The Past and Future of Long-Term Care: 1989 to 2039

May 28, 2014
Financing Long-Term Care: More Same Than Different, But With Some Twists

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Problems of Long-Term Care Financing

- Services are expensive
- Medicare not cover and few people have private insurance
- Routine catastrophic costs
- Primary source of financing is Medicaid, a means-tested welfare program
- Institutional bias in financing
- With aging population, costs are certain to grow
### Financing for Long-Term Care: 1989 and 2011, ($ billions)

<table>
<thead>
<tr>
<th>Financing Source</th>
<th>1988</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>24.4</td>
<td>136.2</td>
</tr>
<tr>
<td>Medicare</td>
<td>2.9</td>
<td>62.5</td>
</tr>
<tr>
<td>Other payers</td>
<td>5.0</td>
<td>9.7</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>15.7</td>
<td>45.5</td>
</tr>
<tr>
<td>Private insurance and other private</td>
<td>4.0</td>
<td>24.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52.0</strong></td>
<td><strong>278.3</strong></td>
</tr>
</tbody>
</table>

Source: Truven Health Analytics, various years; Centers for Medicare & Medicaid Services, various years; National Health Policy Forum.
## Medicaid Expenditures for LTC, 1988 and 2011 (in $ billions)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>1988</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-institutional LTC Services</td>
<td>2.4</td>
<td>64.3</td>
</tr>
<tr>
<td>Nursing home</td>
<td>14.6</td>
<td>52.4</td>
</tr>
<tr>
<td>ICF-IID</td>
<td>5.9</td>
<td>13.3</td>
</tr>
<tr>
<td>Mental health facilities and mental health DSH</td>
<td>1.5</td>
<td>6.2</td>
</tr>
<tr>
<td>Total LTC</td>
<td>24.4</td>
<td>136.2</td>
</tr>
<tr>
<td>Total Medicaid</td>
<td>58.6</td>
<td>410.9</td>
</tr>
</tbody>
</table>

Source: Truven Health Analytics, various years
Medicaid (cont.)

- Eligibility standards fairly stable
  - Spousal impoverishment provisions as part of Medicare Catastrophic Coverage Act
  - Some tightening of related to transfer of assets and estate recovery

- Conservatives propose to block grant Medicaid:
  - Hard to achieve savings without cutting services for older people and persons with disabilities
  - Unclear how to achieve savings

- Liberals have few proposals to liberalize Medicaid, focusing on public insurance
Medicare

- Historically, Medicare a trivial portion of Medicare and of nursing home and home care expenditures
- 1989: Change in definition of skilled care
- Medicare SNF, home health and hospice as percentage of Medicare expenditures:
  - 1988: 3.6%, 2011: 18.3%
- High Medicare SNF payments change dynamics of nursing home industry
- Medicare quality measures for public reporting
## Medicare Post-Acute Care Expenditures (in $ billions)

<table>
<thead>
<tr>
<th>Service</th>
<th>1988</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facilities</td>
<td>1.0</td>
<td>30.3</td>
</tr>
<tr>
<td>Home Health</td>
<td>1.9</td>
<td>18.5</td>
</tr>
<tr>
<td>Hospice</td>
<td>0.0</td>
<td>13.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2.9</td>
<td>62.5</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services, 2012
Private Long-Term Care Insurance

- “The Dream”
- Market begin in mid-1980s, prior to that long-term care thought to be uninsurable
- 1988: 0.5 million policies; 2010: 7.3 million policies
- After 25 years, about 6% of 45+ have private long-term care insurance; 12% of 65+
Number of People with Private Long-Term Care Insurance, 1992-2010

Source: National Association of Insurance Commissioners, 2011
Private Long-Term Care Insurance (cont.)

