

# CEAL Issue Brief



## Medicaid: Impact on Long-Term Care

### I. Introduction: State Budget Deficits & Medicaid

The current recession is having a severe impact on state budgets in general and on Medicaid spending in particular. Just four months into fiscal year (FY) 2009, well over half of state Medicaid directors have reported that enrollments and expenditures are increasing to levels well above those projected at the beginning of the year.<sup>1</sup> In response, states have made notable changes to their Medicaid budgets for fiscal year 2009 and beyond. Nineteen states have enacted or proposed Medicaid or CHIP cuts for FY 2009 or FY 2010. Secondary budget cuts will likely include actions that will make it harder for new families to get coverage, actions that will make it more complicated for those currently enrolled to keep their coverage (cuts in eligibility and enrollment), and actions that could prevent currently enrolled families from getting health care (cuts in provider reimbursement, cuts in benefits, and increases in cost-sharing).<sup>2</sup> The most common type<sup>3</sup> of Medicaid reform undertaken by states is a reduction in how much participating providers are paid for their services, which may result in enrollees having a harder time finding a health care provider to provide services. States are attempting to close these staggering budget deficits while facing increased demand for services.<sup>4</sup> States are accordingly paring services under Medicaid, which complicates the goal of expanded assisted living services championed by many advocates of community-based care.

### II. The Impact on Long-Term Care Options

Long term care services, which comprise a significant portion of the Medicare and Medicaid budget, are provided to older persons and those with disabilities in the form of institutional care and community care. Approximately 70% of all formal long-term care services is funded by government programs; Medicaid contributes 48% percent, Medicare contributes 18%, and other public spending accounts for the remaining 4%.<sup>5</sup> Private insurance and out-of-pocket spending make up the remainder of long-term care spending. Public and private spending is increasing at an alarming rate; the Congressional Budget Office (CBO) projects that in 2009, the federal Medicaid spending for long-term care will reach \$66 billion,<sup>6</sup> one-third of the program's spending on benefits.

Currently, long-term care provided in **institutional settings** (i.e. nursing homes) is a mandatory benefit under Medicaid, while community based services (such as assisted living) are not a mandated benefit. While there

---

<sup>1</sup> Kaiser Family Foundation, *Medicaid in a Crunch: A Mid-2009 Update on State Medicaid Issues in a Recession*, Available at: <http://www.kff.org/uninsured/upload/7848.pdf>, 2009.

<sup>2</sup> Family USA. *A Painful Recession: States Cut Health Care Safety Net Programs*. Available at: <http://www.familiesusa.org/resources/publications/reports/a-painful-recession-findings.html>, 2009.

<sup>3</sup> States using this tactic include California, the District of Columbia, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New York, South Carolina, and Utah.

<sup>4</sup> Jane Zhang, *The Wall Street Journal*, page B5B (January 28, 2009)

<sup>5</sup> Government Accountability Office, *Long-Term Care Financing Growing Demand and Cost of Services Are Straining Federal and State Budgets*. Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 2005.

<sup>6</sup> Congressional Budget Office, *Budget Options, Volume I: Health Care*. December 2008.

# CEAL Issue Brief

is no statutory limit on the number of people who may receive care in the *institutional* setting under Medicaid, states have the *option* of providing for community-based services through optional state plan amendments or waivers. Given the current pressure on state budgets, optional programs – such as community-based services – are in a precarious position.

A survey of several states shows the impact of the recession on the provision of community-based care. In **Minnesota**, the state capped its Community Alternatives for Disabled Individuals waiver and its Traumatic Brain Injury waiver, both of which allow people with disabilities to be cared for in a community setting rather than a nursing home or institution.<sup>7</sup> As part of its plan for FY 2009, **South Carolina** capped its Community Choices waiver, which provides home and personal care services to the elderly and people with disabilities. Capping this waiver means that individuals will be put on a waiting list for these services.<sup>8</sup> **Nevada** has used cuts rather than caps, as its Community Homebased Initiatives Program (CHIP) was reduced 450 slots (services for the frail elderly), and the assisted living (AL) waiver was cut 34 slots in FY 2009. For FY 2010-2011, the CHIP waiver will be reduced another 78 slots and AL another 12 slots, averaging about 1,708 cases per month. The state also enacted wage decreases for personal care assistants (PCAs); this program saves roughly \$5.5 million a year, but the state will lose this same amount in federal funds and may witness a loss of vendors willing to provide PCA services. The **District of Columbia** announced a limit on the health care services that individuals who are covered under certain home- and community-based Medicaid waiver programs can receive in their home or in a community setting in FY 2009.<sup>9</sup> Lastly, **Massachusetts** cut funding in FY 2009 for the Community First Initiative Medicaid waiver, which would have allowed older beneficiaries and those with disabilities to move out of nursing homes and be treated in community-based settings.<sup>10</sup>

