

# Nebraska Medicaid Managed Long-Term Services and Supports

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## *Program Concept and Design*

### **Background**

A significant shift in the management and administration of Medicaid services has taken place over the past several years with the growth of managed care. Full-risk managed care is a health care delivery system in which Managed Care Organizations (MCOs) are contracted to operate health plans that authorize, arrange, provide, and pay for the delivery of services to enrolled clients. Managed care offers an opportunity to assure access to a primary care provider, emphasizes preventive care, and encourages the appropriate utilization and coordination of services in the most cost-effective setting.

Nebraska implemented managed care to improve the health and wellness of Medicaid clients by increasing their access to comprehensive health services in a way that is cost effective to Medicaid. Nebraska Medicaid has utilized managed care in limited regions since 1995, expanding to statewide managed care for physical health services on July 1, 2012. On September 1, 2013, Nebraska also shifted its behavioral health program to an at-risk model. The Program for All-Inclusive Care for the Elderly (PACE) was also implemented in very limited areas of the state in 2013. PACE is a Medicare program and optional Medicaid State Plan service that provides comprehensive, coordinated health care and long-term services and supports for voluntarily enrolled individuals.

### **Introduction**

Similar to managed physical and behavioral health care programs, Medicaid Managed Long-Term Services and Supports (MLTSS) refers to delivering long-term care services and supports through an integrated managed care program. Long-term care services and supports may encompass a broad range of medical and social services - ranging from nursing home care to home and community-based (HCBS) services for the elderly and disabled.

MLTSS programs may also be designed to include comprehensive integration of other services common to the Medicaid population as a whole, such as physical and behavioral health care. Two essential components of MLTSS are service delivery and service coordination

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within a managed care environment. Medicaid MLTSS programs have grown considerably in the last 10 years and are expected to increase. Studies of such programs show that:

- they can reduce the use of nursing homes and increase the use of home and community-based services (HCBS) compared to fee-for-service programs; and
- quality of life; consumer choice regarding where to live and receive services and supports; and consumer satisfaction generally improve under MLTSS programs.

Because of the success of this model and the benefits to Medicaid clients, Nebraska Medicaid has begun developing a statewide MLTSS. The targeted implementation date is January 2017. Nebraska will seek federal authority to operate the program under concurrent Section 1915(b) and (c) Federal Medicaid waiver authorities.<sup>1</sup> This paper outlines several key elements of the Nebraska MLTSS program concept and design, and identifies issues for future consideration and resolution.

## **Purpose**

Under a fee-for-service system, Medicaid programs may find it difficult to hold providers accountable for care coordination, quality of services, adequate access to services, and cost controls. MLTSS is intended to improve our ability to assess and define client service needs, coordinate care, integrate services, and more effectively and efficiently deliver, manage and pay for quality, integrated long-term care services and supports.

## **Program Goals**

Managing long-term services and supports will help Nebraska Medicaid accomplish the following goals for clients who use these services:

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<sup>1</sup> States can provide traditional long-term care (LTC) benefits (e.g., institutional care), as well as home and community-based (HCBS) services (e.g., adult day health services) using a managed care delivery system, rather than fee-for-service. This is done by implementing a 1915(c) HCBS waiver (allowing States to provide LTC services in home and community settings rather than institutional settings) concurrent with a 1915(b) managed care waiver (allowing states to limit choice of providers by delivering services through managed care delivery systems and mandating enrollment into a managed care plans).

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1. Improve client health status and quality of life by better coordination of medical care, behavioral health care, and community-based services and supports.
2. Promote client choice and use of the right services and supports at the right time in the right amount.
3. Increase client access to responsive, quality services and supports.
4. Use financial resources wisely to sustain Nebraska Medicaid.

Our vision for MLTSS in Nebraska includes other anticipated outcomes, such as reducing reliance on institutional services; removing barriers to service delivery; improving cost predictability; and further strengthening our ability to measure and improve the quality of care.

## **CMS Guiding Principles for Program Design**

The U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) developed 10 key characteristics of an effective MLTSS program.<sup>2</sup> Nebraska Medicaid's MLTSS program development efforts will incorporate these guidelines.

### **CMS Guiding Principles for MLTSS**

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| <b>1.</b> Adequate Planning and Transition Strategies   | <b>6.</b> Person-centered Processes                      |
| <b>2.</b> Stakeholder Engagement                        | <b>7.</b> Comprehensive and Integrated Service Package   |
| <b>3.</b> Enhanced Provision of HCBS                    | <b>8.</b> Qualified Providers                            |
| <b>4.</b> Payment Structures Aligned with Program Goals | <b>9.</b> Participant Protections                        |
| <b>5.</b> Support for Beneficiaries                     | <b>10.</b> Comprehensive Quality and Oversight Structure |

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<sup>2</sup> CMS MLTSS guidance can be accessed at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf>

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### **Stakeholder Collaboration**

Nebraska Medicaid will seek input from stakeholders in program design, implementation, and monitoring. This includes establishing an Advisory Council comprised of clients or client's family members/caregivers, providers, and community-based organizations that support and advocate for children with disabilities, adults with disabilities, and the elderly; holding multiple local town-hall meetings; and collecting surveys and web-based input from all interested parties.

