



COMMUNITY-BASED ORGANIZATIONS AND MLTSS:

An Issue Brief to Assess CBO Readiness

COMMUNITY-BASED ORGANIZATIONS AND MLTSS:

An Issue Brief to Assess CBO Readiness

EXECUTIVE SUMMARY

The growth of managed long-term services and supports (MLTSS) across the country pose challenges and opportunities for community-based organizations (CBOs). These organizations have been historic providers of home- and community-based services, which in a MLTSS delivery system, moves from direct control by the state to managed care organizations (MCOs). CBOs are faced with determining what, if any, role they want to play in this new system.

There are a series of considerations that CBOs need to address when assessing the feasibility of participating in an MLTSS program including:

- relevant skill set and experience;
- performance tracking and reporting;
- geographic reach and scale; and
- financial viability.

Each of these considerations should be reviewed in the context of the new or expanded business opportunities that present themselves in an MLTSS program. CBOs could serve as the State's level-of-care/functional assessment provider, options/choice counseling agency, enrollment broker, or MLTSS ombudsman as well as a care management/service coordinator subcontractor to the MCOs. These opportunities may or may not have existed under a state's fee-for-service system but under an MLTSS system, are expected to be in place consistent with CMS' guidance for MLTSS programs.

This issue brief discusses each of these opportunities in the context of the four enumerated considerations. CBOs are encouraged to complete a self-assessment before pursuing any of these opportunities.

INTRODUCTION

Community-based organizations, such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) have formed the backbone of the home- and community-based service (HCBS) delivery system for seniors and adults with physical disabilities for the past three decades. CBOs have provided long term services and supports (LTSS) using a variety of funding sources including both federal funds (such as the Older American Act funding) as well as state appropriations. Increasingly, however, CBOs have been relying heavily on Medicaid fee-for-service payments to support their operations. For many of these agencies, providing care planning and service coordination for Medicaid beneficiaries receiving HCBS has become a significant source of revenue.

As states transition their LTSS system from a fee-for-service orientation to a primarily risk-based managed care model, CBOs are faced with carving out new roles for themselves. Moreover, the extraordinarily rapid shift to managed long-term services and supports (MLTSS) seems to have caught many of these agencies by surprise. The shift also presents a real threat to their sustainability. Rather than the state controlling, or directing service provision using the CBOs, that role has now shifted to MCOs. It is important to note that new requirements on state agencies moving to MLTSS also presents opportunities for CBOs.

States and CBOs have a mutual interest in finding new roles to sustain the aging and disability networks. States are understandably concerned by the prospect that they might lose safety net capacity, particularly in rural regions, if large numbers of these CBOs close or become insolvent. While some attrition can be expected under a MLTSS program, states cannot afford to see the existing delivery system completely diminished.

The advent of MLTSS offers an opportunity to reinvent the aging and disability networks and set new expectations based on customer needs and desires. At the same time, AAAs and/or CILs may be especially well-suited to provide key support services, drawing on their core competencies, their visibility within their communities, and their historical strengths.

For MLTSS programs, states need new consumer education, enrollment and advocacy infrastructure—components that may or may not have been in place in fee-for-service programs. CMS' May 2013 guidance on MLTSS programs¹ outlined specific program features that states are expected to incorporate into those programs. These include:

¹ "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs" <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>.

- Functional eligibility assessments conducted by entities free from conflict of interest
- Consumer education and pre-enrollment assistance
- Consumer advocacy and post-enrollment assistance

This issue paper outlines a series of considerations that CBOs need to analyze as they assess their readiness to participate in MLTSS. The genesis of this work was a day-long MLTSS intensive at the 2013 HCBS conference. This paper begins with an overall discussion of the business capacity and structural considerations that CBOs should consider to determine if they want to and can participate in the MLTSS opportunities. While it does lay out a framework for analysis and discussion, the paper does not provide an exhaustive list of questions for consideration. Finally, the paper discusses five possible functions that CBOs could perform in an MLTSS environment.

1. Level of care/functional assessments
2. Options/choice counseling
3. Enrollment broker
4. MLTSS Ombudsman
5. Case management/service coordination

The paper also carefully references recent policy guidance from CMS, setting out the federal Medicaid agency's expectations for states implementing these functions. A successful transition by one state's CBOs into new roles is also highlighted. Additional case studies of CBOs that have successfully adapted their business models to the MLTSS environment are discussed in separate publications.

