

THE LONG AND WINDING ROAD TO REFORM OF  
LONGTERM SERVICES AND SUPPORTS

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RTI INTERNATIONAL.

WASHINGTON, DC.

NOVEMBER 4, 2009.

Lewis: THIS IS LEWIS KRAUS. THE WEBINAR IS AUDIO WITH SLIDES. YOU CAN SELECT CC IF YOU WOULD LIKE TO HAVE CAPTIONS.

IF YOU PREFER TO LISTEN BY PHONE, YOU DO NOT HAVE TO LISTEN BY PHONE, YOU CAN LISTEN THROUGH YOUR COMPUTER, BUT IF YOU PREFER TO LISTEN BY PHONE, YOU CAN USE THE TELEPHONE HANDSET BUTTON IN THE AUDIO WINDOW AND YOU WILL BE CONNECTED TO TELECONFERENCE OR THE DIAL IN NUMBER AND THE PASS CODE NUMBER WILL BE GIVEN AND YOU CAN DIAL IN ON YOUR PHONE IF YOU PREFER. YOU DON'T HAVE TO BE ON THE TELEPHONE. IT MAY BE MORE CONVENIENT FOR YOU TO BE ON YOUR COMPUTER AND HAVE YOUR AUDIO COMING IN. IN EITHER SITUATION, WE WOULD LIKE YOU TO MUTE YOUR AUDIO BECAUSE THIS WILL BASICALLY BE AUDIO ONLY. IF EVERYBODY STARTS TO TALK AT ONCE YOU CAN IMAGINE THE CACOPHONY.

IF YOU ARE USING YOUR COMPUTER AUDIO, AND THAT'S INDICATED IN THE AUDIO WINDOW BY THE MICROPHONE, THE PICTURE OF THE MICROPHONE, EITHER HAVE THAT UNCHECKED, IN OTHER WORDS, MAKE SURE THAT MICROPHONE IS GRAY, NOT YELLOW. IF IT'S GRAY RIGHT NOW, NOBODY'S

GOT THE MICROPHONE ON, SO YOU'RE FINE. IF YOU CLICK IT AND IT TURNS YELLOW, YOUR VOICE WILL BE ACROSS THE ENTIRE ROOM. SO WE PREFER YOU TO NOT. IF YOU ARE ON THE TELEPHONE, WE WOULD LIKE YOU TO MUTE YOUR TELEPHONE, BECAUSE THE SAME THING WILL HAPPEN THERE. IF YOU CAN MUTE YOUR TELEPHONES AND MUTE YOUR AUDIO ON YOUR COMPUTERS, THAT WILL BE THE BEST.

THE PRESENTATION WILL TAKE ABOUT 30 MINUTES. WE WILL OPEN THE FLOOR TO QUESTIONS ABOUT 15 MINUTES BEFORE THE HOUR.

BECAUSE OF THE SIZE OF THE GROUP WE WILL ONLY TAKE WRITTEN QUESTIONS SO YOU CAN WRITE TO US IN THE CHAT WINDOW ON THE LEFTHAND SIDE OF YOUR SCREEN. YOU CAN SEE THE SCREEN THERE. IT WILL PROBABLY BE BEST TO SEND YOUR MESSAGE TO MODERATOR. IF YOU CLICK ON THE ARROW PULL DOWN TO MODERATOR, YOU CAN SEND THAT QUESTION TO ME. I WILL READ THAT TO EVERYONE AND THEN WE WILL CONTINUE TO HAVE THAT BE CLEAR ON AUDIO.

IF YOU HAVE AN ISSUE DURING THE TALK YOU CAN SEND A MESSAGE TO ME THROUGH THAT CHAT WINDOW. IN THE MEANTIME WHAT I'M GOING TO DO, I'M GOING TO BASICALLY TAKE OVER THE WINDOW AT THE MOMENT AND MAKE IT INTO BE THE ENTIRE SCREEN. FIRST WE HAVE A COUPLE QUESTIONS COMING IN. THERE ARE NO PRINTOUTS; THEY ARE ON THE WEB SITE. THE SAME SLIDES YOU ARE SEEING NOW ARE AT THE PAS CENTER WEB SITE UNDER WEBCASTS. FOR JESSICA, FOR THE MUTE BUTTON ON YOUR AUDIO,

IF YOU ARE ON THE COMPUTER JUST MAKE SURE YOUR MICROPHONE IS NOT YELLOW IN THAT AUDIO WINDOW. I THINK YOU ARE MUTED. IF YOU ARE ON THE TELEPHONE USE MUTE BUTTON OR STAR SIX.

I BELIEVE WE ARE READY TO BEGIN.

LET ME TAKE OVER THE WINDOW HERE. IF YOU NEED TO WRITE ME A MESSAGE OR WANT TO GO BACK TO THAT OTHER WINDOW IN THE UPPER RIGHT HAND CORNER, THERE'S A LITTLE ARROW, YOU CAN CLICK ON THAT. IT WILL SHOW A RETURN ARROW WITH A SCREEN, YOU CAN CLICK THAT AND YOU CAN GET OFF THE FULL SCREEN. I THINK FULL SCREEN, YOU MIGHT PREFER.

THE CENTER FOR PERSONAL ASSISTANCE SERVICES IS FUNDED BY THE (I WANT TO GIVE YOU BACKGROUND ABOUT THE CENTER FIRST) IS FUNDED BY THE NATIONAL INSTITUTE ON DISABILITY AND REHABILITATION RESEARCH IN THE U.S. DEPARTMENT OF EDUCATION. IT'S A FIVE YEAR RESEARCH AND TRAINING CENTER ESTABLISHED HERE AT UNIVERSITY OF CALIFORNIA SAN FRANCISCO. THE FIRST CENTER WAS ESTABLISHED IN 2003. THIS CURRENT ONE WAS ESTABLISHED IN 2008. THE GOAL OF P.A.S. CENTER IS TO IMPROVE THE ACCESS, QUALITY AND COST FOR PAS FOR PEOPLE WITH DISABILITIES, TO LIVE INDEPENDENTLY, COMFORTABLY AND SAFELY IN THE COMMUNITY AND PARTICIPATE IN SOCIETY, INCLUDING EMPLOYMENT. THE UCSF CENTER TEAM IS MADE UP OF SEVERAL RESEARCHERS BASED AT UCSF AND ELSEWHERE. THERE'S A LIST OF THE PEOPLE AT

UCSF WHO ARE PARTICIPATING ON THE PROJECT.

THERE ARE PARTNERS ACROSS THE COUNTRY WHO WORK ON THE CENTER, INCLUDING THOSE AT INFO USE IN BERKELEY, AT THE TOPEKA INDEPENDENT LIVING RESOURCE CENTER IN KANSAS, AT PHI IN NEW YORK, AT RESEARCH TRIANGLE INSTITUTE IN WASHINGTON D.C., AND BURTON BLATT INSTITUTE IN WASHINGTON D. C. THERE ARE UNIVERSITY PARTNERS AT THE UNIVERSITY OF MARYLAND, BALTIMORE COUNTY, UNIVERSITY OF MICHIGAN AND CARDIFF BUSINESS SCHOOL IN THE UNITED KINGDOM.

THE P.A.S. CENTER HAS A BLUE RIBBON ADVISORY COMMITTEE MADE UP OF THOSE INDIVIDUALS ON THE SCREEN AT THE MOMENT. THEY GIVE ADVICE ON CENTER ACTIVITIES. THE CENTER IS RESEARCHING INTO THE FOLLOWING FIVE AREAS. THE NEED FOR PERSONAL ASSISTANCE SERVICES, HOME AND COMMUNITY-BASED SERVICES, AND WORKERS AND CAREGIVERS, OR THE P.A.S. WORK FORCE, ECONOMICS AND WORKPLACE P.A.S., AND EMERGENCY PREPAREDNESS.

TODAY'S SPEAKER IS JOSH WIENER. AND DR. WIENER WILL BE SPEAKING ON "THE LONG AND WINDING ROAD TO REFORM OF LONGTERM SERVICES AND SUPPORTS."

Dr. Wiener: THIS IS JOSH WIENER.

LEWIS, IF YOU COULD ADVANCE THE SLIDES, I'D APPRECIATE IT.

