Medicaid and Medicare Spending on Acute, Post-Acute, and Long-Term Services and Supports in California

This fact sheet presents key findings from the recently-released report entitled: *Medicaid and Medicare Spending on Acute, Post-Acute and Long-Term Services and Supports in California,* produced by the California Medicaid Research Institute (CAMRI).

Introduction

Home- and community-based services (HCBS) are a significant and growing area of service delivery in Medicaid programs, and California is interested in pursuing policies that can support high quality care and contain costs. A major barrier to planning, monitoring and evaluating HCBS programs has been the complexity of the available information that is often spread across multiple data systems. With the assistance of California's Department of Health Care Services and the Centers for Medicare and Medicaid Services, the California Medicaid Research Institute (CAMRI) has taken significant steps to combine Medi-Cal (California's Medicaid program), Medicare, and other state datasets to gain a better understanding of who makes up the state's HCBS population and what services they receive. This process has become increasingly important as California has faced mounting financial challenges in delivering services, and policymakers are looking for alternative approaches for delivering higher quality care that meets consumer needs at lower costs. Understanding the population services and cost drivers can facilitate this process.

The *Comprehensive Analysis of Home- and Community-Based Services in California* is a multi-year project conducted by CAMRI under contract with the California Department of Health Care Services with co-funding by The SCAN Foundation.[1] The project team built a dataset that links Medicare claims, Medi-Cal claims, and Medi-Cal assessment data for recipients of long-term services and supports (LTSS) in California. Detail on how this dataset was constructed can be found in a report previously published by The SCAN Foundation.[2]

The first data report in this series from CAMRI, *Recipients of Home- and Community-Based Services in California*,[3] described the demographic characteristics, service use, functional characteristics, nursing facility admissions, and mortality for California HCBS recipients in 2008.

This fact sheet complements the second report in the series entitled: *Medicaid and Medicare Spending on Acute, Post-Acute and Long-Term Services and Supports in California*.[4] The report describes the health

care and LTSS expenditures for individuals age 18 and older who received services from any of several Medi-Cal-funded HCBS program or had a nursing facility stay at any time during Calendar Year (CY) 2008. The LTSS user population was defined as that population who had any expenditures in a nursing facility (either for post-acute care or long-stay admission) or who had any expenditures in one or more of the following HCBS programs: the Medi-Cal State Plan home health benefit, the In-Home Supportive Services (IHSS) program, Adult Day Health Care (ADHC)*, Targeted Case Management (TCM), and Section 1915 (c) HCBS waiver programs (Multi-Purpose Senior Services Program (MSSP); AIDS Waiver; Assisted Living Waiver (ALW); In-Home Operations (IHO) Waiver; and Nursing Facility/Acute Hospital (NF/AH) Waiver). Spending data were divided into three service categories: acute and other medical, post-acute care, and LTSS (please see Appendix A of the full report for a list of the specific services included in each of these three categories of spending).

Key Findings

Medi-Cal & Medicare Enrollment and Study Characteristics:

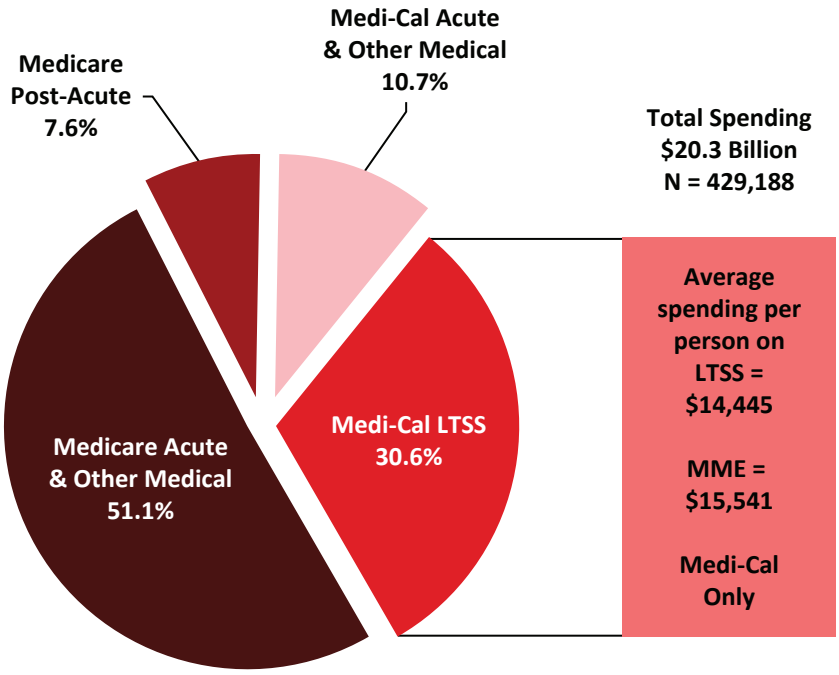
- In CY 2008, 429,188 individuals were enrolled in the Medi-Cal fee-for-service (FFS) system and used LTSS during the year; 76.1 percent were eligible for both Medi-Cal and Medicare.
- Approximately 65 percent of the population was age 65 and older; this proportion rose to 81 percent among Medicare/Medi-Cal enrollees (MMEs).
- Almost two-thirds (65.1 percent) were female. The study population was racially/ethnically diverse; 38.7 percent were White, 24.5 percent were Hispanic, 13.4 percent were African-American, 18.8 percent were Asian/Pacific Islander, and 4.6 percent were categorized as "other."

