

Memo

From Brian Burwell, Kate Sredl, and Steve Eiken

To Distribution

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Copies

Subject **Medicaid Long-Term Care Expenditures in FY 2006**

This memorandum presents data on Medicaid long-term care expenditures in Federal Fiscal Year 2006 (October 2005 through September 2006). Total Medicaid long-term care expenditures in FY 2006 equaled \$99.3 billion, an increase of 3.4 percent over FY 2005. Based on a review of previous years' reports, we expect reported long-term care spending to increase by an additional 1.5 to 2.0 percent after states submit all of their prior period adjustments (See *Use of Prior Period Adjustments* below). Thus, we anticipate FY 2006 long-term care expenditures to exceed \$100 billion, and to show about a 5 percent increase over FY 2005.

In FY 2006, long-term care represented 33.2 percent of total Medicaid spending, which equaled \$298.7 billion. Total Medicaid expenditures decreased 1.6 percent in FFY 2006. However, total Medicaid expenditures will likely increase by 1.0 to 1.5 percent after all adjustments are submitted. The decrease reflects the implementation of the Medicare Part D benefit on January 1, 2006, which reduced Medicaid payments for prescription drugs. Medicaid prescription drug expenditures dropped \$14.5 billion in FFY 2006, from \$43.2 billion to \$28.7 billion. We expect a further decrease in drug expenditures in FFY 2007, the first full fiscal year that Medicare Part D will be in effect.

Institutional long-term care spending was essentially flat in FY 2006. Reported Medicaid nursing home expenditures increased 0.5 percent in FY 2006, from \$47.5 billion to \$47.7 billion. Expenditures for services provided in ICFs/MR increased 0.6 percent, from \$12.4 billion to \$12.5 billion. We expect prior period adjustments to have little impact on national nursing facility expenditures, but to increase reported ICF/MR expenditures by about 3 to 4 percent.

Expenditures for community-based long-term care services continue to increase more rapidly than institutional expenditures. Total home and community based services (HCBS) increased by 8.1 percent to \$39.1 billion. HCBS waiver expenditures increased 10.6 percent to \$25.6 billion and now account for about 65 percent of all Medicaid community-based long-term care spending. Reported expenditures under the Medicaid personal care services benefit increased 2.6 percent to \$9.3 billion. Medicaid home health care expenditures increased 5.1 percent to \$3.7 billion. The Texas Community Assistance Services program

accounts for an additional \$0.3 billion in home and community-based services.¹ Research and Demonstration Waivers account for the remaining \$0.1 billion (See *Research and Demonstration Waivers* below).

We anticipate prior period adjustments will increase reported spending for HCBS waivers and for personal care by several hundred million dollars each. After states have submitted all adjustments, we expect reported HCBS waiver expenditures to increase by another 2 to 3 percent, and reported personal care expenditures to increase another 10 to 12 percent. Together, these adjustments would increase total community long-term care spending by about 3 to 5 percent.

Overall, spending for community-based long-term care services rose to 39 percent of all Medicaid long-term care costs, while 61 percent was spent on institutional services. When all adjustments are included, the HCBS portion of reported long-term care expenditures may increase to 40 percent. This distribution continues to change by one to three percentage points each year, as states continue to invest more resources in alternatives to institutional services.

The data presented in Table 1 and Tables A through T are based upon CMS 64 reports, which states submit to the Centers for Medicare & Medicaid Services (CMS). States use the CMS 64 report to claim Federal Financial Participation (FFP) for state Medicaid outlays, and the Federal government audits these reports. It is therefore considered one of the more reliable sources of information on state Medicaid spending. Two tables present HCBS waiver expenditures for the two major population groups that constitute 98 percent of all HCBS waiver spending. Table H presents data for waivers serving people with mental retardation and other developmental disabilities and Table I presents data for waivers serving older people and people with physical disabilities (Aged/Disabled or A/D waivers). More detailed information about HCBS waiver spending is available in a separate memo.²

Research and Demonstration Waivers

Starting this year, we also provide data on six Research and Demonstration waivers authorized by Section 1115 of the Social Security Act, for which we can identify long-term care spending using data in the CMS 64 report. The six programs are:

- The original Cash and Counseling Demonstration programs in Arkansas, Florida, and New Jersey;
- Consumer-directed services programs in Colorado and Oregon; and
- Vermont's managed long-term care program for older adults and people with physical disabilities.

