

NEBRASKA LONG TERM CARE REDESIGN PLAN — DRAFT

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Mercer Government Human Services Consulting
National Association of States United for Aging and Disabilities



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1

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 persons 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 (MLTC) and the Division of Developmental Disabilities (DDD) in their mission to provide services and supports to Medicaid beneficiaries. 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 manner¹

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. After extensive statewide stakeholder engagement meetings, feedback from DHHS staff and independent research and analysis, Mercer and NASUAD compiled and analyzed the feedback and developed draft recommendations for system redesign. Using these recommendations as building blocks for redesign efforts, Mercer and NASUAD developed this draft plan, which details our proposed approach for addressing these recommendations.

¹ 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>

We developed three major focus areas for LTC redesign:

- Address high-priority systemic issues in the current LTC programs
- Transition to a Managed Long Term Services and Supports (MLTSS) delivery system
- Continue to pursue other recommended system changes over time

Address High-Priority Systemic Issues in the Current LTC Programs

Through feedback from stakeholders and DHHS staff, we identified several high-priority systemic issues that need to be addressed in the current LTC programs regardless of the service delivery model. We recommend DHHS begin work to address these five high-priority areas as soon as possible 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

Transition to an MLTSS delivery system

In addition to the high-priority issues described above, we identified several other key recommendations to improve the quality and efficiency of the LTC program in Nebraska. Mercer and NASUAD 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. We recommend building the MLTSS program using the existing infrastructure of the Heritage Health Program. We further recommend 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 we recommend resources are focused on these two areas, we recognize that there are additional system changes that DHHS should continue to pursue as resources allow:

- Implement a systematic way to reassess consumers
- Increase awareness of the Medicaid buy-in 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 is committed to ongoing stakeholder dialogue throughout the redesign process. As such, stakeholders will have opportunity to provide written and in-person comments on the draft LTC Redesign Plan during March and April 2017.

After the comment period has ended in mid-April 2017, a final LTC Redesign Plan will be developed taking into consideration public comment that has been received since this project began in June 2016. A final LTC Redesign Plan is expected to be publicly available by June 2017. Upon finalization of the LTC Redesign Plan, DHHS will immediately begin the planning and implementation phases of the redesign. DHSS will continue to provide updates and solicit feedback from the stakeholder community during the design and implementation of the program.

2

LTC Redesign Recommendations

Based upon the extensive stakeholder engagement with beneficiaries, advocates, providers, managed care organizations (MCOs) and feedback from DHHS staff interviews and research, Mercer and 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 A and a listing of the 25 preliminary recommendations is included in Appendix B. All references to recommendation numbers in the rest of the report refer to those listed in Appendix B. All recommendations were thoroughly considered and vetted with DHHS leadership.

In developing the redesign plan, Mercer and NASUAD recognized that addressing all 25 recommendations in the short term is not feasible. Therefore, to make the redesign process achievable, we undertook a process to categorize and prioritize these recommendations.

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, nine 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	Establishing the infrastructure to support consumer self-direction, PAS and independent providers (see Section 5 of report)
<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 (EVV) for in-home services	
<i>Recommendation #2A</i> – Consolidate HCBS waiver administration	Align DHHS functions for maximum performance (see Section 6 of report)
<i>Recommendation #3</i> – Realign Nebraska DHHS organizational structure to fully effectuate LTC redesign	
<i>Recommendation #24</i> – Enhance oversight and licensure of 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 changing the state’s LTC delivery system. Several delivery system model alternatives were evaluated, including contracting with Accountable Care Organizations (ACOs), 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, we recommend DHHS contract with capitated risk-based MCOs – which we have termed MLTSS (*Recommendation #25* – see Appendix B). 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 11 preliminary recommendations that can be addressed, in total or in part, by transitioning to MLTSS.

Recommendation(s)	Area to be Addressed	How MLTSS Addresses Identified Need
<i>Recommendation #2B</i> – Consolidate HCBS waiver services and populations	Certain waiver services are available only to individuals in specific waivers, when it is possible that additional populations could benefit from those services. For example, consolidating the TBI waiver with other waivers could expand the services available for these individuals.	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 individuals’ needs in a person-centered way.
<i>Recommendation #4</i> – Complete a comprehensive redesign of the Nebraska information systems (IS)	A comprehensive evaluation of the existing system and redesign plan 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. DHHS, for example, will still need an IS to manage state-funded only programs that require state staff to provide prior authorization for services and processing and payment of claims. MCOs will take over the majority of claims payment and also reporting functions.
<i>Recommendation #6</i> – 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 (LOC) 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.
<i>Recommendation #8</i> – Ensure ongoing integration of person-centered planning principles in all NE 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><i>Recommendation #9</i> – Complete a comprehensive redesign of the care management/service coordination functions to align with the LTCS 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><i>Recommendation #13</i> – 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 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 services and supports are not inappropriately denied or withheld by the MCOs.</p>
<p><i>Recommendation #15</i> – Address gaps in behavioral health services to meet the needs of the LTC populations</p>	<p>There is a lack of coordination between behavioral health (BH) services, physical health (PH) services, and LTC for consumers in Nebraska.</p>	<p>By consolidating the delivery of all BH, PH and LTC under a single entity, coordination of all services can be improved and coordinated, resulting in treatment of the whole person. In addition, with care management provided by a single organization, a more person-centered approach to care will integrate BH and LTC. Furthermore, DHHS can build into the MCO contract a requirement that case managers/service coordinators for persons with BH 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
<i>Recommendation #17</i> – Eliminate negotiated rates with providers	The large number of providers in the LTC system and the historic process of individually negotiating rates with providers leads 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 beneficiaries.
<i>Recommendation #20</i> – 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.
<i>Recommendation #22</i> – Address transportation service issues	There is a lack of adequate accessible transportation for individuals with disabilities and older adults.	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 participants, they can better coordinate transportation services centered on the whole person rather than the type of service.
<i>Recommendation #23</i> – Expand and align the scope of the quality program to align with the LTC redesign	Each waiver program has its own quality structure, while certain services are not required to have quality oversight. This has led to disparate approaches to ensuring quality services are delivered to the person, irrespective of the program they are enrolled in.	When MCOs are responsible for the entire scope of LTC services, DHHS can require a comprehensive quality approach that addresses all LTC services. Moreover, new federal managed care rules require states and MCOs to create and execute a comprehensive quality strategy that includes LTC.

Recommendations for Ongoing System Changes

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

- Implement a systematic way to reassess consumers (Recommendation #7)
- Increase awareness of the Medicaid buy-in and other employment programs for consumers with disabilities (Recommendation #12)
- Continue to improve coordination and services for children 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

Building an Effective Navigation System for LTC

Entry and navigation of Nebraska's LTC system is challenging for consumers. There was near universal 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 were confused regarding the eligibility rules for the various waivers and the PAS program.

Once in the system, consumers and their advocates often find the system too complicated and difficult to navigate. The needs of the LTC consumers change over time and consumers feel they must initiate and drive the entire process from start to finish. This is especially difficult when facing health challenges or changes. Consumers 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. Consumers also shared that there was inconsistency in the delivery of person-centered planning to meet the needs of the LTC client. For example, stakeholders expressed concerns that consumers with brain injuries 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. Persons can apply for these programs online through the ACCESSNebraska website, by telephone and in-person at local 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, it was reported a lack of personalized support for seniors and persons with disabilities resulted in some LTC providers assisting consumers, but without compensation for doing so. Moreover, ACCESSNebraska only interacts with individuals 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 individuals to non-Medicaid services until their needs are more appropriately addressed through Medicaid.

