PROJECTING THE IMPACT OF THE MONEY FOLLOWS THE PERSON PROGRAM ON IDAHO MEDICAID LONG-TERM CARE EXPENDITURES

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ABSTRACT

Background: It is well established that access to home and community-based services (HCBS) as an alternative to institutional long-term care (LTC) leads to better health outcomes. Because Medicaid is the primary payer for formal LTC services, changes in Medicaid policies favoring access to HCBS play a crucial role in "rebalancing" the nation's LTC delivery system. Prior research indicates that expanding Medicaid HCBS may result in lower per patient expenditures. A key part of Medicaid's rebalancing effort is the recently expanded Money Follows the Person (MFP) program, whereby the federal government offers enhanced match funds to assist state Medicaid programs in transitioning institutionalized LTC patients to the community.

Problem: Despite the potential benefits of increasing access to Medicaid HCBS, in this time of budget cuts, policymakers may be resistant to expanding such services.

Method/Data: A model to project the impact of MFP on Idaho's Medicaid expenditures over 10 years was designed using established cost projection methodologies, Medicaid Statistical Information System (MSIS) data, and pertinent Medicaid policies. The model was then applied to Idaho's MFP program from state fiscal year (SFY) 2011 to 2020 to compare projected Medicaid expenditures in the absence of MFP with such projected expenditures under low and high model projections of how effective the MFP program will be in transitioning institutionalized LTC patients to the community.

Results: Baseline projections indicate that Idaho Medicaid will spend approximately $6.8 billion on LTC between SFY 2011 and SFY 2020. High and low model projections indicate that, after accounting for estimated increased acute care expenditures, Idaho Medicaid will be $16.5-32.5 million more cost effective over ten years with MFP. Projected efficiencies may be partially offset by the "moral hazard" of expanding HCBS.

Discussion: Implementing the MFP Program in Idaho is projected to reduce overall Idaho Medicaid expenditures in coming years. Such reductions, however, will be greater if Medicaid acute care expenditures for Medicaid HCBS recipients can be reduced. Accordingly, coordination of cost-effective LTC and acute care in the community is crucial to reducing Medicaid LTC expenditures in coming years.

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CHAPTER I: INTRODUCTION

In recent years, there has been significant discussion as to how to improve long-term care (LTC) delivery and financing in Idaho. Traditionally, LTC was provided primarily in institutional settings, such as nursing homes, and was funded by Medicaid. In light of concerns regarding individual preferences to "age in place" and the increasing drain Medicaid LTC puts on state budgets, there has been a nationwide push towards increasing access to potentially more cost-effective home or community-based Medicaid LTC services.

Part of this policy effort to rebalance the LTC system towards offering more home and community-based services (HCBS) as an alternative to institutional case is the Money Follows the Person (MFP) program. For state Medicaid programs operating MFP programs, the federal government offers enhanced incentives to help transition institutionalized Medicaid LTC patients back to the community. Idaho recently obtained a MFP grant to operate the Idaho Home Choice demonstration project from 2011-2016. If effective, the Idaho Home Choice project could then continue beyond this demonstration period.

The average per beneficiary cost of providing Medicaid LTC in the community is substantially less than providing such services in an institutional setting. As such, by transitioning institutionalized Medicaid LTC beneficiaries back to the community, the MFP program has the prospect of reducing Medicaid expenditure below what they would have been in the absence of such a program. Thus, it may be of particular interest to

policymakers to have an estimate of the fiscal impact that MFP will have on Idaho Medicaid. Additionally, policymakers may be interested in the various factors that may either increase or reduce the cost-effectiveness of increasing access to HCBS through programs such as MFP.

Research Question

Will implementation of an MFP patient transition program in Idaho reduce Medicaid expenditures in the state from SFY 2011 to 2020 below what they would have been in the absence of such a program? And if so, by how much?

Overview Study Design

This study entails a review of existing Idaho Medicaid reimbursement records maintained by the federal Center for Medicare and Medicaid Services (CMS) in the Medicaid Statistical Information System (MSIS) and the Medicaid Analysis eXtract (MAX). Applying state and national cost growth projections to cost data for recent years obtained from these data sources, this study creates baseline projections as to what Idaho Medicaid LTC expenditures likely would be from SFY 2011-2010 in the absence of an MFP program. Next, this study develops low and high model cost projections of patient transitions under the MFP program between SFY 2011-2020, and compares these low and high model projections with the baseline projections.

Limitations and Assumptions

The key limitation to this study design is the numerous assumptions required to generate the baseline, low, and high model projections. For this reason, the identification of limitations and assumptions has been combined.

In addition to the assumptions identified in Chapter III, the most significant assumption involved in this study is that the per capita cost of providing HCBS to individuals transitioned through MFP will be equivalent to the per capita cost of providing HCBS to all Medicaid patients. As explained further in Chapters II and III, however, applying this assumption in order to conduct this type of study is not unprecedented and this researcher takes measures to adjust for potential errors in this assumption.

The limitations inherent in the data sources used to develop the cost projections poses another potential threat to this study. Specifically, the average annual per capita expenditures reported in MSIS include patients who received services for less than a year. Accordingly, such averages are lower than average 12-month-equivalent per capita expenditures. Because of limitations in how MSIS data is collected and compiled, such 12-month-equivalent per capita expenditures are unavailable. Similarly, this study relies on data obtained from CMS' MAX Validation Tables regarding average expenditures for services other than LTC for Medicaid patients who receive either community LTC (CLTC) or institutional LTC (ILTC) in a given year. Such data, however, are averages for all such individuals, regardless of whether they are eligible to receive Medicaid LTC as a result of age, physical disability, or developmental disability.

Delimitations

This study assesses only the fiscal impact of transitioning Idaho Medicaid LTC patients currently in institutional setting back to the community through the MFP program. This study does not assess the potential fiscal impact of efforts to divert Medicaid LTC towards HCBS, and reduce the number of individuals entering institutions.

Additionally, similar to other studies on this topic, this study does not separately adjust for inflation in providing future cost projections. Rather, as explained in Chapter III, the projections are based on projected growth in costs of providing such services (which generally outpace inflation).

CHAPTER II: REVIEW OF THE LITERATURE

This literature review proceeds by first explaining the growing role that "long-term care" plays in health care and surveying the changing landscape in which such services are provided. This first portion of the literature review specifically highlights the growing need for LTC nationwide and in Idaho, and the various ways LTC is currently financed. Part B then reviews the literature relating to the growing trend toward rebalancing the American LTC system in favor of home and community-based LTC options. This section specifically highlights research assessing the potential cost-effectiveness of home and community-based services (HCBS) and explains the role that MFP plays in expanding access to such HCBS for LTC patients. In light of the fact that this thesis involves projecting future costs of LTC services in Idaho, Part C then reviews the methodologies used in prior studies projecting Medicaid LTC costs.

Overview of LTC Generally

Definition of LTC: What the Term Encompasses

In order to frame any discussion of policies related to LTC, it is important to have a sound understanding of what the LTC entails and who receives such care. Specifically, it is important to bear in mind that there is no clear consensus on specifically what LTC entails. Defining LTC in terms of what such care perhaps ideally should entail, Shi and Singh (2008) aspirationally define LTC as "a variety of individualized, well-coordinated services that are designed to promote the maximum possible independence for people

with functional limitations, and these services are over an extended period of time to meet the patients' physical, mental, social, and spiritual needs while maximizing their quality of life" (p. 383).

On the other hand, Keckley and Frink (2010) offer a less expansive explanation of the term: "LTC includes medical and nonmedical services for people who have a chronic illness or disability. LTC helps meet health and 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" (p. 2). Other sources similarly define LTC in terms of the types of services necessary to aid individuals in performing "activities of daily living" (ADLs), such as bathing, eating, or using the restroom (Brown & Finkelstein, 2009). For example, an individual who is covered under a LTC insurance policy will generally be required to demonstrate "a deficiency in the ability to perform [a certain number of ADLS] or the presence of a cogitative impairment" in order to make a claim on the policy. Idaho Long-Term Care Minimum Standards Rule (2011). Idaho's statute regarding LTC insurance then defines LTC services to encompass "necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital" Idaho Long-Term Care Insurance Act (2011). However, some LTC insurance policies may only pay for services provided in an institutional setting (Idaho Long-Term Care Minimum Standards Rule, 2011; Brown & Finkelstein, 2009).

Given the variation in what the term LTC may encompass, it is worth noting that discussions regarding the costs of LTC generally reflect only the costs of formally providing on-going services necessary to aid individuals in performing ADLs through sources such as Medicaid, Medicare, or private long-term care insurance. As touched upon above, LTC may also be viewed as more broadly encompassing services needed to meet individuals' various social, spiritual, and emotional needs–not merely assisting individuals in performing ADLs (Shi & Singh, 2008). Similarly, while LTC generally refers to services provided on a regular, on-going basis, the term is also used to refer to services often provided on a more *ad hoc* basis, including "transportation, public information, ombudsman and adult protection" (Beard & Miller, 2008, p. 23). Finally, in recent years, there has been a growing recognition of the valuable LTC services "informally" provided by family, friends and neighbors (Levine, Halper, Priest & Gould, 2010). Specifically, one study estimates that as much as 75-80 percent of all LTC in the United States, amounting to $375 billion worth of care a year, is provided informally and without monetary compensation (Levine et al., 2010). As such, the types and extent of services necessary to provide an elderly or disabled person with a decent quality of life over the "long-term" likely extends well beyond the scope of services normally considered in discussing the costs of LTC.

Growing Need for LTC Services Nationwide and in Idaho

As indicated, "LTC may be needed at any age" (Keckley & Frink 2010, p. 2). In other words, LTC is used by individuals who need assistance whether because of physical

disability, cognitive impairment, or age. In a given year, in excess of 10 million Americans will need some sort of LTC; 42 percent are under the age of 65 (Kaiser Family Foundation, 2011a). As the population ages and people live longer with disabling and chronic conditions, however, the growth in the need for LTC is of particular concern for policymakers (National Governors Association, 2004).

By 2030, there will be twice as many individuals 65 years or older living in the United States as there were in 2000 (Kapp, 2006). As baby-boomers age and people live longer with chronic conditions, the need for long-term care (LTC) will continue to increase (Weiner, Tilly, & Goldenson, 2000). In 2050, it is projected that people aged 85 and over, the so-called "oldest old" will make up 5.2 percent of the nation's population (Kapp, 2006, p. 73). Many of these aged individuals will require LTC for a number of years. One estimate projects that the number of individuals who need assistance performing ADLs will double between 2000 and 2040 (Kapp, 2006). Accompanying this significant growth in need for LTC services is the projected growth in the cost of such services. In 2030, it may cost as much as $200,000 to provide institution-based LTC to a typical patient for one year (National Governors Association, 2004). As a result of these factors, overall long-term care expenditures are expected to, in real terms, triple in the coming decades nationwide (Brown & Finkelstein, 2009).

Idaho is no exception to this nationwide growing need for and cost of LTC. The proportion of Idahoans age 65 and over is projected to rise from 12 percent in 2010 to 15.5 percent in 2020 and 18.3 percent in 2030 (U.S. Census Bureau, 2005). Moreover, while there were 18,057 Idahoans age 85 or over in 2000, there are expected to be over

47,000 Idahoans in this demographic by 2030 (U.S. Census Bureau, 2005). In light of the fact that Idaho is a rural state with many highly remote regions, providing adequate LTC for this rapidly growing segment of the population may be particularly difficult (Beard & Miller, 2008). In 2002, 14.3 percent of Idahoans lived in highly rural counties with no towns or cities greater than 10,000 (Salant, 2003). Additionally, Idahoans age 75 and over report that in order to remain in their homes, their greatest needs are generally assistance finding transportation and assistance in performing physical tasks (Miller, Beard, & Carver, 2008). Providing such services in highly rural areas may be particularly difficult. Additionally, rural areas of Idaho are generally composed of an older population, individuals with less formal education, and more people living in poverty (Salant, 2003). As such, in addressing Idaho's growing need for LTC services, policymakers should be aware of the unique challenges presented by the state's rural makeup.

Care Financing: Medicaid and Proposals for Alternatives

This section provides a brief overview of the LTC policy literature to illustrate the key role that Medicaid plays in paying for formal LTC services and to highlight potential alternatives to Medicaid to provide for LTC.

While Medicaid may have initially been intended to provide health coverage for only America's poorest residents when the program was created in 1965, it quickly evolved into a significant payer for LTC for both non-elderly and elderly individuals (Kaye, LaPlante, & Harrington, 2009). As such, it is now debated "whether Medicaid is

still intended to be exclusively a program for the poor" (Karp & Gershbein, 2005, p. 1). It is recognized that the Medicaid now pays for LTC services used by many middle-class individuals in the later years of life (Karp & Gershbein, 2005; Brown & Finkelstein, 2009). As one commentary explained: "Medicaid, a program originally intended to finance health care for the poor, has evolved over time into the primary public payer for long-term care services for people who are not poor by conventional standards but who lack the means to pay the high and on-going cost of such care" (U.S. Department of Health & Human Services, Office of the Assistant Secretary for Policy & Evaluation (ASPE), (2005a, p. 1). Unlike most other health services for totally disabled individuals or individuals 65 and over, Medicare does not cover most types of LTC. Rather, Medicare only provides a limited amount of LTC immediately after an individual is discharged from an inpatient, acute-care hospitals.

Given this context, Medicaid covers approximately 40 percent of formal LTC expenditures nationwide (Kaiser Family Foundation, 2011a). In comparison, Medicare post-acute LTC accounts for 23 percent of LTC spending, out-of-pocket payments cover 22 percent, private LTC insurance covers only 9 percent, and the remaining 6 percent of LTC spending nationwide are covered by other private and public sources (Kaiser Family Foundation, 2011a). Considering that Medicaid covers significantly more LTC than any other source, it is often considered the "default" payer of such services (National Governors Association, 2004, p. 1). Because Medicaid is a partnership between federal and state governments, a large proportion of state budgets are currently consumed to pay for Medicaid LTC (National Governors Association, 2004; Weiner et al., 2000).

Despite the reality that Medicaid has assumed the default role of paying for LTC services, there is evidence that this may not be good public policy. Even though Medicaid is routinely used by middle-class individuals to cover LTC, it still requires "spending down" assets to financially qualify. Especially where one spouse remains in the community while the other requires Medicaid financed LTC, the financial eligibility rules can be quite complex (Kapp, 2006). Given this context, it is not surprising that Brown and Finkelstein's (2009) economics research demonstrated that Medicaid "does not provide very good insurance" for LTC because Medicaid "provides an inadequate consumption-smoothing mechanism for all but the poorest of individuals" (Brown & Finkelstein, 2009, p.21).

Additionally, the reliance on Medicaid by middle-class individuals to pay for LTC spawned the practice of Medicaid planning, which has been defined as the process of "mak[ing] someone poor on paper so that he or she may qualify for Medicaid" (Karp & Gershbein, 2005, p. 1). Kapp (2006) further explains that the means tested nature of the Medicaid program "creates a powerful incentive for individuals to arrange their finances in such a way that, at a future date when they might apply for Medicaid coverage of their long-term care, they will be able to satisfy the financial means test of the program" (p. 74).

