

CONTENTS

1. Executive Summary	1
• Address High-Priority Systemic Issues in the Current LTC System	2
• Transition to a MLTSS Delivery System	2
• Continue to Pursue Other Recommended System Changes	2
• Seven Key Themes Emerged from the Stakeholder Feedback.....	2
2. Background.....	4
• Nebraska Multimodal Stakeholder Engagement	5
• Participating Stakeholders	6
• Stakeholder Listening Sessions.....	7
3. Key Themes.....	9
• Cost.....	9
• Timeframes	10
• Concern with Heritage Health MCOs.....	10
• Quality	11
• Communication with LTC Stakeholders	12
• Outstanding Design Decisions.....	12
• Caregivers.....	13
4. Long Term Care (LTC) Redesign Considerations: High-Priority Systemic Changes	14
• Build an effective navigation system for LTC using a NWD Model.....	14
• Ensure Consistent and Fair Determinations for Medicaid LTC using a Standardized Assessment System.....	16
• Establish the Infrastructure to Support Consumer Self-Direction, PAS Program and Independent Providers	17
• Align DHHS Functions for Maximum Performance	20
• Improve Assurance of Health and Safety for EFH Residents.....	22
5. Transition to Managed Long Term Services and Supports (MLTSS) Delivery System.....	23
• Innovative Approaches to Delivering Medicaid Supports and Services	25
• Shift Focus of Care to Community Settings While Preserving Institutional Settings.....	25

- Accountability Rests with a Single Entity 25
- Administrative Simplification 25
- Budget Predictability 25
- Stakeholder Feedback..... 26
- Develop a Detailed Implementation Plan 28
- Execute and Monitor Implementation Plan 30
- Timing 31

6. Other Recommended Changes 32

- Implement a Systematic Way to Reassess Consumers 32
- Increase Awareness of the Medicaid Buy-In Program and Other Employment Programs for Workers with Disabilities 32
- Improve Coordination and Services for Children Aging out of the Educational System..... 33
- Address Issues in the Provider Enrollment Process..... 33
- Establish a Process to Rebase Home and Community-Based Services (HCBS) Rates More Frequently 33
- Other Issues That Were Not Addressed 34

Appendix A: Acronym Dictionary 35

1

Executive Summary

The Nebraska Department of Health and Human Services (DHHS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to assist in the redesign of its long term care (LTC) system. Mercer subcontracted with the National Association of States United for Aging and Disabilities (NASUAD) to engage the public, including consumers, caregivers and providers, in providing input and information regarding the issues of concern associated with the current LTC system. The feedback obtained from the stakeholder engagement opportunities, along with an assessment of the LTC system, will form the foundation for the Final LTC Redesign Plan. The following document reflects the findings, comments and statements of the stakeholders in the second round of stakeholder engagement activities on the Draft LTC Redesign Plan from March through April 2017. The authors did not validate any of the concerns expressed.

From March through April 2017, Nebraska providers, consumers, policymakers, advocates, academics and other stakeholders involved in the LTC system engaged in a robust conversation about the Draft LTC Redesign Plan. The Draft LTC Redesign Plan was available for public review beginning in March 2017 on the Nebraska Department of Health and Human Services Long Term Care Redesign Project website.¹ A multi-pronged approach to stakeholder engagement was used to obtain feedback on the document that included: LTC Redesign Advisory Council (LTC Advisory Council) meetings, key informant interviews, onsite listening sessions across the State of Nebraska (State), webinars, video conferences, emails, phone calls and the use of social media. The consultants who conducted the first round of stakeholder engagement in 2016 conducted the subsequent sessions through March and April 2017.

Stakeholders were asked to comment on the three major focus areas of the Draft LTC Redesign Plan: 1) Address high-priority systemic issues in the current LTC system; 2) Transition to a managed care long term services and supports (MLTSS) delivery system; and 3) Continue to pursue other recommended system changes. Highlights of each of these areas are outlined below.

¹ <http://dhhs.ne.gov/medicaid/Pages/LTCResources.aspx>

Address High-Priority Systemic Issues in the Current LTC System

Through a careful review of Nebraska's existing LTC system, including soliciting feedback from a wide variety of stakeholders in the current system, the following items were identified as key priorities for the redesign of Nebraska's LTC system:

- 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 a MLTSS Delivery System

In addition to the high-priority issues described above, the Draft LTC Redesign Plan calls for transitioning to an MLTSS delivery system to address other key systemic 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. The recommendation is to build the MLTSS system using the existing infrastructure of the Heritage Health program. The Draft LTC Redesign Plan also includes a recommendation that DHHS undertake a careful planning and design process, with significant ongoing stakeholder engagement, to ensure the MLTSS system 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 the Draft LTC Redesign Plan calls for resources to be focused on these two areas, there are additional system changes that DHHS should continue to pursue as resources allow:

- Implement a systematic way to reassess consumers
- Increase awareness of the Medicaid buy-in and other employment programs for consumers with disabilities
- 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

Seven Key Themes Emerged from the Stakeholder Feedback

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

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

Changes will be made to the Draft LTC Redesign Plan based on stakeholder feedback. The Final LTC Redesign Plan will be submitted to DHHS in late June 2017.

2

Background

The Department of Health and Human Services (DHHS) posted the Draft Long Term Care (LTC) Redesign Plan, dated March 7, 2017 on the Long Term Care Redesign Project website for public comment.² Shortly thereafter, DHHS began stakeholder engagement on the Draft LTC Redesign Plan, led by the National Association of States United for Aging and Disabilities (NASUAD). Stakeholder engagement should be meaningful, inclusive and transparent, and managed throughout the life cycle of the reform initiative. To ensure these principles apply to the stakeholder engagement process for the Draft LTC Redesign Plan, NASUAD employed a multimodal system of stakeholder engagement that included face-to-face meetings, public listening sessions, LTC Redesign Advisory Council (LTC Advisory Council) meetings, social media, webinars, telephone calls, emails and key informant interviews.

NASUAD began the second round of stakeholder engagement for the Draft LTC Redesign Plan in March 2017. NASUAD hosted a webinar for the LTC Advisory Council in early March 2017, outlining the next round of stakeholder sessions and formally launching the Draft LTC Redesign Plan. NASUAD asked the LTC Advisory Council members to forward materials and disseminate information about the stakeholder meetings to their distribution lists and colleagues. NASUAD also asked members of the LTC Advisory Council to share additional contacts who should be included in distribution lists.

In late March 2017, Mercer and NASUAD interviewed key informants about the Draft LTC Redesign Plan and solicited ideas for changes to the report. Key informants included DHHS leadership and staff, aging and disability advocacy groups the Nebraska Planning Council on Developmental Disabilities and the three Heritage Health Managed Care Organizations (MCOs).

NASUAD convened listening sessions across Nebraska during March and April 2017 to ask individuals their opinions about the Draft LTC Redesign Plan. DHHS selected locations for the listening sessions that represented all regions of the State. DHHS advertised public sessions in multiple ways, including posting on the Long Term Care Redesign Project website, contacting media in each town and reaching out to key stakeholders, including members of the LTC Advisory Council. Additionally, NASUAD sent an email message to each stakeholder who participated in stakeholder events in the fall of 2016 announcing the dates for the new listening sessions and providing a link to the Draft LTC Redesign Plan.

