

Improving Access to and Equity of Care for People with Serious Illness: A Workshop

Roundtable on Quality Care for People with Serious Illness
Session 4

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Filling the need for trusted information on national health issues.

A Policy Agenda to Improve Access to Care and Achieve Health Equity for People with Serious Illness

- Making Medicaid More Available
- Making Medicare More Affordable
- Addressing Disparities for Vulnerable Populations

Making Medicaid More Available

- Increasing access to home and community-based services
- Reducing variations across states
- Facilitating integration of services
- Closing the coverage gap for low income adults

Figure 3

Key areas to support equity and access for people with serious illness under Medicaid.

- **HCBS eligibility**
 - Maintaining federal Medicaid matching funds with no pre-set limit and offering enhanced funds for states to cover HCBS.
 - Re-authorizing ACA Section 2404 to permanently apply the spousal impoverishment rules to HCBS.
- **Direct care workforce**
 - Supporting states in implementing wage increases and workforce development strategies for direct care workers.
- **Housing supports**
 - Reauthorizing the federal Money Follows the Person demonstration to offer housing-related services and staff to support people moving from nursing homes to the community.
- **Quality measures**
 - Advancing the development of HCBS quality measures to monitor and evaluate progress in LTSS rebalancing, community integration, and beneficiary quality of life.

Figure 4

Most Medicaid HCBS are provided at state option.

Number of states covering benefit as of FY 2017:

■ Mandatory ■ Optional

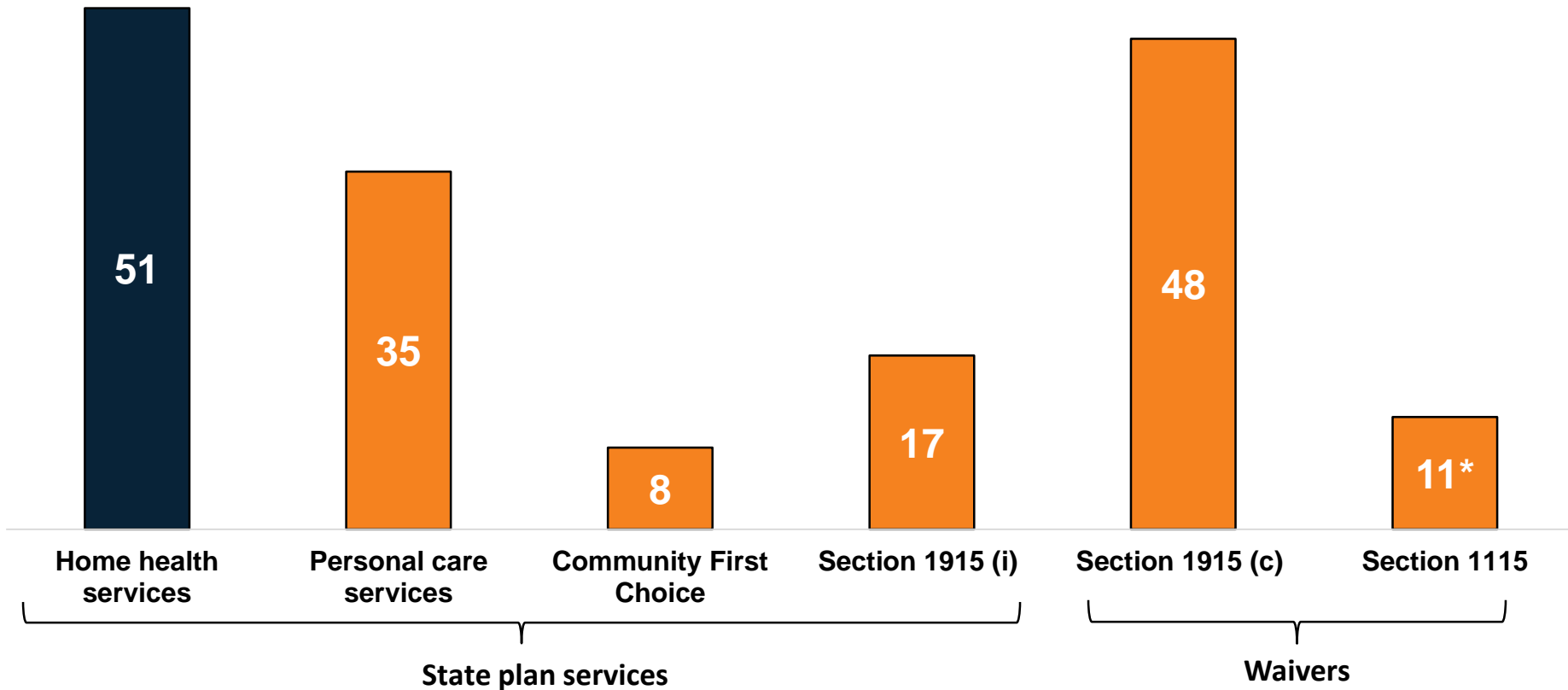


Figure 5

Most Medicaid eligibility pathways for seniors and people with disabilities are optional for states.

