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Policy Brief

Medicaid Expansion, Long-Term Care Financing in Retirement States and the Post World War II Birth Cohort

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This policy brief contains a formal consideration of ideas discussed during a presentation to the 2012 Syracuse Seminar on Aging. Like most briefs, it will appeal to policy makers and academics craving detailed demographic, fiscal and policy data. Before diving into this brief, I would encourage readers to view the presentation video (available at http://www.youtube.com/watch?v=bsv8K7DdJFY). As you will see, the seminar was informal and the discussion was wide ranging. In contrast, this brief focuses on limitations faced by states as they finance long-term care. It is primarily concerned with the Medicaid expansion and growing need for care as the post-World War II cohort reaches the age of frailty.

As I developed this briefing, the following issues were uppermost in mind:

Issue #1 - Medicaid is a public insurance plan. This means that the states are the primary source of long-term care fiscal support in the United States.

Issue #2 – The Affordable Care Act (ACA) of 2010 expands health insurance coverage to millions of uninsured citizens by leveraging existing Medicaid policy. The expansion does not address Medicaid's role in financing long-term care (LTC).

Issue #3 – Any discussion of state budgets and long-term care policy is complex. Demography, finances, and policy shape this complexity.

During the next twenty years, growth of the population aged 85 years and older will be dynamic. This is the period when the post-World War II birth cohort moves into old age. Any policies developed during this period will need review on a regular basis. Growth of the population is not uniform across the states. Responses to this growth will need adjustment as the population changes. To facilitate the discussion about the impact population changes will have on state policies, I developed four tables for this brief. Tables 1 to 3 capture individual factors that influence state Medicaid financial resources. Table 4 shows the collective impact of these factors as they shape state decisions to participate in federal programs linked to LTC. At the end of the brief, I offer four policy recommendations: two at the federal level and two at the state level.

Demography and Growth

States are entering a period where population growth will have a major impact on resources. The dynamics of growth affect public financing of LTC. The data in Table 1 clearly shows that existing populations – large and small – are growing rapidly (Colello, 2007). The table shows the current pattern of growth at the state-level before the arrival of the Boomers (Benetsky and Koerber, 2012). Long-term care financial policy needs to incorporate the dynamics of growth as it considers financing available from the states. The five and ten year periods used in the table reflect the constraints of the census data process. Most states use an annual or biannual budgeting process. The accurate management of state LTC budgets will require improved estimates to monitor growth for smaller periods.

Table 1: Demography and Growth: States with more than 500,000 residents aged 65 years and older in 2005.

State	Number of people Aged 65 and older** 2005	Number of people Aged 85 and older** 2005	Percent change, aged 65 and older 2000 – 2005**	Percent change, aged 65 and older 2000 – 2010^Δ	Percent change, aged 85 and older 2000 – 2010^Δ
Top Ten, Ranked by Number^Ω					
United States	**36,790,113**	**5,095,938**	**5.14**	**15.1**	**29.6**
California	3,868,574	543,323	**7.59**	**18.1**	**41.2**
Florida	2,993,160	399,410	**6.61**	**16.1**	**31.0**
New York	2,515,064	369,722	2.72	6.9	25.5
Texas	2,271,845	257,368	**9.62**	**25.5**	28.3
Pennsylvania	1,892,847	305,404	-1.37	2.1	28.7
Illinois	1,530,074	227,797	2.00	7.3	22.3
Ohio	1,529,430	217,462	1.44	7.6	**30.3**
Michigan	1,258,494	184,074	3.24	11.7	**34.7**
New Jersey	1,129,356	170,896	1.46	6.5	**32.1**
North Carolina	1,054,098	127,415	**8.78**	**27.3**	**39.8**
States with 500,000 – 999,999					
Alabama	603,733	67,975	4.13	13.5	12.5
Arizona	758,181	91,207	**13.53**	**32.0**	**50.9**
Georgia	870,422	100,395	**10.84**	**31.4**	29.6
Indiana	777,506	108,635	3.28	11.7	25.9
Kentucky	525,764	60,584	4.15	**14.5**	18.8
Louisiana	531,581	62,274	2.83	7.9	11.9
Maryland	644,560	89,325	**7.55**	**18.1**	**46.7**
Massachusetts	852,826	142,336	-0.85	4.9	24.4
Minnesota	623,241	103,012	4.88	15.0	24.6
Missouri	773,171	103,752	2.36	11.0	15.4
South Carolina	534,980	63,570	**10.23**	**30.2**	**40.7**
Tennessee	749,951	86,286	**5.92**	**21.3**	22.7
Virginia	865,103	109,003	**9.18**	**23.3**	**40.3**
Washington	720,874	110,519	**8.87**	**25.0**	**39.5**
Wisconsin	721,633	115,269	2.72	10.6	23.9
Bottom Ten, Ranked by number					
Idaho	163,917	23,420	**12.34**	**33.4**	**39.8**
New Hampshire	163,105	23,503	**10.23**	**20.5**	**35.8**
Rhode Island	149,775	27,554	-1.72	-0.3	28.0
Montana	128,834	19,187	**6.52**	**21.3**	**30.5**
Delaware	112,214	14,338	**10.31**	**27.1**	**49.2**
South Dakota	110,530	18,663	2.22	7.8	19.5
North Dakota	93,650	17,139	-0.88	3.2	13.3
Vermont	81,982	11,917	**5.77**	**17.5**	28.0
Wyoming	62,037	7,515	**7.53**	**21.5**	27.7
Alaska	44,026	3,907	**23.33**	**53.9**	**78.9**