Beginning January 2017, Nebraska LTC consumers who are eligible for Medicaid started receiving all of their non-LTC benefits from a Heritage Health 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.

Risks Associated with Continuing Current Practices

As noted above, stakeholders have 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

States and the federal government, for nearly a decade, have participated in various demonstrations to streamline access to LTC options for all populations and payers. Often, individuals 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. 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 (VHA) and has the express intent of improving the entry into and navigation of LTC systems.

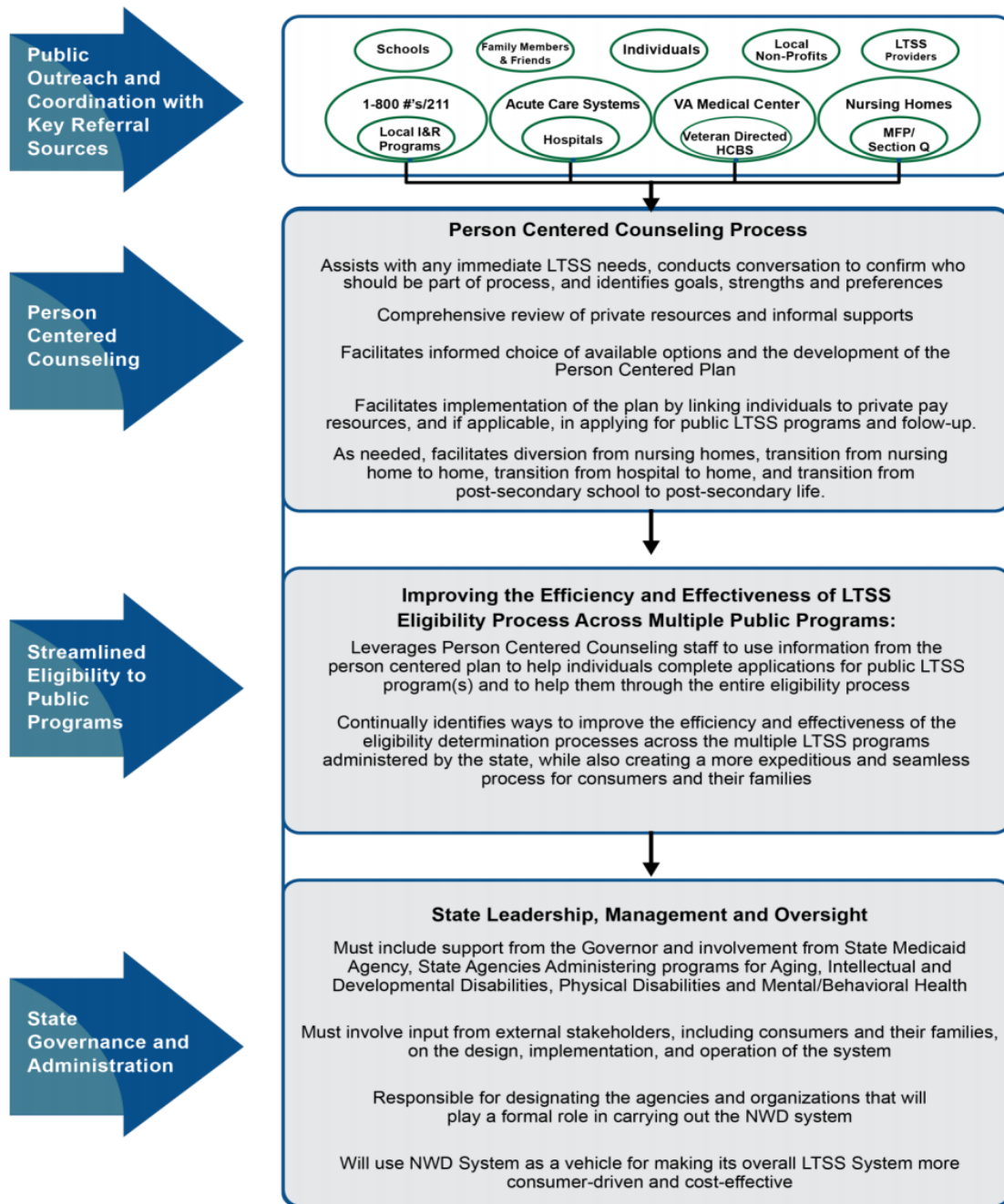
The NWD system conducts activities such as outreach, referral, assessments, functional and financial eligibility and even final determinations. Key partners in the NWD systems are the state Medicaid agency, state aging and disability divisions and all social service departments that touch consumers' lives. The NWD system builds on the strengths of the Area Agencies on Aging (AAA) and the Centers for Independent Living (CIL) by providing a single, more coordinated system of information and access for all persons 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 individual choice and supports informed decision making. Key elements of a NWD system include:

- Public outreach and coordination with key referral sources
- Person-centered counseling
- 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.

No Wrong Door Schematic



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 consumers who are older and for individuals of all ages with disabilities. The ADRC pilot runs through June 30, 2018 and is slated to be evaluated at the conclusion of the pilot. Our recommendation is to fold the pilot into the NWD initiative. Nebraska should continue to work with their current consultant on the ADRCs to migrate their ADRC to the NWD system using the best practices learned from the 47 states with more mature ADRC and NWD programs. 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 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 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 instruments 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 seeking long term care resources. Providing this information to the consumer 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 person 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 consumers who are older, state agencies representing individuals with physical disabilities and intellectually and developmentally disabled (I/DD) populations, the Governor's office and other state agencies and stakeholders working together. 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. 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.

A strong NWD system can also provide opportunities for training and outreach on programs that are not as widely utilized. Our 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 Medicaid Buy-In program, Ticket to Work, as well as Vocational Rehabilitation Programs. This was an area of need that was specifically identified by stakeholders, especially for the I/DD population.

Timing

It is clear, based on stakeholder comments, that a permanent NWD program is needed for Nebraska. The NWD program should be implemented as soon as possible with the goal of being operational before the implementation of MLTSS.

The following graphic presents a high-level overview of the stages and key activities required for developing the NWD program.



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 individuals 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. Therefore, DHHS should seek legislation in 2018 to establish and fund a permanent statewide NWD system. Our recommendation would be to direct the funding currently slated to evaluate the ADRC pilot towards implementation of the NWD and utilize the evaluations of the other states to determine best practices. It will be important to have a statewide NWD program in place prior to the transition to MLTSS so that individuals and families can obtain unbiased support in making their MCO selection.

Necessary Resources for Implementation

Resources for implementation will need to include DHHS appropriations to fund the implementation of a NWD program, state staff to support the NWD and technology to support the NWD 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 delaying Medicaid eligibility, especially for expensive institutional services, and two, they have repurposed existing funds and added new sources of funding, such as Medicaid administrative Federal Financial Participation.²

In addition to the staffing resources needed at DHHS, 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.

² 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 an NWD program is implemented but does not provide robust I&R and options counseling, individuals and their families can make decisions that are financially detrimental to their wellbeing. In addition, without appropriate I&R, DHHS risks individuals entering the expensive Medicaid LTC programs before it is actually necessary. Examples include:

- Making I&R and options counseling available to private pay individuals 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 an individual to a nursing facility because the beneficiary and family were unaware of state and Medicaid funded services that could have supported the beneficiary to continue to reside in the community.

