



The Hilltop Institute

analysis to advance the health of vulnerable populations

Dual Eligibles in Nursing Facilities and Other Long-Term Care Settings

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Preconference Symposium I



The Hilltop Institute was formerly the Center for Health Program Development and Management.

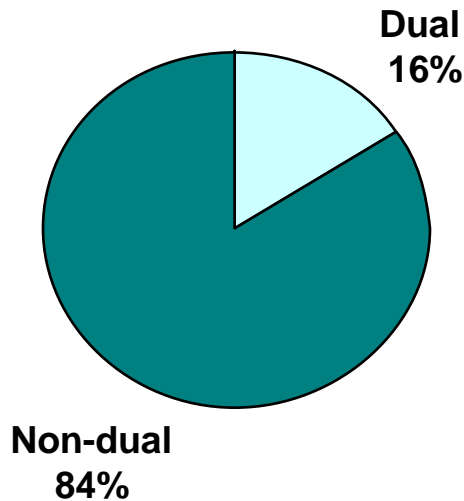
Overview of Presentation

- Dual Eligibles and Long-Term Care in Maryland
- The Problem (continued) ... and the Opportunity
- New Mexico Coordination of Long-Term Services (CoLTS)

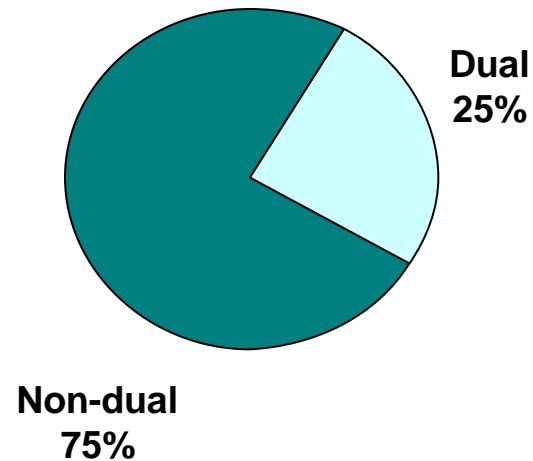
Dual Eligibles and Long-Term Care in Maryland

Even though they have Medicaid, dual eligibles cost Medicare more than other Medicare beneficiaries . . .

