

Washington's Medicaid Long Term Services and Supports Progress in Context

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For the Long Term Care and Chronic Care
Management Task Force

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Overview

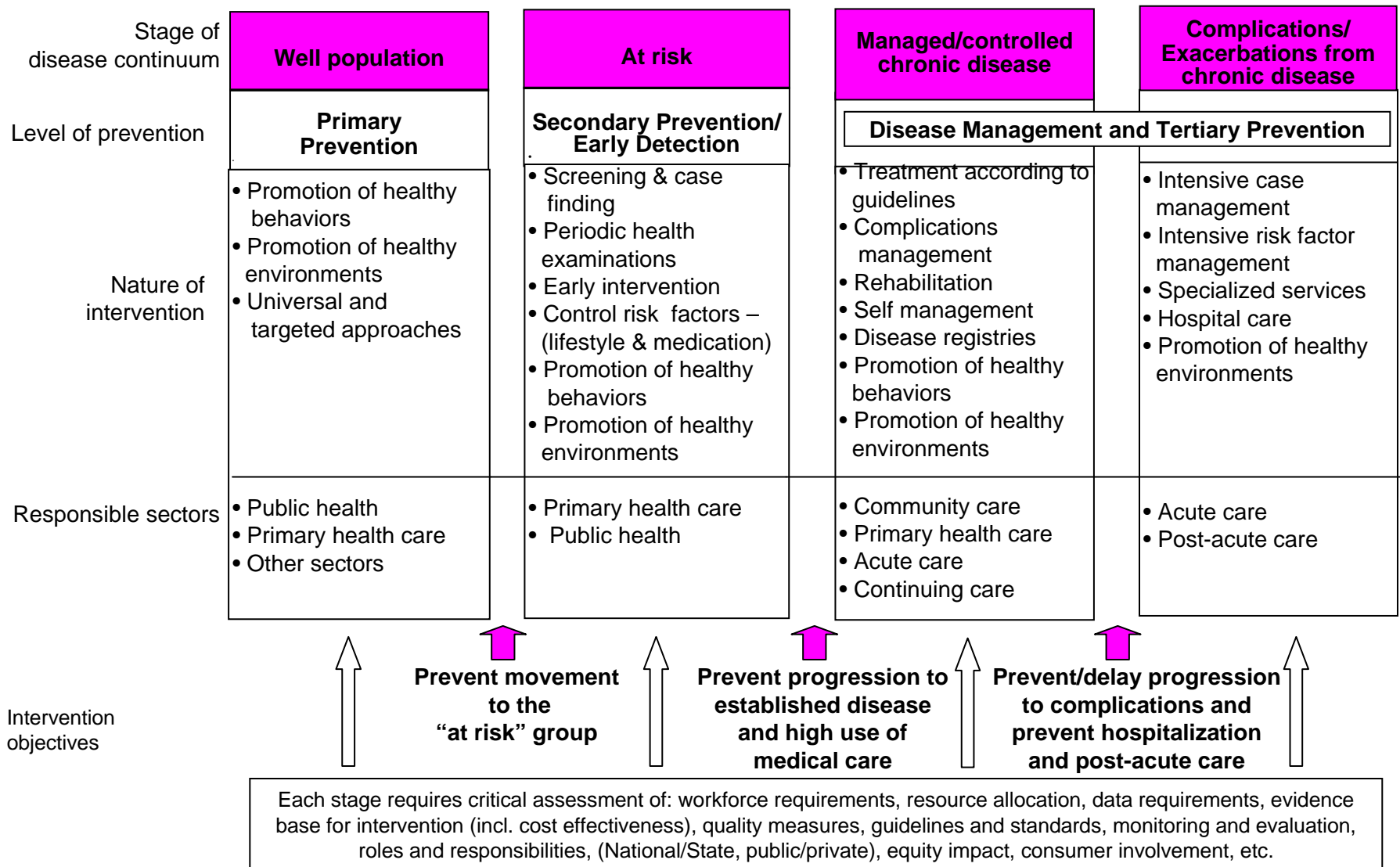
- ◆ Review of Interim Report Findings
- ◆ Comparison of Washington to the Rest of the Country
- ◆ Integrating Financing of Dual Eligibles Through Medicare Special Needs Plans

Key Findings from the Interim Report

Current System Evaluation

- ◆ Indicator of Potential Need
 - Population over age 85 = 1.4% of population
 - Nationally 1.5% age 85+
 - Varies by county - 0.9% in Benton to 3.5% in Garfield
 - % age 5+ with a disability = 16.6% (U.S. 15.9%)
- ◆ Ethnically diverse, range of incomes, mix of urban and rural and differing long term care needs
- ◆ Rural areas lack availability of some services – e.g., alternative residential and adult day services
- ◆ Highlights need for a combination of strategies and sufficient flexibility to respond to individuals needs and circumstances

