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MONEY FOLLOWS THE PERSON

CMS CENTERS for MEDICARE & MEDICAID SERVICES

THE NATIONAL EVALUATION OF THE
MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION GRANT PROGRAM

REPORTS FROM THE FIELD

Number 4 • May 2010

The Starting Point: The Balance of State Long-Term Care Systems Before the Implementation of the Money Follows the Person Demonstration

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The Money Follows the Person (MFP) demonstration provides federal grant funds to 29 states and the District of Columbia[1] to support state efforts to rebalance their long-term care systems. This report provides an early assessment of the balance of state long-term care systems before the implementation of the demonstration. We examine the starting points for the grantee states before the effects of MFP began to occur to develop a baseline against which the impacts can be measured as the program matures and evolves. We use this baseline information to identify key differences in the makeup of states' long-term care systems. These observations suggest that the impacts of the MFP program are likely to differ across states.

- *In 2005, of the 2.79 million Medicaid beneficiaries who used long-term care services in the MFP grantee states, 60 percent received home and community-based care services (HCBS). Nonetheless, HCBS accounted for only 38 percent of total spending for long-term care services that year.*
- *Variation across states in the relative size of state HCBS programs was large: HCBS expenditures ranged from 13 to 59 percent of total long-term care spending, while the proportion of long-term care users receiving HCBS ranged from 24 to 83 percent.*
- *A comparison between states allocating relatively high and low percentages of their long-term care spending to HCBS programs revealed important differences and implications for the likely range of effects MFP may have on state long-term care systems. Relative to low HCBS states, high HCBS states*
  - *Provided HCBS to a larger proportion of long-term care users*
  - *Were more likely to offer state plan HCBS*
  - *Had HCBS programs that served greater proportions of elderly and nonelderly beneficiaries with physical disabilities*
  - *Provided HCBS to larger proportions of both "established" users of long-term care, who had used long-term care in the prior year, and "new" users of long-term care*

Despite these differences, HCBS spending per recipient was comparable in high and low HCBS states. The state variations suggest that the high HCBS states were relatively well balanced compared to the low HCBS states not because of the generosity of their HCBS benefits but because they provided these services to a much larger proportion of long-term care recipients.

[1] Hereafter, we refer to all grantees together, including the District of Columbia, as grantee states.

ABOUT THE MONEY FOLLOWS THE PERSON DEMONSTRATION

The MFP demonstration, first authorized by Congress as part of the 2005 DRA and then extended by the 2010 Patient Protection and Affordable Care Act (PPACA), is designed to shift Medicaid's long-term care spending from institutional care to HCBS. Congress has now authorized up to $4 billion in federal funds to support a twofold effort by state Medicaid programs to: (1) transition people living in nursing homes and other long-term care institutions to homes, apartments, or group homes of four or fewer residents and (2) change state policies so that Medicaid funds for long-term care services and supports can "follow the person" to the setting of his or her choice. MFP is administered by CMS, which initially awarded MFP grants to 30 states and the District of Columbia. Several states launched their MFP transition programs in late 2007, and the demonstration is authorized through 2016. CMS contracted with Mathematica Policy Research to conduct a comprehensive evaluation of the MFP demonstration and report the outcomes to Congress.

The Money Follows the Person demonstration resulted from a broad concern that state long-term care systems and Medicaid financing for long-term care emphasized institutional care options over home and community-based care services, such as personal assistance services. Advocates and others have argued that state long-term care systems too often do not adequately support beneficiaries in the most integrated setting possible. The MFP program aims to address these concerns by increasing access to HCBS and reducing state reliance on institutional care for Medicaid beneficiaries who need long-term services and supports.

To achieve these broad goals, states participating in MFP are implementing transition programs designed to move individuals who would like to live in the community from institutional to community-based care, whenever the Medicaid program can support adequately such a change. To be eligible for MFP, Medicaid beneficiaries must have been in institutional care for at least 90 days.[2] Federal statute also requires MFP programs to make financial investments in their state long-term care systems to improve their capacity to care for people in the community.[3] Financing for these new investments comes from the enhanced federal matching funds states receive when they provide HCBS to MFP participants.[4] These enhanced matching funds are accrued during the first year after the transition from institutional to community-based care.[5]

Twenty-nine states and the District of Columbia have implemented MFP demonstration programs under the guidance of the Centers for Medicare & Medicaid Services (CMS), the federal agency charged with oversight of this program.[6] Although the 30 grantee states' HCBS programs vary in breadth, maturity, and level of experience transitioning institutionalized populations to the community (Lipson and Williams 2009), the MFP program necessarily builds on long-term care systems that predated the demonstration. This report looks at state long-term care systems before the MFP program was implemented.

Because nursing home care is a mandatory service that all Medicaid programs must cover, all state long-term care systems include statewide networks of facilities that provide institutional care. Conversely, HCBS are

[2] The Patient Protection and Affordability Care Act (P.L. 111-148) passed in March 2010 limits eligibility for MFP to Medicaid beneficiaries who have been in institutional care for at least 90 days, not counting any days covered by Medicare's skilled nursing home benefit. Prior to the passage of this legislation, the requirement was 180 days of institutional care before someone could be eligible for the MFP demonstration.

