Long Term Care Stakeholders Meeting – GENERAL

Questions/Issues:

1. Why do we need CommunityChoice?

   We need CommunityChoice for several important reasons:

   (1) Maryland Medicaid has expanded home and community-based services in recent years; however, the availability of these services is still limited. CommunityChoice would create greater flexibility to offer cost-effective community services to more individuals.

   (2) Currently there are no financial rewards for helping people stay healthy and live independently. CommunityChoice would change the financing of services to create incentives to promote health, prevent unnecessary hospitalizations and nursing facility placements, and use the most cost-effective means of care.

   (3) The long term care system we have today is fragmented and not very consumer-friendly. In addition, there is no coordination with the Medicare program. Our goal is to integrate the financing of health care services under CommunityChoice so community care organizations (CCOs) can help consumers and their families better navigate the long-term care system.

2. Is Maryland pioneering this managed long term care program? What other states have managed long term care programs?

   Maryland is not the first state to develop a managed long term care program. A number of other states, including Arizona, Florida, Minnesota, Texas, New York, and Wisconsin, have experience with operating managed long term care programs. However, Maryland’s managed long term care proposal has a number of innovative components, particularly the consumer direction option.

3. What is a community care organization (CCO)?

   A CCO is a managed care entity that receives a Medicaid capitation payment to coordinate and pay for health services for CommunityChoice participants. A CCO could be a nonprofit or for-profit organization that meets a variety of quality, financial, organizational, and systems requirements established by DHMH.

4. What are the differences between HealthChoice managed care organizations (MCOs) and the new CCOs?

   The populations served by CCOs and MCOs will be different. CCOs will need to coordinate Medicaid and Medicare services in order to help participants get the right services in the right settings. In addition, CCOs will need to provide a different set of benefits than MCOs provide. MCOs primarily provide primary and acute care services. CCOs will provide primary and acute care services, long-term care, community-based services, and
comprehensive mental health care. Individuals enrolled in CCOs will also need different levels and types of outreach and assistance in navigating the system.

5. How will CommunityChoice save money?

One objective of CommunityChoice is to slow the growth of long-term care expenditures. Examples of how savings can be achieved include: substituting lower cost community care for more expensive nursing home care; reducing the number of preventable hospitalizations; and improving care coordination to ensure participants receive the right care, at the right time, in the right place.

6. How many nursing home residents will be transitioned to the community?

We are unable to estimate exactly how many nursing home residents will be transitioned to the community. There will be systemic financial incentives for the CCOs to provide alternatives to nursing home care to support Olmstead objectives and expand options to people who need long term care. We anticipate that more individuals will transition to the community under CommunityChoice than under our current system. Individuals will not be transitioned to the community against their will. They will always have the choice to remain in the nursing home.

7. Have you established any long-term estimates of nursing home utilization?

Not yet. We will need to eventually establish nursing home utilization estimates in order to establish CCOs’ capitation rates. In establishing estimates, we will need to take into account the aging of the population and the anticipated increase in community options.

8. Is PACE the model for CommunityChoice?

There are many components of PACE (Program for All-Inclusive Care for the Elderly) that CommunityChoice will build upon; however, CommunityChoice will not be modeled after PACE. PACE is an integrated model of acute and long term care that focuses on the frail elderly who meet the nursing home level of care standard. PACE serves individuals in one catchment area in Maryland, and care is based at a medical day care center. CommunityChoice will serve a much larger, broader population.

9. What will be the role of assisted living facilities?

Under CommunityChoice, assisted living facilities will become an option for even more individuals. Right now assisted living is only an option for participants in the Older Adults Waiver.

10. How will chronic hospitals fit into CommunityChoice?

Individuals served in chronic hospitals will enroll in CommunityChoice. Chronic hospitals, like other providers, will receive their payments through CCOs.
11. Will there be protections for independent nursing facilities?

*Independent nursing facilities will have the same opportunity as any other nursing facilities to contract with CCOs. All nursing facilities must meet State licensing requirements and quality standards established by the Department.*

12. What are the next steps in the design of CommunityChoice?

*During the late summer and early fall, we will be reviewing stakeholder comments and drafting a federal waiver application. A second round of stakeholder forums will take place in September to review the draft waiver application. The Department’s submission of the waiver application this fall will not be the end of the stakeholder process. Throughout the upcoming year, we anticipate holding regular stakeholder meetings to provide updates and seek guidance from stakeholders as we refine the program’s policies and procedures.*

13. What is the timeline for the implementation of CommunityChoice?

*The earliest possible implementation date for CommunityChoice is January 1, 2006. This timetable will depend at least in part on the speed of the waiver review by the federal Centers for Medicare and Medicaid Services (CMS).*

