RESEARCH PAPER

MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS EXPENDITURES

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BACKGROUND

Since 1988, Thomson Reuters has produced annual reports on state Medicaid spending for long-term services and supports (LTSS).[1] These reports are based upon quarterly submissions by states to claim Federal matching funds for Medicaid services. The quarterly report, called the CMS 64, organizes Medicaid expenditures by various "categories of service," including LTSS. These categories of service have been used to track state Medicaid LTSS spending.

In our annual reports, we have noted various limitations in the data. One limitation is that LTSS spending provided through Medicaid managed care programs often is not identified. Specifically, states using managed care purchasing strategies for LTSS often report these LTSS expenditures under categories of service for managed care payments instead of LTSS categories. Thus, the Thomson Reuters reports of annual Medicaid expenditures for LTSS underreport actual expenditures.

Historically, only a small number of states used managed care purchasing strategies for serving LTSS populations, so the impact on total Medicaid LTSS spending was relatively small.[2] However, several states now have relatively large managed care programs, which affect state-to-state comparisons.[3] Also, states are increasingly turning to managed care models for purchasing LTSS, which will increase the percentage of total Medicaid LTSS spending made through managed care contracts. For this reason, CMS asked Thomson Reuters to collect and assess available data on state spending for LTSS under managed care.

To provide a more complete picture of national Medicaid LTSS expenditures, this report presents estimated Federal Fiscal Year (FFY) 2008 and 2009 Medicaid LTSS expenditures not included in previous LTSS expenditures reports. These estimates are

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[1] The most recent report in this annual series is Eiken S, Sredl K, Burwell B, Gold L. *Medicaid Long-Term Care Expenditures in FY 2009* August 17, 2010.

[2] Saucier P, Burwell B, Gerst K. *The Past, Present and Future of Managed Long-Term Care*. Prepared for the Office of Disability, Aging and Long-Term Care Policy of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 2005.

[3] Eiken S, Sredl K, Burwell B, Gold L. *Medicaid Long-Term Care Expenditures in FY 2009* August 17, 2010 identified 13 states with expenditures reported as managed care and therefore not captured in that report: Arizona, California, Florida, Hawaii, Kansas, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Vermont, and Wisconsin. This list does not include states that provide managed long-term care as part of a Program of All-inclusive Care for the Elderly (PACE). The CMS 64 report includes a category of service for PACE.

based on data provided by states with managed LTSS programs. To the extent data are available we present each state's managed LTSS expenditures for six types of services or programs that comprise Medicaid LTSS expenditures in our annual reports:

- Nursing Facilities
- Intermediate Care Facilities for People with Mental Retardation (ICF/MR)
- Personal Care
- Home Health
- Home and Community-Based Service (HCBS) Waivers authorized by Section 1915(c) of the Social Security Act, and programs that provide similar services using different authorizing legislation
- Program of All-Inclusive Care for the Elderly (PACE)

First, we describe the methodology we used to obtain the data. Next, we provide a summary of the impact managed LTSS expenditures have on total Medicaid LTSS spending. We then present data for each state separately because the estimation methods differ based on the state data sources available. Most states provided data based on encounter data and/or LTSS components of managed care capitation rates. In each state section, we note the data sources and methodologies used, as well as any caveats. Finally, we identify some challenges associated with collecting and analyzing state managed LTSS data.

METHODOLOGY

We requested FFY 2008 and 2009 managed LTSS expenditure data, via telephone and e-mail, from the 13 states identified as having programs not included in the LTSS expenditures reports. If states did not have data available by FFY (October through September), we asked them to submit data for any time period in which data were readily available and overlapped with FFY 2008 and 2009. We received data from 11 states: Arizona, California, Florida, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Vermont and Wisconsin. For Massachusetts and New Mexico, only FFY 2009 data were collected. Two states we contacted—Hawaii and Kansas—were not able to provide data.

States provided two main sources of information for estimating LTSS expenditures made under managed care contracts. The first is rate-setting data. States will often designate a percentage of their capitation payments as attributable to the expected cost of paying for LTSS in the target population. These reports typically presented costs by subgroup (e.g., by MCO, service area, dual eligibility status, and/or level of care), which were then multiplied by the number of member months for each subgroup. Since capitation rates are generally based on analyses of fee-for-service data, rate-setting data can be viewed as estimates of what states would have paid for LTSS for the target population if they continued to be served on a fee-for-service basis. Thus, while rate-setting data may be a good proxy for LTSS expenditures made through managed care contracts, their limitation is that they do not represent actual experience.