BUSINESS CAPACITY AND STRUCTURAL CONSIDERATIONS FOR CBOs

The first, most critical question that a CBO must answer is this: Does the CBO want to engage in the MLTSS program? One of the first steps in assessing whether or not a CBO wants to participate in MLTSS is to determine what their business and legal capacity is for such participation. There are fundamental differences in a MLTSS environment than the typical grant-based and fee-for-service environment within which CBOs are accustomed to operating. Additionally, the governing/legal structure of the CBO may determine feasibility; a government-sponsored CBO (i.e. one operated as a county agency) may face limitations in operating in a business environment. Non-profit or independent CBOs may have fewer barriers to overcome.

As a first step, CBOs should do a careful analysis of its strengths and weaknesses, mission, and core objectives to determine if a partnership in MLTSS fits. They are likely to be asked to expand scope, meet more rigorous performance expectations, and serve constituencies they haven't served before. Further, CBOs should carefully consider whether they want to partner with other CBOs in order to carry out the objectives. As discussed below, each CBO's reach may be limited.

The CBO will have to ‘make a case’ to either the MCO or the state that they can:

1. Demonstrate a track record of success in similar activities;
2. Maximize administrative efficiency realized by using existing community structures; and
3. Provide performance and outcome data.

The CBO should also be prepared to demonstrate that its ability to provide those functions is not hampered by conflicts of interest. Such conflicts have existed in the fee-for-service system, particularly in the area of functional eligibility assessments, where service providers are frequently involved in determining waiver eligibility for individuals for whom they then provide services. In May 2013, CMS issued seminal guidance regarding its expectations as states deploy MLTSS programs, “Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs.” In that document, CMS made it clear that such conflicts are not acceptable in MLTSS programs:

MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, and consumer-friendly.²

Consequently, CBOs will need to decide whether they want to continue to be service providers—very likely for the MCOs contracted with the state—or provide system support functions for the state, such as functional/level-of-care assessments, choice counseling, managed care enrollment, or ombudsman services.

Once the threshold question—does the CBO want to pursue MLTSS opportunities?—is answered affirmatively, each CBO will have to assess their skills, abilities and resources relative to each of the following considerations to determine which MLTSS opportunities align the best:

- relevant skill set and experience;
- performance tracking and reporting;
- geographic reach and scale; and
- financial viability.

Relevant Skill Set and Experience

Key Questions: Does the CBO have leadership and employ personnel that can operate in an entrepreneurial way? Is the CBO ready to broaden the base of its clientele? Is the CBO able to demonstrate quality control?

CBOs will need to decide whether they want to continue to be service providers—very likely for the MCOs contracted with the state—or provide system support functions for the state, such as functional/level-of-care assessments, choice counseling, managed care enrollment, or ombudsman services.

² “Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>, page 3.

Moving from a grant-based environment to a competitive business environment can be challenging. Contracting with either the state or an MCO requires a business focus.

Not all CBOs have leadership and staff to successfully navigate the changes in operations, such as defining and packaging a 'product'; translating labor hours into a product price; calculating the buyer's return on investment for purchasing the product; and ensuring existing data systems and technology can support (or new systems can be built to support) data analytics and performance measurement.

Moreover, contracting with a MCO may require CBOs to expand their clientele from just serving the elderly or adults with physical disabilities to also serving individuals with intellectual/developmental disabilities. Individuals receiving LTSS include a range of populations including the elderly, adults with physical disabilities, individuals with intellectual/developmental disabilities, traumatic brain injury, and in some cases, children with special health care needs. Serving the entire population base of those receiving MCO services may require the CBO to hire additional personnel with specialized skills and knowledge. CBOs will also need to provide evidence that they are able to serve clients in a variety of settings from community or an institutional setting. CBOs need to demonstrate experience and understanding of the unique needs and preferences of these diverse populations in order to provide the most value to either the state or the MCOs. Familiarity with assisted living facilities, adult day programs, home health and home care services, transitional programs such as Money Follows the Person, transportation, financial management, and nutrition programs may all be required. In some cases, a deep understanding of managed care principles and operations may also be necessary depending upon which type of role the CBO chooses to pursue.

