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Issue Brief:

Medicaid Long-term Care: *The ticking time bomb*

Foreword

As the dust settles from passage of the 2010 Patient Protection and Affordable Care Act (PPACA), most state legislatures are left to ponder how they will ultimately fare, given growing fiscal constraints, increased enrollment in Medicaid and the Children's Health Insurance Program (CHIP), and a political season where government spending is likely to be a prominent issue. Appropriately, state leaders must look to promising areas where opportunities for cost savings also improve results: Among these is long-term care (LTC) for the Medicaid population.

Left unattended, states' obligation to their LTC Medicaid enrollees has the potential to debilitate government effectiveness. The health care reform bill provides little near-term relief: States must innovate with a sense of urgency to address this burning platform.

Medicaid LTC programs offer significant opportunity for state officials to demonstrate leadership; however, it requires urgent, thoughtful attention and deliberate action.

Paul H. Keckley, Ph.D.
Executive Director
Deloitte Center for Health Solutions

Executive Summary

There currently is no coordinated, comprehensive system of the provision and financing of LTC services in the United States. For the disabled and elderly who lack personal financial resources, navigating the complexities and regulations associated with LTC decisions can be extremely challenging. No less daunting is the task facing policy makers, whose decisions on behalf of these vulnerable populations directly and dramatically affect both state and federal budgets.

By design, state-administered Medicaid has become the nation's primary funding source for LTC for those in need. Because of this, the pressure on states to control costs while making effective decisions regarding the provision of community- versus institutional-based LTC services presents an opportunity to transform LTC as a whole. This transformation assumes a sense of urgency as state and local governments face new and growing fiscal challenges generated, in part, by the needs of an aging Baby Boom generation. Prior to 1995, elderly residents exceeded 15 percent of the population in only five states; by 2025, the elderly will exceed 15 percent in every state except California and Alaska. The number of Americans aged 65 and older will more than double in at least 20 states and then continue to grow.[1]

Produced by the Deloitte Center for Health Solutions

Current health care reform efforts have been focused on controlling costs and increasing health care access for the uninsured, poor, elderly and disabled. The 2010 PPACA was signed into law in March; however, the full effect of this landmark legislation may not be apparent for several years. As evidenced by the public response to health care reform activities, it is clear that the outcomes of the PPACA legislation will be of great interest to Baby Boomers, who will increasingly rely on public programs for care.

Glossary of Key Terms

Medicaid: Medicaid is a state and federal government program that pays for certain health services and nursing home care for people with low incomes and limited assets. In most states, Medicaid also pays for some LTC services at home and in the community. Eligibility requirements and services covered vary from state to state. Most often, eligibility is based on income and personal resources.

Long-term Care (LTC): LTC includes medical and non-medical services for people who have a chronic illness or disability. LTC helps meet health or personal needs. Most LTC services assist people with daily living like dressing, bathing, and using the bathroom. LTC can be provided at home, in the community, in assisted living facilities or in nursing homes. LTC may be needed at any age.

In-home/Community Care: In-home/Community Care programs provide personal activity assistance to seniors and people with disabilities. Example programs include Meals-on-Wheels, transportation services, adult day care and chore services.

Institutional Care: Institutional care facilities provide care to individuals who cannot be cared for in the community or at home. Examples include nursing homes and some assisted living facilities.

The convergence of an aging population and health care reform's mandate for increased access to care will have far-reaching consequences for Medicaid. Not only will it force Medicaid to examine existing benefit programs for the elderly and the poor, it will also push Medicaid to rethink how it can address the full range of elderly needs with the resources it possesses and can mobilize. A key beneficiary of those resources will be people needing LTC.

This paper examines the Medicaid expenditures for LTC, in both institutional and community-based settings. If the current trend continues as demonstrated in this paper's base model, more than 35 percent of a state's budget will be needed for Medicaid by 2030, of which half will be for LTC services. Research indicates that nursing facility expenditures are not driving this cost escalation, so a push to manage LTC costs by eliminating less-costly home/community care programs could boomerang, with the result that beneficiaries end up requiring more costly institutional care.

The paper also examines how health care reform's mandate for increased access will worsen Medicaid's expenditure trend. The Senate bill estimated that Medicaid coverage would be expanded to include an additional 14 million individuals. At a time when unemployment rates remain high, state tax revenues have decreased and state budget deficits have increased, states are being asked to do more with less in regard to health care resources. While the bill states that new Medicaid enrollees will be subsidized through 100 percent federal funds from 2014 to 2016,[2] state budget deficits are projected to be more than $350 billion between 2010 and 2011, a dangerous fiscal scenario for which there is no short-term solution. This paper presents ideas for consideration for states to transform their Medicaid LTC programs to help address budget constraints – and to find the way to do more with less.

1 U.S. Census Bureau

2 Except for Nebraska, which will receive a permanent federal subsidy to cover the costs of increased Medicaid eligibility under the bill.

