Louisiana Developmental Disabilities Council

LaDDC NEWS

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Managed Care for Long-Term Supports and Services: What You Need to Know

(Much of the information in this article, including the list of recommendations provided, were derived from two documents: Putting Consumers First: Promising Practices for Medicaid Managed Long-Term Services and Supports by Community Catalyst, Inc. and Recommendations on Medicaid Managed Care for People with Disabilities by the National Council on Disability.)

A move to managed care for long-term supports and services (MLTSS) will impact individuals receiving services through the New Opportunities Waiver (NOW), Children's Choice, ROW, Community Choices, and Supports Waivers, on the waiting list for these waivers, and those receiving services in a residential or institutional setting. The Department of Health and Hospitals (DHH) recently released a concept paper outlining the principles and foundation for moving Louisiana to MLTSS. DHH is seeking input from stakeholders on MLTSS. Below is a summary of what you need to know about MLTSS including the potential benefits and risks as well as some guidance on what feedback to share with DHH.

What are Managed Long-Term Supports and Services (MLTSS)?
Managed Long-Term Supports and Services refers to the delivery of home and community-based services (e.g., waiver services, personal care services) and institutional care (e.g., ICF/DD community homes, large institutions, and nursing homes) where providers are paid a fixed payment (capitation) per recipient they serve, regardless of the number or type of services the individual requires. In a managed care system, most or all services are coordinated or "managed" by a Managed Care Organization (MCO) under contract with the state. The MCO contracts with community and institutional service providers who actually provide the service to the individual with a disability. These service providers enroll in the MCO's "network" and the individual chooses providers from within the network.

Current examples of managed care in Louisiana include Bayou Health and the Louisiana Behavioral Health Partnership (Magellan).

How is this different from the current system?
Currently, long-term supports and services are provided under a fee-for-service model, where providers are paid a fee for each service they provide (e.g., one hour of personal care assistance or therapy, one day in a community home, etc.).

Why shift to MLTSS?
Many states are shifting to MLTSS because of limited state funding, the desire to increase home and community-based services, as well as federal incentives to integrate long term supports and services with medical and behavioral health care for people who are dually eligible for both Medicaid and Medicare.

Unfortunately, there is no consistent evidence that access to home and community-based services will increase or use of institutional settings will decrease. Furthermore, only two states using MLTSS have shown overall cost savings. Achieving savings from managed care and the shift to community based services doesn't occur quickly because of the need for upfront investments and savings are not guaranteed.

What are the potential benefits of MLTSS?

- **More access to home and community-based services** (e.g., waiver services and other community supports).
  Some states have expanded eligibility to more people by ending waiting lists and shifted the focus from institutional care to home and community based supports.
- **Improved coordination of care**
  If the same MCOs provide acute care, behavioral health care and long term supports and services, MLTSS could reduce fragmentation and improve the coordination of services.
- **Increased quality and efficiency of services.**

What are the potential risks of MLTSS?

- **Services could be cut**
  State budget cuts and MCOs' interest in increasing profits pose the greatest risk for people with disabilities through loss of services that could result in out-of-home placement. In addition, access to supports and services may suffer if states make MCO rates too low. For example, Florida is spending less on their MLTSS system than they spent under the fee-for-service system and plan to add more people to its waiting list.
- **Community providers might be pushed out**
  Managed care plans may forego existing community providers with experience serving people with disabilities and choose medical providers instead.
- **Support services might be medicalized.**

Many decisions about MLTSS remain and stakeholders have the opportunity to share their input. For instance, a decision has not yet been made to include people with developmental disabilities in the initial phase or wait and include this population in years to come. DHH needs to hear from people with disabilities and their family members on this question. It is vital to share the issues most important to you with DHH, in case people with developmental disabilities *are* included in MLTSS.

The following recommendations are offered as guidance to assist you in developing your own recommendations to DHH.

As an overall goal, the managed care system must assist people with disabilities to live full lives in their community. DHH must ensure that MLTSS is person-centered, focused on individual goals and needs. The system should maximize the individual's control, choice and independence and families should receive the support they need to support and effectively advocate for their family members.

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Promoting Independence and Home and Community-Based Supports (HCBS)

- Elimination or reduction of waiting lists for home and community based supports should be included in MCO contracts.
- Any savings achieved from MLTSS should be invested into the expansion of home and community based supports.
- Financial and performance measures should be used to encourage MCOs to increase access to home and community based supports.
- Home and community based supports and residential/institutional services should both be included in the MLTSS system to promote the transition of people to their own homes in the community.
- No cap on services should be allowed.
- Self-direction should be available to enrollees.
- DHH must not relinquish responsibility for training of Direct Support Professionals (DSPs). In addition, family members are often the most qualified, preferred and/or only available DSP and therefore should not be excluded as paid DSPs.
- Supports for competitive employment must be available for working-age individuals with disabilities so that they are included in their communities and able to be independent.
- DHH should ensure that MCO contracts are in line with the Olmstead ruling and give people the right to live in the least restrictive environment even if it costs more.

Assuring Quality

- MLTSS should be phased in and enrollment should be voluntary.
- DHH should incorporate performance measures into MCO contracts and link them to payments to guarantee quality services. The principles of independence, productivity, integration, inclusion and self determination should be integrated in the quality indicators.
- DHH should provide funding for independent ombudsmen, preferably with an organization trusted by people with disabilities.
- DHH should require majority of premiums to be spent on services and supports.
- DHH should establish oversight committees with enrollee representation and should seek regular input from stakeholders in each region of the state.
- MCOs should be required to include enrollee representation on their governing boards.

Rates/Payment

- The method for determining MCO rates should be equitable and transparent, and take into consideration that people with disabilities have varying support needs which change over time.
- Rates for MCOs should be the same if a person with the same level of need is served in a residential/institutional setting or in their own home in the community.
- Rates should be sufficient to support a provider network capable of meeting all the health care, behavioral health, and long-term support needs of all enrollees with disabilities, including those with highly specialized needs.

General Recommendations

- Acute and behavioral health services should be integrated with long term supports and services in MLTSS to maximize coordination of supports.
- To avoid problems such as hospitalizations and out-of-home placements, support teams should be able to authorize long term supports and services without prior approval from the MCO.
- Independent support coordination, including access to highly specialized care coordination, should be available to assist enrollees with the intake, assessment, service planning, provider selection, and service monitoring processes. The system should also include a component for optional self-directed support coordination by the primary caregiver.

Submit your comments to DHH at LongTermCare@la.gov. You are encouraged to do this ***before October 3, 2013*** when the Advisory Council will hold its first meeting.

Read the DHH Concept Paper on MLTSS here.