Milbank Memorial Fund

Primer

Strategies to Encourage Home- and Community-Based Care through Value-Based Contracting in Managed Care

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Nationally, Medicaid payments represent approximately 44% of all spending on long-term services and supports (LTSS).[1,2] Most of this spending is for individuals who are dually eligible for Medicaid and Medicare.[3] These costs are expected to increase dramatically as the US population ages and the need for LTSS grows, placing a significant and growing financial burden on Medicaid programs in the near future.[2,4] As a result, Medicaid agency leaders are looking for ways to contain the costs of LTSS while also improving the quality of the care provided.[2]

Medicaid agencies are seeking to implement value-based strategies to encourage managed care organizations (MCOs) to keep or place beneficiaries in home- and community-based settings instead of in more expensive institutional settings like nursing homes. According to a survey conducted by the Kaiser Family Foundation, 18 Medicaid agencies include rebalancing incentives in their MCO contracts — financial mechanisms through which MCOs can realize savings for serving Medicaid beneficiaries in the community — to encourage the provision of care in non-institutional settings.[5]

In addition to cost savings, Medicaid agencies are seeking to keep or place individuals in home- and community-based settings in response to beneficiaries' preferences and community integration requirements set forth under the Americans with Disabilities Act[6] and the Supreme Court's decision in *Olmstead* v *L.C.*[7,8]

This primer examines the financial and policy levers available to states to encourage MCOs to provide care in home- and community-based settings.

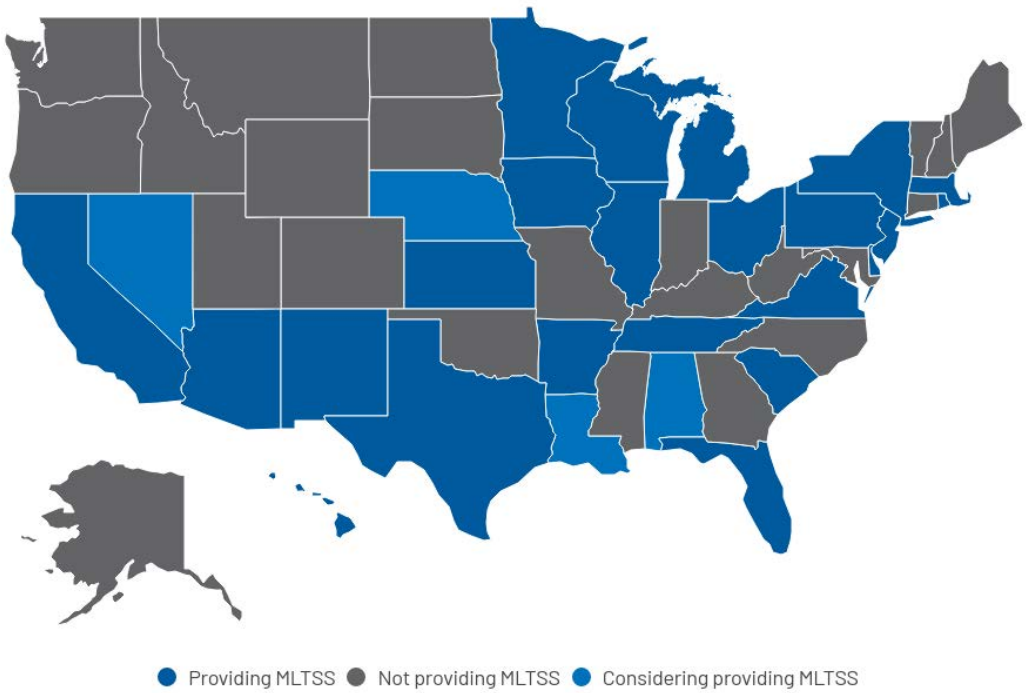
BACKGROUND OF MANAGED LONG-TERM SERVICES AND SUPPORTS

Long-term services and supports (LTSS) assist individuals who have chronic conditions and disabilities with activities of daily living. These services are provided in various care settings, which are typically classified as either institutional settings (nursing homes, intermediate care facilities, etc.) or home- and community-based settings.[9] Traditionally, LTSS have been provided through the fee-for-service (FFS) model.[2] However, due to the promising advantages of managed care, Medicaid agencies have shifted toward providing Managed LTSS (MLTSS) over the last 20 years.[2] The number of states whose Medicaid programs provide MLTSS for at least some of their LTSS populations increased from only eight in 2004[9] to 23 by July 2019 (Figure 1).[10] In addition to these states, Alabama, Louisiana, Nebraska, and Nevada are considering developing MLTSS programs.[11]

Medicaid programs use a range of authorities to implement MLTSS, such as section 1115, 1915(a), 1915(b), and 1915(c) waivers[12] and the Financial Alignment Initiative[13] demonstrations.[9]

> Value-based contracting (VBC) consists of financial arrangements with value-based payments between Medicaid agencies and managed care organizations that aim to hold Medicaid plans accountable for both costs and quality of care provided to LTSS beneficiaries.[4,14]
>
> There are distinct challenges to instituting value-based approaches for LTSS.[14] For example, LTSS are typically supplied by smaller service providers that do not have the financial resources or capacity necessary to engage in risk-bearing contracting.[14] However, many Medicaid programs have successfully implemented VBC in their MLTSS programs, and others report that LTSS is the next area of focus for implementing value-based payment models.[15]

Figure 1. Map of State Medicaid Programs Providing MLTSS



Source: Kaiser Family Foundation[10]

SPECIFIC APPROACHES TO PROMOTE CARE IN HOME- AND COMMUNITY-BASED SETTINGS

Financial Incentives

Medicaid agencies use financial incentives to encourage MCOs to offer care in home- and community-based settings.

