HEALTH MANAGEMENT ASSOCIATES

MLTSS: the Last Frontier for Managed Care

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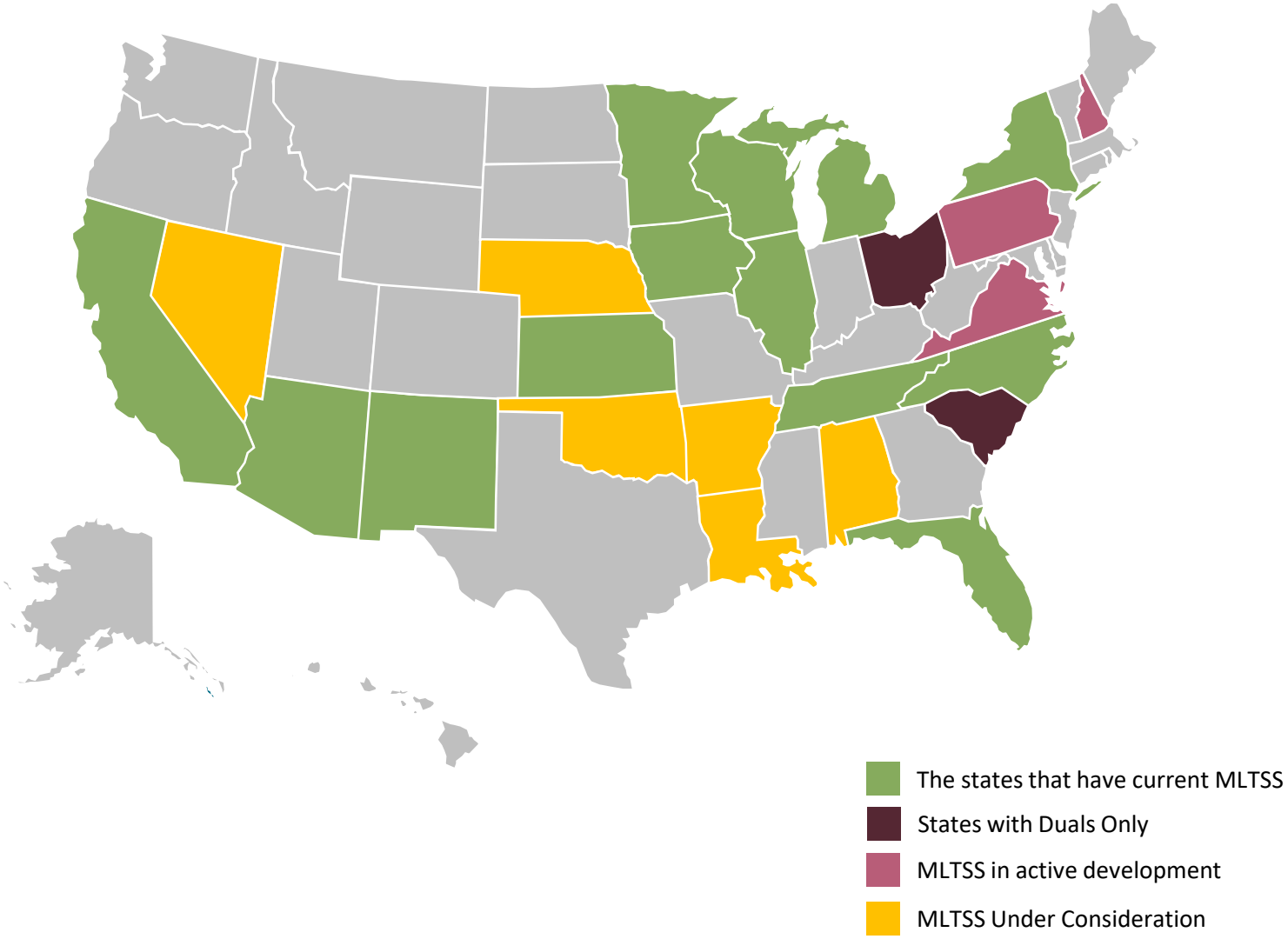
MLTSS: Medicaid's Last Frontier

- Delivery System Reform is what everything is about in healthcare today. MLTSS is a significant delivery system reform.
- MLTSS is growing as states search for ways to increase efficiency, coordination, quality, cost efficient services and budget predictability to a vulnerable and expensive population.
- Significant growth in past 24 months. LTSS is now a third of Medicaid spending.
- CBO has estimated Medicaid annual spending on LTSS will increase from $60B currently to more than $100B in 2023.
- There is a reason that Medicaid LTSS enrollees have not moved to managed care until relatively recently, when considering the overall Medicaid program.
- LTSS enrollees are largely medically and behaviorally complex, receive services from non traditional and sometimes unsophisticated service providers, and are frequently reluctant to move into "uncharted territory".

MLTSS Landscape



Medicaid MLTSS Authorities

- CMS grants approval to states for MLTSS programs through a variety of authorities, that combine Medicaid managed care authorities (State Plan Amendments (SPA), 1915a or 1915b waivers, or through 1115 demonstration waivers; and home and community based services (HCBS) authorities that include State Plan services, 1915i or j options, Community First Choice option, a 1915c waiver, or an 1115 demonstration.
- The CMS Managed Care Rule as revised addresses MLTSS, with new requirements for accountability, readiness reviews, stakeholder engagement, member advisory boards , and person centered processes. The Rule also preserves member choice of provider(s), and addresses participant supports and specific quality elements for MLTSS.

