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State Cost Containment Initiatives for Long-Term Care Services for Older People

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Joshua M. Wiener, Consultant
Domestic Social Policy Division
with David G. Stevenson and Jessica Kasten

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Summary

Although the rate of growth for Medicaid long-term care expenditures for the elderly has slowed in recent years, spending on these services still represents a substantial proportion of total Medicaid expenditures. The aging of the population guarantees greater future need for long-term care. Consequently, state policymakers have sought to reduce the rate of growth in these expenditures through a variety of strategies.

One approach is for states to create more effective and efficient financing and delivery systems by developing home and community-based services and by integrating acute and long-term care services through the use of managed care. Although some of the recent emphasis on community-based care is surely based on consumer preference, a major impetus for this reform is the promise of cost-savings – an outcome about which research has been equivocal. Two relatively new areas of policy development involve consumer-directed home care and nonmedical residential facilities.

Almost all states are looking to managed care and the integration of acute and long-term care services as a potential way to reduce the rate of increase in expenditures. Progress on these initiatives has been slow, in part because Medicaid and, often, Medicare, waivers are needed for their implementation. Also, the mixed experience with Medicaid and Medicare managed care for a less complicated population has resulted in a relatively cautious approach to integrated managed care programs for the frail older population.

A second strategy to reduce state expenditures is to substitute private, Medicaid, and Medicare financing for state funding. States have sought to promote private long-term care insurance as a way to reduce Medicaid long-term care expenditures by enacting tax incentives, offering private long-term care insurance to state employees, and establishing public/private partnerships. These initiatives have not increased the number of people with private long-term care insurance significantly. Although almost all states believe that "Medicaid estate planning" is a problem, it is a major concern in only a few states. While increasing federal contributions through Medicare and Medicaid maximization are being used effectively by some states, these strategies simply shift costs to the federal government.

In the short run, if faced with an economic downturn, states are likely to rely on more traditional strategies to reduce spending, such as cutting reimbursement rates and controlling nursing home supply. Many states are using certificate of need restrictions or moratoria on new nursing home construction to limit the supply of services, and, therefore, utilization. With the repeal of the Boren amendment in the Balanced Budget Act of 1997, states have much greater legal freedom to impose rate cuts on nursing homes. However, so far, relatively few states have done so, reflecting good economic times and the political power of the nursing home industry.

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State Cost Containment Initiatives for Long-Term Care Services for Older People

Long-term care services for older adults represent a substantial share of total health care spending in the United States and an area of major concern for state policymakers. Nursing home and home health care for people of all ages accounted for almost 12% of personal health expenditures in 1998, and they were approximately 20% of all state and local health care spending.[1] Importantly, neither private health insurance nor Medicare cover long-term care services to any significant extent, and few older adults currently have private long-term care insurance. The disabled elderly must rely on their own resources or, when these are depleted, turn to Medicaid or a few state-funded programs to pay for their long-term care. In 1997, 68% of nursing home residents were dependent on Medicaid to finance their care.[2] Medicaid long-term care expenditures are projected to increase by 74%-103% in inflation-adjusted dollars between 2000 and 2020.[3]

Because of the high cost of long-term care (a year in a nursing home is estimated to cost an average of $56,000 in 1998), Medicaid coverage for long-term care provides a safety net for the middle class as well as the poor.[4] Approximately one-third of discharged nursing home residents pay privately when admitted and eventually spend down their resources to establish eligibility for Medicaid.[5]

This paper reviews state policies on long-term care for the older population, emphasizing efforts to control the rate of increase in Medicaid expenditures for these services. Data for this paper draw heavily from the 13 states – Massachusetts, New York, New Jersey, Florida, Alabama, Mississippi, Texas, California, Colorado, Washington, Wisconsin, Minnesota, and Michigan – that have been intensively studied

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[1] Health Care Financing Administration. Office of the Actuary. National Health Statistics Group. *Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Selected Calendar Years 1998-98*. [http://www.hcfa.gov/stats/nhe-oact/tables/t9.htm], accessed May 3, 2000.

[2] American Health Care Association. *Facts and Trends: The Nursing Facility Sourcebook, 1999.* American Health Care Association, Washington, DC, 1999.

[3] U.S. Congressional Budget Office. *Projections of Expenditures for Long-Term Care Services for the Elderly*, CBO Memorandum, Washington, March 1999.

[4] Unpublished estimates of nursing home revenue per day, Office of National Health Statistics, Office of the Actuary, Health Care Financing Administration, 2000.

[5] Wiener, J.M., C.M. Sullivan, and J. Skaggs. *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care.* Washington, American Association of Retired Persons, June 1996.

as part of The Urban Institute's *Assessing the New Federalism (ANF)* project.[6] These 13 states account for a majority of total Medicaid spending for long-term care for older people.

Like the rest of the Medicaid program, states have considerable flexibility in the provision of long-term care services and efforts at reform differ across the states. Furthermore, the strategies used by states to control long-term care expenditures are much more varied than for acute care, where there is a single-minded focus on increasing managed care enrollment.

Background

Table 1 contains demographic characteristics of the United States and the ANF states and their Medicaid programs. While nearly 13% of the U.S. population was over the age 65 in 1997, this proportion ranges across ANF states from a low of 10.1% in Colorado to 18.4% in Florida. Similarly, the proportion of Medicaid beneficiaries who are elderly varies by state, from a low of 7% in Washington to a high of 13.5% in Alabama. Nationally, older Medicaid beneficiaries accounted for just over 10% of enrollees.

Table 2 details some of the characteristics of the long-term care systems in the ANF states in 1998, including licensed nursing facilities, nonmedical residential care facilities, and home health agencies. These market characteristics vary widely across the states by service provider. The number of nursing home beds per 1000 elderly age 75 and above among the ANF states ranged from 63.3 in Florida to 150.7 in Minnesota (the U.S. average is 113.2). Mississippi had the fewest licensed, nonmedical residential care beds, such as board and care homes and assisted living facilities, per capita (22.6 beds per 1,000 elderly aged 75 and over), while Washington had the most (102.2 beds per 1,000 elderly aged 75 and over). Finally, the number of home health agencies per capita in 1998 ranged from a low of 0.15 per 1,000 elderly aged 75 and over in New Jersey to a high of 4.08 per 1,000 elderly aged 75 and over in Texas, compared to 1.40 nationally.

Almost $60 billion was spent on long-term care for people of all ages by the Medicaid program in 1997, 41% of total Medicaid expenditures for services (excluding disproportionate share hospital payments).[7] Long-term care spending on older beneficiaries accounted for the majority ($32.2 billion) of this spending, 22% of

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[6] Funding for the long-term care component of the *Assessing the New Federalism* project was provided by The Commonwealth Fund. Financial support for the *Assessing the New Federalism* project was provided by the Annie E. Casey Foundation, the Henry J. Kaiser Family Foundation, the W. K. Kellogg Foundation, the John D. and Catherine T. MacArthur Foundation, the Fund for New Jersey, the McKnight Foundation, and the Robert Wood Johnson Foundation. Additional support for the *Assessing the New Federalism* project is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through grants to the University of Wisconsin at Madison.

[7] Urban Institute calculations based on HCFA 64 data and DSH.

total Medicaid spending. As shown in **Figure 1**, nearly three-fourths of Medicaid expenditures for older people were for long-term care services. Eighty-six percent of these long-term care expenditures were for institutional care or mental health services, while nearly 14% were for home care services. Medicaid long-term care spending for older people is more institutionally-based than it is for younger people with disabilities.

Table 3 shows Medicaid long-term care spending on the elderly for the ANF states and the United States, spending on these services as a percent of total Medicaid spending, spending per elderly enrollee and resident, and the proportion of expenditures by type of service. In 1997, while long-term care expenditures for the elderly were approximately 22% of all Medicaid spending in the United States, this proportion ranged from 12.5% in California to 31.2% in Minnesota among the ANF states. Per elderly resident Medicaid spending for long-term care varies from a low of $372 in Florida to a high of $2,455 in New York, while the national average was $943. The share of long-term care expenditures spent on home care varied from 0.3% in Mississippi to 28% in Texas, with a national proportion of 11.7%. Some states, such as California, Florida, Massachusetts, and Wisconsin, have significant state-funded long-term care programs which do not appear in these data.

Table 4 presents trend data for Medicaid long-term care expenditures for the elderly between 1990 and 1997. Medicaid long-term care spending for the elderly increased an average of 8.3% annually from 1990-1997 (compared to 10.9% for total Medicaid expenditures over the same time period) and grew more slowly in later years. Although it has been a change from historical patterns, in later years, rates of growth for home care have been higher than rates of growth for institutional care. From 1995 to 1997, annual rates of growth for home care were 9.2% compared to 3.5% for nursing home care.