CBOs must be able to address the concern of quality control and consistency. Either the state or the MCO—as a purchaser of the CBO's services—will expect that services are provided consistently and at a high level of quality. This is of particular concern for functional/level-of-care assessments, where standardization and consistency of determinations is critical. Inaccurate or inconsistent assessments can have deleterious effects on the program. Timeliness is also a concern for enrollment functions, where both the state and the MCOs have a mutual interest in facilitating expeditious enrollment into the MCO.

Performance Tracking and Reporting

Key Questions: Can the CBO track, monitor and report on its performance, including metrics of reliability/validity, timeliness and quality? Is the CBO's current information technology infrastructure sufficient?

This is a critical competency in all functions a CBO may perform. As an MCO contractor, the CBO must be able to demonstrate adequate performance and assist the MCO in meeting its contractual obligations to the state. Very often, the CBO who is providing services—case management, transportation, meals—to MCO enrollees will have to demonstrate value for the payment received. That may involve calculating return-on-investment to the MCO or improved results on member satisfaction surveys.

Likewise, a CBO that provides support services as a contractor to the state will need to have the capabilities of tracking both activities—calls answered, beneficiaries assessed—as well as outcomes, including timeliness. Having information technology systems that provide for systemic collection of information, data analytics and communication with other systems will be critical.

Reach and Scale

Key Questions: Does the CBO have the geographic reach and resource scale to provide services regionally or statewide? Does the CBO need to consider joining a collaboration of multiple CBOs or partners in order to be successful?

MCOs may be reluctant to divide service contracts between numerous, modestly capitalized local agencies, fearing that doing so might limit those smaller organizations capacity to attract and hire sufficient skilled staff to manage the caseload (particularly in smaller job markets) and compromise their ability to afford and/or acquire the technology systems necessary to effectively meet contract requirements. The infrastructure requirements for many of these service functions may dictate that they need to be housed within organizations that have the necessary critical mass. Moreover, states and MCOs desire consistency across their service areas. States may also use the move to MLTSS to standardize and streamline the aging network's services. Contracting with one Aging and Disability Resource Centers (ADRC) (as Kansas did) or a single ombudsman organization may be preferable for administrative purposes. This may make it more challenging for smaller CBOs to compete. As such, it may make some sense for CBOs to partner in order to build capacity and streamline the administrative burden.

Financial Viability

Key Question: Can the CBO maintain fiscal solvency with the volume of work available under the contract?

CBOs which contract with MCOs as service providers need to assess whether the volume of MCO beneficiaries they might serve will bring in sufficient revenue. Unless the CBO intends to contract with multiple MCOs, it is likely that they will serve fewer beneficiaries than they had previously served under fee-for-service (FFS). Likewise, when taking on the service support functions under the state's control, it is possible that scope of services—and funding attached—may be less than what had previously been received when the CBO was providing direct services.

A unique issue is presented for CBOs conducting level-of-care/functional assessments. While the CBO generally will conduct assessments for Medicaid beneficiaries new to service, in nearly every state implementing MLTSS thus far, responsibility for the annual reassessments shifts to the MCOs. Revenue from this line of business may taper off once the managed care systems become established and have enrolled the majority of Medicaid-eligible individuals.

The next section discusses each of the five areas of opportunities for CBOs in an MLTSS environment. Concerns unique to that business opportunity are addressed in each, while also referencing the key questions and considerations discussed above.

LEVEL-OF-CARE/FUNCTIONAL ASSESSMENT

In the FFS delivery systems, states frequently contracted with CBOs to conduct an initial functional eligibility assessment³ to determine whether an applicant for Medicaid long-term care services required care and services equivalent to that rendered in an institutional setting, such as a nursing facility—generally referred to as a ‘level of care’ (LOC) determination. Along with the financial eligibility test conducted by the Medicaid agency, the functional eligibility assessment determined whether Medicaid would cover the cost of a nursing facility or HCBS waiver services.

In the FFS system, it was not uncommon for the entity conducting the functional assessment—which for all practical purposes dictates Medicaid eligibility—to also serve as a provider of Medicaid waiver services, such as case management, financial management, transportation or meals. In many states, both roles were filled by CBOs.

