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## *Systems of Care: Environmental Scan of Medicaid-Funded Long- Term Supports and Services*

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### **Innovations in the Medicaid Continuum of Care Series**

This report 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](http://www.chcs.org) include:

- **Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options** – Brief outlines initial federal policy suggestions for reforming the nation's Medicaid-funded LTSS system.
- **Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation** – Report presents innovative initiatives from across the nation offering alternatives for reforming the delivery of Medicaid-funded long-term care.

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

*The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers and consumer groups to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.*

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- **Alicia Smith, JD, Leena Hiilivirta, JD and Deidra Abbott, MPH** – Alicia Smith and Associates (*consultants to the states of Tennessee and Hawaii*)

### Additional Interviewees

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- **Fredda Vladeck** – Director, United Hospital Fund’s Aging in Place initiative – New York

## Foreword

National policymakers and state Medicaid leaders across the country 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 forms of 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. This document provides a comprehensive scan of the current Medicaid-funded long-term supports and services environment and outlines recommendations for improving LTSS delivery. 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 our gratitude to my colleagues at CHCS — Alice Lind, Lindsay Palmer Barnette, Lorie Martin, and Melanie Bella — 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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## Executive Summary

With comprehensive health reform in place, cash-strapped states are forging ahead to rebalance their Medicaid long-term care programs away from expensive and unpopular institutional care. Over the next two decades, analysts project that states will spend nearly \$1.6 trillion dollars for Medicaid-funded long-term care supports and services (LTSS) for elderly and disabled individuals and the federal government will contribute an additional \$2.1 trillion, for a total of \$3.7 trillion. Current estimates are that more than two-thirds of Americans age 65+ today will need LTSS – ranging from non-skilled personal care assistance at home to nursing home care – with an average duration of need of about three years.<sup>1</sup>

Owing to a host of factors, few people are insured against the risk of needing LTSS. In fact, 90 percent of people over age 55 have no LTSS insurance coverage, despite the risk of costs exceeding \$70,000 annually for skilled nursing facility care. Few have adequate assets and some two-thirds of the elderly could not afford more than one year of nursing facility care. The current distribution of Americans' ability to pay for nursing facility care is as follows:

- Only 19 percent of elderly Americans living in the community can afford three or more years of nursing facility care;
- 16 percent can afford one-to-three years; and
- 65 percent can afford less than one year.<sup>2</sup>

Consequently, Medicaid has become the *de facto* payer of last resort for long-term care. In 2008, more than 5.8 million elderly individuals, or 15 percent of the total population over age 65, were enrolled in the program. If this proportion remains constant, by 2027 more than 10 million elderly individuals will be dependent on Medicaid for LTSS.<sup>3</sup> The newly adopted Community Living Assistance Services and Supports (CLASS) act, which creates a federally administered, voluntary LTSS insurance program, may alter these projections, but it is far too early to gauge its potential impact (the CLASS act is described in more detail in Section III).

### Long-Term Care Reform

In 2008, the Lewin Group issued a report for the Association of Community Affiliated Health Plans that concludes that Medicaid spending for the elderly and disabled in “the unmanaged, fee-for-service setting imposes an ever-accumulating fiscal strain that hampers our ability to achieve other important public objectives.” However, despite the many benefits and advantages that a comprehensive managed long-term care program can offer both to states and beneficiaries, for a host of political, cultural, institutional, and financial reasons, states have been hesitant to initiate them. And with the leading edge of the baby boom generation now turning 60, the potential consequences of not acting expeditiously to rationalize and integrate the delivery of publicly-funded services to the frail elderly and disabled would seem too severe to ignore.<sup>4</sup>

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<sup>1</sup> D.A. Shostak and P.A. London. *State Medicaid Expenditures for Long-Term Care, 2008-2027*. America's Health Insurance Plans. September 2008. Available at <http://www.ahip.org/content/default.aspx?docid=244597>.

<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured (2009). “Medicaid and Long-Term Care Services and Supports.” Available at [http://www.kff.org/medicaid/upload/2186\\_06.pdf](http://www.kff.org/medicaid/upload/2186_06.pdf); K. Polzer, “Providers' View of Long-Term Care Financing Reform.” Presentation given at Ninth Annual Intercompany Long-Term Care Insurance Conference, March 31, 2009; D. Rowland. “Filling in the Long-Term Care Gaps.” Testimony before the U.S. Senate Special Committee on Aging, June 3, 2009. Available at <http://aging.senate.gov/events/hr210dr.pdf>.

<sup>3</sup> D.A. Shostak, *op.cit.*

<sup>4</sup> “Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities.” Lewin Group report prepared for the Association for Community Affiliated Health Plans (2008). Available at

A primary obstacle to reform is that most of the initial savings from long-term care reform initiatives accrue almost entirely to Medicare and that, owing to previously unidentified individuals coming forward to access home- and community-based services (HCBS), states can actually incur a net cost increase on the Medicaid “side” during the initial years of the program. These concerns are not without merit. However, multiple studies demonstrate that there are a host of factors that can favorably influence the savings timeframe in the states, including:

- ***The mix of home- and community-based settings used by the current population.*** States that already have a large percentage of their eligible populations in home- and community-based settings are likely to accrue smaller savings than those that do not.<sup>5</sup>
- ***The existing home- and community-based infrastructure.*** States that have a robust home- and community-based infrastructure at present will accrue savings more quickly than states that must build one. This infrastructure includes the availability of the full continuum of services such as personal care services (PCS), meals-on-wheels, assisted living, personal emergency response systems, and adult day programs, among others.
- ***The political strength of the nursing facilities.*** States where the nursing facility industry has strong influence will experience savings at a slower rate. Managed long-term care as well as “Money Follows the Person” initiatives are founded on a rebalancing of nursing facility and home- and community-based spending. The result is that fewer dollars will be available to support nursing facility services.
- ***Nursing facility occupancy rates.*** States with low nursing facility occupancy rates are likely to accrue savings more slowly. Potentially states with low occupancy rates have already successfully diverted elderly and disabled individuals from nursing facilities.
- ***The turnover in nursing facilities.*** Contrary to popular assumptions, nursing facility turnover averages roughly 27 percent annually, which translates to a 100 percent turnover every four years.<sup>6</sup> Under managed care, a large percentage of newly eligible individuals can be diverted to HCBS and thereby generate significant savings.

This environmental scan was commissioned by the Center for Health Care Strategies (CHCS) to provide an overview of the current status of the publicly funded long-term care delivery system and promote an enhanced understanding of the opportunities and obstacles for LTSS reform and rebalancing. It addresses each of the factors discussed above in more detail, with an emphasis on the actual systems for delivering long-term supports and services rather than the financing. The primary objectives of this environmental scan are to:

- Provide a snapshot of current rebalancing and reform activities across the nation;
- Explain how and why the Medicaid LTSS system has evolved as it has;
- Identify existing barriers to reform; and
- Offer suggestions for improvement.

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[http://www.communityplans.net/Portals/0/Policy/Medicare/Lewin%20dual%20eligibles%20cost%20savings%20report\\_463514.pdf](http://www.communityplans.net/Portals/0/Policy/Medicare/Lewin%20dual%20eligibles%20cost%20savings%20report_463514.pdf)

<sup>5</sup> States with high average HCBS costs that are largely unmanaged today have opportunities for cost savings in a managed care framework for HCBS spending.

<sup>6</sup> “Tennessee Nursing Home Trends.” Fact Sheet from Tennessee Department of Health. July 2007.



The analysis is divided into four sections, as follows:

- Section I surveys the states' current HCBS expenditures and utilization as well as efforts to rebalance long-term care systems away from an over-reliance on nursing facilities toward more robust home- and community-based options.
- Section II analyzes the array of historic, institutional, bureaucratic, and legal factors underpinning Medicaid's longstanding institutional bias.
- Section III looks at the many federal and state initiatives to improve the ratio between institutional and community-based care, including Real Choice Systems Change Grants, Money Follows the Person, and consumer-directed options, among others.
- Section IV points to a number of statutory and regulatory "fixes" that could significantly enhance the states' ability to improve their long-term care delivery systems.

A companion analysis<sup>7</sup> explores an array of innovative strategies that various states, providers, and localities are implementing to improve their long-term care delivery systems, enhance beneficiary satisfaction, and control costs.

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<sup>7</sup> To download *Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation*, visit [www.chcs.org](http://www.chcs.org).



## Section I: The HCBS Role in Long-Term Care Today

### Overview of HCBS Utilization

Interestingly, even though most people tend to associate LTSS with nursing homes, only 3.3 percent of individuals age 65 and over resided in nursing facilities in 2007. In fact, between 2002 and 2007, the number of nursing facility residents increased by only 0.9 percent while the age 85+ population increased by 6.5 percent. The percentage of nursing facility residents eligible for Medicaid has held steady during this same period at about 67 percent.<sup>8</sup>

According to a Kaiser Family Foundation study, in 2006 there were 2.9 million or approximately 50 percent of eligible individuals receiving HCBS services through Medicaid, including more than one million individuals served through HCBS waivers, just under 900,000 through the home health benefit, and roughly 800,000 receiving personal care services.<sup>9</sup>

Among individuals enrolled in various waiver programs, 56 percent were frail elderly and/or physically disabled (EPD); 40 percent were developmentally disabled (MR/DD); and the remaining four percent included children with special needs and individuals with HIV/AIDS, traumatic brain injuries, spinal cord injuries (TBI/SPI), and mental health needs. The MR/DD group consumed 72 percent of waiver expenditures, followed by the EPD at 21 percent, and all others at seven percent.<sup>10</sup> Eligible individuals receiving HCBS increased by 34 percent between 2000-05, while expenditures for HCBS increased by 68 percent during 2002-07.<sup>11</sup>

Nationwide, the average number of HCBS beneficiaries was 9.38 per 1,000 in 2005, reflecting an increase from 6.83 per 1,000 in 1999 (a five percent annual increase). The states with the highest per-capita number of HCBS beneficiaries were Missouri (15.4 per 1,000 population), Vermont and Iowa (14.4), and New York (14.1), while the lowest included Virginia (3.0), Nevada (3.1), and Tennessee (3.2).<sup>12</sup>

### Overview of HCBS Expenditures

In 2006, HCBS expenditures consumed 41 percent, or \$38.1 billion, of Medicaid's roughly \$100 billion in total LTSS expenditures, including \$25 billion for optional 1915(c) waivers, \$8.5 billion for optional state plan personal care services, and \$4.6 billion on mandatory home health services (see Figure 1). Medicaid pays for 49 percent of all LTSS not provided by informal/unpaid caregivers,<sup>13</sup> including 45.8 percent of nursing home care and 37.6 percent of home health in 2006.<sup>14</sup>

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<sup>8</sup> A.N. Houser, et al. *Across the States: Profiles of Long-Term Care and Independent Living*. AARP Public Policy Institute. March 2009. Available at [http://www.aarp.org/research/ppi/ltc/Other/articles/across\\_the\\_states\\_2009\\_profiles\\_of\\_long-term\\_care\\_and\\_independent\\_living.html](http://www.aarp.org/research/ppi/ltc/Other/articles/across_the_states_2009_profiles_of_long-term_care_and_independent_living.html), 11.

