





The Hilltop Institute

analysis to advance the health of vulnerable populations

Medicaid Long-Term Services and Supports in Maryland:

FY 2009 to FY 2012
Volume 1

A Chart Book

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Maryland Department of Health and Mental Hygiene

UMBC
AN HONORS UNIVERSITY IN MARYLAND

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Chapter 1. Maryland Medicaid Long-Term Services and Supports Overview

Maryland Home and Community-Based Services

The *Medicaid Long-Term Services and Supports (LTSS) in Maryland Chart Book, Volume 1*, summarizes demographic, service utilization, and Medicaid expenditure data for Marylanders using LTSS in state fiscal year (FY) 2009 through 2012. Medicaid programs and services addressed in this chart book include the following:

- *The Living at Home (LAH) Waiver*
- *The Medical Day Care Services (MDC) Waiver*
- *The Waiver for Older Adults (WOA)*
- *Medical Assistance Personal Care (MAPC) Program*
- *Medicaid Nursing Facility Services*
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Each of the three waivers provides home and community-based services and supports (HCBS) to individuals with low income and functional limitations. The waiver programs serve people who might otherwise require the services of a nursing facility, enabling them to return to or remain in the community. The waiver programs are authorized under §1915(c) of the Social Security Act and approved by the federal Centers for Medicare and Medicaid Services.

The MAPC Program provides personal assistance services to Medicaid recipients who have a chronic illness, medical condition, or disability but whose income exceeds the financial eligibility criteria for Medicaid waiver programs.

This chart book also provides information about Maryland Medicaid participants residing in nursing facilities. It summarizes demographic, service utilization, acuity, expenditure, and length of stay data for FY 2009 through 2012.

Living at Home Waiver

The LAH Waiver provides services and supports in home and community-based settings that enable people with physical disabilities to continue living in their own homes. Enrollees in the waiver must be aged 18 to 64 years at the time of enrollment. The waiver had 944 legislatively funded slots in FY 2012, up from 850 in FY 2011. The LAH Waiver offers services such as attendant care, medical day care, environmental assessments and modifications, case management, home-delivered meals and nutritionists, and personal emergency response systems.

Medical Day Care Services Waiver

The MDC Waiver, a single-service waiver program, began operating on July 1, 2008. Prior to that date, medical day care was a State Plan service. Under this waiver, approved medical day care agencies provide health, social, and related support services in an organized setting to individuals aged 16 years and older who reside in the community and who are assessed to need a nursing facility level of care. Individuals who were receiving medical day care as a State Plan service prior to July 1, 2008, but were not enrolled in another waiver, were transitioned into the MDC Waiver. There were 5,000 legislatively funded MDC Waiver slots in FY 2012. Over 30% of the MDC Waiver participants also received MAPC services in FY 2012.

Waiver for Older Adults

The WOA provides services to individuals living in their own homes or in assisted living facilities. WOA participants must be aged 50 or older at the time of enrollment. In FY 2012, the waiver served a total of 4,205 individuals. Waiver participants transitioning from a nursing facility via the Money Follows the Person Demonstration did not count against the FY 2012 3,750 legislatively funded waiver slots. This waiver was administered by the Maryland Department of Aging and a network of 19 Area Agencies on Aging with oversight provided by Medicaid. WOA services include personal care, assistive technology, environmental assessments and modifications, personal emergency response systems, medical day care and Senior Center Plus, home-delivered meals and nutritionists, respite care, behavior consultation, and case management.

Medical Assistance Personal Care Program

The MAPC Program provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to Medicaid recipients who have a chronic illness, medical condition, or disability. Services are provided by agency-employed providers or providers employed directly by the participants who are approved and monitored by a nurse case monitor from a local health department. Personal care services are provided in the individual's home, community residence, or employment site and include assistance with ADLs and household services related to medical needs, such as food shopping and escorts to medical appointments. The frequency of service delivery is determined by the Medicaid recipient's assessed level of need. MAPC participants frequently supplement their personal care services with other State Plan services, such as home health services.

Money Follows the Person

Money Follows the Person (MFP) is a federal demonstration program that provides enhanced federal medical assistance funds to states to provide qualified HCBS to persons who transition from an institutional setting into the community. The MFP demonstration provides funding for expenses related to the person's transition to the community, and the state receives an enhanced federal match on qualified services provided to that person for up to 365 days of participation in the program. Typically, MFP participants transition to the community through one of the waivers and continue with uninterrupted waiver services at the completion of the MFP year. This chart book includes certain MFP totals and expenditures for participants in their respective waivers.

Medicaid Nursing Facility Residents

For the purposes of this chart book, a Medicaid nursing facility resident is defined as a Medicaid beneficiary who had at least one Medicaid-paid day in a nursing facility during the given fiscal year, a bed hold payment, or Medicaid cost-sharing payments (premiums, co-payments, etc.) for services covered by Medicare. In FY 2012, there were 22,365 Medicaid nursing facility residents, a decrease of less than 1% from the previous fiscal year. Slightly more than one in five (21%) of the nursing facility residents were under the age of 65, and 39% of this population required a "heavy" or "heavy special" reimbursement level.

Chart Book Organization

The data in this chart book are presented in two sections:

- **Maryland Long-Term Services and Supports Users:** This section includes data on the number of Maryland Medicaid HCBS waiver participants, nursing facility residents, and MAPC recipients, with breakdowns by age, race, gender, and region of residence. It also contains data on the number of individuals on the Maryland Waiver Interest Lists, settings from which individuals entered the waiver programs, and prior Medicaid coverage. Comparisons across care settings are provided where appropriate.

- **Medicaid Expenditures and Service Utilization:** This section provides data on Medicaid waiver expenditures and utilization for Medicaid waiver, non-waiver, and pharmacy services that are used by waiver participants, as well as utilization and expenditures for individuals receiving MAPC. This section also contains information about Medicaid expenditures and Medicaid services that individuals may receive while residing in a nursing facility, as well as data related to reimbursement levels and average length of stay for nursing facility residents.

Data Sources

The information in this chart book was derived from the following data sources:

- **Maryland Department of Health and Mental Hygiene (DHMH) Medicaid Management Information System (MMIS2):** This system contains data for all individuals enrolled in Maryland's Medicaid program during the relevant fiscal years, including Medicaid eligibility category and fee-for-service (FFS) claims. Hilltop warehouses and processes all MMIS2 data on a monthly basis.

- **DHMH Decision Support System (DSS):** This system provides summary reports based on MMIS2 data and functions as a resource for figures in this chart book.

- **Maryland Office of Health Care Quality, Minimum Data Set (MDS 3.0):** The MDS is a federally mandated assessment instrument that is conducted for each nursing facility resident upon admission and at least quarterly thereafter. Hilltop receives MDS 3.0 data for Maryland nursing facilities on a routine basis.

- **DHMH Long-Term Care and Waiver Services:** This includes LAH Waiver and WOA Interest Lists and waiver administrative costs data.

- **U.S. Census Bureau:** This source includes 2012 Modified Race Data, prepared by the Maryland Department of Planning, Projections and Data Analysis, State Data Center, June 2013.

Key Findings

The shift in HCBS users and expenditures continues as the proportion of HCBS users and expenditures increases.

The proportion of all LTSS users receiving HCBS increased, on average, 1% each year from FY 2009 to FY 2012. HCBS users made up 38% of all LTSS users in FY 2012, up from 34% in FY 2009 (Figure 19). Conversely, the proportion of nursing facility residents decreased 4%. A corresponding sift in the proportion of LTSS expenditures for HCBS services occurred as the proportion of LTSS HCBS expenditures increased from 20% in FY 2009 to 24% in FY 2012.

Baltimore/Metro region nears balance between institutional and community-based settings while the rest of Maryland lags.

The Baltimore/Washington Metro region served 44% of its Medicaid LTSS users in the community in FY 2012 (Figure 7). Other parts of the state had a higher reliance on institutional settings to serve the same populations (i.e., 77% in Western Maryland, 70% in Southern Maryland, and 69% on the Eastern Shore). The ratio of nursing facility residents to HCBS users varies greatly at the county level, with Washington and Frederick Counties having the highest ratio (4 to 1) of nursing facility residents to HCBS users (Figure 9). Additional analysis may be helpful in identifying the underlying drivers (i.e., rural versus urban areas, travel distance, labor shortages) responsible for the variations in service utilization and HCBS and nursing facility balance.

The majority of Medicaid nursing facility residents enter the nursing facility following an acute hospital stay.

The largest percentage (85%) of nursing facility residents entered the facility in FY 2012 following an acute hospital stay (Figure 13). An additional 6% entered from another nursing facility or swing bed and 7% entered from the community. Additional analysis should be completed to compare hospital re-admission rates by pre-admission setting and to determine if there is a correlation between the reason for the acute care stay and the likelihood of a nursing facility placement.

Transitions of nursing facility residents to the community occurred across all acuity levels.

Although two-thirds of the nursing facility residents transitioning to the community in FY 2012 had a "light" or "moderate" reimbursement level, nursing facility residents with higher levels of reimbursement were also transitioned. Of the 816 individuals transitioned, 136 had a "heavy" reimbursement level and 34 had a "heavy special" reimbursement level (Figure 15). Further analysis is needed to determine if significant differences exist in the cost to Medicaid for supporting individuals with higher reimbursement levels in the community and to determine if individuals transitioning with a higher reimbursement level are more likely to be re-admitted to a nursing facility or hospital.

Key Findings continued

Per member per month (PMPM) expenditures for nursing facility residents continue to outpace those for HCBS Users.

PMPM expenditures for HCBS users have consistently been lower than those for nursing facility residents. FY 2012 Medicaid PMPM expenditures for HCBS participants ranged from $2,040 for MAPC users to $5,887 for LAH Waiver participants, compared to $6,321 for nursing facility residents. Of the HCBS programs, LAH Waiver participants had the largest PMPM increase over time: by $1,007 PMPM since FY 2009. PMPM expenditures for the remaining HCBS programs have remained relatively stable. The variation in PMPM expenditures may be influenced by a number of factors, such as the mix of services offered and used by participants, age differences among the enrollees, and differences in Medicare coverage among the enrollees. The number of nursing facility residents has decreased 2% since FY 2009; however, PMPM expenditures for this population increased, on average, 5%. Additional research may identify and analyze the impact of selected cost drivers (i.e., payment rates, number of users, units of service used, nursing facility lengths of stay) on HBCS and nursing facility expenditure increases.

Personal and attendant care services dominate the HCBS waiver expenditures for LAH and WOA Waiver participants

LAH Waiver attendant care services and WAO personal care services accounted for the largest percentage of waiver expenditures. At $37 million in FY 2012, attendant care services for LAH Waiver participants accounted for 86% of all LAH Waiver expenditures for waiver services. Personal care for WOA participants totaled $71.2 million, or 63% of all WOA expenditures for waiver services.

Chapter 2.
Maryland Long-Term Services and Supports Users

Chapter 2. Maryland Long-Term Services and Supports Users

Medicaid is the primary payer for LTSS, financing services in the community (through HCBS waivers) and in nursing facilities. In FY 2012, nearly 14,000 Marylanders received Medicaid-paid HCBS through the three waivers and through MAPC. Over 22,000 Marylanders had at least one Medicaid-paid nursing facility stay (Figure 1). In FY 2012, nearly one-third of all MDC Waiver participants also received MAPC services while enrolled in the waiver (Figure 2). While growth was noted in each of the waivers, in the number of MAPC users, and in the number of nursing facility residents each year, the rate of growth varied. From FY 2009 to FY 2012, the annual rate of growth in the number of LAH Waiver participants was stable at 11% each year. After remaining stable from FY 2009 to FY 2011, the WOA experienced a 11% increase in the number of participants from FY 2011 to FY 2012. "MAPC only" users – MAPC users who also received medical day care services – increased 12% from FY 2009 to FY 2012, while the number of MAPC users who were also enrolled in medical day care increased nearly 31% during this same period. There was a negative annual rate of growth in the number of nursing facility residents from FY 2009 to FY 2013 (Figure 3).

Maryland Long-Term Services and Supports Users

Notable demographic finding were seen in the age, gender, and race of LTSS users. In FY 2012, the highest percentage (49%) of LAH Waiver participants were aged 50 to 64; the highest percentage (32%) of MDC Waiver participants and MAPC users (25%) were aged 75 to 84. Persons aged 85 and older made up the highest percentage of WOA (33%) participants and nursing facility residents (38%) (Figure 4).

Maryland LTSS users tend to be female. In fact, female participants outnumbered male participants by a ratio of 2 to 1 in the MDC Waiver, WOA, MAPC Program, and nursing facilities. The LAH Waiver gender distribution was equal (Figure 5).

Caucasians made up the largest percentage of nursing facility residents (46%) and WOA participants (50%). The LAH Waiver was more heavily populated by African American (55%) participants. Participants in the MDC Waiver were more equally distributed, at 27% Asian, 32% Caucasian, and 33% African American (Figure 6).

Distribution of Home and Community- Based Services Users and Nursing Facility Residents

The FY 2012 distribution of institutional and HCBS users varied both regionally and by county. At 77%, Western Maryland had the largest percentage of nursing facility residents; 23% of LTSS users in that region received HCBS. The use of LTSS services in the Baltimore/Washington metropolitan region was more equally distributed, with 56% being nursing facility residents and 44% being HCBS users (Figure 7).

The proportion of HCBS users to nursing facility residents has increased slightly each year. In FY 2012, 38% of LTSS users received HCBS, up from 34% in FY 2009. Conversely, the

percentage of LTSS users with a nursing facility stay decreased from 66% in FY 2009 to 62% in FY 2012 (Figure 8).

In FY 2012, six Maryland counties and Baltimore City had one nursing facility resident for every one person receiving services in the community. However, the ratio of nursing facility residents to HCBS users—4 to 1—was much higher in Washington and Frederick Counties (Figure 9).

LAH Waiver and WOA participants who left their respective waivers do so for a variety of reasons. In FY 2012, 42 (5%) of the LAH Waiver population were disenrolled; the largest percentage (43%) of these individuals were disenrolled due to the loss of financial, medical, or technical eligibility. Of the 4,205 WOA participants in FY 2012, 400 (10%) left the waiver. Disenrollment due to death accounted for over half of the WOA participants and one-third of LAH Waiver participants. Disenrollment due to an admission to a facility accounted for 12% and 26% of LAH Waiver and WOA participants, respectively. (Figure 10).

Marylanders wanting to participate in the LAH Waiver or WOA are placed on the Interest List. As of June 2013, the number of persons on the LAH Interest List was 3,507, a decrease of 16% from 4,197 as of June 2012. The number of persons on the WOA Interest List increased 10%, from 19,982 as of June 2012 to 21,870 as of June 2013 (Figure 11).

Maryland Medicaid Nursing Facility Residents

Consistent over the last several years, the largest percentage (85%) of nursing facility residents entered the facility from an acute care hospital setting. Seven percent entered the nursing facility from a community-based setting, such as a private home or apartment, group home, or assisted living facility (Figure 12).

Nursing facility residents can be analyzed by reimbursement level, which serves as a proxy for acuity level. In FY 2012, 42% of nursing facility residents under age 65 and 43% of residents aged 65 and older required a "moderate" reimbursement level. A moderate reimbursement level is defined as being dependent in three or four ADLs. However, compared to the older age group, those under 65 had twice the proportion requiring a "heavy special" reimbursement level. This suggests a younger population with severe medical needs and functional limitations (Figure 13).

In recent years, transitioning nursing facility residents to the community has been an important goal for Maryland. In this chart book, transitions are defined as residents who did the following: left a nursing facility for reasons other than admission to a hospital, maintained Medicaid eligibility, and began receiving either waiver services or non-waiver HCBS within 180 days. The number of transitioned Medicaid nursing facility residents grew 35% from FY 2009 to FY 2012, with 816 transitions in FY 2012 (Figure 14). Transitions were not limited to those residents with the lowest care needs as evidenced by 21% of transitioned residents requiring a "heavy" or "heavy special" level of care.

Length of Nursing Facility Stays

The vast majority of Medicaid nursing facility residents discharged in FY 2012 had a stay of less than one year. Nearly half (49%) of those discharged in less than one year had a stay of three months or less.