Overview

Medicaid is the primary payor for LTC services and support to the elderly and disabled in the U.S.[3] and, by default, has become the primary support for U.S. LTC.[4] Medicaid currently finances nearly 34 percent of all home health care and 43 percent of the nation's nursing home spending. Medicaid covers a wide range of LTC services, including a broad spectrum of critical support for the poor in both community and institutional settings. The total LTC Medicaid expenditures for FY 2008 were $106.4 billion – 32.1 percent of Medicaid's total spending of $331.8 billion. That same year, institutional LTC spending rose 2.9 percent to $61 billion and community-based LTC spending rose 4.9 percent to $45.4 billion. The distribution of LTC resources between institutional care and home/community-based care was 57 percent and 43 percent respectively.[5]

The balance between institutional LTC and community-based LTC services is important for several reasons. First, there is no comprehensive, well-coordinated system of LTC in the U.S. Second, an informal LTC system supported by unpaid family members and volunteer services is being strained by cultural, demographic and economic pressures. The relationship between institutional care and community care is not a simple one. For example, in situations where individuals have personal or family resources to support LTC, the high expenses of institutional care may result in impoverishment, leading to their eligibility for Medicaid and a resulting increase in Medicaid nursing home care expenditures.[6] Recent research has shown that individuals may be cared for in community settings without sacrificing quality and, in fact, with an increase in beneficiary satisfaction. However, in the current economic climate, more states are cutting in-home/community services to address their Medicaid LTC fiscal challenges. Unfortunately, these cuts will further aggravate state Medicaid performance since in-home/community programs are less expensive to provide and often reduce the need for institutional care.[7]

This paper highlights the potential state budget effects of the impending LTC services demand brought about by increasing Medicaid enrollments. It also presents scenarios that forecast two likely outcomes: The effect of the aging population's demographic bulge on Medicaid enrollment, and the potential increase in Medicaid eligibility due to legislative mandates associated with health care reform. The combination of these two potential outcomes could be a catastrophic fiscal "left hook" that state and federal policy makers ignore at their peril. To provide context for those states contemplating the policy implications arising from these outcomes, the paper provides a selection of innovative programs (both recent and current) that may be useful to policy makers as they consider ways in which to restructure or transform LTC services for their disabled and elderly Medicaid beneficiaries.

National Enrollment Trends in Medicaid LTC

The recession, increased numbers of unemployed who have lost employer-sponsored health care coverage, and the aging baby boomer demographic are some of the trends expected to affect health care spending – including Medicaid enrollment – in the next decade.[8]

Medicaid LTC spending, including community- and home-based services (HCBS), is expected to increase over the next decade. Projected combined federal and state Medicaid expenditures for 2009 represent a 9.9 percent increase over the prior year, for a total of $378.3 billion. This is the most rapid spending growth (10.7 percent) since 2002. The primary cause of this increase is postulated to be the rising unemployment rate during 2009, which resulted in a 6.5 percent increase in Medicaid enrollment.[9] Projections for 2010 Medicaid include 5.6 percent enrollment growth and 8.9 percent cost growth, again attributed to unemployment rates. If the economy continues to improve and the unemployment rate decreases, Medicaid is projected to grow an average of 7.5 percent per year, due primarily to increasing age-related beneficiary enrollment and LTC services for the disabled and elderly populations.[10]

3 Catlin A, Cowan C, et al. (2008). "National Health Spending In 2006: A Year Of Change For Prescription Drugs," *Health Affairs*, 27(1): 14-29, http://content.healthaffairs.org/cgi/content/abstract/27/1/14. Accessed March 6, 2010.

4 National Governors Association. Policy Position HHS-28. Long-term Care. 28.1 Preamble, Accessed February 25, 2009, http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a278110501010a0/?vgnextoid=47a0d3add6da2010VgnVCM1000001a01010aRCRD&vgnextchannel=4b18f074f0d9ff00VgnVCM1000001a01010aRCRD. Accessed February 23, 2010.

5 Burwell B, Sredl K and Eiken D. *Medicaid Long-Term Care Expenditures in FY 2008*, Research Paper, Thomson Reuters, December 1, 2009. pp.1-2. http://www.hcbs.org/files/165/8249/2008LTCExpenditures_final.pdf. Accessed March 6, 2010.

6 2008 Actuarial Report on the Financial Outlook for Medicaid; Office of the Actuary Center for Medicare & Medicaid Services, http://www.cms.hhs.gov/ActuarialStudies/downloads/MedicaidReport2008.pdf. Accessed March 6, 2010.

7 Catlin A, Cowan C, et al. (2008). "National Health Spending In 2006: A Year Of Change For Prescription Drugs," *Health Affairs*, 27(1): 14-29, http://content.healthaffairs.org/cgi/content/abstract/27/1/14. Accessed March 6, 2010.

8 Truffer CJ, Keehan S, et al. "Health Spending Projections Through 2019: The Recession's Impact Continues," *Health Affairs*, 29(3): 522-529.

9 Ibid, p. 527

10 Ibid, p. 527

The use of HCBS is expected to increase substantially more than institutional care; this shift toward non-institutional settings for LTC is attributed to beneficiaries' perceived preference for non-institutional settings, and the tendency for community settings to be less costly than institutional sites.[11] Despite this increase, in 2007, only 31 percent of Medicaid LTC expenditures were attributed to community care.[12]

Medicaid spending on blind or disabled beneficiaries is expected to grow the most rapidly, as they receive the largest amount of HCBS LTC. The blind and disabled increasingly have moved from institutional settings to HCBS as the availability of these services has expanded.

To more closely examine the financial implications of these trends, Deloitte modeled four scenarios as examples of potential impact on Medicaid costs:

- Scenario 1: Base Case Scenario – Trends without intervention,
- Scenario 2: Best Case Scenario – Five percent expenditure savings without enrollment increases,
- Scenario 3: Worst Case Scenario – 40 percent enrollment increase without expenditure decreases and
- Scenario 4: Most Likely Scenario – 20 percent enrollment increase.

