MAX
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICAID POLICY BRIEF

MATHEMATICA Policy Research

Brief 3 • May 2011

Which States Have Limited Medicaid Managed Care Enrollment for Long-Term Care Users?

Valerie Cheh

Researchers and policymakers are working to measure and improve the long-term care system, and Medicaid Analytic Extract (MAX) data can be used in this effort. However, enrollment in managed care—long-term managed care, medical managed care, behavioral managed care, or comprehensive managed care such as the Programs of All-inclusive Care for the Elderly (PACE)—can limit researchers' ability to use the data to address certain issues. In this issue brief, we explore the levels of managed care enrollment among long-term users on a state-by-state basis, to help researchers identify suitable states to address their study needs.

The long-term care system has been changing substantially over the past two decades. Since the Supreme Court's 1999 *Olmstead v. L. C.* decision affirmed the right of persons with disabilities to receive services in the most integrated setting appropriate for their needs (U.S. Supreme Court 1999), state Medicaid programs have introduced many innovations in long-term care, including the increased use of Medicaid home and community-based services (Ng et al. 2009) and increased use of managed long-term care programs, such as PACE (National PACE Association 2011). State and federal policymakers want to measure their progress toward improving this system and the quality of care, and conduct other research to help them make good decisions. While many data sources could be used for these purposes, claims data are a readily available source since they are collected for program administration. The Agency for Healthcare Research and Quality has proposed to use claims data as one component of measuring quality of care for home and community-based services (Potter 2010), and other measures of balance that use MAX data have been developed (Wenzlow 2011; Irvin and Ballou 2010).

Medicaid Managed Care Enrollments

One factor that could impede this work is the substantial increase in the use of Medicaid managed care. Enrollment in Medicaid managed care plans increased from 56 percent in 2000 to 71 percent in 2009 (CMS website) and the use of managed care in long-term care is expected to continue to grow (Saucier et al. 2005). Some states do not require managed care organizations to submit encounter data to Medicaid, and some states that collect such data do not provide them to CMS (OEI May 2009). As a result, the measures being developed and the research being conducted are not necessarily representative of the long-term care population. CMS is working with states on including encounter data in the Medicaid Statistical Information System (MSIS) and MAX. But until that occurs, researchers and policymakers can benefit from understanding which states currently have most of their long-term care population in a fee-for-service environment with detailed claims data that can be used to address more questions. Furthermore, since the data needs of research projects differ, identifying the types of managed care programs long-term care recipients use in each state (such as comprehensive medical programs, behavior health, or primary care case management) will help investigators assess the potential of the data to address their research questions. To help researchers understand these issues, this brief answers the following questions:

About This Series

The MAX Medicaid policy issue brief series highlights the essential role MAX data can play in analyzing the Medicaid program. MAX is a set of annual, person-level data files on Medicaid eligibility, service utilization, and payments that are derived from state reporting of Medicaid eligibility and claims data into the Medicaid Statistical Information System (MSIS). MAX is an enhanced, research-friendly version of MSIS that includes final adjudicated claims based on the date of service, and data that have undergone additional quality checks and corrections. CMS produces MAX specifically for research purposes. For more information about MAX, please visit: http://www.cms.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp.

1. How many of the aged and disabled enrollees are covered by Medicaid long-term care managed care programs? How many enrollees are receiving long-term care under fee-for-service? If a high proportion of states' enrollees are in fee-for-service long-term care, then these states are good candidates for understanding long-term care service use.

2. Among enrollees in fee-for-service long-term care, how many are covered by other types of managed care programs? If the research or measure development requires information on, for example, preventable hospitalizations, then the study will want to include states with low-levels of medical managed care. However, if this is not critical to the questions, then researchers may wish to include these states.

3. What proportion of the fee-for-service Medicaid enrollees who are only enrolled in Medicaid are covered by a comprehensive or medical managed care program? For those who are dually eligible, Medicare data may provide the claims data needed and Medicaid managed care may not be important. But not all disabled enrollees qualify for Medicare, and as a result, not all long-term care recipients obtain acute and primary care through Medicare. Researchers studying this special population of Medicaid only enrollees can benefit from understanding which states may have the fee-for-service data they need.

