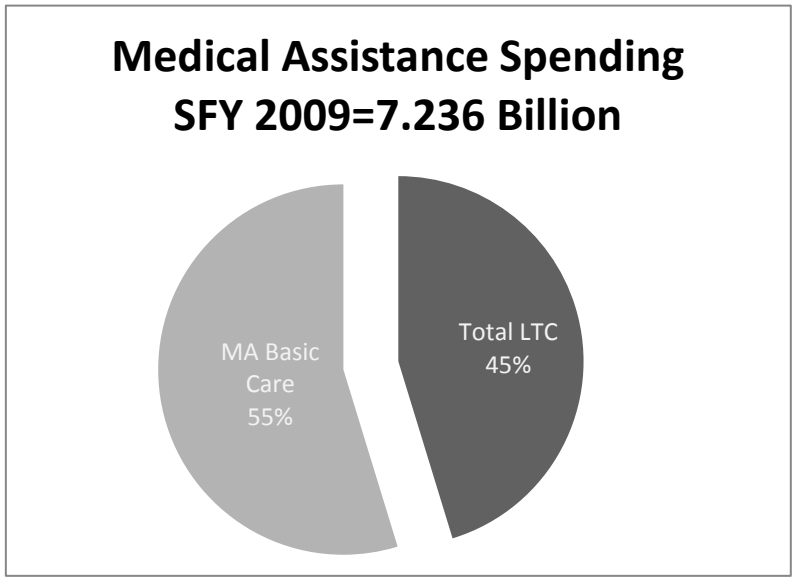
Long Term Care for Elderly and Disabled



45% of Overall Medical Assistance Spending is for Long Term Care (LTC).

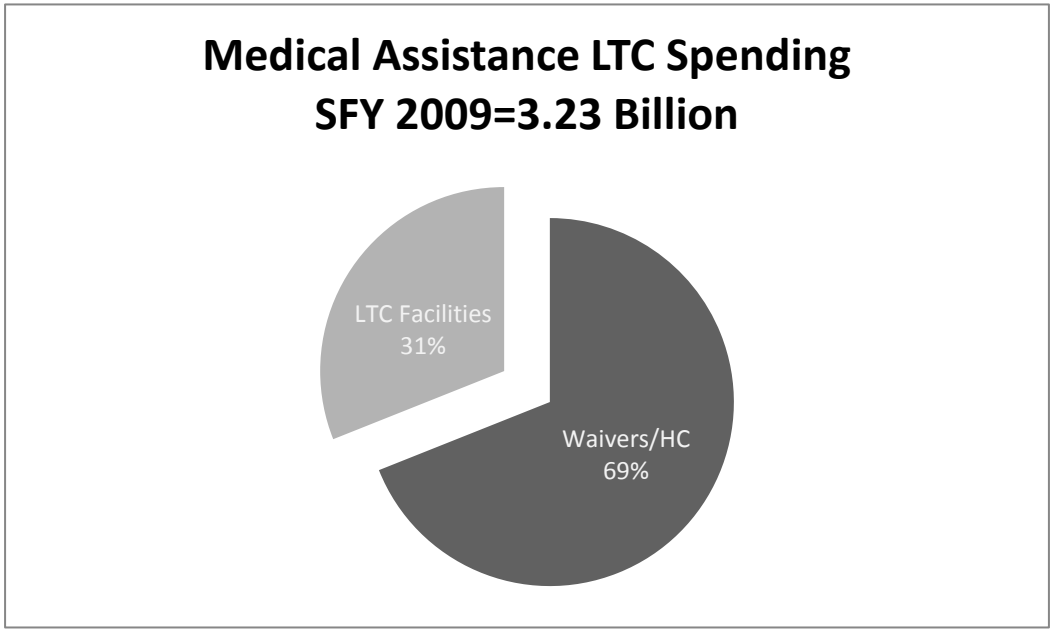
LTC services include LTC facilities and Waivers and Homecare.

MA basic care includes payments to hospitals, physicians, drugs, health plans, etc.

About 69% of long term care funding is spent on waivers and homecare.

