# Five Good Reasons Why States Shouldn't Cut Home- and Community-Based Services in Medicaid

Families USA • July 2010

States are facing tough economic times. As they confront budget shortfalls, many states are looking to cut Medicaid benefits, including home- and community-based services (HCBS). Home- and community-based services are vital to helping seniors and people with disabilities stay in their communities and out of institutions.[1] If home- and community-based services cuts are on the table in your state, you can use these arguments to fight those cuts.

## 1 Cutting home- and community-based services can cost the state more in the long run.

- **Home- and community-based care costs less than institutional care**. On average, home- and community-based care costs one-fifth as much per person per year as nursing home care. In addition, average costs for home- and community-based services are rising at a slower pace than costs for institutional care.
- **Cutting home- and community-based services can increase the use of more costly institutional care**. Higher state spending on home- and community-based services reduces the use of institutional care among childless seniors.[2]
- **States that spend more on home- and community-based services see a decrease in Medicaid long-term care spending over time**. A 2009 study of Medicaid long-term care spending found that, over a 10-year period, states that offered few Medicaid home- and community-based service options experienced an average increase of nearly 9 percent in Medicaid long-term care spending, while states with well-established home- and community-based care programs saw an 8 percent reduction in spending.

## 2 Cutting home- and community-based services can be bad for state economies.

- **Cutting home- and community-based services can reduce or eliminate jobs and hurt economic growth.** Medicaid brings new money into states in the form of federal matching dollars. These new dollars create jobs and stimulate economic growth. Cuts to home- and community-based services reduce the amount of federal matching dollars that states receive, resulting in lost jobs and reduced business activity.

# 3 Cutting home- and community-based services increases the burden on informal caregivers, which has implications for U.S. businesses and state economies.

- **Demands on caregivers already affect their financial stability and health**. Over the course of a year, it is estimated that more than 50 million people nationwide provide informal care to those who need long-term services. They are vital sources of support for people needing care and a critical supplement to existing care delivery systems. These informal caregivers—mostly family members and friends of those who require long-term care—often risk their own financial stability and health in performing caregiving functions. The typical family caregiver, who already has a job, loses approximately $110 per day in wages and health benefits due to caregiving responsibilities. More than one-third of caregivers cut back on household spending, one-third limit their work hours, and approximately one-quarter postpone personal medical care.
- **Cutting home- and community-based services increases the burden on caregivers.** Medicaid home- and community-based services such as adult day care can provide essential support to caregivers and give them an opportunity for respite. These services can also reduce caregivers' stress and help them to participate more fully in the workforce. Cutting home- and community-based services takes away valuable support for informal caregivers and increases their medical, emotional, and financial stress, which can negatively affect state economies.
- **The demands of caregiving cost U.S. businesses billions annually.** The workplace accommodations that caregivers must make, such as reducing hours or taking unpaid leave, affect businesses as well. Costs to employers include increased absenteeism, workday interruptions, reduced employee hours, reduced productivity, and costs associated with replacing workers who leave the workforce because of caregiving responsibilities. Businesses lose an estimated $33.6 billion annually because of the demands that caregiving places on full-time employees.
- **The burden on caregivers also has implications for state economies**. Demands of caregiving affect caregivers themselves, the businesses they work for, and, in turn, state economies. Economic activity is reduced because caregivers earn and spend less, and their medical costs end up being higher because they postpone their own medical care until their health problems are more advanced and more expensive to treat. Lost business productivity affects business receipts and, ultimately, state revenue.

## 4 Cutting home- and community-based services runs counter to consumer preferences.

- **Most consumers who need long-term care prefer to remain in their homes or in the community**. About 80 percent of people needing long-term services would prefer community-based care over institutional care.
- **States can both serve their residents better and save money by shifting their service focus to home- and community-based care**. States that have actively shifted their long-term care delivery from institutional to home- and community-based care have not only given their residents better choices, they have also been able to serve more people at lower overall cost. For example, during the 1980s, Oregon was able to save more than $100 million (in 2010 dollars) in the first years of an aggressive effort to reduce nursing home admissions and expand home- and community-based services in Medicaid. Since Oregon's efforts started, the state has saved more than $550 million total (in 2010 dollars) and expanded services to an additional 37,000 residents.[3]

## 5 Cutting home- and community-based services may violate the Supreme Court's *Olmstead* decision.

- **States must have a plan for placing individuals with disabilities in the least restrictive care setting.** In the 1999 case *Olmstead v. L.C.*, the Supreme Court held that unjustified institutionalization of people with disabilities who were able to function in the community constituted a form of discrimination that violates the Americans with Disabilities Act (ADA). To comply with *Olmstead,* states must have a working plan for placing individuals in the least restrictive setting that is appropriate to their needs.
- **Recent court cases challenge state cuts to home- and community-based services that violate *Olmstead***. The Obama Administration is taking action to enforce *Olmstead.* As part of its enforcement activities, the Department of Justice has recently filed briefs in several cases arguing that state reductions in home- and community-based services or failure to provide sufficient home- and community-based services violate *Olmstead* and the Americans with Disabilities Act because they place individuals at risk of institutionalization.[4]
- **Patients and their advocates can challenge state home- and community-based services cuts based on *Olmstead***. Final decisions have not yet been reached in the cases noted above. However, when cuts in home- and community-based services limit services to the point that individuals are placed at risk of institutionalization, patients and their representatives can argue that the cuts may constitute an *Olmstead* violation and could consider a court challenge.