[3] States have considerable flexibility in the types of investments they make. They may focus on providing additional services to MFP participants; investing in other beneficiaries who use HCBS; or pursuing broad, system-wide investments such as those that improve the supply of direct service workers or accessible housing.

[4] States receive enhanced matching funds for qualified HCBS (services for which beneficiaries would have been eligible regardless of their enrollment in MFP) and demonstration HCBS (standard HCBS the state provides only to MFP participants). Supplemental HCBS—services that are unique to the MFP program and are traditionally not covered by Medicaid—are not eligible for enhanced matching funds, but receive the state's standard federal match.

[5] Beneficiaries who transition to community-based care through the MFP program are eligible for MFP-financed HCBS for 365 days after the transition to the community. When they have exhausted their 365 days of eligibility for MFP-financed services, the states must continue all care necessary and for which beneficiaries remain eligible.

[6] In 2007, CMS awarded MFP demonstration grants to 30 states and the District of Columbia. One state elected not to implement a program as of the date of this report.

optional services and states need not provide them, although all states do so through public and private agencies and individuals who work independently. Medicaid programs organize HCBS around an array of waiver programs and optional state plan services for personal assistance and home health care. The waiver programs operate under the authority of Section 1915(c) of the Social Security Act (known as HCBS or 1915(c) waivers) and they allow states to waive specific Medicaid requirements. Typically, states design waiver programs to target HCBS to specific population groups and geographic areas, although some states have established large waiver programs that enroll tens of thousands of Medicaid beneficiaries. To be eligible for 1915(c) waiver programs, beneficiaries must meet state eligibility requirements for institutional care, a federal requirement that establishes waiver programs as alternatives to institutional care.[7] States can limit enrollment in waivers and waiver services in ways they cannot when the services are available through the state plan. HCBS waivers give states more control over the number of beneficiaries accessing community-based long-term care services—and ultimately more control over spending on these services—than is possible with state plan HCBS.

This report focuses on the overall balance of state long-term care systems in calendar year 2005. By studying a year before the demonstration began, we begin to establish a baseline against which we will assess MFP effects on state long-term care systems. We also identify the range of starting points for the 30 grantee states. We distinguish those grantee states that allocated a disproportionate share of their Medicaid long-term care spending to HCBS before they began implementing their MFP programs from those that allocated a disproportionate share to institutional care. State differences in the size and scope of long-term care systems suggest that the MFP program offers different opportunities for the growth of HCBS in different states. These opportunities are expected to be larger and especially significant for states that were spending a smaller share of their long-term care funds on HCBS when the MFP demonstration began.

In addition to describing state long-term care systems at baseline, this report identifies some key characteristics of states that allocate disproportionate amounts of their long-term care spending to HCBS. Knowing these characteristics provides a start to identifying strategies states could follow to shift the emphasis of their long-term care systems and to make community-based care more accessible.

This study uses Medicaid administrative data from calendar year 2005. Future analyses will expand this work to include more indicators and years of data, including years after the implementation of MFP. The ultimate goal is to study trends in the balance of long-term care systems and how these trends changed after the MFP demonstration began.

LONG-TERM CARE SYSTEMS AT BASELINE

To gain some insight into state long-term care systems before the implementation of MFP, we used Medicaid claims records from 2005 to analyze state-level variations in the provision of HCBS. Specifically, we examined (1) differences in spending and use of HCBS—with a particular focus on how states that allocated disproportionate amounts of long-term care expenditures to HCBS compare with states that allocated disproportionate amounts to institutional care; (2) differences in the use of HCBS by subgroups, including the elderly, the nonelderly disabled, and individuals with mental retardation or other developmental disabilities (MR/DD); and (3) differences in how long-term care recipients accessed HCBS.

STATE DIFFERENCES IN BALANCE OF LONG-TERM CARE SPENDING

In 2005, the 28 grantee states for which reliable data were available provided long-term care services to 2.79 million Medicaid enrollees (Table 1), at a cost of $71 billion.[8] Of these enrollees, 60 percent received HCBS, but expenditures for these services accounted

[7] HCBS waivers are also subject to budget neutrality requirements, and federal spending on waiver services cannot exceed what the federal government would have spent on institutional care for the beneficiaries in these programs.

[8] Because the MAX data appeared to be either incomplete or inaccurate for two states—Michigan and New Hampshire—these states were excluded from the analysis. States routinely report aggregate financial data on HCBS spending and use on CMS Form 64 and CMS Form 372. As discussed in the Data and Methods box, we compared our ranking of grantee states to rankings developed by Burwell et al. (2006), which were based on CMS Form 64 data. We also compared *utilization* of HCBS to data based on Ng and Harrington's (2009) analysis of CMS Form 372 data. Our ranking of Michigan and New Hampshire departed considerably from the Burwell et al. rankings, and our estimated numbers of HCBS spending or recipients in 2005 were significantly different than the numbers indicated by the Form 64 and Form 372 data. These discrepancies led us to exclude these states from the analysis.