Identifying Long-Term Care Users

To answer these questions, we used the 2006 MAX data and identified all of the aged and disabled enrollees. We then identified the long-term care fee-for-service population as those who (1) had a fee-for-service claim for one of seven types of long-term care services that were provided as state plan services,[1] or (2) were enrolled in a home and community-based services waiver program, or (3) had expenditures for other nursing services and (4) were not covered under long-term managed care or received any long-term care services under managed care during the year.

Identifying this fourth group is a bit challenging. MAX data has information on those who are enrolled in long-term managed care or PACE programs. However, the MAX data only has one category for comprehensive medical managed care; and does not differentiate between comprehensive medical managed care programs that cover only medical services and those that cover medical and long-term care services. To identify those who received long-term care under a comprehensive medical managed care program, we noted the comprehensive medical managed care enrollees who had an encounter claim for one of seven types of long-term care services, recognizing that this will be a lower bound on the number identified, as the encounter data are missing in many cases.

One challenge with identifying long-term care users is that some states have not been able to report their waiver enrollees or their claims data. To identify these states, we used the MAX data anomalies tables to find known discrepancies. One state, Maine, did not have a functioning MMIS, and thus its counts of long-term care services are inaccurate; for this reason, we excluded Maine from the study. Thirteen states had other issues in reporting their waiver enrollees, including potential over-reporting and under-reporting. We opted to include these states (Florida, Kentucky, Louisiana, Missouri, Montana, North Dakota, Oregon, Rhode Island, Texas, Utah, Virginia, Washington, and Wisconsin) for this issue brief, but encourage researchers to investigate these anomalies to determine if they affect their particular study.

Findings

Despite the high levels of managed care among the Medicaid population in general, few individuals were enrolled in managed long-term care. Four states (Arizona, Massachusetts, New York, and Wisconsin) reported 8,000 or more long-term managed care or PACE enrollees, but these reflected a small percentage of the elderly and disabled populations in those states (Table 1). Enrollment was also low among those we identified in long-term care through encounter claims; only California, Minnesota and New York had 9,000 or more enrollees who met this criteria, and with the exception of Minnesota, they represented less than 1 percent of the states' elderly and disabled populations.

As a percentage of all identified long-term care users, the combined known enrollment in long-term managed care and comprehensive managed care with encounter data for long-term care services exceeded 5 percent of the states' long-term care users in six states: Arizona, Massachusetts, Minnesota, New York, Oregon, and Wisconsin. In Arizona, almost none of the long-term care users received care in the fee-for-service setting, but this state is clearly the outlier; in the next two highest managed long-term care states—Minnesota and Wisconsin—more than 80 percent of the long-term care users received long-term care under fee-for-service. Thus, the majority of the long-term care users in each state received long-term care under fee-for-service in 2006, and hence the lack of encounter data for long-term care services will not thwart studies that need to identify those using long-term care services.

Of course, even if Medicaid enrollees receive their long-term care services under fee-for-service, studies may require information on other kinds of health care service use—such as inpatient admissions or psychiatric care—to achieve their goals. In these cases, enrollment in other types of managed care can be the factor that limits the usability of the data for a specific research project. To understand how many long-term care users receive services other than long-term care through

managed care plans, we examined how many long-term care users were enrolled in other types of managed care.

Despite the prevalence of managed care for the Medicaid population, only a minority of states enrolled their fee-for-service long-term care users in medical or behavioral managed care programs. Nine states had 10 percent or more of their fee-for-service long-term care users enrolled in a comprehensive medical managed care program, with two states—Maryland and Oregon—enrolling about half or more (Table 2). Twelve states had 10 percent or more of their fee-for-service long-term care users in behavioral managed care programs, and five states (Colorado, Michigan, Tennessee, Utah, and Washington) enrolled virtually all of their long-term care users in a behavioral managed care program.

Thirteen states enrolled a substantial proportion of their long-term care users in primary care case management—another form of managed care. However, since these programs generally pay primary care providers a fee for case management services and continue to pay for health services on a fee-for-service basis, primary care case management will not hinder most long-term care studies.

