The Nelson A. Rockefeller Center at Dartmouth College
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Policy Research Shop

Long-term Care in Grafton County

Shifting from Institutionalized to Home and Community-Based Care

Presented to the Grafton County Nursing Home Administrator & Grafton County Senior Citizens Council

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1. EXECUTIVE SUMMARY

In the context of an increasingly older population and rising medical costs, especially for the elderly population, New Hampshire policymakers have recently decided to shift the state's resources for long-term care from institutional providers (e.g., county nursing homes) to home- and community-based care (HCBS). While national studies of HCBS show mixed results in terms of efficiency vis-à-vis institutional care, a dramatically lower per-patient cost, combined with the social benefits of remaining independent and in one's home and community, makes HCBS attractive to policymakers. This report analyzes case studies from states that have adopted HCBS in the past and examines national studies of HCBS effectiveness to elucidate best practices for making HCBS cost-effective.

2. INTRODUCTION

New Hampshire's elderly population is steadily rising. In 2010, fifteen percent of Grafton County's elderly population was over age sixty-five. By 2030, the New Hampshire Center for Public Policy Studies projects this proportion to reach 32.7 percent.[1] While Medicare provides coverage for all those over 65, Medicaid primarily provides coverage for members of this group who fulfill the low-income requirement. And of Medicaid recipients, this group represents a sizeable proportion: in 2011, one-fourth of Medicaid spending in New Hampshire was allocated to people over age 65, and projections suggest that by 2030, this group will account for more than one-half of Medicaid spending in the state.[2] People over age eighty are responsible for more Medicaid expenses than any other age group, and nursing home care accounts for the majority of these expenses. A rising elderly population thus presents a significant increase in Medicaid spending. The aging of the state and county population, which reduces the tax base, combined with rising healthcare costs, will strain the resources available to senior citizens.

Counties in New Hampshire bear a large portion of the financial burden for long-term care. Long-term care refers to various services (both health care and other personal services) for people needing assistance for ninety days or more.[3] Long-term care is primarily, though not exclusively, a service for senior citizens: nationwide, 58 percent of long-term care recipients are over the age of 65.[4] This report investigates the ways through which Grafton County can reduce its future Medicaid costs by shifting efforts from **institutional care**, defined as health care provided for seniors in nursing homes and other full-time care facilities, toward **home- and community-based care (HCBS)**, meaning health care services provided outside of such formal institutional facilities.[5]

This report first describes the procedures by which Medicaid pays for long-term care, including both HCBS and institutional care. Understanding these procedures is essential for determining how Grafton County can control its Medicaid costs. In section 4, the

report analyzes the relative costs of HCBS and institutional care, drawing upon both case studies and nationwide academic studies. We conclude with an analysis of options for Grafton County, informed by both the academic literature and by discussions with individuals involved in long-term care provision in the county.

3. MEDICAID OVERVIEW

The goal of this section is to elucidate the processes by which Medicaid pays for long-term care, and how these processes affect long-term care policy. More specifically, this section explores various practices that may prove to reduce long-term care Medicaid spending.

Medicare, the federal health insurance program for those over age sixty-five, structures its long-term care benefits differently from Medicaid. Medicare includes a "hospice benefit" for *end-of-life* care provided either at home or in a nursing home setting.[6] Medicare also pays for "acute and short-term post-acute" care for those receiving long-term care, as well as others. However, Medicare does not pay for long-term care *per se*; citizens pay for these services privately or, in the case of low-income senior citizens, through Medicaid.[7] Medicare funds can be used for long-term care however, by pooling Medicare and Medicaid funds together through the use of 1915(b) waivers. These waivers, while still funding Medicaid-provided long-term care, allow qualifying patients to use their Medicare funds along with their Medicaid funds to provide this care. In order to qualify for these waivers, patients must be covered both under Medicaid (low-income) and Medicare (over 65).

When Medicaid pays for long-term care, it has usually been through nursing homes. Indeed nationwide, 73 percent of Medicaid spending on long-term care for the elderly and physically disabled population goes to institutional care (mainly nursing homes) while only twenty-seven percent goes to home- and community-based services (HCBS). States expand HCBS by using one of several "waivers" established by the Social Security Act. In addition to the 1915(b) waivers for combining Medicaid and Medicare funding, the most common are section 1915(c) and 1915(i) waivers.

