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A NETWORK ON THE MOVE

POLICY BRIEF

The Role of the Aging Network in Medicaid Managed Care for LTSS

The health care delivery landscape is undergoing a major transition as the vast majority of states are expanding use of managed care organizations to deliver Medicaid acute health care and attempting to incorporate Medicaid long-term services and supports (LTSS) into managed care for the first time.

While this transformation of Medicaid LTSS state-level delivery systems creates opportunities to predict costs, improve coordination and possibly enhance quality, it presents risks as well. This brief will examine key elements of the move to Medicaid managed care for the delivery of LTSS; the risks and rewards for consumers and government; and the pivotal role the Aging Network can and will play in this transformation.

Forces at Work: Cost Control and Improved Coordination

Medicaid expenditures represent a significant portion of state budgets. The economic downturn has created a dramatic situation for states faced with both rising Medicaid expenditures and dwindling revenues. States' recent interest in expanding managed care within Medicaid comes from these real fiscal pressures. The shift to introducing or expanding managed care is driven by states' predictions that it will lower costs or at least create a more stable, predictable growth rate.

Specifically, Medicaid managed care is attractive to state officials because it provides the means to achieve budget stability, over time, through capitation. Rather than paying multiple entities various fees per service, states are increasingly choosing to reimburse one entity at a fixed, capitated rate with the expectation that quality and access will not be compromised. By paying a single fixed fee per enrollee, states limit their financial risk, passing on part or all of it to managed care organizations (MCOs). Because of the capitated rate, MCOs are given incentives to provide the most efficient care possible, limiting their financial risk and maximizing their potential profit.

The rush to adopt managed care is also driven by, and driving, another health care trend: better coordinated care. Shifting to a managed care system potentially offers states the chance to better coordinate care for beneficiaries; to reduce silos and integrate care between health and LTSS systems; and to improve quality by incorporating a strong emphasis on health outcomes. This trend is reflected across the health care continuum and can be seen through Affordable Care Act (ACA) provisions mandating improved coordination for dually eligible beneficiaries of Medicare and Medicaid; realignment of offices and goals at the Centers for Medicare and Medicaid Services (CMS); the creation of new standards and emphasis on care coordination; and now, states' interest in reform. While managed care is not the only way to reach CMS's "triple aim" of better care, better health and lower costs, states are looking for solutions that achieve multiple purposes, further fueling interest in managed care.

Managed Care Moves into Long-Term Services and Supports

Historically, healthy children and families made up the majority of Medicaid managed care beneficiaries; however, with new Medicare–Medicaid dual integration demonstrations and other CMS initiatives, seniors and people with disabilities are increasingly being moved into managed care programs for LTSS and acute care. Again, the primary force is economic: the populations previously excluded from (or "carved out" of) managed care systems, such as older adults with multiple chronic conditions and LTSS needs, or people of all ages with disabilities, are smaller in number than their younger, healthier or less disabled counterparts. Yet, they are a disproportionate major driver of Medicaid costs. In FY 2009, older adults and people with disabilities represented 25 percent of all Medicaid beneficiaries, but drove 66 percent of total costs ($230 billion out of $346 billion).[1]

Key Terms

LTSS

Long-Term Services and Supports. Refers to the wide range of assistance (formerly called long-term care), that is provided in a variety of settings, that goes beyond acute medical care and deals with all the other ADL needs of people with disabilities or illness.

Home and Community-Based Services. LTSS that is provided in individuals' homes and in the community. An alternative to institutional care, HCBS includes a wide range of supports—including meals, transportation, chronic disease self-management programs, in-home care and much more—to help older adults or people with disabilities maintain their health and independence at home and in the community.

HCBS

AAAs

Since their creation in the Older Americans Act amendments of 1973, **Area Agencies on Aging (AAAs)** have developed and coordinated a wide array of HCBS for older adults and caregivers. These services include information and assistance; case management; transportation; nutrition; caregiver support and respite; health promotion and disease prevention; senior employment; legal services; senior centers; elder abuse and neglect prevention; housing modification and repair; in-home chore services; long-term care planning; and more.

At this point, financially strapped states are hoping that including these higher-need populations and the non-acute LTSS Medicaid services, such as home and community-based services (HCBS), will help them manage their overall Medicaid budgets.

