

Managed Long Term Supports and Services in Michigan Medicaid

A planning guide for MSA

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Introduction

A transition to Managed Long-term Supports and Services (MLTSS) has been on the horizon for the Michigan Medicaid program as legislative interest has escalated for a number of years now. Bit by bit, the environment of long-term care has been evolving toward a managed care approach. This evolution has progressed to the point where the movement has reached critical mass and Medicaid must begin to consciously prepare to move to a comprehensive MLTSS system.

This paper has been prepared by the Michigan Department of Health and Human Services (MDHHS) to summarize some of the guidance offered in literature from the Center for Medicare and Medicaid Services (CMS) and lessons learned from other sources. It is intended as both a decision guide and as a recipe for the state to use in making this transition. The paper is meant to be dynamic as well; updated as the project progresses.

What Is MLTSS?

According to CMS, managed long-term supports and services (MLTSS) “refers to the delivery of long term supports and services through capitated Medicaid managed care programs.” As of 2012, 16 states had MLTSS programs and interest in the model continues to grow. The provision of long term supports and services is perhaps the last element of health care to venture down the path of managed care. Managed care is been a staple in the physical health realm as well as in the behavioral health world. As efforts intensify to integrate services, it becomes increasingly important that the services be provided from similar platforms.

MLTSS has, in fact, already gained a foothold in Michigan as a number of the Medicaid LTSS programs are reimbursed through capitation. This includes MI Choice, PACE, MI Health Link, and the Community Living Support (CLS) services provided through the Behavioral Health waivers. This managed care experience must be recognized in the planning and design of a more global delivery system.

Background

The Michigan Legislature first began signaling its interest in having Medicaid long term supports and services provided through a managed care arrangement with P.A.107 of 2013. Specifically, Section 105 (4) stipulated, “By September 30, 2015 the department of community health shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus plans.” The department’s response was largely measured; watching the MI Health Link demonstration project for lessons that could be applied to a broader program.

The discussion has intensified recently with the boilerplate language for fiscal year 2018 in Section 1957 that reads “By July 1 of the current fiscal year, the department shall explore the implementation of a managed care long-term support service.” This requirement was fueled by internal realities, specifically the existing nursing facility reimbursement methodology which inhibits the state’s ability to achieve its goal of rebalancing the LTSS environment and the need to renew the waiver authority for MI Choice while achieving compliance with the federal managed care and home and community-based settings rules. It might appear that all of these factors are inextricably linked.

From a Medicaid perspective, the services that would be included in an MLTSS initiative would certainly comprise those provided by:

- Skilled Nursing Facilities and County Medical Care Facilities
- Hospital Long Term Care Units
- MI Choice waiver
- Home Health agencies
- State plan Private Duty Nursing (PDN) services
- Hospice services
- Home Help
- Personal Care Services/Community Placement Services
- Community Transition Services

Additional discussion will be needed to determine if the following LTSS services would be included in this initiative:

- PACE
- MI Health Link
- Community Living Supports provided through BHDDA programs