- Market collapse:
  - Most insurers exit market
  - Most insurers have substantially raised premiums (100% not unusual), including on existing policyholders
  - Tighten underwriting and reduce benefits

- What’s going on?
  - Low to negative rate of return on reserves
  - Lower lapse rate than assumed
  - For most insurers, a minor part of business
Social Insurance

- Germany, Japan, Taiwan, Spain, and South Korea implemented social insurance
- US: Many proposals, no action
- 1988-1989: Many Democratic legislative proposals for social insurance programs
- 1990: Pepper Commission
- 1993: Clinton health plan
- 2010: Community Living Assistance Services and Supports (CLASS) Act
- 2013: Long-Term Care Commission not propose social insurance
Public Long-Term Care Expenditures as a Percentage of Gross Domestic Product, 2005 and 2050
Conclusions

- Key question: Are we willing to pay the additional cost?
- Key question: Individual vs. social responsibility
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Past and Future of LTSS Quality

Charlene Harrington, Ph.D. RN, Professor
University of California San Francisco
Last 25 Years Since Nursing Home Reform Act -- OBRA 1987

- Eliminated ICFs – all meet NF standards
- Developed new regulations and ratings for scope and severity of deficiencies
- Established sanction procedures
- Implemented the MDS assessment system
- Developed quality measures
- Adopted QIS survey process
- Testing NH value purchasing
Medicare Nursing Home Compare


Established by CMS in 1999   Added 5–star Rating 2007

• Facility characteristics – location, size, ownership

1. State in-person annual inspection and complaint surveys with federal requirements
   • Quality – (scope and severity of violations
   • Life safety violations

2. Nurse staffing hours
   • RNs, LVNs, NAs, total hours
   • Adjusted for resident case mix

3. Resident Quality Measures – MDS 3.0/RAI
   • 18 measures
Average Deficiencies Per Nursing Home From Surveys & Complaints

1994: 7.2
1998: 5.2
2002: 6.1
2006: 7.2
2010: 6.2
2014: 6.8

Harrington et al., CASPER and CMS NH Compare, 2014
Facilities with Harm/Jeopardy Deficiencies from Annual & Complaint Surveys

Harrington et al. CASPER Data

- 2003: 25%
- 2005: 26%
- 2006: 28%
- 2008: 26%
- 2010: 23%
- 2011: 22%
33% of Medicare nursing home residents had adverse events or harm during their SNF stays in 2013
  - 59% of those were preventable – due to substandard treatment, inadequate resident monitoring and failure or delay in care.
  - Over 50% with harm returned to a hospital with a cost of $2.8 billion [Link](http://oig.hhs.gov/oei/reports/oei-06-11-00370.asp)

25% of Medicare nursing home residents were readmitted to a hospital in FY 2011
  - cost $14.3 billion
  - for septicemia and other common problems
  - [Link](http://oig.hhs.gov/oei/reports/oei-06-11-00040.asp)

Recent research shows stronger state enforcement improves quality outcomes
  - (Mukamel et al. 2012, Health Services Research)
Average Nursing Home Nurse Staffing in the US in Hours Per Resident Day


<table>
<thead>
<tr>
<th>Year</th>
<th>CNAs</th>
<th>LPNs</th>
<th>RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>3.5</td>
<td>2.1</td>
<td>0.7</td>
</tr>
<tr>
<td>2000</td>
<td>3.7</td>
<td>2.3</td>
<td>0.7</td>
</tr>
<tr>
<td>2004</td>
<td>3.6</td>
<td>2.3</td>
<td>0.7</td>
</tr>
<tr>
<td>2008</td>
<td>3.8</td>
<td>2.4</td>
<td>0.8</td>
</tr>
<tr>
<td>2010</td>
<td>3.9</td>
<td>2.4</td>
<td>0.8</td>
</tr>
<tr>
<td>2014</td>
<td>4.1</td>
<td>2.5</td>
<td>0.8</td>
</tr>
</tbody>
</table>
CMS 18 NH Quality Measures
MDS Version 3.0

Long Stay Measures
- Falls with major injury
- Urinary Track Infection
- Moderate to severe pain
- Pressure ulcers – high risk
- Incontinence – low risk
- Catheter
- Physical restraints
- Need for help increased
- Weight loss

Short Stay Measures
- Depression
- Flu vaccinations
- Pneumonia vaccinations
- Antipsychotic RX

CMS 5–Star NH Compare 2014
Nursing Home Quality Measures for 1.4 Million Residents

Impacts 14,000 to 300,000 residents
MDS data Medicare NH Compare

24% 21%
6% 7%
4% 1%
7% 6%
11% 8%
8% 6%
14% 15%

Antipsychotics
Weight loss
Restraints
Pressure ulcers
Pain
UTIs
Need for help worse

