CHCS Center for Health Care Strategies, Inc.

Policy Brief

Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options

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Foreword

National policymakers and state Medicaid leaders are paying greater attention to better management of long-term supports and services (LTSS). The reasons are obvious: aging of the baby boom population; severe fiscal pressures; the disproportionate share of costs absorbed by those with serious long-term conditions; an ongoing over-reliance on institutional care; and the fact that LTSS remains almost entirely in the unmanaged fee-for-service system. This combination of factors presents state purchasers with significant opportunities to improve care and control costs by better coordinating and managing the full continuum of long-term care services.

To help states explore and understand emerging options, CHCS is launching a new publications series: ***Innovations in the Medicaid Continuum of Care***. With support over the past several years from the Robert Wood Johnson Foundation and Aetna, CHCS has been working with states to design and test new approaches for organizing, financing, and delivering LTSS. This new series builds on this in-the-field work. Future materials will delve more deeply into specific options for transforming long-term care programs to support the full continuum of consumer needs.

We thank all of those who have contributed to this series, especially Gretchen Engquist, Cyndy Johnson, and William Courtland Johnson and the many state and program innovators interviewed along the way. I extend gratitude to my colleagues at CHCS — Alice Lind, Lindsay Palmer Barnette, Melanie Bella, and Lorie Martin — and to all of the funders who have supported our efforts to inform national and state policymakers about emerging opportunities to improve LTSS.

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Commensurate with national health reform, cash-strapped states are forging ahead to develop home- and community-based initiatives that shift Medicaid long-term care programs away from expensive institutional care. According to an industry analyst, over the next two decades, states will spend an estimated $1.6 trillion for long-term care supports and services (LTSS) for their elderly and disabled residents; the federal government will contribute an additional $2.1 trillion, for a total of $3.7 trillion.[1]

It is estimated that roughly two-thirds of Americans age 65 and older today will eventually need some type of long-term care — ranging from personal care assistance for managing daily activities at home to nursing home care — for an average of three years.[2] Despite this reality, few people are insured for long-term care and few have adequate assets, with as many as two-thirds of the elderly unable to afford more than one year of nursing facility care. Consequently, Medicaid is the *de facto* payer of last resort for LTSS, picking up 40 percent of the nation's long-term care costs.[3]

In response, many states are expanding the availability of home- and community-based services (HCBS), including both HCBS waivers plus other non-institutional services, to provide LTSS beneficiaries with high-quality, more cost-effective care. On average, Medicaid can provide these services — which emphasize keeping individuals out of costly nursing facilities — for three individuals for the same cost as serving one in a nursing home.[4] Over the last two decades, Medicaid funding for HCBS programs has increased steadily and by 2007, approximately 43 percent of Medicaid LTSS dollars were dedicated to these programs (Figure 1).[5] The bulk (72 percent) of Medicaid HCBS spending, however, is for the developmentally disabled population, whereas nearly three quarters of Medicaid LTSS dollars for elderly adults and adults with physical disabilities continue to support nursing home care (Figure 2).[6]

Thus, despite the recent growth in HCBS programs, there remains ample opportunity to expand community-based alternatives even further. According to the AARP Public Policy Institute, only five states (i.e., Alaska, California, New Mexico, Oregon, and Washington) currently spend more Medicaid LTSS dollars on HCBS than nursing homes.[7] An array of financial, administrative, bureaucratic, and political obstacles are impeding states from rebalancing their LTSS programs toward greater emphasis on HCBS alternatives. This policy brief and an accompanying environmental scan[8] provide states and federal policymakers with useful tools for understanding:

