

TBI Waiver Application Stakeholder Meeting #1

Wednesday, July 30, 2014

Today's Objectives

- ▶ Quick overview of the application process
- ▶ Stakeholder input process
- ▶ Home & Community Based Settings Rule
- ▶ Conflict-Free Level of Care Determinations
- ▶ Managed Care Environment

Overview of Waiver Application Process

- »» What is a waiver
 - Basic Assurances to CMS
 - Additional Assurances to CMS
 - Application Process
 - Post Application

What is a Waiver?

- ▶ A waiver program waives certain requirements of the Social Security Act (Sections 1915 (b) and (c))
- ▶ These Sections discuss requirements for a Medicaid program
- ▶ Can waive
 - Comparability
 - Statewideness
 - Income/Resources

Basic Assurances to CMS

- ▶ Before CMS will approve a waiver application, the state must assure:
 - The health and welfare of participants (State sets adequate standards for providers)
 - Financial Accountability
 - The provision of an individual Evaluation of Need (meet NFLOC criteria)
 - Initial evaluations
 - Periodic reevaluations
 - The state offers each participant an explanation of available alternatives

(42 CFR 441.302)

Additional Assurances to CMS

- ▶ CMS Requires all waiver programs to be:
 - **Person-driven:** individuals have choice of where to live, services, work, who to include
 - **Inclusive:** system encourages individuals to live where they want to live and have access to quality services and supports in the community.
 - **Effective and Accountable:** the system has high quality services that improve the QOL of individuals. Focus on accountability and responsibility
 - **Sustainable and Efficient:** services and supports are managed and coordinated & appropriate for individual
 - **Coordinated and Transparent:** system mixes funding streams for a seamless package of supports
 - **Culturally Competent:** system accounts for cultural and linguistic needs of individuals

Application Process

- ▶ Obtain input from stakeholders
- ▶ Write application
- ▶ May submit portions of application to CMS for review prior to submission
- ▶ If managed care, obtain actuarially sound rates
- ▶ Allow public comment on completed application
- ▶ Submit application
- ▶ CMS has 90 days to approve

Post Application

- ▶ Will need to issue a Request for Proposal (RFP) for interested parties to apply to administer the TBI waiver program (waiver agency)
- ▶ Will need to execute signed contracts with chosen entity (waiver agency)
- ▶ Entities contracted as waiver agency will need to build a provider network
- ▶ Waiver agency will need to pass readiness review
- ▶ Can start enrolling participants
- ▶ Terminate current TBI MOU program

TBI Stakeholder Input

- » Your expectations
 - Services and Providers
 - Quality/Performance Measures
 - Timing Requirements

Your Expectations

- ▶ What should this waiver “look” like?
- ▶ What services should be offered?
- ▶ Who should be served?
- ▶ What is a qualified provider?
- ▶ Who measures that?
- ▶ How are services paid for?
- ▶ Who authorizes services?
- ▶ What do you expect from MDCH?
- ▶ What should participants expect?

Services

- ▶ The current application basically has two sets of services
 - Intensive Rehabilitation (Transitional)
 - Ongoing Home & Community Based Services
- ▶ What do we require from providers?
 - How do we assure providers are qualified and provide quality services and supports?
- ▶ We will go over these as needed in future stakeholder meetings

Quality/Performance Measures

- ▶ CMS requires MDCH to measure quality
 - These measurements are called performance measures
 - Each section of the waiver application has a number of performance measures
 - We need your input to assure
 - What to measure
 - The best way to measure what is proposed
 - When corrective actions are required
 - What is the best way to communicate our findings to you?

Timing Requirements

- ▶ New HCBS Ruling requires MDCH to meet with stakeholders
- ▶ Must include summary of process in the application
- ▶ Must be completed 30 days prior to implementation of the proposed change or submission of the change
- ▶ Must consult with Federally-recognized Tribes

Home & Community Based Settings Rule

- » Home & Community Based Settings
If Setting is Provider Owned
Person Centered Planning
Plan of Care Requirements

Home & Community Based Setting

- ▶ Must have the following qualities
 - Integrated & supports full access to the community, including employment, controlling personal resources & receiving services
 - The individual selects the setting
 - Ensures the individual's rights of privacy, dignity and respect and freedom from coercion & restraint
 - Optimizes initiative, autonomy & independence
 - Facilitates choice re: services & supports & providers

If Setting is Provider Owned

- ▶ Must also assure
 - A specific physical place that can be owned, rented or occupied under a legally enforceable agreement and individual has same legal protections as others
 - Individuals have privacy in sleeping units
 - Entrance doors lockable
 - Choice of roommates
 - Can furnish & decorate unit
 - Control own schedules and activities and access to food at any time
 - Have visitors at any time
 - Setting is physically accessible
 - Modifications to above must be documented in PCP

