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## Issue Brief

### Community Living Exchange

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Money Follows the Person:  
Reducing Nursing Home Facility  
Utilization and Expenditures to  
Expand Home and Community-Based Services

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## Executive Summary

One of the major challenges of expanding home- and community-based services (HCBS) alternatives to institutional long-term care, especially during times of widespread state budget deficits, is the difficulty finding funding sources to pay for HCBS. In many states, expansions in HCBS cannot be made unless there are identifiable savings in other areas of Medicaid, which usually involves reducing nursing facility utilization and expenditures. Unless states can develop policy interventions that *actually* reduce expenditures in institutional settings, any expansion in HCBS requires new state funds.

This issue brief will present several approaches that attempt to tackle the underlying challenge of reducing nursing facility utilization and expenditures. These range from an incrementalist strategy (modifying the nursing facility reimbursement methodology); to bolder approaches used in a handful of states (converting nursing facilities to assisted living centers, paying nursing facilities to take beds off-line, and using capitated managed long-term care); to approaches with theoretical promise that have yet to be adopted in any state (an 1115 waiver to alter the entitlement to nursing facility care, and a 1915(b) waiver to force nursing facilities to compete for the authority to serve the state's Medicaid program).

In varying ways, each of these approaches could effectively and truly move funding out of nursing facilities, making those funds available to expand HCBS without any net increase in the state's expenditures. Whether one or more of these approaches is appropriate in a given state depends on factors outlined in each of the approaches.

**Approach 1:**  
**Altering Nursing Facility Reimbursement to Promote HCBS:**  
**Lessons from Indiana**

**A. Description of Approach**

In recent years, many states modified their nursing facility (NF) payment methodologies to save money; typically to meet Medicaid cost containment objectives. What makes Indiana unique is that it pursued these often-controversial measures, not just for the purpose of reducing expenditures to NFs, but also for the purpose of depositing the savings into a dedicated fund to expand services in the community.

**B. Background**

Indiana's Medicaid program faced a deficit for the two-year budget period that ended June 30, 2003. The state had experienced significant growth in Medicaid costs, particularly in the areas of hospital and pharmacy costs and NF care. Indiana's Governor, Frank O'Bannon, developed a balanced budget plan for the state that directed the Indiana Family and Social Services Administration (FSSA) to find substantial program savings for the 2002-2003 budget period. As a result, the Indiana FSSA announced on December 19, 2002, a Medicaid Balanced Budget Plan (MedBBP). This plan required regulatory and legislative actions.

Much of the savings/spending reductions were targeted at reforms in the state's approach to funding long-term care, specifically in nursing facilities. Cost saving measures included 1) elimination of non-Medicaid costs in the cost basis for NF payment rates, 2) modification to the profit add-on payment allowed for nursing facilities, 3) establishment of a minimum occupancy rate in the derivation of NF reimbursement, 4) an NF provider tax,<sup>1</sup> and 5) a restructuring of payments for Medicare crossover claims. The measures taken to address the budget shortfall are explained below in greater detail. The changes were projected to save Indiana approximately \$120 million during the 2002-2003 budget period. These changes also generated savings to be applied toward expanding home- and community-based services (HCBS).

**C. Summary of Cost Saving Measures**

*Eliminate Non-Medicaid Costs in Nursing Facility Rates* – Indiana Medicaid no longer considers the indirect costs for ancillary services provided to non-Medicaid NF residents when setting its reimbursement rates. Removing the non-Medicaid certified indirect ancillary costs removes additional costs, such as housekeeping, for Medicare therapy services in order to exclude them from possibly being included as a Medicaid cost.

*Modify Profit Add-On Payment for Nursing Facilities* – Indiana eliminated the profit add-on for the direct care component of NF reimbursement. Allowable costs per patient per

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<sup>1</sup> The provider tax was not initiated by the O'Bannon Administration. The Indiana General Assembly supported the measure and included it in the biennium budget bill passed in 2003.

day for capital-related costs will be computed based on an occupancy rate equal to the greater of 95 percent, or the provider's actual occupancy rate from the most recently completed historical period.

*Establish Minimum Occupancy Requirement for Reimbursement of Nursing Facilities*<sup>2</sup> – Indiana Medicaid imposed a minimum occupancy standard of 85 percent for the direct care, indirect care, and administrative rate components of NF reimbursement. Providers whose occupancy is below 85 percent will only have their fixed costs subjected to the 85 percent minimum and variable costs will not be subjected to the minimum occupancy standard. Allowable costs for direct care, indirect care, and administrative rate components will be assigned the following fixed and variable percentages:

Rate Component	Fixed	Variable
Direct Care	25%	75%
Indirect Care	37%	63%
Administrative	84%	16%

For rate setting purposes, each facility's occupancy rate will be determined by dividing the resident census by the licensed bed days available as reported on the nursing facility's Annual Financial Report, unless the number of facility beds licensed by the Indiana State Department of Health (ISDH) is changed after the end of the facility's Annual Financial Report period. In such cases, de-licensed beds will be removed from the calculation of bed days available for rate-setting purposes effective on the same date that the de-licensure is effective. This means that the change in beds will be adjusted quarterly to recognize de-licensed beds that occur during the rate year.

A single median will be applied to all nursing facilities regardless of their occupancy level. To set the median each calendar quarter, the nursing facilities' per patient day costs will be determined by applying the 85 percent minimum occupancy standard to costs determined to be fixed based on the above percentages.

A minimum occupancy standard means that providers below 85 percent occupancy will have their rates calculated with the assumption that they have 85 percent occupancy in their licensed NF beds, resulting in a lower rate. The occupancy percentage will be based on providers' last completed cost report for which they received a rate.

For example, consider a 100-bed facility that currently has 50 residents. If this facility's cost per patient per day for indirect care is \$25, then the facility is spending \$1,250 total per day on indirect care for the 50 residents. The state will take that cost of \$1,250 and divide it by 85, dropping the provider's allowable cost per patient per day to \$14.71. The state will only recognize this amount as the allowable cost for indirect care.

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<sup>2</sup> The minimum occupancy rate was initially proposed to be set at a 65 percent minimum with a stepped phase-in to a higher standard.

*Reduce the HCFA/SNF Index*<sup>3</sup>: Indiana Medicaid applied an inflation reduction factor of 3.3 percent to the HCFA/SNF Index. The HCFA/SNF Index is an inflation adjustment used to inflate allowable historical costs that providers have submitted when setting their rate for the next year. The index is intended to increase old costs by using an inflation adjustment in order to set a rate that will be paid to a provider prospectively. The 3.3 percent reduction in the inflation adjustment means that providers will see less of their actual cost increases reflected in their Medicaid rate.<sup>4</sup>

*Implement a Temporary Nursing Facility Provider Fee* – Indiana Medicaid considered imposing a temporary fee (or provider tax) of \$2 per resident per day. The fee would have been imposed for a two-year period in an effort to alleviate the state's Medicaid deficit. The assessment would have been an allowable cost for Medicaid certified nursing facilities. This initiative never was implemented.

