Costs and Benefits of Home and Community Based Services: Relevance to IHSS

Presentation to:

BASSC County Directors & University Members

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by

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Parameters of Literature Review

- Wide Audience: BASSC Directors and Adult Services Directors, State policy makers, students, others?

- Purpose:
  - Explain IHSS
  - Examine Benefits & Costs of HCBS Programs
  - Explore Other State and International Models
  - Relate Key Findings to Recommendations for IHSS

Premise Items

- Historic pressure on systems to respond to demographic shifts and increased need
- Facility-based care is both financially and socially more costly than home or community based care for most populations
- Reducing home-based care services poses significant burden to families and informal caregiver's ability to earn a living
- Solution must be a combination of federal, state and local resources giving flexibility to address needs of diverse communities (geographic-rural/urban, cultural, availability of workforce, etc.)

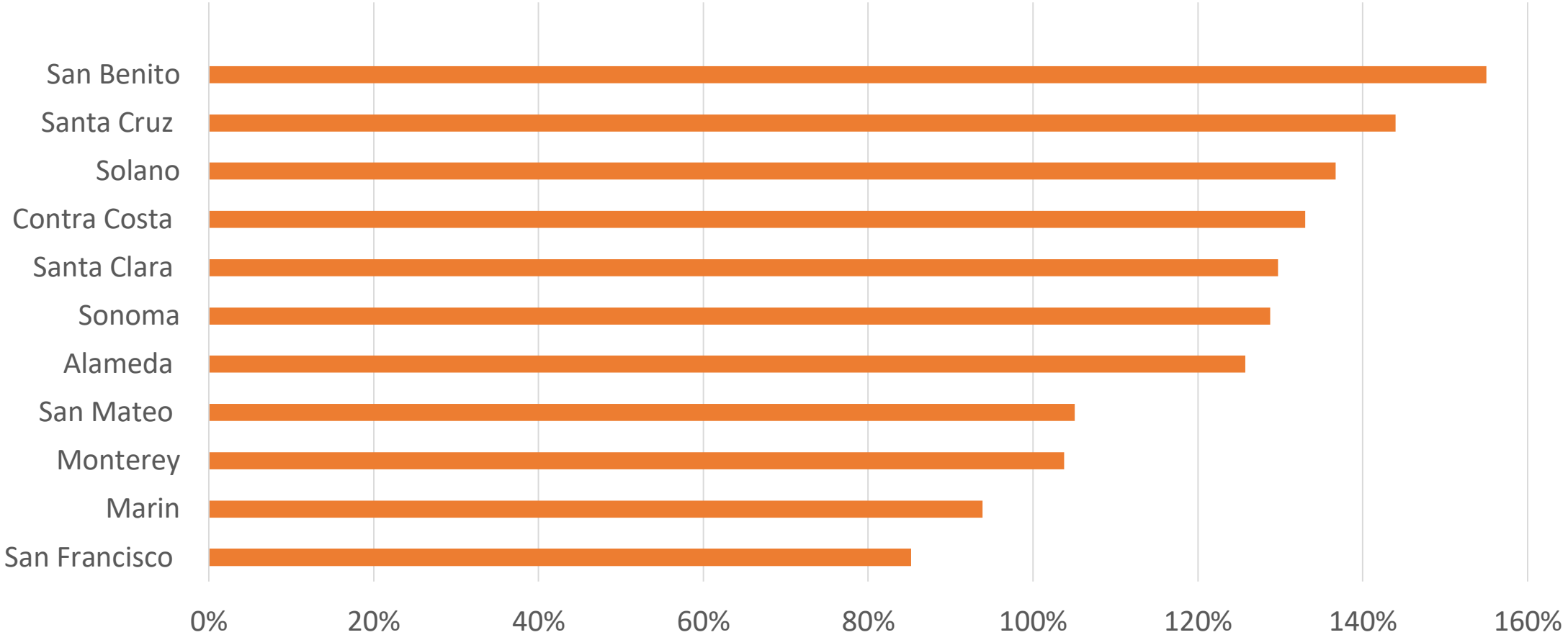
Roles for this Presentation

- Ours …… Information Synthesizers:
  - Summarize the literature on current state of IHSS, benefits and costs, and review other models

- Yours …… Experts:
  - Review the key findings and recommendations
  - Discuss next steps