4

Ensuring Consistent and Fair Determinations for Medicaid LTC Programs

For LTC programs, the process of assessing needs of individuals is an essential step in reaching the goal of ensuring that the appropriate individuals are enrolled in the LTC programs and that each eligible individual 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 a strain on a state's finite resources, but 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, 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 and who is using 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 C. 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 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 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 individuals 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 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 of services. It would be difficult for DHHS to effectively monitor and determine if individuals 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 recommends that DHHS use a standardized assessment instrument to apply to as many subpopulations (e.g., persons with I/DD, persons with Traumatic Brain Injury (TBI), working-age adults) as possible. 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 and 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, we 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 adult I/DD populations) systems are probably two of the most commonly known and used assessment instruments in the marketplace 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 such as the interRAI 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., persons with I/DD, persons with TBI, working-age adults)
- 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 the Nebraska's Heritage Health MCOs urged DHHS to decide what instrument they would like to utilize if migrating to MLTSS.

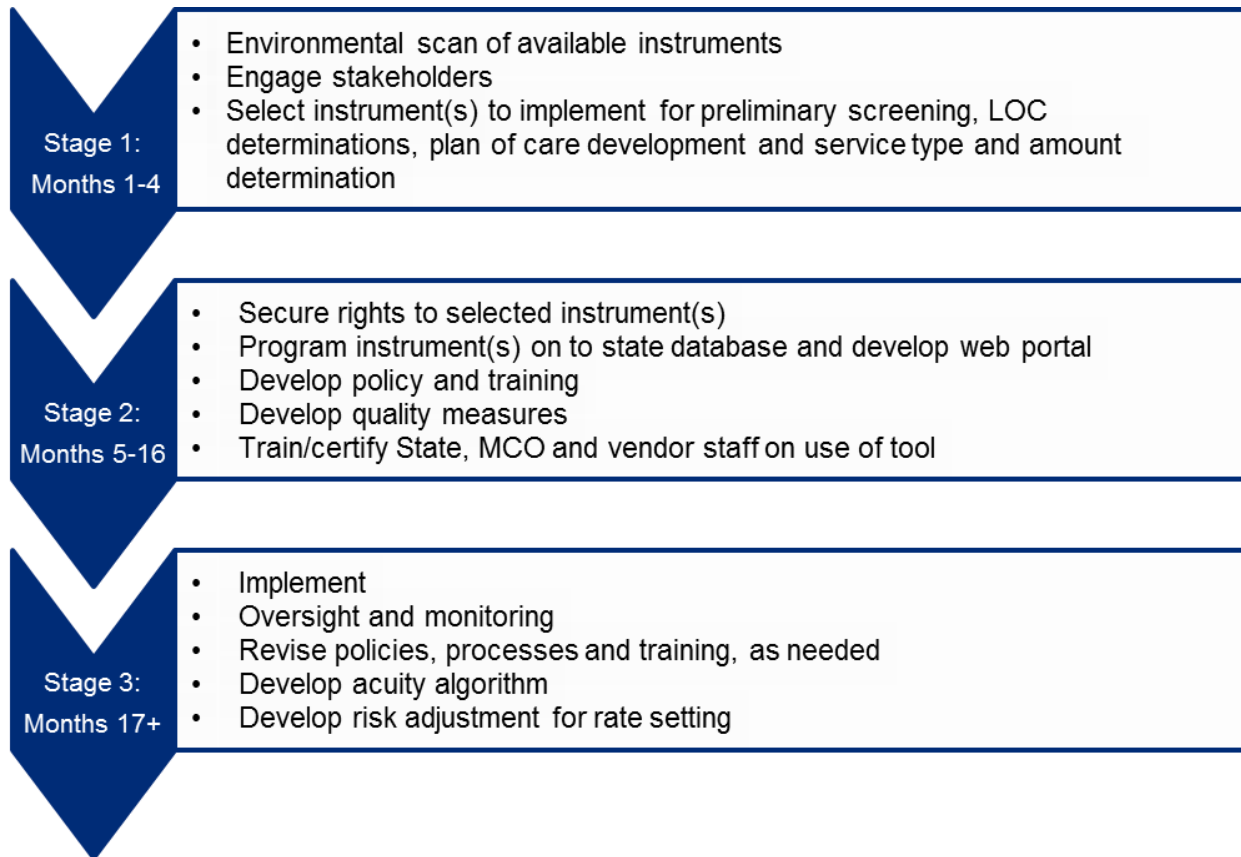
Best Practices and Key Characteristics in Implementation

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 physically disabled populations and another for those persons 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.

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.

When adopting an existing instrument as recommended, the following is a high-level overview of the stages and key activities:



Potential Additional Costs/Savings

Like most of the redesign efforts, this change will come with a 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 IS platform must also be accommodated (e.g., within a capitation rate). 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 member 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.”³

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 the 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

We believe that establishing a new assessment instrument and process must be in place before moving to MLTSS. Staying with the current instruments and processes risks continuing the current concerns from stakeholders and staff about inconsistent needs assessments of individuals and that depending on the case worker and/or MCO, individuals 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,

³ www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_Manual_2.0.pdf

DHHS risks having individuals inappropriately enrolled in the LTC programs or having eligible individuals getting the wrong type or amount of services.

5

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, interest groups and 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 caregivers
- Need for an EVV system to improve oversight and reduce manual intervention to process timesheets and payroll
- Manual rather than automated processes related to the Department of Labor overtime requirements

The consumer self-direction options in the DHHS 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

Currently, DDD HCBS waivers all offer a formal consumer-directed option for their participants. While the MLTC HCBS waiver programs do not formally offer a consumer-directed option, they do integrate the philosophy throughout their programs. Overall, DHHS has demonstrated a strong commitment to person-centered planning and service delivery.

With the DDD HCBS waivers, opportunities for consumer self-direction are available to individuals that choose certain DD services (e.g., Supported Employment Service — Individual, Respite, Habilitative Community Inclusion and Adult Companion Service). These services are directed by the individual or advocate that can be either a family member or a trusted friend. Consumer self-directed services are intended to give the individual 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 individual and family strengths and to strengthen and support informal and formal services already in place.⁴

The service coordinator (SC) or community coordinator specialist (CCS) is involved in supporting consumer self-direction, from informing the consumer about the option to self-direct their services and supports to supporting the individual or their advocate as needed while enrolled in the self-direction program. The SC/CCS supports self-direction by meeting with the individual, advocate and family to facilitate discussion of the individual's budget, the self-directed services available to the participant, and the rights and responsibilities associated with choosing self-directed services. The individual 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 individual or their advocate is the common law employer of individual workers that provide waiver services. As such, the employer, the individual 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 workers, as the designated fiscal agent they are 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.

Personal Assistance Service (PAS)

PAS is a State Plan service available to individuals 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 individual 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 the individual to remain in the home, other community supportive services can be provided. These services could include housekeeping and accompanying and assisting an individual when they cannot travel alone to medical appointments.

⁴ 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

The PAS does not allow a caregiver 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 an individual 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 individual and/or their representative using a standardized form called the Time Assessment and Service Plan. Utilizing this form, the worker discusses with the individual and/or their 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 individual needs more than this amount of time the additional hours must be approved by DHHS central office.

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

Independent Providers

DHHS has over 4,800 independent providers that provide LTC services to members enrolled in the Medicaid and non-Medicaid funded LTC programs. MLTC and DDD manages 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. 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 and HCBS providers.

