

# **Managed Long-Term Services and Supports 101**

# What is Managed Care?

- A way to pay for and provide health care services and long-term services and supports
- The payer (Medicaid or Medicare) gives a managed care organization an agreed upon monthly amount of money per member, which the managed care organization uses to coordinate services and supports
- The managed care organization may make a range of services and supports available to members through a network of providers who have contracts with the managed care organization

# What is Managed Care?

- Under the contract with the payer (Medicaid or Medicare), the managed care organization is responsible to manage some or all of the financial risk for their members
- It is in the managed care organization's best interest to keep members healthy and coordinate members' care because it will cost them less
- If services and supports are provided to keep people healthy the managed care organization avoids paying higher costs for psychiatric hospitalization, emergency room visits, and costs related to chronic health conditions

# What is Managed Care?

Under Medicaid, Managed Care has 3 Forms:

- **Comprehensive** - the State Medicaid Agency pays a per member per month rate to a Managed Care Organization to provide a range of services for its' members
- **Non-comprehensive** - the State Medicaid Agency pays the Managed Care Organization to provide certain types of services – for example, behavioral health only
- **Primary Care Case Management** – the State Medicaid Agency pays certain primary care providers a monthly fee to provide care management, this is sometimes called “A Health Home or A Medical Home”

# What are Managed Long Term Supports & Services?

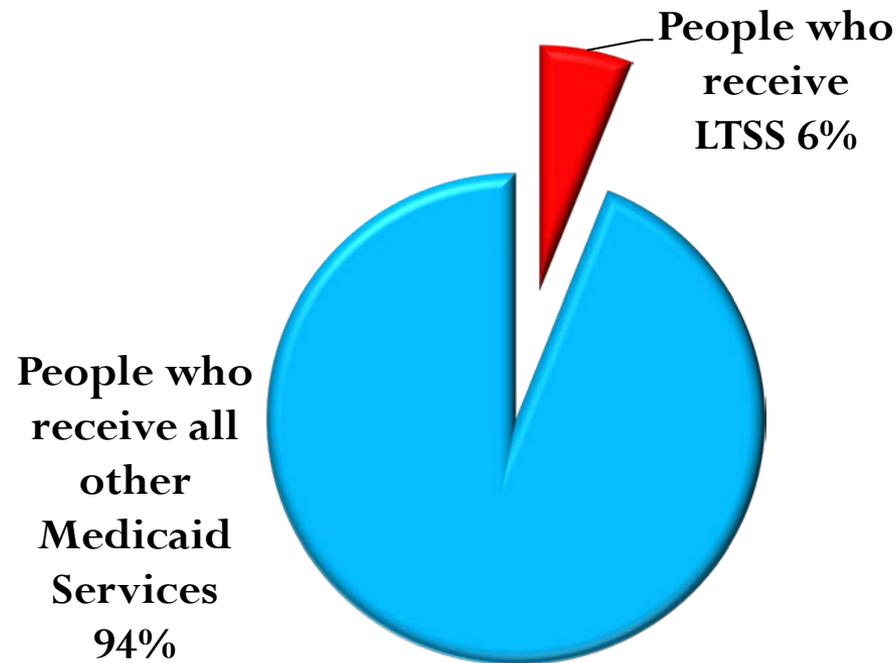
- Payer – usually the State Medicaid Agency – contracts with an Managed Care Organization to coordinate and provide Long Term Services and Supports
- May cover home and community-based services as well as institutional care (example: nursing homes)
- May serve different populations: older adults, people with physical disabilities, people with developmental-intellectual disabilities, or behavioral health needs

