



Long Term Care Delivery System

October 26-27th, 2005

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Medicaid Commission Meeting



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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.

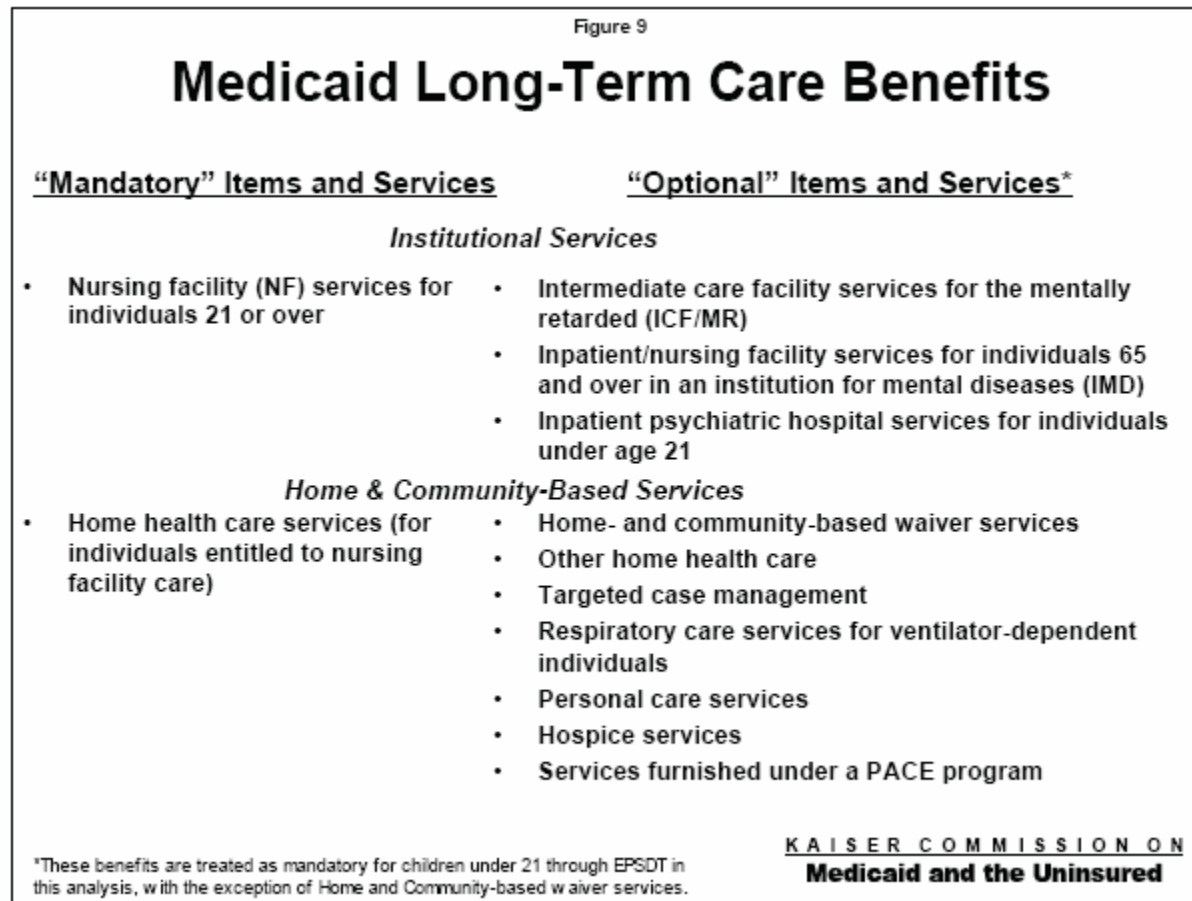


. . . and Medicaid may cover other long-term care benefits . . .

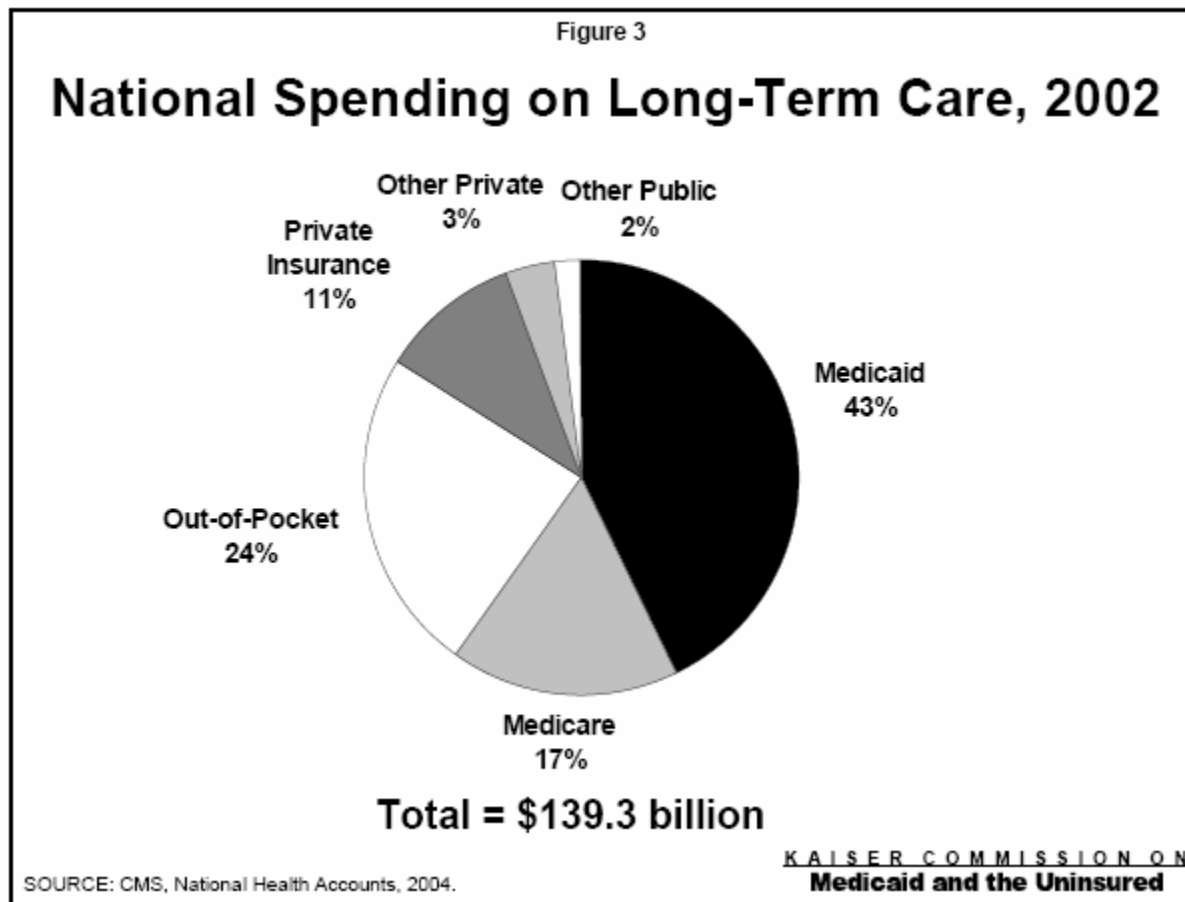
- Personal care (without an HCBS waiver)
- “Home and community-based services” (HCBS) with a 1915(c) waiver



