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FORUM SESSION

Medicaid Managed Long-Term Services and Supports (MMLTSS):

Increasing State Interest and Implications for Consumers, Quality of Care, Providers and Costs

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OVERVIEW

By many accounts, state interest in initiating Medicaid managed care for long-term services and supports (MMLTSS) is growing at a rapid pace. To date, MMLTSS arrangements have been confined to a handful of states with limited enrollment and expenditures. A number of factors are causing more state Medicaid agencies to consider managed LTSS, including objectives to balance the availability of home- and community-based services with institutional care; slow the rate of spending growth and establish some predictability in Medicaid LTSS costs; and better integrate LTSS with primary, acute, and chronic care. Some observers predict that, over the next few years, fee-for-service under Medicaid for LTSS will gradually disappear in many states. Whether or not this is the case, increased state interest in moving to MMLTSS has stirred objections and fears among some consumers and providers. Some caution that states should learn from other states' experiences with MMLTSS programs when planning implementation and also ensure that effective consumer protections and quality oversight procedures are in place. Further, some are concerned about the impact that capitated financing will have on the traditional LTSS community provider system. This Forum session explored lessons learned from state experiences with MMLTSS, evidence of its effect on cost savings and quality outcomes, actions being taken by the Centers for Medicare & Medicaid Services (CMS) to help states interested in moving to MMLTSS, and consumer protections to be considered.

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MMLTSS EVOLUTION

Under managed care arrangements, a state Medicaid agency makes an entity (and in some cases more than one entity) responsible for arranging services, and the entity accepts financial risk for paying for services provided. The entity receives a fixed payment—a capitation amount—to care for each member of a specified population group, which may include the elderly and younger adults with functional, cognitive, intellectual, developmental, and/or behavioral health issues. An entity may be a health plan, a community services agency or provider organization, a county, or another organization.[1] Entities are responsible for providing and coordinating services, arranging for providers, and keeping costs within an overall capitation amount. Capitation amounts are generally based on average costs for the population group(s) served, adjusted for various factors such as age, geographic location, and disability levels.

Enrollment of children and families in Medicaid managed care arrangements is relatively standard practice in many states.[2] In contrast, most states have little experience with MMLTSS, and evidence about the impact of this type of Medicaid managed care is limited.[3] The elderly and younger adults with disabilities who need institutional or home- and community-based LTSS have generally remained outside the scope of Medicaid managed care, and MMLTSS has been considered "a niche product."[4] A recent survey indicated that, at the end of 2011, 12 states reported a MMLTSS program in operation (Arizona, Florida, Hawaii, Idaho, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Washington, and Wisconsin). A report for CMS found that in fiscal year 2009 MMLTSS spending in ten states accounted for more than $5 billion, representing 10 percent of total Medicaid LTSS spending in those states.[5] Although MMLTSS spending and enrollment continue to be rather low, both have increased considerably in recent years. Spending is estimated to have increased by 25 percent from 2008 to 2009[6] (from more than $4 billion to more than $5 billion) and enrollment by more than four times from 2004 to 2009 (from 68,000 to 250,000 beneficiaries).[7]

Among states with MMLTSS experience, three models have emerged. In the first model, managed care organizations are at risk for providing, arranging for, and financing Medicaid institutional and home- and community-based services. In the second, organizations are responsible for LTSS services and additional Medicaid-covered services, such as primary and acute services, for beneficiaries not covered by Medicare. In the third, plans are responsible not only for

Medicaid LTSS, acute care, and primary care, but also for Medicare-covered services for Medicare beneficiaries.[8]

According to a report for the U.S. Department of Health and Human Services, several factors have contributed to the slow growth of MMLTSS. These include "complex program design choices (including payment methodology), relatively long planning and start-up periods, resistance of long-term care providers and advocates, difficult state-federal policy issues, the need for a substantial population base, limited interest among potential suppliers, and inadequate state infrastructure in an era of government downsizing."[9] Other concerns cited are the difficulties in developing adequate rate-setting methodology that could help states accomplish cost-saving objectives and ensure that managed care plans and providers will be adequately reimbursed.[10]