The second source of information is encounter data submitted by managed LTSS contractors to the state, which represent the amount paid by the managed care organization for these services. Encounter data are similar to claims data in that they represent actual events of care. However, state reports of encounter data differ from CMS 64 data in that they are based on date-of-service rather than date-of-payment. Also, unlike CMS 64 data, encounter data are generally not audited by states and can vary in quality from contractor to contractor.[4] In a study of Medicaid encounter data for all managed care services, the Office of Inspector General found that over 27 percent of

[4] DR Levinson. *Medicaid Managed Care Encounter Data: Collection and Use*. Office of Inspector General. U.S. Department of Health and Human Services. May 2009. Reasons cited included limitations in state information systems and inconsistent and/or flawed data submissions.

the 40 states collecting encounter data reported difficulty in using these data.[5] This difficulty may reflect staff capacity to use data as well as data quality. Some states do not have the resources to use encounter data for planning purposes such as projection of program utilization and costs. One state with an integrated Medicare and Medicaid managed LTSS program noted that it was difficult to parse out the encounter data into the respective payers' acute and LTSS "buckets," let alone into LTSS categories.

We encouraged states to submit available data and did not request specific types of data. In general, states' abilities to submit managed LTSS data by service category varied greatly. Some states were able to supply this information quickly, whereas others struggled.

An additional complication in tracking LTSS spending in managed care contracts is that states often use financing mechanisms such as withholds, incentive payments, performance payments, risk-sharing, and reinsurance mechanisms in paying their managed care contractors. Adjusting LTSS encounter data or capitation rate components by the values associated with these managed care payment practices would be quite cumbersome.

[5] *Ibid.*

MANAGED LTSS IMPACT ON TOTAL MEDICAID LTSS EXPENDITURES

Tables 1 and 2 show additional managed LTSS spending reported by states for FFY 2008 and FFY 2009. These tables do not include Florida because the State already reported managed LTSS expenditures on the CMS 64. Florida's data refined expenditure totals by category of service. As shown in Table 1, in FFY 2008 states spent $4.0 billion on managed LTSS not reflected in CMS 64 LTSS categories. This amount increased combined Medicaid LTSS expenditures for those states by about 9% and national FFY 2008 LTSS expenditures by 3.7%. In FFY 2009, states spent about $5.1 billion on managed LTSS programs not included in the CMS 64 service categories (See Table 2). Total Medicaid LTSS spending increased by 10% for states with managed LTSS data and national Medicaid LTSS spending increased by 4.5%.

TABLE 1: Impact of Adding Medicaid Managed LTSS Expenditures to Total CMS 64 Medicaid LTSS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Arizona	$42,662,489	$1,355,692,285	$1,398,354,774	3,178%
California*	$11,459,721,783	$444,274,589	$11,903,996,372	4%
Minnesota	$3,059,753,830	$284,766,850	$3,344,520,680	9%
New York	$19,071,621,702	$644,182,156	$19,715,803,858	3%
Tennessee	$1,916,444,742	$313,548,000	$2,229,992,742	16%
Texas	$5,193,380,929	$335,449,886	$5,528,830,815	6%
Vermont	$170,255,229	$154,615,953	$324,871,182	91%
Wisconsin	$1,682,861,498	$478,574,770	$2,161,436,268	28%
Total for Reporting States	***$42,596,702,202***	***$4,011,104,489***	***$46,607,806,691***	***9%***
U.S. Total	***$109,201,122,961***	***$4,011,104,489***	***$113,212,227,450***	***3.7%***

* California managed LTSS data are for Calendar Year 2008.

TABLE 2: Impact of Adding Medicaid Managed LTSS Expenditures to Total CMS 64 Medicaid LTSS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Arizona	$42,152,650	$1,456,213,446	$1,498,366,096	3,455%
California	$11,097,802,261	$450,379,907	$11,548,182,168	4%
Massachusetts	$3,620,676,478	$194,817,372	$3,815,493,850	5%
Minnesota	$3,175,806,702	$202,701,586	$3,378,508,288	6%
New Mexico	$503,643,718	$444,067,183	$947,710,901	88%
New York	$20,237,825,602	$739,973,705	$20,977,799,307	4%
Tennessee	$1,916,773,226	$242,356,000	$2,159,129,226	13%
Texas	$5,635,627,491	$390,446,418	$6,026,073,909	7%
Vermont	$175,071,974	$148,427,848	$323,499,822	85%
Wisconsin	$2,255,268,605	$819,487,942	$3,074,756,547	36%
Total for Reporting States	***$48,660,648,707***	***$5,088,871,407***	***$53,749,520,114***	***10%***
U.S. Total	***$114,080,193,960***	***$5,088,871,407***	***$119,169,065,367***	***4.5%***

STATE-SPECIFIC ESTIMATES

ARIZONA

Having never had a traditional Medicaid fee-for-service (FFS) program, Arizona has provided the vast majority of its Medicaid services through mandatory managed care programs for the past twenty years. The Arizona Long Term Care System (ALTCS) serves people who require a nursing home of level of care, providing primary and acute care and institutional and community-based LTSS.

