

Testimony of
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The Future of Long-Term Care and Medicaid
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Introduction

Chairman Manzullo, Congresswoman Velazquez, Congressman Bartlett and other members of the Committee, thank you for inviting me here today to discuss the future of long-term care and the transformation efforts underway in the Medicaid program. As a result of the Deficit Reduction Act of 2005 (DRA), we are on the verge of entering a new era in Medicaid long-term care. The reforms in the DRA – funding for self-directed and home and community based services, new support for long-term care insurance, and especially, the Money Follows the Person initiative – enable CMS to work with the States to rebalance Medicaid long-term care services.

Medicaid is the largest public source of funding for long-term care in the United States. It is an essential lifeline for the most vulnerable Americans. In 2004, Medicaid paid for 49 percent of the total amount spent on long-term care services in the United States. State and federal financing of long-term care costs is a significant issue both for state and federal budgets. About one-third of Medicaid spending is for long-term care and this is projected to be approximately

\$100 billion in FY 2007. Nationally, institutional-based care still accounts for 70 percent of long-term care spending in Medicaid. The 8.4 million individuals with disabilities who are enrolled in Medicaid account for 44 percent of total Medicaid expenditures (\$102 billion in 2003) and the 5.1 million low-income elderly in Medicaid account for 24 percent of expenditures (\$55.5 billion in 2003). Of the Medicaid funds spent on behalf of individuals with disabilities, 37 percent of Medicaid dollars are for long-term care services. Of the Medicaid funds spent on behalf of aged individuals, 69 percent of Medicaid dollars are for long-term care.

The growth in spending by the federal government and states for long-term care services through Medicaid will likely continue to increase as our population ages. Using the tools made available through the DRA, CMS is working with States to make changes that contribute both toward improving the quality of life for more people with disabilities and long-term care needs and ensuring the sustainability of the Medicaid program. The changes complement and build upon successful reform efforts of the President's New Freedom Initiative (NFI) – an important commitment toward ensuring that all Americans have the opportunity to develop skills, engage in productive work, choose where to live, and participate in community life. Helping individuals remain in their own homes and allowing them to make their own choices of providers, for example, has been demonstrated to increase consumer satisfaction that translates into lower utilization of less appropriate (and higher cost) emergency rooms and institutional care.

Long Term Care Reforms in the Deficit Reduction Act of 2005

With the enactment of the DRA, States have an opportunity to implement new options to create programs that are more aligned with today's Medicaid populations and the health care environment. The DRA reflects a growing consensus on transforming the long-term supports provided under Medicaid — reforming State programs from being institutionally-based and provider-driven, to “person-centered” and consumer-controlled. It recognizes the role of Medicaid in supporting individuals in their desire to attain and retain independence and self-care in their own homes and communities. It renews the promise of freedom for every individual with a disability or long-term illness. The DRA is a long-awaited commitment to independence, choice, and dignity for countless Americans who want to have control of their lives, and gives States many of the tools they need to “rebalance” their long-term support programs.

Money Follows the Person Rebalancing Demonstration

The key change in the DRA is a program that will provide states with an enhanced match rate for implementing the Money Follows the Person Rebalancing Demonstration (MFP). The enacted MFP demonstration is nearly identical to the proposal in the President's Budget over the past several years and provides a strong financial incentive to set up choice-based financing for long-term services. It supports state efforts to “rebalance” their long-term support systems between institutional and community-based care by offering \$1.75 billion in competitive grants to States over 5 years, beginning January 1, 2007. Specifically, the Federal Government will give an MFP-enhanced Federal Medical Assistance Percentage (FMAP) rate for the provision of home and community-based services, for a period of one year, for the cost of transitioning individuals from an institution to the community.

With this critical assistance, States will be able to make targeted reforms to shore up the community-based infrastructure so that individuals have a choice of where they live and receive services. CMS will continue working with our Federal and state partners and others in broadening the scope of what is traditionally viewed as the long-term care system to include more efficient use of a full complement of support services. The MFP grants will also encourage states to adopt a strategic approach to improving quality in both HCBS and nursing homes as the state designs and implements its rebalancing initiative.

There is strong evidence supporting this reform – evidence that personal control leads to much better beneficiary satisfaction, better health outcomes, and lower costs per person served. This means that by rebalancing long-term care systems in states, Medicaid dollars go further and do more.

Texas

For example, Texas helped lead the way with a Money Follows the Person program in September, 2001. As of March 31, 2006, 10,711 people have chosen to leave nursing facilities, have the institutional funds follow them, and move into the community. The Texas experience has provided three important lessons.

