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Long-Term Care for the Elderly and State Health Policy

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Long-term care services for older adults represent a substantial share of total health care spending and an area of increasing 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] Importantly, neither private insurance nor Medicare cover long-term care to any significant extent, and less than 5 percent of 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 to pay for long-term care. Medicaid is the dominant source of public financing for long-term care for the elderly, and expenditures are projected to more than double in inflation-adjusted dollars between 1993 and 2018 due to the aging of the population and to price increases in excess of general inflation.[2]

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Because of the high cost of long-term care (a year in a nursing home cost an average of $41,000 in 1995[3]), Medicaid coverage for long-term care provides a safety net for the middle class as well as the poor. Approximately one-third of discharged nursing home residents pay privately when admitted and eventually spend down to Medicaid. In order to be eligible for Medicaid in nursing homes, single individuals must have less than $2,000 in nonhousing assets and must contribute all of their income toward the cost of their care, except for a small personal needs allowance (generally $30 a month). When the institutionalized person is married, the community-based spouse may keep significantly more in income and assets. In 1997, 68 percent of nursing home residents were dependent on Medicaid to finance their care.[4]

This policy brief discusses three broad strategies that states could use to control spending for Medicaid long-term care services for the elderly. An overview of utilization and expenditures associated with long-term care for the elderly provides context for the discussion.

Utilization and Expenditures

Most older adults are free of disability and do not need long-term care. In 1994, 21 percent of the 33 million individuals over age 65 were disabled. Of the 7.1 million elderly who were disabled, almost three-fourths lived at home, usually receiving unpaid care from relatives and friends. In recent years, a growing number

of these individuals have received home care services through Medicaid and Medicare. Approximately one-fourth of older persons with disabilities lived in institutional settings.[5] However, a much greater number—over two-fifths of people who live to age 65—will spend some time in a nursing home before they die. The number of disabled elderly, along with the absolute number of older persons, will increase substantially over the next several decades as the population ages.

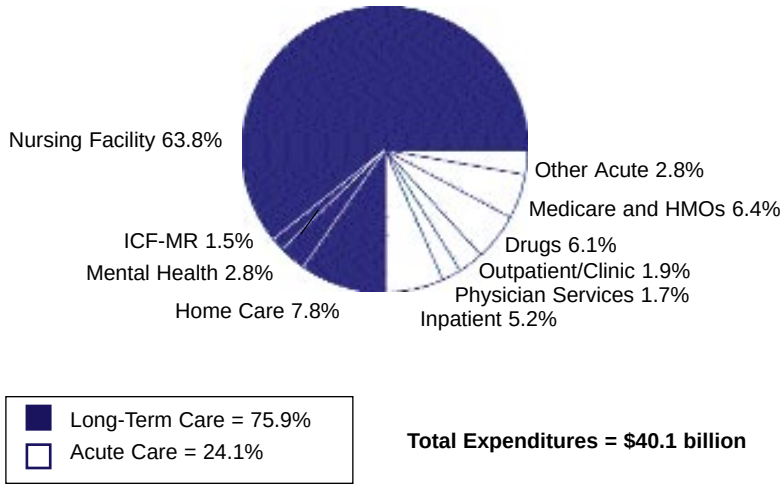
Medicaid and out-of-pocket spending are the primary sources of financing of long-term care for the elderly in the United States. In 1993, Medicaid paid for 35 percent of long-term care for the elderly while older adults and their families paid for 42 percent, whereas Medicare and private insurance paid for 19 percent and less than 1 percent, respectively.[6] Other federal and state spending accounted for almost 4 percent of long-term care spending. These figures understate the importance of Medicaid because contributions of income by Medicaid beneficiaries toward the cost of care are counted as an out-of-pocket rather than a Medicaid payment.

Almost $54 billion was spent on long-term care for people of all ages by the Medicaid program in 1995, 34 percent of total Medicaid expenditures, and 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, while around 10 percent were for home care services.

Table 1 shows Medicaid long-term care spending on the elderly for each state, spending per elderly beneficiary and resident, and the proportion of expenditures by type of service. There is considerable variation across states. Per elderly beneficiary spending for long-term care ranges from a low of $3,593 in Mississippi to a high of $19,406 in the District of Columbia. The proportion of long-term care spending for the elderly for nursing facilities ranges from 58.7 percent in Oregon to 98.6 percent in Mississippi. These same states were also the extremes in the proportion of spending for Medicaid home care. The share spent on home care varied from 0.2 percent in Mississippi to 38.8 percent in Oregon.

