Timeline for Developing a Managed Long Term Services and Supports (MLTSS) Program

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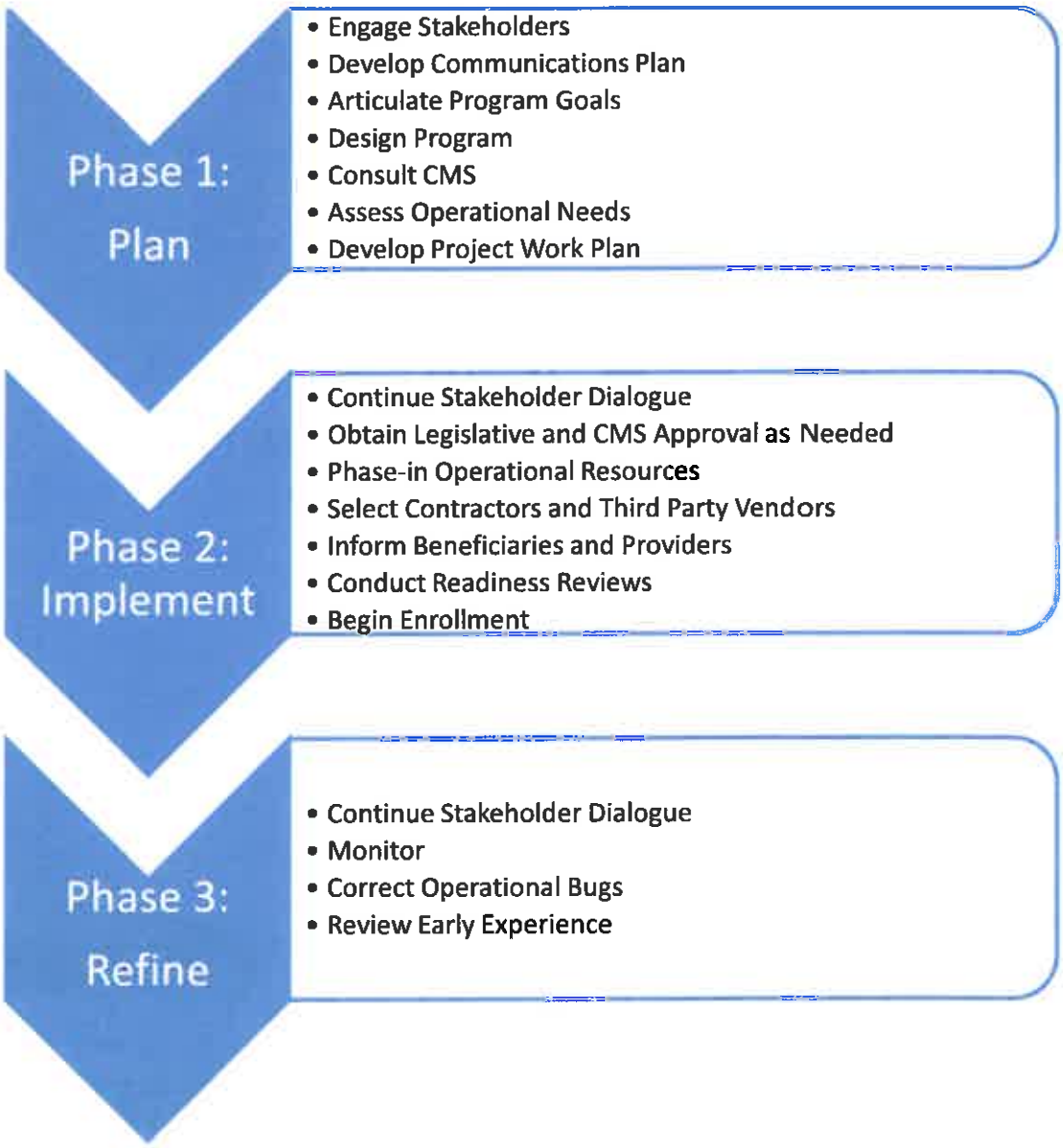
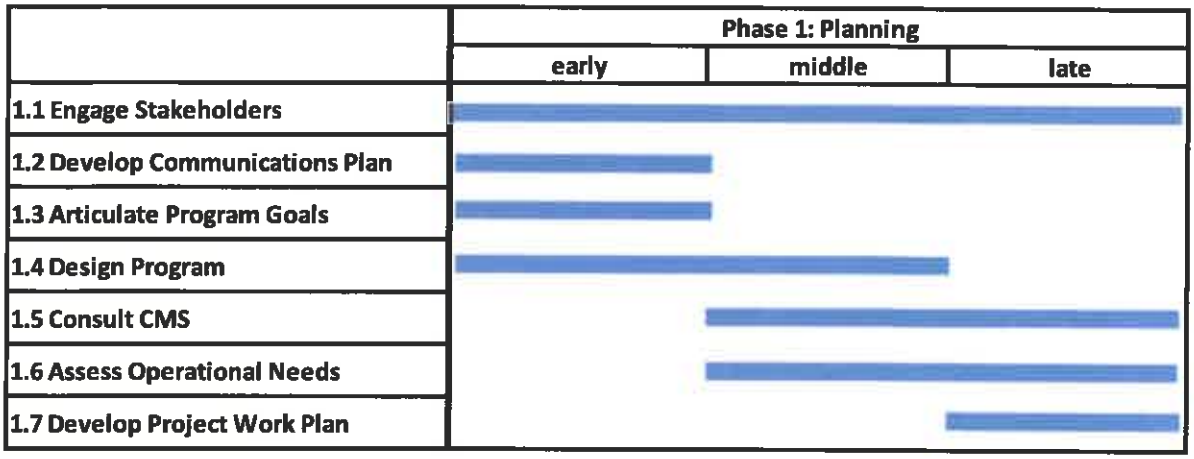
The following timeline indicates major activities that must occur in States in order to implement an MLTSS program. Each phase of the timeline is described in greater detail in subsequent pages. The specific time required for each phase will vary by State, depending on such readiness factors as managed care infrastructure, stakeholder support and procurement policy.



