Long-Term Care for the Elderly: Profiles of Thirteen States

Joshua M. Wiener
David G. Stevenson

The Urban Institute

Occasional Paper Number 12
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This report is part of The Urban Institute's Assessing the New Federalism project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is project director and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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Assessing the New Federalism

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.
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Long-term care services for older adults represent a substantial share of total health care spending in the United States and an area of major concern for state policymakers. Nursing home and home health care accounted for almost 12 percent of personal health expenditures in 1995, and they were approximately 14 percent of all state and local health care spending.¹ Neither private insurance nor Medicare covers long-term care to any significant extent, and few older adults have private long-term care insurance. The disabled elderly must rely on their own resources or, when these are depleted, turn to Medicaid or state-funded programs to pay for their long-term care. Because of the high cost of long-term care (a year in a nursing home costs an average of $46,000 in 1995), Medicaid coverage for long-term care provides a safety net for the middle class as well as the poor.² In 1997, 68 percent of nursing home residents were dependent on Medicaid to finance at least some of their care.³ Medicaid long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018 because of the aging of the population and price increases in excess of general inflation.⁴

This report focuses on long-term care for the elderly in each of the 13 states that have received intensive examination in the Assessing the New Federalism study: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. In particular, this report summarizes efforts within these states to control the rate of increase in Medicaid long-term care expenditures for the elderly. Readers interested in more extensive cross-state analyses (rather than details about individual states) should see Joshua M. Wiener and David G. Stevenson, “State Policy on Long-Term Care for the Elderly,” Health Affairs, vol. 17 (May/June 1998), pp. 81–100.
The Assessing the New Federalism project analyzes state health, income support, and social service programs for the low-income population, with special emphasis on the 13 states mentioned above, which account for 54 percent of total Medicaid spending for long-term care for the elderly. The information included in this report comes largely from interviews and documents collected at site visits performed in the second half of 1996 and the first half of 1997, with updates obtained from various tracking services and publications. Qualitative data collected from representatives of state health and social service agencies, state legislatures, long-term care provider associations, and advocates for the elderly and disabled provide the basis for the state-specific information presented. Persons interviewed were assured that they would not be quoted by name.

**Utilization, Supply, and Expenditures**

Table 1 contains demographic characteristics of the 13 focal states and their Medicaid programs. While nearly 13 percent of the U.S. population was over age 65 in 1996, this proportion ranges across these states from 10.1 percent in Colorado to 19.0 percent in Florida. Similarly, the proportion of Medicaid beneficiaries who are elderly varies by state, from 7.4 percent in Michigan to 14.0 percent in Massachusetts and Wisconsin.

Table 2 details some of the characteristics of the long-term care systems in the 13 states studied, including licensed nursing facilities, nonmedical residential care facilities, and home health agencies. These market characteristics

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<th>Table 1 Demographic Characteristics and Potential Demand for Long-Term Care Services across the 13 Focal States</th>
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<tr>
<td><strong>Total Elderly Population (000)</strong></td>
</tr>
<tr>
<td>United States</td>
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<tr>
<td>Alabama</td>
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<tr>
<td>California</td>
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<td>Washington</td>
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<tr>
<td>Wisconsin</td>
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</tbody>
</table>

vary widely across the states by service provider. The number of nursing home beds per 1,000 elderly age 75 and above among the states ranges from 76.7 in Florida to 211.8 in Wisconsin (the U.S. average is 133.1). Massachusetts has the fewest licensed residential care beds per capita (16.3 beds per 1,000 elderly age 75 and over), while California has the most (106.2 beds per 1,000 elderly age 75 and over). Finally, the number of home health agencies per capita ranges from 0.18 per 1,000 elderly age 75 and over in New Jersey to 3.43 per 1,000 in Texas.

In 1995 the Medicaid program spent almost $54 billion on long-term care for people of all ages, 34 percent of total Medicaid expenditures. Long-term care spending on older beneficiaries accounted for the majority ($30 billion) of this spending. In that same year, older persons were 11.1 percent of all Medicaid beneficiaries but accounted for 26.3 percent of total Medicaid expenditures. As shown in figure 1, three-fourths of Medicaid expenditures for the elderly were for long-term care services. Almost 85 percent of these long-term care expenditures were for institutional care, around 10 percent were for home care services, and the remaining 5 percent were for intermediate care facilities for the mentally retarded and mental health services. Medicaid long-term care spending for the elderly is more institution based than it is for younger people with disabilities.

Table 3 shows Medicaid long-term care spending on the elderly for the focal states and the United States, spending on these services as a percentage of total Medicaid spending, spending per elderly enrollee and resident, and the
LONG-TERM CARE FOR THE ELDERLY

Figure 1 Medicaid Expenditures for Elderly Beneficiaries by Type of Service, 1995

Table 3 Medicaid Long-Term Care Expenditures by State, 1995
(Elderly Beneficiaries, by Type of Service)

Source: Urban Institute calculations based on HCFA 64 data. Prepared for the Kaiser Commission on the Future of Medicaid. Does not include disproportionate share hospital (DSH) payments, administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
proportion of expenditures by type of service. There is considerable variation across states. While long-term care expenditures for the elderly were almost 20 percent of all Medicaid spending in the United States, among the study states this proportion ranged from 11.1 percent in California to 31.7 percent in Minnesota. Spending for long-term care per elderly resident varies from $475 in Florida to $2,444 in New York. The proportion of long-term care spending for the elderly that is for nursing facilities ranges from 66.4 percent in New York to 98.6 percent in Mississippi. These same states were the extremes in the proportion of Medicaid spending for home care. The share of long-term care expenditures spent on home care was uneven across the study states and varied from 0.2 percent in Mississippi to 23.1 percent in New York. In 1995, New York alone accounted for over 40 percent of all Medicaid home care expenditures for the elderly. The proportion of Medicaid long-term care expenditures spent on home care falls from 10.3 percent to 7.3 percent if New York is left out of the calculation. In addition, states such as California, Florida, Massachusetts, and Wisconsin have significant state-funded long-term care programs that do not appear in these data.

Table 4 presents trend data for total Medicaid long-term care expenditures for the elderly between 1990 and 1995. Medicaid long-term care spending for the elderly increased an average of 10.7 percent annually from 1990 to 1995 (compared with 16.7 percent growth for total Medicaid expenditures over the same period) and has grown more slowly in recent years. More than 40 states, including 11 focal states, reported lower growth rates for these expenditures for 1993 to 1995 than for 1990 to 1993 (not shown). Finally, the emphasis on institutional care for the elderly mentioned above has not changed substantially since 1990. Recent growth rates for Medicaid home care expenditures for the elderly have usually been below growth rates for nursing facility spending.

<table>
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<tr>
<th>Table 4 Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
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<tr>
<td><strong>Long-Term Care Expenditures ($ millions)</strong></td>
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<tr>
<td>Total</td>
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<tr>
<td>Service</td>
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<tr>
<td>Nursing Facility</td>
</tr>
<tr>
<td>ICF-MR</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>Home Care</td>
</tr>
</tbody>
</table>

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Strategies to Control Spending

States have considerable flexibility in the provision of long-term care services, as in the rest of the Medicaid program, and reform efforts differ across the states. In fact, the strategies states use to control long-term care expenditures are much more varied than for acute care, in which there is a single-minded focus on increasing managed care enrollment. Overall, states use three broad strategies to control spending: bring more outside resources (e.g., private resources, Medicaid, and Medicare) into the long-term care system to offset state expenditures; reform the delivery system so that care can be provided more efficiently; and reduce Medicaid eligibility, reimbursement, and services. Not surprisingly, the 13 states studied diverge in the extent to which they focus on each of these strategies and in how far each state has progressed in implementing substantial long-term care reform.

Private and Federal Funding

One strategy to reduce state expenditures is to substitute private, Medicaid, and Medicare financing for state funding.

- While some have heralded private long-term care insurance as a potential fix for rising Medicaid long-term care expenditures, states have made little progress in this area, and only two of the states studied seem seriously committed to this strategy. The “public-private partnerships” in California and New York that have generated so much controversy at the national level have failed to attract many participants, and such partnerships are not important sources of financing at this time.

- Almost all states believe that “Medicaid estate planning” is a problem, but only Massachusetts, New Jersey, and New York view it as a major concern. The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) has achieved its goal of increased estate recovery in all of the study states—except Texas and Michigan, where there is strong political opposition to establishing these programs—but few observers expect major savings.

- While some study states (California, Massachusetts, New York, and Wisconsin) are effectively increasing federal contributions through Medicare and Medicaid maximization, these strategies simply shift costs to the federal government. In some states, the low Medicaid reimbursement rate gives providers a logical incentive to bill Medicare rather than Medicaid if at all possible.

System Reform

A more ambitious approach is for states to develop more effective and efficient financing and delivery systems by encouraging the integration of acute and long-term care and the expansion of home and community-based programs.

- Almost all of the states studied are looking to managed care and the integration of acute and long-term care services to reduce the rate of increase in
expenditures. However, many of these efforts are only in the planning stage and limited in scope. Though there is substantial interest among state policymakers, progress on these initiatives has been slow, in part because Medicaid, and often Medicare, waivers are needed for their implementation.

- While the recent expansion of Medicaid home and community-based care has focused mostly on younger people with disabilities, some states are making efforts to expand home and community-based services for older persons. All focal states have a policy commitment to the expansion of home and community-based services for long-term care, although the extent of this commitment varies. In all but two states, New York and Texas, only a small percentage of funds for the elderly is spent on noninstitutional care. Several focal states have shifted state-funded home care programs into Medicaid, especially through the use of Medicaid home and community-based services waivers, taking advantage of the flexibility these waivers offer in terms of services and the ability to limit enrollment and expenditures. While some states complain about the paperwork relating to the waivers, none found the current system prevented them from doing what they wanted. Although some of the recent emphasis on community-based care is the result of consumer demand, the primary impetus for this reform is the promise of cost savings—an outcome about which research has been equivocal. To achieve these savings, states will have to be effective in keeping per-person costs down and in limiting the “woodwork effect,” the use of such services by those who would not have sought them if only nursing home care were available.

- Most of the states studied are increasingly debating the use of nonmedical residential care for the elderly as an alternative to nursing home care. Although several states have a sizable stock of residential facilities, states face a number of difficult issues as they consider this expansion, most notably how to allow people with substantial disabilities to age in place without making residential facilities into substandard nursing homes.

Traditional Cost-Containment Mechanisms

In the short run, especially if faced with an economic downturn, states are likely to rely on more traditional strategies to reduce spending, such as controlling nursing home supply, cutting reimbursement rates, and tightening eligibility.

- Many states are using certificate-of-need restrictions or moratoriums on new nursing home construction to limit the supply, and therefore utilization, of services. While this tactic will probably save money over the short to medium term, it does not address the underlying demographics of an aging population.

- All of the states studied thought it was impossible to meet the Boren amendment’s requirements in a way that the courts would approve without having to provide overly generous reimbursement to nursing homes. With the repeal of the Boren amendment in the Balanced Budget Act of 1997, states will have much greater legal freedom to impose rate cuts on nursing homes. However, doing so may still be very difficult. In all the focal states, the for-profit
nursing home industry is thought to be one of the most powerful health care interest groups and it will resist these cuts. Moreover, advocacy groups for the elderly will oppose these cuts as well if they believe they will affect nursing home residents adversely.

**Conclusion**

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

**Notes**


3. Ibid.


5. Unless otherwise noted, all Medicaid data presented in this paper come from Urban Institute analysis of HCFA Form 64 and Form 2082 data.
As in many states, Medicaid long-term care expenditures for the elderly in Alabama are almost entirely for institutional services. No major initiatives are under way to maximize private or federal financing or to integrate acute and long-term care services. Moreover, while state policymakers express interest in expanding home care, relatively little money is available to do so. Instead, the state has relied on more traditional methods of cost containment, including, until recently, a moratorium on new nursing home construction. In recent years, nursing home reimbursement has been fairly generous and was partly responsible for a Medicaid budget overrun in 1997. The governor proposed dramatic cuts in nursing home rates, which were successfully resisted by the legislature and the nursing home industry. A strong political force in Alabama, the nursing home industry has a history of successfully rallying public sentiment in favor of nursing homes and, more generally, Medicaid spending.

Utilization, Supply, and Expenditures

As shown in table 1, Alabama had a slightly greater proportion of elderly residents than the national average in 1996. While 12.8 percent of the U.S. population was over the age of 65 in 1996, the percentage was 13.1 percent for Alabama. Similarly, the proportion of Medicaid beneficiaries who were elderly was also higher in Alabama than the national average in 1995 (13.3 percent vs. 11.1 percent).

Like several other southern states, Alabama has a lower-than-average supply of nursing home beds and a substantial number of home health agencies. As shown
in table 2, Alabama had 24,318 nursing home beds in 238 facilities—90.0 beds per 1,000 elderly people age 75 and above, compared with a national average of 133.1 beds per 1,000. The state also has a very low supply of nonmedical residential facilities. It had only 208 licensed residential facilities with a total of 4,892 beds in 1995—only 18.1 beds per 1,000 elderly, compared with the national average of 52.8. Reflecting the recent increases in Medicare home health use, the number of home health agencies in Alabama has been increasing rapidly. As of 1995, there were 180 Medicare-certified agencies, up almost 50 percent since 1989. Historically, the Alabama Department of Public Health has been the state’s largest provider of home health services, especially in rural areas. In addition, many rural hospitals have begun their own home health agencies in an effort to remain economically viable.

Medicaid long-term care services for the elderly totaled $371 million in Alabama in 1995, up from only $158.3 million in 1990—accounting for 19.0 percent of Alabama’s Medicaid spending excluding disproportionate share hospital (DSH) costs, just about the percentage nationwide (table 3). Long-term care spending per elderly resident in Alabama was lower than the national average—$632 versus $967. Of these expenditures, 95.5 percent were for institutional services and only 4.5 percent for home and community-based services. As shown in table 5, spending for long-term care for the elderly grew by 18.6 percent per year between 1990 and 1995, compared with 10.7 percent nationwide, largely because of higher payment rates and provider taxes for nursing homes. In recent years, the rate of increase in nursing home spending has far outpaced changes in home care expenditures.

Maximizing Private Payments

Alabama does not have major initiatives to reduce Medicaid long-term care spending by promoting private-sector initiatives. Only a very small number of people have long-term care insurance, and while the state recently enacted tax incentives to stimulate the purchase of such insurance, the incentives are unlikely to increase significantly the number of people with policies.

<table>
<thead>
<tr>
<th>Table 5</th>
<th>Alabama Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
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</thead>
<tbody>
<tr>
<td><strong>Long-Term Care Expenditures ($ millions)</strong></td>
<td><strong>Average Annual Growth</strong></td>
</tr>
<tr>
<td>Total</td>
<td>158.3</td>
</tr>
<tr>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>133.3</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>1.7</td>
</tr>
<tr>
<td>Mental Health</td>
<td>4.6</td>
</tr>
<tr>
<td>Home Care</td>
<td>18.8</td>
</tr>
</tbody>
</table>

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

Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
The state has not actively attempted to discourage or prohibit asset transfer, because it is perceived to be a relatively modest problem, albeit one that causes concern for nursing facilities when residents are retroactively denied Medicaid eligibility. Nor is Alabama aggressively pursuing estate recovery, in part because the state already requires Medicaid nursing home residents to sell their homes after living six months in a facility if they are not planning to return home. In 1995, Alabama recovered about 0.6 percent of Medicaid nursing home spending for the elderly.