### III. Reforms Proposed and Enacted at the State Level

While many states are limiting long-term care options in the wake of budget deficits, several states are maintaining or *increasing* their long-term care options for beneficiaries. A review of several states shows the innovative measures being taken across the nation:

#### A. New York: Restructuring Reimbursement Rates<sup>11</sup>

In New York, the budget proposal for 2009-2010 calls for lowering the Medicaid reimbursement rates to nursing homes. The proposal involves the replacement of a flawed nursing home reimbursement structure with a regional pricing system that encourages greater efficiencies in nursing home management. The plan aims to more accurately reflect the costs of hard-to-serve patients, promote better quality services, and support the development of assisted living beds. The plan also extends to home-care, aiming to replace the current provider-specific cost based system with a pricing methodology based on the patient's medical needs.

---

<sup>7</sup> State of Minnesota, Office of Management and Budget, *2008 Legislative Session - Enacted Budget Changes*, July 2008,

available online at <http://www.mmb.state.mn.us/doc/budget/op08/budget-changes.pdf>

<sup>8</sup> South Carolina Department of Health and Human Services, op. cit.

<sup>9</sup> A Painful Recession: States Cut Health Care Safety Net Programs. FAMILY USA. Available at: <http://www.familiesusa.org/resources/publications/reports/a-painful-recession-findings.html>.

<sup>10</sup> Massachusetts Budget and Policy Center, *MassBudgetBrief: Examining the Plan to Close the Budget Gap* (Boston: Massachusetts Budget and Policy Center, November 7, 2008), available online at [http://www.massbudget.org/file\\_storage/documents/FY099Ccuts.pdf](http://www.massbudget.org/file_storage/documents/FY099Ccuts.pdf).

<sup>11</sup> *Health-Care Execs Examine Budget Cuts*. Business First of Buffalo (Dec. 17, 2008). Available online at: <http://buffalo.bizjournals.com/buffalo/mobile/stories/2008/12/15/daily26.html>

# CEAL Issue Brief

The plan would phase out 6,000 nursing home beds and replace them with community alternatives, including reforming assisted living program reimbursements and phasing in 6,000 new assisted living beds over five years. The state also intends to lift the moratorium on new community-based, adult day care programs.

## **B. Maine: Saving Costs By Limiting Services<sup>12</sup>**

Rather than restrict the *number* of residents that are able to access assisted living services, Maine incurred cost-savings by reducing the number of services *provided*. Beginning January 1, 2009, three (of the seven) assisted-living centers in Maine will no longer provide breakfast, forcing residents to subsidize their own morning meal.

## **C. Florida: Using Tobacco Settlement**

Florida funded care for 40,000 people who are “medically needy” (people whose medical bills take up the vast majority of their income) or who qualify for a special Medicaid waiver program for the elderly and people with disabilities with onetime funding from the state’s tobacco settlement fund in its FY 2009 budget.

## **D. Colorado: Reliance on Veterans Administration Funding**

Despite announcing a “lean” budget for fiscal 2009-10, Colorado provides for extending access to assisted living by relying on funding from the Veterans Administration. Governor Ritter has proposed spending \$200,000 in fiscal year 2009-10 to begin planning and designing a first-of-its-kind residential care center for military combat veterans at Fitzsimons in Aurora. The care center would include a 47-bed assisted-living facility for aging veterans. The \$49 million project would be built in partnership with the federal government, with 65 percent of project funds coming from a Veterans Administration federal grant program.

## **E. Illinois: Expand Medicaid Coverage**

Illinois initiated the “Illinois Supportive Living Program” to provide services akin to assisted living by providing accommodations for residents under Medicaid coverage. As for February 2008, 91 Supportive Living communities were in operation throughout the state of Illinois offering over 7,000 apartments, and another 56 sites and 4,800 apartments were under development. In all, 71 Illinois counties will be served with supportive living, which makes the Illinois Supportive Living program one of the largest affordable assisted living models in the country. The program itself provides apartment homes for residents, and while living independently, these residents have access to meal service, housekeeping, social, educational and wellness activities, help with bathing and dressing, medication management and scheduled transportation.