14. Will the federal government use this waiver request as an opportunity to block grant the Maryland Medicaid Program?

*The federal Centers for Medicare and Medicaid Services has no legislative authority to approve a waiver that would block grant the Medicaid Program in any state.*
Long Term Care Stakeholders Meeting – ENROLLMENT

Questions/Issues:

1. Who will and will not be enrolled in CommunityChoice?

   CommunityChoice will serve approximately 70,000 who are:
   - Age sixty-five and over, or
   - Enrolled in Medicare, or
   - Living in nursing facilities or chronic hospitals, or
   - Qualified for a nursing facility or chronic hospital level of care including people currently receiving community based long term care services such as Medical Day Care, Older Adults Waiver, and the Living at Home Waiver, or
   - Others living in the community that qualify for a nursing facility level of care.

   The following individuals will not be enrolled in CommunityChoice:
   - Children under age twenty-one,
   - Individuals enrolled in the Waiver for Individuals with Developmental Disabilities,
   - PACE enrollees,
   - People who are only eligible for Medicaid’s cost sharing for Medicare services, (Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries),
   - Individuals who are community Medicaid eligible based on spend down.

2. Would CommunityChoice serve more people than are currently served?

   Initially, we do not envision CommunityChoice as an eligibility expansion, so the number of people eligible for Medicaid will remain about the same. The objectives of CommunityChoice are to improve services and stabilize the financing of long term care services. This program will make community long term care services available to more individuals and their care will be better coordinated. In the long run, a more efficient, cost effective long term care system will become the platform for expanding eligibility and meeting unmet needs.

3. Why would CommunityChoice be a mandatory program?

   There are several reasons CommunityChoice will be a mandatory program:
   - The current long-term care program is extremely fragmented, therefore we need one integrated long-term care delivery system to coordinate services and reduce confusion. Giving individuals the choice of two or more long-term care programs would create additional fragmentation and make coordination of care even more difficult. (It is important to note that even within a mandatory program, participants will have a choice of CCOs. If nursing facility placement is necessary, participants will also have a choice of any nursing facilities);
   - It is important that the CommunityChoice population is large enough to build and sustain the infrastructure and build large provider networks;
− It will provide a more stable population for the CCOs, resulting in more incentive for the CCOs to invest in preventive care and community based long term care services; and
− It is important for us to be able to predict who would participate in CommunityChoice to avoid over- or under funding the community care organizations (CCOs). If the program were voluntary and more of the sicker (and more expensive) population opts to take advantage of the benefits under CommunityChoice (called adverse selection) than what was anticipated and built into the CCOs’ payment rates, the payment rates more than likely would be too low. If, however, more of the healthier population opts to take advantage of the benefits in CommunityChoice than what was anticipated and built into the CCOs’ payment rates, the payment rates more than likely would be too high; and
− Other states have already proven that managed long-term care can work.

4. Why not pilot the program first?

For the reasons above in question 3, CommunityChoice will be more successful if implemented statewide. Additionally, administering a single long-term care program is more efficient than administering two separate programs. CommunityChoice will be phased in to assure a smooth transition period.

5. What is the income level required for program eligibility?

Financial and medical eligibility rules will remain as they are today. This means that an older adult or person with disabilities who would qualify for Medicaid today would also qualify for CommunityChoice. For individuals who today only qualify for Medicaid in a nursing facility, we are asking permission from the federal government to maintain the individual’s Medicaid eligibility if they transition from a nursing facility to the community.

6. Will the eligibility rules and eligibility process remain the same?

Financial and medical eligibility rules will remain as they are today as discussed in the previous question; however, the eligibility process will likely improve. Right now, we are looking at models of other states’ eligibility systems and processes.

7. What kinds of changes will be made to the level of care instrument?

The state recently adopted a new scoreable instrument to determine level of care. Since level of care may be used for setting future CCO capitation rates, we may need to further revise the tool to capture more information. We will be looking at options as we begin the CCO rate setting process.

8. Why is the Waiver for Individuals with Developmental Disabilities population excluded from CommunityChoice?
The Waiver for Individuals with Developmental Disabilities has been successful in meeting the needs of its enrollees for twenty years. The central nature of Developmental Disabilities services is different from medical service, despite some areas of overlap.

9. How will CommunityChoice affect REM enrollees?

*Adult REM enrollees who meet the nursing home level of care will be enrolled in CommunityChoice.*

10. Will individuals who “spend down” to Medicaid eligibility in the community enroll in CommunityChoice? Will they still be able to access medical day care?