*Nursing Facility License Fee* – Indiana considered implementing a \$6 per patient day NF license fee for all NF beds in the state and would have used the resulting funds in the creation of an Eldercare Trust Fund. Had it been created, the Eldercare Trust Fund would have been a source of funds to pay the state's share of the costs to supplement and enhance reimbursement to nursing facilities for certain Medicaid services. However, the legislation that would have created the fund was not itself passed by the Indiana legislature. Instead, a new license fee proposal was developed and is pending at CMS. The new proposal would waive the broad-based and uniformity requirements for permissible provider taxes to shift funds from low-Medicaid-census NFs to high-Medicaid-census NFs. If approved, the license fee would be an allowable administrative cost component for Medicaid reimbursement purposes. Medicaid-certified nursing facilities would recover, on average, approximately 68 percent of the cost of the fee through increased rates due to higher allowable costs.

*Modify the Indiana Bed Hold Policy* – Indiana Medicaid discontinued paying an NF provider half of its daily rate to hold a Medicaid resident's bed when that resident leaves the facility for a hospital stay or therapeutic leave unless the provider is at or above 90 percent occupancy the day the resident leaves.

*Maximize Federal Medicaid Funding* – Make additional payments to non-state government-owned nursing facilities up to the maximum allowable payment, otherwise known as the Medicare Upper Payment Limit (UPL).

*Require Medicare Certification* – This policy would not require Medicare certification as a condition of participation in the Medicaid program. However, non-Medicare certified providers who admit a dually eligible resident must demonstrate that the resident's stay is not a Medicare-covered stay. The nursing facility must certify to the Indiana Office of

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<sup>3</sup> The HCFA/SNF Index is computed by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA). This is an index much like the Consumer Price Index, except that it measures the historical change in nursing facility costs instead of the costs of consumer items.

<sup>4</sup> The 3 percent reduction to the HCFA/SNF Index is a temporary measure that will be eliminated when CMS approves Indiana's waiver and state plan amendment for a provider tax.



Medicaid Policy and Planning (OMPP) that it will not request payment from Medicaid for services rendered to a dually eligible Medicaid recipient that is eligible to receive Part A nursing facility benefits through Medicare. The nursing facility must substantiate that a recipient for whom Medicaid payment was requested is not entitled to or eligible for Part A nursing facility Medicare benefits.

*Restructure Payment of Medicare Crossover Claims* – Indiana Medicaid will no longer pay crossover claims for Medicare Part A and B coinsurance and deductibles whenever the Medicaid allowable cost is below or equal to the Medicare allowable cost. When a Medicare-eligible Medicaid recipient receives Medicare services, Medicare is first billed for those services as the primary payor. Prior to this change, Indiana Medicaid paid the coinsurance or deductible portion of the bill incurred by the Medicaid recipient. This Medicaid payment on coinsurance and deductibles is commonly referred to as a “crossover payment.”

Services eligible for Medicare crossover claims will only be reimbursed by Indiana when the Medicaid allowed amount exceeds the amount paid by Medicare. As an example, assume that a facility provided a service to a Medicare-eligible Medicaid recipient with a cost of \$76 per unit. If Medicare allows \$76 per unit and pays \$60.80 a unit and Medicaid allows \$65 a unit, Medicaid would reimburse the facility \$4.20 per unit. Prior to this change, Medicaid would have reimbursed up to the Medicare allowable cost – \$15.20 in this example.

#### **D. Reinvest Long-Term Care Savings**

What makes Indiana unique is that it pursued all of the difficult reimbursement changes described above largely to fund a Long-Term Care Closure/Conversion Fund. This fund received the program savings generated by the reimbursement changes. The fund has many statutory purposes, all to assist Medicaid recipients: expand waiver slots, pay for transitional assistance to move individuals from nursing facilities to the community, provide assistance for people moving between institutional settings, provide assistance to individuals affected by the closure of a nursing facility, and support nursing facilities that close beds and/or transition to assisted living services.

#### **E. Conclusion**

Indiana implemented and proposed the preceding measures in an effort to address a budget shortfall. States not facing similar deficits but seeking avenues for program savings or funds that could be redirected to other care venues, such as care in home- and community-based settings, may want to consider some of the spending reduction/cost saving approaches taken by Indiana.

## **Approach 2:** **Convert Nursing Facility Beds to Assisted Living Units**

### **A. Description of Approach**

This approach involves state-funded assistance for NF operators to permanently convert NF beds to assisted living units that meet state requirements for assisted living.

### **B. Background**

In an effort to expand consumers' options for home- and community-based long-term care services, several states have established funding programs to assist nursing facilities to convert NF beds into assisted living units. Two states—Nebraska and Iowa—have implemented conversion-funded programs. This is a voluntary program supported entirely by the state. Nebraska was the first state to offer a conversion-funded program to nursing facilities; Iowa instituted a similar model shortly thereafter.

In 1996, Nebraska's Health and Human Services System studied the long-term care services provided to older adults and individuals with disabilities. The study showed that many people living in NFs could be cared for in alternative settings. Inferred from the study was that many people were residing in NFs because they had limited options for alternative housing.<sup>5</sup> Similarly, a report commissioned by Iowa's Department for the Senior Living Coordinating Unit in May 1999 showed a deficiency of alternative services to nursing facilities.<sup>6</sup>

### **C. Legislation**

In 1998, as a follow-up to the Health and Human Services System's study, Nebraska's legislature passed a law that allocated \$40 million to create the Nursing Facility Conversion Cash Fund, which finances the Nursing Facility Conversion Program. An increased interest in the Conversion Program by the NF industry motivated the legislature to appropriate an additional \$14 million for the program in 2001. The objective of the Conversion Program is to provide grants to help NF owners convert part of their facilities to assisted living or adult day care units. The goals are two-pronged: to decrease Medicaid spending, and to provide people living in low-density rural areas with a variety of home- and community-based service options.<sup>7</sup>

In March of 2000, Iowa passed legislation that created the Senior Living Trust Fund. The goal of this legislation was to provide a balanced and cost-effective long-term care service system. An \$80 million appropriation was mandated from the Senior Living Trust

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<sup>5</sup> Nebraska Health & Human Services (HHS) System Long-Term Care Study Overview.  
[www.http://nncf.unl.edu/assisted/study.html](http://nncf.unl.edu/assisted/study.html).

