INSIGHT on the Issues

# Taking the Long View: Investing in Medicaid Home and Community-Based Services Is Cost-Effective

**Targeting Medicaid home and community-based services (HCBS) for budget cuts may be shortsighted. Recent evidence indicates that the cost savings from HCBS manifest in the long run; over time, states that invest in HCBS experience slower Medicaid expenditure growth than states with low HCBS spending.**

## Key findings and policy recommendations

The current fiscal crisis is causing most states to make deep budget cuts. In this climate, many state policymakers are targeting Medicaid home and community-based services (HCBS) because they are optional Medicaid benefits. But this approach may be shortsighted. Recent evidence indicates that the cost savings from HCBS manifest in the long run; over time, states that invest in HCBS experience slower Medicaid expenditure growth than states with low HCBS spending.

With declining revenues, states should take the opportunity to focus on longer-term and more cost-effective reform options for their long-term care (LTC) systems, such as promoting HCBS over institutional care. Doing so has the dual benefit of not only slowing the growth in Medicaid LTC spending but also improving consumer choices. Key facts about HCBS investment include:

- Over time, states that invest in HCBS programs experience slower Medicaid spending growth than states with low HCBS spending. Although Medicaid spending generally increases during a transitional period, states that commit to comprehensive reforms can realize cost savings over time if they increase HCBS and, at the same time, decrease their reliance on nursing home use.[1]
- LTC services do not drive Medicaid spending growth. Between FY 1997 and FY 2007, Medicaid LTC spending increased by 80 percent, while spending other than LTC increased by 102 percent.[2]
- Vermont's Choices for Care demonstration created an entitlement to HCBS for "highest need" clients. It reduced the number of Medicaid nursing facility residents by 9 percent and increased HCBS caseloads by 155 percent, which included extending services to 1,183 "moderate need" individuals. The state used a global LTC budget, which allowed it to eliminate the institutional bias inherent in Medicaid eligibility. Vermont reduced spending growth to less than half of what the state projected when the program was designed.[3]
- A 1994 Government Accountability Office (GAO) study of LTC programs in Oregon, Washington, and Wisconsin found that these states were able to serve more beneficiaries with available dollars and slow the rate of growth in LTC

expenditures by expanding HCBS and limiting supply and use of nursing facility beds.[4]

- A Lewin Group study found that HCBS programs produced savings from what would have been spent in 1994 of $43 million in Colorado, $49 million in Oregon, and $75 million in Washington.

> **"Despite the fears of critics that it would expand Federal spending, the HCBS program actually contained institutional costs and helped States moderate the growth of Medicaid spending overall."**
>
> Thomas Hamilton, Director, Survey and Certification Group, CMS, 2009 testimony to the Senate Special Committee on Aging

As state policymakers consider LTC budget and policy decisions, it is important that they do so in the context of an LTC philosophy that supports consumer choice and control. If budget reductions are necessary, they should be consistent with this philosophy and avoid increasing Medicaid's institutional bias. States should:

- Establish measurable goals to achieve balance between institutional services and HCBS and make policy and funding decisions relative to these goals.
- Facilitate Medicaid savings by establishing effective care management and HCBS infrastructure to transition nursing home residents into community settings.
- Support consumer choice and control by using Aging and Disability Resource Centers or other single entry points to screen and/or provide options counseling to all individuals before they are admitted to a nursing home.
- Recognize that cuts in HCBS will affect the balance between institutional and HCBS spending and may increase nursing facility admissions.
- Provide services and supports for family caregivers, whose unpaid assistance is a major factor in preventing or delaying nursing home use.

## What is cost-effectiveness?

Most Medicaid HCBS spending is authorized through programs that "waive" federal rules. By law, these programs are approved by the Centers for Medicare & Medicaid Services (CMS) only if the state demonstrates that spending will not exceed what would have been spent on LTC services in the absence of the waiver. HCBS waiver beneficiaries must meet the same functional eligibility criteria as nursing home residents. States do not receive federal reimbursement for waiver expenditures that exceed the amount stated in the cost neutrality calculation approved by CMS. As a result, the term cost-neutrality often is used to refer to cost-effectiveness.