**Kirsten Colello, Congressional Research Service RL33897 'Where do older Americans Live? Geographic Distribution of the Older Population.' 2007.

^ΩThese ten states contain 54.5% of the U.S. population aged 65 years and older. &Source: U.S. Census Bureau, Census 2000 Summary File 1 and 2010 Census Summary File 1, Table 2

Bold numbers are greater than the U.S. average.

In 2005, 35 states had an estimated 500,000 or more persons aged 65 years and older in residence. During the period between 2000 and 2005, 17 states saw growth rates of the population aged 65 and older that was greater than the U.S. average of 5 percent. Over the ten-year span of 2000 to 2010, 18 states had growth rates exceeding the U.S. average of 15.1 percent. All states experienced growth in the population aged 85 years and older. This is the group most likely to require long-term care. Sixteen states had increases greater than the U.S. average of 29.6 percent. During this period, the pattern of growth was somewhat patchy. For example, Alaska has the smallest resident population aged 65 years and older (44,026). This state experienced the largest percent increase in the numbers of persons aged 85 years and older – 78.9 percent. Arizona saw an increase of 50 percent in their population aged 85 and older. Five states saw increases of 40 percent or more. These states are Virginia (40.3 percent), South Carolina (40.7 percent), California (41.2 percent), Maryland (46.2 percent) and Delaware (49.2 percent).

Medicaid, LTC Spending and Policy

The simple explanation of Medicaid financing is a match of state and federal dollars. States use these pooled dollars to purchase the goods and services required by all groups of Medicaid beneficiaries. This simple explanation obscures the demographic trends shown in Table 1. It also ignores the cash flow problems experienced by states since the fall of 2008. Table 2 shows indices of financial pressure on state Medicaid budgets.

Table 2: Medicaid, LTC Spending and Policy – States with more than 500,000 residents aged 65 years and older in 2005.

State	Federal Medical Assistance Percentage (FMAP)@ FFY 2013	Federal Match Multiplier@	Total Taxable Resources (TTR) per Capita Index@	Percent of total Medicaid Expenditures for Mandatory Services / Core Enrollees@	Percent of Long Term Care Spending in Community Settings@	Percent of State General Funds Spent on Medicaidβ (Exclude federal match)
Top Ten, Ranked by NumberΩ						
United States	**50.0**	**$1.00**	**$1.00**	**39.6%**	**44.8%**	**15.8%**
California	50.0	$1.00	1.05	**40.5**	58.7	11.8
Florida	**58.1**	**1.39**	**0.91**	**47.0**	**33.8**	13.3
New York	50.0	1.00	1.25	28.5	49.6	11.6
Texas	**59.3**	**1.46**	1.01	**57.1**	45.8	**17.0**
Pennsylvania	**54.3**	**1.19**	**0.96**	39.0	**38.7**	**22.8**
Illinois	50.0	1.00	1.07	37.6	**34.0**	**33.9**
Ohio	**63.6**	**1.75**	**0.86**	25.3	**33.4**	12.6
Michigan	**66.4**	**1.98**	**0.79**	**40.2**	**33.4**	**18.9**
New Jersey	50.0	1.00	1.27	35.4	**30.6**	13.6
North Carolina	**65.5**	**1.90**	**0.92**	**45.2**	**43.5**	12.5
States with 500,000 – 999,999						
Alabama	**68.5**	**2.18**	**0.77**	**48.4**	**31.5**	4.8
Arizona	**65.7**	**1.91**	**0.83**	**76.9**	44.2	13.1
Georgia	**65.6**	**1.90**	**0.87**	**58.1**	**39.1**	11.4
Indiana	**67.2**	**2.05**	**0.88**	38.5	**34.5**	9.2
Kentucky	**70.6**	**2.40**	**0.79**	**48.9**	**31.6**	9.6
Louisiana	**61.2**	**1.58**	1.06	39.8	**36.0**	8.8
Maryland	50.0	1.00	1.20	34.3	**43.6**	14.9
Massachusetts	50.0	1.00	1.24	32.2	47.1	**34.3**
Minnesota	50.0	1.00	1.08	26.1	65.7	**17.8**
Missouri	**61.4**	**1.59**	**0.88**	36.9	47.2	**18.8**
South Carolina	**70.4**	**2.38**	**0.75**	**44.4**	**39.2**	10.3
Tennessee	**66.1**	**1.95**	**0.85**	**53.7**	**39.0**	**16.5**
Virginia	50.0	1.00	1.15	37.7	44.6	**17.3**
Washington	50.0	1.00	1.07	37.6	66.3	**25.0**
Wisconsin	**59.7**	**1.48**	**0.93**	26.0	**39.2**	10.7
Bottom Ten, Ranked by number						
Idaho	**71.0**	**2.45**	**0.77**	**44.2**	48.8	12.3
New Hampshire	50.0	1.00	1.11	22.3	45.0	**27.9**
Rhode Island	51.3	1.05	1.05	37.2	**0.6**	**25.0**
Montana	**66.0**	**1.94**	**0.81**	**40.7**	49.0	8.4
Delaware	**55.7**	**1.26**	1.51	**40.2**	**35.0**	15.6
South Dakota	**56.2**	**1.28**	1.03	**42.7**	**38.4**	**19.9**
North Dakota	**52.3**	**1.10**	1.12	23.5	**31.1**	12.2
Vermont	**56.0**	**1.27**	**0.90**	18.9	**4.8**	19.0
Wyoming	50.0	1.00	1.39	39.1	51.8	5.1
Alaska	50.0	1.00	1.34	**43.0**	67.5	6.1