TABLE 1. LONG-TERM CARE UTILIZATION AND EXPENDITURES BY STATE

	LTC Recipients	HCBS Recipients	HCBS Recipients as a Percentage of All LTC Recipients	LTC Expenditures (Millions of Dollars)	HCBS Expenditures (Millions of Dollars)	Percentage of LTC Expenditures Due to HCBS
Washington	77,717	59,380	76	1,301	774	59
California	587,033	482,347	82	9,128	4,941	54
Oregon	45,348	37,456	83	629	327	52
Kansas	40,448	25,652	63	817	421	51
New York	384,473	244,093	63	17,438	7,575	43
Wisconsin	65,174	30,137	46	1,805	760	42
North Carolina	145,093	102,094	70	2,683	1,127	42
Maryland	59,251	33,831	57	1,754	687	39
Missouri	93,202	61,533	66	1,450	561	39
Virginia	53,769	33,477	62	1,495	571	38
MFP Grantee Total	**2,791,051**	**1,667,776**	**60**	**70,952**	**26,790**	**38**
Hawaii	9,287	4,637	50	311	116	37
Iowa	48,929	28,826	59	1,111	402	36
Oklahoma	52,135	26,903	52	982	353	36
Nebraska	22,692	10,512	46	588	205	35
Texas	189,642	85,074	45	3,971	1,301	33
Connecticut	55,762	27,548	49	2,108	683	32
Delaware	6,876	3,050	44	277	89	32
Ohio	157,186	83,512	53	4,871	1,499	31
Illinois	161,412	81,078	50	3,293	980	30
New Jersey	100,799	56,490	56	3,386	1,000	30
Louisiana	70,305	26,373	38	1,535	421	27
Georgia	69,434	30,321	44	1,495	402	27
Indiana	59,881	15,987	27	1,851	484	26
North Dakota	10,836	5,682	52	317	83	26
Arkansas	45,254	20,556	45	912	209	23
Kentucky	49,704	19,709	40	1,179	265	23
District of Columbia	7,879	2,893	37	307	52	17
Pennsylvania	121,530	28,625	24	3,957	503	13

Source: Mathematica analysis of the 2005 Medicaid Analytic Extract files for 28 MFP grantee states.

Note: Includes all grantee states except Michigan and New Hampshire. HCBS users include beneficiaries who were in a 1915(c) waiver program for at least one month during the year or received state plan personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care. LTC users include both HCBS users and recipients of institutional care.

HCBS = home and community-based services; LTC = long-term care; MFP = Money Follows the Person.

for only 38 percent of total spending for long-term care services that year. These totals and percentages mask considerable variation at the state level. We find that the proportion of long-term care users receiving HCBS varied from 24 to 83 percent of all long-term care users, and HCBS expenditures varied from 13 percent of total long-term care expenditures in Pennsylvania to 59 percent in Washington. Of the 28 states with accurate data, 10 spent a higher percentage on HCBS than the average for grantee states.

In this study, we designated as high HCBS states the 7 states that allocated more than 40 percent of their long-term care spending to HCBS—California, Kansas, New York, North Carolina, Oregon, Washington, and Wisconsin. We designated the 8 states that allocated less than 30 percent to HCBS as low HCBS states and the remaining 13 states as moderate HCBS states. This study focuses on comparisons between the high and low HCBS states. The ranking of states in Table 1—from those dedicating the highest percentage of long-term care expenditures to HCBS to those dedicating the lowest percentage—is similar to previously published rankings based on CMS Form 64 data (Kassner et al. 2008; Burwell et al. 2006).[9]

FACTORS ASSOCIATED WITH DIFFERENCES IN RELATIVE HCBS SPENDING

Many factors are likely to explain why some states allocate more of their long-term care expenditures to HCBS than other states. Among others, these factors include (1) the intensity and breadth of HCBS provided, (2) the populations served, and (3) the ease of entering the Medicaid-financed long-term care system through HCBS rather than through institutional care.

Intensity of HCBS Programs and Breadth of Use

We measured service intensity as HCBS spending per HCBS recipient. The breadth of service provision was measured in two ways: (1) the percentage of long-term care users accessing HCBS and (2) the percentage of HCBS users obtaining state plan HCBS relative to services offered through 1915(c) waiver programs.

Higher intensity of service and greater breadth of service provision are both potential indicators of more generous HCBS programs. We measured these components of HCBS spending separately to distinguish states that focus their HCBS expenditures on a smaller group of HCBS users (resulting in higher per user expenditures) from those that spread HCBS expenditures over a larger group (and have lower per user expenditures).

HCBS expenditures per recipient. On average, grantees spent about $16,000 annually per HCBS recipient, with high and low HCBS states spending similar amounts.

- High HCBS states spent about $16,200 per HCBS recipient, while low HCBS states spent only slightly less (about $16,100) (Figure 1).
- At slightly more than $15,700 per user, moderate HCBS states spent less per HCBS recipient than either the high or the low HCBS states.

