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During 1995 and 1996 Congress debated numerous proposals that would dramatically reduce the rate of growth in Medicaid spending, initiatives that inevitably would affect long-term care for the elderly. There are three broad strategies that states might use to control long-term care spending — bring more private resources into the long-term care system to offset Medicaid's expenditures, reform the delivery system so that care can be provided more cheaply, and reduce Medicaid eligibility, reimbursement, and service coverage. Based on the available research evidence, there is little evidence to suggest that large savings are possible without adversely affecting beneficiaries' eligibility, access to services, and quality of care received.

Key Words: Medicaid, Long-term care, Budget

Can Medicaid Long-term Care Expenditures for the Elderly Be Reduced?[1]

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In 1995 Congress passed legislation (vetoed by President Clinton) that would convert Medicaid from an open-ended entitlement program with a number of federal requirements to a block grant (MediGrant) with few national standards. Moreover, federal expenditures for Medicaid would be capped and indexed at far below the expected rate of growth under current law. Federal Medicaid expenditures would be cut by $167 billion during the years 1996 to 2002; in that year, federal Medicaid expenditures would be 28% below what would be expected under current law (Holahan & Liska, 1995a). In 18 states, federal expenditures would be more than 30% below estimates under current law.

For his part, President Clinton has proposed establishing per-beneficiary limits on the growth of federal expenditures, while giving states greater flexibility in contracting with managed care organizations, setting reimbursement rates, and organizing long-term care services. President Clinton's proposal would cut federal Medicaid expenditures by $54 billion by the year 2002, substantially less than the Congressional MediGrant plan.

More recently, the National Governors' Association has developed a proposal that attempts to marry the block grant approach of the MediGrant with the per beneficiary limits on the growth of expenditures proposed by the Clinton Administration. Although a dollar savings level was not proposed by the governors, most analysts assume that it would be between President Clinton's and Congressional Republicans' last budget offers — $59 and $85 billion, respectively.

A key issue in evaluating these proposals is how states will live within the budget levels envisioned by these proposals. Unlike proposed welfare and Medicare reforms, advocates of greater state flexibility and substantially reduced federal Medicaid spending have not put forth a detailed blueprint of how states could stay within their budgets. The policy debate begins and ends with the notion that if states are given enough flexibility, they will figure out how to reduce the rate of growth in expenditures without hurting beneficiaries. Indeed, many governors explicitly reject the argument that reduced federal funding and requirements will adversely affect the poor (Edgar, 1995; Engler, 1995).

If states are to control Medicaid expenditures, they will have to confront the issue of services for the elderly and persons with disabilities. The following statistics bring this issue into focus:

- Although about three quarters of Medicaid beneficiaries are children and nonelderly, nondisabled adults, they account for only about a third of expenditures (Liska, Obermaier, Lyons, & Long, 1995).
- Older people and persons with disabilities account for the other two thirds of Medicaid expenditures.
- In 1995, 33% of Medicaid expenditures were for long-term care services — nursing facilities, personal care, home health, intermediate care facilities for the mentally retarded, and home- and community-based services (Burwell, 1996).
- In 12 states, long-term care accounts for 45% or more of Medicaid program expenditures (Holahan & Liska, 1995b).

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- Approximately three fifths of Medicaid long-term care expenditures are for the elderly (Kaiser Commission on the Future of Medicaid, 1995).
- Medicaid is the dominant source of public funding for long-term care for the elderly, accounting for 62% of government spending for nursing home and home care in 1993 (Wiener, Illston, & Hanley, 1994b).
- Most Medicaid long-term care spending for the elderly goes for care in a nursing home, where the costs for 69% of residents in 1994 were at least partly financed by the program (American Health Care Association, 1995).

This article focuses on whether or not large savings might be achieved through more widespread implementation of initiatives to control the rate of increase in long-term care expenditures for the elderly. Overall, there are three broad strategies that states might use to control spending — bring more private resources into the long-term care system to offset Medicaid's expenditures, reform the delivery system so that care can be provided more cheaply, and reduce Medicaid eligibility, reimbursement, and service coverage. In brief, based on the available research, there is little evidence to suggest that large savings are possible without adversely affecting beneficiaries' eligibility, access to services, and the quality of care received. As a result, claims that large Medicaid long-term care savings can be obtained easily should be viewed with caution by policymakers.

Strategies to Control Spending: Increase Private Resources

The first general strategy to control spending is to bring additional private resources into the long-term care system. This could be done in three ways — by encouraging private long-term care insurance, by more strictly enforcing prohibitions against transfer of assets prior to receiving long-term care, and by more aggressively recovering money from the estates of deceased Medicaid nursing home residents. This strategy builds on the observation that a substantial proportion of Medicaid nursing home residents were not poor before they entered the nursing home. Rather, they were impoverished by the $40,000 per year average cost of nursing home care (author's estimate based on unpublished data from the Office of National Cost Estimates, 1995). About a quarter of discharged Medicaid residents were admitted as private pay residents, exhausted their savings, and then qualified for Medicaid during their course of stay (Wiener, Sullivan, & Skaggs, 1996). Thus, those nursing home residents may have private resources that can be more effectively drawn upon to offset their Medicaid expenditures.

Encourage Purchase of Private Long-Term Care Insurance. — One way to reduce Medicaid long-term expenditures might be to encourage the purchase of private long-term care insurance. For the initially nonpoor Medicaid nursing home population, private long-term care insurance could possibly prevent both their impoverishment and subsequent Medicaid expenditures. Currently, only about 4 to 5% of the elderly have any type of long-term care insurance, much of which is deficient in terms of coverage (author's calculation based on data from Coronel & Fulton, 1995).

