

# Medicaid Managed Long-Term Services and Supports

Presentation for Nebraska Health Care Association  
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Division of Medicaid and Long-Term Care  
Department of Health and Human Services



Nebraska Medicaid is in the process of developing a statewide Medicaid managed care program for the delivery of long-term services and supports. The targeted implementation date is January 2017.



## Current work of the Managed Long-Term Services and Supports (MLTSS) Operating Committee and Work Groups includes:

- Identifying implementation issues, developing program design, and writing Request for Proposal (RFP) requirements
- Evaluating Request for Proposal (RFP) recommendations received from stakeholder organizations
- Complying with the Centers for Medicare and Medicaid Services' (CMS) 10 "essential elements"



### Regarding work groups:

- Information Systems work group is considering all the changes and adaptations needed to the Medicaid Management Information System (MMIS), N-FOCUS, and a software program called CONNECT in which level of care determinations reside.
- Enrollment & Benefits work group is developing a plan for enrolling clients into managed care during the transition to MLTSS. They will also be writing the RFP business requirements pertaining covered services in the benefits package.
- Stakeholder & Education work group is developing a plan to continue to obtain stakeholder input into the design of the program, as well as stakeholder education throughout the transition period leading up to "go-live".
- Reimbursement group is tasked with developing the capitation rates. The work of this group will involve basing capitation rates upon the most current information available.
- In compliance with CMS' directive that states develop a comprehensive quality strategy, the Quality work group has identified numerous sources of quality measures and is discussing how to align them into a manageable approach to quality monitoring and oversight.
- Operations and Change Management work group is considering the impact of MTLSS implementation upon the various contracts Nebraska Medicaid holds, as well as potential shifts in work responsibilities among Division staff.
- Care Coordination work group is identifying level of care assessment processes and considering comprehensive assessment options.
- Provider Enrollment & Education work group is considering the best way to educate providers regarding MLTSS and to facilitate their enrollment in MCO networks, as well as

establishing standards for an adequate network.

Regarding RFP recommendations received from stakeholder organizations:

- We have received correspondence from several professional associations in Nebraska recommending requirements to be included in the MLTSS RFP.
- We are carefully evaluating the recommendations by charting each issue raised in each letter and the association's desired action.
- We are determining whether the issue should be addressed as a RFP requirement or a check point for readiness reviews to be conducted prior to "go-live".
- Nebraska Medicaid may not have the authority to implement some recommendations.

## RFP Recommendations received from the Nebraska Health Care Association (NHCA):

- Achieve savings as a result of increased care coordination and better consumer health outcomes rather than reducing provider rates, withholding approval of services, or limiting access
- Prevent managed care organizations (MCOs) from refusing to enroll in their provider networks specialized service providers who serve high risk, high cost populations
- Provide a DHHS appeals process for providers who are denied network enrollment or service authorization



### Bullet #1

Cost savings is not an initial goal of Nebraska Medicaid MLTSS. The goal is to use financial resources wisely to sustain Nebraska Medicaid. MLTC's expectation is that savings will be realized over time as the result of increased care coordination and better consumer health outcomes. Facility rates will continue to be set by MLTC. Other providers will need to negotiate their rates with the MCO. Contract managers will be overseeing MCOs to ensure they are not withholding approval of services and/or limiting access to services through other means.

### Bullet #2

Federal regulations prohibit discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 CFR 438.214 (c))

The RFP will have requirements for network adequacy.

The RFP will require the MCOs to contract with "Any willing provider of LTSS" for the first year of contract.

### Bullet #3

DHHS allows providers to appeal denial of enrollment as Medicaid providers. Providers will have the right to appeal their network participation with the MCO, but this is not a Medicaid agency function.

Clients have the right to request a state fair hearing and/or appeal to the MCO if services are not authorized.

## RFP Recommendations received from NHCA cont'd:

- Ensure consumers make an informed choice to leave facilities and that safe and appropriate community services have been arranged by the MCO
- Ensure MCOs facilitate safe transitions from facility to community living
- Require MCO payment for out-of-network providers in identified situations
- Establish provider access standards specific to the distance the client must travel
- Allow clients to change MCOs at any time



### Bullets #1 and #2

The RFP will include requirements regarding person-centered planning. The MCO will be required to provide care coordination including a safe transition to the community. MFP services will be available to facilitate the transition from NF to community living for eligible clients.

