State Policy on Long-Term Care for the Elderly

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In 13 states included in the Assessing the New Federalism project, strategies to control the rate of increase in long-term care spending are extremely varied. 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, such as controlling nursing home bed supply and cutting Medicaid reimbursement rates.

Long-term health care for older adults is a critical component of Wisconsin's health care system and plays a major role in its Medicaid program. The increasing number of older adults in the United States and the continuing higher costs of health care have caused Wisconsin and all states to look seriously at ways to curb spending on long-term care services for the elderly (see Table 1). Neither private insurance nor Medicare has been likely to cover long-term care, and few older adults carry private long-term care insurance. As a result, in 1995, nursing home and home health care accounted for 12% of all personal health costs and 14% of all state and local health care spending nationwide (Levit, Lazenby, Braden, Cowan, & McDonnell, 1996). Wisconsin has higher percentages both of older adults and Medicaid beneficiaries than the national average, and spent a much higher proportion of Medicaid expenses on long-term elderly care than most other states—31% of all non–disproportionate share hospital (DSH) Medicaid expenses in 1995, or a total of $750 million (Wiener & Stevenson, 1998).

Most older adults who are disabled must rely on their own resources until they are depleted. Then, even middle-income people who have exhausted their savings turn to Medicaid or state-funded programs to pay for long-term care, at an average cost of $46,000 for a single year of nursing home care. In 1997, more than two thirds of nursing home residents depended on Medicaid to pay for at least some of their care (American Health Care Association, 1997). Medicaid long-term care expenses for older adults, when adjusted for inflation, are projected to more than double nationwide between 1993 and 2018. Wisconsin is a national leader in innovative home and community-based services. Still, in 1995, 96% of Medicaid funds went to institutional care, whereas only 4% went for home and community-based services. Because Wisconsin counties control a large portion of long-term care funds, local officials have a large influence over policy and resource allocation. This means there is great variation in services from county to county.

Wisconsin spent a much higher proportion of Medicaid expenses on long-term elderly care than most other states.

This study is part of the Urban Institute's Assessing the New Federalism (ANF) project, which has analyzed state health, income support, and social service pro-

grams for low-income residents in 13 states. Together, these states account for more than half of all Medicaid spending in the United States for long-term elderly care.

Table 1. Medicaid Long-Term Care Expenditures for Elderly Beneficiaries in Thirteen States, by State and Type of Service, 1995

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

Note. The data do not include disproportionate-share hospital (DSH) payments, administrative costs, accounting adjustments, or spending in the U.S. Territories. The totals may not add because of rounding. "Nursing facility" refers to skilled nursing facilities and intermediate care facilities. The table was compiled from Urban Institute calculations based on Health Care Financing Administration (HCFA) Form 64 data, which were prepared for the Kaiser Commission on the Future of Medicaid.

[a]Intermediate care facility for the mentally retarded.

Strategies to Control Long-Term Care Spending

The 13 states in the study use three very different strategies to control long-term care spending: (a) offsetting state spending for long-term care with increased private and Medicare contributions; (b) reforming the delivery system for more efficient care delivery; and (c) using traditional cost-control mechanisms, such as controlling nursing home bed supply and cutting Medicaid reimbursement rates. Each state in the study varies in how much they use each strategy and in how far they have gone in creating substantial reform.

Increased Private and Federal Resources

States use several strategies to add private and federal resources to the long-term care financing system.

Encourage private long-term care insurance. Private long-term care insurance could prevent both impoverishment and state Medicaid spending for many middle-class nursing home residents. However, only 6% of older adults have this type of insurance because of its high cost. One option with potential for making private insurance more affordable is to offer long-term care policies through employers to large numbers of younger persons. This would allow families, in effect, to purchase group insurance. Group rates are always lower than individual rates and may make this type of insurance more affordable for some families. If employers sponsor but do not help pay for private insurance, Medicaid expenditures could decline as much as 31% and the number of nursing home residents could fall by as much as 17% by the year 2018. For this method to work, however, the employer-sponsored market must dramatically increase because less than one tenth of 1% of middle-aged people currently have long-term care insurance. In addition, most middle-aged workers have more pressing expenses, such as mortgages, children's educations, and child care.