*Individuals who “spend down” to Medicaid in the community will not be enrolled in CommunityChoice. They are enrolled in Medicaid for no more than a six-month period at one time. During the period of Medicaid eligibility, community spend-down individuals may access any State Plan service, including Medical Day Care.*

11. How will this new program affect people in the Older Adults Waiver or people on the Registry for the Older Adults Waiver?

*Older Adults Waiver participants will be enrolled in CommunityChoice. The benefit package will be the same as it is in the current waivers, but some of their providers and case managers may change. Additionally, in the CommunityChoice program, Older Adults Waiver participants will be able to consumer direct their personal care services if they choose to do so.*

*People on the Registry for the Older Adults Waiver are waiting for a waiver “slot” to become available. If the person on the Registry is already community Medicaid eligible and meets the medical requirements, they will be eligible for CommunityChoice services through their CCO without waiting for a waiver slot. Individuals with incomes above the community Medicaid standard will remain on the Registry until a waiver slot becomes available (as is current practice) and they can apply for the program.*

12. If the Older Adults and Living at Home waivers are folded into CommunityChoice, what happens to individuals whose incomes exceed the current community Medicaid levels?

*The Older Adults and Living at Home waiver “slots” will remain, but they will essentially be financial eligibility categories. This means that individuals whose incomes exceed the current community Medicaid levels may be enrolled in CommunityChoice from the community if a waiver slot is available.*

13. Why not just expand the Older Adults or Living at Home Waivers?

*The Department wants to reform the entire Medicaid long term care program. Under CommunityChoice, the CCOs will coordinate a comprehensive set of benefits. CCOs will also have the financial incentive to provide home and community based care rather than*
institutional care to all participants, not just those enrolled in the current waivers. This will result in additional services for all participants.

Expanding the waivers is very costly to the State because many waiver participants were new to Medicaid and the costs of their services were new to Medicaid. For example, 30 percent of LAH waiver participants and 60 percent of Older Adults Waiver participants were not eligible for Medicaid prior to the waiver.

Waivers are limited in scope – they are capped by a number of funded slots and target only individuals with an institutional level of care and have a defined set of services. Under CommunityChoice, CCOs will have the flexibility and financial incentives to ensure participants receive needed services in the most appropriate setting. Currently, if a waiver participant needs a service that is not part of the benefit package (like private duty nursing), they must go without it.

14. Does everyone have to meet a nursing facility level of care to be enrolled in CommunityChoice?

No. Many CommunityChoice individuals will not meet a nursing facility level of care since all dual eligibles will be enrolled in the program.

15. If you are over the community Medicaid eligibility level (>100% SSI), could you enroll in CommunityChoice without a waiver slot?

If you are living in the community and your income is over the community Medicaid eligibility level, you will not be able to enroll in Medicaid or CommunityChoice without a waiver slot. These slots will be maintained in CommunityChoice as they are in the current waiver programs.

16. Can someone who is not community Medicaid eligible directly enroll into CommunityChoice without going into a nursing facility first?

If you are living in the community and your income is over the community Medicaid eligibility level, you will not be able to enroll in Medicaid or CommunityChoice without a waiver slot.

In the CommunityChoice waiver application, we are requesting that individuals who are only Medicaid eligible in a nursing facility and leave the facility may continue to be Medicaid eligible in the community if they remain meeting the nursing facility level of care.

17. Will individuals in state facilities be in CommunityChoice? Will state nursing facilities have to be in the network?

We want CCOs to manage a participants’ entire care, including care in state nursing facilities. State nursing facilities can serve people in or out of a CCO’s network.
18. Can participants change CCOs only once a year? In what cases will participants be able to change CCOs?

*We envision an annual open enrollment period for CommunityChoice, during which participants can change CCOs. There will also be rules that will let participants change CCOs under certain conditions, for example, if the participant is moving to a new service area.*

19. Will CommunityChoice participants be in fee-for-service until they select a CCO?

*Yes. We are proposing to give Medicaid recipients more time to select a CCO than under the HealthChoice. (Under HealthChoice, beneficiaries have 21 days.) During this period, the participant will be in fee-for-service Medicaid.*

20. Would a CommunityChoice enrollee moving between two housing settings (for example from a nursing facility to the community) have to reapply for Medicaid?

*Our goal is to make CommunityChoice a seamless program. We are in the early stages of developing a new eligibility system that will facilitate seamless setting transitions.*

21. If you’re in a nursing facility, will you have a choice of multiple CCOs to choose from or just the one that has a contract with your nursing facility?