<sup>6</sup> Request for Proposal #MED-05-008 Senior Living Program Grants, P. 10, <http://services.iowa.gov/rfp/>

<sup>7</sup> "Alternatives to Nursing Home Care: States Pursue Innovative Strategies," National Conference of State Legislatures, State Health Notes. Volume 23, Number 380, September 23, 2002.  
<http://www.ncsl.org/programs/health/nursinghome.pdf>

Fund over four years to finance various long-term care initiatives and establish the Senior Living Program Grants (SLPG). Three grants are available under the SLPG umbrella: 1) the Conversion Grant used to convert all or a portion of the licensed nursing facility to an affordable certified assisted living program, 2) a Conversion Grant with Provision of Additional Services used to convert all or part of a nursing facility to an assisted living program and be eligible to request an additional \$50,000 if the facility also develops an added service (e.g., an adult day care, a safe shelter for victims of dependent adult abuse, or respite care services), and 3) the Long-Term Care Services Development Grant awarded to service providers to develop needed long-term care services covered under Medicaid HCBS waivers.<sup>8</sup>

#### **D. Funding**

The Intergovernmental Transfer Program funded both states' conversion programs. However, private foundations have been valuable sources for funding the development and construction of assisted living facilities. The Robert Wood Johnson Foundation's *Coming Home* project, The Retirement Research Foundation, Duke Endowment, and the Kate P. Reynolds Foundation provided grant money to assisted living projects in Illinois, Oregon, and North Carolina. Local banks have provided loans in Illinois, Nebraska, and North Carolina for the planning phase of assisted living facility development.<sup>9</sup>

Nebraska allocated a one-time amount to the Nursing Facility Conversion Cash Fund; the program will end at the depletion of the funds. Currently, three facilities are in the process of receiving the last of the grant funds. The program was successful in meeting the goals of the state legislature and thus will not be extended.<sup>10</sup>

Of the \$80 million appropriated from Iowa's Senior Living Trust Fund to finance long-term care initiatives, about \$8 million per year was allocated for the Senior Living Program Grants. The grant program received full funding during the first two years; however, in subsequent years funding resources were diverted to other programs. (A moratorium was placed on the program in its third year, and the fourth and final year of the program is funded for less than the full amount of \$6 million.) The state legislature will determine whether to extend the Senior Living Program Grants.<sup>11</sup>

#### **E. Operations**

To publicize the Conversion Program, Nebraska's Department of Health and Human Services (DHHS) enlisted support from the nursing facility trade associations. Trade association leaders and DHHS representatives conducted meetings throughout the state, informing NF owners and administrators of the application process and incentive benefits of their ability to receive from the Conversion Program.

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<sup>8</sup> Interview with Iowa State Official

<sup>9</sup> "Creating Assisted Living Facilities: Expanding Options for Long-Term Care," Health Policy Studies Division, <http://www.nga.orglca/files/000215ASSTLIVING.PDF>

<sup>10</sup> Interview with Nebraska State Official

<sup>11</sup> Interview with Iowa State Official

Nursing facilities applying for Nebraska's Conversion Program must submit a letter of intent to DHHS disclosing the number of NF beds to be closed and the number of assisted living units to be created. DHHS requests that applicants perform feasibility studies to ensure that the area of the proposed development is not overabundant with Medicaid assisted living facilities. DHHS reviews the feasibility studies, confers the grant awards, and administers the Nursing Facility Conversion Program.<sup>12</sup>

Iowa's Department of Human Resources solicits grant applications through a request for proposal (RFP) process. The evaluation of the proposals is divided into two phases. In the first phase, the initial application is evaluated for pre-screening and mandatory requirements by an evaluation committee consisting of representatives from multiple state departments (i.e., Public Health Inspections and Appeals, Elder Affairs, and Human Services). Also during this phase, three physical structure construction/design specialists from the Department of Elder Affairs, Department of Inspection and Appeals, and/or the State Fire Marshall's Office evaluate the schematic plans. In the second phase, the proposal is evaluated on the architectural and financial feasibility of the plan. The evaluation committee consists of representatives from the state departments mentioned above. The evaluation committee determines final rankings and makes recommendations to the Medicaid Director of the Department of Human Services. The Medicaid Director either accepts or rejects the committee's recommendations. DHHS administers the Senior Living Program Grants.<sup>13</sup> Three RFPs have been issued to date.

## **F. Funding Terms for Applicant**

The largest grant awarded to one facility is \$1.1 million, or \$52,000 per assisted living unit. A pre-grant award of \$15,000 may be requested by a facility for financial feasibility work and consultations with architects. A 20 percent match is required of applicants, which can be used for start-up costs, construction, training expenses, or first-year operating losses. Other applicant requirements include reserving 40 percent of the newly constructed units for Medicaid-eligible residents, reducing the licensed NF beds by at least the number of assisted living units created, and operating as an assisted living facility for 10 years. The length of time between design and completion of a project is approximately 18 months. As of 2002, a total of \$52.5 million was awarded in grants.<sup>14</sup>

Terms for Iowa grant applicants have similarities to Nebraska's (e.g., reserving a minimum number of Medicaid-eligible assisted living units and requiring at least a 20 percent match by the applicant). In addition, the planned conversion must be "located in an area determined by the Senior Living Coordinating Unit to be underserved with respect to a particular long-term care alternative service, and has demonstrated the ability

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<sup>12</sup> Interview with Nebraska State Official

<sup>13</sup> Request for Proposal (RFP) # MED-05-008 Senior Living Program Grants, <http://eservices.iowa.gov/rfp>

<sup>14</sup> "Nebraska: Making Converts," State Health Notes, September 23, 2002, Vol. 23, Number 380, p. 6.

or potential to provide quality long-term care alternative services.”<sup>15</sup> The maximum grant award to one facility is \$1 million, or \$45,000 per assisted living unit.<sup>16</sup>

## **G. Program Requirements**

Nebraska’s assisted living facilities are expected to provide services such as assistance with personal care, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health maintenance. Construction requirements prescribe the minimum number of square feet for each unit’s living area. Assisted living facilities must also provide common dining and activity areas. However, facilities that house both nursing facility and assisted living residents must have separate areas for each.<sup>17</sup>

In Iowa, assisted living programs must include assistance with personal care or health-related services and at least one meal per day. Construction guidelines require that each assisted living unit have lockable doors and a kitchen area. Square footage of the rooms is also specified.<sup>18</sup>

## **H. Outcomes**

Nebraska’s Nursing Facility Conversion Program has assisted a total of 74 project conversions, creating 967 new assisted living units and de-licensing approximately 750 NF beds.<sup>19</sup> The state has projected an annual savings of \$5.5 million.<sup>20</sup>

The first two years of Iowa’s Conversion Grant Program created 240 assisted living units and de-licensed 282 NF beds. The third RFP was issued October 22, 2004. To date, projected savings have not been determined, as many of the beds remain unfilled by Medicaid consumers. Nursing facilities are required to reserve 40 percent of the assisted living units for Medicaid consumers. However, as long as nursing facilities demonstrate that they have tried to fill the beds with Medicaid consumers (e.g., through advertising, brochures, and public meetings) but were unsuccessful, the nursing facility may then fill these beds with private pay consumers.<sup>21</sup>

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<sup>15</sup> Iowa Code 2003 Supplement: Section 249 H.6

<sup>16</sup> Request for Proposal #MED-05-008 Senior Living Program Grants, P. 17, <http://services.iowa.gov/rfp/>

<sup>17</sup> “Creating Assisted Living Facilities: Expanding Options for Long-Term Care,” Health Policy Studies Division, <http://www.nga.org/lcda/files/000215ASSTLIVING.PDF>

<sup>18</sup> Iowa, CareScout, [http://www.carescout.com/resources/assisted\\_living/state\\_policies/ia.html](http://www.carescout.com/resources/assisted_living/state_policies/ia.html)

<sup>19</sup> “Alternatives to Nursing Home Care: States Pursue Innovative Strategies,” National Conference of State Legislatures, State Health Notes. Volume 23, Number 380, September 23, 2002. <http://www.ncsl.org/programs/health/nursinghome.pdf>

<sup>20</sup> “Alternatives to Nursing Home Care: States Pursue Innovative Strategies,” National Conference of State Legislatures, State Health Notes. Volume 23, Number 380, September 23, 2002. <http://www.ncsl.org/programs/health/nursinghome.pdf>

<sup>21</sup> Interview with Iowa State Official.

