Managed Long-Term Services and Supports & overview of MACPAC June report

Medicaid and CHIP Payment and Access Commission

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Overview

• Introduction to MACPAC
• Overview of June 2018 report to Congress
  – Medicaid drug rebate program
  – Substance use disorder confidentiality regulations
  – Access to substance use disorder treatment in Medicaid
• Focus on long-term services and supports (LTSS) and managed care
Who is MACPAC?
MACPAC’s Role

- Non-partisan legislative branch agency
- Provides analyses and makes recommendations to Congress on a wide range of issues affecting Medicaid and CHIP
  - Can also make recommendations to the Secretary of the Department of Health and Human Services (HHS) or states
- 17 commissioners appointed by the U.S. Government Accountability Office
- Meets 6 times annually in public session
- Mandated reports each March and June
- Regular consultation with stakeholders
Take a Look at Our Publications

Report to Congress on Medicaid and CHIP

MACStats: Medicaid and CHIP Data Book

Fact Sheet

Medicaid Home- and Community-Based Services: Characteristics and Spending of High-Cost Users

Medicaid (Medicaid and CHIP Payment and Access Commission, 2018) Home and Community-Based Services (HCBS) are an essential part of the Medicaid program. HCBS is a broad category of long-term services and supports (LTSS) that enable people to remain in their homes and communities. In 2016, for the fourth consecutive year, more than half of Medicaid spending for LTSS was for home- and community-based services (HCCS) rather than institutional care (Ahern et al., 2018). This shift is the result of a variety of factors, including efforts by federal and state policymakers to restructure Medicaid LTSS spending towards HCBS in order to cut operating deficits and meet humanitarian preferences to live in the community. Medicaid spending on HCBS users remains disproportionately high relative to their share of enrollees. In 2016, approximately 2 percent of Medicaid enrollees used HCBS, accounted for 7.3 percent of Medicaid LTSS spending on all services ($17.8 billion of $554.3 billion) (CMS, 2018).

HCBS users have diverse needs, and thus vary in the types of HCBS they use. To date, however, analyses of service use and spending associated with HCBS users have not taken a detailed look at the types of HCBS users and the characteristics of HCBS users. This fact sheet presents the results of an analysis of other HCBS users that provides, in greater detail than has been done before, the characteristics and service use of Medicaid enrollees who used HCBS in 44 states in 2016, and analyzes Medicaid spending for those HCBS users.

We focused particularly at high-cost users, defined as the 7 percent of HCBS users with the highest spending on HCBS in each state. These high-cost users accounted for nearly one-third of Medicaid spending on HCBS in our analysis ($17.8 billion of $554.3 billion). Most HCBS users, and particularly those who are high-cost users, were aged 19 to 64 and qualified for Medicaid because they were disabled, had a chronic illness and, where applicable (such as home and community-based services), were either enrolled in Medicaid or CHIP. High-cost users were the most common HCBS users reported in claims for high-cost users. This proportion of high-cost users, at 7 percent of Medicaid spending on HCBS by state was for around the cost care.

Details on the methodology used in the analysis can be found in Appendix A. The complete results are available in the MACPAC’s national report by Mathematica Policy Research, HCBS claims analysis summary: Final report (Mathematica Policy Research, 2018).

Who are HCBS users?

In 2016, about 2 million individuals used Medicaid-covered HCBS, and 114,230 individuals met our definition of being a high-cost user. One percent of all HCBS users, 1.6 percent of high-cost users and 7 percent of HCBS users were 19 to 64 and qualified for Medicaid coverage. HCBS users are a disability. Those who were persistent, in 2012, most high-cost users (25 percent) used HCBS services for 10 to 12 months of the year, and about three of four were living at home in the year prior.
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Overview of June Report to Congress
MACPAC’s June Report Chapters

- Improving Operations of the Medicaid Drug Rebate Program
- Substance Use Disorder Confidentiality Regulations and Care Integration in Medicaid and CHIP
- Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution
- Access to Substance Use Disorder Treatment in Medicaid
Improving Operations of the Medicaid Drug Rebate Program

• Describes Medicaid Drug Rebate Program

• Identifies technical issues
  – Authorized generic can be used to artificially lower a brand drug’s rebate obligation
  – Lack of clear authority for HHS to address misclassification of drugs

• MACPAC recommended that Congress make technical changes to ensure appropriate rebates are paid
  – Do not include authorized generic in brand drug price calculation
  – Allow HHS to levy financial penalties for misclassification
SUD Confidentiality Regulations and Care Integration

- Disclosure of an individual’s substance use disorder (SUD) can result in harm and discourage treatment seeking
- Special privacy rules place limits on disclosure without patient consent
  - More stringent than HIPPA
  - Some stakeholders say they are too restrictive, confusing, and challenging to implement
  - Concern that they pose a barrier to providing effective and coordinated care
- There is evidence that amid confusion about the rules, providers are not sharing information with each other, even in ways that are currently permissible
- MACPAC recommended that the Secretary provide additional guidance and training to stakeholders, which may help promote information sharing
Access to SUD Treatment

• Ensuring Medicaid beneficiaries have access to SUD treatment requires:
  – Coverage of services along a continuum of care
  – An adequate supply of providers that participate in Medicaid
• MACPAC reviewed states’ coverage of SUD treatment
  – Only 12 states cover full continuum
  – Largest gaps are for partial hospitalization and residential treatment; also few providers of these services
• Chapter describes use of Section 1115 demonstrations to improve SUD delivery system
  – 26 states have sought federal approval; 15 already approved
  – One component of demonstrations is relief from the institutions for mental diseases (IMD) exclusion
  – Early results from demonstrations in CA and VA show improvements in access to treatment
Long-Term Services and Supports (LTSS) and Managed Care
Medicaid and LTSS: Covered Services

