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Center for Studying Disability Policy

Serving Medicaid Beneficiaries Who Need Long-term Services and Supports: Better Outcomes at Lower Costs

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June 5, 2019

Welcome

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Understanding High-Cost Home and Community-Based Service Users

An analysis using Medicaid claims data

Victoria Peebles

June 5, 2019

Overview

- **Background**
- **Purpose**
- **Data & methods**
- **Key findings, by research question**
- **Conclusions and implications**

Background

- **Home- and community-based services (HCBS) allow individuals to live in their home or a community-based residence by providing them with a diverse set of services and supports.**
- **State Medicaid programs cover HCBS through a variety of programs, including state plan services and waiver authorities.**
  - HCBS include many different services such as personal care, day habilitation, and respite care
  - HCBS are provided to individuals of all ages and include persons with a wide range of physical and intellectual or developmental disabilities
- **Over the past 20 years, states have sought to increase access to HCBS.**
  - In 2015, more than half of Medicaid spending for LTSS was for HCBS (Eiken et al. 2017)

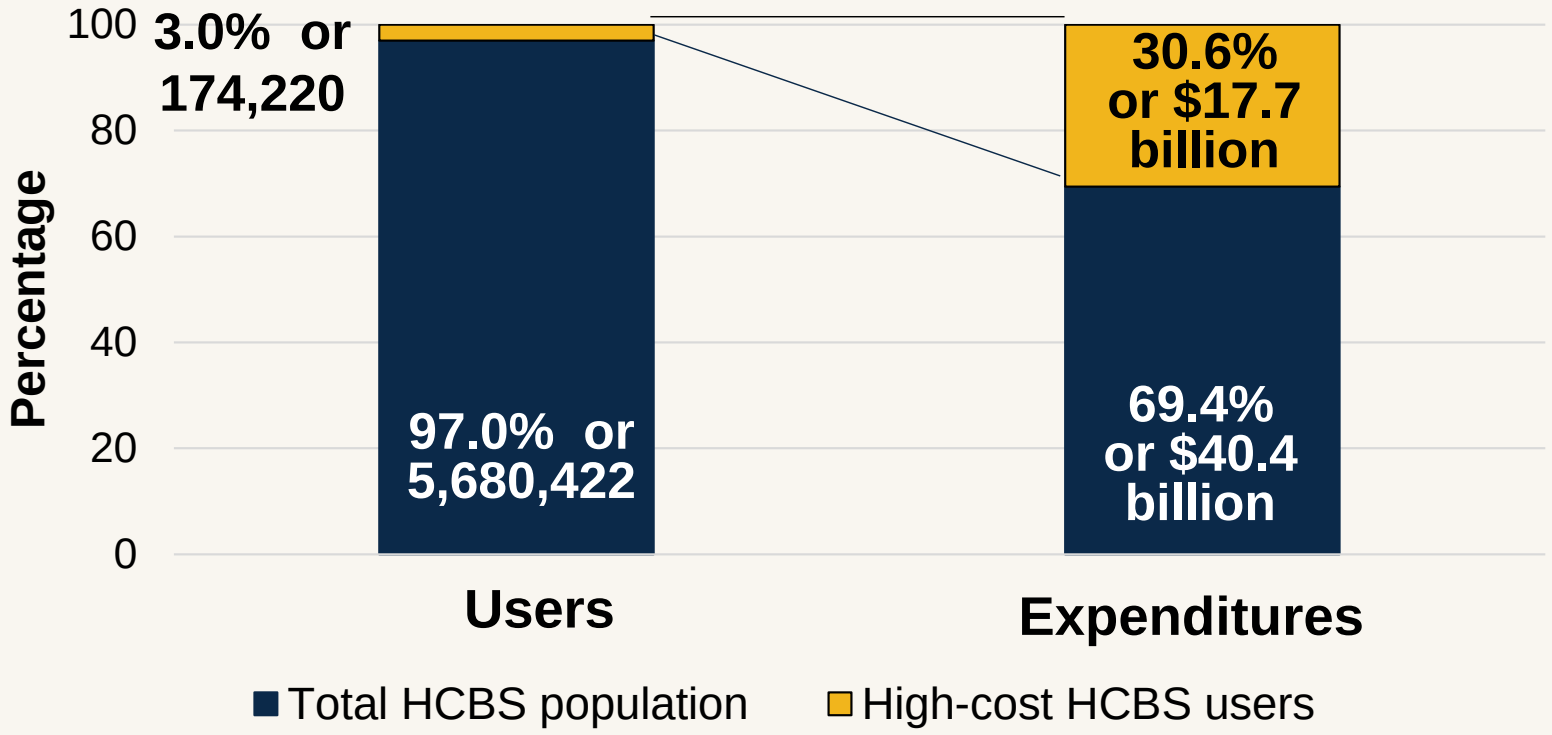
Study Objectives and Research Questions

- **Identify patterns of use and spending on specific types of HCBS for two groups of fee-for-service (FFS) Medicaid HCBS users:**
  1. All HCBS users, regardless of the amount of services or spending associated with them
  2. High-cost HCBS users
- **Research questions:**
  1. What are the characteristics of FFS Medicaid beneficiaries who use HCBS?
  2. What types of HCBS services are they using?
  3. How much is spent on HCBS?

Data and Methods

- **Medicaid Analytic eXtract (MAX) files, 2010–2013**
  - Included 44 states and the District of Columbia with available data
- **Beneficiaries with at least one FFS 1915(c) waiver service claim or one state plan service claim.**
  - Managed care was excluded
- **High-cost beneficiaries are defined as the 3 percent of HCBS users with the highest spending on HCBS in each state.**
  - These high-cost users accounted for nearly one-third of Medicaid spending on HCBS in our analysis ($17.7 of $58.1 billion)

Total Population and High-Cost Users and Expenditures, 2012



Source: Mathematica analysis of 2012 MAX PS, and OT files.