Expenditure Calculations

Arizona provided ALTCS managed LTSS expenditure data for FFY 2008 and 2009 based on capitation reports. The capitation reports are the managed care organizations' estimates of cost and utilization based on prior experience.[6] Tables 3 and 4 present managed LTSS and total LTSS spending data. A small amount of FFS Medicaid LTSS is paid for individuals eligible to receive Medicaid LTSS who have not yet selected a managed LTSS plan (e.g. persons in nursing homes with retroactive Medicaid eligibility).

TABLE 3: Arizona Long Term Care System Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$33,455,176	$390,577,284	$424,032,460	1,167%
ICF/MR	$0	$28,242,824	$28,242,824	n/a
HCBS Waiver or equivalent*	$0	$936,872,177	$936,872,177	n/a
Personal Care	$8,396,750	$0	$8,396,750	0%
Home Health	$810,563	$0	$810,563	0%
PACE	$0	$0	$0	n/a
Total	***$42,662,489***	***$1,355,692,285***	***$1,398,354,774***	***3,178%***

* Arizona reported all non-institutional LTSS spending under this category.

[6] Kronick R, Llanos K. Rate Setting for Medicaid Managed Long-Term Supports and Services: Best Practices and Recommendations for States. Center for Health Care Strategies, Inc. March 2008.

TABLE 4: Arizona Long Term Care System Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$33,119,468	$414,225,432	$447,344,900	1,251%
ICF/MR	$0	$28,383,904	$28,383,904	n/a
HCBS Waiver or equivalent*	$0	$1,013,604,110	$1,013,604,110	n/a
Personal Care	$7,919,299	n/a	$7,919,299	n/a
Home Health	$1,113,883	n/a	$1,113,883	n/a
PACE	$0	$0	$0	n/a
Total	***$42,152,650***	***$1,456,213,446***	***$1,498,366,096***	***3,455%***

* Arizona reported all non-institutional LTSS spending under this category.

CALIFORNIA

The County Organized Health System (COHS) plans are comprehensive health plans at risk to provide LTSS as well as acute and primary care.[7] The COHS plans are five non-profit independent public agencies that provide managed care to over 500,000 Medi-Cal residents of eight counties under a 1915(b) waiver.[8]

Expenditure Calculations

The State provided the following expenditure information based on encounter data for calendar years (CYs) 2008 and 2009. We used CY 2008 data for FFY 2008 expenditures. In order to approximate FFY 2009 spending, we weighted the CY data so 2008 represented 25% of expenditures and 2009 represented 75%. COHS also spent roughly $380,000 per year on LTSS provided in hospitals, but we did not include these expenditures in Tables 5 and 6 below. The only categories of managed LTSS spending are nursing facility and ICF/MR because COHS are not responsible for providing community-based LTSS under their capitation. HCBS are available through FFS.

[7] According to the California Department of Health Care Services, one COHS program -- the Health Plan of San Mateo -- was not responsible for providing long-term care services under its capitation in calendar years 2008 and 2009.
[8] California Organization of Health Insuring Organizations, accessed on February 7, 2011 at http://www.cahio.org/ (waiver authority from CMS *2009 National Summary of State Medicaid Managed Care Programs*).

TABLE 5: California County Organized Health System Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility*	$3,885,689,693	$378,180,743	$4,263,870,436	10%
ICF/MR*	$781,106,620	$65,720,698	$846,827,318	8%
HCBS Waiver	$1,877,960,570	$0	$1,877,960,570	0%
Personal Care	$4,625,120,257	$0	$4,625,120,257	0%
Home Health	$171,640,488	$0	$171,640,488	0%
PACE	$118,204,155	$0	$118,204,155	0%
Total	***$11,459,721,783***	***$443,901,441***	***$11,903,623,224***	***4%***

* California managed LTSS data were reported for Calendar Year 2008.

TABLE 6: California County Organized Health System Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$3,945,503,021	$387,355,960	$4,332,858,981	10%
ICF/MR	$634,412,454	$63,023,947	$697,436,401	10%
HCBS Waiver	$1,820,321,687	$0	$1,820,321,687	0%
Personal Care	$4,403,014,003	$0	$4,403,014,003	0%
Home Health	$178,803,449	$0	$178,803,449	0%
PACE	$115,747,647	$0	$115,747,647	0%
Total	***$11,097,802,261***	***$450,379,907***	***$11,548,182,168***	***4%***

FLORIDA

The Florida Nursing Home Diversion Program is a 1915(c) waiver that provides institutional and community-based services to older adults eligible for both Medicare and Medicare (dual-eligibles) who require a nursing home level of care. It was available in 33

counties in state fiscal year 2009-10 (July 2009 to June 2010).[9] Although Florida reports its Nursing Home Diversion Program on the CMS 64 through its waiver reporting, there is no breakdown of the managed LTSS expenditures by service category.

