State Policy On Long-Term Care For The Elderly

States approach their long-term care policies differently, but all agree that curbing spending is the top priority.

by Joshua M. Wiener and David G. Stevenson

ABSTRACT: In the thirteen Assessing the New Federalism states, strategies to control the rate of increase in long-term care spending are extremely varied, especially in comparison with acute care’s single-minded focus on managed care. States use three broad strategies: offsetting state spending with increased private and federal contributions, making the delivery system more efficient, and using traditional cost-control mechanisms, including controlling the nursing home bed supply and cutting Medicaid reimbursement rates.

LONG-TERM CARE services for older adults represent a major share of total health care spending in the United States and an area of growing concern for state policymakers. Nursing home and home health care accounted for almost 12 percent of personal health expenditures in 1995 and approximately 14 percent of all state and local health care spending.1 Importantly, 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. 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.2

Because of the high cost of long-term care (a year in a nursing home cost an average of $46,000 in 1995), Medicaid coverage for long-term care provides a safety net for the middle class as well as for the poor.3 Approximately one-third of discharged nursing home
residents pay out of private funds when admitted and eventually spend down to Medicaid eligibility. In 1997, 68 percent of nursing home residents were dependent on Medicaid to finance at least some of their care.

Although states are motivated by a variety of goals, the vast majority of long-term care initiatives are aimed at controlling the rate of increase in state spending, especially since Medicaid is the primary source of financing for long-term care. As in the rest of the Medicaid program, states have considerable flexibility in providing long-term care services. In fact, states’ strategies to limit long-term care spending are far more varied than for acute care, where there is a single-minded focus on increasing managed care enrollment.

Methodology And Background
This analysis is part of the Urban Institute’s Assessing the New Federalism (ANF) project. In brief, the project analyzes state health, income support, and social service programs for the low-income population, primarily in thirteen states that account for 54 percent of total Medicaid spending for long-term care for the elderly. The information included in this paper was collected 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 legislators, long-term care provider associations, and advocates for the elderly and disabled provide the basis for the state-specific information we present. Persons interviewed were assured that they would not be quoted by name.

Exhibits 1 and 2 present indicators of potential demand for and supply of long-term care services in the ANF states and nationally. Almost $54 billion was spent on long-term care for persons of all ages by the Medicaid program in 1995 (34 percent of total Medicaid expenditures). Long-term care spending on older beneficiaries accounted for the majority ($30 billion) of this spending. Three-fourths of Medicaid expenditures for the elderly were for long-term care services.

There was considerable diversity among the ANF states in the level and distribution of long-term care spending for the elderly in 1995 (Exhibit 3). The growth in Medicaid long-term care spending nationwide was 10.7 percent annually from 1990 to 1995 (compared with 16.7 percent for total Medicaid spending); nursing facility spending outpaced home care spending over this same period (Exhibit 4).
Strategies To Control Long-Term Care Spending

Overall, states might use three broad strategies to control spending: (1) offset state spending for long-term care with increased private and Medicare contributions; (2) reform the delivery system so that care can be provided more efficiently; and (3) use traditional cost-control mechanisms such as controlling nursing home bed supply and cutting Medicaid reimbursement rates. The thirteen ANF states vary in the extent to which they focus on each of these strategies and in how far they have progressed in implementing substantial reform.

**Increase private and federal resources.** States are bringing additional private and federal resources into the long-term care financing system in several ways.

*Encourage private long-term care insurance.* For middle-class nursing home residents, private long-term care insurance could prevent both their impoverishment and subsequent Medicaid spending. However, only about 5 percent of the elderly have any type of long-term care insurance, primarily because of its high cost. While Joshua Wiener and his colleagues found that long-term care insurance policies are unlikely to have much impact on Medicaid long-term care expenditures, Marc Cohen and his colleagues had more optimistic projections.

Although some ANF states (such as California, Minnesota, Washington, and Wisconsin) offer private long-term care insurance

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**EXHIBIT 1**

Demographic Characteristics And Potential Demand For Long-Term Care Services In Thirteen States, 1995 and 1996

<table>
<thead>
<tr>
<th>State</th>
<th>Total elderly population (thousands)</th>
<th>Elderly as percent of total population</th>
<th>Elderly Medicaid beneficiaries (thousands)</th>
<th>Elderly beneficiaries as percent of total beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>34,100</td>
<td>12.8%</td>
<td>3,899</td>
<td>11.1%</td>
</tr>
<tr>
<td>Alabama</td>
<td>566</td>
<td>13.1%</td>
<td>71</td>
<td>13.3%</td>
</tr>
<tr>
<td>California</td>
<td>3,486</td>
<td>10.6%</td>
<td>486</td>
<td>9.8%</td>
</tr>
<tr>
<td>Colorado</td>
<td>382</td>
<td>10.1%</td>
<td>37</td>
<td>12.5%</td>
</tr>
<tr>
<td>Florida</td>
<td>2,743</td>
<td>19.0%</td>
<td>211</td>
<td>12.2%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>841</td>
<td>14.1%</td>
<td>101</td>
<td>14.0%</td>
</tr>
<tr>
<td>Michigan</td>
<td>1,193</td>
<td>12.4%</td>
<td>86</td>
<td>7.4%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>583</td>
<td>12.5%</td>
<td>57</td>
<td>12.3%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>338</td>
<td>12.6%</td>
<td>67</td>
<td>12.8%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1,100</td>
<td>13.8%</td>
<td>90</td>
<td>11.6%</td>
</tr>
<tr>
<td>New York</td>
<td>2,419</td>
<td>13.3%</td>
<td>371</td>
<td>12.3%</td>
</tr>
<tr>
<td>Texas</td>
<td>1,927</td>
<td>10.2%</td>
<td>308</td>
<td>12.2%</td>
</tr>
<tr>
<td>Washington</td>
<td>646</td>
<td>11.5%</td>
<td>53</td>
<td>8.3%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>698</td>
<td>13.4%</td>
<td>64</td>
<td>14.0%</td>
</tr>
</tbody>
</table>