Times may be changing. A survey indicated that, in addition to the 12 states that already have MMLTSS, 11 more states have plans to implement MMLTSS in 2012 or 2013 (California, Delaware, Indiana, Illinois, Kansas, Maine, Michigan, Nevada, New Jersey, Ohio, and Rhode Island). Some of these states indicated they have plans to expand statewide eventually.[11] Although it is difficult to predict what will happen over the next few years, the likelihood of increased Medicaid LTSS enrollment and expenditures under managed care umbrellas in the near future seems high even though some state plans are in flux. Also, gaining CMS approval of the necessary waivers of federal law can take some time.[12]

A number of factors are spurring more states to move their LTSS populations into managed care arrangements. State budget constraints in recent years have caused states to look for cost savings. Some states believe that moving to managed care for their LTSS populations, who consume a significant portion of Medicaid expenditures, will slow the rate of increase in Medicaid expenditures. Although to date there is scant or mixed evidence that cost savings have been achieved,[13] some believe that, at a minimum, states will have some predictability about their LTSS costs once they move to MMLTSS. States are also moving to balance their LTSS systems; that is, offer more home- and community-based services to balance the preponderance of institutional care available. By requiring managed care plans to ensure beneficiary choice and access to home- and community-based services, this end may be more easily achievable for some states. Some observers, however, have pointed out that some states have attained a more balanced system without managed care.

Many states also want to design systems of care that coordinate primary, acute, and chronic care with institutional and home- and community-based services and ensure seamless transitions among providers. These objectives have taken on substantial relevance over the last year as CMS initiated a program called the State Demonstrations to Integrate Care for Dual Eligible Individuals.[14] Under this initiative, states are considering how to develop models that will focus on ways to integrate LTSS with health care services for dual eligibles.[15]

PROGRAM DESIGN COMPLEXITY

States have many complex decisions to make in designing their MMLTSS programs. Observers have pointed out the importance of program design if MMLTSS programs are to meet their objectives.[16] Questions that need to be addressed include:

- Which populations will be covered? Elderly and younger people with disabilities, people with behavioral health conditions, people with developmental or intellectual disabilities? People who are only Medicaid eligible, or those who are eligible for both Medicare and Medicaid? People who meet the institutional level of care as well as those who do not?
- Which services will be included? Home- and community-based services, such as personal care and adult day care? Supported employment services for those who can and want to work? Institutional services, such as nursing facility and intermediate care facilities for people with developmental disabilities? Services that integrate LTSS as well as primary, acute, and behavioral health services?
- Will enrollment be mandatory or voluntary? If mandatory, will participants be offered an opportunity to opt-out?
- If waiting lists for home- and community-based services exist, what role will the managed care entity play in eliminating them?
- How will provider network adequacy be ensured?
- Will consumer-directed services be offered?
- What procedures will be used to ensure beneficiary choice of managed care plans, providers, and services?
- How will meaningful stakeholder engagement that includes prospective beneficiaries and their representatives as well as providers be ensured?

- What needs assessment tool will be used? And how will states ensure that conflict-free needs assessment procedures will be used to determine an individual's service plan?
- Which entity or entities will be responsible for needs assessment, case management, and care planning?
- How will capitation rates be determined?
- What procedures will states put in place to monitor the managed care organization's operations and the quality of care provided to beneficiaries and to hold the organization accountable for services provided?

Each of these questions involves complex decisions by many state officials as well as significant stakeholder involvement. In order to help states make these decisions, CMS is in the process of developing an online tool to provide technical assistance consistently. The tool is designed to offer guidance to states on the relevant federal authorities available for program development and will contain a checklist of key program design issues as well as sample contract language from existing state programs. It will help states that want to include only Medicaid services in their programs or both Medicaid and Medicare services for dually eligible beneficiaries.[17] The rollout of the tool is expected later this year.