In addition to the inefficiencies with how the PAS is operationalized, there is limited ability to know if a beneficiary 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.

Recommended Change

To provide individuals with more opportunities for self-direction, DHHS should amend their current Aged and Disabled Waiver to explicitly include the consumer self-direction program option. While DHHS staff has demonstrated commitments to person-centered planning and service delivery, there needs to be a formalized mechanism to allow for the development of a true self-directed program.

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 or FI).

EVV systems allow for remote verification that an in-home service was appropriately provided, including confirmation of the individual 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. 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. This in turn can allow for DHHS and MCOs to receive electronic claims and make electronic payments much more quickly than any manual processes in operation today.

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. EVV technologies today allow for this service to be deployed in rural areas where landline and cellphone services may be limited or non-existent. Moreover, the recently passed Federal legislation, 21st Century Cures Act, requires states to have an EVV system in place for PAS by January 1, 2019 and for all other home care services by January 1, 2023. Failure to implement an EVV system timely can subject the state to a 0.25%-1% reduction in FMAP. DHHS can receive a 90% FMAP for the design, development and installation of EVV and a 75% FMAP for the operation and maintenance of an EVV system.

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 individuals 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 individuals needing PAS or HCBS. For support of the consumer self-direction program, the FMSA would also be responsible to track and

report to an individual and to other designees (e.g., case manager, advocate) on the status of the individual'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. We 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 MLTSS, it is recommended that DHHS continue with the PAS State Plan service as it is today, but transition that responsibility to the Heritage Health MCOs as the EVV and FMSA vendors become operational. To convert the PAS benefit to a different federal authority 1915(i), 1915(j) or 1915(k) — DHHS will have to revise eligibility criteria for the benefit, which will likely result in fewer Nebraskans having access to PAS. Appendix D outlines the implications of each of those alternative authorities. (If DHHS prefers one of these three 1915 options, a thorough analysis would be needed to understand the impact on the individuals who currently receive PAS.)

Since individuals 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 individual's current status and need for any revision to their services. FMSA services could still be provided to MCO members using PAS, thereby minimizing duplication of efforts across all three MCOs in those functions.

Best Practices and Key Characteristics in Implementation

The DD 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.⁵

A best practice is to implement consumer self-direction across all applicable HCBS waiver programs. Nationally, it is estimated that 850,000 consumers through 270 LTC programs self-direct their own long term care services, and studies show that self-direction improves consumer care quality and health while containing costs.⁶

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 building in quality assessment and improvement methods in the design. This should include a definition of quality, measurements of quality, data collection and quality improvement

⁵ <https://www.medicaid.gov/medicaid/ltss/self-directed/index.html>

⁶ <https://www.geron.org/press-releases/55-2017-press-releases/710-pp-ar-finds-americans-more-in-control-of-their-long-term-care>

based on the data. The quality assessment practices should include consumer satisfaction and quality ratings.⁷

EVV systems should, at a minimum, include the ability to verify the specific in-home service provided, the individual 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.⁸ Other aspects that states have built into EVV systems are the ability to match services to the services authorized, allow for flexible scheduling rather than to specific start and stop times, be notified in real time when a service is not delivered as scheduled, capture worker notes and create an electronic claims file in the 837 format.⁹ 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.¹⁰

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.¹¹ 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 1040 hours in a year.¹²

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, 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 beneficiaries needing PAS. The FMSA and EVV system should be in place before the transition to MLTSS, as there are clear opportunities for improvement in these programs immediately. The recommended modification to the PAS under Heritage Health needs to be in place at the time MLTSS begins.

⁷ <https://academic.oup.com/ppar/article/doi/10.1093/ppar/prw022/2432522/Expanding-Self-Direction-and-Its-Impact-on-Quality>

⁸ H.R. 34 (21st Century Cures Act)

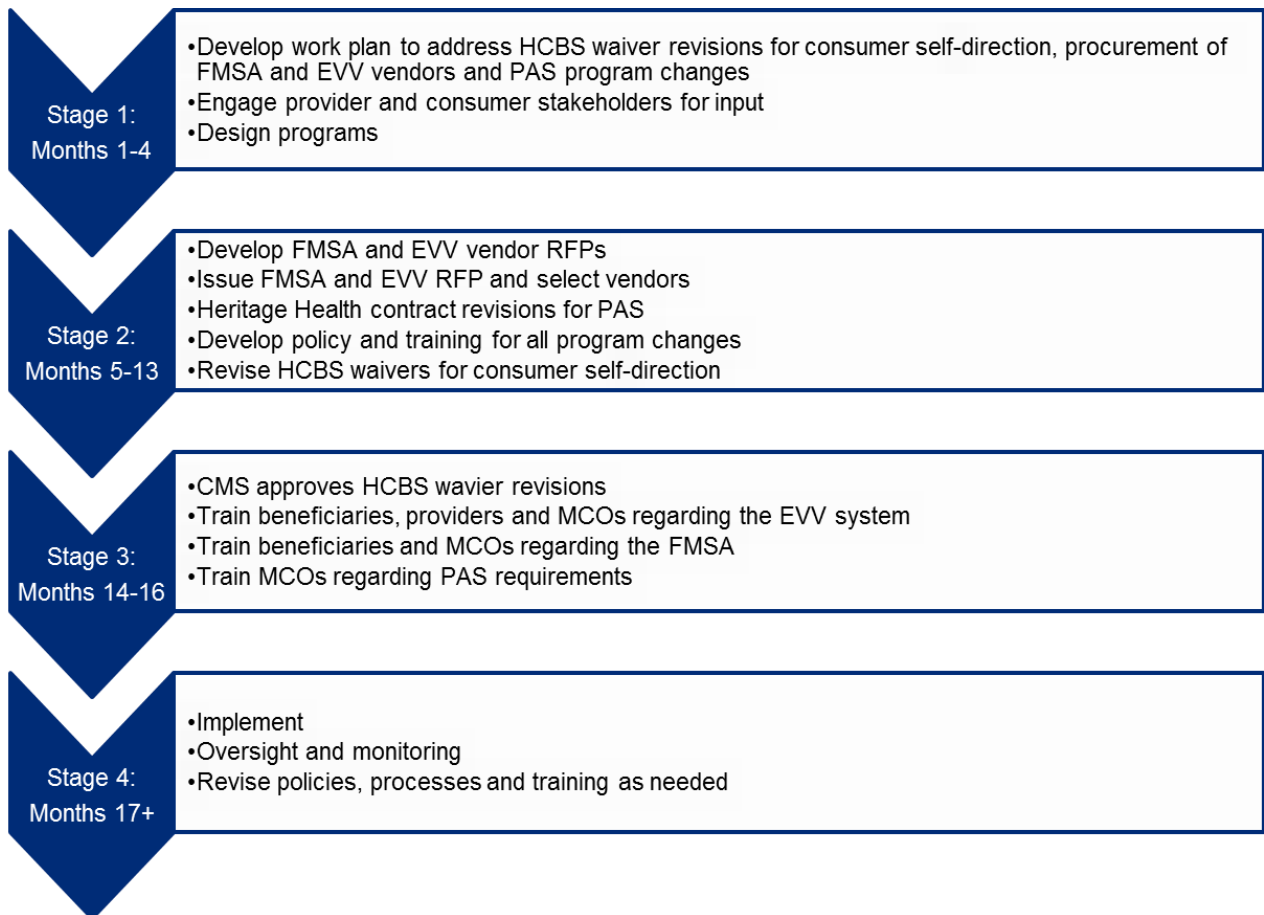
⁹ TennCare Statewide Contract with Amendment 2 – July 2015, Section 2.9.6.13.5

¹⁰ <http://www.medicaid.ohio.gov/INITIATIVES/ElectronicVisitVerification.aspx>

¹¹ http://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_60%20Home%20Care%20Services%20M anual.doc

¹² <http://kff.org/medicaid/state-indicator/personal-care-services/?currentTimeframe=0>

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:



Potential Additional Costs/Savings

States have found that implementation of an EVV system has resulted in cost savings upon implementation. Texas reported an 8% program savings with the implementation of EVV.¹³ 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.