In response to concerns over abusive and excessive Medicaid estate planning, Congress enacted legislation requiring state Medicaid programs to restrict financial eligibility requirements and to engage in estate recovery efforts to recoup the costs of services provided after a Medicaid LTC beneficiary's death (ASPE, 2005a; ASPE,

2005b; Kapp, 2006). Specifically, in an effort to prevent Medicaid LTC applicants from becoming financially eligible for Medicaid by gifting away assets, in 1993 Congress created a set of rules that "impose periods of Medicaid ineligibility based on the dollar value of those gratuitous transfers that occurred during [a] look-back period" of 36 to 60 months (Kapp, 2006). In 1993, Congress also enacted a provision requiring states to engage in estate recovery (ASPE, 2005b). As such, after a Medicaid LTC recipient dies, state Medicaid programs are now required to attempt to recoup some of its costs by recovering assets from the recipient's estate. There are a variety of circumstances under which Medicaid will not pursue recovery of certain assets, and states vary significantly as to how aggressively they pursue estate recovery (ASPE, 2005c). In 2005, Congress further tightened spend down eligibility rules (Kapp, 2006).

The overall effectiveness of such policies in curbing growing Medicaid LTC expenditures and encouraging alternatives to Medicaid to finance LTC is somewhat dubious. For example, Brown, Coe, and Finkelstein (2007) estimated that even if every state implemented the most stringent Medicaid asset requirements permitted by the federal government, the demand for private LTC insurance would only increase by 2.7 percent. Likewise, in 2003, Medicaid estate recovery efforts only recouped 0.13 percent of total nationwide Medicaid spending (ASPE, 2005b). Moreover, states vary significantly as to the effectiveness and extent of their estate recovery efforts. For example, in 2004, Idaho recouped 4.5 percent of its nursing home expenditures, ranking third in the nation. In the same year, the neighboring state of Utah, however, ranked in

the bottom three of the nation, recouping a negligible amount that rounds out to 0 percent of the state's annual nursing home expenditures (ASPE, 2005c).

Additionally, the increasingly complex Medicaid LTC eligibility requirements, accompanying Medicaid planning strategies, and estate recovery collections efforts have raised a number of ethical and practical concerns. Kapp (2006) observes that there is a perception that Medicaid planning constitutes "gaming the system." Regarding Medicaid LTC estate recovery, Kapp (2006) notes that "[n]o other health insurance or social welfare program has similar estate recovery procedures" and contends that Medicaid estate recovery "raises a number of public policy dilemmas" (p. 76). Karp & Gershbein (2005) similarly note the issues of fairness raised by Medicaid planning contend that Medicare should be expanded to cover LTC services as a way of resolving and/or avoiding these issues.

The problematic nature of the complex and confusing Medicaid eligibility rules in Idaho is perhaps best exemplified by the case of *Stafford v. Idaho Department of Health & Welfare* (2008), wherein the Idaho Supreme Court, in a 3-2 decision, struggled to reach a consensus as to whether a particular Medicaid planning practice was permissible. Given the Court's difficulty in interpreting the rules regarding one specific type of asset transfer, one must question whether it is good public policy to confront aged or disabled Medicaid LTC applicants and their families with such a complicated set of rules.

As a result of the problems and expense associated with Medicaid LTC, a variety of state and federal level policies have been implemented in recent years with the aim of creating alternative funding sources for LTC. These policy changes include ways to

stimulate the private LTC insurance market (Tumlinson, Aguiar, & Watts, 2009): a variety of LTC insurance policy-related tax incentives at both state and federal levels (National Governors Association, 2004; Weiner et al., 2000), the creation of a voluntary federally-run LTC insurance program as part of the 2010 Health Reform bill (Kaiser Family Foundation, 2011b); the development and promotion of "reverse mortgages" as a way for individuals to use home equity to finance LTC (Robert Wood Johnson Foundation, 2008); and, the development of educational programs to encourage individuals to plan for LTC needs through private means (National Governors Association, 2004). Additionally, a substantial amount of research has gone into investigating and developing a variety of other policy changes that could possibly be implemented in coming years (Brown & Finkelstein, 2009).

Given the continued and growing demand for Medicaid financed LTC, it is questionable as to how effective many of these policy initiatives have been or will be. Moreover, even if some recent policy changes are effective in encouraging people to begin planning to cover their LTC needs without relying on Medicaid, it could be years before such planning actually yields benefits. Therefore, in assessing ways to address the growing need for Medicaid LTC finance, it is necessary to examine not only alternatives to Medicaid but also *how* Medicaid LTC is provided and ways to potentially improve the cost-effectiveness of such care.

Care Delivery and the Potential for Cost-Effective Home and Community-Based LTC

At the same time policymakers have considered ways to reform payment mechanisms for LTC, there have also been significant changes in how formal LTC is delivered. Significantly, there has been a push to "rebalance" the nation's LTC system away from institutional care centers with the aim of allowing recipients of LTC to receive care in more independent home and community-based settings. This section first provides an overview of this shift towards providing LTC in home and community settings—rather than institutions. Next, this section reviews the literature assessing the cost-effectiveness of home and community-based LTC, relative to institutional LTC. Third, this section looks at the role that the Money Follows the Person (MPF) program has played in these rebalancing efforts generally. Finally, this section concludes by describing the program Idaho Medicaid is implementing with a MFP grant: the Idaho Home Choice program.

Shift Towards Home and Community-Based LTC

From Medicaid's creation in 1965 up to the mid-1980's, Medicaid paid almost exclusively for institutional LTC (Kaye et al., 2009; Grabowski, 2006). Beginning in the mid-1980s, however, a variety of factors have shifted to a greater reliance on so-called Medicaid "home and community-based services" (HCBS). In recent decades, there has been an increased recognition of health and wellness benefits of allowing individuals to retain independence by remaining in the community, rather than being moved into a

nursing home (Grabowski, 2006). Accompanying this recognition in increased health benefits, the United States Supreme Court held in *Olmstead v. L.C.* (1999) that under the Americans with Disabilities Act (ADA), state Medicaid programs were required to offer LTC services in "the most integrated setting" possible. Such recognition within the health care community of the benefits of HCBS over institutional LTC complements the expressed views of older Americans: the vast majority of surveyed individuals over 50 reported preferring to age-in-place with HCBS rather than moving to an institution (AARP, 2005).

Therefore, states have incrementally increased the extent to which Medicaid programs will pay for HCBS (Kaiser Family Foundation, 2009). Between 1999 and 2006, the number of individuals receiving Medicaid HCBS grew an average of 6 percent per year, while enrollment in Medicaid as a whole grew at an average rate of 4.3 percent during that time (Kaiser Family Foundation, 2009). In addition to steady growth in the raw number of individuals receiving HCBS, the proportion of funds Medicaid spends on HCBS relative to institutional LTC has also grown substantially in recent years. Nationally, Medicaid LTC spending on HCBS grew from 19 percent in 1995 to 41 percent in 2007 (Kaiser Family Foundation, 2009).

While institutional LTC services are a required part of any state Medicaid plan, states are not required to provide HCBS. As such, these types of services are generally part of "waiver" or enhanced benefit programs. While each state is different, Medicaid HCBS is generally provided through optional section 1915(c) Home and Community-Based Waiver programs, Personal Care Services (PCS) Optional Benefit programs, and

the mandatory, but limited, Medicaid Home Health Benefit (Kaiser Family Foundation, 2009; Kaye et al., 2009).

In Idaho specifically, HCBS are available through two different waiver programs. In 1994, Idaho created a Developmentally Disabled (DD) Waiver program intended to provide a home or community-based LTC option for individuals who would otherwise require institutional care in an ICF/MR. Likewise, since 1999, Idaho's Aged and Disabled (A&D) Waiver has provided HCBS as an LTC option for individuals who would otherwise require care in an institutional nursing facility (NF) setting (Beard & Miller, 2008). According to the Kaiser Family Foundation, between 1999 and 2006, Idaho Medicaid's total HCBS expenditures nearly quadrupled from $41 million to $152 million (Kaiser Family Foundation, 2009). Idaho's average annual growth rate of 21 percent in Medicaid HCBS expenditures between 1999 and 2006 is well above the national rate of 12 percent during the same time period (Kaiser Family Foundation, 2009).

In addition to shifting away from institutional care in favor of HCBS options, the manner in which Medicaid LTC is provided has evolved in other ways in recent decades. Specifically, there has been an emergence of a "consumer-directed" care model (Grabowski, 2006), under which consumers have varying degrees of choice in selecting caregivers and allocating their service budgets (Kaiser Family Foundation, 2009). In 2005, Idaho received a federal grant from the Aging and Disability Resource Center, which allowed it to create a pilot program to provide "person centered" counseling to facilitate "an intensive dialogue with individuals and informal caregivers to assist people

in being more aware of services options, along with planning tools to help assess which options are right for them" (Idaho Commission on Aging, 2009, p. ii). In relation to coordinating informal caregiving and Medicaid funded HCBS, Arizona's Medicaid program obtained a special waiver "to remunerate individuals who provide informal home care services" (Queener, 2003, p. 873).

This shift towards HCBS has been effectuated by both diverting patients needing lower levels of care away from institutions and transitioning institutionalized patients back to the community (Lipson & Williams, 2009).

Research Assessing Cost Effectiveness of HCBS

As discussed above, the availability and utilization of Medicaid financed HCBS has increased significantly in recent years. This focus on rebalancing towards HCBS has been motivated by both a response to patient preference as well as fiscal concerns. Grabowski (2006) explains this as follows:

> State and federal policymakers have considered the expansion of noninstitutional services a mechanism that both increases client welfare and lowers costs. That is, individuals generally prefer care in the home or community, and for certain individuals with less intensive care needs, it may be possible to provide lower per capita cost care in the home or community relative to a nursing facility (p. 6.)

The extent to which HCBS has realized savings to Medicaid, however, is somewhat disputed and unclear.

At least for some patients, HCBS may be less expensive than institutional LTC services (Grabowski, 2006). A variety of other factors, however, potentially influence whether expanding access to and Medicaid coverage for formal HCBS yields a net

savings for Medicaid. Some research suggests that only "very carefully targeted" formal HCBS services are generally effective in deferring or eliminating the need for an LTC patient to enter an institution (Cohen, Miller, & Weinrobe, 2001, p. 185). During the 1980s and 1990s, a variety of demonstration projects were implemented and studied to assess the cost-effectiveness of HCBS. In summarizing a review of these studies, Grabowski (2006) explains that these "early demonstration studies found that HCBS slightly reduced nursing home use, but HCBS still increased aggregate long-term care spending, because the small decrease in nursing home utilization observed under HCBS was more than offset by increased HCBS spending on individuals who would not have entered a nursing home even in the absence of the HCBS program" (p. 4).

As such, there is concern that expanding HCBS programs would create a "moral hazard" or "woodwork effect," in which, as Kaye et al. (2009) explain, "large numbers of people who previously received help from family members and did not seek institutional services might sign up for the more desirable noninstitutional services, thus increasing overall costs" (Grabowksi, 2006, p. 263).

Despite the results of the earlier demonstration projections, more recent research has yielded inconclusive results regarding whether growth in aggregate costs due to this "woodwork effect" more than offsets any expansion of HCBS due to lower per capita costs (Kaye et al., 2009; Grabowski, 2006). Grabowski (2006) postulates that more recent research has yielded different results because of changes in the current status quo relative to when the early demonstration studies were conducted, changes in the types of HCBS offered, and changes in the overall context in which HCBS and institutional LTC

are provided. As such, this body of research as a whole may support the conclusion that *well implemented* HCBS programs may be more cost-effective in the aggregate.

For example, one study found that approximately one-half of the LTC recipients and informal caregivers surveyed responded that they would need to turn to institutional LTC but for the formal HCBS they received through private LTC insurance (Cohen, et al., 2001). This study also found that having formal HBCS paid for through private LTC insurance benefits did not substantially reduce the amount of informal care provided to LTC recipients (Cohen et al., 2001). Based on this finding, Cohen et al. (2001) postulate that "formal care may substitute for some, but not most, informal care, and that the two systems appear to be working in tandem to meet the LTC needs of claimants" (p. 186). Other recent research reinforces the important role that family, friends, neighbors, and natural supports play in providing "informal" home or community-based LTC (Levine et al., 2010). Levine et al. (2010) contend there is a need for greater partnership and coordination between informal and formal caregiving.

Overall, this line of research tends to support the view that the problematic "woodwork effect" can be avoided or reduced by carefully crafting formal HCBS expansions to complement, rather than supplement, existing informal community care options. Research conducted by Kaye et al. (2009) offers at least some empirical support for this conclusion. Kaye et al. (2009) compared overall Medicaid LTC expenditures from 1995 to 2005 between states with substantial noninstitutional Medicaid LTC options and states primarily offering only institutional LTC through Medicaid. These researchers found that both categories of states had comparable rates of growth overall, and that for

spending on LTC patients other than those with developmental disabilities (MR/DD), those states with "well-established noninstitutional programs actually reduced their overall, inflation-adjusted LTC spending" (Kaye et al., 2009). It is worth noting, however, that this study does not take into account whether savings were offset by potential increases in non-LTC Medicaid expenditures associated with having beneficiaries in the community as opposed to an institutional setting. In other words, this study does not take into account additional acute care costs that individuals living in community setting may incur, relative to similar individuals in institutions.

MFP Program: Stimulating Further Rebalancing of the Nation's LTC System

The "Money Follows the Person" program was created to help stimulate further rebalancing of Medicaid LTC expenditures and increase overall availability of HCBS as an LTC option (Wenzlow & Lipson, 2009). Specifically, the MFP program was created through Section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171). This provision "authorized $1.75 billion to support state efforts to move people currently residing in institutions back into their communities and to rebalance their long-term care systems to emphasize HCBS rather than institutional placement" (Lipson et al., 2007). The MFP Program has four main objectives: (1) rebalance the LTC system by increasing HCBS relative to institutional LTC services; (2) eliminate policies or laws that would prevent Medicaid funding from "following a person" to fund HCBS after transitioning back to the community; (3) assure continuity of services for individuals to transition from

an institution back to the community; and, (4) implement quality assurance and improvement procedures related to HCBS (Lipson et al., 2007).

While the MFP Program is focused specifically on Medicaid LTC, "[a]s the primary payor for long-term care services in the United States, Medicaid plays a key role in implementing new policy initiatives aimed at transitioning such individuals to the community" (Wenzlow & Lipson, 2009). Accordingly, by stimulating a rebalancing of Medicaid LTC, the MFP program seeks to effectuate broad change in the LTC system as a whole. By the end of 2007, CMS had committed more than $1.4 billion to fund grants awarded to 30 states (of which Idaho was not a part) and the District of Columbia to create MFP programs (Lipson et al., 2007). Under this initial round of grants, the grantees proposed implementing programs that would transition a total of 36,000 people in institutional care back to the community between 2007 and 2011 (Wenzlow & Lipson, 2009). In 2008, one state dropped out of the program, and the remaining programs proposed transitioning a total of 34,000 patients and extended the initial period to 2013 (Lipson & Williams, 2009; Denny-Brown & Lipson, 2009).

Idaho's MFP Proposal

As somewhat of a late-comer into the MFP program, Idaho Medicaid recently submitted a proposal for a federal Money Follows the Person Rebalancing Demonstration Grant (Idaho Department of Health & Welfare (IDHW), 2011), which was approved by the federal government in April 2011. The grant allows for the creation the Idaho Home Choice (IHC) Project, which has the goal of transitioning 265 institutionalized Medicaid

beneficiaries between 2011 and 2016. However, the overall intention of the IHC Project goes beyond merely transitioning patients back to the community. Rather the IHC Project aims to help rebalance and improve the overall LTC system in Idaho (IDHW, 2011). In order to accomplish this, IDHW identified five benchmarks to measure the IHD Project's activities:

1. Benchmark #1: Successfully transitioning the projected number of eligible individuals in each target group from an inpatient facility to a qualified residence during each calendar year of the demonstration.
2. Benchmark #2: Increase State Medicaid Expenditures for HCBS during each calendar year of the demonstration program.
3. Benchmark #3: Demonstrate a percentage increase in HCBS versus institutional long-term care expenditures under Medicaid for each calendar year of the demonstration.
4. Benchmark #4: Demonstrate an increase in the utilization of transition managers used to assist Medicaid participants to find appropriate services and supports in the community for each calendar year of the demonstration.
5. Benchmark #5: Demonstrate expansions to and improvements in health information technology for each calendar year of the demonstration. (IDHW, 2011, pp. 12-14)

Accordingly, it is important to bear in mind that the Project's overall aims go beyond simply transitioning a certain number of patients during a five year period. The fiscal impact projections created herein, however, relate specifically to the impact of transitioning patients through the IHC Project (Benchmark #1).

