NACDEP
National Coalition for Dually Eligible People
3315 Tulane Avenue
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DUALLY ELIGIBLE PEOPLE WITH MEDICARE AND MEDICAID

PART 2

THE NURSING HOME BURDEN

Improving Access to Health Care for
Dually Eligible People with
Medicare and Medicaid Will Decrease
Their $500 Million Louisiana Medicaid Nursing Home Bill and
Their $34 Billion National Medicaid Nursing Home Bill.

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New Orleans, Louisiana
January 20, 2003

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INTRODUCTION

Dually eligible people have both Medicare and Medicaid benefits. They worked and earned the right to Medicare, and they receive it when they become elderly or disabled. They also have Medicaid because they are still so poor that they qualify for their state's Medicaid program for the needy. Dually eligible people are the oldest, poorest, sickest, and most disabled group of people in the nation. They are the people at greatest risk of becoming ill and requiring long-term nursing home care.

Health care for these vulnerable, elderly and disabled people begins in the community physician's office and frequently ends with the dually eligible person permanently residing in an impersonal, expensive nursing home. It is ethically, medically, and financially wiser to keep dually eligible people in their own homes, than it is to institutionalize them in nursing homes.

Recent decisions by the Louisiana Department of Health and Hospitals (DHH) have made it more difficult for Louisiana's 104,110 dually eligible people to obtain timely access to health care in the community, and therefore more likely that they will be sent to live in expensive nursing homes. These actions by DHH disrupt long held family and community ties and increase our state's Medicaid nursing home budget.

Louisiana DHH Decision No. 1: Decreasing Access to Community Services

In 2000, Louisiana DHH essentially eliminated $24 million of Medicare-Medicaid *crossover payments* for dually eligible people, as sanctioned by the Balanced Budget Act of 1997.[*] By effectively eliminating crossover payments — which is payment for the $100 yearly Medicare deductible and the 20% Medicare coinsurance, which Medicaid *used* to pay — DHH lowered the insurance reimbursement for these frail, medically complex, elderly and disabled people by a *minimum* of 20%. (For a discussion of crossover payments see the chapter in Part 1 titled, "'Second-Class Medicare': How Do Medicare-Medicaid 'Crossovers' Work?")

[*] Technically, Louisiana DHH is not allowed to "eliminate" crossover payments for dually eligible people. DHH's final rule, which appeared in the Louisiana Register on October 20, 2000, states that DHH will compare the actual Medicare payment (without the Medicare deductible and 20% coinsurance) to the Medicaid payment rate. If the Medicare payment exceeds the Medicaid payment rate, the claim is adjudicated as a fully paid claim with a zero Medicaid payment — which means a minimum loss of 20% of the Medicare fee. If the Medicaid rate exceeds the Medicare payment (e.g., if Medicare pays little or zero because the Medicare deductible has not been met), the claim is reimbursed at the lesser of the actual Medicare payment amount or up to the Medicaid maximum payment — a loss which may exceed 80% of the Medicare fee. The patient and Louisiana DHH have no further legal or financial liability to make payment for the service. The net effect of this complicated rule — which was sanctioned by the Balanced Budget Act of 1997 — is that "discretionary" crossover payments for dually eligible people have been essentially eliminated. (For a discussion of "discretionary" versus "mandatory" crossover payments, see the chapter titled, "Most of Louisiana's $500 Million Nursing Home Bill is Spent on Dually Eligible People.")

Because of this harmful budgetary decision these vulnerable elderly and disabled dually eligible people have decreased access to their community physician's office, and are more likely to be admitted to a nursing home. One example of this decreased community medical access is the attached January 2001 letter I was forced to send to the daughter of a 95-year-old, bed-bound, dually eligible patient with Alzheimer's disease. This letter explained that I was no longer able to make a house call to see her mother because, by eliminating Medicare-Medicaid crossover payments, the State of Louisiana had *cut the reimbursement for a physician house call service by 81%*. (See Attachment: Inability to make house call letter.)

Louisiana DHH Decision No. 2: Increasing Nursing Home Payments

In 2002, DHH in essence took the $24 million that had been removed from the community physicians' Medicare-Medicaid crossover budget two years previously, added $3 million to the total, and appropriated the entire $27 million to our state's nursing homes as a "cost-of-living raise." By transferring money out of community access programs and into nursing homes, Louisiana DHH encourages and subsidizes the institutionalized long-term care of dually eligible people. Louisiana is pushing our elderly and disabled people out of their relatively inexpensive family homes and physicians' offices and into expensive nursing homes, which house these dually eligible people at enormous state government expense.

In addition to significant family and social costs, moving dually eligible people out of their physicians' offices and into Medicaid-sponsored nursing homes is financially unwise. Louisiana pays approximately *four times* more *Louisiana treasury money* than Medicare does, for *Medicaid-sponsored* nursing home care, because of the effects of the Medicare-Medicaid Payment Seesaw. (See the chapter titled, "The Medicare-Medicaid Payment Seesaw and Our Nursing Home Budget.") Conversely, Medicare pays approximately *four times* more *federal government dollars* than Medicaid does, for *Medicare-sponsored* community care in the physician's office, hospital, and home health venues. Therefore, Louisiana DHH must do everything in its power to keep dually eligible people in the *Medicare-sponsored* community and out of the expensive Louisiana *Medicaid-sponsored* nursing homes.

Because of this advantageous Medicare community care reimbursement ratio of four to one, the $27 million which DHH gave to nursing homes could have helped purchase the equivalent of $135 million of *Medicare-sponsored* services in the physician's office, hospital or home health, using federal dollars. Instead, DHH chose to purchase only $34 million dollars of *Medicaid-sponsored* nursing home services, using money that comes primarily out of the Louisiana treasury. (See the chapter titled, "The $27 Million Nursing Home Raise Could Have Purchased $135 Million of Community Services.")

Many physicians and policymakers believe the impact of dually eligible people on Louisiana's Medicaid budget is confined to the $24 million Medicare-Medicaid crossover payment program. But the actual financial impact of Louisiana's elderly and disabled

dually eligible population is closer to *twenty times* that number. In addition to the obvious $24 million crossover bill, we must consider the *enormous $500 million* bill, which Louisiana Medicaid pays for this population's nursing home care every year, along with the recent $27 million DHH nursing home appropriation — *for a total of $551 million.* (See the chapter titled, "Most of Louisiana's $500 Million Nursing Home Bill is Spent on Dually Eligible People.")

Because the "old-old" and the "non-elderly disabled" are the fastest growing segments of our Medicare and dually eligible population, the management of this group's Medicaid expenses is of critical importance to the health of our *entire* Louisiana Medicaid budget. By encouraging — or discouraging — this group to live in the much less expensive community environment, DHH has the ability to greatly impact the financial stability of its entire Medicaid budget. This affects every Louisiana Medicaid recipient, as well as the physicians who serve them. Removing money from the physicians' program and shifting this money to the nursing home industry is financially unwise and is an inefficient use of Louisiana's Medicaid money.

Demographic and financial statistics regarding Louisiana's dually eligible population are not readily available. Given this lack of local Louisiana information, I will apply several *national* dually eligible statistics and estimates to the Louisiana population and its Medicaid budget to determine their overall budgetary effect.

Louisiana's dually eligible population has a greater than $500 million impact on our state's Medicaid budget because a large percentage of dually eligible people live in our nursing homes, and Louisiana Medicaid pays their expenses. (See the chapters titled, "Most Nursing Home Residents Are Dually Eligible People," and "Louisiana Medicaid Pays the Nursing Home Bill for Dually Eligible People.") This money represents 3% of the *entire* Louisiana State budget.

Similarly, just as our local dually eligible population has an enormous impact at the state level, our *national* dually eligible population has an enormous impact on the national Medicaid budget — because the national dually eligible Medicaid bill is the sum of all the states' dually eligible Medicaid bills. Nationally, the dually eligible nursing home population has an approximate *$34 billion* impact on our nation's Medicaid budget each year. This money, which goes to house dually eligible people in expensive nursing homes, represents approximately 1.8% of *total* federal expenditures.

At least 78% of these state and national totals — or 2.4% of all Louisiana State expenses and 1.4% of total federal expenditures — was spent on room and board, and other non-medical *custodial* services for dually eligible people who live in our nation's nursing homes. (See the chapter titled, "Dually Eligible People Have a $34 Billion National Medicaid Nursing Home Bill.")

The key to Louisiana Medicaid's financial strength, therefore, lies in the proper management of its dually eligible population. Louisiana DHH must do everything in its

power to keep dually eligible people in the *Medicare-sponsored* community and out of expensive Louisiana *Medicaid-sponsored* nursing homes.

The first step towards this goal must be restoring the physician Medicare-Medicaid crossover program to allow these frail elderly and disabled people proper access to community physician services. This will afford these frail people the opportunity to stay in the community and allow for less expensive early-stage care by their physician.

The second step toward this goal must be to stop subsidizing the nursing home industry. Transferring money from the physician crossover program to the nursing home industry supports an industry in retreat, subsidizes empty nursing home beds, and costs the Louisiana treasury an enormous amount of money.

MOST NURSING HOME RESIDENTS ARE DUALLY ELIGIBLE PEOPLE

Although dually eligible people comprise only 17% of the national Medicare and Medicaid populations, nursing home residents are *overwhelmingly* dually eligible people. According to HCFA, approximately 70% of the nursing home population are dually eligible.[1] Dually eligible people are twelve times as likely to live in a nursing home, than non-dually eligible Medicare beneficiaries. In 1997, nearly one-quarter of dually eligible people lived in nursing facilities as opposed to only 2% of non-dually eligible persons.[2] (See Figure 1.) According to the AMA in 1995, 89% of all nursing home residents were 65 years old or older. Only 11% of nursing home residents were younger, non-elderly disabled people under age 65.[3]

HCFA — now renamed the Centers for Medicare & Medicaid Services — has acknowledged that the healthcare costs of dually eligible people are more than *double* the healthcare costs of non-dually eligible people because dually eligible people are far more likely to use a nursing home. Their costs are so "inflated because almost one-third of them were part- or full-year nursing home residents."[4] William Scanlon, Director of Health Financing and Systems Issues of the Health, Education, and Human Services Division, testified in 1997 before the Senate's Special Committee on Aging and agreed that over 20% of dually eligible people reside in nursing homes.[5] In Massachusetts in 1995, 36% of dually eligible seniors lived in a nursing facility or other long-term institutional setting.[6] Also, in Minnesota 60% of that state's dually eligible seniors reside in nursing homes.[7]

Although individual state percentages may vary, approximately 25% of the national dually eligible population live in nursing homes. According to testimony before the Senate Finance Committee in 1999, there were approximately six million dually eligible people in the United States.[8] Multiplying six million by 25% shows that approximately *1.5 million* dually eligible people live in nursing homes.

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[1] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population: Data from the 1995 Medicare Current Beneficiary Survey. <http://www.hcfa.gov/surveys/mcbs/PubHHC95.htm>.

[2] United States. Dept. of Health and Human Services. HCFA. Characteristics and Perceptions of the Medicare Population: Data from the 1997 Medicare Current Beneficiary Survey. 3 Sept. 2001 <http://www.hcfa.gov/surveys/mcbs/PubCNP97.htm>.

[3] American Medical Association. Council on Medical Services. Status Report on the Medicaid Program. Dec. 1999. 14 Sep. 2002 <http://www.ama-assn.org/ama/upload/mm/372/i99cms5doc.doc>.

