Only 16 states currently use managed long-term care in their Medicaid programs, but many more are considering moving in that direction. There are several reasons for this shift. Many states see managed long-term care as a way to rein in Medicaid costs or provide greater budget certainty: paying a managed care plan a set rate per Medicaid enrollee per month is more predictable than fee-for-service Medicaid. Additionally, the Affordable Care Act creates opportunities for states and the federal government to test new ways to deliver care to dual eligibles, people who are eligible for both Medicaid and Medicare, with the goal of improving quality of care and saving money in the long run. As of June 2012, 26 states are pursuing demonstration proposals to integrate Medicare and Medicaid funding and care delivery. Most of these proposals include some form of managed long-term care.

Managed long-term care has the potential to better coordinate long-term services and supports for people in Medicaid and to expand consumers’ access to home- and community-based care. But it also has the potential to make it even harder for people in Medicaid to get the long-term services they need. Whether a program helps or hurts consumers depends largely on how it is structured.
That’s why it is critical that you get involved as soon as you learn that your state is considering a Medicaid managed long-term care program, and stay involved through program implementation, evaluation, and ongoing oversight. Families USA's Managed Long-Term Care in Medicaid: What Advocates Need to Know outlines some policy issues for you to consider if your state is moving forward with managed long-term care in Medicaid.

This brief takes a closer look at specific items related to program structure that you should evaluate as your state starts designing its managed long-term care program. It does not comment on whether managed care might be good or bad in any particular state. Rather, its goal is to help you look more critically at proposals and get involved in the process. You can push your state to design a program that will ultimately help consumers with Medicaid coverage to better obtain the full spectrum of long-term services they need.

Although this brief is focused on advocacy at the state level, states need to get approval from the Centers for Medicare and Medicaid Services (CMS) before they start a Medicaid managed long-term care program. That means there will likely be opportunities for you to submit comments to or voice your concerns with CMS. The kinds of opportunities will depend on the type of proposal your state submits. (See State Plan Amendments and Waivers: How States Can Change Their Medicaid Programs and How the Affordable Care Act Makes the Section 1115 Waiver Process More Transparent: An Advocates Guide for more information on the processes through which states seek approval from CMS and related advocacy opportunities. Both these briefs are available online at www.familiesusa.org.)

Note: In this brief, “Medicaid managed long-term care” refers to a program where the state is paying one or more managed care plans on an at-risk basis: a per-enrollee-per-month, or capitation, payment for a defined set of long-term care services. The plans lose money if costs for services exceed the capitation payments, but they make money if costs are less than payments.

As noted above, many states are submitting proposals to CMS for funding to test programs that integrate acute, behavioral health, and long-term care in Medicare and Medicaid for dual eligibles. While many of the points discussed in this brief would also apply to those proposals, this brief is focused solely on state proposals that apply to Medicaid long-term care.
Managed Long-Term Care: How It Can Help

Skeptics may wonder if managed long-term care can actually help anyone. Consider the story of Miss Bennet (not her real name), a woman in her mid-nineties who has been losing her sight to glaucoma. She lived alone and had little family support, but she managed, nonetheless: She was happy living in the community she had been in for decades. However, she needed someone to read her mail, clean her home, take her shopping, and make her meals. She cobbled together volunteers for some of this, but she wasn’t able to get consistent help at home, and no one was helping her navigate the system of available services. As her vision deteriorated, she had more and more difficulty preparing meals. One day, she wasn’t feeling well, so she called an ambulance. She was admitted to the hospital, and it turned out her problem was simply that she hadn’t been eating properly.

She stayed in the hospital a few days and felt much better with proper meals. But it was clear that she couldn’t stay at home without more help. Since there was no one to organize this help for her, Miss Bennet was instead discharged to a skilled nursing facility, where her condition worsened, and then to a group home, where it finally began to improve.

No one can predict what might have happened if circumstances had been different. But in Miss Bennet’s case, if someone had been responsible for overseeing her care—someone invested in seeing that she didn’t get hospitalized or sent to a nursing facility—she might have been able to stay in her home longer, perhaps for the rest of her life. Hers was the kind of situation that Medicaid managed long-term care has the potential to help.