Health Promotion and Chronic Care Management Across the Life Course



Chronic Care Management and Disease Prevention

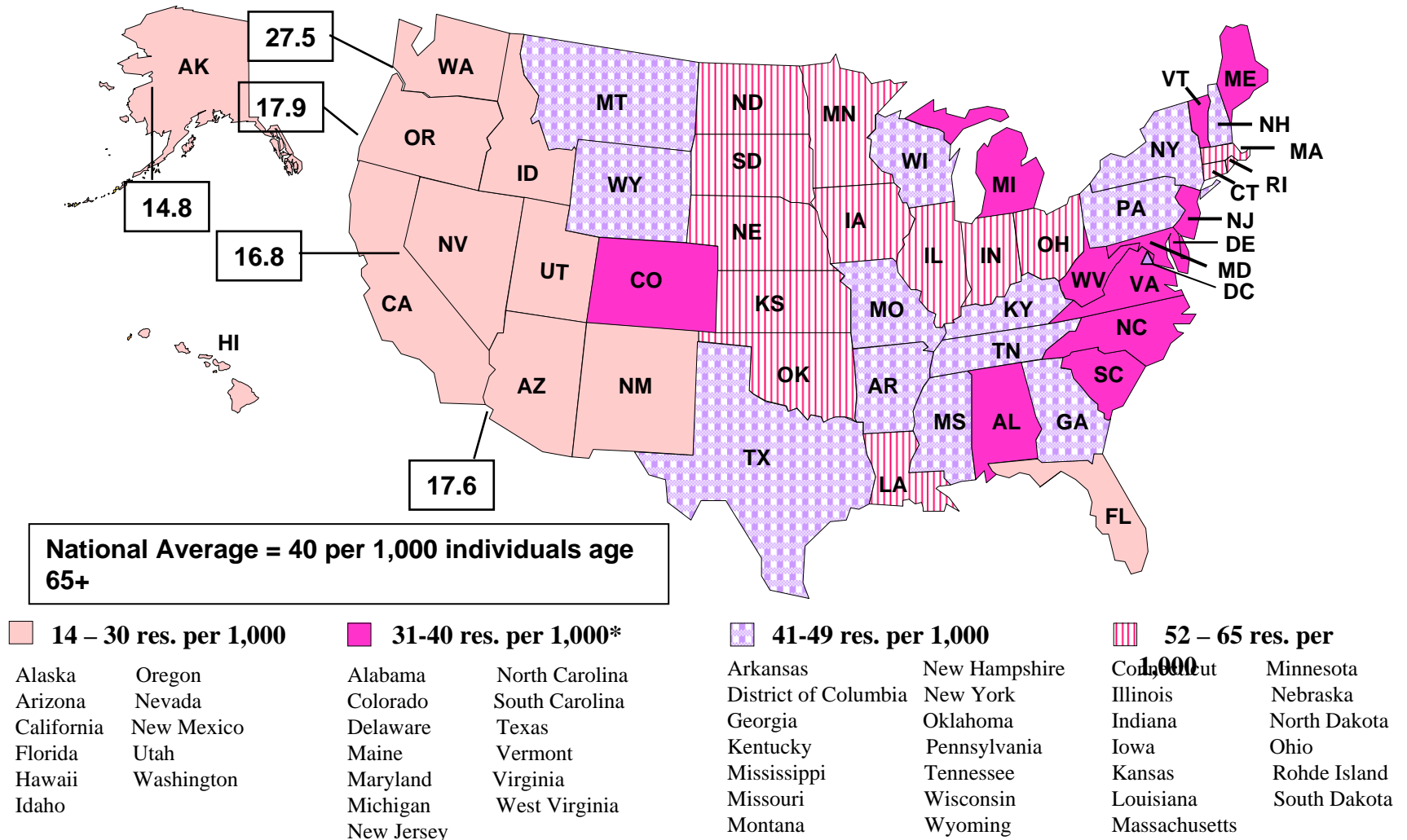
- ◆ Grounded in a Model of Health Promotion and Chronic Care Management Across the Life Course
- ◆ Investigated four models tested in Washington:
 - Area Agencies on Aging care management focused primarily on long term care
 - Intensive Chronic Case Management (ICCM) for both acute and LTC piloted by AAAs and targeted to high cost Medicaid enrollees; outcomes being investigated
 - Medicare/Medicaid Integration Project (MMIP) –Evercare operated in King and Pierce Co.; less than 100 enrolled as of the start of the year
 - Pursuing Perfection in Chronic and Complex Conditions – PeaceHealth operated in Whatcom Co.; participatory approach with use of electronic health records

New Funding

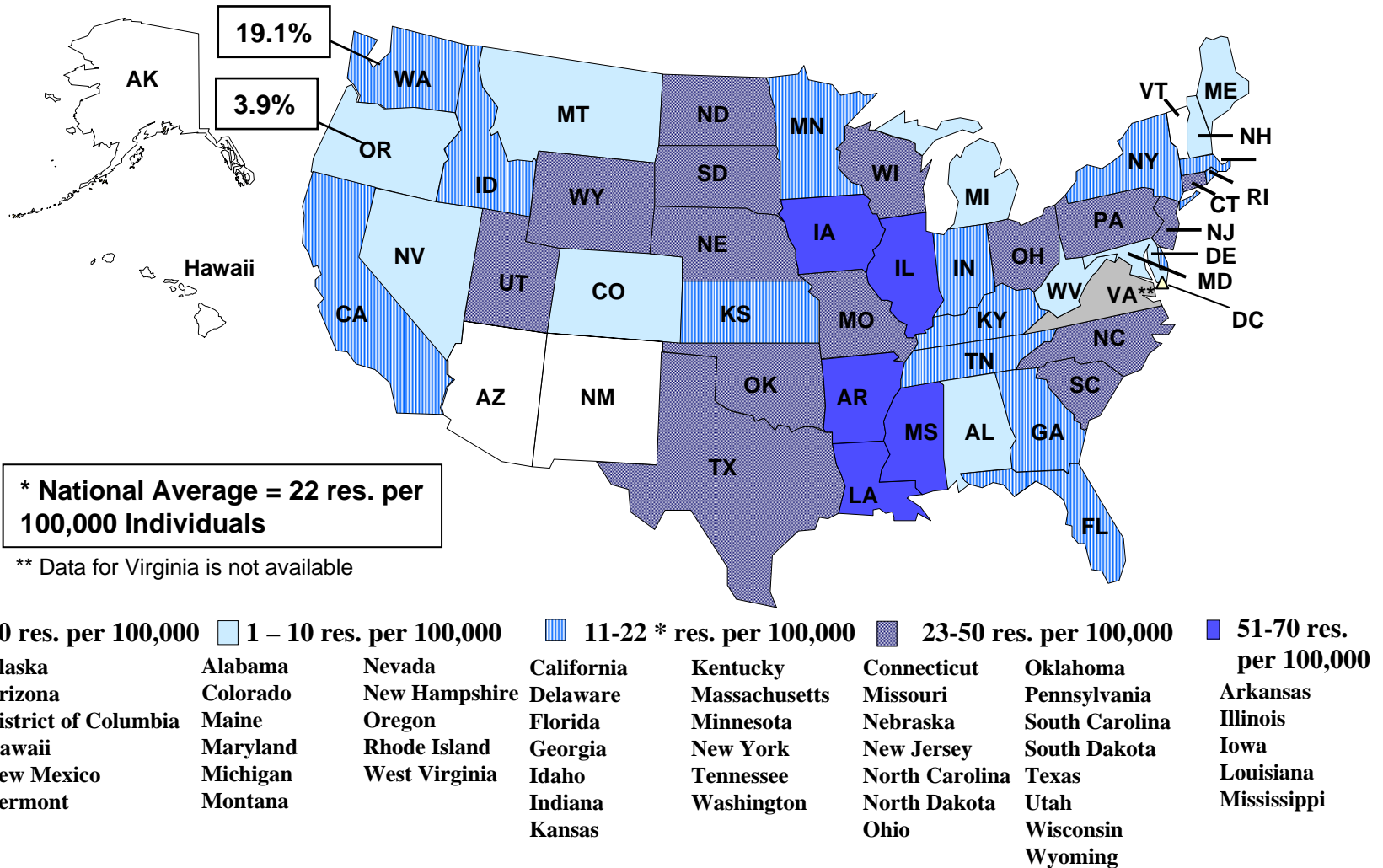
- ◆ Adequacy of personal savings and pensions
- ◆ Availability of family care and financial support
- ◆ Creative community-based strategies or partnerships
- ◆ Enhanced health insurance options
- ◆ Long term care insurance options
- ◆ Life insurance annuities
- ◆ Reverse mortgage and other home equity products
- ◆ Social insurance

