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The Future of Long-Term Care: Medicaid
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Executive Summary

Americans today are living longer than in previous generations, often with chronic conditions and functional impairment at older ages, increasing the number of individuals who will need long-term services and supports (LTSS). The percentage of the "oldest old," or those age 85 and above, is expected to increase over 25 percent by 2030, and LTSS needs are highest among this age group.[1] Most Americans are not effectively prepared for the high likelihood of needing LTSS at some point in their lives. When individuals and families have exhausted their personal resources and can no longer shoulder LTSS costs on their own, they have to depend upon Medicaid for help. Those who qualify for financial assistance through Medicaid for LTSS generally need this support for the rest of their lives.

Medicaid, the federal-state program that provides health care to millions of low-income Americans, is fundamental to the current financing and delivery of LTSS. Of the nearly 70 million individuals enrolled in Medicaid in FY 2011, nearly 6 million were over the age of 65 and almost 11 million were people with disabilities.[2] Individuals age 65 and older represented about eight percent of Medicaid enrollees, but account for 20 percent of all program expenditures.[3] Medicaid paid for over 62 percent of total U.S. spending on LTSS in 2010, representing almost one-third of all Medicaid spending.[4] Slightly more than half (53%) was for institutional care.[4]

This testimony describes Medicaid's critical role as this country's LTSS safety net and describes delivery system and financing opportunities to ensure its continued role to provide person-centered, quality care for low-income Americans with substantial daily needs. Current laws and federal regulations already exist that allow for states to upgrade their operations and administrative structures to create more integrated, beneficiary-protected, and efficient care. Savings generated by delivery system reforms, however, are necessary but insufficient to compensate for what will likely be a net increase in LTSS need in the future. Some states will experience the impact of population aging on their Medicaid LTSS programs faster than others. Policy options are needed to ensure that there is not a growing disparity among states to absorb these costs through already constrained resources, those same resources that face potential cuts as part of a larger entitlement reform discussion.[1]

Medicaid is poised to take on more LTSS costs due to the trifecta of increasing life expectancy, increasing prevalence of chronic conditions and functional limitations at older ages, and low savings rates among baby boomers. American families deserve affordable, accessible, and comprehensive solutions in order to plan for their future LTSS needs without having to spend down to Medicaid. Policy options in the public and private realms should be thoroughly explored to meet these aims so that Americans can receive high-quality services provided with dignity, respect, and transparency.

Introduction

Long-term services and supports (LTSS) is defined as assistance with activities of daily living (ADLs, including bathing, dressing, eating, transferring, walking) and instrumental activities of daily living (IADLs, including meal preparation, money management, house cleaning, medication management, transportation) to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more. LTSS include such things as human assistance, supervision, cueing and standby assistance, assistive technologies, and care and service coordination for people who live in their own home, a residential setting, or an institutional setting such as a nursing facility. LTSS also include supports provided to family members and other unpaid caregivers.[5]

Seventy percent of Americans who reach the age of 65 will need some form of LTSS in their lives for an average of three years.[6] Most individuals desire to receive these services in their homes and communities rather than in an institution, such as a nursing home.[7-9]

The cost of LTSS is substantial, impacting family financial resources and their potential to engage in the labor market. Private market costs of LTSS can far exceed most families' resources, particularly for families of older and disabled Americans.[10,11] In 2011, personal care at home averaged $20 an hour, or about $21,000 annually for part-time help. Adult day care services cost an average of $70 per day, or about $19,000 on an annual basis for five days of services per week. For people who need extensive assistance through nursing home care, the average annual cost is $78,000 for a semi-private room.[12]

When the need for LTSS arises, individuals and families initially finance this care by utilizing their own resources. Families draw on their income and assets, and family caregivers provide a substantial amount of unpaid care. In 2009, nearly 62 million family caregivers in the United States provided care to an adult with LTSS needs at some time during the year. The estimated economic value of their unpaid contributions was approximately $450 billion in 2009, up from an estimated $375 billion in 2007. Businesses in the United States lose up to $33 billion per year in lost productivity from full-time caregiving employees.[13] Private long-term care insurance plays a small role in financing LTSS, as about 6 to 7 million private policies are in force.[4]

When individuals and families have exhausted their resources and can no longer shoulder the costs of LTSS on their own, they reach to Medicaid for help. Individuals who qualify for financial assistance through Medicaid for LTSS generally need this help for the rest of their lives. This testimony will describe Medicaid's critical role as this country's LTSS safety net and describe delivery system and financing opportunities to ensure its continued role to provide person-centered, quality care for low-income Americans with substantial daily needs.

What is Medicaid and How Does it Relate to LTSS?

Overview of the Medicaid Program

Enacted in 1965, Medicaid is the federal-state jointly funded program that provides medical services and LTSS to millions of low-income Americans across the 50 states, the District of Columbia, and the Territories. Title XIX of the Social Security Act (SSA) outlines the operational structure of the program and authorizes funding to states to finance services. The Medicaid program is the responsibility of both the states and the federal government, with states having primary responsibility for how the program is administered. Within national guidelines, each state can establish its own eligibility standards for the program; determine the type, amount, duration, and scope of services that will be provided; and set payment rates for these services. However, Medicaid is an entitlement program, meaning that states must provide certain mandatory services to specified populations in order to receive federal funding. While participation is voluntary, all states in some fashion currently participate in the program and provide these benefits to their residents.[3]

Medicaid financing is a shared responsibility of the federal and state governments. States incur Medicaid costs by making payments to service providers and performing administrative activities and are then reimbursed by the federal government for the "federal share" of these costs. The amount of the federal contribution to Medicaid relative to state dollars is termed the "federal medical assistance percentage" (FMAP) and is determined by a statutory formula set in law that establishes higher FMAPs for states with per capita personal income levels lower than the national average and lower FMAPs for states with per capita personal income levels that are higher than the national average. An FMAP of 50 percent is the statutory minimum. For fiscal year 2012, state FMAPs ranged from 50 percent to 74 percent.[3,14]

As required by Section 1902 of the SSA, each state operates its Medicaid program under a state plan, which describes the populations the state intends to cover as well as the nature and scope of services it plans to offer. Each state plan is subject to the approval of the Centers for Medicare and Medicaid (CMS; the federal agency responsible for the federal portion of Medicaid), and serves as a state's agreement that it will conform to the SSA requirements and the official Medicaid-related issuances from CMS.[15] To qualify for Medicaid coverage, an applicant's income and assets must meet program financial requirements. States are required to serve select groups of individuals, also known as "categorically needy" populations, as part of their state plans. At their discretion, states may choose to cover additional "categorically related" groups beyond those required by law.[3] For the purposes of this document, we will focus on individuals who are included in the following groups:

Categorically needy as defined by law:[3]

- low-income individuals who are age 65 and older, or blind, or under age 65 and disabled who qualify for cash assistance under the Supplemental Security Income (SSI) program.

Categorically related as defined by each state:[3]

- individuals who are ages 65 and over, or blind, or under age 65 and disabled whose income exceeds the SSI level (about 75 percent of the federal poverty level (FPL) nationwide) up to and including 100 percent FPL;
- certain children with disabilities who live at home but need the level of care provided in an institution;
- individuals who are living in institutions (e.g., nursing facilities or other medical institutions) with income up to and including 300 percent of the maximum SSI benefit (about 220 percent FPL); and
- the "medically needy" or individuals in categories selected by the state (e.g., age 65 and above, the disabled, families with dependent children) whose income is too high to qualify as categorically needy.

In addition to covering certain populations, states must also provide certain services as part of their participation in the Medicaid program (See Table 1). These consist of a basic set of mandatory medical care services and institutional LTSS. States may choose to offer optional services, which vary by state, as part of its Medicaid state plan.[16]

Table 1. Examples of Mandatory and Optional Medicaid State Plan Services

Mandatory Service Examples	*Optional Service Example*
• Inpatient hospital services • Outpatient hospital services • Physician services • Nursing facility services for persons age 21 or older • Home health care for persons eligible for skilled nursing services • Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other setting • Rural health clinic services • Laboratory and x-ray services	• Diagnostic services • Clinic services • Rehabilitation and physical therapy • Home- and community-based services to certain persons with functional impairments; • Intermediate care facilities for the intellectually disabled • Nursing facility services for children under age 21 • Transportation services • Hospice care • Targeted case management services • Prescribed drugs and prosthetic devices • Optometrist services and eyeglasses • Dental services

Source: *Office of Retirement and Disability Policy, U.S. Social Security Administration. Annual Statistical Supplement, 2010: Medicaid Program Description and Legislative History. 2010*

States may also apply to CMS to waive certain Medicaid requirements in order to modify their Medicaid programs and implement new approaches in the delivery and payment of services. Medicaid waivers allow states to limit the following elements: services to specific geographic areas; the amount, duration, and scope of services; and the number of individuals served or target services to certain populations. Medicaid waivers also allow federal matching payments to state investments that would otherwise not be matched under existing Medicaid rules. These waiver provisions are codified in several sections of the SSA.[17] Specifically, states can request to waive the following core Medicaid provisions:[17]

> ***Comparability:*** Medicaid benefits must be comparable across the entire eligible population. This provision prohibits states from offering different services to individuals within specific eligibility groups or limiting services based on diagnosis, type of illness, or condition.
>
> ***Statewideness:*** States are generally required to make Medicaid benefits available to all eligible individuals, regardless of their geographic location within the state.
>
> ***Freedom of Choice:*** Medicaid beneficiaries are guaranteed the freedom of choice of providers to ensure access to services.

Medicaid waivers consist of Section 1115 research and demonstration waivers, as well as 1915(b) and 1915(c) program waivers. Section 1115 research and demonstration waivers offer the broadest form of waiver authority that exists and permit the U.S. Secretary for Health and Human Services (HHS) to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid program. Section 1915(b) and 1915(c) program waivers are intended to allow states administrative flexibility to operate their programs while managing costs. Specifically Section 1915(b) waivers permit states to waive the freedom of choice provision and require eligible beneficiaries to receive services from a limited set of providers, a mechanism often implemented using managed care models. Section 1915(b) waivers also allow states to waive comparability and statewideness provisions, affording states the ability to target specific populations in certain parts of the state. Section 1915(c) waivers allow states to provide home- and community-based services (HCBS) to individuals who would otherwise require care in an institutional setting, such as a nursing home. HCBS can include personal care services, homemaker services, case management, environmental modifications, and respite care. Section 1915(c) waivers allow the HHS Secretary to waive comparability and statewideness provisions, waive certain income and asset rules, and allow states to use enrollment caps to limit the number of beneficiaries that can be served by the waiver program.[17]

LTSS and Populations in Medicaid Who Use These Services

As noted above, LTSS services covered by Medicaid include institutional services such as those provided in a nursing facility or intermediate care facilities for the mentally retarded (ICFs/MRs). LTSS that are provided outside of institutional settings, such as nursing homes, over an extended period of

time are referred to collectively as HCBS.[16] Non-institutional LTSS covered by Medicaid include home health, private duty nursing, rehabilitative services, personal care services, Program for All-inclusive Care for the Elderly, and a variety of HCBS provided through Medicaid waivers.[4,18]

Nationally, Medicaid is the primary payer of LTSS for millions of Americans. Of the almost $208 billion in total U.S. spending on LTSS in 2010, Medicaid paid for over 62 percent ($129.3 billion). These payments represent almost one-third of all Medicaid spending. Of Medicaid LTSS spending for FY 2010, slightly more than half (53%) was for institutional care.[4] This proportion of spending on institutional care relative to HCBS varies across states. In FY 2010, the percentage of Medicaid spending that went towards HCBS for older adults and people with disabilities ranged from 62.1 percent in Washington to 12.1 percent in North Dakota.[*],[18]

Of the nearly 70 million individuals enrolled in Medicaid in FY 2011, 10.7 million were people with disabilities and 5.7 million people were over the age of 65.[2] That year, individuals with disabilities represented approximately 15 percent of Medicaid enrollees, but accounted for 41 percent of Medicaid expenditures, the largest share across all groups.[3] Additionally, individuals age 65 and older represented about 8 percent of Medicaid enrollees, but about 20 percent of all program expenditures.[3]

As Americans continue to live longer than in previous generations, often with chronic conditions and functional impairment, the number of individuals needing LTSS is expected to increase. The percentage of the “oldest old” or those age 85 and older is expected to increase by more than 25 percent by 2030 and it is among this population that the LTSS need is most substantial. Approximately 30 percent of those age 85 and older have moderate to severe LTSS needs – three times the proportion among those 75 to 84 years old.[1] Many Americans are not effectively prepared for the likelihood of needing these services at some point in their lives, increasing the potential that the high cost of LTSS will deplete personal resources and leave them to rely on Medicaid to finance these services.

The Medicaid LTSS landscape is highly fragmented, resulting from differing funding streams or authorities. For example, nursing home care is a mandatory state plan benefit but HCBS is not. Additionally, the eligibility criteria, limited capacity, and limited geography of most HCBS offered through waivers restrict equal access. Across the country, there are over 300 Medicaid 1915(c) waivers for HCBS alone.[19] Furthermore, the broader service infrastructure that includes services provided under the Older Americans Act through the Aging Network is not always linked to the Medicaid-funded LTSS. This structure results in fiscal and administrative inefficiencies at the state level. It also forces consumers, particularly those requiring a variety of different services, to navigate a complex maze of programs to receive the care they need. Programs such as Money Follows the Person, which can support individuals who wish to leave an institution and return to the community, as well as care

[*] Selected states with a high penetration of Medicaid managed LTSS are excluded from this figure: Arizona, Florida, Massachusetts, Minnesota, New Mexico, New York, Rhode Island, Tennessee, Texas, Vermont, and Wisconsin.

coordination programs provided through Medicaid waivers and sometimes through state funds or the Aging Network are successful in helping the consumer to navigate the labyrinth of services and cobble together the supports they need to live as independently as possible. However, these programs are small due in part to the intensive nature of the work and the available resources to fund them.

Improving Medicaid LTSS via the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) includes several provisions to improve LTSS provided through Medicaid. First, these provisions seek to rebalance the Medicaid-funded LTSS system in the states toward increased use of HCBS and away from institutional settings. Secondly these provisions seek to improve the operational efficiency of state LTSS systems to plan, implement, and monitor the quality and cost of these services. The goal of these initiatives is to encourage a broader range of available services. However, none are part of the mandatory entitlement and do not fundamentally recalibrate the financial imbalance that currently favors institutional care services over HCBS.

Key ACA provisions to improve Medicaid-funded LTSS include:[20-22]

- ***Community First Choice State Plan Option (CFC):*** CFC is a new Medicaid State Plan option that provides community-based attendant services and supports to those meeting nursing facility eligibility criteria, which includes a six percent FMAP increase.

- ***State Balancing Incentive Payments Program (BIPP):*** BIPP provides enhanced federal matching funds to states that adopt strategies to increase the proportion of their total Medicaid LTSS spending devoted to HCBS and implement delivery system reforms that will increase consumer accessibility to needed services and supports, including: 1) the establishment of a "No Wrong Door— Single Entry Point System" that creates a statewide system of access points for LTSS; 2) adoption of conflict-free case management; and 3) application of core standardized assessment instruments for determining eligibility for non-institutional services and supports used in a uniform manner throughout the state.

- ***Medicaid Home- and Community-Based Services State Plan Option (1915(i*)):** Section 1915(i) of the SSA permits states to both extend HCBS enrollment to individuals with incomes up to 300 percent of SSI and offer the full range of Medicaid benefits to all eligible individuals receiving services through the 1915(i) option. Additionally, the law requires that these benefits be available statewide.

- ***Spousal impoverishment protections for Medicaid HCBS*:** The ACA requires states to apply spousal impoverishment rules to beneficiaries who receive HCBS for a five-year period beginning on January 1, 2014.

- ***Money Follows the Person (MFP):*** MFP helps to facilitate the relocation of eligible individuals receiving ongoing care in institutions back to the community. MFP provides a 75 percent FMAP for HCBS provided to individuals in the first year following relocation from an institution. The ACA reduced the institutional length of stay requirement from six months to 90 days and extended this demonstration through 2016.

- ***Health Homes:*** As of January 2011, states have the option to enroll Medicaid beneficiaries with chronic conditions into a health home to better coordinate care across health care, and potentially LTSS, providers. States who take up this option will receive an enhanced FMAP of 90 percent for two years.

- ***Medicare-Medicaid Coordination Office (MMCO) & Center for Medicare and Medicaid Innovation (CMMI):*** MMCO is a new office within CMS that is working to better align Medicare and Medicaid for those who are eligible for both programs. A primary goal of MMCO is to ensure full access for this population to seamless, high quality health care and to make the system as cost-effective as possible. The CMMI is also another new office within CMS, which was created to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care within Medicare and Medicaid. MMCO and CMMI are partnering to test financial models to support state efforts to coordinate care for individuals eligible for both Medicaid and Medicare.

Special Emphasis on Those Eligible for Medicaid and Medicare

There are over 9 million individuals that are eligible for both Medicaid and Medicare ("dual eligibles").[23] While dual eligibles account for a smaller percentage of enrollees in both programs, they account for a disproportionate share of the costs. Duals represent 15 percent of Medicaid enrollees but account for 39 percent of Medicaid costs.[24] These individuals are universally acknowledged to be an extremely vulnerable and medically fragile group. Thirty-three percent of dual eligibles have one or more of the following chronic conditions – diabetes, stroke, dementia, and/or COPD – that often result in functional limitations and may require the use of personal care and supportive services.[25] They are more likely to have multiple chronic conditions, use more health services, and have higher per capita spending than Medicare-only beneficiaries.[26,27]

While dual eligibles are generally sicker and use more health services and LTSS than Medicare-only beneficiaries, there is still substantial heterogeneity among this population. Dual eligibles are all low-income, but there are both aged and younger disabled populations; 41 percent of dual eligibles are under the age of 65.[28] Approximately 17 percent of dual eligibles live in institutional settings and those who live in the community may or may not use LTSS.[26] Approximately one-third of dual eligibles have a mental illness and 24 percent require help with three or more ADLs.[26] What these data suggest is that the only common element in this population is their eligibility for Medicare and Medicaid. Dual eligibles are a special population with varied health and LTSS needs and they would benefit

substantially from a more person-centered system of care that evaluates their needs in a uniform manner and matches high quality services to their needs and preferences.

For these individuals, the Medicare and Medicaid programs were meant to complement each other, with Medicare covering medical services, while Medicaid provides assistance with Medicare premiums and cost sharing and providing coverage for LTSS. However, misalignments between the two programs often make it challenging for dually eligible individuals to access needed services in a timely and customer-focused manner.[29] Regulatory inconsistencies between Medicare and Medicaid have been articulated and solutions are being sought within CMS. In 2011, MMCO launched its Alignment Initiative, the goal of which is to "to identify and address conflicting requirements between Medicaid and Medicare that potentially create barriers to high quality, seamless and cost-effective care for dual eligible beneficiaries." As part of the Alignment Initiative, MMCO identified 29 "alignment opportunities" in six broad categories: coordinated care, fee-for service benefits, prescription drugs, cost sharing, enrollment and appeals.[29] In May 2011, MMCO published its Opportunities for Alignment list in the Federal Register and made it available for public comment.[30]

Changing Role of States in the Medicaid Program

Across the states, Medicaid programs are evolving from direct payers and operators of services to purchasers of coordinated services.[31] A growing trend in states is to contract with managed care entities and mandatorily enroll Medicaid populations in these plans for their medical services. The proportion of Medicaid beneficiaries enrolled in managed care increased from almost 57 percent in 2001 to 72 percent in 2010 nationwide.[32] As of June 2010, all but three states (Alaska, New Hampshire, and Wyoming) had enrolled at least part of their Medicaid populations in managed care; 29 states have Medicaid managed care penetration higher than the national average.[33] Another more recent and growing trend among states has been to purchase LTSS through managed care plans. As of 2009, 13 states used managed care purchasing strategies to deliver LTSS to their Medicaid beneficiaries, although only a few states broadly employ managed care for all LTSS provisions.[34] In addition, another 11 states recently reported that they are planning for the implementation of managed LTSS.[35]

The establishment of the MMCO and CMMI in the ACA created the infrastructure to better align Medicare and Medicaid for those dually eligible for both programs. Last year, 15 states were awarded design contracts of up to $1 million from CMS to develop new approaches to better integrate the full range of services including primary, acute, rehabilitative, and behavioral health services, as well as LTSS. In addition to those 15 states, another 23 states submitted letters of interest to CMS indicating their intent to develop integration models as well. Of the 38 states indicating interest, 27 states are considering managed care as the vehicle to integrate the full range of medical and supportive services

available through Medicare and Medicaid for the dually eligible population.[36] Already, 13 states among these 38 have submitted proposals for comment at the state/federal levels.[†,36]

While managed care entities and the states that monitor these entities have experience providing quality care for a general Medicaid population, which largely consists of children and women of child-bearing age, this is not the case for serving adults across the age span who have substantial disabilities and require LTSS. As states increase the purchasing of LTSS from managed care entities for their Medicaid populations, states must also increase their quality monitoring and oversight roles of these entities to ensure that beneficiary access and quality protections are incorporated clearly in the managed care contracts and are strictly upheld in practice.[37] States seeking only to solve what they perceive as a cost problem in their Medicaid LTSS programs without giving sufficient attention to improving person-centered access and delivery of care have great potential to create undue harm to some of the country's most vulnerable residents under these new arrangements.