Not every case will be like Miss Bennet’s, but many people probably know (or know of) someone in similar circumstances. If done right, managed long-term care has the potential to help them.
Evaluating Managed Long-Term Care Proposals in Your State

As you start to evaluate the specifics of a state proposal for Medicaid managed long-term care, there are a few things about managed long-term care in Medicaid that you should keep in mind:

- **This is new.** Managed long-term care is not just new in Medicaid, it’s new everywhere. Unlike acute medical care, where there are generally established and tested treatment protocols for specific conditions—like what to do if a patient is having a heart attack—needs for long-term services and supports are very individualized. There are few data showing which approaches work best for which populations. There are also limited data on costs for managing long-term care or how to best set payment rates. Therefore, programs should be flexible and include continuous opportunities for the state and the managed care plans to review and take quick action on payment rates, the care management process, and overall program performance.

- **This takes time.** It takes time for a managed care plan to build an adequate, comprehensive provider network to deliver long-term care. Most managed care plans do not have experience working with support services like transportation or housing, or with the range of home care workers that a plan will need. The state should incorporate adequate lead-time for the managed care plans to make the connections needed to offer supportive services and build an adequate provider network.

- **The population is diverse.** People of all ages with a vast array of needs rely on Medicaid for long-term care—the frail elderly; people with developmental disabilities, physical disabilities, head or spinal-cord injuries, or dementia; accident or stroke victims; and the list goes on. These groups have different needs that program design should account for. A “one size fits all” approach will not work for Medicaid managed long-term care.

- **This does not have to be done all at once.** The state’s program can be set up to evolve over time as both the state and managed care plans learn more about the best ways to manage care for different groups. States can start with a program operating in limited geographic areas and open only to limited groups of Medicaid long-term care users.

- **It is imperative that states measure, monitor, and reward plans for outcomes and quality.** States are rushing to move Medicaid long-term care into managed care in order to save money, even though cost-savings are not well documented. If programs are not well structured and carefully monitored, access to care can suffer. It is critical that states use multiple measures of quality of, access to, and patient experience with care to evaluate plans. The state’s contract with managed care plans should include real incentives for plans to meet quality standards and real penalties if they do not. It is also imperative that the state invest in monitoring managed care plans so that any quality or access issues can be detected and addressed as soon as possible.

These are points you should keep in mind as you look at a state proposal, and you should also make sure that state officials understand them.
Evaluating State Proposals

State proposals for managed long-term care in Medicaid will vary. There are, however, certain areas of program development that all states will need to make decisions about as they set up their programs, such as enrollment structure, benefit design, plan payment rates, state oversight, and program evaluation. This section looks at those decision points, lays out preliminary questions you should ask, and suggests things you should look for as you review a state proposal. (See the list below for a summary of the topic areas and questions addressed in this section.)

This list is not exhaustive, but it should help you get started by identifying areas where a state proposal might fall short. You can then push for changes that will make the program work better for consumers.

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Some Questions to Ask About State Proposals for Managed Long-Term Care in Medicaid

**Consumer Input - page 7**
- Is there a permanent state-level advisory board or comparable body that includes ample consumer representation?
- Are the managed care plans required to have an oversight or advisory committee that includes consumers?
- Is there an ongoing process for the public to submit comments to the state?

**Program Structure - page 8**
- **Enrollment**
  - What groups will the program cover?
  - Is enrollment optional or mandatory?
  - Is the state providing consumers with adequate enrollment support?
  - Are there safeguards to ensure continuity of care?
  - Will the program operate statewide or in select areas?
- **Services**
  - What services will the managed care plans be responsible for?
  - Are there incentives to reduce the use of institutional care?
  - Does the program include assessments of individual needs?
  - Will the managed care plans have service flexibility?
  - Does the program include consumer-direction?
Payment Rates and Financial Incentives
- Will the state review plan payments on a regular basis, particularly during the first year of operation, and adjust them if needed?
- Will the state’s contract with managed care plans include outlier protection and shared savings?
- Will plans be rewarded for meeting quality and other non-financial performance measures?

Plan Selection - page 13
- How many managed care plans will be in the program?
- What are the criteria for plan selection?
- Are plan networks adequate in terms of both number and mix of providers and services?
- What is the transition time?

Consumer Protections - page 14
- Are plans required to have adequate grievance and appeals processes?
- Are there systems in place to ensure adequate and timely notice to consumers?
- Is there an ombudsman program?

Plan Evaluation - page 15
- Is the plan required to report on a variety of performance measures?
- Will plan performance reports be made public?
- Is the state outlining clear criteria for how it will evaluate plan performance?
- Are there real penalties for poor performance?