[4] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

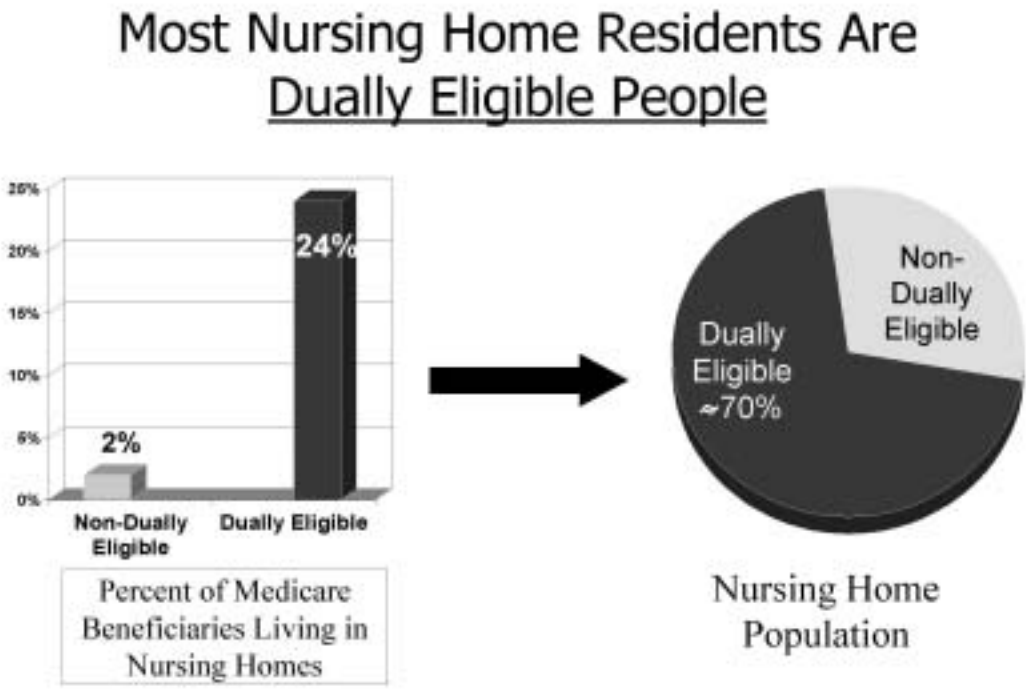
[5] Scanlon, William J. Medicare and Medicaid: Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues. US Cong. Senate. Special Committee on Aging. Washington: GAO, Apr. 29, 1997.

[6] Perrone, Christopher, and Daniel Gilden. Profile of Dually Eligible Seniors in Massachusetts 1995. Massachusetts Division of Medical Assistance and JEN Associates. Mar. 1999.

[7] Parker, Pamela. States Face Major Obstacles in Integrating Financing and Service Delivery for Persons Dually Eligible for Medicare and Medicaid. US Cong. Senate Special Committee on Aging. Apr. 29, 1997. 18 July 2001 <http://aging.senate.gov/hr3pp.htm>.

[8] Scheppach, Ray. Changes to the Medicare system. US Cong. Senate. Finance Committee. May 27, 1999. 18 July 2001 <http://finance.senate.gov/5-27sche.htm>.

Figure 1.



Source: HCFA

Most nursing home residents are dually eligible people. Dually eligible people are twelve times more likely to live in a nursing home than non-dually eligible people.

Looking at the actual number of nursing home residents the AARP has observed, "According to the 1997 National Nursing Home Survey, there were 1,465,000 residents age 65 and older in nursing homes." Adding an additional 181,000 residents or 11% of nursing home residents whom the AMA stated were under 65 years old, reveals a total of 1.65 million nursing home residents — a number similar to the 1.5 million dually eligible people who theoretically populate our nation's nursing homes. Also, "nearly three-fourths of these [nursing home] residents were women, and about one-half were age 85 and older" — typical descriptions of dually eligible people.

Similar information can be obtained by counting the number of occupied nursing home beds in the United States. In 1999, our nation had 1.81 million nursing home beds. But not all nursing home beds are occupied, because the nursing home industry is undergoing a period of contraction. "The national average occupancy rate of nursing homes was 82.7% in 1999, a decrease from 1994 when the occupancy rate was 85.5%."[9]

Multiplying 1.81 million nursing home beds by an 82.7% occupancy rate demonstrates that in 1999, there were 1,496,870 occupied nursing home beds in the United States — a number which is almost exactly the same number of dually eligible people that was predicted to live in nursing homes. This demonstrates that, although not all residents living in nursing homes are dually eligible people, it is certain that the *majority* of people who live in nursing homes across the nation are in fact dually eligible people.

The number of dually eligible people who reside in *Louisiana* nursing homes can be computed by applying the national estimate of 25% to Louisiana's dually eligible population. According to David Hood, Secretary of Louisiana DHH, there were 104,110 dually eligible persons in Louisiana in fiscal year 2000.[10] Multiplying the 25% national nursing home average by Louisiana's 104,110 dually eligible population shows that theoretically, *26,028 dually eligible people* live in Louisiana's nursing homes.

According to The Times-Picayune, "Louisiana has historically spent most of its Medicaid resources on nursing homes . . . for more then 25,000 people."[11] This number of 25,000 Louisiana citizens residing in nursing homes is very close to the number of dually eligible people calculated in theory to be living in Louisiana nursing homes using the national dually eligible nursing home average. Clearly, not all residents living in Louisiana nursing homes are dually eligible people, however, this fact is clear: The *majority* of people who live in Louisiana nursing homes are dually eligible people.

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[9] Pandya, Sheel. Nursing Homes. AARP Public Policy Institute. Public Affairs. Washington: Feb. 2001. 9 Sept. 2001 <http://www.research.aarp.org/health/fs10r_nursing.html>.

[10] Hood, David. Letter to the author. 2 July 2001.

[11] Walsh, Bill. "More choices urged in care for seniors." The Times-Picayune [New Orleans] 19 July 2001: A1+.

LOUISIANA MEDICAID PAYS THE NURSING HOME BILL FOR DUALLY ELIGIBLE PEOPLE

Although some nursing home residents have other, non-Medicaid insurance coverage, most nursing home residents are dually eligible people and have both Medicare and Medicaid benefits. Medicare is primarily responsible for community medical care in the physician's office, hospital, and through home health, while Medicaid is primarily responsible for nursing home care. According to HCFA in 1995, *Medicaid covered 75% of all nursing home residents*, compared with only 17% of community residents.[12] The Kaiser Family Foundation has confirmed that "Medicaid finances care for over two-thirds of the nation's nursing home residents."[13]

Louisiana Medicaid spends approximately $26,000 per person, per year, to care for approximately three-quarters of all residents in our state's nursing homes. Most of these Medicaid-eligible residents are dually eligible people, some of whom could be well cared for in their own communities for much less money each year. What is important to remember is that Medicaid pays the *majority* of nursing home bills for nursing home residents — most of whom are dually eligible people — in Louisiana and across the nation.

[12] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

[13] Kaiser Family Foundation. Medicaid's Role for Low-Income Medicare Beneficiaries. Feb. 2001. 25 Apr. 2002 <http://www.kff.org/content/2001/2237/2237.pdf>.

MOST OF LOUISIANA'S $500 MILLION NURSING HOME BILL IS SPENT ON DUALLY ELIGIBLE PEOPLE

Dually eligible people are the oldest, poorest, sickest, and most disabled group of people in the country. Senator John Breaux, in his opening statement before the Senate Special Committee on Aging in April 1997, stated:

> Any serious attempt to hold down Medicare and Medicaid costs must take the needs of the dually eligible — the elderly and disabled poor — into account. They are the most expensive of the Medicare and Medicaid beneficiaries. They account for a disproportionately large share of spending in both Medicare and Medicaid. As 16% of the Medicare population, they account for 30% of its expenditures. As 17% of the Medicaid population, they consume 35% of its payments. Overall, $106 billion was spent in 1995 on dual eligibles. This amounts to nine times more money than was spent nationally on medical research.
>
> As only 2% of the nation's population, they account for 10% of the country's health care spending. They are also the two fastest growing segments of the Medicare population. These groups — the nonelderly disabled and individuals 85 years and older — are the two groups most likely to be dually eligible.[14]

The medical expenses of dually eligible people with Medicare *and* Medicaid are approximately *twice* the expenditures of beneficiaries with Medicare *or* Medicaid. (See Figure 2.)

Although 35% appears to be a large percentage of a state's Medicaid budget for dually eligible people to consume, in some states dually eligible people consume even higher percentages. In her congressional testimony, Pamela Parker of the Minnesota Department of Human Services stated, "People who are dually eligible for Medicare and Medicaid comprise only about 18% of Minnesota's Medicaid enrollees, but they account for as much as 50% of Minnesota's Medicaid costs."[15]

In fiscal year 1998/1999, Louisiana's total Medicaid budget was $3.384 billion.[16] Applying the national average, 35% of this Medicaid budget was spent to care for dually eligible people in our state. Therefore, 35% of Louisiana's $3.384 billion Medicaid budget, or *$1.18 billion* was theoretically spent by Louisiana Medicaid on our relatively small dually eligible population in fiscal year 1998/1999.

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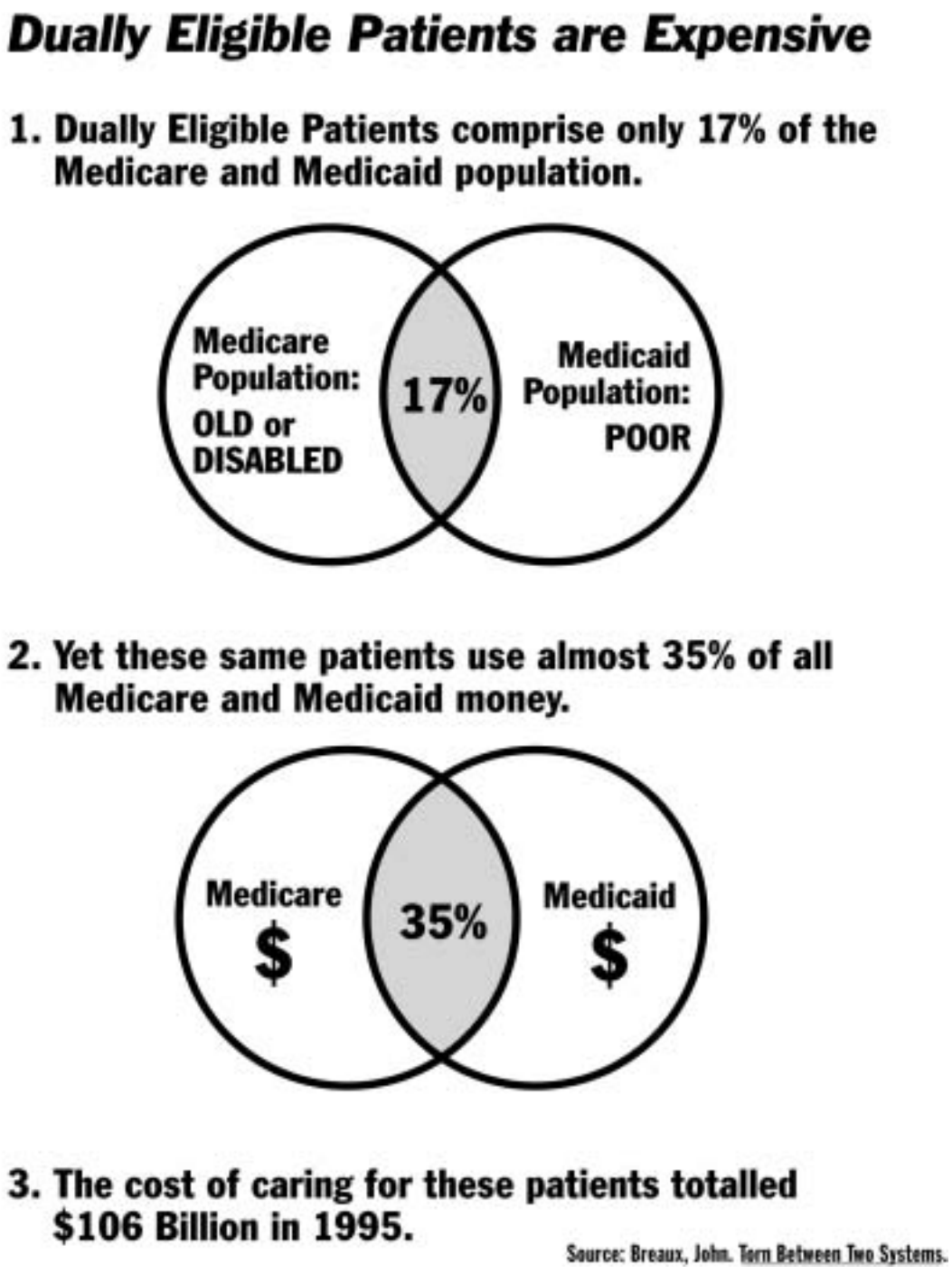
[14] Breaux, John. Torn Between Two Systems: Improving Chronic Care in Medicare and Medicaid. US Cong. Senate. Special Committee on Aging. Apr. 29, 1997. 19 Aug. 2001 <http://www.senate.gov/~aging/hr3jb.htm>.

