14. The Long Term Care Medicaid Reimbursement Problem

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THE LONG-TERM CARE MEDICAID REIMBURSEMENT PROBLEM

The SUNY BROCKPORT PUBLIC ADMINISTRATION TEAM:

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INTRODUCTION

A growing public concern about the high cost of Medicaid reimbursement for Long Term Care (LTC) has created the need for careful analysis of the causes & consequences of past public policies and to develop strategies that provide solutions to identified problems.

Guiding the team through the assigned simulation, that reflects a serious public concern, were our stated political values serving to shape our policy proposals.

Using a systems approach, we analyzed current public policy and explored alternatives. We considered the forces that operate in the environment producing demands on the political system, pressing for allocation of resources toward desired objectives.

An integral part of the medical inflation picture, Medicaid reimbursement costs reflect the system's failure to create a cost-effective balance between supply and demand, government and the private sector, quality and price, provider and consumer, flexibility and control.

POLITICAL VALUES GUIDING THE SIMULATION

It needs to be remembered that government cannot do all things for all people. The mix of essential services ultimately provided involves, of necessity, the allocation of scarce resources and its attendant decision-making process.

Three decades of government-stimulated construction of medical facilities, medical research, education and regulation have created greater demand for and use of health care. This advance comes at great and ever-escalating cost to society.
The question begins to loom: what can we afford as a nation and how should we allocate our resources? Can the enormously expensive Medicaid program, with its component of reimbursement for LTC be afforded? Given the unforeseen costs involved, the inflationary bias and the changing demographic composition of our society, the question of such reimbursement necessitates a rethinking.

In order to determine a strategy for change, we must begin with a clear statement of the political values which will guide us in the analysis. They are as follows:

All individuals should have access to basic health care and related social services.

Government has an obligation to ensure reasonable access for all to LTC. In so doing, the government has the responsibility to regulate the quality, quantity and cost of such service.

The individual must take responsibility for maintaining his own good health. Preventive strategies will be emphasized.

Government should provide only those goods and services which the individual cannot provide for himself.

A LTC plan should include options to provide for freedom of choice, thus preserving the pluralistic nature of our private sector.

Free enterprise is essential to our democratic and economic order. It must be kept essentially intact in planning for the delivery of health services.

No single system for providing health care will satisfy everyone or prove to be regionally cost effective.

The lower the level of government responsible for administering a service, the more responsive to the needs of the people and efficient the service provided.

Fiscal responsibility and restraint must guide policy.

Health resources are scarce resources and do require difficult decisions on allocation.

Regulation, to be effective, should focus on cost and standards to guarantee the most appropriate utilization of available resources.
Government intervention is needed to ensure a fair and efficient allocation of resources. It must intervene to correct the lacking incentives normally provided by the market mechanism.

The cost of health care is a major contributing factor to inflation.

The role of the family unit in providing LTC is of primary importance. Home care with supportive services is desired over institutional care.

VALUES, PROBLEMS AND CAUSES

The problems connected with Medicaid reimbursement for LTC are numerous and interrelated. It is extremely difficult to see where one begins and another stops. The team has tried to identify and separate these problems into three problem sectors. They are as follows:

PROBLEM #1: HIGH COST

The implementation of the Medicaid reimbursement system has proven to be far more costly than originally envisioned and costs are continuing to escalate at an uncontrolled rate. Originally totaling $2.4B in 1967, projections for 1980 run to $22.3B. Interestingly enough, the annual increase in the cost of medical care first began to skyrocket the very year of Medicaid's inception, jumping from 2.9% in 1966 -- to 6.5% in 1967 -- to 12.5% in 1975. (See Appendices 1 & 2).

Two critical elements are missing which are needed to guide the Medicaid system: 1) a cost control component, 2) clearly delineated national spending priorities to keep spending in line and to assure the desired allocation of national resources.

HOW THE PROBLEM OF HIGH COST RELATES TO THE STATED POLITICAL VALUES

Since national resources are scarce resources, unlimited spending for one commodity cannot be allowed. Fiscal restraint must be a guiding feature of national planning for the provision of social services as
well as others. What we opt to spend for LTC must be cut from somewhere else if spending is not kept within bounds. Given equally important and growing societal emphasis on education, welfare, and national defense, (to name but a few), our position must be that we cannot sustain the kind of growth that has occurred in the area of health care.