In an MLTSS environment, states are anxious to minimize any inherent or perceived conflicts. Therefore, they have moved to identify and separate those functions so that directly or

CMS’ 2013 MLTSS guidance included an explicit directive that “MCOs may not be involved in any eligibility determination or functional assessment processes for a potential participant prior to that participant enrolling in the MCO.”

indirectly, the organization conducting the functional assessment does not have a financial stake in whether applicant is determined eligible for Medicaid services. CMS has also weighed in with their expectations for MLTSS programs. The 2013 MLTSS guidance included an explicit directive that “MCOs may not be involved in any eligibility determination or functional assessment processes for a potential participant prior to that participant enrolling in the MCO.”⁴

The result of CMS’ stance is that states moving their long-term care systems to MLTSS must acquire the capacity to perform conflict-free functional eligibility assessments.⁵ Because care planning and care coordination functions that many of these CBOs performed for Medicaid waiver participants in FFS is the responsibility of the MCOs

in an MLTSS environment, CBOs can provide that service to states since the potential for conflict-of-interest that existed in the FFS system is mitigated. Several states have turned to AAAs, CILs, or ADRCs to serve as the independent eligibility gateway into MLTSS, conducting functional assessments for every individual entering managed care.

Even for agencies that performed functional assessments in the FFS world, significant opportunity exists to expand that role, evaluating not only individuals coming into HCBS, but also those entering nursing facilities. Tennessee provides an example of this expanded scope of work. Prior to the implementation of the states MLTSS CHOICES waiver, the Area Agencies on Aging and Disability (AAADs) conducted the initial LOC determinations

³ Some states, such as Maine, contracted with an independent entity to perform the functional eligibility assessments, while a few others, like Vermont, elected to perform the assessments in-house with state staff.

⁴ “Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>, page 10.

⁵ For an example of this conflict of interest issue in an MLTSS program, see <http://www.nytimes.com/2013/04/23/nyregion/day-centers-lure-fit-elders-and-bill-medicaid.html?ref=nyregion>. A FFS example can be found at http://muskie.usm.maine.edu/Publications/ihp/CO_ConflictOfInterest.pdf.

for HCBS, but nursing facilities did their own functional assessments. With the implementation of CHOICES, the state amended its contract with the AAADs, expanding their functional assessment responsibilities to encompass both HCBS and prospective nursing facility residents.⁶

As states adopt MLTSS and restructure their long-term care systems, LOC determinations may be one of the functions that they procure through competitive bidding processes (other contracted functions might include enrollment broker and options/choice counseling).

It should be expected that requests for proposals for the LOC determination function will attract a variety of bidders. But, assuming potential for conflicts-of-interest have been neutralized, CBOs that have historically conducted functional assessments in the FFS system are ideally positioned to perform a similar role in a state's MLTSS system. Their extensive experience making LOC determinations, capacity to make independent unbiased eligibility determinations, and their familiarity with the MLTSS populations all make a strong case for filling this role.

OPTIONS/CHOICE COUNSELING

Another result of the shift to MLTSS has been the growing consensus that prospective beneficiaries should have access to independent, unbiased counselors who can discuss the range of available options and assist the consumer in making a person-centered choice with respect to their care and services.

Perhaps the most important role that options/choice counselors play in MLTSS is in the enrollment process, where consumers must decide which MCO to select. Options/choice counselors provide crucial advice during this stage, reviewing the respective MCOs, discussing their benefit packages and value-added services, comparing their provider networks and pharmaceutical coverage plans and, optimally, matching MLTSS consumers with the managed care plan that best meets their needs and preferences.

Beyond assisting consumers with the choice of MCO, options/choice counselors will also describe alternatives to an MCO, such as a capitated Program for All-Inclusive Care for the Elderly (PACE) program and discuss the range of long-term care options available, including nursing facility care, assisted living, and the range of HCBS supports. Options/choice counselors typically inquire as to whether the consumer wishes to self-direct their services. And, finally, options/choice counselors also provide advice and information when beneficiaries are considering switching managed care plans.