Medicare enrollees by eligibility in U.S., 2005

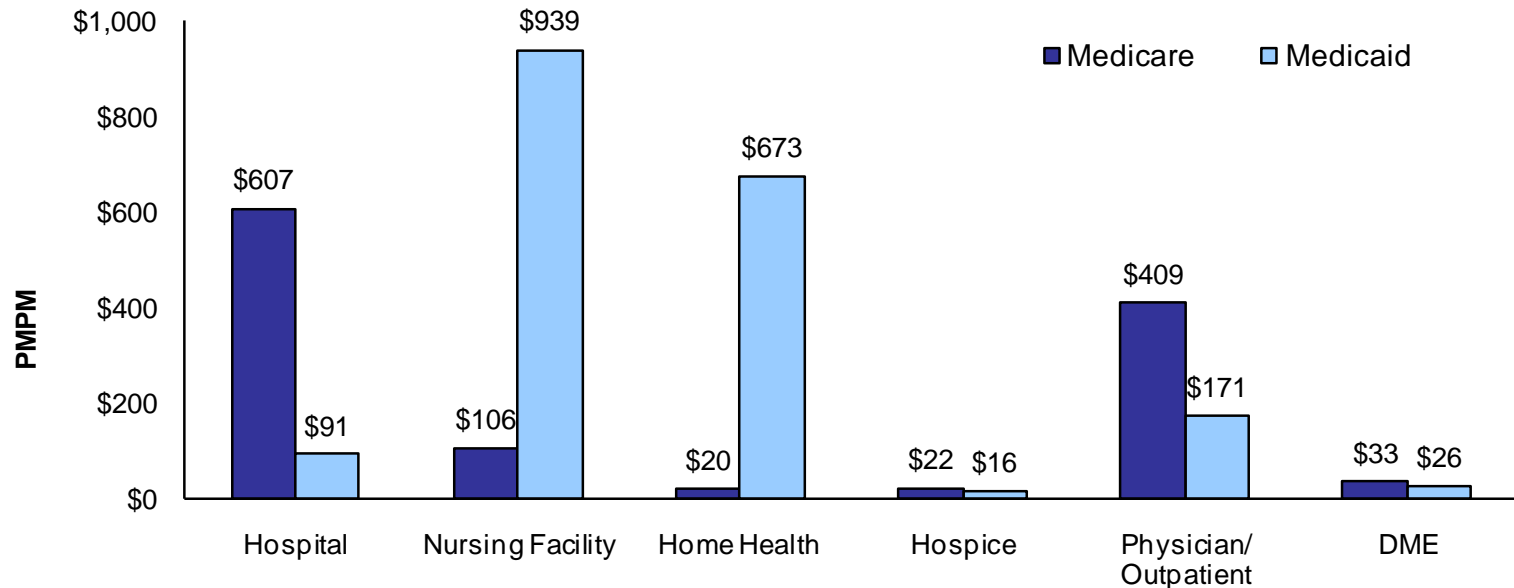


Medicare spending by eligibility in U.S., 2005



Source: MedPac, June 2008

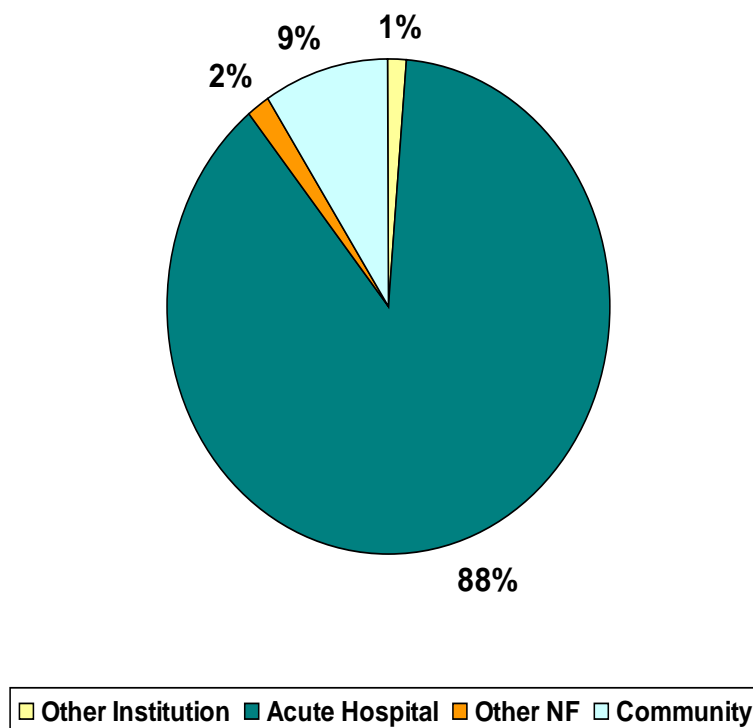
In Maryland, combined Medicaid and Medicare expenditures for duals by service look like this:



Source: The Hilltop Institute, 2008

Notes: 2006 data. Includes only continuously enrolled full-benefit duals with no group health coverage. Includes coinsurance and deductibles on Medicare claims paid by Medicaid. Nursing Facility figures include ICF-MR expenditures and "Home Health" includes all Medicaid HCBS waivers.

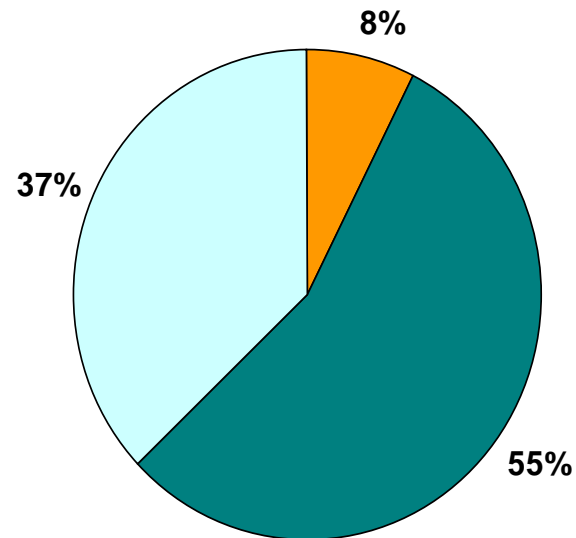
For “extended stays,” the majority of initial Medicare SNF and Medicaid NF admissions came from a hospital . . .



