Medicaid and Long-Term Care for the Elderly: Implications of Restructuring

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ANY DISCUSSION OF MEDICAID RESTRUCTURING IS necessarily a discussion of long-term care. With the cost of long-term nursing-home or in-home care beyond the means of most elderly and their families, it is Medicaid that fills the breach. Unlike insurance that protects against catastrophic expenses, Medicaid covers long-term care once financial catastrophe has occurred and resources are exhausted. In so doing, it has become the primary payer for long-term care, accounting for 47 percent of the almost \$72 billion spent on nursing-home services in 1994 (Levit et al. 1996).

Although Medicaid is often perceived primarily as a health insurance program for low-income mothers and children, long-term care absorbs a sizable and, relative to the number of users, disproportionate share of the program's spending. Over one-third of Medicaid's dollars go to long-term care received by fewer than 10 percent of all recipients (fig. 1). The elderly are the primary, although not the sole, users of long-term care, accounting for nearly 60 percent of total expenditures on long-term-care services (Kaiser Commission on the Future of Medicaid 1996).

FIG. 1. Medicaid spending on long-term care for fiscal year 1994. Long-term care includes spending for nursing homes, intermediate care facilities for the mentally retarded, and home health care. DSH = disproportionate share hospital payments.

Given Medicaid's significance to long-term care, and long-term care's significance to Medicaid, changes in Medicaid's financing or program structure have enormous implications for long-term care, as they affect how much assistance is available, for which kinds of services, and on what terms. Even with no federal changes in Medicaid, fiscal pressure at the state level may produce policies that affect the availability of long-term-care services. However, legislative action to restructure Medicaid, as contemplated in the 1995–96 debate on balancing the federal budget, could have even more dramatic effects.

Neither the 1995–96 debate nor the 1997 budget agreement actually produced Medicaid restructuring of this kind. However, the pressures that produced restructuring proposals are likely to persist. The purpose of this article is to inform future debates on Medicaid by examining the potential impact of 1995–96 restructuring proposals on long-term care. Potential effects reflect two kinds of policy changes: financial restructuring—changing the way federal dollars are provided to states; and program restructuring—changing the ways states use federal dollars. In brief, this examination of 1995–96 balanced budget legislation reveals the following points: Proposals like that offered by the congressional majority, which fix, reduce, and reallocate federal Medicaid funds,

reduce state even more than federal spending and disproportionately affect states that have historically provided the broadest long-term-care coverage. Even federal spending limits that neither fix nor reallocate federal funds (like the Clinton administration proposal for per capita caps) favor substitution of low-cost elderly Medicaid beneficiaries for relatively high-cost users of long-term care. Regardless of approach, all proposals would increase competition among Medicaid beneficiaries and services for a more limited pool of public dollars. Although long-term care's middle-class constituency and a heavily dependent nursing-home industry may give long-term care a competitive advantage, limited resources and financial incentives could nevertheless reduce states' willingness or ability to invest in long-term care. Home- and community-based care may be particularly at risk. Reduced investment, along with program restructuring that gives states more flexibility, could mean significant reduction in the choice and quality of long-term-care services available, reduced access to care, and higher out-of-pocket payments for Medicaid beneficiaries and their families.

Proposals to Restructure Medicaid

Proposals to restructure Medicaid were initiated as part of efforts to balance the federal budget. However, some proposals went well beyond simply limiting federal dollars to fundamentally alter the nature of Medicaid's insurance protections—both in general and specifically with regard to long-term care. In the course of the 1995–96 budget debate, three sets of proposals received serious consideration: proposals the congressional majority introduced, most notably, the Balanced Budget Act of 1995¹; proposals President Clinton's administration put forward following his veto of the Balanced Budget Act²; and proposals based on recommendations by the National Governors' Association,³ aimed at reconciling the congressional and administration approaches. These three sets of proposals affected long-term care both indirectly, by constraining total Medicaid dollars and altering the terms of their availability, and

¹H.R. 2491.

²FY 1997 Budget. U.S.DHHS (March 12, 1996).

³National Governors' Association (1996). *Restructuring Medicaid, as Adopted 2/6/96*. Washington, D.C.

directly, through specific changes in Medicaid long-term-care policy. The most significant changes involved five key policy areas: federal and state financing; entitlements to coverage; family financial protections and obligations; nursing-home quality; and state flexibility in program design and operation.

Proposals for Financing

Both the total amount and the structure of Medicaid financing were central issues in the budget debate. Currently, spending on Medicaid is determined by the cost of care for enrolled people. The federal and state governments split this cost, based on a matching rate or federal medical assistance percentage (FMAP) that varies inversely with a state's per capita income. In aggregate, the federal government pays 57 percent and state governments pay 43 percent of total Medicaid costs. The 1995–96 proposals, for the first time, capped federal Medicaid spending. The congressional proposals would, in addition, substantially alter the distribution of federal dollars across states and reduce many states' contribution to Medicaid costs.

The initial congressional proposal⁴ and the subsequent Balanced Budget Act replaced the open-ended Medicaid funding structure with fixed-dollar or block grants to states; grants were to be determined independent of actual program costs. The initial 1995 balanced budget proposal capped federal funding between 1996 and 2002 at a level \$183 billion less than expenditures projected under current law—nearly a 30 percent reduction in anticipated federal spending in 2002 alone. In the Balanced Budget Act, federal savings were \$163 billion. The proposals allocated the fixed federal total to states through initial "allotments" and specified growth rates for subsequent years that reduced variation in federal spending across states. Receipt of the federal allotment remained contingent on matching payments by states. However, the proposals changed the matching rates, so that many states' minimum matching payments were reduced from 50 percent to 40 percent of program spending.

The Clinton administration also proposed to cap federal funding, but by modifying rather than replacing the current financing of Medicaid.

⁴H.R. 104–208. Medicaid Transformation Act of 1995.

The administration proposal constrained the year-to-year growth in federal payments per enrollee (per capita cap). In contrast to a block grant proposal, a per capita cap does not constrain total spending; federal expenditures change as enrollment changes. Under the proposal, maximum federal funding to each state would be set based on the state's 1995 spending per beneficiary, calculated separately for four groups (aged, disabled, adults, and children) to adjust for states' different mixes of beneficiary and benefits, increased by a set factor, and multiplied by the actual enrollment in the states. These proposed limits, in conjunction with reductions in special Medicaid payments for hospitals with disproportionate shares of Medicaid or uninsured patients, would reduce federal spending by an estimated \$54 billion through 2002, about 13 percent below projected program spending under current law in 2002 alone.

To help bridge the congressional and administration proposals, the governors' resolution included elements of both. Under the resolution, a state's funding would have two parts: a fixed allocation (similar to the congressional approach) plus an "umbrella" fund to provide supplemental funds if enrollment growth rose higher than anticipated (similar to the administration approach). The resolution, like the congressional proposal, also recommended reductions in many states' required shares. In the congressional majority's interpretation of the resolution,⁵ the umbrella fund did not truly allow funds to vary with actual changes in enrollment, and the base allocation was virtually identical to their earlier approach. In contrast, a bipartisan interpretation allowed the funding to reflect enrollment growth, did not allow changes in the state contribution, and had an umbrella also adjusted for enrollment changes.⁶

Proposals for Entitlement to Coverage

One of Medicaid's defining characteristics is the federal entitlement it confers on its beneficiaries. That entitlement, roughly analogous to an insurance contract in the private sector, has three components: (1) a legal right, enforceable in federal court, to (2) a defined set of benefits for (3) people who satisfy specified eligibility criteria. All aspects of this Medicaid entitlement were challenged in the 1995–96 debate.

⁵H.R. 3507 and S. 1795. Welfare and Medicaid Reform Act of 1996.