The Need for System Transformation in Medicaid LTSS

Given the opportunities available through the ACA and spurred by the rapid transformation of Medicaid through managed care, states have many opportunities to maximize the value of care delivered to those receiving Medicaid-funded services now and into the future. States will need to transform their LTSS systems in many ways to achieve a sound, person-centered LTSS system for seniors and persons with disabilities. The SCAN Foundation has identified five core elements or "pillars" of system transformation that are building blocks to achieving a more person-centered system. These five pillars of LTSS system transformation are:[38]

- Administrative reorganization;
- Flexible accounting practices;
- Uniform assessment;
- Integrated information systems; and
- Quality measurement and quality assurance.

Currently in many states, multiple departments or agencies have a role in administering LTSS. Similarly, LTSS are funded by multiple siloed funding streams, even among services funded by Medicaid. The result of the fragmented administration and funding streams is an inefficient system that is very difficult for consumers and providers alike to navigate and utilize most appropriately. Furthermore, the siloed funding streams create barriers to establishing a person-centered system for consumers in which they can access the services they need and prefer, which are most often in their

[†] The following states have released their proposal for state (S) comment or have completed their state comment period and have posted their proposal for federal (F) comment: California (S), Illinois (S), Massachusetts (F), Michigan (F), Minnesota (S), New York (S), North Carolina (S), Ohio (S), Oklahoma (S), Oregon (S), Vermont (S), Washington (S), Wisconsin (S).

homes and communities.[39] Solutions include creating more streamlined administrative structures in states, for example having all state staff with management and oversight responsibility for LTSS under one administrative unit. Also, states can utilize flexible accounting practices that seek to allocate existing funding in ways that better respond to the needs of persons who receive LTSS. Flexible accounting practices consist of budgeting practices and contractual language that incentivize the use of less-expensive HCBS, which can result in savings that can be reinvested into the HCBS system to further reduce the use of institutional services. Administrative reorganization and flexible accounting practices are tightly linked to each other given that organizing the administrative and financing activities related to LTSS under one "roof" can create greater efficiencies and reduce the fragmentation that currently plagues state LTSS systems.

A uniform assessment can be defined as a common assessment tool or process to assess an individual's functional capacity and needs that is used across programs and services to guide care planning and resource utilization.[40,41] The value of a uniform assessment is that it enables a process to identify individual needs and preferences, and then connect that individual to the appropriate services that can best meet his or her needs. Furthermore, it provides information about a population of people served across multiple programs to facilitate service planning, resource allocation, and quality monitoring at the person, program, and state levels in a standardized way.

Integrated information systems are the technological framework in which the uniform assessment lives and support the transmission of information from the case manager to the program, county, and/or state levels for purposes of planning, evaluation, and quality monitoring. Uniform assessment and integrated information systems are also tightly linked, as having common ways to evaluate need and preferences across LTSS programs (i.e., uniform assessment) and having a mechanism to share that information at the consumer, program, and state levels can go a long way to better understanding who is served and support quality measurement and monitoring.

Finally, quality measurement and quality assurance is critical to ascertaining the extent to which the system provides services for "the right people, in the right place, at the right time," as well as whether the program or policy achieves intended outcomes. Quality assurance systems require a common measurement approach, a systematic approach to data collection, data systems and analytic processes to interpret measures, and leadership to promote policy/programmatic change. Critical to the establishment of a quality measurement/quality assurance system is both the uniform assessment and integrated information systems, as these provide the vehicles through which a core set of quality indicators can be consistently measured and evaluated. Without uniform assessment and integrated information systems in place, quality efforts may be substantially hamstrung. The inability to develop quality measures that can be used across programs and populations with a common definition derived from common data points creates an incomplete and inconsistent approach to program and policy improvement.

Given the increasing trend in states toward responsibility for oversight and quality assurance, system transformation elements are necessary to ensure high quality and value of service for beneficiaries. States that have implemented some or all of these system features have stronger functioning LTSS systems.[5]

Profiles in State Innovation on Improving LTSS

Several states have taken strides to bolster their Medicaid LTSS systems with the goal of providing high-quality, consumer-focused, and cost-effective care to their residents. These have sought to transform their systems of care through either upgrading the state's traditional fee-for-service model, or opting for a managed care model. The overarching desired outcome from both models is to ensure the most person-centered and effective use of Medicaid LTSS expenditures with an emphasis on improved access to quality HCBS. Below is a description of the lessons learned from some leading states using one of these two service platforms based on analysis completed by the Center for Health Care Strategies.[42]

Rebalancing LTSS using a Fee-For-Service Approach[43]

Four states – Georgia, Oregon, Vermont, and Washington – have succeeded in creating innovative LTSS systems and are pioneers that learned by trial and error how to build and improve their programs. These pioneering states have achieved dramatic shifts away from institutional care and toward the home and community settings that maximize independence and are preferred by most beneficiaries. These four profiled states each have different approaches to rebalancing care toward greater use of community-based services in a variety of geographical and political environments, and in programs initiated in the 1980s as well as those launched more recently. Lessons learned that are described below clarify the key elements that other states seeking to rebalance their LTSS systems should adopt:

1. Communicate a clear vision for LTSS and identify a champion to promote program goals.
2. Bridge the gaps between state officials responsible for medical assistance and LTSS.
3. Engage stakeholders to achieve buy-in and foster smooth program implementation.
4. Embrace a "No Wrong Door" philosophy for all HCBS to help consumers fully understand their options.
5. Deploy case management resources strategically.
6. Use a uniform assessment tool, independent of provider influence, to ensure consistent access to necessary LTSS.
7. Support innovative alternatives to nursing homes.
8. Expand the pool of personal care workers to increase the numbers of beneficiaries in home and community settings.
9. Take advantage of initiatives that help people move out of nursing homes and into the community.
10. Analyze relevant data to track quality of care metrics that reflect the vision of the long-term care program.

Transforming LTSS using a Managed Care Approach[44]

Five innovative states – Arizona, Hawaii, Tennessee, Texas, and Wisconsin – with expertise in managed care approaches for individuals with long-term care needs were identified and lessons learned were gathered through interviews and in-depth site visits. While these featured states each have different approaches to managing the full spectrum of long-term care needs, they are joined by the common vision of providing higher quality and more cost-effective LTSS. These lessons learned illuminate the key elements that states seeking this transformation pathway should adopt:

1. Communicate a clear vision for managed LTSS to promote program goals.
2. Engage stakeholders to achieve buy-in and foster smooth program implementation.
3. Use a uniform assessment tool to ensure consistent access to necessary LTSS.
4. Structure benefits to appropriately incentivize the right care in the right setting at the right time.
5. Include personal attendant care and/or paid family caregivers in the benefit package.
6. Ensure that program design addresses the varied needs of beneficiaries.
7. Recognize that moving from a 1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing and plan accordingly.
8. Develop financial incentives to influence behavior and achieve program goals.
9. Establish robust contractor oversight and monitoring requirements.
10. Recognize that performance measurement is not possible without including LTSS-focused measures.

Considerations for States Integrating Care for Dual Eligibles

As noted above, states are actively considering mechanisms to better integrate care for their dually eligible population with the goal of high-quality, consumer-focused, and cost-effective care. A third state Profile report[45] created in 2010 from interviews with seven states – Arizona, Hawaii, New Mexico, Oregon, Tennessee, Texas, and Vermont – offered guideposts for improved integration of care for dual eligibles. This report offered three strategies that states should consider when deciding what direction to choose for designing integrated programs for dual eligibles based on their current state strengths and capacities:

1. States that have a strong managed care system for medical services, but lack a robust LTSS program, should consider building on their existing managed care system to serve dual eligibles.
2. States that have a strong system for LTSS, but lack a strong managed care system for medical services, should consider broadening their LTSS system to include managed medical services for dual eligibles.

3. States with both a strong medical care system and a strong LTSS program should consider bridging these systems to integrate services.

Considerations to Reinforce the Medicaid LTSS Safety Net

Medicaid is the major payer of LTSS and, without a more comprehensive and affordable mechanism to help people plan for the high cost of care, this reality will remain so. This is increasingly true given the known trends of population aging and the fact that individuals in the highest age brackets have the greatest need for LTSS among all age groups. LTSS costs will also increase over time given historic trends,[46] so the likelihood that all payers – individuals and families as well as Medicaid – can absorb these costs without a policy intervention is minimal.

For LTSS (and medical care), Medicaid is also the payer of last resort. It accepts the responsibility of fulfilling vital daily care needs that are beyond the financial capacity of most American families. Medicaid is also beholden to the outcomes of a Medicare-funded care delivery system that favors acute care episodic services over a person-centered continuum of quality care. There are a number of models and mechanisms to improve the efficiency and effectiveness of state Medicaid LTSS systems while decreasing pressure on federal and state budgets. These solutions generally rest in four interrelated categories:

1. Structural and delivery system reforms in state Medicaid programs;
2. Structural and delivery system reforms that improve the interface between Medicaid and Medicare;
3. Improvements in Medicaid's responsiveness to increasing LTSS need via targeted FMAP enhancements; and
4. Creation of more accessible, affordable, and comprehensive solutions for individuals and families to plan for likely LTSS needs in the future.

Federal and state stakeholders should support the systems transformation efforts articulated in the first two options as long as the goal of creating high-quality, person-centered care is paramount. We believe that coordinated care delivery in state Medicaid LTSS programs, as a standalone effort or part of integrating LTSS with medical care, has great opportunity to meet the illustrious "triple aim" of health care – improved personal experience of care, improved population health, and reduced per capita costs.[47]

While calculating the cost savings that each state can achieve depends upon a number of endogenous and exogenous factors, most states choosing to improve their LTSS systems estimate savings over time usually from an overall reduction of institutionally-based care. However, savings generated by delivery system reforms are necessary but not sufficient to compensate for what will likely be a net increase in LTSS need created by population aging. Some states will experience the impact of population aging on

their state Medicaid LTSS programs faster than others. This situation will create a growing disparity among states to absorb these costs through already constrained resources, those same resources that face potential cuts as part of a larger entitlement reform discussion.[1] Given Medicaid's substantial role in financing LTSS, without policy intervention, these individuals will experience the greatest impact of federal and/or state budget cuts to Medicaid.

Beyond gaining cost savings through state efforts at system transformation and minimizing future cuts to Medicaid, there are federal level policy options to improve Medicaid's responsiveness to increasing LTSS need by making some targeted FMAP enhancements. One option is to provide an enhanced federal match for Medicaid LTSS provided in the community that would be tied to a state's rate of population aging over a defined period of time.[1] This strategy could provide some relief to states that will experience the effects of rapid population aging and its associated impact on LTSS need. A second option is to create an FMAP enhancement that accounts for the intensity of chronic conditions and functional limitations among its Medicaid population. The current FMAP calculation may be appropriate for covering expenditures for a healthier categorical group, but it is potentially insensitive to wide variation of needs and costs for those individuals who have serious chronic illness burden and concordant functional limitation. The current categorical aid codes provide a very limited risk adjustment to states for certainly high use populations, and therefore a more nuanced approach to reimbursing states in accordance with their population characteristics may be merited.

Finally, right now Medicaid is poised to take on more LTSS costs due to the trifecta of increasing life expectancy, increasing prevalence of chronic conditions and functional limitations at older ages, and low savings rates among baby boomers. American families deserve affordable, accessible, and comprehensive solutions in order to plan for their future LTSS needs without having to spend down to Medicaid. Policy options in the public and private realms should be thoroughly explored to meet these aims so that Americans can receive high-quality services provided with dignity, respect, and transparency.

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Appendix

1. AARP: *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers—Fact Sheet*

2. The SCAN Foundation: *DataBrief No. 27: Medicaid Managed Care and Long-Term Services and Supports Spending*

3. The SCAN Foundation: *DataBrief No. 26: Dual Eligibles, Chronic Conditions, and Functional Impairment By Age Group*

4. Center for Health Care Strategies: *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*

5. Georgetown University: *The Importance of Federal Financing to the Nation's Long-Term Care Safety Net*

Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers is the first of its kind: a multi-dimensional approach to measure long-term services and supports (LTSS) system performance at the state level, both overall and along four key dimensions.

Scorecard Purpose: Public policy plays an important role in LTSS systems by establishing who is eligible for assistance, what services are provided, how quality is monitored, and the ways in which family caregivers are supported. Actions of providers, consumers, and other private sector forces also affect state performance, both independently and in conjunction with the public sector. The *Scorecard* is designed to help states improve the performance of their LTSS systems so that older people and adults with disabilities in *all* states can exercise choice and control over their lives, thereby maximizing their independence and well-being.

The *Scorecard* examines state performance across four key dimensions of LTSS system performance:

- Affordability and Access
- Choice of Setting and Provider
- Quality of Life and Quality of Care
- Support for Family Caregivers

Each dimension is composed of 3 to 9 data indicators, for a total of 25 indicators. All 50 states and the District of Columbia were ranked. Overall state rankings, including each state's quartile of performance in each of the four dimensions, are displayed below.

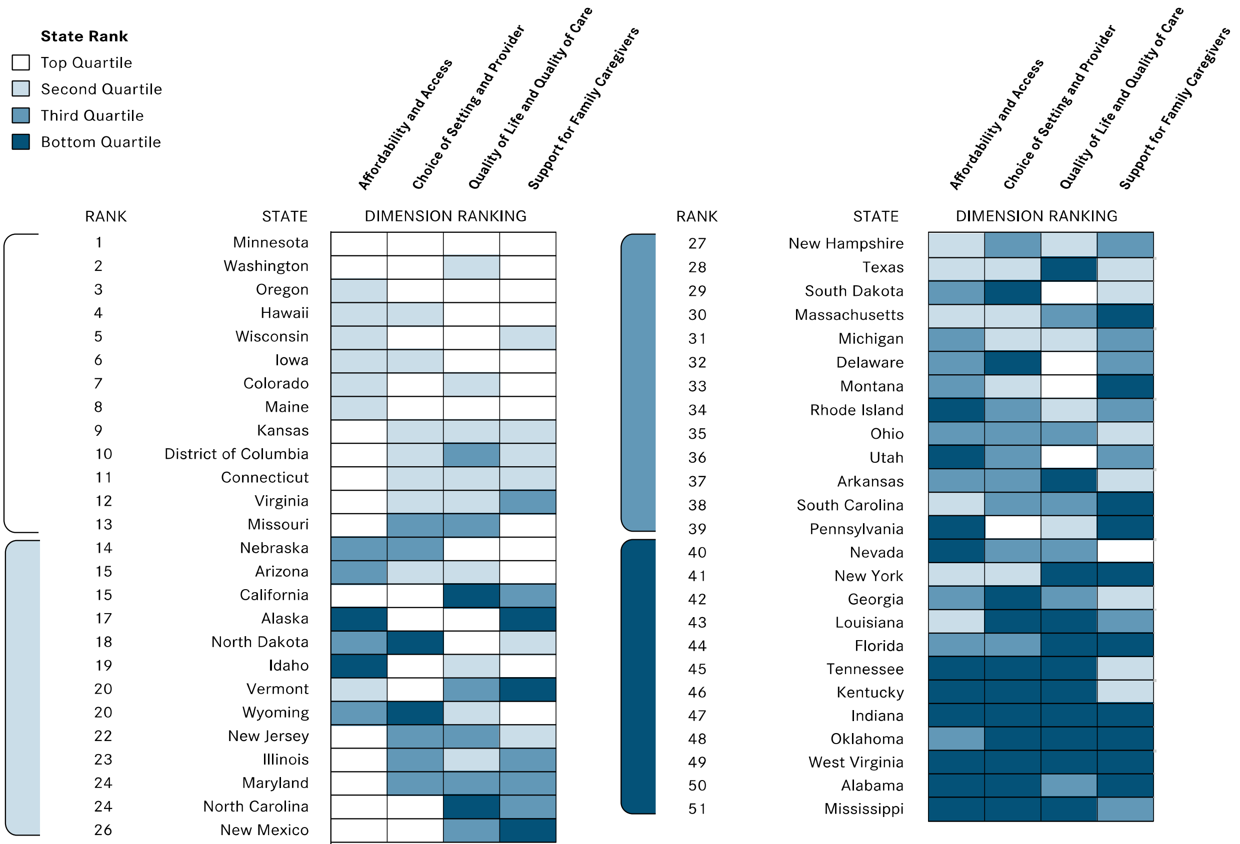
Major Findings: High-level findings of the Scorecard include:

- Leading states often do well across dimensions, but all have opportunities to improve.
- Wide variation exists within dimensions and indicators.
- State Medicaid policies dramatically affect consumer choice and affordability.
- Support for family caregivers goes hand in hand with other dimensions of high performance.
- The cost of LTSS is unaffordable for middle-income families.

How to Get the Full Report: The full report is available at www.longtermscorecard.org

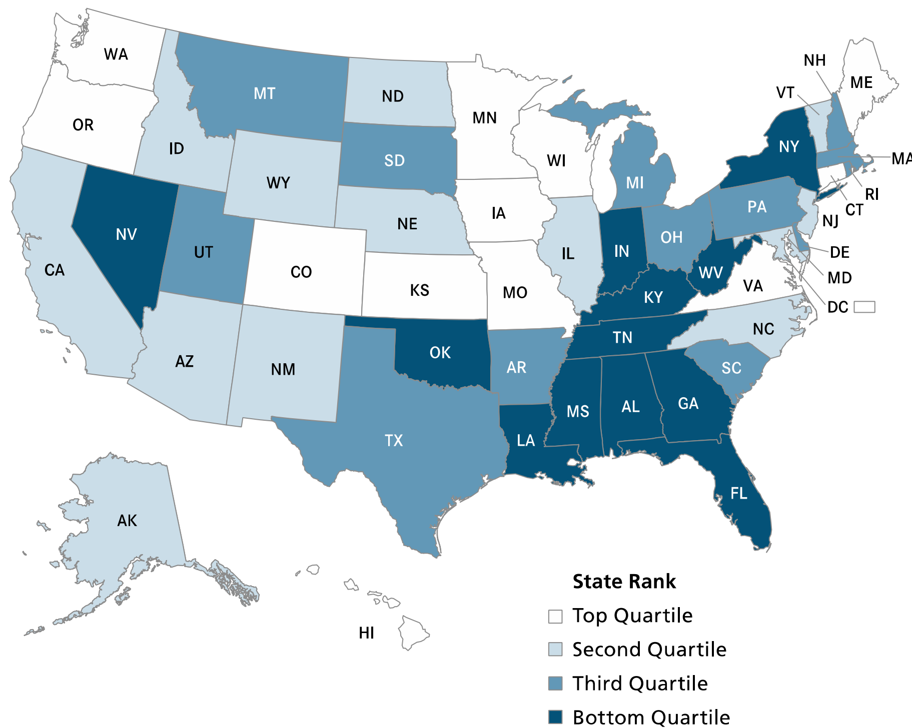
To order hard copy of the report, contact the AARP Public Policy Institute at (202)434-3890 or email jgasaway@aarp.org.

State Scorecard Summary of LTSS System Performance Across Dimensions



Source: State Long-Term Services and Supports Scorecard, 2011.

State Ranking on Overall LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2011.

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Data*Brief*: Medicaid Managed Care and Long-Term Services and Supports Spending

Did you know...

In 2009, 13 state Medicaid programs used managed care to deliver long-term services and supports?

About the data:

This analysis is based on 2009 data collected by Thomson Reuters on Medicaid managed care spending on LTSS, as well as 2009 data reported in the CMS Form 64 and published by Thomson Reuters, which details each state's Medicaid expenditures. Thomson Reuters identified 13 states using Medicaid managed LTSS and polled state departments to determine how much they spent on managed LTSS and in what categories. Each of the 13 states, except Hawaii and Kansas, reported expenditures.