Medicare Maximization

The state has not developed a Medicare maximization program beyond requiring nursing homes and home health agencies to file with Medicare before they bill Medicaid. For home health, however, Medicaid reimbursement rates are low; thus, economic incentives, not policy, dictate that agencies seek reimbursement from Medicare whenever possible.

Managed Care

Alabama has not focused much attention on overall reform of the long-term care delivery system and financing. The lack of managed care organizations has limited possible interest in integrating acute and long-term care services.

Home and Community-Based Services

Alabama covers only limited home and community-based services. Medicaid home care for the elderly consists of mandatory home health services and a home and community-based waiver program, but the state does not cover personal care as an optional service. Alabama funds no state-only home care program, and only a small amount of money is available for home care through the federal Older Americans Act (OAA). As in some other southern states, the state Department of Public Health in Alabama is an important home health provider to the low-income population. Alabama is debating the future role of assisted-living facilities and other forms of nonmedical residential facilities for the elderly. In part because of nursing homes’ high occupancy rates, the nursing home industry does not view home and community-based services as a threat, nor does it feel that nursing homes directly compete for funds with these services.2

The elderly and disabled component of the Medicaid home and community-based waiver program is administered partly by the Department of Public Health and partly by the Commission on Aging.3 While the Commission on Aging contracts out for its services, the Department of Public Health provides
most of its services directly. To be eligible for the waiver, a person must be Medicaid eligible and meet the nursing home level of disability, but no other risk of institutionalization is required. Services include skilled and unskilled respite care, personal care, homemaker services, adult day health, and case management. Individual expenditures are capped at about $450 per month, but this limit rarely causes a problem. In 1996, 6,513 people received care under this waiver at a cost of $3,978 per recipient. The state does not fund all of the “slots” for home and community-based services that have been approved by the Health Care Financing Administration (HCFA).

Alabama Medicaid officials expressed some frustration with the waiver process, which they considered unnecessarily time-consuming. Moreover, compliance monitoring by HCFA is viewed as repetitious and focused on chart review rather than outcomes. However, the state’s overall relationship with HCFA is good, and there are no serious barriers to the state maintaining its waiver.

The volume of Medicaid home health services is limited, partly because of low reimbursement. Medicaid reimburses home health agencies $27 per visit, the same rate it paid in 1981. As a result of this low rate, most private agencies refer Medicaid patients to the public home health agencies, while private home health agencies focus on Medicare patients.

The low-income and rural character of much of the state raises some special problems. Providing home care to people who live in the rural parts of the state requires traveling long distances and working in very difficult conditions. In some cases, recipients have no running water or electricity. However, because there are often no other jobs available, recruiting and retaining lower-level home health staff in rural areas is not difficult.

Finally, like many other states, Alabama is examining the potential role of assisted living facilities. Advocates of assisted living facilities contend that providing Medicaid reimbursement in such facilities could help alleviate the rising costs of nursing home care, an assertion disputed by the nursing home industry, which argues that nursing home residents require too much skilled care to be efficiently provided for elsewhere.

**Medicaid Reimbursement Rates**

In 1997, Medicaid reimbursement for nursing homes became a highly contentious issue between Governor Forrest “Fob” James and the nursing home industry, with the governor proposing major reductions in nursing home rates. In Alabama, nursing facilities are reimbursed by Medicaid on a cost-based, facility-specific, prospective basis. In 1995, the average Medicaid reimbursement rate was $72, compared with $85 nationally. However, by 1997 Alabama’s average rate had increased to over $100 per day.
There is widespread agreement that Medicaid nursing home reimbursement rates are rather generous, although the nursing home industry contends that higher rates are compensation for low payments in the past. Rates jumped 15 percent between 1993 and 1994, and costs continue to rise, partly as a result of the need to conform to federal quality standards and the relatively recent rise in the minimum wage. To help offset some of its costs and to draw down additional federal funds, the state also imposed a provider tax of $1,000 per bed per year.

Relatively high payment rates in Alabama have prevented lawsuits over state compliance with federal nursing home reimbursement standards (the Boren amendment), although there have been threats of litigation. In October 1996, the time of the study team's site visit, most observers thought that repeal of the Boren amendment would make little difference in Alabama, in part because the nursing home association was so politically powerful.

The political environment changed dramatically in March 1997, when the Medicaid commissioner announced that the Medicaid program was running an $80 million (federal and state) deficit, amounting to about 4 percent of total Medicaid spending. Nursing home and prescription drug costs were identified as the principal reasons for the overspending. Some legislators proposed an increase in the cigarette tax to help close the gap, but Governor James strongly rejected any tax increase, preferring to cut spending. State officials argued that Alabama's nursing home rates had increased much faster and were much higher than those of “comparable” southern states, including Mississippi, Georgia, and Tennessee, and that the existing system offered no incentives for cost containment. The nursing home industry rejected the notion that rates were unreasonably high and warned of declines in the quality of care and of the possibility of current residents' being forced out of their nursing homes. Nursing homes blamed regulatory changes for the increase in spending.

In April 1997, the legislature killed a plan by the Medicaid agency to reduce nursing home rates. Hoping for a compromise, the nursing home industry proposed a plan to cut rates modestly and increase the provider tax. This proposal proved unacceptable to the state, which contended that it would lock in a payment system favorable to the nursing home industry. In May 1997, the governor-appointed Medicaid Reform Task Force proposed dramatically changing nursing home reimbursement from a facility-specific, cost-based prospective system to a system based on a flat daily fee at a level that would reduce spending by as much as 30 percent. The proposal was endorsed by Governor James even though the nursing home industry argued that it would be devastated by the changes. Responding to charges that quality would decline and jobs would be lost, Governor James accused the industry of “relying on scare tactics and diversions in order to hide the all-consuming greed that drives them.” In August, the governor sent out letters to 32,000 Alabama nursing home residents and their families attempting to refute the allegation that the reduction in payment levels would cause them to be turned out of their nursing homes.
In fall 1997, a compromise was reached, relatively close to what the nursing home industry had proposed in the spring. The legislature established a two-year commission to investigate nursing home reimbursement, trimmed nursing home reimbursement rates slightly, and raised the nursing home provider tax from $1,000 to $1,200 per bed. Since payment of the provider tax is an allowable expense for Medicaid purposes, the net effect is that the federal government will finance almost all of the Medicaid shortfall that generated the crisis.

### Controlling Long-Term Care Supply

Alabama has a certificate-of-need process that covers both nursing homes and home health agencies. A moratorium on new home health agencies ended in 1991. The governor ended a long-standing moratorium on the construction of new nursing homes in 1996, largely as a result of pressure by the legislature. Because of the state's high nursing home occupancy rate and the lack of home care, many observers believe that Alabama has an unmet need for long-term care. However, the state Medicaid agency is concerned that increasing the number of beds will increase its expenditures because almost three-quarters of nursing home residents are Medicaid eligible.\(^9\)

Despite the freeze on nursing home construction, an exemption process that allowed for increases in beds at existing facilities made the moratorium fairly "leaky." Nursing homes located in an area with a high occupancy rate could add up to 10 percent more beds, not to exceed 10 beds total, a standard that allowed a significant increase in beds. This process benefited existing providers over new applicants.

### Notes


3. In addition, there is a “homebound waiver” that serves disabled adults between the ages of 21 and 64 who have specific medical diagnoses and are at risk of being institutionalized. In 1996, there were 355 recipients.


7. The Boren amendment, enacted as part of the Omnibus Reconciliation Act of 1980, required states to pay nursing homes enough to cover the costs of an economically and efficiently
operated facility that meets quality and safety standards. The Balanced Budget Act of 1997 repeals these requirements.


Long-term care services for the elderly are administered by several different agencies in California. Nursing home care is administered by the Department of Health Services (DHS). Home care and personal care services are administered through the Department of Aging (DOA) and the Department of Social Services (DSS), respectively. One problem with different agencies administering separate parts of the long-term care system is that there are different eligibility criteria for different benefits. DOA and DSS service evaluation criteria are oriented to the social needs of the individual, while DHS's nursing home criteria are more medically based. As a result, long-term care services can become fragmented.

California is attempting to address this fragmentation of services. An intergovernmental task force is designing a standardized admission instrument for all Medi-Cal (California Medical program) long-term care, including nursing home care, home care, and personal care. In addition, the Long-Term Care Integration Pilot Program will seek to consolidate the administration and financing of long-term care services at the county level beginning in late 1998. However, many observers worry that this integration effort will face considerable challenges.

Utilization, Supply, and Expenditures

As shown in table 1, California had a lower proportion of elderly residents than the national average in 1996. While 12.8 percent of the U.S. population was over the age of 65, that percentage was 10.6 percent for California. The proportion of Medicaid beneficiaries who were elderly was also lower in California than in the nation as a whole in 1995 (9.8 percent vs. 11.1 percent).
As shown in table 2, the long-term care system in California is defined by a large number of residential care beds and a smaller number of nursing home beds. In 1995, California had 1,397 nursing facilities with 130,125 beds; the state’s 91 beds per 1,000 elderly people age 75 and above was substantially lower than the 133 beds per 1,000 nationwide. In contrast, California’s 9,572 residential care facilities with a total of 152,419 beds gave the state a much higher than average supply of residential care beds in 1995—106.2 beds per 1,000 elderly people age 75 and above versus 52.8 beds per 1,000 nationwide. In fact, California was the only focal state to have more residential care beds than nursing facility beds. California had more than 800 licensed home health agencies in 1995.

Although California spent over $2.1 billion on Medicaid long-term care for the elderly, such expenditures accounted for only 11.1 percent of California’s Medicaid non-DSH expenditures in 1995, compared with 19.5 percent nationwide (table 3). The state also spent well below the national average per elderly resident—$620 versus $967 nationwide. Among the studied states, only Mississippi had lower expenditures per elderly resident than California in 1995. Of these expenditures in California, 91.6 percent were for institutional care and 8.4 percent were for home and community-based services. Finally, as shown in table 6, Medicaid long-term care spending for the elderly increased more slowly in California than in the nation as a whole—from 1990 to 1995, spending increased 7.4 percent annually in California versus 10.7 percent nationwide.

### Maximizing Private Payments

The state has begun some innovative efforts to reduce state expenditures on long-term care by increasing private contributions. One effort is the Partnership for Long-Term Care program. California is one of four states (California, Connecticut, Indiana, and New York) to receive grants from the Robert Wood Johnson Foundation to implement public-private partnerships that com-

<table>
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<th>Table 6 California Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
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<td>Service</td>
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Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
bine long-term care insurance with Medicaid. Consumers who purchase qualified insurance policies can become eligible for long-term care services after their private insurance is exhausted without spending all of their assets, as is typically required to meet Medicaid eligibility criteria. The intent is to increase the number of middle-income elderly Californians who have quality long-term care insurance coverage and thereby keep them from impoverishment. As of December 31, 1996, eight companies were participating in the program and had only 4,762 policies in force. Many people contend that the qualified insurance products are too costly and complicated. The program is attempting to redesign the product to make it more competitive and less costly, but officials worry that any product of this type will have a hard time being viewed as a success because its payoff to the state will be well into the future.

The state does not seem particularly focused on policies to reduce transfers of assets. In addition, the state already had an estate recovery program in place when Congress mandated that states implement such programs in 1993. California recovered $28 million in 1993, the largest amount of revenue recovered in any state. This amount was only 1.9 percent of the Medi-Cal nursing home expenditures, but only five states recovered a larger percentage of their Medicaid expenditures.

### Medicaid Maximization

In addition to maximizing private contributions, California has made some efforts to increase federal contributions to long-term care. When personal care was made a covered option in California in 1993, the move made a large portion of the In-Home Supportive Services (IHSS) program—a program previously funded with only state and county funds—into a Medicaid benefit eligible for a 50 percent federal match.

### Home and Community-Based Services

The state has initiated a number of efforts to expand community-based care. It has 11 Medicaid waiver programs that serve 53,000 individuals, most of them younger people with developmental disabilities. California has several important waiver programs for the elderly, but they serve relatively few individuals given the size of the state, and expenditures are modest. The largest is the Department of Aging’s Multi-Purpose Senior Services Program (MSSP), which provides case management services to Medi-Cal beneficiaries who are 65 and older. Eligibility is limited to individuals who are at risk of institutionalization. The program has a 6,000-person cap on the number of clients who may be served at any one time, a limit that has permitted the program to provide services to approximately 8,000 frail clients a year.
Personal care services under Medi-Cal are generally provided by the Department of Social Services’ IHSS program. This program provides services to approximately 200,000 aged, blind, and disabled persons who are unable to remain safely in their homes without assistance. Services include domestic help, heavy cleaning, transportation, protection, supervision, and nonmedical personal care. The program has two parts, one funded with federal matching funds through Medi-Cal and the other funded by state and county funds. Program eligibility is limited to Supplemental Security Income (SSI) beneficiaries. Approximately 65 percent of IHSS recipients receive care through the Personal Care Services Program (PCSP) of Medi-Cal. This component of the IHSS program is 50 percent federally funded, with the balance coming from counties and localities (32.5 percent from counties, 17.5 percent local). The residual program is 65 percent state funded and 35 percent county funded. To be eligible for the residual program, a person must be 65 or older, blind, or disabled; candidates must also need IHSS services, live in their own home, and meet SSI financial criteria. To be eligible for PCSP, individuals must meet the same criteria as for the residual program, and they must also have a disability expected to last at least 12 months or until death, require at least one personal care service, and not have a parent or spouse as sole provider.

The state has three waiver programs to encourage the integration of acute and long-term care services—On Lok in San Francisco, the Program of All-inclusive Care for the Elderly (PACE) in Sacramento and Oakland, and a social health maintenance organization (SHMO) in Long Beach. All these programs are small, with about 300 enrollees each in the On Lok and PACE programs and about 625 enrollees in the SHMO.

**Medicaid Reimbursement Rates**

California spends almost 10 times as much on nursing home care as on home care services for the elderly ($1.7 billion versus $177.3 million). Despite the state’s reputation as a poor payer of nursing homes, the average reimbursement rate in 1995 was $88.99 per day for free-standing nursing facilities, compared with a national average rate of $85.05. Rates are set prospectively using class rates, with nonprescription drugs, medical supplies, and oxygen included. Advocates argue that Medi-Cal rates cover only about three-fourths of the cost of a nursing home day. As a result, they allege that nursing aides are poorly paid and often poorly qualified. These advocates worry that further rate reductions will result in staffing reductions.

The governor’s 1997–98 budget proposed modest changes in payment for nursing home and related care, savings for which are not expected to exceed $10 million in state general funds. For instance, hospitals currently do not transfer patients to nursing facilities on weekends, and Medi-Cal pays the hospitals an “administrative” day rate, about $215. The budget proposes to pay the hospitals the statewide average nursing home rate during weekend days. Another change
the state proposes is to discontinue payment for “bed-hold days,” days when nursing home patients temporarily receive acute inpatient care. With a statewide occupancy rate of 85 percent in nursing facilities, the state argues that the payment is unnecessary because beds will be available for patients when they return from hospital stays.

**Controlling Long-Term Care Supply**

California has no regulatory restraints on institutional supply. California’s certificate-of-need program was discontinued in 1987. In addition, the state failed to enact a provision in the governor’s most recent budget that would have established a moratorium on new nursing home construction.

**Note**

Although Medicaid long-term care expenditures are projected to increase much faster than acute care spending, issues concerning long-term care for the elderly are not center stage in Colorado. In part, this is because a small percentage of the population is elderly, and many participants express general satisfaction with the current system. Nonetheless, legislation passed in 1997 will change the way nursing homes are paid, which may have important consequences for the future. In addition, the state is experimenting with using managed care organizations to integrate acute and long-term care services.