¹Community Assistance Services provides an entitlement to personal care - and no other Medicaid services - for people with incomes under 300% of the Supplemental Security Income benefit. Texas operates this program under section 1929 of the Social Security Act.

² Eiken, S. and Burwell, B. *Medicaid HCBS Waiver Expenditures, FY 2001 through FY 2006* Thomson Healthcare: August 2007.

Table J presents home and community-based services expenditures data for these following programs, starting with FFY 2004 expenditures. Most of these programs only provide home and community-based services. The exception, Vermont's Section 1115 waiver, reported other services separately. Vermont's nursing facility and home health expenditures are included on Tables A and E, respectively, along with other states' data for these services.

We did not include Section 1115 waivers that cover both acute and long-term care because the data in the CMS 64 report do not specifically identify long-term care spending. These include the Arizona Section 1115 waiver that incorporates its entire long-term care system and a Vermont waiver that encompasses the rest of that state's Medicaid program, including services for people with developmental disabilities.

Use of Prior Period Adjustments

We continue to include data from CMS on *prior period adjustments* for the following services for the following years:

- HCBS waiver data since 1995
- State plan personal care services since FY 2002 (starting in FY 2001 for California)
- Nursing facility, ICF/MR, inpatient hospital, mental health hospital, and Disproportionate Share Hospital (both acute and mental health) since FY 2002
- Program of All Inclusive Care for the Elderly (PACE) since FY 2004

The HCBS waiver and personal care adjustments correct historical underreporting for community-based services in California that occurred largely because state agencies other than the Medicaid agency administer the personal care services benefit and certain HCBS waivers. We included adjustments on several types of facility services and for PACE programs after we learned that several states report a significant portion of these expenditures through prior period adjustments. We plan to continue including such adjustments in future years. Our experience with prior period adjustments suggests that states submit most adjustments within two years. As a result, data reported in future years may show significant changes in certain states' FY 2005 and FY 2006 spending.

In addition, national expenditure totals for FY 2006 are likely to increase for the services listed above. For most of these services, reported expenditures for FY 2002 through FY 2005 are greater than expenditure amounts originally reported (i.e., the FY 2005 expenditures reported in last year's memo). The exception is nursing facility expenditures, where adjustments have indicated a decrease in FY 2002 and FY 2003 expenditures. Adjustments increased expenditures by less than five percent for HCBS Waivers, ICFs/MR, nursing facilities, and inpatient hospitals. Adjustments have had a larger impact on personal care (10 to 12 percent), acute hospital DSH (6 to 9 percent), mental health hospitals (7 to 16 percent), mental health Disproportionate Share Hospital (DSH) expenditures (3 to 18 percent), and PACE (5 to 10 percent). In most years, large adjustments from California explained the national expenditures increases in personal

care, mental health hospital, and acute hospital DSH spending. Adjustments from New York, North Carolina, and Ohio explained most of the increase in mental health hospital DSH payments.

The prior period adjustments have a much greater impact on reports for individual states. We updated state rankings for per capita FY 2005 spending based on adjustments to FY 2005 data submitted since last year's memo. We also used the latest Census Bureau estimates for July 1, 2005 population to ensure our population information was also up to date. Most state rankings did not change or changed by only one or two positions. The biggest changes in FY 2005 state rankings for long-term care services were for California and Colorado. California's rank in total home care rose from 23rd to 18th because of its large adjustments to HCBS waiver and personal care expenditures. These adjustments and changes to reported ICF/MR spending increased California's rank in total long-term care spending from 44th to 39th. Colorado's rank in aged/disabled HCBS waiver expenditures increased from 35th to 24th. The adjustments to aged/disabled waiver expenditures also increased Colorado's rank in overall waiver expenditures (from 32nd to 27th) and in total home care (from 35th to 30th).

Upper Payment Limit Programs

States' use of Medicaid Upper Payment Limit (UPL) programs continue to distort reported Medicaid nursing home spending as we have described in previous memos. UPL programs allow states to pay a targeted group of providers more than the actual cost of services, as long as total Medicaid payments do not exceed the amount Medicare would pay for the same services. Several states use UPL programs to draw down additional federal matching dollars without having to contribute additional state funds. Twenty-three of the 34 states that participated in a study of DSH and UPL programs had active UPL programs in state fiscal year 2002.³

In earlier years, state UPL programs made extra payments to providers – usually county and state-owned nursing facilities – and then required those providers to return some or all of the excess funds as an intergovernmental transfer. As CMS has required states to reduce such intergovernmental transfers, some states are moving to taxing certain providers—subject to federal limits—and then reinvesting those funds into these services. These providers include nursing facilities, ICFs/MR, home health care agencies, and managed care organizations. We are aware of at least a few states tax on ICFs/MR, which distorts reported ICF/MR expenditures.