# Why Now?

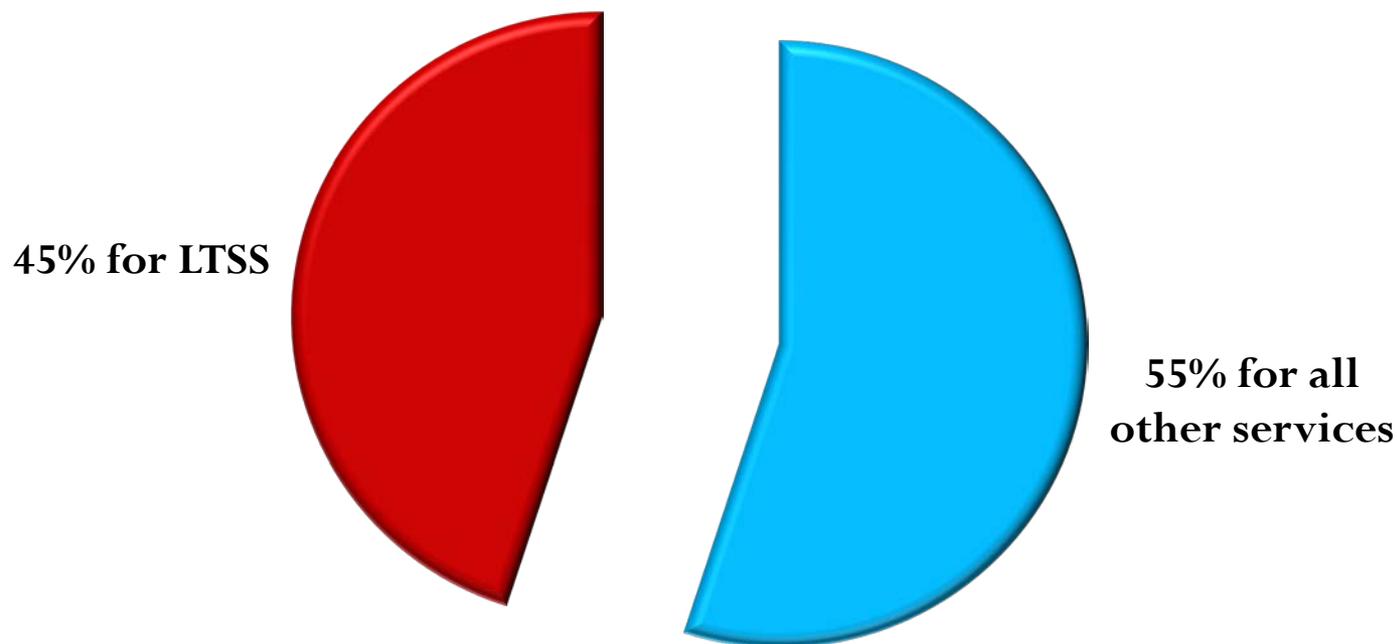
- State budget deficits around the country...not enough money to pay for all the services provided through Medicaid
- The Affordable Care Act encourages states to come up with new ways to deliver services and new ways to pay for those services
- The current spending for Long Term Services and Supports is not something our country can keep up with as more and more people need services and supports

# Why Now?

- People who get Medicaid Long Term Services & Supports are 6 percent of the total Medicaid population, but nearly half of the total amount spent in Medicaid is spent on that 6 percent



# Total Medicaid Spending



# Some good things...

- Improved care coordination among health care providers
- Improved awareness and coordination between Long Term Services & Supports and Medical services (doctor visits, hospitalizations)
- Improved oversight for quality services

# Challenges to Managed Long Term Services & Supports

- Limited experience with managed care in states
- Process is moving very quickly in some states
- Are states ready? Are plans ready?
- Transitioning people from fee-for-service to managed care

# Challenges to Managed Long Term Services & Supports

- Who is in the network?
- What happens to existing community-based organizations and networks?
- Concerns about services viewed through the Medical Model of service delivery
- Loss of focus on independence, community living, recovery
- Meeting people's needs

# Challenges to Managed Long Term Services & Supports

- Making sure person-centered planning is at the core of services provided
- Make sure services are approved by qualified people
- Make sure important Home and Community Based Service features are not lost
- Meaningful involvement and participation by people with disabilities and seniors

# Managed Care

Ready or not...here it comes!