The Value of Rebalancing Long-Term Services and Supports

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ADVANCING STATES
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Executive summary

Rebalancing long-term services and supports (LTSS) aims to achieve more equity and balance between the share of spending on LTSS delivered in home and community-based settings (HCBS) relative to institutional care. Because there is an institutional bias in Medicaid LTSS coverage – institutional care is a mandatory benefit while HCBS is an optional benefit – states have historically spent more on institutional care than HCBS. Rebalancing shifts LTSS away from institutional settings and toward community care, which reflects many older adults' desire to live in their home and community. Given the growing population of older adults, it is more important than ever to mitigate growing LTSS costs to support future system needs. Analysis of states' HCBS systems have repeatedly demonstrated the cost effectiveness of HCBS compared to institutional care.

Medicaid pays for the majority of LTSS in the country and has seen significant growth in both the number of individuals served in HCBS settings as well as increased spending on these services. The Centers for Medicare & Medicaid Services (CMS) provides support to states' rebalancing efforts a few ways, one of which is the LTSS Rebalancing Toolkit, which contains key background information, rebalancing strategies, and other helpful resources for states to use. CMS also provides support through the Money Follows the Person demonstration, which provides Federal funds to states for their rebalancing efforts. Additionally, the Section 504 notice of proposed rulemaking (NPRM) reinforces federal support for and protection of individuals with disabilities.

Several state case studies showcase successful rebalancing strategies, which can be separated into two categories: strategies that precede Medicaid eligibility, and strategies that support Medicaid-eligible individuals. In this brief, we look at rebalancing strategies in four states: Washington, Connecticut, Minnesota, and Tennessee. Each of these states provides a majority of their LTSS in home and community-based settings, which they achieved through implementing successful rebalancing strategies.

Moreover, the American Rescue Plan Act (ARPA) and its provision of additional Federal funds for HCBS has spurred additional rebalancing efforts. In this brief, we take a look at ARPA HCBS initiatives in Oklahoma, the District of Columbia, Maine, Alabama, and New Mexico. These initiatives include streamlining communications within healthcare systems, coordinating transitions from institutional to HCBS care, and enhancing care coordination.

