Changing Patterns of LTC Service Delivery

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The American Context

- Medicaid as the means-tested safety-net program for poor people – primary public payer for LTC
  - Nursing home is a mandated benefit
  - Policy goal of preventing Medicare from becoming a source of LTC (Medicare = public health insurance for people 65+ and with disabilities)
  - Jimmo decision
  - VA
- Eligibility and benefits are determined at the state level
  - BUT – states are constrained by balanced budget laws
  - Consequently, states are drivers of LTC policy

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Long-term shift to non-institutional services

- Medicaid has been "rebalancing" away from institutional services toward great funding of HCBS,
  - Less so for elderly than for other subgroups.
  - Eg, in 2000 there were 1.5 million NF residents. In 2011, only 1.4 million, despite population growth.
- More "consumer/participant-directed" (PD) HCBS for Medicaid and other public program participants.
- Shift from fee-for-service payment to managed care (bundled payment) is expected to exacerbate the trend.

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Proliferation of nursing home alternatives

- These include: assisted living and related facilities (e.g. personal care homes), board and care homes, adult family foster care, senior housing with services, including independent living providing meals, housekeeping, and social/recreational services only.
- Data sources variably estimate the numbers of elderly in such “non-nursing home” settings as between .8 and 2 million.

So….

- Are wealthier people choosing assisted living over nursing homes?
- Nursing homes increasingly becoming options mainly for the poor?

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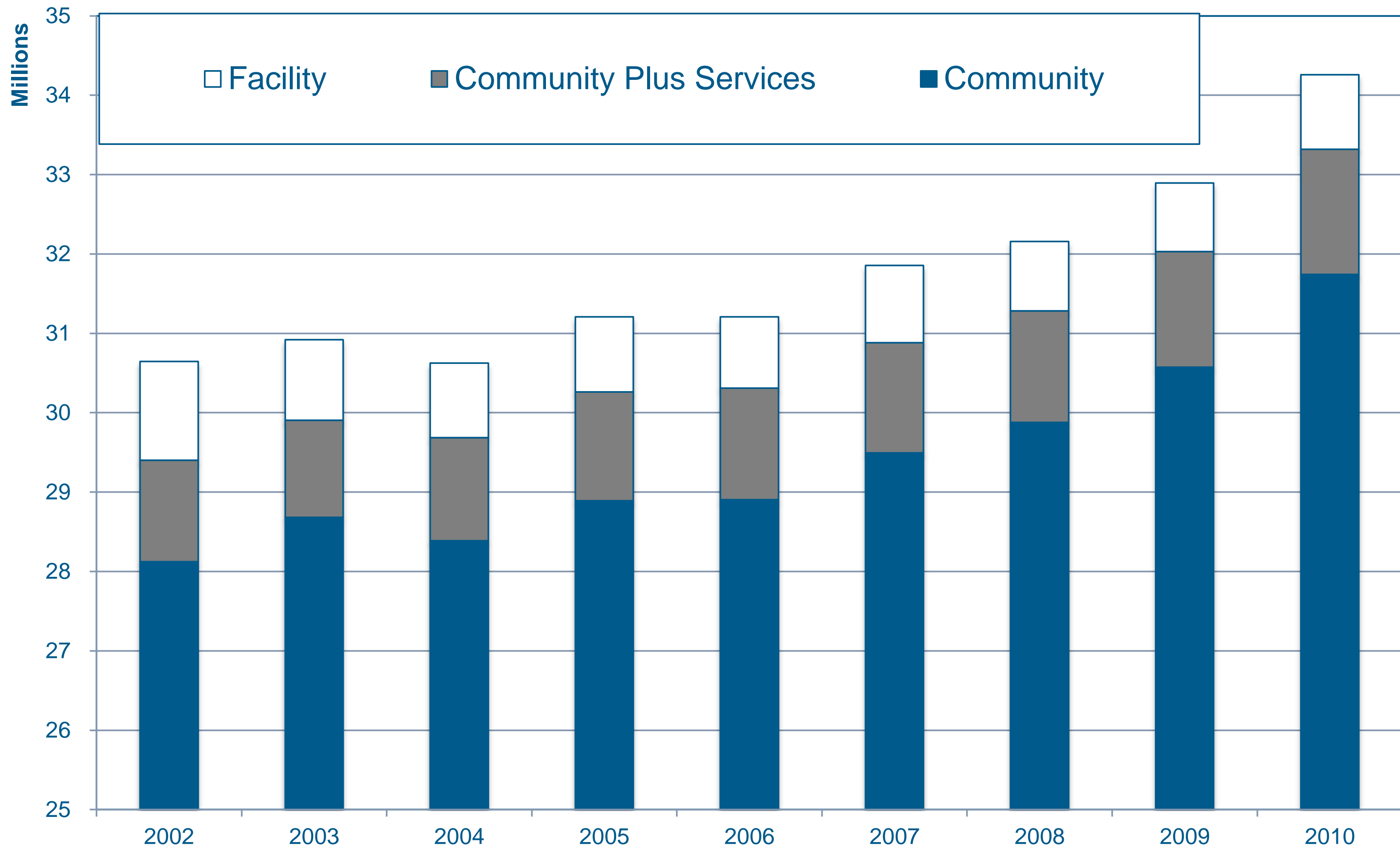