Demographic Changes & Projections

BASSC County Projected Population 65+ Growth 2010-2030

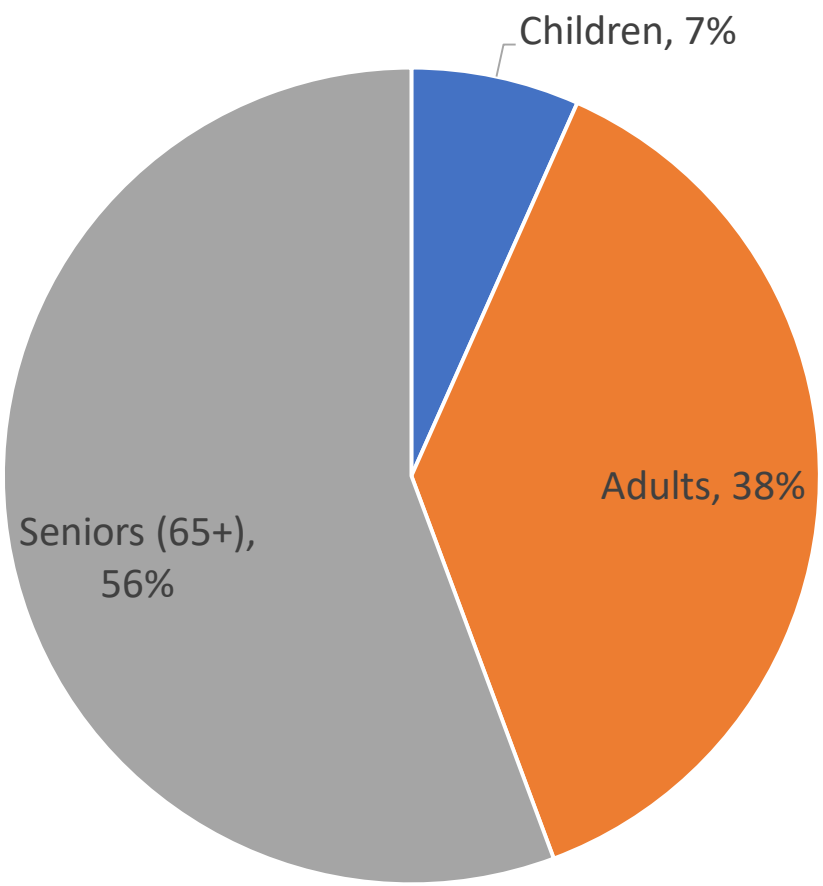


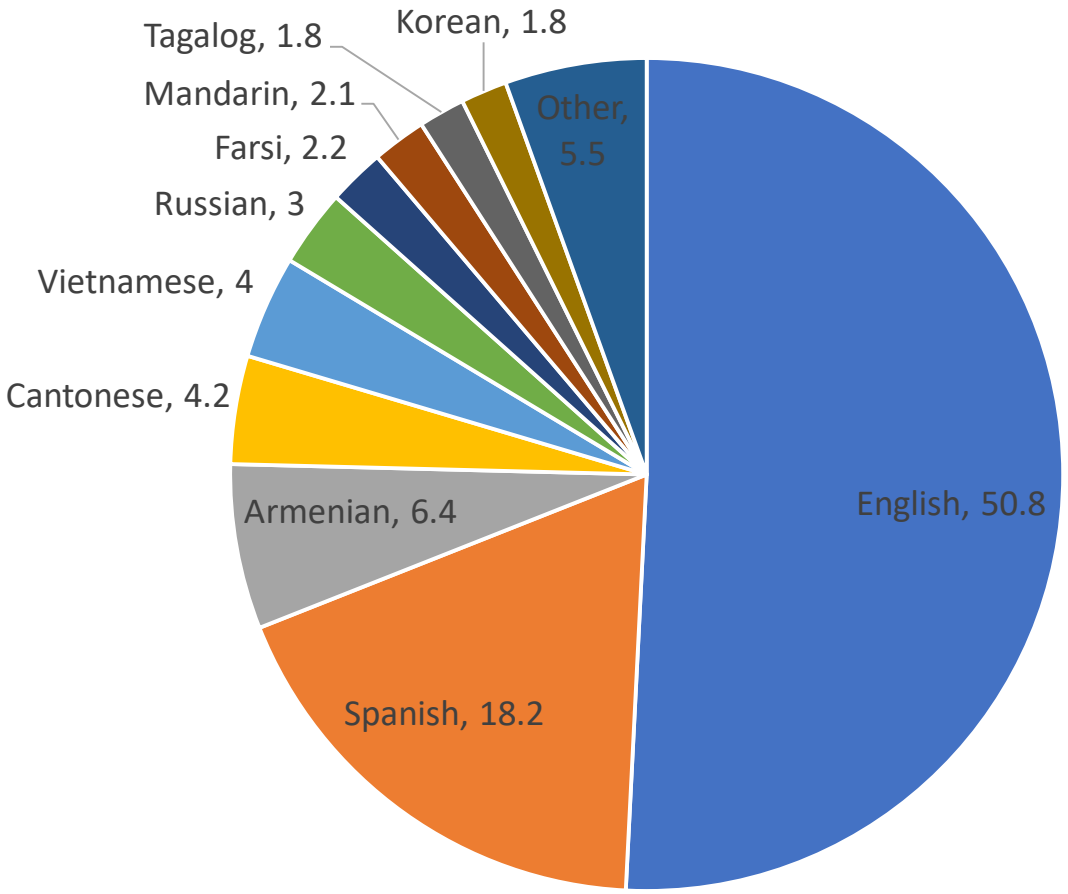
Retirement (in)security projections (2035)

- Largest population growth will be in economically vulnerable populations who have the least resources in retirement: Latinx and Asian populations, women, and people 80+
- In general, people of color reach retirement with significantly less wealth than white households
- Women are a larger share of the older senior population and tend to accumulate less retirement wealth than men because of lower wages and careers shortened by caregiving
- Most seniors will be on fixed incomes and limited income.
  - Currently:
    - 57% of 65+ depend on Social Security / SSI for 80% or more of their income
    - 44% of California seniors over 60 have any type of retirement income; median amount is $16K annually

