

Rebalancing Long-Term Care in the US: the Role of Medicaid Managed Long-Term Services and Supports

September 8, 2022

13:00 (Room 3)

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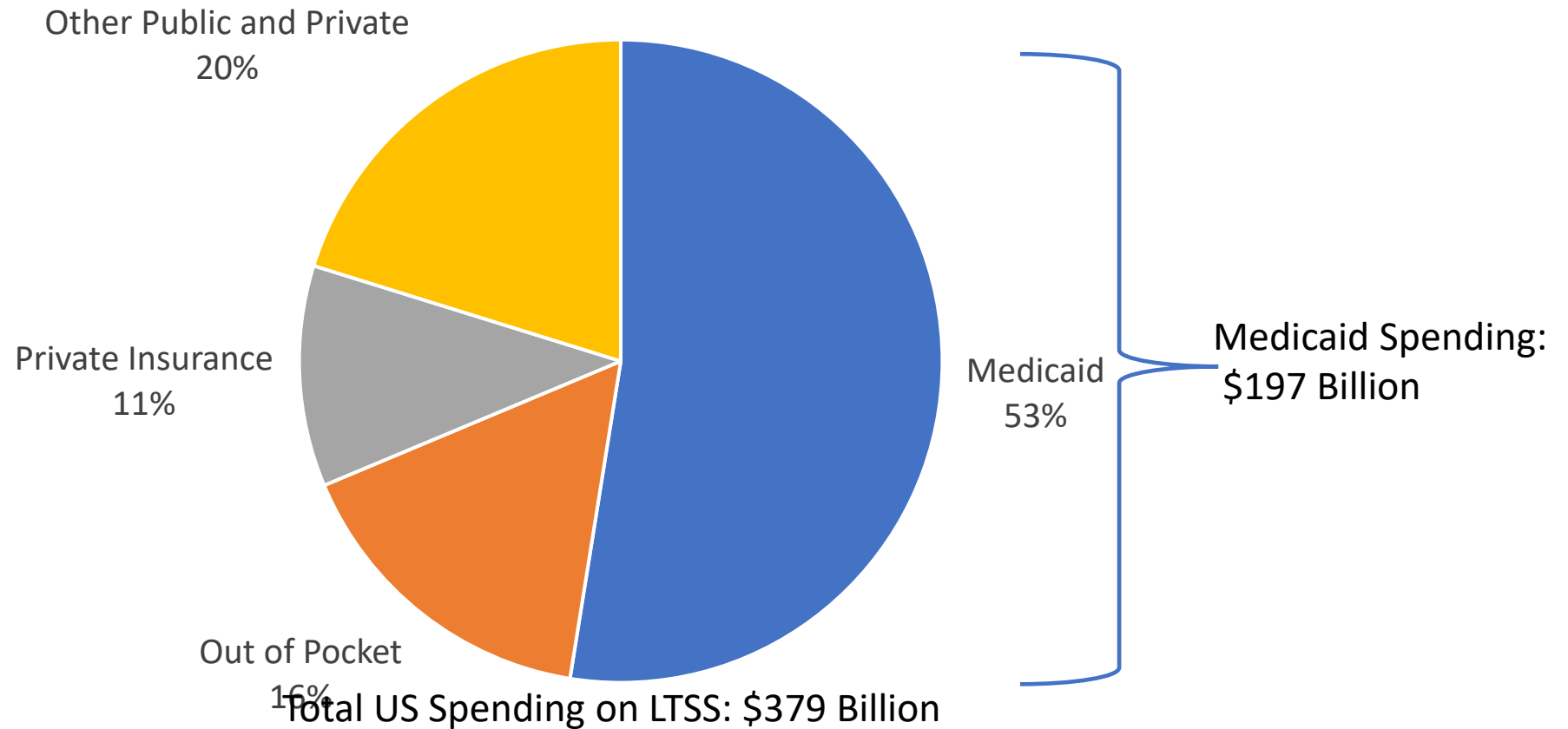
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Overview

- Background on Medicaid LTSS
- What is MLTSS?
- Effect of MLTSS on Rebalancing
- Drill Down on Specific Services:
 - Personal Care
 - Adult Daily Living
 - Home Delivered Meals

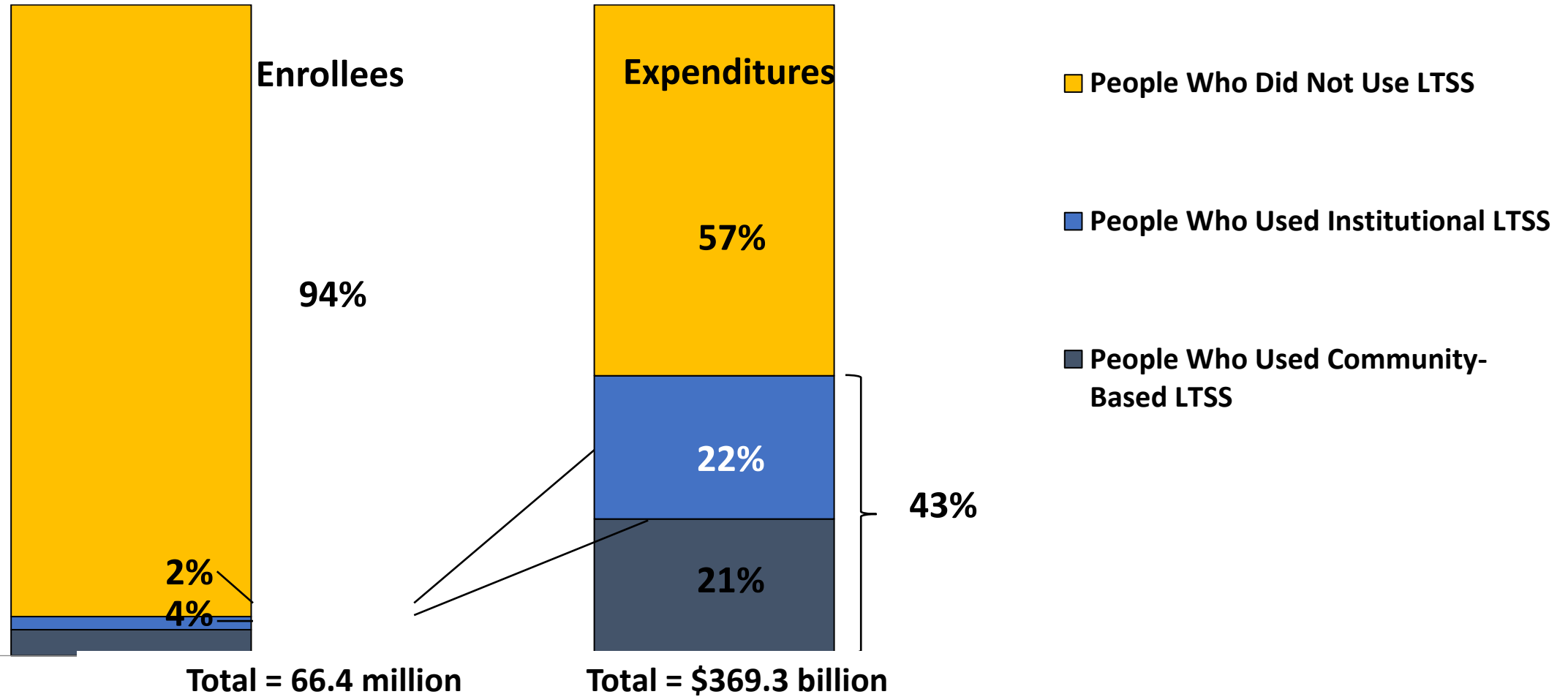
Long-Term Services and Supports by Payer (2018)



