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National Council on
MEDICAID HOME CARE

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The Council Releases Survey Results on Medicaid Managed Care in Home Care

In July and August, the National Council on Medicaid Home Care (the Council) surveyed its members as to the status of their adoption of Medicaid managed care in home care. The Council conducted two surveys. The first had 45 respondents, and the second, a modified and more detailed version of the first survey, had 69 respondents, for a total of 114 respondents. The Council discusses the results of these surveys below.

The survey results are based on the responses received from agencies and associations, and are not stratified by state. Therefore, some states may be represented by multiple responses. The survey results represent only a small cross-section of those adopting Medicaid managed care in home care nationally. The total number of states and enrollees adopting Medicaid long-term services and supports (MLTSS) is shown in tables 1 and 2, below:

Table 1: National MLTSS Adoption, States

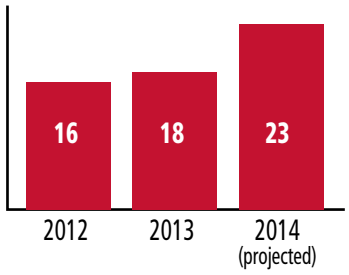
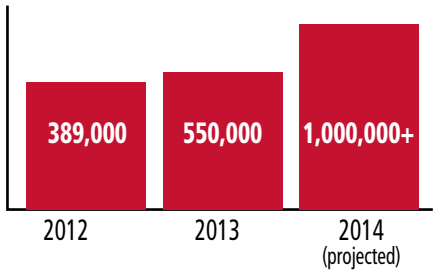


Table 2: National MLTSS Adoption, Enrollees



Source: The Scan Foundation, Truven Health Analytics.

Affiliation. Most respondents were representatives of home care agencies rather than hospice companies or the Forum of State Associations. Out of both surveys, 83 stated that they represented a home care agency, 16 stated that they represented an agency that provides both home care and hospice, 13 stated they represented a member of the Forum of State Associations, and three stated that they represented a hospice company. Since the first survey did not delineate "hospice" as an independent category, one of the three that represented a hospice company indicated so in the "other" category in the first survey (in addition to responding that he/she represented a home care agency), so these numbers total 115 and not 114.

Current implementation of managed care. Out of the total of those surveyed, 55 stated that their state now has managed care in home care, four stated that they have Medicaid managed care through coordination of dual eligibles, and 51 stated that their state has both Medicaid managed care in home care and through coordination of dual eligibles. Only three of those surveyed stated that their state does not have Medicaid managed care at all.

Services. The most popular services that respondents noted were already in Medicaid managed care in their states were: home health services (96), home and community based waiver services (69), personal care services (47), and hospice (42). The most popular services pending transition were: home and community based waiver services (11), private duty nursing (10), mental health services (9), and personal care services (9).

Patient populations. The most common patient populations that respondents noted were already in Medicaid managed care in their states were: elderly (70), dual eligibles (64), physically disabled (54), and pediatric (47). The most common patient populations that were pending transition were: dual eligibles (17), intellectual or developmentally disabled (I/DD) (11), and physically disabled (9).

Level of satisfaction with managed care. In both surveys, the Council asked respondents to rank numerous aspects of their transition to managed care on a scale of 1 to 5, with 1 being a very negative experience and 5 being a very positive experience. In both surveys, none of the aspects averaged a score of three (neu-

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tral) or higher. All of the responses averaged between a 2 (negative) and 3 (neutral score). This was true both looking at the two surveys independently of each other, as well as aggregating the results.

Separate survey results. In the first survey, the highest satisfaction scores went to joining provider networks (2.89), enrollment (2.87) and case management (2.76). In the second survey, the highest satisfaction scores went to breadth and depth of covered services (2.70), enrollment (2.69), joining provider networks (2.61), and case management (2.59).

Aggregate survey results. When both survey results were combined, the highest satisfaction scores went to: enrollment (2.76), joining provider networks (2.72), and breadth and depth of covered services (2.70). The lowest scores went to: stakeholder input opportunity prior to Implementation (2.14), prior care authorizations (2.22), and timely payment of claims (2.24).

Most of the aspects of the transition to managed care were most commonly scored as neutral (3), and negative (2). The most common rating for the aspects of the transition was neutral (3) for eight out of twelve aspects, negative (2) for three out of twelve, and one aspect had an equally common very negative (1) and neutral (3) rating. A synopsis of the aggregate survey results from question #9 can be found below, in Table 3.

Table 3: Home Care Providers, Associations Give Tepid Ratings to Managed Care

Question: How would you rate your experience with the following aspects of the transition to Medicaid managed care?*

	Average Rating	Respondents
Breadth and Depth of Covered Services	2.70	61
Case Management	2.66	106
Claims, Approval of	2.28	104
Claims, Submission of	2.56	103
Claims, Timely Payment of	2.24	63
Communications between Plan and Provider	2.44	104

	Average Rating	Respondents
Contact Negotiation	2.43	101
Enrollment	2.76	99
Joining Provider Networks	2.72	92
Prior Care Authorizations	2.22	104
Reimbursement (Compared to FFS Rates)	2.25	100
Stakeholder Input Opportunity Prior to Implementation	2.14	57

*Respondents were asked to rate their experience on a scale of 1 to 5, with 1 being very negative and 5 being very positive.