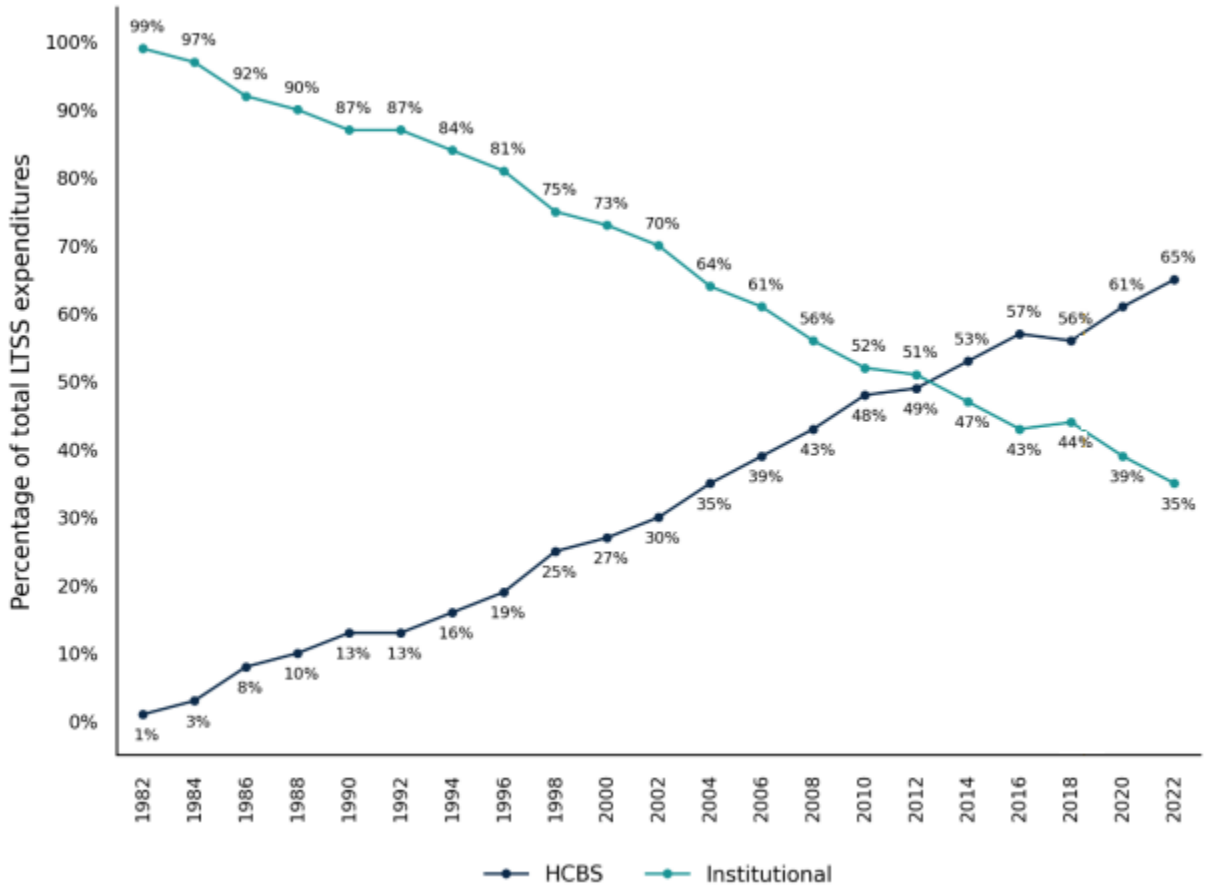
Introduction

Rebalancing LTSS aims to shift more spending for LTSS towards HCBS relative to institutional care to align with people's preferences as well as in recognition of the lower costs of these services.[1] Service delivery of HCBS varies widely across states. States have undergone significant efforts in the last two decades to create and implement LTSS policies regarding service delivery, departing from an institutional focus to providing services in the community – often in the home where the person lives. An institution may include places such as skilled nursing facilities, hospitals or psychiatric or behavioral health centers.

Background

Medicaid is the primary payer in the United States for LTSS, accounting for approximately 54% of Medicaid spending in 2020.[2] Because there is an institutional bias in Medicaid LTSS coverage – institutional care is a mandatory benefit while HCBS is an optional benefit – states have historically spent more on institutional care than HCBS. Rebalancing shifts LTSS away from institutional settings and toward community care, which reflects many older adults' desire to live in their home and community. Not only does HCBS honor people's preferences, but it is also a more cost-effective way of addressing individuals' functional needs.

As noted in the figure below, states have made slow but steady progress in 'moving the needle' toward HCBS.



In 2020, 1.4 million Medicaid beneficiaries received institutional LTSS across 50 states and Washington, D.C. Of the total institutional service users in 2019, 1,052,707 beneficiaries (62.7%) received services through the traditional fee-for-services delivery system, while 748,521 beneficiaries (44.6%) received services through a managed care (MC) delivery system.[3] As noted, the fee-for-services and managed care percentages do not equal 100% because some beneficiaries had claims from both FFS and MC.

Most individuals who need LTSS are dually eligible for both Medicaid *and* Medicare; these individuals are colloquially known as 'dual eligibles." In 2020, there were 12.2 million dual eligibles in the U.S., accounting for 14% of the Medicaid population and 30% of Medicaid spend. While dual eligibles are most likely to be impacted by rebalancing, more dually eligible individuals receive HCBS compared to institutional LTSS (27% vs. 17%), and HCBS accounted for a larger share of Medicaid spending as compared to institutional LTSS (44% vs. 39%).

CMS released an LTSS Rebalancing Toolkit to guide states in their rebalancing efforts. The toolkit includes four sections. The first provides background, explaining the fundamentals and terminology for LTSS/HCBS and rebalancing, and a timeline of key events such as the ADA, the Settings Rule, and Olmstead decisions. The second section focuses on advancing state rebalancing strategies and outlines key elements for creating a solid HCBS program, such as person-centered planning and No Wrong Door systems which ensure individuals can access the help they need regardless of where they enter the system. The third section focuses on the current flexibility under Medicaid services to support state rebalancing strategies, outlining waiver and authority options. Finally, the fourth section includes case studies of state rebalancing strategies.