Benefits of a Managed System

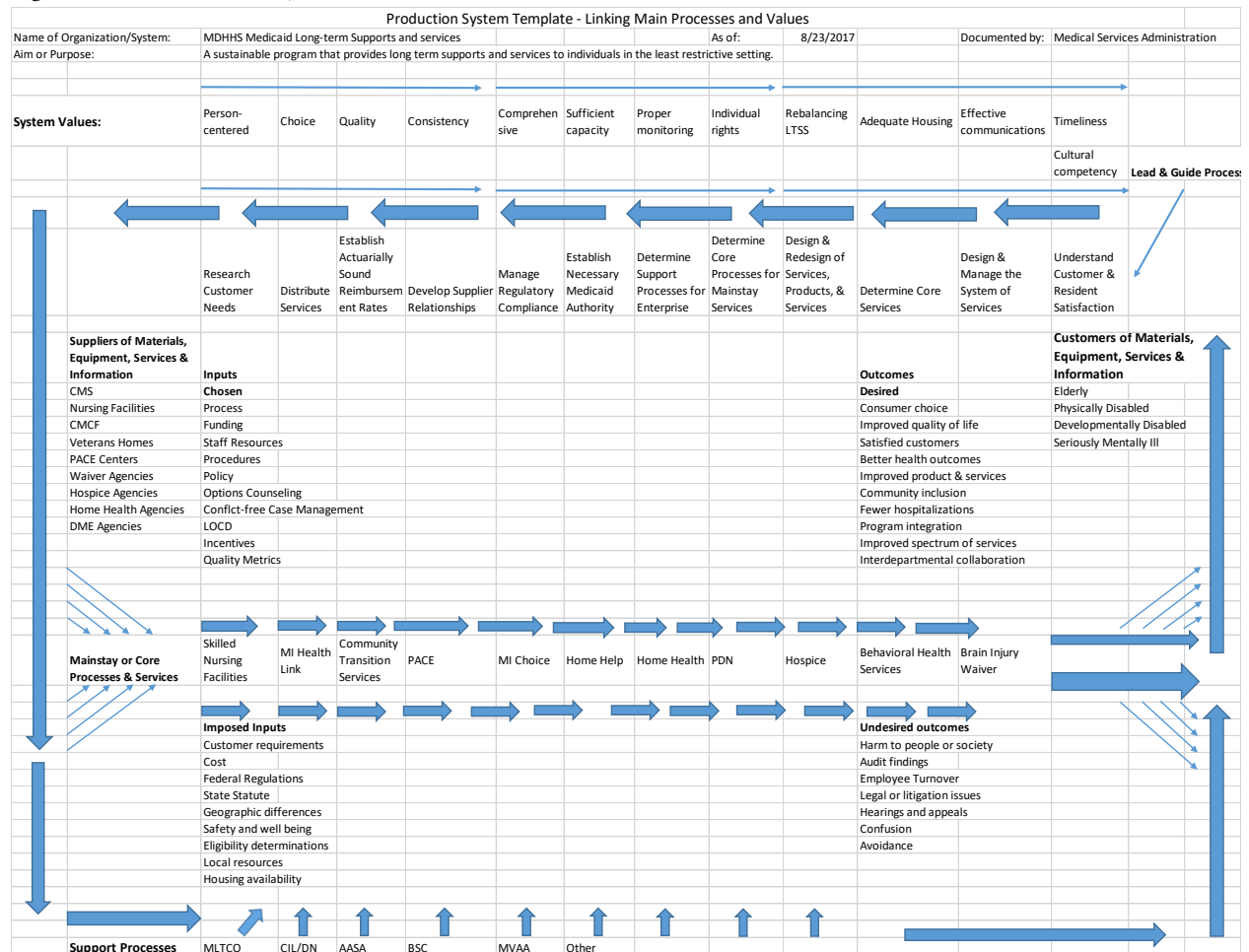
As MLTSS systems become established throughout the county, the advantages that can accrue from such a system have become more evident. CMS suggests that expected benefits might include increasing efficiency of the LTSS system, promoting community inclusion by incentivizing services in less restrictive settings, and ensuring quality throughout the system. It is apparent that the approach can be used as a mechanism to streamline and integrate systems, increase coordination and collaboration, and improve the experience of the customer. While it might not be the primary consideration in play, managed care systems are often thought to have a financial benefit due to the efficiencies involved.

Regardless of the hypothetical or potential benefits that MLTSS might bring, it is critical that the state articulate exactly what benefits it hope to achieve by implementing such a system. This must be done early in the development phase of the project. Those expectations will be vital in guiding the direction of the project and will ultimately determine the success of what is achieved.

