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Potential Cost Shifting Scenarios from Eliminating Medicaid Personal Care Assistance and Home and Community Based Services Waiver Programs

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You asked about the potential cost impacts of eliminating the Medicaid Personal Care Assistance (PCA) and Home and Community Based Services (HCBS) waiver programs.[1]

Our research indicates that moving virtually any substantial portion of recipients of Personal Care Assistance (PCA) and/or those receiving Home and Community Based Services (HCBS) through Medicaid would ultimately cost the State of Alaska hundreds of millions of dollars in additional spending annually. In particular, participants in the HCBS program, by definition, qualify for an institutional level of care under Medicaid rules. Although costs per participant are much higher for HCBS than for PCA services, those expenses are still less than half of the cost for nursing home or intermediate care facilities for those with intellectual and developmental disabilities.

In addition to increases in direct costs, the elimination of PCA / HCBS would generate a great deal of demand for long-term care facilities on a statewide system that is already operating near capacity. Given that the private sector is expected to struggle in meeting the demands for institutional care brought about by Alaska's rapidly growing senior population, the absence of Medicaid programs designed to keep people in their homes could force the state to directly participate in the construction and administration of long-term care facilities with capital and operating costs potentially reaching hundreds of millions of dollars.

Background and Methodology

Two previous efforts by this agency to estimate the primary cost impacts of eliminating the PCA and HCBS programs used differing foundational data. The first, LRS Report 04.155 focused on the projected rapid growth in the portion of the Alaska population over the age of 65. Later, LRS Report 10.153 used the projections of consultancies that were hired to forecast program participation. Ultimately, our 2004 estimate, which examined only the PCA program, substantially understated future program participation. By contrast, data produced by the Lewin Group and ECONorthwest dramatically overestimated program enrollment for both PCA and HCBS services. The reasons for these missed projections are manifold and complex, and include the inherent difficulties of making projections based on limited data and in ever-changing circumstances.

Another significant factor in changes to participation rates and costs has been cost control and efficiency measures put in place by the Alaska Department of Health and Social Services (DHSS), including controls on program utilization and

[1] This report is part of a series by this agency looking at the same question. This installment assumes the reader has a basic understanding of the services provided by the PCA and HCBS programs. Earlier reports, which provide additional detail, include LRS 04.155 (*http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2004/04-155m.pdf*) and LRS 10.153 (*http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2010/10-153m.pdf*). Although all of these reports reach the same broad conclusion—that eliminating the PCA and HCBS would likely substantially increase costs to the state—due to differences in data availability and the resulting variations in methodology, caution should be employed when comparing results. Further, as a result of changes in policy that have altered program participation rates and costs, which we will briefly discuss in this report, projections from previous reports have varied significantly from actual program experience. Additional information on the PCA and HCBS programs is available on the Alaska Department of Health and Social Services website at *http://dhss.alaska.gov/dsds/Pages/default.aspx*.

significantly increased efforts at preventing and countering waste, fraud, and abuse.[2] The DHSS attributes recent substantial declines in program enrollment and costs to these changes. Significantly, the PCA program saw declines in persons served from 5,280 in fiscal year (FY) 2013 to 4,414 in FY 2015, while total program spending fell from roughly $125.8 million to $88.7 million over the same time period. Annual costs per participant also dropped from $23,800 to $20,100.

Based on past experience, we hold little confidence in the accuracy of projected program participation rates and, in any case, DHSS did not provide us with projections past 2020, perhaps in recognition of the rapidly moving nature of those targets. As a result, in this report we focus on the near past rather than the future to inform the broad impact on costs that would likely arise should the PCA and HCBS programs be eliminated. Specifically, we use data from FY 2015 to roughly estimate the costs if certain portions of participants served by these programs had instead been receiving institutional care in nursing homes.

Direct Cost Shifting

The attached table shows participant counts and total costs for FY 2015. It also shows our estimates of the difference in expenditures if certain percentages of participants in both programs would instead have been receiving care in a nursing home. It is unlikely that equal proportions of PCA and HCBS enrollees would move to an institutional level of care were the programs to be discontinued. Instead, we believe it reasonable to assume that those who currently require higher intensity care would be the most likely to move to nursing homes. By definition, individuals receiving HCBS are those who would otherwise require institutional care. Therefore, our table provides calculations for moving 35 to 75 percent of FY 2015 HCBS recipients to nursing homes. Conversely, we assume relatively few individuals who would otherwise be receiving only PCA services would have moved to an institutional level of care; therefore, we use a range of 15 to 35 percent of those participants to calculate the cost shift to nursing homes.

