Addressing the Long-Term Care Needs of Nebraska's Aging Population through Expanded Assistance to Caregivers

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Members of the baby boom generation began turning 65 years old in 2011. As a result, the number of persons aged 65 or older in Nebraska will increase during the next 20 years. There are a number of relevant issues related to this aging population that should be of concern to Nebraska's policymakers. One immediate concern is the financial impact of the long-term care needs of this growing population, especially the impact on Medicaid if there is a corresponding increase in the number of persons requiring nursing home placement. The most effective way to delay or eliminate nursing home placement is to develop alternatives with home and community-based services. In this report, we present three policy options that could result in fewer nursing home placements. These options involve providing additional assistance to caregivers.

Introduction

Several tables in the Legislature's Planning Committee 2011 Report highlight the Medicaid and CHIP expenditures for the state (pp. 91 and 92). These tables demonstrate the current financial impact the aging population has on Nebraska's Medicaid system. In this section, we bring in additional information to consider the future impact of this growing population.

1. Medicaid Expenditures and Eligibility

In FY 2011, Medicaid expenditures for the Aged category totaled $337.7 million. Table 1 shows that the 2011 value was lower than most in the previous six years. In addition, the Aged category accounted for a smaller proportion of Medicaid expenditures in FY 2011 than in the previous six years. Expenditures for the Aged represented 21.4% of the total Medicaid expenditures in FY 2011, which was considerably lower than the 26.1% reported in FY 2005.

Despite the fact that Medicaid expenditures for the Aged category has declined in recent years, both in absolute value and as a percentage of total expenditures, there are two reasons Nebraska policymakers should still be concerned about future Medicaid expenditures for the Aged category. First, expenditures in this category are relatively high. The average monthly expenditure per eligible person in the Aged category was $1,583 in FY 2011. This was about the same as the average monthly expenditure per eligible person in the Blind and Disabled category ($1,595) but was more than seven times the average monthly expenditure per person for the Children category (Table 2). Because of the high average monthly expenditure per eligible person in the Aged category, small changes in the number of eligible persons in this category will lead to much larger changes in total Medicaid expenditures. For example, for every 100 person change in the Aged category, total annual Medicaid expenditures will change nearly $2 million.

Second, even though the number of eligible persons in the Aged category has declined since FY 2005 this trend is not likely to continue due to the aforementioned aging of the baby boomer generation. This is shown on Table 3 and Figure 1.

Table 1. Medicaid and CHIP Vendor Expenditures by Eligibility Category for Nebraska: FYs 2005-2011

	Aged	Blind and Disabled	ADC Adult	Children (includes CHIP)	Total
			(millions)		
FY 2005	$365.0	$566.6	$104.1	$360.9	$1,396.6
FY 2006	$356.2	$580.6	$102.0	$392.1	$1,430.9
FY 2007	$333.4	$586.0	$105.2	$414.2	$1,438.8
FY 2008	$341.1	$610.6	$105.5	$439.5	$1,496.8
FY 2009	$345.6	$639.8	$108.7	$444.4	$1,538.4
FY 2010	$347.3	$655.3	$129.7	$439.7	$1,572.0
FY 2011	$337.7	$664.5	$175.2	$398.4	$1,575.8

Source: Nebraska Department of Health and Human Services; prepared by UNO Center for Public Affairs Research, September 2012

Table 2. Average Monthly Medicaid and CHIP Vendor Expenditures by Eligibility Category for Nebraska: FYs 2005-2011

	Aged	Blind and Disabled	ADC Adult	Children (includes CHIP)
FY 2005	$1,663	$1,644	$367	$235
FY 2006	$1,616	$1,630	$361	$253
FY 2007	$1,526	$1,621	$387	$265
FY 2008	$1,588	$1,664	$423	$276
FY 2009	$1,628	$1,695	$419	$272
FY 2010	$1,633	$1,655	$413	$248
FY 2011	$1,583	$1,595	$460	$220

Source: Nebraska Department of Health and Human Services; prepared by UNO Center for Public Affairs Research, September 2012

Table 3. Average Monthly Medicaid and CHIP Eligible Persons by Category for Nebraska: FYs 2005-2011