Beginning midway through calendar year 2011, the IHC Project aims to transition at least 265 institutionalized Medicaid LTC beneficiaries back to the community by the end of 2016. Elderly and physically disabled individuals enrolled in the program would be transitioned out of NFs and thereafter receive home or community-based LTC offered through Idaho's A&D Waiver. Individuals with developmental disabilities transitioned through the IHC Project would return to the community from intermediate care facilities

for the mentally retarded (ICF/MRs) and receive services through Idaho's DD Waiver. The largest cohort of individuals to be transitioned is elderly Medicaid beneficiaries in NFs (IDHW, 2011). The project aims to transition patients residing throughout the state.

In order to qualify for participation in the IHC Project, individuals must be residing in a long-term institution for at least 90 days and be eligible for either the Medicaid A&D Waiver or DD Waiver. The IHC Project will pay for up to eight hours per month of transition coordination/management services for 60 days prior to transitioning and 60 days after the transition back to the community. The IHC Project will also provide up to $1500 per participant to cover certain transition related expenses, including: acquiring basic home furnishings, utilities security deposits, etc. (IDHW, 2011). All other services offered to IHC Project participants are offered through the existing waiver programs. The federal government will pay an enhanced match rate for all transition expenses as well as the cost of providing HCBS to participants for one year after transition. After the one year period expires, individuals will continue as regular beneficiaries of one of the existing waiver programs, and Idaho Medicaid will be receive the normal federal match for providing care to such patients.

In order to operate the IHC Project, the IDHW will hire a full-time project director, a full-time project manager, and a half-time information technology data specialist. Rather than hiring transition coordinators, the IDHW will contract with the Idaho Commission on Aging (ICOA) and the University of Idaho's Center on Disabilities and Human Rights (CDHR). The ICOA will focus on transitioning patients needing care due to age and physical disability, while the CDHR will focus on patients with

developmental disabilities. The ICOA and CDHR will also handle training transition managers. The specifics of the contractual arrangements for transition coordination services are in process, and Idaho Medicaid "is currently considering proposals from the [ICOA] and [CDHR] to provide transition managers" (IDHW, 2011, pp. 35-36).

Patients transitioned out of NFs care back into the community must live in either a home owned or leased by the individual or a family member, an individually leased apartment, or an adult foster care home. Currently, Residential Care and Assisted Living Facilities (RALFs) are an approved living arraignment for A&D Waiver participants, but not for individuals transitioned back to the community through the MFP program. As such, Idaho plans to "form a work group to evaluate how [RALFs] could meet the qualified housing criteria for this MFP demonstration" (IDHW, 2011, p. 55).

Patients transitioned out of ICF/MR's back into the community must reside in either a home owned or leased by the individual, an individually leased apartment, or in a Certified Family Home/Supported Living setting. IDHW (2011) explains that "[t]he purpose of a certified family home in Idaho is to provide a home-like alternative designed to allow individuals to remain in a more normal family-style living environment, usually within their own community" (IDHW, 2011, p. 51).

IDHW has proposed a total budget of $8,379,192 to be used over the five year period, which consists of $2,264,682 for administrative expenses and $6,114,510 to cover the costs of providing HCBS to patients transitioned through the IHC Project. Based on the assumption that the IHC Project will exceed the transition benchmark, IDHW projects that all but $41,871 of the administrative costs will be borne by the federal government;

the proportion that the federal government covers depends on whether the project meets its transition goals. Of the $6,114,510 projected costs of services, the federal government will pay an enhanced match rate of approximately 85 percent. In short, IDHW estimates that the IHC Project will cost an average of $23,074 per enrollee per year (IDHW, 2011).

Methods and Data Sources for Projecting Health Expenditures

A variety of governmental agencies and private organizations have either produced or sponsored studies offering projections regarding future health care expenditures at both state and national levels, including Medicaid financed LTC. Accordingly, before presenting in Chapter III the methods and data sources used in this project, it is worth reviewing similar studies that have projected Medicaid LTC expenditures. Specifically, this section reviews the methods used and the results from several recent studies projecting LTC expenditures generally and then a closer examination will be made of several studies projecting the fiscal impact of MFP programs in other states. Finally, this section reviews the literature regarding the potential data sources for generating Medicaid cost projections.

Recent Studies Projecting the Medicaid LTC Expenditures

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) provides helpful expenditure projections in its *2008 Actuarial Report on the Financial Outlook for Medicaid* ("Report") (Centers for Medicare & Medicaid Services, Office of the Actuary (CMS OACT), 2008). This report offers general projections regarding national Medicaid expenditures, including LTC, between 2007 and 2017.

Although the report makes projections regarding all types of Medicaid expenditures at the national level—not just for LTC services—it provides projections specific to various subcategories of LTC services (CMS OACT, 2008).

Although OACT's report provides ten year projections regarding costs and utilization of Medicaid LTC services at the *national level*, the report provides no such data at the state level. Specifically, the OACT explains that one of the limitations of the report is:

> …the unavailability of demographic, macroeconomic, health care, and program assumptions specific to each State. Because these State-specific assumptions are not available, it is not possible to project Medicaid spending and enrollment separately by State (CMS OACT, 2008, p. 5).

Accordingly, while OACT's 2008 report provides valuable and highly relevant Medicaid LTC cost projections at the national level, the results of this report alone cannot be used to accurately project such costs at the state level.

The report projects the average annual growth rate in Medicaid spending between FY 2008 through FY 2017 by eligibility group. Specifically, the report notes that "[s]pending on blind and disabled enrollees is projected to grow the fastest at an average of 7.2 percent per year per enrollee" (CMS OACT 2008, pp. 18-19). For aged enrollees during this ten year period, however, the report projects a slower average annual growth rate of only 6.4 percent per year per enrollee. OACT explains such differences in spending growth depend on eligibility group as follows:

> These variations in per capita growth rates are mainly due to the different mix of services assumed for each group of enrollees. Specifically, blind or disabled enrollees receive the largest amount of home and community-based long-term care (as they have moved from institutional long-term care settings to home and community-based care or increased their use of

> these services as the availability has expanded. Such care is expected to be the fastest-growing service category over the next 10 years. (OACT, 2008, p. 19)

It is important to note, however, that these growth projections take into account *all* types of services paid for by Medicaid (whether acute care, LTC, pharmaceutical, etc.) for enrollees in a particular eligibility group, not just LTC services. Given that beneficiaries in the blind or disabled and aged eligibility groups may receive significant amounts of LTC services, however, such projected growth rates are nonetheless relevant in projecting growth in LTC spending.

Another study, released in September 2008 and funded by America's Health Insurance Plans, projects Medicaid LTC expenditures at both state and national levels from 2008 through 2027 (Shostak & London, 2008). In creating their national-level projections, Shostak and London appear to use essentially the same data and methodology as the CMS OACT. Although the published explanation of their methodology is somewhat limited, it appears that Shostak and London combined historical data and existing projections to create their own projections through 2027. Specifically, using a combination of CMS's historical data regarding Medicaid LTC expenditures from 1995 to 2006 and CBO projections for such expenditures from 2007-2018, these researchers modeled "[a] time-series total state Medicaid long-term care expenditures for 1995-2018" and then "extrapolated" this model "through 2027" (Shostak & London, 2008, p. 8).

Using this projection methodology, Shostak and London estimated that between 2008 and 2027 overall state Medicaid LTC expenditures would grow by a total 124

percent, with a projected 4.1 percent annual real rate of growth. Accordingly, these researchers projected that in 2027 states would expend a total of $115 billion on Medicaid LTC, compared to the $51.5 billion spent in 2008 (Shostak & London, 2008).

In addition to creating such projections at the national level, this study also projected Medicaid LTC costs for each state. Specifically, the authors report that they made such state-specific projections from their national projections as follows:

> Then a linear regression model was developed using historical data to project state-specific per capita expenditures based upon the smoothed projected national per capita expenditures. Linear estimates were developed for each state and served as the basis for per capita expenditures. Linear estimates were developed for each state and served as the basis for per capita state forecasts. Finally, state expenditures were calculated by multiplying the estimated state-specific per capita costs in each year by the U.S. Census Bureau state-specific population projections (Shostak & London, 2008, p. 8).

These researchers relied on state specific data compiled by CMS from between 1995-2006 to apply to this methodology. Using these methods and data, Shostak & London made projections regarding each state's projected total Medicaid LTC expenditures between 2008 and 2027, each state's average annual rate of growth for such expenditures, the per capita cost of Medicaid LTC in 2027 in each state, and the average rate of growth for the per capital cost of Medicaid LTC in each state between 2008 and 2027. Based on these results, Shostak and London also ranked each state relative to other states.

Regarding Idaho, these researchers estimate that between 2008 and 2027, the total state Medicaid LTC expenditures will total approximately $4 billion. These researchers further estimate that Idaho's Medicaid LTC expenditures would grow an average of 4.7 percent per year during that time period, which is above their predicted national annual

growth rate of 4.1 percent. For average total expenditure growth rate, the researchers identify Idaho as ranking 13th relative to other states. Regarding per capita expenditures, the researchers estimate that such expenditures will grow at an average of 3.4 percent in Idaho (which is the same as the national estimated growth in per capita Medicaid LTC expenditures), from $82 per person in 2008 to $158 in 2027 (Shostak & London, 2008).

It is important to note that Shostak & London's per capita growth rate and expenditures compare Idaho's Medicaid LTC expenditures with Idaho's population as a whole; such figures do not reflect the average per Medicaid LTC enrollee cost of providing services, as do other studies discussed in this chapter. Furthermore, the estimated average annual growth of 4.7 percent in total expenditures necessarily reflects both growth in costs of services/utilization *and* increases in the number of beneficiaries. Taking this into consideration, Shostak and London's (2008) projections may be lower than other studies discussed herein.

Finally, another recent study produced by the private consulting firm Deloitte LLP makes projections regarding the proportion of state budgets that overall Medicaid costs and Medicaid LTC costs in particular will consume between 2010 and 2030 in ten different states (Keckley & Frink, 2010). The authors explain their study findings as follows:

> This paper highlights the potential state budget effects of the impending LTC services demand brought about by increasing Medicaid enrollments. It also present scenarios the 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 reform" (Keckley & Frink, 2010, p.3).

These researchers then provide projections based on four different scenarios:

- 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 (Keckley & Frink, 2010, p.4).

The study presents projections for each scenario "for both Medicaid as a whole and Medicaid LTC services in ten states, representing multiple regions and the nation's most populous states" (Keckley & Frink, 2010, p. 4).

The problem with these projections, however, is that they erroneously assume that federal health reform contains legislative mandates that will cause significant increases in enrollment for Medicaid LTC. Part of the Patient Protection and Affordable Care Act (PPACA) signed into law March 23, 2010 expands Medicaid health benefits to all individuals under age 65 with incomes up to 133 percent of the federal poverty level (FPL) (Kaiser Family Foundation, 2011b). While this provision may have a significant impact on the number of individuals enrolled in other aspects of Medicaid, it will have little to no appreciable impact on the amount of individuals enrolled in Medicaid LTC. Both prior to and after the passage of health reform in March 2010, the eligibility limit for Medicaid LTC for individuals who are disabled or over the age of 65 is 300 percent of the maximum Social Security Benefit (Kaiser Family Foundation, 2011b; Tumlinson et al., 2009).

Moreover, an applicant for Medicaid LTC can generally avoid this income eligibility limit by placing excess income into a so-called "Miller trust" and thereby

transforming it from income into an asset (Wytychak, 2000). Thus, increasing eligibility from 100 percent to 133 percent of the FPL for other aspects of the Medicaid program should have no impact on Medicaid LTC. There are no other provisions in the PPACA that could conceivably create the significant increases in Medicaid LTC that the Deloitte study assumes (Kaiser Family Foundation, 2011b).

As such, the Deloitte LLP study apparently makes an incorrect assumption in equating the potential for overall increases in Medicaid enrollment in coming decades due to health reform with proportional increases in enrollment in the LTC aspects of Medicaid. Accordingly, the study's projections regarding the potential for 20 percent or 40 percent increases in Medicaid LTC are arguably meaningless. Unfortunately, this study and its projections gained a fair amount of attention in news media (Briody, 2010; PR Newswire, 2010), possibly contributing to confusion among policymakers and the public regarding the causes for growth in Medicaid LTC expenditures.

Studies Projecting the Impact of MPF in Other States

As mentioned above in describing the MFP program, Idaho is somewhat of a late-comer to the program, in that nearly 30 other states began implementing MFP programs in 2007. As West Virginia and Delaware were either considering or embarking on MFP programs, the Medicaid programs in both of those states contracted with private consulting firms to conduct studies as to project the potential fiscal impact of MFP in each respective state (Public Consulting Group, 2008; The Lewin Group, 2006). Accordingly, these two studies provide a helpful template from which to draw upon in

generating a model to project the fiscal impact of MFP in Idaho. This section, therefore, provides an overview of the steps the Public Consulting Group (PCG) (2008) and The Lewin Group (2006) followed.

A first step in studies projecting the fiscal impact of MFP programs in both Delaware and West Virginia was to create baseline projections as to what Medicaid LTC expenditures would be in each respective state in the absence of patient transitions through the MFP program. Both of these studies relied on historic Medicaid expenditures as a starting point.

Specifically, in creating projections for West Virginia, PCG considered the state's Medicaid growth rates from 1995 to 2006 for both case load (number of beneficiaries) and per beneficiary costs in four categories: the state's A&D Waiver HCBS, Medicaid NFs, the state's DD Waiver HCBS, and ICF/MRs (PCG, 2008). For all of these categories except DD Waiver services, PCG extrapolated out the average growth rate from 1995 to 2006 in order to project the baseline in for the coming decade. For the DD category, however, the researchers considered that it would be unreasonable to assume that the expenditure growth rate of 18.5 percent would continue for the coming decade. Accordingly, the researchers apparently used their judgment to estimate that from 2008 to 2017 West Virginia's per beneficiary DD Waiver costs would grow at an annual rate of 4.85 percent and the number of beneficiaries would grow at an annual rate of 2.5 percent (PCG, 2008).

The Lewin Group (2006) applied a similar methodology in creating baseline projections of Medicaid LTC enrollment and per beneficiary costs in Delaware from

2006 to 2016 in four categories: NFs, ICF/MRs, the state's A&D Waiver HCBS, and the state's DD Waiver HCBS. For NFs, The Lewin Group determined the number of Delaware NF residents from 2001 to 2005 using data maintained by the American Health Care Association. Based on this data, The Lewin Group determined that NF enrollment grew at an average annual rate of 0.4 percent during this period, and used linear regression to project Delaware Medicaid NF enrollment for ten years into the future. The Lewin Group then projected per beneficiary cost of Medicaid NF care by referencing Medicaid data from fiscal years 2003 and 2004, and applying a 5 percent annual growth rate in per beneficiary costs. With little explanation, The Lewin Group's report notes that this 5 percent figure is "based on recent Delaware trends and national estimates" (The Lewin Group, 2006, p. 57).