Washington's Progress in Context

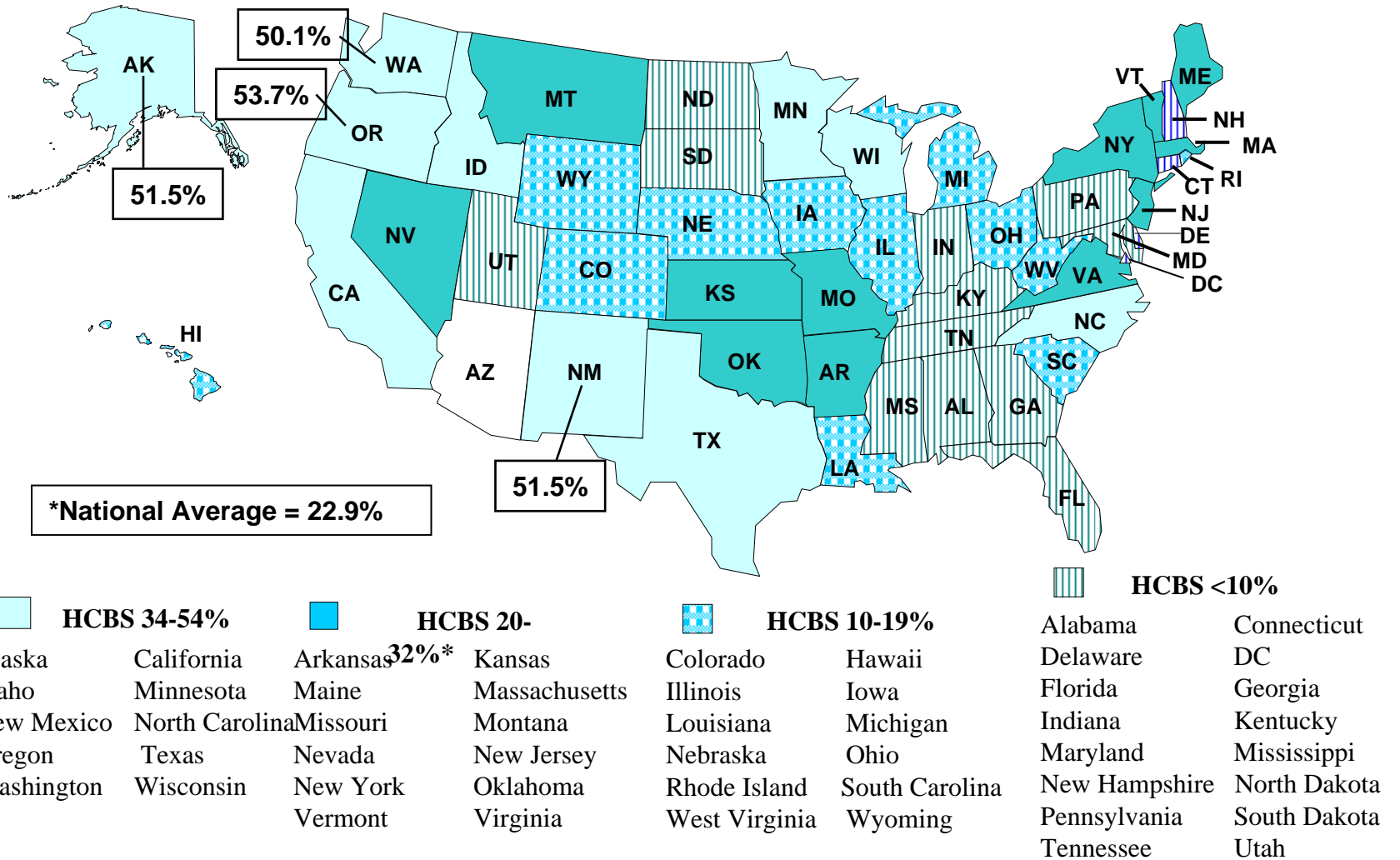
Nursing Facility Residents per 1,000 Individuals Age 65+, 2005



