ISSUE BRIEF
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Improving Benefits and Integrating Care for Older Medicare Beneficiaries with Physical or Cognitive Impairment

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ABSTRACT

Issue: Two-thirds of Medicare beneficiaries with physical and/or cognitive impairment (PCI) who live in the community have three or more chronic conditions and could benefit from integrated medical and social services. Over one-third of those with PCI have incomes under 200 percent of the federal poverty level but are not covered by Medicaid, exposing them to risk of financial burdens and nursing home placement. **Goal:** To analyze two policy options that expand financing for home- and community-based care for older adults with PCI. **Methods:** Potential costs are estimated using the Medicare Current Beneficiary Survey. **Key findings and conclusions:** Medicare Help at Home–a proposal to add supplemental home- and community-based services–could be financed by income-related cost-sharing, beneficiary monthly premiums of $42, and an incremental payroll tax on employers and employees of 0.4 percent. This could produce savings to Medicaid of $1.6 billion over 14 years. Using a different option–an extension of Medicaid Community First Choice–would cost $16,224 per person assisted, with costs offset by reduced nursing home placement.

BACKGROUND

When Medicare was enacted in 1965, its major goals were to ensure access to physicians and hospital care and to provide financial protection for beneficiaries against high costs. As life expectancy has increased and the cost of caring for people with physical and cognitive impairments has risen, the issue of providing access to long-term services and supports—particularly those that could support aging beneficiaries in living independently—has taken on greater urgency.

An estimated 4.5 million Medicare beneficiaries age 65 and older have serious impairments, and an additional 7.5 million have mild cognitive impairment. Older adults with serious physical and/or cognitive impairments (PCI) are at higher risk for chronic conditions: almost two-thirds of community-dwelling Medicare beneficiaries with PCI have three or more chronic conditions; 96 percent with PCI have at least one chronic condition.[1]

Most of these beneficiaries need medical care services, which Medicare covers, and home- and community-based care, most of which Medicare does not cover.

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Medicare's omission of home- and community-based care also puts older adults at risk of exhausting their savings, entering nursing homes to receive the care they need, and qualifying for Medicaid. Although Medicaid may cover home- and community-based services for those who are very poor, 33 percent of individuals with serious physical impairment, 37 percent of individuals with mild cognitive impairment, and 39 percent of individuals with dementia have incomes below 200 percent of the federal poverty level but are not covered by Medicaid.[2] Moreover, when people do qualify for both Medicare and Medicaid, the disjointed financing system contributes to fragmented care. That is, beneficiaries do not receive a plan of care that takes into account the full array of services they need and their preferences for care and living arrangements.

This brief examines two policy options to support community-dwelling older adults with long-term services and supports and provides estimates of potential costs, assuming robust enrollment, using the Medicare Current Beneficiary Survey, Cost and Use File, 2012, inflated to 2016. (See How This Study Was Conducted.) A companion brief, *Risks for Nursing Home Placement and Medicaid Entry Among Older Medicare Beneficiaries with Physical or Cognitive Impairment,* provides the rationale for the policy options analyzed in this issue brief.[3]

POLICY OPTIONS TO IMPROVE FINANCING FOR HOME- AND COMMUNITY-BASED CARE

The need for comprehensive long-term care financing will grow as the population ages. There are currently multiple proposals for funding long-term services and supports for older Medicare beneficiaries. Some are organized around providing catastrophic coverage for those who have experienced severe impairment for some minimum period of time, while others are designed to provide benefits immediately.[4] Barriers to these proposals include the cost of such coverage, the limited market for long-term care private insurance, and concerns about adverse risk selection.[5]

Two targeted options could help older adults with PCI continue to live independently at home or in the community in independent-living group residences. The first option would provide a benefit for home- and community-based care under Medicare. This would have a potential offsetting savings from delaying or reducing Medicaid coverage and nursing home placement. The second policy option would extend the Medicaid Community First Choice program to all low-income older adults.