Other Technical Information

We wish to note several caveats regarding CMS 64 data. First, CMS 64 data are by date of payment, not date of service. Thus, rates of change in state Medicaid spending for specific services, as reported on the CMS 64, can be due to factors related to state payment policies as well as to real changes in service utilization by Medicaid beneficiaries. For example, simply by delaying one month's payments to nursing

³ Coughlin, T., Bruen, B., and King, J. "States' Use of Medicaid UPL and DSH Financing Mechanisms" *Health Affairs* (23):2. March/April 2004.

home providers from June 30th to July 1st, a state can push 13 months of nursing home spending into a later fiscal year, leaving only 11 months of nursing home payments in the earlier year. These kinds of “bill paying” practices definitely occur in some states, usually in response to budgetary pressures.

Second, CMS 64 reports represent state *claims* to the Federal government of health care expenditures that states believe are eligible for Federal matching funds under the Medicaid program. As a result of its audit process, CMS may disallow some of these claims as not eligible for Federal matching funds, which are then adjusted on future CMS 64 reports. These adjustments are not reported by type of service and therefore cannot be used to adjust previously-reported data on Medicaid spending by type of service.

Third, CMS 64 reports on Medicaid spending by type of service usually do not identify long-term care spending provided through capitated managed care programs. In most states, long-term care recipients and/or long-term care benefits are exempt from Medicaid managed care programs. However, Arizona's entire long-term care system (called ALTCS) is capitated, and the accompanying tables only include fee-for-service expenditures in Arizona's long-term care system (persons newly eligible for long-term care services in Arizona may receive long-term care services on a fee-for-service basis before enrolling in a managed care plan). In addition, several states (e.g. Florida, Massachusetts, Michigan, Minnesota, Wisconsin, Texas, and Vermont) have implemented relatively large managed care programs that pay for long-term care benefits on a capitated basis. Also, increased enrollment of TANF-related recipients and SSI recipients who are not dual eligibles into managed care programs may be affecting reported spending on the CMS 64 for personal care and Medicaid home health benefits.

Finally, the CMS 64 categorizes expenditures into several service categories. This memo presents data for those services that are clearly long-term care services. Many states provide long-term care within service categories that include both acute and long-term care, such as targeted case management and rehabilitation. Several states, such as Georgia, have large case management programs specifically focused on people with long-term care needs.

States submit aggregate CMS 64 reports on a quarterly basis to CMS, and these aggregate reports have generally formed the basis of our annual Medicaid Long-term Care Expenditures memos. In addition, however, states are also required to submit *individual* CMS 64 reports for each 1915(c) Home and Community-Based Services Waiver Program that the state operates, since CMS is required to compare actual expenditures incurred under each HCBS waiver with estimates provided by states in approved waiver applications. In recent years, we have been able to obtain data from CMS on individual HCBS waiver expenditures, which we report in a separate memo. Based upon feedback from states, we believe that the *individual* CMS 64 reports on HCBS waiver expenditures, aggregated to the state level, provide a more accurate estimate of actual Medicaid spending for HCBS waivers than the aggregate CMS 64 reports. Therefore, *for HCBS waiver services only*, we use the individual CMS 64 reports as the basis for constructing Tables D, H, and I, with exceptions for four states that did not submit expenditure data for individual waivers in one or more quarters (Michigan and Wyoming in 2001, Connecticut in 2002, and Mississippi from 2004 through 2006).

A few other words of explanation: Table F, Total Home Care, is the sum of Personal Care (Table C), HCBS Waivers (Table D), Home Health (Table E), HCBS in 1115 Waivers (Table J), and Section 1929 (Table T, the Texas Community Assistance Services program). Table G, Total Long-term Care, is the sum of Nursing Facility (Table A), ICF/MR (Table B), and Table F. The “Expenditures Per Capita” number that appears in the final column of each table is simply expenditures divided by the *total* state population.

As always, we appreciate any comments which you may have about these data. We would like to thank John Klemm in CMS’s Office of the Actuary; and Melissa Hulbert, John Hoover, Betsy Hanczaryk, and Sharon Jackson in CMS’s Center for Medicaid and State Operations for their assistance in making these data available.