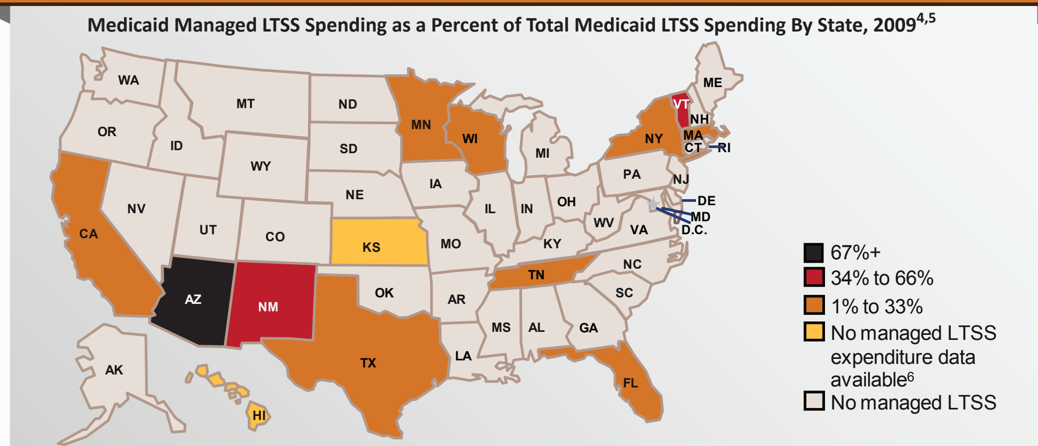
In this analysis, spending on LTSS includes spending on nursing facilities; intermediate care facilities for the mentally retarded; home- and community-based services (HCBS) expenditures authorized under Sections 1915(c) and 1915(j) of the Social Security Act; the home health benefit; the optional personal care benefit; the Program of All Inclusive Care for the Elderly (PACE); and select HCBS spending authorized under Section 1115 of the Social Security Act. HCBS expenditures authorized under Section 1915(i) of the Social Security Act are not included.

Analytics powered by Avalere Health LLC

- Medicaid is a state and federal partnership program that covers medical care and long-term services and supports (LTSS) for low-income individuals.
- In most parts of the U.S., the provision of LTSS is highly fragmented. Furthermore, this fragmentation can lead to lower quality care and inefficiencies in care delivery.[1]
- Although most Medicaid LTSS is paid as fee-for-service, some states provide these services to beneficiaries through managed care plans. These predominantly private plans receive a set payment per month and are responsible for providing all necessary services to their enrollees.
- In 2009, 13 states delivered LTSS through managed care ("Medicaid managed LTSS") to individuals with disabilities.
    - The 13 states were: Arizona, California, Florida, Hawaii, Kansas, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Vermont, and Wisconsin.
    - In three states, Medicaid managed LTSS accounted for over 40 percent of total Medicaid LTSS spending.[2]
- Increasingly, states are exploring ways to expand Medicaid managed care to include LTSS, making it easier to coordinate all facets of care for enrollees.[3]

Few States Use Medicaid Managed Care to Deliver Long-Term Services and Supports

Medicaid Managed LTSS Spending as a Percent of Total Medicaid LTSS Spending By State, 2009[4,5]



A Clear Policy Connection

As LTSS costs continue to account for a growing proportion of Medicaid spending, states have shown significant interest in using managed care to improve care coordination and reduce costs, particularly for seniors and people with disabilities who have complex medical and LTSS needs.

Many states are quickly expanding their managed LTSS programs and several states are also pursuing the integration of LTSS with medical services. However, only 13 states have experience with Medicaid managed LTSS programs upon which to build. Given that this is a new venture for many states, there are a number of issues they should consider. Managed care infrastructures—specifically, networks of physicians, hospitals and LTSS providers—take time to build. Though some states have built similar infrastructures for other Medicaid populations, they will need to modify them to ensure that networks can meet the needs of seniors and people with disabilities.[3] Additionally, states should seek to incorporate best practices that include: communicating a clear vision for managed LTSS to promote program goals; engaging stakeholders to achieve their buy-in for program implementation; and ensuring that benefits are designed to meet varying beneficiary need by encompassing the full array of LTSS.[7] States can also benefit from requiring the use of a uniform assessment tool as part of their managed LTSS programs. These assessment tools can ensure consistent evaluation of need and provide for the development of LTSS-focused measures to evaluate program performance and quality of care provided to individuals.[7]

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[5] Total percentages of state long-term services and supports spending in managed care: Arizona 97%, California 4%, Florida 1%, Massachusetts 5%, Minnesota
[6] Hawaii and Kansas have Medicaid managed LTSS programs, but did not provide data on program expenditures.
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THE scan FOUNDATION

Data*Brief*: Dual Eligibles, Chronic Conditions, and Functional Impairment By Age Group

Did you know...

In 2009, 29% of dual eligibles under age 65 and 35% of duals age 65 and over had both functional impairment and chronic conditions?

About the data:

This analysis is based on the 2009 Medicare Current Beneficiary Survey (MCBS) Access to Care file, an annual, longitudinal survey of a representative sample of Medicare beneficiaries enrolled for the full year. The MCBS collects information on Medicaid eligibility, chronic conditions, and functional impairment.

In this analysis, individuals who either self-reported that they had Medicaid coverage or who were identified by the Centers for Medicare and Medicaid Services as having Medicaid coverage were considered to be dual eligibles. Individuals who indicated that they received help or standby assistance with one or more Activities of Daily Living (ADLs) and/or three or more Instrumental Activities of Daily Living (IADLs) were considered to have functional impairment. This analysis included respondents residing in the community and in institutions.

Individuals who indicated that they had ever been diagnosed with any of the following conditions were considered to have a chronic condition: arthritis, Alzheimer's Disease, broken hip, cancer (excluding skin), congestive heart failure, depression, diabetes, hypertension, mental illnesses (excluding depression), myocardial infarction and other heart conditions, osteoporosis, Parkinson's Disease, pulmonary diseases such as emphysema, asthma and Chronic Obstructive Pulmonary Disease, and stroke.

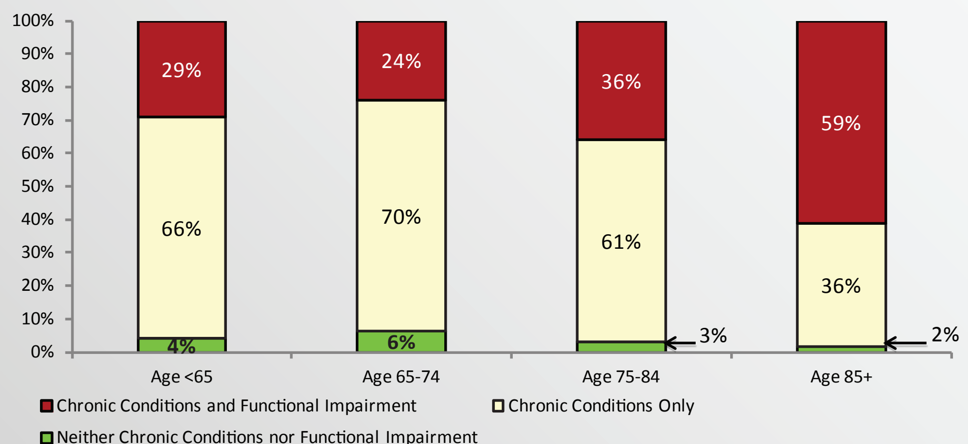
This analysis excludes Medicare beneficiaries who enrolled or died during 2009.

Analytics powered by Avalere Health LLC

- "Dual eligibles" are low-income individuals who are eligible for both Medicare and Medicaid benefits. They are often in poor health and among the most costly patients to both programs.[1]
- Most beneficiaries qualify for Medicare at the age of 65, though some younger people also qualify if they have disabilities, end-stage renal disease, or amyotrophic lateral sclerosis.[2] If these individuals fall below certain income and asset limits, they can also qualify for Medicaid.[3]
  - In 2009, 41% of duals were under age 65, compared to 10% of Medicare-only beneficiaries.
- Dual eligibles have higher rates of chronic conditions than their Medicare-only counterparts. In particular, they have higher rates of mental illness and cognitive impairment than Medicare-only beneficiaries.[1] In addition to chronic conditions, they more often have functional impairment and require long-term services and supports (LTSS) to assist with daily activities such as eating, bathing, and dressing.[4] These factors make duals a complex population to care for.
- In 2009, 33% of duals of all age groups had both chronic conditions and functional impairment. This varied by age group, reflecting the diverse care needs of this population.[4]

Dual Eligibles Are a Diverse Population with Differing Long-Term Services and Supports Needs

Dual Eligibles by Age Group, Number of Chronic Conditions, and Functional Impairment, 2009*



*N = 3,279,733 duals age <65, 2,140,048 duals age 65-74, 1,692,792 duals age 75-84 and 942,033 duals age 85+
Note: Totals may not sum to 100% because duals with functional impairment only are not shown in this chart; among all duals, 1% have functional impairment only. Among the age groups, 1.1% of <65, 0.44% of 65-74, 0.19% of 75-84, and 3.34% of 85+ duals had functional impairment only. Also, 4% of dual eligibles under age 65 have neither chronic conditions nor functional impairment as defined in this analysis, but may have qualified for Medicare due to a condition not included in the current definition of chronic disease (e.g., end stage renal disease or amyotrophic lateral sclerosis).

A Clear Policy Connection

Dual eligibles across all age groups have high rates of both chronic conditions and functional impairment and may require both medical services and LTSS to meet their care needs.[4] Experts agree that the coordination of medical care and LTSS could help improve duals' quality of life and reduce expenditures for Medicare and Medicaid. However, this population is very diverse. For example, younger duals with functional impairment and chronic conditions may have significantly different preferences for how they receive LTSS than seniors.[1]

Section 2602 of the Affordable Care Act created the Medicare-Medicaid Coordination Office (MMCO), responsible for coordinating Medicare and Medicaid benefits to improve quality of care for this population.[5] In April 2011, the MMCO awarded contracts to 15 states to develop new models of care for duals that integrate primary care, acute care and behavioral health services, as well as LTSS. For care models targeting dual eligibles to significantly impact health outcomes and reduce costs, they must go beyond a disease-centered focus and address functional impairment in a person-centered manner. The MMCO opportunity provides states a platform from which to accomplish this objective.

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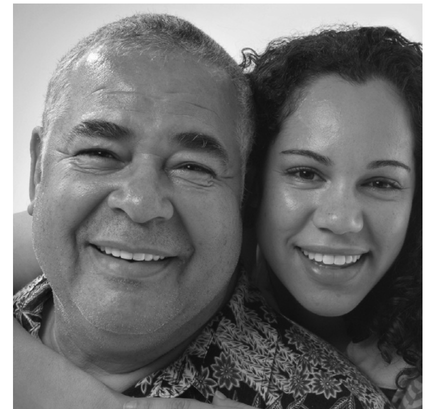
CHCS Center for Health Care Strategies, Inc.



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Center for Health Care Strategies

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The **Center for Health Care Strategies** is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries.

For more information, visit **www.chcs.org**.

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Foreword

The Affordable Care Act of 2010 presents national policymakers and state leadership across the country with the opportunity to improve quality outcomes for low-income adults receiving long-term supports and services (LTSS). Even prior to its passage, a number of states had developed successful long-term care models, particularly in the home- and community-based service area. The SCAN Foundation wanted to create an opportunity for all states not only to learn about these various model programs, but also to provide a specific roadmap for states interested in implementing similar programs. Key issues include what concrete steps state officials need to consider within their own state as well as how to best interface with the Centers for Medicare & Medicaid Services to implement these options.

To this end, the Center for Health Care Strategies (CHCS) has developed three ***Profiles of State Innovation*** roadmaps to help states explore and understand emerging options, best practices, and proven models of success in three areas: (1) rebalancing LTSS care options to support home- and community-based services; (2) the development and implementation of a managed LTSS program; and (3) integrating care for adults who are dually eligible for Medicaid and Medicare.

The mission of The SCAN Foundation is to advance the development of a sustainable continuum of quality care for seniors. The ***Profiles of State Innovation*** roadmaps outline ways to achieve a more balanced, integrated, and efficient LTSS system. The information included in each roadmap has the potential to ensure that older adults and people with disabilities can age with dignity, choice, and independence while remaining in their homes or in the environment they prefer.

We thank all of those who have contributed to this series, especially the state and program innovators profiled, and members of the project's National Advisory Group, who gave so generously of their time and expertise. We also acknowledge the dedication and hard work of the CHCS staff: Stephen A. Somers, Alice Lind, Lindsay Barnette, Suzanne Gore, and Lorie Martin.

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Top Ten Mileposts for Reaching Effective Managed Long-Term Supports and Services Delivery

This roadmap outlines best practices to help states reach the following critical mileposts in developing effective models for managed long-term supports and services.

1. Communicate a clear vision for managed long-term supports and services (LTSS) to promote program goals.
2. Engage stakeholders to achieve buy-in and foster smooth program implementation.
3. Use a uniform assessment tool to ensure consistent access to necessary LTSS.
4. Structure benefits to appropriately incentivize the right care in the right setting at the right time.
5. Include attendant care and/or paid family caregivers in the benefit package.
6. Ensure that program design addresses the varied needs of beneficiaries.
7. Recognize that moving from a 1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing and plan accordingly.
8. Develop financial incentives to influence behavior and achieve program goals.
9. Establish robust contractor oversight and monitoring requirements.
10. Recognize that performance measurement is not possible without LTSS-focused measures.

Introduction

The passage of the Affordable Care Act (ACA) left a fair amount of unfinished business in the U.S. health system in the long-term supports and services arena. It may be some time before Congress takes on major legislation on long-term care, but there is little doubt that demographics and economics will compel policymakers to consider more dramatic changes in how the nation organizes, finances, and delivers long-term supports and services (LTSS). In the meantime, with the exception of the Community Living Assistance Services and Support (CLASS) Act and some more modest features of ACA, the onus for rethinking publicly financed LTSS delivery will reside at the state level, particularly in Medicaid, which finances more than 40 percent of LTSS in America.[1]

Fortunately a good number of states have made genuinely innovative and robust investments in this arena over the past several decades. These efforts can be grouped into three areas:

- Rebalancing LTSS to provide more home- and community-based services (HCBS) options as well as nursing facility alternatives;
- Developing and implementing a managed long-term supports and services (MLTS) program; and
- Integrating care for adults who are dually eligible for Medicare and Medicaid.

IN BRIEF

Medicaid pays for more than 40 percent of the nation's long-term supports and services (LTSS) costs. Although costs for LTSS represent almost one-third of all Medicaid spending, these services are often disconnected and financially misaligned. Overhauling the delivery of long-term care offers significant opportunities for states to improve health care quality, control costs, and enhance the quality of life for millions of Americans. Health reform legislation extends new funding options for states to achieve a more equitable balance between institutional and home- and community-based care.

This roadmap culls from state best practices across the country to outline key elements for managing LTSS that provide high-quality, consumer-focused, and cost-effective care.

Through support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) conducted an environmental scan to identify state best practices in each of these three critical areas. The resulting *Profiles of State Innovation* series culls lessons from state LTSS pioneers to create roadmaps for other states to follow as they develop new or improved systems of LTSS.

For this report, CHCS, with assistance from an advisory group of state staff and other experts,[2] identified five innovative states — Arizona, Hawaii, Tennessee, Texas, and Wisconsin — with expertise in managed care approaches for individuals with long-term care needs (see sidebar for selection criteria). The lessons herein were gathered through interviews and in-depth site visits with these pioneering states. CHCS also drew from its extensive work with additional states in pursuing MLTS programs and integrating care for duals. While the featured states each have different approaches to managing the full spectrum of long-term care needs, they are joined by the common vision of providing higher quality and more cost-effective long-term supports and services.

[1] Kaiser Commission on Medicaid and the Uninsured estimate based on CMS National Health Accounts data, 2008.
[2] See appendix for list of advisory group members.

State Environment

Today, 94 percent of Medicaid beneficiaries needing LTSS receive their care through the fragmented fee-for-service (FFS) system.[3] LTSS costs continue to account for greater proportions of Medicaid spending and the nation's aging population is generating increasing need for services. This is motivating many states to look for ways to offer consumers broader access to home- and community-based options, while at the same time better managing overall long-term care spending. Thus, more states are interested in pursuing managed care approaches for these types of services.

Interviews with the states indicated that they sought to implement an MLTS program to:

- Build upon existing managed care experience and/or infrastructure, as in Arizona and Tennessee;
- Use managed care organizations to decrease and/or end waiting lists for home- and community-based waiver services, as in Hawaii, Texas and Wisconsin;
- Provide a more flexible set of benefits and more choice than typically found in Medicaid FFS, particularly for community-based care;
- Achieve a more cost-effective long-term supports and services system;
- Strengthen the quality of care; and/or
- Take an important step toward fully integrating the delivery and financing of the full range of acute and long-term supports and services for those needing long-term care.

Prevailing wisdom tells us that if "you've seen one Medicaid program, you've seen one Medicaid program." There is no aspect of the program wherein this is more true than in the design of MLTS programs. These programs vary dramatically from one state to the next in terms of target populations, covered benefits, enrollment options, and contracting. The decisions states make in the design of MLTS programs are dependent on their individual histories and context, including existing infrastructure (both in terms of managed care as well as LTSS) and the political support for and stakeholder concerns about managed

State Selection Criteria

To identify state innovators, CHCS and the advisory group members referenced several information sources on state progress in improving LTSS systems, including the Kaiser Family Foundation's and Thomson Reuters' reports on waiver expenditures, and an AARP report that breaks out LTSS expenditures by eligibility category.[4]

General criteria:

1. State's system for assessment, determination of need, and case management of LTSS is independent of providers.
2. State collects and analyzes data for performance measurement, and mines data to track utilization and program impacts on costs.
3. Consumers and other stakeholders are engaged in program design and quality monitoring.
4. State is committed to continuous quality improvement of its LTSS towards statewide system that supports multiple populations.
5. State has formal and informal bridges across medical/LTSS systems.

Criteria for managed LTSS states:

1. State has regulatory and/or legislative support for non-FFS approach to LTSS.
2. State engages consumers in program implementation.
3. State relies on cross-agency integration to blend financing and delivery systems.
4. State has commitment to evaluate along multiple dimensions.
5. The managed care system in the state is replicable.

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[3] P. Saucier. "Overview of Medicaid Managed Long-Term Care." Presented at the National Health Policy Forum on Medicaid Managed Long-Term Care, April 25, 2008.

[4] B. Burwell, et al. "Medicaid Long-Term Care Expenditures in FY 2008." Thomson Reuters, December 1, 2009 (available at **http://www.hcbs.org/moreInfo.php/doc/2793**); T. Ng, C. Harrington, M. O'Malley-Watts. "Medicaid Home and Community-Based Service Programs: Data Update." Kaiser Commission on Medicaid and the Uninsured, November 2008 (available at **http://www.kff.org/medicaid/upload/7720_02.pdf** ; and E. Kassner, et al. "A Balancing Act: State Long-Term Care Reform." AARP Public Policy Institute, July 2008 (available at **http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf**).

care. While Figure 1 (see pages 8-9) provides detailed information on the key characteristics of the MLTS programs found in the states interviewed, there are a few distinctions worth highlighting:

- While most states have a broad inclusion policy (all adults age 65 and over as well as people with physical disabilities are eligible to enroll), some states (Arizona and Tennessee) have chosen to focus on those at risk for or at the nursing home level of care. Wisconsin includes people with developmental disabilities in its program in addition to other eligibility categories. Hawaii includes all age groups, which means that medically fragile children are served under the MLTS program as well as frail elderly.
- Contractors in Arizona, Hawaii, and Tennessee are responsible for providing the full-range of Medicaid acute and long-term supports and services to the population being served, while Wisconsin's program includes Medicaid long-term supports and services only. While Texas includes both acute and LTSS, its STAR+PLUS program does have some notable carve-outs including hospital and nursing facility care.
- Arizona, Hawaii, Tennessee, and Texas have elected to make their MLTS programs mandatory for eligible beneficiaries while Wisconsin's Family Care program is voluntary.
- Hawaii, Tennessee, and Texas have chosen to include large, national managed care organizations among their contractors, while Wisconsin uses "public" managed care organizations (MCO), composed of consortia of counties, as well as private plans. Arizona has more of a hybrid approach, contracting with a mix of large, national plans as well as local, home-grown or county-based MCOs.
- The majority of states have created an MLTS program that is separate from the managed care program providing acute care to the broader Medicaid population. Tennessee is the exception — it chose not to have a separate procurement for MLTS contractors and instead chose to amend contracts with their existing MCOs to bring LTSS into the mix.

Three of the five states interviewed have been operating their respective MLTS programs for more than 10 years. As a result, these states are focused primarily on expanding or improving upon the existing program infrastructure. For example, the Arizona Long Term Care System (ALTCS) program was established in 1989. Texas is in the midst of expanding its STAR+PLUS program into the Dallas/Fort Worth area, which will bring the total of those with LTSS needs in managed care to approximately 45 percent. Similarly, Wisconsin is in the process of expanding Family Care statewide. As of summer 2010 the program, which began as a five-county pilot, was operating in 55 of the state's 72 counties. Hawaii and Tennessee are relative newcomers; Hawaii implemented its program statewide in 2009, and Tennessee completed implementation of its CHOICES program in August 2010.