I'M GOING TO TALK ABOUT WHAT'S HAPPENING WITH HEALTH REFORM IN RESPECT TO LONGTERM SERVICES AND SUPPORTS HERE IN WASHINGTON.

AS EVERYBODY KNOWS WASHINGTON IS CURRENTLY BEING CONSUMED BY THE FIRST MAJOR DEBATE ON COMPREHENSIVE HEALTH REFORM SINCE 1994 WHEN PRESIDENT CLINTON PROPOSED SIGNIFICANT CHANGES TO BOTH THE HEALTH CARE SYSTEM AND LONGTERM SERVICES AND SUPPORT SYSTEMS. HEALTH REFORM IS CLEARLY A VERY HIGH PRIORITY FOR PRESIDENT OBAMA AND CONGRESS HAS BEEN PROMOTING A GREAT DEAL OF RESOURCES TO IT. I THINK AN HONEST ASSESSMENT IS THAT THE FOCUS OF HEALTH REFORM IS ON THE ACUTE CARE SIDE ON THE HEALTH INSURANCE SIDE WITH RELATIVELY MODEST ATTENTION TO LONGTERM SERVICES AND SUPPORTS. BUT THERE ARE A SUBSTANTIAL NUMBER OF PROVISIONS IN THE MANY BILLS THAT DO RELATE TO LTSS. CURRENTLY THE PROCESS IS THAT THE HOUSE HAS IN THE LAST WEEK OR SO MERGED TOGETHER INTO A SINGLE BILL. THE THREE BILLS THAT WERE COMING OUT OF THE MAJOR COMMITTEES IN THE HOUSE AND THE SENATE IS STILL UNDERWAY OF TRYING TO FIND A WAY TO MERGE THE HEALTH REFORM PROPOSALS OF ITS TWO MAJOR HEALTH COMMITTEES.

SENATE MAJORITY LEADER REID HAS SAID HE IS RUNNING A LITTLE BEHIND SCHEDULE SO IT MAY TAKE A WHILE TO DO THAT. IN THE NEWSPAPER TODAY IT REPORTED THAT CHECKS MODERATE DEMOCRATS WERE

Lewis: CAN WHOEVER HAS THEIR TELEPHONE ON PLEASE HIT STAR SIX. HIT YOUR MUTE BUTTON.

LEAH, CAN YOU UNCLICK YOUR MICROPHONE

BUTTON PLEASE? THANK YOU.

Dr. Wiener: SO WE STILL HAVE A LONG WAY TO GO BEFORE WE GET ANY KIND OF BILL. THE FINAL SHAPE OF THE BILL IS STILL VERY MUCH UP IN THE AIR. ONCE THERE IS A FINAL BILL THERE IS STILL A QUESTION WHETHER OR NOT IT WILL BE ENACTED.

SO, WHAT I'M GOING TO TALK ABOUT TODAY IS HOW TRUE HEALTH CARE REFORM WILL AFFECT LTSS PROVIDERS, WORKERS AND CONSUMERS, WHAT ARE THE LONGTERM SERVICES AND SUPPORTS PROVISIONS IN THE HEALTH REFORM BILLS. LOOKING OUT BEYOND THE CURRENT REFORM EFFORTS, WHAT ARE THE MAJOR ISSUES WE WILL HAVE TO DEAL WITH IN THE FUTURE, AND WHAT ARE SOME OF THE POLITICAL DYNAMICS THAT WILL AFFECT WHETHER HEALTH REFORM IS AFFECTED, OR IS ENACTED, ESPECIALLY WITH LONGTERM SERVICES AND SUPPORTS PROVISIONS.

SO, THE FIRST ISSUE IS HOW WILL THE HEALTH INSURANCE PROVISIONS AFFECT LTSS PROVIDERS AND CONSUMERS? ONE OF THE THINGS WE HAVE TO REMEMBER IS THAT PROVIDERS ARE OFTEN CONSUMERS AND DIRECT CARE WORKERS, SUCH AS PERSONAL CARE ATTENDANTS, HOME HEALTH AIDS, CERTIFIED NURSE ASSISTANTS ARE OFTEN UNINSURED. ABOUT 16 PERCENT OF CNA'S IN NURSING HOMES ARE UNINSURED. ABOUT 30 PERCENT OF HOME HEALTH AIDS ARE UNINSURED. WHILE THERE IS NOT A LOT OF DATA AVAILABLE, MY ASSUMPTION IS THAT PERSONAL CARE ATTENDANTS HAVE EVEN HIGHER LEVELS OF UNINSURANCE. PEOPLE WITH DISABILITIES, OF

COURSE, HAVE ACUTE CARE NEEDS AS WELL AS LONGTERM SERVICES AND SUPPORT NEEDS. ABOUT 12 PERCENT OF PEOPLE WITH DISABILITIES ARE UNINSURED, WHICH IS ACTUALLY SOMEWHAT LESS OF THE POPULATION AS A WHOLE AND BASICALLY REFLECTS THE FACT MANY PEOPLE WITH DISABILITIES ARE RECEIVING INSURANCE EITHER THROUGH MEDICAID OR THE MEDICARE PROGRAMS. MEDICARE BENEFICIARIES WITH DISABILITIES HAVE SUBSTANTIALLY HIGHER HEALTH EXPENDITURES THAN PEOPLE WITHOUT DISABILITIES. FOR THE MEDICARE POPULATION, PEOPLE WITH TWO PLUS ADLS HAVE OVER FOUR TIMES THE EXPENDITURES OF BENEFICIARIES WITHOUT ADL PROBLEMS. SO CLEARLY WHAT HAPPENS ON THE ACUTE CARE SIDE IS OF IMPORTANCE TO THEM AS WELL.

SO, THIS IS KIND OF AN IDEAL TYPE OF WHAT IS IN MANY OF THE BILLS. THERE IS SOME LEVEL OF REQUIREMENT THAT EMPLOYERS PROVIDE HEALTH INSURANCE OR PAY SOME KIND OF FINANCIAL PENALTY. IN THE SENATE FINANCE BILL IT IS FAIRLY MINIMAL IN TERMS OF WHAT EMPLOYERS WILL HAVE TO PAY, IF THEY DON'T COVER HEALTH INSURANCE IN THE HOUSE BILL, IT IS A PRETTY STRONG MANDATE. ON ALL THE BILLS SMALL BUSINESSES WERE EXEMPTED FROM HAVING TO PROVIDE HEALTH INSURANCE.

THERE'S AN INDIVIDUAL MANDATE, THAT IS PEOPLE WILL BE REQUIRED TO HAVE HEALTH INSURANCE OR PAY A PENALTY. AGAIN, THERE ARE VARIOUS KINDS OF EXEMPTIONS, IF PEOPLE CAN'T PAY FOR, CAN'T FIND A HEALTH

INSURANCE PLAN THAT MEETS CERTAIN FINANCIAL REQUIREMENTS. THERE WILL BE LOW INCOME SUBSIDIES FOR PURCHASE OF INSURANCE, A VERY SUBSTANTIAL EXPANSION OF MEDICAID. STATES WILL ESTABLISH SO-CALLED INSURANCE EXCHANGES WHERE INSURERS WILL OFFER HEALTH INSURANCE PLANS TO PEOPLE WHO DON'T HAVE HEALTH INSURANCE THROUGH THEIR EMPLOYERS. AND THERE WILL BE INSURANCE REFORMS WHICH ARE DESIGNED TO DEAL WITH SOME OF THE ISSUES LIKE PREEXISTING CONDITION EXCLUSIONS, WHICH WILL NARROW THE BAND OF COSTS IN TERMS OF HEALTH INSURANCE BY AGE TO TRY TO SPREAD THE RISK MORE BROADLY OVER THE POPULATION AS A WHOLE.

AND, FINALLY, THERE IS REDUCTION OF MEDICARE PART D DONUT HOLE WHICH IS THE PART OF THE PRESCRIPTION DRUG BENEFIT UNDER MEDICARE WHERE THERE IS ESSENTIALLY NO COVERAGE AND YOU HAVE TO GET THROUGH THAT BEFORE CATASTROPHIC COVERAGE COMES BACK IN.

