Trends in Medicaid Long Term Services and Supports

Presentation for the National Association of Medicaid Directors Fall 2013 Meeting
Cindi B. Jones, Director

November 2013
Composition of Virginia Medicaid Expenditures – SFY 2012

Long-Term Care Expenditures

- Nursing Facility: 39%
- ID/DD: 26%
- Other Waivers: 2%
- EDCD: 13%
- ICF/MR: 21%

Medical Services by Delivery Type

- Managed Care: $1.7b
- Fee-For-Service: $1.4b

Long-Term Care Services: 43%
- Behavioral Health Services: 9%
- Indigent Care: 5%
- Medicare Premiums: 7%
- Dental: 2%

Notes:

43%
2%
7%
5%
9%
34%
ID/DD
Other Waivers
Nursing Facility
EDCD
ICF/MR
$1.7b
$1.4b
Medicaid Enrollment v. Spending

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Expenditures</th>
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<tbody>
<tr>
<td>QMB</td>
<td>1%</td>
</tr>
<tr>
<td>Non Long-Term Care</td>
<td>33%</td>
</tr>
<tr>
<td>Long-Term Care</td>
<td>35%</td>
</tr>
<tr>
<td>Caretaker Adults</td>
<td>8%</td>
</tr>
<tr>
<td>Pregnant Women &amp; Family Planning</td>
<td>2%</td>
</tr>
<tr>
<td>Children</td>
<td>21%</td>
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</tbody>
</table>

- 55% Enrollment
- 7% QMB
- 18% Non Long-Term Care
- 7% Long-Term Care
- 10% Caretaker Adults
- 3% Pregnant Women & Family Planning
- 3% Children
Virginia Medicaid Expenditures – Long Term Care Services

Notes:
Average annual growth total Long Term Care services – 8%
Average annual growth Institutional services – 4%
Average annual growth Community-Based services – 14%
Proportion of Long Term Care services paid through Community-Based care has increase from 30% in FY02 to 51% in FY12
Key Components of a Managing Long Term Care and Supports

- State’s history for LTSS
- Informal Caregivers
- Gateway to LTSS: No Wrong Door and Independent Assessors
- Uniform Assessment Instrument
- Standardized Program Criteria
Key Components of a Managing Long Term Care and Supports

- Person and Family Centered
- Home and Community Based Alternatives
- Rebalancing/Blended Funding Sources
- Consumer Direction
- Care Coordination/Integrated Care
Implementing PACE is a Good Start for Integration

- The Program of All-inclusive Care for the Elderly (PACE) model is centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

- PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area.

- 13 Sites (Health Systems, Area Agencies on Aging)
Goal: To provide Virginians high quality care and supports by coordinating the benefits of Medicare and Medicaid into a single person-centered program.

Services include primary, preventive, acute, behavioral, and long term care services and supports (nursing facility and HCBC waiver)

January 2014 through December 2017
Target Population

- 78,000 Virginians, 21 and over
- Enrolled in Medicare and Medicaid
- Living in one of five regions of the state
Key Challenges/Confounding Issues

- **Agency**
  - Workload Issues due to ACA and competing priorities, internal staff resistance
  - Reorganized agency
  - Communicated this top priority to all staff

- **CMS**
  - Medicare rules reign
  - Enrollment process complex
  - Moving forward without all the information
  - More than 100 quality measures
  - Three way contract clunky
Key Challenges/Confounding Issues

- Health plan interest
  - Initially too many Plans interested.
    - Negotiating with 3 plans, available statewide
Accomplishments: Great Stakeholder Input and Support

- Created a formal Advisory Committee
- Hired communications and outreach specialist
- Requests put in the MOU/Three Way Agreement
- Required behavioral health homes for SMI population
- Emphasis on transitions between settings of care
- Waived Skilled Medicare hospital stay
- Followed Medicaid rules for Telehealth
- Required standard fiscal agent for consumer directed services
- Required Plans to describe how they will reimburse nursing facilities; minimize administrative burdens
What’s Left

