Long-Term Care Overview and Summary of Reform Proposals

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Medicaid Commission Meeting

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Preview of Presentation

- Overview of Medicaid Long-Term Care
- Vermont's LTC 1115 Reform Waiver
- Summary of Reform Proposals

Overview of 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)

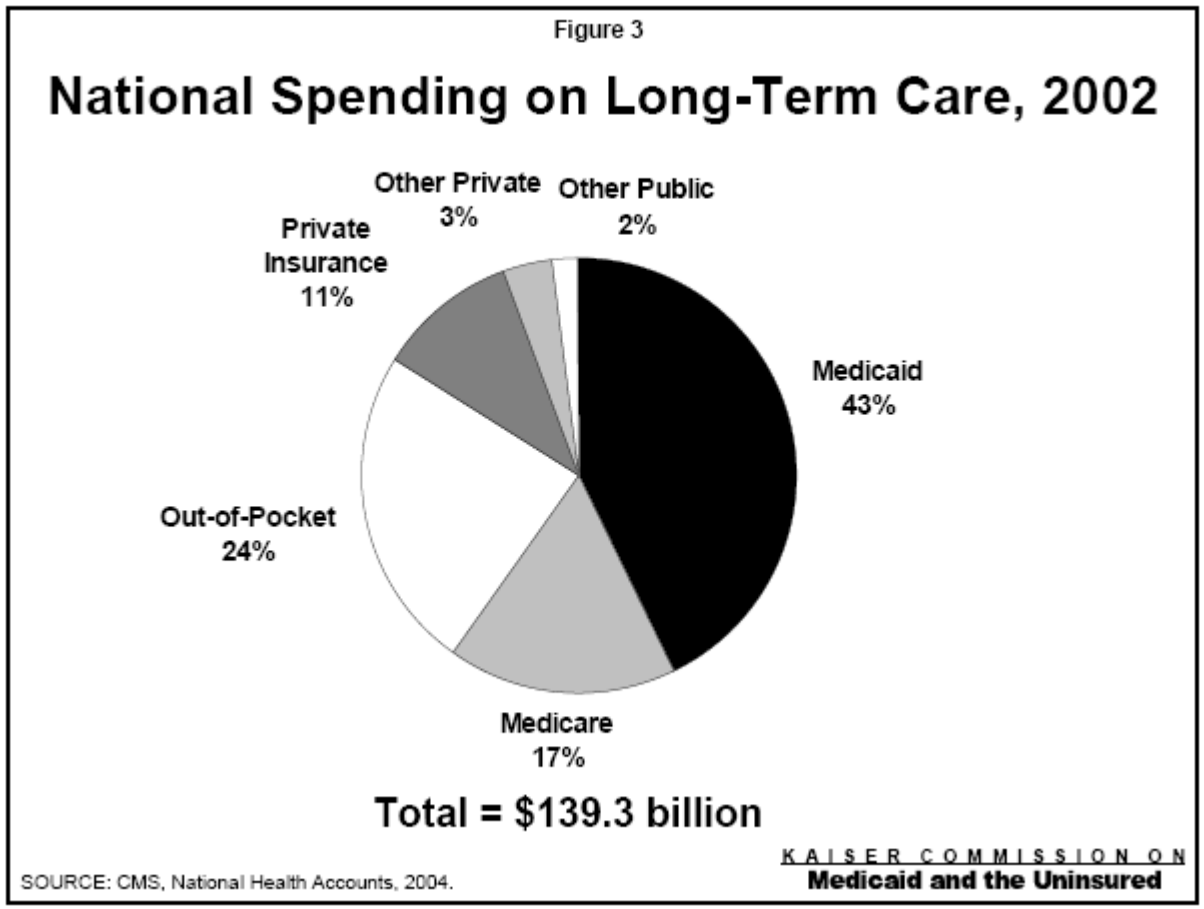
- Home health for adults who meet a nursing facility level of care

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

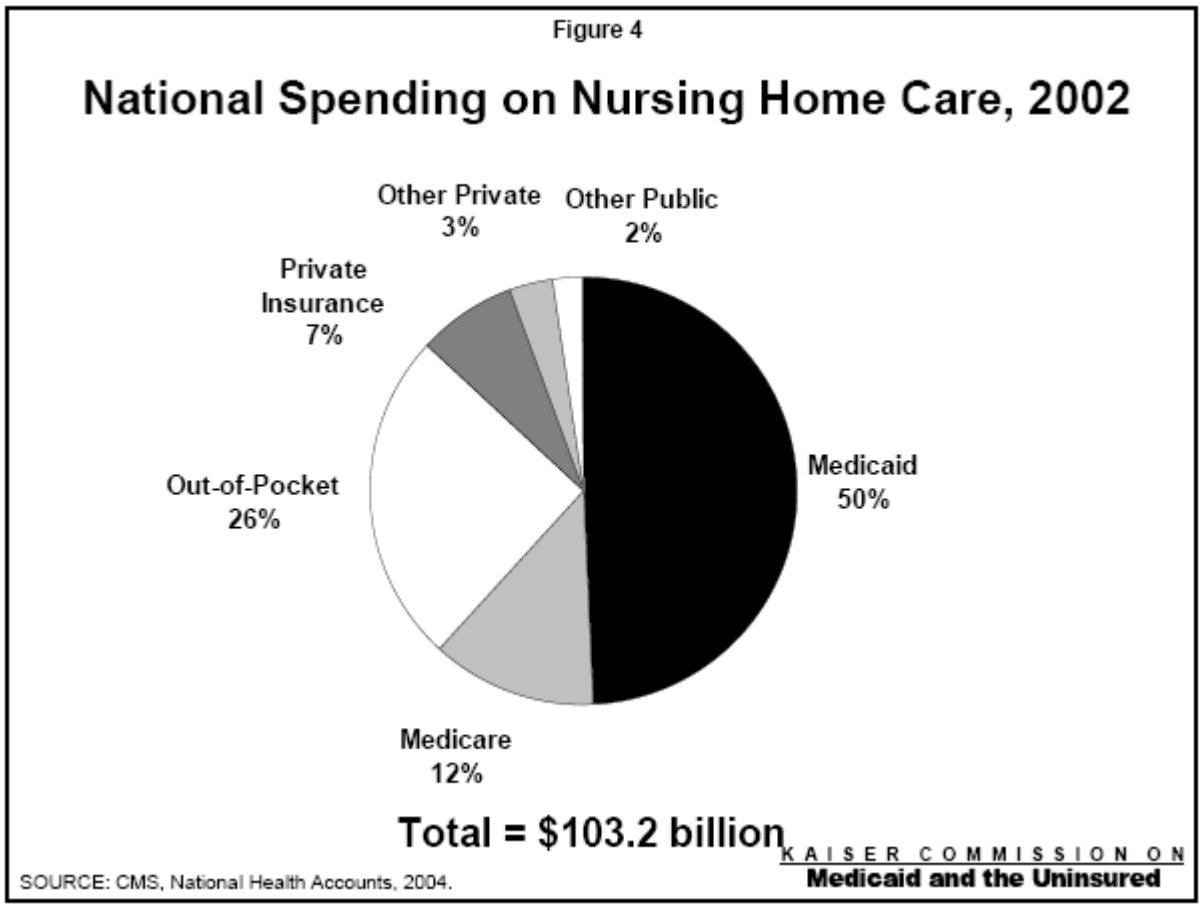
. . . and as an option, a state Medicaid program may cover other long-term care benefits . . .