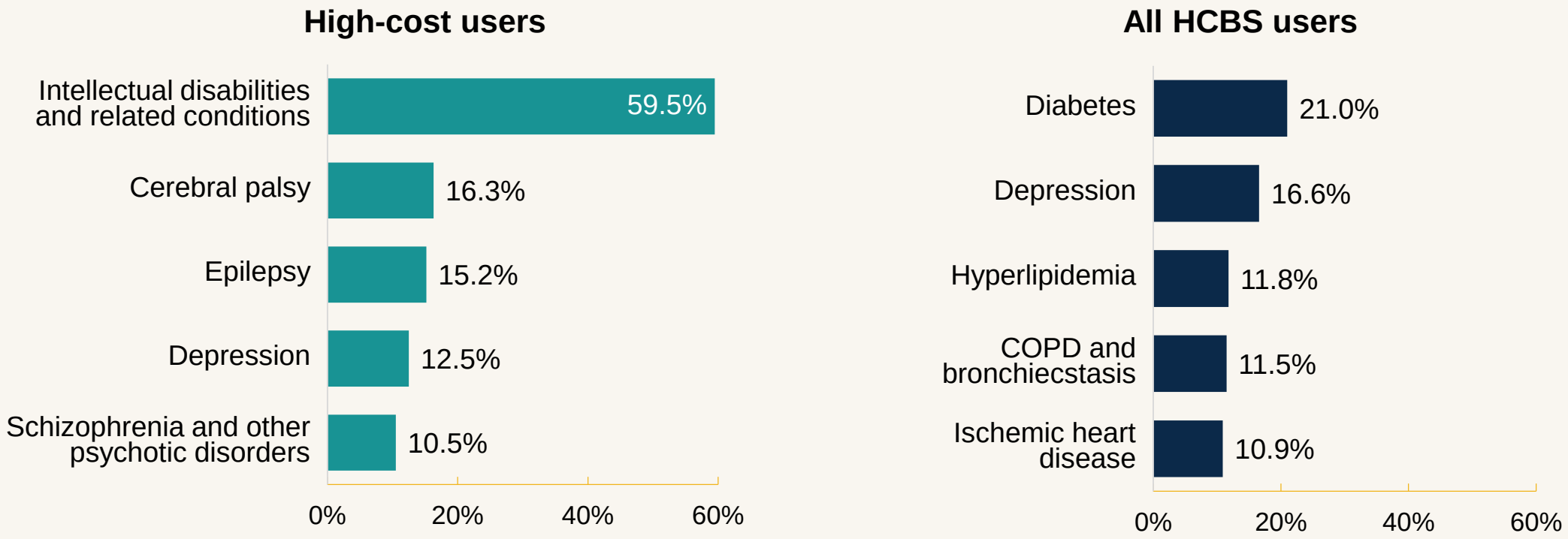
Notes: 2012 analyses included 44 states. The analysis includes all states that had FFS HCBS expenditures, including states that provided HCBS through other program types and authorities, such as 1115 waivers, or provided FFS HCBS to specific populations not enrolled in managed LTSS.

Key Findings

High-Cost HCBS Users

- **In 2012, there were 174,220 high-cost users (3 percent of the total population of 5.8 million).**
- **The high-cost HCBS users have similar characteristics; however, a greater proportion of high-cost HCBS users were:**
  - Qualified for Medicaid based on a disability (86.6 vs. 63.9 percent)
  - Between the ages of 19 and 64 (73.3 vs. 51.8 percent)
  - Male (56.7 vs. 42.5 percent)
  - White, non-Hispanic race/ethnicity (62.9 vs. 49.9 percent)

Most Commonly Reported Conditions of HCBS Users, 2012



Source: Mathematica analysis of 2012 MAX PS, and OT files.

Notes: 2012 analyses included 44 states. The analysis includes all states that had FFS HCBS expenditures, including states that provided HCBS through other program types and authorities, such as 1115 waivers, or provided FFS HCBS to specific populations not enrolled in managed LTSS.

Beneficiaries may also have more than one chronic condition in a study year. We determined a beneficiary as having a chronic condition in a given year if the beneficiary had at least one claim with that chronic condition flag during the study year.

High-Cost Users for Two Consecutive Study Years

Year	2010	2011	2012	2013
Total number of high-cost HCBS users	182,445	181,931	174,220	113,599
Total number of consistently high-cost users (in subsequent year) (%)	137,000 (75.1%)	133,606 (73.4%)	87,102 (76.7%)[a]	N/A

Source: Mathematica analysis of 2010 - 2013 MAX PS, and OT files.

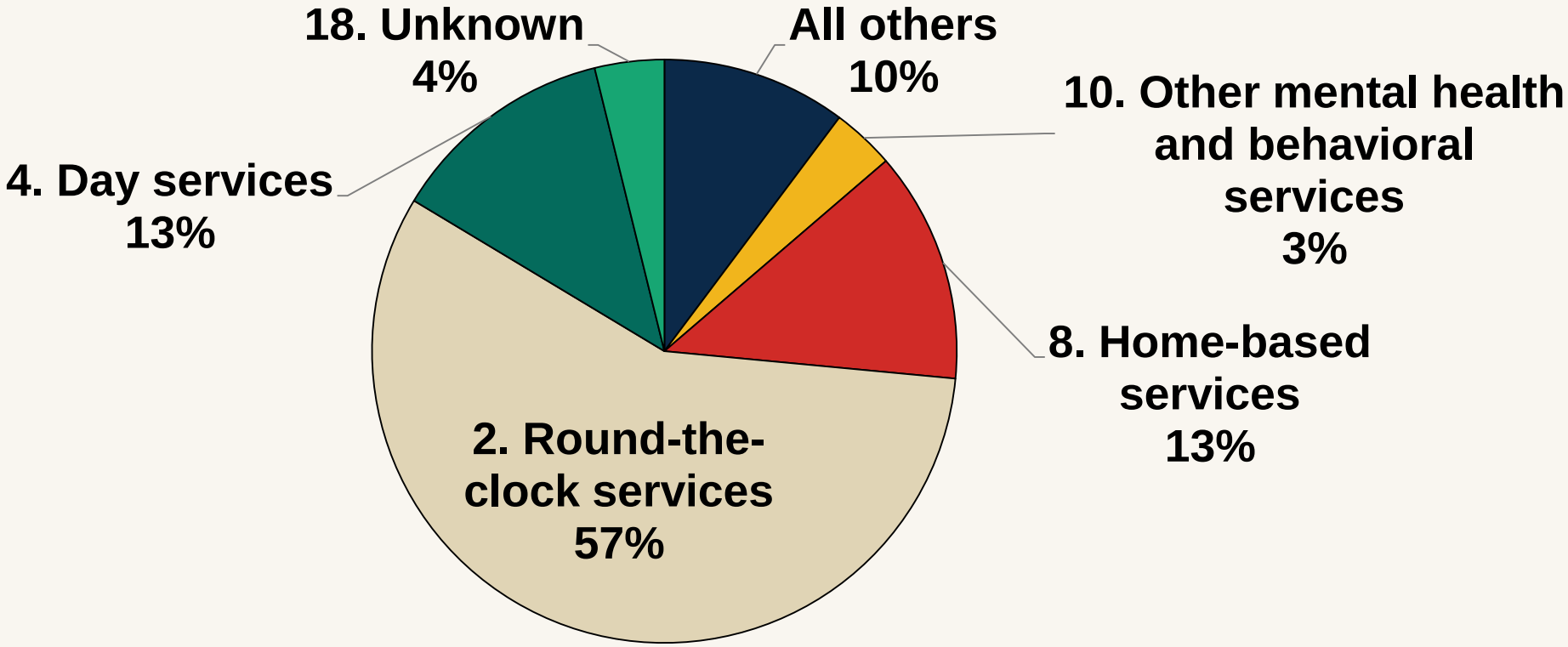
Notes: 2010-2011 analyses included 44 states. For 2012 - 2013, 19 additional states were excluded due to incomplete MAX data. The analysis includes all states that had FFS HCBS expenditures, including states that provided HCBS through other program types and authorities, such as 1115 waivers, or provided FFS HCBS to specific populations not enrolled in managed LTSS.