Finally, since Medicaid enrollees who are dually eligible receive most of their medical services through Medicare, researchers may not find enrollment in Medicaid medical managed care limiting for the dually eligible, but they may find it limiting for those who are only enrolled in Medicaid.[2] Among those long-term care users only enrolled in Medicaid, 12 states enrolled 10 percent or more in medical managed care programs, with Maryland enrolling nearly all of them in managed care (Table 3). In contrast, only six states enrolled 10 percent or more of their dual eligibles in medical managed care to provide wraparound coverage.

Table 1. Aged and Disabled Enrollees in Different Long-Term Care Services

State	Number of Aged and Disabled Enrollees	Number of Aged and Disabled Enrollees in Managed Long-Term Care or PACE[a]	Number of Aged and Disabled Enrollees in a Medical or Comprehensive Care Program with Encounter Data for Long-Term Care	Number of Aged and Disabled Medicaid Enrollees Using Fee-for-Service Long-Term Care Services	Percentage of Identifiable Long-Term Care Users in Fee-for-Service Long-Term Care Services
Alabama	315,773	0	0	67,484	100.0
Alaska	22,870	0	0	7,569	100.0
Arizona	213,979	44,643	3,247	315	0.7
Arkansas	181,318	0	0	41,879	100.0
California	1,889,820	2,322	15,700	578,130	97.0
Colorado	128,971	1,312	0	43,566	97.1
Connecticut	130,375	0	0	56,691	100.0
Delaware	34,853	0	150	6,771	97.8
District of Columbia	45,707	0	0	7,735	100.0
Florida	884,229	141	0	164,522	99.9
Georgia	426,334	0	5	67,725	100.0
Hawaii	48,139	0	16	10,061	99.8
Idaho	51,354	0	0	17,338	100.0
Illinois	539,440	279	1	172,236	99.8
Indiana	234,038	0	694	59,036	98.8
Iowa	112,203	0	1	51,625	100.0
Kansas	96,198	222	24	41,473	99.4
Kentucky	308,515	0	1,259	50,279	97.6
Louisiana	308,706	0	0	58,439	100.0
Maine	94,265	0	0	4,110	100.0
Maryland	201,878	185	1,173	107,934	98.8

(continued)

Table 1. Aged and Disabled Enrollees in Different Long-Term Care Services *(continued)*

State	Number of Aged and Disabled Enrollees	Number of Aged and Disabled Enrollees in Managed Long-Term Care or PACE[a]	Number of Aged and Disabled Enrollees in a Medical or Comprehensive Care Program with Encounter Data for Long-Term Care	Number of Aged and Disabled Medicaid Enrollees Using Fee-for-Service Long-Term Care Services	Percentage of Identifiable Long-Term Care Users in Fee-for-Service Long-Term Care Services
Massachusetts	400,248	8,714	0	90,414	91.2
Michigan	436,700	279	0	64,675	99.6
Minnesota	205,507	0	19,451	90,867	82.4
Mississippi	251,907	0	0	39,342	100.0
Missouri	280,098	204	0	92,797	99.8
Montana	29,107	0	0	9,076	100.0
Nebraska	58,723	0	45	21,227	99.8
Nevada	61,446	0	5	12,138	100.0
New Hampshire	35,557	0	0	13,189	100.0
New Jersey	316,824	0	366	99,289	99.6
New Mexico	91,890	0	1,190	24,564	95.4
New York	1,178,909	20,535	9,212	385,307	92.8
North Carolina	471,604	0	0	145,072	100.0
North Dakota	20,783	0	0	9,459	100.0
Ohio	523,656	0	0	169,414	100.0
Oklahoma	173,664	0	0	51,126	100.0
Oregon	130,369	792	1,860	46,429	94.6
Pennsylvania	729,581	1,309	0	136,945	99.1
Rhode Island	65,012	0	222	18,080	98.8
South Carolina	234,371	445	0	43,110	99.0
South Dakota	29,136	0	0	10,300	100.0
Tennessee	461,736	373	0	51,718	99.3
Texas	962,698	0	1,606	193,760	99.2
Utah	50,879	552	0	11,287	95.3
Vermont	40,705	0	0	9,505	100.0
Virginia	259,887	0	1,473	54,359	97.4
Washington	256,672	291	44	75,381	99.6
West Virginia	147,165	0	0	25,383	100.0
Wisconsin	296,800	12,777	102	60,589	82.5
Wyoming	15,242	0	0	6,108	100.0

Source: Mathematica calculations from MAX 2006 data.
[a] Ohio, Rhode Island, Texas had active PACE Programs in 2006, but they were not identified in MAX data.

