



**Managed Care Solutions for
Long-Term Services and Supports—
A Sustainable Future**

March 2014

Executive Summary

Implementing a Medicaid Managed Long-term Services and Supports (MLTSS) program represents a unique opportunity for a “win-win” solution for all stakeholders. Under this model, consumers receive higher quality services in settings of their choice, state program costs are contained, care for dual eligibles is coordinated and enhanced and unnecessary and expensive hospital admissions are reduced.

To better coordinate Long-term Services and Supports (LTSS), improve health outcomes, and lower costs, a fully integrated, actuarially sound, capitated managed care approach is the solution for populations receiving LTSS. This program improves quality of care for the recipient while minimizing financial risk to the state by coordinating services. Managed LTSS decreases recipient confusion, service fragmentation, and duplication of services.

Aetna recommends a capitated managed care approach, built around an integrated model of care for all populations receiving LTSS that includes all services:

- Acute care
- Behavioral health
- Institutional/facility services
- Home and community based care
- Care management
- Social supports and services

A recent survey commissioned by the Centers for Medicare and Medicaid Services (CMS) found an accelerating trend among state programs:

- **In 2004, eight States had implemented Medicaid managed long-term services and supports programs.**
- **By June 2012, six of the eight States had more than doubled the size of their programs, and an additional seven States had implemented programs.**
- **By 2014, the number of States projected to have MLTSS programs is 24, based on State planning documents or waiver applications submitted to CMS.**

We believe managed LTSS is the best way for Louisiana to meet its objectives of:

- Improving quality of services and health outcomes
- Decreasing fragmentation and improve coordination of care
- Creating a system that utilizes proven and/or promising practices
- Refocusing the system to increase choice and provide more robust living options
- Rebalancing systems to meet growing demand for services within existing LTSS expenditure levels

Louisiana's Existing LTSS Program

As the Department of Health and Hospitals noted in its Request for Information for Long Term Services and Support Rebalancing, Louisiana lags far behind the nation in promoting community based supports and services as an alternative to institutional placement.

Existing LTSS program: Nursing Home¹

- Ranked first in the nation in the percentage (31%) of nursing home residents with low care needs
- Ranked among the top five States for nursing home utilization per capita for persons over age 85
- Medicaid primary payer (73%) of nursing facility residents
- High utilization co-exists with low occupancy rates as Louisiana has one of the highest per capita ratios of nursing home beds in the country
- Utilization decreasing while expenditures to nursing homes increasing
- As a group, Louisiana nursing homes perform below average on most quality indicators

Existing LTSS Program: Intermediate Care Facilities/Home and Community Based Services²

- Lags behind the nation in promoting community-based supports and services as an alternative
- Only 60% of the DD receive HCBS services compared to the national average of 85%
- Spending for DD in HCBS settings is 20 percent lower than the national average of 66%
- Only 49% of older adults and adults with physical disabilities receiving services through HCBS compare to the national average of 61%
- Louisiana's HCBS programs perform as well or better than nursing facilities in regard to avoidable hospitalizations and HEDIS measures while costing nearly \$13,000 less for older adults and people with adult onset disabilities

Rebalancing Louisiana's LTSS

One popular approach to reforming LTSS is to “rebalance” the setting in which a recipient's care is delivered, most commonly by moving services recipients receive from nursing facilities/institutional settings to a recipient's home or community.

Shifting LTSS from institutional settings to home and community based services (HCBS) is consistent with the care delivery model that recipients overwhelmingly prefer. A recent AARP survey found that nearly 90% of people age 65 and older would prefer to stay in their homes as long as possible³. In addition,

¹ Louisiana Department of Health and Hospitals. Request for Information; Long Term Services and Supports for Persons Enrolled in Louisiana Medicaid. Source: <http://dhh.louisiana.gov/assets/docs/BayouHealth/RFI-11282012/LTC-RFI-1129.pdf>

² Louisiana Department of Health and Hospitals. Request for Information; Long Term Services and Supports for Persons Enrolled in Louisiana Medicaid. Source: <http://dhh.louisiana.gov/assets/docs/BayouHealth/RFI-11282012/LTC-RFI-1129.pdf>

³ Aging in Place: A State Survey of Livability Policies and Practices. A Research Report by the National Conference of State Legislatures and the AARP Public Policy Institute. December 2011. Source: <http://assets.aarp.org/rgcenter/ppi/liv-com/aging-in-place-2011-full.pdf>

focusing on models that emphasize care delivery in homes and communities over institutional settings is cost effective for states and recipients alike.