There are several reasons why so few people have private long-term care insurance. First and most importantly, such insurance is unaffordable for most of the elderly. The average annual premium for high-quality insurance policies sold by the leading sellers in 1993 was $2,137 if bought at age 65 and $6,811 if bought at age 79 (Coronel & Fulton, 1995). Most studies have found that only 10 to 20% of the elderly can afford private long-term care insurance (Crown, Capitman, & Leutz, 1992; Friedland, 1990; Rivlin & Wiener, with Hanley & Spence, 1988; Wiener et al., 1994b; Zedlewski & McBride, 1992).

Second, many older persons incorrectly believe that Medicare covers long-term care services (Employee Benefit Research Institute, 1993). Obviously, people will not be motivated to buy private long-term care insurance if they think they already have coverage.

Third, although people seem to accept the possibility that they will someday need hospital and physician care, few are willing to admit that they face a significant lifetime risk of becoming disabled and will need extensive nursing home or home care. Yet, research suggests that over two fifths of people who live to age 65 will spend some time in a nursing home and about a quarter of all elderly will stay more than a year (Kemper & Murtaugh, 1991).

To estimate the potential impact of various private long-term care insurance options, Wiener, Illston, and Hanley simulated several different private long-term care insurance options using the Brookings-ICF Long-Term Care Financing Model (Wiener et al., 1994b). Figure 1 describes the assumptions, which represent an optimistic upper-bound estimate of potential market penetration and impact for some of the options. Under these assumptions, affordability is the only barrier to the purchase of policies. The simulations suggest that, even by the year 2018, private long-term care insurance is unlikely to substantially affect Medicaid nursing home expenditures or the number of Medicaid nursing home beneficiaries (Table 1). Because nursing home residents must deplete virtually all of their income and assets in order to qualify for Medicaid, the number of Medicaid nursing home beneficiaries is a rough estimate for the number of persons who incur catastrophic out-of-pocket nursing home expenses. Assuming people purchase insurance when they are elderly, Medicaid nursing home expenditures might be 1 to 4% less than what they would be without private long-term care insurance in 2018. Similarly, for these same options, the number of Medicaid nursing home beneficiaries might fall from 0 to 2% compared with what they would be without private insurance. Thus, private long-term care insurance has little impact because it is too expensive for the elderly who currently depend on Medicaid to pay for their nursing home care.

All persons purchase insurance policies that cover two or four years of nursing home and home care and pay an initial indemnity value of $60 per day for nursing home care and $30 per visit for home care in 1986. Indemnity values increase by 5.5% per year on a compound basis. Premiums for nonelderly persons increase by 5.5% per year until age 65 and are then level. All nondisabled persons who meet affordability criteria buy as much insurance as they can afford.

- *5% Income:* All elderly purchase policies if they can afford them for 5% of their income or less and if they have $10,000 or more in nonhousing assets.
- *Medicaid Insurance:* Elderly who purchase private long-term care insurance may receive Medicaid nursing home benefits while retaining liquid assets beyond what is normally allowed. The additional assets that they keep equal the amount that the private insurance policy pays out in benefits. All elderly persons purchase policies when they can afford them for 7% of their income or less and if they have $10,000 or more in nonhousing assets.
- *Tax-Favored Insurance:* Provides an income-related tax credit of up to 20% of the premium cost for elderly purchasing insurance. All elderly purchase policies when they can afford them for 5% of their income or less and if they have $10,000 or more in nonhousing assets.
- *Accelerated Death Benefits:* Persons with cash value life insurance use it to finance their nursing home stay. The amount they use is 2.5% a month of the life insurance face amount, following a six-month deductible.
- *Employer-Sponsored Insurance:* Persons as young as age 40 purchase group or individual long-term care insurance policies. Nonelderly purchase policies if premiums are between 2% and 4% of income (depending on age). Elderly persons purchase policies if they can afford them for 5% or less of income and if they have $10,000 or more in nonhousing assets.

Source: Wiener et al., 1994b.

Figure 1. Private long-term care insurance options: simulation assumptions.

Table 1. How Much Can Private Insurance Do? Simulation Results of Five Major Options, Year 2018

Option	Reductions in Medicaid Nursing Home Spending (%)[a]	Reductions in Number of Medicaid Nursing Home Patients (%)[a]
Five percent income	–2%	–2%
Medicaid insurance	–4	–2
Tax-favored insurance	–3	–2
Accelerated death benefits	–1	0
Employer-sponsored insurance	–31	–17

Source: Wiener et al., 1994b.

[a]Compared to what they would be without private long-term care insurance.

Only the option where large numbers of younger persons purchase private long-term care insurance through their employers provides the potential for significant reductions in Medicaid nursing home expenditures and the number of Medicaid nursing home beneficiaries. If employers sponsor but do not help pay for private long-term care insurance, Medicaid expenditures could decline as much as 31% and the number of Medicaid nursing home residents could fall by as much as 17% by the year 2018. However, this option would require a dramatic increase in the employer-sponsored market, since less than .1% of the nonelderly population currently has private long-term care insurance (author's estimate based on data from Coronel & Fulton, 1995). Moreover, most middle-aged workers are not interested in buying private long-term care insurance, because they have more pressing immediate expenses, such as child care, mortgage payments, and college education for their children. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Prevent Transfer of Assets. — Over the last few years, policymakers and the media have focused attention on middle- and upper-class elderly persons who transfer, shelter, and under-report assets in order to artificially appear poor so that they can qualify for Medicaid-financed nursing home care (Bates, 1992; Burwell & Crown, 1995; Gray, 1992; Kosterlitz, 1991). Often referred to as "Medicaid estate-planning," Congress legislated against these activities in the Tax Equity and Fiscal Responsibility Act of 1982, the Medicare Catastrophic Coverage Act of 1988, and the Omnibus Budget Reconciliation Act of 1993. However, some observers argue that the legislative prohibitions are easy to circumvent and that the prevalence of Medicaid estate-planning has increased dramatically in recent years (Moses, 1994, 1995a, 1995b, 1995c; Serafini, 1995). Speaker Newt Gingrich alleged that transfer of assets by "millionaires" to gain Medicaid eligibility is a "very common problem" (Schmidt & Rich, 1995). Moreover, according to some estimates, as much as $5 billion a year — roughly 20% of Medicaid nursing home expenditures — could be saved by reducing the incidence of Medicaid estate-planning (Cantwell, 1995).

