Unlocking the Value of Enabling Technology in Managed LTSS

Streamlining Funding Pathways

Challenges

- Independence may be facilitated by person-centered interventions, including assistive and enabling technologies, provided by MLTSS plans. Unfortunately, the funding structure in MLTSS is often tied to the volume of services provided, instead of the outcomes achieved. Successful adoption and provision of ET is contingent upon a transformation of how plans and providers are currently incentivized. This means ensuring solid value-based reimbursement models are implemented that reward providers and plans for improving member outcomes and decreasing costs.
- Existing State contracts often do not contain clear funding mechanisms or processes (no common service codes, billing units, common rates, caps, etc.) to adequately offer and pay for assistive and enabling technologies, which leads to administrative barriers for MLTSS plans and partner organizations. Many States and health plans require a denial in order to access specialized medical supplies, which then allows access to some technology.
- Cost shifting between Medicaid and Medicare for dually eligible members continues to be problematic.
- For dually eligible individuals, ET will largely be paid for under their Medicaid coverage. However, ET may lead to decreases in members' acute care costs, leading to cost savings for Medicare that are not necessarily attributed back proportionately to Medicaid.
- Providers also expressed difficulties obtaining ET coverage for dually eligible members if they are initially denied under a member's Medicare coverage. Creating synergies between these two programs could lead to reduced administrative burden for both plans and providers.

Federal Recommendations

- MACPAC should establish a policy/research initiative focused on effective financing models for ET, with an emphasis on creating adequate rates and effectively incentivizing providers to adopt ET and shift their focus to delivering outcomes, as opposed to solely relying on a fee-for-service model. The focus of this research initiative would be to analyze and propose funding structures for ET, specify basic minimum areas of ET for dual-eligible special needs plans (DSNPs), and outline potential models for shared savings across payers (i.e., how to attribute savings to both Medicaid and Medicare for dually eligible members).

- CMS should promulgate guidance regarding available coverage mechanisms for ET.

State Recommendations

- States should create requirements that specify that if an ET is denied under Medicare for a dually eligible individual, the claim automatically flows to the member's Medicaid coverage for review/approval. Additionally, if there are benefits that cannot be covered under an individual's Medicare coverage, States should not require that the claim flow through an individual's Medicare coverage and instead allow it to go directly to Medicaid.
- State Medicaid Agencies and HCBS sub-operational entities should engage in cooperative agreements with other publicly-financed systems (education, vocational rehabilitation, workforce development, housing, transportation, and others) to leverage resources and incentivize MCOs to work with these other systems to expand ET offerings for LTSS populations.
- States should issue clear guidance to MCOs and providers that outline clear policies for the coverage and payment of specific ET interventions, as well as to support the design of a value-based reimbursement model for ET and the core data elements needed to consider expansion, scalability and sustainability of a Value-Based Reimbursement (VBR) model over the long-term.
- States should promote and invest in the creation of financial pathways and flexibilities that help plans and providers make upfront investments in the infrastructure necessary to operationalize new categories of ET. Additionally, plans must be allowed to implement payment methodologies that temporarily offset decreased provider reimbursement resulting from introducing technological supports and reducing in-person care. Such flexibility is needed to sustain provider stabilization, particularly in service areas where provider network adequacy is a challenge.
- States should clarify the coverage, payment, and data collection/evaluation requirements for ET within State Medicaid programs during the contracting process with State regulatory agencies.

Plan Recommendations

We recommend plans use the contracting process, as well as contractual flexibilities (value-added benefits, in-lieu of services, and options for innovation within existing waiver services), to achieve the following:

- Garner buy-in and support from State Medicaid authorities to allow plans to work with providers to leverage other public funds – including, but not limited to, education, housing, transportation, vocational rehabilitation, and workforce development – to ensure optimal financing of technological solutions in support of LTSS participants' individualized needs and goals.
- Create processes for providers with innovative value-based reimbursement strategies to bring their ideas and proposals to the plan for consideration, review, and potential partnership support.

- Provide financial incentives for HCBS providers to invest in the education and skills of direct care workers and front-line supervisors for exposing, informing, educating, providing, and evaluating various categories of ET and new technological innovations coming to the HCBS market.

Provider Recommendations

To remain competitive in the next phase of MLTSS provision, both technology vendors and providers will need to adapt to ever-changing market dynamics, fiscal constraints, and heightened expectations from stakeholders. Technology vendors and providers should work to improve access to technological tools that can directly improve the health and quality of life outcomes for LTSS participants. We recommend that providers and vendors consider the following strategies to strengthen the successful provision and uptake of ET:

- Complete all ET-related training and certification required by the State regulatory authority or plan.
- Participate regularly in person-centered planning processes (if/when appropriate) and provide feedback to HCBS consumers' case managers and service coordinators regarding observed needs and potential technological tools that could address such needs.
- Engage with plan market representatives early and often regarding any interest in piloting or introducing new technological innovations to HCBS clients to ensure a seamless partnership and approval process with respect to pilot design, reimbursement, and evaluation.
- Cultivate partnerships between providers and vendors to collaborate on ET initiatives with health plans to maximize the impact of ET uptake, utilization, data collection, and evaluation.