Utilization, Supply, and Expenditures

Colorado had a lower proportion of elderly residents than the national average in 1996 (10.1 percent vs. 12.8 percent). In fact, as shown in table 1, the elderly as a proportion of the total population in Colorado was the lowest among the 13 focal states. In contrast, the proportion of Medicaid beneficiaries who were elderly in Colorado was slightly higher than the national average in 1995 (12.5 percent vs. 11.1 percent).

Table 2 shows that the long-term care supply in Colorado is higher than the national average in each provider category. In 1995, Colorado had 226 nursing facilities with 20,251 beds—207.5 beds per 1,000 elderly age 75 and over, which is much higher than the national average of 133.1. Colorado had the second-highest bed-population ratio of the focal states. Colorado’s 372 residential care facilities with 7,444 beds gave the state a higher than average concentration of residential care beds in 1995—76.3 beds per 1,000 individuals age
75 and above versus 52.8 beds per 1,000 nationwide. Colorado had 183 certified home health agencies in 1995.

In 1995, Colorado spent almost $270 million on Medicaid long-term care services for the elderly, accounting for 17.5 percent of all Medicaid expenditures in the state (compared with 19.5 percent nationwide) (table 3). Colorado spent less per elderly resident than the national average—$862 per elderly resident, compared with $967 nationwide. Of these expenditures, 90.9 percent were for institutional care, while 9.1 percent were for home and community-based care. As shown in table 7, Medicaid long-term care expenditures for the elderly grew at a faster annual rate in Colorado than the national average from 1990 to 1995—13.5 percent compared with 10.7 percent nationally.

Maximizing Private Payments

Most of the efforts to restrain the growth in long-term care costs have focused on traditional cost-saving strategies and much less on maximizing non-Medicaid revenues. Few of the people interviewed in Colorado even mentioned such efforts.

The Department of Health Care Policy and Financing oversees the estate recovery activities under Medicaid. In FY 1996, the department recovered $2 million from estates and liens on property of current nursing home residents, up 125 percent from the 1995 level. The state implemented new regulations in 1996 to close Medicaid loopholes allowing the transfer of assets. In addition, the department has begun to recover some resources from the income trusts that allow individuals to pay a portion of their nursing home costs. The state is the beneficiary of trust monies left when the trust closes. In FY 1996, $648,821 was recovered. State officials did not expect trust fund recovery to be a source of major savings.

<table>
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<tr>
<th>Table 7 Colorado Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
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<td>Long-Term Care Expenditures ($ millions)</td>
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Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data. Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Officials believe that encouraging long-term care insurance is unlikely to save Medicaid dollars. A 1995 review of policy options for reducing Medicaid expenditures mentioned this approach but treated it with considerable skepticism. Since those who can afford long-term care insurance are often well above the eligibility level for Medicaid, expanding insurance coverage may not result in Medicaid savings. Long-term care policies are affordable mostly to people who would not spend down to Medicaid without the insurance. This is particularly true since Colorado does not have a medically needy program, which means that there is an absolute ceiling on the amount of income a person in an institution can receive and still qualify for Medicaid.

Home and Community-Based Services

Colorado views its home and community-based services (HCBS) waiver program as highly successful, largely as a cost-saving device. Available services include adult day care, access to alternative care residential facilities, electronic monitoring, home modifications, transportation, respite care, personal care, and homemaker services. To qualify, an individual must have income of less than $1,410 per month and countable resources of less than $2,000. The cost of services is restricted to be less than the cost of nursing facility care, and Colorado takes this requirement very seriously. Eligibility has also been strictly limited, with an additional screen required to determine the risks of institutionalization (discussed in the next section).

The waiver for the elderly, blind, and disabled is limited to just over 6,200 persons. While estimates vary, the number of participants in this program totals about half the number of Medicaid nursing home residents. The HCBS Elderly, Blind and Disabled (EBD) waiver was budgeted at $57 million for the 1998 fiscal year,\(^3\) up from $36.9 million in FY 1996. The regular Medicaid home health program is about half the size of the waiver program.

A recent analysis of this waiver program concluded that overall medical savings were $53 million in 1994—an amount equal to 17 percent of the projected total long-term care budget.\(^4\) The study found that the drop in the proportion of Colorado’s population in nursing homes was faster than the national average rate of decline. Reasons for the program’s cost-effectiveness are the strict cost controls and the targeting of people at high risk of institutionalization.

Two nonfederally funded programs also provide long-term care benefits. The first is the Home Care Allowance (HCA), which allows families to purchase care for themselves and enables them to avoid more expensive institutional arrangements. It pays clients up to $355 in cash per month for the purchase of in-home functional supports and care. The exact amount varies according to the needs of the clients. It is more commonly used for younger people with disabilities than for the elderly, however. In 1996, the HCA served 5,796 persons, with payments totaling $14.5 million. The 1997–98 budget request for HCA was
$17 million. (This includes a 95 percent state contribution from the general fund and a 5 percent local match.) In addition, the state has a small Adult Foster Care program that provides 24-hour (nonmedical) supervised residential care. Adult Foster Care served just 537 persons in 1996 at a cost of $0.8 million. The FY 1998 level was expected to be $0.9 million. Most of the individuals in these two programs also participate in the traditional Medicaid program. Thus, altogether about as many people are served in the community as in nursing homes.

Older Americans Act services are administered by Aging and Adult Services (AAS) of the Department of Human Services. The Department of Human Services annual report for 1997 indicates that 137,537 Coloradans participated in OAA services, including 34,140 congregate meal participants, 11,362 home-delivered meal participants, and 12,867 participants receiving transportation services. Minorities seem to be well served by these programs. For example, although low-income minorities make up only 3 percent of the state’s population, they make up 9 percent of the congregate meals programs and 24 percent of recipients of in-home services for the frail. Finally, local ombudsman programs investigated 8,089 complaints by residents of nursing homes and personal care boarding homes in 1996.

Colorado has a single-entry-point system for qualification for all long-term care services, both under Medicaid and state-only programs. AAS oversees this system, and it sets statewide rules and coordinates the activities of 25 local agencies across Colorado. Eligibility for services is based on a person’s functional capacity score, which includes activities of daily living, instrumental activities of daily living, and cognitive measures; and a person must need services for these impairments at least five days a week. Need for skilled treatments, therapies, and rehabilitation is also taken into account. Care managers—usually social workers—working in the single-entry-point agencies conduct the assessments and then send them to the Colorado Foundation for Medical Care (CFMC), which determines the level of care.

The comprehensive single-entry-point system covers intake, assessment of clients, referrals, case management, resource development, and planning. This combination of tasks enables the program to manage care closely to ensure that it is appropriate and to control spending. AAS monitors this system and reports its findings to the Department of Health Care Policy and Financing. (Officials indicated that there is a reasonable level of coordination between these two state agencies.)

All Medicaid recipients go through this assessment system, and state officials expressed a desire to extend this service eventually to private paying clients as well. After meeting the screens for nursing home services, recipients interested in the HCBS waiver program must meet another tougher screen to determine if they have a high risk of institutionalization. Unlike other states, Colorado seeks to distinguish between people who are eligible for the nursing home level of care but would not enter a nursing home and those who would
enter a nursing home. Thus, several observers commented that it is harder to qualify for HCBS than for nursing home care, a situation that exacerbates the institutional bias of the delivery system.

Managed Care

While Colorado has focused mostly on enrolling people with disabilities in managed care programs that provide acute care, it is also pursuing options that integrate acute and long-term care services. One pilot project that combines acute and long-term care is the Integrated Long-Term Care and Financing (ILTCF) project in Mesa County (Grand Junction), which is in the early stages of operation. Enrollment is voluntary and builds on a successful health maintenance organization (HMO) in Grand Junction (Rocky Mountain HMO), which dominates the local market and enrolls a large share of the Medicare beneficiaries in the area. This project is part of an initiative funded by the Robert Wood Johnson Foundation. In addition, the state has two PACE sites and an SHMO (in its early stages of development with small enrollment).

Medicaid Reimbursement Rates

Medicaid pays nursing homes using a facility-specific prospective rate. In 1995, the per diem nursing home rate was $78, compared with a U.S. average of $85. Nonetheless, state officials believe the rates in Colorado are high relative to comparable neighboring states. Nursing home payment rates have been growing at double-digit levels over the past decade in Colorado. Several successful Boren amendment lawsuits, the political strength of the industry, and the high cost of Medicare services have all helped to drive up Medicaid reimbursement rates, which state officials are optimistic they can slow in the future.

Recently enacted legislation authorizes a case-mix payment system and makes a number of other changes expected to result in savings over the current system. Overall growth in payment rates will be constrained to no more than 6 percent for administrative costs and 8 percent for resident services each year. In addition, Medicare Part B ancillary costs will be taken out of the rate calculation. Officials expressed confidence that holding the line on nursing home payment levels will not cause quality of care to suffer; but advocates are not so certain, particularly with the repeal of the Boren amendment. An April 1997 budget analysis of the bill suggested that the changes will save $15.7 million in FY 1998, mostly from the spending caps.

The state has kept payment levels for HCBS well below nursing home rates, which advocates argue adds to the cost-effectiveness of noninstitutional services. Reimbursement rates for home health care are on a flat-rate fee schedule and vary from $32 for a visit by a home health aide to $61 for a visit by a registered nurse.
Controlling Long-Term Care Supply

Despite a moratorium since 1990 on new Medicaid nursing home bed construction, occupancy rates average 85 to 89 percent, indicating an availability of beds. In part, this is because the moratorium has not been absolute. When special needs have arisen (such as shortages in certain locations), new beds have been allowed. Since 1980, the number of nursing home beds has grown only 11.7 percent, compared with a 33.5 percent growth nationally. State officials attribute this slow growth to the Medicaid HCBS waiver, changing attitudes, and more assisted living options. The ratio of licensed residential care beds per 1,000 elderly population is above the national average.

Eligibility for Medicaid Services

Because Colorado has no medically needy program, persons needing long-term care who are not categorically eligible can qualify in one of two ways. First, persons of any age with incomes below 300 percent of the federal SSI level ($17,424 in 1996) are eligible to receive nursing home or home and community-based waiver services. Persons needing nursing facility care whose income is over 300 percent of the SSI payment level but below the cost of nursing home care can become eligible by establishing special income trusts.

Notes

6. This single-entry-point system is also sometimes referred to as Options for Long-Term Care.
8. Alexis Senger, Memorandum to Joint Budget Committee Members, April 8, 1997.
The need for long-term care services for older adults is potentially enormous in Florida. The proportion of the population that is elderly is the highest of any state in the country. Thus, there is substantial pressure to develop a larger, but low-cost, system of long-term care. Long-term care policy for the elderly in Florida is largely defined by a tight supply of nursing home beds, a comparatively large and growing supply of residential care beds, and a cautious interest in expanding home and community-based services to the elderly.

Utilization, Supply, and Expenditures

In 1996, 19 percent of Florida's population, or 2.7 million people, were over the age of 65, which was substantially higher than the national average of 12.8 percent (table 1). The proportion of Florida Medicaid beneficiaries who were over the age of 65 in 1995 was much closer to the national average (12.2 percent vs. 11.1 percent).

As shown in table 2, the long-term care system in Florida is dominated by a large supply of nursing homes in nominal terms and a surprisingly low bed-population ratio. In 1995, Florida had 678 nursing homes with 77,145 beds—76.7 beds per 1,000 people age 75 and over, much lower than the national average of 133.1 and one of the lowest ratios in the country. There were also 2,341 licensed residential care facilities with 63,877 beds in 1995—63.5 beds per 1,000 elderly, compared with 52.8 beds per 1,000 elderly nationwide. These residential facilities included assisted living facilities and adult family-care homes. The state had 1,912 licensed home health care agencies in 1995.
As in other states, long-term care in Florida is heavily financed by the Medicaid program, and long-term care services are an important part of the total Medicaid budget, though slightly less so than in many other states. As shown in table 3, Florida spent $1.1 billion in 1995 on long-term care for the elderly—18.2 percent of its total Medicaid budget, compared with the national average of 19.5 percent. Long-term care spending per elderly resident was much lower than the national average—$475 versus $967—primarily because of a low supply of nursing home beds and relatively little spending on home and community-based care. The state relies more heavily than most other states on nursing home care to provide long-term care services to the elderly. In 1995, 96 percent of long-term care expenditures for the elderly under the Medicaid program were for institutional services, and only 4 percent were for home care. Medicaid spending on long-term care for the elderly in Florida has grown more rapidly than for the nation as a whole in recent years: between 1990 and 1995, Medicaid long-term care spending grew at an annual rate of 14.3 percent, compared with the national average of 10.7 percent (table 8).

Maximizing Private Payments

While no hard estimates exist, the leader of an advocacy group for the low-income elderly speculated that approximately 5 to 10 percent of new Medicaid applicants become eligible through “artificial impoverishment schemes.” While Florida has yet to address this problem, the Agency for Health Care Administration (AHCA) expanded its estate recovery efforts. One law (SB 886) allows the Department of Revenue to share estate information with AHCA’s Medicaid estate recovery program, a system that may increase the funds obtained from estates.

| Table 8 Florida Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries) |
|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
|                                                 | Long-Term Care Expenditures ($ millions) | Average Annual Growth |
| Total                                           | 572.7 | 695.0 | 796.9 | 930.1 | 980.7 | 1,117.5 | 14.3% | 17.5% | 9.6% |
| Service                                         |    |    |    |    |    |    |    |    |     |
| Nursing Facility                                | 560.2 | 674.0 | 766.5 | 880.9 | 929.2 | 1,052.9 | 13.5 | 16.3 | 9.3 |
| ICF-MR                                          | 2.0 | 2.4 | 2.7 | 5.1 | 6.0 | 6.8 | 27.7 | 36.3 | 15.9 |
| Mental Health                                   | 2.5 | 10.7 | 11.9 | 13.1 | 12.8 | 13.3 | 39.7 | 73.5 | 0.8 |
| Home Care                                       | 7.9 | 7.9 | 15.8 | 31.1 | 32.8 | 44.5 | 41.2 | 57.8 | 19.6 |

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data. Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Medicare Maximization

In 1996, the legislature required AHCA to ensure that home health care beneficiaries exhaust all Medicare benefits before using Medicaid coverage. It also required prior authorization for home health care.

Home and Community-Based Services

Although there appears to be growing interest in expanding home and community-based care for the elderly and disabled, Florida continues to lag behind many states in doing so. Advocates and policymakers acknowledge that the current system of nursing home care, with its low number of beds, may be unsustainable and that there is likely to be a huge long-run increase in demand that will make long-term care unaffordable. The nursing home industry supports alternatives to nursing homes, including the small waiver programs the state has implemented, because it believes that if the state purchases services more cost-effectively, it can stretch long-term care dollars further.

Florida operates a state-funded home care program, Community Care for the Elderly (CCE), which helps functionally impaired elderly live in the least restrictive environment suitable to their needs. In FY 1996-97, the state spent an estimated $41 million in state general revenues to provide community-based services to approximately 38,500 functionally impaired older people, including those served under a Medicaid home and community-based services waiver. According to the Department of Elder Affairs, another 8,000 to 11,000 people are on waiting lists. All CCE clients are screened annually for Medicaid waiver eligibility; those found financially eligible and meeting level-of-care requirements are transferred to the waiver program, allowing the Department of Elder Affairs to maximize federal funding. Priority is given to those who are at risk of entering an institution or those who have been abused, neglected, or exploited.

The Department of Elder Affairs and AHCA share responsibility for administering the state’s several home and community-based care waivers that serve the elderly. The FY 1996-97 estimated budget for all services under this waiver was $36.1 million. The federally assigned enrollment cap in this waiver program for FY 1996-97 was 16,943, but only 9,550 individuals received services under the program because the state did not appropriate the required matching funds.