Sources: @Kaiser Family Foundation Report #8378 – Factors Driving State Spending. November 2012. **FMAP** is the ratio of its per capita income compared to the national average. The formula is defined in statute and ranges from a floor of 50% to a ceiling of 83%. **Multiplier** is defined by every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year. **TTR** is defined as the unduplicated sum of the income flows received by its residents which a state can potentially tax. βState Expenditure Report Examining Fiscal 2009 – 2011 State Spending. National Association of State Budget Offices, December 2011.

Bold numbers indicate states with indicators *worse* than U.S. average.

The Federal Medical Assistance Percentage (FMAP) is a ratio of per capita income compared to the national average. Twelve of the 35 states in the table receive the minimum 50 percent Medicaid FMAP (Kaiser Family Foundation, 2012b). Popular retirement destinations, known as destination states, have FMAPs of 58 percent or more. Among the destination states, South Carolina at 70.4 percent has the highest eligibility FMAP rate. The multiplier column translates the FMAP into the federal matching dollars. The multiplier for destination states ranges from $1.39 (Florida) to $2.38 (South Carolina). This means that South Carolina can receive $2.38 for every single state dollar it allocates to Medicaid. Although FMAP is one marker of the resources a state can allocate to LTC, it does not completely show public financing limits. The next column shows other indicators of state fiscal resources.

There are multiple ways to measure the income flows of a state. Personal income is one strategy. Gross state product is another. These two measures do not capture the regional or cross-border income flow available for taxation. The Total Taxable Resources (TTR) per Capita Index is a comprehensive measure of resources available to state taxing authorities. Policy makers use the TTR to allocate funds for Community Mental Health Services and Substance Abuse Prevention and Treatment block grants. In all of the destination states, the TTR is less than 1.0. These states have fewer taxable resources. Taxes translate into dollars available for matching. In the destination states, there is conflicting evidence around the issue of the impact of retirees on TTR and ultimately state resources. Some researchers argue that retirees bring additional financial resources to the destination states (Bradley and Longino, 2009). The data in this table suggests that in the current era of retiree population growth and migration, careful study is needed (Wilmoth and Longino, 2006).

Within the Medicaid population, there are a number of sub-groups. Aged, blind, disabled, pregnant women and children are mandatory service groups. There are statutory requirements to provide clinical services to these groups. Table 2 shows that for many states, mandated spending is a large portion of overall Medicaid. Among the destination states, Arizona has the highest proportion of Medicaid spending consumed by mandatory services to core enrollees – 78 percent. Like all the other destination states, Arizona is eligible for an enhanced federal match multiplier of $1.91. Its TTR is 0.83. These indices suggest that Arizona has limited resources if policies require additional matching funds to participate.

On average, states spend 44.8 percent of their long-term care dollars in community settings. States that are popular with retirees have uniformly low rates of Medicaid spending on home and community-based services (HCBS). In most cases, the rate is in the 30 to 40 percent range. States with low rates of HCBS spending include seven of the top ten states with large populations aged 85 and older.

