

Striking A Balance

In Medicaid Options

Lynn Wagner

States are looking for savings from home- and community-based services and managed care.

There are some new kids on the Medicaid waiver block, bigger and bolder than previous generations.

Driven by fiscal constraints, and encouraged by heightened flexibility at the federal level, states around the country are developing a new breed of Medicaid waivers that blend capitated managed care, global expenditure limits, and shifts in eligibility and benefits in an effort to curb spending.

Long term care services are increasingly the target of these dramatic program changes, coupled with an intensive push to expand the use of home- and community-based services (HCBS) as an alternative to nursing facility care.

While provider groups and health policy experts support the enhancement of HCBS options, many observers have raised concerns about the nature and scope of other policy changes reflected in the waivers. Skeptics fear that some state plans, which are in various stages of development, amount to rewriting the Medicaid entitlement in ways that might deprive beneficiaries of needed services, and exacerbate the tight-fisted payment climate for providers.

"I do think we are at a crossroads with respect to the Medicaid program," says Alan Weil, executive director of

the National Academy for State Health Policy in Portland, Maine. "Concerns about the cost of the program are very high at both the national and state level, and there are policy makers who, looking at the fiscal future, feel that reducing the cost of the program is not only important but essential. In doing that, there are now options and discussions of fundamental changes in the nature of the program that have not been on the table before. We are very much at a decision point about whether fiscal pressure will yield fundamental change."

Medicaid costs are rising, Weil adds, "largely due to how much we ask the program to do, not due to waste, inefficiency, inappropriate care, or fraud." The program suffers from problems common to the entire health care system, he says. In the absence of broad, systemwide changes needed to make care less expensive, Medicaid reform that focuses primarily on meeting budget targets will lead to a rising uninsured rate and inadequate safety-net coverage, he adds.

"The consequences will be terrible for people," Weil says.

Soaring Costs, Desperate Measures

Medicaid cost-control efforts are ramping up in the face of a spending trend that state officials describe as unsustainable.

According to the National Governors Association (NGA), Medicaid spending growth over the past five years has been driven by a 40 percent increase in caseload and a 4.5 percent annual hike in the health care price index. The program now covers 53 million individuals and is projected to reach \$329 billion in 2005, NGA said in a June report calling for broad reforms in the program, including greater flexibility and streamlined approval for waiver programs.

Medicaid accounted for 16 percent, or \$267 billion, of total health care expenditures in 2003, according to the latest available data from the Centers for Medicare & Medicaid Services (CMS). Program growth slowed that year for the first time since 1997, to 7.1 percent, down from a 12.6 percent

increase in 2002 and a 10.3 percent increase in 2001. CMS attributed the decline to “austere” actions across 34 states that ratcheted back eligibility and benefits and lowered payments to nursing facilities and hospitals.

Medicaid accounted for more than 46 percent of the \$110.8 billion spent on nursing facility care in 2003. Growth in those outlays, however, nearly ground to a halt, rising a meager 1 percent, to \$51 billion, following an 8.1 percent hike in 2002. The spending free-fall was largely due to a reimbursement squeeze on nursing facilities and broader use of HCBS, which cut into nursing facility utilization, CMS reported last January in the journal *Health Affairs*.

Despite the higher growth rate in 2002, the shortfall in Medicaid nursing

facility payments was a staggering \$4.5 billion, according to an April report from BDO Seidman. The average shortfall—the difference between Medicaid payment and allowable program costs—was \$12.58 per Medicaid patient day, said the report, which was based on data from 36 states representing more than 86 percent of Medicaid patient days. BDO Seidman, which has been tracking payment shortfalls for four years running for the American Health Care Association (AHCA), reported that the payment deficits rose 9 percent in 2002, up from an \$11.55 shortfall in 2001. The gap between reimbursement and costs has risen 39 percent since 1999, the study found.

States Seek Waivers

Now, states are pushing long term care controls further, advancing new strategies through the use of Medicaid

waivers—specifically, the 1115-type waivers (*see box, page 25*)—that allow states to develop programs that aren't bound by the usual Medicaid rules in areas such as eligibility, benefits, financing, and delivery structure. Most waiver programs are limited in scope, targeted to a geographic area or a defined group of beneficiaries, and for many years have been used predominantly as a means to enhance program eligibility and services, enabling states to draw federal matching funds for coverage beyond the normal scope of the Medicaid program. That objective is shifting, however, as more states seek waiver authority to constrict program growth, according to a December 2004 report, "Restructuring the Medicaid Long Term Care System," from AHCA.

