Long Term Care Delivery System

October 26-27th, 2005

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Medicaid Commission Meeting

CENTER FOR HEALTH PROGRAM DEVELOPMENT AND MANAGEMENT

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Preview of Presentation

- Medicaid long-term care
- Waivers in long-term care
- Dual eligibles
- Challenges to long-term care reform
- Preview of some key questions for the May 2006 session

Medicaid Long-Term Care

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Medicaid must cover certain long-term care benefits . . .

- Nursing facility services for adults (age 21 and older)
- Home health for adults who meet nursing facility level of care

The mandate to cover nursing facilities is one source of the institutional bias.

. . . and Medicaid may cover other long-term care benefits . . .

- Personal care (without an HCBS waiver)
- “Home and community-based services” (HCBS) with a 1915(c) waiver

. . . showing that long-term care means more than just nursing facilities.

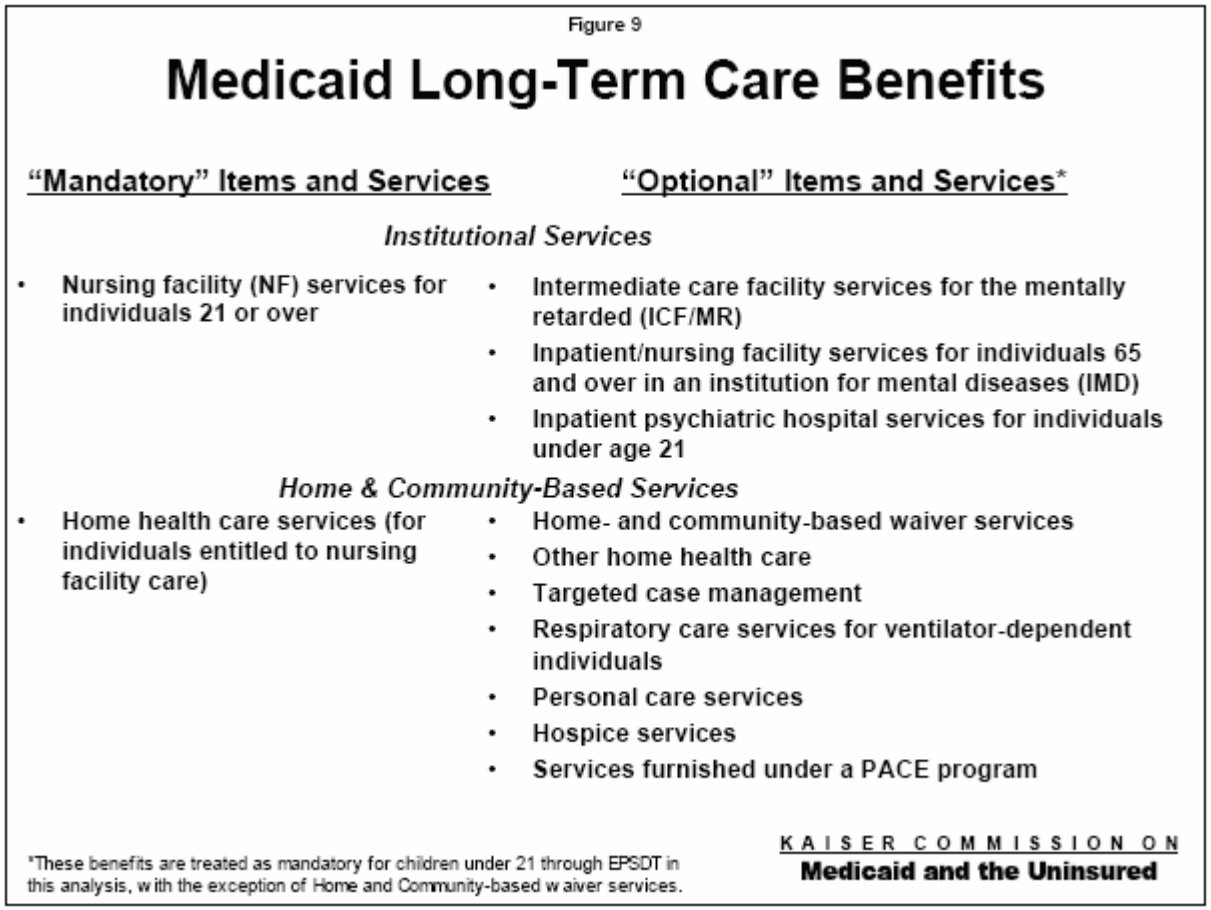

Figure 9

Medicaid Long-Term Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
Institutional Services	
• Nursing facility (NF) services for individuals 21 or over	• Intermediate care facility services for the mentally retarded (ICF/MR) • Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD) • Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services	
• Home health care services (for individuals entitled to nursing facility care)	• Home- and community-based waiver services • Other home health care • Targeted case management • Respiratory care services for ventilator-dependent individuals • Personal care services • Hospice services • Services furnished under a PACE program

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community-based waiver services.

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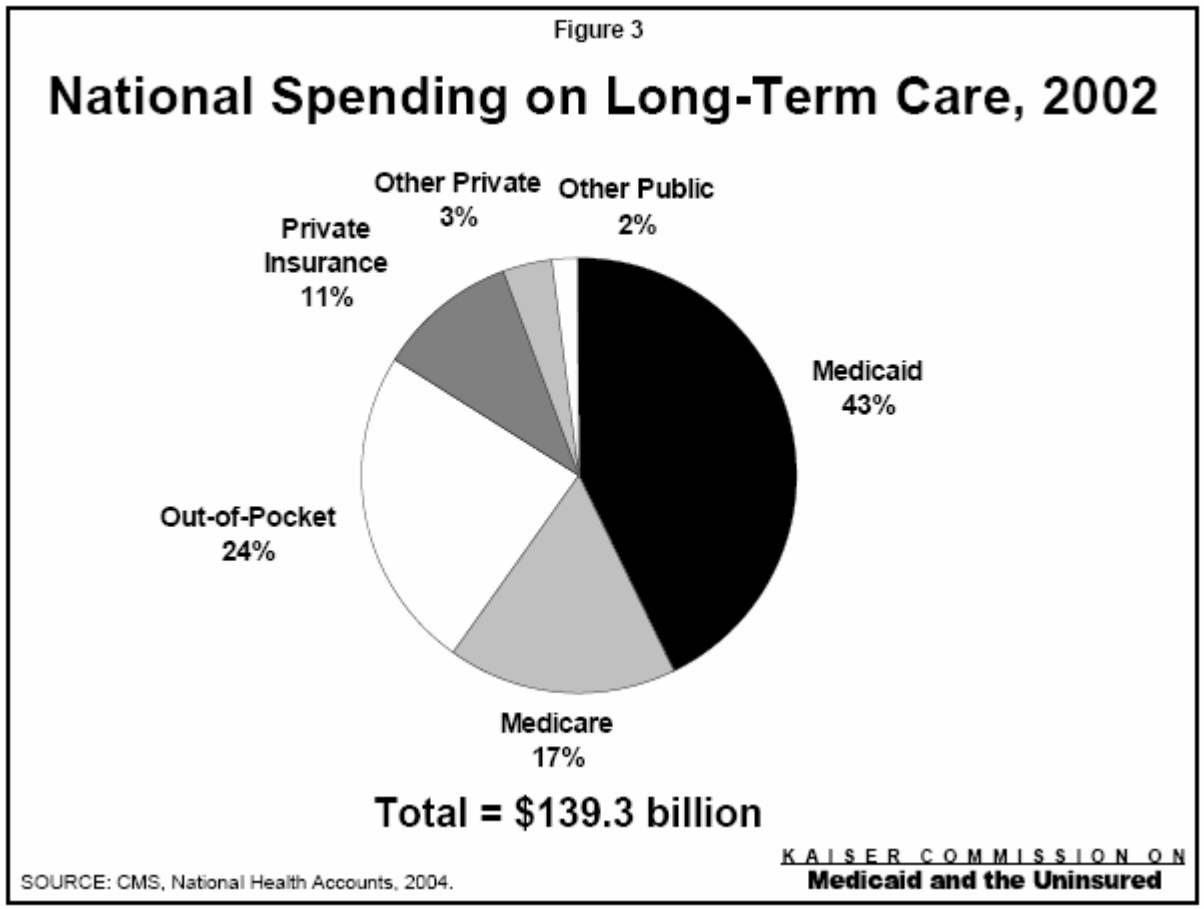
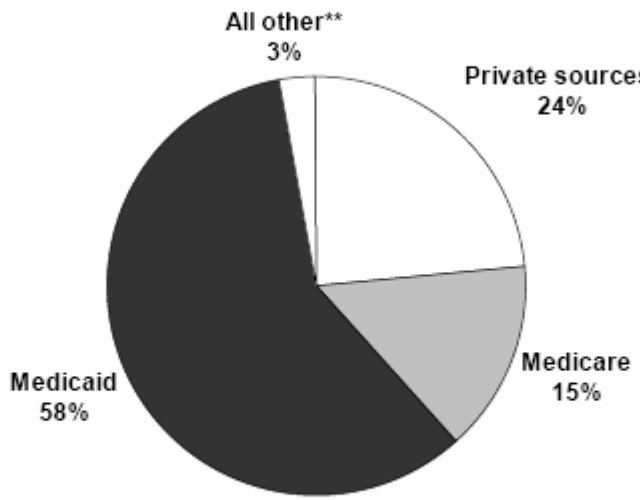
In aggregate, Medicaid is the largest funder of long-term care services nationally . . .



