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Home and Community Based Services in Federal and State Policy: Considerations from Indiana and Elsewhere

By John Cardwell

Overview

Presently, Congress and the Obama Administration are seeking ways to dramatically rein in federal domestic spending. The 2011 Budget Control Act has literally put a timer on the search for major savings in public spending including dollars spent for long term care. In Indiana, consumers and the state have long realized considerable savings while accessing quality home and community based services (HCBS) through the state's CHOICE program when compared to the cost of Medicaid and private pay nursing home care. Consumers and the state still realize significant savings when utilizing Medicaid waivers that provide HCBS in addition to the Medicaid state plan services required under federal law. The implications for savings at the state and national level are significant when the use of publicly funded HCBS is compared to publicly funded nursing home care.

A Special Consideration

Special attention should be given to the legal entitlement status in federal law of Medicaid funded nursing home care when addressing solutions to the delivery of long term care in Indiana and the United States. *The failure to grant entitlement status to all forms of long term care, especially home and community based services, inherently and dramatically drives up the cost of long term care. The failure to grant entitlement status to all forms of long term care also harms and discriminates against any and all persons, seniors and non-seniors alike, that need HCBS.* More is said on this subject under point eleven in the recommendations that follow.

Indiana's CHOICE Program and Medicaid

CHOICE, or the Community and Home Options to Institutional Care for the Elderly and Disabled Program, was established by the 1987 Indiana General Assembly. The act was authored by State Representative John Thomas, passed the legislature by a combined vote of 149 to 1, and was signed into law by Governor Robert Orr.

The CHOICE program was designed to fund the provision of home and community based services (HCBS) for senior citizens and non-seniors of all ages with disabilities who otherwise could not afford those services. The authors of the legislation specifically sought to prevent the forced placement of persons in nursing homes on Medicaid due to the lack of affordable home care services.

The ratio of persons in the two populations served by the CHOICE program is approximately four seniors to each non-senior. The clients range in age across the entire life span.

CHOICE is a state funded program. *CHOICE is NOT an entitlement.* CHOICE is budget driven. If the funds provided by the Indiana General Assembly are exhausted in any given budget cycle then further services cannot be provided until additional funds are appropriated by the legislature. For the July 1, 2011 to June 30, 2013 budget biennium the General Assembly has appropriated \$48,765,643 per state fiscal year for the CHOICE program. The state budget act allows a portion of those dollars to be sub-allocated by the Indiana Family and Social Services Administration (FSSA) as Medicaid match for the state Medicaid aging and disabled waiver. A far smaller portion of the CHOICE appropriation is used for administration. In SFY 2012, slightly more than \$29 million from the original appropriation will be used for the funding of HCBS through CHOICE.

The CHOICE program is locally administered by the area agencies on aging, the sixteen private non-profit corporations that also administer Older Americans Act programs in Indiana. Under CHOICE, the AAAs do not provide services. Instead, AAA case managers broker and construct HCBS service packages for individuals that have been properly assessed by a AAA professional and found to be qualified for CHOICE services. The actual services are delivered by qualified private providers.

The program has always been remarkably popular with the citizens that use CHOICE for the following reasons. CHOICE is designed to provide home care services per the needs of each individual client using whatever services are needed as long as they fit within the program's financial guidelines. In other words, it is not a one size fits all program. Services are designed to meet each individual's needs. This makes the services very effective because the state is only paying for the services that are needed.

It should be noted that three studies have given the CHOICE program remarkably high grades. An extended review by Indiana University (1989, 1991) found the CHOICE program to be serving people with high quality services and concluded that 75 percent of the people receiving those services had conditions that would otherwise require nursing home care. The clients interviewed in that study felt their health and outlook on life had improved because of the provision of HCBS through the CHOICE program. A second Indiana University study (1998) found client ratings of CHOICE funded services, and like services through the state's Medicaid aged and disabled waiver, to be exceptionally high. A third study by the Hudson Institute (1998) concluded the CHOICE program was a rare government program that actually worked very well and rated it as a high value program for taxpayers. The Hudson Institute study noted the productive partnership created by CHOICE between a state government agency, private non-profit area agencies on aging, and private providers.