"Historically, waivers were used to expand eligibility," the report says.

"But now there is an alarming trend of using Medicaid waivers to narrow eligibility and reduce services. States seem to view waivers as a way to address budget problems, but for the most part, waivers achieve savings principally by reducing coverage," the AHCA report says.

BDO Seidman predicted that the implementation of 1115 waivers will exacerbate providers' Medicaid shortfalls, "at least in the short run," as utilization drops in favor of home- and community-based options. Declining occupancy means nursing facilities will bear increased per diem costs "in areas such as property costs, utilities, maintenance, and administration."

Furthermore, as lower-needs patients are diverted, the acuity of nursing facility patients will rise,

along with the cost of providing care.

"These factors are not being taken into account in states' cost projections," the report said.

Georgia's Radical Plan

In one of the most dramatic measures that sought to restrict coverage and eligibility as part of an 1115 waiver, Georgia Gov. Sonny Perdue (R) drafted a waiver "concept paper" last May that would have eliminated nursing facility services altogether as a mandatory Medicaid benefit, giving the state more latitude to provide less costly community-based services. The plan was developed without input from, or awareness of, providers, consumers, or the state legislature, says Fred Watson, president of the Georgia Health Care Association (GHCA). The program,

HomeFirst, called for capping Medicaid spending for three to five years, consolidating all levels of long term care services, and using a network of Area Agencies on Aging as a single entry point for case management of individual care needs.



The concept paper argued that the current requirement for people who are elderly or have disabilities to qualify for nursing facility care as a prerequisite for community-based services hobbled state initiatives to shift care away from nursing facilities to less costly settings.

“By eliminating the nursing facility level care requirement for community services, the state may be able to provide more preventive and less expensive services to the elderly and disabled, thus avoiding the more expensive nursing facility beds,” the paper said. “In addition, converting nursing facility services from an entitlement to an optional service would limit back-filling of nursing facility beds and promote more affordable options for care in the community. As an optional service, nursing facility care would be available only after it is determined that there is no suitable community placement for an individual.”

Georgia’s Medicaid spending has been rising by an average of 14.4 percent a year since 2000, according to Perdue’s proposal, reaching a projected total of \$6.6 billion in 2005. By 2009, the program is expected to consume over half of all new state revenue.

The plan leaked from the governor’s office in May and has since been thrown open to legislative and stakeholder input, says Watson. GHCA hopes the public process will mitigate the drastic changes initially proposed, and that nursing facilities will ultimately participate in the case management function envisioned under HomeFirst.

“I think we’ve made some headway,” says Watson, who predicts that it will take a year to arrive at a final waiver

plan. “The governor’s office has been very receptive.”

Vermont ‘Choices’ Caps Spending

Vermont, a small state with 41 nursing facilities serving about 2,100 Medicaid beneficiaries, has developed one of the most closely watched waivers, venturing into this territory with a plan to cap spending and redistribute a larger share of long term care services into HCBS. The state projects that, if successful, the program will lead to the closure of about 300 of the state’s 3,400 nursing facility beds, as an anticipated 9 percent of nursing facility-eligible patients choose home- and community-based alternatives. An additional 366 beneficiaries with moderate needs, who would not have been eligible for care under the traditional Medicaid program, are expected to gain access to HCBS.

The plan, called Choices for Care, has won federal approval and took effect Oct. 1 on a statewide basis. The program gives beneficiaries who qualify for nursing facility care the option of choosing from a menu of HCBS as an alternative to nursing facility placement. The opportunity to remain at home or in a community setting has generated broad appeal.

But nursing facility and some consumer advocates are concerned that the program puts a two-pronged squeeze on long term care benefits, by chipping away at the population automatically entitled to Medicaid-funded long term care services and imposing a global spending cap.

