# State Experiences with Managed Long-term Care in Medicaid*

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**Abstract:**

*Across the country, state Medicaid programs are expressing renewed interest in developing managed care programs for beneficiaries who require long-term care. Several states have programs already in place. Others are in the planning or early implementation stages. This brief examines the current status of the Medicaid managed long-term care market, discusses the potential benefits and challenges of implementing new managed long-term care programs and briefly describes North Carolina Medicaid's preliminary ventures into the managed long-term care arena. It concludes with a short discussion of the potential impact of managed long-term care on families.*

North Carolina's Medicaid program spent almost 2.5 billion dollars on long-term care services in FY 2004. (See Table 1.) Combined Medicare and Medicaid expenses for persons receiving publicly financed long-term care were approximately $132 billion during that same year. These figures include skilled nursing care, some intermediate care facilities, home health care, home- and community-based care and personal care services. With the aging of the baby boomers, these figures will likely increase dramatically in the coming years. Some states are trying to anticipate and plan for the growing long-term care population by implementing programs of managed care. Many state Medicaid programs already provide some case management

* Most of the material in this brief is taken directly or adapted from *The Past, Present and Future of Managed Long Term Care* by Saucier, Burwell and Gerst (April 2005).[1] Additional sources consulted include "Medicaid and Long-Term Care," Kaiser Commission on Medicaid and the Uninsured (March 2005)[2] and North Carolina Institute of Medicine, "A Long-Term Care Plan for North Carolina: Final Report" (January 2001).[3] The brief was prepared by Aimee N. Wall, UNC School of Government.