State Readiness - page 16
- Does the state have the capacity to oversee the managed care plans?
- Will the state continue to invest in building home- and community-based care capacity?
Consumer Input

As soon as you learn that your state is considering managed long-term care in Medicaid, you should encourage the state to set up formal structures for stakeholder input. “Stakeholders” should include consumers from all of the groups that will be enrolled in the managed care plans; professional and informal caregivers; and agencies that work closely with people who need long-term care, such as Centers for Independent Living, Area Agencies on Aging, and Aging and Disability Resource Centers. These are people who are familiar with what works and doesn’t work in the current system. These groups should be involved early on and throughout the program development process and through program oversight and evaluation. Managed long-term care plans should also participate in the process. This will give them an opportunity to learn from consumers, and they can comment on whether the programs envisioned are feasible.

- **Is there a permanent state-level advisory board or comparable body that includes ample consumer representation?**
  The state should set up a formal advisory board or oversight committee that has more than token consumer representation. This can ensure that consumers will have an ongoing voice in the managed long-term care program. The board should be engaged in everything from setting program goals through evaluation and oversight after the program is operating. Meetings should be regularly scheduled, open to the public, and held in a building that is accessible, and minutes should be publicly available. The state documents that establish the program should make it clear that the state will fully consider the board’s recommendations and publish its rationale when a board recommendation is not acted on.

- **Are the managed care plans required to have an oversight or advisory committee that includes consumers?**
  The state should require managed care plans to have a formal process for engaging consumers who are enrolled in the Medicaid managed long-term care program. This could be through an oversight or advisory committee that the plan convenes. This would be separate from any advisory board set up to work with the state. In its contract with managed care plans, the state should specify how quickly the plan must establish this committee, how frequently the committee will meet (e.g., monthly or at least quarterly), that meetings should be open to the public and held in a building that is accessible, and that meeting minutes should be publicly available. Plans should be required to report to the state on issues raised at the meetings and follow-up actions.
Is there an ongoing process for the public to submit comments to the state?
There should be ongoing opportunities for the public to give the state feedback on the managed long-term care program. This should include a formal mechanism that actively engages on-the-ground stakeholders, such as State Health Insurance Assistance Programs (SHIPs) and legal services programs that work with consumers to resolve problems they may encounter in obtaining health care services. These programs are able to identify systemic issues that may not become apparent through other means of evaluation and monitoring, and they can spot problematic trends long before data are reported. Regular engagement with these programs will allow states to address issues that affect consumers before they become widespread. The state should also continue to engage consumers directly through periodic public forums, as well as having a continual process for the public to provide comments by mail, by phone, or online. The state should work with consumer groups to determine which format works best for the groups that will be enrolled in the managed care program. The state should clearly indicate how it will review and respond to comments.

Program Structure
Whether Medicaid managed long-term care ultimately improves care coordination and increases use of home- and community-based care or makes it more difficult for consumers to get needed care will depend on how the program is structured: enrollment requirements, services included, and the incentives for and requirements placed on the managed care plans.

While there are some approaches that are generally better for consumers, you will need to evaluate each of these issues in light of the shortcomings of your current system, the managed care capacity in your state, and the specific goals for the managed care program.

Enrollment

What groups will the program cover?
Very different populations rely on Medicaid long-term care. They need different services at different levels of intensity. At the outset of a managed long-term care program, you should push your state to limit enrollment to groups that are less medically complex and gradually add more complex groups as the program gains experience.

Is enrollment optional or mandatory?
Enrollment can be optional or mandatory. Optional enrollment can be active, where consumers must select a plan or “opt-in” to be in the managed care program, or passive, where the state assigns consumers to managed care plans and consumers have to disenroll or “opt-out” if they want to go back to traditional Medicaid. Optional opt-in enrollment is the best approach for protecting consumer
choice, so advocates should push for that. Getting states to adopt this approach may be difficult. We’ve outlined some considerations for advocates under different enrollment scenarios.

- **Include real opportunities to disenroll, even if enrollment is optional.** Make sure that beneficiaries have sufficient information to make an informed choice and that there are clearly defined, frequent opportunities to disenroll or change managed care plans, so that the “optional” aspect of the program is real.

- **Move to passive enrollment gradually.** If the state is committed to passive or opt-out enrollment, advocates should push for active or opt-in enrollment at the start of the program, with a gradual transition to passive enrollment.