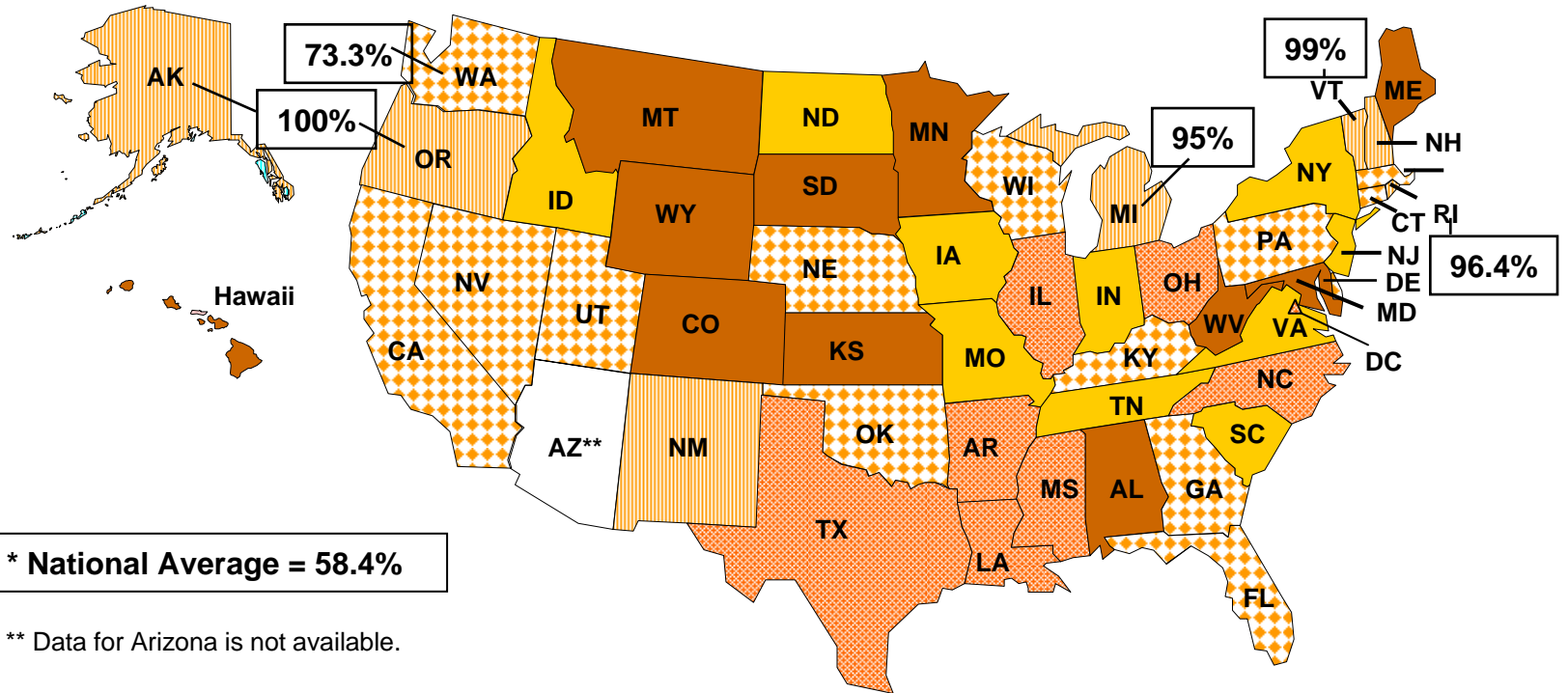
Intellectual Disabilities/Developmental Disabilities per 100,000 Individuals in 16+ Resident Settings, 2005



Percent HCBS Spending of Medicaid LTC Among Aged/Disabled, 2005



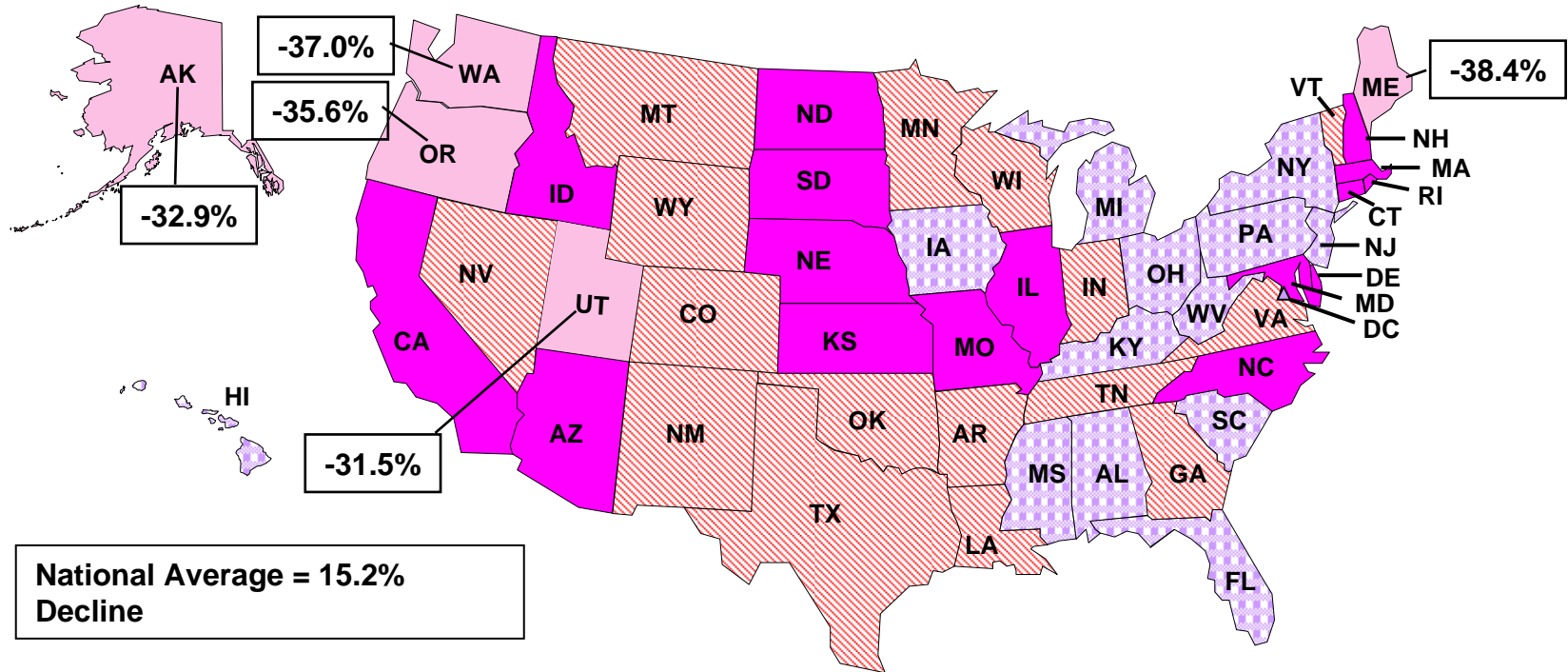
Percent HCBS Waiver Spending of Medicaid LTC Among Intellectual/Developmental Disabilities (Intellectual Disabilities/Developmental Disabilities), 2005