⁶*Cong Rec.*, 4/25/96; Senate Amendment 4018 (May 20, 1996).

Currently, federal law requires states to cover nursing-home care for very poor elderly people judged to need such care and gives states the option (which all states take) to cover people with resources above poverty but still insufficient to cover long-term-care costs. States are required to cover people who qualify for Supplemental Security Income (SSI). In 1995, eligibility standards were \$5,640 for individuals and \$8,640 for couples. States may cover people whose spending on nursing-home care reduces income to eligibility levels or whose incomes are below a special income standard (up to 300 percent of the SSI level). In states that use this special income standard, people with higher incomes can become eligible only if they put income above the standard in so-called Miller trusts, recoverable by the state when the resident dies.

Federal law also allows but does not require states to cover long-term care at home or in the community. Although it requires states to cover home health care for people eligible for nursing-home care, home health may focus more on skilled care than on the personal care services that constitute long-term care. Federal law gives states the option to cover personal care, but most spending for such services is in New York (U.S. Health Care Financing Administration 1994 data). Through waivers, it explicitly allows states to limit these services with respect to the number, type, and location of people served, as well as the volume of services provided.

Despite the entitlement, access to Medicaid coverage for long-term care (even more than for other services) has always been limited by the availability of providers willing to deliver services at Medicaid's relatively low rates. This has been explicitly the case for home- and community-based services and indirectly the case for nursing-home care. However, Medicaid's entitlement means that for nursing-home care and, up to limits for home- and community-based care, eligible people who obtain service from a provider willing to participate can count on Medicaid to pay for their care.

The earliest proposal by the congressional majority eliminated all elements of the Medicaid entitlement. Instead, the proposal required only that states "set aside" a share of each year's total spending—to use on any services they might choose—for three of the groups the law currently requires states to cover: low-income mothers and children, people with disabilities, and low-income elderly. Set-asides were to reflect states' historical shares of spending on federally required coverage for these groups—along with spending on nursing-home residents whom

states currently have the option to cover. In total, these set-asides obligated less than 50 percent of the block grant funding (U.S. Department of Health and Human Services 1995). Criticism of such limited population protections led to modifications as this proposal went through the legislative process. Although lacking any further specification of benefits, the Balanced Budget Act of 1995 required states to “guarantee” coverage for poor pregnant women and children under the age of 13, and for people with disabilities, as defined by states. No “guarantees” were included for low-income elderly or elderly in need of long-term care. No group or individual had the right to sue for coverage.

The administration proposal left Medicaid’s current entitlement and coverage provisions intact. The governors’ resolution restored some protections but fell short of Medicaid’s current entitlement. The resolution recommended extension of the “guarantees” in the Balanced Budget Act of 1995 to include almost all population groups that federal law now requires states to cover, although it did not recommend coverage guarantees for children aged 13 through 18, a group that would be covered under current law by 2002. In addition, its recommendation of state rather than federal definitions of disability could exclude people in these categories who are covered under current law. The resolution further required that states offer almost all benefits, including nursing-home care, that federal law compels them to offer. However, the resolution gave states “complete flexibility” to establish the amount, duration, and scope of these benefits, and to vary their provision across population groups and geographic areas. While establishing individuals’ right to sue for benefit enforcement in state court, it retained prohibitions on individuals’ access to federal courts. Like earlier congressional proposals, this proposal allowed the secretary of health and human services to sue states for compliance in federal court. The congressional majority’s interpretation of the governors’ resolution offered similarly limited “guarantees” of coverage and legal remedies. The bipartisan proposal restored the entitlement in current law.

Although the legislative process moved congressional proposals ever closer to current Medicaid law, even the 1996 proposals departed significantly from Medicaid’s current federal entitlement and coverage provisions. First, despite the language of “guarantees,” elimination of the Medicaid statute and, by extension, associated federal regulations and case law creates an opportunity for states to exercise considerable discretion in specifying who qualifies for what kinds of services. Second,

access to state courts is not a perfect substitute for access to federal courts in terms of enforcement of "guarantees." Federal courts provide a broader and more forceful set of remedies for action found to be unlawful than are typically available under state law, including injunctions that stop the action or force alternative action. In addition, federal courts establish precedent that applies consistently across cases, over time, and across the 50 states. Reliance on state rather than federal court would instead produce considerable variation in interpretation and enforcement across states. Finally, when considered in conjunction with the financing changes described above, these legislative proposals provide insufficient federal dollars to support the entitlement to coverage specified in current law. Whether that fact abrogates the entitlement or leaves states on the fiscal hook would undoubtedly be litigated (and differentially resolved) in any number of state courts.

Proposals for Family Protections and Obligations

Although Medicaid's long-term-care protections are contingent upon beneficiaries' exhaustion of their own incomes and resources, family members are currently protected against similar impoverishment in a variety of ways. Proposals to repeal and replace the Medicaid statute called these protections into question.

Under current law, people who are not impoverished can become eligible for Medicaid long-term-care protections, but, once eligible, they contribute virtually all their income to the cost of nursing-home care. In many states, they must turn over all income in excess of the poverty or SSI standard to the cost of home- and community-based care. However, the law protects spouses and adult children of beneficiaries using long-term care-services from financial liability for these services. "Spousal impoverishment" provisions protect spouses of institutionalized persons (and, at state option, recipients of home- and community-based care) who do not have an income of their own. If income or assets of community spouses falls below specified levels (a minimum of \$1,295 per month in income and \$15,348 in assets in 1996), they may retain a portion of their institutionalized spouse's resources to sustain these levels. Adult children are protected from liabilities because the income of family members living independently is not considered in determination of eligibility. Further, both spouses and adult children are finan-

cially protected by requirements that long-term-care providers must accept Medicaid payment rates as payment in full—that is, providers are prohibited from what is called “balance billing” in Medicare.

All of these protections were absent from the initial 1995 congressional Medicaid proposal. The Balanced Budget Act explicitly restored current statutory provisions regarding spousal impoverishment, but not balance billing and full protection for adult children. However, the meaning of these protections in a program without entitlements was unclear, given the uncertainty of anybody’s coverage.

The administration proposal maintained the family protections of current law. The governors’ resolution did not address family protections. In the resolution’s legislative successors, both the spousal impoverishment and the balance billing protections were restored. As earlier, however, the practical value of these protections remained in question, given other aspects of the proposal.

Proposals for Nursing-Home Quality Standards

The Omnibus Budget Reconciliation Act of 1987 (OBRA’87) included a major initiative to reform Medicaid’s approach to regulating quality of care in nursing homes. The OBRA’87 reforms included the establishment of standards and enforcement mechanisms that for the first time focused more on evaluating the care nursing-home residents actually received than on homes’ compliance with rules intended to affect that care. Federal enforcement of states’ implementation of standards, already a Medicaid requirement, was enhanced by the establishment of a broader range of penalties appropriately reflective of the nature and severity of quality problems (Hawes 1996). The 1995–96 proposals challenged both the OBRA’87 reforms and their federal enforcement.

The original congressional proposal replaced the nursing-home reform law with fewer and more general requirements and gave states the authority to establish and enforce standards. Although the Balanced Budget Act of 1995 incorporated much of the current statute, it substantially amended it to achieve similar results. The administration’s plan maintained current law quality protections and enforcement.

The governors recommended that the OBRA’87 standards be retained. However, they recommended that states have full responsibility for enforcement of the standards, without federal oversight. The 1996

legislative proposals that followed the governors' resolution ultimately restored the federal enforcement as well as the standards provisions of OBRA'87.

Proposals for State Flexibility

Although states have considerable flexibility in operating their Medicaid programs, both in general and with specific respect to long-term care, federal requirements nevertheless limit state policy options. In long-term care, states have particularly objected to federal requirements that restrict their ability to set or negotiate payments to nursing homes and to requirements for federal approval of targeted programs to cover home- and community-based services. All parties' 1995–96 legislative proposals granted greater autonomy to states in both areas.