The similarities in per-user HCBS spending in the high and low HCBS states suggest that differences in HCBS spending intensity did not drive overall differences in the balance of care. Because these numbers do not reflect differences in population health or the cost of living across states, however, further research is needed to determine whether spending intensities are indeed nearly equal across state groups.[10]

Proportion of long-term care recipients using HCBS. High HCBS states provided HCBS to a greater share of long-term care users compared with low HCBS states. The high HCBS states appear to be providing these services to a broader population of people.

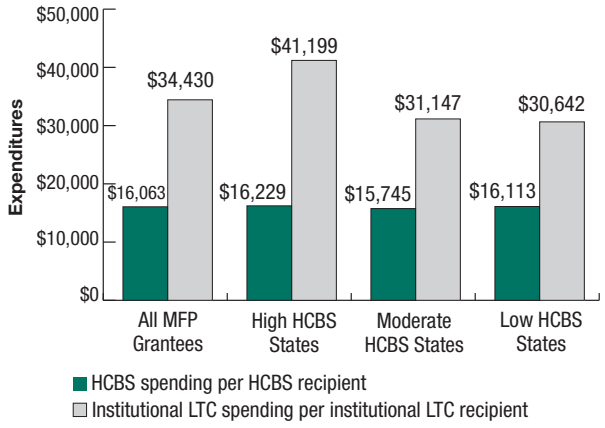
- High HCBS states provided HCBS to 73 percent of their long-term care users, compared with 35 percent in low HCBS states and 53 percent in moderate HCBS states (Figure 2).
- By contrast, high HCBS states provided institutional care to only 32 percent of their long-term care recipients, compared with 69 percent in low HCBS states and 54 percent in moderate HCBS states.

Thus, the balance of long-term care utilization at baseline reflected the balance of spending: in states where the balance of spending favored HCBS, a larger proportion of the Medicaid-financed long-term care population

[9] In particular, the grouping of high, moderate, and low HCBS states would have been essentially the same if the rankings had been based on Form 64 instead of MAX data: six of the seven high HCBS states would have remained in the high HCBS group, and seven of the eight low HCBS states would have remained in the low HCBS group.

[10] Comparing spending intensities across states is also complicated by the difficulty of separating spending on valuable services from inefficiency and waste.

Figure 1. HCBS and Institutional Long-Term Care Expenditures per Recipient



Source: Mathematica analysis of the 2005 Medicaid Analytic Extract files for 28 MFP grantee states.
Note: Includes all grantee states except Michigan and New Hampshire. HCBS users include beneficiaries who were in a 1915(c) waiver program for at least one month during the year or received state plan personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care.
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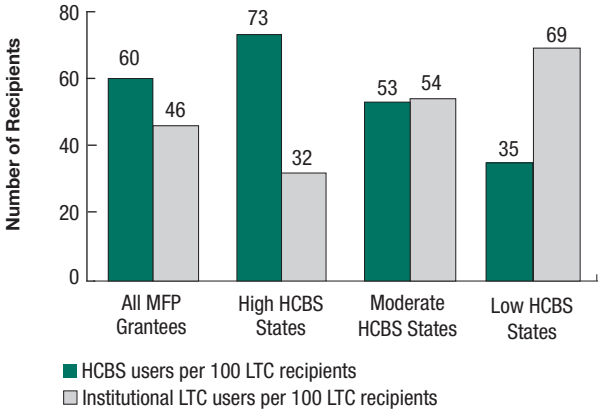
Figure 2. HCBS and Institutional Long-Term Care Utilization per 100 Long-Term Care Users



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used HCBS and a smaller proportion used institutional care.[11] Together with the findings on the intensity of services provided, these results suggest that high HCBS states' programs appear to be broader than those in low HCBS states, in the sense that the former provided HCBS to larger proportions of enrollees using long-term care, but at a comparable cost per recipient.

Use of state plan HCBS. The design of a state's HCBS program may partly explain why high HCBS states provide HCBS to a greater proportion of long-term care users relative to low HCBS states. State plan HCBS are available to anyone in the Medicaid program who may need them, whereas waiver services are restricted to beneficiaries in the waiver programs, who typically must meet institutional care requirements.

High HCBS states were more likely to offer state plan HCBS and the least likely to rely exclusively on waivers to provide services. By contrast, low HCBS states relied heavily on waivers to provide HCBS.

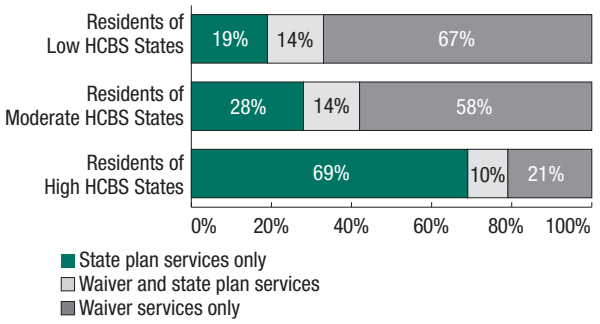
- Over two-thirds (69 percent) of HCBS users in high HCBS states obtained state plan HCBS exclusively; 21 percent accessed services through waiver programs only, and 10 percent received both state plan HCBS and waiver services (Figure 3).
- Only 19 percent of HCBS users in low HCBS states accessed only state plan HCBS; the large majority relied on either waivers only (67 percent) or a combination of waiver and state plan services (14 percent).