Table 2 presents more detailed data for 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 to 16.7 percent for total Medicaid expenditures over the same time period) and has grown more slowly in recent years. More than 40 states reported lower rates of growth for these expenditures for 1993–95 than for 1990–93 (not shown). There is considerable variation among states: Medicaid long-term care expenditures for the elderly grew less than 5 percent annually from 1993 to 1995 in 12 states, while they grew over 10 percent annually in 15 states. The emphasis on institutional care for the elderly mentioned above has not changed in recent years. Recent rates of growth for Medicaid home care spending for the elderly have usually been below rates of growth for nursing facility spending.

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



Source: Urban Institute calculations based on HCFA 2082 and HCFA 64 data.
Does not include disproportionate share hospital payments, administrative costs, accounting adjustments, or the U.S. Territories. Totals may not add due to rounding. "Other Acute" care services include case management, family planning, dental, EPSDT, vision, other practitioners' care, etc. "ICF/MR" refers to intermediate care facilities for the mentally retarded. "Nursing Facility" refers to skilled nursing facilities/other intermediate care facilities.

Strategies to Reduce Long-Term Care Expenditures for the Elderly

If states are to control Medicaid expenditures, they will have to address long-term care for the elderly. Overall, there are three broad strategies that states might use to control spending: bring more outside resources (e.g., private resources and Medicare) into the Medicaid long-term care system to offset state expenditures; reform the delivery system so that care can be provided more cheaply; and reduce Medicaid eligibility, reimbursement, and service coverage.

Strategies to Control Spending: Increase Outside Resources

Bringing additional outside resources into the Medicaid long-term care system could be done in four ways: encouraging private long-term

Table 1: Medicaid Long-Term Care Expenditures by State, 1995
Elderly Beneficiaries, by Type of Service

State	Total Long-Term Care ($ in thousands)	Per Elderly Beneficiary	Per Elderly Resident	Proportion of Long-Term Care Expenditures by Type of Service			
				Nursing Facility	ICF-MR	Mental Health	Home Care
Alabama	$371,497	$5,210	$632	92.0%	0.4%	3.1%	4.5%
Alaska	39,175	8,776	1,641	94.3	0.0	0.0	5.6
Arizona[a]	201,839	8,188	383	84.6	2.3	3.2	9.8
Arkansas	268,337	5,100	839	83.2	0.1	0.0	16.7
California	2,100,690	4,319	620	79.8	3.4	8.4	8.4
Colorado	266,248	7,290	862	89.9	0.1	0.8	9.1
Connecticut	835,759	15,785	1,792	88.0	0.6	1.2	10.2
Delaware	66,787	10,945	836	79.2	2.6	7.7	10.5
District of Columbia	151,695	19,406	2,356	78.6	1.8	16.2	3.3
Florida	1,117,491	5,293	475	94.2	0.6	1.2	4.0
Georgia	417,923	4,023	552	88.4	0.4	2.8	8.4
Hawaii[a]	117,972	6,793	816	94.5	0.2	0.0	5.2
Idaho	73,224	7,842	566	90.1	0.2	0.0	9.8
Illinois	803,594	6,344	581	96.9	0.4	0.2	2.5
Indiana	604,075	9,157	828	94.8	2.8	1.3	1.1
Iowa	230,354	6,141	590	95.8	0.1	0.2	3.9
Kansas	212,452	8,254	697	92.1	1.5	1.0	5.4
Kentucky	346,672	5,484	701	93.3	0.1	0.3	6.3
Louisiana	484,577	4,995	1,080	96.3	1.9	0.2	1.5
Maine	233,822	10,413	1,424	94.1	2.0	0.2	3.7
Maryland	435,324	9,331	721	87.7	0.0	0.3	12.1
Massachusetts	1,302,359	12,872	1,763	92.7	2.3	1.1	4.0
Michigan	934,999	10,859	793	89.9	1.4	4.7	4.0
Minnesota	871,810	15,403	1,817	93.2	1.4	1.8	3.6
Mississippi	239,414	3,593	752	98.6	1.2	0.0	0.2
Missouri	574,465	6,180	808	77.7	1.0	0.6	20.7
Montana	111,270	12,456	917	82.0	0.0	6.0	11.9
Nebraska	184,337	8,881	983	91.6	1.0	0.5	6.9
Nevada	58,505	5,172	314	93.1	0.0	0.4	6.5
New Hampshire	200,747	11,853	1,434	89.5	0.2	4.4	5.9
New Jersey	1,011,315	11,184	1,008	83.7	3.5	2.3	10.5
New Mexico	98,519	5,667	525	91.0	0.2	0.0	8.7
New York	5,702,398	15,354	2,444	66.4	3.2	7.4	23.1
North Carolina	766,499	5,036	854	83.5	1.4	2.0	13.1
North Dakota	106,757	9,893	1,296	86.9	2.7	5.4	5.0
Ohio	1,712,214	10,124	1,232	90.0	2.3	3.1	4.6
Oklahoma	250,866	4,892	605	92.3	1.2	0.5	6.0
Oregon[a]	237,439	6,284	656	58.7	1.0	1.6	38.8
Pennsylvania	2,086,621	12,459	1,202	91.1	2.2	6.2	0.5
Rhode Island	213,086	10,875	1,386	94.2	0.5	0.0	5.3
South Carolina	280,831	3,669	700	78.3	4.5	6.7	10.4
South Dakota	90,268	10,052	987	91.3	1.1	6.2	1.3
Tennessee[a]	509,983	4,463	928	96.5	1.4	0.2	1.8
Texas	1,400,461	4,547	785	76.3	2.5	0.0	21.2
Utah	70,412	7,716	374	95.1	2.5	0.6	1.8
Vermont	71,662	7,107	1,114	91.5	0.9	0.0	7.6
Virginia	452,584	5,302	659	72.4	1.6	11.6	14.4
Washington	483,899	9,111	876	92.7	1.4	0.2	5.7
West Virginia	219,041	6,301	762	95.8	0.3	0.0	3.9
Wisconsin	747,715	11,676	1,418	92.4	2.5	0.7	4.4
Wyoming	43,734	7,382	1,032	90.3	3.2	0.1	6.3
United States	**$30,413,715**	**$7,821**	**$967**	**84.1%**	**2.0%**	**3.6%**	**10.3%**