- **Retain traditional Medicaid options even when enrollment is mandatory.** If your state is pursuing mandatory enrollment, you should try to make sure that the state retains options for consumers to disenroll from the program and return to traditional Medicaid for long-term care if the managed care plans are not serving their needs. You should also push your state to start with optional enrollment and transition to mandatory enrollment.

- **Clearly communicate program changes to consumers.** The state should provide consumers with educational materials and notices about program changes that are written in plain language at an appropriate reading level, and that provide clear information about any actions that are required of consumers and where they can call for assistance. Translations of materials and notices, as well as oral assistance, must be available for individuals with limited English proficiency. The state should use agencies and other programs that already work with people who need long-term care, like Area Agencies on Aging, Aging and Disability Resource Centers, and SHIPs, to help inform consumers about the changes to Medicaid long-term care. If the state is using passive or mandatory enrollment, its communication program should include direct contact with consumers and their providers, such as through telephone outreach.

- **Is the state providing consumers with adequate enrollment assistance?** If multiple managed care plans are participating in the program, the state should provide enrollment assistance to help people pick the plan that has the provider network that best matches the services and providers they use now, rather than randomly assigning consumers to plans. You should push to have the state contract with third-party entities to provide enrollment assistance. This will ensure that consumers receive unbiased information. States might provide additional funding to Area Agencies on Aging, Aging and Disability Resource Centers, and SHIPs that serve dual eligible beneficiaries to provide counseling about plan options, or states may contract with private enrollment brokers.
As part of contracts, states should include requirements that assistors receive adequate training and specify standards to ensure the quality of assistance. States should also ensure that the entities contracted to provide enrollment assistance have sufficient capacity to serve the population enrolling in managed care, offer services in multiple languages, and provide aides for people with disabilities. Notices about program changes and enrollment options should provide contact information for enrollment assistors, and assistance should be available by phone and in person.

**Are there safeguards to ensure continuity of care?**
The program should include systems or processes to support continuity of care and ease the transition if consumers need to change providers. This is particularly critical if the state is using passive or mandatory enrollment. Safeguards could include a transition period where enrollees are allowed to continue using non-plan providers for a limited period of time as they move to plan providers. After the transition period, there should still be options for individuals to receive care from non-plan providers, such as “single care agreements,” which allow an individual to continue using a non-plan provider on a long-term basis. Services that have been authorized under the old system should automatically be covered for the period authorized when the person moves into managed care.

**Will the program operate statewide or in select areas?**
Generally, it is preferable to start programs in a few geographic areas and then expand the program statewide. This is particularly true if the state has limited experience with Medicaid managed care or if it has large rural areas where it might be difficult for plans to recruit an adequate number of providers.

**Services Included**

- **What services will the managed care plan be responsible for?**
  States can vary the services that will be included in the managed long-term care program. Programs can include just home- and community-based care, all long-term care, or all Medicaid services for plan enrollees. While it may seem like a good idea to limit services in managed care at the outset, doing that can take away the incentives for plans to really manage care. In fact, it can create incentives for plans to shift costs. When looking at the services included and the scope of the program, advocates should keep the goals of the program in mind.

  - **If a program goal is to increase the use of community-based care:** When managed care plans are responsible for all long-term care, including community-based and institutional care, they have more of an incentive to divert people from, or transition them out of, nursing facilities to lower-cost community-based care.
If a program goal is to slow growth in Medicaid long-term care costs: Programs where managed care plans are only at risk for home- and community-based care have not been as successful at containing Medicaid long-term care costs.\(^3\)

If a program goal is better care coordination: Putting plans at some risk for a whole spectrum of care can give plans an incentive to make sure that all care is coordinated. Even if plans are not at risk for certain services, they should still be required to help beneficiaries coordinate all of the services they are receiving.

Are there incentives to reduce the use of institutional care?
The program should include incentives for plans to direct people to home- and community-based care whenever appropriate. Such incentives are particularly important if the plan is not at financial risk for institutional care. See the section on “Payment Rates” for a more detailed discussion of setting plan payments and incentives.

Does the program include assessments of individual needs?
Long-term care needs are specific to the individual. They depend on a person’s level and type of disability, living situation, and available family or other support. Additionally, because costs of care will vary widely with individual need, plan payments should be adjusted based on enrollees’ needs. States should require plans to arrange for individual needs assessments within a short time after enrollment. Ideally, an independent third party will conduct these assessments to ensure that evaluation is not affected by a conflict of interest. If the plans do the assessments and payments are based on patient acuity, they have a financial incentive to inflate care needs. Plans should be required to arrange for updated assessments at set intervals as well as when individuals have an incident, such as a hospitalization, that signals that their needs might have changed.