However, the above definition ignores the equally compelling consideration of meeting consumer preferences. An overwhelming majority of consumers prefer to remain in their home or community. If states establish goals that support consumer choice and eliminate institutional bias, the evaluation of cost-effectiveness would include an assessment of whether the LTC system provides services that meet the needs and preferences of people with disabilities at the lowest possible cost. Researchers have, therefore, looked at

alternate definitions of cost-effectiveness beyond simply cost-neutrality. They have asked:

- Does expanding HCBS reduce overall Medicaid spending?
- Does expanding HCBS slow the rate of Medicaid spending growth?
- Do HCBS programs serve more people than nursing homes for the same amount of spending?

#### Does expanding HCBS reduce overall Medicaid spending?

A review of the literature by Grabowksi[5] found inconclusive evidence that state spending was actually reduced when HCBS expanded because:

> Program administrators have found it very difficult to structure coverage such that only individuals who otherwise would have entered nursing homes use non-institutional services. States have employed targeting (or screening) mechanisms in an attempt to limit care to only those individuals who otherwise would have accessed nursing home care.

Although this level of targeting could reduce overall costs, this focus is somewhat unrealistic given that many low-income older people living in the community have unmet LTC needs.[6] Their welfare would improve significantly with HCBS. States should, instead, be applauded for addressing these unmet needs through HCBS expansion.

#### Does expanding HCBS slow the rate of Medicaid spending growth?

A new study by Kaye et al. found that states with established HCBS programs reduce their LTC spending over time.[7] Based on an analysis of Medicaid expenditures from 1995 to 2005, the authors concluded that aggregate spending growth was greater in states with limited HCBS programs than in states with large, well-established programs. The report stated that the expansion of HCBS "appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings." The authors found that total LTC spending in states with established programs declined 8 percent between 1995 and 2005, adjusted for inflation. Spending in states with low HCBS spending increased 9 percent during the same period. However, states that were in the process of expanding their HCBS programs increased spending by 24 percent.[8] The study did not determine whether other factors might explain these differences in state Medicaid spending over time.

> **"Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings."**
>
> H. Stephen Kaye, et al., 2009.

#### Do HCBS programs serve more people than nursing homes for the same amount of spending?

A 1994 GAO study of LTC programs in Oregon, Washington, and Wisconsin found that HCBS program were able to manage expected growth in demand and control overall expenditures. It found the programs to be cost-effective because of savings that resulted from control on the number and use of nursing facility beds. A Lewin Group study found that HCBS programs produced savings in 1994 of $43 million in Colorado, $49 million in Oregon, and $75 million in Washington.[9] This study also pointed to decreased use of nursing homes as an important factor.

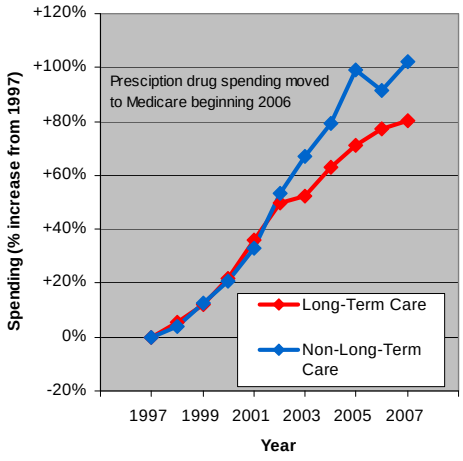
Thus, while expanding HCBS may not reduce overall Medicaid LTC spending in absolute terms, there is significant evidence that it can effectively slow the rate of growth-- a more realistic goal, given the aging of the population.

Moreover, states that shift their mode of service delivery away from institutional services and toward HCBS can serve more people at a lower aggregate cost. This outcome is possible because, on average, the cost of providing HCBS to an individual is lower than the cost of providing institutional services. One study found that, compared with nursing facility care in 2002, HCBS waivers for older people and adults with disabilities saved $15,210 in public spending per participant[10] This estimate included non-Medicaid public spending for waiver participants' room and board.

## Why is this issue critical now?

Economic recessions tend to increase Medicaid spending when families lose employer-sponsored health insurance.

**Figure 1**
**Medicaid non-LTC spending increased faster than LTC spending 1997–2007**




Source: S. Eiken, B. Burwell, and K. Sredl, *Medicaid Long-Term Care Expenditures FY 2007*. Thompson Reuters, 2008.

Medicaid spending increases $3.4 billion for every 1 percent increase in the unemployment rate.[11] As unemployment continues to rise, a majority of states are "scrambling to find ways to get through the rest of the year without hacking apart vital services or raising taxes."[12] Growing demand for Medicaid services will increase spending at a time when state revenues decline. As a result, states generally look to cut back on Medicaid services that are considered optional. Medicaid beneficiaries are entitled to nursing home services (provided they meet their state's eligibility criteria) but not to HCBS (whether provided through a waiver of federal rules or as personal care services offered at state option); thus, HCBS are at risk.