CMS also supports state rebalancing efforts through initiatives such as Money Follows the Person. This demonstration supports state efforts for rebalancing their LTSS so that individuals have a choice of where they live and receive services. From the start of the program in 2008 through the end of 2020, states have transitioned over 107,000 people to community living under Money Follows the Person program.[4] As of April 2023, 40 states and territories have taken advantage of the Money Follows the Person program.[5]

Courts have also supported rebalancing through requirements for community-based service delivery. Courts held in Olmstead v. United States, 277 U.S. 438 (1928) that public entities must provide community-based services to persons with disabilities when (1)

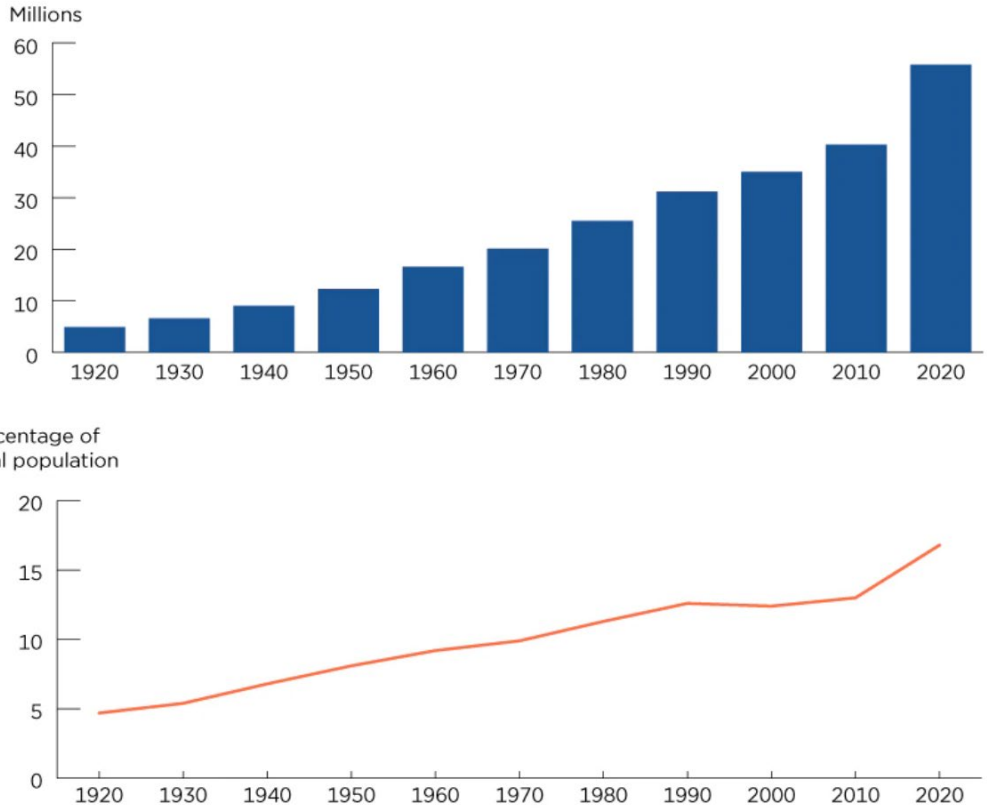
such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.[6]

The Department of Health and Human Services (HHS) Office of Civil Rights (OCR) issued a notice of proposed rulemaking (NPRM) on September 14, 2023. As the first substantive update to Section 504 of the Rehabilitation Act, the NPRM strengthens the law with necessary updates and underscores the critical importance of non-discrimination in the administration of the many programs and activities within the purview of HHS – including state and territory Medicaid, Disability, and Aging programs that receive federal funding through the Administration for Community Living (ACL) and CMS. This NPRM reinforces the federal government's commitment to Olmstead.

Rebalancing – A Longitudinal View

The 2020 U.S. Census found that the population over 65 is continues to grow at an increasing rate.[7] The figure below illustrates these trends.

Population 65 Years and Over by Size and Percentage of Total Population: 1920 to 2020



Note: For information on data collection, confidentiality protection, nonsampling error, and definitions, refer to <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.pdf>.