Structurally, the options/choice counseling role can be a standalone function, interposed between the LOC determination/functional assessment process and the enrollment broker. In this model, the agency conducting the LOC determination hands Medicaid-eligible consumers off to the options counseling entity which reviews the menu of MCOs and service choices with the consumer and, in turn, hands the consumer off to the enrollment broker to handle the process of signing them up with their chosen MCO or PACE program. More typically, however, options/choice counseling is part of the MCO

⁶ http://nasuad.org/documentation/HCBS_2013/Presentations/MMLTSS%20Full.pdf, page 44.

enrollment function. Opportunities for CBOs will depend on which structure their state has chosen: standalone options counseling, or a combination of options counseling and the enrollment functions.

When MLTSS first emerged in the 1990s, choice counseling was not a universal feature of Medicaid MLTSS programs. However, the rapid spread of MLTSS programs in 2012 drew calls for independent choice counseling to assist consumers with the MLTSS enrollment process. As noted earlier, CMS' May 2013 guidance cautioned states that MLTSS participants must be offered conflict-free, independent, and no-cost choice counseling.

As additional states prepare to implement new MLTSS programs, and existing MLTSS states that lack choice counseling take steps to come into compliance with the CMS guidance, CBOs have yet another opportunity to adapt their business models and play a key role in MLTSS. Options/choice counseling is an area where CBOs can leverage their traditional skill sets as consumer advocates and advisors, along with lengthy experience in the HCBS environment providing options counseling to Medicaid recipients. Agencies that have formed ADRCs are also a natural choice for the options/choice counseling role in MLTSS, a synergy recognized by CMS and the Administration for Community Living (ACL) when they developed the "Enhanced ADRC Options Counseling Program."⁷

Capitalizing on this opportunity and positioning a community-based agency to serve as the MLTSS options/choice counseling entity will require CBOs to address the conflict-free prerequisite outlined in the CMS guidance. As discussed earlier, this is also an example of the "multiple hats" dilemma where CBOs will have to "choose the business they want to be in."

A state that has taken steps to find a contractor that can competently execute multiple roles—LOC determinations and options/choice counseling—is highlighted in Appendix 1. Kansas fundamentally modified the structure of its LTSS system as part of its implementation of MLTSS in 2013.

ENROLLMENT BROKER

As Medicaid long-term care shifts to managed care, the need for an independent entity to assist Medicaid recipients in choosing a managed care organization emerged. Medicaid regulations require a state to assure that consumers will have a choice between at least two MCOs in any region, except in rural areas.⁸

The services offered enrollees by MCOs are not necessarily identical. In fact, a recent trend among states procuring managed care contracts to deliver MLTSS is to require the MCO bidders to offer "added value" features to their benefit packages. One insurer might offer dental or vision care, while another covers over-the-counter drugs. Consumers often require assistance comparing "apples to apples" and selecting the most attractive benefit package. Moreover, since MCO provider networks may differ, it is vital that enrollees receive information and assistance in comparing the MCOs' offerings, and determining whether

⁷ <http://www.acl.gov/Programs/CDAP/OIP/ADRC/index.aspx>; <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-05-12.pdf>.

⁸ 42 C.F.R. § 438.52(a).

a consumer's preferred provider or primary care physician is "in network." One state migrating to MLTSS has described the MLTSS enrollment broker's charge as "assist[ing] persons to select and enroll in the managed care program that best meets their needs."⁹

It is the responsibility of the broker to assure consumers receive accessible, meaningful, and clear notices about programs, services, and rights under managed care plans, including enrollment rights and options, plan benefits and rules, coverage denials, appeal rights and options, and potential conflicts that may arise from relationships among providers, suppliers, and others.

The necessity for including enrollment brokers in MLTSS program design has also evolved since 2012. Although enrollment brokers have been common in Medicaid managed care programs for many years, not every MLTSS program relied upon independent brokers to enroll beneficiaries. Some relied exclusively upon passive enrollment and auto-assignment processes to distribute MLTSS beneficiaries among the state's MCOs. In a few states, the MCOs themselves managed the enrollment process, much like Medicare Advantage plans are permitted to do.

