NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

PRE-CONFERENCE WORKSHOP

MANAGED LONG-TERM SERVICES AND SUPPORTS: THE IMPACT ON PARTICIPANT DIRECTION

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Welcome & Agenda

- Today's Agenda:
  - Managed Care Overview
  - Dual Eligibility
  - Managed Care & Financial Management Services Observations & Recommendations
- Interactive session – please ask your questions between sections

History of Managed Care

- Early 1930's: Prepaid Health Plans in Oklahoma
- Mid-1940's: Prepaid Plans continue
- American Medical Association's attempt to suspend
- Former President Nixon – Health Maintenance Organizations - $375 Million
- Fast forward to 1990's
- Today's trend – State's looking at Section 1115s or Section 1915 b/c to develop Managed Care option

Why Managed Care?

- States looking for health care cost controls
- Shift toward integrated, coordinated care
- Less reliance on sole source revenue and more on competitive market – providers more responsive
- Service coordination reduces fragmentation
- Focus on transition planning
- Diversion easier to home and community-based services (HCBS) rather than institutions
- Elimination of waiting lists
- More frequent contacts with members by staff

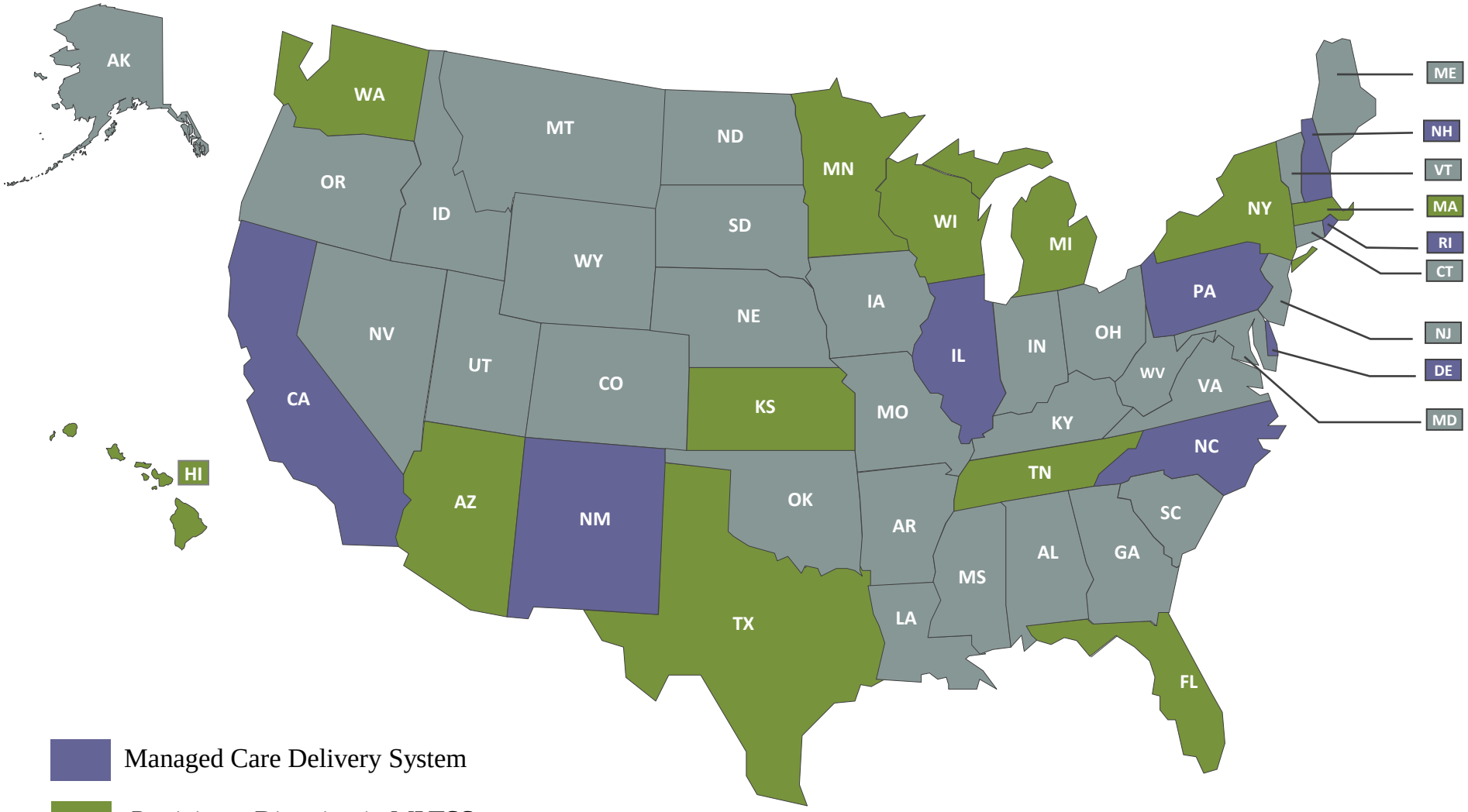
Managed Care Challenges

- Managed care focus has been on acute care - less familiar with home and community living and chronic illnesses
- High reliance on medical model
- Are health plans in a position to transfer responsibility and control to members?
- Should family caregivers provide services for free?
- Is sufficient guidance from the state offered to Managed Care Organizations (MCOs)?
- Health outcomes for managed long-term services and supports (MLTSS) not articulated
- Coordinating acute care with LTSS – new territory

