Health reform gives Rhode Island new opportunities to provide home- and community-based services (HCBS) through Medicaid, the major payer of long-term services for seniors and people with disabilities. The health reform law, signed by President Obama on March 23, 2010, includes two new Medicaid options that will be available to states beginning in October 2011: The Community First Choice Option and the State Balancing Incentive Payments Program. Both are designed to strengthen non-institutional long-term care services in Medicaid, and both give states added federal matching payments to make it easier to expand services and develop new systems to support home- and community-based care.

There are several good reasons why Rhode Island should seriously consider these new opportunities to build home- and community-based services capacity in Medicaid.

This state fact sheet explores the following issues:

- The growing demand and rising costs of long-term care;
- How expansion of home- and community-based care can help states; and
- New opportunities that are available in health reform to expand home- and community-based services.
Growing Demand, Rising Costs

More Rhode Islanders will need long-term services in the next few decades.

People with disabilities and seniors are the groups of people that are most likely to need long-term services. For example, about 70 percent of people over age 65 will need long-term services at some point. Over the next 20 years, the number of Rhode Islanders who will need these services is projected to increase dramatically.

- Today, more than 245,000 Rhode Islanders fall into at least one of the groups that is most likely to need long-term services.
- In the next 10 years, the number of Rhode Islanders over age 65—just one of the groups that is most likely to need long-term services—is projected to increase by nearly 26 percent, making up approximately 17 percent of the state’s population.
- By 2020, a projected 25 percent of Rhode Islanders will fall into at least one of the groups that is most likely to need long-term services. By 2030, it will be 29 percent.

Many Rhode Islanders who need long-term services will turn to Medicaid to help cover the costs of care.

Only 10 percent of people over age 55 and even fewer of those under age 55, have private insurance that covers long-term care. In addition, Medicare doesn’t cover most long-term services. As a result, most people who need this care must pay for it out of their savings. That can be financially devastating. About 16 percent of elderly individuals who enter a nursing home as private pay patients exhaust their savings to the point that they qualify for Medicaid. Among the nearly 17 percent of seniors who stay in a nursing home for five years or more, that figure increases to 29 percent.

- In Rhode Island, the average annual cost of a semi-private room in a nursing home is $85,000, which is more than 1.5 times Rhode Island’s median household income of $55,700.
- Though home care is much less costly, paying for it can still be a financial challenge. In Rhode Island, home health aides cost an average of $25 per hour, which can easily exceed $40,000 per year.
- The cost of long-term services is rising faster than general inflation, meaning it will be harder for Rhode Islanders to afford care in the future.
Medicaid spending on long-term services has increased in Rhode Island—and will likely continue increasing.

Rhode Island’s population is growing and aging—since 2000, the population has increased by more than 68,000 and the population over 65 by more than 5,000—and with that, the state has seen increases in both the use of long-term services and in their cost. Long-term services are taking up more and more of the state’s Medicaid budget. This trend is likely to continue as more Rhode Islanders begin to need long-term services and deplete their assets paying for care.

- In 2006, more than 18,500 Rhode Islanders received long-term services through Medicaid.
- In 2009, Rhode Island Medicaid spent more than $571 million on long-term services, which was about 30 percent of the state’s overall Medicaid spending.
- From 2004 to 2009, Rhode Island Medicaid spending on long-term care increased by 10 percent.

Expanding home- and community-based services can help

Expanding home- and community-based services could save Rhode Island money.

Investing in home- and community-based care has been shown to save states money. The per person costs of home- and community-based care are less than institutional care costs.

- In Rhode Island, home- and community-based services are cost effective. Average Medicaid spending on non-institutional care for seniors and people with disabilities is approximately 71 percent less per person than nursing home care.
- A 2009 study of Medicaid costs over a 10-year period found that states that offer few Medicaid home- and community-based service options experienced nearly a 9 percent increase in overall Medicaid long-term services spending, while states with well-established home- and community-based care programs saw a reduction in spending of 8 percent on average.

Expanding home- and community-based services can help Medicaid participants and their families.

Most people who need long-term services would prefer to receive care in their community, rather than having to move into an institution. Expanding home- and community-based services gives more residents care in the setting they prefer, reduces nursing home admissions, and provides support for informal caregivers.
A study of nursing home admissions from 1995 through 2002 found that a higher level of state expenditures on home- and community-based services was linked to lower nursing home admissions among childless seniors. States that doubled expenditures on home- and community-based services reduced their nursing home admissions in this population by 35 percent.

Higher spending on home- and community-based services can provide needed assistance and support to family and other caregivers.

- An estimated 171,000 Rhode Islanders are uncompensated caregivers—they provide care to family members or others in need for free. These caregivers are a critical part of the long-term care workforce.
- Without adequate support, the demands on uncompensated caregivers can have negative consequences. Caregiving costs and responsibilities cause more than one-third of caregivers to reduce their work hours, one-third to cut back on household spending, and approximately one-fourth to postpone personal medical care.
- Lost wages, reduced spending, and delayed medical care can hurt Rhode Island families, reduce revenues to Rhode Island businesses, and harm the state’s economy.

