The Hilltop Institute

analysis to advance the health of vulnerable populations

Workable Solutions for Long-Term Care
Private Sector Models in the Context of Medicaid Reform

Introduction

The title of this session, "Private Sector Models in the Context of Medicaid Reform", could have many meanings. It could focus on the need to expand the private long-term care insurance market, in order to relieve the financial burden that Medicaid bears in covering long-term care: in 2006, private insurance only comprised seven percent of nursing facility revenue, and eleven percent of home health care. Or it could focus on the benefits of expanding Medicaid Cash & Counseling models for home and community-based care, which would enable more Medicaid beneficiaries to receive and manage a budget and to therefore become active and value-oriented consumers who, for example, might purchase a microwave oven and thus avoid the need for caregivers to be paid each day to prepare hot meals.

Instead, this session will focus on the emerging opportunities to align Medicaid and Medicare payments and incentives, with the goal of reforming Medicaid (and Medicare) in several key ways, which include:

- Creating incentives in Medicare to improve hospital discharge planning in a way that might avoid or reduce Medicaid-paid nursing facility stays and days;
- Creating incentives in Medicaid to improve the quality of long-term care services in a way that avoids unnecessary Medicare-paid hospital admissions and emergency room usage;
- Promoting greater flexibility in benefit delivery.

These opportunities best present themselves when Medicaid and Medicare financing is aligned in private sector managed care organizations that receive risk-based capitation payments from both Medicare (as a Medicare Advantage plan) and Medicaid.

Dual Eligibles and Long-Term Care

Most Medicaid long-term care expenditures are incurred on behalf of dual eligibles – those individuals who are enrolled in both the Medicaid and Medicare programs, and qualify for benefits in both programs.[1] The two programs collectively constituted 60 percent of the 2006 nursing facility industry revenue of $124.9 billion (17 percent from Medicare, and 43 percent from Medicaid), and constituted 72 percent of 2006 home health industry revenue of $52.7 billion (38 percent from Medicare, 34 percent from Medicaid). The next closest source of payment in both settings was patient out-of-pocket.

The two programs often have misaligned incentives that derive from their varying coverage rules. Medicare was designed with a benefit package that resembles employer-sponsored insurance, with a heavy emphasis on services delivered by licensed professionals and focused on acute care, treatment, and improvement. Medicare was not designed to maintain a person's functional status, nor was it designed to provide long-term custodial and paraprofessional (or so-called unskilled) support.

