



LTSS Care Plans, Authorizations and Consumer Protections

Governor's Commission on Medicaid Care Management

January 14, 2016

Agenda

- Introduction
- Acute vs. LTSS authorizations
- Critical role of member care plan
- Ensuring members get services
- LTSS Ombudsman
- Questions

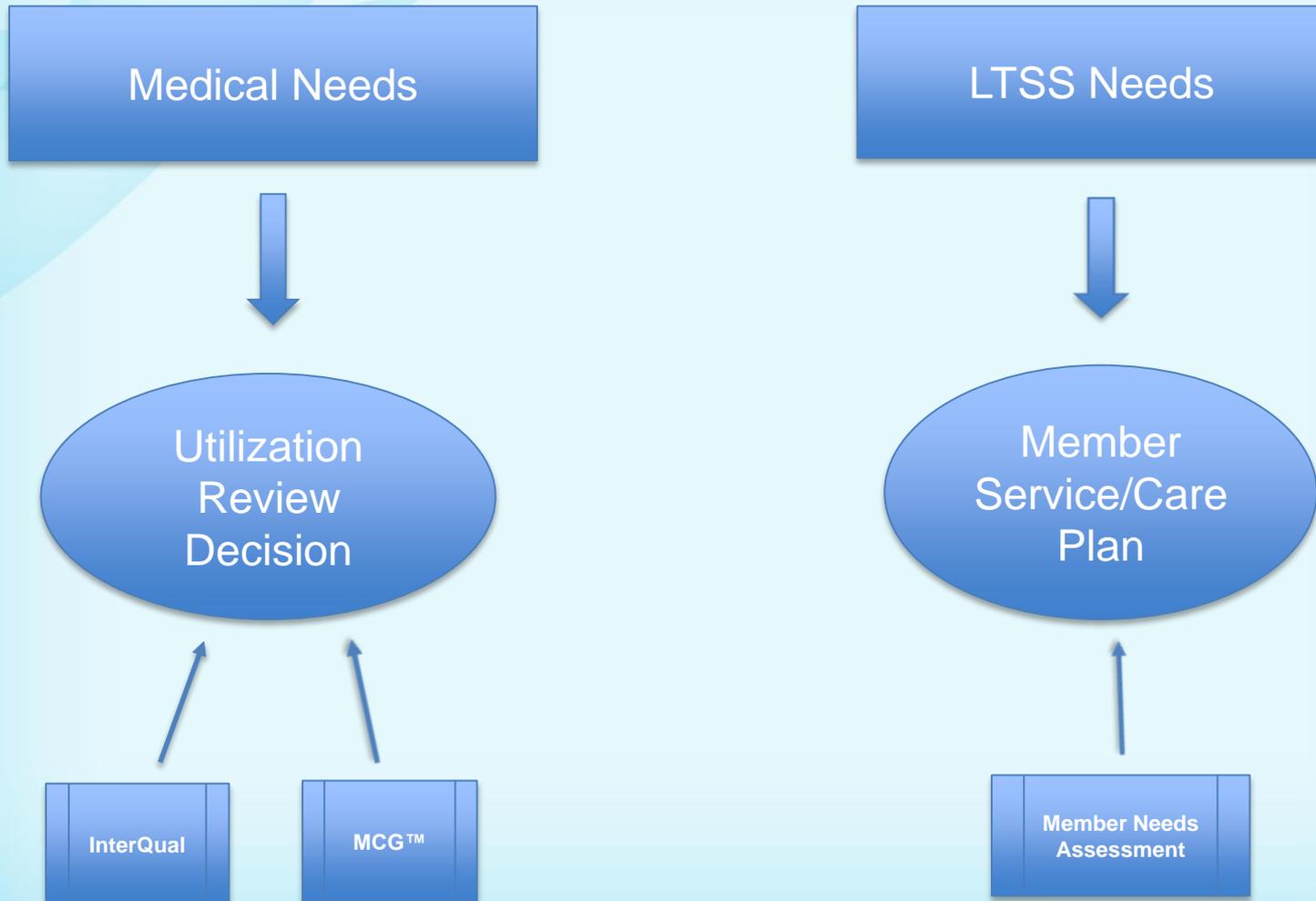
My Background

- 20 years in Medicaid managed care:
 - Worked in Medicaid MCOs in Maryland doing operations and regulatory compliance for 10 years
 - Increasingly senior positions in CMS on Medicaid delivery systems since 2005
- Senior Policy Advisor on Medicaid managed care
 - National expert on MLTSS
 - one of primary authors of CMS MLTSS guidance and proposed Medicaid managed care regulations
- Providing intensive TA to new MLTSS states at NASUAD

MCO Authorization Processes

- For medical services, there are nationally-recognized, clinically-based guidelines which suggest the amount, duration and scope of service provision based on consumer's diagnosis (either prior to or concurrent with service provision)
- For LTSS services.....
 - Personal care services; homemaking; environmental modifications; PERS; home-delivered meals; adult day
 -no such widely-accepted guidelines exist.
 - The member's care plan is the driver!
 - Services are planned and coordinated

MCO Authorization Processes



MCO Authorization Processes - Comparison

- Hypertension diagnosis → need for Rx → MCO uses UM criteria to determine drug and refill frequency

VS.