Source: U.S. Census Bureau, Decennial Census of Population, 1900 to 2000; 2010 Census Summary File 1, and 2020 Census Demographic and Housing Characteristics File (DHC).

The growing population of older adults has led to an increased need for LTSS. While rebalancing efforts have led to LTSS expenditures decreasing as a proportion of state Medicaid expenditures, spending on LTSS programs has increased in recent years.[8] Mitigating the

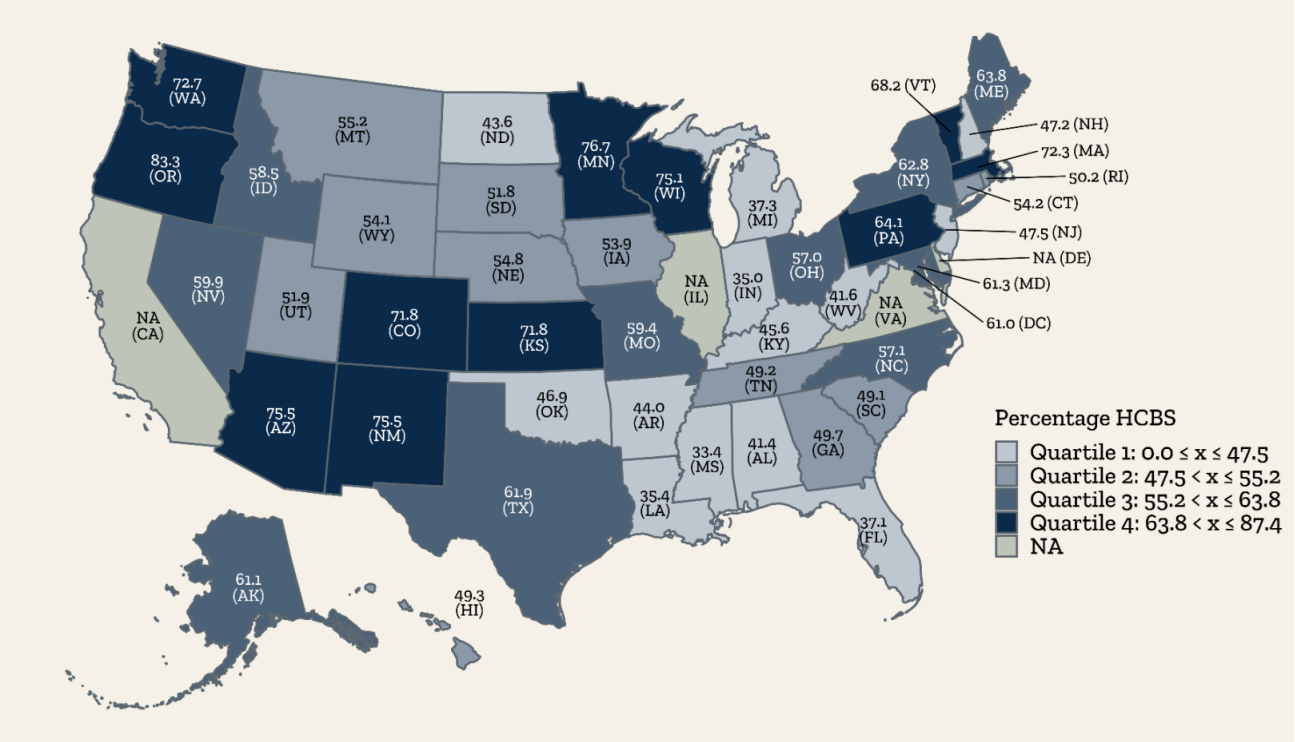
continued increase of LTSS expenditures through rebalancing is increasingly pertinent as the U.S. aging population and their LTSS utilization grows.[9]

Cost Effectiveness

States have produced studies that demonstrate the cost savings of delivering service in the community compared to in institutions.[10] Medicaid LTSS costs continue to increase year after year; however, that cost trend is dampened by the increasing reliance on HCBS.[11] CMS reports that HCBS costs less than half as much as institutional long-term care.[12] Prioritizing HCBS over institutional care will lead to significant savings for states, individuals, and families.