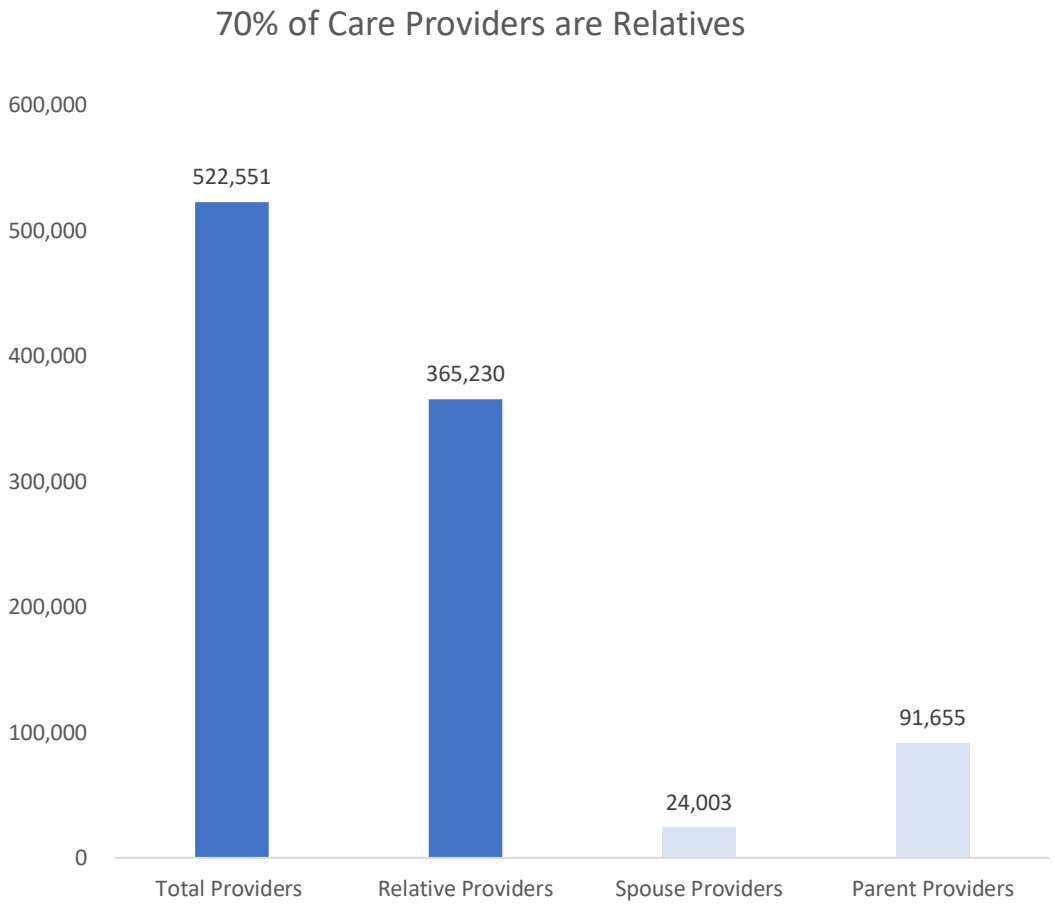
IHSS Recipients

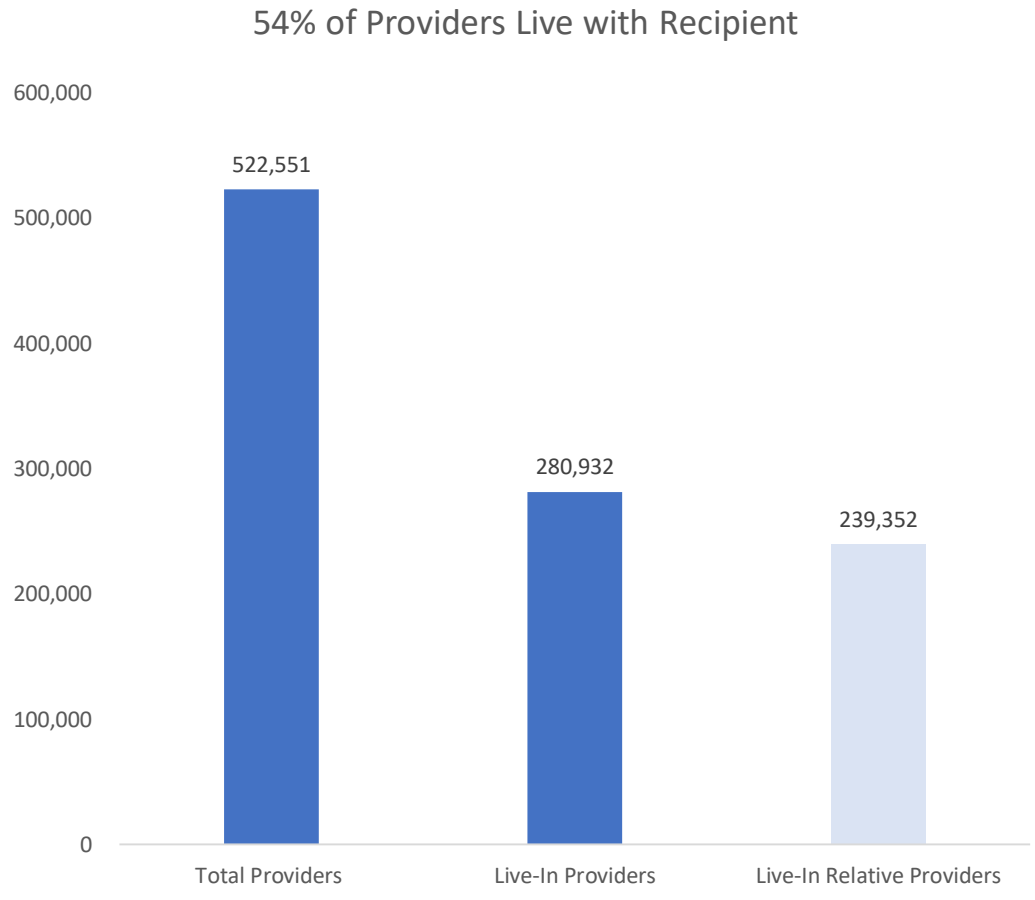
- In FY 2017/18, IHSS served approximately 565,000 Californians.