Each scenario is presented for both Medicaid as a whole and Medicaid LTC services in ten states, representing multiple regions and the nation's most populous states. See Appendix for more information on the different scenarios and assumptions.

Who needs Medicaid LTC services?

According to a July 2006 report from the Kaiser Commission on Medicaid and the Uninsured, nearly 10 million Americans need LTC services. The majority of beneficiaries who receive LTC services are age 65 and above; 37 percent are under 65.

LTC includes a range of services that assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include assistance with things like eating, dressing and toileting. IADLs include assistance with things that are not necessary for fundamental living but enable an individual to live independently in a community. These include doing light housework, preparing meals, taking medicine and grocery shopping.

For some people, LTC services are lifetime needs. Children born with severe physical impairments, developmental disabilities or a degenerative disease often need care throughout their lives. Teenagers and adults who incur traumatic brain injuries may need care for decades. The elderly often need some LTC services due to decreasing mobility and cognitive functioning that accompany aging. Those who are disabled by a serious illness often require more extensive services.

11 Ibid

12 National Conference of State Legislatures. http://www.ncsl.org/Default.aspx?TabID=160&tabs=832,98,333#333. Accessed March 6, 2010.

Emerging Trends for State Medicaid: A closer look across the most populous states

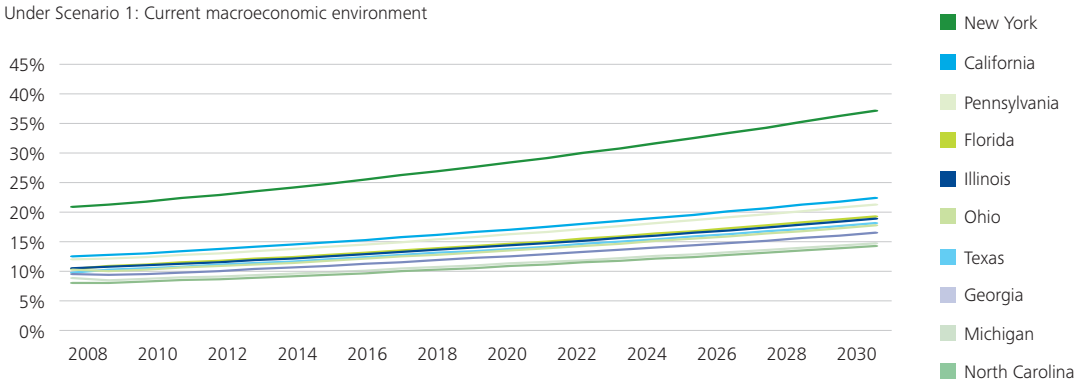
The 2008 Medicaid Report from the Centers for Medicare and Medicaid Services (CMS) projects that future LTC spending will increase at an average rate of 8.6 percent per year. CMS' projection is based on expected continuing increases in the use and costs of LTC, as well as projected increases in enrollment – especially for aged and disabled beneficiaries.

As Deloitte's model indicates (Figure 1), if the current trend continues, Medicaid budgets as a percentage of state operating budgets will almost double by 2030 – some reaching levels close to 40 percent. In certain states, expenditures for LTC account for about half of this trend (Figure 2).

CMS further expects HCBS to grow substantially more than institutional care, at an average annual rate of 11.9 percent and 5.5 percent, respectively. CMS attributes this difference primarily to the continuing trend of beneficiaries using non-institutional settings for a greater share of LTC services. Non-institutional care tends to be less expensive than institutional care, and beneficiaries are generally believed to prefer receiving care in their homes or communities rather than in nursing homes or other institutional settings.[13]

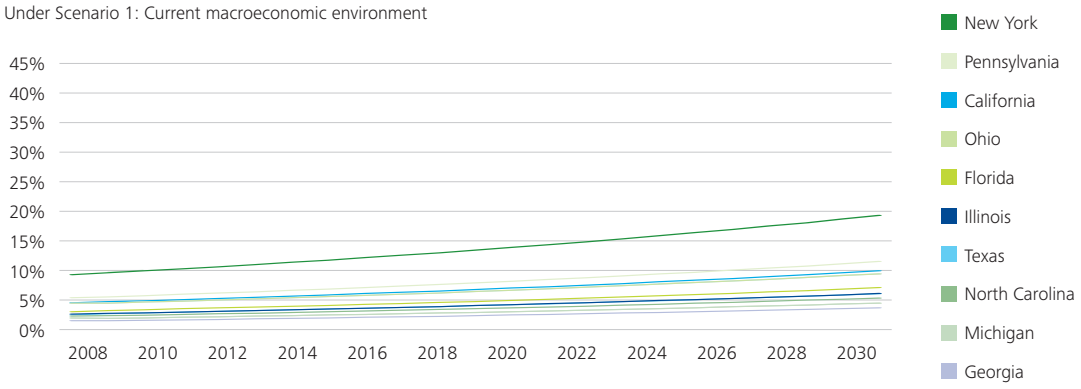
Scenario 1: Base Case Scenario – Current state of how Medicaid expenditures are trending without intervention

Figure 1: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Figure 2: LTC portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