Expenditure Calculations

The State provided the following data based on encounter data for CY 2007, 2008 and 2009. In order to approximate FFY 2008, we weighted the CY data so 2007 represented 25% of the expenditures and 2008 represented 75%. We used the same method to estimate FFY 2009 spending, using CY 2008 and 2009 data. In the CMS 64 report, all expenditures are reported within an HCBS waiver. The data in Tables 7 and 8 redistributes some of these expenditures amongst other CMS 64 LTSS categories. The term "HCBS Waiver or equivalent" is used because Florida's data include several 1915(c) waivers and a program authorized under Section 1915(j) that was one of the original Cash and Counseling Demonstration Waivers.

TABLE 7: Florida Nursing Home Diversion Program Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$2,413,194,844	$10,066,361	$2,423,261,205	<1%
ICF/MR	$338,699,599	$0	$338,699,599	0%
HCBS Waiver or equivalent*	$1,357,118,040	($20,499,995)	$1,336,618,045	-2%
Personal Care	$37,111,202	$10,426,108	$47,537,310	28%
Home Health	$172,553,127	$7,526	$172,560,653	<1%
PACE	$2,740,820	$0	$2,740,820	0%
Total	***$4,321,417,632***	***$0***	***$4,321,417,632***	***0%***

* Florida's HCBS data includes Section 1915(c) waivers and a program authorized under Section 1915(j)

[9] Florida Medicaid Summary of Services, Fiscal Year 09/10, Florida Agency for Health Care Administration.

TABLE 8: Florida Nursing Home Diversion Program Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$2,402,791,045	$12,157,471	$2,414,948,516	0.5%
ICF/MR	$328,017,908	$0	$328,017,908	0%
HCBS Waiver or equivalent*	$1,295,573,143	($27,656,724)	$1,267,916,419	-2%
Personal Care	$40,992,889	$15,488,960	$56,481,849	38%
Home Health	$165,515,352	$10,293	$165,525,645	0.006%
PACE	$4,987,088	$0	$4,987,088	0%
Total	***$4,237,877,425***	***$0***	***$4,237,877,425***	***0%***

* Florida's HCBS data includes Section 1915(c) waivers and a program authorized under Section 1915(j)

MASSACHUSETTS

Senior Care Options (SCO) is a voluntary program that integrates acute and behavioral health, LTSS, and geriatric social services for people age 65 or older. SCO includes full Medicare and Medicaid benefits for dual eligible individuals and also serves people who only qualify for Medicaid. SCO is available statewide except for certain locations in Western Massachusetts and Cape Cod.[10]

Expenditure Calculations

To estimate LTSS expenditures, Massachusetts first identified the estimated per member per month cost attributed to LTSS in each rate category. Massachusetts uses several rate categories, including three tiers of rates for people in institutions and community rate categories for people who meet nursing facility level of care, people with Alzheimer's or chronic mental illness, and other community-dwelling individuals. For each rate category, the state divided the PMPM cost for LTSS by the total PMPM rate (adjusted for regional rate differences). The result was the portion of total PMPM attributable to LTSS. For each quarter starting July 2008, the state then multiplied this percentage by total capitation payments in that rate category.

[10] Massachusetts Executive Office of Health and Human Services "Senior Care Options Billing Frequently Asked Questions" 2011

Thomson Reuters added data from all quarters and all rate categories in FFY 2009 to estimate total managed LTSS spending in that year. Table 9 presents these estimates and total LTSS expenditures data.

TABLE 9: Massachusetts Senior Care Options Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$1,616,521,340	$159,660,054	$1,776,181,394	10%
ICF/MR	$265,098,972	$0	$265,098,972	0%
HCBS Waiver*	$908,959,456	$35,157,317	$944,116,773	4%
Personal Care	$639,285,871	$0	$639,285,871	0%
Home Health	$102,054,809	$0	$102,054,809	0%
PACE	$88,756,030	$0	$88,756,030	0%
Total	***$3,620,676,478***	***$194,817,372***	***$3,815,493,850***	***5%***

* Thomson Reuters summarized all HCBS in this category because Massachusetts' service categories did not clearly distinguish between state plan and waiver services.

MINNESOTA

In FFY 2009, Minnesota offered four managed care programs that included LTSS. Three programs provided services to people age 65 or older:

1. Minnesota Senior Health Options (MSHO), a voluntary program that includes traditional Medicare, Medicare Part D, and Medicaid services.

2. Minnesota Senior Care Plus (MSC+), a mandatory program for people who live in the community and chose not to enroll in MSHO.