For ICF/MRs, The Lewin Group considered trends and downsizing initiatives at major facilities in the state to conclude that ICF/MR enrollment would decline by 3 percent per year in the coming decade. Then based on the cost growth between fiscal year 2003 and 2004, as wells as "Delaware trends and national cost estimates," the researchers projected that ICF/MR per beneficiary costs would increase at a rate of 5 percent per year. For growth in enrollment in Delaware's A&D Waiver program, The Lewin Group considered the annual growth rates from the prior five years and established 7 percent as the baseline growth for the A&D waiver (The Lewin Group, 2006). Referencing the cost growth between the 2003 and 2004 fiscal years, and "based on Delaware trends and national cost estimates," The Lewin Group projected per enrollee A&D Waiver costs to grow at 6 percent annual during the coming decade. For

DD Waiver HCBS, the researchers used a similar process to project enrollment growth at 4.5 percent per year and per enrollee costs to grow at 3 percent year. For each of these four categories, unlike PCG, The Lewin Group also took into account beneficiary attrition from each of these programs in creating baseline projections (The Lewin Group, 2006).

After using historic data and trends to generate "baseline" projections for Medicaid LTC spending ten years into the future in the absence of MFP, both The Lewin Group and PCG created low and high models to project the potential impact of MFP during this ten year period (PCG, 2008; The Lewin Group, 2006). This discussion first considers the methodology The Lewin Group used in projecting the cost effectiveness of Delaware's MFP program. Next, this section summarizes PCG's methods for projecting the cost effectiveness of West Virginia's MFP program and studies analyzing the cost effectiveness of MFP in other states.

Looking first at The Lewin Group's low model projections for Delaware, this model assumed that MFP would be able to transition 1 percent of the state's institutionalized patients during the first year, increasing incrementally to 3 percent by year five of the program, and then level out at 3 percent for the following five years (The Lewin Group, 2006, pp. 61-62). Using these percentages, and factoring some turnover, The Lewin Group estimated that Deleware's MFP program would transition 396 NF residents and 43 ICF/MR residents over ten years. For its high model, The Lewin Group estimated the number of patients transitioned each year would be between 1.5 percent and 5 percent, reaching a total of 657 NF and 72 ICF/MR residents transitioned over ten

years. The Lewin Group reached its estimates on the prior experiences of six other states in transitioning patients (The Lewin Group, 2006, pp. 59-66).

Assuming that for each transitioned patient, Medicaid would pay the average per capita cost for providing HCBS and avoid the average per capita cost of providing institutional care, The Lewin Group then calculated that Medicaid would avoid or save a gross of approximately $131 million under the low model and $217 million under the high model. The Lewin Group then offset these savings by estimated costs for implementing the MFP program, including: program administration costs, direct transition costs ($600 per person), outreach and marketing costs, and information technology improvements. These total implementation costs for ten years were estimated at approximately $5.2 million under the low model and $9.8 million under the high model. Finally, The Lewin Group calculated the portion of projected MFP savings that the state government, as opposed to the federal government, would receive. Overall, The Lewin Group estimated that Delaware could save between $63 million and $104 million over ten years by implementing the MFP program. Unlike other studies discussed below, The Lewin Group apparently did not take into account potential decreases in state revenue or increase in acute care costs related to the MFP program.

Regarding PCG's projections for West Virginia, PCG's low model assumes that the MFP program would transition an average of 75 individuals per year (which was equivalent to approximately 0.67 percent of the total number of NF residents in West Virginia in 2006), that 90 percent of transitioned individuals would receive Medicaid funded HCBS (with remaining 10 percent able to live in the community with other non-

state or natural supports); and that 10 percent of transitioned patients would return to NF care within one year. Additionally, PCG assumed that transitioned patients would incur an additional $1,500 in acute care costs each year. Interestingly, PCG (2008) considered this $1,500 increase a "conservative estimate since the long-run trend in the difference between acute care costs for waiver versus NF persons has been narrowing" (p. 23). Next, PCG assumed that any savings from transitioning patients would be offset by $300,000 annual administrative costs to run the program beginning in 2008 (adjusted for inflation in subsequent years) and a 5.5 percent adjustment to account for the loss of tax revenue that would otherwise be provided. Making adjustments based on these assumptions, PCG used this low model to calculate net savings by replacing the projected average per capita cost of institutional care for each transitioned patient with the average per capita cost of HCBS for a four year period (excluding those patients who either returned to institutional care or no longer relied on Medicaid after returning to the community). Through this method, PCG calculated that using MFP would make West Virginia's Medicaid program $57 million more cost-effective over a ten year period.

In generating high model projections for the cost-effectiveness of West Virginia's MFP program, however, PCG utilized a much more intricate methodology. PCG explained the need for this alternative methodology as follows:

> PCG's high model presupposes working with double the number of people in the low model and assumes that the state has encouraged and adopted policy changes that provide more residential options, other waiver expansions and expanded state plan services. The policy assumptions create the need for a different analysis to look at costs and savings of a more "aggressive" model. (PCG, 2008, p. 23)

Accordingly, PCG's high model first estimates the average per capita cost of providing a variety of different types of HCBS, including: home health agency services, adult day care, assisted living, traumatic brain injury services, telemedicine, personal care services, DD Waiver services, and A&D Waiver services. PCG then estimated the number of transitioned patients that would use each specific services type. PCG then applied the same methodology used in the low model to determine that MFP would save $62 million over a ten year period. Unlike The Lewin Group's (2006) projections regarding the cost-effectiveness of Delaware's MFP program, however, PCG apparently did not determine which portion of the savings would inure to the state budget.

A comparison of PCG's low and high models projections—$57 million and $62 million, respectively—illustrates that the cost-effectiveness benefits of MFP may plateau as the program more aggressively works to transition patients who may need higher levels of HCBS. Specifically, according to PCG's projections, West Virginia's Medicaid program would be only $5 million more cost-effective by transitioning twice as many patients under the high model. This assumption that a transition program may be more cost effective in initial phases when it is focusing on patients who can most easily be returned to the community with lower levels of HCBS (*i.e.*, the "low hanging fruit") is reflected in other literature (Hendrickson & Reinhard, 2006; Grabowski, 2006). Looking to other research, however, PCG's high model's assumptions regarding the extent to which costs and levels of HCBS utilization would increase may be too high.

Wenzlow and Lispon (2009) note that the initial phase of the MFP program initiated in 2007 targeted less than 1 percent of the approximately 1 million

institutionalized Medicaid LTC recipients eligible for transition. Additionally, several states have reported significant proportions of transitioned individuals no longer needing state support once returned to the community. For example, 40 percent and 65 percent of individuals transitioned back to the community in New Jersey in 2005 and 2006, respectively, did not use state services once back in the community. Similarly, 29 percent if individuals transitioned in Michigan did not use state services once back in the community (Hendrickson & Reinhard, 2006).

Moreover, an analysis of the potential effectiveness of a highly aggressive Wisconsin "community integration program" found that transitioning the patient-days equivalent to 540 patients—approximately 2.7 percent of the state's institutionalized LTC recipients—would save the state over $5 million in one year alone (Hendrickson & Reinhard, 2006; Wisconsin State Legislative Fiscal Bureau (WSLFB), 2005). This analysis determined that it would cost Medicaid approximately $24 less a day after taking into account the differences in payments made by Medicaid for institutional LTC or HCBS, "the loss of provider tax assessments" due to closing NF beds, and "increases in state plan services used by persons in the community and additional state supplemental funding for personal needs" (Hendrickson & Reinhard, 2006, p. 13; WSLFB, 2005).

CHAPTER III: METHODOLOGY

This study consists primarily of collecting and analyzing existing archival data and policies in order to generate expenditure projections over a ten year horizon. This section first describes the sources from which the underlying data are obtained. In doing so, this section identifies the justification for and benefits of using this type of data, as well as the limitations presented by this data. Next, this section provides detailed explanations of each step involved in generating the expenditure projections.

Similar to studies projecting the impact of MFP programs in other states, this study also first creates baseline projections for Idaho Medicaid's LTC expenditures ten years into the future (state FY 2011 to FY 2020), and then uses low and high models to estimate the potential savings from implementing an MFP program. Accordingly, this study mirrors for Idaho the general models used in two studies projecting the fiscal impact of MFP programs in Delaware and West Virginia (PCG, 2008; The Lewin Group, 2006).

Specifically, this researcher created projections incorporating all four major types of Medicaid LTC expenditures (NF, A&D Waiver services, ICF/MR, and DD Waiver services). These projections are based on the general rule that A&D Waiver services generally serve as a substitute for NF care, and that DD Waiver services generally serve as a substitute for ICF/MR care (Beard & Miller, 2008). This mirrors the approach taken in the Delaware and West Virginia studies (PCG, 2008; The Lewin Group, 2006).

Developing a Baseline Estimate of Idaho Medicaid LTC Expenditures from FY 2011 to FY 2020

A first step in projecting the cost-effectiveness of implementing a MFP program in Idaho was to develop baseline projections of what Medicaid LTC expenditures would be if current practices and policies were to continue. The baseline projected total and per beneficiary expenditures were informed primarily by Medicaid LTC utilization and expenditures data from FY 2005 to FY 2009, as reported to CMS by Idaho Medicaid and compiled by CMS in the Medicaid Statistical Information System (MSIS) (Centers for Medicare & Medicaid Services, 2004). Using trends illustrated by these data, as well as other available projections regarding the growth rates of LTC costs and utilization, this researcher generated projections from FY 2011 to FY 2020 for total expenditures and utilization of: (1) NFs, (2) A&D Waiver services, (3) ICF/MRs, and (4) DD Waiver services. The sections below provide an outline of the factors considered in creating baseline projections for each of these four categories.

Projection of NF Expenditures, Beneficiaries and Per Beneficiary Cost

Projected growth in NF expenditures required the overall expenditures and number of beneficiaries for this service type as contained in MSIS from state FY 2005 to FY 2009. While the pertinent MSIS data is available retrospectively to FY 2000, this researcher chose to inform these projections with only the five most recent fiscal years available in order to better take into account more recent trends. Such an approach reflects the methods used in studies conducted by PCG (2008) and The Lewin Group (2006).

By dividing expenditures by the number of beneficiaries, this researcher calculated the average per beneficiary cost of the service. Then, the number of beneficiaries and average per beneficiary costs between years were compared to determine the average growth rate in number of Medicaid beneficiaries receiving NF services and the per beneficiary costs of such services. Therefore, based on MSIS data, Idaho Medicaid NF expenditures increased at an average annual rate of 6.10 percent between SFY 2005-2009, the number of Medicaid beneficiaries receiving NF care in a given year grew by an average of 1.91 percent during this period, and the average cost of providing NF care to each beneficiary grew by an average annual rate of 6.20 percent during this five year period. These data and calculations are illustrated in Table 1 below.

Table 1

Historical MSIS Data Re: Idaho Medicaid NF Expenditures

Fiscal Year	**Total Expenditures**	**Number of Beneficiaries**	**Avg. Cost Per Beneficiary**	**% in Total Expenditures from prior yr**	**% change # of Beneficiaries**	**% change in Avg. Cost Per Beneficiary**
2005	$133,954,859	5046	$26,547			
2006	$145,090,862	5029	$28,851	1.083132505	0.996630995	1.086793919
2007	$152,929,024	6215	$24,606	1.054022437	1.235832173	0.852884769
2008	$173,553,155	5337	$32,519	1.134860803	0.858728882	1.321558908
2009	$168,688,071	5258	$32,082	0.971967758	0.985197677	0.986571306
				= 6.10% avg. annual growth FY 2005-2009	***= 1.91% avg. annual growth FY 2005-2009***	***= 6.20% avg. annual growth FY 2005-2009***

With the FY 2005 to FY 2009 rates as a reference and taking into account other factors, this researcher then projected average annual growth rates between SFY 2010 to SFY 2020, as explained herein.

The annual growth rate between FY 2005 and FY 2009 for the number of unique beneficiaries receiving Medicaid funded NF care was 1.91 percent. Such an average growth rate, however, may not be indicative of the trend in Medicaid NF utilization over the next ten years. Specifically, in FY 2006, FY 2008, and FY 2009, the number of unique beneficiaries receiving NF care actually *decreased* at an average rate of 6.64 percent for those three years. This decrease, however, is offset by an increase of 23.6 percent in FY 2007, making for the average 1.91 percent growth rate mentioned above. In light of the fluctuating historical rate of change in number, unique beneficiaries receiving NF care in recent years, relying solely on such historical trends, may lead to potentially misleading results. Accordingly, taking into consideration other factors, the baseline projections estimate an annual increase in Medicaid NF patients of 1.0 percent over the next ten years. This researcher chose this figure for several reasons. First, even in the absence of Idaho implementing a MFP program, the trend in LTC is for more patients to remain in the community rather than move to NFs (Kaye et al., 2009). Thus, it may be unreasonable to assume that the number of Medicaid beneficiaries receiving NF care will continue to increase by nearly 2 percent annually for the next ten years.

However, while the *proportion* of LTC patients in Idaho in NFs relative to the number of LTC patients in home and community settings may decrease in coming years, it is reasonable to expect that the *actual* number of such patients may still increase in the coming years. The U.S. Census Bureau projects that the number of individuals in Idaho age 65 and over will grow from 181,416 in 2010 to 269,439 in 2020 (U.S. Census Bureau, 2005). Given the dramatic overall growth in Idaho's elderly population that will

occur, it is reasonable to assume 1.0 percent annual growth in the number of individuals receiving Medicaid funded LTC in NFs over the next ten years.

In addition to the projected 1.0 percent annual growth in number of individuals receiving Medicaid funded NF care, the baseline projections also assume an annual increase of 5.0 percent in per beneficiary spending from FY 2010 to FY 2020. This estimated increase of 5 percent is conservative in light of the fact that between FY 2005 and FY 2009, such per capita costs increased at an annual rate of 6.20 percent. Other factors, however, weigh in favor of estimating per beneficiary spending growth at 5.0 percent. Shostak and London (2008) project Idaho's *total* Medicaid LTC expenditures for all types of services to grow an average of 4.7 percent per year from 2008 to 2027. Because this projected growth in total expenditures necessarily reflects both growth in costs and utilization of services *and* increases in the number of beneficiaries, such projections reflect an annual rate of growth in per beneficiary spending substantially lower than 6.20 percent. In light of the CMS OACT's 2008 national level projections, however, Shostak and London's projected growth rate may be too low. Specifically, OACT estimated that national Medicaid spending on aged enrollees in Medicaid will grow at an annual average rate of 6.4 percent between 2008 and 2017. Another study projected national Medicaid institutional LTC expenditures (for both NFs and ICF/MRs) to grow at an average rate of 5.5 percent between 2010 and 2030 (Keckley & Frink, 2010).

Given the range of these various projections, it is reasonable to generate baseline projections based on a round estimate of 5.0 percent annual growth in per beneficiary

Medicaid spending on NF care. Such an approach is consistent with The Lewin Group's approach in creating baseline projections, who likewise chose a 5 percent per person cost growth rate "based on recent Delaware trends and national estimates" (The Lewin Group, 2006, p. 56). These projected growth rates are summarized in Table 2 below.

Table 2

Projected NF Growth Rates

Projected annual percent change in number of beneficiaries FY 2010-FY 2020	**1.0 %**
Projected annual percent change in average per beneficiary expenditures FY 2010-FY2020	**5.0%**

Applying the respective 1.0 percent and 5.0 percent growth rates to FY 2009 figures, this researcher then generated baseline projections for Medicaid's total NF expenditures, the number of Medicaid beneficiaries receiving NF care, and the average annual cost of providing such care to each beneficiary from FY 2010 to FY 2020. Table 3 below summarizes these baseline projections.

