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Medicaid Managed Care and Managed Long-Term Services and Supports:
Trends and Policy Considerations

Presented to the HCBS Conference: Medicaid 101 Intensive
By Patti Killingsworth, Chief Strategy Officer
August 28, 2023

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ADVANCING STATES

Introduction

Patti Killingsworth

- Chief Strategy Officer, CareBridge Health
- Lifelong family caregiver
- 25 years of Medicaid experience in MLTSS, value-based LTSS, dual eligible initiatives
- Long-standing TennCare Chief of LTSS at TennCare
- Newly appointed Commissioner, Medicaid and CHIP Payment and Access Commission

Medicaid Managed Care Delivery Models

CAPITATED MANAGED CARE is the primary delivery system by which states deliver services to Medicaid enrollees

A capitation fee—a fixed amount of money per person (per member per month or PMPM) is paid in advance for the delivery of needed services.

- Comprehensive-risk based managed care

States contract with managed care plans to cover Medicaid-covered services for their Medicaid enrollees. Plans are paid a capitation fee to cover a defined set of services. The plans are at financial risk if spending on benefits and administration exceed payments.

Other Managed Care Models:

- Primary care case management (PCCM)

A primary care provider is paid a monthly case management fee to manage and coordinate basic medical care. The PCP is paid on a FFS basis and is generally not at financial risk.

- Limited-benefit plans

States contract with an entity to manage certain benefits (e.g., behavioral health, dental) or to provide services for a particular subpopulation.

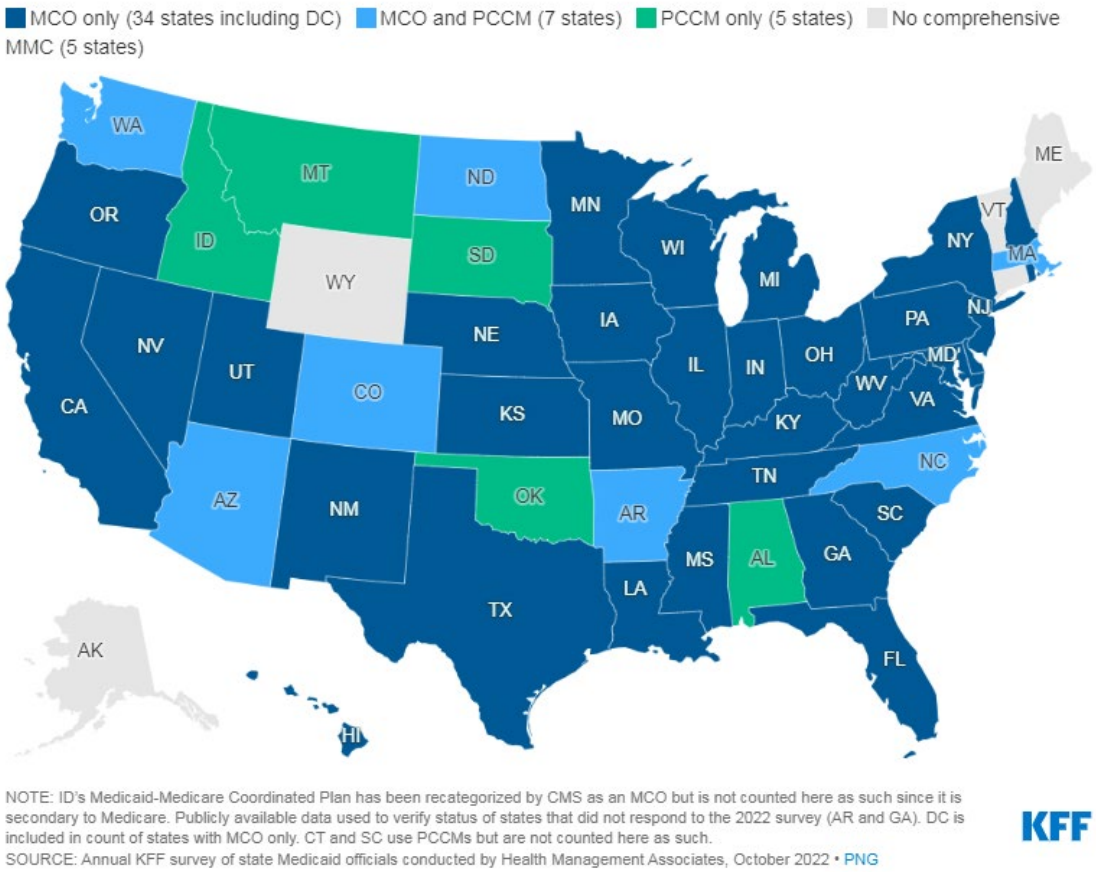
Why Managed Care in Medicaid?

- Strengthen and improve primary, preventative care
- Reduce unnecessary utilization of higher cost care, settings (right care, right place)
- Improve access (right time)
- Improve coordination of care, management of chronic conditions
- Measure and improve health outcomes
- Cost efficiency, budget predictability

More recently…

- Address social determinants of health (SDOH)
- Reduce health disparities, improve health equity
- Support eligibility redetermination (ensure continuity of coverage)
- Address systemic health issues, crises—e.g., opioid epidemic, COVID-19 pandemic