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

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



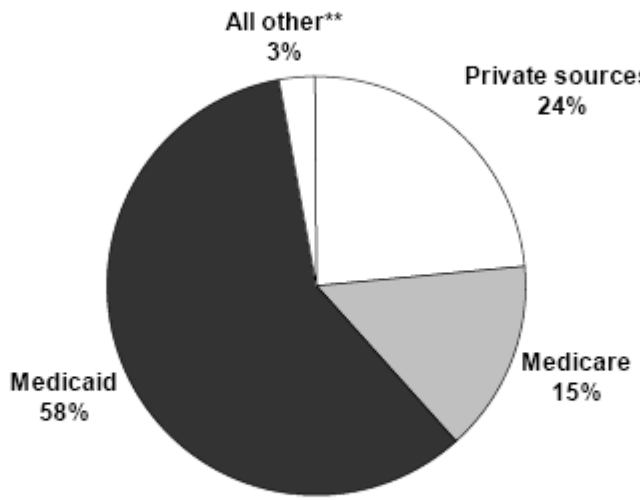
. . . and provides half of all nursing facility revenue . . .



. . . and is the primary source of funding for most residents of 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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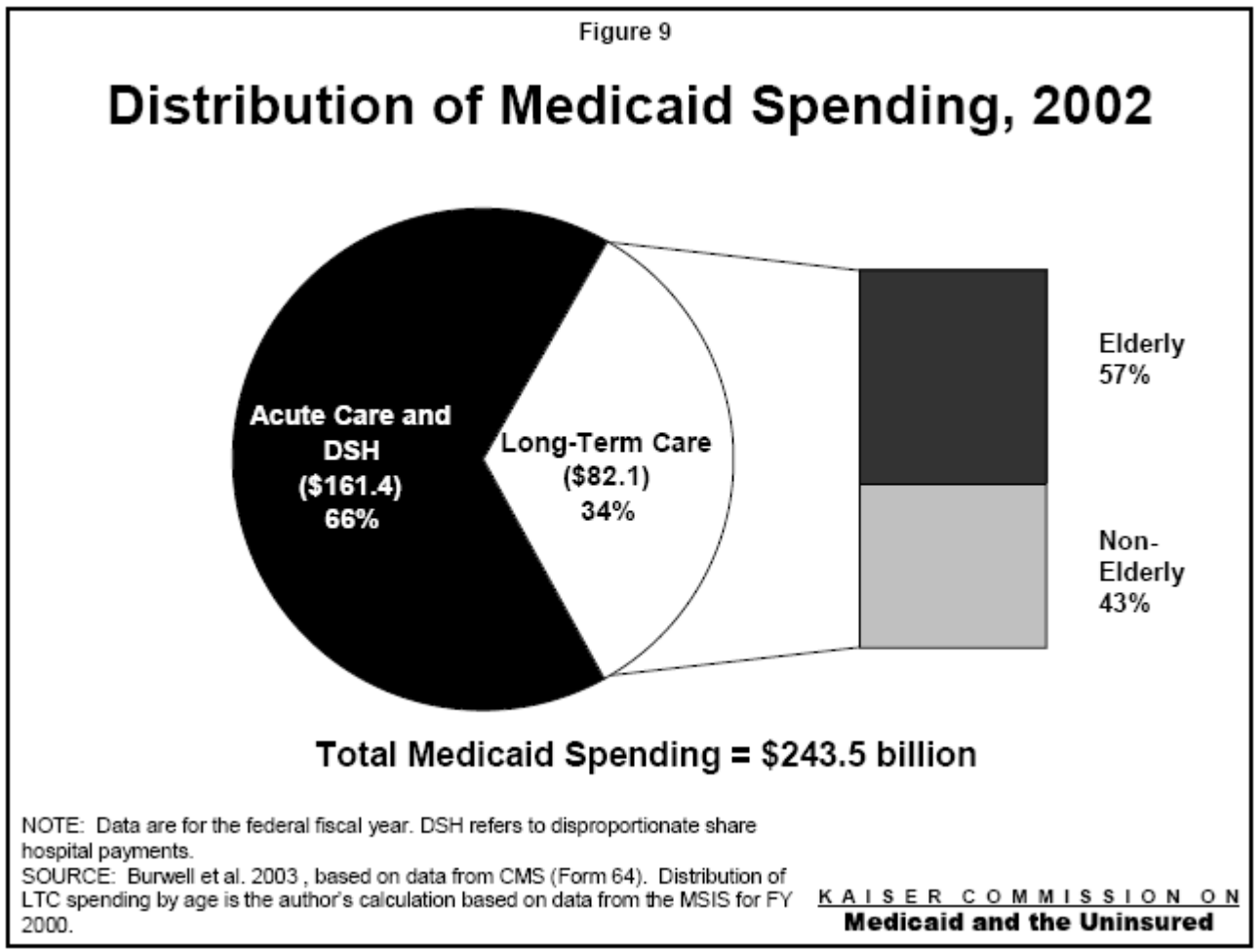
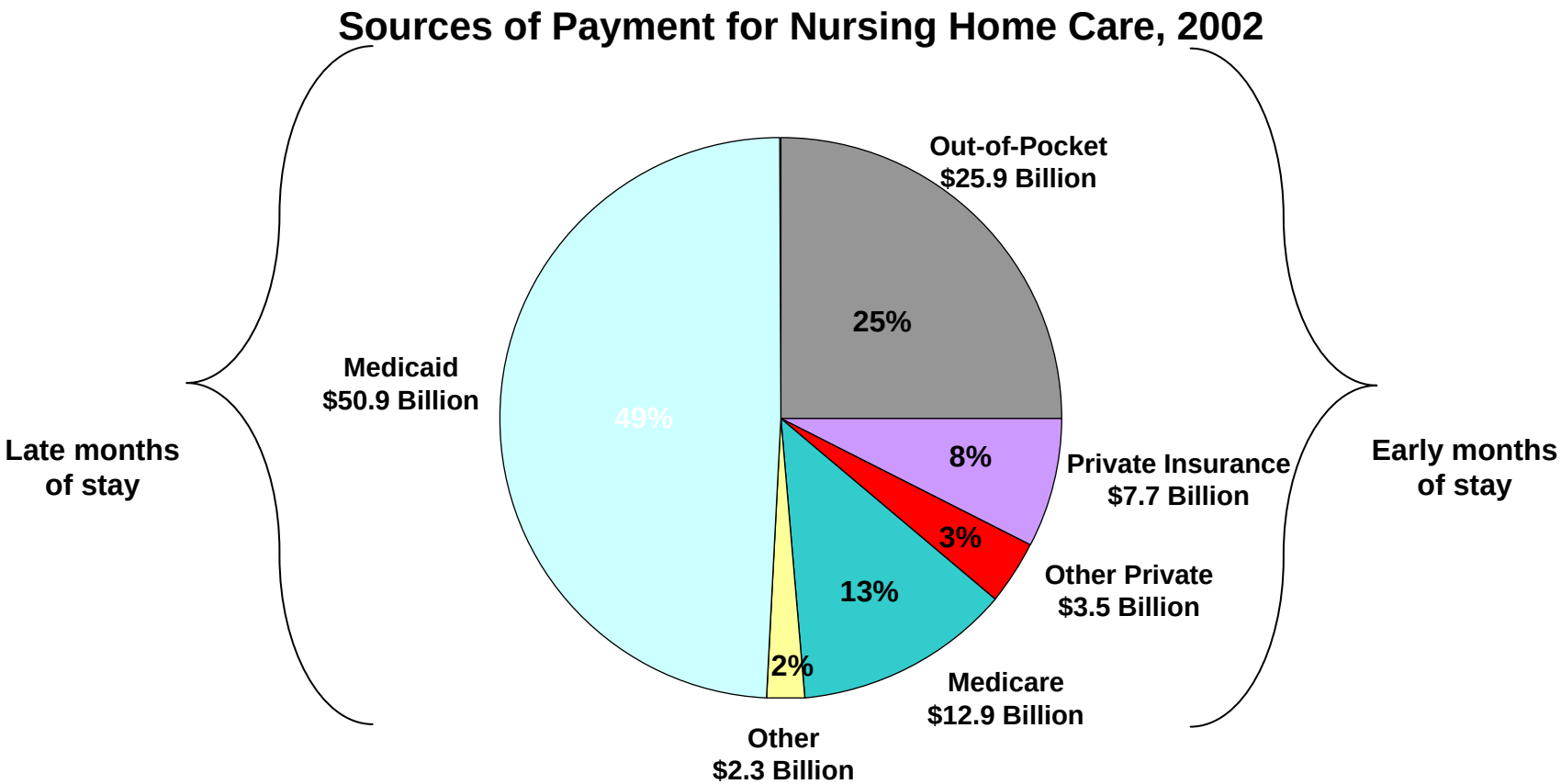
Long-term care services represents 34% of all Medicaid spending.