3. Minnesota Senior Care (MSC), which was discontinued starting January 2009. MSC was a mandatory program for people who lived in the community, chose not to enroll in MSHO, and did not require nursing facility

level of care. Before January 2009, MSC+ only served people who required nursing facility level of care.

These programs were statewide, or nearly statewide, as of calendar year 2009. Managed care was mandatory for Minnesota Medicaid recipients ages 65 or older, including those using LTSS, with a number of exemptions.[11]

The fourth program, Minnesota Disability Health Options (MnDHO), was a voluntary program for people ages 18 – 64 with a physical disability who lived in a seven-county area that includes Minneapolis and Saint Paul. MnDHO included all Medicare services for people eligible for Medicare and Medicaid (dual eligibles). MnDHO was closed to new enrollees as of March 1, 2010, and ended during calendar year 2010.

Expenditure Calculations

Minnesota provided a combination of capitation rate-setting components and encounter data to estimate the state's Medicaid managed LTSS expenditures. Minnesota had distinct per member per month (PMPM) capitation rate components for most LTSS in these programs. These rates were paid in addition to the rate set for acute care and other Medicaid services (called the Basic Care rate). To calculate total expenditures, we multiplied the PMPM LTSS rate component by the number of member months for which it was paid. For home health and for personal care for older adults, the state provided PMPM estimates based on encounter data, which we multiplied by the number of member months.

For older adults (MSHO, MSC and MSC+), Minnesota sent data for CYs 2007 through 2009. To estimate expenditures for FFY 2008, we combined the two years, weighting the 2007 data by 25 percent and the 2008 data by 75 percent. We used the same method to estimate FFY 2009 expenditures, using 2008 and 2009 data. For MnDHO, the state provided CY 2008 and 2009 data. CY 2008 data were used to estimate FFY 2008 spending. FFY 2009 expenditures were estimated by weighing 2008 and 2009 data in the same manner as for older adult programs. Tables 10 and 11 present estimated managed care and total LTSS expenditures data.

[11] Some groups were not required to enroll in managed care, including people receiving ICF/MR or the HCBS Waiver for people with developmental disabilities.

TABLE 10: Minnesota Managed LTSS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS*	Revised Total	Increase from CMS 64
Nursing Facility	$825,447,661	$34,426,300	$859,873,961	4%
ICF/MR	$178,358,058	$0	$178,358,058	0%
HCBS Waiver	$1,601,159,056	$148,250,173	$1,749,409,229	9%
Personal Care	$370,881,302	$80,188,815	$451,070,117	22%
Home Health	$83,907,753	$21,901,561	$105,809,314	26%
PACE	$0	$0	$0	n/a
Total	***$3,059,753,830***	***$284,766,849***	***$3,344,520,679***	***9%***

* Data for one of four managed care programs, Minnesota Disability Health Options (MnDHO), were reported for Calendar Year 2008. Data do not include managed LTSS spending reported on the CMS 64 report within Minnesota's HCBS waiver for older adults.

TABLE 11: Minnesota Managed LTSS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS*	Revised Total	Increase from CMS 64
Nursing Facility	$835,049,290	$35,987,316	$871,036,606	4%
ICF/MR	$176,405,610	$0	$176,405,610	0%
HCBS Waiver	$1,674,010,243	$44,978,698	$1,718,988,941	3%
Personal Care	$409,853,665	$95,023,780	$504,877,445	23%
Home Health	$80,487,894	$26,711,792	$107,199,686	33%
PACE	$0	$0	$0	n/a
Total	***$3,175,806,702***	***$202,701,586***	***$3,378,508,288***	***6%***

* Data do not include managed LTSS spending reported on the CMS 64 report within Minnesota's HCBS waiver for older adults.

NEW MEXICO

The New Mexico Coordination of Long-Term Services (CoLTS) program coordinates primary and acute care and LTSS (except for persons receiving HCBS waiver or ICF/MR

services for people with developmental disabilities). CoLTS requires participating MCOs to offer Medicare Special Needs Plans (SNPs) so dual eligible enrollees can enroll for both their Medicare and Medicaid services. However, enrollees are not required to enroll in the SNPs for their Medicare services and may use the Medicare FFS system. The program started in August 2008 and was phased in statewide by April 2009. CoLTS enrollment as of February 2011 was 38,350 people.[12]

Expenditure Calculations

New Mexico spent roughly $444 million in capitation payments for CoLTS in FFY 2009.[13] The State does not currently track CoLTS expenditures by LTSS category, tracking spending by Medicaid eligibility group instead. However, the state estimates that 16% of managed LTSS expenditures go towards nursing facility care. This figure is used for the managed LTSS estimates in Table 12.

