Informing the Debate

Health Policy Options for Michigan Policymakers

Rationing Long-Term Care: Michigan's Home and Community Based Waiver Program

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About this Series

This paper is part of a series entitled **Informing the Debate: Health Policy Options for Michigan Policymakers.** The series is a collaboration between Michigan State University's Institute for Public Policy and Social Research and Institute for Health Care Studies. The papers are designed to inform state and local elected officials and candidates on Michigan's critical health policy issues. They were created to present balanced and nonpartisan background information and possible solutions for this important policy subject area. *Additional copies of the reports are available online at http://www.ippsr.msu.edu/PPIE and http://www.ihcs.msu.edu/policy.htm.*

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EXECUTIVE SUMMARY

The State of Michigan has a unique opportunity to restructure its long-term care system for our disabled and older population. In order to meet the burgeoning needs for long-term care services, Michigan finds itself at a crucial juncture in which it will substantially increase institutionally based long-term care services or choose an innovative route to make home and community-based care the primary venue of care. Historically, Michigan has rationed both institutional and community-based services, particularly when compared to other states. This paper describes the background for the current long-term care system in Michigan and traces the development of the Medicaid Home and Community Based Waiver (HCBW) program.

Two years ago an ambitious effort to frame the future direction of Michigan's long-term care system culminated in an extensive plan with a number of worthy recommendations. However, actual implementation of this plan has faltered. Contrary to one of the stated goals of the plan, the number of participants in the HCBW program was reduced. One of the most visible outcomes of the reduction in HCBW slots has been a lawsuit filed by multiple individual plaintiffs and advocacy organizations against the State of Michigan. The fact that Michigan allocates relatively few resources to long-term care, places us in an ideal position to meet the growing demand for long-term care services with community-based solutions. The experience of other states suggests that a system of care focused on community-based services rather than institutional care can result in lower state expenditures with greater consumer and public satisfaction. This paper provides specific policy recommendations, as briefly summarized below, for making this transition a reality within our state.

Michigan finds itself at a crucial juncture in which it will substantially increase institutionally based long-term care services or choose an innovative route to make home and community-based care the primary venue of care.

Summary of policy recommendations:

1. Conduct a needs assessment with long-range planning and intermediate goals through 2030.
2. Establish an accurate count of immediate unmet needs for long-term care by creating a waiting list of eligible HCBW beneficiaries.
3. Create a single-point of entry for all long-term care services.
4. Provide a mechanism for both follow-through and accountability within the state plan for long-term care.
5. Mandate a state board of long-term care with consumer representation.
6. Educate nursing-home residents and families about community options.
7. Increase HCBW slots to 50,000 to match nursing home beds.
8. Create a consumer directed HCBW model and allow hiring of family members and friends to provide services.

Overview of Issues in Michigan

Michigan's Aging Population and Current Long-term Care Policies

Michigan has significantly fewer beds per 1,000 elderly (65+ years) than the rest of the United States (41.3 beds per 1,000 in Michigan and 52.2 beds per 1,000 in the United States in 1999).

The majority of older adults who need long-term care prefer to receive it in their own home whenever possible. Given this preference, the range of home-based long-term care services is severely limited, except for individuals who can afford to pay for them privately. Historically, Medicaid has reimbursed costs for nursing homes but has paid for less expensive home and community-based services on a very restricted basis. Therefore, without the ability to pay for home-care services, most individuals have been faced with institutionalization as their only option.

Similar to the rest of the nation, Michigan's population is rapidly aging. Based on 2000 census, 12.4 percent of the state population is over age 65, a figure that is expected to match Florida's current senior population (18%) within the next two decades. The projected number of aged Michiganians will place unprecedented demands on long-term care services. Already, Medicaid expenditures for long-term care represent a substantial cost to the State of Michigan. The highest long-term care cost is related to nursing home care which represents two-thirds of the state Medicaid budget, over 1.2 billion dollars annually.

The Michigan nursing home industry is comprised of 456 skilled nursing facilities with roughly 52,000 residents. The State of Michigan continues to operate a certificate of need program that requires most hospitals, nursing homes and other health-care facilities to apply for permission to open or expand a major health service. Health-care providers who fail to obtain a certificate of need for their facilities or program would be excluded from Medicare, Medicaid and Blue Cross Blue Shield reimbursement for services provided in the unapproved facility. Through its certificate of need program, the State of Michigan has limited the growth in the number of licensed nursing home beds during the last 20 years, not keeping pace with the growth in the elderly population. Consequently, Michigan has significantly fewer beds per 1,000 elderly (65+ years) than the rest of the United States (41.3 beds per 1,000 in Michigan and 52.2 beds per 1,000 in the United States in 1999). Michigan's nursing home bed capacity differs significantly from other Great Lakes states (Illinois, Indiana, Minnesota, Ohio and Wisconsin), which had 73.4 nursing home beds per 1,000 elderly in 1999. [1]

Michigan's nursing home care is widely perceived to be substandard. Two public opinion polls conducted by the MSU Institute for Public Policy and Social Research reported that more than half of Michigan adults rated the quality of Michigan nursing home care as fair or poor; the corresponding rating for Michigan hospitals was 19 percent. [1,2]

Nearly half of the poll respondents thought that the State of Michigan was very or somewhat ineffective in assuring nursing home quality of care. This assessment was confirmed by a recent report from the Government Accounting Office (GAO),[3] which found that nursing home inspections in Michigan were frequently not protecting nursing home residents from potential serious or life-threatening harm. Public opinion regarding nursing home quality and state regulatory effectiveness was most negative in the metropolitan Detroit area of Macomb, Oakland and Wayne (including the City of Detroit), a region with a nursing home occupancy rate below the statewide average.