Does the plan provide case management services?
Plans should assign each beneficiary to a case manager who is trained to work with individuals who have long-term care needs. Case managers should be responsible for ensuring that providers are coordinating plans of treatment. They should also help beneficiaries make decisions about the care they receive and assist them in obtaining services. Case managers should be in contact with beneficiaries on at least a monthly basis, when any changes to treatment are made, and if an incident occurs that may indicate that a patient’s needs have changed or that requires additional care to be provided. Beneficiaries should have the option of receiving case management services in person or by phone. It is important that case managers have access to all of the data the plan and providers have about the patient they are working with, as well as up-to-date information about plan networks, providers, and programs that offer supportive non-medical social services.
Appropriate oversight should be conducted to ensure that case managers are not affected by conflicts of interest, and that the recommendations of case managers are given appropriate weight in decisions that the plan makes about approving services.

- **Will the managed care plans have service flexibility?**
  The state should give plans flexibility to add services or items not traditionally covered by Medicaid if that will either help individuals stay in or transition to the community or otherwise improve quality or reduce the cost of care.

- **Does the program include consumer-direction?**
  Medicaid programs should include consumer-direction as an option in the managed care program. This means that enrollees should have the option to manage their own services and supports, including deciding who provides in-home services or what type of medical equipment is needed. The state should require the managed care plans to counsel consumers on the availability of self-direction.

### Payment Rates and Financial Incentives

Until states and managed care plans have more experience with managed long-term care, it will be hard for states to set plan payment rates that are not too low or too high. Rates that are too low create incentives for plans to skimp on necessary care. Rates that are too high give a windfall to plans at the expense of the state Medicaid program. The program can include some safeguards to make sure that rates are adequate while keeping state spending in check.

- **Will the state review plan payments on a regular basis, particularly during the first year of operation, and adjust them if needed?**
  The state should review capitation rates on a periodic basis during the first years of the program to ensure that low rates are not adversely affecting service use or that high rates are not reducing savings to Medicaid. State contracts with managed care plans should include provisions for the option of mid-year rate adjustments.

- **Does the state’s contract with the plan include outlier protection and shared savings?**
  Along with including provisions for periodic capitation rate review, state contracts with managed care plans should include some financial protections for plans that experience individual cases that cost much more than anticipated. That way, plans will not have financial incentives to skimp on care for high-cost individuals. Likewise, if overall service use is much lower or less costly than anticipated, there should be a mechanism for some of the added savings to be shared with the state.
Will plans be rewarded for meeting quality and other non-financial performance measures?

Plans should be financially rewarded for meeting quality and access measures in addition to lowering cost. These measures can include: number of people receiving home- and community-based services; hospitalization and institutionalization rates; percent of nursing facility residents with bed sores; enrollee experience (consumer experience of care surveys, grievance and appeals rates and resolutions); enrollees’ access to support services like transportation; housing placements; meeting a variety of service measures such as customer service telephone response times, number and frequency of contacts with home-bound enrollees; and success keeping enrollees living in the community. The Center for Health Care Strategies, Inc. publication, Managed Long-Term Care Supports and Services Performance Measures Resources, has links to multiple resources that outline quality measures (available online at http://www.chcs.org/usr_doc/Performance_Measurement_Resources_for_MLTS_programs.pdf).

Plan Selection

How many managed care plans will be in the program?

Ideally, states will contract with multiple plans to offer consumers throughout the state a choice. The state should actively try to interest a mix of plans, including locally based and not-for-profit plans, rather than just offering large, national managed care plans. Even with robust state efforts, it might be difficult to attract a large number of plans. The fewer the choices of plans, the more important it is for consumers to have the option to use traditional Medicaid.

What are the plan selection criteria?