States' flexibility in determining the amount that Medicaid pays nursing homes has been limited by what is known as the Boren amendment. Enacted in 1980, the amendment requires that payment rates be "reasonable and adequate to meet the necessary costs of efficiently and economically run facilities." Although the amendment was intended to enhance state flexibility by clarifying that states could use payment methods that differed from Medicare's approach, in practice nursing homes have successfully used the statutory requirement to challenge (and thereby increase) states' payment rates (Anderson and Scanlon 1993; Wiener 1996).

States' flexibility in providing home- and community-based services is limited by the necessity for a federal waiver to offer services beyond what the Medicaid statute allows, to offer services in some geographic areas or to some populations and not others, and to explicitly limit the number of persons served. Waivers are contingent upon a state's demonstration to the Department of Health and Human Services that spending per person served under the waiver is no greater than spending for these individuals would be in the absence of a waiver.

By repealing the Medicaid statute, the original congressional proposal and the Balanced Budget Act of 1995 gave states total autonomy with respect to payment policy and service delivery. The administration proposal made specific statutory changes to allow states flexibility in these particular areas. It repealed the Boren amendment and authorized targeted home- and community-based service programs without require-

ments for federal waivers. The governors' resolution and subsequent legislation endorsed these particular actions.

Implications of Financial Restructuring Proposals for Long-Term Care

By reducing resources, changing their distribution across states, and altering federal program requirements, all of the above proposals would have an impact on funding for long-term care and other Medicaid services. How long-term care would fare, both in general and relative to other services, would depend on the size of the spending cuts, the mechanisms for implementing them, and the flexibility or constraints governing states' decisions about whom to cover for which services. States' behavior in response to flexibility or constraints only partly reflects federal program requirements; it also reflects political support for long-term care relative to other services and populations competing for limited dollars.

Size of Spending Reductions

As described earlier, reductions in federal spending in the 1995–96 budget proposals ranged from \$54 billion to \$183 billion over the budget periods. These reductions are measured relative to a “baseline”—that is, the Congressional Budget Office's estimates of future spending under current law. Since 1995, Medicaid spending has slowed dramatically, without any changes in federal law. This means that part or all of the targeted savings will be achieved without Medicaid restructuring. It also means that to pursue these same target savings from a much slower-growing program would impose far more serious reductions in Medicaid resources.

As shown in figure 2 (illustrating the 1996 proposals), the 1995–96 proposals reduced state as well as federal spending. Currently, states get a federal matching payment that is limited only by how much the state spends and how high its matching rate is set. In contrast, under restructuring proposals, the federal government matches states' payments only up to a limit. Without the incentive of federal payments beyond this limit, states are unlikely to spend above it. Therefore, in 1996, total

FIG. 2. Comparison of estimates of federal and state Medicaid reductions in 1996 budget proposals. Note that the bipartisan plan's budget period covers the years 1997 to 2003, whereas the other two cover the period from 1997 to 2002. Administration and congressional majority federal savings are based on Congressional Budget Office estimates. Estimates were made on the assumption that states will contribute only the minimum necessary to draw down their federal allotments. *Sources:* Congressional Budget Office baseline projections (April 1996); General Accounting Office estimates of the effect of the change in matching rate under the congressional majority plan (December 1995).

federal and state spending would decline by about \$95 billion (1997 to 2002), and by \$110 billion from 1997 to 2003, under the administration and the bipartisan proposals, respectively.

In addition to limits, the congressional majority's proposals reduced the extent to which most states have to match federal payments. (Under the 1996 proposal, each state's matching rate would be the lower of [1] the current rate, [2] a new rate based on the state's taxable resources [U.S. General Accounting Office 1993], and [3] 40 percent.) More than 35 states could reduce their contribution with this change. If states spent only as much as necessary to get their maximum federal payments, total Medicaid spending would be reduced by an estimated \$243 billion under the congressional majority's interpretation of the governors' resolution. The Balanced Budget Act would have reduced total spending by over \$400 billion between 1996 and 2002.

One way to evaluate the implications of proposed reductions is to consider how much each proposal would allow spending to grow annually, relative to some reasonable norm or standard. While there is no

FIG. 3. Comparison of total Medicaid spending growth per beneficiary under the 1996 budget proposals. The Clinton administration average includes DSH reductions. The index value for benefits averages only 5 percent over the period. The numbers are based on Congressional Budget Office baseline and cost estimates (April 1996). The assumption is that states will contribute only the minimum necessary to draw down full federal funding.

“right” rate of growth, the lower the spending growth rate, the harder it will be to adequately fund Medicaid and long-term care over time.

Figure 3 illustrates the various proposals’ growth rates per beneficiary, relative to private insurance and to current trends. The administration’s proposal limited the growth in spending per beneficiary to about 4.3 percent on average, slightly lower than medical inflation. (The rate includes Disproportionate Share Hospital (DSH) payment reductions. The actual growth rate limits for health care spending per beneficiary average 5 percent over the budget period.) This growth rate would be lower, probably at or below general inflation, if the administration were to continue to seek the same dollar savings from the now slower-growing Medicaid program. The congressional majority’s 1996 proposal constrained total federal and state aggregate growth rates to 1.7 percent per beneficiary per year, a level well below general inflation. Since long-term care has historically grown more slowly than acute-care costs (U.S. Health Care Financing Administration 1995), the former may be less constrained by growth rate limits than the latter. However, if acute-care spending in a particular state is severely affected by the limits, the state may turn to long-term-care spending to reduce the pressure. Growth limits below inflation—which mean cuts in real

terms—would put pressure on both acute- and long-term care, making it difficult, if not impossible, for states to continue offering the same services to the same groups.

Mechanisms for Spending Reductions

The size of the reductions is not the only feature of the financing proposals that would affect long-term care. Even if all of the proposals offered equal levels of reductions, their effects could be dramatically different, depending on how they restrain Medicaid spending growth and on their incentives related to long-term-care coverage.

The original congressional Medicaid proposal sought to gradually redistribute federal funds from states with historically high spending to states that have spent less. The proposal works as follows: A state's maximum federal funding is determined by multiplying its "base allotment" by its "allowable growth rate." The base allotment, written into the legislation, approximates 1996 spending. The allowable growth rate for a state is determined by comparing its base allotment to its "needs-based amount." The needs-based amount is, basically, the number of poor people in the state multiplied by the national spending per poor person (with a limited adjustment to reflect state costs and type of users). The needs-based amount is intended to reduce the variation in states' spending per beneficiary, introducing more uniformity into Medicaid funding.

However, since movement to a needs-based formula would make major changes in states' funding, this movement is bounded by minimum and maximum growth rates. If the needs-based amount is well above its base allotment, then a state receives a "ceiling" or maximum growth rate. In the congressional majority's 1996 proposal, the highest growth rate was 7.2 percent per year beginning in 1998. Alternatively, if the needs-based amount is below the base allotment, the state receives a "floor" rate (the lowest is 2 percent per year). These are aggregate, not per beneficiary, growth rates, meaning that they must accommodate any increases in enrollment as well as in price or utilization. Because the needs-based amount is so different from current spending, almost all states are at their floor or ceiling growth rates. In fact, the U.S. General Accounting Office (1996) has estimated that it would take until 2037 before all states are at their needs-based amount. The indirect effect of this formula is to dis-

proportionately give states with extensive long-term-care spending low growth rates. A state can be characterized as having "extensive" long-term-care spending in at least two ways. Table 1 ranks states by their Medicaid long-term-care spending per aged resident of the state. Eight of the top 10 states in long-term-care spending per aged resident receive the lowest possible aggregate growth rate under the congressional majority's formula: 2 percent per year at full implementation. The 11 states receiving the lowest growth limits account for nearly 40 percent of all long-term-care spending.