The Health Care Association of Michigan collected resident satisfaction data in their member facilities.[4] These satisfaction surveys generally show high levels of resident or family member satisfaction with their nursing home care. Although an outside contractor has been used to administer the survey, concerns about potential bias have arisen because more than one-third of nursing homes did not participate. Moreover, resident/family member contact information was provided by the facilities, which may have excluded some residents or family members from participation. The possible threat of retribution following negative survey responses also poses concerns about response bias in this data.

In 1998, Michigan spent $250 per capita on nursing home care, roughly three-quarters of the national average of $325 and only about two-thirds of the per capita spending of other Great Lakes states. Michigan's spending on home healthcare services,[5] a substitute for nursing home care, is the same as other Great Lakes states ($86 vs. $87 per capita), but this region in general spends only 80 percent of the national per capita average of $108 on home health care. In 1990, Michigan's spending on home health care through the Medicaid and Medicare programs was at the national average. From 1997 to 1998, Medicaid and Medicare spending on home health care services in Michigan fell by 16 percent, compared to four percent nationally.

Given the aging of the state population and the relative scarcity of state funding for nursing homes and other systems of long-term care, the time may be ideal for careful assessment of public expenditures of resources for care of older and disabled persons in Michigan.

What Has Michigan Already Done?

In 1992, Michigan began attempting to rein in the rising Medicaid costs for nursing home care and provide consumers with greater choice by piloting a statewide HCBW program in 11 counties.

Often referred to as simply the Waiver program, HCBW is based on the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration) federal 1915c provision. This provision is designed to offer low-cost care alternatives to nursing home eligible individuals. Table 1 illustrates the array of services provided through the HCBW program.

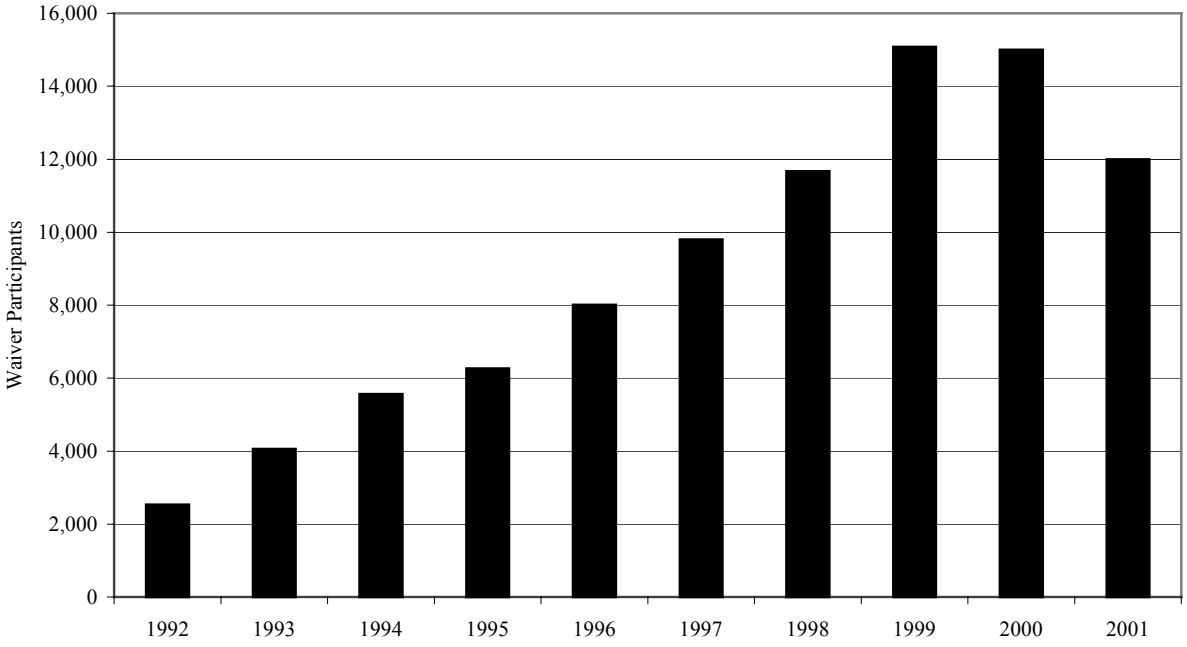
The HCBW program was adopted statewide in 1998, expanding to 15,000 federally authorized slots in FY 2000. (Figure 1) Michigan planned to spend $126M in FY 2000 for the HCBW program with 15,000 slots; however, the cost of the HCBW program exceeded the budgeted cost by $20M.[6] In FY2001, the State of Michigan reduced the number of slots to 12,000 in order to maintain a budget expenditure of $126 million.

Michigan's spending on nursing home care is also appreciably lower that the national average and significantly lower than other Great Lakes states.