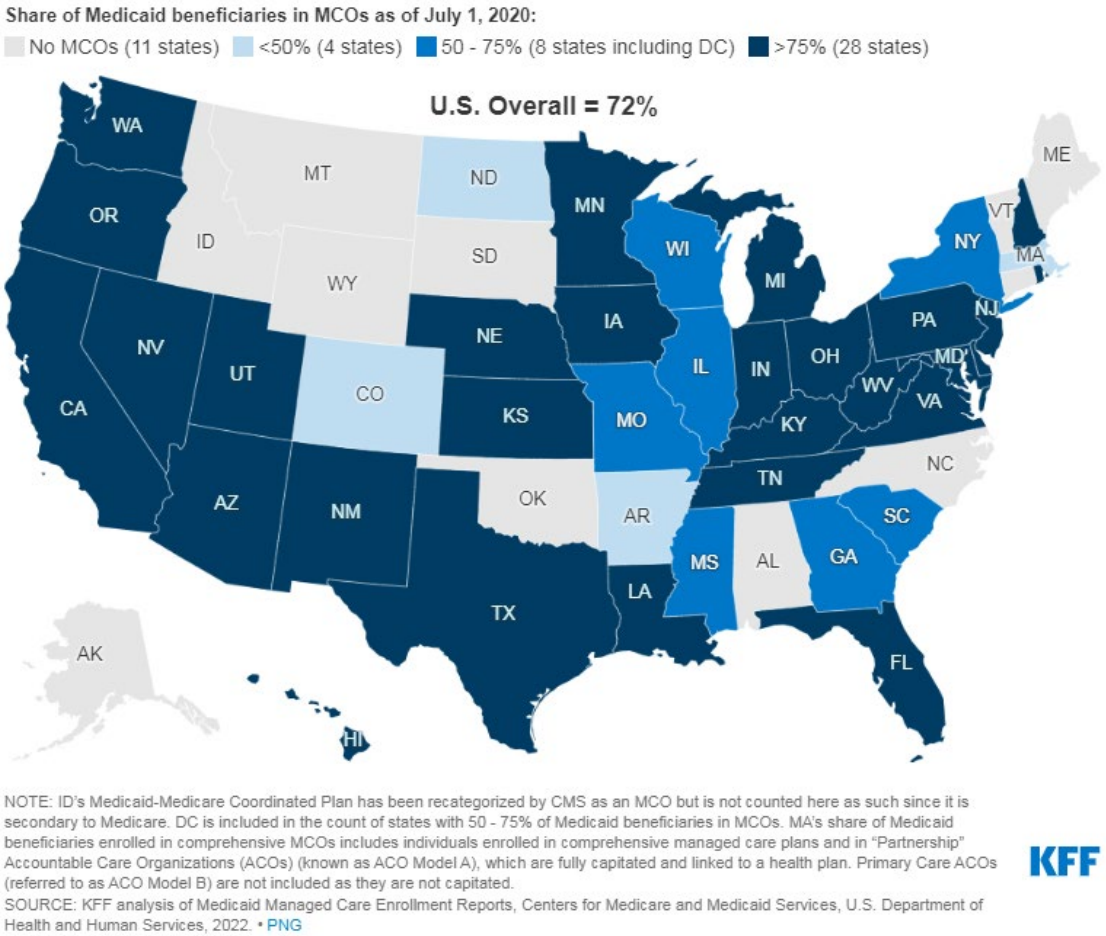
Trends in Medicaid Managed Care Delivery



Source: [10 Things to Know About Medicaid Managed Care | KFF]

As of July 2022, 41 states used capitated managed care models to deliver services in Medicaid

Trends in Medicaid Managed Care Enrollment



NOTE: 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. DC is included in the count of states with 50 - 75% of Medicaid beneficiaries in MCOs. MA's share of Medicaid beneficiaries enrolled in comprehensive MCOs includes individuals enrolled in comprehensive managed care plans and in "Partnership" Accountable Care Organizations (ACOs) (known as ACO Model A), which are fully capitated and linked to a health plan. Primary Care ACOs (referred to as ACO Model B) are not included as they are not capitated.
SOURCE: KFF analysis of Medicaid Managed Care Enrollment Reports, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2022. • PNG

KFF

Source: [10 Things to Know About Medicaid Managed Care | KFF]

In most states with comprehensive MCOs, at least 75% of beneficiaries are enrolled in one

Trends in Medicaid Managed Care Enrollment

As of July 2020, 57 million Medicaid enrollees are enrolled in comprehensive risk-based MCOs

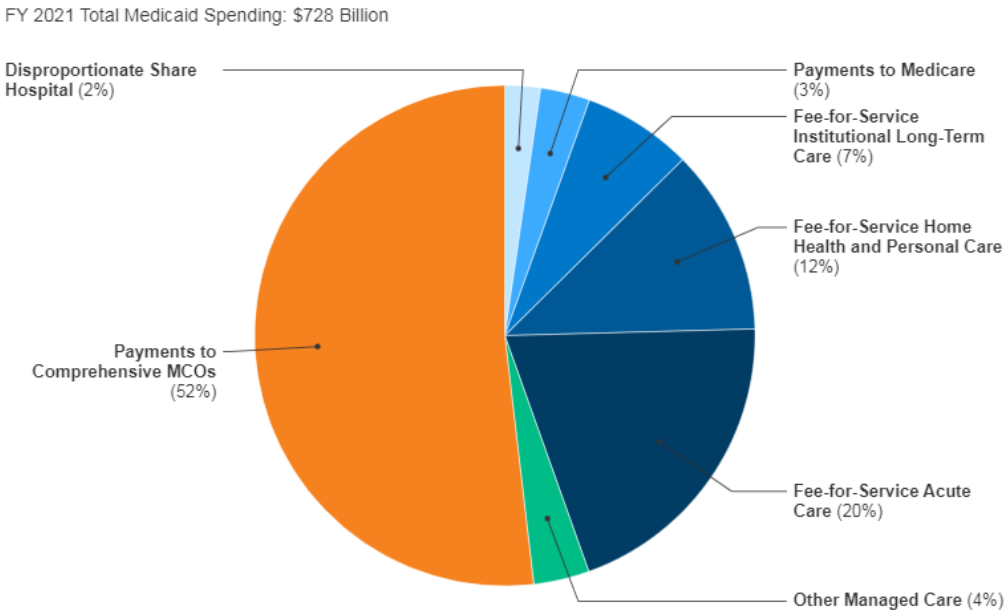
72%

Children and non-disabled adults most likely to be enrolled

Over time, states have expanded managed care to:

- **Add populations**
  - + Aged, blind, and disabled eligibility groups
  - + ACA expansion populations
  - + Children receiving SSI or with special health care needs
  - + People with I/DD
- **Carve-in additional services**
  - + Behavioral health
  - + Pharmacy, dental benefits
  - + Long-term services and supports

