

## MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Medicaid Managed Long-Term Care

The Medicaid population, like that of the United States as a whole, is steadily aging. Even though people are generally living longer, it is a statistical fact that as people age, the prevalence of disabilities and disease increases. Typically, individuals with disabilities require more assistance and supportive services — whether from unpaid or paid caregivers, private health insurance, or government-sponsored programs such as Medicaid. As state populations age and Medicaid budgets continue to expand, states are faced with increasing costs from this growing cohort but have limited resources to meet the growing need.

Furthermore, surveys and studies of consumers indicate the same result: **People prefer to remain in their homes and communities rather than be institutionalized.** Despite their preferences, consumers may be directed toward institutional services because of public funding or public-policy preferences.

Many policymakers have looked to managed care as a tool to help improve long-term care (LTC) and the overall health care systems, including institutional and home and community-based services (HCBS). Many see the benefits of having a dynamic and consumer-friendly care delivery system in which the needs of the elderly and individuals with disabilities are met through various community-based care settings, with quality of life, functional health status, and consumer input promoted, measured, and evaluated. The goal is to improve the quality of life and health status of individuals who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.

Managed LTC models have been effective in a number of states in reducing unnecessary hospitalizations and nursing home utilization, increasing access to HCBS, streamlining administration, increasing consumer satisfaction, and developing capitation rates and contracts to reflect and incentivize the provision of HCBS. Removing system fragmentation, rebalancing nursing home utilization with HCBS alternatives, and improving the quality of care through better care coordination are reasons cited by many states for considering integrated managed care models for their Medicaid-eligible populations. Some programs focus on individuals needing LTC services and support, while others focus on those services, while additionally integrating services for healthy enrollees (that is, physical and/or behavioral health services).

A benefit of Medicaid–capitated managed care is the flexibility to adjust the capitation rates and contracts to create incentives for the provision of HCBS. This approach can be accomplished in multiple ways, such as:

1. Using specific waiver authority and provisions to use savings in state plan services to contractually require plans to provide additional non–state plan services, such as HCBS
2. Building non–state plan community–based services into managed care rates, considering cost–effective alternatives, such as HCBS, to more costly covered state plan services, such as institutional care
3. Including community–based services in managed care contracts and rates if separate waivers or state plan provisions make such services available

## MERCER CAN HELP

With an interdisciplinary team of policy consultants, actuaries, accountants, clinicians, and information technology experts, Mercer can help bring an entirely new managed care program to reality or assist states in expanding or improving existing programs. Mercer has assisted states with the following:

- Strategic program planning, including program design and waiver development
- Support in Centers for Medicare and Medicaid Services (CMS) negotiations
- Facilitation of stakeholder meetings to determine the level of support and identify potential barriers
- Development of budget and savings estimates
- Procurement assistance
- Actuarial rate development and analysis
- Health plan financial reporting and monitoring
- Review and assistance in the modification of assessment instruments
- Contractor readiness reviews
- Design of an encounter data collection system and evaluation of encounter data
- Financial reporting tools
- Development and monitoring of performance measures for the LTC population

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# Case Study



## SITUATION

The state governor and Medicaid agency had approved exploration of a statewide Medicaid managed care model to serve Medicaid eligibles, with full service coordination including acute and LTC services. The costs for LTC services were rapidly increasing, creating additional strains on the state Medicaid budget.



## CHALLENGE

The state policymakers wanted to start managed LTC for Medicaid eligibles very quickly after obtaining approval. The state already provided Medicaid managed care for physical health services.



## ACTION

Mercer worked with the state, potential managed care plans, and the CMS to make the Medicaid managed LTC program fully operational.

The project included:

- Developing an options paper for review by state policymakers
- Facilitating an options discussion and developing a better understanding of option implications
- Developing the concept paper and waiver application, participating in negotiations with CMS and the state
- Revising contract language, adding LTC service requirements
- Conducting readiness reviews to confirm that contractors were ready to provide LTC services
- Calculating the actuarially sound rates to ensure appropriate payments to the contractors
- Creating strategies to overcome implementation and operational challenges



## RESULT

The state successfully implemented the Medicaid managed care model, meeting state policymaker requirements. The state received approval from CMS on the waiver and was able to add the additional services to currently functional managed care plans.