Financially, residents who qualify are offered a Medicaid-funded financial assistance program that makes the cost of these assisted living-type services more affordable to those with moderate to modest means. Unlike assisted living communities (which do not accept payment from Medicaid, and may force residents to leave the community when they are no longer able to pay privately), Supportive Living is a Medicaid benefit, and residents are able to continue living in the community without worry about payment. Illinois expects the program to produce cost-savings, as the state’s Medicaid budget is expected to benefit by offering seniors with fewer healthcare needs a more residential setting that is less expensive than nursing home care and more conducive to the residents’ lifestyle and needs.

---

<sup>12</sup> Meg Haskell, *Breakfast Cut At Assisted Living Sites*. Bangor Daily News (Dec. 10, 2008). Available online at: <http://bangornews.com/detail/94920.html>

# CEAL Issue Brief

## IV. Suggested Reforms by the Congressional Budget Office<sup>13</sup>

In its *Budget Option, Volume I* compilation, the CBO proposes an increase in the federal matching rate for home and community based services, and a *decrease* in the federal matching rate for nursing home services. Currently, regardless of whether a beneficiary receives care in an institutional or community setting, states receive the same federal medical assistance percentage (hereinafter FMAP) rate from the federal government.

Rather than maintain the current differences in reimbursement rates, CBO proposes a similar treatment for services regardless of setting, whereby the FMAP for home and community based services (hereinafter HCBS) would increase by five percent. This increase would encourage states to increase the number of eligible individuals receiving care in the community setting; the corresponding decrease in the FMAP rate for nursing homes would ideally lessen the current bias towards institutional care. This approach: (1) ensures that individuals who prefer HCBS would have a better chance of placement; and (2) provides states with additional resources to service individuals in the HCBS setting. The additional federal funding may allow states to build a more comprehensive infrastructure and provide more HCBS services.

Alternatively, the CBO proposes a change in the Medicaid structure that would make HCBS a mandatory benefit under Medicaid. States would be required to provide HCBS to all Medicaid beneficiaries who meet the requirement for receiving *institutional* care if the individual prefers HCBS. Financially, this would increase Medicaid spending by about \$20 billion over the 2010-2014 period, which includes the estimated reduction in nursing home spending as a result of the decline in Medicare beneficiaries receiving institutional care. Research indicates that short-term investments made by states to rebalance their resources to emphasize HCBS and reduce institutional expenditures pay off in long-term savings.<sup>14</sup>

## V. The Argument Against Medicaid Cuts

Despite the current trends at the state level, there is a strong argument that reductions in Medicaid spending are not the rational response to the budget deficits, and may in fact *worsen* state economies. Medicaid spending generates economic activity including jobs, income and state tax revenues at the state level. Furthermore, Medicaid generates income within the health care sector and throughout other sectors of the economy due to the multiplier effect.<sup>15</sup>

Studies consistently show a positive correlation between Medicaid spending and state economies, depending on the level of state Medicaid spending, the state's matching rate (FMAP), and the economic conditions in a state. Accordingly, *reductions* in this spending will lead to declines in federal Medicaid dollars, decreases in the flow of dollars to health care providers, and declining activity within state economies. To help states meet the demand, Congress included \$87 billion in additional Medicaid spending in the American Recovery and Reinvestment Act, and President Obama signed it on February 17, 2009. The economic stimulus package includes an enhanced federal share for Medicaid, especially targeting states with high unemployment. While the bill has no specific spending for long-term care, it should relieve some of the budgetary pressure to cut optional programs.

---

This CEAL Issue Brief was prepared by Kate Abramson, CEAL intern, and Don Redfoot, PhD, CEAL board member.

---

<sup>13</sup> Congressional Budget Office, *Budget Options, Volume I: Health Care*. December 2008.

<sup>14</sup> H. Stephen Hayes, Mitchell P. LaPlante, and Charlene Harrington, "Do Non-Institutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs*, Vol. 28, No. 1, pp. 262-272 (January/February 2009).

<sup>15</sup> Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Economies: A Look at the Research* (January 2009).