<sup>9</sup> T. Ng, et al. *Medicaid Home and Community-Based Service Programs: Data Update*. Kaiser Commission on Medicaid and the Uninsured. December 2008. Available at <http://www.kff.org/medicaid/7720.cfm>.  
<sup>10</sup> *Ibid.*, 7.

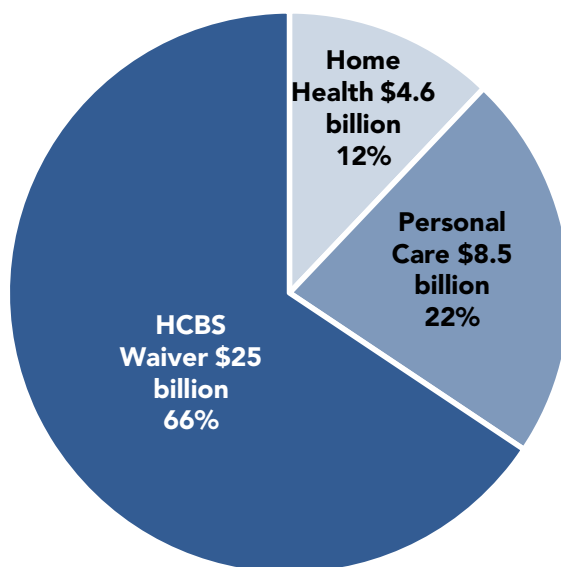
<sup>11</sup> A.N. Houser, et al., *op. cit.*

<sup>12</sup> C. Harrington, et al. *Medicaid Home and Community Based Services: Proposed Policies to Improve Access, Costs and Quality*. University of San Francisco. September 2009. Available at [http://www.pascenter.org/documents/Harrington\\_Ng\\_Kaye\\_Newcomer.pdf](http://www.pascenter.org/documents/Harrington_Ng_Kaye_Newcomer.pdf).

<sup>13</sup> AARP estimates that the value of services provided through unpaid family caregivers in 2007 was \$375 billion. "Value of Family Caregiving Hits \$375 Billion." AARP Public Policy Institute. November 2008. Available at [http://www.aarp.org/aarp/presscenter/pressrelease/articles/Cost\\_Of\\_Caregiving.html](http://www.aarp.org/aarp/presscenter/pressrelease/articles/Cost_Of_Caregiving.html).

<sup>14</sup> C. Harrington, et al., *op.cit.*

**Figure 1: Medicaid Home- and Community-Based Services Expenditures, by Program, 2006**



Source: Kaiser Commission on Medicaid and the Uninsured and UCSF analysis of CMS Form 372 data and program surveys.

Importantly, because states have broad flexibility in designing their Medicaid 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. For example, per-capita spending for Medicaid long-term care in 2004 ranged from \$833 in New York to about \$100 in Utah and Nevada. Only five states (Alaska, California, New Mexico, Oregon, and Washington) spent more than 50 percent of their Medicaid LTSS funds for HCBS for the EPD population; Arizona, Minnesota, and Texas spent between 40 and 50 percent. On the opposite end of the spectrum, nine states (Alabama, Connecticut, Delaware, Indiana, Kentucky, North Dakota, South Dakota, Tennessee, and Utah) spent 10 percent or less, with the remaining states expending between 20 and 40 percent. Except for Connecticut and Vermont, all states have increased HCBS expenditures over the past decade, with the highest in Louisiana, Mississippi, and Nevada.<sup>15</sup>

Nationwide, the HCBS per-capita average expenditure was \$118 in 2005, reflecting an 11 percent annual increase since 1999. States with the highest per-capita expenditures included New York (\$363), Minnesota (\$268), and Alaska (\$235), while the lowest were Nevada (\$30), Georgia (\$37), and Mississippi (\$48).<sup>16</sup> Average annual HCBS waiver program expenditures in 2002 were \$18,332 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 \$3,612 to a high of \$34,581. The highest costs are for the MR/DD population because of their intensive need for habilitation training and supervision, often on a 24-hour per-day basis.<sup>17</sup> See Table 1 for the average costs of various LTSS in 2007-08.<sup>18</sup>

<sup>15</sup> T. Ng, et al., op.cit.

<sup>16</sup> C. Harrington, et al., op.cit.

<sup>17</sup> C. Shirk. *Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program*. National Health Policy Forum. March 2006. Available at [http://www.nhpf.org/library/background-papers/BP\\_HCBS.Waivers\\_03-03-06.pdf](http://www.nhpf.org/library/background-papers/BP_HCBS.Waivers_03-03-06.pdf).

<sup>18</sup> MetLife Mature Market Institute (2007). "The MetLife Market Survey of Nursing Home and Assisted Living Costs." Available at [http://www.orgcorp.com/pdf/2007\\_Nursing\\_Home\\_and\\_Asst\\_Living\\_MetLife.pdf](http://www.orgcorp.com/pdf/2007_Nursing_Home_and_Asst_Living_MetLife.pdf); MetLife Mature Market Institute (2008).

"The MetLife Market Survey of Adult Day Services and Homecare Costs." Available at [http://www.hcbs.org/files/148/7373/2008\\_survey\\_adult\\_day\\_home\\_care\\_costs.pdf](http://www.hcbs.org/files/148/7373/2008_survey_adult_day_home_care_costs.pdf).

**Table 1: Average National Long-Term Care Costs, 2007-2008**

TYPE OF CARE	AVERAGE COSTS	LOW	HIGH
<b>Nursing Facility Care</b>	\$77,745 for a private room (\$213 per day) \$68,695 for a semi-private room (\$189 per day)	\$41,975 (\$115 per day) for a semi-private room in Shreveport, LA	\$183,960 (\$504 per day) for a semi-private room in Alaska
<b>Assisted Living</b>	\$35,628 for standard care (\$2,969 per month) \$51,240 for dementia-related care (\$4,270 per month)	\$19,740 for standard care in Jackson, MS (\$1,645 per month)	\$55,548 for standard care in Boston, MA (\$4,629 per month)
<b>Home Health Aide</b>	\$20 per hour	\$12 per hour in Shreveport, LA	\$26 per hour in Rochester, MN
<b>Homemaker/ Companion Services</b>	\$17 per hour	\$12 per hour in Shreveport, LA	\$26 per hour in Rochester, MN
<b>Adult Day Services</b>	\$64 per day	\$27 per day in Montgomery, AL	\$141 per day in Vermont

Source: "The MetLife Market Survey of Nursing Home and Assisted Living Costs," October 2007; "The MetLife Market Survey of Adult Day Services and Homecare Costs," September 2008.

The most recent data from FY2008 reflect continued robust growth in HCBS, with expenditures increasing by 4.9 percent over FY2007 to \$45.4 billion. Commensurate with the increase in HCBS, nursing facility expenditures increased by 4.1 percent in FY2008, to \$49 billion, after experiencing a net decrease the previous year.<sup>19</sup> Table 2 provides nationwide Medicaid expenditure data for LTSS from FY2004 through FY2008.

**Table 2: Medicaid Spending for Long-Term Supports and Services, FY 2004-2008 (in billions)**

SERVICE	FY2004	FY2005	FY2006	FY2007	FY2008
<b>Personal Care</b>	\$7.8	\$9.1	\$9.48	\$10.49	\$10.9
<b>HCBS Waiver</b>	\$21.8	\$23.0	\$25.7	\$27.9	\$29.9
<b>Home Health</b>	\$3.4	\$3.6	\$3.7	\$4.0	\$4.6
<b>SNF</b>	\$45.9	\$47.5	\$47.7	\$47.0	\$49.0
<b>ICF/MR</b>	\$12.2	\$12.45	\$13.0	\$12.2	\$12.0
<b>Total LTC</b>	\$91.5	\$96.0	\$100.3	\$102.6	\$106.4
<b>Total Medicaid</b>	\$285.9	\$304.2	\$302.1	\$316.8	\$331.8

Source: B. Burwell, K. Sredl, and S. Eiken, "Medicaid Long-Term Care Expenditures in FY 2008," Thomson Reuters (December 2009), Table 1.

<sup>19</sup> B. Burwell, et al. "Medicaid Long-Term Care Expenditures in FY 2008." Thomson Reuters. December 1, 2009.

## State Rebalancing Efforts

Nationwide, spending for HCBS rose to 41 percent of all Medicaid LTSS expenditures in 2007, reflecting a decade-long rebalancing of the spending ratio between nursing facility and community-based care.<sup>20</sup> Table 3 provides a state-by-state snapshot of the balance between HCBS and nursing home utilization for the EPD population by expenditures and beneficiary participation, including the rebalancing trends among EPD beneficiaries over a five-year period.<sup>21</sup>

**Table 3: Medicaid Spending and Utilization for HCBS for Elderly People and Adults with Physical Disabilities**

State	Medicaid LTSS Expenditures for HCBS, 2007	Change in EPD HCBS Expenditures, 2002-07	LTSS Beneficiaries Receiving HCBS, 2005	Change in EPD HCBS Participation, 2000-05*	Are Personal Care Services in State Plan, 2007?
Alabama	9%	+55%	36.5%	+35%	no
Alaska	51%	+84%	90.9%	+77%	yes
Arizona	40%	+83%	72%	+83%	no
Arkansas	21%	+45%	59.5%	-9%	yes
California	51%	+106%	79%	+47%	yes
Colorado	22%	+60%	60.3%	+17%	yes
Connecticut	9%	+113%	40.1%	+20%	no
Delaware	10%	+89%	39.7%	+63%	no
Dist. Of Columbia	33%	+1,600%	54.1%	+69%	no
Florida	14%	+38%	50.2%	+45%	yes
Georgia	18%	+71%	40.9%	+22%	no
Hawaii	17%	+67%	52.4%	+121%	no
Idaho	39%	+48%	74.5%	+131%	yes
Illinois	23%	+106%	47%	+53%	no
Indiana	5%	+117%	25%	+64%	no
Iowa	14%	+149%	40%	+34%	no
Kansas	33%	+34%	53.7%	+21%	no
Kentucky	8%	-17%	38.7%	-16%	no
Louisiana	24%	+1,480%	26.2%	+344%	yes
Maine	26%	+163%	64.5%	+186%	yes
Maryland	11%	+157%	42.8%	+73%	yes
Massachusetts	23%	+67%	42.1%	+78%	yes
Michigan	18%	+42%	63.4%	+12%	yes
Minnesota	44%	+156%	62.8%	+76%	yes
Mississippi	11.3%	+78%	46.5%	+188%	no
Missouri	31%	+26%	67.8%	+16%	yes
Montana	26%	+8%	57.4%	+13%	yes
Nebraska	18%	+100%	41.9%	+83%	yes
Nevada	35%	+261%	55.4%	+137%	yes
New Hampshire	13%	+95%	41%	+49%	yes
New Jersey	20%	+37%	45.5%	+5%	yes
New Mexico	61%	+97%	72.3%	+440%	yes

\*Figures for this column are estimated based on data from Houser, et al., "Across the States," AARP Public Policy Institute (2008).