[a] Because only 25 states had data for 2013, we calculated the percentage of consistently high-cost HCBS users in 2012 only considering those states.

HCBS Service Categories

HCBS Service Categories	
1. Case management	10. Other mental health and behavioral services
2. Round-the-clock services	11. Other health and therapeutic services
3. Supported employment	12. Services supporting participant direction
4. Day services	13. Participant training
5. Nursing services	14. Equipment, technology, and modifications
6. Home-delivered meals	15. Non-medical transportation
7. Rent and food expenses for live-in caregiver	16. Community transition services
8. Home-based services	17. Other services
9. Caregiver support	18. Unknown

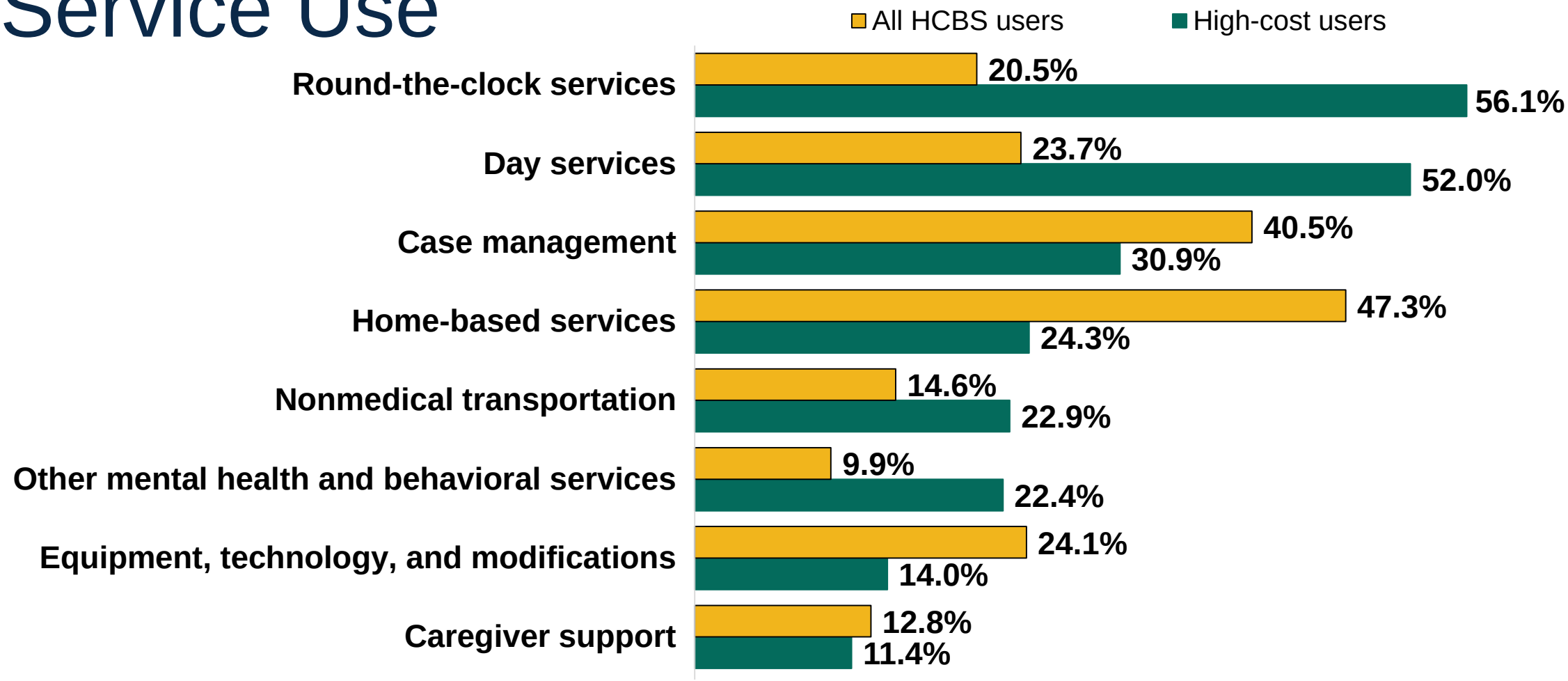
HCBS Service Use: Expenditures



Source: Mathematica analysis of 2012 MAX PS, and OT files.

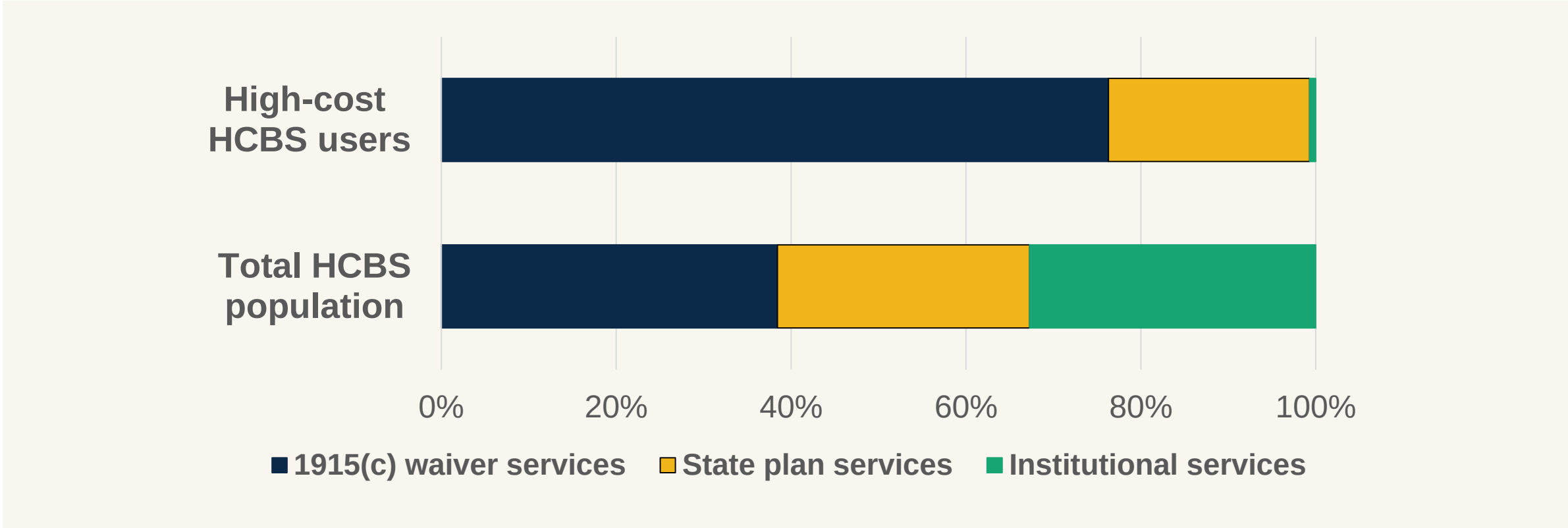
Notes: 2012 analyses included 44 states.