Medicaid LTSS System Map

The current Medicaid LTSS system is a complex array of programs, objectives, customers, providers, and influences. It is helpful to graphically portray these elements and relationships as each of these must be analyzed, understood, and incorporated into whatever MLTSS model the state adopts. A depiction of what the Medicaid LTSS production system might look like is presented below:

Figure 1: Medicaid LTSS System



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While this representation of the various components that factor into the LTSS system is complex, in reality, it is incomplete. Each segment of the flow could be expanded depending on who is providing the input. Still, it provides an introduction to the extensiveness of the elements that will need to be considered in the development of a comprehensive MLTSS system.

Scope Considerations

Perhaps the initial task the department must face is to define the parameters of exactly what it wishes to accomplish with this initiative. Otherwise, the inertia may prove impossible to overcome. The questions will not be easy to answer and maintaining a reasonable scope will surely be elusive.

First and foremost, what are we trying to accomplish? Is it the integration of long term supports and services or are other services to be included? Does this mesh with the wishes and expectations of the customers and other partners? How do we know it will be an improvement? The department must have a conversation about these topics before it is ready to reach out to others.

Looking at the Medicaid LTSS process map, it is easy to see why the scope must be adequately defined. Is it the intent of MLTSS to assure the continued existence of the discrete programs or the providers of those programs? Will it address the known overlap of services and the differences in reimbursement rates? Will it fill in the service gaps that currently exist? Should it consolidate the many versions of personal care services into a standard source and definition? Can it successfully address topics that have perplexed the current system, such as how to recognize and utilize assisted living facilities, how to provide adequate training and respite for informal caregivers, and how to incorporate a fair system to establish eligibility? Some of these issues may well be inherently corrected by implementing a managed care model, while others remain beyond the reach of this work.

As was learned in the implementation of the MI Health Link program, financial concerns are often paramount in any public transformation. The immediate suspicion among stakeholders is that the state is making this type of move solely to save money. The natural reaction then is for stakeholders to protect their “enlightened self-interests.” What savings expectations does the department have? Is it the intent to make or keep any set of providers financially whole? How can the goal of rebalancing between institutional care and home and community-based services best be achieved? Is this a good opportunity to move to a more contemporary reimbursement model, such as Value-Based Payment?

There is little question that a transformation of this magnitude presents a natural opportunity to improve quality of the services and systems. Defining what that quality looks like is often difficult. Relying on a “know it when you see it” approach is insufficient. The department cannot wait until it has designed a model before it begins addressing questions of quality, how it is to be measured, and more importantly, how it is to be rewarded.

Other fundamental questions must still be answered. Will this integrate physical health services? Can behavioral health services also be added? What happens to MI Health Link in 2020? Are individuals eligible for both Medicare and Medicaid to be included in this initiative? If so, how can the model retain savings from physical health and acute care efficiencies and not have all of those accrue to the federal government? The manner in which the department chooses to answer each of these questions will be vital in determining how to design the MLTSS system.

Basic Design Principles

MDHHS is not undertaking this process without some tools already available. The CMS website provides links to a toolkit that includes a variety of resources that are immediately relevant and useful. These tools can supplement the experience that has been gained by operating long term supports and services programs in a managed care environment. Rather than re-invent the wheel, it will be advantageous for the department to recognize this established body of learning and incorporate it into its planning and preparation.

One of the tools offered on the CMS site is a compilation of ten key principles inherent in a strong MLTSS program. They provide a checklist of the considerations that will need to be included in this project. The elements are:

1. Adequate Planning and Transition Strategies¹
 - a. Clear vision for the program
 - b. Stakeholder input
 - c. Training and education
 - d. Readiness assessment – state and plan level
 - e. Quality standards
 - f. Safeguards
 - g. Oversight
2. Stakeholder Engagement
3. Enhanced provisions of HCBS
4. Alignment of Payment Structures with MLTSS Programmatic Goals
 - a. Incentives to
 - i. Improve health
 - ii. Improve experience
 - iii. Reduce costs
5. Support for Beneficiaries
 - a. Enrollment/disenrollment services
 - b. Option counseling
 - c. Peer support
 - d. Ombudsman
 - e. Appeals process
6. Person-centered Process
 - a. Active participation by the beneficiary or designees
 - b. Holistic service plans
 - c. Comprehensive needs assessment
 - d. Opportunity for self-direction
7. Comprehensive and Integrated Service Package
 - a. Physical health
 - b. Behavioral health
 - c. Community-based and institutional LTSS
8. Qualified Providers
 - a. Adequate capacity of network
 - b. Continuity of care
9. Participant Protections
 - a. Robust health and welfare safeguards
 - b. Critical incident management
 - c. Appeals process
10. Quality

