
Executive Summary

Long-term care includes a broad range of services needed by people with chronic illness or disabling conditions over a long period of time. In 2004-2005, Wisconsin's Medicaid program spent nearly \$2.2 billion on long-term care, about half on home and community-based programs (48%) and half on institutional care (52%). In 2003, Wisconsin ranked 11th highest in the nation for percent of elderly in a nursing home. Often forgotten is that most care for the elderly and disabled is provided free by family members and friends.

Policymakers are anticipating increased demand for long-term care services, because of an increasing elderly population and less time for families to care for the elderly and disabled. Caregivers are experiencing a heavy emotional and physical toll, and often have to make workplace accommodations to meet caregiving demands. Employers are concerned given recent national estimates that lost productivity due to caregiving responsibilities costs them between \$11 and \$29 billion each year. In response, this briefing report features three national experts who review how Wisconsin and other states are reforming long-term care policy.

The first chapter, written by **Wisconsin Family Impact Seminars** staff, reviews why there is so much interest in long-term care and encourages policymakers to consider the important role that families play. Long-term care needs are increasing because of technologies that keep people alive longer and the aging of the baby boomers. Of all the people in human history who have ever lived past the age of 65, half are alive today.

In Wisconsin, the proportion of elderly is growing from 13% of the population in 2000 to an estimated 21% in 2030. The fastest growing age group is those most likely to need long-term care services—the oldest old, those 85 years and older. In fact, in 2002, Wisconsin ranked 8th in the nation for percent of people aged 85 or older.

Informal caregivers, primarily family and friends, are the only source of care to 78% of the elderly and disabled who need long-term support. The value of this care, estimated to be three times the amount spent by Medicaid, does not show up in state or federal budget ledgers. Yet, in one study, 50% of elderly people with long-term care needs who lacked a family network lived in a nursing home, compared to 7% who had family caregivers.

Given data like these, some observers have recommended reframing the policy debate to the individuals, mostly family members, who provide most of the care. One central policy question is how we can supplement and strengthen family caregiving. States are supporting family caregiving in many ways, such as respite services, caregiver support programs, tax credits for caregiver expenses, and expansion of family and medical leave. The chapter concludes with criteria that policymakers can use to assess how family friendly long-term care legislation is.

Next, **Mark Meiners**, national director of the Robert Wood Johnson Medicaid/Medicare Integration Program, reports that Wisconsin is widely recognized as a leader for integrating long-term care services. The Wisconsin Partnership Program began in 1996 and operates through four non-profit health plans in selected locations. To improve access and quality, the Partnership Program fully integrates acute and long-term care for clients dually eligible for Medicaid and Medicare. The Partnership Program was able to achieve significant outcomes, even though payments were 5% less than in nonprogram sites. After one year in the Partnership Program, the number of nursing home days decreased 25% for the elderly. The program also decreased hospital use for the elderly and disabled, and prescription drug increases were well below the national average.

Family Care is a Medicaid-only program that was piloted in five Wisconsin counties in 2000. Family Care is administered by county care management organizations. Family Care relies on nurses and social workers to *coordinate* primary and acute care services, rather than to *provide* those services. Family Care has eliminated waiting lists for over three years now. In independent evaluations, members' health outcomes remained good and the cost savings were encouraging. Over the two-year study, Medicaid costs for Family Care members outside Milwaukee were, on average, \$452 less per month than in the comparison group; in Milwaukee, monthly costs were \$55 lower.

The bottom line is that no clear consensus has emerged about how best to integrate long-term care services. The direct link of Medicaid to Medicare in the Wisconsin Partnership Program is thought to be the most cost-effective way to care for the aged and disabled, because it allows full integration of all primary, acute, subacute, and long-term care dollars. Yet Medicare is still a difficult partner, and evaluations of Family Care suggest that significant improvements can be made with partial integration.

Roy Fredericks is the Estate Administration Manager of Oregon's nationally known estate recovery program. Oregon's program is based on this premise: if someone uses taxpayer resources for long-term care and if assets remain in their estate upon their death, it is fair that these assets go back to the taxpayers who have been footing the bill. The chapter begins by identifying ways that assets can be transferred between spouses to avoid estate recovery: (a) taking advantage of the penalty for transferring assets; (b) using court orders to transfer assets to the spouse during the Medicaid recipient's lifetime; (c) transferring interest in the home to one's spouse; and (d) transferring assets to annuities that are excluded in determining Medicaid eligibility.

In fiscal year 2003, Oregon recovered \$20 million or 2.2% of Medicaid long-term care expenditures; in contrast Wisconsin's recovered \$17.6 million or 0.8% of Medicaid long-term care expenditures. Oregon is able to recover an estimated \$14 for every dollar invested in the program using a number of best practices. For example, if Wisconsin expanded its definition of estate to include survivorship interests, life estate interests, living trusts, and remainder interests in client-centered annuities, recoveries could increase by an estimated 20% to 25%. Wisconsin could increase its recoveries by an estimated 10% to 15% by pursuing claims against the estate of the surviving spouse for assistance to the spouse who died first. Oregon has also made changes in its probate statutes to make the state a priority creditor, so that the state's interests are paid off before credit cards and other general creditors. In Oregon, the estate recovery unit must be notified of a client's death within 10 working days of the field unit's notification.

Oregon has generated public and political support for its program in several ways. First, any money that is returned to the state goes directly back into human services programs or to help other low income seniors and disabled clients. Second, when heirs want to keep the home, Oregon is willing to take a mortgage and have the family pay back in installments. Third, Oregon's public education program ensures that no client or their family is surprised when the state tries to recover the costs of public assistance. Finally, Oregon's program has highly qualified, well paid staff, who receive training on family-centered practices such as being sensitive to families grieving the loss of their loved one.

In the fourth chapter, **Charles Milligan** and **Ann Volpel** of the Center for Health Program Development and Management discuss two ways that states have entered into public-private partnerships in long-term care: managed care and long-term care insurance. Managed care is fairly common in the delivery of Medicaid acute care services across the nation, with 58% of Medicaid beneficiaries receiving their care this way. In contrast, managed care is rare in the delivery of long-term care services; only 3% of Americans who receive Medicaid long-term care services get them from a managed care organization. One state—Arizona—delivers all of its Medicaid long-term care services through managed care. Six states, including Wisconsin, have managed care programs for certain populations in the state. Of the managed care organizations providing care across the country, 70% are nonprofits and 15% are local government agencies (e.g., counties).

Another public-private venture involves long-term care insurance. Four states (California, Connecticut, Indiana and New York) currently participate in the Long-Term Care Partnership Program. Only 1.3% of the 212,000 people who purchased policies have ever received insurance benefits, and almost 900 people died while receiving benefits. Yet, it is unclear if these facts mean that the Medicaid program saved money. Although many other states are interested in joining the Partnership Program, it cannot be expanded nationwide unless Congress changes the federal estate recovery statutes to relax the asset requirements of individuals who purchase insurance policies. Wisconsin currently has legislation on the books that requires the Department of Health and Family Services to seek federal approval and financing for projects that would allow Wisconsin Medicaid recipients to keep more of their assets if they purchase long-term care insurance.