Destination states have some of the lowest rates of general fund spending on Medicaid (NASBO, 2011). Taken alone, this statistic suggests that states with low rates have the capacity to supply increased resources to finance Medicaid LTC. The average state spends 15.8 percent of its general funds on Medicaid. These states allocate 8 to 13 percent of state dollars to Medicaid spending. However, when placed within the context of high FMAP eligibility and low TTR, these states have few options for implementing new long-term care policies. The combination of low TTR and increasing need for spending on mandatory population limits future dollars available for new policy initiatives. This is particularly true for policies requiring states to provide matching funds.

Table 3: Long Term Care Programs and Experiments - States with more than 500,000 residents aged 65 years and older in 2005.

State	Policies Predating the ACA				Changed by ACA	
	Medicaid State Plan Home Health Participants@, % Change 2008 - 2009	**Financial eligibility § 1915 HCBS Waiver Aged, % of SSI FBR IN 2011, ** No state program**	**§ 1915 HCBS Waiver for HCBS: % Change 2008 – 2009. ** No state program**	**HCBS with § 1115 Waiver@**	**Participate in *Money Follow the Person* & *(2005 Deficit Reduction Act)***	**Approved for *Community First Choice* (1915 k)**
Top Ten, Ranked by NumberΩ						
United States	**6%**		**10%**			
California	-1%	**	5%		Current	Y
Florida	-7%	300%	**35%**		New	
New York	-1%	**	6%	Y	Current	Y
Texas	6%	**	9%	Y	Current	Y
Pennsylvania	**7%**	300%	10%		Current	
Illinois	**26%**	100%	7%		Current	
Ohio	**10%**	**	8%		Current	
Michigan	-2%	**	9%		Current	
New Jersey	**8%**	**	**35%**		Current	Y
North Carolina	**2%**	**	**42%**		Current	Y
States with 500,000 – 999,999						
Alabama	**43%**	**	-2%		New	
Arizona	**8%**	300%	**	Y	**None**	Y
Georgia	-6%	**	**12%**		Current	
Indiana	**58%**	**	**15%**		Current	Y
Kentucky	-9%	**	-2%		Current	
Louisiana	1%	**	**12%**		Current	Y
Maryland	**7%**	300%	4%		Current	Y
Massachusetts	3%	300%	7%		Current	
Minnesota	-3%	**	9%		New	Y
Missouri	6%	**	-2%		Current	Y
South Carolina	-4%	**	1%		Inactive	
Tennessee	-7%	**	2%	Y	Current	
Virginia	6%	**	**12%**		Current	
Washington	-1%	**	6%		Current	
Wisconsin	**3%**	**	**20%**		Current	Y
Bottom Ten, by number						
Idaho	**58%**	**	8%		Current	Y
New Hampshire	**10%**	100%	4%		Current	
Rhode Island	-2%	**	-18%	Y	Current	
Montana	5%	**	3%		New	Y
Delaware	-4%	100%	0%	Y	Current	
South Dakota	-2%	300%	**12%**		New	
North Dakota	2%	**	5%		Current	
Vermont	2%	**	**	Y	Current	
Wyoming	3%	**	6%		**None**	
Alaska	6%	300%	**8%**		**None**	

Sources: @Kaiser Family Foundation Report #7720-06 Medicaid Home and Community-Based Services Programs 2009 Data update. December 2012. # http://www.nasuad.org/medicaid_integration_tracker.html Last reviewed May 27, 2013. & Kaiser Family Foundation Report #8142-03 Money Follows the Person: A 2012 Survey of Transitions, services and costs. February 2013.

Long-Term Care Programs and Experiments

There is flexibility built into the design and management of state run LTC programs. Table 3 lists current active policies designed to achieve wider long-term care service access and cost control. Programs in the table are divided into two broad categories - operational prior to the ACA and those altered by the ACA. The new LTC policy – Balancing Incentives Program – appears in Table 4. The Appendix includes a detailed description of the Balancing Incentives Program. Prior to the enactment of the ACA, publically financed home and community-based services (HCBS) were organized around Medicaid State Plan Home Health or §HCBS 1915 Waivers. The ACA added the Community First Choice Option to the complement of §HCBS 1915 (k) Waivers. For states with more resources or active advocacy groups, there are §HCBS 1115 Waivers. The §HCBS 1115 waivers are strictly defined as temporary, experimental programs. As can be seen in the table, few states received approval to test LTC strategies under this statute.

