MEDICAID MANAGED LONG-TERM CARE

Challenges and Opportunities for State Policymakers and Low-Income Individuals

James M. Verdier

Michigan Family Impact Seminar

Lansing, MI
October 23, 2007

MATHEMATICA
Policy Research, Inc.

Introduction and Overview

- Medicaid spending in Michigan compared to national average
  - All services
  - Long-term care (LTC)
- Managed LTC in Medicaid
  - Challenges and opportunities
- Models and lessons from other states

Distribution of Medicaid Enrollees and Expenditures, MI vs. US, FY 2004

	MI	US
• Enrollees		
– Children	52.3%	52.5%
– Adults	24.1	22.8
– Disabled	16.1	14.7
– Elderly	7.5	10.1
• Expenditures		
– Children	16.0%	17.2%
– Adults	10.8	11.8
– Disabled	39.4	40.0
– Elderly	19.4	26.4
– Unknown	14.4	4.6

- Michigan is similar to national average, except for low percentage of elderly enrollees and expenditures

SOURCE: Kaiser Family Foundation, statehealthfacts.org

Medicaid Payments Per Enrollee, MI vs. US, FY 2004

	MI	US
Children	$1,334	$1,531
Adults	1,950	2,012
Disabled	10,629	13,014
Elderly	11,192	11,455
Total	3,724	4,248

- Michigan payments per enrollee are below the national average in all eligibility categories

SOURCE: Kaiser Family Foundation, statehealthfacts.org

Distribution of Medicaid LTC Expenditures, MI vs. US, FY 2006

	MI	US
• Total Medicaid LTC Expenditures		
♦ Institutional services	68%	61%
♦ Community-based services	32	39

- Michigan devotes more to institutional services and less to community-based services than the national average
- Michigan ranked 36th nationally in share of LTC expenditures devoted to community-based services

SOURCE: Burwell, Sredl, and Eiken, "Medicaid Long-Term Care Expenditures in FY 2006," August 10, 2007

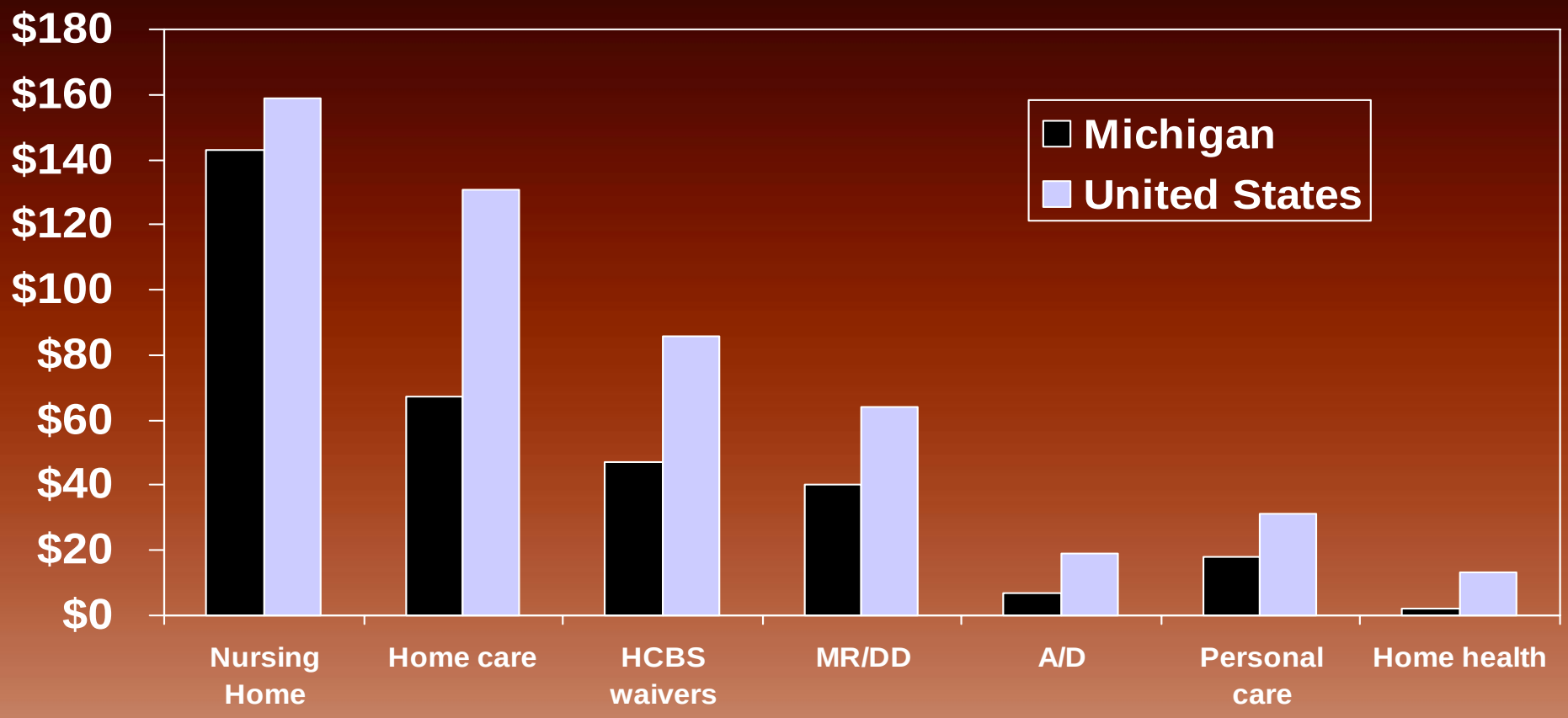
Per Capita Medicaid Expenditures MI vs. US, FY 2006