WHAT ABOUT LONGTERM SERVICES AND SUPPORTS? THERE ARE A LARGE NUMBER OF PROVISIONS, MANY OF THEM RELATIVELY MODEST, BUT THERE ARE A LARGE NUMBER OF PROVISIONS THAT RUN THE GAMUT FROM STATEMENTS OF GRAND POLICY, ESTABLISHING A SOCIAL INSURANCE PROGRAM FOR LONGTERM CARE ON A VOLUNTARY BASIS, A VARIETY OF PROVISIONS RELATED TO HOME AND COMMUNITY-BASED SERVICES, AND A NUMBER OF OTHER PROVISIONS AS WELL.

SO THE GRAND POLICY IS THAT IN THE SENATE FINANCE COMMITTEE BILL THERE IS THIS SENSE

OF THE SENATE PROVISION. THIS IS THE ENTIRE PROVISION BASICALLY. WHILE THE SENATE FINANCE COMMITTEE DID NOT THEMSELVES ADDRESS COMPREHENSIVE LONGTERM SERVICES AND SUPPORT REFORMS, THEY SAY THAT THE SENATE SHOULD DO THAT OVER TIME. AND DO IT IN THE 111TH CONGRESS WHICH IS THE ONE WE ARE HAVING NOW.

THE MOST CONTROVERSIAL AND THE MOST SIGNIFICANT PROVISION IN SOME OF THE BILLS IS THE COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS ACT, BETTER KNOWN AS THE CLASS ACT. THIS IS IN THE HOUSE, CONSOLIDATED HOUSE BILL AND IS IN THE SENATE HELP COMMITTEE BILL. IT IS NOT IN THE SENATE FINANCE COMMITTEE BILL. BASICALLY WHAT IT IS, IS A VOLUNTARY PUBLIC SOCIAL INSURANCE PROGRAM FOR LONGTERM SERVICES AND SUPPORTS DEVELOPED INITIALLY BY SENATOR TED KENNEDY. AND BASICALLY WHAT IT TRIES TO DO IS ADDRESS SOME OF THE LIMITS OF THE CURRENT PRIVATE LONGTERM CARE INSURANCE SYSTEM ESPECIALLY TRYING TO PROVIDE A BROADER RANGE OF SERVICES THAN IS TYPICALLY AVAILABLE AND ALSO DEAL WITH SOME OF THE ISSUES AROUND MEDICAL UNDERWRITING AND RELATED ISSUES.

IT IS A VOLUNTARILY PUBLIC SOCIAL INSURANCE PLAN. SO PEOPLE WHO DON'T WANT TO JOIN WON'T HAVE TO. THAT RAISES A NUMBER OF ISSUES WE WILL TALK ABOUT IN JUST A MINUTE. IT IS A CASH BENEFIT RATHER THAN A SERVICE BENEFIT. AND THE BENEFIT IS

SUPPOSED TO BE ON AVERAGE ABOUT \$50 A DAY. BUT IT COULD VARY DEPENDING ON THE INDIVIDUAL PERSON. BUT THE PREMIUM IS SUPPOSED TO BE ADEQUATE TO COVER AN AVERAGE OF \$50 A DAY. IT IS ENTIRELY AND TOTALLY SELF-FINANCED BY THE ENROLLED POPULATION. SO THAT RAISES A NUMBER OF VERY DIFFICULT QUESTIONS RELATED TO THE COSTS OF THE PEOPLE WHO ACTUALLY ENROLL AND WHETHER THEY HAVE HIGHER COSTS OR LOWER COSTS AND WHETHER THEY ARE GOING TO BE USING SERVICES IN THE NEAR TERM.

THE LATEST ESTIMATED PREMIUM ON A MONTHLY BASIS WOULD BE ABOUT \$122 A MONTH, WHICH I THINK MOST PEOPLE WOULD CONSIDER FAIRLY SUBSTANTIAL. IN SOME OF THE EARLIER VERSIONS OF THE BILL, THERE WAS A SUBSIDY FOR LOW INCOME INDIVIDUALS THAT WAS BUILT INTO THE PREMIUM THAT IS THAT THE LOW INCOME POPULATION WOULD PAY ONLY \$5 PER MONTH AND STUDENTS WOULD PAY ONLY \$5 A MONTH. THAT PROVISION FOR SUBSIDY HAS BEEN DROPPED OUT OF THE HOUSE VERSION OF THE BILL. I DON'T KNOW WHAT WILL HAPPEN TO IT ON THE SENATE SIDE IF IT SHOULD BE INCLUDED IN THE OVERALL CONSOLIDATED BILL.

OVER A TEN YEAR BUDGET WINDOW, IT SAVES \$59 BILLION WHICH IS IN LARGE PART DUE TO THE FACT IT BUILDS UP RESERVES OVER A PERIOD OF TIME BEFORE IT STARTS TO PAY PREMIUMS.

WELL, BY FAR, THE MOST COMPLICATED ISSUE RELATED TO THE CLASS ACT HAS TO DO WITH THE

ISSUE OF ADVERSE SELECTION. ADVERSE SELECTION OCCURS WHEN PEOPLE WHO ARE MOST LIKELY TO USE SERVICES ENROLL IN AN INSURANCE PLAN AND PEOPLE WHO DON'T THINK THAT THEY ARE GOING TO USE SERVICES OR DON'T THINK IT IS WORTH THE MONEY DON'T ENROLL IN THE SERVICES. SO OBVIOUSLY THE MORE PEOPLE YOU HAVE ENROLLED IN THE INSURANCE PLAN WHO ARE GOING TO USE SERVICES RELATIVE TO PEOPLE WHO AREN'T GOING TO USE SERVICES, THE HIGHER THE INSURANCE PREMIUM IS GOING TO BE. AND SO ONE OF THE MAJOR CONCERNS IS THAT WITHOUT EXPLICIT MEDICAL UNDERWRITING, THAT WOULD EXCLUDE PEOPLE WITH DISABILITIES WHO ARE LIKELY TO USE SERVICES IN THE NEAR TERM THAT THE PREMIUMS WILL GO UP. THAT IS A MAJOR, MAJOR ISSUE IN A VOLUNTARY PROGRAM. OBVIOUSLY IN A MANDATORY PROGRAM YOU DON'T HAVE THESE KINDS OF ISSUES BECAUSE EVERYBODY WOULD BE ENROLLED. AND SO, SOME INFORMAL ESTIMATES I'VE SEEN SUGGEST THAT IF IT WAS A MANDATORY PROGRAM, THE PREMIUM WOULD PROBABLY BE MORE ON ORDER OF 30 TO \$40 A MONTH RATHER THAN THE \$122 A MONTH THAT IS CURRENTLY BEING ESTIMATED.

THE CLASS ACT TRIES TO DEAL WITH THIS ISSUE OF ADVERSE SELECTION IN A NUMBER OF WAYS. FIRST, IT IS AN OPT OUT RATHER THAN AN OPT IN ENROLLMENT. THAT IS PEOPLE WILL BE AUTOMATICALLY ENROLLED IN THE CLASS ACT BUT IF THEY DON'T WANT TO BE IN THEY CAN LEAVE. NO QUESTIONS ASKED. THEY CAN

LEAVE. THEY ARE AUTOMATICALLY ENROLLED TO START WITH. PEOPLE HAVE TO PAY PREMIUMS FOR FIVE YEARS BEFORE THEY USE SERVICES OR, RATHER, BEFORE THEY RECEIVE THE CASH BENEFIT. AND THEN MOST IMPORTANTLY THE INITIAL ENROLLMENT IS LIMITED TO THE WORKING POPULATION. NOW, THERE'S A FAIRLY MINIMALIST DEFINITION OF WHAT IT MEANS TO BE WORKING. WHILE THAT IS UNDER SOME FLUX, IT'S BASICALLY BEEN ONLY ABOUT \$1,000 A QUARTER. THAT IS NOT A VERY HIGH LEVEL OF INCOME TO BE CONSIDERED WORKING. BUT IT DOES MEAN THAT IT EXCLUDES OLDER PEOPLE WHO HAVE RETIRED AND ARE NOT WORKING, AND IT EXCLUDES THE CURRENT POPULATION WITH DISABILITIES WHO DO NOT WORK. SO CURRENTLY ABOUT 70% OF PEOPLE WITH SOME LEVEL OF DISABILITY ARE OUT OF THE WORK FORCE AND ONLY A VERY SMALL PERCENTAGE OF PEOPLE WITH ROUGHLY TWO OR MORE PROBLEMS WITH THE ACTIVITIES OF DAILY LIVING OR SUBSTANTIAL COGNITIVE IMPAIRMENT WHICH IS THE TRIGGER FOR RECEIVING BENEFITS ARE CURRENTLY IN THE WORK FORCE.