## **I. Conclusion**

Two states used conversion grants to successfully de-license NF beds and increase the number of assisted living units. Nebraska's Nursing Facility Conversion Program met the state legislature's goals of reducing Medicaid costs and expanding alternative service options in rural areas. Likewise, Iowa increased alternate service options in rural areas through its Senior Living Program Grants.

### **Approach 3:**

## **Minnesota's Voluntary Planned Closure Program**

### **A. Description of Approach**

Minnesota's Voluntary Planned Closure Program (VPCP) grants an adjusted rate increase to nursing facilities that voluntarily close beds.

### **B. Background**

Like many other states, Minnesota has observed a steady decline in NF utilization. This decrease in utilization of NF beds by the elderly is attributed to shorter lengths of stay and an increasing number of home and community alternatives for long-term care.<sup>22</sup>

Minnesota's ratio of NF beds per one thousand people 65 years or older is higher than the national average. Minnesota averages 62.2 beds per thousand around the Twin Cities and 85.5 in the Southwest part of the state<sup>23</sup>; the national average is about 53.6 beds per thousand. In 2003, Minnesota's approximate total number of NF beds was 39,530. Even the highest of the future projections made to determine NF bed needs were below the number of actual beds.<sup>24</sup> The Minnesota State Legislature sought to close NF beds and divert people from nursing facilities to home- and community-based services.<sup>25</sup> To offset increased spending from expanding HCBS programs, Minnesota decided to close 5,100 beds, achieving a savings of \$44 million.<sup>26</sup>

The Voluntary Planned Closure Program was created from legislation passed in 2001 to give nursing facilities incentive to voluntarily close beds. Legislation set a cap of 5,140 beds to be closed; the negotiated adjusted rate paid to nursing facilities for closing beds was not to add costs to the state.<sup>27</sup> Legislative language does not state how long the NF beds must remain closed, but it is implied that the closed beds are to remain closed forever, as there is a moratorium on creating new beds.<sup>28</sup>

### **C. Operations**

The application process for nursing facilities to voluntarily close beds begins with written notification from the nursing facility to the county social service agency or the Area Agency on Aging (AAA). A letter of support must be obtained by the nursing facility

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<sup>22</sup> Minnesota Department of Health, Information bulletin 00-13 NH-42, CBC-21 ([http://www.health.state.mn.us/divs/fpc/profinfo/ib00\\_13.htm](http://www.health.state.mn.us/divs/fpc/profinfo/ib00_13.htm))

<sup>23</sup> "Profile of Nursing Homes in Rural Minnesota," Office of Rural Health Primary Care Minnesota Department of Health, May 2003.

<sup>24</sup> Status of Long-term Care in Minnesota, 2003

<sup>25</sup> Interview with Minnesota State Official

<sup>26</sup> Minnesota "Reshaping Long-Term Care in Minnesota," Independent Living Research Utilization, <http://www.ilru.org/online/handouts/2002/Donlin2/coleman.html>

<sup>27</sup> Interview with Minnesota State Official

<sup>28</sup> Status of Long-Term Care in Minnesota, 2003 and interview with Minnesota State Official

from the notified agency. The nursing facility submits the letter of support along with an application form to the Department of Human Services (DHS), which decides whether the nursing facility is eligible for the adjusted rate. DHS then notifies the nursing facility of its eligibility status. If the nursing facility is eligible, it has 18 months in which to close the beds. The nursing facility sends written confirmation to DHS when the beds have been closed. The adjusted closure reimbursement begins the first day of the month after the closure is complete. Recent legislation allowed the support letter from the county social service agency or AAA to be waived if a nursing facility wants to close a small number of beds (the greater of either 5 beds or 6 percent of the nursing facility's bed capacity) in counties that have been determined to have a large number of beds per one thousand people 65 years or older. There are no set criteria for the number of beds that can be closed. The decision to award a nursing facility the reimbursement incentive is at the discretion of DHS.

For complete closures, counties are reimbursed for costs related to assisting in the relocation of residents into nursing facilities or into other less restrictive settings (e.g., if the county had hired additional staff to assist with the resident's relocation). It has been Minnesota's experience that about 95 percent of displaced NF residents transferred to other nursing facilities, while the other 5 percent went to less restrictive settings.<sup>29</sup>

$\text{Planned Closure Adjustment Rate} = \frac{(\text{number of beds closed} \times \$2,080)}{(\text{number of beds that remain open} \times 365)}$
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The planned closure adjustment rate is computed by multiplying the number of beds closed by \$2,080 divided by the product of the number of beds receiving the adjusted rate times 365. While the planned closure adjusted rate can be negotiated, Minnesota never exceeds the \$2,080 per bed factor. Currently, Minnesota has a moratorium on adding new beds to facilities; however, nursing facilities can request that beds be transferred within chains. Facilities that close entirely can transfer their incentive benefit to another facility within their chain.

Minnesota also has a provision for facilities to temporarily close beds on a voluntary basis. The 2000 state legislature established the NF bed lay-away program. Program incentives for nursing facilities include 1) exemption from paying license and surcharge fees on beds placed in the lay-away program, 2) reimbursement of an adjusted rate that is equal to the reallocation of their property rate, and 3) bed-hold rates (an added compensation Minnesota pays when the facility is at 93 percent occupancy). Once a bed has been placed in the lay-away program, it must remain closed for a minimum of one year and a maximum of five years. When the bed is reopened, the nursing facility cannot place it in lay-away for one year. The commissioner of health may waive the one-year rule if some type of emergency or necessity arises.<sup>30</sup> As of spring 2003, 2,519 beds have been placed in lay-away status.<sup>31</sup>

<sup>29</sup> Interview with Minnesota State Official

<sup>30</sup> Information Bulletin 00-13 NH-42 CBC-21

<sup>31</sup> "Profile of Nursing Homes in Rural Minnesota," Office of Rural Health Primary Care, Minnesota Department of Health, May 2003.



#### **D. Outcomes**

Since the beginning of the program, a little over 4,900 applications for closed beds have been approved; 3,300 beds have actually closed statewide. It is uncertain whether more beds will close because facilities can choose not to close the beds after receiving the approved application.

Currently neither fiscal outcomes nor number of individuals diverted to home- and community-based services have been determined.

#### **E. Conclusion**

According to a state official, opposition to the VPCP was mild. Minnesota's NF industry, which is 70 percent non-profit or governmental, was only tepidly opposed to the program. Hospital discharge planners voiced concerns about the program to state officials, but policy discussion with legislators was not raised.

One potential flaw in Minnesota's program is that legislation did not limit the time for which the adjusted rate payment was to be paid to the nursing facilities. Thus, a Minnesota state official recommends that states considering this program ensure that legislation does so. A suggestion would be to increase the adjusted payment rate for a shorter length of time (e.g., ten years).

