

# Medicaid Health Plans of America Briefing: Medicaid Funded Long Term Supports and Services

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# Agenda

- I. Long Term Supports and Services (LTSS) Basics
- II. LTSS Reform and Evolution
- III. Medicaid Health Plan Considerations in Providing LTSS



# I. Long Term Supports and Services Basics

- What are LTSS?
- Who are the people who need LTSS?
- How are LTSS financed?
- How are LTSS delivered?
- Dual Medicare and Medicaid Enrollment
- Dual Enrollment and LTSS Connection



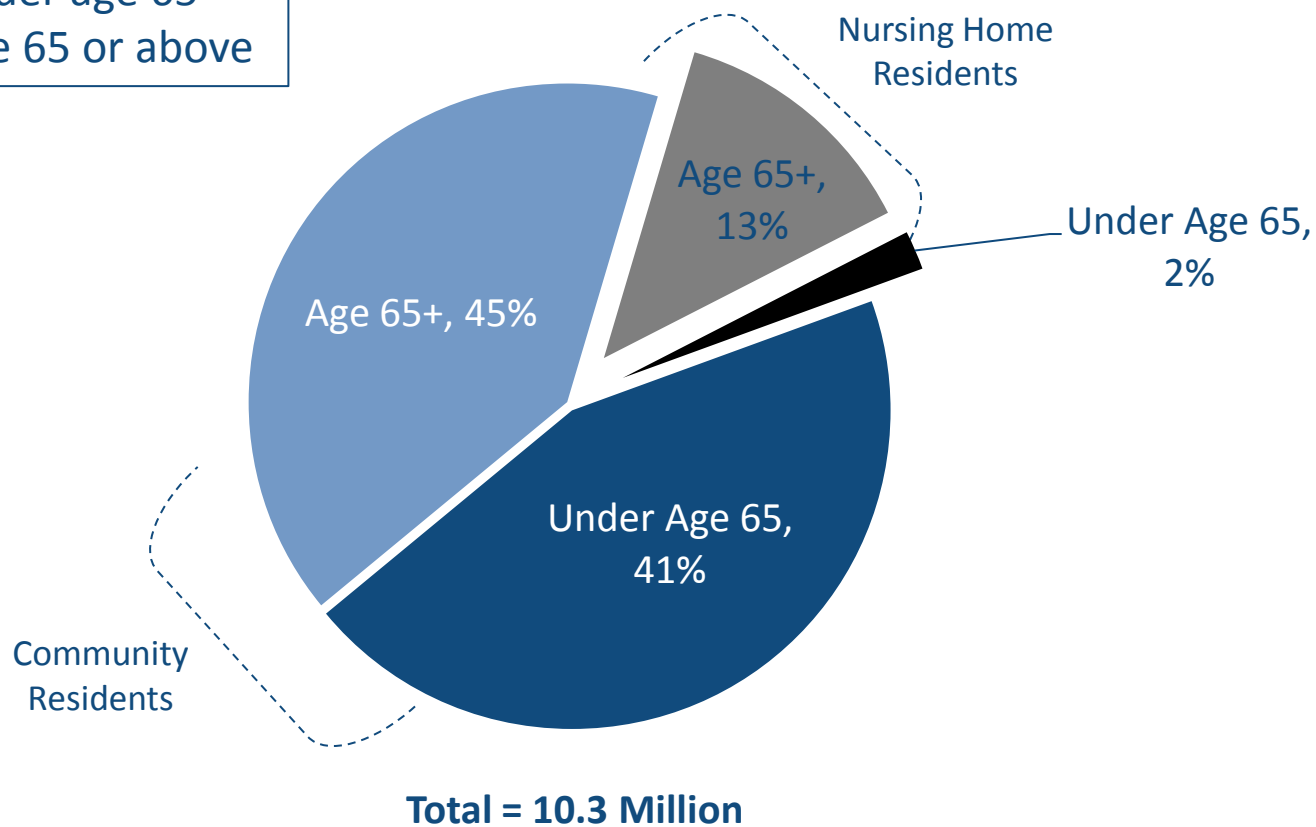
# What are LTSS?

