Texas Public Policy Foundation

Assuring a Future for Long-Term Care Services and Supports in Texas

Report prepared for the Texas Public Policy Foundation
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Table of Contents

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Executive Summary

Texas Medicaid spending is on an unsustainable trajectory. The program's expenditures now consume 25 percent of the state budget, making it increasingly difficult to adequately address other vital state needs. With the recent recession and a slowly recovering economy, Texas is struggling to close budget gaps. The problem has been exacerbated by an increase in Medicaid enrollment and spending, which is a reflection of the tough economic times.

This is not the first time, nor is it likely to be the last, that the counter-cyclical nature of the Medicaid program has created a heavy burden on the state. Although reductions have been seen in services and provider payments, the state's ability to meet other important commitments continues to be challenged. Even in good economic times, Medicaid spending has outpaced growth in state tax revenues. With new federal mandates and changing demographics, the budget needs of the program will consume more and more of the state's available revenues. Under the existing program structure, there is no relief in sight.

Texas Medicaid expenditures totaled approximately $28 billion in 2011. The largest share of total Medicaid spending, nearly 23 percent, provides long-term care services and supports to roughly 400,000 aged and disabled Texas Medicaid enrollees.[1] With an existing interest list for long-term community-based care services exceeding 100,000 people, and the senior population projected to double by 2030, the demand for and cost of these services will continue to expand. There is little room within the existing Medicaid structure to divert resources to pay for this growing long-term care expense given the limited availability of optional programs or benefits on the acute care side of the program. Bottom line, with the entire program consuming 25 percent of the state budget, there is little room to infuse more state revenue into the program.

The Medicaid program structure itself is much to blame for today's problems. The federal-state matching program creates enticing opportunities for states to maximize federal funding. An open-ended ability for Texas to draw down federal dollars with relatively modest state contributions has grown the program well beyond its intended scope. Despite the recognition that the state is on a financially deleterious path, perverse incentives persist. Federal restrictions on state reductions, together with the natural reluctance on the part of the state to reduce state expenditures when it can mean a two-fold loss of federal contributions, make it almost impossible to rein in Medicaid program costs. As such, it is time to discuss fundamental reform of the Medicaid program.

Fundamental structural change must begin by ending states' open-ended entitlement to federal funding. This can be done by eliminating the link between state contributions and federal matching payments, through a federal block grant to the states. The federal government would benefit from a defined and predictable expenditure trend line, and the state from a steady federal revenue source. States would be motivated to clarify goals and manage programs efficiently. It would provide states with flexibility in how to best meet program goals as well as increase state accountability for program outcomes.

Within a block grant, Texas could restructure its long-term care delivery system to better meet the needs and preferences of its residents while also staying within budgetary constraints. One such approach would be to modify the Medicaid benefit entitlement. The current "one size fits all" approach often entitles Medicaid enrollees to unnecessary, even unwanted benefits, and has the unintended consequence of providers receiving de facto entitlement to provide a broad range of services to enrollees.

The approach put forth in this report could function within the context of a block grant scenario. It would establish and fund financial accounts for enrollees to purchase long-term care services and supports (LTCSS). The funding

amount would be based on the needs of each individual, with assessments being performed by independent, accredited professionals. Providers would be pre-approved and regulated by the state (using sufficient, but not excessive regulation). The approach to creating the participating pool of providers should foster quality, price competition, and innovation; thus, providing program participants the best value, as well as appropriate and preferred care. The program participants would retain unused funds for future care and support needs.

Nursing home care would be excluded from this system, but still be a covered service financed through the traditional Medicaid structure. The level of care threshold for Medicaid approval of nursing home placement could be set at a high, but reasonable level to maximize the use of community-based care. Institutional care would only be used when less expensive community-based options have been exhausted. Systems would be established to ensure that the long-term care services and acute care services are coordinated and not duplicative.

Moving to a defined level of financial support will provide budgetary control with options to address potential budget shortfalls. With a defined financial benefit, the State, if need be, could uniformly reduce all participants' future allocations, prioritize the provision of services based on the level of need, or increase the state contribution.

It is important to remember that while any significant reduction in spending will involve painful trade-offs, the unsustainable nature of the current spending trajectory mandates that action be taken. The framework proposed here offers several advantages. It will turn program participants into engaged cost-conscience participants, providing them with real incentives to use cost effective services. It will foster competition within the provider community, keeping prices in check and encouraging innovation. Finally, the approach will allow Texas to refine benefit entitlements to target individual care needs, while taking into account financial and informal support circumstances.

This major restructuring is not an immediate solution to Texas' current budget issues. As such, incremental program changes that could have a short and medium term impact are also discussed. Options at the forefront of current discourse between Texas officials and advocates include:

1. Tightening up the estate recovery program
2. Eliminating Miller Trusts
3. Including nursing home, 1915(c) waiver, and other long-term care populations in the dual eligible integrated care demonstration project
4. Requiring Supplemental Security Income (SSI) children to be enrolled in risk based managed care
5. Instituting parental financial contributions for children receiving LTCSS
6. Using waivers to provide a more limited entitlement for LTCSS
7. Imposing some financial responsibility on adult children whose parents are receiving Medicaid coverage for LTCSS
8. Adopting some different approaches to providing community care
9. Competitively bidding nursing home care.
10. Closing or downsizing the Texas State Supported Living Centers

Some of these changes can be accomplished in the short term; others would likely require a waiver or could be incorporated as part of a more comprehensive restructuring of the program.

Introduction

In the aftermath of the financial collapse and recession of 2007–2009, the State of Texas has experienced severe budgetary turmoil. According to various sources, the Governor and the Legislature were forced to close a budget gap of approximately $15 billion in 2011. And again in 2013, the state is forecasting a shortfall of $10 to $13 billion in the 2014-15 budget that must be closed.[2]

This is not the first time Texas has faced daunting fiscal challenges. During the less severe economic downturn in 2002–2003, the state government also faced a substantial budget shortfall, in large part because of rapid growth in the State's Medicaid program. And while it is certainly the case that the current crisis had origins outside of health care spending, there is no question that the growing burden of Medicaid has made it more difficult for Texas—and other states—to emerge from the crisis on sound financial footing for the future.

Indeed, over the last four decades, Medicaid has become the most pressing and intractable problem in states' budgets. According to the National Association of State Budget Officers (NASBO), state spending on Medicaid was roughly equal to 16 percent of state budgets in the early 2000s. Today, states are spending at least 23.6 percent of all state revenue on the Medicaid program.[3] Even in good economic times, states, including Texas, have struggled to prevent rising Medicaid spending from crowding out other priorities. But when economic times are bad, it becomes nearly impossible for states to cover Medicaid's costs and still meet other state commitments.

Consequently, states have a great interest in finding a solution to the perennial problem of Medicaid cost growth. The search, however, is substantially complicated by the fact that the program has split political accountability. The overall structure for the program is found in federal law, and much of its financing comes from the federal government. But it is the states that must administer the program and live with the consequences of rising costs within a construct of state governance that generally requires a balanced budget.

In recent years, proposals have been advanced at both the federal and state levels to fundamentally change how Medicaid operates. In particular, the U.S. House of Representatives passed budget plans in 2011 and in 2012 that called for converting Medicaid from a federal-state matching program into a federal block grant to the states.[4] Some states have begun considering how they might reform parts of Medicaid to make the program more sustainable within a block grant.

Indeed, a previous report published by the Texas Public Policy Foundation examined how to reform Medicaid in the State of Texas for the non-elderly and non-disabled participants (mainly women and dependent children).[5] This report is a companion to that earlier study and examines the rest of Medicaid—that is the services provided to the elderly and permanently disabled who are in need of extensive support in their daily living activities.

The aim of this report is to provide recommendations to the State of Texas on how to reform its Medicaid-financed long-term care program so that it becomes sustainable and affordable for Texas taxpayers while also providing high quality services to those who are truly in need.

Basics of Medicaid in the State of Texas

There are three basic components to the Medicaid program: eligibility, coverage, and payment. For each of these components, the federal government mandates certain minimum requirements and offers states some optional program elements.

These components are the three levers the states can use Medicaid to meet the needs of their low income and medically needy populations in a sustainable manner that is responsible to its taxpayers.

Beyond these three levers, expenditures and budget are also an important component of the Medicaid program. The ability to control expenditures and provide an adequate state budget is a major concern to states—and states' ability to meet these needs vary with their economic stability. Texas is actively examining its options and has included some budget control measures in its 2014–15 budget proposals.

Details on each of these five important program components and concerns are provided on the following pages.

Eligibility

Medicaid eligibility is defined as either "categorically needy" (need based on income) and/or "medically needy" (need based on health needs). People eligible for Medicaid coverage include low income children and their parents, pregnant women, the aged and disabled, and low income individuals age 65 or older, many of whom also receive Medicare.

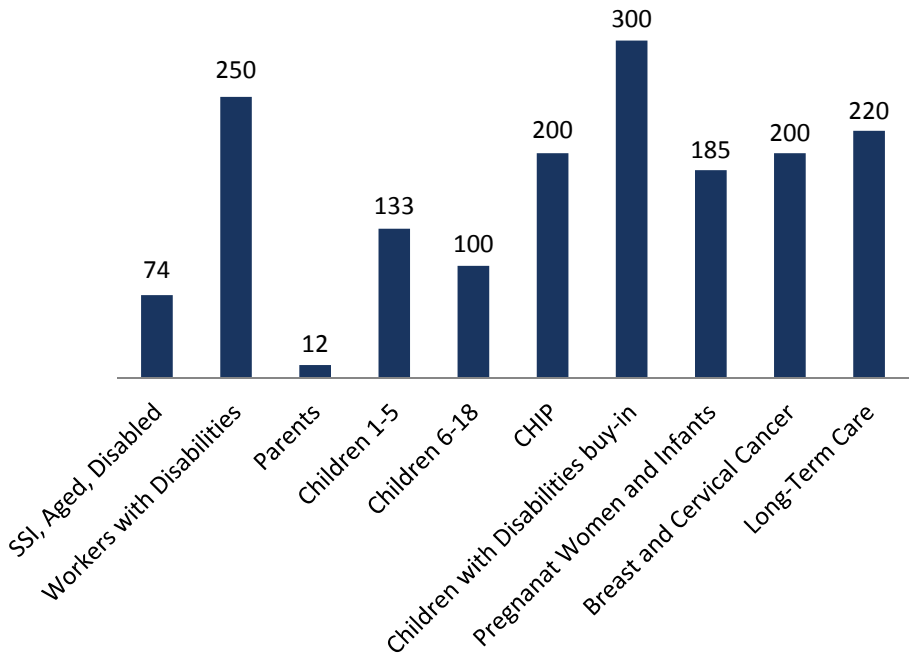
Texas covers few optional eligibility groups. The optional categorically and medically needy groups are limited primarily to pregnant women, infants, and some children for whom the state has legal responsibility to provide care. The largest optional group is pregnant women and infants up to 185 percent of the federal poverty level (FPL). (The federal minimum is 133 percent FPL.)

Texas is conservative in setting its eligibility thresholds. Most eligibility income and resource thresholds for acute care Medicaid services are set at the federal minimum levels. Coverage for seniors, persons with disabilities, and the blind is provided for SSI recipients with an income level of approximately 75 percent FPL. The income level for other non-pregnant adults is 12 percent FPL. Texas also provides coverage for several discrete populations, including uninsured women with breast and cervical cancer, and buy-in programs for workers and children with disabilities. Resource limits are generally set at the federal minimum of $2,000 for an individual and $3,000 for a couple. The breakdown of the Texas Medicaid program's various income levels is displayed in **Figure 1**.