² <http://dhhs.ne.gov/medicaid/Pages/LTCResources.aspx>

Nebraska Multimodal Stakeholder Engagement



Listening Session Locations

Date	City
March 20, 2017	Lincoln
March 21, 2017	Norfolk
March 22, 2017	Fremont
March 23, 2017	Omaha
March 27, 2017	Grand Island
March 28, 2017	Kearney
March 29, 2017	North Platte
March 30, 2017	Gering

In addition to the statewide listening sessions, NASUAD conducted two public webinars on March 28, 2017 during the afternoon, and on March 29, 2017 in the evening. These webinars were open to any interested member of the public. NASUAD also hosted additional webinars for broader interest groups, as requested. A combined video webinar was held for the two Nebraska nursing home associations: Leading Age and Nebraska Health Care Association members, with total attendance of nearly 90 individuals. NASUAD hosted separate conference calls with all three

Heritage Health MCOs, service providers and vendors of LTC services, and Nebraska caregivers and consumers. NASUAD hosted two additional conference calls/webinars: one for providers of services to individuals with intellectual and development disabilities (I/DD), and a second for the families and caregivers of individuals with traumatic brain injury (TBI) and brain injury who reside in the community.

In each of the cities where listening sessions were held, NASUAD staff also took the opportunity to visit with groups that requested meetings. NASUAD worked with DHHS and the LTC Advisory Council for suggested places to visit and made every attempt to accommodate all invitations that were extended. In Kearney, North Platte and Gering, meetings were held with Area Agencies on Aging (AAA) staff.

NASUAD also monitored two email boxes where comments were posted. One email box was on the Long Term Care Redesign Project website and the second was hosted by NASUAD. NASUAD reviewed all emailed comments and summarized them in this report.

NASUAD also communicated with stakeholders via phone (providing a Google voicemail number to receive messages about the Draft LTC Redesign Plan) and social media (sending tweets and Facebook updates regularly throughout the onsite listening sessions).

Participating Stakeholders

Key to the success of any stakeholder engagement is ensuring a broad cross-section of stakeholder participation. NASUAD worked collaboratively with DHHS to develop a broad distribution list of consumers, advocates and providers. NASUAD urged the members of the LTC Advisory Council to share the dates and locations of the stakeholder meetings with their constituents.

A sample of the stakeholders who participated in the various stakeholder opportunities is listed below.

Legal Aid Staff	Seniors	Individuals with Disabilities
Medicaid Consumers	Meals on Wheels volunteers	Trade Associations
Medicare Consumers	AAA Staff	Service Providers
Consumer Advocates	Services Coordinators	State Legislators
Caregivers	Centers for Independent Living Staff	Personal Care Attendants
Pharmacists	Physicians	Assisted Living staff and Directors
Home Health Aides	Rehabilitation Facility Staff	Specialty Hospital Staff
Congressional Staff	Veterans	Senior Center Staff
Hospital Administrators	Nebraska Taxpayers	DHHS Staff
Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants	Substance Use Disorder Counselors	Nursing Home Administrators and Staff
Managed Care Organization staff and leadership	Mental Health Counselors	Local Medicaid Staff

Stakeholder Listening Sessions

NASUAD created two slide decks and a discussion guide for the listening sessions. One slide deck was designed for professionals in the LTC field, and the second slide deck was a more consumer-friendly version of the meeting materials. The discussion guide was also created for use in smaller groups and included a form commenters could complete to provide their feedback. (Copies of the PowerPoint presentations and discussion guide are available on the Long Term Care Redesign Project website.) Additionally, stakeholders requested a guide to the acronyms included in the Draft LTC Redesign Plan; that document was available at all listening sessions, as well as online.

The agenda for the listening sessions was divided into the three sections, with breaks after each section to solicit stakeholder input, answer questions and engage with the audience. The three main areas addressed in the listening sessions were:

- High-priority systemic issues in the current LTC system
- Transition to a managed long term services and supports (MLTSS) delivery system
- Other lower-priority recommended system changes

Stakeholders and the LTC Advisory Council members shared early in the stakeholder engagement process that they did not believe the initial deadline of April 14, 2017 for providing comments on the Draft LTC Redesign Plan provided sufficient time for thoughtful comments on a

long and detailed plan. In response, DHHS extended the deadline for submitting comments until May 1, 2017.

3

Key Themes

Stakeholder appreciation for the new administration and the positive strides taken to improve the system remained strong throughout our visits in March and April 2017. There continued to be broad agreement that the Nebraska Department of Health and Human Services (DHHS) is committed to improve the long term care (LTC) system design and function. It was apparent that stakeholder input was being heavily influenced by the current changes in the Medicaid program — in particular, the implementation of Heritage Health — during the time in-person stakeholder sessions were held.

Seven key themes emerged from the conversations with stakeholders:

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

Cost

There are significant cost implications for some of the recommendations and uncertainty about the resources DHHS would be given to implement them.

Many of the groups participating in the stakeholder feedback process were supportive of components of the Draft LTC Redesign Plan, but were concerned about the cost of the system updates. For example, the Area Agencies on Aging (AAA) and the League of Human Dignity both expressed support for the “no wrong door” (NWD) system, but also shared that this system cannot be built without a substantial upfront investment in technology at both the State and local levels.

Stakeholders were concerned that the State would be able to make the necessary investment in order to ensure that the recommended changes can be implemented successfully.

Timeframes

The proposed dates for MLTSS implementation are too aggressive and do not sync with the time it will take to implement the other systemic initiatives.

Stakeholders expressed concerns that the timelines outlined in the LTC Redesign Plan were too aggressive, in particular those for implementation of MLTSS. Not surprisingly, because Congress was debating repeal and replace options for the Affordable Care Act during the time of the stakeholder sessions, stakeholders were keenly aware of and concerned about how federal Medicaid policy would impact the LTC Redesign Plan and Nebraska's Medicaid program overall, especially as it relates to the timeframes and costs of the LTC system. Additionally, stakeholders expressed the strong desire that the priority recommendations be implemented before moving to MLTSS.

Concern with Heritage Health MCOs

There is anxiety about the move to managed care for LTC consumers due to difficulties in the early months of implementation that started in January 2017.

The consolidation of three programs (behavioral health, physical health and pharmacy) into the new Heritage Health program and the enrollment of individuals with disabilities and seniors into MCOs occurred on January 1, 2017. As with any large-scale system change, some challenges have been experienced by LTC consumers enrolled in Heritage Health and these challenges were shared widely during our stakeholder listening sessions. Under the State's prior managed care program, consumers receiving LTC services were excluded from enrollment, and so are now experiencing managed care for the first time under Heritage Health.

That context explained the confusion expressed by stakeholders about the migration to Heritage Health. They did not understand that Heritage Health is the name of Nebraska's Medicaid managed care program and that there are three separate managed care plans operating under Heritage Health. Further, a number of consumers were unable to identify the MCO they were enrolled in. Many shared that they wish that the State had provided more hands-on guidance when they were selecting plans.

Consumers also reported some transition issues with the migration to the new Heritage Health program. Some examples of issues included:

- Cards have the wrong providers listed.
- Some specialists are not accepting the cards, even though they previously had.
- YMCA coverage/Weight Watchers coverage is slow to happen.
- Lack of smooth transfer for consumers with guardians.

There was also widespread concern from stakeholders that the MCOs' appeared to have limited understanding of the LTC needs of the populations new to managed care. Specific examples shared by stakeholders included not knowing basic acronyms for disability programs and services, a lack of understanding of current tools and technology to assist individuals with disabilities, and difficulty understanding mobility challenges.

There was also concern about changes in covered services under Heritage Health. Of specific concern were the new limits on the number of incontinence supplies, changes in durable medical equipment providers and supply limits, and other new prior authorization requirements. Due to the fact that many consumers receiving LTC have difficulty finding accessible transportation, they also expressed concerns about the new mandate for 30-day fills for prescriptions rather than the 90 days they were able to get under fee-for-service (FFS). Moreover, there was a high level of frustration about the requirement for step therapy (trying first-line medications before moving to more specialized and typically more expensive medications). For consumers who had been stable on existing medications, this has caused significant anxiety and effort.