3.1 Expanding HCBS through section 1915(c) waivers

In 1981, states gained flexibility to rebalance their Medicaid spending from nursing homes toward HCBS through section 1915(c) of the Social Security Act.[8] Section 1915(c) waivers allow states to provide HCBS, holding them exempt from certain general requirements of Medicaid. For example, under the waiver program, the Medicaid-financed HCBS need not be available statewide, but can be targeted to areas of the state

where services are most needed. States also may restrict HCBS eligibility on the basis of age, disease, or condition, rather than solely by financial need.[9]

A state may operate many of these waivers, each of which is targeted at a specific population and a specific "level" of care needed. The three main "levels" discussed in the research we reviewed are the nursing home level (i.e., people who need the type of services a nursing home provides), the mentally/developmentally disabled level (i.e., people with permanent mental disabilities), and the hospital level (i.e., people who need acute care).

The Center for Medicaid and Medicaid Services (CMS) must verify that waivers are "cost-neutral" (i.e., the average Medicaid cost per participant with the waiver is no greater than the average Medicaid cost per participant in institutional care). However, as we will see, this criterion does not guarantee overall cost-effectiveness of HCBS in general.

3.2. Expanding HCBS through section 1915(i) state plans

Section 1915(i) of the Social Security Act, as enacted by the Deficit Reduction Act of 2005, allows states to provide HCBS as part of the regular state Medicaid plan.[10] However, until recently, the rules for such plans were different from those for 1915(c) waivers in the following ways:

- States were required to make the plan available to everyone meeting the particular state's financial need-based criteria.
- States were prohibited from offering services to those with incomes over 150 percent of the federal poverty level.
- States could not restrict eligibility based on disease or condition.[11]

Under the Patient Protection and Affordable Care Act (PPACA), many of these restrictions on state plans are eliminated.[12] PPACA makes the following changes to section 1915(i):

- States may now offer services only to a specific population, rather than to all eligible Medicaid participant.
- States are allowed to offer services for people with incomes above 150 percent of the federal poverty level, as long as their incomes are still below 300 percent of the federal Supplemental Security Income (SSI) level. This is the same financial standard that applies to 1915(c) HCBS waivers.
- However, states cannot target services on a geographic basis; services provided under 1915(i) programs must be available in all parts of the state. In contrast, 1915(c) waivers allow states to focus services in the areas of highest need.

It is too early to tell how states will respond to these changes. However, the act seems to blur the lines between 1915(c) waivers and regular state Medicaid programs, which could potentially pave the way for New Hampshire and Grafton County to expand HCBS without applying for waivers.

3.3 The issue of moral hazard

A principal reason for the historical focus on nursing homes in Medicaid is the issue of moral hazard. The term "moral hazard" refers to overuse of a good or service by people who do not pay its full cost, or who do not require the good or service to be provided by the public. In the context of publicly funded HCBS, the concern stems from the fact that long-term care in the home has traditionally been provided by unpaid family members and friends.

If Medicaid covers HCBS, then people may claim Medicaid benefits for services they would otherwise have received from family and/or friends for free. In other words, the Medicaid-financed HCBS might not be "replacing" nursing home care, but replacing family-provided care. This situation would cause Medicaid spending to rise even if HCBS were more efficient than institutional care because of an increase in the number of total participants. Therefore, Medicaid long-term care services have historically been strictly limited to those eligible for institutional care.[13]

Under 1915(c) waivers and other HCBS programs, it is very difficult to prevent all moral hazard, and some studies have shown an increase in costs after a shift toward HCBS for this reason, as we address later in this report. Moral hazard is one of the most important issues facing HCBS as an alternative to institutional care.

3.4 Long-term care funding in New Hampshire

New Hampshire is currently undergoing a shift from institutionalized care to HCBS. This shift provides the opportunity for New Hampshire to reduce its Medicaid costs, and paves the way for other changes that could further decrease long-term care costs on the state's Medicaid budget.

