

**Consumer Choices and Continuity of
Care in Managed Long-Term
Services and Supports:
Emerging Practices and Lessons**

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Research Report

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EXECUTIVE SUMMARY

Background

State Medicaid programs increasingly are moving toward managed care models for purchasing long-term services and supports (LTSS). This shift to managed care has raised policy and operational questions among stakeholders. Concerns include the possible interruption of LTSS during the initial transition to managed care and reduction of services over time as managed care contractors seek to lower costs. Stakeholders also have concerns about losing access to existing LTSS providers if their providers do not participate in managed care networks.

This study examines how two important consumer protections are addressed during implementation of MLTSS programs: (1) consumer choices and (2) continuity of care. These are examined specifically during short periods of system transition, including transitions from fee-for-service to managed care, and transitions from one managed care contractor to another. The study's findings are limited to this snapshot in time.

Methodology

From November 2012 through April 2013, Truven Health Analytics conducted a study for the AARP Public Policy Institute on consumer choices and continuity of care in Medicaid MLTSS. The study included analysis of contract provisions in 14 states and an in-depth review of how provisions were implemented during recent system transitions in Kansas, New York, and Wisconsin. The AARP Public Policy Institute also convened an Innovation Roundtable meeting of national and state experts to discuss the findings and inform this report.

In Kansas, approximately 30,000 LTSS consumers were transitioned to managed care on January 1, 2013, as part of the statewide implementation of KanCare. In New York City, approximately 45,000 LTSS consumers were transitioned to managed care beginning in November 2012 and continuing into 2013. In a five-county region in west-central Wisconsin, about 2,700 LTSS consumers were transitioned from one managed care contractor to another on January 1, 2013. The report offers a snapshot of how consumer choices and continuity of care provisions were implemented in these states during transitional periods of about 3 months, beginning with pre-enrollment activities and continuing through enrollment to early service delivery.

Key Findings

- ***The three study states established “transition periods” designed to safely transfer LTSS consumers from one service delivery system to another without abrupt change to the consumers’ experiences.***

For example, during transition periods, states are requiring MLTSS contractors to reimburse all existing Medicaid LTSS providers at current fee-for-service rates, regardless of whether they are participating in the contractors’ networks. The result of this requirement is that consumers retain their existing LTSS providers during the transition, regardless of which contractors they have selected.

- ***LTSS consumers experienced little or no change as responsibility for their service plans transitioned from one service delivery system to another.***

In the short transition period studied, consumers moved from fee-for-service to managed care (Kansas and New York) or from one MLTSS contractor to another (Wisconsin) without significant interruptions in authorized service plans, according to a broad range of stakeholders interviewed. In most cases, authorized services continued to be delivered by the same providers. Consumers who had been self-directing services continued to do so. States and contractors worked cooperatively to ensure that transitions caused no disruption in existing service arrangements for LTSS members.

- ***Protecting consumer choices within MLTSS programs is a high priority for stakeholders across the board.***

As states implement mandatory MLTSS programs, providing consumers with a choice among competing program models or managed care contractors is accorded high priority in both federal and state policy. Consumer choices within managed care plans, such as choice of LTSS providers, choice of care coordinators, and choice to self-direct LTSS, are not uniformly protected in contracts or policy, but are broadly supported by stakeholders across the board, including contractors, who are motivated to maximize choices as a strategy for attracting and retaining members.

- ***A significant constraint on choice is the lack of sufficient or timely investment in consumer education strategies to ensure informed decision making.***

Stakeholders across the board agreed that consumers could use more or better information, or the same information provided in a different format or in a more timely way. For example, using written information to contact a hard-to-reach population with traditionally low literacy levels has limited effectiveness and should be combined with information provided by community organizations already familiar to consumers. The community organizations themselves need to be educated early, so they are prepared to help consumers in a timely way.

- ***The transition of the care coordination function to the MLTSS contractors creates particular challenges and requires focused attention.***

In both Kansas and Wisconsin, the incoming MLTSS contractors hired a majority of care coordinators from the outgoing care coordination organizations. While this had the effect of preserving local knowledge of resources and systems, it created a short-term transitional issue that needed to be managed closely. Both former and new employers needed to be flexible to effect an orderly transition.

- ***MLTSS practices continue to evolve.***

Close examination of recent transitions in three states suggests that MLTSS program practices have evolved as a result of stakeholder scrutiny, lessons learned from earlier program initiatives, and evolving regulatory oversight. Emerging practices include the creation of transition periods, greater standardization of forms and processes across contractors, state-imposed provider rate structures, targeted outreach to LTSS stakeholders, continuation of existing consumer-provider relationships, and highly intensive monitoring of early program implementation. These and other practices are described in greater detail.

Lessons

- ***Expect a large demand for information at and near the “go live” date.***
Consumer and provider hotlines, choice counseling agencies, and other organizations need to anticipate and plan for a spike in demand for information in the few days prior to and following the effective date of enrollment.
- ***State policy regarding consumer choices only goes so far.***
For successful implementation, the policy must be communicated effectively and consistently to all stakeholders, and providers must be successfully recruited into networks.
- ***Greater standardization of certain business processes across contractors would facilitate participation for LTSS providers.***
One state reported, for example, that more could have been done to standardize provider billing practices across contractors.
- ***Public forums and an array of mailings are each critical as outreach vehicles, but are not sufficient engagement by themselves.***
Communication strategies should be multifaceted and should include a wide range of marketing, educational, and outreach activities (including targeted outreach to home care agencies, nursing homes, advocacy groups, information and referral sources, etc.).
- ***While the establishment of continuity of care policies may be relatively straightforward, the implementation of those policies at the plan level is not.***
To implement a continuity of care policy, plans had to obtain pre-existing service plans prior to enrollment. While some service plans were available in electronic format, many were not.
- ***In states where the care coordination function is moving from one entity to another during the MLTSS transition, continuity of care coordination may become an issue before the “go live” date.***
In Kansas and Wisconsin, for example, incoming contractors were hiring care coordinators away from the outgoing care coordination entities prior to the “go live” date. This created the risk of consumers losing their care coordination services for a period of time before they were enrolled with the new contractors.
- ***LTSS providers require substantial technical assistance with billing.***
This should be a significant expectation of contractors, and the assistance should begin before program implementation and continue as needed going forward.

Conclusion

The study was limited to short transition periods (90 to 180 days surrounding the effective dates of enrollment), during which existing individual service plans and LTSS providers remained largely in place. The policies and practices observed were effective at protecting consumer choices and continuity of care during the short transition period, resulting in minimal disruption at the consumer experience level. As contractors

gradually work with members to review and revise service plans where appropriate, and as they gain greater flexibility to manage their networks, the longer-range impact on choices and continuity is unknown and should be carefully monitored.

1. INTRODUCTION

States are increasingly shifting from fee-for-service models to managed care models for purchasing Medicaid long-term services and supports (LTSS). The goals of this shift vary by state and include (1) acceleration of LTSS system balancing efforts; (2) greater statewide control over the quality and consistency of LTSS services; (3) slower growth in Medicaid spending for LTSS; (4) person-centered approaches that coordinate LTSS with other needs, including acute care and behavioral health; and (5) consolidation of state Medicaid systems and oversight, which are now largely geared toward managed care for other populations.

