Contracting for Managed LTSS: Best Practices and Cautionary Tales

For CMS/LTC/CCO Study Group

June 11, 2013

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CHCS Mission

To improve health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

Our Priorities

► Enhancing Access to Coverage and Services
► Advancing Quality and Efficiency through Delivery System Reform
► Integrating Care for People with Complex and Special Needs
► Building Medicaid Leadership and Capacity
Agenda

I. Overview of Medicaid MLTSS

II. State Best Practices in MLTSS

III. Other Examples of Integration
I. Overview of Medicaid MLTSS

II. State Best Practices in MLTSS

III. Other Examples of Integration
Background

Medicaid is THE major player in long-term services and supports (LTSS) in the US:

• 62% of LTSS funded by Medicaid, mostly fee-for-service*

• 64% of Medicaid LTSS dollars go to nursing home care


* Does not include LTSS expenditures funded by Medicare (i.e., post-acute care and home health services).
Managed Care as a Purchasing Strategy for MLTSS

- Reduces fragmentation of acute and primary care, behavioral health, and LTSS
- Provides high-quality, person-centered and cost-effective care to eligible beneficiaries in the setting of their choice
What are MLTSS Programs?

• Deliver LTSS through capitated Medicaid managed care programs

• Provide state plan services – home health and nursing facility care; optional state plan services – targeted case management, home- and community-based services (HCBS); and additional services

• Use managed care strategies – contracting with a provider network, performance measurement for accountability, and capitated payments
States with MLTSS Programs

- MLTSS programs more than doubled between 2004 and 2013
  - 9 states have mandatory enrollment, 7 voluntary, and 1 has both
  - 12 states offer consumer-directed options
  - 400,000 beneficiaries enrolled
- Number of MCOs in the MLTSS market has expanded accordingly
- By 2014, 26 states have indicated their intent to have MLTSS programs
- LTSS benefits included varies by state

SOURCE: The Growth of Managed Long-Term Services and Supports Programs: A 2012 Update, Truven Health Analytics for Centers for Medicare & Medicaid Services, July 2012; (2013 data provided by CMS)
# Promoting Rebalancing and Choice of MLTSS

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>State</th>
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<tbody>
<tr>
<td>Plans responsible for nursing facility (NF) and HCBS under blended capitation rate (full risk, full profit)</td>
<td>MN, NJ, WI</td>
</tr>
<tr>
<td>Plans responsible for NF and HCBS under blended capitation rate (risk and profit shared with state)</td>
<td>AZ, HI, TN</td>
</tr>
<tr>
<td>HCBS available as an entitlement (enrollment not capped) for NF level of care</td>
<td>TN, TX, WI</td>
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<tr>
<td>Higher rate for HCBS services</td>
<td>MN</td>
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<tr>
<td>Transition allowance benefit</td>
<td>TN</td>
</tr>
<tr>
<td>Plans required to work with consumers who want to transition</td>
<td>HI, MN, TN, TX</td>
</tr>
<tr>
<td>Performance measures require service timelines for sentinel events</td>
<td>AZ, TN, TX</td>
</tr>
<tr>
<td>Performance measure with penalty for NF utilization</td>
<td>TX</td>
</tr>
</tbody>
</table>

Source: Mildred Consulting -- Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services -- Recommendations for California. 2012. [http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf](http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf)
Number of Beneficiaries Enrolled in MLTSS Programs

Growth in Enrollment
## Populations Enrolled

<table>
<thead>
<tr>
<th>Category</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors only</td>
<td>California, Florida, Massachusetts, Minnesota</td>
</tr>
<tr>
<td>Both older persons and people with disabilities</td>
<td>Arizona, Delaware, Hawaii, New Mexico, New York, Tennessee, Texas, Washington, Wisconsin</td>
</tr>
<tr>
<td>Individuals with intellectual/developmental disabilities</td>
<td>Arizona, Hawaii, Michigan, North Carolina, Pennsylvania, Washington, Wisconsin</td>
</tr>
<tr>
<td>Adults with Serious Mental Illness</td>
<td>Michigan, North Carolina, Washington</td>
</tr>
<tr>
<td>Children*</td>
<td>Arizona, Delaware, Michigan, New Mexico, North Carolina, Tennessee, Texas</td>
</tr>
</tbody>
</table>

