Medicaid Managed LTSS:

Great Opportunities, Big Risks

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The Tennessee Context

- Tennessee has mandatorily enrolled ***all*** Medicaid beneficiaries in capitated managed care organizations since 1994. (This includes SSI & groups protected by 1997 Balanced Budget Act amendments.)

- Until 2010, LTSS were carved out and reimbursed by the state on a fee-for-service basis.

The Tennessee Context

- Heavy emphasis on institutionalization - Tennessee consistently ranked 50th in % of LTSS $$ spent on HCBS.

- A 2003 settlement of a class action, *Newberry v. Goetz*, committed the state to development of capitated LTSS.

- Consumer advocates supported capitation as a way to redistribute LTSS $$.

Tennessee's Experience

- Tennessee began phasing in capitation of LTSS in 2010 with a program called "TennCare CHOICES."
- In less than two years, enrollees receiving HCBS have increased from 18% to 33% of CHOICES enrollment.
- See: Center for Health Care Strategies, *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*,

http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261187

Managed LTSS: An Opportunity

- ***Rebalancing***: If consumers' preferences for home and community-based services are consistent with MCOs' drive for lower cost services, consumers are more likely to avoid institutionalization.

- ***Integration***: Offers incentives and opportunities to integrate care across continuum of acute and chronic, physical and behavioral needs.

Managed LTSS: An Opportunity

- **Prevention**: For MCOs that also manage acute care, managed LTSS may create "reverse woodwork effect", i.e., MCO has incentive to identify enrollees at risk for nursing home care and proactively provide preventive support services. Program design can enhance incentive by, e.g.:
  - Authorizing MCOs to cover cost-effective alternatives to covered services.
  - Capitation payment design.

Managed LTSS: The Risks

Funding:

- State may use it as vehicle to squeeze overall Medicaid funding of LTSS.
- But squeezing may be better than alternative of wholesale service or rate cuts to meet budget.

Managed LTSS: The Risks

Quality:

- Longstanding concerns about LTSS quality across all settings.
  - E.g. Government Accountability Office. "Nursing Homes: Despite increased oversight, challenges remain in ensuring high-quality care and resident safety," GAO-06-117, (December 2005).
- Medicaid managed care has had its own issues with quality, e.g.:
  - P. Galewitz, Kaiser Health News, "Medicaid managed care programs grow; so do issues," *USA Today* (11/12/10)
  - P. Galewitz, Kaiser Health News, "Connecticut drops insurers from Medicaid," *USA Today* (12-29-11)
- The financial imperatives of managed care can compound potential for abuse in LTSS settings.

Managed LTSS: The Risks

- Capitation creates incentives not just to divert from nursing homes but also to underserve.
- MCOs purchase institutional care from the lowest bidder and may be able to exert continuing pressure to reduce facilities' costs and possibly affect quality care. In many localities, Medicaid's market share will give the MCO enormous leverage.

Who's at Risk? – High Need, High Cost Patients

- MCOs may focus cost-containment efforts on heavy care patients, restricting access to medically necessary services.
  - Budget neutrality and other cost caps, combined with "consumer safety" requirements, will deny HCBS to heavy care patients.
  - At same time, access even to nursing home care could be curtailed.

Who’s at Risk? - The Poor

- HCBS assumes you already have housing in which to receive LTSS.
- HCBS won’t be an option for those who are poor and do not own their homes, unless subsidized housing agencies and resources are engaged in the design and implementation.

Who's at Risk? - The Poor

- In the name of "rebalancing," acuity requirements for nursing facility care may be increased, assuming the availability of HCBS for less acute individuals.

- Those without housing who cannot meet the more stringent acuity requirements may be unable to access either NF or HCBS.

Risks: Potential Impact on Racial Disparities

- Sharp racial disparities in access to Medicaid LTSS is longstanding problem receiving little attention from policy makers. [See: David Barton Smith, Health Care Divided: Race and Healing a Nation, (Ann Arbor: 1999).]

- Because of lower rates of home ownership, HCBS will not be option for many minorities, unless the housing issue is addressed.