Description of Care Providers





Key Finding – Demographic Shifts

- The aging population is growing and a growing segment of the over 65 population in California will be single, childless, and low income with little retirement savings.
- Childlessness is a strong predictor of nursing home use and institutionalization is untenable because of cost, limited infrastructure, and quality of life issues.
- Currently only 30% of IHSS providers are non-relatives.
- **Given the demographic shifts, there will be a greater need for non-relative care providers**

Recommendation – Demographic Shifts

- *Significant steps are needed to prepare a trained workforce to the meet the care needs of this growing population to ensure uniform high quality care and low turnover.*
- *This will require training infrastructure, as well as, appropriate compensation and incentives to the workforce.*
- *Strengthening the Public Authority and considering the expanded use of Contract Mode within counties should be part of this process.*

What are the Benefits?

IHSS Benefits to Recipients & Providers

- Honors Primacy of Family Relationships
- Social and Emotional Health
    - The feeling of being in control over one's life is considered essential to the quality of life
    - Quality of life is improved by maintenance of existing social relationships and greater autonomy over decision making
    - Aging in place (in the home) provides for continuity of living environment and social relationships
- Physical Health
    - Increases physical well being and mitigates risk due to issues with hygiene, nutrition, dehydration, falls, and medication management
    - When relative is an IHSS provider, the average monthly Medicaid costs found to be lower
- Potential for Greater Financial and Housing Stability
    - Informal caregiving is a women's issue

Benefits to the System

- IHSS provider income is reinvested in the local economy; 85% of IHSS funding goes to wages, and “low-income workers spend a greater share of their income locally, and create more jobs, than do high-income residents.”
- Providing care is less expensive especially for certain growing populations; the odds of using nursing home services increased by 48% for older women with no children
- Formalizing care provision for family members can delay institutionalization
  - Burnout can result in “near total substitution of paid for unpaid family care” via entry to a nursing home
  - Family members who experience less abrupt entries into their caregiving roles are more likely to delay nursing home placement as well as indicate decreases in emotional distress and depression
- Fears that compensating informal caregiving lead to “crowding out” of existing care and drive up costs were not supported; it appears to encourage and sustain the continuation of existing caregiving for longer periods with greater levels of satisfaction
- HCBS can reduce further medical and ED costs by lowering readmission rates following hospitalization.
- The lowest rates of avoidable hospital admissions among those HCBS recipients with a SNF classification are in states with less restrictive eligibility requirements and higher percentage of spending on HCBS.

Key Finding - Benefits

- Formalizing informal care, particularly care provided by relative and spouse caregivers, can improve the caregiving experience and prevent institutionalization in some instances.
- Studies of IHSS found that recipients report greater satisfaction and caregivers report greater incentives to continue care.
- Research has found that high levels of burnout among unpaid caregivers may result in the “near total substitution of paid for unpaid care” via entry to a nursing home.

Recommendation - Benefits

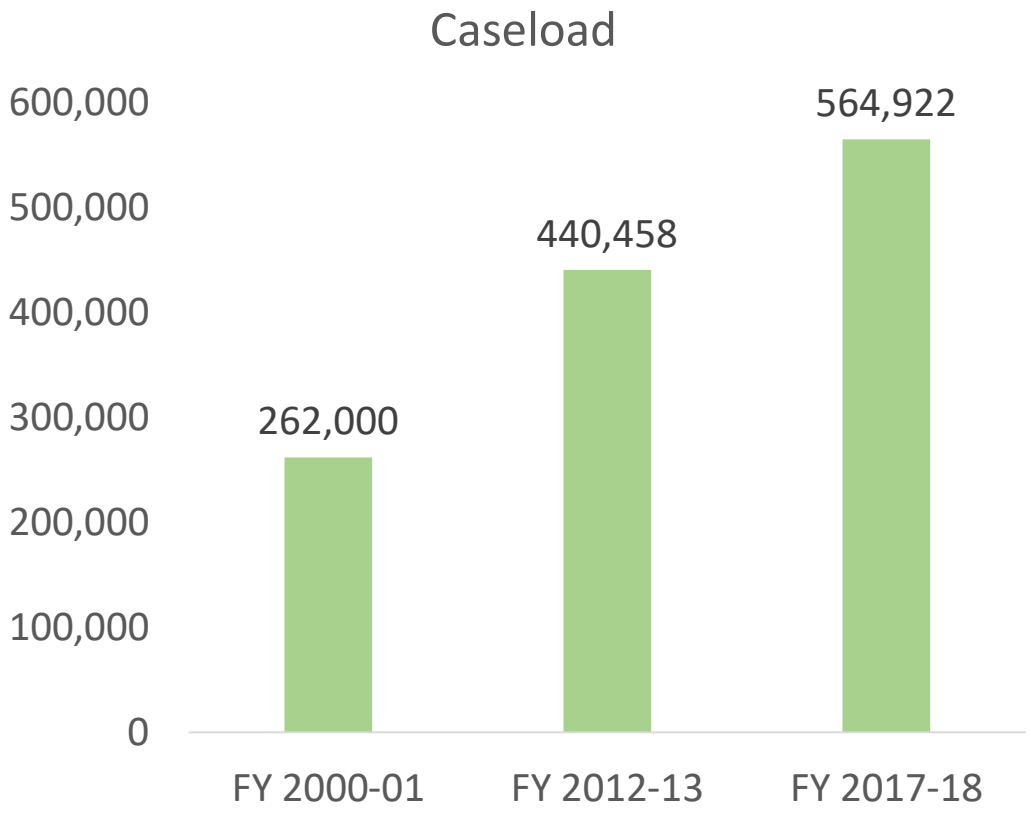
- *Any approach to meet the needs of CA's growing elder population must take into account: professionalizing unpaid labor within existing family units and preparing a new field of caregivers to address the needs of the growing population for whom care from a family member is not an option.*
- *There needs to be more research specific to IHSS populations in California. Conduct a retrospective cost/benefit analysis of IHSS implementation in BASSC counties to understand the trajectory including no care, informal care, formal care, and institutional care.*

