Medicaid Managed Care and Managed Long Term Services and Supports (MLTSS)

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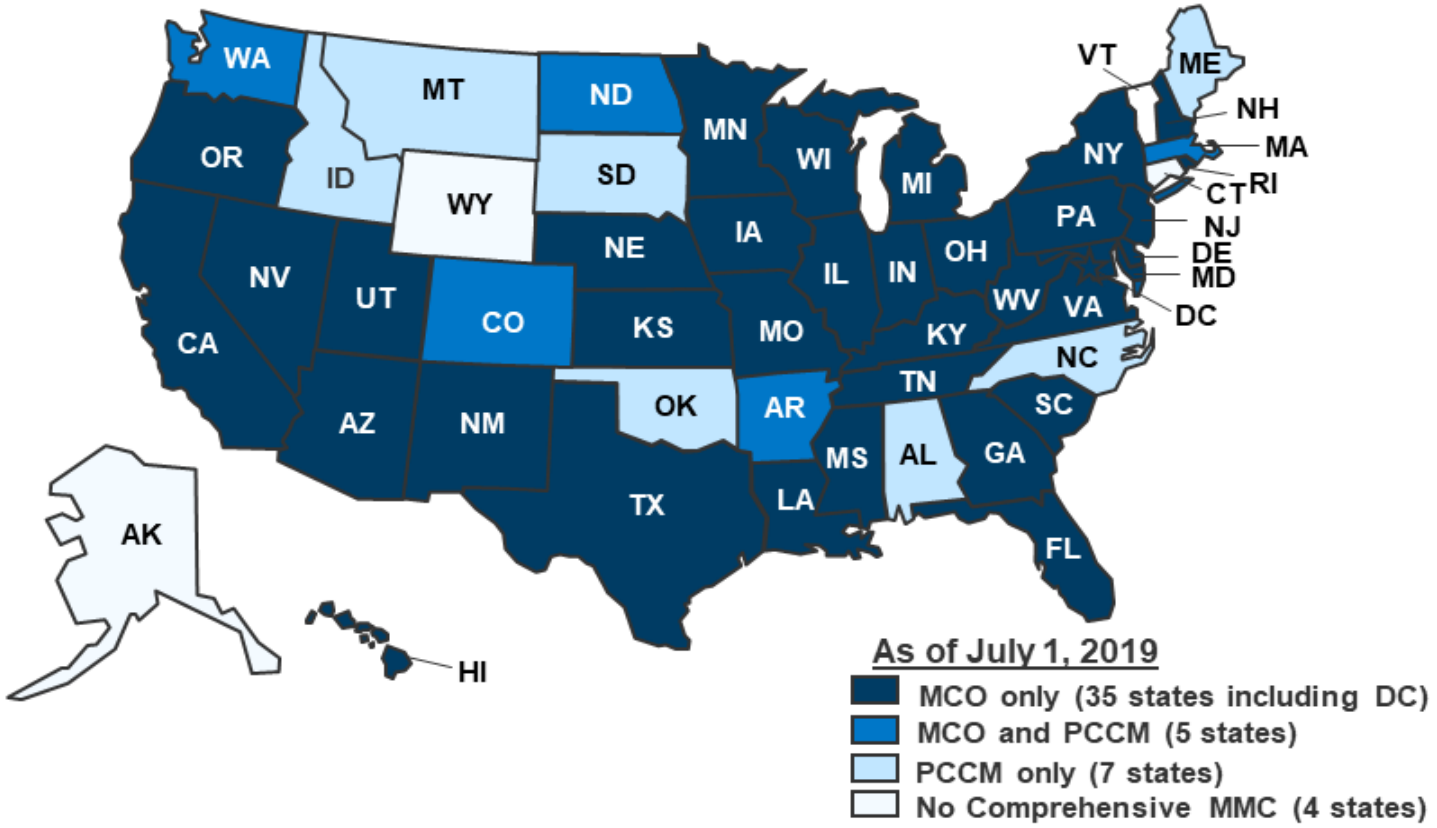
November 17, 2020

Medicaid Managed Care

- Capitated managed care is the predominant delivery system now employed by state Medicaid programs
  - 40 states utilize comprehensive risk-based managed care organizations (MCOs) to provide services
  - 33 of these 40 states had more than 75% of their Medicaid beneficiaries enrolled in MCOs as of July 1, 2019.
  - Other variants of Medicaid managed care models include limited benefit prepaid health plans (e.g. behavioral health, dental PHPs) and state primary care case management (PCCM) programs
- Over time, States have expanded managed care to include additional populations (e.g. aged, blind, and disabled; ACA expansion populations, kids with special needs) and carve-in additional services (e.g. behavioral health; long term services and supports)

