Checklist: How Consumer Focused Are Your State's Medicaid Managed Long Term Services and Supports?

Many states are overhauling the delivery of long-term supports and services (LTSS) for consumers in Medicaid who are living with chronic illnesses and disabilities. They are shifting from fee-for-service models to contracting with Medicaid managed care organizations (MCOs) for some or all LTSS. In some states, this change is happening as part of demonstration projects to coordinate care for people eligible for both Medicaid and Medicare.

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.

To help minimize the risks and maximize the benefits of this overhaul, consumer advocates and other stateholders can assess state programs using this checklist. The checklist draws from federal guidance[1], Community Catalyst's paper[2] on states' best practices and expert advice from other stakeholders, including agencies serving people who are aging and/or have disabilities. A two-page checklist is also available from Community Catalyst.

Adequate Planning

Has the state

- ❑ Allocated adequate time for planning, typically at least two years

Set clear goals including

- ❑ expanding home and community-based services
- ❑ making the program person-centered (see page 4)
- ❑ covering a full range of LTSS in all settings

Worked with a planning team including

- ❑ state agency officials with expertise in LTSS, mental health, substance use disorders, aging, disabilities, managed care, chronic diseases
- ❑ consumers and consumer advocates with experience and expertise in LTSS
- ❑ LTSS stakeholders
- ❑ hired LTSS experts, if needed

Included these components in its preparations

- ❑ plans for stakeholder and consumer engagement (see page 2)
- ❑ plans for education of and outreach to participants, families and caregivers (see page 3), about LTSS changes, including what will change and how to navigate managed care

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- ❑ plans for education of providers, contractors and community organizations
- ❑ IT systems
- ❑ plans for state management of program, including staff training
- ❑ plans for oversight including independent ombudsman and state monitoring (see pages 3 and 7)
- ❑ plans for rapid identification and resolution of problems including state hotline
- ❑ transition plan from fee for service to managed care for providers and consumers, including phase-in starting with low-need consumers (see page 5)
- ❑ draft quality strategy (see page 6)

Assessed the readiness of each managed care organization (MCO)

- ❑ consumer hotline
- ❑ LTSS expertise in leaders, line staff and contractors
- ❑ training in independent living, recovery philosophies
- ❑ financial solvency
- ❑ above average quality ratings from the Centers for Medicare and Medicaid Services and the National Committee for Quality Assurance
- ❑ consumer engagement plan (see next section)
- ❑ Americans with Disabilities Act (ADA) compliance plan
- ❑ compliance plan for mental health and addiction parity
- ❑ strategies to address racial and ethnic disparities
- ❑ compliance with federal standards on culturally and linguistic competence (CLAS)
- ❑ robust networks of skilled, culturally competent community providers (see page 5)
- ❑ ongoing plans for consumer and provider education

Stakeholder Engagement in Design, Implementation and Oversight

Communications/Transparency

- ❑ Is the state regularly communicating with stakeholders, including through a website and public meetings
- ❑ Are communications from the state and MCOs culturally and linguistically tailored and available in alternate formats for people with impairments
- ❑ Has the state posted all proposals, revisions, and contracts for public comment – and responded to that comment – prior to finalizing them
- ❑ Does the state require MCOs to publicly report on finances, profits, reserves, provider rates, and patient outcomes

To engage stakeholders, has the state

- ❑ established a state-level stakeholder planning and oversight committee with at least 50 percent consumer representation

- ❑ required contractors and MCOs to include at least 25 percent consumer representation on governing boards and establish local or regional consumer advisory boards
- ❑ ensured consumer representation reflects the diversity of consumers
- ❑ gathered public input through quarterly stakeholder meetings in each region of the state, a website, focus groups, consumer surveys
- ❑ provided and required MCOs to provide consumers with supports needed to enable them to participate, including interpreters, personal care assistants, transportation, refreshments, compensation, staff support, accessible facilities
- ❑ required MCOs to report on consumer engagement
- ❑ followed tribal consultation requirements

