Medicaid and the Post Acute Care Marketplace

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Medicaid Congress

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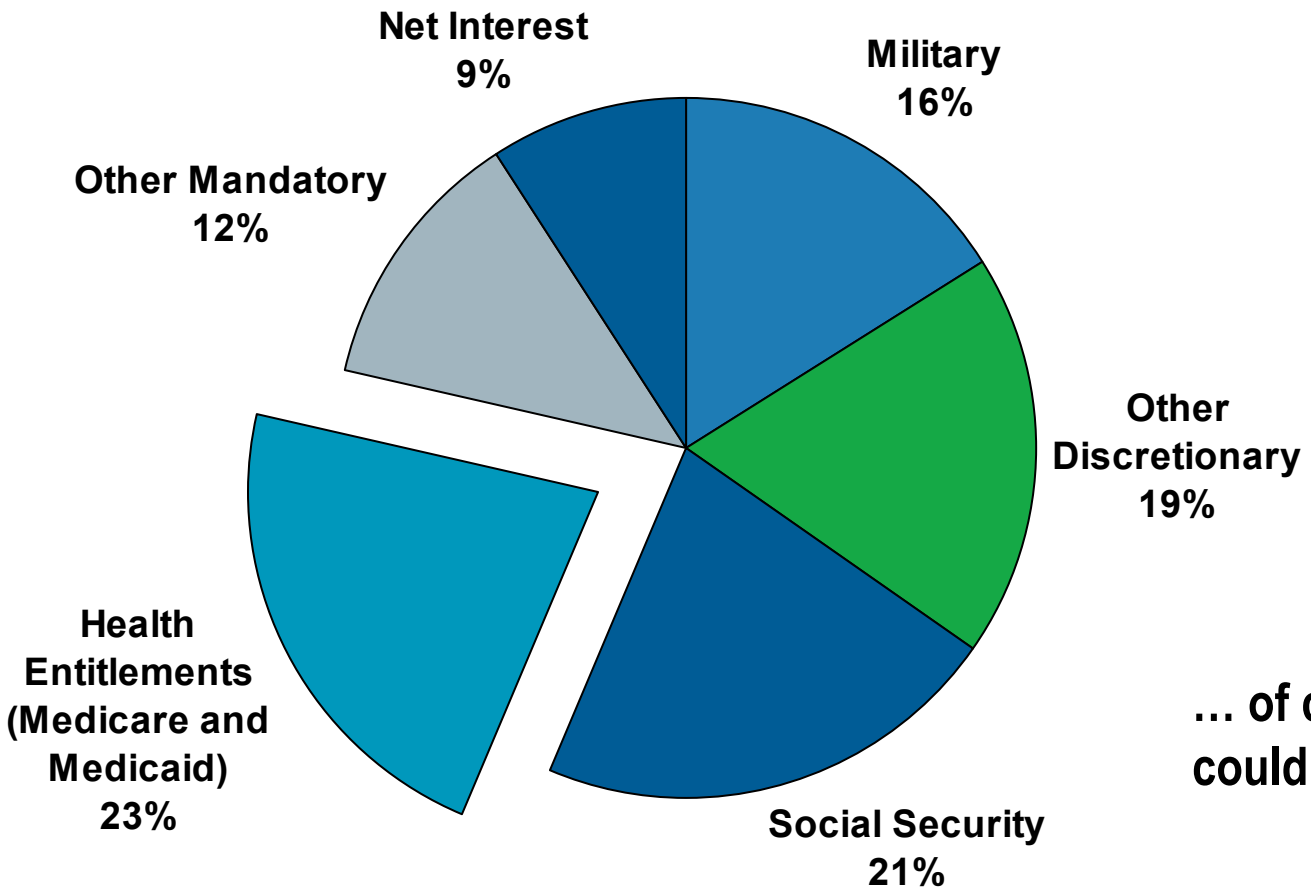
Agenda

- Environmental Imperatives
  - » Fiscal / Demographic
  - » Payment systems
  - » Quality / pay for performance
- Emerging Models of Reform
  - » Managed care
  - » Post-Acute Care Unification
  - » De-institutionalization
  - » State Medicaid experimentation
- Implications for LTC providers