For those residents discharged in FY 2012, the length of nursing facility stays varied greatly by discharge type (i.e., return to the facility was not anticipated, return was anticipated, or the person died in the facility). For persons who were discharged and not expected to return to the facility, the mean length of stay was 8.6 months and the median length of stay was 2.6 months. Residents who at the time of discharge from the nursing facility were anticipated to return had a mean length of stay of 12.4 months and a median stay of 3.5 months. Lastly, persons who died in the facility had a mean length of stay of 21.2 months and a median length of stay of 8.0 months (Figure 15).

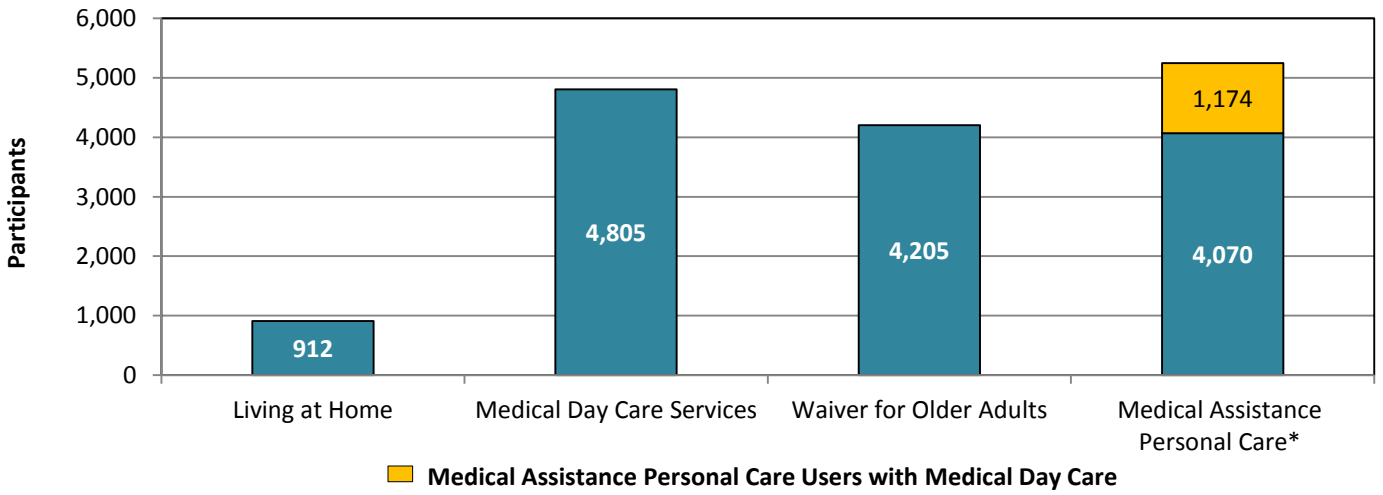
When examined across age groups, mean lengths of stay at discharge for residents under age 65 ranged from less than 1 month to over 15.5 years, with a mean length of stay of 7.6 months and a median of 1.9 months. Lengths of stay for discharged residents aged 65 and older ranged from less than 1 month to 25.4 years, with a mean length of stay of 17.5 months and a median of 5.7 months (Figure 16).

Figure 1. Number of Long-Term Services and Supports Users, FY 2009 – FY 2012

	FY 09	FY 10	FY 11	FY 12
Living at Home	666	738	820	912
Medical Day Care Services	4,086	4,320	4,621	4,805
Older Adults	3,627	3,717	3,807	4,205
Medical Assistance Personal Care*	4,529	4,819	5,147	5,244
Medical Assistance Personal Care Only	3,630	3,792	4,018	4,070
Medical Assistance Personal Care with Medical Day Care	899	1,027	1,129	1,174
Total Home and Community-Based Services Users	**12,009**	**12,567**	**13,266**	**13,992**
Nursing Facility Users	22,903	22,816	22,419	22,365

Source: DSS

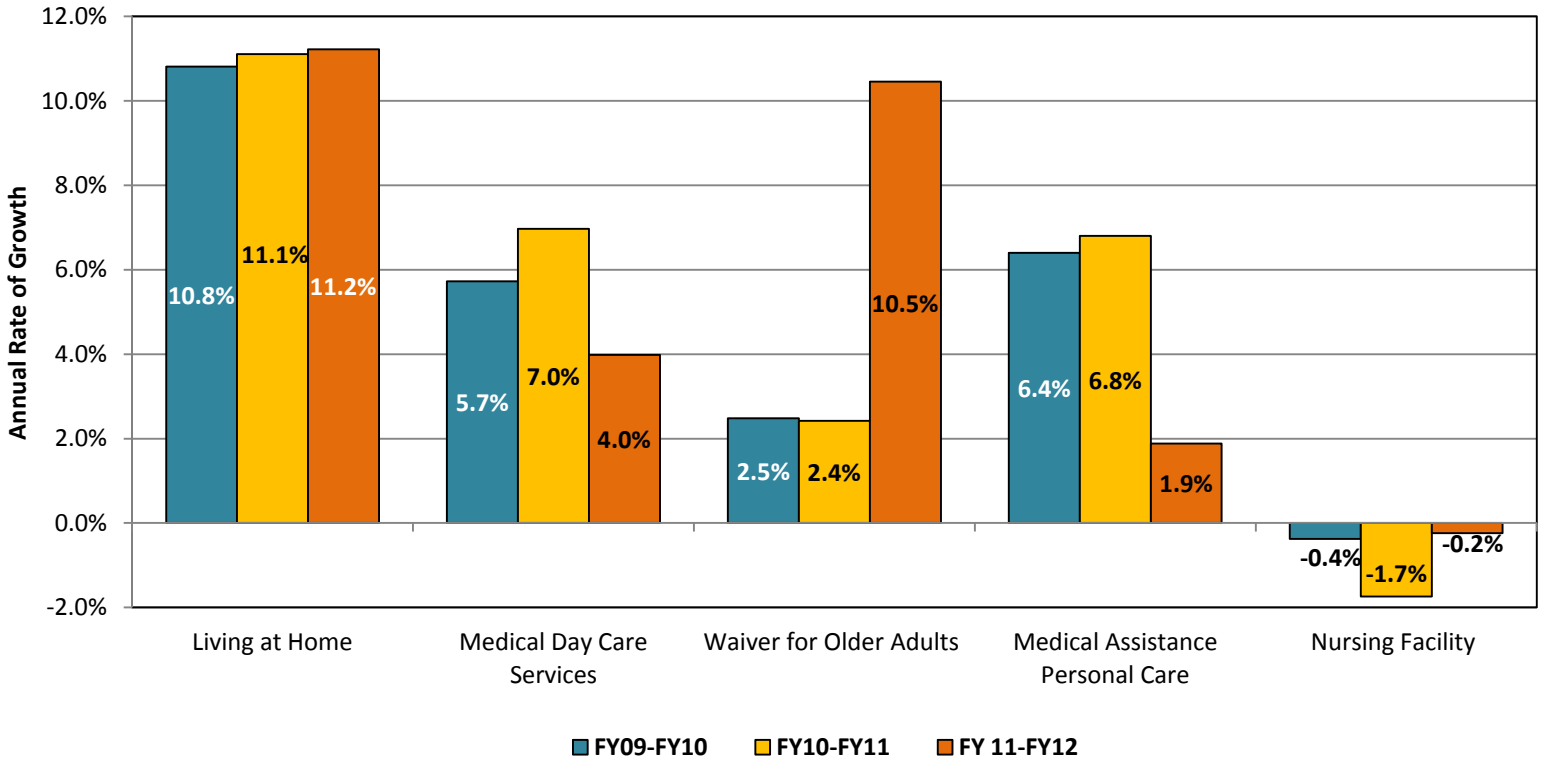
Figure 2. Home and Community-Based Services Users, FY 2012



* In total, 5,244 individuals received MAPC services; 1,174 of these individuals received MAPC services while enrolled in the Medical Day Care Services Waiver.

Sources: DSS and MMIS`

Figure 3. Annual Rate of Growth in the Number of Long-Term Services and Supports Users, FY 2009 – FY 2012



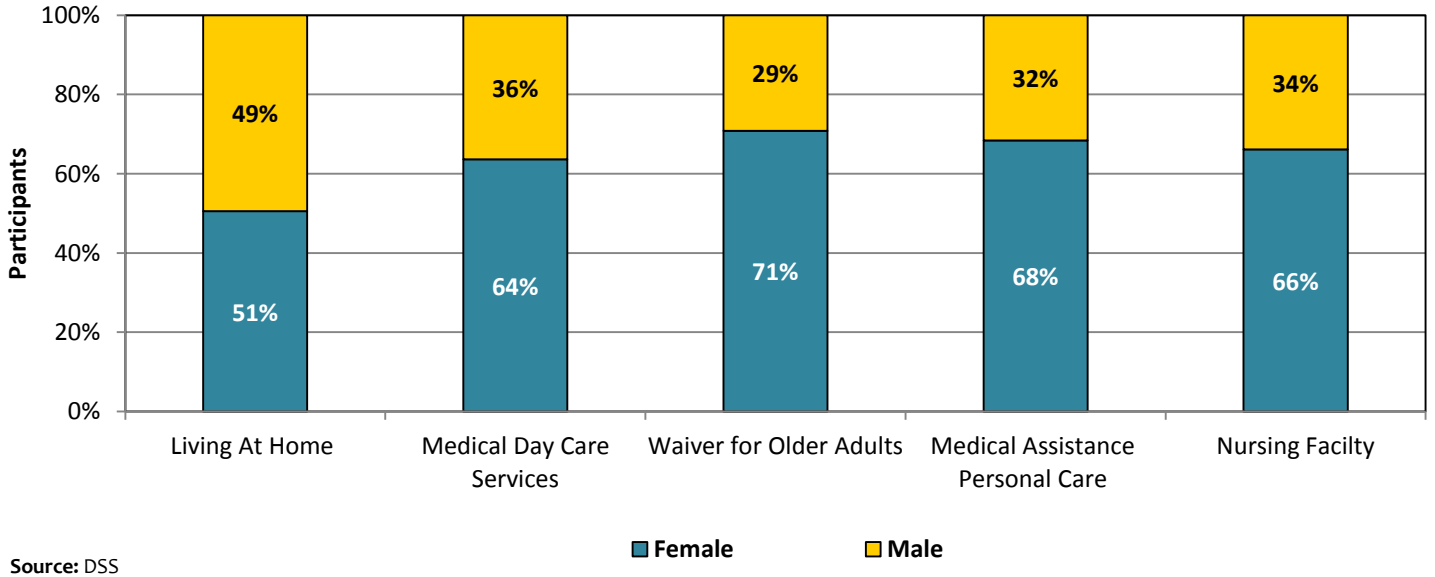
Source: DSS

Figure 4. Medicaid Waiver Participants and Nursing Facility Residents, by Age Group, FY 2012

	Living at Home*	Medical Day Care Services	Waiver for Older Adults	Medical Assistance Personal Care	Nursing Facility
0-21	1%	0%	0%	3%	0%
22-49	47%	15%	0%	17%	5%
50-64	49%	18%	16%	22%	16%
65-74	3%	18%	22%	17%	16%
75-84	0%	32%	29%	25%	25%
85+	0%	17%	33%	16%	38%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

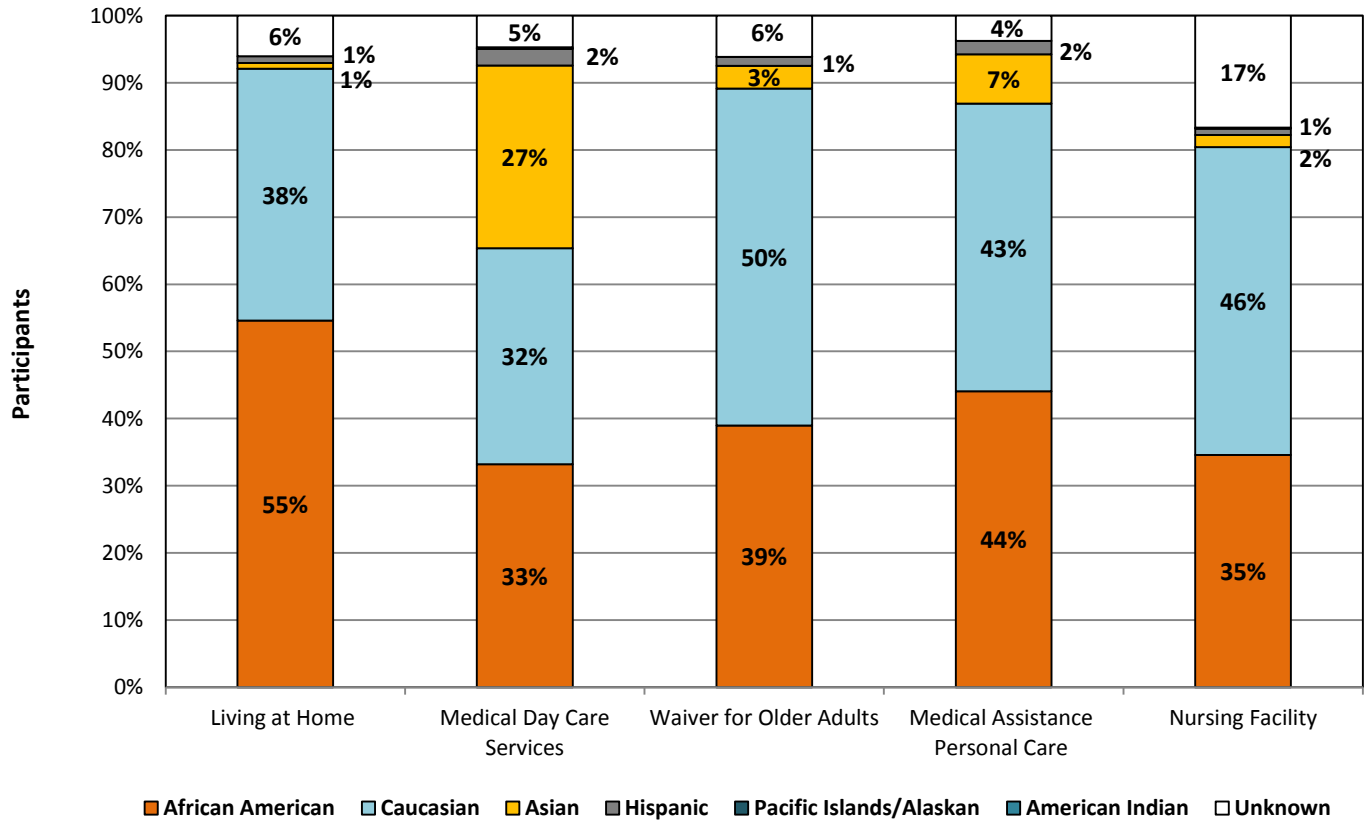
* Participation in the LAH Waiver is limited to persons under age 65 at the time of enrollment.

