



Putting Consumers First: Promising Practices for Medicaid Managed Long-Term Services and Supports: Executive Summary

Background

Across the country, states are pursuing a major shift in the delivery of long-term supports and services (LTSS) for consumers in Medicaid who are living with chronic illnesses and disabilities. By 2014, as many as half of states will have shifted from fee-for-service models of LTSS to relying on Medicaid managed care organizations (MCOs) for some or all of LTSS, up from the 16 states that rely at least in part on MCOs for LTSS today.¹

LTSS, sometimes also called long-term care, include everything from nursing home care to community based supports such as help with chores, personal care, transportation and maintaining a home. These services are essential to help seniors and people with disabilities live with dignity and as much independence and community participation as possible.

At its best, managed care could reduce fragmentation of care, expand access to community based services and increase the quality and efficiency of services. But there are significant risks for consumers if states or MCOs use managed care to cut services, squeeze out community providers or medicalize support services. Consumers using LTSS are among the sickest and most vulnerable. In some of the 16 states now running Medicaid managed LTSS programs, access to home and community based care has increased and avoidable use of hospitals and nursing homes has decreased. However, these improvements have not been consistent.² Similarly, cost savings have been elusive, with studies of just two states showing overall savings.³ The programs vary greatly in size – from just dozens of participants in some states to hundreds of thousands in others. No one state offers a model of success in all areas.

To help ensure better results for consumers, this brief offers guidance based on lessons from the 16 states that now manage Medicaid LTSS and advice from LTSS consumers and other experts.

Promising Practices

Designing the program

Adequate planning: A phased approach with extensive input from stakeholders and clear goals will produce the best results. The federal Centers for Medicare & Medicaid Services (CMS) recommends a two-year planning process at a minimum.⁴ **Tennessee** took three years, securing stakeholder buy-in first, and then working with health plans for the better part of a year to ensure all systems were ready and that there were enough providers.⁵ A key focus of planning should be ensuring LTSS is person-centered – focused on individual goals and needs. Other critical issues include availability of skilled community providers and MCOs' ability to take on this business.

Consumer engagement in planning, governance and monitoring: States should directly engage consumer advocates in planning, should establish oversight committees with at least 50 percent consumer representation and should gather additional consumer input through focus groups, surveys and quarterly stakeholder meetings in each region of the state. States should require MCOs to include at least 25 percent consumer representation on their governing boards or to establish regional consumer advisory committees that reflect the diversity of the population to be served. Plans should also conduct community meetings. All methods of consumer engagement should be accessible to people with disabilities and culturally and linguistically competent. **Wisconsin** requires one-quarter of the board of each MCO be members or their advocates. Contracts or regulations in **Arizona, Massachusetts, New Mexico, New York and Tennessee** require MCOs to establish member councils or include consumers on advisory committees.⁶ States and plans should provide staff support and stipends for time and transportation to help consumers and advocates participate.

Integration of LTSS with acute and behavioral health care: States should manage LTSS in conjunction with acute and behavioral care, either by folding them into one system, as **Arizona, Massachusetts and Tennessee** do,⁷ or by requiring LTSS plans to coordinate with other programs and services, as **New York** does.

Voluntary enrollment: Making plans attractive enough to draw consumers voluntarily is a good way to ensure consumer needs are being met and quality is high. **Minnesota's** Senior Health Options program has demonstrated voluntary enrollment can work at a statewide scale for seniors, enrolling 36,000 (about two thirds of those eligible);⁸ advocates report relatively few systemic consumer complaints. Seven of 16 states use voluntary enrollment,⁹ but in all but **Minnesota and Wisconsin** consumers are automatically enrolled unless they opt out (passively enrolled). The remaining nine states mandate enrollment. In states where enrollment is mandatory, federal rules require states to give consumers a choice of at least two plans. To educate consumers on their choice of plans and providers, states should use organizations consumers trust, such as Aging and Disability Resource Centers, Independent Living Centers, Area Agencies on Aging, and Recovery Learning Communities.

Broad range of LTSS: Programs should cover all LTSS services included in Medicaid state plans, all LTSS waiver services, and other supports, such as home modifications, needed to enable people to live in the community. Programs in **Massachusetts, Arizona, Hawaii and Tennessee** follow this model.¹⁰ Since as many as half of those getting LTSS in some states have behavioral health needs, peer support and recovery services should be part of the network. There should be no waiting lists or caps on services.

Robust provider network ensuring continuity of care: A diverse and robust network of providers who are culturally and linguistically competent, accessible for people with disabilities, and experienced in providing LTSS is essential. **Arizona, Texas and Tennessee** use “secret shoppers” to monitor network adequacy.¹¹ To protect continuity of care for people transferring into managed care, states should require plans to enroll current providers, as **Texas** did for the first three years of managed LTSS.¹² Consumers should also be permitted to continue seeing

providers for at least a year, even if those providers don't join the new plans, as **California and Ohio** have proposed for their new programs.¹³

Running the program

Preference for home and community based services: Caring for people in the least restrictive setting – often their home – is federal law, and should be an explicit priority in managed LTSS contracts. To help reduce unnecessary use of nursing homes, states should use payment methods that incentivize community based care. Examples include paying plans the same rate whether a person with the same level of need is served in a nursing home or in the community, as many states, including **Arizona, Hawaii, New Mexico, and Tennessee** do; setting a rate that assumes a reduction in nursing home use, as **Arizona and Tennessee** do; and letting the MCO keep some savings resulting from reduced use of nursing homes, as many states do.¹⁴

Conflict-free assessment focused on consumer goals: Once consumers choose a managed LTSS plan, their needs and preferences should be comprehensively assessed within 30 days by someone knowledgeable about LTSS who will not benefit from the decisions made. The assessment should be standardized statewide. It should include illnesses, physical and mental functional status, quality of life goals, and personal preferences, as **Washington** does.¹⁵ It should lead to an individualized service plan.