Medicare Help at Home

Medicare Help at Home is a policy proposal to add a supplemental home- and community-based services coverage option for Medicare beneficiaries.[6] The benefit option would be available for enrollment upon eligibility into Medicare by paying a premium. Qualified individuals—those with PCI—would receive up to 20 hours a week of personal care or an equivalent cash benefit (up to $400 per week or $20,800 a year) for other home- and community-based care. Beneficiaries who receive services would contribute toward their cost, ranging from 5 percent of cost for those with incomes below 150 percent of the federal poverty level, to 15 percent for those with incomes between 150 percent and 199 percent of poverty to 25 percent for those with incomes between 200 percent and 399 percent of poverty, and up to 50 percent for those with incomes at or above four times the poverty level. Based on the eligible population and assumptions about participation and utilization rates, we estimate that the Medicare Help at Home benefit could be financed by monthly premiums of

approximately $42 paid by all Medicare beneficiaries and an incremental payroll tax on employers and employees of 0.4 percent each (Exhibit 1). To reduce adverse risk selection, beneficiary premiums would be increased for those delaying take-up of the option after qualifying for Medicare, similar to late enrollment premiums under Medicare Parts B and D.

Exhibit 1

Medicare Help at Home Impact Estimates for Community-Dwelling Individuals with PCI Who Are Not on Medicaid

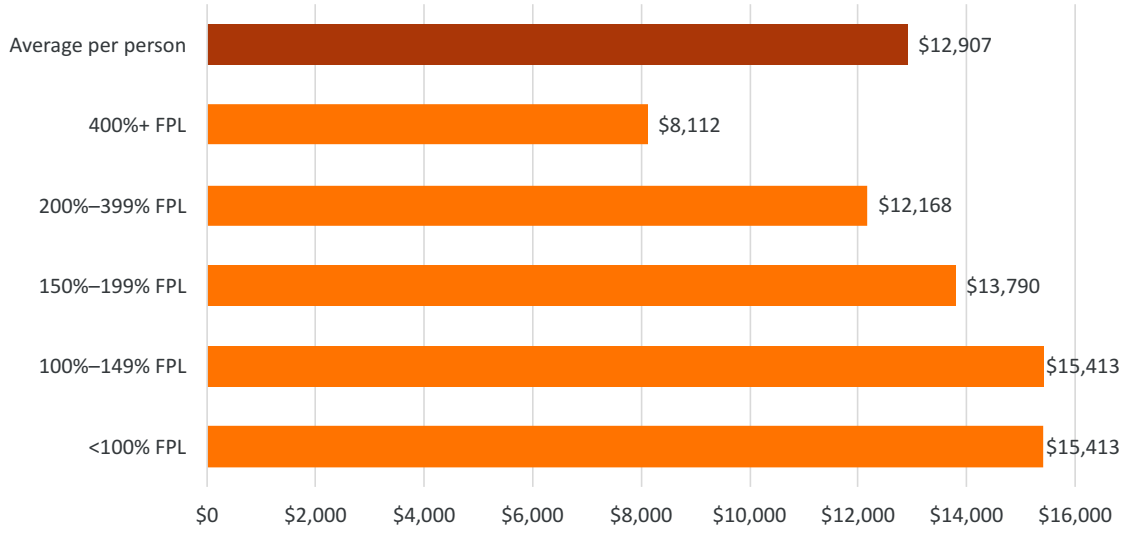
Beneficiaries with PCI	8,457,000
Assuming 75% of beneficiaries participate	6,343,000
Maximum annual benefit per beneficiary	$20,800
Total cost[a]	$102,908,000,000
PCI coinsurance[b]	20%
Beneficiary payments	$21,041,000,000
Medicare payments	$81,867,000,000
Financing	
Premiums: 25%	$16,373,000,000
Monthly premium per beneficiary[c]	$41.60
Payroll tax: 75%	$61,400,000,000
Employer contribution[d]	0.40%
Employee contribution[d]	0.40%

[a] Assuming 60% full year; 40% half year.
[b] Ranges from 5% for those at <100% FPL to 50% for those at 400%+ FPL.
[c] Assuming 75% of all beneficiaries purchase benefit.
[d] Estimate based on CBO estimates that 1% payroll tax in 2016 would generate $77 billion.
Data: Estimates based on PCI beneficiary and poverty counts from the Medicare Current Beneficiary Survey, Cost and Use File, 2012, by the Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health. CBO payroll tax estimate from Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (CBO, Nov. 13, 2013).