Table 1. Demographic Characteristics and Potential Demand for Long-Term Care Services across the ANF States, 1997

	Total elderly population (000)[a]	Elderly as % of total population[a]	Elderly Medicaid beneficiaries (000)[b]	Elderly beneficiaries as % of total beneficiaries[b]
United States	**34,185**	**12.8%**	**4,114**	**10.1%**
Alabama	565	13.1	85	13.5
California	3,568	11.1	562	8.8
Colorado	394	10.1	41	11.7
Florida	2,705	18.4	202	9.7
Massachusetts	861	14.1	96	11.8
Michigan	1,218	12.5	98	7.2
Minnesota	581	12.4	62	10.5
Mississippi	336	12.3	66	12.2
New Jersey	1,102	13.7	105	12.2
New York	2,421	13.3	373	11.5
Texas	1,969	10.2	332	11.8
Washington	647	11.5	64	7.0
Wisconsin	690	13.3	67	11.6

[a] U.S. Department of Commerce, Bureau of the Census, State Population Estimates, 1997. Elderly defined as age 65+.

[b] Urban Institute calculations based on HCFA 64 data.

Table 2. Characteristics of the Long-Term Care System Among ANF States, 1998

	Licensed nursing facilities			Licensed residential care			Licensed home health care[a]	
	Total facilities	Total beds	Beds/1000 75 +[b]	Total facilities	Total beds	Beds/1000 75 +[b]	Total agencies	Agencies/1000 75 +[b]
Alabama	231	25,713	101.0	282	7,014	27.6	180[a]	0.71
California	1,456	131,941	79.0	10,652	169,184	101.3	1101	0.66
Colorado	234	20,720	114.9	456	10,880	60.3	163[a]	0.90
Florida	698	81,172	63.3	2,421	67,684	52.8	1,273	0.99
Massachusetts	516	54,881	129.8	258	10,189	24.1	217[a]	0.51
Michigan	457	51,886	91.7	4,673	46,191	81.6	251[a]	0.44
Minnesota	435	43,782	150.7	3,307	17,400	59.9	767	2.64
Mississippi	180	17,501	114.9	165	3,441	22.6	69	0.45
New Jersey	355	49,871	96.0	443	19,210	37.0	80	0.15
New York	673	118,885	104.7	1,332	41,328	36.4	963	0.85
Texas	1,331	131,172	148.2	1042	29,844	33.7	3,613	4.08
Washington	285	27,204	86.7	2,676	32,080	102.2	159	0.51
Wisconsin	429	48,135	142.6	1,922	23,853	70.7	192	0.57
United States	**17,458**	**1,810,000**	**113.2**	**51,227**	**878,804**	**54.9**	**23,263**	**1.40**

Source: B. Bedney et al. *1998 State Data Book on Long-Term Care Program and Market Characteristics.* The University of California San Francisco, November 1999.

[a] Certified Home Health Agencies.
[b] U.S. Department of Commerce, Bureau of the Census. State Population Estimates, 1998.

Table 3. Medicaid Long-Term Care Expenditures by State, 1997
Elderly Beneficiaries, by Type of Service

					Proportion of LTC expenditures, by type of service			
	Total Long-term care (000s)	LTC as percent of total Medicaid	Per elderly beneficiary spending	Per elderly resident spending[a]	Nursing facility[b]	ICF-MR[c]	Mental health	Home care
United States	**$32,239,612**	**22.2%**	**$7,838**	**$943**	**83.9%**	**1.7%**	**2.7%**	**11.7%**
Alabama	447,124	25.1	5,237	791	92.0	0.2	3.5	4.3
California	1,929,001	12.5	3,435	541	76.5	0.7	11.7	11.1
Colorado	334,451	24.4	8,090	848	83.1	3.8	0.5	12.6
Florida	1,006,501	16.5	4,974	372	95.0	0.4	1.2	3.5
Massachusetts	1,173,272	25.2	12,240	1,362	93.1	1.7	0.9	4.3
Michigan	988,211	18.8	10,071	811	94.6	1.8	2.7	0.9
Minnesota	839,536	31.2	13,524	1,445	91.5	1.3	0.9	6.3
Mississippi	265,914	17.9	4,020	792	98.3	1.5	0.0	0.3
New Jersey	1,067,944	24.0	10,171	969	84.4	2.5	1.6	11.6
New York	5,944,054	27.4	15,950	2,455	71.8	2.9	3.7	21.6
Texas	1,718,106	21.2	5,175	873	69.5	2.5	0.1	28.0
Washington	498,519	17.6	7,828	771	89.2	1.8	0.2	8.8
Wisconsin	739,114	28.9	11,039	1,072	88.5	2.4	0.5	8.6

Source: Urban Institute calculations based on HCFA 64 data. Prepared for the Kaiser Commission on the Future of Medicaid. Does not include Disproportionate Share Hospital payments, administrative costs, accounting adjustments, or the US Territories. Totals may not add due to rounding.

[a] U.S. Department of Commerce, Bureau of the Census. State Population Estimates, 1997. Elderly defined as age 65+.
[b] Nursing Facility refers to skilled nursing facilities/other intermediate care facilities.
[c] "ICF/MR" refers to intermediate care facilities for the mentally retarded.

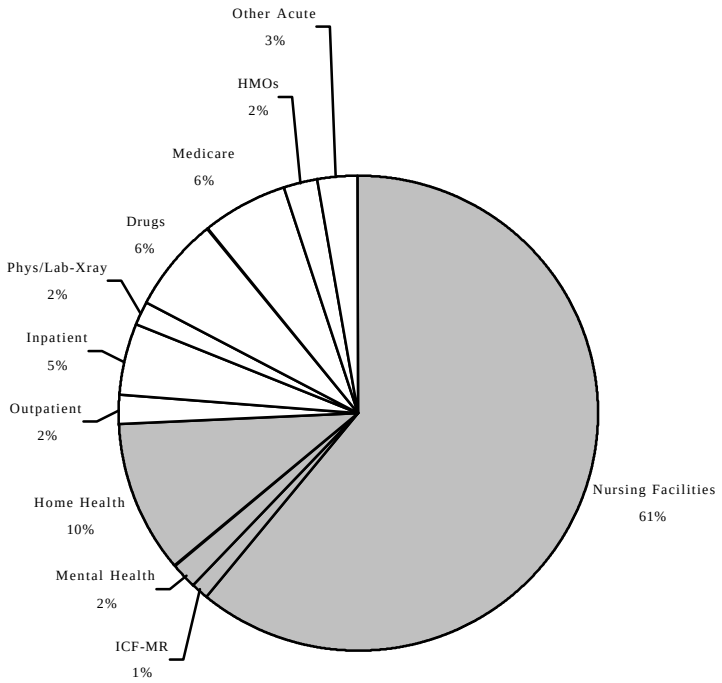
Table 4. Medicaid Long-Term Care Expenditures by Type of Service, 1990-1997
Elderly Beneficiaries

	LTC expenditures ($ in millions)								Average annual growth			
	1990	1991	1992	1993	1994	1995	1996	1997	1990-97	1990-93	1993-95	1995-97
Total	**18,442**	**21,162**	**25,640**	**26,251**	**28,466**	**30,172**	**30,616**	**32,240**	**8.3%**	**12.5%**	**2.0%**	**3.4%**
SNF/ICF-Other[a]	15,107	17,279	20,485	21,860	23,687	25,221	25,608	27,043	8.7	13.1	7.4	3.5
ICF-MR[b]	313	334	393	468	489	570	569	549	8.3	14.3	10.4	-1.9
Mental Health	1,042	1,253	2,160	1,145	1,137	1,221	1,267	882	-2.4	3.2	3.3	-15.0
Home Care	1,980	2,296	2,602	2,778	3,153	3,160	3,172	3,766	9.6	11.9	6.7	9.2

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include Disproportionate Share Hospital payments, administrative costs, accounting adjustments, or the US Territories.
Totals may not add due to rounding.

[a] SNF/ICF refers to skilled nursing facilities/other intermediate care facilities.
[b] "ICF/MR" refers to intermediate care facilities for the mentally retarded.

Figure 1: Medicaid Expenditures for Elderly Beneficiaries by Type of Service, 1997



Long-Term Care = 74.1%

Acute Care = 25.9%

Total Expenditures = $44.5 billion

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data

Does not include Disproportionate Share Hospital payments, administrative costs, accounting adjustments, or the US Territories.