HCBS 0%-40%
 HCBS 41% - 58%*
 HCBS 59% - 75%
 HCBS 76% - 90%
 HCBS 91%-100%

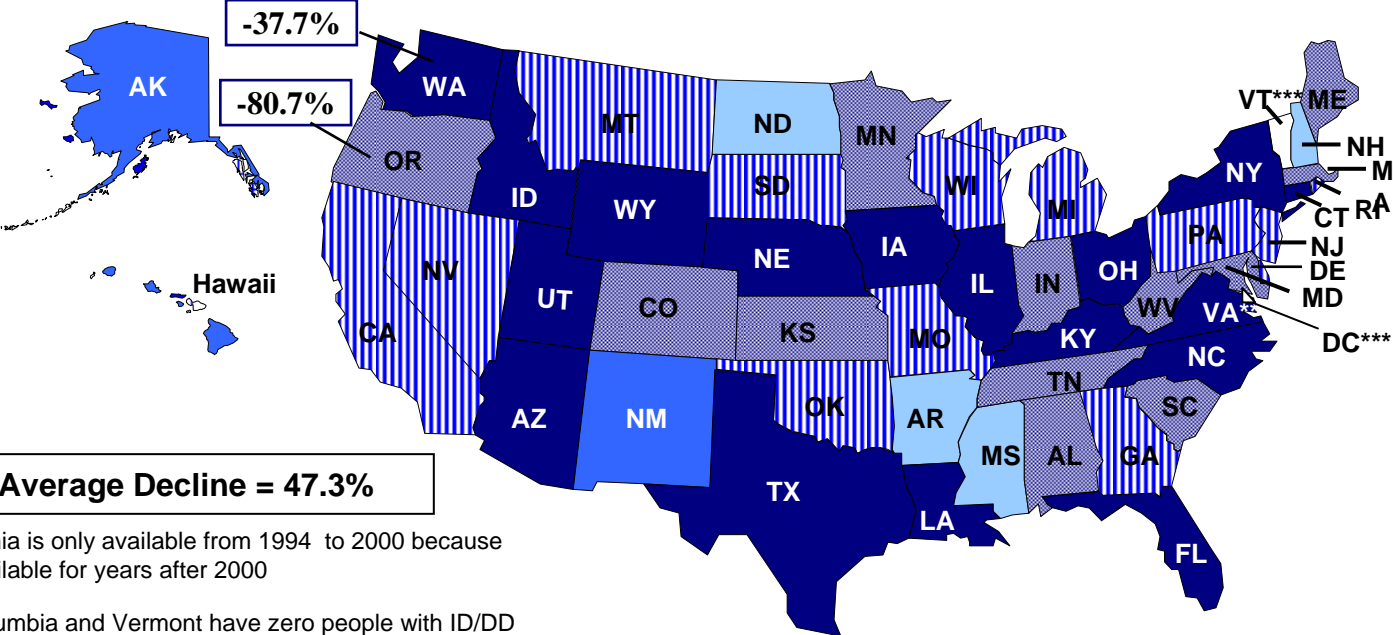
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|----------------------|----------------|----------------|-------------|---------------|-----------|---------------|---------------|
| Arkansas | Idaho | South Carolina | California | Nevada | Alabama | Montana | Alaska |
| District of Columbia | Indiana | Tennessee | Connecticut | Massachusetts | Colorado | South Dakota | Michigan |
| Illinois | North Carolina | Iowa | Delaware | Oklahoma | Hawaii | West Virginia | New Mexico |
| Louisiana | Texas | Missouri | Florida | Pennsylvania | Kansas | Wyoming | New Hampshire |
| Ohio | | New Jersey | Georgia | Washington | Maine | | Oregon |
| Mississippi | | New York | Kentucky | Wisconsin | Maryland | | Rhode Island |
| | | North Dakota | Nebraska | Utah | Minnesota | | Vermont |