To encourage further rebalancing, the Affordable Care Act (ACA) expanded and created several new state options and waivers to support approaches that move recipients out of institutional settings and into HCBS.

State efforts to shift institutional care to HCBS have continued to grow, particularly following the passage of the Affordable Care Act. As of March 2013:

- 46 states have developed Money Follows the Person Demonstrations
- 19 states pursuing and/or implementing the CMS Dual Eligible Financial Alignment Demonstration⁴
- 15 states have implemented or plan to implement Balancing Incentives Programs
- 14 states have implemented or plan to implement 1915(i) initiatives
- 9 states have implemented or plan to implement 1915(k) programs

MLTSS Programs

Medicaid Managed Long-term Services and Supports (MLTSS) is an integrated managed care program for seniors and individuals with disabilities that encompasses a broad range of medical and social services (wrap around services)—ranging from nursing home care to HCBS for the elderly and disabled. The goal of MLTSS is to keep recipients in the community longer by providing support for daily living and access to quality health care services.

The MLTSS program is designed to include comprehensive integration of other services common to the Medicaid population, such as physical and behavioral health. Comprehensive managed care, without behavioral health or pharmacy carve-outs, is the best way to care for this population.

As the number of individuals needing LTSS grows and budgetary pressures increase, states are exploring innovative approaches to provide budget predictability, deliver services more effectively, and drive higher-quality outcomes for LTSS recipients. Managed LTSS programs have grown considerably in the last ten years and are expected to increase as states recognize the value of better management of this population, increasing from eight states with managed LTSS programs in 2004 to an estimated 25 states by the end of 2014.

While only a small percentage of Medicaid beneficiaries are LTSS users, these recipients account for a substantial portion of Medicaid spending. Nationally in 2010, 4.2 million Medicaid enrollees—or about 6.7% of all Medicaid beneficiaries—used LTSS. An estimated two-thirds of Medicaid beneficiaries who require LTSS are dually eligible. Given the disproportionate amount of spending tied to LTSS recipients, identifying ways of decreasing costs while maintaining quality long term care of this population is critical.

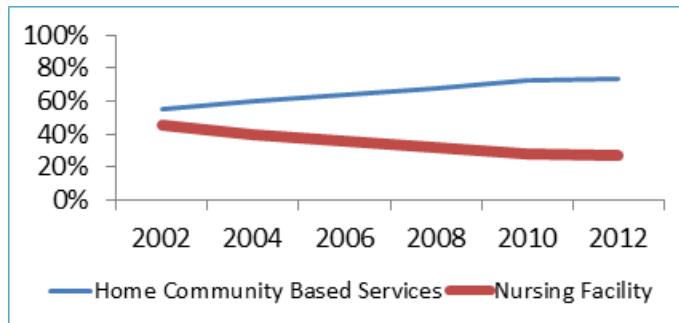
Interest in managed LTSS has accelerated with the Centers for Medicare and Medicaid Services' (CMS) recent launch of several initiatives aimed at better coordinating services and lowering costs for people who are dually eligible for Medicaid and Medicare benefits.

⁴ Source: CMS.gov at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/StateProposals.html>



Aetna’s MLTSS program improves the quality of life for recipients while reducing the states’ LTSS cost burden. Mercy Care Advantage, an Arizona-based Medicare and Medicaid plan managed by Aetna Medicaid has been successful in rebalancing services from institutional to HCBS over a 10 year period.