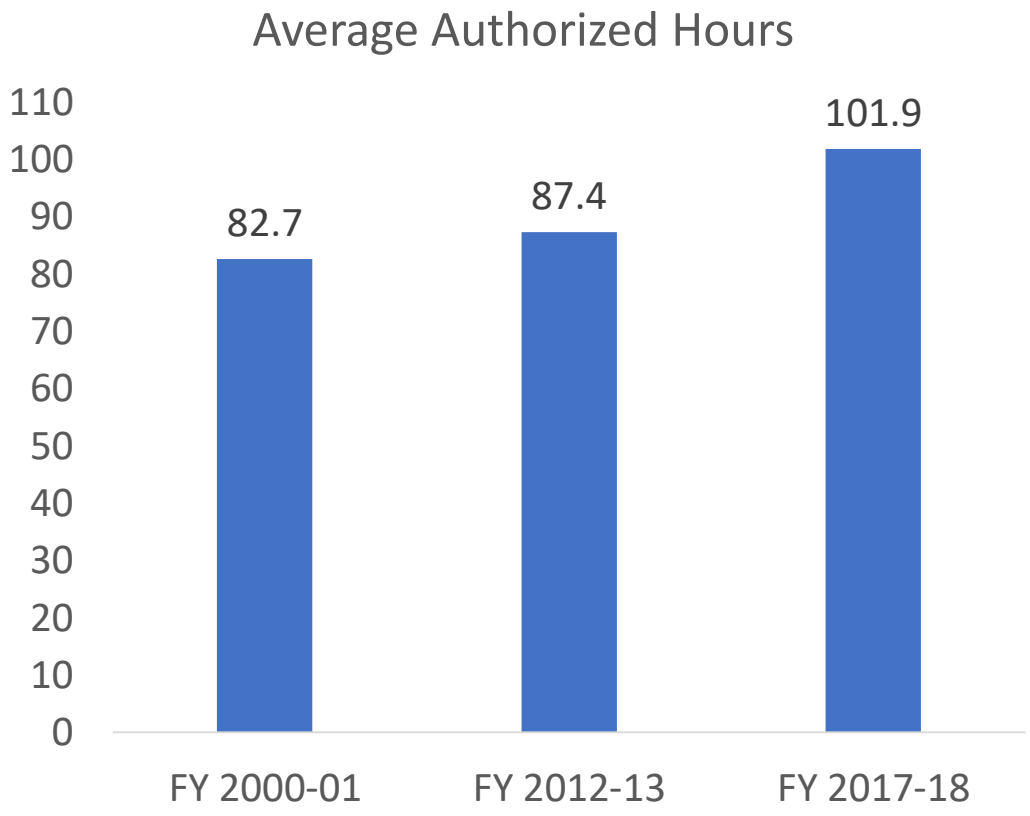
What are the Costs?

IHSS State Costs

- IHSS cost approximately $10.6 billion in 2017-2018, with about $3.1 billion from the state general fund
  - Effective federal reimbursement rate is est. 54%
  - Cost per individual $10.6 billion/565,000 = $18,761

