Medicaid Managed Long-Term Care: Will it Solve Medicaid’s Financial Crisis?

Jenna Steffy∗

I. INTRODUCTION

The number of elderly persons in the United States continues to grow as a result of increased life expectancies and the aging baby boomer population.1 Accordingly, the demand for long-term medical care assistance through Medicaid is certain to rise.2 Medicaid is the dominant financing system for individuals with long-term medical needs.3 However, Medicaid programs are bound to abide by their particular state’s budget while endeavoring to meet the increased demand for long-term medical services.4 A Medicaid system that offers managed long-term care for the elderly would help programs maintain a high quality of care as its state incurs more financial responsibility.

This article is a brief introduction to the Medicaid system and how it

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∗ Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2013. Ms. Steffy is a staff member of Annals of Health Law.

2. Id.
4. Id.
addresses managed long-term care for the elderly. Medicaid and managed long-term care programs are extremely complex. This article is intended to give a broad overview of how a managed long-term care program could integrate within the Medicaid system. This article provides a look into the bulk of long-term care expenditures by the Medicaid system, whether a managed care or fee-for-service system is most cost effective, and whether a proposed managed long-term care program should be mandatory or voluntary.

II. OVERVIEW OF MEDICAID

In 1965, the federal government created Medicaid and Medicare to provide health care entitlements to needy individuals. Medicaid is the nation’s primary provider of public health care coverage for millions of high-need and low-income Americans. Federal and state governments jointly finance the Medicaid program; states maintain the autonomy to manage their programs while remaining consistent with broad federal guidelines. Because each state has the power to control its Medicaid program, distinction between state programs is widespread.

In order to qualify for Medicaid, candidates must fit into an eligibility group that is required by both federal and state law. Federal law requires that candidates for Medicaid be “categorically needy” individuals. The coverage groups of categorically needy individuals are persons who receive welfare, minors and the parents of minors, persons with disabilities, pregnant women, and the elderly. Individuals that fall within any of the aforementioned coverage groups must also have income or economic

6. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM 1 (Apr. 2010).
7. Tenzer, supra note 5, at 342.
8. Id.
10. Tenzer, supra note 5, at 339.
11. Id.
resources that fall below a certain level; the economic resource level that
determines Medicaid eligibility may vary from state to state. 12  Aside from
the categorically needy, states are permitted to expand their coverage to
groups that are “medically needy.” 13  A medically needy individual is
someone who belongs to a specific coverage group and whose income or
economic resources exceed the limit set for the categorically needy. 14
However, a medically needy candidate can become eligible if a certain
amount of his or her income and personal resources are spent on medical
care. 15  Once a medically needy candidate’s expenses on medical care
exceed the established state limit, Medicaid will cover any additional
expenditure required for the care of that candidate. 16

Federal law not only mandates the population that is covered by
Medicaid, it also determines the services that are afforded to them. 17
Inpatient and outpatient hospital services, physician services and care
within nursing facilities are among those covered under the law. 18
Congress’s intent in the Medicaid statute was to provide individuals in need
with the same standard of medical services received by individuals who
have health insurance. 19

III. WHAT IS MANAGED LONG-TERM CARE?

Among the millions of individuals on Medicaid, a significant portion
requires long-term care. 20  Long-term care services include those provided
within the community, such as doctor visits and personal care at the home,
as well as institutional care, namely hospital and nursing home placement. 21
The aging process often results in decreased mobility and cognitive

12. Id.
13. Id.
14. Id.
15. Id.
16. Id.
17. Id. at 342-43.
18. Id. at 343.
19. Id. at 339.
20. SAUCIER ET AL, supra note 1, at 2.
functioning, as well as the onset of debilitating diseases. 22 This combination of factors creates the need for increased medical services on a more frequent basis. 23 Medicaid managed long-term care seeks to provide a system of care for the elderly to support them within their communities and postpone or prevent the need for institutional placement in hospitals and nursing homes. 24