Figure 2

Comprehensive Medicaid Managed Care Models in the States, 2019



NOTES: ID's Medicaid-Medicare Coordinated Plan has been recategorized by CMS as an MCO but is not counted here as such since it is secondary to Medicare. SC uses PCCM authority to operate a small, children's care management program and is not counted here as a PCCM.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

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Medicaid Managed Care vs. Fee for Service

Distinguishing features of the two delivery systems:

- Freedom of Choice
- Comparability of Services
- State-wideness
- Provider Payment Methodologies
- Administrative Functions
- Regulatory Framework

What is MLTSS?

- Managed Long-term Services and Supports (MLTSS) refers to institutional and home and community based long-term services and supports delivered through a managed care model. LTSS are often delivered by a single managed care organization (MCO) as part of an overall benefit package that includes acute care, pharmacy, and behavioral health services.
  - Although some states use stand-alone plans that solely include LTSS and not other benefits, this model is less common today than in the past
- Services delivered through a managed care model can include nursing facility care, home nursing, attendant care, habilitation, and specialized therapies.
- MLTSS may be authorized on the federal level using an 1115 demonstration waiver, or through combining the authorities of either 1115 or 1915(b) waivers, or 1932 State Plan authority, with one or more 1915(c) waiver.

What is Covered?

- States using MLTSS vary widely in the number and types of LTSS included under the managed care capitation.
- A 2018 Mathematica interim program evaluation found that Home and Community Based Services (HCBS) comprised nearly 70% of total MLTSS expenditures.
- Currently, it is more common for states to cover services for the older adults and those with physical disabilities than to cover HCBS for individuals with IDD in MLTSS programs.

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MLTSS Adoption

- 25 states operate managed long-term services and supports (MLTSS) programs, in which state Medicaid agencies contract with managed care plans to deliver long-term services and supports (LTSS), up sharply from just 8 states in 2004 (Lewis et al. 2018; ADvancing States 2020).
- Concurrently, expenditures for MLTSS have sharply increased, from about $5 billion in FY 2008 to about $39 billion in FY 2016.
  - Reported MLTSS expenditures were $39 billion in FY 2016, a 24 percent increase from $32 billion in FY 2015. A 2018 IBM Watson Health/Medicaid Innovation Accelerator Program report attributes much of the recent to expansions in New York ($5 billion) and Texas ($1 billion).
- Although much of this growth has been recent, a few states have operated MLTSS programs for more than 20 years.

