Study Looks at Seniors Who Opt Out of Connecticut Medicaid Home and Community-based Care Program

Resource use by non-participants in Connecticut's Medicaid home and community based waiver program

SUMMARY

Researchers at the Urban Institute under the direction of Korbin Liu, Sc.D., and Sharon K. Long, Ph.D., studied how low-income, older adults in Connecticut who are disabled were managing their long-term care needs after they chose not to participate in, or were excluded from, the state's Medicaid's home and community-based care program.

The project was part of the Robert Wood Johnson Foundation (RWJF) Home Care Research Initiative national program (for more information see Program Results Report).

The researchers compared 336 nonparticipants with 1,354 participants in Connecticut's Medicaid home and community-based care program. The researchers also conducted an analysis of the impact of the Balanced Budget Act of 1997 (BBA) on Medicare home health utilization. And they studied the impact of the BBA's home health provisions on the interaction between Medicare and Medicaid home care in Connecticut.

Key Findings

- Participants and non-participants in Connecticut's Medicaid home and community-based care program were very similar in most demographic and health status characteristics.

- Although participants and non-participants were equally likely to use Medicare home health services, the non-participants were more likely (12.8%) to be admitted to nursing homes than participants (6.1%) within six months of program assessment.

- Non-participants in Connecticut's home and community-based care program offered many reasons for not participating, including concerns about Medicaid estate

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1 BBA (Balanced Budget Act of 1997): The BBA included a variety of home health policy changes, including eligibility and coverage criteria and, most significantly, payment policy to home health care agencies (through limits on allowable costs per visit and caps on the number of visits per beneficiary). It mandated major changes in the way Medicare home health is reimbursed.
recovery, preference for other ways to meet long-term care needs and the belief that they would not meet financial eligibility requirements.

- Few subgroups in Connecticut were disproportionately affected by BBA policies. People with more activities of daily living (ADL)\(^2\) limitations received disproportionately fewer visits than those without such limitations.

- Some home health agencies in Connecticut closed or merged with others because of the change in the Medicare payment structure resulting from the BBA. Many agencies reduced staff and benefits and scaled back overhead.

- The number of referrals to the Connecticut Medicaid home and community-based care program increased by 40 percent after the passage of the BBA.

Researchers published articles about the project in *Home Health Care Services Quarterly* and *Health Care Financing Review*; another has been accepted by the *Journal of Aging & Social Policy*. See the Bibliography for details.

**Funding**

RWJF supported this project from 1998 to 2002 with a $309,532 grant.

**THE PROBLEM**

Since the early 1980s, home and community-based care has been seen as a potentially more cost-effective strategy than nursing home care for providing long-term care services to elderly people who are disabled.

A major impetus for home and community-based care programs was the authority given to the federal government in 1981 to grant waivers under Medicaid for provision of such services. With a home and community-based service waiver, states can cover a wide range of nonmedical, community-based long-term care services, including personal care, adult day care, rehabilitation and respite care.

Despite the popular support for home and community-based service waivers and their potential for cost savings, some people who are referred for services choose not to participate. In earlier research on referrals to Connecticut’s home and community-based care program, researchers from the Urban Institute (an economic and social policy research organization based in Washington) found that 25 percent of those who applied for the program and met eligibility requirements did not enroll.

\(^2\) ADL (activities of daily living): Basic daily tasks of life, such as eating, continence, transferring in and out of bed, toileting, dressing and bathing. An ADL scale allows a health professional to establish the levels at which an older adult functions in caring for himself or herself and performing these activities.
Some nonparticipants entered nursing homes. Others had care needs that exceeded costs allowed by the program, withdrew before care plans were developed or refused services after care plans were completed. The researchers also found that 44 percent of nonparticipants were still living outside of nursing homes six months after their assessment.

This study, however, did not enable them to determine how low-income, older adults in Connecticut who are disabled could remain in the community without waiver-financed services.

**THE PROJECT**

Researchers at the Urban Institute studied how low-income, older adults in Connecticut who are disabled were managing their long-term care needs after they chose not to participate in, or were excluded from, the state's Medicaid's home and community-based care program.

Researchers compared program nonparticipants and participants in terms of: personal and health characteristics, use of informal and paid long-term care services and major transitions such as nursing home admission. They also studied why people chose not to participate in the program.

Researchers collected data on all people (1,690) who were referred to Connecticut's home and community-based care program from March 1999 through February 2000; this included 1,354 people who enrolled in the program and 336 nonparticipants. Staff at Connecticut Community Care Incorporated, a private, nonprofit organization, performed the assessments and case management for home and community-based care waiver clients in Connecticut.

Researchers collected primary data from:

- a supplemental data form attached to Connecticut Community Care Incorporated's routine patient assessment.

- telephone interviews with non-participants on the reasons for their choice about one month after the initial assessment.

- follow-up telephone interviews with nonparticipants on how they were managing their long-term care needs three to four months after their assessment.

The researchers also analyzed secondary data on both groups, including:

- initial assessment information.

- Connecticut Community Care Incorporated care plan data on participants.
Medicare claims data.

The researchers studied substantially fewer people than originally projected (1,354 participants and 336 nonparticipants versus the projections of 2,700 participants and 900 nonparticipants), because applications to the program were far lower than expected. This was due, in part, to the BBA\(^3\) home health provisions, which resulted in a 50 percent decline in Medicare home health spending in 1999, the year primary data collection began.