Nebraska has also established a website (<http://dhhs.ne.gov/medicaid/Pages/MLTSS.aspx>) where information about the developing MLTSS program is published, and is also seeking input from managed care experts.

### **Target Populations**

Nebraska Medicaid believes that broad inclusion of clients needing long-term services and supports establishes a strong program foundation and ensures these clients receive the benefits of integrated and coordinated services. Populations to be served by the Nebraska MLTSS Program include:

- Clients who are Aged, Blind and Disabled (ABD), which includes:
  - o Clients living in the community (not included in other categories below)
  - o Clients living in nursing facilities
  - o HCBS Waiver clients:
    - Aged and Disabled (AD) Waiver
    - Traumatic Brain Injury (TBI) Waiver
  - o Katie Beckett Program clients
- Medicaid spend-down clients<sup>3</sup> in the above categories will also be included in MLTSS.

Clients who are currently enrolled in the Nebraska Medicaid physical health and/or behavioral health managed care programs and fall into

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<sup>3</sup> Individuals who exceed the Medicaid income limit may be able to get Medicaid if they pay a spend-down, which is the dollar amount of medical bills that must be paid out-of-pocket prior to Medicaid coverage beginning during a specified time period.

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the target population categories listed above will be enrolled in the MLTSS Program when it is implemented.

## **Excluded Populations**

Clients receiving services through the Department of Health and Human Services (DHHS) Division of Developmental Disabilities<sup>4</sup> are excluded. In addition, clients living in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) are excluded, as well as clients in eligibility categories that receive financial support only - i.e., Specified Medicare Low-income Beneficiaries (SLMBs)<sup>5</sup>, Qualifying Individuals (1) (QI-1)<sup>6</sup>, and Medicare Savings Program (MSP)<sup>7</sup> clients. Persons enrolled in the Program for All-Inclusive Care for the Elderly (PACE) Program are also excluded from MLTSS.

## **Covered Services**

An integrated benefit design will facilitate a "whole person" approach, e.g., one that addresses coordination of physical and behavioral health care (like physician services, medications, mental health services, etc.) with social supports (like at-home chore services and personal care). The MLTSS Program will integrate the following services:

- Physical Health Care Services
- Pharmacy
- Dental
- Nursing Facility
- Hospice
- Behavioral Health Care Services
- Personal Assistance Services (PAS)
- Aged & Disabled (AD) HCBS Waiver Services
- Traumatic Brain Injury (TBI) Waiver Services

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<sup>4</sup> Clients receiving DD Waiver or any other state-funded DD services through the Division of Developmental Disabilities: DD Adult Day Waiver; DD Adult Comprehensive Waiver; DD Children's Waiver; DD AID state-funded service and on Medicaid; DD service coordination only and on Medicaid.

<sup>5</sup> SLMB clients only receive payment for Medicare Part B premiums.

<sup>6</sup> Similar to SLMB clients, QI-1 clients only receive payment for Medicare Part B premiums.

<sup>7</sup> MSP clients only receive payment for Medicare Part B premiums, co-insurance and deductibles.

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- Targeted Case Management<sup>8</sup>

### **Excluded Services**

Non-emergency transportation (except as currently included in Medicaid nursing home per diem payments for transportation to Medicaid-covered services) will not be integrated into the MLTSS program. These services will remain available via the existing delivery system. Early Development Network (EDN) services coordination for children age birth to 3 years old will also be excluded from the MLTSS benefit package. This is due to the special education regulations and the Early Intervention state statute. (The children remain on the MLTSS Program, however, so this presents potential challenges to the MLTSS MCOs to enable EDN to coordinate services provided through MLTSS.)

### **Program Administration**

Implementation of an integrated MLTSS Program is a complex undertaking. Nebraska Medicaid anticipates the need to redesign administrative operations, roles, and responsibilities to perform MLTSS MCO oversight roles. Many important program decisions are still under consideration. We continue to research best practices from successful programs in other states and to actively seek input from our stakeholders as we develop the Nebraska MLTSS Program.

### **Initial MLTSS Framework**

Nebraska Medicaid has developed an initial high-level framework for the program administration/change management issues that will support program implementation. The following sections offer a brief outline of this framework.

