Transitioning Long Term Services and Supports Providers Into Managed Care Programs

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I. Introduction

State purchasing strategies for long-term services and supports (LTSS) are shifting from fee-for-service (FFS) models to managed care models.[1] This shift is in turn having significant impacts on direct service providers of LTSS. These impacts will only grow in intensity as an increasing number of states adopt managed care approaches to their LTSS systems. By 2014, 26 states are planning to have managed long-term services and supports (MLTSS) programs in operation.[2]

At the most basic level, the adoption of MLTSS models means that direct service providers will be selling their services to different customers. Instead of contracting directly with states (or their regional entities), LTSS providers are now being required to negotiate contracts with the managed care entities selected by states to manage their LTSS populations. Instead of having a single contract with the state, direct service providers may have contracts with multiple managed care entities. If the MLTSS program has voluntary enrollment, LTSS providers may have one or more managed care contracts for some care recipients, yet still bill the state directly for recipients who have elected to stay in the FFS system. These changes in the LTSS market are putting pressures on direct service providers to change their business practices, and in some cases, their entire business models.

The purpose of this paper is to identify some of the business challenges faced by the LTSS provider community in transitioning from a FFS system to a MLTSS system. The findings of the study are based on qualitative interviews conducted with a variety of stakeholders, including state Medicaid program officials, representatives from managed care companies, LTSS providers, LTSS provider associations, and private consultants. The study is exploratory in that we conducted only a limited number of interviews with the time and resources available. Had the study been broader in scope, we might have identified additional challenges faced by LTSS providers. However, we were able to identify a good number of challenges faced by LTSS providers caught in the tidal shift to managed care.

In addition to identifying some of the challenges faced by LTSS providers, we also queried stakeholders about technical assistance efforts aimed at facilitating transitions among the LTSS provider community. Some states, as part of their implementation plans, have actively provided technical assistance to LTSS providers to ensure as smooth a transition as possible. Moreover, the designs of state MLTSS programs often include features which support the existing LTSS provider network to make the shift with minimal negative financial impacts, at least for a designated transitional period. Many LTSS providers were also receiving technical assistance from their state provider associations, whose mission it is to support their members through whatever changes may be taking place in the policy arena. A secondary purpose of this report is to highlight some "best practices" in the provision of technical assistance to LTSS providers during the transition process.

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[1] Saucier, P., Kasten, J., Burwell, B. and Gold, L. *The Growth of Managed Long-Term Services and Supports Programs: A 2012 Update.* Prepared for the Centers for Medicare & Medicaid Services by Truven Health Analytics, July 2012.

[2] Ibid.

II. Methods

In this exploratory study, we conducted interviews with 12 stakeholders representing federal and state agencies, managed care entities, provider organizations, and provider associations (see Appendix 1 for a list of respondents). Interviews were targeted to stakeholders with direct experience in states which had recently transitioned from a FFS system to an MLTSS system, or states that were currently in the midst of a transition. We selected stakeholders based on recommendations received from a number of sources, including other stakeholders. We do not infer that the observations made by stakeholders interviewed in this study are representative of the experience of the universe of LTSS providers undergoing MLTSS transitions. Thus, the suggestions made at the end of this document should be interpreted within this context of limited evidence.

III. General Observations

In this section, we provide some general observations from our stakeholder interviews.

1. **There was significant variation across states in the level of preparedness of LTSS providers to shift their business practices from FFS to managed care, which was dependent upon numerous factors.** Among the factors which contributed to the variation in preparedness were the length of time of the MLTSS implementation process, the extent to which states had included requirements in their contracts with managed care entities to protect the existing LTSS network, the scale of the MLTSS program, and the amount of technical assistance provided by states during MLTSS implementation.

2. **LTSS providers are being required to become more business savvy in negotiating contracts with managed care entities.** The LTSS provider community encompasses a broad range of business entities, from large national corporations to very small family-operated businesses and small non-profit agencies. Many of the smaller organizations that participate in the Medicaid program as LTSS providers have limited business experience. These smaller organizations are often challenged in selling their services to large managed care companies with large corporate infrastructures. Further, managed care companies are often not as "accommodating" of small LTSS providers as state agencies (e.g. they demand for rigid adherence to contract terms).