Providing long-term care services in community settings is a key concept in the design of these policies. Destination states have low participation rates in these programs (Kaiser Family Foundation, 2011). At this point, we can only speculate about the barriers encountered. Many states pointed to the ACA maintenance of eligibility (MOE) requirements. MOE prevented many states from imposing HCBS eligibility restrictions in FY 2012 and FY 2013. The MOE required states to maintain eligibility for adults until January 1, 2014, and for children in Medicaid and the Children's Health Insurance Program (CHIP) until October 1, 2019. Because eligibility for Medicaid LTC services and Medicaid eligibility is linked, the Centers for Medicare and Medicaid determined that the MOE requirement was violated when:

- States increased the stringency of the institutional level of care determination processes;

- Switched from an aggregate to an individual cost neutrality method for HCBS waivers;

- Reduce occupied HCBS waiver capacity by reducing or eliminating HCBS waiver slots that were funded but unoccupied as of July 1, 2008. States were allowed to increase the institutional level of care criteria.

- States were not in violation of the MOE if an alternative eligibility pathway to Medicaid HCBS services was created for affected individuals. For example, a state could utilize the Section 1915(i) HCBS State Plan Option or Section 1115 demonstration waiver authority to offer level of care for receipt of HCBS and institutional services, ensuring that the available capacity for Medicaid eligibility remains unchanged.

- CMS has also noted that HCBS waivers are time limited and that the ACA MOE requirement does not require a state to renew a waiver that is expiring. Thus, a state may discontinue an HCBS waiver when it expires or may request a renewal at the end of the approved waiver period, with modifications, without creating an MOE issue.

All studies of barriers and facilitators of state-level LTC programs must consider the complex web defining maintenance of effort and its relationship to the Medicaid Expansion. Simply put, states that do not comply with MOE requirements are not eligible for enhanced expansion dollars.

The Home and Community-Based Services State Plan Option was created by the Deficit Reduction Act of 2005. This plan gave states an option to offer home and community-based services through a Medicaid State Plan Amendment rather than through a Section 1915(c) waiver. The first column in Table 3 shows the impact of the 2008 Recession on participation in the HCBS plan. Few states were able to increase enrollment – Illinois (26 percent), Alabama (43 percent), Indiana (58 percent) and Idaho (58 percent). The remainder implemented stringent eligibility criteria to slow growth or reduce the number of participants. Responding to low

state participation, effective October 1, 2010, the ACA utilized policies in place to expand eligibility. Under this option, adding individuals with incomes up to 300 percent of the maximum SSI federal benefit rate is one of many changes to address state concerns. MOE was a barrier to the ACA 1915(i) option that eliminated the states' ability to cap enrollment, maintain a waiting list or waive the requirement for the benefit to be offered statewide. Seven states (California, Colorado, Iowa, Nevada, Oregon, Washington and Wisconsin) reported having the HCBS state plan option in place prior to FY 2012. Also, since the ACA eliminated the ability of states to impose an enrollment cap on the HCBS State Plan option, one of the seven states that had previously implemented this option (Washington) reported eliminating it in FY 2012 and transitioning enrollees into comparable HCBS waiver services (NASUAD, 2013).

States also can deliver HCBS through §1115 demonstration waivers. Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services to waive state compliance with certain federal Medicaid requirements and authorizes the use of federal Medicaid funds in ways that are not otherwise allowable. Section 1115 waivers enable "experimental, pilot or demonstration project[s] which, in the judgment of the Secretary, [are] likely to assist in promoting the objectives of" the Medicaid program. Section 1115 waivers have been used to implement a variety of initiatives related to HCBS, such as consumer direction of personal care services, payments for spouses as personal care services providers, and managed long-term services and supports (LTSS). Three states (Arizona, Rhode Island, and Vermont) presently use §1115 waivers to administer statewide Medicaid programs that include HCBS for all populations and services. These states do not offer any §1915(c) waivers. Rhode Island delivers HCBS on a fee-for-service basis through its §1115 waiver. Arizona and Vermont use §1115 waivers

to apply managed care delivery systems to HCBS. Another five states (Delaware, Hawaii, New York, Tennessee, and Texas) use §1115 waivers for Medicaid managed care programs that include HCBS for at least some geographic areas and/or populations. These states also offer §1915(c) waivers for other HCBS. Other states implement Medicaid managed long-term services through combination §1915(b)/(c) waivers. Vermont's model is unique in that the state serves as the managed care entity. Other states administer Medicaid managed care programs that include a HCBS contract with private health plans to provide covered services. This patchwork quilt of programming cannot be predicted solely by the population growth factors shown in Table 1 or the spending factors shown in Table 2.