Table 2. Percent of Fee-For-Service Long-Term Care Users in Managed Care

State	Total Fee-for-Service Long-Term Care Users	Percent Enrolled in a Medical or Comprehensive Program Managed Care Program	Percent Enrolled in a Behavioral Managed Care Program	Percent Enrolled in a Primary Care Case Management Program
Alabama[a]	67,484	2.04	0.00	16.37
Alaska[a]	7,569	0.00	0.00	0.00
Arizona	315	2.86	6.03	0.00
Arkansas[a]	41,879	0.00	0.00	19.05
California	578,130	12.54	0.00	0.00
Colorado	43,566	19.56	99.09	26.56
Connecticut[a]	56,691	0.27	0.00	0.00
Delaware[a]	6,771	4.42	0.00	1.62
District of Columbia[a]	7,735	0.62	0.00	0.00
Florida	164,522	10.61	10.90	12.21
Georgia[a]	67,725	0.38	0.00	14.84
Hawaii[a]	10,061	1.33	0.46	0.00
Idaho[a]	17,338	0.00	0.00	67.54
Illinois[a]	172,236	0.01	0.00	0.00
Indiana[a]	59,036	0.30	0.00	10.34
Iowa	51,625	0.01	45.44	0.44
Kansas[a]	41,473	0.31	0.00	4.08
Kentucky[a]	50,279	2.59	0.00	5.92
Louisiana[a]	58,439	0.00	0.00	22.65
Maine	4,110	0.00	0.00	0.27
Maryland	107,934	64.09	0.00	0.00
Massachusetts	90,414	1.94	13.17	18.23
Michigan	64,675	5.37	99.75	0.00
Minnesota	90,867	37.28	0.00	0.00
Mississippi[a]	39,342	0.00	0.00	0.00
Missouri[a]	92,797	0.20	0.00	0.00
Montana[a]	9,076	0.00	0.00	13.96
Nebraska	21,227	1.20	21.95	2.83
Nevada[a]	12,138	0.18	0.00	0.00
New Hampshire[a]	13,189	0.00	0.00	0.00
New Jersey	99,289	10.17	0.00	0.00
New Mexico	24,564	20.45	20.53	0.00
New York	385,307	2.69	0.61	0.60
North Carolina[a]	145,072	0.07	5.59	24.53
North Dakota[a]	9,459	0.02	0.00	0.44
Ohio[a]	169,414	0.59	0.00	0.00
Oklahoma[a]	51,126	0.00	0.00	0.22
Oregon	46,429	49.09	84.14	5.20
Pennsylvania	136,945	10.78	25.50	5.48
Rhode Island[a]	18,080	3.46	0.00	0.00
South Carolina[a]	43,110	0.59	0.07	1.34
South Dakota[a]	10,300	0.00	0.00	3.74

(continued)

Table 2. Percent of Fee-For-Service Long-Term Care Users in Managed Care *(continued)*

State	Total Fee-for-Service Long-Term Care Users	Percent Enrolled in a Medical or Comprehensive Program Managed Care Program	Percent Enrolled in a Behavioral Managed Care Program	Percent Enrolled in a Primary Care Case Management Program
Tennessee	51,718	0.00	99.55	0.00
Texas[a]	193,760	2.33	4.81	4.10
Utah	11,287	0.00	96.63	0.00
Vermont[a]	9,505	0.00	0.00	18.06
Virginia[a]	54,359	2.64	0.00	1.97
Washington	75,381	1.31	100.00	15.60
West Virginia[a]	25,383	0.44	0.00	0.58
Wisconsin	60,589	0.29	0.01	0.00
Wyoming[a]	6,108	0.00	0.00	0.00

Source: Mathematica calculations from MAX 2006 data.
[a] States with limited Medicaid managed care enrollment for long-term care users.

