



SNP Stakeholder Meeting for Seniors and People with Disabilities in Managed Care

12/11/17

Gretchen Ulbee, Manager of Special Needs Purchasing, DHS

1. Welcome and Introductions

1) Welcome and Introductions - Gretchen Ulbee, Special Needs Purchasing, DHS

2. Contracts 2018

2) 2018 Contracts- Gretchen Ulbee, Special Needs Purchasing, DHS

Health plan contracts are signed for all products for 2018

No changes in service area

New contract provisions for 2018

- Medicaid managed care regulations
- IMD
- Home health agency face-to-face requirement

3. Care Plan Audits

3) Care Plan Audits – Jorie Coll, Special Needs Purchasing, DHS

Care Plan Audit Summary Overview

1. Overview of HCBS Services
2. Overview of the DHS Lead Agency Review (HCBS) and Managed Care Audit Process
3. DHS Lead Agency Review (HCBS) and Managed Care Audit Process (a side by side comparison)
4. Questions

Overview of Home and Community-Based Services (HCBS)

1. Overview of Home and Community-Based Services (HCBS):

- DHS has **five waiver agreements** with the federal government.
- **HCBS** provides long-term services and supports across the **five HCBS Medicaid waiver programs** including the Alternative Care Program.
- **HCBS** waivers are designed to help people stay in their homes via the provision of services in a person's **home and community** setting. The services support both medical needs and help maintain one's community connections, social relationships, social roles and daily life.
- Of the five **HCBS** waiver programs administered via Fee for Service (Medicaid), the **Elderly Waiver (EW)** is one of the five HCBS waivers that is provided by **both HCBS and the Managed Care Organization's (MCO's)** contracted delegates.

2. Overview of HCBS audit process in Fee for Service:

- The current **Home and Community Based (HCBS)** audit process began in 2006 and demonstrates compliance with **state and federal requirements across counties and tribes** that administer HCBS programs and also shares performance on key measures/outcomes.
- The **HCBS** audit process occurs over a **three year review schedule**. For example, this year (2017) is referred to as “round three” of the three year schedule (2015 to 2018).
- The **DHS Lead Agency Review (LAR) team** is responsible for audit reporting efforts across all five waiver programs and Alternative Care. The LAR team audit findings help with policy development, monitors for performance improvement with lead agencies, and promotes collaboration with **counties, tribes and MCOs**.

Overview of Managed Care Audit Process

2. Overview of Managed Care audit process:

- **Managed Care** audit process is conducted by MCOs **annually** and helps demonstrate compliance with **state and federal and contract requirements across Managed Care Organizations (MCOs) and their delegates.**
- **Managed Care** audit process provides a comprehensive review of the contract requirement for **assessment and care planning.** In managed care, this is an annual requirement for all enrollees not just people with EW.
- Similar to the LAR team audit of HCBS, the **Managed Care** audit process also allows DHS to monitor MCO's strengths and challenges across the programs and obtain recommendations for improvement to address challenges encountered during the audit.

Overview of the Managed Care Audit Process

2. Overview of the Managed Care audit process:

- The **MSHO/MS C+ audit process** focuses on enrollees served on the **Elderly Waiver (EW)** and Community Well (**Non-EW**).
- The **MSHO/MS C+ member assessment and EW case management** may be provided by contracted agencies of the MCOs, such as local tribe agencies, counties, clinics, and provider care systems or health plan staff.
- The **Elderly Waiver (EW)** as noted earlier, is the one waiver audited by both the DHS LAR team and Managed Care.