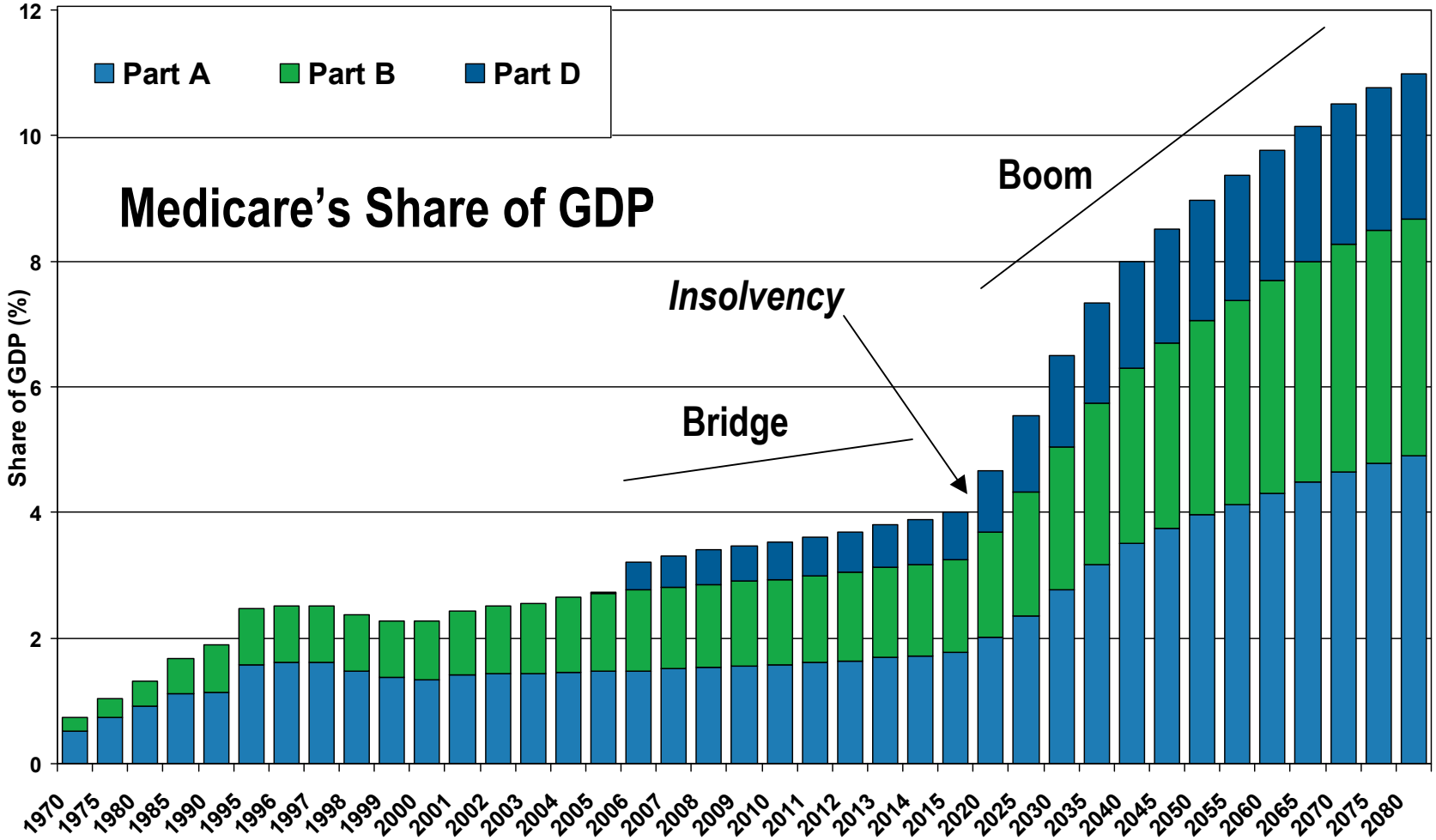
Control of Health Entitlements is the Only Way to Balance