Service Use



Source: Mathematica analysis of 2012 MAX PS, and OT files.
Notes: 2012 analyses included 44 states.

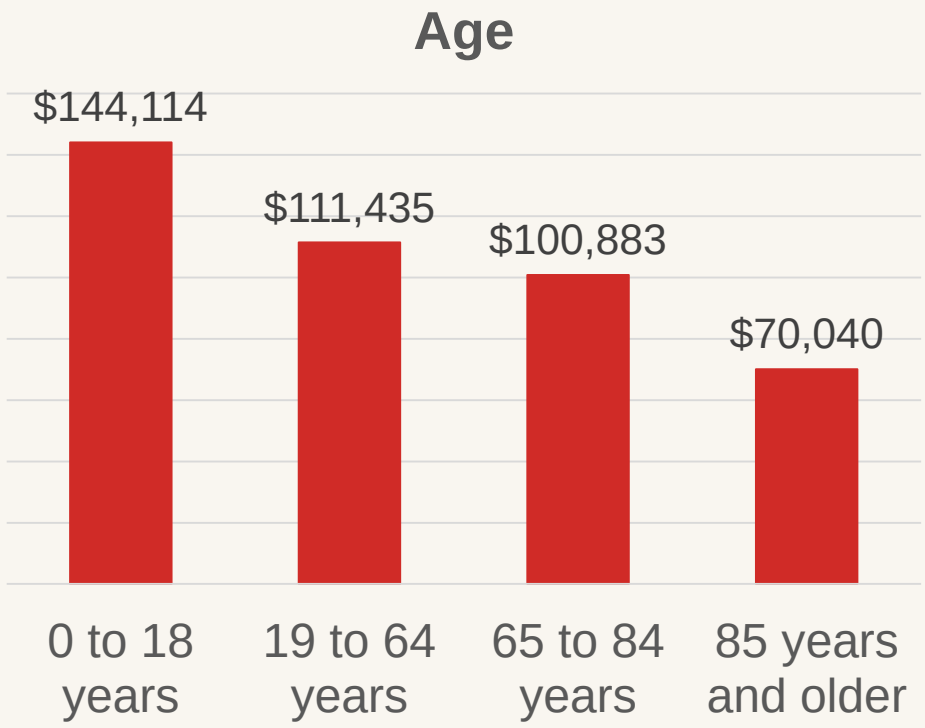
Total LTSS Spending

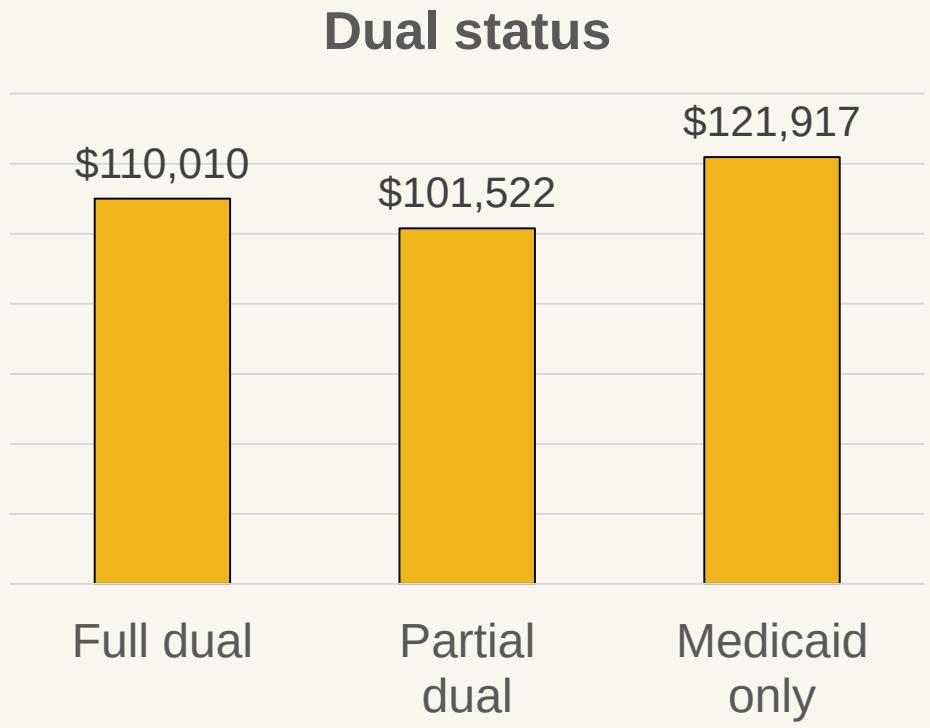


Source: Mathematica analysis of 2012 MAX PS, and OT files.

Notes: 2012 analyses included 44 states. The analysis includes all states that had FFS HCBS expenditures, including states that provided HCBS through other program types and authorities, such as 1115 waivers, or provided FFS HCBS to specific populations not enrolled in managed LTSS. All reported expenditures are annualized.

LTSS Spending





Source: Mathematica analysis of 2012 MAX PS, and OT files.

Notes: 2012 analyses included 44 states. The analysis includes all states that had FFS HCBS expenditures, including states that provided HCBS through other program types and authorities, such as 1115 waivers, or provided FFS HCBS to specific populations not enrolled in managed LTSS. All reported expenditures are annualized.

HCBS Expenditures

Top 10 types of HCBS	Average Medicaid FFS HCBS expenditures per user
Round-the-clock services	$93,635
Home-based services	$48,510
Participant training	$36,182
Unknown	$32,888
Nursing services	$26,806
Services supporting participant direction	$24,205
Day services	$22,134
Community transition services	$21,859
Other mental health and behavioral services	$14,293
Supported employment	$12,135

Source: Mathematica analysis of 2012 MAX PS, and OT files.
Note: 2012 analyses included 44 states.

