Home and Community-Based Services: System-wide Coordination to Improve Care, Hold Down Costs

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Altarum Institute integrates independent research and client-centered consulting to deliver comprehensive, systems-based solutions that improve health and health care. A nonprofit, Altarum serves clients in both the public and private sectors. For more information, visit ***www.altarum.org***

Average LTSS Expenditures for Users Turning 65 2015-19

TABLE 3B. Average Sum ($2015) of Expenditures from Age 65 through Death Projected for Users of Paid, Formal LTSS Who Turn 65 in 2015-2019

	TOTAL EXPENDITURES		COMMUNITY-BASED (INCLUDES RESIDENTIAL CARE)		NURSING FACILITY	
PAYER	DOLLARS	PERCENTAGE	DOLLARS	PERCENTAGE	DOLLARS	PERCENTAGE
Public	$119,000	44.6%	$40,000	28.6%	$79,000	62.6%
Medicare	26,000	9.8%	12,000	8.6%	14,000	11.1%
Medicaid	91,000	34.2%	27,000	19.3%	64,000	50.8%
Other public	2,000	0.6%	1,000	0.7%	1,000	0.6%
Private	$147,000	55.3%	$100,000	71.4%	$47,000	37.3%
Out-of-pocket	140,000	52.6%	96,000	68.6%	44,000	34.9%
Private insurance	7,000	2.6%	4,000	2.9%	3,000	2.4%
Total	**$266,000**	**100.0%**	**$140,000**	**100.0%**	**$126,000**	**100.0%**

Out-of-pocket costs average $72,000. Among those who have out-of-pocket costs, these costs average $140,000. About three-fifths of individuals face no out-of-pocket costs.[14] Looking at community and institutional expenses together, two predominant payers are Medicaid, comprising 34 percent and out-of-pocket payments, comprising 52 percent of the sum of total LTSS expenditures, respectively. Medicare is the next most important payer, followed by private insurance and other public programs. Payer predominance varies by setting. For example, Medicaid pays for 51 percent of the total for institutional settings. For community expenses, in contrast, out-of-pocket payments by families comprise the majority, about 88 percent.[15]

Favreault M & Dey J. Long-term services and supports for older Americans: risks and financing research brief. Washington, DC: ASPE. 2015.

The Face of Aging: Women Are and Will Continue To Be the Majority of Older Adults

Blue Nudes, Henri Matisse, 1952

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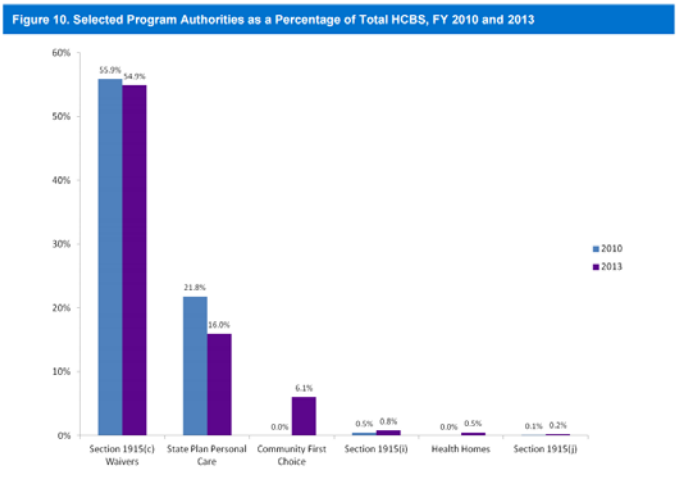
3

Medicaid Authorities as a Percentage of Total HCBS



Source: Eiken et al. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Washington, DC: Truven Health Analytics. 2015.

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Medicaid HCBS Waivers and State Plan Options

