

## **How Will States Pay for Long Term Care?**

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# HOW WILL STATES PAY FOR LONG-TERM CARE?

## Introduction

Discussions of health care policy and financing typically place long-term care at the end of the agenda. This may stem from humans' denial about aging or policy makers' frustration with vexing long-term care issues, or perhaps both. But the times are changing. Fast.

The states are turning their attention to long-term care mainly because they are worried about Medicaid spending. Long-term care spending accounts for one-third of states' Medicaid budgets, which now account for 21.9 percent of states' total budgets (National Governors Association and National Association of State Budget Officers (NGA & NASBO), 2005). With Medicaid spending exceeding combined elementary and secondary education spending for the first time in 2003 (National Association of State Budget Officers, 2004), it is hard to ignore the facts. The National Governors Association has made Medicaid reform its top priority, with long-term care close to the top of the list (NGA, 2005a). As they grapple with the implementation demands of the Medicare Modernization Act, states are decrying the "sea change in the state-federal relationship...(that has money) flowing upward, from the states to the federal government" (Matthews, 2005) to pay for Medicare coverage of prescription drugs over which they have no control.

Written as states negotiate their budgets while they continue to recover from "the most severe fiscal downturn in 60 years" (NGA & NASBO, 2005), this paper explores the major long-term care challenges that confront states and what they are doing about them. Examples used are not exhaustive, but are illustrative of potential trends for purposes of inquiry and debate.

## Major Challenges: Old and New

Deliberations on how states will pay for long-term care begin with projections of care and support needs, and costs for meeting them. State, federal and personal responsibilities for sharing costs rest on these projections.

### *Demand for Long-Term Services and Supports*

The population of older adults is growing dramatically. Currently, more than 35 million Americans are over the age of 65. An accelerated aging pace begins in 2011 when the country's baby boomers will reach retirement age. Between 2010 and 2030, the number of older adults will double, reaching 71.5 million. By 2030, one in five Americans will be 65 years or older. Among this older population, the group known as the "oldest old" - those 85 years or more - will more than double from 4.6 million in 2002 to 9.6 million in 2030 (US Department of Health and Human Services (USDHHS), 2004). This group will most likely need long-term care services and supports because they experience multiple chronic health conditions and difficulties in performing daily

activities like bathing, dressing, cooking and taking medications. Currently, more than 7 million older adults are chronically disabled (Allen, 2005). That means that about one in five Americans over 65 need assistance with everyday activities. Among the oldest old, 58 percent have a severe disability, and 35 percent of them require help due to the limitations imposed by disabling conditions (Gill, Allore, Holford & Guo, 2004; USDHHS, 2004).

These demographic statistics should help fuel strategic planning for long-term care, although it is important to note two caveats. First, over the next decade there will be a relatively slow growth in the 85-plus population segment that is most in need of long-term care. Sixty-five year old baby boomers are not the big concern; 75-year-old and 85-year-old baby boomers are the concern. Second, there is some evidence that disability rates among older adults are declining. Analyzing data from the National Long-Term Care Survey, Manton and Gu (2001) found that the disability rate for all seniors fell from 26.2 percent in 1982 to 19.7 percent in 1999, amounting to a reduction of 100,000 disabled seniors during this period despite a 33 percent rise in the elderly population. Schoeni, Freedman and Wallace (2001) contend that that disability trends are declining at a slower pace, finding a 1.1 percent average annual drop in disability from 1982 to 1996, most of it taking place in the 1980s. Experts will continue to monitor disability rates, which may remain in a downward trend among better educated cohorts of older adults since education is related to disability rates (Knickman & Snell, 2002). Of course, this optimism may be countered by those who observe that obesity trends in the 50-69 age group may increase disability rates by 1 percent per year (Sturm, Ringel, & Andreyeva, 2004).

These demographic projections concern state policy makers who face continued spending pressure in their Medicaid budgets. Because Medicaid is the primary payer for long-term care, they worry about the case mix of their Medicaid population. An increasing proportion of frail elders translates into a Medicaid caseload of those in the most expensive category - people who need long-term care.


### ***Long-Term Care Cost Projections***

State policy makers are becoming quite vocal about their financial exposure to long-term care costs. Medicaid covers 53 million Americans, including 15 million elders and people with disabilities, at a projected 2005 cost of \$329 billion (state and federal), more than 2.6 percent of the country's Gross Domestic Product (Smith & Moody, 2005). Although state revenue collections are now narrowly exceeding budgeted estimates in nearly all states, the National Association of State Budget Officers projects Medicaid cost growth will far exceed state budget growth due to significant spending pressures; states estimate a 12.1 percent Medicaid growth rate (National Conference of State Legislatures (NCSL), 2005a; NGA & NASBO, 2004).

☰ Medicaid costs for older adults and people with disabilities, particularly for long-term care, are a significant part of that projection. The 15 million older adults and persons with disabilities enrolled in Medicaid account for 27 percent of total Medicaid beneficiaries but 75 percent of total spending. Long-term care accounts for 35 percent of all Medicaid

spending, despite the fact that less than 10 percent of beneficiaries use long-term care services (O'Brien & Elias, 2004). As the primary funder of long-term care, Medicaid pays for over two-thirds of nursing home residents, accounting for 46 percent of all nursing home revenues (Smith & Moody, 2005).

The biggest point of contention for states surrounds the cost of paying for the care of the almost seven million people who are eligible for both Medicaid and Medicare, commonly known as the “dually eligible” or “duals” for short. Most (two-thirds) of these duals are elders. The duals are Medicaid’s most expensive population group. Costs for duals are about twice as high as costs for other people on Medicare. Forty-two per cent of all Medicaid (and 24 percent of Medicare) expenditures are spent on duals, even though they represent a small percent (14 percent) of the Medicaid case load for states and are fully covered by the Medicare program. This is a costly population to serve because more than half are in fair or poor health, one in three have significant limitations in activities of daily living, and about one in four reside in nursing homes. Long-term care costs account for 65 percent of Medicaid spending for the duals (Kaiser, 2005).

The National Governors Association (NGA) has long held that the federal government should assume full responsibility for the duals, including acute, primary, long-term, and pharmaceutical care (NGA, 2005b). The 2003 Medicare Modernization Act (MMA) transferred responsibility for pharmaceutical coverage, but the federal government is “clawing back” most of the states’ savings and many states claim this transfer will actually cost them significant dollars and staff resources to implement the complicated low income subsidy for Medicare prescription coverage. For example, Ohio estimates a \$55.7 million cost in 2007 alone (Edwards, 2005). The NGA calls it a “reverse block grant,” as federal law will require states to transfer billions of dollars each year for a Medicare benefit that offers states no means for controlling costs and diminished data capacity to implement programs like disease management (Salo, 2004). 