Totals may not add due to rounding. “Other Acute” care services include case management, family planning, dental, EPSDT, vision, other practitioners’ care, etc. “ICF/MR” refers to intermediate care facilities for the mentally retarded. “Nursing Facility” refers to skilled nursing facilities/other intermediate care facilities.

Strategies to Control Long-Term Care Expenditures

If states are to control Medicaid expenditures, they will have to address long-term care for the elderly. Overall, there are three broad strategies that states use to control state spending: (1) reform the delivery system so that care can be provided more efficiently; (2) bring more outside resources (e.g., private resources, Medicaid, and Medicare) into the long-term care system to offset state expenditures; and (3) reduce Medicaid eligibility, reimbursement, and services. Like many of the characteristics discussed above, states diverge in the extent to which they focus on each of these strategies and how far each state has progressed in implementing long-term care reform.

System Reform

An important general strategy for saving money is to reorganize the health care delivery system in ways that make care more efficient and effective. Such a reorganization can be accomplished through expanding home care and nonmedical, residential long-term care services and by extending managed care to include long-term care as well as acute care services.

Expand Home and Community-Based Services. The most widespread reform to the public long-term care system has been the effort to shift the delivery system towards home and community-based care and away from institutional care. Policymakers in almost every state endorse creating a more balanced delivery system as a goal. However, Medicaid long-term care expenditures for the elderly are still overwhelmingly for nursing home care. Noninstitutional services spending has increased in recent years, although expenditures are still small. In 1997, 14% of Medicaid long-term care expenditures for older people were for home and community-based services, up from 10% in 1995.[8] Although total Medicaid home and community-based service spending has increased rapidly in recent years, the vast majority of these expenditures are for younger persons with disabilities, especially those with mental retardation or developmental disabilities.

Pushing states in the direction of home and community-based services is the U.S. Supreme Court's *Olmstead v. L.C.* decision in 1999, which found that the Americans with Disabilities Act (ADA) meant that unnecessary institutionalization is illegal discrimination, and required the option of home and community-based services be provided. This right is not unlimited and may be bounded by state fiscal limits. Although the reasoning of the decision would appear to apply to all persons with disabilities, the exact implications for older people are not clear since the case was brought by two Georgia women with mental retardation and mental illness. In a letter to state Medicaid directors in January 2000, the Health Care Financing Administration (HCFA) asks states to develop plans to comply with the *Olmstead* decision.[9]

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[8] Ibid.

[9] Letter to State Medicaid Directors from Timothy M. Westmoreland, Director, Center for (continued...)

Medicaid home care spending is very uneven. California, Massachusetts, New York, and Texas alone accounted for 54% of total Medicaid home care expenditures for the elderly in 1997 (elderly beneficiaries in these four states were 33% of all elderly Medicaid beneficiaries). Spending for all home and community-based services for the elderly in New York was far greater than any other state, and accounted for 34% of national Medicaid home care expenditures for the elderly in 1997 even though elderly beneficiaries in New York were just 9% of all elderly Medicaid beneficiaries. As discussed above, several states also have sizable state-funded programs that provide home and community-based care. For going federal Medicaid matching funds allows states maximum flexibility in determining eligibility, providing services, and budgeting expenditures. However, most states are increasingly choosing to finance their home and community-based services through the Medicaid program.

Medicaid Funding Strategies. States can fund Medicaid home and community-based services either through the regular Medicaid program with coverage of home health (which is a mandatory benefit) and personal care (which is an optional benefit) or through home and community-based services (HCBS) waivers (Section 1915(c) of the Social Security Act). Although all states have Medicaid home and community-based service waivers for older people, these programs are not always a large part of the home care available in the state. For example, California, Massachusetts, New York and Texas have focused much of their expansion of home and community-based services through coverage of personal care and home health within the regular Medicaid program. If states choose this approach, then services must be offered as an open-ended entitlement, with services available on a statewide basis and coverage not limited to specific eligibility groups (e.g., just the elderly or younger people with physical disabilities).

Because of a fear of runaway spending resulting from the large number of people in the community who are not currently receiving home and community-based services, states are increasingly choosing to expand their commitment to this type of care through the more tightly controlled Medicaid waivers. Under this option, states can cover a wide range of nonmedical long-term care services, including case management, personal care services, home modification, transportation, adult day care, habilitation, rehabilitation, and respite care. States must target people at high risk of institutionalization and assure HCFA that the average cost of providing services with the waiver will not exceed the average cost without the waiver. Because of this cost-effectiveness requirement, states may provide these services only to a pre-approved number of people, limiting the potential financial liability that would accompany an open-ended entitlement benefit. Under the waiver provisions, services do not have to be offered statewide and can be limited to highly-targeted groups of Medicaid eligibles. After a relatively slow start in the early 1980s, total home and

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[9] (...continued)
Medicaid and State Operations, Health Care Financing Administration, and Thomas Perez, Director, Office of Civil Rights, U.S. Department of Health and Human Services, January 14, 2000.

community-based waiver expenditures (for the elderly and young people with disabilities) had increased from $0.7 billion in 1988 to almost $8 billion in 1997.[10]

Although conflict between the federal government and the states over approval of waivers was substantial and bitter during the Reagan and Bush Administrations, regulatory changes implemented by the Clinton Administration have made obtaining waivers routine. Indeed, some states are not using all of the "slots" approved by HCFA, primarily because state matching funds are not available. Most ANF states uniformly described their relationship with HCFA regarding the waivers as good and reported that the HCFA regional offices were helpful and responsive. However, states complain about the paperwork and staff time involved in obtaining waivers, and some note that the monitoring by HCFA was primarily a paper review which does not focus on client outcomes.

Given the greater ease with which states can secure approval from HCFA, the importance of HCBS waivers for the older population is likely to increase. For example, Michigan expanded its HCBS waiver from 4,100 slots in 1998 to 15,000 slots projected for 2000. And Mississippi is looking to expand its HCBS elderly and disabled waiver from 3,200 slots in FY2000 to 10,000 slots over the next 3 years.[11]

Cost Containment Strategies. In almost every state, home and community-based services are "sold" primarily on their ability to achieve cost savings, although meeting the needs of people in the community and providing consumers with the services they want is also important. While states hope to save money by substituting lower cost home and community-based services for more expensive nursing home care, most research suggests that expanding home care is more likely to increase rather than decrease total long-term care costs.[12] The primary reason for this result is what many call the "woodwork effect." While many older persons would for go paid long-term care services if given only the option of nursing home care, many of these same individuals would use home care services if given the choice. Thus, the costs associated with large increases in home care use could more than offset the relatively small reductions in nursing home use. Budget neutrality or cost savings will be especially difficult to obtain if the cost per person of serving people in the community is high.

Despite this traditional view among researchers, some recent research is more encouraging about the potential cost-effectiveness of home and community-based care. For instance, a 1996 study of Washington, Oregon, and Colorado by Alecxih et. al. concluded that home and community-based services were cost-effective

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[10] Harrington, C., H. Carillo, V. Wellin, F. Norwood, and N. Miller. *1915(c) Medicaid Home and Community-Based Waiver Participants, Services, and Expenditures, 1992-1997*. San Francisco, University of California, March 2000.

[11] Mississippi Medicaid, *HCBS Waiver Programs: Elderly and Disabled Waiver*, [http://www.dom.state.ms.us/ltc1/body_ltc2.htm], accessed April 14, 2000.

[12] Wiener, J.M., and R. J. Hanley. *Caring for the Disabled Elderly: There's No Place Like Home*, in S. M. Shortell and U. E. Reinhardt, *Improving Health Policy and Management: Nine Critical Research Issues for the 1990s* Ann Arbor, Health Administration Press, 1992. p. 75-110.

alternatives to institutional care in these states.[13] A 1994 study by the U.S. General Accounting Office came to similar conclusions about home and community-based services in Washington, Oregon, and Wisconsin.[14] Moreover, some states argue that their Medicaid waiver costs are so low that they are achieving cost neutrality, if not cost savings, even while serving additional people who would not otherwise be institutionalized. For example, New York claims that its home and community-based services clients cost only half as much as nursing homes residents.[15] Similarly, Alabama claims its waiver beneficiaries cost $17,000 less than nursing home clients.[16] On the other hand, states may be serving a significantly less disabled population than in nursing homes and persons who might not otherwise be institutionalized.