Trends in Medicaid Managed Care Expenditures

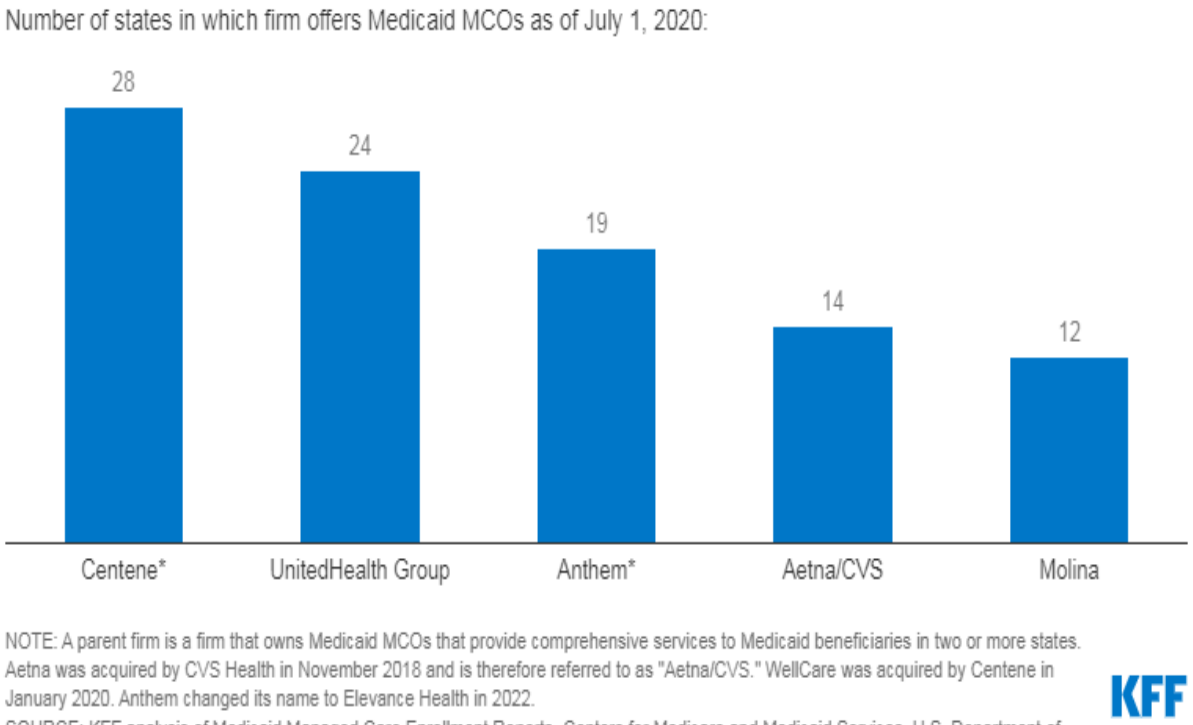


Source: [10 Things to Know About Medicaid Managed Care | KFF]

In FY 2021, payments to comprehensive risk-based MCOs accounted for **over half of Medicaid spending**

- Up 3% from previous fiscal year
- Expected to increase as higher cost populations and benefits (LTSS) are included in managed care

Trends in Medicaid Managed Care Companies



Five health plan firms have a wide geographic reach in Medicaid, each with health plans in 12 or more of the 40 managed care states

Source: [10 Things to Know About Medicaid Managed Care | KFF]

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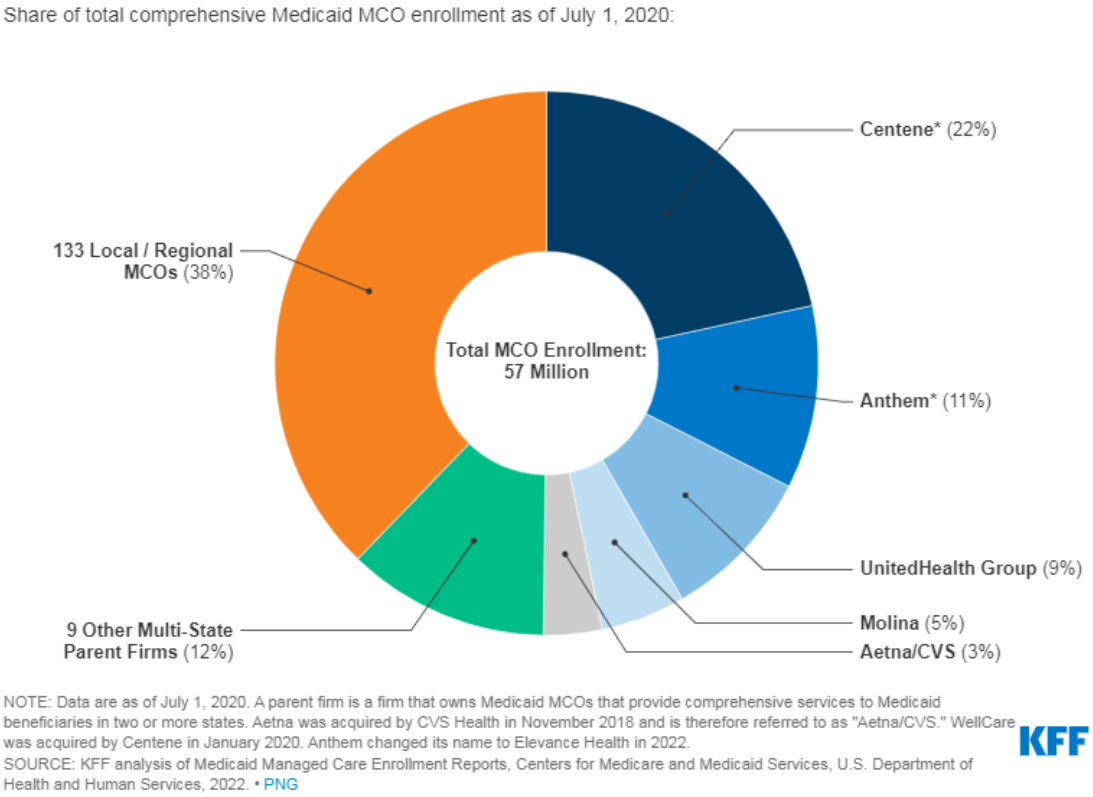
Trends in Medicaid Managed Care Companies