13 Ibid

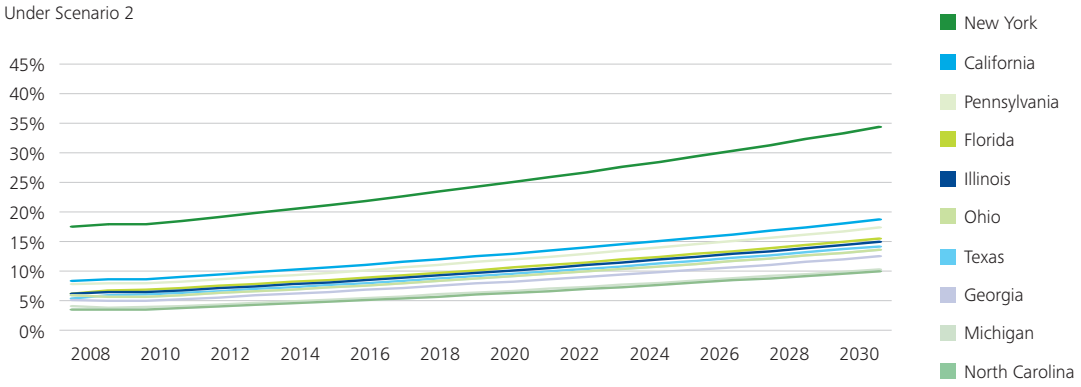
The Need for Transformation

One of the focuses of health care reform is increasing access to health care while constraining cost escalation. Deloitte has modeled various scenarios based on CMS' projections for future costs to provide examples of the impact of such reform on eligibility and resulting expenditure trends for LTC. The second scenario, presented here, assumes no increase in states' LTC eligibility (current macroeconomic trends continue) but models modest attempts at managing the current cost trend with a five percent savings to future Medicaid LTC expenditures.

As is evident in both Figure 3 and Figure 4, five percent savings will not significantly bend the cost curve. States will need transformational change to temper this cost trend. By 2030, LTC costs will still nearly double their percentage of the operating budget. Enterprise cost restructuring and fundamental program redesign will be needed to improve the efficiency and effectiveness of LTC cost performance.

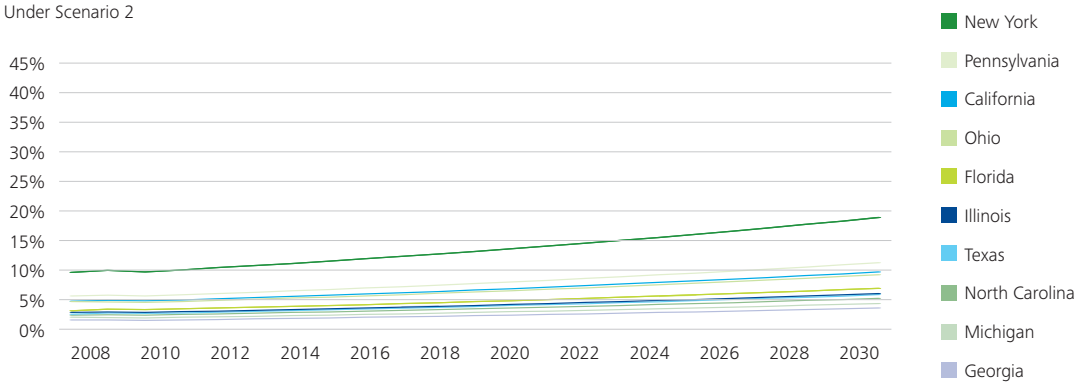
Scenario 2: Best Case Scenario – Five percent savings in future Medicaid LTC expenditures without enrollment increases

Figure 3: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Figure 4: LTC portion of states' operating budgets



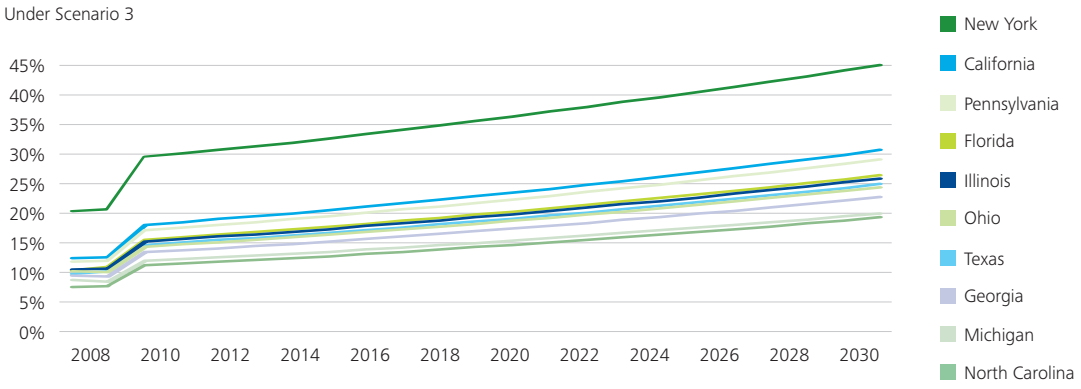
Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

In contrast, Scenario 3 (Figure 5 and Figure 6) assumes an aggressive 40 percent increase in Medicaid enrollment due to legislative mandates associated with the 2010 health care reform legislation.

In this scenario, the percentage of states' operating budgets allocated to LTC increases nearly three-fold – from 2008's 10 percent to almost 25 percent in 2030. In this worst-case scenario, Medicaid is projected to be close to 50 percent of the operating budget by 2030 for at least one state. Obviously, this is not sustainable.