### *Federalism, Again*

The state-federal tensions surrounding the implementation of the MMA are further fueled by talk of Medicaid reform, again. Authorized by federal law but administered and partially financed by states, Medicaid is a federal-state partnership. From the state long-term care perspective, this partnership has been uneven, particularly as the states are forced to assume the escalating costs for people who are already on Medicare (the duals). As discussed below, a handful of states have demonstrated considerable leadership in shaping social policy to finance and deliver long-term care. They may be considered examples of “compensatory federalism” in which state governments step up their activity to make up for a diminished federal role (Pandey, 2002). However, most states have found it difficult to create new frameworks for long-term care without long, complex negotiations for “waivers” of federal Medicaid policy. Governors seek federal legislative and regulatory action to give them the flexibility to offer older adults and people with disabilities a “more balanced choice between nursing home and community-based service” (NGA, 2005c).

At the time of this writing, Congress has approved a non-binding budget resolution that includes a \$10 billion reduction in federal Medicaid spending over five years. A bipartisan commission to study the Medicaid program would deliver an interim report by September 1 and a final report by December 2006. Medicaid cuts, whatever the final amount may be, would not occur until 2007 after the Commission provides its final report. The Commission's agenda may include fundamental restructuring of Medicaid. If President Bush appoints the members, the commission will no doubt address issues highlighted by U.S. Secretary of Health and Human Services Mike Leavitt, the country's longest serving governor before his appointment. Leavitt recently outlined several areas to "modernize Medicaid" including three that directly affect how states will pay for long-term care (NCSL, 2005b):

- Prevent people from shifting their assets to qualify for Medicaid;
- Allow states flexibility to tailor their basic benefit packages; and,
- Change the basic LTC Medicaid framework to allow more home and community-based care.

These are not new ideas. Both Republican and Democratic leaders have advanced various Medicaid reform proposals for more than 20 years, often with intense debate about how long-term care responsibilities should be allocated between state and federal governments (Weiner, 1998). Some of those ideas are resurfacing.

The 1980s "Great Swap" paradigm of the Reagan administration proposed to trade the federal role in welfare for the state role in Medicaid (Barfield, 1983). The states were eager to shed their role in Medicaid. They resisted full responsibility for welfare and food stamps, but were willing to assume responsibility for other federal programs in education, economic development, and transportation. Both the governors and the Reagan administration agreed that a swap should be fiscally neutral for both parties, but they disagreed on how to achieve this goal. Some say that one way to move closer to neutrality today would be for the federal government to assume responsibility only for the elderly on Medicaid, sorting federal and state roles by populations (the federal government takes the elderly and disabled and the states the non-elderly poor) rather than functions (federal health care and state welfare) (McLaughlin, 2005). While this particular reshuffling of federal and state roles in welfare and Medicaid may not be on the table now, NGA representatives do say that the current Medicaid paradigm is unsustainable and needs to be radically rethought and reformed (NGA, 2005a).

The 1990s Medigrant proposal that Congress passed in 1995 took a different approach by eliminating the entitlement to long-term care and most federal long-term care requirements, including federal oversight of nursing home quality (Weiner, 1998). The states would have had great discretion and authority for designing long-term care, including coverage of non-medical services for people who are likely to need institutional care without more community supports.

Ten years later, the state-federal responsibility balance for long-term care debate continues. Again, “state flexibility” is the unifying theme. In the absence of a resolution negotiated in Washington, the states are acting to balance their budgets and attempt innovation within the moderate flexibility they have now through 2,500 waivers of Medicaid rules.


### **States In Action**

With a focus on Medicaid, states have been pursuing ways to manage their long-term care costs. In general, states did not turn first to major cost containment in long-term care during the most recent period of fiscal stress on state budgets. But as they run out of other options, they are now turning to this large budget area, which accounts for one-third of most states’ Medicaid budgets. In fiscal year 2005, 17 states were focusing on long-term care Medicaid costs, up from 10 states in 2003 (Smith, et al. 2004).


In this budget season, some states are using traditional cost-control measures that leave the basic Medicaid long-term care structure unchanged, such as cutting Medicaid rates or services. Others are exploring old ideas with renewed interest, in some cases fueled by actual or potential federal action. A handful of states are exploring innovative, major system reform. Consumer direction trends cut across and challenge all three areas.

#### ***1. Traditional Approaches***

Although state Medicaid nursing home payment policies vary substantially across the states, they maintained their level of payment rates through 2002 (Grabowski, Feng, Intrator & Mor, 2004). This year, several states are considering cuts in provider payments as well as cuts in supportive services for older adults and people with disabilities. A few examples include:

- Mississippi lawmakers approved a Medicaid bill to reduce the state's Medicaid costs from a projected \$683 million to \$516 million, a 24 percent decrease. If approved by Governor Haley Barbour, these cuts will reduce home health care visits from 60 to 25 per year (Pettus, 2005).
- Missouri plans to cut eligibility for many people, including persons with disabilities who are employed, and authorize the legislature to eliminate coverage for elders and people with disabilities in years when there are insufficient state funds to support services (Kaiser, April 8, 2005 ber, 2005).
- Ohio is trying to remove nursing home rate-setting from state law so the administration can more easily make payment adjustments to avoid paying for 12,000 empty beds that are partially subsidized by the statutorily prescribed methodology (Ohio Office of Budget and Management, 2005).
- Louisiana Governor Kathleen Blanco is also proposing to change the nursing home reimbursement structure to allocate fewer dollars to nursing homes with

lower occupancy rates, a strategy that Louisiana's AARP supports but nursing home providers strongly oppose (Donchess, 2005; Hansen, 2005).

- North Carolina's proposed Medicaid budget would freeze nursing home payment rates and reduce the number of potential personal care hours from 60 to 50 hours per month (Kaiser, April 15, 2005 

As is customary at this time of year, state budget negotiations on long-term care spending are progressing in the context of many other financing issues. What makes this year different is the focus on the states' fiscal liability for the MMA Part D "claw-back" and any savings that might accrue in states that have a robust state pharmacy assistance program (SPAP) that can enroll low-income beneficiaries into the Medicare prescription program. States like Pennsylvania, New York and New Jersey stand to save millions of dollars on the SPAP spending line, which will help on the Medicaid claw-back side. Balancing state budgets in this climate has been particularly challenging. The focus on traditional spending cuts is related in part to this confusing budget climate.

## ***2. Old Ideas with Renewed Interest***

Several states are considering ideas that have been tried by others but have been slow to diffuse. This renewed interest is spurred by several factors, including the MMA, potential federal action, and federal funding of pilot projects advocated by aging and disability groups. These ideas include managed care, case management/disease management, long-term care insurance, and strategies to balance institutional and community-based services.

### ***Resurgence of Managed Care***

Despite their general interest in managed care, only seven states at present (Arizona, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin) have developed capitated managed long-term care programs to move funding from institutional settings to home and community-based HCBS settings in the last two decades. Only a few of these states have attempted to integrate acute and long-term care services for older adults and people with disabilities across the Medicaid and Medicare streams.

The overall concept is that a managed care organization (MCO) receives a monthly capitation payment per person for individuals at risk of institutional care. With this fairly large capitated payment, the MCO should have the resources and incentives to offer individuals less expensive, and more desirable, alternatives to institutional care. In the most successful programs, the capitation rate methodologies are structured to encourage providers to keep individuals in lower cost community settings. There is no limitation on the length of time a provider may be responsible for the costs of a nursing home placement, and the rate of decline in nursing home utilization decreases over time (Milligan, 2005).