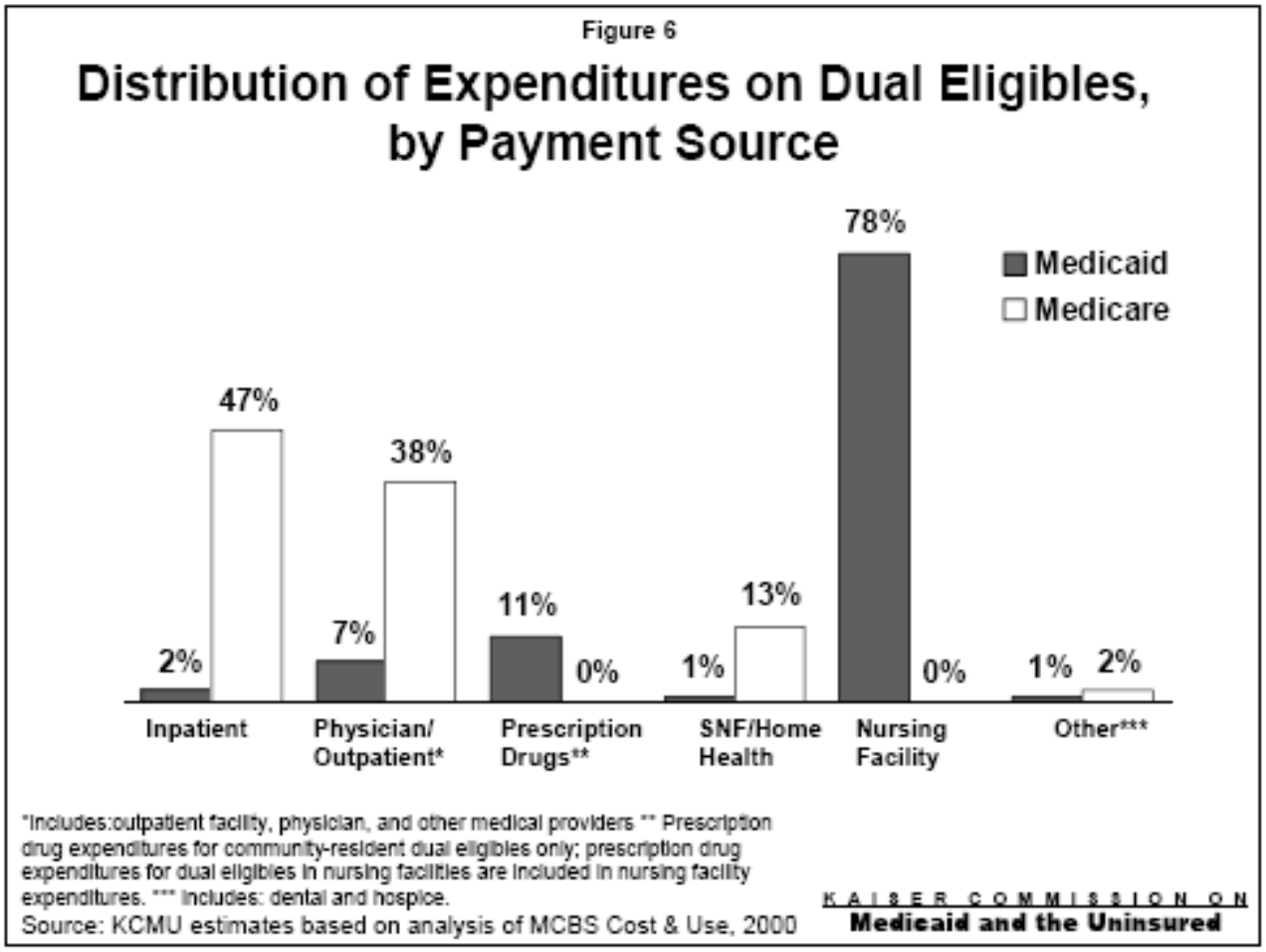
Medicaid is the major payer for long-term custodial supports aimed at meeting an individual's basic support needs, which might relate to dementia or incontinence, for example. Under federal law, Medicaid state plans must include coverage of institutional long-term care for those individuals who qualify on the basis of financial tests (for Medicaid) and functional tests (to meet the given state's determination of who requires a nursing facility level of care).

Figure 1 depicts the primary payer for services delivered to dual eligibles.[2] It shows that Medicare pays the vast majority of inpatient hospital care and "skilled nursing facility" (SNF) care (generally short-term stays, post hospitalization, for intensive nursing and therapy services), and that Medicaid is the only program of the two that pays for (non-skilled) "nursing facility" services.

[1] For purposes of this session, "long-term care" is defined to mean an array of services, both institutional and community-based, that are delivered to individuals who meet a nursing facility level of care. It should be distinguished from "chronic care", which also involves services that are delivered over a long period of time for someone with a chronic condition (such as diabetes), but where the recipient does not qualify for nursing facility admission.

[2] Figure 1 is based on data prior to the launch of Medicare's drug benefit, so the pharmacy data is not reflective of current benefit design.