An **EXTENDED STAY** consists of all contiguous discrete nursing facility stays across facilities (with no more than a 30-day gap).

Hilltop refined MDS data, **Extended** Stays in Maryland, 1999-2009.
Limited to Medicaid participants and those who convert to Medicaid during a stay.

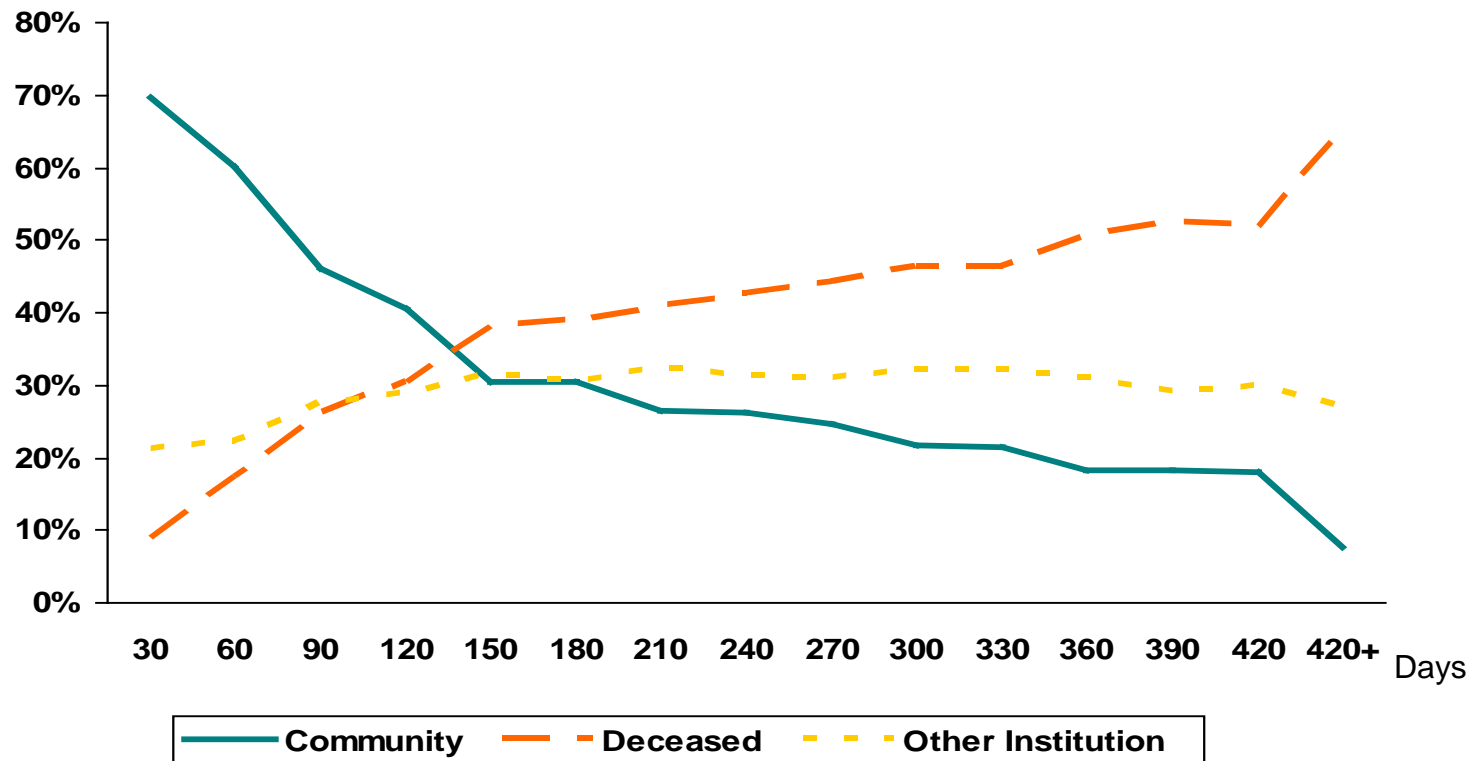
. . . and the initial payer was Medicare.