3. **Many managed care companies expanding into the MLTSS market have a limited understanding of LTSS, and of the LTSS provider community.** Most managed care companies are used to contracting for acute health care services that are highly regulated and licensed. They are not used to contracting for LTSS services that are more socially oriented, less well defined, and more tailored to the individualized needs of the LTSS recipient. Further, managed care companies are not used to contracting with non-licensed agencies with very limited corporate infrastructures. Finally, some of the new delivery models that have been developed in LTSS, such as participant-directed services, are unfamiliar to managed care entities, and do not fit into their usual contracting processes. However, the supply of managed care entities with MLTSS experience is growing.

4. **While states recognize the need to support their LTSS providers in the transition from FFS to MLTSS, tight implementation schedules and lack of resources can preclude states from offering much assistance to providers during the transition process.** In states where there is no organized technical assistance activity, many LTSS providers can be left to "fend for themselves" during the MLTSS transition process. In addition to state technical assistance efforts, however, state provider associations are also actively helping their LTSS members maneuver the MLTSS transition process as smoothly as possible.

5. **There is a general fear in the LTSS provider community that the shift to MLTSS will result in the "winnowing out" of smaller, less sophisticated LTSS providers.** Moreover, there was concern expressed that the winnowing out of smaller providers may limit access by persons in need of LTSS to the providers with which they feel most closely affiliated, and which are most person-centered. In other words, the concern is that smaller LTSS providers will be excluded from MLTSS provider networks because they lack corporate infrastructures that are capable of dealing with MCO contractual requirements, not due to any deficiencies in the quality of services they provide.

IV. Specific Challenges Encountered by LTSS Providers

This section discusses some of the more specific challenges that are encountered by LTSS providers in the shift to MLTSS.

1. **More formal and complex contracting processes.** The process of negotiating contractual agreements with managed care entities is more formal and complex than the process by which LTSS providers, particularly providers of home and community-based services, become qualified to participate in state Medicaid programs and negotiate payment rates. Managed care contracts can be lengthy and legalistic, prepared by legal and contract departments of large national corporations. On the other side of the table, the legal and contracting expertise available to small LTSS providers is often quite limited.

2. **Increased need to assess risk in contract negotiations.** Managed care companies, in general, are less "accommodating" than state agencies in ensuring that LTSS providers adhere to terms of executed contract agreements. Understandably, managed care companies will attempt to limit their own risks and make LTSS providers ultimately accountable for client outcomes. LTSS providers, in negotiating contracts with managed care entities, need to place increased focus on the specific risks associated with the terms of the contract, and the potential consequences associated with non-adherence.

3. **Increased focus on accurate pricing.** Negotiating prices for specific units of service can be more complex in a managed care environment. Managed care entities may require more detailed pricing structures (e.g. different rates for weekday services and weekend services) than typically required by state agencies. In turn, LTSS providers need to re-examine their pricing structures in the context of their overall business models, to ensure that their prices for various services are adequately capturing costs. This kind of focused business analysis is often a new experience for many LTSS providers.

4. **More extensive contract requirements.** Managed care companies can have more extensive contractual requirements for LTSS services than are typically required in state FFS systems. One example is that MCOs will sometimes require that LTSS services be available to their members 24 hours a day, seven days a week (24/7), while state contracts only require services to be provided during normal business hours. LTSS providers are sometimes being required to alter their business operations in order to accommodate the contractual requirements of managed care entities.

5. **New billing practices.** LTSS providers cited new and more stringent billing practices as a particular challenge in the shift to MLTSS. Managed care entities generally use standardized claim forms for provider billing, while many states use home-grown, non-standard claim forms for LTSS. Thus, LTSS providers often need training on the proper completion and submission of new claim forms in order to be paid for their services. Second, in contrast to pre-existing FFS systems, providers may have contracts with multiple MCOs for their clientele, requiring them to become proficient at more than one billing system. Third, MCO billing systems generally have more rigid edit checks on their claims processing systems, rejecting claims on which certain fields are not populated. LTSS providers must receive training to use these new MCO billing systems and to ensure that submitted claims meet all edit requirements for payment.

6. **Licensure/credentialing requirements.** MCOs are used to developing provider networks comprised of providers that are fully licensed and credentialed. In contrast, many providers of LTSS services are not licensed, and are only required to meet other non-standard provider requirements established by the state. Since MCOs may have liability concerns about contracting with non-licensed providers, their tendency is to contract with larger organizations that are licensed and formally certified as home care providers. Alternatively, MCO licensure/credentialing requirements may force LTSS providers to seek licensure as a condition of participation in the MCO's network.