Clearly, we have no means of precisely estimating what portion of program recipients would move to institutional care were these home care programs eliminated; however, as our calculations show, even if only 15 percent of FY 2015 PCA and 35 percent of HCBS recipients were to have instead been in nursing homes funded by Medicaid, program costs would have nearly doubled, increasing by over $335 million. At the current 50 percent federal medical assistance percentage (FMAP) rate, the state's portion of those costs would have been over $167 million.[3] We believe it likely that a much higher percentage of HCBS recipients would have been institutionalized were the program not in operation in FY 2015. Had that figure been 75 percent of participants, actual spending for *just the HCBS cohort* would have increased by over $482 million above actual spending. In its February 19, 2016, presentation to the Senate Health and Social Services Committee, the Division of Senior and Disability Services stated that were all HCBS recipients moved to institutional care, the total costs to Medicaid of nursing home and intermediate care facilities would exceed $1 billion.[4]

[2] A number of these efforts were presented by the Department to the Senate Health and Social Services Committee on February 19, 2016. Minutes and audio of this hearing are available online at *http://www.akleg.gov/basis/get_minutes.asp?session=29&comm=HSS&chamb=B&date1=20150219&date2=20160219*. Documents provided by DHSS for the hearing are available at *http://www.akleg.gov/basis/get_documents.asp?chamber=SDHS&session=29&bill=&date1=20160219&time2=1100*.

[3] As you know, services for individuals enrolled through Medicaid expansion under the Affordable Care Act are eligible for increased federal reimbursement rates; however, the DHSS informed us that the expansion population is generally healthier than the average Medicaid recipient. As a result, the Department does not expect those enrolled under expansion to receive HCBS services, and expect only one percent of that cohort to receive services through the PCA program. We therefore find the differences in reimbursement rates due to the ACA to be insignificant in relation to overall spending on the programs and exclude consideration of the expansion population from this report.

[4] These data are available on page 28 of the DHSS presentation to the committee, which can be viewed at *http://www.akleg.gov/basis/get_documents.asp?session=29&docid=40896*. The costs for nursing home and intermediate nursing facility care are similar at an estimated FY 2015 average $187,000 and $186,000, respectively. For the sake of simplicity, and because many times more institutionalized Medicaid participants are served by nursing homes, we use the higher figure in our calculations. For the sake of comparison, FY 2015 average costs for PCA recipients was $20,100 and roughly $88,000 for the blended average for all individuals receiving care under HCBS waivers.

Other Potential Costs to the State

As we discussed in earlier reports, outside of direct Medicaid spending, primary among potential costs associated with eliminating the PCA and HCBS programs are the capital and operating expenditures required to construct and administer sufficient institutional care facilities to accommodate residents who otherwise would have been served in their homes and communities through the existing programs.

It has long been known that Alaska's rapidly growing population of seniors aged 65 years and over will strain the ability of the state to provide sufficient long-term care facilities to meet demand.[5] Specifically, the Alaska Department of Labor and Workforce Development projects that the state's population aged 65 and over will more than double from 63,832 in the year 2012 to 144,623 in 2032. Seniors will also nearly double as a percentage of the total population over this time period, from about 8.7 percent to 16.6 percent. With nursing homes in Alaska maintaining an average occupancy rate of approximately 90 percent in recent years, it appears reasonable to conclude that any shifting of HCBS and PCA enrollees to institutional care will further burden a system that is already projected to struggle in meeting demand. It is unclear based on current economic conditions that private providers can meet this demand, which would further lead one to conclude that the state may have to incentivize private sector participation in creating additional long-term care capacity or begin directly building institutional care facilities.