The three MCOs and DHHS were able to respond to specific consumer concerns while at the various stakeholder events and followed up with consumers after the events. Additionally, on April 3, 2017, DHHS and the MCOs shared with the LTC Advisory Council the steps they had taken to rectify the concerns listed above, as well as other systemic issues that were raised in the first three months of Heritage Health.

Finally, it was clear that the difficult transition to managed care in Iowa heightened the concern of consumers and providers. Several providers that operate in both Iowa and Nebraska shared details about the issues they are encountering there.

Quality

The State needs to measure the quality of the current LTSS system so it can ensure that any proposed changes improve outcomes.

Stakeholders expressed concern about the lack of a specific recommendation on quality in the Draft LTC Redesign Plan. They shared their desire to understand where the State currently ranks in terms of the quality of care in the system, as well as how the State will ensure it not only maintains quality, but improves it. Providers expressed concern that the quality of services currently offered would not be maintained in an MLTSS system. The MCOs all agreed that the State should develop and implement a quality framework.

Additionally, stakeholders requested DHHS share background data on where the State currently ranks in terms of LTC expenditures, services provided, etc. AARP requested that the State consider a series of studies to "benchmark" Nebraska's LTC system. The studies that they requested included: a systemic review of consumer direction in LTC programs; an analysis of the benefits of and the barriers to creating integrated LTC providers in rural communities; a review of the existing working relationships between the LTC system and the medical service delivery system; and an analysis of the impact of family caregivers on Medicaid spending. All of the

studies requested by AARP are designed to better understand the current state of LTC in Nebraska.

Communication with LTC Stakeholders

The State needs to continue robust communications with stakeholders.

Stakeholders at many of the listening sessions indicated they believe there was a lack of awareness about the LTC Redesign effort among consumers and families. Part of this concern was associated with their feeling that they did not have as much information as they would have liked in the migration to Heritage Health. Stakeholders also expressed concern that the State was not sharing information with the LTC community in methods that were targeted to their needs. There was more vocal concern among family members and caregivers of consumers with intellectual and development disabilities (I/DD) about the lack of information on the LTC Redesign Plan.

There was widespread fear among many consumers with disabilities that the LTC Redesign Plan and the migration to MLTSS, coupled with potential changes at the federal level, would result in moving large populations of individuals with disabilities back into institutions. Consumers and families caring for loved ones with brain injury and traumatic brain injury (TBI) expressed concern that specific programs to meet their needs were not included in the Draft LTC Redesign Plan. Disability Rights Nebraska supported the recommendation that engagement with stakeholders is critical to the successful and accountable operation of the program, but they urged the State to consider a clearer definition of stakeholders and to include agencies that serve persons with behavioral health care needs.

The LTC Advisory Council requested monthly meetings with DHHS as they begin to implement the various components outlined in the LTC Redesign Plan. Others suggested that a separate stakeholder group be set up for each recommendation to help guide the State's efforts.

Outstanding Design Decisions

The "open questions" regarding specific redesign decisions are causing anxiety.

For every recommendation included in the Draft LTC Redesign Plan, DHHS will have to make design decisions — the "who, when, where, what" that will underpin implementation. For example, to establish the proper infrastructure to support consumer direction, decisions will need to be made regarding the choice of a Financial Management Services Agency (FMSA), as well as its role with regard to the State's enrollment broker. The State will also need to decide how both will interact (or not) with an Electronic Visit Verification (EVV) system. Consumers and providers wanted more detailed information about how the recommendations would be implemented than could be provided at that time. As a result of not having more detailed answers, stakeholders felt uneasy with the recommendations. It will be imperative that stakeholders are engaged throughout the process — as design decisions are made — to help to allay their concerns, seek their feedback and ensure they are engaged throughout the process.

Caregivers

Unpaid caregivers are the backbone of the LTC system and without their continued support the system would fail. The State needs to find additional ways to support the caregivers.

Family caregivers participated in all eight public listening sessions. Their needs covered the gamut, such as respite, assistance navigating the system and having someone they could call who could explain Heritage Health. Some participants in the listening sessions shared heartbreaking stories of caregivers who had lost their jobs, lost their homes and damaged their own health, in order to care for a loved one. An overwhelming sense of exhaustion among the caregivers was clear and evident.

Regrettably, national statistics show that one in ten seniors 65+ are abused and in 60% of those cases, the abuse — typically neglect — is at the hands of a caregiver. In addition to the human toll, this abuse is reported to add an additional \$5.3 billion in medical spending across the country. Further studies have reported that interventions such as providing information, support groups, adult day programs, access to support telephonically and respite can dramatically reduce abuse, and furthermore, allow the caregiver to continue to provide care for the individual in the home at a much lower cost to the system.³

Those caregivers/stakeholders were fierce advocates for the individuals in their care, as well as for the LTC system overall. AARP estimates that family caregivers in Nebraska provide 182 million hours of care at a savings of \$2.5 billion.⁴

³ <https://ncea.acl.gov/whatwedo/research/statistics.html#perpetrators>

⁴ <http://states.aarp.org/nebraska-family-caregivers-provide-2-5-billion-in-unpaid-care/>

4

Long Term Care (LTC) Redesign Considerations: High-Priority Systemic Changes

The stakeholder engagement sessions provided an opportunity to obtain feedback on the recommended five high-priority systemic changes. The five high-priority systemic changes were selected out of the list of 25 recommendations based upon a combination of one or more of the following:

- Extent of the risk of compliance or legal implications if issue is not addressed immediately
- Importance of the issue to stakeholders
- Necessity for transition to managed long term services and supports (MLTSS)
- Impact on the Nebraska Department of Health and Human Services (DHHS) and financial resources
- If the activity will continue to be a DHHS responsibility, regardless of MLTSS implementation

The five high-priority systemic changes are as follows, with the stakeholder feedback regarding each provided below:

1. Build an effective navigation system for LTC using a “no wrong door” (NWD) model
2. Ensure consistent and fair determinations for Medicaid LTC using a standardized assessment system
3. Establish the infrastructure to support consumer self-direction, Personal Assistance Services program (PAS) and independent providers
4. Align DHHS functions for maximum performance
5. Improve assurance of health and safety for Extended Family Home (EFH) residents

Build an effective navigation system for LTC using a NWD Model

The NWD system conducts activities, such as outreach, referrals, assessments, functional and financial eligibility and even final determinations. The NWD system builds on the strengths of the Area Agencies on Aging (AAA) and the Centers for Independent Living (and can include the Nebraska Aging and Disability Resource Center (ADRC) demonstration) by providing a single, more coordinated system of information and access for all persons seeking LTC both publicly and privately funded.

In general, there was broad support for building a NWD system and consensus that consumers have a difficult time accessing resources, navigating the system and understanding what types of services and supports are available. Stakeholders appreciated that the design of the NWD system could include private pay options and would include the full array of long term services and supports offered by the State. Stakeholders urged the State to study promising practices from

other states, especially around financing and sustaining the program and the technology platforms utilized.

Stakeholders from the aging network raised concerns about how the current (ADRC) demonstration would fit into the NWD system. Specifically, the aging network asked for an explanation of how the evaluation of the ADRC system promised to the legislature would be conducted if the resources are migrated to the NWD system. They also expressed concern about ensuring adequate funding for the new system at the state and local level that would support the creation and maintenance of a robust NWD infrastructure. Particularly since, due to limited funding, only three of the eight components of a fully functioning ADRC were implemented in the demonstration. Additional concerns from the aging network included that there needed to be strong leadership at the state level in order to ensure a commitment from all of the partners in the NWD, including disability advocates.