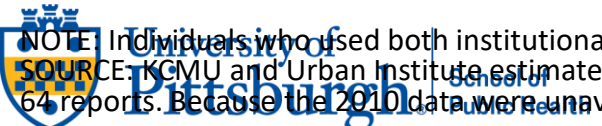
NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care (\$83.3 billion in 2018). All home and community-based waiver services are attributed to Medicaid. SOURCE: KFF estimates based on 2018 National Health Expenditure Accounts data from CMS, Office of the Actuary



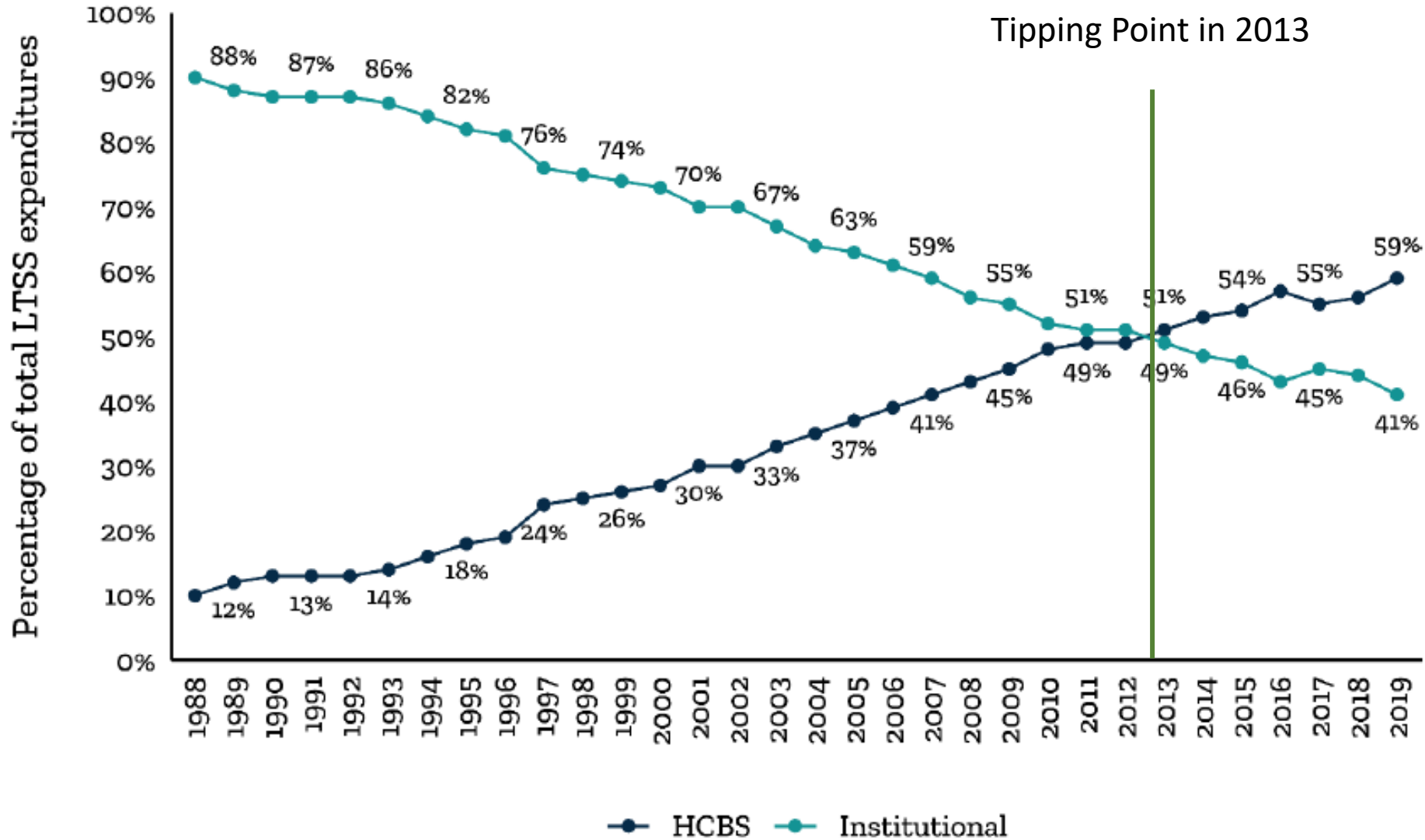
Medicaid Long-Term Services and Supports (LTSS) Users are a Minority of Medicaid Participants, but Account for Nearly Half of Medicaid Spending (FY 2010)



NOTE: Individuals who used both institutional and community-based services in the same year are classified as using institutional services in this figure.
 SOURCE: KCMU and Urban Institute estimates based on data from FY 2010 Medicaid Statistical Information System (MSIS) and Centers for Medicare & Medicaid Services (CMS)-64 reports. Because the 2010 data were unavailable, 2009 data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.