The tendency of high HCBS states to offer state plan HCBS is one way they demonstrate their commitment to providing these services to a broader group of beneficiaries rather than to a more limited population, as waivers do.[12] The widespread use of state plan HCBS partly explains why the proportion of long-term care users accessing HCBS was greater in the high HCBS states than in the low HCBS states. However, the data in Figure 3 also reveal the importance of the waiver

[11] Because beneficiaries can use both HCBS and institutional care in a given year, for any state or group of states the sum of the percentage using HCBS and the percentage using institutional care is generally greater than 100 percent.

[12] Some states serve large numbers of Medicaid beneficiaries in 1915(c) waiver programs, which also demonstrates a commitment to providing HCBS to a large group of beneficiaries.

Figure 3. Percentage of HCBS Users Accessing Services Via Waivers Versus State Plans Only



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programs, particularly for beneficiaries living in low HCBS states, many of whom might not have been able to access HCBS at all without them.

Populations Served by HCBS Programs

Differences in populations served might also account for differences in HCBS spending and utilization—as well as differences in the balance of HCBS and institutional care—in high and low HCBS states. For example, because HCBS expenditures for individuals with MR/DD are often greater than for the elderly (as illustrated in Figure 4), states with a relatively large MR/DD population might spend relatively more on HCBS.[13]

HCBS spending and utilization by subgroup. Compared to low HCBS states, HCBS users in high HCBS states were more likely to be elderly or disabled and less likely to have developmental disabilities. Patterns of spending between programs in high and low HCBS states reflected these differences.

- The elderly and disabled together constituted 84 percent of HCBS users in high HCBS states, compared with 14 percent for persons with MR/DD (Figure 4).
- In low HCBS states, the elderly and disabled accounted for only 75 percent of HCBS users; persons with MR/DD constituted 23 percent.
- High HCBS states allocated a lower percentage of all HCBS spending to the population with MR/DD (37 percent) and a higher percentage to the elderly and disabled (62 percent); in contrast, spending was almost evenly split on persons with MR/DD and the elderly and disabled in low HCBS states.

Balance of HCBS and institutional care by subgroup. The balance of spending on HCBS and institutional long-term care—as measured by the percentage of all long-term care spending directed to HCBS—varied widely across populations and between high and low HCBS states. High HCBS states allocated a greater percentage of long-term care spending to HCBS than low HCBS states for each population served.

- For the elderly, HCBS accounted for 36 percent of their long-term care expenditures in high HCBS states, compared with only 10 percent in low HCBS states (Figure 5).
- For the nonelderly disabled, HCBS accounted for 61 percent of long-term care expenditures in high HCBS states, compared with 34 percent in low HCBS states.
- For persons with MR/DD, HCBS accounted for 58 percent of their long-term care expenditures in high HCBS states, compared with 41 percent in low HCBS states.

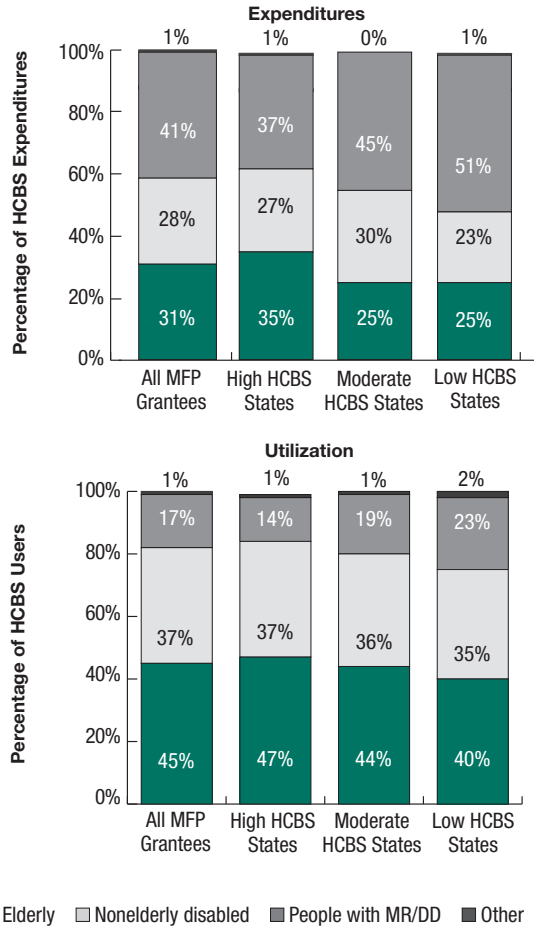
The differences in the balance of care between high and low HCBS states reveal that state differences in spending devoted to HCBS were not simply a reflection of differences in populations, as high HCBS states allocated substantially greater proportions of long-term care dollars to HCBS for all three populations of beneficiaries.

