U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

PUBLIC FINANCING OF LONG-TERM CARE:

FEDERAL AND STATE ROLES

September 1994

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PUBLIC FINANCING OF LONG-TERM CARE: Federal and State Roles

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INTRODUCTION

This paper provides an overview of public financing of long-term care services for the elderly under Medicare, Medicaid and other public programs.[1] Recent program data on public spending for both nursing home and home care services are presented, as well as selected data on recent expenditure trends, particularly under Medicare and Medicaid. Long-term care expenditures under both of these entitlement programs are increasing rapidly as the demand for services is fueled by the demographics of an aging population. In addition to presenting statistical highlights, the chapter also describes the organizational characteristics of the public financing of long-term care, and how the financing of long-term care vanes across states.

While this paper is limited to a discussion of public financing of long-term care services, it is important to put this discussion in a proper context. Public financing of long-term care services is substantial, and is increasing in response to the growing demand for services. But it is important to underscore the fact that most long-term care is not publicly funded, and very little long-term care is financed through private insurance. *Most* long-term care is provided informally by the spouses, children, relatives and friends of the disabled elderly who needs assistance in everyday life activities. Three out of four elderly persons living in the community receive help *only* from informal sources of care.

In addition, when the elderly and their families turn to the formal health care system for help with long-term care services, they are much more likely to pay for their care out of their own pockets. The elderly pay a much higher percentage of long-term care costs privately than they do for acute care. Due to Medicare's coverage of acute care services, the elderly's private share of total spending for inpatient hospital costs in 1987 was only 15 percent (for deductibles, coinsurance, and non-covered stays). Similarly, the elderly, on average, pay only about 36 percent of the total cost of physician services out of pocket. In contrast, about 48 percent of all spending for nursing home services is paid privately by the elderly users of nursing home services and by their families.

As the demographics of our elderly population continues to change, there will be an increasing demand for long-term care. In brief, the largest increases in demand will occur for those services for which the elderly are insured the least. Informal care and private financing of long-term care will likely to continue to play a major role in the provision and purchase of long-term care services, but the public sector's role in supplementing private systems of care will also increase as well.

[1] Public financing of long-term care services for the non-elderly, including persons with developmental disabilities, is not addressed in this paper.

WHO GETS HELP? AN OVERVIEW OF MEDICARE AND MEDICAID FINANCING OF LONG-TERM CARE

Medicare and Medicaid are the two major public funding sources for long-term care, although the circumstances under which elderly persons receive long-term care assistance under each of these programs is very different. Persons who receive long-term care assistance from these two public programs generally fall into two categories: (1) Medicare enrollees who are recovering from an acute illness; and (2) poor elderly persons who are eligible for Medicaid and who qualify for Medicaid-covered long-term care benefits.

The Medicare program provides limited long-term care coverage as an entitlement, without means-testing. Thus, while almost all elderly persons are eligible for Medicare, the long-term care benefits provided under Medicare are limited. Many elderly persons still do not realize that Medicare does not protect them from the most of the costs associated with long-term care.

From its inception in 1965, the primary purpose of the Medicare program has been to provide elderly persons with protection from the high costs of acute medical illness, particularly costs associated with inpatient hospital care. As such, in determining what Medicare will and will not pay for, a boundary has historically been drawn between services that are oriented toward the treatment of acute illness and services that are primarily custodial in nature. Prior to 1989, Medicare home health services were largely confined to short-term homebound patients requiring skilled services during recovery from an acute illness. In July of 1989, however, the Health Care Financing Administration (HCFA) issued revisions of its Health Insurance Manual (HIM-11) which clarified eligibility and coverage for the home health benefit. The result has been a rapid expansion in the use of the Medicare Home Health benefit.[2] Thus, some analysts believe that Medicare's traditional role in only providing coverage for episodes of care related to acute illness has eroded, and that the Medicare home health benefit is now being used to a large extent to cover services related to more chronic conditions.

Unlike Medicare, State Medicaid programs have always provided coverage for both skilled care related to acute illnesses and custodial care for persons with long-term disabilities. However, the breadth of the Medicaid benefit package varies from State to State. Medicaid is also a means-tested program--only the elderly poor qualify for Medicaid coverage. In 1992, about 11.2 percent of the elderly were enrolled in the Medicaid program at some point during the year--about 3.6 million persons.[3] Thus, the

[2] Christine Bishop and Kathleen C. Skwara. 1993. "Recent Growth of Medicare Home Health." Health Affairs. (Fall), 95-110.

[3] Based on HCFA 2082 data and Census Middle Series population projections.

Medicaid program provides a more generous benefit package for long-term care services than the Medicare program, but these services are limited to persons who lack the financial resources to pay for their own care.

Medicaid also serves as a public safety net for elderly persons who cannot afford the cost of a long nursing home stay. Many elderly persons do not qualify for Medicaid when they first enter a nursing home, but become eligible for Medicaid coverage after depleting what resources they had in paying for their own care over a period. of months or years. In this manner, the Medicaid program at least provides some assurance that a long-term care safety net exists for all elderly persons, once their private resources are gone.

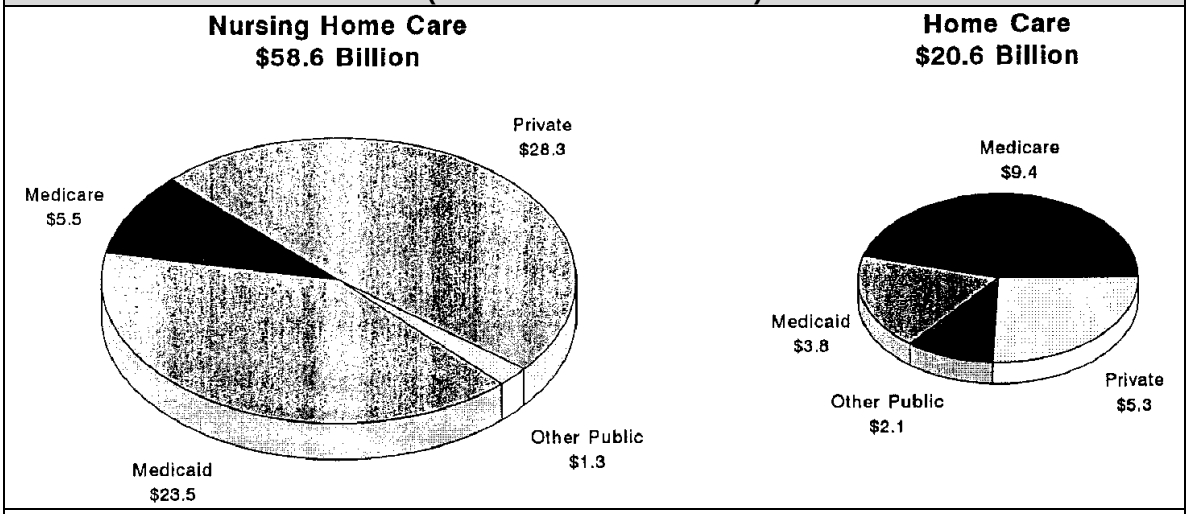
Medicaid is a program that is jointly financed by the Federal government and by State governments, and the generosity with which individual States finance long-term care varies enormously. States also vary in the amount of their own general revenue funds that they allocate to community-based service programs for the elderly outside of Medicaid. An extremely important feature of the public long-term care system is the lead role that State governments have in shaping the characteristics of local financing and delivery systems for long-term care services. Consequently, where an elderly person lives can have an great impact on the access which he or she has to publicly-financed long-term care.

MOST PUBLIC LONG-TERM CARE DOLLARS PAY FOR NURSING HOME CARE

Although about two-thirds of elderly persons with disabilities live in the community, over three out of four public dollars spent on long-term care are spent for nursing home care. As shown in Figure 1, total public expenditures for elderly nursing home care totalled $58.6 billion in 1993, compared to $20.6 billion for home care services.

At the same time, public spending accounts for a greater share of total spending for home care than for nursing home care. The public sector accounts for just over half of all spending for nursing home care, but about 74 percent of all spending for formal home care. This is largely due to the fact that informal care is more likely to substitute for formal paid home care than for 24-hour nursing home care. When an elderly family member needs care at home, most families elect to provide care themselves rather than pay for care. But when nursing home care can no longer be avoided, families must pay for care out of their own pockets, unless the disabled elder is eligible for Medicaid.

FIGURE 1. National Long-Term Care Expenditures for the Elderly: 1993 (in billions of 1993 dollars)



SOURCES: Brookings/ICF Long-Term Care Financing Model

The Medicare Skilled Nursing Facility (SNF) Benefit

Medicare provides some nursing home coverage as an entitlement, without means-testing, but this coverage is restricted to short-term nursing home stays after discharge from a hospital. Medicare does not cover custodial nursing home care. The Medicare Skilled Nursing Facility (SNF) benefit was originally enacted and is presently administered as extended hospital care for patients who are recovering from an acute

illness episode, but who can be more economically served in a skilled nursing facility, rather than in an inpatient hospital setting.

The Medicare SNF benefit provides up to 100 days of coverage per spell of illness. To qualify for coverage, a Medicare beneficiary must have been transferred to a skilled nursing facility directly from a hospital stay of not less than three days. The beneficiary is also liable for a copayment amount for all covered days after the 20th day. In 1993, the Medicare SNF copayment amount was $84.50 per day for days 21 through 100. Since the SNF copayment requirement may be higher than the Medicaid nursing home rate, or even private pay rates in a facility, some patients convert to private pay or Medicaid status on the 21st day, even though they still qualify for Medicare coverage.

Medicare beneficiaries must meet relatively restrictive functional criteria for Medicare SNF coverage. The Medicare SNF regulations stipulate that a beneficiary must require skilled nursing care or skilled rehabilitation services, and explicitly state that individuals who require custodial care only are not eligible for Medicare SNF coverage.

There has been continuing controversy regarding the interpretation of these Medicare SNF criteria by the fiscal intermediaries who process claims from nursing home providers for Medicare reimbursement. To address these concerns, the Health Care Financing Administration (HCFA) implemented new guidelines in April 1988 for fiscal intermediaries to use in reviewing SNP claims in order to achieve greater uniformity in determining what types of patients were eligible for Medicare SNF coverage.

In 1989, under the provisions of the Medicare Catastrophic Coverage Act (MCCA), the Medicare SNF benefit was temporarily expanded. The copayment requirement was reduced, the total days of coverage per calendar year was expanded from 100 days to 150 days, and the three-day prior hospitalization requirement was eliminated. When the Medicare Catastrophic Coverage Act was subsequently repealed, these expanded benefits were terminated effective January 1, 1990, and the Medicare SNF benefit reverted to its pre-MMCA provisions.

Partly due to the revised guidelines for interpreting Medicare SNF functional criteria, and partly due to the expansion in benefits enacted under the MCCA, Medicare SNF expenditures for beneficiaries over the age of 65 more than tripled from 1988 to 1989, as shown in Figure 2. Between 1980 and 1988, expenditures for SNF care rose from $340 million to $723 million, an average annual rate of increase of 9.9 percent.[4] Between 1988 and 1989, SNF expenditures rose 241 percent, from $723 million to almost $2.5 billion. With the termination of the MCCA expanded benefits in January 1990, Medicare SNF expenditures declined to $2.1 billion. By 1992, however, Medicare SNF expenditures again increased--to over $3.0 billion. Therefore, although the expanded coverage provisions for SNF care under MCCA were subsequently repealed,

[4] Medicare data for SNF expenditures are reported for calendar year, not fiscal year. Source: Office of Statistics and Data Management, Health Care Financing Administration.

it appears that the temporary expansion of these benefits has had a long-term impact on the growth in expenditures.