**SOURCES:** See below.


b Urban Institute calculations based on Health Care Financing Administration (HCFA) Form 64 data for 1995.
to state employees, few states have organized efforts to promote the purchase of policies. Nonetheless, many Medicaid officials and providers voice great anxiety over whether the current financing system is sustainable and hope for a long-run shift of financing from Medicaid to private insurance.

Of the ANF states, California and New York are the most active in promoting private long-term care insurance and have established public/private partnerships to encourage its purchase.10 Under these partnerships states allow persons who buy a state-approved long-term care policy to keep more assets than normally allowed to qualify for Medicaid. California consumers can buy a level of private coverage equal to the amount of assets that they wish to protect.11 New York consumers can protect an unlimited amount of assets from spend-down by purchasing three years of coverage.

Other states have considered similar approaches. In Massachusetts a planned partnership program similar to California's was discontinued by Gov. William Weld's administration in 1990 out of concern that it contributed to the perception that Medicaid was a middle-class entitlement rather than a program limited to the poor. Colorado and Michigan have sought to establish partnerships but have not implemented them because federal rules established in the Omnibus Budget Reconciliation Act (OBRA) of 1993 make the protected assets subject to mandatory estate recovery.

### EXHIBIT 2

**Characteristics Of The Long-Term Care Systems In Thirteen States, 1995**

<table>
<thead>
<tr>
<th></th>
<th>Licensed nursing facilities</th>
<th>Licensed residential care</th>
<th>Licensed home health care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total facilities</td>
<td>Total beds</td>
<td>Beds per thousand persons age 75 and older</td>
</tr>
<tr>
<td>United States</td>
<td>14,264</td>
<td>1,781,912</td>
<td>133.1</td>
</tr>
<tr>
<td>Alabama</td>
<td>238</td>
<td>24,318</td>
<td>90.0</td>
</tr>
<tr>
<td>California</td>
<td>1,397</td>
<td>130,125</td>
<td>90.7</td>
</tr>
<tr>
<td>Colorado</td>
<td>226</td>
<td>20,251</td>
<td>207.5</td>
</tr>
<tr>
<td>Florida</td>
<td>678</td>
<td>77,145</td>
<td>76.7</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>591</td>
<td>56,912</td>
<td>168.7</td>
</tr>
<tr>
<td>Michigan</td>
<td>453</td>
<td>51,203</td>
<td>83.9</td>
</tr>
<tr>
<td>Minnesota</td>
<td>440</td>
<td>44,792</td>
<td>200.9</td>
</tr>
<tr>
<td>Mississippi</td>
<td>176</td>
<td>16,604</td>
<td>140.9</td>
</tr>
<tr>
<td>New Jersey</td>
<td>363</td>
<td>49,818</td>
<td>121.3</td>
</tr>
<tr>
<td>New York</td>
<td>663</td>
<td>114,601</td>
<td>111.7</td>
</tr>
<tr>
<td>Texas</td>
<td>1,346</td>
<td>129,677</td>
<td>185.2</td>
</tr>
<tr>
<td>Washington</td>
<td>304</td>
<td>28,869</td>
<td>122.5</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>424</td>
<td>48,332</td>
<td>211.8</td>
</tr>
</tbody>
</table>

**SOURCE:** B. Bedney et al., 1995 State Data Book on Long-Term Care Program and Market Characteristics (San Francisco: University of California, San Francisco, November 1996).

*Certified home health agencies*
So far, the partnerships have failed the market test. The California and New York partnerships have spurred the purchase of fewer than 17,000 policies in both states combined, despite the presence of more than six million elderly persons in the two states. Yet both states remain committed to expanding private coverage for long-term care. California intends to make its insurance product more affordable. New York Governor George Pataki has made increasing private

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**EXHIBIT 3**

Medicaid Long-Term Care Expenditures For Elderly Beneficiaries In Thirteen States, By State And Type Of Service, 1995