. . . and is the primary source of funding for people in nursing facilities . . .

Figure 5

Source of Payment for Nursing Home Residents



Total = 1,628,300 Residents

NOTE: Primary expected source of payment at time of survey.
* Includes private insurance, own income, family support, Social Security benefits, and retirement funds.
** Includes Supplemental Security Income (SSI), other government assistance or welfare, religious organizations, foundations, agencies, Veterans' Administration contracts, pension or other VA compensation, payment source not yet determined and other and unknown sources.
SOURCE: National Nursing Home Survey, CDC/NCHS, 2002.

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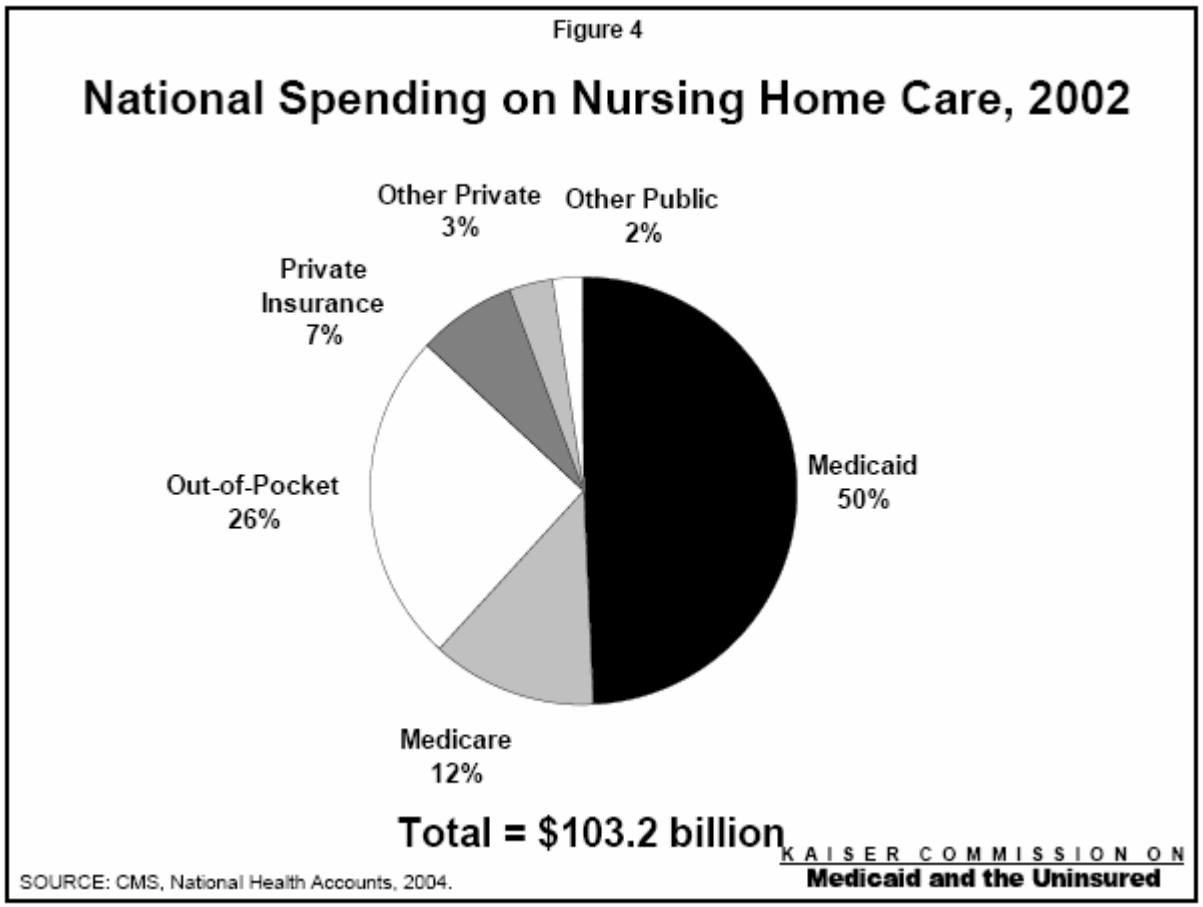
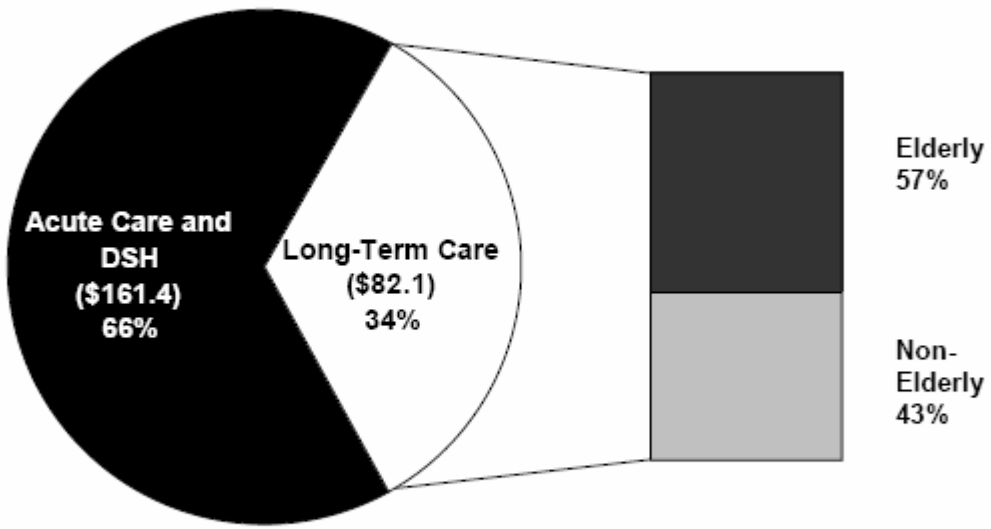
. . . and provides half of all nursing facility revenue.