	Aged	Blind and Disabled	ADC Adult	Children (includes CHIP)	Total
FY 2005	18,291	28,724	23,635	128,107	198,757
FY 2006	18,370	29,682	23,556	129,062	200,670
FY 2007	18,204	30,128	22,646	130,030	201,009
FY 2008	17,900	30,585	20,815	132,743	202,043
FY 2009	17,687	31,451	21,595	136,347	207,080
FY 2010	17,717	33,005	26,158	147,580	224,459
FY 2011	17,783	34,708	31,723	151,140	235,353

Source: Nebraska Department of Health and Human Services; prepared by UNO Center for Public Affairs Research September 2012,

2. Medicaid Expenditures for Long-Term Care Services

Table 4 illustrates that long-term care services totaled $617.5 million in FY 2011 and was down 4.3% from FY 2010. Even with this decline, expenditures for long-term care services accounted for approximately two out of every five dollars spent on Medicaid in Nebraska. Moreover, nursing facility costs totaled 19% of all Medicaid expenditures (Nebraska Medicaid Annual Report, 2011). The average annual cost in 2011 for a Nebraska senior in a nursing facility, under the Nebraska Medicaid program, was $86,040 (DHHS, Costs of Senior Care, 2011). Clearly, any intervention that delays or eliminates the need for nursing home care will have a substantial impact on long-term care costs for Nebraska.

As can be seen from Table 4, Nebraska's Department of Health and Human Services (DHHS) is moving in this direction and has initiated a number of programs to develop home and community-based alternatives to nursing home care. However, two areas that could be expanded are Aged & Disabled Waivers and Home Health/Personal Assistance Services.

Table 4. Medicaid Expenditures for Long-Term Care Services for Nebraska: FYs 2010 and 2011

	FY 2011	FY 2010
Nursing Facilities	$299.1	$317.0
ICF/MR	$20.8	$43.0
Developmental Disability (DD) Waivers	$195.3	$179.4
Aged and Disabled (A&D) Waivers	$38.7	$35.4
Home Health/Personal Assistance Svcs.	$33.3	$40.6
Assisted Living	$30.2	$29.7
Total	$617.5	$645.0

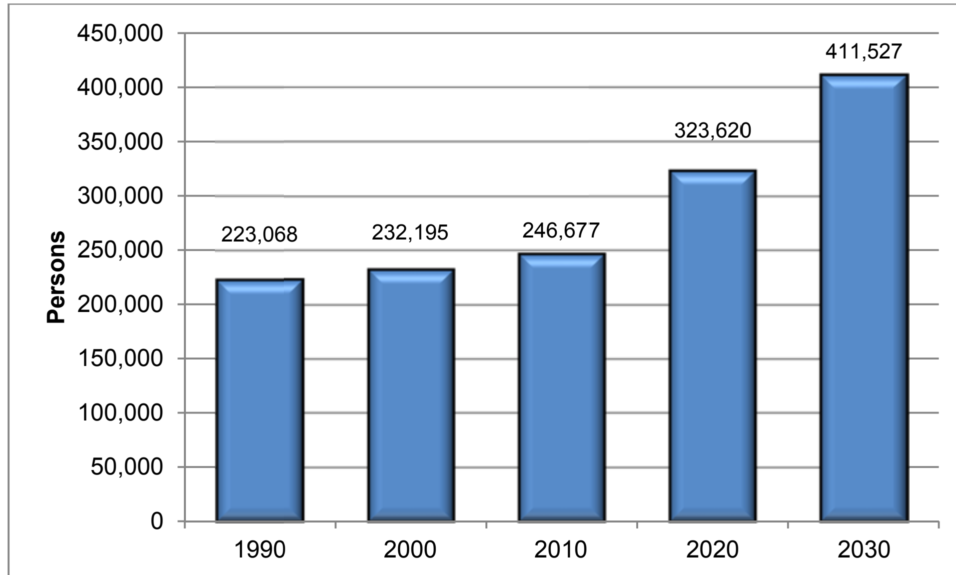
Source: Nebraska Department of Health and Human Services; prepared by UNO Center for Public Affairs Research, September 2012

3. Historical Population and Projections

If the aging of the baby boom generation is going to influence Medicaid expenditures, we need to know how large the increase in the elderly population is going to be in the upcoming years. Figure 1 examines the population aged 65 years or older by decade since 1990, with projections for 2020 and 2030. As can be seen, the number of persons aged 65 years or older grew slowly between 1990 and 2010 but is projected to increase rapidly between 2010 and 2020 and between 2020 and 2030. The number of persons is projected to grow from 246,277 in 2010 to 323,620 in 2020 (a 31.2% increase); and then to 411,527 in 2030 (a 27.7% increase).