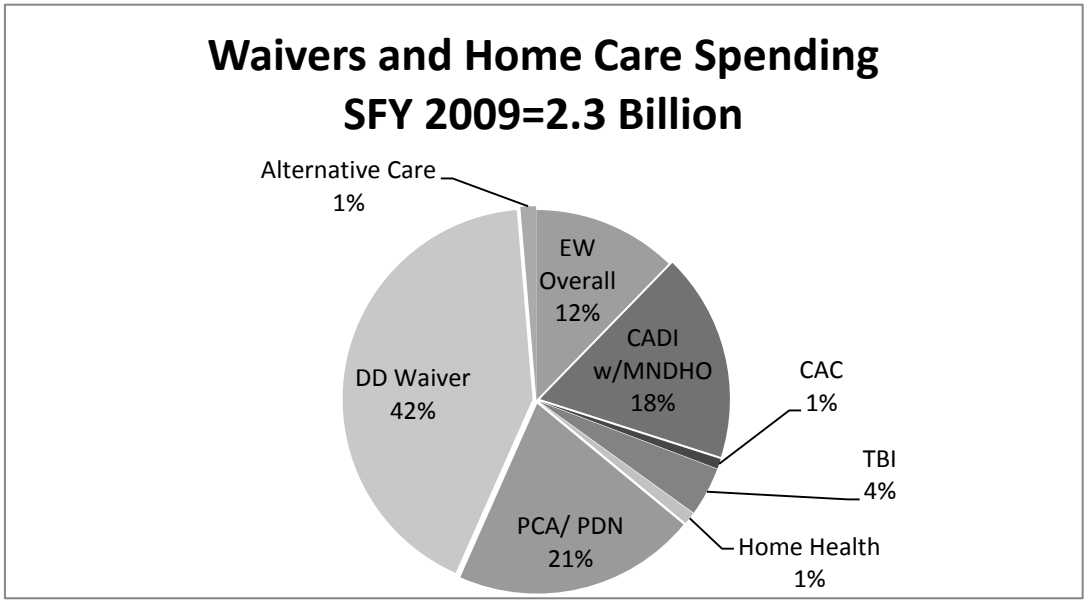
Waivers and home care include programs like the DD waiver, CADI waiver, Elderly Waiver (EW), TBI waiver, CAC waiver, personal care, private duty nursing, and home health services. Waivered services purchased from health plans has been included as a home and community-based service.

LTC Facilities include nursing homes, ICFs/MR, and MA portion of Regional Treatment Centers (RTCs).



Dollars reflect <u>total</u> Medical Assistance spending including federal, state, and county shares.

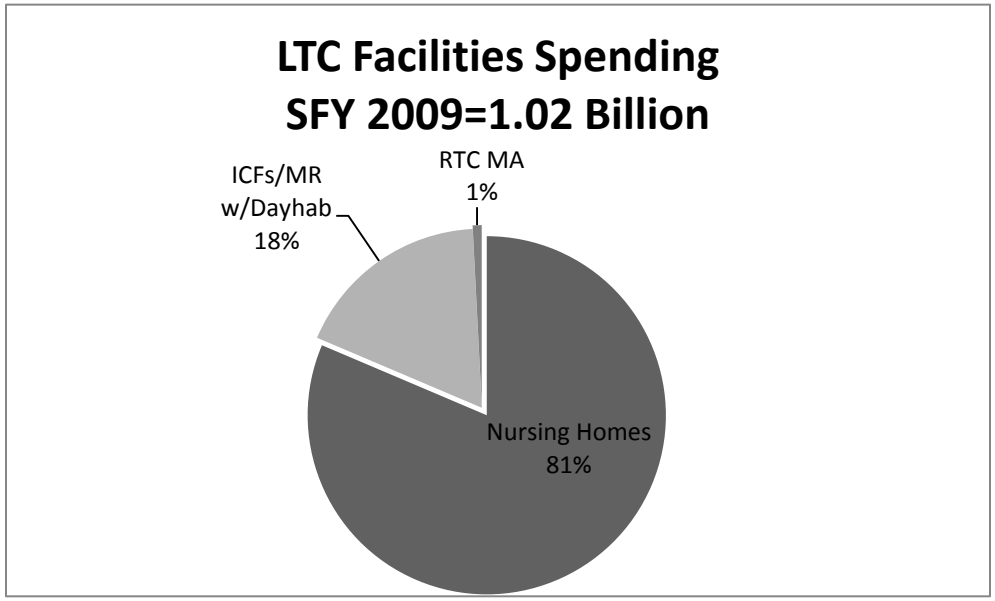
Figures taken from the November 2010 DHS Forecast, assuming the delay in NF LOC implementation



About 85% of waiver and home care funding is spent on services to persons with disabilities.