¹³ Electronic Visit Verification Overview, Sandata.
http://www.akleg.gov/basis/get_documents.asp?session=29&docid=52974 (slide 12)

Texas and Ohio have designed their EVV systems to have all EVV transaction costs paid for by the MCO or their fee-for-service (FFS) 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 beneficiary assuming they use the State's contracted EVV vendor.¹⁴

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 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 beneficiaries 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.¹⁵

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

Risk(s) Associated with Implementation

It will be important to ensure the FMSA and EVV system are functional prior to or at the time of MLTSS implementation. If not ready at or 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.

¹⁴ <https://www.dads.state.tx.us/providers/communications/alerts/EVVUpdate-06-2014Handout.pdf>
<http://www.medicaid.ohio.gov/Portals/0/Initiatives/EVV/FAQforEVV.pdf>

¹⁵ 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>

6

Aligning DHHS Functions for Maximum Performance

Consolidation of the program administration of all programs across the LTC continuum is a critical initial step towards building efficiencies into the system. Currently of the five HCBS waivers and Program of All-Inclusive Care for the Elderly (PACE) (optional State Plan program), three of the waivers (to become two waivers effective April 1, 2017) are administered by the DDD and two of the waiver programs and the PACE program are administered by the 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. 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.

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 CMS, 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.

Recommended Change

We recommend consolidating functions, such as provider enrollment, participant enrollment, systems administrations 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, we 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.

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 waiver 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.

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 beneficiaries 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.

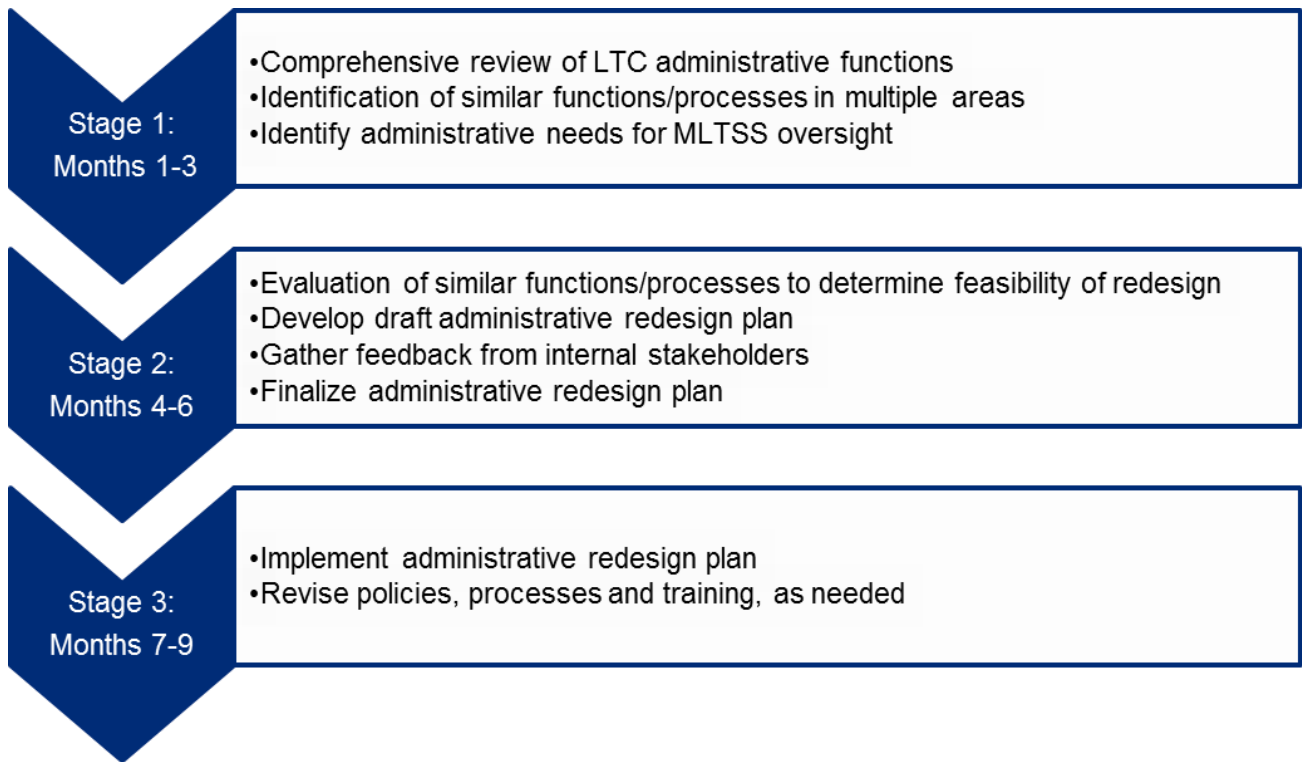
Best Practices and Key Characteristics in Implementation

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. We do not believe either of these states included the I/DD populations in the realignment initiative. We also do not believe a "best practice" administrative model exists that can be applied across multiple states. We are recommending 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 should start immediately. While the functional realignment will need to consider how MLTSS oversight will fit within the structure, it should happen before MLTSS implementation is completed.

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. 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.

7

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

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 individuals.

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 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 these individuals.

Risks Associated with Continuing Current Practices

Continuing with the status quo limits DHHS' ability to understand the true quality of care being provided to individuals that 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. This 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 beneficiaries 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 individuals 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 individual residents.

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 we support DDD's intent to implement as soon as feasible.

8

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 MCOs. Currently, 22 states operate Medicaid MLTSS programs for all Medicaid consumers who need 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, five other states are considering or planning to develop MLTSS in the near future (Alabama, New Hampshire, Oklahoma, Pennsylvania and Virginia).

Rationale for MLTSS delivery System

The following are the key reasons noted by states for pursuing MLTSS.

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 an individual 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 CMS. However, regardless of the federal authority, states can incentivize MCOs to provide supports and services to Medicaid populations that the state may not have been able to offer.

Shift Focus of Care to Community Settings

Through 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 participants 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.

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 beneficiaries 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 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 in a single MCO. The next logical evolution is to enhance this integration by adding LTC to the MCO portfolio, thereby creating a comprehensive system of care that is appropriately focused on treating the whole person, regardless of their service need or the cost of care. The MCO is financially at risk for the provision of all care. This provides leverage for DHHS, through contract requirements, to incentivize MCO performance to achieve better health outcomes and quality of life for beneficiaries.

Administrative Simplification

An additional benefit of vesting the accountability for the delivery of a comprehensive model of care (PH, BH, pharmacy and LTC) in a single MCO is that it creates administrative simplification and enhances administrative efficiencies. For example, DHHS would no longer retain the function of contracting with and monitoring hundreds of individual LTC providers. Instead, the MCOs would take on this responsibility. Through contract requirements and strong oversight and monitoring by DHHS, the result would be a more efficient process that allows beneficiaries timely access to qualified providers.

