

Strategies to Support HCBS

States are spending more money on home- and community- based services (HCBS) and are spending a greater proportion of their long-term care (LTC) dollars on these services rather than on institutional care. Some states have been more successful than others in supporting HCBS. This brief reviews strategies states have used to promote HCBS and summarizes existing research on the effectiveness of these strategies in increasing access, expanding revenues, and moderating institutional bed supply. Research shows that increased use of Medicaid waivers and Medicare home health services are important predictors of increased access to HCBS. Using regulation to constrain the number of institutional beds (and redirect resources to HCBS) shows mixed results. Research on the effectiveness of capitating LTC to increase access to HCBS has not been conclusive, though initial findings are promising and appear to be worth pursuing

This brief examines evidence on the effectiveness of state strategies to increase access to home- and community- based services (HCBS) and is based on Miller's (2003) conference paper, "State Strategies to Support Community-Based Long-Term Care." Efforts to expand HCBS have been fueled by several forces. First, state policymakers are aware that most people prefer to receive long-term care (LTC) services at home or in their community instead of in a nursing home or other LTC facility. Second, the 1999 Olmstead decision¹ –in which the Supreme Court ruled that states have an obligation to provide care in the least restrictive setting has also spurred state policymakers to increase HCBS options. Lastly, concerns with the growing and substantial cost of institutional care, as well as the quality of care provided in institutions,

have contributed to state efforts to expand HCBS. The degree to which states have successfully increased access to HCBS has varied (see Figures 1 and 2), in part based on the type of strategies used by the different states. The strategies fall into three main categories:

1. Increasing HCBS capacity by expanding the supply of, public and private funding for, and eligibility for HCBS
2. Constraining institutional growth in order to increase the LTC dollars available for HCBS
3. Implementing managed LTC, which aims to increase the dollars available for HCBS and use them more efficiently by giving a single entity control over the LTC dollars allocated to an individual

¹*Olmstead vs. L.C.* 98-536, 9 (1999).

Strategies that aim to increase HCBS capacity by expanding the supply of, public and private funding for, and eligibility for HCBS have been successful.

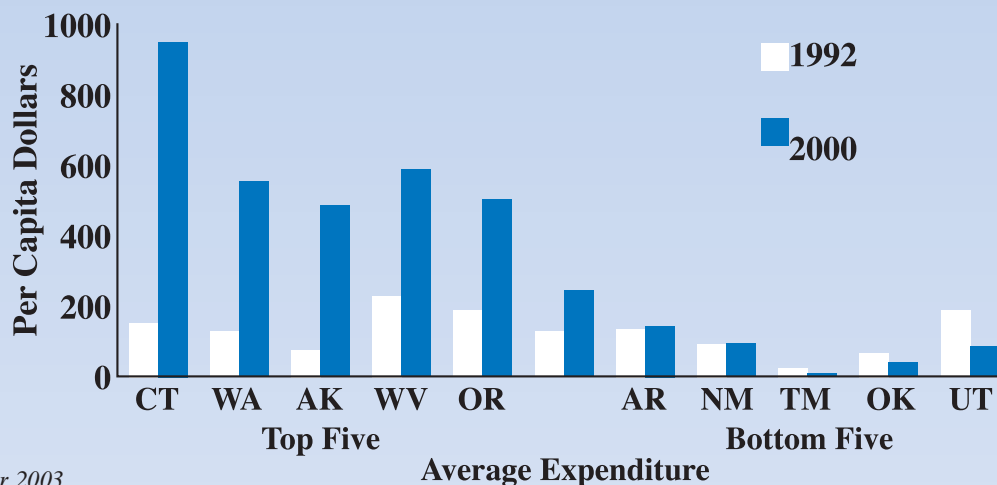
States have a variety of tools to influence the availability of HCBS. Examples of strategies states have employed to increase capacity include:

- Expanding public and private funding sources and revenues: States have used

Medicaid waivers and state-only programs to direct more funding to HCBS, encouraged the use of Medicare home health services, and developed policies that increase the availability of private LTC insurance.