Further, the federal government has encouraged states to identify and remedy barriers to community-based care and assist nursing home residents relocate to the community through its "Date Certain" and "Nursing Home Transition" grants programs. Colorado, Michigan, New York, Texas, Wisconsin, New Hampshire, New Jersey, and Vermont received such grants from HCFA in 1998 and 1999.[17]

States have addressed the issue of cost-effectiveness of home and community-based services in a variety of ways. First, states set a maximum amount (generally the average Medicaid expenditure for nursing home care) that they will spend on home and community-based services for a single individual. According to some researchers, expenditures at this level are probably too high to achieve budget savings because of the difficulty of targeting services only to people who would be institutionalized without them.[18] Some states, however, are spending much less. The average per-recipient cost of in-home and alternative care facilities in Colorado, a state identified by Alecxih et. al. as having a cost-effective system of care, is 16% and 14%, respectively, of the average per-recipient Medicaid expenditure for nursing home care.[19]

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[13] Alecxih, L. M. B., S. Lutzky, and J. Corea. *Estimated Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States*. Washington, American Association of Retired Persons, 1996.

[14] U.S. General Accounting Office. *Medicaid and Long-Term Care: Successful Efforts to Expand Home Services While Limiting Costs*. Washington, 1994.

[15] Raetzman, Susan and Susan Joseph. *Long-Term Care in New York: Innovations in for Care Elderly and Disabled People.* Issue brief, New York, The Commonwealth Fund, 1999.

[16] Alabama Medicaid Agency, *1998 Annual Report*, [http://www.Medicaid.state.al.us/about/98anrep/longterm.htm], accessed April 24, 2000.

[17] Letter to State Medicaid Directors from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, Health Care Financing Administration, January 11, 2000. [http://www.hcfa.gov/medicaid/smd11100.htm]

[18] Weissert, W.G. One More Battle Lost to Friendly Fire – Or If You Spend Too Much It's Hard to Save Money. *Medical Care*, v. 31, no. 9, suppl: SS119-SS121.

[19] Alecxih, L. M. B, S. Lutzky, J. Corea, B. Coleman. *Estimated Cost Savings From the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States,* Washington, American Association of Retired Persons, 1996.

Second, states are providing services to a more disabled population who have a higher risk of institutionalization than they did 10 years ago, increasing the probability of substitution of home care for nursing home care. However, given the requirement that home and community-based waiver services be targeted to persons who would be institutionalized without them, surprisingly few states impose eligibility requirements for waiver services beyond meeting the nursing home level of disability, even though many severely disabled people live in the community and would not enter a nursing home even if home and community-based services were not provided.

Third, states are experimenting with consumer-directed home care programs, which give beneficiaries, rather than home care agencies, the power to hire, train, supervise and fire the worker.[20] Relatively common for services among younger people with physical disabilities, these initiatives are just starting for older persons in many states, although there are well-established programs in California, Colorado, Kansas, Maine, Michigan, Oregon, Washington, and Wisconsin. Consumer-directed care is often less expensive than agency-directed care because independent workers receive less supervision and fringe benefits and sometimes lower wages than agency-directed employees. Stakeholders report that beneficiaries of all ages can manage their services and appear to derive significant benefits from doing so.[21]

Fourth, recognizing that there are certain economies of scale in residential settings that are lacking in traditional home care where services are provided to one person at a time, many states are exploring the potential role of residential alternatives to nursing home care, including adult foster care and assisted living facilities. Medicaid home and community-based services waivers can cover the "service" component of these nonmedical residential facilities, but not the room and board components. In 1998, 35 states covered or planned to cover the service component of assisted living facilities or other congregate care through Medicaid for frail older persons.[22] The states hope to provide services that are more home-like, provide greater personal autonomy, and cost less than nursing homes. In general, the nursing home industry contends that its residents are too disabled to be served adequately in these alternate settings, although in some states, such as Wisconsin and Michigan, the nursing home industry is expanding into nonmedical residential facilities.

As states consider expanding these residential alternatives, they face a number of very difficult issues. One issue that has greatly perplexed states is how to superimpose these new concepts of consumer-oriented, homelike residential facilities on a large existing stock of nonmedical residential facilities (see **Table 2** for a comparison of the number of nonmedical residential and nursing home beds by ANF state), which has been all but ignored by national and many state policymakers. For

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[20] Tilly, J. and J.M. Wiener. *Consumer-Directed Home Care Programs: Experience of Beneficiaries, Caregivers, and Workers*. Washington, The Urban Institute, 2000.

[21] However, there are disadvantages, including increased risk for people with cognitive impairments. Although fear of substandard consumer-directed care is a major barrier to its expansion, limited quantitative and qualitative data provide little evidence of lower quality care for beneficiaries who direct their own care compared to agency-directed services. Ibid.

[22] Mollica, Robert. *State Assisted Living Policy, 1998*. Augusta, National Academy for State Health Policy, 1998.

example, while Florida has 81,000 nursing home beds, it also has over 67,000 residential facility beds. Moreover, residential settings of care are expanding rapidly in many states and are usually not subject to the certificate of need restrictions that apply to nursing homes. Going by a wide variety of names, including community-based residential facilities (in Wisconsin), adult homes (in New York), Level IV nursing homes (in Massachusetts), and assisted living facilities (in Florida and Michigan), these settings are often viewed as more institutional than homelike in character.

Another major issue concerns how to regulate these facilities in a way that allows individuals to age in place without having to move to obtain needed services, but at the same time prevent these facilities from becoming unlicensed nursing homes. While persons residing in nursing homes are more severely disabled than those in assisted living facilities, a recent study found that 34% of people in assisted living facilities had cognitive impairment and 24% needed help with three or more of the activities of daily living.[23] The problem is that federal and state regulatory structures are built on the concept of a continuum of care in which individuals move from one level to another as they become more disabled. However, the whole notion of allowing individuals to age in place means bringing services to individuals in their "homes," wherever they may be, as they become more disabled.

Finally, states are concerned about how to make these new residential options available to the moderate and lower-income elderly population. Outside of Oregon, most assisted living facilities are expensive and geared to upper-income older persons. A recent analysis found that assisted living facilities were not affordable for most moderate and low-income persons age 75 and older unless they used their assets to help pay for the cost.[24] In Alabama, Minnesota and Wisconsin, some critics contend that middle-class individuals exhaust their private resources paying for their care in residential facilities and, once impoverished, apply to nursing homes as Medicaid residents. Further, to the degree that some assisted living facilities are affordable for low- and moderate-income older persons, they are more likely to offer minimal services and less privacy than more expensive facilities.[25]

Integrate Acute and Long-Term Care Services through Managed Care. Older persons who need long-term care services currently encounter a fragmented financing and delivery system. Financing acute care is largely the province of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state governments. Because of the separation of financial responsibilities, there exists a strong incentive for the federal government to shift costs to the states and vice versa.

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[23] Hawes, C., M. Rose, and C.D. Phillips. *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities*. Prepared for the Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, U.S. Department of Health and Human Services, U.S. Department of Health and Human Services, December 1999.

[24] Ibid.

[25] Ibid.

There is also a lack of coordination in the delivery of services. For example, some nursing home residents are unnecessarily discharged to a hospital because adequate physician services are not available in the long-term care facility. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system.

There is strong interest among state policymakers in finding ways to integrate acute and long-term care, primarily through expanding the role of managed care and capitated payments to include long-term care services. States have four goals in integrating acute and long-term care services. First, they hope that they will achieve better quality care, with providers no longer hamstrung by arbitrary divisions between acute and long-term care. Second, they seek lower costs, as providers substitute lower cost ambulatory and home-based care for more expensive hospital and nursing home care. States also hope to save money by explicitly shifting costs to Medicare for individuals eligible for both Medicaid and Medicare or by claiming most of the potential savings for Medicaid. Third, some states, such as Massachusetts, Minnesota and Wisconsin, have a conscious strategy of trying to reduce the number of providers with whom they must deal directly so that officials can focus on setting contract standards and monitoring performance. Finally, as with all capitation strategies, states use per person payments to shift much of the financial risk of unforseen cost increases from the government to providers, making state spending more predictable.

A number of states, including California, Colorado, Massachusetts, New York, Texas, Washington, and Wisconsin, have Program of All-inclusive Care of the Elderly (PACE) or Social Health Maintenance Organization (Social HMO) sites that represent some of the first acute and long-term care integration models.[26] While these demonstrations have required state participation in Medicaid waivers, they have not been primarily state initiatives. State officials are generally supportive of these demonstrations, but they are looking for "purchasing strategies" that can enroll thousands of Medicare and Medicaid dually-eligible individuals, and the PACE and Social HMO demonstrations do not provide that mechanism. Enrollment in these demonstration programs has been very limited; for example, each PACE site generally enrolls only about 300 persons.