At present the Choices for Independence (CFI) program is the primary mode of HCBS provision in New Hampshire. CFI is a "Medicaid-funded program that supports choices for adults who meet both financial and medical requirements."[14] Individuals who are eligible for Medicaid-funded institutional care have the option, through 1915(c) waivers, to put their Medicaid funds toward either HCBS or institutional care. The New

Hampshire Department of Health and Human Services uses a screening program run by the Bureau of Adult and Elderly Services to determine eligibility. CFI then offers eligible applicants services that range from basic in-home care and meal services, to nursing home and HCBS. However, Medicaid does not cover emergency services.[15]

3.4.1 Powers of Grafton County vis-à-vis New Hampshire

The state of New Hampshire has a great deal of flexibility in redesigning its Medicaid program. Grafton County operates a nursing home, which relies on Medicaid and Medicare funding, but does not have the latitude to change the state's Medicaid program or policy. Therefore, Grafton County's ability to shift its policy will depend largely on state initiatives. These facts, combined with the prominence of Medicaid as opposed to Medicare in financing long-term care, makes New Hampshire's Medicaid program the primary focus for Grafton County's attempts to save money via HCBS. While this funding/implementation disconnect complicates the county's efforts to shift to HCBS, the following sections demonstrate that some of the best practices for HCBS cost-savings occur at the implementation level.

4. STATE PROGRAMS MOVING TOWARD HCBS

Given that New Hampshire has decided to shift towards HCBS, our research begins with an analysis of HCBS programs adopted in other states, including funding process, implementation practices, and outcomes, with a particular eye toward cost-effectiveness vis-à-vis institutional care. This section considers three major state-level HCBS programs, two of which—PACE and the Arkansas Community Connector Program—may serve as good programs for New Hampshire and Grafton County to emulate.

4.1. Program of All Inclusive Care of the Elderly (PACE)

One growing trend in many states across the country is toward *managed and capitated* long-term care. For a long time, the main method of reimbursement for doctors through Medicaid has been on a fee-for-service basis. However, some states have tried to switch to a system where doctors are reimbursed a set amount per capita (hence, *capitation)* for providing care based on minimum requirements set by the state. The most common example of this type of system is the Program of All-Inclusive Care for the Elderly (PACE).

The first PACE program received Medicaid funding in 1990, and by 1996 the program was active in 15 states; today there are 29 states operating a total of 82 PACE programs.[16]

The main goal of the program is to take individuals who are eligible for both Medicaid and Medicare, and integrate the funding and provision of services from the two into one pooled system. Through 1915(b) and 1915(c) waivers, states can allow individuals to "buy into" the PACE program, and draw on funding from Medicare and Medicaid to provide HCBS. The goal of PACE is to limit health care expenditures by shifting away from the fee-for-service model, which tends to lead to ballooning costs.[17] PACE uses per-capita reimbursements and caps the money health care providers receive from individuals based on the available pool of Medicare and Medicaid funds.

The results of the program have been largely positive. A study by Chatterji et al., found that states that have implemented the PACE program have "effectively maintained frail elderly individuals in the community and demonstrated positive health and functional outcomes."[18] In addition, the capitated reimbursement system, while not lowering aggregate costs, has seen slightly slower growth in overall health expenditures compared to states that still rely on fee-for-service systems.[19]

4.2. Arizona Long Term Care System (ALTCS)

Another program that has received national interest is the Arizona Long-Term Care System (ALTCS). Instituted in 1989, the ALTCS retains the fee-for-service system.[20] In order to pool costs effectively, the state of Arizona mandates that *all individuals* who are receiving Medicaid enroll in the program.[21] By incorporating all individuals who receive Medicaid, Arizona can control its overall Medicaid costs for HCBS. Arizona is one of a few states that has chosen to make participation in its community-based care system mandatory, and has since served as an example for other programs such as the *Texas Star+ Plan*.[22]

The results of the ALTCS have been mixed. A study by Weissert et al., has found that the ALCTS led to "a substantial increase in the use of community-based care for the elderly, as well as savings on institutional care."[23] While these results are promising, the study also came across a substantial amount of anecdotal evidence from patients that care was substandard in nursing homes under the program.[24] This is not entirely surprising, however, as an enrollment mandate would dramatically increase the number of participants in long-term care, without necessarily increasing Medicaid receipts proportionately, because Medicaid expenditures are based on the level of services required by the patient. Thus, in redistributing its fixed amount of resources toward HCBS quickly, the stat may have caused a decline in the quality of care in nursing homes. Arizona continues to use this program today, and is now checking and trying to improve the quality of care in its nursing homes.