LAR and Managed Care Audit Process

3. LAR and Managed Care Audit Process (side by side comparison)

- **The next section reflects a side by side comparison of the DHS LAR team EW audit process to the Managed Care EW audit process specific to MSHO/MSO+:**
 - a. Audit process - starting an evaluation (record review)
 - b. Audit process - during an evaluation (compliance criteria)
 - c. Audit process - following an evaluation (corrective action plans, follow-up)
 - d. Audit process – report outcomes/findings

LAR and Managed Care Audit Process

3a. LAR and Managed Care audit process (starting an evaluation):

- **The DHS LAR team's** audit process starts with a validated and approved **CMS** random sampling method, whereby 10% of the case files from each program are drawn.
- **Managed Care** audit process conducts a validated and approved **NCQA** random sampling method, whereby **30 “eligible”** Elderly Waiver (EW) MSHO/MSD+ care plans are selected per each delegate, and **8 files** of the 30 randomly selected are reviewed.
- If any of the **8 records** produce a **“not met”** score for any of the outcomes outlined in the Audit Protocol/Data Collection Guide, the remaining **22 records** are examined for those outcome(s) or elements resulting in **“not met”** findings.

LAR and Managed Care Audit Process

3b. LAR and Managed Care audit process (during an evaluation):

- **The DHS Lead Agency Review Team (LAR)** conducts a comprehensive evaluation of programs for each lead agency visited. The evaluation (reviews each lead agency every three years) includes:
 - A thorough review of case file reviews, conducts case manager and assessor surveys, focus groups, an HCBS assurance plan and a provider survey. Case file categories reviewed include: assessment, planning practices, community participation, current level of support/services, organizational design, evaluation of person-centered practices.
- **Managed Care** audit process, **MCOs** audit all internal/contracted delegates thorough review of enrollee files (hard copy/electronic) based on the DHS audit protocol containing a list of specific elements to review in each record.
 - The case file categories reviewed include: assessment, enrollment, disenrollment, and outcomes related to care planning process and the care plan.

LAR and Managed Care Audit Process

3b. LAR and Managed Care audit process (during an evaluation):

- **LAR** audit supports the CMS quality benchmark of **86% compliance** for each of the **27 quality audit indicators** listed in table 1A in the current LARs report.
- **Managed Care** audit outcome achievement is also based on the HCBS quality benchmark of 86%, however, MCOs have elected for the Managed Care audit, a higher criteria for achievement of met or not met based on a **95% or better compliance** criteria for each of the **18 core elements and 56 sub-elements** compared to findings in the record review.
- Managed Care has **three audit elements** that require **100% compliance** for outcome achievement: **1) Annual reassessment of EW 2) Care plan completed within 30 days of assessment and 3) Enrollee choice demonstrated via a signed enrollee signature page.**

LAR and Managed Care Audit Process

3c. LAR and Managed Care audit process (following an evaluation):

- **Both the LAR and Managed Care** audit concludes with a summary provided for each lead agency noting audit strengths, challenges, recommendations, and corrective actions.
- A corrective action is written when care plans do not meet audit requirements achievement criteria.
- **LAR** audit requires a corrective action plan when deemed necessary; developed by the lead agency and reported to the DHS LAR team.
- **Managed Care** audit also requires a corrective action plan when deemed necessary; however, the corrective action plan is submitted to the MCO directly describing how the delegate will bring audit elements into full compliance.

LAR and Managed Care Audit Process

3c. LAR and Managed Care audit process (following an evaluation):

- Following a **LAR audit** and a **Managed Care audit**, a list of non-compliant items or deficiencies is provided to the lead agencies and are required to correct all instances of non-compliance.
- **The LAR** audit process gives lead agencies **60 days** to correct the identified items.
- **Managed Care** audit process gives lead agencies a **30 day** timeline for delegates with deficiencies to submit a corrective action plan to the respective MCO.

LAR and Managed Care Audit Process

3c. LAR and Managed Care audit process (additional follow-up requirements)

- Following a **LAR** audit, DHS sends a **brief follow-up on-line survey**, one year after a site visit to each lead agency, designed to help monitor ongoing compliance with corrective action plans in between audits.
- **The LAR team** may also conduct a **follow-up audit** one year after the scheduled audit review, if a lead agency has had a significant number of corrective actions.
- **Managed Care** audits require an additional review conducted **every three years** by the MN Department of Health (**MDH**). This is a care plan review specifically for the **DHS Triennial Compliance Assessment (TCA)**. MDH also prepares for DHS, a summary report presenting each MCO's care plan review findings and DHS conducts follow-up when indicated.