<sup>20</sup> T. Ng, et al., op.cit.

<sup>21</sup> A.N. Houser, et al., op.cit.

**Table 3: Medicaid Spending and Utilization for HCBS for Elderly People and Adults with Physical Disabilities (continued)**

State	Medicaid LTSS Expenditures for HCBS, 2007	Change in EPD HCBS Expenditures, 2002-07	LTSS Beneficiaries Receiving HCBS, 2005	Change in EPD HCBS Participation, 2000-05	Are Personal Care Services in State Plan, 2007?
New York	28.3%	+36%	59.3%	-3%	yes
North Carolina	38%	+50%	65.4%	+185%	yes
North Dakota	5%	+92%	45.7%	+389%	yes
Ohio	17%	+59%	38.7%	+30%	no
Oklahoma	27%	+99%	56.7%	+40%	yes
Oregon	56%	+41%	83.8%	+7%	yes
Pennsylvania	11%	+240%	36.4%	+199%	no
Rhode Island	11%	+58%	40.4%	+18%	no
South Carolina	22%	+41%	54.7%	-6%	no
South Dakota	7%	+78%	40.3%	+11%	yes
Tennessee	1%	+163%	16.4%	+80%	no
Texas	40%	+33%	58.7%	+14%	yes
Utah	5%	+96%	55%	+135%	yes
Vermont	35%	+109%	63%	+188%	yes
Virginia	26%	+123%	40.3%	+18%	no
Washington	54%	+44%	75.3%	+39%	yes
West Virginia	19%	+37%	56.8%	-14%	yes
Wisconsin	28%	+46%	59%	+32%	yes
Wyoming	14%	+54%	58.1%	+56%	no
United States	27%	+68%	56.3%	+34%	na

Source: Houser, et al., "Across the States," AARP Public Policy Institute (2008).





## Section II: Key Factors Contributing to the Current Status of Home- and Community-Based Services

### Overview

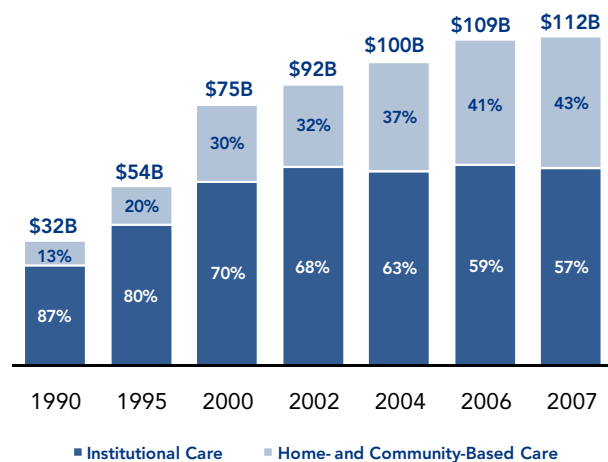
In spite of the recognition among policymakers that HCBS are less expensive than facility-based care and that the overwhelming preference of most individuals and their families is to remain at home or in the community, and in spite of the courts' position that services must be provided in the least restrictive setting possible, HCBS currently represents less than half (43 percent) of total Medicaid long-term care expenditures (Figure 2).<sup>22</sup> The bulk (72 percent) of Medicaid HCBS spending 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 3).<sup>23</sup>

While Medicaid expenditures and the number of people receiving HCBS today are significantly greater than in 1981 when 1915(c) waivers were first introduced, there is nonetheless a clear expectation that the majority of LTSS dollars should be spent on HCBS and most people should be served at home or in the community.

In order to identify opportunities for continued rebalancing, it is helpful to examine the following factors:

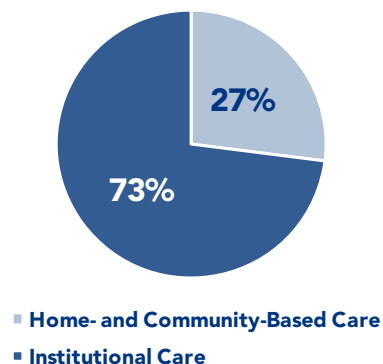
- Federal statutory and regulatory requirements and limitations;
- Structural flaws in Medicaid and the service delivery system;
- The role of certain stakeholders and the courts; and
- State-specific variables.

**Figure 2: 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 3: Medicaid Long-Term Care Spending for 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).

<sup>22</sup> V. Smith, et al. "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession, Results of a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010." Kaiser Commission on Medicaid and the Uninsured. September 2009.

<sup>23</sup> T. Ng, et al. *Medicaid Home and Community-Based Service Programs: Data Update*. Kaiser Commission on Medicaid and the Uninsured. December 2008. Available at <http://www.kff.org/medicaid/7720.cfm>.

This section briefly analyzes each of these factors and their impact on the ability of states to rebalance the long-term care system.

## 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 their waiver programs, but only incrementally. In addition to 1915(c) waivers, states can also expand the availability of HCBS as a research and demonstration project under Section 1115 or 1915(d) waiver authority or use the state plan rehabilitation, home health, and personal care options (since 1993).

Key changes to federal HCBS policies took place with the signing of the Deficit Reduction Act (DRA) of 2005. As a result, beginning in 2007, states have had the option to provide HCBS (including consumer-directed HCBS) without a waiver as a state plan service (through a state plan amendment). However, to date few states have taken advantage of this new option (Iowa, Nevada, and Colorado have added HCBS to their state plan and West Virginia has a plan in development) owing to three disadvantages:

- States have not been allowed to cover individuals with incomes greater than 150 percent of the FPL under the DRA state plan option as compared to 300 percent of SSI under Section 1915(c) waivers (or approximately 225 percent of the FPL). Thus, if a state shifted from a waiver to a state plan, some individuals would lose eligibility. The more restrictive income criteria in the HCBS state plan option was intended to prevent wholesale “conversion” of existing 1915(c) waivers to the state plan in order to:
  - » Ensure the state plan option expanded HCBS to new populations versus converted populations;
  - » Prevent states from moving waivers to the state plan option to avoid the cost-effectiveness test required under 1915(c) but not under the state plan; and
  - » Prevent states from moving waivers to the state plan option to avoid the administrative burden of waivers, including the more elaborate description of the programs required in the waiver application and renewals.

The Patient Protection and Affordable Care Act (PPACA) that was signed into law on March 23, 2010 eliminates this restriction and allows states to cover individuals up to 300 percent of SSI under a state plan option.

- Unlike Section 1915(c) waivers, states have not been allowed to target services to specific populations under the state plan option. For example, attendant care had to be offered to everyone who met 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 who meets the criteria. PPACA also eliminates this restriction, providing important flexibility for states to target services to specific populations.
- Only the home- and community-based services specified in a 1915(c) waiver can be offered. Other services that have been approved by the Secretary cannot be included.

Together with Medicaid's legal and regulatory bias in favor of institutions, including nursing facilities, additional federal policies have had the unintended effect of slowing the growth of HCBS in a number of significant ways. Examples include:

### **Program Silos**

Section 1915(c) waivers require states to demonstrate cost-effectiveness when compared to a specific institutional level of care, including nursing facilities, ICF-MRs, acute-care hospitals (added as an option), and residential treatment facilities serving children and adolescents under age 21 (on a pilot basis under the DRA of 2007). As a consequence, they have had limited applicability for the mentally ill, with the exception of a handful of waivers targeted at children with serious emotional disturbance, because services in an Institution for Mental Disease (IMD) for individuals age 21-64 are not covered under Title XIX and cannot be used in the cost-effectiveness test.<sup>24</sup> As an example, Colorado has an approved waiver for serving mentally disabled adult clients residing in a nursing facility for the cost-effectiveness standard.

Because of this cost-effectiveness test strategy, states are required to create separate waiver programs for each target population they wish to serve (e.g., elderly and physically disabled, developmentally disabled, technology dependent children, TBI, etc.). As of 2007, there were 300 HCBS program waivers operated by the 50 states, with an average of six waivers per state.<sup>25</sup> States with the largest number of waivers include Florida with 13, Colorado with 12, and California with 11, while Arizona has none inasmuch as all of its LTSS are authorized through its Section 1115 demonstration waiver.<sup>26</sup> 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.<sup>27</sup>

### **Cold Bed and Supplier-Induced Demand**

Prior to 1994, HCFA (now CMS) required states to demonstrate the cost-effectiveness of HCBS waiver programs by showing that waiver slots would substitute for "cold beds" (i.e., unused or not-yet-built nursing facility slots). The rationale behind the cold bed methodology derives from a concept known as "supplier-induced demand," as articulated in Roemer's law, which states that "a bed built is a bed filled." Numerous studies demonstrate that this can occur when states do not opt to apply the same rigorous screening criteria for both nursing facility and HCBS waiver programs. States also find it difficult to convince state legislatures to appropriate funds for HCBS out of fear that increased demand will drive up aggregate costs. However, numerous studies reflect that while expanded HCBS programs may result in some additional costs at first, they actually reduce LTSS expenditures over time.<sup>28</sup>

In 1994, the cost-effectiveness demonstration was changed from "cold bed" to a per-capita test (i.e., HCBS placement vs. facility-based care) that states could readily demonstrate.

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<sup>24</sup> The Patient Protection and Affordable Care Act now offers states the ability to provide a broad range of home- and community-based services targeted to individuals with mental illness under the 1915(i) state plan option. See New York Association of Psychiatric Rehabilitation Services, "Health Care Reform Boosts Self Directed Medicaid Mental Health Community Services Option," Mental Health E-News (April 1, 2010). [http://www.nyaprs.org/Pages/View\\_ENews.cfm?ENewsID=8570](http://www.nyaprs.org/Pages/View_ENews.cfm?ENewsID=8570)

<sup>25</sup> B. Burwell, et al., op.cit.

<sup>26</sup> Ibid.

<sup>27</sup> C. Harrington, et al., op.cit.

<sup>28</sup> H.S. Kaye, et al. "Do Non-Institutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs*, 28, no.1 (2008).

### ***Growing the HCBS Population***

In order to increase the number of HCBS slots under a 1915(c) waiver during either the initial three-year period or five-year renewal, states were required to file a formal amendment to the waiver and a revised cost-effectiveness demonstration. Now states can submit a brief letter.

### ***Eligibility – Coverage Effective Date and the 300 Percent of SSI Group***

Federal statute and regulation requires states to make eligibility effective on the first day of the month of application and to apply prior quarter coverage criteria to determine if the individual would have been eligible during the previous quarter. In the long-term care arena, this means that state Medicaid programs are required to pay for nursing facility services for an individual who could have been a resident in the facility for as many as four months before Medicaid ever received an application. It is very difficult to counsel individuals on HCBS alternatives after the family has made a nursing facility placement decision.

