Effects of Medicaid Managed Long-Term Care: Two Decades of Evidence from Wisconsin

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Medicaid is the largest public payer of long-term services and supports (LTSS) to people with difficulty completing self-care tasks due to aging, chronic illness, or disability. In 2018 LTSS accounted for one-third of total Medicaid spending,[1] and growth in LTSS spending exceeds growth in overall healthcare spending, spurring state-level efforts to lower costs and improve the efficiency of service delivery. One such policy that has gained traction over the past two decades is the introduction of Medicaid managed care, in which Medicaid pays private providers a fixed amount to absorb the financial risk of covering enrollees. Managed care is typically motivated as a way to reduce expenditures or make them more predictable; however, for populations receiving LTSS, concerns that reductions in costs will be achieved through reductions in services that may reduce quality and/or health are particularly salient.[2]

While the number of states adopting Medicaid managed LTSS tripled between 2004 and 2017,[3] there is little research evaluating its impacts. Existing studies focus on managed Medicaid programs for non-LTSS beneficiaries and find mixed results, suggesting that the needs of the underlying population are of primary importance for managed care outcomes.[4–7] Medicaid LTSS populations are highly vulnerable: they are older, more disabled, have more comorbidities, and are more likely to be living with dementia than Medicaid beneficiaries who do not receive LTSS. The lack of causal evidence on managed LTSS stems in part from a lack of identifying variation: most states that implemented managed LTSS programs did so statewide and often in conjunction with other initiatives, which makes it difficult to separately identify the effects of managed LTSS.[8–10]

Our study exploits a natural experiment in Wisconsin in which a voluntary enrollment managed LTSS program ("Family Care") was gradually rolled out across counties to provide the first causal evidence on the effect of Medicaid managed care for LTSS. Understanding who chooses to enroll in managed LTSS, how it changes the health care services they use, and whether health and quality are affected will provide crucial evidence to inform ongoing policy discussions of efficiently providing LTSS for the growing population of older adults with care needs.

We will examine three main questions:

1. Who enrolls in Medicaid managed care for LTSS?
2. What is the causal effect of managed LTSS on the services used by beneficiaries?
3. How did managed LTSS impact health and quality of care received?

Beginning in 2000, Family Care was offered to Medicaid-eligible adults living in five Wisconsin counties, promising expanded access to home- and community-based services and more care coordination relative to traditional Medicaid LTSS, but with cost-containment strategies such as gatekeeper models. Family Care expanded gradually by county statewide from 2007 to 2018, and today serves more than 50,000 Medicaid enrollees across the state.

After a county's adoption of Family Care, Medicaid LTSS-eligible patients could choose to remain in traditional Medicaid or voluntarily enroll in managed LTSS, which allows us to study selection into the program based on observable characteristics such as race, gender, and level of care needs.

We will use event study and generalized difference-in-difference designs that exploit the staggered county-level roll-out of the Family Care program, combined with Medicaid enrollment files that include detailed information on the universe of Medicaid LTSS beneficiaries, to identify the characteristics of beneficiaries who select into managed care and of those who opt for traditional Medicaid LTSS.

Next, using detailed Medicaid claims and again leveraging the staggered roll-out of the Family Care program, we will quantify how Medicaid beneficiaries' use of LTSS, including nursing home services and expenditures on home- and community-based services, changes when Family Care is introduced in a county. We also will use facility level data to study changes in the composition of nursing home residents.

Finally, we will examine the effect on health outcomes and quality. We will construct indirect measures of the quality of care received by using well-known care quality indices including the Billings algorithm and the AHRQ Prevention Quality Indicators to classify from diagnosis codes visits that may have been preventable or avoidable, and adapt appropriate CMS measures of nursing home quality.[11] To the extent that Medicaid LTSS enrollees are dually eligible for Medicare, we will not observe the small fraction of services that are fully paid by Medicare,[12] but any mismeasurement of services should be the same across counties and thus should not affect our estimates of the effect of Family Care on such outcomes.

Data on Medicaid beneficiaries and LTSS claims will come from a partnership between the State of Wisconsin Department of Health Services and the University of Wisconsin – Madison's Institute for Research on Poverty (IRP), which provides data expertise and infrastructure. We expect to obtain access by summer 2024 following state and institutional review board approval. Our research team has familiarity with the Medicaid administrative enrollment and claims data and related processes. Access to LTSS claims has just been secured by IRP for the first time, and this project will serve as a first stage in a broader research agenda around understanding how the availability and quality of LTSS services impacts the wellbeing of Medicaid beneficiaries and their families.

References

1. Centers for Medicare & Medicaid Services. *Medicare-Medicaid Coordination Office Fact Sheet-March 2020*.; 2020.
2. Gorges RJ, Sanghavi P, Konetzka RT. A National Examination of Long-Term Care Setting, Outcomes, And Disparities Among Elderly Dual Eligibles. *Health Aff (Millwood)*. 2019;38(7):1110-1118. doi:10.1377/hlthaff.2018.05409
3. Lewis E, Eiken S, Amos A, Saucier P. The growth of managed long-term services and supports programs: 2017 update. *Mena Rep*. Published online 2018.
4. Layton TJ, Maestas N, Prinz D, Vabson B. *Private vs. Public Provision of Social Insurance: Evidence from Medicaid*. National Bureau of Economic Research; 2019. doi:10.3386/w26042
5. Burns ME. Medicaid managed care and cost containment in the adult disabled population. *Med Care*. 2009;47(10):1069.
6. Duggan M, Garthwaite C, Wang AY. *Heterogeneity in the Impact of Privatizing Social Health Insurance: Evidence from California's Medicaid Program*. National Bureau of Economic Research; 2021.
7. Kuziemko I, Meckel K, Rossin-Slater M. Does managed care widen infant health disparities? Evidence from Texas Medicaid. *Am Econ J Econ Policy*. 2018;10(3):255-283.
8. Mellor J, Cunningham P, Britton E, Walker L. Use of Home and Community-Based Services After Implementation of Medicaid Managed Long Term Services and Supports in Virginia. *J Aging Soc Policy*. Published online 2023:1-19.
9. Grabowski DC. The cost-effectiveness of noninstitutional long-term care services: Review and synthesis of the most recent evidence. *Med Care Res Rev*. 2006;63(1):3-28.
10. Meret-Hanke LA. Effects of the program of all-inclusive care for the elderly on hospital use. *The Gerontologist*. 2011;51(6):774-785.
11. Centers for Medicare and Medicaid Services. *Nursing Home Quality Initiative Quality Measures*; 2022. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqiqualitymeasures
12. Tucker A, Johnson K, Rubin A, Fogler S. A Framework for State-Level Analysis of Duals: Interleaving Medicare and Medicaid Data. *Hilltop Inst UMBC Works*. Published online 2008.