7. **Prior authorizations.** MCOs may impose more stringent prior authorization on services than those imposed by the state in the FFS system. For example, MCOs may ask providers to submit more detailed justification for providing services which exceed the cost of a previously-established care plan.

8. **Prompt payment and impact on financial viability.** Many small LTSS providers operate on extremely limited financial reserves, and are at risk of financial catastrophe if there are significant delays in receiving payment for services rendered. The more stringent billing practices of MCOs (stricter edit checks on claim submissions, prior authorization requirements, etc.) may negatively impact cash flows for LTSS providers that have limited reserves to draw upon.

9. **Tracking enrollments and disenrollments.** Unlike the Medicaid FFS system, where the state is the sole payer for all LTSS services, a MLTSS environment is more complex, as eligible participants are provided a choice of plans, and have the option to switch enrollment from one plan to another at certain periods. Thus, in billing for LTSS services, although their

clientele may remain relatively stable, providers must have up-to-date information on their clients' MCO enrollment.

V. Specific Challenges Encountered by MCOs

The transition from a FFS framework to a MLTSS framework has not only proven challenging for LTSS providers, but for managed care entities as well. The challenges faced by MCOs are, to a large extent, the flip side of the challenges faced by LTSS providers.

1. **MCOs' general lack of understanding of the LTSS market and the LTSS provider community.** Most managed care entities that are expanding into MLTSS come from a traditional health care model. Moreover, MCOs may have the misconception that managing LTSS populations and LTSS services is somehow "easy" relative to the management of traditional acute care services. In the world of Medicaid, they also may have the mistaken belief that most users of LTSS services are frail elders in need of nursing home or skilled home care. Many MCOs are not well prepared to deal with the challenges of managing LTSS services for younger persons with disabilities, and particularly persons with severe disabilities.

2. **Lack of experience in payment methods for LTSS services.** Many MCOs are used to paying claims for episodic acute care services, such as births, hospitalizations, specialty visits, and so on. They are not as used to paying for services that are used daily, and in some cases, continuously, by LTSS recipients. MCOs also may not have experience in financing 24-hour residential services for persons with disabilities, including persons with intellectual disabilities. Finally, states may place expectations on MCOs to develop new service models for LTSS populations, particularly service models that are more cost-effective, and more person-centered than the models that have traditionally been used in the FFS system. The development of new types of service delivery models for LTSS populations requires a higher level of creativity and innovation than many MCOs are used to. However, it is clear that many states are turning to MLTSS models with the hope that private sector organizations can be more innovative and creative in meeting the needs of LTSS populations than is feasible within the constraints of the public sector.

3. **Lack of experience in negotiating contracts with small non-profit entities or sole proprietors.** Just as small LTSS providers lack experience in negotiating contracts with large corporate entities, the same large corporate entities lack experience in negotiating contracts with small non-profit or for-profit LTSS providers. For example, adult foster care is a service that many states utilize as a cost-effective residential model for supporting persons requiring 24-hour supervision. In an adult foster care model, a single proprietor may decide to enter the LTSS business by opening up his or her home to three or four individuals who require continuous services. In a MLTSS framework, adult foster care may be a required service that the MCO is expected to provide under its contract with the state, and the MCO may be required to negotiate numerous contracts with adult foster care providers as sole proprietors within its service area. The MCO may need to significantly

modify its usual contracting processes in order to recruit an adequate number of adult foster care providers into its network.

4. **Lack of experience in contracting for participant-directed services.** Since most states now provide participant-directed services for persons who are able to self-direct their own services within their FFS systems, states are also requiring their MLTSS contractors to provide a participant-directed service option for their members. Participant-directed service models also come in several flavors, including "employer authority" models and "budget authority" models, which include flexible budgets for purchasing goods and services. In most cases, the implementation of participant-directed service models requires contracting with fiscal intermediaries, who manage the federal and state payroll requirements for participants as employers. These models are largely unfamiliar to most MCOs, and require an educational process for MCOs to come up to speed.

5. **Legal liability concerns over participant-directed services among MCOs.** In participant-directed service models, MCOs have limited ability to control who the LTSS participant selects as his or her personal care attendant, including people who may have prior criminal backgrounds. Since MCOs, unlike states, can be rendered legally liable for negligent and abusive acts perpetrated by personal care attendants on LTSS participants, MCOs may have increased liability concerns regarding the use of participant-directed care models in MLTSS programs. This concern was more hypothetical than actual, and we heard no examples of an MCO limiting the use of participant-directed services due to such concerns.