Change in Per Capita Medicaid Nursing Facility Residents, 1995-2005



30% or More Decline	20% to 30% Decline	10% to 20% Decline	Less than 10% Decline
Alaska	Arkansas	Arizona	Alabama
Maine	Colorado	California	District of Columbia
Oregon	Georgia	Connecticut	Florida
	Indiana	Delaware	Hawaii
	Louisiana	Idaho	Iowa
	Minnesota	Illinois	Kentucky
	Montana	Kansas	Michigan
	Nevada	Maryland	Mississippi
	New Mexico	Massachusetts	New Jersey
	Oklahoma	Missouri	New York
	Tennessee	Nebraska	Ohio
	Texas	New Hampshire	Pennsylvania
	Vermont	North Carolina	South Carolina
	Virginia	North Dakota	West Virginia
	Wisconsin	Rhode Island	
	Wyoming	South Dakota	

Change in ID/DD per 100,000 in 16+ Resident Settings, 1994-2005

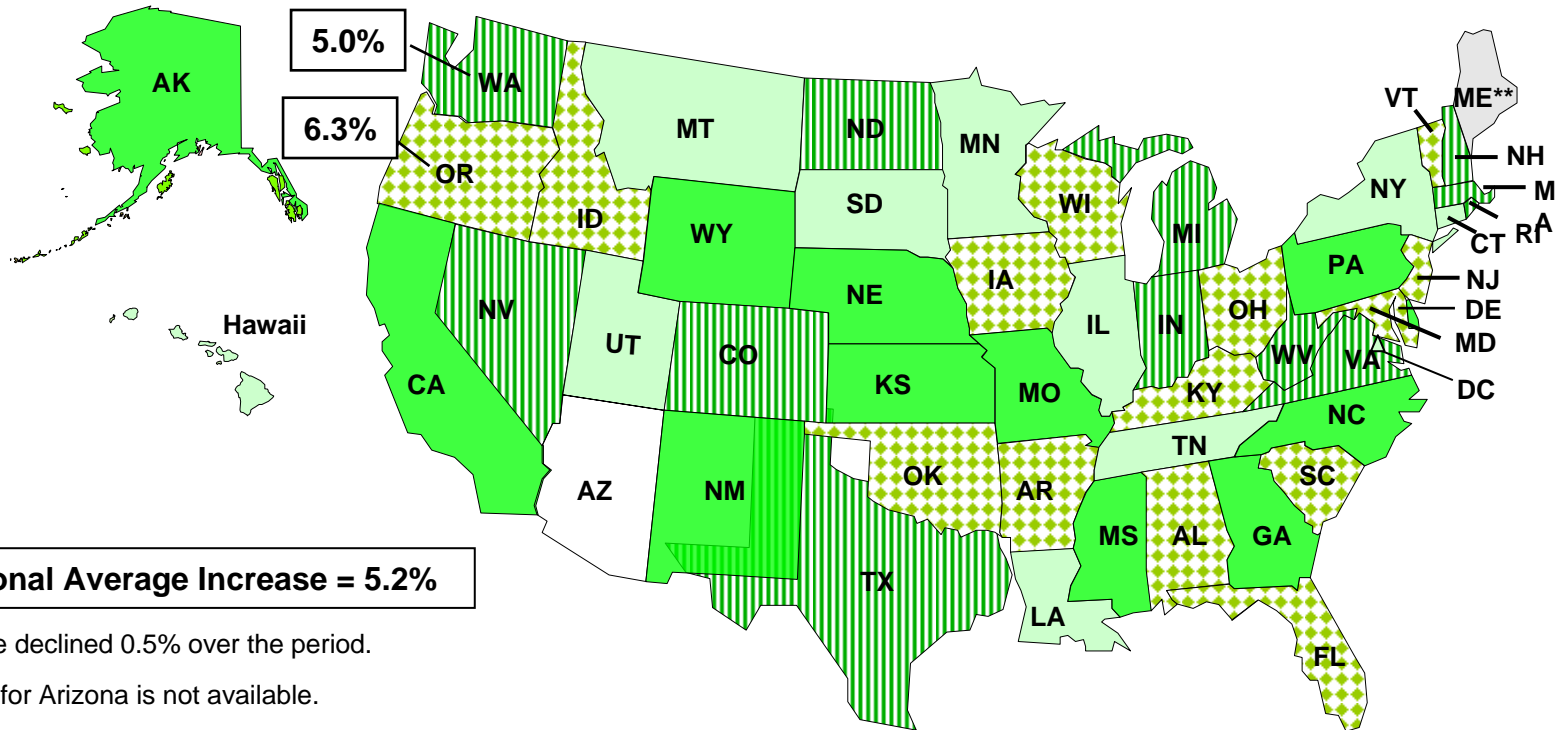


** Data for Virginia is only available from 1994 to 2000 because no data is available for years after 2000

*** District of Columbia and Vermont have zero people with ID/DD living in 16+ ICF-MR from 1994-2005

100% Decline	83% – 60% Decline	59% - 46%* Decline	45%-15% Decline	14%-3% Decline
Alaska	Alabama	Minnesota	Arizona	New York
Hawaii	Colorado	Oregon	Connecticut	North Carolina
New Mexico	Indiana	South Carolina	Florida	Ohio
	Kansas	Tennessee	Idaho	Texas
	Maine	Wisconsin	Illinois	Utah
	Maryland	West Virginia	Iowa	Virginia
		Michigan	Kentucky	Washington
		Missouri	Nebraska	Wyoming
		Dakota		

Average Annual Change in Per Capita Total Medicaid LTC Spending for Aged/Disabled, 1994-2005



