National Committee for Quality Assurance in
Collaboration with Health Management Associates

Trends in Medicaid Long-Term Services and Supports: A Move to Accountable Managed Care

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Key Takeaways:

- **Delivery of long-term services and supports (LTSS) is shifting to capitated managed care arrangements as state Medicaid programs seek to increase accountability.**
- **LTSS home and community-based services (HCBS) providers can demonstrate their value as trusted resources in this shifting environment. Many are community-based organizations (CBO) or have strong relationships with CBOs.**
- **HCBS providers must acquire new skills and develop the infrastructure necessary to participate in new financing and delivery system arrangements.**

More than 5 million people receive LTSS under the Medicaid program. Major trends are reshaping LTSS delivery systems from siloed, fee-for-service (FFS) care to value-based, person-centered care. Increasing demand for HCBS, reflected by a 7.6 percent growth in HCBS expenditures per year since federal fiscal year 2012, and the need to develop system capacity and raise quality while controlling spending, has led to increased state interest in managed care and value-based purchasing. HCBS providers have long been a part of the Medicaid system supporting individuals needing LTSS. They have close relationships with CBOs, which include social service organizations, local charitable health-related organizations and other organizations that operate locally with deep connections to and knowledge of community resources. Expansion of managed care delivery systems for LTSS will require these HCBS providers to forge new relationships with MCOs to support development and delivery of integrated, high-quality care to individuals who prefer community-based LTSS.

Person-centered care: the foundation of LTSS

People who need LTSS include the elderly and those with intellectual and/or developmental disabilities, physical disabilities, behavioral health issues (including dementia), spinal cord or traumatic brain injuries and other disabling chronic conditions. In addition to needing LTSS, they often have substantial acute care needs. Person-centered care planning and coordination of

services are essential to help these individuals and their families navigate the health care system and to ensure that providers and services are in place to meet their care needs and preferences. "Person-centered care" means that values and preferences are defined by the person needing services and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals.

Federal regulations require the planning process for Medicaid LTSS to be person-driven, focusing on an individual's strengths, preferences, clinical and support needs and desired outcomes. Done well, care coordination is "high-touch" and is backed by a multidisciplinary team that includes the individual, caregivers (both informal and paid) and clinical and care management professionals.

Home and community-based LTSS delivery continues to grow

LTSS began as Medicaid coverage of care in nursing homes and other institutional settings, and evolved to encompass HCBS. In 2015, Medicaid spent $158 billion in state and federal funds on LTSS, with expenditures on HCBS representing more than 55 percent of all Medicaid spending for LTSS. In addition, 28 states reported that HCBS accounted for the majority of Medicaid LTSS spending. The dominance of home and community-based services is a reflection of consumer preference for community-integrated living and aging in place. It also reflects the impact of the Olmstead Supreme Court decision in 1999, which required states under the Americans with Disabilities Act to offer "publicly financed services in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

The aging baby boom generation (20 percent of the American population) is adding urgency to state efforts to reform LTSS.

Long-Term Services and Supports—Institutional and HCBS Providers

Medicaid LTSS benefits vary by state. Institutional care always includes nursing facilities and, in most states, intermediate care facilities for people with intellectual and/or developmental disabilities. HCBS always includes care coordination and care planning, and may include homemaker/home health aide/personal care, adult day health, habilitation, respite, day treatment/partial hospitalization, psychosocial rehabilitation, transportation, extended home health, supported housing, supported employment, shared living and more.

By 2029, all baby boomers will be aged 65 or older, with the leading edge of the demographic group older than 80—the age group most likely to need LTSS.

Adoption of capitated managed care for provision of LTSS

Often, people with LTSS needs are enrolled in managed care for most (if not all) Medicaid services, including LTSS. Managed LTSS (MLTSS) may be operated by a variety of health plans, including MCOs, prepaid inpatient health plans and prepaid ambulatory health plans.

Medicaid LTSS Managed Care Goals

- ☑ Improve care and lower costs for high-cost, high-need populations
- ☑ Accelerate movement to HCBS over institutional care
- ☑ Achieve person-centered care
- ☑ Integrate services through care coordination and management
- ☑ Increase access to primary and preventive care
- ☑ Reduce unnecessary hospital admissions and readmissions, emergency department use
- ☑ Slow loss of function

By July 2017, 23 states had MLTSS programs in place or under procurement. From 2013–2015, MLTSS spending increased 182 percent (by $18 billion). Much of this growth has been driven by states participating in federally authorized financial alignment programs that test approaches to integrate coverage across Medicare and Medicaid services for dual-eligible enrollees. These models of care promote integration and coordination of LTSS (for which Medicaid is the primary payer) with primary and acute care (for which Medicare is the primary payer). In May 2017, nearly 400,000 dual-eligible enrollees were in capitated financial alignment programs operating in 10 states.

States have also advanced an alternative model to promote integration between Medicare and Medicaid services, requiring Medicaid-contracting MLTSS plans to offer a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) as an option for dual-eligible enrollees. D-SNPs must have a separate contract with each state where they conduct business, to facilitate coordination of services. A number of these contracts also require specific integration activities (e.g., use of service coordinators).