Figure 5. Medicaid Waiver Participants and Nursing Facility Residents, by Gender, FY 2012



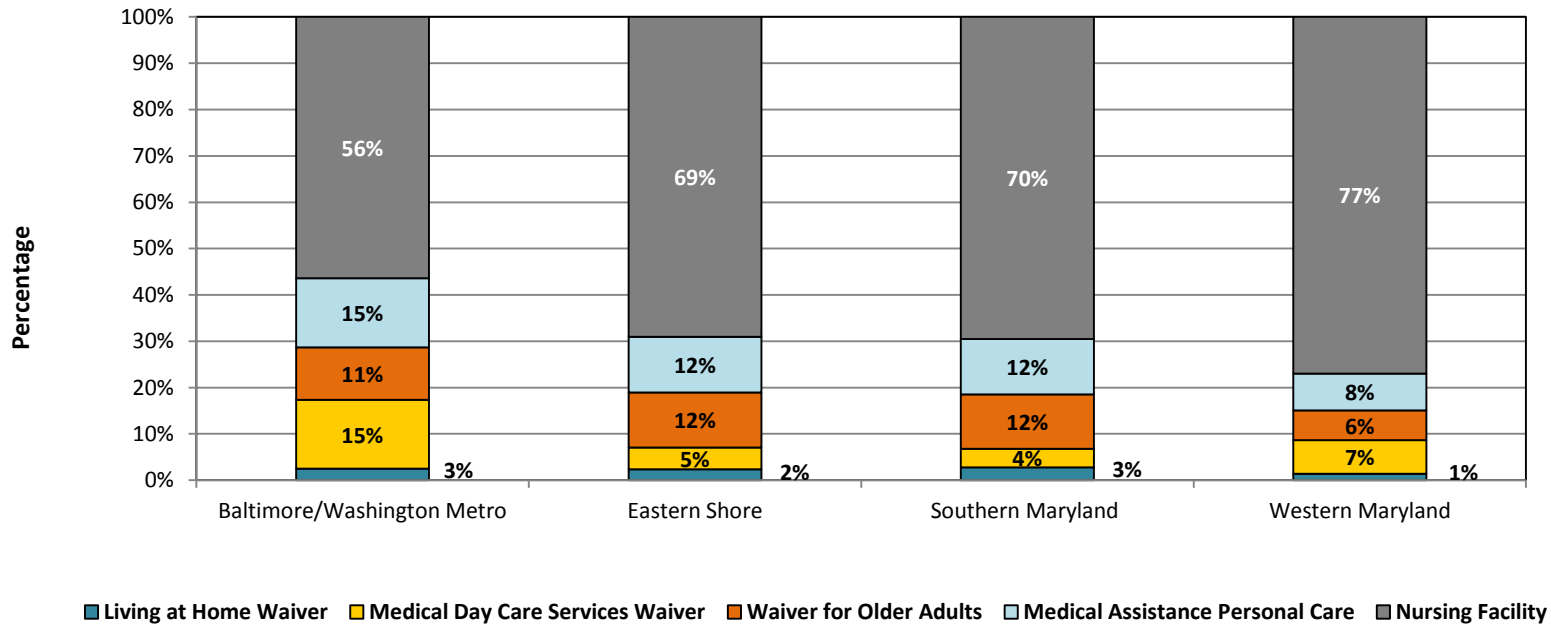
Source: DSS

Figure 6. Medicaid Waiver Participants and Nursing Facility Residents, by Race, FY 2012



Source: DSS

Figure 7. Number of Medicaid Waiver Participants, Medical Assistance Personal Care Recipients, and Nursing Facility Residents, by Region, FY 2012



Regions:

Baltimore/Washington Metro: Anne Arundel County, Baltimore County, Baltimore City, Carroll County, Harford County, Howard County and Montgomery County, Prince George's County, Frederick County.

Eastern Shore: Caroline County, Cecil County, Dorchester County, Kent County, Queen Anne's County, Somerset County, Talbot County, Wicomico County, Worcester County.

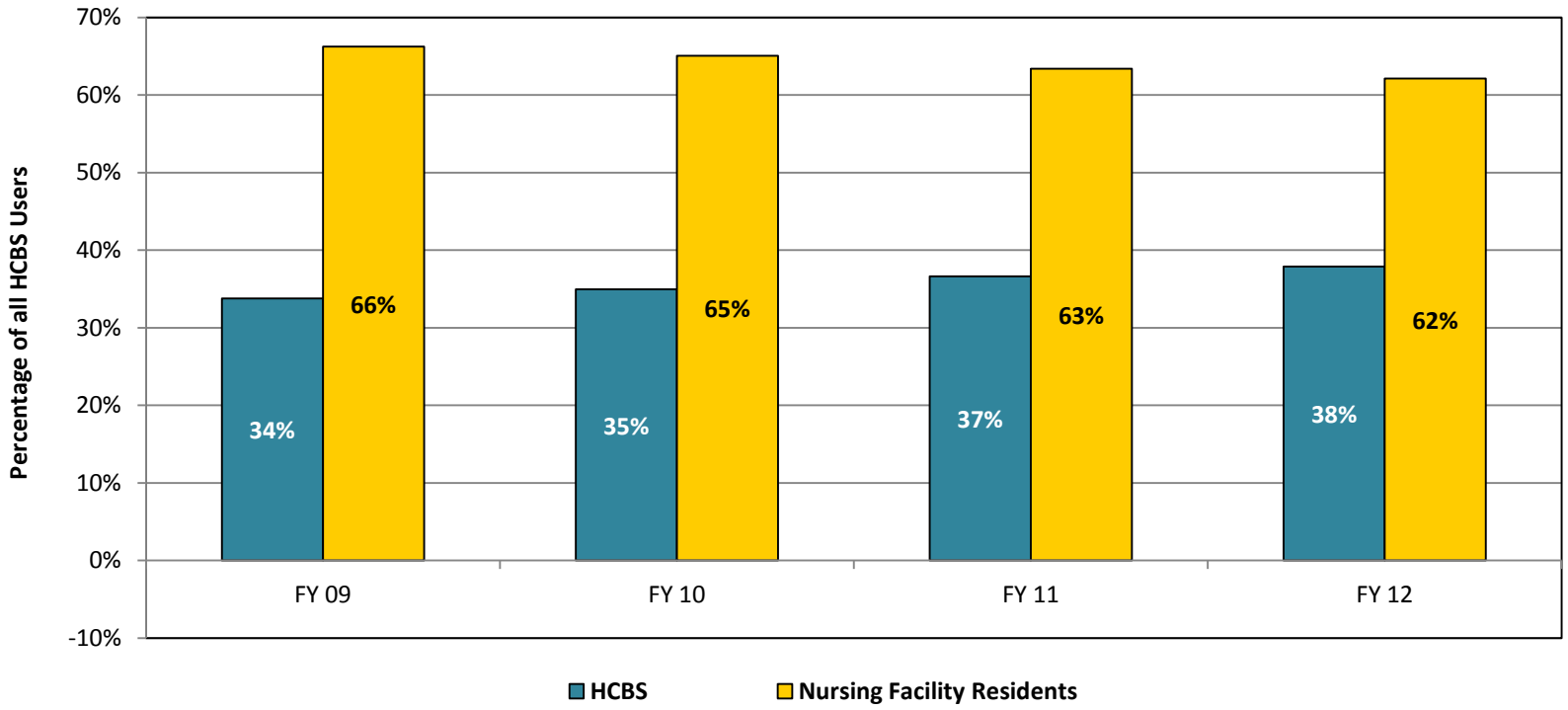
Southern Maryland: Charles County, Calvert County, St. Mary's County.

Western Maryland: Allegany County, Garrett County, Washington County.

Note: Region was not available for all waiver participants and nursing facility residents. It is possible that a nursing facility resident may have transitioned to a waiver at some point or that a waiver or MAPC user may have had a nursing facility stay during the fiscal year.

Source: MMIS2

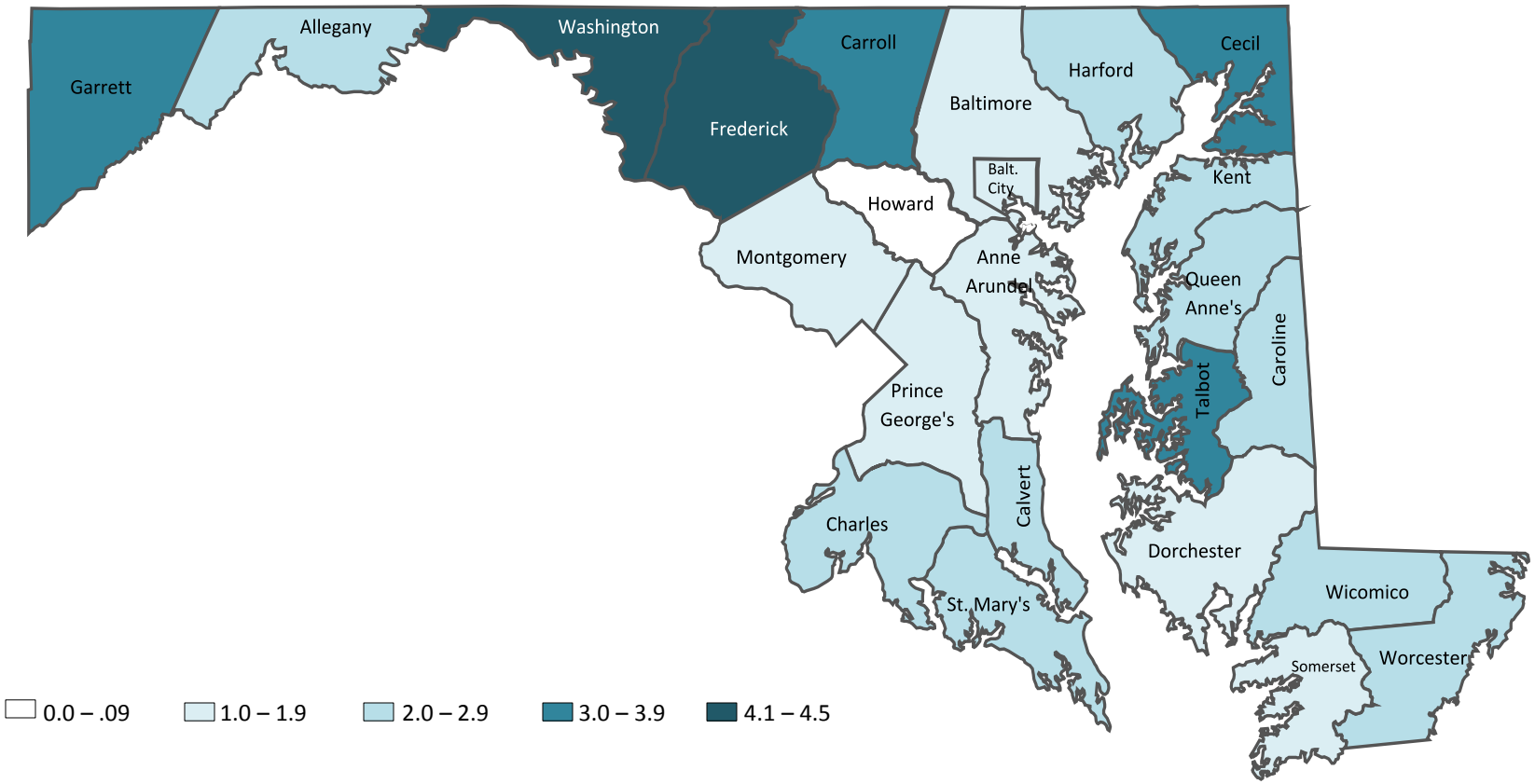
Figure 8. Home and Community-Based Services Users and Nursing Facility Residents as a Proportion of All LTSS Users, FY 2009 – FY 2012



Note: HCBS users include LAH, WOA, and MDC Waiver participants, as well as MAPC users.

Source: MMIS

Figure 9. Ratio of Nursing Facility Residents to Waiver Participants and Medical Assistance Personal Care Recipients,* by County, FY 2012

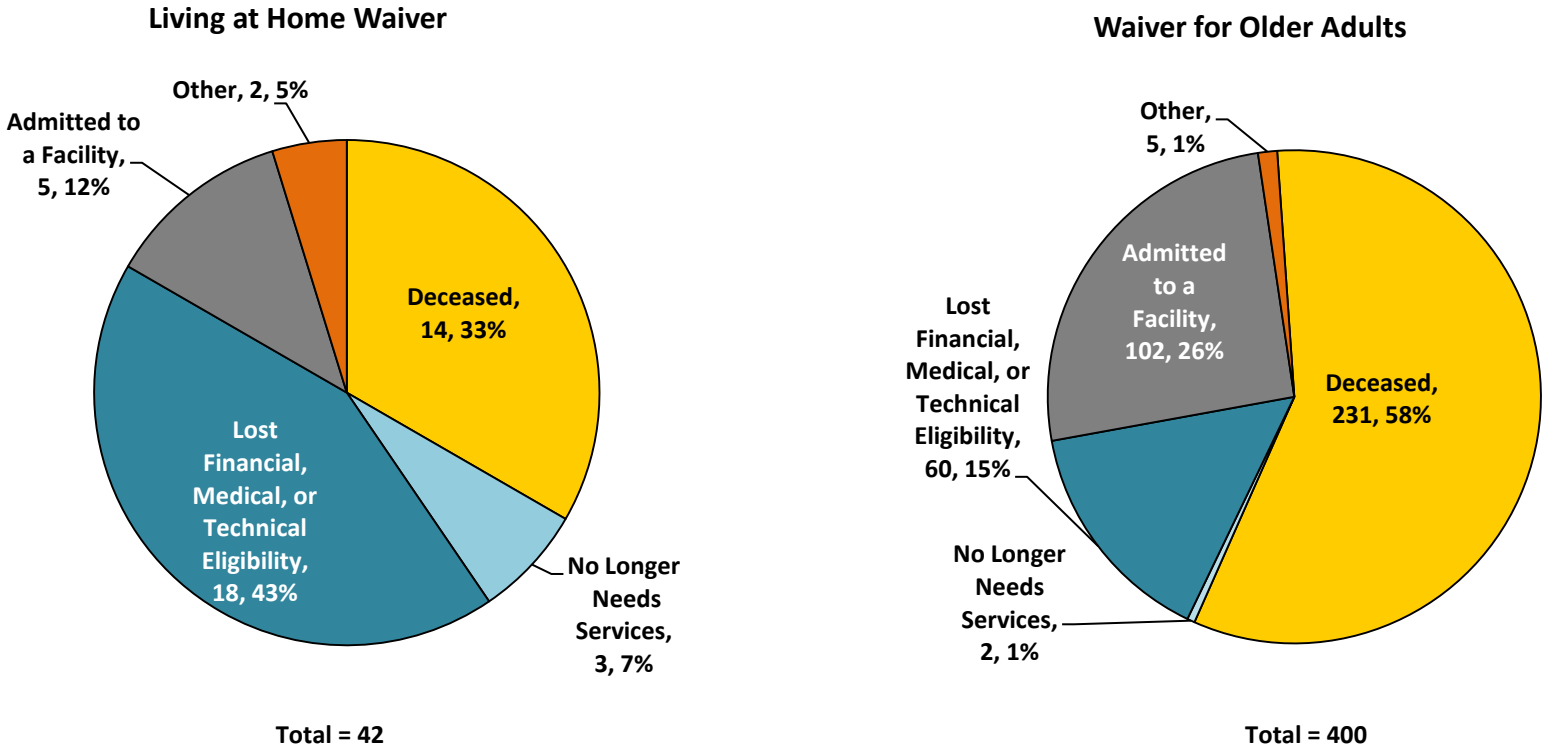


***** County was not available for all waiver participants and nursing facility residents.

Note: Census Bureau and MMIS nursing facility residence counts are based on the location of the nursing facility.

