

Medicaid Report: New Hampshire and Vermont

Long-Term Care for the Elderly

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EXECUTIVE SUMMARY

The demand for long-term care in the United States is rapidly rising due to the high growth rate of the elderly population. Along with other states, New Hampshire and Vermont must develop financially viable strategies to ensure adequate and efficient programs for long-term care. Medicaid is the largest public source of funding long-term care but it is administered differently from state to state. This paper focuses on the contrast between New Hampshire and Vermont Medicaid programs for long-term care. It explains how New Hampshire may reduce its disproportionately high average Medicaid long-term care costs by adopting elements of the Vermont model and reducing its reliance on institutional care. It also explores other potential initiatives such as social insurance and the promotion of preventative care programs.

1. LONG-TERM CARE AND THE RISE OF THE ELDERLY POPULATION

Long-term care refers to the supportive services needed by individuals with a chronic condition, trauma, or illness that limits their ability to live independently. These persons require assistance in carrying out basic activities of daily living (ADLs) such as bathing, dressing, or eating, or instrumental activities of daily living (IADLs) such as laundry, housework, meal preparation, or money management.¹ Half of the individuals 85 years and older are disabled and need assistance with one or more ADLs. Furthermore, long-term care ranks as a top priority for the senior population because about 6 million of the 12 million Americans needing long-term care are over 65.

The significant growth rate of the elderly population in the United States suggests that the demand for long-term care will more than double in the next thirty years.² In 2001, there were 35 million Americans who were over the age of 65, and 4 million over the age of 85.³ By the year 2030, it is estimated that the senior population will reach 70 million, with the number of residents 85 and older reaching 9 million.⁴ State governments across the country (including New Hampshire and Vermont) face the significant challenge of addressing this imminent expansion of the long-term care needs of the elderly population. States need to develop solutions to financing long-term care, assuring the quality and efficiency of care, and balancing the use of institutional and non-institutional (home- and community-based) care.⁵

2. MEDICAID AND LONG-TERM CARE

The largest public source for funding long-term care is Medicaid, which pays for 39 percent of U.S. total long-term care expenditures.⁶ In 2004, the federal and state governments spent a total of \$100.5 billion on long-term care Medicaid expenditures, roughly one-third of all Medicaid spending.⁷

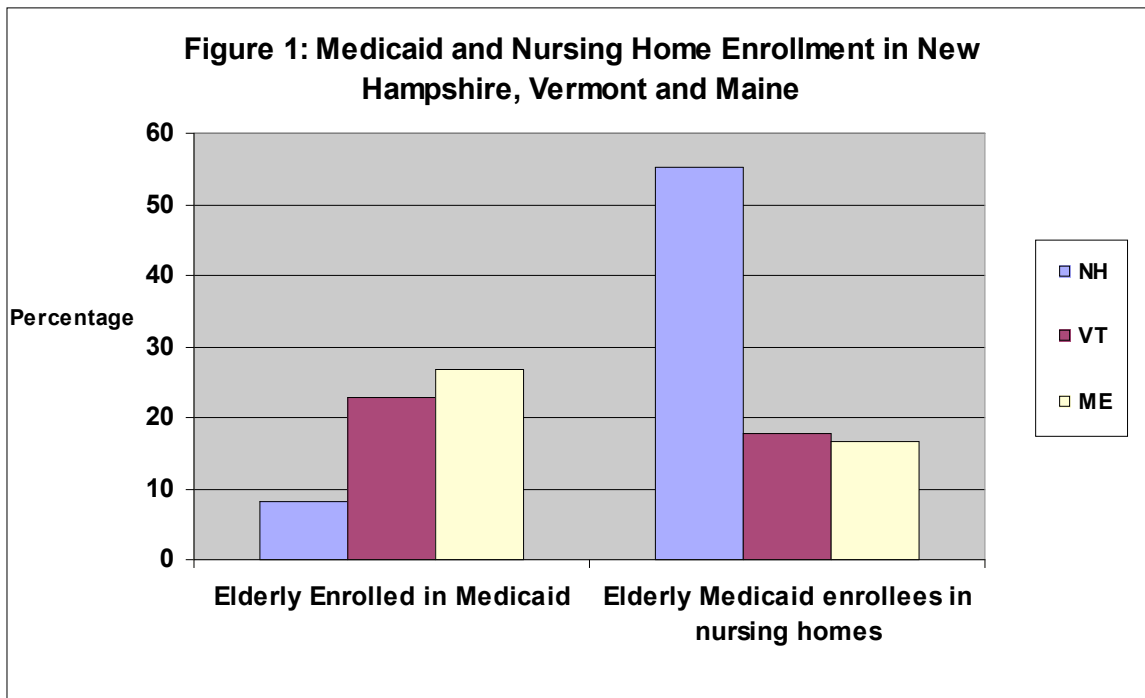
However, since each state has the prerogative to design its own long-term care program, there are variations in Medicaid long-term care spending, eligibility, and accessibility

across the nation.⁸ State policy makers typically influence the coverage of their long-term care programs in three ways: first, states can establish their eligibility levels; second, states can limit enrollment even among eligible individuals by creating a cap on enrollees or by targeting their programs at specific population groups; third, states can control access by regulating the supply of nursing home beds and the rates paid to nursing homes per beneficiary.⁹

3. NEW HAMPSHIRE AND LONG-TERM CARE

New Hampshire faces higher average Medicaid costs for the care of its elderly population and enrolls a smaller proportion of them compared to the rest of the country. New Hampshire spends \$17,769 per enrollee, in contrast to the national average of \$10,026 per enrollee.¹⁰ The high average spending is as a result of the demographics of the individuals covered by New Hampshire’s program. A significant proportion of senior enrollees are “higher-need” participants who need costly services and long-term care.

