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Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers

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EXECUTIVE SUMMARY

Delivery system reforms continue to play a significant role in shaping state Medicaid programs, including initiatives focused on beneficiaries who need long-term services and supports (LTSS). A growing number of states are enrolling seniors and people with disabilities in Medicaid managed care and implementing initiatives aimed at better coordinating and integrating Medicare and Medicaid services for dual eligible beneficiaries, often through capitated managed care arrangements. In addition, a significant number of states report that incentives built into their managed long-term services and supports (MLTSS) programs are expected to increase beneficiary access to home and community-based services (HCBS) in lieu of institutional care.

This issue brief examines key themes in 19 capitated Medicaid MLTSS waivers approved to date by the Centers for Medicare and Medicaid Services (CMS), including § 1115 demonstrations in 12 states (AZ, CA, DE, HI, KS, NJ, MN, NY, RI, TN, TX, VT) and § 1915(b)/(c) waivers in six states (FL, IL, MI (2 waivers), MN, OH, WI). MLTSS programs provided under these authorities are the subject of CMS's 2013 best practices guidance to states. Key themes in the capitated MLTSS waivers include the following:

Covered Populations and Services in Capitated MLTSS Waivers

- State interest in MLTSS is increasing, with over half (11 of 19) of these waivers approved in 2012, 2013, or 2014.
- All 19 MLTSS waivers include seniors and non-elderly adults with physical disabilities, while five include people with intellectual/developmental disabilities. All include dual eligible beneficiaries.
- Most (15 of 19) of the waivers are or will be providing MLTSS statewide.
- Most (17 of 19) of the waivers require beneficiaries to enroll in managed care to receive LTSS.
- Most (14 of 19) of the waivers cover or will soon cover a comprehensive set of benefits, including nursing facility (NF) services, HCBS, acute and primary care, and behavioral health services.

MLTSS Waiver Provisions Aimed at Increasing Beneficiary Access to HCBS

- Four states use MLTSS waivers to increase access to HCBS by expanding Medicaid financial eligibility criteria.
- Seven states use or are seeking MLTSS waiver authority to provide HCBS to people at risk of institutionalization.
- Two states use MLTSS waiver authority to allow beneficiaries to employ spouses as paid caregivers as part of their option to self-direct HCBS.
- Three waivers include financial incentives for health plans that provide increased HCBS, and two waivers include provisions for increased state HCBS funding.
- Three waivers include requirements for health plans regarding NF to community transitions or NF diversion.

Beneficiary Protections in Capitated MLTSS Waivers

- Eight waivers include provisions for independent enrollment options counseling to assist beneficiaries with choosing a health plan.
- Eleven waivers provide for an ombudsman program as part of their MLTSS programs.
- Six waivers include provisions that expand beneficiaries' right to change health plans outside of open enrollment, such as when a residential or employment supports provider leaves the plan network.
- Seven waivers require the state to maintain a managed care advisory group to provide input on the MLTSS program, and six waivers require health plans to establish beneficiary advisory groups.

Quality Measurement and Oversight in Capitated MLTSS Waivers

- Eight waivers mention quality of life measures, although generally little detail is provided.
- Five waivers require reporting on LTSS rebalancing and community integration measures.
- Five waivers provide for beneficiary satisfaction surveys.
- Four waivers require reporting of health plan encounter data.