IV. ELDERLY LONG-TERM CARE EXPENSES

The average yearly cost to an individual for nursing home stay is $70,000. 25 Medicaid covers approximately fifty percent of nursing home costs. 26 Elderly individuals with income levels and assets that strip them of Medicaid eligibility can quickly become eligible due to the depletion of personal resources from an extended nursing home stay. 27 Consequently, over half of all nursing home residents will become eligible for Medicaid support due to the enormous cost. 28 Services provided by nursing homes include skilled nursing care, rehabilitative therapies, and basic custodial care. 29 Medicaid incurs the cost for approximately half of these services. 30 Managed long-term care, through an organized and coordinated system of assessing the breadth of an individual’s medical needs, aims to disrupt nursing home placement by providing care to the elderly within their

21. Id.
22. KAISER, LONG-TERM CARE SERVICES AND SUPPORTS, supra note 3, at 1.
23. Id.
25. KAISER FAMILY FOUND., KAISER COMM’N ON MEDICAID AND THE UNINSURED, PAYING FOR NURSING HOME CARE: ASSET TRANSFER AND QUALIFYING FOR MEDICAID (Jan. 2006) [hereinafter KAISER, NURSING HOME CARE].
27. KAISER, NURSING HOME CARE, supra note 25.
28. Id.
30. Id. at 5.
communities.31

V. MANAGED LONG-TERM CARE VERSUS FEE-FOR-SERVICE

Services needed by Medicaid beneficiaries range from acute to long-term care.32 Nearly all beneficiaries that require acute care receive their services through a managed care organization (MCO).33 Alternatively, nearly all long-term care beneficiaries receive their services on a fee-for-service basis.34 Managed care differs from the fee-for-service system because the MCO assumes either full or partial financial risk.35 Under the traditional fee-for-service system, medical providers issue a fee for each service they provide and are reimbursed by the state’s Medicaid program.36 Fee-for-service providers are only responsible for the specific service that they provide.37 Little incentive exists to perform the most efficient service because under this system, each service provided is reimbursed, resulting in provider profit.38

However, under the risk-based approach to managed long-term care, the state’s Medicaid program arranges to have a single MCO, also known as a contractor, provide a package of long-term care benefits.39 The MCO then contracts with medical providers to render medical services to the beneficiaries within their program.40 When choosing which medical providers to contract with, the MCO may seek providers known to be cost-effective or it may choose to pay providers a capitated per patient fee.41

31. KAISER, LONG-TERM CARE SERVICES AND SUPPORTS, supra note 3.
32. Id. at 1.
33. PAUL SAUCIER & WENDY FOX-GRAE, MEDICAID MANAGED LONG-TERM CARE 1 (Nov. 2005).
34. Id.
36. Tenzer, supra note 5, at 334.
37. SAUCIER & FOX-GRAE, supra note 33, at 2.
38. Tenzer, supra note 5, at 334.
39. SAUCIER & FOX-GRAE, supra note 33, at 1.
40. Tenzer, supra note 5, at 336.
41. Id.
Medical providers with a capitated per patient fee bear the burden that the cost of each beneficiary’s care will not exceed the providers’ per capitated fee, impinging upon profit margins.\(^{42}\) Conversely, if a medical provider does not have a capitated fee, but instead bills the MCO for each service, the MCO bears the financial risk when the cost of care exceeds the pre-set budget per beneficiary.\(^{43}\) Because the MCO is responsible to pay for services that exceed its budget, it will want to provide services in full consideration of a beneficiary’s entire breadth of needs as opposed to spot treating.\(^{44}\)

In order for a managed long-term care program to survive under this risk-based approach, it is crucial that the amount of enrollees is of a significant size so that the MCO is able to manage the financial risk.\(^{45}\) The expenditures will vary significantly among long-term care individuals.\(^{46}\) A significant enrollment size is necessary to manage the risk that some beneficiaries will require more costly care than others.\(^{47}\) Because the MCO assumes the financial risk, there is a strong incentive to provide quality service, which will curb the need for costly ongoing treatment resulting from inadequate care, to manage costs.\(^{48}\)