… of course tax policy could help as well

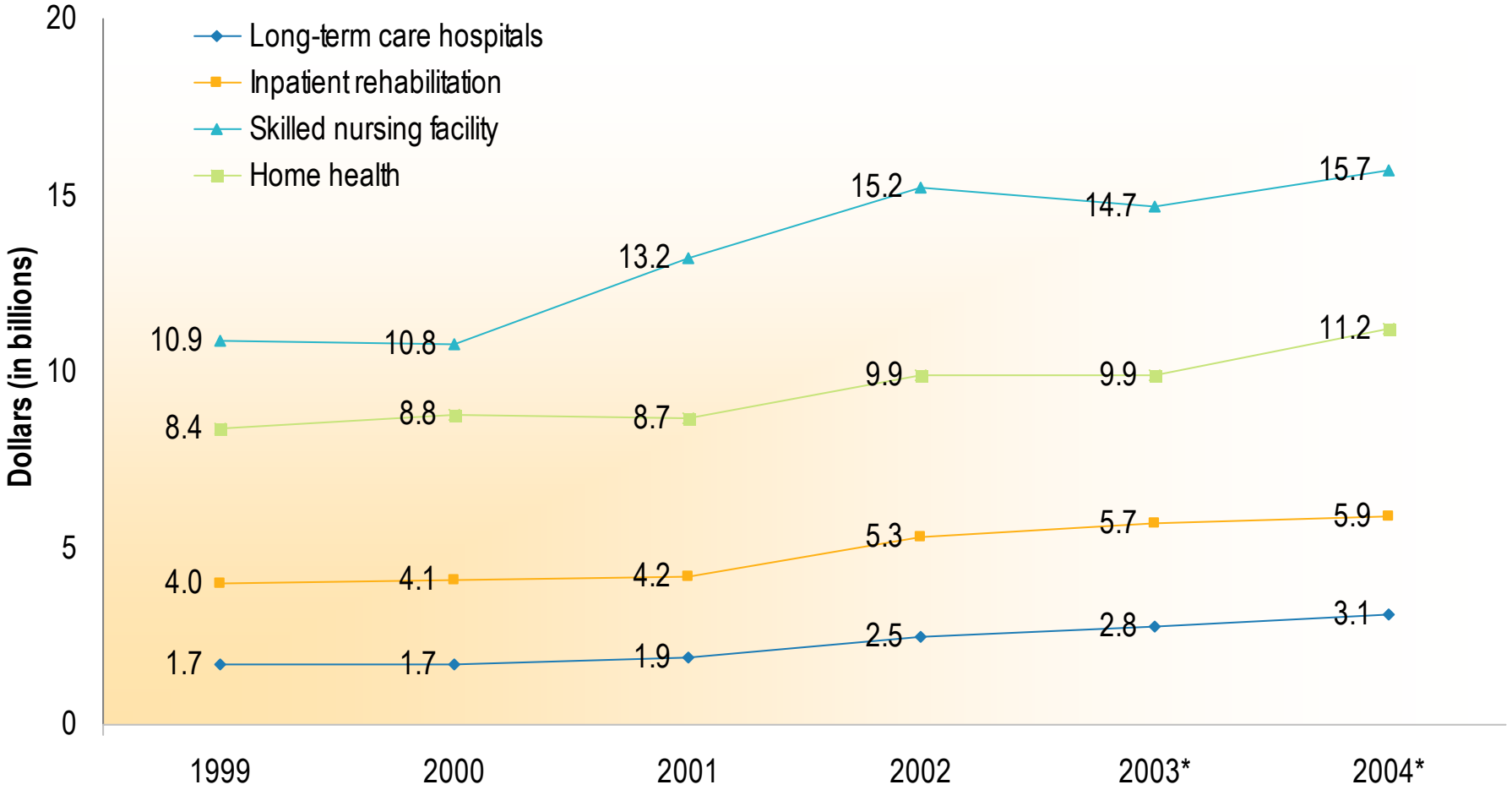
Source: OMB, FY 2006 President's Budget

Looming Fiscal Crisis, or Rational Allocation of Wealth?