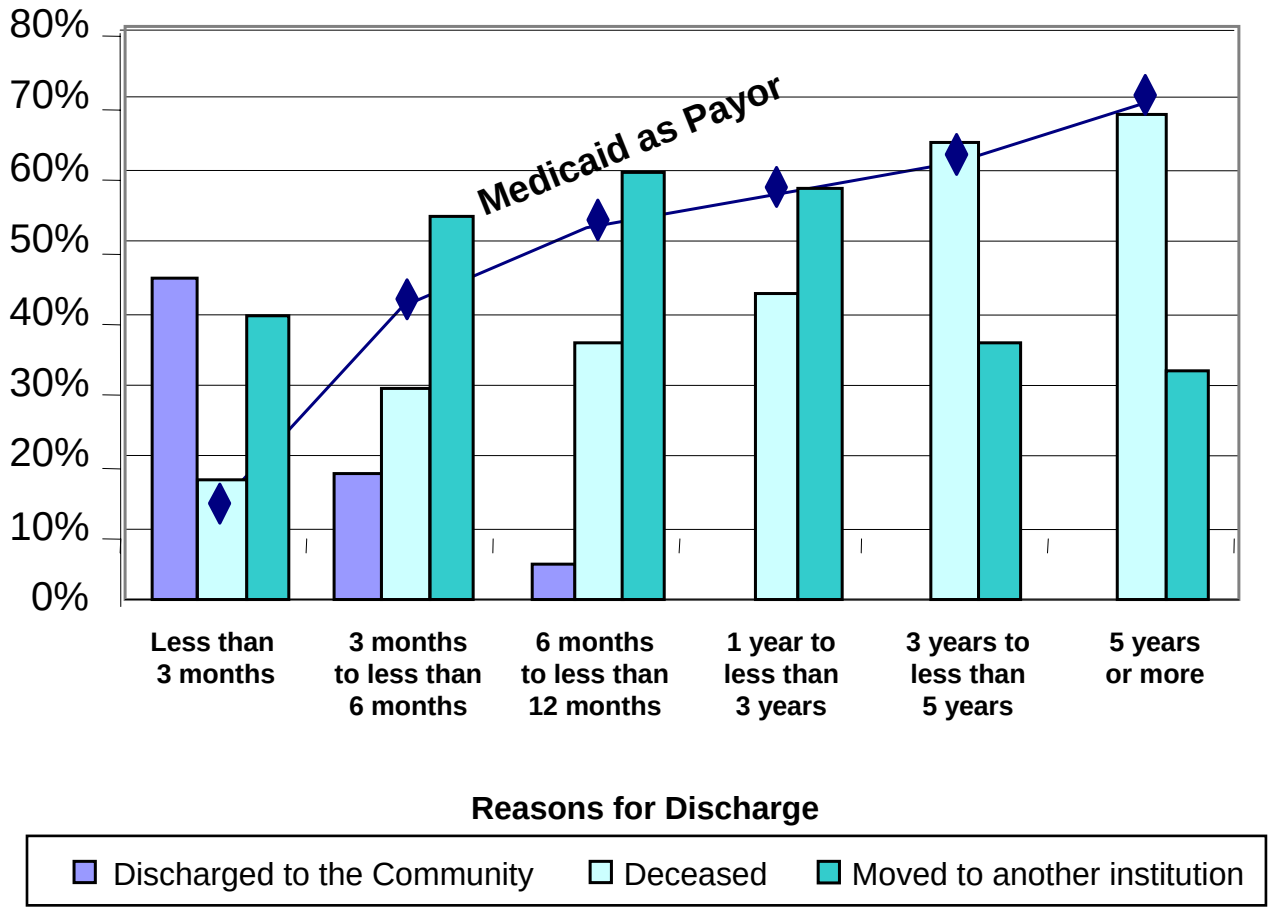


Because other funding sources usually cover the early months of a person's nursing facility stay . . .



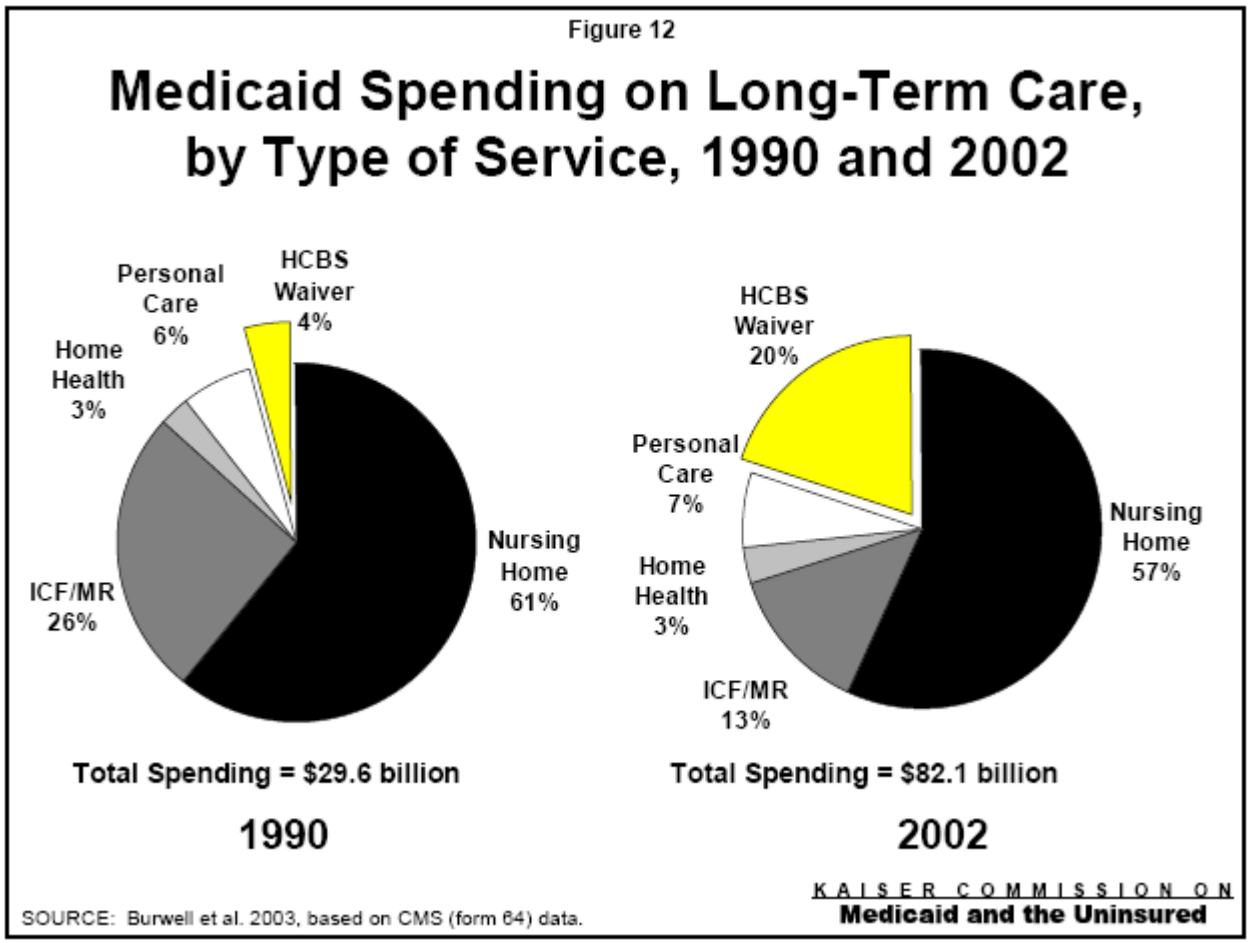
Source: CMS, Office of the Actuary

. . . individuals who move to the community do so after a short stay, before Medicaid can easily divert them.