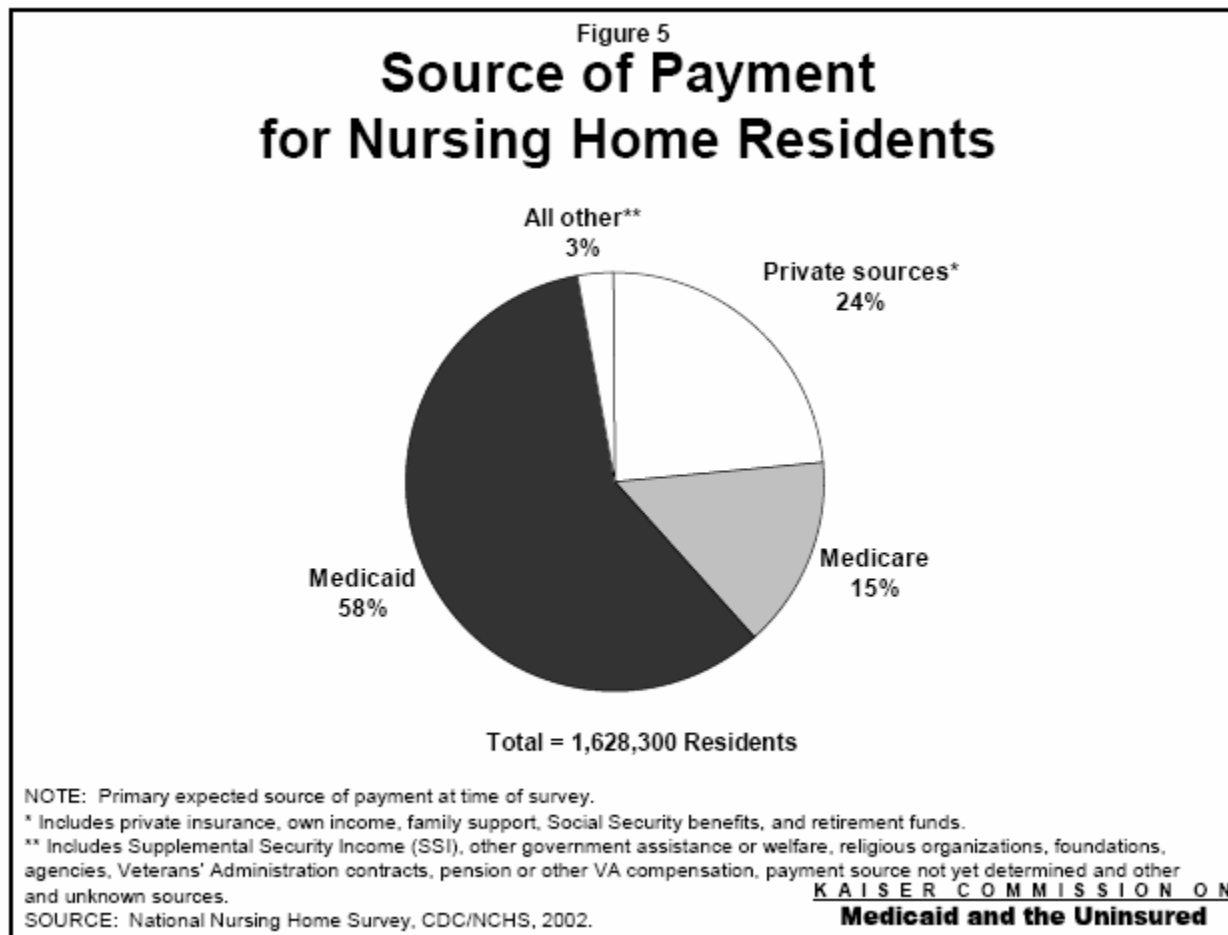
. . . showing that long-term care means more than just nursing facilities.



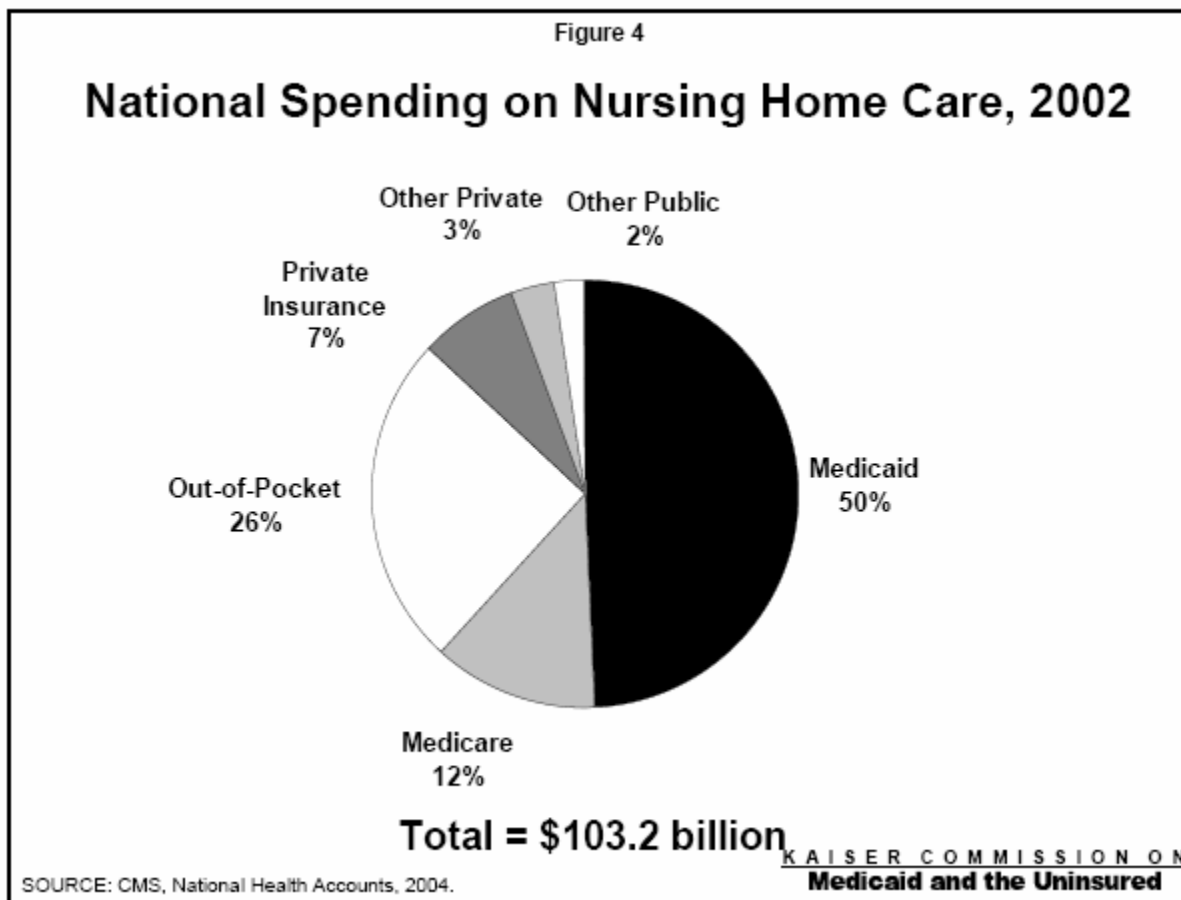
In aggregate, Medicaid is the largest funder of long-term care services nationally . . .