[15] Parker.

[16] Boyd, Curtis. Louisiana's Medicaid Program. Annual Report. State Fiscal Year 1998/99. Louisiana DHH. Baton Rouge: 1999. <http://www.dhh.state.la.us/OMF/PDF/AR_98.pdf>.

Figure 2.


Dually Eligible Patients are Expensive
1. Dually Eligible Patients comprise only 17% of the Medicare and Medicaid population.
Medicare Population: OLD or DISABLED
17%
Medicaid Population: POOR
2. Yet these same patients use almost 35% of all Medicare and Medicaid money.
Medicare $
35%
Medicaid $
3. The cost of caring for these patients totalled $106 Billion in 1995.
Source: Breaux, John. Torn Between Two Systems.

According to HCFA in 1995, *85%* of all money spent by Medicaid on dually eligible people went to pay for their nursing home care — which included *non-medical custodial services* such as room and board expenses, as well as assistance in their activities of daily living. Six percent of Medicaid's dually eligible payments went to pay for prescription medicines. Only 4% of these payments went to medical providers, and 3% went to inpatient hospital services.[17] (See Figure 3.) The Times Picayune confirmed in 2000, 86% of the "Medicaid money that Louisiana set aside for the elderly and disabled went to nursing homes, group homes, and state-run institutions"[18] — a number almost identical to HCFA's 85% dually eligible national nursing home bill.[**]

Applying the national average, 85% of the $1.18 billion spent by Louisiana Medicaid on dually eligible people went to pay for their nursing home costs. Therefore, 85% of $1.18 billion, or *$1 billion* was theoretically spent by Louisiana Medicaid to pay nursing facilities to house our dually eligible population.

In fiscal year 1998/1999 Medicaid only budgeted $504 million for the total Louisiana nursing home bill. How can a theoretical nursing home bill of $1 billion be reconciled with an actual nursing home bill of $504 million?

According to the AARP, "The average annual cost of care in a nursing home [for all payers] in 1998 was about $56,000 or $153 [per patient,] per day. . . . Medicaid reimbursement systems for nursing homes vary considerably from state to state and averaged $95.72 [per patient,] per day [or $34,938 per patient, per year] in 1998."[19]

As described in The Times-Picayune, Louisiana's "nursing home owners . . . have been especially aggressive in lobbying for a share of the budget." According to the Louisiana Nursing Home Association, "At $71 per patient, per day, Louisiana nursing homes are among the lowest-paid in the nation."[20] Multiplying this expense of $71 per day, by 365 days, yields the result that Louisiana is spending $25,915 per nursing home resident, per year.

Dividing Louisiana Medicaid's nursing home payment of $25,915 by the average national Medicaid nursing home payment of $34,938 shows that Louisiana Medicaid pays only 74% of the national average of Medicaid payments to nursing homes. Multiplying the theoretically derived Louisiana dually eligible nursing home bill of

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[17] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

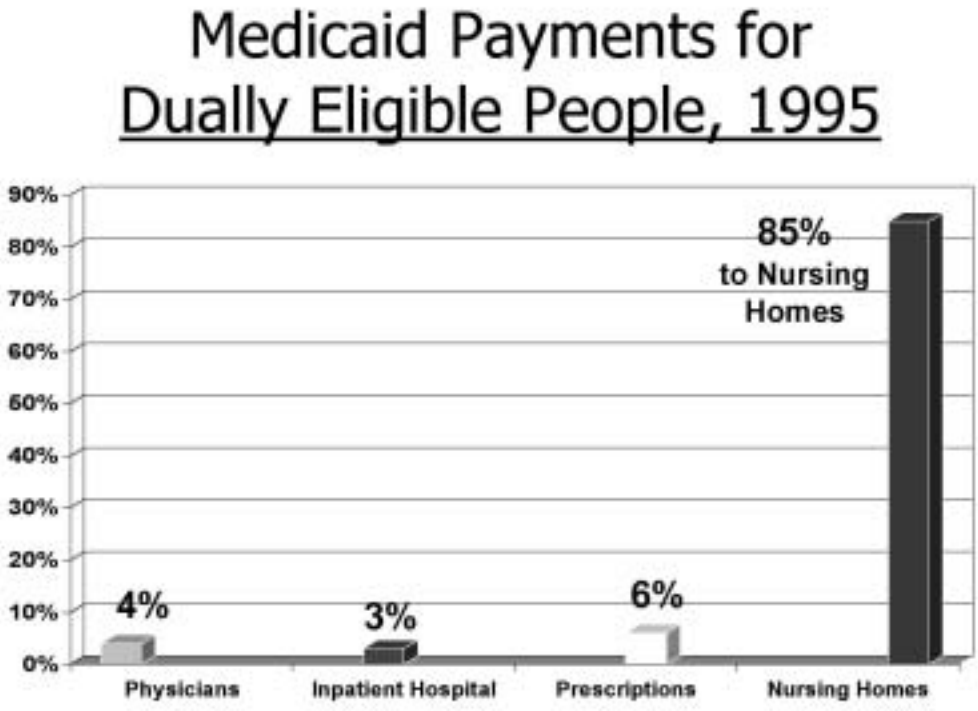
[18] Walsh, Bill. "Ruling puts pressure on institutions." The Times-Picayune [New Orleans] 7 May 2001: A1+.

[**] According to the Annual Report of the Louisiana Medicaid Program for State Fiscal Year 1999/00, in addition to nursing homes payments Louisiana Medicaid paid other long-term care expenses including approximately $350 million to Intermediate Care Facilities for the Mentally Retarded, or ICF-MR facilities. It is not clear whether these funds are included in the 86% total quoted in The Times Picayune article. <http://www.dhh.state.la.us/PDF/Medicaid_99_00.htm>

[19] Pandya.

[20] Walsh, Bill. "Ruling puts pressure on institutions."

Figure 3.



Source: HCFA

In 1995, 85% of all money spent by Medicaid on dually eligible people went to pay for their nursing home care.

$1 billion by the 74% national average lowers the theoretical Louisiana nursing home bill for housing our dually eligible citizens to *$740 million* — closer to the actual bill.

In addition to this top-down approach to estimating Louisiana Medicaid's dually eligible nursing home bill, this bill can be calculated by employing a bottom-up approach using Louisiana DHH's actual numbers. For dually eligible people with both Medicare and Medicaid benefits, Medicare is always the "first payer" for medical providers. The only portion of dually eligible people's medical bills, which Medicaid pays to medical providers are the crossover payments, which include the annual $100 Medicare deductible and 20% coinsurance. Medicaid crossover payments have two components. One part is "mandatory," which Louisiana Medicaid continues to pay, and the second part is "discretionary," which Louisiana Medicaid eliminated in 2000.

Mandatory crossover payments are usually paid at the beginning of each year, before a dually eligible person's Medicare deductible has been met. If the deductible has not been satisfied and Medicare pays the provider little or nothing, then Medicaid pays the patient's medical claim at the usually lower Medicaid rate. This is a mandatory crossover payment that Medicaid cannot legally avoid. The Balanced Budget Act of 1997, however, stated that any payment above this usually low Medicaid rate was discretionary, and could be withheld at the state's discretion. For example, assume the Medicare allowed amount for a provider service is $80, and the Medicaid allowed amount for the same service is only $30. At the beginning of each year, with the Medicare deductible not yet met, Medicare will pay the provider zero. The medical service claim is then automatically crossed-over to Medicaid, which will pay the provider the Medicaid allowed amount of $30. This $30 Medicaid crossover payment is mandatory, and cannot be avoided. The remaining $50, however, is discretionary, and can be legally eliminated at a state's discretion. It is this discretionary crossover payment, along with the 20% coinsurance for the rest of the year, which Louisiana eliminated in 2000.

States that have a relatively low Medicaid payment schedule in comparison to the Medicare payment schedule will have a lower mandatory crossover total and a higher discretionary crossover total. Conversely, states with a relatively high Medicaid payment schedule will have a higher mandatory crossover total and a lower discretionary crossover total.

Although Louisiana DHH eliminated all discretionary crossover payments which were above the Medicaid rate — in the amount of $24 million — Louisiana DHH continues to pay mandatory crossover payments. According to Charles Castille, Undersecretary, Office of Management and Finance, Louisiana DHH, in state fiscal year 2001 (the first full year wherein discretionary crossovers were eliminated) Louisiana DHH continued to pay $9.94 million in mandatory professional crossover claims.[21] Combining the mandatory and discretionary physician crossover totals demonstrates the total Louisiana Medicaid physician crossover bill is approximately $34 million.

[21] Castille, Charles. Letter to the author. 20 December 2002.

According to HCFA only 4% of all national Medicaid money spent on dually eligible people's care went to their medical providers. If this physician crossover total of $34 million represents 4%, or one-twenty-fifth of all Louisiana Medicaid money spent on dually eligible people, then multiplying this $34 million by 25 reveals that the *total* amount Louisiana Medicaid spends on the dually eligible population is $850 million. Multiplying this $850 million by HCFA's national 85% dually eligible nursing home percentage shows that *$723 million* is the amount of money Louisiana Medicaid theoretically spends on housing dually eligible people in our state's nursing facilities. Using Louisiana DHH's actual numbers along with HCFA's national average allows an estimate that is close to the $740 million derived by using the top-down approach.[•••]

Whether Louisiana Medicaid's actual bill to house dually eligible people in expensive nursing homes is $504 million, $740 million, or closer to the national average of $1 billion is a moot point. The most important fact is that the *majority* of the $504 million (plus the recent $27 million raise) Louisiana Medicaid gives to nursing homes goes to care for dually eligible people.

[•••] Henceforth the term crossover payments will refer only to the $24 million discretionary crossover payments which Louisiana DHH essentially eliminated in 2000. It is the elimination of these discretionary crossover payments, which has led to decreased medical access for Louisiana's dually eligible people.

THE MEDICARE-MEDICAID PAYMENT SEESAW AND OUR NURSING HOME BUDGET

According to the Louisiana Register, eliminating crossover payments for dually eligible persons was estimated to save $23.5 million in its first year. Because the federal government contributes 70% of Louisiana Medicaid funds, the Louisiana treasury was estimated to save almost $7 million of this $23.5 million, and the federal government would save the remaining $16.5 million.[22]

This $23.5 million is only a small fraction of the actual cost of caring for dually eligible people. Because mostly Medicaid-sponsored dually eligible people populate our nursing homes, the actual amount of money spent on dually eligible people in Louisiana is closer to *a half a billion* dollars. This money represents approximately 3% of the *entire* $16.3 billion Louisiana State budget for fiscal year 2002/2003.[23]

The Louisiana nursing home budget is both over-budgeted and poorly utilized. According to David Hood, Secretary of Louisiana DHH,

> The current state of long-term care in Louisiana revolves around nursing homes. . . . to almost the near exclusion of other options. . . . '*Louisiana has a very high public demand on long-term care services. The state has the second highest number of nursing home beds per 1000 age 85+ in the nation; however, nursing home occupancy levels and resident acuity levels* [the amount of medical care a nursing home resident requires] *are both very low*.' . . . In Louisiana, older residents who might only need intermediate care have few options other than admission to a nursing home.