- LTSS are needed by people who have limitations in their capacity for self-care, due to physical disability, cognitive disability, and mental disability.
- Only individuals meeting financial requirements *and* clinical level of care (LOC) criteria are eligible to receive Medicaid funded LTSS.
- LOC is generally measured, irrespective of age and diagnosis, by functional status:
  - Inability to perform basic activities necessary to live independently
  - Need for assistance from another person to carry out these activities
- LTSS exclude medical and nursing services required to manage the underlying health conditions that lead to frailty or disability

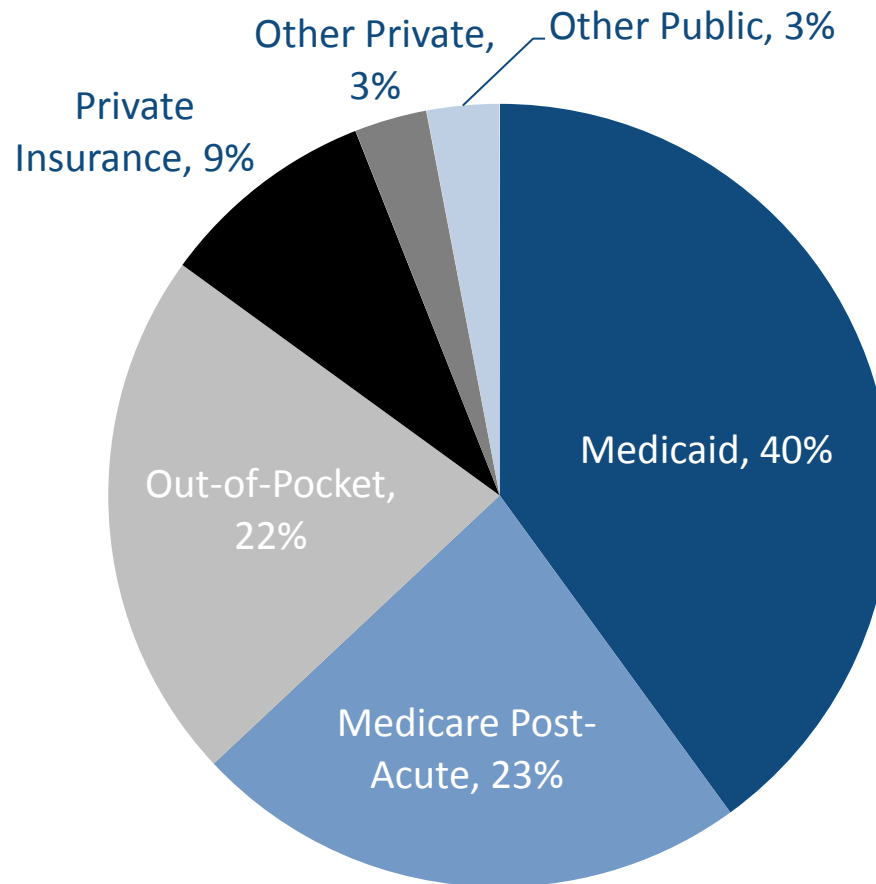


# Who are the people who need LTSS?

42% are under age 65  
58% are age 65 or above



# How are LTSS financed?



**Total\* = \$177.6 billion**

\*Total LTC expenditures includes only spending on nursing home and home health services. Some community-based services financed primarily through Medicaid home and community-based waivers and delivered in other settings are not represented here. SOURCE: KCMU estimates based on CMS National Health Accounts data, 2010.



# Models of Delivery – LTSS Institutional Services

- Most costly model of delivery
- Required State Plan service
- Institutional services include:
  - Nursing Facilities
  - Intermediate Care Facilities (e.g., for individuals with developmental disabilities or serious mental illness)



# Models of Delivery – LTSS Personal Care Services

Personal Care Services generally include assistance with:	
Personal hygiene/grooming	Light housekeeping
Ambulation/transfers	Meal Preparation
Feeding	Shopping

- **Personal Care Services (PCS)**
  - Services vary by state
  - May be covered under state plan or waivers
- PCS may be provided by
  - an agency employee
  - an individual selected by the beneficiary.
- “Consumer-directed” or “self-directed” PCS can be performed through an Agency Model or Employment Model.