With fewer people to study, researchers had substantial funds left over. After discussions with the Home Care Research Initiative program director, they used these funds for two new studies:

- **Impact of the BBA on Medicare Home Health Utilization.** Researchers analyzed data from the Medicare Current Beneficiary Survey to determine which subgroups of older adults may have been disproportionately affected by the BBA. They based their analysis on survey findings from 56,596 people over six years (1994–1999). The federal Centers for Medicare & Medicaid Services, which administers the two programs, conducts the survey.

- **Interaction Between Medicare and Medicaid Home Care in Connecticut.** Researchers studied the impact of the BBA's home health provisions on home care services provided in Connecticut, especially the interaction between Medicare and Medicaid home care payments. They collected data through telephone interviews with six home care providers, three state policy-makers and two advocacy groups in Connecticut.

**FINDINGS**

As reported to RWJF and in a forthcoming article in *the Journal of Aging & Social Policy: Participants and Nonparticipants in Connecticut's Home and Community-Based Care Program.*

- **Participants and nonparticipants in Connecticut's Medicaid home and community-based care program were very similar in most demographic and health status characteristics.** Key differences were that the nonparticipants had slightly higher average income (42% had monthly incomes above $1,000 versus 24% of participants), were more likely to be cognitively impaired (39% had Alzheimer's disease or other dementia versus 27% of participants) and had slightly stronger informal care networks (30% were married versus 19% of participants, and 64% lived with others versus 53% of participants).

\(^{3}\)BBA (Balanced Budget Act of 1997): The BBA included a variety of home health policy changes, including eligibility and coverage criteria and, most significantly, payment policy to home health care agencies (through limits on allowable costs per visit and caps on the number of visits per beneficiary). It mandated major changes in the way Medicare home health is reimbursed.
- Although both groups were equally likely to use Medicare home health services, nonparticipants were more likely to be admitted to nursing homes within six months of assessment for Connecticut's home and community-based care program. 12.8 percent of nonparticipants were admitted to nursing homes within six months of assessment, versus 6.1 percent of participants.

- Nonparticipants offered a range of reasons for their decision not to participate in Connecticut's Home and Community-Based Care program, including concerns about Medicaid estate recovery if they enrolled for the program, preference for other ways to meet long-term care needs and the belief that they would not meet financial eligibility requirements. Factors in not participating included eligibility concerns (30.1%), financial/estate issues (30.9%) and a complicated program application process (22%). Nonparticipants rated eligibility concerns (22.8%) and financial/estate issues (12.2%) as the most important factors in not participating in the program.


- The use of any Medicare home health service, and the intensity of services used, varied widely by health and demographic characteristics. Both the likelihood of using home health services and the intensity of services declined after the passage of the BBA. The overall proportion of home health users was 10.3 percent in 1996 and 7.4 percent in 1999. The average number of visits per user declined from 72.1 in 1996 to 37.3 in 1999.

- Few demographic and health subgroups were disproportionately affected by BBA policies. Yet, people with three or more ADL limitations received disproportionately fewer visits after passage of the BBA than those without ADL limitations.

- In general, the "per-beneficiary cost limit" of the interim payment system mandated by the BBA strongly decreased the use of home care services by people who had a lot of visits in the pre-BBA period. (The Centers for Medicare & Medicaid Services established the interim payment system in 1997 until a prospective payment system—as required by the BBA—could be developed.) After passage of the BBA, the average number of visits fell 30 percent for people who had been hospitalized and 40 percent for others.

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4 ADL (activities of daily living): Basic daily tasks of life, such as eating, continence, transferring in and out of bed, toileting, dressing and bathing. An ADL scale allows a health professional to establish the levels at which an older adult functions in caring for himself or herself and performing these activities.

3 Prospective payment system: A method of reimbursement used by the federal Centers for Medicare & Medicaid Services that bases Medicare payments on a predetermined, fixed amount. The payment amount derived for a particular service is based on the classification system of that service (for example, DRGs for inpatient hospital services).
As reported in *Home Health Care Services Quarterly* (vol. 20, no. 3, 2001): *Interactions Between Medicare and Medicaid Home Care in Connecticut: Responses to the 1997 BBA*.

- "The change in the payment structure under IPS [interim payment system] led some agencies to close down or merge with other agencies." The number of certified home health agencies in Connecticut decreased by about 30 percent between the start of the interim payment system and early 2001. Remaining agencies responded to changes in the payment structure by cutting staff and benefits and scaling back overhead functions to reduce costs. Some agencies decided to stop accepting new Medicaid patients unless Medicaid payment rates were increased. They had been using Medicare payments to subsidize these services, and when the Medicare benefits were reduced, they could not afford to provide services without an increase in Medicaid payment rates.

- "The number of referrals to the [Medicaid] HCBC [home and community-based care] program increased almost 40 percent between 1997 (4,203 individuals) and 1998 (5,989 individuals) and then declined somewhat in 1999 (5,160 individuals)." The increase in referrals in 1998 probably resulted from the interim payment system's constraints on Medicare payment.

- "With a decline in Medicare home health services, participants in Medicaid HCBC [home and community-based care] increased. The increased participation rate contributed to a substantial increase in the number of HCBC [home and community-based care] clients from 6,200 in 1997 to 8,000 in 1998."

**Communications**

Researchers published articles about the project in *Home Health Care Services Quarterly*, the *Journal of Aging & Social Policy* and *Health Care Financing Review*. See the Bibliography for details.

**LESSONS LEARNED**

1. **The timing of data collection should consider "global" developments that could affect the behavior of potential study subjects.** The researchers were surprised at the magnitude of the impact that the change in national Medicare policy affecting home health services (i.e., the BBA Medicare home health provisions) had on applications for Medicaid home health services. (Principal Investigator)

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Articles