- Assess Plans readiness to enroll members (November 2013)

- Sign three way agreement (December 2013)

- Begin roll out: Regional roll-out in two phases: opt in and passive
Other LTSS Reforms Part of Larger Medicaid Reform Package

- Revamp and combine ID/DD waiver services and administration
- Move remaining LTC populations and services into coordinated care models
Summary of Final Report to Congress

Commission on Long-Term Care
Statutory Charge

• Section 643 - “Fiscal Cliff” legislation signed 1/2/2013

• To develop a plan:
  ♦ Establish, implement, and finance a comprehensive, coordinated, and high-quality LTSS system...

  ♦ That ensures availability of LTSS to individuals, including
    ● Older adults
    ● Individuals with substantial cognitive or functional limitations
    ● Others requiring assistance to perform activities of daily living
    ● Individuals desiring to plan for future LTSS needs.
Statutory Charge

• Within 6 months of appointment, Commissioners must:
  ♦ vote on a comprehensive and detailed report based on the long-term care plan...

  ♦ that contains any recommendations or proposals for legislative or administrative action as the Commission deems appropriate.
Commission Activity

• Began organizing on June 10, 2013
• Convened first meeting on June 27, 2013
• Held 4 public hearings with testimony from 34 witnesses
• Solicited extensive comments from public
• Deliberated in 9 executive sessions.
• Decisions reached via process of broad agreement
Commission Vote

• Voted September 12, 2013 – [9 to 6] -- in favor of putting this Final Report forward as the broad agreement of the Commission

♦ Commissioners For: Chernof, Warshawsky, Anwar, Brachman, Guillard, Pruitt, Raphael, Turner, and Vradenburg

♦ Commissioners Against: Butler, Claypool, Feder, Jacobs, Rutledge, and Stein
Commission Report

• Call to Action
• Specific Challenges to Providing LTSS
• Recommendations
  ◆ Service Delivery
  ◆ Workforce
  ◆ Financing
• Advancing the Agenda
• Appendices – Ideas from the Commissioners, List of Public Comments Received, List of Hearings and Meetings
Call to Action

• Today 12 million need LTSS
  ♦ Diverse population – almost half under age 65
  ♦ Most living in their homes and in the community
  ♦ Most are assisted by family caregivers
  ♦ Many get their needs met
Population Needing LTSS, by Age Group and Level of Need (Millions)

- **Institutional Total**
- **Community—High Need** (multiple self-care/ADL)
- **Community—Medium Need** (some self-care/ADL)
- **Community—Low Need** (no self-care/ADL)

**Children**: 0.6
**Working Age**: 5.4
**Elderly**: 6.7

Source: S. Kaye, data from 2012 NHIS, 2010 Census, Nursing Home Data Compendium 2010
Call to Action

• But there are problems -- that will grow more severe with population aging:
  ♦ Family caregivers provide most care
    • financially and emotionally stressful
    • availability will decline in the future

♦ Paid LTSS is expensive
  • long periods can be catastrophic
  • most retirees not adequately prepared for costs
LTSS Expenditures by Source, 2011

- Medicaid: $131.4 billion (62.3%)
- Other Public: $9.7 billion (4.6%)
- Other Private: $24.4 billion (11.6%)
- Out-of-pocket: $45.5 billion (21.6%)

Source: National Health Policy Forum, based on data from 2011 National Health Expenditure Accounts
Call to Action

♦ Direct care workforce – today 70% of paid care
  • inadequately trained, poor retention
  • could affect quality and availability in the future

♦ Paid LTSS - highly fragmented and difficult to access
  • lack focus and coordination to ensure best outcomes
  • can be expensive and inefficient

♦ Future growth in LTSS need with population aging
  • challenge to unpaid caregivers and paid workforce
  • strain on federal and state budgets
The Number of Americans Needing Long-Term Care Will More than Double by 2050

