INFRASTRUCTURE DEVELOPMENT TO SUPPORT MLTSS

WEDNESDAY, AUGUST 30, 2017, 8:30-9:45AM

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SESSION OBJECTIVES

Often overlooked in the program design and planning for a new delivery system when interagency collaboration and coordination needed throughout the process. This blind spot can leave key exercises unchecked and states at risk for non-compliance with federal regulations. In this session we will:

- Discuss the changes in state operations as programs move from FFS to MLTSS.
- Highlight the importance of interagency coordination and defining roles and responsibilities, as well as risks associated with not being proactive in this coordination
- Address lessons learned from various stakeholders who have been involved in this process and discuss applicability for enhanced coordination even in a FFS environment

AGENDA

Topic	Presenter
Why is interagency collaboration imperative to a comprehensive LTSS Strategy?	Jay Bulot
State Perspectives:	
- PA: Mandated per move to MLTSS and statewide Organizational Redesign. Benefits to FFS Operations	Jenn Burnett
- Iowa: Fast-track on MLTSS implementation; Perspective of AAAs	Donna Harvey
- KS: Fast-track on MLTSS implementation and related CAPs	Brad Ridley

OVERVIEW OF LTSS

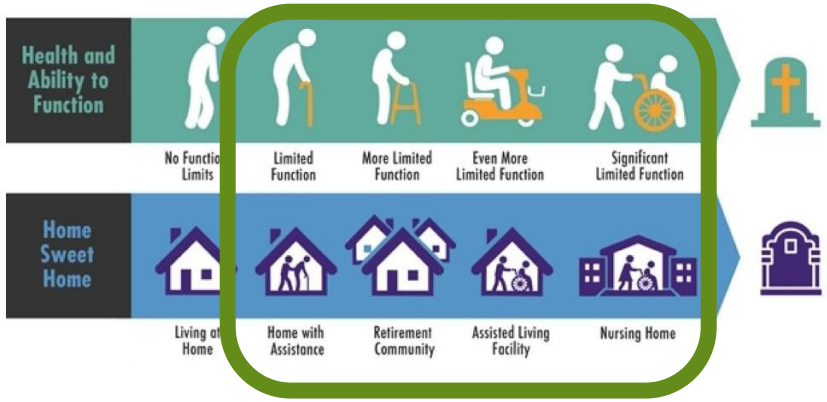
LTSS include services delivered in a nursing facility as well as those delivered in the community (home- and community-based services or HCBS)

HCBS are an optional Medicaid benefit, while nursing facility services are a mandatory Medicaid benefit.

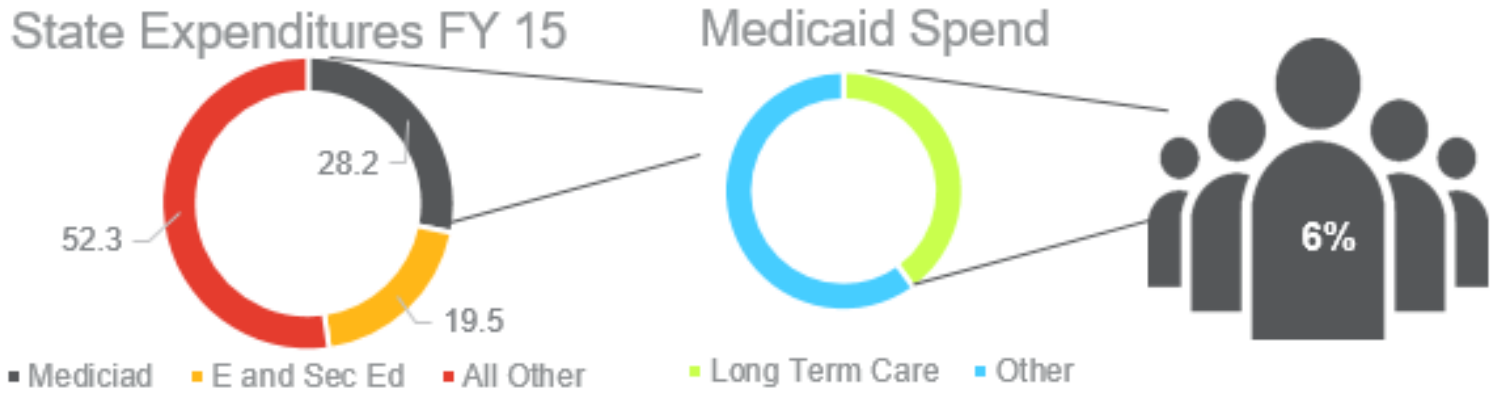
HCBS is often offered in lieu of services provided in a nursing home, and people most often become eligible for HCBS once they need enough help to need nursing facility services (meet level of care)