Phase 1: Planning an MLTSS Program

States report that planning an MLTSS program is challenging and time-consuming. The following Gantt chart lists the major tasks involved in the planning phase and shows their overlapping nature. A description of the tasks follows the chart.



1.1 Engage Stakeholders (throughout all phases)

Continuous engagement of stakeholders is critical to success. This includes stakeholders external to State government, such as beneficiaries who use LTSS, advocates, LTSS providers, and those internal to State government, including aging and disability agencies, the insurance oversight agency, the Governor's Office and the Legislature. Strategies may include:

- A multi-stakeholder advisory committee;
- An internal State workgroup where all relevant State agencies can stay engaged in the process;
- A website where the public may view current information and submit input; and
- Individual interviews, focus groups and surveys of beneficiaries who use LTSS.

1.2 Develop Communications Plan (early Phase 1)

Regular communication is key to success, and many different constituencies must be considered: State agencies, consumer and provider groups, existing vendors, the public, legislative committees, etc. A communications plan should be established early in the planning process and updated as needed throughout the life of the project.

1.3 Articulate Program Goals (early Phase 1)

One of the early roles of stakeholders is to help establish a clear set of goals for the program. MLTSS goals typically fall into 3 areas:

- LTSS system goals, such as expanding HCBS and developing the workforce;
- Quality goals, such as increasing person-centeredness, improving coordination of acute care and LTSS, and reducing preventable hospital and nursing home admissions; and

- Cost goals, such as reducing the average per person Medicaid cost.

Goals will be refined as planning progresses, but they need to be articulated early in the planning process so they can guide program design. They are also critical to evaluating the program later.

1.4 Design Program (early to middle Phase 1)

Program design involves many decisions, including:

- Target group: Who will the program serve in terms of LTSS needs, age, type of disability, LTSS service setting (home, residential, institutional), Medicaid eligibility category, etc.?
- Services: What services will be included in the capitation? All Medicaid? Are HCBS waiver services included? Are Medicare services included?
- Service Coordination: What model of service coordination will be implemented? How will it improve coordination between medical services and LTSS?
- Location: Will the MLTSS program be implemented Statewide? If not, where will it be implemented? How does LTSS service delivery infrastructure impact this decision?
- Contractor Types: What will the requirements for contractor participation be? What capacity must they have for delivering LTSS and managing financial risk?
- Payment Method: How will the payment method provide incentives for HCBS and otherwise advance program goals?
- Authority: Based on all of the above, under what State and federal authorities will the program operate?
- Role of aging and disability organizations: What role will the State aging and disability agencies play in overseeing the program? What role will Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Aging and Disability Resource Centers and others play in the program?