Expanded income eligibility criteria (up to 300 percent of SSI or 225 percent of the FPL) for both nursing facilities and HCBS make individuals eligible for Medicaid only because they are in a facility or receiving waiver services. Although well-intentioned policies, both prior quarter coverage and the 300 percent of SSI criteria put states in the position of trying to impact placement decisions for people who were previously unknown to the program. A number of states have implemented policies to address this, including streamlined screening and assessment programs, presumptive Medicaid eligibility, and placement options counseling, but federal action is needed to ensure minimum standards across the states.<sup>29</sup>

### ***No Integration of State Plan Services***

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 home- and community-based services, they may not necessarily be managed under the waiver as part of that continuum.<sup>30</sup> It is important to recognize that, particularly in rural areas, the personal care worker, the attendant, and the homemaker are often the same person.

### ***Reimbursement Rate Standards***

Prior to 1997, federal law mandated that payments to nursing facilities be governed by a reasonable cost-related reimbursement standard that differed from the payment standard applicable to HCBS. A provision in Section 1902(a)(13) of the Social Security Act, commonly referred to as the Boren Amendment, required states to reimburse nursing facilities at rates that were “reasonable and adequate for the costs incurred by an efficiently and economically operated facility.” Until its repeal in 1997, nursing facility reimbursement was driven by cost reports, audits, a rate reconsideration mechanism, and annual inflation updates. In fact, many states continue annual inflation updates for nursing homes today. But there never has been any cost-related requirement 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 is to attract HCBS

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<sup>29</sup> C. Harrington, et al., op.cit.

<sup>30</sup> There are some noteworthy exceptions. For example, New York’s Long-Term Home Health Care Program waiver (aka The Lombardi Program or “Nursing Homes Without Walls”) manages the full continuum of waiver and state plan services within an individual budgetary cap of 75 percent of the cost of nursing facility care (with some exceptions). If an individual exceeds the budgeted allocation, he/she must disenroll from the waiver program and access services through the state’s fee-for-service program. See A. Hokenstad, M. Shineman and R. Auerbach, “An Overview of Medicaid Long-Term Care Programs in New York,” United Hospital Fund (April 2009). It is presently unclear whether the significant changes to the 1915(i) state plan option in the recently adopted health reform legislation will address this issue.

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.

### ***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 alternative, whether nursing facility or HCBS.

## **Structural Flaws in Medicaid and the Service Delivery System**

Owing in part to federal influences, most state Medicaid programs are imbued with a number of structural flaws that have hampered rebalancing efforts, including:

### ***Fee-for-Service Delivery Systems***

With some exceptions, Medicaid reimburses most HCBS providers and nursing facilities on a fee-for-service (FFS) basis, with no financial incentives to rebalance expenditures. Accordingly, the delivery system has no financial incentives to rebalance expenditures from nursing facility to HCBS programs. Alternatively, a well-designed system of capitation offers managed care entities financial rewards for reducing expensive nursing facility care in favor of HCBS placement. However, for a variety of reasons many states have been reluctant to enroll aged, blind, and disabled beneficiaries in managed care and even more resistant to implementing capitated managed long-term care programs.

### ***Consolidated Waiver Management***

Most states operate their various HCBS waiver programs independently and have not made any efforts to consolidate them. While 1915(c) requirements preclude states from fully consolidating these programs, service definitions, providers, and rates of reimbursement may appropriately overlap across waivers.

### ***Lack of Integration between LTSS and Acute Care***

Most Medicaid agencies separate the administration of LTSS (both nursing facility and home- and community-based services) from acute care, but not without consequences. Nursing facilities and waiver case managers play a limited role in the management of acute care and many states exclude nursing facility residents and HCBS participants from acute managed care initiatives. However, 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 fulfilled by nursing facilities;
- Residents of nursing facilities are being underserved and acute care needs are not being met; and
- Acute care and LTSS are not well coordinated in either setting.

Whatever the cause, 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, because acute care is not integrated, 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.<sup>31</sup> Further, chronic illnesses among individuals receiving institutional long-term care services may not be appropriately recognized and

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<sup>31</sup> The PPACA creates a new Federal Coordinated Health Care Office within CMS that is designed to improve care coordination and service integration for the dually eligible. The Secretary of HHS will submit an annual report to Congress with recommendations for legislation to accomplish this objective.

managed. Yet another factor that begs further study is the prevalence of dementia among high utilizers of acute care services in home- and community-based settings.<sup>32</sup>

### **Recognition and Treatment of Comorbidities**

In many instances, individuals receiving HCBS may have serious physical and/or behavioral comorbidities that are left unaddressed by the particular waiver program in which the individual is enrolled. 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. Importantly, multiple studies reflect 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.<sup>33</sup> For this reason, Arizona's capitated long-term care program fully integrates acute and behavioral health services.

### **Integration with Informal Supports**

States have increasingly recognized that formal supports must be integrated with informal (i.e., unpaid) supports to make HCBS affordable for more people. Early preadmission screening and/or care planning tools for HCBS waivers did not formally assess and integrate informal supports into the care plan. Given the vital need for unpaid caregiving, which AARP currently values at \$375 billion per annum,<sup>34</sup> HCBS care plans must encourage and support unpaid caregivers (e.g., offering respite services) to ensure these services remain in place. A number of states (e.g., Pennsylvania, California, New Jersey) have implemented informal caregiver support programs, but they vary dramatically in quality and accessibility and are highly vulnerable to budget cuts.<sup>35</sup>

### **Preadmission Screening**

In the past, Medicaid programs required certification by a physician prior to approving an admission to a nursing facility. Recognizing that certification alone often led to inappropriate placements, most states began to require the use of a preadmission screening tool to determine admission (a few states still require only physician certification). Initially, some states used different screening tools for HCBS, which applied either more stringent or less stringent criteria than the nursing facility admission. Acknowledging the deficiencies in this approach, a majority of states now employ common criteria for acceptance into a waiver program and/or admission to a nursing facility. To protect the integrity of their programs, states must ensure that preadmission screening is independent of the service delivery system.<sup>36</sup>

### **Independent Care Management**

Under a fee-for-service environment, independent care management represents one of the most important tools a state possesses for ensuring that limited resources serve as many individuals as possible. "Independence" means that the care manager is not employed by a provider who might gain from case

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<sup>32</sup> V. Mor et al. "The Revolving Door of Rehospitalization From Skilled Nursing Facilities," *Health Affairs*, 29 no.1 (2010); L. P. Sands, et al. "Comparison of Resource Utilization for Medicaid Dementia Patients Using Home and Community-Based Waivers for Long-Term Care," *Medical Care*, 46, no.4 (2008).

<sup>33</sup> S. Melek and D. Norris. *Chronic Conditions and Comorbid Psychological Disorders*. Milliman Research Report. July 2008. Available at <http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/chronic-conditions-and-comorbid-RR07-01-08.pdf>.

<sup>34</sup> A.N. Houser, et al., op. cit.

<sup>35</sup> C. Levine, et al. "Bridging Troubled Waters: Family Caregivers, Transitions, and Long-Term Care," *Health Affairs*, 29 no.1 (2010).

<sup>36</sup> The PPACA includes a State Balancing Incentive Payments Program that will require participating states to implement a standardized assessment process statewide to determine eligibility for HCBS.



management decisions. Unfortunately, not all state HCBS programs have independent care managers and some lack any care managers at all.<sup>37</sup>

### ***Agency versus Independent Providers***

Traditionally, many states have relied primarily on agency-based HCBS providers. But as states increasingly move toward greater consumer direction, independent HCBS providers typically assume a greater role given that they are often more cost effective than agency-based services. The trade-off for some states is the loss of supervision and agency-based training.

### ***Reporting Requirements***

Few states require HCBS providers to submit cost reports with the level of detail that would be needed to support rate-setting for specific services or individuals at different levels of care. For independent providers serving a single individual, cost reporting makes little sense, but it should not be an onerous requirement for agencies that receive a substantial percentage of their revenue from Medicaid.

### ***Technological Tools***

Most states lack the technological tools necessary to: (1) address the complex needs of clients living in the community; (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 resources they need to ensure that similarly situated individuals receive comparable services. Sophisticated tools like predictive modeling software and care planning and tracking applications are essential to the broader penetration of HCBS.

### ***Small Solutions – PACE/Voluntary Initiatives***

Because of the many challenges states confront coupled with their reluctance to pursue mandatory or large-scale managed care initiatives, a number of states have looked to managed care solutions that serve small numbers of participants on a voluntary basis. PACE programs represent an apt example of such an approach (see Section III). While not without merit, such programs contribute little toward promoting overall rebalancing goals.

## **Role of Certain Stakeholders and the Courts**

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

### ***Nursing Facilities***

Despite their best efforts, most states have not been able to garner nursing facility support for rebalancing by encouraging and/or incentivizing them to diversify their facilities by including certain HCBS (e.g., respite care, adult day health). In the view 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.

States need to address this challenge directly. A number of states have adopted measures to address these concerns (see Section III), but the nursing home industry nonetheless represents a potent obstacle to reform.

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<sup>37</sup> The State Balancing Incentive Payments Program in the PPACA will require participating states to adopt a “conflict-free” case management system.

### ***Upper Payment Limits (UPL)***

States that make UPL payments to nursing facilities face a number of challenges. Under current law, UPL payments may only be made under a fee-for-service reimbursement model. If a state wishes to pursue managed care, it can either convert the UPL payments to rate adjustments that managed care plans would then pass on to the facilities or withstand objections from the industry over payment reductions.

### ***Provider Taxes***

A number of states require nursing facilities to pay provider taxes. Such taxes are typically used for one or more of the following purposes:

- Nursing facility rate increases;
- Nursing facility UPL payments;
- Nursing facility quality incentives;
- HCBS program expansion (e.g., Indiana); and/or
- Contributions to the general fund.

States wishing to move dollars from nursing facilities to HCBS or those wanting to implement managed care programs must address provider tax issues or face considerable opposition from the industry. It should be noted that under managed care a premium tax can replace a provider tax; however, the tax must be structured in a manner that complies with federal regulations and guidelines.

### ***Role of Parents/Families***

Parents and family members constitute 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.

Recent developments in Illinois provide an example. In response to a class action Olmstead lawsuit brought against Illinois' Division of Developmental Disabilities, advocacy groups and the state worked collaboratively to develop a settlement agreement that included resources for expanded community-based services. However, a group of individuals who were currently being served in institutions filed an objection to the class action defined in the litigation and settlement. It should be noted that Illinois operates nine large state developmental centers today.

### ***Role of Labor Unions***

Like parents and family members, 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 (e.g., group homes in Rhode Island). In Maryland, the union proposed a variation to the Money Follows the Person initiative in which, if requested by the resident and/or family, direct-care state staff would follow the resident into the community.

### ***Role of the Courts***

The courts have also played both a positive and negative role in promoting HCBS. Olmstead-related litigation has in many cases led to an increase in HCBS placements and the transition of individuals from institutions into the community. On the other hand, some state-level court decisions have had a negative impact by defining a certain class as entitled to services that are so costly that individuals who are not members of the class receive very little HCBS support. Probably the best known example is the



Hissom decision in Oklahoma that resulted from a class action lawsuit to compel the state to create community-based alternatives to institutional placements for the developmentally disabled.<sup>38</sup> The complexity and cost of doing so effectively foreclosed the state from providing such alternatives to eligible individuals who were not involved in the lawsuit.