<table>
<thead>
<tr>
<th>State</th>
<th>Total long-term care spending (thousands)</th>
<th>Long-term care as percent of total Medicaid</th>
<th>Long-term care spending Per elderly beneficiary</th>
<th>Per elderly resident</th>
<th>Proportion of long-term care spending</th>
<th>Nursing facility</th>
<th>ICF-MR</th>
<th>Mental health</th>
<th>Home care</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$30,413,715</td>
<td>19.5%</td>
<td>$7,821</td>
<td>$967</td>
<td>84.1%</td>
<td>2.0%</td>
<td>3.6%</td>
<td>10.3%</td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>371,497</td>
<td>19.0</td>
<td>5,210</td>
<td>632</td>
<td>92.0</td>
<td>0.4</td>
<td>3.1</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>2,100,690</td>
<td>11.1</td>
<td>4,319</td>
<td>620</td>
<td>79.8</td>
<td>3.4</td>
<td>8.4</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>266,248</td>
<td>17.5</td>
<td>7,290</td>
<td>862</td>
<td>89.9</td>
<td>0.1</td>
<td>0.8</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>1,117,491</td>
<td>18.2</td>
<td>5,293</td>
<td>475</td>
<td>94.2</td>
<td>0.6</td>
<td>1.2</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1,302,359</td>
<td>23.3</td>
<td>12,872</td>
<td>1,763</td>
<td>92.7</td>
<td>2.3</td>
<td>1.1</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>934,999</td>
<td>18.3</td>
<td>10,859</td>
<td>793</td>
<td>89.9</td>
<td>1.4</td>
<td>4.7</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>871,810</td>
<td>31.7</td>
<td>15,403</td>
<td>1,817</td>
<td>93.2</td>
<td>1.4</td>
<td>1.8</td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>239,414</td>
<td>15.7</td>
<td>3,593</td>
<td>752</td>
<td>98.6</td>
<td>1.2</td>
<td>0.0</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>1,011,315</td>
<td>18.8</td>
<td>11,184</td>
<td>1,008</td>
<td>83.7</td>
<td>3.5</td>
<td>2.3</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>5,702,398</td>
<td>24.2</td>
<td>15,354</td>
<td>2,444</td>
<td>66.4</td>
<td>3.2</td>
<td>7.4</td>
<td>23.1</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>1,400,461</td>
<td>16.1</td>
<td>4,547</td>
<td>785</td>
<td>76.3</td>
<td>2.5</td>
<td>0.0</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>483,899</td>
<td>17.1</td>
<td>9,111</td>
<td>876</td>
<td>92.7</td>
<td>1.4</td>
<td>0.2</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>747,715</td>
<td>31.0</td>
<td>11,676</td>
<td>1,418</td>
<td>92.4</td>
<td>2.5</td>
<td>0.7</td>
<td>4.4</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Urban Institute calculations based on Health Care Financing Administration (HCFA) Form 64 data. Prepared for the Kaiser Commission on the Future of Medicaid.

**NOTES:** Does not include disproportionate-share hospital (DSH) payments, administrative costs, accounting adjustments, or spending in the U.S. Territories. Totals may not add because of rounding. “Nursing facility” refers to skilled nursing facilities/other intermediate care facilities.

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So far, the partnerships have failed the market test. The California and New York partnerships have spurred the purchase of fewer than 17,000 policies in both states combined, despite the presence of more than six million elderly persons in the two states. Yet both states remain committed to expanding private coverage for long-term care. California intends to make its insurance product more affordable. New York Governor George Pataki has made increasing private

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**EXHIBIT 4**

Medicaid Long-Term Care Expenditures For Elderly Beneficiaries Nationally, By Type Of Service, 1990–1995

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>1990 (millions)</th>
<th>1995 (millions)</th>
<th>Average annual growth 1990–1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>18,307</td>
<td>30,414</td>
<td>10.7%</td>
</tr>
<tr>
<td>SNF/ICF—other</td>
<td>15,072</td>
<td>25,572</td>
<td>11.2</td>
</tr>
<tr>
<td>ICF-MR</td>
<td>384</td>
<td>616</td>
<td>9.9</td>
</tr>
<tr>
<td>Mental health</td>
<td>959</td>
<td>1,107</td>
<td>2.9</td>
</tr>
<tr>
<td>Home care</td>
<td>1,892</td>
<td>3,119</td>
<td>10.5</td>
</tr>
</tbody>
</table>

**SOURCE:** Urban Institute calculations based on Health Care Financing Administration (HCFA) Forms 2082 and 64 data.

**NOTES:** Does not include disproportionate-share hospital (DSH) payments, administrative costs, accounting adjustments, or spending in the U.S. Territories. Totals may not add because of rounding. Skilled nursing facilities/other intermediate care facilities.

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financing the centerpiece of “Securing New York's Future,” the state’s plan for long-term care, and the legislature has provided permanent statutory authorization for the partnership. Both states hope that improved marketing strategies will boost enrollment.

Reduce Medicaid estate planning. Over the past several years policymakers and the media have focused attention on middle-class and wealthy elderly persons who transfer, shelter, and underreport assets—so-called Medicaid estate planning—to appear poor enough to qualify for Medicaid-financed nursing home care.13 Congress has legislated against these practices on numerous occasions (most recently in the Balanced Budget Act [BBA] of 1997), but some argue that the legislative prohibitions are easy to circumvent.

Although the rhetoric surrounding the issue is passionate and all states acknowledge it as somewhat of a problem, Massachusetts, New Jersey, and New York were the only ANF states in which asset transfer was thought to be a major public policy issue. It is of particular concern in New York, where there are approximately 1,200 elder-law attorneys and where newspaper and magazine advertisements relating to asset transfer are said to be ubiquitous. The litigious culture and the hostility of the state courts to rules requiring middle-class citizens to impoverish themselves make cracking down on asset transfer difficult. Nonetheless, state officials believe that reducing asset transfer is a critical prerequisite to motivating citizens to purchase long-term care insurance policies and, more generally, to viewing long-term care as a private responsibility.