“We have been probably a lone voice in the consumer advocacy community saying, ‘hold on,’” says Stephen McConnell, senior vice president for advocacy and public policy for the Chicago-based Alzheimer’s Association. “You may want to believe that no one wants to be in a nursing facility or needs to be, but we know otherwise. There is a point in the dis-

Medicaid Waiver Basics

There are three types of Medicaid waivers available to states:

■ **1115 Research and Demonstration Projects.** These are used to test new ideas and reform strategies. States may experiment with managed care, capitation, and case management.

Demonstrations must be budget-neutral over the life of the project, which is generally five years. The Centers for Medicare & Medicaid Services evaluates the impact of these projects on costs, utilization, access, and quality. The most dramatic and long-standing use of this waiver authority in the long term care arena is Arizona’s Medicaid program, which operates entirely under an 1115 waiver and capitated managed care structure that’s been in place since 1989.

It is these waivers that have become a favorite among states seeking stringent cost controls because they “allow states to cap enrollment, narrow the benefit package below minimum standards, and increase beneficiary out-of-pocket costs above what is otherwise allowed under federal rules,” said a 2004 American Health Care Association report on restructuring Medicaid long term care benefits.

These 1115 waivers limit federal funds that will be spent over the life of the waiver, putting states at risk for costs incurred above that limit.

■ **1915(b) Freedom of Choice Waivers.** These allow states to curtail beneficiaries’ freedom of choice by limiting providers or mandating enrollment in managed care plans. States can also use these waivers to develop “carve out” plans for specialty services, such as behavioral health.

■ **1915(c) Home- and Community-Based Services (HCBS) Waivers.** These give states wide latitude to provide services that help people remain at home and avoid nursing facility or other institutional placement. Benefits may include case ➤

management, homemaker services, home health and personal care, adult day care, and supportive services such as transportation or home modifications. States can't spend more on an individual's service mix than if the person were in a nursing facility, hospital, or other institution. Participation in each waiver is limited to a fixed number of slots. Programs must be renewed every five years.

Since 1981, when legislation authorizing 1915(c) waivers was enacted, HCBS programs have proliferated, especially those for the elderly. By 2002, 49 states and the District of Columbia had 252 1915(c) waivers targeting defined groups, including the elderly, people with physical or developmental disabilities, and children, according to a July 2005 HCBS report from the Kaiser Commission on Medicaid and the Uninsured.

Aged beneficiaries made up the largest group of HCBS recipients, comprising more than half—487,870 (58 percent)—of the total 920,833 waiver participants in 2002, Kaiser reported. Spending on programs geared to the elderly, however, accounted for just 24 percent of resources, or \$3.5 billion of the total \$16.9 billion in HCBS waiver outlays. Recipients with developmental disabilities, who made up 39 percent of total participants, were the most costly, accounting for 73 percent, or \$12.4 billion, of all 2002 HCBS waiver spending, Kaiser reported.

To control costs, states limit enrollment, narrow eligibility, and create waiting lists, the study said. In 2004, 206,427 individuals in 34 states were on HCBS waiting lists. More than half of them, 107,898, were elderly, who wait an average of five months for waiver slots to open. Waiting list numbers are climbing, Kaiser found, up 14 percent in 2004 from the previous year, when 180,347 individuals awaited services, and 84,151 of them were elderly.

ease where there is no other option. We want to make sure that [patients] have access to nursing facility care.”

Shifts In Eligibility

Choices for Care creates three levels of eligibility for long term care services: highest needs, high needs, and moderate needs. Beneficiaries who meet the clinical standard for the highest-needs group retain an entitlement to services and gain the option to choose HCBS instead of nursing facility care (*see box, page 30, for clinical criteria and benefits*). Those in lower tiers, however, can be put on a waiting list and receive services for which they qualify only when funds are available.

The state proposed outright elimination of entitlement status for the second group—high needs—which is defined by a clinical needs standard that calls for a potentially intensive level of care.

The intent was to deem these individuals eligible for, but not entitled to, nursing facility care or HCBS alternatives. Services would be provided only when the state had enough funds in its budget to pay for them. Federal regulators, however, objected to that provision, says Joan Senecal, deputy commissioner of Vermont's Department of Disabilities, Aging, and Independent Living.

