AARP® Public Policy Institute

1985 Celebrating 20 Years 2005

IN BRIEF

In Brief: Medicaid Managed Long-Term Care

Introduction and Purpose

This is a summary of the AARP Public Policy Institute issue brief *Medicaid Managed Long-Term Care*. Medicaid managed long-term care (MMLTC) is a contractual agreement between a Medicaid agency and a contractor (health maintenance organization, community services agency, provider organization or other entity) under the terms of which the contractor accepts financial risk through a capitated payment for providing long-term care benefits to Medicaid beneficiaries.

In 2003, nearly 28 million of 40.5 million Medicaid beneficiaries (69%) received some or all of their services through risk-based managed care organizations. Despite the prominence of managed care in the Medicaid program overall, nearly all seniors and people with disabilities who receive Medicaid-funded long-term care continue to receive services in traditional fee-for-service programs.

Amid federal and state budget pressures, policymakers in many states are either planning to start new managed care programs for Medicaid beneficiaries with long-term care needs or expanding existing programs.

This issue brief reviews the limited but important experience of states that have implemented MMLTC programs to date, identifies key policy issues, and assesses the likelihood of future growth in these programs.

Key Findings

1. Enrollment in MMLTC programs is small but likely to grow in the near future. Estimated national enrollment in 2004 in MMLTC programs was just under 70,000. State-specific MMLTC programs exist in Arizona, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin, and Programs for All-inclusive Care for the Elderly (PACE) operate in 18 states. In the next two years, California, Hawaii, Maryland, and Washington hope to enter the market. More significantly, a number of existing programs (for example, those in Texas, Florida, and Minnesota) have proposed expansions that could add significant numbers of people to MMLTC programs by the end of the decade.

2. MMLTC reduces the use of high cost services (including emergency rooms, hospitals, and nursing homes) and promotes greater access to home and community-based services. A limited but growing number of studies have shown positive outcomes regarding MMLTC changes in utilization of services, generally reducing the use of emergency rooms, hospitals and nursing homes, and increasing the use of community-based services such as personal care, home health, and home-delivered meals.

3. Although policymakers are drawn to the potential cost savings associated with MMLTC, cost studies to date are inconclusive. Cost savings have been difficult to demonstrate with

certainty, but state officials value the increased predictability of costs that MMLTC provides. Unlike fee-for-service, in which the states' costs depend on the use of services, MMLTC costs are based on a set payment per beneficiary, which makes budgeting more predictable.

4. MMLTC programs appear to increase or maintain quality. Consumer satisfaction tends to be high among consumers and family members. Functional status has been maintained in some programs and improved in others. A study of the PACE program found that enrollees lived longer and spent more days in the community than members of a fee-for-service comparison group.

5. MMLTC has been slow to develop, in part because it involves complex policy choices and intense stakeholder engagement. Some consumers, advocates, and providers have resisted managed care for long-term care populations because of consumer concerns regarding loss of choice and restricted access to care and provider concerns about being displaced. Program designers and policymakers have found MMLTC much more challenging to develop than managed care for parents and children. They must weigh a number of program and policy choices, including the type of contractor to use, mandatory versus voluntary enrollment; what benefits to include in the capitation; program eligibility (e.g., the broad long-term care Medicaid population versus only those who are eligible for nursing facilities); the geographic area to be served (statewide versus regional); payment methods and rates; quality assurance; and federal waivers needed, if any. The issue brief explores each of these options.

Conclusions

In the past, policymakers have been cautious about moving toward MMLTC, in part because of the potential for instability arising from private contracting (as illustrated by the withdrawal of private Medicare managed care plans from the Medicare program in the late 1990s); the complexity of the design options; the difficulty of receiving approval from the federal government; and resistance from some consumers, advocates, and providers. Because managed care organizations aim to control costs, some consumers, providers, and policymakers are concerned that access to needed and costly care will be reduced inappropriately for seniors and people with disabilities, jeopardizing their safety and quality of life.

Now, interest in MMLTC appears to be rising. A still limited but growing number of studies has emerged providing evidence that a central goal of MMLTC, reducing hospital and nursing home care in favor of more community-based care, is achieved. With state and federal efforts to contain Medicaid costs and provide more community-based long-term care to growing numbers of people of all ages, pressure is building for alternatives to traditional fee-for-service approaches, which some view as unsustainable. Despite inconclusive evidence of cost savings, these factors may result in a new wave of MMLTC planning and implementation in states.

For the full issue brief, see AARP Public Policy Institute Paper #79
In Brief prepared by Wendy Fox-Grage and Paul Saucier, November 2005
©2005, AARP. Reprint with permission only.
AARP, 601 E St., NW, Washington, DC 20049
http://www.aarp.org/ppi 202-434-3860 ppi@aarp.org