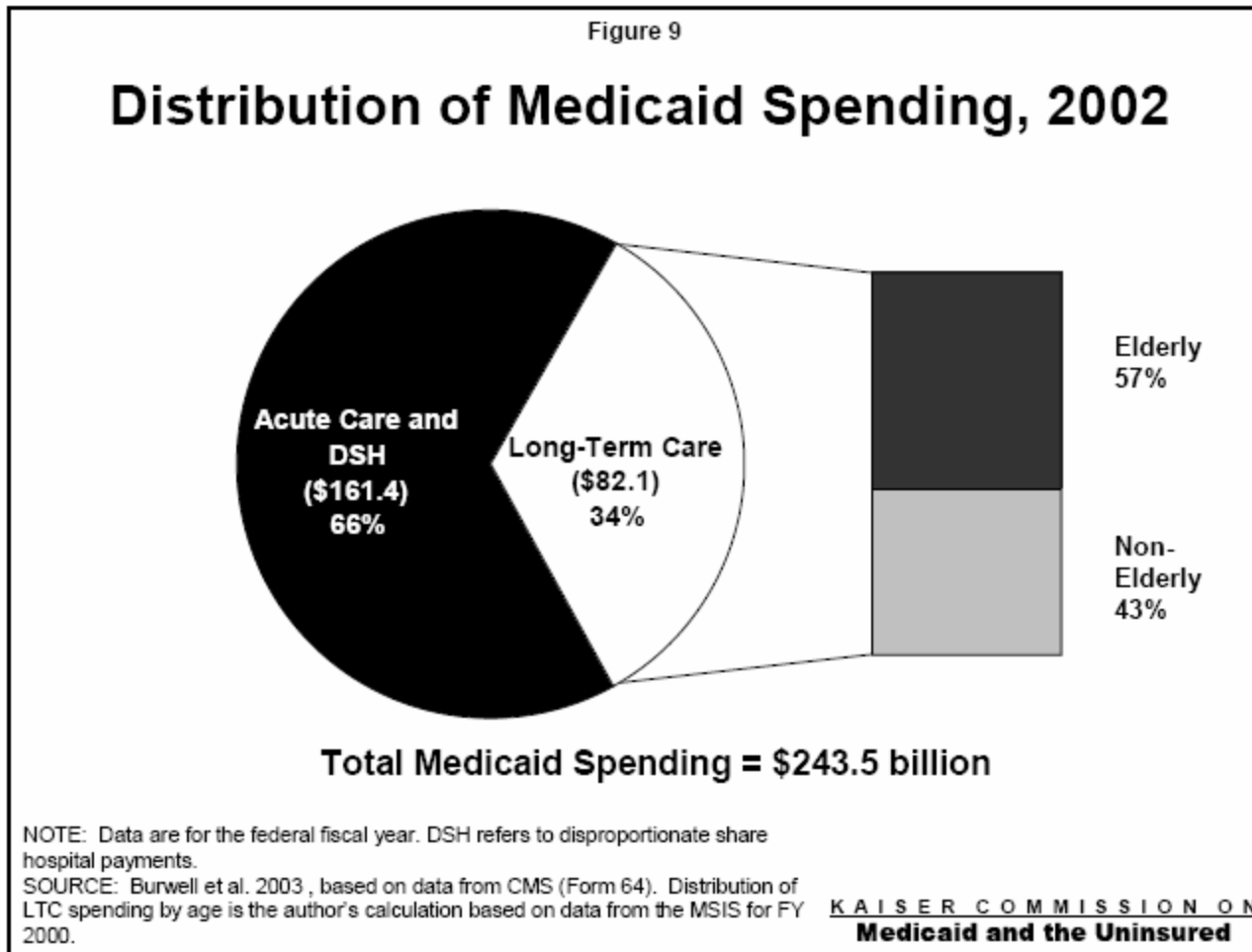
. . . and is the primary source of funding for people in nursing facilities . . .



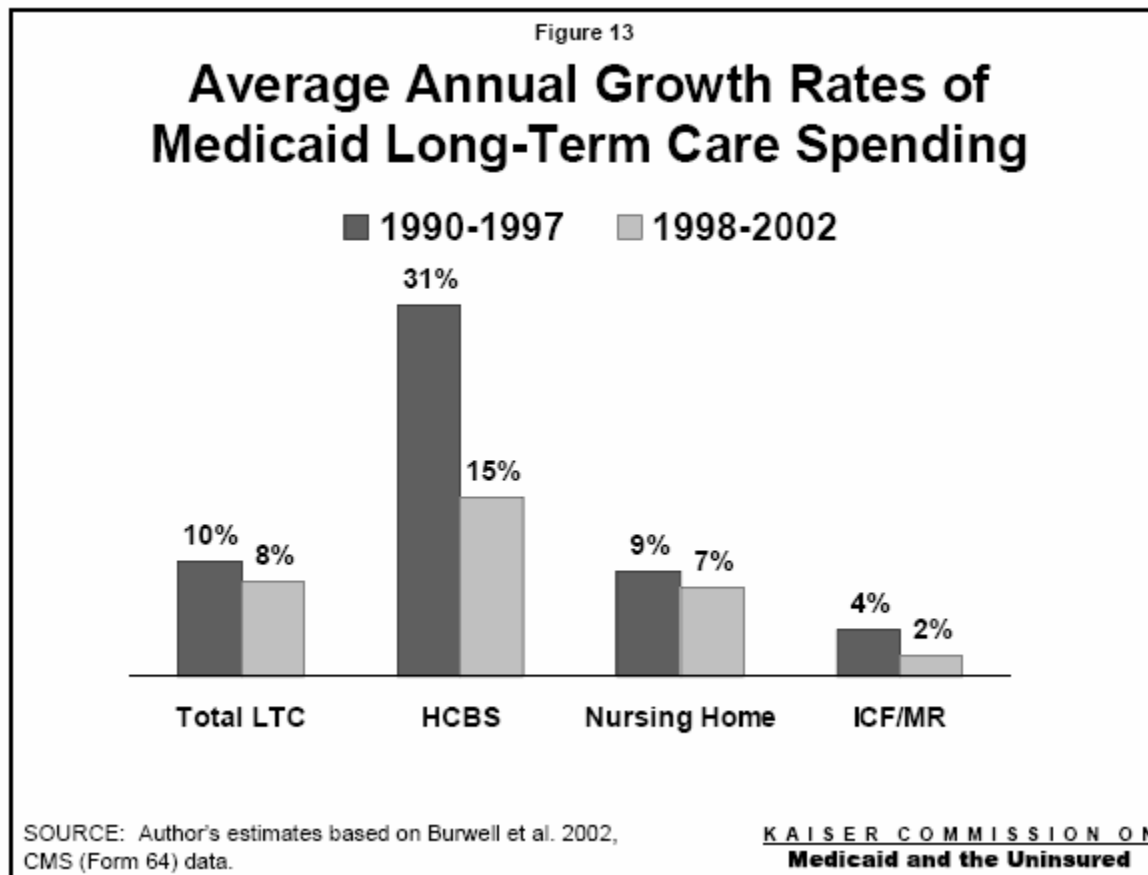
. . . and provides half of all nursing facility revenue.