THE NEXT BROAD CATEGORY OF PROVISIONS RELATE TO HOME AND COMMUNITY-BASED SERVICES. THERE IS SOME ADDITIONAL MONEY FOR AGING AND DISABILITY RESOURCE CENTERS WHICH ARE PROVIDING INFORMATION AND REFERRAL TO PEOPLE ABOUT LONGTERM SERVICES AND SUPPORTS AND ARE TRYING TO BE A SINGLE POINT OF ENTRY TO THE LONGTERM CARE SYSTEM. THERE IS AN EXTENSION OF "THE MONEY FOLLOWS

THE PERSON" PROGRAM DEMONSTRATION FOR SOME ADDITIONAL YEARS AND IT CHANGES THE CRITERIA FOR ELIGIBILITY FOR THE PROGRAM TO RESIDING IN AN INSTITUTION FOR 90 DAYS RATHER THAN SIX MONTHS. THIS RELATES TO THE PERIOD IN WHICH STATES COULD IDENTIFY PEOPLE WHO WOULD BE ELIGIBLE FOR A HIGHER FEDERAL MEDICAID MATCH. THERE ARE SEVERAL PROVISIONS THAT PROVIDE UNDER MEDICAID ADDITIONAL HOME AND COMMUNITY-BASED SERVICES OPTIONS FOR STATES. ONE IS THE COMMUNITY FIRST CHOICE OPTION, WHICH IS A DIRECT DESCENDANT OF MICASSA LEGISLATION, AND A VOLUNTARY VERSION OF THE COMMUNITY CHOICE ACT THAT HAS BEEN FLOATING AROUND WASHINGTON FOR AWHILE. IT AGAIN IS A STATE OPTION RATHER THAN MANDATORY FOR THE STATES, AND IT PROVIDES ADDITIONAL OPTIONS TO STATES ABOUT SERVING PEOPLE WHO WOULD OTHERWISE QUALIFY FOR INSTITUTIONAL CARE, ESSENTIALLY PEOPLE WHO WOULD QUALIFY FOR HOME AND COMMUNITY-BASED SERVICES WAIVERS.

ANOTHER SIMILAR PROVISION WITH IN FACT A GREAT DEAL OF OVERLAP WITH THE COMMUNITY FIRST CHOICE OPTIONS PROVISIONS ARE A VARIETY OF FIXES TO THE SECTION 1915 I STATE PLAN OPTION, WHICH ALSO TRIES TO PROVIDE SERVICES TO PEOPLE WHO HAVE MORE OF A SEVERE DISABILITY AND ALLOWS STATES TO TARGET DIFFERENT HOME AND COMMUNITY-BASED SERVICES TO DIFFERENT POPULATIONS AND ALLOWS STATES TO TARGET PARTICULAR GROUPS LIKE THEY DO NOW FOR HCBS WAIVERS. THERE

ARE PROVISIONS FOR STATES TO RECEIVE A HIGHER MEDICAID MATCH IF THEY ENGAGE IN CERTAIN REBALANCING INITIATIVES. IN ORDER TO QUALIFY FOR THE HIGHER MATCH THEY WOULD HAVE TO HAVE A SINGLE POINT OF ENTRY LIKE ADRCS OR HAVE PRESUMPTIVE ELIGIBILITY FOR MEDICAID, AND HAVE "CONFLICT FREE CASE MANAGEMENT," THEY WOULD HAVE TO USE A STANDARDIZED ASSESSMENT INSTRUMENT. THE NOTION HERE IS TO TRY TO MIMIC SOME OF THE ACTIVITIES OF STATE'S LIKE OREGON AND WASHINGTON, WISCONSIN, WHO HAVE MANAGED TO MOVE THEIR LONGTERM SERVICES AND SUPPORTS TOWARDS HOME AND COMMUNITY-BASED SERVICES.

THE LEGISLATION REQUIRES STATES TO PROVIDE SPOUSAL IMPOVERISHMENT PROTECTIONS UNDER HOME AND COMMUNITY-BASED SERVICES WAIVER. MOST STATES ALREADY DO THIS, BUT THERE WOULD BE A REQUIREMENT NOW SO IT WOULD ALLOW SPOUSES TO KEEP MORE OF THEIR INCOME AND ASSETS. FINALLY, HOME HEALTH AGENCIES WOULD BE REQUIRED TO SUBMIT QUALITY DATA TO CMS.

THERE ARE QUITE A NUMBER OF PROVISIONS RELATED TO THE MEDICARE POST-ACUTE CARE BENEFIT. MEDICARE DOES NOT COVER LONG TERM SERVICES AND SUPPORT, BUT IT DOES, IN FACT, MAKE SUBSTANTIAL PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES, LARGELY FOR POST-ACUTE CARE, FOR EXAMPLE, WHEN SOMEBODY HAS A HIP REPLACEMENT AND NEEDS ADDITIONAL REHABILITATION OR CONVALESCENT CARE AFTER A

HOSPITALIZATION. SO ONE OF THE MAJOR WAYS IN WHICH HEALTH REFORM IS FINANCING EXPANSION OF SERVICES INSURANCE TO THE UNINSURED IS TO CUT PAYMENTS TO PROVIDERS. ALL THE BILLS CALL FOR SUBSTANTIAL MEDICARE PAYMENT CUTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES, THE RATIONALE FOR THAT IS RELATIVELY HIGH PROFIT MARGINS ON MEDICARE SERVICES. ACCORDING TO THE MEDICARE PAYMENT ADVISORY COMMISSION, THE PROFIT MARGIN ON MEDICARE HOME HEALTH SERVICES IS ABOUT 12 PERCENT AND ABOUT THE SAME LEVEL FOR SKILLED NURSING FACILITIES. SO THEY WOULD CUT PAYMENTS AND PRESUMABLY CUT THE PROFIT MARGINS AS WELL. PROVIDERS ARGUE BACK, YES, THEY ARE MAKING SUBSTANTIAL AMOUNTS OF PROFITS ON MEDICARE, BUT THAT IS LARGELY TO COMPENSATE THEM FOR THE UNDER PAYMENT THAT THEY HAVE RECEIVED FROM THE MEDICAID PROGRAM.

OVER THE LONGTERM, A PROVISION IN MANY OF THE BILLS, IS A NEW MEDICARE COMMISSION THAT WOULD HAVE THE POWER TO RECOMMEND HIGHLY SPECIFIC PAYMENT POLICY AND OTHER CHANGES TO MEDICARE WHICH WOULD HAVE TO BE VOTED UP OR DOWN BY CONGRESS. THIS IS GENERALLY DESCRIBED AS THE MEDPAC ON STEROIDS, WHETHER THAT ENDS UP BEING INCLUDED OR NOT IS STILL AN OPEN QUESTION.

THE OTHER MAJOR THING THAT IS BEING PROPOSED FOR MEDICARE POST-ACUTE CARE IS A FAIRLY ELABORATE AND EXTENSIVE SO-CALLED POSTACUTE CARE BUNDLING DEMONSTRATION.