2012
2014
1999 - Medicare-certified HHAs must assess residents & submit OASIS data for payment

2010: Major revision implemented and new HH quality measures being developed

Medicare Home Health Compare
- Has quality measures (not audited)
- Home Health Consumer Assessment of Health Care Providers and Services (HHCAHPS)

No deficiency and complaint data

Infrequent state inspections of HHAs
Changes in Home Health Quality Measures

CMS CMS OASIS data 2014

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2009</th>
<th>2014</th>
</tr>
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<tbody>
<tr>
<td>Admitted to hospital</td>
<td>28%</td>
<td>22%</td>
<td>16%</td>
</tr>
<tr>
<td>Had less pain</td>
<td>60%</td>
<td>64%</td>
<td>68%</td>
</tr>
<tr>
<td>Better at taking meds</td>
<td>38%</td>
<td>43%</td>
<td>51%</td>
</tr>
<tr>
<td>Better at walking/moving</td>
<td>37%</td>
<td>46%</td>
<td>61%</td>
</tr>
</tbody>
</table>
Residential Care and Home Care/Personal Care Services

- Many quality problems in Residential Care
- No federal quality regulatory system
- New CMS efforts to develop quality measures and CAHPS surveys for HCBS
- Minimal state regulations for personnel, client assessment, and service delivery
- Minimal state oversight & sanctions
- Minimal or no state data on quality
- Clients may not complain – fear of losing their provider or services
Conclusions

- Major effort is needed to improve regulatory oversight and quality for all LTSS

- Quality measures are needed for residential care and HCBS

- Data reporting needs to be improved in terms of availability and accuracy for LTSS quality measures
Changing Patterns of LTC Service Delivery

Pamela Doty, Ph.D.
Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
Major Trends over Last 25+ Years – All Elderly with LTC Needs

- Decreased reliance on nursing home care.
- Increased use of other residential care settings ("assisted living," board and care, adult foster care, elder housing with services).
- Nursing home "culture change."
- Use of any paid home care increased, then decreased; currently only slightly higher than it was 25-30 years ago.
- Growing reliance on assistive technologies and home modifications, less on human assistance (paid/unpaid).
- Medicaid has been “rebalancing” away from its longstanding, widely criticized “institutional bias” toward great funding of HCBS, but less so for elderly than for other subgroups.

- More “consumer(participant)-directed” (PD) HCBS for Medicaid and other public program participants.

- States with more PD for elderly/younger non IDD disabled have higher ratio of spending on HCBS compared to ILTC for those populations.

- Fee-for-service to managed care. Recent and accelerating.
Back in 1980, when Josh Wiener and I first met and worked together in the Office of Policy Analysis in the Health Care Financing Administration (now CMS), we helped write a report entitled “Long-Term Care: Background and Future Directions.” It included projections that the U.S. nursing home population would grow from 1.3 million in 1977 to 2 million as of 2000.

Instead there were 1.5 million NF residents in 2000 and only 1.4 million in 2011, despite population growth.
Since 1995 or thereabouts, growing numbers have gone to other residential care settings.

These include: assisted living and related facilities (e.g. personal care homes), board and care homes, adult family foster care, senior housing with services, including independent living providing meals, housekeeping, and social/recreational services only.

Data sources variably estimate the numbers of elderly in such “non-nursing home” settings as between .8 and 2 million. (At least 1/3 of NF + non NF).
• 43% of RCFs have at least one Medicaid resident – but estimates of percentage of RCF residents on Medicaid range from 15-20% to 33 percent.

• According to a 2013 CBO report, 66% of elderly NF residents are on Medicaid compared to 33 percent of elderly residents in other RCFs, 13 in senior housing with support services, and 11 percent of elderly living in private homes.

• Medicaid does not pay for room and board outside of nursing homes; most elderly who are financially eligible for Medicaid cannot afford to pay these charges except in board and care facilities oriented toward SSI (income assistance) clientele.
• Private LTCI claimants use of assisted living and home care is roughly equal.