* May be limited to children with intellectual/developmental disabilities, serious mental disturbance, or SSI-related eligibility depending on the state.
Covered Services

**Traditional LTSS Services**
- Institutionally-based services (nursing facility, ICF/MR)
- Home- and community-based services (home health, personal care, adult day health, case management, respite care)

**Value-Added Services**
- Eyeglasses
- Home modifications
- Employment services
- Non-emergency transportation
Provider Networks

- **Provider networks** – Include providers for the full range of LTSS offered

- **Network adequacy** – Include factors such as number and location of providers

- **Provider qualifications** – Establish minimum provider qualifications or use past performance considerations, references, or licensure/certification to ensure quality service delivery

- **Provider training** – Consider requiring specific training to address major goals, areas of concern, and/or target populations

- **Integration with Medicare** – Build larger networks and include primary and acute care
Financial Incentives

• Properly designed MLTSS financing can encourage:
  ► High-quality, person-centered care and services
  ► Use of Home and Community Based Services

• Capitation of Targeted Benefits
  ► Carved out services creates risk of cost-shifting
  ► Including all components under MCO responsibility helps to protect against cost-shifting
  ► Risk adjustment possible but experience is limited

• Performance incentives for achieving performance improvements can be built in
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III. Other Examples of Integration
1. Communicate a Clear Vision

Hawaii’s QUEST Expanded Access (QExA) program goals:

• Improve the health status of seniors and persons with disabilities
• Establish a “provider home”
• Empower beneficiaries by promoting independence and choice
• Assure access to high-quality, cost-effective care (in homes/communities when possible)
• Coordinate all care (acute, behavioral, LTSS)
2. Engage Stakeholder to Achieve Buy-in

- Texas STAR+PLUS: Healthcare Matters held beneficiary focus groups and meetings with health plans and providers

- Tennessee CHOICES: State staff identified roles for Area Agency on Aging and Disability

- Wisconsin Family Care: Contractors developed local committees with provider and consumer representatives
3. Use a Uniform Assessment Tool

Wisconsin Long-Term Care Functional Screen

- Activities of daily living such as bathing, dressing, transferring, mobility, and eating
- Instrumental activities of daily living (e.g., meal preparation and medication management)
- Diagnoses and health-related services or tasks
- Communication and cognition (e.g., memory loss, decision-making ability)
- Behaviors and/or mental health (e.g., wandering, substance abuse)
- Available transportation or employment
4. Structure Benefits to Appropriately Incentivize the Right Care

Tennessee CHOICES

- TennCare managed care organizations responsible and at-risk for full continuum of LTSS services, including nursing facility and HCBS, plus all primary, acute, and behavioral health services
- Care management/coordination included
- Fewest exclusions are the ideal!
5. Include Attendant Care and/or Paid Family Caregivers in Benefit Package

Arizona Long-Term Care System (ALTCS)

- Includes paid family members as caregivers through traditional attendant or self-directed attendant care program
- Family members in traditional attendant care program are hired by home health/attendant care agency
- Training includes CPR, first aid, infection/disease control
- Spouse as paid caregiver (up to 40 hours per week) recently added to program
6. Ensure Program Design Addresses Beneficiaries’ Needs

- Arizona Long-Term Care System (ALTCS)
  - Interdisciplinary care team approach to help determine the needs for services
  - Behavioral health (as part of health plans’ interdisciplinary team) coordinates care for beneficiaries identified as having behavioral health needs
- Other states’ health plans may coordinate with behavioral health services outside the health plan
7. Recognize Shift to Risk-based Managed Care

- States vary in their approach to contracting out vs. building in-house expertise
  - Rate-setting and risk adjustment
  - Financial oversight and monitoring
  - Data collection and analysis

