



A Guide to Long-Term Care for State Policy Makers

RECENT STATE INITIATIVES IN REBALANCING LONG-TERM CARE

“Reaching a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community-based supports. A balanced LTC system offers individuals a reasonable array of ... options, particularly adequate choices of community and institutional options.”

U.S. Centers for Medicare and Medicaid Services

A number of states have been moving on several fronts to rebalance their long-term care (LTC) systems so that the elderly and other adults with disabilities have greater access to home and community services instead of facing institutionalization.¹ Realizing that changing an LTC system from its historic institutional bias can be a complex process, states have had to transform the policies, infrastructures and services that govern their LTC systems. They have tapped into federal demonstration grant money, Medicaid funds, and state general revenue to:

- Strengthen the state government infrastructure, either by merging all LTC programs and services, regardless of funding source, into one centralized LTC agency, or by improving coordination among various state LTC agencies;
- Improve information about LTC options and access to publicly funded services for eligible people;
- Develop public information campaigns to encourage people to plan for their own future LTC needs, including financial planning that might include the purchase of LTC insurance,
- Divert people from nursing homes by offering a greater array of home and community-based services (HCBS); and
- Help people to move out of nursing homes to the community through the “money follows the person” program that allows the Medicaid funds used for nursing home care to be transferred to community care for the people making the transition or through nursing home transition programs.

¹ If people meet the financial and functional criteria for Medicaid-funded nursing home care, they have an “entitlement” to that care. There is no such entitlement to Medicaid-funded HCBS. States maintain slots for HCBS waiver programs. Once those slots are filled, eligible people must be placed on waiting lists or enter a nursing home whose services are guaranteed under Medicaid.



A state's rebalancing strategy calls for the state to plan and adopt the range of initiatives described above, as well as others that make it possible to expand HCBS and reduce institutional use. Most states have been assisted in this process by a series of federal Systems Change demonstration grants initiated in 2001.

For the five funding cycles, CMS made 340 grants totaling \$256.5 million to all 50 states, two territories, the District of Columbia and 11 independent living centers. These grants have made possible:

- The development or expansion of Aging and Disability Resource Centers (one-stop LTC information and access points).
- Money Follows the Person programs that allow Medicaid funds used for a nursing home resident's care to move with that resident to community living.
- Consumer-directed models of service delivery that enable a person receiving publicly funded services to direct those services and hire people of their choice, including family members in some cases, to provide the care.

For some states, rebalancing meant a consolidation of LTC funds and programs into one agency that has flexibility to allocate Medicaid and state general revenue funds for the LTC services most appropriate to each eligible recipient.

Vermont has made a major commitment to rebalancing its LTC system by combining nursing home and HCBS funds into a “global budget” that is available to fund a consumer's entitlement to either nursing home or home and community care.

As early as 1996, Vermont began to alter the balance between institutional and HCBS by enacting landmark legislation—Act 160—that required the state to shift to HCBS dollars saved from reduced Medicaid nursing home use. Vermont adopted a 60/40 goal—40 Medicaid HCBS participants for every 60 Medicaid-funded nursing home residents.² A major effort was made to increase the availability of publicly funded services in the home and community, including new residential services.

In 1996, when Act 160 was passed, 88 percent of Medicaid long-term care dollars in the state were allocated to nursing home care, and 12 percent went to HCBS. In 2006, the allocation was 68 percent to nursing homes and 32 percent to HCBS.

Vermont took an even bigger step in October 2005 with implementation of its “Choices for Care” program. After three years of planning and working with federal officials, Vermont received federal approval for a Section 1115 Medicaid waiver that provides an entitlement to HCBS. The premise of the program is that people should have equal access to the full array of LTC services, whether a nursing home or HCBS.

Financed by a global budget, the program combines HCBS waiver funds with the state's nursing home appropriation. Vermont can limit the funds it will spend on this program because the entitlement to HCBS is available only for people with the “highest needs,” such

² Seven of 12 counties that had nursing homes had met this goal by 2006.

as needing extensive or total assistance with at least one daily activity (toilet use, eating, transferring, bed mobility) and requiring at least limited assistance with any other daily activity, or having an unstable medical condition that requires daily skilled nursing services. (The state offers limited case management, adult day services and/or homemaker services for people with “moderate” needs who need minimal assistance at home.)

Other state rebalancing examples include the following.

Iowa

In 2005, the Iowa legislature passed the IowaCare Act (House File 841), also known as Iowa’s Medicaid Reform Proposal. While the Act expands Medicaid health care coverage, it also mandates fundamental LTC reform under a section of the law called “Rebalancing Long-Term Care.” The intent of the LTC provisions is to improve access, expand choices about where and how to obtain services, and build the capacity of Iowa communities to sustain independent living for people with disabilities.

