Medicaid and Managed Long-Term Care

Context, Authorities and Next Steps

Mary P. Sowers
Disabled and Elderly Health Programs Group
Centers for Medicare and Medicaid Services (CMS)
Context

- Tight State Budgets
- Increasing per person Medicaid costs
- Increasing percentage of population over age 65
- Increasing life expectancies
Proportion of U.S. Residents Age 65 and Older

Source: Thomson Healthcare; Steve Eiken, Brian Burwell, Kate Sredl, and Amanda Stubbs
May 1, 2008
LTC Expenditures by Payer: United States, 2005

- Medicaid: 48.9%
- Medicare: 20.4%
- Out-of-Pocket: 18.1%
- Other Private: 2.7%
- Private Insurance: 7.2%
- Other Public: 2.6%

Source: Georgetown University Long-Term Care Financing Project
Source: Thomson Healthcare; “LTC Chartbook” Steve Eiken, Brian Burwell, Kate Sredl, and Amanda Stubbs May 1, 2008
Medicaid Institutional and Community-Based Expenditures in 2005 Dollars: FFY 1980-2005

Source: CMS Form 64 Reports, adjusted for price increases based on the Skilled Nursing Facility Input Price Index.
Source: Thomson Healthcare; “LTC Chartbook” Steve Eiken, Brian Burwell, Kate Sredl, and Amanda Stubbs May 1, 2008
Increased Interest in Managed Long-Term Care

- States pursue managed long-term care for a number of reasons:
  - Budget predictability
  - Coordinated, accountable care options
  - Quality

- Managed long-term care models strive to achieve a coordinated approach to serving a vulnerable population.
Managed Long-Term Care: Early Assessments

“Studies of managed long-term care programs have been largely positive, finding high consumer satisfaction levels, lower utilization of institutional services and increased access to home- and community-based services. Cost studies have been more mixed, with no clear consensus emerging as to whether managed long-term care saves money for public purchasers. Savings notwithstanding, the budget predictability that comes with capitated payments is appealing to state policymakers as growing numbers of long-term care consumers place increasing pressure on Medicaid budgets.”

US Dept. of HHS; ASPE; Saucier, Burwell, Gerst; “The Past, Present and Future of Managed Long-Term Care. April 2005
Vehicles for Medicaid Managed Long-Term Care

- Section 1915(b)/1915(c) Waivers
  - 1915(b) Waivers
    - 1915(b)(1) – mandates managed care
    - 1915(b)(2) – utilize a central broker
    - 1915(b)(3) – use cost savings to provide additional services
    - 1915(b)(4) – limits number of providers for services
  - 1915(c) Waiver
    - Allows Waiver of:
      - Comparability
      - Statewideness
      - Income and Resources for the Medically Needy
Vehicles for Medicaid Managed Long-Term Care, Continued

1915(b)/1915(c) Side by Side

- **1915(b)**
  - Managed Care
  - Title XIX Eligibility
  - State Plan Services
  - Cost Effective
  - Initial - 2 Years
  - Renewal - 2 Years
  - CMS 64

- **1915(c)**
  - HCBS
  - NF/ICF/MR LOC
  - Alternative Services
  - Cost Neutral
  - Initial - 3 Years
  - Renewal - 5 Years
  - HCFA 372
Vehicles for Medicaid Managed Long-Term Care, Continued

- Section 1932(a) State Plan/1915(c) Waiver Concurrent Authority

- Section 1115 Research and Demonstration Projects
  - Arizona, Vermont and Hawaii
Vehicles for Medicaid Managed Long-Term Care, Continued

- Section 1915(a)
  - Provision of the Social Security Act that allows for voluntary managed care, including pre-payment and capitation;
  - May be limited geographically;
  - Does not provide for a limitation of provider;
  - For LTC, this authority may be coupled with a 1915(c) waiver
  - All applicable managed care rules (42 CFR 438) will apply (i.e., for PAHP, PIHP and MCO)
Challenges and Next Steps for CMS

- Identification and removal of barriers to managed long-term care while:
  - Ensuring quality for Individuals
  - Ensuring financial accountability
  - Assisting States to Identify Positive Incentives