## Table 1: North Carolina Medicaid Expenditures for Long-term Care Services: 1999-2003

| SERVICE | FY 1999 EXPENDITURES | FY 2000 EXPENDITURES | PERCENT CHANGE 99-00 | FY 2001 EXPENDITURES | PERCENT CHANGE 00-01 | FY 2002 EXPENDITURES | PERCENT CHANGE 01-02 | FY 2003 EXPENDITURES | PERCENT CHANGE 02-03 | FY 2004 EXPENDITURES | PERCENT CHANGE 03-04 | FY 2004 EXPENDITURES PER CAPITA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing Home Services | $812,806,762 | $832,715,476 | 2.4 | $876,233,835 | 5.2 | $893,316,570 | 1.9 | $895,224,875 | 0.2 | $1,096,619,059 | 22.5 | $128.39 |
| ICF-MR Total | $393,413,325 | $396,863,370 | 0.9 | $400,129,463 | 0.8 | $416,422,558 | 4.1 | $418,466,631 | 0.5 | $431,968,043 | 3.2 | $50.58 |
| ICF-MR Public | $198,921,469 | $199,779,469 | 0.4 | $201,603,802 | 0.9 | $217,246,697 | 7.8 | $218,023,828 | 0.4 | $226,581,561 | 3.9 | $26.53 |
| ICF-MR Private | $194,491,856 | $197,083,901 | 1.3 | $198,525,661 | 0.7 | $199,175,861 | 0.3 | $200,442,803 | 0.6 | $205,386,482 | 2.5 | $24.05 |
| Personal Care | $153,648,159 | $181,578,642 | 18.2 | $221,200,189 | 21.8 | $269,054,608 | 21.6 | $299,929,413 | 11.5 | $362,050,065 | 20.7 | $42.39 |
| HCBS Waivers-Total | $320,851,451 | $379,056,944 | 18.1 | $454,909,887 | 20.0 | $481,491,981 | 5.8 | $471,709,572 | -2.0 | $503,455,508 | 6.7 | $58.95 |
| HCBS Waivers-MR/DD | $149,910,940 | $190,496,958 | 27.1 | $235,232,775 | 23.5 | $254,035,290 | 8.0 | $263,186,889 | 3.6 | $269,303,718 | 2.3 | $31.53 |
| HCBS Waivers-A/D | $158,674,755 | $175,386,785 | 10.5 | $201,447,795 | 14.9 | $205,384,679 | 2.0 | $183,297,444 | -10.8 | $208,165,729 | 13.6 | $24.37 |
| Home Health | $76,262,699 | $83,412,799 | 9.4 | $84,772,196 | 1.6 | $97,169,928 | 14.6 | $96,337,348 | -0.9 | $101,671,283 | 5.5 | $11.90 |
| Total Home Care | $550,762,309 | $644,048,385 | 16.9 | $760,882,272 | 18.1 | $847,716,517 | 11.4 | $867,976,333 | 2.4 | $967,176,856 | 11.4 | $113.24 |
| Inpatient Hospital Care | $872,956,725 | $1,020,053,634 | 16.9 | $1,089,213,851 | 6.8 | $1,114,697,390 | 2.3 | $1,088,507,536 | -2.3 | $1,215,215,373 | 11.6 | $142.28 |
| Inpatient DSH | $227,672,613 | $263,744,946 | 15.8 | $259,509,072 | -1.6 | $276,816,659 | 6.7 | $379,978,702 | 37.3 | $416,749,256 | 9.7 | $48.79 |
| Inpatient Mental Health | $16,846,455 | $24,327,737 | 44.4 | $25,885,125 | 6.4 | $32,442,979 | 25.3 | $35,937,626 | 10.8 | $37,024,688 | 3.0 | $4.33 |
| Mental Health DSH | $170,292,750 | $176,842,977 | 3.8 | $174,935,077 | -1.1 | $179,324,307 | 2.5 | $2,917,716 | -98.4 | $3,178,664 | 8.9 | $0.37 |
| Medicaid Managed-Care Premiums | $46,209,841 | $55,263,543 | 19.6 | $66,807,897 | 20.9 | $33,271,385 | -50.2 | $20,485,785 | -38.4 | $21,838,098 | 6.6 | $2.56 |
| Prescribed Drugs | $620,864,891 | $803,648,718 | 29.4 | $984,643,814 | 22.5 | $1,089,180,219 | 10.6 | $1,291,255,693 | 18.6 | $1,575,005,285 | 22.0 | $184.41 |
| Total Long-term Care | $1,756,982,396 | $1,873,627,231 | 6.6 | $2,037,245,570 | 8.7 | $2,157,455,645 | 5.9 | $2,181,667,839 | 1.1 | $2,495,763,958 | 14.4 | $292.21 |
| Targeted Case Management | $67,102,065 | $72,276,927 | 7.7 | $85,574,303 | 18.4 | $99,014,845 | 15.7 | $98,216,787 | -0.8 | $116,061,608 | 18.2 | $13.59 |
| P.A.C.E. | $0 | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 | $0 | 0.0 | $0.00 |
| Total Medicaid | $4,987,172,053 | $5,571,242,345 | 11.7 | $6,239,709,423 | 12.0 | $6,812,021,955 | 9.2 | $7,228,626,129 | 6.1 | $8,290,567,550 | 14.7 | $970.68 |

Source: CMS 64 data, Office of State Agency Financial Management.

services for users of home- and community-based care. Most, however, do not provide a comprehensive program for managing all of a patient's care – from the community to the hospital to the nursing home and possibly back again. While the size of the nation's managed long-term care population is still relatively small, several states are implementing innovative new programs designed to serve this expanding, resource intensive population. This brief is intended to provide readers with a general understanding of the issues involved in implementing a managed long-term care program.

## What Is Managed Long-term Care?

*The term managed care refers to the comprehensive care coordination traditionally provided by HMOs and similar organizations rather than basic case management services.*

To most audiences, the phrase long-term care refers not only to the health care delivered in nursing and adult care homes but also to home health care services and a wide range of supportive services that assist individuals with the basic activities of life, such as preparing food, eating, dressing, and managing medication.

Referring to such care as managed can mean different things to different people. For example, it can mean that a fee is paid to a case manager each month to help enrollees elect health care options, choose providers, and coordinate care. Alternatively, it can mean that a per person monthly fee, called a capitation payment, is paid to a Health Maintenance Organization (HMO) or similar organization. The enrollees receive all of their care from providers participating in that HMO based on care guidelines issued by the HMO. There are multiple variations on these managed care models, but an overarching principle is that the managed care organizations generally bear some financial risk because they must provide all of the covered services and they receive only a capitation payment. This model builds in a strong incentive for these organizations to save money as compared to the traditional fee-for-service model.