*If you are in a nursing facility, you may choose any CCO that operates in your region. If the CCO does not have a contract with that nursing facility, the CCO is required to pay the nursing facility the Medicaid fee-for-service rate for your care. You will not be required to move from that nursing facility.*

22. What will be the auto-assignment criteria? For example, how will someone be auto-assigned, and can they choose a different CCO if they desire?

*Auto-assignment will only happen if an individual does not select a CCO during the selection period. However, participants who are auto-assigned will be allowed to change CCOs anytime during the year following auto-assignment. We have not yet established all of the auto-assignment criteria, but the criteria will include geographic location.*

23. Will enrollment brokers be knowledgeable about provider networks, and will enrollment brokers know which CCOs have contracts with specialty providers such as oxygen providers?

*Enrollment brokers will be knowledgeable about provider networks. For specialty services, the enrollment brokers will know how to research more information about the CCO’s network.*

24. Will there be waiting lists for participation in CommunityChoice?
No. An older adult or individual who meets the nursing facility level of care who qualifies for Medicaid will be enrolled in CommunityChoice.

25. What if individuals have supplemental insurance?

Under CommunityChoice, as in all Medicaid programs, Medicaid is the payer of last resort. That means Medicaid will reimburse for Medicaid eligible services that the supplemental insurance does not cover.
Long Term Care Stakeholders Meeting – BENEFITS

Questions/Issues:

1. What benefits will be available in CommunityChoice?

   *The Department will require certain benefits for CommunityChoice enrollees. CCOs, however, will have the flexibility to provide additional services to meet each participant’s needs, even if those services are not part of the required benefit package.*

   *The required services will include: primary care and acute care services, comprehensive mental health services, long term care services and additional community-based services for individuals who are nursing home level of care and can be served cost effectively in the community. These additional services will include the home and community-based services offered in both the Older Adults Waiver and the Living at Home Waiver.*

2. Will different CCOs have different benefits?

   *The Department will require a certain benefit package for enrollees. Each CCO, however, will have the flexibility to provide additional services.*

3. Will there be limitations on services?

   *The Department will allow CCOs to set limits on certain services in the benefit package, similar to the limitations under the existing home and community-based waiver programs. CCOs will have the flexibility to exceed those limitations in order to keep people in the community and out of a nursing home or hospital.*

4. How do the benefits compare to the Older Adults Waiver?

   *Enrollees who require nursing home level of care will have access to a benefits package that includes the services currently available under the Older Adults Waiver.*

5. Will everyone have a care coordinator? What kind of coordination of care will exist to assist individuals as they transition to the community?

   *We are proposing to require that CCOs have a care coordinator available for all participants who require nursing home level of care in the community. This includes individuals who transition to the community. We have not yet decided whether to require care coordination for other populations, although we expect that CCOs will choose to expand care coordination to other populations.*

6. What incentives or protections would exist to ensure participants receive needed mental health services?
The Department will ensure participants have access to mental health services. Similar to other services, the Department will compare utilization patterns to the current fee-for-service program across CCOs. Areas of concern will be addressed immediately. CCOs will also be required to establish and maintain appropriate provider networks and implement systems and processes to manage mental health benefits adequately. The Department will review the CCOs annually, and performance measures will be established to determine overall success of a CCO’s program.

7. Will participants receive substance abuse services under the CCOs?

Substance abuse services will be covered.

8. Will all participants be able to access personal care?

Participants who meet the medical necessity criteria for personal care will have access to those services.

9. Will participants be able to choose which assisted living facility they go to?

CCOs will have to maintain a sufficient provider network to ensure consumer choice for all medically necessary services. Participants whose plans of care include assisted living will choose among the assisted living facilities within the CCO’s network.

10. How will the State ensure that existing HealthChoice MCOs who become CCOs are able to meet the health needs of the population served under CommunityChoice?

CCOs will be subject to a comprehensive systems and financial application review in order to participate in the program. The review will include: organization and operations; network access and capacity; financial solvency; quality assurance systems; and management information and data reporting systems. The review, however, will cover different organizational competencies than HealthChoice. For instance, organizations will need to have resources and expertise in the needs of older adults and people with disabilities, adequate networks of mental health and long term care providers, and systems in place for transitioning participants from the nursing home into the community.

11. Housing is a major issue. Are you going to wait until the housing situation is solved and then implement this program?

A lack of affordable and accessible housing is a major problem across the state. There are many people in the community who are at risk of going into a nursing home and many people who want to get out of a nursing home. The CommunityChoice program can impact housing in two ways. First, by providing a broader range of community support services, CCOs can prevent someone from losing their housing to begin with. Home care services and environmental adaptations can help people stay in their homes in lieu of nursing home placement. Second, CCOs will provide assistance and support for people transitioning from nursing facilities back into the community. Under our current system, there are constraints
on the use of Medicaid funding for housing. In the CommunityChoice program, we are opening the door for CCOs to provide whatever services and supports can cost-effectively serve someone in the community, even if that includes assistance obtaining and maintaining community housing.