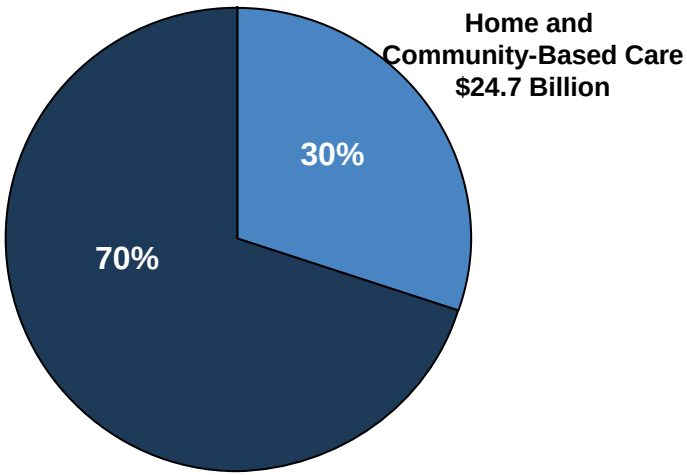
Source: The National Nursing Home Survey: 1999 Discharge Data Summary

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



The risk of substituting paid services for informal care contributes to some concerns about expanding community-based care.

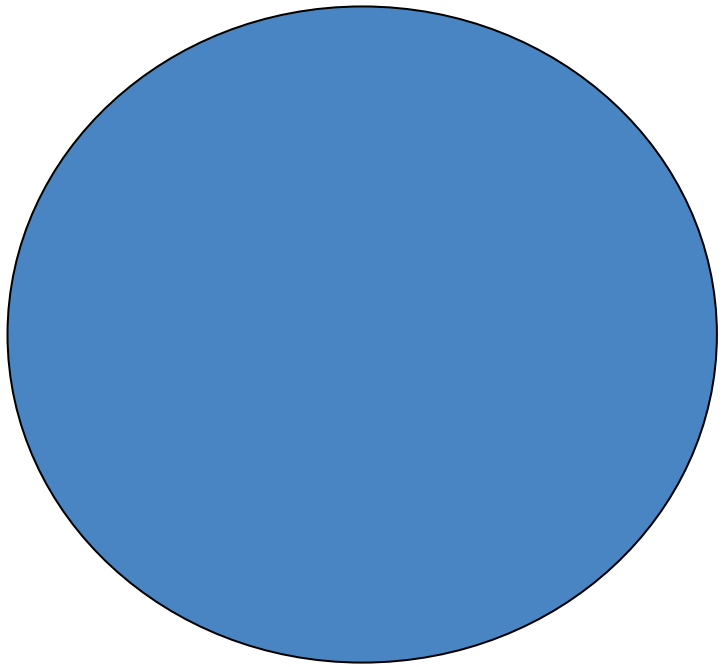
Medicaid Long Term Care Expenditures, 2002



$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

Vermont's Long-Term Care Reform Waiver

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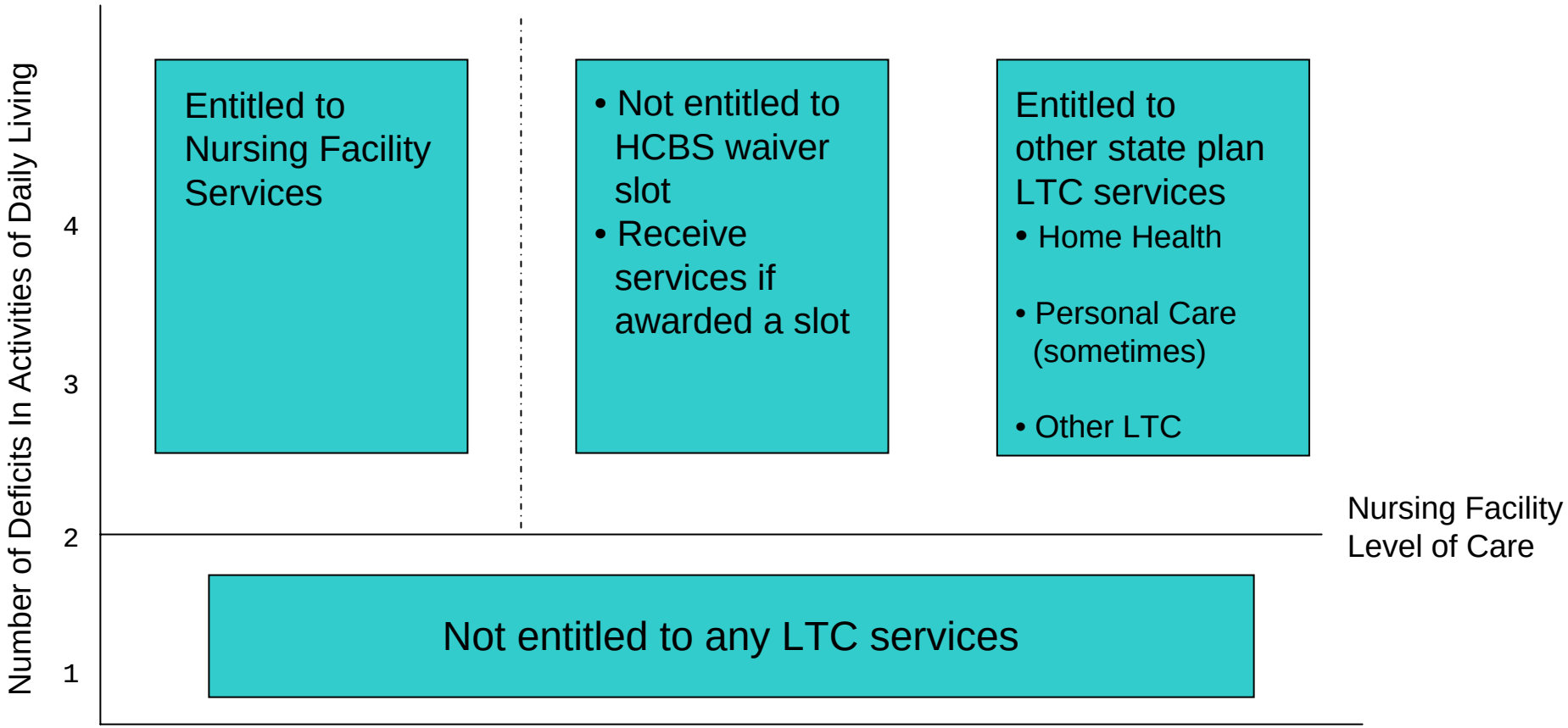
States have the discretion to establish their nursing facility level of care under Medicaid. . .