The enrollment of an individual into the CHOICE program is done by a case manager employed by the area agency on aging where the individual resides. The AAA case manager is charged with assessing the client's needs, developing a plan of care with the client, and brokering the provision of services for the client by qualified providers. The AAA case manager is also charged with the task of being the client's advocate. If a client is not satisfied with a provider, the client can have a bad provider removed.

To receive CHOICE services a potential client must be unable to perform two (2) or more activities of daily living (ADLs), which include basic functions such as walking, feeding, and bathing. The CHOICE ADL screen is far more detailed than the federal screen used for Medicaid waivers, and not surprisingly is far more accurate and more cost effective. The detailed CHOICE screen makes it easier to design a care plan for each client that actually meets the needs of that client.

It should be noted that most CHOICE clients also meet nursing home level of care: meaning, most are unable to perform three (3) or more activities of daily living. For persons for whom Medicaid waiver funded home and community-based services are more appropriate, the minimum impairment standard is the inability to perform three ADLs. However, the income eligibility standards for CHOICE, as explained below, differ from those used for Medicaid and for the Medicaid aged and disabled waiver in Indiana.

Anyone who is eligible for a Medicaid waiver is eligible for CHOICE, but not all CHOICE clients are eligible for Medicaid waiver. That is because CHOICE is designed to deliver HCBS earlier than the waiver. CHOICE thus saves money because it can serve people sooner, when they are not as sick or disabled. Therefore, costs are often far lower, an individual's health is easier to stabilize or to improve, and the chances that Medicaid funded nursing home care will be needed are minimized. By intervening early, CHOICE is much more likely to enable a family caregiver to maintain his or her care-giving role. Conversely, the later HCBS is delivered to a person in need the odds are much greater that a family caregiver will be burned out and unable to continue care-giving services. When that happens the cost of replacing the "free" care-giving falls on the public.

Fiscal corruption in the CHOICE program is virtually non-existent. Previous attempts to find corruption in the program have come up empty. Clients only receive services that are approved in their care plans. Clients do not receive cash assistance through CHOICE.

CHOICE is also the funder of last resort. If the client has other sources of funding to obtain home care, such as private income or private insurance, or if the client is also eligible for another publicly funded home and community based service then the client must use that service, such as a Medicaid waiver. CHOICE also has a generous cost-share formula. Persons receive CHOICE free if their income is 150 percent of poverty or less. Above 150 of the FPL, CHOICE clients must pay 1 percent of their costs for every two percent the costs increase. At 250 percent of FPL a client will pay 50% of the cost of CHOICE funded services. At 350 percent of the FPL, a client must pay for 100 percent of the costs associated with CHOICE funded services. Ongoing and pre-existing medical costs can be counted when calculating the cost share. Persons with assets of \$500,000 or higher do not qualify for the program.

Depending on the data set being used by the state, the average yearly cost of services funded by the CHOICE program is \$4,000 to \$7,000. This compares with costs for nursing home care that typically range from \$55,000 in the Medicaid program to over \$70,000 through private pay although the latter costs may be higher or lower in any given state.

The enormous savings that can be generated when a person uses CHOICE instead of nursing home care are obvious. Nonetheless, CHOICE is not for everyone. CHOICE does provide medical care and does not cover hospitalizations, etc. In other words, CHOICE is not a replacement for Medicaid. CHOICE is about home and community based services for persons with ongoing impairments from aging, disease, accidents and disabilities. CHOICE is about maintaining an impaired person's independence through nursing assistance, attendant and respite care, mobility assistance, home modifications, and transportation in the community. CHOICE is not about curing medical conditions even though HCBS do provide enormous health and quality of life benefits that can tribute to very positive medical outcomes.

Low-income persons that need basic medical, hospitalization and related clinical services should be on Medicaid and/or a Medicaid waiver. Medicaid and Medicaid waivers provide access to those services depending on the details of a given state's Medicaid state plan. However, it is important to not lose sight of the fact that Medicaid waivers that provide HCBS, such as Indiana's Medicaid aging and disabled waiver, are also less costly than Medicaid funded nursing home care. While CHOICE is dramatically lower in costs when compared to Medicaid nursing home care or a Medicaid waiver, the difference between the costs for a person using a Medicaid waiver vs. nursing home care is still significant.