Medicaid Nursing Home Coverage is Means-Tested

Unlike Medicare, which provides limited nursing home coverage for all Medicare beneficiaries, the Medicaid program provides relatively broad nursing home coverage to a limited population--those elderly who cannot afford to pay the total costs of their own care. Over 78 percent of all public spending for nursing home care flows through the Medicaid program.[5] Medicaid also accounts for more than 40 percent of all public and private spending for nursing homes. In 1992, about 1.5 million persons over the age of 65 received some public assistance for the costs of their nursing home care through Medicaid.

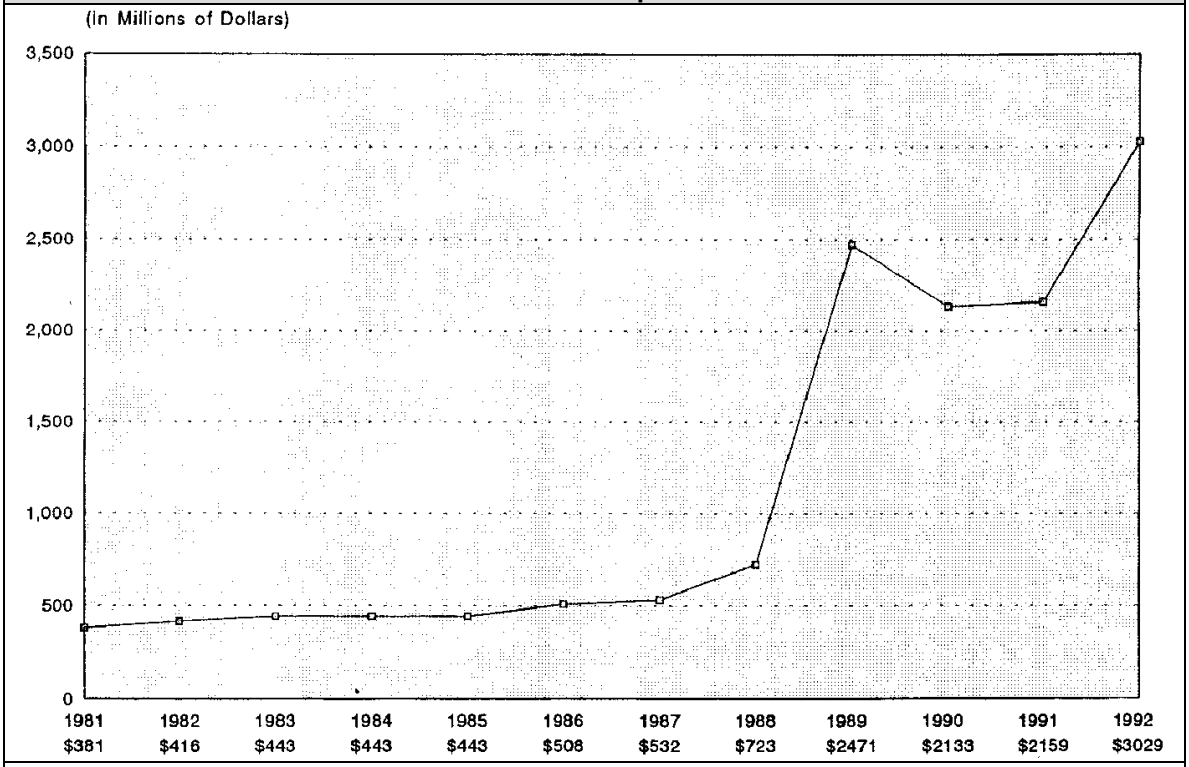
Since Medicaid is jointly financed by the Federal government and the States, Medicaid coverage of nursing home care varies substantially across the fifty State Medicaid programs. This coverage varies across a variety of dimensions including: (a) financial criteria used to determine eligibility for Medicaid coverage; (b) functional criteria used to determine whether nursing home care is needed; (c) access to nursing home beds for those who qualify for coverage; and (d) Medicaid payment rates to nursing home providers, which can affect access to care and the quality of care provided.

The financial criteria used to determine whether an applicant qualifies for Medicaid coverage in a nursing home are complex, and it is not possible to present all of the intracacies of Medicaid eligibility policy in this reports.[6] However, some general rules can be described. It is usually true that any elderly person who is covered by Medicaid prior to entering a nursing home will also qualify for Medicaid nursing home coverage once admitted. Furthermore, many persons who do not qualify for Medicaid prior to nursing home admission become eligible once they enter a nursing home because their income and assets are insufficient to pay the costs of nursing home care. In addition, many persons pay for their nursing home care privately for months or years, and then become eligible for Medicaid after their private resources are depleted. Such persons are considered to have "spent down" to Medicaid eligibility.

[5] U.S. Department of Health and Human Services, 1994, op. cit.

[6] Readers interested in a more detailed explanation of Medicaid eligibility rules for nursing home coverage are referred to: Congressional Research Service. 1993. Medicaid Source Book: Background Data and Analysis. Washington, DC: U.S. Government Printing Office (January).

FIGURE 2. Medicare SNF Expenditures 1980-1992



SOURCES: Health Care Financing Administration/Bureau of Data Management and Strategy

Elderly individuals who seek Medicaid coverage for nursing home care must meet both income and asset criteria. These criteria vary to some degree across the fifty State Medicaid programs. In 35 States (generally those which have adopted medically needy programs covering nursing home care) no income limits apply. In these States, if an individual cannot afford to pay for nursing home care from his or her own income, he or she can qualify for Medicaid, assuming the individual also meets Medicaid asset criteria.

In the remaining 15 States, individuals can only qualify for Medicaid nursing home coverage if their income does not exceed a special income level.[7] This special income level, by Federal law, cannot exceed 300 percent of the Federal income standard used in the Supplemental Security Income (SSI) program, which in 1993 was $434 per month for a single individual. Thus, these 15 States had special income levels at or below $1,302 per month in 1993. As explained later on, these income criteria only determine whether an individual is eligible for Medicaid. Even those who qualify for Medicaid must still pay for part of the cost of their nursing home care out of their available income.

Medicaid eligibility is also contingent upon applicants meeting financial asset criteria. In most States, Medicaid asset criteria are the same used in determining financial eligibility for the SSI program, which in 1993 was $2,000 for an individual and

[7] In addition to satisfying asset criteria.

$3,000 for a couple. In 1992, five States had lower asset criteria, and ten States had higher criteria, up to $4,000.[8] Certain assets, however, are excluded in determining eligibility for Medicaid. These include:

- Life insurance with a face value of less than $1,500;
- Funds up to $1,500 designated for a burial;
- Burial space;
- An automobile, within limits; and
- Equity in a home, regardless of value, provided it is the person's principal place of residence.

One area of eligibility policy that varies across States, however, is the criteria which States use to determine whether a home is or is not still the "principal place of residence." Medicaid rules for determining whether equity in a home is a "countable" or "exempt" resource generally follow rules established for the SSI program, which stipulate that as long as an individual states an intent to return home from the nursing home, regardless of how long he or she has been in a nursing home or whether there is any reasonable expectation that the individual could possibly return home, then the house is to be considered an exempt asset.[9] A few states (so-called 209[b] States) are allowed to use more restrictive criteria than are used in the SSI program, and include home equity as a countable resource once a Medicaid recipient has been in a nursing home for an extended period of time and has no reasonable expectation of returning home. Recipients may be required to sell their homes, in which case they go off Medicaid until the resources obtained from the sale of the home are depleted.

The financial criteria described above apply to individuals in nursing homes who do not have spouses still living at home.[10] Medicaid financial criteria for couples are significantly different, and were recently modified by one of the unrepealed sections of the Medicare Catastrophic Coverage Act (MCCA) of 1988. Prior to enactment of the MCCA, a spouse of a nursing home user could be financially devastated by the costs of providing nursing home care. This was because Medicaid rules stipulated that the countable assets of a Medicaid applicant included any asset that the applicant had the unrestricted right to liquidate or dispose of. This was true even if assets were jointly held by both spouses. Thus, if an elderly couple had joint savings or other financial assets which the nursing home recipient could access without authorization from the other spouse, then all of those assets had to be spent down before the recipient could become eligible for Medicaid. This could leave the community spouse with few or no resources at all.

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[8] Crown, W., and Burwell, B. 1993. An Analysis of Asset Testing for Long-Term Care Benefits. Prepared for the Public Policy Institute, American Association of Retired Persons. Cambridge, MA: SysteMetrics, A Division of MEDSTAT® System, Inc.

[9] Also, a residence is always considered exempt as long as there is a community spouse or a dependent child still living in it.

[10] According to data collected in the 1985 National Nursing Home Survey, about 90 percent of all Medicaid recipients over the age of 65 in nursing homes do not have spouses still living in the community.

Under the provisions of MCCA, all countable resources held by either spouse are now totalled, and then divided equally. Half must be used to pay for the recipient's nursing home care prior to Medicaid coverage, and half remain with the community spouse--subject to both minimum and maximum amounts. In 1993, the community spouse was allowed to retain at least $14,148 of the total. At their option, States may raise this minimum to as high as $70,740. In January 1991, 30 States had elected to protect a minimum of $13,296 for a community spouse, 16 States had opted for a minimum of $66,480, and 5 States had selected protection levels somewhere in-between.[11]

Under the MCCA, community spouses of Medicaid recipients in nursing homes are also guaranteed to receive a protected amount of the institutionalized spouse's income. In 1993, this income amount, known as the Minimum Monthly Maintenance Needs Allowance (MMMNA) is set at a minimum of $1,149 per month (150 percent of the Federal poverty level for a couple). States may set higher protected income levels for community spouses if they so choose--up to $1,769 per month in 1993. In 1991, 21 States had established such higher income levels.

Once a nursing home recipient is determined eligible for Medicaid, and income for a remaining community spouse is allocated (if applicable) then the Medicaid recipient is required to contribute almost all of his or her income to the cost of nursing home care. For example, let us assume that a Medicaid recipient has no living spouse and monthly income of $724. The recipient is required to contribute all income in excess of a personal needs allowance and other eligible deductions towards the cost of his or her care. In 1993, the minimum personal needs allowance was $30 per month. States are allowed to establish higher personal needs allowances, but most do not.[12] Assuming a personal needs allowance of $30, the recipient in the example above would be required to pay to the nursing home all income above that amount, or $694 towards the cost of their care. The nursing home provider would then bill the State Medicaid program for the balance between the monthly Medicaid reimbursement rate and the recipient's contribution.

In determining the recipient's contribution to the cost of care, certain other deductions may be taken. For example, if an individual without a spouse still retains a principal residence, then funds can be deducted for the costs of maintaining the home (e.g. property taxes and maintenance expenses). Also, the recipient may deduct other out-of-pocket medical expenses that are not covered by Medicare or Medicaid.

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[11] Congressional Research Service. 1993. op ct., p. 225.

[12] Elderly persons receiving SSI benefits in the community do not continue to receive these benefits if they enter a nursing home and are covered by Medicaid. If, however, the recipient the minimum personal needs allowance of $30 per month. For a discussion of the personal needs allowance, see: Committee on Ways and Means, U.S. House of Representatives. Overview of Entitlement Programs: 1993 Green Book. (July 7). Washington, DC: U.S. Government Printing Office, p. 825.

Medicaid Transfer of Asset Provisions

Medicaid coverage is generally only available to persons who have less than $2,000 in financial assets. Because the cost of paying for nursing home care with private funds is so high, it is known that some individuals attempt to divest or shelter their assets in order to qualify for Medicaid-financed nursing home care without having to spend their private assets first.[13] Medicaid rules stipulate that persons who give away or sell assets for less than fair market value for the sole purpose of establishing eligibility for Medicaid can be denied eligibility. These rules apply to assets which are given away or sold for less than fair market value for up to 36 months prior to application for Medicaid coverage.