AARP provided specific feedback on the NWD and shared that there are three specific tasks that need to be completed prior to moving from the ADRC project into a NWD: 1) continued development of working relationships between the aging network and the disability network; 2) development of protocols for assuring that callers get information and assistance as quickly and simply as possible; and 3) finalizing a marketing plan that assures that the ADRC is recognizable to a broad cross-section of the Nebraska population as a resource for LTC.

Stakeholders from the disability networks raised concern over historic differences in funding levels between the aging network and the disability network, as well as cultural differences in how to operate a system. The disability network also urged that specific language be included in the Final LTC Redesign Plan regarding the need for adequate funding for all participants in the NWD. Disability network advocates also encouraged the State to make sure that there was cultural competency training for all partners in a NWD system.

Parents, caregivers and providers in the intellectual and development disabilities (I/DD) system expressed concern over what role they would have in the NWD system and what role the services coordinators would have. Parents of older adults with I/DD expressed concern over the fact that there currently is no “door” for them to enter the system and requested help from the NWD. The University of Nebraska Medical Center (UNMC) Munroe Meyer Institute’s (MMI’s) Community Advisory Board (CAB) shared that the State should require additional partners in the system so that families of consumers who receive I/DD services have familiar partners to work with. Examples of some of the additional partners they suggested for the NWD include:

- UNMC MMI staff and Parent Resource Coordinators (PRCs)
- The Family2Family Health Information Center
- PTI-Nebraska
- The Nebraska Lifespan Respite Network Coordinators
- 211
- The Nebraska Resource and Referral System
- The Client Assistance Program (CAP)

It was also suggested that a Neuro Resource Facilitator be available in the NWD system at all locations statewide to provide assistance and support to individuals with brain injuries. Nursing home and assisted living providers asked specifically if they would be allowed to participate in the NWD system, and further, if they would also receive reimbursement for the care management they provide.

A broad array of stakeholders asked design questions including whether the NWD system would conduct the assessments for level of care (LOC) and/or eligibility, or care management.

Ensure Consistent and Fair Determinations for Medicaid LTC using a Standardized Assessment System

DHHS should 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 throughout the assessment processes, such as prescreening for possible LTC needs, LOC eligibility determinations and person-centered plan of care development.

Overall, there was strong support for the idea of a single assessment tool and agreement that the tools utilized today can create inequities. The stakeholders wanted assurances that the unique attributes of the various disability and aging groups could be accommodated sufficiently in a single tool. The National Association of States United for Aging and Disabilities (NASUAD) shared with the stakeholders that while the Draft LTC Redesign Plan does not recommend a specific assessment tool, there are several nationally recognized tools that have additional modules for various population groups.

As noted above in the NWD section, while stakeholders were generally favorable towards this recommendation, there was concern about the assessment process — specifically who would be performing assessments: the Heritage Health Managed Care Organizations (MCOs), the League of Human Dignity (LHD), the AAAs or a new entity. There was significant concern expressed by the services coordinators about allowing the MCOs to do the assessments for fear they might minimize the service needs of consumers to save money. Participants in the stakeholder sessions asked if the Final LTC Redesign Report could include examples of how standardized assessments work in other states. Many stakeholder groups wanted assurances that whatever tool was selected by the State be tested and vetted and that there be rigorous training on the new tool prior to implementation. Additionally, stakeholders noted that in the past State staff have changed existing assessment tools to better fit their needs but in the process have invalidated the tool's results. Stakeholders sought assurances to protect against those types of changes to a new standardized tool.

The AAAs, the LHD, services coordinators and caregivers all asked that they be given the opportunity to participate in discussions about the selection of the new tool as decisions are made by DHHS.

Several guardians and parents of individuals with I/DD, as well as those caring for individuals with dementia, shared similar concerns of the stress that assessments can provoke. They asked that a recommendation be included that a review of the frequency of the assessments be included in the recommendations. Similarly, a few stakeholders reported that they feared requesting reassessments due to the potential loss of services.

Stakeholders also wanted examples of how other states handle continuity of care and services for individuals who receive an assessment that is for a lower level of services.

There was some discussion of including a caregiver assessment when performing assessments of LTC consumers. While many believed it would be useful, others argued that there is likely not funding to provide any services for caregivers, and therefore the State potentially could be setting false expectations.

Advocates for those with brain injuries shared that assessments for individuals with brain injuries are not a one-time event, but rather there is a need for ongoing attention and support for processes across disciplines to manage needs. Additionally, the clinical acumen of those doing the assessments with specialty training is important. Nebraska advocates for those with brain injuries also recommended that the State should also build on existing resource facilitation efforts.

Finally, many advocates suggested that the State consult with advocates, individuals with disabilities, seniors and families in the process of choosing a new tool.

Establish the Infrastructure to Support Consumer Self-Direction, PAS Program and Independent Providers

DHHS should amend their current Aged and Disabled Waiver to explicitly include the consumer self-direction program option.

Stakeholders were in agreement that the current Aged and Disabled Waiver should be amended to include consumer direction. AARP went so far as to say that PAS is the “weak link” in the Nebraska LTC system due to the modest oversight that has been applied to it. State staff also expressed serious concerns about the provision of services in the PAS program due to the lack of strong oversight.

Stakeholders wanted assurances that consumer direction would only be an option and not a requirement for consumers. This concern was repeated at most sessions by parents of individuals with disabilities who expressed concern even over the potential of being overwhelmed with additional responsibilities. Home care providers also expressed concern that there are families for whom hiring and firing their own workers is not optimal and the State needs to take steps to ensure that a range of models are available.

There were some stakeholders who believed that there was too much emphasis placed on this recommendation because they believe there is little to no oversight of the PAS program and that

instead, consumers should be moved into the Aged and Disabled Waiver where they can be monitored for safety.

One of the Heritage Health MCOs noted support for consumer-direction for LTSS members who prefer and are able to manage their own services and supports. They shared that consumer direction results in better outcomes and quality of life, promotes independence, self-efficacy and satisfaction, and can achieve cost savings.

AARP indicated they believed that a systemic analysis of LTC consumer-directed programs would be useful to ensure that the State is taking the steps necessary to have the optimal degree of consumer direction and to ensure that the principles of consumer direction are truly being satisfied.

State staff was confused by this recommendation because they believe that the State offers extensive consumer-directed opportunities currently and the philosophy of self-direction is embedded in all of the programs. Feedback suggested that there was not common understanding about consumer-direction and the various models that are in place in Nebraska, as well as other options that could be implemented.

The State should procure an electronic visit verification (EVV) system to 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. This will also allow for electronic claims and to make payments quicker than manual processes in operation today. It will also allow for the possibility of value-based purchasing of services through MCOs.

During the stakeholder engagement events, NASUAD/Mercer staff shared that there is a new federal requirement — the 21st Century CURES Act — which requires all states to implement an EVV system no later than 2022. EVV systems can be used to ensure that providers show up and deliver appropriate services and to reduce fraud; consequently, the DHHS program integrity staff was strongly in support of the State moving forward as soon as possible.

Stakeholders did not understand what an EVV system was and asked that the Final LTC Redesign Plan provide a better explanation of what it is. Stakeholders also asked that the report provide information on what systems other states are using. Stakeholders also asked that we include examples of how the EVV system would work to ensure backup support in the instances where an attendant does not show up on schedule.

