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# 1

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## Executive Summary

### Overview of Long Term Care (LTC) Redesign in Nebraska

The Department of Health and Human Services (DHHS) is committed to ensuring that all consumers in the State of Nebraska receive quality care, regardless of disability, age or condition. This charge is supported by the Division of Medicaid & Long Term Care and the Division of Developmental Disabilities in their mission to provide services and supports to Medicaid consumers. Noting room for growth and improvement in the current LTC system, DHHS embarked upon an initiative to redesign the service delivery system. On January 22, 2016, DHHS released a concept paper, “*Nebraska Long-Term Services and Supports Program Redesign*”, in which leadership noted the increasing pressures on the current LTC system and the system’s challenges to respond efficiently to address these issues. The concept paper described the six key principles that would guide the Nebraska LTC redesign initiative:

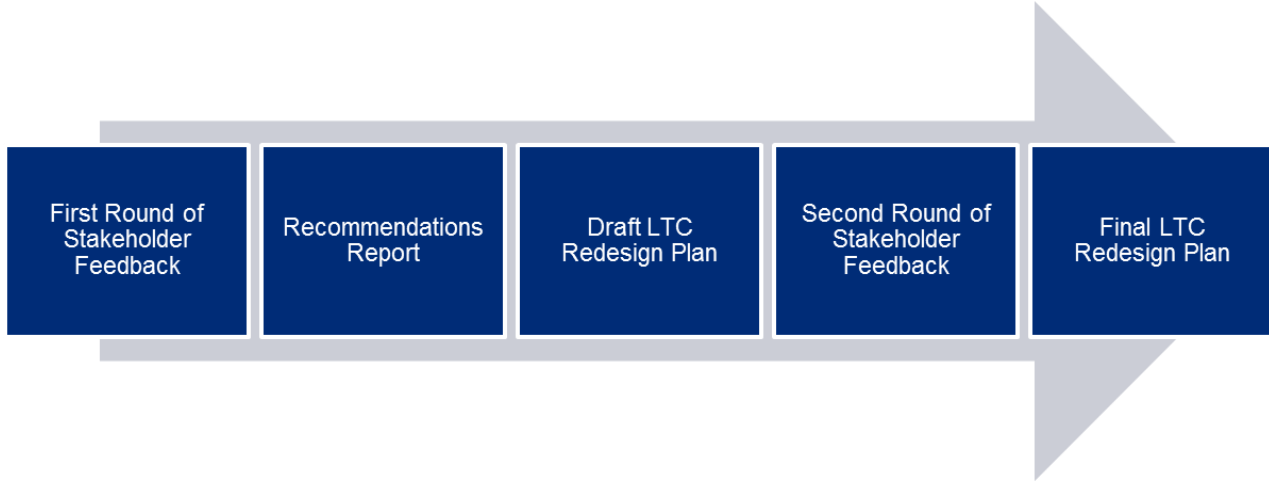
1. Improve the quality of services and health outcomes of recipients.
2. Promote independent living in the least restrictive setting through the use of consumer focused and individualized services and living options.
3. Strengthen access, coordination and integration of care through streamlined LTC eligibility processes and collaborative care management models.
4. Improve the capacity to match available resources with individual needs through innovative benefit structures.
5. Streamline and better align the programmatic and administrative framework to decrease fragmentation for clients and providers.
6. Refocus and rebalance the system in order to match growing demand for supports in a sustainable manner.<sup>1</sup>

To support the redesign initiative, DHHS engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, in partnership with its subcontractor, the National Association for States United for Aging and Disabilities (NASUAD), to study the current system and make recommendations for redesign.

The following graphic outlines the approach Mercer/NASUAD used in developing this Final LTC Redesign Plan.

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<sup>1</sup> Nebraska Department of Health and Human Services. Nebraska Long-Term Services and Supports Program Redesign. January 22, 2016. <http://dhhs.ne.gov/medicaid/Documents/LTSSRedesignConceptPaper.pdf>



Mercer/NASUAD engaged stakeholders in a preliminary feedback process to understand the current system and its challenges. After this extensive statewide stakeholder engagement process, feedback from DHHS staff and independent research and analysis, Mercer/NASUAD compiled and analyzed the feedback and developed draft recommendations for system redesign. Using these recommendations as building blocks for redesign efforts, Mercer/NASUAD developed the Draft LTC Redesign Plan, which detailed Mercer/NASUAD's proposed approach for addressing these recommendations.

### ***Stakeholder Engagement on the Draft LTC Redesign Plan***

Following DHHS' commitment to ensure stakeholder involvement and input throughout the redesign process, the Draft LTC Redesign Plan was released for public comment in March 2017. In addition to the various options for providing written feedback on the Draft LTC Redesign Plan, Mercer/NASUAD conducted an extensive stakeholder listening tour that included two weeks of onsite public meetings throughout the State of Nebraska and numerous webinars and other meetings for consumers, caregivers, advocates and providers to provide feedback. The feedback was summarized in the Stakeholder Engagement Report dated June 12, 2017 and located at [http://dhhs.ne.gov/medicaid/Pages/medicaid\\_LTC.aspx](http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx).

The comments from the stakeholder engagement process were thoroughly reviewed and discussed with DHHS to identify potential revisions to the Draft LTC Redesign Plan. The seven themes that emerged from the stakeholder feedback were:

1. **Cost:** There are significant cost implications for some of the recommendations and uncertainty about the resources DHHS would be given to implement them.
2. **Timeframes:** The proposed dates for managed long term services and supports (MLTSS) implementation are too aggressive and do not sync with the time it will take to implement the other systemic priorities.
3. **Concern with Heritage Health Managed Care Organizations:** There is current anxiety about the move to managed care for LTC consumers due to difficulties in the early months of the implementation, which began in January 2017.

4. **Quality:** DHHS needs to measure the quality of the current LTC system so that it can ensure that any proposed changes improve outcomes.
5. **Communication with LTC Stakeholders:** DHHS needs to continue robust communications with stakeholders.
6. **Outstanding Design Decisions:** The “open questions” regarding specific redesign decisions are causing anxiety.
7. **Caregivers:** Unpaid caregivers are the backbone of the LTC system and without their continued support the system would fail. DHHS needs to find additional ways to support caregivers.

Many of these themes were previously woven throughout the Draft LTC Redesign Plan, but have been further emphasized, and more detail has been added to the Final LTC Redesign Plan as a result of this feedback. Additionally, specific changes have been made in consideration of the feedback on timelines, quality and caregivers.

### ***Final LTC Redesign Plan***

Consistent with the Draft LTC Redesign Plan, Mercer/NASUAD continue to recommend DHHS consider three major focus areas for LTC redesign:

- Address high-priority systemic issues in the current LTC programs
- Transition to an MLTSS delivery system
- Continue to pursue other recommended system changes over time

While these major focus areas remain the same, the individual recommendations have been modified to reflect stakeholder feedback. **None of the recommendations is significantly modified from the Draft LTC Redesign Plan released in March.**

### ***Address High-Priority Systemic Issues in the Current LTC Programs***

Through feedback from stakeholders and DHHS staff, Mercer/NASUAD identified several high-priority systemic issues that need to be addressed in the current LTC programs, regardless of the service delivery model. Mercer/NASUAD recommend DHHS begin work to address these five high-priority areas to ensure the long term sustainability of the Nebraska LTC program:

- Build an effective navigation system for LTC programs
- Ensure consistent and fair determinations for Medicaid LTC programs
- Establish the infrastructure to support consumer self-direction
- Align DHHS functions for maximum performance
- Improve assurance of health and safety for Extended Family Home (EFH) residents

These high-priority issues are unchanged from the Draft LTC Redesign Plan, although further information has been included in the specific recommendations to reflect stakeholder feedback.

### *Transition to an MLTSS Delivery System*

In addition to the high-priority issues described above, Mercer/NASUAD identified several other key recommendations to improve the quality and efficiency of the LTC program in Nebraska. Mercer/NASUAD continue to recommend transitioning to an MLTSS delivery system to address these other key issues and to improve accountability, promote delivery of Home and Community-Based Services (HCBS), deploy DHHS resources more efficiently and ensure long term system sustainability. Mercer/NASUAD recommend building the MLTSS program using the existing infrastructure of the Heritage Health program. However, based on significant stakeholder feedback, this should not occur unless the timeline to implement MLTSS is extended to allow for a stabilization of the Heritage Health program and to ensure a deliberate roll out of MLTSS. The roll out should allow additional time for planning, communicating with stakeholders, addressing financing options, reviewing the Heritage Health implementation, addressing systemic issues and evaluating the quality of current LTC programs. Mercer/NASUAD continue to recommend that DHHS undertake a careful planning and design process, with significant ongoing stakeholder engagement, to ensure the MLTSS program strengthens the delivery of LTC in Nebraska.

### *Continue to Pursue Other Recommended System Changes*

Addressing the high-priority systemic recommendations and transitioning to MLTSS will require a significant commitment of time and resources from DHHS. While Mercer/NASUAD recommend resources focus on these two areas, there are additional system changes that DHHS should continue to pursue as resources allow:

- Implement a systematic way to reassess consumers
- Increase awareness of Medical Insurance for Working Disabled (MIWD) and other employment programs for consumers with disabilities
- Continue to improve coordination and services for children aging out of the educational system
- Address issues in the provider enrollment process
- Establish a process to rebase HCBS rates more frequently

### **Next Steps**

DHHS will review and prioritize the recommendations presented in this report and align its resources to move forward with the most critical activities. Upon determining the highest priority recommendations and available resources, DHHS will outline plans for continued stakeholder engagement and begin work on developing detailed implementation plans. DHHS will continue to seek out the input of consumers, caregivers, advocates and providers to ensure the six guiding principles for LTC redesign are realized and the implementation of the redesign recommendations strengthens the delivery of LTC in Nebraska.



# 2

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## Long Term Care (LTC) Redesign Recommendations

Based upon the extensive stakeholder engagement with consumers, caregivers, advocates, providers, managed care organizations (MCOs) and feedback from the Department of Health and Human Services (DHHS) staff interviews and research, Mercer Government Human Services Consulting (Mercer) and the National Association for States United for Aging and Disabilities (NASUAD) provided DHHS with a Preliminary Recommendations Report including 25 preliminary recommendations for Nebraska LTC redesign. Results of the stakeholder engagement process are included in Appendix B, and a listing of the 25 preliminary recommendations is included in Appendix C. All references to recommendation numbers in the rest of the report refer to those listed in Appendix C. All recommendations were thoroughly considered and vetted with DHHS leadership.

In developing the Draft LTC Redesign Plan, as well as the Final LTC Redesign Plan, Mercer/NASUAD recognized that addressing all 25 recommendations in the short term is not feasible. Therefore, to make the redesign process achievable, Mercer/NASUAD undertook a process to categorize and prioritize these recommendations. After considering the second round of stakeholder feedback on the Draft LTC Redesign Plan, the categories and priorities of the recommendations did not change; however, some changes have been made to the details of certain recommendations and other recommendations have been expanded upon to address the common themes heard from stakeholders. Results of the second round of the stakeholder engagement process related to the Draft LTC Redesign Plan are included in Appendix B.

Please note that in recognition of the terminology and acronyms that are used throughout this report and in the LTC industry that may be new or unfamiliar to stakeholders, Appendix A includes a glossary of acronyms that are used in the redesign plan. Additionally, acronyms will be spelled out the first time they appear in each section of this report.

### Recommendations for High-Priority Systemic Changes

While many recommendations were identified as key to ensuring the long term sustainability of the LTC program, several recommendations stood out as critical for the redesign efforts based on the following factors:

- Extent of the risk of compliance or legal implications if issue is not addressed immediately
- Importance of the issue to stakeholders
- Impact on DHHS and financial resources
- If the activity will continue to be a DHHS responsibility regardless of delivery system changes
- Necessity for transition to a new delivery system

A high rating on two or more of the key factors designated a recommendation as a high priority. Through this classification process, 10 initial recommendations were identified as essential to address in five key program areas.

Recommendation(s)	Key Program Area to be Addressed
<i>Recommendation #1</i> — Increase assistance available for elderly and disabled consumers to access and navigate LTC and other programs	Building an effective navigation system for LTC (see Section 3 of report)
<i>Recommendation #5</i> — Implement a single standardized assessment instrument to be used for all LTC programs	Ensuring consistent and fair determinations for Medicaid LTC programs (see Section 4 of report)
<i>Recommendation #10</i> — Expand and strengthen consumer-directed programs <i>Recommendation #11</i> — Re-engineer the Personal Assistance Service (PAS) program <i>Recommendation #18</i> — Implement fiscal management services for independent providers <i>Recommendation #19</i> — Require Electronic Visit Verification for in-home services	Establishing the infrastructure to support consumer self-direction, PAS and independent providers (see Section 5 of report)
<i>Recommendation #2A</i> — Consolidate Home and Community-Based Services (HCBS) waiver administration <i>Recommendation #3</i> — Realign Nebraska DHHS organizational structure to fully effectuate LTC redesign <i>Recommendation #23</i> — Expand and align the scope of the quality program to align with the LTC redesign	Align DHHS functions for maximum performance (see Section 6 of report)
<i>Recommendation #24</i> — Enhance oversight and licensure of Extended Family Homes (EFHs)	Improving assurance of health and safety for EFH residents (see Section 7 of report)

### Recommendation for LTC Delivery System Transition

In addition to the high-priority systemic issues identified above, several other key preliminary recommendations could be addressed, fully or in part, through a careful and thoughtful transition of the State’s LTC delivery system. Several delivery system model alternatives were evaluated, including contracting with accountable care organizations, provider-led networks and capitated risk-based MCOs.

These models were considered based on:

- Ability to address stakeholder concerns
- Feasibility of their implementation, especially within an environment of limited resources
- Extent to which they can address key issues in the current LTC system
- Effectiveness in achieving DHHS program goals and objectives

Based on these factors, Mercer/NASUAD recommend DHHS contract with capitated risk-based MCOs, which are termed managed long term services and supports (MLTSS) (Recommendation #25 — see Appendix C) in this report. A more detailed rationale for the implementation of MLTSS can be found in Section 8 of this report; however, below is a summary of the 10 preliminary recommendations that can be addressed, in total or in part, by transitioning to MLTSS.

<b>Recommendation(s)</b>	<b>Area to be Addressed</b>	<b>How MLTSS Addresses Identified Need</b>
Recommendation #2B — Consolidate HCBS waiver services and populations	Certain waiver services are available only to consumers in specific waivers, when it is possible that additional populations could benefit from those services. For example, consolidating the Traumatic Brain Injury waiver with other waivers could expand the services available for these consumers.	Making the MCOs responsible for delivering all HCBS services in the MCO contract and allowing flexibility for each MCO to offer the full range of services across waivers will result in meeting consumers' needs in a person-centered way.
Recommendation #4 — Continue the reimaging of DHHS' information system infrastructure	A reimaging of DHHS' information system infrastructure is necessary to ensure efficient and effective administration of LTC in Nebraska.	Moving to MLTSS will alleviate the need for DHHS to assume some of the system redesign tasks as the MCOs will absorb many of the necessary functions. MCOs will take over the majority of claims payment and also reporting functions.
Recommendation #6 — Eliminate the conflict of interest between entities performing eligibility assessments and providing care coordination	Under new federal regulations, DHHS must eliminate all conflicts of interest in the system.	As part of MLTSS implementation, the role for different organizations in the level of care assessment process and care coordination will be defined. Having the MCOs take on some of the roles currently being done by community providers, the potential for conflicts of interest will be eliminated, and federal compliance will be assured.
Recommendation #8 — Ensure ongoing integration of person-centered planning principles in all Nebraska LTC programs	Not all consumers are engaged in a comprehensive person-centered planning process for identifying needs, goals and services.	Through contractual requirements with MCOs and additional training, DHHS can ensure that MCOs conduct meaningful person-centered planning engagement with consumers.

Recommendation(s)	Area to be Addressed	How MLTSS Addresses Identified Need
<p>Recommendation #9 — Complete a comprehensive redesign of the care management/service coordination functions to align with the LTC redesign</p>	<p>There are significant variations in the type and amount of service coordination that consumers receive depending on what services they are getting.</p>	<p>Implementation of MLTSS will allow DHHS to mandate consistent care management/service coordination for all enrolled consumers, thereby ensuring all consumers who require service coordination get it. Issues regarding qualification of care management/service coordination staff, oversight and training can be delegated contractually to MCOs.</p>
<p>Recommendation #13 — Implement prior authorization procedures so the most appropriate and cost-effective HCBS are provided</p>	<p>The current technology infrastructure in DHHS limits its ability to connect the dots between programs and services to ensure that the right care is provided in the right amount at the right time.</p>	<p>Delegating the prior authorization and care management functions to the MCOs will ensure a streamlined process for LTC services without the large technology investment from DHHS that would be needed otherwise. However, DHHS will need to build strong oversight capacity and structure to ensure LTC services and supports are not inappropriately denied or withheld by the MCOs. In addition, there are programs in Nebraska such as child welfare where the State will need to continue to provide the prior authorization and care management functions since these programs will not be included in the LTC redesign.</p>
<p>Recommendation #15 — Address gaps in behavioral health services to meet the needs of the LTC populations</p>	<p>There is a lack of coordination among behavioral health services, physical health services, and LTC for consumers in Nebraska.</p>	<p>By consolidating the delivery of all behavioral health, physical health and LTC under a single entity, coordination of all services can be improved and coordinated, resulting in treatment of the whole consumer. In addition, with care management provided by a single organization, a more person-centered approach to care will integrate behavioral health and LTC. Furthermore, DHHS can build into the MCO contract a requirement that case managers/service coordinators for consumers with behavioral health conditions have specific training and experience working with and addressing the needs of this population.</p>

Recommendation(s)	Area to be Addressed	How MLTSS Addresses Identified Need
Recommendation #17 — Eliminate negotiated rates with providers	The large number of providers in the LTC system and the historic process of individually negotiating rates with providers lead to inefficiencies and large resource demands.	Moving to MLTSS will shift the responsibility for establishing provider rates from DHHS to the MCOs. The MCOs will not negotiate individually with providers, which will lead to greater standardization of rates. However, DHHS will need to continue to monitor access to providers to ensure payment rates are not driving providers out of the program, causing disruption in care or creating service access issues for consumers.
Recommendation #20 — Expand the availability of alternative living settings	There is a lack of community living options leading some Nebraska consumers to remain in institutional settings when they could be — and prefer to be — receiving services in their community.	The move to MLTSS can accelerate access to community living settings, since the MCOs can have financial and contractual incentives to prioritize (and help to create) community living options for their consumers. DHHS will need to work collaboratively with the MCOs to ensure licensing and provider qualifications are appropriate and meet state and federal requirements.
Recommendation #22 — Address transportation service issues	There is a lack of adequate accessible transportation for consumers with disabilities and older consumers.	In moving to MLTSS, DHHS can include contract terms requiring MCOs to meet specific transportation service requirements. With MCOs responsible for all medical and non-medical transportation for consumers, they can better coordinate transportation services centered on the whole consumer rather than the type of service.