There are a variety of "legal" strategies which can be used to establish Medicaid eligibility for nursing home coverage. Indeed, some attorneys have specialized in protecting estates from the prospect of being depleted by high nursing home costs through "estate planning" for Medicaid coverage.[14] For example, one simple strategy is to convert "countable" assets, such as savings and securities, into "exempt" assets, such as home equity, by paying off a mortgage or doing a major home renovation. By using these strategies, assets that would otherwise have to be used to pay for nursing home care can be protected, and individuals can qualify for Medicaid coverage sooner than they otherwise would.[15]

Medicaid Expenditures for Institutional Care

In fiscal year 1992, State Medicaid programs paid more than $20.1 billion for institutional long-term care for recipients over the age of 65.[16] This figure includes $2.1 billion in Medicaid payments for the aged in intermediate care facilities (ICFs) for the mentally retarded, as well as Nursing Facilities (NFs).[17]

Medicaid expenditures for elderly persons in NFs increased from $6.6 billion in 1980 to $18.0 billion in 1992, an average annual rate of growth of 8.7%, as shown in

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[13] Moses, S. 1990. "The Fallacy of Impoverishment." The Gerontologist. 30(1): 21-25; Burwell, B. 1991. Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage. (September). Lexington, MA: SysteMetrics, A Division of MEDSTAT® Systems, Inc.

[14] Bove, Alexander. 1990. The Medicaid Planning Handbook: A Practical Guide to Protecting Assets of Massachusetts Families. Ormond Sacker Press, Boston, MA.

[15] For a discussion of this, and other Medicaid estate planning strategies, see Brian Burwell. 1991. Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage. SysteMetrics, Cambridge, MA. For a discussion of State policies with regard to Medicaid estate planning, see Brian Burwell. 1993. State Responses to Medicaid Estate Planning. SysteMetrics, Cambridge, MA.

[16] State Medicaid programs paid another $11.9 billion for institutional care for persons under age 65, $8.0 billion of which was for persons under age 65 in Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). Source: HCFA 2082 data, Bureau of Data Management and Strategy, Health Care Financing Administration.

[17] Beginning October 1, 1990, the distinction between Skilled Nursing Facilities and Intermediate Care Facilities in the Medicaid program was eliminated. All Medicaid-certified nursing homes must now meet the same certification requirements, and are simply referred to as Nursing Facilities (NFs).

Figure 3. In 1992, Medicaid spending for elderly nursing home care exceeded Medicare SNF expenditures by a ratio of approximately six to one.

However, the number of elderly nursing home recipients on Medicaid per capita has actually declined slightly in recent years, as shown in Figure 4. Elderly persons in nursing homes receiving Medicaid coverage dropped from 457 per 10,000 elderly in 1980 to 418 per 10,000 in 1992, a decline of 8.5 percent.[18] This decline may be partly due to an overall decline in nursing home utilization rates, and/or to the fact that a lower proportion of nursing home users are qualifying for Medicaid coverage.[19]

Contrary to popular belief, Medicaid spending for nursing home care for persons over the age of 65 accounts for a declining proportion of total Medicaid spending, as shown in Figure 5. In 1980, Medicaid payments for nursing home care for persons over the age of 65 accounted for 32 percert of total Medicaid expenditures. In 1992, they accounted for 22 percent.

Other Public Nursing Home Spending

In addition to Medicare and Medicaid, a few other public programs also pay for nursing home care. The Department of Veterans Affairs (VA) operates about 117 nursing facilities of its own, generally located in VA medical centers. In 1988, these homes served an average daily census of about 7,100 residents over the age of 65. In addition, the VA pays the cost of nursing home care for certain veterans in non-VA nursing homes. Total spending for veterans over the age of 65 in nursing homes under both of these programs was approximately $590 million in FY 1988.[20]

In addition, some States finance nursing home care for certain elderly individuals outside the structure of their Medicaid programs. For example, the State of Arizona has only recently begun to claim Federal reimbursement for long-term care services under a special demonstration program that serves as an alternative to Medicaid. Prior to the demonstration, the financing of nursing home care for the indigent elderly in Arizona fell to county governments. Alaska, Delaware and Massachusetts are other States which still finance some institutional long-term care services with all-State funds, outside the Medicaid program.

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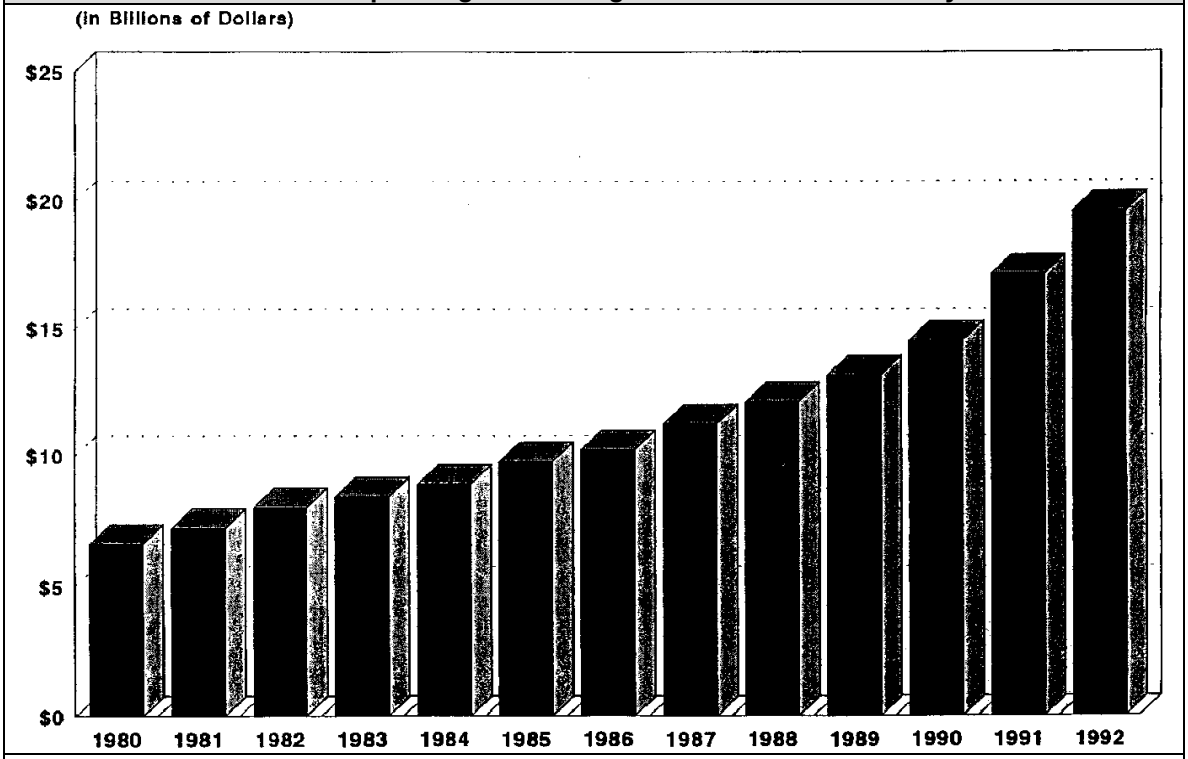
[18] Published data on the annual number of elderly recipients receiving Medicaid-covered nursing home care is imperfect because States report data on Medicaid users by type of service. The data presented simply reflect the reported sum of Medicaid users of ICF and SNF services. Since some nursing home recipients use both ICF and SNF care in a reporting year, some double counting of nursing home recipients inevitably occurs. With the elimination of the distinction between ICF care and SNF care, this reporting problem should no longer occur beginning with FY 1991 data.

[19] As discussed in Chapter 2, data from the NNHS suggest that overall nursing home utilization rates declined by about 2 percent between 1977 and 1985. This suggests that the proportion of nursing home users who qualify for Medicaid for at least part of their nursing home stay is declining gradually.

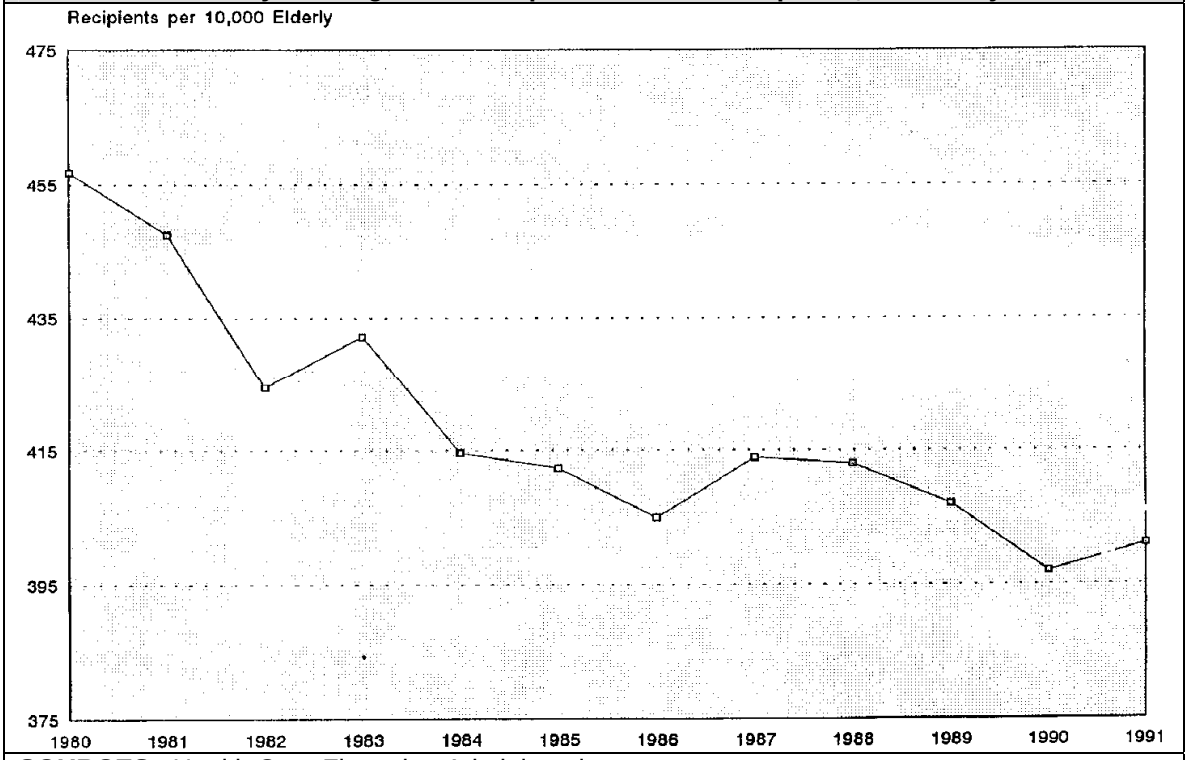
[20] Keenan, M.P. 1989. Veterans and the Demand for Long-Term Care, Issue Paper #8911 of the Public Policy Institute, American Association of Retired Persons, Washington, DC (December).