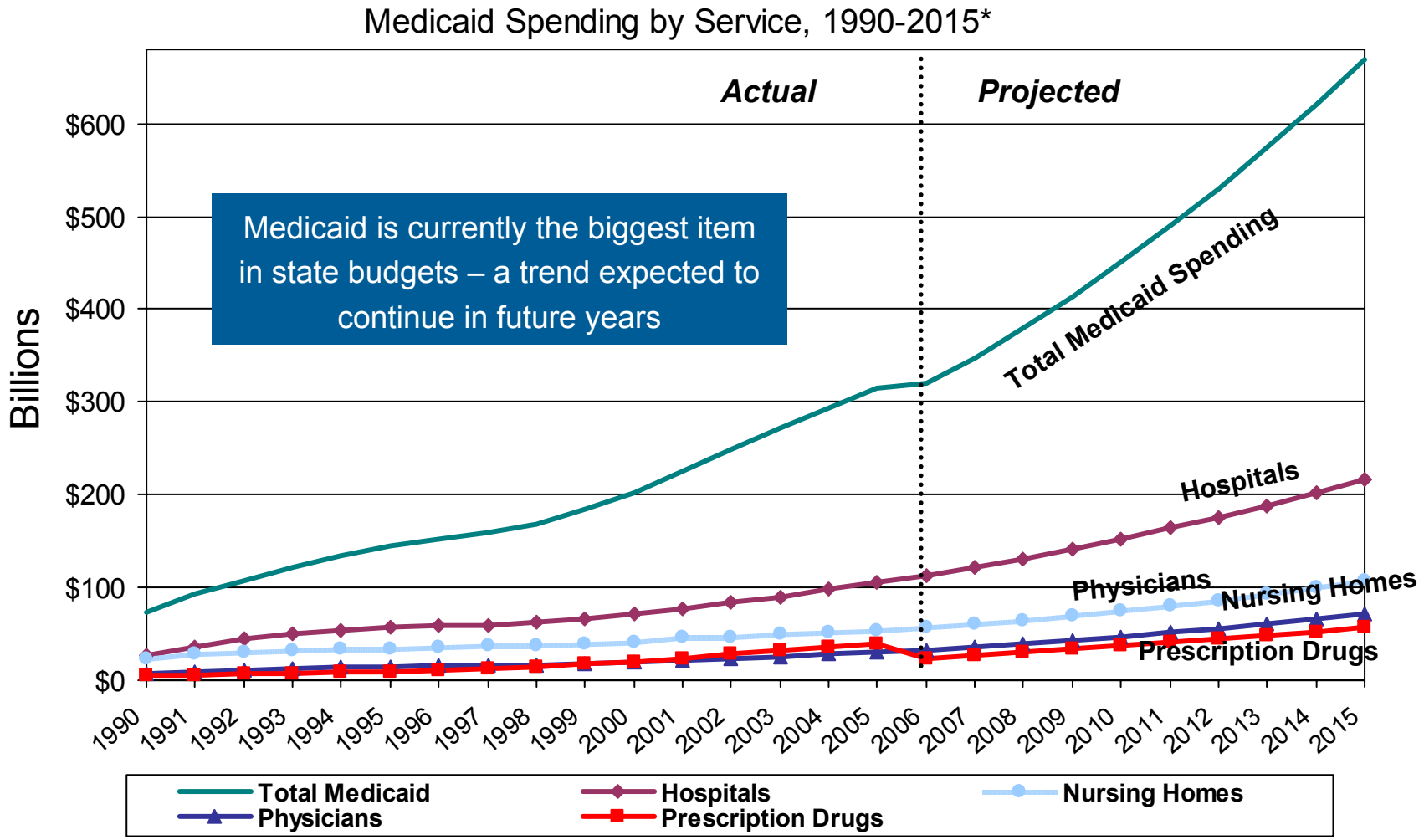
Source: 2006 Medicare Trustees Report

Sector is Relatively Small, but Attracts Focus on Growth



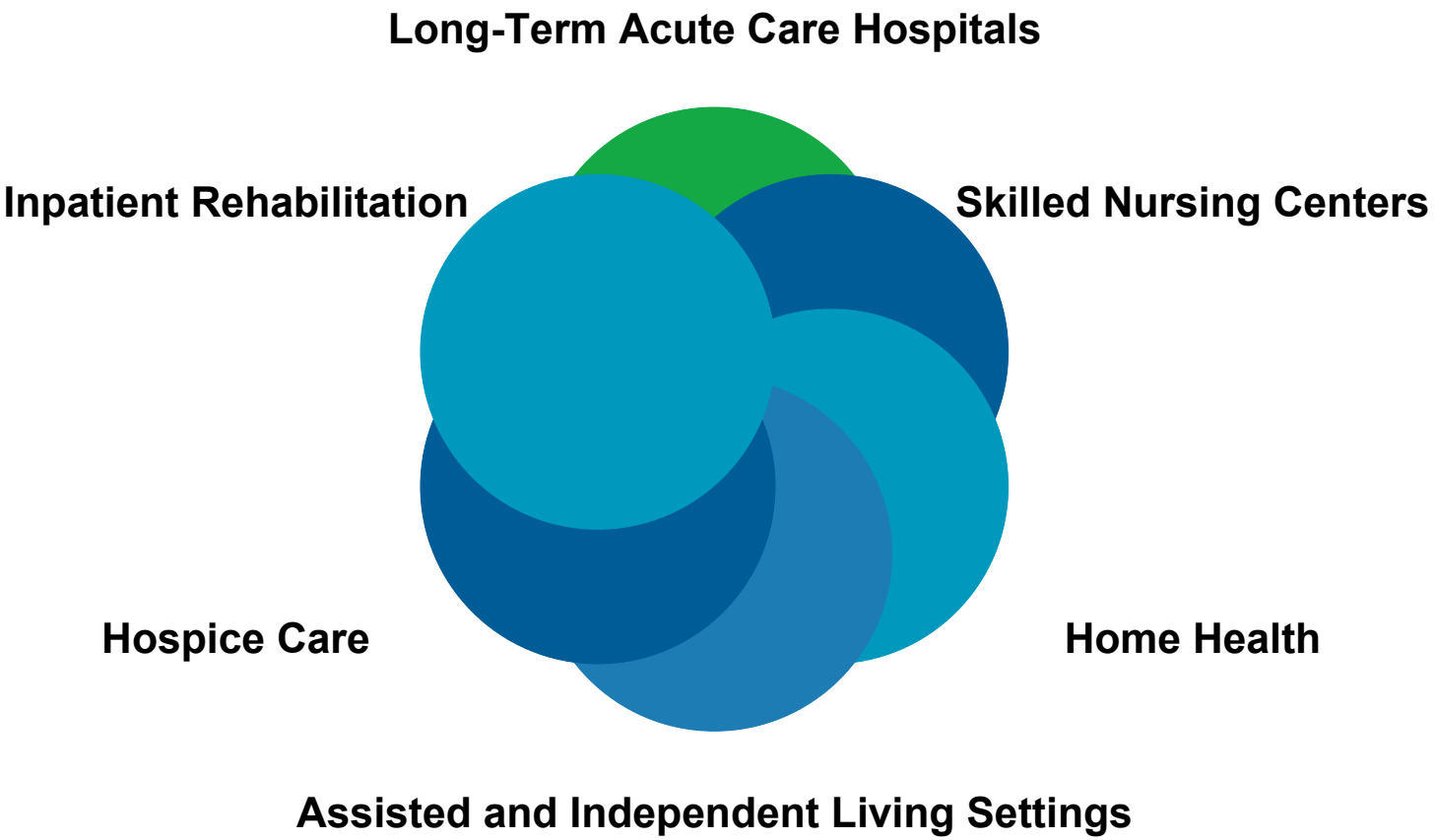
Note: These numbers are program spending only, and do not include beneficiary copays.
*Estimates
Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

As Medicaid Spending Increases, States are Pursuing Innovative Reforms to Increase Efficiency & Reduce Costs