Medicaid enrollees who use long-term care services are typically the elderly and disabled; those receiving cash benefits under the SSI program (or aged, blind, or disabled individuals who meet state criteria that were in place as of January 1972 and are more restrictive than SSI's eligibility criteria); low income individuals over 65 needing assistance; and those individuals for whom Medicaid pays Medicare premiums and cost-sharing, but do not qualify for full Medicaid benefits. It is estimated that up to 400,000 Texas residents receive Medicaid long-term care services and supports.[6]

Eligibility thresholds for the long-term care (LTC) programs offered in Texas are generally more generous than the

Figure 1: Program Income Limits as Percent of Poverty, 2012



Source: Presentation to SB 7 Medicaid Reform Waiver Legislative Oversight Committee by Thomas M. Suehs, Executive Commissioner, HHSC; Billy Millwee, Deputy Executive Commissioner for Health Services Operations, HHSC; Chris Traylor, Commissioner, DADS, Feb. 29, 2012

thresholds for the acute care programs. As with the majority of states, Texas has adopted the optional "special income level" of 300 percent of the SSI benefit level as its income limit for those in long-term institutional care and those in home and community-based services (HCBS) waiver programs. Currently this is $2,094 per month.[7]

Because Texas does not have a medically needy program for institutional care, it is required to allow individuals to utilize Miller Trusts (*see Sidebar*). These Trusts permit those using institutional care to divert, and thereby exclude income exceeding the $2,094 income limit in order to meet income thresholds.

Texas has also opted to use "institutional deeming rules" in its HCBS programs, meaning that the income of spouses and parents are not counted in financial eligibility determinations. In its spousal impoverishment rules, Texas allows the community spouse to retain the maximum allowable amount of income.

Coverage (Benefits)

Like eligibility, some benefits are federally required and some are optional. The following services must be covered for the categorically needy:

- Inpatient and outpatient hospital services
- Physician services
- Medical and surgical dental services
- Nursing facility services for individuals aged 21 or older
- Home health care for persons eligible for nursing facility services
- Family planning services and supplies
- Federally qualified health center and rural health clinic services
- Laboratory and X-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under age 21

Commonly covered optional services include prescription drugs; clinic services; nursing facility services for those under age 21; intermediate care facilities for persons with an intellectual and developmental disability; optometrist services and eyeglasses; and dental services. States also have the option to provide certain individuals home and community-based services, including case management, personal care services, respite care services, adult day health services, and home health services.

Texas uses a minimalist approach in its Medicaid benefit package design. Many optional benefits are not covered for the adult population, including dental (with some exceptions), occupational therapy, speech and hearing services, dentures, and diagnostic and screening services. And for those optional benefits that are covered, service limits are common. For example, the adult in-patient hospital benefit has both a 30-day limit and an annual $200,000 limit.

In terms of long-term care, Texas provides a wide range of programs. In addition to the required coverage of institutional care, the state offers an array of optional com-

Sidebar: Miller Trust

A Miller Trust can be used when a state does not cover institutional care under the Medicaid medically needy option. Congress incorporated the concept into the Social Security Act in the Omnibus Budget Reconciliation Act of 1993, adopting concepts outlined in the Colorado court case Miller V. Ibarra, 746 F. Supp.19 (D. Colo, 1990).

The Miller Trust provisions require Social Security, pensions, and other periodic income to be disregarded in the eligibility determination for institutional care if the income is diverted to a trust where:

- The trust consists only of the income from the periodic income; and
- Amounts remaining in the trust are used to reimburse the state upon the death of the recipient.

The income diverted to the trust is considered in the determination of the individual's share of cost (see Title XIX Sec. 1917(d) (4) (B)).

munity-based approaches, although not all programs are administered statewide. These programs include managed long-term care, community support approaches to care, institutional diversion programs, and de-institutionalization programs.[8] A listing with a brief description of these programs is found in **Table 1** below.

Reimbursement

States have wide flexibility to determine payments rates. Generally states pay fee-for-service (FFS) rates to providers or capitated payments to managed care plans. For FFS, states must assure that payments are consistent with efficiency, economy, and quality of care standards and sufficient to enlist enough providers so that care and services are adequately available in the geographic area. In addition, the state cannot pay more than upper limits, based on Medicare payment principles. For managed care capitated payments, the state must assure that the rates are actuarially sound.

Texas has many LTCSS programs to divert beneficiaries from nursing homes. The following are the FY 2011 reimbursement rates for LTCSS:

- Nursing home per day rate of $125.96
- Texas STAR+PLUS per member per month rate of $808.46
- PACE per member per month rates are geographically based and range from $2,180.28 in Lubbock County to $3,941.51 in El Paso County.
- Home and community-based waiver program rates are based on the services provided, ranging from $29.69 for a licensed vocational nursing visit to $147.84 per day for pervasive companion care.

Table 1: Texas Long-Term Care Programs, 2012

STAR+PLUS	The program provides LTC services through managed care organizations. STAR+PLUS provides an alternative to nursing facility placement. Covered services include both acute and LTC services. Dual eligible and STAR+PLUS receive regular health care through Medicare and LTC services through a Medicaid HMO.
Program of All-inclusive Care for the Elderly (PACE)	PACE provides comprehensive community-based services and supports, including preventative, acute care, and long-term care services and supports for individuals aged 55 or older as an alternative to nursing facility care. PACE is available in the Amarillo, Lubbock and El Paso areas.
Community Based Alternatives (CBA)	Home and community-based services and supports are provided to persons in their own home, an assisted living facility, or in an adult foster care setting as an alternative to institutional care in a nursing facility.
Medically Dependent Children Program (MDCP)	This program provides home and community-based services and supports to families caring for a medically dependent child in their home who is under 21 years of age.
Home and Community-based Services (HCS)	Services and supports are made available to individuals diagnosed with an intellectual disability, or a related condition, and who are living in their family home or in another community setting.
Community Living Assistance and Support Services (CLASS)	Home and community-based services and supports are provided to individuals diagnosed with a developmental disability, classified as a related condition other than an intellectual disability, as an alternative to institutional placement.
Texas Home Living (TxHmL)	Services and supports are made available to individuals diagnosed with an intellectual disability or a related condition, who live in their family homes. Services include community support, adaptive aids, dental treatment, minor home modifications, skilled therapies, behavioral support, nursing, day habilitation,[9] employment assistance, supported employment, and respite care.
Deaf Blind with Multiple Disabilities (DBMD)	Home and community-based services are provided to individuals diagnosed with: 1) legal blindness, 2) a chronic, severe hearing impairment, or 3) a condition that leads to deaf-blindness resulting in impairment to independent functioning.
Money Follows the Person (MFP)	This program supports the movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community.

Expenditures and Budget

Despite tight eligibility, as well as conservative benefit design, Texas Medicaid spending growth has consistently outstripped the national average since 1990 (**see Table 2**). It is estimated the Texas Medicaid program, including CHIP, covers over 16 percent of state residents. The FY 2011 enrollment was approximately 3.5 million persons with an additional 577,000 CHIP enrollees. While Texas' percent enrollment is below the national average, the percent increase in monthly enrollment has been increasing at a faster pace than the national average for the past two years.[10]

Table 2: Average Annual Growth in Spending, FY1990 -FY2010

Fiscal Years	Texas	U.S.
FY1990-2001	12.9%	10.9%
FY2001-2004	11.6%	9.4%
FY2004-2007	8.1%	3.6%
FY2007-2010	9.7%	6.8%

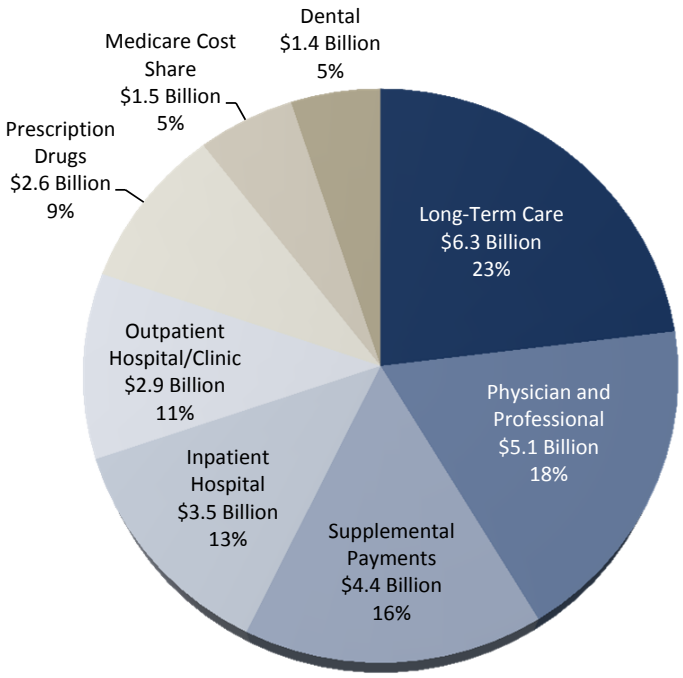
Source: Kaiser State Health Facts

Medicaid spending growth has been accelerating at a rate that far exceeds growth in Texas tax revenue. Compounding this problem is the fact that the percentage of federal financial participation has been declining over the past several years (**see Table 3**).

In 2011, Texas Medicaid expenditures totaled $28 billion. The largest share of the spending, $6.3 billion, or nearly 23 percent of the total Medicaid budget, was for long-term care services and supports. Another $1.5 billion paid for the State's Medicare cost share (**see Figure 2**).

Figure 3 (*next page*) shows how Texas' Medicaid expenditures are distributed across the different eligibility groups. As is typical in Medicaid, aged and disabled individuals account for the highest level of expenditures (58 percent),

Figure 2: Texas Medicaid Expenditures by Service Group, SFY2011



Source: Texas HHS presentation to the Texas Legislative House Appropriations Subcommittee on Article II: Medicaid (May 7, 2012).

but only a relatively small number of total enrollees (25%). Breaking down the 58 percent of program costs incurred by seniors and persons with disabilities shows that 28 percent are for long-term care services and supports, including STAR+PLUS. The remaining 30 percent are for acute care and Medicare premium payments.

Budget Proposals for 2014-2015

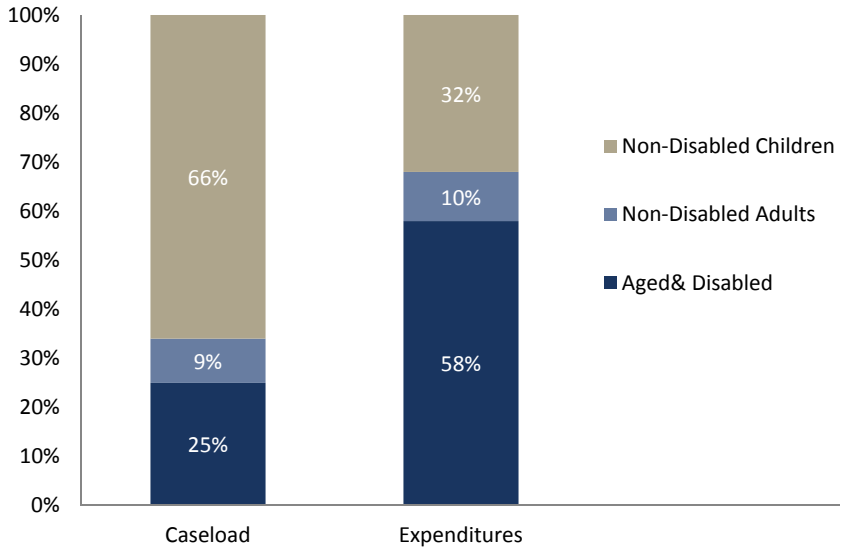
The Texas Department of Aging and Disability Services (DADS) is proposing to maintain its 2013 service levels in 2014–2015. The state will continue to encourage the movement of individuals into HCBS waiver programs rather than into institutional care facilities. It is expected that any

Table 3: Texas Federal Match Rate, FY2004-FY2013

YEAR	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13
RATE	63.17	60.87	60.66	60.78	60.53	69.85*	70.94*	60.56	58.22	59.30

Source: Kaiser State Health Facts
**Reflects ARRA enhanced FFP*

Figure 3: Texas Medicaid Expenditures Distributed Across Eligibility Groups, SFY2010



Source: Texas HHS presentation to the Texas Legislative House Appropriations Subcommittee on Article II: Medicaid (May 7, 2012).

increase in the average cost per individual served in these programs will be primarily due to inflation, acuity, and utilization.

DADS intends to continue this move toward greater use of community services by: 1) promoting independence; 2) preventing institutionalization and providing more community alternatives; 3) promoting Community First Choice in 2015; and 4) instituting a Balancing Incentive Program.