Figure 1: State Managed Long-Term Supports and Services Program Dashboard

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Implementation Date	1989	2008	2010	1998	2000
Medicaid Authority	1115	1115	1115	1915 (b)/(c)	1915 (b)/(c)
Eligibility	Medicaid aged (65+), blind and disabled beneficiaries who need a nursing home level of care. Includes dual eligibles.	Medicaid aged and disabled beneficiaries of all ages, including those on spend-down.	Three target groups: (1) Medicaid beneficiaries receive care in nursing facilities (NF); (2) Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities who need a nursing home level of care; (3) Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities "at risk" of institutionalization.	Medicaid beneficiaries who receive SSI and/or qualify for certain waiver services. Includes dual eligibles.	Medicaid beneficiaries with long-term care needs, including frail elders, people with physical disabilities, and people with developmental disabilities.
Enrollment	Mandatory	Mandatory	Mandatory	Mandatory	Voluntary
Beneficiaries Served	49,501	41,500	Almost 30,000	155,000	30,013
Geography	Statewide	Statewide	Statewide	Limited geographic areas	Limited geographic areas (in process of expanding statewide)
Covered Benefits	Medicaid acute, behavioral health, and LTSS (including HCBS and NF).	Medicaid acute medical and behavioral health, LTSS (including HCBS and NF).	Medicaid acute, behavioral health, and LTSS (including HCBS and NF).	Medicaid acute, limited behavioral health, and home- and community-based services.	Medicaid LTSS (including HCBS and NF).
Integration with Medicare for Dual Eligibles	Contractors are not currently required to be special needs plans (SNPs) but many are, allowing for integration of care for beneficiaries who chose to receive both sets of services from single plan.	Contractors are not currently required to be SNPs.	Contractors are not currently required to be SNPs.	Contractors in the STAR+PLUS expansion area (Dallas/Ft. Worth) will be required to be SNPs in order to fully integrate care for dual enrollees. Contracts in other areas of the state are not currently required to be SNPs but many areas, allowing for some integration.	Wisconsin has a separate program (Family Care Partnership) that uses SNPs and provides fully integrated acute, primary and long-term Medicaid/ Medicare services for dual eligibles.

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Care Management Overview/ Innovations	Require MCOs to use the following case manager/ beneficiary ratios: ▪ 1:48 in home; ▪ 1:60 in assisted living; and ▪ 1:120 in NF In-home visits are required every 90 days.	Mandatory ratios of case manager to beneficiary based on eligibility status. In-person visits are required.	State requires that care management be vested within the MCOs. In-home visits are required quarterly with monthly contacts. Focus on managing transitions—inpatient admissions must be reported to MCOs in order to trigger immediate discharge planning.	State requires MCO service coordinators to be able to authorize services, including waiver services and adult family home. States does not mandate a case manager to client ratio, but has an expectation that the case manager will be able to meet the client's needs, working with community resources.	Each beneficiary is assigned both a care manager and a registered nurse. In-home visits are required every 90 days. Care planning and service decisions are decided by beneficiary and care team. RNs are required to coordinate with acute care providers as well.
Performance Measurement Overview	23 acute care HEDIS measures. Also measure annual initiation of HCBS.	HEDIS, CAHPS measures.	HEDIS, CAHPS and select 1915(c) CMS performance measures regarding applicable waiver assurances.	State tracks quality of care, process measures, complaints and appeals; annual surveys conducted on access and satisfaction.	MCOs required to report on several quality indicators including continuity of care, vaccinations, and dental visits. State also measures personal experience outcomes through state-specific tool.
Contractors	Contractors at risk for all covered benefits. Includes large, national managed care organizations (MCOs) as well as local, public (county-based) plans.	Contractors at risk for all covered benefits. Includes large, national MCOs but HI-focus.	Contractors at risk for all covered benefits. Include large, national MCOs and plans with national affiliations.	Contractors at risk for everything except inpatient and NF care. Include large, national MCOs.	Contractors at risk for all covered LTSS services. Include primarily local and/or public (county-based) plans.

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Rate Structure Overview	Blended capitation rate based on experience of health plan enrollees. Historically rate cells are defined by contract type. In FY 2007, separate capitation rates for (1) Dual; (2) Non-Dual; (3) Acute Care only; and (4) Prior Period Coverage, were developed.	Moving to blended capitation rates.	Blended capitation rate with built in assumptions regarding expected utilization (e.g., mix of HCBS/NF use) and level of care provided. Two rates: (1) Duals and (2) Non-duals.	LTSS portion of capitation rate is based on HCBS waiver experience. Rate cells include: (1) Other Community Care Medicaid Only; (2) Other Community Care Medicaid/ Medicare; (3) Community-Based Alternatives Medicaid Only; (4) Community-Based Alternatives Medicaid/Medicare	Capitation rates built for individual beneficiaries based on functional status and level of care needed in prior year. Rate development starts with base rates for NF level of care and non-NF level of care.
Evaluation	Yes, McCall 1996 and 1997.[5]	Yes; Health Services Advisory Group is the EQRO.	Planned components include EQRO annual reports and NCQA Accreditation Survey reports.	Institute for Child Health Policy (external quality review organization) annual report.[6]	Yes, APS Healthcare 2003.[7]

[5] N. McCall and J. Korb. "Utilization of Services in Arizona's Capitated Medicaid Program for Long-Term Care Beneficiaries." *Health Care Financing Review* 19 (2): 119-34, 1997. McCall, N., C.W.Wrightson, J. Korb, M. Crane, W.Weissert, and J.Wilkin. *Evaluation of Arizona's Health Care Cost Containment System Demonstration*. San Francisco: Laguna Research Associates, 1996.

[6] Texas External Quality Review Annual Report Fiscal Year 2006 for Medicaid Managed Care and Children's Health Insurance Program. Prepared by Texas External Quality Review Organization Institute for Child Health Policy, University of Florida. January 2008. Available at: http://www.google.com/url?sa=t&source=web&cd=2&sqi=2&ved=0CBsQFjAB&url=http%3A%2F%2Fwww.hhsc.state.tx.us%2Freports%2F2006_External_Quality_Review_Annual_Report.pdf&rct=j&q=Texas%20Star%20Plus%20ICHP&ei=a4zlTMqpJYOglAesrIz1Cw&usg=AFQjCNF-0pxvto5dRlE_fc_MbWOiDLwuIw

[7] APS Healthcare, Inc. 2003. *Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness for Calendar Year 2002*. Available at http://www.dhfs.state.wi.us/

Implementation Mileposts

Based on the experiences of Arizona, Hawaii, Tennessee, Texas, and Wisconsin, CHCS identified 10 critical mileposts that states interested in pursuing MLTS approaches should strive for in the development and implementation of their programs.

1. Structure MLTS program around a vision/goal that addresses the needs of the state/community and communicate that vision to the broader stakeholder community.

Health Reform Intersections: The ACA, in §2406, expresses Congressional intent to expand the provision of home- and community-based long-term supports and services. States where legislatures have expressed similar visions have greatly benefited from the transparency and stakeholder involvement that passing such legislation required.

Each of the states interviewed began its respective program with a similar purpose — to provide Medicaid beneficiaries with additional options for receiving care in their homes and communities. Each state then tailored that goal around the specific concerns of the state and its stakeholder community. For Wisconsin and Texas, the emphasis was on ending waiting lists for waiver services, while Tennessee and Arizona focused on providing consumers with additional choices and diverting and/or transitioning consumers from institutional settings to home and community settings where appropriate. It is critically important to start the program design and planning process with a clear idea of where the state wants to go in terms of overall program outcomes. In Hawaii, the goal of increasing HCBS use by 5% was established early in the program design of QExA (see sidebar for additional details). Having a clear vision to guide MLTS program development provided additional clarity to state staff as well as the stakeholder community at large.

States have communicated the identified vision or overarching program goals in various ways. Tennessee and Wisconsin each pursued legislation for the implementation/expansion of MLTS programs. In both states, legislative authority was not required to advance the development and implementation of an MLTS program. However, each state felt that the process of getting legislative approval was an important opportunity to ensure that the state's vision for MLTS was communicated and understood in a very public way. This transparent process helped build buy-in and support for the program from policymakers and stakeholders alike.

Transparency was also critical for success in Hawaii. Two months prior to the go-live date, the legislature expressed concern about implementation of QExA, and state staff began frequent informational briefings with legislators that lasted through the implementation period. One key product of this intensive communication was a QExA Dashboard that allows key indicators to be shared regularly with stakeholders.

By establishing a statutory basis for the MLTS program, Wisconsin was able to codify key program features, such as entitlement and duties of the health plans and the state, which helped protect the integrity of the program design over time. Likewise, Tennessee embedded a series of guiding principles for LTSS in its authorizing statute, including "a global budget for all long-term care services for persons who are elderly or who have physical disabilities that allows funding to follow the person into the most appropriate and cost-effective long-term care setting of their choice, resulting in a more equitable balance between the proportion of Medicaid long-term care expenditures for institutional, i.e., nursing facility, services and expenditures for home and community-based services and supports" and a mandate for the state to rebalance the overall allocation of funding for Medicaid-reimbursed long-term care services by expanding access to and utilization of cost-effective home and community-based alternatives to institutional care for Medicaid-eligible individuals.

Hawaii: Expanding Managed Care to Serve the Users of Long-Term Care

Hawaii created the QExA program to serve seniors 65 and older and beneficiaries of all ages with disabilities. With program implementation, most 1915c waivers were absorbed under a new 1115 demonstration waiver, so that most home- and community-based services could be delivered by a managed care delivery system. Services under QExA include service coordination, outreach, and enhanced quality of health care services. QExA established these goals for the program:

- Improve the health status of seniors and people with disabilities;
- Establish a "provider home" through the use of primary care providers;
- Empower beneficiaries by promoting independence and choice;
- Assure access to high-quality, cost-effective care that is provided, whenever possible, in the homes and/or communities of beneficiaries;
- Coordinate care, including primary, acute, behavioral health, and long-term supports and services; and
- Ensure that beneficiaries are able to receive needed care in their choice of settings.

Establishing a viable long-term vision for MLTS goes far beyond an initial buy-in campaign, however. States that have implemented successful MLTS approaches have done so by allowing the established vision to permeate the very fabric of the program, from concept to implementation and beyond. Wisconsin has worked very hard to ensure that its vision of providing cost-effective support to achieve consumer-identified outcomes was at the core of Family Care's program design. Three of the most important aspects of the program — rate-setting, resource allocation, and performance measurement — have been designed with that goal in mind. Because the program is built on the premise of truly person-centered care, Wisconsin builds capitation rates on a *person-by-person* basis, factoring in individual needs and previous utilization. In addition, care planning is done using a resource allocation decision process that focuses on providing cost-effective services to meet the consumer's desired outcomes. As a result, the consumer and his/her family or caregivers are at the center of the planning and decision-making process. In order to ensure that individual outcomes are being met, the state has developed a new tool — the Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) — to evaluate outcomes from the member perspective.

Similarly, although Arizona already "rebalanced" its LTSS system through its ALTCS program, it remains committed to transitioning beneficiaries out of institutions whenever possible. Notwithstanding Arizona's dramatic accomplishment of serving 70 percent of its seniors and population with disabilities in home and community settings (as opposed to nursing facilities), the state continues to pursue additional strategies to serve beneficiaries in the community. One recent program enhancement expanded the HCBS workforce by allowing spouses to serve as paid caregivers and establishing a self-directed attendant care program. As a result, the state has continued to see a 1-2 percent increase in people residing in home and community settings every year.

Tennessee: A Framework to Support MLTS Program Implementation

Concerned about gaining buy-in from a wide variety of stakeholder groups, Tennessee spearheaded its efforts to transform LTSS by establishing a long-term vision for the program. In doing so, the state looked at the challenges with its current fragmented long-term care system that provided consumers with limited choices and/or decision-making opportunities and resulted in the inefficient use of the state's limited resources. To restructure the LTSS system, the state sought to improve access to the system as a whole, while providing increased service options particularly at the community level.

With the public support of Governor Bredesen, the state initiated stakeholder meetings to solicit input on what the restructured LTSS system should look like. The state met with key advocacy and provider groups, establishing close partnerships to help guide the best approach for improving access and community choices. Based on stakeholder recommendations, the state established a framework that was formalized through the passage of the Long-Term Care Community Choices Act of 2008. An illustration of the broad support the state cemented for this legislation is that it passed unanimously in both the House and Senate of the Tennessee General Assembly without a single "no" vote in any committee. This was a critical step in achieving necessary buy-in for the CHOICES program from community stakeholders.

By initially focusing on the end goal — e.g., providing greater choices for receiving care in the community — rather than the method for getting there, the state could build support for the overall program before having to address potential stakeholder concerns regarding managed care. The Governor also played a critical role in moving the program forward as did the unanimous passage of legislation that helped shore up initial support for the program.

2. Engage stakeholders early and often to achieve buy-in and ensure smooth implementation and sustainability of program.

States that have successfully implemented MLTS have found it necessary to work with a variety of stakeholders both during the early stages of the design process and on a continuing basis thereafter. This is particularly true when a state faces significant opposition to managed care. Proactively addressing the concerns and/or needs of individual stakeholder groups can ease apprehension and support stakeholder buy-in.

Hawaii used multiple mechanisms for gathering stakeholder input. At the request of advocacy organizations representing consumers and family members, the agency implemented a QExA Advisory Committee including advocates for the developmental disabilities community, provider associations, state agencies, the medical school, family organizations, and faith-based organizations. The group met monthly for two years prior to and one year following program implementation. Focus groups were conducted with an array of consumers on different islands. QExA Roundtables were held quarterly to provide a forum for communication with providers and beneficiaries. An ombudsman program was also developed, resulting in a contract with the Family to Family Health Information Center that provides information, referrals, and assistance in navigating the QExA system.

All of the states interviewed conducted extensive initial stakeholder outreach during the program design process. States consistently reached out to both advocacy groups and provider organizations, noting that the latter often foment and/or financially support opposition from the former. They found that provider groups are often the most apprehensive when it comes to transitioning to a new LTSS system since it can result in changes to roles, how they are paid, etc.

Texas: Working with Stakeholders in "HealthCare Matters"

In the early days of STAR+PLUS, advocates in Texas had concerns about managed care, so the state decided to engage consumers to be partners in the design and implementation of its proposed MLTS program. The Texas Health and Human Services Commission (THHSC) contracted with Healthcare Matters in 1998 to conduct a series of consumer focus groups to provide feedback to THHSC on STAR+PLUS. Four focus group meetings were held in Houston, to address a variety of topics including access, quality of care, complaints, coordination, and provider choice.

In addition, Healthcare Matters assisted the STAR+PLUS Program with consumer, provider, and community trainings, and brokered a meeting of MCOs and small providers. Over time, Healthcare Matters developed a close working relationship with the Texas HHSC, and helped to ensure that consumer advocacy input was included in plans, materials, and media products.

As advocates were given the opportunity to learn more about what the program could do (e.g., eliminate wait lists and provide additional benefits), they became STAR+PLUS champions, taking responsibility for working to alleviate the concerns of potential beneficiaries

In Tennessee, for example, state staff worked with Area Agencies on Aging and Disability (AAADs) to identify what role they should play in the new MLTS system. This entailed discussing what the AAADs thought they were doing well in their previous role as operators of the HCBS waiver program and what responsibilities they would be comfortable transitioning to managed care contractors. Based on the discussion, the AAADs continue to serve as the point of entry into the Medicaid MLTS system, but some of their previous responsibilities for building provider networks and facilitating provider reimbursement are now handled by MCOs. In addition, Tennessee realized it was important for the state to address providers' financial concerns and design incentives to ensure provider participation. In particular, the state decided that it would set provider rates for the first few years of the program so that providers would not have to worry that the MCOs were going to reduce costs simply by cutting provider reimbursement rates.

Engaging stakeholders not only entails working with policymakers, providers, and/or the advocacy community, but also with managed care contractors. Successful MLTS states have sought to create a culture of collaboration with their plan partners. This collaborative partnership has allowed the states to ensure that plans fully understand the state's program goals and vision and have a vested interest in seeing the MLTS programs succeed.

During the design phase of the CHOICES program, Tennessee met with its MCOs every week for six to eight months to ensure that the policies and procedures being developed were understood and agreed upon by all those involved. Such collaboration can also lead to the development of innovative processes as a program matures. Arizona, for example, wanted to implement a standardized assessment tool for determining level of care and worked with its plans to develop an agreed-upon approach based on their collective experiences.

To truly ensure that the needs of the beneficiaries are being met on an ongoing basis, it is important for stakeholder engagement to happen at the MCO level as well. In Wisconsin, for example, several of the Family Care contractors have developed their own committees that include consumer and provider

representatives to make sure that local stakeholder needs — e.g., high quality care or sufficient reimbursement rates — are being addressed.

3. Use a uniform assessment tool that is conducted independently from providers.

Health Reform Intersections: §10202 -- *Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes* authorizes incentive payments to qualifying states that are working to rebalance the proportion of LTSS provided in the community. States must meet several requirements to qualify for this incentive payment. One requirement is that states must utilize a standardized assessment instrument to determine eligibility for HCBS and develop individual care plans. A second condition is that states must provide "conflict free" case management. Conflict free case management does not allow the provider agency, which stands to benefit from increased service utilization, to determine the level of services authorized under the care plan. This incentive payment will increase the federal match (FMAP) on a state's total HCBS spending by either two or five percentage points. More guidance on this provision is expected in the next several months.

One of the hallmarks of having a successful long-term care program is the implementation of a needs assessment system (including level of care) that is independent of the agencies that directly provide services. This increases the likelihood that consumers are being assessed objectively and that services are being provided to meet consumer needs rather than provider revenue needs. In some states, as in Wisconsin, this tool can also serve as the basis for capitated rate setting and provide consistent, reliable data for program review and analysis. The states that participated in this project were selected, in part, because of their use of a uniform assessment tool.

Most MLTS states rely on MCOs to perform assessment functions, with MCOs' built-in incentives to align care serving to eliminate conflict. In Hawaii, service coordinators who are employees or contractors of the health plans are responsible for conducting health and functional assessments annually. These assessments are the basis of care plan and service arrangements, determined in collaboration with the beneficiary and their family. In addition, service coordinators conduct the nursing facility level of care functional eligibility review, using the state's standard tool. Once completed, the tools are transferred to the external quality review organization, which reviews them on behalf of the state.

In addition to offering examples of best practices that can be used to guide MLTS programs, the states interviewed also shared missteps that other states may want to avoid. One of the concerns with Tennessee's previous LTSS system was that it had an inadvertent institutional bias. Because the state's nursing facility level of care criteria was extremely low, it essentially served as an open door to nursing homes. As a result, those whose care could have been safely provided in a home or community setting were often entering nursing facilities. The state is now struggling to "tighten the door" by raising level of care requirements, targeting nursing facility services to those with higher acuity needs, while at the same time allowing individuals with lesser levels of need (i.e., at risk of institutionalization) to receive HCBS. Unfortunately maintenance of effort requirements in the American Resource and Recovery Act and, more recently, the Patient Protection and Affordable Care Act are unintentionally creating obstacles for the state. Because of these requirements, states that raise eligibility standards — e.g., by tightening the nursing home level of care requirements in Tennessee's case — may no longer be eligible for enhanced federal matching funds.

Wisconsin: Screening Tool for Determining HCBS Eligibility

With input from stakeholders, consumers, and providers, Wisconsin developed a uniform web-based assessment tool in 2001 to determine eligibility for HCBS waivers in Family Care pilot counties. The resulting Long Term Care Functional Screen (LTCFS) offers an automated and objective way to determine the long-term care needs of elders and people with physical or developmental disabilities throughout the state. The LTCFS has multiple uses including: establishing level of care for Family Care eligibility; providing information to help people making decisions about how to meet their long-term care needs; informing the development of capitation rates; and evaluating the program.

The LTCFS inventories needs across key areas affecting an individual's risk/need for institutionalization, including:

- Activities of daily living (ADLs) such as bathing, dressing, toileting, transferring, mobility, and eating;
- Instrumental activities of daily living (IADLs) such as meal preparation, using the telephone, medication management, and money management;
- Diagnoses and health-related services or tasks;
- Communication and cognition (e.g., memory loss, decision-making ability);
- Behaviors and/or mental health (e.g., wandering, substance abuse); and
- Available transportation or employment.

Upon completion, the clinical professional who administered the screen can instantly see the consumer's level of care and eligibility for Family Care and/or other available LTSS programs. To ensure the quality of the information that is collected through the LTCFS, the state has developed the following requirements:

- Provide all screeners with a single online training program;
- Test and certify all screeners with a single online certification test;
- Provide all screeners with a single written instruction manual;
- Conduct routine and ad hoc monitoring of submitted screens; and
- Schedule regular statewide skills and knowledge testing.

Additional information on Wisconsin's LTCFS can be found at:
http://dhs.wisconsin.gov/ltcare/FunctionalScreen/Index.htm.

4. Structure a benefit package that will appropriately incentivize the right care in the right setting at the right time, including coordination with acute care.

Health Reform Intersections: Historically, states have been required to obtain Medicaid waiver authority in order to provide HCBS. The *Deficit Reduction Act of 2005* (DRA) enabled states to include HCBS in their state plans through the creation of the §1915(i) State Plan Option. To date, however, few states have used the §1915(i) State Plan Option and other states have voiced concerns about the barriers to using this provision.