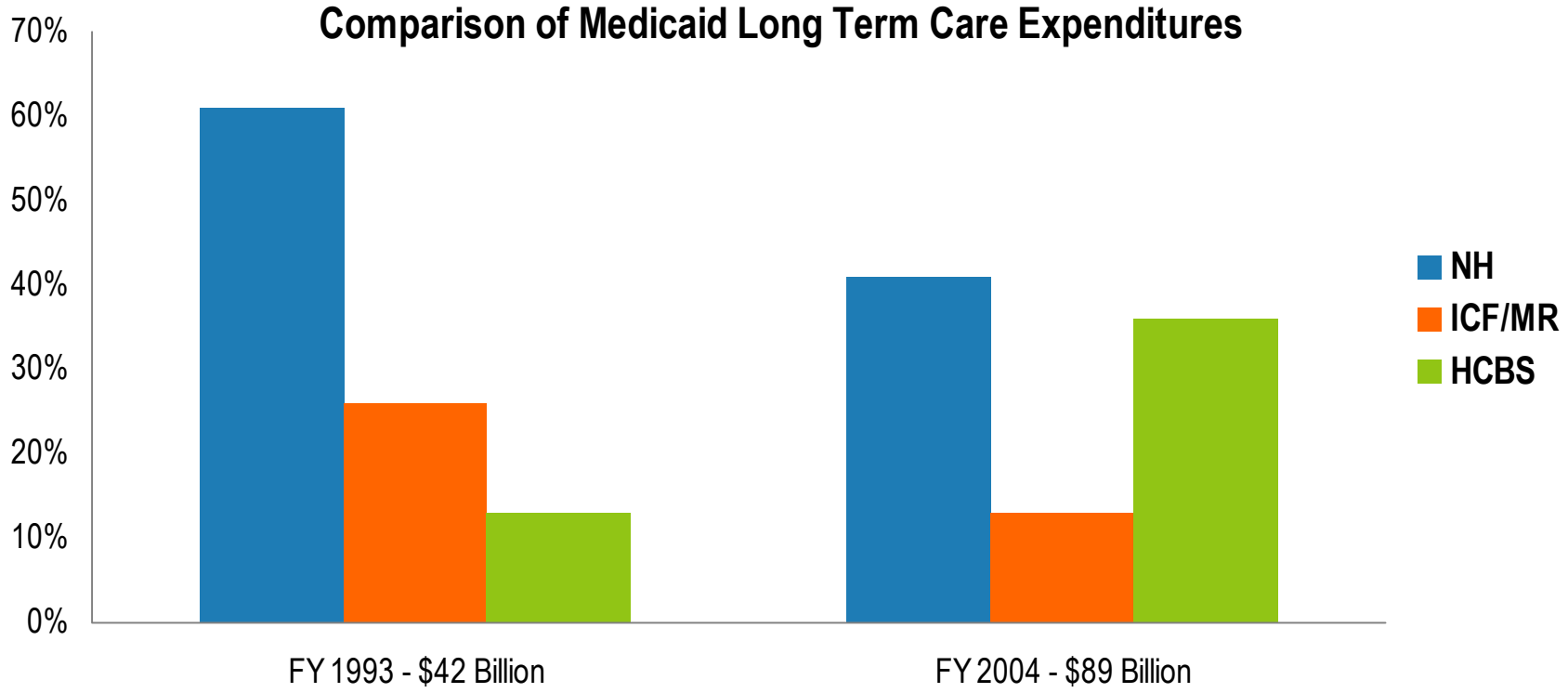


* Source: CMS, National Health Expenditures. Years 2006 and beyond are projections

Inconsistent Payment Systems Offer Varied Incentives



Trending and Strong Policy interest in De-Institutionalization



Source: Avalere analysis of MEDSTAT Group data

Quality Imperative Remains Strong

- Policy evolving rapidly for hospital (pay for quality)
- Physician sector moving more slowly (difficulty of measures, fiscal matters)
- Pressure on health plans at a global and payer level
- LTC status is evolving
  - » Negative bias historically
  - » No common, established measures across settings
  - » Quality First pledge = motion in the right direction
    - – AHCA, Alliance, AAHSA

Future of Self Financing is Murky at Best

- Moderate to lower income Americans are saving less over time
  - » Home is largest asset with 78% of net work, median $85,516 for over 65
    - – Avalere research: reverse mortgage helps only a few
  - » 36% of all households had no retirement assets; median is $10,000 (AOA)
- Those with assets will tend to shelter in advance of a disability
- Medical inflation often grows in excess of assets
- Resulting reductions in use of assets to pay for LTC
  - » Personal spending on LTC fell from 15.2% in 1998 to 12.5% in 2004 (CRS)
  - » Use of LTC insurance fell from 10.8% in 1998 to 7.3% in 2004 (CRS)
- Growth of CCRCs, though, shows there is a market and demand for self pay

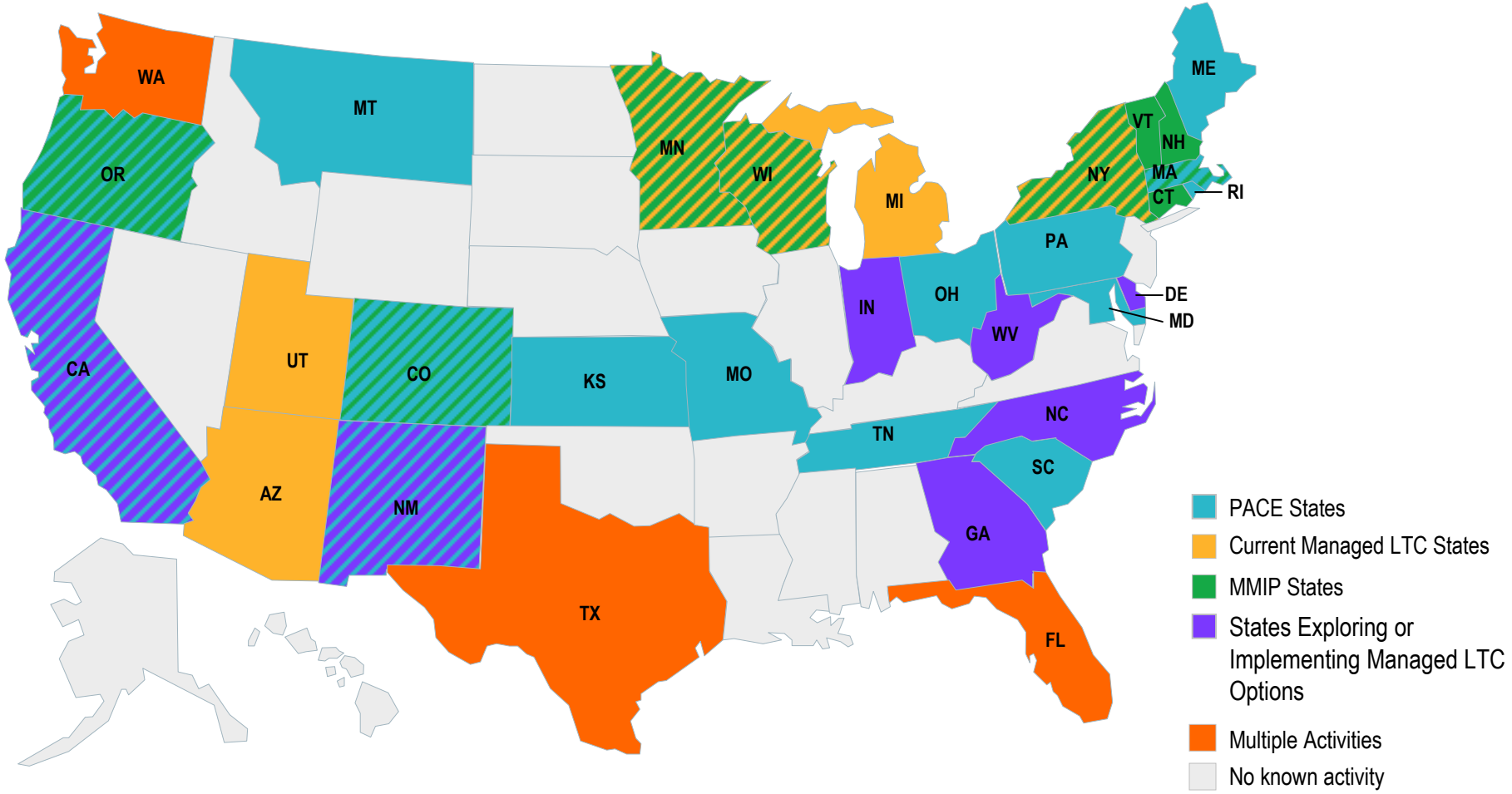
Medicare Part D: Operational Complexities