Although the nursing home bed supply in Florida is quite low, the state has more licensed residential care beds per 1,000 elderly persons age 75 and above than the national average (63.5 compared with 52.8). Residential care facilities include both assisted-living facilities and adult family-care homes. Assisted-living facilities or board and care homes are residential options for the elderly and disabled that provide housing, meals, and support services. The
The state has more than 2,000 assisted living facilities that serve more than 60,000 residents (averaging 33 residents each); another 600 adult family-care homes serve about 1,200 residents. Most residents cover the cost of their own care in these facilities, but the state provides a subsidy for some low-income residents. The state has no certificate-of-need requirement for assisted-living facilities, so it cannot regulate their growth. According to the Florida Commission on Aging with Dignity, occupancy rates for these facilities range from 70 percent to 80 percent, suggesting ample capacity.

Although Florida’s apparent dearth of nursing home beds relative to its elderly population has raised concerns about access, nursing home industry representatives speculate that assisted-living facilities and adult family-care homes may be serving as providers to those not able to secure a nursing home bed. They also speculate that the elderly in Florida may have more financial resources than those in other states and less need for public support for nursing home care, and that when they need care, some disabled elderly return to their home states, where their children live.

**Managed Care**

Florida is in the early stages of implementing the Long-Term Care Community Diversion Waiver pilot project, a Section 1915(c) Medicaid waiver that will allow the state to experiment with managed care. The pilot project in nine counties will integrate acute care and a broad range of long-term care services for elderly individuals who need a nursing home level of care. Several HMOs are said to be interested in participating. Even though the program is not yet operational, the 1997–98 budget bill doubled the program, providing another $11 million. However, advocates and policymakers point out that the program is still very limited in scope and that the waiting list for community services “dwarfs” the program’s 600-person limit.

**Medicaid Reimbursement Rates**

Nursing homes receive Medicaid reimbursement according to a prospective, adjusted cost-based methodology; rates are not case-mix adjusted. Medicaid currently pays on average $83.54 per day, close to the national average of $85.05 per day. Target limits on annual increases are low; for example, the state did not increase reimbursement rates following the establishment of new quality standards in the federal Omnibus Budget Reconciliation Act of 1987.

The state regularly cuts funds from institutional care line items in the Medicaid budget. Over the past five years, Medicaid has absorbed over $1 billion in budget reductions, a substantial amount of which was in the area of institu-
tional provider payments. For example, modifications to nursing home reimbursement policy in 1991 resulted in a $31 million cut, followed by a $20 million cut in FY 1992-93, a $13 million cut in FY 1995-96, and a $17 million cut in FY 1996-97. Despite these reductions, nursing homes did not file any Boren amendment lawsuits, largely because they believed such suits would have consumed too many resources without producing the desired results. However, several nursing home chains have been in state administrative hearings with AHCA over July 1996 rate reductions.

The nursing home industry has made Medicaid reimbursement a perennial priority issue. According to the Florida Health Care Association, 80 percent of nursing homes report that their costs are not covered by Medicaid. The industry reports that “high Medicaid homes” (those with more than two-thirds Medicaid patients) are almost four times as likely as “low Medicaid homes” to be under conditional certification status (i.e., facilities with identified quality problems). As budget reductions for institutional long-term care continue, industry representatives predict an erosion in the quality of patient care.

Controlling Long-Term Care Supply

As mentioned earlier, Florida has one of the lowest supplies of nursing home beds in the country. The supply increases by about 1,800 to 2,400 beds each year, based on allowable growth limits under the state’s certificate-of-need law. According to AHCA officials, 8,000 more long-term care beds are in the construction pipeline.

Eligibility for Medicaid Services

Florida’s medically needy program does not cover institutional services (nursing homes, intermediate care facilities for the mentally retarded, and state mental hospitals), preventing the elderly from qualifying for Medicaid by spending down on nursing home expenses. Although the elderly can use Medicaid trusts to circumvent the restriction, persons with income greater than 300 percent of SSI are, in general, ineligible for Medicaid nursing homes, regardless of the cost of their care.

Many Miami nursing homes were concerned about the impact of the welfare reform law on their Medicaid residents who are legal aliens. The state, however, elected to continue Medicaid eligibility for those who entered the country prior to August 1996, ensuring that the Medicaid nursing home benefit is secure for most people. The industry believes that Miami legislators will support funding for legal immigrants in nursing homes who still will not qualify for Medicaid.
Notes


Massachusetts

Major policy initiatives in Massachusetts include a strong program of Medicare maximization for skilled nursing facility care and home health care, expansion of home and community-based services, and plans to integrate acute and long-term care services through managed care. In addition, the state is pursuing aggressive efforts to control nursing home costs by narrowing admission criteria, tightening reimbursement rates, and freezing the nursing home supply. Through these efforts, the state has been able to keep spending for nursing facilities and home care relatively flat.

Utilization, Supply, and Expenditures

As shown in table 1, Massachusetts had a greater proportion of elderly residents among its population than the national average in 1996. While 12.8 percent of the U.S. population was over the age of 65, the percentage was 14.1 percent for Massachusetts. Among the 13 states studied, Massachusetts was second only to Florida in its proportion of elderly residents. The proportion of Massachusetts Medicaid beneficiaries who were elderly in 1995 was also higher than the national average (14.0 percent vs. 11.1 percent).

As shown in table 2, the long-term care system in Massachusetts is dominated by a large supply of nursing homes. In 1995, Massachusetts had 591 nursing homes with 56,912 beds—168.7 beds per 1,000 elderly age 75 and above, compared with the national average of 133.1. Nursing facility lengths of stay have fallen from 2.4 years in 1988 to 1.4 years in 1994 as a result of the shift in focus to short-term, post-acute care. In contrast, the state had only 167 licensed
residential facilities with a total of 5,500 beds in 1995—only 16.3 beds per 1,000 elderly people age 75 and above, much less than the national average of 52.8. The state had approximately 160 Medicare-certified home health agencies in 1997.

Massachusetts spends a substantial amount on Medicaid long-term care for the elderly—$1.3 billion in 1995. As shown in table 3, long-term care for the elderly accounted for 23.3 percent of Massachusetts’s non-DSH Medicaid expenditures in 1995 (compared with 19.5 percent nationwide). Long-term care spending per elderly resident in Massachusetts was also much higher than the national average—$1,763 versus $967. Most Medicaid long-term care expenditures were for institutional services (96 percent), while only 4 percent were for home and community-based care. Finally, as shown in table 9, Medicaid long-term care expenditures grew at a modest annual rate of 5.2 percent between 1990 and 1995 (compared with a 10.7 percent national rate). In addition to Medicaid home care expenditures for the elderly, Massachusetts spends almost $120 million on state-funded programs for home and community-based care for the elderly.

**Medicare Maximization**

The Weld/Cellucci administration firmly believes that Medicaid should be the payer of last resort; Medicaid should be targeted on low-income people and the state should energetically pursue funding from other sources. So a significant part of the state’s long-term care strategy for Medicaid is to bill Medicare whenever possible for nursing facility and home health services. Partly as a consequence of various initiatives, the proportion of Massachusetts nursing home residents receiving Medicare reimbursement increased from 2 percent in 1990 to 11 percent in 1996.

<table>
<thead>
<tr>
<th>Table 9</th>
<th>Massachusetts Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Long-Term Care Expenditures ($ millions)</td>
</tr>
<tr>
<td>Total</td>
<td>1,010.7</td>
</tr>
<tr>
<td>Service</td>
<td></td>
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<tr>
<td>Nursing Facility</td>
<td>949.8</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>21.0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2.3</td>
</tr>
<tr>
<td>Home Care</td>
<td>37.6</td>
</tr>
</tbody>
</table>

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

Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Maximizing Private Payments

A corollary of the notion that Medicaid should be the payer of last resort is that Medicaid should be a program for low-income people, not the middle class. As a result, rules that prohibit transferring assets to qualify for Medicaid nursing home benefits and recouping Medicaid institutional expenditures through estate recovery are vigorously enforced. Moreover, the Weld administration halted a planned public-private partnership for long-term care insurance that would have allowed the middle-class elderly easier access to Medicaid. The administration was concerned that the partnership contributed to the perception that Medicaid was a middle-class entitlement rather than a program limited to the poor.

Home and Community-Based Services

Massachusetts funds a broad array of home and community-based services through the Medicaid program and the Executive Office of Elder Affairs. Part of the state’s long-term care strategy is to gradually increase the availability of HCBS as a way of diverting people from inappropriate and costly institutional care. The state’s goal is to provide care in the most cost-effective and least restrictive setting possible. Medicaid-covered services include private-duty nursing, personal care services, case management, hospice services, home health care, adult day health care, adult foster care, and group adult foster care.

Unlike that of some other states, Massachusetts’s use of Medicaid HCBS waivers for the elderly is very limited (less than $9 million in 1996). Medicaid officials believe that the HCFA waiver process for HCBS waivers is cumbersome and that the need to obtain waivers at all is a “pain in the neck.” However, given the relative ease of obtaining waivers under the Clinton administration, the state is considering using them to finance more services for the elderly. The ability to limit demand to a predetermined number of slots is particularly attractive.

Because most home and community-based services under Medicaid are offered as an open-ended entitlement, the Division of Medical Assistance (DMA) actively manages the “woodwork effect” (induced demand) through the use of medical necessity criteria and the prior approval process. According to one official, if the service is for respite care or if it is social support and not fulfilling some larger medically related goal, the service is denied payment by Medicaid. In addition, as part of this process, prior approval by Medicaid is required for a wide range of home health services after a relatively brief number of visits.
Managed Care

Massachusetts is strongly committed to extending its managed care program to include the elderly and to integrating acute and long-term care services. The state believes that the current health care system is “horrible” for persons who need both acute and long-term care services and who are eligible for both Medicare and Medicaid. The financing and delivery system is believed to be confusing to beneficiaries and overly expensive because it encourages the use of costly, inappropriate services and lacks accountability and quality control.

In negotiations with HCFA over research and demonstration waivers to integrate acute and long-term care services, the state has identified two issues as sticking points. First, Massachusetts wants to pool Medicare and Medicaid funds into a single capitation payment by Medicaid to managed care organizations, but HCFA has steadfastly maintained that it will not fund the Medicare program as a block grant to the states. Second, Massachusetts would like enrollment to be mandatory, while HCFA insists that freedom of choice for Medicare beneficiaries be maintained and enrollment for dual eligibles be voluntary. Under existing rules, the elderly would have a choice of enrolling in a senior care organization (SCO) or remaining in the fee-for-service system. A major implementation barrier is that the state has no SCOs that provide extensive acute and long-term care benefits.

The Department of Medical Assistance wants to contract with a limited number of SCOs in order to improve the state’s ability to monitor these organizations, reduce its involvement with direct care providers, and lower its administrative costs. Long-term care providers and advocates for the elderly are concerned that this strategy of restricting the number of SCOs will limit participation to large HMOs, which have little or no experience with the disabled elderly or long-term care services. Community-based home care and nursing home providers are worried about being “cut out” of funding by the SCOs or having their rates reduced by them. A key issue has been what the relationship will be between the SCOs and the new, legislatively mandated Aging Single Access Point (ASAP), which is under the direction of the Executive Office of Elder Affairs; both ASAP and SCOs are envisioned to have service coordination functions, but they are the creations of different agencies.

Medicaid Reimbursement Rates

Massachusetts Medicaid reimburses nursing homes using a prospective, cost-based, case-mix-adjusted, resident-specific rate methodology. Care for each resident is paid for based on one of 10 rates per facility; the rate is determined by the individual’s disability. In 1995, average Medicaid nursing home reimbursement rates were $94.25 per day, the ninth highest in the country.

The DMA has been very aggressive in negotiating Medicaid nursing home payment rates. For example, over the past six years, there have been several
freezes in the base year used to calculate subsequent rates. In addition, the state aggressively negotiates inflation factors rather than fixing them by formula.

At the time of the team’s site visit, the nursing home industry had yet to file a Boren amendment lawsuit, but it came close in 1993 after the base year for calculating rates had been frozen for three years. The industry shied away from lawsuits because they were expensive, time-consuming, and unlikely to be resolved for years. Although Medicaid officials said that they would like to see the Boren amendment repealed (which occurred with passage of the federal Balanced Budget Act of 1997), they believed that they had been so successful in controlling the rate of increase in reimbursement rates that repeal of federal rules would not make much difference.

Controlling Long-Term Care Supply

Construction of new and replacement nursing homes in Massachusetts requires a certificate of need. To control expenditures, the state has had a moratorium on new nursing home construction since 1989; in 1995, a moratorium was placed on applications for the renovation and replacement of existing nursing homes. However, because a large number of beds were approved in the late 1980s but are not yet licensed, the nursing home bed supply will probably continue to increase until 2000. As a result of the influx of new beds and somewhat lower (although still high) occupancy rates, both government and industry representatives report that access to nursing facility beds is not a problem.

Eligibility for Medicaid Services

Aside from providing home and community-based services, Massachusetts has attempted to limit nursing home use by tightening eligibility for admission. The home care corporations, funded by the Executive Office of Elder Affairs, do preadmission screening of all Medicaid clients seeking nursing home care, with the goal of diverting them to the community. Consistent with its concept of Medicaid as a “medical” program, the DMA has attempted to raise the level of disability needed to qualify for nursing home care and to eliminate the ability of nursing home residents to leave the facility occasionally. These initiatives were opposed by the nursing home industry and consumer advocates, and the legislature adopted language prohibiting Medicaid from implementing these changes.

Note

1. Based on John Holahan et al., Health Policy for Low-Income People in Massachusetts (Washington, DC: The Urban Institute, 1997).
Long-term care for the elderly in Michigan is an important part of the state’s recent Medicaid reform initiatives and is largely characterized by two intertwined strategies of delivery system reform: the expansion of home and community-based services and the capitation of long-term care services through managed care. Through these reforms—many of which are part of the “Mi Choice” initiative—the state hopes to achieve the goals of increased consumer choice and satisfaction and reduced spending.

Utilization, Supply, and Expenditures

As shown in table 1, the proportion of the population in Michigan over the age of 65—12.4 percent—was close to the national average of 12.8 percent. However, the proportion of Medicaid beneficiaries over the age of 65 in Michigan (7.4 percent) was substantially lower than the national average (11.1 percent) and was the lowest among the 13 focal states in 1995.

As shown in table 2, the long-term care system in Michigan is characterized by a tight supply of nursing home beds and home health agencies and a relatively substantial number of residential care beds. In 1995, Michigan had 453 nursing homes with 51,203 beds (83.9 beds per 1,000 elderly people age 75 and above, compared with the national ratio of 133.1), one of the lowest bed-population ratios in the country. In contrast, the state had 4,760 licensed residential care facilities with a total of 44,793 beds in 1995—73.4 beds per 1,000 elderly people age 75 and above, compared with the national average of 52.8 beds per 1,000. In 1995, Michigan had 190 certified home health agencies.
In 1995, Michigan spent $935 million on long-term care for the elderly, which accounted for 18.3 percent of Michigan’s non-DSH Medicaid expenditures (compared with 19.5 percent nationwide) (table 3). Long-term care spending per elderly resident in Michigan was lower than the national average—$793 versus $967. The bulk of Medicaid long-term care expenditures were for institutional care (96 percent), while only 4 percent were for home care. Finally, as shown in table 10, Medicaid long-term care expenditures for the elderly grew faster than the national average—16.4 percent annually from 1990 to 1995, compared with the national average of 10.7 percent.