The Money Follows the Person (MFP) demonstration grant program was authorized by Congress as part of the 2005 Deficit Reduction Act (Brown et al., 2008; Kaiser Family Foundation, 2013; Lipson, Denny-Brown, and Williams, 2009; Lipson and Williams 2009). MFP provides states with enhanced federal matching funds for 12 months for each Medicaid beneficiary transitioned from an institutional setting to a community-based setting. Qualified community settings include a home, apartment, or group home with less than four non-related residents. The enhanced federal support is designed to encourage state efforts to reduce reliance on institutional care for individuals of all ages needing long-term services and supports. It expands options for individuals with disabilities and the elderly who wish to receive services in the community. The Centers for Medicare & Medicaid Services initially awarded MFP grants to 30 states. Over the past year, 16 more states have applied and received funding to begin an MFP demonstration. Thirteen states were awarded funding in February 2011, and another three states received planning grants in March 2012. Under the Affordable Care Act (ACA), MFP was extended by five years through 2016, and an additional $2.25

billion in federal funds were allocated for the demonstration. The ACA also changes the MFP eligibility length of stay criteria. Under the ACA, individuals who reside in an institution for more than 90 consecutive days are now eligible to participate. The previous criterion for the institutional residency period was six months to two years. Unfortunately, the days an individual resides in an institution for the sole purpose of receiving short-term rehabilitation under Medicare cannot count toward the 90-day residency period required for MFP eligibility. This policy change acknowledges that earlier intervention is often critical to prevent long-term nursing home stays. Residents with long stays often lose their original homes. This makes transitioning to the community more difficult (Lipson and Williams, 2009). Most states anticipated this policy change would increase the number of future MFP participants.

The Community First Choice Option began in October 2011. States electing this state plan option to provide Medicaid-funded home and community-based attendant services and supports receive a Federal Medical Assistance Percentage (FMAP) increase of six percentage points for services. California was the only state to report implementing this option in FY 2012. Upon approval, California immediately claimed funding retroactively for most in-home services provided since December 1, 2011. The state's press release announced that California will receive $573 million in additional federal funds during the first two years of implementation. An additional six states reported definite plans to implement the Community First Choice Option - Arkansas, Louisiana, Minnesota, Montana, New York and Oregon in FY 2013. Because the final federal rule implementing this option was not released by CMS until May 2012, it is possible that more evaluation time is needed in some states before an implementation decision can be made.

Table 4: Potential Drivers of LTC Policy Uptake - States with more than 500,000 residents aged 65 years and older in 2005.

State	Growth of Population aged 85 years and older >30% in 2000 - 2009	Long Term Care Spending in Community Settings <40%	FMAP > 55%	Total Taxable Resources (TTR) <0.95	State General Funds Medicaid Spending >18%	Balanced Incentives Program	Decision to Expand Medicaid Eligibility$
Top Ten, Ranked by NumberΩ							
California	+					+	+
Florida	+	+	+	+			
New York						+	+
Texas			+		+	+	
Pennsylvania		+	+	+	+		
Illinois		+			+		+
Ohio	+	+	+	+			-?
Michigan	+	+	+	+	+		-?
New Jersey	+	+				+	+
North Carolina	+		+	+			
States with 500,000 – 999,999							
Alabama		+	+	+			+?
Arizona	+		+	+			
Georgia		+	+	+		+	
Indiana		+	+	+		+	
Kentucky		+	+	+			Y
Louisiana		+	+			+	-?
Maryland	+					+	+
Massachusetts					+		+
Minnesota					+		+
Missouri			+	+	+	+	
South Carolina	+	+	+	+			
Tennessee		+	+	+			+?
Virginia	+						
Washington	+				+		+
Wisconsin		+	+	+			
Bottom Ten, by number							
Idaho	+		+	+			
New Hampshire	+				+	+	+
Rhode Island		+			+		+
Montana	+		+	+			-?
Delaware	+	+	+				+
South Dakota		+	+		+		
North Dakota		+	+				+
Vermont		+	+	+	+		+
Wyoming							
Alaska	+						

Sources: @Kaiser Family Foundation Report #8378 – Factors Driving State Spending. November 2012. **FMAP** is the ratio of its per capita income compared to the national average. The formula is defined in statute and ranges from a floor of 50% to a ceiling of 83%. **Multiplier** is defined by every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year. **TTR** is defined as the unduplicated sum of the income flows received by its residents which a state can potentially tax. βState Expenditure Report Examining Fiscal 2009 – 2011 State Spending. National Association of State Budget Offices, December 2011.
Bold + indicate states in the program; +? Maybe yes; -? Maybe no. Texas, Ohio, Massachusetts = Case discussion in text.