While Alternative Care is not a Medicaid funded service, this program was included in this chart since it is considered an home and community-based program

State plan home care for elders provided by health plans was not included in this chart.



Over 80% of the LTC facilities funding is spent on nursing homes.

Regional treatment centers claim some of their costs under the MA program for eligible residents particularly for children mental health and TBI programs. Other RTC costs not eligible for MA have not been included in these figures. The day habilitation has been included as part of the ICF/MR cost for those ICF/MR recipients

Dollars reflect <u>total</u> Medical Assistance spending including federal, state, and county shares.

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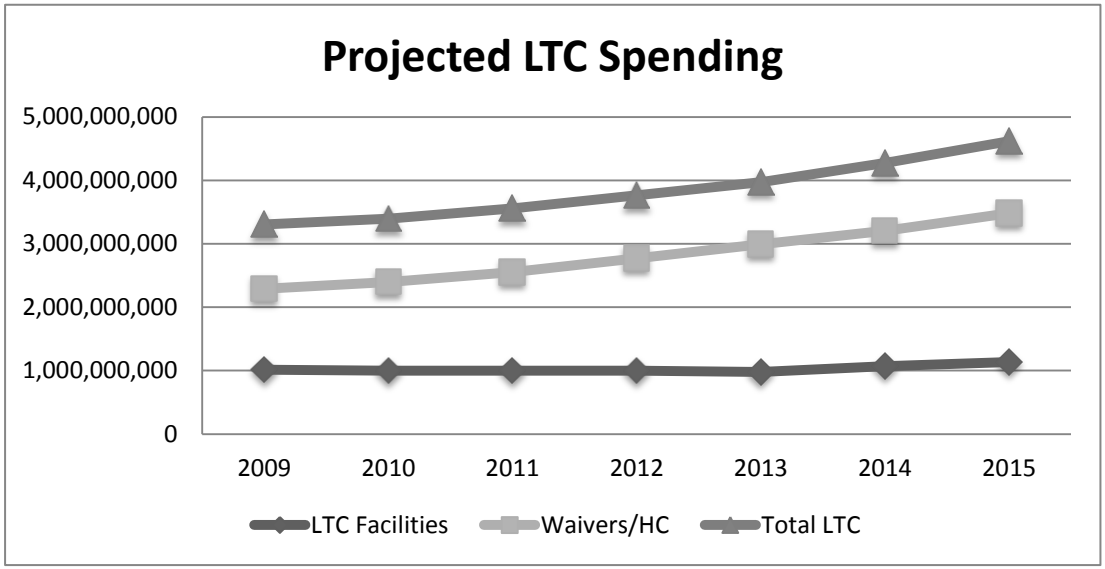


Overall, LTC Spending is expected to increase at an average annual rate of 5.73% from SFY 2009-2015: 1.84% for LTC facilities, and 7.25% for Waivers and Homecare. About half of the cost increase is driven by caseload increases and the other half by increases to the average cost per person.

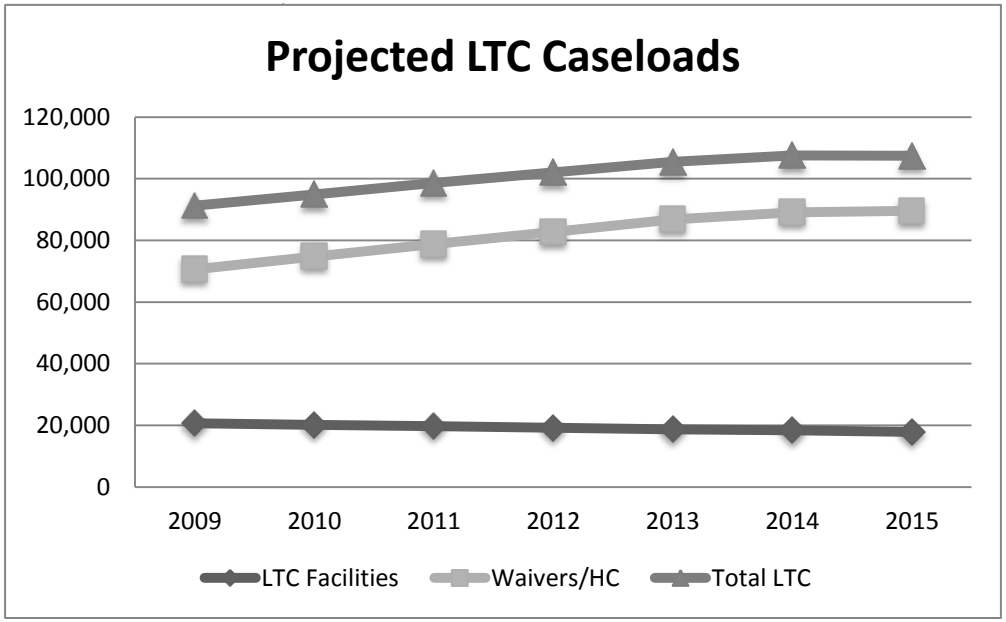
Factors affecting the cost per person include the increased service needs of participants, the increased use of more costly waivered services, average days of service, and re-basing nursing home rates.