POTENTIAL BENEFITS AND RISKS OF MMLTSS APPROACHES

Some observers believe that MMLTSS may help states experience greater predictability in their LTSS budgets, and achieve greater accountability from managed care organizations than under the fee-for-service system. As states continue to suffer funding constraints and loss of experienced state staff, the movement to managed care is viewed as one way to encourage programmatic and financial efficiencies. Advocates for managed care believe that state goals of balancing the LTSS systems and better integration of acute, chronic, and behavioral services with LTSS can be achieved when one organization assumes financial risk for a continuum of services. Some believe that managed care organizations that are financially at risk for providing services may be in a better position to control costs and might be better able to ensure that clients have the appropriate level and types of care. Moreover, some say that managed care organizations may be helpful in fending off some of the political pressure that is currently applied to state legislatures by nursing homes to maintain reimbursement rates favorable to institutions. Others note, however,

that having multiple plans negotiating fees with nursing homes may reduce the leverage states, as the largest purchaser of nursing home care, have been able to exercise in setting rates over the years.

Critics of managed care arrangements, on the other hand, fear that managed care poses significant risks to consumers. Some are concerned that services could be rationed or curtailed if the capitation fees paid are not considered adequate and/or when states experience budget constraints. Others fear that services important to helping those with LTSS needs remain safely at home and in community settings may not be adequately covered. Some say managed care plans' expectations of family caregivers (who already provide most of the care to impaired family members) may be too high. In addition, some consumer advocates say that managed care organizations generally do not fully understand the care needs of vulnerable populations and have less experience with LTSS than they do with primary and acute care. Some observers have been concerned that managed care arrangements may conflict with consumer direction initiatives. Beneficiaries may resist any changes in access to service providers, and, in some cases, to hard-won services they have negotiated over time. Moreover, local service providers, such as area agencies on aging and centers on independent living, may be wary of competing for funds from new managed care entities and potentially losing grant funding from state or county governments with whom they have had long-term relationships.

KEY QUESTIONS

- How extensive are state MMLTSS programs, and what lessons can be learned from these initiatives?
- What are the most important motivations for states in initiating MMLTSS?
- What program design elements are being used by states, and what do we know about their effectiveness? What evidence exists on cost-savings and quality of care under MMLTSS?
- How well developed are state capitation models for MMLTSS? Individual assessment tools?
- In view of state budget cuts and staff turnover, what is the capacity of states to develop, implement, and monitor MMLTSS? What state oversight controls are needed to ensure quality of LTSS under managed care arrangements?

- What consumer protections should be in place for vulnerable populations who participate in MMLTSS? What actions should states take to ensure uniformity of consumer protections statewide?
- What information about provider network adequacy, service provision, and consumer satisfaction for both care recipients and informal caregivers should be collected to provide sufficient oversight?
- How experienced are managed care organizations in providing MMLTSS to vulnerable populations? How effective will they be in creating or sustaining provider networks and negotiating fee structures, particularly for nursing homes?
- What effect will the initiation of MMLTSS have on the local LTSS provider system, including area agencies on aging and centers for independent living?
- What are the relationships between state MMLTSS initiatives and the broader CMS and state efforts to integrate acute, primary, chronic, and behavioral health care for dual eligible Medicare and Medicaid beneficiaries?

SPEAKERS

Paul Saucier, MA, the director of integrated care systems at Thomson Reuters Healthcare, discussed lessons that can be learned from current state experience with MMLTSS, including the effects of these programs on cost-savings and quality of care, rebalancing LTSS, and consumer-directed services. **Mike Hall,** the director of the Division of Integrated Health Systems, Disabled and Elderly Health Programs Group in the Center for Medicaid, CHIP, and Survey & Certification at CMS discussed the potential effect of MMLTSS expansions for service delivery efficiencies and Medicaid financing, CMS's technical assistance to states that are planning MMLTSS programs, and state Medicaid agency capacity to implement and monitor managed care plans. **G. Gordon Bonnyman, Jr., Esq.,** executive director of the Tennessee Justice Center in Nashville, discussed Tennessee's experience with MMLTSS and its effect on consumers, as well as consumer protections that state Medicaid agencies might consider in their planning for MMLTSS expansion.