First, MFP works regardless of age, race, or gender. Currently, in Texas, MFP assists the very young to the very old. One-hundred five participants are children aged nine or younger. An additional 44 are between 10 and 17 years old. Twelve people in the program are over 100 years old. Approximately two-thirds of the people in the program are over age 65; more than seven

percent are older than 90. Sixty-five percent are female, 20 percent are Hispanic, and 13 percent are African American.

Second, MFP works for people with many different living arrangements. In Texas , 22 percent live alone, 46 percent live with family, and three percent live with other persons who are in a waiver program. Most of the remaining 29 percent live primarily in residential care or adult foster care.

Third, we estimate that MFP will save money. It is estimated that Texas saved about 20 percent of what it previously spent on long-term services and supports when comparing the cost of a comparable package of nursing home services to the cost of the services offered under the Texas program.

Vermont

Some very exciting things are happening in Vermont as well. The State's MFP-type program, "Choices for Care," a section 1115 demonstration waiver was implemented in October of 2005, and builds upon Vermont's history of finding creative ways to provide alternatives to institutional care. With a new focus on public information and quality assurance, a new community ombudsman, and a new "cash and counseling" program, Vermont's goals for this program build upon an established history of providing community based alternatives. Specifically, the "Choices for Care" program seeks to provide choice and equal access, serve more people, manage the costs of long term care, create a balanced system, and prevent institutionalization.

Vermont's efforts have led to a significant increase in community services and a significant decrease in the number of older Vermonters who require nursing home care. The most significant was among the state's residents who were over 85 years old. They were 22 percent of the nursing home residents in 1994, compared with being only 13 percent of nursing home residents in 2004.

In Fiscal Year 1996, 88 percent of Vermont's long-term care expenditures went to nursing homes; 12 percent to community-based services. In contrast, in 2005, 68 percent of LTC expenditures went to nursing homes, and 32 percent went to community based services.

Vermont estimates that without its rebalancing initiative, long-term care expenditures would have been more than eight percent higher. With the money it saved, the state says it was able to both expand and better manage the nursing-home and home-based care funds, and not only give consumers choice but also serve more people as funds became available.

So the evidence is persuasive, and now, the funding is there and CMS is working to ensure states are aware of this opportunity. States that do not apply for this program are missing an opportunity to give their beneficiaries the choice and control they deserve; they are also passing up a huge federal funding opportunity. CMS plans to release a MFP request for proposal to states later this summer.

The DRA made other "person-centered" changes that add significantly to this unprecedented opportunity.

State Option for Home and Community Based Services

The DRA gives states authority to boost the availability of home and community-based care for some Medicaid beneficiaries without coming to CMS first to get a waiver. Beginning January 1, 2007, States can amend their State plans to offer home and community-based services as a State plan optional benefit for qualified individuals with incomes below 150 percent of the federal poverty level. This significant step towards ending the “institutional bias” allows States to offer community-based services to individuals based on their functional need, not on their need for institutional care. This option breaks the eligibility requirement that an individual can receive community services only if he or she needs an institutional level of care. Entry into an institution could be made more stringent. This fundamental shift in the program recognizes that not everyone wants or needs institutional care. Individuals will be provided individualized care plans based on an assessment of needs and may be offered the option of self-directing their care. States will be able to establish the number of individuals served under the home and community-based State plan option and thus will have necessary control over the development and growth of their systems so that they can ensure the success of the programs. At the same time, States will be able to tighten the functional standard for admission to institutions and refine eligibility for home and community-based waiver services without necessarily having to request an 1115 demonstration waiver.

State Option for “Cash and Counseling”

The DRA offers new “cash and counseling” support to allow people with disabilities on Medicaid greater flexibility and control to manage their care and its cost. Individual-controlled

budgets provide for the transparency and informed choice believed to be vital to improve quality and value. Self-directed personal care services are currently provided through HCBS and section 1115 demonstration programs. Nearly half the States currently offer self-direction in some capacity, but self-direction is available to only limited numbers of people. With this new option, self-directed personal care services, including self-directed personal care services provided by family members, can be provided under the State plan. States will also be able to provide items that increase independence or substitute for human assistance. Thus, States become partners with individuals and their families, friends, and health care professionals in creating individualized plans and budgets that will give individuals control of their lives. The person's preferences, choices, and abilities drive how they receive services.

Other Medicaid Long-Term Care Reforms in the DRA

State Option for Families of Disabled Children to Purchase Medicaid Coverage

Beginning January 1, 2007, States may choose to allow families (with family income up to 300 percent of the Federal poverty level) to buy Medicaid coverage for their disabled children. This flexibility allows States to help working families have access to the critical supports Medicaid provides without further financial strain. States can extend this critical life-line to families struggling to make ends meet by charging a sliding-scale premium based on family income.