Ultimately, the plan approved by CMS instead allowed the state to place high-needs individuals on a waiting list for care, without stripping away their entitlement, a status that Senecal describes as “confusing,” since the outcome—providing services as funds become available—remains essentially the same as what the state had proposed.

“CMS said if [beneficiaries] are nursing-home eligible, they are entitled [to long term care], but allowed us to create a waiting list if we need to,” Senecal says.

Beneficiaries that fall into the lowest

priority tier, with moderate needs, will also gain access to services as funds are available, though the budget for this group is separate and distinct from the other two categories. The state projects it will spend \$7 million on the moderate-needs group over five years.

The high-needs group will number 200-300 individuals a year, according to state calculations, and officials fully anticipate having sufficient funds in the budget to cover their needs, Senecal says.

But McConnell is not so sanguine, pointing out that “the cap may put pressure [on the state] to keep people out of nursing facilities who really need to be there.” With a spending cap in place, it is “possible that the entitlement will no longer have meaning,” he adds. “The state can bump up against the cap even with the group with highest needs and could scale back [HCBS]. Eligibility is an issue and one that we will monitor closely to see how it plays out.”

Will The Money Hold Out?

Mary Shriver, executive director of the Vermont Health Care Association (VHCA) is concerned that the allotted average spending increase of 7.28 percent a year will be insufficient in a state where costs have historically risen at a faster pace. Furthermore, while VHCA supports giving people choices about where they receive care, “there is a time and place for nursing facility” care, she says. It's not clear “whether there will be enough nursing facilities in the state of Vermont to provide that care” in the wake of the projected shutdown of roughly 10 percent of the state's capacity, she adds. “There doesn't seem to be a rational plan for nursing facility downsizing, which is probably inevitable.”

The state has built into the waiver a 2 percent increase in nursing facility funding to account for rising acuity among patients who remain in facili-

ties. But Shriver says reimbursement will nevertheless be a struggle, as patients enter nursing facilities in a more debilitated state, after spending more time in home care.

Vermont plans to grandfather in all current nursing facility and HCBS waiver recipients, allowing them to continue receiving their current level of care—or take advantage of new options—for the first year of the program. Shriver worries that at the end of that year, however, patients might lose nursing facility and other benefits.

A dozen nurse case managers will roam the state at the outset of the waiver, and yearly thereafter, assessing nursing facility residents and participants in previously existing HCBS waiver programs to assign them to a needs category based on their clinical status.

Funding for the Choices program will be subject to a global cap. The state has agreed to hold its spending growth rate for all services to an average 7.28 percent a year and to keep total expenditures within a \$1.2 billion limit over the five-year life of the waiver. Those terms, set by CMS, put the state at risk for spending above the cap.

Vermont health officials predict the initiative will result in moderate savings of \$4 million over five years, compared with what spending would be without the waiver.

“What we hope we are going to be able to do is serve more people,” says Senecal. “This is not a budgetary issue,” she adds. “It’s a way to make sure we offer people as many real choices as possible about where they receive care and from whom they receive care. Our premise is that given choices, and when choices are available, more people will choose [HCBS] than do so now, and we can provide that at less money than nursing facility care.” As a result, the program will free up funds for a greater number of people to receive services outside of a nursing facility, Senecal says. “We need

to control ever-increasing costs. This is one way to do it and serve more people.”

The Managed Care Solution

Few states have applied capitated managed care to long term care services on a large scale. A study prepared last April by Medstat in Cambridge, Mass., and the University of Southern Maine (USM) in Portland, found that “despite significant activity in a handful of states,” only about 2.3 percent of individuals receiving publicly financed long term care were enrolled in managed care programs.

The study, conducted for the Department of Health and Human Services, attributed the slow growth of managed long term care to the complexity of program design and payment, long planning and start-up periods, resistance from providers and advocates, the need for large population bases, and “inadequate state infrastructure in an era of government downsizing.”

In 2003, 3.1 million who were elderly or had disabilities received Medicaid-funded long term care services, the Medstat/USM study said. Only an estimated 68,117, however, were enrolled in managed care programs in 2004, including 23,427 in Arizona’s statewide managed long term care program, 10,671 in a Texas program, called Star Plus, and nearly 7,000 in Wisconsin’s Family Care program, all of which operate under an 1115 waiver.

