

CONSUMER EXPERIENCE IN MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS) PROGRAMS

This paper has been prepared by Mercer in response to a request from the North Carolina DHHS Division of Health Benefits for assistance in describing key considerations and lessons learned about the consumer experience in states that have implemented MLTSS programs. Mercer drew from a review of a sample of available literature, as well as our own experience working with states that have implemented MLTSS programs to gather other consumer, state, and stakeholder observations. The issues raised in this paper do not represent an all-inclusive list of considerations, as each state's policy and program design decisions may be different and have the potential to influence the consumer experience.

What do consumers say about their experiences with MLTSS programs?

In fiscal years 2014 and 2015, the National Council on Disability (NCD) hosted stakeholder forums in 10 states (California, Florida, Georgia, Illinois, Kansas, Louisiana, New York, Pennsylvania, Texas, and Wisconsin) to promote greater dialogue between the Centers for Medicare & Medicaid Services and the disability community regarding Medicaid managed care waiver applications and dual eligibles demonstration proposals¹. The information gathered in these forums was released in the March 2016 NCD "Medicaid Managed Care Community Forums: Final Report," one of the most comprehensive reports to summarize feedback directly from consumers. The NCD included the following goals for these consumer forums²:

- Facilitate input based on experiences, preferences, and desired outcomes for Medicaid managed care among disability leadership, federal, and state agency representatives, health plans, providers, and consumers
- Assess consumer satisfaction and perspectives on what seems to be working
- Identify early challenges and gaps in care occurring under new delivery systems

The NCD consumer forums highlighted universal themes regarding managed care, including MLTSS and dual eligible demonstrations, that have been summarized below³:

1. *Access to Health Care and LTSS*. Stakeholders expressed concerns that policymakers have assumed people continue to receive their necessary services during the transition to MLTSS programs, but this may not be universally true and requires careful monitoring during the transition process.

¹ NCD, "Medicaid Managed Care Community Forums: Final Report" Executive Summary
<http://www.ncd.gov/publications/2016/medicaid-managed-care-community-forums-final-report>

² NCD, "Medicaid Managed Care Community Forums: Final Report" Executive Summary
<http://www.ncd.gov/publications/2016/medicaid-managed-care-community-forums-final-report>

³ NCD, "Medicaid Managed Care Community Forums: Final Report" Chapter 2
<http://www.ncd.gov/publications/2016/medicaid-managed-care-community-forums-final-report>

2. *Stakeholder Engagement.* Stakeholders, including consumers, voiced concerns about their lack of opportunities for continuous involvement in MLTSS forums that impact program design and implementation.
3. *Authorizations, Grievances, and Appeals Processes.* Stakeholders expressed concerns about whether the grievances and appeals process was being administered as required by law and about extended lengths of time for authorizations.
4. *Network Adequacy.* Stakeholders, including consumers, expressed concerns about inadequate provider directories and their inability to find providers.
5. *Americans with Disabilities Act (ADA) Compliance by MLTSS Plans and Providers.* Stakeholders, including consumers, reported MLTSS plans are frequently out of compliance with ADA requirements.
6. *General Lack of Managed Care Plan Understanding of the Complex Individual Needs of People in the LTSS System.* Last, but certainly not least, stakeholders expressed concern that, while the number of plans with LTSS experience is growing, plans may lack the competencies necessary to serve LTSS enrollees.

Stakeholders also raised other issues including (but not limited to) the strong preference for an independent MLTSS ombudsman, the need for culturally appropriate access to care, the need for transparency and accountability for MLTSS expenditures (e.g., a medical loss ratio requirement), concerns about “carve out” service arrangements, a lack of information about the impact of MLTSS programs nationally on “rebalancing” HCBS and institutional care, and the degree to which MLTSS programs include community-based providers⁴. It is important to note the NCD report does not appear to focus on “what is working” in MLTSS, so there are experiences (such as improved care coordination, additional services, improved outcomes) that are not reflected in these observations but may be reported by consumers or other stakeholders, including MLTSS plans.

What have states learned about consumer experiences when transitioning to MLTSS?

Similar to the NCD report, Mercer has identified key themes based on state experiences implementing MLTSS programs, regardless of the approach to MLTSS program design taken in an individual state. (Mercer’s research includes information from some of the same states in the NCD report, including California, Florida, New York, and Wisconsin and also includes experience from the additional states of Delaware, Illinois, New Jersey, and Ohio.)

The authority and design of these programs vary by state. For example, some of the states discussed below have implemented MLTSS under the CMS dual eligible demonstration authority

⁴ NCD, “Medicaid Managed Care Community Forums: Final Report” Chapter 2
<http://www.ncd.gov/publications/2016/medicaid-managed-care-community-forums-final-report>

while others have used Medicaid-only authorities. Some states, such as Delaware and New Jersey, contracted with their existing managed care organizations (MCOs) while others, such as Florida, separately procured managed long-term care plans. Some of the states below have relatively few “carved-out” services (e.g., non-emergency medical transportation) in their MLTSS programs while others maintained important services such as behavioral health in separate delivery models that then required coordination at the consumer level. Despite these differences in model design, there are a number of common themes from the perspective of the consumer experience these states share.