Demonstration Projects to Offer Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children

In addition, the new law offers fresh support for home and community-based alternatives to psychiatric residential treatment facilities for children. States can keep families together by expanding the availability of HCBS to children under age 21 with serious emotional disturbances. These children would otherwise be removed from their families and placed in a psychiatric residential treatment facility in order to receive needed services. In the past, States were unable to develop home and community-based waiver programs as an alternative to this institutional care because the law had only permitted such programs as an alternative to care in a hospital, nursing facility or intermediate care facility, for the mentally retarded. The Secretary is authorized to conduct five-year demonstration projects in up to 10 States during the period from FY 2007 through FY 2011, and \$218 million is available for the project period.

Long-Term Care Reforms in the DRA and the President's New Freedom Initiative

The LTC reforms in the DRA build upon reform efforts CMS has undertaken in implementing the President's New Freedom Initiative (NFI). The NFI represents an important commitment toward ensuring that all Americans have the opportunity to develop skills, engage in productive work, choose where to live, and participate in community life. The President's Initiative, which we are working to implement throughout the government, is about the promise of *freedom* for every elder and person with a disability. It is a promise of independence, choice, and dignity, and in this way, our existing NFI initiatives and the DRA reforms highlighted above are complementary to one another. Our overall goal with our long-term care initiatives is to work with states to get to the point where consumer choice is the norm in our long-term care system – including in Medicaid.

Real Choice System Change Grants Foster Choice

While the Real Choice System Change (RCSC) grants have provided much evidence of the success of home- and community-based services, it is time to shift resources and move ahead with more systematic, large-scale reforms, such as Money Follows the Person Rebalancing Demonstration. For the FY 2006 RCSC grants, states and other eligible organizations, in partnership with their disability and aging communities, have submitted proposals to design and construct systems infrastructure that will result in effective and enduring improvements in community long-term support systems. CMS invited proposals for grants totaling more than \$20 million to address critical elements of successful systems transformation, including improved access to Long Term Care support services, comprehensive quality management, information technology, increased choice and control, and increased access to safe and affordable housing. Since FY 2001, CMS has awarded over 297 grants to all 50 States, the District of Columbia, and 2 territories, totaling approximately \$240 million.

Independence Plus Initiative Increases Choice and Control

In 2002, CMS launched the Independence Plus Initiative to afford Medicaid participants increased choice and control that results in greater access to community living. Independence Plus (IP) is based on the experiences and lessons learned from states that have pioneered consumer directed care. The IP Initiative expedites the process for states to request waiver or demonstration projects that give individuals and their families' greater control over their own services and supports. IP programs not only deliver service in the community setting, but also allow a growing number of individuals and their families to decide how best to plan, obtain, and

sustain the services that are best for them. The IP programs allow participants to design a package of individualized supports, identify and attain personal goals, and supervise and pay their caregivers. CMS has approved 17 IP programs in 15 states (AR, NH, SC, FL, LA, NC (2), CA, MD, DE, NJ, CT, VT, RI, ND (2) and MT). Collectively, these states permit 42,483 individuals with long term care needs to self-direct their services. Additionally, CMS has awarded \$5.4 million in Real Choice Systems Change grants to 12 states (CO, CT, FL, GA, ID, LA, MA, ME, MI, MO, MT, OH) to develop Independence Plus programs. Numerous other states are in the planning stage.

Independence Plus programs have built on the very successful “Cash and Counseling” demonstrations. The Cash & Counseling Demonstration and Evaluation Program is a three-state experiment to determine the feasibility of offering a cash payment option in lieu of traditional agency services to recipients of personal assistance services. The demonstration enables people to hire whomever they want to provide their care by redirecting personal assistance funds to the consumers themselves (instead of to agencies). There are three original Cash and Counseling section 1115 demonstration programs (Arkansas, New Jersey, and Florida), two other states with section 1115 self-direction demonstrations similar to Cash and Counseling (Oregon and Colorado), and a multitude of states that offer a variety of self-directed program options under their section 1915(c) home and community based waivers.

Home- and Community-Based Waivers offer Alternatives to Institutional Care

Home- and community-based service (HCBS) waivers show that Medicaid can be an effective source of support for community living. Using HCBS waivers, states can provide alternatives to

institutional care by allowing beneficiaries to live at home, where they can enjoy family, neighbors, and the comfort of familiar surroundings. States can only do this as long as the waiver remains cost-neutral, meaning that the costs of providing services under the waiver do not exceed the costs that would be incurred if the services were provided in an institution.