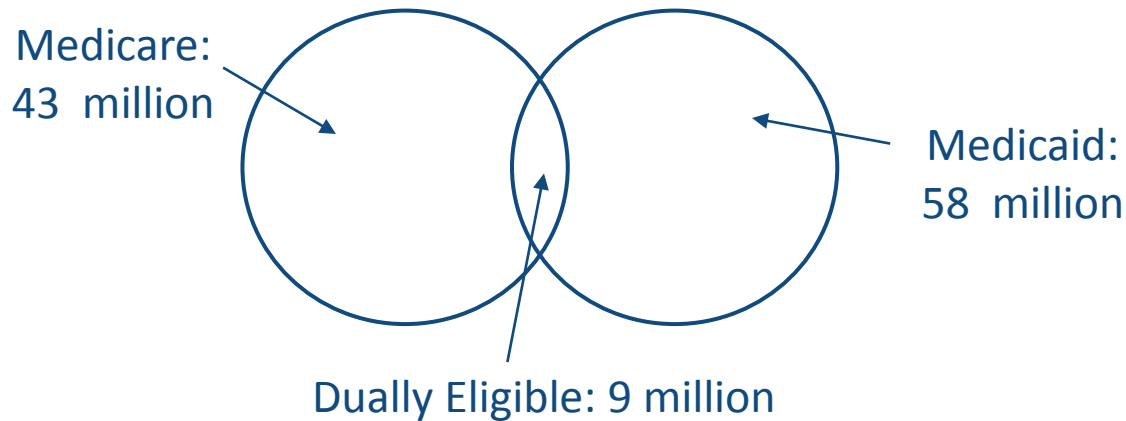
# Models of Delivery – LTSS Home and Community Based Services (HCBS)

HCBS vary by state and the CMS “waiver” under which they are provided; but in all cases are designed to replace costly institutional services

HCBS Examples	
Personal Care (“consumer or self-directed” options)	Adult Day Health Center
Skilled Maintenance Therapy for Adults*	Caregiver Respite
Private Duty Nursing for Adults*	Care Coordination
Community Transition from Institution	Emergency Response Systems
Environmental Modifications	Remote Monitoring
Assisted Living Supports (excludes room & board)	

# Dual Medicare and Medicaid Enrollment

- Nationwide almost 9 million individuals are dually enrolled in both Medicare and Medicaid.



- Full duals (~7 million) receive all Medicaid benefits not covered by Medicare.
- Partial duals (~2 million) receive only coverage for Medicare Part B premiums and/or deductibles and copayments.



# Dual Enrollment and LTSS Connection

- Nationally, 63% of Medicaid Aged Blind and Disabled beneficiaries are dually enrolled in both Medicaid and Medicare.
- There is tremendous overlap of individuals who receive Medicaid funded LTSS and are also dually-enrolled.
- Regardless of payment source (Medicaid only or Medicaid and Medicare), the physical, behavioral and long term care systems operate in silos, rarely coordinating individuals' care needs.
- This fragmentation yields poor health outcomes, reduced quality of life and high costs to both states and the federal government.

*Significant opportunities exist to improve access, quality, and cost of care for these high-need, high-cost individuals.*