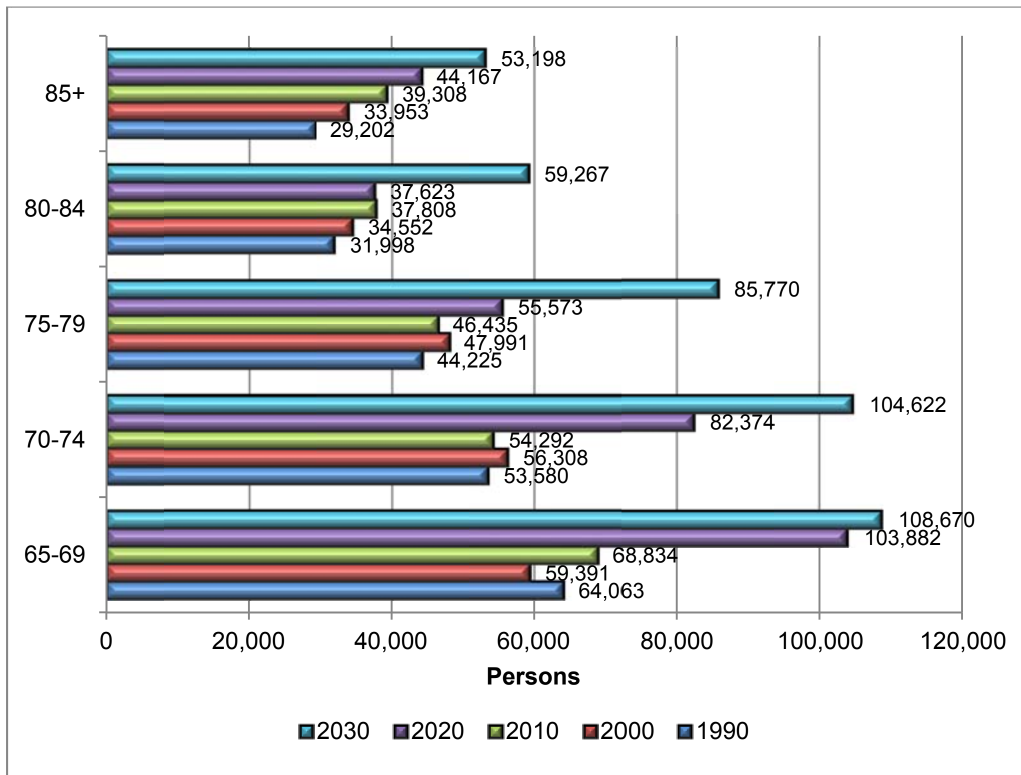
If the number of those persons eligible experiences a similar increase, Medicaid costs for the Aged category could increase by approximately three percent per year. This does not account for price increases. This would translate into annual expenditure increases of more than $10 million. However, Figure 2 suggests that the pressure on expenditures may not be as great between 2010 and 2020, since much of the growth in Nebraska's elderly population will be in the 65 to 69 years and 70 to 74 years age groups. Persons in these two age groups generally have lower Medicaid utilization rates than those in the 75 years and older age groups (especially for the 85 years or older age group). Figure 2 shows that the fastest growing age groups between 2020 and 2030 will be 75 to 79 years and 80 to 84 years.