Table 1. HCBW Services

- Adult day care
- Respite services
- Chore services
- Homemaker services
- Transportation
- Environmental modifications
- Home delivered meals
- Private duty nursing
- Medical supplies and equipment
- Counseling
- Emergency response system
- Personal care supervision

Figure 1. Medicaid Waiver Program, Total Participants in Michigan by Calendar Year[7]



Although the Michigan HCBW program has been growing in recent years, it has maintained its relative position with respect to the rest of the United States and to the Great Lakes states. The Michigan HCBW program continues to be smaller and less well supported than similar programs in other states and especially with respect to the other Great Lakes states. (Figures 2, 3) In 1999, Michigan ranked 36th among all states and last among the Great Lakes states in Medicaid expenditures per capita for long-term care.[8]

Figure 2. Medicaid Waiver Program (per 1,000 population) by Calendar Year[7]

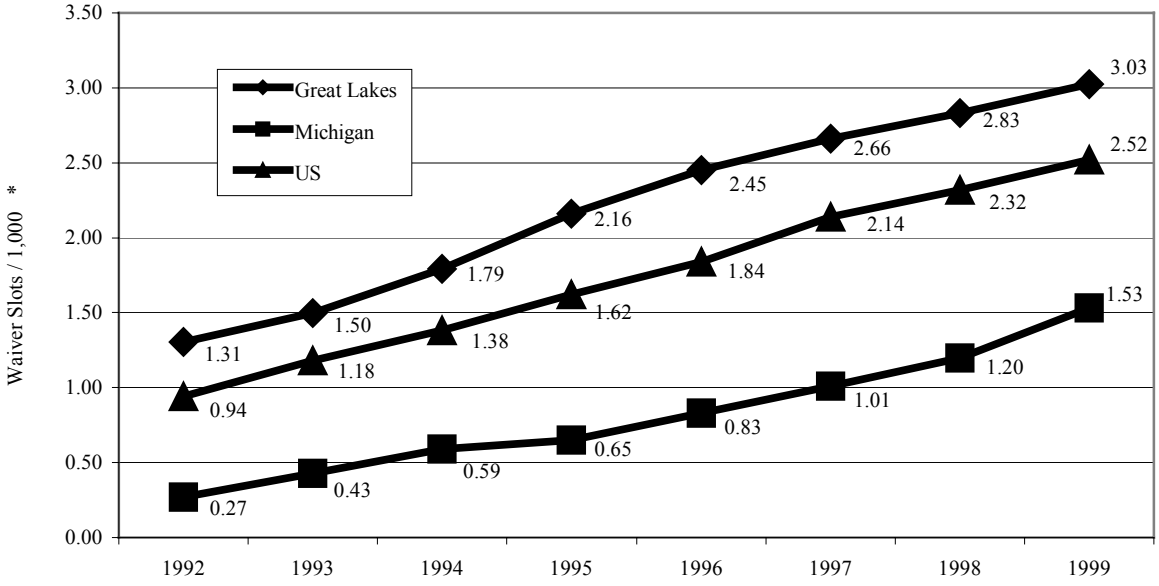
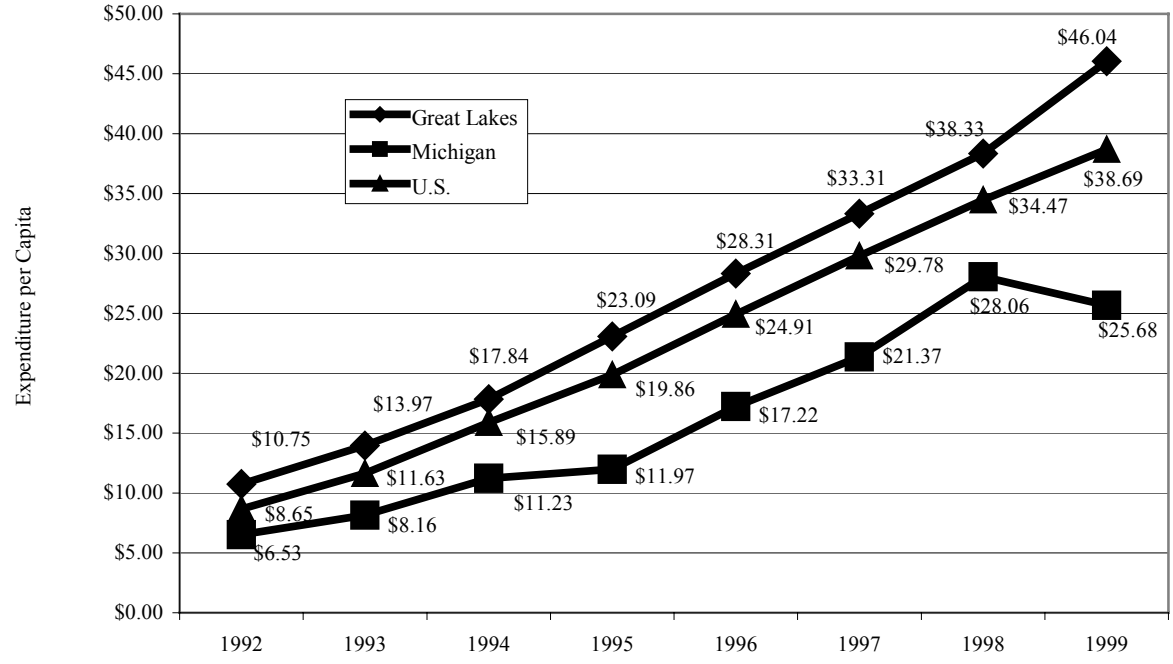


Figure 3. Medicaid Waiver Program Expenditures by Calendar Year[7]



The "Woodwork Effect" and Unmet Needs

One of the overarching concerns among policymakers is that the availability of home and community-based services may alter existing caregiving patterns. The fear is that friends and relatives will curtail their informal caregiving and instead flood the public system with service needs, producing what is sometimes referred to as the "woodwork or substitution effect." Extensive research however finds little support for these concerns.