- Very few actuaries have experience setting rates for MLTSS, so states need to understand rate development
8. Align Financial Incentives to Program Goals

• If the state plans to shift care toward HCBS, rates should include realistic incentives for plans
  ▶ Incentive payments based on achieving objectives
  ▶ Case-mix payment system
  ▶ Penalties for increased reliance on institutions

• Money Follows the Person and other state initiatives can complement the health plans’ strategies
9. Establish Robust Contractor Oversight/Monitoring Requirements

- Most states start with very prescriptive contracts and monitoring practices.
- Over time, if health plan performance is found to be consistently high, the state may focus on a few high-risk, high-cost areas.
- Beneficiaries living outside facilities with state financial support always represent an area of risk for state managers.
- TN best practice: HCBS monitored/reported monthly.
10. Recognize Need for LTSS-focused Performance Measurement

- Many states track process measures (e.g. days to assessment; care plan completion)
- Wisconsin best practice: PEONIES interview
  - Living in a preferred setting; Making one’s own decisions
  - Deciding one’s own daily schedule; Maintaining personal relationships
  - Working or pursuing other interests; Being involved in the community; Having stable/predictable living conditions
  - Being treated fairly and with respect; Having the amount of privacy desired
  - Being comfortable with one’s health situation; Feeling safe
  - Feeling free from abuse and neglect
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Other State Integration Examples: MA Senior Care Options

- Inception: 2004
- Population: Age 65+
- 2012 Enrollment: 21,785 (15,568 LTSS users)
- Contractors: 2 national; 2 local plans
- LTSS oversight
  - Appropriate nursing facility institutionalization
  - Special studies: PIPs; discharge planning study; management of dementia with a focus on community-based care
  - State reviews contractor reporting of utilization of nursing facility and community LTSS
Other State Integration Examples: MN
Senior Health Options

• Inception: 1997
• Population: Age 65+ on Medicare/Medicaid
• 2012 enrollment: 36,128 (25,819 LTSS users)
• Contractors: 8 private; 1 county-based plan
• LTSS oversight
  ► Performance measures: timeliness of HRAs/assessments; care plan audit; SNP measures;
  ► Special studies: annual QA and PIPs;
  ► Annual review of care system subcontractors;
  ► Review of annual submission of LTSS networks.
Other State Integration Examples: NM Coordination of Long-Term Services (CoLTS)

- Inception: 2008
- Population: All ages
- 2012 Enrollment: 39,607 (22,446 LTSS users)
- Contractors: Two large national health plans
- LTSS oversight
  - Performance Measures: NF admits/readmits; home safety evaluations/follow-up for safety issues; Falls risk assessed/treated; Members who transition from NF to community/stay 6 month;
  - State advisory groups; monitors critical incidents; network updates
Other State Integration Examples: WA
Washington Medicaid Integration Project (WMIP)

- Inception: 2005
- Population: Age 21+
- Enrollment: 4,834 (412 LTSS users)
- Contractor: One private health plan
- LTSS oversight
  - Performance measures: falls, critical incident reporting
  - Special requirements: geriatric specialist on QI committee; LTSS-specific practice guidelines
  - Monitoring reports: related to utilization of services, including LTSS, and expenditures; file review and field visits; users and total dollars by service category
Conclusions

- MLTSS requires an intense level of state oversight
- Some evidence that MLTSS programs are improving care and helping to rebalance LTSS
- Experienced states offer valuable models and lessons about effective oversight practices
- For states lacking experience running MLTSS programs, need greater attention to readiness reviews, training and technical assistance
Questions and follow-up:

• Visit [www.chcs.org](http://www.chcs.org) to:
  ► Download practical resources to improve the quality and cost-effectiveness of Medicaid services
  ► **Subscribe** to CHCS email updates to find out about new programs and resources
  ► **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost patients

• Contact: Alice Lind at [alind@chcs.org](mailto:alind@chcs.org)

• Up-to-date information about demonstrations: [http://www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com)