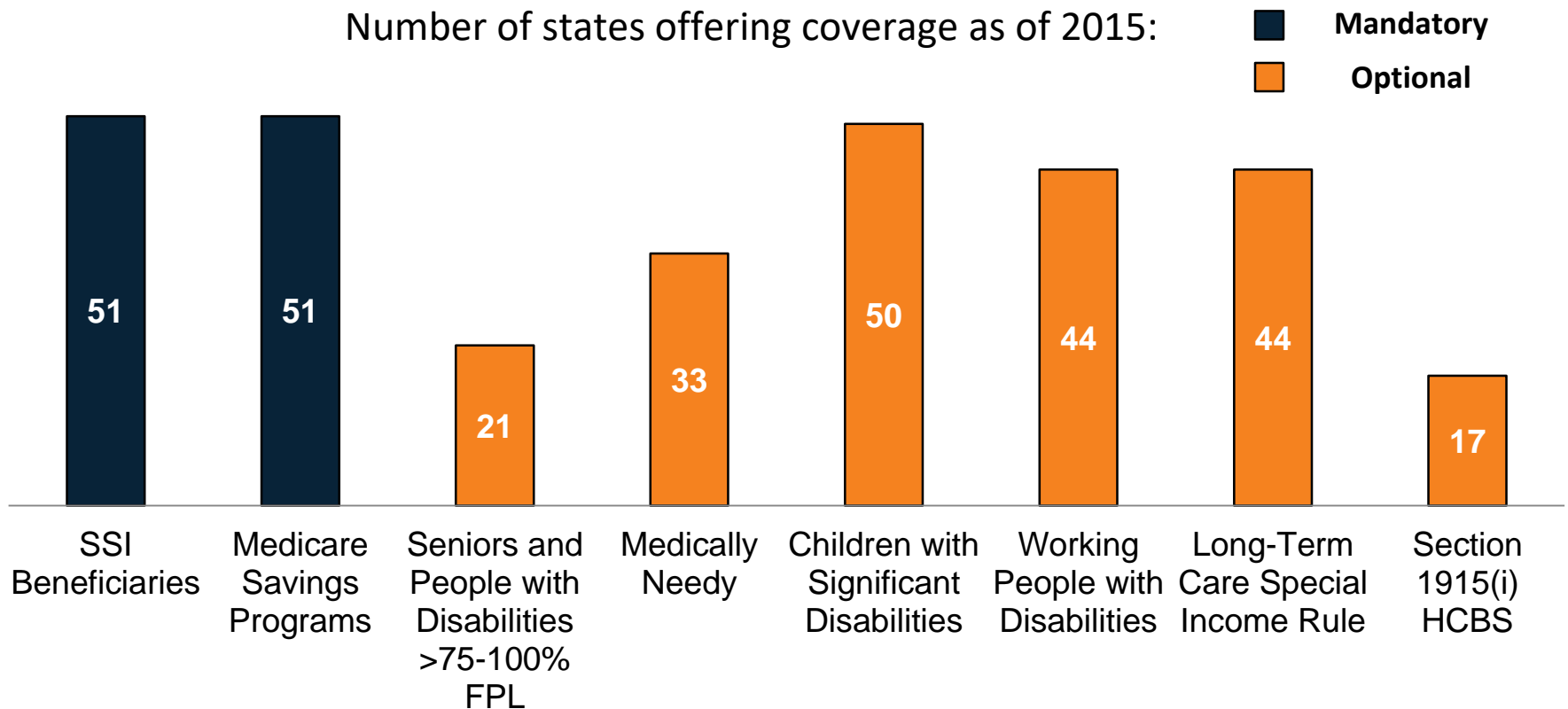
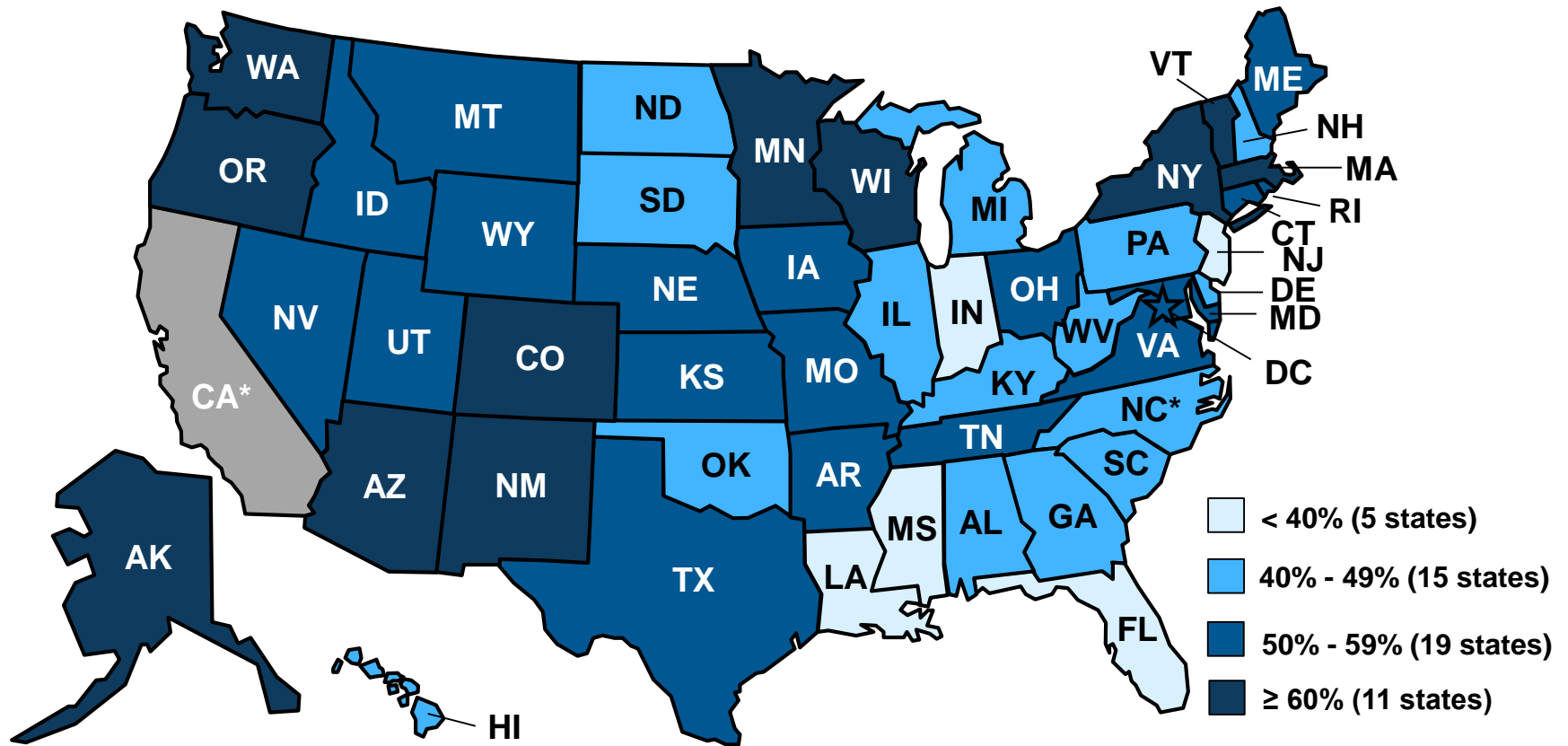


Figure 6

Most states are spending half or more of their Medicaid LTSS dollars in the community, as opposed to institutions.