Perhaps no other policy issue in long-term care has generated as much passion as this one. Opponents of asset transfers contend that Medicaid is meant only for those who really need it and that manipulating loopholes to gain eligibility is a perversion of the program's intent (Moses, 1990). Moreover, they argue that money going to artificially eligible nursing home residents is money that cannot be spent on Medicaid services for low-income children and nonelderly adults.

Defenders of the practice insist that transferring or sheltering assets to qualify for Medicaid is morally indistinguishable from using the tax code to avoid paying estate taxes. Moreover, the disabled elderly who do not want their life savings totally destroyed by the costs of long-term care and who want to leave some inheritance to their spouse and children have few alternatives.

While it seems likely that an increasing number of persons are transferring their assets, the very limited available evidence suggests that the current numbers are much smaller than commonly thought. The only direct evidence is from a 1993 U.S. General Accounting Office study of applicants for Medicaid nursing home care in Massachusetts, a state chosen in part because asset transfer was believed to be common

there (U.S. General Accounting Office, 1993). Of the 403 Massachusetts Medicaid applicants reviewed, 49 had transferred assets, three quarters of whom had shifted less than $50,000 in resources. Furthermore, 26 of the 49 applicants were either denied eligibility or withdrew their application. Six of the seven applicants who transferred more than $100,000 were denied eligibility. Thus, although some clients did transfer assets, existing rules kept most off the Medicaid rolls.

Beyond this direct evidence, there is more indirect data to suggest that asset transfer is not as common as is often assumed. First, logically, older persons cannot transfer large amounts of assets they do not have. Existing data suggests that very elderly, disabled widows, who account for the vast bulk of nursing home patients, have quite low incomes and assets (Wiener, Hanley, & Harris, 1994a). As shown on Table 2, about two thirds of the disabled elderly who were admitted to nursing homes from 1982 to 1984 had incomes below 150% of the federal poverty line in 1982; about a third had incomes below the poverty level. Furthermore, using a synthetic estimate based on data on the noninstitutionalized elderly population from the Survey of Income and Program Participation, Wiener, Hanley, and Harris calculated that about three quarters of nursing home patients had less than $50,000 in nonhousing assets (in 1989 dollars) at the time of their admission to the nursing home; almost half had less than $10,000 in nonhousing assets (Table 3) (Wiener et al., 1994a). In contrast, only about 11% had the level of assets ($100,000 or more) considered typical of estate planners' clients. Of this more wealthy population, about half had enough annual income to pay for nursing home care without recourse to any assets. Thus, this group has little incentive to engage in Medicaid estate-planning.

Second, if a large and rapidly increasing number of the elderly are transferring their assets, then the number of Medicaid nursing home beneficiaries should be rising rapidly. In fact, as shown on Table 4, the number of Medicaid nursing home beneficiaries is increasing slowly and only slightly faster than the number of nursing home beds. Between 1990 and 1993, the average annual compound rate of increase in Medicaid nursing home beneficiaries was 3.3% a year, while the increase in the number of nursing home beds was 1.5% a year. All of the excess increase in Medicaid beneficiaries is due to a relatively large increase in Medicaid nursing home residents in one year — 1992.

Expanding Estate-Recovery. — In general, the home is an excluded asset in determining financial eligibility for Medicaid. However, for a long time states have had the option of recovering Medicaid expenditures for nursing home care from the estates of deceased Medicaid beneficiaries, principally from the sale of their houses. As of 1993, 24 states operated estate-recovery programs (Office of the Inspector General, 1994). The Omnibus Budget Reconciliation Act of 1993 mandated that all states operate such programs, but some states have refused to do so because these initiatives are politically unpopular.

It is likely that a significant proportion of elderly persons discharged from nursing homes own their homes. In an analysis of the 1982–84 National Long-Term Care Survey, Wiener, Hanley, and Harris found that 55% of disabled elderly persons entering nursing homes owned a home, a percentage that is well below the 75% of all elderly who are homeowners, but is still substantial (Wiener et al., 1994a). However, the proportion of deceased Medicaid nursing home residents who own houses is probably much smaller, in part because an unknown proportion sell their homes in order to help pay for their nursing home care. Sheiner and Weil (1992) found that only 42% of all elderly households will leave behind a house when the last member dies. In an analysis in eight states in 1985, the U.S. General Accounting Office found that only 14% of Medicaid nursing home residents owned a home, with an average

Table 2. Distribution of Income of Disabled Elderly Admitted to a Nursing Home from 1982 to 1984

Income in 1982 as Percent of Federal Poverty Level	Percent Distribution
Less than 100%	35.3%
100–149	31.4
150–199	15.0
200–299	11.0
300+	6.7
Total	99.4

Source: Wiener et al., 1994a.
Note: Percent distribution does not total to 100% due to rounding.

Table 3. Estimated Income and Financial Assets of Nursing Home Population, 1989

	Personal Net Worth, Percent of Patients (Non-Housing Assets)				
Income	Total	0–$9,999	$10,000–$49,999	$50,000–$99,999	$100,000+
$7,499 or less	44	34	8	2	0
7,500–14,999	36	12	14	8	2
15,000–29,999	15	2	4	4	6
30,000+	5	0	1	0	3
Total	100	48	27	14	11

Source: Wiener et al., 1994a.

