

Integrating Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care: A Strategy for Strengthening Long-Term Services and Supports

By Stephanie Anthony, Arielle Traub, Sarah Lewis, and Cindy Mann, Manatt Health; Alexandra Kruse, Michelle Herman Soper, and Stephen A. Somers, PhD, Center for Health Care Strategies



Historically, states have “carved out” or excluded Medicaid-only long-term services and supports (LTSS) beneficiaries from managed care. Instead, they have provided these services in a fee-for-service system, or provided LTSS on a fee-for-service basis and physical and/or behavioral health services through managed care, often resulting in siloed and uncoordinated care. Now, many states are including their Medicaid-only LTSS populations in their existing or new managed care programs to address this fragmentation and the resulting poor health and financial outcomes.

► Strategy Description

Some states are expanding their managed care plans for the LTSS population to provide a comprehensive benefits package that includes physical and behavioral health services and LTSS under a single capitated rate.¹ Under these fully integrated Medicaid managed long-term services and supports (MLTSS) arrangements, a single entity (i.e., the health plans contracting with the state) is responsible for coordinating the complex needs of these beneficiaries. States often phase-in managed care enrollment by region and population. For instance, under a regional rollout strategy, states may start with more densely populated regions in which plans can more easily meet network adequacy requirements, and then rollout to more rural regions. With a population phase-in strategy, states could initially exclude certain sub-populations (i.e., individuals receiving LTSS in a nursing facility or other institutional setting), and include them at a later date after the state and health plans build capacity. Additionally, in some cases states have gained experience with an MLTSS pilot program or a voluntary enrollment model before transitioning to mandatory MLTSS enrollment. As part of this strategy, it is critical to ensure that small home- and community-based services (HCBS) providers are able to contract with and get timely payments from health plans, with which these providers are often engaging with for the first time.

More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million Americans to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than \$154 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This LTSS reform strategy is part of a larger toolkit, ***Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment***, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.



To learn more and view the full toolkit, visit www.chcs.org/ltss-toolkit.



► Implementation Mechanisms

To administer Medicaid MLTSS, states must combine authority for delivering services through Medicaid managed care with authority for providing comprehensive Medicaid LTSS, including HCBS.

States may operate Medicaid MLTSS under a Section 1932 state plan amendment or through various waiver authorities including 1915(a), 1915(b), 1915(c) and 1115 waivers.² Section 1915(a) waivers allow states to establish managed care programs with voluntary enrollment, while 1915(b) and 1115 waivers allow mandatory enrollment. Section 1915(b) waivers also give states more flexibility to engage in regional implementation of managed care, rather than requiring managed care benefits to be provided across the entire state, as well as provide varied benefits to different Medicaid populations. States may combine Section 1915(b) with 1915(c) waivers to combine managed care authority with HCBS authority in launching MLTSS programs.

Finally, 1115 waivers, which also provide flexibility for regional implementation and variation in benefits, can include allowances for federal matching funds for Medicaid expenditures that otherwise would not qualify for funding.³ As an example of state flexibility, Virginia originally intended to implement its integrated MLTSS program (Commonwealth Coordinated Care Plus) through an 1115 waiver. However, it realized after several months of planning and negotiations that Virginia's existing Medicaid program cost trends made the 1115 cost neutrality requirements challenging, particularly if unanticipated future costs arose for this vulnerable population. Instead, Virginia changed course and worked closely with its CMS central office to migrate to a 1915(b)/(c) waiver, which provided the flexibilities needed for its program.⁴

► Results to Date

There is limited data available that compare individuals enrolled in MLTSS programs to those in fee-for-service, or that assess the same individuals before and after enrollment. CMS has contracted for a national level evaluation of state MLTSS programs implemented via 1115 waivers. However, the ability to compare outcomes across states and the ability to access data needed to assess MLTSS program performance may be limited. In an informal survey, seven of 12 MLTSS states surveyed by CHCS and the National Association of States United for Aging and Disabilities reported improved health outcomes as a result of their MLTSS programs.⁵ One state reported that 77 percent of respondents to a consumer satisfaction survey said their quality of life had improved since joining an MLTSS plan.⁶ Some state MLTSS programs reported decreases in hospital stays and the duration of those hospital stays, and increases in non-emergency transportation utilization, potentially indicating increased provider visits.