Maximizing Private Payments

Currently, Michigan does not have any major initiatives to increase the amount of private resources paying for long-term care for the elderly. The state eventually hopes to lower Medicaid long-term care spending by encouraging the purchase of private long-term care insurance. In 1995, the legislature passed the Insurance Partnership Act, which raises the asset level for Medicaid eligibility for those who buy a state-approved long-term care insurance policy. However, the legislation has not been implemented because provisions in the federal Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) require that the newly protected assets be subject to estate recovery.

Unlike almost all other states, Michigan does not have an estate recovery program to recoup the costs of nursing home care, making it out of compliance with federal law. The state legislature has chosen not to pass a bill that would initiate such a program, reportedly in part because of the high rate of homeownership in the state. Texas is the only other state studied that does not have an estate recovery program, as mandated by OBRA 1993.

<table>
<thead>
<tr>
<th>Table 10 Michigan Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
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<tbody>
<tr>
<td><strong>Long-Term Care Expenditures ($ millions)</strong></td>
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<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Service</strong></td>
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<tr>
<td>Nursing Facility</td>
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<tr>
<td>ICF-MR</td>
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<tr>
<td>Mental Health</td>
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<tr>
<td>Home Care</td>
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</tbody>
</table>

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Home and Community-Based Services

Although home care spending for the elderly under Medicaid increased less rapidly than nursing home spending over the 1990–95 period, Michigan has stepped up its efforts to encourage home and community-based services. Of the state’s Medicaid spending on home care in 1995 (elderly and nonelderly), almost one-third was spent through home and community-based services waivers; 51 percent was spent for personal care services, which assist disabled persons with activities of daily living (bathing, feeding, etc.); and 10 percent was spent for home health. This breakdown compares with 47 percent, 32 percent, and 19 percent, respectively, for the United States overall.

Michigan has not used the HCBS waiver program for the elderly and physically disabled as much as other states, primarily because of a concern that it would create new demand and increase costs. Initiated in 1992, the waiver program is relatively small, operating in 19 of 83 counties and capped at 3,000 slots and $30 million for FY 1996. The state plans to expand the HCBS waiver program statewide as part of its MI Choice effort, while limiting the program to 9,000 slots.

The waiver program for the elderly and physically disabled is jointly administered by the Office of Services to the Aging (in the Department on Aging) and the Medicaid program. The most commonly delivered services under the waiver are personal care, home-delivered meals, and personal emergency response. Other services include homemaker services, respite care, transportation, durable medical equipment, and private duty nursing. A care manager authorizes provision of the services. Nonwaiver counties apply a similar case management strategy to coordinate home and community-based care for those at risk of nursing home entry. Yet the state currently has no objective criteria to determine nursing home eligibility, nor a universal approach to direct individuals in need of long-term care to the appropriate service. A pre-admission screening tool is under development for all nursing home applicants.

The expansion of non–nursing home residential care settings, such as homes for the aged (21 or more beds) and adult foster care (20 beds or fewer), has further contributed to curtailing growth in nursing homes. The SSI program pays approximately $600 per month for eligible residents in both settings, while Medicaid pays for some personal care expenses. Most residents in these settings, however, are not eligible for SSI or Medicaid.

It is not known how much can be saved by expanding home and community-based services because such services are not necessarily direct substitutes for nursing home care. Based on recent data, the average net cost per day for waiver clients in Michigan is about two-thirds of Medicaid expenditures for nursing home residents, but these costs are not case-mix adjusted. Though waiver participants must be eligible for nursing home care, they are probably less frail than nursing home residents. For example, 30 percent of waiver par-
Participants are reported to have cognitive impairments, versus 60 percent of nursing home residents.

**Managed Care**

Michigan has also looked to managed care in its efforts to reform its long-term care delivery system. Although implementation has been slower than originally planned, the MI Choice program plans to coordinate services through the capitation of long-term care. The program has three primary components: the expansion of the Medicaid HCBS waiver program for the elderly and disabled; the establishment of screening services to determine an individual’s medical eligibility for Medicaid-funded long-term care services and to inform citizens about long-term care options; and the use of competitive bidding to select organizations to participate as MI Choice Health Plans.

Expanding HCBS waiver services from 19 counties to statewide is viewed as a necessary step to build and strengthen the home and community-based service capacity so that a range of options beyond nursing home care can be offered to individuals who participate in the MI Choice program. In addition, the state plans to select organizations (distinct from the providers) on a competitive-bid basis to provide screening and placement services. The expanded HCBS waiver sites and the screening services—designed to work in tandem—were expected to be operational by mid-1998.

Finally, the selection of health plans to provide a range of long-term care benefits under capitation is expected to be complete by the end of 1998, with enrollment beginning at the end of 1999. It remains to be seen what organizations will wish to participate in the program. Recruitment and selection of plans could be a challenge because few providers have experience meeting the health needs of the elderly in a capitated environment (partly owing to the low Medicare payment rates outside the Detroit area) and because virtually no providers in the state have experience coordinating a full range of long-term care benefits.

**Medicaid Reimbursement Rates**

The state pays relatively high nursing home rates as a result of a Boren amendment suit by the industry in 1989–90. The state has also been generous in building into its rates the costs of compliance with quality standards of the Omnibus Budget Reconciliation Act of 1987. As a result of these two forces, Medicaid payment rates to nursing homes increased by 65 percent between 1989 and 1994. By capitulating long-term care services, the state had hoped to be no longer bound by the Boren amendment (which was repealed by the federal Balanced Budget Act of 1997) and will perhaps pass some of the responsibility for quality assurance to the managed care organizations. The nursing
home industry fears that quality of care will suffer as a result. The Medicaid program has recently emphasized the quality of nursing home care and has implemented a number of related measures, including the establishment of a database to track quality and an incentive program to improve quality of life in nursing homes. Despite these efforts, the office of the state long-term care ombudsman received 5,286 complaints about long-term care facilities in 1995 (representing about 10 percent of all nursing home residents). Understaffing in facilities appears to be a significant and growing problem.

Controlling Long-Term Care Supply

As mentioned above, Michigan has maintained tight control on the number of nursing home beds in the state through its certificate-of-need (CON) program, which authorizes new facilities or beds. Nursing home bed supply has remained constant since 1989, and growth in the number of beds from 1980 to 1995 was only 10 percent, less than a third of the national rate. While the CON program is credited with some containment of nursing home costs, the state will eventually have to allow additional beds to be built because CON determination of bed need is linked to demographic changes. At present, the statewide mean occupancy rate stands at 89 percent, slightly higher than the national average. However, concerns have been raised regarding access to nursing homes, since some nursing homes are approaching full occupancy and, according to advocates’ reports, some applicants who qualify for Medicaid are being turned away, particularly in southeast Michigan.

Note

Long-term care has not escaped Minnesota’s recent attempts to contain the growth of health care costs. Short-run priorities for reforming long-term care for the elderly involve system redesign: increasing the use of managed care for the aged, integrating long-term and acute care financing and delivery mechanisms, decreasing administrative costs, changing the pricing strategy for nursing home services, and increasing third-party revenues (i.e., Medicare and private insurance). The state’s long-run cost-containment strategy is to capitate long-term care services and to “redefine the care expectation” for continuing care services among state residents. The idea behind the latter is to make the level of care that younger populations expect consistent with what public programs will realistically be able to support in coming years.

**Utilization, Supply, and Expenditures**

As shown in table 1, the proportion of the population in Minnesota over the age of 65 was close to the national average in 1996—12.5 percent, compared with 12.8 percent. The proportion of Medicaid beneficiaries who were over the age of 65 in Minnesota (12.3 percent) was slightly higher than the national average in 1995 (11.1 percent).

As shown in table 2, the long-term care system in Minnesota is dominated by a large supply of nursing homes and home health agencies. In 1995, Minnesota had 440 nursing homes with 44,792 beds (201 beds per 1,000 elderly people age 75 and over, compared with the national ratio of 133). The state had 2,688 licensed residential facilities with 11,304 beds in 1995—50.7 beds per...
1,000 elderly people age 75 and above, compared with the national average of 52.8. The state had 659 licensed home health agencies in 1995.

In 1995, Minnesota spent $872 million on long-term care for the elderly, which accounted for 31.7 percent of Minnesota’s non-DSH Medicaid expenditures in 1995 (compared with 19.5 percent nationwide)—the most of any of the focal states. Long-term care spending per elderly resident in Minnesota was the second highest among the states studied and also much higher than the national average—$1,817 versus $967. Minnesota spent 96.4 percent of its Medicaid funds for elderly long-term care on institutional care and 3.6 percent on home and community-based services (compared with a national average of 10.3 percent). Finally, as shown in table 11, Medicaid long-term care expenditures for the elderly grew by 12.5 percent annually from 1990 to 1995, slightly higher than the national average of 10.7 percent. In addition to Medicaid home care expenditures, Minnesota spends almost $36 million on state-funded programs for home and community-based care for the elderly.

**Medicare Maximization**

The state is seeking to increase Medicare reimbursement for home care and nursing facility care for the population enrolled in both Medicare and Medicaid. Minnesota is the fourth-lowest state in the nation in terms of Medicare home health use, according to state officials. In 1996, Minnesota began work on a Medicare maximization policy, aimed at enabling the state to better channel home care claims to the appropriate funding source. A primary component of this initiative is the “up-front payer determination method,” an automated process through which providers obtain service and payment authorization and that also directs providers to the correct payer of services. An automated phone system has been designed, and the state hopes that it will be operational statewide by summer 1998.

<table>
<thead>
<tr>
<th>Table 11</th>
<th>Minnesota Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Long-Term Care Expenditures ($ millions)</td>
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<tr>
<td>Total</td>
<td>484.0</td>
</tr>
<tr>
<td>Service</td>
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<tr>
<td>Nursing Facility</td>
<td>449.3</td>
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<tr>
<td>ICF-MR</td>
<td>3.0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>16.0</td>
</tr>
<tr>
<td>Home Care</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data. Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Maximizing Private Payments

Minnesota is also working on a number of fronts to draw more private funding into long-term care. A state work group has been considering policy options to encourage individuals to purchase long-term care insurance. A starting point may be to offer state employees an insurance product for long-term care. Another option under consideration is to extend the period during which the transfer of assets is prohibited from the current 36 months to 72 months. Minnesota’s estate recovery program, implemented in accordance with the Omnibus Budget Reconciliation Act of 1993, recouped approximately $12 million in FY 1995, 1.6 percent of Medicaid nursing home spending.

Home and Community-Based Services

For a number of years, Minnesota has encouraged a movement away from institutional care to home and community-based services. Minnesota’s Medicaid home care benefit is comprehensive, offering personal care and private-duty nursing services as well as two home and community-based waiver programs. The state also uses a preadmission screening (PAS) program to assess and appropriately place individuals who apply to a nursing home. The PAS program, which served approximately 13,000 people in 1994, is administered by the counties.

Managed Care

One of the more well-known initiatives to integrate acute and long-term care services through managed care has been the Minnesota Senior Health Options (MSHO) demonstration. The objective of this demonstration is to create a less fragmented system of care for dual eligibles (i.e., people eligible for both Medicare and Medicaid), a change that hypothetically will control costs (by reducing incentives to shift costs between Medicare and Medicaid) as well as improve the quality of care for beneficiaries.

To implement the demonstration, the state needed both Medicare and Medicaid waivers from HCFA. In the negotiations, which took place over several years, state and HCFA officials struggled to resolve numerous issues. Two major features of the state’s waiver proposal were particularly problematic from HCFA’s standpoint. First, HCFA opposed the state’s proposal that enrollment of demonstration participants into managed care plans be mandatory, and therefore it did not approve this request. Dually eligible seniors in the Twin Cities area have the choice of participating in the MSHO demonstration or remaining in their current arrangement. Second, the state wanted to receive Medicare monies from HCFA and combine Medicaid and Medicare funds into a single payment to managed care plans. HCFA did not approve this request because it did not
want to appear to be “block granting” Medicare; HCFA is paying Medicare providers directly under MSHO. The demonstration began in February 1997 in the Twin Cities area. At the end of 1997, MSHO had enrolled 2,000 individuals. Enrollment has proceeded more slowly than some anticipated, and 1,500 individuals have enrolled in only one of the four participating plans.

Other elements of the MSHO demonstration are summarized below:

- MSHO administrators project that up to 4,000 dual eligibles will enroll.
- The benefit package under MSHO includes all services delivered under standard Medicare risk contracts, Medicaid wraparound services (including limited nursing home care), and services available under the home and community-based waiver program.
- The managed care organizations are responsible for providing the first 180 days of nursing facility care per beneficiary on a capitated basis; nursing facility days beyond 180 days will revert to fee-for-service reimbursement.

Medicaid Reimbursement Rates

Minnesota is one of two states that have adopted an “equalization” statute, which stipulates that any nursing home participating in the Medicaid program cannot charge a private-pay patient higher rates than it would charge for a Medicaid patient. The state is also considering changes to its prospective, cost-based nursing home reimbursement policy. Specifically, it is exploring alternative reimbursement schemes, such as a contracting payment system, under which the state would purchase a nursing home day for a fixed price. In 1996, the state established a demonstration project exempting 120 facilities from certain state regulations in exchange for frozen payment rates, adjusted only for inflation in future years.

Controlling Long-Term Care Supply

Despite a moratorium on nursing home construction that has been in effect since 1983 and an 8.1 percent reduction in nursing home bed supply between 1978 and 1993 (for those 65 and over), Minnesota continues to have one of the highest supplies of nursing home beds in the nation. Similarly, Minnesota has a much higher than average supply of home health agencies (659 agencies—2.96 per 1,000 elderly people age 75 and over, compared with the national average of 0.98). There is no moratorium or certificate of need for home health agencies in Minnesota.

Eligibility for Medicaid Services

Minnesota recently sought to tighten admission criteria for nursing homes. During the 1995 session, the legislature passed so-called “high functioning” leg-
islation, which stipulated that the least disabled nursing home residents would no longer be eligible for nursing home care. Rather, the state would give each individual approximately $250 per month toward the purchase of services. The legislation was controversial. Advocates for such residents were concerned that the stipend would not be enough to maintain individuals in the community and that there would not be sufficient community-based care options. In the wake of these criticisms and in light of new estimates that the legislation would affect fewer than 500 individuals, the legislation was repealed in the 1998 session.

Notes

1. Based on Teresa A. Coughlin et al., Health Policy for Low-Income People in Minnesota (Washington, DC: The Urban Institute, 1997).

2. The elderly enrolled in both Medicaid and Medicare receive Medicaid wraparound services through a capitated managed care Prepaid Medical Assistance Project (PMAP) plan. Participation in PMAP—a Section 1115 waiver demonstration project—is mandatory for the elderly. Those enrolled in HMOs under Medicare may choose a PMAP plan to receive Medicare-covered services as well. Some services, like nursing facility services after Medicare payment ends, are still paid for under Medicaid fee-for-service.


Long-term care is an important part of the health care system in Mississippi. The state is very reliant on institutional care and makes little use of home and community-based care, particularly in Medicaid. The state has sharp limits on the level of long-term care services available; the CON program has imposed a tight moratorium on new nursing home beds and home health agencies. These limits have resulted in a very high occupancy rate in nursing homes and long waiting lists.

Utilization, Supply, and Expenditures

As shown in table 1, Mississippi was close to the national average in the proportion of residents who were elderly in 1996—12.6 percent, compared with 12.8 percent. The proportion of Medicaid beneficiaries who were elderly in Mississippi was slightly higher than the national average in 1995 (12.8 percent compared with 11.1 percent).