It is also proposing a statewide expansion of STAR+PLUS to include primary homecare (PHC), Day Activity and Health Services (DAHS), and Community Based Alternatives (CBA) programs.

In addition, DADS is proposing to expand the Program of All-inclusive Care for the Elderly (PACE). Currently Texas has three PACE sites in El Paso, Amarillo, and Lubbock, which share a total of 1,170 participants. DADS is planning to expand capacity for an additional 24 participants in Amarillo, 24 in Lubbock, and 48 in El Paso. In addition, it is considering two new PACE sites, to serve 150 clients each, to be phased in during FY2015.

Finally, Texas is hoping to receive approval of the dual-eligible demonstration waiver, which was submitted to the Centers for Medicare and Medicaid Services (CMS) in May 2012. CMS has been working with states to create demonstration grants to blend the Medicare and Medicaid funding streams, integrate benefits, and improve care coordination across the Medicare and Medicaid programs for the dually eligible population. Fifteen states received innovation grants and over half of the states are proposing demonstration projects to provide a more coordinated care approach to the population. Many of the proposals include enhanced coordination for the provision of long-term care services and supports, including institutional care.

Texas has proposed providing integrated Medicare and Medicaid benefits through a coordinated, managed care approach using a three party contract between the Health and Human Services Commission (HHSC), CMS, and STAR+PLUS managed care organizations. The target population of 214,404 (out of 328,500 persons state-wide) includes those who are dually eligible for Medicare and Medicaid in the State's most populous counties, excluding long-term nursing facility residents. It is predicted that this demonstration will increase quality of care and significantly decrease costs of caring for this population.

The STAR+PLUS plans will be accountable for all medical and behavior health benefits as well as long-term care services and supports and prescription drugs. The implementation target is January 1, 2014, but Texas, as well as most other states is still awaiting approval from CMS at the time of this writing.

The Block Grant Context

The budgetary pressures states have experienced due to rising Medicaid costs are also reflected at the federal level. Measured in constant 2012 dollars, total federal Medicaid spending has risen from $25.4 billion (or 0.4% of GDP) in 1972 to $282 billion (or 1.8% of GDP) in 2011, according to the Congressional Budget Office (CBO).

Medicaid's rapid rise in spending is heavily influenced by the rising costs of the broader health care system. But it is also the case that the fundamental design of Medicaid is inefficient. The system of federal matching payments for state-determined benefits (and therefore costs) is a major reason cost control is so difficult. For starters, this system, in which the federal government pays a fixed percentage of Medicaid costs based on a complex federal formula, has split political accountability, with neither the federal nor the state government fully in charge. As a result, neither level of government has taken ownership of solving the program's budgetary problems.

Cost control is simply difficult and unattractive for both federal and state politicians to address. Today, on average, the federal government pays for 57 percent of all Medicaid costs, and the states pay the other 43 percent. This arrangement makes cost control very unattractive for state legislators. For instance, in a state with a 60 percent federal matching rate, the federal government would pay $150 out of every $250 in Medicaid medical costs. However, if a state faced a budget crisis and needed to cut its Medicaid spending, legislators would need to cut $250 out of the program for the state to save $100. Put another way, legislators would have to inflict $250 of pain for the $100 budgetary gain. That's not a deal that many politicians would willingly accept.

Instead, many states have chosen to try to maximize their federal Medicaid matching payments, while minimizing state costs. This has been accomplished through two ways. First, states have sought, over many years, to move several previous state-only activities into the Medicaid program to take advantage of federal financing. For example, most states now use Medicaid to pay for a portion of the school transportation expenses for disabled children and for school-based health clinics.

Further, many states have also found ways to minimize their actual state contributions to Medicaid by artificially inflating certain provider payments rates to generate federal funding. Although the state mechanisms used to accomplish this are varied, they all entail selectively boosting certain provider payment rates to generate excess federal matching payments. The incremental additional dollars are then recouped and diverted to other state needs that may fall outside of Medicaid. These mechanisms have the effect of lowering the real (as opposed to the official) state matching payment for the program.[11]

As recognition of these problems has increased, interest has grown in reworking the Medicaid program to provide better incentives for efficient program design at the state level.

A primary focus of these efforts has been on converting Medicaid into a block grant program. Under a block grant, the federal government would provide states with a fixed level of federal financing, most likely based on historical spending trends. The level of federal financing would also factor in other considerations, such as state income and measures of families below certain income thresholds.

The benefits of a block grant for the federal government are straightforward. With a block grant, the federal government would get budgetary predictability. No longer would federal Medicaid spending be a function of state spending decisions.

Some state officials see great promise in a block grant. Under most block grant proposals, states would have near total control of program design, including the use of the federal Medicaid funding. It would entirely eliminate the need for federal approval of waivers and State Plan amendments, and would shift both the authority to run the program as well as the political accountability for program's performance to the states.

In its most basic form, a federal block grant is likely to provide states with an amount of funding that is tied to historical federal spending in the state, indexed in future years to grow with some appropriate measure of state inflation and population growth. For instance, in the budget proposal adopted by the House of Representatives in April 2012, the federal block grant to the states was indexed in future years to general inflation increases, as measured by the Consumer Price Index (CPI), plus population growth.[12] Other block grant proposals have increased the federal portion of the block grant each year by the CPI plus one percentage point, in addition to population growth.

In considering a block grant, states will undoubtedly want to reduce some of the risks associated with accepting a fixed block grant when certain variables can dramatically alter the need for Medicaid services. For instance, during an economic downturn, Medicaid enrollment typically rises rapidly and increases at a rate faster than overall population growth. States may want to press for a federal block grant that takes into account such factors in the formula. One example would be allowing the block grant to grow at faster rates during a recession and slower rates during periods of strong economic growth.

Independent of these block grant design issues, the real question for states is "what would they do if they had the freedom a block grant would provide?"

The remainder of this report is aimed at providing the State of Texas with a framework for how to redesign its Medicaid services for the elderly and disabled if the state were presented with such an opportunity in the context of a federal block grant.

Restructuring the Texas Medicaid Program for Long-Term Care Services

As discussed elsewhere in this report, the State of Texas has a number of available options to streamline eligibility and cut expenses for long-term care services and supports within a framework that is not altogether different from today's program. In other words, there are numerous ways to make the program more targeted and efficient without fundamentally altering the nature of the program itself. These reform options will need to be pursued aggressively to close budget gaps in the near and medium term.

But the state also needs to enact more far-reaching, structural changes to the program that will ensure the program can be sustained over the longer term.

Over the past four decades, Texas (and almost every other state) has had to grapple with periodic budget crises precipitated in large measure by the inability of the state to control Medicaid spending. In Texas, budget crises in 2002–2003 and 2012–2013 were driven in part by rapidly rising Medicaid spending.

Of course, to some degree, Medicaid spending growth is a reflection of cost trends in the broader health care system. But the absence of budgetary control over the program is also a function of how Medicaid is designed. Beneficiaries become entitled to benefits under the program if they meet certain eligibility criteria, some of which are under the control of the states, and some of which are not, as explained in the Basics of Medicaid eligibility section above. Moreover, once a beneficiary becomes eligible, the state is obligated to provide an array of "one size fits all" benefits and services. This sets up a dynamic in which the beneficiaries have strong incentives to qualify for whatever benefits they can, regardless of current need, and in which the providers have strong incentives to maximize their reimbursement for services.

This entitlement to a series of benefits is at the heart of the budgetary problem. To cut costs, the state carries the burden of pressuring those providing the services to do so less expensively. But the delivery of long-term care services and supports to the disabled and frail elderly is an exceedingly complex process that no state can fully manage centrally. The result has been a series of ad hoc efforts to rein in expenses in the face of the much more powerful forces of beneficiaries' and providers' incentives.

Reversing this kind of dynamic on a permanent and sustainable basis will require fundamental reform.

An Alternative Vision—Fundamental Reform

Fundamental reform of Medicaid long-term care in Texas starts with a top-to-bottom rethinking of the nature of the entitlement and what the state is delivering to persons in need.

As matters stand in Texas, and almost every other state, today's Medicaid program is essentially a service entitlement. When a person is found to be disabled and have an income below the eligibility threshold, the state pays for a designated set of services.

This approach has several problems associated with it. First and foremost, it creates a cast of service providers that, in a certain sense, have become part of the entitlement structure. The state is expected to provide financial support through Medicaid that is sufficient to ensure an adequate supply of service providers. This is, by its nature, a subjective judgment that becomes a disputed point in the political process. Inevitably, the state comes under great pressure to make all current providers available to the beneficiaries, which leads to favoring incumbents over new entrants to the detriment of innovation. It also places a floor on future cost cutting.

Second, the entitlement is an "all or nothing" approach. Many Medicaid applicants spend years trying to get on the program because they need help, but once they are on the program, they receive far more benefits than they actually wanted or needed.

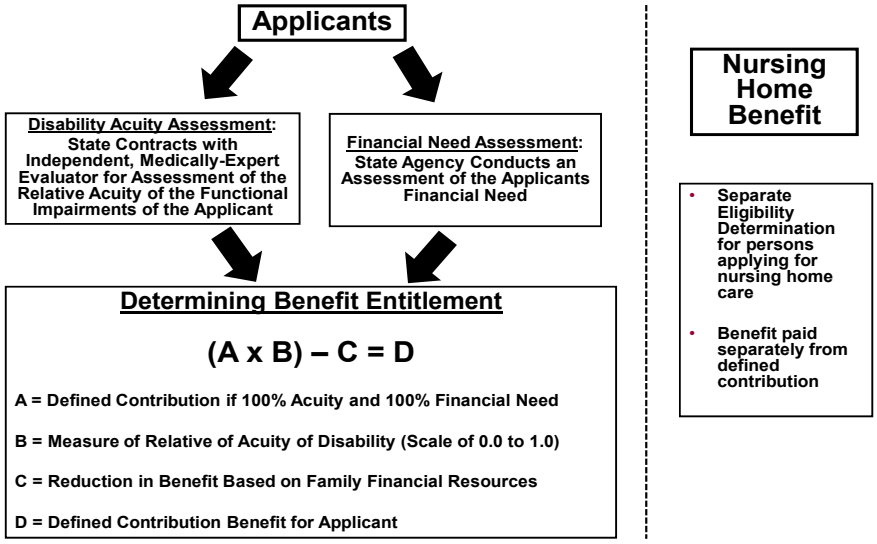
An alternative vision for Medicaid takes an entirely different perspective. Instead of trying to find and deliver services to which all Texas citizens are entitled (the mandatory services described in Section II, Basics of Medicaid), the state could instead provide a pre-determined level of financial support to the frail elderly and persons with disabilities. This financial support would be used, in turn, by the recipients to pay for the services they—and their family members or support network—decide they need, from providers of their own choosing.

This approach to restructuring the long-term care services and supports entitlement in Texas Medicaid is depicted in **Figure 4**.

The process begins by calculating what might be considered the maximum defined contribution payment for someone who needs significant support for their daily living activities, but has no financial resources of their own to pay for them. The state would make this calculation based on an assessment of existing usage of Medicaid program services by the frail elderly and disabled populations. The state would have the option of creating a single estimate that would apply to all applicants, or multiple estimates based on several subcategories of beneficiaries (such as the elderly, non-elderly disabled adults, and disabled children).

Medicaid applicants would then be assessed based on the acuity of their disabilities, relative to a person who would be entitled to the full defined contribution payment. This "disability acuity assessment" would need to be seen by the public as an apolitical and objective process, conducted in-

Figure 4: A Defined Contribution LTCSS Entitlement



dependently of budgetary or other pressures and based solely on the evidence of disability and functional impairment.

In addition to an acuity assessment, the state would then, as it does today, conduct an assessment of the applicant's financial resources and ability to pay for LTCSS. That assessment could include, as much as possible, a comprehensive look at the resources of the applicant and the applicant's family.

Accessing Services

The delivery of the benefit entitlement to the beneficiary would not come in the form of vouchers or checks issued by the state. Rather, once an applicant was found to be eligible for financial assistance, the state would establish and fund an "account" on that person's behalf from which the beneficiary could make payments to approved vendors for services provided by the program.