Table 2 ranks states by the share of their Medicaid spending devoted to long-term care. While many states with large shares also have high long-term-care spending per aged resident, some of them may have lower per capita costs but disproportionately more users of long-term care. All but three of the 11 states with the lowest growth limits had long-term-care shares that were at or above the national average of 34 percent.

States with relatively broad long-term-care coverage are adversely affected for two reasons. First, states with broad coverage have higher than average Medicaid spending per beneficiary and, consequently, high base allotments. Because a state gets a low growth rate (floor) if its base allotment is high relative to its needs-based amount, many long-term-care states are likely to be worse off under the formula. Second, the needs-based amount is the product of the national average spending per poor person and the states' number of poor people. Neither factor is related to adequate financing of long-term care. Even in generous states, there is reason to question whether current Medicaid spending is adequate to meet the long-term-care needs of the current elderly population. Five of the top 10 states in Medicaid spending per aged state resident have a nursing-home-bed ratio per 1,000 population 85 years and older that is in the lower half of the U.S. distribution (DuNah et al. 1995).

Further, the basis of the needs-based formula is the number of people in poverty, which is not the same as the number of people covered by Medicaid or the number of people needing long-term care. Historically, increases in poverty have been unrelated to the enrollment trends for the aged beneficiaries, the primary recipients of long-term-care services. (In fact, calculations based on U.S. Health Care Financing Administration [1995] and Census data indicate that the relation is negative and small.) Hence, poverty growth rates are likely to be insufficient to accommodate the needs of a growing elderly population.

TABLE 1
States' Medicaid Long-Term-Care Spending per Elderly in the State
and Fully Implemented Aggregate Growth Limits
under the Congressional Majority Proposal

	Medicaid long-term-care spending per aged resident (\$) ^a	Fully implemented federal spending growth rate (%) ^b
United States	1,120	5.0
New York ^c	2,935	2.0
District of Columbia ^c	2,249	2.0
Connecticut ^c	2,149	2.0
Alaska	2,115	6.4
Minnesota ^c	2,058	2.0
Massachusetts ^c	1,958	2.0
Rhode Island ^c	1,936	2.0
New Hampshire ^c	1,902	2.0
Maine ^c	1,726	2.0
Vermont	1,639	4.8
Wyoming	1,361	6.4
Wisconsin	1,318	4.3
New Jersey ^c	1,307	2.0
North Dakota	1,303	4.3
West Virginia	1,193	4.3
Ohio	1,193	4.3
Louisiana	1,179	6.4
Montana	1,142	4.9
Pennsylvania	1,125	4.3
Washington ^c	1,104	2.0
Maryland	1,101	4.3
South Dakota	1,085	4.8
Michigan	1,064	4.3
Indiana	1,056	4.3
Hawaii ^c	1,050	2.0
Nebraska	1,044	4.3
Colorado	1,023	4.9
Delaware	1,005	6.4
Kentucky	994	6.4
Arkansas	970	6.4
Georgia	969	4.9
North Carolina	947	4.3
Tennessee	889	4.3

(continued)

TABLE 1 continued

	Medicaid long-term-care spending per aged resident (\$) ^a	Fully implemented federal spending growth rate (%) ^b
Illinois	879	4.8
New Mexico	820	7.2
Alabama	820	6.4
Oregon	819	4.3
Texas	806	7.2
Missouri	794	4.8
Kansas	791	4.3
Oklahoma	775	7.2
Mississippi	771	7.2
California	727	7.2
Idaho	725	7.2
Utah	722	6.4
South Carolina	685	6.4
Virginia	659	4.9
Iowa	615	4.3
Nevada	550	7.2
Florida	507	7.2
Arizona ^d	na	6.4

^aMedicaid total spending in nursing-home, home health, home- and community-based waiver, personal care, frail elderly, and community supported living arrangement (CSLA) categories for fiscal year 1994 is divided by 1994 Current Population Survey (CPS) estimates of people 65 and over by state.

^bFederal allocation growth rate for 2002 under the congressional majority proposal of June 1996, as estimated by the General Accounting Office.

^cStates with the lowest growth rates.

^dArizona, because of its 1115 status, does not report data in a comparable format.

The administration's plan actually works at the other extreme: rather than moving all states to a single average spending per beneficiary, it freezes all states at their current spending per beneficiary. The per capita cap multiplies each state's allowable growth rate by 1995 benefits spending per beneficiary (by eligibility group), which reflects its mix of services and beneficiaries in each group in that year. States with high long-term-care spending will have higher than average dollar limits even if their spending declines. States with low long-term-care spending in 1995 will be inhibited from broadening long-term-care services because their limits are based on their historically low spending per beneficiary.

TABLE 2
States' Medicaid Percent of Medicaid Spending for Long-Term Care
in the State and Fully Implemented Aggregate Growth Limits
under the Congressional Majority Proposal

	Medicaid long-term care (% of total spending) ^a	Fully implemented federal spending growth rate (%) ^b
United States	34	5.0
North Dakota	59	4.3
Minnesota ^c	58	2.0
Connecticut ^c	51	2.0
South Dakota	51	4.8
Wyoming	50	6.4
Wisconsin	47	4.3
Rhode Island ^c	45	2.0
Nebraska	45	4.3
Massachusetts ^c	45	2.0
Indiana	44	4.3
Montana	44	4.9
Idaho	44	7.2
New York ^c	42	2.0
Arkansas	42	6.4
Vermont	41	4.8
Delaware	41	6.4
Iowa	41	4.3
Oklahoma	41	7.2
Ohio	40	4.3
Kansas	39	4.3
Maine ^c	38	2.0
Pennsylvania	38	4.3
Oregon	38	4.3
North Carolina	37	4.3
New Jersey ^c	37	2.0
Colorado	36	4.9
Illinois	35	4.8
Hawaii ^c	34	2.0
Virginia	34	4.9
Washington ^c	33	2.0
Utah	31	6.4
District of Columbia ^c	30	2.0
Kentucky	30	6.4
Maryland	30	4.3
Alabama	30	6.4

(continued)

TABLE 2 continued

	Medicaid long-term care (% of total spending) ^a	Fully implemented federal spending growth rate (%) ^b
Missouri	29	4.8
Florida	29	7.2
Michigan	28	4.3
West Virginia	28	4.3
New Hampshire ^c	27	2.0
New Mexico	27	7.2
Tennessee	27	4.3
Nevada	26	7.2
Mississippi	26	7.2
South Carolina	25	6.4
Texas	25	7.2
Georgia	25	4.9
Alaska	23	6.4
Louisiana	21	6.4
California	19	7.2
Arizona ^d	na	6.4

^aMedicaid total spending in nursing-home, home health, home- and community-based waiver, personal care, frail elderly, and CSLA categories for fiscal year 1994 is divided by fiscal year 1994 total Medicaid spending in the state.

^bFederal allocation growth rate for 2002 under the congressional majority proposal of June 1996, as estimated by the General Accounting Office.

^cStates with the lowest growth rates.

^dArizona, because of its 1115 status, does not report data in a comparable format.

The Clinton administration's spending limits, however, do take into account one of the most important determinants of long-term-care spending growth: enrollment. The per capita cap achieves its savings by fixing the spending growth per beneficiary at inflation plus an additive factor. By allowing each state's limit (and therefore expenditures) to increase or decrease depending on enrollment, this formula intends to eliminate the incentive to reduce enrollment in order to reduce spending to manage within the cap. Enrollment is a major component of long-term-care spending growth, accounting for over 20 percent of nursing-home spending growth between 1984 and 1994 (authors' calculations based on U.S. Health Care Financing Administration [1995]). Although states may be able to restrain long-term-care spending growth per beneficiary, the increasing number of seniors and people with dis-

abilities needing long-term care is out of the states' control. A state with an increasing number of people needing long-term care would fare better under a proposal that takes enrollment increases into account.