Medi-Cal and Medicare Spending on All Services

- Medi-Cal and Medicare spending in California on all acute and other medical care, post-acute care, and LTSS for FFS LTSS beneficiaries was $20.3 billion.
- Medicare services represent approximately 59 percent of all spending with Medi-Cal services representing the remaining 41 percent (see Figure 1).
- Total Medi-Cal-funded LTSS spending per beneficiary was $14,445; LTSS spending on MMEs was $15,541 as compared to $10,950 for Medi-Cal-only beneficiaries (a 42 percent difference).

*In CY 2008, the ADHC benefit was a State Plan Optional Benefit. In CY 2012, the ADHC benefit was eliminated and the Community-Based Adult Services (CBAS) program replaced it under the state's 1115 waiver.

FIGURE 1 **Total Medi-Cal and Medicare Spending on FFS LTSS Beneficiaries, Age 18 and older, CY 2008**



Note: MME = Medicare/Medicaid Enrollee; Medi-Cal post-acute care constituted less than 1% of all spending.

Acute and Other Medical Expenditures

- Spending on acute and other medical care was the largest category of spending for LTSS beneficiaries in 2008, totaling $12.6 billion (Medicare and Medi-Cal combined) with average per capita spending at $29,220. Medicare paid 83 percent of this total.

- The majority of spending was in three categories: ambulatory care (which includes payments to physicians) comprised 39.5 percent of total acute and other medical expenditures, followed by hospitalizations (30.7 percent), and diagnostic testing (15.1 percent). This overall pattern was similar for MMEs.

- For Medi-Cal-only beneficiaries, hospital stays accounted for 60.1 percent of total Medi-Cal acute and other medical expenditures followed by ambulatory care (21.4 percent). Per capita spending on acute and other medical care spending for this population was $13,449.

Post-Acute Care Expenditures

- Total post-acute care spending for all LTSS beneficiaries was $1.5 billion in 2008, with the vast majority of this paid for by Medicare.

- The largest share of post-acute spending was for Medicare skilled nursing facilities (SNFs), $921.5 million, following by Medicare home health at $377.8 million.

Long-Term Services and Supports Expenditures

- Medi-Cal spent $6.2 billion on LTSS for fee-for-service beneficiaries in 2008.

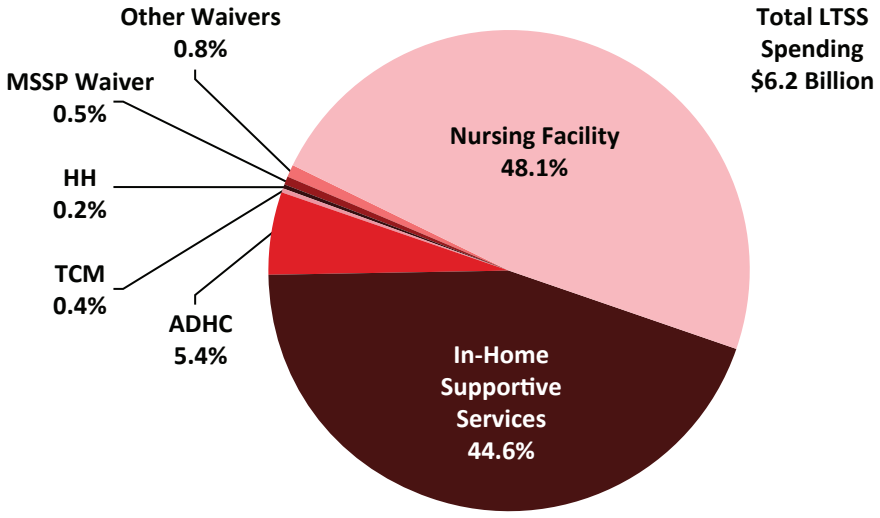
- Approximately 52 percent of all LTSS spending was for home- and community-based services (see Figure 2). However, among those who used these services, per-user spending on nursing facilities was three times higher than for HCBS ($32,406 for nursing facility vs. $9,129 for HCBS).

- IHSS was the largest HCBS expenditure (44.6 percent of total LTSS spending), followed by ADHC at 5.4 percent. Section 1915 (c) HCBS waiver expenditures combined accounted for approximately 1.3 percent of total LTSS spending.

Discussion

A number of important observations emerged from this analysis:

FIGURE 2 **Medi-Cal Spending on LTSS for Californian's FFS LTSS Beneficiaries, Age 18 and older, CY 2008**



- The CAMRI report confirms that the largest overall cost drivers for LTSS beneficiaries in California are ambulatory care, hospital services, and LTSS.

- This study finds that California spends slightly more than half of all LTSS dollars on HCBS, making it one of a select few states that spent more money on HCBS than institutional care.

- California is increasing the emphasis on Medi-Cal managed care through three major policy actions: the state's current 1115 waiver, the Coordinated Care Initiative,[5] and intent to implement a demonstration integrating Medicare and Medi-Cal services. The financial incentives in managed care may encourage health plans to enhance coordinated care in the community and use HCBS to reduce more costly institutional service use.

- The relatively high investment in HCBS in California offers an important foundational opportunity to increase community-based services that can potentially support reductions in institutional services, especially avoidable hospitalizations.

- Ongoing collection and reporting of comprehensive data, such as those available through the CAMRI project, will be critical to monitoring progress toward integration, care coordination, and access to HCBS. Evaluation of the whole array of services used by this population can begin to identify the most optimal mix of services given population characteristics that improve outcomes.

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