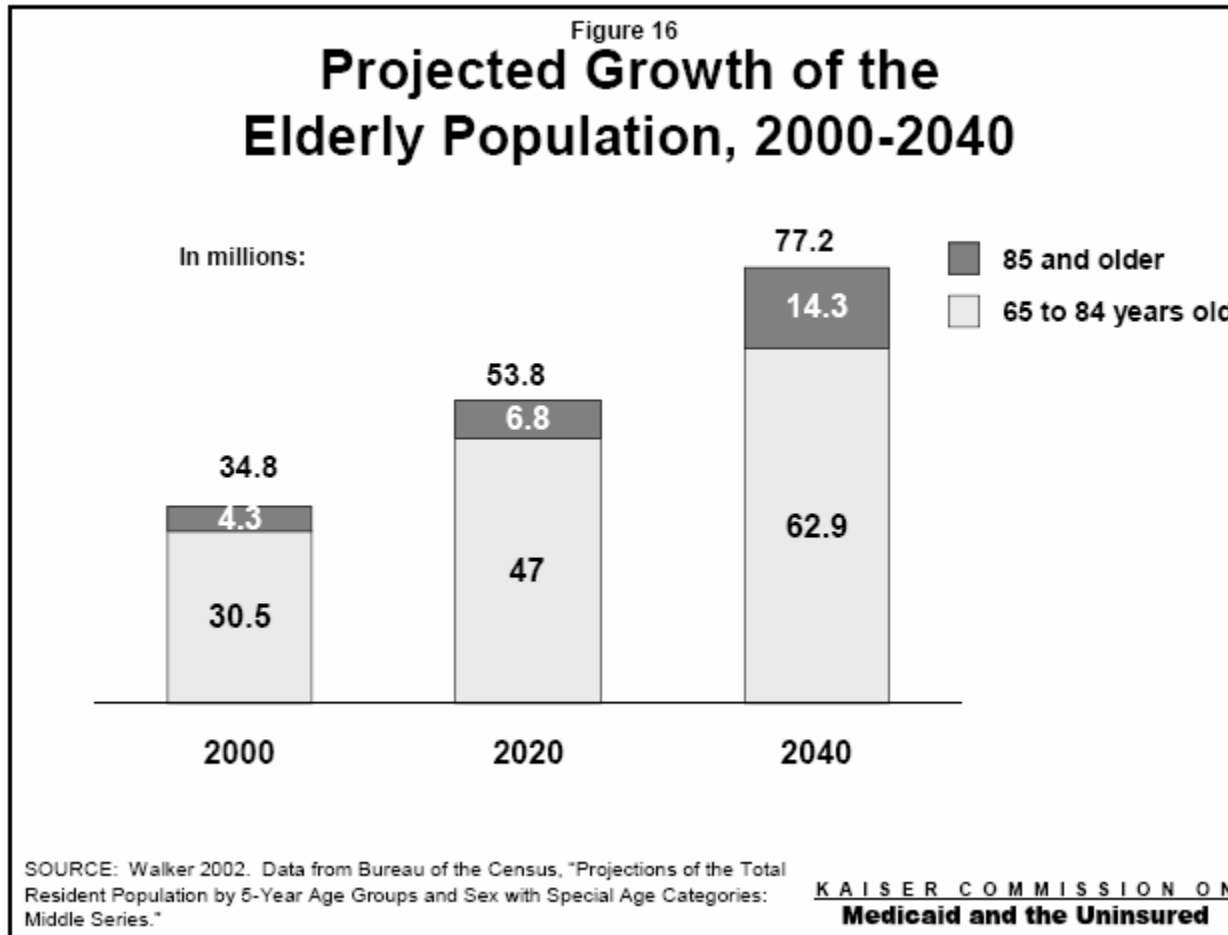
Long-term care services represents 34% of all Medicaid spending.



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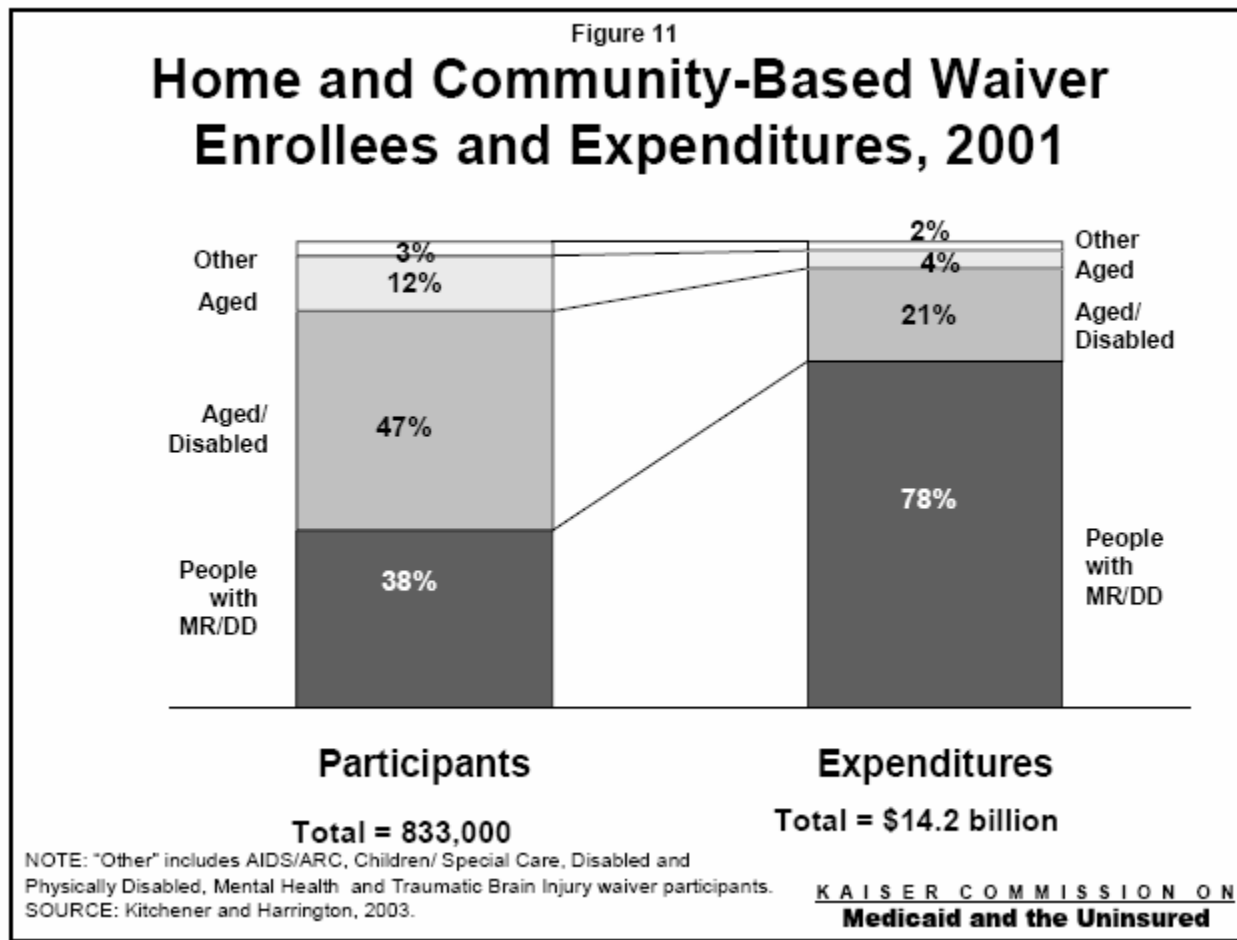
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HCBS waivers help states serve nursing-facility eligible people in the community

