Medicaid Home Care Cuts: Analysis of Unintended and Unnecessary Consequences

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Acknowledgements

Special thanks for collaboration, research and editing:

Phyllis Mitzen, Co-Director, Center for Long-Term Care Reform
Margie Schaps, Executive Director, Health & Medicine Policy Research Group
Manjari Ranganathan, Policy Intern, Health & Medicine Policy Research Group

Special thanks for sharing your expertise on this topic:

Darby Anderson, Addus Healthcare
Carol Aronson, Shawnee Alliance for Seniors
Dr. Robert Applebaum, Miami University of Ohio
Dr. David Grabowski, Harvard University
Dr. Joy Hammel, University of Illinois
Terri Harkin and Sharon Post, SEIU Illinois
Dr. Sue Hughes, University of Illinois
Drs. Mary James, Jen D’Souza, Brant Fries, University of Michigan
Dr. Steve Kaye, University of California San Francisco
Dr. Naoko Murumatsu, University of Illinois at Chicago
Executive Summary

In February of 2012, Illinois Governor Pat Quinn proposed to cut $2.7 billion from the state Medicaid program for 2013. A subsequent plan outlined how these cost savings would be achieved: 50% Medicaid program cuts, 25% Medicaid provider cuts, 25% increased revenue through a tobacco tax.

The following study, completed in May 2012, points out that cuts in Medicaid support for home care services would undermine the home care network that is needed to help the state shift away from more expensive institutional care. The proposed cuts will not only cost the state more in the long run, but will make it harder to respond to the growing needs of aging Baby Boomers.

National and state research studies clearly show that investing in home care (home health, hospice and support services) is associated with a decrease in total long-term care costs, while cutting home care is associated with an increase in hospital, emergency room and nursing facility utilization.

In Illinois, the proposed cuts will result in weakened efforts by the state to provide more care in the community-setting (a state and national goal and required by law); destabilization of a home care infrastructure that took decades to build; and risk of an additional lawsuits in the state for lack of access to community-living. See graphic below.

The study offers suggestions for strengthening the home care network and concludes that Illinois should invest tax dollars based on research and national best-practices and be careful not to put the state’s budget in further peril through short sighted decisions.

Access an electronic copy of this report here:
Introduction

On February 22nd, 2012, Illinois Governor Pat Quinn delivered the annual state budget address with plans to balance Illinois’ budget deficit, in part, by calling for an unprecedented $2.7 billion target in Medicaid cuts for fiscal year 2013. Subsequently, the Governor announced a plan for achieving the Medicaid savings: 50% Medicaid program cuts, 25% Medicaid provider cuts, and 25% revenue increase as a result of a tobacco tax with accompanying federal match

While the state is taking a balanced approach to deal with the Medicaid deficit, a combination of revenue increases and budget cuts, the current proposed Medicaid cuts are too large and are being proposed without time to appropriately analyze and determine their impact. The size of the proposed Medicaid cuts, almost 25% of Illinois’ Medicaid budget, could not have come at worse time for Illinois’ most vulnerable residents who have struggled to make ends meet as a result of the worst recession since the Great Depression.

This report will answer the questions: what are the unintended, and unnecessary, consequences of the proposed Medicaid cuts to home care and will these cuts undermine the state’s effort to balance long term care?
The Illinois Landscape

Home care is part of the larger category of long-term care, or long-term supports and services (LTSS). LTSS are also provided in institutional settings like nursing homes and intermediate-care facilities. Medicaid is the largest payer for LTSS in Illinois and across the country.

LTSS are particularly important given the aging of our population. The likelihood of becoming disabled and requiring LTSS increases with age, and the population of older persons in Illinois, and throughout the United States, is growing rapidly as the baby boomers age. Currently the Illinois population of individuals 60 years and older is 2.3 million, or 18% of Illinois’ total population. By 2020 this number is expected to grow to over 3 million individuals, 21% of the population.

Chronically or terminally ill persons in need of medical or therapeutic care depend on home care provided by skilled nurses, therapists and home health aides for services informal caregivers—family members and friends—are unable to provide. These medical services can speed recovery and in-home disease management can help patients avoid costly institutional care.

Further, longer life spans and improved medical technology allow individuals to live much longer with one or more chronic conditions. Having a chronic condition is often associated with a decrease in functionality, and frequently the need for LTSS. An estimated 130 million Americans live with at least one chronic disease. At least 65 million older adults across the country experience multiple chronic conditions.

In addition to skilled home care, the paraprofessional workforce plays an important role by providing complementary LTSS for individuals living with functional impairment, meaning individuals who need assistance with Activities of Daily Living, ADLs (e.g. bathing, dressing, or toileting), or Instrumental Activities of Daily Living, IADLs (e.g. grocery shopping, or preparing a meal).

Proposed Medicaid cuts will impact both home care and institutional LTSS. Under Medicaid law, nursing home and skilled home health services are an entitlement while non-medical home care is optional. So while cuts will hurt all Medicaid LTSS, examining the potential impact of cutting optional home care is important; there is no safety net for optional home care.

“On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based settings for every person in a nursing facility.”

Houser AN, Fox-Grage W, Gibson MJ. Across the States: Profiles of Long-Term Care and Independent Living. Washington, DC: AARP, 2009
**LTSS Balancing**

Home care is an important component of the reform process known as balancing, rebalancing or reforming Medicaid funded LTSS. Balancing refers to the shifting of state expenditures from institutional care to home and community-based care.

LTSS balancing is a national and state priority that is strongly supported and driven by consumer preference to receive community-based LTSS (i.e. home care). Consumer preference for community living is understandable given higher quality of life outcomes like social activity and social interaction in the community setting, and evidence that unmet needs decreased with home care services.

Further, the United States Supreme Court ruled in the historic Olmstead case that federal law—the Americans with Disabilities Act—mandates LTSS provision “in the most integrated setting appropriate to the needs of the individual.” (See sidebar for an overview of Illinois’ historic Olmstead lawsuits). The Olmstead Supreme Court case translates to: if an individual’s care can be provided in the home and community-based setting, this is where the person should be receiving care, not in an institution.

Additional federal support of LTSS balancing is seen throughout the 2010 Affordable Care Act and in the recent creation of the Administration for Community Living which has brought together the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities within the U.S. Department of Health and Human Services.

**Illinois’ Older Adult Services Act**

In Illinois, balancing is supported by the Older Adult Services Act, enacted in 2004 (PA 093-1031), as a result of strong and persistent advocacy “to promote a transformation of Illinois’ comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system…”

The Older Adult Services Advisory Committee (OASAC) was established with members representing all of the stakeholders involved in providing LTSS in Illinois. With the Illinois Department on Aging taking the lead, OASAC is mandated to provide a forum to advise the Illinois Departments of Aging, Public Health, Health Care and Family Services, Housing and Insurance on this transformation.