In 2001, only 8 percent of New Hampshire’s elderly population was enrolled in Medicaid and 55.1 percent of them lived in nursing homes (See Figure 1). This distribution sharply contrasts with those in Vermont and Maine which have much higher senior Medicaid enrollment rates of 22.9 percent and 26.6 percent but significantly lower proportions of nursing home residents (17.8 percent and 16.6 percent respectively). The more-concentrated medical need of the smaller group of elderly individuals covered in New Hampshire accounts for the high average spending.¹¹



Source: 2005 Rockefeller Center Medicaid Report

4. VERMONT AND LONG-TERM CARE

As illustrated in Figure 1, Vermont's Medicaid program serves a much greater percentage of the elderly population and relies less on institutional care than New Hampshire. Vermont's highly developed home- and community-based health care system ensures that 85 percent of the Medicaid population over age 65 still lives at home. In New Hampshire, only half of them can live at home. As a result, Vermont spends less than half as much per elderly person on Medicaid as New Hampshire.¹²

In June 2005, Vermont became the first state in the country to give beneficiaries equal access to nursing homes and home-based care. Vermont's Long-Term Care Plan is an innovative approach that allows Medicaid seniors to choose their preferred environment for long-term care. It uses a tier-system to evaluate each person's needs. High-needs individuals will be entitled to choose between home-based or institutional care. Second tier persons also receive a choice but will receive services based on greatest need and budget constraints.

The new plan for Vermont is part of a national effort to reverse the bias towards institutional long-term care present in Medicaid. It is based on the belief that if presented with a choice, more Medicaid enrollees will prefer to remain in their communities than move to a nursing home. Home- and community-based service (HCBS) waivers are currently available to (and are being used by) states to provide alternatives to institutional care by allowing beneficiaries to live at home and receive care there provided the home-based care received is not more expensive than living in a nursing home. Living at home allows seniors to remain in familiar surroundings where they can enjoy family and neighbors. It is also potentially more cost-effective. In Vermont, the average annual cost of a Medicaid beneficiary in a nursing home is \$54,000; whereas the cost of home-based care is estimated at \$28,000.¹³

The expected savings from increased home-based care could however be eroded by the "woodwork effect." Policy makers fear that those persons who previously relied on family and friends to care for them out of free will "come out of the woodwork" and enroll in the home-based care program. This increased program participation will lead to an increase in costs.¹⁴

The second important caveat to the Vermont plan is to ensure the quality of care received by Medicaid recipients enrolled in home- and community-based care. Opponents of the program from the nursing home industry warn that enrollees may not receive the appropriate level of care since community-care programs are not as regulated as nursing homes.¹⁵ To address this problem, Vermont has implemented the "State and Local Long - Term Care Ombudsman Program" to ensure the high quality of care in Vermont's home-based services.¹⁶

5. POLICY OPTIONS

Depending on the demonstrated overall effectiveness of Vermont's new program, New Hampshire may consider Vermont's model as a policy alternative. By decreasing reliance on institutionalized care in favor of home- and community-based services, New Hampshire may be able to decrease its average costs of long-term care.

Other policy options that both New Hampshire and Vermont could consider to ensure the long-term viability of long-term care provision are to develop social insurance and to focus on providing preventative care to seniors, possibly through long-term care organizations such as On Lok and PACE.

- **Social Insurance**
Establishing social insurance for long-term care is one of the alternatives that have been suggested to provide for the growing needs of the elderly. Private insurance for long-term care is prohibitively expensive for most elderly persons. They are often charged higher premiums because they are considered "high risk" and only 10 - 20 percent of them are able to purchase experience-rated private insurance.¹⁷ In 1990, the Pepper Commission, a bipartisan federal commission on Comprehensive Health Care, recommended that a social insurance program finance long-term care. With a compulsory social insurance program, the financial risk of illness requiring long-term care is spread among the entire population and not concentrated within the elderly population.¹⁸ This program has been criticized because of the negative political and economic consequences of increasing social security contributions and other taxes.
- **Preventative Care**
Given the high costs of hospitalization and institutional care, programs to maintain the health of elderly residents and minimize hospital visits may be effective in controlling costs. Early intervention mechanisms and intensive primary care can be pursued to achieve this goal. On Lok and PACE, two long-term care organizations employing this strategy, could serve as models for New Hampshire and Vermont.