Table 3

Baseline Projected Medicaid NF Expenditures FY 2010 to FY 2020

Fiscal Year	Total Expenditures	Projected Number of Beneficiaries	Projected Avg. Cost Per Beneficiary	Estimated % change in number of beneficiaries	Estimated % change in Avg. Cost Per Beneficiary
2010	$178,893,699	5311	$33,686	1.0%	5.0%
2011	$189,716,768	5364	$35,371	1.0%	5.0%
2012	$201,194,633	5417	$37,139	1.0%	5.0%
2013	$213,366,908	5471	$38,996	1.0%	5.0%
2014	$226,275,606	5526	$40,946	1.0%	5.0%
2015	$239,965,280	5581	$42,993	1.0%	5.0%
2016	$254,483,179	5637	$45,143	1.0%	5.0%
2017	$269,879,412	5694	$47,400	1.0%	5.0%
2018	$286,207,116	5751	$49,770	1.0%	5.0%
2019	$303,522,647	5808	$52,258	1.0%	5.0%
2020	$321,885,767	5866	$54,871	1.0%	5.0%
2011-2020	**$2,506,497,315**[1]				

Baseline Projections of A&D Waiver Total Expenditures, Number of Beneficiaries, and Average per Beneficiary Spending

Essentially the same process was used in generating baseline projections for NF expenditures, A&D Waiver Service expenditures for SFY 2011 to 2020. Specifically MSIS data from FY 2005 to FY 2009 was compiled to determine average per beneficiary spending and average annual growth rates as set forth in Table 4, below.

[1] Although this provides baseline estimates for FY 2010 to FY 2020, this researcher only applied the projections from FY 2011 to FY 2020 in assessing the potential impact of transitioning patients through a MFP program. Accordingly, in projecting total expenditures, the relevant period is FY 2011 to FY 2020 (that is, excluding FY 2010).

Table 4

Historical MSIS Data Re: Idaho Medicaid A&D Waiver Services

Fiscal Year	Total Expenditures	Number of Beneficiaries	Avg. Cost Per Beneficiary	% in Total Expenditures from prior yr	% change # of Beneficiary	% change in Avg. Cost Per Beneficiary
2005	**$34,986,649**	**6,880**	$5,085.27			
2006	**$58,950,354**	**7,427**	$7,937.30	1.684939	1.079505814	1.560842506
2007	**$66,639,420**	**7,815**	$8,527.12	1.130433	1.05224182	1.074309046
2008	**$75,948,693**	**8,060**	$9,422.91	1.139696	1.031349968	1.105052818
2009	**$89,294,305**	**8,617**	$10,362.57	1.175719	1.0691067	1.099720715
				= 28.27% avg. annual growth FY 2005-2009	***= 5.81% avg. annual growth FY 2005-2009***	***= 21.00% avg. annual growth FY 2005-2009***

Using these historical growth rates as a reference, this researcher then estimated the growth rates for A&D Waiver LTC from FY 2010 to 2020. The number of individuals receiving Medicaid A&D Waiver LTC services increased at an average annual rate of 5.81 percent. In light of this historic rate, and taking into consideration other factors, it was estimated that the annual growth rate for the number of individuals receiving Medicaid A&D Waiver services was 6.0 percent from FY 2010 to FY 2020. This researcher placed this estimate slightly higher than the historic rate for several reasons. First, as Idaho's population ages and lives longer (and grows as a whole), it is reasonable to project that the beneficiary growth rate will be somewhat higher than the historical average.

A particularly problematic task in light of the historical rate, however, is estimating the annual growth rate for average per beneficiary spending on A&D Waiver services. As illustrated in Table 4, such per beneficiary spending grew at an average annual rate of 21 percent between FY 2005 and FY 2009. This figure, however, is

skewed upward by an astounding increase of over 56 percent in per beneficiary spending between FY 2005 and FY 2006. The average from only FY 2006 to 2009 is much lower, at 9.30 percent.

There are several potential reasons why per individual spending for community-based LTC is apparently growing at a faster rate than such per individuals spending for institutional LTC. OACT notes that as patients with more complex LTC needs remain in or return to the community and the availability of formal community-based LTC services expands, the usage of and spending for such services has likewise increased (CMS OACT, 2008). Additionally, as the demand for community-based LTC services increases, market forces may drive up the price for such services. As such, it may be unreasonable to presume that per beneficiary spending will continue to increase so rapidly for the coming decade.

In light of these factors, a conservative 7.0 percent was chosen as the estimated annual growth in average per individual spending for A&D Waiver services. Such a figure is more consistent with national projections than the observed Idaho growth rate of 21 percent from SFY 2005 to 2009. For example, OACT projects the national Medicaid average per individual spending for blind and disabled enrollees to grow at 7.2 percent per year and aged enrollees to grow at 6.4 percent from 2008 to 2017, nationally. While this figure represents spending for all types of services, OACT notes that a significant and growing portion of such expenditures are for community-based LTC (CMS OACT, 2008). Similarly, Keckley & Frink (2010) use CMS data to project that total national Medicaid HCBS will grow at an average annual rate of 11.9 percent until 2030. Such a

projection necessarily incorporates both growth in number of beneficiaries and growth in per beneficiary spending. In light of this fact, the estimated 7.0 percent annual growth in per beneficiary spending, in conjunction with the 6.0 percent estimated annual growth in the number of beneficiaries, appears reasonable.

The projected growth rates for A&D services are summarized as follows in the following Table 5.

Table 5

Projected A&D Waiver Growth Rates

Projected annual percent change in number of beneficiaries FY 2010-FY 2020	6.0 %
Projected annual percent change in average per beneficiary expenditures FY 2010-FY2020	7.0%

Applying these growth rates to MSIS's FY 2009 figures, this researcher created baseline projections for A&D Waiver Services from FY 2010 to FY 2020 as follows in Table 6.

Table 6

Baseline Projected A&D Waiver Expenditures FY 2010 to FY 2020

Fiscal Year	Total Expenditures	Projected Number of Beneficiaries	Projected Avg. Cost Per Beneficiary	Estimated % change in number of beneficiaries	Estimated % change in Avg. Cost Per Beneficiary
2010	$101,277,601	9134	$11,087.95	6.0%	7.0%
2011	$114,869,055	9682	$11,864.11	6.0%	7.0%
2012	$130,284,482	10263	$12,694.60	6.0%	7.0%
2013	$147,768,659	10879	$13,583.22	6.0%	7.0%
2014	$167,599,213	11531	$14,534.05	6.0%	7.0%
2015	$190,091,028	12223	$15,551.43	6.0%	7.0%
2016	$215,601,244	12957	$16,640.03	6.0%	7.0%
2017	$244,534,931	13734	$17,804.83	6.0%	7.0%
2018	$277,351,518	14558	$19,051.17	6.0%	7.0%
2019	$314,572,092	15432	$20,384.75	6.0%	7.0%
2020	$356,787,667	16358	$21,811.69	6.0%	7.0%
2011-2020 Total	**$2,159,459,890**				

Baseline Projections of ICF/MR Total Expenditures, Number of Beneficiaries, and Average Per Beneficiary Spending

Essentially the same processes used to project NF and A&D Waiver expenditures were used to project ICF/MR and DD Waiver expenditures through 2020. Namely, the annual average percentage change rates were calculated for total ICF/MR expenditures, number of beneficiaries, and average cost per beneficiary. Unlike other service categories, the number of Medicaid ICF/MR residents has been generally declining. This trend is likely due to the increases in availability and utilization of HCBS services for individuals with developmental disabilities. These figures are presented in Table 7.

Table 7

Historical MSIS Data Re: Idaho Medicaid ICF/MR Services

Fiscal Year	Total Expenditures	Number of Beneficiaries	Avg. Cost Per Beneficiary	% in Total Expenditures from prior yr	% change # of Beneficiaries	% change in Avg. Cost / Beneficiary
2005	$56,110,154	619	$90,646			
2006	$58,059,356	579	$100,275	1.03473885	0.935379645	1.106223395
2007	$60,704,050	598	$101,512	1.04555156	1.032815199	1.01233169
2008	$65,497,138	570	$114,907	1.07895829	0.953177258	1.13195975
2009	$56,205,351	555	$101,271	0.85813446	0.973684211	0.881327281
				= 0% avg. annual growth FY 2005-2009	***= -2.6% avg. annual growth FY 2005-2009***	***=3.3% avg. annual growth FY 2005-2009***

In light of the trend in a reduction in the number of ICF/MR patients, it is reasonable to assume demand for such services will decline and the cost growth for these types of services may be lower than for other types of services, such as NF care and HCBS. Accordingly, the historic annual average was applied without adjustment in projecting future change, as set forth in Tables 8 and 9.

Table 8

Projected ICF/MR Growth Rates

Projected annual percent change in number of beneficiaries FY 2010-FY 2020	-2.6 %
Projected annual percent change in average per beneficiary expenditures FY 2010-FY2020	1.033%

Table 9

Baseline Projected ICF/MR Expenditures FY 2010 to FY 2020

Fiscal Year	Total Expenditures	Projected Number of Beneficiaries	Projected Avg. Cost Per Beneficiary	Estimated % change in number of beneficiaries	Estimated % change in Avg. Cost Per Beneficiary
2010	$56,550,564	541	$104,613	0.974	1.033
2011	$56,897,898	527	$108,065	0.974	1.033
2012	$57,247,365	513	$111,631	0.974	1.033
2013	$57,598,978	499	$115,315	0.974	1.033
2014	$57,952,751	487	$119,120	0.974	1.033
2015	$58,308,697	474	$123,051	0.974	1.033
2016	$58,666,829	462	$127,112	0.974	1.033
2017	$59,027,160	450	$131,307	0.974	1.033
2018	$59,389,705	438	$135,640	0.974	1.033
2019	$59,754,477	426	$140,116	0.974	1.033
2020	$60,121,489	415	$144,740	0.974	1.033
2011-2020 Total	$584,965,348				

Baseline Projections of DD Waiver Total Expenditures, Number of Beneficiaries, and Average Per Beneficiary Spending

In light of the reduction in the number IFC/MRs, it is not surprising to see rather high average annual increase of 7.9 percent in the number of DD Waiver service recipients between 2005 and 2009. During this period, the average cost per beneficiary, however, grew by only 2.6 percent.

Table 10

Historical MSIS Data Re: Idaho Medicaid DD Waiver Services

Fiscal Year	Total Expenditures	Number of Beneficiaries	Avg. Cost Per Beneficiary	% change in Total Expenditures from prior yr	% change # of Beneficiaries	% change in Avg. Cost Per Beneficiary
2005	$50,548,272	1806	$27,989	1.04998406	1.090808416	0.962574222
2006	$53,074,880	1970	$26,942	1.18777614	1.086294416	1.09342009
2007	$63,041,076	2140	$29,458	1.10980777	1.075700935	1.031706615
2008	$69,963,476	2302	$30,392	1.07817855	1.061685491	1.015534787
2009	$50,548,272	1806	$27,989	1.04998406	1.090808416	0.962574222
				= 10.6% avg. annual growth FY 2005-2009	***= 7.9% avg. annual growth FY 2005-2009***	***= 2.6% avg. annual growth FY 2005-2009***

Similar to the projections for ICF/MR utilization and expenditures, historical average annual growth rates were used, without adjustment, to generate projections for DD Waiver utilization and expenditures. Given that A&D Waiver services are projected to grow at an annual rate of 7 percent over the next ten years, the 2.6 percent could arguably be viewed as too low. However, as A&D Waiver recipients are projected to nearly double from 9,134 to 16,358 in the coming decade, the demand for HCBS targeted for the elderly and physically disabled may drive the cost of these services up more significantly. These baseline projections for DD Waiver services are presented in Tables 11 and 12.

Table 11

Projected Medicaid DD Waiver Growth Rates

Projected annual percent change in number of beneficiaries FY 2010-FY 2020	7.9 %
Projected annual percent change in average per beneficiary expenditures FY 2010-FY2020	2.6%

Table 12

Baseline Projected Medicaid DD Expenditures FY 2010 to FY 2020

Fiscal Year	Total Expenditures	Projected Number of Beneficiaries	Projected Avg. Cost Per Beneficiary	Estimated % change in number of beneficiaries	Estimated % change in Avg. Cost Per Beneficiary
2010	$83,508,536	2637	$31,667	1.079	1.026
2011	$92,448,459	2845	$32,490	1.079	1.026
2012	$102,345,436	3070	$33,335	1.079	1.026
2013	$113,301,925	3313	$34,202	1.079	1.026
2014	$125,431,349	3574	$35,091	1.079	1.026
2015	$138,859,276	3857	$36,004	1.079	1.026
2016	$153,724,717	4162	$36,940	1.079	1.026
2017	$170,181,563	4490	$37,900	1.079	1.026
2018	$188,400,180	4845	$38,885	1.079	1.026
2019	$208,569,173	5228	$39,896	1.079	1.026
2020	$230,897,338	5641	$40,934	1.079	1.026
2011-2020 Total	$1,524,159,417				

The baseline projections created through this methodology are illustrated in Chart 1 below. This researcher estimates that Idaho's Medicaid LTC expenditures will total approximately $970 million over this ten year period. Interestingly, as a result of the higher growth in number of beneficiaries and per beneficiary spending for A&D Waiver services, this researcher projects that Medicaid's total expenditures for A&D Waiver

services to exceed Medicaid NF expenditures in FY 2019 and FY 2020. As indicated by the flat grey line, as the number of individuals using ICF/MR services is projected to decrease and the per beneficiary costs of such services is projected to increase only modestly, such expenditures are projected to remain at approximately the same level.

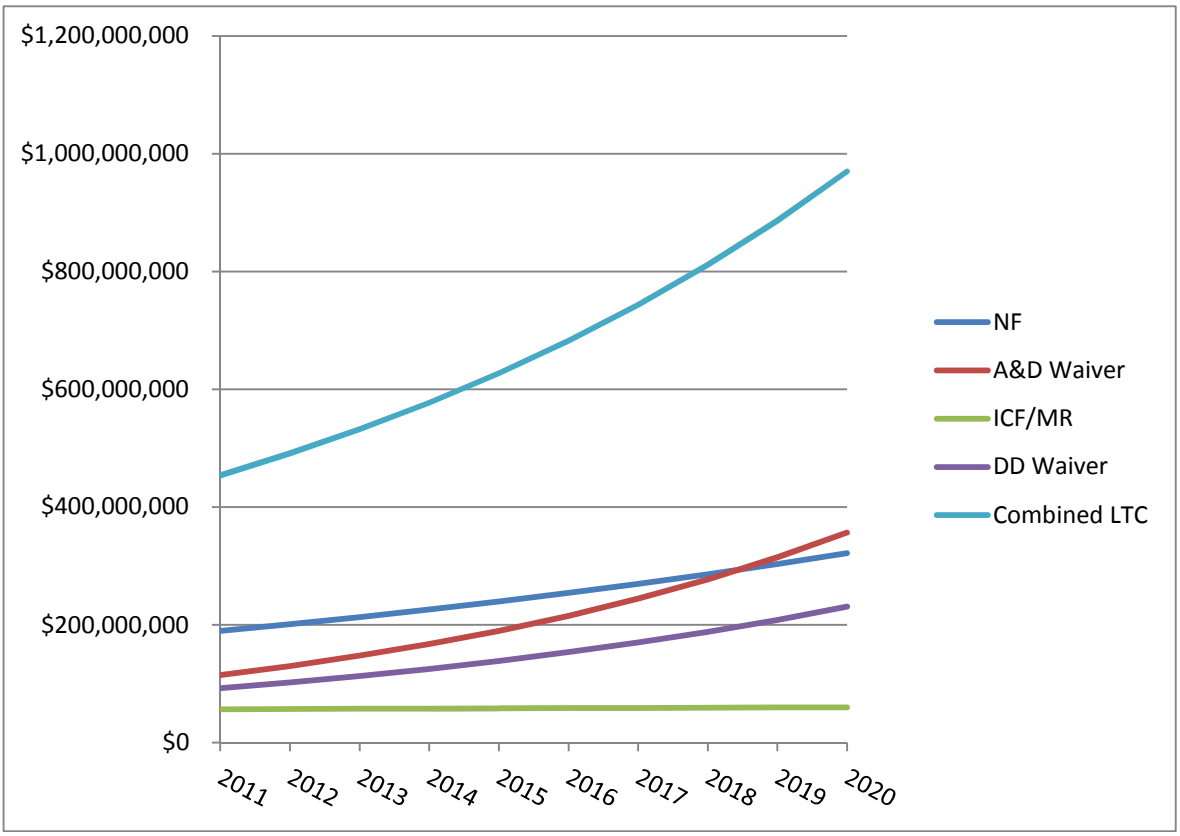

Figure 1 - Baseline reported (SFY 2005 -2009) and projected (2010 -2020), Idaho Medicaid LTC expenditures by service category based on current trends (based on MSIS data).

