States have long used Medicaid managed care to deliver services to children, families, and pregnant women while beneficiaries with complex needs, such as the seriously mentally ill, aged, and disabled remained in traditional fee-for-service (FFS). Increasingly, states are transforming the payment and delivery of Long-Term Services and Supports (LTSS) by shifting to Managed Long Term Services and Supports (MLTSS) models. Over the past ten years, the number of states offering MLTSS programs doubled, from eight in 2004 to nineteen in 2014 and several other states have proposals either under development or awaiting CMS approval. Five states (AZ, KS, MI, RI, and WI) with operational MLTSS programs include individuals with intellectual/developmental disabilities (ID/DD).  

As states continue to expand the use of managed care for their Medicaid programs, persons with ID/DD are a group being considered for participation. However, state managed care experience has typically included only children and healthy adult populations; lack of familiarity with LTSS and the ID/DD populations may result in compromised access to and quality of care for a large number of beneficiaries.

There is a widely held view that providing coverage through a managed care model may lead to improved coordination and cost savings through reductions in utilization. However, research on the effects of managed care on reducing costs and improving outcomes is limited, and the few evaluations conducted to date indicate that results are mixed. Available literature and state experience to date suggest that there are several key issues that must be addressed as managed care increases in popularity and scope. Several of these challenges are highlighted below.

- **Uncertainty Concerning Effect on Quality and Outcomes:** Most of the data available to researchers emphasizes process measures rather than outcome measures, making it difficult to adequately measure the impact of Medicaid managed care on beneficiary outcomes. In addition, quality measures can vary across states and plans, creating challenges in comparing quality across plans and evaluating difference in quality between managed care and FFS.

- **Lack of Adequate State and Plan Readiness Review Procedures:** Many MCOs have little or no experience with Medicaid managed care, particularly with ID/DD populations. Although states require plans to meet certain criteria to ensure beneficiary needs are met, there is limited information about the state’s processes for verification and validation of plan attestation. One state official advised other states to “look at everything and trust no one... not the providers, not the MCOs, not the subcontractors. You have to verify everything.”

- **Unclear Beneficiary Resources for MLTSS Education:** The transition to managed care creates uncertainty, confusion, and concern for many beneficiaries, and can be especially challenging for individuals with low health literacy and/or ID/DD.

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2 Musumeci, MaryBeth, Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers. November 14, 2014.
3 Id.
4 Sparer M. Medicaid Managed Care: Costs, Access, and Quality of Care. Robert Wood Johnson Foundation. September 2012
6 Sparer M. Medicaid Managed Care: Costs, Access, and Quality of Care. Robert Wood Johnson Foundation. September 2012
Unnecessary Prior Authorization Requirements and Challenging Independent Grievance and Appeals: MCOs may employ utilization management tools and other protocols in making coverage determinations which may inappropriately emphasize cost rather than quality of care. Beneficiaries and providers must have sufficient avenues to appeal decisions made by an MCO and to file complaints about issues or concerns with an MCO’s operations. These processes should also take into account physical, and intellectual/developmental barriers to ensure individuals and/or caregivers are aware of beneficiary rights.

Barriers to Access: MCOs often experience difficulty recruiting providers willing to accept lower rates. According to a Kaiser Family Foundation survey, over two-thirds of managed care states reported that beneficiary access to specialists is a challenge, which is particularly problematic for the needs of the ID/DD population. Advocates for ID/DD populations have publicly voiced concern about barriers to needed services resulting from shifts to MLTSS.

Coordination of Care: MCOs vary significantly in their approaches to designing and implementing care coordination models which can create confusion for providers attempting to adhere to care coordination requirements for multiple organizations. In addition, case managers play a critical role in ensuring that individuals with ID/DD receive the full range of services and supports needed. Under managed care arrangements, case managers have an incentive to limit the scope and level of services to contain costs, which may create a conflict of interest.

Mixed Medicaid Budgetary Research Findings: Researchers have found that state Medicaid managed care initiatives have no effect on overall Medicaid spending. States with more generous Medicaid reimbursement prior to MLTSS implementation realized greater cost savings, primarily due to reductions in provider reimbursement rates rather than managed care plan practices. In addition, the administrative costs of contracting with MCOs can be significant. In 2012, Connecticut officials determined that the administrative costs outweighed quality improvements and ended contracts with MCOs in order to reallocate those funds to increase primary care provider payments and other care improvement initiatives.

Need for Stakeholder Engagement and Transparency: The level of collaboration among state officials and other stakeholders vary significantly across states. Beneficiaries, providers and other stakeholders must have sufficient opportunity to prepare and respond to a state’s decision to develop and/or modify an existing MLTSS program. Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and home and community based (HCB) waiver group homes must be among the stakeholder groups consulted in the event a state considers expanding and/or implementing managed care for the ID/DD populations.

Increased Administrative Complexity: Lack of uniformity in plan policies and standards creates administrative burden for both providers and beneficiaries, which can result in delays in beneficiary care and provider reimbursement.

As states continue to transition, it is critical to ensure that states and plans are equipped and able to provide high quality and cost-effective care for complex patients with varying needs. Limited plan data, inconclusive literature, and challenges faced by states implementing MLTSS programs to date suggests that additional evidence is needed before policymakers, states, and plans consider implementing MLTSS programs that incorporate ID/DD populations.

AHCA is asking Members of Congress to make oversight of managed care programs a priority to ensure that the Medicaid program’s most vulnerable beneficiaries have access to high quality health care.

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For more information, contact Kim Zimmerman at kzimmerman@ahca.org or Mike Cheek at mcheek@ahca.org.