

Summary of Long Term Care Services and Support Delivery Models

Long Term Care Supports and Services (LTCSS) can be done in a capitated environment or a fee-for-service environment.

Fee-for-Service LTCSS Model

Pennsylvania currently utilizes a fee-for-service environment for most LTCSS consumers. In this environment, nursing home residents generally receive case management/care coordination services from the nursing home. Home and community based services consumers (HCBS) receive case management/care coordination services arranged through service coordination agencies. HCBS consumers generally only receive case management/care coordination for Medicaid or lottery funded programs and there is minimal coordination with Medicare services. Medicaid services for HCBS consumers are obtained through both the Medicaid State Plan and the Medicaid Waiver Programs.

Capitated Managed LTCSS Models

In a capitated model, a managed care company receives a set dollar amount per member per month to cover the agreed upon services. Some states capitate all long-term care services while other states may exclude services such as nursing home services or behavioral health services. In addition, some states may exclude long-term nursing homes stays (e.g. over 30 or 60 days). Capitated managed care can be done solely for Medicaid eligible only services or dually eligible Medicare and Medicaid services.

States contracting for managed care have several contracting vehicles:

Medicaid Managed LTCSS – States contract with managed care plans solely for Medicaid long-term care services on a capitated basis. This approach creates an incentive for the plans to provide the LTCSS in a cost effective setting and provides predictability for state expenditures. Since acute care services are not included in the capitated services, managed care plans may not be involved in hospital discharge planning or seeking Medicare data to facilitate transitions.

Program for All Inclusive Care for the Elders (PACE) – Pennsylvania's PACE program is called Living Independently for the Elderly (LIFE). LIFE is a provider-based model, which integrates Medicare and Medicaid funding, uses an adult day center model, and incorporates an inter-disciplinary care management team.

Special Needs Plans (SNP) Wrap – SNP is a special type of Medicare Advantage managed care plan. A state could contract with an existing SNP that serves individuals who are eligible for both Medicare and Medicaid. The SNP receives a capitation payment directly from Medicare for acute care services and a capitation payment from Medicaid for long term care supports and services.

Financial Alignment Model

CMS has been working with states on a model that seeks to combine Medicaid and Medicare funding streams and reduce some of the misalignment where states currently receive no financial benefits when their initiatives save Medicare money. There is a capitated and fee-for-service financial alignment model. A state can choose to do one or both of the models. In most cases, the financial alignment models integrate primary, acute, behavioral health, and LTCSS services.

- The capitated financial alignment model is a three way contract between CMS, the state, and a managed care plan. The plan receives a capitation rate from Medicare for acute care services and a Medicaid capitation rate for LTCSS and other Medicaid services. The plan is responsible for all services. This model integrates the funding, reduces administrative and member complexities of two regulatory requirements, provides budget predictability for states and provides the state an opportunity to benefit from Medicare savings.

The managed fee-for-service financial alignment model is an agreement between the state and CMS whereby the state can receive savings from initiatives designed to reduce Medicare and Medicaid costs. In this model, providers still receive fee-for-service payments from both Medicare and Medicaid. The state could choose to take on the care management function or choose to contract with a care management entity. The state is financially responsible for operational costs and reimbursement for Medicaid services. While this model doesn't integrate the funding, it does establish one entity with the responsibility for coordinating all services which may result in savings that are shared with the state.

Other Models – CMS is also reviewing other models that integrate Medicare and Medicaid financing through other Medicare and Medicaid waiver authorities.