This huge nursing home budget is particularly onerous for a poor state like Louisiana. Mr. Hood continued:

> In the Medicaid program, nursing home expenditures account for nearly $500 million yearly. . . . [F]or years this consumed the greatest portion of all Medicaid spending in Louisiana. . . .
>
> Louisiana spent $109 per capita on nursing home expenditures versus only $1.33 per capita on community-based services. . . . Because of this over-reliance on nursing home care, there is an oversupply of nursing home beds while there are people who must wait years for community-based services.

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[22] Louisiana. Office of the State Register. Louisiana Register. "Notice of Intent. Professional Services—Medicare Part B Claims." Baton Rouge: Vol. 26. May 20, 2000. 1156-57.

[23] Louisiana. House of Representatives. Fiscal Division. Fiscal Year 2002-2003. Fast Facts and Talking Points. Baton Rouge: 8 July 2002. 25. 21 Sep. 2002 <http://house.legis.state.la.us/housefiscal/2002FastFacts/2002FastFasts.pdf>.

> The challenge for Louisiana . . . is to . . . get ready quick, in order to meet the needs of our aging citizens. . . . The Supreme Court's *Olmstead* decision has motivated states to make community-based services not only a choice, but a reality."[24]

Because nursing homes are very expensive, underutilized, and consume such a large portion of Louisiana's Medicaid budget, this nursing home budget is where most Medicaid savings can be realized. Cutting down this enormous half a billion-dollar expense by *only 5%* would more than pay for the complete restoration of crossover payments for Louisiana's dually eligible population, which DHH eliminated in 2000.

Medicare and Medicaid pay for most of the healthcare expenses for elderly and disabled dually eligible citizens. In addition to paying all of the costs of Medicare, the federal government also pays more than one-half of all national Medicaid expenses. The federal government, therefore, pays about three-quarters of all Medicare and Medicaid expenses combined. It is the remaining one-quarter of healthcare expenses that each state and its Medicaid department struggle to protect.

In general, Medicare provides coverage for *acute medical care* in the community — in the physician's office, in the hospital, and through home health. Only a small percentage of Medicare dollars is spent for long-term or nursing home care. Medicaid, on the other hand, pays a smaller amount for acute medical care, but pays the bulk of *chronic long-term care* nursing home expenses. Medicaid spends approximately one-third of its entire national budget on the relatively small dually eligible population. And in 1995, 85% of all money spent by Medicaid on dually eligible persons went to pay for their nursing home care, which included non-medical custodial services such as room and board expenses, and assistance in their activities of daily living.[25]

Because the Medicare and Medicaid programs have different missions and different funding mechanisms, the most important thing Louisiana can do to decrease the amount of money leaving its treasury is to *maximize* the amount of money spent by Medicare in the physician's office, hospital and through home health, while at the same time *minimizing* the amount of money spent by Medicaid in the long-term nursing care facility. In other words, keep people in the *Medicare-sponsored* community and out of *Medicaid-sponsored* nursing homes.

Why is this so, and how can we accomplish this? Figure 4 demonstrates that the Medicare and Medicaid programs sit on a seesaw. On the left-hand side of the seesaw is the Medicare program with the three main services that it pays for: physician office services, hospital services, and home health services. On the right-hand side of the

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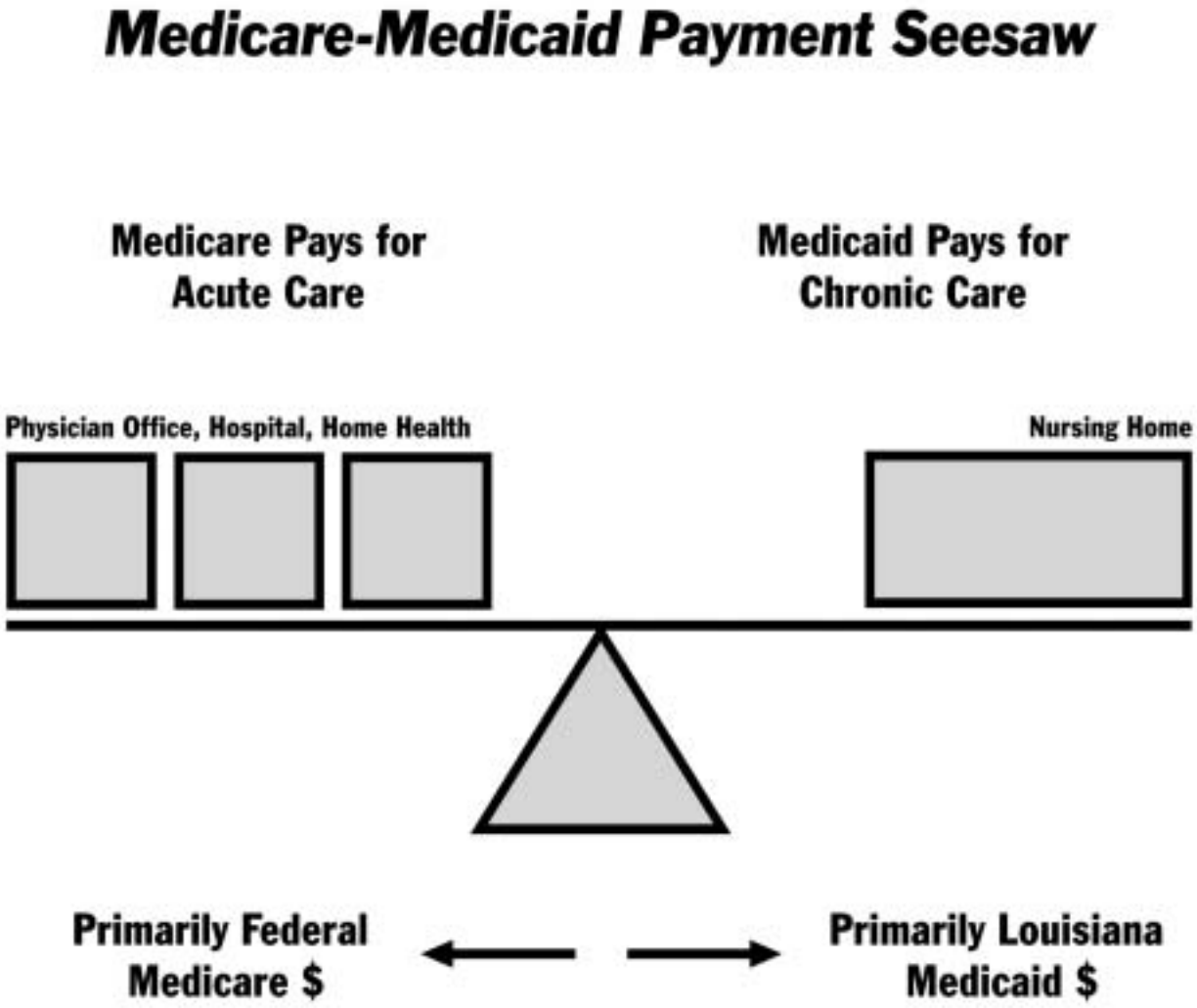
[24] Hood, David. Caring for Our Aging Citizens: The Louisiana Perspective. US Cong. Senate. Special Committee on Aging. July 18, 2001.

[25] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

Figure 4.


Medicare-Medicaid Payment Seesaw
Medicare Pays for Acute Care
Medicaid Pays for Chronic Care
Physician Office, Hospital, Home Health
Nursing Home
Primarily Federal Medicare $
Primarily Louisiana Medicaid $

seesaw is the Medicaid program with its main service of nursing home payments. According to HCFA's Health and Health Care of the Medicare Population, for dually eligible people Medicare pays approximately 80% of all government-funded medical services on the left-hand or *community care* side of the seesaw, and Medicaid pays approximately 80% of all medical services on the right-hand or *nursing home* side of the seesaw.[26]

For every $100 of Medicare and Medicaid money spent on dually eligible people in the physician's office, hospital and through home health, approximately $80 is spent by Medicare, and the remaining $20 is spent by Medicaid. Because Medicaid is a joint federal-state program, Louisiana pays only 30% of its own Medicaid healthcare bills. Therefore, of this remaining $20 Medicaid office/hospital/home health expense, Louisiana only has to spend 30% of $20, or $6 of its own money to pay for its share of these expenses. This $6 Louisiana treasury share pays for all Medicare and Medicaid services for dually eligible people in Louisiana performed in the office/hospital/home health venues, which appear on the left-hand side of the seesaw.

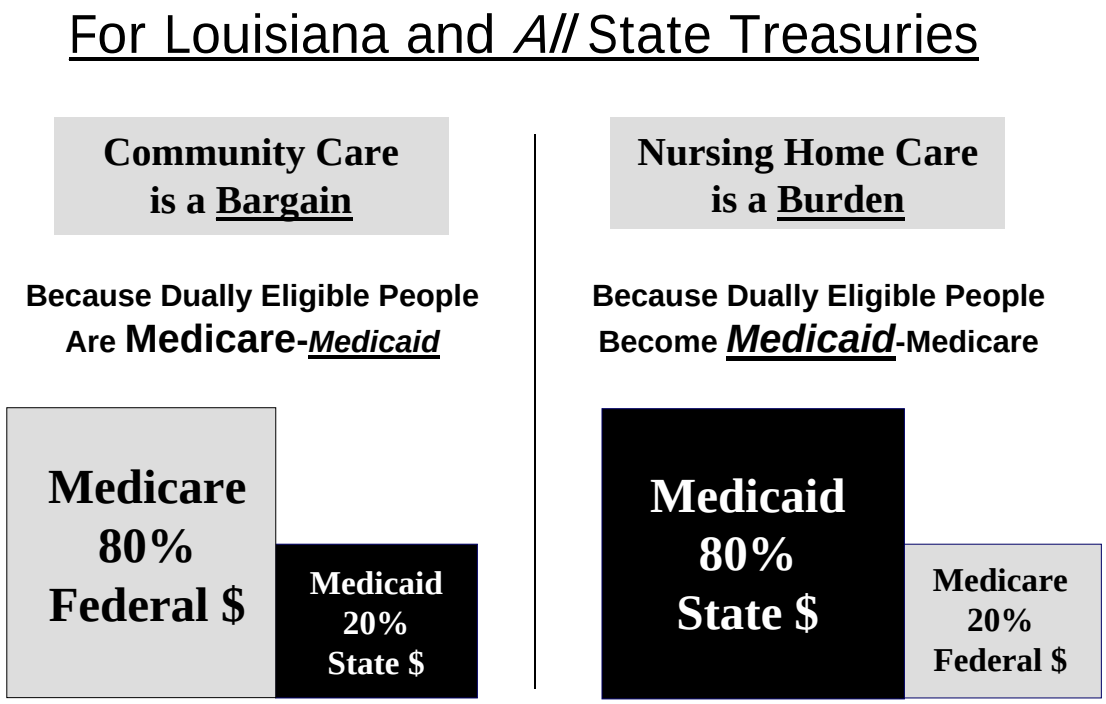
Contrast this with $100 spent on nursing home services, which appear on the right-hand side of the seesaw. Here Medicare pays only 20%, leaving Medicaid to pay 80%, which is the bulk of the cost. Even with the 70/30 federal-state match, Louisiana still has to pay 30% of the entire expense. The result is that 30% of $80 equals $24. Here we see the negative effect nursing homes have on our Medicaid budget. For every $100 of healthcare bills spent on its citizens in the office/hospital/home health arena, the Louisiana treasury only has to pay $6 of its own money. But for every $100 of healthcare expenses spent on its citizens in the nursing home arena, the Louisiana treasury has to pay $24 of its own money, or *four times* the amount.