## State-Specific Variables

Policy analysts often remark that each state Medicaid program is unique and this holds equally true for HCBS waiver programs. For example, depending on a state's individual economic circumstances, HCBS programs often end up competing with different industries for workers (and sometimes each other), e.g., in Nevada's service-based economy, HCBS programs compete with hotels and casinos for their workers.

Other important state-specific variables include, but are not limited to, the following:

### *Urban vs. Rural Infrastructure*

Some states have expansive rural areas where population density is so low that building the infrastructure to support certain home- and community-based services is not possible or practical. In order to provide HCBS in rural communities, states must either limit the availability of certain services or else redesign them to ensure their financial viability. For example, in Arizona one rural county determined that adult day health care could not be developed at an independent site because there were an insufficient number of people to support the service. Instead, they suggested a group day care/respite service provided at a community home. Going forward, many states are hopeful that recent breakthroughs in telehealth technology will assist in addressing the challenge of offering HCBS in rural areas.<sup>39</sup>

### *Special Needs Allowance and the Medically Needy*

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. The higher the special needs allowance, the more likely an individual will be financially able to remain in the home.

Some states offer the medically needy option for long-term care, including both nursing facility and home- and community-based services. For nursing facility placements, under the medically needy option the state takes the income less the individual's modest personal needs allowance and applies it to the cost of nursing facility and other medical services. For HCBS, the medically needy population is more complicated. Individuals eligible under the medically needy category 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 of nursing facility placement. To ensure the continuity of HCBS services, states must seek creative ways to apply spend-down (see Section IV).

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<sup>38</sup> J. Nicholson. "Reflections on Hissom." *State of Oklahoma, Office of Handicapped Concerns: Will's Corner, Oklahoma*, 6 no.2 (April 2005). Available at [http://www.odc.ok.gov/odc/newsletter/nl\\_v6\\_i2.pdf](http://www.odc.ok.gov/odc/newsletter/nl_v6_i2.pdf).

<sup>39</sup> W. Engle. *The Approaching Telehealth Revolution in Home Care*. Telemedicine Information Exchange. March 2009. Available at [http://tie.telemed.org/articles/article.asp?path=articles&article=telehealthRevolution\\_wengle\\_tie09.xml](http://tie.telemed.org/articles/article.asp?path=articles&article=telehealthRevolution_wengle_tie09.xml).



## Section III: Major Program Initiatives

As the primary long-term care payer, state Medicaid programs have long been working in concert with the federal government to improve the availability and quality of long-term care services. This section provides a brief overview of major program initiatives and how they have impacted long-term care reform and rebalancing, including:

- State-Level Rebalancing Initiatives;
- Nursing Home Moratoriums;
- National Long-Term Care Channeling Demonstration;
- Real Choice System Change Grants;
- Consumer-Directed Programs;
- The Deficit Reduction Act of 2005;
- Integrated Long-Term Care Programs;
- Medicare Advantage Special Needs Plans; and
- LTSS-related provisions in the Patient Protection and Affordable Care Act of 2010.

### State-Level Rebalancing Initiatives

Over the past two decades, states have developed and implemented an array of strategies to address the “institutional bias” in the Title XIX long-term care benefit, including:<sup>40</sup>

#### *Global Budgeting*

An initiative that analysts often point to as a “best practice” for enhancing the balance between institutional care and HCBS is to pool state and federal funds for both institutional and HCBS services into a single budget category with an overall spending cap. Known as “global budgeting,” this policy provides states with broad flexibility to shift funds earmarked for long-term care between different programs as needed and appropriate to promote cost efficiency and a suitable balance between institutional and HCB services. Oregon, Washington, and Vermont have successfully implemented this practice and Ohio and New Jersey have recently adopted similar legislation.

#### *Eligibility Determinations*

A pilot program in New Jersey uses a “presumptive eligibility” approach that entails searching two databases, one for the state’s Pharmacy Assistance to the Aged and Disabled program and another that contains information about participants in benefit programs for low-income individuals. Applicants whose names appear in either of the databases are presumptively deemed as financially eligible for services.

Other states, including New Hampshire and Wisconsin, are using an Aging and Disability Resource Center (ADRC)-based single point of entry system that combines functional and financial eligibility assessments with options counseling to ensure that individuals understand their available HCBS and institutional care choices prior to the development of a plan of care.

#### *Revised Eligibility Standards*

Concerned about increased demand for services, a number of states enforce higher eligibility standards for HCBS than for institutional care — a policy that in essence reinforces the Medicaid program’s institutional bias. However, in 2005 the Iowa legislature decided to reverse this policy by including a

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<sup>40</sup> L. Summer. *Efforts in States to Promote Medicaid Community-Based Services and Supports*. Kaiser Commission on Medicaid and the Uninsured. September 2009. Available at <http://www.kff.org/medicaid/upload/7969.pdf>.

provision in the IowaCare Act that establishes a higher eligibility standard for nursing homes than for HCBS waiver services and appropriates sufficient funds to virtually eliminate the waiting lists on the state's HCBS disability waivers.

## Nursing Home Moratoriums

In 1974, Congress passed the National Health Planning and Resources Development Act. Among other things, the act required nursing home operators to acquire a “certificate of need” (CON) prior to constructing any new facilities or expanding existing ones. The direct effect of these policies was to limit the number of new nursing home beds, thereby constraining supply and — presumably — costs. Although the legislation was repealed in 1986, the vast majority of states still maintain CON or other construction moratorium policies.<sup>41</sup>

Interestingly, a 2004 study of the effectiveness of efforts to limit nursing home construction or expansion through the adoption of CON and other moratorium policies found that states that repealed such laws had no significant growth in either nursing home or Medicaid long-term care expenditures. The study concluded that “states have little to fear in terms of increased expenditures with the repeal of CON and moratorium laws.”<sup>42</sup>

Following the repeal, Congress adopted OBRA 87, which supplanted the skilled nursing facility (SNF) and intermediate care facility (ICF) benefits under Medicaid with a consolidated nursing facility (NF) benefit on a mandatory basis. Beginning in 1990, ICFs were required to have 24-hour licensed nursing services (in contrast to day shifts only), seven-day-a-week registered nurse coverage on at least one shift (in contrast to eight hours of consultation weekly) and a full-time social worker on the staff of facilities with 120 residents or more. In effect, OBRA 87 mandated that all Medicaid-certified facilities had to meet a similar set of standards to those of the Medicare SNF benefit. The legislation basically eliminated most differences in requirements between Medicaid SNFs and ICFs.

The legislation also imposed new standards of care that facilities were required to meet in order to receive federal and state funding and further defined the state survey and certification process to determine compliance with the federal standards. Sanctions were established for facilities that failed to meet the standards. Unsurprisingly, OBRA 87's survey inspection procedures and nurse's aide training requirements had the effect of significantly increasing nursing homes' costs.

The two acts had a significant impact on the nursing home industry as well as on the states. Medicaid's NF benefit essentially created an entitlement to nursing facility services, a development that underpins the current institutional bias in the system, even though most beneficiaries express a strong preference for remaining in the community.

## National Long-Term Care Channeling Demonstration

The “Channeling Demonstration,” a joint effort of the Assistant Secretary for Planning and Evaluation (ASPE), the Administration on Aging, and the Health Care Financing Administration (HCFA, now CMS), was launched in 1980 to “channel” individuals in need of LTSS into the most appropriate service setting. The initiative was designed to test the viability of “comprehensive case management of

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<sup>41</sup> For an analysis of the economic and social impact of efforts to limit nursing home supply see B.J. Caldwell. “Certificate of Need Legislation in the Nursing Home Industry: Has it Outlived its Usefulness?” PhD Dissertation, University of South Florida (2006).

<sup>42</sup> D. Grabowski, et al. “The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures.” *Inquiry*, 40 no.2 (2003).

community care as a way to contain the rapidly increasing costs of long-term care for the impaired elderly while providing adequate care to those in need.”<sup>43</sup>

To be eligible for the initiative, individuals had to be age 65 or older, require assistance with essential activities of daily living, and lack adequate informal supports. From 1982 to 1985, when the program was phased out, 10 sites operated demonstration projects. The evaluation found that:<sup>44</sup>

- Channeling substantially increased formal community service use.
- Neither of the two models used in the demonstration had a major impact on informal caregiving.
- Channeling did not affect hospital or nursing home utilization.
- Channeling increased total subsistence, medical, and long-term care costs “due mostly to the costs of Channeling case management and for the extra formal community services arranged by Channeling.”<sup>45</sup> The largest increases in service utilization were for personal care and housekeeping services, which were not typically covered by then-existing public programs or private insurance.
- Channeling had no impact on mortality and the population served was not at high risk of institutionalization.

Three years after the Channeling demonstration ended, Arizona implemented its innovative Arizona Long-Term Care System (ALTCS — described under Integrated Programs on page 34). Its positive results and the impressive independent evaluation<sup>46</sup> of the program’s financial impact and quality indicators significantly contributed to an understanding of how to implement and operate long-term care programs under a “managed” model. ALTCS further demonstrated that HCBS can serve as a cost-effective alternative to institutional care and enhance beneficiary satisfaction.

## Real Choice System Change Grants

Since fiscal year 2001, CMS has awarded 338 grants totaling roughly \$302 million in Real Choice Systems Change (RCSC) Grants for Community Living to 50 states, the District of Columbia, and two U.S. territories. These grants have enabled states and non-profit agencies to build infrastructure that enables individuals to live in the most integrated community setting suited to their needs and exercise more control over the services they receive.

With this support, states were able to address such issues as:

- Transitions from institutions to the community, including personal assistance services and improved linkages to appropriate and affordable housing with support services;
- Direct-service worker shortages;

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<sup>43</sup> U.S. Dept. of Health and Human Services (1987). “National Long-Term Care Channeling Demonstration: Summary of Demonstration and Reports” Available at <http://aspe.hhs.gov/daltcp/reports/chansum.htm>; U.S. Dept. of Health and Human Services (1988). “Evaluation of the National Long-Term Care Demonstration: Final Report, Executive Summary.” Available at <http://aspe.hhs.gov/daltcp/reports/HSRES.HTM>.

<sup>44</sup> Selected from among the findings included in the U.S. Dept. of Health and Human Services (1987). “National Long-Term Care Channeling Demonstration: Summary of Demonstration and Reports” op.cit.

<sup>45</sup> Ibid., 1.

<sup>46</sup> N. McCall, et al. *The Arizona Long-Term Care System: Six Years of Experience Integrating Acute and Long-Term Care in a Capitated Medicaid Program*. Laguna Research Associates. 1996.

- Respite services for caregivers and family members;
- Quality improvement in home- and community-based services; and
- Person-centered care planning.