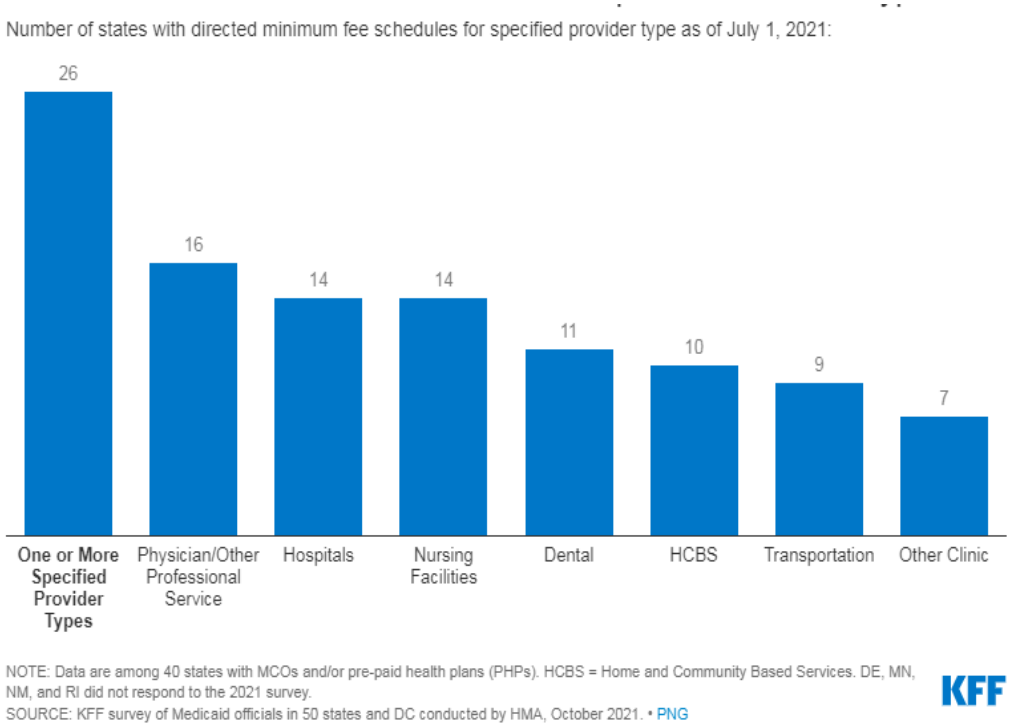


Source: [10 Things to Know About Medicaid Managed Care | KFF]

In the 40 managed care states, those five Fortune 500 firms have **half of the Medicaid managed care market**

- States contracted with a total of 285 Medicaid health plans as of July 2020

Trends in Medicaid Managed Care Provider Payments



Source: [10 Things to Know About Medicaid Managed Care | KFF]

While MCOs generally have broad discretion in setting provider payments, about two-thirds of managed care states have a directed minimum fee schedule for one or more provider types

Trends in Medicaid Managed Care Incentives

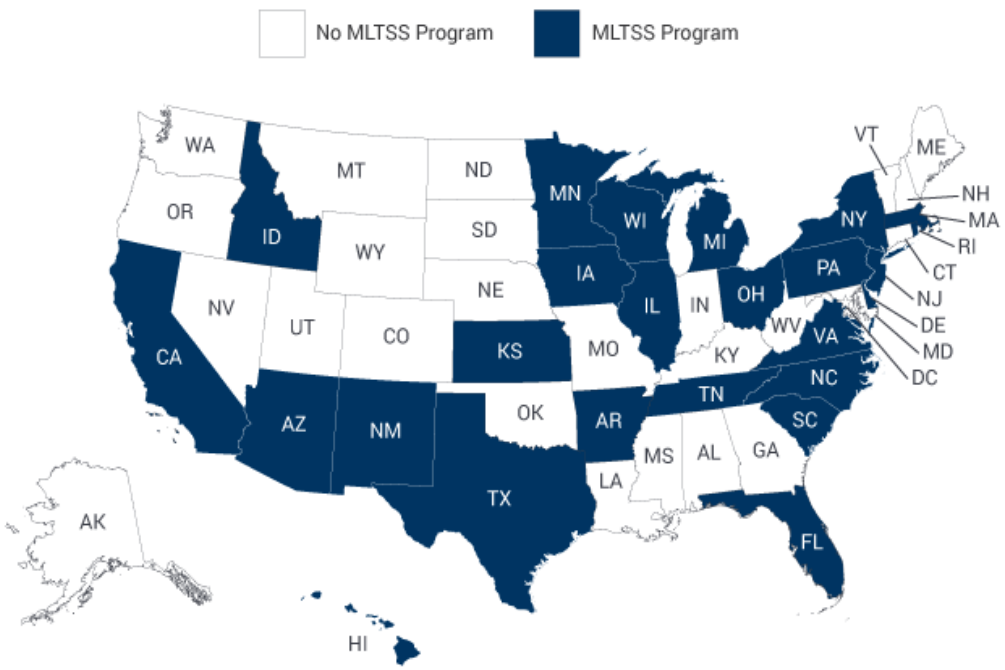
Source: [10 Things to Know About Medicaid Managed Care | KFF]

Over three quarters of managed care states use at least one financial incentive to promote quality of care as of July 2021

- Performance bonuses or penalties
- Capitation withholds
- Value-based state-directed payments

Medicaid Managed Long-Term Services & Supports

LTSS (HCBS and/or institutional)
delivered through a managed care delivery model



Source: [Managed long-term services and supports : MACPAC](), based on analysis of ADvancing States, 2021

24 states operate MLTSS programs as of 2021, up from 8 states in 2004

Medicaid only:

- Comprehensive or integrated
- Limited benefit plans (standalone MLTSS)

Integrated Medicaid/Medicare:

- Aligned D-SNP, HIDE or FIDE
- PACE

Why Managed Care in Medicaid LTSS?