State policy makers usually turn to three primary options to reduce Medicaid spending: Limit eligibility, reduce provider reimbursement rates, and reduce the services that Medicaid covers. Already, 22 states and the District of Columbia have cut a range of services, including those aimed at low-income older people and people with disabilities, according to a report by the Center on Budget and Policy Priorities (CBPP).[13] Citing the CBPP, media reports note that at least 15 states are cutting personal care services to Medicaid beneficiaries.[14]

HCBS may be particularly vulnerable because some policymakers are concerned that paying for HCBS will create a "woodwork" effect; that is, people who would not use Medicaid to enter a nursing facility would be willing to move to assisted living or receive services at home if they are available through Medicaid. However, the experiences of Oregon, Washington, and Wisconsin indicate that states can control overall spending if they reduce their use of nursing homes while they expand HCBS.

Thus, a fourth option is available to states: Reduce the use of institutional services by expanding HCBS. Declining revenues pose challenges to state policymakers who want to offer older people and adults with physical disabilities the services they need to support their independence. But declining revenues also offer states an opportunity to reorganize their LTC systems to promote effective HCBS alternatives.

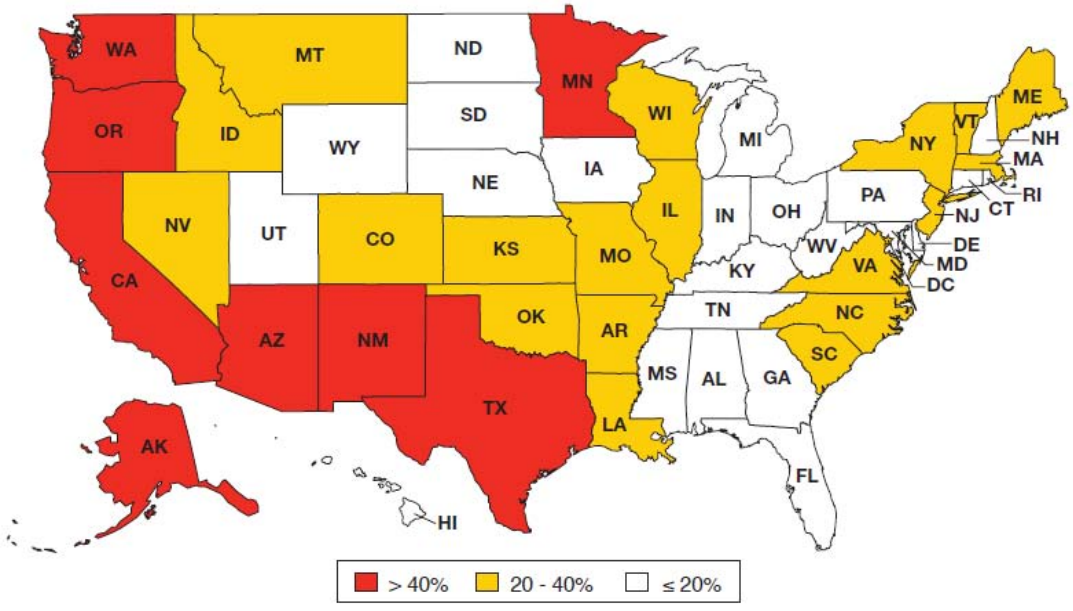
As policymakers consider budget cuts, it is important to note that although Medicaid costs have been on the rise, LTC spending has increased more slowly than non-LTC spending over the last 10 years and particularly since 2002 (see figure 1). Between FY 1997 and FY 2007, Medicaid LTC spending increased by 80 percent, whereas non-LTC spending increased by 102 percent.[15]

## How are different states affected?

States differ in terms of their relative investment in HCBS, as shown in figure 2. The map illustrates how the percentage of Medicaid LTC spending for older people and adults with physical disabilities going to HCBS varies by state. States' response to the budget crisis may vary depending on their existing investment in HCBS.