* National Average Increase = 5.2%

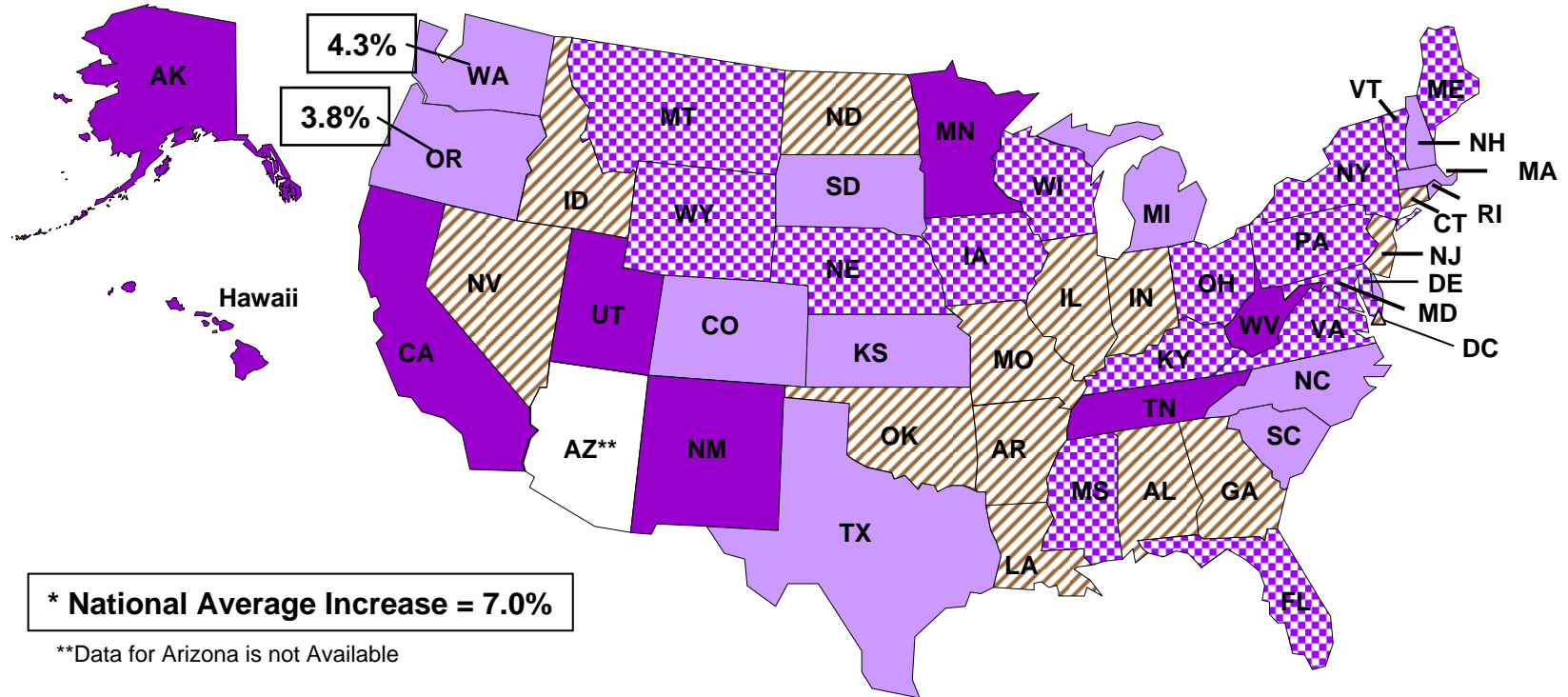
**Maine declined 0.5% over the period.

*** Data for Arizona is not available.

0% - 3.9% Increase
 4.0% - 5.2%* Increase
 5.3%-6.9% Increase
 7.0%-10.5% Increase

- | | | | | | | | |
|----------------------|--------------|---------------|---------------|----------|----------------|-------------|----------------|
| Connecticut | Montana | Colorado | Rhode Island | Alabama | Maryland | Alaska | New Mexico |
| District of Columbia | New York | Indiana | Texas | Arizona | Ohio | California | North Carolina |
| Hawaii | South Dakota | Massachusetts | Virginia | Arkansas | Oklahoma | Delaware | Pennsylvania |
| Illinois | Tennessee | Michigan | Washington | Florida | Oregon | Georgia | |
| Louisiana | Utah | New Hampshire | West Virginia | Idaho | New Jersey | Kansas | |
| Minnesota | | Nevada | | Iowa | South Carolina | Mississippi | |
| | | North Dakota | | Kentucky | Vermont | Missouri | |
| | | | | | Wisconsin | Nebraska | |

Average Annual Change in Per Capita Total Medicaid LTC Spending for ID/DD for 1994-2005



2.2% - 5.0% Increase
 5.1% - 7.0%* Increase
 7.1%-10.0% Increase
 10.1%-20.0% Increase

Colorado
 Delaware
 Kansas
 Massachusetts
 Michigan
 New Hampshire
 North Carolina
 Oregon
 Rhode Island
 South Carolina
 South Dakota
 Texas
 Washington

Alabama
 Arkansas
 Connecticut
 District of Columbia
 Georgia
 Idaho
 Indiana
 Illinois
 Louisiana
 Missouri
 New Jersey
 Nevada
 North Dakota
 Oklahoma