California and New York have established public-private partnerships to promote the purchase of private long-term care insurance. These states allow people who buy state-approved policies to keep more assets than normally allowed to qualify for Medicaid. California consumers can buy a level of private coverage equal to the assets they wish to protect. New York residents can protect an unlimited amount of assets by purchasing 3 years of long-term care coverage. So far, however, these incentives have failed. The California and New York efforts have spurred a total of fewer than 17,000 policy purchases. Yet, both states are committed to expanded efforts.

Offering long-term care policies through employers would allow families to purchase group insurance.

Whereas Wisconsin says it supports the idea of private long-term insurance, it has done relatively little to promote it. A never-enacted proposal in the 1980s would have provided public-private partnerships to encourage purchase of insurance. Currently, private long-term insurance is offered to state employees.

Reduce Medicaid estate planning. Policymakers and the media have focused attention on middle-class and wealthy people who transfer, shelter, and underreport assets, so-called "Medicaid estate planning," to appear poor enough to ualify for Medicaid-financed nursing home care. Congress has attempted to decrease this practice through legislation, but some argue these laws are easy to get around.

Three states in the study—Massachusetts, New Jersey, and New York—identified this problem as a major public policy issue. In New York, state officials believe that reducing asset transfer is critical to motivating people to purchase long-

term care insurance policies and ultimately viewing long-term care as a private, rather than public, responsibility.

Wisconsin's estate recovery program recoups Medicaid expenses for long-term care from the estates of deceased Medicaid beneficiaries. Estate recovery increased from $471,000 in 1991–92 to more than $9.7 million in 1995–96, making Wisconsin's program one of the country's most effective.

Maximize Medicare financing. States have long tried to shift Medicaid long-term care expenses to Medicare, which essentially shifts costs from the state to the federal government. These efforts, however, have been stopped by the narrow range of Medicare coverage for nursing home and home health care. This situation has changed since the late 1980s, when Medicare coverage rules were changed, making benefits more oriented toward long-term care. Some states have responded by initiating "Medicare maximization" efforts to ensure that Medicare pays for home health and nursing facility care whenever possible. These efforts center around educating providers and consumers about Medicare benefits, improving the data system to identify inappropriate billing, finding people eligible for both Medicare and Medicaid, and billing Medicare whenever there is a chance of reimbursement.

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Despite the perceived benefits associated with shifting expenses, these strategies can pose problems. In Wisconsin, which actively pursues Medicare maximization, agencies struggle with extensive audits of home health agency payments and directives for billing Medicare first. Home health agencies say this mandate subjects them to Medicare penalties if too many claims are submitted and then rejected. Retrospective audits also sometimes come after the Medicare window for billing has closed.

Incentives for Medicare maximization also depend on how similar the payment rates are for Medicaid and Medicare. For example, some states say Medicaid rates are so low that economic incentives, not policy, drive providers to seek Medicare payments when possible.

System Reform

A second general strategy for saving money is reorganizing health care delivery in ways that make care more effective and efficient. Two ways to accomplish this are by extending managed care to include long-term care and by expanding home care and non-medical, residential long-term care services.

Integrate acute and long-term care services through managed care. Older adults who need long-term care currently encounter fragmented financing and delivery. Financing acute care, mainly physician and hospital care, is primarily the responsibility of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state government. Because of the separation, there is a strong incentive for each level of government to try to shift costs to the other. A

lack of coordination in delivery is another problem that can result in higher costs. For example, some nursing home residents are unnecessarily discharged to a hospital because adequate physician services are not available in the facility.

State policymakers hope that integrating acute and long-term care through managed care can result in better-quality care and lower costs by substituting home-based care for inpatient care. They also hope to save money by shifting costs to Medicare for people who are eligible for both programs. Some states, including Wisconsin, are deliberately reducing the number of providers so officials can focus on setting contract standards and monitoring performance. A final goal of expanding managed care is to make state spending more predictable by setting per-person rates that shift much of the financial risk from the government to providers.

Although integrating acute and long-term care could improve quality of care, long-term care advocates have some major concerns. One is that HMOs and other managed care providers have little experience with older adults and none with older adults who are disabled. Another concern is that financial pressures will end up shortchanging long-term care. Finally, there is a fear that long-term care will become more focused on medical care and less consumer-directed because the balance of power would shift from individuals and their chosen provider to HMOs, insurance companies, and administrators.