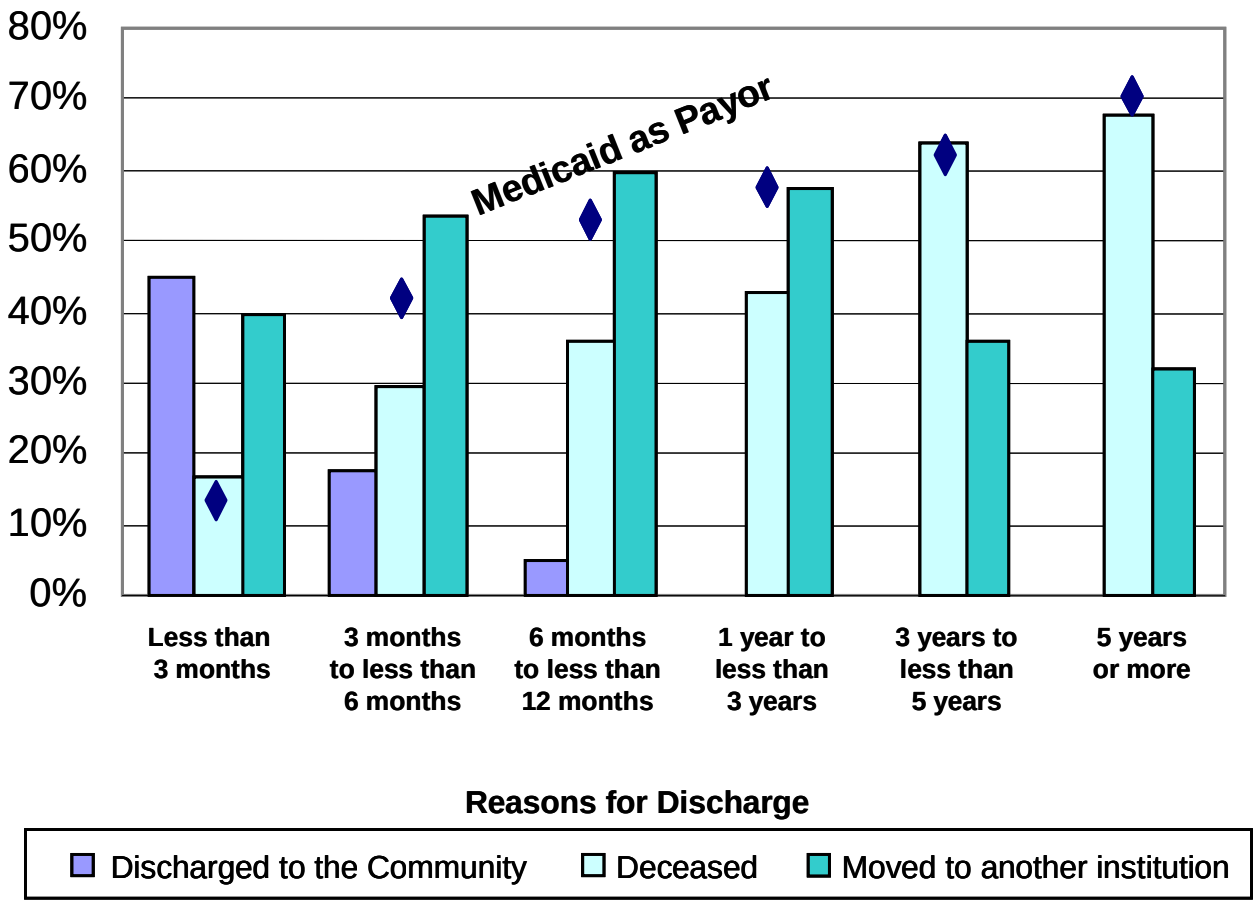
Figure 1: Distribution of Expenditures on Dual Eligibles, by Payment Source, Excluding Private Pay and Patient Out-of-Pocket



Both Medicaid and Medicare administrators often assume that the poor delivery of the other program's benefits drives up the cost of services rendered in the program for which they are responsible. It is not uncommon, for example, for Medicaid program administrators to get frustrated at the frequency with which dual eligibles receive services in a hospital (paid by Medicare), then are discharged into a skilled nursing facility (paid by Medicare) without any regard to the eventual coordination that will be required with Medicaid's long-term care benefits.

Figure 2 depicts how this dynamic often unfolds. Using data from the National Nursing Home Survey, Discharge Data Summary, the bars in Figure 2 represent the reason for the person's discharge. When a person is discharged within the first three months of his/her stay, the major reason for the discharge is returning to the community. The diamonds in Figure 2 represent the percentage of patients for whom Medicaid is the source of payment; Medicaid is the payer for 15 percent of patients in their first three months of a nursing facility stay.

