

# Managed Long-Term Services & Supports

*Managed care comes to Long-Term Care:  
Why it's Happening; How we're Preparing*

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# What's Happening?

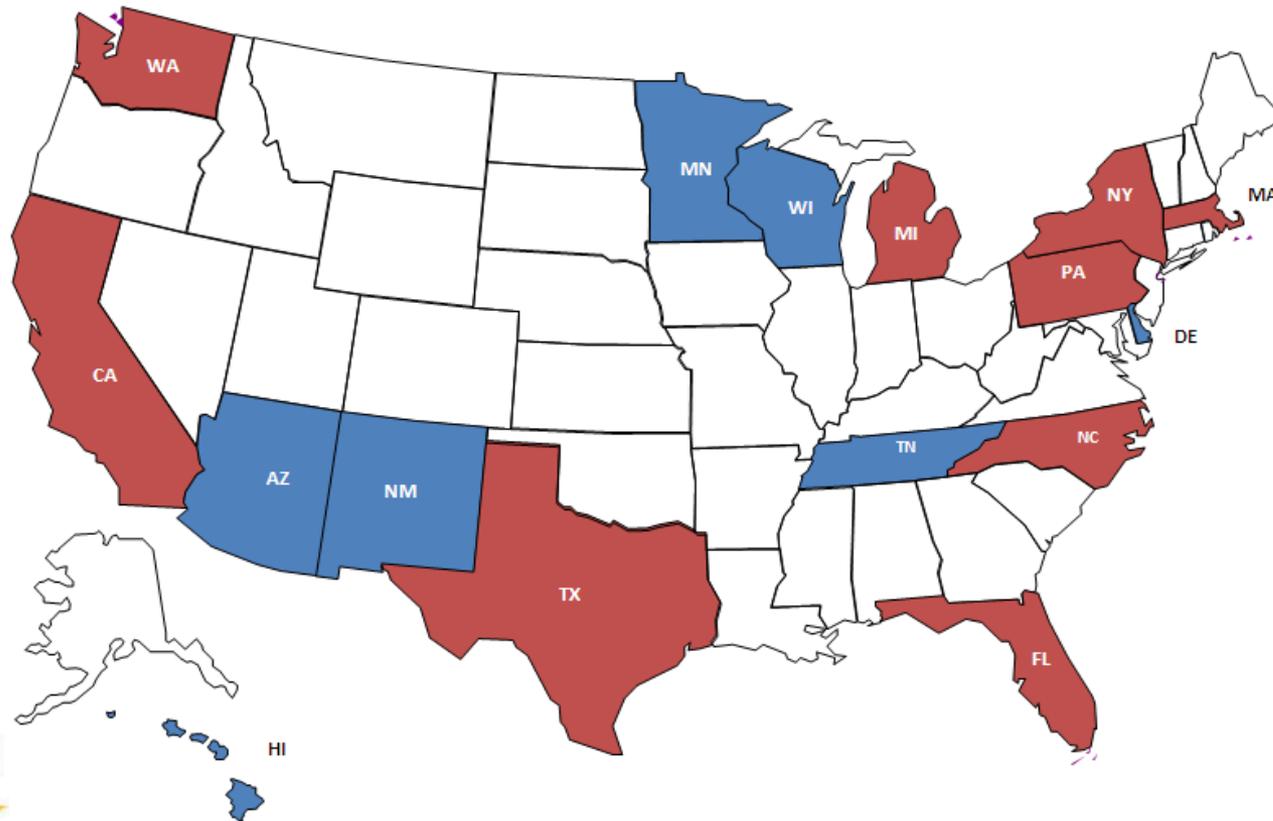
- Dramatic shift in State Medicaid programs away from Fee-for-Service towards Managed Care (and other bundled payment / outcome driven delivery models)
- In 2010, roughly 72% of Medicaid beneficiaries nationally were served in managed care / PCCM programs
- But managed care accounted for only 30% of Medicaid spending.
- Why? Most managed care enrollees are younger adults & children (think TANF & CHIP). Elderly and disabled populations – the most costly – are carved-out and remain in FFS 1915(c) waivers
- 2011 saw a huge increase in States signaling that they would move their Medicaid programs to managed care
- In several cases – Kentucky, Louisiana, New Hampshire – negligible MC penetration, now adopting MC statewide