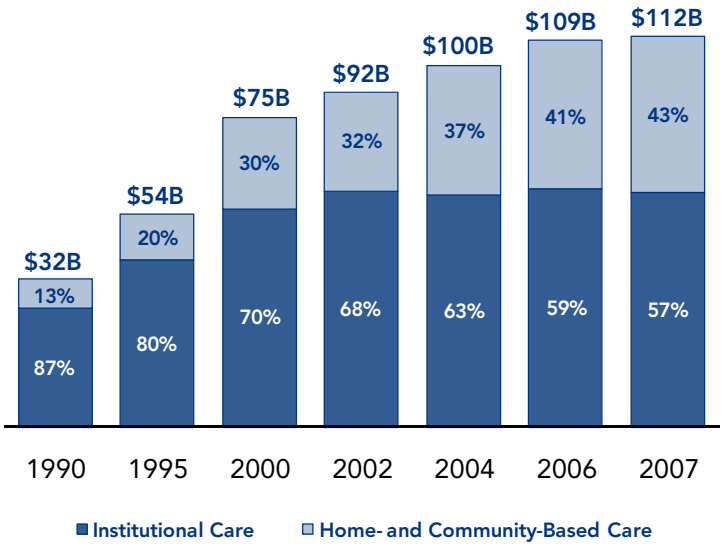
I. The current Medicaid long-term care environment;

II. Legal, regulatory, and bureaucratic barriers to rebalancing LTSS;

III. Promising solutions for rebalancing LTSS; and

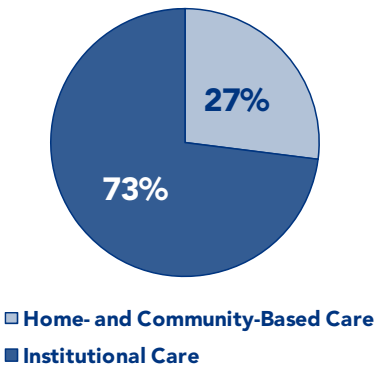
IV. Policy recommendations for improving the Medicaid LTSS system.

Figure 1: Growth in Medicaid Long-Term Care Expenditures, 1990-2007



Source: KCMU and Urban Institute analysis of HCFA/CMS-64 data. Includes all populations served, including elderly, disabled and MR/DD population, etc.

Figure 2: Medicaid Long-Term Care Spending for the Elderly and Adults with Physical Disabilities, 2007



Source: A. Houser, W. Fox-Grage, and M. Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," AARP Public Policy Institute (2009).

I. Overview of the Medicaid Long-Term Care Environment

Over 10 million Americans need long-term supports and services to assist them with life's daily activities. The majority (58 percent) of these individuals are elderly, while 42 percent are under age 65.[9] The latter is comprised largely of children and adults with disabilities, including individuals with physical and cognitive disabilities. The individuals who qualify for Medicaid LTSS are, then, primarily aged, blind, and disabled (ABD) beneficiaries who require a wide array of acute and long-term care services and social supports.

Even though many associate LTSS with nursing homes, fewer than five percent of individuals age 65 and over resided in nursing facilities in 2007. In fact, according to the Kaiser Family Foundation between 2003 and 2008 the number of nursing facility residents increased only 0.9 percent, while the age 85 and over population increased 6.5 percent.[10] Instead, there is a growing emphasis on Medicaid HCBS designed to keep those needing LTSS out of institutions and in less restrictive settings. The most recent data from FY2008 reflect continued growth in HCBS, with expenditures increasing by 4.9 percent over FY2007 to $45.4 billion. Nursing facility expenditures increased by 4.1 percent in FY2008 to $49.0 billion.[11]

States can administer HCBS benefits in several ways (see Figure 3), including: (1) 1915(c) HCBS waivers; (2) the mandatory home health benefit; (3) the optional state plan personal care services benefit; and (4) 1915(i) optional state plan services, which have been significantly revised under recently adopted health reform legislation. HCBS programs can cover a wide variety of services including home health, personal care, medical equipment, rehabilitative therapy, adult day care, case management, home modifications, transportation, and respite for caregivers. Unlike the state plan option that requires states to provide available HCBS benefits to all eligible Medicaid beneficiaries, waivers permit states to limit service use and/or restrict coverage to certain eligibility groups.