Initial Access to Long-Term Care Through HCBS

Accessibility of HCBS is another hallmark of state long-term care systems and includes indicators of whether people new to long-term services and supports can read-

[13] In this study, the elderly category comprised all eligible individuals ages 65 and older who were not in an intermediate care facility for the mentally retarded (ICF/MR) or in a waiver program for beneficiaries with developmental disabilities. The nonelderly disabled include all those who meet the same criteria as the elderly, except they were younger than 65. Beneficiaries with developmental disabilities either used ICF/MR services or were in a waiver program for beneficiaries with developmental disabilities.

Figure 4. HCBS Expenditures and Utilization by Subgroup



Source: Mathematica analysis of the 2005 Medicaid Analytic Extract files for 28 MFP grantee states.

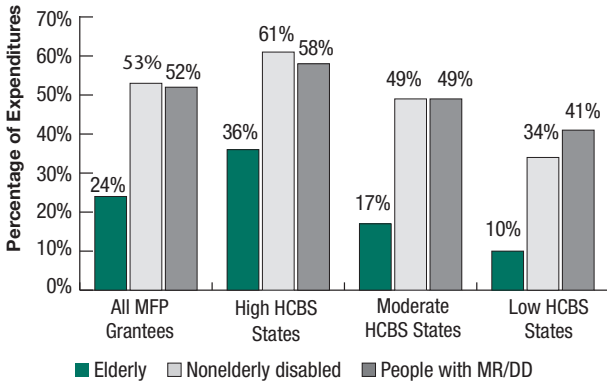
Note: Includes all grantee states except Michigan and New Hampshire. HCBS users include beneficiaries who were in a 1915(c) waiver program for at least one month during the year or received state plan personal care services, home health care, residential care, adult day care, private duty nursing, or hospice care. Beneficiaries who turned 65 during the year are classified as elderly.

HCBS = home and community-based services; MFP = Money Follows the Person; MR/DD = mental retardation or developmental disabilities.

ily access HCBS. To determine whether HCBS served as a point of entry to long-term care in 2005, we compared the experiences of two groups of beneficiaries: new and established users of long-term care. New users were beneficiaries who used Medicaid-financed long-term care services in 2005 (institutional care or HCBS), but not in 2004. Established users included beneficiaries who used these services in both 2004 and 2005.

In general, beneficiaries in high HCBS states were more likely to receive HCBS regardless of whether they were

Figure 5. HCBS Share of Long-Term Care Expenditures by Subgroup



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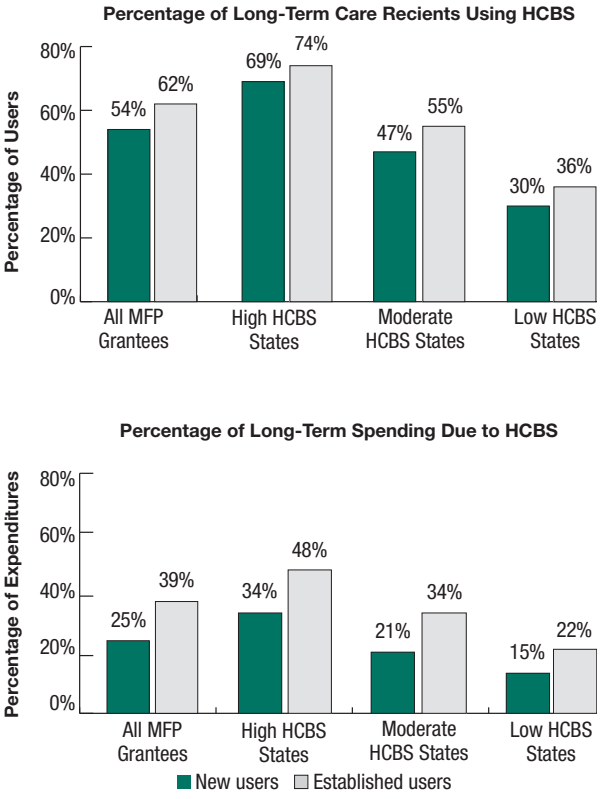
new or established users of long-term care. However, established long-term care users were more likely to use HCBS—and had higher HCBS expenditures as a percentage of all long-term care expenditures for HCBS—than new long-term care users in both high and low HCBS states.

- Among new long-term care beneficiaries, 69 percent in high HCBS states received HCBS, compared with 30 percent in low HCBS states (Figure 6); their HCBS expenditures accounted for 34 percent of their long-term care spending in the high HCBS states and 15 percent in low HCBS states.
- Among established long-term care recipients, nearly three quarters (74 percent) in high HCBS states received HCBS, compared with 36 percent in low HCBS states; their HCBS expenditures accounted for 48 percent of their long-term care spending in high HCBS states but only 22 percent in low HCBS states.