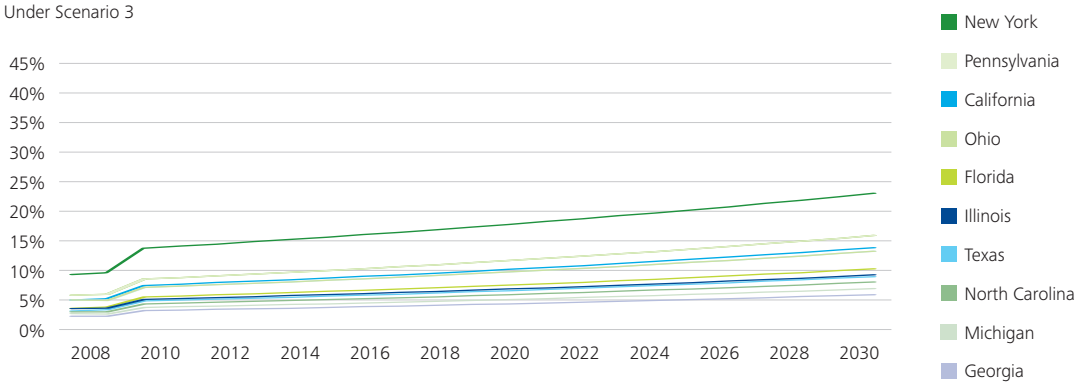
Scenario 3: Worst Case Scenario – 40 percent increase in Medicaid enrollment without cost savings

Figure 5: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Figure 6: LTC portion of states' operating budgets



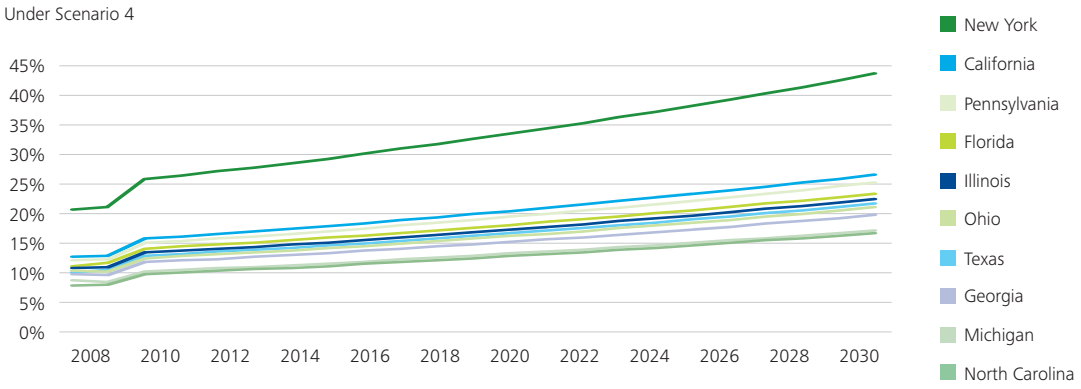
Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Scenario 4 (Figure 7 and Figure 8), a more likely scenario, depicts a more conservative 20 percent increase in states' Medicaid enrollment due to legislative mandates associated with health care reform.

In this more likely scenario of health care reform's expansion of Medicaid eligibility, Medicaid will average nearly 25 percent of states' operating budget in 2030. LTC expenditures are modeled to average 10 percent of the states' operating budget; almost the same amount the total Medicaid budget equals today. As previously demonstrated, even a five percent savings on future Medicaid LTC expenditures would not significantly bend the cost curve.

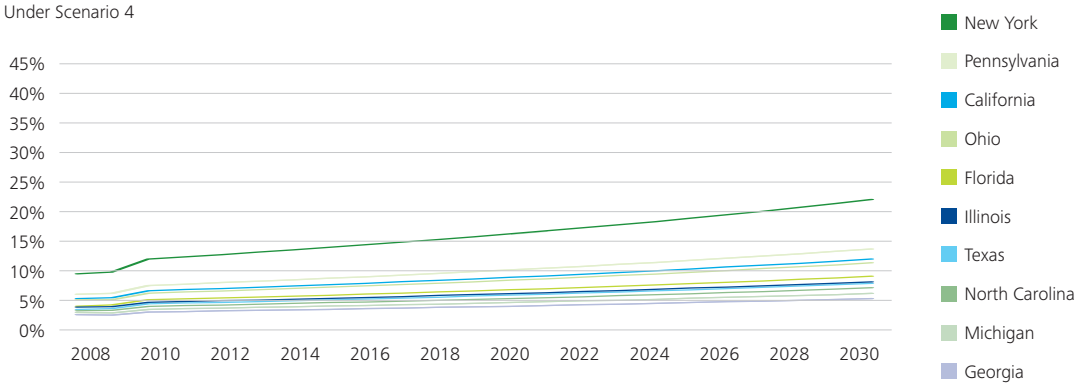
Scenario 4: More Likely Scenario – 20 percent increase in Medicaid enrollment

Figure 7: Medicaid portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Figure 8: LTC portion of states' operating budgets



Source: Deloitte LLP's model using CMS'projections for future growth in expenditures

Trend Summary

Across all scenarios, the results are the same: The portion of states' operating budget for Medicaid expenditures is increasing. In addition, the portion of the budget allocated to support LTC is increasing, and expenditures on nursing facilities are not the only driver. Despite pressures on states to reduce HCBS, the downstream consequences of doing so could be increased costs in institutional LTC, as beneficiaries could become more costly institutional patients. Instead, states should consider implementing aggressive/transformative actions to improve Medicaid LTC programs or continue to face the prospect of budget deficiencies.