Sources: DSS and U.S. Census Bureau

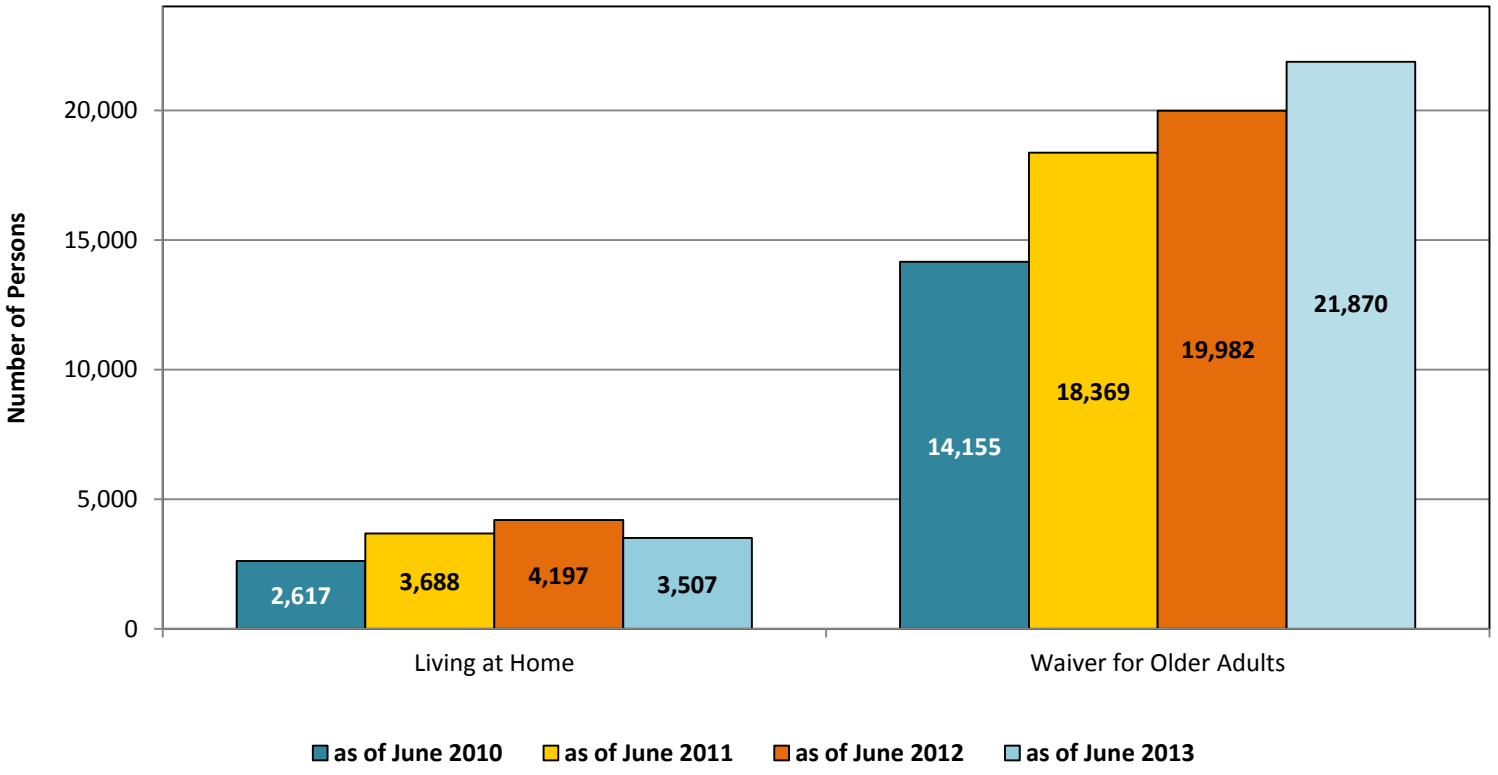
Figure 10. Reason for Leaving the Living at Home Waiver and Waiver for Older Adults, FY 2012



Note: Waiver participants leaving the waivers in each of the fiscal years were identified by examining participants' Medicaid waiver eligibility spans, which run from the beginning date of waiver eligibility to the last date of waiver eligibility. For participants with more than one waiver eligibility span, the last eligibility span was used. Waiver participants whose last eligibility end date occurred during the given fiscal year are represented in this chart. Each participant was categorized by reason for disenrollment. Common reasons for loss of technical eligibility include age and/or change in state and/or county of residence.

Source: MMIS2

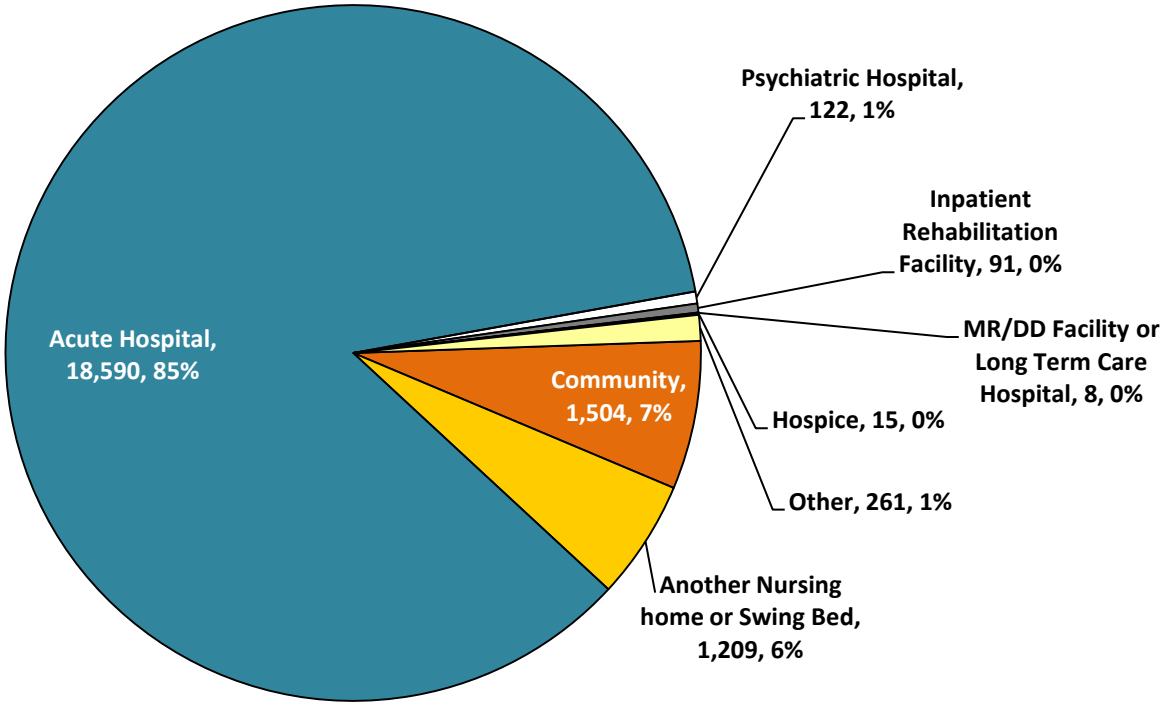
Figure 11. Number of Persons on the Living at Home Waiver and Waiver for Older Adults Interest Lists



Note: The number of Living at Home Waiver slots increased from 850 in FY2011 to 944 in FY 2012.

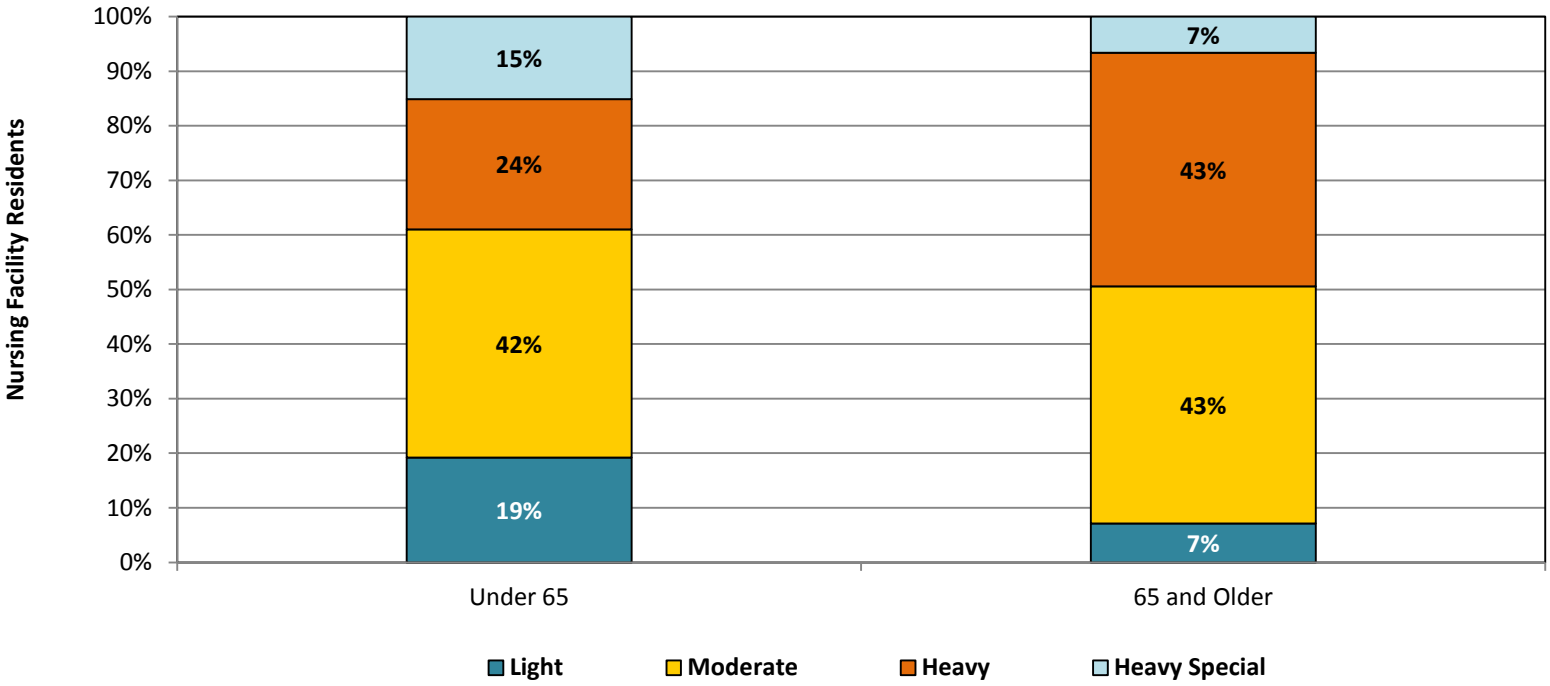
Source: DHMH Long-Term Care and Waiver Services

Figure 12. Pre-Admission Setting for all Medicaid Nursing Facility Residents, FY 2012



Source: MDS 3.0, Item A1800. Entered From.

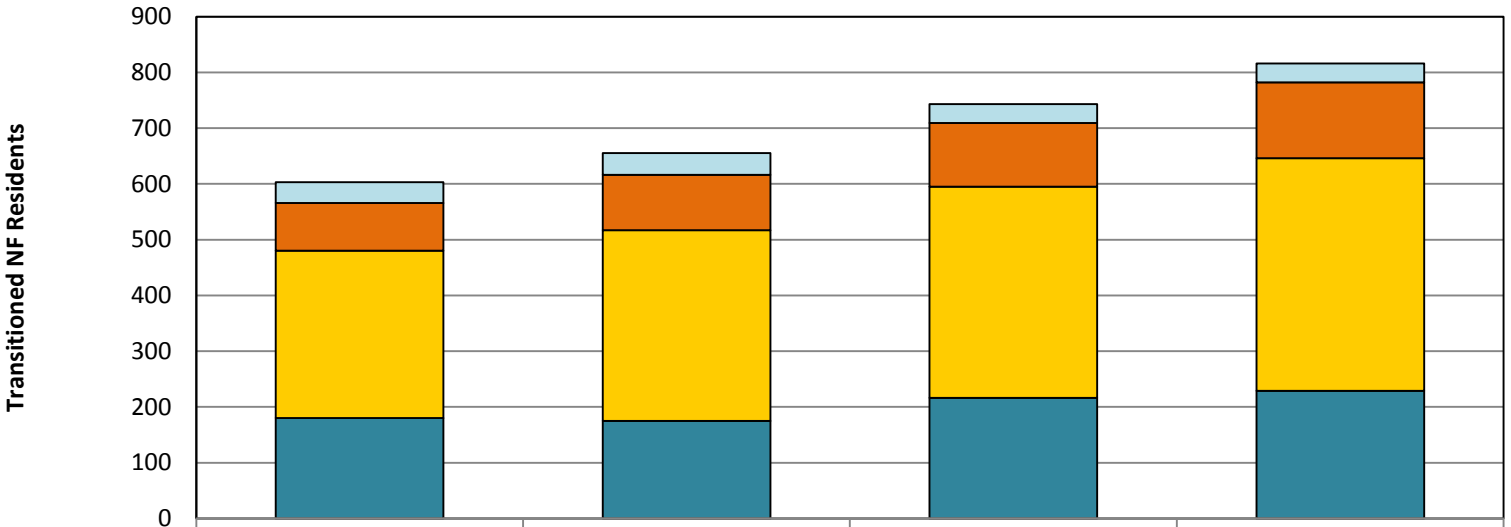
Figure 13. Medicaid Nursing Facility Residents, by Age Group and Reimbursement Level, FY 2012



Note: The total number of nursing facility residents with a reimbursement level designation in FY 2012 was 21,793. Reimbursement levels are defined as follows: Light –Dependent in 0, 1, or 2 ADLs ; Moderate – Dependent in 3 or 4 ADLs; Heavy – Dependent in all 5 ADLs; Heavy Special – Dependent in all 5 ADLs and requires and receives one or more of the following: Communicable Disease Care, Central Intravenous Line, Peripheral Intravenous Care, Decubitus Ulcer Care, Tube Feeding, Ventilator Care, or Support Surface A or B during the majority of the month.

Source: MMIS2

Figure 14. Transitioned Medicaid Nursing Facility Residents, by Reimbursement Level, FY 2009 – FY 2012



	FY 09	FY 10	FY 11	FY 12
Heavy Special	37	39	34	34
Heavy	86	99	114	136
Moderate	300	342	379	417
Light	180	175	216	229

Note: Transitioned Medicaid nursing facility residents are defined as individuals who 1) had at least one Medicaid-paid nursing facility day in a given fiscal year, 2) subsequently moved out of the facility without being admitted to a hospital, and 3) within 180 days, began receiving either waiver services or non-waiver HCBS, such as personal care or home health aide services.

Source: MMIS2

Figure 15. Length of Stay at Discharge for Medicaid Nursing Facility Residents in Years, by Discharge Type, FY 2012

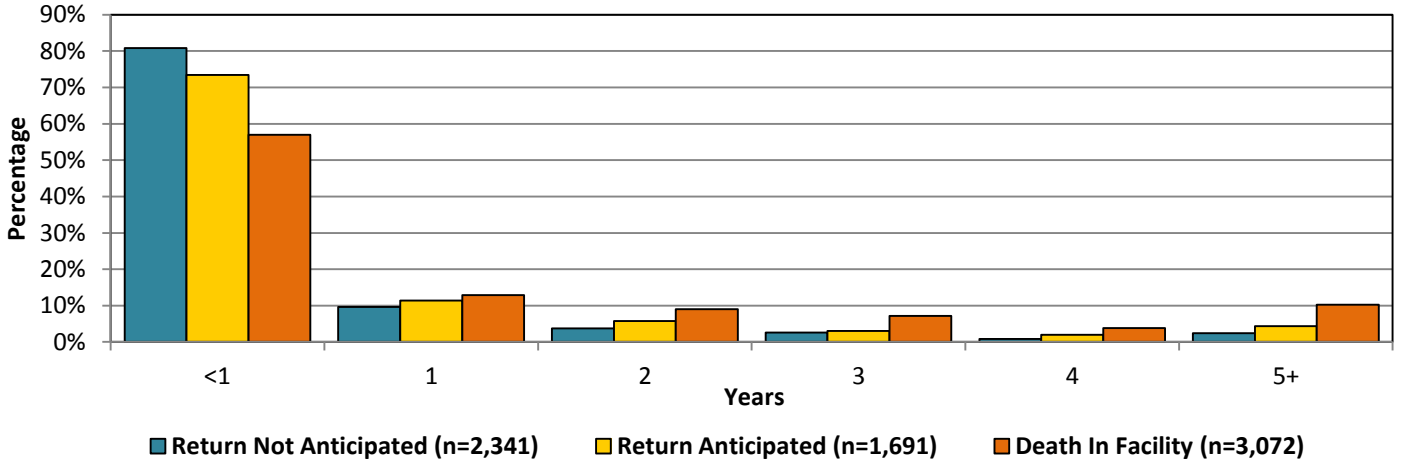
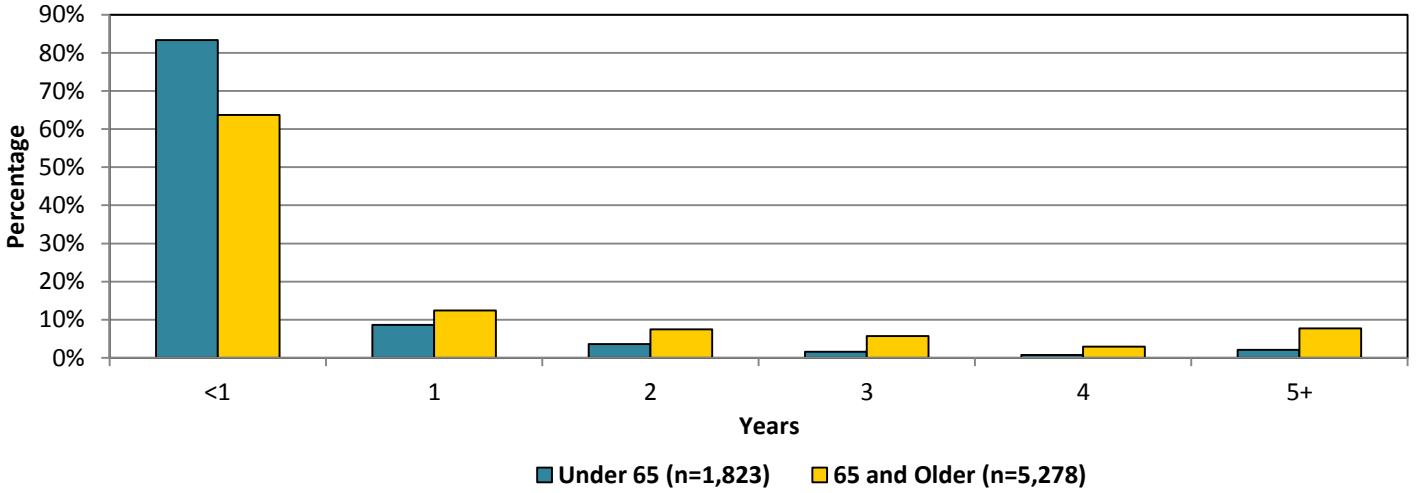


Figure 16. Length of Stay at Discharge for Medicaid Nursing Facility Residents in Years, by Age Group, FY 2012



Note: These charts show the length of the last nursing facility stay for individuals who had at least one Medicaid-paid nursing facility day and an MDS 3.0 discharge or death record in the fiscal year. These charts include all days the individual resided in the facility, regardless of payer. Length of stay is calculated as the reference date of discharge minus the admission date plus one.