Source: the Council's Medicaid Managed Care in Home Care Survey, Question #9, July-August 2014

Responsive measures to managed care. When asked about what steps respondents will take in response to the shift to Medicaid managed care, the most common responses were that respondents would: improve efficiencies (41), alter which patient populations they are serving, or to what degree they are serving existing patient populations (35), decrease the number of clients who have been transitioned into managed care (34), alter which services they provide (28), and increase the number of private pay clients (25).

Incentives for community based settings. Only eight of the respondents stated that there were incentives provided by managed care companies to move beneficiaries from institutions to community based settings, while 38 of the respondents said there were not. Sixty-six of the respondents said that they did not know.

Reimbursement methodology for services. The second survey included a question that asked what the reimbursement methodology was for each service in Medicaid managed care. For home and community based waiver services, the most common response was per time unit (30). For home health services, the most common response was either per visit (33) or per time unit (18). For personal care services, the most common response was per time unit (27).

However, the majority of the respondents put "I don't know" for reimbursement methodology for behavioral health services, home delivered meals, hospice, live-in services, mental health services, private duty nursing (both adult and pediatric) and telehealth.

Reimbursement methodology for patient population. The majority of the respondents put "I don't know" for reimbursement methodology for intellectually or developmentally disabled (I/DD), physically disabled, and serious mental illness or severe emotional disturbance (SMI/SED), and slightly under half of the respondents similarly put "I don't know" for dual eligibles. However, other than "I don't know," these populations were most commonly reimbursed on either a per time unit or per visit basis.

The effect of technology. Twenty-four respondents said that technology (i.e. electronic visit verification, smart phones, etc.) helped the transition to Medicaid managed care, while ten said that it hindered the transition, and forty said that it had no effect on the transition. Thirty-three of the respondents said they did not know what technology's effect was on the transition.

Standards. Asked which standards the managed care plans hold home care providers, 69 stated licensure, 65 stated Medicare certification, 39 stated quality, and 35 stated accreditation. The most common quality standards, as clarified in the second survey, were: experience of care/patient satisfaction (19), outcomes (19), processes (18), and medication management (16).

Self-direct care. Twenty-four respondents stated that their plans offer an option/options to self-direct care, while 20 did not. However, 65 stated that they didn't know.

Recommendations. While the first survey asked an open ended question about what recommendations respondents would have for stakeholders transitioning to managed care, the second survey provided some answer choices, in addition to an open answer option. The most popular an-

swer choices given were: start dialogues with health plans early in the process (44), insist that all processes are the same if there is more than one managed care plan involved (38), start dialogue with the state early in the process (34), and train staff (32).

Write-in responses from the first survey also reflected these answer choices, and included other recommendations such as preparing for prior authorizations. Also expressed in both surveys' open answer option was that the plans paid providers at rates below direct costs. Finally, respondents recommended that stakeholders avoid managed care if there was only one MCO involved, and if the agency has good cash flow and client base.

Limitations of the Survey

Underrepresentation of state associations and hospice agencies. The survey results yielded responses from a total of only 13 out of the 50 state associations, and only two agencies that only provided hospice services.

"I don't know" as a common response. The Council was surprised at how frequently respondents selected "I don't know" as an answer choice, despite the increased specificity of the second survey. For the question regarding what services are pending transition, 74 out of 92 answered "I don't know." Sixty-six respondents, when asked if the managed care plans in their state provide any incentives to move beneficiaries from institutions to community-based settings, said that they did not know. The majority of the respondents put "I don't know" for reimbursement methodology for behavioral health services, home delivered meals, hospice, live-in services, mental health services, private duty nursing (both adult and pediatric) and telehealth. Thirty-three out of 107 respondents stated that they did not know how technology effected the transition to managed care. Also, 65 out of 109 respondents stated they did not know if their plans offered an option/options to self-direct care.

For the raw survey results, click here and here. Open ended questions are provided in these links, but the answers to these questions have been removed for the sake of confidentiality.

Conclusion

The survey results reflect a reaction to managed care from home care agencies, joint home care/hospice agencies, and state associations that can be described as lukewarm at best. While the transition to Medicaid managed care is filled with challenges, stakeholders are not powerless or voiceless in the matter. Agencies and associations alike should take opportunities to learn from previous experience. The Council provided key lessons regarding managed care in NAHC's March on Washington, as well in its recently released toolkit on the transition to Medicaid managed care.

Stakeholders can be very useful in improving a state's transition to managed care in Medicaid. Likewise, if these stakeholders have outright opposition to using managed care in Medicaid, or otherwise need to navigate their transition to managed care, they should consult with both their state associations and the Council. Home care providers are encouraged to keep abreast of managed care transitions in their states, advocate on a state level, and to contact the Council with any questions or concerns. ■

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