4.3. Arkansas Community Connector Program

As mentioned above (see section 2.3, "moral hazard"), transitioning to HCBS could increase overall costs unless services are limited to patients who would otherwise be institutionalized. Felix et al. (2011) undertook a study of the Arkansas Community Connector Program, which attempted to identify such patients in three "disadvantaged counties."[25] The Arkansas methodology appears to have effectively managed the moral hazard issue. Despite increasing the number of people enrolled in Medicaid, the Community Connector Program saved Arkansas Medicaid $2.619 million over three years.

The Community Connector Program placed community health workers in three Arkansas counties in the Mississippi Delta from 2005 to 2008 as a pilot initiative. These workers identified people eligible for Medicaid who had unmet long-term care needs. The workers helped the patients to enroll in Medicaid and obtain home- and community-based services. The study by Felix et al. compared a group of 919 participants in the Community Connector Program with 944 members of a control group. The control group consists of residents of nearby, demographically similar counties, and its members were identified via propensity score matching.

Felix et al. found that participants in the Community Connector Program saw slower increases in Medicaid costs over the three-year period. Over the three-year period average annual Medicaid costs for the participant group increased by $3,100, from $16,074 to $19,174, while costs for the control group increased by $4,665 from $15,559 to $20,224. The participant group also saw a $356 decline in average home health care costs, compared with an $825 increase for the control group—suggesting that the participant group remained healthier than even those members of the control group who did not end up in nursing homes.

5. ACADEMIC RESEARCH ON THE COSTS OF HOME-BASED VERSUS INSTITUTIONAL CARE

Although certain programs such as PACE and Arkansas Community Connector have yielded promising results for HCBS, the results of nationwide academic studies on the cost-effectiveness of HCBS are more equivocal. In this section we examine several statistical analyses done across many states.

5.1. Kaye et al. study: short-term costs, long-term savings

A study by Kaye et al., analyzing state Medicaid spending from 1995 to 2005 shows that

increased HCBS spending may initially increase per capita spending, but then lead to downward trends in both institutional and total per capita Medicaid spending, leading to long-term state savings.[26] The study broke states into four different categories, first differentiating into high- and low-HCBS spenders based on the proportion of their 2005 Long Term Care budget dedicated to HCBS. States that spent an above-median proportion were classified as high-HCBS states while states that spent a below-median proportion were classified as low-HCBS states. High-HCBS states were further divided into states whose per capita, inflation-adjusted HCBS spending more than doubled during the observation period (1995-2005). The authors classified these as expanding-HCBS states and the remainder as established-HCBS states.[27]

States with established HCBS programs originally had higher per capita total Medicaid costs and still had higher costs during the end of the observation period in 2005, but their costs had a downward trend while states with low per capita spending on HCBS saw a slight upward trend in costs. States that were expanding their home-based care between 1995 and 2005 were able to increase their HCBS spending to average more than that of those with established programs and still keep total expenditures on long-term care below that of those with low home and community-based spending despite an initial spike in costs.[28] Both states that expanded home and community-based spending for elderly and disabled residents to higher than median spending and those with established programs demonstrated decreasing or stabilizing per capita costs while those with lower than median home and community-based spending per capita saw increasing costs.

The study further shows that per capita spending on nursing home care decreased in states with high HCBS spending while per capita spending increased in states with low HCBS spending.

The study shows that while Medicaid program costs do vary based on other factors, for example states with established HCBS programs tended to spend more per capita on other Medicaid services, increasing the proportion of HCBS spending for the elderly and those with physical disabilities often leads to downward trends in per capita spending.[29]

5.2. Amaral (2010) and Kitchener et al. (2006): conflicting findings

Amaral (2010) and Kitchener et al. (2006) conducted similar studies based on CMS Form 32 reports, which detail Medicaid spending and participation. These reports consist of four sections for each waiver:

- Number of participants and expenditures
- The “level” of institutional care in question (nursing home, care for the mentally/developmentally disabled, or hospital care)

- Demonstration of Medicaid cost neutrality between the waiver program and institutional care
- The target group of the waiver (children, mentally disabled, HIV/AIDS, or aged and disabled); these studies mainly investigated the aged/disabled portion of long-term care.