1.5 Consult CMS (middle to late Phase 1)

Early consultation with CMS about federal authority options for MLTSS is highly recommended. There is no need to wait until you have a formal waiver or State Plan amendment proposal. In addition to advice, CMS may be able to make technical assistance resources available early in the design process.

1.6 Assess Operational Needs (middle to late Phase 1)

Once basic decisions have been made, you can begin an internal assessment of the State's capacity to effectively administer the new program. In most cases, this will involve working with other State agencies, such as aging, disability, and insurance. Areas to assess will include:

- Contract management: The program will need contract managers who have experience overseeing managed care contracts and expertise in LTSS. Does your State have a Medicaid managed care program for other populations? If so, how must the existing contract management function be enhanced to oversee the MLTSS program adequately? If not, how will this critical function be structured?

- Quality management: How will current LTSS quality resources be integrated into an overall quality management strategy? If your State has an existing Medicaid managed care quality infrastructure, how will it be enhanced and organized to incorporate LTSS quality? Will you need to procure EQRO services, or can you amend a current contract to integrate LTSS-related activities?
- Rate setting: Does your staff and/or actuarial consultant have experience setting capitated rates that include LTSS?
- Medicaid Enterprise System: What system changes will be required to enroll beneficiaries, make capitated LTSS payments, redirect cross-over claims to contractors, collect LTSS encounters, etc.? Who will be responsible for developing specifications and implementing and testing system modifications? How long will these system changes take to implement?
- Enrollment process: Does your State currently have managed care enrollment capacity (in-house or through a 3rd party vendor)? If so, how does that capacity need to be enhanced to provide LTSS-related information and assist the target group with enrollment? If not, how will this function be structured?
- Other fiscal and service impacts: Are State employees currently providing Medicaid-funded case management that will be done by contractors in the future? If so, what are the fiscal impacts for the State and how will the transition be managed?

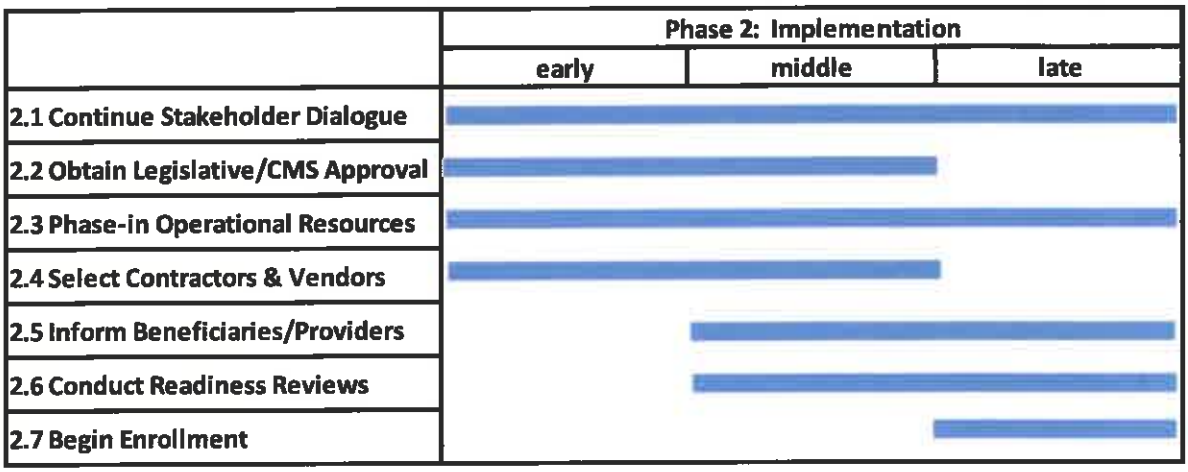
1.7 Develop a Detailed Project Work Plan (late Phase 1)

Toward the end of the planning process, a detailed project work plan should be developed to ensure an orderly and effective implementation. The plan should include:

- A detailed set of tasks with timelines, responsible parties and milestones; and
- A clear sequence, indicating which tasks are dependent on others having been accomplished first.

Phase 2: Implementing an MLTSS Program

This phase begins with the decision to implement the plan and culminates in the enrollment of beneficiaries. Implementation includes putting operational resources into place at the State level, selecting contractors, conducting outreach to beneficiaries and providers and obtaining federal approval for waivers or State Plan amendments as needed.