Source: Urban Institute calculations based on HCFA 64 data.
Does not include disproportionate share hospital 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/other intermediate care facilities.
a. For certain states with active 1115 waivers (Ariz., Hawaii, Oreg., and Tenn.), expenditure and beneficiary data were supplemented with data received directly from the state; adjustments were made to categorize these numbers in the same manner as other states report to HCFA.

Table 2
Medicaid Long-Term Care Expenditures by Type of Service, 1990–1995
Elderly Beneficiaries

	Long-Term Care Expenditures ($ in millions)						Average Annual Growth			
	1990	1991	1992	1993	1994	1995	1990–95	1990–93	1993–95	1994–95
Service										
Nursing Facility	$15,072	$17,449	$20,512	$21,965	$23,723	$25,572	11.2%	13.4%	7.9%	7.8%
ICF-MR	384	471	535	622	662	616	9.9	17.4	-0.5	-7.0
Mental Health	959	1,103	1,326	1,015	960	1,107	2.9	1.9	4.5	15.3
Home Care	1,892	2,193	2,500	2,649	2,933	3,119	10.5	11.9	8.5	6.4
Total	**$18,307**	**$21,216**	**$24,873**	**$26,251**	**$28,278**	**$30,414**	**10.7%**	**12.8%**	**7.6%**	**7.6%**

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/other intermediate care facilities.

care insurance; more strictly enforcing prohibitions against transfer of assets; more aggressively recovering money from the estates of deceased recipients of Medicaid long-term care; and maximizing Medicare payments for long-term care services.

Encourage Purchase of Long-Term Care Insurance

For the middle class Medicaid nursing home population, private long-term care insurance could possibly prevent both their own impoverishment and subsequent Medicaid expenditures. Currently, however, only about 5 percent of the elderly have any type of long-term care insurance, some of which is deficient in terms of coverage. In order to encourage more purchasing of private long-term care insurance, some states offer small tax incentives and others are experimenting with so-called public/private partnerships. Under these partnerships, states apply more generous Medicaid asset standards to individuals who purchase an approved private long-term care insurance policy.