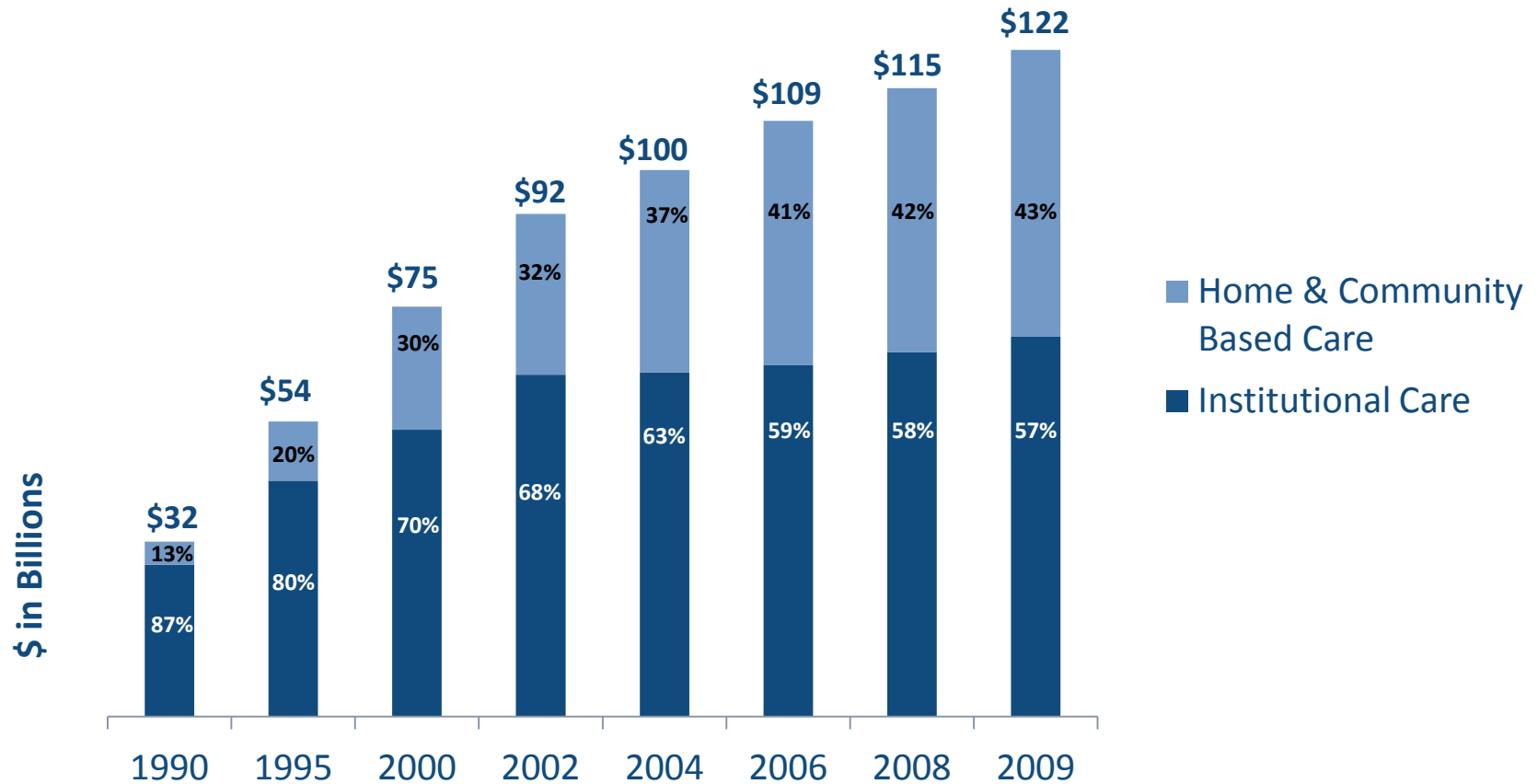
## II. LTSS Reform and Evolution

- LTSS Expenditures
- Managed Medicaid Long Term Care
- LTSS Integrated Care Programs
- Accountable Care Act Provisions Related to LTSS
- Federal Coordinated Health Care Office



# LTSS Expenditures

## Medicaid and Long Term Care Services and Supports



# Managed Medicaid Long Term Care

- The majority of LTSS are reimbursed on a fee-for-service (FFS) basis and are carved out of managed Medicaid programs.
- Some states have implemented programs to manage LTSS only:
  - Wisconsin Family Care
  - New York Managed Long Term Care Partial Capitation Program



# LTSS Integrated Care Programs

- **Capitated Models covering both physical health and LTSS\***
  - **Mandatory Enrollment** for individuals receiving Medicaid funded LTSS
    - The state capitates managed care organizations (MCO) for both physical health and LTSS
    - Requires that contracted MCOs be or have related Medicare Special Needs Plans (SNP) so dual enrollees can opt to have all care provided by a single organization
    - Examples: Arizona, New Mexico and Texas
  - **Voluntary Enrollment** for dual enrollees who wish to receive both Medicare and Medicaid services from one plan
    - States require that contracted MCOs be Medicare SNPs
    - Examples: Massachusetts, Minnesota, New York, Washington and Wisconsin

\*inclusion of behavioral health services varies



# LTSS Integrated Care Programs – Continued

- **Program of All-Inclusive Care for the Elderly (PACE)**
  - Enrolls individuals 55 years and older who are frail elders
  - Fully integrated financing and delivery
    - Primary Care
    - Acute Care
    - Behavioral Health
    - LTSS
  - Uses an inter disciplinary team model of care based in an adult day health center
  - Operates under a three-way contract among CMS, state and PACE organization
- **Primary Care Case Management (PCCM) Model**
  - Primary Care Physicians paid FFS and capitation for care management
  - Example: North Carolina uses enhanced PCCM and Community Care Networks for case management