For example, through in-depth interviews with 661 older adult home care users, Penning (2002) found that the volume of publicly funded care received was not associated with the level of care provided by family and friends. The more typical profile appears to be that formal care supplements self and family care, delaying more costly institutionalization. [1]

Due to Michigan's lower than average number of nursing home beds per elderly population compared to other states, there is a potentially large number of aged individuals whose need for long-term care services would qualify them for nursing home admission but who cannot or will not use nursing home services. This subgroup is likely to represent, in part, the level of unmet need for long-term care services.

It is important to distinguish between a woodwork effect and disabled adults with legitimate unmet needs who are going without important services. The question of unmet need is not one of substituting public for private resources, but rather one of whether or not to provide care to individuals who truly need and qualify for publicly financed long-term care services. If Michigan wants to address unmet long-term care needs, then overall Medicaid costs will inevitably be higher. However, the increase would likely be minimized through the use of the HCBW program compared to institutional care.[21]

How Home and Community Based Waiver Operates in Michigan

The Michigan Department of Community Health (MDCH) oversees the HCBW Program with 23 waiver agents administering the program at the local level. The majority of waiver agents are Area Agencies on Aging that conduct assessments for eligibility. The daily cost for the HCBW program is not to exceed $42/day, $10 of which is used for administrative costs of the waiver agents. These costs are less than half the current Medicaid rate for nursing-home care ($115).

The HCBW program eligibility rests on both medical and financial criteria. Beneficiaries must require nursing-home level of care and have incomes at or below 300 percent of the level necessary to qualify for Supplemental Security Income. Supplemental Security Income is $545 monthly for a single individual with a maximum $1,635 and $817 for a couple with a maximum of $2,451 in 2002.

Once waiver agents determine eligibility, a plan of care is developed with the client. Waiver agents then arrange and oversee subcontracted services as deemed appropriate. Clients within Michigan's HCBW program are permitted to request specific workers. However, concerns about liability have thwarted a more robust consumer directed model in which clients can hire, manage, and fire workers themselves.

Comparing HCBW to Home Help

In addition to the HCBW program, there are other community based long-term care options funded through Medicaid, including the Home Help Program. Home Help began in the 1970s and is administered by the Family Independence Agency (FIA). The program assists functionally limited individuals who are Medicaid eligible to remain in their homes for as long as possible by providing non-specialized personal care services and unskilled nursing care. At first glance, it appears as if Home Help serves the same purpose as the HCBW program. However, the HCBW and Home Help programs have different eligibility criteria. Home Help beneficiaries must need assistance with one or more instrumental activities of daily living (IADLS) such as shopping, money management, meal preparation and housekeeping, a standard that is much less restrictive than the level of care criteria for HCBW beneficiaries. HCBW beneficiaries must meet the level of care criteria required for Medicaid coverage in a nursing home in which basic or skilled care is needed on a daily basis. They would likely reside in a nursing home if not for the HCBW program. Individuals who qualify for the Home Help program receive limited supportive services. In contrast, the HCBW program provides a wider array of services and most importantly, skilled care.

Two other major differences between the two programs is that Home Help allows consumer directed care (the ability of the consumer to hire, fire, and manage workers themselves) and payments to family members and friends. Consequently, the majority of paid Home Help care is indeed provided by family and friends — caregivers who are likely to be providing unrestricted care anyway. FIA Director Douglas E. Howard states that there is a considerable amount of unpaid family services provided over and above the 25 million hours of care to 38,000 customers paid through the Home Help program.[9] Finally, unlike the HCBW, the Home Help program is considered an entitlement just as is Medicaid nursing home care. It is available to any individual who meets the eligibility criteria. Table 2 further illustrates the distinguishing features between the HCBW, Home Help, and nursing home

programs and demonstrates the vast majority of expenditures are for recipients of nursing home care. More individuals have their expenditures covered in nursing homes than in HCBW or Home Help programs.

Table 2. Comparison of HCBW and Other State Medicaid-Funded Plans

ISSUE	HOME HELP	NURSING HOME	HCBW
Funding Source	Medicaid	Medicaid	Medicaid
Recommended Expenditures (FY 01-02)	$158.8 million	Over $1 billion	$128.5 million
Covered Services	Assistance with IADLs and hands-on personal care.	24-hour skilled nursing care and assistance with ADL and IADL	See Table 1 above.
Consumer Direction	Consumers can hire, fire and manage their own individual workers.	Consumers can choose nursing home.	Consumers can choose agencies.
Entitlement Status	Enrollment is not limited to control costs. All eligible beneficiaries receive services.	Enrollment is not limited to control costs. All eligible beneficiaries receive services.	Cost is controlled through an enrollment cap. Waiting lists are not allowed. It requires a federal waiver.
Functional Criteria	Beneficiary must require assistance with 1+ IADLs.	Require basic or skilled care on a daily basis.	Adults 18+ who require a nursing home level of care.
Financial Eligibility	Must meet SSI criteria or be eligible for Medicaid.	Monthly income must be less than the total of the Medicaid rate for nursing-home care and regular monthly medical expenses.	Income eligibility up to 300 percent of monthly federal SSI standard.
Accountability / Quality Assurance	Primary responsibility rests with the consumer.	Annual state inspections.	Waiver agents periodically monitor providers' service delivery.
Number of Individuals Served	38,000 per month	52,000 residents	12,000 slots