Potential Drivers of LTC Policy Uptake

Long-term care in community settings is the most cost effective way to deliver services (Kaiser Family Foundation, 2011, 2012a; Kaye, Harrington and LaPlante, 2010; Irvin, Ballou, and Wenzlow, 2009). States with less than 40 percent LTC spending in community settings have the potential to lower costs or increase service. Is cost control as simple as changing the setting of care? State-level fiscal policy is complex. There is little research to identify barriers to and enablers of state funding streams. Table 4 is a collection of speculative factors - FMAP, TTR, General Fund Dollars, Population growth, LTC Programs. High FMAP combined with low TTR suggests that a state has limited ability to redirect dollars. States with high rates of population growth in a short time span are likely to be cautious about new mandatory Medicaid spending. The final column shows state decisions about two ACA-related policies – the Balance Incentive Program and the Medicaid Expansion. Statistical modeling can measure the size of the association between these factors and program uptake. I have elected to leave that task to others. Some would argue that expanding Medicaid to new populations of uninsured adults is not LTC policy. However, LTC financing and Medicaid expansion are two compartments in the same purse.

Prior to the ACA, almost all states participated in the Money Follows the Person Program. Florida, Alabama, Minnesota, Montana, and South Dakota joined after enactment of the ACA. South Carolina has inactivated its program. South Carolina may be an example of a state that discontinued a waiver program to accommodate MOE policy. It is possible for a state to participate in more than one LTC program. Eleven of 26 MFP states have also obtained approval for the Community First Choice waiver. Two of the five new MFP states – Minnesota and Montana – have also obtained Community First Choice waivers. In most programs, the use of an HCBS 1915 waiver does not add new money to a state.

It gives them permission to redirect the funding stream. Ten of the 26 current MFP states have received permission to participate in the Balanced Incentive Program (BIP). The BIP adds new money to the federal dollars portion of the FMAP match. The state must also add new dollars. None of the new states and none of the states without MFP applied for permission to participate in BIP.

Can we learn more with a case analysis of individual states? Let us examine three states that illustrate common models – Alaska, Texas, and Massachusetts. Alaska has a small older adult population with rapid growth. Texas is a destination state with all the fiscal characteristics described in the prior paragraphs. Massachusetts is a state with a large population, slower growth, and fiscal capacity to adapt. Alaska has seen an explosive growth in its population aged 85 years and older – 78.9 percent in the period between 2000 and 2009. Alaska appears to have the fiscal capacity to accommodate the matching demands of federal programs. It spends 67 percent of its long-term care dollars in community settings. It has a low FMAP rate of 50 percent. Its TTR is 1.34 – meaning that it has resources to generate state income from taxes. It spends 6.1 percent of state general funds for Medicaid. Despite this capacity, it has elected not to participate in the Balanced Incentives Program or Medicaid Expansion. We need research to understand the considerations underlying their decision. Next, consider the fiscal constraints in Texas. Texas has a high FMAP (59.3 percent). It has a favorable Medicaid general fund spending rate of 11.6 percent. It has elected to use its capacity for BIP and not the Medicaid Expansion. Again, understanding the factors used by Texas legislators to participate in one federal program and not the other would be instructive. Ohio is similar to Texas in that it has multiple unfavorable indices - a 30 percent growth rate for the population aged 85 years and older, a high FMAP (63.6 percent), a low rate of community-based LTC spending (33 percent), and a TTR of 0.86. Ohio does not

participate in BIP and is leaning towards a 'no' on the Medicaid Expansion. Are there factors beyond these state fiscal indicators that would explain the choices made by Texas and Ohio that are not captured by the indices shown in Tables 1 to 3? Massachusetts is an example of a state where there appears to have the capacity to finance LTC and participate in new federal initiatives. Massachusetts' only unfavorable index is the 34 percent of the state general fund spending on Medicaid. It was an early adopter of the concept of Medicaid Expansion. Its high rate of community-based service (47.1 percent), low FMAP (50 percent), and high TTR (1.24) all suggest capacity to absorb short-term increases in LTC services. It does not participate in BIP. Again, understanding this decision process could lead to new policies to assist states as they adapt to the growth of complex older patients.

In summary, the data shown in Tables 1 to 4 suggest that variable rates of population growth across the states play a role in long-term care financing. As the U.S. moves into the peak of World War II cohort aging, states will need to adopt a dynamic approach to monitoring long-term care. Policy development will benefit by broadening their view of funding streams. The following list of recommendations are suggested to initiate research to provide a basis for new policy,

Recommendations

Federal Level Policy Recommendations

- We need an alternative to FMAP–based financing of public plans. FMAP (Federal Medical Assistance Percent) is estimated using per capita income. FMAP does not recognize the growth of a retiree population or the loss of state income from their tax- exempt status (Kaiser Family Foundation, 2012b). The two main approaches to financing Medicaid long-term care policy are waiver programs (1915, 1115) and enhanced FMAP

funding (Community First Choice, Balancing Incentives Program). HBCS 1915 waivers are required by law to be revenue neutral for federal funds. The Balancing Incentives Program gives states extra points of FMAP percent for a time limit. Cash-strapped states cannot take full advantage of these programs.