Medicaid Expenditures on LTSS Have Shifted to HCBS



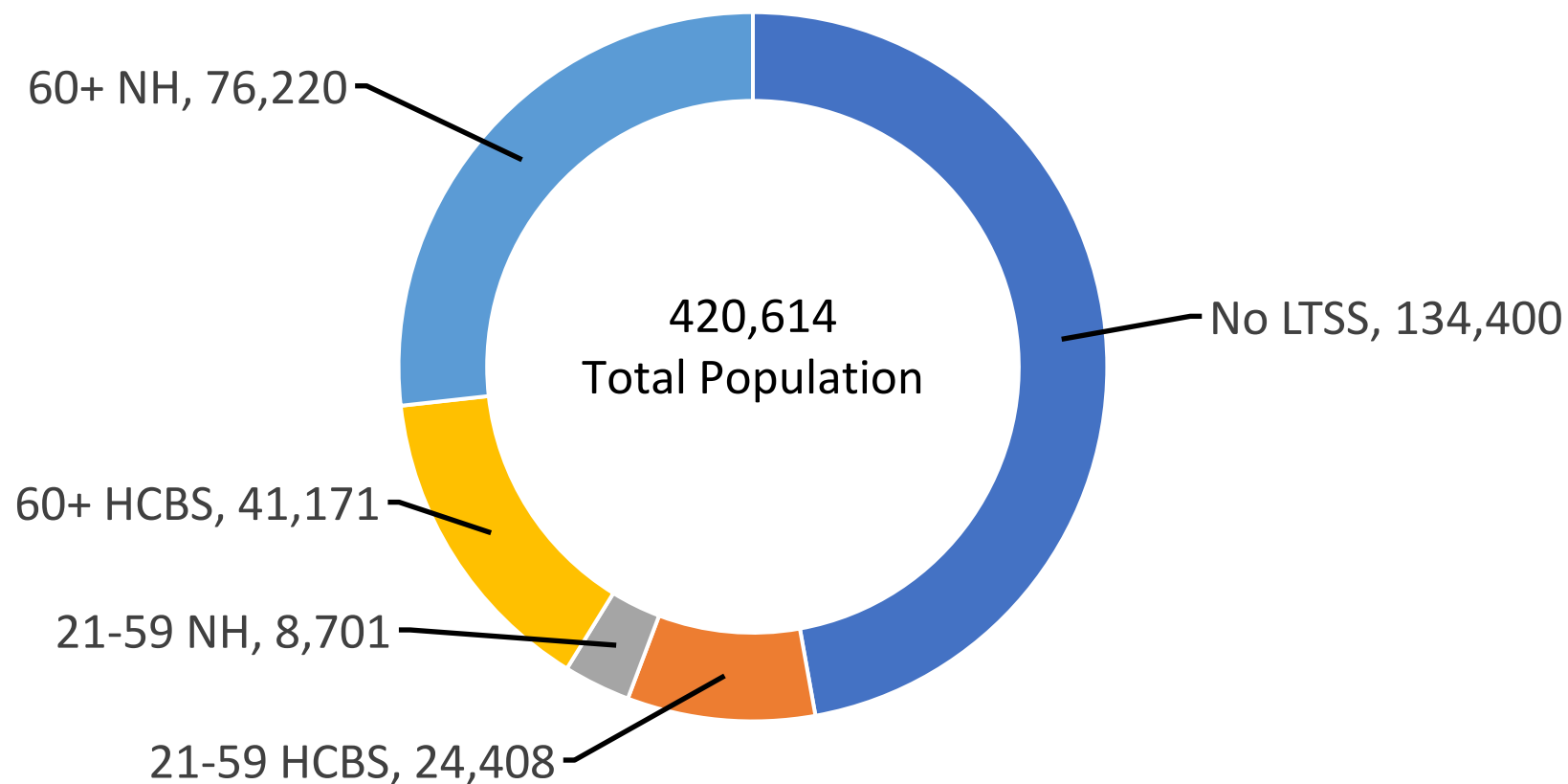
Managed Long-Term Services and Supports

- Managed care companies receive a blended rate to deliver all Medicaid services including LTSS
 - Segment 1: Non-LTSS Participants
 - Segment 2: LTSS Participants
 - Incentivizes rebalancing from nursing home to HCBS
 - Incentivizes identifying non-LTSS participants with LTSS need
- Plans can establish networks of providers and negotiate rates
- Plans can offer supplemental benefits
- State government role has shifted from bill payor to quality oversight
- Two payment groups:
 - Medicaid only
 - Managed care pays all medical, behavioral and long-term services and supports
 - Eligible for both Medicaid and Medicare
 - Managed care pays for LTSS and medical costs that are not covered by Medicare
- Care coordination
 - Straightforward for the Medicaid only group
 - Dual eligible participants are challenging:
 - Limited oversight of medical providers in Fee-for-service Medicare
 - Those in a Medicare managed care product require cooperation between different companies

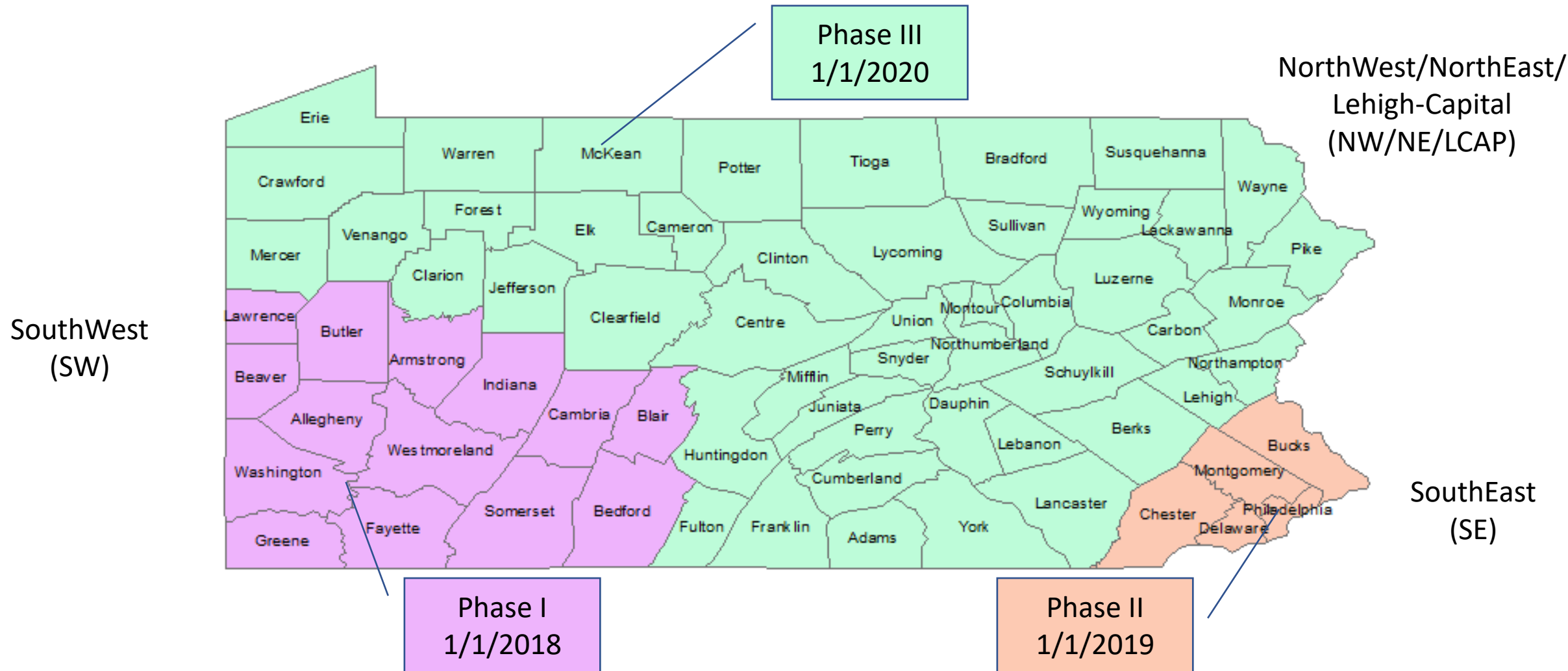
PA Managed Long-Term Services and Supports: Community HealthChoices

- Medicaid Managed Care plan for three populations of adults (21+):
 - People dually eligible for both Medicaid and Medicare
 - Aged and Poor
 - Under age 65 and meet SSI disability
 - Nursing Home Residents covered by Medicaid
 - Includes some Medicaid only and duals
 - Medicaid Home and Community Based Services participants
 - Includes some Medicaid only and duals
- Goals:
 - Increase Community-Based LTSS
 - Improve care coordination
- Behavioral Health is carved out
 - No change to benefits for duals and 21-59 HCBS participants
 - Aged HCBS and NH residents gained benefits
- Three CHC Managed Care Organizations:
 - UPMC CHC
 - PA Health and Wellness
 - AmeriHealth Caritas/Keystone First
- Medicare benefits unchanged
 - Each of the three CHC MCOs offers a Medicare Special Needs Plan (SNP)
 - Plans have incentive to have 'aligned members'