**Aetna Medicaid – Effective use of HCBS
Our HCBS Trend in Arizona**



MCP ALTCS costs	
Medicare	
HCBS	\$1,500
NF	\$5,000
No Medicare	
HCBS	\$3,000
NF	\$10,000

The Managed Care Organization Solution

While state Medicaid programs have long used managed care for traditional Medicaid benefits, a growing number of states have recently expanded managed care to LTSS populations and benefits. Under this approach, states contract with one or more managed care organizations (MCOs) for beneficiaries needing LTSS, often at a fixed, or capitated, cost.

While the breadth and depth of the programs vary significantly, 19 states had LTSS managed care programs implemented or approved by CMS as of April 2013. Significant expansion of managed LTSS is anticipated in the near future, with 1.8 million Medicaid beneficiaries predicted to be eligible for managed LTSS by early 2014. Indeed, CMS reports nearly half of the states are expected to be operating capitated managed LTSS Programs by the end of 2014.

Under MLTSS, Managed Care Organizations (MCOs) work with providers to coordinate services and supports that emphasize prevention, early diagnosis and treatment. A recent study by Avalere Health, a national strategic health care advisory firm, found that Mercy Care Plan (MCP), an Arizona managed care plan administered by Aetna Medicaid, performs better than traditional fee-for-service across four key measures for its dually eligible recipients:

1. Access to preventive/ambulatory health services
2. Inpatient hospital utilization (measured by hospital days, discharges, and length of stay)
3. Emergency department utilization
4. All-cause hospital readmissions

Key Components

States moving from fee-for-service Medicaid programs MLTSS should consider the following key components that influence the implementation and sustainability of managed LTSS programs:

Our Story

Our integrated care management program for our dual eligible members compared to national FFS showed:

- 43% fewer inpatient days
- 19% reduction in length of stay
- 21% fewer readmissions
- 9% fewer ED Visits

2012 - Avalere Study of the Aetna administered Medicaid plan in Arizona

- **Choosing the Right Partner:** Experience has shown that states are best served by partnering with MCOs that have comprehensive experience managing the Medicaid LTSS population utilizing a capitated managed care approach for Medicaid populations receiving LTSS through an integrated model of care. We encourage a state procurement of Medicaid managed care through an *open and fair competitive procurement that does not restrict competition and places significant value on experience specific to Medicaid Long Term Services and Supports*. Choosing the right partner with experience building provider networks and providing integrated care management specifically for LTSS recipients is critical to Louisiana’s success.
- **Provider network development:** States should *select MCOs that have demonstrated success in building LTSS networks* based on: (1) network adequacy; (2) provider qualifications; and (3) provider training. Before serving recipients, health plans should have a variety of provider types who can meet program goals, improve recipient experiences, and learn new approaches for delivering care. States should also encourage the incorporation of existing LTSS providers as part of the MCOs’ network of providers. *We applaud the state’s decision to not require managed care organizations to develop a network prior to a contract award as this often causes confusion and angst among the provider community*. By requiring each prevailing managed care organization to present a fully contracted network that meets adequacy standards prior to serving recipients is an approach that ensures the valid goal of demonstrating compliance with network adequacy requirements before recipients are served, but in a manner that does not inhibit competition, create an unfair advantage for incumbents, or create unnecessary confusion within the provider community.
- **Patient-centered program design:** The focus should be on LTSS consumers throughout the planning and implementation of MLTSS. States such as New York, Arizona, Delaware and Illinois require MCOs to create member councils or advisory committees in which LTSS users can provide feedback to health plans. To ensure continuity of care, LTSS beneficiaries must understand how they will choose and access services—enrollees should be empowered to play an active role in their care through shared decision-making tools or self-managed programs. Arizona and Florida are two states that have adopted this consumer-directed approach to care delivery. Effective programs contain both medical and social components for a fuller complement of services and to more effectively coordinate services.
- **Coordinated, person-centered care delivery:** The long-term care system should be based on an integrated physical, behavioral and social health care model that incorporates person-centered comprehensive care planning.
- **Inclusion of dual eligibles:** States and MCOs should fully leverage existing pathways to integrate funding, benefits and coordination for dual eligible beneficiaries receiving LTSS. Regardless of the underlying program itself, all dual eligible beneficiaries receiving LTSS should be enrolled in integrated and coordinated program of care. Inclusion of all appropriate LTSS populations regardless of age, disability, dual eligibility, or residence is necessary to increase the effectiveness of the program and to meet key state objectives.
- **Contract management and performance:** States should ensure that MCOs have the appropriate systems, capacity, and management processes to comply with contract requirements. Careful monitoring of contracts includes assessing requirements related to provider networks, recipient rights, financial status of plans, and quality. While nationally-recognized, standard measures are not fully developed, state Medicaid agencies have partnered with MCOs to develop that measures that are responsive to the type of delivery system and payment approach the state employs.