LTSS WITHIN AN INTEGRATED DESIGN

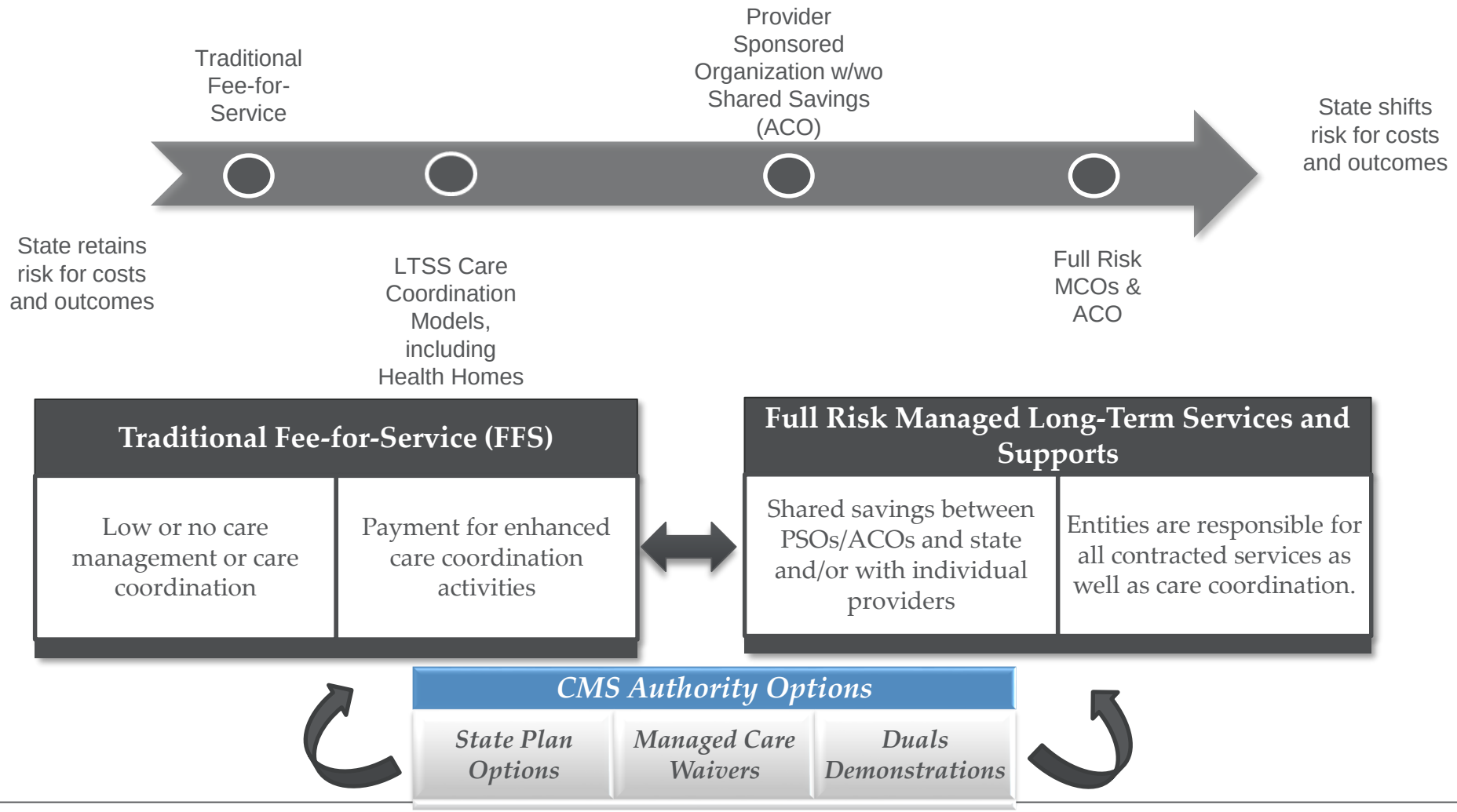
OVERVIEW OF LTSS



Medicaid is one of the largest single items in state budgets, comprising on average 28.2% of total state expenditures and an average of 19.7% of general fund dollars. **Within the Medicaid line item, upwards of 40% of the spend can be attributed to long term support users.**



MEDICAID DELIVERY SYSTEM CONTINUUM



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LTSS IMPLEMENTATION OPTIONS

- With each option, states have the flexibility to determine the scope of the delivery system, including:

- CMS is required to approve all managed care programs regardless of where they are on the ‘risk’ continuum
- Different paths can be taken depending on design choices

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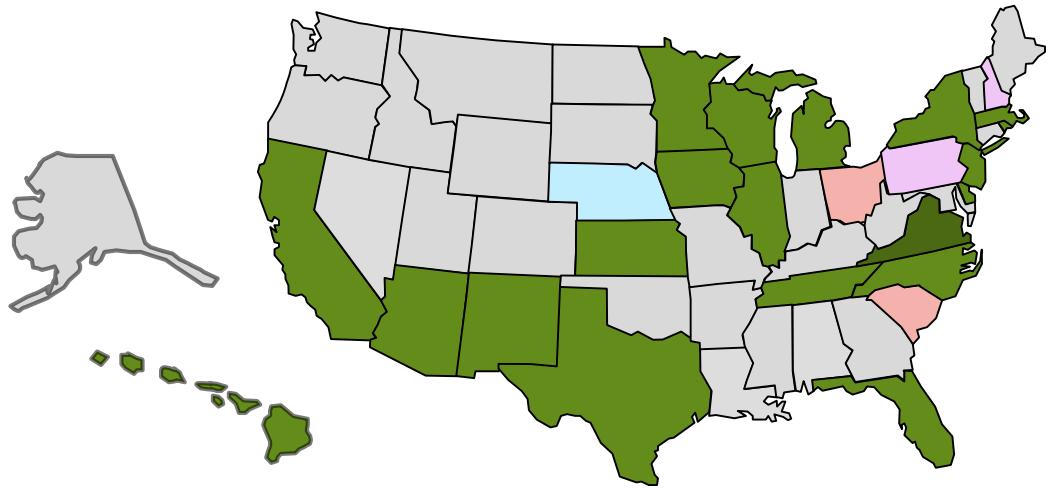
MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS)

Through MLTSS programs, state Medicaid agencies deliver long term services and supports through capitated arrangements with managed care plans.

- MLTSS programs typically cover both institutional-based and home- and community-based LTSS.
- MLTSS programs can cover primary, acute, pharmacy and LTSS in fully-integrated models, or they can cover LTSS only.



Current MLTSS Program
Dual Demonstration Program Only
MLTSS in Active Development
MLTSS Under Consideration

20 States with MLTSS Programs

800,000+ MLTSS Enrollment

30% of Medicaid Spending

Adoption of MLTSS will accelerate if Federal reforms continue in current direction

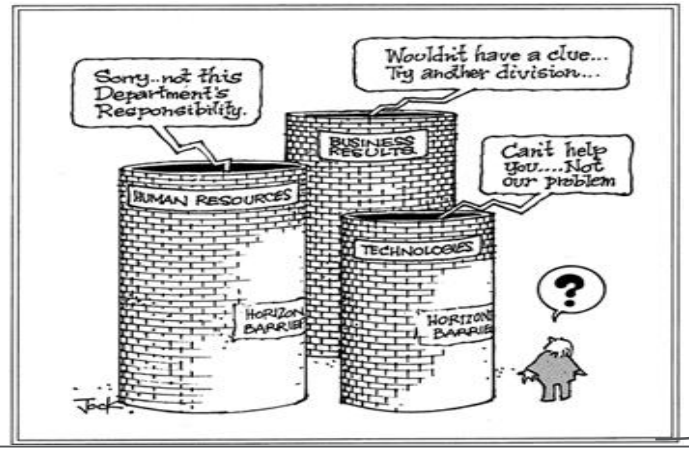
Source: National Association of States United for Aging and Disabilities, Kaiser Family Foundation, NCI Analysis