Minnesota's Voluntary Planned Closure Program is one example of a program implemented as part of an evolution in the long-term care system. Shifts in philosophy from institutional care to home- and community-based care by market forces are the underpinnings for the concept of this program. This innovative program is unique to Minnesota.

## **Approach 4:** **Capitated Managed Long-Term Care**

### **A. Description of Approach**

A handful of states have developed capitated managed long-term care programs in an attempt to move funding from institutional settings to HCBS settings. In general, the concept is that a capitated managed care organization (MCO) would receive a fairly large monthly capitation payment per person for individuals at risk of institutional care. With this capitated payment, the MCO would have the resources and incentive to develop less expensive alternatives to institutional care.

Three state Medicaid managed long-term care programs were selected to review their rate setting methodologies and the effect of those methodologies on the ratio of NF utilization to community-based care over time. The programs selected were the Arizona Long Term Care (ALTC) Program, the Florida Nursing Home Diversion Program, and the Wisconsin Family Care Program.

Each of the three state programs have slightly different methods for calculating capitation rates, but program administrators in all three states believe their rate setting methodologies to have been successful in encouraging managed care providers to assist enrollees to stay in the community.

Common threads that seem to run through each of the three program methodologies are: 1) managed care providers are fully liable for NF care (i.e., there is no limitation on the length of time a provider may be responsible for the costs of an NF placement); 2) over time, as a plan or program matures, the rate of decline in NF utilization seems to decrease; and 3) the capitation rate methodologies are structured to encourage providers to keep individuals in lower cost community settings.

### **B. Background**

Currently, seven states have Medicaid managed care programs that capitate long-term care, including NF care.<sup>32</sup> Of those states, five do not limit the managed care contractor's liability for the duration of NF care.<sup>33</sup> Three of these five state programs —Arizona,

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<sup>32</sup> States that have Medicaid programs that capitate long-term care payments include: Arizona, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin. The programs among these states vary in terms of the type of federal waiver authorizing the program, statewide or pilot sites, mandatory or voluntary, and the degree to which managed care contractors are liable for NF care. There are other programs that involve Medicaid capitated long-term care (e.g., Program of All Inclusive Care for the Elderly, the Wisconsin Partnership, and some state arrangements with Medicare managed care organizations). These programs are fairly small and do not represent large-scale state initiatives to establish managed long-term care programs.

<sup>33</sup> Other states may limit the NF liability to four months or some other period of time and establish rate cells that encourage contractors to transition or keep recipients out of nursing facilities. For example, Minnesota's Senior Health Options Program pays a higher community rate for people who have transitioned out of NF care and continues a community rate for people who transition into NF care.

Florida, and Wisconsin — were contacted, and telephone interviews were conducted with state administrators responsible for rate setting. Florida and Arizona also provided actuarial documentation describing their rate setting methodologies.

## 1. Arizona

Arizona implemented a mandatory statewide managed care program for long-term care, the Arizona Long Term Care Program (ALTC), in 1989. Until recently, the program has operated through one exclusive provider in each local jurisdiction.<sup>34</sup>

Capitated rates are set each year for each contractor using two to three years of previous years' utilization data trended forward. The first level rate divide is based on the ratio of recipients in institutional settings to recipients in community-based settings. Once these ratios and costs are established, other costs are added to the rate to cover acute care, case management, administration, and so on. Rates are set for each site of care and then weighted by the number of recipients in each site. The following table shows the 2005 statewide average rates established for Arizona contractors.<sup>35</sup>

<b>Rate Component 2005</b>	<b>Rate</b>
Nursing Facility	\$3,686
HCBS Home	\$1,104
HCBS Community	\$1,266
HCBS Combined Rate	\$1,143
Case Management	\$91
Acute Care	\$545
Administration	\$214
Risk Contingency	\$58
Share of Cost	\$(273)
Net Capitation	\$2,766

As an example, if a contractor had 1,000 people in NF care in the previous year and 2,000 people in community care, the capitation rate would be weighted to assume that ratio in 2005. The contractor would receive an average capitation rate of \$2,414 for the nursing facility and community-based care, plus the other rates for acute care, case management, and so on. If the contractor is able to increase the proportion of recipients in community care over the proportion expected, the contractor will save money. The contractor retains 80 percent of the savings; the state gets the remaining 20 percent.

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If a person is in NF care for six months, they are disenrolled from the managed care program and revert to the Medicaid State Plan.

<sup>34</sup> In the last two years, one jurisdiction has gained two additional contractors.

<sup>35</sup> Mercer Government Human Services Consulting, Arizona Long Term Care System-Contract Year Ending 2005 Capitation Rate Methodology Letter, August 2, 2004.

This methodology has worked well from the inception of ALTC. In October 1992, the average percent of community placement was 24.4. The projected average percent of community placement in 2005 is 61.2, an increase of 37 percent.<sup>36</sup> The program administrator and the actuarial report note that this rate of increase in community placement has slowed in mature providers.

## 2. Florida

The Florida Nursing Home Diversion Program is a voluntary 1915(c) waiver program operating in nine Florida counties. It enrolls people who are 1) living in the community at the time of enrollment, 2) dually eligible, and 3) at risk of or meeting a level of care determination for NF placement. The program is voluntary and only covers long-term care services. It began operations in 1998 and currently has approximately 2,000 enrollees. The contractors are paid a capitated fee for each recipient.

Rates are established annually based on geographic areas. The claims information for establishing rates is drawn from Florida's home- and community-based fee-for-service (HCBS) waiver populations. At the inception of the program, approximately \$2,300 per recipient per month was paid regardless of placement in a nursing facility or the community. A recent actuarial review of the initial rates demonstrated that the rates were too high, resulting in the establishment of lower rates that will be phased in over three years beginning in 2005. The following table describes the scheduled change.<sup>37</sup>

<b>Current Rate</b>	<b>Year I</b>	<b>Year II</b>	<b>Year III</b>
\$2,342	\$2,068	\$1,881	\$1,732

The capitation rate is based on assessment data for plan recipients, including cognitive impairment, chronic illnesses, and the level of assistance required in ADLs and IADLs. The HCBS data is used to establish a rate for a geographic area and then adjusted with an add-on for NF placement.<sup>38</sup> Contractors who have been operating for five years have higher levels of NF utilization and receive an increase in rates to accommodate for the maturing of the population and the higher need for NF care.

Program administrators believe the program has been successful in providing incentives to keep recipients in the community. Because the program is voluntary, it is possible for program recipients to disenroll at any time, including when they are in nursing facilities, in which case they would revert to the state Medicaid plan. There have been few disenrollments and few transitions to nursing facilities.

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<sup>36</sup> Mercer

<sup>37</sup> Consulting Actuary, State of Florida Department of Elder Affairs July 1, 2004 – June 30, 2005 Capitation Rate Development for Nursing Home Diversion Health Program, August 4, 2004.

<sup>38</sup> Ibid. The waiver program does not include NF care, but recipients in the Nursing Home Diversion Program do sometimes transition into NF care, so a factor was developed to account for the NF use among contractors.

