Improving Medicaid Long-term Services and Supports

Key Informant Interviews and Focus Groups
Executive Summary

04.30.2018

PSC

INTRODUCTION

The Michigan Department of Health and Human Services provides long-term services and supports for people on Medicaid who qualify for in-home or nursing home-level care. In an effort to improve access to high-quality care based on consumers' needs and preferences, the department commissioned the Center for Healthcare Research and Transformation (CHRT) and Public Sector Consultants (PSC) to study other states' LTSS systems and perform in-depth interviews and focus groups with key informants and current LTSS consumers throughout Michigan.

PSC conducted 27 key informant interviews with representatives of managed care organizations (MCOs), LTSS providers, nursing homes, Area Agencies on Aging, community mental health, recipients of services and supports, and the state long-term care ombudsman's office.

In addition, PSC conducted nine focus groups with consumers of LTSS and their caregivers, including people living in nursing homes, older adults living in the community, people with intellectual and developmental disabilities (I/DD), people with serious mental illness, and people with physical disabilities. These consumers receive a wide array of care, services, and supports, including home- and community-based services; assisted living; transportation; medication delivery, review, and assistance; community living supports and respite services for caregivers; physical, occupational, and speech therapies; meals; applied behavior analysis; nursing home rehabilitation; nursing home custodial care; job skills training; care coordination; and caregiver training. Most focus groups occurred in settings where services were received.

This report highlights key findings from the interviews and focus groups as well as observations specific to each of these efforts to engage stakeholders.

WHAT IS WORKING WELL?

- **The MI Choice Waiver Program** is widely praised for the choice and flexibility it affords consumers where LTSS are available and accessible. The most common critique is that accessing the MI Choice Waiver is difficult or becoming more difficult and that there is no way to enroll or serve everyone who is eligible and in need of the waiver.

- **PACE is praised by most stakeholder groups as a model for integrated care** that successfully addresses many of the issues raised by providers and consumers in other segments of the LTSS system. A majority of the LTSS community (ombudsmen, nursing home representatives, advocates for people with I/DD, AAA administrators, and CMH administrators) shared this sentiment. More specifically, the program successfully offers a comprehensive suite of services; allows "spend-downs" to improve access to services; integrates behavioral and physical healthcare services and supports in both communal and residential (home-care) settings; prevents increased acuity and higher-cost care, including hospital visits and institutionalization in nursing homes; and provides respite care and support for caregivers as well as consumers. Interviewees recommended expanding this model for the strength it would bring to an MLTSS system.

- **Nursing home availability** is excellent, according to interviewees. Many, though not all, nursing homes are viewed as providing high-quality care. According to interviewees, a strength of the current

system is many nursing homes' ability to transfer patients from their own facilities to home- and community-based care.

WHAT ARE THE CHALLENGES?

- **Stakeholders agree that informal caregivers are crucial to the LTSS system**, but that they lack adequate information, training, and support. These caregivers provide most of their loved ones' care and/or care coordination, yet few know what LTSS are available or how to obtain them.
- **Stakeholders widely agree that LTSS worker wages are not competitive** and that qualified, skilled workers are in short supply. The LTSS system, particularly home- and community-based care, relies on low-wage workers who regularly cycle out of the industry. This issue underlies and exacerbates many other issues throughout the system.
- **High-cost institutional care is the easiest type of LTSS to access**, even for those who do not need or desire it. Lower-cost home- and community-based care are relatively more difficult for consumers to obtain instead of, or after, institutional stays due to worker shortages and a fragmented service environment (e.g., home-care providers only offering one service out of several a consumer needs). Access to alternatives such as PACE and MI Choice Waiver for home- and community-based services is limited. PACE serves a small portion of the potential LTSS market and long MI Choice Waiver waitlists render the program inaccessible to many consumers. As a result, many consumers who are eligible for and desire home- and community-based care remain in custodial care instead.
- **Availability of LTSS is siloed by demographics, geography, and care coordinating agencies.** While needs differ across consumer group (e.g., older adults vs. people with developmental disabilities), defining services according to consumer group can also mask similarities in functional needs. Services and supports differ from region to region and between urban and rural communities. Specific types of services (e.g., behavioral health, environmental modifications, and supports) are often provided by separate agencies. Available choices are not always easily accessible due to a program's limited target population or service territory, or the need to seek multiple services and supports individually from different providers.
- **Availability of durable medical equipment and repairs is tenuous and at risk.** By not requiring companies to honor their bids, stakeholders say, the state's competitive bidding process has undermined prices and the market for durable medical equipment statewide. Many companies have already gone out of business or stopped serving this market, placing consumers at risk for related issues and ancillary costs (e.g., injuries from improperly fitted equipment and bed sores).

LESSONS LEARNED FROM MI HEALTH LINK

- **Many LTSS providers view clinical care, behavioral health, and services and supports as different paradigms.** As a result, processes differ across LTSS stakeholders. There is a fundamental tension between care approaches that are prescriptive and short term, and that emphasize centralized and streamlined care coordination and reimbursements (e.g., health plans) and long-term, contextual approaches focused on continually meeting participants' expressed and emergent needs through in-depth knowledge of resources available at the community level (e.g.,

PACE, behavioral health). These paradigm differences underlie much of the friction among LTSS stakeholders.

- **Health plans and current LTSS providers envision different futures for managed long-term services and supports (MLTSS).** Health plans favor passive enrollment, autonomy to manage LTSS plans, measurable quality control, and uniform processes. AAAs and CMHs take a prevention-focused long view of care, services, and supports to improve care and reduce costs. Many worry that health plans do not understand the nature of this work or the population they are serving, fearing health plans will unintentionally hurt consumer outcomes and the quality of care they receive.
- **Most stakeholders view MI Health Link as a good concept but are critical of the effort to move MLTSS to health plans,** a move they believe prioritizes cutting costs over improving quality of care. Many providers questioned whether health plan management of LTSS is actually an effective means to either end. Following the Section 298 efforts to shift administration of behavioral healthcare to health plans, many stakeholders felt the state lacked transparency in its dealings with health plans and were mistrustful of MI Health Link as a result.
- **All stakeholders, including health plans, expressed the need for clearly defined goals and roles in any future efforts to integrate managed care.** Without these, most providers, as well as state employees tasked with implementing the pilot, felt that MI Health Link was better in premise than practice. They felt that MI Health Link resulted in duplication of services and administration without delivering on its fundamental premise to improve care coordination.
- **All stakeholders felt that MI Health Link's passive enrollment rollout was "too little, too late."** Interviewees felt that the consumer letter was overly bureaucratic, did not speak to the questions consumers had, and focused more on how to opt out of MI Health Link than on why consumers might benefit from participating. Current LTSS providers, health plans, and consumers alike felt that the rollout hindered the pilot's success.
- **Many stakeholders felt that the pilot did not address fundamental issues hindering the LTSS system,** such as lack of support for informal caregivers, the acute paid workforce shortage, and adequacy of capitation rates to cover hard-to-serve populations.

230 N. Washington Square
Suite 300
Lansing, MI 48933