LTC Industry Perspectives on Medicaid/ LTC By Providers of Supports to Non-Elderly People with Disabilities

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Medicaid Then and Now

- Means-Tested for poorest
- Welfare population, children, elderly and disabled
- Entitlement (GUARANTEE)
- Defined Benefits
- Comprehensive (acute & long-term care)
- Included mandatory services and gave states options for broader coverage

- Expanding coverage to address the problem of 45 million “uninsured”
- Defined contribution, not guaranteed benefits
- Private market determines benefits

Medicaid Then and Now

- Jointly administered & financed
- Uncapped, unlimited Federal match for approved spending
- Program varies due to state decisions Medicaid is jointly financed by the federal and state governments

- Increased beneficiary responsibility (cost-sharing) and health behaviors
- Defined Federal and state spending limits
- Managed care or integrated care
- Greater inter-state and intra-state variability

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Myths Related to Medicaid and LTC

- Medicaid pays majority of LTC costs
- Most people with disabilities who require supports live in institutions
- Medicaid does not pay for housing

- Medicaid pays ½ of LTC, but paid services supplement informal care--with estimated $275 B in informal care annually
- Feds continue to try to slow growth in spending, additional constraints on Medicaid
- More spending for institutions--75% for aged/disabled in nursing facilities and 42% of MR/DD in ICFs/MR
- Medicaid pays for room and board in institutions, but not in community

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Myths Related to Medicaid and LTC

- States made consistent progress in shifting to HCBS across disability populations
- Increasing HCBS will reduce Medicaid spending
- "Boomers" recognize need for LTC planning in the future
- Medicaid is more expensive than private health insurance

- Greater progress made in HCBS for MR/DD than elderly and disabled
- As result of demographics, Medicaid LTC spending will increase—but expanding HCBS cam increase the number of people served and could reduce the rate of increase in spending
- Less than 10% of aged 50+ have LTC insurance; while about two-thirds of all Americans will need some LTC supports after age 65
- Medicaid spending has increased more slowly than the private market (2002-2004, per person Medicaid spending rose 6.7%, almost half the rate of the private market (12.5%) despite serving a sicker and needier population

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Medicaid Enables All Parts of Health Care & LTC Systems to Work

- **Private Health Insurance** relies on Medicaid to keep premiums lower by covering individuals with low-income and complex needs and higher cost coverage with comprehensive services
- **Medicare** relies on Medicaid to finance half the coverage needed by low-income beneficiaries not covered by Medicare (even after Medicare prescription drug coverage is implemented)
- **Public Health, Safety-Net Hospitals and Clinic Infrastructure** rely on Medicaid to respond and support local emergency services and national public health care needs including immunization programs, epidemics (HIV/AIDS), bioterrorism, as well as emergency services

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Current Medicaid Debate

- Framing the discussion correctly
- Absence of national approach to health care
- Misplaced focus
- Real issue is **health care** in general and rising costs.
- U.S. spends 16% of GDP on health care costs while Europe spends 11%.
- U.S. spent $5,635 per person on health care in 2003 -- two-and-a-half times the $2,280 average among industrialized countries

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Current Medicaid Debate

- Absence of national approach to long term support
- Primary source of paid LTC
- Only funding source for poor

- Must align with Medicare, SS, private resources
- Must expand the financing pie
- Requires real public discussion over couple of years.

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LTC Trends and People with Disabilities

- Individual & family preferences for home and community supports
- Legal Challenges: individual & class action cases; 1999*Olmstead* case
- President's 2001 New Freedom Initiative
- Federal and state fiscal pressures
- Drive for home and community supports & cost-effectiveness
- State global budgeting, flexible funding & LTC *rebalancing*

LTC Trends and People with Disabilities

- Failed federal reform & focus on State 1115 demos
- Self-direction and consumer control
- States as laboratories of experimentation
- Deficit Reduction Act of 2005
- State 1115 and DRA initiatives (Florida, Kentucky, Vermont, West Virginia, Idaho)

Trends of Federal Initiatives & DRA

- 1st time Feds offer financial assistance in deinstitutionalizing public and private N.H. & ICFs/MR ($ Follows Person)
- Emphasis on home & community based services through new state plan option & waivers
- Feds offer strong support for self-directed and family-directed services

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Trends in Federal Initiatives & DRA

- Feds continue to try to slow growth in spending, additional constraints on Medicaid
- In exchange for tighter fiscal controls, states can expect enhanced flexibility in designing cost-effective Medicaid services
- "Functionally-based" criteria for HCBS with more stringent eligibility for institutional services

Reliance on HCBS Requires Healthy Community Infrastructure

- **Housing:** Crisis in affordable, accessible Housing
- **Providers:** Sufficient supply of quality providers
- **Payments:** Adequate reimbursement for traditional agency providers or family/friends & independent contractors

- On average, nationally takes 106% of SSI check to rent one-bedroom
- Providers are being driven out of market with payment not covering costs of supports
- Increase in demand (37%) for HCBS will occur at same time when labor supply of traditional labor pool (adults aged (18-39) will not keep pace (7%).