Are Managed Care & Participant Direction Compatible?

- Improving participant health, welfare & health outcomes
- Coordinating and integrating service planning & delivery
- Increasing service satisfaction
- Efficient use of available resources through flexibility
- Meeting the Olmstead obligation

Participant Direction in MLTSS



Center Research

- Reviewed (7 States) with support from Mathematica Policy Research
  - Request for proposals (RFPs)
  - Contracts
  - Policy & procedures
- Reviewed and Interviewed (5 States) with support from Mathematica Policy Research & Truven Health Analytics
  - Contracts, RFPs, & policies/handbooks
  - State officials
  - MCO administration & case managers
  - FMS agencies
  - Advocacy groups

Domain Review

- Degree of flexibility
  - Employer and/or budget authority
- Available supports
  - Information & Assistance (I&A)
  - FMS
- Quality within the participant direction design
  - Reporting
  - Benchmarks
  - Satisfaction

Centers for Medicare & Medicaid Services (CMS) Position

- CMS supports self-direction (SD) in both fee-for-service and managed care settings
- Most recently published in May, 2013
  - Applies to Sections 1115 and 1915(b)

States that offer SD … are expected to continue….

States that do not currently offer SD…should consider providing the opportunity…within MLTSS program

Medicaid Authorities Vary

- Sections 1915(b)/(c): FL, WI, MI, MN – Senior Care Plus Program, NM*
- Section 1115: TN, AZ, TX, HI
- Sections 1915(a)/(c): MA, MN – Senior Health Options Program
- Section 1932(a): WA
- Sections 1115/1915(c): KS

*NM changing from (b)/(c) to Section 1115 in 2013/2014

General Findings

- All MCOs include elders & adults with disabilities
  - Intellectual/developmental disabilities services are typically carved-out
- All MCOs include acute, primary, LTSS (HCBS and nursing facilities) and behavioral health
- MCOs determine medical eligibility in over half the states - remainder use a conflict free entity to establish medical eligibility

General Findings (cont.)

- Participant direction offered in all large MCO plans
- MCO provides initial introduction to participant direction
- Participant direction enrollment numbers are relatively small but growing
- Services using participant direction include personal attendant care with an increasing number allowing skilled care
- All states require MCO to document the participant direction offering to members except one (MA)

Questions?

Please use the microphones

We will have multiple opportunities for audience questions

Duties of the FMS Vary

- Collect and process timesheets
- Manage taxes and insurance
- Pay goods and services invoices
- Execute provider agreements
- Verify direct service worker qualifications are met
- Generate reports and track expenditures
- Conduct criminal background checks
- Train members on the participant direction process
- Coordinate with electronic verification timesheet system
- Provide supports broker services

Employer and Budget Authority

- All 12 states reviewed adopted employer authority
- 8 of 12 states reviewed adopted employer authority & budget authority
- 2 of the 8 states that adopted budget authority have strict restrictions on purchases
- The managed care system does allow for the purchase of non-traditional items

Information and Assistance

- Information & Assistance
  - Internal to MCO or subcontracted
- One state created a new function to manage the day-to-day supports provided to participants and coordinate activity with the MCO case manager and FMS provider
- Training is conducted internally by the MCO often with help from the Aging and Disability Network

FMS

- All 12 states require the provision of FMS
  - States may select/specify/certify the vendor(s): IL, HI, TX, NM
  - States may delegate the selection and legal arrangement between the MCO and FMS: MA, KS, AZ
    - States may execute the legal agreement or may enter into a 3-way contract: TN
- The number of FMS vendors vary from 1 (TN, HI, NM) to 400 (TX)

Unique FMS Practices

- Hawaii
  - State conducts readiness review (FMS included)
  - Case management ratio less for participant direction
- Illinois
  - Relies heavily on Centers for Independent Living to conduct training and provide care coordination
  - Department of Rehabilitative Services serves as FMS in a co-employer arrangement
- Kansas
  - On 6/3/12 had 64 FMS providers – currently in a consolidating/eliminating phase
  - Section 1115 required state separation of administration from service cost