Clearly, these elements represent a tremendous amount of work. The department has engaged the Center for Healthcare Research & Transformation (CHRT) and Public Sector Consultants (PCS) who will be working in tandem

¹ “Summary – Essential Elements of Managed Long Term Services and Supports Programs”; Centers for Medicare and Medicaid Services; <https://www.medicaid.gov/medicaid/managed-care/ltss/index.html>.

to assist the department in this work. CHRT recently submitted a report that reviews long term services and supports in Michigan and what other states are doing in terms of MLTSS. PSC will lead a process to engage stakeholders that will involve three central components:

1. Key Informant Interviews
2. Public Forums or Focus Groups
3. Stakeholder Workgroup

The list provided by CMS can certainly be considered a “basic” list. Even before work has begun, it is readily evident that additional elements must be included. For example, compliance with the recent Managed Care Rule must be part of the design. This includes elements such as application of Medical Loss Ratios, internal appeal processes, conflict-free case management, external quality reviews, well-defined provider sanctions, and access to adequate choice counseling. The HCBS Settings Rule stipulates stringent new criteria that providers must meet to receive Medicaid HCBS reimbursement. The 21st Century Cures Act requires that Electronic Visit Verification (EVV) be phased in for providers of in-home services. Individually, each of these requirements represents a challenge to fully understand, design, and implement. Perhaps it is fortunate that MLTSS provides a blank slate from which to work toward future compliance.

Additional concerns:

- Respecting end of life wishes

Core Staff

Project direction and key approvals and decisions will come from MSA and MDHHS leadership. The department has already begun working with external partners such as CHRT and PSC (mentioned above) to provide additional expertise in planning and designing an MLTSS process. That list is certain to expand. Meanwhile, a core set of internal content experts will be needed to vet the various options that become available and make recommendations to department leaders so that work can proceed in a smooth and timely fashion. The team of core staff might include:

Central Facilitation – Brian Barrie
LTSS Policy – Michael Daeschlein
HCBS Services – Elizabeth Gallagher
MLTSS Facilitation – Liz Aastad
CMS Coordination – Jacqueline Coleman
Cost Analysis & Rate Setting – Penny Rutledge
Nursing Facility – Ryan Tisdale
MI Choice – Heather Hill
PACE – Roxanne Perry
Home Help – Michelle Martin
MI Health Link – Pam Gourwitz
Behavioral Health – Belinda Hawks
PDN/Hospice – Michelle Tyus
Managed Care – Kim Hamilton
State Quality Strategy – Tom Curtis
LTSS Quality Strategy – Cheryl Decker

State and Federal Authority

MDHHS must examine the various options that provide the necessary authority to operate an MLTSS program in Michigan. The type of authority that is ultimately established will fundamentally determine exactly what the program to look like and how it will operate. In order to use Medicaid funding, the program will need proper federal authority. This authority gets more complex if the program will be integrating services for persons covered by Medicare as well. State authority will manifest itself chiefly through the appropriation process, but there are other parameters to consider.

Federal authority will be established through the Medicaid State Plan and through any number of possible waivers or combination of waivers. The selected authority will have a major impact on the ultimate design and operation of the MLTSS model. Each option offers a unique set of benefits and each operates with a distinct set of rules. It is vital that the department carefully examine the advantages of each approach as well as understand the limitations and expectations that each will entail.

MDHHS is not without experience here and CMS stands ready to provide technical assistance when needed. Many of the existing LTSS programs are provided through Section 1915 (c) waivers, 1915 (b) waivers, (b)/(c) combination waivers, and 1115 waivers. This is only a portion of the waiver authorities available. Newer authorities, such as a 1915 (b)/(i) combination may allow for the creativity needed to foster this systemic change.