The number of states with managed long-term services and supports (MLTSS) has grown from 8 in 2004 to 16 in 2012. The number of people receiving Medicaid LTSS through managed care nearly quadrupled in that period, from 105,000 to 389,000.¹ A recent survey found that 11 states were planning to develop new MLTSS programs through 2013.²

While acknowledging the potential advantages of managed care purchasing models, many stakeholders have expressed concerns about the impacts of managed care models on consumers.³ Among these concerns is that managed care will limit the traditional rights of consumers to access Medicaid LTSS services in accordance with their own individual needs and preferences, that choice of LTSS providers will be constricted by closed provider networks, and that critical services will be disrupted during transitions in the service delivery system. Federal rules governing Medicaid managed care include provisions on consumer choices and continuity of care, but lack

¹ P. Saucier, J. Kasten, B. Burwell, and L. Gold, *The Growth of Managed Long Term Services and Supports (MLTSS) Programs: A 2012 Update* (Prepared by Truven Health Analytics for CMS, 2012). Accessed on December 17, 2012, at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

² M. Cheek, M. Roherty, L. Finnan, E. Cho, J. Walls, K. Gifford, W. Fox-Grage, and K. Ujvari, *On the Verge: The Transformation of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, 2012). Accessed on December 17, 2012, at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/On-the-Verge-The-Transformation-of-Long-Term-Services-and-Supports-Report-AARP-ppi-ltc.pdf.

³ See, for example:

National Senior Citizens Law Center, *Medicaid Managed Long-Term Services and Supports: A Review and Analysis of Recent CMS Waiver Approvals in New Jersey and New York* (2013). Accessed on March 7, 2013, at <http://www.nslc.org/wp-content/uploads/2013/03/MLTSS-NY-NJ-Final-030113.pdf>.

Government Accountability Office, *Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs, Payment Systems and States*, GAO-13-100 (2012). National Council on Disability, *Analysis and Recommendations for the Implementation of Managed Care in Medicaid and Medicare Programs for People with Disabilities* (2012). Accessed at <http://www.ncd.gov/publications/2012/CMSFebruary272012/>.

National Disability Leadership Alliance, *Principles for Providing Coordinated Quality Health Care in Medicaid Managed Care Programs for Those Living with Significant Disabilities* (2012). Accessed on December 17, 2012, at <http://www.disabilityleadership.org/files/NDLA%20PRINCIPLES%20FOR%20MEDICAID%20MANAGED%20CARE%20%28March%202012%29%20--%20%20FINAL.PDF>.

specificity related to MLTSS.^{4,5} Consumer protections within MLTSS are evolving on a state-by-state basis as more states launch MLTSS programs.

Study Purpose and Approach

From November 2012 through April 2013, Truven Health Analytics conducted a study for the AARP Public Policy Institute on consumer choices and continuity of LTSS in MLTSS programs. The purpose of this study was to glean lessons from states with existing MLTSS programs regarding how to effectively provide choices and ensure continuity of LTSS as consumers move between and across service delivery systems. The study included three activities: (1) a contract review that identified expectations for consumer choices and continuity of LTSS in 14 state contracts; (2) an in-depth examination of how choices and continuity of LTSS provisions were implemented in late 2012 and early 2013 in Kansas, New York, and Wisconsin; and (3) a Public Policy Institute Innovation Roundtable meeting, attended by federal and state policymakers, MLTSS contractors, consumer representatives, and AARP National Policy Council members.

Key Terms

Managed long-term services and supports (MLTSS) refers to an arrangement between state Medicaid programs and contractors through which the contractors receive capitated payments for LTSS and are accountable for the delivery of necessary services and supports in a way that meets quality and other standards set forth in the contracts. We include all types of MLTSS, from those that include only Medicaid LTSS services to those that include all LTSS, acute, and behavioral services financed by Medicaid and Medicare.

Consumer choices refers to the array of options that consumers have within an MLTSS system, including

- choice to enroll in MLTSS;
- choice among MLTSS contractors;
- choice among LTSS providers;
- choice among care coordinators or interdisciplinary teams; and
- choice to self-direct LTSS within an MLTSS program.

Continuity of LTSS refers to the goal of ensuring seamless transitions with no disruption in existing LTSS. Transitions include

- enrolling into managed care from fee-for-service;
- changing from one managed care contractor to another; and
- disenrolling from managed care.

⁴ A notable exception is the federal PACE regulation, which is specific to the Program of All-inclusive Care for the Elderly.

⁵ In May 2013, CMS issued guidance to states that clarifies the application of existing regulations to MTLSS programs. The guidance is available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

2. CONTRACT REVIEW

The first part of our study consisted of examining the documents governing the relationship between states and their MLTSS contractors. In most instances, this governing document was a contract. However, two states adopted their requests for proposals as their primary contract documents (Hawaii and Kansas). For Wisconsin, we reviewed both the contract between the state and the contractors as well as the Aging and Disability Resource Center (ADRC) contract, which contains key consumer choice provisions because of the ADRC's role in facilitating and effectuating consumer choices. Additionally, the New York contract is undergoing revisions, so a final revised draft was not yet available. Accordingly, the documents used for the contract review for New York were the January 2012 contract and the Section 1115 Demonstration Standard Terms and Conditions.

The purpose of our contract review was to identify how the states had addressed consumer choices and continuity of care in their MLTSS contracts. We examined the most current contracts available as of January 2013 in 14 states that had MLTSS programs for older persons or adults with physical disabilities, or both. The contracts are listed in Appendix A.

During our contract review, it became apparent that many of the state contracts are not self-containing. They routinely incorporate state policy requirements or other applicable laws by reference. For example, several states have patient bill-of-rights laws that apply to all forms of managed care (commercial and public). In this contract study, we relied primarily on what could be found in the contracts themselves.

Contract Review Findings: Consumer Choices

We reviewed contracts seeking answers to the following questions.

- Do eligible individuals have the choice of participating, or is enrollment mandatory?
- If voluntary, do eligible individuals have the option to decline enrollment, or are they auto-enrolled with the option to disenroll?
- Do MLTSS consumers have a choice among MLTSS contractors at initial enrollment, and the ability to switch contractors?
- Once enrolled, do members have a choice of
 - LTSS providers, including home-based, residential care, and nursing homes?
 - care coordinators?
- Once enrolled, do members have the option to self-direct LTSS?
- How are consumers made aware of their choices? Has an enrollment broker, ADRC, or other entity been designated to help consumers exercise their choices?

We discuss our cumulative findings by topic below and present them by state and by topic in Table 1.

Table 1
Contract Provisions on Consumer Choices^a

State	Is the program mandatory or voluntary for eligible persons?	Does the contract state that consumers have a choice of contractor?	Does the contract state that consumers have a choice of LTSS provider?	Does the contract state that consumers have a choice of care coordinator?	Does the contract indicate the use of an enrollment broker?	Does the contract outline enrollment procedures/ notices/ time lines?	Does the contract state that consumers have choice of self-direction?
AZ	Mandatory	Yes ^b	No	No	No	No	Yes
DE	Mandatory	Yes	No	Yes ^c	No	Yes	Yes
FL	Voluntary	Yes ^b	Yes	No	No	Yes	Yes
HI	Mandatory	Yes	No	Yes ^c	Yes	Yes	Yes
IL	Mandatory	Yes	No	No	Yes	Yes	Yes
KS	Mandatory	Yes ^e	Yes, when feasible.	Yes ^c	No	Yes	Yes
MA	Voluntary	Yes ^b	Yes	Yes ^c	No	Yes	Yes
MN	Mandatory ^d	Yes	No	No	No	Yes	Yes
NM	Mandatory	Yes	No	No	No	No	Yes
NY	Mandatory	Yes	Yes	Yes	Yes	No	Yes
TN	Mandatory	Yes ^e	Yes	No	No	Yes	Yes
TX	Mandatory	Yes	No	No	Yes	No	Yes
WA	Voluntary	No ^f	No	No	No	Yes	Yes
WI	Voluntary	Yes ^g	Yes	Yes ^c	Yes ^h	Yes ^h	Yes

^a See Appendix A for a list of contracts analyzed.