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3 historic Olmstead lawsuits were recently settled in Illinois over access to community living.

**Ligas et al. v. Hamos (2011):** persons with developmental disabilities in intermediate care facilities (ICF-DDs) sued the state in a class action lawsuit.

**Williams v. Quinn (2010):** individuals in Institutes for Mental Disease (IMDs) with mental illness sued the state in a class action lawsuit.

**Colbert v. Quinn (2011):** individuals in Cook County nursing facilities with physical disabilities sued the state.

See appendix 1 for more information about Illinois’ settled Olmstead lawsuits.
**Illinois Medicaid Health Reform Initiatives**

In 2010 the Illinois state Medicaid Agency, the Department of Healthcare and Family Services (HFS), launched the Integrated Care Program, a managed care program that serves 37,000 older persons and persons with disabilities with projected savings of $200 million over 5 years\(^ {10} \). The Integrated Care Program is currently launching phase II: the coverage and coordination of LTSS: both institutional and home care services.

In 2011, the Illinois legislature passed Public Act 96-1501, the “Medicaid reform law”, requiring 50% of the Medicaid population to be covered in a care coordination program by 2015. As a result, in addition to the Integrated Care Program, HFS is implementing a series of additional Medicaid reforms that will enhance care coordination (i.e. increase Medicaid managed care programs), providing an estimated $700 million in savings over the next 5 years\(^ {11} \).

The series of reforms is known as the Innovations Project, a two-phase initiative that focuses on providing enhanced care coordination services and/or managed care services. The second phase of the Innovations Project introduces the dual eligible Medicare and Medicaid alignment initiative. This presents an opportunity to provide insurance and coordination of care for dual eligible beneficiaries.\(^ {12} \) Both phases of the Innovations Project are to include LTSS, with an emphasis on balancing: providing more care in the home and community-based setting.

**Budgeting for Results**

To give perspective on how Illinois has integrated LTSS balancing into the Illinois government, it is necessary to understand the framework of the recently signed “Budgeting for Results” law (BFR)\(^ {13} \). BFR represents a shift in the budgeting process by instituting a results-based budgeting process—ending the practice of automatically funding programs based on prior year appropriations. Under BFR, Illinois will only fund programs with proven effectiveness that help the State achieve stated outcomes and goals. BFR will begin with budgets prepared for FY2013.

BFR is in the process of developing performance metrics allowing Illinois to compare the success of programs across State departments. Once the State collects and is able to analyze state spending and program performance data, BFR will allocate funds according to the identified priority areas. The BFR process will also consider the negative outcomes that may result from funding cuts or delayed payment to providers.

Of relevance to this paper, Illinois’ BFR includes 7 priority results including: “All Illinois residents have access to quality affordable health care” and “Human Services: Protection of the Most Vulnerable of our Residents”. The BFR 2010 Commission Report encompasses these priority areas with the statement: “Illinois assures that all residents, but particularly children, the elderly and disabled, are able to experience at least a minimal quality of life.”
Within these priority areas, the state has also identified several goals:

- Improve access to affordable health services when and where they are needed
- Ensure health care is provided in the most efficient and effective manner possible
- Increase the number of Illinois residents with disabilities living in the least restrictive settings appropriate to their needs
- Increase the number of seniors remaining in their homes through essential support services, including nutrition and home aid services
- Rebalance from state-run facilities to community-based care when appropriate
- Improve access to and cost effectiveness of adequate health care

One of the BFR Commission’s recommendations was to better align the legislative process and State departments with BFR priority areas. In the current legislative session, Governor Quinn’s proposed budget cuts to home care do not align with the goals identified above, compromising the integrity of Budgeting for Results. This lack of alignment undermines the state’s commitment to balancing LTSS.

**Illinois’ Medicaid Cuts to Home Care Programs Proposed by the Governor**

The state has proposed a 10% reduction of home health, hospice and DME budgets through utilization controls, impacting the ability of skilled home care providers to effectively provide care for vulnerable individuals. Utilization controls, which are already in place in Illinois, are designed to ensure appropriate utilization of services in a fee-for-service environment\(^1\). The state, however, has not yet described how it will institute additional utilization controls. This presents a potentially dangerous situation for individuals who require care but may be barred from access to needed home care.

Illinois has also proposed budget cuts for the Medicaid waiver programs that could further undermine the home care system. Waiver programs provide a mix of skilled medical care and supportive non-medical services that enable individuals who require LTSS to live in a home or community setting. Waiver programs complement home health, hospice and DME services; together they effectively and efficiently assist individuals to live safely in the community setting.

Finally, Illinois has proposed to increase the financial eligibility threshold for all Medicaid programs, effectively making it more difficult for low-income individuals to access healthcare. The state is also proposing additional across the board cuts to all Medicaid providers. While neither of these cuts are specifically aimed at home care, they will both directly impact home care providers (some smaller provider groups may decide they cannot afford to provide high quality care at the rates being offered) and those in need of home care services (many low income people will forego needed services because they cannot pay for them).
Table 1: Medicaid Home Care Programs and Corresponding Illinois Proposed Cuts FY2013

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Description</th>
<th>Illinois Proposed Cut FY 2013</th>
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<tr>
<td><strong>Medicaid Mandatory Home Health Benefit</strong></td>
<td>Skilled medical care provided by nurses, home health aides and other professionals in the home. May include medical supplies and equipment. May include personal assistance services for activities of daily living support.</td>
<td>10% reduction in budget through utilization control</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>Set of services for individuals who are terminally ill and in need of medical and nursing care, in addition to emotional and spiritual support for the individual and their family.</td>
<td>10% reduction in budget through utilization control</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>Medical equipment, used in-home, necessary for treatment of an individual’s illness or injury to improve functioning.</td>
<td>10% reduction in budget through utilization control</td>
</tr>
<tr>
<td><strong>Medicaid 1915 (c) Home and Community-Based Waivers (Waivers)</strong></td>
<td>Medical and non-medical support services for specific populations with specific long-term care needs. Waivers are typically targeted by disability type and age. Waivers require a nursing-home level of care need, and waiver expenditures must be ‘budget neutral’ meaning individual consumer expenses cannot exceed individual consumer nursing home expenditures. Illinois has 9 waiver programs (see appendix 2 for details on Illinois’ waiver programs).</td>
<td>New applicants for Medicaid funded waiver programs must meet a higher eligibility threshold, meaning individuals must be more disabled, or have higher need, than had previously been determined to receive services.</td>
</tr>
</tbody>
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National Research Findings

Through a comprehensive literature search, including both peer reviewed journals and other official reports, we will describe the findings of studies that most directly relate to the questions being examined in this paper: what are the unintended, and unnecessary, consequences of the proposed Medicaid cuts to home care and will these cuts undermine the state’s effort to balance long term care? Key findings from these studies are identified below and a more thorough analysis is provided in appendix 3.