Conclusions and Implications

- **High-cost HCBS users are relatively young and have persistently high costs over time, which suggests that they will need services for many years**
  - High-cost HCBS users are more likely than the overall population of HCBS users to be younger than 65 or have intellectual or developmental disabilities.
  - Roughly 75 percent of high-cost HCBS users are also defined as high-cost in the next year
- **Round-the-clock services are a major driver of costs for high-cost users.**
  - 56 percent of high-cost users reported claims related to round-the-clock services
  - Round-the-clock services made up 57 percent of total expenditures
- **To reduce LTSS costs, it is important to develop new, more cost-effective delivery models for the high-cost HCBS population**

For More Information

Full report

https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-home-and-community-based-services-characteristics-and-spending-of-high-cost-users

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The Cost Savings Implications of the Money Follows the Person Demonstration

Carol V. Irvin

June 5, 2019

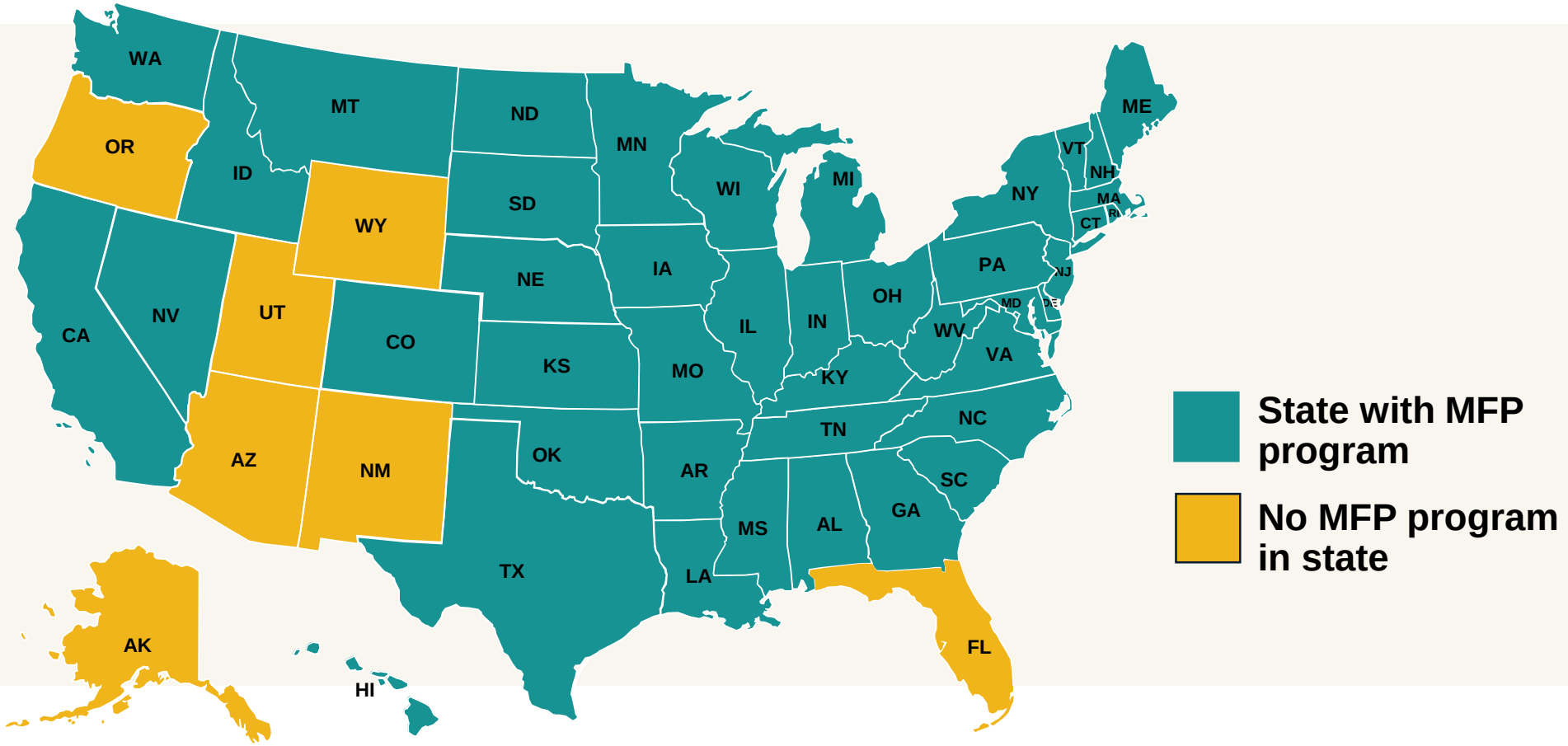
Money Follows the Person (MFP) Rebalancing Demonstration

- **Principal Aims**
  - Reduce reliance on institutional care
  - Develop community-based long-term care opportunities
  - Enable people with disabilities to participate fully in their communities and improve their quality of life

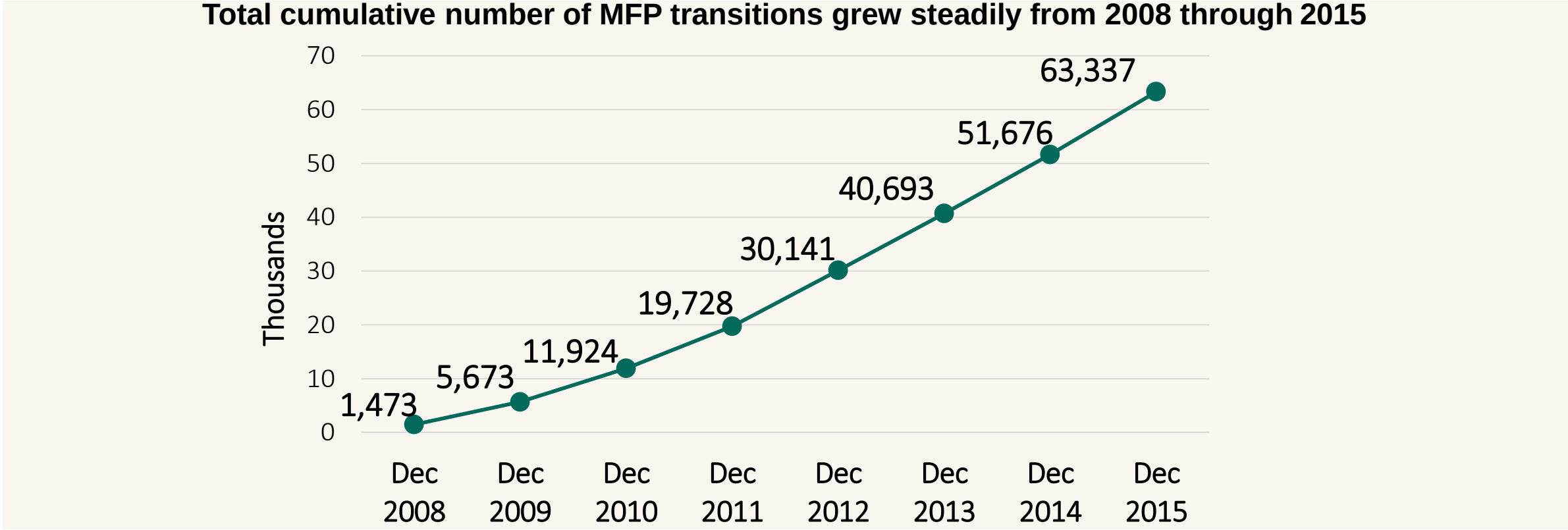
Legislative History

- **Established by Deficit Reduction Act of 2005**
  - 5-year demonstration and $2 billion in grant funding for states
- **Extended and expanded by the Affordable Care Act of 2010**
  - 5-year extension and additional $2 billion in grant funds
- **Extended by the Medicaid Extenders Act of 2019**
  - Added $112 million for federal fiscal year 2019

A Popular Demonstration...