In 2006, roughly 2.9 million eligible individuals were receiving HCBS through Medicaid. Among individuals enrolled in HCBS waiver programs, 54 percent were frail elderly and/or physically disabled (EPD); 41 percent were developmentally disabled (MR/DD); and the remaining five percent included children with special needs and individuals with HIV/AIDS, traumatic brain injuries, spinal cord injuries, and mental health needs. The MR/DD group consumed 72 percent of HCBS waiver expenditures, followed by the EPD at 21 percent and all others at seven percent.[12]

Nationwide, the percentage of Medicaid spending on HCBS more than doubled from 20 percent in 1995 to 43 percent in 2007.[13] Average annual HCBS waiver program expenditures in 2006 were $22,619 per person served across all population groups, exclusive of Medicaid acute care services. However, the average costs by population varied greatly, from a low of $8,034 to a high of $61,544. The highest costs are for the MR/DD population, averaging almost $41,000 per person in annual costs, because of their intensive need for around-the-clock supervision and habilitation training.[14,15]

Because states have broad flexibility in designing their Medicaid programs,

Nationwide, the percentage of Medicaid spending on home- and community-based services more than doubled from 20 percent in 1995 to 43 percent in 2007.

Figure 3: State HCBS Program Options

Program/Description	Mandatory/ Optional	Enrollment (2006)	Expenditures (2006)
1915(c) Waivers - Section 1915(c) of the Social Security Act provides the Secretary of Health and Human Services authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings as an alternative to institutional settings.	Optional	1,107,358	$25 billion ($18.1 billion, or 72%, is for the MR/DD population)
Home Health Benefit - Includes part-time nursing, home care agency services, and medical supplies and equipment for individuals eligible for nursing facility care.	Mandatory	873,607	$4.6 billion
State Plan Personal Services - Includes personal care attendant services primarily related to the performance of ADLs and IADLs.	Optional	881,762	$8.5 billion ($5.5 billion, or 65%, is in two states: CA and NY)
1915(i) Optional State Plan Services - Following adoption of health reform legislation, this option can include all services currently allowable under 1915(c) waivers as well as populations up to 300% of SSI.	Optional	NA	NA

Source: T. Ng, C. Harrington, M. O'Malley-Watts. "Medicaid Home and Community-Based Service Programs: Data Update," Kaiser Commission on Medicaid and the Uninsured, November 2009.

Since the bulk of home- and community-based services are optional, nursing facility care still remains the focus of many state Medicaid long-term care programs.

including the level of resources they are willing to devote to long-term care, there are dramatic geographic variances in the delivery and funding of LTSS services. For example, the percentage of Medicaid LTSS spending devoted to all HCBS ranged from almost 75 percent in New Mexico to about 14 percent in Mississippi in FY2008.[16] Total average Medicaid HCBS spending per eligible beneficiary in 2006 ranged across states from $4,300 to more than $33,000 for all HCBS program options. Despite these variations, the majority of states have increased HCBS expenditures since 1999, reflecting a decade-long rebalancing of the spending ratio between nursing facility and community-based care.[17]

II. Barriers to Rebalancing Long-Term Care

Since the bulk of HCBS are optional services, nursing facility care still remains the focus of many state Medicaid LTSS programs. But this is beginning to change as states attempt to rebalance the system in favor of community-based care, both in terms of the number of beneficiaries receiving care as well as total expenditures. However, states interested in moving toward a greater emphasis on HCBS continue to face a number of significant obstacles.

For example, there is widespread belief that HCBS programs tend to attract individuals who ordinarily would not seek care in a nursing facility.[18] Indeed, studies have shown that this outcome can occur when states do not apply the same *rigorous* screening criteria for both nursing facility and HCBS waiver programs.

Consequently, some states have found it difficult to convince legislatures to appropriate funds for HCBS out of fear that aggregate costs will increase. And yet studies reflect that while expanded HCBS programs may result in some additional initial costs, they actually reduce total LTSS expenditures over time.[19]

In addition, some states have extensive rural and sparsely populated areas where building the infrastructure to support certain HCBS services is not possible or practical. In order to provide HCBS in rural communities, states must either limit the availability of certain services or redesign them to ensure their financial viability.

