

The Growing Need for Managed Care—and Flexible Care Models— In Medicaid Long-Term Care Programs

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In 1991, spending on home and community-based long-term care accounted for 14 percent of total Medicaid long-term care expenditures. By 2005, that number had increased to 37 percent.¹ As the costs of providing long-term care services for the elderly and disabled continue to soar, more and more states, and their Medicaid budgets, are banking on a simple fact: people prefer to remain at home as they grow older and face the inevitable health challenges that come with aging. Keeping people in their homes or community-based facilities (adult day care, assisted living facilities), instead of institutional settings (hospitals, nursing homes) holds an added attraction for financially stretched states. With the plethora of services available today, it is a strategy that can result in better quality care, as well as being more cost-effective.

For many years, the state- and federally-funded Medicaid long-term care system discouraged state programs from investing dollars in programs designed to keep elderly and disabled beneficiaries at home rather than in long-term care facilities. In 1989, Arizona (AZ) elected to challenge these restrictions by planning a program that applies managed care principles to long-term care, i.e., giving preference to lower-cost home and community-based services. Though faced with roadblocks from the federal government, the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, pled its case with HCFA (now the Centers for Medicare and Medicaid Services (CMS)) and received a waiver to implement this new long-term care model. Today, due partially to the AZ experience, this federal barrier no longer exists. In the nearly 20 years since the introduction of AZ's groundbreaking managed care model, other state Medicaid agencies have recognized the value of supporting the elderly and disabled populations with home and community-based care, and adopted this approach.

Studies continue to show the cost-effectiveness of keeping long-term care beneficiaries in a home or community environment instead of an institution. Nationwide, the cost of providing health care services to members in their own homes is 50 percent less than if the member were placed in an institutional setting² In AZ, the financial returns have been even greater. In 2005 (the most recent year for which figures are available), the cost for maintaining a long-term care member in an AZ institutional setting was \$3,518 per month versus \$1,245 for a member in a home or community setting, a cost savings of \$2,273 per member per month, or approximately 65 percent.³

AZ's governor, Janet Napolitano, told a Congressional committee that she will use her role as chair of the National Governors Association to work for "meaningful reform that includes not just the public sector, but also the engagement of the private sector for solutions that improve the health of our health care system."⁴ AZ's Medicaid long-term care program provides "a robust cost-effective model for other states as they and the federal government seek an alternative model," Governor Napolitano told the Senate Special Committee on Aging in July 2006. "Expanding the AZ model to new populations could cut Medicaid spending without eliminating services, limiting enrollment or increasing cost sharing for the poor."⁴

One thing is certain: as states face constant pressure to balance budgets, they will be confronted with increasing numbers of elderly citizens. The nation's elderly population is expected to exceed 70 million by the year 2030—twice the number in 2000, according to the American Geriatric Society.⁵ Many governors and legislatures already have announced plans to re-evaluate their Medicaid programs in light of budget constraints and changing demographics.

At the same time, plenty of opportunities exist to improve health outcomes and control costs for Medicaid long-term care beneficiaries. Currently, 11 states report that less than half of their long-term care populations are enrolled in managed care programs, while three states—Alaska, New Hampshire and Wyoming—have none enrolled in managed care.⁶ Why are these rates still low? Because some of the same skepticism voiced by critics of the AZ plan nearly 20 years ago persist:

1. Managed care requires a new funding model. Long-term care is funded by a handful of federal and state revenue sources. For the managed care program to work, these different funding sources have to be coordinated.

2. While consumers, their families, and their advocates are critical of the existing systems, these systems are still familiar. Change is always threatening. Even if they like the idea of a program that allows their loved ones more flexibility in care models, they also fear a new model might somehow fail them.

In coming years, it will be increasingly difficult for any state to look at its health care costs and statistics and decline to use a managed care approach for its long-term care Medicaid programs. As AZ's Medicaid program for long-term care beneficiaries shows, managed care matched with flexible care models allows states to creatively meet the health care needs of the growing aging population in an efficient, cost-effective manner.

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