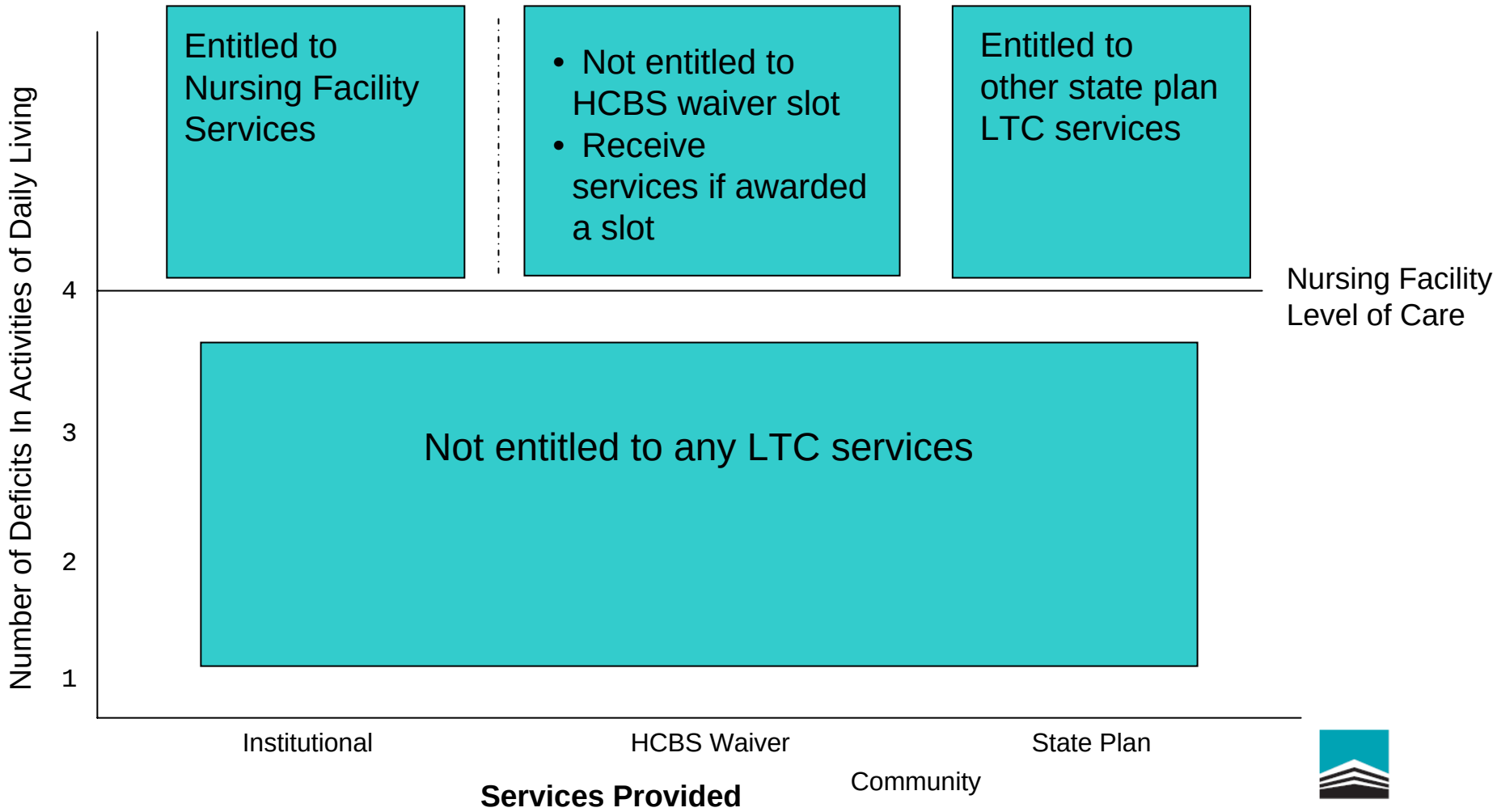
Threshold Levels (Low to High) for NF Level of Care						
Low (1 or 2 ADLs)	Low/Moderate (Few ADLs, Plus some Medical Need)		Moderate (Few ADLs, more Medicaid Need)		**Moderate/High (More ADLs, more Medicaid Need)**	High (Strict)
CA	AR	MS	AK	MO	AZ	AL
DE	IL	NE	CO	MT	NC	HI
KS	IA	OK	CT	NJ	UT	ME
NH	IN	TX	FL	NM		MD
OH	LA	VT	GA	ND		TN
OR	MI	WI	ID	PA		VA
RI	MN		MA	SC		
WA						
WY						