Figure 2: Reasons for Nursing Facility Discharge, and Medicaid Payment Status, By Length of Stay



As Figure 2 demonstrates, the longer someone has been in a nursing home, the more likely they are to be covered by Medicaid, as they exhaust their time-limited skilled nursing facility benefits under Medicare, or exhaust their personal savings. The Catch-22 for Medicaid administrators is that the window of opportunity to serve a person in the community closes quickly; the longer someone stays in an institution, the less likely they are to return home. However, Medicaid generally is not involved in the early months of a person's stay – often, that portion is covered by Medicare. Consequently, Medicaid administrators frequently complain that the lack of good management of the Medicare benefit drives up Medicaid's institutional care costs.

Similarly, Medicare administrators often are frustrated by the management of Medicaid's long-term care benefits. For example, if a dual eligible resides in a poor-quality nursing facility, then the person is more likely to experience pressure ulcers, pneumonia, falls, and other preventable conditions that often result in avoidable Medicare-paid hospitalizations.

The back-and-forth between hospitals and nursing facilities is a poorly understood phenomenon because of the general lack of coordination between Medicare-paid hospital stays and often Medicaid-paid nursing facility stays. Not only does this drive up overall program

costs *in both programs,* it clearly disserves the very dual eligibles who are entitled to better quality care from the two programs.

Using a variety of linked data sources, including Medicaid claims, Medicare claims, and Minimum Data Set (MDS) records, The Hilltop Institute at UMBC (Hilltop) is gaining a better understanding of these dynamics. Specifically, Hilltop has linked individuals' records over time to gain an understanding of movement between providers, and movement over time within a nursing facility (using linked MDS records) to observe changes in functional status.

Table 6 below is rich with information that demonstrates the opportunity here.[3]

Table 6: Nursing Home Residents in Maryland on July 1, 2006
by Medicare Coverage, Medicaid Eligibility, and Length of Extended Stay
All Residents

			Length of Stay in Months to Date					
	# Residents	Avg. LOS	< 1	1-3	3-6	6-18	18-36	> 36
			Residents					
All	**25,305**	**833**	**2,803**	**2,265**	**2,133**	**5,695**	**4,830**	**7,579**
Medicare	3,910	130	2,091	1,167	216	185	125	126
Medicaid	*1,061*	*355*	*329*	*265*	*103*	*140*	*113*	*111*
Non-Medicaid	*2,849*	*46*	*1,762*	*902*	*113*	*45*	*12*	*15*
Non-Medicare	21,395	962	712	1,098	1,917	5,510	4,705	7,453
Medicaid	*16,186*	*1,066*	*324*	*605*	*1,245*	*3,917*	*3,648*	*6,447*
Non-Medicaid	*5,209*	*639*	*388*	*493*	*672*	*1,593*	*1,057*	*1,006*
Medicaid	17,247	1,022	653	870	1,348	4,057	3,761	6,558
Non-Medicaid	8,058	429	2,150	1,395	785	1,638	1,069	1,021
	% Residents	Avg. LOS	Percent of Row (Percent of Detail)					
All	**100**	**833**	**11.1**	**9.0**	**8.4**	**22.5**	**19.1**	**30.0**
Medicare	15.5	130	53.5	29.8	5.5	4.7	3.2	3.2
Medicaid	*(27.1)*	*355*	*(15.7)*	*(22.7)*	*(47.7)*	*(75.7)*	*(90.4)*	*(88.1)*
Non-Medicaid	*(72.9)*	*46*	*(84.3)*	*(77.3)*	*(52.3)*	*(24.3)*	*(9.6)*	*(11.9)*
Non-Medicare	84.5	962	3.3	5.1	9.0	25.8	22.0	34.8
Medicaid	*(75.7)*	*1,066*	*(45.5)*	*(55.1)*	*(64.9)*	*(71.1)*	*(77.5)*	*(86.5)*
Non-Medicaid	*(24.3)*	*639*	*(54.5)*	*(44.9)*	*(35.1)*	*(28.9)*	*(22.5)*	*(13.5)*
Medicaid	68.2	1,022	3.8	5.0	7.8	23.5	21.8	38.0
Non-Medicaid	31.8	429	26.7	17.3	9.7	20.3	13.3	12.7

Notes:
Stays are initially defined as a new admission (or rentry) to a facility to July 1, 2006 with no intervening discharge.
Extended stays are concatenated stays where up to 30 days may occur between stays and facility may change.
Medicaid eligibility is based on full Medicaid benefits (e.g., excludes QMB/SLMB).
Medicare coverage reflects primary payment source, not necessarily general Medicare eligibility.