FIGURE 3. Medicaid Spending for Nursing Home Care for the Elderly 1980-1992



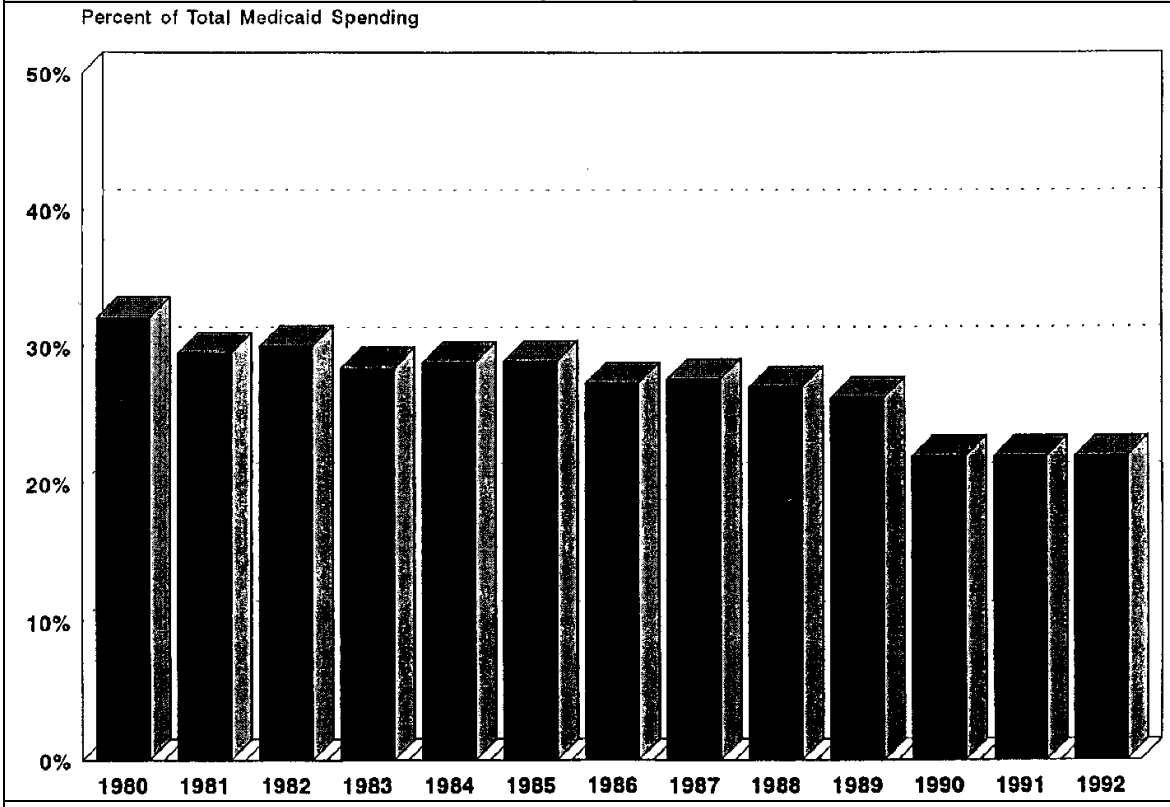
SOURCES: Health Care Financing Administration/Bureau of Data Management and Strategy

FIGURE 4. Elderly Nursing Home Recipients on Medicaid per 10,000 Elderly 1980-1991



SOURCES: Health Care Financing Administration

FIGURE 5. Medicaid Nursing Home Spending for the Elderly as a Proportion of Total Medicaid Spending: 1980-1992



SOURCES: Health Care Financing Administration/Bureau of Data Management and Strategy

HOME CARE SERVICES ARE FINANCED BY MULTIPLE FUNDING SOURCES

Unlike the financing of nursing home care, where Medicaid accounts for over 77 percent of all public spending, public support of home care services for the disabled elderly is distributed across numerous payment sources at the Federal, State and local levels. In addition, even within specific funding programs, such as Medicaid, criteria for allocating public resources for home care services are highly diverse across States, and even sometimes within States. In brief, a major characteristic of the public financing system for home care services is its lack of uniformity across States, regions, programs, and target populations.

Public Spending for Home Care is Much Less than for Nursing Home Care

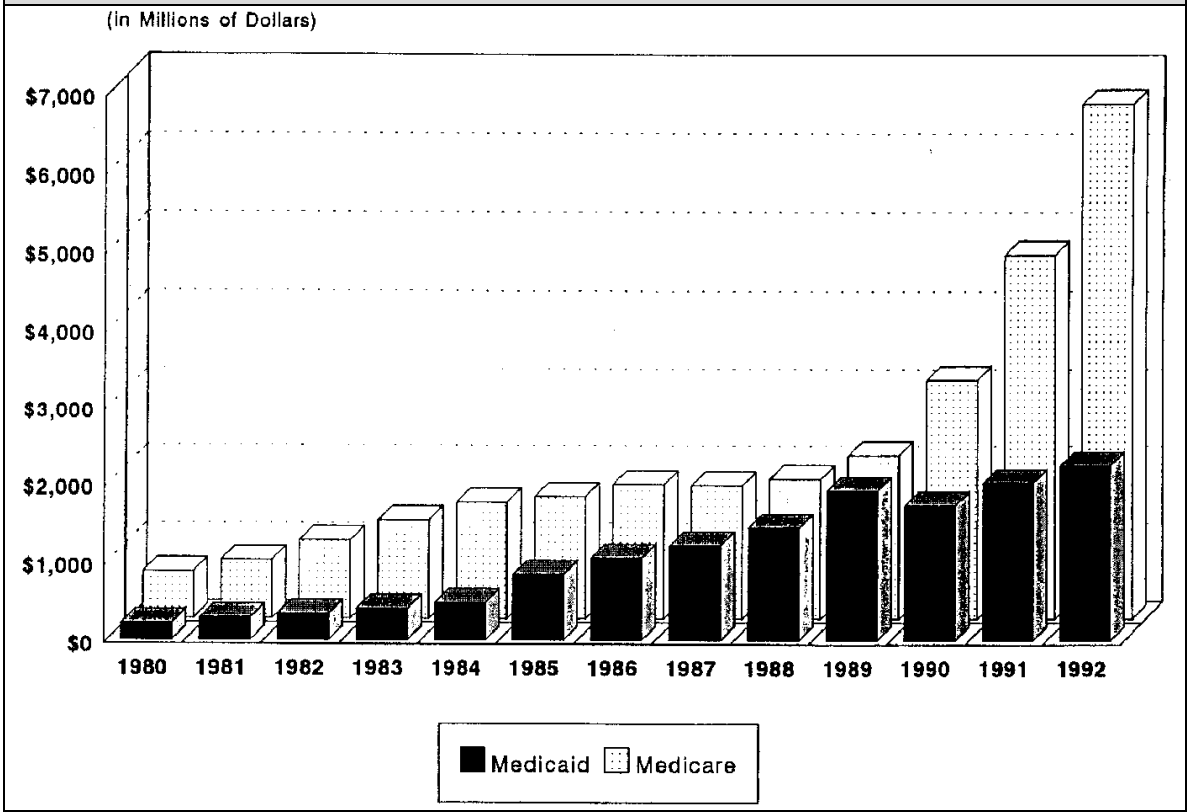
As was shown in Figure 1, public programs spent about $15.3 billion for home care services to persons over the age of 65 in 1993, compared to the $30.3 billion in public spending for nursing home care. Thus, spending for home care services comprised about one-third of total public spending for long-term care in 1993.

This distribution between spending for nursing home care and home care is also reflected in the private sector. Only about 16 percent of all private spending for long-term care is used to purchase home care; 84 percent is used to purchase nursing home care.

Medicare Home Health Benefits

The Medicare home health benefit pays for nursing care; physical, occupational, or speech therapy; medical social services; home health aide services; and durable medical equipment and supplies for Medicare beneficiaries who meet the benefit criteria. To meet these criteria, an individual must be certified by a physician as in need of skilled nursing services on an "intermittent" (as opposed to continuous) basis. Medicare home health recipients must also be "homebound," meaning that they have a condition that restricts their ability to leave home, except with the assistance of another person or the aid of a supportive device.

FIGURE 6. Medicare and Medicaid Spending for Home Health Services for the Elderly: 1980-1992



SOURCES: Health Care Financing Administration/Bureau of Data Management and Strategy
NOTE: Medicaid figures include total spending for home health, home and community-based wavers, and personal care services.

Expenditures for Medicare home health care services for beneficiaries over the age of 65 totalled $6.6 billion in 1992. Expenditures have increased at an annual rate of growth of 25.4 percent since 1980, as shown in Figure 6. Unlike public spending for nursing home care, in which Medicare plays a relatively minor role, Medicare spending for home health care services exceeds Medicaid spending for home care services. Medicare expenditures for home health care are also increasing at a much faster rate than Medicaid expenditures for home health services. The exact causes for this rapid increase in Medicare home health expenditures are not clear, but there is some belief that the fundamental nature of the Medicare home health beneift has changed from its historical post-acute and rehabilitative role to a more chronic care service.

Although Medicare is a Federally-financed program that is uniformly administered nationwide, studies have shown that utilization rates of Medicare-financed home health care services vary from region to region.[21] For example, the likelihood of using Medicare-financed home care in 1985 was about 40 percent higher in New England than in other regions of the country, all other factors being equal.

[21] Kenny, G. and Dubay, L. "The Determinants of Market Variation in Home Health Utilization." Urban Institute Working Paper No. 3740-02. Washington, DC (February).

Medicaid Financing of Home Care Services Varies Across States

The financing of home care services under the Medicaid program occurs primarily under three different coverage options in State Medicaid plans: (1) home health care services; (2) personal care services; and (3) home and community-based waiver services. Home health care services are a mandatory service, meaning that all States are required to cover home health services for certain groups of Medicaid enrollees. Personal care services, and home and community-based waiver services, on the other hand, are optional services, meaning that States may elect to provide coverage for these services, but are not required to do so.

Medicaid home health services are generally services provided by a Medicare-certified home health agency, and are usually the same set of services provided under the Medicare home health care benefit (i.e. skilled services) although State Medicaid programs may have different rules on the amount, duration, and scope of coverage than Medicare, and may pay different rates. For example, while Medicare will only pay for home health services on an intermittent basis to persons who are recovering from an acute illness, Medicaid home health services may be used to pay for skilled care for patients who have chronic conditions that require continuous treatment.

Personal care services are semi-skilled or non-skilled services provided to Medicaid beneficiaries who need assistance with basic Activities of Daily Living (ADLs) in their own home. Personal care providers are generally non-licensed individuals who provide disabled elderly individuals with help in bathing, grooming, dressing, housekeeping, toileting, and other basic living activities. They may be employed by a community agency, or they may work under direct contract to the State Medicaid agency. Federal regulations defining reimbursable personal care services are relatively broad, and only stipulate that they be:

- Prescribed by a physician;
- Provided under a written plan of treatment;
- Provided by a qualified individual;
- Supervised by a registered nurse; and
- Provided by someone who is not a member of the recipient's family.