Despite this small penetration of managed care concepts in long-term care, two forces may help stimulate states to move into managed care or expand existing efforts. First, several states have evidence that their managed care efforts are saving them money and satisfying consumers (Lewin, 2004). Expansions in pioneer states like Florida and Texas may occur this year if not thwarted by federal-state conflicts over Medicare Upper Payment Limits (UPL) discussed below. Second, the MMA's "Special Needs Plan" provision opens a new door for integrating acute and long-term care for the duals and is generating excitement in the field. California is one example.

### **Medicare Advantage Special Needs Plans, a New Opportunity.**

Section 231 of the MMA allows Medicare Advantage (MA) organizations to offer managed care plans that serve "special needs individuals." Medicare populations that are defined as "special" include the duals, institutionalized individuals, and those with severe or chronic conditions as defined by the Secretary of Health and Human Services. More than a hundred managed care organizations, including those who are currently only serving Medicaid populations, have applied to the Centers for Medicare & Medicaid Services (CMS) to become Special Needs Plans (SNPs). They are interested in developing targeted programs for duals, without the requirement to open enrollment to all Medicare beneficiaries. CMS is offering this opportunity in response to states' request to make it possible to design programs that can integrate Medicare and Medicaid financing (including Part D pharmacy coverage) and clinical decision-making without the requirement to apply for complicated waivers. These SNPs can exclusively serve complex dually eligible populations. The "frailty adjuster" (that increases payment for frail populations) may be available to SNPs.

#### ***Florida.***


Governor Jeb Bush's "Empowered Care" Medicaid reform proposal envisions a radical restructuring of its \$14.7 billion Medicaid program that services 2.2 million people. Participants would be assigned a risk-adjusted premium to purchase basic and catastrophic care and people who comply with prescribed medical instructions to improve their health would earn dollars to put into flexible spending accounts. Florida will apply for a section 1115 waiver to implement this program in phases. Mandatory provisions will not apply initially to the duals (Agency for Health Care Administration (AHCA), 2005).

Florida is seeking to increase the number of people in managed care (AHCA, 2005). For the time being, the state is seeking to save money through expansion of its Nursing Home Diversion Program, a voluntary 1915(c) waiver program operating in nine Florida counties (Milligan, 2005; Ormond, 2004). This capitated, voluntary program began in 1998 and enrolls people who are 1) living in the community at the time of enrollment; 2) dually eligible; and, 3) at risk of or meeting a level of care determination for nursing home placement. The program only covers long-term care services. When it began, approximately \$2,300 per person per month was paid, but this rate will decrease to \$1,732 over the next three years (Milligan, 2005).

### *Texas.*

Texas officials are hoping to expand their STAR+PLUS capitated managed care program statewide this year, although current legislative action to promote alternatives to STAR+PLUS may complicate that expansion.

Texas STAR+PLUS is a mandatory program that integrates Medicaid funding and service delivery of acute and long-term care, with no Medicare integration. Currently being implemented in Harris County as a pilot, it covers about 61,500 children and adults, with about half of them dually eligible for Medicare and Medicaid. One in five receives long-term care services. Independent consumer satisfaction and quality studies are positive with estimated savings of \$28.6 million in total funds in fiscal year 2003 and \$29.4 million in fiscal year 2004. Statewide expansion is estimated at \$145.8 million (Gold, 2004).

Based on these findings from the STAR+PLUS pilot, the Texas Health and Human Services Commission (HHSC) released its plan in February 2004 for the statewide expansion of STAR+PLUS by September 2005. However, mandatory expansion of managed care will reduce the flow of dollars to public hospitals by millions because it will remove a significant number of fee-for-service Medicaid claims that factor into the Medicare upper payment limit calculations. A vocal coalition of public hospitals and the Texas Medical Association are advancing an alternative “Integrated Care Management” bill that will keep these Medicaid beneficiaries in the fee-for-service arena and pay physicians a monthly fee for serving as primary care physicians.  the time of this writing, this Integrated Care Management legislation is moving, thereby challenging statewide implementation of STAR+PLUS. Budget deliberations over the next month will determine the outcome and the extent of savings that mandatory managed care can bring.

### *California.*

California’s Medi-Cal Redesign proposal includes the expanded use of managed care from 22 to 35 counties, and establishment of Acute and Long Term Care Integration (ALTCI) health plans in three counties (Orange, San Diego, and Contra Costa). The state will require managed care partners in those three counties to become SNPs so that integration of capitated Medi-Cal and capitated Medicare funding can occur at the health plan level. Seniors and people with disabilities will be required to enroll in managed care plans in all counties where it is available. CMS approval is need for the state to offer home and community-based services in lieu of nursing home care (1915 c waiver) in the three counties (1915 b waiver). In the current climate of “increasing state flexibility,” California is hoping that CMS will not require a section 1115 waiver but permit a section 1915 b/c combination waiver combined with the SNP option (California Department of Health Services (CDHS), 2005).

### ***Case Management with a “New” Disease Management (DM) Focus***

In addition to managed care, there is a growing interest in case management and disease management. Eager to find effective, cost-saving ways to address the cost of uncoordinated chronic care, 42 states began either a disease or case management program in the last two years (Smith et al., 2004). The trend was more in favor of comprehensive case management rather than management of specific diseases like congestive heart failure and diabetes, but Medicare’s demonstration programs are fueling provider (and therefore state) interest in these areas as well.

Disease management (DM) programs are usually considered to be a cost-effective strategy for improving health outcomes for people with chronic and disabling conditions. Expected results of these programs from a quality and cost perspective are encouraging. However, results are not conclusive (Williams, 2004). States have found that some vendors were too specialized, focusing on one or two chronic conditions. States are now seeking vendors that will take on responsibility for multiple disease conditions.

CMS encouraged states to institute Medicaid-based disease management programs that would help people with chronic conditions better control their illnesses. Indeed, last year CMS announced that it will match funds that states spend on coordinating disease management programs, saying these programs can improve health outcomes and cut disease-related expenses (CMS, 2004). Ironically, because disease management requires extensive use of pharmacy claims data, states will have a difficult time implementing disease management programs once Medicare pharmaceutical coverage begins and private sector organizations instead of states have these data.

The MMA includes provisions for the Voluntary Chronic Care Improvement Program and the Care Management Performance pilot program. The former will improve self-care among beneficiaries and furnish technical support to healthcare providers, so that they can better manage patient information. The latter will similarly encourage the use of health information technology among physicians as a way of reducing the hospitalizations of chronically ill patients (CMS, 2004; Super, 2004).

While disease management is promising, the concept is still evolving. The early adopters of disease management under Medicaid have not found it to be an immediate panacea, but they do believe that disease management provides a longer-term direction for state Medicaid programs with potentially significant cost savings (Wheatley, 2002). In addition to data concerns, setting robust operational and economic standards to evaluate and effect improvements and refinements to this concept remains challenging.

### ***Long Term Care Insurance***

Another “old” idea that is resurfacing is long-term care insurance, including private-public partnerships to entice middle and upper income persons to protect their assets through insurance rather than transferring them to their potential heirs. Both state and

federal policy makers continue to promote long-term care insurance as part of the financing solution.