1. *Consumer Stakeholder Engagement.* The foundation for a positive consumer experience with MLTSS is the state’s commitment to consumer stakeholder engagement—starting with initial planning, but continuing through implementation, ongoing program operation, and evaluation. Testing concepts with consumers (including families and other supports) and obtaining stakeholder workgroup input has shown to improve the communication process with consumers.⁵ In California’s capitated dual eligible demonstration, dedicated communication workgroups composed of LTSS providers, health plan representatives, consumer advocates, among others, were established to identify beneficiary groups for stakeholder input, as well as appropriate means of communication.⁶ An initial assessment of New Jersey’s MLTSS implementation which included a robust stakeholder input process noted “disparities among stakeholders combined with resource constraints make it challenging to design processes in which all voices can be heard, as some stakeholders are greater in number or have more resources than others.”⁷ This echoes some of the stakeholder engagement challenges for consumers noted in the NCD report.
2. *Provider Engagement and Education to Benefit Consumers.* States identified active provider engagement and education as important to the consumer experience because the provider is often the first and most significant link between the consumer and the MLTSS plan. Some LTSS providers have limited experience with managed care, and their understanding, cooperation, and consumer interaction is helpful for cohesive MLTSS implementation. In Ohio’s dual eligible demonstration pre-implementation work, dedicated nursing facility forums were formed to educate providers and to discuss operational and programmatic issues.⁸ This approach ultimately benefits the consumers, as well as providers.
3. *Reasonable Implementation Timeline.* Adequate implementation lead time is necessary to work out knowledge gaps with consumers (including families and other supports), managed

⁵ Justice in Aging, “The Duals Demonstration: A First Glimpse at Lessons Learned,” http://www.justiceinaging.org/wp-content/uploads/2016/03/FINALthe-Duals-Demonstration_A-First-Glimpse-of-Lessons-Learned-002.pdf

⁶ Justice in Aging, “The Duals Demonstration: A First Glimpse at Lessons Learned,” http://www.justiceinaging.org/wp-content/uploads/2016/03/FINALthe-Duals-Demonstration_A-First-Glimpse-of-Lessons-Learned-002.pdf

⁷ Rutgers’s Center for State Health Policy, “Initial Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports,” <http://www.cshp.rutgers.edu/Downloads/10740.pdf>

⁸ “Association for Community Affiliated Plans “ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations,” <http://www.chcs.org/media/ACAP-Medicare-Medicaid-Plans-and-the-Financial-Alignment-Demonstrations.pdf>

care plans, and providers. When a plan and providers are ill-prepared to deliver benefits, the negative consequences for consumers can be significant. In Medicaid MLTSS program implementation, stakeholders were often concerned about insufficient time for consumers and providers to adapt to the new care systems.⁹ In capitated dual eligible demonstrations, health plans reported limited experience delivering LTSS benefits to dual eligibles and needed assistance from plans in other states on operational and contracting issues.¹⁰ LTSS providers also reported limited experience working with managed care plans.¹¹ In Delaware, the State opted to contract with its existing MCOs for MLTSS in order to focus the implementation timeline activities (14 months) on the knowledge gaps and a thorough readiness review process, rather than an additional procurement.

4. *Enrollment Communication.* For Medicaid MLTSS, states have the option to offer voluntary (opt-in or “passive” opt-out enrollment) or mandatory enrollment into capitated Medicaid plans. Regardless of the approach selected, consumer outreach activities and choice counseling around enrollment options is a major focus. (This is now also part of the expectations for a beneficiary support system under the new Medicaid managed care rules.) Florida, for example, implemented an intensive choice counseling function for initial rollout of its MLTC program, including visits to nursing facilities around the state.

States that opt for voluntary enrollment should expect additional challenges associated with explaining this option. States with capitated dual eligible demonstration states reported that passive enrollment created communication challenges, such as different notices from different entities which were often overlapping and conflicting. Because passive enrollment includes more variables that must be communicated to consumers, consumers may find the volume of information and options complicated and confusing.¹²

5. *Transition Plan to Minimize Care Disruptions.* Transitioning from fee-for-service (FFS) to a capitated model may cause care disruptions and states typically use various types of service protections to help consumers and providers transition to managed care. State transition plans have included: staggered implementation, both regionally and in terms of benefit changes; required payment of FFS rates for a set period of time; continuation of current care plans for certain periods; and network protections including required use of current HCBS providers for specified time periods (e.g., 90 or 120 days). When Wisconsin implemented its MLTSS program, it required its managed care plans to contract with the consumer’s choice of personal care provider, so long as that provider accepted the rates and met the plan’s

⁹ Mathematica, “Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States,” <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-managed-long-term-services-and-supports-themes-from-site-visits-to-five-states>

¹⁰ Justice in Aging, “The Duals Demonstration: A First Glimpse at Lessons Learned,” http://www.justiceinaging.org/wp-content/uploads/2016/03/FINALthe-Duals-Demonstration_A-First-Glimpse-of-Lessons-Learned-002.pdf