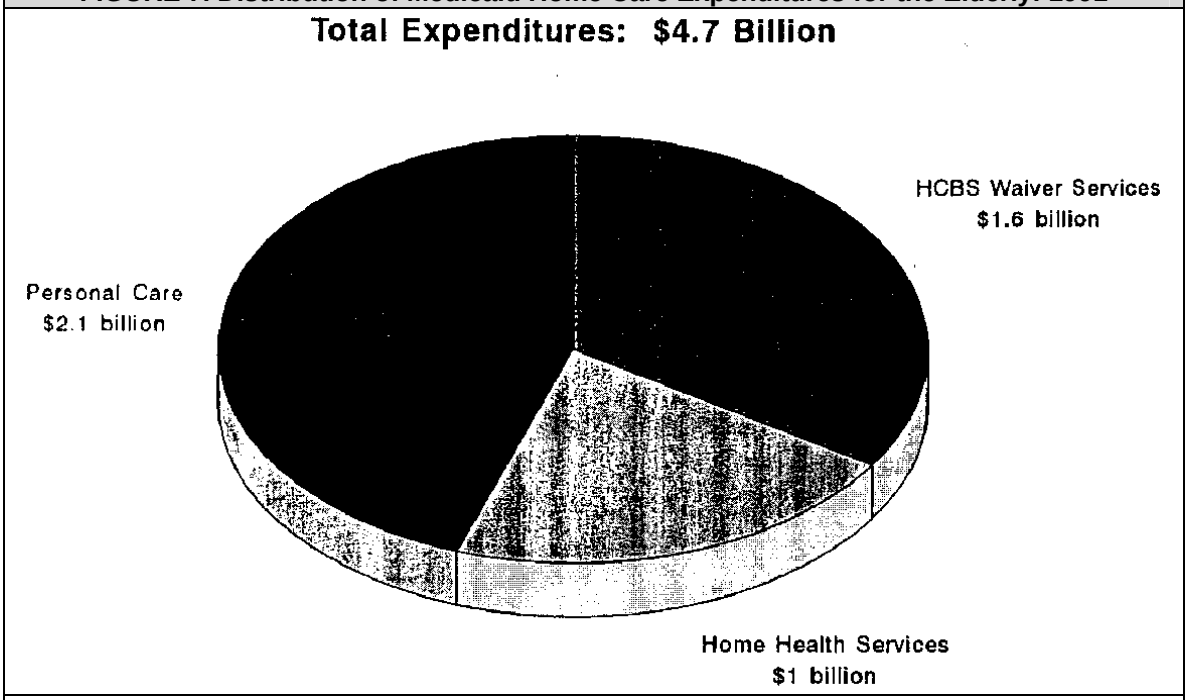
The Omnibus Budget Reconciliation Act of 1990 modified Medicaid coverage of personal care services by expanding the definition of personal care to include services provided outside the recipient's home. This modification will allow a personal care provider to also be paid for shopping, transportation, or for other services provided outside the home. This provision will not take effect in all States until FY 1995.
As of October 1991, 28 States provided personal care services as an optional benefit under their State Medicaid plans.[22] Spending for personal care services accounts for

[22] Congressional Research Service. 1993. op cit., p. 817. Beginning October 1, 1994, Medicaid law requires States to provide personal care services to any persons who qualify for Medicaid nursing home services.

the majority of total spending for home care services under Medicaid, as shown in Figure 7. Of the approximately $4.7 billion spent for home care services under Medicaid for the elderly in 1991, about $2.1 billion was spent under the personal care services option. However, spending for personal care services is also highly skewed across States. Six States--Arkansas, Massachusetts, New York, Michigan, Texas, and Oklahoma--account for over 95 percent of all personal care spending for the elderly. New York alone accounts for over 80 percent.[23]

Home and community-based waiver services were first authorized under the Omnibus Budget Reconciliation Act (OBRA) of 1981. Home and community-based waiver services are not Medicaid State plan options, since coverage of these services requires a separate application to the Health Care Financing Administration (HCFA).

FIGURE 7. Distribution of Medicaid Home Care Expenditures for the Elderly: 1991



SOURCES: Health Care Financing Administration/Office of Research and Demonstrations

The Medicaid home and community-based waiver program allows States to cover a broad array of non-medical community-based services that otherwise cannot be covered by State Medicaid plans under Federal law. These services can be covered only if the States demonstrate to HCFA that such coverage is cost-effective. States must demonstrate to HCFA that spending for home and community-based waiver services will be offset by reduced expenditures for nursing home care of at least an equal amount. Persons receiving services under home and community-based care waivers must meet the same level of care criteria that are used by States to certify Medicaid coverage for nursing home care. Limits are also placed on the number of

[23] These data are all estimates because States do not report separate expenditure data for Medicaid personal care services provided to disabled persons under age 65 and services to the disabled elderly.

individuals who may receive home and community-based waiver services annually in order to maintain cost-effectiveness.

Typical services provided by States under home and community-based waiver programs include case management, non-medical day care, personal care services, non-medical transportation, homemaker services, and respite care. Although some of these services can be offered under regular State Medicaid plans, the waiver program also allows States to provide these services under alternative regulatory requirements than are applied to regular State plan services. For example, a State may limit home health care services to two visits per week under its regular Medicaid program, but allow a higher number of visits for home and community-based waiver recipients. Or a State may provide personal care services under a waiver program without a requirement that these services be authorized by a physician, allocating that authority to professional case managers instead.

As of December 1991, 40 States operated one or more waiver programs for aged and physically disabled Medicaid enrollees.[24] Spending for all home and community-based waiver programs grew rapidly in the 1980s, reaching $1.6 billion in 1991, but spending for waiver programs that target the disabled elderly accounted for only about 32 percent of the total. The majority of Medicaid spending for home and community-based waiver services (64 percent) is for children and adults with mental retardation and other developmental disabilities.

In OBRA 1990, Congress enacted a new Medicaid provision (Section 4711) that allows States to provide home and community-based services, like services provided under the Medicaid waiver program, as a State option. Although States electing to use this option will not have to make a special application to HCFA to provide these services, and will also not have to demonstrate the cost-effectiveness of these services, the circumstances under which these services can be provided as a regular State option are quite proscriptive. To date, only the state of Texas has elected to use this new benefit option in its Medicaid program.

As shown in Figure 6, total Medicaid spending for home health care services for the elderly is increasing rapidly, exceeding annual rates of growth of 20 percent throughout the 1980s. Spending for home health care services to elderly Medicaid recipients was about $2.3 billion in 1992. Nonetheless, Medicaid spending for home and community-based services is increasing at a far lower rate than Medicare home health spending.

Older Americans Act Programs

Under Title III of the Older Americans Act of 1965, as amended, the Administration on Aging allocates Federal grants to States for the development of

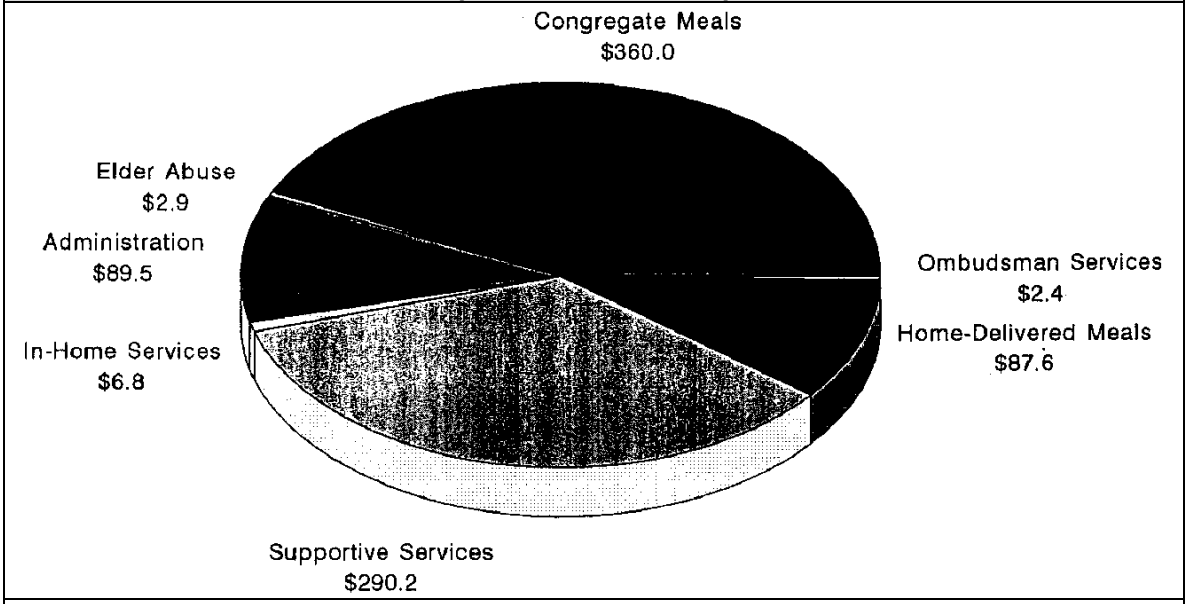
[24] Congressional Research Service. 1993. op cit., p. 818.

comprehensive and coordinated community-based systems of services for the elderly. The objectives of Older Americans Act programs are: (1) to help older persons to secure and maintain maximum independence and dignity in a home environment; (2) remove barriers to independence for older persons; and (3) provide a continuum of care for the vulnerable elderly. Federal Title III funds are allotted to State Agencies on Aging, which in turn allocate funds throughout each State to local Area Agencies on Aging (AAAs) which make provisions for the delivery of services within their respective planning and service areas.

Federal funding for Title III programs is capped at an annual appropriation level and requires matching funds from grantees at a 25 percent rate for program administration and a 15 percent rate for program activities. The grantees' matching share may be either in cash or in-kind. In FY 1989, Federal appropriations for the Title III program equalled $715.5 million.

All persons over the age of 60 are eligible for Title III-funded services, without means-testing. However, particular focus in allocating resources is placed on the most vulnerable elderly, meaning those persons with the greatest economic and social needs. Although Title III regulations prohibit means-testing, the program allows participants the opportunity to contribute toward the cost of services they receive. In FY 1989, approximately $179 million in voluntary contributions were received by AOA program providers.[25]

FIGURE 8. Title III Program Expenditures: 1991 (in millions of dollars)



SOURCES: Administration on Aging

[25] Data provided by the Office of State and Community Programs, Administration on Aging, Department of Health and Human Services, May 1990.

Figure 8 presents the distribution of Federal Title III expenditures, by type of expenditure, in FY 1991. Supportive services, which include information and referral, transportation, employment services, legal assistance, counseling, health education and screening, home repairs and maintenance, and in-home services such as homemakers or home health aides, account for about 35 percent of total program expenditures. Fifty-three percent of all program funds in FY 1991 ($447.6 million) were used for nutrition services. Congregate nutrition services--meals provided in settings such as senior citizen centers, adult day care programs, and elderly housing projects--accounted for $360 million of this amount, while home-delivered meals (the well-known Meals-on-Wheels program) accounted for $87.6 million.[26]

Under the Older Americans Act, States are also required to establish and operate an Office of State Long-Term Care Ombudsman, whose purpose it is to monitor the quality of care provided to disabled elderly persons in nursing homes and to investigate complaints made by nursing home recipients about the services they receive. In FY 1991, approximately $2.4 million in Title III funds were allocated to these programs. Many States provide additional funding of their own.

The 1987 amendments to the Older Americans Act targeted the first funds to provide in-home services for frail older individuals. These amendments marked the first time that Title III funds were specifically targeted to elderly individuals who are dependent in daily activities. Program expenditures under this component of the Older Americans Act totalled $6.8 million in FY 1991.

Older Americans Act programs make an important contribution to the publicly-financed home care system by supporting an infrastructure through which home care resources can be coordinated. State Agencies on Aging and local Area Agencies on Aging are generally not in the business of funding or providing direct home care services for the disabled elderly. Their primary role is to serve as a central information and referral source for all elderly persons seeking help for their long-term care needs. Many AAAs are formalizing their roles as providers of case management services for the disabled elderly, becoming the main access points, gatekeepers, care planners, and service monitors of publicly-financed home care programs.

The Social Services Block Grant

Title XX Social Services Block Grant (SSBG) funds are allocated to the states on the basis of population. Total Federal funding under the SSBG was $2.8 billion in 1993. States are no longer required to provide any matching funds for the Federal dollars they receive through SSI3G. SSBG funds are not specifically intended to be a financing source for home care services. States have broad authority to spend their SSBG allocations on a wide array of social services, of which home care for the disabled

[26] The Child and Adult Care Food Program, administered by the Department of Agriculture, also provides cash reimbursement and donated foods to adult day care centers which serve persons 60 years of age or older. Estimated expenditures under the adult day care component of the program were approximately $3.4 million in FY 1989.

elderly is only one. Since reporting requirements on how States spend their SSBG allocations are minimal, reliable estimates of the amount of SSBG funds allocated to home care services for the disabled elderly are lacking.[27] Nonetheless, the data which are available indicate that many States do use SSBG funds to augment home care programs financed by other sources.