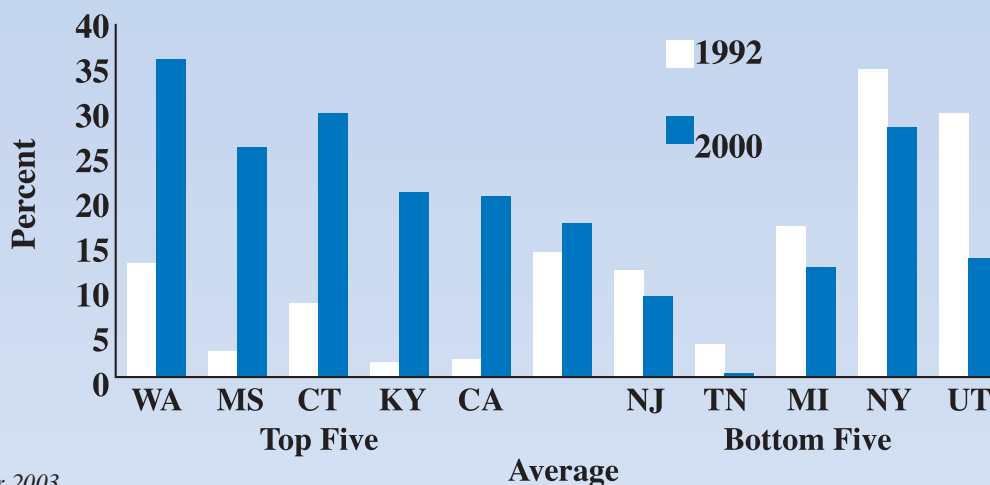
- Implementing payment and regulatory policies that foster expansion of HCBS: Limited regulation of HCBS is associated with increased HCBS capacity.
- Providing coverage for services in alternative residential facilities: States have expanded Medicaid coverage to include payment for services provided in alternative res-

Figure 1. States with the Greatest Increases and Decreases in Per Capita HCBS Expenditures, 1992 - 2000



Source: Miller, 2003.

Figure 2. States with the Greatest Increases and Decreases in Percentage Share of LTC Dollars for HCBS, 1992 - 2000



Source: Miller, 2003.

idential care facilities (e.g., assisted living facilities and board and care facilities).

- **Expanding functional and financial eligibility for HCBS:** States have expanded access to HCBS by revising their financial eligibility criteria for HCBS to include individuals with higher incomes.

Medicaid waivers have been a popular and successful strategy for increasing access to HCBS. These programs typically embody several strategies by expanding funding and/or eligibility and by covering different types of services.

The Use of Medicaid Waivers for HCBS Is Increasing

Between 1992 and 2000:

- The number of participants in Medicaid 1915c waivers serving both older adults and working age adults with disabilities increased from 152,839 to 407,219.
- Waiver expenditures grew from \$0.6 billion to \$2.8 billion.
- The number of states offering waiver programs increased from 40 to 49; the District of Columbia also implemented a waiver program during this period.

Promoting LTC Insurance as a Way to Fund HCBS

In 2000:

- 21 states offered private LTC insurance to state employees at an employer sponsored group rate.
- Four states continued participation in the Partnership program, which encourages potential users of the Medicaid nursing home benefit to purchase private LTC insurance.

States have also aimed to expand the resources available to fund HCBS by encouraging the purchase of private LTC insurance. Few studies have

explored the link between such efforts and access to HCBS, although preliminary work indicates that individuals are more likely to purchase LTC insurance if their employers offer it as a benefit.

Traditionally Medicaid only covered LTC services provided in licensed nursing facilities, but states have recently made efforts to allow Medicaid to pay for services provided in alternative LTC residential settings (both assisted living and board and care) and by using waiver programs, state plan services, and other approaches. By addressing institutional bias of Medicaid regulations, these states have increased the options available to Medicaid participants.

Expanding Medicaid Coverage to More Residential Settings

In 2002:

- 41 states had approval to provide Medicaid services in assisted living and board and care facilities.
- Medicaid covered the services provided to approximately 102,000 individuals in alternative residential settings.

States can use a variety of funding sources other than Medicaid to support HCBS; in some cases, these sources contribute to a significant portion of HCBS funding. Although these additional funding sources expand the revenues available to states, they do not appear to eliminate relative differences among states in residents' ability to access HCBS.

It is important to note that states that use the Medicare program to support HCBS do well on a variety of measures of HCBS access. Increased use of Medicare funding is related to greater *per capita* waiver participation, waiver expenditures, and HCBS expenditures. In addition, increased Medicare funding is associated with larger shares of *total* LTC dollars supporting Medicaid waiver expenditures and HCBS expenditures.

For Some States, Alternative Funding Sources for HCBS Are Significant

- **Medicaid** represented more than 50 percent of HCBS funding in 38 states and the District of Columbia and more than 75 percent in 13 of those states.
- **State funded programs** represent a significant share of HCBS funding in one state (Illinois, at 52.8 percent) and between 25 and 49 percent of funding in an additional six states:
 - California
 - Hawaii
 - Massachusetts
 - New Mexico
 - North Dakota
 - Pennsylvania
- **Medicare** represented more than 50 percent of HCBS funding in three states – Louisiana, Mississippi, and Tennessee—and between 25 and 49 percent in four additional states.
- Funding through the **Older American Act** provided limited resources in all states, exceeding 10 percent of public HCBS funding only in South Dakota (10.5 percent).

States have attempted to constrain institutional growth in order to increase the dollars available for HCBS with some success.

States have widely adopted regulatory approaches that aim to contain the growth of institutional care. These include:

- Requiring institutions to fulfill certificate of need (CON) requirements
- Instituting moratoria on the construction of new institutional beds
- Developing payment policies that constrain spending on institutional care

States' use of CON and/or moratoria appears to reduce the supply of beds, while use of prospective payment has been associated with lower per diem rates as well as a reduction in nursing home expenditures. Additional strategies, such as bed buyouts or conversions, may also be effective, but there is little research on these efforts.