Table 4. Number of Medicaid Nursing Home Beneficiaries and Nursing Home Beds, 1990–1993 (In Thousands)

Year	Medicaid Beneficiaries	Beds
1990	1,461	1,660
1991	1,490	1,685
1992	1,573	1,734
1993	1,610	1,768
Annual compound rate of growth	3.3%	1.5%

Source: Statistical Supplement, 1995, "*Health Care Financing Review*; and Charlene Harrington, University of California at San Francisco, personal communication, October 11, 1995.

Table 5. Top Ten Medicaid Estate-Recovery Programs, 1993

State	Recovery $ as Percent of Nursing Home Expenditures
Oregon	2.51%
New Hampshire	1.36
California	1.16
Massachusetts	1.00
Minnesota	0.91
North Dakota	0.87
Idaho	0.85
Illinois	0.57
Utah	0.57
Wisconsin	0.53

Source: U.S. Department of Health and Human Services, Office of the Inspector General, 1994.

value of about $31,000, at the time of application for Medicaid (U.S. General Accounting Office, 1989).

Experience with currently operating estate-recovery programs suggests that they are likely to recoup only a small proportion of nursing home expenditures. As shown on Table 5, the amount recovered from the estates of deceased Medicaid beneficiaries averaged 1.03% of Medicaid nursing home expenditures in 1993 for the top 10 states, falling rapidly from a high of 2.51% in Oregon to .53% in Wisconsin. Because of the already significant effort underway in many states, additional savings are likely to be limited mostly to those not currently operating estate-recovery programs.

Strategies to Control Spending: System Reform

Another general strategy for saving money is to reorganize the delivery system in ways that make care more efficient and effective. This can be done by adding long-term care to the set of services provided by managed care organizations or by expanding home care and nonmedicalized, residential long-term care services.

Integrating Acute and Long-Term Care Services Through Managed Care. — Persons with disabilities currently receive care in a fragmented and uncoordinated financing and delivery system (Evashwick, 1987; National Chronic Care Consortium, 1991). Financing for acute care is largely the province of Medicare and the Federal Government, whereas long-term care is dominated by Medicaid and state governments. Because of the bifurcation of financial responsibilities, there is a strong incentive for the Federal Government to shift costs to the states and vice versa. At the very least, there is indifference about initiatives that would save money for the other level of government.

In terms of delivery of care, fragmentation exists both within and between the acute and long-term care systems. A major consequence of this fragmentation may be that total costs are higher than they would be in an integrated system (Finch et al., 1992). For example, some elderly patients may remain unnecessarily in expensive acute care hospitals because appropriate nursing home or home care services are not immediately obtainable, appropriate follow-up physician care cannot be arranged, or financing for long-term care is not available.

Because of the growing awareness of the inadequacies of the current system, there is increasing interest among policymakers in finding ways to integrate the acute and long-term care sectors. Almost all integration initiatives depend on expanding the role of managed care to include long-term care services. Under these models, managed care organizations receive a fixed payment per enrollee to provide a range of acute and long-term care services, creating financial incentives to avoid both the functional decline that can result from unmet health care needs and the unnecessary costs associated with providing services in needlessly expensive settings. In theory, this coordinated approach would produce acute care savings because lower-cost outpatient and home-based services could be substituted for more costly inpatient services when appropriate (Leutz, Greenlick, & Capitman, 1994; National Chronic Care Consortium, 1991; Rivlin et al., 1988). These acute care savings, in turn, could be used to fund more comprehensive long-term care benefits or could be captured by third parties as savings.

Although the integration of acute and long-term care services offers the opportunity for improved quality of care, long-term care advocates are concerned with this model for a variety of reasons. One apprehension is that health maintenance organizations and other managed care providers have little experience with the elderly and none with the disabled elderly and their long-term care. Another concern is that fiscal pressures within integrated systems will end up shortchanging long-term care (Harrington & Newcomer, 1991). Finally, there is a fear that long-term care will become overmedicalized and that services will become less consumer-directed because the balance of power shifts from the individual client and his or her chosen provider to HMOs, insurance companies, or other administrative entities.

Demonstration Projects and Other Initiatives. — A substantial number of demonstration projects and

other initiatives are underway to test various approaches to integrating acute and long-term care services. The best known of these demonstrations are the Social Health Maintenance Organizations (Social HMOS), On Lok and its Program of All-Inclusive Care for the Elderly (PACE) replications, and the Arizona Long-Term Care System (ALTCS). Several other initiatives either seek to enroll Medicaid eligibles with disabilities in HMOs for their acute care services or for both their acute and long-term care services (Wiener & Skaggs, 1995). Although not directly involved in long-term care, conventional HMOs participating in the Medicare program are required to provide the full range of benefits, including home health and skilled nursing facility services.

Social HMOs extend the traditional HMO concept by adding a modest amount of long-term care benefits (Leutz, Greenberg, & Abrahams, 1985; Leutz, Greenlick, & Capitman, 1994; Rivlin et al., 1988). A coordinated case management system authorizes long-term care benefits for those who meet the established eligibility criteria. Social HMOs are intended to serve a cross-section of the elderly population, including both functionally impaired and unimpaired persons. In fact, the overwhelming majority of enrollees are not disabled. While all enrollees are Medicare-eligible, relatively few Medicaid beneficiaries are members. Enrollees pay premiums to cover the extra benefits. Originally a four-site initiative, Congress has authorized a "second generation" of demonstrations.