### **3. Wisconsin**

Family Care is Wisconsin's Medicaid managed long-term care program operating under combined 1915 (b) and (c) waivers in three local jurisdictions. The program is voluntary and recipients are elderly, disabled, and/or developmentally disabled. The program operates through local county-based contractors with long histories of reporting fee-for-service (FFS) encounter and cost data. Most jurisdictions have only one contractor, but Milwaukee will have two next year. Family Care has over 8,000 recipients.

The capitated rates are pre-paid based on each contractor's past performance. The past performance data is actual encounter data. The program uses a participant-screening tool (the Long-Term Care Functional Screen) to determine functional limitations in ADLs and IADLs, NF level of care criteria, and other behavioral variables. The screen does not use diagnostic or medical information. The results of the tool are used to adjust the capitation rates.

Program administrators believe there has been a decline in NF use in those counties where the program is operational. However, program administrators are cautious without longitudinal data to compare NF utilization between program recipients and other populations. The most likely comparison groups would be waiver program recipients. Administrators expect to see comparable acuity and NF utilization increases as the program ages.

### **C. Conclusion**

Administrators in all three states feel that NF utilization was reduced in the long-term care managed programs and that the rate setting methodologies provided financial incentives that encouraged contractors to assist people to remain in the community.

Arizona had the longest experience with documented declines in NF utilization over the duration of the program. The Florida and Wisconsin program administrators anecdotally described declines in NF use, but were cautious due to lack of longitudinal and comparative data.

Arizona and Florida used location of care as a factor in setting rates, as well as individual contractor experience and mix of recipients. Wisconsin eliminated location of care as a factor and relied only on acuity as described through an assessment instrument.

Regardless of whether rates are set appropriately from the start, it seems that when contractors are capitated based on acuity, location of care, or both, they are encouraged to manage care below the expected acuity rate or the expected ratio of recipients in nursing facilities and community-based settings. The effect of this form of capitation is more pronounced in newly developed programs where recipients have not aged-in and where contractors are still working on managing care toward community settings that are less costly than nursing facilities.

## **Approach 5:**

### **Section 1115 Waiver to Alter the “Entitlement” Nature of Long-Term Care Services**

#### **A. Description of Approach**

An 1115 waiver could be structured to provide long-term care services in the most appropriate setting, whether it is a nursing facility or community-based care. The decision of “appropriate setting” could be made by the state (or its contractors), applying objective criteria and assessment practices that are capable of determining different level of care needs among program recipients. An 1115 demonstration waiver could include multiple categories of “level of care,” not all of which would “entitle” a recipient to NF care. For example, perhaps deficits in two ADLs would entitle a person to HCBS services, but it would require four ADL deficits to entitle a person to NF level of care. Vermont has applied for a related type of 1115 waiver; it is currently under consideration by CMS. The Vermont waiver application provides a current example of how a state could de-link HCBS eligibility from the nursing facility “level of care.” The Vermont waiver also creates, for the first time, an “entitlement” to HCBS services.

De-linking the NF level of care from the HCBS level of care would allow a state to avoid NF expenditures for individuals with moderate needs, allowing those funds to be re-invested in HCBS settings.

#### **B. Background**

One of the threshold questions is whether an 1115 waiver legally *may* be granted that de-links NF and HCBS levels of care. Our research determined that this type of waiver legally may be granted. CMS has broad authority in approving 1115 waivers.<sup>39</sup> CMS’ authority includes the power to grant Vermont’s waiver.

Interestingly, the existing Medicaid law does not explicitly state that individuals who are determined to meet NF level of care have an “entitlement” to care in a nursing facility. However, CMS staff and state Medicaid agencies often hold the opinion that such a recipient *is* entitled to NF care. This position seems to be based on two factors: 1) a nursing facility is a federally-mandated service in state plans, and 2) if a person meets a level of care test that is defined as NF care (i.e., a medical needs test), then they are entitled to care in a nursing facility.<sup>40</sup>

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<sup>39</sup> 42 USC 1315 § 1115(a); 1115 demonstration waivers permit waiver of: eligibility rules, minimum benefit requirements, freedom-of-choice, no cause disenrollment, federal standards for “full Risk” managed care plans, provider reimbursement rules, and state administration requirements. (Kaiser Commission on the Future of Medicaid, *Statewide Medicaid Managed Care Demonstrations under Section 1115 of the Social Security Act*, May 1997 at v.)

<sup>40</sup> The logic seems to be based on a concept of medical need, so that if a person were determined to meet NF level of care need, then they would be entitled to that benefit based on medical need. The other primary factor contributing to the belief that NF care is an entitlement is the fact that NF is a mandatory benefit under state Medicaid plans. However, this factor is undercut by the fact that there are a number of

There is no case law directly on point. Doe v. Chiles<sup>41</sup> is the most relevant case, but holds specifically that “under a Florida state Medicaid plan, the state failed to furnish Medicaid assistance with ‘reasonable promptness.’”<sup>42</sup> In this case, the court discussed the requirement of a state to provide services listed in the state plan if it is determined that a recipient is in need of those services.<sup>43</sup>

CMS staff interviewed for this report stated that an 1115 waiver *could* use a broader definition of “level of care” for HCBS than for NF.

### **C. Vermont 1115 Waiver Application**

CMS staff consistently identified the Vermont 1115 waiver application as the only pending example for creating different recipient rights using different levels of service needs. The Vermont 2003 waiver application anticipates a statewide expansion of long-term care Medicaid services for adults with physical disabilities and the frail elderly. The goals of the demonstration are to eliminate the institutional bias in eligibility, provide consumers with equal access to long-term care options (nursing facility and home- and community-based services), and promote early intervention for at-risk populations.<sup>44</sup> The waiver will be mandatory and enroll all recipients under an existing 1915 (c) waiver for the elderly and young adults with disabilities. The waiver will represent a “wholesale replacement of most of the existing long-term Medicaid program in Vermont.”<sup>45</sup>

The major concept behind Vermont’s 1115 waiver is that the state would leave its NF level of care standard unchanged, but create a second tier above that for recipients meeting a higher level of need. Vermont also intends to create a standard for people who do not yet meet a NF level of care, but are “at risk” of meeting this standard.

Vermont’s 1115 waiver design establishes three levels of care. One is the “Highest Need Group,” who would meet all financial and functional NF eligibility standards under the new NF level of care. This population would remain an “entitlement” population – the state could not cap the enrollment level, and all participants would have the right to choose between a nursing facility and community-based care.

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mandatory benefits that by federal law must be included in a state Medicaid plan. Although not all are considered entitlements, all are based on medical need.

<sup>41</sup> Doe v. Chiles, 11<sup>th</sup> Fed. Cir. February 26, 1998.

<sup>42</sup> Ibid. at 1.

<sup>43</sup> Ibid.

<sup>44</sup> October 1, 2003 The Vermont Long-Term Care Plan: a Demonstration Waiver Proposal to the Centers for Medicare and Medicaid Services, p. 3. ([www.dad.state.vt.us](http://www.dad.state.vt.us))

<sup>45</sup> Ibid. at 8.