As shown in **Figure 5**, the state would then make available to the beneficiaries a list of approved vendors for the various services provided by Medicaid LTCSS. For instance, there would be vendors providing assistance with various activities of daily living, transportation, and other social services.

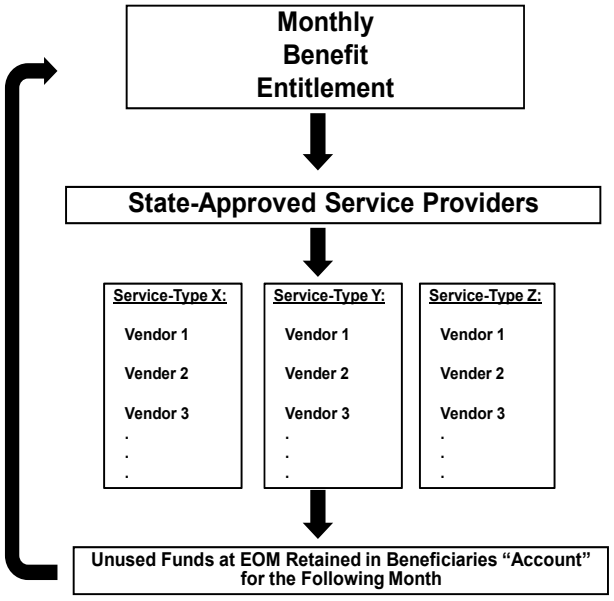
As much as possible, the state's regulations should meet the twin goals of maintaining a certain level of quality for the beneficiaries, while fostering strong price and quality competition among vendors. This will ensure that the program participants receive the highest possible value with the resources made available to them. In order to incentivize economizing behavior, the beneficiaries should be able to retain resources they do not use in one month for later use. Beneficiaries could thus "save" resources in their accounts to provide themselves with additional protection should they need more services in the future.

If Texas receives approval for its dual eligible demonstration proposal, and individuals are indeed enrolled in managed plans responsible for the full continuum of individuals' care, careful consideration would need to be given to the integration of this defined benefit, community-based long-term care account. However, it is likely this policy—resulting in more engaged enrollees with more tailored and cost contained community-based long-term care benefits—would be viewed as an attractive option to participating managed care plans.

The Nursing Home Exception

A crucial feature of this reform approach is its emphasis on keeping beneficiaries, especially the frail elderly, out of nursing homes as much as is clinically appropriate. In particular, the defined contribution payment is available only for non-nursing home long-term care expenses, and can be used only by beneficiaries who are not residing in a nursing

Figure 5: Accessing Services



home. If an applicant is found to need nursing home services, the defined contribution entitlement would end, and the nursing home stay would be financed through the traditional Medicaid structure (with perhaps greater program emphasis on competitive bidding for nursing home beds).

Excluding nursing home care from services covered by the defined contribution payment is necessary because of its high expense relative to community based long-term care services and supports. A key advantage of this reform, however, is that it promotes community-based services and, as such, thousands of Texans who might otherwise be sent to a nursing facility would be cared for in the community (*see Sidebar for a description of the Tennessee reform for an example of a similar approach*). Texas could achieve significant savings if institutionalized Medicaid-eligible people are moved out of the nursing home and into the community.

In order to "rebalance" the long-term care population (that is, to shift the percentage of individuals in need of long-term care from institutional settings to the community), criteria for entering a nursing home should be very strict. The presumption in nearly all long-term care cases is that support in the community is the optimal first line of defense, given both overwhelming preference of those in need of community based care, as well as the significant cost considerations. The state could maintain a separate application process for those who believe they need nursing home care, and that process should be sufficiently strict to ensure that, under this reform, more Texans find the help they need at home and in the community rather than in the high-expense institutional setting.

In Amarillo/Canyon, El Paso and Lubbock counties, Program of All-Inclusive Care for the Elderly[13] (PACE) sites provide an "in-between" alternative to institutional nursing-home care and HCBS waiver programs. PACE enrollees receive a rich and highly customized mix of acute and community based long-term care services and supports, including adult day care. And while not as expensive as institutional long term care, it is significantly more expensive than other HCBS. As such, individuals receiving either institutional care or enrolled in PACE sites in these service areas would no longer receive defined contribution entitlements. In effect, PACE would qualify for the nursing home exception.

Maintaining Budgetary Control

A primary benefit of using this approach to finance Medicaid LTCSS is that it would allow for on-going budgetary control in the context of a fixed block grant from the federal government.

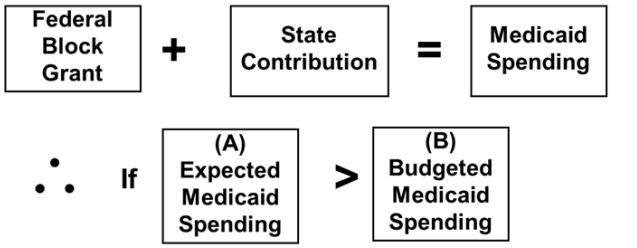
As shown in **Figure 6** (*next page*), the Medicaid budget is the sum of the federal funding from a block grant, plus whatever contribution is required or voluntarily provided by the states.[14] In the context of a federal block grant, the amount paid to a state is very likely to be known well in advance of the fiscal year in question based on whatever indexing formula is adopted in the federal block grant legislation. For instance, the federal block grant payable to a state might be based on the state's historical federal Medicaid funding, indexed to grow with inflation plus one percentage point, or at the rate of growth of the medical CPI.

To keep Medicaid LTCSS spending in line with the amount allocated under the block grant, the maximum defined contribution amounts established by the state could be set to grow at the same rate as the federal block grant. This would provide a link between the aggregate funding levels budgeted for the program and the amounts actually provided to the beneficiaries.

This linkage would not necessarily keep Medicaid spending within the state's budget, given that the number of program applicants might grow beyond what was expected, or that the acuity of the disabilities might worsen over time and thus push average benefit payments higher. Moreover, the financing of the nursing home benefit would remain outside of the control of the defined contribution system, and could be a source of excessive spending for the state.

In the event that expected Medicaid spending exceeded the amount budgeted for the program by the state, this reform would allow for adjustments to be made to other dimensions of state eligibility and its contribution levels in order to align spending with available resources. As noted in Figure 5, the state could apply a uniform benefit reduction factor to all defined contribution payments to bring overall spending back within the budgeted total. This approach to spending control could be automatically triggered and enforced by the state Medicaid office based on actual expenditure experience. However, this approach would reduce ben-

Figure 6: Options for Maintaining Budgetary Control



Then a state can:

1. **Apply a uniform budget reduction factor (BRF) to all defined benefit entitlement determinations [BRF = (A-B)/A]**
2. **Eliminate from eligibility the lowest acuity applicants**
3. **Eliminate from eligibility (or reduce benefits to) the applicants with the most financial resources**
4. **Increase the state's Medicaid contribution**

efits uniformly for all participants, including those most in need, and thus may not be viewed as equitable.

Alternatively, the state could choose to eliminate the lowest acuity beneficiaries from the program, or reduce benefits for those closest to the income eligibility cut-off. Of course, the state could also choose to increase the state contribution to the program, or pursue some combination of these options.

If the federal government were to move to financing Medicaid through a block grant, it is likely that the growth of the block grant provided to each state would be indexed to a pre-determined measure, such as consumer inflation. While there are a number of different approaches to indexing a block grant, something like inflation plus one percentage point would put the annual growth rate in the range of 3–4 percent annually. This growth rate would be well below the historical rate of growth of Medicaid spending nationwide and in Texas. From 2008 to 2010, Medicaid spending in Texas has risen at an average annual rate of 9.7 percent. That rate is expected to moderate with reforms the State has already implemented in recent years to close large budgetary shortfalls. Still, state spending is expected to continue to rise more rapidly than would be implied by a block grant.

Therefore, in a block grant scenario, Texas would need to take steps to ensure total program spending did not outpace the federal block grant. Otherwise, the state would be forced to cover the full differential between the rate of growth of the block grand and the rate of growth of total program costs. A block grant approach would not be financially sustainable unless it is enacted with systematic reforms and Medicaid is moved to a defined contribution system for LTCSS. If not, Medicaid costs may exceed resources allocated in the block grant.

How can Texas limit LTCSS cost growth to no more than 4 percent annually? **Figure 6** provides the framework for doing so. It begins with the conversion of the program's basic entitlement to a defined contribution payment. *That entitlement can be indexed to the same growth rate as the federal block grant.* That alone would substantially moderate overall cost growth for the State, but it may not be sufficient to stay within the State's budgetary goals because of other factors, such as nursing home care use and changes in the acuity assessments and financial resources of the patient population. Consequently, the state may need to control cost growth by employing the other cost-cutting options noted in Figure 6, including applying an across-the-board reduction in the defined contribution entitlement rate and restricting eligibility for benefits to those with the most severe disabilities and least family resources.

The potential budgetary benefits to Texas would be significant if the State successfully employed such a strategy, as indicated in the hypothetical scenario shown in **Figure 7**. In the chart, Texas' LTCSS spending is assumed to grow at an annual rate of 8 percent in coming years. *If* the state were

to successfully control that cost growth and bring it down to 4 percent each year, the savings would build over time. By 2020, it is anticipated that the State would be spending $6 billion less than it otherwise would if the program remained unreformed.

The Benefits of This Approach

This approach to Medicaid has the potential to fundamentally alter the cost structure of long-term care services and supports in three ways.

First, it will convert Medicaid long-term care beneficiaries, and their families, into active participants in the cost control effort. This is because the entitlement they would receive from the state would be a fixed amount, and not open-ended, as it often is today. This would give the participants and their families strong incentives to use the resources they are given as economically as possible and to focus them on the services that are most needed.

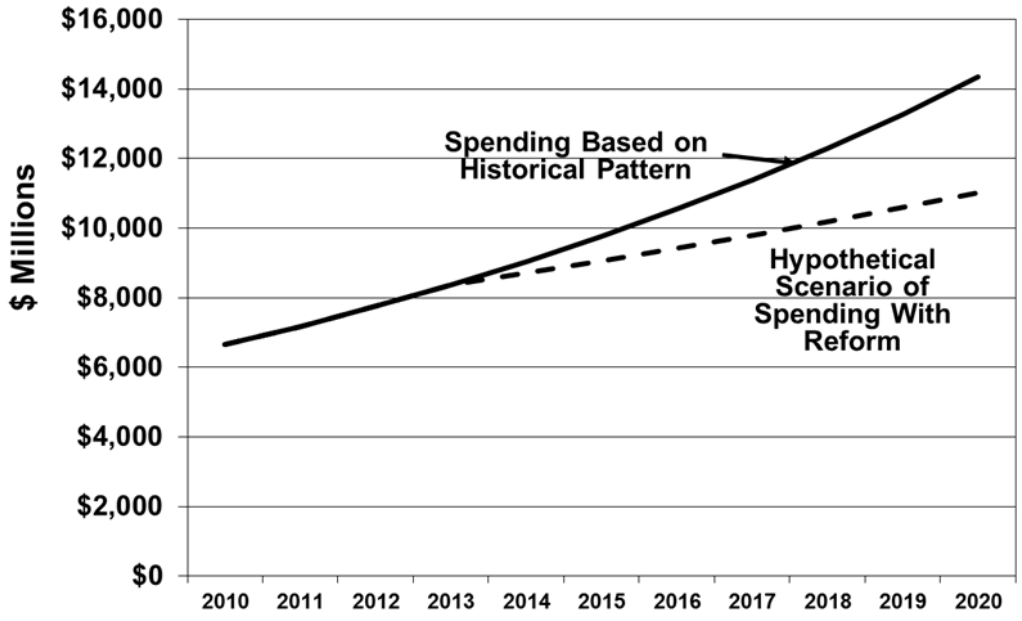
Second, it will foster competition, and therefore innovation, among service providers. The beneficiaries would choose within certain broad guidelines how to use their entitlement, and from which state-approved providers they would receive services. Any service provider wishing to garner a large share of the market would need to please the customers—the beneficiaries and their families—by offering good services at competitive prices. This kind of transparent price competition has the potential to weed out substantial costs.

