An MLTSS Collaboration Framework for People and LTSS Providers

Acknowledgements and Participating Organizations

In Spring 2013, LeadingAge and the American Health Care Association & the National Center for Assisted Living (AHCA/NCAL) invited an array of sister organizations representing persons with disabilities, older adults and LTSS provider organizations to partner on a the development of a set of common principles which should frame Medicaid managed long-term services and supports (MLTSS) initiatives. This document is the output of this collaboration.

We would like to recognize the valuable time and willingness to partner among this diverse group of thoughtful organizations.

Disclaimer

This document does not represent a joint policy statement among the collaborating organizations. Rather it is representative of broad MLTSS concepts which are important to supporting people, their families and LTSS providers.

Additionally, this document does not represent the views of any state chapter or affiliate. The contents merely serve as a framework which state chapters or affiliates may choose to use in MLTSS coalition building and liaison with state officials.

Introduction

A group of eleven national organizations gathered to discuss the rapid expansion of Medicaid managed long-term services and supports (MLTSS). Based on these discussions, the organizations listed above developed a core set of MLTSS concerns and a set of principles to offer people, their families, and LTSS provider organizations a framework for collaboratively working with states and plans as they implement or expand MLTSS programs. Finally, throughout the document are quick tips for successful collaboration.

Overview of Challenges

In the coming years, Medicaid-financed LTSS payment and delivery systems will undergo a significant transformation as states move away from traditional Medicaid fee-for-service models to MLTSS. In many instances, these financing and systems changes are employing untested approaches and being launched by states with little experience with such models. Additionally, the majority of plans moving into MLTSS have limited exposure and/or existing capacity to support people and their families or effectively partner with LTSS providers. At the same time, however, care coordination and other analogous plan functions can be helpful.

Historically, Medicaid managed care primarily has been limited to children and families. Recent research indicates total Medicaid benefit spending is approximately $338.6 billion. Of that total, approximately 21.1 percent is paid to Medicaid managed care plans. Medicaid managed care spending on behalf of older adults and persons with disabilities totals are 7.4 percent or $25 billion, and 13.5 percent or $45.7 billion, respectively.[1] Of these figures, MLTSS composed only $4.0 billion.[2] The remainder of Medicaid managed care spending for older adults and persons with disabilities is for Medicare cost sharing and Medicaid-financed acute care services.

Quick Tip

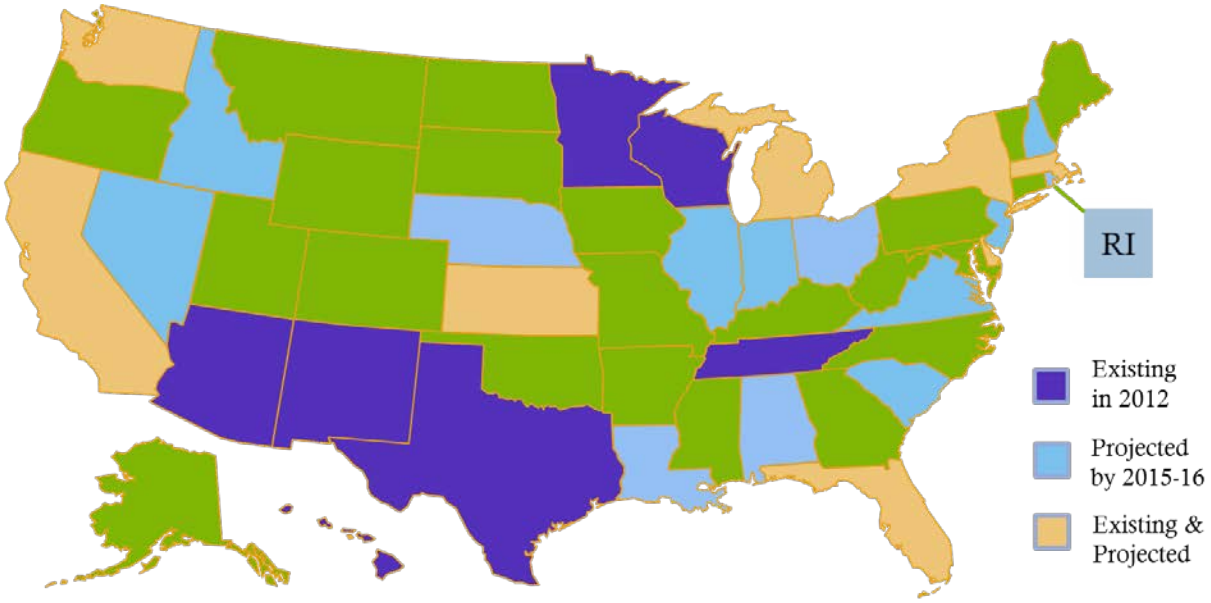
Gather information on your state's current managed care landscape in order to assess its starting point and level of experience.*