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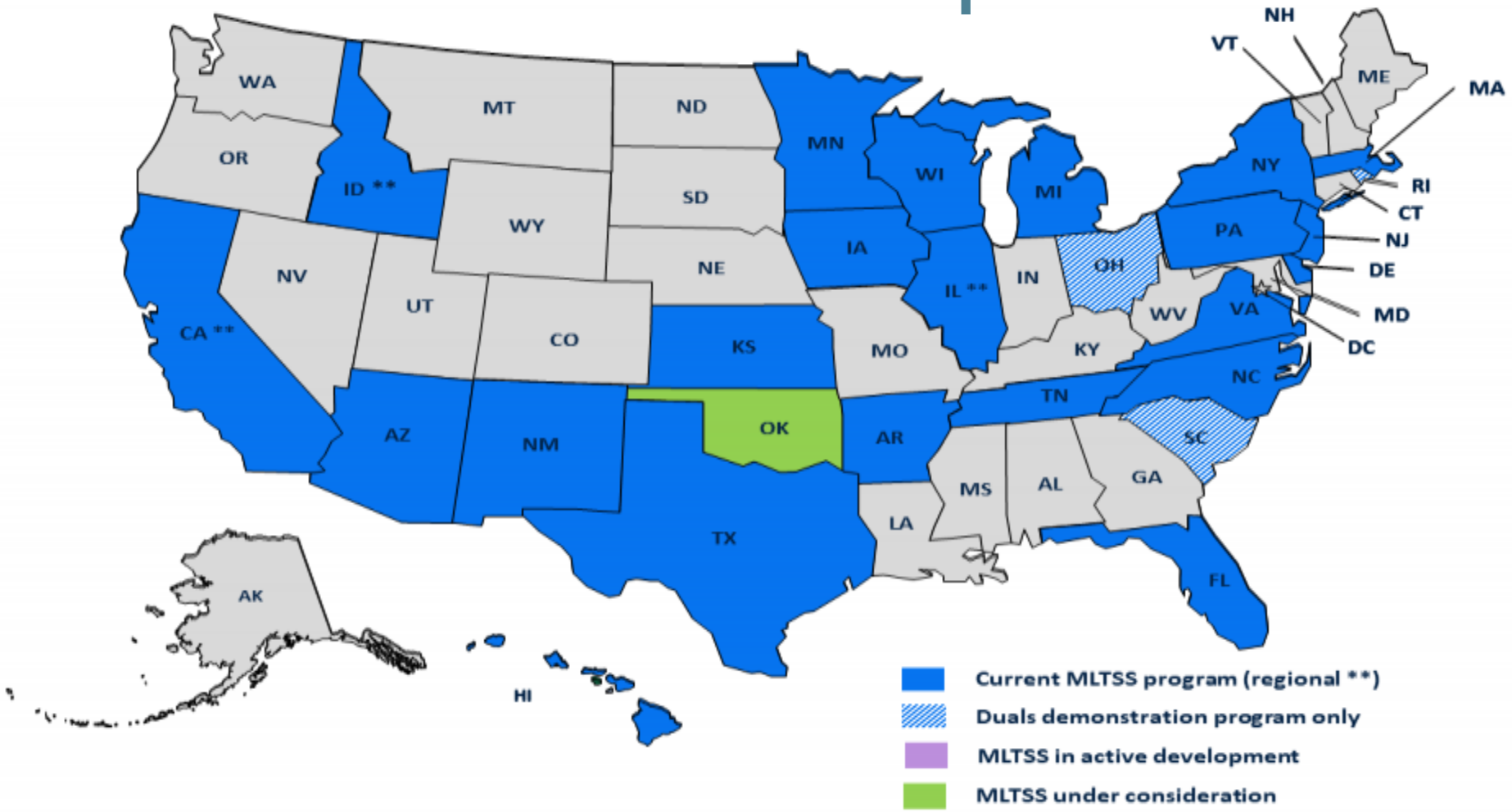
MLTSS Footprint



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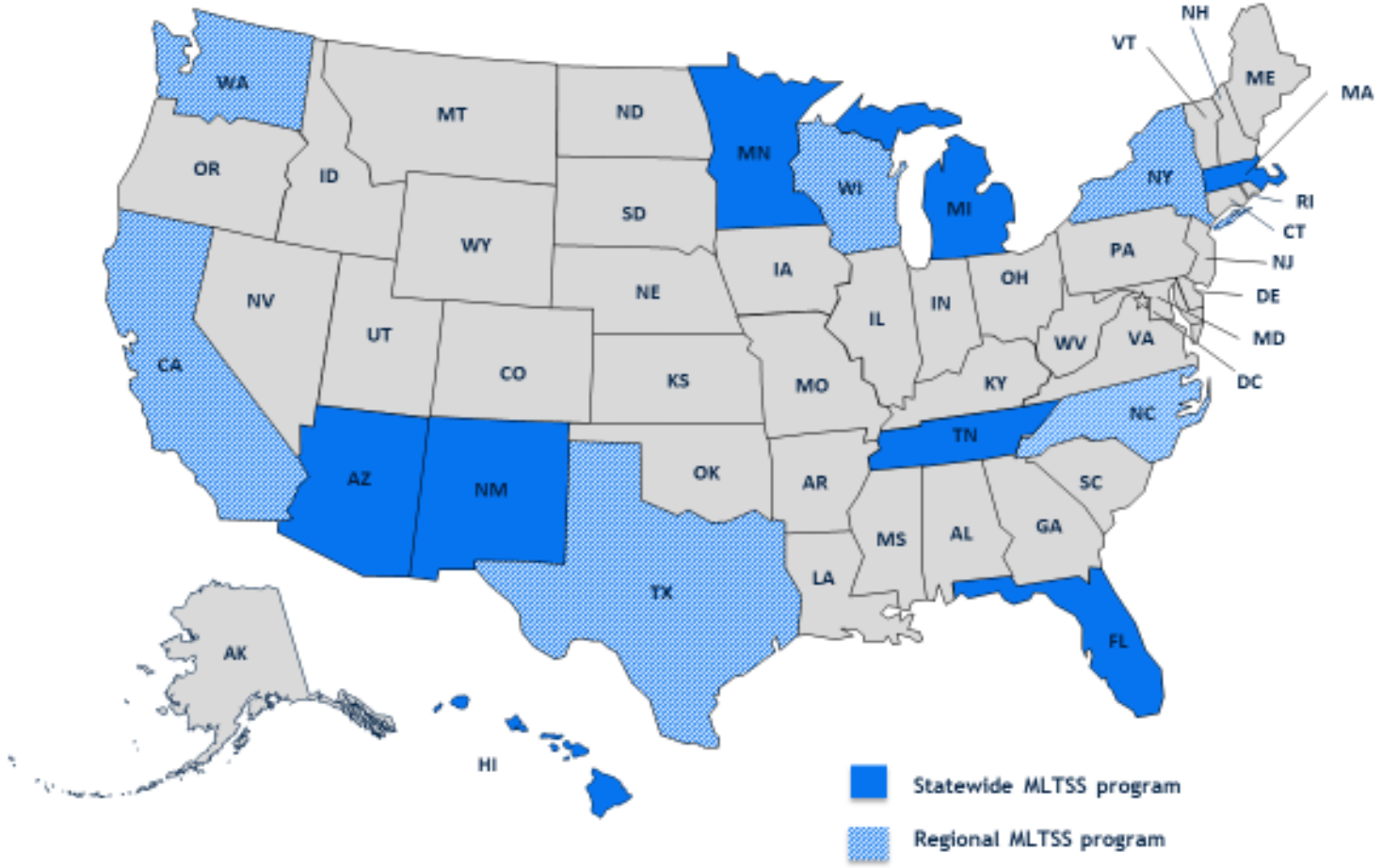
Growth Since 2010