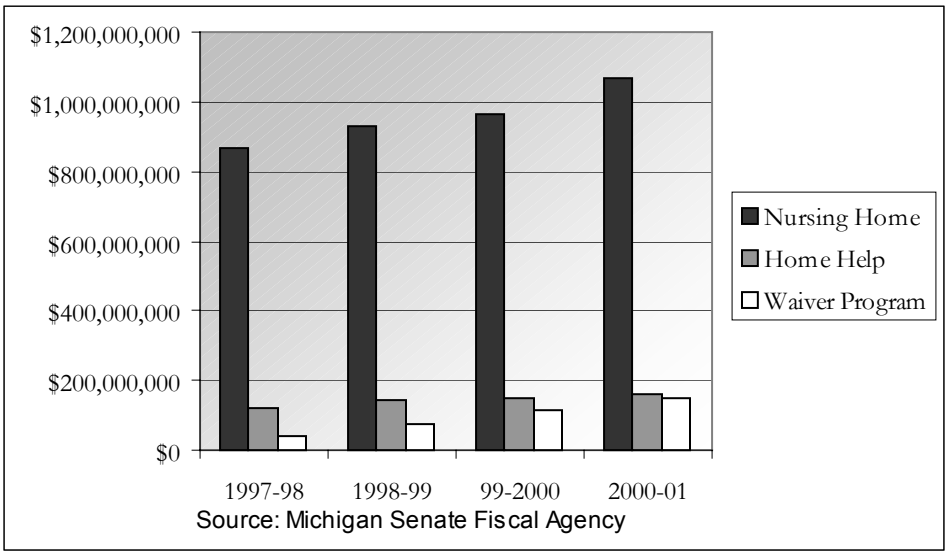
Although the HCBW program has been fully implemented for just four years, evidence suggests that it may have contributed to containing institutional Medicaid expenditures.

HCBW Impact on Medicaid Funds

Michigan's HCBW is still in an infancy stage, in as much as Michigan was the 42nd state to adopt a waiver program.[10] Based on data from the Medicaid HCFA 2082 report, occupancy rates for Michigan nursing-home beds declined only slightly during the first two years of the fully implemented HCBW program (1998-2000). During this same period, Medicaid bed days in these nursing home facilities dropped from 10,964,698 in 1998 to 10,200,000 in 2000. If the HCBW program had not been available during the same time period, the Area Agencies on Aging Association of Michigan notes that Medicaid bed days would likely have risen significantly given the growth of older Michiganians.[11]

Data from more established programs in other states indicate that there is a direct relationship between HCBW programs and cost-savings. For example, in Maine, total long-term care spending for both elderly and adults with physical disabilities actually declined from $284.7 million in 1995 to $264 million in 1998. At the same time, the number of clients served increased from 19,093 in 1995 to 23,346 in 1998 after implementation of the HCBW program. [12]

Figure 4. Medicaid Long-Term Care Expenditures in Michigan 1997-2001



The ratio of Michigan's total Medicaid long-term care expenditures devoted to home or community-based care as compared to nursing homes has risen from 1:6 in 1997-98 to nearly 1:4 in 2000-01. Most of this expansion is due to the HBCW program. Preliminary expenditures for the current fiscal year suggest a possible decline in HBCW program expenditures, with nursing home expenditures remaining roughly constant.

How HCBW Program Fits Into Michigan's Blueprint for Long-Term Care

In 1999, the Long Term Care Work Group was appointed by the Michigan Legislature with representation from the State House, Senate and Department of Community Health (DCH) to develop a vision for improving the long-term care system in Michigan. This bipartisan group received input from a range of stakeholders including providers and consumers. The work group's efforts culminated in a final report released in June 2000 in which it recommended five approaches for the provision of long-term care services.[13] These approaches would be subsumed under a new system known as MI Choice Access (not to be confused with MI Choice), providing a single point of entry for long-term care resources. Features of MI Choice Access would include a statewide toll-free number telephone system, local Information and Assistance Centers, assessments, referrals and a statewide enrollment broker. One of the approaches, the Care Coordination Model (CCM) would expand on the current HCBW program, integrating the range of acute and long-term care services for Medicaid recipients through collaborative, team-based planning and monitoring. Additionally, a wide array of services through public and private partnerships would be established, thereby giving consumers a greater number of choices.

In addition to incrementally implementing all of the components of MI Choice Access, the Long Term Care Work Group made many recommendations to both public and private entities for the future of long-term care in Michigan. These were shaped by the group's guiding principles to increase consumer directed care and choices, improve access to a range of long-term care options, enhance quality of care and life, encourage family and personal responsibility, cost effectiveness, and minimization of inappropriate cost-shifting. *Moreover, the group made a commitment to not reduce or eliminate current services.* Table 3 illustrates the key recommendations that would most directly influence the HCBW program.

Since the release of the work group report in 2000, it is unclear which of the group's 70 plus recommendations have been initiated. Nor is it clear with whom the responsibility for implementation rests. The 2000 report does not indicate to whom the recommendations were given or whether the Governor or MDCH ever made formal commitments to implement them. A number of the recommendations were directed to the private sector with the state bearing no responsibility for implementation. For example, the work group recommended that the long-term care industry consider designs that provide small home-like groupings of residents and that the private sector provide pre-retirement education for their employees. Recommendations were directed, in most cases, to the State of Michigan in general. When a department was specified, it was most often the MDCH.