	MI	US	MI Rank
• All Medicaid services	$815	$998	#37
• Nursing home services	143	159	31
• Home care	67	131	43
– HCBS waivers	47	86	44
♦ MR/DD	40	64	37
♦ A/D	7	19	39
– Personal care	18	31	19
– Home health	2	13	42

NOTES: Per capita Medicaid expenditures are total Medicaid expenditures divided by total state/U.S. population. Home- and community-based (HCBS) waivers in Michigan include those who are mentally retarded/developmentally disabled (MR/DD) or aged/disabled (AD).

SOURCE: Burwell, Sredl, and Eiken, "Medicaid Long-Term Care Expenditures in FY 2006," August 10, 2007

Per Capita Medicaid Expenditures MI vs. US, FY 2006



SOURCE: Burwell, Sredl, and Eiken, "Medicaid Long-Term Care Expenditures in FY 2006," August 10, 2007

Trends in Personal Care Expenditures, MI vs. US, FY 2001-2006

	MICHIGAN		UNITED STATES	
Year	$/Millions	% Change From Prior Year	$/Millions	% Change From Prior Year
2001	$183		$5,711	
2002	177	-3.2%	6,098	6.8%
2003	209	17.6	7,049	15.6
2004	212	1.6	7,847	11.3
2005	217	2.5	9,102	16.0
2006	183	-15.7	9,340	2.6

- Michigan has limited personal care expenditure growth more than most other states (16 states do not cover this service)

SOURCE: Burwell, Sredl, and Eiken, "Medicaid Long-Term Care Expenditures in FY 2006," August 10, 2007

Nursing Facility Utilization, MI vs. US, 2005

	MI	US	MI Rank
• Occupancy rate	86%	83%	#22
• Nursing home residents as a percent of 65+ population	3.2%	3.6%	#16

- Michigan nursing facilities have somewhat lower "unused capacity" than the national average
- A somewhat smaller share of the elderly population in Michigan uses nursing facilities

SOURCE: Kaiser Family Foundation, statehealthfacts.org

Reducing Nursing Facility Use Through Increased Community Care

- A major goal of HCBS waivers, personal care, and home health care in Medicaid is to reduce use of costly nursing facility services
- But unless community care services are limited primarily to those who would otherwise use nursing facilities, expanded use of community care services does not reduce Medicaid nursing facility expenditures
  - Use of community services will increase, but nursing facility use will not decline
  - Called the "woodwork" effect
- Access to community services must be tightly managed to achieve net savings
  - Limits on eligibility and/or services used