## Recommendations for Ongoing System Changes

As noted above, addressing all 25 recommendations from the preliminary recommendations report is not feasible given current resources. While Mercer/NASUAD recommend DHHS focus its limited resources on addressing the high-priority systemic changes and transitioning the delivery system to MLTSS, there are several recommendations Mercer/NASUAD encourage DHHS continue to pursue over time:

- Implement a systematic way to reassess consumers (Recommendation #7)
- Increase awareness of the Medical Insurance for Working Disabled (MIWD) and other employment programs for consumers with disabilities (Recommendation #12)
- Continue to improve coordination and vocational services for children with Developmental Disabilities aging out of the educational system (Recommendation #14)
- Address issues in the provider enrollment process (Recommendation #16)
- Establish a process to rebase HCBS rates more frequently (Recommendation #21)

Additional detail on these recommendations can be found in Section 9 of this report.

# 3

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## Building an Effective Navigation System for Long Term Care (LTC)

Entry and navigation of Nebraska's LTC system is challenging for consumers. There was widespread frustration with the complexity in how consumers enter the Medicaid system. Stakeholders reported that the system is fragmented and that they are required to fill out multiple applications for similar assistance (e.g., Medicaid and Social Services). Stakeholders voiced confusion regarding the eligibility rules for the various Home and Community-Based Services (HCBS) waivers and the Personal Assistance Service (PAS) program.

Once in the system, consumers, their advocates and caregivers often find the system too complicated and difficult to navigate. The needs of the LTC consumers change over time and consumers and their caregivers feel they must initiate and drive the entire process from start to finish. This is especially difficult when facing health challenges or changes and is burdensome to caregivers who already shoulder great responsibility. Consumers and caregivers expressed frustration that unless they knew the name of the program, the income guidelines and the name of the specific person running the program, they were unable to get connected to the right service for their needs. Stakeholders also shared that there was inconsistency in the delivery of person-centered planning to meet the needs of the consumers receiving LTC services and supports. For example, stakeholders expressed concerns that consumers with traumatic brain injury were not getting community-based services and supports that they require in some regions of the State, while others shared positive stories of how the LTC staff worked with them to receive necessary services.

### Current Practice

ACCESSNebraska is the primary entry point for enrollment into Medicaid and Economic Assistance programs. Consumers can apply for these programs online through the ACCESSNebraska website, by telephone and in-person at local Department of Health and Human Services (DHHS) offices. Stakeholders expressed concern over DHHS' reliance on the ACCESSNebraska call center and website materials alone because consumers who are older and those with disabilities have a harder time understanding people on the phone and need more personalized attention. Stakeholders also reported receiving inconsistent answers and urged DHHS to consider making local staff available to help consumers who need additional assistance in enrolling and maintaining their eligibility. Additionally, stakeholders reported a lack of personalized support for older consumers and consumers with disabilities that resulted in some LTC providers assisting consumers, but without compensation for doing so. Moreover, ACCESSNebraska only interacts with consumers once they determine to seek public assistance. A more effective system provides person-centered counseling to present consumers with a wide array of public and private pay LTC options. A strong and effective "no wrong door" (NWD) could

help to direct consumers to non-Medicaid services until their needs are more appropriately addressed through Medicaid, and help alleviate the strain on caregivers by more proactively introducing needed supports for consumers.

Beginning January 2017, Nebraska LTC consumers who are eligible for Medicaid started receiving all of their non-LTC benefits from a Heritage Health Managed Care Organization (MCO). As voiced by stakeholders, consumers who are older and those with disabilities have a harder time understanding people on the phone and need more personalized attention, including in-person assistance. The current Heritage Health enrollment process does not require the enrollment broker to proactively contact at-risk consumers who could benefit from a more personalized approach to assist in making their MCO plan selection. These thoughts were further confirmed by stakeholders when soliciting feedback on the Draft LTC Redesign Plan. For example, several consumers and caregivers reported that consumers were automatically enrolled into one of the Heritage Health MCOs and were unaware that they could make a choice. Additionally, stakeholders expressed concern that the current process and enrollment broker needs to be expanded to ensure a strong knowledge base of the specific and distinct needs of different populations and the available resources to support those needs.

### **Risks Associated with Continuing Current Practices**

As noted above, stakeholders expressed concerns with the complexity of entering the current Medicaid system in Nebraska. Without changes to the program, this frustration will continue to exist with Nebraska's program and could grow over time. The difficulty in navigating the system may lead consumers to "give up" pursuing eligibility or services and ultimately lead to consumers being cut off from receiving services or not receiving the most effective set of services. Conversely, consumers may also opt for a higher-level of services than they may need if they are not provided counseling about all of their options.

### **Recommended Change**

For nearly a decade, states and the federal government have participated in various demonstrations to streamline access to LTC options for all populations and payers. Often, consumers who use publicly funded services are left with high-cost options when they desire a low-cost option. The NWD system helps states use resources more efficiently and effectively on behalf of consumers and caregivers. The NWD system represents a collaborative effort of the U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration, and has the express intent of improving the entry into and navigation of LTC systems.

The NWD system can conduct activities such as outreach, referral, assessments, functional and financial eligibility, and even final determinations. States can decide which of these functions the NWD should take on; Nebraska will need to determine the exact functions of their NWD program. Key partners in the NWD systems are the state Medicaid agency, state aging and disability divisions, and all social service departments that touch consumers' lives. The NWD system builds on the strengths of the Area Agencies on Aging (AAAs) and the Centers for Independent Living



(CILs) by providing a single, more coordinated system of information and access for all consumers seeking LTC both public and privately funded. In Nebraska, the Aging and Disability Resource Center (ADRC) demonstration should play a critical part of the NWD system. This minimizes confusion, enhances consumer choice and supports informed decision making. Key elements of a NWD system include:

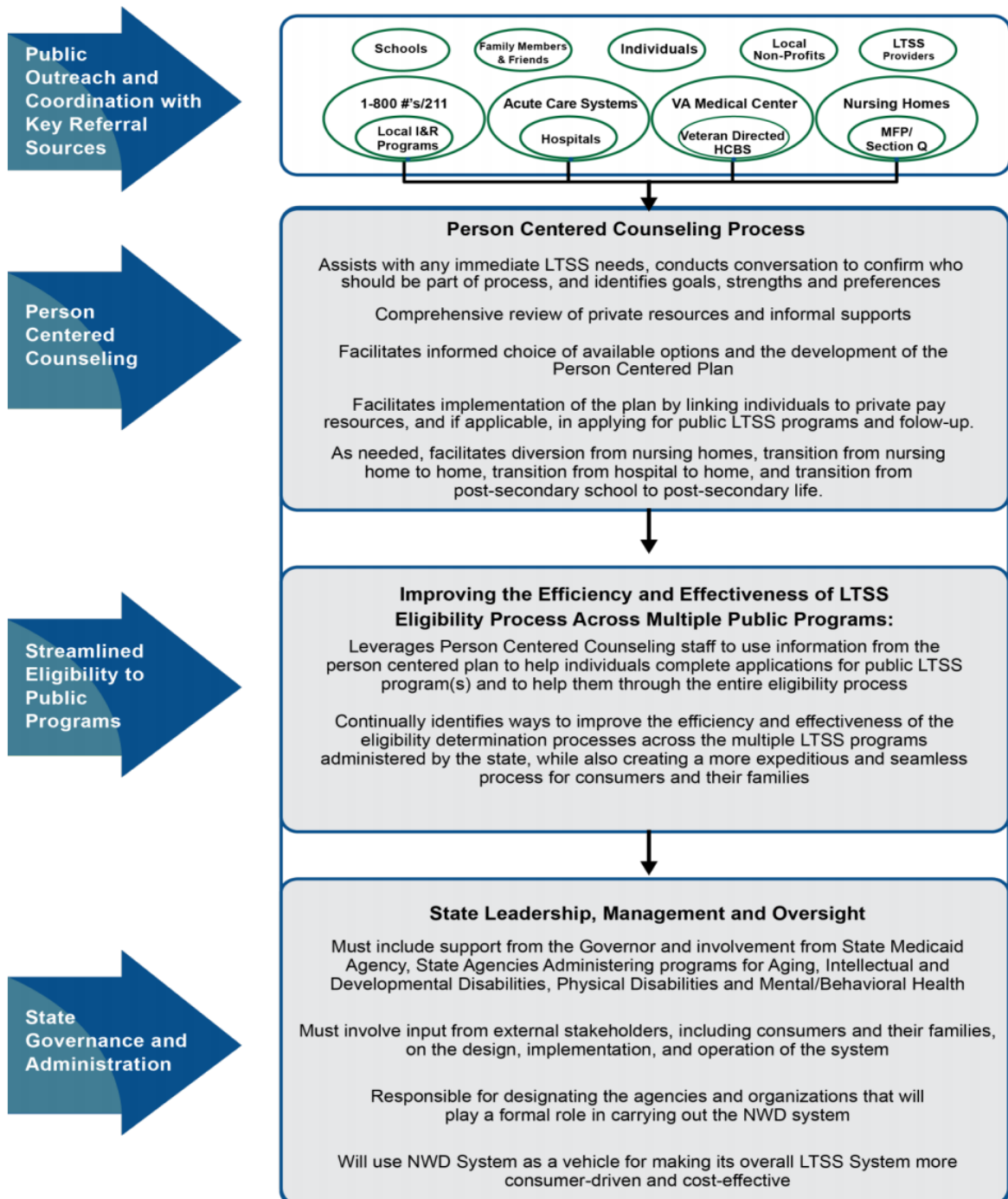
- Public outreach and coordination with key referral sources, including those with expertise in various populations
- Person-centered counseling that considers the needs of various populations
- Streamlined eligibility to public programs
- State governance and administration

The CMS schematic on the following page outlines the key components of the NWD system. Additionally, CMS and ACL have developed an administrative claiming guide to assist state Medicaid agencies so that some of the ongoing expenses for running the NWD system can receive federal Medicaid matching funds.<sup>2</sup>

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<sup>2</sup> <https://nwd.acl.gov/docs/NWD-National-Elements.pdf>

# No Wrong Door Schematic



Note that in the graphic above, the eligibility process refers to functional eligibility. Final program eligibility will be determined by ACCESSNebraska.

DHHS has recently implemented an ADRC statewide pilot project in Nebraska to offer information and referral (I&R) and options counseling on a wide array of services for older consumers and for consumers with disabilities of all ages. The ADRC pilot runs through June 30, 2018 and is slated to be evaluated at the conclusion of the pilot. Nebraska should draw upon the best practices learned from the 47 states with more mature ADRC programs and from NWD programs that are relevant to Nebraska. Important advances from other states include training on person-centered planning, options counseling, the use of technology and leveraging partnerships.

Feedback from stakeholders indicated that current LTC consumers and their caregivers in Nebraska do not utilize web-based technology or even smart phones in the same ways that LTC consumers in other states have reported. However, Nebraska does need to build a robust NWD web-based system that can continue to evolve as the needs of the consumers and their caregivers also develop. Additionally, there are a growing number of adult children caring for elderly parents and even siblings with disabilities from across the nation. The ability of the State of Nebraska to connect long-distance caregivers with tools and information to enable them to continue to support their loved ones will save the State vital resources. Often times, caregivers will pay the entire cost of services if they are provided the option to do so.

### **Best Practices and Key Characteristics in Implementation**

Implementing a NWD system is a best practice for offering information, assistance and referral to services for consumers and their caregivers seeking LTC resources. Providing this information to the consumer and their caregivers decreases their frustration and potential delay of services. The NWD system best practices include, but are not limited to:

- Creating one name for the NWD system throughout the State
- Creating person-centered, community-based environments
- Establishing an easy to understand and remember toll-free phone number that will route to the community in which the consumer lives
- Providing person-centered education, information and counseling for public and private LTC options
- Ensuring active engagement of all aging and disability networks in the NWD system
- Providing consistent training and protocols for aging and disability networks
- Ensuring access to resources and supports for family caregivers

For a state to successfully implement a NWD system it should have the Medicaid agency, state agencies representing older consumers and consumers with physical, intellectual and developmental disabilities, the Governor's office and other state agencies and stakeholders working together. Leadership from the Medicaid agency needs to ensure the inclusion of both aging and disability community-based organizations in the NWD system. Additionally, the Medicaid agency will need to continue its emphasis on stakeholder involvement in the design and implementation of the NWD system.

CMS has developed a starter kit for states looking to implement the NWD. Several states have implemented a successful NWD process. It should be noted that states have implemented successful NWD programs with different structures.

The Administration on Community Living funded eight states (Connecticut, Maryland, Massachusetts, New Hampshire, Oregon, Vermont, Washington and Wisconsin) to develop and disseminate their promising practices and elements for success.<sup>3</sup> DHHS leaders may find it useful to bring leaders from the NWD programs in several of these states to Nebraska to share lessons learned. While not a formal NWD grantee, Minnesota's program is often cited as a national leader in this area and should also be included in the review. DHHS should select design elements based on their success in other states and should take care to ensure the program design is appropriate and relevant to Nebraskans.

A strong NWD system can also provide opportunities for training and outreach on programs that are not as widely utilized. Mercer/NASUAD's recommendation is that there be an employment specialist at all NWDs to ensure that all consumers who want to work be connected to the various programs offered by DHHS to support that desire including the MIWD program, Ticket to Work, as well as Vocational Rehabilitation Programs. This was an area of need that was specifically identified by stakeholders, especially those consumers with intellectual/developmental disabilities (I/DD).

## Timing

It is clear, based on stakeholder comments, that a permanent NWD program is needed for Nebraska. The following graphic presents a high-level overview of the stages and key activities required for developing the NWD program.

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<sup>3</sup> Ibid.



DHHS will need to develop a detailed implementation plan specific to the NWD program that includes ongoing stakeholder communication and involvement in the design and implementation. The NWD program should be implemented in conjunction with the ending of the current ADRC pilot and to allow for implementation 6 to 12 months prior to managed long term services and supports (MLTSS) implementation to address any immediate implementation issues and to allow the program to stabilize in advance of MLTSS.

**Potential Additional Costs/Savings**

Implementing a statewide NWD program to improve navigation in the system would involve further building and, potentially, large funding for this program. Federal matching funds may be available to fund the NWD program to lessen the financial burden on Nebraska. More nuanced and difficult to quantify is the potential cost savings by directing public and private pay consumers

from the more expensive Medicaid LTC programs to privately paid services or some of the lesser expensive Social Services programs.

One of the most significant lessons learned from all of the ADRC initiatives operated in the other states is that determining a sustainable source of funding is critical. AAAs, CILs, ADRCs and other key partners will not put forth the necessary effort into the NWD system unless they believe that this is a program that will have continuous sources of funding. A robust technology platform with a searchable database and shared taxonomy needs to be continuously updated in order to be the most effective. It will be important to have a statewide NWD program in place prior to the transition to MLTSS so that consumers and caregivers can obtain unbiased support in making their MCO selection.

Given the substantial funding and/or resource requirements necessary to implement this recommendation, DHHS should consider a variety of options for funding a NWD system that could include:

- Exploring and applying for additional or enhanced federal match opportunities
- Reallocating State funds previously used in other areas where enhanced federal match has been obtained
- Evaluating existing expenditures to determine areas where streamlining and efficiencies can be gained and reallocate available expenditures to LTC redesign priorities
- Securing additional funding through a budgetary request, as needed

## **Necessary Resources for Implementation**

In addition to the DHHS resources to fund the implementation of a NWD program, State staff to support the NWD and technology to support the NWD program are necessary for implementation. In addition, DHHS will need to provide strong leadership at the State level to ensure all of the various partners are committed and working together towards a successful program. Sustainability and cost-effectiveness are important factors that are key to supporting a successful NWD program. NWD efforts that have been successful in other states have taken two primary approaches on this issue. One, they have made the business case that the NWD program will save the State money by helping people avoid the impoverishment that typically is required to become Medicaid eligible and identify other ways they can get needed services; and two, they have repurposed existing funds and added new sources of funding, such as Medicaid administrative Federal Financial Participation.<sup>4</sup>

DHHS may also benefit from hiring a vendor with NWD experience to provide guidance on program design and to provide support to DHHS staff in implementing the program. Additional resources include the ACL-funded resource centers on NWDs and I&R.

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<sup>4</sup> Nebraska's Aging and Disability Resource Center Pilot - Initial Report and Evaluation, HCBS Strategies. November 29, 2016.

## **Risk(s) Associated with Implementation**

LTC programs are complex and the financial requirements are not easily understood. A successful NWD program also has strong support of multiple agencies such as Medicaid, I/DD, Aging, Education, Transportation and Vocational Rehabilitation. At the local and regional level, aging and disability networks must unify if a NWD program is to be successful. Each network brings its own expertise to the NWD and all should be fully utilized. If a NWD program is implemented but does not provide robust I&R and options counseling, consumers and their families can make decisions that are financially detrimental to their wellbeing. Caregiver burnout, given limited availability of sufficient information regarding available resources, would remain a high likelihood for many families. In addition, without appropriate I&R, DHHS risks consumers entering the expensive Medicaid LTC programs before it is actually necessary. Examples include:

- Making I&R and options counseling available to private pay consumers can help them continue to safely reside in their home and community through their own resources and can help to prevent or delay spend down to Medicaid.
- Admitting a consumer to a nursing facility because the consumer and family were unaware of State and Medicaid funded services that could have supported the consumer to continue to reside in the community.

# 4

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## Ensuring Consistent and Fair Determinations for Medicaid Long Term Care (LTC) Programs

For LTC programs, the process of assessing needs of consumers is an essential step in reaching the goal of ensuring that the appropriate consumers are enrolled in the LTC programs and that each eligible consumer receives the right type and amount of services. Too few services, too many services or the wrong combination of supports and services contributes to an inefficient LTC system of care, gaps in care, adverse outcomes and strain on a state's finite resources; however accurately and objectively assessing need is often easier said than done.

A well-designed and comprehensive assessment instrument is intended to replace subjectivity with objectivity and inconsistency with consistency. Moreover, a well-designed assessment instrument and related processes, as depicted in Figure 1, can directly support several program operational functions, such as prescreening for LTC needs, level of care (LOC) eligibility determinations, person-centered plan of care development, resource allocation, quality assurance/performance improvement projects, risk stratification, utilization benchmarking studies, service authorization and financial-based analysis/rate setting; however, this all depends on the instrument selected, how the instrument is used, who is using the instrument and training on use of the instrument.



Figure 1: Standardized Assessment System Framework



### Current Practice

Nebraska currently uses multiple assessment instruments across the various LTC programs. A list of Nebraska’s current assessment instruments as well as their function can be found in Appendix D. In addition to the multiple assessment instruments, Nebraska’s current LTC programs have outdated assessment training and limited resources for oversight of the LOC assessors. This is producing concerns from stakeholders and staff about inconsistent needs assessments of the population. Stakeholders also expressed concerns that there were some case workers who universally allowed for more services than other case workers, leading to bias and unequal treatment. Additionally, stakeholders expressed concerns that the assessment instruments are being used by staff without medical training and/or knowledge about specific conditions.

In addition to concerns of inconsistency across programs, LOC eligibility determinations are currently administered by entities that also provide service coordination. With the implementation of managed long term services and supports (MLTSS), it will be necessary to eliminate this conflict of interest by separating the LOC determination responsibilities from service coordination responsibilities.