Share of total FY 2016 Medicaid LTSS spending devoted to HCBS:



U.S. = 57%

Figure 7

A majority of states deliver Medicaid long-term services and supports through capitated managed care as of 2019.

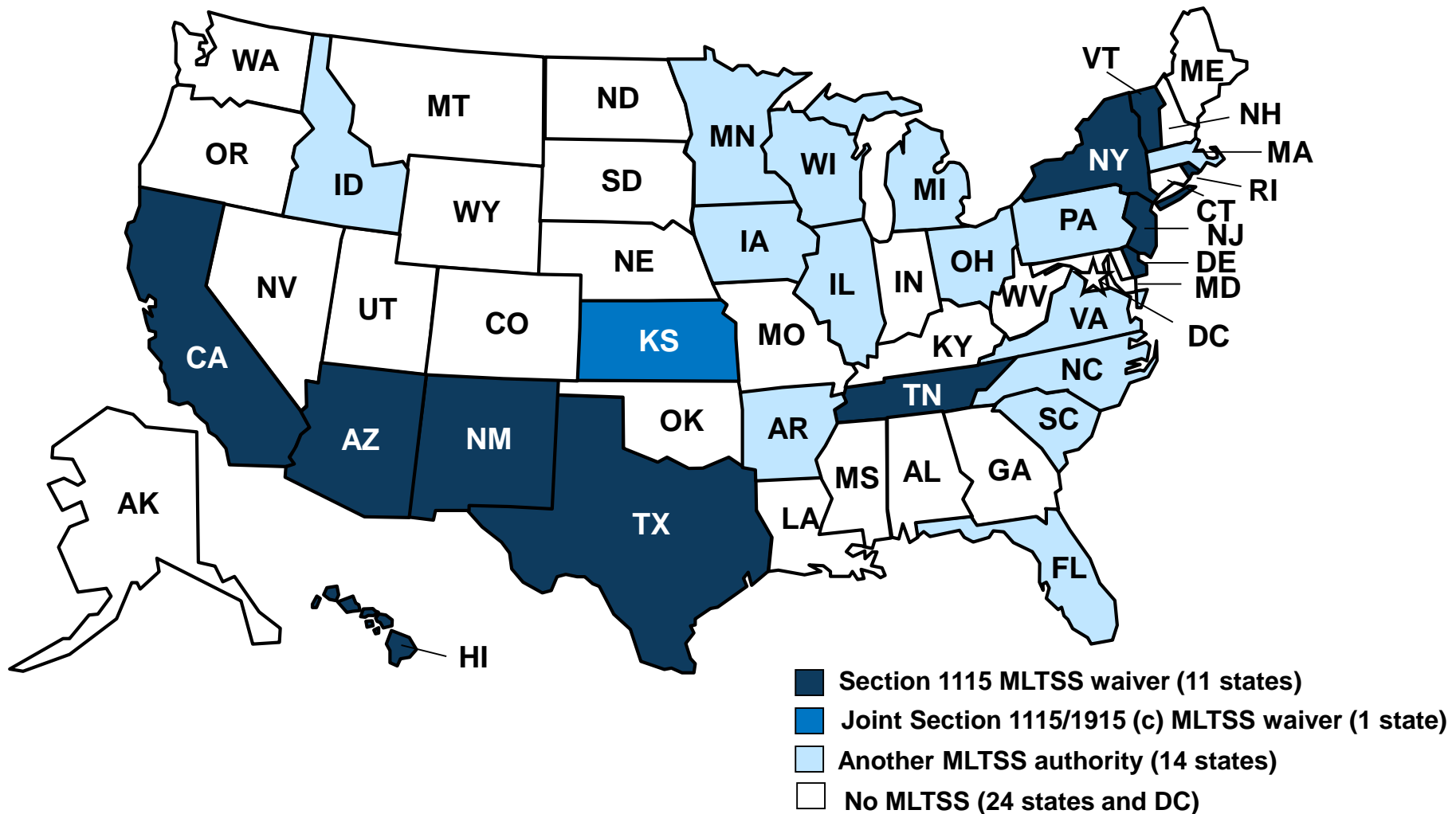


Figure 8

State implementation of Medicaid managed long-term services and supports programs can be complex.