An example at the state level is Hawaii's Governor Lingle and Democratic legislators. These policy makers are advancing proposals to provide a tax credit for people who purchase long-term care insurance and for companies who purchase policies for their employees. Two years ago, Governor Lingle vetoed a bill that would have charged taxpayers \$10 a month for a long-term care program available to qualified individuals for a year of cash benefits (DePledge, 2005).


At the federal level, H.R. 2096, sponsored by Representatives Nancy Johnson and Earl Pomeroy, a former Insurance Commissioner in North Dakota, would provide \$38 billion of tax deductions to purchase long-term care insurance. The Pomeroy-Johnson bill would provide "above-the-line" tax deductions for long-term-care insurance premiums; it would permit use of that insurance under cafeteria plans, flexible spending accounts and a \$3,000 tax credit for those who provide at-home care. Introduced in several recent Congressional sessions, it has stalled in both the House Ways and Means committee and the Senate Finance Committee. The \$38 billion fiscal note from the Congressional Budget Office damped potential enthusiasm from those who espouse the belief that development of the private long-term-care market must be encouraged to cope with rapidly rising Medicaid costs to both the federal government and the states.


There is renewed interest in federal legislation needed to clear the way for expansion of state-level long-term care partnership programs. Passage of the Long-Term Care Partnership Program Act would change Medicaid's "spend down" rules that count the proceeds of long-term-care payments against an insured's eligibility for Medicaid programs. In place since passage of the Omnibus Budget Reconciliation Act in 1993, the rules preclude any new programs to offer asset protection but do not apply to the "Partnership" states that were implementing a demonstration project at the time Congress enacted this law (see below). With 38 bipartisan cosponsors, the partnership program bill stands a much stronger chance of passing in 2005 (Meiners, 2005). Under the bill, people receiving \$100,000 in long-term-care insurance benefits would see \$100,000 of their personal assets disregarded in determining eligibility for Medicaid.

The experience in the Long-Term Care Partnership states offers some lessons. Authorized by the Robert Wood Johnson Foundation in 1987, almost two decades ago, this demonstration project aimed to help states plan and implement public private partnerships that link Medicaid and private long term care insurance to protect an individual's assets and possible future eligibility for Medicaid (Meiners, McKay, & Goss, 2001). The private part of these policies is the insurance coverage for long term care. Consumers who purchase these approved policies for a pre-determined period of time can continue their long-term care under Medicaid without spending all of their assets to meet the usual Medicaid eligibility requirements. California, Connecticut, Indiana and New York implemented the program; four other states (Massachusetts, New Jersey, Oregon, and Wisconsin) had been part of the planning phase but did not implement a Partnership program.

The Partnership program has had some degree of success despite its complications and political opposition at the federal level (McCall, 2001). According to the National Association of Health Underwriters (2004), consumers in the four Partnership states have purchased 180, 531 policies, with 148,405 still in effect. Only 2,057 have received long-term care through these plans and 89 accessed Medicaid because they had exhausted their private long-term care insurance benefits. These beneficiaries made significant financial contributions to their long-term care, having spent all of their uninsured assets before becoming eligible for Medicaid (Ahlstrom, Clements, Tumlinson, & Lambrew, 2004). Still, the debate about how the Partnership approach affects Medicaid spending continues. Proponents claim these policies can save money for both states and consumers (Meiners, et al., 2001). The Congressional Budget Office (2004) disagrees, saying these policies might increase Medicaid spending.

Despite this ongoing debate, the Long Term Care Partnership approach enjoys strong, bipartisan support at the state level (McCall, 2001). The NGA has made a Partnership expansion a priority (NGA, 2005c). Several states have indicated strong interest in expanding the Partnership effort. Oklahoma, Idaho, and Illinois have memorialized Congress to delete the May 14, 1999 deadline for states to approve long-term care partnership plans. Indeed, according to a recent report, 16 states have passed legislation and are staged to implement a Partnership program as soon as Congress acts to change the 1993 restriction (Ahlstrom, et al., 2004). For example, Florida's Senate Bill 1208 would establish the Florida Long-Term Care Partnership Program (LTCPP) to incent individuals to purchase long-term care insurance. The amount of countable assets for purposes of determining Medicaid eligibility would be reduced by \$1 for every \$1 of benefits paid by the LTCPP policy.

Some federal and state lawmakers view versions of the Partnership approach as a companion or alternative to another favored option to restrict the transfer of assets to establish eligibility for Medicaid. For example, New Hampshire is considering a bill (HB 691) that promotes long-term care insurance while allowing officials to more aggressively prevent seniors from transferring their assets to others to qualify for Medicaid coverage of nursing home care. There would be a 10-year "look back" period for asset transfers to a trust and a five-year look back for asset transfers to an individual. However, seniors will be exempt from these provisions if they purchase at least three years of long-term care insurance (Kaiser, April 15, 2005). 

The Bush administration is also proposing to tighten Medicaid eligibility rules to delay benefits for up to five years for applicants who transfer their assets, projecting \$4.5 billion in savings over the next 10 years. Connecticut, Massachusetts, and Minnesota  have proposed similar restrictions and more than a dozen other states are discussing plans to do the same. Some challenge this policy direction. AARP makes the case that the administration's eagerness to repeal the estate tax to help persons holding more than \$1 million in assets is inconsistent with its proposal to tighten asset transfer rules for middle income seniors (Kassner, 2005). Furthermore, extending the look-back period might

unfairly disadvantage many persons who were not disabled at the time of the asset transfer and were not attempting to obtain Medicaid eligibility (Weiner, 2005).

### ***3. Balancing Long Term Care***

In part spurred by the CMS “Real Choice Systems Change” grants that started in 2001, most states are engaged in at least some aspect of the “balancing long-term care” agenda that attempts to pay for long-term care for more people by shifting public expenditures from an almost exclusive focus on nursing home care to a more balanced investment in institutional and community services (Mollica & Reinhard, 2005). Most states have been using Medicaid home and community based waivers to accomplish this goal (Reester, Missmar, & Tumlinson, 2004). Examples of other initiatives are noted here.

#### ***The Nursing Home Transition Movement***

More than half the states are advancing nursing home transition programs to help qualified Medicaid beneficiaries and others move from institutional to community-based settings. Federal and state officials are working with advocates for seniors and people with disabilities to help identify people in nursing homes who want to return to their communities (CMS, 2005a; Reinhard, Hendrickson, & Bemis, 2005).

In 2000, CMS instituted a grant initiative aimed at helping states develop transition programs that would enable beneficiaries who so desired to leave nursing facilities and re-enter the community. This initiative was spurred partly by the Olmstead decision, with its focus on the civil right of disabled people to receive services in the most integrated setting that will fulfill their needs; CMS initially allocated \$2 million to the grant program. In 2001 and 2002, CMS provided grants to 23 states and 10 independent living centers to develop policies and programs to support older adults and younger persons with disabilities to transition from institutions to their preferred setting (CMS, 2005). The agency announced in 2002 that it would allow the use of home and community-based services (HCBS) waivers to pay for relocation costs arising from nursing home transitions. These waivers can subsidize several transition costs, including security deposits, essential furniture, moving expenses, and deposits for utility services (Eiken, Holtz & Steigman, 2005).