Managed LTC in Medicaid

- Managed LTC puts contractors (public or private, for-profit or non-profit) "at risk" for a defined package of Medicaid services
  - Contractors are paid a "capitated" amount in advance per member per month (PMPM) to provide needed care
  - If needed services cost less than capitated payments, contractor keeps the difference
    - ♦ If they cost more, contractor incurs a loss
- Variants of this approach share risk in different ways between the state and contractors
  - State may bear a larger share of the risk at start of new programs

Managed LTC Risks and Opportunities

- Major risks
  - Contractor may "stint" on needed care to increase profits
  - Contractor may not fully understand Medicaid population and its needs
    - Managed care contractors have less experience with LTC (nursing facilities and HCBS) than they do with acute care
  - Contractor may not have needed experience in financing, managing risk, provider networks, payment, enrollee communications, complaints and grievances, reporting, etc.
    - Running a managed care organization (MCO) is a complex business

Managed LTC Risks and Opportunities *(Cont.)*

- Major opportunities
  - Having a single entity at risk for nursing facility and community services can facilitate shifts of funding and services between institutional and community care
    - ♦ May increase availability of community services
  - MCO can help coordinate care for disabled and elderly beneficiaries with complex care needs
    - ♦ Expanding MCO risk to include acute care (hospitals, physicians, Rx drugs) can enhance care coordination opportunities
    - ♦ Including Medicare services for dual eligibles can further expand care coordination opportunities
      - - Being done in a limited number of states

Managed LTC Program Design Issues

- Who should be covered? Elderly? Under-65 disabled? Both?
- Should program be mandatory or voluntary?
  - Initial assignment can be mandatory, with easy opt-out
- What services should be covered?
  - LTC only, or also include acute care?
- Who is eligible to be an MCO?
  - What kinds of entities are interested and capable?
- Should program start statewide, or in selected areas?
- How many MCOs per area?
  - CMS usually requires more than one
- For more discussion of program design issues, see CHCS checklist for states at: http://www.chcs.org/usr_doc/ICP_TA_Tool.pdf

Models From Other States

- AZ, FL, MA, MN, NY, TX, WI currently have managed LTC programs
  - For details, see 11/05 AARP Issue Brief: http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf
- All but Fl and MA cover both elderly and disabled
- All but WI and NY cover both acute and LTC services
- All are voluntary, except AZ, TX, and WI
- Only AZ and MA are statewide

Lessons From Other States

- Program design and implementation takes time
  - Consultation with stakeholders is critical
- Savings will not occur immediately
  - Many enrollees will have accumulated unmet needs
  - Savings from reduced use of institutional and hospital services and improved use of Rx drugs take time to achieve
- Current LTC providers are likely to resist managed care
- Organized beneficiaries may also resist
  - Many are managing their own care better than an MCO could
  - Those who may be helped most by managed LTC are generally not organized or vocal

Longer-Term Opportunities to Manage Both Medicaid and Medicare Services

- Almost all elderly Medicaid beneficiaries and one-third of disabled are enrolled in both Medicare and Medicaid ("dual eligibles")
  - 134,000 elderly dual eligibles and 89,000 disabled duals in Michigan in 2003
- States can contract with Medicare Special Needs Plans (SNPs) to cover Medicaid services
  - SNPs are authorized to serve Medicare beneficiaries who are dually eligible, institutionalized, or who have severe or disabling chronic conditions
  - Potentially allows coordination of all services for duals
  - But there are currently only about a dozen states that contract with SNPs, and most contracts do not include Medicaid LTC
- There are currently four SNPs in Michigan
  - United/Erickson, Molina, Midwest Health Plan, and Fidelis SecureCare
  - Four more have been approved for 2008
    - Humana, Community Choice, DaVita, and Great Lakes

Conclusion

- Managed LTC has major potential to improve care and reduce costs
- Other states provide models and lessons for Michigan
- For some states, the ultimate goal is to fully integrate and coordinate both Medicaid and Medicare acute and LTC services
  - Only a small number of states are currently doing this, however, and there are significant obstacles
- Medicaid-only managed LTC can be a valuable step on its own merits