Medicaid and the Post Acute Care Marketplace

Dan Mendelson
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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

Source: OMB, FY 2006 President’s Budget
Looming Fiscal Crisis, or Rational Allocation of Wealth?

Medicare’s Share of GDP

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

Medicaid Spending by Service, 1990-2015*

Medicaid is currently the biggest item in state budgets – a trend expected to continue in future years

* Source: CMS, National Health Expenditures. Years 2006 and beyond are projections
Inconsistent Payment Systems Offer Varied Incentives

Long-Term Acute Care Hospitals

Inpatient Rehabilitation

Skilled Nursing Centers

Hospice Care

Home Health

Assisted and Independent Living Settings
Trending and Strong Policy interest in De-Institutionalization

Comparison of Medicaid Long Term Care Expenditures

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

- PACE States
- Current Managed LTC States
- MMIP States
- States Exploring or Implementing Managed LTC Options
  - Multiple Activities
  - No known activity
SNPs Emerging, Focus on Duals and Institutionalized People

296 Special Needs Plans Approved

- 226 Dual Eligible
- 37 Institutional

13 Chronic Condition

- Cardiovascular Disease
  - Osteoarthritis
- Congestive Heart Failure
  - Mental Illness
- Diabetes
  - ESRD
  - HIV/AIDS
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

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**
- Need not be statewide
- State may limit enrollment
- State may limit by population – i.e., aged, disabled, MR/DD, TBI, or MH
- Answerable to statutory “health, safety, and welfare” requirements
- Eligibility tied to institutional level of care

**Preliminary DRA HCBS SPO Interpretation**
- Need not be statewide
- State may limit enrollment
- Service must be “comparable” across all enrolled populations
- For self-direction, state must develop a “risk management technique”
- 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

Healthy Lifestyle Programs 2006

- Planned or Proposed
- Waiver Proposal
- No Activity
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