As of May 2012, only 16 states were using managed care plans to provide long-term care in their Medicaid programs. However, in coming years this number is likely to increase. Many states are expressing an interest in adopting managed care for some or all of their Medicaid long-term care services. That includes states with a long history of using managed care to deliver medical services in Medicaid, as well as those with much less managed care experience.

States’ interest in managed long-term care for Medicaid is driven by a desire to reduce costs and increase budget predictability. Nationally, about one-third of all Medicaid spending is on long-term care, and that share is projected to increase dramatically as the population ages. As states continue to struggle with budget issues, interest in moving some—or, in some cases, all—of Medicaid long-term care into managed care will grow. Advocates should be prepared for this possibility. If your state isn’t already considering Medicaid managed long-term care, it may do so in the near future.

What Medicaid managed long-term care might mean for consumers in any given state depends on a number of factors, including what the state’s current Medicaid long-term services delivery system looks like, the state’s experience with managed care in Medicaid in general, and how the state structures the managed long-term care program. This issue brief gives a general background on managed long-term care in Medicaid and outlines some points to consider if your state is moving toward managed long-term care in Medicaid. For more information about evaluating different approaches and assessing which might be best for consumers in your state, see Evaluating Managed Long-Term Care Proposals in Your State: Key Areas for Advocacy, available online at www.familiesusa.org.
“Managed Long-Term Care” Can Mean Different Things

Historically, states have paid for long-term care in Medicaid on a fee-for-service basis, meaning that when someone with Medicaid uses long-term services, the providers bill Medicaid for payment. Typically, there is little formal coordination between different providers.

States are moving toward managed long-term care in order to encourage care coordination and enhance budget certainty. In this issue brief, we use the term “managed long-term care” to refer to an arrangement where the state contracts with one or more managed care plans to provide a set of long-term services and supports to Medicaid beneficiaries. The plans are paid on an at-risk basis, meaning that plans receive a set amount of money per Medicaid beneficiary per month (a capitation payment). Plans are at financial risk: They lose money if costs exceed payments, and they make money if payments exceed costs.

This at-risk arrangement gives states greater budget certainty. Additionally, because there is an incentive for plans to provide care efficiently, it should result in better care coordination and greater use of lower-cost community care as opposed to institutional care. However, if the state’s contracts with the health plans aren’t carefully designed, plans may have an incentive to skimp on care or leave consumers without access to the services they need.

Managed care is the primary way that states are looking to restructure long-term care in Medicaid, but it is not the only option. Other ways to improve care and achieve greater value for state dollars include the development of health or medical homes. Additionally, the Affordable Care Act offers opportunities for states to better integrate care in Medicare and Medicaid for individuals who are eligible for both programs (dual eligibles). These other options for improving long-term care can be part of a move toward managed care, or they can be pursued on their own. If your state is just starting to look at managed long-term care, you should make sure they are considering all the options. (See “Other Options for Managing Long-Term Care in Medicaid” on pages 3 and 4.)
Other Options for Managing Long-Term Care in Medicaid

There are lots of ways states can improve management of long-term care in Medicaid. These options can be done as stand-alone programs or as part of an at-risk managed care program.

1. **Paying providers a case management fee**

States can pay providers a monthly case management fee per patient to coordinate care. For example, some states operate Enhanced Primary Care Case Management (EPCCM) programs, in which primary care practices receive payments to work with other types of providers, such as home health agencies, specialists, and community-based social service providers to coordinate the full range of services that their patients need.

2. **Medical homes that include a long-term care component**

Many states provide enhanced reimbursement rates to a range of providers that are designated as “medical homes.” These medical homes actively monitor and coordinate care for high-need patients. Medical homes can vary in both the populations they serve and in the services they focus on.

3. **Health homes**

This is a new Medicaid option created in the Affordable Care Act. Participating states receive a 90 percent federal match for health home services for two years. Like medical homes, health homes coordinate care, but there are important differences. To qualify as a health home under the Affordable Care Act, a program must include specified acute and long-term services, it must be limited to certain chronically ill Medicaid enrollees, and the state must file evaluation reports with the Center for Medicare and Medicaid Services (CMS). (For more information about health homes, see Families USA’s forthcoming issue brief, *Understanding Health Homes in Medicaid.*

4. **Program of All-Inclusive Care for the Elderly (PACE)**

PACE programs provide a full range of Medicaid and Medicare services to people over 55 who would otherwise qualify for nursing facility care. Over half of the states currently operate one of these programs, which offer another model for managing long-term care in Medicaid.