In FY 2019, HCBS expenditures were 58.6% of total Medicaid LTSS expenditures. The proportion consistently increases year over year nationally but varies significantly by state. Five states—Oregon, Minnesota, New Mexico, Arizona, and Wisconsin—spent more than 75 percent of their Medicaid LTSS dollars on HCBS. The five states with the lowest share of spending on HCBS in FY 2019 included Mississippi, Indiana, Louisiana, Florida, and Michigan.[13]

The figure below reflects the percentage of LTSS dollars spent on HCBS by state.



Sources: Mathematica's analysis of FY 2019 CMS-64 data, state-submitted MLTSS data, and MFP worksheets for proposed budget.

Notes: The state percentages are rounded to one decimal place in the figure, but states were grouped into quartiles based on the unrounded values. We excluded California, Delaware, Illinois, and Virginia because of missing data. Further details about the data sources, methods, and data limitations are available in Appendices A and B.

CMS = Centers for Medicare & Medicaid Services; FY = fiscal year; HCBS = home and community-based services; LTSS = long-term services and supports; MFP= Money Follows the Person; MLTSS = managed long-term services and supports; NA = not available.

Most People Want to Age at Home

Most individuals want to live in their own homes for as long as possible. According to a 2018 survey by AARP, 76% of people 50 and older want to age at home.[14] More than 90% of those 65 and older are living at home.[15]

For those who do not wish to live in an institutional setting, community integration is vital. Community integration allows people to have access to a range of services and supports, such as safe and affordable housing and transportation that facilitate LTSS in the setting of their choosing, thereby increasing consumer choice and strengthening HCBS.[16]

Data Outcomes Comparing Institutions to HCBS

The National Core Indicators – Aging and Disabilities (NCI-AD) is based on the responses of 13,633 respondents in 15 states to the 2021-22 NCI-AD Adult Consumer Survey. The results indicated differences among people living in the community and institutional settings. While the analysis does not account for state-level variance, outcomes in domains such as Community Participation, Access to the Community, Relationships and Choice and Control, often appear more favorable for individuals who live in community settings, as compared to institutional settings:[17]

Indicator	HCBS	Nursing Facility
Gets to do things outside of their home as much as they want	62%	42%
Takes part in activities with others as much as they want to (in-person or virtually)	58%	53%
Has transportation to do the things they want outside of home	74%	53%
Able to see or talk to their friends and family when they want (if there are friends or family they do not live with who are a part of their life)	85%	69%
Feels in control of their life	73%	38%

Lessons Learned

Based on literature review, state surveys and state interviews, several states achieved success in their rebalancing efforts. These states typically took one of two approaches: strategies that precede Medicaid eligibility and strategies that support Medicaid-eligible individuals.

State rebalancing strategies that could precede Medicaid eligibility:

- Investing in consumer education and "No Wrong Door" infrastructure to promote awareness of HCBS options
- Developing pre-Medicaid/pre-LTSS supports to delay the need for LTSS
- Improving the HCBS eligibility process so that HCBS is a more viable option

State rebalancing strategies that often support Medicaid-eligible individuals:

- Creating housing options for people to transition to, or remain in, affordable, accessible settings
- Using data to find people during transitions in care so they can be diverted from LTSS
- Providing incentives for plans and providers to maximize HCBS access

State Case Studies

Washington provides an extensive array of HCBS under multiple authorities, using a fee-for-service delivery model. The state has been long-heralded as a leader in delivering HCBS, as 73% of all LTSS in the state are HCBS. The state implemented successful consumer education and No Wrong Door infrastructure to support rebalancing efforts, as well as supporting pre-Medicaid individuals. Washington's Medicaid transformation project section 1115(a) demonstration is testing two new programs that delay or divert the need for Medicaid LTSS services:

- *Medicaid Alternative Care (MAC):* This benefit package allows individuals who are eligible for Medicaid LTSS to wrap services (defined during the person-centered planning process) around to their unpaid family caregiver rather than receiving services through traditional personal care services. The MAC benefit package provides an alternate community option, provides support to unpaid caregivers, and avoids or delays the need for more intensive Medicaid-funded services.
- *Tailored Supports for Older Adults (TSOA):* Eligible individuals are "at risk" of future Medicaid LTSS, but do not currently meet Medicaid financial eligibility requirements. TSOA benefits are nearly identical to the MAC benefits.