Many states are planning initiatives or already are enrolling individuals in managed care programs that integrate acute and long-term care services. However, so far, most of these efforts are small in scale and preliminary in their planning and implementation. Especially notable are Minnesota's Senior Health Options demonstration, Colorado's Integrated Long-Term Care Financing Project, Florida's Long-Term Care Community Diversion Pilot Project, Texas' STAR+Plus Integrated Care Project, and Massachusetts' Senior Care Organizations. Although there are

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[26] PACE demonstration sites operate as geriatrics-oriented, staff-model HMOs that provide the complete range of acute and long-term care services to people who meet nursing home admission criteria. Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care benefits. They seek to enroll a cross-section of the elderly population in terms of disability levels. Other demonstrations, such as the Wisconsin Partnership Program, seek to modify the PACE model by eliminating the requirement to use adult day center services and by allowing participants to bring in their own physician.

exceptions, most of these efforts borrow from the PACE projects in their focus on dual eligibles (although not PACE's focus on people at risk of institutionalization) and from the Social HMOs in their general use of conventional HMOs rather than organizations that specialize in care of the elderly or younger people with disabilities. Some states, such as New York, Michigan, and Wisconsin, are beginning the process by integrating long-term care alone, without adding acute care services.

At this point, however, there is more discussion and debate than action: many of the projects are still in planning stages or have encountered obstacles to implementation. For example, Colorado's Integrated Long-Term Care Financing Project was slated for implementation in November of 1999, but was halted because the health plan dropped out because of a dispute with the state related to its Medicaid managed care program. Wisconsin dropped its ambitious plan to integrate acute and long-term care services because of opposition from counties and advocates for older people (discussed below).

In part, the slow pace of integration is because almost all of these initiatives require Medicaid and sometimes Medicare research and demonstration, freedom-of-choice, or home and community-based services waivers. States have generally found negotiations with HCFA and the federal Executive Office of Management and Budget (OMB) to be difficult on two major points. First, some states want Medicare payments to be made to the state, who would then combine them with Medicaid funds into a single capitation payment to the managed care organizations, but HCFA has steadfastly maintained that it will not "block grant" the Medicare program to the states. As a result, Medicare and Medicaid capitation payments are made separately. Some states, such as Texas, contend that this leads to fragmentation within the managed care organizations and hampers service integration. Within this context, the federal government has also been suspicious that the states are trying to shift Medicaid costs to Medicare and capture all the savings for themselves.

Second, some states would like power to make enrollment mandatory. In part because the combination of Medicare and Medicaid benefit packages for the elderly are already so comprehensive, states fear that enrollment in these integrated systems will be slow to modest if it is allowed to be voluntary; from the point of view of beneficiaries, there is simply not a compelling reason to join these managed care organizations. HCFA, however, has insisted that dual eligibles are Medicare beneficiaries first and foremost and, therefore, are entitled to freedom of choice of providers for Medicare services.[27] Thus, it has rejected efforts to make enrollment mandatory for Medicare services, and most states have abandoned any hope of doing so.

Like all managed care initiatives, the integration of acute and long-term care services can potentially realign how services are delivered and financed in dramatic

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[27] HCFA does allow states to require dual eligibles to join HMOs for Medicaid-covered services, but does not allow states to require beneficiaries to receive Medicare services through the HMOs. If beneficiaries choose to receive services outside of the managed care organization, then either the state or the managed care organizations must pay the applicable deductibles and coinsurance.

ways that not all agree are desirable. For example, in May 1997, the Wisconsin Department of Health and Family Services proposed to "redesign" the public long-term care system across the age spectrum by relying on managed care and a single capitated payment to integrate acute and long-term care. The redesign also would have created county-level resource centers to provide a single point of entry for information and counseling and access to services. The nursing home industry was generally supportive of the plan because it believed that it would financially benefit from the substitution of nursing home for hospital care. The proposal, however, was withdrawn in response to heavy criticism from elderly and disability advocacy groups and county officials, and now includes only long-term care services.

Opponents of the redesign were critical of the state's reliance on conventional managed care organizations to meet the long-term care needs of individuals. Specifically, opponents of the redesign believed that HMOs in Wisconsin had little experience or skill with the elderly or with long-term care. Despite relatively high market penetration by HMOs for the nonelderly population, low Medicare payment rates have meant that Wisconsin HMOs have not enrolled many older people. Thus, they may not be skilled in providing services to this vulnerable population.

Joining acute and long-term care services could also have an adverse effect on long-term care, according to critics. Fiscal pressures within an integrated system could short-change long-term care by shifting funds from long-term care to acute care if providers do not view long-term care as a priority or if acute care overruns its budget. In addition, long-term care may become over-medicalized and services less consumer-directed because the balance of power might shift from the individual client and her chosen provider to HMOs, insurance companies, or other administrative entities. Home care providers in Wisconsin, who have little experience with managed care, were also concerned about their relative negotiating strength and the potential bias of managed care toward institutional care that could result. Finally, counties were concerned that the redesign would diminish their substantial historic role in long-term care service delivery, since not all counties would be willing to bear the financial risk of a capitated model. These criticisms are not unique to Wisconsin; they are indicative of concerns shared by many long-term care advocates, especially in states where there is a well developed set of home and community-based providers.

A final factor in the slow pace of integration initiatives is the recent turmoil in Medicaid managed care and Medicare managed care efforts. Managed care programs have been plagued with highly publicized financial instability and plan withdrawals. Many mainstream, "commercial" plans have withdrawn from Medicaid, often leaving Medicaid-only plans the dominant participants.[28] Moreover, the pace of enrollment in Medicare managed care plans has slowed in recent years and some HMOs have withdrawn from the market, making it more difficult for states to build on a robust elderly-oriented managed care market.[29] In part, this reflects a backlash against

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[28] Kilborn, P.T. *Largest HMOs Cutting Poor and the Elderly. New York Times*, July 6, 1998. p.1.

[29] Medicare enrollment increases in managed care totaled 28,000 beneficiaries a month from January to June 1999, compared to 91,000 beneficiaries a month in 1997. The number of (continued...)

managed care plans in general and their efforts to reduce costs.[30] Neither program has proved thus far to be uniformly successful in bringing about improved access and quality, or cost containment, making all parties – state and federal officials, health plans, and consumers and their advocates – cautious about expanding managed care to the frail elderly population.

Increase Private and Federal Resources

One general strategy that states are using to control spending is to bring additional private and federal resources into the long-term care financing system in order to offset state expenditures. Bringing outside resources to offset state long-term care expenditures could be done in several ways, including: encouraging purchase of private long-term care insurance; more strictly enforcing prohibitions against transfer of assets; and, maximizing Medicare and Medicaid financing for long-term care services. The first two approaches build on the observation that a substantial proportion of Medicaid nursing home residents were not poor before they entered the nursing home. The last strategy is rooted in the fact that long-term care has many sources of government financing and that states can minimize their own spending by shifting costs from state-only programs to Medicaid and from Medicaid to Medicare, thus increasing federal expenditures.

Encourage Private Long-Term Care Insurance. For the middle class nursing home population eligible for Medicaid, private long-term care insurance possibly could prevent both their impoverishment and subsequent Medicaid expenditures. Currently, however, only about 8% of the elderly have any type of long-term care insurance.[31] A primary reason for the lack of purchase is the high cost of long-term care insurance, which can exceed $2,300 for a good quality policy purchased at age 65.[32] By most estimates, only 10% to 20% of the elderly can afford private long-term care insurance.[33] Wiener et al. found that long-term care insurance policies are

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[29] (...continued)
HMOs participating in Medicare declined over the 2 year period. Health Care Financing Administration, *Medicare+Choice: Changes for the Year 2000*, [http://www.hcfa.gov/medicare/mcanch13.pdf], accessed April 24, 2000.

[30] Blendon, R.J., M. Brodie, J.M. Benson, D.E. Altman, L. Levitt, T. Hoff, and L. Hugick, Understanding the Managed Care Backlash. *Health Affairs*, v. 17, no. 4, July/August, 1998, pp. 80-94; and, M. Peterson, ed., Managed Care Backlash: Special Issue, *Journal of Health Politics, Policy and Law*, v. 24, no. 5, October 1999.

[31] Authors' estimate based on data from S. Coronel, *Long-Term Care Insurance in 1997-1998*, Washington, Health Insurance Association of America, 2000; and M. Cohen, personal communication.

[32] Ibid., Coronel.