- Improve coordination of care (across the continuum of physical, behavioral, LTSS)
- Expand access to HCBS, reduce HCBS waiting lists
- Reduce unnecessary utilization of institutional care
- Measure and improve quality of life outcomes, improve member experience
- Cost efficiency, budget/program sustainability

More recently…

- Promote employment, independence, inclusion
- Address social determinants of health (SDOH) that impact community living, e.g., affordable housing
- Address systemic challenges to community living, e.g., HCBS workforce shortage
- Advance innovation, delivery system transformation
- Increase system capacity for specialized populations (I/DD)
- Improve Nursing Facility quality
- Manage natural disasters and crisis events—e.g., COVID-19

Enrollment in MLTSS by Target Population

- Seniors, persons with physical disabilities most likely to be enrolled in MLTSS on a mandatory basis, followed by persons with SMI or SED
- MLTSS enrollment impacted by dual eligibility only for SPMI/SED population
- Individuals with I/DD and medically fragile children most likely to be excluded from mandatory enrollment in MLTSS

MLTSS Enrollment by Population (# of States), FY 2019 and 2020

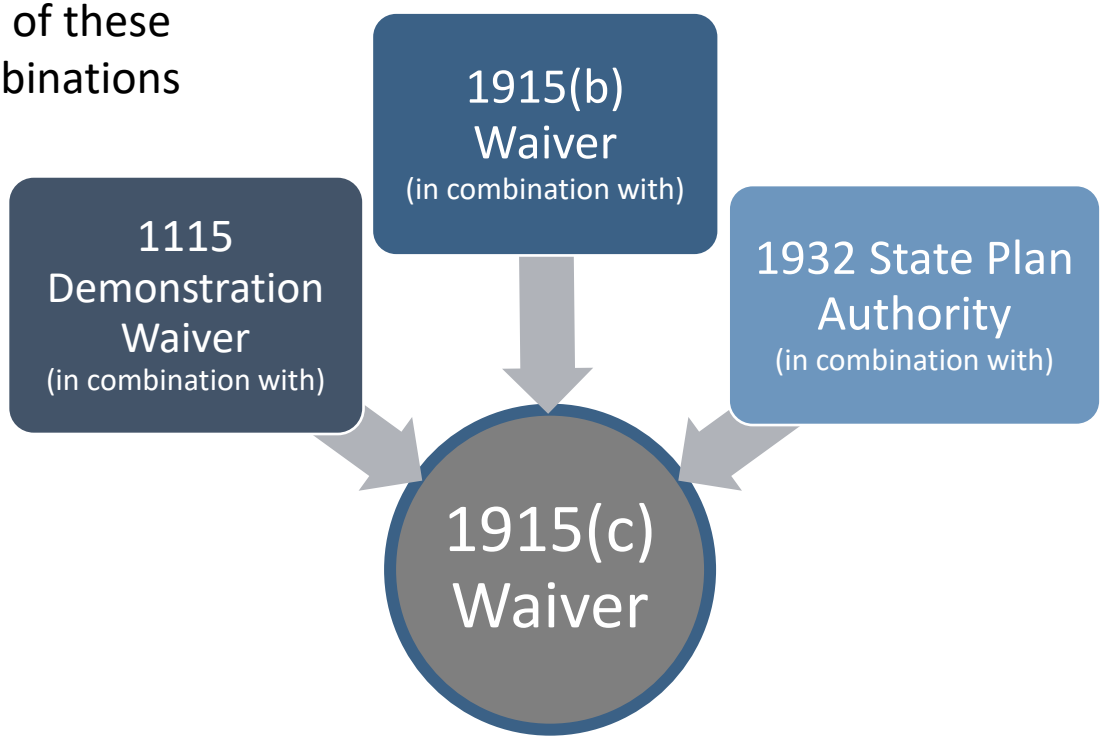
	Non-Dual Eligibles				
	Seniors	Persons w/ Physical Disabilities	Persons w/ I/DD	Medically Fragile Children	Persons with SMI/SED
Always mandatory	15	15	6	9	13
Always voluntary	3	3	5	1	2
Varies	1	2	8	5	5
Always excluded	6	5	6	10	5
	Dual Eligibles				
Always mandatory	15	15	6	9	17
Always voluntary	3	3	5	1	4
Varies	1	2	8	5	2
Always excluded	6	5	6	10	2

Source: [A View from the States: Key Medicaid Policy Changes – Long-Term Services and Supports – 9357 | KFF]