At least 38 States used some portion of their SSBG funds to support home and community-based services for the frail elderly in 1986.[28] Estimated allocations for home care services totalled $375 million, about 15 percent of the total Federal SSBG allocation of $2.6 billion in that year. However, over 50 percent of this SSBG spending for home care was made by the State of California alone, which used $195 million of its SSBG allocation to fund its In-Home Supportive Services program, a broad home and community-based services program for the elderly and physically disabled. Other States that use significant portions of their SSBG allocations (more than 10 percent) to finance home care services include Indiana, Michigan, Ohio, Texas, Virginia, Washington, and Wisconsin.

Department of Veterans Affairs Home Care Progrms

The Department of Veterans Affairs (VA) operates a range of programs for disabled veterans living at home or in alternative residential care facilities. About 78 VA medical centers operate home care programs that provide primary medical care and supportive services to veterans in their own homes. The VA also operates a small number of adult day care centers, a community residential program for about 11,000 veterans, a respite care program, and an Aid and Attendance program, which provides pension supplements to low-income veterans living in the community who require help with activities in daily living, or to spouses or parents of veterans who are similarly impaired, and a Senior Companion Program.

Home Care Services Funded Out of State General Revenues

Adding to the complexity of multiple Federal funding streams for home care is the fact that many States support their own home care programs with general revenue funds. The majority of State funds spent on home care are used for State matching requirements under Medicaid and the Older Americans Act programs.[29] However, most States also provide additional funding for home care above and beyond these Federal matching requirements. This additional financing is generally expended in one or more of the following ways: (1) supplemental funding of Social Services Block Grant

[27] The Family Support Act of 1988 strengthened reporting requirements for SSBG-funded services. These requirements went into effect beginning with expenditures made in FY 1990.

[28] Lipson, D., Donohue, E. and Thomas, C. 1988. State Financing of Long-Term Care Services for the Elderly. Intergovernmental Health Policy Project, George Washington University, Washington, DC (May).

[29] Across all States and all Medicaid services, the Federal government pays for about 56 percent of total Medicaid service costs, and States pay about 44 percent.

programs and/or OAA programs; (2) special State Supplementation Payments to Federal SSI benefits targeted to elderly persons with long-term care needs and/or living in supervised residential settings, such as board and care homes; and (3) "stand-alone" programs which provide home and community-based services to eligible elderly persons.

A survey of all fifty States estimated that total State-only spending for home and community-based services and special State supplements to Federal SSI benefits totalled approximately $770 million in FY 1986.[30] This exceeded the amount spent by States for matching requirements under Medicaid and Older Americans Act Programs. Given the wide variation across States in both the level of public support for long-term care, and in the financing and program structures through which this support is provided, Sections 3.6 and 3.7 of this chapter discuss State variation in the financing of long-term care services more directly.

[30] Lipson et al., op. cit.

COST CONTAINMENT IN THE LONG-TERM CARE SYSTEM

Numerous mechanisms are employed in the Medicare and Medicaid programs to constrain the rate of growth in public expenditures for long-term care. In Medicare, long-term care spending is controlled primarily by policies to maintain the boundary between the acute care orientation of Medicare benefits, and custodial care. Medicare coverage of nursing home and home care services generally ends when a "spell of illness" is completed. Although is it is often difficult to ascertain exactly when a "spell of illness" is over, Medicare's primary cost containment mechanism in long-term care is to maintain its orientation towards coverage of acute illness. The high copayment rate ($84.50 in 1993) for Medicare SNF coverage after the 21st day of coverage also serves as a significant cost containment mechanism.

Since Medicaid is jointly administered by the Federal government and the States, both entities participate in efforts to control costs. As under Medicare, the Federal government's primary cost containment mechanism in Medicaid has been to define the boundaries of Medicaid-covered benefits. In other words, Federal Medicaid policy defines what types of services are or are not eligible for Medicaid reimbursement, and therefore Federal Financial Participation (FFP).

Although the boundary of Medicaid-covered services is considerably broader than under Medicare (Medicaid coverage definitely includes custodial care and other long-term care services related to chronic conditions) Medicaid policy still limits coverage to "medically-oriented" services. For example, Federal Medicaid policy has historically limited coverage of more socially-oriented services, such as homemaker services, case management, housing modifications, meal preparation, and non-medical transportation. More recently, however, these services have become increasingly eligible for Medicaid coverage under the Home and Community-Based Waiver Program and other Medicaid program options.

State Medicaid programs employ a number of strategies to contain the growth in long-term care costs. Limiting the overall supply of nursing home beds has been found to be one effective strategy for controlling Medicaid nursing home expenditures; Certificate of Need programs, and statewide moratoria on the construction of. new nursing home beds, are common strategies. Many States have resorted to these controls on supply after coming to the conclusion that other strategies to contain nursing home costs were not as effective. Many States feel that "a bed built is a bed filled." Limits on the supply of nursing home beds obviously raise questions about whether access to nursing home care is also being inappropriately restricted, however.

Other cost containment mechanisms used by States include:

- Financial criteria for Medicaid eligibility, including the relative restrictiveness with which States enforce prohibitions on transfers of assets and the circumstances under which home equity is included as a countable resource;
- Functional ("level of care") criteria for Medicaid coverage in nursing homes, including the use of nursing home pre-admission screening programs to determine whether applicants meet Medicaid criteria prior to nursing home entry;
- Medicaid payment levels for nursing home care, as well as the methodologies used in setting rates and paying providers, such as prospective payment and case-mix reimbursement methods;
- State development of alternative service options for persons in need of intensive levels of care, including adult foster care, assisted living facilities, and home and community-based care programs targeted to high risk individuals.
- Efforts to maximize the participation of family members and other informal caregivers in the provision of care, including actively including family members in the care planning process, supporting respite care programs, and caregiving education programs.

Last, but not least, several States, such as Oregon and Washington, are involved in efforts to dramatically restructure their entire long-term care service delivery systems. A common thread in these restructuring strategies has been the consolidation of financing and delivery systems into more streamlined, coordinated, and efficient administrative structures.

FEDERAL AND STATE REGULATORY EFFORTS TO ASSURE QUALITY

Public payers of long-term care services continually face the challenge of assuring the quality of services being purchased with taxpayer dollars. This focus of this report is on the financing of long-term care services, partly due to the fact that major policy initiatives aimed at improving the quality of publicly-financed long-term care have been recently implemented, particularly under the provisions of the Omnibus Budget Reconciliation Act of 1987. Nonetheless, discussions of Federal and State spending for long-term care services must always be presented in the context of what is being bought with these public dollars. Regulatory mechanisms are the primary means by which public payers ensure that the services they buy meet minimum standards of care.

Nursing homes which receive reimbursements from Medicare and/or Medicaid must meet Federal and State certification requirements. Compliance of Medicaid-certified nursing facilities and Medicare-certified skilled nursing facilities with regulatory standards is assessed, on average, every 12 months through surveys conducted by State agencies. The Federal government also conducts its own surveys to determine the validity of State assessments. The surveys examine, at a minimum, the following dimensions: (1) quality of care; (2) residents' assessments and plans of care; and (3) compliance with patients' rights.

Noncompliance with, certification standards can result in the imposition of various remedies, including directed plans of correction, denial of payment for new admissions, civil monetary penalties (CMPs), temporary takeover of management, enhanced State monitoring and/or termination of certification. The Federal government can also reduce its contribution to State administrative costs when State survey performance is found to be deficient. In 1991, there were 15,175 Medicare- and Medicaid-certified nursing facilities. During the period from October 1990 to September 1991, 35 homes were involuntarily terminated from the Medicare and/or Medicaid programs for noncompliance with quality of care standards.

The process of determining the compliance of Medicare-certified Home Health Agencies (HHAs) with certification standards is similar to the nursing home survey process outlined above. Additionally, home visits to Medicare beneficiaries may be conducted with the consent of the beneficiary. Medicaid-certified HHAs must meet Medicare requirements.

The quality of other Medicaid-financed home care services, such as personal care services and home and community-based care waiver services, are less regulated by the Federal government. States are required to develop their own standards for these services, and provide assurances to the Federal government that these standards are being implemented, but there is no minimum Federal standard that must be met,

other than that all providers must be "certified." All recipients of home and community-based waiver services must also have access to case management services.

As with financing policy, a major issue in regulating the quality of care produced by providers of publicly-financed long-term care services is the level of involvement which the Federal government should have in establishing and enforcing standards. Historically, the Federal government has taken a more active role in the establishment of quality of care provisions for the elderly, and less involvement in quality of care standards for the non-elderly disabled. This distinction is evident in the new community care benefits enacted under the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) which specifies detailed standards for community services provided to the elderly, but relies on State standards for services provided to the developmentally disabled.