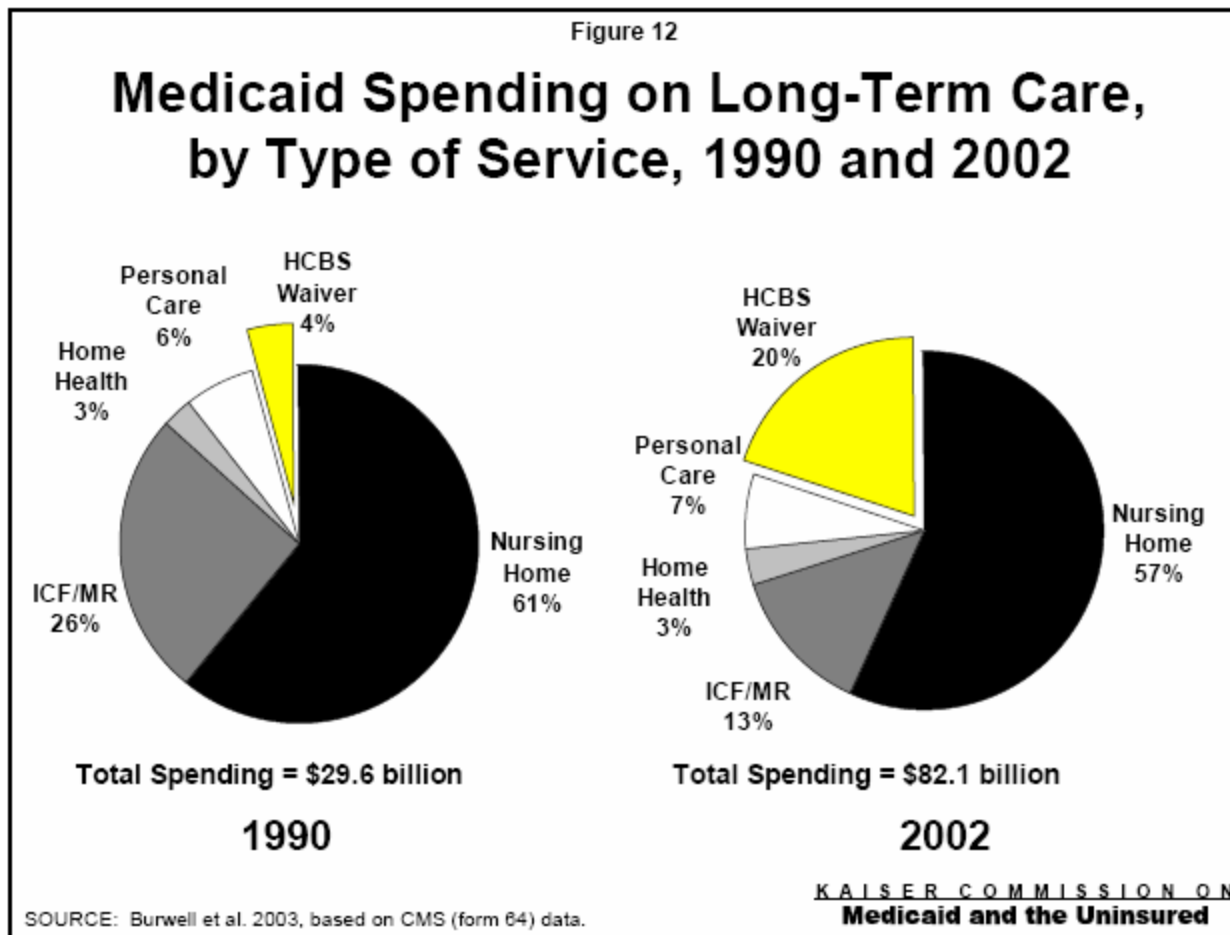
- 1915(c) Home and Community Based Waiver program
- HCBS waivers permit states to provide supportive services to people *who would otherwise qualify for an institutional admission (nursing facility, or ICF/MR)*
- Every state except AZ has at least one
- Must be “cost neutral”



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

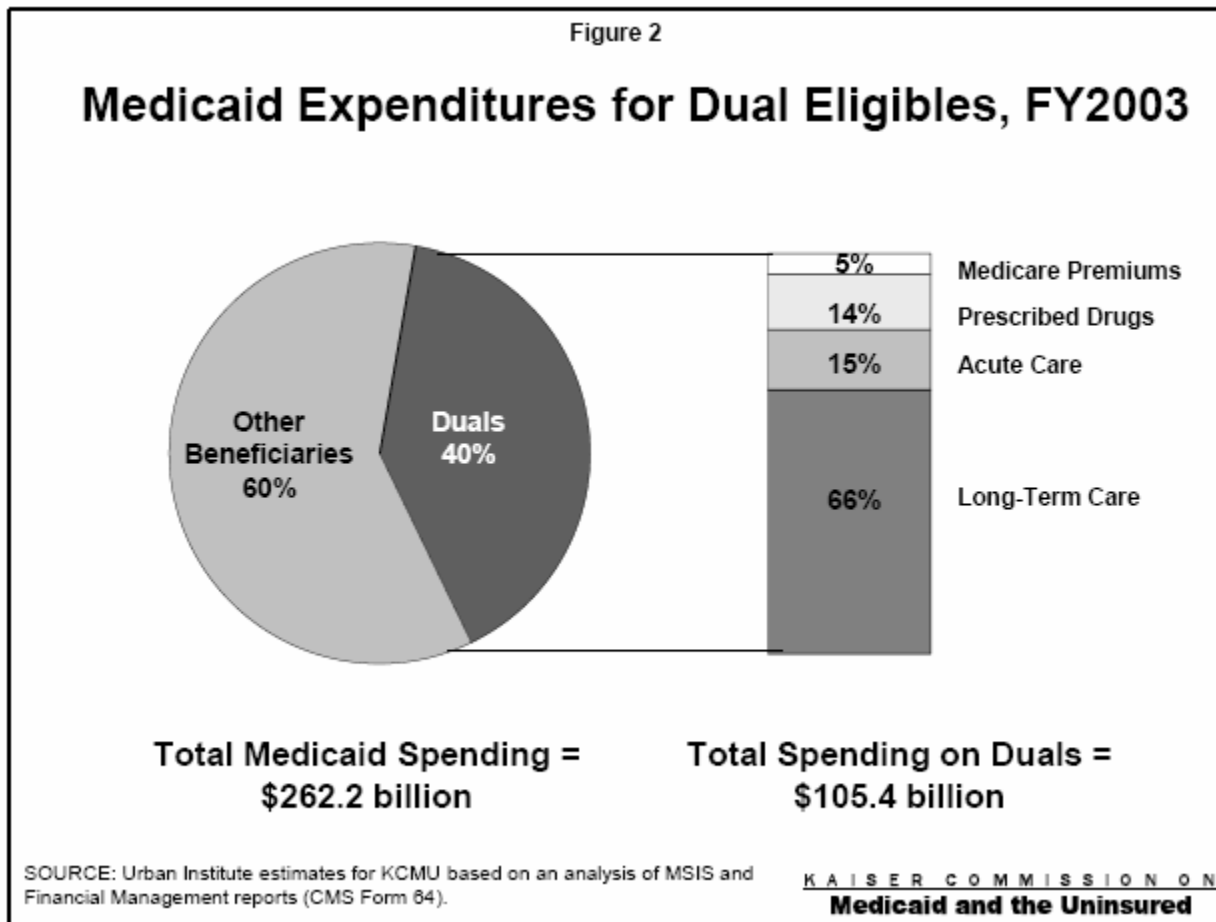


Why does Medicaid supplement Medicare?