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.

CMS LTC expenditure data reports provided by Truven Health Analytics in 2016 noted that the State of Nebraska ranked 30 (out of 49 states and the District of Columbia) in the percentage of Medicaid LTCS expenditures for HCBS.¹⁶ In fiscal year (FY) 2014, Nebraska spent 48.5% of LTC dollars on HCBS, while the national average was 53.1%.¹⁷ Implementing an MLTSS program offers the promise of promoting high-quality, community-based services while ensuring long term program stability. Designing an MLTSS program must reflect the goal of serving more individuals in the community while also increasing the accountability for high-quality services.

¹⁶ Truven Health Analytics. Medicaid Expenditures for LTSS in FY 2014. April 15, 2016. <https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf>

¹⁷ Ibid.

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:

Maintain the Current System

Stakeholders identified numerous challenges in the current system, such as fragmented system of care, inadequate services and inconsistent assessment for needs that need to be addressed (refer to Appendix A for additional information). DHHS resources are limited and organizational capacity to undertake the improvements needed 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 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 are able to 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 beneficiaries 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. However, 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 in order 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, the MLTSS approach can build upon the existing Heritage Health infrastructure, thereby maximizing existing efficiencies and resources.

Addressing Stakeholder Concerns about MLTSS

We 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 Report (Appendix A).¹⁸ In general, these stakeholder concerns can be grouped as follows: ensuring quality, providing consumer protections, increasing access to services and providing timely and accurate information.

On May 6, 2016, CMS published a Final Rule updating requirements for states operating Medicaid managed care programs.¹⁹ 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, 2013.²⁰

The 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 members' 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 members at all phases of the process to ensure that members 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 and NASUAD have identified key requirements for the program design.

¹⁸ 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>

¹⁹ 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>

²⁰ 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>

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 draft 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. We 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.

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 BH, PH and pharmacy services through three separate delivery systems. The implementation of Heritage Health offers beneficiaries with Medicaid an integrated approach to care that provides comprehensive BH, PH and pharmacy benefits in a single delivery system.²¹ Given DHHS' commitment to continue an integrated and coordinated approach, and to simplify program administration, we recommend that DHHS build off the existing Heritage Health infrastructure to implement MLTSS.

Leverage Existing Heritage Health MCOs

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

- Aged and Disabled Waiver
- TBI Waiver
- Children's Developmental Disabilities Waiver (consolidated with the DD adult waiver effective April 1, 2017)
- Adult Day HCBS Waiver
- Developmental Disabilities Adult Comprehensive Waiver (consolidated with the DD child waiver effective April 1, 2017)

Existing Heritage Health MCOs are already administering the PH, BH and pharmacy benefits for the individuals served in Nebraska's current HCBS programs. They will know these individuals, having already been responsible for helping to provide connections as needed to social supports and services. In addition, as services and supports transition to the MCOs, existing MCOs can facilitate smooth transitions of care as they have a relationship with their members and are familiar with their needs and current services, thereby facilitating continuity of care. We also

²¹ 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>

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 beneficiaries in their initial rollout of MLTSS. However, initially excluding these beneficiaries 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 (PACE), which is only available in the Omaha area, will remain an alternative integrated care model for individuals 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 service 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 individuals to receive their services through an MCO.

It is common practice to stagger implementation by population, so that provider and consumer impacts are mitigated. We therefore recommend that DHHS enroll older adults and persons with disabilities (phase 1 populations) into the MLTSS program first, followed shortly thereafter by individuals with an intellectual or developmental disability (phase 2 populations). Given DHHS' long history of managed care, and the successful implementation of Heritage Health, it is recommended that MLTSS be mandatory and begin on January 1, 2019 for phase 1 populations and July 1, 2019 for phase 2 populations.

An 18-month planning and implementation period is consistent with state norms and federal expectations. CMS, in its 2013 guidance on elements for MLTSS programs, recommended no less than one year from design to implementation. Moreover, using existing Heritage Health plans 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 working well for two years. This recommendation mirrors the approach taken by New Jersey, which built its successful MLTSS program on the core of the state's pre-existing managed care program in approximately 18 months.

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.

Best Practices in Program Design and Implementation

To design, implement and maintain a strong MLTSS program, we 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.

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? 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, we

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 beneficiaries
- 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.

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

- Stakeholder engagement
- 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. We recommend the implementation plan also

clearly outline the systems of responsibility and process for reporting, monitoring and escalation of issues.

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. We 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.

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 individuals 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, we recommend the roll out of MLTSS to take place on two different schedules with implementation for the elderly and disabled populations on January 1, 2019 and on July 1, 2019 for the I/DD populations. The following provides a high-level overview of the timing of the major planning and implementation steps for each phase.

MLTSS Planning and Implementation – Elderly and Disabled Populations



MLTSS Planning and Implementation – I/DD Population



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. DHHS will need to continually monitor progress against the implementation plan. Opportunities for stakeholder feedback throughout the process will be important in identifying issues. DHHS will also need to implement a comprehensive process for timely identification and resolution of issues throughout the implementation process. We strongly recommend DHHS develop risk mitigation strategies in the development of the implementation plan. DHHS’ experience in the Heritage Health implementation will provide a valuable roadmap for MLTSS implementation.

Potential Additional Costs/Savings

Most states do not undertake MLTSS programs with the goal of saving money. 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.²² By FY 2014, Arizona reported 70.4% of LTC expenditures for HCBS.²³ Even a more recent MLTSS program, Tennessee, reported similar shifts. In 2010, only 17% of LTC consumers were receiving services in the community; by 2015, 44% were receiving services in the community.²⁴

²² 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

²³ Truven Health Analytics. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014. April 15, 2016.

²⁴ Killingsworth, Patti. Presentation to Disability Rights Wisconsin. http://www.disabilityrightswi.org/wp-content/uploads/2015/11/Patti-Killingsworth-TN-Presentation-2_Wisconsin-Managed-Care-Discussion-11-18-15.pdf

In the short term, it is likely that the implementation of MLTSS will result in an overall increase in expenditures. 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.

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. 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 beneficiaries into the community.

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 beneficiaries 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 individuals in the community will occur. DHHS may also limit the ability of the MCOs to change any members' 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 member's care plan and will reduce any savings opportunities after managed care implementation.

While it is difficult to predict savings from MLTSS, there are financial advantages. 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.

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Other Recommended System Changes

Not all of the preliminary recommendations for LTC redesign are addressed as high-priority systemic changes or through the implementation of MLTSS. The remaining five preliminary recommendations from the 25 total recommendations (Appendix B) should not be lost. 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 LOC assessment process, DHHS can also work on developing a more robust system for reassessments.
- *Recommendation #12 – Increase awareness of the Medicaid buy-in program:* DHHS should consider additional ways to ensure beneficiaries, choice counselors and DHHS staff are made aware of the Medicaid buy-in program. Over time, DHHS should consider how to build incentives into the MCO contract to increase awareness of the Medicaid buy-in program.
- *Recommendation #14 – Improve coordination and services for children aging out of the educational system:* DHHS has made efforts to improve transitional support to children aging out of the school system, but continued monitoring of these activities and outcomes for young adults is needed.
- *Recommendation #16 – Address issues in the provider enrollment process:* We 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.
- *Recommendation #21 – Establish a process to rebase HCBS rates more frequently:* Regardless of the delivery system, a FFS fee schedule will need to be maintained for any services delivered in the FFS system. CMS expects that fee schedules are rebased at least every five years. 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.