The act establishes a higher eligibility standard for nursing homes than for HCBS waiver services, and mandates planning for expansion of HCBS and reducing the population in Iowa’s ICF/MR facilities. The 2006 Department of Human Services budget provided enough funds to virtually eliminate the waiting lists on the state’s HCBS disability waivers.

Washington

The state has made steady, consistent progress toward an LTC system to the point that, in 2007, more than twice as many people are served under the Medicaid waiver programs for seniors and the disabled persons as are in nursing homes. A single state government agency, the Aging and Disability Services Administration, manages a single LTC appropriation for older people and people with physical disabilities, developmental disabilities and mental retardation.

Washington’s assessment and information system, Comprehensive Assessment and Reporting Evaluation (CARE), provides care planning and access not only to Medicaid waiver services but also to Medicaid state plan personal care and state-funded services. The state uses an eligibility determination system that provides speedy access to publicly funded HCBS.

As a result, the Medicaid nursing home caseload declined from 17,353 in FY 1992 to 11,654 in September 2006. During the same time, the average home and community caseload has increased from 19,330 to 37,042. The percentage of the Medicaid LTC budget for nursing home care decreased from 82 percent in 1992 to 44.76 percent for the 2005-2007 biennium.

Indiana

The secretary of the Family and Social Services Administration adopted a goal of rebalancing LTC funding by the close of FY 2009 through a major expansion of HCBS. The Aging Reform Agenda developed in 2005 and early 2006 called for a “new strategic direction for a comprehensive, integrated LTC system.” The agenda’s objectives were to improve public awareness, increase service capacity, expand access, and rebalance LTC spending.

The state integrated all HCBS, nursing facility and hospice services into a single program, Indiana Options for Long-Term Care (OPTIONS).³ Through a Nursing Home Closure and Conversion Fund, the state has sought to close 1,500 nursing home beds through a combination of incentives and a direct sales effort to the nursing home industry that identified the beds to be closed by July 1, 2007.

A major part of the strategy was to increase the number of adult day services and residential alternatives to nursing home care. The state increased the number of certified assisted living providers from 22 on July 1, 2006, to 50 by January 1, 2007. During the same time period, it also increased the adult day service providers from 35 to 38 and the number of adult foster care homes from none to 23. The state had expanded Medicaid waiver slots by 3,500 and reduced waiting lists from a combined total of more than 3,000 to 550 by the end of 2006.

Rebalancing Issues

A state's progress toward rebalancing its LTC system—moving from an over-reliance on institutionalization can be a complex process. The fact that the state is increasing the number of people served through HCBS programs may not be the only story. Nursing home use also may be increasing, and, even if the number of residents has slowed or decreased, state spending for that care may continue to increase. Acuity levels in the state's nursing homes may be increasing, resulting in higher costs for their care. Waiting lists for HCBS (because of a ceiling on Medicaid waiver slots or limited funding totals for HCBS programs) may still be forcing people into nursing homes.

However, state officials who are assessing a state's rebalancing efforts might want to review the following.

- Whether the state has a long-term care reform agenda or should have one. If one exists, what are its components and timelines?
- Are state agencies with various LTC funding sources and programs able to coordinate their efforts to reduce confusion, paperwork and delays for consumers, or would a consolidated LTC agency approach work better?
- Do demographic data and future trends give some indication of the future demand for LTC and how those trends compare to present data?
- What is the proportion of Medicaid LTC spending allocated to HCBS compared to institutional care? How has that changed over the past five years? What are the numbers of people served in HCBS compared to institutional residents and how has that number has changed over the last five years?
- How successful has a nursing home transition program been in the state, and what are its costs and the characteristics of the people who have made a successful transition?

³ The Options program used Medicaid funds to allow seniors to select their preferred options for long-term care based on their personal service needs.

- How has the state used federal Systems Change grants and other demonstration funds to promote an LTC reform agenda?

Resources

Assessing a State Long-Term Care System: A Technical Assistance Guide. Centers for Medicare and Medicaid Services,

http://www.cms.hhs.gov/NewFreedomInitiative/037_StateProfiles.asp.

University of Minnesota Long-Term Care Resource Center. *Abbreviated and full case studies of eight states activities in rebalancing their LTC systems.*

<http://www.hpm.umn.edu.LTCResourceCenter/>.

Fox-Grage, Wendy; Barbara Coleman; and Dann Milne. *Pulling Together: Administrative and Budget Consolidation of State Long-Term Care Services.* (Publication #2006-05)

Washington D.C.: AARP, February 2006.

http://www.aarp.org/research/longtermcare/trends/fs132_hcbs.html.

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