The reason nursing home payments are harmful to our state budget (in addition to there being so many nursing home residents) is that a significant portion of each dollar spent in the nursing home is *local Louisiana money,* as opposed to the money spent in the office/hospital/home health arena where the majority of the money is *someone else's money* (i.e., the federal government's money). For Louisiana Medicaid, community care for dually eligible people is a *bargain*, while nursing home care for dually eligible people is a *burden*. In the community dually eligible people are *Medicare*-Medicaid people with *Medicare paying 80%* of the bill. In the nursing home dually eligible people are essentially *Medicaid*-Medicare people with *Medicaid paying 80%* of the bill. (See Figure 5.)

Therefore, the financial key for Louisiana is to keep as many people as possible on the office/hospital/home health side of the seesaw to maximize Medicare's federal payment dollars, and as few people as possible on the nursing home side of the seesaw to

[26] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

Figure 5.



For Louisiana Medicaid, community care for dually eligible people is a bargain because *Medicare pays 80%* of the bill with federal dollars, but nursing home care for dually eligible people is a burden because *Louisiana Medicaid pays 80%* of the bill using Louisiana treasury dollars.

minimize Medicaid's state payment dollars. Louisiana can do this, but in order to be successful, Louisiana must enlist the aid of its physician base.

The physician is the medical service "gatekeeper" and patient advocate *par excellence.* Figure 6 shows the effect of physician services on the Medicare-Medicaid Payment Seesaw. The single purpose of the physician has always been to help keep patients as functional as possible, living in the community, and out of nursing homes. Therefore, physicians will always strive to push the seesaw down to the left. This helps keep patients on the office/hospital/home health-Medicare side on the left and away from the nursing home-Medicaid side of the seesaw on the right. In addition to being medically and ethically correct, using the physician as gatekeeper to keep people in the community on the Medicare-payment side of the seesaw has the added bonus of keeping people out of the nursing home, thereby lowering the Medicaid bill for Louisiana.

Figure 6 shows that by allowing physicians to keep people in the community the seesaw is weighted down on the Medicare-payment side, resulting in a net saving for the Louisiana Medicaid program. At the bottom of Figure 6 is what I refer to as the "Louisiana Scorecard." By enlisting physicians to keep people out of nursing homes, the patients and their families are pleased, the physicians are pleased, and the Louisiana treasury is pleased. In order to obtain this result, however, Louisiana must be certain that physicians are adequately reimbursed to fulfill their patient advocate-gatekeeper role.

This situation contrasts with the situation in Figure 7. This graphic represents the current state of affairs after Louisiana eliminated Medicare-Medicaid crossover payments for dually eligible people and imposed its "geriatric penalty" on the very same group of physicians it needs to make this money-saving model work. (See Part 1, "Second-Class Medicare.") In Figure 7, there is no physician counterweight on the left-hand Medicare side of the seesaw. Without the physicians' care and attention, the frail, vulnerable, dually eligible patients are left without their best patient advocate.

Since I (or any other physician) have been forced to decrease my geriatric (i.e., dually eligible) office practice by 10% and have been forced to stop making home visits to these frail patients, dually eligible patients have less access to timely medical care. I have, in effect, stepped off the office/hospital/home health side of the seesaw. The result is that dually eligible patients, whom I would have previously been happy to accept into my practice in year 1999 in Figure 6, have now shifted, in year 2001, to Figure 7. Because they have less medical access, these patients now have to wait for medical care until they become sicker and more vulnerable to nursing home placement. In this instance the seesaw has tilted to the right-hand, Medicaid-nursing home side, causing added expense to Louisiana and extra suffering for its dually eligible citizens.

Louisiana's geriatric penalty on the oldest, poorest and sickest patients in our state has pushed me off the office/hospital/home health side of the seesaw, thereby allowing the scale to tip over to the nursing home side. The bottom of Figure 7 shows the revised Louisiana Scorecard. By imposing this geriatric penalty on dually eligible patients and their physicians, Louisiana has decreased medical access for our most

Figure 6.

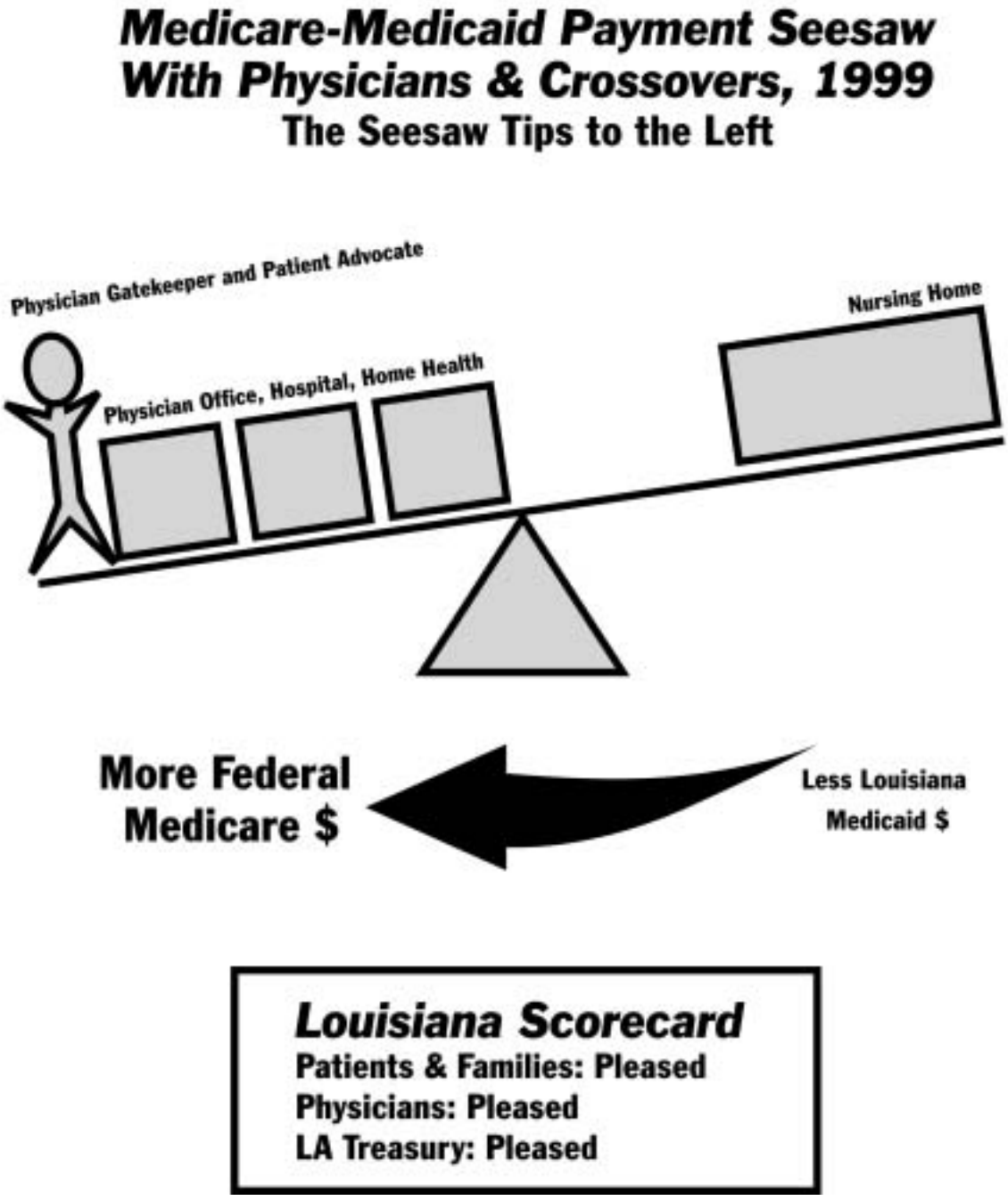
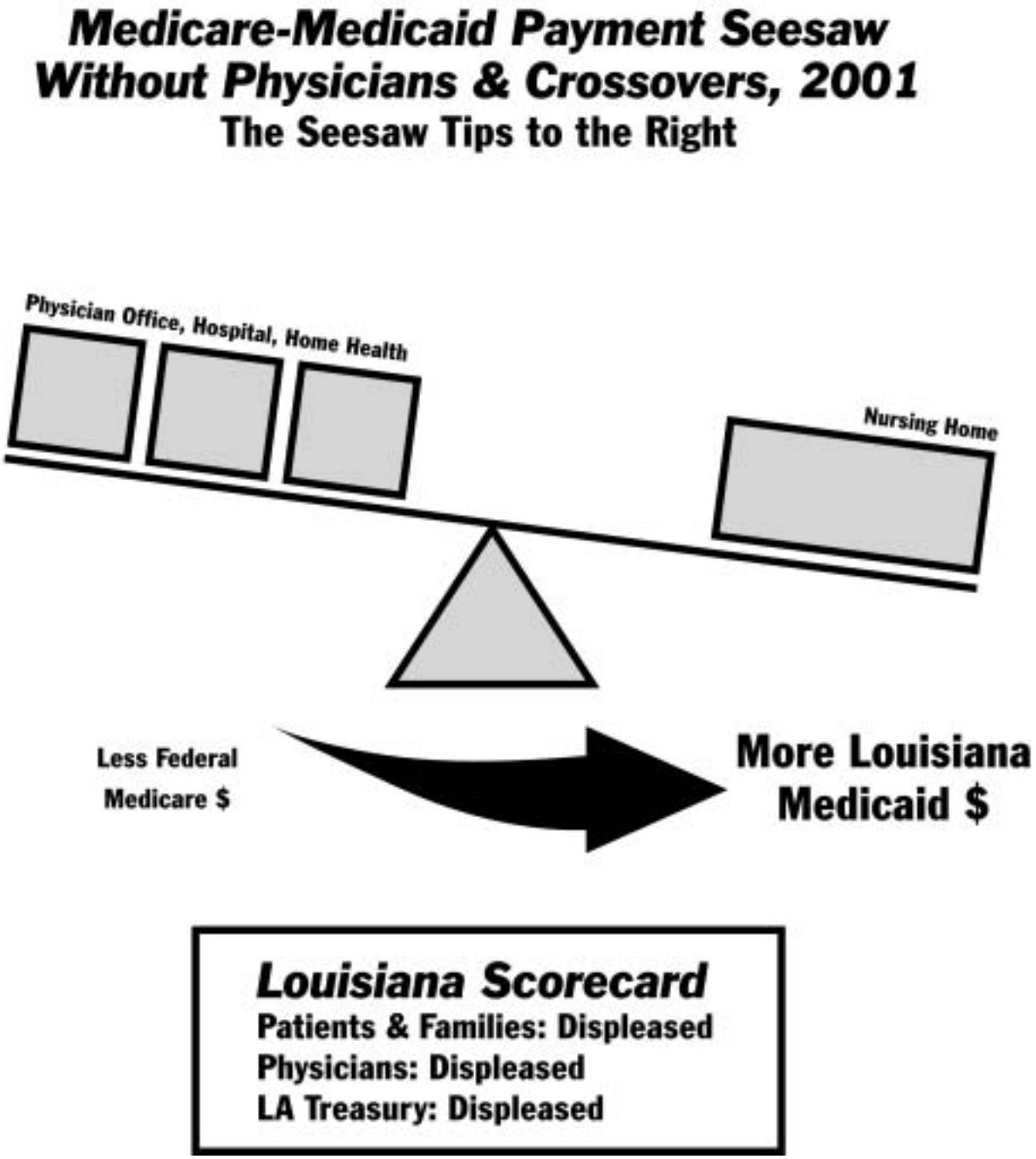

Medicare-Medicaid Payment Seesaw
With Physicians & Crossovers, 1999
The Seesaw Tips to the Left
Physician Gatekeeper and Patient Advocate
Physician Office, Hospital, Home Health
Nursing Home
More Federal
Medicare $
Less Louisiana
Medicaid $
Louisiana Scorecard
Patients & Families: Pleased
Physicians: Pleased
LA Treasury: Pleased

Figure 7.


