CENTER FOR
LONG-TERM CARE
REFORM

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Briefing Paper #4:
Rebalancing Long-Term Care

Is Rebalancing a Panacea?

Briefing Paper #1 in this series on "The History of Long-Term Care Financing" explained how Medicaid's bias toward funding nursing home care crowded out a privately financed home and community-based services (HCBS) market. Since the 1980s Medicaid has gradually moved away from financing nursing home care toward paying for more HCBS. Will this change save money and improve the program as advocates of rebalancing insist? Or could it cost more and potentially harm access and quality? What are the downside risks?

Institutional Bias Gives Way

The federal Medicaid LTC program started in 1965. To win industry support, the new program originally paid exclusively and generously for nursing home care. But exploding costs and declining quality led in time to calls for Medicaid to "deinstitutionalize" or "rebalance" LTC benefits.

The Omnibus Budget Reconciliation Act of 1981 authorized HCBS waivers which allowed state Medicaid programs to fund home care with restrictions. For example, states couldn't spend more for HCBS than they would have spent for nursing home care.

The Supreme Court's 1999 "Olmstead" decision held that people with disabilities have the right to live at home or in the community if they are able and do not prefer nursing home care. Olmstead encouraged states to provide more HCBS within reasonable budget limitations.

Major initiatives during the George W. Bush Administration expanded opportunities for state Medicaid programs to cover HCBS. The Deficit Reduction Act of 2005 and the Affordable Care Act of 2010 (health reform) added options and funding to encourage rebalancing to HCBS.

The Argument for Rebalancing

The argument in favor of HCBS, made strenuously by many academic and policy experts, is that taking care of frail or chronically ill elders in their homes is much cheaper than in a nursing home. Therefore, rebalancing from skilled nursing facility (SNF) services to HCBS should save the state and federal Medicaid programs money while giving people more of what they want (home care) and less of what they would rather avoid (nursing home care). But is that true?

Considerations

Intuitively, it would seem so. SNF services are expensive and HCBS apparently much less so. Surely, Medicaid can serve more people in their homes and communities for less money and with better outcomes than in nursing facilities. But the reality is more complicated. Decades of empirical studies show HCBS delay but do not replace institutionalization. For example:

> When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care.[1]
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> An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that non-institutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations.[2]
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> Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective.[3]
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> The Channeling demonstration . . . found that, while community-care models were often welcome by recipients and their caregivers, they led to overall increases in public spending for long-term care.[4]

> The primary argument for the cost savings potential of home care rests on a comparison of the average per person Medicaid expenditures for people in the community and in nursing homes. The average annual Medicaid expenditures for home care for older people and adults with physical disabilities ($8,355 in 2004) per person are dramatically less than average annual Medicaid expenditures ($27,650 in 2004) per person for nursing home care. This comparison, however, is incomplete because it does not address differences in disability levels, use of acute care services, and the exclusion of housing and room and board costs from home care expenditures. Thus, it is not strictly an 'apples to apples' comparison.[5]
>
> The research evidence that changing the delivery system will produce substantial Medicaid savings is not strong, but it is a premise strongly held by many state officials and consumer advocates.[6]

Year after year, combined costs for SNF care and HCBS continue to rise in spite of, or perhaps because of, rebalancing. Tough questions arise. Would people who receive HCBS have otherwise entered SNFs? Do they reduce costs or merely add recipients? Isn't losing the institutional economy of scale very expensive? How can providing home care services people want instead of nursing home care they dread save money?

California Case Study[7]

In-Home Supportive Services (IHSS) is California's largest Medi-Cal (Medicaid in California) HCBS program. IHSS has lenient functional eligibility requirements and allows Medi-Cal recipients to hire and pay their own caregivers, including family members. One study found that this policy helps "prevent further functional decline," "addresses tight labor pools and supports family caregiving."[8] The same study claimed that HCBS programs are cost-effective.

Unfortunately, this policy of easy access to IHSS and paying family members for care drives up program participation and induces population-wide complacency about LTC risk. It replaces free private care-valued in 2007 at $48 billion or five times Medi-Cal LTC spending and 9.1 times Medi-Cal HCBS spending[9]-with paid services at enormous public cost.