Alternative care has been included as an home and community based service.

Overall, LTC caseloads are expected to grow at an average annual rate of 2.7% from SFY 2009-2015: -2.4% for LTC Facilities, and 4.0% for Waivers and Homecare.

Factors affecting caseload changes include the increase demand for home and community-based services, the implementation of nursing home level of care (LOC), and the expiration of waiver enrollment caps.

Alternative care has been included as an home and community based service.



Dollars reflect <u>total</u> Medical Assistance spending including federal, state, and county shares.

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Summary of Home and Community-Based Waivers, LTC Facility, and Home Care Funding and Eligibility

HCBS Waiver	Persons Served and Spending		Funding Sources	Management of Funding	Eligibility for Services
CAC Community Alternative Care	Monthly average recipients	300	State share Federal share *Recipient contributions	* Funds managed on an aggregate basis across the CADI, CAC, and TBI Waivers at the local level by the county agency * Rates are negotiated by lead agency and paid directly to providers on a fee for service (FFS) basis; future change with new statewide rate setting methodologies	* Certified disabled by the State Medical Review Team (SMRT) or the Social Security Administration (SSA) * Under age 65 when starting CAC services * Determined to need hospital level of care
	Monthly cost per recipient	$5,364			
	Annual spending	**$19m**			
CADI Community Alternatives Disabled Individuals	Monthly average recipients	13,320	State share Federal share *Recipient contributions	* Funds managed on an aggregate basis across the CADI, CAC, and TBI Waivers at the local level by the county agency * Rates are negotiated by lead agency and paid directly to providers on a FFS basis; future change with new statewide rate setting methodologies	* Certified disabled (SMRT/SSA) * Under age 65 when starting CADI services * Need nursing facility-level of care
	Monthly cost per recipient	$2,294			
	Annual spending	**$361m**			
DD Develop-mental Disability	Monthly average recipients	14,176	State share Federal share *Recipient contributions	* Funds managed on an aggregate at the local level by the county agency * Rates are negotiated by lead agency and paid directly to providers on a FFS basis; future change with new statewide rate setting methodologies	* Determined to have mental retardation or related condition * Determined to require level of care provided in Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)
	Monthly cost per recipient	$5,673			
	Annual spending	**$962 m**			
TBI Traumatic Brain Injury	Monthly average recipients	1,357	State share Federal share *Recipient contributions	* Funds managed on an aggregate basis across the CADI, CAC, and TBI Waivers at the local level by the county agency * Rates are negotiated by lead agency and paid directly to providers on a FFS basis; future change with	* Certified disabled (SMRT/SSA) * Documented diagnosis of TBI or degenerative brain disease * Experience significant to severe cognitive/behavioral impairments related to the brain injury * Under age 65 when starting TBI services
	Monthly cost per recipient	$5,883			
	Annual spending	**$95m**			

*Source: November 2010 forecast, fiscal year '09 actual numbers

				new statewide rate setting methodologies.	* Determined to need level of care provided in nursing facility or neurobehavioral hospital
EW **Elderly Waiver**	Monthly average recipients Monthly cost per recipient **Annual spending:** **** Includes both FFS and managed care***	19,654 $1,191 **$281m**	State share Federal share *Recipient contributions	* 10% of the EW recipients' services are paid directly to providers on a FFS basis * Maximum FFS service rates and individual budget caps determined by legislative action. * 90% of the EW recipients' care is managed through a contractual relationship with health plans	*Age 65 or older * Need nursing home level of care
AC **Alternative Care**	Monthly average recipients Monthly cost per recipient **Annual spending:**	3,315 $772 **$30m**	100% State funded *Recipient contributions	* Counties manage AC costs for AC enrollees within their allocation * Rates are paid directly to providers on FFS basis * Maximum FFS service rates and individual budget caps determined by legislative action	*Recipient's income and assets insufficient to sustain 135 days in a nursing facility *Age 65 or older * Need nursing home level of care *Monthly cost must be 75% less than average EW Medicaid payment limit for comparable case mix *Recipient pays assessed fee
Nursing Facility	**Persons Served and Spending**		**Funding Sources**	**Management of Funding**	**Eligibility for Services**
NF **Nursing Facility**	Monthly average recipients Monthly cost per recipient **Annual spending:** ****Note: the health plan capitation includes a payment for the risk of NF placement for elderly***	18,763 $3,696 **$833m**	County share State share Federal share *Recipient contributions of $31.84/day	* NF recipients' services are paid directly to providers on a FFS basis * Rates determined by legislative action	* Need nursing home level of care