Medicare-Medicaid Payment Seesaw
Without Physicians & Crossovers, 2001
The Seesaw Tips to the Right
Physician Office, Hospital, Home Health
Nursing Home
Less Federal
Medicare $
More Louisiana
Medicaid $
Louisiana Scorecard
Patients & Families: Displeased
Physicians: Displeased
LA Treasury: Displeased

vulnerable, dually eligible citizens. Now, the patients and their families are displeased, the physicians are displeased, and the Louisiana treasury is displeased.

The dually eligible population is the most likely group to be admitted to a nursing home. If only 5% of Louisiana's nursing home budget can be trimmed by providing timely medical care to this population, the entire $23.5 million crossover budget could be fully restored. If each Louisiana physician was allowed to do his or her work unfettered by this discriminatory geriatric penalty on dually eligible patients, this amount of savings from the half a billion-dollar nursing home budget could be realized.

GIVING NURSING HOMES A $27 MILLION RAISE SUBSIDIZES AN INDUSTRY IN RETREAT

According to The Times-Picayune, Louisiana recently approved a tax on nursing home residents that would provide a $27 million "cost-of-living increase to nursing home operators." Patricia DeMichele, state director of AARP said, "Louisiana has one of the lowest [nursing home] occupancy rates in the nation, about 80%." Ms. DeMichele added, "Louisiana needs to be wary that any increase in financing for nursing homes [does not] help subsidize about 6,000 empty nursing home beds in the state."[27]

This $27 million nursing home raise for the predominantly dually eligible population is essentially the same $24 million (plus an additional $3 million) that Louisiana DHH removed from the physicians' program in 2000 when DHH eliminated crossover payments for dually eligible people. This is the opposite strategy DHH should be taking with respect to dually eligible people. As previously seen, by eliminating the $24 million crossover program from the Medicare office/hospital/home health side of the Medicare-Medicaid Payment Seesaw Louisiana DHH is decreasing access to community care for these elderly, frail, dually eligible people and tipping the seesaw over to the right-hand, Medicaid-nursing home side.

By eliminating crossover payments DHH has eliminated payment for the Medicare deductible and 20% coinsurance. Therefore, for the first part of each year these patients' insurance reimbursement will be equal to the lower Medicaid payment schedule until their medical bills reach the $100 Medicare deductible level. The beginning of each calendar year is a financially difficult time for physicians treating these patients because Louisiana has effectively turned all of these Medicare patients into Medicaid patients. (For a discussion of crossover payments see the chapter in Part 1 titled, "'Second-Class Medicare': How Do Medicare-Medicaid 'Crossovers' Work?")

Turning dually eligible Medicare patients into Medicaid patients means that at the beginning of each year these patients may experience the same difficulty obtaining access to health care as Medicaid-only patients, because many physicians find the Medicaid payment schedule inadequate and do not actively participate in the Medicaid program. Although 99% of Louisiana physicians accept Medicare patients and Medicare fee assignment,[28] a much smaller number of physicians accept Medicaid patients and Medicaid fees. The Times-Picayune reported that a study by the Louisiana Hospital Association demonstrated "less than 10% of Louisiana doctors actively participate in the [Medicaid] program."[29]

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[27] Ritea, Steve. "Tax boost hits some in nursing homes." The Times-Picayune [New Orleans] 10 Aug 2002: A4.

[28] Kaiser Family Foundation. State Health Facts Online: Louisiana: Medicare Assignment Rates for Physician Services, 1998. 5 May 2002 <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Louisiana&category=Medicare&subcategory=Medicare+Access+to+Services&topic=Medicare+Assignment+Rates>.

[29] Anderson, Ed. "Sales tax losing temporary status." The Times-Picayune [New Orleans] 17 Nov. 2001: A4.

Louisiana DHH compounded the harmful physician crossover elimination by placing this "new" $27 million raise squarely on the Medicaid-nursing home side of the seesaw, thus enabling more dually eligible people to be housed in expensive nursing homes. By transferring millions of dollars from the physicians' program to the nursing home industry DHH continues to subsidize an industry in retreat.

Although the number of frail, elderly patients is increasing at almost three times the rate of our national population, the number of people requiring care in a nursing home continues to *decline*. According to the Census Bureau, while our nation's total population rose only 13% during the 1990s, the "number of Americans older than 85 surged 37%." Despite this marked increase in this "old-old" group, because of "investments in medical care and treatment" 400,000 *fewer* people across the country needed care in a nursing home, which saved "$19 billion last year . . . at an average annual cost of $47,000" per nursing home resident.[30]

The result of this decline in the use of nursing homes is that 20% of all nursing home beds in Louisiana are empty. With the U.S. Supreme Court's 1999 *Olmstead* ruling mandating more community-based and home care services be made available for the elderly and the disabled, the percentage of empty beds in Louisiana's nursing homes will only rise further. Although the nursing home industry may insist this new $27 million will be used to improve patient care, as Patricia DeMichele pointed out, "there are no safeguards in state law to make sure that the increased state financing for nursing homes will translate into improved patient care."[31]

Realistically, nursing homes *must* use a portion of this money to subsidize the 20% of empty beds in Louisiana's nursing homes. The state nursing home industry has been slow to acknowledge that there has been a permanent change in their industry's infrastructure. With increased recognition of the need for more community-based and home-based long-term care, the nursing homes' 20% empty bed rate will climb higher unless there is consolidation in the industry or nursing homes find some other way to occupy their empty beds.

If a nursing home owner operates a facility that can house 100 patients, and the owner can only fill 80 beds, then Louisiana Medicaid will pay the owner only enough money to care for the occupied 80 patient beds. Although the owner may insist that no Louisiana Medicaid money will be used to maintain the empty 20 beds, the total reimbursement received from Louisiana for patient care must pay for more than the custodial care, room and board, and nursing care of the 80 actual patients. The money must also be allocated to help pay for the facility's mortgage as well as the physical plant that was built for 100 patients, along with the extra janitorial service, insurance, maintenance, and utilities for the part of the nursing home that is empty. There will always be certain fixed nursing home infrastructure costs that must be paid, regardless of

[30] Rosenblatt, Robert. "We're getting older . . . and better, too." The Times-Picayune [New Orleans] 15 May 2001: A5.
[31] Ritea.

the number of beds that are actually occupied. The result is a diminishing amount of money that can be spent on good patient care for the remaining 80 patients.

The higher the empty bed rate climbs, the thinner this Louisiana Medicaid money will have to be spread. Giving the nursing home industry a "cost-of-living increase" at this time is simply a euphemism for this nursing home subsidization process.

Louisiana has historically preferred to place elderly and disabled persons in nursing homes rather than in community or home care. The Times-Picayune noted that while many states try to keep people in the community by investing in "at-home treatment and community services . . . Louisiana has continued to pour the bulk of its healthcare money into nursing homes and other facilities that segregate mentally and physically disabled people from the rest of society."[32]

According to The Times-Picayune, Senator John Breaux recently commented that Louisiana depends too heavily on nursing home care for its elderly citizens. Louisiana, he stated, ranks last in the nation in providing choices for the low-income elderly other than placing them in an institution when they become infirm and need help doing their day-to-day tasks.

At a Senate hearing, Vermont Governor Howard Dean testified that since Vermont decreased its reliance on nursing homes in 1996, the state's nursing home population decreased 18%. Vermont turned these savings into a community-based "menu of alternative-care options for elderly and disabled residents . . . . [which includes] an average of 30 hours per week of services including therapy, housekeeping, bill-paying and shopping." Each nursing home resident costs Vermont $48,000 per year, whereas community-based care costs less than $20,000 per patient, per year. Governor Dean said, "we can take care of much sicker people in their homes and it's cheaper than it would be in a nursing home."

Last year Louisiana spent almost $500 million to care for more than 25,000 — mostly dually eligible — nursing home residents. But it only "spent $6.3 million last year on two programs offering 694 seniors health-related services such as daycare, a personal-care attendant and help around the house."[33] Louisiana, therefore, spent $20,000 to care for each of the 25,000 persons living in nursing homes. However, it cost only $9,078 to care for each of the 694 seniors living in less restrictive home-based settings, which resulted in a savings of almost $11,000 for *each* of the home-based seniors.

In an article in The Times-Picayune, Senator Breaux suggested that Louisiana help pay the costs of assisted living services for low-income seniors who are "too frail to live by themselves but not sick enough to be confined in expensive nursing homes." Assisted living "provides seniors with basic services, such as cooking and bathing, while allowing them to live independently in private apartments." An assisted living advocate

[32] Walsh, Bill. "Ruling puts pressure on institutions."
[33] Walsh, Bill. "More choices urged in care for seniors."

said, "about 30% of residents in nursing homes are able-bodied enough to be in assisted living, if it were available." Thirty-eight states have received a waiver from the federal government to use Medicaid finances to subsidize assisted living for poor people because they believe it will help people and will be less expensive than a nursing home. However, "Louisiana has never applied for a waiver."[34]

In a recent editorial, The Times-Picayune encouraged the use of "less restrictive forms of long-term care." Elderly Louisiana citizens who are ill and have difficulty doing their household chores "shouldn't have to choose between giving up their freedom [in a nursing home, or] being abandoned." According to this editorial, one-fifth of Louisiana nursing home beds are empty and providing more community-based alternatives could decrease the occupancy rate further. "Given the possibility of saving money while giving more seniors the chance to live happily and freely, there is no excuse for slow progress."[35]

The State of Vermont was able to save more than half of the nursing home costs by providing 30 hours a week of social services and medical care to the elderly enrolled in its community care program, and was able to decrease its nursing home population by 18%. Similarly, a study of three other states — Colorado, Oregon, and Washington — which have used community-based alternatives to nursing homes, showed these states had 18% to 39% fewer nursing home residents, and "saved between 9% to 23% of the amount they would have spent on long-term care."[36]

If Louisiana could save $11,000 a year for each person cared for in a community setting, home-based setting, or assisted-living facility, the amount of savings would easily restore crossover payments for the dually eligible population. Moving people out of nursing homes and back into the community would also allow Louisiana to comply with the new realities of long-term care brought about by the Supreme Court's *Olmstead* ruling.

In 2001, Senator John Breaux criticized the nursing home industry for being slow to recognize that many elderly consumers want other long-term care options besides nursing home care, and has urged nursing homes to offer other types of community-based services. Senator Breaux continued, "I don't, for the life of me, understand why people in the nursing home industry don't wake up and realize that baby boomers don't want to be in an institutional setting."[37]

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[34] Walsh, Bill. "Breaux wants assisted living coverage." The Times-Picayune [New Orleans] 27 Apr. 2001: A5.

[35] "Options for older people." Editorial. The Times-Picayune [New Orleans] 22 July 2001: B6.

[36] Alecxih, Lisa Maria B., et al. Estimated cost savings from the use of home and community-based alternatives to nursing facility care in three states. AARP Public Policy Institute. Washington: Nov. 1996. Abstract. AARP AgeLine Database ID #9618 Dec. 1996. 9 Sept. 2001. <http://www.research.aarp.org/health/9618_savings.html>.

[37] Walsh, Bill. "More choices urged in care for seniors."