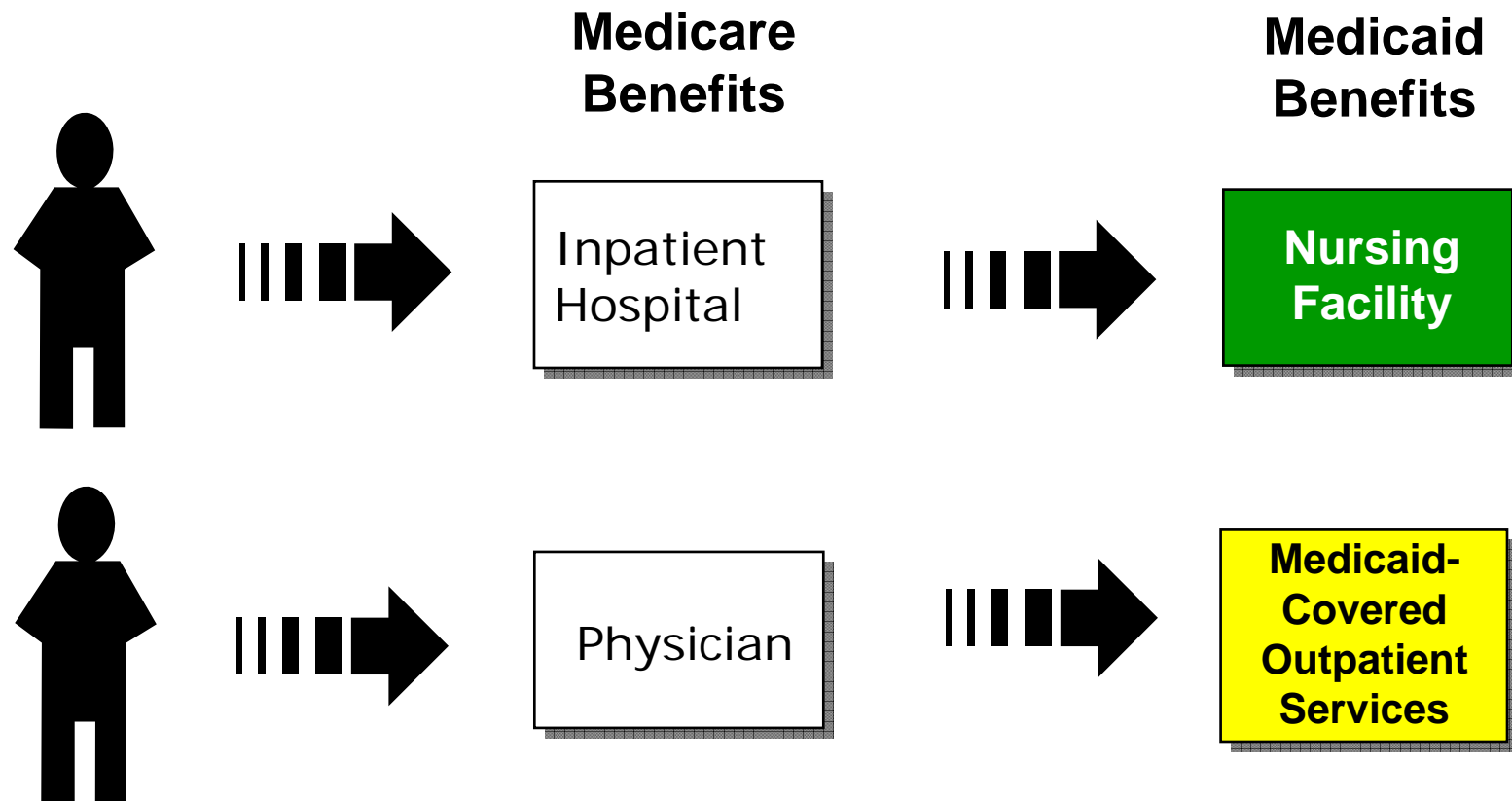
- Dual eligibles generally are below the poverty line – the floor is 74% FPL, the ceiling is 100% FPL
- Medicare does not offer a comprehensive benefit package (e.g., no coverage for most long-term care services)
- Medicare has a premium of \$78 per month for Part B
- Many Medicare-covered services have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



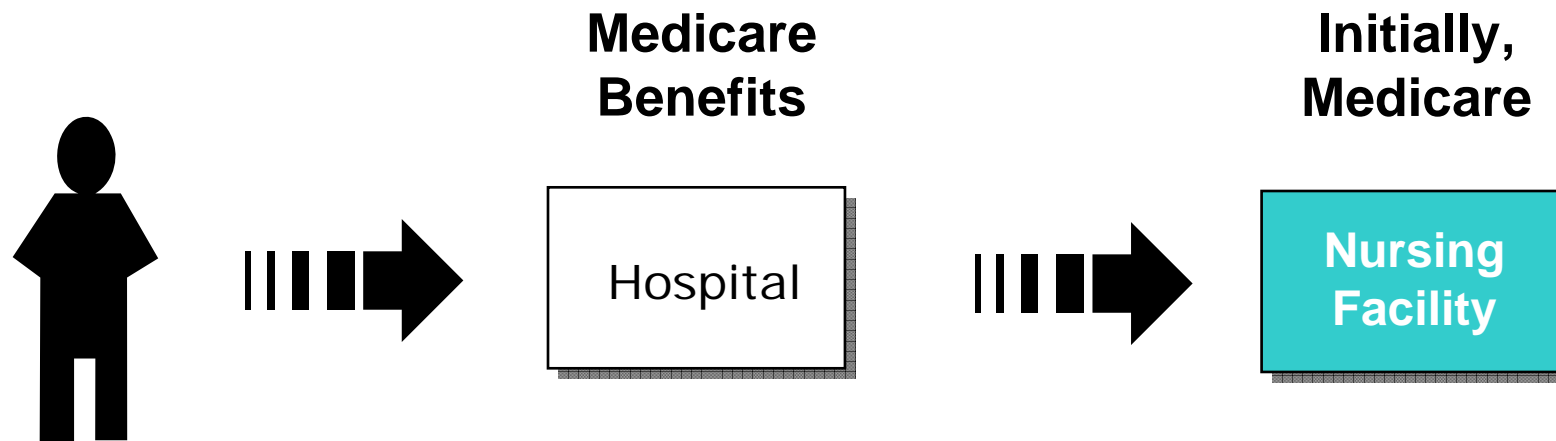
Dual eligibles represent 14% of Medicaid enrollment yet account for 40% of spending