From a programmatic standpoint, eight states reported that MLTSS promoted rebalancing their LTSS delivery systems, which aligns with national trends: fiscal year 2013 was the first year that HCBS accounted for just over half, or 51 percent, of LTSS spending in the United States.⁷ A few states reported decreasing or eliminating waitlists for certain services, thereby

increasing access to those services. Other states were able to offer additional services (e.g., non-medical transportation and vision services) due to cost reductions from implementing an MLTSS program. Seven states reported employing data collection to demonstrate cost and utilization trends, with one state confirming meeting savings targets and many others reporting increased budget predictability.⁸ Despite these early successes, states continue to experience challenges in moving LTSS populations into managed care, including setting appropriate health plan capitation rates, developing sufficient LTSS provider networks, particularly in rural areas, and establishing meaningful LTSS quality metrics.

► Key Lessons

States with established MLTSS programs reported that a variety of initial and ongoing capacities are required for a successful transition to a comprehensive capitated model:

- **Integration requires careful planning, Medicare expertise, and resource commitments.**

States must be able to invest in sufficient planning and implementation resources to launch a comprehensive managed care program with care coordination across fragmented points of care.⁹ Involvement of dedicated staff with expertise in primary care, behavioral health, and LTSS is critical to ensure a smooth transition from fee-for-service or an otherwise siloed system into a cohesive program for LTSS populations. As noted in the Virginia case study (see next page), states may consider potential agency reorganization strategies to support the transition of internal operations from oversight of fee-for-service providers to management and oversight of managed care plans. Offering both targeted small and full agency trainings, which should include visible leadership participation, may help staff prepare for new roles and is an important element of internal readiness, adaptability, and collaboration.

- **Consider a phase-in strategy.** States may want to consider phasing in their managed care program over time, whether by provider type, enrollee population, and/or geographic region. Implementing managed care payment and system delivery reforms over time gives health plans time to build experience with these provider, beneficiary, and geographic groups. Virginia, as well as many other states, has used this strategy successfully when implementing its transition from fee-for-service to managed care. This approach may help states work through implementation issues and mitigate concerns from beneficiaries, as well as smaller HCBS entities, around contracting and timely payments from health plans, particularly in rural areas.

► Independent Ombudsman Requirement

CMS' 2016 Medicaid managed care rule requires states to establish an independent beneficiary support network that offers education on enrollee rights, a streamlined access point for filing complaints, assistance during the grievance and appeals process, and data collection and review of systemic issues to better inform the state on how to address them. Furthermore, CMS announced funding to support demonstration ombudsman and counseling programs for states' Medicare-Medicaid Financial Alignment Initiative.



Currently there is limited information on the impact of these initiatives on service access and delivery outcomes as states are in the initial implementation phases.

Sources: CMS. "Funding to Support Ombudsman Programs". September 2016. Available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.





Define program goals and collect data relevant to achieving those goals from the outset. States recommend starting early with building a case to demonstrate program value to adequately respond to requests for information on outcomes and financial sustainability from legislators, advocates and other stakeholders. However, there are several challenges with quality measurement in these programs. There is a lack of standardized LTSS quality measures that are used consistently across state and federal programs, and consumer advocate concerns that existing measure sets do not adequately measure what is most important to beneficiaries and their families—including functional status, cognitive health, and safety. While there are extensive LTSS quality reporting requirements in use, it may be difficult to determine what data are best to assess whether program goals are being met. It also may be difficult to objectively assess the reliability of self-reported data about beneficiary satisfaction and quality of life, even though these are important cornerstones of MLTSS programs. In addition, collecting and analyzing survey or in-person assessment data can be labor intensive for states and plans. To be best positioned to report on outcomes related to new reforms, states recommended: (1) collecting baseline health status, cost, and utilization data prior to launch; and (2) defining program goals upfront and designing targeted quality measurement and data collection requirements around those goals.