### **Risks Associated with Continuing Current Practices**

Using the current instruments and processes — with or without the transition to MLTSS — will result in the Department of Health and Human Services (DHHS) utilizing multiple assessment instruments, which require staff resources to maintain, and can result in inconsistent assessment of service needs. For example, staff must update policies, revise training curricula and develop oversight mechanisms to better ensure consistent application for such things as LOC, service types and amount determinations. Inconsistent LOC determinations can result in enrolling consumers who do not truly meet LOC criteria, which has a potential financial impact and strains limited resources. If DHHS transitions to MLTSS with the current array of instruments, each managed care organization (MCO) would also have their set of instruments they would want to use for person-centered plans of care and determining the service type and amount. It would be difficult for DHHS to effectively monitor and determine if consumers were getting the appropriate type and amount of services if each MCO utilizes their own instruments rather than a standardized instrument designated by DHHS. Also, as described earlier, continuing to have the same entities conduct LOC eligibility determinations and provide service coordination creates a conflict of interest under MLTSS and does not comport with federal requirements.

### **Recommended Change**

Mercer/NASUAD recommend that DHHS use a standardized assessment instrument to apply to as many subpopulations (e.g., consumers with intellectual/developmental disabilities (I/DD), consumers with traumatic brain injury (TBI), working-age consumers) as possible. Such an instrument would have a set of core questions applicable to all populations (e.g., activities of daily living) and additional questions target to a subpopulation (e.g., employment questions for consumers of working age). The instrument would be utilized by DHHS, MCOs and others as designated by DHHS, as appropriate, throughout the various assessment processes, such as prescreening for possible LTC needs, LOC eligibility determinations, person-centered plan of care development. If DHHS opts to pursue a standardized assessment instrument, selection of the instrument is a central decision point from which all other activity flows. DHHS must explore options to “build or buy” when selecting an instrument. To implement in the least amount of time, Mercer/NASUAD recommend that DHHS select an existing assessment instrument.

There is a handful of existing assessment instruments that have been created by other entities, which several state Medicaid programs use in varying ways. InterRAI and the Supports Intensity Scale (for children and adults with I/DD) systems are two of the most commonly known and used assessment instruments in LTC systems today. Adopting an existing instrument alleviates the need to create and validate an instrument from scratch or modify and validate an instrument built in a different state.

Advantages of an existing instrument are the following:

- Already tested for reliability and validity
- Manuals and clinical assessment protocols for care planning are already completed
- Algorithms for resource utilization groups, resource scales and quality measures are already completed; plus additional quality measures can be developed
- Additional questions or modules can be added to address any specific population (e.g., consumers with I/DD, consumers with TBI, working-age consumers and informal caregivers)
- There is no cost to state agencies in return for aggregated data, although MCOs may have to pay fees to the vendor for the use of the instrument
- Given their more common use across states, MCOs may have prior experience and familiarity

It is also important to note that Nebraska's Heritage Health MCOs urged DHHS to decide what instrument they would like to utilize before migrating to MLTSS.

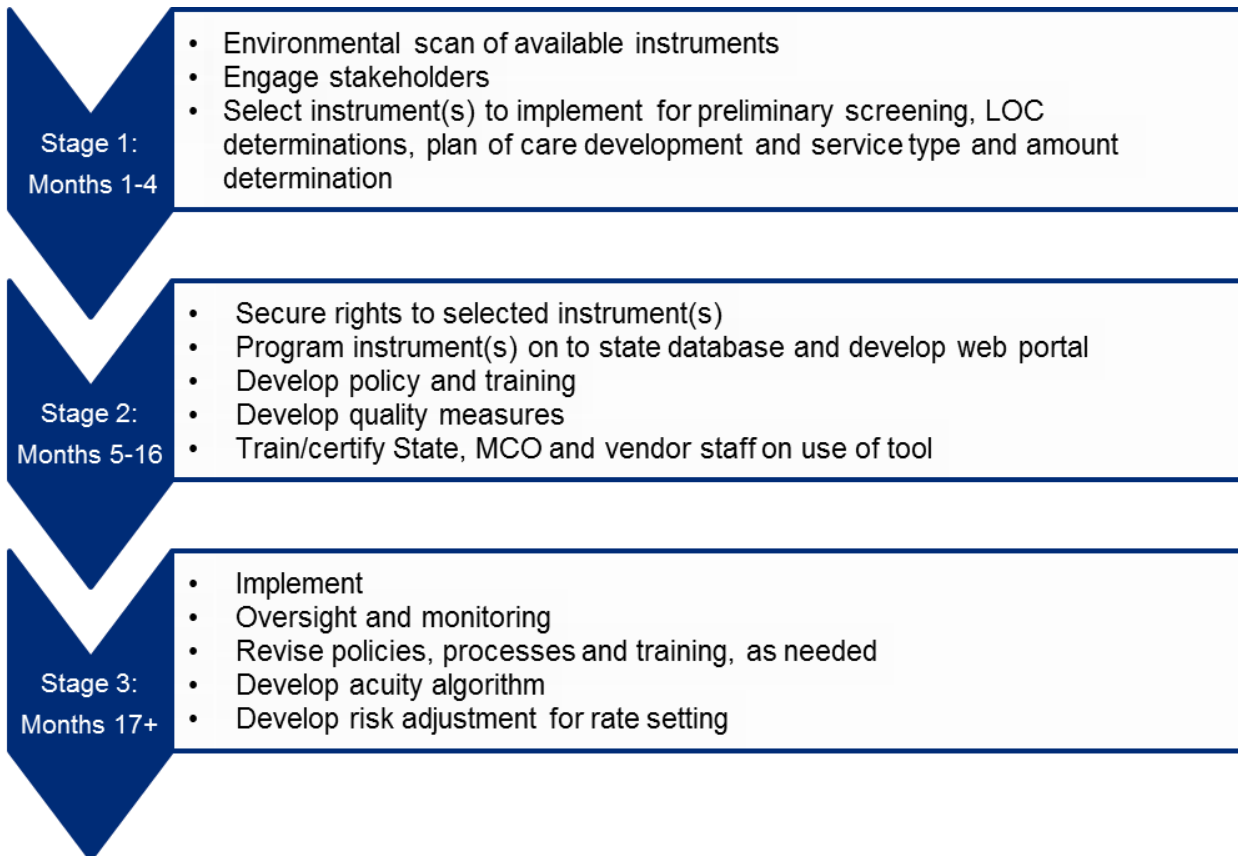
### **Best Practices and Key Characteristics in Implementation**

The Centers for Medicare & Medicaid Services (CMS) has put an emphasis on designing a single assessment instrument (or suite of instruments) for determining LOC and utilized the Balancing Incentives Program (BIP) to demonstrate how states could effectively migrate in that direction. The progress has been slow as different state agencies are reluctant to move to a single instrument for fear that the unique needs of their populations will not be adequately reflected in a single instrument. However, states can still streamline their approach to determine LOC and have one instrument for the aged and disabled populations, and another for those consumers with I/DD. The most popular instrument being used is the interRAI, with 24 states utilizing it for some of their populations. Seven states, including Connecticut, Hawaii, Illinois, Iowa, Kansas, Mississippi and Texas, have all recently migrated to this platform.

The Medicaid agency will need to continue its emphasis on stakeholder involvement in the selection and implementation of a standardized assessment tool or suite of instruments. Stakeholders will provide valuable input into decision points related to the tool and implementation. For example, stakeholder input will be valuable in determining how an assessment tool should address the needs of various populations and their informal caregivers, as well as informing components of training, such as the specific needs of each population and how to best obtain input from informal caregivers and family.

## Timing

The time to implement a comprehensive instrument can vary greatly depending upon the desire to obtain an existing instrument, utilize another state’s instrument or develop a new instrument. Nebraska will need to consider the impact of a potential procurement on the timing of implementation. When adopting an existing instrument as recommended, the following is a high-level overview of the stages and key activities:



DHHS will need to develop a detailed implementation plan specific to a standardized assessment tool or suite of tools that includes ongoing stakeholder communication, including input on tool design. The implementation of a standardized assessment tool or suite of tools should be implemented in a manner that allows for implementation 6 to 12 months prior to MLTSS implementation to resolve implementation and tool use issues well in advance of MLTSS startup.

## Potential Additional Costs/Savings

Implementing a standardized assessment tool or suite of tools may come with a significant cost that will be dependent on what tasks can be performed by DHHS staff and what, if any, may need to be performed by a contracted vendor. With a delivery system change, costs to a vendor to

incorporate the tool into their care management information system platform must also be accommodated (e.g., within a capitation rate).

Given the substantial funding and resource requirements that may be necessary to implement this recommendation, DHHS should consider a variety of options for funding implementation of a standardized assessment tool or suite of tools that could include:

- Exploring and applying for additional or enhanced federal match opportunities
- Reallocating State funds previously used in other areas where enhanced federal match has been obtained
- Evaluating existing expenditures to determine areas where streamlining and efficiencies can be gained and reallocate available expenditures to LTC redesign priorities
- Securing additional funding through a budgetary request, as needed

Standardizing the assessment instrument is not a simple endeavor, but if done in a methodical manner, DHHS can see benefits such as administrative simplification, useful information and improved monitoring of consumer needs and service delivery. As noted in the CMS BIP 2013 implementation manual:

*A well-designed universal assessment can offer several benefits to a State, such as promoting choice for consumers, reducing administrative burdens, promoting equity, capturing standardized data, and automating data systems to indicate programs for which an individual is likely eligible (Engelhardt & Guill, 2009). Universal assessment information and data systems can also support State efforts to project future service, support and budget needs and prioritize individuals for services when waitlists are present or budgets are limited.<sup>5</sup>*

## **Necessary Resources for Implementation**

Program and information technology staff will be needed to support this effort. Selecting an existing assessment instrument will greatly reduce needed staff resources to fully implement. For example, an existing instrument will already have much of the programming language already written so that it can be readily applied to the platform DHHS would be using. Significant investments will be necessary to appropriately train staff, MCOs and others on the use of the instrument.

In addition to the staffing resources needed at DHHS, DHHS may also benefit from hiring a vendor with assessment instrument design and implementation experience to provide guidance and to provide support to DHHS staff in implementing an LTC assessment instrument and supporting system.

## **Risk(s) Associated with Implementation**

Mercer/NASUAD believe that establishing a new standardized assessment instrument or suite of instruments and process must be in place before moving to MLTSS. Staying with the current

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<sup>5</sup> [www.balancingincentiveprogram.org/sites/default/files/Balancing\\_Incentive\\_Program\\_Manual\\_2.0.pdf](http://www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_Manual_2.0.pdf)

multiple instruments and processes risks continuing the current concerns from stakeholders and staff about inconsistent needs assessments of consumers and that depending on the case worker and/or MCO, consumers may be under or over authorized for the services that they need.

During the selection and implementation of a new assessment instrument, DHHS will need to expend staff resources to update policies and training as well as develop and implement much stronger oversight mechanisms. If the training and oversight are not appropriately implemented, DHHS risks having consumers inappropriately enrolled in the LTC programs or having eligible consumers getting the wrong type or amount of services.

In the end, regardless of the assessment instrument and process selected, stakeholder education about the process and tool, including what it is and what it is not and how the information is used, will be key for a successful implementation. This is a critical element that is often overlooked, and based upon stakeholder feedback, is a challenge in Nebraska's current LTC system.

# 5

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## Establishing the Infrastructure to Support Consumer Self-Direction, Personal Assistance Services (PAS) and Independent Providers

The need to expand and strengthen self-directed programs was a very common theme when Mercer/NASUAD requested feedback from stakeholders and Department of Health and Human Services (DHHS) staff. Included in those discussions was also the need to modernize the State Plan PAS program. This benefit was frequently brought up by DHHS staff and stakeholders as an area that needs a significant redesign. Areas of concern for the PAS program included:

- Duplication of services with other similar services provided under Nebraska's waiver programs, such as chore services
- No face-to-face assessment of consumers
- Lack of care coordination for those receiving PAS
- Need for a fiscal intermediary to manage independent providers
- Need for an electronic visit verification (EVV) system to improve oversight and reduce manual intervention to process timesheets and payroll. The EVV is federally mandated and must be implemented by January 1, 2019 for PAS to avoid reduced federal financial participation.
- Manual rather than automated processes related to the Department of Labor overtime requirements

The consumer self-direction options in the DHHS Home and Community-Based Services (HCBS) waivers and the PAS program both rely heavily on the use of independent providers. DHHS has the responsibility to register and oversee approximately 4,800 of these independent providers, which can be time intensive and challenging. Adding a limited number of automated processes facilitates more efficient management.

### Current Practice

#### ***Consumer Self-Direction***

During the stakeholder feedback process, stakeholders expressed confusion over the recommendation around consumer self-direction. Specifically, many felt that consumer self-direction exists in all Nebraska Long Term Care (LTC) programs. It is understandable how such confusion exists, since, at a high level, the Centers for Medicare & Medicaid Services (CMS) offers states two options for a consumer self-directed program that may be used in combination with the other. Option one is employer authority where the consumer is the formal employer of their workers and allows the consumer to hire, fire and supervise his/her workers. Consumers can exercise that authority on their own (as is the case in Nebraska) or with the help of an agency who might screen potential employees for the consumer to decide among.

Option two is budget authority, which allows consumers the flexibility to choose services within their allocated budget. That authority quite often is used in combination with employer authority so that the consumer has the maximum amount of choice and control over his or her services. However, it is not uncommon for states to operate employer authority independently of budget authority.<sup>6</sup>

Overall, DHHS has demonstrated a strong commitment to person-centered planning and service delivery in their LTC programs. Consumer self-directed services are intended to give the consumer more control over the type of services received as well as control of the providers of those services. The underlying philosophy of offering consumer self-directed services is to build upon the consumer and family strengths and to strengthen and support informal and formal services already in place.<sup>7</sup> However, only the Division of Developmental Disabilities (DDD) HCBS waivers include a formal consumer-directed option for their consumers.

DDD HCBS waivers provide opportunities for consumer self-direction to consumers who choose certain DD services (e.g., Supported Employment Service — Individual, Respite, Habilitative Community Inclusion and Adult Companion Service). These services are directed by the consumer or advocate who can be either a family member or a trusted friend. The DDD HCBS waivers offer both employer and budget authority.

The services coordinator (SC) or community coordinator specialist (CCS) is involved in supporting consumer self-direction, from informing consumers about the option to self-direct their services and supports to supporting the consumers or their advocates as needed while enrolled in the self-direction program. The SC/CCS supports self-direction by meeting with the consumer, advocate and family to facilitate discussion of the consumer's budget, the self-directed services available to the consumer, and the rights and responsibilities associated with choosing self-directed services. The consumer or advocate can request that the SC/CCS assist in locating independent providers and facilitate interviewing the perspective providers and may assist in setting up referral meetings with certified DD provider agencies. The SC/CCS also facilitates and documents the service plan meeting.

In the DD consumer self-direction program, the consumer or his/her advocate is the common law employer of individual workers that provide waiver services. As such, the employer, the consumer or their advocate is allowed to hire, dismiss and supervise their individual workers. DHHS is appointed the employer's fiscal agent and is responsible for ensuring all state tax and Internal Revenue Service rules are being followed. When DHHS processes claims submitted by individual

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<sup>6</sup> Developing and Implementing Self-Direction Programs and Policies: A Handbook at: [http://www.bc.edu/content/dam/files/schools/gssw\\_sites/nrcpds/cc-01.pdf](http://www.bc.edu/content/dam/files/schools/gssw_sites/nrcpds/cc-01.pdf)

<sup>7</sup> Participant Direction of Services for the Developmental Disabilities Day Services Waiver for Adults and Developmental Disabilities Comprehensive Services Waiver at [http://dhhs.ne.gov/developmental\\_disabilities/Pages/PublicComment.aspx](http://dhhs.ne.gov/developmental_disabilities/Pages/PublicComment.aspx)



workers, as the designated fiscal agent it is responsible for withholding the appropriate state and federal taxes. DHHS also processes claims from provider agencies. To process payroll and pay claims is a labor intensive process because of the need to handle paper claims and associated timesheets. DHHS is also responsible for determining if any independent workers also qualify for overtime.

Unlike the DDD waivers, the MLTC Aged and Disabled (AD) waiver program does not formally offer a consumer-directed option that includes budget or employer authority. Rather, this waiver integrates the philosophy throughout the program. In order to operate a formal consumer self-directed program, states must specifically request authority from CMS in their waiver application.

### ***Personal Assistance Service (PAS)***

PAS is a State Plan service available to consumers with disabilities and chronic conditions to enable them to accomplish tasks that they would normally do for themselves if they did not have a functional limitation. PAS is based on consumer needs for one or more of the following:

- Basic personal hygiene
- Toileting/bowel and bladder care
- Mobility assistance and transfers
- Nutrition (e.g., preparing meals, assisting with feeding and drinking fluids)
- Medication (e.g., assistance with taking medication, medication reminders)

When any of the above services are needed to help consumers to remain in the home, supportive services can be provided. These services could include housekeeping and accompanying and assisting consumers when they cannot travel alone to medical appointments. The PAS does not allow caregivers to provide for supervision/companionship if there are no specific tasks to be completed.

In addition, specialized procedures can be performed by a PAS provider at the direction of a consumer or the caretaker for a minor child or adult under legal guardianship. Such procedures are considered health maintenance activities under the Nebraska Nurse Practice Act and include, for example, insertion and care of catheters, sterile dressing changes, filling insulin syringes and giving injections. To perform these specialized procedures, a physician or registered nurse must determine that these procedures can be safely performed in the home and community by the PAS provider.

To determine the type and amount of supports that are needed, a local DHHS social services worker performs a telephonic-only interview with the consumer and/or his/her representative using a standardized form called the Time Assessment and Service Plan. Utilizing this form, the worker discusses with the consumer and/or his/her representative the various tasks that need to be performed and the amount of time needed to complete each task. The worker can authorize no more than 40 hours of PAS per week. If the consumer needs more than this amount of time, the additional hours must be approved by DHHS central office staff.

Once the number of PAS hours is determined and authorized, the consumer is responsible for finding a provider that can deliver the authorized services. The consumer may be able to ask for some assistance from a local resource developer in locating a provider, but that assistance is typically minimal. In many cases, a friend or family member becomes a PAS provider to meet the consumer's need. In this way, PAS is a consumer-directed program.

The worker enters the information gathered from the interview and the scope of the service that will be authorized in the Nebraska Family On-line Client User System (NFOCUS) software. NFOCUS is used for intake, eligibility determinations, payments and monitoring ongoing services. For claims to be paid, the consumer or agency provider submits a completed claim form and the applicable signed timesheet. The processing of claims can be labor intensive, since there is no electronic claim or timesheet. Individual providers who work more than 40 hours in a designated seven day time period for one or more Medicaid consumers are required to be paid overtime. This is also a labor intensive process that is not automated.

### ***Independent Providers***

DHHS has over 4,800 independent providers who provide LTC services to consumers enrolled in the Medicaid and non-Medicaid funded LTC programs. The Division of Medicaid & Long Term Care and DDD manage their own providers including, but not limited to, certification that a provider meets minimum requirements, authorizing services, determining hours that qualify for overtime, payment of claims, withholding individual state and federal taxes and investigating critical incidents involving a provider.