TABLE 12: New Mexico Coordination of Long-Term Services Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$59,720,513	$71,050,749	$130,771,262	119%
ICF/MR	$24,014,829	$0	$24,014,829	0%
HCBS Waiver*	$325,914,531	$373,016,434	$698,930,965	114%
Personal Care	$82,925,708	$0	$82,925,708	0%
Home Health	$310,990	$0	$310,990	0%
PACE	$10,757,147	$0	$10,757,147	0%
Total	***$503,643,718***	***$444,067,183***	***$947,710,901***	***88%***

* Thomson Reuters included all HCBS expenditures in this category, because the state did not provide information distinguishing state plan and waiver HCBS spending.

NEW YORK

New York has two managed LTSS programs aside from PACE: Partial LTC and Medicaid Advantage Plus (MAP). Both are voluntary programs serving adults who

[12] New Mexico Human Services Department, Medical Assistance Division.
[13] Ibid.

require nursing home level of care. The Partial LTC program capitates LTSS, care management, and a few other outpatient services. All other services, including inpatient and outpatient hospital, physician services, and pharmacy are covered in FFS. MAP is a fully integrated Medicare and Medicaid primary, acute, and LTSS program. The Partial LTC program enrollment was approximately 30,000 in March 2011, and MAP enrollment was about 1,300.[14]

Expenditure Calculations

The State provided spending data for LTSS categories for CYs 2007 through 2009 based on the health plans' cost reports (encounter data). In order to approximate FFY 2008, we weighted the CY data so 2007 represented 25% of the expenditures and 2008 represented 75%. We used the same method to estimate FFY 2009 spending, using CY 2008 and 2009 data. In Tables 13 and 14, we present the managed LTSS expenditures and total expenditures by service category. The State also spent roughly $13.6 million on adult day health care, which is included in the State Plan rehabilitative services benefit and not within the six LTSS categories of service identified in the CMS 64 as of FFY 2009.[15]

TABLE 13: New York Managed LTSS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$7,248,695,821	$56,489,689	$7,305,185,510	<1%
ICF/MR	$3,007,566,914	$0	$3,007,566,914	0%
HCBS Waiver	$4,077,799,423	$0	$4,077,799,423	0%
Personal Care	$2,943,132,648	$527,285,542	$3,470,418,190	18%
Home Health	$1,647,321,020	$60,406,925	$1,707,727,945	4%
PACE	$147,105,876	$0	$147,105,876	0%
Total	***$19,071,621,702***	***$644,182,156***	***$19,715,803,858***	***3%***

[14] New York Department of Health, Bureau of Continuing Care Initiatives
[15] CMS added rehabilitative services as a category of service on the CMS 64 starting with reports submitted in FFY 2010.

TABLE 14: New York Managed LTSS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$7,618,853,959	$56,394,896	$7,675,248,855	<1%
ICF/MR	$3,112,018,238	$0	$3,112,018,238	0%
HCBS Waiver	$4,853,734,029	$0	$4,853,734,029	0%
Personal Care	$2,721,249,447	$611,083,420	$3,332,332,867	22%
Home Health	$1,775,254,729	$72,495,389	$1,847,750,118	4%
PACE	$156,715,200	$0	$156,715,200	0%
Total	***$20,237,825,602***	***$739,973,705***	***$20,977,799,307***	***4%***

TENNESSEE

Tennessee's TennCare program, authorized under an 1115 waiver, is a mandatory Medicaid managed care program covering all Tennessee Medicaid-eligible individuals. Until March 2010, LTSS such as nursing facility, ICF/MR, and HCBS waiver services were not included in TennCare, but home health care and private duty nursing services were included.

As part of an effort to expand access to HCBS and rebalance LTSS expenditures, the state launched a managed LTSS program – TennCare CHOICES in Long-Term Care – in March 2010. The program became statewide on August 1, 2010. CHOICES integrates all of the state's nursing facility services into the existing managed care program and also provides a broad array of HCBS for persons requiring a nursing facility level of care, including nursing facility residents who desire and are appropriate for transition to the community. The HCBS program is limited to older adults and adults with physical disabilities. Other LTSS programs (including ICF/MR and HCBS Waivers for people with developmental disabilities) remain FFS.

Expenditure Calculations

The State provided estimates of home health and private duty nursing expenditures under TennCare based on encounter data submitted by the TennCare MCOs. These

data, along with total LTSS data, are presented in Tables 15 and 16. FFY 2009 home health expenditures are lower than FFY 2008, reflecting the state's implementation of home health and private duty nursing benefit limits for adults.