In 1983, On Lok Senior Health Services obtained federal waivers allowing it to receive monthly capitation payments from Medicare, Medicaid, and (in a few cases) privately paying individuals to provide a comprehensive range of acute and long-term care services (Ansak, 1990; Zawadski & Eng, 1988). As an offshoot, PACE is replicating the On Lok model in 10 sites throughout the country (Irvin, Riley, Booth, & Fuller, 1993; Kane, Illston, & Miller, 1992). Enrollment is limited to persons who are so disabled that they meet nursing home admission criteria. Because expenditures per person are so high, very few persons can afford to pay an actuarially fair insurance premium out-of-pocket. As a result, almost all enrollees are Medicaid-eligible. PACE sites operate as geriatrics-oriented, staff model HMOS, i.e., their primary care physicians are employees of the organization. Finally, the approach makes heavy use of adult day health care, which is integrated with primary care.

The Arizona Health Care Cost Containment system (AHCCCS) is a statewide demonstration project that finances medical services for the Medicaid-eligible population through prepaid, capitated contracts with providers. Beginning in 1989, the ALTCS program incorporated Medicaid long-term care services into the AHCCCS demonstration (Irvin et al., 1993; McCall, Korb, & Bauer, 1994; McCall et al., 1993; Northrup, 1995). Participation in the program is limited to individuals who are certified to be at high risk of institutionalization. ALTCS covers acute care services, as well as care in nursing facilities, intermediate care facilities for the mentally retarded, and home- and community-based services. Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for covered services to elderly and physically disabled eligibles. In the overwhelming majority of cases, the contractor for elderly people and persons with physical disabilities is the county government.

Potential for Cost Savings. — As with more traditional acute care services, it appears that capitation can reduce expenditures. Evidence concerning Social HMOs and On Lok/PACE show that acute care utilization can be lowered in capitated care settings, but it is less clear that integrating acute and long-term care services generates additional savings (Leutz et al., 1994; National Chronic Care Consortium, 1991; On Lok, Inc., 1993; Rivlin et al., 1988). Social HMOs did not appear to do substantially better than conventional HMOs in reducing acute care expenditures. The early evidence from On Lok/PACE is more encouraging, but the data are very preliminary, do not adjust for case mix, and involve a relatively small sample. PACE sites tend to be very small, enrolling on average about 200 persons per site. Complicating the evaluation of cost savings are the inadequacies of the current Medicare and Medicaid payment methodologies, which do not adjust sufficiently for risk (Brown, Bergeron, Clement, Hill, & Retchin, 1993; Kane et al., 1992; National Health Care Consortium, 1993). As a result, estimating costs under a traditional, unintegrated fee-for-service system is difficult, and, hence, comparisons are hard to make.

In an evaluation of the ALTCS, Laguna Research Associates compared the total costs of ALTCS with an estimate of what a traditional Medicaid program in Arizona would cost (McCall et al., 1993). Evaluating the cost effectiveness of the Arizona program was extremely difficult because the state has never had a conventional Medicaid program. As a result, evaluators were forced to develop a synthetic estimate of what the costs of a traditional Medicaid program in Arizona would have been had it had one. Unfortunately, the choice of states used to develop the synthetic estimate was largely determined by data availability rather than whether states were "comparable" to Arizona in terms of ethnicity, style of care, and other factors.

The ALTCS program appears to save money, largely because of how it provides services to the population with mental retardation and developmental disabilities (McCall et al., 1993). For fiscal year 1993, Laguna Research Associates estimated that service costs for the elderly population were 18% less for ALTCS than they would be under a conventional Medicaid program (see Table 6). ALTCS' higher administrative costs offset a significant portion of these savings. Savings derive almost entirely from providing services to 16% fewer people than would be served in a traditional Medicaid program. Indeed, unlike many other Medicaid programs, the program appears to successfully limit services to persons at

high risk of institutionalization (Weissert, 1992). However, per-member per-month costs, which are an indicator of the ability to provide services more efficiently, were only about 2% lower.

Expand Home- and Community-Based Services. — The most persistent dream in long-term care is that the expansion of home care and other nonmedicalized residential long-term care services could reduce overall long-term care expenditures. The fundamental hope has been that lower-cost home care could replace more expensive nursing home care. However, there is substantial, rigorous research to suggest that expanding home care is more likely to increase rather than decrease total long-term care costs (Kane & Kane, 1987; Kemper, Applebaum, & Harrigan, 1987; Weissert, Cready, & Pawelak, 1988; Wiener & Hanley, 1992).

Older people's aversion to nursing homes explains this increase. Given a choice between nursing home care and no formal services, many elderly people will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset relatively small reductions in nursing home use.

To some extent, ending the entitlement to home care and nursing home care as envisioned under the MediGrant plan could solve this cost problem by allowing states to predetermine how much money they will spend for institutional and for noninstitutional services. In this way, a substitution of home care for nursing home care could be forced, which is a strategy being used by some European countries (Wiener, 1996). Within the United States, some states such as Wisconsin and Washington have a conscious policy of limiting growth in nursing home supply while increasing home care services (Fralich et al., 1995; U.S. General Accounting Office, 1994).

A problem with this strategy is that noninstitutional services may not be cost effective for this population. Home care for nursing home-level persons without extensive family supports is expensive. In an analysis of Connecticut's Medicaid home- and community-based waiver program, Liu et al. found that a substantial number of persons who met the eligibility criteria of being at high risk of institutionalization were prevented from receiving home services because their care plan was too expensive (Liu, Hanson, & Coughlin, 1995). These persons tended to be substantially more disabled and to have far fewer informal supports — strong indicators of being at high risk of institutionalization — than persons who were allowed to participate in the program.