There were several providers that urged the State to wait for federal guidance on EVV before entering into a contract. Further, the providers asked that the State be mindful of the costs associated with purchasing equipment for personal attendants and asked that the State consider reimbursing them for the costs. Additionally, providers asked that a single EVV system be implemented so that they don't have to manage three MCO-specific systems. Providers who also deliver services in Iowa shared that Iowa had not implemented one statewide system, so it is

logistically very difficult for them. The MCOs, on the other hand, urged the State to allow them to have flexibility in the selection of their own preferred EVV vendors. Providers also urged the State to consider the technology challenges in the rural areas of the State and contract with an EVV vendor that is able to work within those specific confines.

Some consumers also asked the State to consider designing the EVV system in a way that is least likely to intrude on their daily lives.

In addition to providers sharing their concerns over the cost of the program, consumers also wanted to know if they would have to pay for the EVV system if they were self-directing; if not, who would be paying to use the system? If it is the direct care worker, there was concern that this might be another factor driving individuals away from this profession at a time when there is not only a shortage of workers, but wages vary widely depending on their particular circumstances. The Nebraska Association of AAA (NAAAA) noted that for both the EVV and Financial Management Services Agency (FMSA) system to be operational, there will need to be additional financial and staffing resources and they wanted assurances that the costs would not be passed on to the providers.

The Heritage Health MCOs recommended that as the State considers its EVV system design, it thoughtfully considers a system that ensures administrative simplicity for providers, limits disruptions in care for members and allows MCOs to integrate the system with their technology to support improving outcomes.

One of the Heritage Health MCOs recommended that Nebraska exempt self-directed attendant services from compliance with EVV as it is counter to the basic philosophy and structure of self-direction. If it is included, the MCO recommended convening a group of consumer stakeholders to develop appropriate standards that are consistent with self-direction. They also recommended that a set of standards be developed for an open EVV platform to allow MCOs and providers to contract with vendors of their choosing in order to ensure that the EVV system: 1) allows for comprehensive system interoperability; 2) meets both State and MCO requirements for data interface, management controls, language access, accessibility and audit requirements; and 3) supports full access for members to the benefits of community living.

DHHS should engage the services of a FMSA to certify and enroll independent 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 home and community-based services (HCBS).

Stakeholders indicated that they needed additional information about the value of this system, and why it should be implemented, as well as the cost-benefit of it. Further, they urged that information and experiences from other states are included in the report. There was some concern regarding the new role of State staff currently processing the claims for individuals enrolled in the PAS program.

Stakeholders also wanted to know whether the State would have the responsibility for this program, or if the MCOs would have responsibility for the FMSA. If this responsibility shifts to the MCOs, stakeholders wanted to know if a single FMSA would be required under the MCOs contracts or if the MCOs could all have their own FMSA. There was some concern that if the MCOs can each have their own FMSA, some consumers, as well as personal care attendants, would not want to switch plans because they would have to work with a different FMSA.

The Heritage Health MCOs argued that they would prefer that the State provide the MCOs with the flexibility to contract directly with independent providers in their managed LTC (MLTC) networks and manage provider screening and enrollment, claims processing and payments. However, they said that the State should have the FMSA provide payroll and other employment functions. They also said that DHHS should maintain a registry of independent providers for members to access to support self-direction.

The State should add a support brokerage function to provide the supports needed for consumers to locate, train and supervise their individual workers.

There was very little understanding of this function and what it would provide to consumers. Stakeholders wanted to know if this function was a part of the FMSA or if this would be a separate contract, as well as the cost of the function. Agency providers also expressed concern that this is a function that they already perform and could result in competition for limited staff.

There was concern expressed for the personal care attendant workforce regarding their low salaries and whether or not the support brokerage function would assist in any way in providing an opportunity for the independent personal care worker to receive a higher salary.

Align DHHS Functions for Maximum Performance

The State should consolidate functions, such as provider enrollment, participant enrollment, systems administrations and day-to-day program operations under a single operating entity, which will ensure consistency in the provision of services across waiver programs and improve consumers' experience by eliminating duplicative processes.

There was very limited feedback about this recommendation from stakeholders. Stakeholders asked that the Final LTC Redesign Plan include potential reorganization charts for DHHS. Stakeholders also suggested that the Final LTC Redesign Plan provide a few examples of states that had successfully reorganized and provide examples of their reorganized structure. Additionally, stakeholders would like a clearer explanation on the timing of the realignment and whether it would take place prior to MLTSS implementation.

Providers wanted to better understand what specific functions would be potentially outsourced under the realignment. For example, they wondered if provider enrollment, a function currently handled by an outside contractor, might possibly become a State function again.

There was some concern expressed that the State proceeds cautiously when aligning DHHS agencies so as to not lose sight of the unique needs of various consumer groups. Some were anxious that they would not have a staff contact who understands their programs if the State agency consolidates functions. However, consumers and caregivers of those with multiple conditions were supportive of closer collaboration within DHHS. There were many that believed that consumers with co-occurring disorders (i.e., mental health and/or substance use along with other conditions) are not being well served under the current system. Many expressed a desire for the State divisions of I/DD and behavioral health to align as soon as possible.

When aligning the programmatic and policy agendas for the agency, the state's University Center for Excellence in Developmental Disabilities (UCEDD) also urged the State to consider adopting the federal definition of developmental disability.

State Disability Rights Nebraska wondered how successful the reorganization would be when the statutory definition of developmental disability still retains an exclusion of mental illness as a developmental disability condition.

To drive innovation and track long term care, the Nebraska State Independent Living Council (NESILC) urged the State to create an office on tracking and innovation to seek innovative ways of providing LTC, but also to track and report the State's progress on achieving LTC goals.

Several stakeholders identified agencies outside of DHHS that need to work in a more coordinated fashion with DHHS (e.g., the Department of Labor and the Department of Education). Additionally, there was concern expressed about lack of support and resources for those with comorbidities that do not receive appropriate treatment for behavioral health or substance use issue and end up in prison.

The Nebraska Association of Service Providers shared:

Nebraska has a history of a separate division for developmental disabilities service provision. Careful analysis should be completed before changing this approach and the criteria used to reach this decision should be clear and public. Specifically, the population of people with developmental disabilities has benefitted from specialized case management in the current division. If changes are made, the current developmental disabilities system must be stabilized before implementation. Currently, the state is implementing a new waiver starting May 1, 2017, and managing challenges ranging from underfunding and a required re-basing of rates to complications for serving high need individuals under the new Heritage Health plan.

Improve Assurance of Health and Safety for EFH Residents

DHHS should require by 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 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 Nebraska Division of Developmental Disabilities (DDD) provider agencies.

Stakeholders had mixed feelings about this recommendation. While many stakeholders were concerned about how the State can ensure the health and safety of residents in EFHs, others expressed concern for the operators of the EFHs and the burden that this might place on them, which could force them out of business. There was confusion on the part of some stakeholders because they believe the State already has the ability to do onsite reviews, at unannounced times, perform quality and safety checks and wondered what this recommendation would actually mean operationally.

Stakeholders were concerned about the funding to support the requirement for onsite licensure review. The State LTC Ombudsman also expressed concern that if the State were to conduct onsite licensure, the EFHs would become subject to LTC Ombudsman oversight, which would be a new programmatic requirement and financial burden for them.

One commenter offered a suggestion that the State consider limiting the types of consumers who can live in EFHs in order to address health and safety concerns.

5

Transition to Managed Long Term Services and Supports (MLTSS) Delivery System

The State should build on the existing Heritage Health program and transition to MLTSS. This approach is recommended to improve accountability, promote delivery of home and community-based services (HCBS), deploy Nebraska Department of Health and Human Services (DHHS) resources more efficiently and ensure long term system sustainability.