...But Not a Large Demonstration



Community-Based Services Are Less Costly than Institutional Care

- **During first year after the transition**
  - Older adults
    - Average per-beneficiary-per-month (PBPM) expenditures declined by $1,840 (23 percent)
  - People with physical disabilities
    - Average PBPM expenditures declined by $1,730 (23 percent)
  - People with intellectual/developmental disabilities
    - Average PBPM expenditures declined by $4,013 (30 percent)

Savings Were Accrued by Medicaid

- **MFP participants generated total savings of $978 million in medical and LTSS costs**
  - $1 billion in savings to Medicaid
  - $25 million increase to Medicare because of gains in Medicare coverage during the first year

Assessing Costs Extremely Difficult—Could Not Assess All Costs

- **Housing – room and board**
- **Costs beyond the first year after the transition**
  - Attempted to look at costs two years post transition, but results were inconclusive

Changes in Costs Not Unique to MFP

- **The decline in costs observed among MFP participants is similar to what we see for others who transition outside the demonstration**
- **Did MFP transition beneficiaries who would not have transitioned otherwise?**
  - Never detected a robust increase in transitions after MFP began
  - MFP participants had characteristics that suggested they had fewer connections to the community

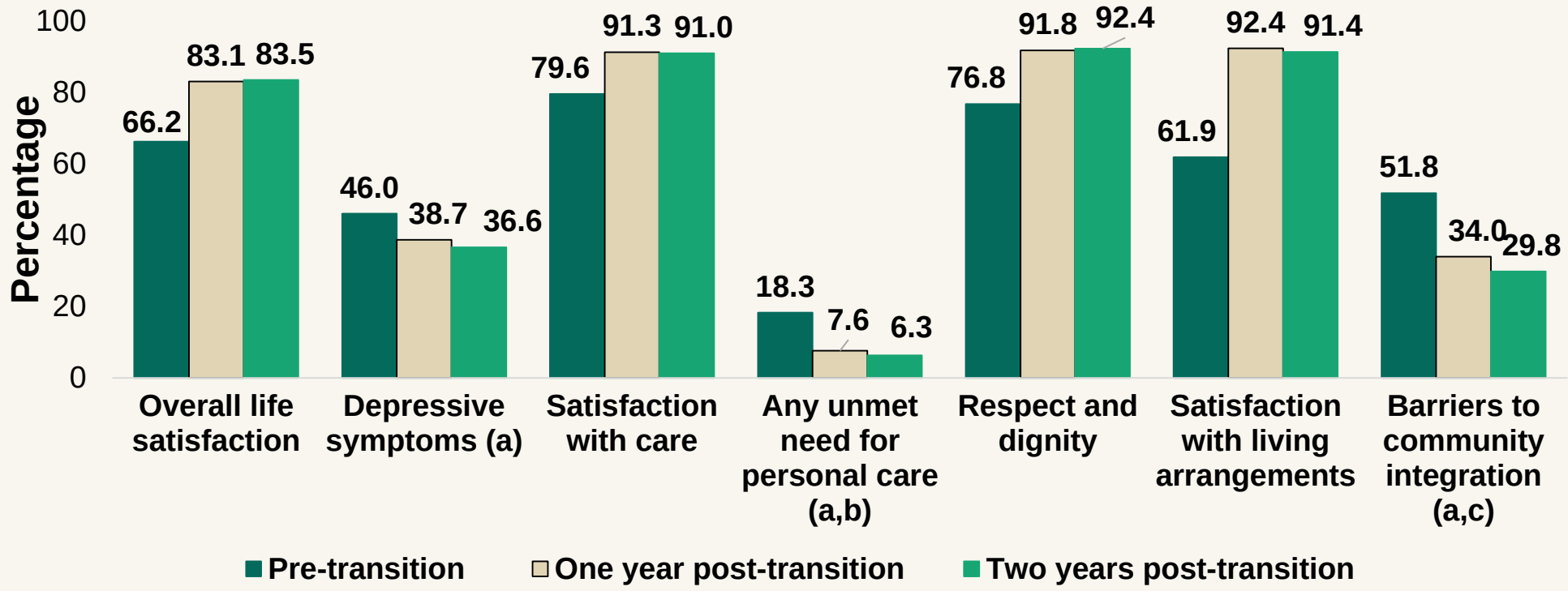
Other Avenues for Cost Savings

- **Did MFP help beneficiaries remain longer in the community?**
  - Did MFP reduce the likelihood of someone returning to facility level care?
  - When someone returns to a facility, is the stay shorter because of MFP?
- **Did MFP provide more access to medical care?**
  - If MFP provides higher quality HCBS, are medical care costs lower as a result?

MFP Provided Other Benefits

- **MFP helped states establish formal transition programs that did not exist previously**
- **MFP was a catalyst to interagency collaboration between health and housing**
- **State grantees used MFP funding to improve access to community-based LTSS**
  - Trainings and resources for direct service workers
  - Promote employment for individuals through support services and infrastructure changes

Invaluable Quality of Life Improvements



Source: Mathematica's analysis of MFP QoL surveys and program participation data submitted to CMS through May 2016.
Note: The analyses are based on surveys from 13,795 MFP participants. All post-transition results were statistically different from pre-transition results at the .01 level, two-tailed test.
[a]A declining percentage indicates improvement in depressive symptoms, or fewer unmet needs, or fewer barriers to community integration.
[b]Measured as "Any unmet need for personal assistance services" in bathing, eating, medication management, and toileting.
[c]Measured as affirmative responses to the question: "Is there anything you want to do outside [the facility/your home] that you cannot do now?"

Next Steps?

- **Demonstrations are temporary**
  - Either end or adopted permanently
- **Community-based beneficiaries are less costly and have a higher quality of life than those residing in facilities**
  - Divert beneficiaries from facility-based care
  - Focus on the transition when a facility admission occurs

Make Community-Based LTSS Available As Early As Possible

- **MFP evaluation and other research suggest that early introduction of community-based LTSS...**
  - Decreases the likelihood of a long institutional stay
  - Increases the likelihood of returning to the community and community-based services when an institutional stay occurs

For More Information

MFP webpage

https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html

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Tennessee's Employment and Community First CHOICES Program