Expand home and community-based services. Policymakers in all 13 states support expanding home care and creating more balanced delivery systems. However, nationwide only 10% of Medicaid long-term elderly care expenses went for home care in 1995. Medicaid home and community-based service spending has increased significantly in recent years, but most of the growth has been for younger persons with disabilities. Some states that have implemented home and community care expansion have chosen to use Medicaid waivers, which give states greater control over use and eligibility. Wisconsin is among several states that have sizeable state-funded home and community-based care programs. As mentioned earlier, however, the amount of Medicaid money spent on long-term care still overwhelmingly goes to institutional care.

In almost every state, home and community-based services are promoted primarily on the ability to save money, although meeting unmet needs and responding to consumer preferences also are important. Most research, however, predicts a rise in total long-term health costs as large increases in the use of home care more than offset small reductions in nursing home use. The "woodwork effect" is that although many older people would forego paid long-term care if the only option is nursing home care, many of these same people would come out of the woodwork to use home care services if given the choice. However, a 1996 study of Washington, Oregon, and Colorado found that home and community-based services were cost-effective alternatives to institutional care in those states (Alecxih, Lutzky, & Corea, 1996). As the commitment to community care in-

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creases, some in the nursing home industry have questioned the cost effectiveness of these services. Wisconsin proponents of community care say the statewide decline in stays at Medicaid nursing homes is a sign of success. Others caution against reading too much into the declines because of other possible influences.

All states in the study are exploring the possibility of residential alternatives to nursing home care. Some states finance the "care" part of residential facilities through their Medicaid home and community-based waivers, or through a combination of state and Supplemental Security Income (SSI) funds. The states hope to provide services that are more homelike, provide greater personal independence, and cost less than nursing homes. The nursing home industry argues that its residents are too disabled to be served adequately in these alternative settings, although in Wisconsin and other states, the nursing home industry is expanding into nonmedical residential facilities.

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Difficult issues come with these alternatives. States struggle over how to combine the new concepts of consumer-oriented, homelike care with a large existing stock of nonmedical residential facilities that do not necessarily share this ideology. Another major issue is how to regulate these facilities so people can "age in place," without making these facilities into substandard nursing homes. Federal state regulatory structures work on the concept of a continuum of care, where people must move from level to level as they become more disabled. However, the notion
of letting people age in place means bringing services to them in the place they live. Wisconsin has adopted detailed regulations for community-based residential facilities, which are limited to people without severe disabilities. Yet, the state has adopted very little regulation for assisted-living facilities, even though it allows these facilities to serve disabled people needing up to 28 hours of care a week.

Finally, states want to know how to make new residential options available to moderate- and lower-income older adults. Except for those in Oregon, most assisted-living facilities are geared to upper-income people. Wisconsin is among the states where critics say middle-class people exhaust their private resources paying for care in residential facilities, then apply to nursing homes as Medicaid recipients.

Traditional cost-control strategies

If states are not successful in reducing costs of long-term care through increasing outside resources or delivery system reform, federal law still allows quite a bit of flexibility in conventional cost-saving methods, such as controlling the supply of providers and lowering reimbursement rates.

Control the supply of providers. Many states have responded to rising Medicaid long-term care spending by limiting the number of providers, particularly at nursing homes, where a majority of beds are likely to be filled with Medicaid recipients. A strategy used by many states, including Wisconsin, is to place a moratorium on more beds for Medicaid participation. However, Wisconsin still has more nursing home beds per 1,000 older adults than most states, and no moratorium for

residential long-term care facilities. Although limiting nursing home supply can control spending in the short term, the care needs of older adults do not disappear just because the supply is limited. Some observers argue that access to nursing home care can be difficult, especially in rural areas.

Lower reimbursement rates. Medicaid payment rates for nursing home care are a logical target for states trying to reduce their rate of long-term care spending because cutting rates results in predictable, immediate, and potentially large savings. Reimbursement rates were targeted for savings in almost all states studied. Savings proposals include reducing ceilings on payment levels; curbing administrative costs; and changing from facility-specific, cost-based reimbursement to case-mix-adjusted, flat-rate systems. A Minnesota demonstration project had 120 nursing facilities agree to freeze rates in exchange for waiver of certain state regulations.