IHSS Caseload & Hours





IHSS Projected Growth Rate

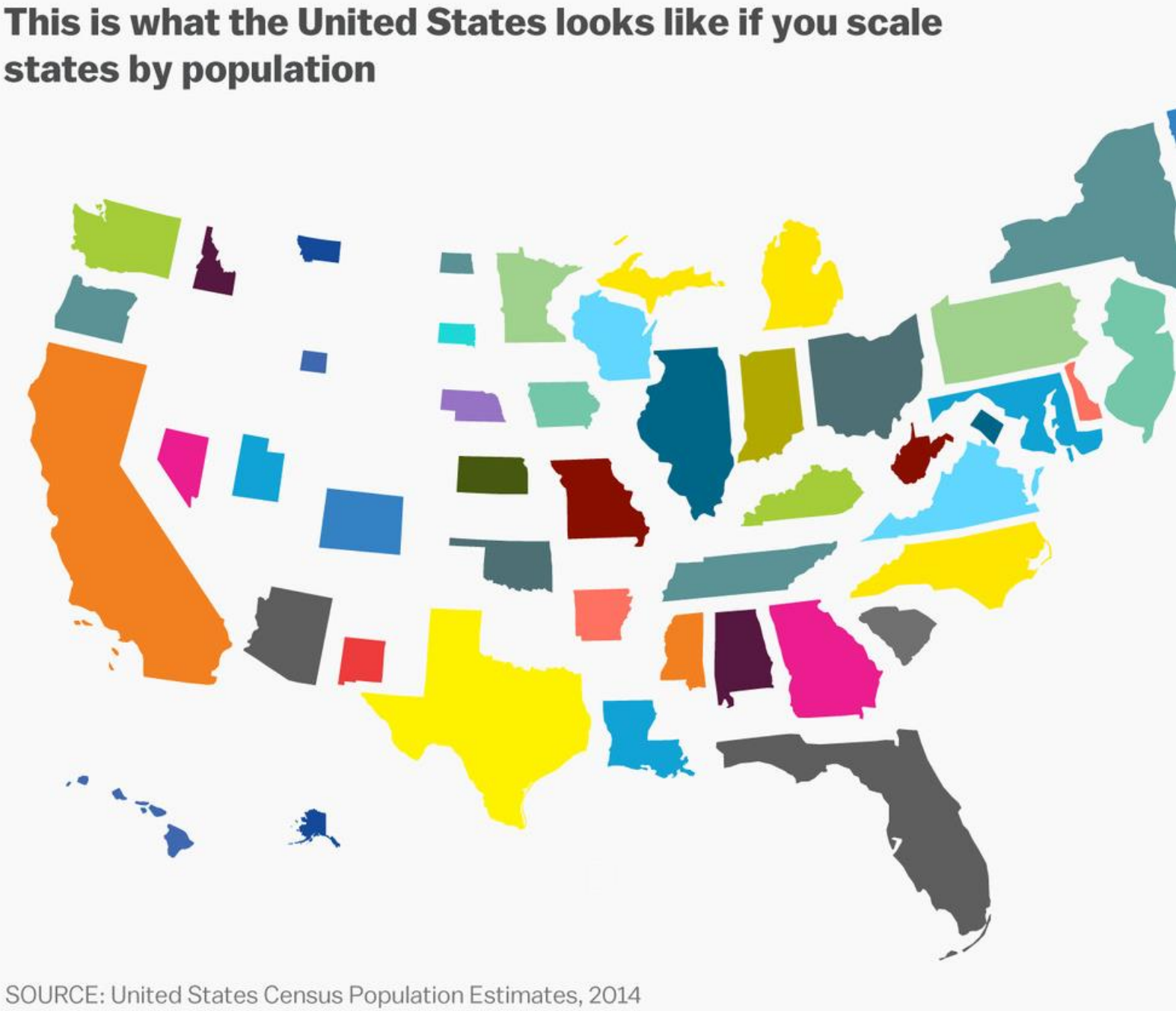
- According to the LAO, between FY 2018-19 and 2022-23:
  - "The projected average annual growth of IHSS General Fund expenditures is about 11 percent—making IHSS one of the fastest growing programs in the state."
  - Projected growth is mainly due to:
    - Caseload growth
    - Increase in hours per recipient
    - FLSA implementation of overtime rules
    - Minimum wage increases

Current Policy Context

- Coordinated Care Initiative (CCI) pilot
  - Move toward managed and coordinated care of MediCal & Medicare “dual eligible”
  - Did not reduce State General Fund contribution as hoped
    - Enrolled relatively few consumers
    - IHSS not fully integrated
    - Cost Shift - capped County contribution at 2012 levels thereby State costs increased at higher rate
- Governor’s “Master Plan for Aging”
    - “it must address: person-centered care, the patchwork of public services, social isolation, bed-locked seniors in need of transportation, the nursing shortage, and demand for In-Home Supportive Service that far outpaces its capacity”

Other Models

Nationally



Cost Efficiency Comparison Across States

- Using data prior to 2007, Chattopadhyay, et al. (2013) analyzed the cost effectiveness of LTC programs funded by Medicaid in all states.
- Findings:
  - California ranked among one of the least cost-efficient states
  - States that only used HCBS for SNF eligible individuals tended to be most cost efficient.
  - States with large HBCS programs had the lowest cost effectiveness rates… possibly due to administrative waste undercutting cost efficiency
  - Only two states ranked less cost effective … NY & PA
  - Highly efficient states included: WY, VT, SD, NV, MT, ID, UT, DE, HI, AK, ND, DC

Key Finding – MediCaid HCBS Spending

- While Medicaid HCBS spending continues to grow, significant differences between States in eligibility requirements, waiting lists, and program services make it difficult to draw broad conclusions about HCBS. There is some indication that states that have stringent eligibility criteria and are targeted geographically leads to improved cost efficiency, however the data used is more than 10 years old.