### **Risks Associated with Continuing Current Practices**

The current inefficiencies will continue without changes to how the consumer self-direction, PAS and independent provider systems operate. New federal law will subject DHHS to a reduction of Federal Medical Assistance Percentage (FMAP) for personal care and home health services expenditures if an EVV system is not implemented by January 1, 2019 for PAS. If a Fiscal Management Services Agency (FMSA) is not procured, DHHS will continue to struggle with the processing of claims and making payments to the PAS, HCBS and non-Medicaid funded providers.

In addition to the inefficiencies with how the PAS is operationalized, there is limited ability to know if a consumer is receiving the appropriate amount of PAS and experiencing a change in condition unless the annual telephonic interview is replaced by a face-to-face assessment and routine telephonic and face-to-face care coordination. The lack of a face-to-face interview and routine care coordination can place the consumer at risk and place an unnecessary burden on unpaid caregivers. Moreover, there is little assistance provided to the consumer on hiring, firing and maintaining his or her employee in any of the DDD or PAS programs.

### **Recommended Change**

To provide consumers with more opportunities for self-direction, DHHS should amend their current AD waiver to explicitly include the consumer self-direction program option for employer

and budget authority, as are in the DDD waivers. While MLTC staff has demonstrated commitments to person-centered planning and service delivery, there needs to be a formalized mechanism for implementation of a truly self-directed program. As is the case with the DDD waivers, self-direction will be an option for those who want to participate; it will not be mandatory.

Two key program changes needed to improve the efficiency of how the consumer self-direction program, PAS and independent providers are managed is to procure both an EVV system and FMSA (also referred to as a fiscal intermediary).

EVV systems allow for remote verification that an in-home service was appropriately provided; including confirmation of the consumer receiving the service, the date of the service, the location of the service delivery, the individual providing the service and the time the service begins and ends. While there are many variations on the approach and technologies employed, the basic concept is that a direct care worker who is delivering a service to a consumer in the community checks in electronically at the start and end of a shift. The exact time that service is delivered is tracked and billing can be automatically generated from the information collected through the electronic check-in. The system will track precisely how long the service was delivered or whether it was delivered at all. By receiving that information electronically — typically through a smartphone app or tablet — EVV systems can eliminate the labor intensive processes of manually preparing and submitting claims and timesheets. This in turn can allow for DHHS and managed care organizations (MCOs) to receive electronic claims and make electronic payments much more quickly than any manual processes in operation today. In addition, caregivers who are not with the consumer when a service is to be provided will know whether the service is indeed being delivered. EVV technologies today allow for this service to be deployed in rural areas where landline and cellphone services may be limited or non-existent so consumers and DHHS can realize the benefits throughout the State.

EVV can also be a critical program integrity element for the Medicaid program and can provide the necessary checks and balances to ensure that in-home HCBS rendered are consistent with care plan authorizations. The recently passed federal legislation, 21<sup>st</sup> Century Cures Act, requires states to have an EVV system in place for personal care services (PAS in Nebraska) by January 1, 2019 and for home health care services by January 1, 2023. Failure to implement an EVV system timely can subject the State to a 0.25%–1.00% reduction in the federal funds that DHHS can receive. DHHS can receive 90% of the cost for the design, development and installation of EVV and 75% of the cost for the operation and maintenance of an EVV system from the federal government. The Secretary of the federal Department of Health and Human Services is required to provide best practices information to states by January 1, 2018. This information may be helpful to Nebraska in ensuring its EVV system is designed to include these best practices.

To support the consumer self-direction program, PAS and independent providers, DHHS should engage the services of an FMSA. Due to the large number of independent providers that the LTC programs and consumers rely upon, it is not practical to transition these independent providers to provider agencies. One of the most efficient options available would be to use an FMSA to

automate and perform many of the tasks done by DHHS staff. To support independent providers, an FMSA could certify and enroll these providers, process and pay claims based on the authorized services, qualify overtime hours, withhold the appropriate state and federal taxes and maintain a searchable list of independent providers for consumers needing PAS or HCBS. For support of the consumer self-direction program, the FMSA would also be responsible to track and report to a consumer and to other designees (e.g., case manager, advocate) on the status of the consumer's service utilization and expenditures.

In addition to the traditional FMSA function, states will often add a support brokerage service to provide the supports needed for consumers to locate, train and supervise their individual workers. Mercer/NASUAD recommend that DHHS consider adding a support brokerage function, as it would strengthen the design of the program and better support consumers' self-directed care.

Given the numerous critical program improvements that DHHS will be taking on as it transitions to managed long term services and supports (MLTSS), it is recommended that DHHS conduct a thorough analysis to understand the impact on the consumers who currently receive PAS. DHHS should research and analyze the impact of converting the PAS benefit to a different federal authority, such as 1915(i), 1915(j), or 1915(k). DHHS must evaluate the impact on eligibility criteria for the different authorities. Appendix E outlines the implications of each of those alternative authorities.

Since consumers will be enrolled with a Heritage Health MCO for all of their services, this would allow DHHS to require the MCOs to complete in-person assessments of need, place into case management and regularly monitor to address the consumer's current status and need for any revision to their services. Transitioning these responsibilities to the MCOs will allow the State to hold the MCOs accountable for consumers receiving the appropriate amount and types of services, which will ensure the well-being of consumers and the appropriate support for caregivers. It will also help to ensure that the right amount of services is delivered to consumers at the right time.

Within all of these recommended changes, Mercer/NASUAD suggest DHHS look for ways in which the program can be further enhanced to support caregivers. During the stakeholder feedback process, caregivers expressed frustration at the difficulty of navigating the current system and ensuring their loved ones received needed supports to live productive, independent lives. For consumers and caregivers who want more direct control over their services and supports, providing the means to self-direct care, in a consistent manner for similar services across the LTC system and the sufficient supports to facilitate this is critical to overall satisfaction and peace of mind. By hiring an EVV vendor, DHHS can ensure consumers receive appropriate services at the right time, and caregivers can feel confident that their loved one is being safely supported. By hiring an FMSA vendor, DHHS can redeploy resources from the administration of a labor intensive system to better support consumers and families. Just as important for consumers and their caregivers is knowing that a FMSA vendor is available to handle the administrative tasks that often serve as an obstacle preventing many from choosing to self-direct their care.

## Best Practices and Key Characteristics in Implementation

The DDD consumer self-direction program as designed includes many of the key characteristics of a well-designed self-direction program. Consumer self-direction options must have person-centered planning processes, individualized service plans and budgets, information and assistance, and financial management services, as well as quality assurance.<sup>8</sup>

A best practice is to implement consumer self-direction across all applicable HCBS waiver and LTC programs. Nationally, it is estimated that 850,000 consumers through 270 LTC programs self-direct their own LTC services and studies show that self-direction improves consumer care quality and health while containing costs.<sup>9</sup>

Quality can often be an overlooked aspect of HCBS waiver programs with most of the emphasis on CMS' quality assurances. No matter the design of the self-direction program, DHHS should look to build in quality assessment and improvement methods in the design. This should include a definition of quality, measurements of quality, data collection and quality improvement based on the data. The quality assessment practices should include consumer satisfaction and quality ratings.<sup>10</sup> As a first step in the quality strategy, quality measures should be identified and measured on the current LTC programs to establish a benchmark in evaluating the performance of the program after implementation of EVV, FMSA and MLTSS.

EVV systems should, at a minimum, include the ability to verify the specific in-home service provided, the consumer receiving the service, the date of the service, the location of the service delivery, the individual providing the service and the time the service begins and ends.<sup>11</sup> Other aspects that states have built into EVV systems are the ability to match services to the services authorized, flexible scheduling rather than to specific start and stop times, notification in real time when a service is not delivered as scheduled, capture of worker notes and creation of an electronic claims file in the 837 format.<sup>12</sup> Ohio will implement an EVV system late in 2017 and has contracted with one vendor. The state encourages providers to use this single vendor but will allow providers to use their own EVV systems. Providers who use their own EVV system/vendor must meet all interface requirements so that a standard set of information is shared with the State. Providers using Ohio's contracted vendor will not have to pay transaction fees; however, if they use their system the State will not compensate the provider for those transaction fees.<sup>13</sup>

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<sup>8</sup> <https://www.medicaid.gov/medicaid/ltss/self-directed/index.html>

<sup>9</sup> <https://www.geron.org/press-releases/55-2017-press-releases/710-pp-ar-finds-americans-more-in-control-of-their-long-term-care>

<sup>10</sup> <https://academic.oup.com/ppar/article/doi/10.1093/ppar/prw022/2432522/Expanding-Self-Direction-and-Its-Impact-on-Quality>

<sup>11</sup> H.R. 34 (21<sup>st</sup> Century Cures Act)

<sup>12</sup> TennCare Statewide Contract with Amendment 2 – July 2015, Section 2.9.6.13.5

<sup>13</sup> <http://www.medicaid.ohio.gov/INITIATIVES/ElectronicVisitVerification.aspx>

Some states that offer PAS as a part of State Plan benefits choose to limit the maximum number of hours that can be authorized during a specific time frame. New Jersey limits the maximum number of hours authorized under the state benefit to 40 hours a week.<sup>14</sup> California limits the number of hours that may be authorized in a month to 283, while Delaware places a limit of 8 hours per day, but no more than 1,040 hours in a year.<sup>15</sup>

The Medicaid agency will need to continue its emphasis on stakeholder involvement in the redesign of these services and the selection and implementation of an EVV and FMSA.

## Timing

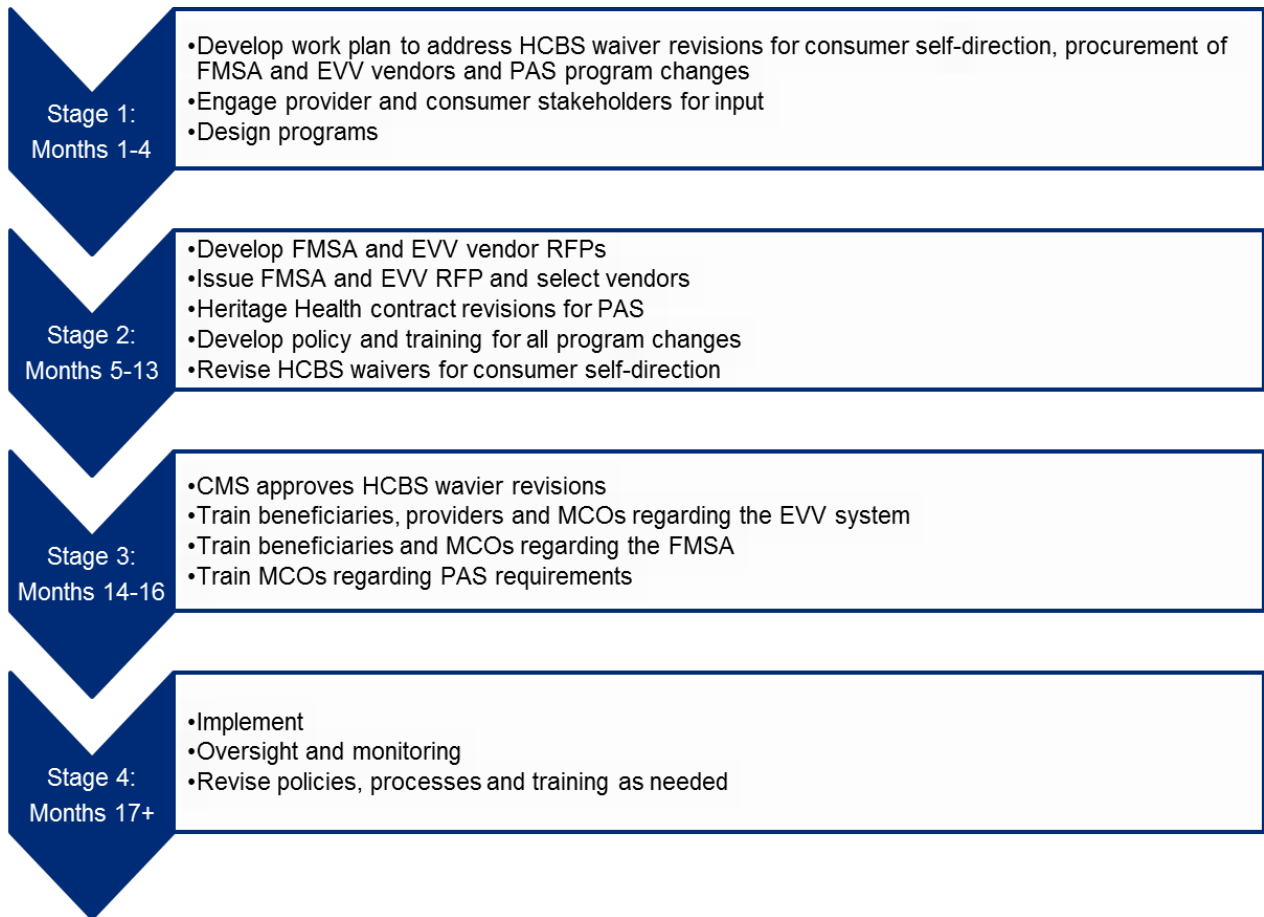
Several key components must be addressed to implement the infrastructure to effectively support consumer self-direction, PAS, and independent providers. The key components that will need to be addressed are procuring an FMSA and EVV system (including the state procurement process); revising the HCBS waivers to align with changes to the consumer self-direction model and modification to the Heritage Health contract so the MCOs can provide face-to-face assessments and care coordination to consumers needing PAS.

To make the best use of resources, it is recommended that DHHS address these as a whole and not as individual projects since there are many interdependencies. The following is a high-level overview of the stages and key activities:

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<sup>14</sup>[http://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010\\_60%20Home%20Care%20Services%20Manual.doc](http://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_60%20Home%20Care%20Services%20Manual.doc)

<sup>15</sup> <http://kff.org/medicaid/state-indicator/personal-care-services/?currentTimeframe=0>



DHHS will need to make key design decisions including the scope of activities the FMSA will undertake, and develop a detailed implementation plan specific to implementation of the EVV and FMSA that includes ongoing stakeholder communication. Specifically, the providers and MCOs need to be consulted on potential challenges they may face with EVV and FMSA and potential solutions.

The implementation of the EVV and FMSA should be implemented in a timeframe to allow for implementation 6 to 12 months prior to MLTSS to address any immediate implementation issues and to allow the program to stabilize in advance of MLTSS. As noted above, the State should review any guidance provided by the federal Department of Health and Human Services to ensure the State has considered all available best practices. The recommended modification to the PAS under Heritage Health needs to be in place at the time MLTSS begins.

### Potential Additional Costs/Savings

Although there is considerable upfront costs for EVV implementation, states have found that implementation of an EVV system has resulted in cost savings upon implementation. Texas

reported an 8% program savings with the pilot implementation of EVV.<sup>16</sup> Cost savings generally result because the caregiver's exact time of arrival and departure is recorded and used for the billing rather than using a hard copy timesheet. An EVV system also does not allow for payment of services that are not within the parameters of the authorization.

Texas and Ohio have designed their EVV systems to have all EVV transaction costs paid for by the MCO or their fee-for-service claims administrator (state or vendor). Texas has already implemented EVV, and Ohio is implementing late in 2017. Both programs will not pass costs on to the provider or consumer assuming they use the State's contracted EVV vendor.<sup>17</sup>

FMSA will be an additional expenditure whether it is considered an administrative or health service under MLTSS. Any potential cost savings would result from repurposing or reducing staffing due to the transition of much of the claims processing and management of the large number of current independent providers to an FMSA. The cost of this service can vary depending upon the design. Some of the factors that can influence the cost are the number of consumers to be served, variations in the payment rates that are allowed, complexity of the payment rules, system and processes needed to exchange data, need for FMSA to be present in state or regional service areas. The approach to reimbursement can vary greatly ranging from a per member per month (PMPM) fee to a PMPM fee plus a fee for each hour billed.<sup>18</sup>

Given the substantial funding and/or resource requirements necessary to implement this recommendation, DHHS should consider a variety of options for funding implementation of this recommendation:

- Exploring and applying for additional or enhanced federal match opportunities
- Reallocating State funds previously used in other areas where enhanced federal match has been obtained
- Evaluating existing expenditures to determine areas where streamlining and efficiencies can be gained and reallocate available expenditures to LTC redesign priorities
- Securing additional funding through a budgetary request, as needed

## Necessary Resources for Implementation

The development and implementation of EVV and FMSA will require significant DHHS staff commitment. DHHS may also benefit from hiring a vendor with EVV system and FMSA experience to provide guidance on program design and to provide implementation support to

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<sup>16</sup> Electronic Visit Verification Overview, Sandata.

[http://www.akleg.gov/basis/get\\_documents.asp?session=29&docid=52974](http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52974) (slide 12)

<sup>17</sup> <https://www.dads.state.tx.us/providers/communications/alerts/EVVUpdate-06-2014Handout.pdf>

<http://www.medicaid.ohio.gov/Portals/0/Initiatives/EVV/FAQforEVV.pdf>

<sup>18</sup> National Resource Center for Participant-Directed Services, Financial Management Services in Participant Direction: What do they Cost? <http://www.appliedselfdirection.com/sites/default/files/FMS%20Cost.pdf>



DHHS staff. DHHS will also need to provide oversight of the EVV and FMSA that could be provided by repurposing existing staff.

While considering the EVV system, DHHS should work closely with stakeholders to ensure the system best meets the needs of Nebraska's consumers. In particular, DHHS will need to work closely with those who have or would like to choose consumer-directed services to determine an approach with this model.

### **Risk(s) Associated with Implementation**

It will be important to ensure the FMSA and EVV system are functional at least a year in advance of MLTSS implementation. If not ready prior to MLTSS implementation, the Heritage Health MCOs would have to dedicate unexpected staff resources to manage the system in a less efficient manner than what they could do with the FMSA and EVV system in place. With delays, there would likely be additional training of independent and agency providers based on how the program would operate pre- and post-implementation.

# 6

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## Aligning DHHS Functions for Maximum Performance

Consolidation of the program administration of all programs across the long term care (LTC) continuum is a critical initial step towards building efficiencies into the system. Currently of the five Home and Community-Based Services (HCBS) waivers and Program of All-Inclusive Care for the Elderly (PACE) (optional State Plan program), three of the waivers (consolidated into two waivers effective May 1, 2017) are administered by the Division of Developmental Disabilities (DDD) and two of the waiver programs and the PACE program are administered by the Division of Medicaid & Long Term Care (MLTC). Non-Medicaid funded aging services programs are also housed in MLTC.

### Current Practice

Current LTC programs operate in silos, with different rules, taxonomies and staffing. Stakeholders confirmed that there is a lack of communication among programs. They felt that the current system places the burden on the consumer to understand the various rules and requirements of each program and to determine how to develop a “package” that would work. Nebraska’s current quality program primarily focuses on HCBS waiver assurances and has limited transparency to consumers. Staff resources are also limited, especially related to the older consumers and consumers with physical disabilities.