The MDCH has taken the lead on continuing to slowly move reforms forward. It created the Long-Term Care Initiative aimed at assuring that a patient's needs are met in the most appropriate setting. In a March 2001 summary of a work group meeting discussion, Brenda Fink, Director of the Long-Term Care Initiative, reported that over 5,000 copies of the work group report had been distributed to a wide variety of stakeholders including Medicaid and Office of Services to the Aging directors across the country.[14] In addition, MDCH issued a request for proposals to develop and evaluate innovative long-term care projects, funded through Tobacco Settlement Funds. Three million dollars of the tobacco funds were designated for a public information and education campaign about individual planning for long-term care with the hope being that if more people plan for retirement, public health care

Table 3. Long-Term Care Work Group Recommendations

1. Expand the HCBW program when current opportunities are full.
2. Allow continuous nursing care in licensed Adult Foster Care homes and licensed Homes for the Aged.
3. Include emergency care and family/caregiver support in long-term care models.
4. Allow consumer directed care. Establish fiscal intermediaries to provide the necessary fiscal functions.
5. Allow coverage of room and board costs in non-nursing home settings.
6. Allow coverage of transition costs from nursing home to community care such as rent deposits and furniture.
7. Providers and associations collaborate to establish cooperatives for worker health benefits.
8. DCH evaluate practices of staff compensation within capitated long-term care systems.
9. Create a registry of available workers and the work they seek.

(Continued on page 12)

Table 3. Long-Term Care Work Group Recommendations *(continued)*

10. Increase family respite care for non-Medicaid eligible individuals with reimbursement on a sliding scale.
11. Use FIA child day care funds to support families who provide care for parents.
12. Expand public housing for adults with disabilities and the elderly that are consumer focused rather than provider focused.
13. Use consumer directed vouchers for purchase of non-traditional services.
14. Consider modifying state building codes to make homes more accessible.
15. Have uniform financial eligibility criteria and ability to "spend-down" for all long-term care services.

dollars can be reduced. Telephone survey research and a marketing strategy were developed to identify what areas of information the campaign should target. MDCH has also assessed long-term care models adopted by other states, developed web-based resources for information, created an initial work plan covering all report recommendations, and reportedly identified which state departments should be involved in implementation of each recommendation. All of these initiatives indicated movement toward eventually implementing the Long Term Care Work Group recommendations.

However, the FY 2002 recommended state budget did not include rate increases for Medicaid providers and did include cost containment strategies such as the elimination of new MDCH initiatives and a reduction of funding for Medicaid outreach efforts. It also required MDCH to reduce general fund expenditures by $85.3 million. These reductions were offset by increased special financing revenue but have led to some program reductions nevertheless. Although the economy is expected to improve and thereby lead to a slow decline in the number of Medicaid recipients, program priorities appear to have shifted somewhat from those outlined in the 2000 Work Group report in order to take advantage of new Bush Administration policies. According to the FY 2003 MDCH budget report, funds are slated for the MIFamily Plan (new initiative to create limited Medicaid health insurance benefits for low-income and disabled residents), a pharmaceutical assistance waiver and increases in Home Help.[15] It is anticipated that the Long Term Care Initiative will save $22.4 million by shifting utilization of nursing facilities to community and in-home long-term care programs. It is unclear how this shift will be accomplished. Also, a single-budgeted line item for nursing-home facilities, HCBW programs and Home Help will be created so that long-term care services will be based on the total state long-term care budget and individual need rather than separate budgets with separate requirements. Combining these line items will make tracking of expenditures for each specific program more difficult.

The majority of the recommendations outlined in the work group report appear to not have been implemented. The work group has not met regularly since 2001. Current information from the state and MDCH about the status of the HCBW program or new future plans for long-term care reform in light of budget concerns is unavailable due to the lawsuit recently filed against the state and MDCH (see HCBW lawsuit section below). The case is related to the state's decision to reduce the number of HCBW beneficiary slots from 15,000 to 12,000, an action contrary to the Long Term Care Work Group's recommendation to expand the program. Although future policy is unclear, this reduction may provide some indication of the future direction in Michigan and the state's commitment to the HCBW program.

HCBW Lawsuit

In March 2002, advocates for elderly and disabled Medicaid recipients filed a lawsuit against the State of Michigan claiming that the reduction in HCBW slots is illegally violating the Medical Assistance Act (Medicaid) and Americans with Disability Act (ADA) pursuant to the Olmstead Supreme Court decision. (See sidebar for discussion of Olmstead ruling.) This lawsuit was filed in U.S. District Court in Lansing and involves seven individual and five organizational plaintiffs who allege that the State of Michigan is forcing individuals into nursing homes unnecessarily.[16] All of the individual plaintiffs are each eligible for and have applied or have attempted to apply for and have been denied services available through the HCBW. Plaintiffs have been unable to gain access to these critical services because of the

October restriction of the HCBW program that has resulted in the closure of the program to virtually all new applicants.

This complaint seeks declaratory and injunctive relief. Specifically, the lawsuit requests that individual plaintiffs be admitted to the HCBW program, that all eligible individuals of the program's existence be notified and a waiting list for all individuals who appear to be eligible be maintained. Furthermore, the lawsuit is demanding a plan that will provide with reasonable promptness, community-based services for individuals on the waiting list, thereby avoiding unnecessary institutionalization.

Experience in Other States

Minnesota provides one of the most promising examples of successful HCBW programs. Similar to Michigan, the State of Minnesota convened a Long-Term Care Task Force in 2000 to address the emerging issues in long-term care. The task force members included 12 legislators, six senators and six representatives, named by the leadership in the Senate and House, with bipartisan representation. Members also included three commissioners of state agencies most involved in long-term care issues: the Minnesota Department of Human Services, Minnesota Department of Health and the Minnesota Health Finance Agency.