LTSS Populations and Settings

- Aged, can include dual eligibles
- Adults and children with physical disabilities
- Adults and children with intellectual and/or developmental disabilities

- May live at home with family
- Independent living alone or with others
- Nursing facility, ICF/DD
- Supported living

LTSS Populations and Settings

- Vast differences in these populations, and their needs
- Institutionalized adults may have no family or support system
- Children may have fiercely dedicated families
- Regardless of situation, MLTSS must be nimble and responsive to service needs
- The move to MLTSS is a nervous one for most enrollees
- It is a new ball game for managed care plans entering MLTSS
- Because it is a new ball game, CMS developed ten guiding principles for states and managed care plans to use when developing MLTSS programs

1. Adequate Planning and Transition Strategies

- Thoughtful and adequate planning process to develop a clear vision for the program. This includes appropriate transition plans, readiness assessment (state, stakeholders, legislature, MCOs), impact to other state agencies.
- Solicitation of stakeholder input; education opportunities for potential program participants
- Development of quality standards and oversight plan, sufficient phase in strategy to allow systems issues, policy and procedure bumps in the road to be adequately addressed.

2. Stakeholder Engagement

- CMS emphasizes transparency to providers, beneficiaries, advocacy groups. Nothing can tank a program faster than suspicion that plans or details are being withheld from the public.
- Stakeholder input should be sought from the beginning, and through each phase of the project, with regular updates to all impacted parties
- CMS recommends a state website as repository for information as well as mailings, public meetings and advisory groups from the planning stage through and including implementation.

3. Enhanced Provision of HCBS

- The Americans with Disabilities Act and the Olmstead decision entitle Medicaid beneficiaries to receive services in the most integrated setting. These requirements are incorporated into the HCBS Settings rule that state waiver programs must come into compliance with by 2019. Many states have HCBS services provided in settings that are contrary to the settings rule.
- CMS has signaled that it may pull back the settings rule, but until that happens, states continue to work to comply. This adds an additional risk to the development of an MLTSS program.

4. Alignment of Payment Structures with Goals

- Payments to managed care plans should support the triple aim of improving health, improving the experience of care, and reducing costs through these improvements.
- Capitation rates should encourage delivery of high quality services in home and community based settings and support community integration.
- Managed care contracts should be performance based with incentives tied to outcome measures, and penalties for poor performance

5. Support for Beneficiaries

- MLTSS beneficiaries in the main are among the most complex and vulnerable of Medicaid beneficiaries, and require levels of support the exceed those of most other Medicaid categories.
- States must offer conflict free support for enrollment and disenrollment, choice counseling and education on options, and an advocate or ombudsman program to assist MLTSS beneficiaries understand their rights responsibilities, and how to handle a dispute with a provider, a plan or the state.

6. Person Centered Process

- Ensure medical and non medical needs are met, quality of life and level of independence is preserved
- Beneficiary or designee is an active participant in service planning and delivery
- Meaningful options offered based on a comprehensive assessment
- Goals are meaningful to the beneficiary
- Opportunity to self-direct.
- Assurance of appropriate supports

7. Comprehensive Integrated Service Package

- Quality delivery of covered services
- Integrated physical and behavioral health in community based services or in institutions
- When all services are not covered by the managed care contract, the contract should contain provisions for coordination of care and referral to assure holistic and person centered plan

8. Qualified Providers

- Network adequacy
- The credentialing and network systems must stretch beyond traditional the acute and primary care service delivery model
- Requires adequate capacity and expertise to provide access to services that support community integration such as employment supports, training and technical assistance to providers
- State continuity of care standards, and managed care plan training and technical assistance to non traditional providers in billing and coding requirements

9. Participant Protections

- A significant percentage of elderly individuals experience some form of abuse ranging from financial exploitation, neglect, or emotional mistreatment
- Robust health and welfare safeguards and monitoring during transition to MLTSS and ongoing throughout the operation of the program
- Strong critical incident management program
- Appeals process that allows continuation of services while an appeal is pending

10. Quality

- Merge existing managed care plan quality initiative with existing LTSS quality measures
- Develop a data driven quality improvement process
- Comprehensive quality strategy
- Oversight structure that includes acute and primary care, behavioral health, and LTSS

LTSS Provider concerns

- For such complex beneficiaries, it is not reasonable to expect savings in the first two or three years
- Significant up front costs for administration and IT systems
- Studies have shown that MLTSS works best when fully integrated with Medicare. “Non integrated MLTSS is like doing care management with one hand tied behind your back”
- There are no recognized credentialing criteria for LTSS providers, causing undo burden for managed care plans

Effects of New Administration on MLTSS

- Watchful waiting
- Increased flexibility to states is probable; some rules may be relaxed; issue will be to have enough safeguards in place for beneficiaries
- Loss of the entitlement could be catastrophic

- Questions?
- Thank you!