Recommendations

Federal policy could be used to promote state directed home care services similar to Indiana's CHOICE program while also promoting the use of Medicaid waivers, and other options, in a more creative and effective manner. Such actions could generate significant cost savings.

One, the federal government could provide financial incentives for states to use programs like CHOICE when it is clear a person only needs the array of home and community based services provided by CHOICE, and not the larger array of medical and clinical services provided through Medicaid or through a Medicaid waiver. Under no circumstances should Medicaid or Medicaid waiver eligible persons be denied critical services for which they are qualified. This would simply put people in greater jeopardy and at greater risk of institutional placement at a much higher cost to the public.

Two, CMS could examine the CHOICE program, and similar programs in other states, as a model of efficiency and service delivery. CHOICE operates with far less red tape than Medicaid and Medicaid waivers. Clients can be enrolled in CHOICE in a matter of a few days, or even hours. This reduces the risk of inappropriate nursing

home placements and, as the CHOICE program has demonstrated throughout its long history, the risk of mistakes are low.

Three, the federal government could use the CHOICE eligibility screen as a model because it allows the development of a much more detailed plan of care, which is more precise in serving the needs of a client. That saves money.

Four, CHOICE and programs like it strongly encourage and support the continued provision of care by family caregivers. CMS should do everything it can to encourage and to support family caregivers. Supporting family caregivers is a powerful way to promote individual responsibility and independence. CMS should look at improving and expanding its existing family caregiver support program. Current federal policy in support of family caregivers is insufficient, which is surprising given the enormous public savings that are generated when family members provide care. CMS could also encourage more states, like Indiana, to consider and make use of paid family caregivers. Many states have proven that paid family care giving can be done in a responsible manner.

Five, CMS could do more to review the use and performance of agency based providers and individual providers in the provision of home and community based services (HCBS) through state Medicaid programs, Medicaid waivers, and state programs such as CHOICE. The evidence is strong that independent providers (individuals that are qualified to provide specified in-home services) provide care that is equal to, or better, than the care given by agency based providers....and at a far lower cost. Overhead costs are far lower, and individual providers are often better trained than agency based providers, especially for complicated care clients because many agencies do not want to assume the financial obligation and liability for caring for the latter. A 2007 study by a Washington state legislative commission found the total cost of an independent provider to average \$12.60 per hour and the total cost of an agency based provider to average \$17.60 per hour. That study also concluded individual providers delivered care that was equal or better in quality than the agency providers. When projected nationally, the fiscal implications of the Washington state study are enormous.

Six, the federal government could increase its support for area agencies on aging, especially, AAA case management services. The federal government could also substantially increase its support of nutrition programs for seniors and persons with disabilities. Nutrition is critical to maintaining the health of persons in these populations.

Seven, CMS could also aggressively expand its support for programs and policies at the state level that promote earlier intervention and preventative care. Indiana's CHOICE program is well designed to do these things, but state budgetary restraints limit the benefits for the citizens that use that program, as well as limiting the fiscal benefits for the public.

Eight, numerous studies demonstrate that purposely driving HCBS and nursing home care to the for-profit private sector is a bad idea: costs are increased for state and federal governments and the quality of care suffers. In Indiana and across the nation, non-profit charitable, fraternal and church affiliated organizations provide higher quality long-term care services. Private for-profit providers should be challenged to equal the non-profit sector in quality.

Nine, the federal government could provide far greater direct incentives for states to retain the savings generated by the use of HCBS instead of nursing home care. This simply means, if a person is receiving Medicaid nursing home care and is transferred to a home care setting, or if a person eligible for Medicaid nursing home care is given HCBS as an alternative, then the Medicaid savings generated by not using the more expensive nursing home care should be reinvested in HCBS for another person. The federal government could make this a requirement, and/or provide a financial incentive to states for each person served in an HCBS setting instead of an institution, when HCBS are appropriate. The federal government's Money Follows the

Person (MFP) grant program, which is suppose to encourage the placement of persons from nursing homes to HCBS, is too limited in scope and slow to intervene.