California's Legislative Analyst concluded in 2010: "After accounting for both costs and savings to the state and counties, IHSS probably results in net costs. This is because the savings (in the form of avoided nursing home costs) are probably more than offset by the costs (to provide IHSS and related services) for those recipients who would not be institutionalized in the absence of the program."[10]

Conclusion

Believers that rebalancing can save money and improve Medicaid-financed LTC cling to hope while disregarding hard reality. The only study supporting their position "found that states with well-established HCBS programs had much lower rates of spending growth compared to those with low HCBS spending" but only after "a lag of several years before institutional spending appeared to decline."[11]

States efforts to reduce Medicaid LTC expenditures by rebalancing from nursing home care to home and community-based care have clearly failed. But the solution cannot be a return to the institutional bias that plagued the program in years past. Not only would covering more people in nursing homes again cost more money, it isn't possible anyway because low-acuity patients no longer qualify medically for SNF care in many states.

The Solution

The path to a more promising outcome lies through a better understanding of why and how most Americans who need long-term care end up on Medicaid. As explained in Briefing Papers #1, #2 and #3 on the History of LTC, Medicaid LTC Eligibility and Medicaid Planning, respectively, easy access to Medicaid LTC benefits after care is needed has resulted in excessive dependency on publicly funded long-term care. Offering more attractive HCBS, without controlling easy eligibility, increases costs and impairs quality.

For Medicaid to afford quality HCBS for all recipients it must have fewer recipients. By tightening eligibility, closing eligibility loopholes, preventing Medicaid planning, and enforcing estate recovery, the program can do a better job for fewer genuinely needy eligibles. When middle class and affluent people understand their savings and home equity are at risk for

LTC, they will avoid Medicaid dependency by paying privately from savings, home equity conversion and private insurance. These points are developed more fully in Briefing Paper #5 on Dual Eligibles and Briefing Paper #6 on Private LTC Financing Alternatives.

End Notes

[1] General Accounting Office, "The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions" (Dec. 7, 1982) p. 43, http://archive.gao.gov/f0102/120074.pdf.
[2] John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-off between Cost Containment and Access to Care*, (Washington DC: The Urban Institute Press, 1986), p. 106.
[3] Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly*, vol. 69, no. 2, 1991, p. 322.
[4] Francis Caro, "Long-Term Care: Informed by Research," AcademyHealth, Washington, D.C., 2003, p. 2; http://www.academyhealth.org/files/publications/ltcresearch.pdf.
[5] Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 10, footnote omitted; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.
[6] *Ibid*, p.22.
[7] Stephen A. Moses, "Medi-Cal Long-Term Care: Safety Net or Hammock?," Pacific Research Institute (San Francisco, CA) and Center for Long-Term Care Reform (Seattle, WA), January 2011; http://www.pacificresearch.org/docLib/20110104_LongTermCare_final(2).pdf.
[8] Robert Mollica and Leslie Hendrickson, "Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians," report prepared for California Community Choices and California Health and Human Services Agency under Grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, November 2009, p. v; http://www.chhs.ca.gov/initiatives/CAChildWelfareCouncil/Documents/REPORT%20Final%20PDF.pdf.
[9] Ari Houser and Mary Jo Gibson, "Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update," *Insight on Issues 13*, AARP Public Policy Institute, Washington, DC, November 2008, table 2, p. 4, and table 3, p. 5; http://assets.aarp.org/rgcenter/il/i13_caregiving.pdf.
[10] Legislative Analyst's Office, "Considering the State Costs and Benefits: In-Home Supportive Services Program," Sacramento, California, January 21, 2010, p. 3; http://www.lao.ca.gov/reports%5C2010%5Cssrv%5Cihss%5Cihss_012110.pdf.
[11] Robert Mollica and Leslie Hendrickson, "Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians," report prepared for California Community Choices and California Health and Human Services Agency under Grant CFDA 93.779 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, November 2009, pps. 1-2; http://www.chhs.ca.gov/initiatives/CAChildWelfareCouncil/Documents/REPORT%20Final%20PDF.pdf citing Kaye, LaPlante, and Harrington, (January, 2009), "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" Health Affairs, vol. 28, no. 1, pp. 262-272; http://content.healthaffairs.org/cgi/content/abstract/28/1/262.