Among actions needed to impact this escalating cost trend are enterprise cost restructuring and fundamental program redesign to improve the efficiency and effectiveness of LTC management. Important first steps are to understand the primary drivers of LTC and to analyze states' non-public data to identify what is occurring in LTC populations and to develop state-specific mitigating action plans.

Selected Factors Affecting LTC

LTC and medical expenditures are influenced by a number of factors. These factors, such as chronic disease incidence and innovative service delivery models, provide a context for considering implications of policy issues in this area.

Chronic Disease Incidence

Sixty percent of the U.S. population suffers from at least one chronic disease and the prevalence is higher among older adults; for example, for individuals over 80 years, at least 80 percent have two or more chronic diseases.[14] The most prevalent and/or high-cost chronic conditions are hypertension, diabetes, cancer (excluding skin), chronic obstructive pulmonary disease (COPD), acute myocardial infarction (AMI), coronary heart disease (CHD) and stroke. Excluding hypertension, the remaining conditions account for more than two-thirds of deaths in the U.S.[15]

Chronic Conditions Driving Medicare Spending

An April 2010 study reports marked changes over the past 20 years in the nature and location of treatment for U.S. Medicare beneficiaries.

1987: Intensive inpatient hospital services for heart disease accounted for the majority of growth in spending.

2006: Outpatient and prescription drug treatment for chronic care conditions – hypertension, diabetes, arthritis and kidney disease – accounted for the majority of the growth in spending.

- More than half of beneficiaries are treated for five or more chronic conditions.
- On average, a beneficiary is seen by two primary care physicians and five specialists in four practices.
- Due to deficiencies in the coordination of chronic care, beneficiaries receive only 56 percent of clinically recommended care.[17]

The majority of both Medicare and Medicaid spending is associated with the treatment of chronic disease; when individuals are eligible for both Medicare and Medicaid services (8.8 million individuals), 98 percent of total expenditures are for chronic disease care. Approximately 39 million individuals with chronic care conditions also require LTC services, which include support for activities of daily living. Such individuals often have multiple care providers and multiple treatment and medication plans, with no primary source of coordination. This lack of continuity of care and coordination may lead to otherwise preventable emergency department visits, hospitalizations and nursing home admissions.[16, 17]

14 AARP and National Conference of State Legislatures. *Long-Term Care Reform Leadership Project Issue Brief No. 2.* June 2009, http://www.ncsl.org/documents/health/carecoord.pdf. Accessed March 6, 2010.

15 Joyce GF, Keeler EB, et al. (2005). "The Lifetime Burden Of Chronic Disease Among The Elderly," *Health Affairs*, hlthaff.w5.r18

16 AARP and National Conference of State Legislatures. Long-Term Care Reform Leadership Project Issue Brief No. 2. June 2009, http://www.ncsl.org/documents/health/carecoord.pdf. Accessed March 6, 2010.

17 Thorpe KE, Ogden LL, et al. "Chronic Conditions Account For Rise In Medicare Spending From 1987 To 2006," *Health Affairs,* hlthaff.2009.0474.

In recent years, the rise in chronic disease has driven Medicaid to develop chronic disease management programs; however, such programs exist as demonstration projects on a state-by-state basis. Evaluating such programs and determining their relative effectiveness – both on expenditures and quality of care – have yet to be determined. However, a 2005 study of chronic disease showed that "although chronic conditions increase annual health care costs, cumulative spending for individuals from age 65 to death was only modestly higher for the chronically ill."[18] Such findings caution that although prevention, coordination and delaying therapies are valuable to pursue, the effect on health care expenditures may not show equivalent improvement.

Some Current Initiatives

The U.S. LTC system is fragmented and complex, and historically has been focused on the provision of institutional care. If private or family-supplied funding is not available to the elderly or disabled who require LTC, state Medicaid funds are required to support those needs. Every state has its own specific eligibility criteria for Medicaid and a complex set of other agency programs. Many public and private partnerships are developing to improve the quality of LTC, control spending and allow for community-focused, personalized, LTC systems.

The National Conference of State Legislatures is focusing on improving LTC in several key areas:

- Making LTC services more person-centered and community-focused,
- Coordinating health and LTC systems through Medicare and Medicaid,
- Developing a high-quality workforce and
- Exploring new public and private financing approaches.[19]

This section describes several LTC initiatives and program innovations.

Pilots and Demonstrations: Person-centered care

CMS is compiling a compendium of "Promising Practices in Home- and Community-Based Services" as a resource for states that are developing programs to promote person-centered and community-focused LTC. These summary reports generally focus on specific components of home and community services that may be included in a comprehensive program. The purpose of the Promising Practice reports is to stimulate innovation in community-based LTC.[20]

In a partnership model with states, consumers, providers and advocacy groups, CMS is working to establish programs that give individuals with disabilities and chronic conditions some choices, control and access to quality health care services that promote independence.

Independence Plus is a report that chronicles the experience of several states that tried innovations in programs designed to promote person-centered planning and services. These programs are defined as "state Medicaid programs that present individuals with options to control and direct Medicaid funds identified in an individual budget." There are eleven approved Independence Plus programs in ten states: New Hampshire, South Carolina, Louisiana, North Carolina, Florida, Maryland, California, Delaware, New Jersey and Connecticut.