There is a growing policy recognition that all health and human services systems must adapt to the pressures of our country's aging boom. The first wave of the baby boomers began turning 65 years old in 2011, and while long anticipated, few policy changes have been made. Forty million Americans—13 percent of the population—are now age 65 or older.[2] By 2030, that percentage will rise to nearly 20 percent.[3] Our aging population will continue to grow, as will the health care costs associated with it, and the implementation of managed care is one strategy that states are pursuing to help them tackle the growth while still trying to improve health quality and outcomes and still reducing costs.

Placing responsibility for Medicaid LTSS with MCOs is a dramatic shift in policy and practice. There is no national consensus on how best to make this change: emerging state proposals are very diverse in their approach to incorporating LTSS into managed care. It is vitally important it is vitally important that states develop strong beneficiary protections specific to the delivery of HCBS to ensure that managed-care LTSS programs truly support independence and the ability of beneficiaries to remain in or return to community settings. AAAs are integral to this process and can serve as important allies to MCOs in the coming years.

Implications for Consumers and MCOs

Health care delivery today is currently siloed, creating inefficiencies and duplicative work across care settings, often wasting time and money. The "medical" side rarely connects with the "social" side, so acute health care and LTSS are often uncoordinated, which exacerbates the problem. This fractured system makes life difficult for consumers, as well, as they attempt to navigate complicated systems that don't communicate with each other.

State Medicaid reforms create a unique opportunity to remedy some of these problems and build bridges between the silos so care is provided comprehensively, treats the whole person and includes consumer-directed services. With a consensus among consumers, advocates and governments to expand HCBS—highlighted by the 2012 creation of the Administration for Community Living (ACL) within the U.S. Department of Health and Human Services—managed care expansion

into LTSS could expand consumers' access to HCBS, helping rebalance our nation's long-term care system toward HCBS from the more expensive institutional options such as nursing homes. But success will require that MCOs rapidly increase their understanding of the complexity of LTSS and develop partnerships and systems of coordinated care to deliver LTSS, which is a very different world than the acute health care (or "medical model") industry MCOs have traditionally operated in.

The integration and transition of heterogeneous populations such as older adults and people with disabilities into the current MCO care model may not be as smooth as expected or hoped. Though MCOs have experience delivering acute health care services, most simply do not have the experience with or expertise in providing HCBS to this population. MCOs will be responsible for incorporating solid and proven HCBS best practices and protocols with very little experience or infrastructure. From the beginning, and at all levels, an MCO will need to work in very close partnership with beneficiaries and advocates to meet very diverse needs. MCOs must create partnerships, seek guidance and potentially contract for services from existing HCBS coordinators and providers (such as AAAs) from the outset to ensure smooth transitions for consumers and optimized capacity for the MCO.

Consumer advocates increasingly fear consumers will face disruptions in LTSS under managed care. Many individuals that comprise the population served under Medicaid are elderly, frail, disabled and economically disadvantaged. In many cases, these individuals and families have established a long trusting relationship with social workers, counselors, care coordinators and case managers who have steered them through the complicated and often overwhelming health care delivery system. A disruption in HCBS is a disruption to the lives of vulnerable individuals and can prove costly not only financially, but, more importantly, physically and/or mentally.

Although providing HCBS through managed care poses significant challenges, there is an opportunity for MCOs to work with local agencies or community-based organizations that are part of a national network that has unique expertise and a proven track record for coordinating and providing these services. The infrastructure for HCBS delivery already exists and should not be re-created. The silos between services *can* be bridged, intersecting and aligning acute health care with HCBS—if it is done right.

Key Terms

ADLs

Activities of Daily Living refers to daily self-care activities within an individual's place of residence, in outdoor environments or both. Basic ADLs include personal hygiene and grooming, dressing and undressing, self-feeding, functional transfers such as getting into and out of bed or onto and off the toilet, bowel and bladder management, and walking with or without the use of an assistive device.

IADLs

Instrumental Activities of Daily Living refers to activities that are not necessary for fundamental functioning, but which allow an individual to live independently in a community. IADLs include housework, taking medications as prescribed, managing finances, shopping, use of telephone or other forms of communication, transportation and more.