The Long Term Care Task Force issued a report in January 2001, "Reshaping Long-Term Care in Minnesota." Legislation was passed in the same year calling for a local analysis and planning process to assess the capacity and gaps in local long-term care services for older persons. Nearly all counties in the state reported the inadequacy or unavailability of many long-term care services and housing options for frail elderly in their county; nearly half of the counties reported excess nursing-home bed capacity. Provisions included in the 2001 legislation sought to initiate the creation of new options that address these gaps in services and housing.

As an example, every two years the Minnesota Department of Human Services issues a report to the Minnesota Legislature concerning the *availability and need for nursing home beds* now and in the future. The first report, "Rightsizing the Nursing Home Industry 2001," was issued in March 2002. It examines trends in population, number of beds, bed utilization by the elderly, occupancy, lengths of stay, and disability rates to assess present and future long-term care needs in Minnesota. More information on the Minnesota Aging Initiative can be found on the state's website: http://www.dhs.state.mn.us/agingint/reports/default.htm.

The implementation of the Minnesota Long Term Care Task Force Report resulted in legislation that requires periodic reporting by state agencies on the achievement of specific goals. The public accountability resulting from the Minnesota legislation appears to have maintained the momentum of the Minnesota Aging Initiative. Like Minnesota, Pennsylvania has established an Intra-Governmental Council on Long-Term Care which continues to meet and study the ongoing long-term care issues within the state, publishing regular reports for policymakers and the public.[17]

Olmstead Supreme Court Decision

In 1999, the US Supreme Court determined that the Americans with Disabilities Act (ADA) required that state governments treat individuals with disabilities in community settings rather than institutions, whenever appropriate.

Justice Ginsburg delivered the opinion of the Court with respect to Parts I, II, and III–A, concluding that, under Title II of the ADA, states are required to place persons with mental disabilities in community settings rather than in institutions when the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.[22]

As a result of the Supreme Court ruling, consumers were granted new rights under the ADA to live in something other than an institution when health or supportive services are needed. While the decision applies to all government-funded programs and to all people with disabilities, regardless of age or the kind of disability, the decision most immediately affects the responsibilities of states to build and fund non-institutional alternatives to long-term care. The *Olmstead* Supreme Court decision and subsequent guidance from the Department of Health and Human Services (DHHS) provide an impetus for nursing home options and a process for the creation of the additional non-institutional services.

…substantial new evidence supports the argument that home and community based services are indeed cost-effective.

Other states provide evidence of successful implementation of the HCBW, particularly with respect to cost-savings. While some research conducted in the 1980s suggested that HCBW programs actually add to overall long-term care costs due in part to the woodwork effect, substantial new evidence supports the argument that home and community based services are indeed cost-effective. As noted earlier, Maine has experienced both significant savings and the ability to serve greater numbers of individuals by transitioning to a greater emphasis on HCBW services. In addition, Colorado, Oregon, and Washington have all shifted their long-term care priority from nursing homes to home and community-based services, primarily through a HCBW program.

Research funded by the American Association of Retired Persons evaluated the HCBW program in these three states and although they were not able to unequivocally establish causality, they concluded that the states appear to have saved Medicaid funds and slowed the increase in Medicaid spending by expanding HCBW services and reducing reliance on nursing home care.[18] Washington, which had the lowest savings, was nevertheless projected to have saved over $1 million dollars in 1994. All measures used, including the number of nursing-home residents, Medicaid nursing home and long-term care spending, the HCBW services as a share of long-term care expenditures, and projected versus actual Medicaid expenditures, indicated both reductions in nursing-home use and cost savings associated with the HCBW services. To realize such savings, Colorado, Oregon and Washington used the following strategies:

- Targeted the HCBW care to a seriously impaired population (individuals who would otherwise be in nursing homes);
- Limited per-person spending on HCBW services by using government funds only after exhausting all other resources and by keeping payments to providers low;
- Aggressively screened all or most people applying for Medicaid-funded nursing-home care to determine if they could remain in the community;
- Provided a wide array of HCBW services;
- Increased the number of people served in the community faster than the growth in the population of adults under age 65 with disabilities and persons age 75 and older;
- Gave local agencies responsibility for the delivery of services; and
- Instituted comprehensive care management.

In addition to the strategies noted above, these three states have used one or more of the following specific components in their long-term care systems:

- Direct payments to family members.
- A centralized agency at the local level.
- Integrated programs covering all forms of long-term care.
- HCBW funding of assisted living facilities.
- Consumer directed care.
- Referrals from hospital discharge planners to home and community-based services.

Several other HCBW implementation strategies are worth noting. In response to the Olmstead Supreme Court Decision, Utah launched a statewide campaign to educate all nursing-home residents within the state's 85 facilities about their community-based long-term care options. This campaign included assessments of individuals interested in living in a less restrictive environment. Almost one-fifth of these residents relocated to a community setting.[19]

The State of Florida has been facing serious challenges providing for its high proportion of elderly persons and in response has developed the Elder Ready Communities Initiative. Local communities can obtain Elder Ready status, recognizing that services and programs are in place to adequately meet the needs of the current and future older population. A survey instrument is utilized at the local level to determine what is needed to address unmet needs. This approach is particularly useful because it allows for regional variation in allocation of long-term care resources versus "one size fits all."[20]

POLICY OPTIONS

CRITICAL QUESTIONS AHEAD

The recent reduction in HCBW slots and the ensuing lawsuit raise critical questions for policymakers to address.

To what extent should our state government prioritize home and community-based long-term care services?