The On Lok Program began in San Francisco as a merger of a variety of long-term care services into one program. Some of the services include daily adult services, in home care, home-delivered meals, housing assistance, comprehensive medical care, respite care for caregivers, hospital care, and skilled nurse care.¹⁹ On Lok receives payments from Medicare and Medicaid through a pooled per capita expenditure formula (capitation) to cover all of its services. Through the use of early intervention mechanisms, few enrollees are hospitalized or need nursing home care; consequently, On Lok is able to use the funds that were saved for intensive primary care and supportive services.²⁰ The results are considerable: "whereas 43 percent of U.S. health care expenditures cover hospital services and

nursing home care, On Lok spends a mere 17 percent on these items, making 83 percent of the capitation dollar available for home- and community-based care.”²¹

PACE (Program of All-Inclusive Care for the Elderly) is modeled after On Lok and began in 1986 as a result of funds granted for sites for community-based care by the Robert Wood Foundation and the Health Care Financing Administration. Twenty-four PACE sites are now operating across the nation. The programs are run by various non-profit organizations and currently serve about 6,000 elderly people, carrying full risk for the health care costs of their participants and are funded with pooled capitation dollars from Medicare and Medicaid.”²² Like their model, On Lok, the PACE programs were created in order to save money on hospital and nursing home services. PACE keeps its enrollees out of hospitals by providing intensive primary care.

An expansion of these programs in Vermont and New Hampshire could be a viable solution for the states’ needs for improvement in long-term care for the elderly.

6. CONCLUSION

Strategic planning for long-term care solutions will be important in the upcoming years. Vermont has already enacted a plan to decrease the state’s reliance on institutional care and move to a method of long-term care that is centered on home and community-based services. If Vermont’s new program is determined to be successful, New Hampshire might find Vermont’s strategy suitable for its own Medicaid and state budgeting plan. In addition, social insurance and promoting programs of long-term care organizations that reduce hospital and nursing home visits are other possible solutions that New Hampshire and Vermont may implement in order to alleviate the burden of increased Medicaid spending in the future.

Disclaimer: All material presented in this report represents the work of the individuals in the Policy Research Shop and does not represent the official views or policies of Dartmouth College.

7. REFERENCES

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- ¹ *Fact Sheet: Selected Long-Term Care Statistics*. 2005. Family Caregiver Alliance. 8 Oct. 2005. <
http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440 >. Page 1.
- ² Feder, Judith, and Harriet L. Komisar. "Long-term care in the United States: An overview." *Health Affairs*. 19 (2000): 40-57. Page 2.
- ³ Bodenheimer, Thomas S., and Kevin Grumbach. *Understanding Health Policy: A Clinical Approach*. New York: McGraw-Hill, 2002. Page 104.
- ⁴ *Ibid.* Page 104.
- ⁵ *Ibid.* Page 2.
- ⁶ *Ibid.* Page 105.
- ⁷ McClellan, Mark B. "Long- Term Care and Medicaid." *Capitol Hill Hearing Testimony*, Committee on House Energy and Commerce and Subcommittee on Health, 27 April 2005. Page 1.
- ⁸ Feder, Judith, and Harriet L. Komisar. "Long-term care in the United States: An overview." *Health Affairs*. 19 (2000): 40-57. Page 3.
- ⁹ *Ibid.*, Page 4.
- ¹⁰ Hall, Douglas. "Data Quality: Medicaid Long-Term Spending in NH" New Hampshire Center for Public Policy Studies, Page 9. September 2004.
- ¹¹ *Ibid.*, Page 9.
- ¹² McClellan, Mark B. "Long-Term Care and Medicaid." *Capitol Hill Hearing Testimony*, Committee on House Energy and Commerce and Subcommittee on Health, 27 April 2005. Page 6.
- ¹³ Sharoky, Catherine. "Home care featured in new Medicaid plan." *UPI*. [Washington] 17 Jun. 2005.
- ¹⁴ Beck, Ellen and Stokely Baksh. "Health Biz: Long-term care in the long run." *UPI*. [Washington] 23 Jun. 2005. Page 2.
- ¹⁵ Mantone, Joseph. "Vermont tests something new; Cost-effectiveness of community-based care studied." *Modern Healthcare*. 20 Jun. 2005. Page 1.
- ¹⁶ "HHS Announces New Medicaid Program to Deliver Care at Home." *PR Newswire US*. [Washington] 13 Jun. 2005.
- ¹⁷ Bodenheimer, Thomas S., and Kevin Grumbach. *Understanding Health Policy: A Clinical Approach*. New York: McGraw-Hill, 2002. Page 107.
- ¹⁸ *Ibid.* Page 110.
- ¹⁹ *Ibid.* Page 111.
- ²⁰ Bodenheimer, Thomas. "Long-Term Care for Frail Elderly People: The On Lok Model." *The New England Journal of Medicine*. 341 (1999): 1324-1328.
- ²¹ *Ibid.*
- ²² Bodenheimer, Thomas S., and Kevin Grumbach. *Understanding Health Policy: A Clinical Approach*. New York: McGraw-Hill, 2002. Page 111.