Table 3. Percent of Medicaid-Only and Dual-Eligible Fee-For-Service Long-Term Care Users in Medical or Comprehensive Care

State	Number of Medicaid-Only Fee-for-Service Long-Term Care Users	Percent of Medicaid-Only Fee-for-Service Long-Term Care Users in Medical or Comprehensive Care	Number of Dually-Eligible Fee-For-Service Long-Term Care Users	Percent of Dually-Eligible Fee-For-Service Long-Term Care Users in Medical or Comprehensive Care
Alabama	15,085	0.15	52,399	2.59
Alaska	2,690	0.00	4,879	0.00
Arizona	149	0.00	166	5.42
Arkansas	8,460	0.00	33,419	0.00
California	168,926	18.54	409,204	10.06
Colorado	10,489	24.84	33,077	17.89
Connecticut	8,978	1.20	47,713	0.09
Delaware	1,170	21.71	5,601	0.80
District of Columbia	2,478	1.65	5,257	0.13
Florida	36,592	12.46	127,930	10.08
Georgia	14,983	1.62	52,742	0.03
Hawaii	2,563	4.60	7,498	0.21
Idaho	4,369	0.00	12,969	0.00
Illinois	45,197	0.03	127,039	0.00
Indiana	11,911	1.39	47,125	0.02
Iowa	11,303	0.04	40,322	0.00
Kansas	10,889	1.14	30,584	0.02
Kentucky	13,981	4.31	36,298	1.93
Louisiana	19,699	0.00	38,740	0.00
Maine	1,043	0.00	3,067	0.00

(continued)

Table 3. Percent of Medicaid-Only and Dual-Eligible Fee-For-Service Long-Term Care Users in Medical or Comprehensive Care *(continued)*

State	Number of Medicaid-Only Fee-for-Service Long-Term Care Users	Percent of Medicaid-Only Fee-for-Service Long-Term Care Users in Medical or Comprehensive Care	Number of Dually-Eligible Fee-For-Service Long-Term Care Users	Percent of Dually-Eligible Fee-For-Service Long-Term Care Users in Medical or Comprehensive Care
Maryland	68,677	93.69	39,257	12.31
Massachusetts	18,948	8.10	71,466	0.31
Michigan	8,709	35.81	55,966	0.64
Minnesota	24,318	7.88	66,549	48.02
Mississippi	7,103	0.00	32,239	0.00
Missouri	17,487	0.93	75,310	0.03
Montana	1,844	0.00	7,232	0.00
Nebraska	4,011	5.71	17,216	0.15
Nevada	3,008	0.63	9,130	0.03
New Hampshire	2,141	0.00	11,048	0.00
New Jersey	19,830	31.52	79,459	4.84
New Mexico	6,395	72.34	18,169	2.19
New York	98,066	8.31	287,241	0.76
North Carolina	33,997	0.24	111,075	0.02
North Dakota	1,417	0.14	8,042	0.00
Ohio	43,744	2.17	125,670	0.04
Oklahoma	10,225	0.00	40,901	0.00
Oregon	10,431	62.70	35,998	45.15
Pennsylvania	25,441	50.93	111,504	1.62
Rhode Island	3,909	15.73	14,171	0.07
South Carolina	9,257	2.56	33,853	0.05
South Dakota	1,780	0.00	8,520	0.00
Tennessee	12,056	0.00	39,662	0.00
Texas	44,857	8.55	148,903	0.45
Utah	3,441	0.00	7,846	0.00
Vermont	2,525	0.00	6,980	0.00
Virginia	11,786	11.22	42,573	0.27
Washington	20,309	3.75	55,072	0.42
West Virginia	7,059	1.46	18,324	0.04
Wisconsin	9,770	0.83	50,819	0.18
Wyoming	1,762	0.00	4,346	0.00

Source: Mathematica calculations from MAX 2006 data.