STATE CHALLENGES THAT POINT TO A NEED TO BETTER DEFINE ROLES AND RESPONSIBILITIES ACROSS AGENCIES

Drivers

- Mandated Move to Managed Care
- Waiver Consolidation (1915c)
- Reorganization
- CAPs

Impediments – What we Find



Solutions

SOPs and MOUs that clearly define who is doing what, communication plans, governance and workflows

COMMON CHALLENGE AREAS

- Over-reliance on “c” waivers
- Increasing interest in “i” like waivers
- Lack of interagency coordination – He said, she said
- Lack of a holistic LTSS strategy – fiefdoms, difficult to integrate
- Recognition of the need for improvement without letting go of how things have always been done
- Timeline for implementation
- Re-Procurement differs from initial implementation due to Managed Care Regulations
- Added requirements for managed care design that may not exist in FFS
- Role of Sister Agencies, CBOs (AAA, CILs, etc) and Case management functions
  - Conflict free case management
  - Expansion of current case management to include integrated care management and medical management models

NEEDED ANALYSES AND DOCUMENTATION

Roles and responsibilities matrix: Determine who is doing what

Work stream analyses: Determine how current operations will change:

Funds flow analyses: Determine financial impacts on secondary operations and how secondary operations will be sustained via the transitions

Oversight and Coordination: Determine if procedures are documented, followed and proper accountability for collaboration

CMS REQUIREMENTS

CMS Final Managed Care Rule

State programs must be capable of managing care for the highest need Medicaid populations

1. Higher level of accountability
2. Impact of CMS approval of state contracts
3. Demonstration of critical elements being met

Under the new federal managed care rule, states must conduct the readiness review process for CMS approval at least 30 days before contract effective dates in the following circumstances:

- Transition to a Medicaid managed care model in the state
- Addition of new eligibility group(s) to existing managed care models
- Expansion of a managed care model to a new geographical region
- Entry of a new managed care program

OVERSIGHT AND COORDINATION AND CMS READINESS

States who are moving new populations such as the LTSS population into Medicaid Managed Care must demonstrate to CMS via a written report readiness of both the Risk-bearing entities as well of the agency in terms of the agency's ability to oversee the program.

NCI recommends readiness reviews be conducted **at least three months** before the effective date of any of those events and in time to ensure smooth implementation, and the reviews must be submitted to CMS for the agency's approval of any associated contract or contract change.

In several states, CMS has issued 13 Readiness Gates as illustrated to the right, and requirements within each that states must be demonstrate for readiness. Generally, CMS aims to see that staff are hired and trained and have the tools needed to ensure fluid transition to a new delivery system and proper support to administer requirements within each of these areas. Demonstrating readiness in these areas also provides some support to the expected transition and continuity of service for both beneficiaries and providers.

To demonstrate readiness with these gates, states must clearly define oversight roles and how these exercises are coordinated to ensure overall compliance and performance improvement within the program. States must similarly describe roles for oversight and program administration as part of their waiver applications and quality strategy.

SAMPLE READINESS REVIEW GUIDE

- Pre-populated fields are shaded blue

A1 | Readiness Review Tool

Readiness Review Tool
[Enter Agency Name]
Tool: 1. Administration
Date Updated: [MM/DD/YY]