Source: Truven Health Analytics, 2012

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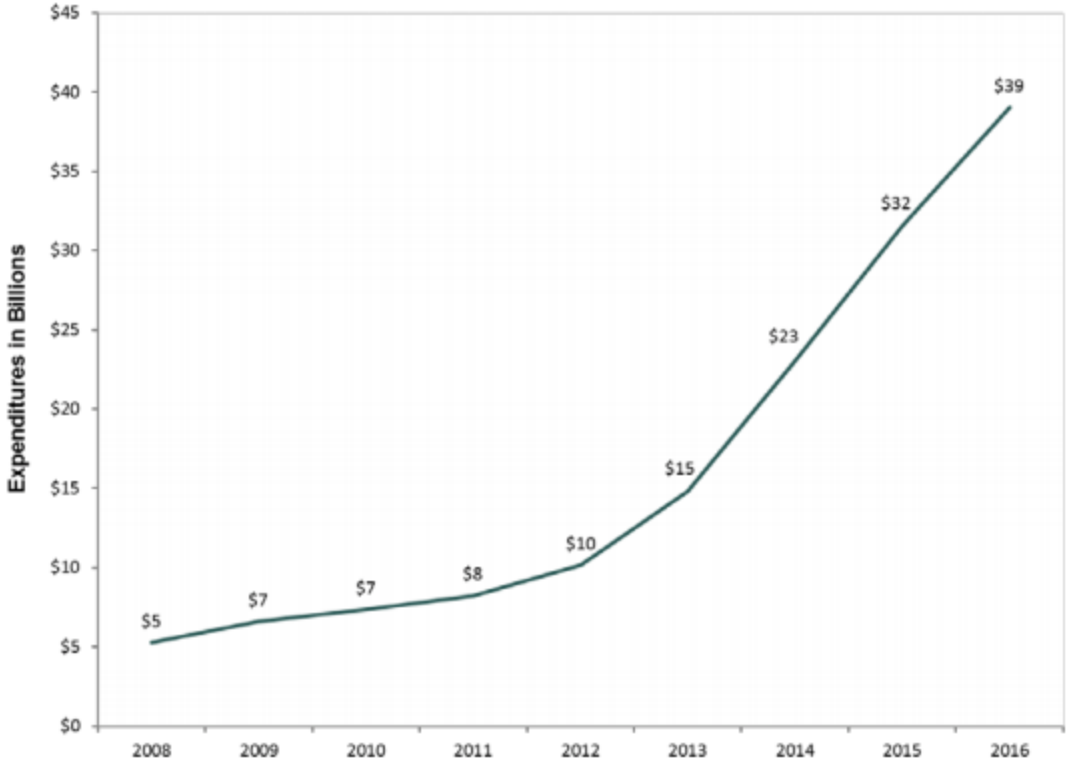
MLTSS Expenditures