[33] Wiener, J.M., L. H. Illston, and R. J. Hanley. *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*. Washington, The Brookings Institution, 1994; Crown, W.H., J. Capitman, and W.N. Leutz, Economic Rationality, the Affordability of Private Long-Term Care Insurance, and the Role of Public Policy, *The Gerontologist*, v. 32, no. 4, 1992. p. 478-485; and, Rivlin, A.M. and J. M. Wiener, *Caring for the Disabled* (continued...)

unlikely to have much impact on Medicaid long-term care expenditures because coverage is affordable mostly to people who would not spend down to Medicaid without insurance.[34] However, Cohen et. al. had more optimistic projections.[35]

In order to expand private long-term care insurance, states are adopting three strategies. First, 18 states offer tax incentives to individuals or employers to purchase private long-term care insurance.[36] These state tax deductions or credits are almost all very small (typically worth $200 or less) and are unlikely to make private long-term care significantly more affordable. Advocates generally argue that the incentives are important, nonetheless, because they put states "on the record" as supporting private insurance.

Second, 19 states either offer or are preparing to offer private long-term care insurance to their employees, retirees, and, in some cases, parents and parents-in-law of employees.[37] All of these offerings are on an employee-pay-all basis. Aside from providing a fringe benefit to employees, states hope to be a "model employer," stimulating offerings by large companies. So far, however, take-up rates have been extremely low – well under 5% of eligible individuals have enrolled (except in California, where it is slightly higher).[38]

Third, Connecticut, Indiana, California, and New York have established "public/private partnerships" to encourage the purchase of private long-term care insurance.[39] Under these partnerships, states allow individuals who purchase a state-approved private long-term care insurance policy to keep far more assets and still qualify for Medicaid. In the Connecticut partnership model, for example, consumers purchase a level of private coverage equal to the amount of assets that they wish to protect. An individual who purchases a policy that pays $100,000 in benefits can keep $100,000 in assets and still qualify for Medicaid nursing home benefits. In New York, individuals can protect an unlimited amount of *assets* from spend-down by purchasing 3 years of a state-approved private long-term care insurance coverage. Individuals in nursing homes in the four states must still contribute all of their *income* towards the cost of care except for a small personal needs allowance.

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[33] (...continued)
Elderly: Who Will Pay? Washington, The Brookings Institution, 1988.

[34] Ibid. Wiener and Rivlin.

[35] Cohen, M.A., N. Kumar, and S.S. Wallack. Long-Term Care Insurance and Medicaid. *Health Affairs*, v. 13, no. 4, fall, 1994. p. 127-139.

[36] Wiener, J.M., J. Tilly, and S.M. Goldenson. Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance. *Elder Law Journal*, in press 2000. (Hereafter cited as Wiener, Tilly, Goldenson, *Long-Term Care Insurance*.)

[37] Ibid. This initiative is mirrored at the federal level by President Clinton's proposal to offer private long-term care insurance to federal employees, retirees, and others, which was enacted on September 19, 2000. (P.L. 106-265).

[38] Ibid.

[39] Ibid.

Under these Medicaid initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that provides unlimited coverage. Proponents of this approach contend that the goal is not asset protection, per se, but rather a means to preserve financial autonomy toward the end of life. Other states have considered similar approaches, but have not implemented them because of requirements for estate recovery imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.[40]

By all accounts, the number of people purchasing partnership policies has been modest. As of 1999, the four states have spurred the purchase of fewer than 53,000 policies, despite there being approximately 7.2 million older people in these states.[41] Thus, the partnerships have failed the market test, at least so far. This may reflect the lack of appeal of easier access to Medicaid on the part of potential enrollees and the unwillingness of insurance agents to aggressively market these policies.

Reduce "Medicaid Estate Planning". Over the last several years, policymakers and the media have focused attention on middle-class and wealthy elderly persons who transfer, shelter and under-report assets in order to appear artificially poor so that they can qualify for Medicaid-financed nursing home care.[42] The goal of this transfer – often called Medicaid estate planning – is to appear poor on paper and yet preserve private wealth in the face of long-term care expenses. Congress has legislated against these practices on numerous occasions, most recently in the Balanced Budget Act (BBA) of 1997, which made it illegal for lawyers and financial advisors to advise senior citizens on transferring assets to qualify for Medicaid assistance upon entering a nursing home. Some observers argue that the legislative prohibitions are easy to circumvent and that the prevalence of Medicaid estate planning has increased dramatically in recent years.

While the rhetoric surrounding the issue is passionate and all states acknowledge it as somewhat of a problem, only in Massachusetts, New Jersey, and New York among the ANF states is asset transfer thought to be widely prevalent (although no systematic data are available).

Asset transfer is of particular concern to policymakers in New York, where there are approximately 1,200 elder law attorneys and where newspaper and magazine advertisements relating to asset transfer are ubiquitous. Especially in New York, the litigious culture and the hostility of the state courts to rules requiring the middle class

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[40] The OBRA of 1993 requires states to recover the cost of Medicaid financed long-term care from the estates of Medicaid beneficiaries. The four states now operating partnership programs plus possible future programs in Iowa and Massachusetts were allowed to exempt insurance-related protected assets from a person's estate. Thus, in all other states, while additional assets may be protected when the individual is alive, persons who become Medicaid beneficiaries by virtue of these partnership initiatives may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.

[41] Wiener, Tilly, and Goldenson, *Long-Term Care Insurance*.

[42] Burwell, B. and W. H. Crown. *Medicaid Estate Planning: Case Studies of Four States*, in Wiener, J. M., S. B. Clauser, and D. L. Kennell, editors, *Persons with Disabilities: Issues in Health Care Financing and Service Delivery*, Washington, Brookings Institution, 1995.

to impoverish themselves make cracking down on asset transfer difficult. Nonetheless, state officials believe that reducing asset transfer is a critical prerequisite to motivating people to purchase the partnership long-term care insurance policies and, more generally, to view long-term care as a private rather than public responsibility. In their view, there is little reason to buy insurance if one can protect family assets by transferring them to relatives. The New York State Bar Association has successfully challenged the constitutionality of federal legislation in the BBA of 1997.

Maximize Federal Financing. Public funding for long-term care for the elderly includes Medicare, Medicaid, and state-only funded programs. Medicare is, of course, entirely federally funded and Medicaid is mostly federally funded. Thus, to the extent that states can shift the source of funding for long-term care from state-funded programs to Medicaid and from Medicaid funding to Medicare, states can potentially limit or reduce their own expenditures.

Over the last 10 to 15 years, several states, including California, Massachusetts, and Wisconsin, have moved home care programs funded solely with state and county funds into the Medicaid program. For example, personal care became a covered option in California in 1993, effectively making a large portion of the In-Home Supportive Services program a Medicaid service eligible for a 50% federal match. Similarly, in 1987, Wisconsin moved a substantial part of its state-funded Community Options Program into a Medicaid home and community-based services waiver. While California and Wisconsin have obtained additional federal contributions by maximizing Medicaid, each state has also maintained large, state-only portions of the programs which are not subject to the federal requirements of the Medicaid program. However, the possibility of further transfers is limited by the fact that states only spent under $2 billion nationally in 1997 on state-funded home care programs, mostly for people who could not financially qualify for Medicaid.[43] Thus, there is only a modest pool of dollars potentially available to be refinanced.

States have long sought to shift Medicaid long-term care expenditures to Medicare, but have been frustrated historically by the narrow range of nursing home and home health services covered by Medicare. That situation changed dramatically in 1989, when Medicare coverage rules were liberalized. Medicare expenditures for home health and skilled nursing facility (SNF) care increased dramatically, peaking in 1997 when they accounted for almost 16% of Medicare expenditures.[44] Medicare spending for home health has declined and in 1999 totaled $10 billion, which still dwarfed the $3.8 billion spent by Medicaid on home and community-based services for the elderly in 1997.[45] While Medicare primarily provides short-term, post acute

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[43] Kassner, E. and L. Williams. *Taking Care of Their Own: State-Funded Home and Community-Based Care Programs for Older Persons*. Washington, AARP, 1997.

[44] Figure 11. Percent Distribution of Medicare Program Payments, by Type of Service: CYs 1967 and 1997. *Health Care Financing Review, Statistical Supplement 1999*. p. 29.