Long-term care services represents 34% of all Medicaid spending.

Figure 9

Distribution of Medicaid Spending, 2002



Total Medicaid Spending = $243.5 billion

NOTE: Data are for the federal fiscal year. DSH refers to disproportionate share hospital payments.
SOURCE: Burwell et al. 2003 , based on data from CMS (Form 64). Distribution of LTC spending by age is the author's calculation based on data from the MSIS for FY 2000.

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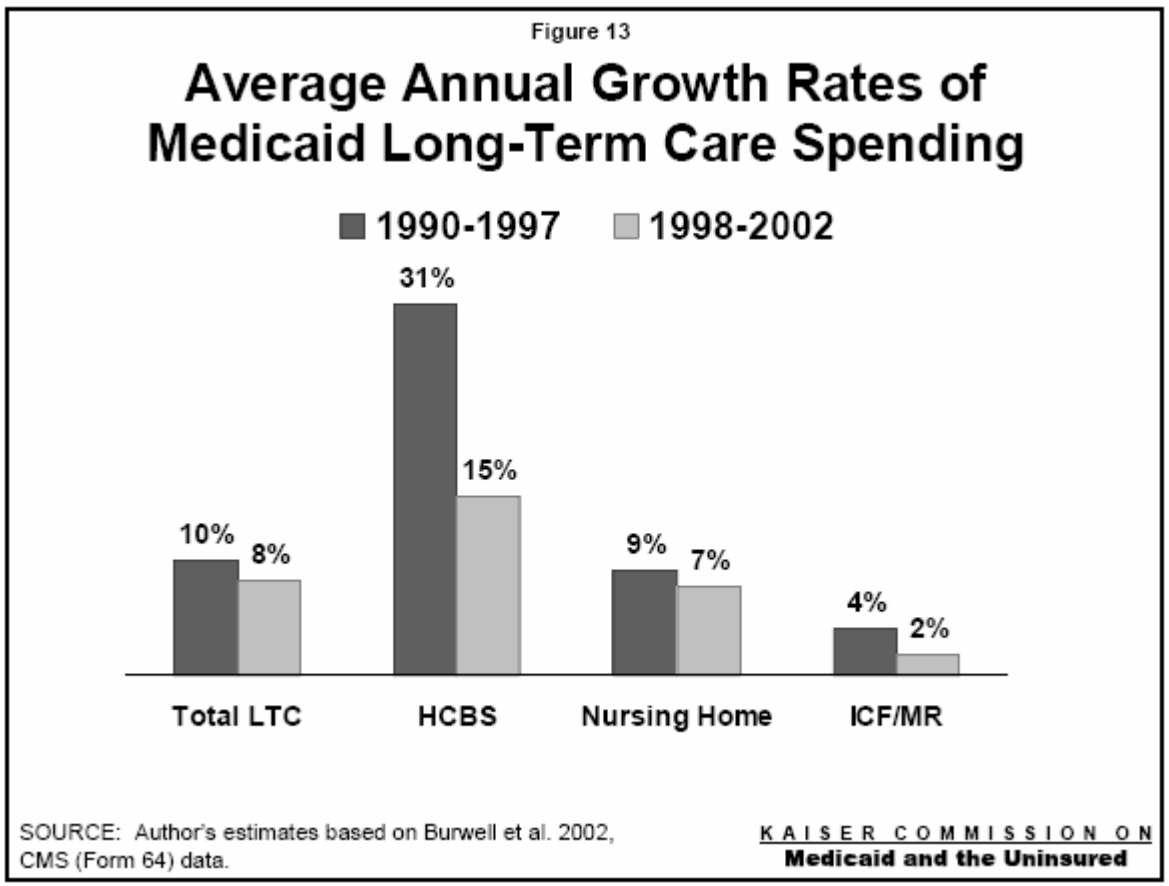
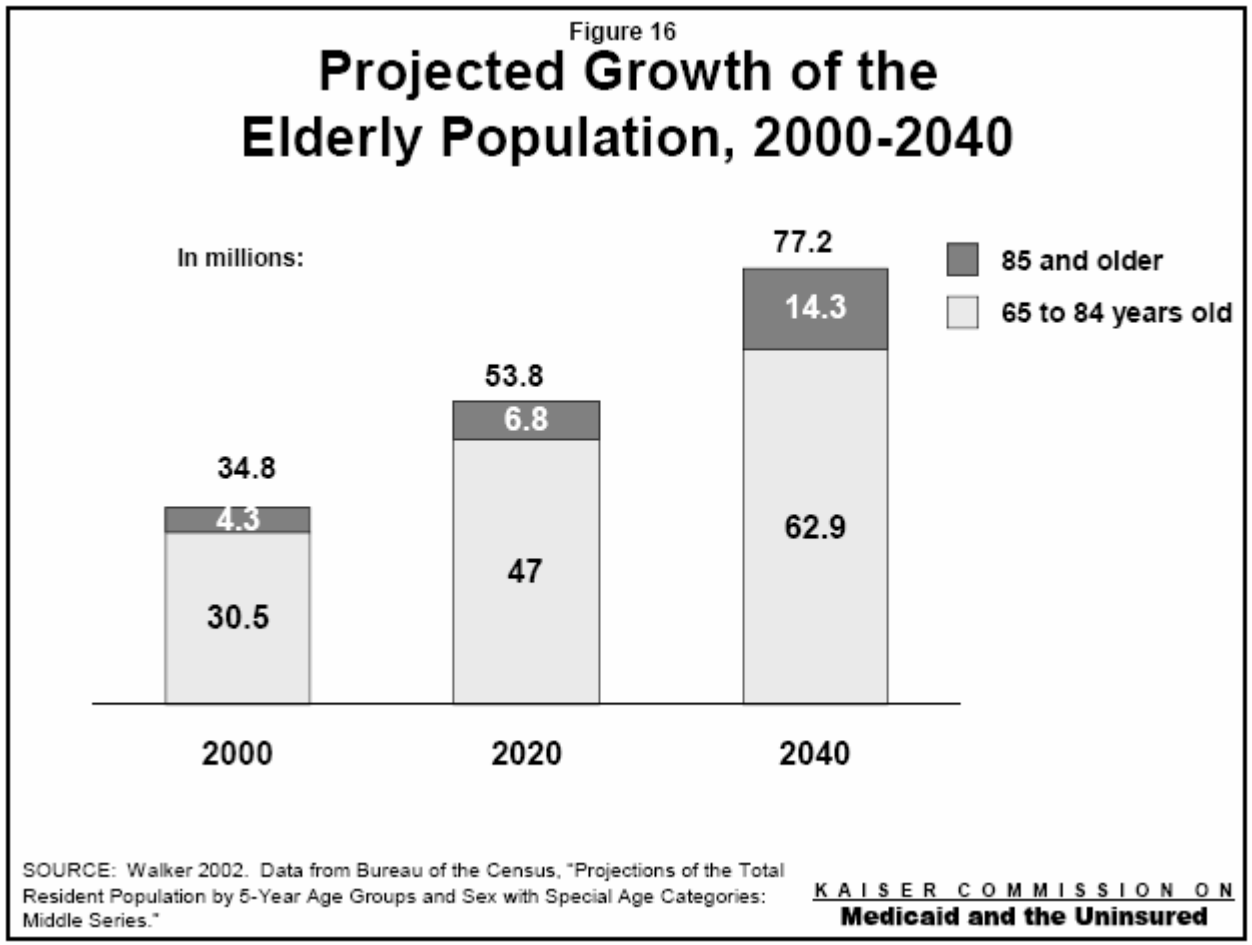
Long-term care spending has slowed down in recent years . . .