Even with a per capita cap, however, there is no guarantee that long-term-care enrollment will be protected. The per capita limit is based on 1995 spending and enrollment for four groups: the aged, disabled, adults, and children recipients. Long-term-care users fall into both the aged and the disabled category, so their costs are averaged with non-long-term-care users. As can be seen in figure 4, the SSI disabled and aged beneficiaries have lower average long-term-care spending than do "other" disabled and aged—primarily people whose incomes exceed SSI levels. Long-term-care costs are high because Medicaid spends, on average, over \$30,000 per year for a full-year nursing-home resident (U.S. Health Care and Financing Administration 1994 data) and about \$67,000 per resident of intermediate care facilities for the mentally retarded (ICFs MR) (Burwell, Bachman, and Lakin 1995). Because the per capita limit does not distinguish long-term-care users, states' limits may be insufficient to accommodate an increase in the proportion of long-term-care users within the aged or disabled groups. The per capita limit may also give states an incentive to enroll less needy, less costly people in-

FIG. 4. Comparison of average Medicaid spending per beneficiary in 1994. *Source:* Urban Institute calculations based on Health Care Financing Administration 64 and 2082 data, excluding DSH and administrative costs. Both federal and state spending are included. Dollar amounts are rounded to the nearest \$50. Other aged beneficiaries include Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries (SLMBs).

stead of high-cost beneficiaries such as long-term-care users, since they could replace an aged beneficiary who requires long-term care with one who has no long-term-care needs at half the cost and still get the same federal spending limit.

These incentives for substitution are mitigated in the per capita cap proposals because beneficiaries who receive only Medicare premium and cost-sharing benefits, and thus have low average costs, are excluded from the calculations. This makes the average costs of those in the program higher, better reflecting long-term-care users' experience. In addition, more than half of the average cost for the aged and disabled categories is spent on long-term care. Thus, even though long-term-care enrollment is not explicitly included in the formula, funding may adjust to accommodate changes in the long-term-care population if limits are not too stringent.

The implications of the proposals based on the governors' proposals mirror those of their predecessors. The congressional majority's interpretation includes a formula that is nearly identical to that of the 1995 proposal; its umbrella fund is small and neither designed nor sufficient to accommodate long-term-care users. The bipartisan bill's financing has most of the features of the per capita cap, thus affecting long-term care in a similar way.

Competition for Limited Dollars

States faced with fiscal pressure to reduce Medicaid spending may have to choose among Medicaid's populations—mothers and children, people with disabilities, and the elderly—as they reduce spending. Even within long-term care, choices arise among various groups in need of care—for example, the elderly, younger persons with developmental or physical disabilities, and people with serious mental illness. Political influence will undoubtedly have a significant impact on the choices states make. Elderly long-term-care users and the providers who serve them have considerable influence relative to others in the Medicaid program. But their ability to wield it effectively will depend on Medicaid's program structure—specifically on the requirements federal legislation imposes on states' use of Medicaid dollars.

Although long-term care for the elderly is not immune from cost constraints, there is little question that it occupies a special policy and

political status relative to other groups and services Medicaid covers. As opposed to spending for other groups, a significant share of Medicaid's long-term-care spending on the elderly is optional, not required, and extends beyond the poor. Because extensive long-term care is so expensive, it is the general elderly population, and their children who might otherwise have to finance or provide care, who rely on Medicaid to pay for long-term care. In contrast, most mothers and children who rely on Medicaid for health insurance come from low-income families—a population with substantially less political influence. Indeed, a recent assessment of population groups' relative influence demonstrated that advantage by quoting a state legislator: "If we have \$20 million and the choice is between spending it for senior citizens or poor kids, it's no contest. The seniors get the money every time" (Deardourff 1996).

Given Medicaid's importance to middle-class as well as low-income people needing long-term care, it is not surprising that the nursing-home industry is heavily dependent on Medicaid for its revenues. Medicaid's share (about half) of nursing-home expenditures is three times its share of hospital payments and about seven times its share of physician payments (Levit et al. 1996). Few other sectors in the health care system are so reliant on a single payer, and nursing homes stand out among other providers as aggressive advocates for Medicaid support.

With the political power of beneficiaries, their families, and providers behind it, long-term care for the elderly has an advantage in a competition for Medicaid resources. However, federal requirements determine rules under which competition takes place. The initial congressional majority proposal had no coverage requirements, specifying only that states "set aside" funding for low-income mothers and children, people with disabilities, and low-income elderly. Although not directly protected, long-term care for the elderly might fare well in an open competition with so few rules. As congressional proposals evolved in the 1995–96 debate, the addition of program requirements tended to protect groups other than elderly long-term-care users. Because so much of Medicaid long-term-care coverage is optional, these requirements protect other groups against the encroachment of long-term-care coverage, rather than protecting long-term-care coverage itself. The stronger these requirements, the more fiscal constraint is likely to produce at least a proportionate reduction in long-term-care services for the elderly.

Proposals that retain federal entitlements and allow federal funds to increase as the number of eligible beneficiaries expands provide entitled

groups the greatest legal protection in a contest for resources. However, even these proposals allow—or, if spending cuts are substantial, promote—trade-offs among population groups. Per capita cap proposals distinguish among four groups: children, adults, the disabled, and the elderly. However, each state gets only one limit, which is applied only when spending across all enrollees exceeds the sum of limits calculated for each group. This means that not only can a state avoid its aggregate limit, as described above, by substituting low-cost for high-cost (e.g., long-term-care) users in each group, but it can also adapt to the limit by offsetting high spending per beneficiary in one group with low spending per beneficiary in another. In other words, if spending on the elderly is higher than expected, a state can offset it by reducing services for adults or children, for example. The level of the allowable growth rate under per capita caps would be a major determinant of how this trade-off would affect long-term care for the elderly. The lower the limit, the more the elderly and their providers would be pitted against others dependent on Medicaid services in the distribution of constrained resources.

State Responses to Restructuring Proposals and Fiscal Constraint

Despite its political support, long-term care for the elderly, along with other services, is likely to be a target for spending reductions as states pursue all possible strategies for coping with fiscal pressure. That means changes in state policies toward long-term-care services. Some of these changes could be undertaken without any modification of federal law; with long-term care, in particular, states already have considerable flexibility in managing their expenditures. Medicaid restructuring proposals, however, could enhance this flexibility.

Program responses affect both how states provide service and how services are financed. Although there is reason to question how much savings states can reasonably expect to achieve (Wiener 1996; Holahan et al. 1995), states will consider and probably pursue a variety of options. On the service side, the primary choices states face will be who will get how much of what kind of service. On the financing side, states' primary choices will be whether and how to find other payers for services they now finance.

Access to Long-Term-Care Services

Under current law, states can and do limit the availability of long-term-care services, particularly the availability of home- and community-based care. Advocates of the latter have hoped that the combination of fiscal pressure and changes in law would encourage states to reduce reliance on nursing-home care—the so-called “institutional bias”—and provide greater support for home- and community-based care. However, experience indicates that states will have a difficult time, fiscally and politically, moving in this direction. Instead, fiscal pressure and changes in law may reduce, rather than enhance, consumer access to quality service, both in nursing homes and in the community.

Access to Nursing Homes. States can limit access to nursing-home care indirectly, by limiting the supply of, or payment for, nursing-home care, or directly, by limiting eligibility for Medicaid benefits.