In a July 2013 research report funded by AARP, researchers from Truven Health Analytics documented considerable variety in how states were approaching the enrollment function. Of the 14 states whose MLTSS contracts were reviewed for the report, it was noted that:

Four states use enrollment brokers in their MLTSS programs, but the role of the brokers vary. In three, the broker is a third-party agent that enrolls each consumer with a contractor. However, the broker does not always play a choice counseling role, in which consumers are assisted in making a decision based on their individual circumstances. The remaining states take a variety of approaches to enrollment. Some do enrollment through state or county offices. At least one uses ADRCs in areas where they are available, and allows direct enrollment by contractors in areas where ADRCs are not available. Several states allow direct enrollment by contractors.¹⁰

As states implement the CMS requirement for independent and conflict-free enrollment assistance, some have elected to amend their existing contracts with the organizations acting as enrollment brokers in the state's Medicaid acute and primary care managed care program. Other jurisdictions, especially those entirely new to managed care, have issued RFPs to procure a contracted enrollment broker through the competitive bidding process. This may be an opening for CBOs interested in carrying out the enrollment broker function in an MLTSS system. This MLTSS function dovetails well with the traditional strengths of CBOs. Their mission of advocacy on behalf of seniors and adults with disabilities, their work helping consumers to qualify for Medicaid coverage and enroll in HCBS waivers, and their familiarity with the long-term care delivery system create an opportunity for these

It is the responsibility of the enrollment broker to assure consumers receive accessible, meaningful, and clear notices about programs, services, and rights under managed care plans, including enrollment rights and options, plan benefits and rules, coverage denials, appeal rights and options, and potential conflicts that may arise from relationships among providers, suppliers, and others.

⁹ http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Publications/LTC/LTSS_Enrllmnt.pdf, page 3.

¹⁰ "Consumer Choices and Continuity of Care in Managed Long-Term Services and Supports: Emerging Practices and Lessons"; http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/consumer-choices-report-full-AARP-ppi-ltc.pdf, pp. 14-15.

organizations to position themselves as neutral parties, assisting consumers to select and enroll in the managed care plan that best meets their needs.

Conflict-of-interest concerns are relevant to this business opportunity as well. Providing case management, service coordination, financial management, transportation or meals are all examples of service provision that would likely disqualify a CBO from taking on the enrollment broker function.

MLTSS OMBUDSMAN

Over the course of the last two years, a significant opportunity has emerged for CBOs to provide the independent ombudsman function that the CMS generally requires states to employ when they implement new MLTSS programs.

Although the concept of an MLTSS ombudsman is not new, it gained tremendous traction as HCBS programs across the country shifted from fee-for service 1915(c) waivers to MLTSS. At the same time, 11 states have financial alignment demonstrations underway to better coordinate care for elderly and disabled beneficiaries enrolled in both Medicare and Medicaid, with another six states still negotiating Memoranda of Understanding with CMS. All but two of these demonstrations utilize capitated managed care models to achieve care and payment coordination.

The 2013 CMS guidance—in addition to opining on functional assessments and conflict-free choice counseling—also laid out expectations that states would provide independent advocacy or ombudsman services to MLTSS enrollees. CMS signaled that it would expect states to “[E]nsure an independent advocate or ombudsman program is available to assist participants in navigating the MLTSS landscape; understanding their rights, responsibility, choices, and opportunities; and helping to resolve any problems that arise between the participant and their MCO.”¹¹ Up to this point, the decision to establish an ombudsman rested solely in the discretion of the state. Minnesota, Wisconsin, and Hawaii are among those that opted to build in an ombudsman/member advocate role. Numerous stakeholders had also been urging states to provide this protection to managed care enrollees.¹²

CMS took steps to ensure such protections were in place by including a requirement for an independent and conflict-free ombudsman/advocate in at least two states managed care authority approvals. Both Kansas and New Mexico’s § 1115 demonstration waivers included such provisions.¹³ The Medicare-Medicaid Coordination Office (MMCO), which is responsible for managing dual eligible demonstration projects, soon followed suit by including a requirement for an ombudsman program in state Memoranda of Understanding for those demonstrations.