While research has shown that managed long term care programs produce “high consumer satisfaction levels, lower utilization of institutional services, and increased access” to HCBS, the ability of these plans to generate savings is murky, the study said. There is “no clear consensus emerging as to whether managed long term care saves money for public purchasers,” the report noted.

Nevertheless, “the budget predictability that comes with capitated

payments is appealing to state policy makers as growing numbers of long term care consumers place increasing pressure on Medicaid budgets.”

As a result, the number of states launching managed long term care programs for the first time, or as an adjunct to an existing program, is growing.

Florida Takes The Plunge

In Florida, for example, state officials have developed an 1115 waiver plan that, if approved by CMS, will save an estimated \$4.6 billion over five years, enrolling the vast majority of Medicaid beneficiaries in managed care plans that will have the flexibility to create benefit packages that are “actuarially equivalent” to standard Medicaid benefits, but can vary in amount, duration, and scope. The plan’s phase-in will begin next year in two counties and ultimately expand statewide.

Joan Alker, senior researcher at the Center for Children and Families at Georgetown University in Washington, D.C., calls the plan “extremely risky,” as it is “based on a number of untested assumptions.” Under the Florida waiver, the state will essentially hand the program over to private insurers, on the assumption that they “can provide quality care in a cost-effective way and beneficiaries won’t be hurt.” That assumption is “flawed,” Alker says, “because private insurance is more expensive than Medicaid on a per capita basis and because increases in private insurance are higher than Medicaid on a per capita basis.” Ultimately, “the beneficiary is the one that will suffer,” she adds.

This “super waiver” excludes long term care services, but that reprieve will not be indefinite, says Tony Marshall, senior director of operations and reimbursement at the Florida Health Care Association (FHCA).

The state is working on a separate track to craft a long term care 1115 waiver, which is expected to be written

Vermont Choices For Care, Clinical Standards, And Benefits

Highest-Need Group (entitlement)

Individuals are eligible if they have any one of these needs or conditions:

- Extensive or total assistance with at least one of select activities of daily living (ADLs) and limited assistance with another ADL;
- Severe impairment with decision-making skills, or moderate impairment in combination with a behavioral symptom, such as wandering;
- Medical condition or treatment that requires daily skilled nursing care, including stage 3 or 4 pressure ulcers, intravenous medication, or tube feeding; or
- Unstable medical condition that requires daily skilled nursing assessment and monitoring, such as wound care or dialysis.

Benefits include:

- Nursing facility;
- Personal care;
- Respite and/or companion care;
- Adult day services;
- Assistive devices and home modifications;
- Enhanced residential care (includes assistance with meals, movement, bathing, and other activities; medication management; social and recreational activities at home or in the community; 24-hour supervision; laundry services; house-keeping; transportation; and meals); and
- Adult foster care.

High-Needs Group (enrollment when funds available)

Individuals are eligible if they have any one of these needs or conditions:

- Extensive to total assistance on a daily basis with bathing, eating, walking, dressing, or toileting;
- Skilled teaching on a daily basis

to regain control in gait, range of motion, speech, bowel and/or bladder function;

- Impaired decision-making skills that require frequent help with select ADLs;
- Behaviors (frequent wandering; aggression) that require a controlled environment to ensure the individual's safety;
- Medical condition or treatment that requires skilled nursing assessment on a less-than-daily basis;
- Health condition that will worsen if services are not provided or are discontinued; or
- Health and welfare will be at imminent risk if services are not provided or are discontinued.

Benefits include:

- Nursing facility;
- Personal care;
- Respite and/or companion care;
- Adult day services;
- Assistive devices and home modifications; and
- Enhanced residential care.

Moderate-Needs Group (enrollment when funds available)

Individuals are eligible if they have any one of these needs or conditions:

- Supervision or assistance three or more times a week with any ADL or instrumental ADL;
- Impaired judgment that requires general supervision on a daily basis;
- Monthly monitoring for a chronic health condition; or
- Health condition that will worsen if services are not provided or are discontinued.

