

Long-term Care Cost in North Carolina Medicaid

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The current movement of the Baby Boomer generation (people born between 1946 and 1964) into retirement age has created significant stress on both financial and human resources associated with the delivery of long-term services and supports. These retirees increasingly expect to live at home with options for maintaining as much independence as possible. Adults with short-term and chronic disabilities expect services and supports that enable an independent lifestyle. Children born with special needs and disabilities require supportive services that are person-centered and that can adjust to their development as they mature and pursue independence. Institutional settings of care have long proven to be suboptimal as the primary health care services and supports option for any of these individuals, both in terms of cost and quality.

It is imperative that NC Medicaid realign existing long-term services and supports programs. The larger ongoing Medicaid transformation effort must address needs of our aging citizens to improve their health and well-being, maximize their opportunities to live in home and community settings, and ensure the services and supports provided, irrespective of setting, meet a quality standard.

According to the Centers for Disease Control (CDC), the human life expectancy across both sexes and all races

in the United States is approximately 76 years [1]. These projections forecast the need for in-home or congregate services to support individuals who, as they age, will experience illness and disabilities that have an adverse impact on their independence and well-being. Since the implementation of the Older Americans Act and Social Security Act in 1965, which established the Medicare and Medicaid programs, federal and state governments have incurred the cost for post-acute long-term services and supports (LTSS), primarily through state Medicaid programs. The passage of the Americans with Disabilities Act in 1990 and the US Supreme Court's 1999 decision in *Olmstead v L.C.* codified the expectation that people experiencing disability because of age and other factors had the right to receive supports and services in the least restrictive settings. It also challenged the government and service providers to develop community alternatives where necessary.

Since the early 1980s there has been a steady realignment of service utilization from primary reliance on institutional care toward increased use of home- and community-based services (HCBS). Notably, 1915(c) waivers allowed states to provide certain services to specific populations through Medicaid [2], and capitated programs like the Program of All-Inclusive Care for the Elderly (PACE)

provide medical and social services to individuals who are dually eligible for Medicare and Medicaid [3].

In 2019, North Carolina expenditures for LTSS were approximately \$3.5 billion; 57% (\$2 billion) was spent on home- and community-based services and 43% (\$1.5 billion) on institutional care, placing North Carolina on par with the national average of 58% HCBS and 42% institutional [4]. As promising as this direction is, we have a formidable challenge: our available workforce for delivering LTSS, irrespective of the setting of care, is catastrophically insufficient. This issue was amplified during the recent COVID-19 pandemic, when the shortage of available health care workers—both licensed and paraprofessionals—reached a crisis point. The pandemic also highlighted the inadequacy of salaries for direct care and other essential workers in all settings.

Basic LTSS program needs are built into NC Medicaid's annual budget request and scaled with projected enrollment growth, but expanding services and addressing unmet needs will require NC Medicaid to work closely with community partners, the Governor's Office, and the General Assembly to design, build, and fund initiatives to meet these needs. In the past two years, these efforts have led to an increase in PACE rates for the first time in 10 years, as well as a change in the rate methodology to maintain reimbursement rates at this higher level moving forward. Additionally, NC Medicaid has increased rates for skilled nursing facility (SNF) and personal care services (PCS) providers to address workforce needs and increased the number of available slots in programs like Medicaid Innovations, Communities Alternatives Program for Disabled Adults (CAP/DA), and PACE to expand their

reach in the state and mitigate existing waiting lists. There is much still to do. Moving forward, NC Medicaid will be challenged to use its payment and policy levers to ensure that the Medicaid health care system is sustainably funded and an appropriately prepared workforce is available to deliver quality services and supports. NCMJ

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