Figure 11. Medicaid Managed LTSS Expenditures, in billions, FY 2008–2016



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States' Goals for MLTSS

- States implement MLTSS for a variety of reasons. In a survey of 12 states with MLTSS (Dobson et al. 2017), states reported that their goals included:
  - Rebalancing LTSS spending—increasing the proportion of Medicaid LTSS spending used for HCBS while decreasing the proportion of spending for institutional services (12 states);
  - Improving beneficiary care experience by increasing care coordination to improve health and quality of life (12 states);
  - Reducing or eliminating HCBS waiver waiting lists to address access gaps and to provide care in the setting that the beneficiary chooses (6 states); and
  - Providing budget predictability and potentially containing costs via rebalancing, efficiencies, and improved quality (7 states)

Promoting Rebalancing Through MLTSS

- Blended rate for nursing facility and HCBS
- Pay for Performance programs that incent HCBS utilization and/or penalize increased NF utilization
- Contract Provisions that encourage innovation in housing-related activities and other supports
- Housing Transition and Tenancy Sustaining Services
- Service Coordinators to help members with diversion, transition and relocation
- Money Follows the Person

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What can MLTSS Mean to HCBS Providers?

- Managed care organizations have historically had little experience contracting and working with LTSS providers, particularly in the IDD space. Conversely, many LTSS providers have had little experience contracting with MCOs and serving individuals in managed care programs. There is a learning curve on both sides.
- The integration of LTSS into managed care has several downstream impacts on providers:
  - Consolidation and acquisition
  - Survival of the fittest
  - Competition for members
  - Any willing provider changes
  - Changing roles for ADRC and AAAs
  - New relationships with different MCOs

Federal Programmatic Requirements

- MLTSS plans must adhere to the same regulations as other Medicaid managed care plans, as well as additional requirements related to MLTSS.
- CMS released guidance released in 2013 outlined what CMS referred to as key elements of an effective MLTSS program (CMS 2013). Most of these items were later codified into regulation in a substantial update of MCO regulations in 2016. Key elements included:
  - Adequate planning and transition strategies, including the solicitation and consideration of stakeholder input; education of program participants; assessment of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS.
  - Stakeholder engagement in the planning, implementation, and ongoing oversight processes;
  - Enhanced provision of HCBS, including alignment and compliance with the requirements of the ADA and the Olmstead decision, as well as the 2014 HCBS final rule, to provide services in the most integrated setting and progress toward community integration goals;

Federal Programmatic Requirements

- CMS key elements, continued:
  - Alignment of payment structures with MLTSS programmatic goals, which include improving the health and care experiences of beneficiaries, and reducing costs;
  - Support for beneficiaries, a beneficiary support system to provide enrollment counseling and access point for complaints or concerns related to MLTSS, as well as member education on grievance and appeals;
  - Person-centered processes, including participation by the individual in the service planning and delivery process, meaningful choices of service alternatives, holistic service plans based on a comprehensive needs assessment which include goals that are meaningful to the beneficiary, and the opportunity to self-direct their community-based services;
  - Comprehensive and integrated service package, either fully integrated plan that covers acute care, behavioral health, pharmacy, and LTSS, or a mechanism to ensure appropriate coordination and referrals when a benefits package is not fully comprehensive;

Federal Programmatic Requirements

- CMS key elements, continued:
  - Qualified providers. States required to ensure an adequate provider network and establish minimum credentialing and re-credentialing policies for all providers, including LTSS. Network providers must have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for enrollees with physical and mental disabilities;
  - Participant protections. Managed care plans required to participate in state efforts to prevent, detect and remediate all critical incidents and safeguard beneficiaries from abuse, neglect, and exploitation; and
  - Quality metrics that take into account outcomes related to LTSS, including HCBS rebalancing and mechanisms to assess the quality and appropriateness of care, incorporated into MLTSS quality assurance and program improvement programs.