WHAT THIS IS TRYING TO GET AT IS THE RELATIVELY HIGH LEVEL OF REHOSPITALIZATIONS THAT ABOUT A QUARTER OF PEOPLE WHO ARE DISCHARGED FROM THE HOSPITAL UNDER THE MEDICARE PROGRAM ARE READMITTED WITHIN 90 DAYS. MEDICARE CURRENTLY PAYS A WIDELY VARIABLE AMOUNT TO A VARIETY OF PROVIDERS FOR THE SAME POPULATION. SO THE NOTION IS TO TRY TO BUNDLE, THAT IS INCLUDE THE PAYMENTS FOR POST-ACUTE CARE IN WITH THE HOSPITAL PAYMENT. AND MAKE A SINGLE ENTITY RESPONSIBLE NOT ONLY FOR THE HOSPITALIZATION, BUT FOR THE POST HOSPITAL CARE AS WELL. AND THE NOTION TOO IS THAT THIS WOULD CREATE INCENTIVES FOR COORDINATION ACROSS PROVIDERS AND MIGHT LEAVE SOME HOSPITALS TO RETAIN PEOPLE FOR A LONGER PERIOD OF TIME INSTEAD OF DISCHARGING THEM TO NURSING HOMES PREMATURELY OR DISCHARGING THEM TO HOME HEALTH AGENCIES PREMATURELY.

OBVIOUSLY, TWO MAJOR QUESTIONS IS, DOES THIS ONLY RESULT IN A FURTHER HOSPITAL DOMINATED SYSTEM BY GIVING THEM CONTROL OF EVEN MORE MONEY?

AND THEN FROM THE POST-ACUTE CARE SIDE, SINCE THE DEFINITION OF WHO NEEDS THE CARE WHEN IS SO OPEN TO QUESTION, WHAT WOULD HAPPEN TO POST-ACUTE CARE? WOULD THEY IN FACT MOVE PEOPLE INTO POST-ACUTE CARE, OR WOULD HOSPITALS POCKET THE MONEY AND SAY, IF YOU NEED THOSE KINDS OF SERVICES YOU WILL HAVE TO PAY FOR IT YOURSELF?

THERE'S QUITE A NUMBER OF PROVISIONS RELATED TO NURSING HOMES INCLUDING THE DISCLOSURE OF OWNERSHIP, SOMETHING THAT HAS BEEN IN THE NEWS OVER THE LAST YEAR OR SO COMING OUT OF "NEW YORK TIMES" ARTICLE THAT ALLEGED POOR QUALITY CARE AND A NUMBER OF SITUATIONS WHERE PRIVATE EQUITY FIRMS HAD PURCHASED NURSING HOMES. A REQUIREMENT FOR ADDITIONAL STAFFING DATA, NEW HIGHLY SPECIFIC RULES ON WHAT FACILITIES HAVE TO DO IF THEY SHOULD CLOSE, DEMONSTRATION PROJECTS ON CULTURE CHANGE AND INFORMATION TECHNOLOGY, NEW REQUIREMENTS FOR TRAINING CERTIFIED NURSE ASSISTANTS ON DEMENTIA AND PATIENT ABUSE. IT DOES NOT INCREASE THE NUMBER OF REQUIRED HOURS, BUT SAYS THESE TOPICS HAVE TO BE ADDRESSED. AND THEY ARE STANDARDIZED COMPLAINT FORM AND ADDITIONAL FUNDS FOR INVESTIGATION OF COMPLAINTS RELATED TO NURSING HOME CARE.

AGAIN, LARGELY NURSING HOME ORIENTED, BUT A NUMBER OF PROVISIONS RELATED TO ELDER ABUSE INCLUDING SETTING UP FORENSIC CENTERS TO HELP PROSECUTORS PROSECUTE ELDER ABUSE CASES. INFORMATION ABOUT ELDER ABUSE WHEN IT INVOLVES NURSING HOMES BE ADDED TO THE NURSING HOME COMPARE WEB SITE. THIS WEB SITE PROVIDES QUALITY OF CARE INFORMATION ON INDIVIDUAL PROVIDERS. AND THERE WOULD BE A SMALL INCREASE IN FUNDS TO STATES TO INVESTIGATE ELDER ABUSE AND FOR THE LONGTERM CARE OMBUDSMAN PROGRAM.

THERE ARE A NUMBER OF PROVISIONS RELATED

TO CHRONIC DISEASE, WHICH OBVIOUSLY INCLUDES A LARGE NUMBER OF PEOPLE WITH DISABILITIES. AND PROVISIONS RELATED TO DUAL ELIGIBLES. MOST OF THESE OF A DEMONSTRATION NATURE OR ADMINISTRATIVE CHANGES, BUT IT DOES SIGNAL, I THINK, A CONTINUING UPWARD CLIMB IN TERMS OF THE RECOGNITION BY MEDICAID AND MEDICARE POLICYMAKERS, CHRONIC ILLNESS, CHRONIC DISEASE, CHRONIC CONDITIONS ARE IMPORTANT AND A DRIVER FOR HEALTH CARE COSTS. SO IT ESTABLISHES A FEDERAL COORDINATED HEALTH CARE OFFICE WITHIN CMS THAT IS SUPPOSED TO OVERSEE INITIATIVES RELATED TO PEOPLE WHO ARE DUALY ELIGIBLE FOR MEDICARE AND MEDICAID. IT ESTABLISHES UNDER MEDICAID A STATE OPTION TO ESTABLISH SO-CALLED HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS WITH THE FEDERAL GOVERNMENT PAYING 90% OF THE COST FOR THE FIRST TWO YEARS. THIS IS IN AN EFFORT TO TRY TO REINVENT PRIMARY CARE AND REALLY GIVE PEOPLE WITH CHRONIC CONDITIONS A MEDICAL HOME. THERE'S A MEDICARE DEMONSTRATION OF THE DEPARTMENT OF VETERANS AFFAIRS HOME BASED PRIMARY CARE PROGRAM WHICH FOCUSES ON PEOPLE WITH SEVERE DISABILITIES. IT EXTENDS THE SPECIAL NEED PLAN PROVISIONS WHICH ARE SPECIAL MANAGED CARE ORGANIZATIONS THAT FOCUS ON DUAL ELIGIBLES OR PEOPLE WHO HAVE HIGH LEVELS OF DISABILITY AND THERE IS A NEW PAYMENTS ADJUSTMENT WITH THAT.

THERE ARE A NUMBER OF PROVISIONS RELATED

TO HOSPICE AND END OF LIFE CARE. CURRENTLY YOU CAN ONLY QUALIFY FOR MEDICARE HOSPICE BENEFIT IF YOU GIVE UP YOUR CLAIM TO REGULAR CARE. AND MANY PEOPLE WHO STUDY END OF LIFE CARE BELIEVE THAT RESULTS IN UNDER USE OF HOSPICE CARE BECAUSE PEOPLE DON'T WANT TO GIVE UP THEIR REGULAR CARE AND THERE ARE A NUMBER OF PEOPLE WHO WOULD BENEFIT FROM PALLIATIVE CARE WHO DON'T CURRENTLY RECEIVE IT. UNDER CONCURRENT CARE PEOPLE WOULD NOT HAVE TO GIVE UP THEIR REGULAR MEDICARE BENEFITS IN ORDER TO GET HOSPICE SERVICES.

THERE ARE PROVISIONS THAT PROHIBIT THE USE OF ASSISTED SUICIDE, PROBABLY A DIRECT RESULT OF THE ERRONEOUS CLAIMS OVER THE SUMMER THERE WERE DEATH SQUADS BEING AUTHORIZED BY THE BILL. THE SENATE BILL SPECIFICALLY PROHIBITS THE USE OF ASSISTED SUICIDE, AND, FINALLY, WHILE IT DOES NOT SAY WHAT IT SHOULD BE, THE SENATE BILL CALLS FOR A REVISION FOR MEDICARE HOSPICE PAYMENT SYSTEM.

THAT IS PRETTY MUCH WHAT IS IN THE CURRENT SET OF BILLS. BUT THAT WILL STILL LEAVE A LOT OF WORK TO DO IN TERMS OF REFORMING THE LONGTERM SUPPORTS SERVICES SYSTEM. OVER THE NEXT 40 YEARS THERE IS GOING TO BE A LARGE PROJECTED GROWTH IN THE NUMBER OF PEOPLE WITH DISABILITIES, LARGELY BECAUSE OF THE GROWTH OF THE OLDER POPULATION, ESPECIALLY THE VERY ELDERLY POPULATION. WE CURRENTLY SPEND NEARLY

ABOUT A QUARTER OF A TRILLION DOLLARS ON LONGTERM SERVICES AND SUPPORT SO THERE IS THE BUDGETARY PRESSURE TO THINK ABOUT HOW WE SPEND THAT MONEY AND WHETHER WE CAN DO IT BETTER. AS WE ALREADY TALKED ABOUT, PEOPLE WITH LONGTERM SERVICES AND SUPPORT NEEDS ALSO HAVE HIGH ACUTE CARE COSTS ON AVERAGE.