Recognizing that there are certain economies of scale in residential settings that are lacking in traditional home care where services must be provided to one person at a time, Oregon has developed nonmedicalized residential alternatives to nursing homes (Kane, Kane, Illston, Nyman, & Finch, 1991). By aggressively expanding assisted living and adult foster care, the state hopes to promote residential settings that are more homelike, provide greater personal autonomy, and cost less. In particular, the state has concentrated on older persons with Alzheimer's disease, who need a lot of supervision but not a great deal of medical care.

Although highly innovative, this approach has been very controversial. For example, the nursing home industry has charged that these alternative residential settings are just substandard nursing homes, and there have been some recent reports of quality of care problems (author's personal communication with Steven Lutzky, December 28, 1995). Moreover, for a portion of the population, Stark et al. found that going to an adult foster home in Oregon was associated with less improvement and more decline in physical functioning than going to a nursing home (Stark, Kane, Kane, & Finch, 1995). Furthermore, there has been no rigorous evaluation of whether money has been saved with this strategy, or how much.

As a first approximation of the potential of expanding home- and community-based services to control expenditures, Table 7 presents the percent increase in Medicaid long-term care expenditures for the elderly from 1988 to 1993 for the United States as a whole and for Oregon, Washington, and Wisconsin — states that have been active in reorganizing the long-term care delivery system. Over that time period, both Oregon and Washington had rates of increase in Medicaid long-term care expenditures that were substantially greater than for the United States as a whole (U.S. General Accounting Office, 1994). Wisconsin had a much lower rate of increase,

Table 6. Comparison of Arizona Long-Term Care System (ALTCS) and "Traditional" Medicaid Program Service Costs, FY 1993

	Traditional	ALTCS	Percent Difference
User Ratio	100.0%	84%	–16.0
Number of Months	124,667	104,460	–16.0
Per Member/Per Month Cost	$2,059	$2,015	–2.0
Total Cost	$256.7 million	$210.5 million	–18.0

Source: Laguna Research Associates, Inc., personal communication, November 15, 1995.

Table 7. Percent Increase in Medicaid Long-Term Care Expenditures, 1988 to 1993

Location	Total Percent Increase from 1988 to 1993
United States	87%
Oregon	164
Washington	128
Wisconsin	54

Source: Urban Institute analysis of HCFA 2082 and HCFA 64 data.
Note: Long-term care expenditures include spending for skilled nursing facilities, intermediate care facilities, other nursing facilities, home health, personal care, and home- and community-based waivers. It does not include spending for mental hospitals and intermediate care facilities for the mentally retarded.

but much of its home- and community-based services are financed outside of the Medicaid program.

Strategies to Control Spending: Traditional Cuts in Eligibility, Reimbursement, Services, and Quality

If states do not succeed in substantially reducing the rate of increase in long-term care expenditures through increasing private resources or through delivery system reform, there are still a large number of more conventional mechanisms that can be used. These include cuts in eligibility, reimbursement, covered services, and quality standards. States already have considerable flexibility in these areas, and all of the major Medicaid reform proposals increase their freedom of action further. Because of the vast range of options that states have, this paper can touch on only a few of the possible initiatives.

Tighten Financial Eligibility Standards by Requiring Family Contributions. — Current financial eligibility standards for Medicaid are quite strict, especially for institutional long-term care. In particular, single individuals, who make up the vast majority of nursing home residents, may retain only $2,000 in nonhousing assets and must contribute all of their income toward the cost of care except for a very small personal needs allowance (generally $1.00 a day).

One possible mechanism to reduce expenditures would be to allow states to require adult children or other relatives to contribute to the cost of Medicaid nursing home care for their parents. Commonly referred to as "family responsibility" requirements, this practice has been explicitly prohibited in the Medicaid program since 1965 (Section 1902(a)(17)(D) of the Social Security Act). The MediGrant proposal passed by Congress would allow states to impose these requirements on adult children who have more than the state's median income.

Advocates of family responsibility programs see them as a way to promote equity, reduce costs, and encourage family care (Burwell, 1986). Some policymakers argue that it is inequitable to tax lower- or moderate-income people to pay for care of the parent of an affluent adult child, as sometimes happens in the current system. A family responsibility program could also encourage informal caregiving by delaying the point at which families seek institutional placement for their elderly kin. Advocates also contend that family members who know that they would be held financially responsible for part of the cost of institutional care of their parents might be more inclined to seek noninstitutional alternatives or to purchase private long-term care insurance for them. Also, elderly nursing home candidates themselves might be more resistant to placement that could lead to a financial burden for their children.

Opponents of family responsibility initiatives take issue with the implicit assumption that family members of many disabled elderly do not do enough to help these relatives. Much research suggests that relatives make enormous commitments to provide informal home care to disabled elderly relatives (Liu & Manton, 1986). Fully 84% of disabled elderly people who were admitted to nursing homes between 1982 and 1984 received assistance from relatives and friends (Hanley, Alecxih, Wiener, & Kennell, 1990). Other studies suggest that caring for disabled elderly relatives imposes large emotional and physical strains on families (Knight, Lutzky, & Macofsky-Urban, 1993; Mui, 1992; Pearlin, Mullan, Semple, & Skaff, 1990; Semple, 1992; Skaff & Pearlin, 1992). As a result, opponents of family responsibility argue that adult children should not be "punished" because they have a parent who needs expensive nursing home care, and they question the wisdom of discouraging people who need institutional care from seeking it because they do not want to burden their kin.