As shown in table 2, the long-term care system in Mississippi is defined by an average supply of nursing home beds and a below-average number of residential care beds and home health agencies. In 1995, Mississippi had 176 nursing facilities with 16,604 nursing facility beds—140.9 beds per 1,000 elderly people age 75 and above, compared with the national average of 133.1. In contrast, Mississippi’s 140 residential care facilities with a total of 2,710 beds gave the state a much lower than average supply of residential care beds in 1995—23.0 beds per 1,000 elderly, compared with 52.8 beds per 1,000 nationwide. Mississippi had only 74 licensed home health agencies in 1995.
In 1995, Mississippi spent $239.4 million on Medicaid long-term care for the elderly, which was 15.7 percent of its Medicaid expenditures, somewhat below the national average of 19.5 percent (table 3). It also spent less than the national average per elderly resident—$752 per capita compared with $967 at the national level.\(^2\) Compared with the rest of the nation, the state has limited home and community-based care, especially for elderly individuals. Institutional services receive practically 100 percent of all Medicaid long-term care funding for the elderly, with home care only receiving 0.2 percent.\(^3\) Finally, as shown in table 12, Medicaid long-term care spending in Mississippi grew faster than the national average from 1990 to 1995—14.6 percent annually versus 10.7 percent annually nationwide.

### Home and Community-Based Services

Most home and community-based care provided in the state is Medicare home health, which has grown dramatically over the past 10 years. Despite more than a decade of a statewide moratorium on home health agencies, the number of home health patients increased 112 percent between 1985 and 1995, while the number of home health visits increased 455 percent. In 1995, home health patients received an average of 97 visits, 95 percent of which were covered by Medicare. The number of Medicare home health beneficiaries per 1,000 Medicare beneficiaries exceeds the national average by about 50 percent—the rate in Mississippi is 140.9, while the national average is 94.2.

In contrast, Medicaid covers far less home health care in the state, and Mississippi has fewer home health recipients than other states. During the 1992–1995 period, Medicaid home health expenditures decreased at an average annual rate of 19.1 percent, while national spending grew an average of 5.1 percent per year. Other southern states also have high Medicare and low Medicaid home care utilization.

### Table 12 Mississippi Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)

<table>
<thead>
<tr>
<th>Service</th>
<th>Long-Term Care Expenditures ($ millions)</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>121.3</td>
<td>172.8</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>120.1</td>
<td>170.8</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>0.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Home Care</td>
<td>0.6</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data. Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
The Medicaid program provides home and community-based services under a small waiver administered by the Department of Human Services. The waiver specifically targets elderly and disabled people 21 years of age and older. Eligibility for waiver services is limited to people who are unable to perform at least three activities of daily living without substantial human assistance or supervision. The program is being expanded statewide.

Managed Care

Unlike other Medicaid programs, Mississippi makes little use of managed care, and it has been primarily for young adults and children. Even this limited use has been extremely controversial, since the health care system in Mississippi is still dominated by fee-for-service medicine with few restrictions on physician practices. Long-term care services are not included in these managed care experiments, and there are no plans to integrate them into future initiatives.

Medicaid Reimbursement Rates

Mississippi reimburses nursing homes based on historical costs on a facility-specific, prospective basis. The direct care costs are case-mix adjusted (using the 35-group version of the Resource Utilization Groups Version III [RUGS-III] classification system), combined with care-related costs, and restricted by a ceiling and floor to arrive at facility-specific base rates. Facilities are grouped according to size to determine limits of other operating costs. Nursing home representatives in the state contend that the case-mix system has had a positive impact on quality of care, since nursing homes have had to “staff up” to meet a growing demand for rehabilitation and therapeutic care. Mississippi is also one of six states (along with Kansas, Maine, New York, South Dakota, and Texas) participating in an HCFA-funded demonstration project to study case-mix nursing home reimbursement. At an average of $59.01, Mississippi’s reimbursement rates are far below the national average.

A lawsuit regarding Medicaid home health rates was recently settled between the state and the Mississippi Association for Home Care, an alliance of 31 home health agencies. The settlement blocked a move by the state to alter retroactively the reimbursement methodology for home health services. The altered methodology would have made home health agencies liable for overpayments for previously provided home health services. In favor of the state, the settlement also lowered physical therapy and speech therapy rates.

Controlling Long-Term Care Supply

Nursing homes across Mississippi have a 99 percent occupancy rate—one of the highest in the country. Part of the reason for Mississippi’s tight bed supply
is its CON program, which imposes limits on nursing home beds and home health agencies. Since 1990, Mississippi has had a permanent CON moratorium for nursing care beds, with limited exceptions. While many other states have similar moratoriums, these states have generally lifted them temporarily or permanently, as in neighboring Alabama, to adjust for increased need. Mississippi has retained its moratorium despite extremely high demand for such care.

Mississippi also has a moratorium on the licensing of new home health agencies, although existing agencies may expand their services within their jurisdictions. In addition to concerns about the overall number of beds and agencies, issues have been raised about equity in geographic distribution and about the lack of competition in such a tightly limited market.

Notes


2. The state spends approximately the same per long-term care recipient ($15,057 per year) as is spent nationally ($15,685). Mississippi nursing home residents have lengthy average nursing home stays (170 days, compared with 100 days nationwide), and the resulting costs offset the lower per diem rates paid by Medicaid and Medicare for routine and skilled nursing care.

3. In 1995, Medicaid expenditures per elderly enrollee on home and community-based services averaged approximately $800 nationally but less than $10 in Mississippi.
Long-term care for the elderly is a priority of the New Jersey Medicaid program. Despite the prominence of institutional care, the state’s policy goals for long-term care for the elderly in the near future include expanding the availability of home and community-based services through the Medicaid HCBS waivers. Future budget pressures will mean more efforts to reduce payment rates in both nursing homes and home health care and tightening eligibility standards for admission into nursing homes. The state is expected to use any savings in nursing facility expenditures to increase the availability of community-based services, but there is considerable concern over the state’s lack of sophistication in this area. It is hoped that the new Department of Health and Senior Services will enhance long-term care policy development.

Utilization, Supply, and Expenditures

As shown in table 1, New Jersey had a somewhat higher proportion of elderly residents among its population than the national average in 1996. While 12.8 percent of the U.S. population was over the age of 65, the percentage was 13.8 percent for New Jersey. New Jersey had the third-highest proportion of elderly residents among the states studied and was the eleventh-highest nationwide. The proportion of Medicaid beneficiaries who were elderly in New Jersey was close to the national average in 1995—11.6 percent, compared with 11.1 percent.

As shown in table 2, the long-term care supply in New Jersey is smaller than the national average in each of the long-term care service types. In 1995, New
Jersey had 363 nursing facilities with a total of 49,818 beds—121.3 beds per 1,000 elderly people age 75 and above, compared with the national ratio of 133.1. Similarly, New Jersey’s 493 residential care facilities with 17,840 beds give the state a slightly below-average concentration of residential care beds—43.4 beds per 1,000 elderly people, compared with 52.8 beds per 1,000 nationwide. New Jersey had 75 licensed home health agencies in 1995.

New Jersey spent over $1 billion on Medicaid long-term care for the elderly in 1995, which accounted for 18.8 percent of its Medicaid non-DSH expenditures, compared with 19.5 percent nationwide. The state spent slightly above the national average per elderly Medicaid resident—$1,008 per elderly beneficiary, compared with $967 nationwide. The distribution of Medicaid long-term care expenditures in New Jersey is close to the national average. Of these expenditures, 89.5 percent were for institutional care and 10.5 percent were for home and community-based services. In recent years, long-term care expenditures for the elderly in New Jersey have grown more slowly than the national average—8.9 percent annually from 1990 to 1995, compared with a national average of 10.7 percent. Medicaid home care expenditures in New Jersey have grown twice as quickly as nursing home expenditures—17.7 percent compared with 8.5 percent (table 13).

### Maximizing Private Payments

New Jersey has made no significant efforts to expand private long-term care insurance, although a task force on the subject is scheduled to meet in 1998. Transfer of assets to obtain Medicaid eligibility is considered a major problem for the Medicaid program. Despite some debate about the size of the problem, asset transfer has become a major target for Medicaid officials in the state. However, many elected officials are not particularly supportive of tightening

<table>
<thead>
<tr>
<th>Table 13</th>
<th>New Jersey Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Long-Term Care Expenditures ($ millions)</td>
</tr>
<tr>
<td>Total</td>
<td>661.6</td>
</tr>
<tr>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>562.7</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>31.3</td>
</tr>
<tr>
<td>Mental Health</td>
<td>20.6</td>
</tr>
<tr>
<td>Home Care</td>
<td>47.1</td>
</tr>
</tbody>
</table>

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

Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
Medicaid transfer-of-asset policies. The state operates a small estate recovery program that recovered $2.2 million in 1994, 0.3 percent of Medicaid nursing home expenditures, from the estates of deceased recipients.

**Medicare Maximization**

New Jersey has not engaged in major efforts to maximize Medicare reimbursement, although it has mandated that nursing homes become dually certified by Medicaid and Medicare. This certification enables nursing homes to bill Medicare as the first payer and then Medicaid as second payer for any remaining service.

**Home and Community-Based Services**

State long-term care policy has historically focused on nursing homes, but the emphasis has shifted to home and community-based care. State legislators are eager to expand home-based services as a substitute for nursing facility care, mainly because of the promise of cost containment. The woodwork effect is controlled by limiting the number of home and community-based waiver slots available for each program and the cost per person. Most of the nine home and community-based waiver programs have waiting lists.

New Jersey provides home care services through all three Medicaid options: home health care, personal care, and home and community-based waivers. In 1996, New Jersey ranked fourth in the United States in home care expenditures. Of the total expenditures for home care for the elderly and nonelderly in New Jersey, personal care services accounted for approximately 23 percent, while home health and home and community-based waiver programs accounted for 27 percent and 50 percent, respectively.

Home health services are provided by licensed home health agencies (HHAs), which provide skilled nursing intervention, home health aide services, physical therapy, speech therapy, occupational therapy, and medical social services. They can be hospital-based or free-standing. About 25 percent of HHA patients are Medicaid beneficiaries, 60 to 70 percent are Medicare beneficiaries, and 5 to 10 percent are self-paying.

Personal care services, an optional Medicaid benefit, provide assistance to individuals with activity of daily living (ADL) and instrumental activity of daily living (IADL) deficits. New Jersey has a relatively large program, with expenditures of $111.4 million in 1995. Personal care services are limited to a maximum of 25 hours per week, with a provision to allow up to 15 additional hours upon review and prior authorization of the case. Personal care services can be restricted when expenditures are equal to or above the costs of institutional care over an extended period.
The state also administers nine Medicaid home and community-based services waiver programs. The Community Care Program for the Elderly and Disabled (CCPED), which began on October 1, 1983, has some 3,000 slots. The waiver program is available to individuals over the age of 65 who are eligible for Medicaid and need nursing-facility level of care. To be financially eligible for the waiver, individuals must have incomes between 100 percent and 300 percent of the SSI payment level. Case managers are responsible for developing service plans with family members and for monitoring the costs of the service package. In 1995, there were approximately 2,800 persons in the program.

A second important waiver program provides an array of supportive and personal care health services that are available 24 hours a day to residents living in one of three assisted-living settings in the state. This program can serve 1,500 individuals. All beneficiaries are assigned a case manager to monitor services and to maintain costs within the cap limitations.

**Managed Care**

New Jersey has a Medicaid managed care program for acute care that is voluntary for the elderly and persons with disabilities. After finding that individuals with relatively light care needs enrolled, the state lowered its capitation rates. The state plans to enroll elderly and disabled individuals, beginning with the latter, on a mandatory basis (with special rules for Medicare-eligible Medicaid beneficiaries). Long-term care services will be carved out and paid on a fee-for-service basis.

**Medicaid Reimbursement Rates**

Nursing home payment rates in New Jersey are the sixth highest in the country. In 1995, the average rate of payment was $114.64 per day, compared with the national average of $85.05 per day. New Jersey pays nursing homes on the basis of prospective, case-mix-adjusted, facility-specific rates. Cost screens are established for each of five cost centers. Compared with those of many other states, New Jersey's nursing cost screens are relatively high, as is reflected in the high per diem costs. Medicaid home health rates are based on the lowest of reasonable costs, published cost limits, or covered costs subject to a post-payment reconciliation process.

**Controlling Long-Term Care Supply**

New Jersey has strong certificate-of-need laws, and there have been periodic moratoriums on nursing home bed growth since the early 1980s. These policies have resulted in some control over bed growth. Nursing home occupancy
rates are 95 percent; and while this figure is high, it is lower than rates have been historically. Representatives of the nursing home industry and state government reported that access to nursing care was not a major problem. Some were concerned that some facilities may be selective regarding the acuity of residents—for example, by avoiding patients with significant behavioral problems or complex medical needs. HHAs are subject to state CON rules, and as a result, the number of home health care agencies has been limited.

**Note**

New York accounts for almost 20 percent of national Medicaid spending on long-term care for the elderly but has only 10 percent of elderly Medicaid beneficiaries. New York has been implementing short-term measures and developing longer-range approaches to control expenditure growth. In recent years, Medicare maximization and payment rate cuts have been the major approaches to meeting budget shortfalls. For the longer term, a task force report, “Securing New York’s Future,” recommends that New York increase private financing by promoting private insurance and tightening Medicaid eligibility rules. The report also recommends changing the delivery system by developing cost-effective alternatives, such as continuing-care retirement communities. The state is also moving toward integrated acute and long-term care delivery systems under capitated payments.

Utilization, Supply, and Expenditures

As shown in table 1, the proportion of the population over the age of 65 in New York was slightly higher than the national average in 1996—13.3 percent, compared with 12.8 percent nationwide. Similarly, the proportion of Medicaid beneficiaries in New York who were elderly was slightly higher than the national average in 1995—12.3 percent, compared with 11.1 percent nationwide.

Given its large population and size, it is not surprising that New York has a sizable supply of providers. In 1995, New York had 663 nursing homes with
114,601 beds (111.7 beds per 1,000 elderly people age 75 and over, lower than the national average of 133.1 beds per 1,000 elderly) (table 2). The state also had 1,341 licensed residential care facilities with a total of 38,926 beds in 1995—37.9 beds per 1,000 elderly people age 75 and above, compared with the national average of 52.8.

New York uses all three Medicaid program options to provide home care services: home health care, personal care, and a home and community-based services waiver. About 180 certified home health agencies (CHHAs) provide Medicare and Medicaid home health services to 100,000 beneficiaries. Personal care services are provided by 475 licensed home care services agencies, which serve 85,000 beneficiaries with functional or cognitive disabilities. New York’s waiver program, known as the Long-Term Home Health Care Program, involves about 100 providers and serves 20,000 beneficiaries.

In 1995, New York spent $5.7 billion on Medicaid long-term care for the elderly, which represented 24.2 percent of all non-DSH Medicaid spending in the state (table 3). Expenditures per elderly resident were $2,444, more than twice the national average of $967 and higher than in the other states studied. New York is the most heavily oriented toward home and community-based care of all of the states studied—home care spending was 23.1 percent of Medicaid long-term care spending for the elderly in the state. In fact, New York’s expenditures for the elderly were over 40 percent of national spending for home and community-based services. As shown in table 14, Medicaid long-term care spending for the elderly in New York has grown moderately in recent years—5.5 percent per year from 1990 to 1995, compared with a national rate of 10.7 percent.