The rationale behind a managed long-term care program, as opposed to fee-for-services, is that the beneficiary will receive a more organized sequence of care and that states will have the ability to hold one entity, the MCO, accountable.\(^{49}\) In a fee-for-service system, where numerous medical providers deliver a variety of medical services, it is difficult and cumbersome to pinpoint accountability for any adverse consumer or system

\(^{42}\) Id.
\(^{43}\) Id.
\(^{44}\) SAUCIER & FOX-GRAGE, supra note 33, at 2.
\(^{45}\) NAT’L CONSORTIUM FOR HEALTH SYS. DEV., supra note 35, at 2.
\(^{46}\) KRONICK & LLANOS, supra note 24, at 18.
\(^{47}\) NAT’L CONSORTIUM FOR HEALTH SYS. DEV., supra note 35, at 2.
\(^{48}\) Id. at 1.
\(^{49}\) SAUCIER & FOX-GRAGE, supra note 33, at 3.
Managed care programs are also appealing to states because paying a fixed amount to the MCO allows the state to stabilize its budget.  

VI. SHOULD A MANAGED CARE PROGRAM BE MANDATORY OR VOLUNTARY?

If states opt to provide their Medicaid coverage to the elderly through a managed long-term care program, issues arise whether the managed care program should be mandatory or voluntary. Several factors control a state’s decision to implement a mandatory or voluntary program. First, and possibly the most determinative, is whether a state plans to integrate long-term care Medicaid services with acute-care Medicare services. If a MCO has medical and financial responsibility over the services provided to a beneficiary, it makes sense that the beneficiary’s entire medical needs should be assessed and managed in conjunction with one another. Medicare programs must be voluntary, and any state seeking to incorporate acute and long-term care under the same MCO must do so under a voluntary program. Second, population size can influence whether a program will be mandatory or voluntary because beneficiary enrollment is crucial for survival. To manage the risk, MCOs must be able to spread the financial risk over a large number of beneficiaries. Lastly, a state may consider the concerns of beneficiaries and medical providers, who often prefer voluntary programs. Beneficiaries are typically comfortable with the relationship they have established with their current medical provider and fear being forced into a new relationship with a different provider.
Additionally, many providers find convenience in the ability to bill the state directly for services provided to a Medicaid beneficiary and are discouraged from entering into a new business relationship with a MCO.61

VII. STUDYING THE SUCCESS

Comparing the success of managed long-term care programs and the fee-for-service system is an arduous process.62 To begin, states exercise an enormous amount of control in the design of their program.63 Therefore, a program in one state may vary greatly from that in another.64 Furthermore, the implementation of managed long-term care programs into Medicaid programs is relatively new and states are still discovering the repercussions of the integration.65 Finally, and perhaps the biggest challenge, is determining whether the switch from a fee-for-service system to managed care improved, or at least neutralized, the quality of and access to care, as well as with minimizing the cost.66 Although it is too early to make a conclusive determination, due to increasing preventative measures taken by MCOs, there has been less reliance on costly emergency room and hospital visits.67

VIII. CONCLUSION

The Medicaid system plays a major role in providing medical coverage to elderly individuals within the United States. The struggling economy creates a need for the Medicaid system to find cost effective ways of providing quality care for people who have nowhere else to turn. A managed care system for individuals with long-term medical needs attempts to remove the daunting financial burden imposed solely upon federal and state governments by placing beneficiaries within a managed care

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61. Id.
62. Tenzer, supra note 5, at 351.
63. Id.
64. Id.
65. Id.
66. Id.
organization that can better control the quality and cost of a beneficiary’s medical needs.

67. Id. at 351-52.