Private/Other Medicare Medicaid

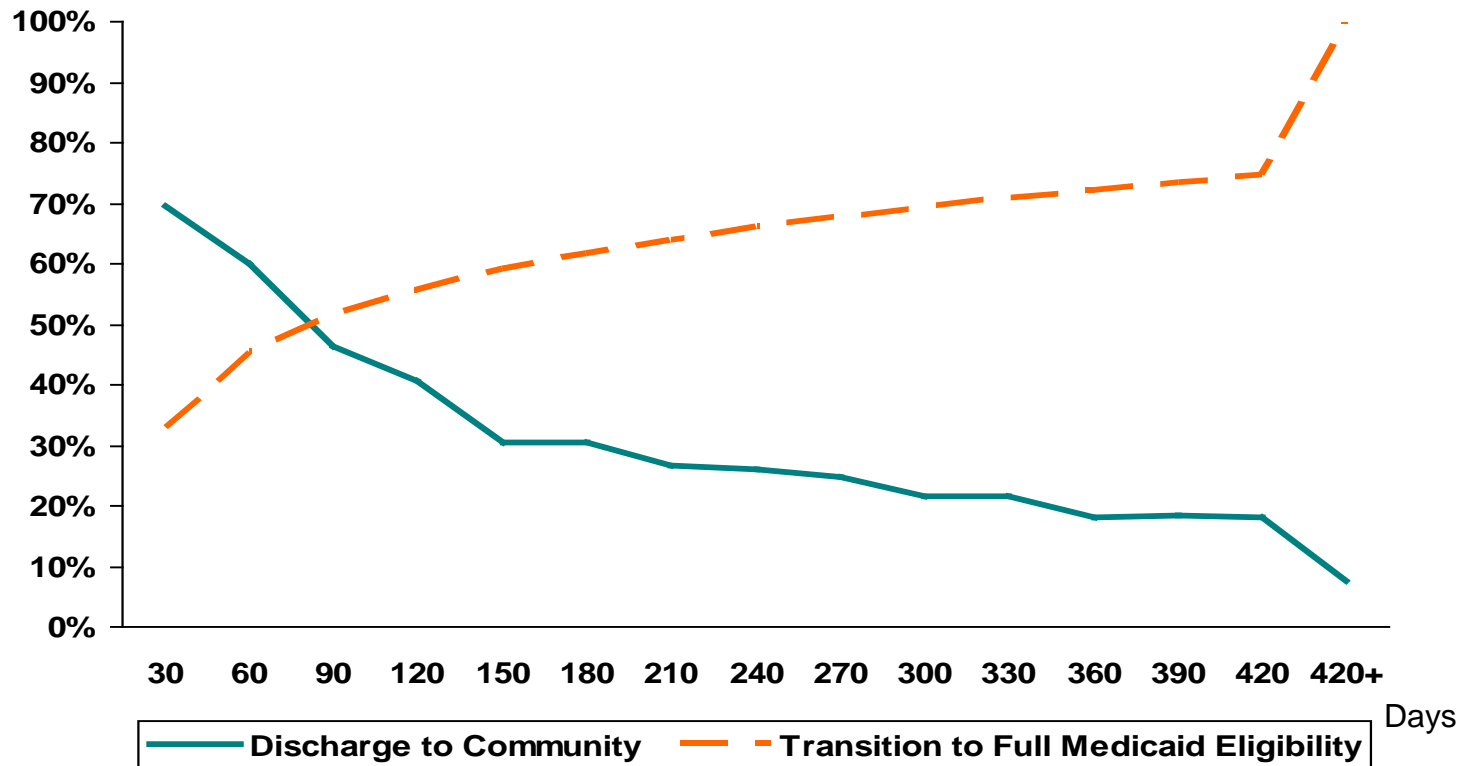
Hilltop refined MDS data, **Extended** Stays in Maryland, 1999-2009.
Limited to Medicaid participants and those who convert to Medicaid during a stay.

After a 90-day nursing facility stay, the odds of discharge to the community drop to below 50% . . .



Hilltop Refined MDS data for Maryland, Extended Stays with Discharge, 1999-2009.
Limited to Medicaid participants and those who convert to Medicaid during a stay.

... and after a 60-day length of stay, the percentage who eventually convert to Medicaid exceeds 50%.



Hilltop Refined MDS data for Maryland, Extended Stays with Discharge, 1999-2009.