- **Alignment of payment structures and goals:** In effective managed care programs, the MCO holds providers accountable through performance-based incentives and/or penalties. MCOs have more flexibility than FFS programs on how providers are paid and incentivized. On an ongoing basis, states must evaluate their payment structures and make changes necessary to ensure MCOs support the goals of their programs. Value-based purchasing and pay-for performance is often employed with MCOs to ensure alignment.
- **Health information technology:** Technology should be a key driver for care coordination and point-of-care delivery optimization and actively engage with providers at the point of care to support the delivery of actionable information about recipients. MCOs should inform the continuum of care using patient centered-information and innovative technology allowing providers to make more informed decisions and to provide greater communication between providers, organizations and state entities.
- **Enhanced provision of HCBS:** Collaboration with locally-based organizations and partnerships with provider and advocacy organizations with expertise in serving Medicaid LTSS populations results in a shared commitment to serving LTSS recipients. MCOs should focus on developing innovative care management models across the community care continuum by incorporating aspects of effective HCBS programs.
- **Educated workforce:** Ensuring that a high-quality workforce is available to deliver managed LTSS is critical for states and MCOs alike. To address this need, states such as Arizona allow family members to be paid for serving as a caregiver. Other states require MCOs to become active partners with the state, providers, and consumer advocacy groups to implement programs to expand the LTSS workforce.
- **Cultural competency and sensitivity:** MCOs should provide cultural-competency training for all staff and network providers and should partner with recipients and local community organizations to address, in a culturally appropriate manner, the various needs and unique circumstances of LTSS recipients.
- **Quality management:** Highest quality should be maintained in all MLTSS operations through the development and implementation of a comprehensive quality strategy that is transparent and appropriately tailored to address the needs of the LTSS population. MCOs must implement robust quality metrics and continuous quality improvement initiatives that are responsive to the setting and type of delivery system and payment approach the state employs. Similarly, MCOs must reward high quality providers.
- **State oversight and fraud and abuse prevention:** In addition to subjecting plans to oversight, states should implement measures to guard against waste, fraud, and abuse. For example, Tennessee has implemented Electronic Visit Verification for home health workers, requiring providers to electronically track and document time spent in a recipient’s residence. Other states, including Louisiana, target enhanced Medicaid fraud and abuse oversight specifically to home and community based service network providers.

Our Story

Key Aetna Medicaid technology enhancements will enable LTSS care coordination activities and tracking, improve LTSS provider collaboration processes, and support new LTSS value-based payment models.

- **Budget Predictability:** The MLTSS approach is attractive to states from a financial standpoint for its potential to deliver services in a more cost-effective manner and for its budget predictability; states have a better sense up-front about how much their Medicaid program will cost. In arrangements with risk-based managed care organizations (MCO) or health plans, states contract with MCOs to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries. The state pays a per-member-per month premium to the plan.

MLTSS Challenges

For states moving to MLTSS from fee-for service, the transition includes challenges such as:

Consumer Protections and Oversight: When states delegate functions to MCOs, they cannot cede responsibility for management and guidance, especially for vulnerable LTSS populations.