Characteristics of LTC Community Service Programs: Partnerships with CMS and States, Consumers, Providers, Advocacy Groups

- Person-driven: Enables the elderly and individuals with disabilities to decide living situations, services they receive and community supports.
- Inclusive: Provides support for individuals to live with access to quality health and community services.
- Effective and accountable: Promotes shared accountability between public and private partners, including planning for LTC needs with greater knowledge of private funding sources.
- Sustainable and efficient: Coordinates and manages packages of paid services.
- Coordinated and transparent: Coordinates multiple funding sources for seamless support, using health information technology to provide transparency to all stakeholders.
- Culturally competent: Accommodates individuals' cultural and linguistic needs in the provision of LTC services.[21]

18 Joyce GF, Keeler, EB, et al. (2005). "*The Lifetime Burden Of Chronic Disease Among The Elderly,*" *Health Affairs*, hlthaff.w5.r18. (w5.r27.).

19 National Conference of State Legislatures: http://www.ncsl.org/Default.aspx?TabID=160&tabs=832,98,333#333. Accessed March 6, 2010.

20 See http://www.cms.hhs.gov/PromisingPractices. Accessed March 6, 2010.

21 See http://www.cms.hhs.gov/IndependencePlus. Accessed March 5, 2010.

Budgetary Adjustments

In the *Guide to LTC for State Policy Makers,*[22] rebalancing refers to the shifting of resources from institutional LTC to HCBS. New funding mechanisms and some federal "flexibility" have created the potential for consumers to remain in their communities for LTC. Several examples excerpted from the *Guide* include:

- Olmstead Supreme Court decision of 1999 – Increased state responsibility for providing a range of community options.
- Real Choice Systems Change Grants – $240 million provided since 2001 for state grants to set up such programs as person-centered care, Independence Plus initiatives, Nursing Home Transitions and Money Follows the Person.
- Deficit Reduction Act of 2005 – Allowed states to offer HCBS as a Medicaid State Plan optional benefit for qualified enrollees.
- Money Follows the Person – Individuals residing in nursing homes have the option to move to a community location. Public funds are transferred from the nursing home to community care.
- Nursing Home Transitions – Funds are authorized by state legislatures to assist in transitions to the community, including support for living arrangements such as security deposits, utilities and furniture.

Several states have used a combination of these initiatives to begin to balance their LTC services. Of particular note are initiatives in New Jersey, Minnesota, Iowa, Ohio, Vermont, Washington, New Mexico and Massachusetts.[23]

Innovation in Service Delivery Models[24]

State and local agencies that provide assistance for individuals who require LTC services have historically not been visible to those who most need help. Both funding and fragmentation issues have plagued the relationship between resource groups and the potential recipients of their services. Some examples of initiatives to address these issues are:

- Aging and Disability Resource Centers (ADRCs) – Funded by federal grants, the goal of these centers is to provide one-stop access for all LTC publically funded services, and to provide prompt Medicaid eligibility determination. Since 2003, CMS and the U.S. Administration on Aging have provided funds to establish ADRCs in 43 states. Demonstration pilots are established at over 100 sites.
- Consumer-directed Care – Through its *Cash and Counseling* program, the Robert Wood Johnson Foundation has provided states with demonstration funds for consumer-directed LTC. The program allows consumers receiving care in their homes to control their LTC funds in hiring and service decisions. Similarly, other states have developed Personal Care Option programs under the Medicaid waiver.

22 National Conference of State Legislatures, http://www.ncsl.org/Portals/1/documents/health/rebalancingltc.pdf. Accessed March 5, 2010.

23 AARP and National Conference of State Legislatures. *Shifting the Balance: State Long-Term Care Reform Initiatives.* Issue Brief No. 1 of 5, February 2009, pp.1-10, http://www.ncsl.org/?tabid=17679. Accessed February 23, 2010.

24 National Conference of State Legislatures, http://www.ncsl.org/Portals/1/documents/health/rebalancingltc.pdf. Accessed March 5, 2010.

Funding Innovations[25]

Many states have taken advantage of various financial opportunities to reform certain aspects of LTC services. Examples include:

- LTC Partnership Program – Consumers who purchase LTC insurance through a partnership policy have access to Medicaid coverage once the insurance benefits are exhausted, without using personal assets to qualify for coverage. The goal is to reduce the exhaustion of personal resources for nursing home care, which may delay the need for Medicaid support.
- Global Budgeting – LTC programs and budgets are consolidated into one state agency or institution and HCBS monies are pooled into one budget with a cap on total spending.
- Own Your Future – Through this grant funded by the Department of Health and Human Services (HHS), 15 states have developed public awareness campaigns for LTC planning. A 2008 initiative is the National Clearinghouse for Long-term Care Information.[26]

Summary

The challenges and trends are clear: Fiscal pressures from multiple sources will continue to stress the allocation and use of Medicaid LTC expenditures. Medicaid, as the nation's primary funder of LTC services, must be viewed within the larger context of health care spending priorities and the complex financial picture of U.S. health care expenditures. States, some more than others, are actively engaged in demonstration initiatives to control LTC expenditures while maintaining and/or increasing quality. Within the current Medicaid structure, there are challenges to the allocation of resources between HCBS and institutional LTC. New public/private partnerships are being explored to better align LTC services with the needs and preferences of people needing care.