Maximize Medicare financing. States have long sought to shift Medicare long-term care expenditures to Medicare but have been frustrated by the narrow range of Medicare coverage for nursing home and home health care. That situation has changed dramatically since the late 1980s, when Medicare postacute coverage rules were liberalized, making the benefits more oriented toward long-term care. Medicare home health spending totaled $17.2 billion in 1995, dwarfing the $3.1 billion spent by Medicaid on home and community-based services for the elderly.14

In response, some states have initiated “Medicare maximization” efforts to ensure that Medicare pays for home health and nursing facility care whenever possible. These efforts take the form of educating providers and consumers about Medicare benefits, improving the data system to identify dual eligibles (persons eligible for both Medicare and Medicaid) and instances of inappropriate billing, and requiring that all long-term care providers be certified by both programs and that they bill Medicare whenever there is the slightest chance of reimbursement. Partly reflecting these initiatives, one recent study of home health expenditures suggested an inverse rela-
tionship between Medicare and Medicaid home health spending. Among the ANF states, Massachusetts and New York have linked Medicaid nursing home payment rates to the industry’s success in Medicare maximization. Nursing home and home care providers in New York were required to increase Medicare revenues by 1 percent (in aggregate) over base expenditures in 1995 and 1996 or face cuts in Medicaid payment. Medicaid nursing home rates in Massachusetts are actively negotiated annually with adjustments contingent upon Medicare utilization rates. The industry seems to have responded: The Medicare occupancy rate in Massachusetts nursing homes increased from 2 percent in 1990 to 11 percent in 1996; and home health providers billed almost $12 million retrospectively to Medicare.

These strategies are not without their problems, however. Agencies in Wisconsin struggle to respond to extensive audits and directives to bill Medicare first. Home health agencies there contend that this mandate subjects agencies to Medicare penalties, which are levied if too many inappropriate claims are submitted. Retrospective home health payment audits also are difficult for providers, sometimes coming after Medicare’s window for billing has closed.

Finally, incentives to maximize Medicare reimbursement also depend on the comparability of Medicare and Medicaid payment rates. For example, home health agencies in Alabama and Minnesota believe that Medicaid rates are low enough that economic incentives, not policy, drive providers to seek Medicare payments whenever possible. Conversely, Medicare payments seem to be less sought by home health agencies in New York because Medicaid reimbursement is perceived to be adequate.

- System reform. A second general strategy for saving money is to reorganize the health care delivery system in ways that make care more efficient and effective. This can be accomplished through extending managed care to include long-term care and by expanding home care and nonmedical, residential long-term care services.

Integrate acute and long-term care services through managed care. States have four goals in integrating acute and long-term care services, primarily through expanding managed care. First, they hope to achieve better-quality care, with providers no longer hamstrung by arbitrary divisions between acute and long-term care. Second, states seek to lower costs, as providers substitute lower-cost ambulatory and home-based care for more expensive inpatient care. Additionally, states hope to save money by shifting costs to Medicare for dual eligibles and by claiming most of the potential savings for Medicaid. For example, in its demonstration in the Houston area, Texas hopes to use “zero-premium” health maintenance organizations (HMOs) (that is, HMOs that charge no additional premiums to Medicare
beneficiaries), which provide more generous benefits than traditional Medicare does. Since Texas Medicaid now pays for some of these benefits (such as prescription drugs), the state can save money simply by enrolling dual eligibles in these HMOs. Third, some states, such as Massachusetts, Minnesota, and Wisconsin, are deliberately reducing the number of providers so that officials can focus on setting contract standards and monitoring performance. Finally, capitation payments shift much of the financial risk from government to providers and make state spending more predictable.

Although several ANF states (including California, Colorado, Massachusetts, New York, Texas, Washington, and Wisconsin) have Program of All-inclusive Care of the Elderly (PACE) or social HMO demonstration sites, state officials are more interested in strategies to enroll thousands of dual eligibles. All of the ANF states (except Alabama and Mississippi, which have little managed care on which to build) are planning or implementing initiatives to enroll persons in managed care programs that integrate acute and long-term care. Especially notable are Minnesota’s Senior Health Options demonstration, Colorado’s Integrated Long-Term Care Financing Project, Florida’s Long-Term Care Community Diversion Pilot Project, Texas’s STAR+Plus Integrated Care Project, and Massachusetts’s Senior Care Organizations. However, many of these efforts are small in scale and preliminary in their implementation.

Although there are exceptions, most of these efforts emulate the PACE model’s focus on dual eligibles (although not PACE’s focus on persons at risk of institutionalization) and the social HMO model’s use of conventional HMOs. New York, Michigan, and Wisconsin are beginning the process by integrating long-term care alone, without adding acute care services.

Progress for these integration efforts is often slow because almost all require Medicaid and sometimes Medicare waivers. States generally have found negotiations with the Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB) to be frustrating on two major points. First, several states would like to receive Medicare payments directly and combine them with Medicaid funds into a single capitated payment, but HCFA has maintained that it will not “block grant” the Medicare program to the states. Second, several states
fear that participation in these integrated systems will be modest unless enrollment is mandatory. HCFA, however, has insisted that dual eligibles are Medicare beneficiaries first and foremost and are entitled to freedom of choice.17

The integration of acute and long-term care services could realign service delivery and financing in ways that not all agree are desirable. In May 1997 the Wisconsin Department of Health and Family Services proposed to “redesign” the public long-term care system across the age spectrum by relying on managed care and a single capitated payment to integrate acute and long-term care. The nursing home industry was generally supportive of the plan, believing that it would benefit financially from the substitution of nursing home care for hospital care. The state’s proposal, however, was withdrawn in June 1997 in response to heavy criticism from elderly and disability advocacy groups and county officials.

