MEDICAID MANAGED CARE: A NATIONAL PERSPECTIVE

Senate Health and Human Services Committee
October 31, 2017
NASUAD: Who We Are

- **State Association**: 56 members, representing state and territorial agencies on aging and disabilities

- **Our Mission**: To design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers.
Our members include:
- State Unit on Aging directors
- Medicaid Long-term Services and Supports directors
- Developmental Disabilities Services directors

11 staff manage Federal policy (congressional and executive branch), administer 6 Federal and Foundation grants, and publish Medicaid Integration Tracker and Friday Update

Conveners of the National Home and Community Based Services Conference – largest conference of its kind with over 1,400 attendees, 5 plenaries, 5 all-day preconference intensives and 115 sessions over 3 ½ days
Leadership, Technical Assistance, and Policy Support to State LTSS Systems

- **Promoting Community Integration**
  - MLTSS Institute
  - HCBS regulations
  - DOL regulations

- **Encouraging Health & Wellness**
  - Oral Health

- **Supporting Consumer Access**
  - I&R Support Center
  - MIPPA Resource Center
  - Volunteer Resource Center
  - SNAP Enrollment

- **Promoting Sustainability**
  - Disability Business Acumen Resource Center

- **Preventing Abuse and Exploitation**
  - Ombudsman Resource Center
  - Elder Justice
  - Adult Protective Services

- **Measuring Quality**
  - NCI-AD
  - Alzheimer’s Workgroup
  - LTQA
NASUAD’s MLTSS work

- MLTSS Institute
  - Provide intensive technical assistance to states
  - Bring thought leaders together to discuss policy issues
  - Publish research papers

- Represented states on National Quality Forum’s Home and Community-Based Services Quality Workgroup

- Provided state perspective to NQF Technical Expert Panel on LTSS measures

First paper: Value of MLTSS
http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-institute
Background

- Provide intensive TA to states operating MLTSS programs
  - Develop and manage semi-annual full day conferences on MLTSS

- 20 years in Medicaid managed care
  - Worked in Medicaid MCOs in Maryland doing operations and regulatory compliance for 10 years
  - Increasingly senior positions in CMS on Medicaid delivery systems since 2005

- Senior Policy Advisor on Medicaid managed care at Center for Medicaid & CHIP Services (4 years)
  - National expert on MLTSS
  - One of primary authors of CMS MLTSS guidance and MLTSS sections of new Medicaid managed care regulations
Capitated managed care is the predominant delivery system for Medicaid beneficiaries

- 75% of all Medicaid beneficiaries in 2016 were enrolled in a health plan (for some or all services)
- 39 States deliver some or all Medicaid benefits through health plans (comprehensive or limited)
- Capitated health plan payments represented ~ 42% of all Medicaid expenditures in 2016

Source: Kaiser Family Foundation, October 2017
Penetration of Medicaid Managed Care

Source: CMS data
A large share of all Medicaid beneficiaries are enrolled in risk-based MCOs.

Why managed care?

- Accountability rests with a single entity
  - Financial risk for health plan provides opportunity to incentivize/penalize performance
  - Plans can integrate siloed streams of care (primary/behavioral/long term care) more effectively

- Administrative simplification for state
  - Eliminates need to contract with and monitor hundreds/thousands of individual providers
  - Managed care plans take on claims payment, member management, utilization review, etc.
Why managed care?

- **Budget predictability**
  - Capitation payments greatly minimize unanticipated spending
  - Can more accurately project costs

- **Innovation and Quality**
  - MCOs can deliver services more flexibly than states
  - They bring best practices from other states/product lines
  - Demonstrated improvement in quality outcomes (HEDIS) over FFS
Why managed care for LTSS?

- Consumer becomes the center, not their services
  - LTSS interventions can lower acute care costs

- Shift focus of care to community settings
  - Most consumers express preference for community-based services
  - Health plans may be able to effectuate transfers from institutions to community more easily
Nearly two-thirds of Medicaid spending is for the elderly and people with disabilities, FY 2014.

- Disabled: 14% (40% of total expenditures)
  - Elderly: 9%
  - Adults: 34%
  - Children: 43%
- Expenditures: Total = $462.8 Billion

Enrollees: Total = 80.7 Million

NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.
HCBS Expenditures as % of all LTSS Expenditures, FFY 2015

Source: Truven Health Analytics, June 2017
But.....