POSSIBLE CAUSES WHICH CONTRIBUTE TO THE HIGH COST OF LTC

Administrative inefficiencies allow patients to be placed at inappropriate levels of care, encourage waste and reward inefficiency.

Third-party reimbursement systems leave the patient (consumer) unaware of the high cost of treatment and serve as a disincentive for him to look for cheaper alternatives.

The advance of new medical technology serves to raise expectations on the part of patients and stimulates its greater use and development.

PROBLEM 2: FAILURE OF THE MARKET-MECHANISM

Medicaid has essentially brought about a condition in which the forces that create price equilibrium do not function in a normal way. Government intervention to assure the consumption of services for those needing LTC stimulates further demand for services. When there is no ceiling on the amount of resources made available, there is incentive for both supplier (physician) and consumer (patient) to generate as much consumption as possible. The Medicaid system of third-party payments leaves the consumer 1) unaware of the cost of service, and 2) with no incentive to cut back on the amount of medical services consumed. The result is overconsumption.

HOW THE PROBLEM RELATES TO THE STATED POLITICAL VALUES

In the case of Medicaid reimbursement for LTC, the health care industry holds an unfair advantage: the supplier controls the market and creates its own demand. Controls must be placed on the supplier
by the government. Health resources are scarce resources because the federal resources which finance LTC are finite. Some form of national priority-setting, decision-making and allocation needs to be implemented.

POSSIBLE CAUSES OF THE FAILURE OF THE MARKET MECHANISM

The allocation of the resources is regulated by the supplier (physician) who determines the nature, extent, and cost of the service the consumer (patient) must have.

The demand for services is inelastic; the patient wants treatment irrespective of cost.

There is a lack of competition among physicians as a result of under-supply due to restrictive medical school admission policies.

PROBLEM #3: FAULTY ALLOCATION AND DISTRIBUTION OF RESOURCES

This is a major cause of substandard care for large segments of the population. Physicians, facilities and the greatest number of services are clustered in and around middle-class urban areas, leaving rural citizens and the inner-city poor underserved and their facilities underfunded.

HOW THE PROBLEM RELATES TO THE STATED POLITICAL VALUES

A basic level of LTC should be available for all. When over-consumption in some areas drains available resources and leaves other areas underserved, the government must then intervene to ensure a more fair and equitable allocation of health-care resources.

POSSIBLE CAUSES OF THE DISTRIBUTIONAL PROBLEM

The private market has not functioned to allocate equitably or to distribute evenly.

Not every individual has equal resources, therefore the distributional problem exists.

There is a lack of comprehensive planning to meet the needs to those needing LTC.

Some are consuming too much.

Adequate governmental control is lacking.
INTERIM SOLUTIONS . . . . Proposals for bringing about changes recommended as possible solutions for immediate implementation and are listed in Appendix 3. The proposals have been divided into three categories: government-based strategies for bringing about change in the Medicaid reimbursement system for LTC, facility-based strategies and physician-based strategies.

A brief synopsis of these proposals: they are aimed at eradicating some of the basic causes of the problems identified with reimbursement for LTC. They include fiscal and management strategies which set limits on spending, encourage efficient use of resources and ensure that standards for quality of patient care are maintained.

Furthermore, the interim strategies proposed are heavily dependent on greater concern for the "total patient" and his family. They advocate for maintenance in the least restrictive, and most economical, level of care. The proposed decentralization of services is in keeping with the most successful modern models for the delivery of LTC in other countries and is in line with our stated political values of advocating variety and responsiveness of local service options.

It must be realized, however, that coming to grips with the enormity of the problems brought about by the present reimbursement system for LTC, requires more than interim solutions. They are necessary for beginning to bring the system under control but are not adequate; they do not provide a comprehensive delivery system for the service and thus do not alleviate the stated problem of faulty allocation and distribution of resources. The question of converting the central political value of "access to basic benefits for all" into
a manageable arrangement of services, facilities and systems requires a comprehensive approach at the national level. We must look beyond the interim solutions to a comprehensive, single-agency provider for an integrated network of services for those in need of LTC... We call that system HEALTHPLAN.

