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# REBALANCING LONG-TERM SUPPORTS AND SERVICES AMONG OLDER ADULTS ENROLLED IN MEDICAID, 2016-2019

## KEY POINTS

- Older adults (65 years of age and older) are less likely to receive long-term services and supports in home and community-based settings than younger adults (ages 18-64), resulting in lower rebalancing ratios.
- Between 2016 and 2019, rebalancing ratios for older adults increased, by two percentage points and five percentage points, respectively, for those with and without intellectual and developmental disabilities.
- There is limited evidence that specific Medicaid policies and programs impact statewide rebalancing ratios.
- Additional mixed-methodology research is necessary to understand how specific elements of Medicaid policy and program implementation impact rebalancing among older adults in the United States.

## BACKGROUND

Long-term services and supports (LTSS) help individuals with functional limitations, including older adults and individuals with disabilities, carry out activities of daily living (ADLs) (e.g., dressing, walking, eating) and instrumental activities of daily living (IADLs) (e.g., cleaning, shopping). LTSS are a variety of health, health-related, and social services that can be delivered in a range of institutional and home and community-based settings.[1] Services delivered in institutional settings, such as nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), and mental health facilities, are collectively referred to as institutional LTSS. Services such as home health aides, personal care services, adult day, habilitation, and non-emergency medical transportation are delivered in home and community settings and referred to as home- and community-based services (HCBS). Medicaid, the federal-state health insurance program for low-income and disabled populations, is the dominant insurance payor for LTSS in the United States.[2]

Historically, Medicaid coverage for LTSS has been biased toward institutional settings because states were only mandated to cover medically necessary nursing facility care and skilled home health services for their eligible enrollees. Today, all state Medicaid programs voluntarily elect to provide some HCBS to eligible enrollees with disabilities. Over the last several decades, policy changes, including those made through legislative amendments, regulations, and court decisions, and federally funded grant programs have greatly expanded HCBS coverage options and supported the delivery of LTSS in the home and community.

With the increase in access to and reimbursement of HCBS, significant efforts from the U.S. Department of Health and Human Services (HHS), including the Centers for Medicare & Medicaid Services (CMS), and states have been undertaken to support Medicaid enrollees with disabilities remaining in their communities for care. This movement away from large-scale institutionalization toward home and community-based care has been referred to as “rebalancing.” Historically, official estimates of LTSS rebalancing efforts have been measured as the share of statewide Medicaid LTSS spending that went toward HCBS instead of institutional LTSS, irrespective of actual service utilization patterns. While we have observed steady increases in rebalancing as

measured by changes in statewide Medicaid spending, this measure tells us very little about the degree to which enrollees are actually receiving appropriate levels care in the most appropriate setting. It also obscures our ability to assess which subpopulations of enrollees are rebalancing faster than others. While many states have seen improvement in overall rebalancing, evidence has shown that rebalancing among older adults (adults 65 years of age and older) has been significantly slower. For example, in fiscal year (FY) 2018, CMS estimated only 33% of Medicaid LTSS expenditures for older adults and people with physical disabilities or other disabilities was for HCBS,[3] while almost 79% of Medicaid LTSS expenditures for individuals with intellectual and developmental disabilities (ID/DD) was for HCBS.[3] In this study, we used Medicaid enrollment and claims data to assess state and national trends in rebalancing among older adult LTSS users, as compared to their younger adult counterparts (aged 18-64).