TABLE 1. State Level Data on Nursing Home Bed Supply, Medicaid Nursing Home Utilization, and Medicaid Expenditures Per Capita								
State	**Nursing Home Beds per 1000 Elderly 1992**	**Elderly Nursing Home Recipients on Medicaid 1992**	**Medicaid Recipients per 1000 Elderly 1992**	**Medicaid Nursing Home Expenditures for the Elderly 1992**	**Average Annual Payment per Nursing Home Recipient 1992**	**Medicaid Nursing Home Expenditures per Elderly State Resident 1992**	**Average Medicaid Reimbursement Rates 1992**	**Certificate of Need Program for Nursing Homes 1992**
United States	53.10	1,350,424	41.83	$20,106,114,499	$14,888.74	622.77	74.58	
Alabama	42.90	17,489	32.57	257,460,646	14,721.29	479.44	62.48	Yes
Alaska	43.00	816	34.00	29,167,582	35,744.59	1,215.32	217.19	Yes
Arizona	32.60	11,366	22.16	8,899.704	783.01	17.35	72.30	No
Arkansas	66.50	17,853	49.87	183,926,038	10,302.25	513.76	49.05	Yes
California	40.30	110,727	34.11	1,537,931,025	13,889.39	473.79	72.92	No
Colorado	57.80	12,376	35.56	172,696,962	13,954.18	496.26	72.55	No
Connecticut	66.00	30,910	67.79	630,077,438	20,384.26	1,381.75	116.57	Yes
Delaware	57.30	2,330	27.41	49,333,866	21,1733.33	580.40	81.80	Yes
District of Columbia	40.60	4,159	54.01	100,438,425	24,149.66	1,304.40	127.38	Yes
Florida	28.60	84,290	33.93	750,051,044	8,898.46	301.95	76.71	Yes
Georgia	58.60	29,661	43.56	381,705,713	12,868.94	560.51	63.49	Yes
Hawaii	25.70	3,459	26.01	84,711,120	24,460.06	636.93	113.01	Yes
Idaho	45.30	4,431	34.62	54,651,017	12,333.79	426.96	65.47	No
Illinois	68.70	55,161	37.68	708,769,407	12,849.10	484.13	62.23	Yes
Indiana	82.20	33,797	47.07	446,638,704	13,215.34	622.06	64.02	Yes
Iowa	81.50	19,352	44.59	176,237,883	9,106.96	406.08	53.01	Yes
Kansas	79.30	15,954	45.71	156,806,245	9,828.65	449.30	50.55	No
Kentucky	48.50	21,705	45.50	248,102,484	11,430.66	520.13	59.50	Yes
Louisiana	78.10	31,724	66.09	352,031,330	11,096.69	733.40	63.82	No
Maine	60.60	9,755	57.72	191,790,213	19,660.71	1,134.85	87.25	Yes
Maryland	51.10	28,257	52.33	320,580,352	11,345.17	593.67	77.52	Yes
Massachusetts	63.30	44,360	53.13	989,194,159	22,299.24	1,184.66	96.07	Yes
Michigan	44.30	37,927	32.95	513,449,220	13,537.83	446.09	64.88	Yes
Minnesota	80.30	35,556	63.38	620,928,168	17,463.39	1,106.82	82.06	No
Mississippi	49.20	14,506	44.50	177,847,096	12,260.24	545.54	55.44	Yes
Missouri	84.40	30,720	41.85	328,872,412	10,705.48	448.06	52.89	Yes
Montana	59.00	4,616	41.96	59,509,041	12,891.91	540.99	63.22	Yes
Nebraska	86.20	11,182	49.48	133,115,111	11,904.41	589.00	57.16	Yes
Nevada	24.40	2,909	19.92	44,480,538	15,290.66	304.66	68.58	Yes
New Hampshire	53.20	6,023	45.98	131,614,234	21,851.94	1,004.69	95.58	Yes
New Jersey	41.90	33,199	31.41	708,782,315	21,349.51	670.56	91.61	Yes
New Mexico	39.00	4,043	23.24	73,042,043	18,066.30	419.78	73.84	No
New York	44.70	102,921	43.35	3,211,017,021	31,198.85	1,352.58	122.90	Yes
North Carolina	41.60	31,359	37.11	431,949,981	13,774.35	511.18	86.75	Yes
North Dakota	76.20	5,173	55.62	80,113,179	15,486.79	861.43	71.98	Yes
Ohio	62.90	82,013	56.29	1,235,898,100	15,069.51	848.25	84.63	Yes
Oklahoma	79.70	22,237	51.24	198,274,250	8,916.41	456.85	46.40	Yes
Oregon	36.00	10,368	25.29	127,172,216	12,265.84	310.18	67.37	Yes
Pennsylvania	47.80	64,624	34.34	1,149,520,942	17,787.83	610.80	68.04	Yes
Rhode Island	66.80	21,274	139.05	144,522,547	6,793.39	944.59	110.88	Yes
South Carolina	38.70	12,674	30.39	190,264,960	15,012.23	456.27	65.24	Yes
South Dakota	78.60	5,762	54.88	67,493,767	11,713.60	642.80	54.32	No
Tennessee	55.30	35,669	55.65	357,650,187	10,026.92	557.96	62.32	Yes
Texas	67.90	83,387	46.40	902,179,632	10,819.19	502.05	54.51	No
Utah	50.20	3,813	23.83	14,135,009	3,707.06	88.34	67.18	No
Vermont	53.60	3,219	47.34	54,685,327	16,988.30	804.20	84.90	Yes
Virginia	42.10	23,716	34.07	297,340,966	12,537.57	427.21	62.58	Yes
Washington	48.70	22,851	38.09	342,183,421	14,974.55	570.31	86.53	Yes
West Virginia	37.10	8,885	32.19	127,076,012	14,302.31	460.42	72.28	Yes
Wisconsin	74.30	37,829	56.55	522,362,381	13,808.52	780.81	75.19	Yes
Wyoming	71.10	2,037	40.74	29,435,066	14,450.20	588.70	70.66	No

STATE VARIATION IN NURSING HOME USE AND FINANCING

Far more than the Federal government, States have the lead role in formulating, financing and implementing long-term care policy. While the Federal government participates in the financing of long-term care services through Medicaid and other programs, most of the policy decisions that determine both the level and character of public assistance for elderly persons with disabilities are made at the State level. As a consequence, long-term care systems vary considerably across States. This section, and the one which follows, discuss how States vary in their financing of both nursing home care and home care services for the disabled elderly.

Nursing Home Use and Expenditures Vary Greatly Across States

Although Medicaid is an "entitlement" program, this does not mean that poor elderly persons are equally served in all States. Table 1 presents selected data on interstate variation in nursing home supply, utilization, payment levels, and public expenditures for nursing home care. The table underscores the wide variation that exists across States.

The supply of nursing home beds per 1,000 elderly State residents vanes dramatically across the fifty States (first column of Table 1). In 1992, nationwide, there were 53.1 beds per 1,000 persons age 65 and over. At the State level, the number of nursing home beds ranged from 24.4 per thousand enrollees in Nevada to 86.2 per thousand in Nebraska, a difference of 253 percent.

States with relatively low supplies of nursing home beds (less than 40 beds per 1,000 elderly) include Nevada, Hawaii, Florida, Arizona, West Virginia, Oregon, New Mexico, and South Carolina. However, a low ratio of nursing beds to the size of the elderly population is not necessarily an indicator that there are too few nursing home beds in a specific State. This is because some States, like Florida, have made extensive use of use board-and-care facilities which serve many disabled elderly who in other States would be cared for in ICF-level nursing homes. States with the highest supply of nursing home beds (more than 75 beds per 1,000 elderly) include Iowa, Indiana, Minnesota, Louisiana, Nebraska, Missouri, North Dakota, South Dakota, Kansas, and Oklahoma.

One factor influencing the supply of nursing home beds is whether States have Certificate of Need programs that require prior approval for new bed development from local and/or State agencies. In 1992, 38 States plus the District of Columbia had Certificate of Need programs for nursing homes, while 12 States did not.

The second and third columns of Table 1 present data on the number of elderly persons receiving Medicaid-financed nursing home care in 1992 and the number of elderly Medicaid recipients in nursing homes per 1,000 elderly population. Nationwide, 41.8 elderly persons per 1,000 population (i.e. about 4 percent of all elderly persons) received Medicaid-financed nursing home care care in 1992. Utilization rates ranged from 19.9 per 1,000 in Nevada to 67.8 per 1,000 in Connecticut (excluding Rhode Island).[31] Moreover, it is important to recognize that the relationship between Medicaid utilization rates and overall bed supply is far from perfect. For example, Illinois has a relatively high supply of nursing home beds, but a relatively low Medicaid utilization rate.

Columns four through seven in Table 1 present State-level data on Medicaid expenditures for nursing home care. Average annual Medicaid payments per nursing home recipient are determined by three major factors: (1) Medicaid reimbursement rates; (2) average length-of-stay; and (3) patient contributions to the cost of care. Average Medicaid payments per recipient ranged from $783 per year in Arizona to $35,745 per year in Alaska. Both of these figures should be interpreted with caution, however. The nursing home expenditure amounts for Arizona are extremely low relative to other states. And Alaska is atypical because of its very high reimbursement rates ($217.19 per day). Excluding Arizona and Alaska, average Medicaid payments for nursing home care ranged from $3,707 in Utah to $31,199 in New York. The average payment nationally was $14,889. Average daily Medicaid reimbursement rates for nursing facility care (excluding Alaska) ranged from $49 per day in Arkansas to $127 per day in the District of Columbia.

A good summary statistic for comparing State Medicaid spending for nursing home care is presented in Column 6, which shows annual Medicaid spending for nursing home care per elderly State resident in 1992. In that year, Medicaid programs spent an average of $623 per elderly State resident for nursing home care. However, excluding Arizona, there was a greater than fifteen-fold difference in per capita expenditures across States, from a low of $88 per capita in Utah to a high of $1,382 per capita in Connecticut. The States with the highest rate of expenditures per capita (greater than $1,000) Were New York, Alaska, Connecticut, Maine, Massachusetts, Minnesota, New Hampshire, and the District of Columbia.

In summary, the level of public support for Medicaid-financed nursing home care varies significantly from State to State. Medicaid spending for nursing home care varies four-fold from the highest spending States to the lowest spending States. Despite lower rates of poverty, wealthier States spend more for Medicaid-financed nursing home care than poorer States. This is because Medicaid spending for nursing home care is affected by a number of factors, including overall bed supply, Medicaid eligibility and functional criteria for nursing home coverage, length-of-stay patterns of Medicaid recipients in nursing homes, and Medicaid payment rates.

[31] These figures exclude Rhode Island because Rhode Island does not report 2082 data to HCFA; Rhode Island Medicaid recipients and expenditures are imputed by HCFA.

Trends in Nursing Home Bed Capacity

Over the past decade, the supply of nursing home beds has remained stable, relative to growth in the elderly population.[32] The total number of certified nursing home beds per thousand elderly was 53.31 in 1980 and 53.1 in 1992. Occupany rates in nursing homes have also remained relatively stable in recent years, although the average occupancy rate in nursing homes is high, at 90 percent in 1991.[33] Interestingly, nursing home occupany rates do not appear to be related to the number of nursing home beds per aged population.[34] Occupancy rates are highest in the northeastern States and lowest in the western States.

Is There a Nursing Home Access Problem?

Many people have expressed concern that Medicaid recipients do not have the same access to nursing homes as people who pay privately. Another concern has been whether nursing homes discriminate against admitting patients with heavier care needs, because they consume more resources, and are ultimately "less profitable" to care for. The evidence on whether these are serious problems is mixed, although there is considerable evidence that there are access problems for some patients in some areas.

Several studies have shown that hospital discharge delays and the probability of nursing home placement are statistically related to nursing home bed supply.[35] Although researchers report mixed results, both quantitative and qualitative studies suggest that Medicaid patients and patients with heavy care needs in hospitals experience longer delays waiting for nursing home placement than private pay patients and patients with lighter care needs.

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[32] Harrington, C., Preston, S., Grant, L. and Swan, J. 1990. "Trends in Nursing Home Bed Capacity in the States." Presented at the Annual Meeting of the American Public Health Association, New York (October).

[33] DuNah, Richard, Harrington, Charlene, and Bedney, Barbara. 1993. "Variations and Trends in Licensed Nursing Home Capacity in the States, 1978-92." San Francisco: Department of Social & Behavioral Sciences and the Institute for Health and Aging, University of California.

[34] Ibid.

[35] Dubay, L., McBride, T. and Holahan, J. "Is There a Nursing Home Access Problem? A Review of the Empirical Evidence." Urban Institute Working Paper 6053-04-01 (Draft) August 1990.

It has often been hypothesized that Medicaid patients in States with lower Medicaid reimbursement rates for nursing home care have more difficulty gaining access to nursing homes than States with more generous Medicaid payment rates, but research has shown only small effects. Nursing home bed supply appears to have a stronger effect on access to nursing homes for Medicaid patients than reimbursement rates. There may be a trade-off between restrictions on supply and Medicaid rates. Medicaid patients in States with low bed supplies may have more severe access problems, leading to pressures to raise Medicaid payment rates. States with higher bed supplies may show higher Medicaid utilization levels, but there may be less pressure to increase payment rates to ensure access. Further research on the complex relationships between nursing home bed supply, Medicaid policies, patient characteristics, and access to nursing home care is still needed.

STATE VARIATION IN THE FINANCING OF HOME CARE

As with the public financing of nursing home, the financing of home care varies across States. However, accurate data on aggregate State spending for home care services is difficult to obtain. For one, States use multiple financing sources to provide home care services for the disabled elderly, as will be discussed further later on. Second, many home care programs serve both persons over the age of 65 with functional impairments, and persons with disabilities under age 65, and many States cannot disaggregate utilization and expenditure data by age groups. Nonetheless, the data that are available make it readily apparent that State spending for publicly-financed home care varies at least as much as spending for nursing home care.[36]

For example, as previously reported, the State of New York alone accounts for about 64 percent of all Medicaid spending for home care services to the disabled elderly. If all States provided publicly-financed home care at the same level that New York does, total Medicaid home care spending for elderly Medicaid recipients would have been over $5.8 billion in FY 1992, instead of the $2.2 billion that was actually spent.[37]

Alternative Financing Mechanisms

The manner in which publicly-financed home care services are funded varies greatly across the States, and the election of different funding mechanisms have different programmatic implications. As previously discussed, Medicaid funding of home care services falls under three major service categories: (1) personal care services; (2) home health care services; and (3) home and community-based waiver services. Although 30 States cover personal care services in their Medicaid benefit package, aggregate personal care spending is concentrated in only a few States.