Given states' challenging fiscal environment, transforming Medicaid's LTC programs is one of the urgent priorities. Optimal performance is necessary in each of the following areas:
☑ **Enrollment and Verification** States should consider optimal enrollment and verification programs.
☑ **Program Structure** States should consider Medicaid program structure.
☑ **Medical Management** States should consider the medical management program in place.
☑ **Infrastructure** States should consider the infrastructure of Medicaid programs.
☑ **Budgeting** States should consider the budgeting for Medicaid programs.
☑ **Compliance** States should consider implementing a compliance program to ensure providers are following federal and state regulations governing the Medicaid program. Such a program could include auditing procedures, training for employees and instructions for reporting violations.
☑ **Medicaid and Medicare Alignment** State should consider closer coordination of Medicaid and Medicare benefits and services for dually eligible beneficiaries to streamline case management activities.
☑ **Tiered Waivers** In recent years, there have been many changes to the Medicaid waiver program. States should confirm that appropriate waiver limits have been implemented and reviewed with enrollees.
☑ **Federal Match** States should ensure they are getting the maximum federal match against their state funds. States should also remember that the temporarily higher American Recovery and Reinvestment Act federal match rates expire January 1, 2011, after which states will have to use a greater portion of state funds to cover Medicaid expenditures.
☑ **Centralized Case Management** States should consider having optimal, centralized case management.

25 Ibid

26 National Clearinghouse for Long-Term Care, http://www.longtermcare.gov/LTC/Main_Site/index.aspx. Accessed March 6, 2010.

Implications

An assessment of the current state of Medicaid's LTC program generates four important questions:

- Might U.S. states partner with the private sector in accelerating transformation efforts? Likely this will be necessary in most states, as the infrastructure and competences required might not be readily available within existing state agencies and/or departments.
- Might states need to "sell" the idea of paying closer attention to Medicaid LTC to legislators and the voting public? Yes. It is a complex topic and prone to misinformation and the political process.
- Might states see a permanent solution to their LTC challenges in the health care reform bill? No. The bill's impact on the LTC population is nominal and additional federal funding not likely, given the government's fiscal constraints.
- Might states wait and see what happens rather than act now? No. Medicaid LTC is one of the most urgent health care problems for most states. Failure to innovate with medical and administrative management initiatives will likely result in increasing costs, voter discontent, poor quality and fiscal challenges.

Medicaid LTC is a burning platform. It needs attention. It cannot wait.

Appendix

The following four scenarios were chosen for illustrative purposes only, as examples of possible outcomes:

1. **Base Case:** Current state of Medicaid expenditures trends without any intervention. This presents the burning platform based on current trends.
2. **Best Case:** Current base case, but with actions that resulted in a five percent cost savings to Medicaid from innovative solutions to bend the curve. (A five percent cost savings target was chosen to highlight the Medicaid cost trend impacts that typical/existing approaches have achieved in the past.)
3. **Worst Case:** Presents the impact if current trends included a 40 percent growth in Medicaid membership due to increased Medicaid access via legislative mandates. (A 40 percent growth in Medicaid membership was chosen to provide an illustration of an extremely high increase in enrollment.)
4. **Likely Case:** Similar to Scenario 3, but instead includes a 20 percent growth in Medicaid membership instead of 40 percent. (A 20 percent growth in Medicaid membership was chosen based on analysis of factors likely to drive enrollment.)

Data sources & key assumptions included:

- **Annual State Operating Budget** – Individual state websites and employees; National Center for State Courts for 2002-2008 and projected to 2030 based on historical averages.
- **Medicaid total expenditure and membership and nursing facility (NF) expenditure –** CMS National Health Expenditure and projected based on the CMS 2008 Medicaid Report.
- **Medicaid LTC expenditure** – Kaiser Family Foundation (www.statehealthfacts.org). Projections based on the CMS 2008 Medicaid Report.
- **Medicaid LTC membership** – AARP. Projections set equal to Medicaid members' trend. Note CMS 2008 Medicaid report factors in population demographics.
- **State LTC and NF expenditure** – Medicaid's LTC and NF expenditures multiplied by one minus the Federal Medical Assistance Percentages (FMAP).
- **NF membership** – UCSF's Department of Social and Behavioral Sciences study. Projections used the CMS 2008 Medicaid Report and were adjusted for an increasing shift of NF residents out of NF and into other LTC facilities (based on The Lewin Group's study, "Can Home and Community-based Services be Expanded Without Busting the Budget?") and for the aging Baby Boomer population (based on U.S. Census data).

Authors

Paul H. Keckley, PhD
Executive Director
Deloitte Center for Health Solutions
pkeckley@deloitte.com

Barbara Frink, PhD, FAAN
bbfrink@msn.com

Contributors

Thanks to many Deloitte colleagues for their contributions and participation:

Robert N. Campbell III
U.S. State Government Leader
Deloitte LLP
bcampbell@deloitte.com

Pat Howard
National Practice Leader
State Health
Deloitte Consulting LLP
pahoward@deloitte.com

Chris Schmidt, FSA, MAAA
Manager
Deloitte Consulting LLP
chrischmidt@deloitte.com

Howard R. Underwood, MD, FSA
Senior Manager
Deloitte Consulting LLP
hunderwood@deloitte.com

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Indu Bulbul Sanwal
Patrick Richard, PhD
Mitesh Patel, MD, MBA
Andrew Lee

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Contact information

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Deloitte Center for Health Solutions
555 12th Street N.W.
Washington, DC 20004
Phone 202-220-2177
Fax 202-220-2178
Toll free 888-233-6169
Email healthsolutions@deloitte.com
Web http://www.deloitte.com/centerforhealthsolutions

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