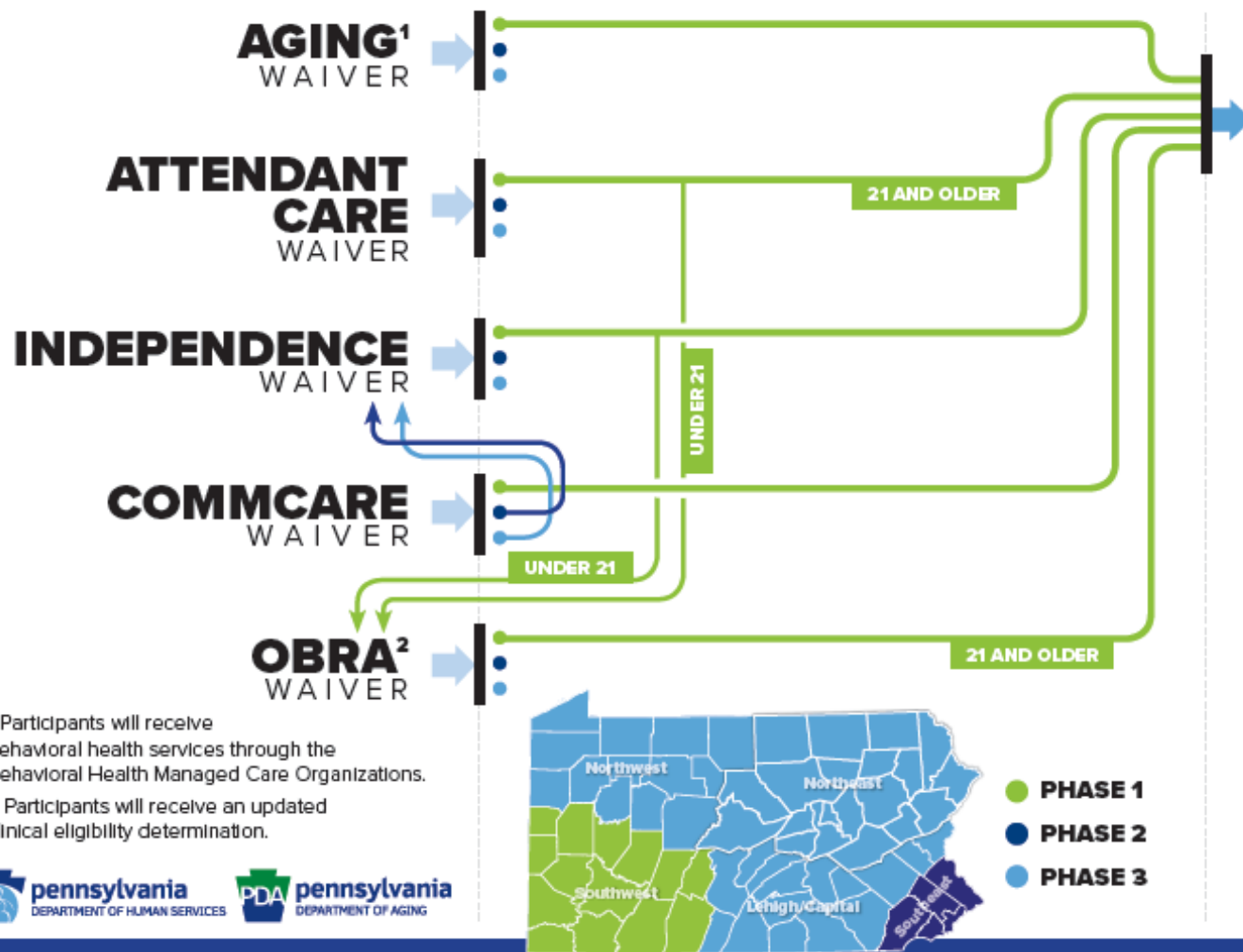
Community HealthChoices Population (2015)



Phased Rollout



Legacy Waiver Transitions: January 2018



CHC WAIVER

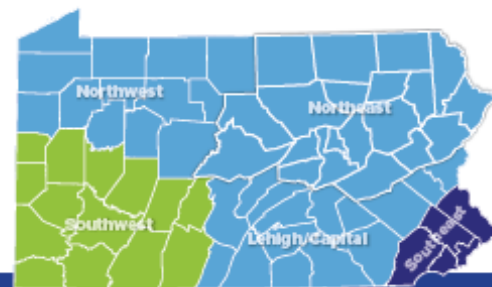
Transitioning to the CHC Waiver:

- Phase 1 Aging Waiver participants.
- Phase 1 Attendant Care Waiver participants ages 21 and older; participants under 21 will transition to the OBRA Waiver.
- The COMMCARE Waiver will become the CHC Waiver; Phase 2 & 3 COMMCARE participants will transition to the Independence Waiver.
- Phase 1 Independence Waiver participants ages 21 and older; participants under 21 will transition to the OBRA Waiver.
- Phase 1 OBRA Waiver participants ages 21 and older who are nursing facility clinically eligible; participants under 21 or **not** nursing facility clinically eligible will remain in OBRA.

Transitioning to LIFE:

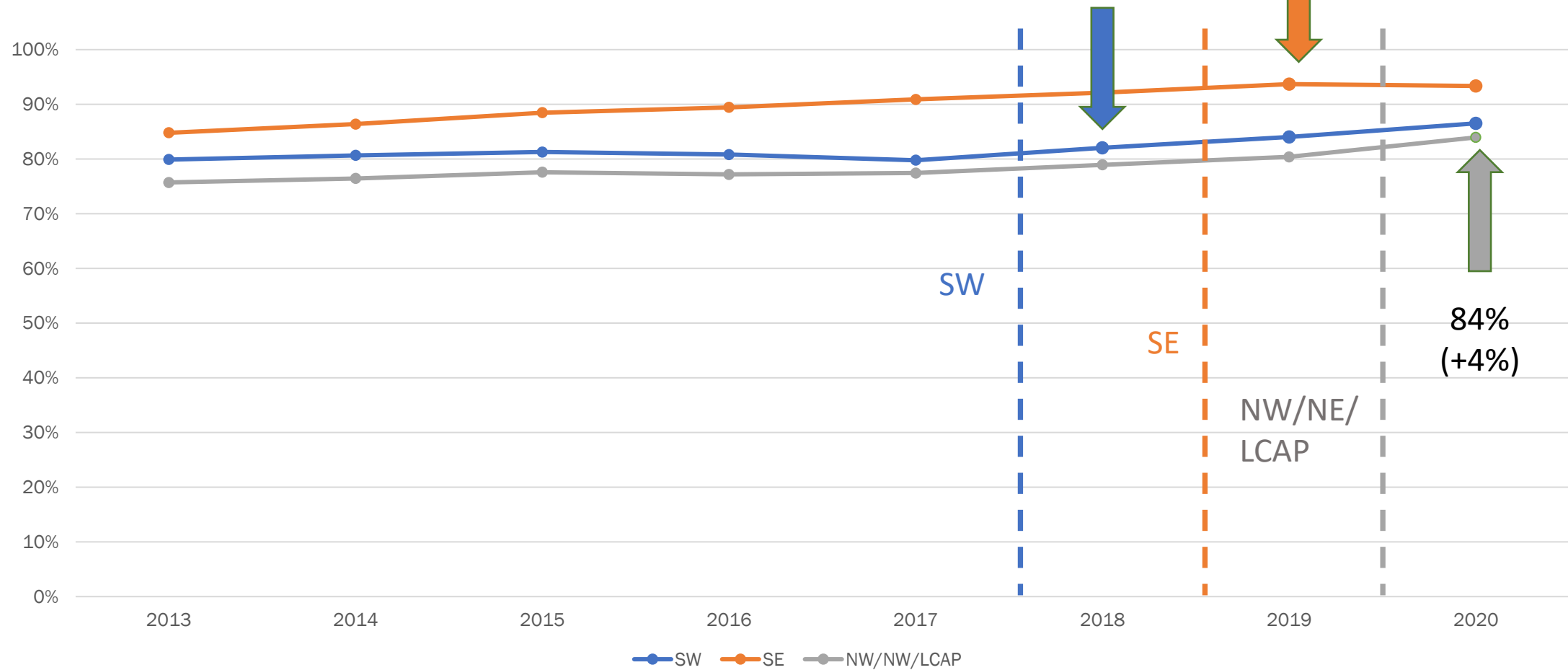
Participants 55 and older who are nursing facility clinically eligible may choose to enroll or remain in a LIFE program instead of CHC.

1 Participants will receive behavioral health services through the Behavioral Health Managed Care Organizations.
2 Participants will receive an updated clinical eligibility determination.