Projected Savings Resulting from MFP Program – Low and High Models

Once the baseline projections are created, they are applied to the projected changes in expenditures associated with transitioning patients out of a NF and ICF/MR care to estimate what, if any, net savings can be expected. As set forth in the introduction, a key assumption involved in this methodology is that the average per beneficiary cost of providing Medicaid LTC in the community to patients transitioned through MFP will be equal to the overall average per beneficiary cost of providing

community-based LTC to Medicaid beneficiaries. As set forth in Chapter II, while there is concern that transitioned patients may require more costly HCBS than other patients, there is also evidence that many institutionalized LTC recipients are strong candidates for cost-effective use of community LTC (Kaye et al., 2009). Moreover, this method of comparing averages per capita costs has been used in prior research (The Lewin Group, 2006; PCG, 2008).

In light of the potential problems involved with using this method to project the fiscal impact of MFP, these projections also attempt to conservatively take into account other increased costs potentially associated with transitioning patients. Such costs include the costs of operating the MFP program as well as potential increased use of Medicaid funded acute care services by patients transitioned back into the community.

Table 13 below is the minimum number of patients Idaho Medicaid intends to transition back to the community through its MPF program. Patients in the Aged and Physically Disabled are primarily in NFs and would be transitioned to receiving HCBS through Idaho Medicaid's A&D Waiver. Conversely, individuals in the DD category are individuals currently residing in ICF/MRs, and would be transitioned to receiving HCBS through Idaho Medicaid's DD Waiver.

Table 13

Idaho Home Choice Patient Transition Schedule (IDHW, 2011).

Grant Year	Aged	DD	Physically Disabled	Total
2011	8	2	5	15
2012	22	4	15	41
2013	25	5	20	50
2014	35	5	20	60
2015 – 2016	55	14	30	99
TOTAL	145	30	30	265

As is apparent from Table 13, Idaho's MFP program is focused largely on transitioning patients from NFs. Therefore, this section first explains the high and low model methods used in projecting the impact of transitioning NF, and then briefly outlines how the models are applied to project the impact of transitioning ICF/MR patients.

Basic Low and High Model Methodology

Similar to prior studies discussed above, this study used a low model and a high model. The low model assumes the MFP program will transition 30 patients per year out of NFs, and the high model assumes the MFP program will transition 60 patients per year. When comparing the low and high model projected number of NF patient transitions to the number of patients Idaho set forth in its grant application, it is important to keep in mind that these projections include both aged and physically disabled NF patients. Accordingly, as set forth in Table 13, above, Idaho's MFP grant application proposes annually transitioning a number of NF patients generally between the low and

high model ranges. For NF patients, the low model first assumes that 30, 12-month equivalent patients will be newly transitioned at an equal rate throughout the year (for a total of 15 patients transitioned during the first year of the MFP program, and 30 every year thereafter). The high model estimates 60 such 12-month equivalent patients transitioned (30 in the first year and 60 in subsequent years).

For ICF/MR patients, the low model assumes that Idaho's MFP program will transition an average of 3 patients per year, and the high model assumes the program will transition 6 such patients per year. The low and high model projections for ICF/MR transitions are similarly based on 12-month equivalents of patients transitioned.

Applying the low and high model projections regarding the number of patients to be transitioned to estimate the fiscal impact of MFP, this researcher first subtracted per beneficiary costs of providing NF care to those patients from the overall Medicaid LTC expenditures. In these projections, it is assumed the savings accrued to be equal to the projected per beneficiary NF or ICF/MR expenditures for that year.

Next, the low and high models both assume that 90 percent of those transitioned to the community through the program will enroll in and receive home and community-based LTC services through Idaho Medicaid's A&D Waiver (or DD Waiver for ICF/MR patients), with the remaining 10 percent obtaining such services through sources other than Medicaid. This 90 percent/10 percent approach mirrors that taken by PCG (2008) in generating projections for West Virginia, and is likely quite conservative. For example, 29 percent of persons transitioned through the community through Michigan's MFP program do not use further Medicaid-funded services. Similarly, 65 percent of patients

transitioned through New Jersey's program in 2006 did not receive further state Medicaid assistance (Hendrickson & Reinhard, 2006).

For the estimated 90 percent projected to enroll in the A&D or DD Waiver program, the average per capita costs of such services are then subtracted from the overall savings incurred by taking the patients out of a NF.

Also mirroring the approach taken by PCG (2008), the models further assume that some attempts will not be successful in the long-term, and that 10 percent of transitioned patients will return to Medicaid funded NF or ICF/MR care after one year. For all other patients, however, this researcher assumes that the savings incurred by transitioning them will cease after a somewhat arbitrary period of four years, which again, is similar to the approach taken by PCG (2008). Some transitioned patients may indeed have remained in an institution for many more years in the absence of MFP. In many other cases, however, the status of the patient (whether in institutional or community care) may be too temporally remote from the MFP-initiated transition to imply that MFP had an effect on it. Accordingly, these projections presume that for the estimated 90 percent of patients who do not return to a NF in one year, Medicaid continues to yield "savings" for transitioning them for a total of four years.

Five Percent Adjustment to Account for Lost State Tax Revenue

Additionally, because many NFs are for-profit, the projected reduction in occupancy and revenue of such facilities by transitioning patients to lower-cost community-based care, the state of Idaho stands to lose tax revenue. Additionally,

Medicaid reimburses NFs based on the average per diem rate for all patients at the facility. Accordingly, if the MFP program results in the healthier patients being transferred out of the facility, with only the more complex cases remaining, the amounts Medicaid reimburses for remaining patients could increase beyond what is projected (Hendrickson & Reinhard, 2006). The extent to which either lost state tax revenue or increases in per diem reimbursement rates may have an effect, however, is difficult to project with certainty. Therefore, using a figure on par with other studies (PCG, 2008; Hendrickson & Reinhard, 2006), these models further reduce the "savings" to Medicaid resulting from MFP transitions by 5 percent.

Adjustment to Account for MFP Program Costs

Finally, this model subtracts the projected cost of implementing the MFP program from the estimated savings. Such costs would include hiring and transition counselors, payments to beneficiaries to assist in transitions (*i.e.*, moving expenses, etc.), and related program operational expenses. For these projections, the low model assumes such expenses as totaling $250,000 per year for NF patients and the high model estimates such expenses at $500,000 for NF patients. For ICF/MR patients, the low model assumes $25,000 in program expenses associated with these transitions; the high model for ICF/MR transitions places this figure at $50,000.

As is apparent from these round numbers above, the projection models incorporate only rough estimates of what the program may cost to implement. Rough estimates are used because it is impracticable to assess with any certainty how much the

program will cost to implement. The Idaho MFP Grant contemplates contracting with independently employed transition coordinators on an hourly basis. Idaho's MFP Grant establishes that the MFP program will fund one full-time equivalent (FTE) Project Director, one FTE support staff, a 50 percent FTE IT specialist, a 25 percent FTE Idaho Medicaid LTC Bureau Chief, and 10 percent FTE for research and development (IDHW, 2010, p. 60). Beyond these costs, however, programs expenditures will vary depending on how much transition care coordination and related services each patient requires. For this reason, this researcher has opted to use rough estimates on par with the figures used in prior studies (PCG, 2008; The Lewin Group, 2006).

Adjusting for Increases in Acute Care Costs Using Medicaid Analytic eXtract Data

For patients transitioned into the community, it is further assumed that their Medicaid funded acute care costs may increase, and therefore should be taken into consideration in determining total savings to Medicaid. As noted in Chapter II, studies failing to take this factor into account may underestimate the true costs of HCBS when compared to institutional LTC implementation. The examination of Medicaid Analytic eXtract (MAX) data from 2005 to 2009 indicates that Medicaid patients receiving community-based LTC on average received roughly $7,000 more in "other" Medicaid financed care (such as the Medicaid portion of acute care physician services) per year than institutionalized Medicaid LTC beneficiaries. These differences are highlighted in Table 14.

Table 14

Average Per Beneficiary "Other" Medicaid Expenditures Depending on Community or Institutional LTC Status

	"Other" Medicaid Expenditures for Beneficiary w/ Community LTC Claims	**"Other" Medicaid Expenditures for Beneficiary w/ Institutional LTC Claims**	**Difference**
2005-07 avg.	$15,023	$8,387	$6,636
2008	$15,775	$8,807	$6,968
2009	$16,563	$9,247	$7,316

CMS OACT projects that average per Medicaid enrollee expenditures will be grow at the annual rate of 6.7 percent between 2007 and 2017 (CMS OACT, 2008, p. 18). Accordingly, given that the total Medicaid expenditures are anticipated to grow in the coming decade, it is reasonable to project that the difference between "other" Medicaid expenditures for Medicaid community-based LTC (CLTC) and institutional LTC expenditures will also grow proportionally. As such, the difference in "other" claims is estimated through 2020 by applying an annual growth rate of 6.7 percent to the 2009 difference. Accordingly, the difference in "other" Medicaid expenditures between CLTC and ILTC patients is expected to grow to $14,931 in 2020. These calculations are set forth in Table 15 below:

Table 15

Projected Average Per Beneficiary "Other" Medicaid Expenditures Depending on Community or Institutional LTC Status State FY 2011-2020

	"Other" Medicaid Expenditures for Beneficiary w/ Community LTC Claims	**"Other" Medicaid Expenditures for Beneficiary w/ Institutional LTC Claims**	**Difference**	**Estimated annual average Growth rate (6.7%)**
2009	$16,563	$9,247	**$7,316**	1.067
2010	$17,673	$9,867	**$7,806**	1.067
2011	$18,857	$10,528	**$8,329**	1.067
2012	$20,120	$11,233	**$8,887**	1.067
2013	$21,468	$11,986	**$9,483**	1.067
2014	$22,907	$12,789	**$10,118**	1.067
2015	$24,441	$13,645	**$10,796**	1.067
2016	$26,079	$14,560	**$11,519**	1.067
2017	$27,826	$15,535	**$12,291**	1.067
2018	$29,691	$16,576	**$13,115**	1.067
2019	$31,680	$17,687	**$13,993**	1.067
2020	$33,802	$18,872	**$14,931**	1.067

Determining Impact on State Budget

Because Medicaid is a partnership between the federal and state governments, any increase or reduction in expenditures will be apportioned between state and federal levels. In light of the increasing concern among state policymakers regarding the high costs of Medicaid LTC (National Governors Association, 2003), it may be of particular interest to know what impact MFP will have on Idaho's state budget.

Accordingly, a final step in projecting the impact of MFP in Idaho is to determine what portion of any potential savings would be yielded by the state of Idaho—as opposed to the federal government.

The percentage of Medicaid expenses borne by the federal government is referred to as the Federal Medical Assistance Percentage (FMAP) and varies from year to year in each state based on the average per capita income in the state (ASPE, 2009). In 2011, Idaho's standard FMAP was 68.85 percent, meaning that the federal government will pay for 68.85 percent of Idaho Medicaid's standard expenditures, with the state government bearing the remaining 31.15 percent of such expenses. The costs of providing care to Medicaid LTC beneficiaries that are not part of the MFP program are matched by the federal government at this standard FMAP.

The MFP program, however, offers states significant additional federal incentives to defray the costs of transitioning patients and to provide HCBS to patients transitioned through MFP. For example, between 2011-2016, Idaho's MFP grant contemplates that the federal government will bear all but 1.8 percent of the administrative costs of administering the MFP program.

Similarly, during the 2011-2016 demonstration, for the first year a patient is back in the community, the federal government will cover 90 percent of that patient's HCBS expenditures (IDHW, 2011). In light of these differing federal match rates depending on the type of services offered, the following basic model was used to calculate the impact of MFP on state budgets:

[Total state LTC expenditures in absence of MFP]	-	[state NF expenditures + state non-MFP expenditures + state MFP expenditures + projected increases in state acute care expenditures and other adjustments]	=	impact of MFP on state budgets

It is important to note that these projections assume that the federal government will continue to offer the enhanced 90 percent FMAP for MFP patients through SFY 2020. Although Idaho's current MFP grant will run only through 2016, given the ongoing nature of the federal government's MFP program, there is a good indication that the grant may be extended in the future.

Assuming that the current standard 2011 FMAP of 68.85 percent will remain constant during SFY 2011-2020, a first step is to determine a baseline amount that the Idaho state government would spend on LTC in the absence of an MFP program. In order to accomplish this, this researcher calculated 31.2 percent of the baseline projected Medicaid LTC expenditures from 2011-2020 as the state portion of such expenditures. The projected expenditures are set forth in Figure 2.

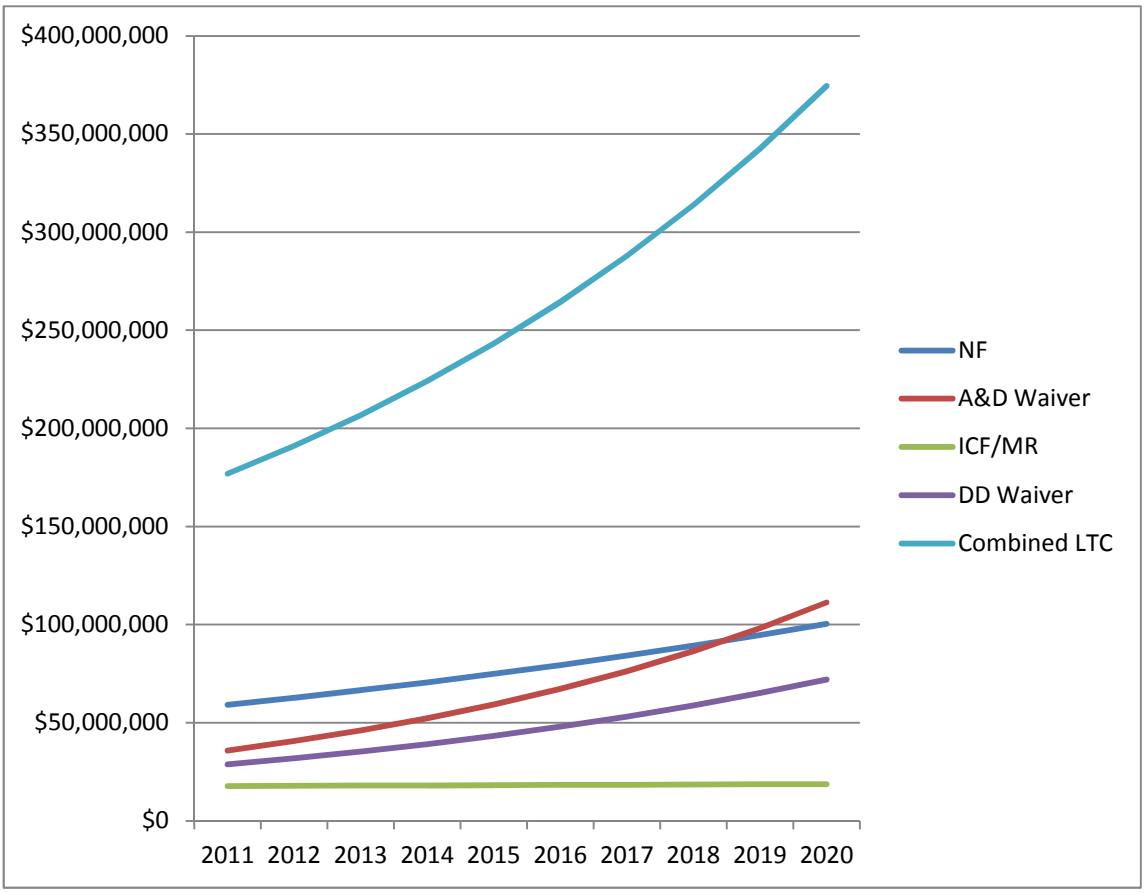

Figure 2. Baseline projected (SFY 2011-2020) state portion of Idaho Medicaid LTC expenditures by service category based on current trends (assuming standard FMAP of 68.88 percent SFY 2011-2020)

Using the state portions of the baseline projections, this research then projected how the state portion institutional LTC and HCBS expenditures would change as a result of MFP transitions. In projecting the state share of HCBS expenditures, this process involved determining what HCBS would be reimbursed at the enhanced rate under the MFP program, and which HCBS expenditures would be subject to the federal government's standard MFAP match rate.