States with mature systems already have made substantial investments in HCBS and have reduced their reliance on institutional services. Their challenge is to maintain HCBS funding to continue the progress they have achieved. A key question for states that spend 40 percent or more of their LTC funds on HCBS (one measure of a mature system) is what impact will cuts in HCBS programs have on institutional spending? HCBS cutbacks may result in more admissions to nursing facilities or more hospital

**Figure 2**
**Percentage of Medicaid LTC spending for older people and adults with physical disabilities going to HCBS, 2007**




Source: A. Houser, W. Fox-Grage, M. Gibson, *Across the States 2009: Profiles of Long-Term Care and Independent Living*, AARP Public Policy Institute, 2009.

admissions and emergency room use. HCBS cutbacks also will shift additional costs and burdens to already overtaxed family caregivers.

States with developing systems may need to increase HCBS spending before they have lowered their use of nursing facilities. Obtaining new revenues to offer a broader array of services, build single entry points to manage access, and expand HCBS participation is difficult when policymakers have yet to reduce institutional spending through diversion or relocation initiatives. However, states that spend less than 20 percent of their Medicaid LTC dollars on HCBS (one measure of a less mature system) may have the greatest opportunities to shift funds to community services because there are likely to be more people living in nursing facilities who could be served in the community.

## Case studies illustrate cost containment

### Washington

Washington is one example of a state that is taking the long view on reforming its LTC system. It has worked to reduce its Medicaid nursing facility caseload and direct resulting available funds to support HCBS growth. Currently, an independent Caseload Forecasting Council projects the need for LTC services. These forecasts are used to determine the appropriation for both nursing facility and HCBS services.

Washington spends more Medicaid funds on HCBS, 55 percent in FY 2007, than on services provided by nursing facilities.[16] Because of its continuing investment in HCBS, Washington can serve a greater number of older persons and adults with disabilities in the community, as illustrated in table 1.[17]

### Vermont

Vermont's Choices for Care demonstration program creates an entitlement to HCBS for participants that meet "highest need" criteria.[18] It uses a global LTC budget, which allows the state to overcome Medicaid's institutional bias in LTC eligibility.

A recent report by the Kaiser Commission on Medicaid and the Uninsured found that, over three years, spending growth in Choices for Care was between half and two-thirds of what the state had projected when the program was designed.[19] The report also noted that "spending growth was just 1.3 percent in FY 2006 and grew to 5.5 percent in FY 2007, putting the state on par with national spending growth for nursing home and home health services" even though beneficiaries are entitled to HCBS.[20]

**Table 1**
**Washington Medicaid long-term care caseload, 2004–2011**

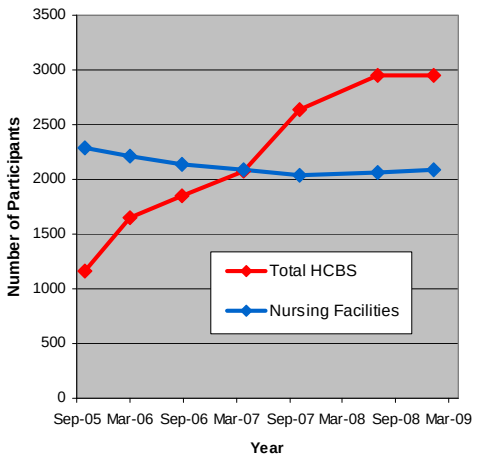
| HCBS | Number | % Change from 2004 |
|---|---|---|
| June 2004 | 34,987 | - |
| June 2008 | 40,335 | 15.3 |
| June 2009* | 41,590 | 18.9 |
| June 2011* | 43,636 | 24.7 |
| **Nursing Facility** | **Number** | **% Change from 2004** |
| June 2004 | 12,259 | - |
| June 2008 | 10,880 | - 11.2 |
| June 2009* | 10,508 | - 14.3 |
| June 2011* | 9,792 | - 20.1 |

* Projected.

Source: Washington Aging and Disability Services Administration.

The number of beneficiaries served in nursing facilities dropped 9 percent under Choices for Care between October 2005 and January 2009 while the HCBS in-home caseload grew 155 percent (see figure 3).[21] The increase included extending new services to 1,183 beneficiaries with moderate needs who do not meet the nursing facility level of care. The statute authorizing the demonstration requires that any savings from lower nursing facility use be invested in HCBS.

**Figure 3**
**Vermont Choices for Care Participants, 2005–2008**




Source: J. Senecal, Commissioner, Vermont Department of Disabilities, Aging and Independent Living, presentation at the 2009 Money Follows the Person conference.

## Conclusion: Take the long view and make needed LTC reforms

These are critical times for states that are trying to develop or maintain balance between HCBS and institutional LTC services. Declining state revenues may lead budget staff to focus spending cuts on Medicaid HCBS programs that are optional and, in some cases, growing rapidly. When considering budget reductions, policymakers should consider the impact on the entire system, since reductions in one service may cause increases in other areas.