States' Objectives for MLTSS



Integrate Physical, Behavioral Health, and LTSS



Coordinate Care for Complex Populations



Incentivize HCBS and Manage Costs

Challenges in MLTSS Implementation



Lack of Community Housing



Setting Payment Rates



Provider Engagement



Workforce Shortages



Selecting Quality Measures



Person-Centered Planning

Figure 9

Uninsured Rate Among Nonelderly Individuals, 2017

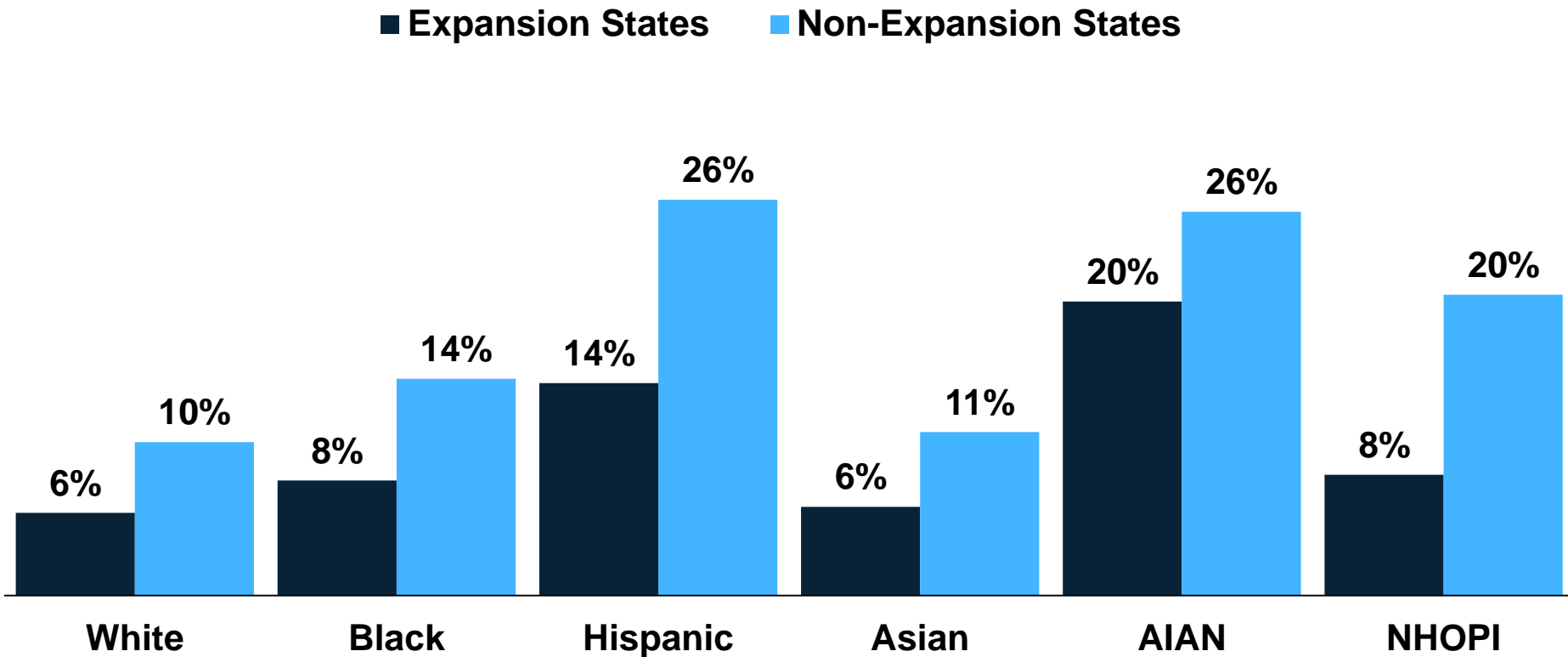
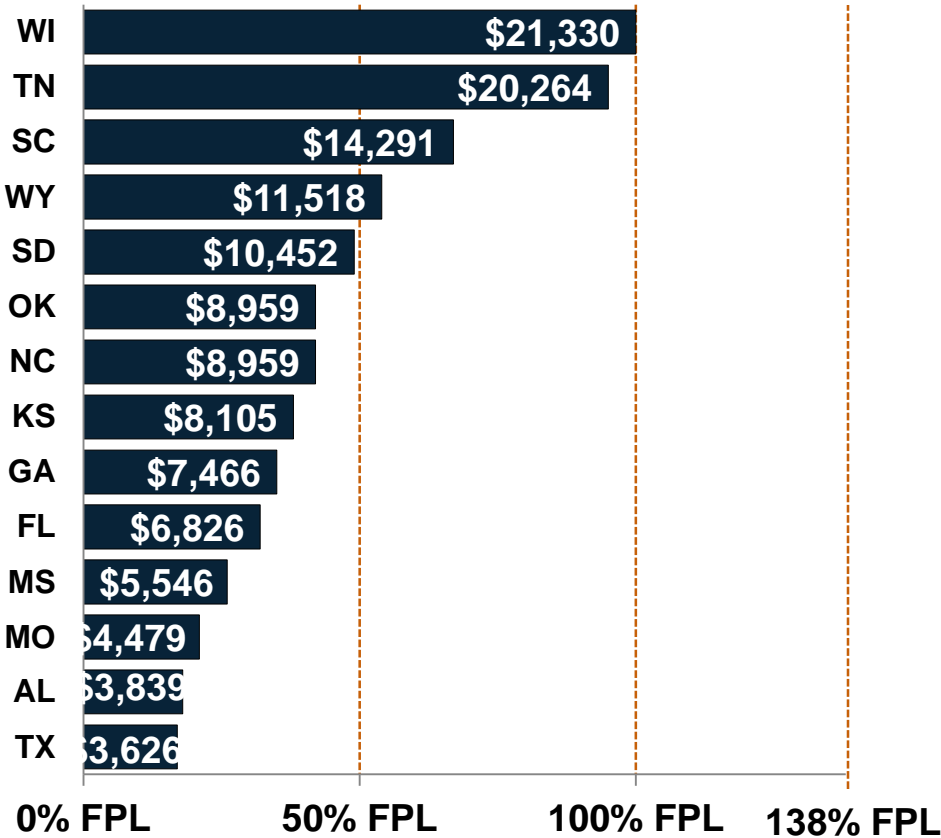


Figure 10

Medicaid Income Eligibility Limits for Adults in States that Have Not Adopted the Medicaid Expansion, January 2019