Third, this approach would allow the state to establish much more refined levels of benefit entitlement, based on the acuity of the disability, the financial status of the family, and their ability (willingness and capacity) to provide some service support.

Near and Medium Term Options for Incremental Reform

Given this strong demand for services and the immediate need for containing expenditures, the Texas community is looking near and medium term policy options to contain program costs. Many of these incremental reforms are discussed below. In discussions with state leaders, many of these policy changes appear to have potential for nearer term budget impact. It is not clear that all of these policy changes can be easily or quickly implemented. Many would require a State Plan change; others would likely require a waiver or could be instituted in the context of a block grant approach. Incremental options for reform include:

Figure 7: Projecting LTCSS Spending



Sidebar: Reform in Tennessee

The latest update to the consolidated 1115 waiver, TennCare Choices program, is that it received federal approval and was implemented on July 1, 2012. The program created a new category of patients who are considered at-risk individuals for institutional care and whose benefits are not currently linked to nursing homes. This program was based on the finding that 40 percent of elderly Medicaid patients receiving community benefits before this change spent less than $15,000 per year in assistance for home-based services prior to needing institutional care. Alternatively, those individuals who did not receive these services and needed nursing home or community-based care, under the institutional level of care requirement, cost up to $55,000 a year. Tennessee hopes to save $47 million from the new program in this year alone.

The program works by revising the current requirement that individuals meet a weighted point threshold standard based on their "activities of daily living" for institutional services. The concept is to change the determination of need from a specific threshold diagnosis to a sliding scale so that patients who may be close to institutional or more comprehensive HCBS can be provided less expensive and more adequate care. This allows healthier patients, who currently qualify for nursing home care, to receive services in a more appropriate and often preferred community based setting, while lessening the future cost burden to the state.

Tightening Estate Recovery Processes

Texas was a latecomer in instituting an estate recovery program in 2003. States with more experience in estate recovery programs achieve varying levels of returns based on the nature of their programs. A 2005 U.S. Department of Health and Human Services report showed wide disparity in estate recovery program collections, not only in the gross amounts collected, but also in the relative percentage of the state's long-term care expenditures. The reported collections varied from nearly 0 percent of nursing home expenditures in Alaska, Louisiana, New Mexico, Texas and Utah to 10.4 percent in Arizona.

Policy options include varying state definitions of "estate" and varying services that are subject for recovery. Texas has taken few options in its estate recovery program. A comparison of the Texas State Plan to that of Arizona's shows some stark differences.[15] Arizona imposes TEFRA liens, it collects funds for almost all State Plan services, and it sets a hardship exemption based on the need for low-income heirs at 100 percent FPL. In contrast, Texas does not impose TEFRA liens; it limits the services tagged for recovery, and sets the low-income threshold at 300 percent FPL.

In 2011, Texas estate recovery collections were $4,482,809. They appear to be increasing for SFY2012, with collections totaling $4,700,449 through May 2012. However, both figures are about two-tenths of a percent of the Texas nursing home budget.

Across all states, there was only a weak connection between the policy options taken by a state and the amount of recovery, although the states with the fewest policy options tended to have lower recovery amounts.[16] Given the budget situation of the Texas program and the very low level of recoveries, it is worth reexamining the choices Texas has made with respect to its estate recovery program design.

Eliminating Miller Trusts

Texas has no medically needy program for those in need of institutionalization, and hence is required to allow the use of Miller Trusts, as discussed in Section II. Like most other states, Texas set its income limit for institutional care (and most of its home and community based LTCSS) at 300 percent of the SSI payment level. However, because Miller Trusts are allowed, there is effectively no upper income limit on eligibility for institutional long-term care. The perception of program administrators is that Miller Trusts are widely utilized and several believe savings could be realized by setting a ceiling or sliding scale on income eligibility. In addition, such a change would also send a clear message that the program is intended to cover only the needs of low income residents. Texas has the option of setting the income limit anywhere between 100 percent and 300 percent of SSI.

It is important to note that a hard income limit for institutional services could result in a payment gap in cases where an individual's income exceeds the Medicaid income limit, but is too low to pay for nursing home care at the private pay rate. At the income limit of 300 percent of SSI, this gap will be over

Sidebar: Reform in Rhode Island and Vermont

Both Rhode Island and Vermont have implemented a consolidated 1115 Waiver to reform long term care. Similar to Tennessee, both restructured and redefined level of care needs to provide more community based services and less institutional services. Rhode Island has established an accessible and comprehensive system of coordinated care that focuses on independence; ensures that all Medicaid beneficiaries have access to a medical home; and establishes health care outcome incentives. Some of the specific initiatives are: 1) the Nursing Facility Transition project; 2) the Shared Living program; 3) revising the Medicaid buy-in program for adults with disabilities who seek to gain or maintain employment; and 4) continuing to encourage use of Money Follows the Person. For the 2nd quarter of 2012, the State transitioned over 1,100 individuals to a community setting.

Vermont has a "Choices for Care" waiver which created a level of care criteria that results in fewer participants qualifying for nursing facility services. This waiver includes individuals who are in need of long-term care services or at risk of requiring nursing facility services. This waiver created an entitlement to Home and Community Based Services for individuals with the highest need for services and also implemented a person-centered assessment and options counseling process to identify what services would be needed to enable individuals to remain in their own homes. From 2005 to 2011, nursing home enrollment dropped from 66 percent to 52 percent and the use of community based settings jumped from 34 percent to 47 percent.

$2,000 per month. Many whose incomes fall in this range would be unable to access nursing home care. The inability to access nursing home care when there is a clinically appropriate need for institutional custodial care could create hardships on families trying to give care when they are not equipped physically, emotionally, or financially. This issue is particularly pronounced for those just above the income limit.

Given these serious issues, Texas could consider setting a cap on the amount of income allowed to be diverted into the Miller Trust equal to the average cost of nursing home care, assuming no maintenance of effort barriers. While several states use this approach, it is not clear that there would be appreciable savings. However, under a waiver or block grant scenario, Texas could consider setting a harder income limit. Under this cap scenario, consideration should be given to setting a future date for the change and beginning to aggressively educate Texans about the need to begin planning for their long-term care needs.

Include the Nursing Home and other Long-Term Care Populations in the Dual Eligibles Integrated Care Demonstration Project

As discussed in Section II, Basics of Medicaid, HHSC submitted its application to CMS for the dual eligible integrated care demonstration project in May 2012. While most dually eligible in the Texas Medicaid program are enrolled in the Texas managed long-term care STAR+PLUS program and/or a Medicare Advantage or Special Needs plan (MA/SNP), only a small percentage are enrolled in the same MCO for both Medicaid STAR+PLUS and the Medicare plan. Having one plan manage medical care and another manage long-term care or behavioral health does not lend itself to well-coordinated care across the care continuum. Hence, the dual eligible demonstration proposes to combine Medicare and Medicaid funding streams in to one combined capitated payment to selected plans that will provide fully integrated medical and behavioral health care, LTCSS, and prescription drugs. The target population is 214,400 non-institutionalized dual eligibles.

The proposal will include the following program elements:

- A comprehensive provider network that will provide the full array of Medicare and Medicaid services,
- Person-centered medical homes, and
- A single care coordinator to assist in the development of person-centered plans of care to facilitate access to community-based care whenever possible.[17]

The proposal excludes from participation significant portions of the long-term care population, including:

- Persons in nursing facilities, Intermediate Care Facilities for Persons with an Intellectual and Developmental Disability, and residents of Institutions of Mental Diseases or State Hospitals.

- Persons enrolled in 1915(c) programs.

Several other states, including Wisconsin, North Carolina, Connecticut, and California are including nursing homes residents and those in 1915(c) waiver programs in their dual eligible integration demonstration proposals. By including these populations, there are opportunities for: 1) enhanced integration across the care continuum; 2) program savings from reduced incentives to cost shift across programs; 3) improved transitions between institutional care and community care; and 4) overall enhanced flexibility in rebalancing the long-term care system.

Several in the Texas community stated that they support the inclusion of the institutionalized and 1915(c) populations. While it would take time to plan and implement the inclusion of these populations into the demonstration, solid experience from Money Follows the Person, STAR+PLUS, and other long-term care population programs serves as a strong basis for this proposal.

Integrate all Disabled Children into Risk-Based Managed Care Plans

Currently, Texas does not require children age 20 or under to enroll in its STAR+PLUS programs. Some have questioned whether this exemption should continue. A 2010 survey conducted by the Kaiser Commission on Medicaid and the Uninsured reported that 26 states mandated the enrollment of SSI children in managed care in at least one program or geographic area.[18]

Texas has solid experience using managed care for less acute populations and is gaining experience using managed care for the adult population with disabilities. Given voluntary enrollment is currently allowed for SSI children, both the state and the managed care organizations have experience managing the health care needs of this population as well as the necessary provider networks. So while it can be argued that Texas is well positioned to take the next step and mandate managed care enrollment for SSI children, some caution should be taken.

The driving force for many of these recommendations is the need to get better control of the Medicaid budget. As such, there are actions targeting both short term and long term budget elements of the program. The movement of the SSI population into mandated managed care could be looked at as a long term return as there is little evidence that Texas will realize a short term financial gain. The short term advantages would likely be better coordination of care for children with serious and often multiple health care needs who require services from a disparate group of professionals (this assumes that the managed care plans can provide strong provider networks and enhanced coordination of care). In the long term, better coordination of care will result in program savings.

Require Financial Contributions from Parents of Children Receiving Long-Term Care Services

Under federal law, when a child becomes institutionalized, the parents' income and assets are not considered in the eligibility determination. While states have the option of using either the community or the institutional deeming rules in their HCBS waivers, most states use the institutional rules to avoid unnecessary costly institutionalization of members of low and moderate income families. There has not been the option to find a middle ground between the two extremes of considering all non-exempt parental income and assets or not considering any parental income and assets.

The result of the eligibility constraints, family preferences, and the cost differentials between the care settings is that many families who could help pay for the care of their children, as well as some who could fully pay for their child's care without hardship, are not financially contributing to their child's care. While caring for children with severe medical and functional needs in the home results in the parents providing much of the care and support without compensation, Texas' current financial situation may require a more direct financial commitment from parents. Several persons in the Texas community suggested that parents could provide some financial contribution; as such, DADS is researching ways to approach this and is looking to other states which have initiated cost sharing requirements.

In its July 31, 2012 presentation to the Texas Senate Committee on Health and Human Services, DADS provided examples of four states that have implemented a parental fee program. The Department points out that under the federal maintenance of effort provisions, Texas cannot deny services to a child because of a parent's failure to contribute to the cost of care. There may, however, be other ways to move toward obtaining some parental support.

Texas could consider, for example, approaching the support obligation as it would child or medical support. In this situation, the assessment becomes a support obligation monitored by a state collection authority, similar to any other child support requirement that would be collected by an IV-D agency. This process takes the collection out of the child's eligibility process. There may also be some utility in graduating payment amounts based on the care setting; for example, the state could assess a higher amount from parents if the child is in an institution or residential care facility and a smaller amount if the child is cared for at home. This approach would help account for the care, as well as the support, the parents provide in the home. It would also provide financial incentive to continue to care for the child at home.

Consider Filial Responsibility

While not explicitly recommended by individuals in the Texas community, another area of growing dialogue is the feasibility of obtaining fee support from adult children of individuals in need of long-term care services. This is not a new idea, but has generally fallen off the radar since the advent of Social Security, Medicare, and the Medicaid entitlement. A good description of the issue, including the implications for Medicaid long-term care funding, can be found in a 2005 brief by Matthew Pakula written for the National Center for Policy Analysis.

Currently, 29 states have filial responsibility laws (although they are rarely enforced). Texas is not among the 29 states with such laws.[19] As with parental contributions to children's care, there are a variety of ways to structure a program that establishes adult children's financial responsibility to parents' care.