States that have not established a philosophy that supports balance and choice between institutional and community-based LTC services should not take the shortsighted "quick fix" of cutting Medicaid HCBS programs. Rather, states should take the long view and make needed investments in LTC reform.

Achieving balance may require states to build an infrastructure with single entry points; inform nursing home applicants about the option to receive HCBS; adopt flexible budgeting; strengthen transition care management for individuals interested in relocating from nursing facilities to the community; and support family caregivers, who provide the majority of assistance. Between 2003 and 2008, the number of Medicaid beneficiaries living in nursing facilities dropped 7 percent nationally. In Minnesota and Wisconsin, nursing home beneficiaries fell by 20 percent – due in part to the expansion of HCBS.[22] These data illustrate that the national trend is moving toward greater system balance. Reducing spending on HCBS programs may reverse this trend and, ultimately, have the undesirable effect of increasing overall Medicaid LTC spending.

By compiling and analyzing the best available data, this report concludes that HCBS is cost-effective. States that invest in HCBS can, over time, slow their rate of Medicaid spending on LTC. Federal incentives to assist states in expanding HCBS could accelerate progress in this area.

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[1] H. S. Kaye, M. LaPlante, and C. Harrington, "Do Non-Institutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs* 28, no. 1 (January/February 2009).

[2] Calculated from data compiled by S. Eiken, B. Burwell, and K. Sredl, *Medicaid Long-Term Care Expenditures FY 2007*, (Thompson Reuters, 2008).

[3] J. Senecal, Commissioner, Vermont Dept. of Disabilities, Aging and Independent Living, presented at the Money Follows the Person conference (Baltimore, MD: March, 2009).

[4] Government Accountability Office, *Successful State Efforts to Expand Home Services While Limiting Costs*, GAO-HEHS-94-167 (Washington, DC: GAO, August 1994).

[5] D. Grabowski, "The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence," *Medical Care Research and Review* 63, no 1 (February 2006).

[6] Harriet L. Komisar, J. Feder, and J. D. Kasper, "Unmet Long-Term Care Needs: An Analysis of Medicare–Medicaid Dual Eligibles," *Inquiry* 42 (Summer 2005): 171–82.

[7] See end note 1.

[8] Data are for the non-MR/DD population, which includes nursing home, personal care, and home-health spending. Ibid.

[9] Alecxih et al., *Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States*, (Washington, DC: AARP, 1996).

[10] Savings were realized for other target groups in the HCBS waiver as well. On average, the HCBS waiver saved $43,950 in public spending per person. M. Kitchener, T. Ng, N. Miller, and C. Harrington, "Institutional and Community-Based Long-Term Care: A Comparative Estimate of Public Costs," *Journal of Health and Social Policy* 22, no. 2 (2006).

Kaiser Commission on Medicaid and the Uninsured, *Medicaid Facts: State Fiscal Conditions and Medicaid* (Washington, DC: Kaiser Commission, November 2008).

[12] Jennifer Steinhauer, "Facing Deficits, States Get Out Sharper Knives," *New York Times*, November 13, 2008.

[13] Center on Budget and Policy Priorities. "States in Trouble Due to Economic Downturn," /www.cbpp.org/policy-points10-20-08.pdf.

[14] Philip Shishkin, "States Cut Services for Elderly, Disabled," *Wall Street Journal*, November 20, 2008.

[15] Calculated from data compiled by S. Eiken, B. Burwell, and K. Sredl, *Medicaid Long-Term Care Expenditures FY 2007* (Thompson Reuters, 2008).

[16] A. House, W. Fox-Grange, and M. Gibson, *Across the States: Profiles of Long-Term Care and Independent Living*, 8th ed. (Washington, DC: AARP, 2009).

[17] Data are available from the Caseload Forecasting Council Web Site, http://www.cfc.wa.gov/#.

[18] Entitlement means that all Medicaid beneficiaries who are eligible for the service must be served if providers are available.

[19] J. Crowley and M. O'Malley, *Vermont's Choice for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded Its Third Year* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2008).

[20] Ibid., page 2.

[21] See end note 3.

[22] Calculations from tabulations by the American Health Care Association using CMS OSCAR Form 672: F75-F78 data for June 2003 and December 2008. (Available at www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/Forms/AllItems.aspx).