MEDICAID MANAGED LONG-TERM CARE
Challenges and Opportunities for State Policymakers and Low-Income Individuals

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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

<table>
<thead>
<tr>
<th>Category</th>
<th>MI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollees</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>52.3%</td>
<td>52.5%</td>
</tr>
<tr>
<td>Adults</td>
<td>24.1</td>
<td>22.8</td>
</tr>
<tr>
<td>Disabled</td>
<td>16.1</td>
<td>14.7</td>
</tr>
<tr>
<td>Elderly</td>
<td>7.5</td>
<td>10.1</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>16.0%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Adults</td>
<td>10.8</td>
<td>11.8</td>
</tr>
<tr>
<td>Disabled</td>
<td>39.4</td>
<td>40.0</td>
</tr>
<tr>
<td>Elderly</td>
<td>19.4</td>
<td>26.4</td>
</tr>
<tr>
<td>Unknown</td>
<td>14.4</td>
<td>4.6</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Category</th>
<th>MI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>$1,334</td>
<td>$1,531</td>
</tr>
<tr>
<td>Adults</td>
<td>1,950</td>
<td>2,012</td>
</tr>
<tr>
<td>Disabled</td>
<td>10,629</td>
<td>13,014</td>
</tr>
<tr>
<td>Elderly</td>
<td>11,192</td>
<td>11,455</td>
</tr>
<tr>
<td>Total</td>
<td>3,724</td>
<td>4,248</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th></th>
<th>MI</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicaid LTC Expenditures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional services</td>
<td>68%</td>
<td>61%</td>
</tr>
<tr>
<td>Community-based services</td>
<td>32</td>
<td>39</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>MI</th>
<th>US</th>
<th>MI Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Medicaid services</strong></td>
<td>$815</td>
<td>$998</td>
<td>#37</td>
</tr>
<tr>
<td><strong>Nursing home services</strong></td>
<td>143</td>
<td>159</td>
<td>31</td>
</tr>
<tr>
<td><strong>Home care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- HCBS waivers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- MR/DD</td>
<td>47</td>
<td>86</td>
<td>44</td>
</tr>
<tr>
<td>- A/D</td>
<td>7</td>
<td>19</td>
<td>39</td>
</tr>
<tr>
<td>- Personal care</td>
<td>18</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td>- Home health</td>
<td>2</td>
<td>13</td>
<td>42</td>
</tr>
</tbody>
</table>

**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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Michigan $/Millions</th>
<th>% Change From Prior Year</th>
<th>United States $/Millions</th>
<th>% Change From Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$183</td>
<td></td>
<td>$5,711</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>177</td>
<td>-3.2%</td>
<td>6,098</td>
<td>6.8%</td>
</tr>
<tr>
<td>2003</td>
<td>209</td>
<td>17.6%</td>
<td>7,049</td>
<td>15.6%</td>
</tr>
<tr>
<td>2004</td>
<td>212</td>
<td>1.6%</td>
<td>7,847</td>
<td>11.3%</td>
</tr>
<tr>
<td>2005</td>
<td>217</td>
<td>2.5%</td>
<td>9,102</td>
<td>16.0%</td>
</tr>
<tr>
<td>2006</td>
<td>183</td>
<td>-15.7%</td>
<td>9,340</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

- 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**

<table>
<thead>
<tr>
<th></th>
<th>MI</th>
<th>US</th>
<th>MI Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupancy rate</strong></td>
<td>86%</td>
<td>83%</td>
<td>#22</td>
</tr>
<tr>
<td><strong>Nursing home residents as a percent of 65+ population</strong></td>
<td>3.2%</td>
<td>3.6%</td>
<td>#16</td>
</tr>
</tbody>
</table>

- 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:
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