States should have clear criteria for selecting the managed care plans that will participate in the program. These should include network capacity, experience with managed long-term care, familiarity with the long-term care system and providers in the state, and adequate information systems and in-house customer services to support care management. The state should consider requiring National Committee for Quality Assurance (NCQA) accreditation and measuring plan performance using NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) measures. Although focused on medical care, a plan's performance on those measures can indicate its overall commitment to quality. Note, however, that some smaller or newer plans that you might want in the program may have difficulty meeting those national measures. You should push the state to have alternative ways to evaluate those plans so they won’t be excluded out of hand. If the state is considering national plans that have Medicaid managed care contracts in other states, you should contact consumer groups in those states and ask about the plans’ performance.
- **Are plan networks adequate in terms of both number and mix of providers and services?**
  States will need to have coverage standards to ensure that all plans have adequate provider and service networks to meet consumer needs in each geographic area that the plans will be serving (e.g., a certain number of home-care providers per 100 enrollees). You should make sure that states are considering multiple factors for network adequacy, including existing Medicaid long-term care providers in the network; community services and supports, like transportation services; providers with accessible facilities; and providers with language capability and cultural competency that match the needs of the population that will be using services. You should encourage the state to do more than simply accept plans’ submitted provider directory. There should be a checking process, such as random calls to providers, to make sure that those listed will actually be participating in the program. The directory should be updated regularly and should include information about the types of services that providers offer, such as whether they offer services in multiple languages. Plans should be required to report periodically on their network. Reports should include information on providers added and those who were terminated or who dropped out of the network. They should also include the phone numbers of providers that are accepting new patients.

- **What is the transition time?**
  It takes time and resources for a plan to build an adequate network. The state should provide ample time for plans to have a solid network in place before people are transitioned to the program. Contacting advocates in states that have managed long-term care in Medicaid can help advocates gauge what lead time the state should build into the contract.

**Consumer Protections**

It is critical that states require plans to have consumer-friendly appeals and grievance processes and processes for ensuring that consumers can get the care they need while any appeal or grievance is pending.

- **Are plans required to have adequate grievance and appeals processes that incorporate all Medicaid protections?**
  Managed care plan enrollees must have the ability to appeal plan decisions. The state should require plans to have meaningful, clearly stated appeals and grievance processes. The process should include enrollees’ rights to appeal plan decisions regarding an individual’s service providers or care plan, request a second opinion on recommended medical treatments or plans of care, appeal denied care or services, and file a grievance about the plan or its participating providers. Plans should also be required to provide coverage pending the outcome of any appeals. If passive or mandatory enrollment is used, beneficiaries must also have the right to appeal their assignment to a managed care plan through an independent entity, and enrollees must have the option to switch to a different plan.
Are there systems in place to ensure adequate and timely notice to consumers?
Plans should be required to provide enrollees with clear notice regarding their right to appeal and file grievances. All appeal determination notices should be written in plain language, and translations and oral language assistance should be available. There should be clear processes for enrollees to request an expedited review, to obtain review by an independent third party and to appeal to an administrative law judge and to the state.

Is there an ombudsman program?
The state should have an ombudsman program to help plan members with access, service, coverage, or other problems with managed long-term care plans. This program should also be available to help members with plan appeals and grievances.

Plan Evaluation

Is the plan required to report on a variety of performance measures?
States should require plans to report on a variety of performance and service utilization measures, some of them monthly and some, quarterly. These measures should serve several purposes: (1) they should help identify service or quality problems early so that corrective actions can be taken; (2) they should help identify good practices that could be adopted by all plans in the program; (3) they should evaluate plan performance; and (4) they should give the public comparative information on plans in the managed long-term care program so that individuals can better choose a plan that meets their needs.

States may want to limit the items plans report on, both to minimize plan requirements and to reduce the state’s evaluation burden. Keeping the list of reported items manageable is a reasonable goal. However, you should identify the critical measures relating to enrollees’ access to appropriate services and supports, active case management, and enrollee experience and push hard for those to be included. (See “Will plans be rewarded for meeting quality and other non-financial performance measures?” on page 13 for some suggested quality measures.) It might be helpful for you to talk with advocates in states with established managed long-term care programs in Medicaid and see what performance measures they think are the most important.

Reports on plan performance should be made publicly available through timely and conspicuous posting of reports on plan websites, as well as the state Medicaid website. In addition, these reports should be provided to stakeholders and consumers during any public forums and advisory board or stakeholder meetings, and they should be provided via stakeholder listservs the state may maintain.
- **Is the state outlining clear criteria for how it will evaluate plan performance?**
  The state should evaluate and reward plans based not only on cost, but also on their performance against quality and access measures.