The next group is the “High Need Group,” which would meet the financial and functional standards for NF level of care, but would not meet the highest needs test. These people will be served only if sufficient funds exist. Should funds exist for "slots" in this group, the recipients would have the right to choose between a NF and an HCBS setting. But note that the "High Need Group" would not be "entitled" to services.

The last group, referred to as the “Moderate Need” group, are people at-risk for NF placement. This is an expansion group under the 1115 waiver. For individuals approved for this group, they would receive a narrow set of community-based services (case management and adult day services).

Clinical eligibility criteria have been established for each of these categories.<sup>46</sup> Financial eligibility criteria for the demonstration will be the same as for the current Medicaid long-term care program, except that a higher level of resources will be permitted for enrollees who elect home-based care.<sup>47</sup> The Vermont demonstration will be FFS. CMS continues to work with Vermont on the major aspects of the pending 1115 waiver. CMS continues to be willing to be responsive to states interested in developing Section 1115 demonstrations.

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<sup>46</sup> To meet the Highest Need Group criteria, a person first requests NF or community care. If the request is for nursing facility, a STEP II PASARR Screen is first conducted. After that, the assessment is the same for a person requesting NF or community care. To qualify for Highest Need Group, the person must: 1) require extensive or total assistance with toileting, eating, bed mobility and transfer, and at least limited assistance in any other ADL; or 2) have a severe impairment with decision making skills or a moderate impairment with decision making skills, and any one of severe unalterable behavioral problems; or 3) specific conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis; or 4) have an unstable medical condition that requires skilled nursing assessment, monitoring, and care on a daily basis.

The High Need Group criteria requires that an individual: 1) require extensive to total assistance on a daily basis with bathing, dressing, eating, toileting and/or physical assistance to walk, or skilled teaching to regain control of ADLs and other functions; or 2) have impaired judgment that requires constant or frequent redirection, or specific behaviors that required a controlled environment to maintain safety; or 3) have specific conditions or treatments that require skilled nursing assessment, monitoring, and care on a less than daily basis.

The Moderate Need Group criteria requires that an individual: 1) require supervision or physical assistance three or more times in seven days with any single or combination of ADLs or IADLs; or 2) have impaired judgment that requires general supervision on a daily basis; or 3) requires monthly monitoring for a chronic health condition; or 4) have a health condition that will worsen if LTC services are not provided or are discontinued. See draft Vermont long-term care clinical eligibility criteria provided by Vermont administrator.

<sup>47</sup> Ibid. at 24.



## **D. Conclusion**

If approved by CMS, a waiver proposed under Section 1115(a)(2) would allow a state to receive federal financial participation for the cost of home and community-based services for those people in the approved expansion group. That is, 1115 waiver authority gives CMS broad powers to work with states to implement demonstrations that de-link the existing 1915(c) HCBS level of care from the NF level of care to provide services to an expansion group.

Currently, CMS is working with Vermont regarding its pending waiver, which would (if approved) categorize people differently regarding the medical need and the entitlement to services. The Vermont Medicaid 1115 waiver application is the best example and, if approved, could serve as a starting point for other states' applications. The Vermont demonstration establishes three categories of level of care. One, the Highest Need Group, is based on the highest level of need and other functional standards; an individual in this group has an entitlement to services, and may select between a nursing facility or the community. The next, the High Needs Group, is not an entitlement program, but for people eligible to participate they may select between a NF and the community. The Moderate Need Group would be an expansion population. The other levels of care are less restrictive but do not carry any entitlement to specific services, or in the case of inadequate funding, to any Medicaid services. Major issues include protection of the most needy recipients and budget neutrality. Similarly, other states could structure 1115 waivers that establish more than one level of care category, with each level defining the types of services to which a recipient is entitled.

## **Approach 6: Utilize a Freedom of Choice Waiver**

### **A. Description of Approach**

A Medicaid “freedom of choice” waiver, commonly known as a Section 1915(b) waiver, permits a state to restrict the providers that a Medicaid recipient may select for a given service. Quite literally, it restricts a recipient’s freedom to choose any Medicaid-participating provider.

### **B. Background**

Freedom of choice waivers have been used by state Medicaid programs almost exclusively in the context of managed care initiatives. These waivers serve as the backbone for primary care case management (PCCM) programs (whereby a recipient is assigned to a single primary care provider to coordinate his or her care), and for capitated programs involving MCOs (whereby a recipient must receive all covered benefits through the provider network affiliated with that MCO).

Other examples of freedom of choice waivers include capitated arrangements for transportation services, behavioral health care, and (on a very small scale) managed long-term care. The technique described below, however, does not involve a capitated arrangement to reduce overall expenditures for, and the usage of, institutional long-term care services. Instead, it draws upon the use of a freedom of choice waiver to “selectively contract” for services.

In simple terms, selectively contracting for services describes a situation in which a state competitively procures the providers eligible to deliver a service, and then mandates that Medicaid recipients secure their health care exclusively through the providers selected through that procurement.

The state of Washington has used a selective contracting 1915(b) waiver for hospital services. In Washington’s waiver—which is targeted at non-MCO enrollees since hospital utilization for MCO enrollees is managed directly by the MCOs—the state contracts with a limited number of hospitals in urban areas to provide all primary care and inpatient hospital services at a prospectively agreed-upon rate. The objectives of the waiver include “shifting routine hospital care for Medicaid clients from higher cost to lower cost settings while ensuring that emergency . . . services are available from all appropriate settings.”<sup>48</sup>

Washington’s selective contracting waiver therefore carves out certain services, including emergency room use, state hospitals, children’s hospitals, alcohol and detox centers, and others. As carve-outs, these services may be provided by (and reimbursed to) any licensed and qualified hospital. Washington estimates that its program saved about \$4 million each in calendar years 2001 and 2002.

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<sup>48</sup> Description of Washington’s waiver, accessed at [www.cms.hhs.gov/medicaid/1915bwa05fs.asp](http://www.cms.hhs.gov/medicaid/1915bwa05fs.asp).

Although selective contracting has not yet been implemented in the institutional long-term care context, nothing would preclude its use there as a technique to similarly drive utilization toward low cost, high quality nursing facilities. Adapted to institutional long-term care, a 1915(b) waiver to selectively contract for NF services would involve these steps:

- The state would determine whether it has more capacity in the system than it needs, and if so, where it may have this excess capacity (such as in an urban area).
- The state would then establish criteria by which providers would bid to be selected by the state to provide the targeted service. The state's criteria in the procurement could include factors such as price, quality, and a provider's willingness to take concrete steps (e.g., screening all new admissions to assist the state in transitioning residents to the community). In terms of establishing the bidding criteria for price, a state could undertake an entirely new pricing structure, with payments keyed to census, converting residents to the community, and other factors.
- The state would then conduct a competitive procurement to determine which providers would be authorized to participate in Medicaid, perhaps by region. The state could either establish the contractual price it is willing to pay directly in the request for proposals (thereby mandating that all bidders indicate an acceptance of that price), or leave the price proposal to a competitive process.
- At the conclusion of the procurement, the successful bidders would become part of the state's FFS network of authorized nursing facilities, at the contracted price. *The supply of beds thereby would be limited to the selected providers, under terms established by contract.* For example, perhaps only 75 beds would be authorized at a given provider, although that provider might have 110 licensed beds. *Just as important, unsuccessful bidders would not be part of the Medicaid program's FFS network, and they could not bill Medicaid for providing services to Medicaid recipients.*

### **C. Advantages Over the Status Quo**

In general, the purpose of this type of freedom of choice waiver is to move away from the come-one-come-all method of enrolling providers that is commonplace in FFS Medicaid. That is, in most services, Medicaid programs typically have had many challenges in enrolling enough providers, often caused by very low Medicaid FFS provider payments. Thus, states generally have been willing to enroll *any* provider that agrees to sign the state's standard provider participation contract; providers have essentially had an "open enrollment" process to join Medicaid.