5.2.1. Amaral study: no substantial savings

Michelle Amaral (2010) studied the 1915(c) waiver program nationwide, using CMS Form 32 and Form 64 reports from forty-seven states between 1992 and 2000. She found no evidence of cost shifting from institutional care to HCBS under the waiver program, implying that the waiver program is simply using resources that would not otherwise be allocated to nursing homes and is therefore making Medicaid more expensive.[30] Amaral models per-participant Medicaid expenditures as a function of the number of waiver participants. The observations in her regression model are states, not individual waiver programs; each state may have many 1915(c) waivers, but she aggregates the spending and number of participants. Amaral uses fixed effects for both the state and the year (1992 through 2000) in order to separate out the variation in spending attributable to the number of waiver participants. She also controls for a number of variables, including the supply of nursing home beds, the unemployment rate, the employment growth rate, and dummies for the state's participation in various welfare programs.[31]

Amaral estimates the effect of an additional HCBS waiver participant on four different categories of Medicaid spending—HCBS waiver, institutional, home health, and pharmaceutical—in addition to the impact on total Medicaid spending. By "home health" spending, Amaral means spending on home health services *not* covered by the waiver. She notes that the impact on HCBS waiver spending and home health spending is almost certain to be positive, but the impact on institutional, pharmaceutical, and total spending is unclear.

In her basic regression, Amaral finds that an additional waiver participant is associated with $14,523.25 of additional institutional spending and $54,591.00 of additional Medicaid spending overall. This is the basis for her claim that there is no "cost-shifting" away from institutional care toward HCBS—in fact, institutional spending goes up, not down.

Amaral's results are inconsistent with the results of the pilot Community Connector program in Arkansas, suggesting that Arkansas' method of using "community health workers" was more effective than the strategies most states have used in implementing HCBS waivers.

5.2.2. Kitchener, et al. study: public savings from HCBS waivers

Martin Kitchener, et al. (2006) also used CMS Form 32 reports to compare the costs of HCBS and institutional care. They used 241 individual waiver programs as observations and analyzed only the 2002 reports, which were the most recently available at the time of writing.

The study attempts to compare institutional care and HCBS on three different metrics, all measures of *per-participant* expenditure:

- The spending on the specific program - i.e., either HCBS or institutional care.
- Total Medicaid costs - i.e., the program plus other Medicaid costs.
- "Total public expenditures"- i.e., Medicaid plus estimated room and board expenditures.

But, the phrase "total public expenditure" may be misleading; it does not refer to the actual total state budget. The estimates of room and board expenditures come from Supplemental Security Income (SSI) and State Supplemental Payments (SSP). It is necessary to include these payments as an equalizer because institutional care covers room and board while HCBS generally does not.

The study found that Medicaid HCBS waivers produced public savings of $43,947 per participant, on average across the nation. For those patients requiring a nursing home level of care - the main focus of this paper - the average savings were $15,489. They found that for a nursing facility level of care, the total per-participant Medicaid cost (i.e., the second metric in the list above) was $50,540 for institutional care, while the total per-participant Medicaid HCBS cost was $27,709, giving savings of $22,831. This figure is substantially less than the $43,947 overall figure because the other two "levels" of care—mental/developmental and hospital—are both more expensive than nursing homes. For the mental/developmental case, the annual cost of institutional care was $104,720 and of HCBS care was $39,795, producing savings of $64,925. For a hospital level of care, institutional cost was $213,077 and HCBS cost was $59,958, for savings of $153,119.

However, the methodology of this paper is suspect: it is valid only if HCBS patients have the same level of health care *needs* as institutional patients. In fact, long-term care institutions in general prefer to host higher-need patients, as they bring higher Medicaid reimbursements. Moreover, high-needs patients may be difficult or impossible to treat in a home-setting, leaving institutions with the higher-need population. If institutions do have a significantly higher-need, higher-cost, patient, on average, then many of the study's findings are questionable.

5.2.3. Comparison

While the Kitchener paper certainly suggests that HCBS waivers can be helpful in cost reduction, its methodology does not account for the systematically lower level of need among HCBS patients than institutional patients. If this were true, it would void their entire analysis, which they essentially admit in their discussion. While the investigators note that eligibility for HCBS waivers is restricted to those who have demonstrated need for the institutional level of care corresponding to the waiver, it is still possible that those who *actually* end up in nursing homes (or other institutions) have yet higher levels of need, and therefore are more expensive patients, for reasons already discussed.

In contrast, the Amaral study—which found no substantial savings—compared overall Medicaid expenditures by time period. Because of the way she uses the time-series component of her data, Amaral's results are valid even if institutional patients are on average sicker than HCBS patients—this does not affect her finding that increasing the number of HCBS waiver participants tends to increase per-participant Medicaid spending over time. Because Amaral uses fixed effects for individual states and years, her results cannot be ascribed to some states having healthier populations than others, or to a uniform upward trend in health spending.