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 Medicaid managed care organizations (MCOs). Currently, 22 states operate Medicaid MLTSS programs for all Medicaid consumers who need long term care (LTC) or only those dually eligible for both Medicaid and Medicare and five other states are considering or planning to develop MLTSS in the near future.

Stakeholders generally did not believe that the Draft LTC Redesign Plan provided sufficient justification for a move to MLTSS. Many noted they believe the State already has a balanced LTC system (institutional versus community-based care), does not have LTC expenditures that are growing at the rate of some other states, does not have long waiting lists and has an adequate provider network that is relatively satisfied with the current fee-for-service (FFS) system.

Stakeholders overwhelmingly questioned the implementation timeline associated with this recommendation. A consistent theme was that the State should first implement the “high-priority” changes and then wait to see if by implementing those changes, the efficiencies and improvements that the State is seeking could be realized.

AARP urged the State to continue to prioritize the services that are being provided to Nebraskans who are not eligible for Medicaid by continuing to focus on programs funded by the Older Americans Act, the Community Aging Services Act and the Care Management Services Act. AARP wrote, “[b]y delaying the institutional placement for people who are not eligible for Medicaid, the spenddown process is delayed and, as a consequence, Medicaid eligibility is delayed.” According to AARP, spending on non-Medicaid programs for older Nebraskans grew by 25% between State Fiscal Year (SFY) 2007 and SFY 2016. At the same time, the number of Nebraskans on Medicaid for seniors grew by only 0.18%.

As noted earlier, there was additional reluctance on the part of some stakeholders to consider MLTSS due to some of the difficulties they reported experiencing in the first few months of the implementation of Heritage Health.

The nursing home industry — both Leading Age and NEAHCA — remain opposed to the transition to MLTSS because they believe that there is no qualitative data that demonstrates the benefits of MLTSS for beneficiaries and providers.

The Nebraska Association of Service Providers, the Brain Injury Alliance, Quality Living, Inc. and the Nebraska Brain Injury Advisory Council commented that because the needs of the consumers with brain injury are so unique, they believe they should be excluded from the MLTSS program.

Several stakeholders also shared that what they believed to be previous attempts by DHHS to privatize health care have not gone well — specifically citing ACCESSNebraska and the non-emergency medical transportation call center as two examples. AARP shared that while they are not opposed to MLTSS, states should implement cautiously to ensure that the move to MLTSS is smooth.

Stakeholders also expressed concern that Nebraska's rural and less populated areas pose significant challenges to a MCOs' ability to deliver services. Additionally, stakeholders expressed concern that there is a need to preserve the right balance of options, both institutional and non-institutional settings in rural areas. AARP recommended that the State spend time trying to develop innovative approaches (potentially allowing multiple functions to be provided all by a single provider in rural areas) to preserve and grow options for Nebraskans needing LTC services.

The University of Nebraska Medical Center Munroe Meyer Institute's Community Advisory Board (CAB) urged the State to include the following protections for family caregivers in contracts with MCOs. The following is an excerpt from CAB's written comments:

- *Recognize that support for family caregivers is a component of a high-performing LTSS system and identify this within the MCO contracts.*
- *Require training on the philosophy of and principles of person and family-centered care by the management of MCOs and care-coordinators/services coordinators. Make this training available to options counselors within the "no wrong door" (NWD) system.*
- *Require that the MCOs engage, assess and support family caregivers through a face-to-face interview.*
- *Include training for family caregivers as part of the MCO contract.*
- *Incorporate into the performance measures use of and tracking of respite care.*

Finally, there was a great deal of concern, particularly expressed by those with disabilities and their caregivers, that MCOs will implement a "medical model" of care because stakeholders do not believe the MCOs adequately understand the social model including housing, transportation and employment. Many stakeholders reported initial experiences with the Heritage Health MCOs that are consistent with these types of concerns.

Innovative Approaches to Delivering Medicaid Supports and Services

Stakeholders expressed some skepticism that MCOs can introduce innovation into the system and wanted specific examples in the Final LTC Redesign Plan.

AARP of Nebraska state they believe that DHHS will “improve quality, accountability, promoted delivery of home and community based services, deploy resources more efficiently to ensure sustainability, by implementing the high priority systemic changes.”

Shift Focus of Care to Community Settings While Preserving Institutional Settings

During the meeting with the nursing home industry, they shared their belief that the State already had a good balance between institutional and community-based care. Additionally, because the State had made rebalancing progress under Money Follows the Person and other programs, they did not see a need for DHHS to implement MLTSS.

Accountability Rests with a Single Entity

Stakeholders were interested to know how having accountability resting with a single entity could help improve the quality of service delivery. They shared some skepticism in light of the roll-out of Heritage Health that consolidated the three types of services (behavioral, pharmacy and physical), which they believe has not yet improved accountability or quality of the services provided.

Administrative Simplification

Providers wanted to better understand this justification; when from their perspective, under MLTSS they would deal with multiple MCOs versus only dealing with the State. Caretech shared their experiences in Iowa, and stated that the system actually became much more administratively complex for them. They also noted that Nebraska should provide careful and direct mandates regarding training on LTC to ensure that MCOs will treat providers in a fair manner when it comes to billing and coding processes.

Budget Predictability

Stakeholders were skeptical about the justification for budget predictability and wondered instead if DHHS was proposing MLTSS so services can be cut. Individuals with disabilities were concerned that MCOs would put them back in nursing facilities as a way to save funds. They also wondered how the State would pay for the upfront costs associated with the implementation of MLTSS.

AARP expressed concerns that the Medicaid-funded LTC services has remained steady and has grown by an annual rate of 1.4%; however, in the next 30 years, the growth in the 80+ population in Nebraska is expected to grow significantly. AARP urges the State to prepare an aging and disability profile to help better predict and prepare for the necessary changes in the LTC Medicaid program.

Stakeholder Feedback

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.

As a result of some of the challenges in the roll out of Heritage Health, including stakeholder perceptions of limited communication and outreach, stakeholders expressed a strong desire for more intensive engagement and communication from DHHS should the State move forward with MLTSS implementation. There was significant discussion at almost all the stakeholder sessions that the State had not adequately prepared consumers for the transition to Heritage Health and further that the tools that they used to share the information were not effective. Many consumers asked for in-person or peer-to-peer support should additional changes occur in the system. They also asked that the State consider sharing the outreach materials in advance with some of the advocacy community for review and feedback to ensure that the language used is easy to understand.

There were significant stakeholder requests that if the State is to proceed with MLTSS they do so in a transparent fashion that engages stakeholders at every step. Numerous comments were provided urging the State to engage stakeholders in MCO contract requirement discussions and that all documents are posted on an easy to use and navigate website.

Establish Program Goals and Develop Comprehensive Program Design

The first step in the process is to establish the vision and goals for the MLTSS program to allow DHHS and other stakeholders to determine whether the program has been successful and whether improvements should be made. Once the goals have been established, DHHS, in partnership with the stakeholder community, must undertake a rigorous program design process reflecting the requirements under the Medicaid managed care final rule.

Essential Elements in MLTSS Program Design

- *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*

The majority of stakeholders, when reviewing the list of essential elements in the MLTSS design, shared that the State would need more time to plan. Several stakeholders also wondered if the

State was going to seek assistance in developing the plan since it is very complex and State staff are stretched to the limit already.