2.1 Continue Stakeholder Dialogue (throughout all phases)

Interest among stakeholders increases when it becomes clear that the State intends to move forward with implementation. Effective dialogue becomes even more important in this period. State procurement rules should be reviewed and communicated to stakeholders as they relate to conflict of interest. Stakeholders with interest in bidding on all or parts of the future program may need to recuse themselves from the advisory process at this point. This may include managed care organizations and provider organizations interested in becoming program contractors, advocacy organizations interested in performing a consumer support function for the program, administrative organizations interested in becoming enrollment brokers, etc.

2.2 Obtain Legislative and CMS Approval as Needed (early to middle Phase 2)

The need for Legislative approval varies across States, but at a minimum, the Legislature should be consulted at this point to ensure ongoing support for the initiative. Even if statutory authorization is not required, the program is very likely to need budget approval for operational resources, including new and reallocated staff positions and funding for third party vendors.

The federal approval process depends on the authorities used and the completeness of the proposal submitted. CMS has 90 days to review State Plan amendments and 1915(b) and (c) waivers. If CMS submits questions to the State, a new 90-day period begins with the State's submission of answers. There is no set period of time for reviewing 1115 demonstration proposals, so time involved will vary.

Note that many LTSS users (e.g., Medicare-Medicaid enrollees and children with special needs) are exempt from mandatory enrollment under a Section 1932 State Plan amendment, so States

pursuing mandatory enrollment for those populations must seek a 1915(b) waiver or 1115 demonstration.

2.3 Phase-in Operational Resources (throughout Phase 2)

Operational resources (new staff and contract resources) will be phased in during this time. These may include reassigning staff from Medicaid, aging and disability departments, amending current contracts (e.g., with the State's Medicaid Enterprise System vendor), and procuring new vendors (e.g., for external quality review organization services). Based on the assessment of needs conducted in the planning phase, the following will be addressed:

- Contract management capacity that includes knowledge of managed care and of LTSS;
- Quality management capacity specific to LTSS for the populations included in the program. This may include both internal staff resources, and a special LTSS focus in an EQRO scope of work;
- Rate setting capacity to incorporate LTSS into capitated rates and develop incentives for HCBS. As part of the procurement process, the staff or contractors working on rate setting will also be called upon to assemble historical data for prospective bidders; and
- Significant changes to the Medicaid Enterprise System which will take time and should begin immediately.

2.4 Select Contractors and Vendors (early to middle Phase 2)

Depending on a State's procurement rules and strategy, this may take many forms, but typically involves:

- Developing program specifications that address person-centered case management, level-of-care assessments, LTSS network adequacy, participant-directed service options, coordination or integration with Medicare services, LTSS quality measures, LTSS workforce development expectations, and other topics not typically found in Medicaid managed care;
- Developing a data book of historical experience for prospective contractors that includes detailed data on LTSS claims and the eligible population groups;
- Issuing a request for proposals, holding informational session(s) for bidders, and selecting contractors, contingent on successful readiness reviews; and
- Procuring third party vendor services, either by amending existing contracts or awarding new ones. These may include contracts for level-of-care assessments, financial management services and/or supports brokers for beneficiaries who are self-directing, enrollment broker services, other third-party assistance services, and EQRO.

2.5 Inform Beneficiaries and Providers (middle to late Phase 2)

In addition to general stakeholder dialogue, a specific outreach campaign is needed to reach all individuals who will be eligible for the program, as well as all impacted providers. The beneficiary notice process typically consists of a series of letters, initially alerting beneficiaries to future changes, and culminating in instructions regarding how to enroll. For LTSS users, this process must include guardians and representatives and is likely to create anxiety for persons in long-term residential or supported environments. Outreach to these groups should be closely

coordinated with community organizations likely to receive questions, such as Aging and Disability Resource Centers, Centers for Independent Living, State Health Insurance Counseling and Assistance Programs, Area Agencies on Aging, and State Councils on Developmental Disabilities.

LTSS providers also need information about how the MLTSS program will impact them. These range from large, multi-service agencies to individuals hired directly by beneficiaries as part of participant-directed options. Providers need to know how business practices, such as service authorization and billing, will work and whether or not they are assured continuing business. Also, transitional provisions and billing must be explained. In addition to communication, the State should ensure that training opportunities are made available to providers regarding the changing nature of their Medicaid business.