Some states, like Washington, Oregon, and New Jersey, have established nursing home transition programs that relocate hundreds of residents a year. Other states are planning to move aggressively in this area and combine the strategy with other long-term care reforms. For example, Governor Doyle recently announced his administration’s plan to reduce Wisconsin’s nursing home populations by 25 percent over eight years. The state plans to move about 540 people from nursing homes to community settings in the first year and about 900 people in the second year for an estimated savings of more than \$9 million in Medicaid dollars over the next two years. At the same time, the state will move to an acuity-based reimbursement for nursing home care to remove the incentive for nursing homes to admit people who might be better served in the community. The state

will also identify more managed care providers that are willing to serve elderly and disabled people on Medicaid (Groves, 2005).

### ***Global Budgeting and Money Follows the Person Financing***

In addition to using transition waivers, states are exploring “Money-Follows-the-Person” (MFP) initiatives that allow people to use Medicaid funds for nursing home stays, as well as home and community-based care (Hendrickson & Reinhard, 2004). In 2003, CMS provided \$6.5 million in funding to nine states (California, Idaho, Michigan, Nevada, Pennsylvania, Texas, Washington, and Wisconsin) to develop MFP strategies.

Texas is often credited for popularizing the MFP terminology when the state enacted Rider 37, one of the first MFP initiatives in 2001. This law, subsequently replaced with Rider 28 in 2003, allows nursing home residents who still need “nursing home level of care” to return to their communities and receive Medicaid home and community services. From September 2001 to August 2004, Texas used this strategy to relocate more than 5,708 nursing facility residents from nursing homes to the community; two-thirds of these former nursing home residents were older adults (TDADS, 2004;Weiner et al., 2004).

Washington has made significant progress in managing its long-term care costs through a global budgeting process that is tied to many other assertive strategies to balance its long-term care system. Authorized spending for long-term care services in the 2003-2005 biennium was \$2.4 billion in total funds. Of this amount, \$942.3 million will be spent on community-based services and \$1.035 billion on nursing home care. That means Washington is spending approximately 48 percent of its long-term care budget on home and community-based services and 52 percent on nursing homes. Three out of four (73 percent) of Washington’s long-term care beneficiaries are served in a community setting (Hendrickson & Reinhard, 2004). The Medicaid nursing home caseload dropped from 17,353 in 1992 to 12,447 in 2004, while the community caseload increased from 19,330 to 34,638 during the same period. Washington officials report that if the nursing home caseload had increased 3% a year as it had been in the early 1990s, the state would have almost doubled its spending on institutional care. Instead, they claim that they have avoided \$400 million in costs by investing in community care (Black, 2005).

Global budgeting is embedded in the way Washington creates its budget. All long-term care funds are within the same department that prepares the costs and costs per case, and uses the caseload projections from a legislatively mandated Caseload Forecasting Council. The Administration exercises both an overall cost control and an individual level control on how much can be spent on a person’s care. The overall control is an effort to keep total average per person waiver costs at 90 percent of what the nursing home costs are. The individual level of control is made possible through the state’s assessment instrument, the CARE tool, which assigns a level of care to each person assessed or a number of home care hours if the person is receiving home care. A person’s rate is set by the computerized assessment.

Many states are examining these and other pioneer states to explore how they can “balance” their spending on long-term care. States can use these techniques to reduce spending and/or serve more people for the same amount of planned spending.

#### ***4. Advanced Ideas Gaining Ground***

Some states are advancing fundamental restructuring that is consistent with some national Medicaid reform proposals. Vermont, one of the smallest states in the nation with about 600,000 residents, is expected to receive approval from CMS this fall for a bold initiative. Other states are waiting in the wings to see what happens before submitting similar proposals.

After extensive public hearings across the state, Vermont submitted a research and demonstration 1115 waiver in 2003 to CMS that would eliminate the entitlement to institutional long-term care. Approval of this waiver would allow Vermont to “de-link” the nursing facility level of care from the home and community level of care. An approach that was recommended recently by experts convened by the National Academy for State Health Policy (Smith et al., 2005), this radical policy would help a state avoid nursing facility expenditures for individuals with moderate needs, and allow those funds to be re-invested in community-based settings (Milligan, 2005).

Vermont’s goal is to provide long-term care services in the most appropriate setting. The state would make that decision by applying objective criteria and assessment practices that determine multiple categories of “level of care,” not all of which would “entitle” a Medicaid beneficiary to a care in a nursing home. Essentially it creates multiple definitions of level of care that establishes different beneficiary recipient rights to services.

Vermont officials anticipate a statewide expansion of long-term care Medicaid services for older adults and people with physical disabilities (Flood, 2005). They seek to eliminate the institutional bias in eligibility and provide equal access to nursing home and community-based services. They also want to promote early intervention for at-risk populations. As a mandatory requirement for entry onto long-term care services in Medicaid, it is a “wholesale replacement of most of the existing long-term Medicaid program in Vermont” (Vermont Department of Aging and Independent Living (VDAIL), 2003).

If approved, Vermont will raise its nursing home level of care criteria to a new, higher level than the current level, continue making home and community-based services available to people who meet the current nursing home level of care, *and* make community-based services available to those who are “at-risk” for nursing home placement but do not yet meet the required level of care. That means there will be three levels of care - not just one that means a person is “in” or “out”:

- The “**Highest Need Group**” would remain an “entitlement” population. The state could not limit enrollment to this category. Anyone who meets these criteria

would have the right to choose between a nursing facility and community-based care. To qualify for this entitlement group, the person must: 1) require extensive or total assistance with toileting, eating, bed mobility and transfer, and at least limited assistance in any other ADL; or, 2) have a severe impairment with decision making skills or a moderate impairment with decision making skills, and any one of severe unalterable behavioral problems; or, 3) specific conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis; or 4) have an unstable medical condition that requires skilled nursing assessment, monitoring, and care on a daily basis.

- The “**High Need Group**” would meet the former (current) nursing home level of care criteria that requires that an individual: 1) needs extensive to total assistance on a daily basis with bathing, dressing, eating, toileting and/or physical assistance to walk, or skilled teaching to regain control of ADLs and other functions; or, 2) has impaired judgment that requires constant or frequent redirection, or specific behaviors that required a controlled environment to maintain safety; or, 3) has specific conditions or treatments that require skilled nursing assessment, monitoring, and care on a less than daily basis. These individuals have the right to receive community-based services, not nursing home services. If they choose nursing home services, they could be placed on a waiting list, as is now the case for home and community based waivers when funds are not available. Those who are on a waiting list for nursing home care would have the right to community-based services and Medicaid state plan services while they are waiting. **This policy reverses the existing federal and state institutional bias toward institutional care. The entitlement would be to community-based services, while nursing home access could be subject to a waiting list depending on available funds.**
- The “**Moderate Need**” group includes people who are at-risk for nursing home placement. This is an expansion group under the 1115 waiver. The services include a narrow set of community-based services, case management and adult day services. To qualify for this expansion group, the individual must: 1) require supervision or physical assistance three or more times in seven days with any single or combination of ADLs or IADLs; or, 2) have impaired judgment that requires general supervision on a daily basis; or, 3) requires monthly monitoring for a chronic health condition group under the 1115 waiver; or, 4) have a health condition that will worsen if LTC services are not provided or are discontinued.