^b Except in areas where only one contractor exists.

^c Subject to availability, members may request a change in care coordinator and/or care team.

^d Dual eligibles are subject to mandatory enrollment in a Medicaid-only plan, with a voluntary option to enroll in a fully integrated Medicare-Medicaid plan instead.

^e Consumers are auto-assigned to a contractor and can switch to a different contractor during the first 45 days of enrollment (pending federal approval).

^f The Washington program has only one contractor.

^g In Wisconsin, the choice is between one or more MLTSS contractors and they Include, Respect, I Self-Direct (IRIS) self-directed services program.

^h The enrollment process is addressed in the state's contract with ADRCs.

PLEASE NOTE: Results are limited to provisions contained in MLTSS contracts and do not necessarily reflect broader state policies on consumer choices and continuity of care.

Choice of Whether to Participate

The majority of states (10 out of 14 states reviewed) have mandatory programs. Among the voluntary programs, one uses passive enrollment, in which a newly eligible person is automatically enrolled into the MLTSS program but may disenroll from the program for any reason. The other voluntary programs require consumers to actively opt in before they are enrolled.

Choice of Contractor

Most voluntary programs provide choice of contractors, except in areas where only one contractor exists. The mandatory programs all give consumers a choice of contractors, with some limitations. Programs generally offer a choice of at least two contractors, but some include rural areas where only one contractor operates. Some states assign new members to contractors automatically but allow them to change contractors within a set period of time, usually within the first 30 to 45 days of enrollment. The criteria for auto-enrollment vary from state to state, and include current contractor affiliation (if already enrolled for acute care, for example), participation of key providers, and distribution of members across contractors. The ability to move from one contractor to another is allowed at any time in some states, and at least annually in all states.

Choice of LTSS Provider

A minority of state contracts (six) indicate that members have a choice of LTSS provider, which is generally contingent on availability of providers within the contractors' networks. All contracts have network adequacy standards that require a sufficient number of providers to serve the enrolled population, but in rural areas, the supply may be limited to one nursing home or one home care agency. Several contracts indicate an objective of maximizing choice of providers, including keeping current providers, without explicitly mandating the choice. In those provisions, states appear to be balancing a desire for choice with a contractor's ability to manage its network.

Choice of Care Coordinator

Six state contracts specify that members may change care coordinators or interdisciplinary teams, or both, subject to availability. One state specifies that such a change may be requested twice per calendar year.

Choice of Self-direction

All of the analyzed contracts specify that members have the option to self-direct their LTSS. Some contracts specify when members must be notified of this option, and how notice must be documented.

Entity to Assist with Consumer Choices

Four states use enrollment brokers in their MLTSS programs, but the role of the brokers varies. In three, the broker is a third-party agent that enrolls each consumer with a contractor. However, the broker does not always play a choice counseling role, in which consumers are assisted in making a decision based on their individual circumstances. The remaining states take a variety of approaches to enrollment. Some do

enrollment through state or county offices. At least one uses ADRCs in areas where they are available, and allows direct enrollment by contractors in areas where ADRCs are not available. Several states allow direct enrollment by contractors.

Clarity on Enrollment Procedures and Process

Enrollment provisions, including time frames, notice procedures, and default options, are outlined in most (10) contracts, though most of the steps leading up to the point of actual enrollment are not usually the responsibility of the contractors and are not included in the MLTSS contract. For example, the state usually takes direct responsibility for notifying consumers when a new MLTSS program is being implemented, how it will affect them, and when they need to take certain actions or the state assigns this role to a contracted enrollment broker.

Contract Review Findings: Continuity of Care

We searched contracts seeking answers to the following continuity of care questions:

- Is continuity of LTSS addressed in MLTSS contracts?
- For what period of time do continuity provisions apply?
- What scope of services do the continuity provisions address?
- Do the continuity provisions address requirements for contractors to include pre-existing LTSS providers in their networks?

Our cumulative findings are discussed below and are presented by state and topic in Table 2.

Inclusion of Continuity Provisions

Although all of the contracts we examined address continuity of services in some way, their attention to the subject ranges from lengthy provisions directly on topic to single lines or phrases embedded in broader provisions about enrollment, care coordination, or overall responsibilities of the contractors. Additionally, the precise scope of the continuity of care provisions was harder to tease out when the scope of the program was broader than just LTSS.

The provisions are usually framed in terms of the contractor's financial responsibility on the first day of enrollment for services authorized in a member's prior service system. By focusing on financial responsibility, the provisions address the practical problem that the contractor may have little or no information about a new member until the member is enrolled. The provisions make clear that services continue in this transitional period as authorized in the prior system, and the contractor must pay for them.

Duration of Continuity Provisions

Most (nine) of the contracts specify a time frame during which the continuity provisions apply. The time frames range from 30 days to 6 months, with 90 days being

Table 2
Continuity of Care Contract Provisions^a

State	Does the contract address continuity of services?	Does the contract specify a time frame during which the continuity provision applies?	What is the scope of the continuity provision?	Does the contract require the contractor to include pre-existing Medicaid LTSS providers?
AZ	Yes	Yes. 30 days.	Applies to an existing LTSS service plan.	No
DE	Yes	Yes. At least 30 days, and until the contractor conducts an assessment and implements a service plan.	Applies to an existing authorized LTSS services.	Yes, in part. Must contract with all NFs that participate in Medicaid for 3 years. Must offer a contract to all AIDS Waiver care coordinators for 1 year.
FL	Yes	Yes. Until the contractor conducts an assessment and implements a service plan.	Applies to an existing LTSS service plan.	No
HI	Yes	Yes. 90 days or until the contractor conducts an assessment and implements a service plan, and the first visit to the PCP has occurred.	Applies to medically necessary covered services that the individual was receiving the day before enrollment.	No
IL	Yes	Yes. 90 days.	Applies to a current course of treatment being provided by an out-of-network physician.	No
KS	Yes	No	Applies to existing authorized services.	Yes, in general terms. Language requires contractors transition new consumers with “continuance of current providers.” Community Mental Health Centers are specifically required to be included.

Table 2 (continued)

State	Does the contract address continuity of services?	Does the contract specify a time frame during which the continuity provision applies?	What is the scope of the continuity provision?	Does the contract require the contractor to include pre-existing Medicaid LTSS providers?
MA	Yes	No	Broad scope makes the primary care practitioner responsible for ensuring continuity of care at enrollment.	Yes, in part. Must contract with at least one existing Aging Services Access Point (ASAP) to arrange for community LTSS.
MN	Yes	Yes. 90 days for PCAs at disenrollment; 90 days for existing Rx at enrollment.	Applies generally to all medically necessary services authorized prior to enrollment, with additional specific application to elderly waiver services, PCA, and Rx.	No
NM	Yes	Yes. 90 days for existing Rx; 60 days for services.	Applies to LTSS, hospital, and Rx authorized prior to enrollment.	No
NY	Yes	Yes. 60 days or until a care assessment has been completed by the contractor, whichever is later.	Applies to pre-existing service plan.	Yes. Initially, all personal care vendors in New York City had to be offered contracts through March 31, 2013. Policy has been extended through December 31, 2013, and includes three additional counties.
TN	Yes	Yes. 30 days or until the contractor conducts an assessment and implements a service plan for community LTSS; indefinite (no time limit) for persons in NF or residential care at enrollment.	Applies to all LTSS services authorized prior to enrollment.	Yes, in part. Must include all NFs and residential care settings at which new enrollees are getting care.