The ACA attempted to alleviate some of states' concerns by amending §1915(i). Section 2402, *Removal of Barriers to Providing Home- and Community-Based Services*, amends the §1915(i) State Plan Option by expanding certain eligibility requirements and allowing states to target services to specific populations. The ACA expands this provision in some areas; however, it eliminates states' flexibility in others. For example, states can no longer require that individuals accessing HCBS through the §1915(i) State Plan Option meet an institutional level of care. Further, states cannot limit the number of participants that receive §1915(i) State Plan Option services.

§2402 creates additional options for states regarding the provision of HCBS; however, its usefulness may be limited due to current state budget limitations and the need for many states to manage enrollment.

States often vary in deciding what services to include in their MLTS benefit packages. However, among the states interviewed for this project, all agreed that it is critical that the benefit package be structured to align incentives to ensure that beneficiaries receive the right care in the right setting at the right time. Arizona, Hawaii, and Tennessee all felt that the success of a managed long-term care program relies heavily on the development of a comprehensive benefit package that includes all relevant acute and LTSS services, including nursing facility care. These states felt that the only way to truly align all of the incentives was to place the plans at risk for the full array of Medicaid acute and LTSS services so that there would be a greater focus on keeping consumers in the community for as long as appropriate.

While Wisconsin chose not to include acute care in its Family Care program, it has still taken great pains to ensure that the acute and long-term supports and services are coordinated as closely as possible for beneficiaries. The decision to focus solely on LTSS was due, in large part, to the feeling among many Wisconsin advocates that the integration of acute and LTSS would lead to more of a "medical model" focused primarily on the underlying diagnosis and medical/acute care treatment rather than providing the social supports and community-based services often needed to keep people out of institutions. As a result, the state decided that at a minimum, managed care organizations should be responsible for all institutional and community-based LTSS and have specific requirements and/or incentives to actively coordinate with acute care and/or other services not included in the benefit package. For example, the Family Care team includes a registered nurse who is responsible for contacting a member's acute care providers within the first 90 days of enrollment to set up a plan for coordinating care. The plan includes a system for sharing test results, prescriptions, and/or other information that would potentially have implications for the member's overall health. The nurse is also responsible for working with physicians and pharmacists on medication reconciliation every six months. Generally speaking, the state has found this process to work well. However, the nurses often need to educate acute care providers about how Family Care's resource allocation system works when beneficiaries come away from office visits with "prescriptions" for items such as scooters or other LTSS-related services.

Where and how care coordination/case management is provided also varies among state MLTS programs. In some states services are provided by an entity separate from the health plan, generally through a sub-contract between the plan and the organization providing the care coordination/care management services. Such arrangements can help quell stakeholder concerns that a managed care entity will deny costly services even if such services are believed to be needed and appropriate. However, both Wisconsin and Tennessee felt that it was critical that care coordination/case management be vested within the managed care entity in order to ensure that a single organization is responsible for the totality of care provided to a consumer. These states believe that is the only way in which care can truly be integrated and incentives aligned. They assert that if managed care entities are at risk for the full range of services that may be needed by the member, the care coordinator working for the MCO will be able to ensure that members receive the care they need to live safely in the community, and avoid the more costly institutional setting.

A state's MLTS benefit package is often influenced by the needs and concerns of the broader stakeholder community including providers, policymakers, and advocates. While it is important to listen to and address these concerns whenever possible, states should balance those concerns with their own vision for MLTS and the program's long-term sustainability. During the development of the STAR+PLUS program, Texas faced significant opposition from the nursing home industry which did not want to participate in managed care. After months of negotiations, the state carved nursing facility care out of the benefit package for fear that the initial STAR+PLUS pilot would never get off the ground if it placed plans at risk for those services. More than 10 years later, the state is finding that it is difficult to incentivize greater use of HCBS options when institutional care is carved-out of the program. Over time, the state hopes to adjust its MLTS program to include more of the risk for institutionalization.

Texas' experience with institutional care highlights another important lesson for states pursuing MLTS programs — if possible, states should include all desired benefits and/or program design elements at the start of an MLTS program. Hawaii's leadership was emphatic about this as well, saying that if they had implemented acute care only, "we would still be here two years later planning to include long-term care

Tennessee: Use of Existing Infrastructure to Facilitate MLTS Approach

During Tennessee's initial stakeholder process, the state examined a variety of LTSS delivery system options to achieve its overall goal of improving access and choices for consumers needing LTSS. Given that the state's Medicaid acute care system has long relied on managed care, the state was concerned that a separate LTSS program would only perpetuate the fragmentation that characterized its current LTSS system. After much deliberation, the state concluded that the best vehicle was to integrate the long-term care system within TennCare — its existing managed care delivery system. The state felt that this was the only way to truly align all parts of the Medicaid system.

Once this decision was made, the state began working with its existing managed care contractors (several of which are national plans with experience in managing LTSS in other states). Together, they designed ways to provide a single set of Medicaid services to covered beneficiaries, expand access to HCBS in order to divert nursing home placement, and transition beneficiaries out of nursing facilities and into HCBS where appropriate. In addition, the state began working with stakeholders to address concerns that providers and/or advocates might have with managed care and to build strong consumer protections into the program.

Today, the three TennCare managed care organizations are responsible and at-risk for providing the full continuum of LTSS services, including nursing facility and HCBS, in addition to all primary, acute, and behavioral health services for eligible members. Care coordination is provided by the health plans, and focuses on support for member preferences regarding services and settings as well as intensive management of transitions between care settings. Tennessee is one of the few states with experience in integrating all services, including behavioral health, into managed care. This integration positions the state for undertaking a unique demonstration of how to integrate all care for adults who are dually eligible.

benefits." State experience demonstrates that it can be more difficult to add things in or make substantial changes to existing MLTS programs. This may mean taking more time during the planning stage to work with relevant stakeholders or to develop systems for implementation, but it is usually time well-spent that will save states resources in the long-run.

5. Include attendant care and/or paid family caregivers within the benefit package as these services often play an important role in keeping consumers out of institutions.

Health Reform Intersections: The ACA contains numerous provisions related to expanding the pool of caregivers and providing training opportunities for these individuals.

- §2401 -- *The Community First Choice Option* establishes a new state plan option through §1915(k) of the *Social Security Act* for attendant services and includes a provision for the compensation of family members (to be defined by the Secretary). States that meet certain requirements related to this provision may be eligible for a six percentage point increase in federal match (FMAP) for services provided through §1915(k).

- §2402 -- *Removal of Barriers to Providing Home- and Community-Based Services* amends the §1915(i) State Plan Option by expanding certain eligibility requirements and allowing states to target services to specific populations. As discussed in Milepost #4, the ACA expands this provision to allow a greater range of services to be provided through the state plan. This provision limited some state flexibility in providing HCBS through §1915(i); however, states may wish to review this section to see whether it is a good fit for their state for expanding access to attendant care services.

One of the first things a state can do when trying to shift care away from institutions toward more home- and community-based settings is to focus on the development of in-home programs. By starting with the expansion of in-home services, a state can build upon existing systems rather than invest considerable resources in developing new and/or additional infrastructure (e.g., alternative residential settings). In addition, it is typically far less complicated to build programs aimed at keeping consumers out of nursing facilities than transitioning them out of institutions. As a result, it may make sense for a state to start with diversion and move toward transition and relocation once more community-based services and options are in place.

For many states this may mean starting with the development or expansion of attendant care programs as part of the overall MLTS benefit structure. Attendant care is a term that usually covers a variety of services that are provided in a consumer's home as an alternative to nursing facility care. These services may include homemaking, personal care, general supervision, and/or companionship. Hawaii includes personal assistance services (level 1 chore services), which were previously covered as a state-only benefit, in its 1115 waiver. By doing so, the program has been able to double the number of clients receiving these benefits since QExA was implemented. All of the states interviewed include attendant care in their respective MLTS programs. In the majority of the interviewed states, attendant care may also be provided through consumer-directed programs offered in conjunction with an MLTS program. In this scenario, consumers are given the opportunity to directly hire, fire, and supervise their own attendant care providers without going through a home care agency. In addition, consumers have the ability to make decisions about how best to get their needs met, including who will provide services and when the services will be provided.

Many states have found that allowing family members, neighbors, and friends to participate in attendant care programs is a way to increase the available direct care workforce. States vary in how they implement this benefit. In Tennessee, the consumer direction benefit offers a formal pathway for hiring family members (excluding spouses) as well as others with whom a consumer has a close personal relationship. All consumer-directed care providers in Tennessee are required to undergo background checks, even family members. In Hawaii, the employment of family members reinforces the traditional value of family-centeredness, and allows families to maintain close living arrangements preferred by many ethnic subcultures in Hawaii (e.g., Native Hawaiians, Asian Americans, etc.). In Arizona, family caregivers can participate both in the self-directed attendant care program as well as the traditional attendant caregiver program (see sidebar for more detail).

Arizona: Providing Options for Family Caregivers

Arizona, which has one of the highest percentages of consumers receiving care in home- and community-based settings in the country, attributes much of its success in keeping consumers out of institutions to the inclusion of family members as paid caregivers in its attendant care program. However, the state has developed a series of requirements and protocols to ensure the quality of care.

To be eligible for the benefit, the person needing care must qualify medically and financially for ALTCS. Family members providing the care must be trained and hired by a qualified home health or attendant care agency. This training, which lasts only a couple of days, provides the new caregiver with knowledge and training in CPR, basic first aid, and infection and disease control. Once the training is complete and the family member is certified by the agency, the family caregiver is paid an hourly rate by the home health or attendant care agency for care authorized for the consumer. The care manager and home health agency are still involved in determining the types of services and number of hours that will be provided through the ALTCS program.

Notably, Arizona recently added the Spouse as Paid Caregiver option to its overall attendant care program. Under this option, the ALTCS consumer's husband or wife can be compensated to provide up to 40 hours a week of attendant care or similar services. The state believes that allowing spouses to serve as paid caregivers will help reduce the challenges of ensuring an adequate caregiver workforce and allow additional ALTCS consumers to remain at home.

6. Ensure that the program design sufficiently addresses the varied needs of MLTS consumers.

Health Reform Intersections: §10202 -- *Incentives for States to Offer Home- and Community-Based Services as a Long-Term Care Alternative to Nursing Homes* authorizes incentive payments to qualifying states that are working to rebalance the proportion of LTSS provided in the community. States must meet three specific conditions to qualify for this incentive payment. One condition is that states must use a core standardized assessment instrument to determine eligibility for HCBS and to develop individual service plans to address identified needs. To ensure that *all* of an MLTS consumer's needs are adequately addressed in his or her service plan, states should consider incorporating behavioral health assessment questions into this standardized assessment instrument.

More than 10 million Americans currently need some type of long-term supports and services to assist them with life's daily activities.[8] While much of the LTSS population is elderly, almost 42 percent are under age

[8] Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long Term Services and Supports," February 2009. Available at http://www.kff.org/medicaid/upload/2186_06.pdf.

65. These younger beneficiaries include both children and adults with disabilities, encompassing individuals with physical as well as behavioral or developmental disabilities. While there may be some overlap in the type of care provided from one group of beneficiaries to the next, the needs and preferences of a 30-year-old with paraplegia differ significantly from those of an 85-year-old with multiple chronic conditions in need of a hip replacement. Given the population's heterogeneity, a one-size-fits-all approach to the benefit package will not meet the varied needs of every MLTS beneficiary. It is important that states recognize this from the outset and ensure that all aspects of the MLTS program — from the benefit structure to the care management approach to the provider networks — are designed with commensurate flexibility.

One area often overlooked or inadequately addressed by states is the intersection of LTSS and behavioral health. The majority of the interviewed states indicated a need to focus attention on the behavioral health issues of beneficiaries. Tennessee has fully integrated behavioral health benefits into its MLTS program. Hawaii includes treatment for chemical dependency and acute behavioral health services in its MLTS system. In some states, among them Wisconsin, more than half of the beneficiaries receiving LTSS also have a mental health diagnosis.

As Wisconsin's Family Care has expanded to additional counties, the state has seen a significant increase in the number of consumers previously served primarily by the local mental health system enrolled in the program. For many managed care entities serving as Family Care contractors this is a significant challenge since they have had little prior experience in providing care to consumers with severe mental illness and, in many areas, community-based resources are lacking. The state has begun to address this concern by providing web-based trainings to MLTS staff around mental health diagnoses, related needs, and available resources. In addition, Wisconsin is working with its contracted MCOs to find creative ways to provide psycho-social rehabilitation services to help deter acute psychiatric hospitalization for those with mental health diagnoses or developmental disabilities.

Arizona: Interdisciplinary Care Teams Focus on Behavioral Health Needs

Given the prevalence of mental health diagnoses among many of its beneficiaries needing LTSS, Arizona believes that the appropriate placement of consumers with severe mental illness is critical. To that end, the state has ensured that the ALTCS program has sufficient flexibility to allow its managed care contractors to establish additional services.

For example, Mercy Care Plan has developed an interdisciplinary team (IDT) model for consumers identified as high-need and high-cost who have had two or more inpatient admissions for behavioral health issues in the past 30 days and/or other internal or external referrals. Members of the IDT include the consumer's case manager as well as the plan's medical director, a variety of nurses, and the behavioral health medical director, and behavioral health coordinator. The IDT meets on a regular basis to discuss participating consumers' needs, preferences, barriers to care, etc. and make recommendations for a care plan that will prevent future hospitalizations/ED visits and increase overall health and satisfaction outcomes. Consumer readmissions are monitored at 30-, 60-, and 90-day intervals. In addition, Mercy Care has 12 certified behavioral health case managers to assist in care coordination for consumers with behavioral health needs.

Bridgeway Health Solutions, another ALTCS contractor, also employs an IDT model for its enrollees and includes a behavioral health specialist on the team. In addition, because medication often plays such a critical role in the treatment of certain mental illnesses and because behavioral health providers may not be as connected to the acute or LTSS community, Bridgeway includes a pharmacist as part of the IDT to address poly-pharmacy issues.

Another way that the varied needs of the LTSS population can be addressed is to require the use of interdisciplinary (or multidisciplinary) care teams as part of the care planning and care management

processes. Several of the states interviewed require that managed care entities use an interdisciplinary team to develop an individualized plan of care based on each beneficiary's needs and preferences and to help ensure that care is being properly coordinated across all aspects of the system (e.g., acute, LTSS, behavioral health, etc.). Although the composition of these teams varies depending on the level and type of care needed by individual beneficiaries, teams typically include the following mix of professionals: physicians; nurses; social workers; community resource specialists; certified case managers; pharmacists; and other specialists.

Building a program that is designed to meet the varied needs of all eligible beneficiaries may mean establishing clear linkages between the MLTS program and other systems in the state that affect it. For example, Wisconsin has worked to develop close ties between Family Care and Adult Protective Services as well as the mental health system outside of what is covered by Medicaid. As the benefit design in Texas wavered between including and excluding behavioral health services, health plans actively worked to maintain bridges to the mental health system. In 2007, Tennessee moved to full integration of behavioral and physical health services in the managed care delivery system. Tennessee MCO's contracted with existing Community Mental Health Centers in order to ensure the stability of the mental health system and continuity of care for members.

7. Recognize that moving from a 1915(c) waiver system to risk-based managed care represents a fundamental shift in how both the state and managed care entities think about LTSS financing.

Implementing a managed care system can be a significant challenge for many states, often requiring the development of additional infrastructure and skill sets at the state level. For example, in the fee-for-service setting providers are paid based on a pre-determined rate for every unit of service provided. These rates may be in place for a number of years before any adjustments are made. In a managed care setting, states must set rates for multiple contractors, usually on an annual or semi-annual basis. In setting these rates, states must make assumptions about the types and amount of services beneficiaries will use in the future. In order to effectively set rates, states must often invest in new data systems and infrastructure to analyze encounter data from managed care entities as well as information regarding the functional status or acuity of the target population.

In addition, managed care also introduces new requirements such as actuarial soundness to ensure that Medicaid managed care entities are adequately reimbursed based on predicted health care expenditures for the populations served. Most states have elected to engage actuarial firms to assist in the development of MLTS rates, at least until this internal capacity set can be developed.

As a state's knowledge of and comfort with the rate-setting process grows, it can take on more responsibility in-house. In Wisconsin, for example, the state has taken a shared actuarial approach in which its staff adjusts pre-established rates, but relies on its independent actuary to provide an un-biased, outside perspective. Arizona now employs its own in-house actuary to develop rates more efficiently and effectively. Arizona does acknowledge, however, that this would not have been possible in the early years of the program. It is important to note, however, that relatively few actuarial firms are experienced in setting capitated rates for LTSS, so states and their actuarial partners may be on a learning curve together.

In some states, pre-existing HCBS waivers have operated at a local level with community organizations or county-based entities responsible for the day-to-day management of the LTSS system. As these states move toward a more standardized, statewide approach via an MLTS program, they may be faced with payment variations among provider groups in different parts of the state. Wisconsin has faced such challenges. Prior to Family Care, the LTSS system was run out of county-based entities with each responsible for setting its own rates. Now that Family Care is expanding statewide, the state seeks to develop a standardized set of rates for the various HCBS provider groups.

Given the fact that relatively few states have implemented MLTS to date, accepting risk for LTSS can represent a change for the managed care entities as well. Three national firms have extensive experience with managed LTSS — United, AmeriGroup, and Aetna/Schaller Anderson. National firms like Molina and Centene as well as regional entities such as Massachusetts' Community Care Alliance and Wisconsin's Family Care organizations, are also becoming significant players in MLTS. States will need to work closely with their selected plans to develop and implement successful programs. However, even for national plans that have experience with MLTS, states have found that ongoing collaboration between the state and managed care contractors is critical for ensuring that the state's program goals and financial incentives are aligned in the rate-setting process. Wisconsin, for example, meets with health plan staff on a monthly basis during the rate-setting process each year. Hawaii is moving to blended rates in the next contract cycle in order to improve its incentive structure.

Texas: Building In-House Expertise in Rate-Setting and Financial Oversight

It is important for states to hire staff with both technical rate-setting knowledge as well as a comprehensive understanding of how MCOs operate on a business level. Texas, for example, has a financial group comprised of staff who primarily come from the private sector and know the MCO business model. By knowing where to look, these state staff have found examples of inaccurate data and aggressive accounting techniques, saving the state millions of dollars.

For example, it is a useful skill for state staff to be able to comprehend and compare health plan reports submitted to the Securities and Exchange Commission with other financial reports filed with the state. Texas also has the contract teeth to back up its demand for accurate encounter data, which is used to validate service utilization. Payment withholds are applied for inaccurate data. They have achieved a 96 percent accuracy rate across their encounter data, which is used to set rates going forward.

8. Develop financial performance incentives to achieve the stated goals of the program.

State MLTS programs should use contractual incentives to achieve their goals. In Tennessee for example, the capitation rates are being set with the expectation that the CHOICES program will result in a fundamental shift in how and where LTSS care is provided. In order to promote movement away from institutional care and toward more home and community options, Tennessee factors in assumptions about the impact the CHOICES program will have on the mix of institutional and HCBS services provided to LTSS beneficiaries. In determining these assumptions, which include a three to four percent decrease in institutional care over two years, the state has had to find a balance between incentivizing appropriate HCBS use while being realistic about what plans can do in relatively short periods. The state plans to reassess these assumptions on an annual basis. In Hawaii, incentive payments are incorporated into contracts to reward increasing the use of HCBS and decreasing institutional care.

Arizona uses a similar process to encourage greater reliance on home- and community-based options through the development of its rates. As in Tennessee, the state uses an HCBS-nursing facility mix to help set the rates. However, if a given contractor provides HCBS to a greater number of beneficiaries than projected, it is rewarded in a reconciliation process at the end of the year.

Despite the nursing facility carve-out, Texas has incorporated a number of disincentives into the STAR+PLUS program to prevent potentially avoidable institutionalizations. The state structured the contract so that plans face a financial penalty if they go above the nursing home occupancy baseline based on the previous year. As a result, the state has reduced nursing facility utilization month by month.

Texas: Incentives to Support HCBS

In 2001, Texas became one of the first states to implement a Money Follows the Person program. Over the years, the state's managed care STAR+PLUS program has had great success using this program to divert beneficiaries (and dollars) from nursing home care. In fact, more consumers within managed care have chosen consumer direction than those in traditional fee-for-service. In STAR+PLUS service areas, MCO representatives are required by contract to visit beneficiaries when they are admitted to a nursing facility to identify opportunities to transition individuals back into the community. In addition, through a separate budget, the state provides extra financial incentives to consumers to help them move out of institutions and into the community.

Since the MFP program began, more than 20,000 individuals have been relocated to the community. A pilot project in San Antonio, including the state, MCOs, the Center for Independent Living, and the behavioral health agency, is providing services beyond those in the 1915c waiver to ease transition. Beneficiaries and their families are prepared for what it will like to be back in community, and are given post-relocation assistance for 365 days. Keys to success in Texas include the availability of specialized providers, housing alternatives for beneficiaries with complex needs, transportation, and financial support for rent deposits.