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Reliance on HCBS Requires Healthy Community Infrastructure

- **Workers:** Adequate supply of quality direct support workers—wages and supply are issues
- **Decentralized:** No longer will workers provide supports in agency setting with direct access to supervisors.
- **Technology:** Health IT and other technologies.
- Recruitment and retention focus on workers with different skill sets
- Each year of increased average lifespan translates roughly to a 2.4% increase in demand for DSP workers
- On per capita basis in 2005, US spent 43 cents on Health IT compared with $193 in United Kingdom

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Medicaid Commission

- All recommendations must have a major impact on the Medicaid program.
- All recommendations must address the long-term sustainability of the Medicaid program.
- The recommendation must not increase aggregate Medicaid costs.
- The recommendations must not increase the number of uninsured.
- All recommendations should honor HHS Secretary Leavitt's direction.

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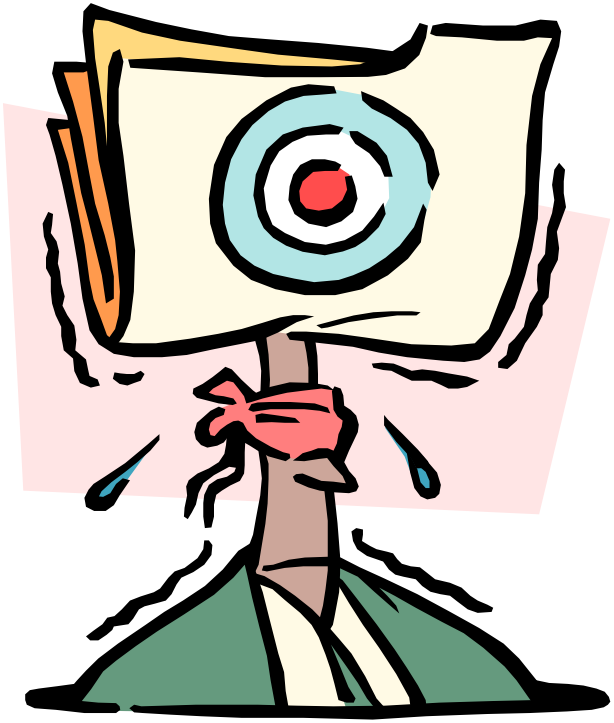
Cautionary Notes for Reform

- Medicaid is nation's health safety net
- Beneficiaries are poor with limited resources
- Many have chronic conditions with multiple health
- Medicaid assists people with disabilities of all ages requiring both acute and LTC services
- Limits on Medicaid result in more uninsured and increased unmet needs

Cautionary Notes



- No private sector alternatives for the poor
- No insurance market for high-cost, chronically ill or disabled individuals
- No alternatives to supplement Medicare for 7 million dually eligible beneficiaries
- No effective market for financing LTC
- Inadequate financing for safety net

Real Reform—Reduce Reliance on Medicaid as Nation's Only LTC Payer

- Engage the public in real discussion of need for LTC
- Intersection of Medicare, Medicaid, & SS benefits
- Expand the pie for financing of LTC, incentives to purchase, creation of broader LTC social insurance model with Medicaid as safety net
- Eliminate the cost to Medicaid of Medicare's nearly 7 million dual-eligibles' long-term support, Medicare premiums and co-payments
- Authorize HCBS mandatory, Medicaid entitlement

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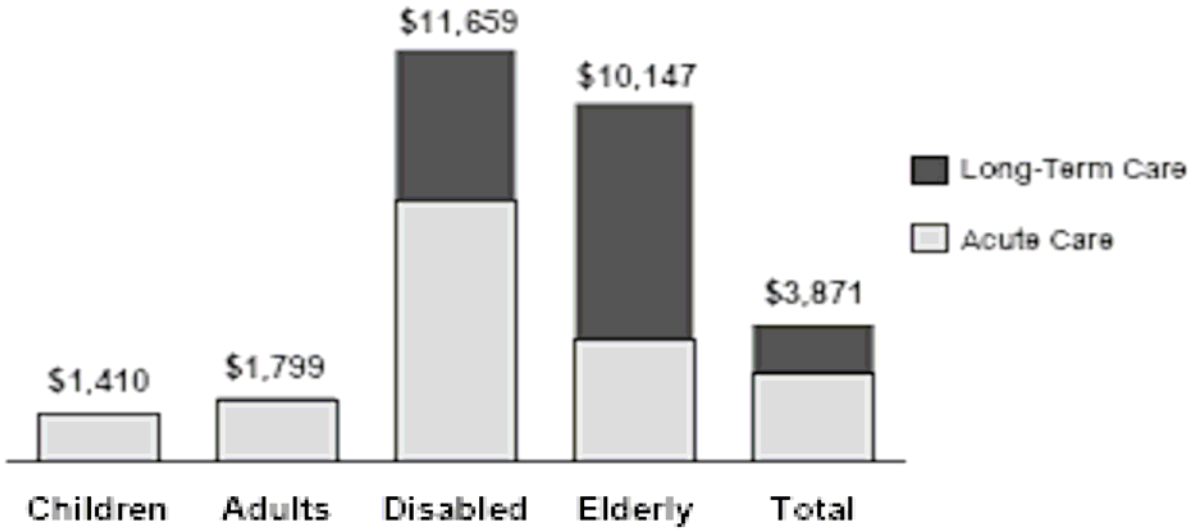
Figure 3