THE $27 MILLION NURSING HOME RAISE COULD HAVE PURCHASED $135 MILLION OF COMMUNITY SERVICES

Medicare has recognized that much of what we refer to as "care" in nursing homes is really custodial care and not medical care, and has refused to pay for room and board and activities of daily living services for dually eligible people who live in nursing homes and yet have few acute medical needs. According to Medicare's philosophy, each state has a responsibility to encourage its citizens to live in their own communities. If a state cannot or will not adopt policies to encourage the use of community facilities — such as the physician's office, hospital, and home health — and instead substitutes the use of expensive nursing homes, then the state must pay for that choice by itself, using money that comes out of its own pocket.

Recall that Medicare pays approximately four times as much money for medical care in the community than Medicaid does. This is similar to Medicare paying 80% of its "allowed charge" for physician services, and Medicaid being responsible for only the remaining 20% coinsurance. Because of this very advantageous ratio, Louisiana DHH could have used the recent $27 million nursing home subsidy to much better financial advantage if it spent the $27 million on *community* services, as opposed to nursing home services.

Since Medicaid only pays 20% of a dually eligible person's community healthcare bill and Medicare pays 80%, multiplying the $27 million — the *Medicaid 20%* — by five, shows this $27 million nursing home raise could have helped purchase approximately $135 million of *Medicare-sponsored* healthcare services in the physician's office, in the hospital or through home health, using the federal government's money. By encouraging the use of community medical care services, Louisiana could have leveraged this $27 million nursing home subsidy and brought an additional *$108 million federal* dollars into Louisiana to help pay for our dually eligible patients' community health care.

Conversely, since Medicaid pays 80% of a dually eligible person's nursing home bill and Medicare pays only 20%, dividing the $27 million Medicaid nursing home raise by 80% will reveal the much smaller amount of federal dollars that Medicare will now invest in Louisiana and the nursing home care of its dually eligible citizens. Dividing this $27 million nursing home raise by 0.80 reveals that this $27 million has only helped purchase a total of $34 million of nursing home services in the *Medicaid-sponsored* nursing home. Subtracting the original $27 million Louisiana portion from the $34 million total leaves the smaller sum of $7 million — the *Medicare 20%* — which is the amount of federal dollars that will now flow into Louisiana as a result of DHH giving the $27 million subsidy to the nursing home industry.

Subtracting the actual $7 million Medicare investment Louisiana *will* receive from the $108 million Medicare investment Louisiana *could have* received, shows that DHH lost the chance to bring an additional $101 million of federal healthcare funding into our state by encouraging dually eligible people to live in nursing homes instead of in their own communities. It is disheartening to realize that instead of the *federal*

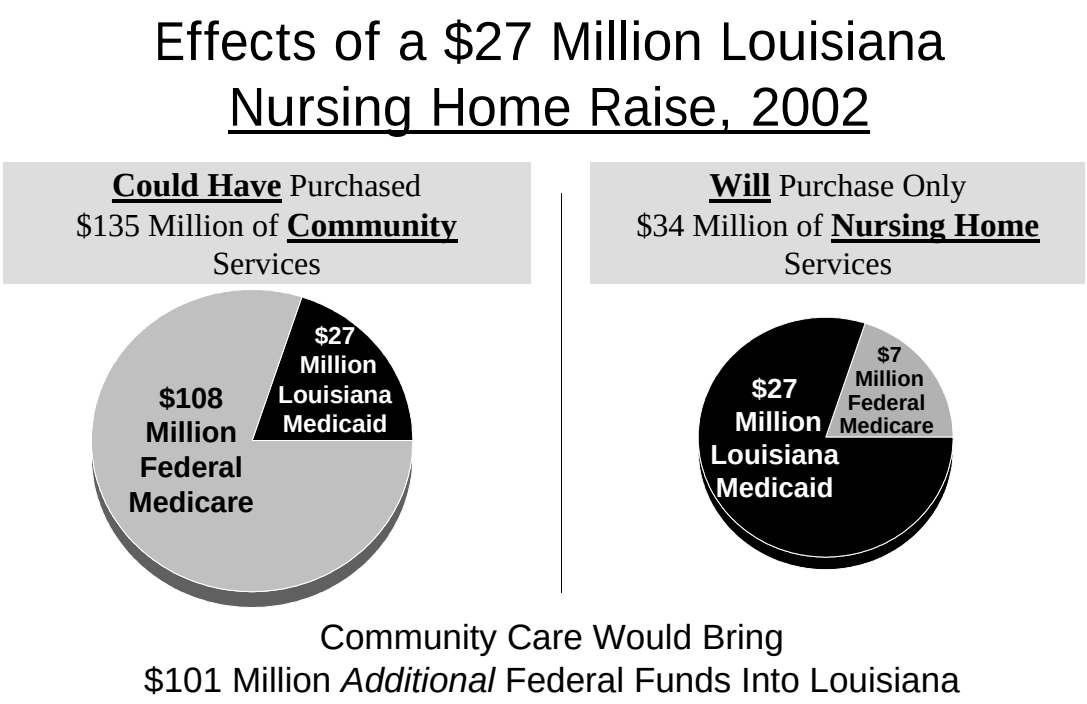
government paying for the majority of the $135 million community care bill, most of the actual $34 million nursing home bill must now be paid with money that comes directly out of the *Louisiana treasury*. (See Figure 8.)

A state cannot keep its citizens in the community and out of a nursing home by taking away money from programs that provide access to medical care by a physician and giving this money to improve access to a nursing home. Physicians are needed to help our elderly and disabled citizens "age in place" in their own home, and not in an expensive nursing home. But in 1995, Medicaid spent 85% of its dually eligible money to pay for their nursing home care, and only 4% of its dually eligible money to pay physicians who actually treat these frail, elderly and disabled people.[38] Transferring money out of the already small (4%) Medicaid physician program, and into the already large (85%) Medicaid nursing home program makes little sense — and results in decreased access to primary care physicians, increased use of nursing homes, and costs the Louisiana treasury a great deal of money.

Even if Medicare paid Louisiana exactly the same $101 million bonus to care for dually eligible people in the nursing home as it does in the community model, caring for our frail, elderly and disabled citizens in the community would still be a far better choice. It is better to invest this extra $101 million to pay for the services of the additional nurses, doctors, physical therapists, social workers, and nurse's aides along with others, who will be needed to care for these community residents in their homes. It is better to invest this $101 million to help build ramps to patients' homes, provide wheelchairs for those elderly and disabled people who are crippled by arthritis, provide meals on wheels for dually eligible people who can no longer cook or shop by themselves, and to provide better transportation for the frail elderly who can no longer ride public transportation to get to the physician's office. It is better to invest this $101 million to help provide prescription drug coverage for low-income seniors. It is better to invest this $101 million to strengthen our hospitals and home health agencies so they can provide proper services for our growing dually eligible population. It is better to financially encourage our community's many civic organizations to help a burgeoning elderly and disabled population live in their own communities. It is better to invest this $101 million to educate and train more geriatricians, and geriatric psychiatrists and nurses who will specialize in caring for this frail group of people living in our communities. And, it is better to invest this $101 million to help the families of these elderly and disabled people care for their relatives in the comfort of their own homes. Therefore, even if the money were equal, community care would still be a better choice for the waning years of many of Louisiana's and the nation's dually eligible people.

[38] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

Figure 8.



Multiplying the $27 million nursing home raise by five demonstrates this money could have helped purchase $135 million of community services — $108 million of this money would have come from the federal government. Dividing the $27 million nursing home raise by 0.80 demonstrates this money will now purchase only $34 million of nursing home services — $27 million of this money will come from Louisiana Medicaid.

DUALLY ELIGIBLE PEOPLE HAVE A $34 BILLION NATIONAL MEDICAID NURSING HOME BILL

In April 2000, the Congressional Budget Office (CBO) published an analysis of President Clinton's proposed healthcare budget and health insurance proposals for year 2001. According to the CBO the President's proposals declared:

> After Social Security, Medicare and Medicaid are the largest federal entitlement programs. . . . This fiscal year, Medicaid will spend about $115 billion on health care for 43 million low-income people . . . . And Medicare will pay for the health care of some 39 million elderly and disabled people at a gross cost of about $221 billion. . . . Together, these [programs, in addition to the $2 billion SCHIP program for uninsured children,] . . . will account for about 18% of federal outlays in 2000.
>
> CBO estimates that total Medicaid enrollment will rise from 43 million in 2000 to almost 51 million by 2010. . . . Between 2010 and 2030, the elderly population will increase at a rate three times faster than between 2000 and 2010.[39]

Senator Breaux stated that dually eligible people consume 35% of our national Medicaid budget. Multiplying this 35% dually eligible share of the national Medicaid budget by the President's estimated national Medicaid budget for 2001 of $115 billion, shows that $40.25 billion of our national Medicaid budget would be spent on the relatively small dually eligible population.

HCFA stated that 85% of all national Medicaid money spent on dually eligible people went to pay for their nursing home care. Multiplying the $40.25 billion by 85% shows that dually eligible people have a national Medicaid nursing home bill of more than *$34 billion* each year. The CBO also pointed out that total Medicaid enrollment, as well as the total elderly population will experience rapid growth in the near future.

In 2000, HCFA stated, "In 1998, Medicaid spent $44 billion on institutional long-term care services. The vast majority, 77.7 percent [or $34 billion], of these funds went to nursing homes . . . ."[40] Since the vast majority of Medicaid beneficiaries living in nursing homes are dually eligible people, this HCFA statement confirms the $34 billion dually eligible nursing home bill calculated above.

As a rule of thumb, multiplying Senator Breaux's dually eligible percentage of 35% by HCFA's dually eligible nursing home percentage of 85% equals 30% — which is

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[39] United States. CBO. An Analysis of the President's Budgetary Proposals for Fiscal Year 2001. The President's Health Insurance Proposals. Washington: April 2000. <http://www.cbo.gov/showdoc.cfm?index=1908&sequence=3&from=5>.

[40] United States. Dept. of Health and Human Services. HCFA. A Profile of Medicaid. Chartbook 2000. Washington: Sep. 2000. 18 Jan. 2003 <http://www.cms.hhs.gov/charts/medicaid/2tchartbk.pdf>.

the percentage of *any* state or federal Medicaid budget that is theoretically spent on nursing home payments for dually eligible people. (See Figure 9.)

The national Medicaid budget of $115 billion, plus the national Medicare budget of $221 billion, plus the national SCHIP budget of $2 billion, equals a total budget of $338 billion for these three national healthcare programs. According to CBO estimates, this $338 billion total "accounts for about 18% of federal outlays in 2000." Dividing the national Medicaid dually eligible nursing home bill of $34 billion into this $338 billion healthcare budget shows that *10%* of all national Medicare, Medicaid and SCHIP payments is spent by Medicaid to house the relatively small dually eligible population in our nation's nursing homes.

The $338 billion Medicare, Medicaid, SCHIP healthcare budget "accounts for about 18% of federal outlays in 2000." Multiplying this "18% of federal outlays" by 10% shows that the $34 billion Medicaid dually eligible nursing home bill equals *1.8% of total federal outlays* in 2000. It is astounding to discover that 1.8% of the total federal budget in year 2000 was spent by Medicaid to keep only 17% of the Medicare and Medicaid population — the dually eligible population — in expensive nursing homes across the country.

According to HCFA in 1995, approximately 5% of the Medicare population lived in a long-term care facility full-time, at a total cost of $79.1 billion. Only 22% of these long-term care expenses were for *medical* services. Approximately $62 billion or 78% of this amount went to pay for *custodial services* such as "room [and] board and non-medical care services such as assistance in daily activities like eating, dressing, toileting, and bathing."[41]

Medicaid probably spends *more* than 78% of its long-term care funds on custodial services because Medicare continues to pay for medical services for dually eligible people while they reside in a long-term care facility, thereby allowing Medicaid to use a larger percentage of its money for custodial services. Multiplying the $500 million Louisiana Medicaid nursing home bill by this conservative estimate of 78% shows that each year at least $390 million of Louisiana Medicaid money is spent solely on custodial care for our state's nursing home population — most of whom are dually eligible people. This represents at least 2.4% of the *entire* Louisiana State budget.