# What's Happening? (cont'd)

- In several other cases, States with experience in MC, concentrated in urban areas – New York, Texas, California – announced they will expand MC statewide to cover all their Medicaid beneficiaries – millions of beneficiaries
- “Within two years, we do not expect to have any significant FFS presence in our Medicaid program.” *quote from Medicaid director of large State*
- And what else is happening? Most of these States are also proposing to migrate their carved-out 1915(c) populations into MLTSS
- Would not be surprising if MC market share in Medicaid increases to 90% (or higher) by 2014, with MC accounting for 50% or greater share of Medicaid spend nationally

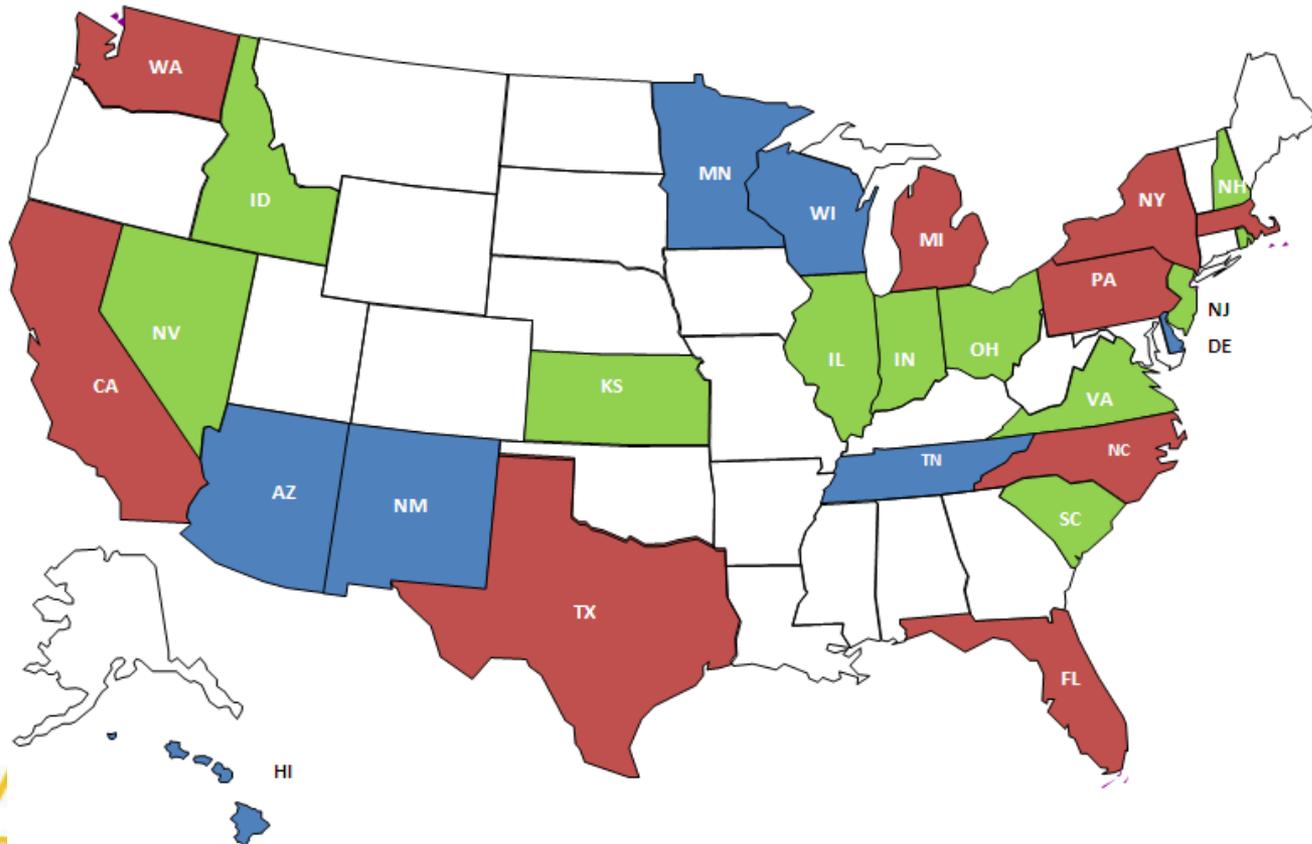
# Current MLTSS States expand the footprint

- 9 of 16 States with existing MLTSS programs plan to expand by January 2014 (Red)



# New States join the fray

- 11 additional (new) States plan to migrate populations to MLTSS by January 2014 (Green)