Before MFP, the percentage of established long-term care users receiving HCBS exceeded the percentage of

Figure 6. HCBS Utilization and Expenditures for New and Established Long-Term Care Users



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HCBS = home and community-based services; MFP = Money Follows the Person.

new users receiving HCBS in high, moderate, and low HCBS states. The differences between new and established users might have occurred because beneficiaries new to the long-term care system were not fully aware of their options for community-based care and hence did not seek services until they required institutionalization. Alternatively, long waitlists for enrollment in waiver programs might have compelled beneficiaries who would have preferred receiving HCBS to seek institutional care. A third explanation is that many "new" users had previously purchased institutional care out of pocket and spent down their own assets, becoming eligible for Medicaid while institutionalized.[14]

To the extent that a lack of awareness of long-term care options or inability to access HCBS through restrictive waiver programs explains the lower percentage of HCBS recipients among new long-term care users, focusing attention on increasing the availability and visibility of HCBS for beneficiaries not yet in the long-term care system will help states to strengthen the balance of their long-term care systems while improving beneficiaries' access to the most appropriate forms of care.

POLICY IMPLICATIONS AND CONCLUSIONS

This early assessment of the balance of long-term care systems before the implementation of the MFP demonstration illustrates key differences in the makeup of states' long-term care systems. These state-level differences suggest that the effects of the MFP program on long-term care systems will vary across states, partly because state long-term care systems started at different points. In 2005, HCBS expenditures ranged from 13 to 59 percent of long-term care spending, while the proportion of long-term care users receiving HCBS ranged from 24 to 83 percent.

The comparison between high and low HCBS states revealed important differences in the proportion of long-term care users receiving HCBS, the availability of state plan HCBS, the populations using HCBS, and the receipt of HCBS among new and established users of long-term care. However, HCBS spending on a per-recipient basis appears to be similar in the high and low HCBS states. This descriptive analysis appears to suggest that high HCBS states were serving a broader population of Medicaid beneficiaries.

Although the findings presented here do not necessarily imply that replicating the policies and programs of high HCBS states will lead to comparable outcomes in

[14] Wenzlow et al. (2008) estimated that roughly half of all beneficiaries in nursing facilities were not enrolled in Medicaid when their stays began. Because out-of-pocket expenditures are not observable in the Medicaid Analytic Extract files, the extent to which new long-term care users (as we have defined them) previously purchased services with their own funds could not be determined.

moderate or low HCBS states,[15] they do suggest that the approaches adopted by high HCBS states merit consideration by other states seeking to shift the emphasis of Medicaid long-term care programs from institutional to community-based care. Ideally, HCBS programs support diversions and enable individuals who otherwise would have been institutionalized to remain in the community; at the same time, HCBS programs would also fully support transitions that move beneficiaries from institutional to community-based care and keep them in the community. In addition to helping more beneficiaries with long-term care needs remain in the community, expansions in HCBS might ultimately reduce costs (Kaye et al. 2009).

Our findings have important implications for states seeking to rebalance their long-term care systems. For example, high HCBS states were more likely to serve populations with high rates of complex medical needs—specifically, the elderly and physically disabled—suggesting that low HCBS states might focus more on developing community-based services and supports for these populations. In addition, established users of long-term care were more likely to receive HCBS than new users in both high and low HCBS states. To the extent that beneficiaries not yet in the long-term care system were unaware of the HCBS options available to them or were unable to access these options, states could strengthen the balance of their long-term care systems by expanding access to HCBS while more actively promoting the variety of options available to beneficiaries requiring long-term care.

Although this study sets the stage for a more in-depth evaluation of MFP impacts on long-term care systems in the 30 grantee states, important limitations on the analyses affect our ability to draw definitive conclusions. For example, this study did not control for differences in the level of need for long-term care services and supports across states or between institutional and HCBS users within states. As noted previously, high HCBS states might be providing HCBS to disproportionate numbers of beneficiaries who need only small amounts of HCBS to live in the community successfully. This study also did not control for differences in other long-term care policies and processes, such as universal assessments (such as those used by Washington State) or parallel transition programs (such as those in Texas and other states) that transition beneficiaries not eligible for MFP. Controlling for these other factors will be necessary to understand the differential effects the MFP program has on grantee states. This study also did not consider the use of non-Medicaid-financed long-term services and supports such as those paid by Medicare, out of pocket, or by private long-term care insurance. Recent work by Kaye et al. (2010) indicates that, although Medicaid pays for all or part of the services received by about one-third of people using community-based services, 19 percent pay for most of this care themselves. Medicaid is the primary payer for nursing home care, but consumers pay 20 percent of the cost of nursing home care out of pocket. Thus, changes in Medicare and consumers' willingness or ability to pay for long-term care services will have some influence on states' overall long-term care systems.

This study represents the beginning of Mathematica's assessment of the effects of the MFP demonstration on the balance of long-term care systems in grantee states. By measuring the balance of long-term care prior to the implementation of MFP, this study establishes an initial understanding of the starting point for grantee states. Future studies will address some of the limitations of the current study and examine trends in a range of indicators (such as the measures reported here). These analyses will include comparisons of trends in HCBS as a proportion of overall long-term care spending and use before and after MFP, as well as trends in the characteristics of the populations receiving both institutional care and HCBS.

[15] For example, states placing less emphasis on HCBS might be able to provide institutional care more efficiently (relative to HCBS) than other states. Moreover, to the extent that demographic differences across states suggest that different mixes of institutional care and HCBS are appropriate, it is not clear that rebalancing toward HCBS will ultimately yield cost savings for low and moderate HCBS states. Such results will depend, in part, on woodwork effects (people who enter long-term care because HCBS becomes more readily accessible) and the extent to which HCBS replaces or complements informal care provided by family and friends.