Prepopulated By Agency

No.	Contract Requirement	Applicable Entity	Contract Section	Regulatory Requirement	Priority: 1 - Critical 2 - Non Critical	Expected MCE Deliverables (RR Team to Complete)	Review Type: 1 - Desk 2 - Site Visit 3 - Desk and Site Visit
D.14.01	The contract requires the MCE to submit documentation to the State, in a format specified by the State, to demonstrate that it offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area 1) at the time it enters into a contract with the state, and 2) any time there is a significant change (as defined by the state) in the MCE's operations that impacts services.	MCO PIHP PAHP		42 CFR 438.207(b)(1)			
D.14.02	The contract requires the MCE to submit documentation to the State, in a format specified by the State, to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area 1) at the time it enters into a contract with the state, and 2) any time there is a significant change (as defined by the state) in the MCE's operations that impacts services.	MCO PIHP PAHP		42 CFR 438.207(b)(2)			
G.4.01	**Staffing Training.** The contract requires that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines.	MCO PIHP PAHP		42 CFR 438.236(d)]			
G.4.02	**Staffing Training.** The contract requires that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	MCO PIHP PAHP		42 CFR 438.210(b)(3)			
I.2.01	**Requirements, Procedures, and Reporting.** The contract requires the MCE to certify enrollment information, encounter data, and other information submitted to the state for purposes of developing MCE payments.	MCO PIHP		42 CFR 438.604; 42 CFR 438.606			
I.2.02	**Requirements, Procedures, and Reporting.** The contract requires that data submitted to the state by the MCE for purposes of developing MCE payments be	MCO PIHP		42 CFR 438.604; 42 CFR 438.606			

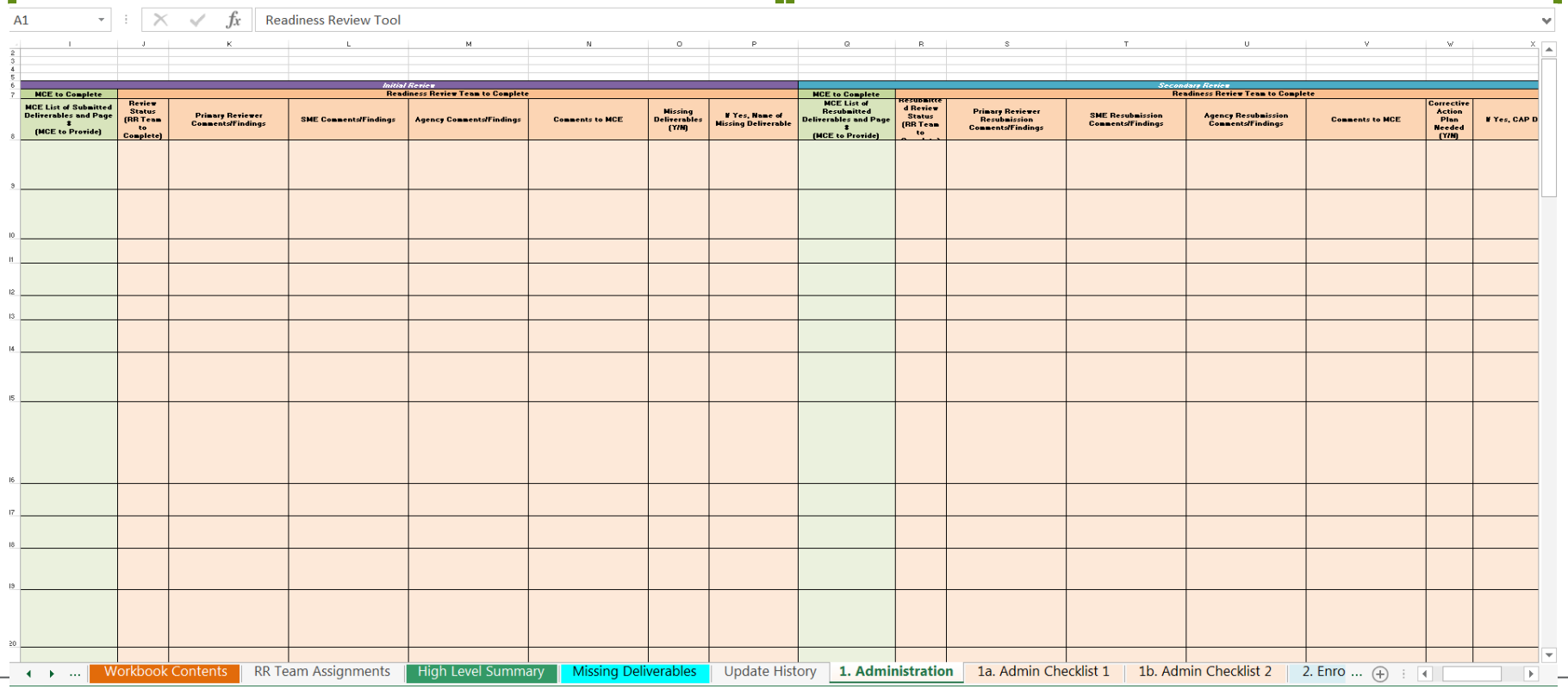
Cover Sheet | Workbook Contents | RR Team Assignments | High Level Summary | Missing Deliverables | Update History | 1. Administration | 1a. Admin Checklist 1 | 1b. Admin Checkli ...