Care coordination: Each consumer should have a choice among independent, conflict-free care coordinators experienced in working with seniors and people with disabilities but who are not providers, nor employees of the MCO. **Massachusetts**, in its duals demonstration project, plans to use an independent living and LTSS coordinator as part of the interdisciplinary care team that will oversee all acute, behavioral and long-term services.¹⁶ Care teams, including the LTSS coordinators, should have the power to authorize LTSS without prior approval from the MCO so they can quickly head off problems that could lead to avoidable hospitalization or nursing home use. **Texas** empowers coordinators to do this in its Star+Plus integrated system.¹⁷

Consumer-directed services and support for family caregiving: Consumers should have the option of directing their own personal care services, including hiring and firing personal care workers, as 12 of the 16 states do.¹⁸ Plans should train interested consumers in how to direct their own care workers. At the consumer's request, family members should be trained and paid to be personal care workers, as is the case in **Arizona, Hawaii and Tennessee**, among others.¹⁹

Monitoring the program

Quality measures: States should incorporate LTSS-specific performance measures into MCO contracts and tie payments to quality through incentives or penalties. Measures need to incorporate the different needs and goals of people with physical and mental disabilities at various stages of life. Work to devise national standards is underway both inside and outside the government. In the meantime, states should at least track preventable hospitalizations and nursing home placements, grievances, trends in services denied, and disparities in care and outcomes by race, ethnicity and disability. They should also survey consumers about whether their goals are being met. **Wisconsin** uses a very comprehensive survey called [PEONIES](#).²⁰

Other consumer protections and oversight: States should hire independent ombudsmen with extensive knowledge of LTSS or train federally required long-term care ombudsmen, who now focus on care in nursing homes, to take on this broader role. **Wisconsin and Hawaii** both contract with non-profit advocacy organizations to serve as ombudsmen for their managed care programs, providing individual assistance and flagging systemic problems.²¹ States should run simple, accessible systems for resolving consumer disputes with managed care plans, continue services while any dispute is pending, and enforce compliance with contracts and with federal laws protecting people with disabilities. Finally, transparency is imperative. **Minnesota** makes all MCO contracts public and requires plans to publicly report on their finances, reserves, provider rates and patient outcomes.²²

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The complete report can be found online here:

http://www.communitycatalyst.org/doc_store/publications/putting_consumers_first_LTSSmanagedcare.pdf

¹ Saucier, Paul et al. [The Growth of Managed Long-Term Services and Supports \(MLTSS\) Programs: A 2012 Update](#). Truven Health Analytics and CMS. July 2012.

² Saucier, Paul. [Managed Long Term Services and Supports presentation](#). National Health Policy Forum. May 2012.

³ Saucier, July 2012.

⁴ <http://www.medicaid.gov/mltss/index.html>

⁵ Lind, Alice et al. [Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services](#). Center for Health Care Strategies. November 2010.

⁶ Saucier, July 2012.

⁷ Lipson, Debra J. et al. [Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports](#). AARP Public Policy Institute. July 2012.

⁸ [Redesigning Integrated Medicare and Medicaid Financing and Service Delivery for People with Dual Eligibility in Minnesota](#). Minnesota Department of Human Services. April 2012.

⁹ Saucier, July 2012.

¹⁰ Lind, 2010.

¹¹ Lipson, Debra J. et al. [Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports](#). AARP Public Policy Institute. July 2012; Conversation with Thomas J. Betlach, director, Arizona Health Care Cost Containment System. October 2012.

¹² Summer, Laura. [Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider](#). Kaiser Commission on Medicaid and the Uninsured. October 2011.

¹³ [California Proposal for Demonstration to Integrate Care for Dual Eligibles; Ohio Proposal for Demonstration to Integrate Care for Medicare-Medicaid Enrollees](#)

¹⁴ Saucier, July 2012, and Lipson, 2012. Gore, Suzanne and Julie Klebonis. [Medicaid Rate-Setting Strategies to Promote Home and Community Based Services](#). Center for Health Care Strategies. May 2012.

¹⁵ [Washington Comprehensive Assessment Reporting Evaluation](#)

¹⁶ [Memorandum of Understanding between CMS and Massachusetts](#). August 2012. And [Chapter 224](#) of the Acts of 2012, An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation.

¹⁷ Lind, 2010; [Texas Star+Plus contract](#).

¹⁸ Saucier, July 2012.

¹⁹ Lind, 2010.

²⁰ <http://chsra.wisc.edu/peonies/>

²¹ [Hawaii QUEST Expanded Section 1115 Draft Annual Report](#). April 3, 2012; [Wisconsin Family Care and IRIS Ombudsman Program](#) and interview with ombudsman.

²² <http://mn.gov/governor/multimedia/pdf/Executive-Order-11-06.pdf>