As explained above, these projections conservatively estimate that a patient successfully transitioned back to the community and remaining there for at least a year will, on average, yield efficiencies to Medicaid that are attributable to the MFP program for four years. However, the federal government only pays the enhanced rate for the first year after the patient is transitioned back to the community. As such, this requires determining what portions of LTC expenditures for patients transitioned through MFP are matched by the federal government at the enhanced rate and which are matched at the standard rate. Tables 16 and 17 below set forth this process for MFP patients projected to be transitioned from NF care to A&D Waiver HCBS under the low model and high model, respectively. Tables 18 and 19 then set forth this process for such patients projected to be transitioned from ICF/MR care to DD Waiver HCBS under the low and high models.

Table 16

Low Model Projections of State Portion of Expenditures for NF Patients Transitioned through MFP

Year	LM Trans12 Mnth A&D Patients	Avg. A&D costs	LM A&D Expenditures	Proportion 90% MFAP	Proportion 69% MFAP	State Portion Enhanced	State Portion Standard LTC MFAP	Unadjusted State LTC Costs for MFP Transitioned Patients
2011	15	$11,864	$177,962	100%	0%	$17,796.2	$0.000	$17,796.2
2012	43	$12,695	$545,868	75%	25%	$40,940.1	$42,577.686	$83,517.8
2013	73	$13,583	$991,575	50%	50%	$49,578.8	$154,685.725	$204,264.5
2014	100	$14,534	$1,453,405	25%	75%	$36,335.1	$340,096.697	$376,431.8
2015	100	$15,551	$1,555,143	25%	75%	$38,878.6	$363,903.466	$402,782.0
2016	100	$16,640	$1,664,003	25%	75%	$41,600.1	$389,376.709	$430,976.8
2017	100	$17,805	$1,780,483	25%	75%	$44,512.1	$416,633.078	$461,145.2
2018	100	$19,051	$1,905,117	25%	75%	$47,627.9	$445,797.394	$493,425.3

table continues

Table 16 (continued)

Year	LM Trans12 Mnth A&D Patients	Avg. A&D costs	LM A&D Expenditures	Proportion 90% MFAP	Proportion 69% MFAP	State Portion Enhanced	State Portion Standard LTC MFAP	Unadjusted State LTC Costs for MFP Transitioned Patients
2019	100	$20,385	$2,038,475	25%	75%	$50,961.9	$477,003.211	$527,965.1
2020	100	$21,812	$2,181,169	25%	75%	$54,529.2	$510,393.436	$564,922.6
2011-2020								**$3,563,227.3**

Table 17

High Model Projections of State Portion of Expenditures for NF Patients Transitioned through MFP

Year	HM Trans12 Mnth A&D Patients	Avg. A&D costs	LM A&D Expenditures	Proportion 90% MFAP	Proportion 69% MFAP	State Portion Enhanced	State Portion Standard LTC MFAP	Unadjusted State LTC Costs for MFP Transitioned Patients
2011	30	$11,864	$355,923	100%	0%	$35,592.3	$0.000	$35,592.3
2012	87	$12,695	$1,104,430	75%	25%	$82,832.3	$86,145.552	$168,977.8
2013	141	$13,583	$1,915,234	50%	50%	$95,761.7	$298,776.538	$394,538.2
2014	195	$14,534	$2,834,139	25%	75%	$70,853.5	$663,188.559	$734,042.0
2015	195	$15,551	$3,032,529	25%	75%	$75,813.2	$709,611.759	$785,425.0
2016	195	$16,640	$3,244,806	25%	75%	$81,120.1	$759,284.582	$840,404.7
2017	195	$17,805	$3,471,942	25%	75%	$86,798.6	$812,434.502	$899,233.1
2018	195	$19,051	$3,714,978	25%	75%	$92,874.5	$869,304.918	$962,179.4
2019	195	$20,385	$3,975,027	25%	75%	$99,375.7	$930,156.262	$1,029,531.9
2020	195	$21,812	$4,253,279	25%	75%	$106,332.0	$995,267.200	$1,101,599.2
2011-2020								**$6,951,523.7**

Table 18

Low Model Projections of State Portion of Expenditures for ICF/MR Patients Transitioned through MFP

Year	LM Trans12 Mnth DD Patients	Avg. DD costs	LM DD Expenditures	Proportion 90% MFAP	Proportion 69% MFAP	State Portion Enhanced	State Portion Standard LTC MFAP	Unadjusted State LTC Costs for MFP Transitioned Patients
2011	1.5	$32,490	$48,736	100%	0%	$4,874	$0	$4,874
2012	4	$33,335	$133,341	75%	25%	$10,001	$10,401	$20,401
2013	7	$34,202	$239,413	50%	50%	$11,971	$37,348	$49,319
2014	10	$35,091	$350,912	25%	75%	$8,773	$82,113	$90,886
2015	10	$36,004	$360,035	25%	75%	$9,001	$84,248	$93,249
2016	10	$36,940	$369,396	25%	75%	$9,235	$86,439	$95,674
2017	10	$37,900	$379,000	25%	75%	$9,475	$88,686	$98,161
2018	10	$38,885	$388,854	25%	75%	$9,721	$90,992	$100,713
2019	10	$39,896	$398,965	25%	75%	$9,974	$93,358	$103,332
2020	10	$40,934	$409,338	25%	75%	$10,233	$95,785	$106,018
2011-2020								**$762,627**

Tables 19

Low Model Projections of State Portion of Expenditures for ICF/MR Patients Transitioned through MFP

Year	LM Trans12 Mnth DD Patients	Avg. DD costs	LM DD Expenditures	Proportion 90% MFAP	Proportion 69% MFAP	State Portion Enhanced	State Portion Standard LTC MFAP	Unadjusted State LTC Costs for MFP Transitioned Patients
2011	3	$32,490	$97,471	100%	0%	$9,747	$0	$9,747
2012	9	$33,335	$300,017	75%	25%	$22,501	$23,401	$45,903
2013	14	$34,202	$478,827	50%	50%	$23,941	$74,697	$98,638
2014	19.5	$35,091	$684,278	25%	75%	$17,107	$160,121	$177,228
2015	19.5	$36,004	$702,069	25%	75%	$17,552	$164,284	$181,836
2016	19.5	$36,940	$720,323	25%	75%	$18,008	$168,555	$186,564

table continues

Table 19 (continued)

Year	LM Trans12 Mnth DD Patients	Avg. DD costs	LM DD Expenditures	Proportion 90% MFAP	Proportion 69% MFAP	State Portion Enhanced	State Portion Standard LTC MFAP	Unadjusted State LTC Costs for MFP Transitioned Patients
2017	19.5	$37,900	$739,051	25%	75%	$18,476	$172,938	$191,414
2018	19.5	$38,885	$758,266	25%	75%	$18,957	$177,434	$196,391
2019	19.5	$39,896	$777,981	25%	75%	$19,450	$182,048	$201,497
2020	19.5	$40,934	$798,209	25%	75%	$19,955	$186,781	$206,736
2011-2020								**$1,495,954**

Next, the figures calculated through the process set forth in Tables 16 through 19 were subjected to a same 5 percent adjustment to account for lost state tax revenue and potential increases in the per diem rate Medicaid would pay for patients continuing to receive ILTC. Finally, the state portion of expenditures for projected increases in Medicaid funded acute and other care were taken into account.

CHAPTER IV: RESULTS

Based on the methods described above, low and high model projections were generated to estimate the fiscal impact of the Idaho's MFP program between SFY 2011-2020. This chapter first reports the total projected impact of Idaho's MFP program on both federal and state Medicaid NF and A&D Waiver expenditures. Next, this chapter explains the total projected impact of Idaho's MFP program on both federal and state ICF/MR and DD Waiver expenditure. Finally, this chapter projects the impact of Idaho's MFP program on Idaho state expenditures, specifically.

Impact of the Idaho MFP Program on State and Federal Medicaid Expenditures

Applying the above described low and high model methodologies, this researcher projected that transitioning NF patients to the community through Idaho's MFP program would reduce Medicaid total (both state and federal) expenditures between approximately $10.6 million and $20.5 million over a ten year period. Table 20 and Figure 3, below, outline the difference in combined NF and A&D Waiver expenditures for each year from FY 2011 to FY 2020 under the baseline, low model, and high model. Table 21 and Figure 4 then outline the differences in projected ICF/MR and DD Waiver expenditures under the baseline, low model, and high model. Table 22 then summarizes the total projected impact on Medicaid expenditures as a result of the MFP program.

Table 20

Projected Combined Adjusted Medicaid NF and A&D Waiver Expenditures and Reductions in Expenditures Under Low and High Models

	Baseline Combined NF and A&D Waiver Expenditures	**Low-Model Combined NF and A&D Waiver Expenditures**	**High-Model Combined NF and A&D Waiver Expenditures**	**Low-Model Projected Reduction in Expenditures**	**High-Model Projected Reduction in Expenditures**
2011	$304,585,823	$304,500,790	$303,991,558	$85,032	$170,065
2012	$331,479,114	$331,112,697	$328,439,508	$366,418	$747,171
2013	$361,135,567	$360,315,444	$355,346,545	$820,123	$1,566,950
2014	$393,874,819	$392,627,494	$385,090,842	$1,247,325	$2,419,783
2015	$430,056,308	$428,778,941	$420,819,420	$1,277,366	$2,478,364
2016	$470,084,423	$468,778,556	$460,380,619	$1,305,867	$2,533,941
2017	$514,414,342	$513,081,903	$504,229,522	$1,332,439	$2,585,757
2018	$563,558,635	$562,201,848	$552,878,640	$1,356,787	$2,633,235
2019	$618,094,739	$616,716,035	$606,905,396	$1,378,704	$2,675,973
2020	$678,673,434	$677,275,860	$666,960,601	$1,397,573	$2,712,768
2011-2020 Total	**$4,665,957,205**	**$4,644,821,934**	**$4,585,042,651**	**$10,567,635**	**$20,524,007**

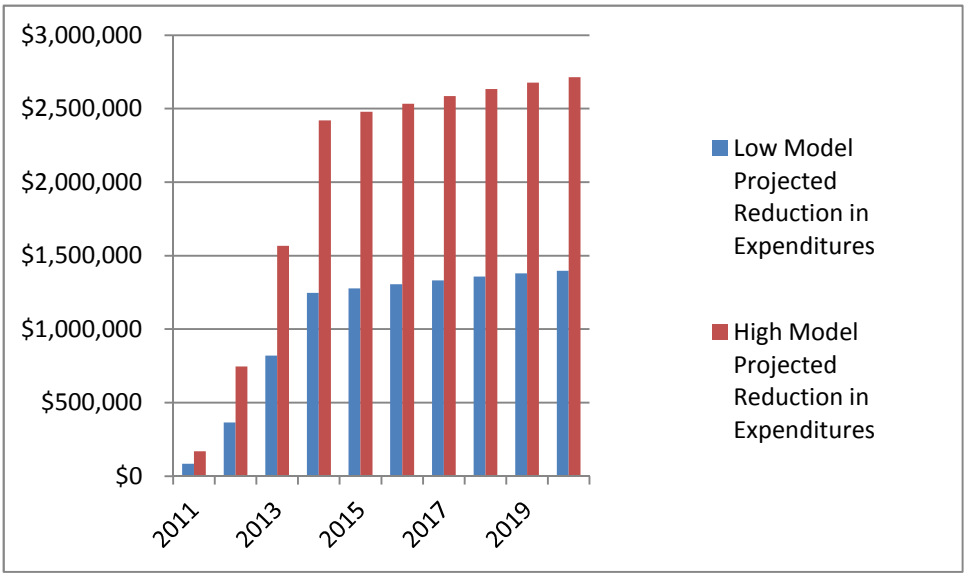

Figure 3. Projected reductions in combined Medicaid NF and A&D waiver expenditures under low and high model

Table 21

Projected Combined Adjusted Medicaid ICF/MR and DD Waiver Expenditures and Savings Under Low and High Models

	Baseline Combined ICF/MR and DD Waiver Expenditures	**Low-Model Combined ICF/MR and DD Waiver Expenditures**	**High-Model Combined ICF/MR and DD Waiver Expenditures**	**Low Model Projected Savings**	**High Model Projected Savings**
2011	$149,346,357	$149,263,656	$149,168,456	$82,700	$177,901
2012	$159,592,801	$159,355,824	$159,028,353	$236,977	$564,448
2013	$170,900,903	$170,452,881	$169,979,860	$448,021	$921,043
2014	$183,384,100	$182,712,002	$182,049,758	$672,098	$1,334,341
2015	$197,167,973	$196,473,978	$195,790,933	$693,995	$1,377,040
2016	$212,391,546	$211,675,098	$210,970,721	$716,449	$1,420,825
2017	$229,208,724	$228,469,270	$227,743,038	$739,454	$1,465,686
2018	$247,789,886	$247,026,868	$246,278,251	$763,018	$1,511,634
2019	$268,323,650	$267,536,494	$266,764,946	$787,156	$1,558,704
2020	$291,018,826	$290,206,978	$289,411,973	$811,848	$1,606,854
2011-2020 Total	**$2,109,124,766**	**$2,103,173,049**	**$2,097,186,290**	**$5,951,716**	**$11,938,476**