TABLE 15: TennCare LTSS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$1,040,918,452	$0	$1,040,918,452	0%
ICF/MR	$241,018,741	$0	$241,018,741	0%
HCBS Waiver	$627,323,201	$0	$627,323,201	0%
Personal Care	$0	$0	$0	n/a
Home Health	$0	$313,548,000	$313,548,000	n/a
PACE	$7,184,348	$0	$7,184,348	0%
Total	***$1,916,444,742***	***$313,548,000***	***$2,229,992,742***	***16%***

TABLE 16: TennCare LTSS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$975,022,948	$0	$975,022,948	0%
ICF/MR	$267,567,506	$0	$267,567,506	0%
HCBS Waiver	$663,092,694	$0	$663,092,694	0%
Personal Care	$0	$0	$0	n/a
Home Health	$0	$242,356,000	$242,356,000	n/a
PACE	$11,090,078	$0	$11,090,078	0%
Total	***$1,916,773,226***	***$242,356,000***	***$2,159,129,226***	***13%***

TEXAS

Texas STAR+PLUS is a large mandatory managed care program for older adults and persons with disabilities that includes primary and acute care and LTSS. Enrollees do

not need to meet nursing home level of care. STAR+PLUS operates in five metropolitan areas (29 counties), with a 2011 expansion to 13 additional counties planned. July 2008 enrollment was over 157,000,[16] including about 23,000 people using LTSS.[17]

Expenditure Calculations

The state provided managed LTSS spending by service category for state fiscal years (SFY) 2008 and 2009.[18] Since Texas' SFY (September to August) is only one month different from the FFY, we did not distribute SFY data across multiple years. Texas reported expenditures based on encounter data. In addition to the data on Tables 17 and 18, STAR+PLUS MCOs also spent $41.6 million in adult day services, part of the State Plan rehabilitative services benefit and not within the six LTSS categories of service identified in the CMS 64 in FFY 2009.[19]

TABLE 17: Texas STAR+PLUS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$1,937,996,577	$9,510,352	$1,947,506,929	<1%
ICF/MR	$954,068,383	$0	$954,068,383	0%
HCBS Waiver	$1,250,657,067	$25,349,836	$1,276,006,903	2%
Personal Care*	$784,749,865	$300,589,698	$1,085,339,563	38%
Home Health	$236,179,151	$0	$236,179,151	0%
PACE	$29,729,886	$0	$29,729,886	0%
Total	***$5,193,380,929***	***$335,449,886***	***$5,528,830,815***	***6%***

* Texas personal care data includes a program under Section 1929 of the Social Security Act that provides an entitlement to personal care – and no other Medicaid services – to people with incomes up to 300% of the Supplemental Security Income benefit.

[16] Texas Medicaid Managed Care Monthly Confirmed Eligibles Report, July 2008.
[17] Communication with Pamela Coleman, Texas Health and Human Services Commission.
[18] This includes claims in process, estimated expense of incurred but not reported healthcare services, withholds from paid claims and capitation, capitation payable to providers, and reinsurance payable to reinsurers for ceded risk net of reinsurance receivable for assumed risk.
[19] CMS added rehabilitative services as a category of service on the CMS 64 starting in FFY 2010.

TABLE 18: Texas STAR+PLUS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$2,151,950,372	$55,895	$2,152,006,267	<1%
ICF/MR	$898,706,862	$0	$898,706,862	0%
HCBS Waiver	$1,385,393,697	$31,565,932	$1,416,959,629	2%
Personal Care*	$896,981,319	$358,824,591	$1,255,805,910	40%
Home Health	$272,651,021	$0	$272,651,021	0%
PACE	$29,944,220	$0	$29,944,220	0%
Total	***$5,635,627,491***	***$390,446,418***	***$6,026,073,909***	***7%***

* Texas personal care data include a program authorized under Section 1929 of the Social Security Act that provides an entitlement to personal care – and no other Medicaid services – to people with incomes up to 300% of the Supplemental Security Income benefit.

VERMONT

Vermont operates its Medicaid program under two separate 1115 waiver programs: Choices for Care and Global Commitment. Federal Medicaid financing is capped under both programs, with the State acting as the managed care organization. The state reports LTSS expenditures by service category on the CMS 64 for the Choices for Care waiver, but not for the Global Commitment waiver. LTSS are funded through both waivers.

Expenditure Calculations

The State provided managed LTSS expenditures for its Global Commitment waiver based on its claims reporting system. Tables 19 and 20 show managed LTSS expenditures and total expenditures by service category.

TABLE 19: Vermont LTSS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility	$114,200,592	$1,153,174	$115,353,766	1%
ICF/MR	$0	$1,183,582	$1,183,582	n/a
HCBS Waiver or equivalent	$52,519,965	$130,945,701	$183,465,666	249%
Personal Care	$0	$17,855,477	$17,855,477	n/a
Home Health	$2,163,312	$4,377,876	$6,541,188	202%
PACE	$1,371,360	$0	$1,371,360	0%
Total	***$170,255,229***	***$155,515,810***	***$325,771,039***	***91%***

TABLE 20: Vermont LTSS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility*	$118,215,099	($1,629,526)	$116,585,573	-1%
ICF/MR	$0	$1,226,274	$1,226,274	n/a
HCBS Waiver or equivalent	$51,497,379	$137,276,566	$188,773,945	267%
Personal Care	$0	$19,476,649	$19,476,649	n/a
Home Health	$2,366,484	$4,323,039	$6,689,523	183%
PACE	$2,993,012	$0	$2,993,012	0%
Total	***$175,071,974***	***$160,673,002***	***$335,744,976***	***92%***

* Vermont nursing facility managed LTSS expenditures are negative because the state's estimate of total claims paid is less than reported expenditures on the CMS 64 through September 2009. It is possible the CMS 64 amount was reduced by subsequent adjustments.