THIS SLIDE SHOWS WE ARE NOT ALONE ON THIS. A LOT OF OTHER DEVELOPED COUNTRIES ARE MOVING IN THE DIRECTION OF AN OLDER POPULATION.

THIS IS PUBLIC AND PRIVATE EXPENDITURES ON LONGTERM SERVICES AND SUPPORTS FOR OLDER PEOPLE AS A PERCENTAGE OF THE GROSS DOMESTIC PRODUCT. MANY OF THE DEVELOPED COUNTRIES ARE WHERE WE ARE, WE ARE THERE AT ABOUT 1.29% OF GDP. THEY ARE ALL PRETTY MUCH IN THAT RANGE UNDER ONE AND A HALF PERCENT OF GDP. SWEDEN IS AN OUTLIER AT A LITTLE LESS THAN 3 PERCENT OF GDP.

THESE ARE SOME PROJECTIONS DONE BY THE ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT. THESE ARE PROJECTED LONGTERM CARE EXPENDITURES FOR ALL AGES IN SELECTED COUNTRIES AS A PERCENTAGE OF GDP. THE BLUE IS 2005 AND THE GREEN IS IN 2050. CURRENTLY WE ARE ALL, ALL THESE COUNTRIES ARE ABOUT 1 PERCENT OF GDP AND A CONSERVATIVE ON THE HIGH SIDE ESTIMATE IS THEY GO TO MAYBE 3% IN 2050. A LOWER ESTIMATE BY OECD WAS THAT THEY WOULD GO TO 2% OF GDP.

SO, IN THINKING ABOUT FUTURE OPTIONS FOR REFORM, THERE IS CLEARLY A POLITICAL DIVIDE OVER THE ROLE OF GOVERNMENT PROGRAMS VERSUS PRIVATE SECTOR INITIATIVES. THERE IS ALSO A KEY ISSUE ABOUT THE FISCAL SUSTAINABILITY FOR THE FUTURE. AS WE SAW IN THE PREVIOUS SLIDES OVER THE NEXT 50 YEARS WE ARE TALKING ABOUT AN EXTRA ONE TO 2% OF GDP FOR PUBLIC LONGTERM SERVICES AND SUPPORTS EXPENDITURES. IF YOU THINK THAT IS ABSOLUTELY UNSUSTAINABLE, THEN, OBVIOUSLY, YOU WILL BE THINKING MORE ABOUT PUBLIC INSURANCE AND REVERSE MORTGAGES AND THOSE KINDS OF THINGS. IF YOU THINK THAT, YES, THAT IS A SUBSTANTIAL AMOUNT OF MONEY, BUT WE ADDED OVER ONE AND A HALF PERCENT TO HEALTH EXPENDITURES OVER THE LAST TEN YEARS WITHOUT TOO MUCH DIFFICULTY AND WE COULD DO THAT IN THE FUTURE, THEN YOU ARE WILLING TO CONSIDER MORE PUBLIC OPTIONS SUCH AS SOCIAL INSURANCE, MEDICARE, MEDICAID EXPANSIONS, INCREASES IN APPROPRIATED PROGRAMS LIKE OLDER AMERICANS ACT. IT SEEMS CLEAR TO ME THAT IF WHAT WE WANT IS MAJOR CHANGES BE IT EITHER PUBLIC SECTOR OR PRIVATE SECTOR, EITHER THE FEDERAL GOVERNMENT OR STATES WILL HAVE TO HAVE LARGE INCREASES IN DIRECT GOVERNMENT SPENDING OR WE WILL NEED LARGE TAX INCENTIVES TO MAKE PRIVATE INSURANCE MORE AFFORDABLE AND DESIRABLE.

SO, THAT IS ON THE FINANCING SIDE. THE DELIVERY SIDE OVER THE LAST TEN YEARS HAS BEEN A STEADY INCREASE IN HOME AND

COMMUNITY-BASED SERVICES. AND IN 1997 ABOUT 13% OF MEDICAID LTSS EXPENDITURES WERE FOR HOME AND COMMUNITY-BASED SERVICES FOR THE AGING AND DISABLED. IT HAS GONE STEADILY UP. IT HAS HIT ABOUT 24 PERCENT IN 2005 AND IS NOW UP AROUND 31%.

THERE IS MORE POLITICAL CONSENSUS ON THE DELIVERY SIDE THAN THE FINANCING SIDE. THERE IS A LOT OF CONSENSUS BOTH ON THE RIGHT AND LEFT TO MOVE TOWARDS THE MORE BALANCED LONGTERM CARE SYSTEM WITH MORE CONSUMER CONTROL. SO WE SEE A LOT OF ENERGY GOING INTO EXPANSION AND DIRECT TO HOME CARE, MONEY FOLLOWS THE PERSON FOR ALTERNATIVES TO NURSING HOMES SUCH AS ASSISTED LIVING. THE REALITY IS, STATES HAVE PRETTY MUCH ALL THE AUTHORITY THAT THEY NEED NOW TO MOVE IN THAT DIRECTION, CLEARLY HEALTH REFORM OFFERS A NUMBER OF ADDITIONAL OPTIONS FOR THEM TO DO THAT, BUT AS WE SEE FROM STATES LIKE OREGON AND WASHINGTON, THEY CAN WORK WITHIN THE SYSTEM NOW. SO THE QUESTION IS, REALLY, SHOULD WE PUT MANDATES ON STATES TO MOVE IN THAT DIRECTION TO OFFER CERTAIN KINDS OF SERVICES. SO FAR WE HAVE NOT BEEN WILLING TO DO THAT.

SO, TO CONCLUDE, LONGTERM SERVICES AND SUPPORTS IS NOT THE CENTERPIECE OF HEALTH REFORM BUT IT IS ALMOST CERTAIN IT WILL PLAY A ROLE. I THINK COMPREHENSIVE REFORM OF LONGTERM SERVICES AND SUPPORTS WILL FOLLOW ONCE WE HAVE TAKEN CARE OF HEALTH

CARE FOR THE UNINSURED, BUT I THINK IT IS GOING TO BE HARD TO HAVE COMPREHENSIVE REFORM UNTIL THAT IS ADDRESSED FIRST.

LONGTERM SERVICES AND SUPPORTS IS HARD TO REFORM FOR A VARIETY OF REASONS. ONE, I THINK IS THAT PEOPLE SEE THAT THERE IS ALREADY A SAFETY NET AND THAT SAFETY NET IS BOTH THE FAMILY, INFORMAL CARE, AND THE MEDICAID PROGRAM. BOTH OF THOSE HAVE THEIR PROBLEMS. BUT WE ARE NOT A SOCIETY THAT LET EITHER OUR SONS AND DAUGHTERS OR OUR PARENTS JUST KIND OF DIE IN THE STREET WITHOUT RECEIVING CARE FOR THEIR DISABILITIES. SO, I THINK THE FACT THAT ALTERNATIVE EXISTS MAKES IT HARD TO GET MORE COMPREHENSIVE REFORM. THE OTHER THING IS THAT WHILE POLICYMAKERS LIKE TO COMPLAIN ABOUT THE COST OF THE CURRENT SYSTEM, IT IS IN FACT A FAIRLY CHEAP SYSTEM IN CERTAIN RESPECTS. WE ONLY PAY WHEN PEOPLE HAVE IMPOVERISHED THEMSELVES, THEY HAVE TO CONTRIBUTE ALL THEIR INCOME TOWARDS THE COST OF CARE IF THEY ARE IN A NURSING HOME, IT CAUSES INSTITUTIONAL BIAS. MANY PEOPLE THAT NEED SERVICES DON'T RECEIVE THEM AND IN GENERAL WE PAY PROVIDERS LESS THAN THE MARKET RATE. ALL THAT IN MANY WAYS RESULTS IN A RELATIVELY LOW COST SYSTEM THAT MAKES IT HARD TO DO ANYTHING WITHOUT SPENDING MORE MONEY. AS WE LOOK AT LTSS REFORM, I THINK COMPREHENSIVE REFORM WILL COST MONEY, BUT WE CAN DEFINITELY MOVE IN THE RIGHT DIRECTION WITH LOW COST OPTIONS AND THAT IS

MOSTLY WHAT WE HAVE IN THE CURRENT HEALTH REFORM BILLS AND I THINK THAT MAKES A CONTRIBUTION. THANKS.