Recognizing that the budget is finite and difficult decisions are inevitable, the first step is to determine the priority that the state chooses to place on the provision of state funded long-term care services. If meeting a higher proportion of long-term care needs becomes a high priority, then one available option is to simply designate more of the total state budget for long-term care. Assuming that the goal would be to expand home and community based programs rather than increase the number of nursing home beds, greater funding would make it possible to either offer more services or provide current services to a larger number of recipients. If, in contrast, priority is placed on keeping the current Medicaid budget for long-term care fairly constant or reducing it, then there are only three foreseeable options available to policymakers, which are as follows:

1. Tighten Medicaid eligibility standards.
2. Limit the capacity for services to eligible individuals such as capping the number of nursing home beds authorized under Certificate of Need criteria or by limiting the supply by capping the number of HCBW slots.
3. Eliminate the scope of services under existing plans. For example, allow only a certain number of services to be provided under Medicaid depending on the designated available budget. If the budget changes, modify the number of available services rather than the number of recipients.

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Is the level of rationing of long-term care services to Medicaid recipients necessary and appropriate? Is the rationing being implemented fairly to different segments of the Medicaid long-term care population? How do we distribute and justify the expenditure of Medicaid dollars among the various long-term care options that exist?

There appear to be three policy responses:

1. Expand the supply of institutional facilities (lifting the cap on Certificate of Need for nursing homes);
2. Hold this supply constant and expand residential and community services.
3. Maintain the status quo or decrease resources in which case individuals either go without needed care or more of the responsibility of care is shifted to family and friends.

…it is unclear as to whether the primary goal for Michigan's HCBW program was to prevent institutionalization of frail and disabled individuals or to relocate nursing-home residents back into the community when appropriate.

This latter strategy does not account for state costs associated with informal care, such as lost wages and productivity for the caregivers, or the projected growth in the aging population. If these factors were taken into account, and the budget for long-term care remains constant, there will be a large increase in unmet needs. Alternative Medicaid spending patterns that are fiscally responsible without sacrificing quality of care need to be considered on an ongoing basis.

Have the HCBW goals been clearly delineated and communicated to the necessary stakeholders including the general public?

For example, it is unclear as to whether the primary goal for Michigan's HCBW program was to prevent institutionalization of frail and disabled individuals or to relocate nursing-home residents back into the community when appropriate. The current structure of HCBW, administered by community waiver agents, suggests that the state's goal was to prevent or delay institutionalization. Yet on the contrary, DCH spokeswoman, Geralyn Lasher has stated that the state in fact had expected patients to leave nursing homes and sign up for waiver services, redirecting Medicaid funding into less costly community care. Lasher noted that few individuals actually left nursing homes and the HCBW filled with community-based patients instead.[6] Clarifying these goals would provide a marker of success for the program in the future.

What is a sufficient time frame for objectively evaluating the HCBW? In evaluating the success/failure of the program, what factors are the most salient?

Outcomes research conducted by outside objective parties would lend credibility and provide much needed data on the actual impact of the program.

POLICY RECOMMENDATIONS

Based on research, other states' experiences and Michigan's current policy, state officials should consider the following policy recommendations:

1. Conduct a needs assessment with long-range planning and intermediate goals through 2030. Ensure that goals included are regionally responsive to variations in resources and projected growth.
2. Establish an accurate count of immediate unmet needs for long-term care by creating a waiting list of eligible HCBW beneficiaries.
3. Create a single-point of entry for all long-term care services.
4. Provide a mechanism for both follow-through and accountability within the state plan for long-term care. Appoint a leader within state government who is responsible for ensuring implementation of the Long Term Care Work Group recommendations in a timely fashion. Track progress in a manner that is accessible to the general public.
5. Mandate a state board of long-term care with consumer representation that is able to make policy decisions and determine the State of Michigan's specific responsibility for meeting the long- term care needs of its populace either directly through Medicaid or by providing leadership to marshal the necessary private resources.
6. Educate nursing-home residents and families about community options. Conduct a thorough evaluation of residents who may be relocated from nursing homes back into the community with supportive services. Legislate necessary transitional funds for relocation for those residents who have exhausted private finances. Extend HCBW for use in residential settings such as assisted living facilities and adult foster care homes.
7. Increase HCBW slots to 50,000 to match nursing home beds. Once the HCBW program is solidly in place, scale back on nursing home beds. When faced with Medicaid funding shortfalls, cap nursing home beds rather than waiver slots.
8. Create a consumer directed HCBW model and allow hiring of family members and friends to provide services.

A VISION FOR THE FUTURE

Setting both goals and limits for the future of long-term care will undoubtedly require involvement of many stakeholders: state government, providers, consumers and the general public. Finding ways to bring together groups which have been historically divergent in the past requires a commitment to the greater goal at hand—the provision of affordable, quality and desired services for the frail and disabled among us. The analytic tasks needed to restructure our long-term care system require more than a simple cost-benefit formula, but rather political will and a commitment of values. Above all, this restructuring should force us to rethink the very way we conceptualize long-term care services in general.

The analytic tasks needed to restructure our long-term care system require more than a simple cost-benefit formula, but rather political will and a commitment of values.

A quarter of a century ago in a hearing before the Special Committee on Aging, James Callahan cautioned:

> *We may decide that the institution is indeed the way of solving many problems of elders...Yet, the community is not an alternative to the institution. Rather, the institution is an alternative, a very specialized alternative, to community living.*[21]

With the rising cost of institutional care, the choice among most older and disabled persons to remain at home, and the rapid aging of our state, perhaps it is time to revisit what constitutes the starting point for redesigning long-term care in Michigan.

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