...yet the demographic age wave is approaching



Waivers in Long-Term Care

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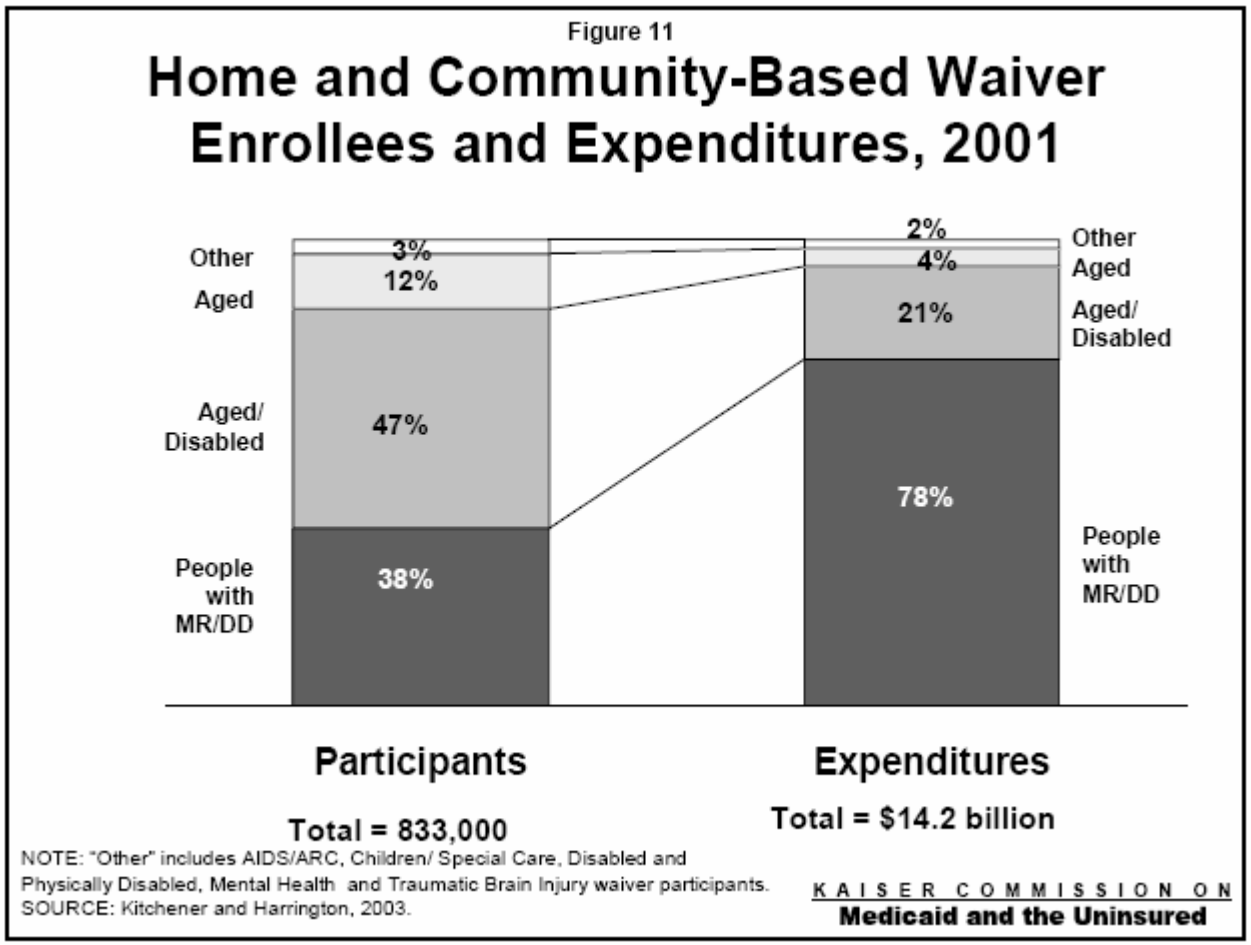
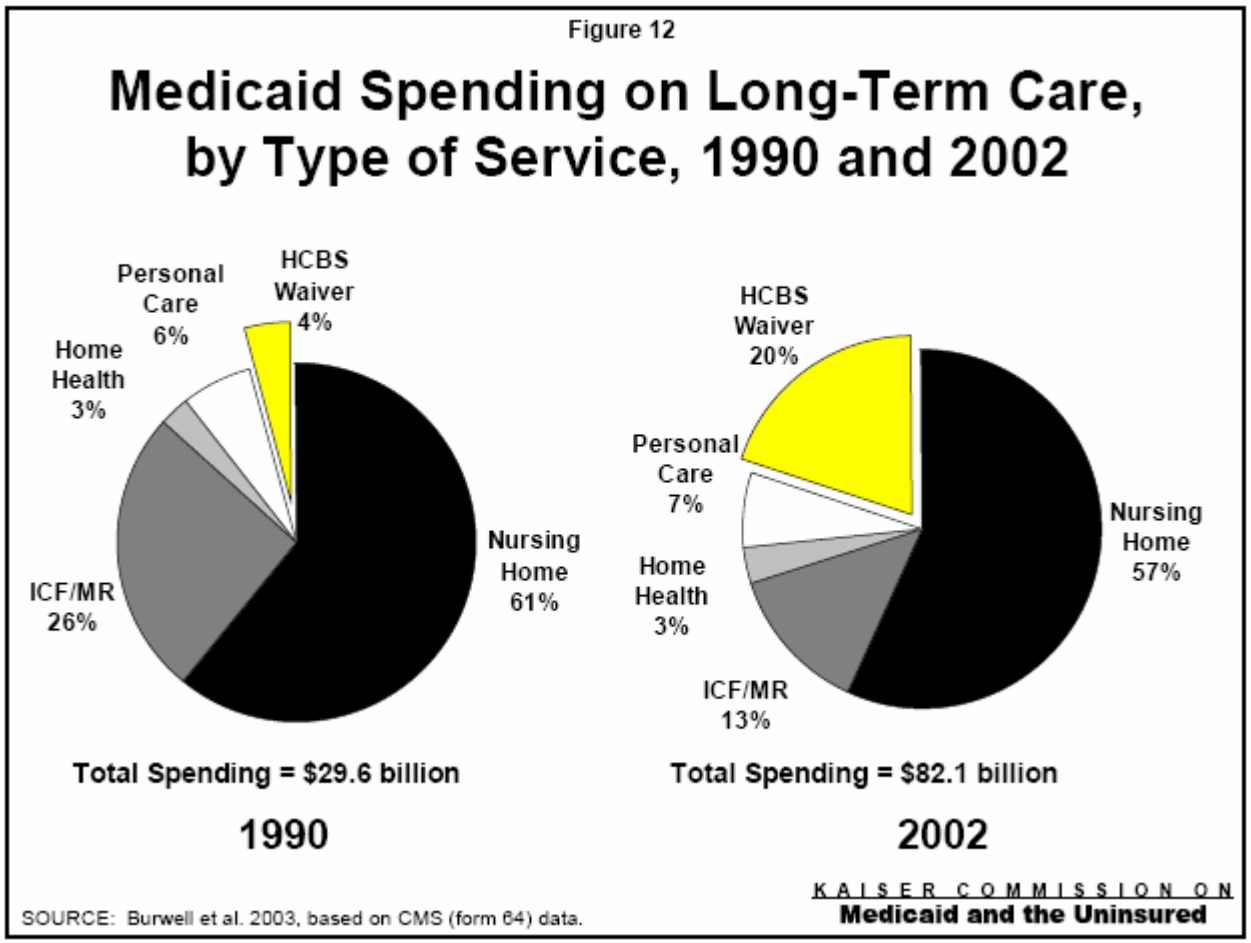
HCBS waivers help states serve nursing-facility eligible people in the community

- 1915(c) Home and Community Based Waiver program
- HCBS waivers permit states to provide supportive services to people *who would otherwise qualify for an institutional admission (nursing facility, or ICF/MR)*
- Every state except AZ has at least one
- Must be “cost neutral”

HCBS waivers serve aged/disabled and MR/DD populations.