In order to achieve further rebalancing, Medicaid must confront these and other challenges, including:

- Federal statutory and regulatory requirements and limitations;
- Challenges in the Medicaid service delivery system; and
- The role of certain stakeholders and the courts.

The following sections provide a brief discussion of each of these areas.

Federal Statutory and Regulatory Requirements and Limitations

Federal law and regulation (and CMS policies not grounded in statute or regulation) have limited the provision of HCBS under Title XIX. Until enactment of the 1915(c) waiver authority in 1981, there was virtually no federal support in Medicaid for non-institutional long-term care services. Since that time, the federal government has gradually introduced changes that have enabled states to expand waiver programs to support HCBS, but only incrementally.

The signing of the Deficit Reduction Act (DRA) of 2005 allowed states to provide HCBS (including consumer-directed HCBS) without a waiver as a state plan service through a state plan amendment, but owing to a number of important restrictions (see below), few states exercised this option. The recently adopted Patient Protection and Affordable Care Act (PPACA) removes a number of these restrictions, but it is too early to gauge its potential impact. PPACA also provides an enhanced federal matching share for states actively pursuing rebalancing.

State Plan Option Limitations

To date few states have taken advantage of this option due to three disadvantages:

1) Under the DRA state plan option, states could not cover individuals with incomes greater than 150 percent of the FPL as compared to 300 percent of SSI under Section 1915(c) waivers. Thus, if a state shifted from a waiver to a state plan, a number of individuals would lose eligibility. The more restrictive income criteria in the HCBS state plan option were intended to prevent wholesale "conversion" of existing 1915(c) waivers to the state plan. The PPACA eliminates this restriction, but its impact going forward remains to be seen.

2) Unlike HCBS waivers, states have been unable to target services to specific populations under the state plan option. For example, attendant care had to be offered to everyone who meets the state's need-based criteria. And, even though a state may believe habilitation services are appropriate only for people with developmental disabilities, under the DRA these services had to be made available to anyone meeting the criteria. Again, the PPACA eliminates this restriction, but also prohibits states from waiving state-wideness or imposing enrollment limitations.

3) Only the HCBS services specified in a 1915(c) waiver can be offered. Other services that have been approved by the Secretary of Health and Human Services cannot be included. Again, the PPACA eliminates this restriction.

Program Silos

Section 1915(c) waivers require states to demonstrate cost-effectiveness when compared to a specific institutional level of care, including nursing facilities, intermediate care facilities for the mentally retarded (ICF-MRs), acute-care hospitals, and residential treatment facilities serving children and adolescents under age 21. Hence, states are required to create separate programs for each target population (e.g., elderly and physically disabled, developmentally disabled, etc.). Despite similarities in waiver management requirements, service definitions, and overlapping provider networks, in most cases states administer each waiver program separately, losing not only opportunities for management efficiencies, but also creating competition between waivers for the same workforce. Combining and consolidating HCBS programs for all target groups and eligibility categories would resolve most of these issues, but federal legislative action is required.[20]

Similarly, under 1915(c) federal policies, states may not include services under a waiver that are otherwise covered under the state Medicaid plan. For example, many states include home health and personal care as state plan services, so even though these services are a vital part of the full continuum of HCBS services, they may not necessarily be managed under the waiver as part of that continuum.[21] While the expansion of the 1915(i) state plan option under PPACA seems to provide states with the ability to manage all state plan and HCBS services, states may be reluctant to pursue this option because they cannot impose enrollment limitations permitted under 1915(c).