The costs to the state for such an undertaking are difficult to estimate due to variations in demand and the cost of construction and operation among geographical areas. In our 2009 report, we attempted to provide a ballpark figure based on the estimated construction and operations costs of a 60-bed Veterans Home in Anchorage.[6] In 2015 dollars, the estimated costs for such a facility is $12.6 million for construction with first-year operating expenses of $3.75 million, which would increase with inflation thereafter.[7] If, for example, 75 percent of 2015 HCBS recipients were moved to nursing homes with comparable construction and operations costs, Alaska would have needed to construct 61 facilities at a cost of over $768 million with first-year operating costs in excess of $228 million. Clearly, these figures should not be viewed as real-world projections. Instead we intend this simplistic calculation to be illustrative of the daunting prospect of moving so many additional Alaskans to institutional care, and the scale of spending that would likely accompany such an effort.

Costs to Families, the Private Sector, and Local Economies

Although private sector costs are outside the scope of our inquiry, it is nonetheless important to mention that those costs would likely be substantial. The recipients of PCA and HCBS and their families have, by their enrollment in the programs, at least tacitly expressed their collective desire to remain out of institutional care facilities. It seems likely that at least some of these individuals would avoid moving to such facilities where any other viable option exists. Consequently, the elimination of PCA and HCBS would likely force a certain portion of program participants' families, many of whom are already stressed by the challenges of providing care to loved ones, to make additional sacrifices in order to keep those family members in their homes and local communities. Although difficult to identify and measure precisely, it appears reasonable to assume that those sacrifices might include committing additional funds to pay for care directly, giving up a job or business, quitting school or apprenticeship programs, or other actions that would be detrimental to family finances and local economies in order to commit additional time to care giving.

We hope this is helpful. If you have questions or need additional information, please let us know.

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[5] See, for example, "Alaska Long-Term Care and Cost Study," Final Report, *Public Consulting Group*, February 2006, pp. 166-167; *http://www.hss.state.ak.us/hspc/files/pcg.pdf*.

[6] "Alaska State Veterans Home Feasibility Study," McDowell Group, July 2003, p. 2; *http://www.akrepublicans.org/samuels/23/pdfs/samu2003070901p.pdf*.

[7] Inflation adjustments are Legislative Research calculations using Anchorage consumer price index data compiled by the Alaska Department of Labor and Workforce Development, *http://laborstats.alaska.gov/cpi/cpi.htm*.

Potential Increase to Medicaid Expenditures as a Result of Moving Participants from Medicaid Home Health Programs to Nursing Home Care

Program	Participants[1]			FY 15 Total Costs[1]	Projected Cost *Increase* if Programs are Eliminated and Selected Portions of Participants Move to Nursing Home Care[2] (State share of increase is 50 percent of costs listed here)		
	2005	2015	Increase		15%	25%	35%
Personal Care Assistance	2,700	4,414	1,714	$88,688,200	$110,509,470	$184,182,450	$257,855,430
Home and Community Based Services	3,573	4,871	1,298	$267,937,800	35%	50%	75%
					$225,028,720	$321,469,600	$482,204,400
Net Total[3]	6,273	9,285	3,012	$356,626,000	$335,538,190	$505,652,050	$740,059,830

Notes and Sources: 1) 2015 participant figures and FY 15 total costs are from a document presented by the Alaska Department of Health and Social Services, Division of Senior and Disabilities Services (DSDS), presentation to the Senate Health and Social Services Committee on February 19, 2015, which can be viewed at *http://www.akleg.gov/basis/get_documents.asp?session=29&docid=40896* .

2) The DSDS presentation also provides the costs for nursing home and intermediate nursing facility care, which were similar for FY 2015, at an average of $187,000 and $186,000, respectively. For the sake of simplicity, and because many times more institutionalized Medicaid participants are served by nursing homes, we use the higher figure in our calculations. For the sake of comparison FY 2015 average costs for PCA recipients was $20,100 and roughly $88,000 for the blended average for all individuals receiving care under HCBS Waivers.

To make our projections, we multiplied the total number of program recipients by the percentages indicated and multiplied that figure by the FY 15 average cost of nursing home care paid per recipient by Medicaid ($187,000). We then subtracted from that figure the product of multiplying actual FY 15 program costs by the percentage in question to reach our totals.

3)Net total are the sum of adding each vertical column of PCA and HCBS figures. In the case of projected costs in the far three columns to the right, those figures represent *only cost increases above actual FY 2015 expenditures* as a result of shifting the given percentages of program employees to nursing home care. So, the third column from the right assumes that 15 percent of PCA recipients and 35 percent of HCBS participants would have been in nursing home care in FY 2015, increasing total Medicaid costs by roughly $335.5 million.