12. How will prescription drugs be covered under this program? What is going to be the relationship between Medicare Part D and CommunityChoice?

For Medicaid-only participants, prescription drugs will be covered under CommunityChoice. Medicare, however, will be taking over prescription drug coverage for the dual eligibles starting in January 2006. Dual eligibles who enroll with a CCO for both Medicaid and Medicare services will have a complete and coordinated set of benefits (Medicaid, traditional Medicare, and the new Medicare drug benefit). Please remember that these coordination issues will exist regardless of whether the Department goes forward with CommunityChoice, but the opportunity for coordination would improve under the managed care model.

13. If CCOs offer incentives to individuals to choose particular nursing homes, how will we protect against steering to low quality nursing homes?

Nursing homes have the responsibility to provide quality care. The Department will require that all nursing homes that are licensed and certified for Medicaid patients be included in the CCOs’ networks. The Department will require that the CCOs pay nursing facilities at the Medicaid fee-for-service rate unless CCOs and nursing homes mutually agree on different payment rates. Since the Department will be measuring and evaluating the CCOs across different performance measures, the CCOs will have an incentive to steer participants to higher quality facilities, not lower quality.
Long Term Care Stakeholders Meeting – CONSUMER DIRECTION

Questions/Issues:

1. What is consumer direction? Why is DHMH proposing this to be part of a managed long term care program?

Consumer direction allows individuals more control in the delivery and quality of personal care services. Consumer-directed programs enable individuals with disabilities to make their own decisions regarding their long term care needs. Consumers can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. DHMH believes that a consumer-directed program will provide older adults and individuals with disabilities with greater independence and autonomy in obtaining services, increase participant satisfaction, and improve access to services. DHMH will require participating CCOs to offer consumer-directed services as an option for certain participants.

2. Who will get to choose the consumer direction option?

Consumer direction of personal care services is an option that will be made available to individuals that require personal care services. Similar to best practices in other states, individuals wishing to pursue the consumer direction option will go through a “screening” process with their care coordinator to be certain the individual understands the consumer-direction option and makes informed decisions about their services.

3. What type of services will be consumer-directed? Consumer direction should mean that consumers have input in their care plans, not just personal care services.

Consumers will always have input in developing their care plans. For CommunityChoice, consumer direction means consumers have the option of directing their personal care services, for example, hiring personal care attendants and negotiating payment rates.

4. How are managed long term care and consumer direction consistent with Olmstead?

Managed long term care is not about reducing costs at the consumer’s expense—it will be about making community-based services more available and creating greater flexibility in providing those services. We believe that transitioning individuals from nursing homes to the community will be more likely to happen under this type of program than under the current limited waiver programs, which is consistent with the Olmstead decision.

5. What other states are you looking at as models for the consumer direction program?

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We are looking at a range of consumer-directed programs from states that have Independence Plus waivers and other consumer directed models such as California, New Hampshire, Louisiana, South Carolina, North Carolina, and New Mexico.

6. Who will be in charge of an individual’s care?

   Individuals who want to choose the consumer direction option are responsible for their own care. The consumer will work with a care coordinator in developing a care plan, which will then be coordinated with the CCO. The care coordinator will follow up with the individual to make sure care is being administered appropriately.

7. What experience do CCOs have with consumer direction?

   Many of the potential CCOs have extensive experience in developing care plans, fiscal responsibilities, and quality oversight—all components in a consumer-directed program. Some of the potential CCOs are participating in managed long-term care programs in other states and have experience serving people with special needs. DHMH will work with CCOs to help provide necessary guidelines, training materials, and oversight to help ensure a successful program.

8. Will a standard set of rules apply to all CCOs? Or will each CCO have their own rules for services they choose to provide?

   DHMH will set standard rules for CCOs—requirements around types of services that must be provided, quality assurance, etc. Each CCO will be responsible for meeting the same standards, but will have some flexibility in how they choose to meet those standards as well as whether they want to provide additional services.

9. How will participants’ health and safety be assured?

   Quality control safeguards will have to be established between the consumer and their personal care provider, the CCO and the care coordinator, and DHMH and the CCO to ensure there is proper monitoring, positive outcomes, and adherence to the care plan.