Key Findings from National Home Care Studies:

1. In a national study, Avalere Health LLC\(^{16}\) analyzes the impact of home health use on Medicare spending and rehospitalization for beneficiaries with chronic illnesses\(^*\) (see note below regarding the comparison between Medicare and Medicaid funded home health services). The key findings from the study show that post-hospitalization home health services are associated with significantly lower post-hospital costs and hospital readmissions.

2. In another national study, Fitch and Pyenson illustrate the role that hospice plays in Medicaid cost-savings\(^{17}\). Their findings show that an investment in hospice decreases Medicaid costs by decreasing utilization of acute hospital care and medications. The hospice benefit also provides an added service of coordinating other home care services like DME and medications. Any cut to hospice will negatively impact individuals who require end-of-life care, and result in Medicaid cost increases.

3. In a Missouri study, Zuckerman, Miller and Shelton examine the impact of Missouri’s 2005 Medicaid budget cuts \(^{18}\). Missouri’s benefit cuts were similar to Illinois’ FY2013 proposed cuts: impacting not only hospice and DME but also including benefit changes to programs like dental, podiatry, and more. Missouri also reduced eligibility, similar to the eligibility cuts Illinois is proposing. The results are important: Medicaid cost savings were not achieved, though the cost growth was slowed.

4. Another national study by Kaye, LaPlante and Harrington shows evidence that after a state’s initial investment in home care (through increased waiver and home health expenditures) and a concurrent decrease in institutional spending, total state LTSS costs are predicted to decline\(^{19}\).

5. In an Ohio study, a state similar in demographics to Illinois, Mehdizadeh, Applebaum, Nelson and Straker show that Ohio’s increased waiver expenditures and decreased nursing home expenditures for the aging population resulted in an overall decline in state LTSS spending\(^{20}\).

\(^*\) Home health services are essentially the same, whether the payer is Medicare or Medicaid, so the impact on home health services for Medicare beneficiaries is comparable to Medicaid beneficiaries. One fundamental difference is that Medicare home health eligibility requires an individual to be unable to leave their home, i.e. homebound. Medicaid home health eligibility does not require an individual to be home bound. Medicare also covers medical social work services, while Medicaid does not.
6. In a Michigan study, D’Souza, James, Szafara, and Fries show an association between home care waiver cuts for the aging and physically disabled populations and a subsequent increase in nursing facility utilization, along with increases in hospital and emergency room utilization\textsuperscript{51}. The Michigan study is particularly noteworthy, as cost-shifting was seen not only among LTSS programs (home care cuts were associated with increased institutional utilization), but also cost-shifting from LTSS to acute care (home care cuts associated with increased hospital and emergency room utilization).

7. In an Oregon study, Josephson, Tapogna, and Johnson analyze the impact of a loss of federal Medicaid matching funds (as a result of Medicaid budget cuts) on Medicaid home care services\textsuperscript{22}. The Medicaid program is a shared federal and state program, meaning that the federal government matches all eligible state Medicaid expenditures. This magnifies any Medicaid budget cut greatly, as the Oregon study showed: Medicaid home care cuts resulted in substantial loss of economic activity and jobs.

All of these studies arrive at the same basic conclusions: cuts to home care, whether skilled home care or supportive home care services, ultimately do not result in cost savings; and investment in home care, along with a decrease in institutional LTSS, ultimately results in cost savings. Furthermore, many studies show that Medicaid home care cuts result in an overall increase in Medicaid expenditures due to cost shifting to more expensive institutional care (nursing facilities, hospitals and emergency rooms).
Weakened Balancing Effort
Over the last decade, Illinois has shown a commitment to balancing LTSS. Medicaid cuts to home care undermine the progress already made and jeopardize the process moving forward, on both a state policy level, and a Medicaid service provision level.

On a state policy level, the Older Adult Services Act and the new Budgeting for Results law are both undermined if home care cuts are enacted. On the Medicaid service provision level, the ability to provide care in the home and community-setting is jeopardized as was shown through review of national and state studies that demonstrate that home care cuts result in increased utilization in other, more costly, Medicaid services—primarily hospitals, emergency rooms and nursing facilities.
**Frayed Home Care Network**

According to the Campaign for Better Health Care and Families USA “Medicaid Cuts will Hurt Illinois’ Economy” report, the FY2013 Illinois Medicaid budget cuts will result in:

- Loss of $1.35 billion in federal Medicaid match funding
- Over 25,000 jobs at-risk of being lost, and many of these will be direct-care workers who provide home care services

The impact of this proposed loss in federal funding and subsequent job loss will dismantle the home care system that has taken Illinois more than three decades to build, and which studies show saves money by preventing institutionalization (nursing home, hospital, and emergency room).

The proposed budget cuts will result in fewer individuals eligible to receive Medicaid funded home health, hospice and home care support services—even though they still require care. If these cuts are enacted as proposed, the providers who deliver home and community-based care will also be negatively impacted.

Without an adequate level of Medicaid funding to provide care for those in need, home health and home care support service agencies, already under severe stress, will have even less income—necessitating the laying off of trained home care providers or closing of agency doors. As it is, many home health agencies are financially unstable due to low Medicaid reimbursement (see sidebar) and the wide disparity between Medicare’s reimbursement rates and their actual costs.

Yet the professionals who provide home care services—the skilled professional workforce and the paraprofessional care workforce—are already in shortage. The need for a competent, trained home care workforce is projected to increase greatly as the population ages.

This loss of home care workforce and community care infrastructure puts the home care industry at a distinct disadvantage at a time when they must invest in innovative technologies, care processes and delivery models in order to stay current and competitive. Cutting home care now, only to later reinvest in the critical workforce and infrastructure is short-sighted and will set-back the home care industry at a time when the state has legal mandates to build and make it stronger.

Further, the Medicaid coordinated care projects that Illinois is in the midst of implementing will be undermined if these cuts are implemented. These reform projects have estimated cost savings based on a functional home care system. A compromised home care system will prevent the state from successfully implementing its necessary and promising reform initiatives—and estimated cost savings are no longer reliable.
It is also important to recognize the role that informal caregivers play in providing home care services. Informal caregivers are the families and friends of persons requiring home care, providing care free of charge to the state. In Illinois there is an estimated 2.3 million informal caregivers. Medicaid funded home care enables the millions of informal caregivers to work outside the home (earning income, paying taxes) and rest when they need a break from caregiving. Medicaid home care reduces the financial, emotional and health stresses of caregiving.

Medicaid home care cuts will place informal caregivers at certain risk of being overburdened by their caregiving duties. In fact, research shows that over-burdened informal caregivers have higher rates of hospitalizations, poor mental health (depression), poor physical health, and higher mortality rates. Without the support of Medicaid home care, informal caregivers will not be able to provide the supplemental care that enables many individuals to stay in the home and community setting—individuals can be expected to seek out care in hospitals, emergency rooms and eventually nursing facilities.