Some providers wanted additional information and examples of how the payment structures would be aligned and to what extent that would affect the providers' reimbursement. One Heritage Health MCO expressed support for LTC managed care rates that reflect the enrollees' acuity and the availability of alternative care settings and that incentivize MCOs to find care for enrollees in the most appropriate and cost-effective setting. Several stakeholders commented that because rate-setting for LTC enrollees is more complex, Nebraska should negotiate rates with MCOs that reflect the enrollees' functional needs and acuity.

Consumers and advocates asked for examples of the types of consumer protections that would be included in the MLTSS program. They expressed their desire that their current specialty providers be included in MCO networks and want the State to ensure that enough qualified providers participate in MLTSS.

Stakeholders also expressed some concern over whether or not MCOs understood person-centered practices. This theme was particularly strong when presenting the Draft LTC Redesign Plan to the current services coordinators.

Two of the Heritage Health MCOs recommended that the State consider combining DHHS' separate LTC waivers into a single waiver authority. This would provide the State the ability to smooth out some of the eligibility criteria across programs and the flexibility to pursue tiered approaches for LTC benefits and eligibility.

Specific recommendations to "ensure a person-centered and family-centered approach is integrated into the care delivery of MCOs" were provided by CAB. Specifically, CAB believed that the State needs "to identify ways to support families in their caregiving role, keep the individual in need of LTC in their family home, and keep both parents in the workforce." They asked the State to consider implementing best practices and prioritize person-centered care and require the MCOs to do so as well. They offer specific recommendations on supporting caregivers as well.

Further, CAB recommended the following in their comment letter:

- *Make the MCO's contractual performance measures and their progress in meeting the measures available to stakeholders and clients at minimum twice per year.*
- *Make the State's goals and objectives for continuous quality improvement available to the public.*
- *Establish an independent Ombudsman program with no ties to the MCOs, the entity that determines level of care (LOC) or does services coordination. The Ombudsman program should be outside of DHHS to assist individuals and families who have been denied services and supports and to track calls to identify systemic issues.*
- *Offer an external medical review process as part of the appeal process for services denied.*

- *Require that services coordination is separate from service provision. This means it should NOT be within a MCO, a service provider OR the entity which determines LOC. We suggest that services coordination be competitively bid and open to community based organizations with experience in LTSS.*
- *Offer financial incentives (bonuses, etc.) to MCOs to insure that individuals who have more complex needs are able to access services and their providers are adequately reimbursed.*
- *Require institutional settings to be part of the LTC integration into managed care and reallocate any savings to decrease the waiting list for HCBS.*

Develop a Detailed Implementation Plan

Using the program design as the guide, DHHS will need to undertake an intensive planning and implementation process. Key elements in the implementation plan should include:

- *Stakeholder Engagement*
- *Authority*
- *Infrastructure Changes*
- *Contracting and Procurement*
- *Readiness*
- *Communications and Education*
- *Network Adequacy*
- *Quality Management Strategy*

DHHS will need to establish systems of internal accountability to ensure that the necessary steps are completed appropriately and within the anticipated timelines under rigorous oversight and monitoring.

When stakeholders reviewed the requirements in the Draft LTC Redesign Plan, they were reassured because the requirements are specific and detailed, but also concerned that DHHS staff may not have the capacity to develop a comprehensive plan. Stakeholders asked for information regarding how long it takes to develop a comprehensive implementation plan.

Caretech noted that financial requirements developed for the MLTSS system should assure that provider rates are not cut after implementation. Additionally, Caretech urged the State to consider requiring an inflationary rate increase method in MCO contracts.

Several providers who operate in Iowa and Kansas shared that one major concern they are experiencing are “prior authorization delays.” The providers believe that the MCOs are using authorization delays and denials for provider payments as a tactic to “save” money. They urge that Nebraska put in place strict MCO guidelines to avoid delays.

Many stakeholders wanted to see in the Draft LTC Redesign Plan specific details that would normally be included in the implementation plan; for example, assigning LOC assessments to specific parties. Services coordinators expressed strong reservation about moving to MLTSS for several reasons. They were concerned that MCOs would not have the same support for

consumers as they currently have under FFS. They also shared concern that they had developed relationships with consumers over years that would be lost. Service coordinators were also concerned about losing their own positions and benefits. To alleviate this concern, several of the Heritage Health MCOs suggested that the State develop a plan to allow the MCOs to work with the services coordinators for a period of time to get to know each other, facilitate continuity of care, and provide cross training and coordination to ease the transition.

Several MCOs urged the State to consider a blended rate-setting methodology to help drive further rebalancing.

Many stakeholders indicated that they wanted to know the current quality of the services that consumers are receiving now so they can benchmark that to any changes they potentially could experience under an MLTSS system. Stakeholders want the Final LTC Redesign Plan to specifically recommend that the State regularly undertake a process to measure quality of life of consumers so that they can determine if the changes are improving the system.

One of the Heritage Health MCOs encouraged the State to consider developing a managed LTC (MLTC) quality framework that is person-centered, specific to the needs of LTC consumers and developed by experts. The MCOs also urged the State to consider adopting integrated quality benchmarks to measure MCO performance that address all services (acute care, behavioral health and LTC) to incentivize whole-person approaches and drive integration down from the MCOs to the provider level. The MCO submitted a white paper on the MLTC quality framework that they are using.

Another Heritage Health MCO urged the State to use reasonable and appropriate operational health outcome and quality of life measures that reflect a MCO's ability to effect change in LTC beneficiaries' lives and acknowledge and account for the unique characteristics and needs of individuals accessing LTC. They urged the State to consider quality of life measures when gauging MCOs' performance and provided the following examples of quality of life measures that they would agree to be measured against:

- *Percentage of members able to see friends/family when desired*
- *Percentage of members able to participate in activities outside of the home*
- *Percentage of members who are satisfied with where they live*
- *Percentage of members who are able to make decisions about daily routine*
- *Percentage of members who have a job or volunteer in the community*
- *Percentage of members who feel safe*

One of the Heritage Health MCOs also shared with the State a copy of the National MLTSS Health Plan Association's paper on Model LTSS Performance Measurement and Network Adequacy Standards for States. This Heritage Health MCO also shared their recommendation for assuring network adequacy and said that the State should require the plans to have network adequacy deadlines a full 120 days prior to going live.

Stakeholders who had worked in multiple states as providers indicated they found value in having the State perform a readiness assessment of its own operations prior to going live with MLTSS.

The Nebraska State Independent Living Council (NESILC) urged the State to involve stakeholders in the development of performance measures that will be used by the MCOs and also urged the State to develop a cross disability Quality Assurance Committee with voting membership composed of 51 percent of individuals with disabilities and their families, representation from the NESILC, the Centers for Independent Living, the DD Planning Council, the University Center for Excellence in Developmental Disabilities, Protection & Advocacy Services, National Alliance on Mental Illness, the Federation of Families and two State senators. The committee would work with the State to review the quality of the services provided by the MCOs, make recommendations to improve quality and oversight to protect consumer services, ensure a person-centered delivery system and improve transparency.

One of the Heritage Health MCOs urged the State to consider the inclusion of dual eligibles in MLTSS built on a dual eligible special needs plan (D-SNP) platform. The MCO shared that DHHS should consider creating a favorable environment for organizations to operate a D-SNP in conjunction with its Medicaid plan by leveraging the federally-required Medicare Improvement for Patients and Providers Act (MIPPA) agreement.

The existing Heritage Health MCOs shared that case managers are essential to coordinating care and improving outcomes and states should allow MCOs to employ their own case managers rather than contracting with outside entities. They also recommended that the MCOs be given the flexibility to establish ratios of care managers to members because fixed ratios ignore the uniqueness of each member and prohibit MCOs from developing tailored solutions for its memberships.