Limited to Medicaid and those who convert to Medicaid during a stay.

For more on resource use by Maryland dual eligibles, go to http://www.hilltopinstitute.org/publication_view.cfm?pubID=245&st=tbl_Publications

The Problem (continued)... and the Opportunity

Medicare administrators assert that there is Medicaid cost shifting to Medicare ...

- Medicare program administrators and the Medicare Advantage plans often assert that Medicaid fails to adequately pay nursing facilities, leading to insufficient staffing, avoidable hospitalizations paid by Medicare due to falls, pressure ulcers, and pneumonia
- Medicare administrators assert that limited oversight by Medicaid agencies of HCBS providers, and low payment rates for HCBS services, lead to avoidable use of the emergency room and inpatient hospitalizations, which are paid by Medicare

... and Medicaid administrators respond that there is Medicare cost shifting to Medicaid

- Medicaid program administrators often assert that Medicare program administrators fail to manage hospital discharges and fail to manage Medicare providers, leading to avoidable Medicaid expenses due to long nursing facility lengths of stay, and unmanaged Medicaid benefits ordered by Medicare-paid physicians
- Medicaid administrators assert that overly strict Medicare utilization management inappropriately denies Medicare coverage for home health and DME, thereby leading to cost shifting to Medicaid

The opportunity: A coordinated program could improve care and outcomes

- Coordinate (Medicare) hospital discharge planning with (Medicaid) community-based supports and services to avoid unnecessary languishing in nursing facilities
- Monitor quality of care in nursing facilities to prevent falls, pressure ulcers, and other causes of avoidable hospitalizations
- Coordinate Medicare home health, physician, and Rx services with Medicaid attendant care, transportation, and HCBS waiver services for a well-designed community-based plan of care

New Mexico Coordination of Long-Term Services (CoLTS)

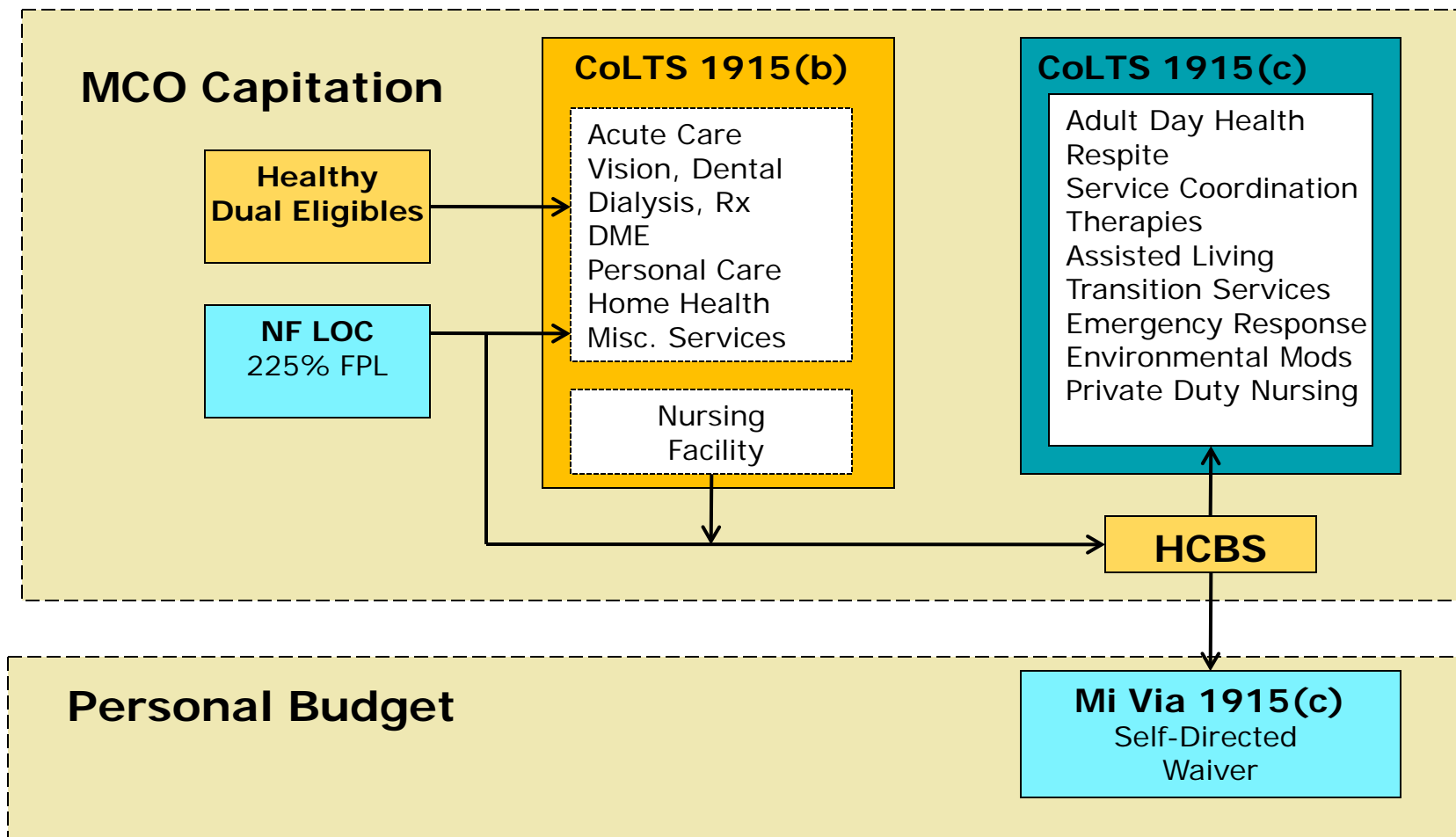
New Mexico's CoLTS program has these goals ...