Recommendation – MediCaid HCBS Spending

- *Targeting populations by geography and separating care needs among different populations could improve cost-efficiency.*
- *This would also allow for more specific reforms to be tailored to the diverse populations within each program (e.g. children, dual-eligibles, those requiring a SNF level of care).*
- *1915(c) waiver is one mechanism that allows flexibility and jurisdiction-specific solutions.*
- *More research is needed at the individual level to better understand the quality of care and the populations who are being served, with a specific focus on the 1915(c) waiver programs with IHSS populations in California.*

Common Strategies Across States to Reduce Costs

- Separating HCBS populations into separate programs, i.e. separating the over 65 from the developmentally disabled or blind population under 65 (including children)
- Utilizing managed care
- Capping enrollment at a certain caseload
- Limiting eligibility to those with an institutional / SNF classification
- Offering cash-based programs (e.g. Cash & Counseling)

Comparison Across Selected States

State	Cost Efficiency Score	AARP LTSS Ranking	% of Medicaid and state-funded LTSS going to HCBS for the elderly and adults with disabilities	% of new Medicaid beneficiaries first receiving care in the home	# of 1915(c) waivers	# of 1915(c) waiver participants	Adopted CFC in state Medicaid Plan?	# in nursing home / occupancy rate	Est annual NH Medicaid cost	Est cost of HCBS program
CA	Very Low	#9	58.4%	74.6%	8	146,200	Yes	101,030 (85%)	$50,000	$12,000
CO	Moderate	#8	54.4%	66.4%	11	45,900	No	16,078 (78%)	$41,819	$26,319
HI	High	#7	26.5%	43.8%	1	2,800	No	3,474 (85%)	n/a	n/a
MN	Very Low	#2	68.5%	83.6%	5	76,900	Yes	24,755 (86%)	n/a	n/a
WY	High (#1)	#25	37.2%	37.2%	5	5,200	No	2,428 (82%)	$48,000	$2,241

The PACE Model

- Operates 72 Centers in 31 states
  - “PACE organizations create health care delivery systems that address the unmet needs of a medically complex, functionally impaired, low-income and historically underserved population.”
  - PACE is both a direct care provider and a managed care plan: serves 8,800 via 47 care centers and alternative care sites in 14 counties
  - Eligible patients must be over 55, require a state-certified SNF level of care, and be able to live within the community safely
- Benefits:
  - Saves money compared to SNF (costs 20-30% less)
  - Lower readmission rates after hospitalization: readmissions within 30 days are half the Medicare average
  - Though PACE serves an exclusively frail population, acute care utilization is comparable to the overall Medicare population
- Limitations:
  - Restrictive eligibility requirements
  - Up front capital costs to start and expand a PACE center
  - State and federal regulations
  - Unintended conflict with County Organized Health System

Key Findings – Managed Care

- States with effective managed care programs are among the most cost efficient and responsive. In California, incorporating IHSS into managed care is highly promising. Research from CCI found that when IHSS was part of several programs used together, unmet care needs were lower. However, IHSS integration into CCI was not fully tested.

- The PACE model offers impressive statistics on the quality of care and the prevention of hospitalization and institutionalization among the highest risk frail population of 'dual-eligibles.' PACE has also demonstrated cost savings with respect to institutionalization, though a side-by-side comparison is still not complete.

Recommendation – Managed Care

- *IHSS and CCI should not be deemed unsuccessful without further review. Re-testing a more integrated version of IHSS through CalAIM is needed, with close monitoring and review.*

- *While the growth of PACE in California faces key constraints, where it is replicable it is worth exploring for both the frailest and highest need populations within IHSS.*

Key Finding – Other States

- The Colorado experience with IHSS suggests that cost savings are possible when the program is limited to specific populations and expanded slowly, with regular legislative review. This model also demonstrated cost savings when compared to institutionalization.

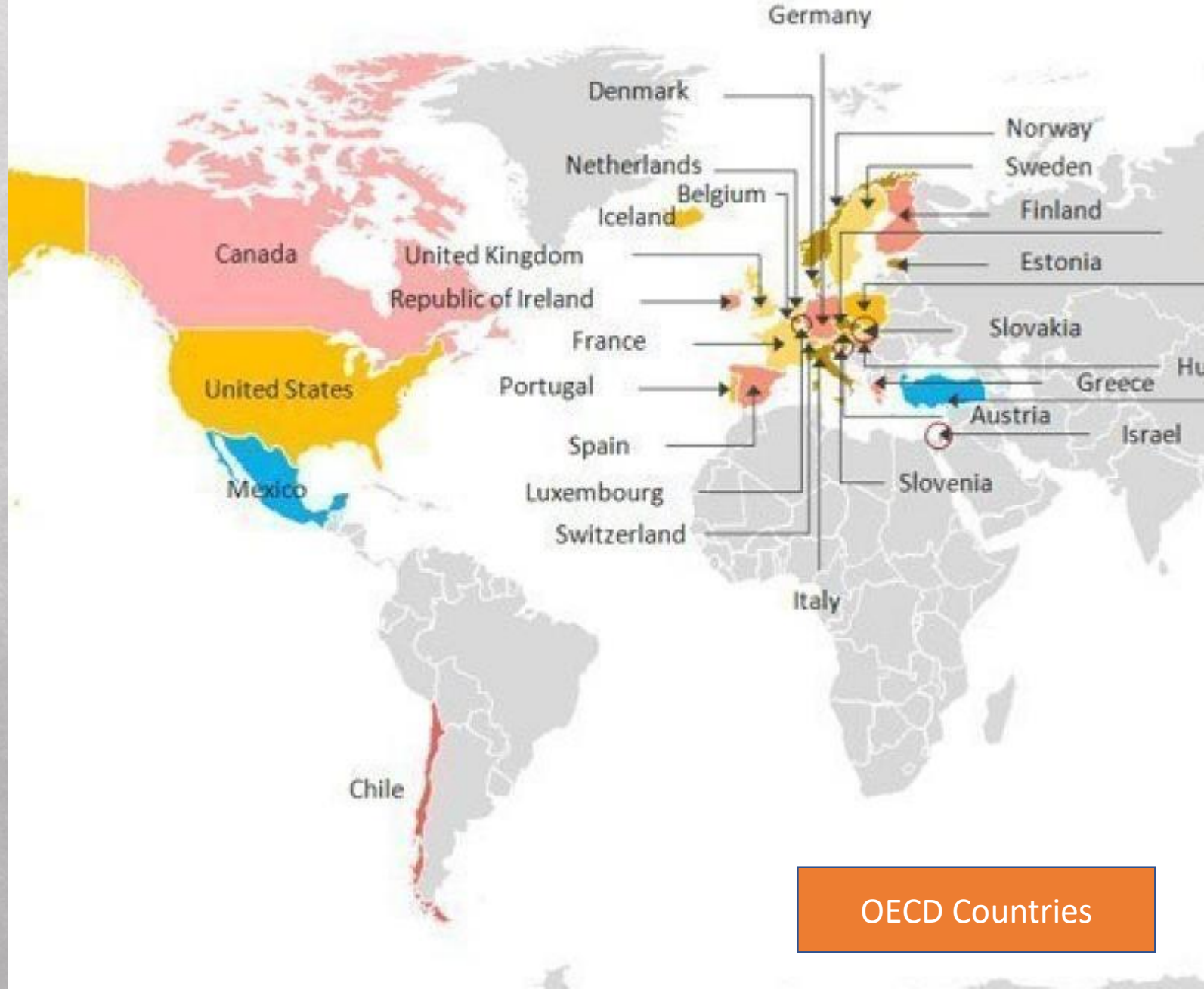
- The Wyoming model suggests that availability of a broad selection of service types may be most effective; comprehensive integrated care may be more effective at preventing institutionalization than expenditure or number of hours alone.