Despite the growth in HCBS models, an "institutional bias" in spending still exists.



Another type of long-term care waiver is known as "Cash and Counseling"

- In this waiver, the Medicaid beneficiary is given the cash the state otherwise would have paid for his/her personal care services
- The beneficiary then may hire, fire and manage his/her own caregivers
- This requires a Section 1115 waiver
- States with these waivers include AR, FL, and NJ

Managed care waivers in long-term care are rare . . .

- Only Texas and Arizona have mandatory programs, whereby Medicaid beneficiaries who qualify for nursing facilities must enroll in an MCO
- Other states operate voluntary programs (e.g. MA, MN, NY, WA, WI)
- And voluntary PACE programs also exist in many states

. . . in part because of the challenges coordinating with Medicare . . .

- Difficult to coordinate funding streams and enrollment in the face of voluntary managed care enrollment in Medicare
- Effective care In Medicaid may accrue savings in Medicare, which may not be counted for budget neutrality
- Program administrative requirements are not coordinated in the two programs
- Data sharing is a challenge due to limited reporting requirements in Medicare Advantage

. . . although states are hopeful about Medicare "special needs plans"

- The Medicare Modernization Act created the opportunity for MCOs to target enrollment niches in Medicare:
  - Dual eligibles
  - Medicare beneficiaries meeting nursing facility level of care
- States are working with these MCOs to pursue joint enrollment of dual eligibles in the same MCO, operating in both programs
- Yet, the underlying issue of voluntary enrollment in Medicare will remain one key barrier

Dual eligibles

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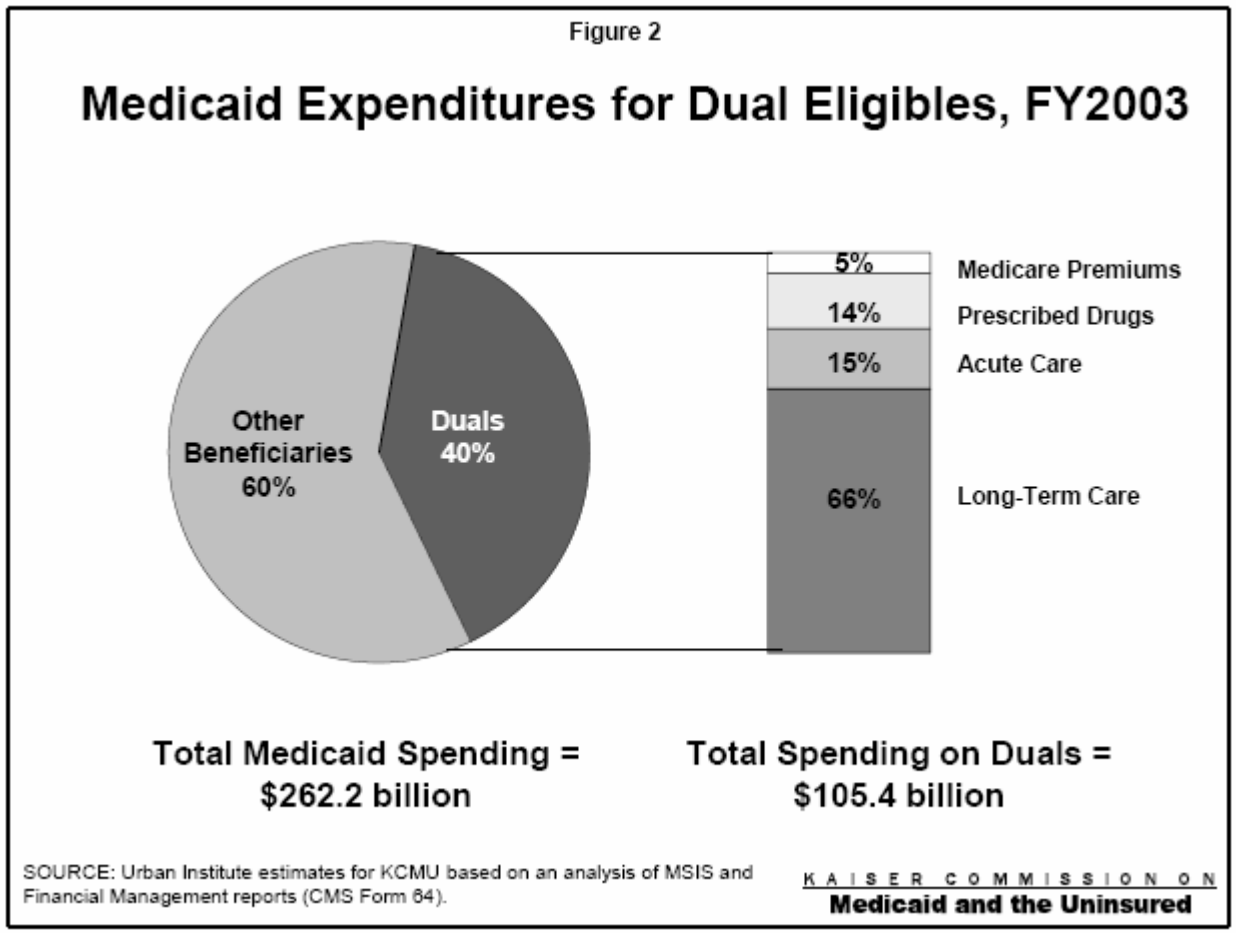
Dual Eligibles

- Entitled to Medicare and some level of Medicaid benefits
  - 6.2 million receive full Medicaid benefits (in addition to assistance with Medicare premiums and cost-sharing)
  - 1.3 million receive only assistance with Medicare premiums and cost-sharing