Conclusions

This study investigated the use of managed care among those who use long-term care services under Medicaid, to help researchers identify the states that have the most potential to support future work. This issue brief, however, has limitations. One limitation is that identifying those who are in long-term care is imprecise. We have identified long-term care users based on services they used—such as home health care or personal care—but those services could also be used by those who eventually recover from their disability or illness and thus are not truly long-term care recipients. A second limitation is that we cannot be certain that we identified all of the long-term care users in managed care. If the encounter data are missing, the MAX records have no information that allows us to identify enrollees who are receiving long-term care under the comprehensive care plan. Thus, our number of fee-for-service long-term care users may be overstated. The third limitation is that this brief is stagnant—Medicaid programs are constantly evolving and what was true in 2006 may not be true in later periods. Thus, the information in this issue brief should be used as a snapshot that provides a starting point for researchers, but it cannot be the end of any investigation into this issue.

Nevertheless, based on 2006 MAX data, this issue brief finds that, despite the fact that most Medicaid enrollees are in managed care programs, 31 states (see Table 2) continue to provide most health, behavior, and long-term care services to their long-term care recipients under fee-for-service.

However, this brief also underscores the need for encounter data. The 31 states that provided the vast majority of fee-for-service data enrolled 6.6 million aged and disabled Medicaid recipients, while the 19 states that provided some care under managed care enrolled just over 8 million.[3] Thus, it is the relatively larger states that are providing services under managed care, and it will be important to include these large states in future work related to developing measures of quality and balance and addressing other issues in long-term care.

Endnotes

[1] Long-term care services included are nursing home, intermediate care facilities for the mentally retarded, personal care, private duty nursing, residential care, adult day care, and home health services.

[2] For dually-eligible recipients, the issue is whether they are enrolled in a Medicare Advantage Plan.

[3] Maine is excluded from these tabulations.

References

Centers for Medicare & Medicaid Services. "National Summary of Medicaid Managed Care Programs and Enrollment as of June 30, 2009." Available at http://www.cms.gov/MedicaidDataSources GenInfo/downloads/09Trends.pdf.

Irvin, Carol V., and Jeffrey Ballou. "Starting Point: The Balance of State Long-Term Care Systems Before the Implementation of the Money Follows the Person Demonstration." The National Evaluation of the Money Follows the Person Demonstration Grant program, Report from the Field No. 4. Cambridge, MA: Mathematica Policy Research, May 2010.

National PACE Association. "PACE in the States." Alexandria, VA: NPA, 2011. Available at http://www.npaonline.org/website/download.asp?id=1741.

Ng, Terence, and Charlene Harrington. "Medicaid Home and Community-Based Service Programs: Data Update." Menlo Park, CA: Kaiser Family Foundation, 2009. Retrieved from http://www.kff.org/medicaid/upload/7720-03.pdf on December 23, 2010.

Office of Evaluations and Inspections. "Medicaid Managed Care Encounter Data: Collection and Use." OEI-07-06-00540. May 2009.

Potter, D.E.B. "Home and Community-Based Services (HCBS) Measure Scan Project and Indicators of Potentially Preventable Hospitalizations Among the Medicaid HCBS Population." Presentation at the CMS NBIC Data Summit: Long-Term Support System Indicators Research, Baltimore, MD, October 28-29, 2010. Available at http://www.nationalbalancingindicators.com/images/deb%20potter.pdf.

Saucier, Paul, Brian Burwell, and Kerstin Gerst. "The Past, Present and Future of Managed Long-Term Care," Report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Cambridge, MA: Medstate, April 2005.

United States Supreme Court. Olmstead v. L. C. 527 U.S. 581 (1999).

Wenzlow, Audra, Rosemary Borck, and Dean Miller. "An Investigation of Interstate Variation in Medicaid Long-Term Care Use and Expenditures." Report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Ann Arbor, MI: Mathematica Policy Research, April 2011.

For further information on this issue brief series, visit our website at www.mathematica-mpr.com

Princeton, NJ • Ann Arbor, MI • Cambridge, MA • Chicago, IL • Oakland, CA • Washington, DC