- Revive the CLASS ACT and fix its fiscal problems. In the U.S., the private insurance model is our preferred structure for financing health care. One approach to private LTC insurance is Prepaid Health Plans (PHPs). A personal PHP with limited services would help to off-load the pressure on state Medicaid budgets.

State Level Policy Recommendations

- Commit to a primary strategy of home and community-based long-term care. This is easy to say and difficult to accomplish. Some states require legislation to change payment policy. Others will need to encourage for-profit institutions to change their business model. Still others will need to create incentives for older adult housing.

- Experiment with sales of PHP riders on policies sold within the ACA Health Insurance Exchanges. Encourage approved companies to enhance their non-medical benefits by including limited care to meet intergenerational needs. These non-medical benefits could include light housekeeping, meal delivery, and local transport. Scenarios that apply across the age groups include persons with temporary walking disability (fracture, sprain); three months post-delivery maternity care; or limited convalesce after a surgical procedure.

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Appendix: Balancing Incentives Program

Balancing Incentive Program (NASUAD, 2013)

The Balancing Incentive Program authorizes grants to States to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011.

The Balancing Incentive Program will help states transform their long-term care systems by:

- Lowering costs through improved systems performance and efficiency
- Creating tools to help consumers with care planning and assessment
- Improving quality measurement and oversight

The Balancing Incentive Program also provides new ways to serve more people in home and community-based settings, in keeping with the integration mandate of the Americans with Disabilities Act (ADA), as required by the Olmstead decision. The Balancing Incentive Program was created by the Affordable Care Act of 2010 (Section 10202). States can qualify for a 5 percent FMAP increase if less than 25 percent of their total Medicaid long-term services and supports expenditures in 2009 were for non-institutionally-based services. The only state to meet this requirement is Mississippi. States can qualify for a 2 percent FMAP increase if less than 50 percent of their total Medicaid LTSS expenditures in 2009 were for non-institutionally-based long-term support services. The following 37 states meet this requirement: ME, MT, TX, NY, ID, RI, MA, CT, UT, NC, HI, VA, TN, NV, OK, NH, MO, SD, WV, IA, NE, SC, GA, MD, LA, DE, FL, MI, PA, OH, KY, IN, AR, AL, ND, IL, NJ.

How the Balancing Incentive Program Is Financed

The Balancing Incentive Program increases the Federal Matching Assistance Percentage (FMAP) to states that make structural reforms to increase nursing home diversions and access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a state's LTSS spending, with lower FMAP increases going to states that need to make fewer reforms. Total funding over 4 years (October 2011 – September 2015) can't exceed $3 billion in Federal enhanced matching payments.

Federal Funding for State Programs

To participate in the Balancing Incentive Program, a state must have spent less than 50 percent of total Medicaid medical assistance expenditures on non-institutionally-based LTSS for fiscal year 2009. States must also submit an application that meets programmatic and structural reform requirements.

- States that spent 25-50 percent on non-institutionally-based LTSS are eligible for a 2 percent enhanced FMAP. These states must reach 50 percent of total LTSS expenditures on non-institutionally-based LTSS by September 30, 2015.

- States that spent less than 25 percent on non-institutionally based LTSS are eligible for 5 percent enhanced FMAP. These States must reach 25 percent of total LTSS expenditures on non-institutionally based LTSS by September 30, 2015.

The Balancing Incentive Program Guidelines

Beginning in October 2011, the Balancing Incentive Program (BIP) makes enhanced Medicaid matching funds available to states that meet certain requirements for expanding the percentage of LTC spending for HCBS (and reducing the percentage of LTC spending for institutional services). Funding is available through September 2015. To qualify, states must: develop a "no wrong door/single entry point" system for all long-term care services, create conflict-free case management services, and develop core standardized assessment instruments to determine eligibility for non-institutionally-based LTC. In last year's survey (before CMS had released the program application and related guidance in September 2011), a large majority of states (34) reported that they did not know whether they would apply for the program. In this year's survey, four states reported having already implemented the program (Georgia, Iowa, Maryland and New Hampshire), and 10 states reported plans to implement the program in FY 2013. The Balancing Incentive Program requires states to implement structural changes, including a no wrong door/single entry point system (NWD/SEP), conflict-free case management services, and core standardized assessment instruments. The Balancing Incentive Program state must agree to use the enhanced FMAP only to provide new or expanded home and community-based LTSS. The state can't restrict LTSS eligibility more than the standards already in place as of December 31, 2010.