Opponents of the redesign were critical of the state’s reliance on managed care organizations that they believed had little experience or skill with the elderly or with long-term care. Critics in Wisconsin also worried that fiscal pressures within an integrated system could short-change long-term care if providers do not view long-term care as a priority or if acute care overruns its budget. In addition, long-term care could become overmedicalized and services less consumer-directed if the balance of power shifts from the individual client and his or her chosen provider to HMOs. Home care providers also were concerned about their relative negotiating strength and the potential bias of managed care toward institutional care. Finally, counties were concerned that the redesign would diminish their traditional role in long-term care service delivery.

Expand home and community-based services. Policymakers in every ANF state endorse expanding home care and creating a more balanced delivery system as goals. However, only 10 percent of Medicaid long-term care expenditures for the elderly were for home care in 1995, and spending was uneven across the states.18 California, Massachusetts, New York, and Texas accounted for 60 percent of national Medicaid home care expenditures for the elderly in 1995 (33 percent of all elderly Medicaid beneficiaries reside in these states).19

In addition, California, Florida, Massachusetts, and Wisconsin have sizable state-funded home and community-based care programs. Forgoing federal Medicaid matching funds allows states maximum flexibility in determining eligibility, providing services, and setting budgets. All states together spent only $1.2 billion on state-funded home care programs for the elderly, mostly for persons who could not qualify for Medicaid.20

States can fund Medicaid home and community-based services
either through coverage of home health (a mandatory benefit) and personal care (an optional benefit) or by applying for home and community-based services waivers through Section 1915(c) of the Social Security Act. All of the ANF states deliver long-term care services for the elderly through home and community-based waivers, but the extent to which Medicaid home care in each state is defined by these waivers varies greatly.

California, Massachusetts, New York, and Texas have accomplished most of their expansion of home and community-based services through coverage of personal care and home health through the regular Medicaid program. If states choose this approach, then services must be offered as an open-ended entitlement.

Because of a fear of runaway spending, many states have chosen to use Medicaid home and community-based waivers, which give states greater control over utilization and eligibility. After a relatively slow start in the early 1980s, home and community-based waiver expenditures (for the elderly and nonelderly) have risen from $0.7 billion in 1988 to $4.6 billion in 1995, although the vast majority of spending is for younger persons with mental retardation or developmental disabilities.

Although federal/state conflict over approval of waivers was substantial and bitter during the Reagan and Bush administrations, regulatory changes implemented by the Clinton administration have made obtaining home and community-based services waivers fairly routine. Indeed, some states—including Alabama, Florida, and Texas—have not used all of the “slots” approved by HCFA, primarily because state matching funds are not available. ANF states uniformly described their relationship with HCFA regarding home and community-based waivers as good.

Cost containment strategies. In almost every state, home and community-based services are “sold” primarily on their ability to achieve cost savings, although meeting unmet needs in the community and responding to consumers’ preferences also are important. Most research, however, suggests that total long-term care costs are likely to rise as large increases in the use of home care more than offset small reductions in nursing home use. On the other hand, a 1996 study of Washington, Oregon, and Colorado concluded that home and community-based services were cost-effective alternatives to institutional care in these states.

As the policy commitment to community care has increased, some in the nursing home industry have questioned the cost-effectiveness of these services. Proponents of community care in Wisconsin believe that the significant decline in Medicaid nursing home utilization rates in the state is a sign of success, but others caution against
reading too much into these declines because of the potentially confounding effects of the nursing home moratorium, tightened eligibility standards for Medicaid nursing home coverage, and increased Medicare funding for skilled nursing care.26

To generate savings through the use of home and community-based services, states must limit per person spending and overall use for these services. Many states have established per person spending limits—generally, the average Medicaid nursing home care cost. According to some researchers, expenditures at this level are probably too high to achieve budgetary savings because of the difficulty in limiting use to those who otherwise would be institutionalized.27

In Colorado the average per recipient cost of in-home and alternative care facilities is 16 percent and 14 percent, respectively, of the average per recipient Medicaid expenditure for nursing home care.

To mitigate the “woodwork effect,” states also must limit use of home and community-based care to those who otherwise would be institutionalized without services. Colorado is one of the few ANF states to impose two screens: first to determine whether a person needs nursing home care, and second to determine risk of institutionalization. This process is criticized by some as making it more difficult to obtain home and community-based services than to obtain nursing home care, which reinforces the institutional bias of the delivery system. Similarly, Texas sought to use “unmet need” as a criterion for obtaining waiver services but did not make the change because of resistance from providers and consumer groups, who said it posed an unfair burden on informal caregivers.

All of the ANF states are exploring the potential role of residential alternatives to nursing home care. Florida, New Jersey, and New York finance the “care” part of some residential facilities through their Medicaid home and community-based waivers (Washington and Massachusetts provide residential care through a combination of state and Supplemental Security Income [SSI] funds), and California and Alabama are debating the provision of such benefits. The states hope to provide services that are more homelike, provide greater personal autonomy, and cost less than nursing homes do. In general, the nursing home industry contends that its residents are too disabled to be served adequately in these alternative settings, although in some states, such as Wisconsin, the nursing home industry is expanding into nonmedical residential facilities.