*Source: November 2010 forecast, fiscal year '09 actual numbers

ICF **Intermediate Care Facility**	Monthly average recipients Monthly cost per recipient **Annual spending** Adding Day Habilitation	1,825 $6,491 **$142m** **$33m**	County share State share Federal share *Recipient contributions of $19.12 /day	* Rates are negotiated by lead agency and paid directly to providers on a FFS basis; future change with new statewide rate setting methodologies.	* Must be determined to have mental retardation or a related condition *Manifest conditions before age 22 Require a 24-hour plan of care
Home Care	**Persons Served and Spending**		**Funding Sources**	**Management of Funding**	**Eligibility for Services**
HHA **Home Health Agency**	Monthly average recipients Monthly cost per recipient **Annual spending:**	4,959 $401 **$24m**	State share Federal share	* FFS service rate is determined by legislative action *Health plans also purchase services for their enrollees	* HHA services include: home health aide, skilled nursing visits, therapy, and medical equipment. * Home health aide, skilled nursing and therapy visits require prior authorization and a physician order
PCA **Personal Care Assistance**	Monthly average recipients Monthly cost per recipient **Annual FFS spending:** **Annual health plan spending**	14,808 $2,264 **$402m** **$120m**	State share Federal share	* 77% of the PCA recipients' services are paid directly to providers on a FFS basis. * FFS service rate is determined by legislative action *Health plans also purchase services for their enrollees.	* Have a stable medical condition * Be able to identify their needs, direct PCA tasks, and provide for their health and safety OR have a responsible party that can do so * Must live in their own home
PDN **Private Duty Nursing**	Monthly average recipients Monthly cost per recipient **Annual spending:**	508 $11,555 **$70m**	State share Federal share	* FFS service rate is determined by legislative action *Health plans also purchase services for their enrollees	* Must have nursing needs that are medically necessary and physician ordered. * Service is prior authorized

*Source: November 2010 forecast, fiscal year '09 actual numbers

- **Home and community-based waivers** – are cost effective alternative services to institutional care (nursing facility, Intermediate Care Facilities for Persons with Developmental Disabilities or hospital), that Minnesota has received permission from the federal government to provide as an alternative to institutional care and the federal government will share in the cost of providing that service to eligible recipients.

- **Distinction between basic and long-term care.** Basic care (also known as acute care) means that a recipient is receiving health care services e.g. hospital, physician, prescription coverage. The basic health care dollars are not reflected in the above chart; only the long-term care funding is shown.

- **Economic Supports for elderly and people with disabilities.** Many of the recipients in the above chart may also receive economic supports from the state or federal government. Examples include: Supplemental Security Income, Minnesota Supplemental Aid, Group Residential Housing (income supplement for room and board), food supports, subsidized housing. The numbers above do not reflect any other sources of funding; only the long-term care funding is shown.

- **Assessment for services.** All recipients in the programs above are required to receive an assessment which is conducted by the county, health plan, or tribal lead agency to determine their level of need for long-term care services. A community support plan is developed in concert with a case manager to define the services that will be provided to the recipient to meet their long-term care needs.

- **Other sources of funding for providers**: long-term care providers may have a variety of funding sources such as: private pay, private health and long-term care insurance and Medicare. The department does not collect cost reports for home and community-based providers; therefore, not able to determine the portion of provider revenue directly related to public Medical Assistance funding. However, the department does collect cost reports for nursing facilities and intermediate care facilities. The percent of nursing home days paid on average by Medical Assistance is 57.8% for the year ending 9/30/09 and the percent of intermediate care facility days paid on average by Medical Assistance is 92%.

*Source: November 2010 forecast, fiscal year ’09 actual numbers