- Shift of drug spending for duals from Medicaid to Medicare
- Introduction of multiple formularies and multiple plans
- Serious operational complexities introduced
  - » Enrollment of residents into plans
  - » Formulary compliance
  - » State law requiring pharmacy access
- Change in role of long-term care pharmacies
  - » Rebates under fire by CMS
  - » Difficulty navigating plans as business partners (e.g., Omnicare suit)
  - » Pricing implications going forward

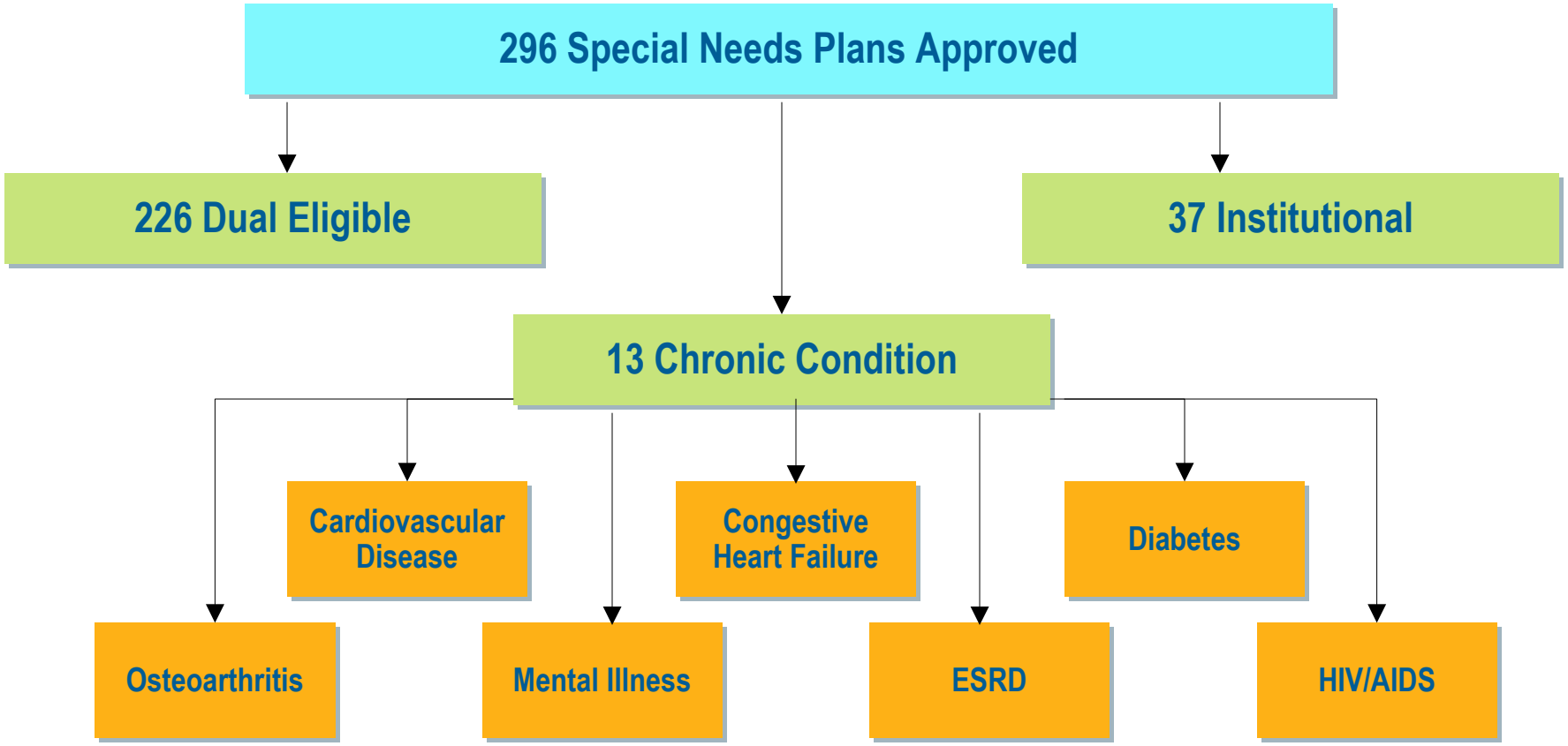
Emerging Models for Change

- Federal Focus
  - » Managed Care
  - » Post Acute Care Unification
  - » De-institutionalization
  - » Tax incentives, asset test restrictions
- State Models
  - » Managed Care (FL)
  - » Consumer Director and Managed Care (SC)
  - » State global budgeting (VT)
  - » Elimination of categorical eligibility (ID)
  - » “Healthy Lifestyles”
  - » Increased savings (e.g., NE health savings accounts)