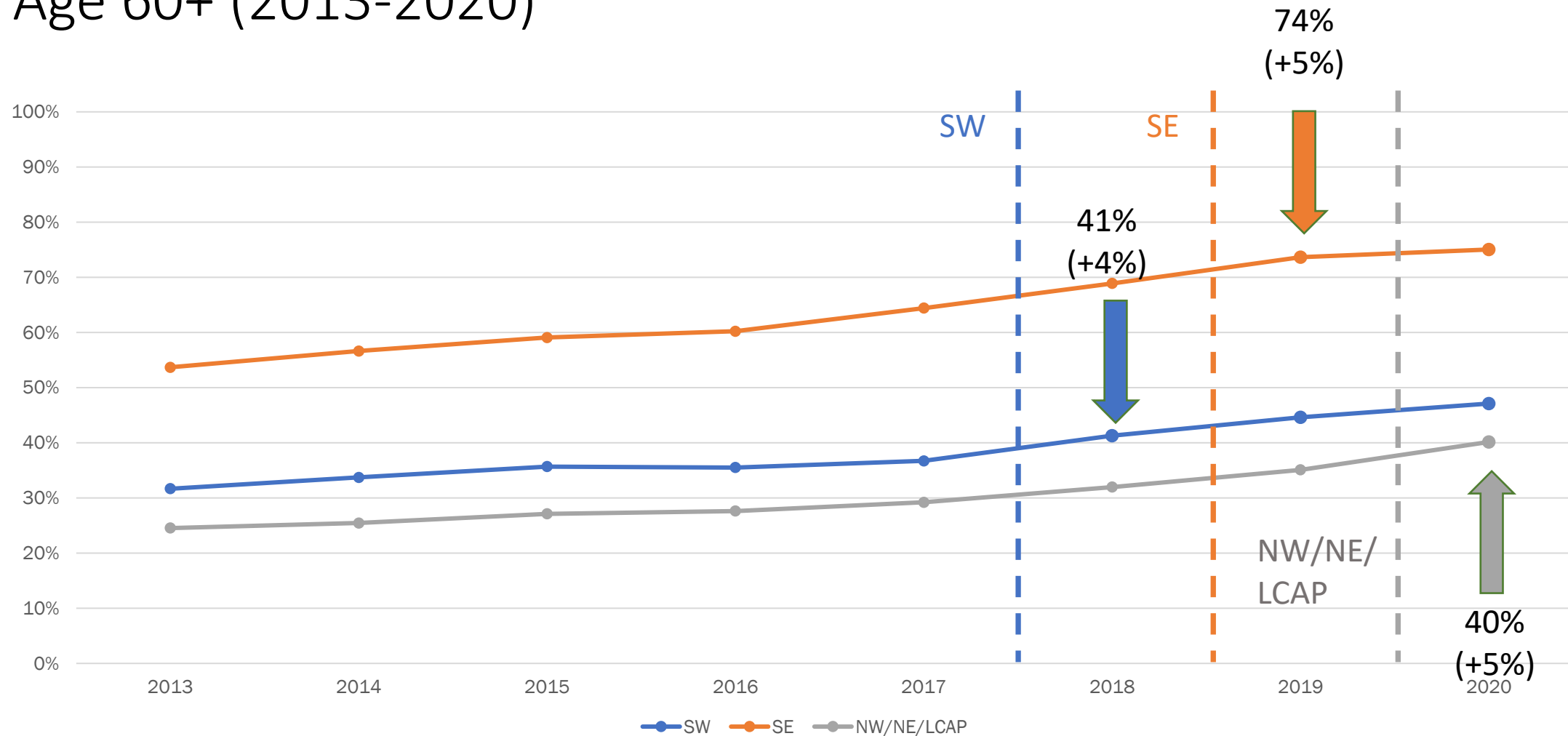
- PHASE 1
- PHASE 2
- PHASE 3

Percent of LTSS Participants in HCBS, Age 21-59 (2013-2020)



Note: Estimates based on December of each year.
Source: Medicaid enrollment data 2013 to 2020.

Percent of LTSS Participants in HCBS, Age 60+ (2013-2020)



Note: Estimates based on December of each year.
Source: Medicaid enrollment data 2013 to 2020.

Causal Estimates of MLTSS on Rebalancing

- Difference-in-Difference models
 - Change in ‘treatment’ compared to change in ‘comparison’ group
 - Multiple comparisons available
 - Relies on assumption that trend in comparison group is suitable counter-factual
- Linear probability model
 - Unadjusted model uses all Medicaid
 - Adjusted model uses only FFS Dual Eligible
 - Controls for chronic conditions
- No strong pattern for age 21-59
- Consistent finding of an increase of 3 percentage points among people age 60+

Age 21-59 – Average Effect .006/ns

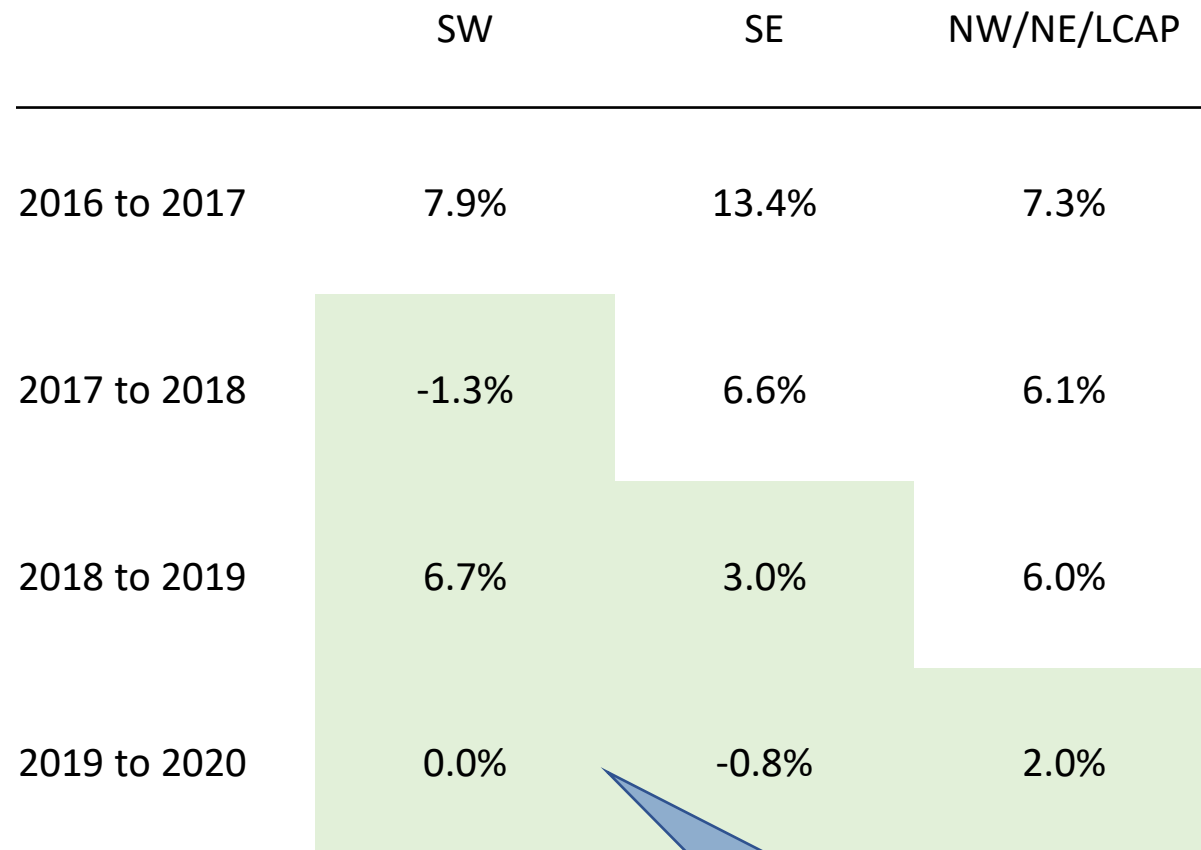
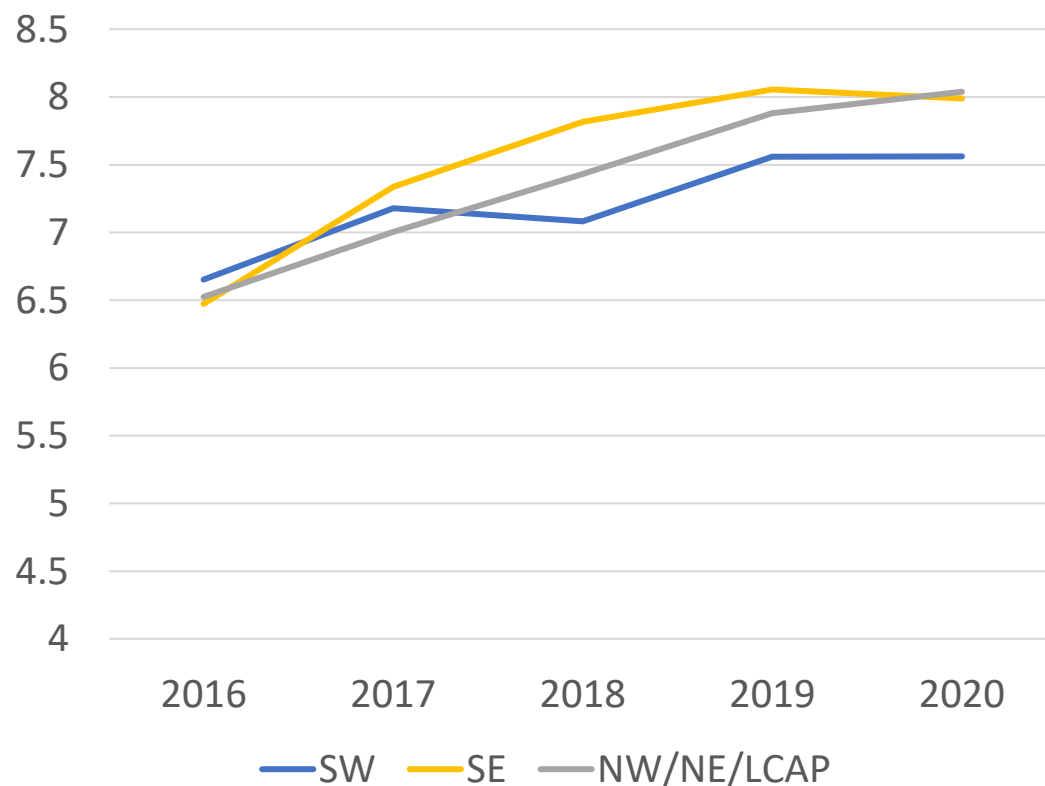
Comparison	Year	Medicaid Unadjusted	Duals Only Adjusted
SW vs. NW/NE/LCAP	Pooled	.010	ns
	2018	.011	ns
	2019	.008	ns
SW vs. SE	2018	.006	ns
SE vs. NW/NE/LCAP	2019	ns	.004