# Why now? Why so fast?

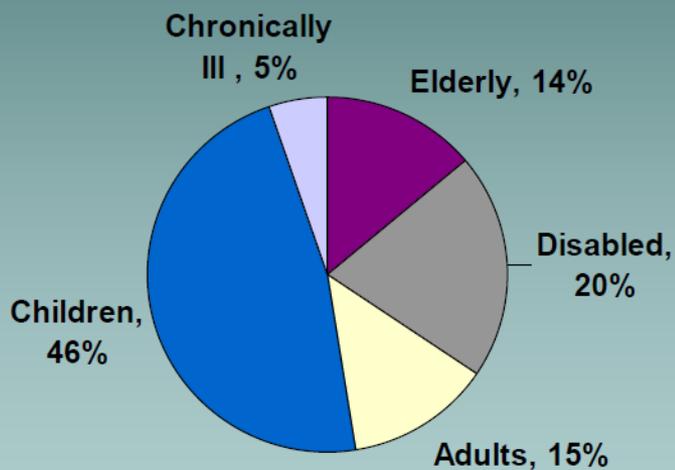
- State budget deficits – collective deficits of \$175 billion through 2013, on top of the \$230 billion in budget gaps states filled between fiscal years 2009 and 2011.
- Total Medicaid spending increased by 7.9% in FY10, estimated to increase by 11.2 % in FY11
- Long-term care spending trends are unsustainable – even before we start focusing on the baby boomer demographic
- MMCO / Duals Office Financial Alignment Initiative
- 2014 Medicaid expansion -- 17 million new beneficiaries

# Why now? Why so fast? (cont'd)

- New State leadership – 29 new Governors, most in history
- The 80/20 rule and cost of chronic disease – the most popular pie chart in health care
- Fiscal implications of continuing to ignore cost of chronic illness
- “Never let a good crisis go to waste”
- “If not now when . . .”

# Compare where the beneficiaries are . . .

## Children, Elderly and Persons with Disabilities are Largest and Fastest Growing MA Populations

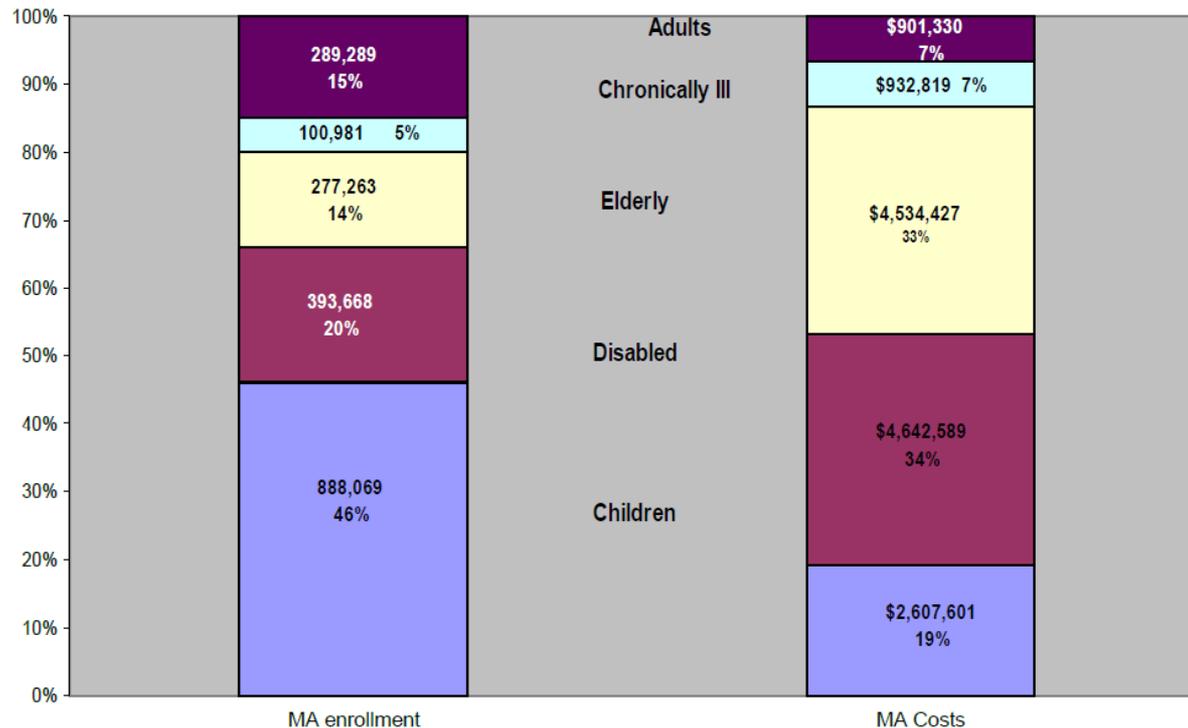


	Enrollment Growth (FY06 to FY07)
Elderly	5.6%
Children	3.8%
Persons with Disabilities	2.2%
Chronically Ill Adults	0.0%
Adults	-1.1%

