Assessing Members' LTSS Needs: Key Considerations for Health Plans

More states are relying on managed care organizations to coordinate long-term services and supports (LTSS). If your health plan provides managed LTSS, it will need to contract with appropriate providers to ensure that the full range of Medicaid services covered in the state are available to your plan's members. These services may include both institutional and non-institutional based services, for example, chore or homemaker services, personal care, meals, or transportation. It is important to work closely with your state to clearly define your plan's role in assessing and managing members' home and community-based services (HCBS) needs as well as providing services. This brief provides key considerations for assessing HCBS needs and creating person-centered service plans for your plan's members.

Key Considerations

- **Understand the populations you serve.** The HCBS needs of your members will vary depending on whether they are aging, or have physical disabilities, intellectual and developmental disabilities, or mental health challenges. Individual needs also depend on the types of family or informal caregiver supports already available to them. Your members' cultural background and ethnicity may also factor into the types of supports that will work best for them. The assessment process can identify barriers to care and can be used to stratify your health plan's members into risk levels for care coordination purposes.

- **Review your state's functional assessment tool and requirements.** Your health plan and state should have an approved protocol clearly describing responsibilities, timeframes, and reporting requirements for assessments. The number of members that need to be assessed may vary based on the enrollment policies in your state. Many states require a functional assessment for Medicaid enrollees who need HCBS. Depending on your state, the functional assessment may be completed by the state, a third-party, or your health plan. In other cases, your plan may be required to complete a comprehensive health assessment while another party completes each member's functional assessment. If the functional assessment is conducted outside of your health plan, your health plan's staff should have access to the results. For a brief overview of the types of functional assessment processes states use, see an overview from The Scan Foundation. The scope of functional assessments varies across states; however, the Manual

Functional Assessment Components

Although the components of a functional assessment will vary across states, there are several core domains. These include:

- Activities of daily living (e.g., bathing, dressing, shopping, housework)
- Medical conditions
- Cognitive function and memory (e.g., judgment and decision-making)
- Behavior concerns (e.g., injurious, destructive)

Your health plan should contact your state to determine 1) who is responsible for conducting the functional assessment with your members and 2) what specific domains are included. Your health plan may need to implement additional case management and care coordination procedures to review your members' needs between mandated reassessments.

for the Balancing Incentives Program from the Centers for Medicare & Medicaid Services (CMS) provides some guidance on core concepts that should be included in a core standardized assessment.

- **Create a person-centered service plan.** Depending on the state, service planning may occur concurrently with the functional assessment or may be a secondary process. States with HCBS waivers are required to develop individualized plans of care with participants; these plans of care may be part of or in addition to service plans developed for the full range of health care benefits. Your health plan's role in the planning process will vary depending on the state and the timeline for service planning. The state's planning process and your organization's role should be clearly documented. Even if your plan is not responsible for developing the service, your plan's staff should have timely access to it.
  - **Definition.** Person-centered planning aims to preserve the member's autonomy, while engaging their natural supports in helping to determine their LTSS needs. CMS provides an overview of person-centered service planning.
  - **Resources.** There are several person-centered planning processes, including PATH, MAPS, and Essential Lifestyle Planning. The University of Minnesota Institute on Community Integration provides a manual for person-centered planning facilitators, which combines content from several different programs.
- **Remind members of reassessment requirements.** While reassessment will most likely be performed by the same entity that determines initial functional eligibility, your health plan should take an active role in reminding members of upcoming reassessment periods. The timing of reassessments will vary depending on the guidelines of the state (e.g. every six months or one year after initial enrollment). Assessment can impact the eligibility of your plan's members and your health plan should work with your state to keep members informed about reassessment processes and deadlines. This will help ensure that your members do not experience a gap in Medicaid coverage and needed services.