Eligibility

Federal statute requires states to make eligibility effective on the first day of the month of application and to apply prior quarter coverage criteria to determine eligibility during the previous quarter. This means that Medicaid programs are required to pay for nursing facility services for an individual who could have been in the facility for up to four months before Medicaid received an application. It is difficult to counsel individuals on HCBS alternatives after the family has made a nursing facility placement decision. State policies addressing this include streamlined screening and assessment programs, presumptive Medicaid eligibility, placement options counseling, and

Few states have taken advantage of home- and community-based options presented by the Deficit Reduction Act of 2005 due to a variety of obstacles; new health reform legislation addresses some of these prior impediments.

In addition to federal limitations, most state Medicaid programs face a number of challenges that further hamper rebalancing efforts.

elimination of prior quarter coverage through waivers, but federal action is needed to ensure minimum standards across states.[22]

In addition, under 1915(c) waivers, states are allowed to establish the amount of the special needs allowance up to the income standard for program eligibility, or 300 percent of SSI in most cases. For HCBS, the eligibility process for the medically needy population can be complicated as individuals must spend-down, usually on a monthly basis, to be eligible for services. However, if HCBS services are not provided until the spend-down is met, the individual may be put at-risk for nursing facility placement. To ensure the continuity of HCBS services, states must seek creative ways to apply spend-down.

Nursing Facility Placement Option

Section 1915(c) requires states to offer nursing facility placement to all waiver applicants. Arizona, under its Section 1115 waiver, is permitted to *require* placement in the most cost-effective and appropriate alternative, whether nursing facility or HCBS.

Reimbursement Rate Standards

There are currently no cost-related requirements for the payment of HCBS services or for cost reporting or annual updates. In fact, it is not unusual for a state to leave HCBS reimbursement rates unchanged for a decade. The higher the reimbursement rate, the more likely a state will attract HCBS providers — and vice versa. Thus, an artificially low HCBS payment rate may result in fewer HCBS providers and thus a perverse advantage in favor of nursing facility care.

Challenges in the Medicaid Service Delivery System

In addition to the federal limitations discussed above, most state Medicaid programs face a number of challenges that further hamper rebalancing efforts.

Fee-for-Service Delivery Systems

In most cases, Medicaid reimburses HCBS providers and nursing facilities on a fee-for-service (FFS) basis. FFS, however, offers less flexibility for rebalancing expenditures from nursing facilities to HCBS programs than exist in a managed care setting. Nevertheless, for a variety of reasons most states have made slow progress in enrolling aged, blind, and disabled beneficiaries in managed care programs, including capitated long-term care options. While managed LTSS offers greater options for blending funding and helping to keep clients in the community, rebalancing can still be done in a FFS setting, as Oregon and Washington have shown. Such approaches may require more leadership at the state level.

Lack of Integration between LTSS and Acute Care

Early studies on the cost-effectiveness of HCBS reflect greater utilization of acute care services among this population than among residents of nursing facilities. Possible reasons for this may include:

- Acute/medical needs are being met by nursing facilities;
- Residents of nursing facilities are being underserved and acute care needs are not being met; or
- Acute care and long-term care are not well coordinated in either setting.

Whatever the reason, it is clear that many states do not integrate acute care with LTSS, often resulting in fragmentation, opportunities for cost-shifting, and/or other negative, unintended consequences. For example, nursing facilities routinely call 911 in circumstances where another, less-expensive approach may be more appropriate. Similarly, the lack of integration between Medicare and Medicaid leaves states with little incentive to manage acute care utilization for the population of beneficiaries that is dually eligible for both programs.[23]

Recognition and Treatment of Comorbidities

Owing to the restrictions of the various waiver programs, elderly, physically disabled, and developmentally disabled individuals can have serious behavioral and/or physical comorbid conditions that go unrecognized or are inappropriately managed. Multiple studies demonstrate that undiagnosed or ineffectively treated mental health conditions are a dramatic driver of acute care costs, with expenditures running two or three times higher for individuals with one or more mental health diagnoses. For instance, someone with a behavioral diagnosis like depression or severe anxiety who also has two medical conditions will typically have physical health costs that are 180-250 percent higher than the same type of patient who does not have depression or severe anxiety.[24] For this reason, Arizona's capitated long-term care program fully integrates acute and behavioral health services.