[45] U.S. Congressional Budget Office. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001*. Washington, GPO, 2000.

care for nursing facility care, its home health benefit has become substantially more long-term in character in recent years.[46]

In response, some states have initiated Medicare maximization efforts in an attempt to reduce Medicaid long-term care expenditures. These efforts seek to ensure that Medicare rather than Medicaid pays for home health and nursing facility care whenever possible. These efforts take the form of provider and consumer education about Medicare benefits, data system improvements to identify people dually eligible for both Medicare and Medicaid and instances of inappropriate billing, and requirements that all home health providers be Medicare – as well as Medicaid – certified and that they bill Medicare where there is the slightest chance of reimbursement. Partly reflecting these initiatives, one study of Medicare and Medicaid home health expenditures during the mid-1990s suggested an inverse relationship between Medicare and Medicaid home health spending.[47]

Medicare reimbursement cuts in the BBA of 1997 combined with efforts to crack down on fraud and abuse have had a dramatic impact on skilled nursing facilities and home health agencies, potentially making Medicare maximization much more difficult. For example, Medicare home health expenditures declined by 45% between 1997 and 1999.[48] The number of Medicare-certified home health agencies dropped from 10,444 in 1997 to 7,747 in 1999.[49] In addition, several major nursing home chains have filed for bankruptcy protection, which the industry claims is due to Medicare reimbursement changes and which the U.S. General Accounting Office (GAO) largely attributes to poor business decisions.[50]

Traditional Strategies To Control Spending

If states do not succeed in reducing the rate of increase in long-term care expenditures through delivery system reform or by increasing outside resources, there are still a number of more conventional mechanisms that states can use, including cuts in reimbursement and limiting the supply of providers. Existing federal law gives states considerable flexibility in these areas.

Cut Reimbursement Rates. Medicaid payment rates for nursing facility care are a logical target for states trying to reduce the rate of growth in long-term care expenditures for the elderly. Whereas the effects on expenditures from reforms such

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[46] Ibid.

[47] Kenney, G., S. Rajan, and S. Soscia. Interactions between the Medicare and Medicaid Home Care Programs: Insights from States. *Health Affairs*, v. 17, no. 1, January/February 1998. p. 201-212.

[48] Pear, R. Medicare Spending Care at Home Plunges by 45 Percent. *New York Times*, April 21, 2000. p. 1.

[49] National Association for Home Care. *Basic Statistics About Home Care.* [http://www.nahc.org/Consumer/hcstats.html.]

[50] U.S. General Accounting Office. *Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments, But Maintain Access.* HEHS-00-23, Washington, December 14, 1999.

as expanding home and community-based services and integrating acute and long-term care through managed care are uncertain, the impact of nursing home rate reductions on state budgets is predictable, immediate, and potentially large. As can be seen in **Table 5**, there is significant variation among the ANF states in Medicaid nursing home reimbursement. (An important caveat in comparing the state rates is that some rates include ancillary services, such as physical therapy, while others do not.) While some of this variation reflects different levels of service provision, it might also be indicative of real differences in how generous (or frugal) states are in nursing home reimbursement.

Table 5. Average Medicaid Rates for Nursing Facility Reimbursement by ANF State, 1998

State	Per diem rates
Alabama	$98.69
California	$83.12
Colorado	$101.55
Florida	$97.99
Massachusetts	$116.63
Michigan	$96.05
Minnesota	$106.65
New Jersey	$80.60
New York	$158.93
Texas[a]	$71.11
Washington	$116.00
Wisconsin	$91.70
United States	$95.72

Source: C. Harrington et al. 1998 State Data Book on Long Term Care Program and Market Characteristics. San Francisco: The University of California San Francisco, 1999.

[a] Composite of two rates ($70.83 1/97-8/97 and $71.69 9/97-12/97).

Between 1980 and 1997, the "Boren amendment" governed how states reimbursed nursing homes under Medicaid. The amendment required that rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards" (Section 1902(a)(13) of the Social Security Act).

Strongly opposed by the states, the Boren amendment was repealed as part of the BBA of 1997. States now have almost complete freedom in setting nursing home payments rates, except for the requirement to hold public hearings. The retention of the "equal access provision," a clause within the Medicaid legislation requiring states to set payments "consistent with efficiency, economy, and quality of care" could provide nursing homes with some legal protection. However, physicians, home care agencies, and other noninstitutional providers have not found this standard to be of much help in forcing higher reimbursement rates. In a few states, including Texas, the nursing home industry believes that existing state laws can be used to force adequate payments.

The problem with repealing the reimbursement standard is that Medicaid nursing home payment rates are already fairly low in many states, especially in comparison to Medicare and private pay rates. Not surprisingly, then, nursing homes often prefer higher paying private-pay to Medicaid residents, which can result in problems of access for Medicaid beneficiaries. To the extent that states cut Medicaid reimbursement rates and the payment differential between private pay and Medicaid patients widens, access problems could worsen for Medicaid beneficiaries. Recognizing this problem, Minnesota and North Dakota require nursing homes to charge private pay residents the same amount that Medicaid pays, but they are the only states that do so. However, few nursing homes can survive without Medicaid residents, limiting the extent to which facilities can reduce access.

In addition, while there is little evidence of a simple relationship between cost and quality, there is probably some threshold level of reimbursement below which it is impossible to provide adequate quality of care.[51] While the quality of care in nursing homes has improved over the past 20 years, advocates for nursing home residents remain extremely concerned about the quality of care provided in many facilities. A series of GAO studies have highlighted continuing problems of quality of care in nursing homes.[52] In Texas, where poor quality of care has been a constant

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[51] Wiener, J.M., and D.G. Stevenson. Repeal of the 'Boren Amendment': Implications for Quality of Care in Nursing Homes. *New Federalism: Issues and Options for States*, Series A, No. A-30, December 1998.

[52] U.S. General Accounting Office. *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight.* GAO/HEHS-98-202, Washington, 1998; U.S. General Accounting Office. *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality.* Washington, GAO/HEHS-00-6, 1999; U.S. General Accounting Office, *Additional Steps Needed to Strengthen Enforcement of Federal Standards*. GAO/HEHS-99-46, Washington, 1999; and U.S. General Accounting Office. *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*.

(continued...)

issue, the nursing home industry contends that the level of care is a direct result of low payment rates. In response, the state contends that nursing homes have not always used the money provided to improve care. In many states, the nursing home industry is fearful that it will be held legally responsible for meeting the federal and state quality standards, but will not be reimbursed enough to allow them to do so.

The potential impact of the Boren amendment's repeal on payment rates is unclear. First, the nursing home industry is politically powerful in every state and may succeed in maintaining the current level of reimbursement or close to it. To some critics, the Boren amendment functioned mostly as a legal rationale to provide the nursing home industry what it wanted. Indeed, because of the influence of the nursing home industry, the Congressional Budget Office (CBO) estimated that repeal of the Boren amendment would reduce federal Medicaid long-term care (and hospital) spending by only $1.2 billion over 5 years, less than a one percentage point reduction in Medicaid nursing home expenditures.[53] Nonetheless, in every state, nursing homes are very concerned that the Boren amendment's repeal will leave them vulnerable to significant Medicaid rate cuts.

Second, in recent years, the rate of increase in Medicaid expenditures has been modest and state revenues have been extremely strong. Thus, few states have a pressing need to reduce Medicaid nursing home rates in order to balance their budgets. The widespread bankruptcies in the nursing home industry, discussed above, may also have made states cautious about payment decreases. While massive cuts have clearly not occurred, some states have trimmed rates. For example, New York extended reimbursement rate reductions that were due to expire; Colorado implemented a new nursing home rate setting methodology that resulted in savings; and Texas increased rates in 2000 by only 3.7% even though the nursing home industry contends that costs increased by 7.0% and many facilities had filed for bankruptcy protection.[54] Anecdotally, some observers note an "attitude adjustment" in relations between nursing home associations and state government officials in negotiations over rates, related to the loss of the ability of nursing homes to sue under the Boren amendment.

Limit the Supply of Long-Term Care Service Providers. Many states have responded to growing Medicaid long-term care expenditures by limiting the number of long-term care providers.[55] **Table 6** details the extent to which ANF states use

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[52] (...continued)
GAO/HEHS-99-80, Washington, 1999.

[53] U.S. Congressional Budget Office. *Budget Implications of the Balanced Budget Act of 1997*. Washington, August, 1997.

[54] Colorado Department of Health Care Policy and Financing, *Trends and Program Highlights*, [http://www.chcpf.state.co.us/trends.html]; and, Bureau of National Affairs, Nursing Homes Crushed as State Sticks to 3.7 Percent Medicaid Reimbursement Hike. *BNA Health Care Policy Report*, v. 8, no. 8, February 21, 2000. p. 301.