Most evaluations of RCSC have reported positive results. An assessment of the program following its first year of grants reported the following:<sup>47</sup>

- The Kentucky Housing Corporation agreed to change its policy to require use of Universal Design principles.
- In Maryland, the Department of Housing and Community Development agreed to modify the weight factor in its Qualified Allocation Plan as an incentive for developers to set aside a percentage of housing units for people with disabilities.
- In Connecticut, a Center for Independent Living formalized the first partnership with a local housing authority.
- In Georgia, two Centers for Independent Living obtained Memos of Understanding with their local Public Housing Authorities that guarantee priority for housing to persons transitioning from a nursing facility.

### Consumer-Directed Programs

In fiscal years 2001 through 2004, as a part of CMS' discretionary research appropriation, Congress appropriated a total of \$205 million in state grants to increase opportunities for individuals of any age with a disability or long-term illness to remain in the community. Of the \$205 million, CMS targeted \$23.5 million to increase consumer direction in Medicaid personal care 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.<sup>48</sup>

In any consumer-directed program there are a series of programmatic and policy issues that states must address, including, but not limited to:

- Eligibility criteria (i.e., who can participate);
- Process for handling fiscal intermediary functions (e.g., monitoring of individuals' budgets, beneficiary's cash allotment, paying direct-service workers, filing tax reports, withholding federal and state taxes, providing worker's compensation insurance, etc.);
- Consumer education, training, and counselor services (i.e., advice and support to the beneficiary);
- Determination of who is the "employer" (e.g., the beneficiary, an agency, the fiscal intermediary, or a self-employed "independent Medicaid provider") and whether or not family caregivers can be paid employees; and

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<sup>47</sup> W. Anderson and J. O'Keeffe. *Real Choice Systems Change Grant Program: First Year Report*. U.S. Dept. of Health and Human Services. October 2003.

<sup>48</sup> Congressional Research Service, Library of Congress (2005). "Long-Term Care: Consumer-Directed Services under Medicaid."

- Provider issues, including provider qualifications and rates, and effect on current service providers.

States must also develop fraud and abuse protections and a quality management program to address complaints and provide oversight of the consumer-directed program.<sup>49</sup> Following are two variations on consumer-directed programs.

### ***Independence Plus Consumer-Directed Initiative***

In 2002, the Department of Health and Human Services (HHS) developed the Independence Plus initiative to provide states with expanded opportunities to allow consumer direction of LTSS under Medicaid.<sup>50</sup> The basic principles behind Independence Plus programs are the same as Cash and Counseling (described below), although the programs differ in several important respects. Most importantly, Independence Plus provides “an opportunity for states to permit self direction of any Medicaid service, not a defined list of HCBS waiver services.”<sup>51</sup>

Independence Plus programs can be operated either under an 1115 demonstration waiver or an HCBS 1915(c) waiver. The latter is used in states where the program design provides services through an individualized budget or by having individuals manage some or all of their HCBS services (e.g., respite, transportation, personal care, home modifications, etc.). The 1115 waiver is needed if the state’s program design calls for:

- Providing cash directly to individuals;
- Paying legally responsible relatives;
- Changing Medicaid eligibility requirements; and/or
- Waiving the requirement for provider agreements (i.e., allowing the use of non-Medicaid providers).

The Independence Plus initiative also provides a template to facilitate the submission of waiver requests. The template outlines the specific waiver application elements and provides technical assistance on key features of consumer-directed programs. It also establishes a minimum set of program design features that states must document in their waiver applications in order to receive federal approval.

Numerous states have obtained approval for Independence Plus waivers, including California, Connecticut, Delaware, Florida, Louisiana, Maryland, New Hampshire, and South Carolina. A 2007 analysis of states that received Independence Plus awards for FY2003 found that “while some made greater strides than others, all have laid the groundwork for increasing the number of individuals who have the option to direct their services and thus attain greater control of their lives.”<sup>52</sup>

### ***Cash and Counseling Demonstration***

The Cash and Counseling Demonstration (C&C) is perhaps the best known and largest demonstration of consumer-directed long-term care under Medicaid. In 1996, the Robert Wood Johnson Foundation

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<sup>49</sup> P. Doty, et al. “New State Strategies to Meet Long-Term Care Needs.” *Health Affairs* 29 no.1 (2010).

<sup>50</sup> J. Crowley. *An Overview of the Independence Plus Initiative to Promote Consumer Direction of Services in Medicaid*. Kaiser Commission on Medicaid and the Uninsured. November 2003. Available at <http://www.kff.org/medicaid/upload/An-Overview-of-the-Independence-Plus-Initiative-to-Promote-Consumer-Direction-of-Services-in-Medicaid.pdf>.

<sup>51</sup> *Ibid.*, 3.

<sup>52</sup> U.S. Dept. of Health and Human Services, Center for Medicare and Medicaid Services (2007). “Increasing Options for Self-Directed Services - Initiatives of the FY2003 Independence Plus Grantees.” Available at <http://www.cms.hhs.gov/RealChoice/Downloads/IPpaper.pdf>.



(RWJF) partnered with HHS (through ASPE and CMS) to conduct demonstrations in three states: Arkansas, Florida, and New Jersey.<sup>53</sup>

The demonstration sought to evaluate the feasibility of providing cash allotments to individuals for directly managing their personal care services.<sup>54</sup> CMS granted the 1115 waivers to allow the states to pay consumers directly as well as to employ legally responsible relatives as direct-service workers. Participation was voluntary and individuals were randomly assigned to either receive the cash allotment or use a traditional, agency-based provider.<sup>55</sup>

Mathematica Policy Research found that the C&C Demonstration:<sup>56</sup>

- Improved the quality of life for beneficiaries and their caregivers and had a positive effect on beneficiaries' well being (e.g., reductions in unmet needs, increases in satisfaction with care);
- Increased personal care costs inasmuch as beneficiaries were able to access more of the care they were authorized to receive;
- Partially offset the higher personal care costs from reductions in institutional and other long-term care costs; and
- Did not result in any misuse of Medicaid funds or abuse of beneficiaries.

Mathematica's assessment of the 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.

Building on the success of the demonstration, in 2005 CMS further simplified the "c" waiver approval process for self-directed services and a separate Independence Plus waiver was no longer needed. States were then allowed to incorporate the "budget authority" (cash and counseling) option into any or all of their HCBS waivers.<sup>57</sup>

The Independence Plus and C&C initiatives supported state activities to significantly increase the quality of — and patient and caregiver satisfaction with — home- and community-based services. However, Jeffrey Crowley of the Health Policy Institute at Georgetown University has issued a cautionary warning, stating that "it will be essential that careful attention be paid to limiting the scope of services available for consumer direction to only those services that can be appropriately managed by individuals and it will be important to ensure that states are held accountable for providing adequate financing of individual plans of care and that state flexibility is appropriately balanced with reasonable beneficiary protections."<sup>58</sup>

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<sup>53</sup> Oregon implemented a separate but similar demonstration in December 2001.

<sup>54</sup> <http://www.hhp.umd.edu/AGING/CCDemo/>

<sup>55</sup> K. Tritz, "Long Term Care: Consumer-Directed Services in Medicaid," Congressional Research Service (2005).

<sup>56</sup> R.S. Brown. "Cash and Counseling: An Innovative Model for Consumer Choice," Presentation at Mathematica Policy Research Disability Research Forum, November 20, 2008. Available at <http://www.disabilitypolicyresearch.org/Forums/20081120/Cash-and-Counseling-Brown-BW-Nov25.pdf>.

<sup>57</sup> P. Doty. "After the Evaluation: Cash and Counseling's Policy Impact," Presentation at Mathematica Policy Research Disability Research Forum, November 20, 2008. Available at <http://www.disabilitypolicyresearch.org/Forums/20081120/Cash-and-Counseling-Doty-Nov25.pdf>.

<sup>58</sup> Ibid, 3; Kaiser Commission on Medicaid and the Uninsured (2003). "An Overview of the Independence Plus Initiative to Promote Consumer-Direction of Services in Medicaid." Available at <http://www.kff.org/medicaid/upload/An-Overview-of-the-Independence-Plus-Initiative-to-Promote-Consumer-Direction-of-Services-in-Medicaid.pdf>.



## Deficit Reduction Act (DRA) of 2005

The DRA introduced significant revisions to Medicaid long-term services and supports. First, it allows states to provide a comprehensive package of community-based services under Medicaid State Plans that previously could only be provided under a waiver. Second, it grants states the authority to offer 1915(j) self-directed personal care services under a State Plan Amendment option. And third, it introduced the Money Follows the Person rebalancing initiative, described below.

### *Money Follows the Person (MFP)*

Established in 2007, the MFP Rebalancing Demonstration is part of a comprehensive, coordinated strategy that, according to CMS, “will assist States, in collaboration with stakeholders, to make widespread changes to their long-term care support systems.”<sup>59</sup> Using the experience of the Real Choice System Change grants as a “foundation,” the MFP initiative is designed to assist states in the development of community-based long-term options that will enable the elderly and people with disabilities to participate in their communities to the greatest extent possible.

In 2007, 29 states and the District of Columbia were awarded grants totaling almost \$1.5 billion to transition nearly 38,000 individuals from institutional to community settings over five years, making it the largest demonstration program of its kind in Medicaid’s history. Then Secretary Alphonso Jackson of the Department of Housing and Urban Development (HUD) informed Public Housing Authorities and State Housing Finance Agencies that the MFP initiative “provides an opportunity for them to collaborate with CMS and disability organizations to expand accessible, affordable, and integrated housing options for persons with disabilities and seniors.”<sup>60</sup>

CMS has contracted with Mathematica Policy Research to conduct a five-year evaluation to: (1) assess how state long-term care systems are supporting the transition of people from institutions to the community; (2) determine whether the changes have been successful; and (3) calculate the extent to which MFP helps rebalance state long-term care spending. The evaluation is also analyzing the effects of MFP on Medicaid beneficiaries’ health and quality of life and identifying the characteristics of individuals and state programs that are strongly associated with success. The final report will be submitted in 2012.<sup>61</sup>

In an interim report on the initiative’s progress through December 2008, Mathematica finds the results thus far somewhat discouraging, with states having transitioned only 37 percent of a planned 3,997 individuals during 2007-08. States cite a number of factors for the slow pace, including delays in garnering program approval; CMS’ strict eligibility and transition requirements; a lack of available housing; a paucity of direct-service workers; an insufficient number of HCBS providers; difficulties in coordinating activities among various state agencies; and, not least, severe budgetary limitations stemming from the economic downturn. The most successful states include Texas (128.5% of transition target), Michigan (118.7%), and Delaware (100%), while laggards include Georgia (3.4%), California (3.9%), and Nebraska (6.4%). Going forward, Mathematica projects “the number of people helped to transition through MFP programs will continue to increase as these programs become fully operational and states overcome initial barriers associated with program startup.”<sup>62</sup>

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<sup>59</sup> U.S. Dept. of Health and Human Services. “Deficit Reduction Act Overview.” Accessed April 2010. Available at [www.cms.hhs.gov/DeficitReductionAct](http://www.cms.hhs.gov/DeficitReductionAct).

<sup>60</sup> Ibid.