Vermont and New Hampshire illustrate how institutional and home- and community-based care can lead to different results. Vermont has a highly developed home- and community based health care system. New Hampshire continues to rely on institutional care for the elderly. In Vermont, 85 percent of the Medicaid population over age 65 still lives at home. In New Hampshire, only half can live at home. As a result, Vermont spends less than half as much per elderly person on Medicaid as New Hampshire.

HCBS waiver programs have been an interim solution of expanding choices while creating value. Between 1999 and 2002, the average nursing home payment increased from \$19,688 to \$22,247, or 13 percent. By comparison, the average cost per participant in a home HCBS waiver increased from \$16,083 to \$16,437, or 2.2 percent.

Transition/Diversion Grants Awarded

When individuals try to move out of an institution for a more independent life, they may need assistance with certain one-time expenses, such as security deposits and essential household furnishings. In May 2002, CMS announced a clarification in policy to allow home- and community-based waivers to cover transition costs. In addition, CMS granted funds since 2001 to states in support of these transition/diversion activities through the Real Choice Systems

Change grants. We estimate that approximately 2,300 individuals have been transitioned from institutional settings or diverted from these settings through these grants. As individuals move into the community, we understand how important it is for support services to be available to them. The long-term care system needs to be one that encompasses these support services as well.

Resources and Support for Obtaining Effective Long-Term Care Services

CMS and the Administration on Aging (AoA) launched the Aging and Disability Resource Center (ADRC) Program in 2003. The Program provides competitive grants to states to assist them in developing and implementing “one stop shop” access to information and individualized advice on long-term support options, as well as streamlined eligibility determinations for all publicly funded programs. The long-range goal is to have ADRCs serve as “visible and trusted” sources at the community level nationwide where people of any age, disability, or income can get information on all available long-term support options. ADRCs will help us bring transparency and choice to long-term care. The program also reduces government fragmentation, duplication, and inefficiencies. To date, 43 states have received grants to begin implementing ADRC programs. These states are making significant progress in creating coordinated systems of access – as part of their overall systems change efforts – to promote informed decision making and consumer choice in long-term care.

Promoting Personal Responsibility and Planning for Long-Term Care Expenses

In addition to making more home- and community-based long-term care options available, we need to improve the financing of long-term care and encourage Americans to plan for their future. For Medicaid to remain sustainable for those who truly need it, we must ensure that Medicaid does not become an inheritance protection plan for those who can pay for their own long-term care. The DRA reforms asset transfer rules and, at the same time, enables states to expand the Long-Term Care Partnership program to help individuals plan and finance their future long-term care needs. Expansion of the Long-Term Care Partnership program will enable individuals to get more affordable insurance for their long-term care needs, and avoid much Medicaid spending at the same time. This program was established to help individuals take more responsibility in planning for and financing their future long-term care needs by purchasing long-term care insurance. The program allows an individual who purchases and uses a qualified policy to apply for Medicaid without having to spend all of his or her assets first. Specifically, an individual will be able to qualify for Medicaid while retaining assets in the amount of insurance benefit payments made on their behalf. These newly protected assets will also be exempted from Medicaid estate recovery provisions. A National Clearinghouse for Long-Term Care Information which will help individuals and their caregivers navigate the range of long-term support options was also established in the DRA.

Quality Improvements will Reduce Costs and Improve Outcomes

Providing better support for high quality, efficient providers is the best way – in fact, I think its the only way – to enable our beneficiaries to have access to modern medicine, to continue to get improvements in medical care and how it’s provided, while ensuring continued Medicaid

coverage of long-term care whether these services are provided in the home or community or in an institutional setting.

Quality Care must be the Standard in HCBS Programs

The Administration has consistently worked to ensure that HCBS waiver programs allow people the independence to stay in their own homes while receiving quality care and support in a community setting. In the last three years, CMS has implemented a standard quality review protocol for regional office use in monitoring state programs; completed the first complete inventory of state HCBS quality assurance and improvement techniques; and developed a uniform national format consisting of key components for quality assurance and improvement in HCBS waiver programs.

CMS is working with the major state associations on an ongoing basis, including representatives of state agencies for developmental disabilities, head injuries, Medicaid, and aging, to assure all our forms and applications reflect current policies and our focus on quality in HCBS waivers. CMS developed a draft revised waiver application for all HCBS waivers, incorporating our quality expectations, and is also developing a new state annual report form to capture better information about states' quality management activities.