In certain discrete situations, however, provider "open enrollment" may work against the state's interests. Limiting provider participation in Medicaid may be appropriate when:

- *The state's reimbursement system is constructed in a way that attracts provider interest.* The state of Washington found that this is true in hospital settings because in general, hospitals must serve the indigent; so receiving any funding from Medicaid is a bonus. As a result, all hospitals participate in Medicaid. This principle also might be true in some states' institutional long-term care programs, especially with the types of cost-based reimbursement (even on a prospective basis) that are still quite prevalent in state payments to nursing facilities. In other words, in institutional long-term care, states may have more providers than they need rather than a shortage.
- *There is a heightened risk of provider-induced demand.* One way that excess capacity arises is when providers can generate demand for their own services. This may lead to excessive utilization, and potentially excess capacity built to support this demand. Several 1915(b) waivers have been used to address this problem; one example is the use of PCCM waivers to reduce the demand for physician specialty services by requiring primary care providers to authorize a referral to a specialist.
- *The state wants to substitute one type of service for another.* Another hallmark of a 1915(b) waiver is its ability to control access to one type of provider (and service) by substituting another type of provider (and service). Again, a PCCM waiver is a good example. In a PCCM waiver, a state is often able to substitute a primary care visit (to treat a non-emergent condition) for a more expensive —and unnecessary —specialty visit.

All of these factors could vindicate the use of a 1915(b) selective contracting waiver in institutional long-term care. First, although it is true that not all licensed nursing facilities participate in Medicaid, many states' cost-based institutional care reimbursement policies encourage provider participation in Medicaid. Simply stated, it is rare for a state to complain that it cannot find enough nursing facilities willing to participate in Medicaid.

Second, there is a heightened risk of provider-induced demand for institutional long-term care. To be fair, at the time of admission, a resident almost always needs NF care, so the demand for institutional services is not induced by providers at that point. (States have become much better at NF utilization review to ensure that residents require an institutional level of care at the time of admission.) Rather, the provider-induced demand exists when providers *fail to actively develop and manage a discharge plan*. In other words, the provider-induced demand does not involve the first few days of the resident's admission; the induced demand arises well into a person's stay.

Third, states increasingly want to substitute HCBS alternatives for institutional long-term care. A 1915(b) waiver is an effective tool to achieve this outcome.

## D. How it Would Work

Beyond the basic steps described above, there are practical considerations that should be evaluated before pursuing this approach. A state may want to consider and resolve these issues in advance of submitting any 1915(b) waiver request to the federal government:

- Implement a careful approach to transfer an individual from a non-network nursing facility to a network (contracted) facility at the time her or she becomes eligible for Medicaid. *It is worth noting that this occurs without state assistance in the current environment* whenever a person spends down in a non-participating provider, such as a nursing facility that does not accept Medicaid. However, if a state undertook to establish a selective contracting model, it might want to implement a careful outreach and counseling model to assist residents when they convert to Medicaid and find themselves in a non-network provider. These services could be provided by independent living centers or area agencies on aging. *Thus, this outreach and counseling intervention might be a very effective opportunity to counsel the resident about HCBS alternatives to institutional care.*
- Consider securing an “enrollment broker.” When 1915(b) waivers have been used in acute managed care, often an enrollment broker has been hired by the state to help Medicaid recipients choose an MCO. The enrollment broker, in this version of the model, provides the outreach and counseling services described above. This arrangement might be helpful in a selective contracting model for institutional long-term care.
- Consider “carve-outs.” Perhaps certain types of institutional long-term care should not be inside the waiver terms of a 1915(b) selective contracting model. That is, there may be a shortage of providers of certain types of services (e.g., providers that serve residents with co-morbid mental health and physical disabilities). Thus, perhaps these services should be carved out, allowing all eligible and licensed providers to participate in Medicaid and offer these services.

## E. Challenges

Apart from the obvious political challenges involved in converting institutional long-term care to a 1915(b) waiver model, the freedom of choice waiver technique would represent a significant departure in oversight and administration for state Medicaid programs. In effect, it would convert the delivery of institutional long-term care from a regulatory model to a contractual model.

This change is more than semantic. Presently, in the regulatory model, a state promulgates the terms under which *any* provider may participate. This model involves a strong reliance on state and federal licensure, survey, and certification functions to monitor the performance of providers. The state Medicaid agency need not, and often does not, deal directly with nursing facilities on any issue outside reimbursement.

In a contractual model, on the other hand, providers would be selected by the state Medicaid agency as the result of a competitive procurement. The language in the contract between the state and the provider would establish the terms of participation and oversight. While these terms could require compliance with all licensure, survey, and certification standards, for this model to be successful, a state Medicaid agency must employ effective contract monitors to exercise *direct* oversight of the providers.

## **F. Conclusion**

When used appropriately, selective contracting achieves two important objectives: it reduces the number of providers (and units of service) in a system, and it lowers the unit cost of a service. This approach, permitted under a freedom of choice or 1915(b) waiver, may be effective in certain states (or regions of states) to reduce NF expenditures, which then could be reinvested in HCBS.

## Conclusion

Several approaches are available to states interested in reducing the utilization of, and expenditures in, institutional long-term care settings such as nursing facilities. This issue brief described six approaches: one incrementalist, three structural reforms that have been pursued, and two innovations that are conceptually sound but have yet to be introduced.

A Brief Look at the Six Approaches Discussed in This Issue Brief	
Incrementalist Approach	<ul style="list-style-type: none"><li>• Altering nursing facility reimbursement</li></ul>
Structural Reforms	<ul style="list-style-type: none"><li>• Establishing a conversion fund to adapt nursing facilities into assisted living</li><li>• Paying nursing facilities to take beds off line</li><li>• Introducing capitated managed long-term care</li></ul>
Innovations yet to be implemented	<ul style="list-style-type: none"><li>• 1115 waiver to alter the entitlement to nursing facilities as a setting for long-term care</li><li>• Freedom of choice waiver to force institutional long-term care providers to compete in order to be approved to provide Medicaid services</li></ul>

For all of these approaches, the ultimate objective is to promote home- and community-based service alternatives to institutional long-term care. This is accomplished by applying *realized* savings in institutional care so that any expansion in HCBS does not necessarily require new state funds. The success of these approaches truly results in a systems change that allows long-term care funding to “follow the person” out of the institution and into the community.