**Referenced data source is Kaiser Family Foundation State Health Facts*

Despite such limited experience among plans and states, the number of states operating Medicaid managed LTSS programs, either piloting or statewide, will rise from 16 states in 2012 to a projected 27 states by 2014.[3] Additionally, members of Congress have long expressed concern about the Centers for Medicare and Medicaid Services (CMS) capacity to oversee Medicaid managed care in more established forms. Recently, Congress also has raised questions about MLTSS in states with significant experience.

[1] MACPAC. Report to the Congress: The Evolution of Managed Care in Medicaid. July 2012.
[2] Kasten, J., Eiken, S., and Burwell, B Medicaid Managed Long-Term Services and Supports Expenditures. Thomson Reuters for the Centers for Medicare and Medicaid Services. April 2011.
[3] Saucier, P., Kasten, J., Burwell, B., and Gold, L. The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Truven Health Analytics for the Centers for Medicare and Medicaid Services. July 2012.

Figure 1. Projected State Expansion



Source: Saucier, P., et. al. The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update (July 2012). Additions based on AHCA research.

Such rapid expansion coupled with the lack of state and plan experience raises a number of concerns including the lack of state infrastructure to oversee such arrangements, virtually no interstate quality measures to nationally assess program performance, and ongoing issues with capitation rate setting and related risk adjustment for LTSS which may result in plan failure and potential service disruption for the people.[4][5]

Quick Tip

Identify a ready venue for Medicaid beneficiary and advocacy groups to share their concerns and ideas with the state Medicaid agency as well as reference the CMS guidance on MLTSS. For example, all state Medicaid agencies are required to maintain a Medical Care Advisory Committee (MCAC).*

**Reference is Cornell University Legal Information Institute and 42*

Below, ***Figure 2*** provides an overview of challenges and concerns associated with layers of MLTSS program operations and plan oversight as well as suggested areas for dialogue with states and plans. Many of the suggested areas for dialogue with states are components of the Centers for Medicare and Mdicaid Services (CMS) Managed Long and Services and Supports Programs Essential Elements. CMS also offers a variety of additional guidance on MLTSS program development, implementation and oversight including:

[4]Lipson, D., Libersky, J., Machta, R., et. al. Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports. July 2012

[5]MACPAC. Report to Congress. March 2013.

- An online curriculum* offering states guidance on program design, Medicaid authorities and other information relative to the effective management of MLTSS;

- Timeline for optimal planning and implementation of MLTSS programs; and

- A paper identifying the concerns and considerations in incorporating traditional LTSS providers into a managed care program.

The CMS guidance provides a helpful foundation for more detailed discussions with states on program design, implementation, and ongoing operations.