**Legal Challenges**

As described earlier in this paper, the Americans with Disabilities Act, as interpreted through the Olmstead Supreme Court ruling in 1999, entitles individuals to community-living. In Illinois there have been 3 recent historic Olmstead lawsuits settled, requiring the state to invest time and resources to ensure that community-living options are available for all populations of individuals with disabilities.

The 3 historic Olmstead lawsuits in Illinois cover a range of disability groups: developmental disabilities, mental illness and physical disabilities for individuals of all ages (referred to as the Ligas, Williams and Colbert cases). The plaintiffs of these cases resided in a range of institutional settings unnecessarily and wanted to receive care in the home and community setting but the state was unable to accommodate their requests.

Cutting Medicaid home care puts the state at risk for additional Olmstead lawsuits and for not meeting the conditions of the existing Olmstead consent decrees. Without sufficient capacity to provide home care services, individuals may not have the option to live in the community—this is not in compliance with federal law and there is certain risk for additional individuals to sue the state under Olmstead.

† See appendix 1 for details on Illinois’ 3 historic Olmstead lawsuits and related settlement actions.
Conclusions and Recommendations for Illinois

While the temptation to achieve immediate cost savings through home care cuts may be attractive, we urge state legislators to think about the implications of these cuts—for Medicaid beneficiaries now, tomorrow and in the years to come.

The primary recommendation of this study is to not cut Medicaid home care funding. If cuts proceed, the state can expect—in a very short time frame—higher Medicaid costs and long-term implications for increased costs and decreased quality of care. However, in recognition that the state is looking to Medicaid cuts to save money, we have several recommendations that are based on the research presented above that suggest that investing in a strong home care system will result in cost savings.

Recommendations

1. Invest in Home Care.

   - Invest in higher Medicaid reimbursement rates for home health services.

     If Illinois intends to adequately prepare for the aging of the baby boomers, the state must invest in our home care agencies and workforce, which are the backbone of the home care system. Enabling people to stay in the community requires a combination of skilled plus supportive home care services. Though rates to providers of supportive home care services for older persons in Illinois' waiver program have consistently increased over the last decade, Medicaid home health rates have not increased at all. Illinois’ Medicaid home health reimbursement rate is one of the lowest in the country at $61.34 per visit. Compared to the actual cost of providing the care, an average of $154 per visit, Illinois’ home health reimbursement rate seriously jeopardizes access to home care services.

     Previously cited research also shows that investing in Medicaid hospice services is associated with savings of $7,000 per person enrolled in hospice. As hospice is clearly a cost-saving program, the state must protect and continue to invest in this benefit.

‡ See appendix 4 for a comparison of Illinois’ Medicaid home health reimbursement rate to other states.
• **Explore potential cost-saving investments for home care through telehealth.**

In a 2003 report to Congress, the Office of Disability, Aging and Long-Term Care Policy recommended enhanced use of technology in long-term care service provision. They recommended exploring the use of technology in various aspects of care including ‘cutting edge advances in the use of technology for recordkeeping, patient care and patient monitoring’.

Home health agencies, in particular, are well positioned to take advantage of cutting edge technology advancements in patient care. Several pilot programs have shown that ‘home telehealth’ has been effective in enhancing communication between patients and health professionals and by enabling health care professionals to update care plans based on telehealth information they received.

In a New York pilot study, nurses installed ‘telehomecare units’ in patient’s homes to collect important patient health information and to record their responses to disease-specific questions. This telehealth intervention resulted in a 55% reduction in hospitalizations and a 29% reduction in emergency room visits, and total medical costs decreased by 42%. The savings incurred were more than enough to cover a slight 2% increase in pharmaceutical costs.

• **Expand current home care waiver services packages to include medication management.**

Medication reconciliation, which is a component of medication management, has been demonstrated to result in improved patient outcomes and reduction in health care costs. It has long been understood that investing in medication management for targeted older persons and persons with disabilities could ultimately decrease overall Medicaid costs by reducing unnecessary hospitalizations and reducing nursing home use. Medication reconciliation and management are services that Illinois’ home care nurses and home health aides already provide through the Medicaid home health benefit, and could be easily added to Illinois waiver program package.

A 2009 study conducted by Health & Medicine Policy Research Group and University of Illinois at Chicago, examined the assessment tool (Determination of Need, or DON) and corresponding service planning tool (Service Cost Maximum, or SCM) for Illinois’ waiver program for older persons. The study found that 72% of people with high-end DON scores have an unmet need for medication management. The study ‘recommends that medication management be added (to the existing service mix) as a new cost, outside the existing SCM schedule.’
• Take advantage of opportunities through the Affordable Care Act that can offset Medicaid home care investment.

The State Balancing Incentive Payment Program (BIP) could provide a 2% enhanced federal match for Illinois’ Medicaid home care expenditures through September, 2015.

  o According to SEIU Research§, Illinois could earn over $25 million in enhanced federal matching money.
  o There is a $3 billion federal allocation for BIP. The sooner Illinois applies, the better chance the state has to maximize its award.
    ▪ Currently two states have successfully applied and are participating in BIP: Maryland and New Hampshire. Illinois can use these states as an example.

The Community First Choice (CFC) Option offers Illinois the opportunity to amend its Medicaid state plan to offer personal attendant services to support individuals in the home and community-based setting with ADL, IADL, and health-related needs.

  o CFC offers a 6% increase in federal matching funds for expenditures through this new program.

2. Evaluate the role of home care in Illinois’ multiple Medicaid reform projects

Future Medicaid cuts and reform decisions should be based on research outcomes, not driven solely by the state’s budget crisis. Illinois has a great opportunity to evaluate the role home care plays in an efficient and effective Medicaid health system through the recently proposed and launched series of reform initiatives:

  • The Integrated Care Program
  • The Innovations Project
  • The Dual-Eligible Initiative

Although the Integrated Care Project is already up and running, the Project is just embarking on phase 2: managing long-term services and supports, including home care. Research and evaluation of the Project is already ongoing, and the state should use the outcomes of this Project to inform the role home care plays in the Medicaid system.

The state should also invest in the research of the other reform initiatives: the Innovations Project and the Dual Eligible Initiative. Home care will play a crucial role in the success of these programs, and Illinois can learn from these projects.

Conclusion

Home care already plays a prominent role in Illinois’ Medicaid system. Home care has a proven place in an effective and efficient health system—research shows that when states invest in home health, hospice and home care support services their total LTSS costs decrease; when states cut these home care services, Medicaid costs rise due to increased hospital, emergency room and nursing facility use.

§ See Appendix 5 for detailed information on potential BIP enhanced match for Illinois
Illinois must look to the home care industry to provide leadership in the coordinated, integrated Medicaid system that the state is attempting to develop. This is a system of care predominantly delivered in the home and community-setting, with a dominant role for skilled care services (home health and hospice) and complementary home care support services.