***Choice of MLTSS Managed Care Organizations.*** Through a competitive bidding process, Nebraska Medicaid will select two MLTSS managed care organizations (MCOs) in which clients can choose to enroll. The MLTSS MCOs will be responsible for service delivery and coordination,

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<sup>8</sup> As defined in the Nebraska Medicaid State Plan, Supplement 1 to Attachment 3.1A, <http://dhhs.ne.gov/medicaid/Documents/Part2.pdf>

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including contracting with Medicaid eligible providers, authorizing services, paying claims, etc.

**Program Eligibility.** Eligibility for the MLTSS Program will be limited to the target populations described earlier in this paper. Nebraska Medicaid will provide the MLTSS MCO with client eligibility data, including spend-down status as applicable.

- **Retrospective Eligibility.** The MLTSS MCOs will not be required to pay for services received before the date that Medicaid eligibility begins. The MLTSS MCOs will receive a capitation payment for the month in which the client was enrolled, regardless of the Medicaid eligibility date or the date of the client MCO selection. Fee-for-service (FFS) payment will be made for services received between the date that Medicaid eligibility was retroactively effective and up to the month in which the client is enrolled in MLTSS.

**Mandatory Enrollment.** MLTSS enrollment will be mandatory for clients in the target populations. Nebraska Medicaid will be responsible for client enrollment and disenrollment. Clients in the target populations may select from among two MLTSS MCOs; if clients do not select a plan within a specified time period, they will be auto-assigned to an MCO. Enrollment efforts are anticipated to begin September 1, 2016.

**Person-centered Processes.** The Nebraska MLTSS places strong emphasis on person-centered services. The individual being served is at the center of the process in planning for medical and non-medical services and supports. This includes the right to a clear explanation of service options, followed by choosing from among available services and qualified providers. When appropriate, families or representatives will also be involved in the process. As an active partner in the planning process, the individual and/or representative may choose to participate in service needs planning; provider selection; and evaluation of the quality of the services received. Nebraska Medicaid will hold the MLTSS MCOs responsible for ensuring that clients continue to have this type of direct involvement and choice to support quality of life and maximize independence.

**Client Safeguards.** The target populations for the MLTSS include vulnerable clients who may be at risk for abuse, neglect, or exploitation. To protect clients, health and welfare safeguards and

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protections and monitoring both the transition to MLTSS and ongoing program operation will be addressed in our program design. In addition, development of quality standards and oversight mechanisms will be critical elements of the program. Contracts will include requirements and reports to monitor appropriate health and welfare assurances; critical incident management to ensure reporting, investigation and remedy of suspected or actual abuse, neglect, etc.; and an appeals process that ensures continuation of services while an appeal is pending, as appropriate.

***Client Support.*** Clients and caregivers alike will need education and support during the transition to, and throughout their experience in the MLTSS program. Common support resources for clients, provided by the state at no cost, will include an advocate or ombudsman to help beneficiaries understand their rights, responsibilities and how to handle a dispute with the managed care plan or state. The MLTSS MCOs will also be required to provide significant education and assistance to clients and caregivers to ensure a successful transition.

***Transition Support.*** Nebraska Medicaid recognizes that support for clients and providers is critical to ensure a smooth transition to MLTSS. The shift will require significant changes in business practices by providers and managed care organizations alike, and they may have limited experience in this arena. Challenges such as complex contracting and negotiating, risk assessment, careful attention to accurate service pricing, adapting to new payment methods, ensuring continuity of care, etc., must be met. The MCOs and providers will also be called upon to help clients transition to the new care delivery system, and to fully understand their options and rights and responsibilities. In some states, MLTSS programs initially focused on basic operational objectives (e.g., "clients get services; providers get paid"); adopted practices to mitigate negative financial impacts on the existing LTSS provider network during the transition; and arranged for technical assistance to providers from state provider associations. Several "best practices" have emerged as a result of other programs' experiences, and Nebraska Medicaid will work with its stakeholders to discuss and define successful transition strategies.

***Level of Care (LOC) Determination.*** Standardized criteria will be used to determine the level of care required by the client. To eliminate

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potential conflicts of interest, the determination will not be conducted by the MCOs.

***Services Needs Assessment.*** Once the LOC is determined, the MLTSS MCOs will conduct the individual client needs assessment. A standardized, person-centered and state-approved instrument will be utilized to assess the client's physical, psychosocial, and functional needs.

***Benefit Package.*** The MLTSS benefit package will include the integrated services described earlier in this paper. As noted earlier, Targeted Case Management is included in the benefit package and will be provided by the MLTSS MCOs.

***Member Relations.*** The MLTSS MCOs will be responsible for member relations, including managing member information, communications, and grievances and appeals.