(Continues on next page)
5. **Accountable Care Organizations (ACOs)**

Under the Affordable Care Act, states are testing a new way of paying for care in which a group of providers from across the continuum of care accepts responsibility for coordinating the delivery of medical and community-based services and supports. In return, providers get to keep a share of the savings that result from avoiding duplicative treatment and improving health care outcomes, giving them an incentive to work together to improve the quality and effectiveness of care. (See Families USA's issue brief, *Making the Most of Accountable Care Organizations (ACOs): What Advocates Need to Know.*

6. **Integrating care for dual eligibles**

The Affordable Care Act includes new opportunities and resources for states to improve care coordination for people eligible for both Medicare and Medicaid (dual eligibles). States are currently submitting proposals to CMS to implement demonstration programs that test a range of approaches to integrating care for this population. These proposals may include managed long-term care in Medicaid. Advocates can review and weigh in on these proposals during public comment periods that are required at both the state and federal levels. (See Families USA's issue brief, *A Guide for Advocates: State Demonstrations to Integrate Medicare and Medicaid.*

In rural areas, it can be difficult for states to contract with managed care plans or develop a comprehensive provider network. In those areas, provider-based case management approaches (see number 1) might work better. If your state does not have very much experience with managed care in Medicaid—meaning that there are not many managed care plans in your state that have experience serving the Medicaid population—it also might be best to start with a case management approach rather than rushing to put plans at risk for long-term care costs. A case management approach can also provide alternatives for Medicaid beneficiaries in states where enrollment in managed care is voluntary. These programs can also provide competition for managed care plans and give states a basis to assess their performance.
Not All Managed Care Plans Look Alike

Managed long-term care can look different from state to state, or even county to county. Program design can differ in the following ways:

- **Enrollment**: Enrollment in managed care can be optional or mandatory for Medicaid beneficiaries who need long-term services.
- **Geographic Scope**: Programs can be statewide or limited to select areas, such as one or more counties or designated urban areas.
- **Services**: Across states, the services for which managed care plans are at financial risk can vary. Plans can be at risk for all medical and long-term services; all long-term services, but not medical care; or just home- and community-based care, excluding medical, nursing home, and other institutional long-term care services. Plans can also be at risk for Medicare services, although that requires a contract with the Center for Medicare and Medicaid Services (CMS), which administers Medicare.
- **Populations**: Programs can cover all Medicaid beneficiaries who need long-term care, or they can limit coverage based on things like age or type of disability. Many programs exclude individuals who are eligible for both Medicaid and Medicare (referred to as “dual eligibles”).
- **Consumer-Direction**: Programs may or may not give beneficiaries the option to direct their own services and supports within the managed care plan. When consumers direct their own services, they are either given a budget to pay for certain goods and services, or they have some control over hiring, scheduling, and training personal care attendants.
- **Flexibility**: Plans may be given the flexibility to cover services or items not typically included in Medicaid if doing so would improve care or increase the likelihood that someone could avoid seeking institutional care.
- **Vendors**: States may contract with a single managed care plan or multiple managed care vendors.

For more information on how to evaluate these different approaches and how to assess which might be best for consumers in your state, see Families USA’s [Evaluating Managed Long-Term Care Proposals in Your State: Key Areas for Advocacy](Evaluating Managed Long-Term Care Proposals in Your State: Key Areas for Advocacy).
Results Thus Far

Because few states have Medicaid managed care programs and most of them are relatively new, performance data are limited. However, the following trends are emerging:

- Compared to fee-for-service Medicaid, managed long-term care tends to reduce the use of institutional care and increase the use of home- and community-based services.⁴
- Studies of quality measures such as patient satisfaction, incidence of pressure ulcers, and general patient decline have largely shown positive results. In six programs where quality of care was evaluated, four reported improvements across the board, and two reported mixed results, with improvements on some measures but not others.⁵
- Data on cost savings for states are less conclusive.⁶ Studies from five states that have reported on costs have found very mixed results: Two reported savings overall, two reported savings in some areas but not others, and one reported no savings.⁷

From these early studies on plan performance, data seem to show that managed long-term care in Medicaid can have some positive implications for consumers, such as increased use of home- and community-based care. However, state experience shows that it does not guarantee savings for state Medicaid programs. States that try to generate savings through low plan payments could be setting up a system that will reduce quality and hurt consumers. That could ultimately mean that more consumers would need more expensive institutional services down the road.