Recommendation – Other States

- *Recommendation: The successful efforts of other states contending with similar challenges should be further evaluated and considered for lessons learned, such as having more health-related services added to the IHSS model for persons meeting certain criteria of need.*

Other Models

Internationally



OECD Countries

Denmark Model

- Relies on coordinated formal in-home caregiving and does not subsidize family members as caregivers; this is in line with cultural norms and ethos of personal and spousal responsibility
  - Universal coverage: all citizens are entitled to care and eligibility is determined by an assessment of individual and household needs
  - Average authorized hours in 2018 - 5.3 hours/week for personal care & 0.8/week hours for necessary practical duties
- Central government establishes policy and regulations
  - Financed by income and property taxes and federal block grants
- Local counties and municipalities are responsible for administration of health and social services
  - While local government is the primary provider of services, Denmark has legally mandated that private providers be included as an option; for-profit private providers grew in market share from 3% to 37% between 2000-2012

International Findings

- Demographics in all developed countries are shifting to significant growth in the aging population
  - 80+ population is particularly notable: this population receives the greatest concentration of social care
- Living with a spouse caregiver, whether paid or informal, is protective against institutionalization
- LTC is geared towards ‘aging-in-place’ in most countries, though disability / need determinations vary between countries
- The majority of LTC is provided informally, though the level and definition of informal care differs among societies (e.g. less common for children to care for parents in Scandinavian countries)
- LTC in OECD countries is primarily legislated and funded by the federal government and administered locally
  - Greater freedom in eligibility requirements can lead to disparities by geography in some countries

International Findings: Cost Saving Efforts

- Other OECD countries use similar efforts to deal with rising costs:
  - **Limiting or restricting eligibility** to the most severely disabled (England, The Netherlands)
    - Separating assessment and delivery of ‘social care’ needs from ‘nursing care’ (IADLs from ADLs)
    - Taking into account income and family support in needs assessment
    - Targeting often leads to less savings than hoped, because average intensity will rise
  - **Imposing higher share of cost payments**
    - Results in greater financial burden to consumer vs government; inhibits usage
  - **Shifting policy to a cash benefit** (Germany, England, Italy)
    - Enables private employment of caregivers and / or compensation of existing family care
    - Studies find that in Germany, the majority choose a cash benefit over services despite being a fraction of the value of services,
    - Findings on the savings of cash over services is mixed; may not provide significant savings if populations are not interested / not yet pursuing the services offered
  - **Establishing Long Term Care Insurance and managed care** (Germany, Japan, Australia)
    - Differences in overall LTC spending still arise because of stricter eligibility requirements and extent of benefits offered

Key Finding

- It is important to acknowledge that once programs and services have been provided, they are often difficult to unwind without a replacement.
- As evident in the Netherlands case and other retrenchment attempts internationally, restricting benefits often leads individuals to put off seeking care until they are the most medically needy, and most expensive.

Recommendations of The Long-Term Care Financing Collaborative: Convergence Center for Policy Resolution (2015)

- Traditional Medicaid gives states three basic choices for creating savings or greater efficiencies in the program: cut eligibility, cut benefits, or cut provider payments "NOT GOOD ENOUGH"

- States, which provide approximately 43% of Medicaid LTC expenditures, face enormous fiscal liabilities in the current program. Shifting costs to counties and vulnerable individuals is not a viable option.
- Expanded eligibility for Medicaid LTC should be combined with improved delivery systems that do a better job integrating LTC, healthcare, and social services to both improve lives for the individuals being served and promote fiscal responsibility.
- Universal catastrophic insurance would generate savings to the Medicaid program.
- The federal government needs to provide stronger financial supports and incentives for LTC delivery innovations.
- Encourage experiments in integrating medical and long-term care coverage through both traditional fee-for service Medicare and Medicare Advantage as well as through commercial insurance for working-age people.