Maximizing Private Payments

Although efforts to increase private initiatives in long-term care have been modest, officials in New York indicated they would address this issue actively

<table>
<thead>
<tr>
<th>Table 14 New York Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Nursing Facility</td>
</tr>
<tr>
<td>ICF-MR</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>Home Care</td>
</tr>
</tbody>
</table>

Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
in the future. The main theme of the state’s “Securing New York’s Future” report is that private contributions for the costs of long-term care should be increased. The major strategies proposed include (1) promoting the purchase of private long-term care insurance by providing incentives through the tax system, (2) tightening Medicaid eligibility rules to reduce the transfer of assets (“Medicaid estate planning”) by nursing home and home care users (and families), and (3) increasing the role of continuing-care retirement communities and assisted-living facilities.

The focus on increasing private contributions was motivated by a perception, shared by several observers, that asset divestment to gain Medicaid eligibility for nursing facility care is a widespread problem in New York. Although it could also reflect the much higher costs of nursing homes and the lack of housing assets in places like New York City, the higher than average proportion of nursing facility patients on Medicaid in New York (83 percent, compared with about 68 percent nationally) was noted as evidence of the asset divestment problem. Some interviewees indicated that asset divestment is only part of a larger problem, which is the lack of an affordable alternative to paying for nursing home care. They noted that private long-term care insurance is not affordable for most elderly New Yorkers.

Despite this perception, New York is one of two focal states (California being the other) that are actively promoting private long-term care insurance, and it has established a public-private partnership program to encourage the purchase of such insurance. Under New York’s plan, individuals who purchase a state-approved insurance policy for private long-term care keep an unlimited amount of assets and still qualify for Medicaid. By all accounts, sales of insurance policies in New York have been modest. The New York partnership had spurred the purchase of around 12,000 policies by the beginning of 1997, when there were over 2.4 million elderly individuals in the state.

Despite disappointing sales, New York remains committed to expanding private insurance coverage for long-term care. The state legislature has given the partnership project permanent statutory authorization. State officials hope that improved marketing strategies (e.g., focusing on the employer market, direct-mail campaigns, wider promotion) will boost sales.

**Medicare Maximization**

In 1995 and again in 1996, the state required nursing homes and home care providers to increase Medicare revenues by 1 percent for each industry as a whole or face penalties in the form of Medicaid payment rate cuts. Although the nursing home and home care industries were able to meet the specified targets for Medicare maximization, their responses to this policy differed. New York is a participant in HCFA’s case-mix and quality demonstration project, which is testing a Medicare prospective payment system for nursing facilities. As a
result of the payment methodology developed for the demonstration, state officials believe that nursing facility payments for Medicare patients in New York are about $40 per day higher than they would have been otherwise. Hence, HCFA has provided strong financial rewards for nursing homes in New York to maximize Medicare revenues.

Medicare maximization is less appreciated by home health agencies, in part because many agencies have relied heavily on the generous Medicaid home care programs in the state. In addition, home care providers are worried that some of the cases submitted to Medicare would not meet Medicare coverage criteria, and that billing for “questionable” cases would result in financial penalties from Medicare. Despite the providers’ concerns, the state or individual counties have sponsored several activities to ensure that home health claims that have any chance of being covered are submitted to Medicare.

**Managed Care**

As in most other states, managed long-term care is mostly experimental in New York and currently involves very few people. New York is home to one of the social HMO sites and two of the Program of All-inclusive Care of the Elderly (PACE) sites. The two PACE sites serve approximately 700 severely disabled elderly persons. In addition, the state is implementing a demonstration project at six sites to test the development of managed long-term care under a capitated Medicaid payment. In 1997, Governor George Pataki proposed to create 24 new pilot programs for managed long-term care that will serve 25,000 chronically ill and elderly Medicaid recipients. HMOs, provider networks, and other managed care models will be allowed to participate in the demonstration. The state hopes that these projects will serve as precursors to a program that will integrate acute and long-term care services with combined funding from Medicare and Medicaid.

**Home and Community-Based Services**

New York spends more than any of the states studied on Medicaid home care services—both proportionally and absolutely. A major reason is its high spending on the personal care program. New York accounts for 65 percent of national Medicaid personal care expenditures. Personal care services account for about 61 percent of total state spending on home care, and 80 percent of the expenditures are incurred in New York City alone. The average spending per recipient of $15,354 per year is high by most standards, but some recipients of personal care services incur costs that exceed $100,000. Some interviewees felt that the personal care program, particularly in New York City, was excessively generous. Others thought that the per-recipient spending levels simply reflected patients’ long-term care needs. Personal care services are the
target for about 50 percent of the proposed savings from home care in the governor’s 1997–98 proposed budget.

To save money, the state is promoting the use of electronic response systems to reduce the need for personal care and the assignment of multiple beneficiaries in the same residential area to the same personal care aides. Because of the high total expenditures and the variation in per-recipient spending, personal care services will continue to draw attention as the state seeks further savings in Medicaid.

New York has also fostered other changes in the delivery system for long-term care. The assisted living program (ALP), for example, was established in 1991 to provide supportive housing and home care to individuals who are medically eligible for placement in nursing homes. The state has approximately 1,500 ALP beds now, but 3,000 additional beds have been approved and are in the pipeline.

**Medicaid Reimbursement Rates**

New York’s Medicaid nursing home reimbursement rates, which averaged $157 per day for freestanding nursing homes in 1995, are almost twice the national average. Medicaid reimburses nursing homes on a combination of facility-specific and case-mix bases. Although some facilities have been very selective about the severity of disability (case mix) among Medicaid beneficiaries whom they admit, access by Medicaid beneficiaries to nursing home care is not thought to be a major problem in light of the high percentage of residents who are covered by Medicaid. In 1996, cuts in nursing home payments included the elimination of the “trend factor” in Medicaid payments and cuts from the base rate to “encourage improved productivity and efficiency by providers.” In the governor’s 1997–98 proposed budget, savings of $313 million from nursing homes and $178 million from other continuing care programs—primarily home care services—were to be derived almost exclusively from provider payment cuts. In contrast, only $10 million of savings were to come from increasing estate recoveries and tightening eligibility rules. Hence, despite the interest in increasing private contributions reflected by the task force report, the traditional approaches for deriving savings were again to be the focus of the budget debate.

**Controlling Long-Term Care Supply**

Certificate-of-need procedures have constrained nursing home bed growth, yet about 11,000 beds with CON approvals are in the pipeline. One problem is that the people who are holding CONs are not building because of location and zoning issues; in addition, occupancy rates may be softening. The number
of CHHAs has been controlled by a need methodology, which some observers thought was antiquated.

Although nursing facilities appear to have been unharmed by the recent cuts in Medicaid payments, in part because of the higher-than-expected Medicare payments, there is concern that continuing Medicaid payment cuts and ending the Medicare demonstration project will threaten quality of care. The industry is working with the governor’s office on regulatory reform to modify New York’s quality-of-care standards, which currently exceed federal requirements. However, it is not clear that “coming down” to federal standards would result in sufficient savings to compensate for expected reductions in payment.

Notes


2. In New York, individuals can protect an unlimited amount of assets from spend-down by purchasing three years’ worth of private long-term care insurance coverage. Individuals in nursing homes must still contribute all of their income toward the cost of care, except for a small personal needs allowance.

long-term care for the elderly in Texas has been dominated historically by institutional care. In an effort to alter this situation, the state’s policy initiatives center on financing and delivery system reform that would increase the supply of home and community-based services. Texas is also planning a major demonstration that will integrate acute and long-term care services through managed care. At the same time, it has relied heavily on traditional methods of controlling long-term care expenditures: a moratorium on new construction of nursing homes and low nursing home reimbursement rates. Partly as a result, quality of care in nursing facilities is a major issue that the legislature has recently addressed.

Utilization, Supply, and Expenditures

Given its large population and huge territory, it is not surprising that Texas has many long-term care providers and spends a lot, at least in absolute terms, on long-term care. As shown in table 1, the proportion of the population in Texas over age 65 was less than the national average in 1996—10.2 percent, compared with 12.8 percent. The proportion of Medicaid beneficiaries who are over age 65, however, was slightly higher than the national average—12.2 percent, compared with 11.1 percent.

The state has a large supply of nursing homes and home health agencies (table 2). In 1995, Texas had approximately 1,346 nursing homes with a total of 129,677 beds—185.2 beds per 1,000 elderly people age 75 and over (compared with the national average of 133.1), the second-largest nominal number of beds of any state in the country. In contrast, the state had only 508 licensed
residential care facilities, with a total of 14,548 beds in 1995—20.8 beds per 1,000 elderly people, compared with the national ratio of 52.8. The state had 2,399 licensed home health care agencies in 1995.

In 1995, Texas spent $1.4 billion on Medicaid long-term care for the elderly, which represented 16.1 percent of its Medicaid expenditures—slightly below the 19.5 percent nationwide average (table 3). Although total spending is substantial, expenditures per elderly resident are lower than the national average—$785 compared with $967. Along with New York, Texas stands out in its proportion of Medicaid long-term care spending for home and community-based services. Texas spent 21.2 percent of its Medicaid long-term care expenditures for the elderly on home care (compared with a national average of 10.3 percent) and 78.8 percent on institutional services. Finally, as shown in table 15, Medicaid long-term care expenditures for the elderly increased faster than the national average from 1990 to 1995—14.4 percent, compared with 10.7 percent. Home care expenditures grew more than twice as fast as nursing home expenditures over this period.

Maximizing Private Payments

Unlike some states, Texas does not have major initiatives to reduce Medicaid spending by maximizing outside payments for Medicaid long-term care. For example, there are no major initiatives to encourage the purchase of private long-term care insurance. Despite the requirement of the Omnibus Budget Reconciliation Act of 1993, the state does not operate an estate recovery program because to do so is considered politically dangerous. (Earlier proposals by one state legislator to establish an estate recovery program contributed to his electoral defeat.) The state believes that the transfer of assets in order to

<table>
<thead>
<tr>
<th>Table 15</th>
<th>Texas Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995 (Elderly Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Long-Term Care Expenditures ($ millions)</td>
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<tr>
<td>Total</td>
<td>715.1</td>
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<tr>
<td>Service</td>
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</tr>
<tr>
<td>Nursing Facility</td>
<td>598.8</td>
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<td>ICF-MR</td>
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<td>Mental Health</td>
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<tr>
<td>Home Care</td>
<td>95.1</td>
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</tbody>
</table>

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

Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
qualify for Medicaid nursing home benefits is a problem, but there are no major efforts under way to prevent it.

### Home and Community-Based Services

Although not nationally known as a model for provision of noninstitutional services, Texas finances a substantial amount of home and community-based services. Texas Medicaid covers personal care and has a large home and community-based care waiver, and Texas is one of the few states to participate in the Medicaid “frail elderly” option. A majority of long-term care beneficiaries receive home and community-based care rather than institutional care. In a recent study by Ladd et al., Texas ranked eighth among the states in 1992 in “commitment” to home and community-based services. While officially supportive of widening the continuum of care, the nursing home industry contends that home and community-based services are not cost-effective.

Demand for Medicaid home and community-based care waiver services far exceeds the number of funded slots, and there are long waiting lists. The number of persons budgeted to receive services is considerably below the number of slots approved by HCFA. Given excess demand, the state wants to ensure that persons receiving services are at high risk of institutionalization, a strategy that has been controversial among consumer and home care advocacy groups.

### Managed Care

In the Medicaid managed care waivers that have been implemented in Texas, the elderly population needing long-term care has been excluded. However, the state is developing a model program—known as the STAR+Plus Integrated Care Project—that will enroll 50,000 aged and disabled Medicaid beneficiaries in Houston in managed care plans responsible for both acute and long-term care. While the state cannot require dually eligible (Medicare-Medicaid) beneficiaries to receive their Medicare benefits through HMOs, it is seeking to provide incentives for the aged and disabled to enroll. Specifically, since many Medicare HMOs in Texas offer extra benefits with no additional premium, Medicaid beneficiaries enrolling in the program will obtain additional prescription drug and eyeglass benefits beyond what Medicaid covers. Because managed care organizations lack experience with long-term care, long-term care providers are nervous about the reimbursement rates that HMOs will pay, particularly for nursing home care. HCFA approved the necessary waivers in January 1998, and the plan was scheduled to begin mandatory enrollment (for Medicaid services) in April 1998.
Medicaid Reimbursement Rates

Texas nursing homes are reimbursed by Medicaid on a case-mix-adjusted, flat-rate basis. Each resident is classified into one of 11 categories, each with a separate statewide rate. In 1995, the average reimbursement rate was $56.17, well below the national average of $85.05. Indeed, the state has the third-lowest average rate in the country, although one expert contended that the average rates were depressed by the large number of low-disability (and, therefore, low-cost) nursing home residents.

A key issue is that facilities make profits in flat-rate reimbursement systems by spending less than they receive in reimbursements. This situation creates an incentive for low levels of service, which may result in poorer quality of care. The position of the Texas nursing home industry is that the state gets what it pays for: Facilities have low staffing ratios because the state is not willing to pay for higher staffing levels. The state, on the other hand, asserts that nursing homes do not always use the money properly when Medicaid rates are increased to improve staffing.

The state has been sued twice under the Boren amendment, and there has been one major threat of an additional suit. Most recently, in November 1996, the Texas Health Care Association sued the state over its nursing home reimbursement system, claiming that rates were inadequate to cover the federally mandated increase in the minimum wage. In February 1997, a settlement was reached that provided Texas nursing homes with about half their requested rate increase.

According to state officials interviewed before the most recent lawsuit, federal nursing home reimbursement rules put the burden on the state to prove the adequacy of the rates, thus creating a losing battle for the state in court. (In addition, the limited resources of the attorney general’s office were no match for the resources of law firms hired by the nursing home industry.) As a result, the threat of a lawsuit was just as effective as an actual lawsuit. Many state respondents felt that it was inequitable that nursing homes receive special protection whereas other providers do not. Speculating about what would happen if the Boren amendment were repealed (as it has been), the nursing home industry believed that it could use general provisions in Texas state law to prevent rate reductions.

Controlling Long-Term Care Supply

Nursing homes in Texas are significantly overbuilt, resulting in very low occupancy rates (only 76 percent in 1995), a situation that has existed for many years. The state has had a moratorium on nursing home construction since 1985.
but has no certificate-of-need requirement. The nursing home industry supports
the moratorium and would like to see it broadened to include hospitals that
are trying to convert empty beds to nursing home beds.

Eligibility for Medicaid Services

The state has not attempted to tighten admission criteria for nursing homes
to control nursing home costs, despite home care advocates' contention that
approximately 25,000 nursing home residents have low levels of disability and
do not need to be institutionalized. In response, the nursing home industry
argues that such residents still need care and that no savings would be realized
by shifting to home-based services. In 1994, the state tried to implement pre-
admission screening for nursing homes, but it was an administrative failure
because no additional funds were allocated for staff.

Quality of Care

Quality of care in nursing homes has been a major focus of legislative activ-
ity in Texas over the past two years. HB 2644, passed in the 1995 legislative ses-
son, prohibited the state from establishing nursing home standards different
from those the federal government uses for Medicare and Medicaid certifica-
tion. The nursing home industry, which proposed the bill, contended that the
state rules did not add much to quality-of-care regulation and that the state
rules never figured into the federal certification decisions. Opponents of HB
2644 said that the law repealed a host of quality standards and made adding
requirements much more difficult.

In September 1996, a committee of the Texas Board of Nursing Facility
Administrators developed new, much stronger draft regulations. These rules
were proposed after it was reported that the board had failed to discipline any
nursing home administrators since 1993, including 23 administrators working
at homes where conditions were so bad that the homes were put under state
control. However, opposition by nursing home administrators caused the pro-
posed rules to be scrapped.