We must move beyond the home care ‘cost’ question, and instead question the effectiveness on home care outcomes we want to achieve, which would ultimately have a positive fiscal impact.

Illinois’ FY 2013 proposed Medicaid budget cuts compromise beneficiaries’ health, which will lead to increased state Medicaid expenditures; this is particularly true for individuals requiring home care services. The proposed cuts for home care are short-sighted and in the near future will create the same fiscal dilemmas that Illinois faces today from its unfortunate history of having made poorly thought out, short-sighted decisions.

With the growing number of older persons and persons with disabilities, Illinois needs a strong home care system as an integral part of an effective and efficient health system. Particularly at a time of fiscal challenge, Illinois must make prudent investments that are based on research and national best-practices. Cutting home care at this time will put the state’s budget in further peril in the very near future—and this is a risk Illinois truly cannot afford.
References


13 Illinois Public Act 96 958.


27 Ibid.

28 Ibid.


### Appendix 1: Olmstead Lawsuits

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<th>Case</th>
<th>Timeline</th>
<th>Primary Target Group</th>
<th>Summary</th>
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| **Ligas et al v. Hamos et al 05-CV-4331 (formerly Ligas v. Maram)** | Date Filed: 2005  
Case Status: Settlement (2011)  
Class Action: Yes (2006) | MR/DD | **Background:** Lawsuit filed in 2005 by nine people with developmental disabilities (Plaintiffs) who reside in large private State-funded facilities (ICF-DDs) or who are likely to be placed in such facilities. Plaintiffs want to receive community services, but their requests have been denied by the State of Illinois.  
**Settlement:** In January 2010, the parties reached a new agreement to provide community services to people living in ICF-DDs who have a current record of wanting community services, and provide community services to an additional 3,000 people with developmental disabilities living at home without services. |
| **Williams v. Quinn 1:05-cv-4673** | Date Filed: 2005  
Case Status: Settlement (2010)  
Class Action: Yes | Mental Illness | **Background:** Lawsuit filed in 2005 by two people with mental illness residing in large private State-funded facilities called Institutions for Mental Diseases (“IMDs”).  
**Settlement:** On September 30th, the Judge gave final approval of the Consent Decree. Over a five year period, all IMD residents who desire placement in the community shall transition to the most integrated community-based setting appropriate for their individual needs. The agreement will result in relieving some of the State’s financial burden currently created by housing individuals in IMDs, which are supported by 100% State funding. The State will now be eligible to receive federal Medicaid reimbursements for medications and health care when an individual is receiving those services in a community-based setting. |

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| Colbert v. Quinn 07-CV-04737 | Date Filed: 2011  
Case Status: Settlement (2011)  
Class Action: No | Physical Disability |
|-----------------------------|-----------------|---------------------|
| **Background:** ADA lawsuit filed in federal court in 2007 by people with disabilities (plaintiffs) who reside in Cook County nursing facilities and who want to live in community based settings and receive community services.  
**Settlement:** Filed a proposed consent decree with the court in August, 2011. In the first 30 months, provide housing assistance that will permit more than 1,000 class members currently living in nursing facilities to move into housing in the community who otherwise would not be able to do so. Require the State to develop a plan to transition other nursing facility residents into less restrictive and less costly community-based settings. Develop community-based services and housing for class members moving out of nursing facilities. Class members include all populations with physical disabilities, including older persons.
Appendix 2: Illinois Waiver Programs\(^3\)

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Eligibility Criteria</th>
<th>Services</th>
<th>Numbers Served</th>
<th>Expenditures (FY2006)</th>
</tr>
</thead>
</table>
| Elderly         | Individuals 60 years of age or older who would otherwise be institutionalized in a nursing facility. | • Homemaker  
• Adult day service  
• Emergency home response | 28,681\(^4\) (see note below for details regarding the growth of the waiver program) | $139,754,400   |
| Physical Disabilities | Individuals with physical disabilities from the ages of 0 to 59 (including ventilator dependent adults) who would otherwise be institutionalized in a nursing facility. Also those 60 or older who began services before age 60, may choose to remain in this waiver. | • Homemaker  
• Personal care (Personal Assistant)  
• Respite  
• Adult day care  
• Skilled nursing and home health aide  
• Physical, occupational and speech therapies  
• Personal emergency response system  
• Environmental accessibility adaptations  
• Specialized medical equipment and supplies  
• Home delivered meals | 18,813 | $186,445,430 |


\(^4\) Please note that the data from this table is from 2006. The source of the most complete, publicly available, data for Illinois waiver programs was the Illinois Department of Healthcare and Family Services website. However, the number of individuals served through some of the waiver programs as increased dramatically—especially for the Elderly Waiver program.
| Adults with Developmental Disorders | Individuals with mental retardation or developmental disabilities; 18 years or older who would otherwise be institutionalized in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). | • Residential habilitation, including 24-hour, Host Family and intermittent Community Integrated Living Arrangements (CILA), and Community Living Facilities (CLF) for 16 or fewer persons and settings  
• Day habilitation, including Developmental Training (DT), Supported Employment (SEP), and Adult Day Care  
• Home Based Support (HBS) services, subject to fiscal year and monthly cost maximums set by the State, that may include HBS service facilitation, day habilitation, personal support, nursing, behavior services, physical therapy, occupational therapy, speech/communication therapy, transportation, personal emergency response systems, training and counseling for unpaid caregivers, and crisis services  
• Behavior intervention, treatment, and counseling  
• Extended state plan services: physical, occupational, and speech/communication therapies  
• Adaptive equipment, assistive technology, home accessibility modification, and vehicle modification | 13,104 | $401,509,994 |
| --- | --- | --- |
| HIV/AIDS | Persons diagnosed with Human Immune Deficiency Virus (HIV), or Acquired Immune Deficiency Syndrome (AIDS), of any age, who would otherwise be institutionalized in a hospital setting. | • Homemaker  
• Personal care service (Personal Assistant)  
• Skilled nursing and home health aide  
• Physical, occupational and speech therapies  
• Personal emergency response system  
• Home delivered meals  
• Environmental accessibility adaptations  
• Specialized medical equipment and supplies  
• Adult day care  
• Respite  
• Transportation for employment | 1,506 | $15,290,017 |
|                     | Individuals with disabilities 22 years and over or individuals 65 years and over who would otherwise be institutionalized in a nursing facility | Intermittent nursing  
Personal care  
Medication oversight and assistance with self-administration  
Laundry  
Housekeeping  
Maintenance  
Social/recreational programming  
Ancillary (transportation to group/community activities, shopping, arranging outside services)  
24 hour response/security staff  
Health promotion and exercise programming  
Emergency call system | 3,697 | $58,010,774 |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| Persons with Brain Injury | Persons with brain injury of any age who would otherwise be institutionalized in a nursing facility. | Homemaker  
Personal care (Personal Assistant)  
Adult day care  
Day habilitation  
Prevocational services  
Supported employment services  
Environmental accessibility adaptations  
Personal emergency response system  
Behavioral services  
Physical, occupational and speech therapies  
Specialized medical equipment and supplies  
Skilled nursing and home health aide  
Respite  
Home delivered meals | 3,554 | $42,407,594 |
| Children and Young Adults with Developmental Disabilities – Support | Children and young adults with mental retardation or developmental disabilities; ages 3 through 21 who are at a risk of placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). | Residential Habilitation, including Child Group Homes for ten or fewer persons  
Assistive Technology  
Behavior Intervention and Treatment  
Adaptive Equipment | Information not provided by IL Dept. of Healthcare and Family Services | Information not provided by IL Dept. of Healthcare and Family Services |
| Children and Young Adults with Developmental Disabilities – Residential | Children and young adults with mental retardation or developmental disabilities; ages 3 through 21 who are at a risk of placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), | - Residential Habilitation, including Child Group Homes for ten or fewer persons  
- Assistive Technology  
- Behavior Intervention and Treatment  
- Adaptive Equipment | Information not provided by IL Dept. of Healthcare and Family Services  
Information not provided by IL Dept. of Healthcare and Family Services |
|---|---|---|---|
| Children That are Technology Dependent/Medically Fragile | Medically fragile and technology-dependent individuals under 21 years of age who meet the Department’s eligibility criteria under 89 Ill. Adm. Code 120.530. The individuals would otherwise require a level of care provided by, and be at risk of institutional care in, a skilled nursing facility or a hospital, the cost of which would be reimbursed under the State plan. This waiver is similar to the "Katie Beckett" waiver in other states, but this waiver is unique to Illinois. | - Nurse training  
- Family training  
- Special medical equipment and supplies  
- Environmental modifications  
- Respite care in the child's home  
- Respite care center services  
- Medically supervised day care  
- Placement maintenance counseling | 574  
$59,471,472 |
### Table: Summary of Key Home Care Research Studies