10. What supports will exist for individuals participating in the consumer direction option?

    Care coordinators will help assist consumers in developing a plan of care as well as highlighting the consumer’s responsibilities. In addition, for those individuals in need of a backup care provider in the case of an emergency, CCOs will be required to provide an alternate provider for the individual.

11. How will personal care be different than the personal; care currently provided under the waivers?

    Currently under the waivers, only a limited number of individuals can receive personal care services and there is little flexibility to add services. CommunityChoice will offer a new
consumer-directed model that builds on the principles that have been successful in the Living at Home Waiver. Consumers will have the flexibility to pay personal care providers at a negotiated rate, choose their own personal care provider (which could include family members), and use additional money saved to pay for other services as needed.

12. Will there be any minimum requirements as to who can provide personal care (when chosen by the consumer)? Will CCOs have their own guidelines?

Personal care providers in a CCO’s network will be required to meet certain minimum criteria (age, criminal history, e.g.) as they currently do in the Medicaid State plan and home and community-based waiver programs. CCOs can choose to have higher standards than required by the State, subject to DHMH approval. Our current plan is to advise, but not require, the same criteria for independent providers chosen by the consumer outside of a CCO’s network. DHMH and/or CCOs will offer to do background, criminal checks, etc., or offer training services for the consumer, but these steps can be waived (at the consumer’s risk) if using individual providers.

13. Will family members (including spouses) be allowed to serve as caregivers?

Family members other than spouses will be allowed to serve as caregivers. The use of a spouse caregiver is still under consideration.

14. What will the rates of pay be for personal care workers?

Under the consumer-directed option, the consumer will be given a budget with which to work. The consumer will have the ability to negotiate his or her own payment rates for personal care services.

15. How will the number of hours of service be determined?

The number of hours will be determined through the consumer’s care plan, based on past usage, anticipated future need and cost effectiveness.

16. How are you going to determine the finite number of dollars that will be allocated for each consumer?

The consumer and care coordinator will work closely to determine the most appropriate care plan for the individual based on their needs, and dollar amounts will subsequently be allocated by the CCO based on these care plans.

17. By providing consumer direction and thereby enhancing personal care services provided, wouldn’t costs increase for personal care?

Under the consumer-directed option, costs may increase in the short-term as more personal care is being provided (compared to the current system). However, experiences in other states show that higher quality of care received through consumer direction has led to
improved health outcomes, reducing the costs of nursing home care and other Medicaid services over the long-term.

18. How will payment work under the consumer direction option? Will cash be given to the consumer? Will CCOs be making the payments?

Payment for personal care services will be directed by the consumer based on their given budget. Consumers will not receive cash. Consumers will authorize payment for services, and the CCOs will handle the responsibilities of making payments.

19. The mindset of older adults is that they do not like to complain, and they may not complain over the telephone. Will there be other avenues for them to file complaints?

Yes. There will be an enrollee hotline and regular meetings with care coordinators. Care coordinators familiar with the consumer will conduct in-person interviews to assess satisfaction, health outcomes, any issues of neglect, or any other related issues. Care coordinators will be required to report back to the CCO, and the CCO will have to respond in accordance with their quality assurance protocol. Consumers will also have access to an enrollee complaint line to voice any complaints.

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Long Term Care Stakeholders Meeting – QUALITY

Questions/Issues:

1. Who will be responsible for monitoring the community care organizations (CCOs)?

   *The Medicaid administration within DHMH will be responsible for quality oversight of CCOs.*

2. Will external contractors monitor the care provided to participants?

   *DHMH will conduct its own quality oversight and will contract with independent external organizations approved by the federal Centers for Medicare & Medicaid Services (CMS).*

3. What will be the role of the Office of Health Care Quality (OHCQ) in relation to CommunityChoice?

   *OHCQ will continue in its current role of licensing, certifying, and inspecting providers.*

4. In addition to OHCQ’s activities, what quality assurance activities will exist for community providers?

   *DHMH will have credentialing criteria for providers. In addition, CCOs may have their own additional credentialing standards. Measures of utilization and outcomes of service delivered by community providers will be developed prior to implementation.*

5. Will CommunityChoice use the same nursing home quality standards as OHCQ?

   *Yes. Nursing homes will continue to need to meet OHCQ quality standards to participate in Medicaid. In addition, individual CCOs could have additional quality improvement initiatives for their providers, including nursing homes.*

6. How will care plans be reviewed for quality?

   *DHMH will regularly review a sample of care plans to ensure that care plans are developed and updated timely, the content of care plans meets the needs of the participant (e.g., adequate service coordination between Medicare and Medicaid), and participants and/or their representatives have input into the care plan.*

7. Will consumer satisfaction surveys include family members?

   *Yes.*

8. How will DHMH ensure adequate staffing to provide necessary quality oversight?
DHMH will adapt its administrative structure to ensure adequate oversight. Staffing needs will be met through a variety of means: hiring new staff, developing new contracts with vendors, working with local public agencies, and redeploying current staff.