READY

FIELDS FOR MCO AND REVIEW TEAM TO COMPLETE

Initial Review

Secondary Review



PROGRAM AREAS AND POTENTIAL ROLES FOR SISTER AGENCY/CBO COORDINATION

Program Area	Potential Function	Existing Infrastructure Description
Expanded Aging and Disability Resource Centers, No Wrong Door Entry-Point **(pre-enrollment broker)**	Level one screening	A level one screening would be performed to identify those individuals who are likely to be eligible candidates for Medicaid-funded LTSS (HCBS, PACE, nursing facilities).
	Options counseling	Options counseling is a person-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values.
	Pre-admission screening	Pre-admission screening in this context refers to screening the applicant for admission to a nursing facility, usually to determine if other alternatives have been considered.
	Local Contact Agency	The Local Contact Agency serves as the initial point of contact for individuals who are interested in receiving information about returning to the community, as part of the Minimum Data Set Section Q (MDSQ) assessment done in nursing facilities.
	Self-direction support (educate and assist)	Support provided to consumers educating them on self-direction processes, navigating the grievance process, counseling and assisting in developing their individual budget, recruiting, employing, hiring and firing assistants.
	List management	Manage a statewide interest list for community-based services, including tracking enrollments/dis-enrollments, nursing facility transitions, etc.
	Education and outreach	Support provided to consumers educating them on processes and providing ongoing outreach to the public on the ICN program and other long term supports and services available in Alabama.

PROGRAM AREAS AND POTENTIAL ROLES FOR SISTER AGENCY/CBO COORDINATION

Program Area	Potential Function	Existing Infrastructure Description
Ombudsman / Grievances and Appeals Support	Conflict free enrollment/disenrollment assistance	Provide grievances and appeals support to beneficiaries; advocate for members in disputes with the MCO or State regarding their services and supports. These activities are different from Older Americans Act (OAA)-funded Ombudsman, which is federally limited to individuals living in nursing facilities.
	Consumer friendly, accessible, in-person advocacy, and mediation with ICNs	
	Assist participants in navigating the MLTSS landscape including co-participation in informal review and hearing processes	
	Assisting participants to understand their rights, responsibilities, and choices, including escalation to formal fair hearing, providing assistance with decision making and required action steps	

PROGRAM AREAS AND POTENTIAL ROLES FOR SISTER AGENCY/CBO COORDINATION

Program Area	Potential Function	Existing Infrastructure Description
Contract monitoring/ quality oversight	Monitor the implementation and use of person centered needs assessment, service planning, and service coordination policies and protocols	Under contract with State, conduct regular monitoring and oversight for contract deliverables and/or 1915c waiver assurances. Work with Medicaid and contractors on corrective action. SUA also authorized under OAA to: Evaluate the performance of OAA programs, activities, and services; Develop methods and practices to improve the quality and effectiveness of the programs, services and activities; Provide technical assistance in planning, developing, implementing, and improving the programs, services, and activities.
	Monitor consumer choice of providers	
	Conduct quality-focused audits	
	Validate that corrective actions have been implemented, critical incident response/remediation	
	Enhanced monitoring of any service reductions during transition from FFS to MCO	
	Conduct audit/verification of person level data used for quality oversight and monitoring	
	Conduct post MCO-implementation stakeholder engagement	
	Oversee MCO case management functions	