# ... to where the money is:

## Seniors and People with Disabilities Use the Greatest Share of Medical Assistance Resources

Medical Assistance Recipients by Category and Projected Recipient Related Costs for 2008-09



# Coordinated & Integrated Care

- Shift to MC part of a larger trend toward Integrated / Coordinated Care, including PCCM, Health Homes, ACOs, bundled payment strategies
- Recognition that we have done a poor job of addressing chronic disease . . . and an even poorer job of integrating physical / acute care with long-term care (see 2001 IOM report: Crossing the Quality Chasm)
- Medicaid-funded MLTSS delivery systems and §1915(c) home- & community-based (HCBS) waivers are almost completely estranged from the physical / acute delivery systems
- Federal / state funding for HCBS emphasized / measured deinstitutionalization, rebalancing, independent living, Olmstead compliance, participant-directed care
- . . . but not health status / outcomes

# Paying for Outcomes, Instead of Volume

- Shift to MC and MLTSS delivery systems is also driven – at least in part – by realization that unit-based FFS delivery system is. . .
- not keeping people healthy
- not fulfilling promise of rebalancing
- not sustaining expansion of independent living / home-& community-based alternatives to institutional care (nursing homes, ICF/MRs, IMDs)
- Extremely difficult to be integrated in the community, to live with independence & dignity -- if you're not healthy
- State & CMS recognition that we must reconsider patient-clinician relationships, realign reimbursement incentives and introduce accountability for outcomes & quality improvement

# Policy Implications of MLTSS Expansion

- Are the States ready? In some cases, limited / no experience administering MC contracts, conducting oversight of MCOs. Gives new meaning to “Readiness Review”
- MLTSS is a brave new world for most States
- Do they have the expertise & infrastructure to effectively manage their relationship with MCOs? Effect of State personnel reductions.
- Will States be proactive purchasers of MLTSS services and define the terms of their relationships with MCOs or instead allow MCOs to tell them what “we do or don’t do.”  
Examples: participant-directed care, interdisciplinary teams

# Policy Implications of MLTSS Expansion (cont'd)

- Concern that MCOs may have expertise in Medicaid physical / acute care world, but are unfamiliar / uncomfortable with LTSS
- Will MCOs demonstrate literacy / competency in serving MLTSS special needs populations: elderly, developmentally & physically disabled, TBI, etc.
- Will core principles of HCBS, independent living, consumer control be preserved?
- Will MLTSS advance cause of rebalancing & deinstitutionalization? *Hint*: Reliance on group homes not a desirable goal.

# Policy Implications of MLTSS Expansion (cont'd . . . again!)

- States not necessarily interested in paying MCOs to build – from scratch –MLTSS delivery system / infrastructure / expertise that States' have spent last two decades building and paying for
- MCOs can fast-track their own competency by purchasing this expertise – and access to already established providers & resources (e.g., literate care coordination, transportation, home-delivered meals) from existing providers: Area Agencies on Aging, Centers for Independent Living, Home Health Agencies, etc.
- Tension between figuring out which aspects of legacy FFS delivery system / providers to preserve **versus** transition to outcomes-based reimbursement
- Will States require MCOs to contract with poor-performing FFS providers?

# How will CMS help States prepare for MLTSS?

- Currently developing policy framework for MLTSS
- Will include policy guidance, tools, checklists
- Preservation of core MLTSS ingredients
- MLTSS website: “Elements of Good MLTSS Program”
- Contract review & oversight tool
- Site visits: promising practices & lessons learned
- New technical assistance resources, with focus on capacity building, State readiness, oversight
- Emphasis on States as proactive purchasers, defining the terms of engagement – from RFP to bidders’ conference; from writing a strong contract to enforcement

# Expected Trends

- Dramatically increased MLTSS enrollment
  - Larger geographic reach
  - State preference for mandatory enrollment
- Increasing supply of contractors
  - National, regional and local MCOs
- Incorporation of participant-directed options
- Integration of Medicare