For HCBS programs, it is critical to not only measure how the programs are working but the impact that they have on consumers’ lives. Assessing the impact that HCBS services have on consumers’ quality of life is a national best practice. Until 2016, the Department of Health and Human Services (DHHS) had not been looking at HCBS quality from that perspective. However, DDD began implementing the National Core Indicators (NCI) adult consumer survey for its Intellectual/Developmental Disability (I/DD) waivers in 2016 and is planning to deploy the NCI — Aging and Disabilities (NCI-AD) for the Aged and Disabled and Traumatic Brain Injury waivers in 2017. Broader DHHS organizational restructuring should be considered to maximize administrative efficiencies and to create a structure better suited for monitoring the redesigned LTC system. DHHS’ current administration structure does not easily lend itself to administrative efficiencies. Moreover, there is no specific role/accountability for stakeholder engagement in DHHS.

### Risks Associated with Continuing Current Practices

Continuing under the current administrative structure reinforces the siloed program administration and inefficient use of DHHS resources. Additionally, the current practice does not provide a single voice of the agency to the Centers for Medicare & Medicaid Services, which could lead to confusion and delay in implementation of key program changes. Consumers have multiple applications, multiple sets of similar questions asked and inconsistent coordination of services. If

the system were consumer-centric rather than provider-centric or state-centric, consumers would have a much better experience.

Additionally, without an understanding of the performance of the current programs, it will be challenging for DHHS to demonstrate the value of the LTC redesign and improved outcomes for consumers. Finally, having dispersed responsibilities for stakeholder engagement does not allow a unified message or approach about DHHS' activities.

## **Recommended Change**

Mercer/NASUAD recommend consolidating functions, such as provider enrollment, participant enrollment, and day-to-day program operations under a single operating entity. This does not necessarily require creation of a new organizational structure, but instead can be achieved by realigning staff responsibilities and functions. However, Mercer/NASUAD recommend a realignment of the organizational structure as the best way to achieve and maintain the desired results of breaking down the current siloed administration. Mercer/NASUAD recommend designating one person – potentially a communications leader – to lead both MLTC and DDD public engagement activities, including being a liaison to the LTC Redesign Advisory Council and other stakeholder groups.

Streamlining access to services, at least HCBS, which was a consistent concern voiced by stakeholders, can also be addressed with a consolidated approach to program administration. Having a single organizational structure that encompasses all LTC programs is critical to eliminate the current siloed program administration. The single organizational structure will ensure more consistency in the provision of services and supports across all of the Nebraska LTC programs and will also improve consumers' experience by eliminating duplicative processes. Ongoing management and monitoring of the LTC programs will also be more effective under a single organizational structure.

Mercer/NASUAD recommend a comprehensive quality measurement take place for the current LTC system prior to implementing any significant changes so it can be used as a baseline to determine if the proposed changes to the program improve outcomes. Many states moving to managed long term services and supports (MLTSS) have used the NCI/NCI-AD assessment pre-migration to MLTSS and post-migration to measure overall system improvement. Nebraska's overall quality program will need to be re-evaluated in conjunction with the LTC redesign. With MLTSS, Nebraska will need to develop a Quality Assurance and Performance Improvement (QAPI) program. The QAPI program needs to be aligned with the LTC population it is going to serve and needs to be comprehensive, addressing level of care assessments, services coordination, specialty populations, informal caregivers, and LTC, physical health and behavioral health providers, among others. The QAPI should be transparent to stakeholders and should also be in alignment with other parts of MLTC's other Medicaid programs so that there is an overarching and complementary strategy to quality that underpins all programs and serves as a de facto mission statement for the State.

As the LTC redesign implementation plan is developed, there may be situations where existing functions and roles transition to contractors, thus freeing up DHHS resources that can be directed to new functions, such as contractor oversight. This may require additional training for those transitioned staff to help them move from directly working with consumers or providers to contract managers.

To understand what organizational changes might create operational efficiencies, a comprehensive analysis of the current operations and identification of impacted functional areas and staff will need to be conducted as part of the realignment process. DHHS would also need to assess the best structure to meet the needs of the department while achieving the goal of integrating the siloed program administration.

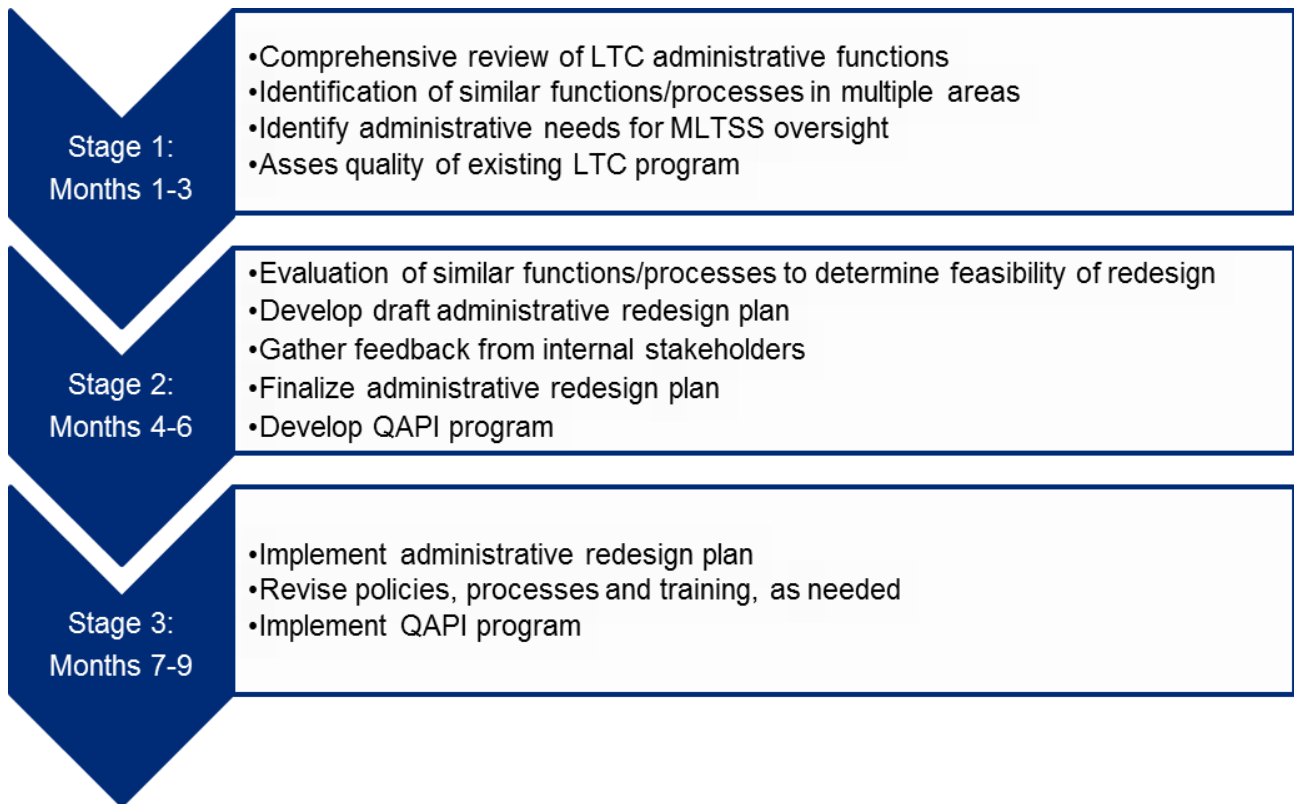
### **Best Practices and Key Characteristics in Implementation**

There are states that have realigned some functions under their LTC programs to maximize performance. New Mexico and Tennessee are examples where some realignment has been completed. Mercer/NASAUD do not believe either of these states included I/DD populations in the realignment initiative. Mercer/NASUAD also do not believe a “best practice” administrative model exists that can be applied across multiple states. Mercer/NASUAD recommend a comprehensive review of Nebraska administrative functions to identify if similar processes or functions are occurring in multiple areas. Once the similar processes or functions that cross areas are identified, Nebraska should evaluate each process or function to determine if it is feasible to streamline under a common area. The goal of this process would be to identify and reduce potential administrative inefficiencies and to improve consistency across programs.

### **Timing**

Aligning DHHS functions for maximum performance is a process that can begin right away. While the functional realignment will need to consider how MLTSS oversight will fit within the structure, it does not need to be dependent upon MLTSS implementation.

The following is a high-level overview of the stages and key activities:



**Potential Additional Costs/Savings and Resources**

Implementing this recommendation will involve relatively low cash expenditures. DHHS will need to dedicate staff resources to this process in order to achieve the desired outcomes. DHHS may need to hire a contractor to assist with the functional review of all DHHS areas in order to achieve the optimal organizational structure. DHHS could also review other state organizational structures and quality programs for implementation of best practices that are appropriate and relevant to Nebraska. These expenditures could be reduced if DHHS staff was used to perform some of the required activities.

**Risk(s) Associated with Implementation**

Organizational changes can always be challenging and impact staff morale. At the same time, changes can be exciting and motivating for staff to be able to have new work experiences. DHHS should approach the potential for organizational changes with transparency and inclusion of staff at all levels so that various perspectives are considered when determining the appropriate changes that need to be made.

As with the other recommendations, DHHS should communicate clearly and transparently about organizational changes. Stakeholders rely on the various agencies and departments in different ways, and they will need to remain informed as to how the organization will change and how those changes impact them.

# 7

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## Improving Assurance of Health and Safety for Extended Family Home (EFH) Residents

The Division of Developmental Disabilities (DDD) staff identified a concern that there is no State onsite certification and oversight process specifically targeted or related to EFHs. Without appropriate oversight of EFHs, there is the risk of not being able to identify potential issues with the delivery of care and being able to act upon the identified issue(s) to improve the care being provided to vulnerable consumers.

### Current Practice

EFHs are subcontracted through a DDD provider agency to provide residential habilitation services. It is the provider agency that is certified and not the actual EFH provider. A provider agency that serves four or more residents will be licensed as a Center for the Developmentally Disabled facility through an onsite review by Department of Health and Human Services (DHHS). EFHs serve three or fewer residents, and are required at a minimum to have a desk (paperwork) review under a provider agency certification process. While some EFHs will be reviewed onsite — as part of a sample review — there is no requirement for 100% onsite review. The EFHs subcontracted with the provider agency are not required to be audited onsite by the provider agency to verify compliance with the EFH requirements, although some provider agencies voluntarily undertake audits as part of their business processes. The lack of oversight requirements limits the ability of DDD to know if appropriate and quality services are being provided to consumers.

### Risks Associated with Continuing Current Practices

Continuing with the status quo limits DHHS' ability to understand the true quality of care being provided to consumers who reside in EFHs. Because EFHs can decide which provider agency they want to contract with, there is concern that some EFH providers may be switching their subcontract relationships from agencies with stricter oversight standards to provider agencies with less strict oversight standards. Switching to a provider agency that does not perform oversight audits is likely an attractive arrangement for poorer performing EFHs, but could also attract other EFHs that do not want the oversight by a provider agency. Without proper oversight, DHHS risks potential health and safety issues for consumers placed in EFHs.

### Recommended Change

The most effective option to address these concerns would be to require, in regulation, that all EFHs receive a regular onsite certification review. If this regulation change is not an option due to DHHS staffing and budget limitations, certification regulations could be revised so that all provider agencies perform regular audits (e.g., annually) of EFHs to determine compliance with EFH

requirements. These annual audits and results would be reviewed as part of the certification renewal review of DDD provider agencies.

### **Best Practices and Key Characteristics in Implementation**

Best practice is that all participating residential providers should have some level of onsite certification oversight related to the certification requirements. Without such requirements, DHHS's ability to know if appropriate and quality services are being provided to consumers residing in EFHs is limited. If the DDD provider agencies provided that oversight without the Division of Public Health certification surveyors conducting onsite reviews, there would be concerns that oversight would not be as objective as it would be if the Division of Public Health was performing a certification.

### **Timing**

DHHS should pursue regulatory changes immediately to allow for onsite reviews by DHHS surveyor staff or require the provider agencies to perform onsite reviews of all EFHs.

### **Potential Additional Costs/Savings**

Additional staffing may be required to perform the onsite certification. Changing the regulations to require DDD provider agencies to perform oversight of their subcontracted EFH providers would have minimal to no cost impact to DHHS. The current provider agencies that do not perform any onsite oversight of their subcontracted EFHs may have some cost increases, but those should be minimal. In addition, a provider agency should, at a minimum, be performing oversight of its subcontracted EFH to know if appropriate and quality services are being provided to consumers.

If DHHS determines that additional funding is necessary to implement this recommendation, DHHS should consider a variety of options for funding implementation of this recommendation:

- Exploring and applying for additional or enhanced federal match opportunities
- Reallocating State funds previously used in other areas where enhanced federal match has been obtained
- Evaluating existing expenditures to determine areas where streamlining and efficiencies can be gained and reallocate available expenditures to long term care redesign priorities
- Securing additional funding through a budgetary request, as needed

### **Necessary Resources for Implementation**

Very limited resources should be required to champion necessary changes to the regulations. Once those regulations have been developed, staff will need to develop relevant policies, disseminate information and educate stakeholders on the changes.

### **Risk(s) Associated with Implementation**

There is limited to no risk in implementing this change, and Mercer/NASUAD support DDD's intent to implement as soon as feasible.



# 8

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## Managed Long Term Services and Supports (MLTSS) Delivery System

### **General Approach and Objectives**

MLTSS is defined as the delivery of long term care services and supports (State Plan services including nursing facility care, waiver services or both) through capitated risk-based managed care organizations (MCOs). Currently, 22 states operate Medicaid MLTSS programs for all Medicaid consumers who need long term care (LTC) or only those dually eligible for both Medicaid and Medicare. They include Arizona, California, Delaware, Florida, Hawaii, Illinois, Iowa, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, Texas, Virginia and Wisconsin. In addition to Nebraska, six other states are considering or in the implementation states of an MLTSS program in the near future (Alabama, Arkansas, New Hampshire, Oklahoma, Pennsylvania and Virginia).

### ***Rationale for MLTSS delivery System***

The following are the key reasons noted by states for pursuing MLTSS. Most of these are highlighted in a new National Association for States United for Aging and Disabilities (NASUAD) publication, *Demonstrating the Value of Medicaid MLTSS Programs*.<sup>19</sup> This report provides objective evidence of MLTSS programs achieving the states' goals in implementing a managed care delivery system.

### ***Innovative Approaches to Delivering Medicaid Supports and Services***

When properly designed, MLTSS programs allow states the opportunity to implement unique design approaches not otherwise available to them under traditional Medicaid. For example, states have used MLTSS to serve populations often underserved by Medicaid programs, such as the working disabled, to develop multiple benefit packages tailored to the defined needs of a consumer and to maximize use of local providers and community supports. The flexibility afforded to states will vary depending on the federal authority selected and approved by the Centers for Medicare & Medicaid Services (CMS). However, regardless of the federal authority, states can incentivize MCOs to provide supports and services to consumers that the state may not have been able to offer, which both increases the quality of life for the consumer and provides much-needed support to caregivers.

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<sup>19</sup> National Association of States United for Aging and Disabilities and Center for Health Care Strategies. *Demonstrating the Value of Medicaid MLTSS Programs*. May 12, 2017.

<http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

### *Shift Focus of Care to Community Settings*

Throughout the stakeholder engagement meetings, stakeholders were very clear about the need for greater availability of and access to community services as the preferred alternative to institutional care. This preference is not unique to Nebraskans and resonates with many throughout the country. MCOs may be better positioned to facilitate this shift in care. Extensive provider networks can ensure the availability of specific community-based providers, such as habilitation and other day programs, as well as the availability of in-home and residential supports. Comprehensive care coordination/care management contract requirements can result in MCOs that are adequately staffed to: identify consumers in institutional settings who desire to and have the capability to transition to the community in a timely manner, ensure that sufficient community supports are available and in place prior to transition and monitor post transition to identify and resolve issues and ensure successful community integration. For example, Florida saw a 12% decrease in the number of Medicaid consumers receiving care in nursing facilities since its MLTSS program was implemented. Likewise, Tennessee saw a 34% increase in consumers living in the community in the seven years since TennCare CHOICES was implemented.<sup>20</sup>

Regardless of the successes in shifting the balance from institutional to community care, there will always be a need to have an adequate network of institutional providers (e.g., nursing facilities) throughout the state, including the rural areas so consumers can remain in their local communities. In order to minimize disruption during the initial years of implementation, MCOs can be required by the state to contract with the existing nursing facility providers and pay no less than the current state fee-for-service (FFS) rates.

### *Accountability Rests with a Single Entity*

The Heritage Health program has laid the foundation for integration of Medicaid services in Nebraska and vesting the accountability for this model of care with the MCO. As with any delivery system transition, there are issues and concerns that arise through implementation. Once those issues have been addressed and the Heritage Health program has stabilized, the next logical evolution is to enhance this integration by adding LTC to the MCO portfolio in a careful and systematic way, thereby creating a comprehensive system of care that is appropriately focused on treating the whole consumer, regardless of his or her service need or the cost of care. The MCO is financially at risk for the provision of all care. This provides leverage for the Department of Health and Human Services (DHHS), through contract requirements and vigorous monitoring and oversight, to incentivize MCO performance to achieve better health outcomes and quality of life for consumers.

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<sup>20</sup> National Association of States United for Aging and Disabilities and Center for Health Care Strategies. Demonstrating the Value of Medicaid MLTSS Programs. May 12, 2017.

<http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

Two states have shown significant improvement in the health of their MLTSS consumers as a result of holding their MCOs accountable for health outcomes. Minnesota's MLTSS consumers (compared to FFS) were 48% less likely to have a hospital stay; 13% more likely to receive Home and Community-Based Services (HCBS); and were 6% less likely to have an outpatient emergency department visit, and those who did had 38% fewer visits.

### *Administrative Simplification*

An additional benefit of vesting the accountability for the delivery of a comprehensive model of care (physical health, behavioral health, pharmacy and LTC) with the MCO is that it creates administrative simplification and enhances administrative efficiencies for the state, which can allow the state to use its finite resources most effectively. For example, Florida, Massachusetts, and Texas reported that implementing MLTSS decreased administrative burden in their Medicaid programs.<sup>21</sup> It can also redistribute administrative activities where interventions will realize the maximum impact. For example, comprehensive consumer support can be provided by the MCO, rather than consumers needing reach out to the State for issues related to some services and the MCO for issues related to other services.

### *Budget Predictability*

As noted previously, the cost of LTC continues to increase. As a result, states struggle with the ability to adequately predict the cost of care. Under an MLTSS system, capitation payments are made to MCOs, which allows states to more accurately project costs (enrollment does not vary as much with changes in a state's economic condition). Furthermore, capitation payments can also minimize unanticipated spending, as the MCOs are at financial risk, rather than the state.

CMS LTC expenditure data reports provided by Truven Health Analytics in April noted that the State of Nebraska ranked 27 (out of 48 states and the District of Columbia) in the percentage of Medicaid LTCS expenditures for HCBS.<sup>22</sup> In fiscal year (FY) 2015, Nebraska spent 51% of LTC dollars on HCBS, while the national average was 55%.<sup>23</sup> Implementing an MLTSS program offers the promise of promoting high-quality, community-based services while ensuring long-term program stability as consumers who are more appropriately served in the community remain in the community. Designing an MLTSS program must reflect the goal of serving more consumers in the community while also increasing the accountability for high-quality services.