The high price of long-term care insurance explains much of why so few people have policies and why the expansion of this coverage has limited potential for saving Medicaid dollars. A good-quality policy can cost $2,186 a year if purchased at age 65 and much more if purchased at older ages.[7] Most studies have found that only 10 to 20 percent of the elderly can afford private long-term care insurance. Thus, long-term care policies are affordable mostly by people who would not spend down to Medicaid without the insurance. Policies are much more affordable if purchased at younger ages, but very few middle-aged workers are interested in buying policies because they have more pressing expenses.

Prevent Transfer of Assets

Asset transfer is a process by which individuals purposefully divest their assets in order to become eligible for Medicaid benefits. The goal of this transfer—often called Medicaid estate planning—is to appear poor on paper and yet preserve private wealth in the face of long-term care expenses. Congress has legislated against these practices on numerous occasions (most recently in the Balanced Budget Act of 1997). But some argue that the legislative prohibitions are easy to circumvent and that the prevalence of Medicaid estate planning has increased dramatically in recent years.

While it seems likely that an increasing number of persons are transferring their assets, the limited evidence suggests that the numbers are much smaller than commonly thought. A 1993 General Accounting Office (GAO) study in Massachusetts, for example, found that although some Medicaid nursing home applicants did transfer assets, existing rules kept most off the Medicaid rolls.[8] Moreover, older persons cannot transfer large amounts of assets they do not have. Older persons with disabilities, and especially the very old who account for a large majority of nursing home patients, have quite low income and asset levels. In 1989, for example, about three-quarters of nursing home patients had less than $50,000 in non-housing assets at the time of their admission to the nursing home, and almost half had less than $10,000.[9]

Expand Estate Recovery

Since the Omnibus Budget Reconciliation Act of 1993, states have been required to recover the cost of Medicaid long-term care from the estates of beneficiaries who have died. Data from earlier estate recovery programs suggest that they are likely to recoup only a small proportion of long-term care expenditures. According to the Office of the Inspector General of the U.S. Department of Health and Human Services, the amount of money collected by the top 10 estate recovery programs averaged only about 1 percent of Medicaid nursing home expenditures in 1993. Total estate recovery in all states was $124.8 million in 1995, less than half of 1 percent of Medicaid nursing home expenditures for the elderly.[10]

Medicare Maximization

Medicare expenditures for home health and skilled nursing facility (SNF) care have increased dramatically in recent years and now account for almost 15 percent of Medicare expenditures. While Medicare primarily provides short-term, post-

acute care for nursing facility care, its home health benefit has become more long term in recent years.

Some states, including New York, Wisconsin, and Massachusetts, have initiated aggressive "Medicare maximization" efforts in an attempt to reduce Medicaid expenditures for beneficiaries who are eligible for both Medicare and Medicaid. Medicare maximization initiatives attempt to ensure that Medicare rather than Medicaid pays for home health and nursing facility care whenever possible. Medicare maximization programs take the form of provider and consumer education about Medicare benefits, data system improvements to identify dual eligibles and instances of inappropriate billing, and requirements that all home health providers be Medicare as well as Medicaid certified and that they bill Medicare when there is the slightest chance of receiving reimbursement. One recent study of Medicare and Medicaid home care expenditures suggests an inverse relationship between Medicare and Medicaid home care spending.[11]

Strategies to Control Spending: System Reform

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

Integrating Acute and Long-Term Care Services through Managed Care

Older persons who need long-term care services currently encounter a fragmented financing and delivery system.

Financing acute care is largely the province of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state governments. Because of the separation of financial responsibilities, there exists a strong incentive for the federal government to shift costs to the states and vice versa.

There is also lack of coordination in the delivery of services. For example, some elderly patients may remain unnecessarily in expensive acute care hospitals because appropriate long-term care services are not immediately obtainable, appropriate follow-up physician care cannot be arranged, or financing for long-term care is not available. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system. Another argument in favor of integrated systems is that quality of care and consumer satisfaction could be improved because artificial barriers between care providers would be eliminated.

There is increasing interest among policymakers in finding ways to integrate the acute and long-term care sectors, primarily through expanding the role of managed care and capitated payments to include long-term care services. Several demonstration projects are under way to test various approaches to integrating acute and long-term care services. These include Social Health Maintenance Organizations (SHMOs), On Lok and its Program for All-Inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCS). Several states, including Colorado, Maine, Massachusetts, Minnesota, Texas, and Wisconsin, are also undertaking demonstration efforts to coordinate acute and long-term care through use of managed care. However, in response to waiver requests from various states, the Health Care Financing Administration has insisted that enrollment in managed care for individuals dually eligible for Medicaid and Medicare must be voluntary and has not been willing to allow Medicare and Medicaid monies to be combined into a single state-administered capitated payment to managed care organizations.

