

RESEARCH PAPER

MEDICAID LONG-TERM CARE EXPENDITURES IN FY 2008

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MEDICAID LONG-TERM CARE EXPENDITURES

This report is the latest in a series of annual reports that present Medicaid long-term care expenditures for Federal Fiscal Year 2008 (October 2007 through September 2008). Total Medicaid long-term care expenditures in FY 2008 equaled \$106.4 billion, an increase of 3.8 percent over FY 2007. 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).

In FY 2008, long-term care represented 32.1 percent of total Medicaid spending, which equaled \$331.8 billion. Total Medicaid expenditures increased 4.7 percent in FY 2008. Reported total Medicaid expenditures will likely increase by 1.0 to 1.5 percent after all adjustments are submitted.

Institutional long-term care spending increased 2.9% in FY 2008, from \$59.3 billion to \$61.0 billion. Medicaid nursing home expenditures increased 4.1 percent in FY 2008, from \$47.1 billion to \$49.0 billion. Expenditures for services provided in ICF/MR decreased 1.8 percent, from \$12.2 billion to \$12.0 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. When all adjustments have been submitted, we expect both nursing facility and ICF/MR spending to have increased. This is a change from FY 2007, a rare year in which spending for these services decreased.

Expenditures for community-based long-term care services continue to increase. Total home and community based services (HCBS) increased by 4.9 percent to \$45.4 billion. We anticipate prior period adjustments will increase total HCBS by an additional 2 to 3 percent. HCBS waiver expenditures increased 7.2 percent to \$29.9 billion and accounted for 66 percent of all Medicaid community-based long-term care spending. After states have submitted all adjustments, we expect reported HCBS waiver expenditures to increase by another 1 to 2 percent. Reported expenditures under the Medicaid personal care services benefit decreased 0.3 percent to \$10.9 billion.

However, we do not expect personal care services to show a decrease when all adjustments have been reported. In previous years, personal care expenditures have increased 5 to 10 percent after the original data were published. Medicaid home health care expenditures increased 4.9 percent to \$4.2 billion. The Texas Community Assistance Services program accounts for an additional \$332 million.¹ HCBS reported in Research and Demonstration Waivers account for the remaining \$84 million (See Research and Demonstration Waivers below).

Overall, spending for community-based long-term care services rose to 43 percent of all Medicaid long-term care costs, while 57 percent was spent on institutional services. As in previous years, this distribution has changed by one to three percentage points each year as states invested more resources in alternatives to institutional services.

TECHNICAL INFORMATION

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. The “Expenditures Per Capita” number that appears in the final column of each table is simply expenditures divided by the total state population estimated by the U.S. Census Bureau Current Population Estimates for July 1, 2008. As always, we appreciate any comments which you may have about these data.

Two tables summarize data found on other tables:

- 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

¹ The Texas Community Assistance Services benefit 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.

States submit aggregate CMS 64 reports to report total spending on a quarterly basis to CMS, and these aggregate reports have generally formed the basis of our annual Medicaid Long-term Care Expenditures reports. In addition, however, states are also required to submit individual CMS 64 reports for each waiver the state operates, including Home and Community-Based Services Waivers authorized under Section 1915(c). Since 2000, we have been able to obtain data from CMS on individual HCBS waiver expenditures, which we report separately.

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, we use the individual CMS 64 reports as the basis for constructing Table D (HCBS Waiver expenditures), with exceptions for a few states that did not submit expenditure data for individual waivers in one or more quarters (e.g., Florida in 2009, Maryland in 2005, and Mississippi since 2004). We also use individual waiver reports for two tables that present HCBS waiver expenditures for major target population groups. Table H presents data for waivers serving people with developmental disabilities and Table I presents data for waivers serving older people and people with physical disabilities (Aging/Disability or A/D waivers).

RESEARCH AND DEMONSTRATION WAIVERS

Starting last year, we have provided data on Research and Demonstration waivers authorized by Section 1115 of the Social Security Act for which states report home and community-based services spending. Since FY 2004, data have been included for the following seven programs:

- The original Cash and Counseling Demonstration programs in Arkansas, Florida, and New Jersey.
- Consumer-directed services programs in Colorado and Oregon
- A Vermont 1115 waiver for long-term supports for older adults and people with physical disabilities.
- An Iowa 1115 waiver that includes home and community-based services for children with severe emotional disturbances.

Table J presents home and community-based services expenditures data for these following programs, starting with FFY 2004 expenditures. Table J only includes data that

are reported as home and community-based services. It does not include data from these waivers reported in other service categories such as nursing facility, personal care, or home health. These expenditures are included on Tables A, C, and E, respectively, along with other states' data for these services. In addition, expenditures for a California Section 1115 waiver that provides personal care are included in Table C (personal care), not in Table J.

We did not include Section 1115 waivers when we could not specifically identify long-term care spending using the data available in the CMS 64 report. 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 for all years included in the tables.
- 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.

Historically, prior period adjustments typically increased national expenditures. Adjustments for FY 2002 through FY 2007 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 (5 to 12 percent), acute hospital DSH (0 to 9 percent), mental health hospitals (7 to 16 percent), mental health Disproportionate Share Hospital (DSH) expenditures (3 to 18 percent), and PACE (0 to 10 percent). For a few states, especially California, the effect of prior period adjustments on state expenditures has often been significant.

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. 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 that tax ICFs/MR, which distorts reported ICF/MR expenditures.

CAVEATS

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 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, Minnesota, Wisconsin, 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 the Medicaid State Plan personal care and 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 rehabilitative services. Several states, such as Georgia, have large case management programs specifically focused on people with long-term care needs.

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