Limiting the Supply of Beds (Certificate-of-Need Restrictions). Most states exercise authority over the nursing-home bed supply by requiring certificates of need for nursing-home construction (Wiener 1996). In 1994, 15 states imposed an actual moratorium on construction of new nursing-home beds. These restrictions in large part explain why the bed supply has not kept pace with growth in the population likely to need nursing-home care. Tighter growth constraints, including moratoria, could be applied in the majority of states. Direct restrictions on the bed supply have been particularly important to states because of the Boren amendment requirements (and threat of lawsuits based on those requirements) that limit states' flexibility to set nursing-home payment rates.

Limiting Payment Rates (Repeal of the Boren Amendment). Eliminating the Boren amendment requirements, consistent with all of the 1995–96 Medicaid proposals (and enacted in the Balanced Budget Act of 1997), allows states to determine payment rates on their own. States that reduce their Medicaid payment rates would save money in two ways. First, and most commonly understood, is that states would pay less for each covered day. Second, and less widely recognized, is that states would probably also pay for fewer days. Medicaid rates are already below those of other payers, and the differential could increase. The lower the rate, the more likely nursing homes will limit access for Medicaid patients (Wiener 1996). A strategy that restricts access by limiting payment rates has the political advantage of having nursing homes, rather than the state, bear direct responsibility for any denials of nursing-home care.

Challenge to Quality Standards. Faced with rate reductions, the nursing-home industry will undoubtedly argue that lower payments will impede their ability to provide quality care or, more specifically, to comply with OBRA'87 quality standards. The initial congressional proposal to repeal these standards served, in part, as a quid pro quo for allowing lower payments. Although political reaction, backed by evidence on the effectiveness of standards (Phillips 1996), led to restoration of federal standards in legislative proposals, both the standards and federal responsibility for enforcing them are likely to remain contentious issues. If federal law is changed, lower payment rates to nursing homes might be accompanied by less stringent enforcement of federal quality standards and, potentially, a decline in the quality of nursing-home care (Hawes 1996).

Limiting Financial Eligibility. States currently have a lot of flexibility in determining financial eligibility for nursing-home care, and they use it to extend coverage well beyond the poorest elderly. Fiscal pressure could reduce states' willingness or ability to sustain coverage that they now offer voluntarily. If the federal entitlement was eliminated, states could make fixed grants to some or all providers of long-term-care services, limiting the number of nursing-home "slots." Less dramatic, and more likely, states would retain but restrict financial eligibility. Under current law, states could limit eligibility to people on SSI. Or, with some changes in the law, states could limit opportunities for people with higher incomes to "spend down" to Medicaid eligibility—by eliminating both medically needy programs and their equivalents (Miller trusts) and establishing fixed dollar income levels for eligibility, without regard to nursing-home spending. States could take an alternative action with a similar impact even under current law by limiting the expenditures that count toward "spend down." Subtracting the Medicaid rate (rather than the actual nursing-home charge) from a resident's income would keep higher-income residents from spending down to eligibility levels. Tighter financial eligibility standards would reduce protections for middle-income people who need care.

Limiting Functional Eligibility. States also have flexibility in determining need or "functional eligibility" for nursing-home care. States vary considerably in the standards they use and the way they apply them (Snow 1995a). A few states use functional assessments for private-pay patients as well as for Medicaid patients (Snow 1995b), a mechanism that may be necessary to avoid a situation in which private residents

exhaust their resources but fail to meet Medicaid's functional eligibility requirements. Many states could tighten functional eligibility standards with more rigorous assessments or impairment criteria. Such action would reduce access to nursing homes for people, regardless of income, who experience less severe, but nevertheless significant, impairments.

Access to Home- and Community-based Care. Many advocates for the elderly hope that fiscal pressure will promote replacement of nursing-home residency with care at home or in the community. However, states face a dilemma in pursuing this goal. More financing for noninstitutional care may make it easier to restrict nursing-home use. But the cost of new coverage may absorb, or exceed, the savings that restrictions achieve (Wiener 1996). States trying to save rather than just redistribute Medicaid dollars therefore may be reluctant to expand noninstitutional care.

Risks to Expansion. Experience shows that expanding home- and community-based services will produce lower nursing-home use only if the availability of nursing homes is directly restricted (U.S. General Accounting Office 1994, 1995). Oregon, Washington, and Wisconsin stand out for their explicit efforts to limit use of nursing homes in order to move people and dollars from nursing homes into home- and community-based care. Redirecting dollars, however, is not the same as spending less. Rather than reducing total long-term-care spending, these states have used available dollars to serve more people (U.S. General Accounting Office 1994, 1995). Coverage of home care in these states has expanded the number of people served, even with limits that, in some cases, have created waiting lists. As a result, despite fairly dramatic reductions in nursing-home use (especially in Oregon), total long-term-care spending continues to rise (Wiener 1996).

This experience raises serious questions about whether, even with more flexibility, states under fiscal pressure would more actively promote expansion of home- and community-based care. Achieving savings as well as redirection would be a major political as well as a policy feat. In the absence of a substantial commitment to home- and community-based care, middle-class elderly and their families may be frightened by limits on nursing-home coverage. Further, nursing homes opposing restrictions are likely to have far more political clout than are home care agencies or individual providers, who would benefit from even a limited home care expansion. Some states will be unwilling to take either the political risk of substantially reducing spending on nursing

homes or the fiscal risk of expanding noninstitutional care. States under considerable fiscal pressure may actually find reductions in home- and community-based care the path of least resistance.

The way fiscal pressure is applied would also affect the fiscal risk of expanding home- and community-based care. The risk that the demand for service will exceed the dollars available is greater under block grant proposals than under per capita caps. Under block grants, federal limits make no allowance for expanding enrollment. The per capita cap reduces this risk, because it allows states' federal funding to increase as the number of people served grows. To the extent that states enroll more people within a group (elderly or disabled) who need lower-cost home care rather than higher-cost nursing-home care, states are less likely to reach their funding cap, which is based on average spending for the group. Regardless of federal fiscal rules, however, the greater the fiscal pressure on states and the greater the political influence of the nursing-home industry, the more likely it is that Medicaid will restrict, not expand, home- and community-based care.

Shift to Residential Care Facilities. Rather than expanding home- and community-based care, states may find attractive an alternative strategy to reduce reliance on nursing homes. That is actually to transform their institutions into "alternatives." To the extent that nursing homes can redefine themselves as residential care facilities and continue to serve the same rather than new populations, they simply become a less expensive form of nursing-home care. If they are not nursing homes, they need not meet federal nursing-home standards, and their residents would retain federal SSI payments they lose in a long-term nursing-home residence. Under current federal law, however, Medicaid could pay only for services, not room and board, in these facilities. Proposals to repeal the current Medicaid statute and its restrictions would eliminate this barrier. Although, even with the federal SSI payment, revenues may be too low to cover the fixed costs for all existing nursing homes, transformation may be both feasible and attractive for some current (and even more future) facilities.

States have taken different positions on the potential role for these facilities. Oregon has aggressively promoted non-nursing-home facilities, even to serve people needing considerable personal care and supervision (U.S. General Accounting Office 1994). Applying Oregon's criteria nationally identifies 70 percent of current nursing-home residents as potential candidates for service in alternative living arrangements. By

contrast, Washington State treats these facilities as appropriate only for persons who do not have substantial care needs. Using Washington's criteria, national estimates are that about 15 percent of nursing-home residents would be appropriately served in alternative living arrangements (Spector, Reschovsky, and Cohen 1996).

Although proponents argue that residential care facilities allow residents greater flexibility and autonomy than do nursing homes, there is considerable risk that they will provide inadequate care and support. These facilities currently serve a far less disabled population than do nursing homes, are far less intensively staffed, and are subject to regulation that varies considerably from state to state (Spector, Reschovsky, and Cohen 1996). Debate about their ability to provide appropriate care of adequate quality has accompanied efforts to expand long-term-care services. If services are constrained, placement and quality issues will undoubtedly arouse even greater concern.