**Rhode Island has done a lot to expand home- and community-based services, but could do more.**

Enabling seniors to stay in their homes for as long as possible is the first goal of the State Plan on Aging from the Rhode Island Department of Elder Affairs. To help reach that goal, Rhode Island has increased spending on home- and community-based services by over 20 percent in the past five years. Even so, the state could do more.

- Only 46 percent of Rhode Island’s Medicaid long-term care spending went toward home- and community-based care in 2009; 54 percent went to institutional care. A program is considered “balanced” if at least 50 percent of its spending is on non-institutional care.
- In 2009, Rhode Island ranked 13th out of 39 states and the District of Columbia in the percent of Medicaid long-term care spending allocated to home- and community-based care (complete 2009 data were not available for all states).
New Opportunities in Health Reform

The health reform law gives states new options to expand Medicaid home- and community-based care to those who need it. However, an initial investment is needed to build capacity for home- and community-based services. The new programs in health reform provide states with added financial help to make those investments and to build up systems that can work for the long run, give people the care they need in the best setting, and save money in Medicaid.

The State Balancing Incentive Payments Program

This four-year, $3 billion program gives qualifying states added federal Medicaid matching funds to expand home- and community-based services in Medicaid. States in which less than 50 percent of Medicaid 2009 long-term care spending was for non-institutional care are eligible for balancing incentive payments. Based on 2009 data, Rhode Island would qualify for this program.

The size of the added federal match (FMAP) that states will receive will depend on the percent of total Medicaid long-term services spending that is allocated to home- and community-based services. States where that allocation was 25 percent or less in 2009 will be eligible for a 5 percentage point FMAP increase, and all other states will receive a 2 percentage point increase. The added payment applies to the costs of non-institutional Medicaid services. The Secretary of Health and Human Services will define which services count toward institutional and non-institutional spending for the purposes of this program.

States must apply for the program and agree to make administrative changes that are designed to support the use of Medicaid home- and community-based services, reduce nursing home admissions, and help contain Medicaid long-term services spending. These changes include instituting a standardized assessment process for determining service eligibility; using conflict-free case management (where counseling is provided by a party without a vested interest in any service decision); and establishing a “no wrong door” policy that creates a coordinated, statewide network of local single entry points where consumers can obtain long-term services. States do not have to make any changes to their existing Medicaid services and benefits beyond the administrative changes that are required by the program, but they must maintain their eligibility criteria for non-institutional services from December 31, 2010.

The State Balancing Incentive Payments Program can help states build up the administrative capacity that they need for a broader, sustained, and cost-effective expansion of home- and community-based services in Medicaid.
The Community First Choice Option

This is a new state plan option for home- and community-based personal attendant services. States that take up this option will receive a 6 percentage point FMAP increase for costs associated with the program. States can cover Medicaid-eligible individuals with incomes up to 150 percent of the federal poverty level ($10,830 for an individual in 2010), or states can use their Medicaid income limit for individuals who are eligible for nursing facility care so long as that income limit exceeds 150 percent of poverty. Participants with incomes over 150 percent of poverty must also meet the state functional eligibility requirement for institutional care based on either an assessment of the applicant’s ability to perform activities of daily living (ADLs) or a diagnosis of a cognitive impairment.

The program must include the following elements:

- Assistance with activities and instruments of daily living (ADLs and IDLs) and health-related tasks;
- Support for the acquisition, maintenance, and enhancement of the skills that are needed to complete daily tasks;
- Back-up systems for patients, such as emergency beepers, that will ensure continuity of care and support; and
- Individual training for participants in self-directed programs on hiring and dismissing attendants.

It also gives states the flexibility to include facility-to-community transition costs and additional items that will increase an individual’s independence or substitute for personal assistance. Care must be provided in a setting that allows for the greatest level of independence and integration with the community that is appropriate based on an individual’s needs. Services must be provided statewide with no enrollment caps. In addition, states must establish a Development and Implementation Council made up of seniors and people with disabilities, or their representatives, to collaborate on program design and implementation.

States cannot target populations based on age, disability, or any other criteria. During the first year of the program, the state must meet or exceed what it spent on Medicaid services for elderly individuals and people with disabilities in the previous year.

The Community First Choice Option gives states added financial support to build a broad home- and community-based care program in Medicaid that will serve residents who need long-term services, providing care to them in the most integrated setting that is appropriate.
Conclusion

Health reform gives Rhode Island two new Medicaid options for expanding home- and community-based care that come with added federal support. These programs will help the state prepare for the growing demand for long-term services as its population ages. They will also help Rhode Islanders get care in their community — care that is less costly and that helps fulfill the state’s commitment to making sure residents who need long-term services can live as independently as possible. The new home- and community-based services programs that are available through health reform are good for Rhode Island and for Rhode Islanders.

References for this publication are available upon request.