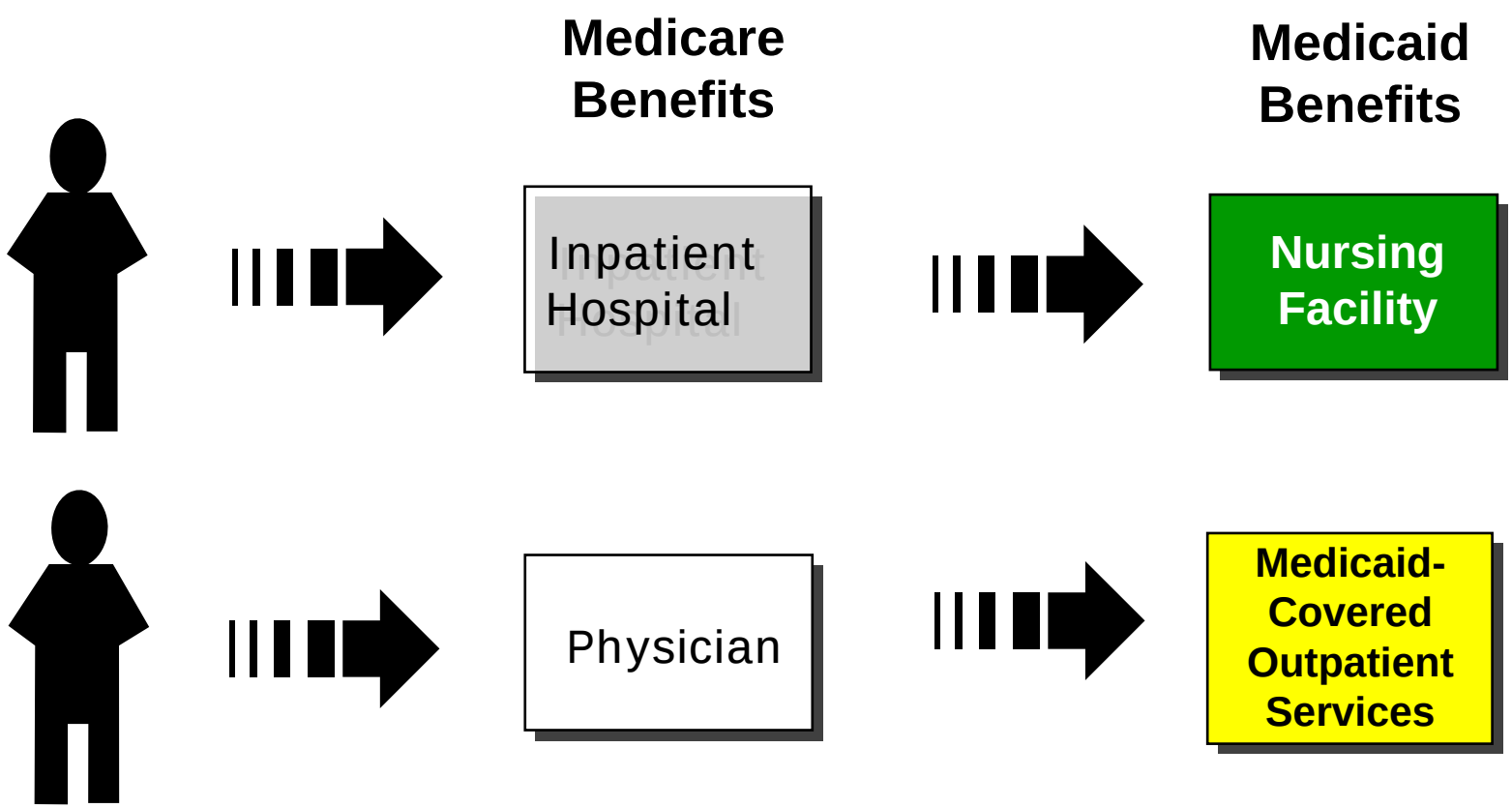
Why does Medicaid supplement Medicare?

- Dual eligibles generally are below the poverty line – the floor is 74% FPL, the ceiling is 100% FPL
- Medicare does not offer a comprehensive benefit package (e.g., no coverage for most long-term care services)
- Medicare has a premium of $78 per month for Part B
- Many Medicare-covered services have a cost-sharing component

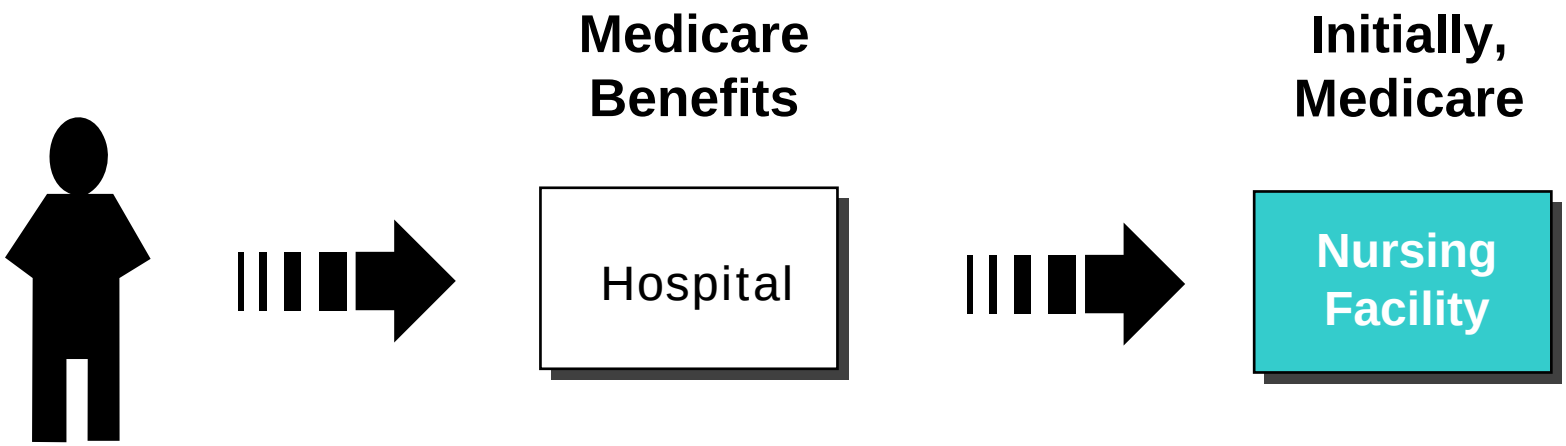
Dual eligibles represent 14% of Medicaid enrollment yet account for 40% of spending



Dual Eligibles: Medicare serves as a gateway to Medicaid



Dual eligibles and long-term care: most nursing home residents enter from a hospital, post Medicare stay



65.4% of all nursing home admissions come from a hospital.

Source: The National Nursing Home Survey: 1999 Summary

Medicare decisions have a major impact on Medicaid.

- Cost sharing levels in Medicare
  - Medicare Part B premiums
  - Medicare Advantage premiums
- Utilization review decisions governing overlapping benefits
  - Skilled nursing
  - Home health
  - DME
- Hospital discharges into nursing facilities
- Medicare-paid physicians order Medicaid-paid services