• Only 1 in 5 ever used nursing home care over 30 month longitudinal follow-up. Short-term, end of life stays.

• Private LTCI expenditures on LTC, as measured in CMS’ National Expenditure Accounts is low, but database does not count services high share of claimants use (assisted living and individually hired home care aides, who were 1/3 of home care aides).
• Growth of RCF alternatives has spurred NF “culture change” movement (e.g. Pioneer Network, “Green Houses”, etc.).

• Aims to make NFs smaller, more home-like, more supportive of independence and choice like “assisted living” ideal.
A Commonwealth Fund study (2007) characterized 31% of NFs surveyed as culture change “adopters” (all or most indicators of culture change present), 25% as “strivers” (fewer changes yet made but leadership committed to change) and 43% as “traditional.”

Adopters gained competitive advantages over other NFs.

**Culture Change NFs more Competitive**
A by-product of the growth of RCFs, differences in models and state regulation of them, is CMS’ effort to define in regulation “HCBS” settings in order to avoid paying for services in “non-NFs” that are “institutional” in character.
• 31 percent of National Long-Term Care Survey respondents (community-dwelling elderly receiving human assistance with basic and/or instrumental daily living tasks) received any paid care in 1984; increased to 43 percent in 1994; went back down to 35 percent in 2004.

• 2011 National Health and Aging Trends (NHATS) respondents: only 35% received any paid care. And only 21% living “at home” as distinct from other non-NF supportive residential settings received any paid help.
1989-1994: liberalized coverage rules (due to a lawsuit) greatly increased use of Medicare home health services, especially home health aide services over lengthy episodes.

1997 Balanced Budget Act introduced prospective payment for Medicare home health led to major reduction in use of Medicaid-financed home health aide services.

Decreased access to Medicare HH coincided with decline in NF but increase in other residential care. Coincidental or not?

Why Did Access to Paid Home Care Increase, then Decrease?
A consistent trend in the NLTCS 1984-2004 is increasing reliance on assistive technologies and home/environmental modifications.

2011 NHATS consistent.

Evidence suggests less dependency on human assistance, especially for mobility.
Examples of AT and Environmental Modifications

- Frequently used AT include canes, walkers, grab bars, raised toilet seats, booster and big button telephones, etc.

- Also important are broader environmental accommodations and societal changes such as curb cuts, handicapped ramps, handicapped parking, grocery shopping scooter carts, grocery delivery services, mail order prescriptions, direct deposit of Social Security checks.
• Nationally, the percentage of Medicaid LTC spending for HCBS (compared to NF, ICF/ID, and other institutional services) reached 47.2% in 2011. (Truven Analytics analysis of CMS-64 data). Growth began in 1995 but accelerated after 1999.

• Reasons: end of “cold bed rule” (1993), Supreme Court’s *Olmstead* ruling (1999), RC/SC grants $289 million to 39 states 2001-2010.

**Medicaid LTC Trends: “Rebalancing”**
However, if the focus is exclusively on elderly and younger physically disabled, only 38% of Medicaid LTC spending goes toward HCBS – although this is still double the 17% in 1995.

Harder to disaggregate spending on LTC for elderly only. However, based on analysis of 2006 and 2009 Medicaid MAX (claims) files and other sources only a handful of states spend more than 45% of LTC for elderly on HCBS.

States Less Successful Rebalancing for Elderly and non IDDD Adults 18-64
States that do a much better job than others in reorienting spending on LTC for elderly away from NF toward HCBS are: California, New Mexico, Oregon, Washington, Alaska, Minnesota.

Least “rebalanced” states were Utah, Kentucky, North Dakota, Mississippi, Florida, and Indiana (under 9% of all spending on LTC for elderly Medicaid users went to HCBS in either 2006 or 2009 MAX claims files or both years)
• State plan personal care benefit.
• SSI State Supplement
• Consumer direction (hire/fire, supervise individual home care aides, may employ family)
• Higher than average numbers of RCF beds per 1000 elderly.
• Higher percentages of elderly NF users got HCBS first (shorter NF stays).

Policy Factors associated with “rebalancing” for elderly.
• Nursing home bed supply – once beds got built, difficult to get rid of them. Some states (e.g. CA, AK, OR, WA, NM) never participated as fully as others in the 1970s NF building boom.