Age 60+ – Average Effect .03

Comparison	Year	Medicaid Unadjusted	Duals Only Adjusted
SW vs. NW/NE/LCAP	Pooled	.027	.022
	2018	.028	.018
	2019	.025	.026
SW vs. SE	2018	ns	.008
SE vs. NW/NE/LCAP	2019	.030	.035

Average Personal Assistive Service Hours Per Person Per Day (2016 to 2020)

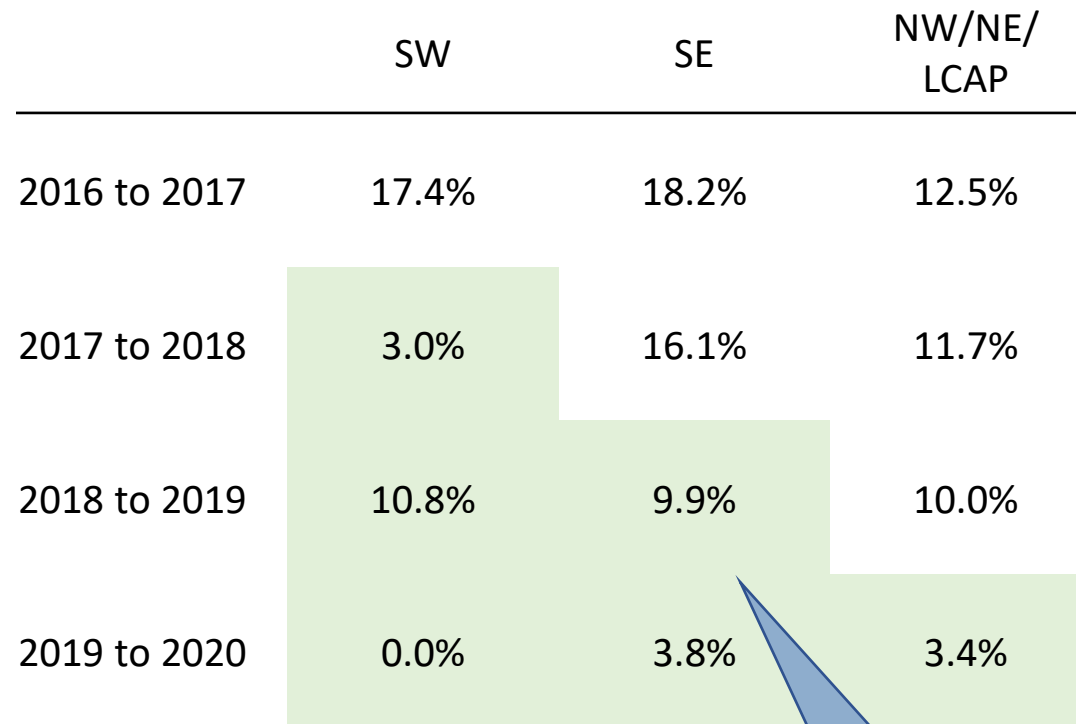
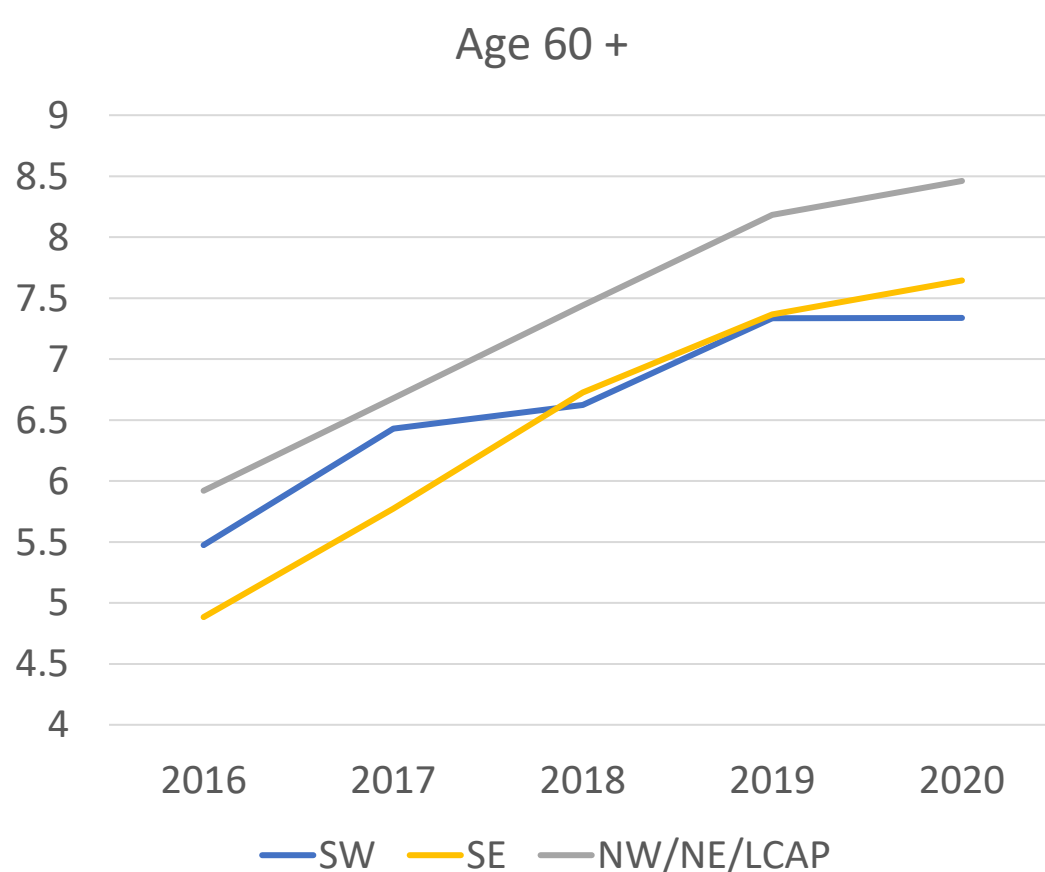
Age 21-59



Post-CHC increases are smaller than prior to CHC.