VI. Technical Assistance Provided to LTSS Providers During the Transition to MLTSS

This section summarizes what we learned about how states have helped LTSS direct service providers in the transition to a MLTSS environment.

1. **Significant variation was reported across states in the extent to which LTSS providers were provided technical assistance by states during the MLTSS transition process.** In some states, there had been a proactive effort to support LTSS providers in making the transition to managed care, with states sponsoring specific outreach efforts to providers to help them prepare for the transition process. In other states, for a variety of reasons, no technical assistance activities were reported. In the latter states, LTSS providers sometimes characterized the transition process as a "Wild West Show," with providers being left to fend for themselves as best they could.

2. **The most common types of technical assistance provided to LTSS providers were simply organized forums where providers and MCOs came together to learn about each other's businesses prior to MLTSS program implementation.** In these cases, the states simply served as a facilitator, and meeting sponsor, to create a forum where LTSS providers and MCOs could interact in an environment that did not involve contract negotiations. The forums were generally characterized as "get to know each other" sessions where both MCOs and LTSS providers could share information that would help inform subsequent business conversations.

3. **Practice "billing sessions" were another type of technical assistance activity.** States also sponsored more technical "billing sessions" which were scheduled closer to the MLTSS "go live" date. These sessions provided opportunities for LTSS providers to obtain detailed information about MCO billing and payment practices, and to actually simulate the billing process. They were scheduled in an effort to minimize the prevalence of denied claims from LTSS providers in actual billing situations after the MLTSS program was implemented.

4. **In addition to states, provider associations were another major source of technical assistance.** Most LTSS providers belonged to state associations whose responsibilities included providing support to their members during the MLTSS transition process. Provider associations generally provided educational assistance to their members to keep them up to date on the MLTSS implementation process. In addition, provider associations served an advocacy function in bringing up specific LTSS implementation issues with state agencies.

5. **In most states, state contracts with MLTSS contractors include provisions which provided limited protections to the existing LTSS provider network during a transitional period.** The two most common types of protections were: (1) "any willing provider" provisions which required MCOs to contract with all LTSS providers which currently held a Medicaid provider agreement within their designated service area; and (2) rate stabilization provisions which required MCOs to pay LTSS providers at the same rate that providers were receiving under the FFS system, at least for a transitional period (e.g. one to three years).

6. **One state (New York) had developed detailed guidelines on how MCOs and LTSS providers were expected to collaborate on the provision of LTSS services to members.** New York promulgated guidelines to MCOs on how personal care services were to be provided under the MCO contract. These guidelines included specific provisions regarding how the MCO was expected to assist LTSS providers in the claims submission process, and also how to work with LTSS providers during member transitions, such as disenrollments and loss of Medicaid eligibility.[3]

VII. Suggestions

The following suggestions are offered as possible mechanisms for assuring that LTSS providers receive adequate technical support from states during the transition from a FFS environment to a MLTSS environment.

1. **Consider requiring technical assistance to LTSS providers as a condition of CMS approval.** As a condition of approval of any MLTSS program, CMS could require states to implement an outreach program to LTSS providers to facilitate their transition to MLTSS. States could be required to submit a written technical assistance plan to CMS outlining the activities it will undertake, either directly or through partners.

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[3]NYS Department of Health, Office of Health Insurance Programs. *Guidelines for the Provision of Personal Care Services in Medicaid Managed Care.* Located at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_personal_care_guidelines.pdf.

2. **Encourage state sponsorship of neutral forums between LTSS providers and MLTSS contractors.** CMS should encourage states to sponsor neutral forums, prior to provider-MCO contract negotiations, for general education and information sharing about organizational values and business practices.

3. **Adopt MLTSS implementation schedules that allow sufficient time for LTSS providers to prepare for MLTSS.** CMS should encourage states to adopt implementation schedules that allow for ample time between final program approvals and MLTSS launch dates so that LTSS providers can prepare for MLTSS transitions. For example, there could a requirement that there be at least a six month implementation phase between the time the state awards contracts to its MLTSS contractors and MLTSS program launch date, so that LTSS providers have ample time for contract negotiations and training.

4. **Encourage MCOs and LTSS providers to conduct practice billing sessions prior to program launch, during which MCOs provide detailed information to providers about proper billing practices, edit checks, prior authorizations, and audit procedures.** Practice billing sessions should be structured by provider type (e.g. nursing homes, adult day care centers, personal care service vendors, etc.) so that LTSS providers can receive training on billing practices specific to the services they provide.