Source: Medicare Current Beneficiary Survey, author's own analysis

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Residential Care Facilities (RCFs) are predominately private pay

- 43% of RCFs have at least one Medicaid resident
- An estimated 15-20% to 33% of RCF residents are on Medicaid.
- An estimated 66% of elderly NF residents are on Medicaid compared to 33 percent of elderly residents in other RCFs, 13 in senior housing with support services ,and 11 percent of elderly living in private homes.
- Bottom line: people who are poor enough for Medicaid cannot afford the cost of room and board even if Medicaid covers the cost of services in alternative settings.

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Data from private LTCI claims supports this shift

- Private LTCI claimants' use of assisted living and home care is roughly equal.
- Only 1 in 5 ever used nursing home care over 30 month longitudinal follow-up. Short-term, end of life stays.

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Competitive pressure on nursing homes

- Culture change movement – “Pioneer network”
  - Aims to make NFs smaller, more home-like, more supportive of independence and choice
  - Infrastructure issues
- One study characterized 31% of NFs surveyed as culture change “adopters” (all or most indicators of culture change present), 25% as “strivers” (fewer changes yet made but leadership committed to change) and 43% as “traditional.”
- Adopters gained competitive advantages over other NFs.

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However, considerable state-wide variation

- In 2010, spending on HCBS ranged from
  - $7,844 in Texas to $34,506 in New York per enrollee year
  - 12% to 68% in terms of total LTSS expenses
- Also extreme variation in eligibility for HCBS, in terms of financial as well as other requirements.
- In 2012, nearly 524,000 people were on §1915(c) wavier waiting lists, with an average waiting time of over two years.
- Also – retrenchment in times of greatest need, due to balanced budget etc.

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Another approach: Coordinated care

- Fragmentation between health care and long-term care
- Medicare and Medicaid separate
  - Leads to incentives for cost-shifting
- Other countries also separate acute and long-term care financing
- Result for older and younger people with disabilities:
  - High and probably unnecessary costs
  - Poor and uncoordinated care
- This matters because the "dually eligible" population is a very expensive one
  - Duals comprise 20% of the Medicare population but use 31% of its funding
  - Duals comprise 15% of the Medicaid population but use 39% of its funding

Policy Hypothesis: Integration of Medicare (acute care) and Medicaid (long-term care) results in better care and lower costs

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Big issue: cost-shifting

- Medicaid has little incentive to invest in initiatives that save Medicare money and vice versa
- In 2005, average Medicare cost of a potentially avoidable hospitalization by Medicaid nursing home residents was $7,661, but $343 to Medicaid
- Medicaid saves money with hospitalization of dual eligibles
- Initiatives to reduce Medicare hospitalizations require Medicaid spending

Potentially avoidable hospitalizations among nursing home residents

Study	Percentage of Hospitalizations Estimated to be Avoidable
Saliba et al. (2000)	40
Carter (2003)	25
Grabowski et al. (2007)	23
Intrator et al. (2004)	37
Ouslander et al. (2010)	60

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Thus, ACA encourages integrated care models

- Federal Coordinated Health Care Office (Duals Office) and Centers for Medicare & Medicaid Innovation take integration of Medicare and Medicaid to scale
- State Demonstrations to Integrate Care for Dual Eligible Individuals (13 states have been approved)
- 39 states originally submitted letter of intent to CMS to pursue financial arrangements of third-party capitation or to have state to receive Medicare funds for dual eligibles
- For the first time, federal government consider sharing Medicare savings with states

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Issues

- For states, only option that is a potential win-win
- Potential to have big impact on long-term care
- Will it save money and improve care?
  - Integrated care is easy in theory, hard in practice
  - History of failed experiments
- Will it overmedicalize long-term care?
- Will people lose their choice of providers?
- Will Feds end up with the short end of the stick?
- How will the universal entitlement philosophy of Medicare meld with the means-tested approach of Medicaid?

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Conclusion

- The landscape has definitely changed
- More HCBS options, particularly for those not participating Medicaid
  - Few data on the quality of private pay HCBS
  - Regulation is spotty
- For Medicaid recipients, extent of change depends on your state of residence, and sometime even your city/county
- Coordination initiatives hold promise, but the jury is out.
  - In any case, local variation is likely to be extreme

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