Medicaid Managed Long-Term Services and Supports (MLTSS): State Oversight and Expectations

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Introduction

- This presentation will describe state oversight activities for MLTSS so that health plans can understand state expectations and be prepared to meet them.

- The information draws largely from a 2012 survey of eight states with MLTSS experience.
Unique Needs of LTSS Users

- LTSS users:
  - Include older adults; people with physical, cognitive, or behavioral disabilities; and people with multiple chronic conditions
  - Rely on hands-on personal assistance to carry out activities of daily living (ADLs) or instrumental activities of daily living (IADLs)
  - Require a wide range of services coordinated across many providers and settings

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Use of MLTSS Is Increasing

• As of July 2014, 29 states offered or plan to offer at least one MLTSS program\(^2\)
  – Up from 8 states in 2004

• States turn to MLTSS because it offers:
  – Predictable costs
  – The ability to create incentives to rebalance care in favor of home and community-based services (HCBS) or to encourage quality improvement

• Capitated rate setting raises new challenges:
  – How to use the rate structure to provide incentives for HCBS
  – How to adjust rates for widely diverse costs and care needs of the LTSS population

• In a managed care setting, the state is an active purchaser
  – Contract requirements and oversight activities help the state get what it pays for

State Oversight of MLTSS (1)

• Many state oversight activities for MLTSS are similar to those used for other Medicaid managed care programs that only cover acute and primary services

• But because LTSS users have greater needs, MLTSS oversight needs to be more frequent and population-specific
  – Monitoring must include additional provider types
    • For example: nursing homes, personal care attendants, adult day health centers, social service providers
  – Services should be monitored more often, ideally in real time
    • For example: through electronic verification systems
  – Travel and accessibility requirements must account for beneficiary needs
    • For example: provider network time-to-travel standards should account for mobility impairments, and language requirements for member education materials should accommodate people with intellectual disabilities

• For Medicare-Medicaid eligibles (“dual eligibles”), oversight of Medicaid services should be coordinated with Medicare
States’ oversight practices vary, even among experienced states

- Variation is due to the length of time operating MLTSS, number and range of contractors/beneficiaries/services, staff knowledge and skills, coordination and communications practices, staff turnover, technology, etc.

The following slides present “norms” and “promising practices” from eight states that have operated MLTSS programs for more than two years

Oversight activities fall into four categories:

- Contract monitoring and performance improvement
- Provider network adequacy and access to services
- Member education and consumer rights
- Quality assurance and improvement
Oversight Activities (1)

• Contract monitoring and performance improvement
  – On-site readiness reviews for new managed care contractors and regular on-site reviews for continuing contractors³
  – Strong partnership with MCOs, characterized by frequent communication about contract issues
  – Financial incentives to drive performance
    • For example, savings for MCOs that exceed targets for use of HCBS as opposed to institutional care

• Provider network adequacy and access to services
  – Medicaid agency or “mystery shoppers” to verify that provider offices are open and accepting new patients

Oversight Activities (2)

• Member education and consumer rights
  – Ombudsman investigates MLTSS member problems
  – Critical incidents are monitored daily
  – Member grievances and appeals are regularly reviewed and discussed with MCO managers

• Quality assurance and improvement
  – Electronic visit verification systems are used to monitor home care services in real time
  – Dashboard of quality indicators presents a comprehensive picture of performance
  – Encounter data are used to construct quality measures and to monitor performance
  – Care management activities are reviewed, usually through a sample of records
Review of Care Coordination Activities

• Monitoring care coordination can help identify system-wide problems
  – Gaps in provider networks, inaccessible sites of care, poor-quality services, need for specific benefit counseling, breach of consumer rights, etc.

• MLTSS programs that use 1915(c) waivers must follow the same procedures to monitor HCBS and care coordination as they would under fee-or-service (FFS)

• Oversight activities include:
  – Specifying responsibilities and qualifications for care managers
  – Reviewing a sample of individual care plans to ensure home visits and comprehensive assessments occur on schedule
  – Reviewing training materials for care managers to ensure that the guidance conforms to state standards and policies
  – Surveying a sample of clients by telephone to discuss their experience of care
Sample MLTSS Quality Measures

Process measures:
- Receipt of HCBS based on a comprehensive care assessment and care plan within 30 days of enrollment
- Share of members asked about their care preferences
- Number of home safety evaluations
- Screening and treatment for falls
- Case manager turnover rates
- Nursing facility diversion rates

Transition measures:
- Plan all-cause readmissions
- Nursing home readmissions within 30 days of discharge
- Follow-up after hospitalization for mental illness
- Medication reconciliation after discharge from inpatient facility

Outcomes measures:
- Percentage of members with a change in ADLs/IADLs
- Employment status
- Member satisfaction
Questions?

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