Benefits include:

- Case management;
- Adult day care; and
- Homemaker.

by December. The program will be piloted in two cities: Pensacola, where enrollment will be mandatory, and Orlando, where Medicaid beneficiaries will have the option of enrolling or staying in the traditional program, Marshall says.

It's too soon to know many details of this piece of the waiver puzzle, he adds, though he does not expect the plan to mirror the super waiver's features of differentiated benefits and risk-adjusted premium bands targeted to distinct populations.

The program will, however, be run by a managed care organization (MCO) that will contract with providers and negotiate capitated rates. The objective of the model will be to "provide services in a more efficient and cohesive manner, coordinate services better, and provide cost savings," Marshall says. In addition, services will be provided in the "least-restrictive setting," meaning outside the nursing facility whenever possible.

Providers Fear Even Lower Rates

Slowing the rate of growth in nursing facility utilization will be difficult, Marshall says, at a time when it is nearly flat, at 1 percent to 1.5 percent over the past two years. In Florida, the portion of the over-65 population in nursing facilities is 2.5 percent—a rate identical to that of Arizona, which has operated under a managed long term care waiver since 1989, Marshall says. Nevertheless, if the program helps place people more appropriately, "we support that," he adds.

Marshall remains concerned, however, about MCOs controlling nursing facility rates, fearing that if they don't meet their savings target for placing patients in HCBS settings, they will ratchet down nursing facility rates. "We support increased funding of [HCBS]," Marshall says, "but not [if it comes] from our funding sources." It's not appropriate to underfund nursing facilities to properly fund HCBS, he adds. That hasn't happened under the

current system, but Marshall fears that managed care entities may resort to more direct strategies to achieve savings. Florida Medicaid rates are already about \$14 below the cost of providing care per patient day, he says.

Given the existing shortfall and the thin margin of elderly receiving nursing facility care across the state, Marshall questions whether there are sufficient savings to be gained in Florida to make it worth the cost of bringing MCOs into the mix, consuming a portion of already scarce Medicaid funds.

“Fundamentally, that is the disagreement we have with wrapping up nursing facility care in a managed care capitated rate,” he says. “We believe there are not enough savings, and eventually it is the providers that will suffer from more inadequate rates than we have today.”

Like Alker, Marshall sees Florida’s waiver activity as “the first step in moving Medicaid more toward an insurance program and away from the social insurance program that it is today.”

FHCA is hoping to get a provision inserted in the waiver that will limit the length of time that a managed care organization controls nursing facility patients, arguing that when patients are in a nursing facility for several months, they don’t need another entity coordinating their care. The compromise would be similar to an arrangement struck between Texas nursing facilities and the state, when the relationship between providers and MCOs became impossibly strained.

“You cannot jam another management structure into an underfunded system and expect it to work,” says Tim Graves, president of the Texas Health Care Association. In Texas, Medicaid long term care beneficiaries in Harris County, which includes Houston, were enrolled five years ago in a managed care program called Star Plus. Nursing facilities had such a hard

‘Florida Medicaid rates are already \$14 below the cost of providing care per patient day.’

time getting paid, sometimes resorting to “extensive administrative efforts, like hand-delivering billing papers,” that the state eventually agreed to pay facilities a fee-for-service rate directly, after the first four months of a patient’s care, says Graves.

While managed care and the concepts of “gatekeepers” and a “medical home” might make sense for a healthy, mobile population, “for folks in a nursing facility, it doesn’t work,” Graves says.

The Case For Managed Care

John Mach, chief executive officer of one of the nation’s biggest Medicaid long term care MCOs, Evercare, disagrees. Evercare operates in six states and is working in and watching an additional 20 states where there is activity or interest in developing a Medicaid managed long term care program.

Mach says Evercare’s objective is not to slash and burn provider rates. “That system has been done,” he says. “We look to the state Medicaid rate as the standard rate and look not to go below that.”

Based in Minnetonka, Minn., Evercare focuses on managing individuals’ comprehensive health needs over time, providing care early in the course of illness and striving to keep people in HCBS settings, Mach says.

The population Evercare serves is complex, and the health care system “tends not to serve [people] well” when their needs are complicated, he adds. “If you get in front of clinical issues, such as early identification of infection

and prevention of pressure ulcers, the result is less need to access acute care and big savings.” ■

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