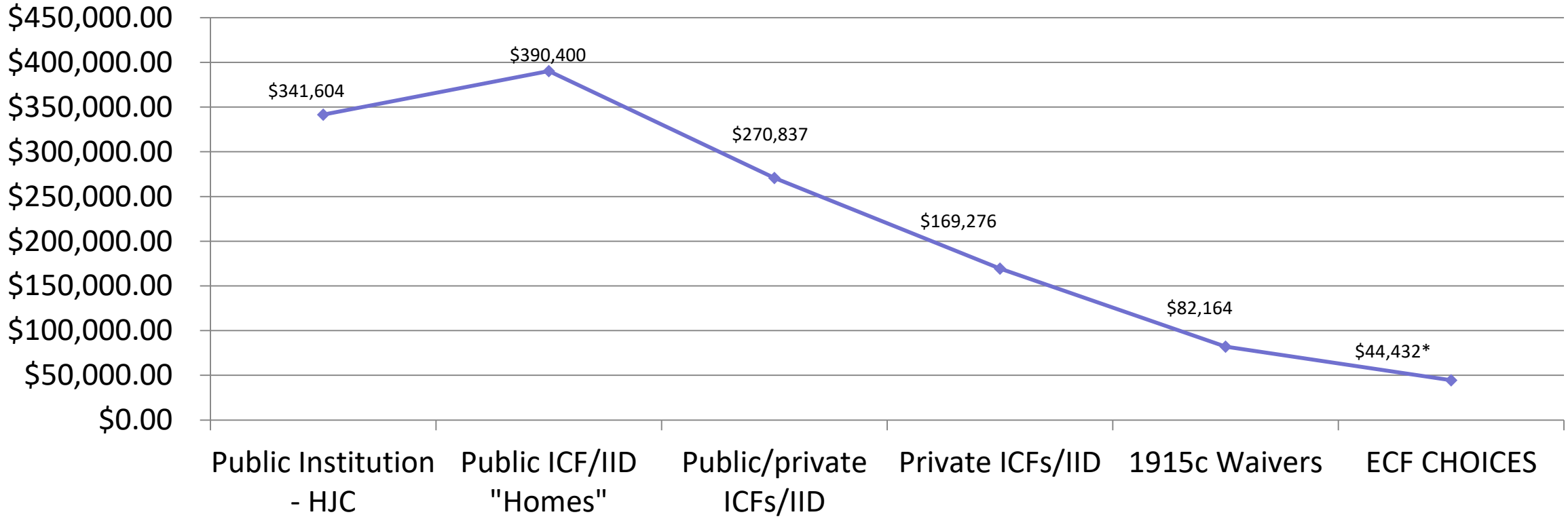
- *Better outcomes, better lives for people with I/DD*
- *Lower costs and increased capacity to serve more people*

I/DD Service Delivery System in Tennessee

- **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)**
  - All large state institutions **CLOSED**
  - Harold Jordan Center – 28 total licensed beds
    - Day One (an ICF-IID) – 12 beds
    - Plus forensic unit, behavior stabilization, overflow
  - 37 state owned/operated ICF/IID "homes" – 148 beds
  - Publicly owned/privately operated ICF/IID "homes" – 20 beds
  - 804 private ICF/IID beds

- **Section 1915(c) Home and Community Based Services Waivers**
  - **Statewide** 4,656 people enrolled as of 3/19
  - **Comprehensive Aggregate Cap** 1,553 as of 3/19
  - **Self-Determination** 1,110 as of 3/19
- **Employment and Community First CHOICES**
  - 2,674 as of 3/19

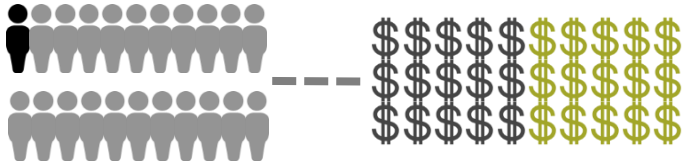
Comparing the Cost of Serving 1 Person



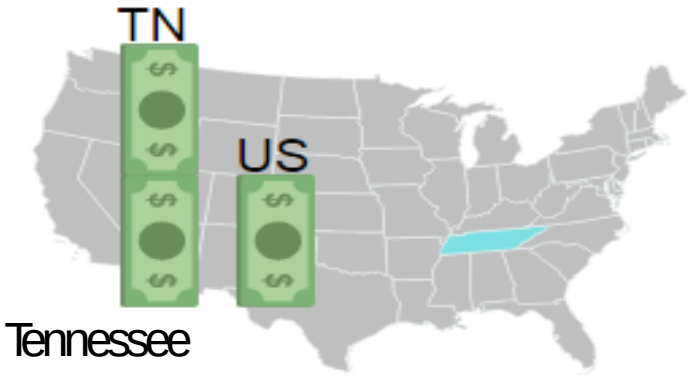
*PMPY budgeted cost for ECF CHOICES is the *only* program that includes other Medicaid expenditures, admin, etc.

Why Managed Care for People with I/DD?

Cost:



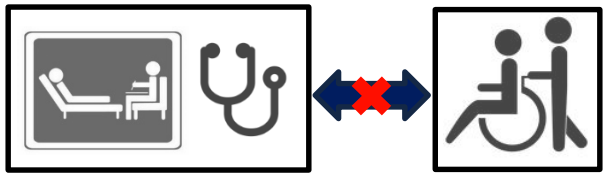
3% of TennCare members account for **50%** of total program costs



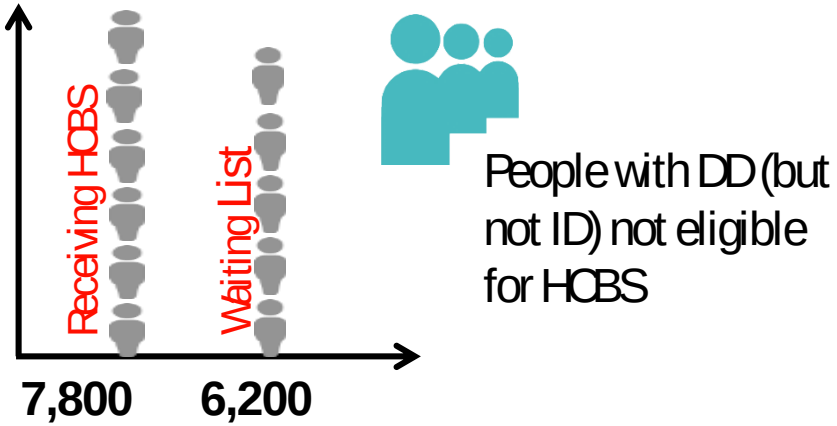
Tennessee spends nearly **2x** the national average per person for people with I/ DD in 1915(c) waivers

Little Coordination:

among physical, behavioral, and LTSS



Demand for HCBS in 1915(c) waivers:



People with DD (but not ID) not eligible for HCBS

Employment Opportunities:

36% of people who did not have a paid job in the community said they want one

Opportunities for Improvement

Stakeholders asked TennCare to consider an MLTSS program for people with I/DD in order to:

- Provide the services people and their families say they need most
- Provide services more cost-effectively
- Serve more people, including people on the waiting list and people with other kinds of developmental disabilities
- Offer more independent community living options (less reliance on 24/7 paid supports) and help engaging in employment and activities that are meaningful
- Focus more on preventive services (not wait for “crisis”)
- Provide services targeted to young adults coming out of high school
- Improve coordination between long-term services and supports and other physical and behavioral support needs
- Align incentives toward employment, community living, community integration, and other things that people with disabilities and their families value most