Lewis: THANK YOU VERY MUCH, JOSH. THAT WAS A FANTASTIC, INFORMATIVE PRESENTATION. I DID WANT TO SAY I FAILED TO GIVE MUCH OF AN INTRODUCTION TO JOSH. I'VE GIVEN YOU THE CHANCE TO WRITE IN YOUR QUESTIONS IN THE CHAT WINDOW SO WHILE YOU WRITE THOSE IN LET ME TELL YOU A LITTLE ABOUT JOSH. HE IS THE SENIOR FELLOW AND PROGRAM DIRECTOR OF AGING DISABILITY AND LONGTERM CARE PROGRAM AT RESEARCH TRIANGLE INSTITUTE, RTI, AND LEADS THE RTI RESEARCH TEAM FOR THE ANALYSIS OF BOTH THE MEDICAID HOME AND COMMUNITY-BASED SURVEY AND NATIONAL LONGTERM CARE SURVEY.

HE IS EDITOR OF EIGHT BOOKS AND OVER 100 ARTICLES ON LONGTERM CARE, PEOPLE WITH DISABILITIES, HEALTH CARE FOR OLDER PEOPLE, MEDICAID AND HEALTH REFORM.

HE IS INVOLVED IN STUDIES OF MEDICAID HCBS INCLUDING P.A.S., LONGTERM CARE WORK FORCE, QUALITY ASSURANCE FOR LONG TERM CARE, RESIDENTIAL CARE FACILITIES, AND PROJECTION AND SIMULATION MODELS FOR LONG TERM CARE. HE HAS DIRECTED RESEARCH ON CONSUMER-DIRECTED P.A.S. HE DEDICATES COMPONENTS OF THE TICKET TO WORK PROGRAM AND OLDER PEOPLE AND YOUNGER ADULTS WITH PHYSICAL DISABILITIES OF A MEDICAID HCBS STUDY THAT ANALYZED THE SURVEY OF MEDICAID HOME CARE BENEFICIARIES MERGED WITH

MEDICAID CLAIMS DATA.

SO, GIVEN THAT, WE HAVE A COUPLE OF QUESTIONS HERE. JOSH, LET ME GET THEM TO YOU. THE FIRST ONE FROM ROBERT SCHOENFELD SAYS, ARE THERE ESTIMATES AS TO HOW MUCH, IF ANY, COULD BE SAVED IF PEOPLE COULD BE KEPT IN THEIR HOMES AS OPPOSED TO GOING INTO A NURSING HOME OR REHAB CENTER, ESPECIALLY FOR PEOPLE WITH TWO OR MORE ADL NEEDS?

Dr. Wiener: THE UCSF HAS DONE A NUMBER OF ESTIMATES IN THAT AREA. I THINK THE BASIC QUESTION HAS ALWAYS BEEN, IT MAY BE POSSIBLE IF YOU EXPAND HOME AND COMMUNITYBASED SERVICES FOR PEOPLE WITH SEVERE DISABILITIES, YOU MAY END UP WITH AN AVERAGE COST LESS THAN BEING IN AN INSTITUTIONAL SETTING. THE QUESTION IS ALWAYS WHETHER YOU DRAW IN ADDITIONAL PEOPLE WHO WOULD NOT HAVE OTHERWISE GONE INTO A NURSING HOME. YOU MAY GET A SITUATION WHERE THE AVERAGE COST IS LESS IN THE COMMUNITY THAN IT IS IN THE NURSING HOME, BUT THE AGGREGATE COST COULD BE THE SAME OR HIGHER. THERE HAS NOT BEEN A WHOLE LOT OF RESEARCH IN THAT AREA. STEVE KAYE AT UCSF HAS DONE A STUDY RECENTLY THAT SHOWS THAT SOME OF THE STATES THAT HAVE BEEN EXPANDING THAT HAD A HISTORY OF HIGH HOME AND COMMUNITY-BASED SERVICE SPENDING HAVE LOWER INCREASES IN COSTS. WE HAVE BEEN DOING SOME WORK AT RTI WHERE WE LOOKED AT THE IMPACT OF HOME AND COMMUNITY-BASED

SERVICES EXPANSIONS ON NURSING HOME USE AND WE DON'T FIND THAT EXPANDING HOME AND COMMUNITY-BASED SERVICES HAS THE NEGATIVE IMPACT ON NURSING HOME USE. SO, IT IS A HIGHLY CONTENTIOUS ISSUE. THERE HAS BEEN RIGOROUS RESEARCH IN THAT AREA IN THE EARLY 1980, MID 1980'S. THERE HAS NOT BEEN A WHOLE LOT SINCE.

Lewis: THE NEXT COUPLE OF QUESTIONS HAVE TO DO IF THE POWERPOINT WILL BE AVAILABLE, WHERE IT WILL BE POSTED. I'M POSTING IN THE CHAT WINDOW THE ADDRESS THAT IS WHERE YOU CAN FIND THESE, ALL OF THE WEB SITES, WEB CASTS FOR THE CENTER FOR PERSONAL ASSISTANCE SERVICES. THAT WILL BE THERE. YOU CAN GET THERE ANY TIME YOU WANT.

AUGUST ASKS, HOW DOES THE V.A. SYSTEM AND CIVILIAN DISABILITY SYSTEM SERVICES AND SUPPORTS COMPARE?

Dr. Wiener: WELL, I'M NOT AN EXPERT ON THE V.A. SYSTEM, BUT I THINK THAT THE V.A. SYSTEM HAS THE ADVANTAGE THAT IT IS A CLOSED SYSTEM. SO THE V.A. IS RESPONSIBLE FOR ALL LEVELS OF CARE. THEY HAVE DONE A LOT WITH PEOPLE WITH DISABILITIES SINCE THAT IS LARGELY THE POPULATION THEY SERVE. AND THEY GENERALLY HAVE A GOOD REPUTATION FOR SOME OF THOSE INITIATIVES. AS I MENTIONED, ONE OF THE THINGS THAT IS IN THE HEALTH REFORM BILL IS A REPLICATION OF THE

( SOUND INTERFERENCE )

MUTE YOUR PHONE.

Dr. Wiener: SO, AS I WAS SAYING, THERE

IS A PROVISION TO DO A MEDICARE DEMONSTRATION THAT TAKES ONE OF THE V.A. PRIMARY CARE HOME CARE MODELS AND TRIES IT OUT ON THE MEDICARE POPULATION.

Lewis: THE NEXT QUESTION IS, PAT ASKS, HOW WOULD REFORM INTERFACE WITH PEOPLE WHO HAVE LONGTERM CARE INSURANCE?

Dr. Wiener: WELL, THE I ASSUME THIS RELATES TO THE CLASS ACT. SO THE CLASS ACT, IF YOU SIGNED UP FOR THE CLASS ACT YOU WOULD BE ELIGIBLE FOR THE CASH BENEFIT AND IF YOU SIGN UP, IF YOU HAVE LONGTERM CARE INSURANCE AS WELL PRESUMABLY YOU COULD DRAW DOWN THAT BENEFIT AS WELL. PART OF WHAT THE SENATE STAFFERS HAVE SAID, THEY VERY MUCH SEE PRIVATE LONGTERM CARE INSURANCE AS WRAPPING AROUND THE CLASS ACT. THE MAXIMUM BENEFIT FOR MOST PEOPLE CERTAINLY IS NOT GOING TO BE ENOUGH TO COVER INSTITUTIONAL CARE, ALTHOUGH IT WOULD COVER A FAIR PERCENTAGE OF THE COST, IT WOULD COVER A SUBSTANTIAL PORTION OF COSTS IN THE COMMUNITY, BUT IT MIGHT NOT COVER ALL THE COSTS THERE AS WELL. SO, I THINK THE NOTION IS THAT THERE WOULD BE, THERE WOULD CONTINUE TO BE A ROLE FOR PRIVATE LONGTERM CARE INSURANCE BUT AS A WRAP AROUND THE BASIC BENEFIT. THE SAME WAY THAT IT APPARENTLY IS WORKING IN FRANCE AT THIS TIME.