<sup>61</sup> D.J. Lipson and S.R. Williams. *Implications of State Program Features for Attaining MFP Transition Goals*. Mathematica Policy Research. June 2009. Available at <http://www.mathematica-mpr.com/publications/PDFs/health/MFPfieldrpt2.pdf>.

<sup>62</sup> N. Denny-Brown and D.J. Lipson. *The National Evaluation of the Money Follows the Person Demonstration Grant Program: Reports from the Field*. Mathematica Policy Research. November 2009. Available at <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFPReportNo3Nov09.pdf>.

The PPACA extends the MFP program through 2016 and reduces the institutional length of stay requirement from six months to 90 days (excluding any Medicare-funded days).

## **Integrated Long-Term Care Programs**

### ***Arizona Long-Term Care System (ALTCS)***

There are several examples of programs that integrate acute and long-term care service delivery, with or without an actual integration of funding streams (e.g., Medicare and Medicaid). ALTCS is by far the oldest and most studied of these programs.

First introduced in 1988, ALTCS was originally developed under an 1115 research and demonstration waiver. The program fully capitates all Medicaid primary, acute, and long-term care services for elderly individuals and persons with disabilities (physical and developmental) who require a nursing facility or ICF/MR level of care and coordinates the delivery of Medicare-covered services. Independent studies have found that the ALTCS program has generated savings in excess of seven percent per year for the acute care program (averaged over the first 11 years of the program) and savings of 16 percent per year for the long-term care program (over the first five years) in comparison to traditional fee-for-service.<sup>63</sup>

Importantly, ALTCS health plan case managers worked with members to coordinate care across the continuum of Medicare and Medicaid benefits even before the introduction of Medicare Advantage Special Needs Plans (SNPs), so there was effective service integration even though the funding streams were not integrated.

### ***Program of All Inclusive Care for the Elderly (PACE)***

PACE, authorized by the Balanced Budget Act of 1997 (BBA), features a comprehensive service delivery system and integrated Medicare and Medicaid financing under a capitated model. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized, although PACE also covers nursing facility services. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under Medicare and Medicaid fee-for-service.

To be eligible, participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing facility care by the appropriate state agency. An interdisciplinary team assesses beneficiaries' needs, develops care plans, and delivers all services. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services. PACE providers assume full financial risk for beneficiaries' care without limits on amount, duration, or scope of services, including skilled nursing facility care.

Most evaluations of PACE have reported favorable results. Enrollees tend to have lower rates of nursing home admissions, shorter hospital stays, lower mortality rates, and better self-reported health and quality of life compared to non-PACE populations. However, PACE's traditional "bricks and mortar" day center model is not easily replicable and the cost of the program is often more expensive than typical 1915 (c) waiver programs.

In the wake of the 1997 BBA legislation, many stakeholders anticipated that states would quickly embrace PACE as a proven solution for integrating Medicare and Medicaid funding streams, enhancing care coordination, and containing costs, but as of 2008 there were just 61 PACE sites serving approximately 17,000 beneficiaries. Policy analysts cite an array of reasons for PACE's lackluster rate of

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<sup>63</sup> N. McCall, et al., op.cit.

growth, including a reluctance among potential enrollees to change primary care providers or use an adult day center model of care, a lack of necessary funding for non-profit providers to start new PACE programs, insufficient funding to market or expand existing small-scale PACE sites, and a lack of interest among for-profit entities to pursue the PACE model. In addition, states have been hesitant to support the program over budget concerns, competition with existing HCBS waiver programs, and opposition from home health agencies and other HCBS providers. Furthermore, states with largely rural populations do not view PACE as a workable solution, although the DRA of 2005 created the Rural PACE Provider Grant Program to provide funding and technical assistance to 15 providers to develop PACE in rural areas.<sup>64</sup>

Many of these obstacles can and should be resolved either through modifications to the PACE model or by legislative and/or regulatory changes.

### ***Minnesota Senior Health Options***

Minnesota launched its Senior Health Options program (MSHO) in 1997 under an 1115 waiver, making it the first state to implement a managed LTSS model that integrated Medicaid and Medicare benefits for the dually eligible. The program later converted to 1915 (a)/(c) waivers. In 2001, a second program, Minnesota Disability Health Options, was implemented to include individuals (both duals and Medicaid-only recipients) with physical and intellectual disabilities.

While MSHO is voluntary, Minnesota requires all Medicaid beneficiaries to enroll in its Prepaid Medical Assistance Program (PMAP) and to select (or be auto-assigned into) a capitated health plan. PMAP members have access to Medicaid-funded LTSS through their health plan and can access other needed services through various HCBS waiver programs as well as standard Medicare fee-for-service and Part D. Alternatively, they can volunteer to join MSHO (in the counties in which it is available — the program is almost statewide as of 2008) and access the full range of Medicaid and Medicare services under a single, fully integrated umbrella. The program is thus “voluntary” to the extent that members have a choice between Medicaid managed care/wraparound services and MSHO.

### ***Massachusetts Senior Care Options***

Massachusetts’ Senior Care Options (SCO) program provides managed LTSS to dually-eligible individuals on a voluntary basis. Implemented in 2004 under a state plan option combined with a Medicare 222 reimbursement waiver, it is somewhat similar to the PACE program in its integration of Medicaid and Medicare benefits and reimbursement, but has more extensive eligibility criteria and greater flexibility in the delivery and coordination of care. There are three contractors, two for-profit organizations (Senior Whole Health and Evercare MA) and a non-profit (Commonwealth Care Alliance) that offer services throughout the state. Beginning in 2007, the program shifted to a Medicare Advantage special needs plan (SNP). As of January 2010, there are approximately 4,000 enrollees in the program.

### ***Special Needs Plans***

Medicare Advantage SNPs were originally authorized by the Medicare Modernization Act of 2003 to offer specialized services for designated beneficiary categories (i.e., institutionalized, chronic illness, dually eligible). Dually-eligible SNPs were designed to integrate Medicare and Medicaid services, but in practice only a small number of states have contracted with SNPs to provide Medicaid services on a capitated basis. To the contrary, many states have concerns that any savings generated as a result of integration with SNPs will flow primarily to Medicare as the result of reductions in acute services (e.g., inpatient hospitalization), providing little financial benefit to the states. While some states have

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<sup>64</sup> M. Lynch, et al. “PACE: Has it Changed the Chronic Care Paradigm?” *Social Work in Public Health* 23, no.4 (2008).

contracted with SNPs on a capitated basis to provide a full range of Medicaid services including LTSS (e.g., Massachusetts, New Mexico), much of this activity has been limited to the provision of the Medicare cost-sharing components and/or limited acute care benefits (e.g., New York's Medicaid Advantage program).

While there has been widespread interest on the part of insurance companies and provider-sponsored Medicaid health plans (440 SNPs were approved and 900,000 dually eligible beneficiaries were enrolled), many SNPs have been all but indistinguishable from Medicare Advantage plans (the key distinction is that SNPs are able to enroll targeted beneficiaries on a continuous basis throughout the year). In late 2007, in response to criticisms that SNPs were failing to achieve their intended purpose, Congress placed a moratorium on new SNP designations as well as on the expansion of existing SNPs. In July 2008, Congress reauthorized existing SNPs for one additional year (until December 2010) with new quality, reporting, and state contracting requirements imposed on all new dual eligible SNPs as well as existing SNPs planning to expand their geographic service area. The PPACA extends them through 2013 (see below); however, states that choose to move ahead with the SNP model may find that many health plans are withdrawing their SNP products from the market as the result of tightened reimbursement and lingering uncertainty around SNP authority. Should there be a retrenchment of interest among existing Medicare Advantage plans offering a SNP product, states may find it necessary to make it possible for smaller, less well-capitalized provider-sponsored entities to participate in initiatives to integrate care.

## **LTSS-Related Provisions in the Patient Protection and Affordable Care Act of 2010**

The newly adopted health reform legislation includes a number of significant provisions related to Medicaid-funded LTSS. Following is a summary of key provisions outlined in a recent National Academy for State Health Policy report, including:<sup>65</sup>

### ***Long-Term Care Insurance:***

- The Community Living Assistance Services and Supports (CLASS) Act creates a federally administered, voluntary LTSS insurance program.
- To qualify for benefits, individuals must contribute to the program for at least five years, have a disability anticipated to last at least 90 days, and meet the functional/cognitive criteria established by the Secretary of HHS.
- LTSS benefits — currently anticipated to average \$75 per day — will vary based on individual need and will have no aggregate or lifetime caps.
- The program will be consumer-directed.
- CLASS beneficiaries who are also receiving Medicaid-funded HCBS will retain 50 percent of their CLASS payment, with the balance applied toward their Medicaid costs; institutionalized beneficiaries will receive five percent.

### ***State Balancing Incentive Payments Program:***

- States can apply for an enhanced FMAP for HCBS expenditures, PACE programs, and state plan home health and personal assistance services. To qualify, states must:

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<sup>65</sup> D. Justice. *Long-Term Services and Supports and Chronic Care Coordination: Policy Advances Enacted by the Patient Protection and Affordable Care Act*. National Academy for State Health Policy. April 2010.

- » Establish a statewide “no wrong door” single point of entry process;
  - » Adopt a “conflict-free” case management system (i.e., case managers cannot be in a position to authorize services that they or their organizations will provide);
  - » Implement a standardized assessment process statewide to determine eligibility for HCBS;
  - » Collect and report utilization and quality data; and
  - » Maintain or loosen the standards and methodologies for determining eligibility that were in effect on December 31, 2010.
- States with less than 25 percent of LTSS expenditures devoted to HCBS in 2009 will receive a five percent FMAP increase during FY2011-2015 with a target of achieving at least 25 percent HCBS expenditures by 2015; states with less than 50 percent of LTSS expenditures devoted to HCBS in 2009 will receive a two percent FMAP increase. Incentive payments must be devoted to funding HCBS.
  - Program is effective October 1, 2011.

***Community First Choice Option:***

- Allows states to offer state plan HCBS to eligible individuals with incomes up to 300 percent SSI.
- Unlike HCBS waivers, participating states may not limit the benefit by the number of individuals or geographic area.
- Permitted benefits include items such as one month’s rent, utility deposits, and household furnishings needed to transfer individuals from institutions into the community; excluded benefits include assistive technology devices, medical supplies and equipment, home modifications, and vocational rehab.
- There is no budget neutrality requirement.
- Participating states will receive a six percent increase in FMAP for these expenditures.
- The Community First Choice Option becomes effective on October 1, 2011.

***Money Follows the Person:***

- PPACA extends this program through 2016 and reduces the institutional length of stay requirement from six months to 90 days (excluding any Medicare-funded days).

***HCBS State Plan Option:***

- Amends the 1915(i) state plan option by broadening the scope of covered services so as to be the same as the services allowed under waiver programs by including an “other services” category;
- Raises the income level for eligibility from 150 percent of SSI to 300 percent, thereby putting it on a level playing field with HCBS;
- Eliminates the provision that allowed states to set a limit on the number of individuals who could receive 1915(i) services; and
- Allows states to target this state plan service to a specific population, such as individuals with psychiatric disabilities.