Amaral's results provide warning for states, like New Hampshire, which are transitioning toward HCBS: without a well-designed HCBS program and consideration for the transition period, the state may well end up losing money. Her results are also consistent with the "moral hazard" issue described in Section 1 above—the increase in HCBS participants does not lead to a decrease in institutional costs. These results highlight the importance of programs like Arkansas's Community Connector, which successfully overcame this problem.

5.3. Other considerations

One consideration not addressed in the preceding studies is the impact of relaxing eligibility restrictions on Medicaid payments for nursing home stays. This will have two major effects. First, more people will become eligible for Medicaid coverage of their nursing home care. This will increase Medicaid's share of nursing home costs, but should not affect total nursing home utilization. Second, allowing individuals to qualify for Medicaid while retaining more of their assets for bequests will raise total demand for nursing home care while reducing the state's ability to seek reimbursement from their patients' estates.

Similarly, raising the amount that Medicaid pays for nursing home care can have two other effects. First, higher Medicaid reimbursement will raise Medicaid's share of

nursing home beds because Medicaid patients will become more profitable in comparison to non-Medicaid ones. Second, higher Medicaid reimbursement will make the marginal patient more profitable, so that nursing homes may raise their total number of patients.

Challenges exist for the delivery of home and community-based health care. One such problem is that there is no standard for reimbursement rates that states must implement for such services, leading to either artificially low rates that stop many providers from accepting Medicaid patients, or rates that are too high, and wind up costing states more money.[32] Another problem is that it often takes a state months to evaluate whether an individual meets the requirements and financial conditions for a particular level of care, and in that time the condition of the patient often deteriorates.[33] Lastly, there may be a fear of taking resources from nursing homes, especially among people with family members in these facilities, even if they may eventually change their minds once their loved ones have been moved back into the community.[34]

Very few studies have been conducted regarding the quality of care in waiver programs and residential care facilities in general. Anecdotal evidence, such as that found in the ALTCS study, is helpful, but future studies should focus on measuring the relationship between Medicaid payment rates and quality of care.

6. THE FUTURE OF LONG-TERM CARE IN GRAFTON COUNTY

Drawing upon the research just discussed, this section of the report will discuss how various implementation practices could affect Grafton County's Medicaid costs, as it redistributes its long-term care resources toward greater utilization of HCBS.

6.1. Opinions of policy makers and other experts

Grabowski et al. (2010) conducted the Commonwealth Fund Long-Term Care Opinion Leader Survey, a questionnaire distributed to 2,577 experts in the long-term care field, of whom 1,147 (44.5 percent) responded.[35] Respondents included care providers (in both nursing homes and other types of care), public officials, consumer advocates, academics and policy experts, and others. The purpose of this survey was to assess expert opinion on the future course of the long-term care system. It asked the respondents three main questions:

- Should the long-term care system be rebalanced?
- How can individuals make effective long-term care choices?
- How can policy makers provide support to informal and family caregivers?

The survey found that 83.8 percent of respondents supported rebalancing the long-term care system toward home-based care. The rate of support varied widely among different categories of respondents. Only 45.7 percent of nursing home providers supported rebalancing the long-term care system, while 80.1 percent of other providers, 88.5 percent of consultants, 90.5 percent of academics, and 92.0 percent of consumer advocates believed so.[36]

The third question is the most relevant to this paper, as it specifically addresses how a county such as Grafton can effectively support a shift to HCBS care. Note that the survey did not ask whether these measures were cost-effective, but simply whether or not they would effectively rebalance the long-term care system. These policy measures included "establish programs that offer comprehensive HCBS" (76.8 percent support), "expand HCBS eligibility under Medicaid" (76.5 percent), and "increased rate of reimbursement for HCBS" (67.1 percent).[37]

Interestingly, reducing the supply of nursing home beds elicited very little expert support, at 20.9 percent, despite being one of the measures New Hampshire has taken to promote HCBS. Political leaders in New Hampshire clearly support rebalancing the long-term care system, but their methods so far do not agree with experts' views on what is effective. Fortunately, New Hampshire's well-developed system of county nursing homes has a role to play in increasing the availability and affordability of HCBS.[38]