Source: Hilltop Refined MDS data.

[3] Please forgive the incorrect numbering scheme: this table was copied as a picture from another document, and brought its old numbering system with it.

To explain how to read Table 6: these data reflect the point in time of July 1, 2006. On that date, a total of 25,305 individuals in Maryland resided in nursing facilities, and their average length of stay on that date was 833 days.[4] On that date, 3,910 residents were covered by Medicare, and *their* average length of stay was 130 days, meaning that on average, they had been back and forth to the hospital at least once. Of these individuals, slightly more than 25 percent also were Medicaid beneficiaries (1,061); the rest only had Medicare (2,849).

On July 1, 2006, the remaining nursing facility residents, or 21,395 people, were not covered by Medicare at the time of the service. The vast majority of these people (17,247) were being covered by Medicaid at the time, and the rest (5,209) were paying privately.

One striking finding from Table 6 is that the Medicaid-paid population – 17,247 people, or 68.2 percent of all residents on that date – had an average length of stay on July 1, 2006 of 1,066 days (see footnote 4), or nearly three years.

Dual Eligibles

Better coordination between Medicare and Medicaid offers a potent opportunity to improve care, promote serving individuals in the manner and setting in which they want to be served, all while containing costs and reforming Medicaid. One significant opportunity, discussed below, is coordinating Medicare and Medicaid payments, on a capitated risk-basis, at a single health plan that is accountable for, and at-risk for, the services in both programs.

Before addressing that, however, it is helpful to get a reminder on who the dual eligibles are. Again turning to Hilltop's recent work, Table 2, below, summarizes various demographic information for those 82,104 individuals who were continuously enrolled in both Medicaid and Medicare in Maryland throughout calendar year 2006. The majority of these individuals (59,761) were entitled to full Medicaid benefits, while the remainder (22,343) only received Medicaid assistance with Medicare cost-sharing. It might surprise some people to learn that over 20 percent are under the age of 50, and that over half have never been diagnosed as being disabled.

And related to the upcoming proposal, it is worth noting that just about 10 percent of dual eligibles were enrolled, in 2006, in some form of Medicare Advantage (indicated on Medicare records as "Group Health").

[4] Table 6 utilized a Hilltop-defined "extended" length of stay to mean a continuous period of being institutionalized, perhaps in more than one institution, and perhaps with hospitalizations interspersed, with no more than a 30 day period in the community along the way.

Table 2: Continuously Enrolled Duals in Maryland: Selected Grouping Criteria

	Full Medicaid		Partial Medicaid		All 2006	
	Persons	% of column	Persons	% of column	Persons	% of column
Total	59,761	100%	22,343	100%	82,104	100%
Age Categories						
Less than 21	162	0.3%	2	0.0%	164	0.2%
21 to 34	4,293	7.2%	567	2.5%	4,860	5.9%
35 to 49	9,440	15.8%	3,383	15.1%	12,823	15.6%
50 to 64	8,606	14.4%	4,896	21.9%	13,502	16.4%
65 to 74	13,118	22.0%	7,095	31.8%	20,213	24.6%
75 to 84	14,526	24.3%	4,892	21.9%	19,418	23.7%
84 & over	9,616	16.1%	1,508	6.7%	11,124	13.5%
Sex						
Female	38,869	65.0%	14,966	67.0%	53,835	65.6%
Male	20,892	35.0%	7,377	33.0%	28,269	34.4%
Race						
Asian	4,300	7.2%	540	2.4%	4,840	5.9%
Black	22,561	37.8%	9,297	41.6%	31,858	38.8%
Caucasian	28,033	46.9%	11,543	51.7%	39,576	48.2%
Hispanic	1,581	2.6%	389	1.7%	1,970	2.4%
Native American/Pacific Isle/Alaskan	117	0.2%	51	0.2%	168	0.2%
Undetermined	3,169	5.3%	523	2.3%	3,692	4.5%
Ever Disabled						
Yes	26,886	45.0%	11,276	50.5%	38,162	46.5%
under 65	*21,896*	*36.6%*	*8,748*	*39.2%*	*30,644*	*37.3%*
65 & over	*4,990*	*8.3%*	*2,528*	*11.3%*	*7,518*	*9.2%*
No	32,875	55.0%	11,067	49.5%	43,942	53.5%
under 65	*605*	*1.0%*	*100*	*0.4%*	*705*	*0.9%*
65 & over	*32,270*	*54.0%*	*10,967*	*49.1%*	*43,237*	*52.7%*
End Stage Renal Disease						
Yes	1,725	2.9%	724	3.2%	2,449	3.0%
No	58,036	97.1%	21,619	96.8%	79,655	97.0%
Hospice Care						
Yes	1,084	1.8%	178	0.8%	1,262	1.5%
Deceased during CY	*785*	*1.3%*	*153*	*0.7%*	*938*	*1.1%*
Not Deceased	*299*	*0.5%*	*25*	*0.1%*	*324*	*0.4%*
No	58,677	98.2%	22,165	99.2%	80,842	98.5%
Deceased During CY						
Yes	5,933	9.9%	971	4.3%	6,904	8.4%
No	53,828	90.1%	21,372	95.7%	75,200	91.6%
Medicare Group Health Plan Coverage						
Yes	5,852	9.8%	2,285	10.2%	8,137	9.9%
No	53,909	90.2%	20,058	89.8%	73,967	90.1%