One of your roles as an advocate can be to educate policy makers and help manage expectations about savings.

(See “Help Manage Your State’s Expectations for Savings” on pages 8 and 9.)
Points to Consider If Your State Is Looking at Managed Long-Term Care in Medicaid

Whether managed long-term care in Medicaid is good for consumers in your state depends on several factors. The program needs to include adequate consumer protections and sufficient attention to quality and access, and it needs to be designed well. Most importantly, it cannot be looked at solely as a way to cut costs. Results from existing programs show that managed care has the potential to improve long-term care in Medicaid and help more consumers get care in their homes and other community-based settings. The results are not conclusive, however, when it comes to immediate cost savings for states.

When you assess whether managed long-term care is a good idea, you should consider the following points:

- **Managed care can help rebalance long-term services use, especially in states with high institutional care use.**

  Managed long-term care in Medicaid can increase the use of home- and community-based services.\(^8\) If the percentage of Medicaid beneficiaries that receive services in home- or community-based settings is low in your state, managed care might help shift that balance.

  Home- and community-based care is less costly per person than institutional care.\(^9\) Since managed care plans have an incentive to reduce costs, they have an incentive to help consumers stay in the community. States can use payment policies that encourage managed care plans to improve access to services in home- and community-based settings, to prevent unnecessary institutionalization, and to move patients in institutions who don’t need that level of care back into the community.

- **Managed care can improve care coordination.**

  People who need long-term care often require an array of medical and social services. Unfortunately, our health care system generally does a terrible job of coordinating these services. It usually falls on consumers or their family members to coordinate long-term services. Navigating the long-term care system can be difficult for anyone, but it is particularly hard for people who have multiple chronic conditions, need a variety of services and supports, or have cognitive impairment—all of which are not uncommon among Medicaid beneficiaries who need long-term care.

  Managed care plans have an incentive to see that people get the services they need in the least costly setting possible, which is usually in the community. If your state’s Medicaid program has repeatedly failed to help consumers adequately coordinate their long-term care or their medical and long-term care, managed care could help.
Managed care plans can help counter a strong nursing home lobby.

If a strong nursing home lobby has stymied efforts to increase home- and community-based options in your state, managed care might help. As noted above, managed care plans will have a strong incentive to keep consumers in the least costly setting, and that is usually not a nursing home. Moving to managed long-term care where the managed care plan is at risk for both institutional and non-institutional care can take the task of dealing with a strong nursing home lobby out of the political forum. Instead, the managed care plans become responsible for negotiating with individual nursing homes as well as ensuring that plan enrollees are not admitted to a costly nursing home if they could receive care in the community.

Managed care can help increase accountability for outcomes.

States can require health plans to collect data on plan participants. States can also adjust plan payments based on a variety of outcomes, such as rates of institutionalization or hospitalization, emergency room and preventive care use, or hospital readmissions. With a comprehensive managed care contract—particularly one where the plan is responsible for both medical and long-term care—a single entity can be held responsible for collecting data, delivering services, and evaluating health outcomes. This can make it easier to identify and address quality of care and plan performance issues.

Managed care could be preferable to other changes in or cuts to Medicaid.

Consider the budget and political realities in your state. If your state doesn’t pursue managed long-term care in Medicaid, would that mean making other cuts that could hurt consumers more? If so, rather than opposing managed long-term care, a better course of action might be to work with your state to make sure that its managed care proposal includes as many consumer protections as possible.
Managed Long-Term Care in Medicaid: What Advocates Need to Know

Help Manage Your State’s Expectations for Savings

States that expect managed long-term care to be a budget cure-all could be disappointed. While Medicaid managed care systems may generate cost savings over time, it’s not guaranteed. Data on cost savings are inconclusive, and some states may even see costs go up initially for the following reasons:

- **Building a comprehensive care management team takes time and money.** Effectively managing long-term care requires a comprehensive, coordinated network of providers. Without this network, care can’t be managed, and the long-term sustainable savings that the state might see from reduced use of nursing homes won’t happen. Therefore, it is essential that contracted managed care plans invest in bringing together a comprehensive provider network, and the state must provide adequate funds for that to happen. States will also face significant up-front costs for administrative and IT systems. In some cases, the shift to managed care might also mean higher provider reimbursement rates.