HEALTHPLAN: A Single-Agency Solution

(See Appendices 4 & 5)

POLITICAL VALUES GUIDE POLICY . . . . Key values underlying HEALTHPLAN reflect those put forward at the beginning of this paper. Critical are issues of freedom of choice and self-sufficiency, which necessitate the development of more LTC alternatives and support options for patients and their families. All individuals will be provided, by means of comprehensive planning and program delivery, with access to basic health care. Costs will be shared by means of deductibles and co-payment systems as a way of equalizing the burden of LTC across society. The consumer of LTC services will be taking the responsibility for choosing and, in part, for financing the options taken. The government will provide incentives for the individual to choose the most cost-efficient LTC alternative which will meet his individual needs. The family unit will be encouraged to act as a support unit to those in need of LTC.

WHAT IS HEALTHPLAN? . . . . HEALTHPLAN is the framework for financing and delivering a comprehensive system for LTC. Primary beneficiaries are the elderly who become seriously ill. HEALTHPLAN applies the basic concept of insurance for acute care to cover LTC expenditures. The result is an insurance policy, owned by an
individual, representing a promise to pay if the individual is certified to be in need of LTC services and can meet eligibility criteria.

The system provides for active consumer choice and serves to encourage economical options by using deductibles and co-insurance policies. These options serve the desired goal of providing basic care for those who need it, while curbing spending for LTC, one of the stated political values.

**THE SYSTEMS APPROACH** . . . Inputs to the HEALTHPLAN system reflect the patient and family needs as well as professional interests. Supports are rendered when individuals accept the single-agency system delivery of LTC and decide to participate in it. The main objective of the LTC system is to help the patient maintain maximum functional independence in the least restrictive environment. The community agency helps to coordinate resources available in the community and puts the patient in touch with the services available to meet his needs.

**RANGE OF SERVICES PROVIDED** . . . HEALTHPLAN will focus on providing long-range support alternatives for individuals who cannot live independently without assistance. The range of services provided will include: 1) nursing-home care (SNF & HRF), 2) domiciliary care, 3) congregate-living arrangements, 4) foster care, 5) day care, 6) housing for the elderly, 7) home-health care, 8) friendly visiting, 9) respite care, 10) meals-on-wheels and other home health-related services.

Again, the service emphasis would be to encourage patients and their families to opt for the least restrictive environment. Financial incentives will be provided to encourage home-health care with supportive services to participating families. Service at
different levels will be open, based on a patient's willingness to pay for such service, if desired above need certification for a standard level of care.

Such provision to provide for the purchase of service desired is in line with the stated political values describing the importance of freedom of choice and the free enterprise system, while shifting emphasis to the importance of the family unit in providing basic resources to support family members needing LTC for as long as possible.

FINANCING AND MANAGEMENT . . . . At the federal level, HEALTHPLAN will be financed from general revenues. Once a national MAXICAP is determined in dollar amounts for LTC expenditures, allocations will be made to states and localities by a formula similar to that used for General Revenue Sharing. The state-level agency will be responsible for system management and operational functions. A central information management system will be an essential component. Operational management includes the service provision to ensure entitlements and benefits.

To assist in developing home and community-based options, the local community agency for LTC will perform patient assessment, offer options and arrange for service. It will also monitor quality to improve patient care. Patient management at the local level means matching the patient to the appropriate desired service.

Clients will be encouraged to opt for the least restrictive environment. The agency will require and receive waivers to pool Medicaid and Medicare funds for LTC.

Once an individual is certified for eligibility by a panel of professionals, he can choose among a wide range of services, after meeting a deductible. Because clients consume more than they would be
willing to pay for if they were participants in the reimbursement process, HEALTHPLAN embodies the co-payment concept. Reimbursement rates are set to pay for a standard intensity of care. Co-payment is required by the consumer in an amount proportional to the covered cost of services provided. The result is an incentive for consumers to economize and thus save money and lower the numbers of patients opting for the higher and more expensive levels of care.

A ceiling payment for catastrophic illness or incapacity could be set on payments based on a sliding scale for different incomes. This would prohibit anyone paying more than 40% of their income on LTC deductibles of co-payment. States could participate by paying for part of the deductible for needy residents, thus preserving the cost-efficiency incentive built into HEALTHPLAN.