Because family financial responsibility is prohibited by current law, there is little direct evidence on this issue. However, the available research suggests that this approach would generate little savings, and could have adverse effects on the disabled elderly. In 1983, the Health Care Financing Administration (HCFA) estimated net savings of only $25 million per year for a national family responsibility initiative, (U.S. Select Committee on Aging, 1983) noting that 75% of the reductions in Medicaid expenditures would be offset by increased administrative costs (Knight et al., 1993; Mui, 1992; Pearlin et al., 1990; Semple, 1992; Skaff & Pearlin, 1992). These costs entail identification of responsible relatives, evaluation of their incomes, distribution of assessments to relatives, and enforcement of collections. Furthermore, compliance with a state's assessment cannot be assumed, especially if the relative lives in another state. Conceivably, states could lower their administrative costs by shifting the burden of collecting the funds to the nursing homes. However, if facilities were unsuccessful in obtaining the funds, then the Medicaid reimbursement level might be inadequate to provide reasonable quality care.

In the early 1980s, Idaho took advantage of a Reagan Administration reinterpretation of the law that allowed family responsibility requirements when contributions are enforced under a general law not imposed solely on Medicaid beneficiaries. The Idaho family responsibility initiative had a goal of $1.5 million in annual collections, but succeeded in collecting less than $32,000 in its six months of operation (Burwell, 1986).

Beyond direct expenditure reductions by increased contributions toward the cost of care, savings could also be achieved from the deterrent effect that these family contributions would likely have on persons seeking nursing home admission. However, the size of the deterrent effect is unclear. During the 1960s, family responsibility requirements under the Old Age Assistance program (the forerunner of the Supplemental Security Income program) resulted in many elderly parents choosing not to apply for assistance rather than force their children to contribute (Schorr, 1980). Some who did seek public assistance chose to survive on less income rather than sue their own children for failure to contribute to their support.

Repeal of family responsibility requirements in the

Old Age Assistance program in Washington and Texas was followed by large increases in the caseloads (Schorr, 1980). Likewise, Idaho's short-lived family responsibility program reported that applications for Medicaid nursing home care dropped 8% after enactment of the law and rose 8% after program termination (Burwell, 1916). On the other hand, few studies have found financial cost to be an important determinant of nursing home placement (Arling & McAuley, 1983; Smallegan, 1985).

Cut Reimbursement Rates. — Under current law, states may set Medicaid payment rates at whatever level they choose for home- and community-based services, but they must meet a minimum standard for nursing home and hospital reimbursement. This standard is prescribed by the "Boren Amendment," which requires that providers be reimbursed under rates that the state "finds and makes assurances satisfactory to the Secretary are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards" (Section 1902(a)(13) of the Social Security Act). Although this law was designed to relax previous standards, many states have had difficulty meeting the new standard; as of 1993, at least 43 nursing home reimbursement lawsuits were filed for violation of the Boren Amendment's substantive or procedural standards (Harrington, Weinberg, Stawder, & DuNah, 1993). Repeal of the Boren Amendment has long been sought by state governors, who contend that it unnecessarily limits their flexibility in setting reimbursement rates. The MediGrant legislation and President Clinton's and the National Governors' Association proposals would all give states complete flexibility in setting payment rates.

Even with the Boren Amendment, some states currently pay in excess of the required level and could cut payment levels further. Without the constraint of the Boren Amendment, however, states would have much greater freedom to reduce their payment rates to fit the level of funds available.

The problem with this strategy is that reimbursement rates are already fairly low, especially in comparison with Medicare and private pay rates. In 1993, average Medicaid nursing home payment rates were $82 per day, while average Medicare payment rates were $170 per day (American Health Care Association, 1995). These figures should be viewed with some caution since not all Medicaid providers participate in Medicare and vice versa. Thus, these two figures are not the average of exactly the same families. Moreover, there are case-mix differences between Medicare and Medicaid nursing home residents that account for some of the rate disparity (Dor, 1989).

Although there is great variation across facilities and states, private pay charges generally tend to be substantially higher than Medicaid rates. Not surprisingly, then, nursing homes prefer private pay to Medicaid patients (Harrington & Swan, 1987; Nyman, 1988a, 1988b; Nyman, Levey, & Rohrer, 1987; Scanlon, 1980). As a result, Medicaid beneficiaries often have difficulty gaining access to nursing homes. To the extent that states cut reimbursement rates and the payment differential between private pay and Medicaid patients widens, access problems may worsen.

In addition, while there is little evidence of a simple relationship between cost and quality, there is probably some threshold level of reimbursement below which it is impossible to provide adequate level quality of care. Repeal of the Boren Amendment would eliminate the safeguard that Medicaid payment levels do not go below that threshold. Thus, if nursing home reimbursement rates are cut substantially, then quality of care in nursing homes might decline because of inadequate financial resources.

Reduce Nursing Home Quality Standards and Enforcement. — Largely in response to concerns about inadequate care in nursing homes, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) dramatically revised and strengthened the Medicaid and Medicare quality standards and the survey and certification process. Facilities that do not meet the standards are not eligible for Medicaid and Medicare reimbursement.

Many states chafe under these quite specific requirements and would like to see them changed. The House of Representatives-passed version of the MediGrant program would have eliminated most of these standards. While the final MediGrant legislation retains the current OBRA 1987 standards, it also gives states much more flexibility in the implementation of the survey and certification process, with federal enforcement of the standards being almost entirely eliminated. In contrast, the Clinton proposal would make only small changes in the survey and certification process; the National Governors' Association proposal is silent on this issue.

Advocates for greater state flexibility in quality enforcement argue that the existing system is unduly bureaucratic and inflexible. Moreover, they contend that state government is, if anything, more concerned about assuring adequate quality of care in nursing homes than the Federal Government because it is their citizens who are in the nursing homes. From a financial perspective, different quality standards might make reimbursement cuts more feasible.