Source: MDS 3.0

Chapter 3.
Medicaid Expenditures and Service Utilization

Chapter 3. Medicaid Expenditures and Service Utilization

Total Medicaid Long-Term Services and Supports Expenditures

Total Medicaid expenditures for waiver participants and MAPC recipients continue to increase annually. In FY 2012, Medicaid expenditures totaled $137.3 million for the WOA, $111.6 million for the MDC Waiver, and $57.2 million for the LAH Waiver. Medicaid expenditures for all MAPC users totaled $111.9 million (Figure 17).

FY 2012 Medicaid expenditures for HCBS users totaled $379.1 million, while Medicaid expenditures for nursing facility residents totaled $1.19 billion during the same period (Figure 18). However, the balance between institutional expenditures and HCBS expenditures continues to shift. Of the $1.57 billon LTSS Medicaid expenditures in FY 2012, nursing facility expenditures accounted for 75%, down from 79% in FY 2009. Meanwhile, FY 2012 HCBS expenditures accounted for 25% of the total; up from 21% in FY 2009 (Figure 19).

At $113.1 million, waiver expenditures for WOA participants composed 82% of total FY 2012 Medicaid expenditures for this population. Waiver expenditures made up 75% ($43.0 million) of the total Medicaid expenditures for LAH Waiver participants. Waiver and non-waiver expenditures for MDC Waiver participants were more equally distributed, with $63.5 million (57%) of the total expenditures being used to provide medical day care services (Figure 20).

Total Medicaid expenditures for LAH Waiver participants increased 56%, from $33.6 million in FY 2009 to $57.2 million in FY 2012. However, the growth rate has slowed considerably, falling from an increase of 29% from FY 2009 to FY 2010 to an increase of 12% from FY 2011 to FY 2012. Expenditures for nursing facility residents grew slightly, at a rate of 3% from FY 2011 to FY 2012 (Figure 21).

The number of HCBS users grew at a rate of 6% from FY 2011 to FY 2012; however, the growth rate of total Medicaid expenditures for this population decreased slightly, from 10% in FY 2011 to 8% in FY 2012 (Figure 22). Although there was zero or negative growth in the number of nursing facility residents from FY 2009 to FY 2012, Medicaid expenditures of this population increased 3% from FY 2011 to FY 2012 (Figure 23).

PMPM Expenditures

Among the factors influencing differences in the PMPM expenditures were the mix of services used by waiver recipients, age differences among enrollees, and differences in Medicare coverage among enrollees. At $5,887, LAH Waiver participants had the highest PMPM expenditures of the three waivers in FY 2012. In fact, these PMPM expenditures were 54% higher than the $3,364 WOA PMPM expenditures and 89% higher than the $2,349 MDC Waiver PMPM expenditures. FY 2012 PMPM expenditures were $6,321 for nursing facility residents (Figure 24).

From FY 2009 to FY 2012, PMPM expenditures increased by $1,007 for LAH Waiver participants, $112 for WOA participants, and $332 for nursing facility residents. The PMPM expenditures for all MAPC users decreased $226, and the PMPM for MDC Waiver participants increased by only $1 during this time (Figure 25).

Distribution of Total Medicaid Expenditures

The distribution of waiver and non-waiver services varied by program. In FY 2012, 75% and 82% of total Medicaid expenditures for LAH Waiver and WOA participants were spent for waiver services, respectively. For MDC Waiver participants, 57% of total Medicaid expenditures went toward providing medical day care services, which may be attributable to the fact that this is a single-service waiver (Figures 26-28). For MAPC users, 27% of the total Medicaid expenditures were spent on personal care services, 35% on home health services, and 14% on MCO capitation payments (Figure 29).

Waiver and Non-Waiver Service Utilization by Service

Personal Care Services

Medicaid expenditures for waiver-based attendant care services and personal care services for LAH Waiver and WOA participants totaled $108 million. Agency-provided attendant care services were used by 80% (730) of LAH Waiver participants at a cost of $26.9 million. WOA participants were more likely to use agency-provided personal care aides without medication services—with 40% (1,701) of the participants receiving this service at a cost of $40.6 million—than agency-based services with medication or consumer-based personal care services. MAPC services were provided to 5,244 individuals at a cost of $30.6 million. Agency-based nursing supervision was widely used by LAH Waiver participants, with 89% of the participants receiving this service at a cost of $0.5 million. Over half (58%) of the WOA participants received this service at a cost of $2.1 million (Figure 30).

Environmental Assistance Services

FY 2012 Medicaid expenditures for environmental assistance services—such as environmental assessments and the installation and monitoring of PERS, assistive devices, and technology—for LAH Waiver and WOA participants totaled $2.6 million, which is similar to FY 2011 spending levels. Of the $2.6 million, $2.0 million (77%) was spent on WOA participants with assistive devices. The maintenance and monitoring of PERS was the most widely used service. Environment assistance services for LAH Waiver participants totaled $0.6 million, with PERS monitoring being the most widely used service (Figure 31).

Medical Day Care and Senior Center Plus Services

In FY 2012, Medicaid expenditures for medical day care services totaled $77.9 million for LAH Waiver participants, WOA participants, and MDC Waiver participants. MDC Waiver participants composed $63.4 million (82%) of medical day care

expenditures, WOA participants made up $13.6 million (17%), and LAH Waiver participants made up $0.8 million (1%).

PMPM expenditures for medical day care services ranged from $1,408 for MDC Waiver participants to $1,028 for LAH Waiver participants.

FY 2012 senior center plus services expenditures totaled nearly $0.2 million for the 57 WOA participants receiving this service (Figure 32).

Nutritional Services

In FY 2012, home-delivered meals were provided to 1,235 WOA and LAH Waiver participants, at a total cost of $2.3 million. This service was more widely used by LAH Waiver participants—with over half receiving at least one home-delivered meal in FY 2012—than by WOA participants—with less than 20% receiving a home-delivered meal. Dietitian/ nutritionist services were used by eight WOA participants in FY 2012, at a total cost of $844. This service was not utilized by LAH Waiver participants during this period (Figure 33).

Respite Care Services

In FY 2012, respite care services for WOA participants totaled $0.5 million. Used by 480 WOA participants, agency-provided respite care was the most frequently used of the offered respite care services (Figure 34).

Other Support Services

Case management services were widely used by both the LAH Waiver and WOA participants. Nearly all (98%) of the LAH Waiver participants received ongoing case management services, at a cost of $3.4 million; 89% of WOA participants received ongoing case management services, at a cost of $0.3 million (Figure 35).

Over 6,000 LAH (79), WOA (1,263), and MDC (4,675) Waiver participants received medical day care services in FY 2012, at a total cost of $77.8 million (Figure 36).

Assisted Living Services

Medicaid expenditures for WOA participants receiving Assisted Living Level 2 and Assisted Living Level 3 services totaled $41.2 million in FY 2012, of which $30.9 million was spent on waiver services. FY 2012 average Medicaid expenditures for Assisted Living Level 2 and Assisted Living Level 3 users were $16,595 and $25,962 per person, respectively; compared to $33,719 for participants not receiving assisted living services (Figure 37).

The most frequently used assisted living service—Assisted Living Level 3 with no medical day care—was used by 1,322 WOA participants, at a total cost of $17.0 million. With 110 users in FY 2012, Assisted Living Level 2 with medical day care was the least used of the available assisted living services (Figure 38).

Non-Waiver Services

Differences in coverage and waiver design contribute to variation in the distribution of non-waiver services across the three waivers. Similarly, costs are distributed differently as some participants have Medicare coverage and some of their services are paid by Medicare, while others do not have this coverage. As a result, the non-waiver service costs are not comparable. However, there were a few noteworthy findings. At $12.5 million, personal care services were the most costly non-waiver service used by MDC Waiver participants. Among the WOA population, durable medical supplies and equipment was the most costly non-waiver service at $6.4 million, followed by Medicare cost share payments at $6.1 million. The most costly of the non-waiver services was capitation payments for LAH Waiver participants, which totaled $5.4 million (Figure 39).

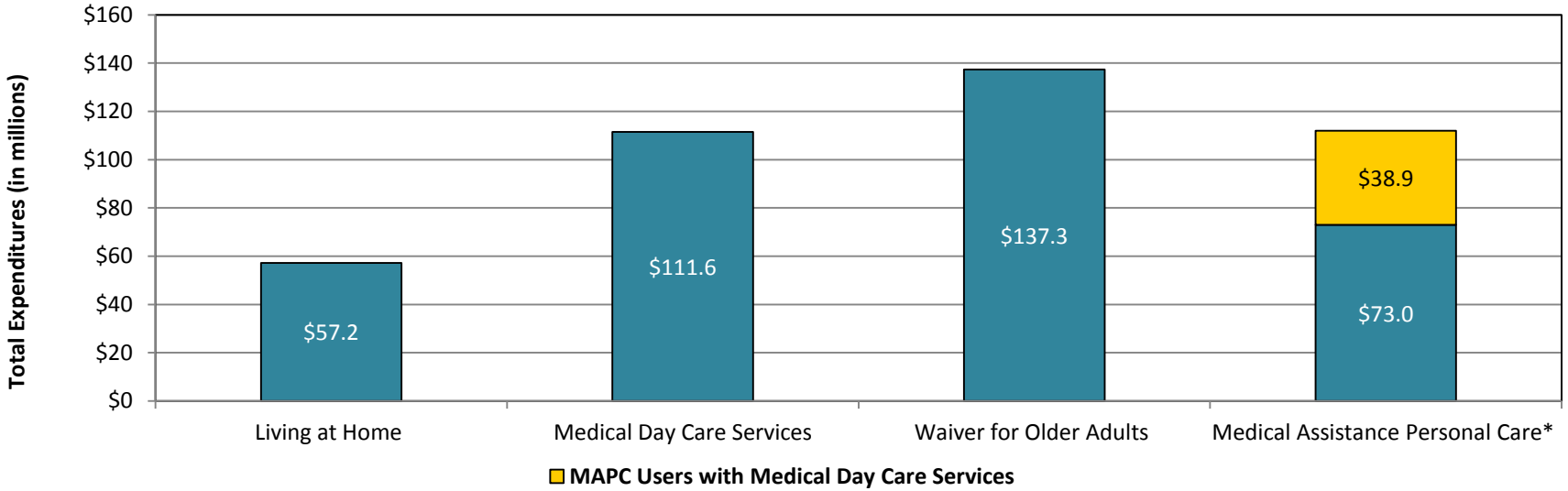
Medicaid Nursing Facility Expenditures

Medicaid expenditures for nursing facility residents totaled $1.19 billion. The distribution of total Medicaid expenditures between nursing facility-related expenditures and other Medicaid expenditures incurred during a nursing facility stay varied greatly by age group. Figure 40 shows that 78% ($856 million) of total Medicaid expenditures for nursing facility residents aged 65 and older was spent on nursing facility-related expenditures. For nursing facility residents under age 65, $248 million of the total Medicaid expenditures for nursing facility residents in this age group were spent on nursing facility-related expenditures.

Figure 41 displays the distribution of Medicaid-paid non-nursing facility expenditures by age group. Combined crossover payments, which are co-payments to Medicare paid by Medicaid, make up more than half of the other Medicaid service expenditures for the 65 and older age group. Inpatient and pharmacy services are the two largest categories (41% and 23%, respectively) of other Medicaid services for the under 65 age group.

Overall, total PMPM costs increased 2.6% from FY 2011 to FY 2012. Nursing facility expenditures are likely the cause of this increase as "other Medicaid service" PMPMs decreased across both age groups. When analyzed by age group, there was a 4.4% increase in PMPM expenditures for the 65 and older age group and a 2.5% increase in PMPM expenditures for the under 65 age group (Figure 42).

Figure 17. Total Medicaid Expenditures for Home and Community-Based Services Recipients, FY 2012



* Total Medicaid expenditures for persons receiving MAPC services while enrolled in the MDC Waiver are also included in the MDC Waiver expenditures.

Source: DSS

Figure 18. Total Medicaid Expenditures for Home and Community-Based Services Recipients and Nursing Facility Residents, FY 2009 – FY 2012

	FY 09	FY 10	FY 11	FY 12
Living at Home	$33,625,276	$43,459,472	$51,133,254	$57,217,863
Medical Day Care Services	$89,807,030	$98,296,106	$107,287,125	$111,556,528
Waiver for Older Adults	$116,293,679	$123,081,921	$127,531,955	$137,339,165
Medical Assistance Personal Care*	$85,204,610	$91,341,537	$105,625,521	$111,941,352
Medical Assistance Personal Care Only	$55,613,262	$59,079,805	$68,928,423	$73,021,366
Medical Assistance Personal Care with Medical Day Care	$29,591,347	$32,261,731	$36,697,098	$38,919,986
Total Home and Community-Based Services Expenditures	$324,930,595	$356,179,036	$391,577,855	$418,054,908
Nursing Facility	$1,158,265,306	$1,133,612,668	$1,158,502,847	$1,188,301,065

* Total Medicaid expenditures for persons receiving MAPC services while enrolled in the MDC Waiver are also included in the MDC Waiver expenditures.