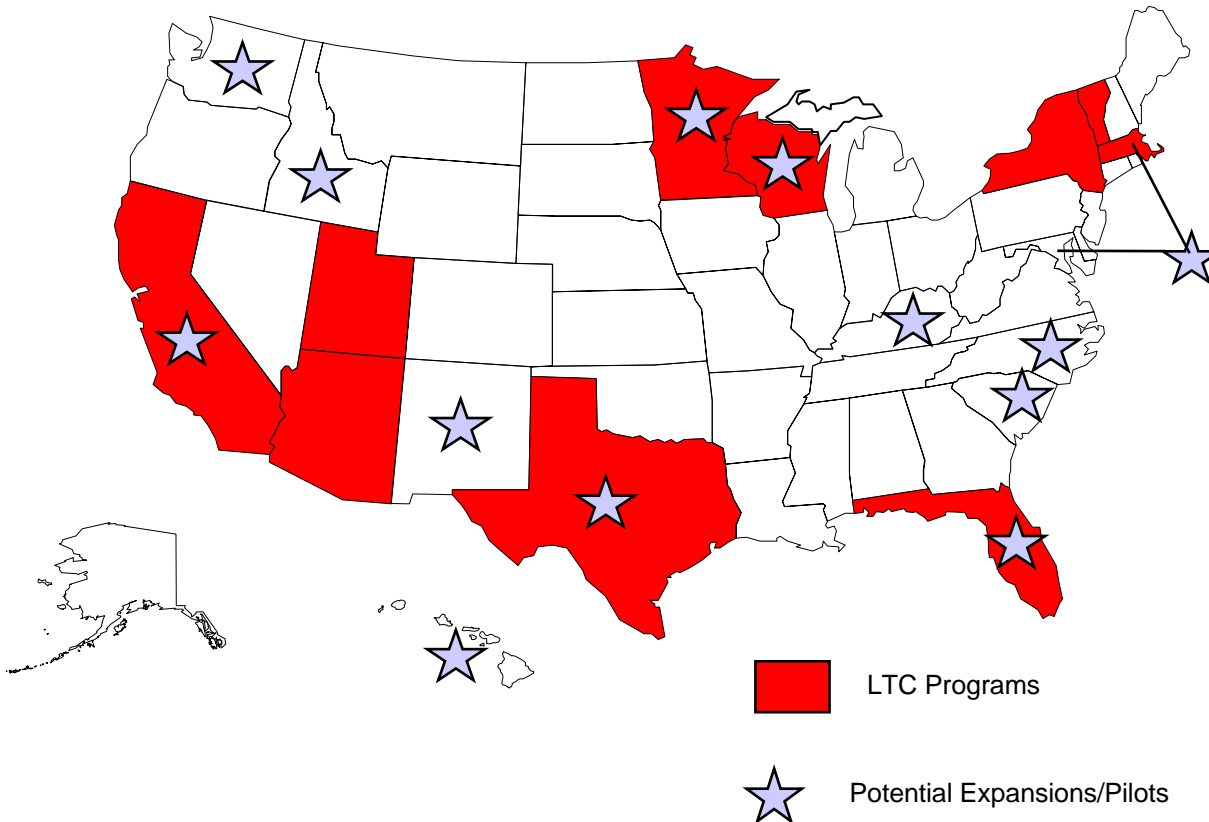
Florida
 Iowa
 Kentucky
 Maine
 Maryland
 Mississippi
 Montana
 Nebraska
 New York
 Ohio
 Pennsylvania
 Vermont
 Virginia
 Wisconsin
 Wyoming

Alaska
 California
 Hawaii
 Minnesota
 New Mexico
 Tennessee
 Utah
 West Virginia

Integrating of Financing Dual Eligibles Through Medicare Special Needs Plans

Many States Looking to Managed Long Term Care to Rebalance Medicaid

A few well established programs and numerous start-ups.



Active & Pending Programs

Top Managed Care Programs:

Arizona – 42,125 lives (8/2006)*
Includes DD
Minnesota – 21,000 lives (1/2006)*
New York – 16,224 lives (8/2006)
Florida – 13,600 lives (8/2006)
Wisconsin – 12,545 lives (8/2006)

Remaining Programs:

Vermont – 4,090 (12/2006)*
Massachusetts – 3,700 lives (2/2006)
Texas – 3,300 lives (4/2006)
California -- *unknown*

*Entire State

New Programs:

Kentucky	Hawaii
Idaho	Maryland
New Mexico	North Carolina
South Carolina	Washington

Integrating Financing Through Medicare Special Needs Plans

- ◆ Medicare Modernization Act (MMA) of 2003, Section 231 authorized the creation Medicare Special Needs Plans (SNPs) targeted to three groups of Medicare beneficiaries:
 1. those receiving care in institutional settings;
 2. those dually eligible for Medicare and Medicaid; and
 3. those with severe or disabling conditions.
- ◆ Eliminates the need for demonstration to combine Medicare and Medicaid managed care contracting
- ◆ Gave Medicaid plans a one-time opportunity to seek SNP designation and “passively enroll” dually eligible members into their companion Medicare plans as part of the initial Medicare Part D enrollment process
 - Passive enrollment – AZ, MN & TX added 47,000 enrollees

State Efforts to Date

- ◆ Require Medicaid managed care plans to become SNPs
- MA, MN, TX, WI (MD if proceed with Community Choices)
- ◆ Become SNPs or develop formal partnerships with SNPs -- AZ
- ◆ Proactively defining the value-added benefits it will look for on the Medicare side as a condition of awarding a Medicaid contract - NY

Source: Saucier, Paul and Burwell, Brian (2007) *The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care* for the Centers for Medicare and Medicaid Services at <http://www.cms.hhs.gov/PromisingPractices/Downloads/SNPFinalReport.pdf>

Issues State Needs to Consider

- ◆ Lack of a state role in Medicare SNP certification
- ◆ Medicaid marketing controls are more restrictive than Medicare Advantage provisions, possibly putting Medicaid plans at a disadvantage
- ◆ Dually eligible beneficiaries can disenroll from Medicare Advantage products (including SNPs) on a month-to-month basis, whereas Medicare-only beneficiaries may switch plans only during an annual open enrollment or special enrollment period
 - Protects duals who lose Medicaid status, but also encourages churning

Issues State Needs to Consider (cont.)

- ◆ SNPs' ability to vary their benefit packages and cost sharing requirements could potentially result in a lack of uniformity across state integrated products
- ◆ Access to information on Medicare capitation rates to SNPs and Medicare claims not guaranteed
- ◆ States may not benefit from savings as a result of coordination