9. Will there be safeguards to ensure individuals get needed care?

Yes. Under HealthChoice, Medicaid beneficiaries’ access to care has increased and provider networks have grown. As in HealthChoice, DHMH will monitor utilization to ensure the enrolled population is getting needed care and individuals will be able to appeal to DHMH as well as their CCO if they are not satisfied with the care they are receiving.

10. What provisions will be in place to ensure participants have input in their care plans?

DHMH will establish standards for the content and timeliness of care plans and for who is involved in developing them. We anticipate that care plans will be developed jointly by the individual, care coordinator, and providers. Specific criteria are yet to be determined.

11. How will the State ensure network adequacy and access to services?

DHMH will establish provider network adequacy requirements that CCOs must meet in order to participate in CommunityChoice. When developing network adequacy standards we will consider factors such as: geographic distance and travel time to providers, availability of providers within the State, and national guidelines on recommended ratios of providers to patients.

12. How will the State ensure access to specialists for people with disabilities?

DHMH will establish specialty provider network adequacy requirements that CCOs must meet in order to participate in CommunityChoice. DHMH will also establish a plan to ensure continuity of care during the transition to CommunityChoice.

13. Does the State have a target number of participating CCOs in mind? Will CCOs be required to operate statewide?

There is not a specific target number of participating CCOs. As in HealthChoice, CCOs will be able to participate in CommunityChoice if they meet the standards of the initial review and continue to meet DHMH’s standards. In order to enable beneficiary choice, at least two CCOs must participate in each area. It has not yet been decided if statewide operation will be a condition of participation.

14. How will differences be reconciled between CCOs and providers over delivery of care?

DHMH will become involved when necessary to reconcile differences. Providers will be able to appeal CCO decisions to DHMH.

15. Will participants be able to file appeals directly with DHMH?
Yes. DHMH will have a consumer hotline to facilitate this.
Long Term Care Stakeholders Meeting – FINANCE

Questions/Issues:

1. Will CommunityChoice be budget neutral?

   Yes. Under a federal waiver program, states must demonstrate that high quality care can be
delivered to recipients in a managed care setting at a cost at or below that of traditional fee-
for-service.

2. Will there be savings? Where are the data to support this concept?

   We have spoken with other states and have reviewed a number of independent evaluations of
other states’ managed long-term care programs. There is evidence that savings can be
achieved under managed long-term care.

3. Will the State set payment rates for all CommunityChoice benefits?

   No. In general, the CCOs will negotiate rates and contracts with the various providers.
Since a number of individuals become eligible for Medicaid after they have entered a nursing
home, we want to ensure that individuals can stay in their nursing home of choice. If CCOs
and nursing homes cannot agree on a rate, the Department will require that the CCOs pay
them the Medicaid fee-for-service rate.

4. Will there be incentives for nursing homes to negotiate lower rates in order to land a CCO
contract?

   Nursing facilities and CCOs are free to negotiate rates in exchange for increased Medicaid
business. However, if CCOs and nursing homes cannot agree on a rate, the Department will
require that the CCOs pay nursing homes the fee-for-service rate.

5. What will the capitation rate be for CCOs?

   We do not know yet. Setting capitation rates is a complex process that will include the State
having actuarially certified rates. Participants will be segmented based on health needs and
geographic regions, if regional cost variations exist. The rates will also be different for dual
eligibles, since some of their care, such as acute care, will be covered under Medicare.
There will be involvement from the CCOs, stakeholders, and the Department to ensure that
the rates are reasonable.

6. Will capitation rates be readjusted on an annual basis?

   Yes. Capitation rates will be adjusted at least annually. The Department still needs to define
the circumstances in which CCOs’ capitation rates might change more frequently. For
example, the HealthChoice program includes mid-year rate adjustments for significant
program changes.
7. What is your cost-effectiveness test for determining which option is financially feasible (community vs. nursing home)?

The participant, family, and CCO will work together to develop a care plan. If the cost of services required to transition or maintain an individual in the community exceeds the cost of nursing home care, the individual may be found ineligible for the community option. This cost-effectiveness test is a federal requirement under home and community-based waivers. Under the Older Adults and Living at Home waivers, the Department performs a cost-effectiveness test before approving community services. The Department, however, is proposing to allow the CCOs to use an individual cost-effectiveness test under CommunityChoice. Instead of an individual’s community needs being compared to the average nursing home cost, they will now be compared to the individual’s actual nursing home needs and costs. This will allow more intensive service plans to be developed for individuals with more intensive needs.