This kind of flexibility to create multiple definitions of level of care that establish different beneficiary recipient rights to services is something that many states are seeking. Currently, this flexibility to create these multiple groups is not available under a traditional 1915(c) waiver, which is somewhat easy to obtain from the federal government. Currently, this kind flexibility to “de-link” nursing home level of care criteria from long-term care service delivery in different settings requires an 1115 waiver from CMS, which takes many years and multiple negotiations. The approach that states are seeking, which currently requires an 1115 waiver as Vermont has submitted, would

allow a state to receive federal financial participation for the cost of home and community-based services for the “pre-duals”—people who do not meet a given state’s nursing home level of care but will eventually have to move into an expensive nursing home option unless the state intervenes with less costly community services.

### ***5. Consumer Direction: An Over-Riding Trend***

Consumer direction is a growing trend that cuts across all of these state approaches to address long-term care financing and delivery. Consumer direction in long-term care is a cluster of approaches designed to give older adults and younger persons with disabilities primary control over the services they receive, the providers who supply services, the terms under which providers work, and the manner in which services are delivered (Stone, 2000). In some consumer-driven programs, payments are provided to beneficiaries, who can then tailor and purchase the services they need, purchase assistive technologies or make needed changes to their homes, and assume responsibility for their workers. They may hire a worker—a traditional health care vendor, a family member, or a neighbor, depending on the program. In many cases, a state entity or private company chosen by the state oversees payroll and taxes, while the consumer selects and trains the personal care worker. A “support broker” or case manager can assist consumers with such tasks as worker recruitment, background checks, and employee training (Coleman, 2003).

The trend toward consumer-directed programs is gaining momentum. More than half the states are developing programs that support consumer direction for people with disabilities, including older adults. In 2003, CMS funded 12 states to develop “Independence Plus” programs that would allow people on Medicaid to direct more of the personal care services provided in their homes (CMS, 2005a). In 2004, the Robert Wood Johnson Foundation funded 11 states to replicate its “Cash & Counseling” project, first launched in 1995 in three states (Arkansas, Florida and New Jersey). Evaluation of the 3-state pilot is being conducted by Mathematica. Findings document high consumer satisfaction and comparable costs to more traditional, agency-based services. In Arkansas, the “Cash & Counseling” group that had the flexibility to hire non-agency workers had higher Medicaid personal care expenditures than the control group that used traditional agency services, because those in the control group obtained only two-thirds of entitled services; many received no services. The higher personal care expenditures in the “Cash & Counseling” group were offset by lower spending for nursing home care and other Medicaid services within two years of enrollment in the more flexible program (Dale, Brown, Phillips, Schore & Carlson, 2003).

### **Conclusion**

As they negotiate their budgets this year and look toward their future aging populations, states are increasingly turning their attention to long-term care. Their main focus now is “unsustainable” Medicaid spending, with long-term care fueling much of the spending pressures (Allen 2005). There is a lot of angst, and some ideas. Some old. Some new.

The nation's governors want the federal government to assume full responsibility for the most costly population, those who are eligible for both Medicare and Medicaid. The MMA's partial solution was to cover prescription costs for these "duals"—and then take back most of the savings to states. States' furor over this federal solution is escalating. Continued state-federal debate over this cost of covering this population is likely.


The governors are also clamoring for more flexibility to run their Medicaid programs, including long-term care, although there is no appetite for a "block grant." Some contend that states have considerable authority now to change their long-term care systems and only a handful have made significant progress to date (Weiner, 2005). Others say that flexibility is cumbersome now and there is a serious need to break the link between entitlement to expensive nursing home care and more affordable home and community based care (Smith et al, 2005). One state is trying to do that through the 1115 waiver route and others are waiting anxiously to see if this can work. This policy approach will more likely help states to serve more people for the same dollars than save money in the aggregate. But with demographic projections predict significant growth in demand, this approach can be helpful in the long run.


The 2005-2006 Bipartisan Commission on Medicaid will debate potential Medicaid redesigns, as similar debates occurred ten and twenty year ago. The governors will declare that it is unacceptable for Medicaid to be the only long-term care program in the country (NGA, 2005b) at the same time the U.S. Comptroller General "re-examines the base of the federal government" and says "the status quo is not an option" (Walker, 2005). Long-term care financing will be a central part of the state-federal responsibility discourse because it consumes 35 percent of states' Medicaid budgets. Finding ways to help individuals and their families participate in the long-term care financing solution will remain a high priority.

How the states and the nation pay for long-term care is inexorably intertwined with our other health and social welfare values and priorities. As with other areas of social policy, we will never be able to afford everything that all of the stakeholders want, and probably not even all that they need. But long-term care should not be at the bottom of the list or the last to be considered. Growing attention from the current fifty year olds who are caring for their parents—and pondering their own future—is elevating inquiry that may help incite innovation.

## References



- Agency for Health Care Administration (AHCA). (2005, March). *Empowered care: A proposed concept for Florida Medicaid (Draft)*. Retrieved April 25, 2005 from [http://www.empoweredcare.com/docs/empoweredcare\\_proposed\\_concept.pdf](http://www.empoweredcare.com/docs/empoweredcare_proposed_concept.pdf)
- Ahlstrom, A., Clements, E., Tumlinson, A., & Lembrew, J. (2004). *The long-term care partnership program: Issues and options*. Washington, D.C.: The Washington University.
- Allen, K.G. (2005). *Long-term care financing: Growing demand and cost straining federal and state budgets*. Washington, D.C.: Government Office.
- Barfield, C. E. (1983). New federalism and long-term care of the elderly. *Health Affairs*, 2(1), 113-126. Retrieved April 25, 2005 from <http://www.healthaffairs.org>.
- Black, P. (2005, February 27). *Presentation at the Aging and Disability Resource Center National Meeting*. Baltimore, Maryland.
- California Department of Health Services: Office of Long Term Care. (2005, March). *Medi-Cal Acute and Long Term Care Integration (ALTCI)*. Retrieved April 25, 2005 from <http://www.dhs.ca.gov/mcs/mcpd/MCReform/PDFs/Acute%20and%20Long%20Term%20Care%20Integration%20Final%203-23-05.pdf>
- Centers for Medicare & Medicaid Services (CMS). (February 26, 2004). CMS Urges States to Adopt Disease Management Programs, Agency Will Match State Costs. *Medicaid News Press Release*. Retrieved April 25, 2005 from <http://www.cms.hhs.gov/media/press/release.asp?Counter=967>
- Centers for Medicare & Medicaid Services (CMS): Public Affairs Office. (2005a). *Opening Doors to Independence: CMS Accomplishments in Support of the Presidential New Freedom Initiative*. Retrieved April 25 from <http://www.cms.hhs.gov/newfreedom/accomplish2.pdf>
- Centers for Medicare & Medicaid Services (CMS). (2005b, February 18). Release of Long Term Care Minimum Data Set (LTC/MDS) Data to State Medicaid Agencies, Section 1915 Waiver Programs, and "Real Choice System Change Grant" Programs in Order to Assist States' Title II, Americans with Disabilities Act (ADA) Compliance Activities (Ref: S&C-05-19). Retrieved April 25, 2005 from <https://www.cms.hhs.gov/medicaid/survey-cert/sc0519.pdf>
- Coleman, B. (2003, October). *Consumer-directed personal care services for older people in the U.S.* (IB Number 64). Washington, DC: AARP Public Policy Institute. Retrieved April 25, 2005, from <http://www.aarp.org/research/housing-mobility/homecare/Articles/aresearch-import-42-INB75.html>