6.2. The role of nursing homes

There is mixed evidence about what will happen to the finances of current nursing homes as Grafton County shifts its focus towards HCBS care. In the Grabowski et al. (2010) survey, it is notable that only 45.7 percent of nursing home providers supported rebalancing the long-term care system, compared with over 80% in all other subgroups. This concern stems from the fear that there will be too much of a radical shift towards HCBS care, and that nursing homes will see their funding cut significantly, while still having to provide services to some of the sickest individuals. However, this result does not correspond with the views of Mr. Labore, the Grafton County Nursing Home administrator. In a February 22, 2012, interview, Mr. Labore revealed that expanding HCBS could be beneficial to the finances of nursing homes.[39]

As discussed previously, Grafton County is responsible for a large percentage of Medicaid long-term care costs, but the state of New Hampshire decides how Medicaid funding is distributed. The state Medicaid program reimburses each county nursing home at a rate based on an assessment of the *average level of care needed* by the nursing home's patients. For example, the state currently reimburses the Grafton County Nursing Home at $151 per patient per day. This Medicaid funding is the nursing home's main

source of income, although it also receives some payments from Medicare and from private insurance. The reason expanding HCBS can benefit nursing homes is because this expansion may lead to a rise in the reimbursement rate nursing homes receive from Medicaid. This phenomenon is discussed in the following section.

6.2.1. The nursing home paradox

A large portion of the academic research on HCBS focuses on overcoming the moral hazard issue, meaning the concern that people will use Medicaid-funded HCBS when they could be receiving the same services for free. Citing the moral hazard issue to justify a preference for institutional care implicitly assumes that nursing homes are not subject to the same problem, i.e., that everyone in a nursing home actually needs a nursing-home level of care. However, the interview with Mr. Labore suggested this assumption is false. In his opinion, a significant percentage of nursing home residents could be easily served by HCBS, but end up in nursing homes due to lack of availability of HCBS medical providers.[40] Meanwhile, the nursing home has limited ability to turn away patients based on need, because under state Medicaid rules, any person with less than $2,500 in assets is eligible for nursing home care.[41]

Essentially, the nursing home would receive more funding if its average incoming patient had a higher level of need, because the rate of reimbursement from state Medicaid funds would increase. Nursing homes' costs would not necessarily see a dramatic increase in this case because a large portion of their costs is fixed. The county could thus increase the overall efficiency of its long-term care system by allowing its nursing home to specialize for the patients in highest need and using HCBS for the majority of enrollees.

6.2.2. Integrating nursing home care and HCBS

Nursing home residents do not necessarily need stay in the institution permanently. Many elderly people move into a nursing home temporarily after an accident or an acute health problem, but move out again after the nursing home helps them recuperate. The Grafton County Nursing Home and other institutions therefore have access to names and medical information of people who have been institutionalized before and may be at risk. As the Arkansas study demonstrated, identifying such people ahead of time can result in large Medicaid savings.

According to Mr. Labore, nursing homes sometimes send employees to check on former patients and assess their need for HCBS. Assisting the county nursing home in providing such outreach is one opportunity for the county to improve the efficiency of the long-term care system.

6.3. Applying the academic research

This paper has identified several different practices for implementing HCBS, and has reviewed the academic literature on this policy, which has found mixed results. States have tried different ways to address many of the issues that lead to higher costs under current institutional based care, some addressing the moral hazard problems discussed above, others addressing the separation of Medicaid and Medicare costs, and others still addressing the fee-for-service system. Some programs have been able to provide evidence that costs can be decreased through a shift towards HCBS, and it should be the goal of Grafton County to find the successful pieces of these programs and try to learn from and/or adapt them for their own purposes.

The Community Connector Program in Arkansas offers a promising strategy to beat the moral hazard issue, and is relatively inexpensive. New Hampshire has great flexibility in allocating Medicaid funding and thus could create a similar program. While Grafton County health workers would play an important role in implementing the Arkansas model, the county is not able to create such a program on its own due to lack of control over Medicaid funding. However, the county could lobby the state legislature to create such a program by pointing out that in Arkansas, it saved the state money in the long run despite adding more people to the Medicaid rolls. Joining with leaders from other counties could help to persuade state-level leadership of the cost savings of such a model. As an alternative to a state-wide implementation, county officials might request funding for a pilot study in Grafton County to test the cost-effectiveness of such a program vis-à-vis a comparator, such as Carroll or Coos County.