- Medicaid is the nation’s largest payer for LTSS
- LTSS may be provided in institutions or through home and community-based services (HCBS)
- HCBS include a range of services such as:
  - Personal care services received at home or in a residential care setting
  - Services provided at adult day care centers
  - Supported employment services for people with disabilities
- Nursing facility services and home health are mandatory benefits that states must cover
Medicaid and LTSS: Users

• LTSS users are a diverse group
  – Older adults (ages 65 and older)
  – Individuals with physical disabilities
  – Individuals with intellectual or developmental disabilities (ID/DD)

• LTSS users qualify for Medicaid based on several criteria
  – Financial: including both income and assets
  – Functional: based on assessments of need for help with tasks such as bathing and dressing
Medicaid and LTSS: Spending

• LTSS users account for a disproportionate share of Medicaid spending
• In fiscal year (FY) 2013:
  – About 6 percent of Medicaid beneficiaries (4.2 of 70 million) used LTSS under fee-for-service (FFS) arrangements, but
  – Approximately 42 percent of Medicaid spending was for these beneficiaries ($171.7 of $409.3 billion)
States Have Made Progress in Rebalancing LTSS

Proportion of Total Medicaid LTSS Spending on Institutional LTSS and HCBS, FYs 2000-2015

Note: LTSS is long-term services and supports. HCBS is home and community-based services.
State Adoption of MLTSS

- Number of states implementing managed long-term services and supports (MLTSS), grew from 8 to 24 over period from 2004 to 2018
  - A few states have been operating MLTSS programs for many years or even several decades
- States may operate multiple MLTSS programs, often targeting them to different populations
- In FY 2015, approximately 18 percent of Medicaid LTSS spending was for MLTSS programs
States with MLTSS, 2018

Reasons States Pursue MLTSS

• In a recent survey of 12 states with MLTSS, states reported that their goals included:
  – rebalancing LTSS spending (12 states);
  – improving beneficiaries’ care experience by increasing care coordination to improve health and quality of life (12 states);
  – reducing or eliminating HCBS waiver waiting lists (6 states); and
  – providing budget predictability and potentially containing costs (7 states)
Key Considerations in MLTSS Implementation

• Mix of services and intense needs of LTSS users add complexity to managed care
• Initial implementation of MLTSS and later re-procurements are critical periods
• CMS has stressed the importance of adequate transition planning to minimize care disruptions
  – Many beneficiaries will need services on the day the MLTSS program begins
Key Considerations in MLTSS Implementation (cont.)

• States often include requirements to promote continuity of care
  – Contract with any willing provider for period of time
  – Requiring that plans pay FFS rates

• Stakeholders have said a successful rollout of MLTSS is carefully planned, deliberate, and incremental (e.g., phasing in by geographic region or by LTSS subpopulation)
Key Considerations in MLTSS Implementation (cont.)

• MLTSS represents a significant change in the delivery system for providers and requires appropriate training

• Stakeholder engagement of beneficiaries, their advocates, and providers is commonly cited as a key factor in successful transitions to MLTSS

• Payment policy is important in determining the financial viability of MLTSS plans
Setting Capitation Rates and Payment Incentives

- LTSS users’ needs can be difficult to predict
- Functional assessment data can contribute to risk-adjusted rates, but many factors may drive costs
- Many state contracts incentivize rebalancing by paying a blended capitation rate that assumes a certain mix of HCBS and institutional care
MLTSS Outcomes and Oversight

- Few rigorous research studies on MLTSS, partially due to a lack of baseline data
- Evaluation of MN integrated care program found enrollees had reduced rates of hospitalizations and ER visits compared to other dually eligible beneficiaries in state
- TX study found 3.5 percent decrease in costs from FY 2010 to 2015 compared to expectations for FFS
- Results from interim federal evaluation of NY and TN were mixed
  - Final evaluation expected in 2019 may include new data or analyses
Progress in Measure Development

• Lack of standardized outcome measures appropriate for LTSS population limits comparisons across states

• Recent efforts to improve measures include:
  – Experience of Care Survey testing completion
  – National Core Indicator surveys on quality of life and outcomes
  – National Quality Forum identified domains for new measure development

• CMS has released technical specifications of eight MLTSS quality measures; more in testing phase
  – CMS has not indicated that it will require implementation and reporting of these measures
Tailoring MLTSS Programs for People with ID/DD

- States expanding scope to include services for people with ID/DD
- Historically this group received services through FFS
  - Stakeholder resistance
  - Managed care plans have not typically served this population
  - Cost savings are difficult to achieve
- Review of MLTSS programs found most frequent contract requirements specific to ID/DD related to training of care coordinators
- Importance of stakeholder engagement emphasized by interviewees, including ongoing activities beyond the implementation period
Integrating Care for Dually Eligible Beneficiaries

- States use several strategies to integrate care for beneficiaries who are dually eligible for Medicare and Medicaid
  - Financial Alignment Initiative
  - alignment of managed care (including MLTSS) with Medicare Advantage dual-eligible special needs plans (D-SNPs)
- Alignment with D-SNPs occurs on a continuum
  - e.g., states may require MLTSS plans to offer a companion D-SNP
- D-SNP authority now permanent; removal of uncertainty may prompt more state interest
Managed Long-Term Services and Supports

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