Integration with Informal Supports

Early preadmission screening and/or care planning tools within HCBS waivers have not done enough to integrate informal supports into patient care plans. Given the vital need for unpaid caregiving — valued at $375 billion per annum[25] — HCBS care plans must encourage and support unpaid caregivers (e.g., offering training, support, respite services, etc.) to ensure these services remain in place. A number of states (e.g., California, New Jersey, and Pennsylvania) have implemented informal caregiver support programs, but they vary dramatically in quality and accessibility and are highly vulnerable to budget cuts.[26]

Technological Capacity: Most states lack the technological resources necessary to: (1) manage clients; (2) support screening and assessment processes; (3) assist in service planning; (4) track services received; (5) manage crises; and (6) provide case managers with the necessary patient data. Sophisticated tools like predictive modeling software and care planning and tracking applications are essential to the broader penetration of HCBS.

The Role of Certain Stakeholders and the Courts

The impact of the courts as well as the activities of certain stakeholders (e.g., nursing facilities, labor unions, parents/families) on state attempts to rebalance their long-term care systems cannot be overstated. Examples include:

Nursing Facilities

From the perspective of nursing facilities, rebalancing has two logical consequences: (1) a decline in occupancy; and (2) an increase in the intensity of services required by those individuals remaining in the facility. A number of states have adopted measures to address these concerns (see below), but the nursing home industry can nonetheless represent a potential obstacle to reform.

Labor Unions

Unions have played both a positive and negative role in rebalancing efforts. In many states, unions have stopped or slowed attempts to downsize or close facilities, while in others they have worked with the state to ensure employment in other state-run or private facilities. In some cases, unions have provided powerful support to HCBS by representing home care workers and managers of adult day health centers.

Parents/Families

Parents and family members are a powerful force that can work either in support of or in opposition to state rebalancing efforts. For example, parents and family members of nursing facility residents often oppose efforts to downsize or close facilities or attempts to relocate facility residents into the community, although they may subsequently reverse themselves after a facility is closed and their loved one is relocated into the community.

As states seek solutions to the barriers and obstacles for rebalancing long-term care options, a number of innovative approaches for addressing them have emerged.

The Courts

Despite some positive rulings, a number of state-level court decisions have negatively impacted rebalancing by defining a certain class as entitled to services that are so costly that other individuals who are not members of the class receive very little HCBS support. Probably the best known example is the Hissom decision in Oklahoma; this class action lawsuit compelled the state to create community-based alternatives to institutional placements for all of the developmentally disabled.[27] The complexity and cost of doing so effectively foreclosed the state from providing such alternatives for eligible individuals who were not involved in the lawsuit.

III. Promising Solutions for Rebalancing LTSS

As states seek solutions to the barriers and obstacles described above, a number of innovative approaches for addressing them have emerged. Following is a brief summary of promising options for rebalancing Medicaid-funded LTSS. For a more comprehensive analysis, see the companion environmental scan.[28]

Eligibility and Enrollment/ Preadmission Assessments: In order to receive HCBS supports under Medicaid, states typically require that individuals meet the nursing facility level of care criteria (or other facility criteria such as ICF/MR) as well as state-mandated financial criteria. A common barrier to "leveling the playing field" between institutional care and HCBS is the length of time that is often required to evaluate an individual's functional and financial eligibility. This is precious time that often leads to further deterioration in an individual's functional capabilities, which in turn renders a nursing facility admission more likely. To avoid nursing facility placement prior to eligibility determination, a number of states have implemented a standardized preadmission assessment for nursing facility admissions regardless of payer (e.g., Indiana, New Jersey, and New York). Other effective approaches include Single Point of Entry assessments and offering HCBS to individuals who do not yet meet the nursing facility level of care (NF LOC) criteria in order to postpone or forestall further deterioration in their condition (e.g., Texas, Vermont).[29]