Call to Action

• Projected increase in LTSS need will confront significant resource constraints due to current and projected fiscal challenges
  ♦ New care integration, technology, and innovative workforce strategies needed to reduce costs and improve outcomes
  ♦ Creative financing solutions needed to insure risk and encourage savings
  ♦ More accessible and sustainable Medicaid safety net needed
VISION

Service Delivery
- Person- and family-centered
- Balance of options – HCBS/Institutional
- Integrated medical and LTSS
- Effective – outcomes focused
- Efficient – financially sustainable

LTSS

Financing
- Full array of LTSS financing options
- Balance of public/private financing
- Protects against catastrophic costs
- Enables individual preparation
- Safety net for those in most need

Workforce
- Attracts and retains trained workers
- Adequately-sized
- High quality, person-centered care
- Across LTSS settings
Recommendations: Service Delivery

• **Rebalancing** – incentivize states to balance HCBS and institutional LTSS

• **Care Integration**
  - Align incentives to encourage integration of person-centered care
  - Establish a single point of contact for LTSS.
  - Use technology to mobilize and integrate resources
  - Create livable communities

• **Uniform Assessment** – implement a standardized assessment tool to produce a single care plan
Medicaid Spending on Long-Term Care Has Been Shifting Toward Community-Based Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Home and Community-Based Care</th>
<th>Institution-Based Care</th>
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<tbody>
<tr>
<td>1995</td>
<td>$54 20%</td>
<td>$80 80%</td>
</tr>
<tr>
<td>2000</td>
<td>$75 30%</td>
<td>$70 70%</td>
</tr>
<tr>
<td>2005</td>
<td>$104 39%</td>
<td>$61 61%</td>
</tr>
<tr>
<td>2010</td>
<td>$121 45%</td>
<td>$55 55%</td>
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<tr>
<td>2011</td>
<td>$123 billion 45%</td>
<td>$55 55%</td>
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Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of CMS-64 data
Recommendations: Service Delivery

- **Consumer Access** – expand “No Wrong Door” to provide enhanced options counseling

- **Quality** – accelerate development of LTSS quality measures for HCBS and make them available to consumers

- **Payment Reform** – promote payment based on the service rather than the setting
Recommendations: Workforce

• **Family Caregiving**
  - National strategy to maintain and strengthen family caregiving
  - Include family caregivers in needs assessment and care planning
  - Encourage expansion of caregiver interventions

• **Paid Workforce**
  - Encourage revision of scope of practice to permit delegation with supervision to direct care workers
  - Enable criminal background checks for LTSS workforce
Recommendations: Workforce

- **Direct Care Workforce**
  - Create meaningful ladders and lattices for career advancement
  - Integrate direct workers in care teams
  - Collect detailed data on LTSS workforce
  - Encourage standards and certification for home care workers
Financing: Vision and Alternative Approaches

Common Vision:

A balance of public and private financing to insure the most catastrophic expenses, encourage savings and insurance for more immediate LTSS costs, and provide a strong safety net for those without resources.

Commission did not agree on a single approach, but offered two approaches that might achieve the common vision:

♦ Private options to strengthen financing
♦ Social insurance
Recommendations: Financing

• Medicaid Improvement
  ♦ New Demo to provide LTSS to persons with disabilities to remain employed
  ♦ Assist states to achieve greater uniformity in Medicaid Buy-In programs

• Medicare Improvement
  ♦ Eliminate the 3-day prior hospitalization requirement for SNF stay
  ♦ Reconsider the “homebound” requirement for home health care services
Recommendations: Financing

- **Savings**
  - Allow individuals with disabilities and their families to set up section 529 savings funds
Next Steps

• Report provides a foundation and guide for more extensive work needed to develop and promote a sustainable comprehensive program to improve the organization and financing of LTSS.

• Commission recommended:
  ♦ Creation of a national advisory committee
  ♦ Convening of 2015 White House Conference on Aging in coordination with the National Council on Disability to focus on LTSS