- **There might be unmet needs.** A good care management program should include greater consumer access to home- and community-based care. As a result, there might be more demand for services from Medicaid beneficiaries whose needs had previously been unmet.

- **Reducing overall costs takes time.** There are data showing that, over time, better service coordination and improved access to community-based services can reduce the use of higher-cost services, such as emergency rooms, hospitals, and nursing homes. It can also result in lower prescription drug costs. However, these kinds of changes don’t happen overnight, and seeing results from better care management can take time.

As an advocate, you can educate state legislators and government officials about limited short-term cost-savings data and make sure that they understand the factors that will help your state ultimately achieve savings through managed long-term care. If your state intends to nickel-and-dime the managed care plan to get short-term savings and skimp on investing in systems to support better care in the long run, it is setting the stage for disastrous outcomes, such as inadequate provider networks, poor care, incentives for plans to deny services, and, over time, the possibility of higher nursing home use. Remind legislators that this could also lead to political backlash.
Getting Involved

If your state is moving forward with managed long-term care in Medicaid, it is important to get involved early on to make sure that the program your state implements is well-structured, with ample consumer protections. The state should also set up a formal procedure for engaging consumers and consumer groups throughout the process of program design, vendor selection, and program monitoring and evaluation. Such a procedure would allow advocates to influence the process and make sure the program reflects consumers’ needs.

When systems for input from advocates and consumers are in place, it’s important to delve into the details of program structure, the contract with the managed care plan, and the state’s proposal for ongoing monitoring and oversight. For a checklist of what to look for in this process, see Families USA’s Evaluating Managed Long-Term Care Proposals in Your State: Key Areas for Advocacy.

Conclusion

It’s probably too late to stop states from moving into managed long-term care in Medicaid, but that might not be bad news. Currently, long-term care is fragmented, it is difficult for consumers and their families to navigate the maze of services, and many states have been slow to shift long-term care in Medicaid from an institutional to a home and community focus. If done well, managed care has the potential to help on all those counts. If done poorly, it can make matters worse and leave consumers without the care they need.

If your state is thinking about moving to Medicaid managed long-term care, or if it has already started to do so, think about where your state is right now in terms of Medicaid long-term care services. Based on the points discussed in this issue brief, the most productive course of action might be to get engaged to make sure that there is consumer input every step of the way—from program design through monitoring and evaluation. That way, you can help make sure that managed long-term care is an improvement over the current system.
Endnotes


5 Presentation by Paul Saucier, op. cit.

6 Kaiser Commission on Medicaid and the Uninsured, op. cit.

7 Presentation by Paul Saucier, op. cit.

8 Wendy Fox-Grage and Paul Saucier, AARP, Medicaid Managed Long-Term Care (Washington: AARP Public Policy Institute, November 2005), available online at http://assets.aarp.org/rgcenter/il/inb108_mmltc.pdf.

9 To see how home- and community-based care costs compare to institutional care costs in your state, see Families USA’s series Health Reform: New Opportunities for States to Invest in Home- and Community-Based Services, available online at http://www.familiesusa.org/issues/long-term-services/states/new-opportunities-for-states.html. Each state fact sheet includes information on the per capita cost difference between institutional and home- and community-based care.

10 Wendy Fox-Grage and Paul Saucier, op. cit.; Kaiser Commission on Medicaid and the Uninsured, op. cit.

11 Kaiser Commission on Medicaid and the Uninsured, People with Disabilities and Medicaid Managed Care: Key Issues to Consider (Washington: Kaiser Family Foundation, February 2012).

12 Wendy Fox-Grage and Paul Saucier, op. cit.; Kaiser Commission on Medicaid and the Uninsured, Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider, op. cit.
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