### **Alternatives to MLTSS**

Multiple delivery system approaches were discussed and evaluated for the Nebraska LTC redesign. In addition to MLTSS, the following approaches were considered.

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<sup>21</sup> Ibid.

<sup>22</sup> Truven Health Analytics. Medicaid Expenditures for LTSS in FY 2015. April 14, 2017.  
<https://www.medicare.gov/medicaid/lts/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf>

<sup>23</sup> Ibid.

### *Maintain the Current System*

Stakeholders identified numerous challenges in the current system, such as fragmented systems of care, inadequate services and inconsistent assessment of needs that need to be addressed (refer to Appendix B for additional information). DHHS resources are limited and organizational capacity to undertake the necessary improvements is challenging. Moreover, a growing demand for LTC services will continue to drive more state spending. It is widely recognized — both from private payers as well as CMS — that lack of accountability for outcomes has led to more and more spending with uneven results.

### *Expand Medicare Accountable Care Organizations (ACOs) Model to Include LTC*

Currently, five regional ACOs operate as Medicare ACOs in the State. While they continue to be paid on a FFS basis, they are able to earn incentive funds if they can save the Medicare program money. They do not accept financial risk (i.e., lose money if delivering services cost more than they are paid). Such a system would not fundamentally change DHHS' relationship with providers. Moreover, the ACOs would not provide statewide coverage for Medicaid consumers. Because they are focused on serving Medicare consumers and delivering acute care services, they do not have any demonstrated expertise in delivering LTC to Medicaid consumers. Finally, there is currently no stand-alone ACO model in the country that is successfully delivering LTC to Medicaid consumers.

### *Provider-Led Networks*

In states where MCOs are not part of the delivery system or there is resistance to traditional MCOs (e.g. Alabama, Arkansas and North Carolina), state leadership has turned to provider-led community networks to manage Medicaid programs on a risk basis. Alabama's program is operational, while Arkansas and North Carolina are still in the development phase. These programs still operate like a MCO, but are constituted by provider entities. Many of them use commercial MCOs to handle 'back-office' operations. In any case, these experiments have focused on acute care benefits; no state has successfully integrated LTC into those systems. Much like the ACO model referenced above, the provider-led plans have experience in the acute care system, but little expertise in delivering LTC to Medicaid consumers. DHHS could contract with these networks — if there was interest and capacity within the State — on a risk basis, but would likely need to provide significant assistance to them in order to bring them up.

None of these alternative approaches are viable options for DHHS to fully respond to the issues identified by stakeholders and to build a comprehensive LTC delivery system that addresses the needs of the populations served, resulting in improved outcomes. In particular, the ACO and provider-led models are more suited to states without a significant existing managed care infrastructure. In Nebraska, once the Heritage Health program stabilizes and current issues are resolved, the MLTSS approach can build upon the existing infrastructure, thereby maximizing existing efficiencies and resources.

## ***Addressing Stakeholder Concerns about MLTSS***

Mercer/NASUAD recognize that many stakeholders expressed concerns about DHHS moving to MLTSS for several reasons, including concern about the loss of essential benefits and services. Details of specific concerns can be found in the Stakeholder Engagement Reports (summarized in Appendix B).<sup>24</sup>

On May 6, 2016, CMS published a Final Rule updating requirements for states operating Medicaid managed care programs.<sup>25</sup> The Medicaid managed care regulations were last updated in 2002, and, as a result, were outdated and not consistent with current best practices. The updated Medicaid managed care regulations, effective July 5, 2016, reinforce CMS key design principles for MLTSS programs, initially released as guidance on May 20, 2013.<sup>26</sup>

The Medicaid managed care Final Rule places particular focus on the consumer experience in MLTSS programs. Several provisions are established to:

- Increase the quality of the care provided
- Increase state oversight
- Add more protections to ensure consumers' well-being is foremost
- Add requirements for provider network adequacy including, LTC providers (e.g., nursing facilities and HCBS)
- Increase the assistance provided to and information made available to consumers at all phases of the process to ensure that consumers are able to make informed decisions

Consequently, the Medicaid managed care requirements will hold DHHS and MCOs accountable to address many of the issues identified by stakeholders. To ensure these requirements are addressed, Mercer/NASUAD have identified key requirements for the program design.

## **MLTSS Implementation**

Designing and implementing an effective and responsive MLTSS system will take careful planning by DHHS and active involvement of the stakeholder community. To that end, this section of the

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<sup>24</sup> Nebraska Department of Health and Human Services. Nebraska Long Term Care Redesign Stakeholder Report. November 1, 2016.

<http://dhhs.ne.gov/medicaid/Documents/Stakeholder%20Engagement%20Report%20Phase%20I%20%20FINAL%20to%20MLTC%2020161115.pdf>

<sup>25</sup> The Federal Register. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Rule issued May 6, 2016. <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>

<sup>26</sup> The Centers for Medicare & Medicaid Services. Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs. Issued May 20, 2013. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf>

Final LTC Redesign Plan is focused on the key elements of program design that DHHS will need to work through with the involvement of its stakeholder community. Mercer/NASUAD have offered a high-level recommended approach for structuring MLTSS in Nebraska, but many program design decisions will need to be made to ensure the final program design addresses the goals of DHHS and the stakeholders. During the second round of stakeholder feedback, many stakeholders expressed anxiety about the recommendation to transition to MLTSS because the Draft LTC Redesign Plan does not address many of the detailed design decisions. At this stage of the planning process, these detailed design decisions are not yet made and will require input from the stakeholder community to ensure the decisions result in an effective LTC system in Nebraska.

Moreover, there was significant disagreement expressed during the stakeholder feedback sessions about the wisdom of DHHS building on the infrastructure of Heritage Health, given the concerns about that implementation from consumers, caregivers and some providers. The MLTSS implementation plan must provide sufficient time for the Heritage Health program to reach 'steady state' and be operating with a minimum of consumer and provider complaints before LTSS benefits are added into the program.

### ***Build on Existing Infrastructure***

On January 1, 2017, Nebraska rolled out Heritage Health, a new integrated Medicaid managed care program. Prior to the implementation of Heritage Health, Nebraskans with Medicaid received physical health, behavioral health and pharmacy services through three separate delivery systems. The implementation of Heritage Health offers consumers with Medicaid an integrated approach to care that provides comprehensive physical health, behavioral health and pharmacy benefits in a single delivery system.<sup>27</sup> Given DHHS' commitment to continue an integrated and coordinated approach, and to simplify program administration, Mercer/NASUAD recommend that DHHS build off the existing Heritage Health infrastructure to implement MLTSS.

During the second round of stakeholder feedback, which occurred after the initial implementation of Heritage Health, many stakeholders expressed concern with the idea of rolling out MLTSS under Heritage Health given some of the challenges consumers — and, in particular, consumers who currently receive services through the LTC system — have experienced initially with the Heritage Health program. As noted above, building upon the infrastructure of Heritage Health will require that the Heritage Health program is running smoothly and with few significant problems. Stakeholders must work with DHHS to identify these problems and address them, timely and appropriately, prior to the roll out of MLTSS. DHHS will also need to hold the MCOs accountable for not only addressing current issues, but ensuring that they are providing services and supports that meet the specific needs of older consumers and consumers with disabilities. It will also be

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<sup>27</sup> Nebraska Department of Health and Human Services. Common Questions and Answers for Members. December 29, 2016.  
<http://dhhs.ne.gov/medicaid/Documents/Common%20Questions%20and%20Answers%20for%20Members%2012.29.16.pdf>

important to allow sufficient time to monitor the success of the fixes to the Heritage Health implementation prior to MLTSS implementation.

### *Leverage Existing Heritage Health MCOs*

Mercer/NASUAD recommend DHHS expand the scope of the existing MCO responsibilities to include coverage of LTC for consumers who are currently served through DHHS' existing HCBS programs. These programs include:

- Aged and Disabled waiver
- Traumatic Brain Injury waiver
- Children's Developmental Disabilities waiver (consolidated with the Developmental Disabilities Adult Comprehensive waiver, effective May 1, 2017)
- Adult Day HCBS waiver
- DD Adult Comprehensive waiver (consolidated with the Children's DD waiver, effective May 1, 2017)

Existing Heritage Health MCOs are already administering the physical health, behavioral health and pharmacy benefits for the consumers served in Nebraska's current HCBS programs. As the Heritage Health program continues to improve and evolve, the MCOs will grow in their knowledge of these consumers, as they are responsible for helping to provide connections as needed to social supports and services. It is critical that DHHS create expectations for the MCOs to regularly engage with LTC stakeholders, both consumers and providers, well in advance of MLTSS implementation. As stakeholders noted, the lack of familiarity with the current LTC landscape has created barriers to care under Heritage Health. It is imperative that those knowledge gaps and barriers are fully addressed prior to MLTSS implementation.

DHHS will need to ensure the MCOs bolster their existing staff with their LTC experts well in advance of adding LTC benefits to the MCO contract to improve current services under Heritage Health and to ensure a smooth transition to MLTSS. In addition, during the transition of LTC services and supports transition to the MCOs, existing MCOs can facilitate smooth transitions of care as they have a relationship with their consumer members and are familiar with their needs and current services, thereby facilitating continuity of care. Mercer/NASUAD also recommend that MCOs be responsible for the full array of LTC benefits, including nursing facilities, assisted living homes and HCBS to avoid any financial disincentives to limit participation in community-based services. Some states have delayed the inclusion of nursing facility consumers in their initial rollout of MLTSS. However, initially excluding these consumers could significantly limit MCOs' ability to achieve the State's rebalancing goal and negatively impact the ability to facilitate transitions of care to more appropriate community settings.

Nebraska's Program of All-Inclusive Care for the Elderly, which is only available in the Omaha area, will remain an alternative integrated care model for consumers over 55 who need LTC services.

### *Leverage Existing Federal Authority*

Amending DHHS' existing 1915(b) and 1915(c) waivers will be the simplest way administratively to gain federal authority for MLTSS. Clearly, modifications will need to be made to the waivers to reflect the MLTSS program design, such as the array of available services and the services coordination process. However, amending these waivers is a fairly administratively straightforward process with clearly defined timeframes and applications dictating the process.

In contrast, while there is additional flexibility allowed through the development of an 1115 demonstration, the time and additional administrative burden of pursuing one would not outweigh the benefit. There is no prescribed timeframe for CMS review and approval of an 1115 demonstration and no standard application — factors that often contribute to very lengthy and resource intensive negotiation and approval process. Furthermore, in recent years CMS has often strongly advised states to consider other federal authorities, when the state's program design can be accommodated with those authorities. Although a new administration may change position on 1115 demonstrations, it is clear that amending existing approved documents is a more prudent approach to pursue.

### *Roll Out MLTSS Statewide in Phases by Population*

While some stakeholders urged DHHS to start MLTSS in regional pilots, this is not a national best practice. Virtually all states that have moved to a MLTSS delivery system in the past five years started with a statewide mandatory program. In this case, because Heritage Health is currently a statewide mandatory program, it makes the most sense to add the additional LTC benefits to those contracts that currently cover the entire state and require all consumers to receive their services through an MCO.

It is common practice, however, to stagger implementation by population, so that provider and consumer impacts are mitigated. Mercer/NASUAD therefore recommend that DHHS enroll older consumers and consumers with physical disabilities (phase 1 populations) into the MLTSS program first, followed by consumers with an intellectual and/or developmental disabilities (I/DD) (phase 2 populations) sometime later. Based on stakeholder feedback and concerns over current issues in the Heritage Health program, it is recommended that a mandatory MLTSS program begin on January 1, 2020 for phase 1 populations and January 1, 2021 for phase 2 populations.

A 30-month planning and implementation period is consistent with best practices and federal guidance and will allow for the implementation of other high-priority recommendations in advance of MLTSS. CMS, in its 2013 guidance on elements for MLTSS programs, recommended no less than one year from design to implementation and encourages states to move forward with a very strategic and thoughtful process. The 30-month period, longer than Mercer/NASAUD's initial recommendation of 18 months, will provide the State the time needed to make the structural changes to the current LTC programs and Heritage Health prior to moving forward; thereby ensuring that the foundation upon which MLTSS is built is strong and sound. Moreover, using the existing Heritage Health MCOs will reduce the scope of general MCO readiness testing and



evaluations DHHS must conduct, since all the managed care fundamentals will have been in place and well established for three years.

DHHS should be guided by the experiences of other states that approached MLTSS in a deliberate manner as well as the requirements in the Medicaid managed care rule and critical elements of the 2013 guidance. Continuing to solicit and integrate input from the stakeholder community and offering transparent and timely communication will also contribute to a successful implementation.

### ***Best Practices in Program Design and Implementation***

To design, implement and maintain a strong MLTSS program, Mercer/NASUAD recommend DHHS undertake the following key steps:

- Establish program goals
- Develop a comprehensive program design
- Develop a detailed implementation plan
- Execute the implementation plan
- Monitor implementation

Throughout the design and implementation processes — from initial program goal development to post-implementation monitoring — it will be critical for DHHS to engage the stakeholder community to offer opportunities for feedback, as well as to provide status updates on progress. Stakeholder communication should include regularly scheduled meetings with the LTC Advisory Council for their ongoing input and also continued communications with the stakeholder community on areas of concern with the Heritage Health program. A mechanism needs to be established to support a continuous feedback loop to improve the program and identify lessons learned to enhance the implementation of MLTSS.

### ***Establish Program Goals***

The first step in the process is to establish the vision and goals for the program. It will be difficult to measure the program's success without first defining what the program aims to achieve and desired outcomes. The goals will not only allow DHHS and other stakeholders to determine whether the program has been successful or whether there are improvements to be made, but the goals should be woven into all aspects of the program design and implementation. As the goals are established, it will be important for DHHS to consider how the goals will be measured. For example, how will a successful program be defined? What outcomes will be realized? How will a successful implementation process be defined? These questions should be answered with the knowledge of the performance of the current LTC programs as a benchmark. Nebraska has already taken the first step in measuring current program quality by participating in the National Core Indicators initiative, which will help the State assess its performance on quality measures specific to services delivered to older consumers and consumers with disabilities. As these questions are answered, they will become a framework for the design and implementation

processes and will serve as a solid foundation for the development of a comprehensive quality management strategy.

### *Develop a Comprehensive Program Design*

Once the goals have been established, DHHS, in partnership with the stakeholder community, must undertake a rigorous program design process. To begin the program design process, Mercer/NASUAD recommend DHHS look to CMS' essential elements for establishing successful MLTSS programs, many of which have been solidified as requirements under the Medicaid managed care final rule.

- Adequate planning and transition strategies
- Stakeholder engagement
- Enhance provision of HCBS
- Alignment of payment structures with MLTSS programmatic goals
- Support for consumers
- Person-centered processes
- Comprehensive and integrated service package
- Qualified providers
- Patient protections
- Quality

These essential elements provide a solid framework for developing a comprehensive program design. As many of these elements are embedded within the Medicaid Managed Care Final Rule, establishing them as the framework will facilitate a program design that is compliant with the rule. Other critical implementation issues, apart from the managed care rule requirements, that will need to be considered are the impact on the current services coordinators and the potential disruption of long standing relationships with consumers. Ultimately, the design decisions, the process and implications must be transparent to stakeholders and inclusive of stakeholder input.

### *Develop a Detailed Implementation Plan*

Using the program design as the guide, DHHS will need to undertake an intensive planning and implementation process. The first step will be to develop a comprehensive implementation plan that outlines the detailed steps required to translate the program design into a functioning program. As with the development of the program goals and design, the implementation plan development should include active and frequent engagement with the stakeholder community to ensure their feedback is considered and that stakeholders have a clear understanding of how the implementation is anticipated to roll out, the design decisions that have been made and the implications of decisions on the stakeholder community. The implementation plan should be published and publicly available to the stakeholder community.

The following outlines the key topics that should be addressed in the comprehensive implementation plan:

- Stakeholder engagement, including a detailed communication plan
- Authority
- Infrastructure changes
- Contracting and procurement
- Readiness
- Communications and education
- Network adequacy
- Quality management strategy

With the development of the comprehensive implementation plan, DHHS will need to establish systems of internal accountability to ensure that the necessary steps are completed appropriately and within the anticipated timelines. Executing the implementation plan will require rigorous oversight and monitoring by a steering committee. Mercer/NASUAD recommend the implementation plan also clearly outline the systems of responsibility and process for reporting, monitoring and escalation of issues. Mercer/NASUAD also recommend regular reporting to the stakeholder community on the status of the activities in the implementation plan.

### *Execute Implementation Plan*

As discussed above, DHHS will need to commit significant staff and technology resources to engage in a deliberate and thoughtful planning and implementation process. Mercer/NASUAD recommend developing a steering committee to lead the planning and implementation processes. The committee will have overall responsibility for program implementation and will report to DHHS leadership on progress and challenges. The committee will need the ability and authority to act quickly to ensure an effective implementation. Members of the steering committee will also need to have the available capacity to devote to the planning and implementation. Therefore, tasks and functions may need to be shifted in the short term to other staff. Finally, the steering committee will need to have timely access to leadership to vet any issues warranting their attention. As part of the execution, the steering committee should plan for regular reporting to the stakeholder community.

### *Monitor Implementation*

Once DHHS has reached the “go-live” dates, it will be critical to engage in a process of continual monitoring, issue identification and remediation. As with any process implementation, valuable lessons will be learned from program successes and challenges. DHHS will need to use those lessons to make needed changes or apply successful approaches to other areas of the program. DHHS will need to develop a plan for monitoring implementation to flag significant issues, such as consumers being inappropriately denied services, providers not being able to participate, services not being delivered, access to services being limited or claims not being paid. As with the rest of the implementation process, it will be essential for DHHS to monitor and report regularly to stakeholders on the status of implementation and ongoing operations. The quality management

strategy will provide opportunities to identify program strengths and challenges, and DHHS will need to engage in a process of continual program and process improvement based on these results.

**Timing**

As noted earlier, Mercer/NASUAD recommend the roll out of MLTSS to take place on two different schedules with implementation for older consumers and consumers with physical disabilities on January 1, 2020 and on January 1, 2021 for consumers with I/DD. The following provides a high-level overview of the timing of the major planning and implementation steps for each phase.

**MLTSS Planning and Implementation — Older Consumers and Consumers with Disabilities**



**MLTSS Planning and Implementation — Consumers with Intellectual and/or Developmental Disabilities**



**Risk(s) Associated with Implementation**

As with any system change of this size and scope, there are always risks. DHHS should take special care to ensure that the implementation process does not inadvertently undermine the goals of the program. For example, DHHS will need to carefully plan for the transition of services coordination activities to ensure that care transitions are effective and that all stakeholders are well-informed of changing roles and responsibilities. DHHS will need to continually monitor progress against the implementation plan. Opportunities for stakeholder feedback throughout the process will be important in identifying issues and addressing concerns. DHHS will also need to implement a comprehensive process for timely identification and resolution of issues throughout the implementation process. Mercer/NASUAD strongly recommend DHHS develop risk mitigation strategies in the development of the implementation plan. DHHS should draw upon its experiences, both strengths and challenges, in the Heritage Health implementation to ensure a smooth transition to MLTSS.