Source: Medicaid enrollment and claims data 2016 to 2020.

Average Personal Assistive Service Hours Per Person Per Day (2016 to 2020)



Note: Pre-CHC Changes re shaded in blue. Post-CHC changes are shaded in green.

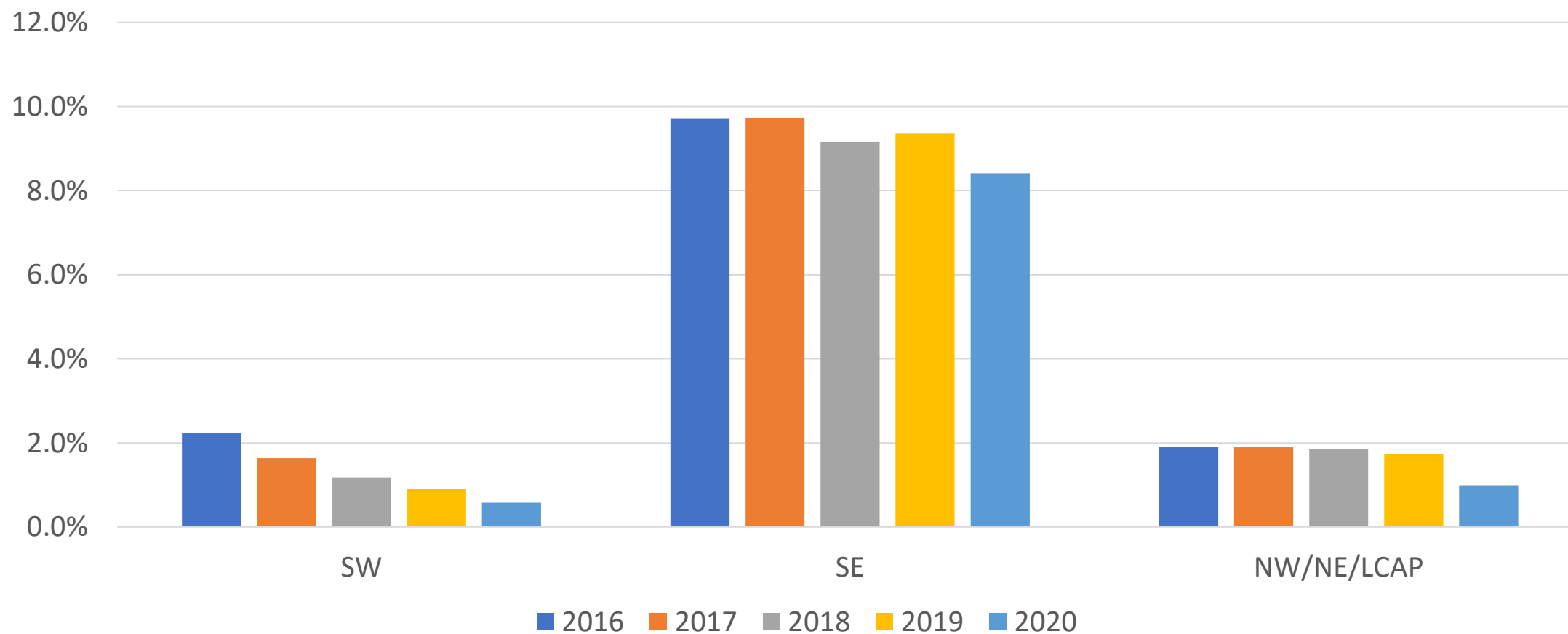
Post-CHC increases are smaller than prior to CHC.

Source: Medicaid enrollment and claims data 2016 to 2020.

Summary of Changes in Hours of PAS

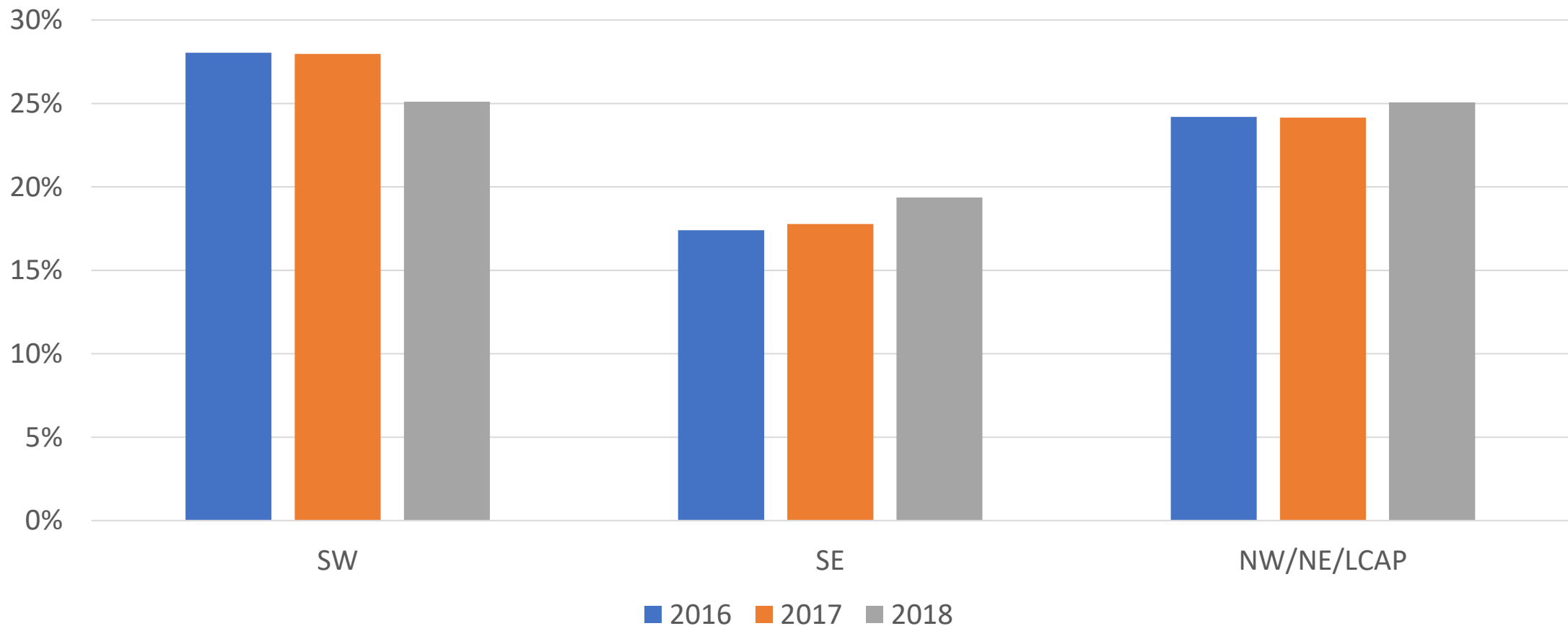
- The average hours per person day increased at double digit rates prior to CHC in both age groups
 - Age 21-59 increased on average of 7.9% per year prior to CHC
 - Age 60+ increased on average of 14.3% per year prior to CHC
- Implementation of CHC was associated with slowing of the rate of growth in all three phases and in both age groups
 - Age 21-59 increased an average of 1.6% per year post CHC
 - Age 60+ increased an average of 5.2% per year post CHC

Adult Daily Living Among HCBS Users Age 60+ (2016 to 2020)



Note: Any Adult Day Care Use per Person per Month
Source: Medicaid enrollment and claims data.