## METHODS

This study used a mixed-methodology approach comprising analyses of Medicaid enrollment and claims data, programmatic and policy analysis, and technical expert panels (TEPs). We used Transformed Medicaid Statistical Information System (T-MSIS) Analytic File (TAF) Research Identifiable Files (RIFs) for years 2016 through 2019 to assess enrollee eligibility, enrollment, and service utilization in all settings and paid for via both fee-for-service and managed care payment arrangements. We used demographic information and diagnosis codes to identify age and ID/DD-related subpopulations of interest, including LTSS users who are age 65 and older with and without ID/DD and LTSS users who are under 65 with and without ID/DD. We created standardized LTSS outcomes for 49 states (omitting Florida because of poor data quality) and Washington, DC to determine patterns of service use and, ultimately, rebalancing. For this study, rebalancing is defined as the ratio of months in a state where an LTSS-using enrollee only used HCBS per the total months of LTSS use among all enrollees (HCBS, institutional, or both). To supplement Medicaid claims data, we used state-level Medicaid program and policy, population characteristics, and health system factor data from a variety of secondary sources to assess how they may influence states' LTSS system rebalancing. For additional information on the methodologies used in this study, see *Rebalancing of Medicaid-Funded Long-Term Services and Supports, 2016-2019: Descriptive Analyses of National and State Rebalancing by Enrollee Age, Health Condition, and Demographic Factors*.

## FINDINGS

Between 2016 and 2019, we identified approximately eight million Medicaid enrollees with claims for LTSS. Older adults (ages 65 and older) without ID/DD made up 39% of all LTSS users, while 1% were older adults with ID/DD. Nationally, the rebalancing ratio among all LTSS users was 72.4%, indicating that for all months in which Medicaid enrollees used any LTSS between 2016 and 2019, 72.4% of those months had at least one claim for HCBS and no concurrent claims for long-term institutional LTSS. However, older adults without ID/DD had the lowest ratio of LTSS rebalancing among the four age and ID/DD-related subpopulations of LTSS users, using HCBS exclusively during 55.2% of all months in which they received any LTSS. Older adults with ID/DD had a slightly higher rebalancing ratio, using HCBS exclusively during 61.4% of all months in which they received any LTSS (**Table 1**). Rebalancing ratios for older adult subpopulations varied by state, ranging from 86.6% to 20.2% for those without ID/DD and 90.4% to 28.9% for those with ID/DD.

| Table 1. Rebalancing Ratio by State and Subpopulation, 2016-2019 | | | | | |
|---|---|---|---|---|---|
| | Rebalancing Ratio | | | | |
| | All LTSS Users | Younger Adults (18-64) | | Older Adults (65+) | |
| | | Without ID/DD | With ID/DD | Without ID/DD | With ID/DD |
| **United States** | **72.4** | **86.8** | **88.9** | **55.2** | **61.4** |
| Alabama | 55.2 | 80.3 | 84.7 | 27.7 | 40.4 |
| Alaska | 91.1 | 93.7 | 97.6 | 86.6 | 90.4 |
| Arizona | 61.4 | 74.4 | 95.2 | 31.4 | 42.4 |
| Arkansas[a] | 86.9 | 93.6 | 95.9 | 77.5 | 82.9 |
| California | 62.8 | 77.8 | 89.7 | 26.6 | 48.8 |
| Colorado[a] | 80.6 | 90.6 | 96.7 | 65.3 | 82.3 |
| Connecticut | 67.5 | 85.1 | 90.2 | 52 | 63.5 |
| Delaware | 67.6 | 81.4 | 91.2 | 44.4 | 77.1 |
| District of Columbia | 77.7 | 87.3 | 85.6 | 64.1 | 57.7 |
| Florida[b] | -- | -- | -- | -- | -- |
| Georgia | 72.7 | 89.7 | 92.9 | 46.6 | 58.6 |
| Hawaii | 78.9 | 93.4 | 93.5 | 59.5 | 80.4 |
| Idaho | 82.2 | 91.6 | 91.2 | 67.2 | 64.1 |
| Illinois | 65.7 | 68.5 | 74.2 | 62.9 | 48.1 |
| Indiana | 57.2 | 77.8 | 81.4 | 33.9 | 48.4 |
| Iowa | 64.2 | 84.2 | 77.9 | 46.9 | 42.7 |
| Kansas[a] | 66.3 | 84.9 | 94.2 | 41.6 | 65.8 |
| Kentucky | 53.4 | 78.2 | 91.9 | 20.2 | 53.1 |
| Louisiana[a] | 49.3 | 65.6 | 74.9 | 29 | 36.8 |
| Maine | 66.7 | 98.7 | 96.2 | 29.5 | 69.6 |
| Maryland | 73.1 | 89.8 | 95.1 | 42 | 64 |
| Massachusetts[a] | 78.3 | 90.6 | 95.1 | 66.6 | 75.9 |
| Michigan | 73.2 | 92.3 | 96 | 27 | 75.1 |
| Minnesota | 78.1 | 93.1 | 93.4 | 51.6 | 68.5 |
| Mississippi | 61.5 | 73.4 | 72 | 52.5 | 54.5 |
| Missouri | 44 | 41.9 | 82.7 | 39.3 | 32.2 |
| Montana | 59 | 83 | 88.8 | 37.7 | 42.2 |
| Nebraska[a] | 55 | 76.1 | 88.5 | 34.2 | 45.2 |
| Nevada[a] | 78.8 | 84.7 | 92 | 70.9 | 71 |
| New Hampshire | 73.3 | 94.4 | 97.6 | 39.3 | 64.4 |
| New Jersey | 66.8 | 75.7 | 88.2 | 58.1 | 60.6 |
| New Mexico | 89.6 | 96.6 | 95 | 74.6 | 80 |
| New York | 80.4 | 92 | 91.6 | 69.7 | 75.7 |
| North Carolina[a] | 69.7 | 85.2 | 80.8 | 55.1 | 55.4 |
| North Dakota | 52.1 | 78.5 | 74.4 | 31.8 | 28.9 |
| Ohio | 65.3 | 78.7 | 81.5 | 51.1 | 53.3 |
| Oklahoma | 63.2 | 75.5 | 78.5 | 52 | 59.6 |
| Oregon | 93 | 97.4 | 98.3 | 86.5 | 90.3 |