Source: NASHP, reported in Bob Mollica, "State Assisted Living Policy: 2002" (not reporting: DC, KY, NV, NY, SD, WV)

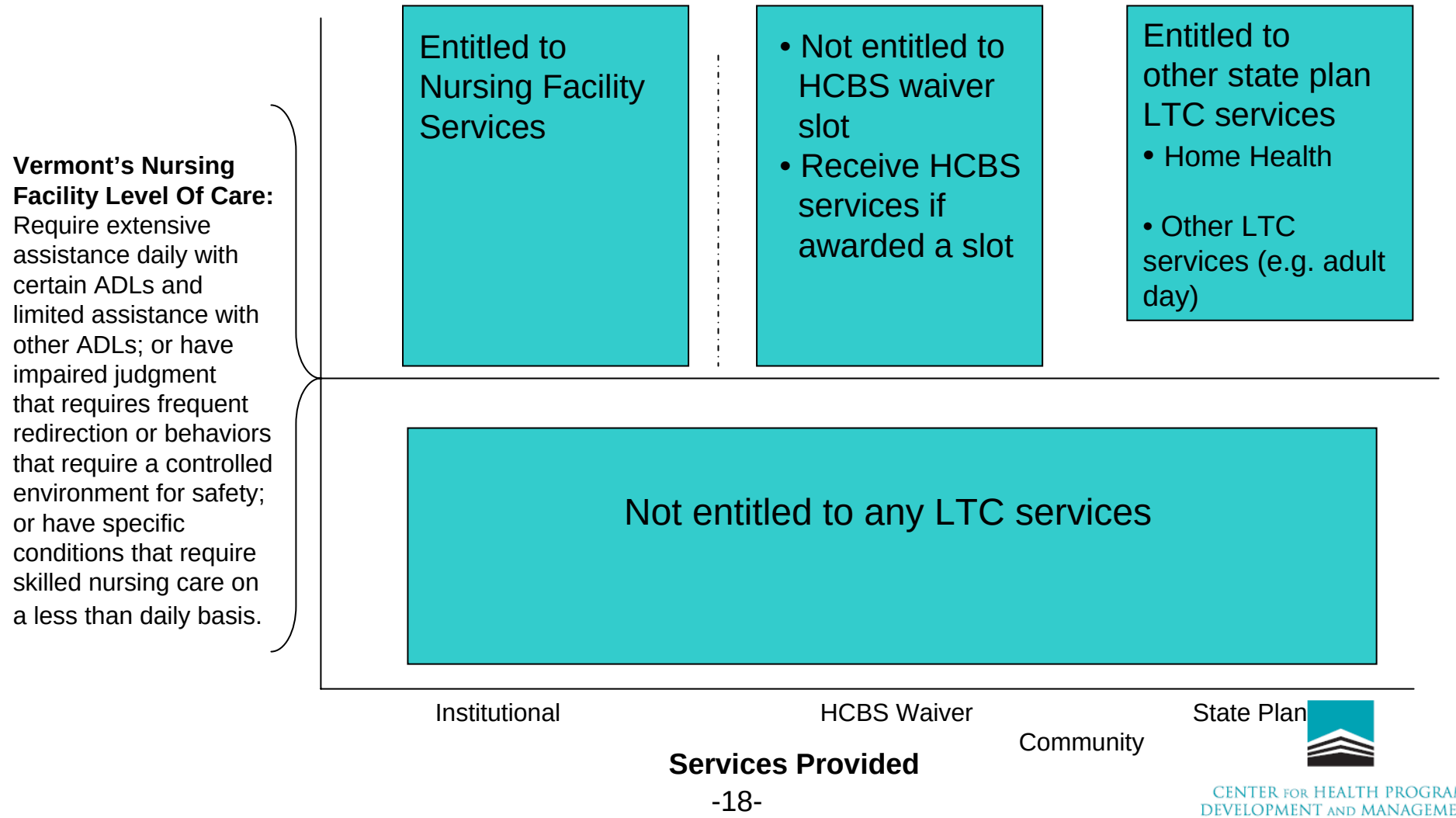
. . . which affects the services a person is entitled to receive, as in this example where a state's level of care is 2 or more ADLs . . .



. . . as compared with a state where the nursing facility level of care is 4 or more ADL deficits



Vermont's program before its approved 1115 Waiver followed these standard rules . . .



In its 1115 waiver, approved in Spring 2005, Vermont established three categories . . .

- "Highest" Need (meet nursing facility level of care, and other criteria)
  - Require extensive assistance with toileting, eating, bed mobility and transfer and at least limited assistance in another ADL; or
  - Have a severe impairment with decision making skills or a moderate impairment and an unalterable behavioral problem; or
  - Have specific conditions that require skilled nursing care on a daily basis; or
  - Have an unstable medical condition that requires skilled nursing care on a daily basis.