AAAs: Bridging the Gap

AAAs were established under the Older Americans Act (OAA) in 1973 to serve as the "on-the-ground" organizations charged with assisting older adults to live with independence and dignity in their homes and communities.

Today, there are 629 AAAs serving older adults in every community in the nation. Supported by the State Units on Aging and joined by the tens of thousands of service providers and community-based organizations that they partner with, AAAs offer a proven track record, well-established community partnerships, stability, and a reputation as a trusted resource for older adults and caregivers in all communities.

For forty years, AAAs have developed, coordinated and often provided congregate and home-delivered meals, transportation, family caregiver support, and other in-home and community supports, as well as services to prevent abuse, neglect and exploitation of older adults. Additionally, AAAs provide comprehensive case management and care coordination services, ensuring that no one is unnecessarily in a nursing home who would rather live at home or in the community. Nearly 60 percent of AAAs currently have a program to divert consumers from institutional care, and of those, nearly 70 percent facilitate transitions from institutional placement to community living.[4]

This expertise is why nearly 60 percent of AAAs also are involved in administering Medicaid HCBS waivers, conducting assessments, providing case management, coordinating services like adult day care, transportation or in-home care, and playing other key roles.

While traditionally masters of the social model of care, increasingly AAAs have demonstrated their ability to effectively partner with health care systems and state quality improvement organizations (QIOs) to administer care transition programs that result in seamless transitions for consumers from acute care settings back home, improved health outcomes and fewer re-hospitalizations.

One example: the ACA's Community Based Care Transitions Program seeks to improve care for high-risk Medicare beneficiaries being discharged from the hospital, in order to prevent unnecessary re-hospitalizations and avoidable costly health care utilization. AAAs are playing lead roles in this new CMS initiative: 23 of 30 projects funded to date are led by a AAA.

As states increasingly move to managed care models for their Medicaid programs, n4a believes it is critical that the Aging Network continues to serve as the bridge to integrate acute and LTSS so that the quality of care for older adults and people with disabilities is not compromised. AAAs have the unique tools, expertise and provider networks to work with MCOs to deliver high-quality, effective and efficient services to older adults.

Not only does this save MCOs the trouble of start-up and ongoing operational maintenance, but AAAs also have the established, long-lasting relationships with community vendors of specific services that MCOs need. AAAs can manage vendors much like they have for the past 40 years on behalf of MCOs, helping to contribute to cost savings and efficiencies in care and care transitions. Marrying the social model with the medical model in this way will have exponential benefit to consumers, while improving sustainability of federal and state government health programs.

The value proposition for MCOs to work with AAAs is very simple. MCOs have limited experience coordinating and delivering HCBS; AAAs have the know-how to coordinate and deliver services, an established infrastructure and an army of highly-skilled aging professionals and vendors. AAAs can serve as the HCBS bridge between the MCO and the consumer.

AAAs have long been their state's partners in the development and coordination of HCBS and are their community's trusted resources. Now they can be a superior, value-added contributor to the managed care model.

Endnotes

1. Kaiser Family Foundation, "State Health Facts: Medicaid & Chip – California," www.statehealthfacts.org/comparecat.jsp?cat=4&rgn=6&rgn=1.
2. U.S. Census Bureau, 2010 Census Briefs, "The Older Population: 2010," www.census.gov/prod/cen2010/briefs/c2010br-09.pdf.
3. U.S. Census Bureau, National Population Projections, 2008, www.census.gov/population/www/projections/summarytables.html.
4. n4a and Scripps Gerontology Center, "Area Agencies on Aging: Advancing Health and Long-Term Services and Supports," 2010 Survey of Area Agencies on Aging, July 2011, www.n4a.org.

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About n4a

The National Association of Area Agencies on Aging (n4a) is the membership organization for the 629 Area Agencies on Aging (AAAs) and a voice in the nation's capital for the 246 Title VI Native American aging programs in the U.S. The fundamental mission of the AAAs and Title VI aging programs is to provide services that make it possible for older individuals to remain in their homes, thereby preserving their independence and dignity. These agencies coordinate and support a wide range of home and community-based services, including information and referral, meals, in-home care, transportation, employment services, senior centers, adult day care and more.

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