CMS then expanded opportunities for states to fund MLTSS ombudsman activities, so that the promise of assistance could be realized. In May 2013, MMCO announced three rounds of funding for states “to plan, develop and provide Demonstration Ombudsman Program services to individuals who participate in the Financial Alignment model.” The grants, providing up to \$3 million of funding over three years (over \$12 million in total)

¹¹ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>, page 10

¹² <http://www.nslc.org/index.php/mltss-toolkit/ombudsman/>; http://www.communitycatalyst.org/doc-store/publications/putting_consumers_first_LTSSmanagedcare.pdf

¹³ http://www.kancare.ks.gov/download/KS_KanCare_Section1115_SPECIAL_TERMS_CONDITIONS.pdf, page 28; <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf>, page 47

to states that have signed MOUs with MMCO, require the states to deploy independent MLTSS ombudsmen advocating for dual eligibles enrolled in managed care plans within six months of the grant award.¹⁴

Finally, in June 2013 CMS clarified its policy regarding Medicaid reimbursement of ombudsman programs by issuing an Informational Bulletin (IB) on this issue. The IB stated that states are able to claim 50 percent federal match for certain administrative costs related to activities performed by long-term care ombudsman (LTCO) programs.¹⁵ Although this policy pronouncement was issued specific to LTCO programs, the principles laid out by CMS apply equally to MLTSS ombudsman activities. The prospect of claiming 50 percent administrative match for these activities allows states to leverage state funds and increase the resources available to support new MLTSS ombudsman programs. It will also prove valuable in sustaining the ombudsman programs funded by MMCO after the three-year grants have expired.

As states move to incorporate independent ombudsmen programs into their MLTSS systems per the CMS directives, some states may expand the scope of their existing LTCO programs by utilizing existing grants and contracts with AAAs or independent LTCO contractors. Conversely, other states may use other entities or issue Requests for Proposals, seeking competitive bids. If CBOs are interested in taking advantage of this business opportunity, they will need to ensure that they are conflict-free and that they are willing to serve as the ombudsman for all enrollees in the MLTSS program.

MMCO is providing each state operating a financial alignment demonstration the opportunity to receive up to \$3 million funding over three years to deploy independent MLTSS ombudsmen.

CARE MANAGEMENT/SERVICE COORDINATION

As noted earlier, MCOs have largely assumed responsibility for care management and service coordination as states shift their long-term care systems from FFS to managed care. However, MCOs face the decision on whether to ‘buy’ or ‘build’ the capacity to provide the type of intensive care management/coordination needed for individuals using LTSS. Health plans have acknowledged that traditional ‘medical model’ care management—which may be focused on specific diseases and is generally telephonic—is insufficient to meet the needs of individuals using LTSS. Further, since LTSS are almost exclusively public benefits, health plans do not have experience from their other lines of business to bring to this work.

The ‘buy’ or ‘build’ decision is keyed off many factors, unique to both the MCO and the state in which it is operating. There is great opportunity for CBOs to make their case to the MCO for a ‘buy’ decision for care management services in particular. Additionally, the other services that AAAs have traditionally provided to FFS beneficiaries (transportation, nutrition, caregiver support and respite, and in-home chore services among others) may be equally valuable to an MCO which may have contractual imperatives from the state to meet. It is important to note that the considerations discussed at the beginning of the paper—resources, performance monitoring, and financial viability—are valid for this business decision.

¹⁴ <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>

¹⁵ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/LTC-Ombudsman-Programs.html>

CONCLUSION

As this paper is published, many states are still in the process of deploying new Medicaid MLTSS initiatives and others—only a year or two after “go-live”—are still in formative stages of development. The shift from fee-for-service §1915(c) waivers to Medicaid managed care has been momentous and swift, and as a result, states, CBOs and managed care organizations are all still finding their way in this new world.

In this new environment, it seems inevitable that there will be a few missteps and course corrections as states and CMS seek an equilibrium that balances improved health care outcomes with independent living, payment and care integration with conflict-free decision-making and choice counseling. Recent CMS guidance will also alter the playing field, both for states new to MLTSS and experienced jurisdictions, requiring further adjustments and adaptations to ensure compliance with federal requirements regarding contracting processes and beneficiary protections.

ACKNOWLEDGEMENTS

This paper was supported in part by a grant from The SCAN Foundation—advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

APPENDIX 1: KANSAS CASE STUDY

Prior to January 1, 2013, the Kansas long-term care system—and the role that Area Agencies on Aging (AAAs) played in that system—was fairly typical. AAAs provided information and referral (I&R) services, and conducted PASRR screens and approximately 7,500 functional assessments annually for seniors entering the state’s §1915(c) HCBS waiver. The AAAs also provided targeted case management for frail elderly HCBS waiver participants and coordinated community-based services, such as homemaker services, home-delivered meals, and transportation for seniors participating in the waiver.