Table 2 (continued)

State	Does the contract address continuity of services?	Does the contract specify a time frame during which the continuity provision applies?	What is the scope of the continuity provision?	Does the contract require the contractor to include pre-existing Medicaid LTSS providers?
TX	Yes	Yes. 6 months, or until the contractor conducts an assessment and implements a service plan.	Applies to community LTSS. (Consumers may not enroll or switch contractors while in an NF.)	In part. For the first 3 years, contractors must seek participation of all “Medicaid Significant Traditional Providers,” defined as LTSS and PCPs who serve the top 80% of clients in the county.
WA	Yes	No	Applies to Rx.	Yes. Contractor must make a good faith effort to contract with existing state-contracted networks for LTSS, mental health, and chemical dependency services.
WI	Yes	Yes. Until the contractor conducts an assessment and implements a service plan. IDT must meet with member within 10 days of enrollment to begin assessment process.	Applies to all services authorized prior to enrollment.	Yes. Contractors must include all Medicaid providers willing to take rate and meet quality standards.

^a See Appendix A for a list of contracts analyzed.

PLEASE NOTE: Results are limited to provisions contained in MLTSS contracts and do not necessarily reflect broader state policy on choices and continuity of care.

the most common, and the contractor usually has the option of shortening the actual time by conducting its own assessment and implementing its own service plan.

Two contracts provide no specific time frame, opting instead to simply state that the continuity provision applies until the contractor conducts an assessment and authorizes a service plan. Presumably, this provides an incentive to the contractor to connect with new consumers as quickly as possible.⁶ Three states' contracts do not state the duration of the continuity of care period.

Scope of Continuity Provisions

In several contracts, the continuity provision applies to any LTSS service authorization that exists on the day of enrollment.

Other contracts do not mention LTSS specifically but are broad enough in scope to include LTSS. For example, Minnesota's provision applies to any medically necessary service authorized prior to enrollment.

Example of Continuity of Care Contract Language: Texas Star+Plus

“The HMO is required to ensure that clients receiving Community-based Long Term Care Services at the time of implementation are guaranteed continued authorization of those services for up to six (6) months after the Operational Start Date, unless a new assessment has been completed and new authorizations issued . . .”

Example of Scope of Continuity of Care Contract Language: Tennessee CHOICES

“For each transitioning CHOICES member, the CONTRACTOR shall be responsible for the costs of continuing to provide covered long term care services previously authorized by TENNCARE or its designee, including, as applicable, HCBS in the member's approved HCBS E/D waiver plan of care and nursing facility services without regard to whether such services are being provided by contract or noncontract providers.”

Requirement to Include Pre-existing Providers in Contractors' Networks

Regarding access to pre-existing LTSS providers, a wide range of contract provisions exist. Five contracts do not offer specific provider opportunities or assurances of any kind.⁷ A few contracts have Any Willing Provider clauses for LTSS and other specified providers (others include physicians, mental health and substance use disorder providers, AIDS waiver case coordinators, etc.), which require contractors to include any Medicaid provider that is willing to take the contractor's rate and can meet quality standards. One state (Tennessee) requires contractors to include in their networks any nursing or residential care facility where a member resides at time of enrollment.

⁶ Most contracts also contain time standards for making contact with new members and conducting needs assessments.

⁷ All of the contracts have network adequacy requirements, which require contractors to have sufficient capacity by type of service, as opposed to requiring specific providers to be in the network.

Regardless of whether they become part of a contractor's network, the continuity provisions are designed to ensure that previously existing providers get paid for services during the designated continuity period. In general, for those transitional services, the contractor must pay out-of-network providers at the state's fee-for-service rate. That said, without provisions requiring contractors to admit pre-existing providers into their networks, it is unclear which providers will be in each network when each state's transition period ends.

3. IMPLEMENTATION EXPERIENCES IN THREE STATES

The second part of the study was an in-depth examination of recent MLTSS transitions in three states: Kansas, New York, and Wisconsin. In Kansas, approximately 30,000 LTSS consumers were transitioned to managed care on January 1, 2013, as part of the statewide implementation of KanCare, a broad, multipopulation program covering more than 300,000 people. In New York City, approximately 45,000 LTSS consumers were transitioned into a partially capitated specialty program targeted specifically to LTSS consumers. Enrollment began in November 2012 and continued into 2013. In a five-county region in west-central Wisconsin, about 2,700 LTSS consumers were transitioned on January 1, 2013, from one managed care contractor to another when the state ended its contract with the former contractor.

We provide a brief description of each program initiative observed, followed by a compilation of emerging practices, lessons, and findings across the three states.

KanCare

In January 2011, Governor Sam Brownback charged his lieutenant governor with leading a working group to reform the state's Medicaid program. In November 2011, the working group announced its design for comprehensive Medicaid reform, named KanCare, which, when implemented, was expected to improve the coordination of care and services for Medicaid enrollees.

In January 2012, Kansas submitted a draft concept paper to CMS for a Section 1115 waiver request to implement the KanCare initiative, and issued a request for proposals for Medicaid contractors to implement the care coordination strategy. Throughout 2011 and 2012, the state also undertook a stakeholder engagement process to elicit input from consumers and providers regarding Medicaid reform. In June 2012, Kansas selected three companies to assume risk for nearly the entire Medicaid population—Amerigroup Kansas, Sunflower State Health Plan (a subsidiary of Centene), and United Healthcare of the Midwest. The following month, Kansas submitted a formal Section 1115 waiver request to CMS for the implementation of KanCare.

In November 2012, Kansas mailed initial enrollment information to every Medicaid enrollee in the state, assigning each person to one of the three selected managed care organizations. The Section 1115 waiver request was finalized on December 27, 2012, and on January 1, 2013, approximately 300,000 Medicaid enrollees were transitioned to a managed care environment under KanCare. About 30,000 of these were receiving LTSS services at the time of the transition.

Prior to KanCare, the state's experience with Medicaid managed care included a program for families and children and two PACE sites.⁸ Neither of the managed care plans that operated in the state prior to KanCare were successful in winning one of the three KanCare contracts, so members in the pre-existing plans were transitioned to the new KanCare contractors.

KanCare is a comprehensive managed care program. Only a very limited number of Medicaid enrollees are exempt from enrollment, and very few Medicaid-covered benefits remain outside the KanCare benefit package. Importantly, all LTSS, including nursing home services, and HCBS are covered under the KanCare benefit package. One notable exception is that HCBS services covered under the state's Intellectual Disabilities 1915(c) waiver program are not included, although the state plans to extend KanCare coverage to include those services starting in 2014.

Consumer Choices and Continuity of Care Provisions under KanCare

The KanCare initiative was designed and implemented in a relatively short time frame. Given both the short time frame and the large magnitude of the initiative, stakeholders expressed considerable concern with potential disruptions to existing service arrangements between Medicaid enrollees and their providers. Given these stakeholders' concerns, the state placed a high priority on ensuring a smooth transition for Medicaid enrollees into the program.⁹

Consumer choices and continuity of care provisions included the following:

- Although auto-assigned to a managed care plan in early November 2012, all KanCare enrollees were allowed to switch plan assignments as often as they liked prior to the January 1, 2013, launch date. Many enrollees waited until the last few days in December to make the change from their assigned plans, creating a spike in activity during the holiday season, just before the “go live” date.
- Between the program launch date of January 1, 2013, and April 4, 2013, enrollees were allowed to switch plans on a monthly basis (i.e., any decision to switch plans takes effect on the first day of the following month).
- After April 4, 2013, enrollees are allowed to switch plans annually during an open enrollment period.
- During the transition period, all MCOs were required to reimburse all existing Medicaid providers at Medicaid fee-for-service rates regardless of whether the provider was in the MCO's network. Thus, no matter which MCO a person was enrolled in, their MCO was obligated to pay existing providers for at least 90 days.
- MCOs are required to pay Medicaid fee-for-service rates to all residential providers—including nursing homes—for the entire first year of the program, even if the

⁸ PACE is the Program of All-inclusive Care for the Elderly, a specific model of care in which provider-based organizations receive capitated Medicare and Medicaid payments to provide all-inclusive care to people aged 55 and older whose needs would qualify them for nursing facility-level care.