<table>
<thead>
<tr>
<th>State/Study</th>
<th>Home Care Program</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Implications for Illinois FY2013 Home Care Cuts</th>
</tr>
</thead>
</table>
| **1. National**<sup>5</sup>  
Avalere Health LLC, 2009 | Medicare home health services | Medicare home health utilization post-hospitalization. | Significant decrease in post-acute care costs and hospital readmissions. | Home health budget cuts for skilled care will result in an increase in post-acute care and hospital readmissions. |
| **2. National**<sup>6</sup>  
Fitch and Pyenson, 2003 | Medicaid Hospice benefit | Study modeled impact of elimination of Medicaid hospice benefit on current Medicaid hospice participants. | Average $7,000 cost increase annually to Medicaid system per Medicaid beneficiary who would otherwise be eligible for hospice.  
Cost increase due to increase in hospital use and less end-of-life care coordination including medication and DME coordination. | Illinois hospice budget cuts will result in cost increases due to unnecessary hospitalizations and unmet end-of-life needs of Medicaid beneficiaries relating to medications, DME and home care visits. |
| **3. Missouri**<sup>7</sup>  
Zuckerman, Miller and Shelton, 2009 | Medicaid DME, Hospice | Cut DME and hospice benefit coverage for Medicaid beneficiaries (in addition to multiple other Medicaid services)  
Reduce Medicaid | Missouri was not able to achieve the intended cost savings through its 2005 Medicaid cuts  
Medicaid spending growth slowed, expenditures did not decline. | Illinois budget cuts to DME and hospice (and other programs) and reduced Medicaid eligibility will not help the state to achieve cost savings; the state may, however, see spending rates slow. |

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<table>
<thead>
<tr>
<th><strong>4. National</strong>&lt;sup&gt;8&lt;/sup&gt; Kaye, LaPlante and Harrington, 2009</th>
<th><strong>eligibility</strong></th>
<th><strong>Policy Implications</strong></th>
</tr>
</thead>
</table>
| Medicaid waivers, Home Health benefit, and Personal Assistant Benefit (non-developmental disability population) | • States doubled their home care expenditures during expanding phase (defined as ‘expanding home care states’, including Illinois) | • Expanding home care states showed a cost **increase** in aggregate LTSS system over time  
• Lag time seen with expanding home care states before potential LTSS cost savings.  
• More ‘established home care states’ showed a cost **decrease** in aggregate LTSS system over time |
| Up until now Illinois has been an ‘expanding home care state’. By cutting home health, waivers, and decreasing home care expenditures, the state jeopardizes LTSS balancing and potential cost savings over the long-term. |

<table>
<thead>
<tr>
<th><strong>5. Ohio</strong>&lt;sup&gt;9&lt;/sup&gt; Mehdizadeh, Applebaum, Nelson, and Straker, 2011</th>
<th>Medicaid Waiver (primarily focused on Aging, includes several other waiver populations)</th>
<th><strong>Policy Implications</strong></th>
</tr>
</thead>
</table>
| Increased waiver expenditures and decreased nursing facility costs for persons age 60 years and older | Decrease in overall long-term care expenditures, despite increase in number of persons served.  
• More individuals served in home/community setting than institutional setting. | Illinois budget cuts to aging waivers undermine home care investment.  
Without investment in home care, the state jeopardizes LTSS balancing and certain cost savings over the long-term. |

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<table>
<thead>
<tr>
<th><strong>6. Michigan</strong></th>
<th>Medicaid Waiver for older persons and persons with physical disabilities</th>
<th>Budget cuts implemented through capping enrollment and increased eligibility threshold for waiver</th>
<th>Increase in Medicaid hospitalizations, emergency room visits and permanent nursing facility placement.</th>
<th>Illinois budget cuts to aging and physical disability waivers will result in increased usage of hospitals, emergency rooms and permanent nursing facility placement.</th>
</tr>
</thead>
</table>

| **7. Oregon** | All Medicaid funded home care services: in-home and adult foster care | Study modeled economic impact of a $1 million loss in federal Medicaid matching funds as a result of state Medicaid budget cuts on in-home care/adult foster home care | For $1 million loss in federal Medicaid matching for home care: 1. Loss of $1.8 million in total economic activity 2. Loss of ~26 full and part-time jobs including in-home service providers, and other sectors. | Illinois budget cuts to home care will be offset through corresponding loss of economic activity and job loss. |

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1. **Avalere Study**\(^{12}\) (Avalere Health LLC, 2009)
Avalere researchers compared Medicare beneficiaries in a fee-for-service environment who received ‘early post-acute care (PAC)’ home health services to beneficiaries who used non-home health PAC services, using Medicare claims data over a 2-year period of time. The analysis looked at 3 conditions: diabetes, chronic obstructive pulmonary disease and congestive heart failure. The study controlled for severity of illness, dual-eligibility status, and hospice utilization among other variables.