¹¹ Justice in Aging, “The Duals Demonstration: A First Glimpse at Lessons Learned,” http://www.justiceinaging.org/wp-content/uploads/2016/03/FINALthe-Duals-Demonstration_A-First-Glimpse-of-Lessons-Learned-002.pdf

¹² Justice in Aging, “The Duals Demonstration: A First Glimpse at Lessons Learned,” http://www.justiceinaging.org/wp-content/uploads/2016/03/FINALthe-Duals-Demonstration_A-First-Glimpse-of-Lessons-Learned-002.pdf

requirements. In many states, including Delaware, Florida, Illinois, New Jersey, and New York, consumers who were transitioning from FFS to managed care were guaranteed previously authorized services for a set amount of time.¹³

6. *Enhanced Consumer Protections.* Many states have included additional consumer supports and protections in the creation of MLTSS and ombudsman programs as one example. Ombudsman programs for MLTSS programs help consumers navigate and access services and assist with issues. In some states, the ombudsman may play a key role the appeals and grievance process. In Hawaii, the ombudsman may be a member of the care team at the beneficiary's request and, in other states, the ombudsman may train plan and provider staff and assist with ensuring services are delivered in a culturally competent manner.¹⁴ An ombudsman may be particularly beneficial during the initial year or two of a new MLTSS program.
7. *Dedicated Planning to Consumer-Directed Services and Supports.* Seamless transition of these services and supports takes additional planning and consideration of how MLTSS can further state and consumer goals for consumer-directed services. Delaware, with a single self-directed service, opted to delegate responsibility to the MCOs and required the MCOs to contract for the financial management support services. New Jersey, with its long-standing Personal Preference Program, spent months working through the MLTSS considerations and opted to share certain responsibilities with the MCOs but maintain a lead state role and the direct contract with a financial management services vendor. When Florida designed its MLTC program, it expanded access to its consumer-directed program and required all MCOs to offer the new Participant-Directed Option.
8. *Connection to Social and Community Supports.* Linking MLTSS consumers with social and community supports may have a direct impact on the consumer experience. MLTSS model designs sometimes incorporate a comprehensive standardized assessment tool that not only measures a consumer's LTSS needs, but other health and social needs including behavioral health and community supports.¹⁵ In Rhode Island's MLTSS care management model, a multidisciplinary team is dedicated to pairing consumers with necessary community supports and care managers help identify and address barriers for consumers living in their homes. Both functions have improved consumer health outcomes and have reduced emergency department visits.¹⁶ Delaware reassessed its service package as part of MLTSS planning and

¹³ Mathematica, "Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States," <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-managed-long-term-services-and-supports-themes-from-site-visits-to-five-states>

¹⁴ Kaiser Family Foundation, "Key Themes in Capitated Medicaid Managed Long-Term Services and Supports Waivers," <http://kff.org/report-section/key-themes-in-capitated-medicaid-mltss-key-themes/>

¹⁵ CHCS, "From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles," http://www.chcs.org/media/TCDE_Core_Elements_122010.pdf

¹⁶ Association for Community Affiliated Plans "ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations," <http://www.chcs.org/media/ACAP-Medicare-Medicaid-Plans-and-the-Financial-Alignment-Demonstrations.pdf>

opted to expand coverage to include home-delivered meals (previously only available to Money Follows the Person recipients) and home modifications.

9. *Coordination of MLTSS with Behavioral Health Services.* Assessment, treatment, and coordination of behavioral health needs for the aged and disabled can present additional challenges, which is why many states have prioritized behavioral health coordination of services in both dual eligible demonstrations and Medicaid MLTSS programs. One approach adopted by a California-based dual eligible demonstration included establishing weekly meetings with plan staff and county mental health providers to help with consumer referrals, treatment decisions, and care management.¹⁷ New Jersey decided to include behavioral health services for its LTSS population in its capitated MLTSS program, even though most of these were not included in the acute care managed care program.
10. *MLTSS Oversight to Enhance the Consumer Experience.* Allocating appropriate state staff to oversee MLTSS operations and contracting for necessary support has helped ensure consumers receive the care they need.¹⁸ When Delaware implemented its MLTSS program for dual-eligibles, the State prioritized aggressive MCO oversight and state monitoring, which was also critical to addressing consumer and advocate stakeholder concerns. Other states, including Florida, New York, and Wisconsin are working to add MLTSS quality measures; however, efforts have been hampered to some extent because there are no national MLTSS quality standards. In absence of national standards, states have looked to “process of care” performance measures like the percentage of members who are screened and treated for falls. States are also considering consumer satisfaction as a means of measuring performance.¹⁹

¹⁷ Association for Community Affiliated Plans “ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations,” <http://www.chcs.org/media/ACAP-Medicare-Medicaid-Plans-and-the-Financial-Alignment-Demonstrations.pdf>

¹⁸ Mathematica, “Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States,” <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-managed-long-term-services-and-supports-themes-from-site-visits-to-five-states>

¹⁹ Mathematica, “Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States,” <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-managed-long-term-services-and-supports-themes-from-site-visits-to-five-states>