### Bullet #3

The MCO will be required to operate a network to cover the service needs of clients.

The FAQ document posted on the MLTSS website states that if a client's medical provider is not in a MCO's network, s/he will need to choose a provider from within their network.

The RFP will define circumstances when out of network coverage/single case agreement is required. This will include services being necessary but not available in the MCO's network.

The MCO will be required to pay out of network during transitions, such as FFS to managed care or a change of MCOs to ensure continuity. The provider will need to be a Nebraska Medicaid enrolled provider.

### Bullet #4

The RFP will have requirements for network adequacy. By federal regulation, the geographic location of providers and Medicaid enrollees must be considered, taking into account distance and travel time, etc.

Bullet #5

DHHS doesn't allow clients to change MCOs at any time. Clients may change health plans if there is a "for cause" reason. Otherwise, they may change during the first 90 days after enrollment and annually thereafter.

All providers will be encouraged to enroll in both MCOs' networks.

MCO enrollment is monthly. Therefore, if a client moves to a different facility that is not in the MCO's network mid-month, the contract will require the MCO to pay the new facility out-of-network during the transition.

## RFP Recommendations received from NHCA cont'd:

- Require MCOs to enroll any willing provider into their networks throughout the length of the MCOs' contracts
- Ensure that smaller, non-profit, non-corporate providers can be enrolled into MCO provider networks
- Require MCOs to tender at least three contract offers (if necessary) at a rate of reimbursement at or above the Medicaid Fee For Service (FFS) rate
- Ensure that the administrative burden upon providers be lessened by specified processes



### Bullet #1

The MLTSS Steering Committee will consider any willing provider of LTSS throughout the three-year contract period.

### Bullet #2

There will be a number of MLTSS providers serving only a few Medicaid clients, including smaller, non-profit providers. (The MLTSS Steering Committee will consider any willing provider of LTSS throughout the three-year contract period.)

### Bullet #3

Nursing and assisted living facility rates will continue to be set by MLTC.

### Bullet #4

The specified processes included:

- a. Reduce or simplify provider enrollment requirements - MCOs must minimally meet the credentialing requirements placed upon them by their accrediting body.
- b. Use simplified, standardized claim forms (require each MCO to use the same claim form) with easy instructions - Facilities will have to use the standardized claim forms used currently.

- c. Accept paper and electronic processing - MCO acceptance of both paper and electronic processing will be a RFP requirement.
- d. Streamline claims processing -A streamlined work flow already accompanies standardized claim forms, and MCOs will be expected to use it.
- e. Streamline service authorization process - MCOs have the administrative flexibility to determine for which services they will require prior authorization and the process.

## RFP Recommendations received from NHCA cont'd:

- Require the MCOs to establish Provider Advisory Councils
- Require continuation of services and provider payments if an appeal is filed within 30 days of notice of action
- Require prompt payments
- Require performance reports to be made public in an easy to understand and useful format
- Require provider technical assistance during transition to MLTSS and upon request after implementation
- Require a Nebraska-based representative to provide assistance to providers



### Bullet #1

Establishing a provider advisory council, composed of all provider types and meeting monthly for the first year and at least thereafter, will be a RFP requirement.

### Bullet #2

Federal regulation speaks to the duration of continued benefits upon appeal. (See 42 CFR 438.420 (c)) If a client appeals to the State within 10 days of the MCO's notice of action, benefits may continue until a State fair hearing decision is reached.

### Bullet #3

Federal regulation defines timely payment of claims which will be a RFP requirement. Nebraska Medicaid will have performance measures and contract incentives related to exceeding timely payment. (NHCA suggested that a claim be deemed "clean if the provider is not notified of the problem within 15 business days - The MCO will be required to follow federal definitions of clean claims.)

### Bullet #4

By federal regulation (42 CFR 438.365 (b)) information produced by the EQRO must be made available to interested parties. Nebraska Medicaid plans on posting data regarding MCO performance.

Bullet #5

The RFP will require provider education and technical assistance to facilitate a smooth transition and after implementation.

(NHCA suggested that technical assistance be provided within 2 business days to providers with claim processing difficulties - The Provider Enrollment and Education Work Group will discuss whether this specific of a requirement will be in the RFP, in the context of all provider support needs.)

Bullet #6

This will be an RFP requirement.