In 2014, Connecticut set a goal of providing 75% of LTSS in the community by 2025. As of March 2023, the state is providing 54% of its LTSS in the community. The state used county demographic data to project "supply and demand" needs for long-term care in the state. Connecticut then created a rebalancing plan that includes the following strategies:

- *Grants to nursing facilities*: This strategy incentivizes repurposing space and implementing new business models in nursing facilities. Funds could be used to obtain architectural and site development plans, with funding for construction awarded in future rounds.
- *Self-directed service budget model:* This strategy uses the Community First Choice section 1915(k) state plan. The budget covers 1) transition costs of establishing a community residence for an individual moving into the community from an institution and 2) expenditures for services substituting for human assistance (e.g., home delivered meals, environmental assessments, and assistive technology).
- *Implement workforce incentives:* This strategy helps nursing facilities staff transition to work in HCBS and increases the availability of caregivers to serve people living in those settings, including:
    a) Re-training nursing aides to provide services in the community.
    b) Providing workforce training that addresses physical and mental health needs across the lifespan, with a focus on informed choice, least restrictive and most enhancing setting, and community inclusion; and
    c) Developing and maintaining a well-trained and equitably reimbursed agency-based HCBS workforce.

Minnesota provides 73% of its LTSS in the community. To achieve this high proportion of HCBS provision, the state implemented four primary rebalancing strategies.

- *Return to Community Initiative*: This statewide program assists non-Medicaid individuals who are at risk of becoming long-stay nursing home residents with returning to the community. Return to Community Initiative identifies individuals who are not Medicaid eligible at nursing facility admission, have resided in a nursing facility for at least 45 days, indicated a desire to return to the community, and have met certain health and functional criteria. The state aims to achieve cost savings by delaying or avoiding consumer spend down to Medicaid. Of note, while this effort is similar in design and approach to the national Money Follows the Person initiative, this program provides earlier intervention for individuals who have not converted to Medicaid coverage.
- *NF Planned Closure Rate Adjustment Program:* The state legislature passed legislation in 2000 that allowed NFs to lay-away up to 50 percent of their licensed and certified beds for up to five years. Such beds had the same status as voluntarily delicensed beds and were not subject to license fees but could be put back into service at any time after at least one year of lay-away status. This was followed in 2001 by a Voluntary Planned Closure Program, which granted a rate increase to nursing facilities that voluntarily closed beds on a permanent basis, at a rate of $2,080 per bed. As of January 2005, 4,900 bed closure applications had been approved, and 3,300 had closed. The program remains in effect.
- *Housing stabilization services program*: Managed long-term services and supports plans pay for a variety of tenant services for older adults and people with disabilities.

Tennessee uses a managed care delivery system and currently delivers 49% of its LTSS in the community. When its Managed long-term services and supports program, CHOICES, started in 2010, the state delivered only 17% of its LTSS in the community.[18] The state has focused its rebalancing efforts on the CHOICES Program, which aims to decrease fragmentation and improve coordination of care, increase options for individuals who need LTSS and increase access to HCBS, and serve more people using LTSS funds. The program implements the following strategies:

- Integrated TennCare (Medicaid) Nursing facilities services and HCBS into the existing managed care delivery system
- MCOs are at full risk for all services, including nursing facilities, and gives them payment for all services, adjusted to take into account both the clinical and functional needs of each participant
- Implements nursing facility diversion and transition programs, including Money Follows the Person; and Tennessee also encourages consumer direction using an employer authority model to allow individuals to hire family and friends to provide HCBS

ARPA Initiatives

The American Rescue Plan Act (ARPA) provided financial relief to states in the wake of the COVID-19 pandemic. In particular, section 9817 provided additional Federal funds to states to expand, strengthen or enhance HCBS. Several states chose to use their ARPA funds to implement HCBS system changes which could improve rebalancing, including Oklahoma, the District of Columbia, Maine, Alabama, and New Mexico.

Oklahoma is developing a digital communication network between the ADvantage Waiver and the Oklahoma Hospital System. This network will communicate referrals for waiver services, care coordination, and submission of questions or requests for guidance of specific member situations. This network could help decrease the number of participants entering a nursing home for services instead of returning home.