LAR and Managed Care Audit Process

3d. LAR and Managed Care audit process (audit reporting)

- Both **LAR and Managed Care** audits provide both qualitative and quantitative reporting annually.
- The **LAR team** drafts an annual report of their findings related to all audited **lead agencies** during the year.
- **MCOs** send their audit findings to DHS each September to report their audit findings related to all **delegates**.
- **LAR and Managed Care** audits both provide the percentage of files reviewed that met identified achievement criteria across each quality indicator/element including percent of corrective actions.

LAR and Managed Care Audit Process

3d. LAR and Managed Care audit process (audit reporting)

- The **Managed Care** audit process also provides a comprehensive review of the contractual requirements for assessment and care planning for people not on EW.
- The **Managed Care** audit process includes:
 - **Assessment and care planning** - provided to all MSHO, MSC+ and SNBC enrollees.
 - **Care coordination** - provided for all MSHO and most MSC+ enrollees.
 - **Care navigation** - provided for SNBC enrollees.

LAR and Managed Care Audit Process

3d. LAR and Managed Care audit process (audit findings/outcomes)

- Review of the EW audit findings for HCBS and Managed Care include the following:
 - **HCBS** audit findings per the LAR report dated Aug. 2015 to Sept. 2016 showed **759** EW case files were reviewed of the total **2,877** case files reviewed for all HCBS programs.
 - **Managed care 2016** audit findings showed an average of **1,000** EW audit files reviewed across health plans and audit elements.
 - **HCBS** audit findings for EW showed a met score of **98%** for all audited quality indicators (referenced in table 1A of the current LAR's report).
 - **Managed Care 2016 EW** audit findings showed a met score of **98%** for all audited elements and a **97%** met score for Non-EW audit elements.

LAR and Managed Care Audit Process

4. LAR and Managed Care audit process:

- **Questions?**

DHS online resources:

HCBS/FFS Lead Agency Review webpage: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/waiver-review/>

HCBS/FFS Lead Agency Review Progress Report (Aug. 2015 to Sept. 2016): <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7235A-ENG>

Link to HCBS Lead Agency Review summary reports and corrective action plans: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/waiver-review/waiver-round-three-reports/>

4. MSHO CAHPS

4) MSHO CAHPS – Sue Kvendru, Special Needs Purchasing, DHS

- CAHPS – Consumer Assessment of Healthcare Providers and Systems
- Overall presentation by Mark Foresman at earlier Stakeholder meeting
- CMS requires CAHPS surveys to be conducted for both Medicare and Medicaid (Medical Assistance)
- Integrated MSHO CAHPS

Integrated MSHO CAHPS

- Provision in Dual Demonstration MOU allows for Minnesota to conduct a combined CAHPS that meets requirements for both
- MSHO members avoid receiving multiply surveys asking the same questions
- Administrative simplification and savings

Integrated MSHO CAHPS

- MSHO health plans contracted with CMS-approved survey vendor to administer the MA and PDP CAHPS survey
- State added supplemental questions care coordination, language interpretation services and having the opportunity to be involved in health care decisions
- CMS analyzed data and compiled a report for each MSHO health plan
- MSHO health plan result's compared to all Medicare Advantage plans

Integrated MSHO CAHPS

- State contracted with Health Services Advisory Group (HSAG) to analyze the data
- Prepared report showing individual MSHO health plan results compared to average for all MSHO health plans
- Because this is the first year of this process, there is no comparison to previous years survey result
- Process will be repeated for 2017 CAHPS
- IMCare results were not included because of the small size of enrollment in the health plan (under 500)

Results – Rating of Health Plan

- Overall, 71.2% of survey respondents rated their MSHO health plan as a 9 or 10 on a scale from 1-10
- This compares to a national average of 61.3%
- All six MSHO health plans had results above the national average