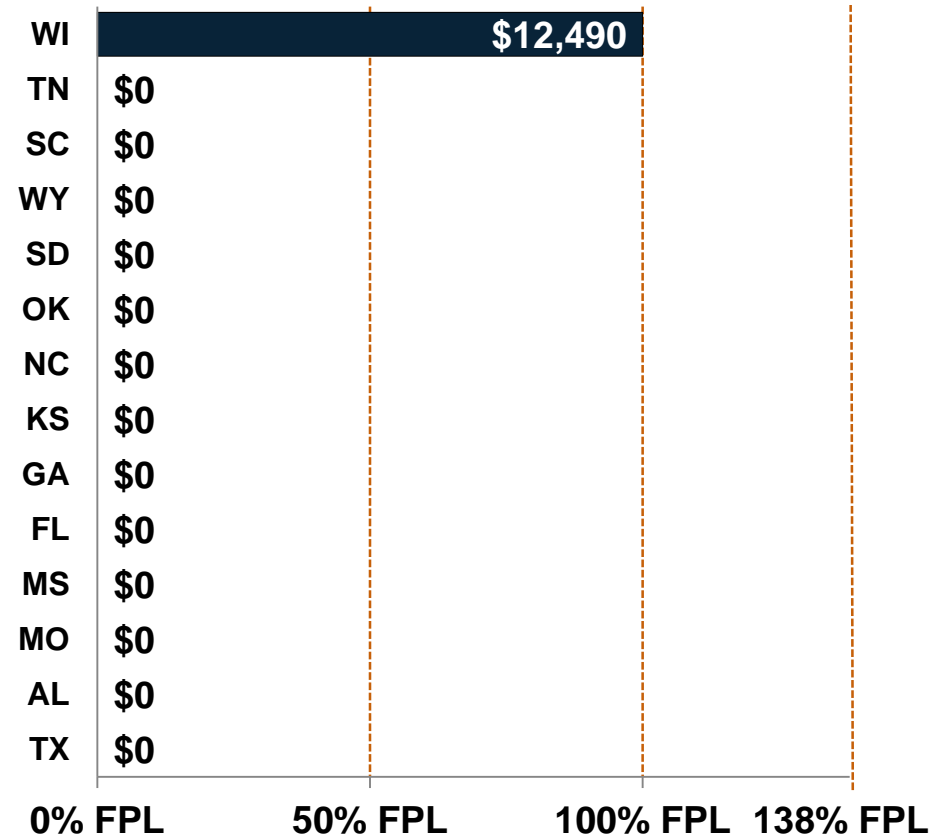
Parents

(Annual Income Limit for a Family of 3)



Childless Adults

(Annual Income Limit for an Individual)



Making Medicare More Affordable

- Capping catastrophic coverage for Part D
- Broadening supplemental coverage through Medicaid