As states consider these alternatives, they face a number of difficult issues. States are struggling over how to superimpose new concepts of consumer-oriented, homelike care on a surprisingly large existing stock of nonmedical residential facilities (see Exhibit 2). For example, although California has 130,000 nursing home beds, it
also has more than 152,000 residential facility beds. Moreover, residential care settings are expanding rapidly in many states and are often not subject to certificate-of-need (CON) restrictions.

Another major issue is how to regulate these facilities in a way that allows persons to “age in place” while ensuring high-quality care. The problem is that federal and state regulatory structures are built on the concept of a continuum of care in which persons move from one level to another as they become more disabled. However, the whole notion of allowing persons to age in place means bringing services to them in their “homes,” wherever they may be, as they become more disabled. The result is sometimes a regulatory structure that is puzzling. Wisconsin, for example, has adopted detailed, institutionally oriented regulations for “community-based residential facilities,” which are limited to persons without severe disabilities. Yet the state has adopted very little regulation for assisted-living facilities, even though it allows these facilities to serve disabled persons needing up to twenty-eight hours of care a week.

Finally, states are concerned about how to make these new residential options available to the moderate- and lower-income elderly population. Outside of Oregon, most assisted-living facilities are geared to upper-income elderly persons. In Alabama, Minnesota, and Wisconsin some critics contend that middle-class persons exhaust their private resources paying for care in residential facilities and, once impoverished, apply to nursing homes as Medicaid recipients.

Traditional strategies to control spending. Existing federal law gives states considerable flexibility in conventional cost-saving mechanisms such as controlling the supply of long-term care providers and limiting reimbursement rates.

Control the supply of providers. Many states have responded to rising Medicaid long-term care spending by limiting the number of providers. These efforts have focused largely on nursing homes, where the general premise is that beds are likely to be filled with Medicaid residents. Although most ANF states limit nursing home beds through either CON requirements or moratoria for new construction, fewer states control the supply of home health agencies.28

Although CON programs can limit nursing home supply, they are usually required to judge only “need” and to ignore state budgetary concerns.29 A blunter strategy used by many states is to pass a law prohibiting construction of new nursing home beds, often through a moratorium on certifying additional beds for Medicaid participation. Nationally, seventeen states had a moratorium on new construction of nursing homes in 1995.30 Six ANF states (Colorado, Massachusetts, Minnesota, Mississippi, Texas, Wisconsin, and, until 1996, Alabama) had moratoria on nursing home construction in
1997. In Alabama, Texas, and Mississippi exceptions have meant that the moratorium on new construction is not total.

In Florida and Mississippi the nursing home industry is particularly concerned about a saturated hospital market and has sought to limit the conversion of hospital beds to skilled nursing units. This "back-door" expansion of hospital-based skilled beds in Mississippi, especially in rural areas, has drawn a heated response from the nursing home industry, which has sought remedies through the state legislature. The New Jersey legislature required hospitals to meet long-term care licensure and certification requirements and prohibited them from serving subacute patients for more than eight days. HCFA is holding up implementation out of a concern that imposing an eight-day maximum might violate Medicare rules.

Although limiting nursing home provider supply is likely to control spending over the short-to-medium term, the care needs of the elderly do not disappear just because provider supply is limited. Medicaid savings may be reduced to the extent that substitute services are provided. Moreover, in several ANF states in which the nursing home supply has been limited (Alabama, Florida, Michigan, and Mississippi), some observers contend that access to nursing home care can be difficult, especially in rural areas.

Cut reimbursement rates. Medicaid payment rates for nursing facility care are a logical target for states trying to reduce the rate of growth in long-term care spending for the elderly. The impact of nursing home rate reductions on state budgets is predictable, immediate, and potentially large. Thus, it is not surprising that reimbursement rates were targeted for savings in almost all of the ANF states during 1996 and 1997. Proposals to achieve these savings rely on a wide variety of mechanisms, including reducing the ceilings on payment levels, curbing administrative costs, and changing from facility-specific, cost-based reimbursement to case-mix-adjusted, flat-rate systems. In an interesting innovation, Minnesota established a demonstration project in which 120 nursing facilities have agreed to a freeze in rates in exchange for waiver of certain state regulations (for example, that half of the beds must be Medicare certified).

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

Although the Boren standard might appear to be minimal, states contended that it was nearly impossible to operationalize and that...
the courts were unreasonable in its interpretation. As of 1993 thirty-eight nursing home reimbursement lawsuits had been filed against states for violation of the Boren amendment’s procedural or substantive standards. Of the thirteen ANF states, nine have been the subject of a nursing home lawsuit. Despite the willingness to go to court in many states, the nursing home industry in Florida, Massachusetts, New Jersey, and Wisconsin had decided in recent years not to file Boren amendment suits because of the legal costs, the length of time it takes lawsuits to be resolved, the possibility that federal rules would be repealed, and the fear that a court case would sour relations with state officials.

State Medicaid officials universally opposed the Boren amendment, although they differed as to how much they thought payment policies would change if it were eliminated. States felt that they were forced to spend too much on nursing homes and to go far beyond the minimalist language of the statute. In some states, such as Wisconsin, consumer advocacy groups supported the repeal of the Boren amendment and saw it as an opportunity to shift money from nursing homes to home care.

With the repeal of the Boren amendment as part of the 1997 BBA, states will now have almost complete freedom in setting nursing home payment rates (although they must hold public hearings). In a few states, including Texas, the nursing home industry believes that existing state laws can be used to force adequate payments.