Figure 2. Overview of MLTSS Concerns and Suggested Collaboration Points

State Level	
Concerns	Suggested Collaboration Points
• Rapidity of expansion or implementation • Expectation of savings rather than budget predictability • Ability to set effectively capitation rates and risk-adjust for LTSS that will ensure plan stability and access to services • Capacity of state agency staff to oversee MLTSS plans and ensure compliance with protections for people and providers included in contracts • Ability of External Quality Review Organizations (EQRO) to perform oversight for possibility unfamiliar LTSS arrangements	• Referencing the CMS framework and timeline, work with the state on phasing the program in slowly; • Highlight the importance of taking action on input from people, their families and LTSS providers; • Learn about the state's strategy to ensure access to services and continuity of LTSS; • Discuss strategies for the state to provide technical assistance to all LTSS providers as they transition from fee-for-service to managed care; and • Learn how the state proposes to effectively oversee plan operations.
Plan Level	
• Lack of experience with people using LTSS and their families • Understanding of how to work with LTSS providers • Understanding of participant direction and individual budgeting • Ability to deliver services 24/7 • Understanding of and ability to deliver or coordinate with non-medical and social supports • Importance of administrative simplification for LTSS providers, particularly smaller providers • Potential layers of care coordination	• Request the opportunity to review and participate in the state's readiness review of plans before the MLTSS program is implemented; • Work with the State Medicaid Agency on the development and ongoing operation of an MLTSS Technical Advisory Group composed of state officials, beneficiary representatives and providers or address challenges; • Discuss how plans will address appeals and grievances; and • Open a dialogue with the state on a MLTSS Ombudsman.

In addition to the documents noted above, CMS has issued an array of guidance not directly targeted to MLTSS but which is applicable and helpful to development of an MTLSS program which offers adequate opportunity for beneficiary input and could aid in LTSS provider transition from Medicaid fee-for-service to managed care:

Quick Tip

Ensure your State Medicaid Agency is aware of these new requirements and work with them on a strategy to implement them in a mutually agreeable and efficient manner.

- Section 1115 Transparency Regulations and Other Public Comment Requirements – The Affordable Care Act (ACA) directed CMS to release detailed guidance on how states must ensure adequate public comments on new Section 1115 waivers at both the state and federal levels. These requirements do not apply to Section 1115 waiver amendments or other Medicaid managed care authorities. Additionally, CMS has requirements for public comment on other managed care program strategies; and

- Administrative Simplification – Managed care offers potential solutions to delivery of complex services through efficient and effective care coordination. However, MLTSS also

presents a new layer to complexity for LTSS providers attempting to deliver services when working with a number of plans with different operating requirements. This new MLTSS environment is in contrast to the fee-for-service environment in which providers only had to work with the state on important issues such as prior authorization of services, eligibility, and payment. The ACA required CMS to begin work on establishing several strategies to streamline operations across plans and ensure peoples' access to services and continuity of supports.

Coalition Principles for MLTSS Programs

The following section offers MLTSS Coalition principles and questions advocates might pose to state officials to better understand how these program components are addressing the MLTSS program design. In every instance, person-centerness and choice must be the cornerstones from which MLTSS operates.

> **Quick Tip**
>
> Plans operations are framed by their contracts with states. Plan accountability for performance or non-performance will be framed in the contracts. Thus, the majority of the principles will be operationalized in state contracts with managed care plans. The opportunity to comment upon and review contracts or requests for proposals should be part of any advocacy strategy.

1. Access **-- MLTSS programs should recognize the unique needs of persons with disabilities and older adults by ensuring *access* to specialized supports and critical long-standing relationships among people, families, and LTSS providers.**

    - CMS has requirements for access and network adequacy in Medicaid managed care. How will the state adapt those requirements (originally designed for acute care services) to LTSS?
    - What metrics will the state use to ensure sufficient numbers of providers are available so people have a choice of providers among the array of LTSS settings?
    - How will the state oversee access and enforce access requirements defined in plan contracts with the state?
    - How will states ensure that people are able to move among LTSS settings based on their needs and preferences?

2. Continuity of Care **-- MLTSS programs should include *continuity of care* provisions aimed at precluding disruptions in LTSS and preserving long-standing relationships between people and the individuals who support them.**

    - Will the state require plans to enroll any willing provider for at least the initial years of the program?
    - How will people and families be provided with easy to understand information about their choices and rights when selecting providers?
    - What will be the plans contractual requirements for ensuring continuity of care?
    - How will the state enforce such requirements?

3. Assessment **– State contracts with plans should ensure that *assessment* tools are as uniform as possible among plans and that plans assess people holistically including non-medical and social supports.**

    - How will the state crosswalk existing fee-for-service assessments and related support plans with plan assessments and related support plans?