Solution: Critical components of effective oversight include explicit contract language about plans' responsibilities, early attention by states to determine how performance will be measured, and ongoing feedback from consumers and providers to help monitor program operations. MCOs need to partner with state Medicaid agencies and stakeholders to develop standard metrics to be used among all LTSS programs.

Care Coordination: The array of services for which MCOs are responsible and at risk may affect their ability to coordinate services effectively or achieve diversions from institutions and transitions back to the community. The switch to managed care also raises questions about who bears responsibility for and has the capacity to address the lack of affordable accessible housing alternatives and inadequate pools of qualified formal caregivers. These continue to be significant barriers to keeping people who need LTSS in the community.

Solution: MCOs must be responsible for collaborating with the state, recipients, stakeholders, providers and others to identify and implement solutions to effectively coordinate necessary LTSS.

Care Models: A concern among recipients is that MCOs will use a medical model rather than the social service model to which recipients are accustomed.

Solution: The LTSS program should be based on an integrated physical, behavioral and social health care model that incorporates person-centered comprehensive care planning.

Transition of Care: Another concern among recipients is that appropriate management of delivery system transitions to avoid gaps in services and disruption of existing provider relationships.

Solution: The LTSS program should include a collaborative transition planning requirement for MCOs to address current care plans and existing provider relationships to avoid gaps in services in transition from fee-for-service to managed care.

Access: Recipients and Stakeholders want assurances that provider networks in managed care plans will have the expertise and capacity to provide the broad array of services and supports that people with disabilities often need. Continuity of care is of paramount importance for people with complex conditions. They seek assurances that they will not have to change providers when managed care programs are implemented.

Solution: The state should contract with managed care organizations that have proven experience building and maintaining adequate networks for Long Term Services and Supports recipients. Health plans should include a variety of providers who can meet program goals, improve recipient experiences, and adopt new approaches for delivering care.



Providers: Providers have questions about whether they will be included in networks, and how much and how they will be reimbursed. They may also be apprehensive about the administrative ramifications of new rules and procedures established by MCOs. Community-based organizations worry that their funding may be cut if some of the functions they traditionally performed are subsumed by MCOs.

Solution: We applaud the state’s decision to not require managed care organizations to develop a network prior to a contract award as this often causes confusion and angst among the provider community. This approach also allows time for collaboration with the state, prevailing managed care organizations and locally-based organizations and advocacy organizations with expertise in serving Medicaid LTSS populations to foster a shared commitment to serve LTSS recipients.

Fraud and Abuse: With MLTSS, MCOs are “at-risk” for the cost of services including the critical priority of detecting fraud, abuse, and waste.

Solution: Medicaid health plans have a financial incentive to find and prevent improper payments and fraud. According to Medicaid Health Plans of America, studies have shown that Medicaid managed care has experienced significantly less fraud and abuse than traditional fee-for-service model.

Aetna’s Model of Care

Aetna’s fully embedded and integrated medical management capabilities, along with the ability to build effective community and provider partnerships and execute strong administrative oversight, culminate in our successful managed care model. We have experience administering benefits and care management for all categories of Medicaid eligible populations, including individuals with disabilities, and for all LTSS eligible consumers regardless of their payment structure.

Aetna currently has contracts in place to manage LTSS and dual eligible populations in Arizona, Delaware, Florida, Illinois, and New York, Pennsylvania (see chart below). Three of Aetna Medicaid’s affiliated health plans were selected to manage integrated benefits for dual eligible recipients in Illinois, Ohio and Michigan. Additionally, Aetna has been selected to participate in that New York’s Fully Integrated Duals Advantage Demonstration Program. These four demonstrations include combined Medicare and Medicaid capitation for dual eligible recipients.

Aetna’s model is a person-centered approach that focuses on community relationships, integrating physical and behavioral health, and the socioeconomic status of our recipients. It also focuses on high-risk vulnerable recipients characterized by biopsychosocial complexity. Care managers address the root causes that drive poor health, within the context of a long-term working relationship with the recipient.

