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# Managed Long-Term Services and Supports

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## What is managed care?

- Way of paying for and delivering health care and/or long-term services and supports (LTSS)
- Generally, payer gives a managed care organization (MCO) a set (capitated) monthly payment per member, which the MCO uses to provide services and supports to its members
- Provide an array of services to members through an established network of contracted providers
- MCOs assume and manage some or all of the financial risk for their members
  - As such, they have a financial incentive to keep members healthy, and to coordinate members' care

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## Where are we now?

- As of May 2012, 16 states offer MLTSS programs (19 programs; 7 statewide)
  - AZ, CA, DE, FL, HI, ID, MA, MN, NM, NY, NC, PA, TN, TX, WA, WI
  - All 16 target seniors, 11 target people with disabilities
  - Represented 5% of total Medicaid LTSS expenditures in FY2009

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## Why now?

- State budget deficits
- Growth in Medicaid spending
- Current LTSS spending trends are unsustainable
  - People receiving Medicaid LTSS represent only 6 percent of the Medicaid population, they account for a disproportionate share of Medicaid spending – nearly half of Medicaid spending overall
  - In most states, long-term services still have a strong institutional bias (nationally only 36.8% of LTSS spending is on community-based services; only 7 states spend more than 50% on community services, the highest at 63.9% and the lowest at 10.5%) AARP Scorecard 2011
- ACA: Incentives to states to develop new service delivery and payment models
  - MMCO financial alignment, medical homes/health homes; 2014 Medicaid expansion

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## Potential benefits of MLTSS

- More care coordination
- Improved integration between acute care and LTSS
- More flexible benefits packages
- Accelerated rebalancing through global budgets
- Improved community alignment
- Improved quality management

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## Challenges in MLTSS

- Limited experience
- Process is moving very quickly in some states
  - Are states ready? Are plans ready?
  - Contracting terms and standards
- Transitioning beneficiaries from fee-for-service to capitated systems
- Network adequacy
- What happens to existing community-based organizations and networks?
- Potential re-medicalization of disability services
- Loss of focus on independence, community living, recovery
- Measuring LTSS – especially HCBS – quality

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## Stakeholder/Consumer Concerns About MLTSS

- Meaningful stakeholder engagement during planning, roll-out and post-implementation
- Assuring MCOs have experience/expertise with LTSS populations including sub-populations with complex needs
- Strong bias toward home and community-based care (including consumer-directed) and compliance with Olmstead
- Focus on person-centered planning
- Participant protections (meaningful appeal rights, freedom from abuse and neglect)

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## Stakeholder Concerns (cont'd)

- Qualified provider network including continuity of previous fee-for-service community providers with good track record
- Adequate resources for state Medicaid agencies and state operating agencies for LTSS to do quality monitoring and oversight
- Mandatory MCO reporting requirements over both encounter data and quality measures, and transparency for stakeholders, policy makers and the public to review these reports on a regular basis
- No carve-outs of institutional services creating perverse incentives