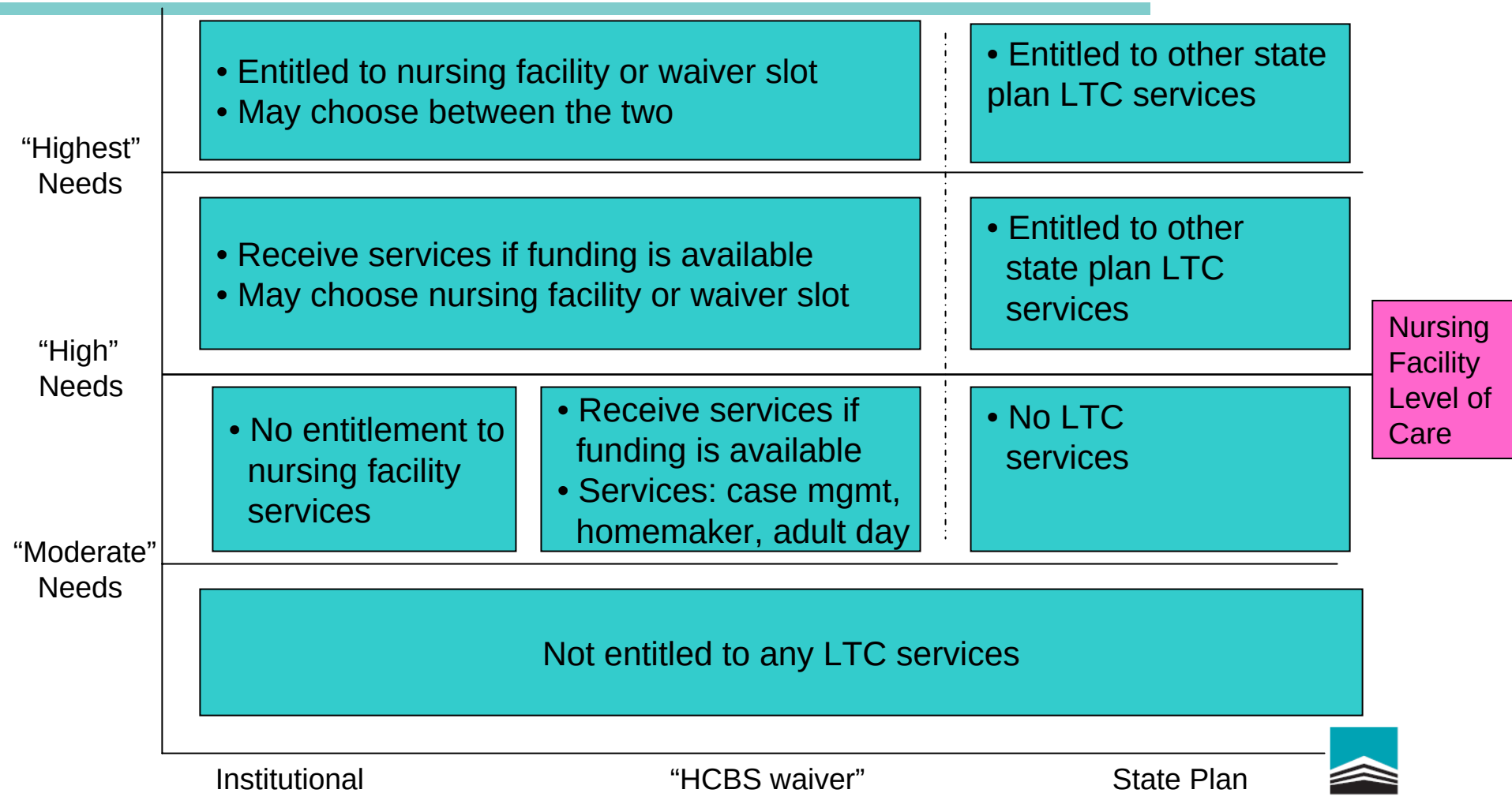
- "High" Need

Nursing Facility Level of Care

  - Require extensive assistance daily with bathing, dressing, eating, toileting and/or physical assistance to walk, or skilled teaching to regain control of ADLs and other functions; or
  - Have impaired judgment that requires frequent redirection, or specific behaviors that require a controlled environment for safety; or
  - Have specific conditions that require skilled nursing care on a less than daily basis.

- "Moderate" Need (an 1115 expansion population; previously unserved)
  - Require supervision or physical assistance 3 or more times a week with at least one ADL or IADL; or
  - Have a health condition that will worsen if LTC services are not provided or are discontinued; or
  - Have impaired judgment that requires general supervision daily; or
  - Require monthly monitoring for a chronic health condition.

. . . and granted services based on these three categories in the 1115 waiver.



Vermont's 1115 Waiver includes many ground-breaking reforms.

- Eliminates the institutional bias
- Reduced the HCBS wait list from 150 to 57
- Creates an entitlement to an "HCBS" slot for everyone in the "highest" needs population
- Utilizes the "High Need" Cohort as the Pressure Relief Valve to Maintain Budget Neutrality
- Provides limited HCBS services to a population that does not meet Vermont's nursing facility level of care (the "moderate" need category)

Summary of Reform Proposals

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Reform Proposals

- Enhanced state program flexibility
- De-link LTC benefits from acute benefits
- Improve options for consumer-directed purchasing
- Alter financial eligibility to prevent abuses
- Create incentives for private financing of LTC

Enhance State Program Flexibility

- Allow “HCBS” to be approved without a waiver
  - Largely but not entirely addressed by DRA
- Allow HCBS waivers to utilize different level of care than nursing facilities
  - Partially addressed by DRA
- Capitated managed LTC without a waiver
- Allow distinct cost sharing rules for LTC
- Allow tailoring of LTC benefits to different populations

De-link Medicaid's LTC benefits from the acute care benefits

- Allow Medicaid to offer LTC benefit array to individuals who would not be entitled to Medicaid acute care services
  - Expect these individuals to receive acute care from Medicare, employer, or retiree insurance
- Similarly allow Medicaid to offer acute benefits to people who would not have entitlement to LTC benefits

Improve options for consumer-directed purchasing

- Expand Cash & Counseling models, in waivers and in Medicaid state plan services
  - Largely addressed in DRA
  - Major area not addressed, and arguably best left outside C&C models, are
    - Certain services where consumers lack bargaining power (such as institutional LTC)
    - Certain services where substitution and negotiation is not likely (such as licensed medical providers)

Alter financial eligibility rules to prevent abuses

- Revise asset transfer and related rules
  - Largely addressed in DRA
- One reform proposal would require a person to draw down value of home equity prior to seeking Medicaid
  - Not addressed in DRA

Create incentives for private financing of LTC

- Tax credits or deductions related to the purchase of private LTC insurance
  - Not addressed in DRA
- Remove moratorium on LTC Public/Private Partnerships
  - Addressed in DRA
- Incentivize reverse annuity mortgages

Questions

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