Managed Care Organizations Will Emerge As More Dominant Payers of Long Term Care



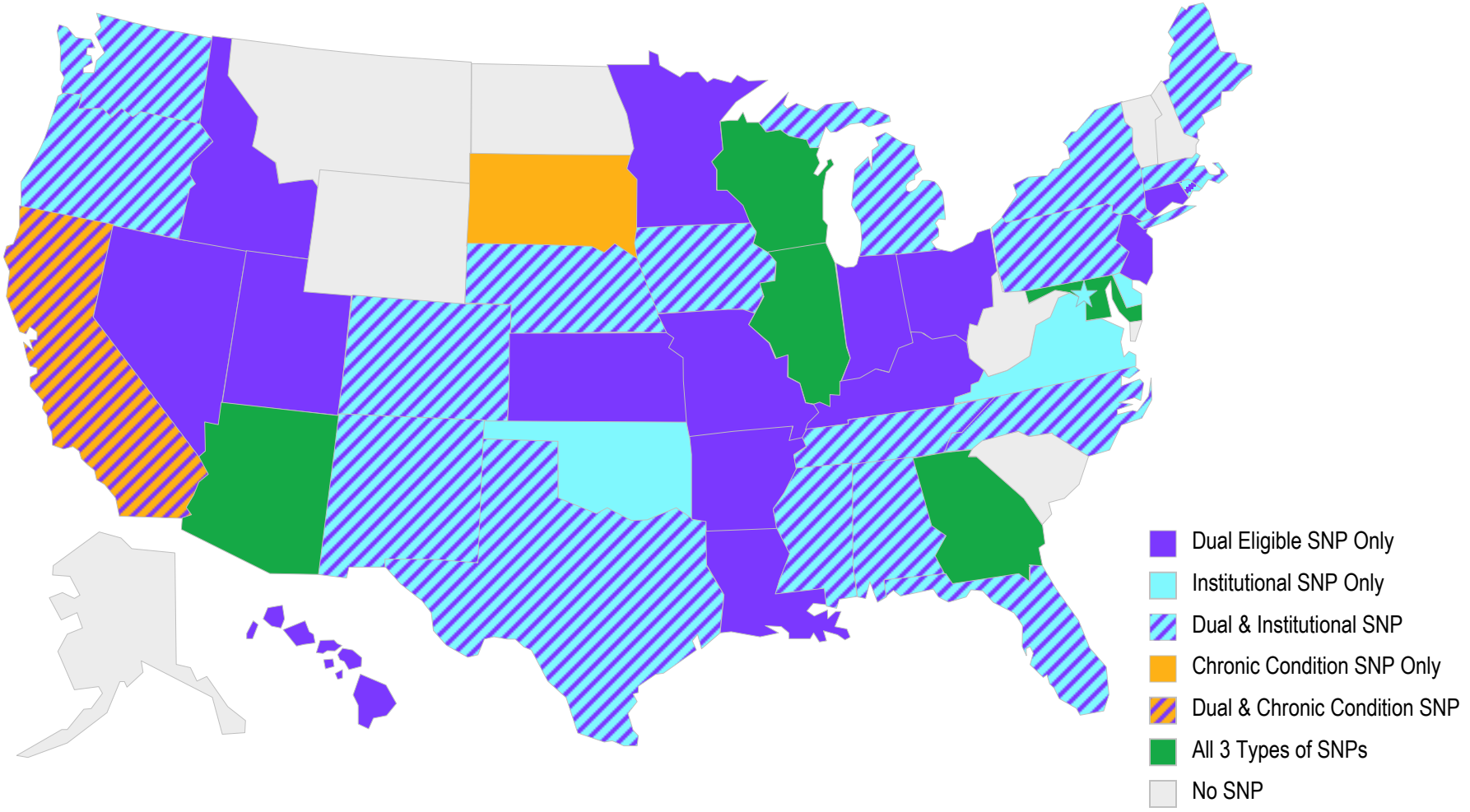
SNPs Emerging, Focus on Duals and Institutionalized People



Commercial plan response has been moderate

- CMS signed contracts with 91 distinct corporate entities
  - » 42 states, DC, and Puerto Rico have one or more SNP offerings
    - – Eight states, DC and PR have one or more SNPs in each county
  - » Overall number of plan offerings is large in some states (NY - 42 & FL - 35)
  - » But larger companies (except United) still thinking and positioning
- Interest is due to
  - » Medicare Advantage Risk Adjuster and pending frailty adjuster
  - » Potential to control both Medicare and Medicaid services and dollars
  - » Potential to control both acute and long term care services
  - » Capacity to target capitation and benefit package
- Shift from inpatient setting can increase demand for SNF

Multiple types of SNPs will be offered in many states in 2006



Source: CMS "Special Needs Plan: Maps" Updated 11-9-2005.
http://www.cms.hhs.gov/healthplans/specialneedsplans/default.asp