For purposes of this brief, the term managed care refers to the comprehensive care coordination traditionally provided by HMOs and similar organizations rather than basic case management services.

## How Many Medicaid Beneficiaries Are Enrolled in Managed Long-term Care?

Historically, state Medicaid programs have implemented managed care models predominantly in the primary and acute care settings. In the 1980s, a few states attempted to implement variations of managed care into the long-term care setting and several more initiated programs in the 1990s. For various reasons, enrollment did not grow at the rate many predicted. In 2004, approximately 2.3% of the Medicaid-funded long-term care population – or just under 70,000 people – received their

long-term care benefits through a managed care program. While this number is relatively small, the potential target population is quite large – with over three million public long-term care users and over $130 billion in public long-term care expenditures in 2003. (See Table 2.)

**Table 2**
**Estimated Size of the Public Long Term Care Market 2003**

| | | |
|---|---|---|
| **Beneficiaries** | In Nursing Homes | 1,700,000 |
| | In HCBS Waiver Programs | 550,000 |
| | Receiving Personal Care Services | 830,000 |
| | **Total** | **3,080,000** |
| | | |
| **Expenditures** | **For Institutionalized Beneficiaries:** | |
| | Medicaid NF Expenditures | $44.8 billion |
| | Other Medicaid Expenditures | $19.2 billion |
| | Medicare Expenditures | $22.5 billion |
| | **Total** | **$86.5 billion** |
| | **For Community – Based LTC Beneficiaries:** | |
| | HCBS Waiver Expenditures | $4.1 billion |
| | Personal Care Expenditures | $5.0 billion |
| | Other Medicaid Expenditures | $10.6 billion |
| | Medicare Expenditures | $26.1 billion |
| | **Total** | **$45.8 billion** |

*Note: These are preliminary estimates. Estimates only include aged and disabled Medicaid beneficiaries receiving long term care benefits. Excludes persons with developmental disabilities and/or severe mental illness.*

**HCBS: Home- and Community-based Services**
**LTC: Long-term care**
**NF: Nursing facilities**

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In the last few years, several states have been showing renewed interest in implementing programs of managed long-term care. Some of the states (Texas, Florida, Minnesota) with existing managed long-term care programs are pursuing or considering expansions. One state is in the process of enrolling individuals in a new program (Massachusetts) and several states (California, Maryland, Hawaii, Washington) are in the early stages of developing and implementing new programs. Table 3 provides a general overview of the characteristics of some of these state programs.

**Table 3. Characteristics of Selected Managed Long Term Care Programs**

| | PACE (includes "pre-PACE") | Florida Frail Elder Option | Arizona Long Term Care System (ALTCS) | Wisconsin Partnership Program | Minnesota Senior Health Options (MSHO) | New York MLTC Plans | State of Texas Access Reform (Star) + Plus | Florida Diversion | Wisconsin Family Care | MnDHO | Mass Health Senior Care Options (SCO) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Implementation Date** | 1983 (On Lok) | 1987 | 1989 | 1995[1] | 1997 | 1997 | 1998 | 1998 | 2000 | 2001 | 2004 |
| **Populations Eligible** | 55+ with NF-level LTC needs | Aged and Disabled; NF-level LTC needs | Aged and Disabled; NF-level LTC needs | Aged and Disabled; any LTC needs | All Aged | Aged and Disabled with NF-level LTC needs (aged/disabled varies by plan) | All Aged and Disabled | Aged with NF-level LTC needs | Aged and Disabled; NF-level LTC needs | All Physically Disabled | All Aged |
| **Voluntary/ Mandatory for Medicaid** | Voluntary | Voluntary | Mandatory | Voluntary | Voluntary | Voluntary | Mandatory | Voluntary | Mandatory | Voluntary | Voluntary |
| **Geographical Coverage** | 40 urban programs in 17 states | 2 urban counties in Southeast Florida | Statewide (urban and rural) | 6 counties (rural and urban) | 7 urban and 3 rural counties | Multiple counties (rural and urban, but mostly urban) | 1 urban county; statewide urban expansion proposed | 25 urban and contiguous counties | 5 counties (rural and urban) | 4 urban counties | Nearly statewide (rural and urban) |
| **Medicaid Payments** | Capitated primary, acute and LTC; rate structure varies. | Capitated primary, acute and LTC; three rate cells. | Capitated primary, acute and LTC;single blended rate | Capitated primary, acute and LTC; multiple rate categories | Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells | Capitated LTC only, (primary and acute FFS); multiple rate cells | Capitated primary, acute and LT (NF limited to 1 mo.; Rx not in cap); multiple rate cells | Capitated primary, acute and LTC; single rate | Capitated LTC only, (primary and acute FFS); two rate cells | Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells | Capitated primary, acute and LTC; multiple rate cells |
| **Medicare Payments** | Capitated | FFS | FFS[2] | Capitated | Capitated | FFS | FFS[2] | FFS | FFS | Capitated | Capitated |