2.6 Conduct Readiness Reviews (middle to late Phase 2)

Before a contractor is allowed to enroll members, a comprehensive readiness review process must occur to ensure the contractor has the staff, policies, protocols, systems and provider network in place to effectively delivery LTSS. This is a substantial undertaking that includes desk reviews of requested material, on-site reviews and weeks of system testing. The process should begin as soon as practical following contract signing, but the contractors will need time to formalize their provider agreements, hire new staff, conduct training, test their systems, etc. Readiness reviews are typically led by State staff and often supplemented by State vendors. MLTSS readiness reviews include, but are not limited to:

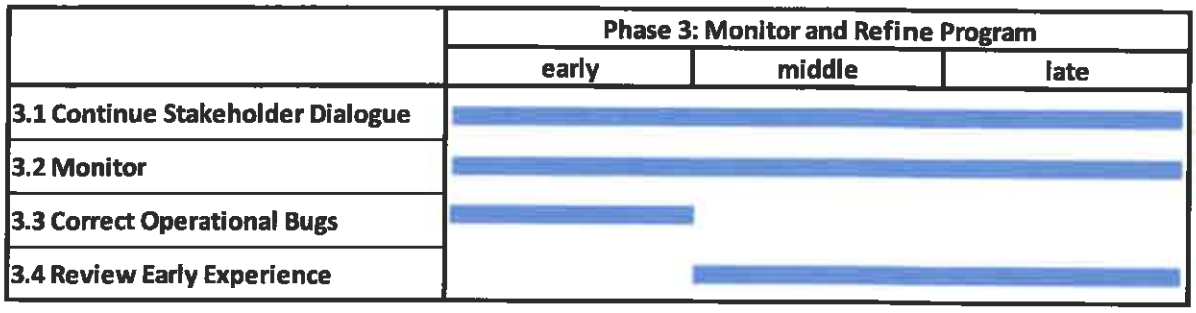
- Observing the case management process, which may include role playing an actual assessment and service planning session;
- Observing the capacity of the case management staff;
- Having contractors explain in detail how they will ensure continuity of care for new members and timely payment of providers during the transition;
- Checking provider agreements between the contractor and LTSS providers;
- Testing LTSS data transfer between providers and contractors, level of care assessors and contractors, financial management services providers and contractors. and contractors and the State;
- Ensuring that critical incident protocols and other member protections are in place; and
- Assessing the capacity of the contractor to measure LTSS quality.

2.7 Begin Enrollment (late Phase 2)

Contractors that are found ready begin enrollment, using whatever enrollment procedure is established in the contract. In the initial months of enrollment, States should monitor the process very closely, including maintaining frequent contact with contractors to identify and resolve any issues in the enrollment and transition process. Most importantly, the State should have a monitoring process that allows it to detect any interruption of service for members and significant payment delays for LTSS providers.

Phase 3: Monitoring and Refining

Once enrollment has begun, the process of close monitoring and continuous improvement begins.



3.1 Continue Stakeholder Dialogue (throughout all phases)

Stakeholder dialogue continues to be critical as the program becomes operational. Stakeholders can help take the pulse of the community and identify early problems or concerns. They can also help direct beneficiaries and providers to designated places to receive information, make suggestions and lodge complaints.

3.2 Monitor Program (throughout Phase 3)

Through in-person visits, phone contact, data monitoring and other means, the State will monitor the program, with particular emphasis on ensuring that LTSS is being delivered in accordance with service plans, and contractors are meeting all LTSS-related contract provisions. This process is very intensive in the early months of enrollment and may become less intensive once the program is operating smoothly.

3.3 Correct Operational Bugs (early Phase 3)

Even the best planning does not foresee every issue that may result from the transition, and the first few months of enrollment will focus on identifying and correcting unanticipated operational bugs. These may include:

- LTSS data lags or failures (e.g., eligibility, level of care assessments, LTSS encounters);
- A high incidence of denied LTSS claims; and
- Confusion about new protocols, such as how and when level-of-care assessments are conducted.

3.4 Review Early Experience (middle to late Phase 3)

Once early operational bugs are resolved, a more systematic review of the program's early experience may be conducted. Little if any quantitative data will be available at this early stage, but legislators and other stakeholders will be anxious to receive early information about the program. In addition to analyzing reports from contractors, the State may want to consider collecting qualitative feedback from members and LTSS providers through focus groups, key informant interviews and phone surveys.