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Next Steps

Once the draft LTC Redesign Plan is published on the Nebraska Long Term Care Redesign Project page (http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx), there will be several opportunities to provide comment.

Written comment on this draft plan is anticipated to be open to public from mid-March 2017 through mid-April 2017. On the LTC Redesign Project page click on the “Comments and Questions” icon at the top of the page. Once on this page, you can enter your comments and questions and complete the remaining fields of the form. You may also submit your written comments via email to DHHS.LTCRedesign@nebraska.gov. It is very important that DHHS receive your thoughtful feedback so that the current LTC program can be redesigned to better meet the needs of its citizens.

Additionally, you can have your voice heard by attending one or more of the many stakeholder meetings being planned throughout the state that will be held in late March through early April 2017. The schedule of dates and times will be published on the LTC Redesign Project page. The stakeholder meetings will also include two webinars to accommodate those who are not able to attend any of the onsite public meetings. The webinars will include an opportunity for questions and comments. These webinars will be recorded and made available to listen to on the LTC Redesign Project page.

After the comment period has ended, a final LTC Redesign Plan will be developed, taking into consideration public comment that has been received since this project began in June 2016. A final LTC Redesign Plan is expected to be publicly available by June 2017. Upon finalization of the LTC Redesign Plan DHHS will immediately begin the implementation phase of the redesign.

Throughout the implementation phase, DHHS will continue to provide opportunities for stakeholder discussions and will provide updates on the LTC Redesign Project page. Please be sure to subscribe to this page so that you can 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

Stakeholder Engagement Report

Stakeholder engagement is an essential component of any successful system redesign. As such, DHHS is committed to implementing a comprehensive stakeholder engagement process.

Stakeholders are broadly defined to include, but not limited to: beneficiaries, caregivers, family members, advocates, providers and provider associations.

Statewide stakeholder meetings occurred throughout September 2016. 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 and 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.

A second round of statewide stakeholder meetings will be conducted starting in March 2017. The purpose of these meetings will be to obtain feedback on the draft LTC Redesign Plan.

APPENDIX B

Preliminary LTC Redesign Recommendations

To fully inform the Nebraska LTC redesign, DHHS contracted with Mercer and NASUAD to collaborate in providing an honest evaluation of the current landscape and to engage members, 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. Our 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 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. Complete a comprehensive redesign of the Nebraska information systems

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 (CM) functions to align with the LTC redesign

Service Array and Authority

10. Expand and strengthen consumer-directed programs
11. Re-engineer the PAS program
12. Increase awareness of the Medicaid buy-in 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 BH 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 EVV 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 EFH

Delivery System

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

APPENDIX C

Current Nebraska LTC Assessment Instruments

Instrument	Populations	Medicaid-funded Community LTC Programs	Purposes: 1 LOC Determination 2 ID of Support Needs 3 Inform Support Planning
Scales for Independent Behavior Revised (SIB-R)	Developmental Disabilities (Adults, Children) to determine adaptive need	<ul style="list-style-type: none"> •Adult Day Waiver •Comprehensive Adult Waiver •Children's Waiver 	1 (statutory eligibility), 2
Inventory for Client and Agency Planning (ICAP)	Developmental Disabilities (Adults, Children) who have some adaptive need	<ul style="list-style-type: none"> •Adult Day Waiver •Comprehensive Adult Waiver •Children's Waiver 	2 individual budget, 3 level of need
Developmental Index ICF-DD LOC Assessment for Determination of DD Waiver Eligibility	Developmental Disabilities (Adults, Children)	<ul style="list-style-type: none"> •Adult Day Waiver •Comprehensive Adult Waiver •Children's Waiver 	1 (waiver eligibility)
Risk Screens <ul style="list-style-type: none"> •Health Risk Screen •Physical Nutrition Management Screen •Enteral Feeding Screen •Spine and Gait •Behavior risk screen 	Developmental Disabilities (Adults, Children)	<ul style="list-style-type: none"> •Adult Day Waiver •Comprehensive Adult Waiver •Children's Waiver 	1, 2
Time Assessment and Service Plan is referred to as "Service Needs Assessment"	Aged, Physical Disabilities (Adults)	•State Plan Personal Assistance Services	1, 2, 3
Functional Criteria HCBS Waiver for Aged Persons and Adults and Children with Disabilities	Aged, Physical Disabilities (Adults) Traumatic Brain Injury (Adults)	<ul style="list-style-type: none"> •Aged and Disabled Waiver •PACE •TBI Waiver 	1,2,3 for AD and TBI Waivers, 1 for PACE
Aged and Disabled Medicaid Waiver Adult Assessment	Aged, Physical Disabilities (Adults) Traumatic Brain Injury (Adults)	<ul style="list-style-type: none"> •Aged and Disabled Waiver •TBI Waiver 	2, 3
Child's LOC or NF LOC	Physical Disabilities 3-17 or receiving specific medical treatments (Children 0-17)	•Aged and Disabled Waiver	1, 2, 3
Child's Functional Assessment and Family Support Survey	Physical Disabilities or receiving specific medical treatments (Children 3-17)	•Aged and Disabled Waiver	1, 2, 3

Instrument	Populations	Medicaid-funded Community LTC Programs	Purposes: 1 LOC Determination 2 ID of Support Needs 3 Inform Support Planning
Individual Family Service Plan	Special Education Plan (Children 0-3 years)	•Aged and Disabled Waiver	1, 2, 3
DETERMINE – Nutrition Risk Assessment	Adults 60+	•No Medicaid-funded LTC Programs. Home Delivered Meals are funded through CASA and Title III-OAA	1, 2, 3
Care Management Basic Assessment	Adults 60+	•No Medicaid-funded LTC Programs. Services are funded through CASA	1, 2, 3
Caregiver Assessment	Individuals who are family or relative caregivers for care recipients age 60+. Grandparents 55+ caring for grandchildren 18 or under.	•No Medicaid-funded LTC Programs. Services are funded through Title III-OAA.	1, 2, 3

APPENDIX D

Federal Authorities

Multiple authorities are available to states for managing their LTC programs, each with their set of challenges and opportunities. On the FFS side, DHHS has recognized the need for state flexibility beyond the 1915(c) 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. persons who do not meet an institutional LOC and persons with mental health and behavioral diagnosis).