The District of Columbia is implementing a system to streamline and enable better management of HCBS individuals transitioning to and from institutional settings.

Maine developed an innovation program with approximately $17 million in funding to pilot programs. These programs will address 1) expanding access to independence-enhancing technologies such as remote monitoring and medication management; 2) innovative living arrangements that reduce required on-site staffing; 3) peer support models; 4) improved transitions across the lifespan; 5) service models enabling individuals in out-of-state placements to return to Maine; and 6) services that better integrate people into their communities.

Alabama is enhancing its Hospital to Home program. This program allows individuals to return to the community with in-home supports rather than transferring to an institutional setting after their hospital stay. It also facilitates successful community transitions and may decrease long-term institutional placements, which strengthens HCBS. The funding supports “dedicated individuals for outreach to hospitals in each Area Agency on Aging service region and be the coordinator for the transition process for Hospital to Home transitions [and] an additional nurse for Level of Care decisions for waiver approval.”

New Mexico is using funds to “increase the number of available Supportive Housing Units with sliding scale rent requirements and associated provider resources that are convenient and easily accessible.” Because lack of accessible, affordable housing is a significant barrier to community living, this initiative could make receipt of HCBS a reality for more individuals.

Conclusion

Shifting LTSS provision away from institutional care toward HCBS allows older adults to age with dignity in their homes and communities. Rebalancing also significantly lowers LTSS costs for the federal government, states, and individuals. States have deployed a number of strategies to rebalance their LTSS systems, including bolstering No Wrong Door programs, implementing workforce incentives, and investing in care integration programs. States invest their own funds as well as ARPA matching funds to make these changes. Individual preferences and state initiatives demonstrate the importance of HCBS and rebalancing LTSS systems.

[1] Source: MACPAC, Examining the Potential for Additional Rebalancing of Long-Term Service sand Supports *https://www.macpac.gov/wp-content/uploads/2021/05/Examining-the-Potential-for-Additional-Rebalancing-of-Long-Term-Services-and-Supports.pdf*

[2] *https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/*

[3] *https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-brief-2019.pdf*

[4] *https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html*

[5] *https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/list-of-money-follows-person-grantees/index.html*

[6] Olmstead v. L. C., 527 U.S. 581 (1999)

[7] *https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html*

[8] *https://www.mathematica.org/news/new-report-states-made-progress-rebalancing-medicaid-long-term-services-and-supports-but-major#:~:text=National%20Medicaid%20LTSS%20expenditures%20totaled,34%20percent%20in%20FY%202019*.

[9] *https://aspe.hhs.gov/reports/most-older-adults-are-likely-need-use-long-term-services-supports-issue-brief-0#:~:text=Older%20adults'%20growing%20use%20of,(Thach%20and%20Wiener%202018*)

[10] Shapiro, A., Loh, C.-P., & Mitchell, G. (2011). Medicaid Cost-Savings of Home- and Community-Based Service Programs for Older Persons in Florida. Journal of Applied Gerontology, 30(1), 3–21. *https://doi.org/10.1177/0733464809348499*

[11] *https://ltsschoices.aarp.org/sites/default/files/documents/2023-09/ltss-scorecard-2023-innovation-and-opportunity.doi_.10.26419-2Fppi.00203.001.pdf*

[12] *https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services*

[13] Source: Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019." Chicago, IL: Mathematica, December 9, 2021. Accessed at *https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html*

[14] *https://www.aarp.org/pri/topics/livable-communities/2018-home-community-preference/#:~:text=While%2076%25%20of%20Americans%20age,within%20their%20community%20(13%25)*.

[15] *https://www.ncbi.nlm.nih.gov/books/NBK51841/*

[16] *https://ltsschoices.aarp.org/sites/default/files/documents/2023-09/ltss-scorecard-2023-innovation-and-opportunity.doi_.10.26419-2Fppi.00203.001.pdf*

[17] *https://nci-ad.org/upload/reports/2021-22_NCI-AD_Adult_Consumer_Survey_Part_1.pdf*

[18] *https://www.governing.com/archive/gov-stay-at-home-mom.html*