Texas could consider linking adult children's financial responsibility to the transfer of assets. Currently there is a five-year look back period on asset transfers. While it would be difficult to increase the look-back period for asset transfers, if transfers are made to children, it is reasonable to expect the children to help cover the cost of their needy parents beyond five years. So, rather than deny coverage to the person in need, Texas could impose an assessment on the recipients of the beneficiary's prior transfer. There may also be an argument to use a similar approach in situations where exempt assets will be inherited.

A more comprehensive approach would be to establish a legal financial support obligation on the children of indigent parents needing nursing home or community based long-term care. The obligation could be placed on all children utilizing a sliding fee schedule based on the individual child's available resources and income. While the support collections may not cover the full cost of care, such collections would help mitigate the cost to the State and could be constructed to provide incentives to care for the parents in alternative settings.

As with many of the proposed approaches to reducing the public funding obligations for long-term care, there are numerous policy and operational challenges in establishing filial responsibility. Consideration will have to be given to issues around the varying financial standing of children, the maze of family structures that exist in today's society, and enforcement. Such policy shifts may require either a waiver or the flexibility of a block grant.

Partial Entitlement to Benefits

Medicaid offers a benefit package that allows qualifying individuals to remain in the community rather than be institutionalized. A common observation of many in the state is that the full benefit package, coupled with a lack of patients' sense of authority over delivered care, often leads to unneeded and unwanted services. A recommended way to control this over-utilization is to eliminate the full entitlement to services and enable individuals to self-direct their care. An individual's qualified services and customized benefit package (or voucher allocation) would be determined through an individualized needs assessment. The expected result would be a tailored benefit design that would likely be preferred by the individual and less costly to the state. This approach could also work within a managed care environment, which may also allow for the substitution of additional customized cost effective services on a case by case basis.

ADAPT of Texas has outlined other policy shifts that could accompany this approach, including the adoption of a single point of entry into the system and the consolidation of the various HCBS programs. A uniform financial and level of care assessment tool would determine service eligibility at the single point of entry. Using the assessment report, an individualized service package could be authorized, based on a common set of service definitions. These changes would allow the state to better control entry into the long-

Evidence from other states has shown that the cost of serving individuals in community-based settings is much lower than the cost of serving individuals in institutional settings.

term care system and therefore better enable it to set budgets and ensure that provider rates are equitable across the service spectrum. Such changes could also carry over into managed care contracts, enhancing provider networks and individual services, along with providing the state with more budget predictability.

Pursue Additional Options for Providing Community Care to those Currently Residing in an Institution

Evidence from other states has shown that the cost of serving individuals in community-based settings is much lower than the cost of serving individuals in institutional settings. Maryland, for example, realized close to a $2,000 PMPM saving in each of its waiver programs by switching long-term care recipients to home and community based services. Texas has been aggressive in pursuing options to reduce institutional care, including developing a variety of waivers, adopting the Money Follows the Person initiative, and instituting managed long-term care initiatives (see Section II, Basics of Medicaid, for specifics). Indeed, Texas ranks 8th in the nation with respect to the percentage of its long-term care population receiving services in the community versus in an institutional environment.[20]

However, further progress could be made. One barrier is the lack of affordable housing suitable for HCBS participants. While current federal HCBS guidelines do not allow for the payment of housing, some states have found that providing assisted-living housing coupled with solid care management to be a less costly alternative to nursing facility care. Given more flexibility, Texas could consider paying, or having providers pay for assisted living or other living arrangements for some individuals who are eligible for a nursing home level of care. Alternatively, the state could assist the recipient in obtaining these living arrangements through select cost-effective contracts.

Nursing Home Competitive Bidding

Like most states, Texas reimburses nursing homes on a FFS basis. Hence, there is little price competition among Texas nursing homes, even with the homes having low occupancy rates. The state may want to consider a competitive bid process that would reduce the number of Medicaid contracting nursing homes, increase the census in the contracting homes, and potentially reduce the prices for services.

Implementation of competitive bidding would have to be done with great care and planning. There would likely need to be a lengthy transition period to minimize the relocation of nursing home residents. Additionally, it would be prudent to construct the bid criteria with a strong quality and cost evaluation component. There would also be a need to consider how best to handle sole community providers operating in the rural areas.

Several approaches can be used when establishing a bid process. One is a "winners take all" approach in which the state pays for care only in facilities that win a contract through the bid process. Another is to parallel components of "pay for performance." This includes creating a preferred provider program based on responses to the competitive bid, allowing the state to direct more patients to nursing facilities that win contracts by providing high quality, lower cost services. The state could direct patients to the desired facilities with the use of financial incentives, such as a higher personal needs allowance in preferred facilities or levying a lower recovery amount.

Close or Downsize State Supported Living Centers

Texas state supported living centers (SSLC) are a collection of 13 residential school facilities operated by the Texas Department of Aging and Disability Services. They provide 24-hour care for more than 4,000 Texans with severe (IQ below 40) or profound (IQ below 25) cognitive disability, some who are medically fragile or have behavioral issues. Each facility serves from about 70 to 550 people. The locations of the facilities are shown in **Figure 8**.

The Texas SSLCs are costly with a current daily rate ranging from $625 in a small facility to $656 in a large facility. This is up from the daily rates of $341 and $381 respectfully from 2008. These rates far exceed the rates paid to any of the privately run facilities, the most expensive of which is cur-

rently just under $400 per day. The majority of the private facilities have daily rates ranging between $110 and $190.

Even with the high payment rates, the SSLCs have struggled with on-going problems of staff turnover, quality and patient abuse over the years. Currently, the state is subject to a May 20, 2009 agreement with the U.S. Department of Justice prescribing a comprehensive action plan to improve care and coordination of services delivered at SSLC's. Among the challenges the state faces with SSLC's, is that the State facilities are aging. The newest facility was built nearly 30 years ago; the oldest in Austin was constructed in 1917. A recent report from the Texas Legislative Budget Board estimated project costs of $213.8 million to address critical deficiencies, while at the same time expressing skepticism that the project funding would alleviate many of the ongoing problems in the SSLC system.[21]

The Budget Board report makes a number of measured recommendations. It suggests, "Closure of at least one SSLC now, and implementation of a process to review continually the size of the SSLC system, would enable the state to shift to a smaller system that provides high quality care to persons most in need while freeing resources to expand community services for persons who choose community care." The actions recommended by the Budget Board accommodate the need for a carefully planned and executed transition of a very high-risk population with significant functional, social and medical needs to alternative settings. And indeed, populations similar to that served by the Texas SSLC system have been successfully moved to less costly and often less restrictive settings—Oregon and Alaska are among states that have made significant progress on this front. Other states' experience supports the Board's recommendations and suggests Texas would be well served to get started.

Texas might consider conducting a thorough assessment of current SSLC residents to determine how many, if any, and which specific profiles (criminal, extreme behavioral, medical) would be unable to be cared for in alternate settings. Such an analysis would enable the state to target the size, location and focus of needed facilities. With detailed information and a solid plan of action, it is possible the State could act more aggressively than suggested by the Budget Board in 2011.

None of the ideas coming out of the discussions outlined above would be easy to implement and all have the potential for unintended consequences that should be considered. Most of the changes would be politically difficult to

Figure 8: Texas State Supported Living Centers (SSLC)

Source: DADS, State Supported Living Centers, http://www.dads.state.tx.us/services/SSLC/#content.

implement. Some would not result in immediate savings to the program, and even if all the ideas were implemented together, it is doubtful that they can provide enough savings to address Texas' looming budget issues. However, if Texas takes a longer view and is able to obtain more Medicaid program flexibility from the federal government, it is likely that even some of the more difficult changes can be molded into a more comprehensive and sustainable long term program redesign.

Conclusion/Recommendations

Medicaid expenditures have been rising rapidly for four decades. There are many reasons for this increasing trend, including base increases in the cost of health care, expansions in the program's scope, states' actions to maximize the use of federal dollars in the local market, and the general tendency for entitlement programs to grow with time as they displace private resources. As costs have risen, federal and state officials have attempted to rein in the program's spending growth. Economic downturns have forced states to reduce the number of people eligible for the program, cut benefits, and reduce rates. In good economic times, states have tried to increase the efficiency of the program by implementing rate setting methodology and service delivery reforms, as well as creating a host of community based alternatives to institutional care. Despite these efforts, Medicaid's growth has far outpaced attempts to restrain costs. What started out over 40 years ago as a small program is now a major part of every state budget.

In Texas, Medicaid spending is now 25 percent of the overall state budget. Medicaid spending is rising at a more rapid rate than state revenue, placing public education and other essential state services at risk. Clearly, this situation is not sustainable, and absent systemic reform, spending pressures are only going to build rather than recede in coming years due to demographic shifts. Already, enrollment of persons with disabilities into Texas' Medicaid program has been increasing at a rate exceeding 6 percent per year since 2000, with no end in sight.[22] In addition, the population aged 65 and older is expected to double in the next 20 years, dramatically increasing the number of people who will likely need expensive LTCSS.

With budgetary pressure building, Texas has little choice but to consider fundamental reforms that will provide more budgetary control over the program. Several shorter term suggestions for savings have been put forth in this report for consideration by state officials—and those recommendations have the potential to relieve the pressure for a short time. But even these changes are unlikely to permanently fix the problem. Without major structural reform, the state will continue to struggle with the same forces that have pushed program spending higher every year. It will also continue to be dependent on generating more federal Medicaid funding for the state.

This report provides a framework for a new approach to providing LTCSS to Texans in need of assistance. The goal is to provide budgetary control for the state while still meeting the needs of disabled and elderly state residents. The concept is built on the belief that providing more control to Medicaid participants and their caregivers can provide very real benefits, both in terms of greater efficiency, by targeting program resources to those in need, as well as higher quality and patient satisfaction. The state's role would largely shift (except in the case of nursing home care) from providing direct reimbursement of services to providing oversight of the program to ensure that participants are receiving necessary and high quality services.

Making this kind of fundamental shift in Medicaid will not be easy. But its potential for success should be assessed on what the program will look like in the future if fundamental reform is not adopted, rather than comparing it to how Medicaid operated in the past. One way or another, Texas—and every other state—will be forced to make changes in Medicaid to reduce costs. The only question is *how* they will do it. The reform recommended here would ensure that the program's participants have just as much incentive as the state to get the best and highest value use out of every available Medicaid dollar. With incentives properly aligned, and with more budgetary control provided to the state government, Texas would have the levers necessary to make adjustments over time to balance the needs of the program's participants with the costs imposed on taxpayers.

Appendix: Brief Technical Description of How Long Term Care is financed by Medicaid (A National Perspective)

A Brief Overview of the Medicaid Matching Program

Unlike Medicare, which is solely a federal program, Medicaid is a joint federal-state program. Each state operates its own Medicaid system, but this system must conform to federal guidelines in order for the state to receive matching funds and grants. The matching rate provided to states is determined using a federal matching formula called Federal Medical Assistance Percentages (FMAP), which generates payment rates that vary from state to state, depending on each state's respective per capita income. The states with a high per capita income only receive a federal match of 50 percent, while states with a low per capita income receive a larger match. Currently, the match rate varies from the low of 50 percent in about 20 states to a high of 74.18 percent in Mississippi. Texas' matching rate for FFY2012 is 58.22 percent; that is, the state must pay 41.78 percent of most Medicaid medical costs.

How Medicaid Became the Largest Payer of Long-Term Care Services

Medicaid is currently the largest payer of long-term care services in all states. There are many reasons why states are currently in this position, but the path was laid out decades ago in the early days of the program. A variety of policy decisions and financial incentives on the part of all involved parties seem to have led to today's unsustainable situation. Below is a brief decade-by-decade description of some of the significant milestones leading up to the current program design.

1960s

Medicare/Medicaid Created: Amendments to the Social Security Act established the Medicare and Medicaid programs. Medicare Part A covered hospital costs and Part B was a voluntary program partially financed by premiums which covered physician and other out-of-hospital costs. The Kerr-Mills act, which gave states the power to decide which patients needed financial assistance, was converted to a program called "Medicaid" to cover children, women, and the indigent elderly. Medicaid was added to the Medicare legislation late in the Congressional process, partly as a compromise for those who wanted to add assistance for low income elderly to Medicare.