As noted in our companion brief, lower-income Medicare beneficiaries are more likely to have physical and cognitive impairment than are higher-income beneficiaries and to spend more than 10 percent of their income out-of-pocket on both medical care and long-term services and supports. They would be the most likely to obtain improved access to services and the greatest relief from out-of-pocket costs and most likely to participate. However, even higher-income beneficiaries are likely to value the asset protection and independent living the benefit provides. Exhibit 2 shows the average benefit for a person receiving Medicare Help at Home services. The benefit would range from over $15,000 per person for those with incomes below 150 percent of poverty to slightly more than $8,000 per person for those with incomes greater than 400 percent of poverty.

Exhibit 2

Medicare Help at Home Average Benefit, by Income



Data: Analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, by the Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health.

Overall, our analysis assumes that 75 percent of elderly and disabled Medicare beneficiaries would participate, based on experience with Medicaid participation and Medicare Part D participation.[7] While long-term care insurance has had quite modest take-up, only one-fourth of the cost of the Medicare benefit would be financed through premiums. This would make the net value of the benefit attractive, even to higher-income individuals. Take-up could be enhanced by information campaigns, like "Own Your Future," that stress that more than half of individuals who live to age 65 will at some point experience PCI and require long-term services and supports.[8]

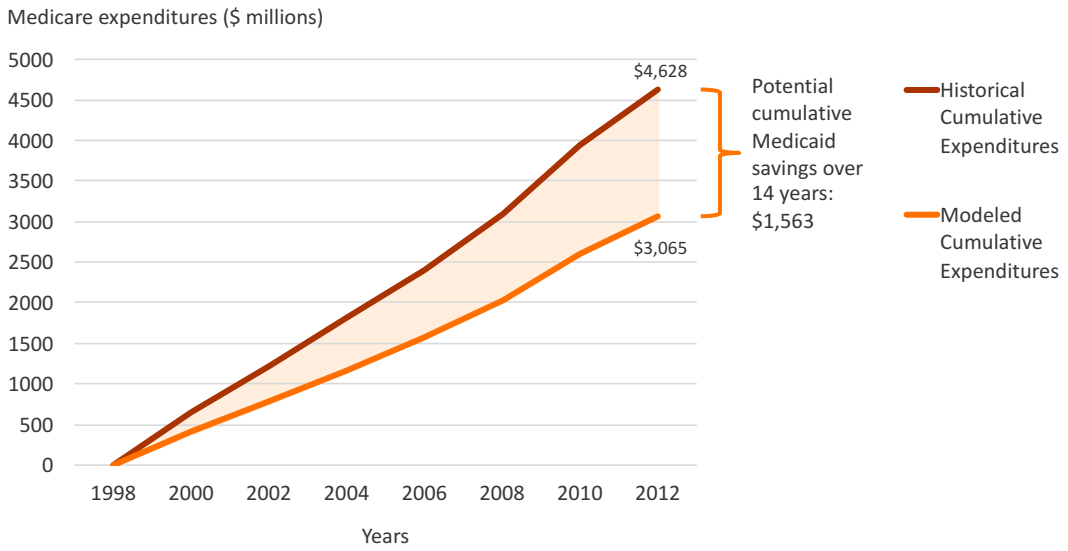
The benefit could improve access to home- and community-based long-term services and supports; reduce the financial burden of out-of-pocket costs; assist family caregivers in providing support to maintain independent living longer; reduce health risks such as falls, pressure ulcers, and infections; and prevent avoidable hospitalization and emergency room use. Most of these benefits would be realized by enrollees; however, if well designed, the benefit could at least partially offset federal budget outlays by reducing entry into Medicaid and lowering use of costly hospitalizations and nursing homes.

Savings Potential from Reduced Medicaid Entry

As shown in Exhibit 3, the offsetting savings from reducing or delaying entry into Medicaid would grow over time. In the accompanying brief, we found that after 14 years, 19 percent of the PCI population with high out-of-pocket expenses entered Medicaid, compared with 12 percent of those without such expenses. If people with high out-of-pocket expenses received a benefit to ensure they had adequate financial protection, 120,000 fewer Medicare beneficiaries would be covered by Medicaid after 14 years; in that year, the Medicaid program would save $220 million. The cumulative savings throughout the 14-year period would be $1.6 billion (see Appendix Exhibit 1).