Constraining Institutional Growth From 1990-2000:

- The use of nursing home bed moratoria grew.
- States substantially increased their use of prospective payment for nursing facility care.
 - In 1990, 17 states and the District of Columbia used this payment mechanism, whereas in 2000, all states but three used prospective payment.
- While 31 states reduced bed supply, 18 states and the District of Columbia had an increased supply, and one state maintained a stable bed supply.

The success of managed LTC has not been established.

Managed LTC involves providing managed care organizations with a fixed dollar amount (the capitation payment) for the care of nursing home eligible individuals. When the managed care organization provides care for these individuals in the community, the theoretical benefits include:

1. Saving the managed care organization money (thus creating an incentive for community-based care)
2. Strengthening the HCBS infrastructure through increased investments
3. Limiting the growth of institutional care
4. Increasing individuals' satisfaction with LTC

Existing research on managed LTC systems suggests, but does not conclusively establish, the ability of these systems to increase the availability of HCBS.²

Growth of Managed LTC

- **Approximately 230,000 older individuals are enrolled in managed LTC, with the Arizona Long Term Care System, Social HMOs in California and Nevada, and Texas Star+Plan accounting for the majority of enrollees.**
- **In 1992 eight states had operational PACE sites under the PACE demonstration. By 2000, 21 states had operational and/or Pre-PACE sites.**
- **Four Social HMO sites are operational.**
- **Arizona implemented a statewide waiver that included integrated care for the dually eligible.³**
- **Four states implemented new programs for the dually eligible:³ Minnesota, New York, Texas, and Wisconsin.**

Empirical studies do not single out a specific strategy as the most effective way to increase access to HCBS for older, disabled adults.

The most robust finding across studies is the positive association between state per capita income—a characteristic that LTC policymakers have little impact on—and access to HCBS. In addition, as stated above, research also finds that the use of Medicaid waivers results in the creation of new HCBS, more funding for services in residential settings, and expanded eligibility for HCBS. Regulatory approaches appear to be effective in constraining institutional growth. The impact of other strategies to expand access

to HCBS remains unclear and points to the need for further research in this area. Important research topics that need to be investigated include:

- The impact of single point of entry systems on access to HCBS.
- Whether lessons from states' efforts in transforming their LTC systems for individuals with developmental disabilities can be applied to older, disabled adults.
- The effectiveness of managed LTC in enhancing access to HCBS.
- Whether state efforts to increase purchase of private LTC insurance are effective in increasing access to HCBS.

Recent evidence on additional programs, such as Cash and Counseling, will add states in their efforts to increase access.

Looking to the Developmentally Disabled Community for Solutions to Expand HCBS.

The developmentally disabled community has successfully moderated institutional bed growth and has invested a substantially greater share of LTC dollars into waivers that support HCBS. What lessons can be learned from them?

New funding mechanisms, as well as sources of funding, will be needed to expand access to HCBS.

The research reported on in this brief was conducted during the 1990 to 2000 economic boom. More recently, states are less able to support HCBS expansions due to budget crises. In fact, LTC expenditure growth has significantly contributed to the budget crisis in many states.

In tight budget times states may need to look to other sources and mechanisms to maintain the support of their HCBS programs, including:

- The Centers for Medicare & Medicaid Services (CMS) Systems Change Grants for Community Living, which provide federal sup-

²The effectiveness of these systems of care is more extensively reviewed by Grabowski (2003).

³People who are eligible for both Medicare and Medicaid.

port to states in their efforts to implement the requirements of the Olmstead decision.

- Lobbying for a change in the Federal Matching Assistance Percentage (FMAP) formula to support expansion. States that have higher proportions of older adults and minorities also tend to have higher rates of disability, along with a greater need for LTC. A change in the FMAP formula that provides more support to states with greater demand for LTC could help these states to support HCBS.

In addition to these potential solutions, more comprehensive solutions for ensuring access to HCBS are needed.

Policy Implications: States should continue to experiment with ways to increase access to HCBS.

States can promote access to HCBS by:

- Continuing to use waivers as an important mechanism for expanded access
- Pursuing Systems Change grants from the federal government
- Promoting private LTC insurance, through educational campaigns and/or encouragement for employers who offer it
- Increasing their efforts to moderate institutional growth

- Continuing to experiment with a variety of managed LTC options

It is difficult for states to address some of the key issues around access to HCBS. The current funding base for HCBS, for example, is unstable due to state budget shortfalls and the inability of states to run deficits. In addition, infrastructure development is difficult where year-to-year planning is difficult. Finally a state's fiscal resources are the stronger predictors of access to HCBS, and, thus, there is extreme variation among states in residents' access to HCBS. These examples suggest that some federal government involvement may be necessary in order to ensure adequate HCBS access for older adults in all states.

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