Challenges to Long-Term Care Reform

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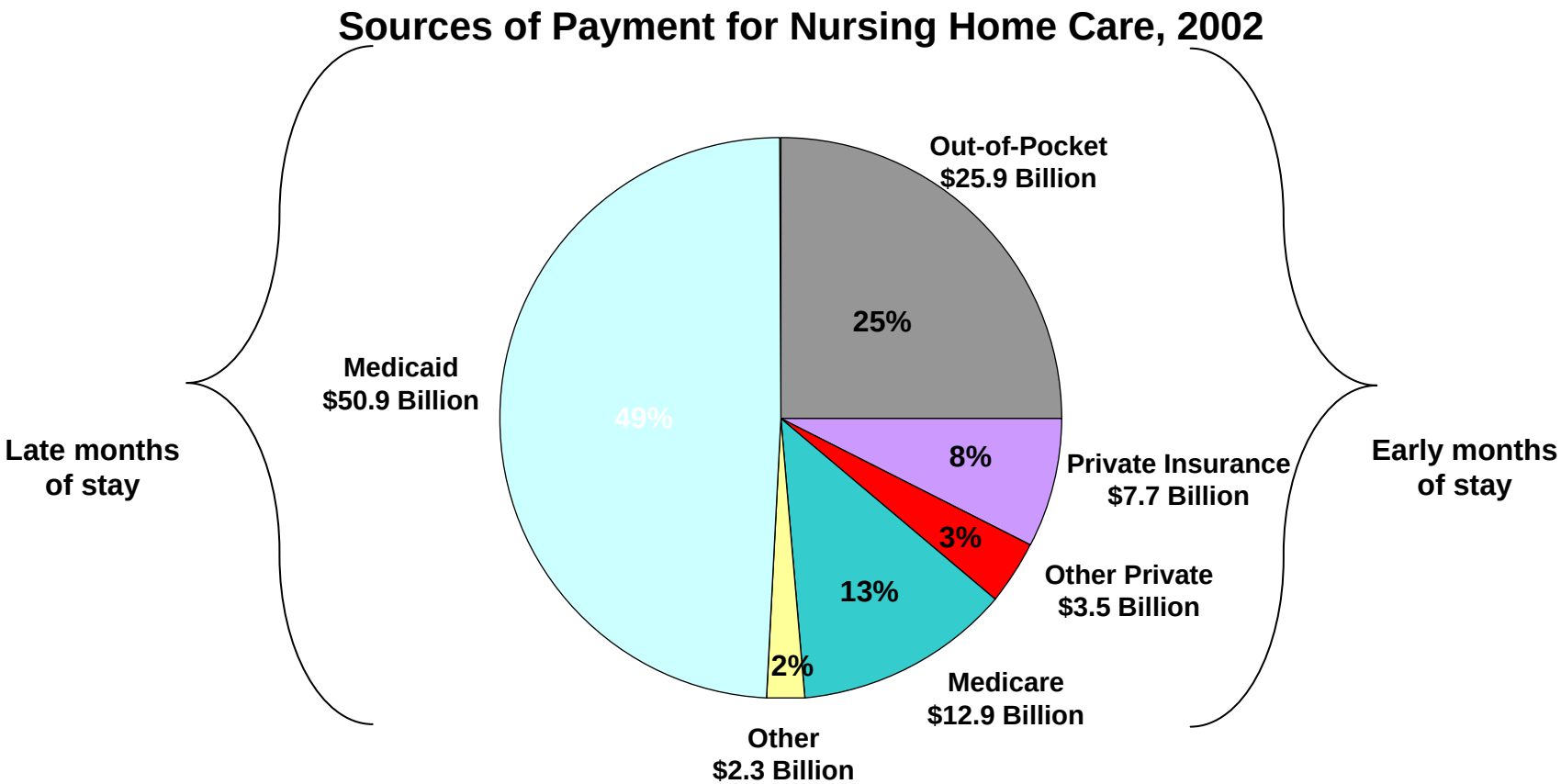
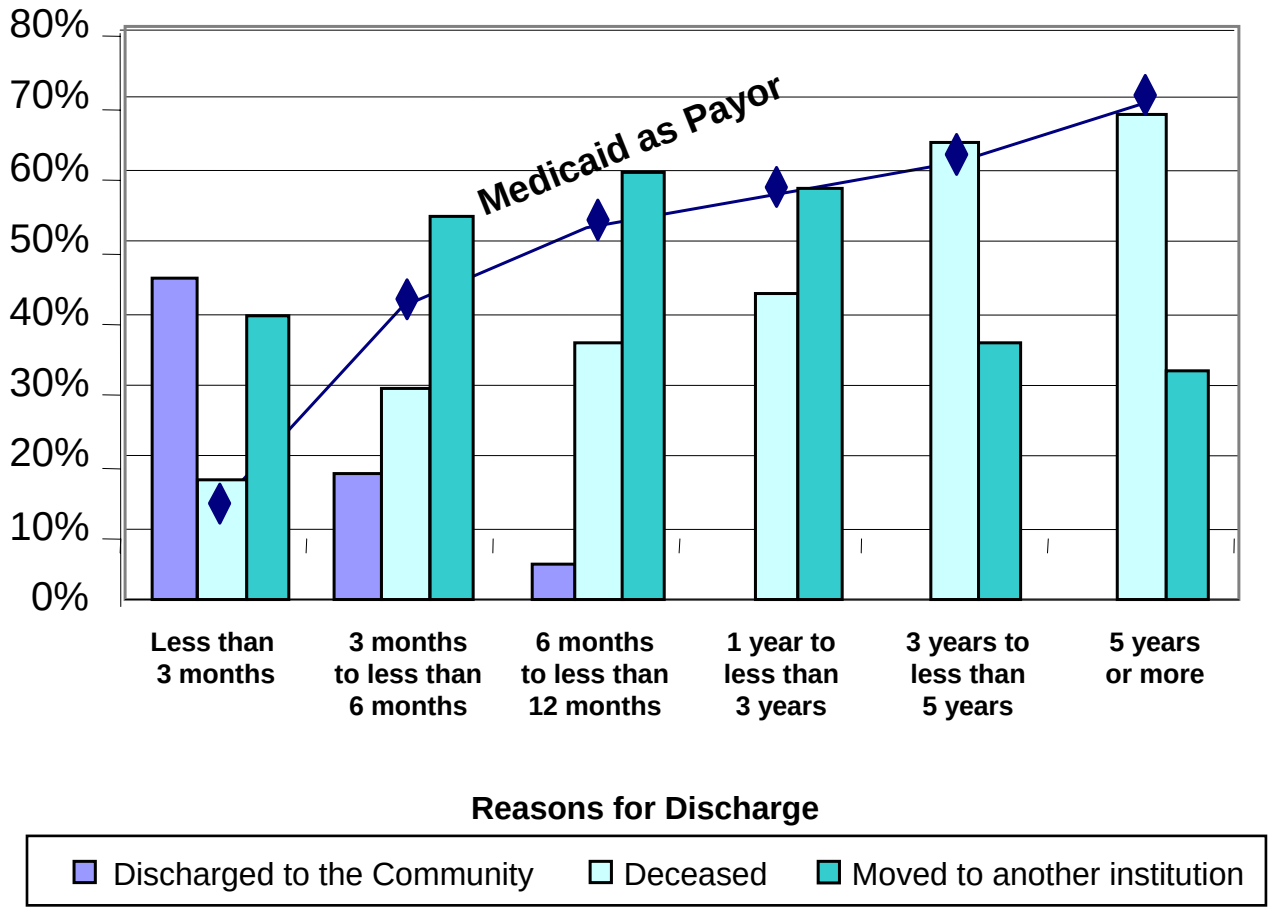
Because other funding sources usually cover the early months of a person's nursing facility stay . . .