Exhibit 3

Medicare Help at Home Benefit Would Have Produced Cumulative Savings of $1.6 Billion to Medicaid from 1998 to 2012



Data: Analysis of the Health and Retirement Study, 1998–2012, by the Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health.

Savings Potential from Delivery System Reform

The Medicare Help at Home proposal also has provisions to improve the coordination and quality of care that beneficiaries receive. Through reduced cost-sharing, beneficiaries would have an incentive to receive care from newly created organizations that would be accountable for integrating medical and social services and providing person-centered, home-based medical and social services. These organizations, called integrated care organizations (ICOs), would be an extension of accountable care organizations, but unlike ACOs would share in savings from reduced long-stay nursing facility placement. ICOs would be responsible for integrating medical and social services, care coordination, and support of family caregivers, and for ensuring that an individualized plan of care is developed and implemented based on patient and family preferences. ICOs would report on quality of care and how well the ICO is able to meet patient and family preferences for care and independent living.

ICOs would be encouraged to adopt promising models for delivering physician and hospital services in the home for people with limited mobility or cognitive functioning. The Center for Medicare and Medicaid Innovation and other funders have tested various models and identified particularly promising approaches. For example, demonstrations by the Centers for Medicare and Medicaid Services have found improved care and savings from Independence at Home, which provides home-based care using primary care teams.[9] Other promising models include Hospital at Home for select conditions,[10] the Program of All-Inclusive Care for the Elderly (PACE), palliative care at home and in residential hospice settings, and group models of housing such as Green House.[11] Social service models that facilitate independent living include the Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program, which uses an interdisciplinary team consisting of a nurse, an occupational therapist, and a handyman,[12] and Maximizing Independence for Persons with Dementia (MIND) at Home, which uses memory care coordinators supervised by geriatric psychiatrists and nurses to deliver a personalized, adaptable care plan and support for family caregivers.[13]

These innovative models and others that are developed over time would be in the ICO toolbox, with options tailored to beneficiary preferences about where they live and receive care.

Delaying nursing home placement could result in substantial savings to families and to the Medicaid program, which pays for 32 percent of all nursing home care.[14] Exhibit 4 displays the potential savings that could be achieved by delaying nursing home placement for people with dementia or cognitive impairment by nine months. A care model focused on supporting independent living that succeeded in delaying nursing home placement by nine months would result in 1.39 million fewer person-years of long-term nursing stay residence, at a total savings of $111.5 billion over 14 years, approximately 32 percent or $35 billion of which would be savings to the Medicaid program. There are an estimated 6 million Medicare beneficiaries with mild cognitive impairment without dementia, and 2.4 million with dementia, who could potentially benefit from such services, at a savings per person of more than $13,000.

Exhibit 4

Potential Savings from Delaying Nursing Home Placement by Nine Months for Community-Dwelling Older Medicare Beneficiaries with Cognitive Impairment

	Risk group		
	Mild cognitive impairment	Dementia	Total among cognitively impaired
Proportion of population by risk group	19%	8%	27%
Population	5,986,835	2,393,494	8,380,328
Percent in nursing home over 14 years *(column %)*	22%	22%	22%
Average time to nursing home (years)	7.08	5.35	6.59
Delay entry into nursing home by nine months			
Total number of years saved	1,004,890	389,182	1,394,072
Total $ saved per person in population	$13,428	$13,008	$13,308
Total $ saved over 14 years	$80,391,216,963	$31,134,566,648	$111,525,783,611

Data: Analysis of the Health and Retirement Study, 1998–2012, by the Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health.