Four federal managed care authorities are available for states to choose from for 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 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 A. 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) Home and Community-Based Services Waiver	Provides HCBS to individuals meeting income, resource and medical (and associated) criteria who otherwise would be eligible to reside in an institution.	<p>Can operate in a managed or FFS setting.</p> <p>Can limit the number of individuals served and are allowed to have waiting lists.</p> <p>Can target the benefit to certain geographic areas of the state.</p>	<p>Any new waiver must be compliant with all requirements of the HCBS final rule at time of CMS approval.</p> <p>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.</p>	<p>For Consideration: Consider requesting authority granted under the Affordable Care Act and the HCBS final rule to consolidate all existing programs into one waiver.</p> <p>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: Siloed program administration Case management and care coordination Service array and authority Measuring and promoting quality</p>	<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>

Table 1 – HCBS Authorities

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1915(i) State Plan Home and Community Based Services State Plan Amendment	Provides HCBS to individuals who require less than institutional LOC and who would not be eligible for HCBS under a 1915(c) waiver. May also provide services to individuals who meet institutional LOC.	<p>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 individuals served or have waiting lists.</p> <p>Individuals who are eligible for Medicaid under the State plan up to 150% of Federal Poverty Level are eligible for the benefit.</p> <p>May include special income group of individuals with income up to 300% SSI if individuals are eligible for HCBS under a §1915(c), (d), or (e) waiver or §1115 demonstration program.</p>	<p>Must be provided statewide</p> <p>Cannot provide a cap on the number of people who can participate in the program</p> <p>If using targeting option, renewal every 5 years.</p>	<p>For Consideration:</p> <p>Expand access to HCBS, such as employment opportunities, for persons not previously eligible.</p> <p>Potential to address the following redesign considerations:</p> <p>Entry into and navigation in the system</p> <p>Assessment of LTC needs</p> <p>Case management and care coordination</p> <p>Service array and authority</p> <p>Measuring and promoting quality</p>	<p>Delaware: http://dhss.delaware.gov/dsaapd/files/pathways_amendment.pdf</p> <p>California: http://www.dds.ca.gov/Waiver/docs/renewalApplication.pdf</p> <p>Ohio: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-15-014.pdf</p>
MERCER/NASUAD		<p>Community income rules for medically needy population</p> <p>Allows for the option of self-directed personal care services.</p> <p>The authority does not expire unless it is amended.</p> <p>Can offer 1915(c) waiver services.</p> <p>May define and limit the target group(s) served.</p> <p>Does not require cost neutrality demonstration.</p> <p>Targeting criteria facilitates access to HCBS by persons with mental health and substance use disorders.</p> <p>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.</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 individuals otherwise eligible for State Plan Personal Care or §1915(c) services.	<p>Allows the state to target the benefit to specific populations.</p> <p>Can be provided in limited geographic areas in the state.</p> <p>Can limit the number of individuals served.</p> <p>Direct cash payments can be made to participants.</p> <p>Financial management services are provided and can be provided directly by the state.</p>	<p>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.</p> <p>Financial management services are only reimbursable as an administrative function and not a service.</p>	<p>For consideration: 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: Entry into and navigation in the system Assessment of LTC needs Case management and care coordination Service array and authority Measuring and promoting quality</p>	<p>California: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA%20SPA%2009-006.pdf</p> <p>Oregon: http://www.oregon.gov/oha/OHPR/Stateplan/Medicaid%20State%20Plan%20Attachment%203.1A%20through%203.2A.pdf (see supplement 3 to attachment 3.1-A)</p> <p>Texas: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/TX/TX-11-52.pdf</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)	<p>State plan benefit not a waiver so eliminates the administrative burden associated with frequent renewals</p> <p>Enhanced 6% FMAP increase for provided services</p> <p>Facilitate self-direction opportunities</p> <p>Increase access to community-based services</p> <p>Program requirement to create a council consisting of members and other stakeholders in the development of the program design</p>	<p>Cannot target the benefit or limit the number served</p> <p>Individuals must meet institutional LOC</p> <p>Claiming enhanced match in a managed care delivery system requires sophisticated actuarial work</p> <p>Maintenance of effort regarding utilization for the first 12 months</p> <p>Must be part of an eligibility group that is entitled to receive nursing facility services; if not, income may not exceed 150% of FPL</p>	<p>For consideration:</p> <p>Create a consolidated personal care state plan benefit, across populations for persons meeting institutional LOC. For those individuals 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> <p>Entry into and navigation in the system</p> <p>Assessment of LTC needs</p> <p>Service array and authority</p> <p>Measuring and promoting quality</p>	<p>Washington:</p> <p>https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-15-0037.pdf</p> <p>Montana:</p> <p>https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-15-0009.pdf</p>

Table 2 – Managed Care Authorities

Federal Authority	Overview	Opportunities	Challenges	Options for Consideration/ Redesign Consideration Addressed	State Example(s)
1915(b) Waiver	Generally provides authority for states to (i) mandate enrollment into managed care including those populations exempt from managed care under Social Security Act section 1932(a), (ii) mandate enrollment into a prepaid inpatient health plan or prepaid ambulatory health plan, and (iii) offer additional services paid through savings achieved under the waiver.	Offers the ability to limit benefits to certain geographic areas. Option to provide additional services to individuals. Flexibility to limit the providers. All populations can be required to enroll.	The waiver must be renewed every 2 years (unless it includes duals then every 5 years). Authority would need to be combined with another authority to provide HCBS. Must demonstrate cost-effectiveness.	<p>For Consideration:</p> <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 (PCCM) model of care</p> <p>Potential to address the following redesign considerations: Entry into and navigation in the system Siloed program administration Assessment of LTC needs Case management and care coordination Measuring and promoting quality</p>	<p>Delaware https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/DE_Pathways-to-Employment_DE-01.pdf</p> <p>Connecticut: 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</p> <p>Michigan: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/MI_Managed-Specialty-Services-and-Supports-Program_MI-14.pdf</p> <p>Wisconsin https://www.dhs.wisconsin.gov/familycare/statefedreqs/fc1915bwaiver.pdf</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.	<p>Permanent state plan authority.</p> <p>No cost-effectiveness or budget-neutrality requirement.</p> <p>Allows selective contracting.</p> <p>State can operate managed care only in certain areas</p> <p>State can limit the number of MCOs it contracts with</p> <p>State can allow MCOs to provide different benefits to enrollees</p> <p>Affords states ability to target benefits</p>	<p>States cannot require individuals eligible for both Medicare and Medicaid (dual eligibles), children with special needs, or Native Americans to enroll in managed care.</p> <p>For the most part builds on existing state plan benefits – affords limited opportunities for innovation.</p>	<p>For Consideration: Consider as an option to maximize existing 1932(a) authority.</p> <p>Potential to address the following redesign considerations: Entry into and navigation in the system Case management and care coordination Provider management and reimbursement Measuring and promoting quality</p>	<p>Nevada: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NV/NV-13-031.pdf</p> <p>Arkansas: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/AR/AR-13-26.pdf</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.	This authority gives the most flexibility for designing a program State can determine target groups, define eligibility criteria and decide what services are covered.	<p>CMS strongly discourages use of 1115 authority when other authorities are available.</p> <p>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 eighteen months before approval.</p> <p>Additional administrative requirements for ongoing monitoring, such as program evaluation, quarterly and annual reports on program implementation.</p> <p>Requires significant public notice and input and can only be authorized for 5 years at a time.</p> <p>New federal requirements create additional administrative and operational challenges.</p> <p>Must demonstrate budget neutrality.</p>	<p>For consideration:</p> <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> <p>Entry into and navigation in the system</p> <p>Siloed program administration</p> <p>Assessment of LTC needs</p> <p>Case management and care coordination</p> <p>Service array and authority</p> <p>Provider management and reimbursement</p> <p>Measuring and promoting quality</p> <p>Delivery system</p>	<p>Washington: https://www.dshs.wa.gov/altsa/sakeholders/1115-global-transformation-waiver</p> <p>Tennessee: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/download/s/tn/tn-tenncare-ii-ca.pdf</p> <p>Delaware: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/download/s/de/Diamond-State-Health-Plan/de-dshp-stc-01312011-12312013-amended-042012.pdf</p> <p>Kansas: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/download/s/ks/KanCare/ks-kancare-stc-01012013-1231207.pdf</p>

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 we have not included it as an option in this table.

Also note that while we 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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