HEALTH WEALTH CAREER

MERCER GOVERNMENT HUMAN SERVICES CONSULTING

LTSS PAYMENT SYSTEM REFORM

Many states are looking broadly across their health care ecosystem to improve opportunities for independence, better health, greater community integration, and more opportunities for gainful employment. States have come to Mercer with questions/challenges such as:

"Our providers and stakeholders continually challenge our decisions for payment/policy changes."

"We have more individuals on waiting lists than currently enrolled in our programs."

"We are looking for alternatives to regular fee-for-service (FFS), as budget predictability is a challenge."

"How can we add value-based purchasing to our managed care program?"

"The Centers for Medicare & Medicaid Services (CMS) is asking us about our Home and Community-Based Services (HCBS) provider fee methodologies, and nobody here knows how these fees were developed years ago."

For some states, these types of questions or goals of payment reform represent a major paradigm shift in the current long-term services and supports (LTSS) culture and can be overwhelming. Mercer can help.

MOVING FROM VOLUME TO VALUE

LTSS encompasses everything from mandatory Medicaid services, such as home health, to facility-based care and HCBS. Broadly speaking, two primary payment strategies can be used to reform some or all aspects of LTSS: managed fee for service FFS and risk-based capitation.

- **Managed FFS:** Includes accountable care organizations, episodes of care/bundled payments, health homes, medical homes, and other payment systems; and also encompasses some risk transfer to providers — for example, using an episode of care payment or relying on standard FFS — but with increased focus, requirements, and structure around care coordination, care integration, transition of care, data sharing, and/or whole-person medical, social, behavioral, medical, nutritional, and housing needs.

- **Risk-Based Managed Care Capitation:** Includes either full or partial risk, depending on the state's population, policies, politics, and priorities. Transitioning to risk-based capitated managed care is a shift away from traditional FFS and requires states to take on new responsibilities and oversight/enforcement duties. Through selective procurement of qualified vendor and strong managed care contract requirements, states can "buy" into payment reform and innovation as opposed to "building" the capabilities in-house under an FFS system.

MODERNIZING FFS PROVIDER PAYMENT RATES

Some LTSS payment reforms are less about creating a new payment system and more about reforming and modernizing the current payment methodology to ensure that it is objective and complies with all federal/state regulations. For example, Mercer has been assisting states with modernizing their HCBS provider FFS payment rates to use objective, quantifiable methodologies and inputs. We bring an independent, fiscally disciplined perspective paired with policy and regulation expertise to partner with states on developing reasonable and defensible FFS provider payment rates using a market-based, cost-based or hybrid payment methodology.

MERCER CAN HELP

Whether you need help with a single issue, such as responding to questions from CMS or providers, or perhaps technical assistance in designing a new provider payment model, Mercer is your best choice for help with:

- Strategic planning for payment reform and implementation.
- Provider fee modeling, financial impact analyses, and fee creation.
- Navigation of federal waivers, creation of state plan amendments or updates to policy manuals.
- Development of and conducting provider training/orientation to new payment system.
- Actuarial rate development for risk-based managed care.
- Quality and/or financial reporting, monitoring, and evaluation.

Benefits of LTSS Reform

In a report to a federal government agency, Mercer documented success in LTSS rebalancing in three state Medicaid programs over a three- to five-year period of increasing the percentage of individuals and expenditures associated with HCBS settings relative to institutionalization.

The populations included developmentally disabled, Medicare/Medicaid dual-eligible, and Medicaid-only enrollees. Although the analyzed populations were not exactly the same for each state, the change in population mix across care settings can be analyzed and compared.

- One state increased the percentage of members served in community-based HCBS settings from 55.5% to 60.0% while increasing the portion to total LTSS per member per month (PMPM) attributable to HCBS settings from 42.50% to 47.25%.

- Another state experienced a two-point increase in members served in community-based HCBS settings, going from 37.75% to 39.75%, while increasing the portion to total LTSS PMPM attributable to HCBS settings from 20.0% to 23.5%.

- The third state improved its percentage of members served in community-based HCBS settings from 50.25% to 55.50%, and its percentage of expenditures increased from 32.0% to 33.75% of total LTSS PMPM.

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