- Providing options for high cost/high need populations
- Filling benefit gaps

Figure 12

The Medicare Part D standard benefit design has no annual limit on out-of-pocket costs

Share of costs in 2019 paid by: ■ Enrollees ■ Plans ■ Medicare

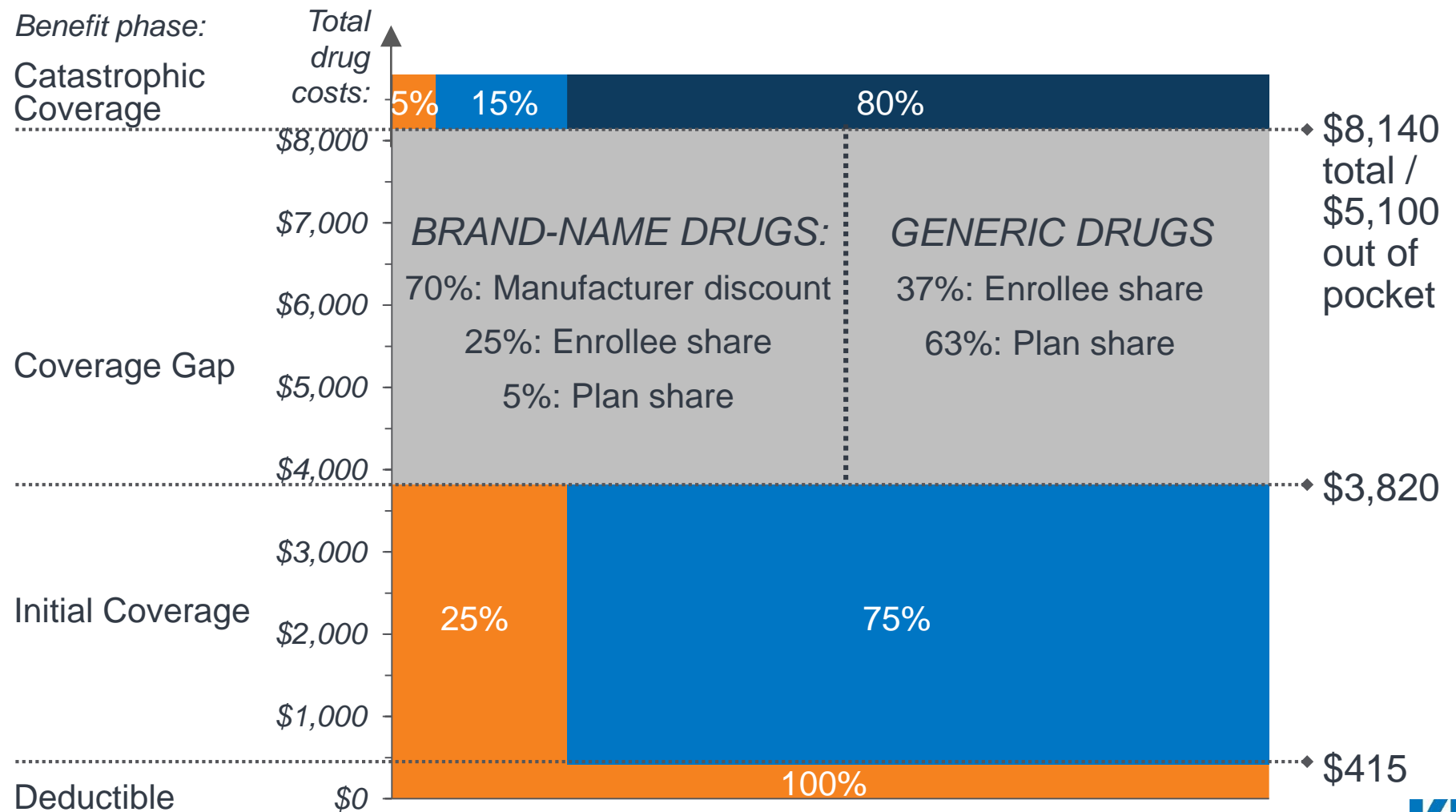
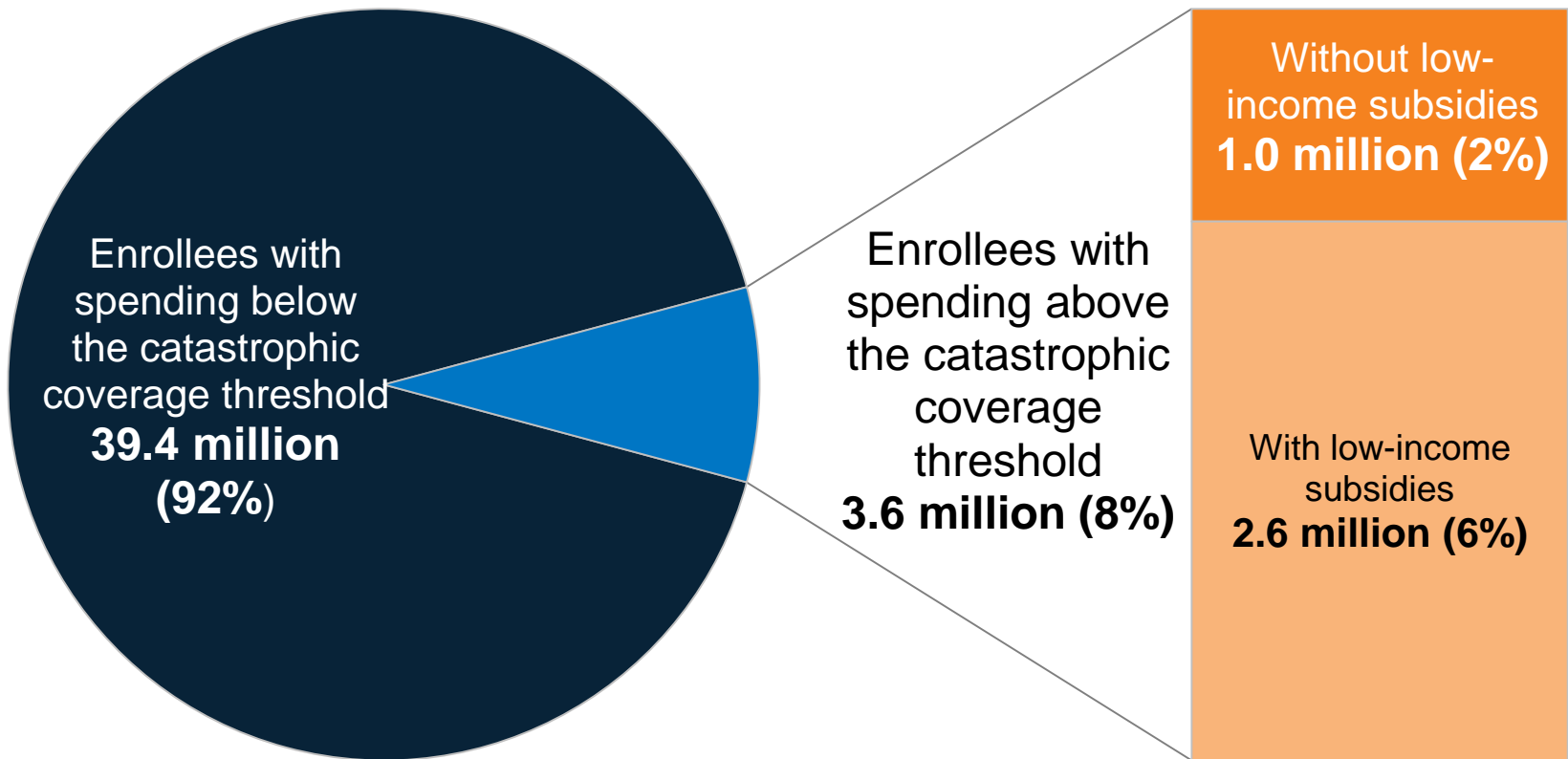