# Accountable Care Act Provisions Related to LTSS

Accountable Care Act Provisions	
State Balancing Incentive Payments Program	Direct- Service Workforce
Community First Choice Option	Aging and Disability Resource Centers
Money Follows the Person	Federal Coordinated Health Care Office
HCBS State Plan	Medicare Advantage Special Needs Plans
Spousal Impoverishment	Patient-Centered Medical Homes



# Federal Coordinated Health Care Office

## Office of Medicare-Medicaid Coordination prefers term **Medicare-Medicaid Enrollee (MME)** to Dual-Eligible

### Initiative Timeline

April 2011	<ul style="list-style-type: none"><li>• Demonstration grants awarded</li><li>• Providing technical assistance to 15 states as they develop integrated care programs</li></ul>
May 2011	<ul style="list-style-type: none"><li>• Medicare Parts A, B and D claims data sharing with state Medicaid agencies for care coordination purpose</li></ul>
July 2011	<ul style="list-style-type: none"><li>• Alignment Initiative tests two models to integrate financing and delivery of primary, acute behavioral and LTSS:<ul style="list-style-type: none"><li>– Capitated model with shared savings</li><li>– FFS model with shared savings</li></ul></li><li>• 37 states and DC replied with letters of interest by 10/1 deadline</li></ul>
Fall 2011	<ul style="list-style-type: none"><li>• Working with states and providers on the Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents</li></ul>



## III. Medicaid Health Plan Considerations in Providing LTSS

- Health Challenges of LTSS Population
- Consumer Advocacy
- Provider Network
- Care Management
- Quality Assessment and Improvement
- Financial/Information Systems
- Getting Prepared for LTSS



# Health Challenges of LTSS Population

- Very diverse population
- Aged vs. Physically Disabled
- Poverty and Social Issues
- Cultural Differences
- Chronic Disease Burden
- Mental Health/Substance Abuse
- Dementia and Cognitive Disorders
- Activities of Daily Living Deficits



# Consumer Advocacy

- Advocacy groups can be both concerned about *and* resistant to managed LTSS.
- Input from LTSS consumers and their advocates are required for developmental activities.
- Ongoing consumer feedback is necessary for:
  - Program refinement
  - Quality monitoring



# Provider Network

- Qualified primary care physicians for LTSS's population's special needs
- Critical access providers who serve high portions of enrollees
- Behavioral health providers for individuals with severe mental illness
- HCBS waiver providers
- Institution-specific providers



# Care Management

- Coordination among physical, behavioral and LTSS providers
- Coordination with Medicare providers or Medicare Advantage Plans for dually enrolled individuals
- Individualized, needs based assessments and care planning with family and caregiver involvement are HCBS waiver and SNP model of care requirements
- Institutionalized vs. community-dwelling individuals
- Care Manager and Interdisciplinary Care Team Models
- “High-touch” care management with frequent face-to-face contacts
- Plan’s member and provider services staff play significant role in care management



# Quality Assessment and Improvement Issues

- Fewer standardized quality measures exist for LTSS performance monitoring and management
- LTSS utilization measures need to be established to monitor under and over utilization
- Tracking of primary and acute care service utilization based upon residency status: institutional vs. community dwelling
- “Consumer” or “self-directed” personal care services
- Care provided to institutionalized residents
- HCBS waiver assurances required under federal regulations 42 CFR Section 441



# Financial/Information Systems

- Capitation rate setting, shared savings, pay for performance models
- Comprehensive, accessible *real time* electronic health records are necessary for effective care management and quality assessment
- Track level of care status for capitation reconciliation
- Track residency status, institutionalized vs. community-dwelling, for care management, quality metrics and capitation reconciliation
- Long term institutional and HCBS claims processing and encounter reporting require new provider type and procedure codes
- Ability to collect member's share of cost for long term institutional services or deduct from facility's payment



# Getting Prepared for LTSS

- Realize lack of experience managing LTSS and establish relationships with LTSS experts:
  - Area Agencies on Aging
  - Councils on Independent Living
  - Aging and Disability Advocates
  - LTSS Providers
  - PACE Organizations
- Initiate “informal” care coordination with LTSS care management organizations
- Assess:
  - Current functional capabilities and identify gaps that need to be addressed in order to manage LTSS
  - Existing staff for long term care expertise and involve them in planning
  - Adequacy of existing network providers’ physical accessibility



# Questions?



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