Lewis: OKAY. THE NEXT IS A COMMENT. CURRENT CLASS PREMIUMS ARE ESTIMATED AT \$146 FOR 75 DOLLAR A DAY BENEFIT OR \$98 PER

MONTH IN THE BENEFIT MAXIMUM IS \$50 PER DAY.

Dr. Wiener: THE ESTIMATES ARE IN FLUX AS VARIOUS PROVISIONS IN THE CLASS ACT ARE TWEAKED. I THINK THE BOTTOM LINE IS THAT UNDER A CONDITION OF VOLUNTARY ENROLLMENT THAT THERE IS LIKELY TO BE ENOUGH ADVERSE SELECTION TO MAKE THE PREMIUMS HIGHER THAN I THINK MANY PEOPLE WOULD HAVE LIKED TO HAVE SEEN.

Lewis: I BELIEVE THAT PAT HAD A FOLLOW UP QUESTION. HE OR SHE, I'M NOT SURE. SO THE INSURANCE WOULD PAY THE PREMIUM FOR THE INSURED?

Dr. Wiener: SAY THAT AGAIN?

Lewis: SO THE INSURANCE WOULD PAY THE PREMIUM FOR THE INSURED? I'M NOT SURE I UNDERSTAND THAT EITHER.

Dr. Wiener: WELL, I THINK THAT REFERS WITH THE CLASS ACT BENEFIT PAY FOR THE PRIVATE LONGTERM CARE INSURANCE. IF THAT IS WHAT THE QUESTION IS, YOU WOULD ONLY GET THE BENEFIT, THE AVERAGE BENEFIT, THE CASH BENEFIT, IF YOU WERE IN CLAIM. IF YOU WISH TO SPEND THAT MONEY TO PAY FOR YOUR LONGTERM CARE INSURANCE PREMIUM, I GUESS YOU COULD. BUT YOU COULD NOT BUY A PRIVATE LONGTERM CARE INSURANCE PRODUCT IF YOU WERE ALREADY SEVERELY DISABLED AND CLAIMING BENEFITS. THE MEDICAL UNDERWRITING WOULD EXCLUDE YOU.

Lewis: THE NEXT QUESTION FROM M. SHERMAN IS: WHAT IS CONSIDERED A SEVERE

DISABILITY? WHY CAN'T THE GOVERNMENT DOLLAR BE SPENT ON MEDICAID WAIVER PROGRAMS INSTEAD OF LTSS. IT WOULD BE CONSIDERABLY MORE AFFORDABLE, AND I KNOW PEOPLE WOULD RATHER RESIDE IN THEIR HOME INSTEAD OF A FACILITY.

Dr. Wiener: THERE IS NO GOVERNMENT PAYMENT IN THE CLASS ACT FOR PREMIUMS. THIS IS ALL NEW MONEY THAT THE INSURED PUT INTO THE INSURANCE POOL. SO, IT'S NOT MONEY THAT CAN BE REDIRECTED TO MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS.

Lewis: OKAY. LOOKS LIKE MAYBE WE WILL TAKE ONE MORE MESSAGE HERE.

WILL THIS PROVIDE BETTER BENEFITS THAN THE LOW END GROUP WOULD RECEIVE?

Dr. Wiener: WELL, IF YOU QUALIFY FOR MEDICAID IT DEPENDS ON WHAT STATE YOU ARE IN. IT PROBABLY DOES NOT PROVIDE BETTER BENEFITS THAN WASHINGTON STATE BUT IT MIGHT PROVIDE BETTER BENEFITS THAN ALABAMA OR MISSISSIPPI. AND IT CLEARLY SINCE IT IS CASH BENEFIT, IT OFFERS THE WIDEST POSSIBLE CONSUMER CHOICE.

Lewis: OKAY. GREAT. I WANT TO THANK PEOPLE FOR ATTENDING. WE DO WANT TO DISMISS PEOPLE WHO WANT TO LEAVE AT THIS POINT. WE WOULD APPRECIATE FEEDBACK ON THIS WEBINAR. THE WEB ADDRESS IS [HTTP://WWW.PASCENTER.ORG/WEBCAST/FEEDBACK.PHP](http://www.pascenter.org/webcast/feedback.php).

I WILL PUT THAT UP ON THE SCREEN RIGHT NOW. YOU CAN GO THERE AND ANSWER THE

QUESTION ON YOUR SCREEN. WHILE THAT IS HAPPENING, LET ME COME BACK AND READ A COUPLE MORE SO ANYONE WHO WANTS TO LEAVE I REALIZE THERE WILL BE A LOT OF HANGING UP AND WHATNOT GOING ON. THERE ARE A COUPLE OF MESSAGES JOSH COULD TAKE. WE WILL TAKE THEM.

LYNN SAYS, I'M A CARE MANAGER FOR HCBP TRYING TO KEEP FRAIL ELDERS LIVING IN THEIR HOME. WE ARE SO OVERBURDENED BY THE REPORTING AND DOCUMENTATION REQUIREMENTS THAT IT MAKES IT DIFFICULT TO DO THE ACTUAL WORK WITH THE PATIENTS. ARE THERE ANY COMMUNITY-BASED PROGRAMS THAT DEVELOPED A STREAMLINE SYSTEM THAT MEETS THE REPORTING REQUIREMENTS THAT ALLOWS CARE MANAGERS TO DO MORE DIRECT PRACTICE WITH THE PATIENTS?

Dr. Wiener: WELL, PEOPLE USUALLY SPEAK HIGHLY OF THE SYSTEMS IN PLACE IN WASHINGTON STATE AND OREGON. I DON'T KNOW WHICH STATE THE QUESTIONER IS IN. BUT CLEARLY ONE OF THE ISSUES IS TRYING TO SET UP SYSTEMS THAT PROVIDE POLICYMAKERS AND MANAGERS WITH INFORMATION THEY NEED WITHOUT OVER BURDENING CARE MANAGERS. OBVIOUSLY THEY NEED TO SPEND THE TIME DEALING WITH THE CONSUMERS. IN THEORY, SOME KIND OF AUTOMATION AND COMPUTER REPORTING OUGHT TO EASE THAT PROBLEM, BUT THAT IS NOT ALWAYS THE CASE.

Lewis: OKAY. THERE IS A QUESTION ON, IS CONGRESS INCLUDED IN THIS INSURANCE PLAN OR WILL THEY KEEP AND THERE IS NO MORE. I'M

NOT SURE IF YOU CAN UNDERSTAND THE QUESTION FROM THAT OR NOT.

Dr. Wiener: WELL, THEY WOULD BE ELIGIBLE TO PARTICIPATE IN THE CLASS ACT AS FEDERAL EMPLOYEES. THEY WOULD ALSO BE ELIGIBLE TO PARTICIPATE IN THE VOLUNTARY FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM FOR LONGTERM CARE INSURANCE THAT IS AVAILABLE TO ALL FEDERAL EMPLOYEES.

Lewis: GREAT. AND I THINK WHERE WE ARE NOW IS EVERYBODY, I THINK WE HAVE OUR QUESTIONS, ROBERT IS ASKING ABOUT THE U.R.L. HERE IS THE U.R.L. FOR THE FEEDBACK. LET ME SAY IT AGAIN.

[HTTP://WWW.PASCENTER.ORG/WEBCAST/](http://www.pascenter.org/webcast/).

>> . I WANT TO THANK JOSH WIENER FOR HIS TIME AND A WONDERFUL PRESENTATION. I HOPE EVERYONE ENJOYED THAT. I APPRECIATE EVERYONE SPENDING THEIR TIME TO COME TO THE CENTER FOR PERSONAL ASSISTANT SERVICES WEB CAST. AND WE LOOK FORWARD TO SEEING YOU AGAIN ON FUTURE WEB CASTS. WE WILL BE ANNOUNCING THOSE ON OUR LISTSERV. THANK YOU VERY MUCH. THAT IS THE END OF THIS PRESENTATION.

Dr. Wiener: THANK YOU.