## ***Provider Participation***

- ***Provider Eligibility.*** All MLTSS providers must first be enrolled in Medicaid. (Nebraska Medicaid is responsible for Medicaid provider enrollment and termination.) MLTSS MCO provider eligibility and disenrollment will be managed by the MCOs. The MLTSS MCOs will be required to conduct additional provider credentialing activities. Nebraska Medicaid will require the MCOs to accept "any willing provider" of LTSS (i.e., nursing facilities, HCBS Waiver services and Personal Assistance Services providers, etc.) during the first year of the program.
- ***Provider Network Adequacy.*** Nebraska Medicaid will adopt network adequacy and access standard requirements. Provisions allowing clients to access out-of-network providers will be included to safeguard against capacity constraints.
- ***Provider Communications.*** Nebraska Medicaid is responsible for provider communications and outreach activities for all Medicaid providers, performing existing activities such as publishing Provider Bulletins, maintaining the Inquiry Line Help Desk function, etc. The MLTSS MCOs are responsible for provider communications with all MLTSS network providers, and will be expected to coordinate with Nebraska Medicaid to ensure consistent messaging.

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- ***MCO and Provider Payment Rates.*** The MLTSS MCOs will be paid a 'per member per month' (PMPM) capitation rate. Nebraska Medicaid will continue to set rates for nursing facility and assisted living services, Indian Health Services (IHS), and services provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs). The MLTSS MCOs are responsible for setting rates for other MLTSS services.

***Medicare Coordination.*** The Nebraska MLTSS program includes Medicaid services only, but the MLTSS MCOs are responsible for coordinating with Medicare regarding services and payments for dual enrollees, and is responsible for paying cross-over claims. (A crossover claim is a claim for a recipient who is eligible for both Medicare and Medicaid, where Medicare pays a portion of the claim and Medicaid is billed for any remaining deductible and/or coinsurance.)

***Claims and Encounter Processing.*** The MLTSS MCOs are responsible for claim and encounter processing, and for reporting encounter data to Nebraska Medicaid. The MLTSS MCOs are responsible for training providers on claims submission rules and requirements, payment schedules, etc.

***Financial Management.*** Nebraska Medicaid is responsible for financial management activities for Medicaid, including accounts receivable (A/R) management, estate recovery, cost settlement, managing A/R information and funds; and accounts payable (A/P) management including managing contractor payments, member financial participation, capitation payments, incentive payments, A/P information, and A/P disbursement.

The MLTSS MCOs will be responsible for certain fiscal intermediary functions (e.g., administration of third party liability (TPL) recovery, administration of individual provider taxes such as FICA and Unemployment, and other duties to be determined). Administration of institutional provider taxes will continue to be the responsibility of Nebraska Medicaid.

***Quality.*** Nebraska Medicaid will create a tailored quality program for all managed care programs including MLTSS. The strategy will include quality measures, statistical sampling where appropriate, mechanisms for tracking and aggregation of performance data, remediation and systems improvement efforts, and reporting quality outcomes. Quality

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outcomes will be publicly reported. The External Quality Review Organization (EQRO) will be utilized in the same manner as for the managed physical and behavioral health programs. The EQRO currently performs quality review and monitoring activities for the managed care program.

## **Accountability**

Nebraska Medicaid will develop and implement standards for the MLTSS MCOs. In developing other Nebraska Medicaid managed care models, Nebraska Medicaid has recognized the need to carefully monitor plan performance; award MCOs for stellar performance; and to impose sanctions as needed for unacceptable performance. Nebraska Medicaid intends to develop a rate methodology and contract requirements that will support the goals of the MLTSS Program. We seek feedback from stakeholders on specific performance measures and effective strategies for promoting high performance by the MCO and connecting plan performance with client outcomes. As we proceed with communicating MLTSS plans to stakeholders, Nebraska Medicaid is asking input from them in the following areas:

1. What should Nebraska Medicaid consider when developing managed long-term services and supports to improve the quality of health care and long-term services available to clients?
2. What should Nebraska Medicaid consider in order to increase client access to quality services?
3. How can Nebraska Medicaid and the selected managed care organizations work with providers to improve the quality of their service performance?
4. What can be done to increase clients' understanding of, and satisfaction with, coverage under managed long-term services and supports?
5. What can be done to improve clients' care continuity and ensure a safe and effective transition to managed long-term services and supports?
6. What are indicators of quality of life?

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### **Implementation**

Nebraska Medicaid anticipates implementing the MLTSS Program on July 1, 2015. As noted earlier, many program design issues remain to be resolved. Nebraska Medicaid will continue to reach out to clients, family members, advocates, providers and other stakeholders to solicit input on the design and implementation of MLTSS; hear concerns; and answer questions.

**For additional information, please visit our website at:**

<http://dhhs.ne.gov/medicaid/Pages/MLTSS.aspx>.

You may also contact us via email at: [DHHS.MedicaidMLTSS@nebraska.gov](mailto:DHHS.MedicaidMLTSS@nebraska.gov)

*Please use the above contact information to submit your questions and comments for creating a successful Nebraska MLTSS Program. We look forward to receiving your input.*