9. Establish robust contractor oversight and monitoring requirements to maintain and improve the MLTS program.

In working with large national plans, states, including Arizona, Tennessee, and Texas, have found it necessary to be very prescriptive, particularly during the early program stage, to ensure that contractors are providing a state-specific model rather than an off-the-shelf product. To that end, they have taken a "manage or be managed" approach and have developed very specific contracts that set clear standards and expectations for plan performance. To ensure these expectations are being met, states have established robust mechanisms for monitoring performance, including monthly/quarterly reports and program dashboards.

Arizona believes that its significant oversight of the program during the early years was a key factor to its success. State staff believe that by working very closely with the plans during the two to three years it took for the ALTCS program to completely transition from fee-for-service to managed care, the state was able to gain a better understanding of how the program would really work, what the challenges were, and what it would take to resolve them. As the managed care entities got their models in place and case managers gained experience, the state was able to cut back on some of its initial requirements — including a 60-page audit guide — and focus on the most important issues. At the same time, since the program's inception the

state has seen a shift from local, non-profit plans to large national, for-profit plans that would prefer to use their own standardized care models. The state has held firm in its specific contracting requirements (e.g., maximum case manger ratios, etc.) and has developed additional requirements. An example is a network development plan designed to examine network capacity over the long-term in order to keep contractors "on their toes." Texas and Tennessee have taken similar approaches in developing specific contract requirements with consequences for failure to meet specified standards.

Even in states like Wisconsin that contract almost exclusively with local managed care entities, robust contract and monitoring requirements help ensure that consumers are receiving comparable benefits from plan to plan. This is particularly important as the state continues to move away from local, county-based long-term supports and service systems in expanding Family Care statewide.

Hawaii initially focused on overseeing provider network adequacy to ensure access to care. In taking a patient-oriented approach, the state built in many reporting requirements for health plans to demonstrate their provision of all medically necessary care and appropriate denial of inappropriate services. The contracts have prescriptive requirements for the handling of grievances and appeals, and an on-site visit occurred to verify compliance. Additionally, an active quality strategy committee reviews health plan quality reports.

Tennessee: Electronic Alert System Ensures HCBS Care Accountability

Careful monitoring to assure that consumers receive needed care on a timely basis is essential, particularly when care is provided outside of more formal care settings. Tennessee implemented an electronic visit verification (EVV) system that provides the state, managed care organizations, and home care agencies with real-time information regarding when consumers are receiving needed HCBS and when they are not.

HCBS providers log into the EVV system when they arrive at the consumer's home to deliver pre-determined/scheduled care and log-out upon their departure. The phone-based system can track where the call originated. When a provider does not log into the system on schedule, a notification is immediately generated and sent to both the home care agency and managed care organization which can then arrange for back-up care. This enhances the ability of both entities to detect and resolve problems. In addition, a claim can be generated from each login, thus facilitating timely payment for providers. The EVV is used both for formal HCBS providers and those hired by consumers in the self-directed option included under CHOICES.

To further ensure accountability for HCBS services the state receives a monthly report from each managed care organization outlining service gaps and delays in service delivery. These are assessed against managed care performance standards and benchmarks. The system helps ensure financial accountability by ensuring that only services provided are reimbursed, and moreover, improves quality of care by quickly identifying and resolving gaps in care. MCOs benefit from the system because it ensures that consumers get services and providers get paid.

Strong, standardized requirements help providers acclimate to a managed care program. For example, Texas requires that all STAR+PLUS contractors use a uniform billing process with the same set of forms across plans and providers. Not only does this make the billing process easier for providers, the plans, and the state, it also allows the state to offer training and technical assistance across plans. Similarly, Tennessee has chosen to take on some of the traditional managed care duties in the first few years of the CHOICES program to ensure a smooth transition from fee-for-service. In particular, the state elected to set all nursing facility and home-and community-based provider rates and even required that plans offer contracts to all currently operating nursing facilities to ensure some control over the initial provider networks and maintain stability in the system during the transitional years of the program.

10. Recognize that performance measurement is not possible without LTSS-focused measures.

Health Reform Intersections: §2701 -- *Adult Health Quality Measures* directs the Secretary to release an initial set of quality measures for Medicaid-enrolled adults no later than January 1, 2011. This provision further directs the Secretary to work with states to develop a standardized format for reporting information based on the selected measures by January 1, 2013. This provision does not specifically include LTSS-focused measures; however, this may provide an opportunity for states to help develop national LTSS benchmarks.

Performance measurement is a critical element of any managed care program, giving states, providers, consumers, and the managed care entities themselves valuable information about the quality and utilization of care provided. This information can be used to track performance over time, identify areas for improvement, facilitate comparisons across plans, and determine priorities for special initiatives.

States are addressing this barrier in a number of ways. For instance, Arizona and Wisconsin have developed additional tools and/or measures of their own with which to assess health plan performance. In Arizona, ALTCS contractors are required to examine the initiation of home- and community-based services for elderly and physically disabled members on an annual basis. This measures the percentage of newly placed HCBS ALTCS members who receive specific services within 30 days of enrollment.[9] In 2009, the performance standard for this measure was 92 percent. In Hawaii, the state partnered with both of its health plans to develop an evaluation tool to objectively and consistently assess need for HCBS.

Wisconsin: Person-Centered Performance Measurement Approach

Wisconsin's Family Care program seeks to provide cost-effective care to achieve individual consumer-identified outcomes. In 2006, Wisconsin contracted with the University of Wisconsin's Center for Health Systems Research and Analysis to develop its own method to identify individuals' desired outcomes. The resulting Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) is structured around 12 domains:

1. Living in a preferred setting;
2. Making one's own decisions;
3. Deciding one's own daily schedule;
4. Maintaining personal relationships;
5. Working or pursuing other interests;
6. Being involved in the community;
7. Having stable/predictable living conditions;
8. Being treated fairly and with respect;
9. Having the amount of privacy desired;
10. Being comfortable with one's health situation;
11. Feeling safe; and
12. Feeling free from abuse and neglect.

The interview tool was completed in June 2008 and has been validated. Because Wisconsin Family Care focuses on providing cost-effective support to achieve a consumer's desired outcomes, PEONIES was a critical step in ensuring plan and case management performance.

[9] http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/ALTCS-HCBS-2009.pdf

Conclusion

Developing and implementing a managed long-term supports and services program can be challenging. Success depends on a variety of factors including state leadership, existing state infrastructure and/or familiarity with managed care in general, as well as an appetite for managed care among stakeholders. Despite the challenges, however, by following in the footsteps of Arizona, Hawaii, Tennessee, Texas, and Wisconsin (while avoiding some of the landmines that befell them on their own roads to success), states should feel that MLTS is within their reach. While this roadmap can serve states as a guide to the stops along the way as they go down the path toward MLTS, it is important that those interested in doing so move forward *not* expecting to be able to "replicate" existing programs to the last detail. Every state is different and programs will need to be developed according to the needs of the local environment. Medicaid agencies can, however, borrow heavily from the elements that have worked in existing programs and incorporate them into their own — new models of MLTS.

Appendix A: List of State and Plan Interviewees

Arizona

Arizona Health Care Cost Containment System (AHCCCS) Staff:
Kate Aurelius, Deputy Director
Kim Elliot, Administrator, Clinical Quality Management
Alan Schafer, ALTCS Manager

Bridgeway Health Solutions Staff:
Duane Angulo, Director of Pharmacy
Richard L. Fredrickson, Chief Executive Officer
Robert Krauss, MD, Medical Director
Nicole Larson, Vice President of Operations and Compliance
Mary Reiss, Director of ALTCS Case Management

Mercy Care Plan Staff:
Kathy Eskra, Vice President of Long Term Care for Aetna Medicaid
Chad Corbett, Director Long Term Care
Mark Fisher, President and Chief Executive Officer

Yavapai County Long Term Care Staff:
Leona Brown, Compliance/Program Development Manager
Jesse Eller, Director

Hawaii

Hawaii Department of Human Services Med-Quest Division:
Patti Bazin, Health Care Services Branch Administrator

Evercare Hawaii:
Dave Heywood, Executive Director
Bill Guptail, COO
Jeri Kakuno, Director of Operations, MDX Hawaii
Mary Campos, Director, Field Clinical Services
Debbie Hughes, Director of Operations
Cheryl Ellis, MD, Medical Director

Ohana Health Plan
Erhardt Preitauer, President, Hawaii Region
Linda Morrison, Senior Director, Operations and IT
Wendy Morriarty, Senior Director, Field Clinical Programs
Jayme Pu'u, Senior Manager, Network Management
James Tan, MD, Senior Medical Director

Tennessee

TennCare Bureau of Long Term Care Staff:
Carolyn Fulghum, Director of Quality and Administration for Elderly and Disabled Services
Keith Gaither, Managed Care Director
Jarrett Hallcox, Director of Long Term Care Project Management
Patti Killingsworth, Assistant Commissioner and Chief of Long Term Care
Julie Johnson, LTC Appeals Manager
Casey Dungan, Assistant Director, Fiscal/Budget

Texas

Texas Health and Human Services Commission Staff:
Pam Coleman, Former Deputy Director for Managed Care Operations (has since retired from state)
Joe Vesowate, Deputy Director for Managed Care Operations
David "DJ" Johnson, STAR+PLUS Project Specialist
Ivan Libson, Implementation Coordinator Managed Care operations
Scott Schalchlin, Director for Health Plan Operations
Rich Stebbins, Manager of Finance
Paula Swenson, Director of Health Plan Management
Marc Gold, Special Advisor for Policy and Promoting Independence, Texas Department of Aging and Disability Services

Evercare of Texas:
Leah Rummel, Vice President, Strategic Account Development
Catherine Anderson, Vice President, Business Development

Beth Mandell, Regional Executive Director

Superior Health Plan:
Cindy Adams, Chief Operating Officer
Ceseley Rollins, Vice President, SSI

Amerigroup:
Cathy Rossberg, Chief Operating Officer

Wisconsin

Wisconsin Department of Health and Family Services Division of Long Term Care Staff:
Fredi-Ellen Bove, Deputy Administrator
Susan Crowley, Administrator
Monica Deignan, Managed Care Section Chief
Charles Jones, Family Care Program Manager
Tom Lawless, Fiscal Management and Business Systems Section Chief
Kathleen Luedtke, Planning and Analysis Administrator
Karen McKim, Quality and Research Manager
Alice Mirk, Care Management Services Manager

Portage Aging and Disability Resource Center:
Janet Zander, Director
Cindy Pitrowski, Assistant Director

Community Care of Central Wisconsin Staff:
Darren Bienvenue, Director of Service Coordination
Jim Canales, Chief Executive Officer
Dana Cyra, Director of Quality Management
Rick Foss, Director of Service Coordination
Mark Hilliker, Chief Operations Officer
Julie Strenn, Director of Provider Network Services

Appendix B: National Advisory Group Members & CMS Participants (in addition to State Interviewees)

Joseph Caldwell
Director, Long-Term Services and Supports Policy
National Council on Aging

Mike Cheek
National Association of State United for Aging and Disabilities

Sara Galantowicz
Senior Research Leader, Thomson Reuters Research Department, Community Living Systems Group

Cyndy Johnson
Independent Consultant

Diane Justice
Senior Program Director, National Academy for State Health Policy

Enid Kassner
Director, Independent Living/LTC
AARP Public Policy Institute

Harriet L. Komisar
Senior Research Analyst, University of Maryland, Baltimore County, The Hilltop Institute

Barbara Lyons
Vice President, Deputy Director KCMU
Kaiser Family Foundation

Anne H. Montgomery
Senior Policy Advisor, Senate Special Committee on Aging

Martha Roherty
Executive Director, National Association of State United for Aging & Disabilities

James M. Verdier
Senior Fellow, Mathematica Policy Research, Inc.

Centers for Medicare & Medicaid Services

Linda Peltz
Director, Division of Coverage and Integration

Carrie Smith
Technical Director, Division of Coverage and Integration

Mary Sowers
Director, Division of Community and Institutional Services
Center for Medicaid, CHIP & Survey Certification
Disabled and Elderly Health Programs Group

CHCS Online Resources

This roadmap is part of CHCS' ***Profiles of State Innovation*** series, made possible through The SCAN Foundation to help Medicaid programs develop high-quality, cost-effective, and consumer-focused approaches for delivering long-term supports and services. Following are additional documents in the series as well as further resources available at **www.chcs.org**.

- ***Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services*** – Outlines key mileposts to help states achieve an equitable balance between institutional and home-and community-based care.
- ***Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles*** – Outlines key considerations to help states decide what direction to choose in designing integrated approaches for duals.
- ***Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation*** – Presents novel alternatives for reforming the delivery of Medicaid-funded long-term care, including both innovations that have been implemented as well as promising practices.

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The Importance of Federal Financing to the Nation's Long-Term Care Safety Net

Judy Feder and Harriet L. Komisar
Georgetown University

February 2012

This paper was supported by a grant from The SCAN Foundation. The SCAN Foundation is dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

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The Importance of Federal Financing to the Nation's Long-Term Care Safety Net

Judy Feder and Harriet L. Komisar*
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I. Introduction

Long-term care is rarely mentioned in political discussions of deficit reduction. But the financing that supports it is most definitely on the table. Medicaid, along with Medicare and Social Security, is an "entitlement" targeted for "cuts", "swaps," or "caps" in numerous deficit-reduction proposals, both Republican and Democratic. And Medicaid—most often characterized as the federal-state health insurance program for low and modest income people—is, in fact, the nation's only safety net for people who need extensive long-term care services. A third of Medicaid spending goes toward that safety net, paying primarily for personal assistance in nursing homes and at home for people who need help with the basic tasks of daily life. Whether publicly recognized or not, deficit-reduction measures that aim to limit federal funding for Medicaid threaten the long-term care safety net.

But deficit pressures are not the only threat. Reliance on state-based financing—even when matched by federal funds—has produced a program with glaring inadequacies and inequities, which is poorly equipped to deal with future, let alone current, challenges in serving a growing elderly population. Policy "solutions" that would limit the federal commitment to long-term care financing without regard to the underlying challenge would increase, not decrease, these shortcomings. To equitably meet last-resort long-term care needs for people of all ages and incomes—across the nation—will inevitably require greater, not reduced, federal responsibility.

Accordingly, this brief reviews Medicaid's importance and limitations when it comes to long-term care and makes the case for strengthening Medicaid's safety net in one of two ways—assumption of full federal responsibility for Medicare beneficiaries who also rely on Medicaid (so-called "dual eligibles") or an enhanced federal match for Medicaid long-term care services. Each approach carries with it a federal commitment to bear the brunt of a growing elderly population—a burden that varies considerably across states. The difference between the two is whether to assure (the first approach) or to encourage (the second) greater equity and adequacy of services for low-income people across states. Either way, federal action is essential both to remedy current limitations and variations in Medicaid's long-term care safety net, and to assure its adequacy and equity into the future.

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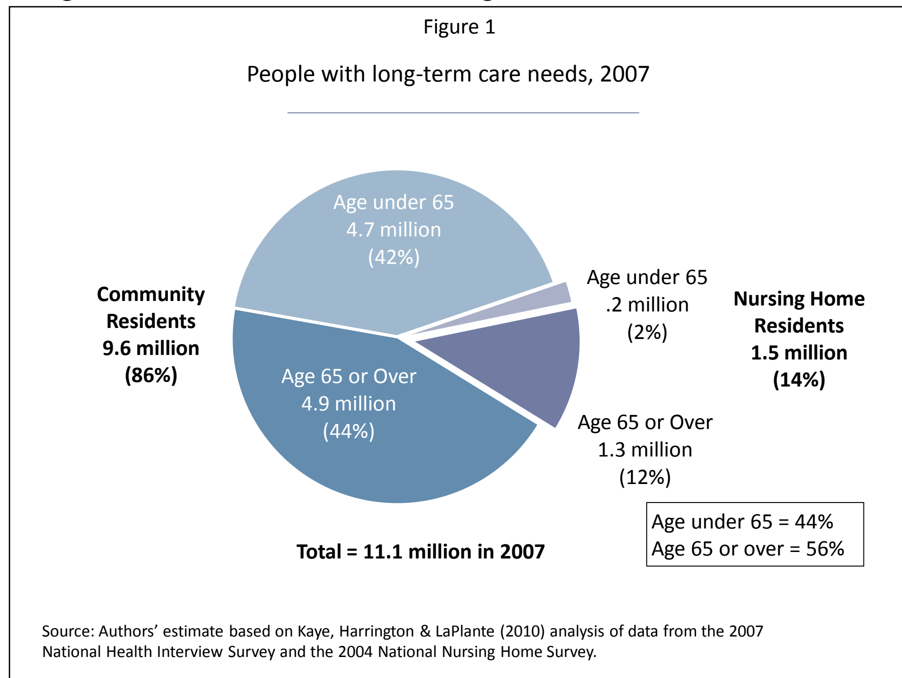
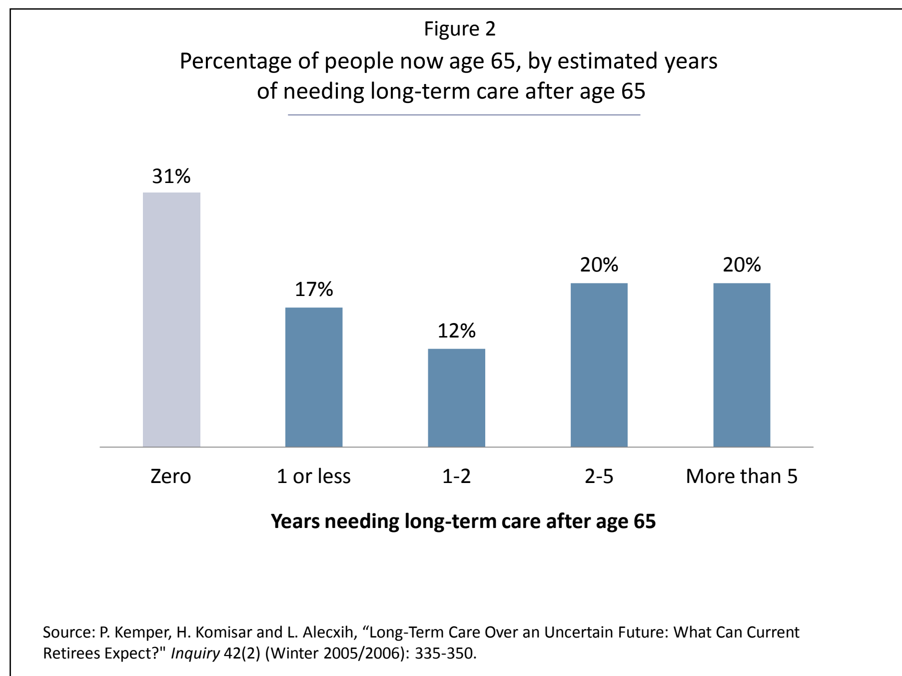
II. Medicaid's Long-Term Care Safety Net is Essential but Flawed

Why do people rely on Medicaid for long-term care? Simply put, because they lack the resources to manage on their own. Critics of Medicaid's safety net role argue that Medicaid reduces families' responsibility to save, purchase insurance, or provide for their own long-term care needs. But such arguments misjudge people's ability to plan for long-term care needs and the resources they have available if needs arise.

First, the need for long-term care is a risk, not a certainty. Although the risk of needing long-term care rises at older ages, people of all ages are at risk—and even at older ages, whether and the extent to which a person may need long-term care varies widely among individuals. Among people under the age of 65, less than two percent have long-term care needs,[1] but they constitute nearly 5 million of the 11 million people who need long-term care (**Figure 1**). Among people now turning age 65, an estimated three in ten will not need long-term care during the rest of their lives, while two in ten will need five or more years of long-term care (**Figure 2**).[2] Most people who need long-term care (over 80 percent of people with long-term care needs living at home) rely solely on family and friends to provide it and do not receive paid services.[3] But families cannot always provide the full amount, intensity, or type of care that is needed.



Source: Authors' estimate based on Kaye, Harrington & LaPlante (2010) analysis of data from the 2007 National Health Interview Survey and the 2004 National Nursing Home Survey.



Source: P. Kemper, H. Komisar and L. Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42(2) (Winter 2005/2006): 335-350.