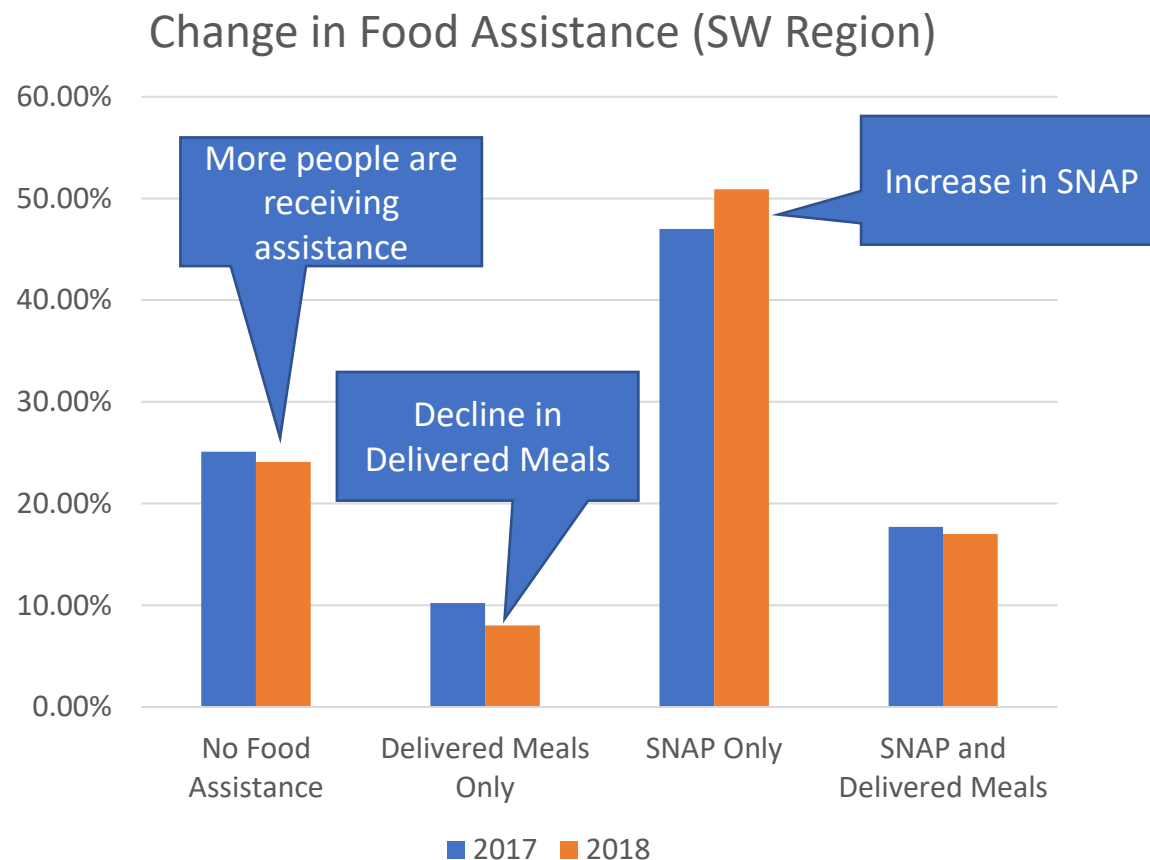
Quantitative Findings: HCBS Use Home Delivered Meal Use Among HCBS Users Age 60+ (2016 to 2018)



Note: Any Meal Use per Person per Month
Source: Medicaid enrollment and claims data.

Overall Food Assistance Increased in SW Region (2017-2018)

- Supplementary Nutritional Assistance Program (SNAP) data merged with Medicaid enrollment and claims
- Cross-tabulated receipt of any SNAP in each year with receipt of any delivered meals
- Limited to Age 60+ HCBS Participants
- Different patterns by Phase:
 - Phase II: SNAP is basically unchanged
 - Phase III: SNAP increases smaller than in Phase I



Conclusion

- MLTSS led to an increase in community-based LTSS
 - Consistent evidence among people age 60 and older
 - Potential ceiling effect among age 21-59 group
- The trend towards increasing hours of PAS per person has flattened out
 - Annual growth rate in hours is lower
- Use of Adult Daily Living has declined, but difficult to attribute to MLTSS
- Limitations
 - Adjustment to chronic condition only
 - Future research will adjust for physical and cognitive function

Extra Slides

Cross-Sectional Analysis of Change in PAS Hours Per Person per Day: Age 21-59

	SW	SE	NW/NE/LCAP
2016 to 2017	7.9%	13.4%	7.3%
2017 to 2018	-1.3%	6.6%	6.1%
2018 to 2019	6.7%	3.0%	6.0%
2019 to 2020	0.0%	-0.8%	2.0%

Post-CHC increases are smaller than prior to CHC.



Cross-Sectional Analysis of Change in PAS Hours Per Person per Day: Age 60+

	SW	SE	NW/NE/LCAP
2016 to 2017	17.4%	18.2%	12.5%
2017 to 2018	3.0%	16.1%	11.7%
2018 to 2019	10.8%	9.9%	10.0%
2019 to 2020	0.0%	3.8%	3.4%

Post-CHC increases are smaller than prior to CHC.

Percent of Participants Experiencing a Decrease of at Least One Billed Hour Per Day Compared to Prior Year

Slightly more decreases under CHC than in FFS

	2018	2019	2020*
SW	10.38%	6.4%	11.41%
SE	4.28%	6.76%	10.9%
NW/NE/LCAP	6.10%	6.82%	10.69%

Note: Shaded cells represent CHC Active Regions. * 2020 represents data through 6/30/2020.

Percent of Person-Months with An Average of > 23 Hours of Care Per Day

	2018	2019	2020*
SW	1.31%	2.25%	2.14%
SE	.91%	1.40%	1.65%
NW/NE/LCAP	1.58%	2.18%	2.40%

Slightly more people with heavy service plans under CHC than in FFS

Note: Shaded cells represent CHC Active Regions. * 2020 represents data through 6/30/2020.

Analysis of Individual Change

- Examined difference in billed hours for “current year” compared to previous year.
 - What percent of people had a decline of at least one hour per day?
 - Comparisons:
 - 2020 compared to 2019
 - 2019 compared to 2018
 - 2018 compared to 2017
 - Person had to be in both years to be included in the analysis
 - Analysis conducted separately for each region
- Examined the percent of people with ‘heavy’ service use of at least 23 hours per day
 - What percent of people fall into this category?
 - Does this sub-group experience large changes (decreases) in billed hours?

Summary of Individual Change Analysis (2017 to 2020)

- In years prior to CHC, around 4%-7% of participants might experience a decline in billed PAS hours.
- In years of Active CHC implementation, from 6% to 11% might experience a decline in billed PAS hours.
- The percentage of participants with > 23 hours per day does not appear to change with the implementation of CHC.
- Caveat: analysis is not adjusted for functional status