- Congressional Budget Office (CBO). (2004). *Financing long-term care for the elderly*. Washington, D.C.: Author.
- Dale, S., Brown, R., Phillips, B., Schore, J., & Carlson, B. L. (2003, November 19). The effects of cash and counseling on personal care services and Medicaid costs in Arkansas. *Health Affairs, Web Exclusive*, 10.1377/hlthaff.w3.566. Retrieved April 25, 2005 from <http://www.healthaffaris.org>
- DePledge, D. (2005, April 17). State may ease burden of long-term care. *HonoluluAdvertise.com*. Retrieved April 25, 2005 from <http://the.honoluluadvertiser.com/article/2005/Apr/17/ln/ln01p.html>
- Donchess, J. (2005, April 12). Don't cut nursing home residents funding. *The Baton Rouge Advocate*, p. 6.B.S.
- Edwards, B. (2005, March 25). Ohio Medicaid Director. Personal communication. 
- Eiken, S., Holtz, J.D., & Steigman, D. (2005, January 10). *Medicaid HCBS waiver payment for community transition services: State examples*. Prepared for The Centers for Medicare & Medicaid Services. Washington, DC: Medstat Research and Policy Division. Retrieved April 25, 2005 from <http://www.hcbs.org/moreInfo.php/nb/doc/1192/>
- Flood, P. (2005, March). Shifting the balance. Presentation to the Balancing LTC Fellows, Antonio, Texas.
- Gill, T.M., Allore, H.G., Holford, T.R. & Guo, Z. (2004). Hospitalization, restricted activity, and the development of disability among older persons. *JAMA*, 292(17), 2115-2124.
- Gold, M. (2004, December 9). Texas experience with integrating managed care: STAR+PLUS. Presentation to the National Conference of State Legislatures, Savannah, Georgia.
- Grabowski, D.C., Feng, Z., Intrator, O., & Mor, V. (2004, June 16). Recent trends in state nursing home payment policies. *Health Affairs, Web Exclusive* (10.1377/hlthaff.w4.363). Retrieved April 25, 2005 from <http://www.healthaffaris.org>
- Groves, E. (2005, April 7). Governor Doyle details steps to reduce nursing home populations by 25 percent over eight years. *US Federal News*.
- Hansen, C. (2005, April 18). Louisiana road show in support of Governor's long-term care agenda. *SNI Source*. Washington, DC: AARP.

- Hendrickson, L. & Reinhard, S. (2004). Global budgeting: Promoting flexible funding to support long-term care choices. New Brunswick, New Jersey: Rutgers Center for State Health Policy. Retrieved April 25, 2005 from <http://www.cshp.rutgers.edu>.
- Kaiser Commission on Medicaid and the Uninsured. (2005, January). *Dual eligibles: Medicaid's role for low income Medicare beneficiaries* (Pub. No. 4091-03). Menlo Park, CA: Author. Retrieved April 25, 2005 from <http://www.kff.org/medicaid/4091-03.cfm>
- Kaiser Reports (2005, April 8). Missouri legislature approves measure to eliminate coverage for 27,000 Medicaid beneficiaries. *Kaiser Daily Health Policy Reports* found at [www.kaisernet.org/dailyreports/healthpolicy](http://www.kaisernet.org/dailyreports/healthpolicy).
- Kaiser Reports (2005, April 15). Kaiser Daily Health Policy Report highlights coverage of state Medicaid developments. *Kaiser Daily Health Policy Reports* [www.kaisernet.org/dailyreports/healthpolicy](http://www.kaisernet.org/dailyreports/healthpolicy).
- Kassner, E. (2005, March 14). *Medicaid reform discussion*. Washington, D.C: AARP.
- Knickman J.R., & Snell, E.K. (2002). The 2030 problem: Caring for aging baby boomers. *Health Services Research*, 37(4), 849–884.
- Lewin Group (2004). *Medicaid managed care cost savings—A synthesis of studies*. Prepared for America's Health Insurance Plans. Falls Church, Virginia: The Lewin Group.
- Manton, K.G., & Gu, X. (2001). Changes in the prevalence of chronic disability in the United States black and non-black population above age 65 from 1982 to 1999. *Proceedings of the National Academy of Sciences of the United States*.
- Matthews, T.L. (2005, March 25). *Cost-cutting Medicare law is a money loser for states*, New York Times, p. 12.
- McCall, N. (2001). Where do we go from here? In N. McCall (Ed.), *Who will pay for long term care: Insights from the partnership programs* (pp. 303-317). Chicago: Health Administration Press.
- McLaughlin, J.P. (2005, March 15) The great swap: Can it work today? *The Philadelphia Inquirer*. 
- Meiners, M. (2005, April 18). Hearings on issues related to long-term care. Testimony before the Subcommittee on Health of the House Committee on Ways and Means, Washington, DC.
- Meiners, M., McKay, H., & Goss, S. (2001). National program office. In N. (Ed.), *Long term care: Insights from the partnership programs* (pp. 49-64). Chicago: Administration Press.

- Milligan, C. J. (2005). *Money follows the person: Reducing nursing home facility utilization and expenditures to expand home and community-based services*. New Brunswick, NJ: Rutgers Center for State Health Policy: Community Living Exchange. Retrieved April 26, 2005 from <http://www.hcbs.org/moreInfo.php/nb/doc/1170/>
- Mollica, R. & Reinhard, S. (in press). Rebalancing state long term care systems. *Ethics, Law and Aging Review*.
- National Association of Health Underwriters (NAHU) (2004). LTC Partnership Statistics June, 2004.
- National Association of State Budget Officers (NASBO). (2004, October). *2003 State Budget Expenditure Report*. Retrieved April 26, 2005 from <http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf>
- National Conference of State Legislatures (NCSL). (2005a, April). *State Budget Update: April 2005*. Washington, DC: Author. Available through [www.ncsl.org](http://www.ncsl.org).
- National Conference of State Legislatures (NCSL). (2005b, April 15). *Federal HHS secretary outlines plan to begin Medicaid reform*. Retrieved from <http://www.ncsl.org>
- National Governors Association (NGA). (2005a, March 7). *Medicaid Reform Topped Governors' Meeting Agenda*. Retrieved from <http://www.nga.org/>.
- National Governors Association (NGA). (2005b). *Medicaid Reform Principles Policy. Revised Winter Meeting 2005*. Retrieved from <http://www.nga.org/>.
- National Governors Association (NGA). (2005c). *Policy position HHS-27. Medicaid reform principles policy*. Revised Winter Meeting 2005: formerly Policy HR-43. Retrieved April 27, 2005 from [http://www.nga.org/nga/legislativeUpdate/1,1169,C\\_POLICY\\_POSITION^D\\_5113,00.html](http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_5113,00.html)
- National Governors Association and National Association of State Budget Officers (NGA & NASBO). (2004). *The fiscal survey of states, December 2004*. Washington, D.C.: Author. Retrieved April 27, 2005 from <http://www.nasbo.org/Publications/fiscalsurvey/fsfall2004.pdf>
- O'Brien, E. & Elias, R. (2004, May). *Medicaid and long-term care*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. Retrieved April 27, 2005 from [http://www.kff.org/medicaid/upload/36296\\_1.pdf](http://www.kff.org/medicaid/upload/36296_1.pdf)
- Ohio Office of Budget and Management. (2005). *State of Ohio executive budget: Fiscal years 2006 and 2007*. Columbus, OH: Author. Retrieved April 27, 2005 from