Figure 1. Nebraska Population Aged 65 Years or Older: 1990, 2000, and 2010 with Projections for 2020 and 2030



Source: U.S. Census Bureau, 1990, 2000, and 2010 Censuses of Population; UNO Center for Public Affairs Research, Projections for 2020 and 2030, prepared September 2012

Figure 2. Nebraska Population Aged 65 Years or Older by Age Group: 1990, 2000, and 2010 with Projections for 2020 and 2030



Source: U.S. Census Bureau, 1990, 2000, and 2010 Censuses of Population; UNO Center for Public Affairs Research, Projections for 2020 and 2030, prepared September 2012

One of the reasons for the decline in the number of Medicaid eligible persons in the Aged category during the past few years is the relatively slow growth in the number of persons aged 65 years or older. As Figure 2 demonstrates, this was due to the decline in the number of persons aged 70 to 74 years and 75 to 79 years between 2000 and 2010. Since the highest eligibility rates are for persons over the age of 80, we may not see the full impact of the aging baby boom generation for another decade.

4. Nursing Home Residence for Persons 65 Years or Older

Table 5 shows that in 2010, 48.6 of every 1,000 persons aged 65 years or older in Nebraska resided in a nursing home. It also shows that the residency rates approximately doubled for each successive age group. The highest rate was for persons aged 85 years or older at 168.0 residents per 1,000 persons.

Table 5. Nebraska Nursing Home Residents per 1000 Population by Age, 2010 Census

	65 years and over	65 to 69 years	70 to 74 years	75 to 79 years	80 to 84 years	85 years and over
Residents per 1000	48.6	9.8	16.0	30.9	63.3	168.0

Source: U.S. Census Bureau, 2010 Census of Population; prepared by UNO Center for Public Affairs Research, September 2012

Table 6 summarizes the impact the aging baby boom generation will have on the number of persons living in nursing homes if the 2010 residency rates for each age category remain the same for 2020 and 2030. In 2010, there were 11,977 persons aged 65 or older living in nursing homes. This is projected to increase to 13,858 persons in 2020 (a 15.7% increase) and to 18,081 persons in 2030 (a 30.5% increase).

Table 6. Nebraska Nursing Home Residents by Age, 2010 Census with Projections for 2020 and 2030

	65 years and over	65 to 69 years	70 to 74 years	75 to 79 years	80 to 84 years	85 years and over
2010	11,977	675	871	1,433	2,393	6,605
2020	13,858	1,019	1,322	1,715	2,381	7,422
2030	18,081	1,066	1,678	2,647	3,751	8,939

Source: U.S. Census Bureau, 2010 Census of Population; UNO Center for Public Affairs Research, Projections for 2020 and 2030, prepared September 2012

Conclusion and Policy Options

From 2010 to 2011, Nebraska trimmed almost $19 million from its Medicaid expenditures. DHHS attributed this cost savings directly to efforts to encourage home and community-based alternatives to facility-based care (Nebraska Medicaid Annual Report, 2011; p. 8). Two reasonable inferences can be drawn from this assertion. First, the most efficient way to save costs in the Nebraska Medicaid program is to delay or eliminate the need for nursing home placement. Second, the most effective way to delay or eliminate nursing home placement is to develop alternatives to nursing home placement with home and community-based services. Following are three policy options that could result in fewer nursing home placements. These options may also improve the quality of care and help in local economic development.

1. **Broaden the definition of client to allow compensation for services informal caregivers provide**

Virtually all of the programs designed to maintain the older adult within the community define the older person as the primary client. According to the federal government, however, the success of state programs to delay or reduce the likelihood of nursing home placement depends in large part on the willingness and ability of informal caregivers to maintain older adults in the community (Spillman & Long, 2007). A number of studies support the view that having an informal caregiver is associated with a reduced likelihood of nursing home entry (Charles & Sevak, 2005; LoSasso & Johnson, 2002; Van Houtven & Norton 2004; Waidmann & Thomas 2003; see also Spillman & Long, 2007).

In a recent study reported by the U.S. Department of Health and Human Services, data were analyzed from the National Long Term Care Survey (NLTCS) and its Informal Care Supplement (ICS). The NLTCS is a nationally representative survey of the Medicare elderly that collects detailed information on the living situation of older adults. The analysis revealed that caregiver stress was one of the best predictors of nursing home placement and that financial hardship due to caregiving was an important predictor of caregiver stress (Spillman & Long, 2007).