- Promote further rebalancing by diverting potential nursing facility admissions and shortening nursing facility lengths of stay
- Promote flexible benefit design to achieve new models for community-based services
- Improve quality through coordination of Medicare and Medicaid benefits
- Achieve financial savings by aligning Medicare and Medicaid incentives

The CoLTS model:

- Mandatory statewide program (in Medicaid) using a 1915(b)(c) combination waiver
- Populations:
 - All Medicaid participants who meet nursing facility level of care
 - All full-benefit dual eligibles
- Medicaid managed care organizations (MCOs) must also be approved Dual Eligible Special Needs Plans (SNPs)

Structure of the CoLTS 1915(b)(c) concurrent waiver



CoLTS is now operating statewide

- CoLTS was launched August 1, 2008, in select counties
- By July 2009, the program was fully implemented statewide with about 37,500 members
- There are two participating MCOs (AMERIGROUP and Evercare)
- Duals are 85% of the enrolled population

Some challenges emerged during program implementation ...

- Moratorium on new SNPs in 2008 stymied SNP expansion in the state
- Averting “woodwork” of “healthy duals” assessed at nursing home level of care—role of third-party assessor
- Limit on the number of CoLTS 1915(c) slots
- High utilization of state plan personal care
- How to manage nursing facility rate setting in a managed care environment

Is coordinated care more efficient? Too early to tell ...

- The two-year time horizon for demonstrating cost effectiveness under a 1915(b) waiver is challenging because managed care efficiencies and administrative savings often take longer to achieve
- Lack of SNPs throughout the state diminishes opportunities for Medicare-Medicaid coordination; however, repeal of the moratorium and new frailty adjustment for dual eligible SNPs should help increase access to SNPs
- Good data are not yet available (e.g., encounter data, Medicare plan enrollment)

Questions for further thought and investigation ...

- To what extent are CoLTS duals enrolled with the same plan for Medicare and Medicaid benefits? For those who are, are there fewer hospitalizations, NF admissions, and other desired outcomes?
- Can a “developed” HCBS state like New Mexico (#1 in proportion of Medicaid spending on HCBS*) achieve further rebalancing through coordinated care?
- How can a state construct a Medicaid benefit package for HCBS that meets the needs of members with varying levels of functional disability without breaking the bank? Is the 1915(i)** an option?

*Thomson Reuters. Distribution of Medicaid Long-Term Care Expenditures, FY 2008.

**The Patient Protection and Affordable Care Act (Public Law 111-148) amends Section 1915(i) of the Social Security Act to give states the option to provide more types of HCBS through a state plan amendment and allows targeting benefits to individuals with selected conditions.

About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluation on behalf of government agencies, foundations, and other non-profit organizations at the national, state, and local levels.

www.hilltopinstitute.org

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