Avalere found statistically significant lower post-acute care costs and hospital readmissions among Medicare beneficiaries who received home health services. Per their calculations, home health use was associated with a $1.71 billion reduction in Medicare expenditures over the 2 year period of time. Of the $1.71 billion in savings, $216 million is associated with an estimated 24,000 fewer hospital readmissions. Further, if the use of home health was applied to the non-home health beneficiaries in the study, Avalere estimates savings could have included an additional $1.77 billion.

Although the Avalere study used Medicare claims data to analyze the impact of Medicare funded home health services, Medicaid home health services are equivalent and often provided through the same home health agencies by the same skilled professional staff. This study was highlighted to emphasize the impact home health utilization has on post-acute hospital utilization, not to focus on the role of the payer (Medicare vs. Medicaid).

2. **Milliman, USA Study on Medicaid Hospice Benefit**\(^{13}\) (Fitch and Pyenson, 2003)
In a Milliman USA, Inc. study commissioned by the National Hospice and Palliative Care Organization (NHPCO), researchers developed a methodology to estimate the cost of Medicaid services a Medicaid beneficiary would incur if their hospice benefit were eliminated. The study found average annual Medicaid savings of $7,000 per beneficiary. Hospice helped to save Medicaid money through three main mechanisms:

1. Avoidance of unnecessary hospitalization. Without hospice, individuals seeking end-of-life care often utilize hospitals.
2. Hospice includes the coordination of medication, durable medical equipment and home care visits. This is all bundled together in a daily rate.
3. When hospice is provided in a nursing facility, Medicaid is charged 95% of room and board. Without the hospice benefit, Medicaid is charged 100% of room and board.

3. **Missouri: Loss of Coverage for Durable Medical Equipment and Hospice** (Zuckerman, Miller and Shelton, 2009)\(^{14}\)
In 2005 Missouri cut many Medicaid programs that impacted 370,000 beneficiaries. Cuts included elimination of coverage for hospice and durable medical equipment (DME), in addition

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Researchers from the Health Policy Center at the Urban Institute examined the impact on enrollees and providers to serve as an example for other states considering Medicaid changes of this nature in response to state fiscal circumstances.

Drawing a comparison between Missouri and Illinois was justified because of the similarity of the cuts proposed, and the similarity in the category of cuts. Researchers concluded that Missouri was not able to achieve savings through its 2005 Medicaid cuts: though the Medicaid spending growth slowed it did not decline. Researchers suggested an alternative solution to Medicaid budget cuts: temporary enhanced federal government Medicaid match to states in need of fiscal relief who do not cut Medicaid program eligibility.

4. National Home Care versus Institutional LTSS Expenditures Study (Kaye, LaPlante and Harrington, 2009)16

Researchers analyzed state Medicaid data for LTC expenditures from 1995-2005. Select analysis of their research focused on data expenditures for: nursing home, personal care, home health and waiver expenditures associated with the non-mentally retarded/developmentally disabled (MR/DD) population. The focus of this analysis is on the non-MR/DD for comparison purposes to the other studies selected.

The study classified states spending more than median LTSS expenditures on home care into 2 categories: established and expanding. Note: Illinois is classified as an expanding home care state as defined below:

1. “Established Home Care States” with greater than median of LTSS expenditures toward home care. Home care expenditures relatively stable, or established.
2. “Expanding Home Care States” with greater than median of LTSS expenditures toward home care. Home care expenditures markedly increasing, or expanding. This was defined as states whose home care spending more than doubled from 1995-2005. Illinois is categorized as an Expanding High Home Care State.

Total LTSS spending (for non-MR/DD population) showed the following trends:

- Established Home Care states showed an aggregate LTSS system cost decrease over the time studied
- Expanding Home Care states (Illinois) showed an aggregate LTSS system cost increase over time the studied
  - Expanding Home Care states can expect an initial increase in LTSS expenditures (an investment into balancing LTSS), followed by a lag period of time before a reduction in institutional LTSS expenditures.

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15 Coverage for individuals who were blind, pregnant or a in a nursing facility maintained prior coverage. For the remainder of the Medicaid population coverage was cut for the following health services: dental services, dentures, podiatry, orthopedic devices, hearing aids, eyeglasses, optometric services, prosthetics, wheelchairs, comprehensive day rehabilitation services (adults with head injuries), hospice, durable medical equipment, and rehabilitative therapy.

Through the coupling of increased home care expenditures and subsequent delayed decreased institutional expenditures, expanding home care states can expect to see a decrease in total LTSS expenditures.

- To achieve institutional LTSS savings (and thus total LTSS cost savings), the number of Medicaid nursing facility residents must be reduced along with a parallel process of investing in home care.

Note: The authors of this research paper spoke with the primary researcher of this study, Dr. Stephen Kaye, Institute for Health & Aging at the University of California San Francisco. (S. Kaye, personal communication, April 18, 2012). Dr. Kaye informed the authors that a subsequent analysis of this data will be published in June, 2012, in a high impact health policy peer reviewed journal. The findings of this analysis are in alignment with this paper’s conclusions and strengthen our argument against Medicaid home care cuts. Once the study is published, we will amend this paper to include and properly cite these pivotal findings.


Since 1993, the Ohio Long-Term Care Research Project has collected data on utilization of institutional and community-based services through grant funding from the Ohio Department of Aging and the Ohio General Assembly through the Ohio Board of Regents. During a 16-year period, data shows that Ohio has changed the way in which it delivers and finances long-term care: more care is provided in the home and community-based setting, and less care in the nursing facility setting.

Key findings from the Ohio longitudinal study for the population age 60 years and over include: more people are being served overall with LTSS for less money as nursing facility utilization decreases and home care utilization increases.

These graphs and findings are based on data from the Ohio PASSPORT Waiver program: ‘providing in-home services to individuals age 60 and over with severe disability’.


In a 2009 article published in The Gerontologist, University of Michigan researchers analyzed the effects of cutting home care services. The study focused on cuts to Michigan’s “MI Choice” waiver program, which serves older persons and persons with physical disabilities.

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18 Cite Ohio’s waiver programs


20 Cite Michigan’s MI Choice Waiver Program separate from Study
Choice offers a range of in-home services: personal care, respite, homemaker, adult day care, environmental modifications, and nurse/social worker team-based case management. Waiver cuts were implemented between 2002 and 2005, through closing new waiver participant enrollment which decreased waiver budget amounts for case management and direct services, and by raising the eligibility threshold. From 2002 to 2005, the MI Choice Waiver saw a decrease in funding of 17%.

As a result of decreased funding, there were less MI Choice waiver participants, and Michigan responded appropriately by reducing the number of case managers. During the same time period, less formal services were provided to waiver participants, meaning less hours of care were provided. The time it took to deliver the waiver services, however, remained the same. Larger decreases in formal services were seen among individuals with moderate physical (functional) and cognitive impairment, compared to individuals with less or greater impairment.