Our Story

Our person-centered planning process facilitates member engagement and encourages our members to focus on their strengths to achieve the goals they define.



Aetna MLTSS Programs- Populations Served as of March 2014					
State	Program Name	Children	Physical Disability	Intellectual/ Developmental Disability	65+
Arizona	Long Term Care System	X	X	X	X
Delaware	Diamond State Health Plan-Plus	X	X	X	X
Illinois	Integrated Care Program		X		X
New York	Managed Long Term Care		X		X
Pennsylvania	Healthy PA	X	X	X	X
Florida	The Florida Long-term Care program and the Florida Managed Medical Assistance program	X	X	X	X

The Benefits of Aetna’s LTSS Experience: Improved Focus on Health

- **More choice** and a **greater voice** for all LTSS recipients in the new LTSS environment.
- **Consistent and accountable quality measures** between MCOs that promote and drive improved health outcomes and quality of life for the LTSS population.
- Improved **levels of care coordination** between primary care physicians, specialists, hospitals, and LTSS providers.
- **Discharge process requirements** to ensure that LTSS recipients transition into effective and appropriate post-inpatient care settings and avoiding the need for costly nursing facility services.
- Expanded **network capability** that provides for the additional demand on the LTSS program.
- Improved focus on **prevention and wellness** to ensure that LTSS recipients receive the right level of preventive care to promote improved health outcomes.
- Enhanced **incentives** for recipient compliance with care recommendations and healthy behaviors that promote improved health outcomes and quality of life for enrollees
- Fully **integrated services and support** using a person-centered care approach to meet the unique needs of each individual recipient.
- Decreased **duplication of services and supports and less fragmented care** when implementing a fully integrated program for all recipient populations regardless of age/disability.
- Most **cost-effective living options** for recipients requiring LTSS when including assisted living settings.
- Decreased demand on **nursing facility services** as network options expand and recipient’s needs are met.
- Increased use of **home and community based services** and expanded HCBS networks.
- Decreased avoidable **hospital admissions and readmissions**

Through this integrated approach we employ best practices for integrating the delivery of care for LTSS recipients throughout the entire continuum of care that includes acute care, behavioral health, and institutional and home and community based and facility services.

Our Story

“Jim” had throat cancer and respiratory failure and required respiratory suctioning. He wanted to remain independent at home and did not want to be placed in a nursing facility. His life expectancy was certified as being six months or less. His caregiver was about to move from the state leaving Jim without support. He needed assistance at home with ADLs and a tracheostomy. He was on service with hospice care; however, he could not be placed in their inpatient unit within the timeframe he needed assistance. Jim’s Case Manager at Aetna’s health plan in Arizona coordinated assistance for this member with his hospice RN, who taught the member how to self-suction. His Case Manager arranged for six hours of attendant care each day in split shifts. This provided Jim with care in the morning and before bed, allowing him to remain as independent as possible while remaining safe in his home, thus diverting a nursing facility placement and allowing him to live with dignity during his final days.

Conclusion

States must continue to play a vital role in developing and promoting a vision to ensure that vulnerable people needing LTSS, including dual eligible populations, receive optimal services and supports. MLTSS is a service delivery option that will increase the breadth, availability, and quality of LTSS available to those who require them. If MLTSS programs are to succeed, selection of managed care organizations with experience serving Medicaid LTSS populations through an open and fair competitive procurement is critical. Also important is a careful program design based on a thorough understanding of the strengths and needs of the various populations that use them is important. Efforts to incorporate effective aspects of current HCBS programs are also critical.

Successful MLTSS programs expand access to HCBS, improve care coordination and recipient outcomes, and reduce government costs. States have used MLTSS programs to not only expand access to HCBS, but also to shift care from institutional to community-based settings. MLTSS programs also enhance care coordination, particularly when states design programs wherein medical, behavioral, and LTSS are managed by a single entity. This model produces comprehensive accountability for MCOs and reduces incentives for one entity to shift responsibility for care to another, without the effort to coordinate services. Finally, managed LTSS holds promise for lower, more predictable costs for states.