Informal caregiving by family members or others is critical in the effort to help older adults remain at home. The finding that financial hardship is a significant determinant of nursing home placement suggests that financial support to the family may significantly reduce placement. One policy change to consider is to provide financial compensation to family member caregivers for the service they provide, which is not currently allowed under the Nebraska Aged and Disabled Medicaid Waiver.

2. **Modify the assessment and referral process to provide personalized recommendations for support services**

The general procedure for assessing need for long-term care services is first to determine if the elder is eligible to receive Medicaid for nursing home placement, then to inform him or her and his or her caregivers about support services that are available in the local community as an alternative to nursing home placement. Unfortunately, most support services offered to caregivers come in a one-size-fits-all package without regard to what type of support services the elder and caregiver need considering their unique situation. A common example is recommending respite to everyone who qualifies for the service. The problem is that some caregivers may be so new to caregiving that they will not yet recognize the potential benefits of respite and some long-time caregivers may be stressed to the point that respite will not prevent nursing home placement. The effects of timing and dosage are well recognized in medicine, but not in support services. For example, the amount of an antibiotic that is dispensed will depend upon when it is administered in the disease process. If administered early, small doses of the antibiotic are effective. Later on, more extensive interventions are required. Although providing the same dosage of medicine for everyone would be tantamount to medical malpractice, it seems to be an accepted practice in the delivery of support services.

Effective targeting of support services requires knowledge of the level and type of stress the caregiver is experiencing. This is difficult because stress is a multidimensional notion (Ankri et al., 2005; Knight, et al., 2000; O'Rourke & Tuokko, 2003). A recent study noted that caregiving activities can affect several different domains of a caregiver's life (Savundranayagam et al., 2011). Stress can affect the interpersonal relationship between the caregiver and care receiver. This is called the relationship burden. Stress can interfere with other aspects of the

caregiver's life, such as relationships with other family members, work responsibilities, or personal privacy. This is called the objective burden. Stress can also be emotional stress. This is called the stress burden. Not surprisingly, the study found that these different types of caregiving stress had different causes and affect the decision regarding nursing home placement differently. For example, for caregivers who were spouses, only stress burden predicted intention to place; and for adult children, only relationship burden predicted intention to place.

The results of this study suggest that to reduce nursing home placement, one policy change to consider is to modify the current assessment and referral process. Case managers and support service providers should assess the type of stress being experienced by the caregiver and use that information to make personalized referrals to specific support services aimed at reducing the type of stress identified. For example, to reduce the likelihood of nursing home placement, support services aimed at adult children may be most effective if they reduce relationship burden. For spouses, support services should be targeted toward reducing stress burden.

This policy can also been seen as a way to improve the quality of care since caregivers will be provided with more personalized support services.

3. **Assist individuals in becoming microenterprises to supplement the pool of caregivers for older adults**

The projected increase in the number of persons 65 years or older in Nebraska is certain to test Nebraska's financial resources to provide them with adequate long-term care, especially the cost of nursing home care if the numbers of placements remain at their current rate. To address this situation, an adequate home care work force is essential, especially in rural areas.

One policy change to increase the home care work force is the creation of microenterprises. These will be small companies (as small as a single provider) established that are intended to relieve the shortage of trained personnel available to provide caregiving services such as respite care to caregivers and custodial care to the elderly.

Many individuals have experience as family caregivers. What they lack is knowledge of how to provide home care professionally from a business perspective. Agencies such as the Alzheimer's Association, or the local Area Agency on Aging (AAA), could provide training for caregiving. Local community colleges or volunteers could provide help in establishing a business (e.g., how to pay taxes). The Area Agencies on Aging could keep a registry of available workers. Issues such as licensure and liability would have to be addressed.

Although such microenterprises could be seen as competition for established agencies, as a practical matter, in rural areas there may be no established agencies near enough to provide such services in a cost-efficient manner. Moreover, such a program would be consistent with already established programs such as Cash & Counseling, a participant-directed program incorporated into the Medicaid program that gives people with disabilities, including older adults, the option to manage a flexible budget and decide what combination of goods and services best meet their personal care needs. The funds of Cash & Counseling participants could be applied toward use of services from these newly established home care micro enterprises.

This policy option can also be seen as an important economic development strategy, offering local employment to willing participants, without the need to travel to metropolitan areas.

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