## RFP Recommendations received from NHCA cont'd:

- Require MCOs to establish a web-based means to check client enrollment and claims status
- Develop pay-for-performance quality standards based upon specified measures
- Require DHHS to continue to contract with Area Agencies on Aging (AAA) and the League of Human Dignity (LHD) to conduct level of care assessments
- Require the MCOs to contract with the AAAs and LHD to determine Aged and Disabled and Traumatic Brain Injury Waiver eligibility and care plan development



### Bullet #1

a) Consumer enrollment is not a MCO based activity. Any provider can be given access to MMIS to view MCO choice or assignment.

b) The MCO will be required to provide service authorization information to providers. A requirement that this be via automated/web based system will be considered.

c) The MCO will be required to provide claims status information to providers. A requirement that this be via automated/web based system will be considered.

### Bullet #2

Incentives will be part of the RFP, and we will take into consideration the five measures recommended. (The 5 measures recommended were timely claims processing, provider grievances, client/provider appeals, customer service, and services authorization.)

### Bullet #3

These recommendations match recommendations that will be forwarded to the MLTSS Steering Committee; however, we have received direction from CMS suggesting agencies not have multiple roles (LOC determination, services coordination, ombudsman, etc.) in MLTSS due to conflict of interest issues.

Bullet #4  
Same as Bullet #3.

## RFP Recommendations received from NHCA cont'd:

- Require the MCOs to contract with the AAAs and LHD to provide ongoing care coordination
- Require the MCOs to establish an office in Nebraska employing existing Nebraska personnel, including a Nebraska physician to serve as Medical Director for MLTSS
- Require the MCOs to reimburse alternative service providers for valued added services
- Prohibit the MCOs from imposing more stringent requirements upon service providers than Nebraska and federal provider requirements and standards



### Bullet #1

As stated on prior slide, these recommendations match recommendations that will be forwarded to the MLTSS Steering Committee; however, we have received direction from CMS suggesting agencies not have multiple roles (LOC determination, services coordination, ombudsman, etc.) in MLTSS due to conflict of interest issues.

### Bullet #2

A local presence will be required which will include a medical director who will have a Nebraska license and will be specifically assigned to the MCO's Nebraska Medicaid line of business.

### Bullet #3

Value added services will be allowed and MCOs must propose what value added services they plan to provide.

### Bullet #4

Federal regulations allow the MCO to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees. (42 CFR 438.12 (b) (3))

## RFP Recommendations received from NHCA cont'd:

- Allow for the option of MCOs to share risk with a provider or group of providers



Nebraska Medicaid continues to seek guidance from CMS about this recommendation.

## Nebraska Medicaid’s response to CMS’ “Essential Elements” of Effective Managed Long-Term Services and Supports (MLTSS) Programs:

1. Adequate Planning and Transition Strategies
  - Delayed implementation date
  - Scope of Work of each Work Group
  - Technical assistance from CMS
  - Readiness reviews
  - Rapid identification and resolution of MLTSS problems
  - State oversight before, during, and after transition to MLTSS



## “Essential Elements” cont’d

### 2. Stakeholder Engagement

- State established advisory council has met four times since last fall
- Ten town hall meetings in eight communities last fall
- State website with information about the MLTSS program initiative: <http://dhhs.ne.gov/medicaid/Pages/MLTSS.aspx>
- Web-based input via on-line stakeholder survey



## “Essential Elements” cont’d

### 3. Enhanced Provision of Home and Community- Based Services (HCBS)

- Services provided in the most integrated setting possible

In spite of this emphasis on the enhanced provision of HCBS, research and analysis indicates the impact of managed care upon nursing facilities will be mitigated by the growth rate of Nebraska’s elderly population.



## Impact on Nursing Facilities

According to AARP Public Policy Institute's paper, "2012 Profile of Nebraska Long-Term Services," there will be 66% more Nebraskans over the age of 75 in the next 20 years due to aging baby boomers and people living longer. This will have a significant impact on Nebraska's State General Fund if the number of Medicaid recipients receiving LTSS increases at the same rate.