The PACE program also provides an interesting way for Grafton County to address the rising costs associated with the fee-for-service system. By using 1915(b) waivers to pool Medicare and Medicaid services, and shifting to a capitated, managed reimbursement system, Grafton County could control its healthcare expenditures more easily. In addition, academic studies show that the PACE program has successfully maintained quality of service for individuals while still managing overall costs. Implementing the PACE program, or some variation of a managed, capitated care program would require greater coordination and cooperation between Medicaid and Medicare officials, as well as providers of institutional and HCBS care.

Grafton County can also look at the ALTCS program for an example of how instituting mandates to participate in HCBS programs could help reduce costs. While this example, along with the Texas Star+ Program can provide good outlines for how mandates can work, it is important to note that both of these programs are instituted on the state level. Adopting a program similar to this one in Grafton County may be very difficult, and any

attempt to emulate the ALTCS or Texas program may require a concerted effort by the entire state of New Hampshire.

4. CONCLUSION

In recent years, the state of New Hampshire, as well as Grafton County, has shown a strong initiative to move toward home- and community-based care. However, the moral hazard issue and the results of academic research show that the cost-effectiveness of this transition depends on the specific practices of program implementation and transition.

While policy transitions are always challenging, county governments in NH face an additional challenge because of their limited control of the Medicaid program despite high financial exposure. This report provides a series of case studies that focus on programs that have been implemented by other states across the nation, that could be adapted by Grafton County (with state support) or at the state level.

The Arkansas study, the PACE Program, and the ALTCS provide three distinct examples of practices by which Grafton County or NH policymakers could shift their services from institutional care towards HCBS. Each of these programs addresses a specific issue that is inherent in the old system of long-term care, either dealing with quality of service or cost of provision. By looking at the results of these programs outlined in the studies presented in this report, Grafton County can weigh the costs and benefits of various ideas to address the shift to HCBS in a cost-effective manner.

It is extremely difficult to prevent increases in demand for home health care as Grafton County switches towards a more HCBS-oriented system. However, procedures exist both to manage the per capita cost of individuals receiving care and to limit a massive influx of new patients who would not otherwise receive these services. Any program implemented in Grafton County should be closely monitored and evaluated regularly to ensure both financial success and quality of care.

Appendix I

States Currently Using or in the Process of Adopting PACE

State	PACE Program	Pre-Pace Program
AL	X	
AR	X	
CA	X	
CO	X	
FL	X	
IA	X	
IL		X
KS	X	
LA	X	
MA	X	
MD	X	
MI	X	
MO	X	
NJ	X	
NM	X	
NY	X	X
NC	X	
ND	X	
OH	X	
OK	X	
OR	X	
PA	X	X
RI	X	
SC	X	
TN	X	
TX	X	
VA	X	
VT	X	
WA	X	
WI	X	

Source: http://www.npaonline.org/website/download.asp?id=1741

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Appendix II

Services Provided by the New Hampshire Choices for Independence Program

Do You Need Help With

- dressing and bathing?
- preparing meals?
- managing medications?
- housekeeping?

If you answered "yes" to any of these questions, please contact ServiceLink because you may qualify for assistance. ServiceLink is a free information, referral and assistance service.

1-866-634-9412
(toll-free)
www.ServiceLink.org

Services Available

In-Home Services

Service	Description
Chore	Cleaning and maintenance tasks
In-home care	Meal preparation, light housekeeping, etc.
Home delivered meals	Delivery of nutritional meals
Home health	Services provided by a nurse or licensed nurse's aide
Homemaker	Provides general household services
Personal care	Help with eating, dressing, etc. (at home or at work)
Personal emergency response	Portable emergency help button

Housing Options

Service	Description
Adult family care	Services provided in a family home setting
Residential care	Supervised group living arrangement
Shared housing	Your caregiver lives with you in your home

Specialized Services

Service	Description
Assistive technology	Consultation about available personal equipment
Case management	Provides assistance in planning and coordinating services
Community transition	Assistance for individuals leaving institutional care
Environmental accessibility	Home adaptations such as grab-bars and widening doorways
Medical day services	Day-time program of social and health services provided in a group setting
Respite care	Short-term care when usual caregiver is unavailable
Specialized medical equipment	Devices and supplies to support independence
Supportive housing	In-home services available in certain public housing settings

Source: http://www.dhhs.nh.gov/dcbcs/beas/documents/cfi.pdf

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