Managed LTSS: Inevitable?

- **The Willy Sutton Principle**: In many states, nursing homes are the last big piece of the Medicaid budget that offers untapped savings. Cutting nursing home rates directly is politically fraught.

- **"Honey Badger Don't Care"**: A state can use MCOs, which are immune to nursing home industry political pressure, to ratchet down LTSS costs.

Managed LTSS: Inevitable?

- The Affordable Care Act creates new options for states to expand HCBS, and financial incentives to rebalance LTSS expenditures. [See L. Cuello, "How the Patient Protection and Affordable Care Act Shapes the Future of Home- and Community Based Services," 45 Clearinghouse Review 299-307 (Nov.-Dec. 2011).]

- As Medicaid's legal and programmatic distinctions between acute and LTSS erode, the ability of the nursing home industry to resist managed care will fade.

The Implications of Inevitability: "No About Us Without Us!"

At the <u>systems</u> level:

- Consumer engagement in planning and design is crucial.
- Consumer advocates must be engaged *early* in the process, to maximize the opportunities and minimize the dangers and must *stay engaged* as implementation takes place, to identify and respond to unforeseen problems.

“No About Us Without Us!”

At the <u>individual</u> consumer level:

Consumer choice of:

- managed care plans
- providers
- services and
- consumer-direction options

is vital.

A Steep Learning Curve for MCOs

Most MCOs have little prior experience with LTSS, which is profoundly different from the acute care benefits they typically administer.

- Dementia care, in particular, is foreign to most MCOs.
- Advocates need to help MCOs understand the needs of a new enrollee population.

Details are Crucial

- The promise of managed care means nothing unless it is properly designed, and the incentives are aligned to produce benign results. The vulnerability of many consumers requires close attention to:
  - Single point of entry/eligibility
  - Contract terms
  - Contract compliance
  - Case management
  - Access to quality services
  - Ancillary services/functions (housing, advocacy, appeal rights.)

Intake & Care Planning

- **Front End Procedures Matter:** For people not already eligible for Medicaid when they need LTSS, their chance of avoiding institutionalization is largely determined not by the MCO, but by the State's eligibility and care planning processes, and service availability.
- **Try this mental exercise**: Think how quickly HCBS must be put into place for a stroke victim about to be discharged from hospital. Unless the process moves *very* quickly, patient will default to a SNF or NF before ever being enrolled in an MCO. Housing and natural supports often erode after institutional placement.

Initial Assessment

- **Quality of assessments & care planning.** CMS is properly requiring that care needs be initially assessed by an agency without a financial interest in the care the person will receive. That agency must be accountable for the quality, timeliness and responsiveness of its services.
- **Consistency** – The states struggle to develop instruments that will ensure consistency in evaluations and inform capitation rates.
- **"Natural Supports"** – There can be pressures to place to rely too heavily on family and other informal caregivers.

Location, Location, Location

- **Housing is key.** As noted above, HCBS is only an option if the person already has housing, which Medicaid won't provide. Program design must take housing needs into account.
- **Program must be nimble enough** to respond as person's capacities/needs change
- **Nursing homes with chandeliers?** MCOs and LTSS providers may offer assisted living as an answer to a person's need for housing and LTSS. This can raise serious quality issues, as such facilities are not subject to the federal quality and patient protections that apply to nursing homes, even though those served have similar needs and vulnerabilities.

Other Important Pieces

- **Ombudsman & Public Guardian Services.** Older Americans Act funding for ombudsmen is inadequate to meet needs of the over-60 population on which funding is based. Public guardian programs are inadequate, too. They often don't serve younger consumers, or those in HCBS settings.

- **Appeal Procedures.** Individuals must have recourse to user-friendly, timely appeals procedures to challenge eligibility, assessment and care planning decisions by the state or its contractors. The design of these procedures requires careful attention, as they must be adapted to the complexities of these programs.

An Existential Challenge?

The vulnerability of LTSS consumers makes stringent MCO oversight, supported by effective performance monitoring, <u>critical</u>.

Is it possible?

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