Ten, the Medicaid Community First Choice Option and the Community Living Assistance and Support Act (or CLASS Act) in the Patient Protection and Affordable Care Act could be enhanced. It should be noted, the many preventative care and anti-discrimination sections of the PPACA are and will be enormously helpful for persons who need HCBS and for saving taxpayer dollars at the state and federal levels of government.

Eleven, Congress *should study and address* the appropriateness of nursing home care. The evidence continues to grow that the nursing home model of care is outdated and harmful to most people. Advances in medical technology and therapy techniques in the past thirty years have made HCBS better and safer than institutional care for the vast majority of people. Research in the past thirty years has confirmed that institutionalization shortens lives and radically reduces the quality of life for vast numbers of people placed in nursing homes.

A rapidly growing number of nursing home industry advocates are now saying their facilities should only be used for short term rehabilitation and end of life care. Persons with disabilities are not subtle in saying placement in nursing homes is a violation of basic human rights. The Olmstead case in Georgia essentially brought the issue of HCBS vs. institutional care into the realm of civil rights. Many conservative and liberal judges increasingly see the forcing of persons into nursing homes against their will, followed by the taking of private property, as problematic under the U.S. Constitution.

Apart from the above considerations, Medicaid funded nursing home care is far more expensive that HCBS. Indiana's CHOICE program and Medicaid waiver data from across the nation offer dramatic proof of that. Nonetheless, nursing home care continues to have legal entitlement status under federal Medicaid law while HCBS does not.

Federal Medicaid law should be changed to grant legal entitlement status to all forms of long term care including HCBS. The failure to extend the entitlement to all forms of long term care has resulted in states designing Medicaid programs with an irrational bias toward nursing home care. Indiana is no exception. That has resulted in federal and state governments spending vast sums of money for institutional care that virtually nobody wants while draining away the dollars from the home and community based services that people *do* want and need. Because home and community based services are far cheaper, produce better health care outcomes, and can served far more people, the bias toward nursing home care harms individuals, their families, and the economy.

Politically, HCBS is very popular with people in all demographic groups and among persons of all political points of view. That is why the CHOICE home care program has always been so popular with all the members of the Indiana General Assembly. Organizations that do advocacy for HCBS in Indiana find equal support for those services in Carmel, Fort Wayne, Columbus, Pendleton, Gary, Evansville, New Albany, Indianapolis, Princeton, South Bend, or rural Tipton County. When people learn there is an entitlement for nursing homes but not for home care they simply don't get it....and why should they. The bias harms their wallets and their loved ones.

Think about this: many states have aggressive Medicaid estate recovery programs that are very much disliked by the public. It is Big Brother and the *heavy hand* of government at its worse. Medicaid estate recovery would virtually disappear if the bias in favor of nursing home care in federal law was removed. Furthermore, when state and federal HCBS programs are available and smartly administered, most family members who were providing care-giving assistance to a loved one continue to do so. When people are forced into nursing homes to get long term care, the care provided by family caregivers is assumed by the facility and the cost of that care is absorbed by the public.

Other States and Sources

States that have a solid reputation for providing publicly financed HCBS include Washington, Oregon, Vermont, and Wisconsin. However, the vast majority of states have increased their investments in HCBS in the past two decades. In 2010, a bipartisan legislative initiative in Ohio increased that state's investment in HCBS in order to realize an even greater savings in Medicaid funded nursing home care. Detailed analyses of state HCBS programs are readily available from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, the National Governors Association, the National Conference of State Legislatures, and the National Academy for State Health Policy.

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About the Author

John Cardwell is the director of The Generations Project, a public policy research and education organization that primarily focuses on issues that affect senior citizens, persons with disabilities, family caregivers, and low income persons. Mr. Cardwell is also the executive director of United Senior Action of Indiana, president of Hoosiers First, and chairperson of the Indiana Home Care Task Force. He has been a policy advocate for over thirty years and previously served on Governor O'Bannon's Citizens Commission on Taxes and as an adjunct professor of psychology at Indiana University at Kokomo. He and his wife own a farm in Tipton County, Indiana. He has crafted model legislation and written articles regarding long term care, state budget issues, tax reform, agricultural policy, welfare reform, and human services.