Financing and Incentives/Expanding HCBS under Managed Care: In order for states to expand HCBS availability under a managed care initiative, a financial incentive ideally should be provided for health plans. One approach is to base capitated payments on the mix of institutional and home-based care. Arizona employs this approach and has reversed the percentage ratio between institutional care and HCBS from 70/30 at program inception in the 1980s to nearly 30/70 at present.[30]

LTSS Information Technology (IT): States recognize that real-time information and systems that link assessment, care management, and utilization tracking data are essential to the success of long-term care initiatives. States have the option to build or buy an IT system; alternatively, states with managed LTSS programs can potentially look to health plans to supply this functionality. Most plans have either developed or purchased sophisticated predictive modeling capability, assessment modules, and care manager planning and tracking systems. Recently, some non-managed LTSS states have adopted initiatives to encourage the use of electronic health records among their long-term care providers (e.g., Minnesota, New Jersey). Federal stimulus legislation adopted in February 2009 should further advance these efforts. It is critical that these and other initiatives include and recognize the unique information requirements for managing long-term care.

Consumer Direction/Consumer Satisfaction: In recent years, states have done more to involve consumers and their

families in ensuring that HCBS programs are meeting their needs. One way of addressing this has been through consumer-directed services. The phrase "consumer direction" refers to programs in which LTSS beneficiaries (or their surrogates) determine which services they need and are given a cash allotment to hire and supervise direct-service workers who perform the services. As needed, beneficiaries are provided training and counseling.[31]

The Cash and Counseling Demonstration (C&C) is perhaps the best known and largest demonstration of consumer-directed long-term care under Medicaid. Under this demonstration, CMS granted Arkansas, Florida, and New Jersey 1115 waivers that allowed these states to pay consumers directly and employ legally responsible relatives as direct-service workers. Mathematica Policy Research's evaluation of Arkansas' C&C initiative found that nursing home use declined, with 18 percent fewer nursing home admissions over three years, and that personal care cost increases were fully or partially offset by reductions in non-personal care services.[32] Building on the success of the demonstration, in 2005 CMS simplified the 1915(c) waiver approval process to include self-directed services. Consumer direction is also growing among managed LTSS plans.

States also often use member satisfaction surveys as part of their overall LTSS performance measurement strategy to ensure high quality care for those receiving HCBS. For example, Washington State requires home care agencies to conduct two supervisory visits per year to the homes of beneficiaries and to conduct beneficiary satisfaction surveys on an annual basis.[33]

Political Support and Leadership for Nursing Home Rebalancing Incentives: To address opposition from the nursing facility industry and HCBS providers, a number of states have implemented policies and programs to ease the rebalancing transition. For example, Tennessee's Nursing Home Diversification Grant program provides funding to nursing homes wishing to diversify their businesses to include HCBS and Iowa's Senior Living Revolving Loan Fund enables for-profit and non-profit entities to apply for below-market loan assistance to convert nursing homes either to assisted living facilities or "housing with services."

IV. Policy Recommendations

Current federal statutory and regulatory policies constitute the primary obstacle to long-term care reform and rebalancing. States have used waiver authorities to surmount a number of the regulatory and statutory barriers in Title XIX, but waivers alone can only accomplish so much. Following are additional "fixes" that would enhance states' ability to rebalance their long-term care systems, either under managed care or other alternative service delivery structures:

a) ***Allow states to place individuals in the most cost-effective setting.*** Under current law, states must offer institutional placement as an option even if there is a more cost-effective, safe alternative available. (Under its 1115 waiver, Arizona is exempt from this requirement.) Without eliminating the nursing facility entitlement, states could be allowed to place beneficiaries in separate "tiers" based on their level of need and provide access to services that are appropriate to those needs.

b) ***Provide options for the coordination of Medicare and Medicaid services, service delivery, and funding in statute.*** Such options could allow states to manage all Medicaid and Medicare expenditures and permit them to share the savings accruing to Medicare as a result of their coordination efforts (e.g., reductions in acute care services resulting from increased case management and

Current federal statutory and regulatory policies constitute the primary obstacle to long-term care reform and rebalancing.