When paid care is necessary, its costs can far exceed most families' resources. In 2011, personal assistance at home averaged $20 an hour, or about $21,000 annually for 20 hour per

week of assistance, and adult daycare center services cost an average of $70 per day, or about $19,000 on an annual basis for 5 days of services per week (**Table 1**). Assisted living services averaged about $42,000 for a basic package of services. For people who need the extensive assistance provided by nursing homes, the average annual cost is now $78,000 for a semi-private room, but varies widely among markets and averages over $100,000 in many of the country's most expensive areas.[4]

Table 1. Average national prices for long-term care services, by type of service, 2011

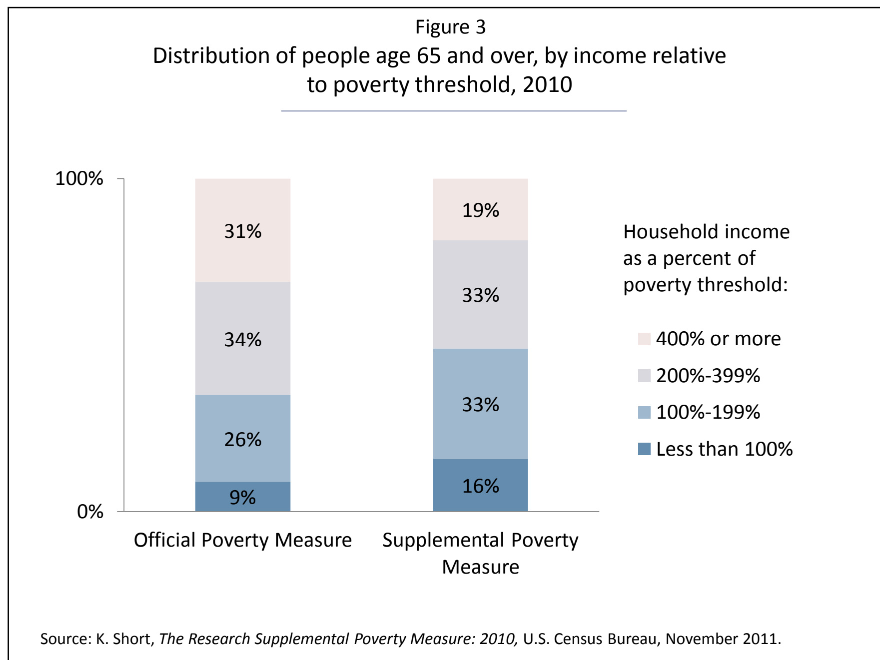
Nursing Home	$78,110 annually, semi-private room $87,235 annually, private room
Assisted Living	$41,724 annually for basic package
Home Care	$20 per hour 20 hours per week = $20,800 annually
Adult Day Services	$70 per day 5 days per week = $18,200 annually

Source: The MetLife Mature Market Institute, *Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs*, October 2011.

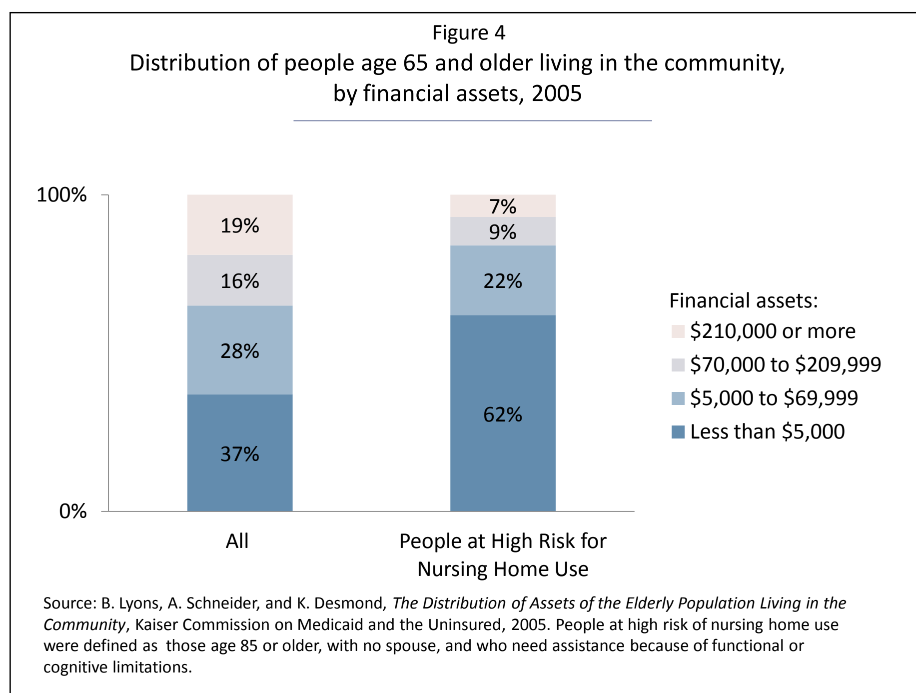
The mismatch between the costs of these services and the resources of the people who need them is dramatic. Focusing on the older people who are most at risk of needing long term care, findings from the Census Bureau allow us to see this in two ways (**Figure 3**). Using the traditional or "official" measure of poverty, fewer than a third of people age 65 and over have incomes equal to or greater than four times the federal poverty level—or about $42,000 for an individual age 65 or older, or $53,000 for a senior couple.[5] Most people's incomes are clearly well below what is necessary to pay for institutional care and insufficient to make intensive care in the community affordable.[6] The new "supplemental poverty measure" indicates that even fewer older people have income sufficient to support care needs.[7] By this measure, which, along with other adjustments, takes out-of-pocket spending for medical care into account, the proportion of people with incomes greater than four times the poverty threshold falls from almost one in three to one in five.

Although, in theory, savings can help fill the gap between income and service costs, in practice, savings are inadequate to the task. For people of working age who need long-term care, their disability often comes well before they have a chance to accumulate savings that might help pay for long-term care costs. Most older people also lack assets sufficient to finance extensive care needs. In 2005, only one in three seniors living in the community had savings of at least $70,000 (equivalent to the average cost of a year in a nursing home in 2005) (**Figure 4**). That proportion fell to 16 percent among seniors most likely to need nursing home care. Numerous seniors have low savings—more than one-third (37%) had less than $5,000 in savings in 2005.

Figure 3
Distribution of people age 65 and over, by income relative to poverty threshold, 2010



Source: K. Short, *The Research Supplemental Poverty Measure: 2010,* U.S. Census Bureau, November 2011.



Source: B. Lyons, A. Schneider, and K. Desmond, *The Distribution of Assets of the Elderly Population Living in the Community*, Kaiser Commission on Medicaid and the Uninsured, 2005. People at high risk of nursing home use were defined as those age 85 or older, with no spouse, and who need assistance because of functional or cognitive limitations.

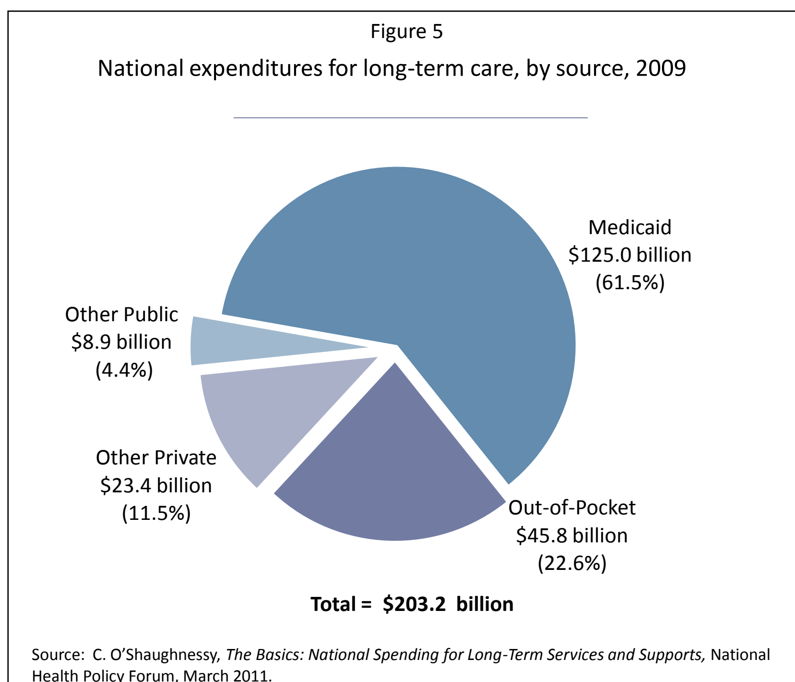
Given the unpredictability and catastrophic nature of extensive long-term care needs, heavy reliance on savings to finance them is never likely to work. Insurance is the best way to protect against the risk of unpredictable, potentially catastrophic expenses. But private insurance for long-term care has never really gotten off the ground. Only about 6 to 7 million people are estimated to currently hold any type of private long-term care insurance,[8] and most purchasers have relatively high incomes.[9] Unfortunately, many people in their 50s and early 60s are accumulating insufficient resources to cover basic living expenses in retirement**,** let alone to finance potential long-term care needs.[10] In addition, available long-term care insurance policies offer limited and uncertain benefits—raising questions about the wisdom of purchase. Policies limit benefits in dollar terms in order to keep premiums affordable, but therefore can leave policyholders with insufficient protection when they most need care; and policies have often lacked the premium stability that can assure purchasers of their ability to continue to pay in year after year, in order to receive benefits if and when the need arises.

Policies to promote or subsidize the purchase of private long-term care insurance (sometimes accompanied by consumer protection requirements) are intermittently proposed to encourage more people to purchase this type of insurance. But analysis shows that such subsidies are more likely to benefit people already able to purchase insurance on their own than to extend the market.[11] Further, without market reforms, these policy options are unlikely to create a dependable insurance marketplace. We need only look at experience in the non-group market for health insurance—plagued by risk selection, high marketing costs, benefit exclusions, and other problems— to recognize that reliance on that market for long-term care insurance will be grossly inadequate to assure most people sufficient protection.

The Community Living Assistance Services and Supports (CLASS) Act—included in the Affordable Care Act—was intended to establish public, rather than private, long-term care insurance as a core means of protection against the risk of long-term care needs.[12] CLASS was designed to provide a limited daily cash benefit to people with functional impairments who make at least five years of payments beginning during their working years (and continue to pay premiums thereafter). CLASS relies on voluntary participation and is required, by law, to be fully premium financed. However, in October 2011, the Secretary of the Department of Health and Human Services suspended implementation of CLASS.[13] Although CLASS has not been repealed, its future as a basis for public long-term care insurance is tenuous, at best.

Medicaid pays for most long-term care expenditures but its protections are limited and vary across states

Given long-term care costs and the absence of insurance, it is not surprising that when people need extensive care, they often rely on Medicaid to help pay for it. In 2009, Medicaid financed 61.5 percent of national long-term care spending ($203 billion) **(Figure 5).**[14] Medicaid paid in part or in full the costs of about two-thirds of the nation's 1.5 million nursing home residents.[15] An estimated 2.3 million people received Medicaid-financed home and community-based services during 2007.[16] Spending on long-term care services accounts for a full third of all Medicaid spending,[17] and for 70 percent of Medicaid spending on the 9 million people who are "dual-eligibles" (that is, beneficiaries of both the Medicare and Medicaid programs).[18]



Source: C. O'Shaughnessy, *The Basics: National Spending for Long-Term Services and Supports,* National Health Policy Forum, March 2011.

To qualify for Medicaid protection, individuals must have low income and savings to begin with, or exhaust the resources they have in purchasing medical and long-term care.[19] Given how high service costs can be, the opportunity to qualify for Medicaid when the costs exceed an individual's income and savings is essential to assure that people have access to care. Most nursing home users age 65 and older who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission.[20] But about 14 percent of nursing home users age 65 and older begin their nursing home stays by spending only their own resources and then become eligible for Medicaid when their financial resources are exhausted.[21] Medicaid recipients in nursing homes are required to spend all of their income on their nursing home care (subject to limits for people with spouses at home), except for a small "personal needs allowance" of $30 to $60 in most states.[22]

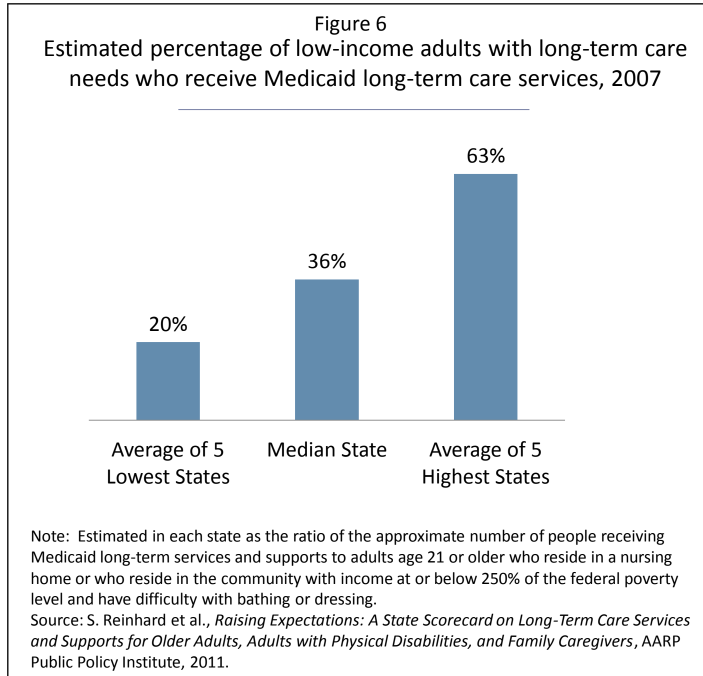
Some argue that people "transfer" their assets in order to qualify for Medicaid rather than exhaust their assets before they qualify, allowing even well-to-do people to qualify for Medicaid benefits. But evidence shows the following realities: 1) few older adults have the income or wealth that would warrant such transfer; 2) people in poor health are more likely to conserve than to exhaust assets; 3) for the elderly population as a whole, transfers that occur are typically modest (less than $2000); and 4) transfers associated with establishing eligibility are not significant contributors to Medicaid costs.[23]

Despite Medicaid's importance, its protections vary considerably from state to state and, in most if not all states, fall short of meeting people's needs. Variation takes multiple forms. The first variation is in the breadth or narrowness of its eligibility requirements and the share of people in need of care each state's program serves. To estimate the "reach" of states' Medicaid long-term care programs, a recent study by the AARP measured the ratio of the number of people receiving Medicaid long-term care services in each state to the state's number of low-income adults with difficulties in activities of daily

living (an estimate of the number of people with long-term care needs).[24] This ratio provides an approximate measure of the proportion of low-income adults with long-term care needs who receive Medicaid long-term care services. The states with the most extensive coverage are estimated to reach about two thirds of low-income adults with long-term care needs—about three times the share in the states with the least extensive programs (**Figure 6**). Half the states reach only about a third of this population.

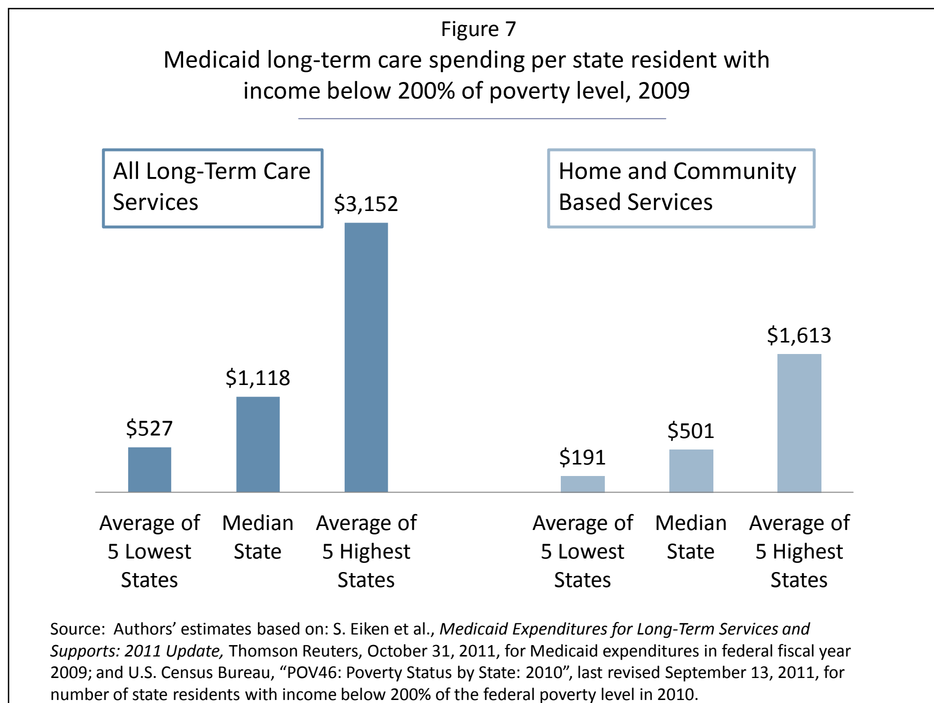
Even greater variation among state programs is apparent when comparing states' Medicaid long-term care spending per low-income state resident. This measure reflects the combined effect of a state's breadth of eligibility with the generosity of services it provides (**Figure 7**). Medicaid long-term care spending per low-income state resident in the highest spending states (averaging $3,000 in federal fiscal year 2009 in the 5 highest states) is about six times the amount of the lowest spending states (averaging $500 in the 5 lowest states). The range is still larger—from about $1600 to about $200, or eight to one—for Medicaid's non-institutional long-term care services for people in the community, the setting where most people with long-term care needs reside.

Figure 6
Estimated percentage of low-income adults with long-term care needs who receive Medicaid long-term care services, 2007



Note: Estimated in each state as the ratio of the approximate number of people receiving Medicaid long-term services and supports to adults age 21 or older who reside in a nursing home or who reside in the community with income at or below 250% of the federal poverty level and have difficulty with bathing or dressing.
Source: S. Reinhard et al., *Raising Expectations: A State Scorecard on Long-Term Care Services and Supports for Older Adults, Adults with Physical Disabilities, and Family Caregivers*, AARP Public Policy Institute, 2011.

Figure 7
Medicaid long-term care spending per state resident with income below 200% of poverty level, 2009



Source: Authors' estimates based on: S. Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011, for Medicaid expenditures in federal fiscal year 2009; and U.S. Census Bureau, "POV46: Poverty Status by State: 2010", last revised September 13, 2011, for number of state residents with income below 200% of the federal poverty level in 2010.

Low spending on community-based care relative to institutional care reflects Medicaid's historical emphasis on nursing homes as the primary locus of long-term care support. Over the past two decades, states have moved toward greater balance. In 2009, 44 percent of Medicaid long-term care spending nationwide was for home and community-based services, up from 18 percent in 1995.[25] But this overall trend obscures disparate treatment within the Medicaid population, as well as across states. Home and community-based services constitute a significantly larger share of spending on long-term care services for people with developmental disabilities (66 percent nationwide) than for older adults and people with physical disabilities (36 percent nationwide). One source of this difference is that community-based long-term care services for people with developmental disabilities are more likely to consist of 24 hours per day of support (for example, provided by group homes). For older people and people with physical disabilities, nursing home and other institutional services continue to dominate spending in most states, with substantial variation across the nation (**Table 2**). Half the states direct more than 70 percent of their long-term care spending on this population to nursing home and other institutional services. But the community-based services' share of long-term care spending in the most community-oriented states was almost six-fold the share in the states that were most institution-oriented (63 percent on average in the five highest states compared with 11 percent on average in the five lowest).

Table 2. Percentage of Medicaid long-term care spending on services for older adults and people with physical disabilities that is for non-institutional services, 2009

Lowest state	4%
Average of 5 lowest states	11%
Median state	28%
Average of 5 highest states	63%
Highest state	79%

Source: Authors' calculations based on data from S. Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update,* Thomson Reuters, October 31, 2011. Amounts are for federal fiscal year 2009.

This variation in the availability of home and community-based care services across states, particularly for older people and people with physical disabilities, has enormous consequences in terms of access to adequate care. Unlike most Medicaid services, which the law requires be made available to all people eligible, home- and community-based care is subject to enrollment caps. Most states have limits on enrollment and establish waiting lists for care at home.[26] Most people who have long-term care needs are, in fact, at home—and dependent primarily on family for the services they need. But surveys have shown that many people living at home are receiving insufficient care and, as a result, are at heightened risk of negative consequences—like falling, soiling themselves, or going without bathing or eating. Analysis indicates that the prevalence of unmet needs for long-term care, though significant across the country, is lower in states with greater availability of services at home.[27]

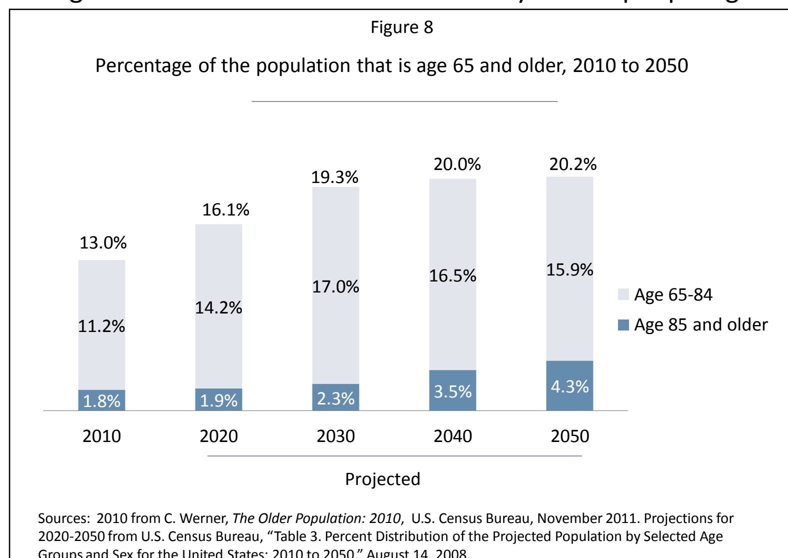
III. Challenges and Choices for the Future

Medicaid's challenges in meeting the needs of its eligible population are not limited to long-term care. The deep and extended economic recession is seriously squeezing Medicaid resources at the same time it increases the demand for services—particularly among low-income families. The availability of an enhanced federal match from 2009-2011 alleviated some of this financial burden. But the extra match ended in June 2011, and the squeeze continues—affecting all Medicaid beneficiaries, whether or not they need long-term care.