WISCONSIN

Wisconsin operates two managed LTSS programs in addition to PACE: Family Care (FC) and Family Care Partnership (FCP). FC only includes LTSS, whereas FCP integrates Medicare and Medicaid funding and includes primary and acute care and LTSS. As of December 31, 2009, FC operated in 48 of Wisconsin's 72 counties with enrollment of almost 28,000. FCP operated in 16 counties, including two counties where PACE is available. Combined FCP and PACE enrollment was over 5,000.[20]

Expenditure Calculations

The State releases annual reports for its LTSS programs that include expenditures data based on CY.[21] In order to approximate FFY 2008, we weighted the CY data so 2007 represented 25% of the expenditures and 2008 represented 75%. We used the same method to estimate FFY 2009 spending, using CY 2008 and 2009 data. In Tables 21 and 22, we present managed LTSS and total expenditures by service category. We include PACE data because Wisconsin's CMS 64 reports do not identify PACE expenditures.

[20] Wisconsin Department of Health Services *Long-Term Care in Motion: 2009 Annual Report of Wisconsin's Long-Term Care Programs* September 2010. This source did not include separate enrollment totals for PACE and FCP.

[21] Wisconsin Department of Health Services Long-Term Care in Motion: 2009 Annual Report of Wisconsin's Long-Term Care Programs September 2010; Long-Term Care in Motion: 2008 Annual Report of Wisconsin's Long-Term Care Programs July 2009; and Long-Term Care in Motion: 2007 Annual Report of Wisconsin's Managed Long-Term Care Programs December 2008.

TABLE 21: Wisconsin Managed LTSS Expenditures: FFY 2008

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility*	$739,684,447	$56,219,949	$795,904,396	8%
ICF/MR*	$38,737,841	$0	$38,737,841	0%
HCBS Waiver	$652,123,523	$408,177,815	$1,060,301,338	63%
Personal Care	$196,545,792	$0	$196,545,792	0%
Home Health	$55,769,895	$14,177,005	$69,946,900	25%
PACE**	$0	$0	$0	n/a
Total	***$1,682,861,498***	***$478,574,770***	***$2,161,436,268***	***28%***

* Managed LTSS data for nursing facility services may include ICF/MR services.

** PACE expenditures were distributed among the other categories of service, similar to other managed LTSS expenditures.

TABLE 22: Wisconsin Managed LTSS Expenditures: FFY 2009

State	Total LTSS per CMS 64	Additional Managed LTSS	Revised Total	Increase from CMS 64
Nursing Facility*	$1,098,776,448	$72,914,961	$1,171,691,409	7%
ICF/MR*	$283,288,787	$0	$283,288,787	0%
HCBS Waiver	$637,868,275	$708,368,911	$1,346,237,186	111%
Personal Care	$179,328,014	$11,613,381	$190,941,395	6%
Home Health	$56,007,081	$26,590,689	$82,597,770	47%
PACE**	$0	$0	$0	n/a
Total	***$2,255,268,605***	***$819,487,942***	***$3,074,756,547***	***36%***

* Managed LTSS data for nursing facility services may include ICF/MR services.

** PACE expenditures were distributed among the other categories of service, similar to other managed LTSS expenditures.

CONCLUSION

As shown in Tables 1 and 2, Medicaid managed LTSS expenditures are a significant and growing portion of LTSS expenditures. In FFY 2009, managed LTSS accounted for more than $5 billion, 10% of total Medicaid LTSS spending in the 10 states with programs that provided data. In one year, reported managed LTSS expenditures increased more than 25%. We expect managed LTSS to continue to grow as more states consider expanding or implementing managed care programs.

Developing a routine way to track state managed LTSS spending will be increasingly important to obtain a more comprehensive picture of total Medicaid LTSS spending, especially in light of Affordable Care Act provisions that encourage states' use of home and community-based LTSS. Managed LTSS programs typically assume more risk for HCBS than for institutional services, so omission of managed LTSS data disproportionately affects estimates of HCBS spending. It will be difficult to measure whether policies aimed at "balancing" state LTSS systems are effective without accounting for managed LTSS expenditures.