- **Communicate with and educate all stakeholders.** States cited the importance of soliciting beneficiary and family members' input and feedback, as well as engaging in clear communication with stakeholders, specifically around network adequacy and provider payment rates to generate positive engagement and buy-in.¹⁰ In addition, securing support from other state constituencies is important. Virginia made concerted efforts to educate state legislators on a one-to-one basis to help them understand program goals and state oversight protocols during design phases for its MLTSS program. Securing informed legislative champions prior to implementation to assist their ability to respond to constituents was a high priority. It also proactively sought feedback about desired program results and implementation concerns to be able to report back on the status of these goals and concerns.

► Case Study

Virginia's Commonwealth Coordinated Care Plus Program Integrates All LTSS, Medical, and Behavioral Health Services Under One Program for Medicaid-Only Beneficiaries. Virginia's Department of Medical Assistance (DMAS) began a phased geographic rollout of its new mandatory MLTSS program in August 2017. Commonwealth Coordinated Care Plus (CCC Plus) is now operating statewide and provides all medical, behavioral health, substance use disorder services, and LTSS for individuals age 65 and older, children and adults with disabilities, and others eligible to receive LTSS. DMAS launched this program following a legislative mandate to improve quality and budget predictability by transitioning LTSS users from a fee-for-service delivery model into an integrated managed care arrangement.

DMAS originally intended to implement CCC Plus through an 1115 waiver. However, it realized after several months of planning and negotiations that current program trends made it unlikely to meet the 1115 budget neutrality requirements. Instead, DMAS changed course and worked closely with its CMS central office to migrate to a 1915(b)/(c) waiver.



Virginia previously operated a financial alignment demonstration, Commonwealth Coordinated Care (CCC), a voluntary program that provided comprehensive, integrated services—including LTSS—for dually eligible individuals in certain regions of the state. Although CCC concluded on December 31, 2017, it provided the foundation of the CCC Plus program. Virginia incorporated many successful elements from CCC to the new statewide program, and further benefited from the stakeholder engagement work completed for CCC as many stakeholders were already familiar with the concept and benefits of a managed care model for this population. CCC Plus plans must offer a companion D-SNP to offer dually eligible beneficiaries the option to enroll in aligned plans for Medicare and Medicaid services.

To help prepare for the managed care transition internally, DMAS conducted an internal reorganization of certain units, evolving its focus on management and oversight of managed care. It also created a new unit to support care management activities that will provide health plans with ongoing training, support high-risk care management activities, and provide a “safe place” for plans to discuss concerns with compliance and other care delivery issues.

ENDNOTES

¹ Centers for Medicare & Medicaid Services. “Summary - Essential Elements of Managed Long Term Services and Supports Programs.” Available at: <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-summary-elements.pdf>.

² C. Dobson, S. Gibbs, A. Mosey, L. Smith. “Demonstrating the Value of Medicaid MLTSS Programs.” National Association of States United for Aging and Disabilities. May 2017. Available at: <http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>.

³ *Ibid.*

⁴ Though both 1115 waiver and 1915(c) waivers have budget/cost neutrality requirements, cost neutrality under a 1915(c) waiver is more standardized and an easier threshold to meet compared to a 1115 waiver. More information available: <https://www.macpac.gov/subtopic/waivers/>.

⁵ C. Dobson, et al., op. cit.

⁶ *Ibid.*

⁷ S. Eiken, K. Sredl, B. Burwell, and P. Saucier. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending.” Truven Health Analytics. April 2016. Available at: <https://www.medicare.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>.

⁸ C. Dobson, et al., op. cit.

⁹ *Ibid.*

¹⁰ *Ibid.*