Note: Calendar year data.

Aligning Payments and Incentives

One major private sector model that would reform Medicaid, improve long-term care, and generate more flexibility and quality for beneficiaries is to utilize managed care incentives in both Medicaid and the Medicare Advantage program, especially given the existence of Medicare Advantage Special Needs Plans (SNPs) that are tailored for dual eligibles.

Under freedom of choice rules that govern the Medicare program, all Medicare beneficiaries, including dual eligibles, have the option of joining a Medicare Advantage health plan (including, for dual eligibles, an SNP), or instead remaining in Medicare fee-for-service (FFS). In Medicaid, the state Medicaid agency has the right to request permission from Centers for Medicare and Medicaid Services (CMS) to require Medicaid beneficiaries, including dual eligibles, to join a Medicaid-contracting MCO.

Consequently, there are five permutations of service delivery for dual eligibles: (1) receive both Medicare and Medicaid services on a FFS basis, with no coordination (the most common permutation); (2) participate in a Medicare Advantage health plan and Medicaid FFS; (3) participate in Medicare FFS and a Medicaid MCO; (4) participate in a Medicare Advantage health plan and a Medicaid MCO, but two *different* health plans; or (5) participate in the *same* health plan in both programs. Only the final option optimizes coordination of care, creates and aligns strong incentives to manage services well to avoid both preventable hospitalizations (paid by Medicare) and preventable long-term institutional nursing facility stays (paid by Medicaid), and creates flexibility inside a capitated model to tailor service-delivery for each individual dual eligibles. This model is dependent on the presence and expertise of health plans that understand care delivery for this population, and that honor and respect dual eligibles' right to self-determination.

At present, the major policy options arise in Medicaid, primarily the decision of whether to pursue a capitated managed care program for dual eligibles, and, if so, whether to (a) make the program mandatory or voluntary under Medicaid and (b) focus only on those dual eligibles who are nursing home level of care or all dual eligibles. These options have various advantages and disadvantages, ranging from honoring "choice" under Medicaid, to scale, to gaming and selection bias, to the vagaries of CMS waiver approval process.

Regardless of the model, however, dual eligibles are best served when there is alignment of Medicare and Medicaid payment streams at the responsible and responsive health plan that will seek to deliver quality care and respect self-determination, and not simply because that is the right thing to do – just as important, it will avoid unnecessary and avoidable costs throughout the health care system.

The opinions expressed herein should not be attributed to UMBC, other employees at Hilltop, or any of Hilltop's clients.

The Hilltop Institute (formerly the Center for Health Program Development and Management) at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and social outcomes of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and other non-profit organizations at the national, state, and local levels.

The Hilltop Institute
University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, Maryland 21250
410.455.6854
www.hilltopinstitute.org