Source: DSS

Figure 19. Proportion of Nursing Facility and Home and Community-Based Services Users and Expenditures, FY 2009 and FY 2012

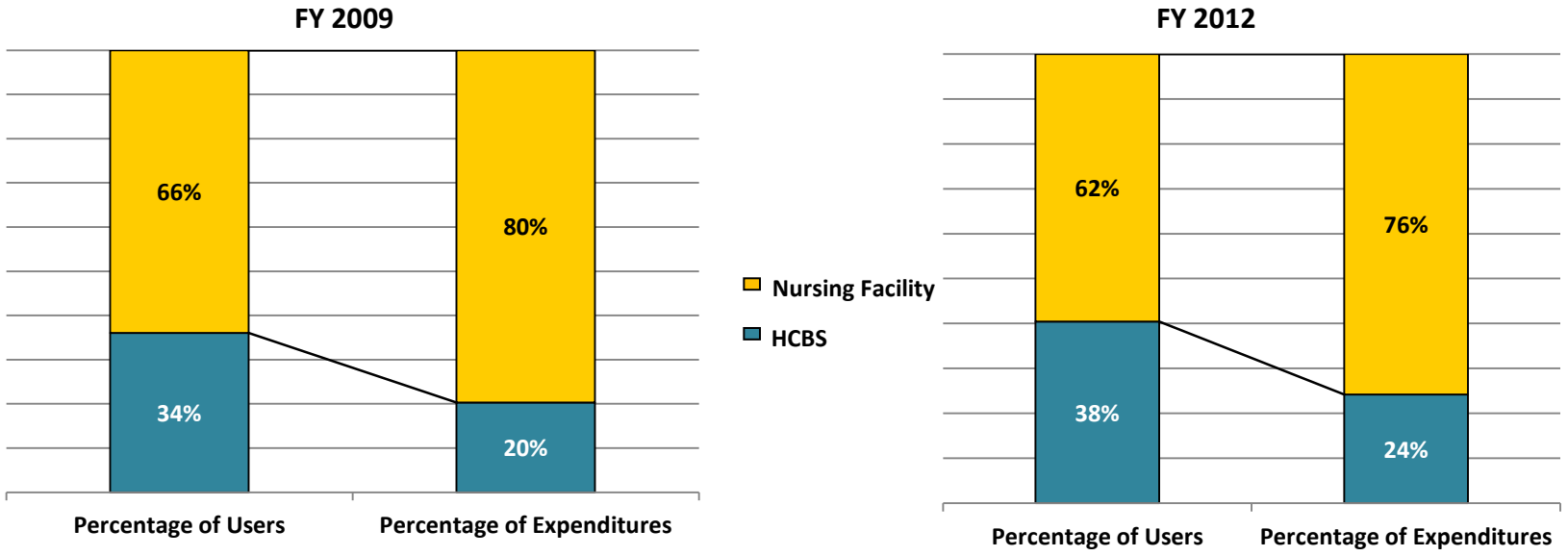
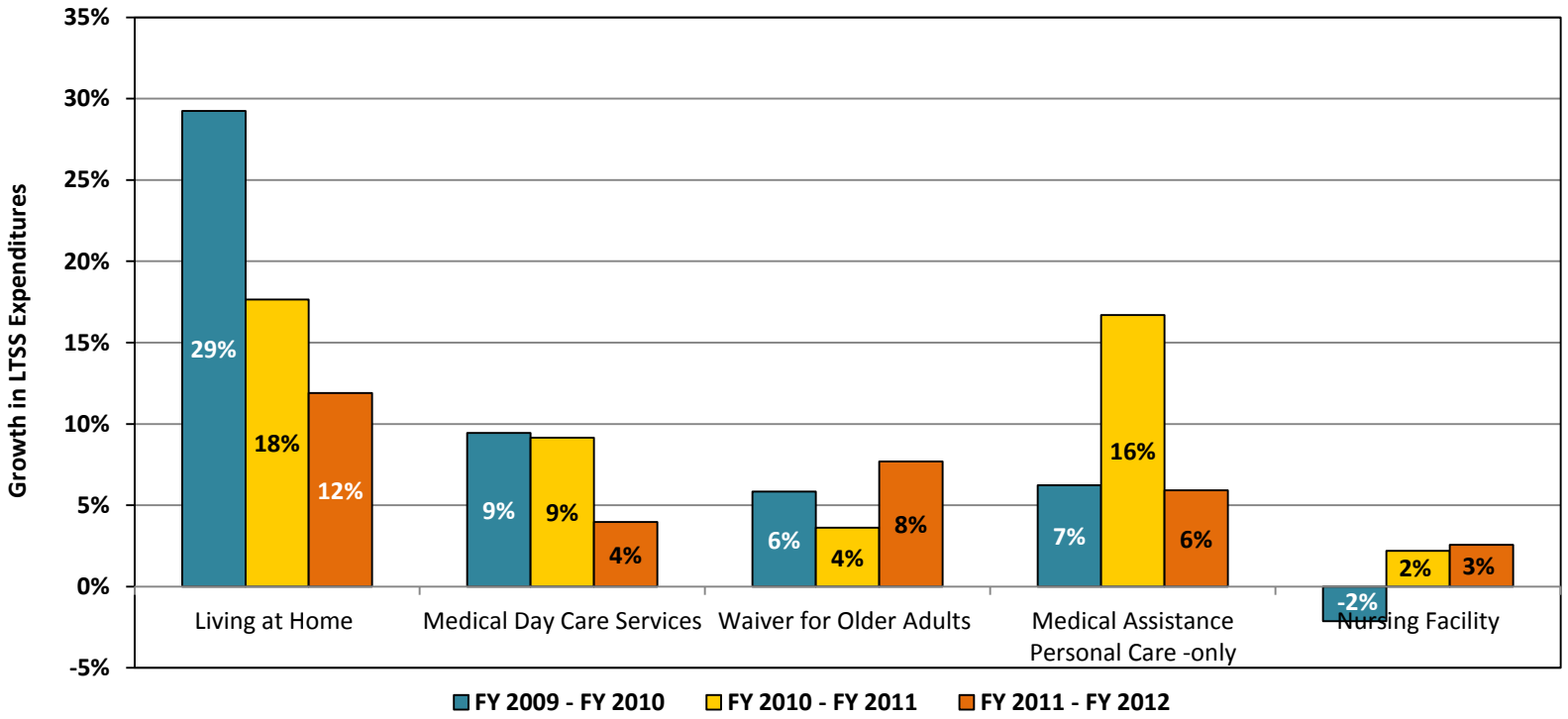


Figure 20. Distribution of Total Medicaid Expenditures for Home and Community-Based Waiver Recipients, FY 2012

	Total Medicaid Expenditures	Waiver Expenditures	Waiver Expenditures as a Percentage of Total Expenditures	Non-Waiver Expenditures	Non-Waiver Expenditures as a Percentage of Total Expenditures
Living at Home Waiver	$57,217,863	$43,028,529	75%	$14,189,272	25%
Waiver for Older Adults	$137,339,165	$113,009,462	82%	$24,329,703	18%
Medical Day Care Services Waiver	$111,556,528	$63,452,399	57%	$48,104,129	43%

Source: DSS

Figure 21. Growth Rate of Total Medicaid Expenditures* for Long-Term Services and Supports, FY 2009 – FY 2012



*Total Medicaid expenditures for waiver participants (including Money Follows the Person participants) include waiver, non-waiver, and pharmacy expenditures but do not include waiver administrative costs.

Source: DSS

Figure 22. Growth Rate in Total Medicaid Expenditures for Home and Community-Based Services Recipients, FY 2009 – FY 2012

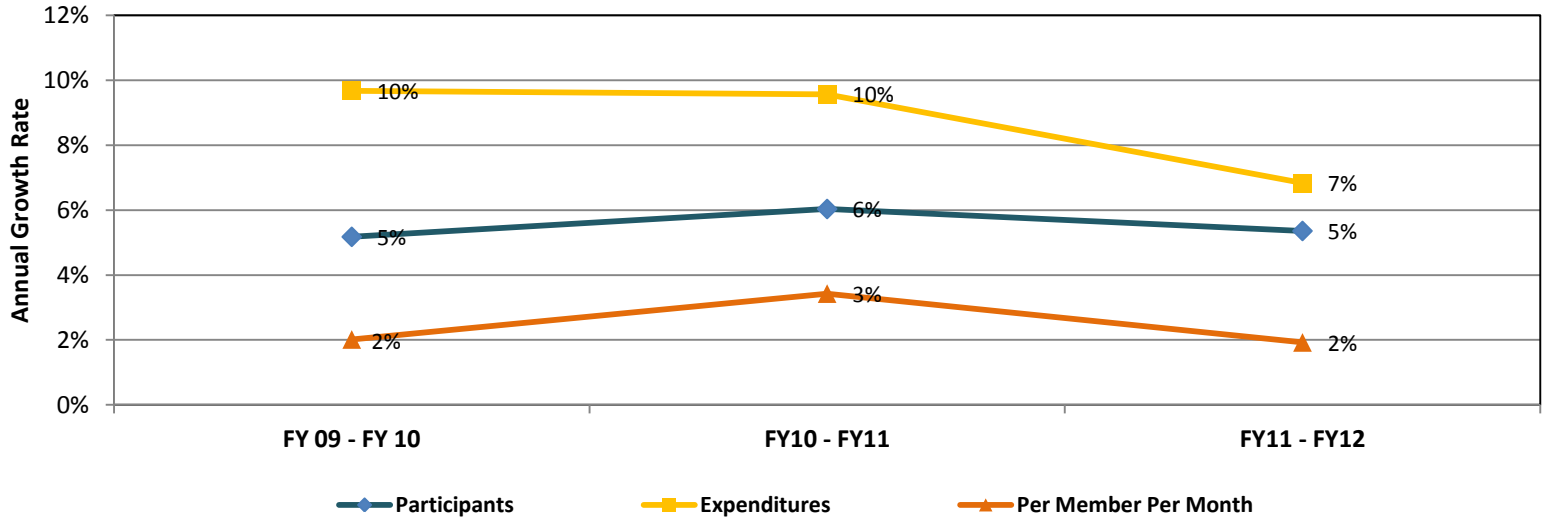
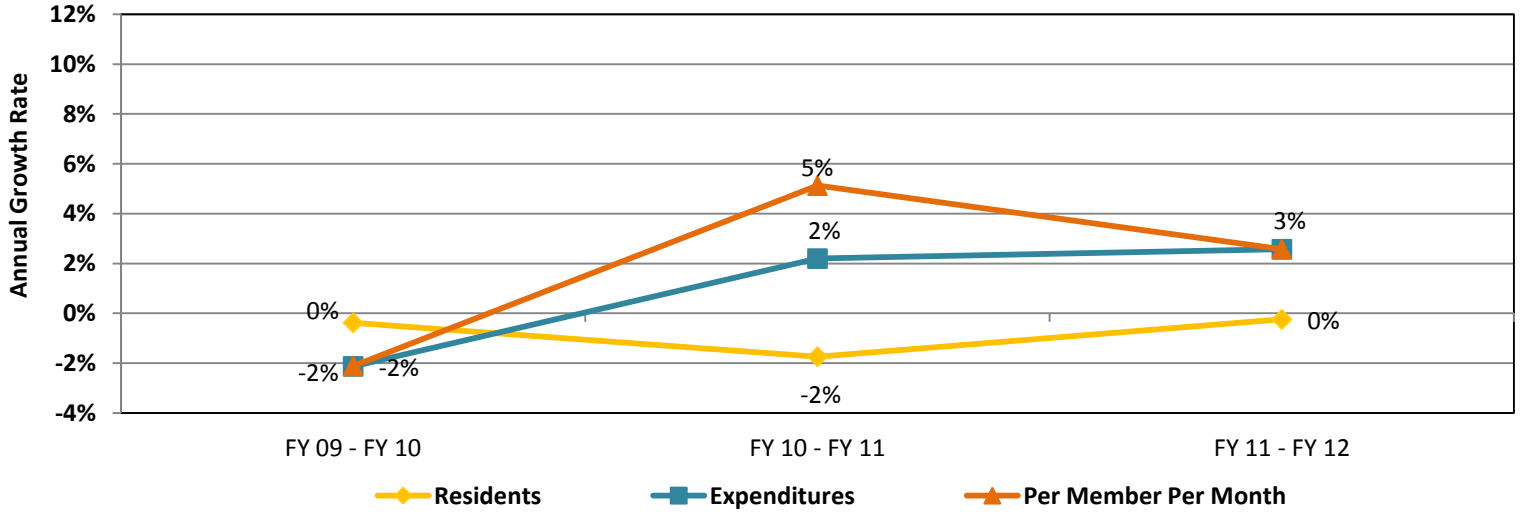


Figure 23. Growth Rate in Total Medicaid Expenditures for Nursing Facility Residents, FY 2009 – FY 2012



Source: DSS

The Hilltop Institute
analysis to advance the health of vulnerable populations

Figure 24. Average Per Member Per Month Total Medicaid Expenditures for Long-Term Services and Supports Users, FY 2012

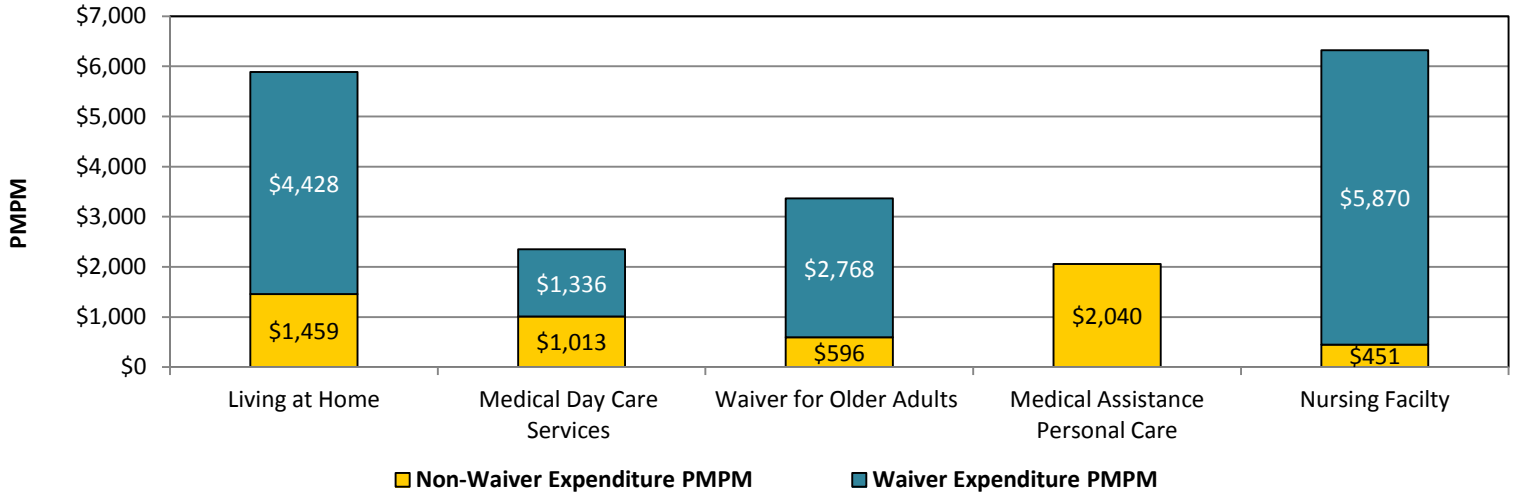
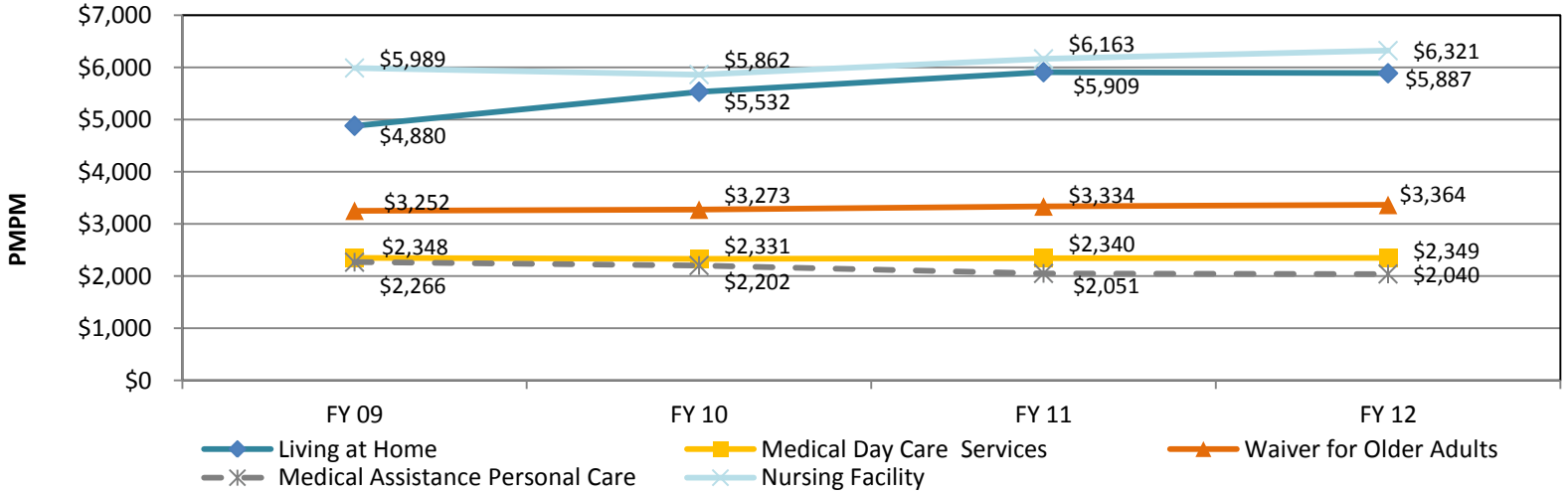