- What will be the core data elements that all plans must include in assessments to ensure continuity of care should people change plans and to streamline provider-plan interactions?
- How will people and providers appeal assessment results which they believe do not reflect the needs of people?
- What is the state's strategy for refining the assessment process as part of its broader quality improvement strategy?

4. **LTSS Provider Groups** – MLTSS programs should allow for and encourage clusters of LTSS providers that offer an array of LTSS as are found in acute care arrangements (e.g., health systems, etc.).

   - What will be the state's definition of an LTSS provider network?
   - How will people and families receive information about LTSS provider network options?
   - How will the state ensure that plans offer a variety of LTSS provider networks to people and families?
   - What incentives will plans offer to maximize the delivery of quality services among LTSS provider networks?

5. **Non-medical and Social Supports** – MLTSS plans must recognize and incorporate into their assessment process, plans of support and provider networks non-medical and social supports.

   - How will the state define non-medical and social supports in plan contracts?
   - What will be plans reimbursement requirements for such services?
   - How will plans ensure that plan case managers or care coordinators understand the nature of such supports and how to incorporate them into plans of support?

6. **Conflict Free Case Management** – MLTSS programs must offer conflict free case management which represents the needs and preferences of people and their families and are not influenced by plan financial incentives.

   - How will the state define conflict fee case management?
   - What infrastructure will the state develop to ensure conflict free case management is being appropriately implemented?
   - What sorts of firewalls will the plans be required to maintain between care coordination units and finance divisions?

7. **Housing and Transportation** – Plans must be prepared to aid people and their families with housing and transportation.

   - What will be the contractual requirements for coordinating housing and transportation?
   - How will the plans interface with traditional housing agencies services and programs targeted to older adults and persons with disabilities?

- How will such needs be addressed in the assessment process?

8. **Plan Stability and Phase-Down** – Medicaid includes protections for plan stability and phase-down but special timelines may be needed for MTLSS considering the complexity of services and number of services people may be using.

    - How will plans be required to ensure continuity of care if they exit the MLTSS program?
    - What role will the state play in ensuring that people experience seamless transition among plans or back to fee-for-service?
    - What steps will CMS take to ensure appropriate technology, supports, and staffing are available to support people and LTSS providers in such transitions?

9. **Quality** – Quality must be at the core of any MLTSS program and be considered before or on par with budget predictability.

    - What will the state use for a quality improvement system?
    - What measures will be used and related data sources?
    - How will plan and program performance data be shared with people and providers?
    - How will plans be held accountable for not meeting quality requirements?
    - What steps will the state take of the MLTSS program is not meeting the programmatic quality requirements?
    - What quality withhold or shared savings principles will be incorporated into plan arrangements with providers who are measured on MLTSS health outcomes or other quality?

10. **Persons with Disabilities** – MLTSS program design must recognize that the needs of younger persons with disabilities differ from older adults.

    - What contractual requirements will be in place to ensure that plans understand and operationalize elements of disability culture?
    - How will plans include employment into plans of support?

11. **Technical Assistance for LTSS Providers** – MLTSS must recognize that LTSS providers often do not have the business or health information technology infrastructure to interface with plans; states must offer technical assistance and resources for health information technology to support LTSS providers as they transition from fee-for-service to managed care.

    - How will states provide technical assistance on how to work with plans?
    - What contract requirements will plans have to deliver technical assistance to providers?
    - How will states support providers with plan business transactions that will ensure access and continuity of care? Specifically, what administrative simplification elements will be included in contracts and how will LTSS providers be assisted with development of interoperable health information technology?

12. Health Information Technology -- To ensure people are able to access quality LTSS in a timely manner, states should ensure that plan contracts include provisions for uniform health information technology functions (e.g., same electronic health record elements, same prior authorization forms and claims forms) and states should ensure providers have the resources to purchase health information technology.

- How will the state operationalize uniform plan requirements building on the new, federal administrative simplification requirements?
- What methodologies will the state use to ensure providers have sufficient resources to purchase and maintain health information technology?
- How will the state use data from health information technology systems in their quality improvement plans?