While Medicaid Home and Community-Based Waiver Programs have become a popular financing mechanism for non-skilled home care services, the size of these programs has been limited by their need to meet the statutory test of cost-effectiveness. Oregon is the only State that uses the waiver program as a major source of funding for home care. Under a modification to the original legislation (Section 1915[d]), Oregon has no restrictions on Medicaid financing of waiver services, as long as total Medicaid

[36] The most recent attempt to collect aggregate State data on public spending for home care for the elderly across all funding sources was a survey conducted in 1987 by the Intergovernmental Health Policy Project, sponsored by The Villars Foundation. Spending for home care services for the elderly in FY 1986 was reported. However, not all States were able to provide all the requested data, and because these data are already outdated, they are not presented in this report. Source: Lipson, et al. 1988, op. cit.

[37] Based on 2082 data for 1992.

spending for long-term care (nursing home care plus home care) stays under a fixed budget amount. Expenditures over this amount are not eligible for Federal Financial Participation.

Other States elect not to use Medicaid as the primary funding source for home care services, and rely on other funding mechanisms instead. One option is for States is to use their allocations under the Social Services Block Grant (SSBG) to fund home care services for the disabled elderly. California is the prime example--it uses virtually all of its Federal SSBG allocation to fund its In-Home Supportive Services, a broad-based program that funds home care services for both elderly and non-elderly persons with functional disabilities. In addition to its Federal allocation, California overmatches its SSBG funds with its own State revenues to support the program. Other States that use a significant percentage of their SSBG allocations to support home care services include Arizona, Mississippi, Nevada, New Mexico, South Dakota, Texas, Virginia and Washington.

Texas combines Federal SSBG funds and Medicaid personal care funds in its large in-home care program. Medicaid personal care funds are used for those clients who meet Medicaid eligibility criteria, while SSBG funds are used for those who are not. The services provided are essentially the same.

Some States do not use many Federal resources at all to finance home care for the elderly disabled; they simply invest their own resources to operate programs outside the constraints that go along with the use of Federal funds. These States include Massachusetts, Illinois, Minnesota, Washington, Colorado, Pennsylvania and Utah. For example, Massachusetts spends over $100 million annually of State general revenue funds on its statewide Home Care Program.

In some cases, State general revenue funds are used in conjunction with other funding sources. For example, Minnesota's Alternative Care Grants (ACG) program for the elderly is primarily funded under the Medicaid home and community-based waiver program, but State general revenue funds are used to pay for services to clients who are not eligible for Medicaid, but who would spend-down to Medicaid within six months if they had to pay for services themselves.

While some States support home care programs, others elect simply to increase the incomes of elderly persons with disabilities, and to leave decisions about the use of these resources to the clients themselves (more akin to a voucher approach). This is usually accomplished through special State supplementation payments (SSP) to Federal SSI benefits. Elderly persons who meet certain disability and financial criteria, or who live in residential care facilities which reflect a need for long-term care services (i.e. board-and-care homes) receive State-financed cash payments that supplement the income they receive from the SSI program. States which have taken this "cash payment" approach to assisting the poor elderly with long-term care needs include California, Alabama, Colorado, Missouri, New York, North Carolina and Virginia.

Do States that Spend More for Home Care Spend Less for Nursing Home Care?

A frequent argument for expanding public funding for home care services has been to ameliorate the growth in public spending for nursing home care. However, support for this argument is illusive. In general, the opposite is true. States that have high expenditures for home care services per capita also tend to have high expenditures for Medicaid-financed nursing home care. Thus, although attempts are often made to classify States along a continuum of "institutionally-oriented" to "community-based oriented" long-term care systems, a more accurate classification of States is simply along a continuum of how much they spend in public dollars for long-term care in general.

There is mixed evidence regarding the relationship between spending for home care and nursing home care, however. While States that spend more for home care also tend to spend more for nursing home care, there does seem to be a relationship between Medicare home health care use and the supply of nursing homes. Research studies show that the number of Medicare enrollees using Medicare-financed home health care is higher in areas where there are fewer nursing home beds.[38] These studies suggest that Medicare home health care utilization may increase in areas where there is an excess demand for nursing home beds.

Why Don't States Tap Medicaid More?

Given the opportunity to leverage Federal resources under the financing structure of Medicaid, why don't States take more advantage of the financing options that are available under the Medicaid program? The Federal government pays for at least 50 percent of all Medicaid-financed services, and in some States up to 80 percent. The answer lies in the nature and intent of the Medicaid program and its inherent limitations as a financing source for home care. For example:

- Medicaid's financial eligibility standards. Only those elderly who receive Federal SSI benefits and/or State supplementation payments are generally eligible for Medicaid-financed care in the community.[39] Less than seven percent of the elderly living in the community receive SSI/SSP benefits. Relatively low protected income levels under State medically needy programs also make it difficult for

[38] Kenny, G. and Dubay, L. 1990. "The Determinants of Market Variation in Home Health Utilization." Urban Institute Working Paper 3740-02, Washington, DC (February).

[39] Although States have the option of raising income eligibility criteria for Medicaid for the elderly up to the poverty threshold, as of March 1990 only six States had elected to use this option. Michigan and Mississippi had raised income levels for Medicaid eligibility up to 85 percent of the poverty threshold, and Florida, Hawaii, New Jersey and Maine had raised income levels up to 100 percent of poverty. States also have the option of using institutional eligibility criteria for persons receiving services under the Medicaid home and community-based waiver program.

other poor elderly persons to participate in the program through "spend-down" provisions.

- Restrictions on the number of persons who can be served under Medicaid home and community-based care waiver programs. By statute, States can only provide home and community-based waiver services to persons who would otherwise be at risk of placement -in nursing homes. Thus, individuals who receive waiver services must meet nursing home level-of-care criteria. Persons who are somewhat disabled, but do not meet nursing home criteria, are not eligible for waiver services.

- Medicaid coverage of non-skilled home care services is still limited by Federal law. Outside the Section 2176 home and community-based waiver program, coverage of other home care services as Medicaid State plan options is still limited. Optional services that can be used to fund community-based care include: (1) personal care services; (2) private duty nursing; (3) professional therapeutic services, such as physical therapy; and (4) medical day care.

- Many States are concerned about their abilitV to control costs for home care when funded as an "entitlement." When States elect to cover optional services under their State Medicaid plans, they are under certain obligations not to arbitrarily restrict access to those services. For example, States cannot arbitrarily deny payment for services simply because expenditures have exceeded amounts appropriated in State budgets. The entitlement nature of Medicaid gives Medicaid beneficiaries the right to sue States if services are arbitrarily denied. Although there are numerous other mechanisms available to States for managing costs, coverage of home care as an "entitlement" under Medicaid is still perceived as risky fiscal policy by many States, particularly given the popularity of these services.

- Medicaid restricts Payments to family members as home care providers. Several States elect to use Medicaid as a funding source for home care services because Medicaid policy generally does not allow family members to be paid as home care providers. Some States, on the other hand, would rather keep the option of paying family members as home care providers if it is determined that a family member is the most appropriate choice for the home care provider. Although States also place restrictions on the circumstances under which family members can be paid with public funds as home care providers, States can establish their own criteria when using their own general revenue funds. Medicaid's restriction on payment to family members is much more inflexible.

- States differ in their perceptions of what can and cannot be done under Medicaid. Medicaid is an an extremely complex program. Some States have not taken full advantage of the Medicaid options that are available simply because they perceive that certain things cannot be done within the statutory and regulatory provisions of the program, even though another State may be using Medicaid

exactly that way. Many States are also concerned about future changes in Medicaid regulation that may render something they are currently doing impermissible. In such cases, States would be faced with the option of cutting services to clients who are presently in the program, or continuing to fund services without Federal Financial Participation (FFP).

In summary, funding of home care under Medicaid is generally restricted to the poor elderly who are eligible for cash assistance under the SSI/SSP program. Even among those elderly who are eligible for Medicaid, a number of barriers still exist to using Medicaid as a financing source for home care services. Consequently, many States prefer to use alternative mechanisms for financing their home care programs.

POLICY IMPLICATIONS OF STATE VARIATION IN LONG-TERM CARE FINANCING

An understanding of the State role in long-term care is key to evaluating the merits of potential Federal reforms, because reforms at the Federal level will affect all States differently. One key policy consideration is the balance between Federal control and State flexibility. Should publicly-financed long-term care benefits be made more uniformly available under a Federalized program? Or should States retain the flexibility which they currently exercise over the allocation of public resources for long-term care services, or even be given even greater discretionary authority than they currently have? And if the balance of authority shifts more toward the Federal government or to States, how would that impact the financing of services? For example, States may be less willing to help finance a system in which they have less control over how resources are used.

The Federal government presently plays a secondary role in shaping the publicly-financed long-term care system; States have the primary role. Federal resources for financing long-term care, particularly home care, are available under a variety of mechanisms that States can use as they choose.

This flexibility in Federal financing approaches has led to substantial variation across States in the level of public support for long-term care, Some States simply spend a lot more tax dollars (both Federal and State) for publicly-financed services than others. This contributes to significant variation across States in the degree to which the disabled elderly can access publicly-financed benefits, both in nursing homes and in the community.

Is this State variation desirable or undesirable? There are numerous trade-offs to consider. One perspective is that the Federal government should not dictate to States what public long-term care systems should be like. A uniform Federal program is not likely to reflect the specific circumstances, politics, history, and preferences of individual States. Federal mandates are likely to stifle State experimentation with new approaches to addressing the long-term care needs of their disabled senior citizens. Indeed, many believe even greater flexibility should be built into Federal financing mechanisms such as Medicaid, so that Federal dollars could be made available for an even broader range of long-term care policies and programs. Also, given the need to allocate public resources in accordance with the availability or unavailability of informal caregivers, local discretion in resource allocation decisions has obvious advantages over a centralized Federal program.

The opposite point of view assumes that because many States are unwilling or unable to invest public resources in long-term care, many poor and disabled elderly are denied access to even a basic level of care. From this perspective, low Medicaid spending for nursing home care may result in some Medicaid beneficiaries having

difficulty getting into nursing homes, even though they are "entitled" to care. It is also argued that low State spending for home care services means that some or many elderly persons who are too poor to buy their own care either go without care, or become extremely heavy burdens on their families. Should Federal long-term care policy have the objective of raising the “minimum” floor of access and quality for publicly-financed services? If so, should new Federal resources be targeted to those States that currently spend the least for publicly-financed care? Should States be mandated to spend more of their own funds, or, if the Federal government is going to mandate a more uniform public benefit for long-term care, should the Federal government be responsible for financing the "minimum" benefit?

Others would go even further and state that the Federal government must be more aggressive in shaping the characteristics of the public long-term care delivery system, such as mandating nursing home pre-admission screening programs, requiring more uniformity in provider reimbursement methods and payment levels, specifying the characteristics of long-term care quality assurance systems, and so on.

This tension between Federal direction and State flexibility runs through the entire Medicaid program, not just in long-term care policy. However, it is important that proposals to reform the manner in which the Federal government finances long-term care services for the disabled elderly include a clear articulation of what their objectives are regarding Federal and State decision-making over long-term care policy.