ACKNOWLEDGEMENTS

This research was conducted by Mathematica® under contract with CMS (HHSM-500-2005-00025I). The authors wish to thank Bob Schmitz, Randy Brown, Audra Wenzlow, and Sam Simon for their insightful comments on earlier drafts. Thanks also go to Dean Miller, Jill Gurvey, and Morris Hamilton for programming assistance; John Schurrer and Rosie Malsberger for research assistance; Cindy George, John Kennedy, and Margaret Hallisey, for editorial support; and Deirdre Sheean for graphic design. The authors also gratefully acknowledge CMS and the 30 MFP grantee states for providing the data used in this report.

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DATA, METHODS, AND LIMITATIONS

Data Sources

The statistics presented in this report are based on data from the 2005 Medicaid Analytic Extract (MAX). These data are derived from the Medicaid Statistical Information System (MSIS), a standardized format states must use to report Medicaid eligibility and claims data on a quarterly basis. MAX is an enhanced, research-friendly version of MSIS that CMS produces. In MAX, interim claims are combined into final action events and data have undergone additional quality checks and corrections.

Identification of Long-Term Care Users

Institutional Care. Service dates from Medicaid institutional care claims were used (nursing home, ICF/MR, or psychiatric facility records) to identify Medicaid enrollees in institutional care in 2005.

HCBS. To identify HCBS users, we used monthly enrollment indicators for Section 1915(c) waiver programs and summary information about total expenditures for 10 different waiver services (personal care assistance, home health care, adult day care, hospice care, residential care, private duty nursing, rehabilitation, case management, transportation, and durable medical equipment) and six different state plan services (personal care assistance, home health care, adult day care, hospice care, residential care, and private duty nursing). We include hospice care because states may offer it as an MFP benefit. For beneficiaries who *only* used state plan home health services and no other type of HCBS, we excluded those who used this service for fewer than three consecutive months to minimize the number of beneficiaries in our analyses who received home health care for an acute episode and not on a long-term basis. For beneficiaries who *only* used state plan hospice or private duty nursing, we excluded those who received this care outside the home.

New and Established Long-Term Care Users. For beneficiaries identified as receiving either institutional care or HCBS in 2005, we retrospectively checked the 2004 MAX data to determine whether they received a long-term care service in that calendar year. Beneficiaries identified as receiving a long-term care service in 2004 were designated as established users of long-term care services. All others were considered new to long-term care.

(continued)

DATA, METHODS, AND LIMITATIONS *(continued)*

MFP Target Populations. To classify beneficiaries into the MFP target populations, we used type of facility and age if the beneficiary received institutional care. We used waiver type and age to classify all other beneficiaries.

Expenditures

The Medicaid expenditure data are based on totals for the entire year. Total long-term care expenditures are for fee-for-service institutional care and HCBS only. These totals do not include expenditures for any services billed in bulk to the state. Because we did not use claims records to construct expenditure amounts, we did not identify the months of HCBS receipt.

Comparison to Other Published Statistics

The data presented in this report may differ from other published statistics on utilization and expenditures for long-term care services. Contributing factors to the differences include our use of individual records and our definition of HCBS. State-by-state estimates of long-term care and HCBS produced by researchers such as Burwell et al. (2008) or Ng and Harrington (2009) rely on data abstracted from state aggregate reports such as the CMS Form 372, CMS Form 64, or state-level survey data such as that collected by the Kaiser Commission on Medicaid and the Uninsured. Aggregate state reports may include some beneficiaries and expenditures that are not identified in the MAX data and vice versa. For example, services billed in bulk may be included in state aggregate reports, but MAX does not capture these services because they cannot be linked to particular beneficiaries. Because we have individual-level data, we define HCBS in a slightly different way than other reports. In this report, HCBS includes all 1915(c) waiver services and state plan services for personal care, home health care, residential care, adult day care, private duty nursing, and hospice care. Beneficiaries who only use state home health services must have used these services for at least three months to be included in the analyses. Similarly, beneficiaries who use only state plan private duty nursing or state plan hospice care must have received this care in the home to be included in the study.

Because of the variance across data sources in the reported statistics, we considered excluding states with large discrepancies. We began by comparing our ranking, based on the MAX data, of states by percentage of Medicaid-financed long-term care spending directed to HCBS with the ranking developed by Burwell et al. (2006). Four states—Indiana, Michigan, New Hampshire, and Texas—were ranked significantly differently (more than five places apart) in the two sets of rankings. For each of these four states, we compared total HCBS spending in 2005, as reported in the MAX data and on CMS Form 64. For Michigan, reported spending was 78 percent lower in the MAX data. We also looked at discrepancies in waiver reporting for each of these states and noted that the MAX data reported substantially more waiver participants in New Hampshire (6,563) than the CMS Form 372 data did (4,899). Given the magnitude of these discrepancies, we elected to exclude Michigan and New Hampshire.

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