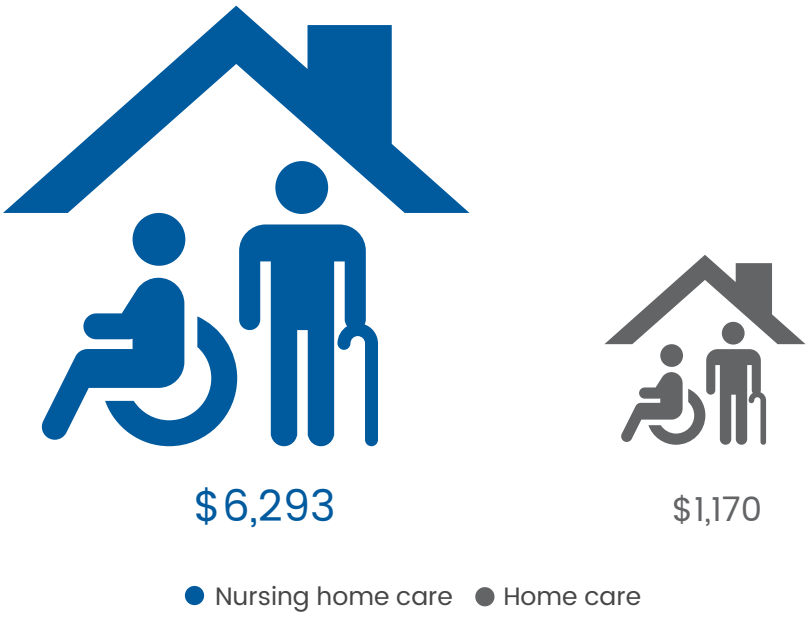
Capitation rates. States with MLTSS pay for the cost of care through capitated payments to MCOs, a fixed amount of money per patient paid in advance to cover the expected cost of all health care services.[16] These capitation rates can influence the type of care that Medicaid beneficiaries receive and the degree to which states can encourage MCOs to provide care in home- and community- based settings.

Florida and Tennessee Medicaid use blended capitation rates, [5] which means that the rate paid to managed care plans to "cover expected costs for each LTSS beneficiary is the same for all beneficiaries, whether they receive care in a nursing home or in a home- or community-based setting."[17] When MCOs have more members receiving care in lower-cost home- and community-based settings, they realize savings.

Similarly, Arizona Medicaid's MLTSS capitation rate assumes a specific mix of members receiving home- and community-based services (HCBS) and those receiving institutional care, thereby creating a direct financial incentive for MCOs to provide individuals with HCBS.[1*] Arizona Medicaid has successfully transitioned most individuals who can receive HCBS out of nursing facilities, with approximately 87% of MLTSS beneficiaries receiving HCBS.[18] Given that nursing home costs are estimated to be $6,293 per month, whereas the costs of home care are estimated to be $1,170 per month for moderate care,[19] a blended capitation rate may incentivize MCOs to provide LTSS to more beneficiaries in home- and community-based settings.

Minnesota Medicaid has been working for more than 30 years to rebalance care by providing more services in home- and community-based settings.[2*] Minnesota Medicaid incentivizes MCOs to provide care outside of a nursing facility by making a one-time payment to MCOs for 180 days of nursing facility payments for seniors and

Figure 2. Estimated Monthly Costs for Moderate MLTSS Care



Source: Source: Johnson R, Wang C[20].

100 days of nursing facility payments for individuals with disabilities.[2*] Minnesota Medicaid staff have found that this prepaid, one-time payment per member per lifetime gives plans a sufficient incentive to help beneficiaries avoid becoming long-term nursing home residents and return to the community when possible.[2*] As a result of this payment structure and other policies aimed at rebalancing care, Minnesota Medicaid staff reported that the length of nursing facility stays has decreased over time.[2*]

In addition to blended capitation rates, some state Medicaid agencies also structure capitation rates to benefit MCOs that assist members with applying for and receiving home- and community-based waiver services. For example, in South Carolina, MCOs are paid an increased capitation rate when they have successfully referred an individual to a waiver program that allows the individual to remain in the community.[3*]

Performance-based incentive payments. Another method for encouraging high quality care in home- and community-based settings is through performance-based incentive payments and penalties linked to quality measures.[16] Historically, most MLTSS value-based payments have gone to nursing facilities,[4] but state Medicaid agencies are working to use these structures to pay HCBS providers as well.

