Improving Medicaid Long-term Services and Supports

Key Informant Interviews and Consumer Focus Groups

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INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) provides long-term services and supports (LTSS) 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, LTSS providers, nursing homes, Area Agencies on Aging, community mental health, people receiving LTSS, 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, people with serious mental illness, and people with disabilities. Key findings from the interviews and focus groups are highlighted below.

OVERVIEW OF KEY FINDINGS

WHAT IS WORKING WELL?

- **The MI Choice Waiver Program** is widely praised for the choice and flexibility it affords customers where LTSS are available and accessible, although it suffers from long wait lists and a fragmented LTSS market.
- **PACE (Programs of All-inclusive Care for the Elderly)** is praised by most stakeholder groups as a model for integrated care that successfully addresses many of the issues raised by providers and customers in other segments of the LTSS system.
- **Nursing home availability** is excellent, according to interviewees, as is nursing homes' ability to transition residents 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.
- **There is widespread agreement among stakeholders 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 don't need or desire it. Lower-cost home- and community-based care is relatively more difficult for customers 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 customer 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 customers. As a result, many customers 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 customer group (e.g., older adults vs. people with developmental disabilities), defining services according to customer 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 customers 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 1) prescriptive, short term, and emphasize centralized and streamlined care coordination and reimbursements (e.g., health plans) and 2) long-term, contextual approaches (e.g., PACE, behavioral health) focused on continually meeting participants' expressed and emergent needs through in-depth knowledge of resources available at the community level. These paradigm differences underlie much of the friction between LTSS stakeholders.
- **Health plans and current LTSS providers envision different futures for managed LTSS.** 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're serving, fearing health plans will unintentionally hurt consumer outcomes and the quality of care they receive. As such, they prefer a horizontally-integrated, capitated LTSS system to a hierarchically coordinated LTSS system managed by health plans.

- **Most stakeholders view MI Health Link as a good concept but are critical of the effort to move managed LTSS to health plans** which, they believe, prioritized cutting costs over improving quality of care. Many providers questioned whether health plan management of LTSS was 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.** Without these, most providers, including 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 customer letter was overly bureaucratic, did not speak to the questions customers had, and focused more on how to opt out of MI Health Link than on why customers might benefit from participating. Current LTSS providers, health plans, and customers 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.