| Table 1 (*continued*) | | | | | |
|---|---|---|---|---|---|
| | Rebalancing Ratio | | | | |
| | All LTSS Users | Younger Adults (18-64) | | Older Adults (65+) | |
| | | Without ID/DD | With ID/DD | Without ID/DD | With ID/DD |
| Pennsylvania | 71.5 | 91.8 | 88.8 | 44 | 58.2 |
| Rhode Island[a] | 38.1 | 60.4 | 73.3 | 28.4 | 42.3 |
| South Carolina | 73.1 | 85.5 | 91.8 | 56.7 | 71.1 |
| South Dakota | 58.5 | 82.4 | 93.4 | 31 | 63.1 |
| Tennessee[a] | 75.5 | 93 | 86.8 | 40.5 | 57.9 |
| Texas | 73.7 | 84.1 | 84.2 | 64.5 | 48.5 |
| Utah [b] | 83.4 | 91.4 | 87.4 | 59 | 79.5 |
| Vermont | 82.2 | 95.4 | 98.8 | 64.5 | 78.4 |
| Virginia | 73.9 | 87.1 | 93.8 | 59.2 | 69.1 |
| Washington | 84.8 | 91.9 | 97.3 | 77.2 | 70.8 |
| West Virginia[a] | 71.2 | 90.5 | 87.6 | 44.4 | 50 |
| Wisconsin | 90.6 | 98.1 | 97.2 | 75.2 | 82.7 |
| Wyoming | 76.8 | 94.2 | 95.5 | 44.9 | 63.2 |