The threat to Medicaid's ability to address long-term care needs goes beyond the business cycle. The aging of the population affects Medicaid just as it affects Medicare and Social Security. Having more older adults—especially very elderly people—will increase the need for long-term care. The percentage of the population aged 85 and older is expected to increase by more than one-quarter by 2030 (from 1.8 percent in 2010 to 2.3 percent in 2030) and to more than double by 2050 (to 4.3 percent) (**Figure 8**). It is among this population that the need for long-term care is most substantial. Nearly 3 in 10 people age 85 years or older have moderate to severe long-term care needs—three times the proportion among 75-84 year-olds (**Figure 9**). As the baby boom generation ages, more people will need more long-term care.

Figure 8

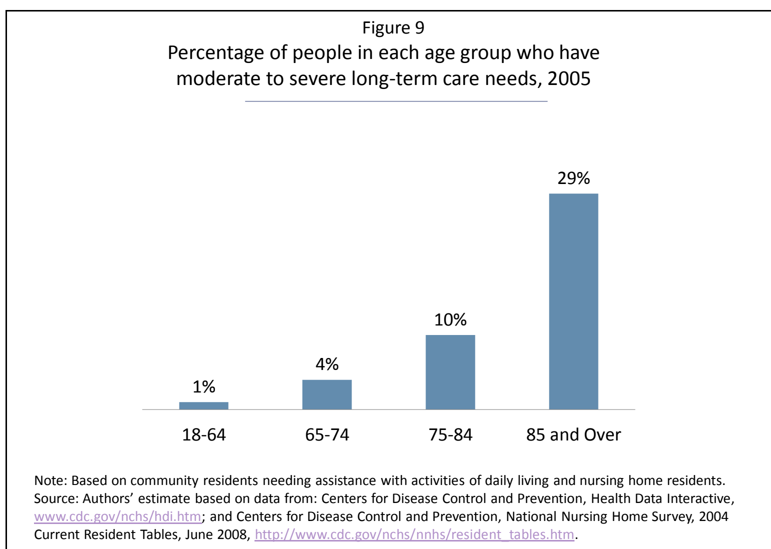
Percentage of the population that is age 65 and older, 2010 to 2050



Sources: 2010 from C. Werner, *The Older Population: 2010*, U.S. Census Bureau, November 2011. Projections for 2020-2050 from U.S. Census Bureau, "Table 3. Percent Distribution of the Projected Population by Selected Age Groups and Sex for the United States: 2010 to 2050," August 14, 2008.

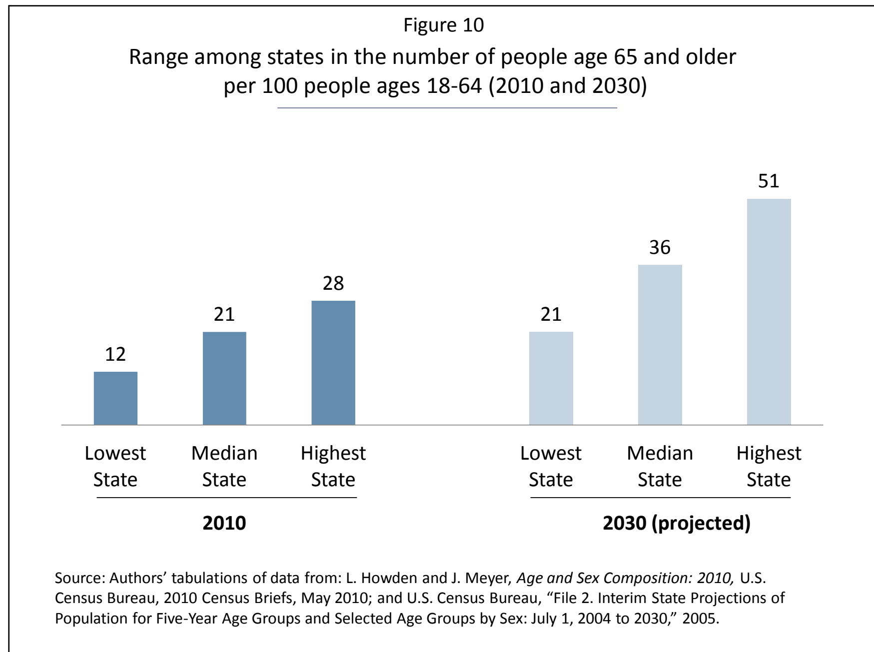
Figure 9

Percentage of people in each age group who have moderate to severe long-term care needs, 2005

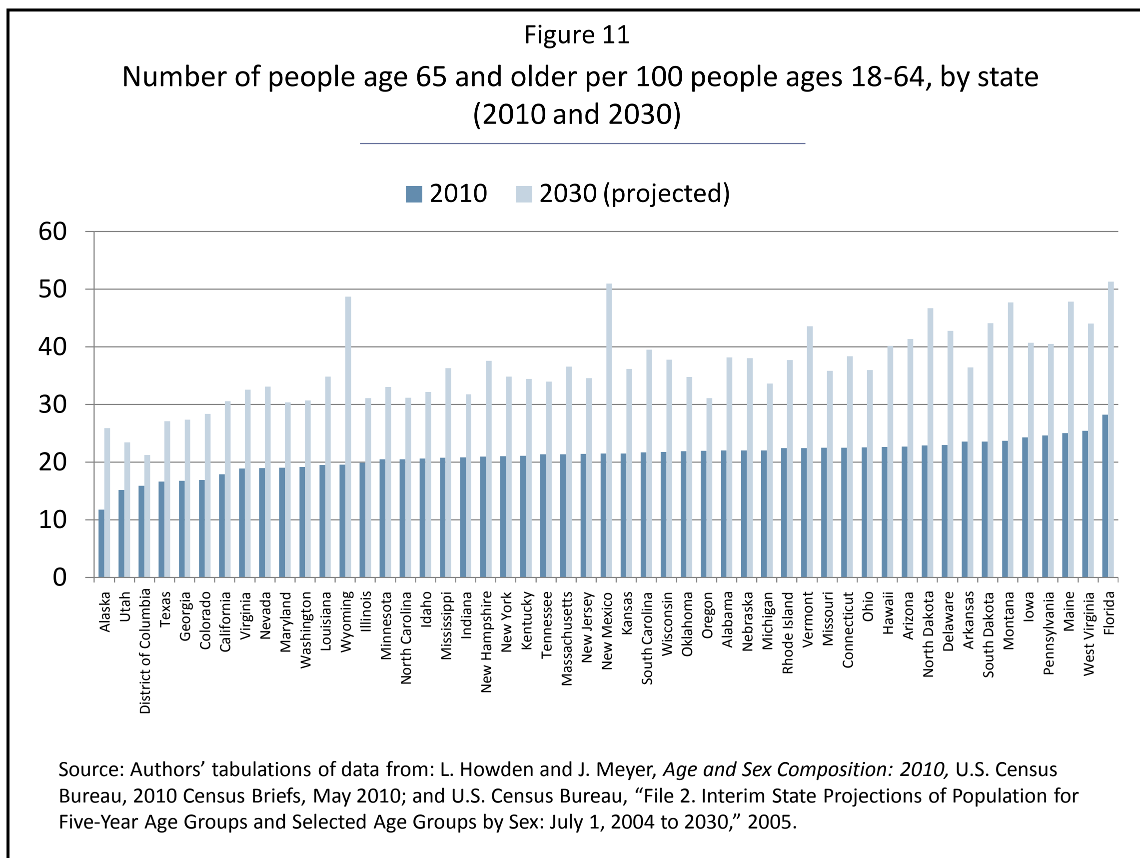


Note: Based on community residents needing assistance with activities of daily living and nursing home residents. Source: Authors' estimate based on data from: Centers for Disease Control and Prevention, Health Data Interactive, www.cdc.gov/nchs/hdi.htm; and Centers for Disease Control and Prevention, National Nursing Home Survey, 2004 Current Resident Tables, June 2008, http://www.cdc.gov/nchs/nnhs/resident_tables.htm.

States are aging at different rates and the adequacy of their resources varies considerably



The population is aging in every state. But the effects—and the burdens—of an aging population will be larger in some states than others. Key to the adequacy of public resources to support the needs of older people will be the availability of working people to generate resources—measured as the ratio of one age group to the other. In 2010, the number of people aged 65 per 100 people aged 18-64 ranged from 12 in the "youngest" state to 28 in the oldest state (**Figure 10**). By 2030, this ratio is projected to grow in all states and the range to expand from 21 in the youngest states to 51 in the oldest. In 2030, more than half of the states will have a ratio greater than the highest state has today. On the whole, the "oldest" states today will continue to be among the "oldest" in 2030 (**Figure 11**).



It is uncertain whether any state has the capacity to deal with the needs of an aging population.[28] What is certain is that the greater the imbalance between the older population and the working age population, the greater challenge states will face in sustaining, let alone improving, the adequacy of long-term care services. As a result, the inadequacy and inequity that already characterizes Medicaid long-term care services across the states is likely to grow substantially worse in the years to come. To address today's insufficiencies and to build a better and more equitable system for the future, a change in financing is required.

Medicaid's current matching approach leaves inequities and inadequacies in place for the future

Medicaid's inadequacies and inequities at least partially reflect the influence of its financing mechanism—an open-ended federal match of state spending. The federal match varies, from a minimum of 50 percent to a high of 74 percent, based on a formula that provides a larger federal share to states with lower per capita incomes.[29] The purpose of the formula is to facilitate spending in poorer states and, in general, to encourage spending.

In practice, however, providing lower-income states' greater incentives to spend has not offset variations in state incomes in shaping Medicaid spending. A 2001 Urban Institute analysis of thirteen states found that a 1 percent increase in per capita income was associated with about a 2 percent increase in state Medicaid spending per low-income person.[30] For example, a state with 10 percent higher average income than another state would spend 20 percent more per low-income resident. As a result, even with higher Medicaid matching rates for low-income states, low-income states had total (federal and state) Medicaid spending per low-income resident that was substantially less than in higher-income states.

The aging of the population is only likely to exacerbate this variation—as the share of the population likely to need services grows relative to the working-age population needed to support them.[31] As the population ages, only an expansion of federal responsibility for financing long-term care services is likely to prevent or reverse growing inadequacy and inequity in the availability of Medicaid support for long-term care.

Enhanced federal support is needed for an equitable and sustainable long-term care safety net

At least two approaches of enhanced federal support are worthy of exploration. First is the full federal financing of a federally-defined long-term care benefit for dual eligibles (that is, low-income seniors and people with disabilities who are eligible for both Medicare and Medicaid)—which from its inception, assures greater equity in service availability across states, as well as absorbing from the states responsibility for financing care to a growing elderly population. Second is a substantially enhanced federal match for Medicaid long-term care, tied to the aging of the state's population, which encourages rather than assures greater equity but, like the first option, largely shifts the financial burden of aging to the federal level.[32]

Full federal financing of long-term care for dual eligibles

The first—and the most straightforward approach to promoting both equity and adequacy—is replacement of the federal-state matching formula with full absorption of financing for a standard package of long-term care services for dual eligibles at the federal level. This option would establish nationally-uniform standards for eligibility and long-term care benefits for low-income Medicare beneficiaries of all ages (that is, seniors and younger people eligible for Medicare because of disabilities). This option could be designed as a uniform long-term care benefit incorporated into the Medicare program. Alternatively, as a program targeted to low-income people, it could be achieved by establishing a nationally-uniform minimum benefit with federal financing that states could enhance with federal matching funds. Because we are focusing on the safety net rather than a universal program (like Medicare, providing coverage to all who qualify without regard to income), we explore the latter approach here. Implementation of the benefit would be handled at the state level, enabling the program to benefit from state initiatives in service delivery and care coordination that are now being promoted.[33] Federalizing long-term care financing for dual eligibles in this way would resemble the establishment of the Supplemental Security Income program for low-income older adults and people with disabilities in 1972, which replaced federal matching grants to states with a federally-financed, federal-state administered, "floor" of income protection.[34]

A new federally-financed long-term care program for dual eligibles would set a nationally-uniform benefit standard for dual eligibles, designed to fall somewhere in the middle of the range of state long-term care programs today. To achieve equity and control spending growth, the benefit would be nationally defined—with specific benefits assigned based on an individual's needs, as determined by a standardized assessment process. In addition, payment rates to providers would be federally defined and adjusted for geographic variation in input costs, like Medicare payment rates. States would have the option of providing additional services to supplement the federal benefit, and could receive federal matching funds for those services.

States would be required to contribute toward the costs of the new federal benefit, as they currently are to the Medicare prescription drug benefit[35]—specifically, states would be required to pay the federal government an amount initially equivalent to either their current long-term care spending on dual eligibles or, for state's whose current programs are "more generous" than the federal standard, an amount equivalent to what it would cost them to offer the uniform federally-defined benefit. The state payment amount would be increased annually by an index measuring inflation (as measured by wage growth or the consumer price index, for example) and growth in the state's population. The population adjustment increases the state's contribution as its revenue capacity increase. The index holds states "harmless" for disproportionate growth in the dually-eligible population in need of service (that is, for growth in the dually-eligible population that exceeds the rate of growth of the overall population). The result is that as states get older, they would pay less than under current arrangements to maintain the same level of service. The federal government, on the other hand, would pick up the costs of expansion to the federally-defined benefit level in states now below it, and most of the costs of a growing number of dual eligibles in all states. Federal matching funds would continue to be available to states providing additional benefits beyond the federally-defined standard.

By establishing and sustaining a nationally-uniform benefit floor across all states, this proposal has the potential to "uplift" a substantial portion of the population to a higher level of service—enhancing both adequacy and equity into the future. Arguments for this proposal include the fact that the federal government is already financing roughly 80 percent of dual eligibles' acute and long-term care—financing nearly all their acute care, through Medicare, and more than half their Medicaid long-term

care services.[36] Were the federal government to pick up the rest, it would bring an end to current incentives to shift responsibilities and costs from one program to the other and, if well managed, encourage federal coordination of services across the full spectrum of an individual's care needs.

Aging-based enhancement of federal match for long-term care services

A different approach to strengthening the long-term care safety net would be a substantial increase in federal financing through an enhanced matching rate, tied to the proportion of a state's population who are low-income seniors. Such an approach would resemble the recent enhancement of state matching rates to reflect states' unemployment levels,[37] that is, increasing federal responsibility for a national challenge—in this case, the aging of the population. However, it would differ from the unemployment approach in its permanence and its design to have the federal government bear most of the burden of an aging population over time. Unlike the previous approach, the enhanced match would leave it to states to determine benefits and payment, much as they do today. Further, this approach would affect all Medicaid recipients of long-term care, rather than applying only to dual eligibles.

Under this approach, the federal government could adopt a range of matching enhancements for long-term care spending depending on the "age" of the state; for example, the enhancements could initially range from perhaps an addition of 5 percentage points to the current federal share for states that are now the "youngest" to an addition of 10 or 15 percentage points for states that are now the "oldest." A state's "age" would be measured based on the ratio of its population age 75 or over with incomes below 300 percent of the federal poverty level (the population most likely to need Medicaid long-term care services) to its working aged population (the population providing the bulk of the financial resources in the state).

Some might advocate that the enhanced match apply only, or differentially, to home and community-based services, in order to encourage "rebalancing" away from institutional care. But aging will challenge states' capacity to deliver both institutional and non-institutional services. Focusing enhanced federal support only on community services could put adequacy of institutional care at risk. An enhanced match applying to all long-term care services will facilitate the increased emphasis on community-based services that is already occurring.

To assure that enhancements expand service and eligibility levels—rather than replace state funds—states would be required to spend enhancement dollars on long-term care and to sustain at least their current eligibility and benefit standards (or initial spending levels). Over time, the enhanced matching rates would partially relieve the states of the burden of an aging population with increasing long-term care needs. A state's "age" would be periodically recalculated and the federal enhancement would increase with the increase in a state's "age" (that is, ratio of people age 75 or older with income below 300 percent of poverty to the working age population). The relationship between the ratio and the enhancement would be fixed, so as states age, the maximum enhancement would also rise (as ratios increase in all states), subject to a maximum enhancement of 20 or 25 percent.

Unlike the previous option, which targeted federal financing to the least generous states, this second option would initially focus enhanced federal financing on states with the largest shares of residents likely to need help paying for long-term care services. This option's different approach to targeting, along with the absence of the previous option's nationally-defined benefit and payment schedule, will likely mean continued wide variation in service availability across the states. Tying the availability of federal financing to the share of a state's population that is older and unable to afford services will likely enhance the adequacy of the safety net in all states.

IV. Conclusion

Forty years ago, Congress enacted the Supplemental Security Income program to promote greater adequacy and equity in income support for low-income older people and people with disabilities. The Supplemental Security Income program replaced federal matching grants to states with full federal financing of basic income support. Now is the time to take a similar step with respect to long-term care financing in Medicaid.

The current Medicaid long-term care safety net, though invaluable to people who rely on it, leaves too many people who need services without them and makes the adequacy of services a function of where people live. Today, variations in adequacy are considerable. Half the states reach only about a third of the low-income population with long-term care needs, and the least generous states achieve only about a third the reach of the most generous. Long-term care spending per low income person in the state—which reflects not only who gets served but how much service they get—varies even more: six-fold from the most generous to the least generous states for all long-term care services and eight-fold for services at home or in the community. Limited service is associated with reports of greater "unmet need"—or going without—among people who rely on others for help dressing, toileting, eating and performing other basic tasks of daily life.

Over the next two decades, the aging of the population will double the share of the population that is over age 85, the age group most likely to need long-term care. All states will experience the increase, but some states will face greater challenges than others—measured by the growth in the ratio of the older population to the working age population. States already strapped in their ability to provide long-term care services will find themselves more strapped over time, and both inadequacy and inequity of service across the nation will likely increase.

Neither the inequity nor the inadequacy of Medicaid long-term care services across states is a problem likely to be solved with greater "flexibility" in states' use of existing resources and admonitions to pursue greater efficiency. Although long-term care at home has the potential to serve more people at lower cost than current reliance on nursing homes for the bulk of care to older adults in need, currently low levels of service resources mean that greater resources will be essential to meet the needs of a growing elderly population.

The fundamental problem is not inefficiency; rather it is basic demographics and distribution of resources. With a growing older population dispersed unevenly across states, deficit reduction proposals that would take the federal government out of the financing picture or reduce its role would clearly worsen, rather than improve, current long-term care financing deficiencies. Block grants or other financing mechanisms to arbitrarily limit growth in federal financing will lock inadequacy and inequity in place and worsen it over time. Even Medicaid's open-ended federal matching grants, designed to provide greater assistance to more hard-pressed states, will increasingly fall short in establishing a decent floor of long-term care protection across the nation.

Achieving an equitable, adequate, and viable long-term care safety net clearly requires greater, not lesser federal financial involvement is required. To that end, we have proposed two options. Full federal financing of long-term care for dual eligibles would, like enactment of the Supplemental Security Income program, replace federal matching grants to the states with a new uniform standard of eligibility and benefits. States would continue to share in benefit costs but would be "held harmless" from the burden of an aging population—which would be absorbed by the federal government. The second option, similar to the recent enhancement of the federal match to help states cope with severe unemployment,

would retain federal matching rates but increase the federal share as the state's "age" increases (as measured by the ratio of low-income older people to people of working age in the state).

An enhanced match for long-term care services would leave in place more variation and inequity across states (at lower federal cost) than full federal financing of long-term care for dual eligibles. But by "cushioning" states from the costs of providing services for a growing older population, enhanced federal matching rates would sustain greater adequacy of long-term care services in all states.

Achieving greater equity and adequacy of long-term care service—along with state fiscal relief—will carry a significant price in increased federal spending. It is hard to be optimistic that the nation will be willing to pay this price, given political battles around financing even current service commitments. But this brief documents that a failure to adequately finance a long-term care safety net also carries a price: the inevitable deterioration in care for growing numbers of people unable to care for themselves. Whether this is a price the nation can tolerate is a question yet to be squarely addressed.

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Notes

[1] Authors' estimate based on data from: H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29(1) (January 2010): 11-21; and U.S. Census Bureau, "Table 1. Population by Age and Sex: 2007," May 2009, http://www.census.gov/population/www/socdemo/age/age_sex_2007.html.

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