<http://www.obm.ohio.gov/budget/executive/0607/bb0607.pdf>

- Ormond, B.A. (2004, February). *State responses to budget crises in 2004: Florida*. Washington, D.C.: The Urban Institute. Retrieved April 27, 2005 from <http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=8765>
- Pandey, S. (2002). Assessing state efforts to meet baby boomer's long-term care needs: A case study in compensatory federalism. In F. G. Caro & R. Morris (Eds.), *Devolution and aging policy* (pp. 161-179). New York: Haworth Press.
- Pear, R. (2005, March 25). Cost-cutting Medicare law is a money loser for states. *New York Times*, p. 12
- Pettus, E. W. (2005, March 26). Lawmakers quickly pass final Medicaid cost-cutting bill. Associated Press Newswires. Retrieved April 28, 2005, from LexisNexis Academic.
- Reester, H., Missmar, R., & Tumlinson, A. (2004, April). Recent growth in Medicaid home and community-based waivers. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. Retrieved April 28, 2005, from [http://www.kff.org/medicaid/upload/36119\\_1.pdf](http://www.kff.org/medicaid/upload/36119_1.pdf)
- Reinhard, S., Hendrickson, L., & Bemis, A. (2005). *Using the minimum data set (MDS) to facilitate nursing home transition*. New Brunswick, NJ: Rutgers Center for State Health Policy Community Living Exchange. Retrieved April 28, 2005, from <http://www.cshp.rutgers.edu>
- Salo, M. (2004, June 25).  Presentation to the Molina Healthcare Board of Directors, Dana Point, California. 
- Schoeni, R.F., Freedman, V.A., & Wallace, R.B. (2001). Persistent, consistent, widespread, and robust? Another look at recent trends in old-age disability. *Journal of Gerontology*, 56(4), S206–S218.
- Smith, V., Kaye, N., Chang, D., Bonney, J., Milligan, C., Milne, D., Mollica, R., & Shirk, C. (2005). *Making Medicaid work for the 21<sup>st</sup> century: Improving health and long term care coverage for low income Americans*. Portland, ME: National Academy for State Health Policy. Retrieved April 28, 2005 from [http://www.nashp.org/Files/Making\\_Medicaid\\_Work\\_for\\_the\\_21st\\_Century.pdf](http://www.nashp.org/Files/Making_Medicaid_Work_for_the_21st_Century.pdf)
- Smith, V., & Moody, G. (2005, February). *Medicaid in 2005: Principles and proposals for reform*. Lansing, MI: Health Management Associates. Prepared for the National Governors Association. Retrieved April 28, 2005, from <http://www.healthmanagement.com/files/NGA-HMA-23Feb2005.pdf>
- Smith, V., Ramesh, R., Gifford, K., Ellis, E., Rudowitz, R., & O'Malley, M. (2004,

January). *The continuing Medicaid budget challenge: State Medicaid spending growth and cost containment in fiscal years 2004 and 2005: Results from a 50-State Survey*. Menlo Park, CA: Kaiser Commission for Medicaid and the Uninsured, October 2004. Retrieved April 28, 2005, from [http://www.kff.org/medicaid/upload/48004\\_1.pdf](http://www.kff.org/medicaid/upload/48004_1.pdf)

Stone R. (2000). Consumer-direction in long-term care. *Generations*, 24(3). Available at <http://www.generationsjournal.org/gen28-3/home.cfm>.

Sturm, R., Ringel, J.S., & Andreyeva, T. (2004). Increasing obesity rates and disability trends. *Health Affairs*, 23(2), 199-205.

Super, N. (2004, May 10). Medicare's chronic care improvement pilot program: What is its potential? *National Health Policy Forum Issue Brief* (No. 797). Washington, DC: George Washington University.

Texas DADS (2004). *The Revised Texas Promoting Independence Plan*. Found at [www.hhsc.state.tx.us/pubs/12XX04\\_tptp\\_rev.HTML](http://www.hhsc.state.tx.us/pubs/12XX04_tptp_rev.HTML).

U.S. Department of Health and Human Services: Administration on Aging (USDHHS). (2004). *A profile of older Americans 2003*. Retrieved April 28, 2005, from <http://www.aoa.gov/prof/Statistics/profile/profiles2002.asp>

Vermont Department of Aging and Independent Living (VDAIL). (2003, October). Vermont's long-term care plan: A demonstration waiver proposal to the Centers for Medicare and Medicaid Services. Retrieved from <http://www.dad.state.vt.us>.

Walker, D.M. (2005, April 12). *21<sup>st</sup> Century Challenges: Reexamining the Base of the Federal Government*. Arlington, Virginia: Government Accountability Office.

Weber, D. (2005, February 23). Fixing Medicaid is a long-term project. *Columbia Daily Tribune*. Retrieved April 28, from <http://archive.columbiatribune.com/2005/feb/20050223comm003.asp>

Weiner, J. (1998). Long-term care and devolution. In F.J. Thompson & J. J. Dilulio (Eds.). *Medicaid and devolution: A view from the states* (pp. 185-243). Washington, D.C.: Brookings Institution Press.

Weiner, J.M., Gage, B., Brown, D., Kramer, C., Maier, J., Moore, A., & Osber, D. (2004, July) Redirecting public long-term care resources. Administration on Aging. Retrieved April 28, 2005, from [http://www.hcbs.org/moreInfo.php/nb/doc/1121/Redirecting\\_Public\\_Long-Term\\_Care\\_Resources](http://www.hcbs.org/moreInfo.php/nb/doc/1121/Redirecting_Public_Long-Term_Care_Resources)

Weiner, J. (2005, March 15). *Medicaid reform discussion*. Washington, D.C: AARP.

Wheatley, B. (2002, December). *Disease management findings from leading state program: State coverage initiatives* (Issue Brief Vol. 3 No. 2). Washington DC.: AcademyHealth. Retrieved April 28, 2005, from <http://statecoverage.net/pdf/issuebrief1202.pdf>

Williams, C. (2004, September). *Medicaid disease management: Issues and promises*. Menlo Park, CA: Kaiser Commission and Medicaid and the Uninsured. Retrieved April 28, 2005, from [http://www.kff.org/medicaid/upload/46784\\_1.pdf](http://www.kff.org/medicaid/upload/46784_1.pdf).