- Older adults and persons with disabilities are disproportionately served in nursing homes rather than in community settings\(^1\)
  - National average: 56.2% in NFs
  - Oklahoma: 71.6% in NFs

- Consumers overwhelmingly express preference for community residence over institutional settings

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\(^1\) Truven Health Analytics, Medicaid Expenditures for LTSS, FY2015, [http://tinyurl.com/ydergz9e](http://tinyurl.com/ydergz9e)
MLTSS Programs - 2017

Source: NASUAD survey; CMS data
Key Elements for an Effective MLTSS Program

- **Thoughtful Program Design**
  - Populations; services; geographic reach; provider protections; quality goals

- **Stakeholder Engagement**
  - Early and ongoing during design, implementation and operation

- **State Oversight Capacity**
  - New roles and responsibilities; adequate staffing; information feedback loops

- **Rigorous RFP and Contract**
  - Specific and detailed; performance expectations; translate FFS policies effectively

- **Consumer/Provider Support**
  - Public education campaign; MCO/provider speed dating; choice counseling; ombudsman assistance
National Best Practices

1. Strong care coordination requirements

- Continuity of care period where current care plans continue unmodified (will be required by MMC regs by 7/1/18)
  - All states have taken this approach

- State review of service plan reductions (at least first year)
  - Important to define what a ‘reduction’ is
  - Substitution of services may be OK if identified needs are met appropriately
  - KS, TN, TX

- Detailed contract language for care coordination and care plan development
  - TN, NJ, DE, AZ
2. Network adequacy standards

- Definitely an area for more creativity, esp. for services delivered in the home (will be required by MMC regs by 7/1/18)
  
  - TN, DE, AZ assess network adequacy in operation by assessing gaps between services needed, authorized and delivered
3. Provider contracting and training (at start-up)

- MCO training; LTSS provider outreach/communication and training, both from state and MCOs
  - PA, TN, VA

- Standardized provider contracts, credentialing and authorization forms, mandatory claims testing between MCOs and providers
  - TN, VA
National Best Practices

4. Consumer protections

- Clear and consistent communication about upcoming changes (and their advocates)
  - NJ, PA, TN, TX, duals alignment demonstrations

- Multi-modal choice counseling for plan selection (now required by MMC regs)
  - FL, VA

- Post-enrollment consumer assistance aka “LTSS ombudsman” (will be required by MMC regs by 7/1/18)
  - IA, NY, duals alignment demonstrations
5. Timely assessments and service delivery; service verification (safety/fraud and abuse)

- Assessments, care plans and service delivery timeframes at least as stringent as FFS
  - Most have shortened timeframes from FFS, including duals alignment demonstrations

- Electronic visit verification systems (required by 21st Century Cures Act by 1/1/19 for personal care services)
  - TN, TX, IL, OH, KS
6. Strong State oversight and accountability mechanisms

- State staff experienced in program management, contract monitoring, provider network adequacy, quality assessment, and rate setting
  - AZ, TN, FL, NJ, DE, NY, TX

- Contract with stringent MCO reporting and liquidated damages for immediate financial consequences
  - TN, DE, NJ, TX

- Public reporting of MCO performance
  - MN, NY
1. Rebalancing LTSS Spending

Rebalancing Medicaid LTSS spending toward HCBS and providing more options for people to live in and receive services in the community—if that is consistent with their goals and desires

- 8 states (AZ, FL, KS, MA, MN, NJ, NM, TN) reported that MLTSS has promoted rebalancing the LTSS delivery system
  - FL – Goals for nursing facility settings
  - TN, AZ – Rebalanced spending and increased HCBS
2. Improving Member Experience, Quality of Life, and Health Outcomes

Ensuring effective care coordination to improve consumer experience and quality of life

- 9 states conduct quality of life surveys
  - TX, TN, NJ – using NCI-AD to get MCO-specific results
- 7 states (AZ, FL, KS, NJ, MA, MN, TN) reported that MLTSS has improved health outcomes
  - FL, TX – MLTSS has improved consumer quality of life
3. Reducing Waiver Waitlists and Increasing Access to Services

Expand HCBS options and move consumers off waiting lists into service

- 6 states (FL, IA, KS, NJ, NM, TN) reporting reducing waiting lists as a goal
  - TN – Used MLTSS savings to create targeted services to ‘pre-Medicaid’ at-risk consumers
  - FL – Used MLTSS savings to enroll wait-listed individuals with the most critical needs into its MLTSS program
4. Increasing Budget Predictability and Managing Costs

Better manage Medicaid budget and bend the cost curve for all services

- 9 states (FL, IA, KS, MA, NJ, NM, RI, TN, VA) reported that MLTSS has stabilized their budget or slowed cost growth
  - FL – achieved five percent savings targets established by the legislature in 2013 and 2014
  - TN – Captured FFS baseline spending to compare to MCO spend
Final Thoughts

- Quality and cost are inextricably linked.
  - Improved quality outcomes will reduce costs
- Managed care is a set of tools and principles that can help improve coordination, quality and cost-effectiveness of care for the most complex populations.
  - It is up to the state to wield that tool in the most effective way
- Working with MCOs is an accountable partnership.
  - Procurement should not just focused on MC basics but on LTSS experience
Final Thoughts

- Implementing managed care well requires a significant investment in the State’s capacity to ‘manage’ managed care plans.
  - It requires different skill sets and an accountability mindset
- It takes time to implement managed care well.
  - Moving too quickly will undermine the success of the program
- It takes time to realize savings from managed care.
  - Focus on short-term savings imperils long-term sustainability of the program.
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