With comprehensive health reform legislation in place, the time is ripe for the federal government and the states to continue the effort toward implementing more cost-effective, consumer-oriented long-term care options.

provision of LTSS). One potential approach would be to allow states to "count" Medicare savings in their budget neutrality calculations. Additional potential options include expanding PACE to provide more flexibility for states to develop programs or providing automatic enrollment for duals into Medicare Advantage plans or special needs plans that also have a Title XIX managed long-term care plan.

c) ***Do not require separate waivers for different target populations.*** This requires elimination of the current cost-effectiveness test based on specific settings. The federal Independence Plus initiative provides a vehicle to combine populations for self-directed waivers under Section 1115, but not for traditional HCBS waivers. The revised 1915(i) state plan option under PPACA: (1) expands services; (2) raises income criteria to the same level as HCBS waiver programs; (3) does not require a budget neutrality or cost-effectiveness test; and (4) gives states the option of targeting select populations. However, as noted previously, these provisions do not allow states to control their financial exposure by imposing limits on enrollment or expenditures.

d) ***Allow states to manage all HCBS services — whether waiver or state plan — under the waiver authority.*** Waiver participants are able to access HCBS state plan services without limits to increase total supports, which hampers a state's ability to control HCBS costs. To address this, allow states that currently have robust state plan personal care programs, private duty nursing, and/or home health nurse and aide programs to better control community-based service funding by requiring waiver participants to access *all* HCBS services — whether state plan or waiver services — through the waiver.

e) ***Obtain appropriations for CMS to conduct/contract for meaningful evaluations of managed long-term care models.*** A notable lack of CMS-funded independent evaluations in recent years has left an information vacuum that needs to be filled. A noteworthy opportunity would be to conduct an evaluation of the Wisconsin Family Care program, which excludes acute care, and compare the results to the Wisconsin Partnership program, which includes such services.

Conclusion

With the leading edge of the baby boom generation entering retirement during a time of great fiscal challenge, states have tremendous incentive to continue the push toward further rebalancing of their Medicaid-funded long-term care systems. A great deal of progress has been achieved, but much more remains to be accomplished to achieve the optimum balance of HCBS options and institutional care.

The goal of this paper has been to identify the primary obstacles hampering continued rebalancing and to suggest a number of pragmatic solutions for moving forward. With comprehensive health reform legislation in place, the federal government and the states should continue to implement more cost-effective, consumer-oriented long-term care options.

Innovations in the Medicaid Continuum of Care Series

This brief is part of CHCS' ***Innovations in the Medicaid Continuum of Care*** series, developed to help state and federal policymakers identify high-quality and cost-effective strategies for addressing the full range of clinical and long-term supports and services (LTSS) needs of Medicaid beneficiaries. The initial three publications in the series, supported by the Robert Wood Johnson Foundation and Aetna, provide policy and technical resources to guide LTSS program development and implementation. Additional materials available at www.chcs.org include:

- **Systems of Care: Environmental Scan of Medicaid-Funded Long-Term Supports and Services** – Details the current publicly funded long-term care delivery system and broadly outlines opportunities and obstacles for LTSS reform.
- **Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation** – Presents innovative initiatives from across the nation offering alternatives for reforming the delivery of Medicaid-funded LTSS.

Future publications in the series will delve more deeply into specific options for transforming long-term care programs to support the full continuum of consumer needs.

Endnotes

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[18] This phenomenon is often referred to as the "woodwork effect," a term considered objectionable by many in the field.
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[28] To download *Systems of Care: Environmental Scan of Medicaid-Funded Long-Term Supports and Services*, visit www.chcs.org.
[29] The Patient Protection and Affordable Care Act of 2010 includes a State Balancing Incentives Program that requires participating states to establish a Single Point of Entry system as well as a standardized statewide assessment process for determining eligibility. Qualifying states will receive an enhanced FMAP for HCBS, PACE, and state plan home health and personal assistance services.
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