The Administration is committed to providing quality services in the home- and community-based setting and continues to engage in improving its role to ensure quality outcomes through federal and state monitoring.

Improving Quality in Nursing Homes is an Essential Part of Effective Long-Term Care Policies

Quality improvement also needs to extend to nursing facilities. We are working to improve quality while avoiding unnecessary costs and expensive, preventable complications for patients in nursing homes through the Nursing Home Quality Initiative (NHQI) and the parallel initiative known as the "Quality First" initiative. Through the NHQI, the Quality First Initiative, CMS has instituted public reporting of nursing home and home health quality measures. These initiatives have been very successful in measurably improving the quality of care in the nation's 16,000 nursing homes in every state and territory. For example, data from NHQI indicates that the long-term care prevalence of pain has improved steadily over the last three years. On average, the prevalence of pain in long-term care patients has declined approximately 47 percent over the last three years. Another measure of quality in nursing homes is the daily use of physical restraints. On average, the daily use of physical restraints has declined by 32 percent over the last three years.

Quality improved even more dramatically in those nursing homes around the country that partnered more intensively with their state quality improvement organizations (QIOs). We strongly encourage nursing homes who wish to join in this effort to contact their state QIO to learn more about quality improvement programs and to obtain resources to help in their quality improvement efforts.

And it is important to remember that quality improvement is not a static process – for example, we are constantly working to enhance our measures and broaden from clinical to patient experience of care and systems of care measures. Our goal should be to create an environment of continuous quality improvement, of sharing and cooperation among the QIOs, State Survey Agencies, nursing homes and professional organizations, and even our beneficiaries and their families together we create an "environment of quality."

In order to achieve this goal, CMS believes that we will have to keep re-examining the way we accomplish our work, and even to re-invent the nature of the public-private partnership. The "Quality First" initiative and the National Commission for Quality Long-Term Care are examples of reinvigorated new partnerships that can propel the quality agenda forward at an ever-increasing pace. To make the participation of our partners easier, in December 2004 we created the CMS Long-Term Care Task Force of the Quality Council. The Long-Term Care Task Force (LTCTF) was created to coordinate the long-term care (LTC) program within CMS and to serve as an internal advisory panel for the Administrator. In late 2004 the Task Force initiated an annual *Nursing Home Action Plan* that is posted on our website each year. The *Plan* provides a comprehensive view of most of the initiatives CMS has underway to promote optimum quality in the nursing home environment. Later this year we plan to solicit the involvement of states in a "Quality-Based Purchasing Demonstration" that will enable both Medicare and Medicaid payment systems to be more sensitive to differences in quality among nursing homes.

Helping Beneficiaries Make Informed Choices

Through NHQI, CMS has expanded its efforts to inform consumers about the care available in the nation's nursing homes through the Nursing Home Compare Web site at www.medicare.gov. Nursing Home Compare web allows consumers to search by state, county, city, zip code, or by facility name for information on any of the 16,000 Medicare- and Medicaid-certified nursing homes. The web site includes data on the facility's care record for regular and complaint surveys, staffing levels, number and types of residents, facility ownership, quality measure scores in comparison to state and national averages, and will soon include information on the presence of fire safety sprinklers. Over the last two years the number of clinical topics covered by the publicly reported quality measures has increased from eight to fifteen. Nursing Home Compare is one of the most popular sites on www.medicare.gov, receiving an average of about 13 million page views each year.

Conclusion

Mr. Chairman, 2006 can be a truly historic year in Medicaid long-term care reform. CMS, along with our partners, are entering a new phase of Medicaid long-term care benefits and I hope this is the year that will be marked by us moving towards rebalancing of the long-term care system. These are critical steps for long-term care reform for at least two reasons. First, more long-term care planning means more people will have the ability to choose the long-term care services that are best for them. Second, more support for long-term care financing means less pressure on Medicaid as the Baby Boom ages. This will help Medicaid continue to serve people with truly limited means, now and in the future. We know that community-based services are not for everyone and for this reason we will continue to ensure quality services are offered in institutional settings. However, today we have the opportunity to continue the work the

President has begun through the New Freedom Initiative and implement the DRA reforms to forward the cause of community living for those who prefer it to institutional care. In adopting the new options available under the DRA, States will help families and individuals attain or retain capability for independence and self-care and rebalance their long-term support programs to make their Medicaid programs more sustainable. Thank you, Mr. Chairman, for the opportunity to speak to you today about the future of long-term care in Medicaid. I look forward to working with you as we move forward with Medicaid reform. I would be happy to answer any questions you may have.