Although the integration of acute and long-term care services offers the opportunity for improved quality of care, long-term care advocates are concerned with this model for a variety of reasons. First, most managed care providers have little experience with the elderly and the disabled and none with long-term care. Thus, they may not be skilled in providing services to this population. Second, fiscal pressures within an integrated system could shortchange long-term care by shifting funds from long-term care to acute care if providers do not view long-term care as a priority or if acute care overruns its budget. Third, long-term care may become overmedicalized and services less consumer-directed because the balance of power will shift from the individual client and her chosen provider to HMOs, insurance companies, or other administrative entities.

Expand Home and Community-Based Services

Although the expansion of Medicaid home and community-based long-term care services has focused largely on the younger population with disabilities, expanding home and community-based services for older adults is a cost-saving strategy advocated by many. Many states, including Oregon, New York, and Texas, are attempting to create a more balanced delivery system by providing a wide range of home and community-based services. In addition to Medicaid home care expenditures for the elderly (over $3 billion in 1995), $1.2 billion was spent on home and community-based services for older persons through programs funded only with state funds in 1997, most notably in Illinois, Massachusetts, California, and Pennsylvania.[12]

Most states have obtained Medicaid home and community-based service waivers in an attempt to expand noninstitutional services. Regulatory changes implemented by the Clinton administration have made obtaining waivers fairly routine in recent years. Using these waivers, states can cover a wide range of nonmedical long-term care services, including personal care services, adult day care, rehabilitation, and respite care. States must target people at high risk of institutionalization and assure HCFA that, on average, the cost of providing services with the waiver will not exceed the cost without the waiver. States may provide these services only to a preapproved number of people, limiting the potential financial liability that would

accompany an entitlement benefit. After a relatively slow start in the early 1980s, home and community-based waiver expenditures (for the elderly and young people with disabilities) have increased rapidly, from $0.7 billion in 1988 to $4.6 billion in 1995.

Although states hope to save money by substituting lower-cost home and community-based care for more expensive nursing home care, most research suggests that expanding home care is more likely to increase rather than decrease total long-term care costs. The primary reason for this result is what many call the "woodwork effect." While many older persons would forgo paid long-term care services if given only the option of nursing home care, many of these same individuals would use home care services if given the choice. Thus, the costs associated with large increases in home care use could more than offset the relatively small reductions in nursing home use.

Some recent research is more encouraging about the potential cost-effectiveness of home and community-based care. For instance, a 1996 study of Washington, Oregon, and Colorado concluded that the expansion of home and community-based services was a cost-effective alternative to institutional care in these states.[13] A 1994 study drew similar conclusions about the expansion of home and community-based services in Washington, Oregon, and Wisconsin.[14]

Strategies to Control Spending: Cuts in Eligibility, Reimbursement, Services, and Quality

If states do not succeed in substantially reducing the rate of increase in long-term care expenditures through increasing outside resources or through delivery system reform, states can still use a number of more conventional mechanisms such as cuts in eligibility, reimbursement, and covered services. Existing federal law gives states considerable flexibility in these areas, including setting reimbursement rates and controlling the supply of nursing home beds.

Table 3
Average Medicaid Rates
for Nursing Facility Reimbursement by State, 1995

State	Per Diem Rates	State	Per Diem Rates
Alabama	$71.91	Nebraska	$62.03
Alaska	315.20	Nevada	67.21
Arizona	NA	New Hampshire	98.74
Arkansas	58.02	New Jersey	114.64
California	88.99	New Mexico	79.10
Colorado	78.08	New York	157.25
Connecticut	125.00	North Carolina	79.91
Delaware	87.35	North Dakota	76.27
Florida	83.54	Ohio	86.55
Georgia	71.11	Oklahoma	52.50
Hawaii	134.82	Oregon	76.00
Idaho	73.24	Pennsylvania	76.09
Illinois	70.41	Rhode Island	94.00
Indiana	64.93	South Carolina	68.78
Iowa	60.12	South Dakota	68.46
Kansas	60.08	Tennessee	49.97
Kentucky	69.24	Texas	56.17
Louisiana	71.24	Utah	74.24
Maine	96.30	Vermont	92.24
Maryland	78.10	Virginia	63.57
Massachusetts	94.25	Washington	92.35
Michigan	67.54	Washington, D.C.	125.46
Minnesota	88.21	West Virginia	76.97
Mississippi	59.01	Wisconsin	85.73
Missouri	58.57	Wyoming	73.31
Montana	79.57	**U.S. Average**	**$85.05**

Source: HCFA Office of Long-Term Care, Medicaid Bureau. Rates as of 3/31/95.