	Comparative Analysis of Medicaid HCBS (1915 & 1115) Waivers and State Plan Amendments				
Features	**§1915(c)** Home and Community-Based Services Waiver	**§1915(i) SPA** State Plan Home and Community Based Services	**§1915(j) SPA** Self-directed Personal Assistance Services (PAS)	**§1915(k) SPA** Community First Choice Option	**§1115** Research and Demonstration Project Waiver
Purpose	Provides Home and Community-Based (HCBS) Services to individuals meeting income, resource, and medical (and associated) criteria who otherwise would be eligible to reside in an institution.	Provides HCBS to individuals who require less than institutional level of care and who would therefore not be eligible for HCBS under 1915(c). May also provide services to individuals who meet the institutional level of care.	Provides a new State Plan participant-directed option to individuals otherwise eligible for State Plan Personal Care or §1915(c) services.	Provides a new State plan option to provide consumer controlled home and community-based attendant services and supports Provides a 6% FMAP increase for this option.	Authorizes the DHHS Secretary to consider and approve experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.
Requirements That May Be Waived	• Statewideness • Comparability • Community income rules for medically needy population	• Comparability • Community income rules for medically needy population	• Statewideness • Comparability	Community income rules for medically needy population	Secretary may waive multiple requirements under §1902 of the Social Security Act if waivers promote the objectives of the Medicaid law and intent of the program.

Cooper RE, Crisp S, and Flanagan S. Comparative Analysis of Medicaid HCBS (1915 &1115) Waivers and State Plan Amendments. Washington, DC: NASDDDS. 2014.

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5

Resources Available to Balancing Incentive Program States

State	Enhanced FMAP-Total Dollars
Arkansas	$67,424,092
Connecticut	$72,780,505
Georgia	$68,832,854
Illinois	$90,311,013
Indiana	$90,223,500
Iowa	$61,769,421
Kentucky	$25,579,577
Louisiana	$82,248,147
Maine	$21,246,061
Maryland	$106,338,569
Massachusetts	$110,668,102

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Wiener et al. Descriptive Overview And Summary Of Balancing Incentive Program Participating States At Baseline. Washington, DC: ASPE. 2015.

6

Resources Available to Balancing Incentive Program States, cont.

State	Enhanced FMAP-Total Dollars
Mississippi	$68,490,726
Missouri	$100,887,328
Nebraska	$8,122,707
Nevada	$3,361,490
New Hampshire	$26,458,827
New Jersey	$108,490,368
New York	$598,665,500
Ohio	$169,076,032
Pennsylvania	$96,785,656
Texas	$277,769,869

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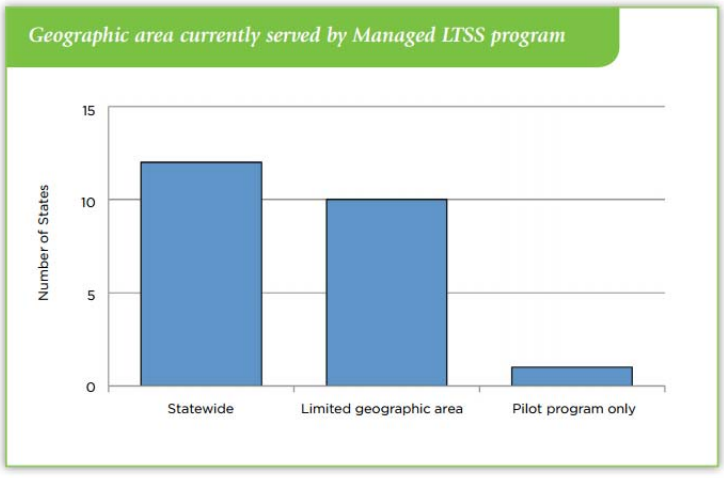
7

Medicaid Managed Long-Term Care Delivery



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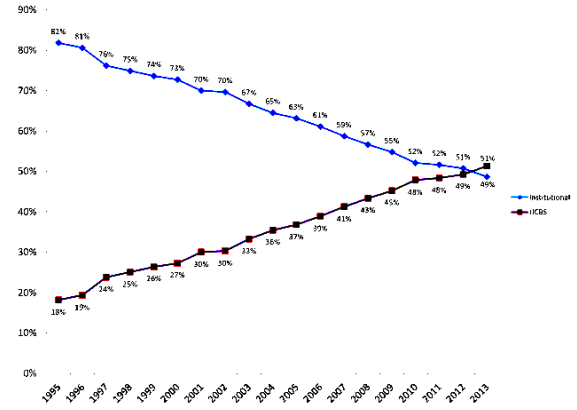
Terzaghi D & White E. The State of the States in Aging and Disability. Washington, DC: NASUAD. 2014.

8

Medicaid HCBS and NH Services: Growth and Decline

Figure 1. Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 1995–2013



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Source: Eiken et al. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Washington, DC: Truven Health Analytics. 2015.

9