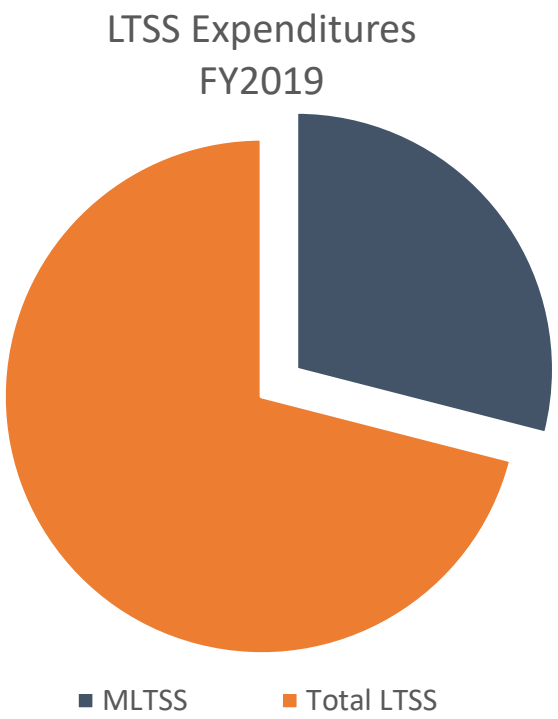
Federal Authorities for MLTSS

1115 Demonstration Waiver

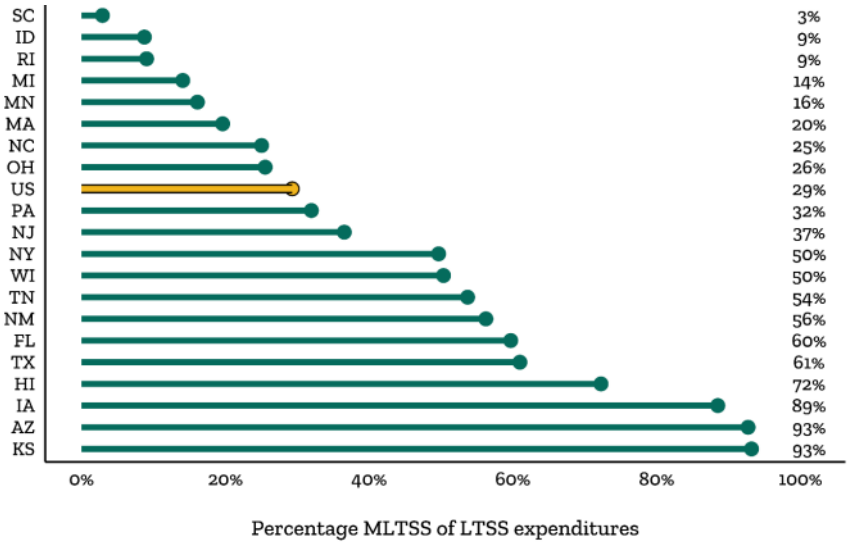
OR
one of these combinations



MLTSS Expenditures



- **29% of all LTSS spending was MLTSS**
- Varies significantly by state

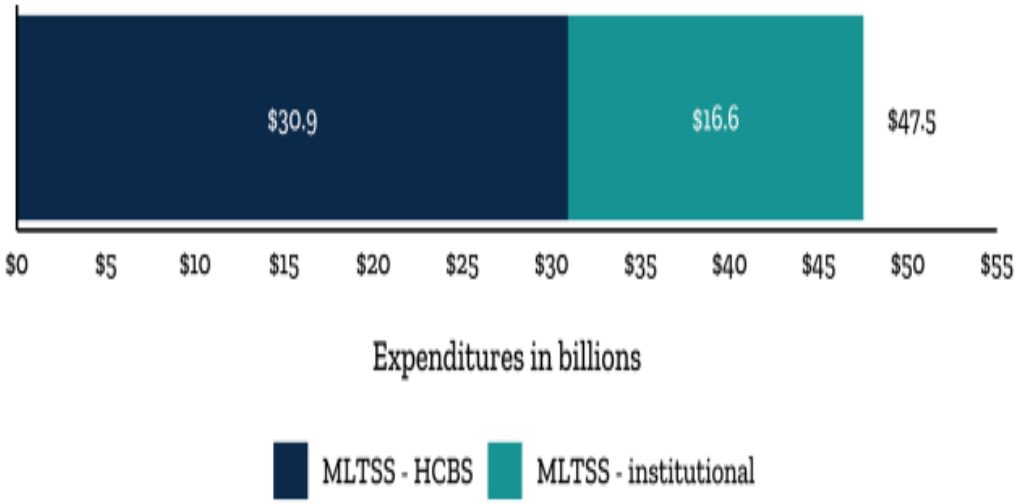


NOTE: MLTSS programs in Arkansas, California, Delaware, Illinois, and Virginia were not able to report and are excluded from total MLTSS expenditures for FY 2019.

Source: Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019." Chicago, IL: Mathematica, December 9, 2021

Rebalancing in MLTSS

Medicaid HCBS and institutional MLTSS expenditures, in billions, FY 2019



Source: Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019." Chicago, IL: Mathematica, December 9, 2021

NOTE: MLTSS programs in Arkansas, California, Delaware, Illinois, and Virginia were not able to report and are excluded from total MLTSS expenditures for FY 2019.

- **65% HCBS, 35% Institutional**
- Compared to 58.6% HCBS across all LTSS delivery models
- **HCBS** expenditures for 3 states—NY, TX, PA—accounted for 60% of MLTSS HCBS expenditures
- **Institutional** expenditures for 3 states—FL, TX, NY—accounted for 50% of total MLTSS institutional expenditures

Policies to Support Rebalancing in MLTSS

- Carve-in institutional as well as HCBS benefits (not time limited)
- Blended capitation payment for nursing facility and HCBS
- Pay for Performance programs that incent HCBS increased, decreased NF utilization
- Money Follows the Person programs
- Community transition allowance
- Streamline eligibility determination for HCBS
- Modify HCBS post-eligibility policies to maintain community personal needs allowance 90 days upon NF admission
- At=risk level of care eligibility for HCBS, "pre-Medicaid" (i.e., Medicaid diversion) services
- Aligned enrollment in Integrated Medicare/Medicare programs, with fully coordinated benefits

Leverage MCO contract to require:

- Nursing Facility diversion programs that target populations most at risk
- Nursing Facility transition programs including requirements, timelines, and reporting for mandatory transition screening, planning, implementation
- Engagement in hospital discharge planning
- Training for Service Coordinators, hospital discharge planners, and providers
- Dedicated housing leadership, requirements, including housing transition and tenancy sustaining support; encourage innovation and investment in housing & related supports
- Notification and discharge planning models to support care transitions based on real-time admission notifications

D-SNP Integrated Care Models

Coordination-Only D-SNPs

- Must meet minimum CMS requirements for D-SNPs
- Must notify state Medicaid agency or its designee of hospital and SNF admissions for at least one designated group of "high-risk," full-benefit dually eligible (FBDE) enrollees

Highly Integrated D-SNPs

- Must cover Medicaid behavioral health benefits, LTSS, or both
- Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company
- In 2025, a HIDE SNP's capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP

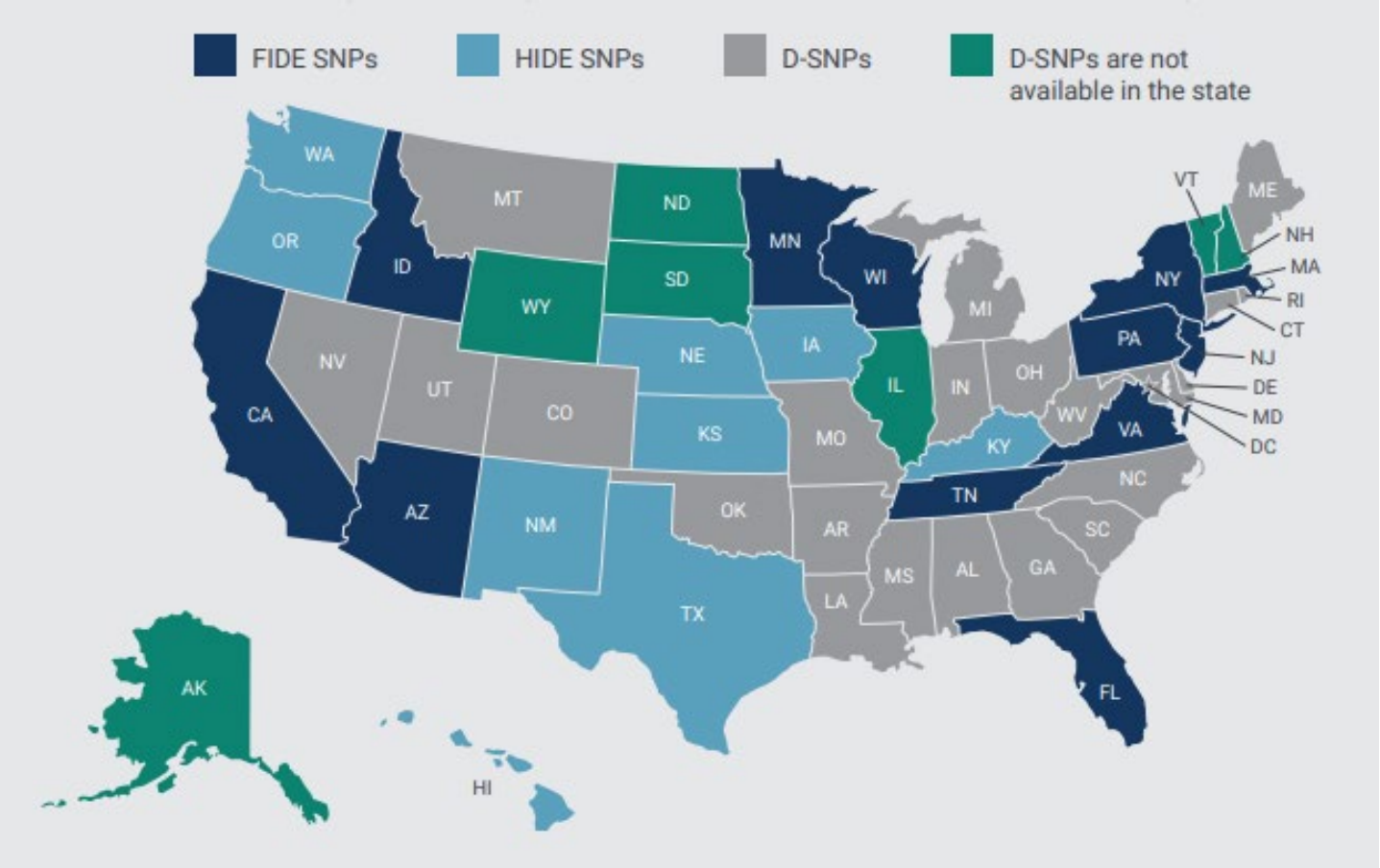
Fully Integrated D-SNPs

- Must cover Medicaid primary and acute care services and LTSS, including at least 180 days of NF coverage
- Must use specialized care management and network methods to coordinate care for high-risk beneficiaries
- Entity contracted to cover Medicaid benefits must be same legal entity that holds D-SNP contract with CMS
- In 2025, must operate with exclusively aligned enrollment and cover additional Medicaid benefits AND capitated contract with the state Medicaid agency must also cover the entire service area of the D-SNP

For more information, see Weir Lakhmani, E. "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025." Integrated Care Resource Center. December 2022. Available at: https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligiblespecial-needs-plan-d-snp-types

How Integrated D-SNP Models Vary By State

Most Highly Integrated Type of Dual Eligible Special Needs Plan Available by State, 2021



Source: [Chapter 6 Improving Integration for Dually Eligible Beneficiaries Strategies for State Contracts with Dual Eligible Special (macpac.gov)]

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D-SNP Integration and Enrollment

Number of D-SNPs by Integration Status (CY 2021-2023)

Source: [4-7-23_Key-insights-into-2023-Medicare-Advantage-D-SNP-landscape.pdf]

- Number of D-SNPs is increasing, but primary growth is in coordination only models
- Enrollment in D-SNPs is also increasing, but that does not necessarily mean integrated care

[Medicare Advantage in 2023: Enrollment Update and Key Trends | KFF]

Leveraging D-SNPs to Achieve Integrated Care Goals

All states can use these strategies:

- Limit D-SNP enrollment to full-benefit dually eligible beneficiaries or establish separate plan benefit packages for full- and partial-benefit dually eligible beneficiaries
- Contract directly with D-SNPs to cover some/all Medicaid benefits (e.g., LTSS, behavioral health)
- Require D-SNPs to use specific or enhanced care coordination methods
- Require D-SNPs to send data or reports to the state for oversight purposes
- Require state review of D-SNP Model of Care
- Require state review of D-SNP materials related to delivery of Medicaid benefits
- Partner with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits

States with Medicaid managed care can use these strategies:

- Selectively contract with D-SNPs or Medicaid managed care plans that offer aligned plans
- Require complete service area alignment
- Require D-SNPs to operate with exclusively aligned enrollment
- Allow or require D-SNPs to use default enrollment
- Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization
- Incorporate Medicaid quality improvement priorities into the D-SNP contract
- Automate Medicaid crossover claims payment processes for payment of Medicare cost sharing

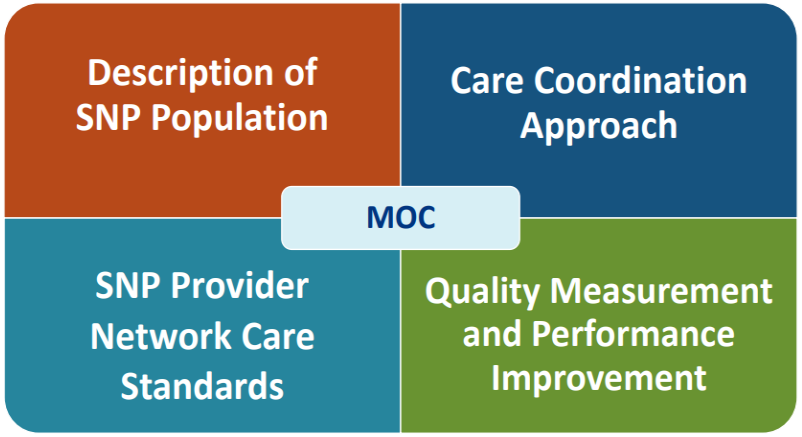
Source: Chapter 6 Improving Integration for Dually Eligible Beneficiaries Strategies for State Contracts with Dual Eligible Special (macpac.gov)