Results – Rating of Drug Plan

- Overall, 72.8% of survey respondents rated their MSHO prescription drug plan as a 9 or 10 on a scale from 1-10
- This compares to a national average of 61.1%
- All six MSHO health plans had results above the national average

Results - Satisfaction with Care Coordination

- Overall, 87.3% of survey respondents were satisfied or very satisfied with help they received to coordinate their care
- We also asked who helped coordinate care with the following results
 - Someone from my health plan – 11.7%
 - Someone from my doctor's office – 16.1%
 - Someone from another organization – 5.7%
 - Friend or family member – 29%
 - Did it myself – 22.3%
 - County case manager/staff person – 12.3%
 - Interpreter – 2.9%

- Key drivers are items identified in the report that have potential for quality improvement
- Key drivers are included for MSHO program as a whole and for each MSHO health plan individually
- DHS will use key drivers section of report in the development of the Quality Strategy for MSHO

For more Information

- Report to be posted on DHS website
- Stakeholders will be notified
- Questions?

5. Managed Care Appeals

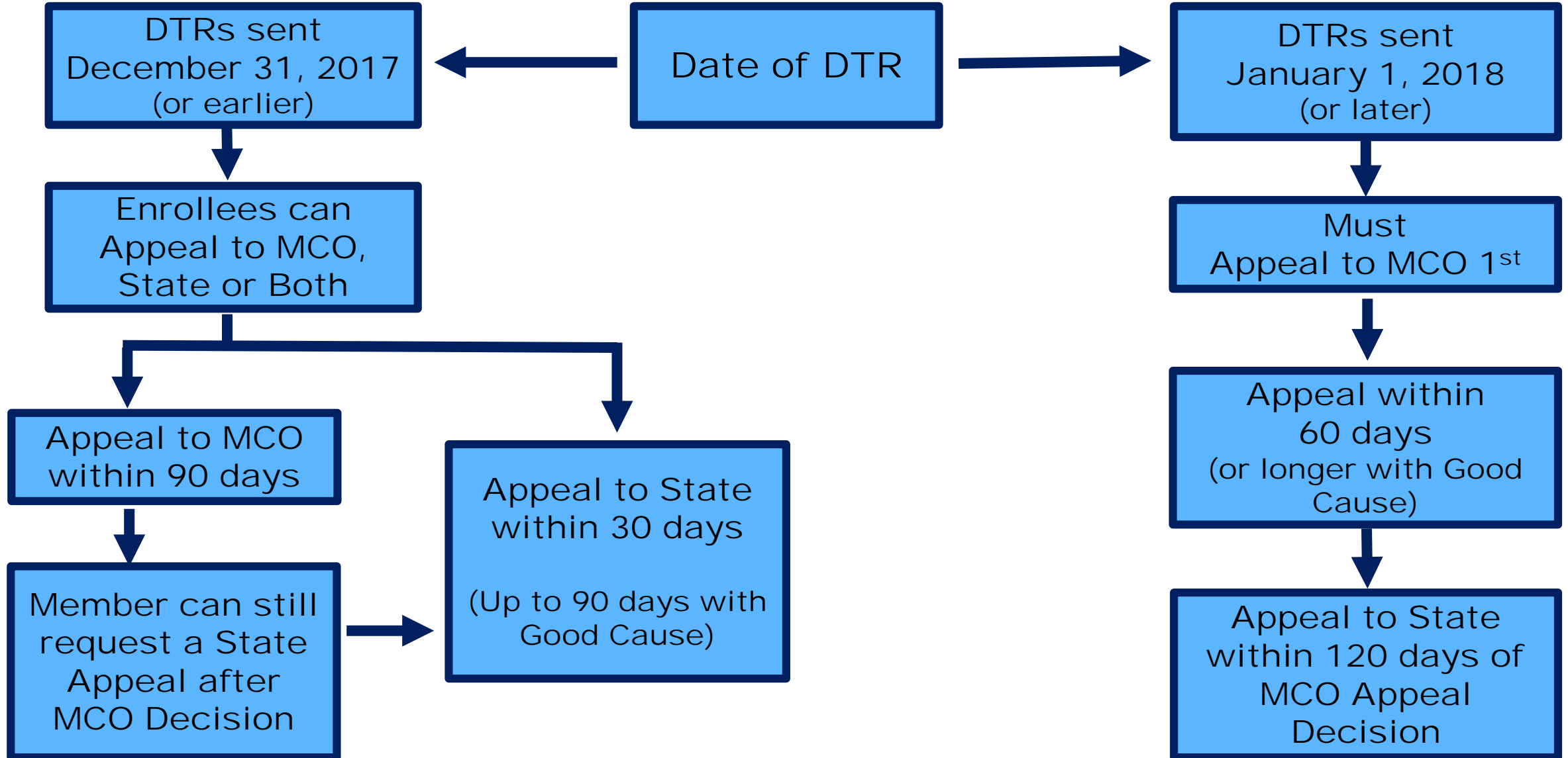
5) Managed Care Appeals – Margaret Manderfeld, Managed Care Ombudsman, DHS