Nursing home costs were deliberately carved out of Medicare because of a fear that it would financially devastate the program. The final "solution" was to provide coverage to the poorest of the elderly under the Medicaid program and to require states to provide both medical home health and nursing home services to the poor elderly in order to receive a federal match for the costs of their Medicaid program.

Costs quickly exceeded expectations. In large part, the costs accelerated as a result of how the program was structured, a structure that continues to this day. Main cost drivers include:

1. The "Medically Needy" provisions, which greatly increase the number of people on Medicaid;
2. The increasing cost per beneficiary;
3. The option of a significant federal match, which provides a huge incentive for states to try to shift other program obligations to the federally matched program;
4. States ability to set rates wherever they want, with no caps or ceilings, and with never having to pay more than 50 percent of the cost;
5. The fact that fiscal control of the system at the federal level is virtually impossible. All of the data is maintained by the states in over 50 different, disconnected systems.

1970s

In the 1970's, Medicaid long-term care expenditures exploded, rising from $900 million in 1970 to $7.1 billion in 1980. In response, the federal government capped the bed supply by requiring "certificates of need" before new nursing homes could be built, reasoning that Medicaid could not be charged for beds that didn't exist. However, to compensate for limits placed on growth, nursing homes began charging Medicaid higher rates. The government responded by capping nursing homes rates. As a result, Medicaid rates fell to about two-thirds of private pay rates. This was the origin of cost shifting Medicaid payment shortfalls to other payers, which resulted in much higher private-pay rates (on average, about 1.5 times the Medicaid rate).

1980s

With nursing home supply and prices capped, and few controls on Medicaid long-term care eligibility, demand soared. Costs continued to explode, rising from $7.1 billion in 1980 to $16.4 billion in 1990.

Unable to build more beds or charge Medicaid more, nursing homes cut corners on quality. By the mid-1980s, reports of dismal conditions in America's nursing homes led to Congressional action. The Omnibus Budget Reconciliation Act of 1987 required nursing homes to improve care or face legal and financial penalties, but provided no extra Medicaid funds to finance the mandated improvements.

Caught between inadequate reimbursement and care quality requirements, nursing homes started suing state Medicaid programs for higher reimbursements. They won most of these lawsuits based on the 1981 "Boren Amendment" which required Medicaid to pay at least minimally adequate rates. But Congress repealed Boren in 1997, leaving no floor to Medicaid nursing home reimbursements.

To address some of the structural deficiencies in the provision of nursing home care, Congress enacted the Medicare Catastrophic Coverage Act of 1988 (MCCA). The Act was designed to improve acute care benefits for the elderly and disabled. It was planned to be phased in from 1989 to 1993. The Act was the first bill to significantly expand nursing home care since the program's inception. In addition to providing outpatient drugs and limiting enrollees' copayments for covered services, the MCCA extended Medicare coverage of nursing home care to 150 days and also removed the three-day hospital stay requirement. It also added the spousal impoverishment. Most of this act was repealed due to push back from seniors and their advocates, largely because they didn't like the fact that seniors had to pay an additional premium to fund the added benefits. While the Medicare provisions were repealed, many of the state cost-sharing provisions remained, including the spousal impoverishment and the Medicare cost sharing Qualified Medicare Beneficiary (QMB) program.

1990s

Several cross currents developed in the 1990s, as Medicaid nursing home expenditures continued to rise from $16.4 billion in 1990 to $31.9 billion in 2000. The number of private payers declined as people, enticed by free or subsidized Medicaid benefits, found more and more creative ways to qualify for the program. Out-of-pocket expenditures fell from 49.5 percent of nursing home revenues in 1970 to 32.5 percent in 2000, while Medicaid's share of costs increased from 23.3 percent to 37.4 percent in the same period.

Countering this dynamic, the federal government tried to restrain the growth of Medicaid long-term care expenditures by closing income and asset eligibility loopholes and by mandating recovery from recipients' estates. The trend began with the Tax Equity and Fiscal Responsibility Act of 1982 and continued through the Deficit Reduction Act of 2005 (DRA). Simultaneously, throughout the 1990s and up to the current day, state and federal policy makers, encouraged by community advocates and academic researchers, have argued that Medicaid can reduce costs by "rebalancing" enrollees from nursing home care to HCBS programs. However, despite efforts to rebalance, nursing home and HCBS expenditures have continued to increase in every state. This trend will likely continue absent restraints on Medicaid's eligibility criteria.

2000s

After 9/11, the Internet bubble collapse, and the ensuing recession, state and federal officials began to worry about Medicaid long-term care more than ever.

In the first decade of the new century, Medicaid nursing home expenditures moderated, growing only 41.1 percent from $31.9 billion in 2000 to $45.0 billion in 2009. Total long-term care cost growth trends continued to climb steeply, however, as Medicaid's home health care expenditures soared 113 percent from $11.5 billion in 2003 to $24.3 billion in 2009.

Meanwhile, through the Deficit Reduction Act of 2005, the federal government tried to restrain Medicaid long-term care growth by tightening eligibility criteria and encouraging the purchase of private long-term care insurance. In the same legislation, however, qualifying for Medicaid was made more attractive by encouraging the program to offer more of the homecare benefits people prefer and less nursing home care they would rather avoid.

Medicaid Long-Term Care Eligibility Rules

Medicaid utilizes two eligibility screens for the receipt of institutional or home and community based services. First, the individual must meet the state's medical/functional cri-

teria that determine the level of care for payment of institutional care. Additionally, the individual must meet the state's Medicaid categorical and financial requirements.

While a recipient who accesses Medicaid long-term care services could qualify under almost any category of Medicaid, as a general rule, someone who meets the level of care criteria required will either be categorically eligible at age 65 or older or be an adult or child with a disability. In 2007, over 3.6 million enrollees received long-term care services and supports through Medicaid. Approximately 52.1 percent were age 65 or older, 39.6 percent were persons with disabilities, and the rest were other adults and children.[23]

Under Medicaid financial eligibility criteria for senior and disabled programs, the income, and often the assets of a parent or spouse are not counted in the financial eligibility determination of the child or spouse requiring long-term care services. This exclusion results in many being eligible where as they may not otherwise qualify if all family financial resources were considered.

States have the option to increase the categorical income eligibility limit for coverage in their long-term care programs up to 300 percent of the Supplemental Security Income benefit level. This equates to roughly $2,000 per month. As of today, most states have adopted this option. Additionally, states that have chosen to implement the Medicaid medically needy option allow those who exceed the state defined categorical threshold to qualify for Medicaid coverage by "spending down" their income. That is, individuals who have countable income exceeding the state's limit, can lower their countable income by making a payment of their excess income to the state or incurring medical bills in an amount equal to their excess income. Most individuals who are receiving long-term care services will have medical bills that exceed the amount of their excess income, making it advantageous to access Medicaid to help cover the difference.

Miller Trusts

There are many details around the counting of specific kinds of income and assets for Medicaid coverage, and many that are specific to long-term care coverage. Most are not necessary to discuss for the purposes of this paper, but one, Miller Trusts, is important to address based on the numerous comments made by individuals within the Texas community.

As mentioned above, many states include long-term care under their optional medically needy programs. This allows most low and middle income individuals to qualify for Medicaid long-term care coverage. However, states that do not offer long-term care coverage under the medically needy option are required under Section 1917(d)(4)(B) of the Social Security Act, to allow those with income over the states' income level to divert that income into a trust. This effectively lowers their countable income, allowing them to meet the income requirements of the state. These trusts are often referred to as "Miller Trusts." If a Medicaid applicant's income exceeds the lawful amount for program eligibility (in most states, around $2000 per month), a Qualified Income Trust (Miller Trust) must be created.

The portion of the Medicaid applicant's income that exceeds the eligibility criteria is placed in the trust, and someone other than the applicant is made the trustee. After the applicant has applied for Medicaid and been approved, the trust income is disposed of in accordance with individual state law.

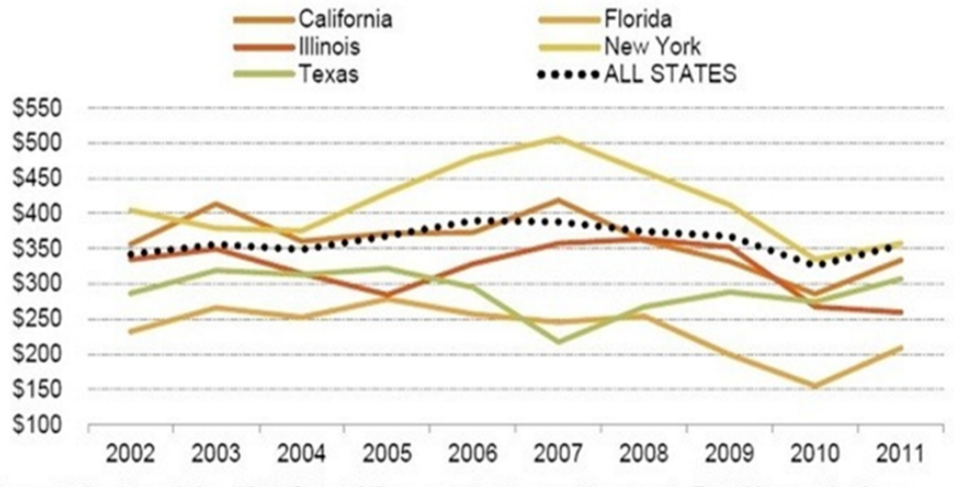
In most states, the applicant is allowed to: 1) retain a small fraction of the income; 2) divert some of the income to their community spouse if the spouse's income falls below the state's community spouse allocation amount per month; and/or 3) pay a fixed amount towards their nursing home care from the trust. In the event that there are excess funds in the account after the applicant dies, state Medicaid programs are entitled to receive reimbursement from those funds.

National Metrics of Enrollment and Per Capita Spending

Since the inception of the Medicaid program, enrollment and spending have been on a continuous upward trend. Today, Medicaid enrollment exceeds Medicare, with a total Medicaid/CHIP enrollment of over 62 million in 2009. Medicaid/CHIP expenditures exceeded $401 billion in 2010.[24] **Figure 9** (*next page*), is an illustration of the recent trends in state Medicaid per capita spending.

Spending on long-term care services is a major driver of total Medicaid spending. Given the demographic trends of the country, this dynamic is likely to continue to accelerate as the baby boomers reach the retirement age and the population over age 85 is pushed to new levels. The Kaiser Commission on Medicaid and the Uninsured published an October 2011 Issue Paper entitled, "Medicaid's Long-Term Care

Figure 9: State Medicaid Spending from General Fund, Per Capita, 2002-2011 (in 2011 dollars)



Source: National Association of State Budget Officers, annual state expenditure reports, Table 28; population figures compiled by Bloomberg, Medicaid spending figures for 2011 are estimates.
Note: These figures do not adjust for the enhanced federal match during 2008-2010.

Users: Spending Patterns across Institutional and Community-based Settings." The findings in this issue paper paint a clear picture of the stress long-term care costs are placing on Medicaid budgets and state general funds. Some of the issue paper's findings include:

- Nationally, Medicaid long-term care users account for 6 percent of the Medicaid population, but nearly half of total Medicaid spending.

- Among those using long-term care services and supports, the average annual spending per Medicaid beneficiary is $43,296 compared to $3,694 for Medicaid beneficiaries not using long-term care services.

- Individuals who primarily use institutional services have per-capita spending of $62,750 versus $31,341 for those who predominately use community-based services and $61,206 for those who use a mix of institutional and community-based services.

- A total of 1.9 million seniors, 404,400 children, and 1.3 million adults under age 65 use long-term care services and supports.

- Long-term care services and supports account for 77 percent of the total spending for long-term care users; the remaining 23 percent is for acute care and other supportive services (in-patient hospital, prescription drugs, physician, therapies, etc.).

- The elderly make up 52 percent of those using long-term care services and 45 percent of the spending.

- The dual eligible account for over two-thirds of Medicaid enrollees who use long-term care services and supports and a similar share of the spending.