Leveraging D-SNPs to Achieve Policy Goals

Model of Care

- D-SNPs must use a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA) to "assure an effective care management structure"
- MOC is a stand-alone document developed by the D-SNP, apart from contracts the D-SNP is required to hold with CMS and SMA

MOC Elements



Source: NCQA. "Model of Care Scores." Available at: https://snpmoc.ncqa.org/

Source: Leveraging Dual Eligible Special Needs Plan (D-SNP) Models of Care to Enhance Enrollee Care Coordination | Integrated Care Resource Center

MOC Opportunities for States:

- Require D-SNPs to implement state-specific provisions aimed at better coordinating Medicare and Medicaid services
  - Specify certain care coordination requirements within the SMAC
  - Specify in the SMAC that the D-SNP(s) must include certain content within their MOC(s)
- State is responsible for reviewing how the D-SNP addresses its requirements (NCQA only evaluates the Medicare-required elements)
- State will need to develop and communicate a process by which D-SNPs submit their MOCs to the state for review and the approach used to evaluate MOCs

Examples of MOC Requirements in Key Areas

Health Risk Assessments

- Integrate Medicaid assessment tools or questions with the D-SNP HRA
- Include Medicaid managed care plan or community agency representatives in assessment process
- Specify HRA timeframes, modalities (e.g., in-person) for HRAs

Care Planning and Management

- Train CM staff about state Medicaid benefits, systems, community support for social needs
- Incorporate Medicaid services and supports into the care plan
- Involve family members or key LTSS, behavioral health and other Medicaid providers in the interdisciplinary care team
- Require D-SNPs to subcontract or collaborate with other entities for portions of their care management responsibility
- Specify care manager contact frequency and/or care manager caseload requirements

Managing Care Transitions

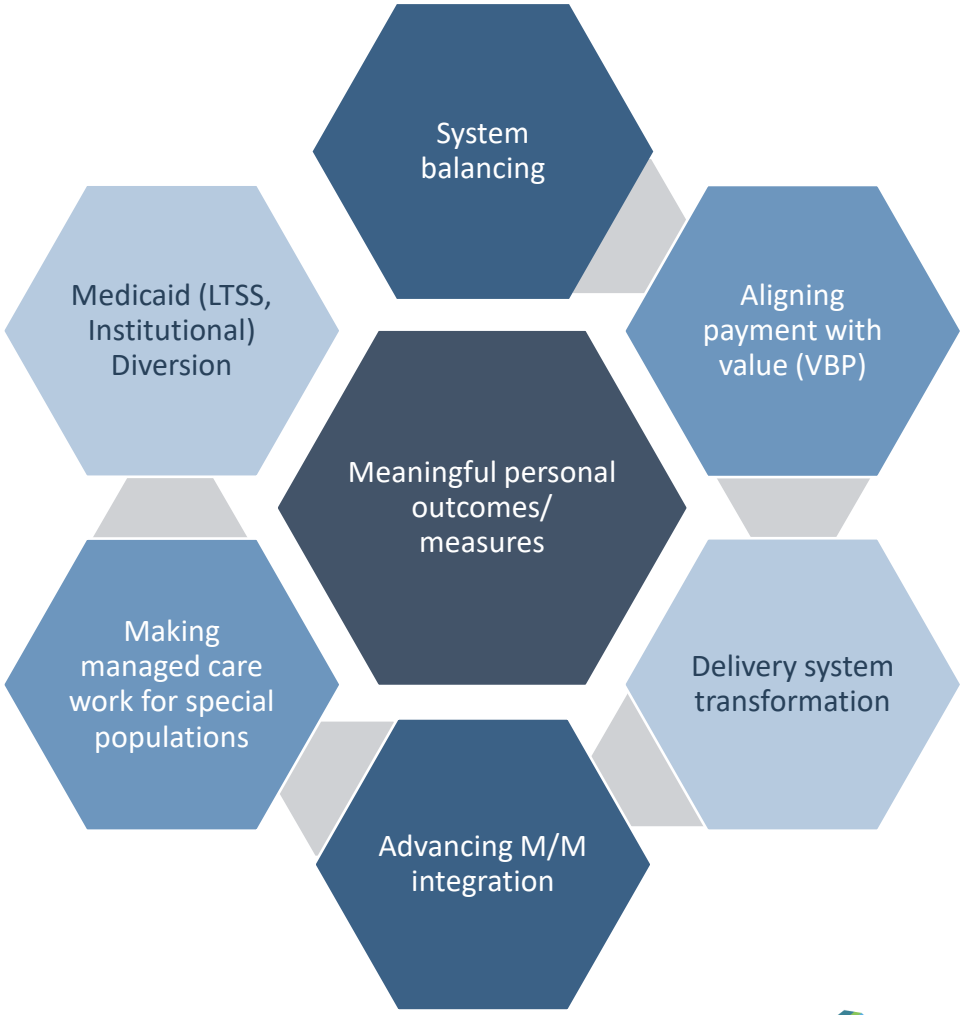
- Require D-SNPs to develop written protocols for how they will support enrollees as they transition from one setting to another
- Require D-SNPs to communicate/collaborate with Medicaid care management entities during enrollees' care transitions

IT, Data, and Reporting

- Require sharing of care plan information with specific LTSS, behavioral health and other key Medicaid providers or Medicaid managed care plans
- Require issuing real-time notifications of emergency room visits and hospital inpatient stays
- Require interaction with state databases to exchange service use information with other entities
- Require submission of care management data or reports to the state

Source: Leveraging Dual Eligible Special Needs Plan (D-SNP) Models of Care to Enhance Enrollee Care Coordination | Integrated Care Resource Center

Exciting Opportunities in MLTSS



Contact Information

Patti Killingsworth
Chief Strategy Officer
CareBridge Health

CareBridgeHealth.com
Patti.Killingsworth@CareBridgeHealth.com