In early 2012, the State of Kansas announced that it intended to submit a request to CMS for a comprehensive §1115 waiver—KanCare—transitioning seniors and people with physical disabilities from the FFS §1915(c) waiver into MLTSS. In the ensuing months, the state contracted with three managed care organizations and advised the AAAs that it would no longer contract with them to perform targeted case management or service coordination, as both these services would be assumed by the new MLTSS plans effective January 1, 2013.

Instead, the state initiated a procurement process to select a single ADRC to provide the following services statewide:

- Information, referral and assistance regarding LTSS to the general population, not limited to Medicaid beneficiaries;
- Initial functional assessments for all KanCare MLTSS populations; and
- Options/choice counseling for MLTSS enrollees as well as the general population.

Southwest Kansas Area Agency on Aging (SWKAAA) won the contract to serve as the single ADRC. SWKAAA then subcontracted with the other 10 Kansas AAAs to deliver statewide ADRC services. The Kansas ADRC now includes a centralized call center, with automatic routing of calls to the appropriate regional AAA subcontractor, and 11 walk-in centers.

The new ADRC contract dramatically expanded the number of LOC/functional assessments the AAAs performed—from 7,500 assessments of seniors per year to an estimated 13,000 assessments of seniors, individuals with physical disabilities and individuals with TBI.¹⁶ Both the I&R and options counseling aspects of the contract also grew in volume well beyond the population of frail elders participating in the §1915(c) waiver that they had previously been served. Janis DeBoer, the Executive Director of the Kansas Association of Area Agencies on Aging (k4a) has observed the ADRC contract expanded the AAAs' customer base from "524,851 Kansans age 60+ to 2,206,600 Kansans age 16+."¹⁷

Implicit in the state's decision to contract for a single, statewide ADRC to provide I&R and options counseling, and conduct functional assessments, was a requirement that the entity winning the bid would address the issue of scale. The ADRC would need to have the staff, technology and telecommunications capacity to serve all 105 counties and work with MCOs that each serve roughly 1/3 of the state. SWKAAA and k4a's strategy for addressing this issue—subcontracts with the other 10 AAAs—also needed to assure the state that I&R, options counseling and LOC assessments would meet the tests of quality and geographic consistency, not only in terms of timeliness, but also outcomes across the diverse geography of the state.

The solution adopted by the Kansas AAAs: a consistent branding strategy with a logo that the ADRC/AAAs used at every site and in all advertising and collateral materials; development and enforcement of uniform operational procedures; and implementation of a quality assurance program to focus on the consistency, reliability and accuracy of the functional assessments and advice and information dispensed by the 11 ADRC sites.

¹⁶ http://nasuad.org/documentation/HCBS_2013/Presentations/MMLTSS%20Full.pdf, page 60.

¹⁷ *Ibid.* at page 64.

Leaders of k4a's efforts to win the ADRC contract understood that, as a statewide vendor, it would be imperative that the new entity present the same face, have the same "look and feel", regardless of which branch of the ADRC a consumer interacted with. Janis DeBoer cited the Walgreen's pharmacy chain as the metaphor k4a used to set up the Kansas ADRC. "When a customer walks in to any Walgreen's store in the country, they know exactly which aisle has cosmetics and where the cold medicine is located," says DeBoer. "It's familiar. It's consistent. That's how we wanted consumers to think about the ADRC."

Finally, the Kansas ADRCs needed to add staff capacity—partly to accommodate the increased volume that would come from providing I&R, options counseling and functional assessments to a much larger population than the seniors seeking HCBS waiver services that the AAAs had previously served. At the same time, the leaders of the Kansas ADRC knew that they would need to demonstrate competency in serving the new constituencies—adults with disabilities, traumatic brain injury, for instance—by acquiring staff with experience and expertise in working with these populations.

The approach taken by the Kansas AAAs is instructive as their contracted arrangement addresses all of the considerations discussed in this paper.

NOTES

NOTES



**National Association of States
United for Aging and Disabilities**
1201 15th Street NW, Suite 350
Washington, DC 20005
Phone: 202-898-2578
www.nasuad.org