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





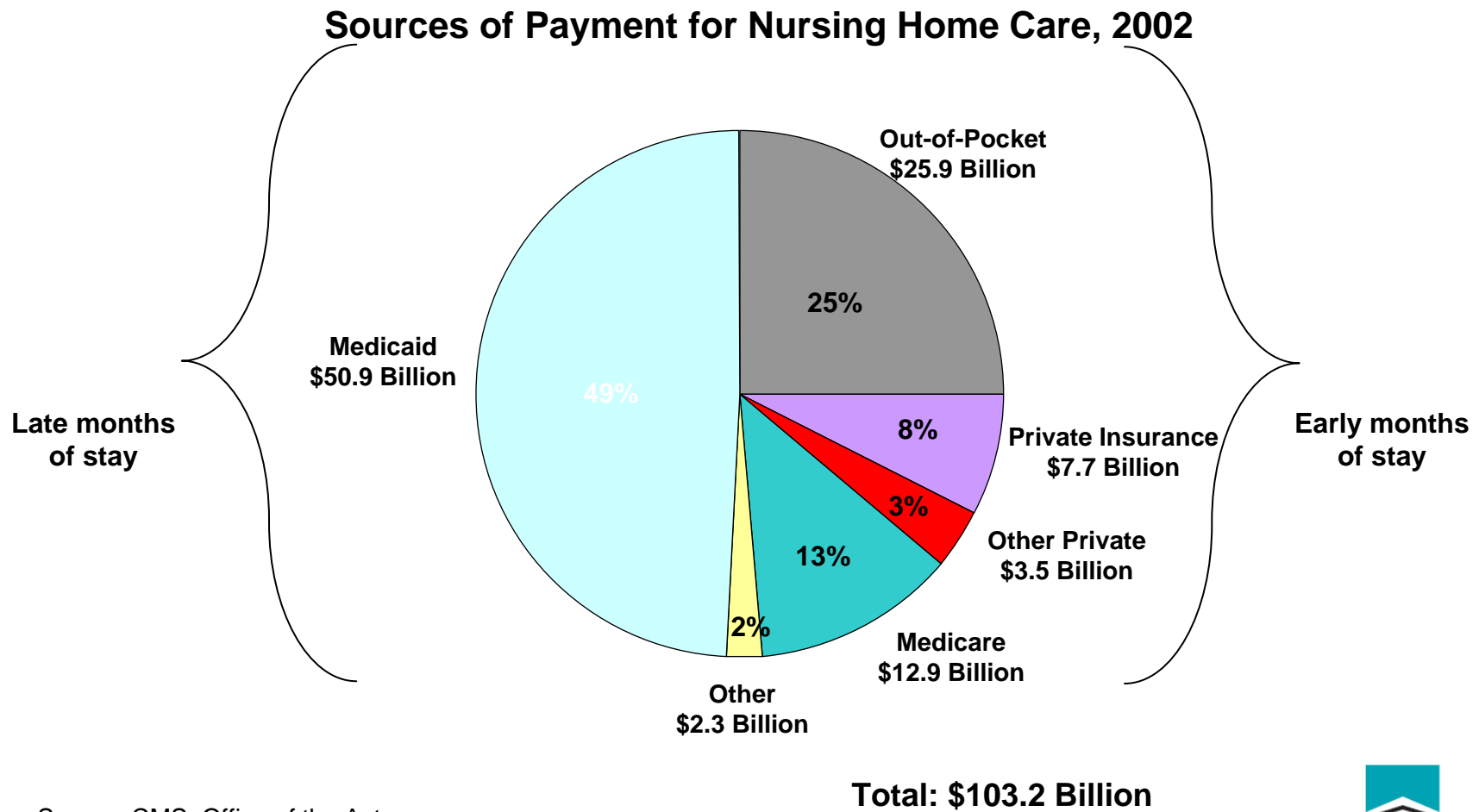
Challenges to Long-Term Care Reform



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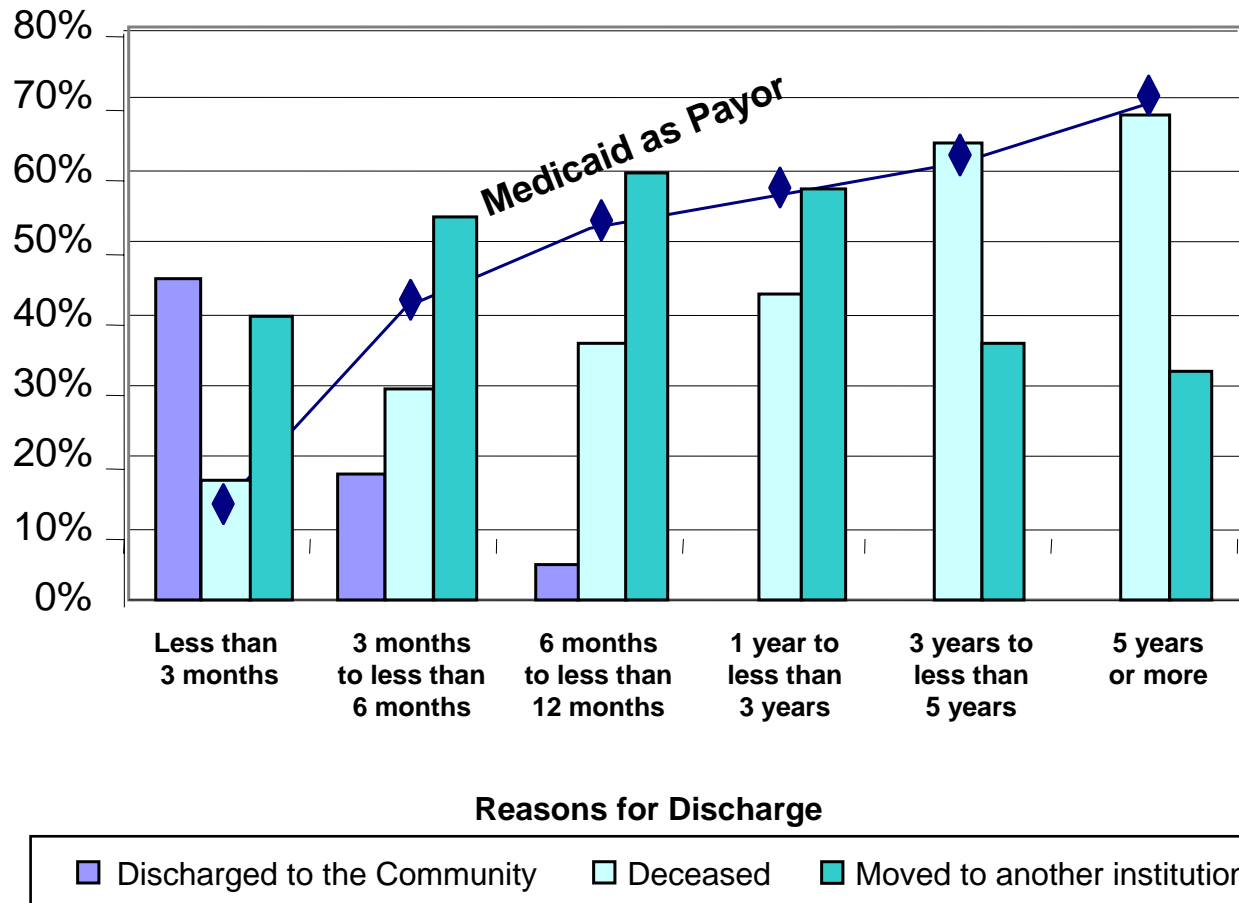
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Because other funding sources usually cover the early months of a person's nursing facility stay . . .