Figure 13

Nearly 1 in 10 Medicare Part D enrollees had drug spending above the catastrophic coverage threshold in 2016, most of whom received low-income subsidies—but 1 million did not

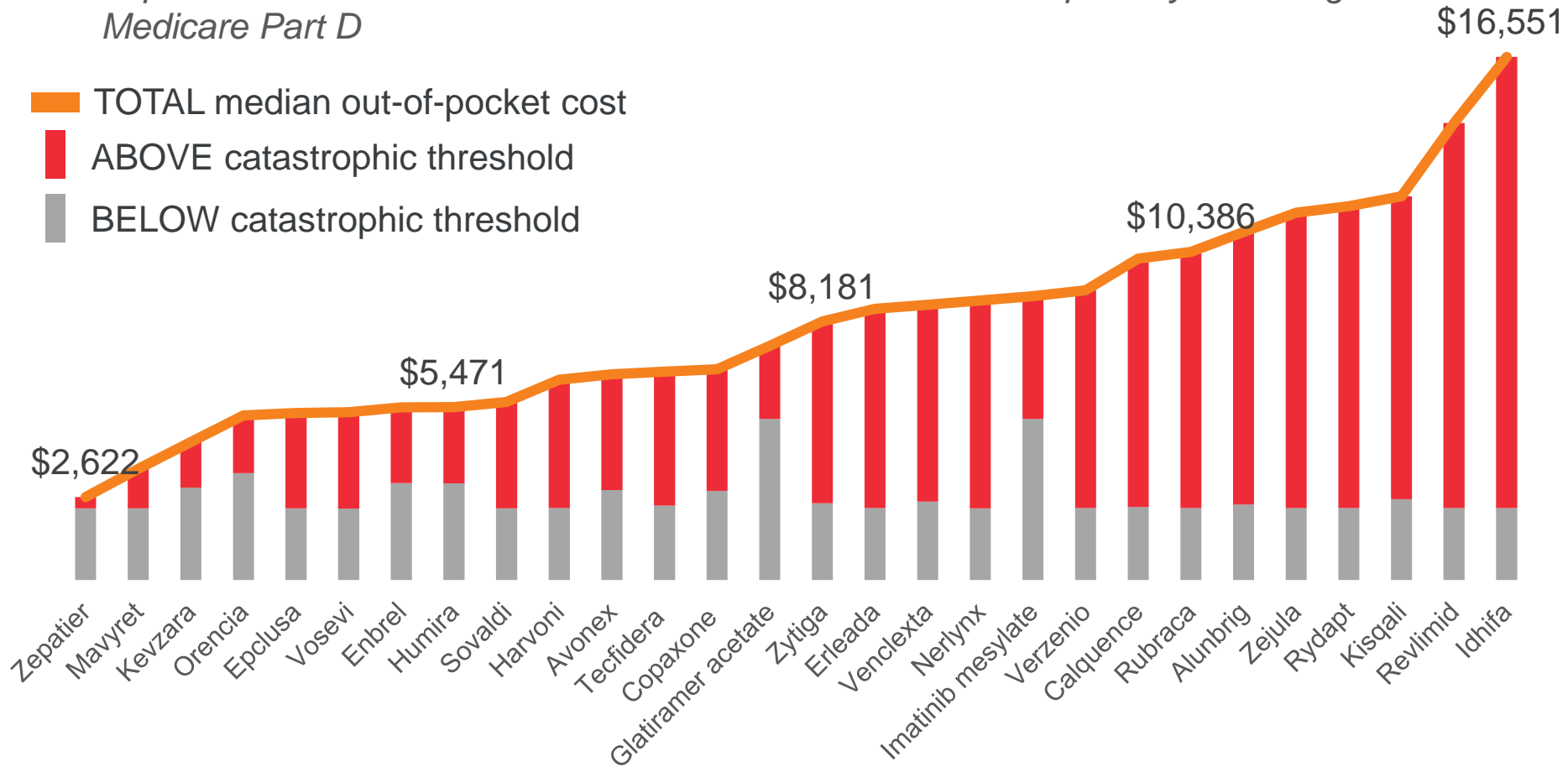


Total Part D enrollment, 2016: 43.0 million

Figure 14

Medicare Part D enrollees can pay thousands of dollars out of pocket for specialty tier drugs, with the majority of costs for many drugs above the catastrophic threshold

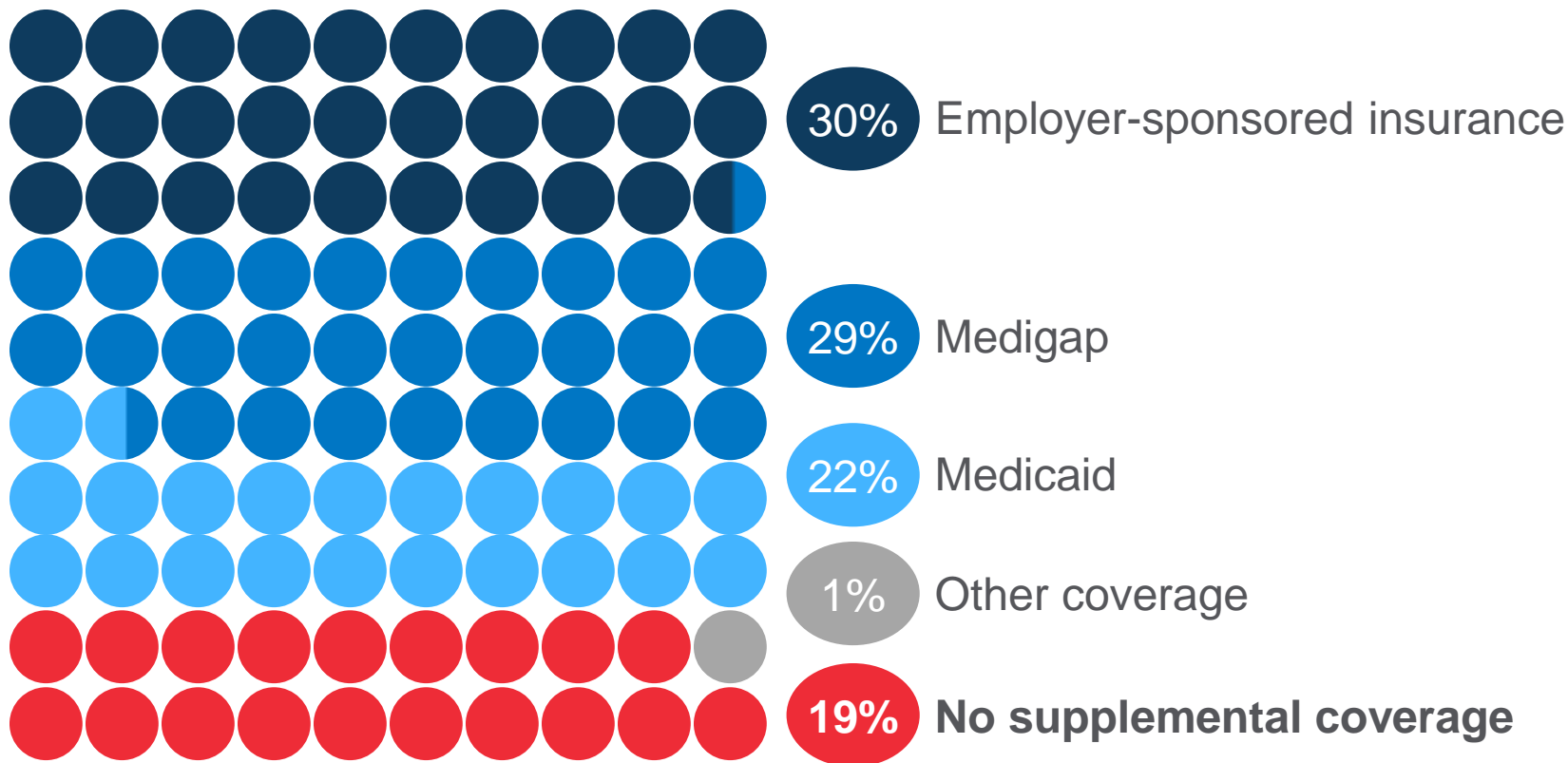
Expected Annual Out-of-Pocket Costs in 2019 for Selected Specialty Tier Drugs in Medicare Part D



SOURCE: KFF, *The Out-of-Pocket Cost Burden for Specialty Drugs in Medicare Part D in 2019*.