[55] Wiener, J.M., S.G. Stevenson, S.M. Goldenson. Controlling the Supply of Long-Term Care Providers in Thirteen States. *Journal of Aging and Social Policy*, v. 10, no. 4, 1999.
(continued...)

certificate of need and moratoria on new construction or certification for participation in Medicaid to control the supply of long-term care providers. These efforts have focused largely on nursing home beds, where the general premise is that any new beds are likely to be filled with Medicaid residents. A study of the change in the nursing home bed supply between 1981 and 1993 found that supply control programs did result in a significant reduction in growth of nursing home beds.[56] While most states limit nursing home beds, fewer states target home care providers and fewer still target residential facilities.

Certificate of need programs require facilities to obtain state approval before construction of new facilities or major renovation of existing facilities. In 1998, 38 states had certificate of need programs that reviewed the need for nursing facilities.[57] While certificate of need programs can limit nursing home supply, they are usually required to judge only "need" and to ignore state budgetary concerns. Given a lack of control over home and community-based services that could arguably be substitutes for nursing home care, these certificate of need programs often do not have the technical rationale to find a lack of "need" for more nursing home beds, especially considering a rapidly aging population. A blunter strategy used by many states is to pass a law prohibiting new construction of new nursing home beds or a moratorium on certifying additional beds for Medicaid participation (which would make them economically unviable). Nationally, as of 1998, 19 states had a moratorium on new construction of nursing homes.[58]

Despite moratoria in several ANF states, some expansion – mostly by existing nursing homes – has occurred, even in the states most restrictive of nursing home growth. For example, in 1995, when Alabama still had a moratorium in place for nursing home beds, over 1,000 new beds were built under a provision that allowed existing facilities to expand in geographic areas of high occupancy. Mississippi and Texas have made similar allowances for existing nursing facilities in recent years.

While limiting long-term care provider supply is likely to control expenditures over the short-to-medium term, this strategy raises several issues. The care needs of the elderly do not disappear just because there are no nursing home beds available. To the extent that these needs are met by home care and other services, Medicaid savings will be reduced. Second, nursing home bed/population ratios have already fallen substantially across the United States, although the situation varies across states. The number of nursing home beds per 1000 elderly age 85 and over fell by

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[55] (...continued)
p. 51-72.

[56] Harrington, C., J. H. Swan, J. A. Nyman, and Helen Carrillo. The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States. *Medical Care,* v. 35, no. 6. p. 574-587.

[57] Harrington, C., J.H. Swan, V. Wellin, W. Clemena, and H.M. Carrillo. *1998 State Data Book on Long-Term Care Program and Market Characteristics.* San Francisco, University of California, 1999.

[58] Ibid.

27% between 1978 and 1998.[59] It is unclear how far supply levels can fall without causing hospital backlogs and other problems. In several ANF states (Alabama, Florida, Michigan, and Mississippi) that have limited the expansion of nursing homes, some observers contend that access to nursing home care can be difficult, especially in rural areas. Finally, freezing provider supply does not address the underlying demographic reality that the United States is an aging society and the number of people with disabilities is sure to rise. Therefore, limiting the supply of nursing home beds could be problematic as a long-run cost containment strategy.

[59] Ibid.

Table 6. Certificate of Need (CoN) and Moratoria in the ANF States, By Provider Type, 1998

	Nursing facilities		Home health		Residential facilities		Hospital bed conversion	
State	**CoN**	**Moratorium**	**CoN**	**Moratorium**	**CoN**	**Moratorium**	**CoN**	**Moratorium**
Alabama	X		X				X	
California								
Colorado		X						X
Florida	X		X				X	
Massachusetts	X	X			X	X	X	X
Michigan	X	X					X	
Minnesota		X						X
Mississippi	X	X	X	X	X	X	X	X
New Jersey	X		X		X		X	
New York	X		X				X	
Texas		X						X
Washington	X		X				X	
Wisconsin	X	X					X	X
U.S. (total)[a]	**38**	**19**	**19**	**1**	**12**	**4**	**33**	**12**

Source: C. Harrington el al. 1998 State Data Book on Long-Term Care Program and Market Characteristics. San Francisco: The University of California San Francisco, 1999.

[a] Includes the District of Columbia.

Conclusions

Although the rate of growth for Medicaid long-term care expenditures for the elderly has slowed in recent years, spending on these services still represents a substantial proportion of total Medicaid expenditures. The aging of the population guarantees greater future need for long-term care. Consequently, state policymakers have sought to reduce the rate of growth in these expenditures through reforming the organization and delivery of long-term care services, bringing in more outside resources, and by reducing Medicaid reimbursement and the supply of services. States differ greatly in their emphasis on one or another of these strategies and how strongly they are searching for savings. Indeed, especially compared to acute care, there is enormous variation in state policy on long-term care for the elderly.

One approach is for states to develop more effective and efficient financing and delivery systems by developing home and community-based services and by integrating acute and long-term care services through the use of managed care. All states have a policy commitment to the expansion of home and community-based long-term care services, although the extent of this commitment varies by state, with most states spending only a modest amount on noninstitutional services. While the recent expansion of Medicaid home and community-based care has focused mostly on younger people with disabilities, efforts are being made to expand services for older persons. Although some of the recent emphasis on community-based care is surely based on consumer preferences, a major impetus for this reform is the promise of cost-savings – an outcome about which research has been equivocal. To achieve these cost-savings, states will have to be effective in keeping per person costs down and in limiting the amount of new utilization due to offering additional home care benefits. Several states have shifted state-funded home care programs into Medicaid, especially through the use of Medicaid home and community-based services waivers, taking advantage of the flexibility these waivers offer in terms of services and the ability to limit enrollment and expenditures. While some states complain about the paperwork relating to the waiver, few find that the current system prevents them from doing what they want.

Two relatively new areas of policy development involve consumer-directed care and nonmedical residential facilities. Although still more common among younger people with disabilities, states are experimenting with consumer-directed home care for the older population, where individuals hire, train, direct, and fire their own workers rather than depend on agencies to perform these functions. The hope is that these services will produce more consumer satisfaction and cost less. In addition, most states are debating the use of nonmedical residential care for the elderly as an alternative to nursing home care. Although a sizeable stock of residential facilities exists in many areas, states face a number of difficult issues as they consider this expansion, most notably how to allow people with substantial disabilities to age in place without making these facilities into substandard nursing homes.

Almost all states are looking to managed care and the integration of acute and long-term care services as a potential way to reduce the rate of increase in expenditures. However, many of these efforts are only in the planning stage and limited in scope. Progress on these initiatives has been slow, in part because Medicaid

and, often, Medicare, waivers are needed for their implementation. Also, the mixed experience with Medicaid and Medicare managed care for a less complicated population has led to a cautious approach to integration.

A second strategy to reduce state expenditures is to substitute private, Medicaid, and Medicare financing for state funding. While private long-term care insurance has been heralded by some as a potential fix for rising Medicaid long-term care expenditures, state tax incentives, offering private long-term care insurance to state employees and public/private partnerships has not increased the number of people with private long-term care insurance substantially. While almost all states believe that Medicaid estate planning is a problem, it is a major concern in only a few states and the low level of assets held by severely disabled older people make it unlikely that much money could actually be saved by halting the transfer of assets. While increasing federal contributions through Medicare and Medicaid maximization are being used effectively by some states, these strategies simply shift costs to the federal government. Medicare reimbursement cuts enacted as part of the BBA of 1997 probably make additional cost shifts extremely difficult by making long-stay patients less desirable to home health agencies. Similarly, BBA changes make Medicare skilled nursing facility patients less financially attractive to these facilities than was the case just a few years ago.

In the short run, if faced with an economic downturn, states are likely to rely on more traditional strategies to reduce spending, such as controlling nursing home supply and cutting reimbursement rates. Many states are using certificate of need restrictions or moratoria on new nursing home construction to limit the supply of services, and, therefore, utilization. While this will probably save money over the short-to-medium term, it does not address the underlying demographics of an aging population. With the repeal of the Boren amendment in the BBA of 1997, states will have much greater legal freedom to impose rate cuts on nursing homes. However, so far, relatively few states have cut rates, reflecting the good economic times and the political power of the nursing home industry.

Almost all states complain about the high costs of long-term care for the elderly, but the hard reality is that the current method of Medicaid long-term care financing is actually quite economical. Payment rates are much lower than Medicare and the private sector. Individuals receive government help only after depleting most of their assets, and they must contribute virtually all of their income toward the cost of care. Medicaid pays only the costs that the elderly themselves cannot. Finally, the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system, it is difficult to obtain large savings. However, the fiscal strains that are inevitable as a result of the aging of the baby boom generation guarantees that the search for cost savings will continue.