⁹ Kansas Office of the Governor. *Continuity of Care Top Priority for KanCare Transition*. Press release, December 27, 2012.

residential provider is not in the MCO's network. This means that, for at least 1 year, no nursing home resident would be required to move to another facility in order to stay in the same MCO plan.

- For HCBS LTSS recipients, MCOs are required to pay existing fee-for-service rates to all existing providers for an additional 90 days after April 4, 2013, if a new HCBS care plan is not put in place within the first 90 days.
- MCOs were required to honor all current prior authorizations (including LTSS service plans) for the initial 90-day transition period, or until the prior authorization ended. This required a substantial effort on the part of the outgoing case management agencies and the plans, because information has to be collected, delivered to the right MCO, and loaded into that MCO's system in a short period of time.

The state also provided technical support to the three MCOs in order to facilitate the development of comprehensive provider networks during the start-up period. For example, the state approved a uniform credentialing form for providers, so that providers would only have to complete a single credentialing form in order to meet the credentialing criteria for all three MCOs. Finally, the state scheduled daily stakeholder calls at 9:00 a.m. every Monday through Friday, during which any stakeholder could call in with a question or issue about KanCare that needed resolution.

New York Managed Long-Term Care Program

Since 1998, the state of New York has sponsored a number of demonstration programs to test managed care models for purchasing LTSS, including a managed long-term care partial capitation program, a number of PACE sites, and an integrated Medicare-Medicaid managed care program called Medicaid Advantage Plus (MAP). Most of the contractors selected to participate in these earlier demonstrations were provider-sponsored plans, and enrollment in the plans was voluntary. By April 2012, approximately 45,000 Medicaid LTSS consumers were receiving their Medicaid-financed LTSS benefits through a managed care entity, about 15 percent of the entire LTSS population in the state.¹⁰

In early 2011, newly elected Governor Andrew Cuomo created the Medicaid Redesign Team, which was tasked to put forth recommendations for major reforms to the state's Medicaid program. The Medicaid Redesign Team identified LTSS as a prime target for reform and recommended a shift to managed care models for all LTSS. The governor adopted this recommendation in his 2011–2012 budget process, and the state's Medicaid administration began implementation of a major shift to mandatory managed LTSS in July 2012. Under this initiative, more than \$13 billion in Medicaid LTSS spending will shift from the fee-for-service system to managed care models over the next few years.

The Managed Long Term Care (MLTC) program in New York is being implemented in multiple phases in regard to geographic areas, target populations, and covered LTSS

¹⁰ S. Samis, A. Detty, and M. Birnbaum, *Implementing Long-Term Care Reform in New York's Medicaid Program* (New York: Medicaid Institute at the United Hospital Fund, 2012).

benefits.¹¹ In the first phase of the program, HCBS covered through the state’s Medicaid personal care benefit, as well as ancillary services, are moving from fee-for-service to managed care within the five boroughs of New York City.¹² At the outset, the initiative is limited to certain Medicaid consumers aged 21 and older, who are dually eligible for Medicare and Medicaid, and who require more than 120 days of HCBS. A total of approximately 45,000 consumers of community-based LTSS in New York City are impacted by the shift to managed care.

The move to mandatory enrollment for MLTSS began in late 2012 but is ongoing as New York phases eligible individuals into the program. New York has also placed a high priority on ensuring a smooth transition for new consumers. Consumer choices and continuity of care provisions included the following:

- An independent enrollment broker assists with the enrollment of eligible individuals. This entity both made outgoing calls to contacts and received incoming calls from new consumers needing help in choosing a plan and understanding the program.
- New consumers receive multiple written notices prior to assigning them to a plan, including (1) an “announcement” letter to introduce them to the program and to provide information about the time line and process for enrollment; (2) a notice 60 days prior to enrollment with information on their choices, how to obtain counseling from the enrollment broker, and how to effectuate a plan choice; (3) additional letters at 45 and 30 days prior to enrollment to again prompt them to call for information and assistance in making a choice; and (4) an outreach call by case managers at the Human Resources Administration as well as by the enrollment broker during the enrollment phase. According to the state, as of December 2012, only 1.9 percent (570 individuals) had to be auto-assigned to a plan—all other targeted individuals had selected a plan prior to their scheduled enrollment date.
- MLTC consumers are allowed to switch plans at any time, with the new enrollment usually effective on the first day of the next month. (Consumers who decide to switch at the very end of a month may need to wait an additional month for processing.)
- MLTC consumers have choice of providers of all covered services.
- Initially in New York City, all MCOs were required to contract with existing Medicaid personal care vendors for the first 150 days of the program. Subsequently, that policy was extended through the end of 2013, and expanded to include Nassau, Suffolk, and Westchester counties.
- All MCOs were required to honor existing care plans for 60 days or until a care assessment is complete, whichever is later.

¹¹ New York used a phased process such that eligible individuals in each county would not all be enrolled in the exact same month. Instead, they are phased in based on their Medicaid eligibility renewal dates as well as their service authorization renewal dates. They are also batched based on the fee-for-service program (personal care program, consumer-directed personal assistance program, certified home health agency, etc.) through which they were receiving services prior to mandatory MLTSS enrollment.

¹² New York state has traditionally funded HCBS under Medicaid through the personal care state option benefit, not through 1915(c) HCBS waiver programs, as in most other states.

LTSS consumers in New York have a large number of managed care options from which to choose. As shown in Table 3, 22 separate plans participated in the partially-capitated MLTC program in January 2013 alone. In addition, eight PACE programs served 4,664 members and nine integrated Medicare-Medicaid plans served about 3,094 members. Stakeholders suggested that a number of the plans in the MLTC program had applied “just to get in the game” but had very low enrollments and would probably drop their MLTC products in the next year or so. Stakeholders believe there will be a significant consolidation of MLTC contractors in New York after the transition to mandatory enrollment is completed.

Wisconsin Family Care

The Wisconsin Family Care program has been in operation since 1999, when it was launched as a pilot program in five Wisconsin counties. The program has since been expanded to 57 counties and had a total enrollment of 40,102 consumers as of December 1, 2012.¹³ Although Family Care managed care entities were initially limited to public entities (primarily county government agencies), the program now includes both public and private nonprofit managed care organizations.

Wisconsin Family Care is a partially capitated Medicaid program in which the managed care contractors are only responsible for providing a subset of the full Medicaid benefit package—namely LTSS. Contractors are at risk for all LTSS and related services, such as durable medical equipment and therapies, but not for inpatient hospital or physician services.