- **Are there real penalties for poor performance?**
  In its contract with plans, the state should include provisions for state recourse during the contract term if a plan performs poorly on quality or access measures. States should make every effort to work with plans to correct underperformance and improve patient care so that enrollees do not have to face any additional care disruptions. However, the contract should include options for the state to freeze enrollment and terminate the contract in cases where plans do not correct performance. In the event of a plan termination, the state’s contract should require the plan to cooperate in ensuring an orderly transition of enrollees to other managed long-term care plans or traditional Medicaid with minimal disruptions in care.

**State Readiness**

States should not look at contracting with a managed long-term care plan as an invitation to abdicate responsibility for Medicaid long-term care. You need to make sure the state will dedicate sufficient resources to plan oversight and will continue to invest in and develop regulations to support the infrastructure to meet the demands for long-term services—demands that will increase as the population ages.

- **Does the state have the capacity to oversee the plans?**
  You should make sure that the state will be investing adequate resources in plan oversight and management. This can be a very intensive process during implementation and program start-up. The state should have an oversight plan and adequate staff dedicated to oversight activities.

- **Will the state continue to invest in building home- and community-based care capacity?**
  Moving Medicaid long-term services to managed care will not address ongoing resource needs. In most states, there are serious long-term care workforce shortages and an insufficient supply of adequate housing for people who need long-term care. States will need to invest in efforts to improve both. For workforce issues, this can include offering worker training programs, ensuring fair wages for workers, and training programs for family caregivers. It will typically require multiple agencies working together to address housing issues. Managed care plans can work with states on ways to address these problems, but contracting with managed care organizations will not make these issues go away. To the extent that managed care plans shift more care to the community, the need for better housing options and more workers may become more acute.
Your Role as an Advocate

There is a lot to consider if your state is moving toward managed long-term care in Medicaid. You should work with state officials who are leading the process to make sure the program is designed to protect consumer choice and improve care delivery. You should also make sure that consumer-friendly provisions are included in the state’s contracts with managed care plans.

One of the most important things you can do is to make sure that the state is involving stakeholders early on in the process. You should become involved in whatever advisory committee or other stakeholder group the state puts in place. That way, you will have more direct information about what the state is considering, and you will have more opportunities to evaluate and comment on state proposals, plan selection, and other aspects of the managed long-term care program. You should also connect with consumer groups in states that have managed long-term care in Medicaid to learn first-hand what has worked and what hasn’t. Their experience should guide you as you evaluate proposals.

If the state is not creating a process that includes consumers and their representatives, you should work with a broad coalition of constituencies to pressure the state to use a more inclusive process. A coalition could include members of the aging and disability communities as well as long-term care workers and their representatives. Providers and managed care plans may be interested in including consumers as well, because people are more likely to accept programs that are built with consumer input, and plans want a smooth transition without bad publicity.

If the state is shutting you out of the process, moving too fast without concern for consumer protections or without making sure that plans are ready, or not conducting a transparent plan selection process, you should not hesitate to notify the media and make the public aware that the state is undertaking a process that puts all people in the state who need long-term care, either now or in the future, at risk. You can also contact appropriate staff at CMS directly to request information on state proposals and to provide feedback.
Conclusion

As an advocate, you have a key role to play in making sure that managed long-term care in Medicaid ultimately helps consumers obtain the long-term services they need and that it gives consumers more opportunities to live in the setting they prefer. As soon as it is clear that Medicaid managed long-term care is happening in your state, you should engage in the process to make the program as good as it can be for consumers. That will require a lot of work getting into the details of the state’s program design and its contracts with managed care plans. But if you don’t do that, there is a real risk that managed long-term care in Medicaid could make the system even worse for consumers. If your state is moving toward managed long-term care in Medicaid, work to make sure that the process includes as many consumer protections as possible, that plans are required to report publicly on performance, and that there are formal processes for advocates to continue to be involved in monitoring, evaluating, and making changes to the program as needed.

Our long-term care system often fails for those who rely on it, frequently because care is poorly coordinated. Done right, managed care could result in a system that works better—if it is carefully structured and immediate short-term savings are not the only goal. That’s a big “if,” and it’s essential that, as an advocate, you get involved and try to make that “if” a reality.
Endnotes

1 The Affordable Care Act created the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation and tasked them with developing better integrated care. Detailed information about these demonstrations is available at CMS’s Integrated Care Resource Center, www.integratedcareresourcecenter.com.


4 At the time this brief was written, home care workers were excluded from federal minimum wage and overtime protections, although several states had minimum wage and overtime requirements. Federal rules to extend minimum wage and overtime protection to home care workers were under consideration but had not been finalized.
Acknowledgments

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