Making Medicaid Work
FOR THE 21ST CENTURY

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Improving Long-Term Services and Supports

Medicaid is a significant payer of long-term services and supports for low-income frail elders and adults and children with physical disabilities and injuries, mental retardation, developmental disabilities, and HIV/AIDS. Total Medicaid spending reached $243.5 billion in 2003, and long-term services and supports accounted for $83.8 billion or 33 percent of that total. Institutional services provided in nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR) account for the largest share of long-term care spending, $57.1 billion, while community services account for $26.7 billion.[1] Community services include personal care and home health services that are delivered through the state plan and home and community-based waiver services.

Despite consumer preference for community-based long-term care, Medicaid spending and policy is biased toward institutional services and has been since coverage of care in nursing homes was added to Medicaid in 1967. At that time, Medicaid law required all state Medicaid programs to cover nursing home services as a condition of receiving federal matching funds. More flexible policies were passed in 1981, when Congress authorized coverage of non-medical services in the community for people who meet a state's criteria for admission to a nursing facility or ICF-MR. Nevertheless, a state must obtain and maintain a federal waiver to offer community-based services, and federal law continues to require that all Medicaid programs provide institutional care. As a result, state and local policymakers face many challenges as they attempt to create balanced, long-term care systems that offer beneficiaries access to an array of high quality service choices.

Current Policies

While the majority of Medicaid long-term care spending pays for institutional care, the balance is shifting towards community-based services. Between 1995 and 2002, spending for community services increased 173 percent while institutional spending rose 43 percent.[2] Increased spending for community care has been accompanied by a reduction in nursing home occupancy rates. An analysis of occupancy trends from 1987 to 1996 by the Agency for Health Care Policy and Research suggests that home and community-based services, including personal care and assisted living, provide alternatives that enable people with functional impairments to avoid nursing homes.[3]

Consumer preferences for community care and state goals to meet these preferences and control costs have produced significant shifts in state policy. Increasingly states are combining the financing and organization of long-term care delivery systems to shift funds from nursing homes to community services.[4] States are also using multiple strategies to create more balanced systems, including limiting the supply of nursing home beds, downsizing or closing institutions for the mentally retarded, expanding home and community-based services, re-organizing state agencies to centralize responsibilities for allocating resources, creating single entry point delivery systems, and increasing coverage for services in residential settings.[5]

How the Current System Can Be Improved

As part of the Making Medicaid Work for the 21st Century project, a subgroup on long-term care issues discussed four principles to guide its deliberations:

1. Long-term care benefits should be designed to provide access to a full array of health and supportive services (community-based, residential, and institutional) to meet the needs of covered populations.

2. Services should be integrated and coordinated through access points.

3. Community services should be organized around consumer needs and preferences.

4. Quality assurance and quality improvement should be included in the design of the program.

Selected Options for Improvement

Workgroup members agreed that Medicaid successfully meets the long-term care needs of many people in the United States. They also agreed that certain aspects of Medicaid's delivery of long-term care services and supports could be improved to the benefit of both beneficiaries and states. Accordingly, the workgroup examined several strategies to facilitate consumers' access to community-based long-term care. In its discussions, the workgroup considered the trade-offs between guaranteed coverage of services and states' ability to manage access and spending. The group's final recommendations are designed to create an environment that responds to consumer preferences for community care, simplifies the eligibility process, and creates organizational structures that are easily recognized and provide seamless access to a full range of services and programs. Among the issues the workgroup examined:

Revising the eligibility process for Medicaid financed community-based long-term care. When determining eligibility, Medicaid now considers an applicant's income and assets separately. Some people whose incomes are low enough to qualify for Medicaid have assets that exceed eligibility thresholds. These people will not receive Medicaid acute or long-term care coverage. They are also unlikely to purchase community (and sometimes acute) care on their own because those with incomes low enough to qualify for Medicaid are unlikely to be able to afford such services. As a consequence, their condition is likely to deteriorate to a point where they have no choice but to enter a nursing home, and they are then forced to draw on their assets to pay for the care. Within a short time, they may have depleted their assets and qualified for Medicaid. Although they might still benefit from home and community-based care, they are now in residence in a nursing home and are unlikely to return to the community. Some workgroup members supported allowing states to modify their income and asset tests to allow those applicants seeking community care who are most likely to use up their resources within a short time of entering a nursing home to qualify for Medicaid financed community care (but not institutional services) while they are still in the community.

Encouraging states to offer community-based services. Currently, states can only offer most community-based services and supports under a waiver which must be periodically renewed and is subject to budget neutrality requirements. Due to these and other issues, states consider the waiver process to be a burdensome one. Additionally, under a waiver, states may only provide community-based care to beneficiaries whose physical or mental conditions

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In the four decades since its inception, the Medicaid program has grown and evolved in dramatic and often unexpected ways. As the program and its costs continue to grow, policymakers have been motivated to consider how Medicaid might be modernized both to contain costs and enhance services. The National Academy for State Health Policy – with funding from the David and Lucile Packard Foundation, AARP, the Agency for Health Care Research and Quality, and the Robert Wood Johnson Foundation – has convened a group of experts with a broad range of experience in the Medicaid program to explore how to make Medicaid work better in the 21st century. The workgroup includes state health and budget directors, legislators, governor's health policy advisors, Medicaid and long-term care directors, as well as advocates, providers, and researchers.