Figure 15

Nearly 1 in 5 traditional Medicare beneficiaries, or 6.1 million people, have no supplemental coverage



2016 Total = 32.4 million traditional Medicare beneficiaries

Questions remain about how well Medicare Advantage plans are serving high-cost, high-need people

- Dual eligibles and Medicare beneficiaries with significant needs are more likely to disenroll from Medicare Advantage plans
 - Little is known about how well plans (including Special Needs Plans) serve those with serious illnesses
 - High disenrollment rates could be due to narrow networks, restrictions on care, high cost-sharing for needed services, or all of the above
- People who switch out of Medicare Advantage may not be able to get a Medigap plan
 - Only 4 states provide continue guaranteed issue rights to all beneficiaries; nearly 1 in 5 people in traditional Medicare have no supplemental coverage
- People enroll in Medicare Advantage because it covers many of the gaps in traditional Medicare
 - Out-of-pocket limit and Medicare-funded extra benefits

Figure 17

In most states, beneficiaries with pre-existing conditions may be unable to purchase Medigap if they want to shift from Medicare Advantage to traditional Medicare

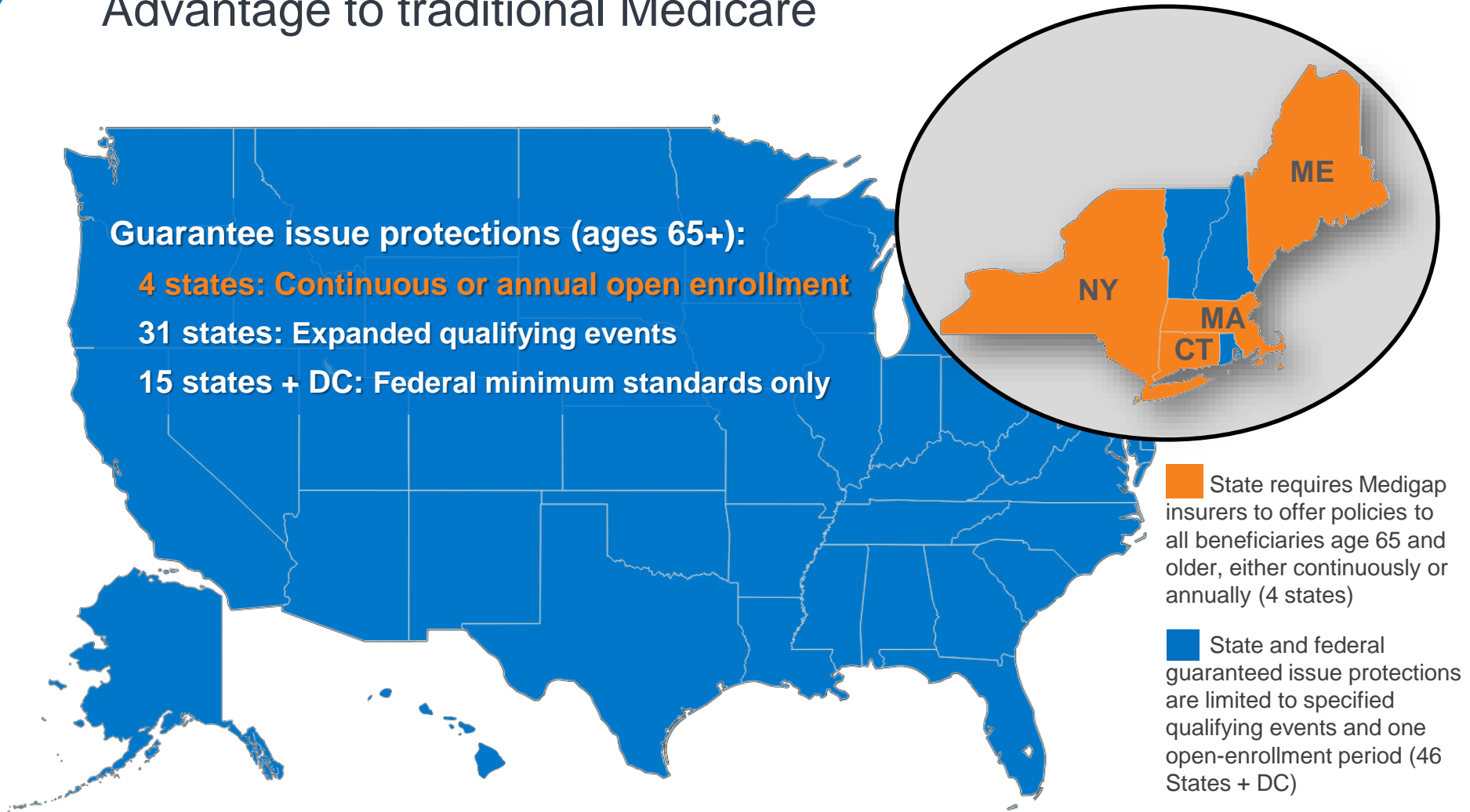


Figure 18

Addressing Medicare's benefit gaps would be an opportunity to address the needs of beneficiaries with serious illness

Traditional Medicare does not cover:

Dental services



Eyeglasses or eye exams



Hearing aids or exams



Long-term services and supports



No annual limit on out-of-pocket costs for medical services



Addressing Disparities for Vulnerable Populations

- Health disparity: a higher burden of illness, injury, disability, or mortality for one group relative to another
- Health care disparity: differences in insurance coverage, access to and use of care, and quality of care
- Affect groups who have systematically experienced greater social or economic obstacles to health
- Occur across a broad range of dimensions, including race/ethnicity, socioeconomic status, gender, age, disability, sexual orientation or gender identity, geographic location, etc.
- Arise from a complex and interrelated set of individual, provider, health system, societal, and economic factors

What is health equity?

Health equity: when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social circumstances.