Reacting to the controversy over HB 2644 and the publicity concerning
the Texas Board of Nursing Facility Administrators, the legislature passed
several new laws in 1997 that strengthened nursing home regulation. The
prohibition against state standards being more stringent than federal law was
repealed, and many new standards were imposed, including a detailed listing
of patients’ rights. To aid consumers, a nursing home consumers’ guide is
to be created. Soon after the governor signed these bills, the state auditor
released a report sharply criticizing the state’s enforcement of nursing home
quality standards.
Notes


Washington

Washington state recognizes that the impending increase in the elderly as a proportion of its population will place significant demands on its publicly funded long-term care services. In recent years, Washington has experienced moderate success in controlling its long-term care costs, primarily by emphasizing home and community-based services, while effectively limiting nursing home bed supply with its certificate-of-need program.

Long-term care services for the elderly are administered by the Aging and Adult Services Administration (AASA) in the Department of Social and Health Services. As of fall 1996, AASA served more than 37,000 clients: 41 percent in nursing homes, 47 percent in their own homes, and 12 percent in community residential care. Over the past decade, “real” AASA expenditures have doubled, growing twice as fast as the total state budget, mostly because of increasing costs per person served. However, Initiative 601—which passed in 1994—requires that the rate of growth of total state spending be based on inflation plus population growth, a constraint that has placed pressure on Medicaid and other health programs.

Utilization, Supply, and Expenditures

As shown in table 1, Washington had a smaller proportion of elderly residents in 1996 than the nation as a whole—11.5 percent, compared with 12.8 percent. Similarly, the proportion of Medicaid beneficiaries who were 65 and over in Washington was lower than the national average in 1995—8.3 percent, compared with 11.1 percent—and was the second-lowest among the states studied.
The long-term care system in Washington is defined by an almost equal number of nursing home beds and residential care beds (table 2). In 1995, Washington had 304 nursing homes with a total of 28,869 beds—122.5 beds per 1,000 elderly people age 75 and above, compared with the national ratio of 133.1. While the supply of nursing home beds was slightly lower than the national average, Washington’s supply of residential care beds was much higher than the national average. Washington had 2,188 residential care facilities and 22,912 beds—97.2 beds per 1,000 elderly people age 75 and over, almost twice the national ratio of 52.8. There were 166 licensed home health agencies in Washington in 1995.

Washington spent $484 million on Medicaid long-term care for the elderly in 1995, which was 17.1 percent of the state’s total Medicaid budget—slightly less than the 19.5 percent nationwide average. Medicaid expenditures per elderly resident were somewhat lower than the national average—$876 versus $967. Although Washington heavily emphasizes home and community-based services for younger people with disabilities, the state has been slower to shift expenditures away from institutional care for older Medicaid beneficiaries. The state spends 5.7 percent of long-term care for the elderly on home and community-based services (compared with 10.3 percent nationally) and 94.3 percent on institutional services (compared with 89.7 percent nationally). As shown in table 16, Medicaid long-term care expenditures for the elderly increased by 9.3 percent annually from 1990 to 1995 (compared with 10.7 percent nationally). Over this same period, nursing home expenditures far outpaced home care expenditures; home care spending actually declined slightly from 1990 to 1995. In addition to Medicaid home care expenditures, Washington spends almost $20 million on state-funded programs for home and community-based care for the elderly.

### Maximizing Private Payments

Washington does not focus many cost-containment efforts on increasing private funding for Medicaid long-term care expenditures, but it has undertaken

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

Does not include administrative costs or accounting adjustments. Totals may not add due to rounding. ICF-MR refers to intermediate care facilities for the mentally retarded. Nursing Facility refers to skilled nursing facilities and other intermediate care facilities.
a few such initiatives. It offers private long-term care insurance to state employees. In addition, Washington has a state plan amendment with provisions for a partnership model similar to California’s, but no insurers have come forward to participate in the program. In compliance with OBRA 1993, Washington also has an estate recovery program.

Home and Community-Based Services

Although home and community-based spending for the elderly has lagged behind home care spending for younger people with disabilities, the state maintains that it is committed to enabling the elderly and functionally disabled to avoid nursing homes if at all possible—both to respond to client preferences and to save public dollars. Overall, Medicaid waiver programs are the state’s primary vehicle for providing options to long-term care recipients. In 1996, 53 percent of Medicaid home and community-based care expenditures were for waiver services, while the remainder paid for the optional benefits of personal care services (27 percent) and home health (20 percent). The state’s main Medicaid home and community-based care waiver—Community Options Program Entry System (COPES)—serves 8,900 elderly and disabled recipients. COPES offers adult residential care, adult family home care, assisted living, personal care, and case management.

There is some evidence that the shift away from nursing home care has reduced the state’s overall long-term care costs. The number of recipients in nursing homes and the number of nursing home beds have declined slightly, and the numbers of residential care facilities and home health agencies have increased considerably. The state is also trying to strengthen case management at the point of hospital discharge and to develop further residential and nursing facility case management to control costs.

Some observers fear that the woodwork effect will lead to overall growth in spending. So far, there may be savings, primarily because home and community-based services are much cheaper to provide—perhaps by as much as two-thirds—than nursing home care. Still, conclusions regarding program savings remain debatable, and opinions among state officials and stakeholders vary.

Managed Care

Washington is currently planning to integrate acute and long-term care services through capitated health plans. While some state officials and providers have championed the idea, others have been less convinced of its merits. A Lewin-VHI study estimated that savings from integration would be trivial. Furthermore, the recent decision to halt the state’s mandatory enrollment of the SSI population into managed care for acute care might delay the implementation
of any plans to integrate acute and long-term care. The initiative was stopped after utilization and costs overwhelmed reimbursement levels and when it became apparent that not enough health plans were willing to continue as providers.10

**Medicaid Reimbursement Rates**

While Initiative 601—which capped the spending growth of state programs—has led the state to consider severely restricting the growth of nursing home payment rates, rates are viewed as at least adequate and perhaps generous, compared with those of other states. Washington reimburses nursing homes on a facility-specific, prospective basis. In 1995, average Medicaid nursing home reimbursement rates were $92.35, slightly above the national average of $85.05. Payment reform (shifting from simple cost-plus payments to case-mix-adjusted, fee-for-service payments) is scheduled for implementation in 1998. Selective contracting authority could also help the state place its clients in cost-effective institutions, but the legislature has not yet granted the authority.

**Controlling Long-Term Care Supply**

The state’s goal is to reduce its nursing home Medicaid census from 15,490 in 1996 to 12,000 in July 2003.11 One way the state plans to do this is by constraining the supply of nursing homes. Partly as a result of certificate-of-need policies, total growth in nursing home beds was only 7.7 percent between 1980 and 1995, the second-smallest increase of the 50 states. At the same time, however, AASA’s assisted living caseload grew 106 percent (no CON is required for residential care).12 Despite CON restrictions, access to nursing home care, even for Medicaid patients, is reportedly good.

**Notes**

5. The state licenses three categories of residential alternatives to nursing homes: boarding homes (three or more persons in a “facility”); adult family homes (two to six persons in a “home”); and assisted living (a combination of housing, health services, and assistance with personal care provided by a licensed boarding home in accordance with the assisted living services contract). The term “adult residential care” is a Medicaid reimbursement term rather than a licensure term and generally refers to care delivered in boarding homes.


8. AASA.


11. AASA strategic plan, July 1996.

12. AASA progress report, Fall 1996.
Wisconsin

Long-term care for the elderly is a critical component of Wisconsin's health care system and plays a major role in its Medicaid program. Compared with some other states, Wisconsin places long-term care very high on the political agenda and is active in many areas of long-term care policy. Although the care delivery system for the elderly historically has been dominated by nursing homes, Wisconsin is a national leader in innovative home and community-based services. In addition, state officials recently proposed and—following strong criticism—quickly withdrew a comprehensive redesign of long-term care that would have integrated acute and long-term care services for individuals of all ages by enrolling people with disabilities in managed care organizations. Because counties control a large proportion of long-term care funds, local officials have significant influence over policy and resource allocation decisions, resulting in substantial geographic variation.

Utilization, Supply, and Expenditures

As shown in table 1, Wisconsin has a higher proportion of elderly residents than the national average. In 1996, 13.4 percent of Wisconsin's population was over the age of 65, slightly higher than the national percentage of 12.8 percent. Similarly, the number of elderly Medicaid beneficiaries as a percentage of total Medicaid beneficiaries in Wisconsin was higher than the national average (14.0 percent, compared with 11.1 percent) and, along with Massachusetts, was the highest among the states studied.

As shown in table 2, the long-term care system in Wisconsin is characterized by a high number of nursing home beds and residential care facility beds.
In 1995, Wisconsin had a much higher than average supply of nursing homes, with 424 facilities and 48,332 beds—the state’s 211.8 beds per 1,000 elderly people age 75 and older is substantially higher than the 133.1 beds nationwide and is the highest among the 13 states studied. Wisconsin’s 1,605 residential care facilities with a total of 20,157 beds also gave the state a much higher than average supply of residential care beds—88.3 beds per 1,000 elderly people, compared with 52.8 beds per 1,000 nationwide. Wisconsin had 202 licensed home health agencies in 1995.

Wisconsin spent almost $750 million on Medicaid long-term care expenditures for the elderly in 1995—31.0 percent of Wisconsin’s non-DSH Medicaid expenditures in 1995, second-highest among the focal states and well above the national average of 19.5 percent. The state spent well above the national average per elderly Medicaid resident—$1,418, compared with $967 nationwide. Of these expenditures, 95.6 percent were for institutional care, while only 4.4 percent were for home and community-based services. Medicaid long-term care spending for the elderly in Wisconsin grew at the national average rate between 1990 and 1995, with nursing facility expenditures far outpacing home care expenditures over this period (table 17). Wisconsin also funds a substantial state-only home care program.

Maximizing Private Payments

While Wisconsin reportedly supports the idea of private long-term care insurance, it has done little to promote it. A proposal in the 1980s would have provided public-private partnerships for the purchase of this insurance, but it was not implemented. Private long-term care insurance is being offered to state employees.

Estate recovery programs recoup Medicaid expenditures for long-term care from the estates of deceased Medicaid beneficiaries. Although some

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interviewees questioned the program’s potential for success, estate recovery increased from $471,271 in 1991–92 to $9,711,562 in 1995–96, over 1 percent of Medicaid nursing home expenditures. This rate makes Wisconsin’s program one of the country’s most effective.

Medicare Maximization

Wisconsin has aggressively pursued Medicare maximization in the area of home health. Actions include provisions requiring home health agencies to bill Medicare first and authorizing retrospective audits of payments to home health agencies. According to some observers, these audits have presented considerable problems for home health agencies, especially because of potential Medicare penalties for incorrect billing, the application of more recent regulations to older payments, and the inability of home health agencies to resubmit older bills to Medicare.

Home and Community-Based Services

Although Wisconsin spends most Medicaid long-term care dollars for the elderly on institutional care, the state has been characterized as having a high commitment to home and community-based services. The popular Community Options Program (COP), originally established in 1982 and funded with only state revenue, seems to have convinced many in the state that home and community-based services are a feasible alternative to institutional services. In 1995, COP served 9,305 elderly and nonelderly individuals, with total expenditures of $57.8 million.

Beginning in 1987, Wisconsin shifted much of the COP program into the Medicaid program, by establishing two Medicaid home and community-based waiver programs for older people and younger persons with disabilities: the COP-waiver (COP-W) and the Community Integration Program (CIP II). Each placement in the smaller CIP II requires the closure of a nursing facility bed. The state has tried to encourage the use of Medicaid home and community-based waiver services wherever possible to maximize federal contributions. Although home and community-based service programs have been expanding rapidly, most counties have a long waiting list for enrollment (8,834 persons on January 1, 1996).

In recent years, the proportion of home and community-based long-term care used by the elderly declined because of the low turnover rate among the younger disabled population enrolled in the COP program. This decline upset advocacy groups for the elderly, who claimed political credit for the increased funding for noninstitutional services and argued that they were not receiving a “fair” share of the slots. In response, the state established a “significant proportions” allocation requiring that a majority of the slots be reserved for the elderly.
With the rising stock of home and community-based care in Wisconsin, nursing homes have become more aggressive in defending their share of the long-term care dollar. While it supports widening the continuum of care, the nursing home industry contends that home and community-based services are not cost-effective. The industry challenged a recent analysis by the Wisconsin Legislative Fiscal Bureau, which concluded that waiver services for the elderly were a less expensive alternative to nursing home care on an individual basis. In fact, the study’s findings are not adjusted for disability level, and analyses by the Wisconsin Office of Strategic Finance and Sager and Arling have both concluded that the Medicaid nursing home population is considerably more disabled than the HCBS waiver population. In addition, the bureau’s study did not take into account the provision of additional home and community-based services to people who would not have been institutionalized without them.

The number of nonmedical, long-term care residential facilities, including assisted living facilities (ALFs) and community-based residential facilities (CBRFs), has increased substantially in recent years. Both ALFs and CBRFs are largely private-pay, which has led some to contend that middle-class individuals might exhaust their resources in these facilities, leading to a higher proportion of nursing home residents who rely on Medicaid to pay for their care. Ironically, CBRFs are subject to more extensive regulations than ALFs, even though ALFs can serve residents who are more severely disabled.

Managed Care

In May 1997, the Department of Health and Family Services proposed to redesign the long-term care system for all ages by relying on managed care and a single capitated payment to integrate acute and long-term care. The redesign also would have created county-level resource centers to provide a single point of access for information and counseling and access to services, which is a variant of the Program of All-inclusive Care for the Elderly (PACE) model.

The proposal, however, was withdrawn in June in response to heavy criticism from advocacy groups and county representatives. Opponents of the redesign criticized the state’s reliance on managed care organizations to meet individuals’ long-term care needs. Specifically, opponents of the redesign felt that HMOs in Wisconsin had little experience or skill with the elderly or with long-term care and that a capitated payment for acute and long-term care would weaken consumer-directed long-term care. Instead of comprehensive redesign, a $1.4 million pilot program will be implemented to test the feasibility of resource centers in five or six counties.

Wisconsin serves 400 individuals through PACE in Milwaukee and Dane Counties (320 in Milwaukee and 80 in Dane). The state plans to extend a version of this model to 300 additional individuals in three counties through the Wisconsin Partnership Program.
Medicaid Reimbursement Rates

Like many states, Wisconsin aims to control Medicaid spending by controlling its reimbursement rates. The nursing home reimbursement level is currently $85 per day (about the national average) and is calculated on a prospective, facility-specific basis. Until recently, the state allowed direct care costs up to 110 percent of the median, but the Thompson administration and the legislature lowered this ceiling to 103 percent of the median during the 1997 legislative session. During that same session, home health rates were raised by 2 percent, the first rate increase since FY 1989-90, but home health advocates contend that reimbursement levels are still far too low.

It is unclear what impact the repeal of the Boren amendment will have. Politically, the nursing home industry is a major force in the state and has been closely linked with the current state administration. While some observers felt that the state would continue its downward pressure on reimbursement rates, others felt that the political strength of nursing homes would prevent further reductions in rates. Advocacy groups for the elderly tended to believe that the Boren amendment was a “fig leaf” that provided an excuse for the governor to give the nursing homes what they wanted and supported a repeal of federal reimbursement standards as a way of freeing the state to reallocate funding to home care.

Controlling Long-Term Care Supply

Although Wisconsin has had a moratorium on new construction of nursing homes since 1980, it still has more nursing home beds per 1,000 elderly people than most states. Wisconsin has no moratorium for residential long-term care facilities such as ALFs and CBRFs, which have expanded substantially in recent years.

Notes

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