Consumer advocates strongly oppose the proposed changes in the MediGrant proposal. They note that prior to OBRA 1987, quality standards and their enforcement were weak in many states (Institute of Medicine, 1986; Wiener, 1981). Moreover, they argue that it is the threat of the loss of federal funds that motivates states to make the quality improvements. In addition, if accompanied by repeal of the Boren Amendment, they worry that state reimbursement rates will be inadequate to provide quality care. Thus, there will be a strong incentive for

state surveyors to "look the other way" because they know that it is unfair to require facilities to meet certain staffing and other standards if the state will not pay enough to satisfy those standards.

While not perfect, there is substantial evidence that the quality standards imposed by OBRA 1987 actually improved quality of care and may have saved money. An evaluation led by Research Triangle Institute, Inc., found that the OBRA 1987 standards reduced the use of physical and chemical restraints, lowered hospitalizations, reduced use of indwelling catheters, and decreased the number of dehydrated patients (Hawes, 1995). The standards also increased the percentage of residents who participated in activities and the proportion of residents who used hearing aids if they needed them.

Stop Construction of New Nursing Home Beds. — Another strategy for controlling Medicaid costs would be to prohibit construction of new nursing home beds on the assumption that they would likely be filled largely with Medicaid-eligible residents. Thus, by controlling the supply of institutional services, expenditure growth would be curbed. As of 1994, 15 states had a moratorium on new construction of nursing homes (Bedney et al., 1995).

There are at least three problems with this strategy. First, the care needs of the disabled elderly do not disappear just because there are no nursing home beds available. Alternative home- and community-based services may not serve the people who need nursing home care, and any additional expenditures for these services would reduce the savings from freezing the bed supply. Moreover, home- and community-based services may be at risk if overall Medicaid expenditures are highly constrained.

Second, although the situation varies across states, the number of nursing home beds per 1,000 elderly aged 85 and over fell by 18% between 1978 and 1994 (Bedney et al., 1995). In addition, while hospital occupancy rates have dropped over the last 15 years, nursing home occupancy rates have remained extremely high, averaging 90% in 1994 (Bedney et al., 1995). Thus, relative to need, the bed supply already has substantially tightened in recent years. It is uncertain how much further it can decline without causing substantial backlogs of nursing home-ready patients in hospitals or increasing unmet needs in the community.

Third, the strategy of freezing the bed supply does not address the underlying demographic reality that the United States is an aging society. Because of demographic changes, projections using the Brookings-ICF Long-Term Care Financing Model suggest that demand for nursing home care will grow by about 1.9% per year from 1993 to 2008 (Wiener et al., 1994b).

Reduce Coverage for Home- and Community-Based Services. — Over the last 15 years, states have moved to create a more balanced long-term care delivery system by expanding home- and community-based care. In 1993, approximately 15% of Medicaid long-term care expenditures for the elderly were for home- and community-based care (Wiener et al., 1994b). However, most of these expenditures were for the optional personal care and home- and community-based waiver services, rather than for mandatory home health care.

If faced with strict budget constraints, states may choose to reduce coverage for home- and community-based services, especially if they are not cost-effective substitutes for nursing home care. In the political process, home care agencies tend to be politically weak at the state level compared to other provider groups, such as hospitals, nursing homes, and physicians (Vladeck, 1980; Wiener, 1981). Thus, in a free-for-all battle for resources at the state level, home- and community-based care may not do particularly well. Moreover, given limited funds, states may decide to allocate resources first to persons with the most severe disabilities without family supports. If they make that allocation decision, then funds will be primarily spent on nursing home care and only secondarily on home care, because the average nursing home resident is far more disabled and has fewer informal supports than the average home care user. In 1994, the average nursing facility resident had 3.95 dependencies in the activities of daily living (American Health Care Association, 1995). In 1989, the average home care user had 2.11 dependencies in the activities of daily living (Liu & Manton, 1994).

Obviously, if states choose to cut back on home care, then the long-term care delivery system will be even more oriented toward institutional care than it is now.

Conclusions

Given the substantial flexibility that states already have in terms of coverage, reimbursement, and eligibility, there is little doubt that they could substantially lower long-term care spending if they were determined to do so, even under current law. However, this study questions whether the rate of increase in Medicaid long-term care spending for the elderly can be substantially reduced without adversely affecting beneficiaries. Furthermore, while there are promising developments in the integration of acute and long-term care services and in creative home- and community-based programs, this review of the literature raises serious questions as to whether obtaining additional private resources or delivery system reform could substantially reduce the rate of increase in long-term care spending, at least over the period from 1996 to 2002. Unfortunately, the research literature does not offer any "silver bullets" that will allow states to easily and painlessly obtain large savings. Whereas it is conceivable that major changes in the Medicaid program could dramatically alter the dynamics under which providers operate so as to generate significant savings, the burden of proof rests on the shoulders of advocates of greater state flexibility and reduced funding to demonstrate that the current research findings are not applicable.

To reduce the rate of growth in expenditures sharply, states will likely turn to more traditional methods of cost control — reducing eligibility, cutting reimbursement, and limiting covered services. These cuts may negatively affect beneficiaries and providers, both in terms of access to services and quality of care. These overall conclusions are consistent with the Urban Institute evaluation of the potential impact of proposals to cap the rate of growth in Medicaid expenditures at far below historical experience (Holahan et al., 1995).

The hard reality is that the current method of Medicaid long-term care financing is actually a pretty economical system. Payment rates are much lower than Medicare and the private sector. Individuals receive government help only after depleting almost all of their assets, and they must contribute virtually all of their income toward the cost of care. Medicaid pays only the costs that the elderly themselves cannot. Finally, the institutional bias of the delivery system limits services largely to persons with the most severe disabilities who do not have family supports. Within this system, it is difficult to obtain large additional savings.

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