Execute and Monitor Implementation Plan

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.

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. 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.

Stakeholders wanted to know what the State currently has in place to flag significant issues with both FFS LTC Medicaid as well as Heritage Health, and how this new procedure would differ.

Stakeholders experiencing issues with Heritage Health expressed that they did not feel reassured that the State would actually take steps to address issues associated with MLTSS implementation because some believed that the State was not taking the necessary steps to address Heritage Health implementation issues.

The NESLIC urged the State to include strengthened appeals and due process provisions in the implementation plans and contracts with the MCOs. They shared that currently there are no protections in place currently if an individual reports his or her provider. They believe that whistle-blower language needs to be included to ensure protection from retaliation while the compliant is being investigated.

Timing

The MLTSS roll out should take place on two different schedules:

- *Elderly & disabled populations — January 1, 2019*
- *I/DD populations — July 1, 2019*

There was overwhelming concern regarding the timelines that were recommended for MLTSS implementation in the Draft LTC Redesign Plan. The majority of stakeholders urged the State to consider a January 1, 2020 implementation for individuals who are Elderly/Disabled and a July 1, 2020 implementation for individuals with I/DD. However, AARP and others indicated that they would prefer a much longer implementation timeframe and expressed that they would consider “*additional years — not months*” as adequate.

The Heritage Health MCOs supported the roll out of MLTSS in phases by population so that they could address concerns of consumers, providers and families appropriately.

The nursing home industry is opposed to the implementation. LeadingAge, however, indicated that they would prefer to delay 3 to 5 years for implementation to allow time for more states to have transitioned to MLTSS, and therefore provide Nebraska with additional best practices to draw from.

The Nebraska Association of Service Providers shared a number of concerns regarding the timing of the roll out of MLTSS, including “...*serious concerns with the ability of MCOs to have the level of expertise needed to serve the developmentally disabled population, and to build up this expertise in an 18-month timeframe. If this process moves forward, oversight roles and*

“Slowing down the implementation process allows Nebraska to do it right and become a national benchmark for other states to follow.”
Nebraska Association of Service Providers

stakeholder engagement should be robust and clear. Requirements should be strict regarding expertise, training, and ability to serve complex individuals.”

6

Other Recommended Changes

The following represents feedback from stakeholders regarding the “Other Recommendations” noted in the Draft LTC (Long Term Care) Redesign Plan.

Not all of the preliminary recommendations for LTC redesign can be addressed through either the implementation of managed long term services and supports (MLTSS) or changes outlined as high-priority system changes. The remaining five preliminary recommendations from the 25 total preliminary recommendations should not be lost and should be addressed as time allows.

Implement a Systematic Way to Reassess Consumers

As shared above, there was concern regarding the entire assessment process. Many stakeholders, in particular those representing individuals with intellectual and development disabilities (I/DD), expressed concern over the frequency of the assessments due to the stress that the assessment process can place on individuals and families. Others asked if there was a way to titrate the assessment process so that some populations do not have to do the assessments as frequently as others.

There were several parents of adult children with I/DD who have dementia that expressed they were told that if they were reassessed they potentially could lose benefits. It was unclear what program the individuals were currently enrolled in, but it was brought up multiple times during the stakeholder engagement sessions.

One Heritage Health Managed Care Organization (MCO) recommended the State consider how they could leverage the MCOs to conduct reassessments.

Increase Awareness of the Medicaid Buy-In Program and Other Employment Programs for Workers with Disabilities

Stakeholders with disabilities shared with us that the design of the Medicaid Buy-In program in Nebraska has statutory design limitations that make the program virtually unworkable, except for the limited number individuals who meet the narrowly defined qualifications. They urged the State to consider changing the program to allow additional individuals to participate in the program. One of the Heritage Health MCOs also raised this concern and noted that the program is critical to individuals with a desire to work.

Disability Rights Nebraska recommended adding a new recommendation about the need to fix the structural flaws in the existing LTC system and then train individuals, including State employees, on what the program is, its parameters and how it operates. They suggested working with

individuals with disabilities, their families and advocates (Easter Seals of Nebraska and Goodwill) to develop this reform.

Stakeholders also urged the National Association of States United for Aging and Disabilities (NASUAD) to consider including in the recommendations additional “employment” initiatives beyond the Medicaid Buy-In program. An example that was shared was encouraging the State to develop and implement an “employment first” initiative. They also shared that they hoped that some additional cross training could be done for the Area Agencies on Aging (AAA) and the League of Human Dignity and asked that we specifically state that “no wrong door” (NWD) would have a strong employment focus.

Improve Coordination and Services for Children Aging out of the Educational System

There was very positive support for the work that the State had already done in improving the coordination of services for children aging out of the educational system. Stakeholders expressed that they hoped that the State could continue to develop relationships across all of the state agencies to further enhance the work that is being done in this area. There was additional support expressed for using the staff of the NWD to assist families in this process as well.

One of the Heritage Health MCOs urged the State to partner with the MCOs to develop stronger aging out programs.

Address Issues in the Provider Enrollment Process

Providers shared that the State had done a very good job in responding to the concerns regarding the provider enrollment process changes that occurred last fall. However, there were a few providers that shared that the process could still use additional work to make it easier for them to enroll.

Establish a Process to Rebase Home and Community-Based Services (HCBS) Rates More Frequently

Providers shared with us that they believed that this recommendation was not likely to occur in the short-run and expressed frustration with the notion that this was included as a recommendation in the same timeframe that the State proposed a three percent reduction in their rates.

Providers of I/DD services shared that they believed strongly that the State needs to rebase the rates now and that putting this into a category at the end of the LTC Redesign signaled that it was not as important to the State. They shared that there was concern that if the State is moving to MLTSS and has not rebased the rates before migrating, many of the providers will not be able to sustain service delivery.

Other Issues That Were Not Addressed

The Nebraska State Independent Living Council (NESILC) encouraged the State to consider including additional support for assistive technology. They urged the State to consider allowing for assistive technology to be made allowable without meeting nursing home or institutional level of care (LOC) so that more individuals could have access to it.

APPENDIX A

Acronym Dictionary

Acronym	Definition
AAA	Area Agency on Aging
AARP	American Association of Retired Persons
ADRC	Aging and Disability Resource Center
CAB	Community Advisory Board
CAP	Client Assistance Program
DD	Developmental Disabilities
DDD	Nebraska Division of Developmental Disabilities
DHHS	The Nebraska Department of Health and Human Services
D-SNP	Dual Eligible Special Needs Plan
EFH	Extended Family Homes
EVV	Electronic Visit Verification
FFS	Fee-for-Service
FMSA	Fiscal Management Services Agency
HCBS	Home and Community Based Services
I/DD	Intellectual/Developmental Disabilities
LHD	League of Human Dignity
LOC	Level of Care
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MIPPA	Medicare Improvement for Patients and Providers Act
MLTC	Managed Long Term Care
MLTSS	Managed Long Term Services and Supports
NAAAA	Nebraska Association of Area Agencies on Aging
NASP	Nebraska Association of Service Providers
NASUAD	The National Association of States United for Aging and Disabilities
NESILC	Nebraska State Independent Living Council
NWD	No Wrong Door
PAS	Personal Assistance Services
PRC	Parent Resource Coordinator

Acronym	Definition
SFY	State Fiscal Year
State	The State of Nebraska
TBI	Traumatic Brain Injury
LTC Advisory Council	The Long Term Care Redesign Advisory Council
UCEDD	University Center for Excellence in Developmental Disabilities Education, Research and Service
UMNC MMI	University of Nebraska Medical Center Munroe Meyer Institute



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