Managed Care Appeals

- There was a major change to federal regulations modernizing the Medicaid managed care regulations. Create alignment of rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans
- 42 CFR sections 438.400 – 438.424
- New timelines effective January 1, 2018

Member Appeals to MCO & State

December 11, 2017



Managed Care Appeals

- Changes in timelines only affect managed care appeals. This means any decision made by your health plan about your health care.
- Timelines for appealing any other Medicaid decisions, including enrollment, remain the same.
- Significant changes to all MCO materials already underway

Managed Care Appeals

- Enrollee required to appeal to the health plan first
- Have 60 days from date of the MCO notice 438.402(c)(2)(ii)
- Plans can give you more time if you have a good reason for missing the deadline
- Enrollee has 120 days from the date of the MCO's appeal decision to request a State appeal 438.408(f)(2)

Notice of Denial of Medical Coverage

Date of Notice:	Date of Authorization Request:
Member Name:	Member Number/ID:
Member Date of Birth:	PMI #:
Provider Name:	Effective Date of Action:
Primary Care Clinic:	First Date of Service:

Your request was denied

We've {Insert appropriate term: denied, stopped, reduced, suspended} the medical services/items listed below requested by you or your doctor [provider].

Why did we deny your request?

- **What happens at a health plan appeal?**

- Informal process
- You can start an appeal by calling your health plan
- You do not have to talk to a judge
- Can present your information in writing, by telephone or in person
- Can have anyone help you including your provider
- Plan must give you a decision in 30 days or up to 45 if they have requested an extension

- **Continuation of benefits**

- Within 10 days of the date of the MCO notice or before the effective date of the decision,
- the enrollee can request continuation of benefits only if:
 - Previously authorized service ordered by an authorized provider
 - The original authorization period has not expired

- **Exhaustion of remedies**

- If an MCO fails to give you a decision within 30 days (sometimes 45 days) then you do not have to wait for their decision 42 C.F.R. section 438.408
- Enrollee can request a State appeal without waiting any longer.

- **What happens at a state appeal hearing?**
- Must appeal in writing
- If your provider appeals for you, you must send something in writing saying that it is alright for your provider to appeal
- You may request an expert medical opinion if your appeal is about whether an item or service is medically necessary
- The expert medical opinion is paid for by the state and is provided by a neutral medical professional not connected to the state or your health plan

Managed Care Appeals

- You can request continuation of benefits if you request a state appeal within 10 days from the date of the health plan decision
- You will receive a notice listing the time of the hearing
- Most hearings are by telephone but you can ask for a face-to-face hearing
- The judge will take testimony from the health plan representatives and from you and any persons assisting you with the hearing