**Potential Additional Costs/Savings**

Most states do not undertake MLTSS programs with the goal of saving money in the short term. More typically, states are looking for long-term sustainability as the need for LTC continues to increase. States look to achieve a greater level of community-based service delivery and

increased program quality and accountability. Arizona, with a very mature program, has seen significant shifts from institutional care to community care. In 1989, only about 5% of LTC was delivered in the community in Arizona, with the remaining 95% delivered in nursing facilities.<sup>28</sup> By FY 2015, Arizona reported 70% of LTC expenditures for HCBS.<sup>29</sup> NASUAD's report, *Demonstrating the Value of Medicaid MLTSS Programs*, highlighted cost savings experienced by Florida in moving to an MLTSS program. Florida officials estimate that continuing its nursing facility spending rate could have cost the state an additional \$284 million in 2014–2015, \$432 million in 2015–2016 and \$200 million per year each year thereafter.<sup>30</sup>

In the short term, it is likely that the implementation of MLTSS will result in an overall increase in expenditures, as an investment in long-term sustainability. There will be initial additional costs associated with implementing MLTSS, such as technology updates, additional vendor contracts and internal system changes. These implementation costs will occur prior to any shifts away from institutional services, which is where any cost efficiencies can be gained. In addition, costs on a cash basis will see a spike as the FFS program is winding down and MLTSS is coming up, as FFS claims will continue to be paid in arrears, while capitation payments will be paid simultaneously on a prospective basis. Certain program design decisions can also impact the ability for any cost savings in addition to increasing HCBS. For example, if DHHS chooses to institute minimum payments that are greater than or equal to FFS levels, there will be no savings (or potentially an additional cost) on a cost-per-service basis; however, DHHS will need to carefully weigh the benefits and challenges of various payment approaches with regards to stability of the provider community.

There will be many factors that will influence how quickly and to what extent DHHS will realize cost efficiencies through the shift of service delivery from institutional to community-based settings. The structure of the capitation payments must be such that it provides strong incentives to improve the mix of services delivered in the community and the shift from institutional care to community services. If the payment incentives are not strong enough, the movement and diversion from institutions to HCBS will not occur as rapidly or as frequently, which will undermine the delivery of more cost-effective services in the community settings and will result in consumers continuing to be served in institutions when they may have the opportunity to remain in their communities. Stakeholders have already identified the availability of community-based housing options as a barrier to receiving HCBS. This, and any capacity constraints on community-based service providers, will also impact the ability of MCOs to transition consumers into the community.

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<sup>28</sup> Betlach, Thomas. Arizona Long Term Care System (ALTCS) Overview. Presented at the 2012 NAMD Fall Conference. [http://medicaiddirectors.org/wp-content/uploads/2015/08/trends\\_in\\_medicaid\\_long\\_term\\_services\\_and\\_supports.pdf](http://medicaiddirectors.org/wp-content/uploads/2015/08/trends_in_medicaid_long_term_services_and_supports.pdf)

<sup>29</sup> Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. April 14, 2017.

<sup>30</sup> National Association of States United for Aging and Disabilities and Center for Health Care Strategies. *Demonstrating the Value of Medicaid MLTSS Programs*. May 12, 2017.

DHHS will need to work diligently with its MCO partners and seize upon the flexibility afforded under an MLTSS program to overcome these types of barriers.

DHHS' design and implementation of the program will also have a significant impact on how quickly a shift to community-based settings can occur. For example, DHHS must ensure there are waiver slots available for consumers to transition into community-based settings. DHHS' ability to monitor and enforce MCO requirements around nursing facility diversion and other activities to promote community placements will impact the degree to which the shift towards serving consumers in the community will occur. DHHS may also limit the ability of the MCOs to change any consumers' care plans for a period of time after the transition to managed care. This requirement will also limit the ability of an MCO to make cost-effective changes to a consumer's care plan and will reduce any savings opportunities after managed care implementation; however, DHHS will need to carefully weigh the potential benefits and challenges with such an approach as it develops its care transition strategies.

While it is difficult to predict savings from MLTSS, there are financial advantages that can be realized even in the short term. The per-capita spending under capitation is more predictable and offers DHHS some budget stability. In addition to shifting services towards community-based settings, MLTSS can provide opportunities to ensure limited LTC resources are used most effectively. MCOs are often in a position to assist a state in identifying areas where resources are not efficiently deployed. For example, they can implement standardized assessment processes, which results in more appropriate assessment of needs and care plans more appropriately addressing those needs. MCOs can also capitalize on the flexibility they are afforded to provide innovative services and supports that are also cost effective.

For the initial upfront cash flow concerns, DHHS should consider a variety of options for funding implementation of this recommendation:

- Exploring and applying for additional or enhanced federal match opportunities
- Reallocating State funds previously used in other areas where enhanced federal match has been obtained
- Evaluating existing expenditures to determine areas where streamlining and efficiencies can be gained and reallocate available expenditures to LTC redesign priorities
- Securing additional funding through a budgetary request, as needed

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## Other Recommended System Changes

Not all of the preliminary recommendations for long term care (LTC) redesign are addressed as high-priority systemic changes or through the implementation of managed long term services and supports (MLTSS). The remaining five preliminary recommendations from the 25 total recommendations (Appendix C) should not be lost. The Department of Health and Human Services (DHHS) can, and should, address these recommendations and prioritize them while working through its internal realignment for MLTSS implementation, resources and time permitted. Greater attention can then be devoted to these additional recommendations once MLTSS is implemented and the other high-priority system changes are realized:

- *Recommendation #7 — Implement a systematic way to reassess consumers:* Once the role of different organizations is established regarding the level of care assessment process, DHHS can also work on developing a more robust system for reassessments that includes the same standards for reassessment regardless of LTC program and triggers to ensure timely reassessments. Part of this process should include education and communication on the purpose and need for reassessments and dispelling concerns that reassessments will reduce the current services provided.
- *Recommendation #12 — Increase awareness of the Medical Insurance for Working Disabled (MIWD) program:* DHHS should consider additional ways to ensure consumers, choice counselors and DHHS staff are made aware of the MIWD program. The State may need to consider changes in state statutes or regulations to broaden eligibility for this cost-effective alternative. Over time, DHHS should consider how to build incentives into the managed care organization (MCO) contract to increase awareness of the MIWD program. Increased awareness should not be limited to the MIWD program, but should also be focused on other employment programs available, specifically for consumers with disabilities. The State should also consider other ways in which it can provide incentive to increase employment opportunities throughout the LTC system.
- *Recommendation #14 — Improve coordination and services for children with Developmental Disabilities aging out of the educational system:* DHHS has made efforts to improve transitional support to child consumers aging out of the school system, but continued monitoring of these activities and outcomes for young adult consumers is needed. DHHS should consider partnering with additional agencies to improve the process and also with the “no wrong door” partners as another key resource that should be aware of the options available. This effort will be especially important to support parents and other caregivers as they navigate the changing landscape between the child and adult systems.
- *Recommendation #16 — Address issues in the provider enrollment process:* Mercer/NASUAD recommend DHHS conduct a comprehensive review and evaluation of the provider enrollment process and consider including performance incentives in future contracting related to provider

enrollment. Additionally, monitoring of performance should be done on an ongoing basis. DHHS should also consider the potential role of the Fiscal Management Services Agency in the provider enrollment process.

- *Recommendation #21 — Establish a process to rebase Home and Community-Based Services rates more frequently:* Regardless of the delivery system, a fee-for-service (FFS) fee schedule will need to be maintained for any services delivered in the FFS system. The Centers for Medicare & Medicaid Services (CMS) expect that fee schedules are rebased at least every five years and that there is a methodology and documentation to support the fee schedule. This CMS expectation, as well as a documented methodology could help support future budget requests for these services. The FFS fee schedule often provides a benchmark for MCOs in establishing provider fees in the contracting process. Ensuring that the fee schedule is adequately maintained can help provide a level benchmark for providers. As the State budget allows, this should be a priority for DHHS and its ongoing efforts in LTC redesign.



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## Next Steps

The Department of Health and Human Services (DHHS) will review and prioritize the recommendations presented in this report and align its resources to move forward with the most critical activities. Upon determining the highest priority recommendations and resources available, DHHS will outline plans for continued stakeholder engagement and begin work on developing detailed implementation plans. DHHS will continue to seek out the input of consumers, caregivers, advocates and providers to ensure the six guiding principles for long term care (LTC) redesign are realized and the implementation of the redesign recommendations strengthens the delivery of LTC in Nebraska.

Throughout the implementation phase, DHHS will continue to provide opportunities for stakeholder discussions and will provide updates on the LTC Redesign Project page (<http://dhhs.ne.gov/medicaid/Pages/LTCResources.aspx>). Please subscribe to this page to receive notice of newly published information. To subscribe for updates click on the “Get Projects Updates” icon on the top of the project page and complete the requested information.

# APPENDIX A

## Acronym Dictionary

Acronym	Definition
AAA	Area Agency on Aging
ACL	Administration for Community Living
ACO	Accountable Care Organization
AD	Aged and Disabled
ADRC	Aging and Disability Resource Center
BIP	Balancing Incentives Program
CCS	Community Coordinator Specialist
CIL	Center for Independent Living
CMS	Centers for Medicare & Medicaid Services
DDD	Division of Developmental Disabilities
DHHS	Department of Health and Human Services
EFH	Extended Family Home
EVV	Electronic Visit Verification
FFS	Fee-for-Service
FMSA	Fiscal Management Services Agency
FY	Fiscal Year
HCBS	Home and Community-Based Services
ICAP	Inventory for Client and Agency Planning
ICF-DD	Intermediate Care Facilities-Developmentally Disabled
I/DD	Intellectual/Developmental Disability
I&R	Information and Referral
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MLTC	Division of Medicaid & Long Term Care
MIWD	Medical Insurance for Working Disabled
MLTSS	Managed Long Term Services and Supports
NASUAD	National Association of States United for Aging and Disabilities
NCI	National Core Indicators

<b>Acronym</b>	<b>Definition</b>
NFOCUS	Nebraska Family On-Line Client User System
NWD	No Wrong Door
PACE	Program of All-Inclusive Care for the Elderly
PAS	Personal Assistance Service
QAPI	Quality Assurance and Performance Improvement
SC	Services Coordinator
SIB-R	Scales for Independent Behavior-Revised
TBI	Traumatic Brain Injury

## APPENDIX B

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### Stakeholder Engagement Reports

Stakeholder engagement is an essential component of any successful system redesign. As such, the Department of Health and Human Services (DHHS) is committed to implementing a comprehensive stakeholder engagement process. Stakeholders are broadly defined to include, but not limited to: consumers, caregivers, family members, advocates, providers and provider associations.

As part of the development of this Final Long Term Care (LTC) Redesign Plan, DHHS engaged Mercer Government Human Services Consulting (Mercer) and the National Association for States United for Aging and Disabilities (NASUAD) to conduct two rounds of direct stakeholder feedback. Statewide stakeholder meetings occurred throughout September 2016, prior to the development of the initial redesign recommendations. Meetings varied in terms of time of day, locations and format in order to allow for maximum participation in the process. Stakeholder meetings were facilitated by NASUAD using a structured set of questions to ensure for a consistent approach for each meeting. The questions were specifically developed to elicit stakeholder feedback on issues of concern and areas for improvement.

Multiple concurrent meetings were conducted with DHHS staff. The purpose of these meetings was to obtain their perspective on operational challenges regarding administering and monitoring the current LTC system.

The feedback received from the stakeholder engagement process was synthesized and released in the Stakeholder Engagement Report (December 2016). In January 2017, Mercer/NASUAD provided DHHS with a Preliminary Recommendations Report containing 25 recommendations developed in response to information received from the stakeholder engagement process. The recommendations were intended to serve as a starting point for DHHS deliberation regarding the most appropriate path to pursue to meet program goals and objectives for Nebraska LTC redesign.

Based on these initial 25 recommendations, as well as additional research and analysis, Mercer/NASUAD developed the Draft LTC Redesign Plan. The Draft LTC Redesign Plan prioritized the initial recommendations and offered approaches for resolving the key issues in the current LTC system. The Draft LTC Redesign Plan was available for public review beginning in March 2017 on the Nebraska DHHS Long Term Care Redesign Project website.<sup>31</sup> A multi-pronged approach to stakeholder engagement was used to obtain feedback on the document that included: LTC Advisory Council meetings, key informant interviews, onsite listening sessions across the State, webinars, video conferences, emails, phone calls and the use of social media.

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<sup>31</sup> <http://dhhs.ne.gov/medicaid/Pages/LTCResources.aspx>

The consultants who conducted the first round of stakeholder engagement in 2016 conducted the subsequent sessions through March and April 2017.

Stakeholders were asked to comment on the three major focus areas of the Draft LTC Redesign Plan: 1) Address high-priority systemic issues in the current LTC system; 2) Transition to a managed long term services and supports (MLTSS) delivery system; and 3) Continue to pursue other recommended system changes. Seven general themes emerged from the second round of stakeholder feedback:

1. **Cost:** There are significant cost implications for some of the recommendations and uncertainty about the resources DHHS would be given to implement them.
2. **Timeframes:** The proposed dates for MLTSS implementation are too aggressive and do not sync with the time it will take to implement the other systemic initiatives.
3. **Concern with Heritage Health Managed Care Organizations:** There is anxiety about the move to managed care for LTC consumers due to difficulties in the early months of implementation, which began in January 2017.
4. **Quality:** The State needs to measure the quality of the current LTC system so that it can ensure that any proposed changes improve outcomes.
5. **Communication with LTC Stakeholders:** The State needs to continue robust communications with stakeholders.
6. **Outstanding Design Decisions:** The “open questions” regarding specific redesign decisions are causing anxiety.
7. **Caregivers:** Unpaid caregivers are the backbone of the LTC system and without their continued support the system would fail. The State needs to find additional ways to support caregivers.

Detailed results of the second round of stakeholder feedback are provided in the Nebraska Long Term Care Redesign Stakeholder Report – Phase II, published on June 12, 2017 on the DHHS Long Term Care Redesign Project website.<sup>32</sup>

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<sup>32</sup> [http://dhhs.ne.gov/medicaid/Pages/medicaid\\_LTC.aspx](http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx)

# APPENDIX C

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## Preliminary Long Term Care (LTC) Redesign Recommendations

To fully inform the Nebraska LTC redesign, the Department of Health and Human Services (DHHS) contracted with Mercer Government Human Services Consulting and the National Association for States United for Aging and Disabilities (NASUAD) to collaborate in providing an honest evaluation of the current landscape and to engage consumers, providers, DHHS staff and other stakeholders in the redesign process. The redesign project includes an extensive stakeholder engagement process, an objective assessment of the current LTC system, a report of preliminary recommendations and a final program LTC Redesign Plan.

The preliminary recommendations provided to DHHS for improving the current LTC delivery system take into consideration themes from the first stakeholder engagement process and staff interviews that occurred over the last several months. Mercer/NASUAD's preliminary recommendations for improving Nebraska's current LTC delivery system are listed below and are aligned with these themes:

### **Entry Into and Navigation in the System**

1. Increase assistance available for elderly and disabled consumers to access and navigate LTC and other programs.

### **Siloed Program Administration**

2. Consolidate existing Home and Community-Based Services (HCBS) waivers:
  - A. Consolidate HCBS waiver administration
  - B. Consolidate HCBS waiver services and populations
3. Realign Nebraska DHHS organizational structure to fully effectuate LTC redesign.
4. Continue the reimagining of DHHS' information system infrastructure.

### **Assessment of LTC Needs**

5. Implement a single standardized assessment instrument to be used for all LTC programs.
6. Eliminate the conflict of interest between entities performing eligibility assessments and providing care coordination.
7. Implement a systematic way to reassess consumers.

### **Case Management and Care Coordination**

8. Ensure ongoing integration of person-centered planning principles in all Nebraska LTC programs.
9. Complete a comprehensive redesign of the care management/services coordination functions to align with the LTC redesign.

**Service Array and Authority**

10. Expand and strengthen consumer-directed programs.
11. Re-engineer the Personal Assistance Service program.
12. Increase awareness of the Medical Insurance for Working Disabled (MIWD) program.
13. Implement prior authorization procedures so the most appropriate and cost-effective HCBS are provided.
14. Improve coordination and services for children aging out of the educational system.
15. Address gaps in behavioral health services to meet the needs of the LTC population.

**Provider Management and Reimbursement**

16. Address issues in the provider enrollment process.
17. Eliminate negotiated rates with providers.
18. Implement fiscal management services for independent providers.
19. Require electronic visit verification for in-home services.
20. Expand the availability of alternative residential living settings.
21. Establish a process to rebase HCBS rates more frequently.
22. Address transportation service issues.

**Measuring and Promoting Quality**

23. Expand and align the scope of the quality program to align with the LTC redesign.
24. Enhance oversight and licensure of Extended Family Homes.

**Delivery System**

25. Implement a well-planned, organized, staggered and phased-in approach to managed long term services and supports that considers populations, services and/or geographic area.