Medicaid Community First Choice Extension to All Low-Income Individuals at Risk

Under a Medicaid Community First Choice program included in the Affordable Care Act, states have the option of covering home- and community-based care. This includes personal care services provided by family members (other than the legally responsible guardian such as a spouse or adult child) for PCI individuals eligible for nursing home placement with incomes up to 150 percent of poverty. The federal matching rate is increased by six percentage points for these services. Seven states have implemented this optional benefit, and an additional two states have State Plan Amendments under review.[15]

One policy option would build on experience with Community First Choice by extending Medicaid to all elderly and disabled Medicare beneficiaries with incomes up to 200 percent of poverty who would otherwise qualify for long-stay nursing home care. This would primarily benefit

2.5 million low-income individuals with PCI with incomes between 100 percent and 200 percent of poverty, assuming 75 percent participation. Exhibit 5 illustrates that the cost would be on the order of $40 billion annually, or $16,224 per person assisted. Without such benefits, many of these individuals would need to obtain nursing home care, with an average cost of $80,000 a year, or an annual cost of $264 billion. The proposed policy option could save Medicaid up to $84 billion annually. If as many as 50 percent of newly eligible individuals avoided nursing home care, the savings to Medicaid would offset the cost. In addition, Medicare beneficiaries would receive savings from costs that they must now bear themselves.

Additionally, Medicaid could be expanded to include disabled individuals who are not covered by Medicare but who would otherwise qualify for long-stay nursing home care. As shown in Exhibit 5, an additional 1.6 million community-dwelling non-Medicare individuals under age 65 with incomes below 200 percent of poverty but not covered by Medicaid could be covered for an additional $27 billion.

Exhibit 5

Potential Cost of Extending Medicaid Community First Choice

	Community-dwelling Medicare beneficiaries with PCI at 100%–200% FPL and not on Medicaid	Community-dwelling non-Medicare beneficiaries with PCI under age 65 at below 200% FPL and not on Medicaid
Individuals with PCI	3,293,415	2,139,505
Assuming 75% of beneficiaries participate	2,470,061	1,604,629
Maximum annual benefit per person	$20,800	$20,800
Total cost[a]	$40,074,270,875	$26,701,022,400

[a] Assuming 60% full year; 40% half year.
Data: Analysis of the Medicare Current Beneficiary Survey, Cost and Use File, 2012, and the Health and Retirement Study, 2012, by the Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health.

CONCLUSION

With carefully targeted design, the cost of home- and community-based care could be financed under Medicare through a combination of income-related cost-sharing, affordable premiums, and a modest increase in payroll tax for employers and employees. Alternatively, Medicaid could be expanded to cover home- and community-based care to at-risk, low-income individuals. This option would shift care into the home and community and avoid long-stay nursing home care—a costly alternative that most older adults wish to avoid.

Improving financing for home- and community-based care, whether under Medicare or Medicaid, would help beneficiaries with PCI continue to live independently and support the families who care for them. Incorporating innovative team-based models of care, delivering more services in the home for those with mobility and cognitive impairments, and redirecting resources to the types of care preferred by beneficiaries hold promise to reduce costly avoidable hospitalization and long-stay nursing home care. By intervening before beneficiaries become impoverished by the cost of home- and community-based services, we could extend their years of independent living, reduce long-term institutionalization, and prevent the exhaustion of assets that results in Medicaid enrollment. Both options would improve quality of life for older adults while making more effective use of resources.

HOW THIS STUDY WAS CONDUCTED

This study uses the Medicare Current Beneficiary Survey (MCBS), Cost and Use File, 2012, a nationally representative survey of Medicare beneficiaries of all ages who reside in the community or in a facility. The 2012 Cost and Use File contains the survey and linked claims data for 11,299 Medicare beneficiaries. We focused on community-dwelling Medicare beneficiaries with physical and/or cognitive impairment as the target population for the proposed Medicare Help at Home benefit. To generate nationally representative estimates, survey weights are applied to all analyses. The weighted population represents 50 million Medicare beneficiaries living in the community. This study also relies on analyses using the Health and Retirement Study, a longitudinal, nationally representative study of Americans age 50 and older. These analyses are described in greater detail in the companion brief *Risks for Nursing Home Placement and Medicaid Entry Among Older Medicare Beneficiaries with Physical or Cognitive Impairment*.[16]

To estimate the potential costs of offering a benefit, we specified a maximum benefit of 20 hours a week of supportive home care. Medicaid already provides long-term services and supports; thus we restricted the cost analysis to beneficiaries with two or more functional impairments or dementia who were not on Medicaid based on the MCBS. We assumed that 75 percent would participate in any given year.[17] We made the simplifying assumption that 60 percent would receive care for the full year at the maximum benefit level and the rest would receive care either part of the year or fewer hours a week, with an assumed average of 10 hours a week averaged over the year.[18]