[1]Wisconsin Partnership began operating in 1995 as a partially capitated Medicaid model. In 1999, it received the federal waivers needed to become a fully capitated Medicaid/Medicare model.
[2]Some beneficiaries have opted to join companion capitated Medicare Advantage plans.

## What Kinds of Organizations Provide Managed Long-term Care to Medicaid Populations?

Most of the organizations providing managed long-term care to aged and disabled Medicaid beneficiaries are small private nonprofit plans with total enrollments under 1,000. The majority of these plans are affiliated with a provider – a company that offers long-term care services (e.g., home- and community-based care, skilled nursing care) and has developed its own plan to manage care for a group of enrollees. One of the problems with this model is that health care providers generally do not have experience with the business side of managed care.

There are some traditional managed care companies that have ventured into the market, but the numbers are much smaller. One of the key problems with these models can be a lack of experience working with patients requiring long-term care (e.g., frail elderly, disabled). There are two national for-profit managed care companies that have established a significant presence in the market – Evercare, an affiliate of UnitedHealth Group, and Amerigroup. In addition, a few public plans have emerged in Arizona and Wisconsin, and in Massachusetts' new program a few start-up companies are rising to the challenge.

*Consumer satisfaction survey results have been consistently high in most managed care programs.*

With the exception of Arizona, these managed long-term care plans focus primarily on developing programs in urban areas. This ensures that they will have access to a critical mass of potential enrollees as well as an adequate supply of health care providers to establish networks.

## What Are The Benefits of Implementing a Managed Long-term Care Program?

### Cost Savings

Opinions vary regarding the specific benefits of or value added by managing long-term care. With respect to cost savings, the studies are inconclusive. Estimates of program savings range from 5 to 35%, but there are limitations and qualifications that apply to all of the research findings. It is simply not clear whether the programs actually save money for state Medicaid programs. States do report that they are refining their payment systems and hope that additional cost savings may be realized in the future. Even without significant savings, states may prefer managed long-term care to fee-for-service because the capitated payment structure allows for more predictability when planning Medicaid budgets.

### Access to care

With respect to access to care, studies clearly show that management of long-term care can have positive outcomes. In general, managed long-term care:

- Reduces the use of higher cost services, including emergency rooms, hospitals and nursing homes
- Increases access to home- and community-based services
- Allows more flexibility in services than fee-for-service
- Allows consumer-directed care without a waiver (e.g., enrollees choose their services and pay for them through a fiscal intermediary)
- Streamlines access to care by helping the enrollee navigate the system more efficiently
- May save the consumer money relative to fee-for-service if the state does not require comparable cost sharing

### Quality

*Managed long-term care has the potential to alleviate some of the burden of time consuming service coordination that families now face.*

It is unclear whether the quality of care delivered in these managed long-term care programs varies from traditional fee-for service. For example, one study of an intensive staff model managed care program (PACE[4]) reports excellent indicators for enrollees (improved quality of life, functional status, longer life span), but a study of a different program found the care of enrollees living in nursing homes to be of poorer quality than the care received by nursing home residents in a neighboring state. Despite the variety of study outcomes, consumer satisfaction survey results (another quality indicator) have been consistently high in most programs.