ENDNOTES

1. Paul Saucier and Wendy Fox Grage, "Medicaid Managed Long-Term Care," prepared for the AARP Public Policy Institute, Issue Brief No. 79, November 2005, available at http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf. (Brief was based on findings from the national study of managed long-term care by Saucier, Burwell, and Gerst cited in endnote 3.)

2. Kathleen Gifford *et al*., "Medicaid Managed Care: Key Data, Trends, and Issues," Kaiser Family Foundation, Policy Brief, February 2012, available at www.kff.org/medicaid/upload/8046-02.pdf.

3. Paul Saucier, Brian Burwell, and Kerstin Gerst, "The Past, Present and Future of Managed Long-Term Care," Thomson/MEDSTAT and University of Southern Maine, prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2005, available at http://aspe.hhs.gov/daltcp/reports/mltc.htm; and Laura Summer, "Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider," prepared for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, October 2011, available at www.kff.org/medicaid/upload/8243.pdf.

4. Richard Kronick and Karen Llanos, "Rate Setting for Medicaid Managed Long-Term Supports and Services: Best Practices and Recommendations for States," Center for Health Care Strategies, Inc., Resource Paper, March 2008, available at www.chcs.org/usr_doc/Rate_Setting_for_Medicaid_MLTS.pdf.

5. Jessica Kasten, Steve Eiken, and Brian Burwell, "Medicaid Managed Long-Term Services and Supports Expenditures," Thomson Reuters, prepared for the Centers for Medicare & Medicaid Services (CMS) , April 6, 2011, available at www.hcbs.org/files/205/10211/MedicaidManagedLTSSExpenditures.pdf. According to the report, expenditures for MMLTSS have not been easily identified in the past because spending for LTSS has been included in a state's spending for managed care and not reported as separate amounts.

6. Kasten, Eiken, and Burwell, "Medicaid Managed Long-Term Services and Supports Expenditures."

7. L&M Policy Research, Muskie School of Public Service & Thomson Reuters, "Efforts to Enhance the Availability and Quality of Managed Long-Term Care," Online Resource, September 12, 2001, available at www.nasuad.org/documentation/hcbs2011/Presentations/M1RegencyA.pdf.

8. Saucier, Burwell, and Gerst, "The Past, Present and Future of Managed Long-Term Care."

9. Saucier, Burwell, and Gerst, "The Past, Present and Future of Managed Long-Term Care."

10. Kronick and Llanos, "Rate Setting for Medicaid Managed Long-Term Supports and Services: Best Practices and Recommendations for States."

11. AARP Public Policy Institute, with the National Association for States United for Aging and Disabilities and Health Management Associates, "On the Verge: The Transformation of Long Term Services and Supports," February 2012, available atwww.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/On-the-Verge-The-Transformation-of-Long-Term-Services-and-Supports-Report-AARP-ppi-ltc.pdf.

12. For example, see Phil Galewitz, "States Pushing Managed Long-Term Care for Elderly and Disabled Medicaid Patients," Kaiser Health News, February 22, 2011, available at www.kaiserhealthnews.org/Stories/2011/February/21/medicaid-managed-long-term-care.aspx.

13. Saucier, Burwell and Gerst, "The Past, Present and Future of Managed Long-Term Care."

14. CMS, Medicare-Medicaid Coordination Office, "State Design Contract Summaries," updated February 28, 2012, available at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDesignContractSummaries.html.

15. Carol V. O'Shaughnessy, "Improving Care for Medicare-Medicaid Dual Eligible Beneficiaries: One Size Does Not Fit All," National Health Policy Forum, Forum Session, January 27, 2012, available at www.nhpf.org/library/details.cfm/2882.

16. Summer, "Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider."

17. L&M Policy Research, Muskie School of Public Service & Thomson Reuters, "Efforts to Enhance the Availability and Quality of Managed Long-Term Care, Online Resource."