For example, MCOs in South Carolina are eligible for an incentive payment when a member returns to the community from a nursing facility due to hands-on care management by the health plan staff.[3*] Similarly, Virginia Medicaid uses an incentive program that pays MCOs for going to great lengths to transfer an individual who has been in a nursing facility for longer than a year back into the community.[4*] If an individual is successfully transitioned out of a nursing facility, meaning that they have remained in the community for longer than nine months due to community supports identified by the MCO, the MCO is eligible for a one-time payment of $7,500.[4*]

Financial resources for home- and community-based care. Medicaid agencies recognize that access to community supports and affordable housing are crucial to enabling beneficiaries to return home after nursing facility stays.[2] One resource that Medicaid agencies use to provide these services is Money Follows the Person (MFP)[21] grant funds, whose benefit in helping beneficiaries transition to home- and community-based settings has been well-documented.[20] MFP is a federal Medicaid demonstration program intended to enable individuals receiving LTSS to have greater choice about where they live and to "incentivize states to shift Medicaid LTSS spending from institutional to home- and community-based settings."[21,22] For each Medicaid beneficiary who ho has resided in an institution for at least 90 days and transitions to a home- or community-based setting, participating states receive an enhanced federal match.[21,22]

> The US Department of Health and Human Services (HHS) found that state Medicaid agencies spent 23% less per beneficiary per month among older adults who transitioned out of nursing homes.[21] In addition to cost savings, HHS also reported that the majority of beneficiaries who had transitioned out of nursing facilities reported that their care needs were met at similar or higher levels compared with nursing facility care.[21]

Texas Medicaid implemented an MFP behavioral health pilot to provide additional benefits to individuals with serious mental illness when transitioning back to the community.[2] Using MFP and other funding sources, Texas Medicaid has also provided housing supports for beneficiaries with disabilities to transition back to the community.[2] Similarly, Wisconsin Medicaid staff reported using MFP funds to transition beneficiaries from nursing facilities to community-based settings.[5*]

Provider Networks

Medicaid agencies use contract requirements to monitor the HCBS provider networks of MCOs. For example, beginning in 2017, Arizona Medicaid asked MCOs to monitor alternative HCBS placement rates to incentivize more at-home placements.[1*] Arizona Medicaid also uses gap reporting to identify any discrepancies between the HCBS a member should receive under their plan of care and those they do receive, helping to ensure that the HCBS provider network is sufficient to meet the needs of members.[1*]

Arizona Medicaid staff has expanded electronic visit verification to better identify any gaps in care created by the limitations of a beneficiary's health plan.[1*]

Medicaid agencies also are working to strengthen HCBS provider networks by examining pay structures for HCBS providers. HCBS providers are often direct-care workers who typically receive low wages and thus are not usually able to withstand decreases in pay tied to benchmarks.[4] To help strengthen their HCBS provider network, Minnesota Medicaid staff are considering whether wages for caregivers could be stratified depending on education and experience.[2*]

Other Medicaid programs offer technical assistance to help HCBS providers successfully transition from FFS to managed care. For example, Minnesota Medicaid staff provide technical assistance to HCBS providers on how to process and receive payments from health plans in a timely manner, which is crucial to small providers, and staff also meet regularly with HCBS provider associations to better understand and address any common issues.[2*]

IMPLICATIONS FOR POLICYMAKERS

Given that the senior population is expected to double by 2050 and Medicaid enrollment is increasing due to the recent economic downturn, state Medicaid programs may want to consider implementing the policy levers outlined and adopting VBC for MLTSS as a way to promote home- and community-based care while simultaneously controlling costs and ensuring quality care.[15]

Lessons Learned

Payment methods. Medicaid agencies should consider implementing blended capitation rates, which provide a financial incentive to MCOs to provide care at home. The rate paid to managed care plans to cover expected costs for each LTSS beneficiary is the same for all beneficiaries whether they receive care in an institution or home- and community-based setting, so the latter approach will generate savings for the MCO.

Additional funding sources. States can seek additional funding to encourage care in home- and community-based settings, such as through Money Follows the Person grants.

Defined objectives. At the outset, a clear goal for VBC, such as having more enrollees in home- and community-based settings than in nursing facilities, is critical to achieving success.[4]

Phased approach. Implementing VBC through a phased approach allows Medicaid agencies and MCOs time to build expertise and address issues that affect providers and beneficiaries.[4*]

1 Arizona Medicaid staff, personal communication*
2 Minnesota Medicaid staff, personal communication*
3 South Carolina Medicaid staff, personal communication*
4 Virginia Medicaid staff, personal communication*
5 Wisconsin Medicaid staff, personal communication*

Notes

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The authors would like to acknowledge the contributions of interviewees who provided their experience and knowledge to the development of the Center for Evidence-based Policy's report.

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The Center for Evidence-based Policy is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.

The Medicaid Evidence-based Decisions Project is housed at the Center. Its mission is to create an effective collaboration among Medicaid programs and their state partners for the purpose of making high-quality evidence analysis available to support benefit design and coverage decisions made by state programs.

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Using evidence to improve population health

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