• Winter precipitation rates – cold, snowy, rural states have a much harder time re-balancing and, if they do, it will be mainly by replacing NF with other RCFs.

• States with high immigrant populations do not face LTC workforce shortages
• Indicators of wealth such as higher single family housing prices and taxable revenues per capita correlate positively with re-balancing toward HCBS, whereas high demand (percentage of state population aged 75 and older) correlates negatively.
“Employer authority” limited to human assistance: authority to hire/fire, schedule, train, pay, or participate in paying. Family, friends, and neighbors may be employed. Usually the program participant is the “legal employer.”

“Budget authority” – dollar budget that may be used to employ aides but may also be used to purchase other disability-related goods and services (e.g. assistive technologies, home-delivered meals, transportation, continence pads). Also called “cash and counseling” model.
• Employer-authority older model – goes back to 1970s in California and Michigan.
• Numbers of program participants “self-directing” services doubled between 2001-2011.
• Modest growth 2011-2013: now approximately 840,000 (mostly Medicaid-funded).

Growth of Consumer Direction
• Increased beneficiary/caregiver satisfaction with services.

• Same or better quality outcomes on objective measures of adverse outcomes (e.g. fewer bedsores).

• Fewer reports of unmet need for ADL/IADL help.

• Less family caregiver stress.

**Research Findings on Consumer-Directed Services: Beneficiary and Caregiver Outcomes**
• High percentage of PD workers are family, friends, neighbors.
• Higher job satisfaction for PD workers (including non-family) compared to agency workers.
• Same pay or better compared to agency workers (especially when unionized – get health benefits).
Impact of Consumer Direction on LTSS Use/Cost

- Lower nursing home use in some states (e.g. Arkansas)
- Increased access to home care (especially if agency-providers unable to deliver all services in care plan.
- Lower NF use can offset costs of increased access to home care aide services.
- Lower costs per unit of service (e.g. per hour of aide care) delivered.
21 states have some Medicaid managed LTSS as of May 2014.

In states with PD before MLTSS, rate of enrollment in PD has mostly stayed the same.

MLTSS has increased PD in TN and DE.

In TX, take-up of PD among elderly/younger adult non-IDD disabled is higher in MLTSS than FFS, but still low.
Concerns about Future of Participant Directed Services: Long-Term Impact of MLTSS

- Long-term impact of MLTSS on PD is unclear.
- More states will adopt mandatory MLTSS and promote integrated acute/LTSS managed care for dual eligibles.
- MCO case managers are often skeptical and resistant, especially about PD for 65+. Think it means more work for them.
- MCOs often more bureaucratic, less flexible.
Revised FLSA rule issued September 2013 extending OT pay protections to Medicaid home care aides may have unintended adverse consequences.

- States with most generous benefits (e.g. CA) may prevent cost increases by capping worker hours to avoid OT pay.
- If so, this will reduce work hours and pay for workers of high need beneficiaries.
- And will erode continuity of care and participants’ choice and control. Greatest impact will be on hard-to-serve beneficiaries and live-in paid family workers.
Managed Long Term Service and Supports (MTLSS)

Cheryl Phillips, M.D.
SVP Advocacy and Public Policy
LeadingAge, Washington, D.C.
WHAT is Managed LTSS?

- Typically the state Medicaid Agency contracts with a private managed care org to pay for and coordinate LTSS
- Not all states cover same benefits (HCBS, NH, Assisted Living)
- Not all states cover same populations (older adults, younger disabled adults, those with intellectual disabilities, behavioral health)
WHY Managed LTSS?