## What Challenges Face a State Medicaid Agency Considering Development of a Managed Long-term Care Program?

One of the most daunting challenges facing states wishing to enter this market is program design. Existing managed long-term care programs are highly diverse. There is not necessarily a model that can easily be replicated. A state must decide which populations will be eligible, where the services will be offered, whether enrollment will be mandatory or voluntary, how to coordinate with Medicare with respect to dual eligibles, and perhaps most importantly, how to establish appropriate payment rates. Other challenges to consider include:

- Obtaining legal authority from the federal government (waivers), particularly if the program is intended to integrate Medicare and Medicaid
- Negotiating with other interested parties, such as aging networks, the long-term care industry and the hospitals
- Building an adequate infrastructure in the state Medicaid agency to support a new program
- Identifying organizations interested in establishing new plans

### What Is Happening in North Carolina with Respect to Medicaid Managed Long-term Care?

In the 1990s, North Carolina began the process of developing a program of managed long-term care, but the effort was abandoned prior to implementation. In 2004, the General Assembly authorized the creation of two pilot PACE programs, one in the east and one in the west.[5] PACE is a federal program that combines Medicaid and Medicare funding streams into a single capitated managed care program that serves all of the health care needs of a relatively small frail elderly population. In other words, PACE programs assume the financial risk of providing health care services to elderly people who qualify for nursing home care services with the hope of keeping the enrollees out of the hospital or nursing home for as long as possible.

***PACE is a federal program that combines Medicaid and Medicare funding streams into a single capitated managed care program that serves all of the health care needs of a relatively small frail elderly population.***

The North Carolina Division of Medical Assistance (DMA) has hired a program manager for PACE and is working closely with one potential PACE provider in the Wilmington area who is considering setting up a pilot site in the eastern part of the state. To date, no providers have expressed interest in setting up the second pilot site in the west. DMA expects to begin actively seeking potential candidates in June 2005. Development of a new PACE site typically takes at least 18 - 24 months. DMA updated the General Assembly on their progress on March 1, 2005; the report is available at http://www.dhhs.state.nc.us/dma/PACELegislativeStatus.pdf.

If these PACE pilot sites begin actively enrolling patients, they would be the state's first Medicaid managed long-term care program. While they would provide important information for state policymakers, the budgetary impact of such programs would be slight because the populations served would be quite small.

## How Would Managed Long-term Care Impact Families?

Families with adults or children who require complex, long-term medical care and personal care services spend tremendous amounts of time and energy coordinating the patient's care. Managed long-term care has the potential to alleviate some of this burden on families. On the other hand, depending on program design, managed care could also be perceived as disempowering family members who wish to have some level of control over or participation in the patient's care. Some families may prefer a fully integrated, comprehensive managed care system like PACE. Other families may prefer a program that allows them to play a more hands-on role in the patient's care, such as some of the consumer-directed models that are being tested in other states. While perhaps not immediately intuitive, it is certainly possible to design a program that provides both managed care and consumer direction. Such a system could allow the patient (and the patient's family) flexibility in choosing services and service providers, but impose a cap on the total amount of resources used.

Given that the research suggests managed long-term care programs generally have high consumer satisfaction ratings and that the programs may result in fewer out-of-pocket expenses for the patient and his or her family, chances are good that families would react positively to such a program. But program design, as discussed above, will present a significant challenge for any state entering this market. When designing a new program, the state will have to consider the different effects that their decisions could have not only on providers and patients, but also on the patients' families.

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### Endnotes

[1] *The Past, Present and Future of Managed Long-term Care* by Paul Saucier, Brian Burwell and Kerstin Gerst (April 2005). Soon to be available at http://aspe.hhs.gov/_/topic/topic.cfm?topic=Long-Term%20Care.

[2] "Medicaid and Long-Term Care," Kaiser Commission on Medicaid and the Uninsured (March 2005). Available at http://www.kff.org/kcmu.

[3] North Carolina Institute of Medicine, "A Long-Term Care Plan for North Carolina: Final Report" (January 2001). Available at http://www.nciom.org/pubs/long-term.html.

[4] Program of All-Inclusive Care for the Elderly.

[5] S.L. 2004-124, § 10.12.