Controlling Access through Capitation. For long-term care as for other services, capitation—that is, a fixed payment per person, rather than payment for each service used—offers states the fiscal advantage of encouraging substitution of low-cost for high-cost services (home care for nursing-home care; or primary care, home care, or prescription drugs for hospital or nursing-home stays). Capitation also offers states a political advantage by delegating to someone other than state government direct responsibility for determining access to both nursing-home and non-nursing-home services. However, capitation is not without risks, both to states and to beneficiaries. As most parties recognize, it is a challenge to establish rates that simultaneously save money and support quality care.

To date, experience with capitation and managed care for long-term care has been limited primarily to demonstrations (Wiener and Skaggs 1995; Wiener 1996). The best example of capitation for long-term care is Arizona's Long-Term Care System (ALTCS), a statewide alternative to the way Medicaid covers long-term care in other states. Under ALTCS, the state makes a capitation payment to contractors (typically county governments) for Medicaid long-term care and other services for elderly (and other) persons at risk of institutionalization. The contractor is charged with managing care for these beneficiaries, including care financed under Medicare's fee-for-service system.

The best examples of capitation for both long-term and acute care are Medicare/Medicaid demonstrations involving social health maintenance

organizations (SHMOs) and the Program of All-Inclusive Care for the Elderly (PACE). The two demonstrations differ in their target populations and financing. SHMOs are HMOs that extend Medicare's benefits to include some additional home and nursing-home care. However, SHMOs are marketed to the general elderly population and spread the cost of these extra benefits across everyone's premiums. Only a small proportion of enrollees are disabled or Medicaid eligible. PACE also offers broader benefits. But enrollment in PACE is limited to people who satisfy nursing-home admission criteria. Not surprisingly, most enrollees are Medicaid eligible. PACE sites receive capitation payments from both Medicare and Medicaid to finance services.

Limited experience with capitation involving long-term care has generated considerable debate about its potential to produce good quality care at lower cost (Wiener and Skaggs 1995; Wiener 1996). Evaluators of ALTCS find that Arizona has lower costs and lower-cost growth than other states, in part because of rigorous state eligibility determinations (McCall 1996). Further, in implementing ALTCS, Arizona has had an advantage that other states lack. Its capitated long-term-care system is the only Medicaid system Arizona has had; it did not replace a traditional Medicaid system with all of its entrenched industry and consumer interests. Evaluations of SHMO and PACE demonstrations also show some savings (primarily for acute care). However, the ability to interpret results has been confounded by questions about favorable risk selection, that is, concerns that demonstration populations are less disabled and costly than beneficiaries served in the traditional system, and therefore not comparable to them.

Given limited experience, states as well as the federal government have been cautious in moving toward capitation that involves long-term care. Most states have excluded people who need long-term care and long-term care services from their Medicaid managed care program. Minnesota is the only state that has received a waiver from Medicare as well as Medicaid requirements to coordinate capitation for both sets of benefits, including nursing-home care, and its program limits the extent to which health plans are at risk for nursing-home care.

Despite awareness of the risks of capitation, state Medicaid officials are expressing growing interest in capitation and managed care for so-called dual eligibles—beneficiaries eligible for both Medicare and Medicaid—many of whom are recipients of long-term care (Saucier 1995). Federal legislation that substantially increases fiscal pressure, and concomitantly

reduces federal oversight, could have considerable influence on the aggressiveness with which states pursue options in this area.

Shifting Responsibility to Pay for Long-Term Care

States can also reduce liabilities by getting other parties to pay the bills, specifically, the people (or families of people) who need long-term care or the federal government, through its income maintenance and health care programs.

Shifting Costs to Beneficiaries and Families. Despite requirements that beneficiaries exhaust their own income and resources in order to receive Medicaid, concern has arisen that beneficiaries and their families are inappropriately drawing on Medicaid resources to finance their long-term-care needs. Concerns are of two kinds: first, that Medicaid rules can be manipulated, so that beneficiaries can protect rather than exhaust the assets they have; and second, that Medicaid rules are too generous, relieving spouses or other family members of financial responsibilities they ought to have. Changes in federal law as contemplated in congressional proposals would allow a variety of strategies for more aggressive pursuit of contributions from beneficiaries and their families.

Pursuit of Assets or Estates. Currently, federal law requires states to prohibit people seeking Medicaid coverage for long-term care from transferring resources at less than fair market value for 36 months prior to their application (five years for trusts). Current law also requires states to recover the cost of Medicaid nursing-home coverage from beneficiaries' estates. If federal law were changed, states could become more aggressive, for example, by treating assets, regardless of when they are transferred, as "available" for nursing-home payment or by more actively enforcing current law on estate recovery, including sale of their homes.

The fiscal gains from such actions appear limited (Wiener 1996). Evidence indicates that, despite concerns about abuse by the wealthy, asset transfers have been relatively small in size and current prohibitions on inappropriate transfers have been effectively enforced. Furthermore, many states appear reluctant to enforce 1993 federal requirements that they operate estate recovery programs, given potential political repercussions. Greater aggressiveness will likely depend less on a fiscal calculation than on calculation that public concern about "greedy geezers" exceeds public sympathy for a family needing long-term care.

Pursuit of Family Contributions. Even under current law, states could reduce the protections now in place for spouses of nursing-home residents. In 1995, 29 states established protection above the minimum required by law: \$1,230 per month in income and \$14,964 in assets in 1995 (Price 1995). Under the congressional block grant proposals, states could require adult children of nursing-home residents to contribute toward the costs of their care. Changes in current law could allow states to use more subtle mechanisms to draw on family resources—by eliminating prohibitions on such nursing-home practices as requiring patients to pay lump sums on admission, to permanently waive access to Medicaid benefits, or to make payments to supplement Medicaid rates. Politically, such changes might gain the nursing-home industry's acquiescence to lower payment rates, without requiring the state to directly increase resident or family payments. Practically, however, these changes raise out-of-pocket payments for nursing-home residents' families and reduce access for residents without families to help them.

Shifting Costs to the Federal Government. Two possible shifts from state to federal funding seem particularly likely: greater reliance on the federal SSI program and Medicare maximization.

Shifts to SSI. The transformation of nursing homes into lower-level facilities offers the potential to draw more heavily on both the SSI and Medicare programs to support long-term care. As noted above, SSI payments terminate when people enter nursing homes. If people are served in alternative facilities (or in their own homes), they retain these payments. SSI payments are too low to support current facility costs; as a result, states that rely on personal care homes supplement SSI payments with their own dollars (State Supplemental Payments, or SSP). However, with a change in federal law, federal Medicaid funds could become available to supplement SSI for those living in lower-level facilities. Furthermore, the sicker the residents of these facilities, the easier it becomes to obtain Medicare home health benefits to finance their care.

Medicare Maximization. More broadly, Medicare can substitute for Medicaid long-term-care spending in a variety of ways. The Medicare home health benefit, now financing extended service for some people who need long-term care (Feder and Lambrew 1997), can substitute for Medicaid home and community-based care. States may require or encourage providers' pursuit of Medicare benefits before seeking Medicaid coverage. Medicare can also replace Medicaid funding for people in

nursing homes. Although Medicare coverage is for short-term rather than long-term nursing-home care, nursing homes' increased involvement in the Medicare program (Feder and Lambrew 1997) facilitates billing for the initial portions of long-stay Medicaid patients.