States seek accountable, integrated health care delivery

Through value-based payment arrangements with accountable care organizations (ACO) and MCOs, states are encouraging integration of care (primary, acute, behavioral, LTSS) across the health care delivery system. Providers in value-based payment arrangements assume more responsibility for health outcomes, ranging from receiving financial rewards if they achieve targeted quality and outcomes measures, to risking penalties if they do not.

Including LTSS providers in care coordination and integration can contribute to meeting value-based payment goals of improved outcomes, including reducing hospital readmissions and emergency department use. HCBS can play an essential role: coordinating care transitions from community-based care to acute inpatient, to short-term rehabilitation care and back to the community, and from institutional care to community-based care.

Value-based payment arrangements that reward outcomes can also encourage medical providers to link patients with social services and supports that help reduce use of costly inpatient services and sustain community integration. HCBS providers and CBOs can be important partners to MCOs as value-based payment arrangements prompt MCOs to respond to the non-clinical factors that impact health care outcomes, including risks such as unstable housing, food insecurity, unemployment and poor health literacy.

As states work to improve the health of their communities—and of the Medicaid population—there is an increased need for measuring the quality of life and tenure of community living (e.g., healthy days in the community) for individuals who need LTSS. Federal and state governments and private entities are developing and testing HCBS outcome and quality-of-life measures. NCQA is developing several measures of LTSS quality, including effective care coordination, rebalancing of care from an institutional setting to the community and a new approach to measuring outcomes that is based on achievement of individualized goals.

Summary recommendations

Delivery of LTSS is shifting to capitated managed care arrangements as state Medicaid programs seek to increase accountability, improve quality and promote a cost-effective service delivery system that integrates care across all services—medical, behavioral, social and LTSS. Service and payment models are evolving and bringing increased expectations for an outcome-based delivery system that requires new skills and infrastructure for MCOs and LTSS, including HCBS providers and CBOs. LTSS providers can demonstrate their value and retain their position as trusted resources in this shifting environment. MCOs can provide technical and organizational support to LTSS providers as the system evolves to incorporate value-based payment arrangements and quality measures that capture quality of life and outcomes.

Recommendations include:

- **Establish strong, high-touch, person-centered approaches to comprehensive assessments, care planning and coordination across providers, including LTSS.** Many MCOs have limited experience with LTSS providers and with coordinating and integrating medical care with LTSS. They need to expand their knowledge, or leverage the experience of traditional LTSS care managers and service coordinators to increase their understanding of providing direct care in an individual's home and connecting with community resources.

- **Build collaborative relationships between MCOs and HCBS.** The move to MLTSS and the shift to HCBS from institutional care will require HCBS providers and MCOs to work together. LTSS providers—particularly HCBS providers—have less experience with value-based payment arrangements. HCBS providers will need organizational capacity for contract negotiations, data collection and quality reporting. MCOs may need to help HCBS network providers on both the data collection and technology fronts to support value-based payments and quality reporting.

- **Increase information exchange, data analytics and technology in LTSS.** The move to managed whole-person care requires timely exchange of information across an individual's spectrum of providers. MCOs should use reporting and data analytics to identify needs, gaps in care and opportunities to improve quality and reduce costs. MCOs with experience providing MLTSS have data and technology platforms that identify high-risk, high-need individuals for intensive care coordination that includes online connectivity across providers. Electronic care management systems and electronic health records with enhanced capabilities can support care managers and providers across the care landscape.

- **Promote cultural competency in LTSS. States and MCOs should deliver culturally competent care—not only from the perspective of country of origin, but from that of disability and age.** MCOs can train care coordinators to create care plans that respect an individual's preferences, living situation/environment and goals for community living. They can also partner with HCBS providers and CBOs to build cultural competency. MCOs can hire care managers, service coordinators and community health workers who reflect the diversity of a population served, and seek relationships with HCBS providers and CBOs that are experienced in the delivery of culturally competent services.
- **Expand quality measurement and quality improvement in LTSS.** In order to know whether care is high quality and drives quality improvement, states and MCOs must use validated, standardized quality measures that can set benchmarks for performance across MCOs and states. Given the unique nature of the LTSS population, traditional quality measures focused on medical care are not appropriate. LTSS quality measures should focus on the degree to which the care being provided is centered around individuals' preferences and goals and allows them to live in the least restrictive setting as possible while engaging with their community.

About NCQA

The National Committee for Quality Assurance (NCQA) is a private, nonprofit organization dedicated to improving health care quality. With ongoing support from The SCAN Foundation and The John A. Hartford Foundation, NCQA explores ways to measure and evaluate the quality of care for people who need long-term services and supports. NCQA convened a national stakeholder advisory group and learning collaborative to guide development of standards and measures. This, with help from a learning collaborative of health plans and CBOs that arrange for LTSS, informed NCQA's Case Management for LTSS Accreditation program and LTSS modules for NCQA-Accredited health plans and MBHOs. Organizations that coordinate LTSS can learn these standards, apply them to their organization and, if they meet the standards, earn accreditation from NCQA.

Under contract with the Centers for Medicare & Medicaid Services, NCQA also developed and tested a set of quality measures for MLTSS and piloted two approaches to person-driven outcome measurement that considered patient goals and preferences in support of care planning and quality measurement. NCQA plans to pilot similar approaches for people with serious illness.

NCQA is committed to ensuring that health care evaluation programs address the needs of people with functional limitations and complex needs, and works to develop quality measures that reflect the preferences and goals of the individuals served.

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NCQA1086-0917