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Insight on the Issues

Stretching the Medicaid Dollar: Home and Community-Based Services Are a Cost-Effective Approach to Providing Long-Term Services and Supports

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INTRODUCTION

Approximately 17.4 million children and adults with disabilities and older adults rely on Medicaid for health care and assistance with long-term services and supports (LTSS). Of these 17.4 million Medicaid enrollees,[1] approximately 5 million receive LTSS through Medicaid.[2]

LTSS include assistance with daily tasks such as eating, bathing, dressing, transportation, and managing medications and finances. LTSS can be delivered in institutional settings (such as nursing facilities) or through home and community-based services (HCBS). However, an overwhelming majority of people would prefer to live in their homes and communities for as long as possible.[3] Related to those preferences, they want to maintain their independence and have control over their own decisions.

The Medicaid program is the largest payer for LTSS, covering 51 percent of national LTSS expenses in 2013.[4] Over the past 30 years, Medicaid LTSS dollars have increasingly gone toward HCBS, allowing more people to stay in their homes and integrated within their communities. However, the pace has not been fast enough, particularly in light of the increase in the aging population. Importantly, HCBS are not only the preference of most people, they are cost-effective. HCBS are typically less expensive than nursing facility care, so increasing investments in and access to HCBS could allow the Medicaid program to serve more people without increasing costs.

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Despite these realities, however, certain federal Medicaid rules make nursing facilities more easily accessible than HCBS. For older people and adults with physical disabilities, nursing facility care still accounts for 59 percent of Medicaid LTSS spending.[5]

WHAT ARE HCBS?

Many people with physical, cognitive, or mental impairments need assistance with activities of daily living (ADLs) such as bathing, dressing, and toileting, or instrumental activities of daily living (IADLs) such as shopping, managing money, and preparing meals. The term HCBS refers to assistance with ADLs and IADLs, which generally helps older adults and people with disabilities maintain employment or remain in their homes and communities. HCBS also promote community integration through transportation and employment supports.

People of all ages with disabilities who use these services live in a variety of settings: their own homes or apartments; nursing facilities; assisted living facilities and other supportive housing settings; and integrated settings, such as those that provide both health care and supportive services. HCBS can come in many forms, and the services an individual uses are specific to functional needs.

MEDICAID HCBS SPENDING

Medicaid spent $152 billion on LTSS in fiscal year (FY) 2014;[6] a majority of the expenditures, in fact, have gone toward HCBS.[7] These figures, however, mask substantial spending variations, both by state and by demographic group. In short, older adults and people with physical disabilities are still disproportionately served in nursing facility settings. In FY2014, the majority of Medicaid LTSS funds for older adults and people with physical disabilities went to nursing facilities, with just 41 percent of the LTSS funds going toward HCBS[8] (see table 1).

MANAGED LTSS AND MEDICAID HCBS

Another trend of note is that states are increasingly turning toward managed care models to offer LTSS, including HCBS. Currently, 24 states have at least one managed LTSS (MLTSS) plan,[9] and MLTSS spending accounted for $22.5 billion in FY2014, a 55 percent increase from the $14.5 billion in MLTSS expenditures in FY2013.[10,11]

A 2017 report of select MLTSS plans found that states adopted a variety of policies to promote HCBS and reduce costs by delaying or preventing nursing facility placements. Some states, for example, adopted rate-setting methodologies that blend HCBS and nursing facility costs to encourage plans to use HCBS when possible. Some states provided other incentives to their MLTSS plans (such as bonus payments) to increase HCBS use and transition people from nursing facilities to their homes and communities.[12]

Some MLTSS states extended HCBS eligibility to people who have lower care needs but are "at risk" for a nursing facility placement. By offering HCBS to this population, these states and MLTSS plans found that they could save money by delaying and potentially preventing more expensive nursing facility care.[13]

IMPACT OF MEDICAID'S INSTITUTIONAL BIAS ON HCBS

Because Medicaid is a federal–state partnership administered at the state level, where people live affects their ability to access publicly funded HCBS to meet their LTSS needs.