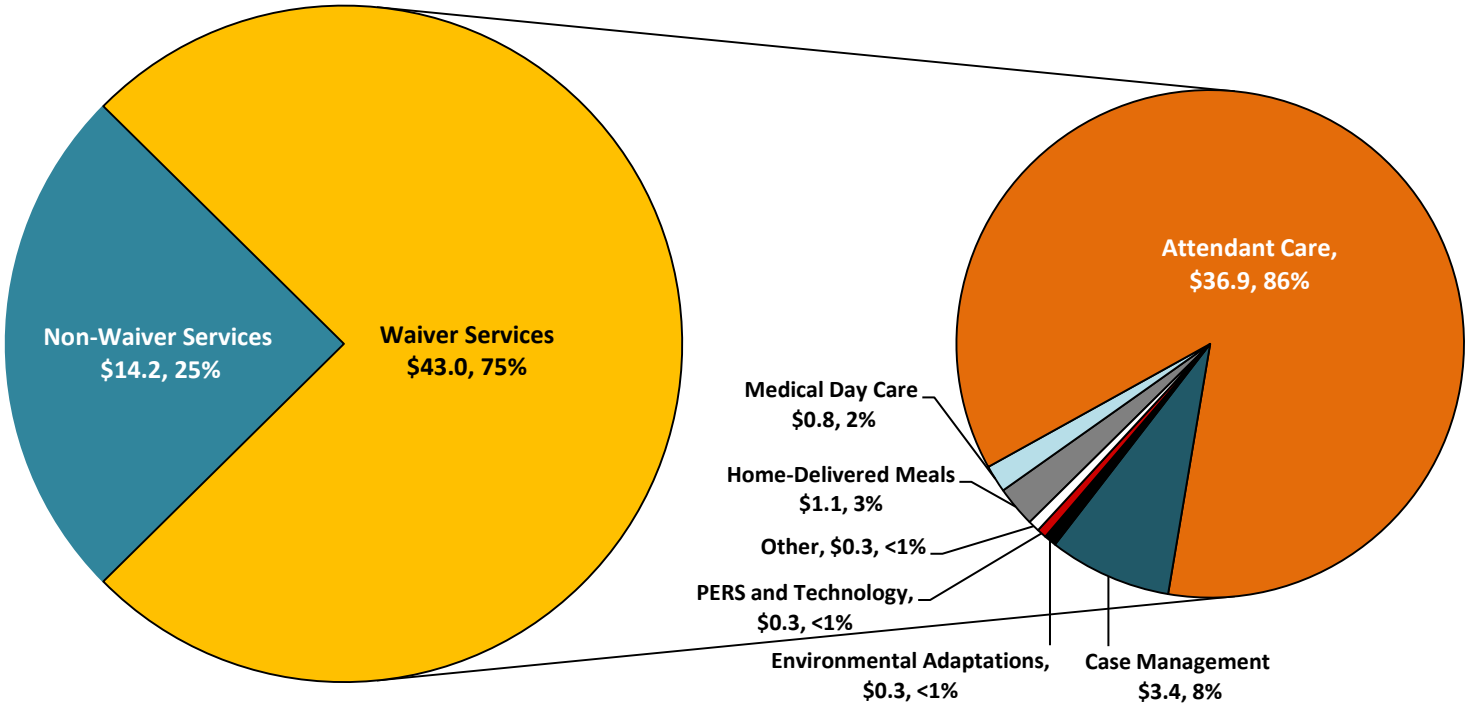
Figure 25. Average Per Member Per Month Total Medicaid Expenditures for Long-Term Services and Supports Users, FY 2009 – FY 2012



Source: DSS

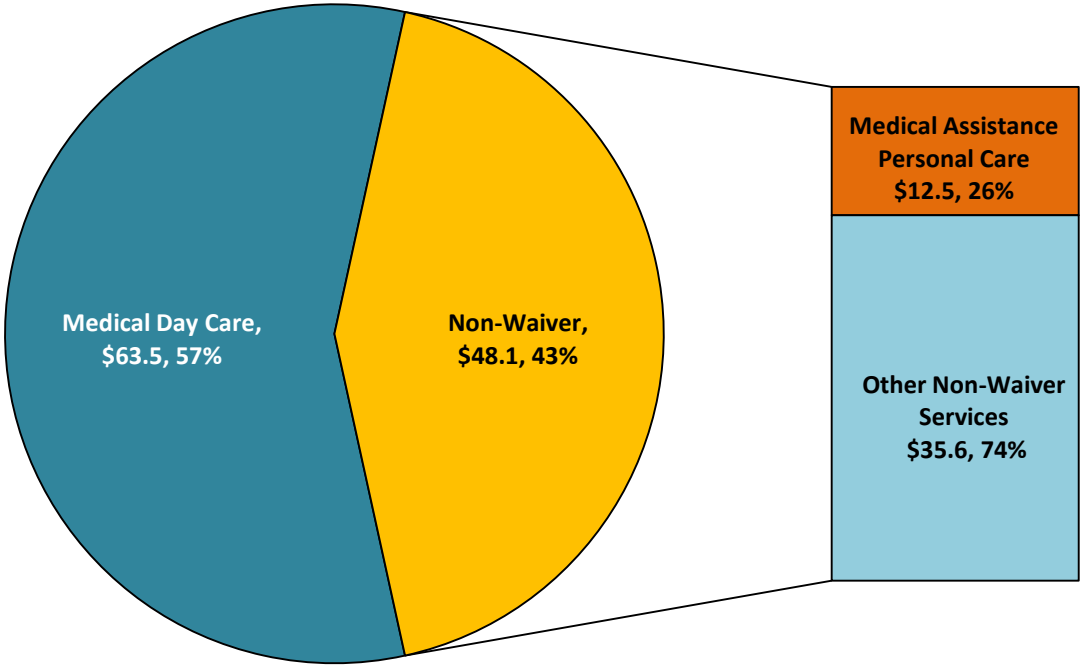
The Hilltop Institute
analysis to advance the health of vulnerable populations

Figure 26. Distribution of Total Medicaid Expenditures (in Millions) for Living at Home Waiver Participants, FY 2012



Source: DSS

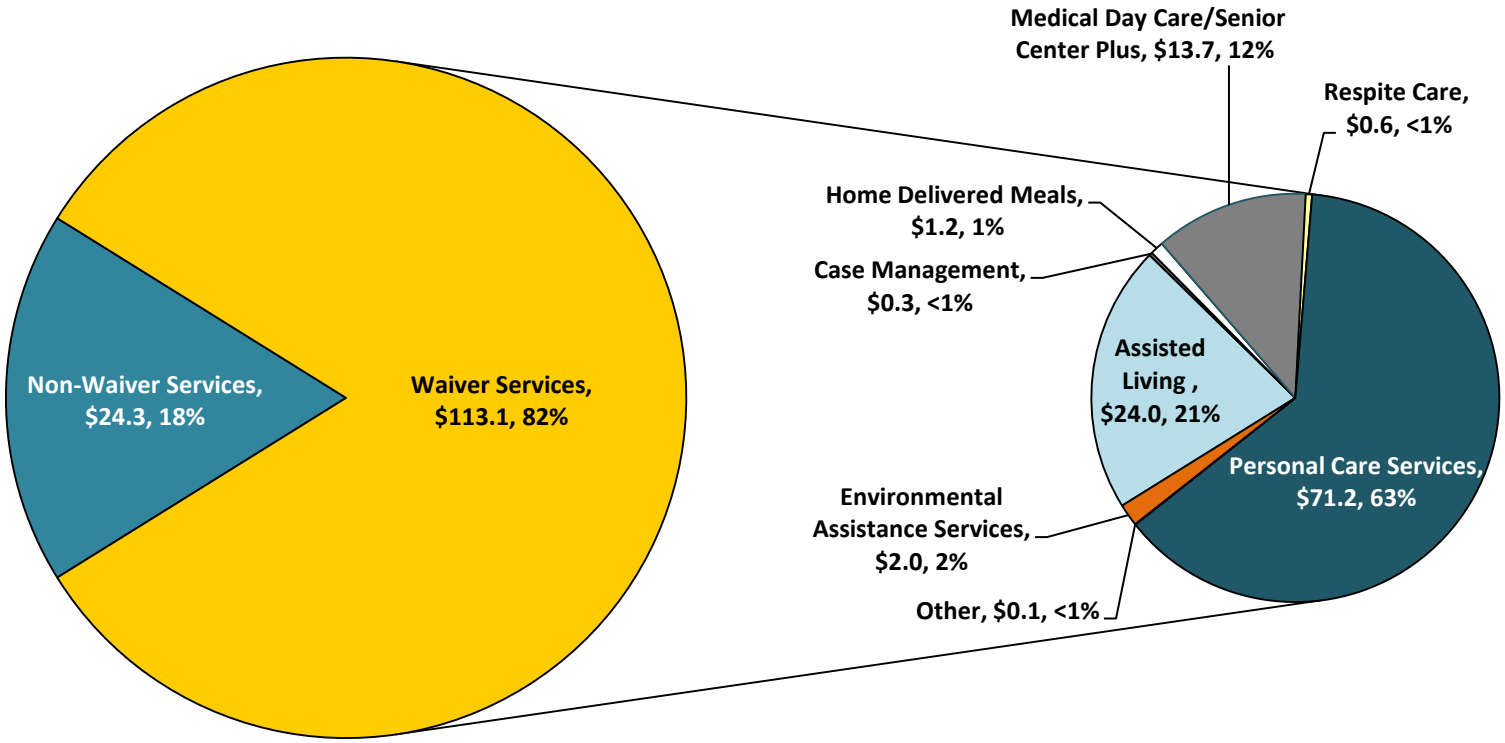
Figure 27. Distribution of Total Medicaid Expenditures (in Millions) for Medical Day Care Services Waiver Participants, FY 2012*



*Includes total Medicaid expenditures for MDC Waiver participants receiving MAPC services.

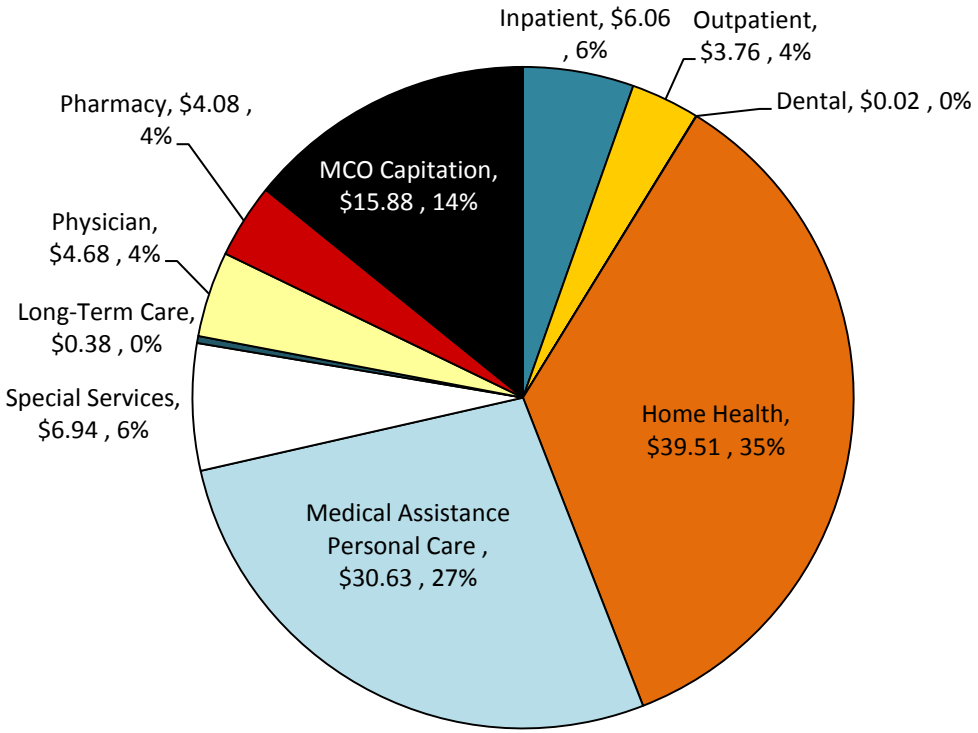
Source: DSS

Figure 28. Distribution of Total Medicaid Expenditures (in Millions) for Waiver for Older Adults Participants, FY 2012



Source: DSS

Figure 29. Distribution of Total Medicaid Expenditures (in Millions) for All Medical Assistance Personal Care Recipients,* FY 2012



Total= $111,941,352

***** Medicaid expenditures for persons receiving MAPC services while enrolled in the MDC Waiver are also included in Figure 27. Distribution of Total Medicaid Expenditures (in Millions) for MDC Waiver Participants**.** Expenditures reflect Medicaid expenditures incurred within 7 days of the receipt of MAPC.

Sources DSS

Figure 30. Use of Personal and Attendant Care Services by Living at Home Waiver, Waiver for Older Adults, and Medical Day Care Services Waiver Participants, FY 2012

Personal and Attendant Care Services	Number of Users	Percentage of Users	FY 12 Expenditures	PMPM
Living at Home Waiver				
Attendant Care – Agency	730	80%	$26,947,004	$3,658
Attendant Care – Non-Agency	304	33%	$9,420,966	$2,901
Nursing Supervision – Agency	809	89%	$499,113	$81
Nursing Supervision – Non-Agency	45	5%	$13,572	$54
Total			**$36,880,655**	
Waiver for Older Adults				
Personal Care Aide without Medications – Agency	1,701	40%	$40,579,768	$2,652
Personal Care Aide with Medications – Agency	672	16%	$20,944,615	$3,730
Personal Care Aide without Medications – Consumer-Employed	267	6%	$5,942,085	$2,426
Personal Care Aide with Medications – Consumer-Employed	55	1%	$1,619,870	$3,170
Nursing Supervision – Agency	2,439	58%	$2,129,915	$98
Total			**$71,216,253**	
Grand Total			**$108,096,908**	
Medical Assistance Personal Care Recipients*				
Level 1	931	18%	$2,202,972	
Level 2	4,536	86%	$26,973,226	
Level 3	149	3%	$1,430,156	
Day of Training	1,216	23%	$19,663	
Total			**$30,626,016**	

* MAPC recipients may receive more than one level of MAPC in a given fiscal year.