Workgroup participants agree that the Medicaid program should support the health and well-being of low-income populations by prudently managing programs that ensure access to quality health care and support services through a federal-state financial partnership. Accordingly, the group's final recommendations for long-term care are designed to create an environment that responds to consumer preferences for community care, simplifies the eligibility process, and creates organizational structures that are easily recognized and provide seamless access to a full range of services and programs.

are severe enough to qualify them for institutional care. Nevertheless, states find that the waiver authority does offer at least one important benefit: states can limit the number of people served under a waiver. Many consider this the Medicaid program's strongest tool for controlling long-term care costs.

The workgroup developed three potential strategies for making it easier for states to offer community-based services. They are:

1. *Change federal law to create a new optional Medicaid program of "home and community-based services."*

   This program would operate as part of the state plan, but states could establish a limited capacity for enrollment. States that chose to offer this new program would not need to continue to operate under a waiver with its renewal, cost neutrality requirements, and enforced link to institutional eligibility. States would be able to set a higher standard for admission to an institution than for receipt of community care, giving them more flexibility to serve people who are at risk of entering an institution.

2. *Expand scope of personal care under the state plan.*

   Currently, states can choose to cover personal care services by filing an amendment to add this service to the Medicaid state plan. Another option for improving states' ability to offer community-based care would be to expand Medicaid's definition of this existing service to include supports that substitute for or complement direct service (e.g., home modifications, assistive technology, home delivered meals, and other services currently covered under home and community-based services waivers).

3. *Provide incentives to promote community-based care.*

   The workgroup also considered recommending incentives for states to shift the balance away from institutional care and towards community services. These options include creating a higher temporary federal match for states that demonstrate a decline in Medicaid nursing home or ICF-MR use or a shift in the percentage of beneficiaries served in community settings. Another option would simply establish a higher matching rate for all home and community-based services.

This issue brief is one in a series developed by NASHP as part of the Making Medicaid Work for the 21st Century project. The briefs are designed to share with federal and state policymakers, as well as other stakeholders, the issues and options raised by the project's workgroup. A final NASHP report will describe many of the options and recommendations for improvement that have been considered by the workgroup. Although the funders of this project have generously supported its work, the opinions contained in these briefs are not necessarily the views of the funders or of individual workgroup members.

Restructuring the system to improve beneficiary access to a full range of care. Some workgroup members supported other options for easing beneficiary access to appropriate care. Two of these are described here.

1. *Encourage states to create single entry points into long-term care services.*

   Many states already simplify access by designating a local organization (often called a single entry point) to provide Medicaid beneficiaries with information, assistance, and help in determining eligibility and service needs. These entities also typically offer screening and counseling for people who need services, assessment, functional eligibility determination, care plan development and authorization, monitoring, reassessment, and coordination with other community resources. They also often provide case management services for nursing home residents who are interested in moving to the community. Systems without these access points are more fragmented; responsibility for the many tasks they perform may be spread among state agencies, funding sources, and provider organizations. Access agencies provide information and assistance to anyone – including people who are not seeking publicly funded services – who needs help understanding what services are available and how to access them. The workgroup also considered options to encourage those states that do not already have these systems to develop them.

2. *Encourage states to provide assessments to all beneficiaries seeking long-term services and supports to help them determine their needs and how to meet them.*

   Under this option all beneficiaries seeking long-term services and supports would receive an assessment to determine eligibility, identify functional capacities and unmet needs, and develop an appropriate care plan. All applicants would receive information about available service options and assistance accessing them through an appropriate delivery system.

As noted elsewhere, this brief is designed to share with federal and state policymakers, as well as other stakeholders, specific issues and options related to long-term services and supports. A final NASHP report will describe many of the overall options and recommendations for improvement that have been considered by the workgroup.

For updates on this project and a list of advisory group participants and staff, visit the NASHP website at **www.nashp.org**.

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[1]Steve Eiken and Brian Burwell, *Medicaid Long Term Care Expenditures in FY 2003* (Ann Arbor, MI: Medstat, May 25, 2004).

[2]Steve Eiken, Kate Sredl, and Brian Burwell, *Medicaid Long Term Care Expenditures in FY 2002* (Cambridge, MA: Thomson Medstat, May 2003).

[3]Jeffrey A. Rhoades and Nancy A. Krauss, *Nursing Home Trends, 1987-1996* (Rockville, MD: Agency for Health Care Policy and Research, 1999). MEPS Chartbook No. 3. AHCPR Pub. No. 99-0032.

[4]Barbara Coleman, *New Directions for State Long Term Care Systems: Second Edition* (Washington, DC: AARP Public Policy Institute, 1998).

[5]Barbara Coleman, *New Directions for State Long Term Care Systems: Volume I: Overview* (Washington, DC: AARP Public Policy Institute, 1996).

[6]The budget neutrality requirement stipulates that, in their waiver requests, states must demonstrate that they will spend no more federal funds under a waiver than they would without the waiver.