Finally, Medicare funds could be used even more aggressively to finance services if states controlled Medicare as well as Medicaid spending for elderly beneficiaries (and others) eligible for both programs. The debate on Medicare restructuring included consideration of a demonstration to make grants to states to cover Medicare services for beneficiaries also eligible for Medicaid, and to make states responsible for arranging for their Medicare as well as Medicaid benefits (e.g., U.S. Senate reconciliation bill, October 1995). Although, in theory, such a policy could, through efficiencies, generate savings to expand coverage, in practice, explicit limits on Medicare funds could reduce funding and quality of care for low-income seniors. States might find that there are fewer savings than they anticipate or they could substitute Medicare for state funds. Either way, care to low-income seniors could be jeopardized.

Conclusion

Given its significance in the Medicaid program, long-term-care services and the people who rely on them will undoubtedly be affected if Medicaid's financial or program structure is significantly altered. Analysis of the 1995–96 restructuring proposals and likely state responses suggests five fundamental policy choices that affect the availability of affordable, quality long-term care.

First, the size of state as well as federal Medicaid spending reductions will determine how much fiscal pressure long-term care, along with other Medicaid services, will face. Although the initial gap between the congressional majority and administration proposals for federal spending reductions narrowed over the course of the 1995–96 debate, the change in states' matching requirements could have enormous effect on total resources. The congressional majority's proposal of 1996 could make the combination federal and state spending growth per beneficiary (1.7 percent per beneficiary per year) less than general inflation—a level that makes it decidedly difficult to sustain current coverage.

Second, some mechanisms to limit federal spending will affect long-term care more than others. Any spending constraint, even if it allows

spending to rise with enrollment, will likely encourage substitution of relatively low-cost for high-cost (long-term-care) elderly beneficiaries. But spending caps like the congressional majority's that fix, reduce, and reallocate federal dollars fall disproportionately on states that have provided the most extensive long-term care. Under the congressional majority's 1996 proposal, eight of the top ten states in long-term-care spending per aged resident would receive the lowest possible aggregate growth rate.

Third, regardless of fiscal pressure, how long-term care will fare relative to other services and beneficiaries will depend on federal program rules. Given the political influence of long-term care's beneficiaries and providers, the fewer the protections for groups other than elderly long-term-care users, the better their ability to protect long-term care at others' expense when resources are limited. Alternatively stated, the greater the protection afforded mothers, children, and people with disabilities, the more long-term care is at risk.

Fourth, whether or not program rules are changed, states facing fiscal pressure may not only reduce access to nursing homes but may also be reluctant to de-emphasize institutional in favor of home- and community-based long-term care. States that expand noninstitutional services risk spending more dollars than they are willing or able to remove from nursing-home care. Efforts to substitute lower-cost for higher-cost settings without expansion may reduce choices and quality of care.

Finally, federal policy toward Medicare as well as Medicaid will affect states' ability to substitute family or federal (especially Medicare) dollars for Medicaid (or other state) financing. Political pressure and Medicare rules limit, but do not prohibit, substitution; policies to give states control over Medicare funding for dual eligibles could promote it.

These conclusions are drawn from analysis of a broad array of legislative proposals debated during 1995–96, none of which was enacted (either then or when Congress and the administration agreed on a balanced budget in 1997). However, Medicaid's role in the federal budget and debate about the role of government will continue to fuel national efforts to alter the Medicaid program. Politics will undoubtedly determine which proposals will resurface, how much consensus or conflict will ensue, and how long-term care and other services will be affected. The debate so far does not allow us to predict which action, if any, will be taken. But it does provide a good indication of the difference that alternative actions will make.

References

Publications

- Anderson, G., and W. Scanlon. 1993. Medicaid Payment Policy and the Boren Amendment. In *Medicaid Financing Crisis: Balancing Responsibilities, Priorities, and Dollars*, eds. D. Rowland, J. Feder, and A. Salganicoff. Washington, D.C.: American Association for the Advancement of Science.
- Burwell, B., S. Bachman, and K.C. Lakin. 1995. Medicaid Community-Supported Living Arrangements. In *Residential Services for Persons with Developmental Disabilities: Status and Trends through 1994*, eds. R.W. Prouty and K.C. Lakin. Minneapolis: University of Minnesota.
- Deardourff, J. D. 1996. Guarantees for the Children. *Washington Post* (June 9): C7.
- DuNah, R., C. Harrington, B. Bedney, and H. Carrillo. 1995. Variations and Trends in State Nursing Facility Capacity: 1978–93. *Health Care Financing Review* 17: 183–99.
- Feder, J., and J. Lambrew. 1997. Why Medicare Matters to People Who Need Long-Term Care. *Health Care Financing Review* 18:99–112.
- Hawes, C. 1996. *Assuring Nursing Home Quality: The History and Impact of Federal Standards*. New York: Commonwealth Fund.
- Holahan, J., T. Coughlin, L. Ku, K. Liu, C. Kunte, and S. Wall. 1995. *Cutting Medicaid Spending in Response to Budget Caps*. Washington, D.C.: Kaiser Commission on the Future of Medicaid.
- Kaiser Commission on the Future of Medicaid. 1996. *Medicaid and Long-Term Care*. Washington, D.C.
- Levit, K.R., H.C. Lazenby, L. Sivarajan, et al. 1996. National Health Expenditures, 1994. *Health Care Financing Review* 17:205–42.
- McCall, N. 1996. *The Arizona Health Care Cost Containment System: Thirteen Years of Managed Care in Medicaid*. Washington, D.C.: Henry J. Kaiser Family Foundation.
- Phillips, C.D. 1996. *Evaluation of the Nursing Home Resident Assessment Instrument*. Baltimore, Md.: Health Care Financing Administration.
- Price, R. 1995. *Medicaid: Spousal Impoverishment Protections* (95-1053 EPW). Washington, D.C.: CRS Reports for Congress.
- Saucier, P. 1995. *Dual Eligibility: A Tale of Two Systems*. Portland, Maine: National Academy for State Health Policy, and Waltham, Mass.: Center for Vulnerable Populations.
- Snow, K. 1995a. *State Long Term Care Programs at a Glance*. Portland, Maine: Center for Vulnerable Populations, in collaboration with the National Academy for State Health Policy and the Institute for Health Policy Studies.

- . 1995b. *How States Determine Nursing Facility Eligibility for the Elderly*. Public Policy Institute Report #9517. Washington, D.C.: American Association of Retired Persons.
- Spector, W.D., J.D. Reschovsky, and J.W. Cohen. 1996. Appropriate Placement of Nursing-Home Residents in Lower Levels of Care. *Milbank Quarterly* 74(1):139-60.
- U.S. Department of Health and Human Services. 1995. *Analysis of Medigiant Set-Asides*. Washington, D.C.
- U.S. General Accounting Office. 1993. *Medicaid: Alternatives for Improving the Distribution of Funds* (GAO/HRD- 93-112FS). Washington, D.C.
- . 1994. *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs* (GAO/HEHS-94-167). Washington, D.C.
- . 1995. *Long-Term Care: Current Issues and Future Directions* (GAO/HEHS-95-109). Washington, D.C.
- . 1996. *Medicaid Formula Transition* (GAO/HEHS-96-169R). Washington, D.C.
- U.S. Health Care Financing Administration. 1995. *Statistical Supplement 1995*. Baltimore.
- Wiener, J.M. 1996. *Can Medicaid Long-Term Care Expenditures for the Elderly Be Reduced?* New York: Commonwealth Fund.
- Wiener, J.M., and J. Skaggs. 1995. *Current Approaches to Integrating Acute and Long-Term Care Financing and Services*. Public Policy Institute Report #9516. Washington, D.C.: American Association of Retired Persons.

Data Sources

- Congressional Budget Office. 1996. Medicaid baseline projections (April). Washington, D.C.
- U.S. Health Care Financing Administration. 1994. Data for fiscal year 1994 from Medicaid statistics from HCFA 64 form. Baltimore.

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