Consumer Support and Protections

For enrollment and choice of MCOs, does the state

- ❑ make enrollment voluntary
- ❑ provide conflict-free counseling to help consumers choose an MCO by hiring an enrollment broker and contracting with trusted community groups
- ❑ bar MCOs, service providers and agencies determining eligibility from choice counseling
- ❑ use multiple means, including letters, calls, meetings, advertising, websites to inform consumers
- ❑ if enrollment is mandatory, allow consumers 90 days to choose a health plan and allow them to opt out of managed care at any time
- ❑ if consumers haven't chosen a plan in 90 days, assign consumers to the plan that includes their current providers or best provides for their needs
- ❑ allow consumers to switch among plans at any time, and provide independent help for the switch

For all issues, does the state

- ❑ contract with and provide dedicated funding to an independent ombudsman to address individual consumer problems and identify systemic problems
- ❑ provide consumers with a statement of their rights and require MCOs contracts to include it? The rights include treatment with respect, dignity and privacy; timely receipt of services; participation in decisions on services; freedom from discrimination; accessible information on policies, services and grievance/ appeals procedures
- ❑ provide a system to identify, respond to and prevent abuse, neglect, and exploitation; train MCOs, providers and consumers in how to use it
- ❑ provide an easy to use grievance and appeals system, fair hearing protections, and continue to provide services in the same amount, duration, and scope during appeals

Enhancing Home and Community-Based Services

- ❑ Has the state ensured the program and MCOs meet all requirements of the ADA and the Supreme Court's Olmstead decision requiring services be delivered in the least restrictive setting possible
- ❑ Do the MLTSS benefits include services to support active participation in the workforce and community, including personal assistance, supported employment and peer support services

Does the state use payment methods that incentivize community based care, such as

- ❑ including nursing homes in the capitated rate and holding MCOs financially responsible for the entire stay
- ❑ paying plans the same rate whether a person with the same level of need is served in a nursing home or in the community
- ❑ sharing with MCOs some or all of the savings resulting from appropriate reductions in the use of nursing homes and increases in community services
- ❑ requiring MCOs to reduce or eliminate waiting lists for community services

Person-Centered Processes

Does the LTSS program offer consumers

- ❑ the opportunity to direct their care, and provide supports and training to do so
- ❑ a choice of services, providers and care settings

Does the state require a needs assessment of each consumer that

- ❑ examines physical, psychosocial and functional strengths and needs, personal goals and preferences
- ❑ is conducted face-to-face in the consumer's preferred location within 30 days of enrollment
- ❑ is redone promptly when the consumer's needs, preferences or situation changes
- ❑ is conducted by someone independent of the MCO and service providers

Does the assessment result in an individualized service plan

- ❑ drawn up under the consumer's direction that meets the consumers' needs, goals and preferences
- ❑ is modified as needed and reviewed at least annually

Does the state require an interdisciplinary, individualized care team

- ❑ chosen by and led by the consumer or his/her designee
- ❑ with expertise in community living and person-centered service delivery
- ❑ authorized to provide services beyond the list of standard benefits if needed
- ❑ including a care coordinator who visits and calls the consumer regularly

- ❑ Can the consumer request a family member be trained to be their paid personal care worker
- ❑ Does the state provide respite services for family paid and unpaid caregivers

Comprehensive Integrated Service Package

- ❑ Does the state require MCOs to provide or coordinate a full range of services for physical health, behavioral health, and LTSS, including peer and recovery services
- ❑ If the state carves out services from MCO control, does the state provide justification and routinely assess whether this harms consumers or violates their right to care in an integrated setting
- ❑ Do consumers get needed supports to transition among care settings, including among home, hospital and nursing home
- ❑ Does the state set a medical loss ratio that requires MCOs to spend at least 85 percent of premiums on services and supports
- ❑ Does the state prohibit waiting lists or caps on services

Provider Quality, Quantity and Continuity

Does the state require MCOs to maintain a diverse and robust network of providers