3 Benefit Groups

Tiered benefit packages target resources more efficiently, serve more people, reduce the waiting list over time

Design Choices to Accomplish Program Goals

- Tiered benefit structure based on needs of people in each group provides comprehensive and flexible service array, designed to promote employment, community integration, and individual/family empowerment
- Enrollment target supports controlled growth while developing sufficient community infrastructure to provide services (persons transitioning from a NF and certain persons at risk of NF placement are exempt)
- Cost and utilization managed via individual benefit limits, levels of care—institutional/ at-risk, expenditure (including individual cost neutrality) caps

Employment and Community First CHOICES

- Designed to promote integrated competitive employment and community living as the first and preferred outcome
- Array of 14 different Employment Services create a pathway to employment even for people with significant disabilities
- Comprehensive and flexible wraparound and supportive services, including self-advocacy and family supports, and self-directed options designed to support active community participation and as much independence as possible
  - Intermittent supports; expectations of fading
- ***Employment Informed Choice*** process ensures that employment is the *first* option considered for every person of working age *before* non-employment day services are available
- Individuals engaged in competitive integrated employment have access to more benefits

Employment and Community First CHOICES

- Groups prioritized for enrollment include those who need/want support to keep or obtain competitive integrated employment (CIE), plan/prepare for CIE, or are at least willing to explore CIE
- Comprehensive person-centered assessment and planning process explores employment early in process and in significant depth
- **Value-based payment** aligns incentives with employment outcomes, incentivizes fading (independence)
  - **Outcome-based reimbursement** for pre-employment services
  - **Tiered outcome-based reimbursement** for Job Development, Self-Employment Start-Up based on level of need, **paid in phases to support retention**
  - **Tiered reimbursement for Job Coaching** based on person's "acuity" level, length of time employed, and amount of support as a percentage of hours worked
    Payment is higher per hour if fading achieved is greater.
- Memorandum of Agreement with VR agency operationalized through statewide joint training of VR and MCO staff

Baseline Data Plan to Measure Program Outcomes

- **Objective #1: Expand access to HCBS**
  - Number of individuals receiving HCBS (point in time and unduplicated across the year)
- **Objective #2: Provide more cost-effective HCBS as an alternative to institutional care**
  - Average per-person LTSS expenditures
- **Objective #3: Continue balancing LTSS spending**
  - Total HCBS versus ICF/IID expenditures
- **Objective #4: Increase competitive, integrated employment**
- **Objective #5: Improve quality of life**

Outcomes

- More people with I/DD enrolled into HCBS in the first *20 months* than in the previous *6 years*
- For the first time in the state's history, people with DD *other than ID* have access to HCBS
- Nearly 85% of people enrolled in an employment-related priority category
- Annualized cost of HCBS less than half the current average
- Nearly 25% of working-age individuals with I/DD working in competitive integrated employment (50% higher than national average with many people enrolled less than a year)
  - Average wages: $8.63/hour
  - Average hours worked: 17 per week

Next Steps…

- **Cross-walk lessons learned from Employment and Community First CHOICES into existing 1915(c) waivers**
  - Establish separate rates for job development/customization or self-employment start-up, coaching, and stabilization and monitoring with payment approaches similar to Employment and Community First CHOICES
  - Realign existing waiver funds with desired outcomes. For example:
    - Invest substantially more resources in higher rates for services that achieve competitive, integrated employment
    - Reduce reimbursement for services that do not support desired outcomes, including facility-based programs
  - Extensive engagement with State I/DD Department (waiver operating agency) and HCBS providers, education for waiver participants/families
  - Help providers plan/prepare for success, that is, *transformation*

Discussant

Debra Lipson
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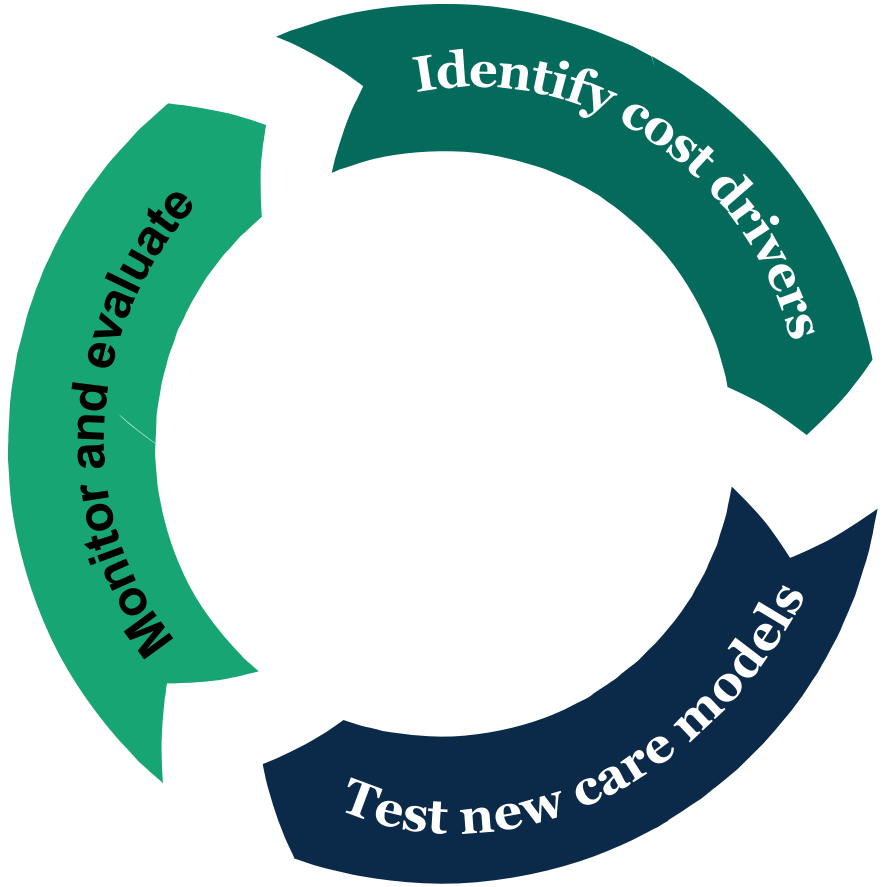
Challenge: Meeting Increased Need for HCBS by More People (*without busting budgets*)

- **Identify cost drivers and characteristics of high-cost beneficiaries**
- **Re-think care models for people who are now high-cost LTSS beneficiaries, or at risk of becoming high-cost**
- **Conduct rapid-cycle monitoring and evaluation**



Promising Innovations to Lower Costs

- **Integrated care models for Medicare-Medicaid dually eligible beneficiaries**
- **New HCBS care models for people with intellectual and developmental disabilities**
- **Expanded access to HCBS for people at risk of needing institutional care who do not yet qualify for Medicaid**
- **Addressing the social determinants of health, especially housing**

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Questions?