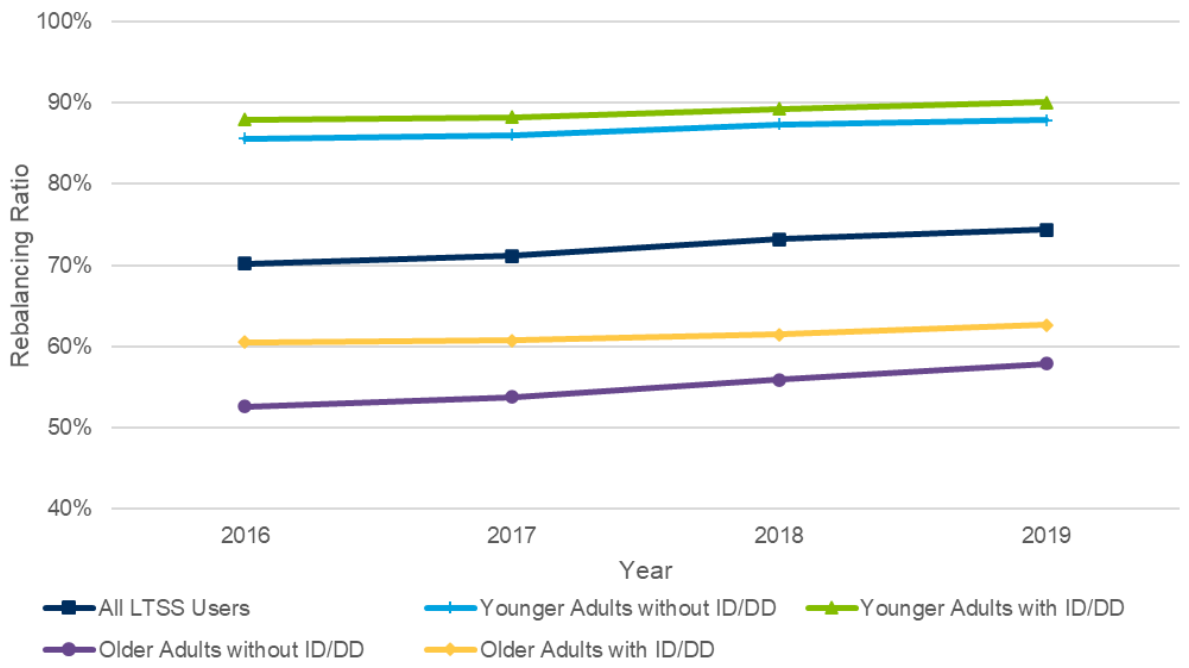
Source: RTI analysis of TAF RIF enrollment and claims data, 2016-2019.

Notes:

a. These states had at least one year in the study period that was omitted from analyses due to data quality concerns.
b. Florida was omitted from analyses due to data quality concerns.

Between 2016 and 2019, rebalancing ratios increased more for older adults than younger adults. **Figure 1** shows the annual rebalancing ratios for all LTSS users and by age and ID/DD-related subpopulations during the study period. National rebalancing ratios for younger adults without ID/DD, younger adults with ID/DD, and older adults with ID/DD all increased by 2 percentage points between 2016 and 2019. The rebalancing ratio for older adults without ID/DD increased the most, by 5 percentage points, during that time.

**Figure 1. Annual National Rebalancing Ratio by Subpopulation, 2016–2019**




**Source**: RTI analysis of TAF RIF enrollment and claims data, 2016-2019.

## DISCUSSION

By utilizing person-level Medicaid claims, we were able to detect variations in rebalancing trends by certain age and ID/DD-related subpopulations that showed significant disparities between older and younger adult Medicaid enrollees who use LTSS. Estimates of HCBS use and rebalancing among all LTSS users, such as those done using statewide cost report data, hide variations in service use across subpopulations, specifically older adults (ages 65+). Nationally, older adults without ID/DD had a rebalancing ratio of 55.2%, while older adults with ID/DD had a rebalancing ratio of 61.4%. Comparatively, younger adults without ID/DD had a rebalancing ratio of 86.8%, while younger adults with ID/DD had a rebalancing ratio of 88.9%. The gap between rebalancing for younger and older adults persisted in all states, with an average difference of 32 percentage points for enrollees without ID/DD and an average difference of 28 percentage points for enrollees with ID/DD.