Also, multiplying the $34 billion national Medicaid nursing home bill for dually eligible people by 78% shows that each year at least $27 billion of national Medicaid money is spent solely on custodial care for dually eligible people in nursing homes. Similarly, multiplying the 1.8% of the total federal budget, which Medicaid paid to house dually eligible people in expensive nursing homes, by the conservative estimate of 78% shows that 1.4% of the *total* federal budget in year 2000 was spent by Medicaid on room and board, and other custodial services for dually eligible people who live in our nation's nursing homes. (See Figure 10.)

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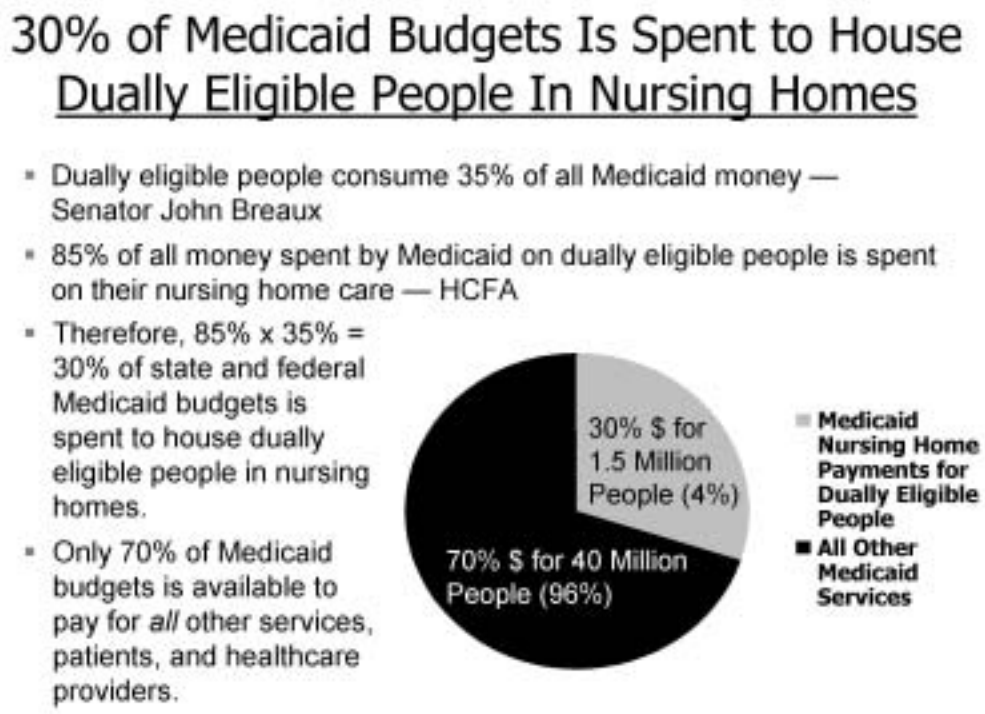
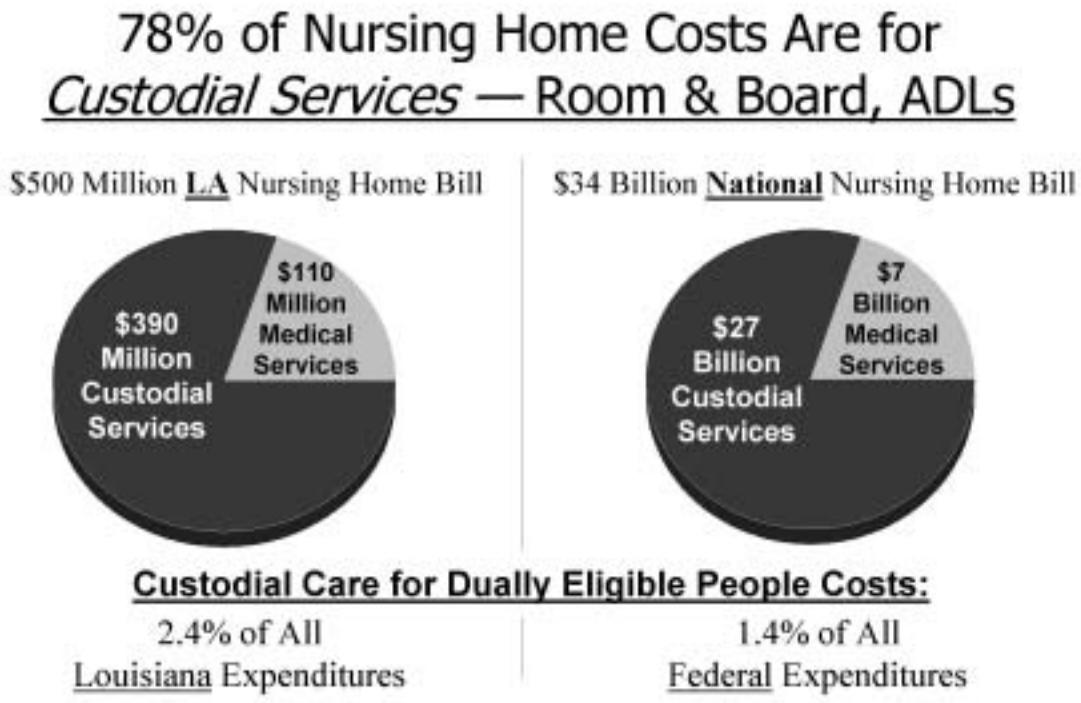
[41] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population

Figure 9.



Payments to nursing homes to care for 1.5 million dually eligible people (4% of the Medicaid population) consume 30% of Medicaid budgets. The remaining 70% of Medicaid budgets must care for the remaining 40 million Medicaid beneficiaries (96% of the Medicaid population.)

Figure 10.



Only 22% of long-term care expenses were for medical services. Approximately 78% of long-term care expenses went to pay for custodial services such as room and board and non-medical services such as assistance in daily activities.

Each year $390 million of Louisiana Medicaid money or 2.4% of the entire Louisiana State budget is spent solely on custodial care for Louisiana's nursing home population — most of whom are dually eligible people.

Each year $27 billion of national Medicaid money or 1.4% of the total federal budget in year 2000 is spent solely on custodial care for dually eligible people in nursing homes.

SUMMARY

1. Dually eligible people with Medicare and Medicaid are the oldest, poorest, sickest, and most disabled group of people in our country. These people live with the greatest risk of becoming ill and requiring long-term nursing home care.

2. The majority of people who live in nursing homes both at the state and national levels are dually eligible people.

3. Medicaid pays the majority of nursing home bills for nursing home residents in Louisiana and across the nation because most of these residents are dually eligible people.

4. The majority of the $500 million (plus the recent $27 million raise) Louisiana Medicaid pays to nursing homes every year goes to care for dually eligible people.

5. For Louisiana Medicaid, community care for dually eligible people is a *bargain*, while nursing home care for dually eligible people is a *burden*. Medicare pays 80% of the community healthcare bill in the physician's office, hospital, and through home health, whereas Medicaid pays 80% of the nursing home bill. In order to save state treasury money, Louisiana must keep dually eligible patients on the *Medicare-sponsored* office/hospital/home health side of the Medicare-Medicaid Payment Seesaw, and away from the *Medicaid-sponsored* nursing home side of the Seesaw. (See Figures 4 through 7.)

6. The $27 million raise, which the Louisiana Department of Health and Hospitals (DHH) gave to nursing homes could have helped purchase approximately $135 million of *Medicare-sponsored* services in the physician's office, hospital or home health, using money primarily from the federal government. Instead, DHH chose to purchase only $34 million dollars of *Medicaid-sponsored* nursing home services, using money that comes primarily out of the Louisiana treasury.

7. Louisiana Medicaid must not encourage patients to enter expensive nursing homes and should stop subsidizing 6,000 empty Louisiana nursing home beds in a contracting nursing home industry.

8. Eliminating Medicare-Medicaid crossover payments has decreased primary geriatric care for dually eligible people in the physician's office and in the home environment. If dually eligible people cannot obtain access to the physician's office, they will be forced to find access to expensive nursing homes. Louisiana DHH must restore Medicare-Medicaid crossover payments in order to decrease our onerous Medicaid nursing home budget. Louisiana DHH should stop transferring physician crossover money to the nursing home industry

9. According to Senator Breaux, dually eligible people consume 35% of the national Medicaid budget. According to HCFA, 85% of all Medicaid money spent on dually

eligible people is spent on their nursing home care. Multiplying the 85% by the 35% shows that 30% of our nation's entire Medicaid budget goes to house dually eligible people in nursing homes. This includes money spent for non-medical, custodial services including room and board, and help with their activities of daily living.

10. Dually eligible people with Medicare and Medicaid have a $500 million impact on Louisiana's Medicaid budget, and a $34 billion dollar impact on the nation's Medicaid nursing home budget. This represents approximately 3% of *all* Louisiana State expenses and 1.8% of *total* federal expenditures.

11. In 1995, 78% of money spent on nursing home care went to pay for *custodial services* such as room and board and other non-medical care services. At least $390 million of Louisiana Medicaid money and $27 billion of national Medicaid money was spent on room and board, and other custodial services for dually eligible people who live in nursing homes. This represents 2.4% of all Louisiana State expenses and 1.4% of total federal expenditures.

12. Increasing dually eligible people's access to community health care and decreasing their use of nursing homes will allow part of this $500 million Louisiana Medicaid nursing home budget, and part of this $34 billion national Medicaid nursing home budget to be used for other services that can benefit our community as a whole. Instead of spending this enormous fortune on expensive nursing home care — most of which actually consists of custodial care — consider how many more childhood vaccinations, obstetrical services, or adult daycare services Louisiana and our nation could provide for all citizens if there were that many extra millions or billions of dollars available each year.

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(Letter sent on Hersh Medical Clinic stationery)

January 15, 2001

XXXXXXXXXXXX
XXXXXXXXXXXX
New Orleans, LA XXXXX

Re: Inability to make a house call
for XXXXXXXX

Dear Ms. XXXXXX:

As I told you on the telephone last week, I am sorry that I will not be able to make a house call to see your mother. I realize that your mother is 95 years old, has Alzheimer's disease and has had cancer. I realize that your mother is completely bed-bound and will need an ambulance to leave the house to go to see a doctor. I understand that this is a hardship for you and your mother. However, as I explained to you on the telephone, the Medicaid Department and the State of Louisiana have severely and unjustly cut the reimbursement for elderly patients such as your mother who have both Medicare and Medicaid insurance. Since last year, Louisiana Medicaid has cut the reimbursement for a house call to your mother by 81%. They have, therefore, made it more difficult for your mother to get efficient, cost-effective medical care.

I would be pleased to see your mother in my office in the near future, but I am not certain if Medicare or Medicaid would pay for an ambulance to bring her to my office. If necessary you may bring your mother to the hospital Emergency Room where the doctor-on-call will see your mother. I realize that this doctor may not be an internal medicine physician or a geriatrician who specializes in treating the elderly. I realize that this doctor will not know you or your mother and that you may never see this doctor again in the future.

The Medicaid Department and the State of Louisiana have made a serious mistake and are discriminating against the elderly. The cost of the ambulance service and the Emergency Room visit will far outweigh the money they think they are saving by abolishing the payments for dually eligible Medicare-Medicaid patients such as your mother. If you are as angry about these unjust cuts as I am, then I suggest you write a letter to the people on the enclosed list and urge them to reverse these severe and unjust budget cuts. You may also enclose a copy of this letter with your correspondence.

Sincerely yours,

Sheldon Hersh MD

Enclosures.