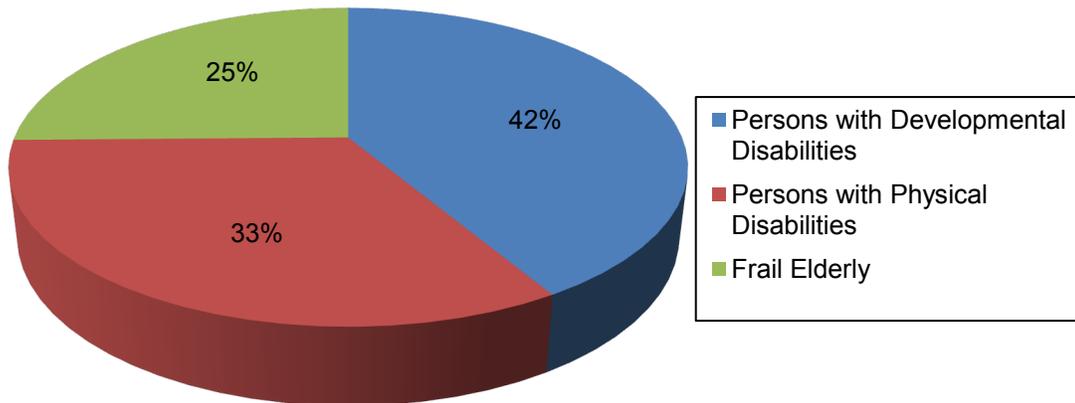
The populations served in the Family Care program include all people eligible for LTSS under the Medicaid program. People with developmental disabilities comprise about 42 percent of the enrolled population, people with physical disabilities comprise 33 percent of enrollees, and frail elderly people account for the remaining 25 percent of enrollees.

Table 3
Program Enrollment in Managed Long-Term Care in New York
January 2013

Plan Name	Total Enrolled
Aetna Better Health	101
AgeWell New York	143
Amerigroup	2,466
ArchCare Community Life	129
CCM Select	6,904
Elant	271
Elderplan	7,086
ElderServe	7,415
Fidelis Care at Home	2,661
GuildNet	10,570
HHH Choices	1,770
HIP of Greater New York	460
Independence Care Systems	3,805
MetroPlus MLTC	5
Senior Health Partners Inc	6,422
Senior Network Health	385
Senior Whole Health	103
Total Aging in Place Program	129
United Healthcare	33
VillageCare	1,112
VNS Choice	17,792
WellCare	3,796
TOTAL MLTC PARTIAL CAPITATION ENROLLMENT	73,558

¹³ Family Care, Partnership and PACE Enrollment Data, Monthly Snapshots as of December 1, 2012. See <http://www.dhs.wisconsin.gov/lcicare/Generalinfo/enrollmentdata.pdf>.

Populations Served in Family Care Program



An audit conducted by the Legislative Audit Bureau in 2011 determined that three of the nine MCOs participating in the Family Care program had ongoing net assets and reserve fund shortages that put them at risk of insolvency.¹⁴ The Department of Health Services (DHS) worked to improve the financial solvency of these three MCOs and reported in August 2012 that all but one MCO—Community Health Partnership (CHP)—had fully funded their restricted reserves. CHP continued to struggle financially, and in September 2012, DHS informed CHP that it intended not to renew its Family Care contract on January 1, 2013. DHS underwent a competitive process to select another MCO to take over the CHP membership, and in October 2012 announced that it had selected Southwest Family Care Alliance (Southwest), a plan that operated in eight counties to the south of CHP, to take over the CHP contract.

In October 2012, DHS sent letters to all 2,700 CHP members stating that CHP would no longer participate in the Family Care or Family Care Partnership programs, and that Southwest had been selected as the new MCO in their geographic area. CHP members were auto-assigned to Southwest and informed that they had the option to enroll instead in Wisconsin’s self-directed services program called IRIS (Include, Respect, I Self-Direct). The IRIS option is available to all consumers in the Family Care program, regardless of their geographical location.

The transition of CHP members was complicated by the fact that most CHP members were enrolled in CHP’s fully integrated Medicare-Medicaid plan, Family Care Partnership. Southwest is a Medicaid-only plan and does offer the partnership option. Thus, those CHP consumers who were enrolled in the fully integrated plan needed to find other options for receiving their Medicare-funded services, in addition to making choices about how to receive LTSS.

Unlike managed care entities in Kansas and New York, Southwest was under no contractual obligation with the state to honor existing care plans for consumers transitioning from CHP. However, Southwest made every effort to provide continuity of services for consumers transitioning into the plan on January 1, 2013, both out of a sense of mission and

¹⁴ State of Wisconsin Legislative Audit Bureau, *An Evaluation: Family Care* (April 2011).

because it made good business sense. According to interview respondents, Southwest made extraordinary efforts during the transition process to engage with their new members and to ensure that members' service needs were being adequately met. On the other hand, Southwest made it clear to the Medicaid provider community in the counties covered by the contract that it could not continue to pay the same reimbursement rates for LTSS services that had been paid by CHP. What it did offer providers was the promise to utilize sound business practices to keep rates stable, and to pay their invoices from providers on time.

Although a few providers that had been participating in CHP's network decided not to contract with Southwest, the company was highly successful in contracting with most of the CHP network providers and in honoring existing service plans for the transitioned consumers, albeit at lower payment rates for some LTSS providers.

One difficulty faced by the CHP members who were enrolled in the fully integrated plan was finding another Part D plan to cover their prescription drug costs. These individuals could choose either a Medicare Advantage option that included prescription drug costs, or traditional Medicare and a Part D plan. In the event that they did not make an affirmative choice between those options, they would be defaulted to traditional Medicare. Generally, they would need to choose a Part D plan or they would be auto-enrolled into one. When CHP members were transitioned out of the plan on January 1, 2013, however, the Part D open auto-enrollment period (which occurs in the fall) was over. Remarkably, the pharmacist working at CHP stayed in place until the end of the process and ensured that every CHP member in the integrated plan was enrolled in a Part D plan that matched up with that person's pharmacy and formulary needs. CHP also worked closely with Southwest to ensure a smooth transition for people who were at high risk due to severe physical or psychosocial deficits.

4. PUBLIC POLICY INSTITUTE INNOVATION ROUNDTABLE MEETING

On April 2, 2013, the AARP Public Policy Institute convened national and state experts to discuss preliminary findings from this study. Participants included federal and state policymakers, MLTSS contractors, consumer representatives, AARP National Policy Council members, and others. The discussion highlighted emerging practices and lessons that may be useful as states develop new and expanded MLTSS programs, and identified additional policy considerations.

5. FINDINGS FROM IMPLEMENTATION EXPERIENCES AND INNOVATION ROUNDTABLE

Consumer Choices

- ***Maximizing consumer choices within MLTSS programs is a high priority for stakeholders across the board.***

As states implement mandatory MLTSS programs, choice of contractor is considered key both to promoting good customer service and to promoting choice of LTSS provider. Contractors are motivated to offer as broad a provider network as feasible in order to attract and retain members. Contractors also recognize the importance of offering self-directed options as a strategy for attracting consumers who want it. States have found that maximizing choice at the provider level is a key issue for both consumers and LTSS providers.

- ***Policies aimed at providing fair and objective information to consumers may be impeding the flow of valuable information.***

Stakeholders across the board agreed that consumers could use more or better information, or the same information provided in a better fashion. This includes not only basic information about one's choices, but advice about which choices might be the best ones for a given consumer. In an effort to create a level playing field for contractors, most states prohibit any form of "steering" consumers toward particular contractors. In some cases, this may result in choice counseling that articulates people's choices, but offers little by way of guidance for decision making. This is an area that needs more stakeholder discussion to explore whether it is possible to develop models in which more qualitative information and advice are offered to consumers without exposing them to information that is unduly biased or not in their best interests.

- ***Consumers' ability to switch plans creates a strong incentive for contractors to engage new consumers and solidify their LTSS provider networks as quickly as possible.***

Contractors have found that early engagement with new consumers promotes retention, so they emphasize early outreach to new consumers. In MLTSS programs, contractors are motivated to assign care coordinators and conduct home visits as soon as possible to establish bonds with new consumers. Also, contractors work to shore up their LTSS provider networks as quickly as possible, with steps like targeted outreach to the existing providers of their new consumers.