Managed Care Appeals

- The judge will write a decision and mail it to you
- You will usually receive a decision within 90 days from when you requested an appeal
- If you disagree with the judge's decision you can request reconsideration within 30 days from the date of the decision
- You can request a copy of the recording of the hearing
- You can appeal a state decision to District Court

Managed Care Appeals

- Ombudsman for Public Managed Health Care Programs
- You can call, fax, or write our office.
- 651-431-2660 or 800-657-3729 or use your preferred relay service
- Fax: 651-431-7472
- Ombudsman for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, MN 55164-0249

6. PCA Updates

6) PCA Updates - Gretchen Ulbee, Manager, Special Needs Purchasing, DHS

- PCA Provider subcommittee met on 12/1
- follow up meeting with MCO's scheduled 12/14
- DHS contracting staff are monitoring concerns raised about January 2018 network changes
- Transition planning for 2019 is ongoing

7. SNBC Dental Project

7) SNBC Dental Project – Deborah Maruska, Special Needs Purchasing, DHS

2017 Special Needs BasicCare (SNBC) Dental Clinic Survey

- DHS collaborated with the SNBC health plans to conduct an electronic survey of health plan contracted community dental clinics to assess their interest and willingness in making practice accommodations needed to treat people with special health care needs.
 - The survey shows that dental clinics are serving patients with special needs, and are willing to see more SNBC patients if DHS and the health plans can provide meaningful ways to overcome some of the barriers to dental care experienced by people with disabilities.
 - Dental staff want and would benefit from access to information and consultations about special needs dentistry. Dentists want to care for their community members and need mentoring, care support and access to tangible information about a person's unique needs.

2017 Use of Dental Services Surveys

- DHS sponsored a Dental User Survey and Dental Non-user Survey of people with disabilities on medical assistance.
- The primary reason to conduct the user and non-user dental surveys was to establish baseline information regarding:
 - People's experiences with dental services
 - Reasons for underutilization of dental services
 - Barriers to the use of dental services
- Understanding the reasons that people initiate and delay dental service use is necessary in order for health plans are to develop tools to address issues that may prevent people from seeking dental services.

Survey Findings

- When interpreting the findings of the surveys it is difficult to compare the SNBC and fee-for-service (FFS) population. There are different characteristics of the populations enrolled in the two delivery systems such as variable living arrangements, need for care giver assistance, chronic conditions and the fact that more people with developmental disabilities chose to remain in FFS. It is possible that some of the variation between Medicaid FFS and SNBC enrollees were due to factors other than the delivery system.
 - A high percentage of enrollees report emotional (fear/pain/bad previous experience) and financial reasons for not accessing dental care.
 - Difficulty getting an appointment and travel distance barriers were reported more often by Non-Metro respondents in SNBC and FFS.
 - Another interesting difference seen is in the “self-reported oral health” ratings between the User and Non-user populations. There is a large difference in how the user and non-user of dental services respondent’s rate their oral health.

Rating of overall condition of teeth and gums	Excellent/Good	Poor
User of Dental Services	27%	16%
Non-user of Dental Services	8%	38%

Conclusion

- The surveys may provide an initial step in understanding which barriers people perceive are important in utilization or non-utilization of dental care.
- Survey findings suggest that a case manager/navigator can help arrange travel services for members to get to their dental appointments, and can work to connect individuals to dentists that accept their insurance may serve SNBC enrollees better.
- The SNBC health plans are implementing interventions to increase SNBC enrollees access to dental services as well as working to identify other causal factors that prevent SNBC enrollees from accessing dental services.
- Reports Availability:
 - 2017 Special Needs BasicCare Dental Clinic Survey – approved and ready to be emailed out
 - 2017 Use of Dental Services Surveys – in final stages of approval

8. Wrap Up and Next Meeting

8) Wrap Up and Next Meeting – Gretchen Ulbee, Special Needs Purchasing, DHS

Thank You

Thank you

Special Needs Purchasing, DHS

For general Special Needs Purchasing questions, contact: dhs.snp.stakeholders@state.mn.us.