Despite lower rebalancing among older adults nationwide, several states achieved high degrees of rebalancing among older adult populations, with Alaska, Oregon, and Arkansas having the highest ratios. These states have undertaken various policy reforms and operate in vastly different state and health system contexts, yet achieved similar results. All three states expanded Medicaid,[4] covered self-directed personal care services via a 1915(j) or state plan,[5,6] and covered personal care services. However, each state also had unique contextual factors, such as Arkansas' adoption of a 1915(i) state plan option[5] and Oregon's adoption of a 1915(k) state plan option.[5] Arkansas participated in the Balancing Incentive Program, but none of the states participated in the CMS's Value-Based Payment IAP for HCBS or Financial Alignment Initiative. Arkansas's LTSS population was significantly more frail, likely to be dually eligible for Medicare and Medicaid, and live in poverty than the LTSS populations in Oregon and Arkansas. Oregon's score on the Aging and Disability Resource Center's No Wrong Door metric was significantly higher than Arkansas and Alaska's scores.[8]

Among the 10 states with the highest rebalancing ratio for older adults, only one programmatic or policy condition was present in every state: coverage of personal care services.[5,6] However, seven of the ten states

with the lowest rebalancing ratios for older adults also cover personal care services. Across the Medicaid programs and policies analyzed in this study, no program or policy was quantitatively associated with rebalancing among older adults, other subpopulations, or the LTSS population as a whole. Additional mixed-methodology research is necessary to understand how specific elements of policy and program implementation impact rebalancing efforts. For additional information on the programmatic and policy factors assessed, see *Measuring Progress in Rebalancing Medicaid Long-Term Care toward Home and Community-Based Services: Final Report*.

## CONCLUSION

Historically, rebalancing has been assessed at the state level using cost report data, with an expectation that states should be spending more on HCBS than institutional LTSS. Although this metric has been helpful for assessing state progress toward enhancing HCBS, the metric does not directly assess actual service use rebalancing and cannot capture variations across certain subpopulations of LTSS users. In this study, we show that a utilization-based rebalancing metric can assess the degree to which states provide HCBS in lieu of institutional LTSS, as appropriate. This metric can be generated for numerous subpopulations, including those with select health conditions, living in certain geographic regions, or enrolled in Medicare. Similarly, this metric uses a denominator that is limited to only those people receiving LTSS, thereby accurately reflecting the distribution of HCBS and institutional LTSS utilization among the relevant population. To continue gaining insights into how Medicaid enrollees are receiving LTSS, states and the Federal Government should prioritize improved data quality, particularly related to quality and participation in HCBS waivers and state plans. Additionally, in 2022, CMS announced the introduction of the first standardized quality measure set for HCBS.4 With the introduction of the new measure set, states received formal guidance and technical assistance to support best practice data collection, submission and analysis for a number of critical LTSS outcomes.5 As data become available in the coming years, researchers should consider incorporating these measures into comprehensive rebalancing research.

A key consideration for this research, and all research related to rebalancing efforts, is that there is not an ideal ratio at which LTSS users should receive their care in home and community settings versus institutional settings. Although efforts are generally focused on increasing access to and utilization of adequate HCBS and avoiding unnecessary institutional stays, the degree to which a population is receiving care in the appropriate setting is highly dependent on their individual care needs, familial and community support systems, and personal preferences. This study showed high degrees of rebalancing variation across subpopulations, but additional research is needed to understand what factors contribute to these differences, including availability of service providers and how different groups of LTSS users make decisions regarding their care needs and care setting. In particular, additional research is needed to understand what factors account for differences in rebalancing by age, race, ethnicity, and gender. Additionally, more quantitative and qualitative research is needed to understand the individual, community, and health system factors that influence enrollee transitions between home and community-based care and institutional settings. Lastly, future rebalancing research should reconsider the role of statewide spending and instead place greater emphasis on enrollee access to care, service utilization, quality of care, and patient experience measures.

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