- Desire for employment → discuss interests /opportunities, need for job coach in care plan → options offered and support secured

LTSS Needs Assessment

- Key to appropriate and effective service authorization in LTSS is consistently applied **needs assessment tools/processes** and a **service/care plan** that is person-centered and responsive to whatever has been identified in the assessment process.
- Is intended to elicit information about member's goals, preferences and choices

LTSS Needs Assessment

- Typically includes the following dimensions:
 - Activities of daily living (i.e., bathing, dressing, mobility, transfers, eating, or toileting);
 - Instrumental activities of daily living (i.e., meal preparation, medication management, money management, telephone, and employment);
 - Natural (informal caregiver) supports;
 - Cognition;
 - Health status; and
 - Mental/behavioral health status.
- MCO may be able to glean some of this information from functional eligibility determination process (ie. ADL/IADL needs)

LTSS Needs Assessment → Care Plan Development

- Needs assessment information naturally leads to determination of services necessary to meet those needs: the Care Plan
 - National plans with experience in multiple states may have started to develop ‘home-grown’ guides for care plan development
 - States/plans using InterRAI™ assessment tool have access to interpretive guides to assist care plan development

Care Plan Development and Implementation

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- Generally a shared mutual focus on maintaining community living
 - For waiver recipients, individual cost limit adherence is also a factor
- Care plan should address every aspect of need identified in assessment

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Ensuring 'members get services'

- One of two tenets underlying TN transition to MLTSS
- State must take responsibility for this; multi-faceted approach
 - MCO contract
 - MCO expectation-setting/training
 - Consumer and provider education
 - State oversight and monitoring
 - LTSS Ombudsman

Ensuring ‘members get services’

Identified ‘best practices’ include:

- Continuity of care period where current care plans continue unmodified
- State review of service plan reductions (at least first year)
 - Important to define what a ‘reduction’ is
 - Substitution of services may be OK if identified needs are met appropriately
- Detailed contract language for care coordination and care plan development
 - Prohibition on shortened period of service authorizations

Ensuring ‘members get services’

Identified ‘best practices’ include:

- MCO training on care coordination and current waiver programs
- LTSS provider outreach/communication and training
 - State to current providers
 - MCO training and expectation-setting
- Clear and regular communication about changes to consumers (and their advocates)

Ensuring ‘members get services’

Identified ‘best practices’ include:

- System of accountability and responsibility in state agency
- State staff training on MCO contract and expectations
- Quality monitoring system in place with policies in place for trend identification and remediation
 - Appeals and grievance/ombudsman reporting
 - Critical incident reporting and follow-up
 - Stakeholder feedback
 - Quality measures
- Functioning LTSS ombudsman program

LTSS Ombudsman Program

- Identified in long-standing MLTSS programs as significant benefit for consumers as well as quality improvement (AZ, WI)
- Required by CMS for LTSS programs (currently through waiver approvals; by end of 2016 will be a regulatory requirement)
 - At state option, can extend to non-LTSS programs

LTSS Ombudsman Program

- Core functions:
 - Access point for complaints and concerns about MCO enrollment, access to services, and.
 - Advocate on member's behalf to informally resolve problems with their providers or MCO
 - Help members understand MCO appeal process and right to State fair hearing
 - Assist members in filing an MCO appeal, including guiding them through needed documentation
 - Assist members in requesting a State fair hearing
 - Referring beneficiaries to legal counsel if necessary.

LTSS Ombudsman Program

- System design options
 - State-managed (ideally outside Medicaid agency)
 - Contracted
- Identification of trends, patterns critical part of MCO monitoring
 - Assist members in filing an MCO appeal, including guiding them through needed documentation
 - Assist members in requesting a State fair hearing
 - Referring beneficiaries to legal counsel if necessary.

Questions/Discussion



For more information, please visit: www.nasuad.org

Or call us at: **202-898-2583**

Camille Dobson
Deputy Executive Director
cdobson@nasuad.org