5. **Continuity of Care requirements could be included in all CMS agreements with states for MLTSS programs.** These requirements are already included in most, if not all, CMS agreements with states. Continuity of Care requirements mandate MLTSS contractors to continue existing LTSS care plans with newly enrolled members for some period after their initial enrollment in the MLTSS plan (often 30 days or until a new comprehensive assessment is conducted, whichever comes later). Continuity of Care requirements have the secondary effect of encouraging MLTSS contractors to include existing LTSS providers in their networks, and to honor existing care plan arrangements with those providers. Through these requirements, LTSS providers are essentially guaranteed that they will not experience serious disruptions in their FFS revenue streams during the initial transition to MLTSS.

6. **States could give consideration to allowing high-performing LTSS providers to become MLTSS contractors.** This option is currently available to LTSS providers in New York's MLTSS program, where, at least initially, MLTSS contractors are only required to accept risk for Medicaid personal care services. Over time, the state expects MLTSS contractors to gradually assume risk for a greater share of the total Medicaid (and eventually Medicare) benefit package. Just as managed care entities are being allowed the opportunity to become care managers of LTSS populations, LTSS providers could be allowed the opportunity to assume the responsibilities of a managed care entity.

7. **States could encourage/require MLTSS contractors to use uniform billing practices for LTSS, to the extent possible.** States should work with their MLTSS contractors to develop claim forms and billing practices that are uniform across all contractors. Claim forms should be specifically structured for LTSS services, and not simply variants of claim forms used for

medically-oriented services. To the extent possible, claim forms used for billing LTSS services in MLTSS programs should align closely with claim forms used for billing LTSS services in the FFS system.

8. **States could be encouraged to make technical support available to small LTSS providers in negotiations with MLTSS contractors.** States should adopt practices which promote the continued participation of small, local LTSS providers in MLTSS programs. For example, a 56-year widow who operates an adult foster care program for three clients could be provided technical support from a business consultant to assist her in negotiations with the managed care entity in which her clients are enrolled.

9. **MLTSS contractors could be encouraged/required to have an LTSS specialist in their Provider Relations departments.** There should be at least one person in the MLTSS contractor organization who specializes in issues related to LTSS providers. The MLTSS contractor should make its LTSS provider network aware of this person (or persons, in larger programs) as the single point of contact for any question/issue LTSS providers may have.

Appendix 1
Interview Respondents

1. Peter Pierri, Executive Director
   InterAgency Council of Developmental Disabilities Agencies,Inc.
   150 West 30th Street, 15th Floor
   New York, NY 10001

2. Ann M. Hardiman, Executive Director
   New York State Association of
   Community and Residential Agencies
   240 Washington Avenue Ext., Suite 501
   Albany, New York 12203

3. Rick Surpin, President
   Independence Care System
   257 Park Avenue South, 2nd Floor
   New York, New York 10010 - 7304

4. Kathy Eskra, Former Vice President, Medicaid Long-Term Care
   Aetna Medicaid
   3218 E. Maldonado Dr.
   Phoenix, AZ 85042

5. Bruce E. Darling, Executive Director
   Center For Disability Rights, Inc. (CDR)
   497 State St
   Rochester NY 14608

6. Barbara Merrill, Vice President of Public Policy
   and
   Diane McComb
   State Association Executives Forum Liaison
   American Network of Community Options and Resources
   1101 King St., Suite 380
   Alexandria, VA 22314-2944

7. James D. Toews, Senior Policy Advisor
   Administration for Community Living
   U.S. Department of Health and Human Services
   200 Independence Ave.. S.W.
   Washington, DC 20201

8. John Wren, Deputy Assistant Secretary for Disability and Aging Policy

Administration on Community Living
1 Massachusetts Avenue, 4th floor
Washington, DC 20201

9. Sandy Markwood, Chief Executive Officer
   and
   Amy Gotwals
   Director of Public Policy and Advocacy
   National Association of Area Agencies on Aging (n4a)
   1730 Rhode Island Avenue, NW, Suite 1200
   Washington, DC 20036

10. Rosanne Mahaney, Director
    and
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    Division of Medicaid & Medical Assistance
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11. Cindy Adams, Chief Operating Officer
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12. Pat Kelleher, Executive Director
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