- ❑ sufficient to ensure consumer access and choice
- ❑ experienced and credentialed in LTSS
- ❑ culturally and linguistically competent
- ❑ accessible for people with disabilities
- ❑ trained in independent living and recovery philosophies and person-centered planning

Does the state

- ❑ routinely assess unmet consumer needs and require network expansion
- ❑ regularly test network adequacy with secret shoppers
- ❑ review capitated rates to MCOs, and MCO payment rates to providers to ensure these are not barriers to robust networks

During the transition to managed care, does the state minimize disruption by

- ❑ requiring MCOs to include current community providers and offer transition support
- ❑ permitting consumers to continue seeing non-network providers for at least a year and requiring MCOs to pay those providers the full Medicaid fee-for-service rate
- ❑ requiring plans to allow exceptions to network requirements when needed by consumers
- ❑ maintaining contract provisions for transitions among managed care plans
- ❑ allowing consumers to get previously authorized services until a new service plan is implemented

Overall Quality

Has the state developed a comprehensive quality strategy that annually analyzes and improves outcomes and processes including

- ❑ consumer quality of life, (ability to maintain independence and participate in work, relationships and community activities if desired, live in preferred setting)
- ❑ consumer satisfaction
- ❑ consumer engagement
- ❑ consumer health and functional status
- ❑ rebalancing of care from institutions to the community
- ❑ reductions in health disparities
- ❑ continuity of services and care transitions
- ❑ person-centered processes, including consumer participation in care decisions
- ❑ compliance with the ADA, including the Olmstead decision, anti-discrimination laws and the Mental Health Parity and Addiction Equity Act
- ❑ preventable hospitalizations and nursing home stays
- ❑ grievances and appeals
- ❑ timeliness of assessments, service plans and plan revisions
- ❑ extent to which service plan is followed
- ❑ denials and reductions of services
- ❑ extent of self-direction
- ❑ network adequacy
- ❑ disenrollment from plans and churning among plans
- ❑ fraud, neglect and abuse
- ❑ referral patterns from choice counselors

❑ Does the state require at least annual MCO reports on measures in the above list that are under plan control with data stratified by race, ethnicity, primary language, disability status, educational level and employment status

❑ Is quality of life and satisfaction data being gathered through a face-to-face survey or interview

Does the state work to improve LTSS quality through

- ❑ MCO-specific performance improvement plans
- ❑ incentives and penalties spelled out in MCO contracts

❑ Does the state release publicly all quality data, including analyses of surveys on consumer quality of life

❑ Does the state provide summary reports on MCO performance, including consumer-oriented report cards

Oversight

Does the state

- ❑ maintain ultimate responsibility for all aspects of MLTSS and spell this out in MCO contracts
- ❑ maintain enough staff skilled in and dedicated to contract management, including auditing and analyzing data, evaluating outcomes, investigating problems, developing improvements and enforcing corrections
- ❑ enforce compliance with contracts and laws by issuing penalties and dropping poorly performing contractors
- ❑ engage stakeholders in designing evaluations and in monitoring, including through an implementation council
- ❑ monitor to ensure there is no system-wide reduction in use of LTSS, particularly services in the community
- ❑ review all MCO reductions in service, including gathering consumer input
- ❑ annually review and adjust payment rates, incentives and penalties

Resources

[1] Putting Consumers First: Promising Practices for Medicaid Managed Long-Term Services and Supports
http://www.communitycatalyst.org/doc_store/publications/putting_consumers_first_LTSSmanagedcare.pdf

[2] Federal Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

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About Community Catalyst

Community Catalyst is a national, non-profit consumer advocacy organization founded in 1998 with the belief that affordable quality health care should be accessible to everyone. We work in partnership with national, state and local organizations, policymakers, and philanthropic foundations to ensure consumer interests are represented wherever important decisions about health and the health system are made: in communities, courtrooms, statehouses and on Capitol Hill. For more information, visit www.communitycatalyst.org.

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