History of Home and Community Based Waivers—1915(c) Waivers

Prior to 1981, when a child with long-term care needs lived at home, the parent's income and assets were counted in the child's eligibility determination. However, when the child lived in an institution, the parents' income was not counted. If the child (or spouse, if an adult) returned home, parental and spousal income and resources were again considered available (deemable) in the eligibility determination. Often, this led to families having to keep their family member in the institution in order to receive needed care.

For example, Katie Beckett had spent most of the first three years of her life living in an Iowa hospital because she needed

to breathe on a ventilator. Medicaid would only pay for the expensive treatment if she stayed in the hospital. Just over a month after President Ronald Reagan brought her case to the media, Katie received a waiver from the Department of Health and Human Services (HHS) to receive care at home. Soon after, the Medicaid HCBS waiver program was established with the passage of Section 2176 of the Omnibus Budget Reconciliation Act (OBRA) of 1981. Section 2176 created Section 1915(c) of the Social Security Act, which authorized states to request the option of providing home and community-based alternatives to institutional care.

Many of the first waivers were targeted toward the aged and disabled or those with developmental disabilities. The program has since evolved to target Medicaid-eligible persons with a variety of conditions and chronic disorders, such as physical disabilities, acquired immunodeficiency syndrome (AIDS), acquired brain injuries, and other forms of severe disability, including, to a limited extent, chronic mental illness.

Currently, the waivers cover programs that provide a combination of standard medical services and non-medical services that help maintain the individual in the community. Standard services include: 1) case management (i.e. supports and service coordination); 2) homemaker, home health aide, personal care, and adult day health services; 3) habilitation (both day and residential); and 4) respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings to their homes and the community. Lastly, HCBS waivers are not an entitlement like institutional care. The number of people is capped, and states have wide latitude in design.

1115 Waivers

Section 1115 of the Social Security Act gives the HHS Secretary authority to waive provisions of major health and welfare programs authorized under the Act, including certain Medicaid and CHIP requirements. Under Section 1115, the Secretary can allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules, as long as the Secretary determines the initiative is a "research and demonstration project" that "furthers the purposes" of the program. Following are some examples of 1115 waivers.

Broad Expansion Waivers (Mid-1990s to 2001): In the mid-1990s through the early part of this decade, most waivers focused on expanding coverage.

CHIP Waivers (2001 Forward): In July 2000, based on research showing that covering parents benefited their children, the Administration under President Clinton issued waiver guidelines permitting waivers to expand coverage to parents using CHIP funds under certain conditions.

HIFA Waivers (2001 Forward): In August 2001, under President Bush, the Administration announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative. This initiative promoted the use of waivers to expand coverage within "current-level" resources and offered states increased flexibility to reduce benefits and charge cost sharing to offset expansion costs.

Reform Waivers (2005 Forward): Beginning in 2005, some broad waivers were approved that restructured Medicaid financing and other key program elements. Examples include setting a global cap on federal funds and allowing a state to shift new authority to private managed care plans to determine benefits and cost sharing.

Emergency Waivers: Beyond these themes, waivers have also helped states quickly provide Medicaid support during emergency situations. For example, these waivers enabled New York to use a vastly streamlined enrollment process in the wake of the September 11th attacks. They also assisted states in providing temporary Medicaid coverage to certain groups of Hurricane Katrina survivors.

New Initiatives

As the country learned more about the provision of HCBS services, and pressure mounted to provide these services in new ways that would help rebalance Medicaid long-term care, a variety of approaches were developed and authorized by Congress. A brief description of some of these newer programs is described below.

"Money Follows the Person" Rebalancing Demonstration Program (MFP): The MFP program helps states rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Forty-three states and the District of Columbia have implemented MFP Programs. From Spring 2008 through December 2010, nearly 12,000 people have transitioned back into the community through MFP Programs. The Patient Protection and Affordable Care Act (PPACA) strengthens and expands the "Money Follows the Person" program to more states.

State Plan Amendment Option to Provide Home and Community-Based Services for Elderly and Disabled Individuals 1915(i): Section 1915(i) was added by the Deficit Reduction Act of 2005 and enhanced by the PPACA. Section 1915(i) includes a service package similar to that provided under a HCBS waiver, but it allows states to provide the services to individuals who do not meet the state's institutional level of care. Under original DRA provisions, the option was limited to individuals with incomes under 150 percent FPL, and the service package did not include all possible HCBS services. The original provisions allowed the state to change level-of-care (LOC) criteria, but required the state to grandfather those receiving care under the old criteria as long as they continued to meet that criteria (for as long as the option was authorized). It also allows states to cap enrollment.

The PPACA added provisions allowing states to cover individuals who are eligible for a HCBS waiver with incomes up to 300 percent of the SSI federal benefit rate. Financial criteria can reflect institutional rules like other HCBS waivers. The PPACA also provides states with the option to offer a wider range of services, potentially beyond the scope of 1915(c) services, and to target very specific populations for coverage. Section 1915(i) provides for self-direction of services as well.

The PPACA also added new restrictions on 1915(i). States can no longer limit the number of individuals who can be enrolled under the 1915(i) option and services must be provided on a statewide basis.

Self-Directed Personal Assistant Services 1915(j): Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State Plan and/or Section 1915(c) waivers the state already has in place. Participation in self-directed PAS is voluntary and participants set their own provider qualifications and train their PAS providers. Participants determine how much they pay for a service, support, or item.

Through PAS, states can:

- Target people already receiving Section 1915(c) waiver services
- Limit the number of people who will self-direct their PAS
- Limit the self-direction option to certain areas of the state, or offer it statewide

PAS participants can:

- Hire legally liable relatives (such as parents or spouses)
- Manage a cash disbursement
- Purchase goods, supports, services, or supplies that increase their independence or substitute for human help (to the extent that they would otherwise have to pay for human help)
- Use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases

1915(k) The "Community First Choice Option": The Community First Choice option was established by the PPACA. This option lets states, through their State Plan, provide home and community-based attendant services to Medicaid enrollees with disabilities. 1915(k) became available on October 1, 2011 and provides a 6 percent increase in federal matching payments to states for expenditures related to this option. A notice of proposed rulemaking for the Community First Choice State Plan Option was published in the February 25, 2011 Federal Register. Further guidance is expected to be issued.

The Dual Eligible Population and Associated Issues

Among those served by Medicare and Medicaid, dual enrollees are the most costly. The high levels of service use associated with providing care for these individuals has prompted endorsements by state governors to shift more of the costs to the federal government.

According to CMS, dual eligibles account for 16 percent of Medicare enrollees, but 27 percent of Medicare spending. They make up 15 percent of Medicaid enrollment, but 39 percent of Medicaid spending.

Two drivers of this spending are chronic diseases and the heavy use of nursing homes. However, another potential compounding factor is the way care and financing are split between the two payers. This appears to lead to poorly managed or coordinated care and the use of money and scarce medical and support resources on inefficient treatment. ✯

Endnotes

[1] Leavitt Partners estimate based on data from the Texas Public Policy Foundation and Texas State Government sources.
[2] The constitution in the State of Texas requires that the state legislature cannot provide for spending authority in excess of what the Comptroller for the state certifies as revenue available for expenditure. In other words, the state must balance its budget. *States Continue to Feel Recession's Impact*, Center on Budget and Policy Priorities, June 27, 2012.
[3] National Association of State Budget Officers, 2002 State Expenditure Report (Nov. 2003). The Fiscal Survey of States, National Association of State Budget Officers, Spring 2012.
[4] *The Path to Prosperity: A Blueprint for American Renewal*, Fiscal Year 2013 Budget Resolution, House Budget Committee. The Path to Prosperity: Restoring America's Promise, Fiscal Year 2012 Budget Resolution, House Budget Committee.
[5] *Medicaid Reform: Constructive Alternatives to a Failed Program*, The Honorable Arlene Wohlgemuth, Brittani Miller, and Spencer Harris, (Feb. 2011) http://www.texaspolicy.com/center/health-care/reports/medicaid-reform.
[6] Leavitt Partners estimate based on FY2011 data from the Texas Public Policy Foundation and Texas State Government. Data from the Texas Public Policy Foundation provided the average number of clients served per month for each long term care program in the state. This number did not include STAR+PLUS, which was added to the total using data from the Texas Health and Human Services Commission.
[7] Texas HHSC, *Medicaid for Elderly and People with Disabilities Handbook*.
[8] A complete list of services offered by the Department of Aging and Disability Services (DADS) can be found at http://www.dads.state.tx.us/services/listofservices.html#physical.
[9] Medicaid defines habilitation services as "services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings." 42 U.S.C. § 1396n(c)(5)(A).
[10] Medicaid Enrollment: June 2011 Data Snapshot, Kaiser Commission on Medicaid and the Uninsured, June 2012.
[11] According to a report produced by the Kaiser Family Foundation, 47 states use provider taxes of some sort to finance their Medicaid programs, including Texas. Texas imposes a special tax on Medicaid managed care organizations to partially finance Medicaid expenditures (*see* Medicaid Financing Issues: Provider Taxes, Kaiser Family Foundation, May 2011). In addition, Texas uses Medicaid funding to partially finance administrative costs in the Texas school system based on the fact that Texas schools are providing services to some Medicaid-eligible disabled children (*see* Medicaid and Schools, Elijia J. Herz, Congressional Research Service, Feb. 17, 2009).
[12] *The Path to Prosperity: The Blueprint for American Renewal*, House Budget Committee (Mar. 2012) 42, http://budget.house.gov/uploadedfiles/pathtoprosperity2013.pdf.
[13] PACE was established as a permanent Medicare benefit by the Balanced Budget Act of 1997. It is a Medicare managed care option and a state plan option.
[14] The block grant would finance both the acute care and LTCSS portions of Medicaid. For simplification purposes, the portion for acute care is not depicted here but would necessarily need to be taken out of the block grant as well, with the remainder used for LTCSS. For more on how to reform the acute care portion of Medicaid consistent with a block grant, *see* TPPF's report: *Medicaid Reform: Constructive Alternatives to a Failed Program*, The Honorable Arlene Wohlgemuth, Brittani Miller, and Spencer Harris (Feb. 2011) http://www.texaspolicy.com/center/health-care/reports/medicaid-reform.
[15] *See* Section 4.17 of each State's Medicaid State Plan for more detail.
[16] Thomson/MEDSTAT, 2005.
[17] Texas Dual Eligibles Integrated Care Demonstration Project Application, 2012.
[18] Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, 2011.
[19] Adult Children Could Be on Hook for Parents' Nursing Home Bills, 2012.
[20] *Rebalancing Long-Term Services and Supports: Progress to Date and a Research Agenda for the Future*, the Hilltop Institute (14 June 2011) http://www.hilltopinstitute.org/publications/RebalancingLTSSforAcademyHealthARM-June2011.pdf.
[21] Transform State Residential Services for Persons with Intellectual and Developmental Disabilities, Texas Legislative Budget Board, Jan. 2011.
[22] Texas HHSC May 7, 2012, Presentation to the House Appropriations Subcommittee on Article II: Medicaid.
[23] Kaiser Commission on Medicaid and the Uninsured, 2011.
[24] Centers for Medicare and Medicaid Services.
[25] Medicaid's Long-Term Care Users: Spending Patterns across Institutional and Community-based Settings, Kaiser Commission on Medicaid and the Uninsured, Oct. 2011.

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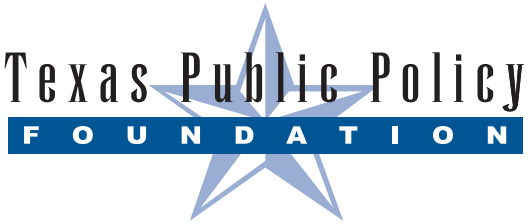
About the Texas Public Policy Foundation

The Texas Public Policy Foundation is a 501(c)3 non-profit, non-partisan research institute. The Foundation's mission is to promote and defend liberty, personal responsibility, and free enterprise in Texas by educating and affecting policymakers and the Texas public policy debate with academically sound research and outreach.

Funded by hundreds of individuals, foundations, and corporations, the Foundation does not accept government funds or contributions to influence the outcomes of its research.

The public is demanding a different direction for their government, and the Texas Public Policy Foundation is providing the ideas that enable policymakers to chart that new course.



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