Data analysis showed that among Medicaid beneficiaries over the period from 2001 through 2006 on an aggregate level there was an increase in hospitalizations, permanent nursing facility (NF) placement, hospital emergency room visits, and caregiver burden. These adverse outcomes indicate unmet needs increased and that waiver participants could not continue to be maintained in their homes and communities.

Researchers concluded that for some waiver participants, lower levels of services were associated with health status and the choice to remain at home. Further, more research is needed to determine if increasing, rather than decreasing, home care resources may have been a more appropriate response to reduced state financial resources. The increase in costs associated with the adverse outcomes of increased hospital, nursing facility and emergency home utilization during a financially strained time may have been mitigated by increasing in-home services.

Researchers also noted that budget cuts to home care intended to save money may be offset if individuals experience more adverse consequences, and recommended that policymakers consider ‘overall cross-program effects of budget reductions on access to preferred care settings and health outcomes’.

It’s important to note that Michigan’s response to budget cuts was to decrease the number of care management staff, though there are many different responses a state could make to a decline in waiver funding. Importantly, prior research has shown that case management as a waiver service is associated with significant reduction in nursing facility placement.

7. Oregon: Economic Impact of Medicaid Home Care Cuts and Subsequent Loss of Federal Matching Funds (Josephson, Tapogna, and Johnson, 2009)

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In 2009, Oregon’s Governor’s Office requested that all state government agencies reduce their expenditures by 10% over a 2-year period of time. For the Oregon Department of Human Services, this resulted in the loss of $37.4 million in state funding, and the loss of $62.8 million in federal matching funds, for home care providers (in-home and adult foster care providers).

The researchers, ECONorthwest, developed a model to analyze the impact of just $1 million in lost federal Medicaid matching funds. For each $1 million in lost funding for the Oregon home care sector, a total of $1.8 million would be lost across such diverse sectors as: natural resource, construction, manufacturing, retail, professional services, government, and more. For every $1 million in lost federal matching funds, the following losses would be seen, totaled across industry sectors:

- $719,000 in lost wages
- $73,600 in lost small-business income
- $189,000 in lost rent, profit and other incomes
- $81,820 in lost state and local tax revenues
- 33 jobs
Appendix 4: Medicaid Reimbursement Rate for Home Health Care\textsuperscript{23}—Comparison of Illinois to other Midwestern and Large States\textsuperscript{24}

<table>
<thead>
<tr>
<th>States</th>
<th>RN</th>
<th>PT</th>
<th>OT</th>
<th>ST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>$99.28</td>
<td>$108.55</td>
<td>$109.28</td>
<td>$117.95</td>
</tr>
<tr>
<td>Indiana</td>
<td>$68.01</td>
<td>$89.05</td>
<td>$89.75</td>
<td>$91.85</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$84.28</td>
<td>$80.52</td>
<td>$82.67</td>
<td>$85.35</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$87.15</td>
<td>$85.05</td>
<td>$89.05</td>
<td>$85.05</td>
</tr>
<tr>
<td>Missouri</td>
<td>$62.79</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Michigan</td>
<td>$80.98</td>
<td>$78.12</td>
<td>$63.39</td>
<td>$78.12</td>
</tr>
<tr>
<td>Ohio</td>
<td>$55.00</td>
<td>$70.00</td>
<td>$70.00</td>
<td>$70.00</td>
</tr>
<tr>
<td>California</td>
<td>$74.86</td>
<td>$68.86</td>
<td>$71.36</td>
<td>$78.43</td>
</tr>
<tr>
<td>Arizona</td>
<td>$79.31</td>
<td>$73.90</td>
<td>$78.65</td>
<td>n/a</td>
</tr>
<tr>
<td>Illinois</td>
<td>$61.34</td>
<td>$61.34</td>
<td>$61.34</td>
<td>$61.34</td>
</tr>
</tbody>
</table>

| States Avg. from above | $76.85 | $81.76 | $81.77 | $86.68 |
| Difference            | -$15.51 | -$20.42 | -$20.43 | -$25.34 |

\textsuperscript{23} Includes Registered Nurses (RN), Physical Therapists (PT), Occupational Therapists (OT) and Speech Therapists (ST).
\textsuperscript{24} National Association of Homecare and Hospice, Forum of States Data Repository. (2012).
Appendix 5: Balancing Incentive Payment Program (BIP) analysis of potential increased federal Medicaid matching money for Illinois

NOTE

To: Interested Parties
From: Justin Foley, SEIU Research  
(Justin.Foley@seiu.org)
Re: BIP FMAP $ Increase for Illinois
Date: April 9, 2012

Based on the most recent guidance and information from The Centers for Medicare and Medicaid Services (CMS), SEIU has conducted an analysis of the additional amount Illinois might reasonably expect to receive as a result of a successful application for the Balancing Incentives Program (BIP). As noted below, we believe these estimates to be conservative.

Using the figures provided in Attachment C of the BIP Initial Announcement, we first simply applied the applicable Federal Medical Assistance Percentage (FMAP) increase to the Home and Community Based Services (HCBS) total provided for FY2009. This provides a minimum estimate that assumes zero HCBS program growth from FY2009 through FY2014. The estimate is a constant annual amount over the program’s four years.

<table>
<thead>
<tr>
<th>I. Annual FMAP Increase; Basic</th>
<th>Illinois</th>
<th>$18,330,341</th>
</tr>
</thead>
</table>

A successful BIP application requires a commitment to rebalancing. This commitment includes meeting a minimum target percentage of HCBS as a part of total LTSS spending. The second estimate models spending to reach this target at a constant, compounding growth rate. It also assumes that each dollar of new HCBS spending will equal one less dollar of Institutional spending. The estimate represents an average annual amount for the program’s four years.

<table>
<thead>
<tr>
<th>II. Annual FMAP Increase; Spending to BIP Target; Institutional Spending Declining</th>
<th>Illinois</th>
<th>$26,837,605</th>
</tr>
</thead>
</table>

The third estimate performs the same calculations as Estimate II with one key difference. This model assumes that Institutional spending will stay at FY2009 levels, and that HCBS growth will be due to new spending. As with Estimate II, this is an average annual amount for the program’s four years.

<table>
<thead>
<tr>
<th>III. Annual FMAP Increase, Spending to BIP Target, Institutional Spending Constant</th>
<th>Illinois</th>
<th>$34,527,119</th>
</tr>
</thead>
</table>

As these estimates do not include additional assumptions (such as population growth or the effects of inflation) we consider them to be conservative. For more information, please contact Justin Foley at Justin.Foley@seiu.org/212-471-1316.

25 United States Department of Health and Human Services, Center for Medicaid and Medicare Services, State Balancing Incentive Payments Program, Initial Announcement.  