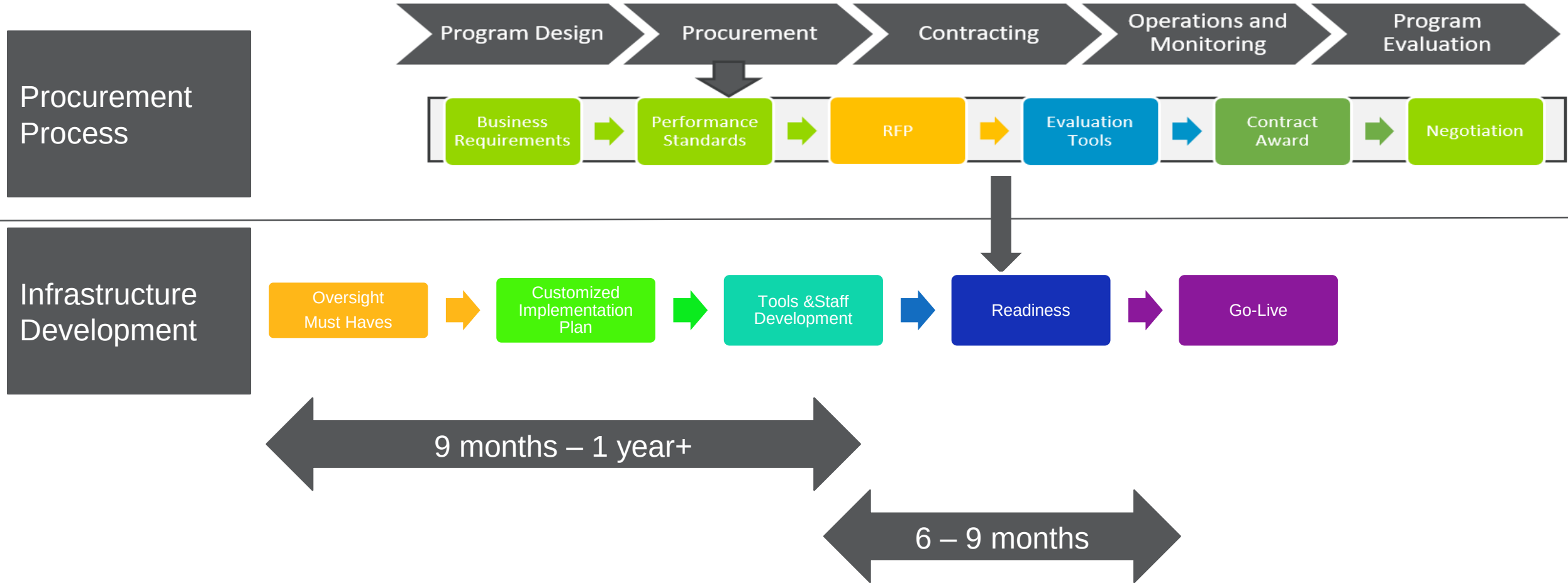
PROGRAM AREAS AND POTENTIAL ROLES FOR SISTER AGENCY/CBO COORDINATION

Program Area	Potential Function	Existing Infrastructure Description
Network Adequacy/ Development	Work collaboratively with AMA and ICNs on expanding and developing HCBS services across the State	Sister Agency is currently authorized under the OAA to ensure there is necessary and adequate supply of HCBS service providers and could continue support in this area by working with both Medicaid and MCOs. OAA authorization also include: education and training to develop an adequately trained workforce and to apply social research and analysis to improve access to and delivery of services for older individuals.

PROGRAM AREAS AND POTENTIAL ROLES FOR SISTER AGENCY/CBO COORDINATION

Program Area	Potential Function	Existing Infrastructure Description
Provider Credentialing/ Certification/ Training	Establish minimum provider qualifications and credentialing requirements for all MLTSS providers	Sister Agency currently certifies and enrolls HCBS waiver providers; allow Medicaid to continue licensed certifications for non-MLTSS providers. Note: For states transitioning from FFS to MLTSS, states should encourage or require through contract provisions, the incorporation of existing LTSS providers as MCO network providers to the extent possible.
	Credential HCBS providers	
	Provide standard training on operating a successful MLTSS program (topics could include assessment process, person-centered planning, population specific trainings, self-direction, etc.)	

TIMING OF KEY EFFORTS



PANEL DISCUSSION

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