The problem with repealing the reimbursement standard is that Medicaid nursing home payment rates are already fairly low, and access to nursing home care could be compromised for Medicaid beneficiaries as the payment differential between private-pay and Medicaid patients widens. (Few nursing homes can survive without Medicaid residents, however, which limits the extent to which facilities can reduce access.) Recognizing the payment gap as a potential problem, Minnesota requires nursing homes to charge private-pay residents the same amount that Medicaid pays.

In addition, although there is little evidence of a simple relationship between cost and quality, there is probably some threshold level of reimbursement below which it is impossible to provide adequate quality of care. Quality of care in nursing homes has improved over the past twenty years, but advocates for nursing home residents remain extremely concerned about the quality of care provided in many facilities. A recent *Time* magazine report on poor quality of care in California nursing homes, which allegedly has resulted in a large number of deaths, triggered a state and U.S. General Accounting Office investigation. In Texas, where quality has been a persistent issue, the nursing home industry contends that
the level of care is a direct result of low payment rates; the state argues that nursing homes have not always used the money provided to improve care. In many states the nursing home industry is fearful that it will be required to meet federal and state quality standards but will not be reimbursed enough to do so.

The future impact of the Boren amendment’s repeal on payment rates in ANF states is unclear. The nursing home industry is politically powerful in every state and may succeed in maintaining the current level of reimbursement or close to it. To many observers, the Boren amendment was a “fig leaf,” providing a convenient excuse to give the nursing home industry what it wanted. Nonetheless, nursing homes in every state are concerned that Boren’s repeal will leave them vulnerable to significant Medicaid rate cuts.

Alabama is a case in point. Despite the political power of the nursing home association, Gov. Fob James Jr. moved to cut nursing home rates by as much as 30 percent after nursing home spending was identified as a primary reason for an $80 million (federal and state) Medicaid deficit in March 1997. The governor bitterly attacked the nursing home industry for its “greed,” reasoning that Alabama’s rates had grown much more quickly than national or regional averages had. The nursing home industry responded by warning about reduced quality of care and the possibility of patients’ being turned out of their residences. In fall 1997 the legislature adopted a compromise establishing a commission to investigate nursing home reimbursement, making modest rate reductions, and raising the provider tax. Since the provider tax is an allowable Medicaid expense, the net effect is that the federal government will finance most of the Medicaid shortfall that generated the crisis.

Resource Allocation And Politics

Efforts to reform long-term care are strongly influenced by state politics. In the ANF states the political landscape is dominated by the nursing home industry, and the strength of home care groups and consumer groups for the elderly and young persons with disabilities varies by state.

The for-profit nursing home industry is viewed as the strongest health lobby on Medicaid issues in all of the ANF states. This influence derives from several sources. First, nursing homes are far more focused on Medicaid and state policy than other provider groups are. Comparatively, nursing homes are much more dependent on Medicaid revenue than hospitals or physicians are. Second, because nursing homes are so focused on state policy, they meet frequently with state officials, which increases the level of personal acquaintance and friendship. Third, the industry is large and well financed.
enough to afford highly paid lobbyists and can commission studies to support its positions. Finally, nursing homes are frequent and large contributors to the political campaigns of governors and state legislators. Moreover, almost every legislative district contains some nursing homes, which means that nursing homes are constituents as well as lobbyists. In many states the nursing home industry is aligned with Republicans, who share the antiregulation views of the providers, even though they are often more fiscally conservative and less willing to support Medicaid than Democrats are.

The industry may be strong, but it does not always get its way. Much of what nursing homes want is higher rates, which states are not always willing or able to fund. In addition, a history of quality concerns and of fraud and abuse has damaged the industry’s public image, and policymakers and the public may be unconvinced that more money will improve patient care. Moreover, the for-profit status of most nursing homes leaves them vulnerable to charges that they are maximizing profits at the expense of residents.

Finally, there are other players on the long-term care stage, including various home care associations and advocacy groups for the elderly and young persons with disabilities. In general, except in New York, the home health care associations are not very influential in state Medicaid policy, in part because they often focus on Medicare rather than Medicaid policies. In all of the ANF states the elderly are believed to be a powerful group, but that power often does not derive from identifiable organizations. While in some states, such as New York and Wisconsin, elderly advocacy groups are well organized and well financed, they are largely lacking in other states, such as Alabama and Mississippi.

There seems to be little “generational warfare” over Medicaid funding in the ANF states, contrary to popular belief. Few observers see explicit trade-offs between Medicaid services for low-income children and younger adults and services for the elderly. Instead, spending decisions within Medicaid, especially within low-benefit states, are made largely in response to federal mandates and requirements. Almost everyone, however, believes that situation would have changed radically if the Medicaid block grant had been enacted, as Medicaid would have become a zero-sum game. It is widely believed that the elderly would do well in such a world, in part because of the nursing home industry’s influence and in part because the elderly are a politically favored group.

With the long-term care population, there is a significant amount of cooperation and strategic unity between advocacy groups for the elderly and younger persons with disabilities. In some states, however, there is tension over perceived inequity in resource allocation.
In California there is a perception among some that younger persons with disabilities have been more successful than the elderly have been in their lobbying efforts. In Florida some feel that the elderly dominate social services because they represent such a large percentage of the population. Elderly and disabled groups in Wisconsin recently have worked together successfully to increase funding for home and community-based services, but in the past there has been tension over a decline in the share of home and community-based care funds spent on the elderly. This led to the establishment in law of minimum percentages for each target group.