From 1980 to 1997, states set Medicaid payment rates at whatever level they chose for home and community-based care. However, they met a minimum standard for nursing home and hospital reimbursement under the Boren Amendment, which required that Medicaid nursing home 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 law was supposed to relax previous standards, many states said they had difficulty meeting the standard. State Medicaid officials opposed the Boren Amendment, saying they spent too much on nursing homes and courts forced them to go beyond the minimal language of the law. In Wisconsin, advocacy groups also supported repeal of the Boren Amendment, seeing it as an opportunity to shift money from nursing home care to home care.

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With the repeal of the Boren Amendment in 1997, states have almost complete freedom in setting nursing home payment rates. The problem with repealing the standard is that Medicaid nursing home payment rates already are low, and access to nursing home care could be a problem for Medicaid recipients as the payment differential between private-pay and Medicaid patients widens. Because few nursing homes could survive completely independent of Medicaid recipients, the extent to which facilities can restrict access is somewhat limited. In addition, although there is not a simple relationship between cost and quality, there is probably some level of reimbursement below which it is impossible to provide quality care. Although care in nursing homes has improved nationwide over the past 20 years, advocates for nursing home residents remain concerned about quality issues.

Resource Allocation and Politics

State politics play a major role in long-term care reform efforts. Players in the political landscape include the nursing home industry, home health care groups, and consumer groups focused on the rights of the elderly and younger

people with disabilities. The for-profit nursing home industry is the strongest health lobby on Medicaid issues in all states studied, largely because nursing homes are far more focused on Medicaid and state policy than other provider groups and are much more dependent on Medicaid revenue than are hospitals or physicians. Because nursing homes are so focused on state policy, they meet frequently with state officials and develop strong personal ties. The nurs-ing home industry also is well financed to afford lobbyists, make contributions to political campaigns, and commission studies that support its positions. However, states are still not always willing or able to fund higher rates for nursing homes. Quality concerns and reports of fraud and abuse also have damaged the industry's image.

In addition, there are other players on the long-term care stage, includ-ing home care associations and advocacy groups for people with disabling conditions. In Wisconsin, elderly advocacy groups are relatively well organized and financed.

Conclusions

States vary greatly in their policies regarding long-term care for older adults. Private, long-term care insurance has been heralded as a poten-tial fix for rising Medicaid long-term care spending. However, only 2 of the 13 states studied seem seriously committed to this strategy. Although most states believe Medicaid estate planning is a major problem, only a few states have tried to address it through public policy. Wisconsin's estate recovery program has been one of the country's most effective. Some states are increasing federal contributions through effective Medicare maximization, but this strategy simply shifts costs from state to federal government.

A more ambitious approach being discussed in almost every state studied is using managed care to integrate acute and long-term care services. Progress has been slow, in part because Medicaid and Medicare waivers often are needed for implementation.

To save money, states must keep per-person costs down and limit the wood-work effect.

All states in the study have committed to expanding home and community-based care for older adults. However, most Medicaid home care growth seen recently has focused on younger people with disabilities. In fact, most states, including Wisconsin, spend a significant proportion of Medicaid long-term dollars on institutional care for older adults. To save money, states must keep per-person costs down and limit the woodwork effect. Several states continue to look at what role the sizable number of nonmedical residential care facilities should play in cost-saving efforts.

In the short term, states tend to rely on traditional cost-saving strategies. However, this approach does not address the increasing number of aging adults in this country. With the repeal of the Boren Amendment in 1997, states have had much greater legal freedom to impose rate cuts on nursing homes. Yet, cutting rates may still be difficult because the for-profit nursing home industry is powerful at

the state level. Also, advocacy groups working with older adults oppose rate cuts, believing that they will have a negative effect on quality of care. Although all states complain about the high costs of long-term care for older adults, 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. People receive government help only after going through their own assets. Finally, the focus on institutional care assures that people with the most severe disabilities who do not have family supports are most likely to use the care. In this current system, it is difficult to find further ways to cut spending.

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