Options for States to Integrate Care for Duals

- More than 12 million individuals enrolled in Medicaid and Medicare. These dually eligible individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors. Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive long-term care services and supports (LTSS), and 60 percent have multiple chronic conditions.
- Dually eligible individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and prescription drugs, and Medicaid for the coverage of LTSS, certain behavioral health services, and Medicare premiums and cost-sharing.
- Dual eligible individuals account for a disproportionate share of Medicaid and Medicare expenditures – 15% of Medicaid population and 33% of the costs; 20% of Medicare population and 34% of the Medicare program costs
- Goal: Full Integration of Medicaid and Medicare services to meet the needs of dual-eligible individuals
- Several options available to States to accomplish this goal

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Options for States to Integrate Care for Duals

- **Financial Alignment Demos**
  - Allows for shared savings of Medicare dollars
  - Capitated
    - Utilizes three-way contracts between CMS, state, and plans
    - 9 states participating: CA, IL, OH, MA, MI, NY, RI, SC, TX
    - 402,000 enrollees as of October 2020
  - Managed Fee For Service
    - WA state already demonstrated significant savings through their Health Homes-based model

Options for States to Integrate Care for Duals

Dual Eligible Special Needs Plans (D-SNPs)

- Nearly 3 million enrollees nationally in these Medicare Advantage plans for dual eligible beneficiaries (including FIDE enrollees)
- Opportunities to leverage D-SNPs to provide more integrated care
- Separate Medicaid and Medicare funding streams
- D-SNPs required to sign MIPPA contracts with state Medicaid agencies to operate
- 42 states have D-SNPs

Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)

- 285k enrollees nationally
- Highest level of integration on the D-SNP platform that incorporates LTSS, primary, acute, and behavioral healthcare into a single plan
- FIDE-SNPs must be at risk for coverage of Medicaid LTSS and have procedures for administrative alignment of Medicare and Medicaid
- May be eligible to receive additional MA payments that reflect frailty of enrollees
- Examples: AZ, ID, MA, NJ, WI

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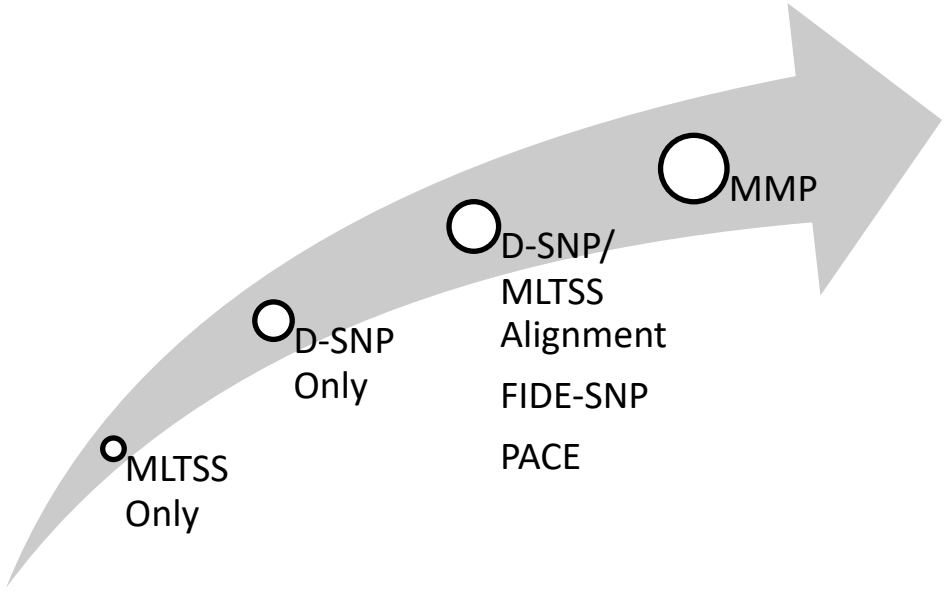
Options for States to Integrate Care for Duals

- **Program for All-Inclusive Care (PACE)**
  - Center-based program for adults over 55 who need NF level of care. Members receive all services through PACE provider
  - PACE provider receives capitation payment from Medicare and Medicaid and is at risk for the provision of services
  - As of October 2020 – sites in 31 states served 49,717 enrollees

Medicaid/Medicare Integration



The Future of MLTSS

- Development of LTSS quality metrics – In 2019 CMS released several new quality metrics for use by MLTSS plans related to topics such as assessment and care planning and successful transitions from long term care facilities
- Improved data -- To better understand and expand best practices related to MLTSS
- Increasing alignment of Medicaid MLTSS with D-SNPs
- Integration of additional populations into MLTSS
  - States likely to expand to new populations, e.g. IDD
- Washington State Managed Fee for Service program may provide an alternative pathway for states to better integrate care for dual eligibles

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