Under current rules, states must offer Medicaid enrollees a certain package of services. These

TABLE 1
HCBS and LTSS Expenditures, FY2014

	HCBS Expenditures	All LTSS Expenditures (HCBS and non-HCBS)	% of LTSS as HCBS
Older adults and people with physical disabilities	$37.9 billion	$93.1 billion	40.7%
All LTSS recipients	$80.6 billion	$151.8 billion	53.1%

mandatory benefits include hospital, physician, and nursing facility services.[14] States also have the discretion to offer additional services, or optional benefits, to their enrollees. HCBS is an optional benefit in the Medicaid program, and states have substantial flexibility to design their own HCBS offerings and set eligibility criteria at their discretion.[15] This split in optional and mandatory benefits for Medicaid LTSS creates a structural bias toward nursing facility care and can limit one's ability to receive services in the setting of one's choice.

Every state has mechanisms through which they can offer HCBS, mainly through a variety of waiver and state plan options. Many of these programs limit enrollment to a certain number of "slots," which results in waiting lists for most HCBS programs. In 2015, more than 640,000 people were on an HCBS waiver waiting list.[16] In comparison, there are no waiting lists for Medicaid-funded nursing facility care, which as a mandatory Medicaid benefit is an entitlement for people who meet their state's eligibility criteria. This creates a bias toward placement in institutions.

This institutional bias is a costly component of Medicaid LTSS. Medicaid pays nearly three times as much for each person served in institutional settings as it does for each person served in the community. This is true across populations, including older people and adults with physical disabilities as well as people with intellectual disabilities.[17]

ADDITIONAL HCBS SPENDING

Programs under the Older Americans Act (OAA) provide home-delivered meals, in-home assistance (such as chore or homemaker), and adult day services for people ages 60 and older. OAA programs target people with the "greatest social or economic need." OAA was reauthorized in 2016, and for FY2016, Congress appropriated $1.2 billion for OAA meals and supportive services, such as family caregiver supports. OAA funds can serve as a safety net for older adults who are not yet eligible for Medicaid LTSS but still need some basic services (such as home-delivered meals). Studies have shown that increasing investment in OAA programs can realize savings for the Medicaid program.[18]

FOCUSING ON THE RETURN ON INVESTMENT: INVESTING IN HCBS IS COST-EFFECTIVE

There is significant evidence that investing in HCBS is cost-effective and can slow the rate of Medicaid spending growth.

- On average, Medicaid dollars can support nearly three older people and adults with disabilities with HCBS for every person in a nursing facility. In 2011, Medicaid spending for HCBS for older adults and adults with physical disabilities receiving services averaged $10,418 per person, compared with $29,855 for each person receiving services in a nursing facility.[19] See table 2 for state-level, per-user average costs for Medicaid HCBS and nursing facility care.
- A meta-analysis of 38 studies including state-specific public studies, evaluations, and fiscal analyses that examined the cost-effectiveness of HCBS programs consistently found that states that expanded HCBS experience a slower rate of Medicaid spending growth.[20] In Ohio, for example, the older adult population grew by 15 percent between 1997 and 2009. The state, however, actually spent approximately $100 million less on Medicaid LTSS for this population because it increased HCBS enrollment and reduced nursing facility placement.[21]
- Statistical modeling found that increasing the portion of Medicaid LTSS dollars toward HCBS by 2 percentage points annually can reduce overall Medicaid LTSS spending by 15 percent over 10 years. Spending cuts to HCBS would actually increase overall Medicaid LTSS spending because individuals would now receive these services in institutional settings.[22]
- The Money Follows the Person Rebalancing Demonstration Program encouraged states to transition Medicaid beneficiaries living in institutional settings back to their homes and communities. Independent evaluations of the program suggest that the cost of serving people who transition decreases once they are in their homes and communities. Among older adults in particular, there is an estimated cost decrease of 16 percent, which is an annual savings of $11,912 per person.[23]

- States that offer MLTSS spend less per beneficiary receiving HCBS than they do for those living in institutions. MLTSS plans in these states typically offer comprehensive health care and LTSS services to their beneficiaries. For all populations, the monthly cost per HCBS beneficiary was $1,949, and the cost for institutional care was $5,745. Among older adults only, the monthly per beneficiary costs were $1,153 and $3,381 for HCBS and nursing facilities in 2015, respectively.[24]
- Tennessee delivers all LTSS for older adults and people with physical disabilities through MLTSS. The state incentivized its managed care organizations to offer HCBS through incentives and benchmarks, and from 2010 to 2013, the portion of these populations receiving HCBS increased from 17 percent to 40 percent.[25]

In short, redirecting more resources to provide Medicaid HCBS instead of nursing facility services is cost-effective compared with nursing facilities. In addition, HCBS are more responsive to the preferences of older adults and people with disabilities to remain in their homes and communities, and have the potential to improve the quality of life of people receiving these critical services.