# APPENDIX D

## Current Nebraska LTC Assessment Instruments

Instrument	Populations	Medicaid-funded Community LTC Programs	Purposes: 1 = Level of Care (LOC) Determination 2 = ID of Support Needs 3 = Inform Support Planning
Scales for Independent Behavior Revised (SIB-R)	<ul style="list-style-type: none"> <li>Developmental Disabilities (DD) (Adults, Children) to determine adaptive need</li> </ul>	<ul style="list-style-type: none"> <li>Adult Day Waiver</li> <li>Comprehensive Adult Waiver</li> <li>Children's Waiver</li> </ul>	1 (statutory eligibility), 2
Inventory for Client and Agency Planning (ICAP)	<ul style="list-style-type: none"> <li>DD (Adults, Children) who have some adaptive need</li> </ul>	<ul style="list-style-type: none"> <li>Adult Day Waiver</li> <li>Comprehensive Adult Waiver</li> <li>Children's Waiver</li> </ul>	2 individual budget, 3 level of need
Developmental Index Intermediate Care Facilities-Developmentally Disabled (ICF-DD) LOC Assessment for Determination of DD Waiver Eligibility	<ul style="list-style-type: none"> <li>DD (Adults, Children)</li> </ul>	<ul style="list-style-type: none"> <li>Adult Day Waiver</li> <li>Comprehensive Adult Waiver</li> <li>Children's Waiver</li> </ul>	1 (waiver eligibility)
Risk Screens: <ul style="list-style-type: none"> <li>Health Risk Screen</li> <li>Physical Nutrition Management Screen</li> <li>Enteral Feeding Screen</li> <li>Spine and Gait</li> <li>Behavior risk screen</li> </ul>	<ul style="list-style-type: none"> <li>DD (Adults, Children)</li> </ul>	<ul style="list-style-type: none"> <li>Adult Day Waiver</li> <li>Comprehensive Adult Waiver</li> <li>Children's Waiver</li> </ul>	1, 2
Time Assessment and Service Plan is referred to as "Service Needs Assessment"	<ul style="list-style-type: none"> <li>Aged, Physical Disabilities (Adults)</li> </ul>	<ul style="list-style-type: none"> <li>State Plan Personal Assistance Services</li> </ul>	1, 2, 3



Instrument	Populations	Medicaid-funded Community LTC Programs	Purposes: 1 = Level of Care (LOC) Determination 2 = ID of Support Needs 3 = Inform Support Planning
Functional Criteria Home and Community-Based Services Waiver for Aged Persons and Adults and Children with Disabilities	<ul style="list-style-type: none"> <li>• Aged, Physical Disabilities (Adults)</li> <li>• Traumatic Brain Injury (TBI) (Adults)</li> </ul>	<ul style="list-style-type: none"> <li>• Aged and Disabled (AD) Waiver</li> <li>• Program of All-Inclusive Care for the Elderly (PACE)</li> <li>• TBI Waiver</li> </ul>	1,2,3 for AD and TBI Waivers, 1 for PACE
Aged and Disabled Medicaid Waiver Adult Assessment	<ul style="list-style-type: none"> <li>• Aged, Physical Disabilities (Adults)</li> <li>• TBI (Adults)</li> </ul>	<ul style="list-style-type: none"> <li>• AD Waiver</li> <li>• TBI Waiver</li> </ul>	2, 3
Child's LOC or Nursing Facility LOC	<ul style="list-style-type: none"> <li>• Physical Disabilities 3–17 or receiving specific medical treatments (Children 0–17)</li> </ul>	<ul style="list-style-type: none"> <li>• AD Waiver</li> </ul>	1, 2, 3
Child's Functional Assessment and Family Support Survey	<ul style="list-style-type: none"> <li>• Physical Disabilities or receiving specific medical treatments (Children 3–17)</li> </ul>	<ul style="list-style-type: none"> <li>• AD Waiver</li> </ul>	1, 2, 3
Individual Family Service Plan	<ul style="list-style-type: none"> <li>• Special Education Plan (Children 0–3 years)</li> </ul>	<ul style="list-style-type: none"> <li>• AD Waiver</li> </ul>	1, 2, 3
DETERMINE — Nutrition Risk Assessment	<ul style="list-style-type: none"> <li>• Adults 60+</li> </ul>	<ul style="list-style-type: none"> <li>• No Medicaid-funded LTC Programs. Home Delivered Meals are funded through CASA and Title III-OAA</li> </ul>	1, 2, 3
Care Management Basic Assessment	<ul style="list-style-type: none"> <li>• Adults 60+</li> </ul>	<ul style="list-style-type: none"> <li>• No Medicaid-funded LTC Programs. Services are funded through CASA</li> </ul>	1, 2, 3

Instrument	Populations	Medicaid-funded Community LTC Programs	Purposes: 1 = Level of Care (LOC) Determination 2 = ID of Support Needs 3 = Inform Support Planning
Caregiver Assessment	<ul style="list-style-type: none"> <li>• Individuals who are family or relative caregivers for care consumers age 60+</li> <li>• Grandparents 55+ caring for grandchildren 18 or under</li> </ul>	<ul style="list-style-type: none"> <li>• No Medicaid-funded LTC Programs. Services are funded through Title III-OAA.</li> </ul>	1, 2, 3

# APPENDIX E

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## Federal Authorities

Multiple authorities are available to states for managing their long term care (LTC) programs, each with their set of challenges and opportunities. On the fee-for-service (FFS) side, the Department of Health and Human Services has recognized the need for state flexibility beyond the 1915(c) Home and Community-Based Services (HCBS) waiver authority for implementing LTC programs. As a result, additional state plan authorities, such as 1915(i), 1915(k) and 1915(j), were implemented, beginning 2007, to provide greater flexibility in designing HCBS programs. These HCBS State Plan authorities allow for increased access to and approaches for self-direction and in some instances increases in federal matching. Furthermore, 1915(i) and 1915(j) allow for expansion of HCBS to populations that traditionally had not been eligible for community-based care (e.g. consumers who do not meet an institutional level of care (LOC) and consumers with mental health and behavioral diagnosis).

Four federal managed care authorities are available for states to choose from for managed long term services and supports (MLTSS) programs: 1915(a), 1915(b), 1932(a) State Plan authorities and 1115 Research and Demonstration waiver. The 1115 Research and Demonstration waiver offers the greatest flexibility for innovative program design features. However, this must be balanced with the fact that this authority is also the most time consuming to develop and implement, both in terms of the time required for the Centers for Medicare & Medicaid Services (CMS) negotiation and approval and state resources. Each of the HCBS authorities noted above can be operated simultaneously with any of the managed care authorities noted here to provide for a comprehensive MLTSS delivery system. More often than not, however, 1115 Demonstration waivers subsume the various existing HCBS programs upon implementation.

This appendix describes the federal authorities that could be used by Nebraska independently or in conjunction with one or more authorities to address the preliminary recommendations included in Appendix C. It is important to note that many of the recommendations identified in this report do not require a change in or new federal authority to implement.

The first table, HCBS authorities, outlines “service” authorities — those that can be used to authorize HCBS, followed by the managed care authorities — those that can be used to authorize delivery systems other than FFS. The tables also provide examples for consideration of how the authority can be used to address some of the redesign recommendations identified from the LTC program assessment and stakeholder engagement sessions. However, it is important to note these are just examples and are not intended to be an exhaustive list of how the authority can be used.

**Table 1 — HCBS Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1915(c) HCBS Waiver	Provides HCBS to consumers meeting income, resource and medical (and associated) criteria who otherwise would be eligible to reside in an institution.	<ul style="list-style-type: none"> <li>• Can operate in a managed care or FFS setting.</li> <li>• Can limit the number of consumers served and are allowed to have waiting lists.</li> <li>• Can target the benefit to certain geographic areas of the State.</li> </ul>	<ul style="list-style-type: none"> <li>• Any new waiver must be compliant with all requirements of the HCBS final rule at time of CMS approval.</li> <li>• Must be cost neutral so the average annual cost per person served under the waiver cannot exceed the average annual cost of institutional care for each target group served.</li> </ul>	<p>Consider requesting authority granted under the Affordable Care Act and the HCBS final rule to consolidate all existing programs into one waiver. However, the request must be made carefully — i.e., telegraphing that Nebraska would be consolidating/collapsing existing waivers into one — to avoid triggering total compliance with HCBS final rule at approval.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>• Siloed program administration</li> <li>• Case management and care coordination</li> <li>• Service array and authority</li> <li>• Measuring and promoting quality</li> </ul>	<p>Currently there are no states that have combined all of their HCBS waivers into a single operating program under the 1915(c) waiver authority as permitted under the HCBS final rule. While the authority does exist, the challenge identified about complete compliance with the HCBS final rule has made this alternative unattainable. States, prior to the HCBS final rule being finalized in 2014, used 1115 Research and Demonstration waivers to combine HCBS waivers into a single operating program (examples are provided under the discussion of 1115 authority, below).</p>
1915(i) State Plan HCBS State Plan Amendment	Provides HCBS to consumers who require less than institutional LOC and who would not be eligible for HCBS under a 1915(c) waiver. May also provide services to consumers who meet institutional	<ul style="list-style-type: none"> <li>• Must be offered statewide to anyone who qualifies (however the State may define the target group served) and, as such, cannot limit the number of consumers served or</li> </ul>	<ul style="list-style-type: none"> <li>• Must be provided statewide.</li> <li>• Cannot provide a cap on the number of people who can participate in the program.</li> <li>• If using targeting option, renewal</li> </ul>	<p>Expand access to HCBS, such as employment opportunities, for consumers not previously eligible.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>• Entry into and</li> </ul>	<p><b>Delaware:</b> <a href="http://dhss.delaware.gov/dsaapd/files/pathways_amendment.pdf">http://dhss.delaware.gov/dsaapd/files/pathways_amendment.pdf</a></p> <p><b>California:</b> <a href="http://www.dds.ca.gov/Waiver/docs/renewalAp">http://www.dds.ca.gov/Waiver/docs/renewalAp</a></p>

**Table 1 — HCBS Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
	LOC.	<p>have waiting lists.</p> <ul style="list-style-type: none"> <li>• Consumers who are eligible for Medicaid under the State plan up to 150% of Federal Poverty Level (FPL) are eligible for the benefit.</li> <li>• May include special income group of consumers with income up to 300% Supplemental Security Income if consumers are eligible for HCBS under a §1915(c), (d) or (e) waiver or §1115 demonstration program.</li> <li>• Community income rules for medically needy population.</li> <li>• Allows for the option of self-directed personal care services.</li> <li>• The authority does not expire unless it is amended.</li> <li>• Can offer 1915(c) waiver services.</li> <li>• May define and limit the target group(s) served.</li> </ul>	every 5 years.	<p>navigation in the system</p> <ul style="list-style-type: none"> <li>• Assessment of LTC needs</li> <li>• Case management and care coordination</li> <li>• Service array and authority</li> <li>• Measuring and promoting quality</li> </ul>	<p>plication.pdf</p> <p><b>Ohio:</b>  <a href="https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-15-014.pdf">https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-15-014.pdf</a></p>

**Table 1 — HCBS Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1915 (j) State Plan Authority	State Plan participant-directed option to consumers otherwise eligible for State Plan Personal Care or §1915(c) services.	<ul style="list-style-type: none"> <li>• Does not require cost neutrality demonstration.</li> <li>• Targeting criteria facilitates access to HCBS by consumers with mental health and substance use disorders.</li> <li>• Financial management services must be provided if self-direction is provided and may be covered as a service, an administrative function, or performed directly by the State.</li> <li>• Allows the state to target the benefit to specific populations.</li> <li>• Can be provided in limited geographic areas in the state.</li> <li>• Can limit the number of consumers served.</li> <li>• Direct cash payments can be made to participants.</li> <li>• Financial management services are provided and can be provided directly by the State.</li> </ul>	<ul style="list-style-type: none"> <li>• Must either operate in conjunction with an HCBS waiver covering personal care services or have an approved State Plan Amendment for “traditional” personal care services.</li> <li>• Financial management services are only reimbursable as an administrative function and not a service.</li> </ul>	<p>Use as an opportunity to demonstrate a model for self-directed personal care services that could be expanded upon demonstration of successful outcomes.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>• Entry into and navigation in the system</li> <li>• Assessment of LTC needs</li> <li>• Case management and</li> </ul>	<p><b>California:</b>  <a href="http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA%20SPA%2009-006.pdf">http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA%20SPA%2009-006.pdf</a></p> <p><b>Oregon:</b>  <a href="http://www.oregon.gov/oha/OHPR/Stateplan/Medicaid%20State%20Plan%20Attachment%203.1A%20through%203.2A.pdf">http://www.oregon.gov/oha/OHPR/Stateplan/Medicaid%20State%20Plan%20Attachment%203.1A%20through%203.2A.pdf</a> (see supplement 3 to attachment 3.1-A)</p> <p><b>Texas:</b></p>

**Table 1 — HCBS Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1915(k) Community First Choice Option State Plan Amendment	State Plan option to provide consumer controlled Home and Community-Based attendant services and supports (e.g. personal care), including back-up systems or mechanisms to ensure continuity of services and supports (e.g., the use of beepers or other electronic devices)	<ul style="list-style-type: none"> <li>• State Plan benefit, not a waiver, so eliminates the administrative burden associated with frequent renewals.</li> <li>• Enhanced 6% Federal Medical Assistance Percentage increase for provided services.</li> <li>• Facilitate self-direction opportunities.</li> <li>• Increase access to community-based services.</li> <li>• Program requirement to create a council consisting of consumers and other stakeholders in the development of the program design.</li> </ul>	<ul style="list-style-type: none"> <li>• Cannot target the benefit or limit the number served.</li> <li>• Consumers must meet institutional LOC.</li> <li>• Claiming enhanced care delivery system requires sophisticated actuarial work.</li> <li>• Maintenance of effort regarding utilization for the first 12 months.</li> <li>• Must be part of an eligibility group that is entitled to receive nursing facility services; if not, income may not exceed 150% of FPL.</li> </ul>	<p>care coordination</p> <ul style="list-style-type: none"> <li>• Service array and authority</li> <li>• Measuring and promoting quality</li> </ul> <p>Create a consolidated personal care state plan benefit, across populations for consumers meeting institutional LOC. For those consumers not meeting an institutional LOC, maintain a limited state plan personal care benefit (potentially through a 1915(j)). This can allow for a better managed, consistent approach to personal care across all populations.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>• Entry into and navigation in the system</li> <li>• Assessment of LTC needs</li> <li>• Service array and authority</li> <li>• Measuring and promoting quality</li> </ul>	<p><a href="https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/TX/TX-11-52.pdf">https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/TX/TX-11-52.pdf</a></p> <p><b>Washington:</b> <a href="https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WAWA-15-0037.pdf">https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WAWA-15-0037.pdf</a></p> <p><b>Montana:</b> <a href="https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-15-0009.pdf">https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-15-0009.pdf</a></p>

**Table 2 – Managed Care Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1915(b) Waiver	<p>Generally provides authority for states to:</p> <ul style="list-style-type: none"> <li>(i) Mandate enrollment into managed care including those populations exempt from managed care under Social Security Act section 1932(a).</li> <li>(ii) Mandate enrollment into a prepaid inpatient health plan or prepaid ambulatory health plan.</li> <li>(iii) Offer additional services paid through savings achieved under the waiver.</li> </ul>	<ul style="list-style-type: none"> <li>• Offers the ability to limit benefits to certain geographic areas.</li> <li>• Option to provide additional services to consumers.</li> <li>• Flexibility to limit the providers.</li> <li>• All populations can be required to enroll.</li> </ul>	<ul style="list-style-type: none"> <li>• The waiver must be renewed every 2 years (unless it includes duals then every 5 years).</li> <li>• Authority would need to be combined with another authority to provide HCBS.</li> <li>• Must demonstrate cost effectiveness.</li> </ul>	<p>1915(b)(4) (FFS selective contracting) — Consider amending Heritage Health (b)(4) waiver to obtain authority to selectively contract for care coordination services for all LTC populations or a subset of LTC populations and operate concurrently with one or more 1915(c) waivers to maximize efficiencies and quality strategies.</p> <p>1915(b)(2) — Build on existing Heritage Health managed care authority by developing concurrent 1915(b) and 1915(c) MLTSS program design.</p> <p>Use 1915(b)(1) — Authority to develop Person Centered Care Management model of care.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>• Entry into and navigation in the system</li> <li>• Siloed program administration</li> <li>• Assessment of LTC needs</li> <li>• Case management and</li> </ul>	<p><b>Delaware</b>  <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/DE_Pathways-to-Employment_DE-01.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/DE_Pathways-to-Employment_DE-01.pdf</a></p> <p><b>Connecticut:</b>  <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CT_Home-Care-Program-for-Elders-Case-Management-Freedom-of-Choice-Waiver_CT-06.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CT_Home-Care-Program-for-Elders-Case-Management-Freedom-of-Choice-Waiver_CT-06.pdf</a></p> <p><b>Michigan:</b>  <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/MI_Managed-Specialty-Services-and-Supports-Program_MI-14.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/MI_Managed-Specialty-Services-and-Supports-Program_MI-14.pdf</a></p> <p><b>Wisconsin</b>  <a href="https://www.dhs.wisconsin.gov/familycare/statefedreqs/fc1915bwaiver.pdf">https://www.dhs.wisconsin.gov/familycare/statefedreqs/fc1915bwaiver.pdf</a></p>



**Table 2 – Managed Care Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1932(a) State Plan Option	State Plan authority for mandatory and voluntary managed care programs on a statewide basis or in limited geographic areas.	<ul style="list-style-type: none"> <li>• Permanent State Plan authority.</li> <li>• No cost-effectiveness or budget-neutrality requirement.</li> <li>• Allows selective contracting.</li> <li>• State can operate managed care only in certain areas.</li> <li>• State can limit the number of managed care organizations (MCOs) it contracts with.</li> <li>• State can allow MCOs to provide different benefits to enrollees.</li> <li>• Affords states ability to target benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• States cannot require consumers eligible for both Medicare and Medicaid (dual eligibles), children with special needs, or Native Americans to enroll in managed care.</li> <li>• For the most part builds on existing state plan benefits — affords limited opportunities for innovation.</li> </ul>	<p>care coordination</p> <ul style="list-style-type: none"> <li>• Measuring and promoting quality</li> </ul> <p>Consider as an option to maximize existing 1932(a) authority.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>• Entry into and navigation in the system</li> <li>• Case management and care coordination</li> <li>• Provider management and reimbursement</li> <li>• Measuring and promoting quality</li> </ul>	<p><b>Nevada:</b>  <a href="https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-13-031.pdf">https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-13-031.pdf</a></p> <p><b>Arkansas:</b>  <a href="https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AR/AR-13-26.pdf">https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AR/AR-13-26.pdf</a></p>

**Table 2 – Managed Care Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1115 Research and Demonstration Waiver	Authorizes the Secretary of the Department of Health and Human Services to consider and approve experimental, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid statute.	<ul style="list-style-type: none"> <li>This authority gives the most flexibility for designing a program.</li> <li>State can determine target groups, define eligibility criteria and decide what services are covered.</li> </ul>	<ul style="list-style-type: none"> <li>CMS strongly discourages use of 1115 authority when other authorities are available.</li> <li>There is no timeframe for CMS review and approval. As a result, CMS negotiations can be long and drawn out, sometimes requiring more than a year, and as long as 18 months, before approval.</li> <li>Additional administrative requirements for ongoing monitoring, such as program evaluation, quarterly and annual reports on program implementation.</li> <li>Requires significant public notice and input and can only be authorized for 5 years at a time.</li> <li>New federal requirements</li> </ul>	<p>This approach affords the greatest flexibility and could allow for wholesale system redesign and innovative approaches to service delivery including, but not limited to, buy-out of State funding, modifying nursing facility LOC and creating eligibility for at-risk of LTC populations with a more limited benefit package.</p> <p>Potential to address the following redesign considerations:</p> <ul style="list-style-type: none"> <li>Entry into and navigation in the system</li> <li>Siloed program administration</li> <li>Assessment of LTC needs</li> <li>Case management and care coordination</li> <li>Service array and authority</li> <li>Provider management and reimbursement</li> <li>Measuring and promoting quality</li> <li>Delivery system</li> </ul>	<p><b>Washington:</b>  <a href="https://www.dshs.wa.gov/altsa/stakeholders/1115-global-transformation-waiver">https://www.dshs.wa.gov/altsa/stakeholders/1115-global-transformation-waiver</a></p> <p><b>Tennessee:</b>  <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-ca.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-ca.pdf</a></p> <p><b>Delaware:</b>  <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/Diamond-State-Health-Plan/dshp-stc-01312011-12312013-amended-042012.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/Diamond-State-Health-Plan/dshp-stc-01312011-12312013-amended-042012.pdf</a></p> <p><b>Kansas:</b>  <a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-stc-01012013-1231207.pdf">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-stc-01012013-1231207.pdf</a></p>

**Table 2 – Managed Care Authorities**

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
			create additional administrative and operational challenges. <ul style="list-style-type: none"> <li>• Must demonstrate budget neutrality.</li> </ul>		

**Note:** Voluntary managed care enrollment under section 1915(a) state plan authority is available; however, it offers much less flexibility than other managed care authorities, so Mercer/NASUAD have not included it as an option in this table.

Also note that while Mercer/NASUAD do not believe that some of the redesign issues require a federal authority to address (entry into and navigation in the system, siloed program administration and assessment of LTC), one or more of the federal authorities noted above can be used to develop models that can facilitate the state’s ability to respond to critical issues.



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