Source: DSS

Figure 31. Use of Environmental Assistance Services by Living at Home Waiver and Waiver for Older Adults Participants, FY 2012

Environmental Assistance Services	Number of Users	Percentage of Users	FY 12 Expenditures	PMPM
Living at Home Waiver				
Assistive Technology/Devices	181	20%	$64,672	$297
Environmental Accessibility Modifications	86	9%	$236,528	$2,628
Environmental Assessment	99	11%	$38,380	$384
Personal Emergency Response Systems–Purchase/Install	91	10%	$5,706	$63
Personal Emergency Response Systems–Monthly Monitoring	559	61%	$255,945	$44
Total			**$601,231**	
Waiver for Older Adults				
Assistive Technology/Devices	1,960	47%	$696,328	$91
Environmental Accessibility Modifications	192	5%	$636,460	$2,920
Environmental Assessment	220	5%	$84,820	$384
Personal Emergency Response Systems–Purchase/Install	306	7%	$18,027	$57
Personal Emergency Response Systems–Monitor/Maintenance	1,451	35%	$556,474	$35
Total			**$1,992,109**	
Grand Total			**$2,593,340**	

Source: DSS

Figure 32. Use of Medical Day Care and Senior Center Plus Services by Living at Home and Medical Day Care Services Waiver Participants, and Waiver for Older Adults Participants, FY 2012

Medical Day Care and Senior Center Plus Services	Number of Users	Percentage of Users	FY 12 Expenditures	PMPM
Living at Home Waiver				
Medical Day Care	79	9%	$750,392	$1,028
Medical Day Care Services Waiver				
Medical Day Care	4,675	97%	$63,452,399	$1,408
Waiver for Older Adults				
Medical Day Care	1,263	30%	$13,561,799	$1,169
Senior Center Plus	57	1%	$187,078	$472
Total			**$13,748,877**	
Grand Total			**$77,951,668**	

Source: DSS

Figure 33. Use of Nutrition Services by Living at Home Waiver and Waiver for Older Adults Participants, FY 2012

Nutrition Services	Number of Users	Percentage of Users	FY 12 Expenditures	PMPM
Living at Home Waiver				
Dietitian/Nutritionist Services	0	0%	$0	$0
Home-Delivered Meals	462	51%	$1,117,921	$271
Total			**$1,117,921**	
Waiver for Older Adults				
Dietitian/Nutritionist Services	8	<1%	$844	$106
Home-Delivered Meals	773	18%	$1,199,668	$201
Total			**$1,200,512**	
Grand Total			**$2,318,433**	

Source: DSS

Figure 34. Use of Respite Care Services by Waiver for Older Adults Participants, FY 2012

Respite Care Services	Number of Users	Percentage of Users	FY 12 Expenditures	PMPM
Waiver for Older Adults				
Respite Care – Agency	480	11%	$539,921	$391
Respite Care – Self-Employed	21	0%	$17,845	$293
Respite Care – Assisted Living	23	1%	$11,087	$358
Respite Care – Nursing Facility	1	0%	$1,842	$1,842
Total			**$570,695**	

Source: DSS

Figure 35. Use of Other Services by Living at Home Waiver and Waiver for Older Adults Participants, FY 2012

Other Services	Number of Users	Percentage of Users	FY 12 Expenditures	PMPM
Living at Home Waiver				
Case Management Ongoing	893	98%	$3,365,682	$352
Community Transition Waiver Service	137	15%	$310,878	$2,189
Consumer Training	6	1%	$1,682	$129
Family Training – Agency	1	0%	$151	$151
Family Training – Non-Agency	0	0%	$0	$0
Total			**$3,678,393**	
Waiver for Older Adults				
Behavior Consultation	158	4%	$50,367	$116
Case Management Ongoing	3,763	89%	$275,470	$73
Case Management Transitional	10	0%	$577	$58
Family or Consumer Training	2	0%	$302	$151
Total			**$326,716**	
Grand Total			**$4,005,109**	

Source: DSS

Figure 36. Distribution of Medical Day Care Services Users and Expenditures, by Waiver, FY 2012

Waiver	Medical Day Care Services Users	Percentage of Waiver Participants	Medical Day Care Expenditures	Percentage of Total Medicaid Expenditures
Living at Home Waiver	79	9%	$750,392	1.3%
Medical Day Care Services	4,675	97%	$63,452,399	56.9%
Waiver for Older Adults	1,263	30%	$13,561,799	9.9%
Total	**6,017**		**$77,764,590**	

Note: In FY 2012, 3% of the MDC Waiver participants did not have an MMIS medical day care services claim.

Source: DSS

Figure 37. Total Medicaid Expenditures for Waiver for Older Adults Participants Residing in Assisted Living Facilities, FY 2012

	Number of Users*	Total Medicaid Expenditures	Average Annual Total Medicaid Expenditures	Waiver Expenditures	Non-Waiver Expenditures
Assisted Living Level 2	394	$6,538,396	$16,595	$4,751,106	$1,787,290
Assisted Living Level 3	1,334	$34,633,463	$25,962	$26,193,939	$8,439,524
Assisted Living 2 and 3	1,353	$41,171,859	$30,430	$30,945,045	$10,226,814
Not in Assisted Living	2,852	$96,167,306	$33,719	$82,140,507	$14,026,798
Grand Total	**4,205**	**$137,339,165**	**$32,661**	**$113,085,552**	**$24,253,612**

Figure 38. Use of Assisted Living Services by Waiver for Older Adults Participants, FY 2012

Assisted Living Services	Number of Users*	Percentage of WOA Participants	FY 12 Expenditures	PMPM	Billed Days	Average Days Billed Per Person
Waiver for Older Adults						
Assisted Living Level 2, no medical day care	383	9%	$3,091,905	$1,005	55,510	145
Assisted Living Level 2, with medical day care	110	3%	$467,446	$567	11,186	102
Assisted Living Level 3, no medical day care	1,322	31%	$16,967,278	$1,358	241,390	183
Assisted Living Level 3, with medical day care	519	12%	$3,427,670	$725	65,054	125
Grand Total for Level 2 and Level 3	**1,353**	**32%**	**$23,954,299**	**$1,354**	**373,139**	

***** Residents may receive services in one or more assisted living category.

Note: Assisted Living is a residential or facility-based residence that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of residents who are unable to perform (or who need assistance in performing) ADLs or IADLs. The assisted living levels are determined by the amount of assistance provided. Assisted Living Level 1 providers are authorized to care for residents with low-level care needs. Assisted Living Level 2 providers care for residents with moderate care needs. Assisted Living Level 3 providers care for residents with high-level care needs. The WOA does not provide Assisted Living Level 1 services. Reimbursement rates for assisted living services differ for assisted living with medical day care and assisted living without medical day care.

Source: DSS

Figure 39. Medicaid Non-Waiver Expenditures for Living at Home, Waiver for Older Adults, and Medical Day Care Services Waiver Participants, FY 2012

Service Category	Living at Home Waiver	Medical Day Care Services Waiver	Waiver for Older Adults
Dental Services	$1,371	$3,229	$0
DME/DMS*	$1,389,820	$3,518,886	$6,383,097
Emergency Room Services	$24,063	$72,486	$32,183
Evaluation and Management	$117,552	$359,275	$191,792
Hospice Services	$1,627	$135,045	$204,885
Inpatient Services	$1,723,023	$4,411,952	$2,274,984
Medicine/Pharmacy	$1,451,139	$4,964,002	$2,156,279
MCO Capitation Payments**	$5,382,580	$9,918,782	$2,657,190
Medicare Cost Share	$1,738,226	$4,632,479	$6,072,144
Medical Services	$270,680	$1,050,265	$406,483
Mental Health	$2,397	$82,361	$41,716
Nursing Facility Services	$738,013	$514,969	$2,169,009
Other Services***	$562,417	$1,202,272	$855,823
Outpatient services	$695,626	$1,307,218	$592,794
Medical Assistance Personal Care		$12,506,583	
Psychiatric Rehabilitation Program	$90,738	$3,424,325	$291,325
Total	**$14,189,272**	**$48,104,129**	**$24,329,703**

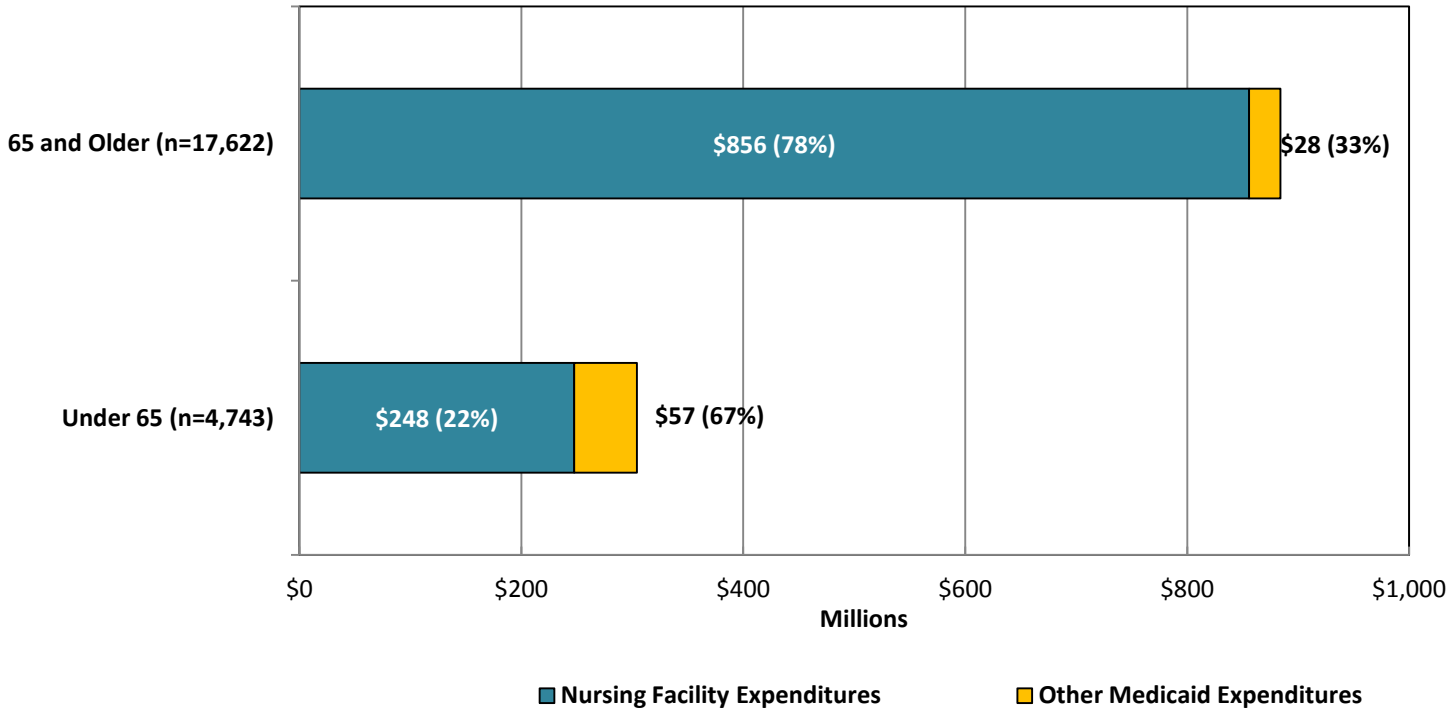
* DME refers to durable medical equipment, and DMS refers to disposable medical supplies.

** MCO Capitation Payments are fixed monthly amounts paid to MCOs to provide services to Medicaid beneficiaries who are enrolled in the Maryland HealthChoice program. Capitation payments are based on actuarial projections of medical utilization. MCOs are required to provide all covered, medically necessary Medicaid services within that capitated amount.

*** Other Non-Waiver Services are services other than those listed above and those provided under the waiver that are paid for by Medicaid on behalf of Living at Home, Older Adults, and Medical Day Care Services Waiver participants.

Source: MMIS2

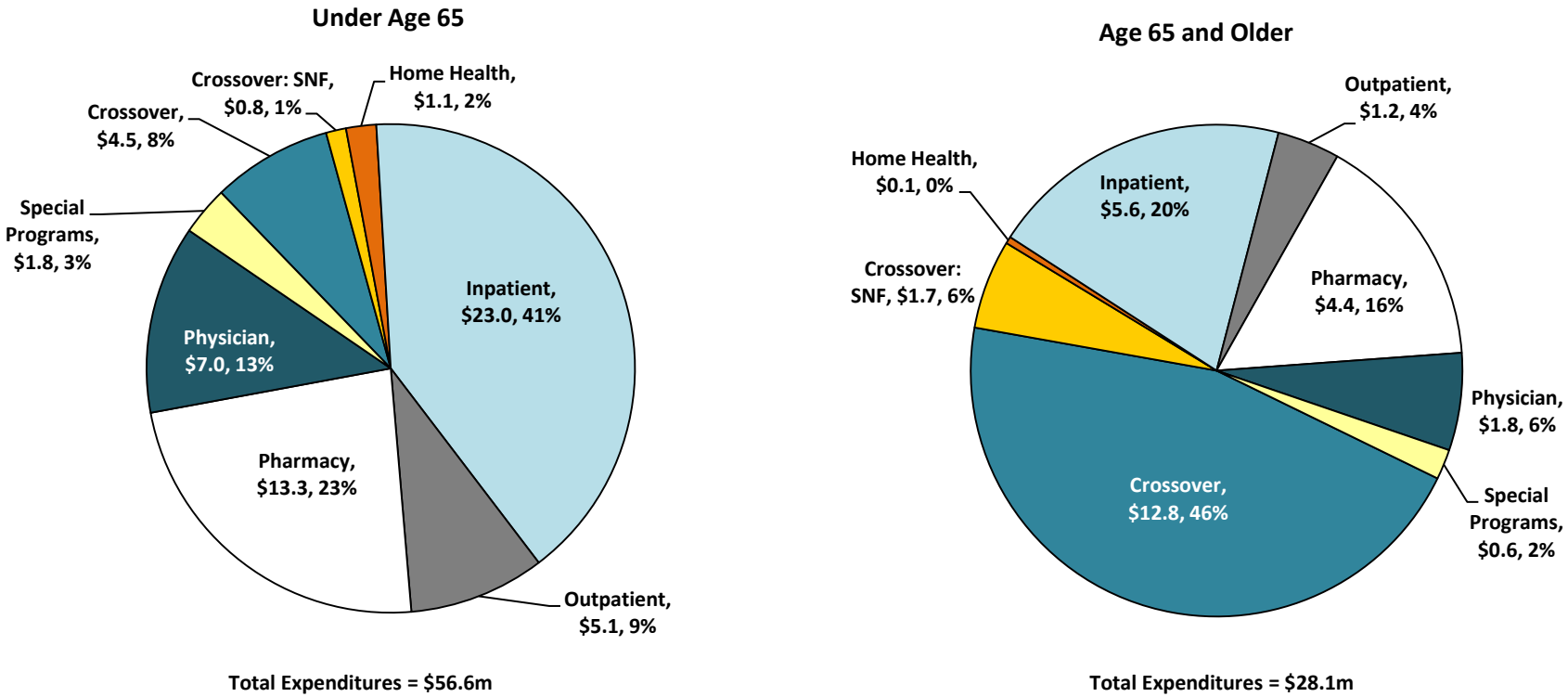
Figure 40. Total Medicaid Expenditures for Nursing Facility Residents, in Millions, by Age Group, FY 2012



Note: Total Medicaid expenditures include a) Medicaid nursing facility expenditures, b) other Medicaid expenditures with dates of service concurrent to a resident's nursing facility claims, and c) Medicaid expenditures for an intervening hospital stay (i.e., the beginning day of the hospital claim coincides with the last day of a nursing facility claim, and the last day of the hospital claim coincides with the beginning day of a nursing facility claim).

Source: MMIS2

Figure 41. Other Medicaid Service Expenditures for Nursing Facility Residents, in Millions, by Age Group, FY 2012



Note: Other Medicaid service expenditures include Medicaid expenditures with dates of service concurrent to a resident's nursing facility claims and Medicaid expenditures for an intervening hospital stay (i.e., the beginning day of the hospital claim coincides with the last day of a nursing facility claim, and the last day of the hospital claim coincides with the beginning day of a nursing facility claim).

Crossover: Non-NF (Nursing Facility) – Medicaid cost-sharing payments (premiums, co-payments, etc.) for non-NF services covered by Medicare.
Crossover: SNF (Skilled Nursing Facility) – Medicaid cost-sharing payments (premiums, co-payments, etc.) for SNF services covered by Medicare.
Home Health – HCBS that include 1915(c) waiver services and state plan services such as personal care, home health services, nursing services, etc.
Inpatient – Services provided to patients who are admitted to a hospital, including bed and board; nursing services; diagnostic, therapeutic, or rehabilitation services; and medical or surgical services.
Outpatient – Medical or surgical care that does not require an overnight hospital stay, such as ambulatory care, therapeutic care, rehabilitation services, clinic services, medical supplies, and laboratory tests.
Pharmacy – Prescription medications and certain "over the counter" medications.
Physician – Services provided by a licensed physician.
Special Programs – Services that do not fall into any of the categories listed above (e.g., transportation services; occupational, physical, and speech therapy; and oxygen services).

Source: MMIS2

Figure 42. Average Medicaid Expenditures Per Member Per Month for Nursing Facility Residents, by Age Group, FY 2009 – FY 2012

	FY 09	FY 10	FY 11	FY 12
Total				
Total PMPM	$5,989	$5,862	$6,163	$6,321
Nursing Facility Services PMPM	$5,509	$5,382	$5,620	$5,870
Other Medicaid Services PMPM	$479	$480	$468	$451
Under 65				
Total PMPM	$7,898	$7,870	$7,996	$8,198
Nursing Facility Services PMPM	$6,327	$6,240	$6,406	$6,673
Other Medicaid Services PMPM	$1,571	$1,630	$1,590	$1,525
65 and Older				
Total PMPM	$5,531	$5,373	$5,612	$5,859
Nursing Facility Services PMPM	$5,314	$5,173	$5,424	$5,673
Other Medicaid Services PMPM	$217	$200	$188	$187

Note: PMPM calculations were made by dividing the annual expenditures by the total number of member months (defined as a count of months with at least one Medicaid paid day for each Medicaid nursing facility resident) in each year. Medicare costs for nursing facility residents are not included in this analysis.

Source: MMIS2

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