Source: CMS, Office of the Actuary

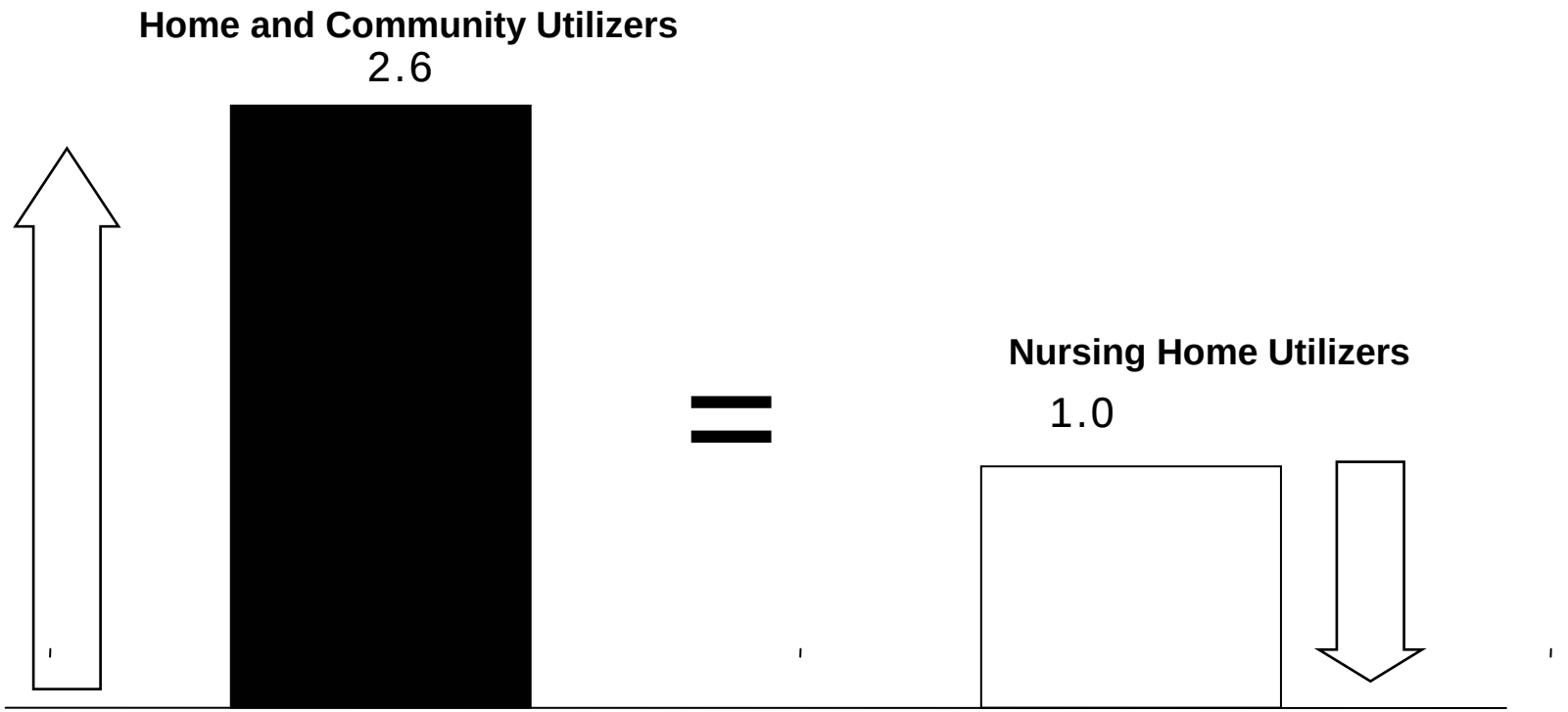
. . . individuals who move to the community do so after a short stay, before Medicaid is a major payor.



Source: The National Nursing Home Survey: 1999 Discharge Data Summary

Second, states fear the "woodwork" effect: reducing the people served in NFs often adds to a state's net Medicaid enrollment.

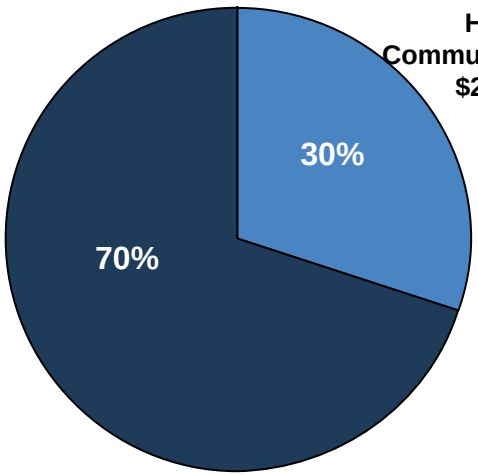
Reducing NF Utilization by One Person Led to an Increase in HCBS Utilizers by 2.6 People. Oregon (1998)



Source: R. Kane, et al., The Heart of Long Term Care

The risk of substituting paid services for informal supports also contributes to fears of the woodwork effect.

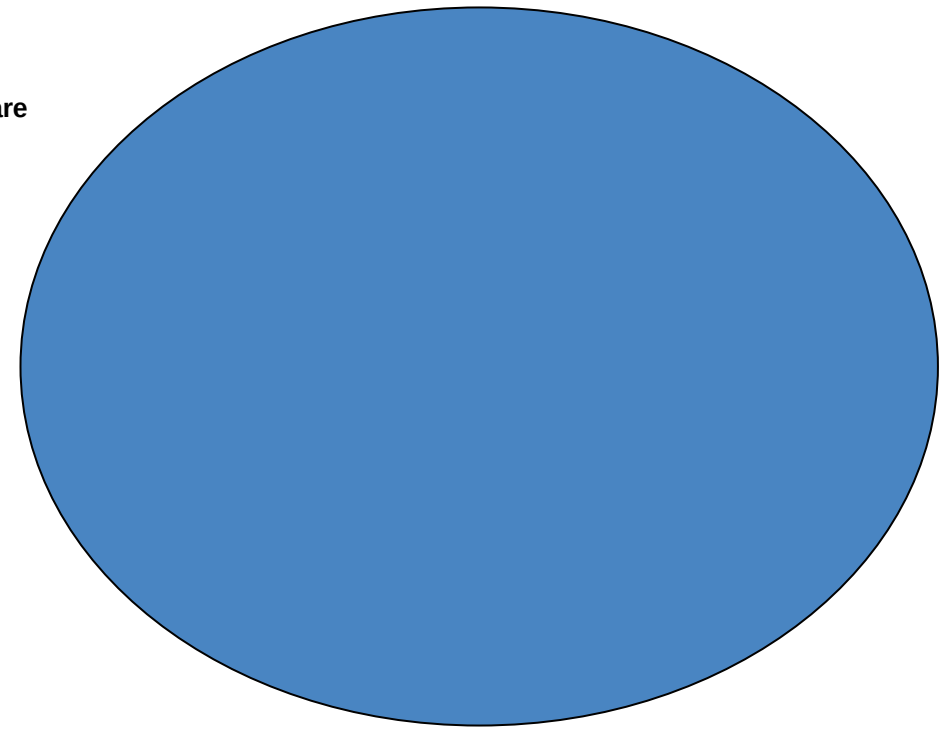
Medicaid Long Term Care Expenditures, 2002



$82 Billion

Source: The MEDSTAT Group, Medicaid HCBS Waiver Expenditures, FY 2002

Value of Informal Caregiving, 2002



$256 Billion

Source: P. Arno, et al., The Economic Value of Informal Caregiving, Health Affairs

. . . but one reform idea is found in the Long-Term Care Partnership Programs

- Programs in four states (CA, CT, IN, NY)
- Allows beneficiaries who purchase LTC insurance to protect assets if they exhaust their private LTC benefits and need Medicaid
- Models include dollar-for-dollar, total asset protection, and hybrid
- Over 211,000 policies have been sold
  - Only 2,761 (1.3%) purchasers have ever accessed their LTC insurance benefits
  - 251 of them have exhausted their LTC benefits, but only 119 (47%) of those have accessed Medicaid
- It remains an unknown whether those who purchased LTC insurance policies through this partnership would have accessed Medicaid if they had not purchased the LTC policies.

Preview of Some Key Questions for the May 2006 Session

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Key recommendations in "long term care" from the Commission will include:

- Should minimum national "benefits" standards be set?
- If so, should the minimum national standards be altered?
- Should some rules be set about policies that are within a state's discretion vs. policies that require express federal approval (like the current waiver model)?
  - HCBS vs. institutional care
- If so, where is that line drawn?
- Should changes to made to affect the institutional bias, and if so, what should they be?
- What mechanisms can be used to expand the use of non-Medicaid financing in LTC?
- What is the best role for consumer direction in Medicaid LTC?
- How should service delivery and financing be coordinated for dual eligibles?

Questions

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