Source: CMS, Office of the Actuary

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

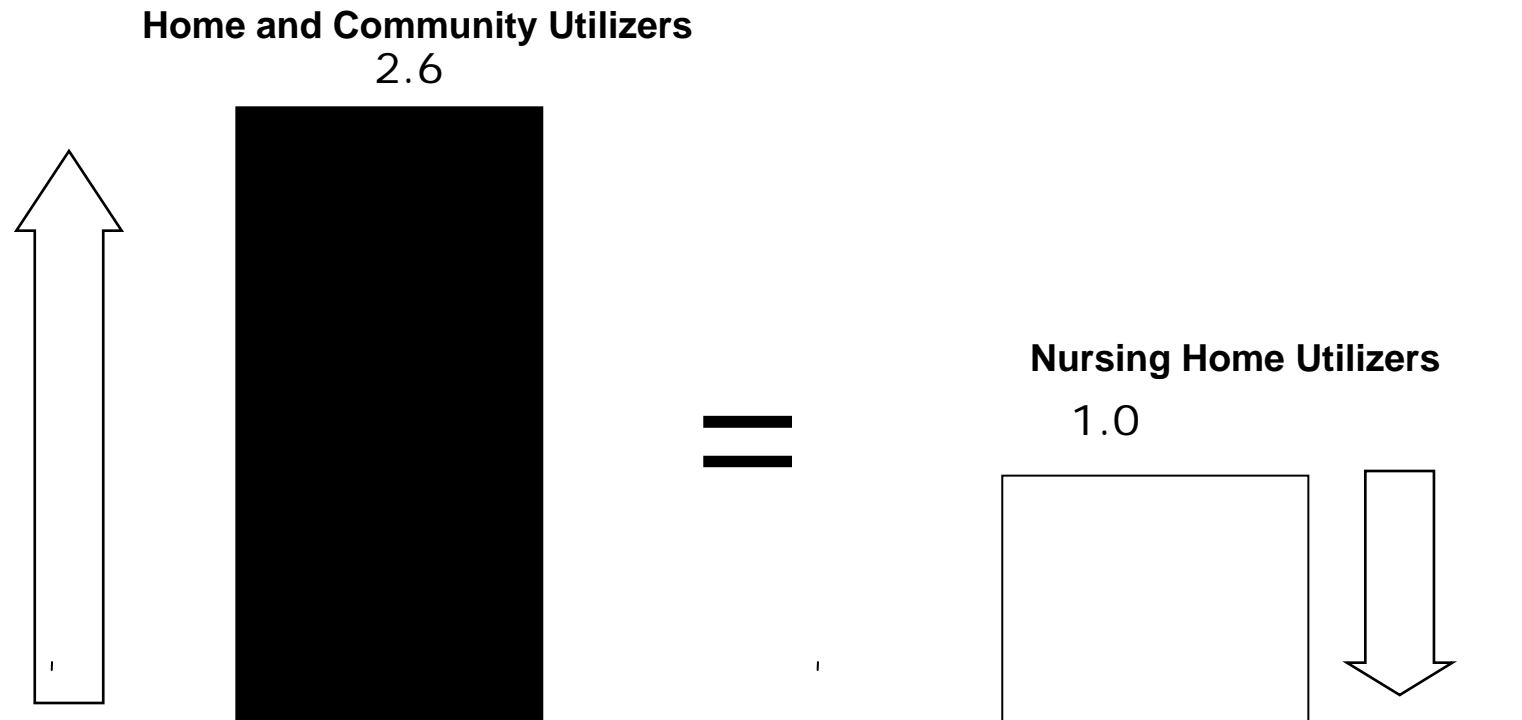


Source: The National Nursing Home Survey: 1999 Discharge Data Summary



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

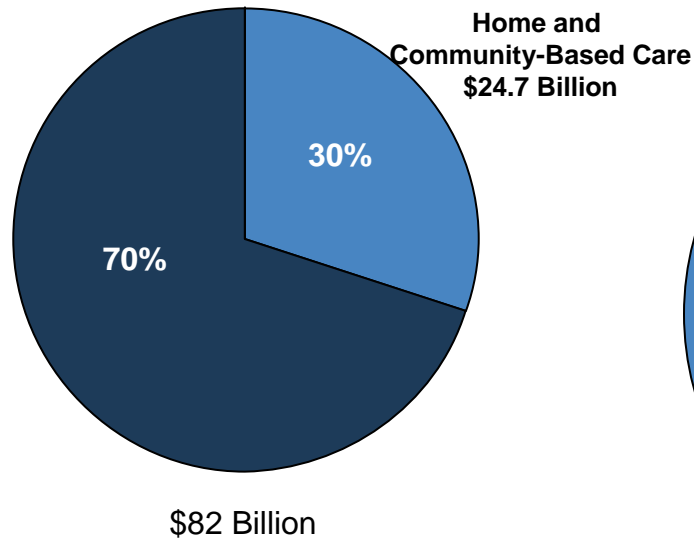
Reducing NF Utilization by One Person Led to an Increase in HCBS Utilizers by 2.6 People.
Oregon (1998)



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

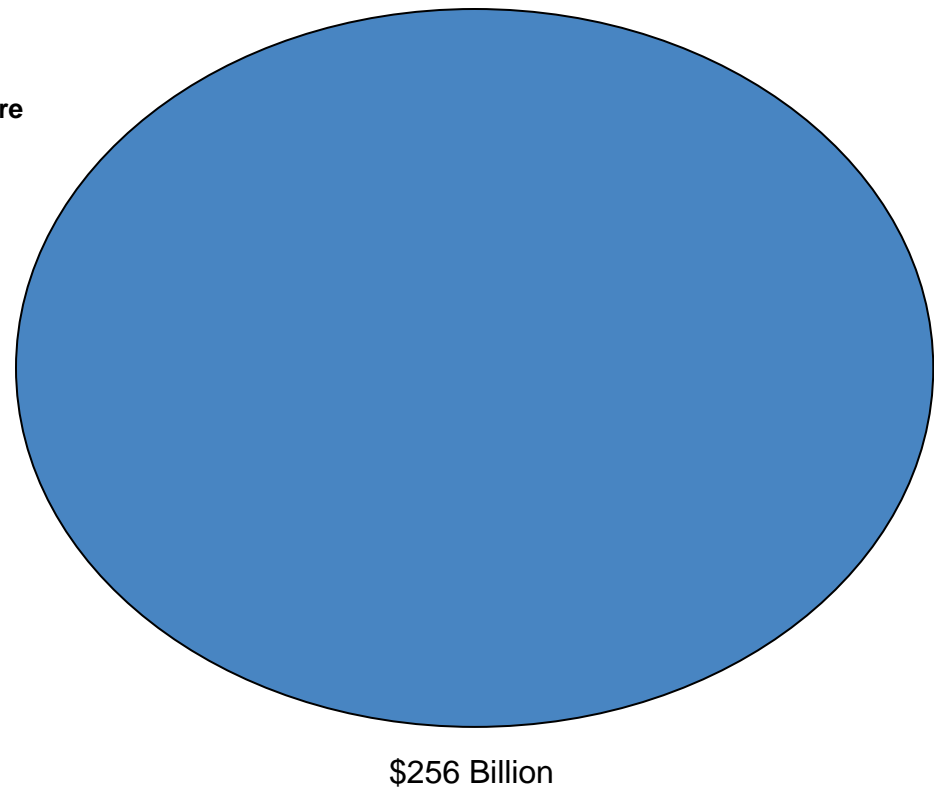
The risk of substituting paid services for informal supports also contributes to fears of the woodwork effect.

Medicaid Long Term Care Expenditures, 2002



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

Value of Informal Caregiving, 2002



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



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. . . 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 be 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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