2011-2014; each state can get an amount equal to the percentage of total elders in the state multiplied by 0.75 of the amount appropriated that year.
- ◆ Fund states to create demonstration projects to test: training modules that detect or prevent elder abuse and financial exploitation of elders; methods to detect abuse; evaluation of whether these trainings work. Each grantee will submit a report to the HHS secretary.
 - ▶ Funding: \$25 million for FYs 2011-2014.

- “Sec. 2043”: Long-term care ombudsman

- ◆ Make grants available for long-term care facilities and other long-term care entities as determined by the Secretary to improve the capacity of state long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect. Also, conduct pilot programs with state long-term care ombudsman offices or local ombudsman entities and provide support to these programs.
 - ▶ Funding: \$5 million for FY 2011, \$7.5 million for FY 2012, \$10 million for FYs 2013 and 2014.
 - ▶ Funding for ombudsman training programs: \$10 million for each FY 2011-2014.

- “Sec. 2044”: Provision of information regarding and evaluations of elder justice programs.

- “Sec. 2031”: Forensic centers for detecting elder abuse, neglect, and exploitation.

- ◆ The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation. Four grants for institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers. Six grants for mobile forensic centers.
 - ▶ Funding: \$4 million for FY 2011, \$6 million for FY 2012, \$8 million for each FY 2013 and 2014.

- “Sec. 2041”: Enhancement of Long-Term Care.
 - ◆ Certified EHR Technology Grant Program. Provide grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.
 - Funding: \$20 million for FY 2011, \$17.5 million for 2012, \$15 million for each FY 2013 and 2014.
 - ◆ Long-term care staffing. Provide grants and incentives to enhance training, recruitment, and retention of long-term care staff. Provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care. Provide financial incentives for achieving certification to LTC aides.
 - Funding: \$20 million for FY 2011, \$17.5 million for 2012, \$15 million for each FY 2013 and 2014.

- Funding: No more than \$1 billion for the two year period beginning with 2009.

Medicare demonstration based on the study of home health agencies (Sec. 10315)

- Conduct demonstration to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries.
- Waive budget neutrality for this demonstration.
- Conduct demonstration for four years beginning no later than Jan. 1, 2015. If the demonstration goes forward, the Secretary will evaluate the program and report to Congress.
- Funding: \$500 million from Medicare Trust Funds for FYs 2015-2018, funding is available for the study and the demonstration.

Nationwide program for national and state background checks on direct patient access employees of long-term care facilities and providers (Sec. 6201)

- Establish a program to identify efficient, effective, and economical procedures for long-term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis.
- Funding: Payment to each new participating state will be three times what the state has made available for the program, up to \$3 million; previously participating states have a cap of \$1.5 million. Total: No more than \$160 million for FYs 2010-2012. Up to \$3 million can be reserved for evaluation.
- The inspector General of HHS will conduct an evaluation of the programs and submit a report to Congress.

Qualifying therapeutic discovery project credit (Sec. 9023)

- Provide grants and tax credits to businesses with fewer than 250 employees that undertake a qualifying therapeutic discovery project to
 - 1) treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product by the FDA;
 - 2) diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions; or
 - 3) develop a product, process, or technology to further the delivery or administration of therapeutics.
- Priority goes to projects that develop new therapies that address long-term care needs and chronic illness, especially working to cure cancer.