In general, there is not much conflict for resources between nursing homes and home care providers, but the potential for competition for resources is greater in states with more-developed home care systems. This is particularly true in Massachusetts, Texas, and Wisconsin, where home care advocates have sought to reduce nursing home expenditures and shift the money to noninstitutional services. Nursing home providers in these states have been vocal in questioning the cost-effectiveness of community-based services.

Conclusions

There is enormous variation in states’ policies on long-term care for the elderly. Private long-term care insurance has been heralded by some as a potential fix for rising Medicaid long-term care spending; however, only two ANF states seem seriously committed to this strategy. And while most states believe that “Medicaid estate planning” is a problem, it is a major policy concern in only a few ANF states. Finally, some states are increasing federal contributions through effective Medicare maximization, but this strategy simply shifts costs to the federal government.

In a more ambitious approach, almost all of the ANF states are looking to managed care and the integration of acute and long-term care services as a way to reduce spending. However, progress on these initiatives has been slow, in part because Medicaid and, often, Medicare waivers are needed for their implementation.

All of the ANF states express a policy commitment to expanding home and community-based care for the elderly; however, the recent growth in Medicaid home care has been mostly for younger persons with disabilities. In fact, all but a few ANF states spend the vast majority of Medicaid long-term care dollars for the elderly on institutional care. To achieve cost savings, states will have to keep per person costs down and limit the woodwork effect. Finally, several states are debating what role the sizable stock of nonmedical residential care facilities should have.

In the short run, states are likely to rely on traditional strategies...
to reduce long-term care spending. However, this does not address the underlying demographics of an aging population. With the repeal of the Boren amendment in the 1997 BBA, states will have much greater legal freedom to impose rate cuts on nursing homes. Yet doing so may still be very difficult, since the for-profit nursing home industry is powerful at the state level. Moreover, to the extent that these cuts are believed to affect nursing home residents adversely, elderly advocacy groups will oppose them as well.

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 usually much lower than Medicare and the private sector. Persons receive government help only after depleting most of their assets. 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.

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NOTES
5. Ibid.
7. Unless otherwise noted, all Medicaid data presented in this paper come from Urban Institute analysis of Health Care Financing Administration (HCFA) Forms 64 and 2082 data for 1995.
8. Authors’ estimate based on data from S. Coronel and M. Kitchman, Long Term Care Insurance in 1995 (Washington: Health Insurance Association of America,


11. For example, a person who buys a policy that pays $100,000 in benefits can keep $100,000 in assets and still qualify for Medicaid nursing home benefits.


16. PACE demonstration sites operate as geriatrics-oriented, staff-model HMOs that provide the complete range of acute and long-term care services to persons who meet nursing home admission criteria. Social HMOs extend the traditional HMO concept by adding a modest amount of long term care benefits. They seek to enroll a cross-section of the elderly population in terms of disability levels.

17. HCFA allows states to require dual eligibles to join HMOs but does not allow states to require beneficiaries to receive Medicare services through the HMOs. If beneficiaries choose to receive services outside of the HMO, then either the state or the HMO must pay the applicable deductibles and coinsurance.

18. Although total Medicaid home and community-based service spending has increased significantly in recent years, almost 80 percent of the growth in these expenditures between 1990 and 1995 was for younger persons with disabilities. Authors’ estimate based on Urban Institute calculations.

19. Spending in New York alone accounted for more than 40 percent of all Medicaid home care expenditures for the elderly in 1995 (elderly beneficiaries in New York were almost 10 percent of all elderly Medicaid beneficiaries).

20. E. Kassner and L. Williams, Taking Care of Their Own: State-Funded Home and Community-Based Care Programs for Older Persons (Washington: AARP, 1997).

21. Although data solely on the elderly are not available, home and community-based waiver programs were 75 percent of total Medicaid home care expenditures in Alabama but only 13 percent in Mississippi. Urban Institute calculations based on HCFA Forms 64 and 2082 data.

22. Using these waivers, states can cover a wide range of nonmedical long-term care services. States must target persons at high risk of institutionalization and assure HCFA that the average cost of providing services with the waiver will not exceed that without the waiver. Because of this cost-effectiveness...
requirement, states may provide these services only to a preapproved number of persons, limiting the potential financial liability that would accompany an open-ended entitlement benefit. Under the waiver provisions, services do not have to be offered statewide and can be limited to highly targeted groups of Medicaid eligibles.


28. CON requirements and moratoria affect the number of home health agencies, but they have no impact on the amount of services provided or the number of persons served by a particular agency. Any agency that wishes to expand services greatly can do so. Thus, CON in these instances serves to protect existing providers but is a particularly weak expenditure control.


32. The retention of the “equal access provision,” a clause within the Medicaid legislation requiring states to set payments “consistent with efficiency, economy, and quality of care,” could provide nursing homes with some legal protection, but physicians, home care agencies, and other noninstitutional providers generally have not found this standard to be much help in forcing higher Medicaid reimbursement rates.


34. In two ANF states high-level bureaucrats have become senior officials in the nursing home association or obtained senior management positions in major nursing home chains. There is nothing inherently wrong in that, but it underlines the ongoing personal relationship between state officials and the industry.


36. In Wisconsin the coalition of elderly advocacy groups even had its own MasterCard credit card, the use of which resulted in contributions to the coalition.