TABLE 2
Expenditures for Medicaid HCBS and Nursing Facility Care per Person in 2011, by State

Location	HCBS			Nursing Facilities
	Home Health	Personal Care	Aged/Disabled 1915(c) Waivers	
United States	$7,323	$10,954	$12,945	$29,855
Alabama	$4,362	N/A	$11,079	$31,612
Alaska	$1,242	$24,359	$25,020	$96,445
Arizona	$21,561	N/A	N/A	$25,214
Arkansas	$2,610	$5,397	$10,792	$19,606
California	$4,946	$9,527	$10,942	$33,335
Colorado	$13,393	N/A	$9,653	$33,384
Connecticut	$8,334	N/A	$12,221	$34,132
Delaware	$4,483	$0	$11,509	$48,751
District of Columbia	$4,413	$3,287	$25,456	$71,838
Florida	$16,514	$21,904	$9,327	$32,983
Georgia	$623	N/A	$10,563	$29,378
Hawaii	$2,010	N/A	N/A	N/A
Idaho	$2,394	$7,396	$11,394	$20,904
Illinois	$3,867	N/A	$10,478	$21,173
Indiana	$14,055	N/A	$11,984	$28,351
Iowa	$9,148	N/A	$6,472	$29,390
Kansas	$2,579	$16,193	$15,347	$24,017
Kentucky	$2,436	N/A	$7,348	$21,811
Louisiana	$4,048	$10,258	$19,531	$28,999
Maine	$432	$10,243	$17,713	$26,861

Location	HCBS			Nursing Facilities
	Home Health	Personal Care	Aged/Disabled 1915(c) Waivers	
Maryland	$721	$5,744	$22,052	$44,268
Massachusetts	$7,182	$20,226	$7,808	$36,111
Michigan	$823	$4,208	$12,265	$35,099
Minnesota	$10,076	$18,631	$17,382	$30,170
Mississippi	$855	N/A	$8,599	$32,662
Missouri	$1,047	$7,192	$6,311	$24,779
Montana	$1,211	$13,032	$15,420	$34,312
Nebraska	$4,458	$5,505	$11,735	$28,614
Nevada	$41,053	$13,039	$4,160	$38,283
New Hampshire	$1,361	$28,969	$13,353	$29,286
New Jersey	$3,298	$12,266	$15,160	$34,133
New Mexico	$1,022	$16,927	$10,101	N/A
New York	$17,514	$30,197	$2,018	$31,106
North Carolina	$3,548	$6,456	$17,715	$29,339
North Dakota	$8,922	$16,630	$10,688	$37,624
Ohio	$6,404	N/A	$13,940	$29,133
Oklahoma	$2,682	$3,201	$8,803	$25,991
Oregon	$160	$1,199	$11,194	$31,596
Pennsylvania	$8,577	N/A	$19,928	$30,517
Rhode Island	$1,741	$0	N/A	$48,337
South Carolina	$4,455	N/A	$10,461	$30,257
South Dakota	$2,814	$1,538	$9,213	$25,757
Tennessee	$17,463	N/A	N/A	N/A
Texas	$2,886	$7,945	$16,807	$20,605
Utah	$6,179	$3,304	$15,666	$31,627
Vermont	$1,999	$8,864	N/A	$28,102
Virginia	$1,663	N/A	$18,701	$31,186
Washington	$1,272	$13,319	$13,816	$22,393
West Virginia	$1,684	$6,422	$15,884	$44,136
Wisconsin	$3,213	$10,580	$23,090	$25,881
Wyoming	$4,102	N/A	$7,962	$31,002

Source: Ng et al., "Medicaid Home and Community-Based Services Programs: 2011 Data Update" (HCBS) and 2013 Medicare and Medicaid Statistical Supplement (Nursing Homes).

Notes: For HCBS, Home Health and Personal Care reflect all populations; Aged/Disabled 1915(c) Waivers reflect older adults 65+ and people with physical disabilities.

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