Calculations for the potential savings from reduced Medicaid entry or nursing home placement were based on the analyses in the accompanying brief referenced above. Medicaid savings were based on average annual Medicaid spending per enrollee ($13,249) from the Kaiser Family Foundation's "State Health Facts."[19] These savings were then applied to the population with high out-of-pocket spending who would not have entered Medicaid had they followed the same rate of entry as the group who did not have high out-of-pocket spending. The savings from nursing home placement were based on the median annual cost of a semiprivate nursing home room ($80,000).[20]

Appendix Exhibit 1

Trajectory of Older Medicare Beneficiaries with High Out-of-Pocket Costs into Medicaid, Current and Reduced Rate

Based on Low Out-of-Pocket Trajectory over 14 Years

	Current rate for high out-of-pocket costs			Assuming same rate as low out-of-pocket costs			
Years	Cumulative percent enter into Medicaid	Counts	Cumulative cost to Medicaid	Cumulative percent enter into Medicaid	Counts	Cumulative cost to Medicaid	Cumulative savings
1998	0%	0	0	0%	0	0	0
2000	3%	48,544	$643,157,829	2%	31,740	$420,526,273	$222,631,556
2002	5%	92,189	$1,221,406,191	3%	59,270	$785,270,973	$436,135,219
2004	7%	136,561	$1,809,292,026	5%	88,195	$1,168,496,070	$640,795,956
2006	10%	181,554	$2,405,408,263	6%	118,436	$1,569,157,910	$836,250,353
2008	13%	233,805	$3,097,682,634	8%	153,409	$2,032,511,544	$1,065,171,090
2010	16%	297,502	$3,941,609,755	11%	196,250	$2,600,119,745	$1,341,490,010
2012	19%	349,298	$4,627,852,339	12%	231,338	$3,064,990,861	$1,562,861,478

Source: Analysis of the Health and Retirement Study, 1998–2012, by the Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health.

NOTES

[1] A. Willink, K. Davis, and C. Schoen, *Risks for Nursing Home Placement and Medicaid Entry Among Older Medicare Beneficiaries with Physical or Cognitive Impairment* (The Commonwealth Fund, Oct. 2016).

[2] Ibid.

[3] Ibid.

[4] M. M. Favreault, H. Gleckman, and R. W. Johnson, "Financing Long-Term Services and Supports: Options Reflect Trade-Offs for Older Americans and Federal Spending," *Health Affairs* Web First, published online Nov. 16, 2015; Bipartisan Policy Center, Long-Term Care Initiative, *Initial Recommendations to Improve the Financing of Long-Term Care* (BPC, 2016); S. Glied, "The Community Living Assistance Services and Supports Act (CLASS)," testimony before the Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Subcommittee on Health, U.S. House of Representatives, Oct. 26, 2011; K. Davis, A. Willink, and C. Schoen, "Medicare Help at Home," *Health Affairs Blog,* April 13, 2016; and B. Chernof, M. Warshawsky, J. Anwar et al., *Commission on Long-Term Care—Report to Congress* (U.S. Senate, Sept. 30, 2013).

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[8] M. M. Favreault and J. Dey, *Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief* (Assistant Secretary for Planning ane Evaluation, 2015); and Centers for Medicare and Medicaid Services, "Own Your Future: Planning Guide for Long-Term Care," informational brochure, pub. no. CMS-11026 (U.S. Department of Health and Human Services, Dec. 2002).

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[14] Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditure Tables 2014," NHE Fact Sheet (CMS, 2015).

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[16] A. Willink, K. Davis, and C. Schoen, *Risks for Nursing Home Placement and Medicaid Entry Among Older Medicare Beneficiaries with Physical or Cognitive Impairment* (The Commonwealth Fund, Oct. 2016).

[17] B. Sommers, R. Kronick, K. Finegold et al., *Understanding Participation Rates in Medicaid: Implications for the Affordable Care Act* (Assistant Secretary for Planning and Evaluation, March 2012).

[18] J. L. Wolff, K. Davis, M. Leeds et al., *Family Caregivers as Paid Personal Care Attendants in Medicaid* (Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins University, 2016).

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[20] *Genworth Cost of Care Survey* (Genworth Financial, Inc., 2016).

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