8. If home care is more expensive than nursing home care, will the CCO be required to pay for care in a community setting?

As mentioned above, CCOs will not be required to pay for home or community care when it is more expensive than nursing home care. However, CCOs may decide to pay for community services even though it is more expensive if they feel that it will be more cost-effective in the long-term.

9. What happens if an individual wants to transition to a nursing home but the CCO says that staying in the community is less expensive?

Individuals will not be forced to live in the community if they meet the nursing home level of care standard. They will have the choice of living in a nursing home.

10. If there is a financial incentive for CCOs to discharge residents, will the consumer still have a choice of staying in a nursing home if they want?

Yes. Individuals meeting the nursing home level of care standard will not be forced to live in the community. Individuals who only require short-term, rehabilitation care in a nursing home, however, will need to transition back to the community when they no longer meet the nursing home level of care standard.

11. How will you monitor CCOs when they deny a patient care because of “cost-effectiveness”?

The rate structure will have no incentive to deny cost-effective care. We are proposing to require that CCOs notify the Department when they deny individuals access to community services. We also are proposing that the Department audit a sample of the CCOs’ care plans annually to determine whether or not they are being developed appropriately. Participants will be able to appeal decisions they believe were made unfairly by the CCOs or the Department.
12. How will the Department set capitation rates if Medicare provides CCOs payments as well?

Our capitation rates will only pay for services covered under Medicaid, not for services that are covered under Medicare. (Similarly, Medicare capitation rates will not pay for services that are covered under Medicaid.) The CCOs, therefore, will not receive inflated or duplicative payments.

13. Will for-profit organizations be allowed to become CCOs?

The Department will ensure through its quality assurance program and rate-setting process that the capitation rates will include a reasonable profit level. The Department will audit the CCOs’ financial records annually, develop performance measures and targets and establish a sanction methodology for when performance targets are not met.

14. Do you see fee-for-service rates driving provider reimbursement?

Initially the capitation rates will be based on fee-for-service data. When capitation rates are updated (at least annually), the new rates will reflect provider rate changes in the fee-for-service program. For instance, if there were an increase in fee-for-service nursing home rates or the Health Services Cost Review Commission hospital rates, the updated capitation rates would reflect these increases. Eventually CCO rates will be based on actual expenditures from previous years.

15. What have other states done regarding risk adjustment for mental health services for this population?

Other states, such as Arizona and Texas, include mental health services in the capitation rates. We will learn from their experiences in setting capitation rates for this population.

16. Will Medicaid rates cover coinsurance payments for dual eligibles? Will rates reflect any cost-sharing requirements for dual eligibles that are associated with the Medicare Advantage Plan?

Yes. Any Medicare cost-sharing requirements covered by Medicaid for dual eligibles will be included in the rates.

17. Have you studied the cost differences between geographic regions? Will the payment rates reflect these differences?

We have not yet studied the cost differences between geographic regions. If there are significant cost differences between regions, the rates will be adjusted accordingly. For instance, in HealthChoice, MCOs receive higher rates if enrollees live in Baltimore City. We analyze regional cost differences annually to determine if the HealthChoice population needs further segmentation.
Long Term Care Stakeholders Meeting – OUTREACH

Questions/Issues:

1. Are consumers going to be made aware of the new program so they can attend the meetings?

   We are working hard to ensure that all interested parties, especially consumers, know about the program and the stakeholder meetings. The next round of meetings will be held in September. We encourage all interested consumers to attend. We also would like all stakeholders to educate consumers about CommunityChoice and tell them to visit the CommunityChoice website for more information on the program.

2. How will DHMH get input from the general public?

   DHMH created a website - http://www.dhmh.state.md.us/mma/communitychoice/index.html where all relevant material is posted. There is also an email address, CommunityChoice@dhmh.state.md.us, where anyone can submit their comments and concerns.

3. Communication to seniors will be essential for this program. Are you coordinating with the Senior Health Insurance Assistance Program (SHIP) to help seniors understand their insurance options?

   Yes. We will coordinate with the Department of Aging who runs the SHIP program in Maryland.

4. Will there be an independent agency/person that will assist seniors with making decisions under the new program?

   There will be several different entities that will be able to help consumers make decisions. The CommunityChoice enrollment broker will give consumers information on each CCO in order to help them choose. We will also be working with the Department of Aging on how best to inform and educate older adults about the new program. Care coordinators will help consumers navigate the services and assist them in developing their care plans.