***Spousal Impoverishment:***

- Beginning in 2014, PPACA requires states to apply the same spousal impoverishment protections to HCBS beneficiaries as it currently does to institutionalized beneficiaries.

***Direct-Service Workforce:***

- PPACA funds a three-year pilot program that will be competitively awarded to six states to implement a training and certification program for direct-service workers. The secretary of HHS will compare the results with a control group to determine the initiative's effectiveness.
- PPACA also establishes a national and state background check program for the LTSS workforce, including employees of SNFs, ICF/MRs, assisted living facilities, adult day care workers, hospice, and home health and personal care attendants.

***Aging and Disability Resource Centers:***

- PPACA appropriates \$10 million per year for five years to expand ADRCs.

***Federal Coordinated Health Care Office:***

- Establishes a dedicated department within CMS to improve coordination and integration among the dually eligible. The secretary of HHS will submit an annual report to Congress with recommendations for legislation to improve care coordination and benefits for the duals.

***Medicare Advantage Special Needs Plans:***

- Reauthorizes the program through 2013 and maintains the moratorium on geographic expansion of existing SNPs that lack Medicaid contracts through 2012, when SNPs that still lack contracts will be terminated;
- Authorizes a new risk adjustment algorithm based on the PACE frailty adjustment system; and
- Requires SNPs to achieve NCQA approval by 2012.

***Patient-Centered Medical Homes:***

- Beginning in January 2011, states will have the option to amend their state plans to fund medical home services such as case management, care coordination, transitional care, patient and family support, community referrals, and the use of HIT to link services.
- States can waive statewideness and comparability requirements.
- Participating states will receive a 90 percent FMAP for these expenditures for the initial two years of the program.
- Beginning in January 2011, states can apply for planning grant awards for development of a medical home State Plan Amendment.

In addition, there are an array of Medicare demonstration programs for such initiatives as Accountable Care Organizations, Community-Based Care Transitions Program, a payment bundling program, and other initiatives. PPACA also includes a number of nursing home reforms.



## Section IV: Promising Solutions

As states seek solutions to the challenges described in this analysis, a number of innovative approaches for addressing them have emerged. Following is a brief summary of some state-level “best practices” as well as a discussion of a number of regulatory and statutory “fixes” that would enhance the states’ ability to rebalance their long-term care delivery systems, either under managed care or other alternative service delivery structures. This section also examines proposals to both enhance the federal match for state innovations in community-based long-term care and to promote the private financing of care.

### State-Level Best Practices

Over the past decade a number of states have successfully implemented strategies to streamline and rationalize their long-term care systems. These include:

- **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, some states have implemented a standardized preadmission assessment for nursing facility admissions regardless of payer (e.g., New York, New Jersey, and Indiana). 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., Vermont, Texas).<sup>66</sup>
- **Financing and Incentives/Expanding HCBS under Managed Care:** In order for states to expand HCBS availability under a managed care initiative, a financial incentive should ideally 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 went from 70/30 in the early years of the program, to nearly 30/70 at present.<sup>67</sup>
- **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., New Jersey, Minnesota). Federal stimulus legislation adopted in February 2009 will further advance these efforts. It is critical that these

<sup>66</sup> PPACA includes a State Balancing Incentive Payments Program that will require participating states to establish a statewide single point of entry system as well as a standardized assessment process.

<sup>67</sup> Interview with K. Eskra, Vice President LTC, Aetna Medicaid Business Unit, Phoenix, AZ (December 2009).

and other initiatives include and recognize the unique information requirements for managing long-term care.

- ***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 home- and community-based services 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.”

### Statutory/Regulatory Barriers and Fixes

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. State rebalancing efforts currently face limitations in four areas:

- Fragmented home- and community-based programs based on target populations as a result of federal statutory and regulatory policies;
- An inability to control the services covered under individual state Medicaid plans;
- An inability to provide short-term HCBS support for individuals who do not meet the nursing facility level of care that would improve their ability to function at home or in the community and delay or prevent the need for institutional care; and
- A lack of integration between Medicaid and Medicare for dual eligible beneficiaries.

Some of the solutions to these barriers require federal statutory and/or regulatory change or an appropriation, while others simply require a committed effort by the federal government to work with states to craft a workable solution.

### Statutory/Regulatory Solutions

Solutions that require statutory/regulatory change or an appropriation include:

- ***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, CMS could 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.<sup>68</sup>
- ***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

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<sup>68</sup> At this point, it is unclear whether the 1915(i) or Community First Choice Option provisions in the PPACA will address this issue.



1115, but not for traditional HCBS waivers. The Deficit Reduction Act of 2005 allowed the provision of some HCBS services under the state plan absent a target population, but did not allow coverage of individuals up to the same income level as HCBS waivers nor does it allow states to control their financial exposure. The PPACA allows states to provide state plan HCBS to targeted populations and resolves the income-level differentiation, but leaves the risk of financial exposure unaddressed, which may deter cash-strapped states from exercising this option.

- ***Allow states to provide certain environmental modifications and major durable medical equipment (e.g., lifts) to individuals who are not otherwise eligible for HCBS.*** In order to provide states the ability to limit their financial exposure, these services could not be state plan services.
- ***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.
- ***Eliminate the exclusion of Institutes for Mental Disease from the HCBS waiver cost-effectiveness test for stays less than 30 days to promote HCBS service use for the seriously mentally ill.*** Many institutions for mental disease today are more cost-effective than psychiatric care in acute care hospitals and have comparable lengths of stay. The Community First Choice Option in PPACA offers states the ability to target state plan HCBS to select populations, but prevents them from limiting the number of individuals receiving services or controlling their financial exposure.
- ***Provide options for the coordination of Medicare and Medicaid services, service delivery, and funding in statute.*** These options could include:

  - » *Provide the authority for states to limit co-insurance and deductible payments for dually eligible individuals to Medicaid managed care in-network services.* Both Oregon and Arizona were initially permitted to do this, but the authority was not extended to other states. This allows for the management of all services (Medicare and Medicaid) and results in savings for both states and the federal government.
  - » *Allow states to manage all Medicare and Medicaid dollars.* This option will be attractive in states where the existing Medicare Advantage rates are high and the full-risk adjustment is provided for the nursing facility level of care.
  - » *Expand PACE options to provide states with more flexibility to develop regional or even statewide programs.*
  - » *Provide automatic enrollment for dually eligible individuals into Medicare Advantage Plans that also have a Title XIX Managed Long-Term Care Plan and/or Special Needs Plan.* This integrates the care and funding of the individual within a single plan.

- » *Using a standardized formula, allow states to share the savings accruing to Medicare as a consequence of their coordination efforts. One approach to accomplishing this would be to allow states to “count” Medicare savings in their budget neutrality calculations.*
- » *Mandate the use of state-approved preadmission screening instruments for all Medicare admissions to nursing facilities and communicate the results to states upon completion.*
- » *Mandate preadmission screening (using the state’s tool) for all admissions to nursing facilities regardless of payer source (perhaps as a condition of Medicare certification and mandate participation in Medicare and Medicaid).*
- **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 acute care.
- **Provide states with increased options for financial eligibility determination in long-term care.** Examples include:
  - » Provide spend-down options that promote the initiation and continuation of HCBS, perhaps by charging premiums or taking a percentage reduction, as alternatives to the current system of first-in, first-out;
  - » Allow temporary asset disregards for up to 180 days of an institutional stay if discharge remains a possibility;
  - » Increase asset limitations under SSI;
  - » Allow states to incorporate the SSI disability determination within their Preadmission Screening tools (e.g., Arizona); and
  - » Provide presumptive eligibility options without payback.

### ***Federal and State Solutions***

Solutions that simply require a commitment by the federal government to work with states include:

- Develop a combination 1915(b/c) template with the same timeframes and renewal periods to enhance administrative efficiencies.
- Provide states with the ability to coordinate managed long-term care programs with Medicare notices of enrollment and disenrollment in Medicare Advantage and Part D.
- Provide states with prompt notification of all Medicare nursing and rehabilitation facility admissions.
- Provide states with Medicare spending and utilization data for each dual eligible on at least a monthly basis.

- Allow daily (residential) or monthly rates (case management) for HCBS services for all populations, including the elderly, physically disabled, mentally ill, and developmentally disabled. The most efficient way to pay for some services is not in 15 minute increments. In its quest for accountability, CMS may have gone too far and did not focus on the output. (This is not to advocate the adoption of what are essentially capitation rates in which several services are rolled into one except in a formal managed care environment.)

## Financing Long-Term Care

To date, Money Follows the Person and long-term care insurance partnerships<sup>69</sup> have been the primary vehicles for enhancing federal funding and promoting private financing for long-term care. Money Follows the Person funds are narrowly targeted to the transition of Medicaid-eligible individuals from facilities to the community and the dollars are limited. Long-term care insurance partnerships reached a peak of eight percent of total long-term care spending during pre-recession 2007 and have since declined to approximately five percent today.

In addition, the recently passed health care reform legislation includes three provisions that directly address the financing of long-term care — each of which may potentially benefit the states. They include:

- The Community Living Assistance Services and Supports (CLASS) Act;
- The Community First Choice Act;
- Extension of the Money Follows the Person Rebalancing Demonstration and an appropriation of \$10 million per year for Aging and Disability Resource Center (ADRC) initiatives;

The CLASS Act is a significant attempt to influence the financing of long-term care outside of the Medicare and Medicaid framework. The Act establishes a voluntary payroll deduction insurance program (i.e., people can elect to “opt out”) that will develop a trust fund to provide individuals with a cash benefit for the purchase of long-term supports and services. In order to be eligible for benefits, an individual must vest in the program by making premium payments for a five-year period. The program’s framework also provides significant opportunities for enhancing benefits going forward, generating additional insurance products that would “wraparound” the available benefits and slow the growth of Medicaid long-term care spending.<sup>70</sup>

The Community First Choice Act creates a new state plan option under section 1915 to provide community-based attendant care to Medicaid-eligible individuals who require an institutional level of care. States with approved programs will receive an additional six percentage points above the FMAP for five years.

Finally, the legislation establishes an agency within CMS tasked with improving the coordination of Medicare and Medicaid services. While it is not clear what authority the agency will have to impact policy, clearly it provides a focal point for discussion.

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<sup>69</sup> Through the *Long-Term Care Partnership* program states promote the purchase of private LTC insurance by offering consumers access to Medicaid under special eligibility rules should additional LTC coverage (beyond what the policies provide) be needed. For more information, visit [www.chcs.org](http://www.chcs.org).

<sup>70</sup> P. Span. “A New Long-Term Care Program.” *New York Times*. March 24, 2010.

## 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. As this Environmental Scan and accompanying Policy Brief<sup>71</sup> emphasize, a great deal of progress has been achieved, but much more remains to be accomplished. Our goal has been to identify the primary obstacles hampering continued rebalancing and suggest a number of pragmatic solutions for moving forward. Now that comprehensive health reform legislation is 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.

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<sup>71</sup> To download the policy brief, *Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options*, visit [www.chcs.org](http://www.chcs.org).