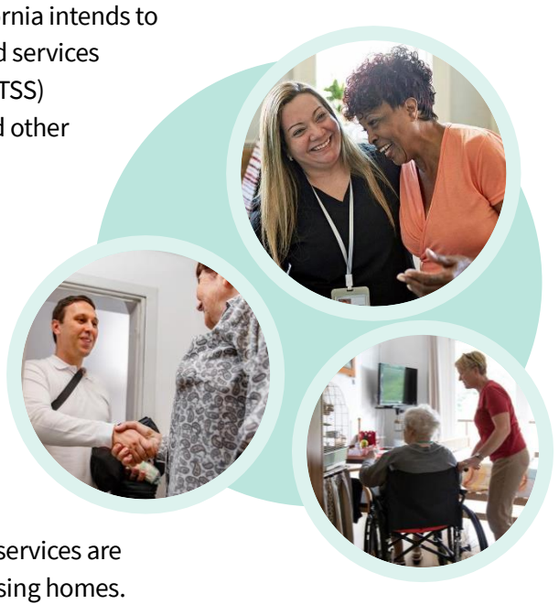
Center for Health Care Strategies

# Moving Home- and Community-Based Services to Medicaid Managed Care: How States can Address Provider Concerns

As part of its Medi-Cal transformation effort, CalAIM, California intends to move select 1915(c) waiver home- and community-based services (HCBS) to managed long-term services and supports (MLTSS) in 2028 (timeline and waivers subject to change). As California and other states transition to MLTSS, stakeholders can learn from the experiences of states that already moved to MLTSS over the last three decades.



**This fact sheet can help states to address questions that HCBS providers might have about transitioning to MLTSS, including how it may impact their practices and the patient experience.**

## What are HCBS?

HCBS help older adults and people with disabilities with daily activities, like eating, bathing, and managing medications. These services are provided in the home rather than in institutional settings, like nursing homes.

## What happens under MLTSS?

States without MLTSS reimburse providers directly through their Medicaid programs for each HCBS service provided to a member, often referred to as fee-for-service. Under MLTSS, Medicaid programs subcontract with managed care plans (MCPs) to administer HCBS to members. In this arrangement, MCPs are paid a standard monthly rate for each enrolled member, regardless of how many services the members use.

## What can states do to prepare HCBS providers for a transition to MLTSS?

Following are three common HCBS provider concerns about an MLTSS transition and ways states can address them, based on lessons from other MLTSS states and novel approaches not yet adopted by states. To learn more and access sources, read the companion explainer, ***Moving Home- and Community-Based Services to Medicaid Managed Long-Term Services and Supports: Considerations for California and Other Transitioning States***.

### *Will providers experience delays in payment?*

#### Lessons from States that Already Transitioned

- **Kansas** withheld three percent of MCPs' monthly payments for the first year of its MLTSS program, which could be earned back if an MCP exceeded minimum standards for timely provider payments.
- **New Mexico** and **Hawaii** require MCPs to adhere to strict timelines, oversight mechanisms, and quality review processes for provider claims processing and payments.
- **Pennsylvania** and **Florida** impose monetary penalties on MCPs that do not reimburse providers within a defined timeframe after claims submission.
- **New York** requires MCPs to deposit five percent of annual projected medical expenses into an escrow account that providers can draw from if their payments are delayed.
- **Indiana** requires standardized contract language that all MCPs must use for all LTSS providers in their network to simplify the billing process and minimize delayed payments.

#### Novel Approaches States Might Consider

- Incentivize MCPs and providers to use community care hubs for their billing and administrative functions.
- Standardize contract templates, provider rates by type, and billing across MCPs in a geographic region.
- Allow HCBS users to pay providers directly through self-directed financial management service entities.
- Develop readiness review standards to proactively address payment challenges before implementation.

*Made possible by the California Health Care Foundation.*

## *Will care coordination staff be replaced by MCP care coordinators or vendors?*

### Lessons from States that Already Transitioned

- **Ohio, Indiana,** and **Pennsylvania** require MCPs to contract some or all HCBS care coordination functions to existing HCBS providers.
- **Many MLTSS states** require MCPs to have select LTSS-related National Committee for Quality Assurance (NCQA) accreditations to provide care coordination.
- **Most MLTSS states** require MCPs to use consumer experience of care surveys (HCBS-CAHPS or NCI-AD) to ensure HCBS user satisfaction with care management.

### Novel Approaches States Might Consider

- Prohibit MCPs from contracting with care management entities in which they have a financial interest.
- Require MCPs to keep internal care management and utilization management functions separate.
- Develop written guidance on expectations for how care coordination and communications should occur.
- Require MLTSS care managers to serve as the primary care manager for dually eligible HCBS users.
- Develop an experience of care survey supplement to assess user satisfaction with care managers' HCBS knowledge, understanding of independent living principles, and non-clinical care management services.
- Require MCPs to share data with aging- and disability-related organizations (such as Area Agencies on Aging and Independent Living Centers) to improve opportunities for coordination and care delivery.

## *Will provider payment rates and staffing ratios keep up with an increased demand for services or an increase in members who have more complex needs?*

### Lessons from States that Already Transitioned

- **Arizona** and other states require annual actuarial review of payment rates to determine if adjustments are needed.
- **Most MLTSS states** set care manager staffing ratios to ensure care managers can meet service demands.

### Novel Approaches States Might Consider

- Require MCPs to calculate provider reimbursement rates using functionally based risk adjustment at the HCBS provider level.
- Expand CMS' "access rule" beneficiary advisory committees to include review of MLTSS payment rates for all HCBS provider types.
- Require smaller or fluctuating care manager ratios during the initial HCBS assessment and care planning process to better support the higher upfront care management burden when a person first joins an MCP.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## Learn More

Read the explainer, ***Moving Home- and Community-Based Services to Medicaid Managed Long-Term Services and Supports: Considerations for California and Other Transitioning States***, to learn more about perspectives from HCBS users, providers, MCPs, and state Medicaid agencies on MLTSS transitions and how transitioning states can create systems that best serve Medicaid members.

### ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

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