Work Plan and Time Line

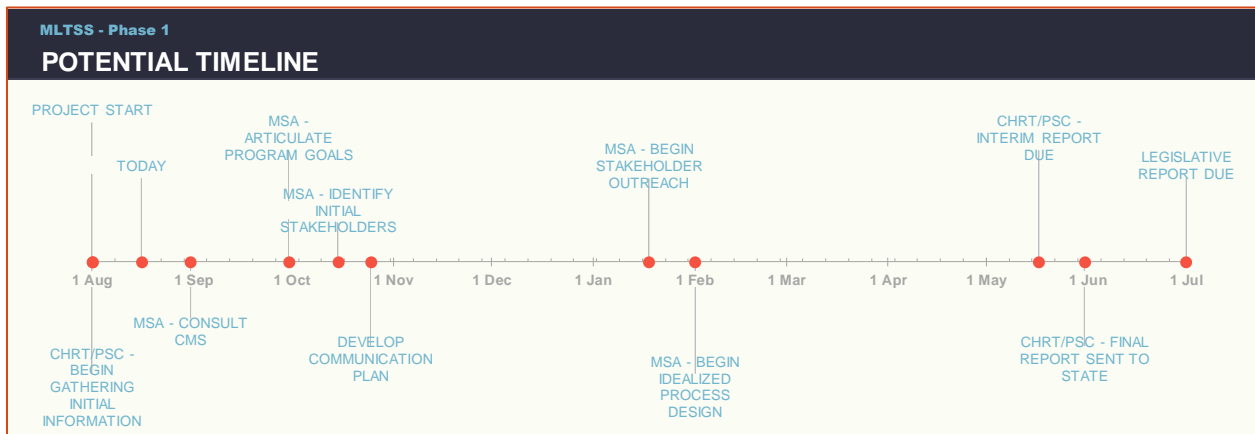
CMS has provided guidance on the elements that are most often included in the work plan to develop an MLTSS system. Michigan's approach may differ slightly, but the essential components and general order is likely to look much the same. The CMS approach includes:

1. Phase 1: Planning²
 - a. Engage Stakeholders
 - b. Develop Communications Plan
 - c. Articulate Program Goals
 - d. Design Program
 - e. Consult CMS
 - f. Assess Operational Needs
 - i. Internal capacity to administer program
 1. Contract management
 2. Quality management
 - a. EQRO
 3. Rate setting
 4. CHAMPS
 5. Other IT

² "Timeline for Developing a Managed Long Term Services and Supports (MLTSS) Program"; Centers for Medicare and Medicaid Services; Prepared by Truven Health Analytics; <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-timeline.pdf>; May 2013.

6. Enrollment process
7. Other
- g. Develop Project Work Plan
2. Phase 2: Implementation
 - a. Continue Stakeholder Dialogue
 - b. Obtain Legislative and CMS Approval as Needed
 - c. Phase In Operational Resources
 - d. Select Contractors and Third-Party Vendors
 - e. Inform Beneficiaries and Providers
 - f. Conduct Readiness Reviews
 - g. Begin Enrollment
3. Phase 3: Refinement
 - a. Continue Stakeholder Dialogue
 - b. Monitor
 - c. Correct Operational Bugs
 - d. Review Early Experience

The work plans submitted to date generally follow this suggested format. CHRT and PSC have already begun the initial work of researching options and preparing for stakeholder outreach. The timeline below suggests a work plan that includes many of the tasks needed to prepare a report on a plan to be submitted to the legislature by July 1, 2018.



As this time line is quite high-level, there are a number of steps that need to be taken soon. In particular, the department needs to:

- Identify departmental resources and responsibilities
- Begin articulating programmatic objectives
- Oversee the establishment of key guiding principles
- Continue working with CHRT and PSC to develop background information, a work plan, and begin receiving stakeholder input.