• Predictability for state Medicaid budgets
• Attempt (? false believe) to control spending and decrease costs
• Marked variation in LTSS spending
• ACA incentives to develop new service delivery and payment models
Growth in States with MTLSS


2002: 8
2004: 16
2006: 26
Policy Evolution on Medicaid LTC

Home and Community-Based Service Expansion

Medicaid Managed LTSS

Dual Eligibles Integration
States with Dual Demonstrations
(Duals’ Financial Alignment Initiative)

Yellow – MOU Accepted

Blue – MOU Pending

Red – MOU Withdrawn
A Word (or two) on LTSS and the Financial Alignment Demos

• CMS put a limit to 2 million dually eligible beneficiaries nationally

• Anticipated savings (related to increased care coordination and HCBS to reduce NH, ER and acute hospital care) will be **deducted up-front** from the Medicare and Medicaid contributions to the health plans in the capitated model (risk corridors defined in the MOUs for each state)

• Enrollment (passive vs. voluntary and “opt-out” provisions)
Big Assumptions about Medicare Savings

- For states: (AZ, HI, ID, OR, MN, NM, TN, VT, WI) withdrew due to risk

- For HCBS providers: (decreased Medicaid payment doesn’t mean they receive savings from Medicare)

- Currently only two models with true financial integration are PACE and selected D-SNPs
Potential Benefits of MLTSS

• Improved transitions between acute and LTSS
• Enhanced care coordination between settings and services
• Increased flexibility in benefits packages
• Accelerated rebalancing
• Alignment of quality measurement and management
Challenges to MLTSS

• Moving VERY quickly, often before plans and networks are ready
• Network challenges
  – ? Adequate
  – ? What happens to existing providers
• Can they ensure person-centered planning and meet service needs
• Risk of focusing on medical needs, losing sight of social needs and goals of independence
• How to measure quality across diverse providers and heterogeneous populations
And More Challenges

• Few MCOs even understand the scope of LTSS
• How can the MCO ensure that service authorizations are made by qualified individuals who know the beneficiary's needs
• Are there appropriate appellate rights and is there access to “conflict free” case management
• Was there MEANINGFUL consumer engagement in plan design and on-going
In summer 2013 CMS published MLTSS guidance for states based on best practices for establishing and implementing MLTSS programs.

- Also clarifies expectations of CMS from states using section 1115 demonstrations or 1915(b) waivers combined with another long term services and supports (LTSS) authority in an MLTSS program.

- Includes 10 key elements that CMS expects to see incorporated into new and existing state Medicaid MLTSS programs.

The Future for MLTSS

- Managed care is NOT going away, will take on additional forms (bundled payments, etc)
- Likely increased resistance to mandatory and passive enrollment for LTSS
- ?? If more states will take on long-stay NH care (in the interim—see what other states are doing)
- Opportunity to look beyond “traditional” providers and explore service-enriched housing
4 Possible Scenarios

1. **Community Networks** are created to include health, long term care, and additional needs such as transportation, nutrition, and psychosocial supports.

   These networks will provide care managed services in a variety of housing setting with funds from both private (insurers and individuals) and public payors.
2. **Health Systems** control most component of health care delivery and are at risk for efficient and effective outcomes across populations. They will focus on strong networks, prevention/wellness and care management and will work to identify key HCBS providers.
4 Possible Scenarios

3. Long Term care hubs would provide and collaborate with the full range of PAC and HCBS providers and serve as the link for hospitals and physician groups to coordinate services. The hubs would likely assume risk and thus negotiate contracts and strive to provide least expensive services while being accountable for positive outcomes.
4. **It all fails** because networks don’t meet LTSS needs, hospitals don’t look beyond “medical services”, LTSS providers cannot navigate risk. Focus would then most likely shift to value-based purchasing for medical services and various local incentives to create innovative practices to integrate LTSS.
Resources

• Center for Health Care Strategies LTSS resources: http://www.chcs.org/info-url_nocat5108/info-url_nocat.htm?type_id=1051 (includes resources on community integrations, duals, and MLTSS)

• Community Catalyst Duals resources: http://www.communitycatalyst.org/topics?id=0015 (Duals)

  http://www.communitycatalyst.org/topics?id=0018 (Integrated care)

• Kaiser Family Foundation Medicaid resources: http://kff.org/medicaid/ (includes duals and LTSS)

• N4a Aging & Disability Exchange: http://www.mltssnetwork.org/ (focuses on business capacity and integrated care)

• NASUAD State Medicaid Integration Tracker: http://www.nasuad.org/medicaid_integration_tracker.html

• National Senior Citizens Law Center resources on duals for advocates: http://dualsdemoadvocacy.org/
Questions

View webcast:
www.visualwebcaster.com/RTILTC
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