Cut Reimbursement Rates

Since the Omnibus Reconciliation Act of 1980, the "Boren Amendment" governed how states have reimbursed nursing homes until its recent repeal. This 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." As can be seen in table 3, there is considerable variation in how much states pay for nursing home reimbursement. (An important caveat in comparing state rates is whether or not they include ancillary services, such as physical therapy.) While some of this variation reflects different levels of service provision, it might also indicate real differences in how generous (or frugal) states are in nursing home reimbursement.

With repeal of the Boren Amendment as part of the Balanced Budget Act of 1997, states will have almost complete freedom in setting nursing home payment rates. Opponents of the Boren Amendment argued that courts forced the states to spend too much on nursing home care and to go far beyond the minimal standard embodied in the statute. However, even with the repeal of the Boren Amendment, the political power of the nursing home lobby at the state level may prevent rates from being reduced very much.

The problem with repealing the reimbursement standards is that Medicaid nursing home payment rates are already fairly low in most states, especially in comparison to Medicare and private pay rates. Not surprisingly, nursing homes often prefer higher-paying private pay to Medicaid residents, which can result in problems of access for Medicaid

beneficiaries. To the extent that states cut Medicaid reimbursement rates and the payment differential between private pay and Medicaid patients widens, access problems could worsen for Medicaid beneficiaries. However, there is a limit to how much nursing homes can avoid Medicaid residents, since Medicaid represents such a large portion of most nursing home budgets. In addition, while there is little evidence of a simple relationship between cost and quality, some are concerned that repeal of the Boren Amendment could result in payment rates below the level necessary to maintain adequate quality of care in nursing homes.

Stop New Construction of Nursing Home Beds

Another strategy for controlling Medicaid costs is to prohibit new construction of nursing home beds on the assumption that they would likely be filled with Medicaid residents. As of 1995, 17 states had such a moratorium on new construction of nursing homes. However, there are three problems with this strategy. First, the care needs of the elderly do not disappear just because there are no nursing home beds available. To the extent that these needs are met by home care and other services, Medicaid savings will be reduced. Second, nursing home bed/population ratios have already fallen substantially. The number of nursing home beds per 1,000 elderly 85 and over fell by 18 percent between 1978 and 1994, although the situation varies across the states.[15] It is unclear how far supply levels can fall without causing hospital backlogs and other problems. Third, the strategy of freezing bed supply does not address the underlying demographic reality that the United States is an aging society. Limiting the supply of nursing home beds might have value in the short term but could cause other problems as a long-term strategy.

Conclusions

Although the rate of growth for Medicaid long-term care expenditures for the elderly has slowed since 1993, spending on these services still represents a substantial proportion of total Medicaid expenditures. And the aging of the population guarantees greater future need for long-term care. For both these reasons, state policymakers have sought to reduce the rate of growth in these expenditures through reform in the organization and delivery of long-term care services as well as through coverage and benefit decisions.

In the short run, states are likely to turn to more traditional strategies to reduce spending such as reducing reimbursement rates to nursing homes, especially with repeal of the Boren Amendment. Although states have considerable flexibility to reduce long-term care spending through rate cuts, eligibility determinations, and benefit decisions, these cuts could potentially have a negative impact on quality of care and access to long-term care services for the elderly. If states maintain current levels of access and quality, they eventually will need to utilize other cost-saving strategies, such as increasing the amount of outside resources used to finance Medicaid long-term care, coordinating acute and long-term care through use of managed care, and expanding home and community-based care. It is uncertain how much reforms could reduce spending in the short or long term, but there are some encouraging developments in the integration of acute and long-term care and in creative home and community-based programs. States will seek to build on the promise of these findings as they attempt to reform Medicaid long-term care and to contain spending.

Notes

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