## Impact on Nursing Facilities cont'd

Projected Growth of Nebraska Medicaid LTSS Recipients Under Two Scenarios:

<b>Scenario #1: Status Quo (Aging Effect <i>without</i> Managed Care)</b>			
	Custodial members	HCBS Members	Nursing Facility Mix
Current	n/a	n/a	41%
5 years	25%	26%	41%
10 years	44%	49%	40%
15 years	56%	64%	40%
20 years	63%	74%	40%



## Impact on Nursing Facilities cont'd

Scenario #2: Managed Care (Aging Effect <i>with</i> Managed Care)			
	Custodial Members	HCBS Members	Nursing Facility Mix
Current	n/a	n/a	41%
5 years	-2%	37%	33%
10 years	4%	72%	30%
15 years	10%	99%	28%
20 years	15%	119%	27%



After 20 years, the implementation of managed care still shows a 15% increase in Medicaid NF residents as compared to the current year of status quo. The growth rate of HCBS members increases more under managed care, but the cost of these members in the community is far less than in nursing homes so the overall savings is substantial as compared to status quo. It takes managed care programs 15 to 20 years to fully mature.

## Impact on Nursing Facilities cont'd

In summary, the managed care impact to nursing facilities will be mitigated by the growth rate of Nebraska's elderly population.

Nursing facilities will still care for 15% more Medicaid nursing facility clients in 20 years as compared to today. Coupled with the baby boom effect on non-Medicaid payers, nursing facilities will care for 41% more members in 20 years (which includes a 66% increase in Medicare and private pay residents).

Research and analysis conducted by Todd Galloway, Actuary, JS3 Consulting



## “Essential Elements” cont’d

### 4. Alignment of Payment Structures and Goals

- Delivery of community-based care
- State oversight and evaluation of payment structures to evaluate:
  - Whether or not the structures are supporting the goals of the MLTSS program:
    - Improve client health status and quality of life by better coordination of medical care, behavioral health care, and community-based services and supports
    - Promote client choice and use of the right services and supports at the right time in the right amount
    - Increase client access to responsive, quality services and supports
    - Use financial resources wisely to sustain Nebraska Medicaid
  - Whether or not the structures are allowing client access to quality providers



## “Essential Elements” cont’d

### 5. Support for Beneficiaries

- Independent, conflict-free eligibility determination and functional assessment process
- Availability of independent ombudsman program

### 6. Person-centered Processes

- Standardized, person-centered and state-approved instrument to assess client needs
- Person-centered service planning process that promotes:
  - Use of self-determination principles
  - Active engagement of the client and individuals of their choice
- Service plan reflects the client’s or caregiver’s needs and preferences



#5, bullet 1: Which entity(ies) will conduct assessment process continues to be under consideration.

#5, bullet 2: Long-Term Care ombudsman. How this will be operationalized continues to be determined.

#6, bullet 1: Whether the instrument is prescribed by the state or each MCO chooses their own instrument to be approved by the state continues to be considered.

## “Essential Elements” cont’d

### 7. Comprehensive, Integrated Service Package

- Physical and behavioral health care, dental care, and pharmacy will be included in the benefits package
- Comprehensive needs assessment

### 8. Qualified Providers

- State specified provider network composition and access requirements
- Minimum provider qualification and credentialing requirements
- Provider support during transition to MLTSS



#8, bullet 1:

- a. We continue to research access requirements and are consulting with an expert in MCO network composition.
- b. We will require “any willing provider” of LTSS for the first MCO contract year
- c. We will require standards around payment of claims

#8, bullet 2: Minimally, MCOs must use the credentialing requirements placed upon them by their accrediting organization.

#8, bullet 3: MCOs will be required to work together with the State to develop a plan that will educate providers about the network enrollment process, authorization and claim submission procedures and practice billing sessions. Other technical assistance requirements are under consideration.

## “Essential Elements” cont’d

### 9. Client Protections

- Statement of client rights
- Critical incident reporting system
- Complaints process
- Appeal rights



#9, bullet 2: The requirements for the critical incident reporting system are under consideration.

#9, bullets 3 & 4: Complaint processes and appeals rights are federally required.

## “Essential Elements” cont’d

### 10. Quality

- Comprehensive Medicaid managed care quality strategy that is integrated with other relevant State quality initiatives and includes quality measures
- Use of State External Quality Review (EQR) process
- Mandatory managed care organization reports related to the critical elements of MLTSS such as network adequacy; client health and functional status; and appeal actions
- Measurement of key experience and quality of life indicators



#10, bullet 1: The required quality measures are under consideration.

#10, bullet 2: The Island Peer Review Organization (IPRO) is Nebraska Medicaid’s EQRO

Input can continue to be provided via a stakeholder survey at

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

or email

[DHHS.MedicaidMLTSS@nebraska.gov](mailto:DHHS.MedicaidMLTSS@nebraska.gov)