- ***Some stakeholders are concerned about how choices will be impacted when transition periods end.***

Our observations in Kansas and New York were conducted during a transition period (the first 90 to 180 days following enrollment), during which consumers could change contractors, contractors were required to reimburse out-of-network LTSS providers, and existing service plans remained in place. These policies are highly effective at protecting consumer choices during the transition. As contractors gradually work with consumers to review and possibly revise service plans, and as they gain greater flexibility to implement their own policy on out-of-network providers, it remains to be seen whether similar levels of choice will be preserved over time.

- ***MLTSS provisions aimed at maximizing choice may constrain efforts to improve the quality of provider networks.***

To the extent that state contracts require all Medicaid LTSS providers to be included in contractors' networks, the status quo of the fee-for-service system is preserved, including the participation of both high- and low-quality providers for as long as the requirement is in place. Contractors may not cull out low-quality providers during the transition period. What happens to the quality of the provider network after transition periods end is an issue for future study.

Continuity of Care

- ***In all three transitions observed, LTSS consumers were moved from one service delivery system to another with no reported interruptions in existing LTSS service delivery.***

In the study period (the few months just before enrollment and the first months following enrollment), consumers moved from fee-for-service to managed care (Kansas and New York) or from one MLTSS contractor to another (Wisconsin) with no reported interruptions in their authorized services, according to a broad range of stakeholders interviewed. In most cases, the authorized services continued to be delivered by the same providers. Consumers who had been self-directing services continued to do so.

- ***Continuity of care over time remains to be seen.***

Continuity of care is viewed as a bridge to the new service plan and new provider network, and the protections and procedures that were put in place ensured continuity of care during the transition to MLTSS. As contractors gradually implement service plan reviews and fine tune their networks, some consumers may experience changes in services and providers. Some changes will be implemented individually, as part of a service planning process, and should not result in any abrupt or systemic discontinuity of service. Changes in provider network may impact a large number of consumers at one time.

- ***The care coordination function moved in all three transitions, and, in two states, significant numbers of care coordinators moved with the function from one organization to another.***

Particularly in Kansas and Wisconsin, incoming contractors hired a majority of care coordinators from the organizations that were losing the function. While this had the effect of preserving local knowledge of resources and systems, it created a short-term transitional issue that needed to be managed closely. Both the former employer and the new employer needed to be flexible with their normal human resources policies to affect an orderly transition. In terms of caseload assignments, contractors reported that they tried to honor requests, but could not guarantee that members would be assigned their former care coordinators because they needed to balance member preferences with maintaining reasonable caseloads.

- ***Contractors saw benefits in having continuity of care transition periods.***

The creation of a “transition period” during which existing service plans for all new consumers continued uninterrupted, and all providers were paid regardless of network status, reduced the likelihood that consumers would fall through the cracks upon enrollment and gave the plans time to engage consumers while continuing to formalize their networks. At initial enrollment, there was essentially no differentiation across contractors in terms of service authorization or provider network. Contractors noted that in such an environment, customer service and care coordinator relationship become key retention factors. The transition period provided a strong incentive for contractors to make contact with their new consumers and establish relationships as quickly as possible.

6. EMERGING PRACTICES

Consumer Choices

- ***Choice facilitation by known points of contact.***

New York’s enrollment process included multiple written notices from the state and the enrollment broker to encourage consumers to affirmatively make choices about their MLTSS enrollment. Fee-for-service care coordinators also placed calls to consumers who had not made a choice, and facilitated their choice process through three-way calls with the enrollment broker. This is believed to have contributed to the low number of consumers that were assigned to MLTSS contracts (570 out of 30,000 that transitioned).

- ***Standardized provider forms.***

Kansas required contractors to collaborate on developing a universal form for provider credentialing. The objective was to allow LTSS and other providers to complete one form and use it with all three KanCare contractors, thereby reducing an administrative barrier to participating in multiple networks and increasing the likelihood of broad provider choice.

- ***Rate incentive to join network.***

Kansas and New York both require contractors to pay LTSS providers at 100 percent of the Medicaid fee-for-service rate during a transition period (60 to 180 days), regardless of whether the providers are in the contractors’ networks. After the transition, contractors may drop the rate for out-of-network providers. This gives providers an incentive to become participating providers, and preserves choice for consumers.

- ***Auto assignment with ample period for switching.***

In both the KanCare implementation and the Wisconsin Family Care transition, the state used an auto-assign process. The advantage to doing so was the ability to achieve substantial enrollment (or re-enrollment in the case of Wisconsin) within a relatively short period of time, ensuring that no individual would be without care on the “go live” date. In Kansas, an assignment algorithm was employed that prioritized keeping consumers with their existing residential care providers and primary care providers. Consumers could switch at any time prior to the effective enrollment date, and for at least 90 days after enrollment, or longer if the contractor has not conducted an assessment within the first 90 days. In Wisconsin, there is no lock-in, so consumers can choose a different option at any time.

- ***Guaranteed choice of existing providers during transition.***

In the event that consumers do not have sufficient information to make informed decisions in the short term, or that contractor networks are still evolving as the “go live” date approaches, states can essentially hold consumers harmless by requiring that they continue to have access to existing providers during a transition period. This gives consumers time to learn whether their existing providers are in the network, and contractors time to conduct individual outreach to those providers. If network participation is not accomplished during the transition period, the consumer still has

the option to change contractors. In essence, the first decision a consumer makes (including the decision to accept an auto-assignment) has no short-term consequences on the consumer's choices.

- ***Options counseling available at public consumer information meetings.***

In Wisconsin, the weeks leading up to the transition from one contractor to another, the Aging and Disability Resource Centers participated in public informational meetings, with options counselors on hand for any attendees who wanted to receive information or make choices immediately. Consumers with more involved information needs were able to make appointments for in-home or in-office options counseling.

- ***Targeted letter for LTSS consumers.***

In the context of a large, multipopulation enrollment effort, Kansas sent an additional letter to LTSS consumers to supplement the more generic information contained in letters that went to all consumers. This allowed the state to inform consumers directly about LTSS, including assurances that their existing service plans would continue and that providers would be paid throughout the transition.

Continuity of Care

- ***Protection for existing LTSS provider relationships.***

In both Kansas and New York, all contractors were required to pay existing Medicaid LTSS providers at the fee-for-service rate throughout the transition period, regardless of whether they were in a contractor's network. (In Kansas, this applied to all LTSS providers. In New York, it applied to personal care providers only.) Furthermore, contractors were required to offer contracts to providers during the transition period, and it was hoped that this would encourage or facilitate the providers continuing participation beyond the transition period.

- ***Information sharing during transition.***

In New York, the agency that had been providing the LTSS under the fee-for-service system played a crucial role in easing the transition to MLTSS through information sharing. The Human Resources Administration (HRA) in New York City provided the MLTSS contractors with not only the most current service plans for consumers but also the consumers' case records, contact information, and any other pertinent information HRA maintained in its files.

- ***Longer protection for residents of nursing homes and residential settings.***

Kansas requires plans to pay nursing homes and residential care providers at the fee-for-service rate for a year, regardless of whether they join the network. This minimizes the chances that consumers residing in those facilities will need to be moved.

- ***Prohibition on exclusive LTSS provider agreements.***

Kansas prohibits contractors from negotiating exclusive agreements with LTSS providers because the state wants consumers to be able to access providers regardless of which contractor they select. The policy objective is for all LTSS providers to participate in all networks.