Unique FMS Practices

- Texas:
  - State qualifies FMS providers through training, MCO negotiates contracts
  - One FMS provides support brokerage
  - Reimbursement for FMS – flat rate or separation of administration from service costs
  - Quality Challenge Award - If PD enrollment increases by .5% or more from previous year, MCO is paid a bonus
- New Mexico:
  - MMIS vendor manages FMS sub-contract
  - Plan of care is managed electronically

Unique FMS Practices

- Massachusetts
  - Commonwealth offers no guidance on participant direction
  - Three FMS providers operate individually
  - One FMS provider has had success with private pay
- Tennessee
  - FMS provides:
    - Typical FMS duties
    - Support brokerage
    - Training to members initially and on-going
    - Verifies worker qualifications
    - Detailed reporting requirements
  - State very prescriptive with policy and procedures
  - Great emphasis on quality measures (benchmarks established for participant direction increases) and reporting

Challenges Identified by FMS Providers

- Lack of communication between members, FMS, MCO and State
- Short submissions time frame (e.g., 90 days)
- Flow of funding – MMIS to MCO to FMS to worker
- Reconciliations are a puzzle to MCOs
- Inconsistent service coordination staff training

Feedback from MCO & FMS Providers

- Lack of policy and procedures (MCO & FMS)
- Lack of standardization may result in confusion or more work (MCO & FMS)
- One thing for an MCO to offer participant direction, another to promote the option (FMS)
- Focus – meeting the terms of contract, but not providing quality service (FMS)
- We asked an MCO, "How do you know if the FMS is providing poor quality services?" Their response was, "*We would get a complaint.*" (MCO)

Questions?

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Observations

- Commitment to participant direction is related to the state's expectations and guidance
- States are supportive of participant direction, but they lack specificity in their contracts
- Unclear if MCOs understand how to operationalize participant direction
- Specific language in state policy & procedures may yield more flexibility than language embedded in contracts
- Worker registries are needed, but are not offered

Observations

- The introduction, orientation, & on-going support of participant direction can be time-consuming for service coordinators
- Measures are not in place to ensure this option is presented in a consistent manner
- Stringent EVV systems limits program flexibility
- While participant engagement is mentioned in most contracts, advocates question whether meaningful participant involvement occurs

PD Disincentives

- New Mexico
  - If new to LTSS, must use traditional services for 120 days prior to self-directing.
- Tennessee
  - Extensive credentialing process for direct service workers
  - Service plan with specific date, time and services are electronically monitored and work in conjunction with a telephone verification system. If services do not occur within 45 minutes – claim suspends. If worker does not show, FMS and MCO are notified immediately.
  - Strict hiring criteria – if a person has lived with the participant in the last 5 years that person can't be hired
- Arizona care coordinator responsible for ensuring the back-up plan is working

Recommendations

- States should provide guidance on participant direction to MCOs
- States should encourage standardization among providers and health plans, up to MCOs
  - Software Issues
  - Consistent policies, processes, and protocols
- Participants need better information and more time to make an informed decision
- State may delegate too much responsibility to MCOs
  - Each MCO sets hourly wage
  - Uses own screening criteria

Recommendations

- Outcomes should be tied to LTSS outcomes
- Training of health plan staff should be consistent
- Conducting readiness reviews measures preparedness
- Ensure MCOs understand participant direction and the member's rights to hire (or refer), train, supervise and dismiss workers (at least from the home)
- FMS could be part of the value added to MCO plans
- Ensure a solid quality assessment and improvement plan is in place
- Data should have meaning

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Dual Eligibility

- Individual who is eligible to receive both Medicare & Medicaid
- More than 9 million individuals are dually eligible
- Typically, high-need, high-cost, and account for a disproportionate share of spending in both programs

Current System

- Medicare and Medicaid are not integrated or coordinated
- Policies and provider reimbursement are separate
- Benefits, enrollment, and protections are inconsistent
- Individuals are not empowered to make decisions due to the complexities of the system
- Billing differences between providers create administrative inefficiencies
- Unnecessary or duplicative spending

Brief History

- Affordable Care Act of 2010
- Created Medicare-Medicaid Coordination Office (MMCO)
- Two New Opportunities
  - State Demonstration for Integrated Care for Dual Eligible Individuals ($1 Million for 15 States)
  - Financial Alignment Demonstration (as of 9/13 - 20 states)
    - Capitated model
    - Managed fee-for-service
- Purpose: Improve coordination and alignment of services for Medicare/Medicaid enrollees

Current Status

- Financial Alignment Demonstration:
  - 6 states withdrew – concerns about workload
- State Demonstration for Integrated Care & Financial Alignment Demonstration:
  - 7 states have signed Memorandum of Understanding (MOUs) with CMS and health plans

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-THANK YOU-

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