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Memo

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To Distribution

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Copies

Subject **Medicaid Long-term Care Expenditures in FY 2005**

This memorandum presents data on Medicaid long-term care expenditures in Federal Fiscal Year 2005 (October 2004 through September 2005). Total Medicaid long-term care expenditures in FY 2005 equaled \$94.5 billion, an increase of 3.8 percent over FY 2004. Based on a review of previous years' reports, we expect reported long-term care spending to increase by another 1.5 to 2.0 percent after states submit all their prior period adjustments (See *Use of Prior Period Adjustments* below). Thus, we anticipate FY 2005 long-term care expenditures will eventually show about a 5.0 percent increase over FY 2004. In FY 2005, long-term care represented 31.5 percent of total Medicaid spending, which equaled \$300.3 billion. Reported total Medicaid expenditures are also likely to increase by 1.0 to 1.5 percent after all adjustments are submitted.

Institutional long-term care spending increased little in FY 2005. Reported Medicaid nursing home expenditures increased 2.9 percent in FY 2005, from \$45.9 billion to \$47.2 billion. Expenditures for services provided in ICF/MRs increased 0.6 percent, from \$12.0 billion to \$12.1 billion. We expect prior period adjustments to have little impact on national nursing facility expenditures, but to increase reported ICF/MR expenditures by an additional 3.0 to 4.0 percent.

Expenditures for community-based long-term care services continued to increase more rapidly than institutional expenditures. Total home and community based services (HCBS) increased by 6.1 percent to \$35.2 billion. HCBS waiver expenditures increased 5.4 percent to \$22.7 billion and now account for about 65 percent of all Medicaid-financed community-based long-term care spending. Reported expenditures under the Medicaid personal care services benefit increased 8.9 percent to \$8.6 billion. Medicaid home health care expenditures increased 3.6 percent to \$3.6 billion. The Texas Community Assistance Services program accounts for the remaining \$0.3 billion in home and community-based services.¹ Starting with this

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.

year's memo, we are including this program in our data for total community long-term care expenditures to more accurately describe HCBS spending in that state.

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 waiver expenditures to increase by another 1.5 to 3.0 percent, and reported personal care expenditures to increase another 9.0 to 12.0 percent. Together, these adjustments would increase total community long-term care spending by 2.0 to 4.0 percent.

Overall, spending for community-based long-term care services (HCBS waivers, personal care, and home health services) rose to 37 percent of all Medicaid long-term care costs, with 63 percent spent on institutional services. When all adjustments have been included, the HCBS portion of reported long-term care expenditures may increase to 38 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 S 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. The tables include two tables that present HCBS waiver expenditures for 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

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

² Eiken, S., Burwell, B., and Selig, B. *Medicaid HCBS Waiver Expenditures, FY 2000 through FY 2005* Thomson Medstat: June 30, 2006.

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 HCBS waiver expenditures data 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 2004 and FY 2005 spending.

In addition, national expenditure totals for FY 2005 are likely to increase for the services listed above. For most of these services, reported expenditures for FY 2002 through 2004 are greater than expenditure amounts originally reported (i.e., the FY 2004 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. For HCBS Waivers, ICF/MR, and inpatient hospital services, expenditures increased by four percent or less. Adjustments have had a larger impact on personal care (10 to 12 percent), mental health hospital (8 to 17 percent), mental health Disproportionate Share Hospital (DSH) expenditures (4 to 18 percent), and acute hospital DSH (6 to 11 percent). These large increases were caused by large adjustments from California (for personal care, mental health hospital, and acute hospital DSH spending) and New York (for mental health hospital DSH payments).

The prior period adjustments have a much greater impact on reports for individual states. California submitted adjustments that added \$1.1 billion to FY 2004 reported spending for personal care, HCBS Waivers, and ICF/MR. The inclusion of prior period adjustments also explains the decrease in New Jersey's reported FY 2003 nursing home expenditures.

We updated state rankings for per capita FY 2004 spending based on adjustments to FY 2004 data submitted since last year's memo. We also used the latest Census Bureau estimates for July 1, 2004 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 2004 state rankings for long-term care services were for Arkansas, California, Colorado, and Montana. Arkansas' ranking in total home care spending rose from 42nd to 34th because of an adjustment to HCBS waiver expenditures for people with developmental disabilities. California's rank in total home care rose from 35th to 19th because it submitted large adjustments to HCBS waiver and personal care expenditures. Colorado's rank in aged/disabled HCBS waiver expenditures dropped from 24th to 32nd. A decrease in nursing facility expenditures changed Montana's rank from 17th to 28th.

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, ICF/MRs, and managed care organizations. We are aware of at least a few states that have such taxes on ICF/MRs, which distorts reported ICF/MR expenditures.

Other Technical Information

We wish to reiterate the usual caveats about 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 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. Since long-term care recipients (and/or long-term care benefits) are usually exempt from Medicaid managed care programs, the growth in managed care enrollment should not be having a large impact on CMS 64 reports of spending for long-term care services. 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, a few other states (e.g. Florida, Michigan, Minnesota, Wisconsin, and Texas) 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.

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

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 in 2004 and 2005).

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), and Frail Elderly (Table S, the Texas Community Assistance Services program). Table G, Total Long-term Care, is the sum of Tables A, B, and F. Also, 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 Betsy Hanczaryk, John Hoover, and Sharon Jackson in CMS's Center for Medicaid and State Operations, Division of Financial Management, for their assistance in making these data available.