- ***Incentive to meet consumers and conduct assessments early.***

The continuity of care policies cited above (honoring existing service plans and providers) were generally stated as required to last for 90 days (or some other time period) or until a new functional assessment is conducted by the plan, whichever comes later. These provisions not only promote continuity, but also provide a strong incentive for contractors to complete assessments for all new LTSS consumers within the transition period. Contractors also wanted to complete assessments as soon as possible to establish solid relationships with members and thereby retain them during the open enrollment period.

- ***Clear transition priorities.***

Kansas borrowed a clear set of transition objectives that had been developed earlier by Tennessee: Consumers get services; providers get paid. In the crush of a large scale implementation with hundreds of tasks at hand, having a strong continuity of care priority that can be easily communicated is very effective.

- ***Intensive early monitoring.***

Kansas required weekly reports on several aspects of LTSS, including claims paid. This allows early identification of a problem if LTSS is not being delivered, or providers are not being paid. (The weekly report was in addition to daily calls with all stakeholders and contractors.)

7. LESSONS

Consumer Choices

- ***Expect a large demand for information at and near the “go live” date.***

Even when a state provides a significant amount of notice to consumers and providers, demand for information peaks when the program goes live. Consumer and provider hotlines, choice counseling agencies, and other organizations need to anticipate this spike and plan short-term additional capacity to ensure a reasonable response time.

- ***Insufficient information is collected from consumers about why they choose the contractor they first choose, or about why they change contractors.***

The scripts used by enrollment agents to determine reasons why LTSS consumers choose or change plans are not refined enough to be meaningful. The most common reason recorded in one state, for example, is “consumer’s choice.” Stakeholders report anecdotally that provider recommendation is a common reason, but there is little evidence about what drives the choices of LTSS consumers.

- ***State policy regarding consumer choices only goes so far.***

For successful implementation, the policy must be communicated effectively and consistently to all stakeholders, and providers must be successfully recruited into networks. Consumers may hear that all providers are guaranteed participation, only to find that their providers have chosen not to participate.

- ***Greater standardization of certain business processes across contractors would facilitate participation for LTSS providers.***

One state reported, for example, that more could have been done to standardize provider billing practices across contractors. This would have been particularly helpful to small HCBS providers, who were not accustomed to billing MCOs, and who are generally not set up (or lack capacity) to engage in multiple, unique billing requirements.

- ***Public forums and an array of mailings are each critical as outreach vehicles, but are not sufficient engagement by themselves.***

Communication strategies should be multifaceted and should include a wide range of marketing, educational, and outreach activities (including targeted outreach to home care agencies, nursing homes, advocacy groups, information and referral sources, etc.).

- ***The principle of provider choice does not always mean each consumer will have all his or her choices honored, and appropriate expectations must be set with stakeholders.***

Although MLTSS rules providing for consumer choices may increase access to and choice of some providers, it may never be feasible, for example, for a contractor to have more than one care coordinator assigned to a remote rural region, or to be able to offer an array of transportation options in all parts of a state. The consumer's choices may also be limited by such things as caseload limits when a requested care coordinator has a full caseload.

Continuity of Care

- ***While the establishment of continuity of care policies may be relatively straightforward, the implementation of those policies at the plan level is not.***

To implement a continuity of care policy, managed care contractors had to obtain information on the characteristics of pre-existing care plans, so the contractors could enter existing service plan authorizations in their systems. While in some cases, states may have automated records of existing service plans, in other cases, service plans may exist only in hard copy or PDF format. States need to anticipate this issue and work with existing care coordination vendors well in advance of launch dates to ensure timely transfer of service plan information.

- ***In states where the care coordination function is moving from one entity to another during the MLTSS transition, continuity of care coordination may become an issue before the “go live” date.***

In Kansas and Wisconsin, for example, incoming contractors were hiring care coordinators away from the outgoing care coordination entities prior to the “go live” date. This created the risk of consumers losing their care coordination services for a period of time before they were enrolled with the new contractors. In both states, the transition was managed very closely to prevent that from happening. Incoming contractors agreed to train staff before their actual start dates, and outgoing contractors agreed to give their employees leave for the training time.

- ***LTSS providers require substantial technical assistance with billing.***

This should be a significant expectation of contractors, and the assistance should begin before program implementation and continue as needed going forward. Many small LTSS providers have very limited cash flow, and any interruption in payment creates a potential continuity of care issue.

8. CONCLUSION

This study examined policies and practices governing consumer choices and continuity of care in MLTSS programs. Although formal regulatory policies for protecting consumer choices and service continuity in MLTSS programs continue to evolve, both federal and state oversight agencies have placed a high priority on these protections when transitioning LTSS populations from fee-for-service to managed care models. Managed care organizations have been generally supportive of these policies, as it is in their best business interest to minimize service disruptions during managed care transitions, and to respond to member preferences in order to retain them.

Although this study observed strong practices that protected consumer choices and continuity of care during the early implementation of MLTSS programs, it raises a longer-term question of how consumers will be impacted over time as managed care entities are given greater discretion over provider contracting and service planning, especially given the goal of improving cost-effectiveness. Preserving the status quo in terms of choice and continuity is an effective strategy for achieving a smooth transition from fee-for-service to managed care, but may constrain contractors' ability to improve quality and reduce costs.

APPENDIX A. CONTRACTS ANALYZED

State	Contracts
AZ	Arizona Health Care Cost Containment System, Division of Business and Finance. Contract/RFP No. YH12-0001. October 1, 2011.
DE	Delaware Medicaid Managed Care Program, Chapter II, Program Description, as amended to include the Diamond State Health Plan Plus program. April 2012.
FL	Florida Department of Elder Affairs. Standard Contract, Long-term Care Community Diversion Pilot Project. September 2010.
HI¹	QUEST Expanded Access (QExA) Managed Care Plans to Cover Eligible Individuals Who Are Aged, Blind, or Disabled. No. RFP-MQD-2008-006. October 2007.
IL	Illinois Department of Healthcare and Family Services Contract for Furnishing Health Services in an Integrated Care Program by a Managed Care Organization. 2010.
KS¹	Kansas Department of Health and Environment Contract for Managed Care for Medicaid and CHIP Programs (KanCare). June 2012.
MA	MassHealth Contract for Senior Care Organizations. January 2009.
MN	Minnesota Department of Human Services Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services. 2012.
NM	Agreement between the New Mexico Human Services Department, the New Mexico Aging and Long-Term Services Department, and Contractors for the Coordinated Long-Term Services Program. 2008.
NY²	MISCELLANEOUS/CONSULTANT SERVICES (Non-competitive Award) Managed Long-term Care Partial Capitation Contract
TN	Contractor Risk Agreement between the State of Tennessee, d.b.a. TennCare and Contractors. Includes General Amendment 12. July 1, 2011.
TX	Texas Health and Human Services Commission General Contract Terms and Conditions Version 1.8. September 2012.
WA	Washington Department of Social and Health Services Contract for the Washington Medicaid Integration Partnership (WMIP). Amendment No. 0812-39411-01. 2009.
WI³	Family Care Contract between Department of Health Services Division of Long-Term Care and MCO. April 13, 2012.

¹ The Hawaii and Kansas contracts incorporate the states' request for proposals, which contain details regarding choice and continuity of care requirements.

² We also reviewed the 2012 Standard Terms and Conditions for New York's revised 1115 Demonstration.

³ We also reviewed the 2013 contract between the Wisconsin Department of Health Care Services Division of Long-Term Care and the Aging and Disability Resource Centers, which contains key consumer choice provisions.