Two Difficult Policy Goals: PACU and De-Institutionalization

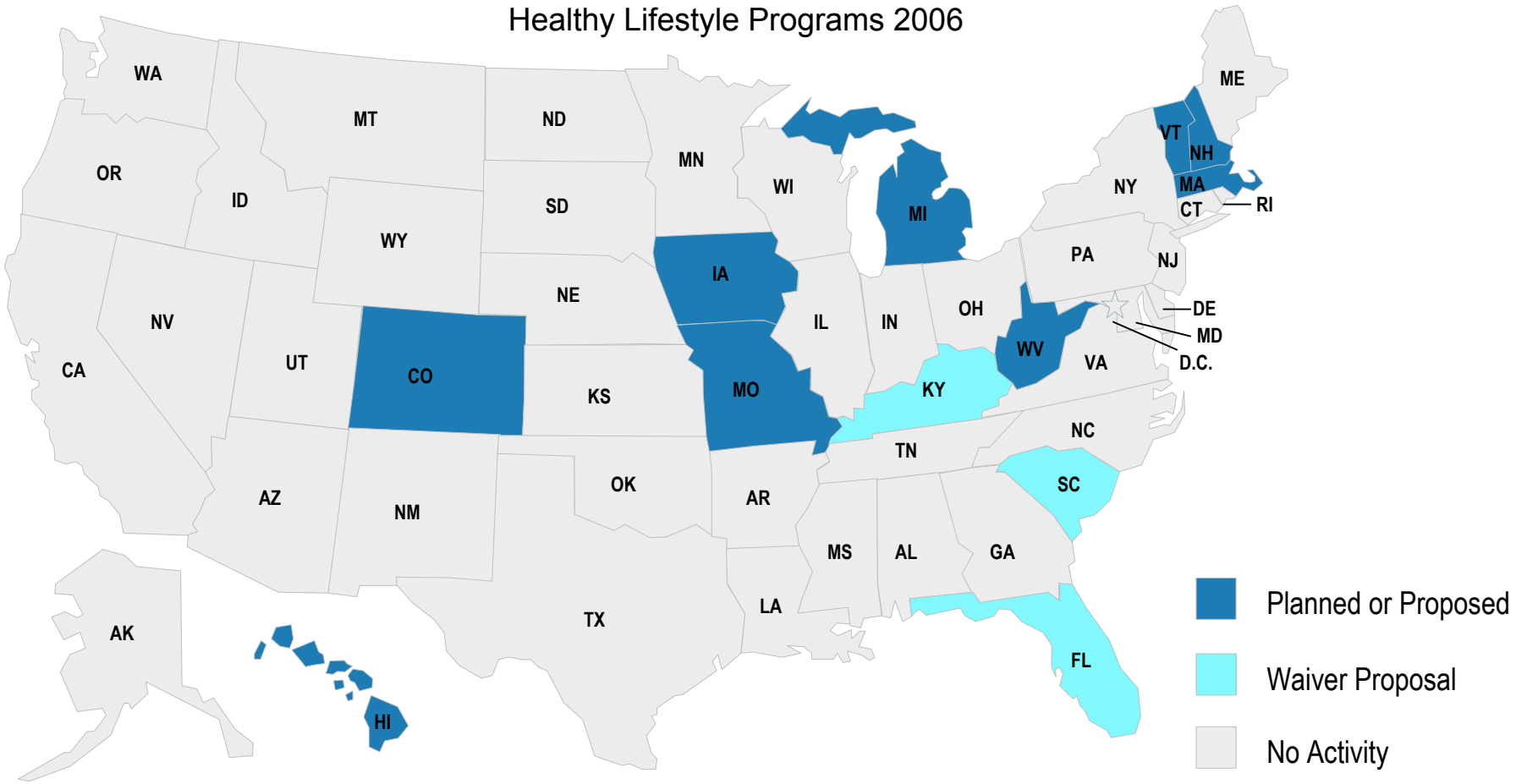
- Post Acute Care Unification has been an elusive target
  - » Concern about double paying relative to acute, perverse incentives
  - » No unified post-acute care assessment tool
  - » Strong interest by CMS in demonstrations, research
  - » LTACH payment issues showed willingness of Congress to engage
- De-institutionalization / HCBS evident in many policies
  - » CMS demo: Money Follows the Patient (MFP)
    - – $1.7 B / 3-5 years; Medicare demonstration
    - – States get funding, pass to care coordinators
    - – Goal is to shift patients out of NF, SNF, ICF-MR
    - – Effect primarily on working aged people with disabilities

HCBS State Plan Option Encourages De-Institutionalization

Section 1915(c) Waiver	Preliminary DRA HCBS SPO Interpretation
▪ Need not be statewide	▪ Need not be statewide
▪ State may limit enrollment	▪ State may limit enrollment
▪ State may limit by population – i.e., aged, disabled, MR/DD, TBI, or MH	▪ Service must be "comparable" across all enrolled populations
▪ Answerable to statutory "health, safety, and welfare" requirements"	▪ For self-direction, state must develop a "risk management technique"
▪ Eligibility tied to institutional level of care	▪ De-links level of care between HCBS SPO and institutional test but not to existing Section 1915(c) waivers

*** CMS will implement both the HCBS and Cash and Counseling State Plan Options via State Medicaid Directors' Letters and technical guidance. States may begin to move before the NPRM will be available for comment.**

States Are Implementing Programs that Create Incentives for Beneficiaries to Make Good Behavioral Health Choices



Implications for Post Acute Care Markets

- Long term fiscal pressures will challenge public reimbursement, demand
- Motion to less intensive sites of care will continue
  - » Opportunities to partner with states on $1.7B from MFP demonstration
  - » CCRCs will continue to grow, perhaps public under full capitation
- Managed care has emerged and will continue to grow in LTC markets
  - » Experience in capitation; change of incentives
  - » Advantage to having access to different settings
  - » Site of service shift starts in the inpatient setting
- Post-acute care unification is a strong goal, but will proceed slowly
  - » Differential payment rates will persist over the next 5 years
- Consumer financing is an idea worth nurturing but won't solve the problem