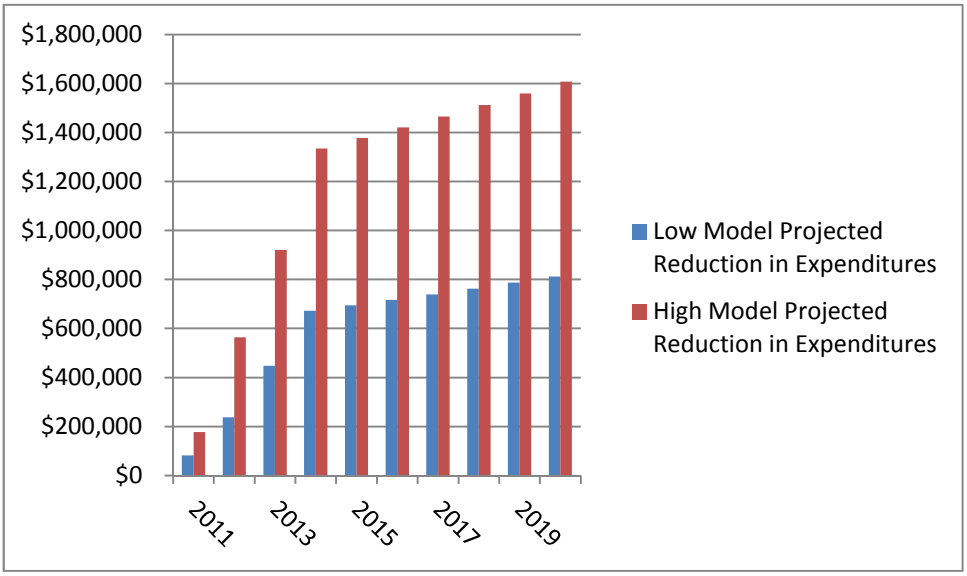

Figure 4. Projected reductions in combined Medicaid ICF/MR and DD waiver expenditures under low and high model

Table 22

Projected Total Medicaid LTC Expenditures (NF, A&D Waiver, ICF/MR, and DD Waiver) and Savings Under Low and High Models

	Total BL LTC Expenditures	Total LTC LM	Total LTC HM	Total LM Projected Savings	Total HM Projected Savings
2011	$453,932,180	$453,764,446	$453,160,014	$167,732	$347,966
2012	$491,071,915	$490,468,521	$487,467,861	$603,395	$1,311,619
2013	$532,036,470	$530,768,325	$525,326,405	$1,268,144	$2,487,993
2014	$577,258,919	$575,339,496	$567,140,600	$1,919,423	$3,754,124
2015	$627,224,281	$625,252,919	$616,610,353	$1,971,361	$3,855,404
2016	$682,475,969	$680,453,654	$671,351,340	$2,022,316	$3,954,766
2017	$743,623,066	$741,551,173	$731,972,560	$2,071,893	$4,051,443
2018	$811,348,521	$809,228,716	$799,156,891	$2,119,805	$4,144,869
2019	$886,418,389	$884,252,529	$873,670,342	$2,165,860	$4,234,677
2020	$969,692,260	$967,482,838	$956,372,574	$2,209,421	$4,319,622
	$6,775,081,970	$6,758,562,617	$6,682,228,941	**$16,519,351**	**$32,462,483**

The projections reported in Table 22 do not specify what portion of the projected savings will be reaped by Idaho's state budget, and what savings will go to the federal government. Moreover, while these figures account for potential increases in Medicaid expenditures for acute care and other non-LTC services, they do not take into account potential increases in acute care expenditures borne by other payors, such as Medicare.

Impact of Idaho's MPF Program on State Medicaid Expenditures

In light of the interest of state policymakers in the increasing burden of LTC on state budgets (National Governors Association, 2003), estimating the impact of the MFP Program on the Idaho state budget specifically may be of particular interest. As set forth in Table 23, the MFP program is projected to reduce state expenditures on NF and A&D

Waiver services from SFY 2011 to 2020 by between $5.1 and $10 million, based on the low and high model projections. Regarding ICF/MR and DD Waiver expenditures, Table 24 sets forth how such expenditures are projected to reduce the state portion of these expenditures by between $2.2 million and $4.3 million during this time period.

Accordingly, as set forth in Table 25, this study projects that Idaho state budget expenditures will be reduced by a total of between **$7.3 million** and **$14.4 million** over the ten year period during SFY 2011 to SFY 2020. It is worth reiterating that, using the methodology explained in Chapter III, these projected reductions in expenditures are adjusted to take into account potential increases in acute care expenditures.

Table 23

State Portion of NF and A&D Expenditures Under Baseline, Low Model, and High Model

	Baseline State Proportion of Combined NF and A&D Waiver Expenditures	**Low-Model State Proportion of NF and A&D Waiver Expenditures**	**High-Model Combined State Proportion of NF and A&D Waiver Expenditures**	**Low-Model Projected Savings to State Budget**	**High-Model Projected Savings to State Budget**
2011	$95,030,777	$94,922,944	$94,815,110	$107,833	$215,667
2012	$103,421,483	$103,130,314	$102,832,372	$291,169	$589,111
2013	$112,674,297	$112,216,994	$111,791,012	$457,303	$883,285
2014	$122,888,944	$122,323,120	$121,785,588	$565,824	$1,103,356
2015	$134,177,568	$133,596,743	$133,044,959	$580,825	$1,132,609
2016	$146,666,340	$146,070,664	$145,504,771	$595,676	$1,161,569
2017	$160,497,274	$159,886,999	$159,307,237	$610,275	$1,190,037
2018	$175,830,294	$175,205,742	$174,612,418	$624,552	$1,217,876
2019	$192,845,559	$192,207,095	$191,600,554	$638,464	$1,245,005
2020	$211,746,111	$211,094,269	$210,475,019	$651,842	$1,271,092
2011-2020 Total	**$1,455,778,648**	**$1,450,654,883**	$1,445,769,041	**$5,123,765**	$10,009,607

Table 24

State Portion of ICF/MR and DD Waiver Expenditures Under Baseline, Low Model, and High Model

	Baseline State Proportion of Combined ICF/MR and DD Waiver Expenditures	**Low-Model State Proportion of ICF/MR and DD Waiver Expenditures**	**High-Model Combined State Proportion of ICF/MR and DD Waiver Expenditures**	**Low-Model Projected Savings to State Budget**	**High-Model Projected Savings to State Budget**
2011	$46,596,063	$46,554,514	$46,512,964	$41,549	$83,099
2012	$49,792,954	$49,686,191	$49,552,738	$106,763	$240,216
2013	$53,321,082	$53,141,828	$52,962,575	$179,253	$358,507
2014	$57,215,839	$56,971,364	$56,739,112	$244,475	$476,727
2015	$61,516,408	$61,264,269	$61,024,737	$252,139	$491,671
2016	$66,266,162	$66,006,161	$65,759,159	$260,002	$507,004
2017	$71,513,122	$71,245,058	$70,990,397	$268,064	$522,724
2019	$83,716,979	$83,432,180	$83,161,621	$284,799	$555,358
2020	$90,797,874	$90,504,402	$90,225,603	$293,472	$572,271
2011-2020 Total	$658,046,927	$655,840,083	$653,700,512	$2,206,844	$4,346,415

Table 25

Projected State Portion of Medicaid LTC Expenditures (NF, A&D Waiver, ICF/MR, and DD Waiver) and Savings Under Low and High Models

	Total BL LTC Expenditures	**Total LTC LM**	**Total LTC HM**	**Total LM Projected Savings**	**Total HM Projected Savings**
2011	$141,626,840	$141,477,458	$141,328,074	$149,382	$298,766
2012	$153,214,437	$152,816,505	$152,385,110	$397,932	$829,327
2013	$165,995,379	$165,358,822	$164,753,587	$636,556	$1,241,792
2014	$180,104,783	$179,294,484	$178,524,700	$810,299	$1,580,083
2015	$195,693,976	$194,861,012	$194,069,696	$832,964	$1,624,280
2016	$212,932,502	$212,076,825	$211,263,930	$855,678	$1,668,573
2017	$232,010,396	$231,132,057	$230,297,634	$878,339	$1,712,761
2018	$253,140,738	$252,239,859	$251,384,024	$900,879	$1,756,714
2019	$276,562,538	$275,639,275	$274,762,175	$923,263	$1,800,363
2020	$302,543,985	$301,598,671	$300,700,622	$945,314	$1,843,363
2011-2020	**$2,113,825,575**	**$2,106,494,966**	**$2,099,469,553**	**$7,330,609**	**$14,356,022**

Discussion

Overall, these findings show that transitioning Medicaid LTC patients back to the community through the MFP program in Idaho will result in lower overall Medicaid expenditures than there would be in the absence of such a program. Specifically, over a ten year period, state expenditures are projected to be approximately $7 to $14 million lower. Moreover, such projections reflect only the reduction in state expenditures, and do not account for the increased quality of life generally associated with receiving LTC in a home or community-based setting, as opposed to an institution. Therefore, the aggregate economic value of MFP in Idaho may be substantially higher.

In sum, the MFP program in Idaho presents state policymakers with an opportunity to both make Idaho's Medicaid LTC system more cost-effective *and* expand service offerings without increasing state expenditures. In other words, through MFP, Idaho Medicaid can now offer transition coordination services—a service previously unfunded by Medicaid—while also decreasing state budget expenditures. This discussion briefly highlights why these results may be of interest to researchers and policymakers in other states and then analyzes factors that may further impact to the cost-effectiveness of MFP in Idaho.

Applicability of Model and Projections in Other States

The projection models used here and these results may be of interest to policymakers in other states as well—especially states with demographics or Medicaid HCBS Waiver policies similar to Idaho. As discussed above, the cost projection models

used here rely solely on MSIS data and data contained in the MAX Validation Tables. Such data for all state Medicaid programs are widely available on CMS's website (CMS 2011; CMS 2004). Using the models created here as templates, researchers or policymakers could replicate these projections to create projections for other state Medicaid programs with relative ease.

Moreover, given that these projections align with prior studies projecting or reporting the cost-effectiveness of MFP (Hendrickson & Reinhard, 2006; The Lewin Group, 2006; PCG, 2008), these results offer additional supporting evidence for the cost-effectiveness of MFP and HCBS in general. Therefore, especially for states similar to Idaho, these projections may offer insight into the experience such states may have with MFP in the coming years.

Factors to Consider to Increase Cost-Effectiveness of MFP in Idaho.

Although MFP is projected to increase efficiency in Medicaid LTC in Idaho, such a program alone cannot be considered any sort of "silver bullet" for solving the looming LTC financing crisis. However, MFP does hold promise in offering some savings and it assists in rebalancing the LTC system in favor of more desirable HCBS options. Despite this potential for contributing to a more cost-effective LTC system in Idaho, there are several issues that should be considered and possibly researched further in order for MFP to yield the greatest cost reductions and quality improvements. Specifically, the following factors should be considered: (1) the potential "woodwork" effect or "moral hazard" of increasing availability of Medicaid HCBS; (2) the general increase in acute

care expenditures for LTC patients in the community, compared to institutionalized LTC patients; (3) and, the importance of coordinating care between Medicaid LTC caregivers, informal caregivers, and other medical providers.

As explained in Chapter II, a policy concern that arises in relation to expanding access to publicly financed HCBS is the potential "woodwork effect": the concern that individuals who were previously receiving such services through other means (e.g., informally provided by family members) will "come out of the woodwork" and increase utilization of such services (Grabowski, 2006). Accordingly, there may be a concern that potential reductions in expenditures associated with implementing the MFP program could be offset by an increase in HBCS utilization caused by this "woodwork effect."

Despite this concern, when considering what Idaho's MFP program will do, the program will likely not give rise to a "moral hazard" for many individuals to unnecessarily rely on Medicaid HBCS. Specifically, although the MFP program aims to rebalance the LTC system in favor of greater use of HCBS rather than ILTC, the program does not expand access Medicaid of HCBS—other than for individuals who are already receiving Medicaid funded LTC in an institution. Rather, it provides transition services to patients who are currently receiving Medicaid funded ILTC. As discussed above, Idaho Medicaid has offered a variety of HCBS through several waiver programs since the 1990s to the extent that the presence of Medicaid funding for HCBS creates a moral hazard to over-utilize such services. This effect is already occurring. Therefore, this researcher concludes that the potential "woodwork effect" will not have a significant impact in offsetting the expenditure reductions projected in this study.

Unlike the woodwork effect, however, this study illustrates that projected increases in the utilization of Medicaid-financed acute and other non-LTC types of care associated with Medicaid LTC patients in the community will have a very substantial impact on limiting the cost-effectiveness of MFP. As set forth in Table 15, above, by 2020, Idaho Medicaid is projected to pay an average of nearly $15,000 more per year in acute and other services for CLTC patients than for ILTC patients (see Table 15, p. 63). This difference likely consists of Medicaid-paid premiums and deductibles for Medicare services for dual-eligible patients receiving LTC.

It is worth noting, however, that these projected increases in acute care expenditures by Medicaid CLTC patients are based on extrapolating historic trends, and therefore do not take into account recent federal-level policy changes that may result in reduced acute care expenditures in coming years. For example, the PPACA contains provisions to encourage the creation of accountable care organizations (ACOs), which may facilitate spending reductions through greater coordination of care, including coordination between acute care and LTC providers. Specifically, the federal government projects that this program may reduce national Medicare expenditures by $960 million during the first three years of the program (U.S. Department of Health & Human Services, Press Office, 2011).

While these ACOs relate specifically to Medicare, the care coordination and cost-efficiencies potentially generated by such ACOs could have a spill-over effect in facilitating better care coordination for Medicaid LTC patients. Additionally, the PPACA also dedicates funding for the expansion of services to coordinate Medicaid and

Medicare services for “dually eligible” beneficiaries (Kaiser Family Foundation, 2011b). In short, better coordination of acute care and LTC services through such efforts may result in lower acute care expenditures by Medicaid CLTC patients; this would translate into more significant expenditure reductions than projected by this study.

Additionally, however, further research efforts should go into investigating why CLTC patients use more and more expensive acute care services, and ways such utilization can be reduced. For example, one hypothesis may be that HCBS patients use relatively expensive acute care in the community for services that would be part of the LTC provided in a NF. For example, an HCBS patient experiencing an urgent, but non-emergent, adverse event may go to the emergency room to receive care that would be routinely offered by the nursing staff in an LTC institution. Another cause of the increased acute care expenditures may be that individuals in the community do not sufficiently access preventative care.

If these indeed are among the causes for increased acute care expenditures by CLTC patients, efforts should be made to increase access to low-cost alternatives and preventative care in the community. Such efforts may include offering additional training and support to informal caregivers (Levine et al., 2010). Therefore, further research is need to investigate ways to better coordinate care between informal caregivers, acute care providers, and formal LTC providers for Medicaid HCBS patients.

CHAPTER V: CONCLUSION

Using Medicaid MSIS and MAX data from recent years, this study generated baseline projections of what Medicaid LTC expenditures in Idaho would likely be in the absence of the MFP program between SFY 2011 and SFY 2020. These baseline projections estimate that Idaho Medicaid LTC will cost approximately $6.8 billion over this ten year period, with state fund paying approximately $2.8 billion of this amount.

Applying a low model and high model regarding how successful the MFP program would be in transitioning patients, this study then projected how much these total expenditures would be affected by the MFP program. This study projects that Idaho's MFP program will reduce these projected total expenditures between approximately $16.5 and $32.5 million, and reduce the state portion of these expenditures by between $7.3 and $14.4 million.

Although the projected reductions in expenditures are not insubstantial, they represent only a small portion of the total projected Idaho Medicaid LTC expenditures in coming years. Accordingly, while MFP may be effective in rebalancing Idaho's LTC system to allow more individuals to "age in place," this program alone may not have an significant impact on reducing Medicaid LTC expenditures in Idaho. Rather, the MFP program should be implemented in conjunction with other initiatives to encourage individuals to use alternatives to Medicaid for LTC and to improve care coordination.

As explained above, Medicaid LTC patients in the community generally use more and more expensive non-LTC services (e.g., acute care services). Accordingly,

transitioning Medicaid LTC patients back to the community will likely have a more substantial impact on reducing overall Medicaid expenditures if Medicaid expenditures for acute care services for these patients do not increase. Efforts should be focused on offering well-coordinating and cost-effective LTC and acute care services in the community.

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