## Conclusion

State cuts to home- and community-based services in Medicaid can be shortsighted. While they might produce some short-term cost savings, those savings can result in higher costs to states in the long term, including increased use of higher-cost institutional care, lost caregiver wages and the associated negative economic effects, and lost Medicaid matching funds. In addition to being a bad idea from an economic perspective, cuts are contrary to the wishes of the majority of constituents who need these services, and, in addition, they may violate the Supreme Court's *Olmstead* decision.

There are better options for states. Among them is the option to expand home- and community-based services through new opportunities that are available in health reform. These include improvements to the Medicaid state plan option for home- and community-based services (section 1915(i) of the Social Security Act) as well as two new programs that will start in October 2011.[5] The new programs, the Community First Choice Option and the State Balancing Incentives Payments Program, include added federal matching dollars to help states expand home- and community-based services. (For more information on these programs, see Families USA's publication, Helping People with Long-Term Care Needs: Improving Access to Home- and Community-Based Services in Medicaid, available online at http://www.familiesusa.org/assets/pdfs/health-reform/help-with-long-term-health-needs.pdf.)

Rather than cutting home- and community-based care programs, states should maintain their current programs and explore health reform's new options to expand home- and community-based care. This could save money in the long term, provide economic benefits, and better serve state residents.

# Endnotes

[1] Both the American Recovery and Reinvestment Act of 2009 (ARRA) and the health reform legislation passed in March 2010 (the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010) include a maintenance of effort requirement for state Medicaid programs. This requirement protects access to Medicaid for millions who rely on the program. However, states can still reduce services and provider payments. For more information on the maintenance of effort requirement, see Families USA's fact sheet, *Maintenance of Effort Requirements under Health Reform* (Washington: Families USA, March 2010), available online at http://www.familiesusa.org/assets/pdfs/health-reform/maintenance-of-effort.pdf.

[2] A study of nursing home admissions from 1995 through 2002 found that higher state home- and community-based services expenditures were linked to lower nursing home admissions among childless seniors. States that doubled their home- and community-based services expenditures reduced nursing home admissions in this population by 35 percent. The study was based on nearly 250,000 person-months of survey data of people born after 1923 regarding their use of long-term services.

[3] Budget and caseload data prepared by staff of the Oregon Senior and Disabled Services Division, Department of Human Services, Salem, Oregon, 1995. Savings are calculated based on the program savings offset by start up spending from 1981 to 1987, adjusted to 2010 dollars using the Department of Labor Bureau of Labor Statistics CPI inflation calculator, available online at http://data.bls.gov/cgi-bin/cpicalc.pl.

[4] Cases filed by the Department of Justice include Oster v. Wagner, filed in the 9th Circuit Court of Appeals on March 2, 2010, brief available online at http://www.ada.gov/briefs/oster_amicusbr.pdf; *Ligas, et al. v. Miram*, et al., filed in the U.S. District Court for the Northern District of Illinois, Eastern Division, on January 26, 2010, brief available online at http://www.ada.gov/briefs/Ligas_soi_br_%201_26.pdf; and *Haddad v. Arnold*, filed in U.S. District Court for the Middle District of Florida, Jacksonville Division, on May 25, 2010, brief available online at http://www.ada.gov/briefs/interest_Haddad_br.pdf. The District Court ruled on the Haddad case in June 2010. A U.S. District Court in Jacksonville declared that the Florida could not first require a person to have a nursing home admission as a pre-requisite to receiving HCBS through Medicaid. A brief write-up of the decision is available online at Disability.gov, the Administration's information website on ADA enforcement actions, and services available for people with disabilities, http://www.disability.gov/civil_rights/enforcement_actions.

[5] Section 533 of the Patient Protection and Affordable Care Act includes improvements to the state plan option for home- and community-based services, 1915(i). Among the changes to 1915(i), states are given more flexibility in the services they can offer through the 1915(i) option. The changes to 1915(i) also give states the ability to extend full Medicaid eligibility to individuals with incomes up to 150 percent of the federal poverty level ($16,245 per year for an individual in 2010) who meet 1915(i) clinical eligibility criteria.

*Additional resource information is available online at http://www.familiesusa.org/long-term-care/publications/Five-Good-Reasons-Resources.pdf.*

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