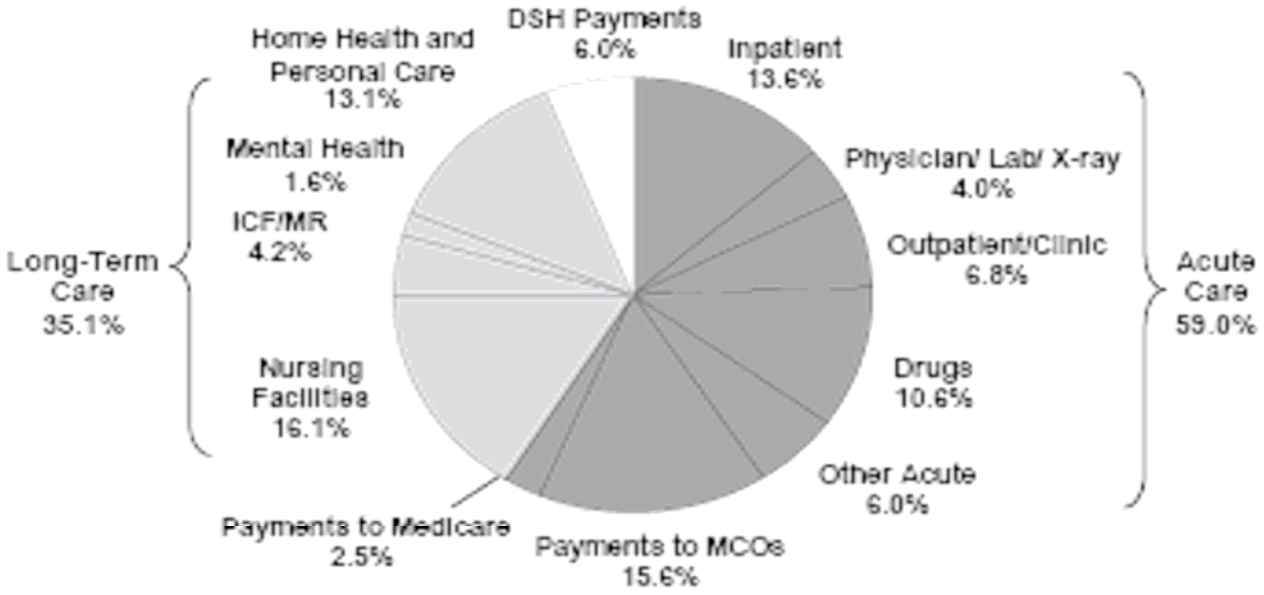
Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2003



SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2003 MSIS and CMS 64 data.

Figure 6

Medicaid Expenditures by Service, 2004

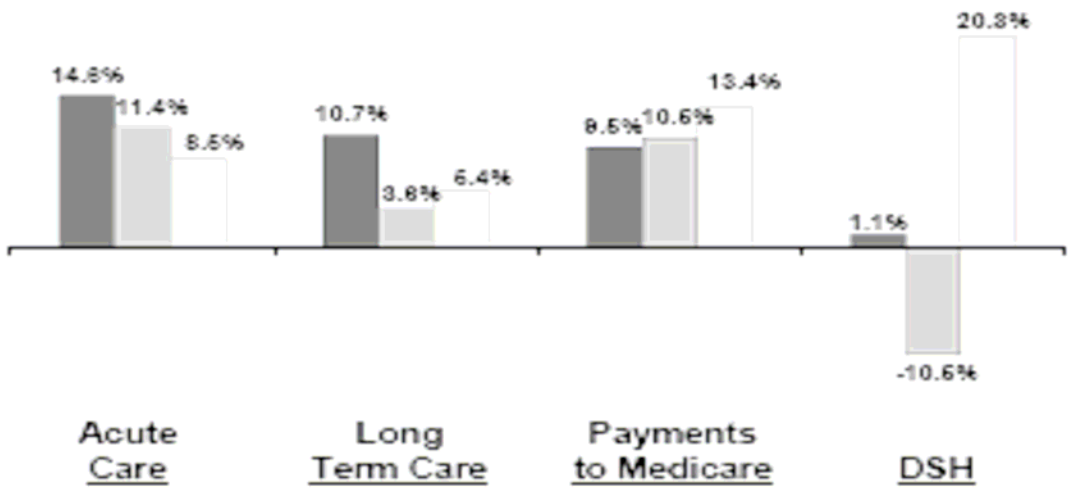


Total = $288.1 billion

SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured

Figure 3

Medicaid Spending Growth
Average Annual Growth Rates, 2000-2004



SOURCE: Urban Institute, 2006; estimates based on data from HCFA Financial Management Reports, 2004 (HCFA-64/CMS-64).

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Medicaid and the Uninsured