Person Centered Planning

- ▶ Individuals will lead the planning process where possible. Representatives may have a participatory role, unless state law specifies otherwise
- ▶ Must also
 - Include others the individual wants to participate
 - Provide information and support for informed decision making
 - Be timely and convenient to the individual
 - Reflect cultural considerations
 - Include strategies for resolving conflicts
 - Providers cannot provide case management
 - Offer informed choices
 - Includes methods for updating plan
 - Records alternative settings discussed

Plan of Care Requirements

- ▶ Include what is important for the individual to meet identified needs and what is important to the individual re: preferences
 - Reflects the preferred setting & individual's choice of current setting
 - Reflect strengths and preferences
 - Reflect clinical and support needs
 - Include individually identified goals and desired outcomes
 - Reflect all services and supports (paid/not paid)
 - Reflect risk factors & measures to mitigate risks
 - Be understandable to the individual
 - Identify entity monitoring plan
 - Individual agrees with signature
 - All providers also sign

Plan of Care Requirements, cont.

- Individual & others receive copy of the plan
- Identify self-directed services
- Prevents unnecessary or inappropriate services and supports
- Modifications to plan must be supported by a documented need

POC Requirements for Changes

- ▶ Identify a specific and individualized assessed need
- ▶ Document positive interventions used prior to modification
- ▶ Document less intrusive measures tried
- ▶ Clear description of condition proportionate to the directly assessed need
- ▶ Regular collection and review of data to measure effectiveness
- ▶ Include time limits for reviews
- ▶ Include informed consent of individual

Conflict-Free Level of Care Determinations

- » Definition of Conflict-free
- » Benefits of Conflict Free LOCDs
- » Why Conflict-Free?
- » Conflict Free Scenarios

Definition of Conflict-Free

- ▶ Clinical or non-financial eligibility determination is separated from direct service provision
 - Waiver Agencies may not be involved in any eligibility determination or functional assessment processes for a potential participant prior to that participant enrolling in the TBI Waiver.
 - All program enrollments must be processed through an independent entity.
- ▶ Case Managers and evaluators are not related to the individual, the individual's caregivers, or to anyone financially responsible for the individual
- ▶ The state has robust monitoring and oversight
- ▶ Consumers know how to submit grievances and request hearings

What Does Conflict-Free Mean?

- ▶ Grievances, complaints, appeals, and decisions are tracked and monitored
- ▶ State QM staff oversee clinical or non-financial eligibility determinations and service provision business practices
- ▶ State QM staff track and document consumer experiences
- ▶ If one entity is responsible for determining eligibility, providing case management, and service delivery (including authorization), appropriate safeguards and firewalls exist to mitigate the risk of potential conflict
- ▶ Meaningful stakeholder engagement strategies are implemented.

Benefits of Conflict Free LOCDs

- ▶ Keeps individuals at the center of the service system;
- ▶ Ensures consumer choice;
- ▶ Promotes optimal outcomes and quality of life for individuals; and
- ▶ Safeguard state resources

Why Conflict-Free?

- ▶ Conflicts may arise from:
 - incentives to find an individual eligible or ineligible because of their potential service needs;
 - potential pressure or interest in “steering” the individual to their own organization; and
 - potential pressure for retaining the individual as a client rather than promoting choice, independence and requested or needed service changes.
- ▶ These conflicts may not be conscious decisions on the part of individuals or entities responsible for the provisions of service.

Conflict-Free LOCD Examples

- ▶ State Retention of Certain Functions:
 - Example:
 - State completes level of care determinations, authorizes enrollment
 - Waiver agencies complete iHC assessment and develop plans of care

Conflict-Free LOCD Examples

- ▶ State Contracts with a separate organization for Certain Functions:
 - Example:
 - A separate entity completes level of care determinations (MPRO, Public Health, other qualified agency, etc.)
 - Waiver agencies do full assessment and develop plans of care.

Conflict-Free LOCD Examples

- ▶ Administrative Firewalls Within Organizations for Certain Functions:
 - Example:
 - One unit within waiver agency conducts LOCD
 - Another unit within waiver agency but with a completely separate management or chain of command complete assessments and plan of care development

Conflict-Free LOCD Requirement

Regardless of the structure that is put in place, we must utilize stakeholder input, consumer oversight, and transparent lines of communication.

Managed Care Environment



Managed Care

- ▶ Rather than a Fee For Service Program, MDCH has determined the TBI Waiver should be a managed care program.
- ▶ Will need to complete a 1915 (b) waiver
- ▶ Will need to develop actuarially sound rates with Milliman

Questions?

Contact MDCH

Email:

MSA-TBIWaiver@Michigan.gov

Website:

http://www.michigan.gov/mdch/0,4612,7-132-2943_4853-114948--,00.html

Future Meeting Topics

2. Services & Provider Qualifications
3. Eligibility, Rights and Responsibilities, Assessment Tool
4. Finance and Reimbursement
5. Performance Measures and Critical Incidents
6. Miscellaneous