**Managed Long-Term Services and Supports Scope of Work Excerpts Frequently Asked Questions**

As of April 19, 2022

## Section 1: Waiver Services

1. **Will an individual be able to receive Aged and Disabled waiver services and MLTSS concurrently?**

   Yes, individuals 60 years of age and over who qualify for the A&D waiver will receive MLTSS. There will be no need to disenroll from MLTSS to access A&D waiver services. The A&D waiver services will be provided to those who meet Level of Care in the new MLTSS Program, and several services are in the process of being added to the waiver to ensure a smooth transition into MLTSS. Note individuals under age 60 who are functionally and financially eligible for the waiver will continue to receive fee-for-service Medicaid for their A&D waiver services and will not be in the MLTSS program.

## Section 2: Eligibility and Level of Care

2. **Will the Aged & Disabled Level of Care work be done by the enrollment coordinator?**

   FSSA is finalizing plans related to the Level of Care determinations and will continue discussions with stakeholders. A&D waiver Level of Care determinations will remain independent of the managed care entities.

3. **What is the process and timeline for selecting Contractor(s) for Nursing Facility Level of Care and MLTSS plan selection?**

   The nursing facility Preadmission Screening and Resident Review (PASRR) will continue to be an essential component of the LTSS continuum following all federal and States rules and regulations. With the introduction of MLTSS, FSSA will also be required to employ a contractor to assist individuals who are deemed eligible with selection of a health plan. FSSA is finalizing details related to these two essential duties and will continue to provide updates to stakeholders in the coming months. Competitive procurements are anticipated in alignment with State policies and procedures.

4. **Who will determine the reasonably expected period of nursing home use for 30, 60, 90, or 120 days (currently the "short-term" stay)? Will there be a 120+ day time period for nursing facility placement (currently the "long-term" stay)?**

   PASRR will be conducted independent of the managed care entity. At the current time, FSSA does not anticipate any changes to the Preadmission Screening and Resident Review (PASRR) process. As planning continues, FSSA will share details with stakeholders.

## Section 3.1: Eligibility & Level of Care Redetermination Questions

5. **The phrase "assure…accurate level of care" [in the Scope of Work] appears to require the Contractor to verify the work of the Enrollment Contractor –**

**who's determination carries – the Enrollment Broker or MCE? What happens if and when there is disagreement on Level of Care determination between the Contractor (MCE) and the Enrollment Contractor? Are the Medicaid members notified? Are the Medicaid member's providers notified?**

An independent Level of Care determination contractor is responsible for determining nursing facility Level of Care. The MCE will be responsible for communicating with the contractor regarding whether they suspect an error in the determination and that another determination should be performed. The member will continue to have appeal rights if a nursing facility Level of Care is denied by the independent contractor and will be notified as required by federal statute.

6. **What is the MCEs role in functional eligibility re-determination? How do members undergo functional eligibility re-determination after enrollment in the program, including members who do not have a change in condition? What happens if a member no longer has a nursing facility Level of Care?**

   A member is functionally eligible to receive LTSS and HCBS services, if they meet an indefinite nursing facility Level of Care. A member will have a nursing facility Level of Care as determined by the InterRAI assessment. This Level of Care assessment will be completed by the State and independent enrollment contractor(s), not the managed care entity. Managed Care Entities will not determine the member's Level of Care for the purpose of establishing and maintaining eligibility. The MCE is responsible for making sure that the information about a member's Level of Care is current and accurate and that a member has a re-determination at least annually by the independent enrollment Contractor regardless of change in the members condition.

   A member could be re-assessed more than once a year. A re-assessment will occur at any point the member's condition changes and following certain trigger events to ensure that the member continues to be eligible for services and authorizations that align with their condition and Level of Care needs.

**Section 4: Plan Enrollment**

7. **Can Medicaid members still choose a different Medicare benefit after default enrollment into the aligned D-SNP product?**

   Yes, FSSA recognizes the importance of maintaining and honoring Medicare freedom of choice. All D-SNPs required to default enroll will have to meet requirements pertaining to notifications and notification time periods for members to disenroll and to make a different choice. A key component of default enrollment is that the member will be enrolled into a Medicare plan that will be aligned with the member's Medicaid plan, but FSSA understands that there might also be highly valid reasons why a member wants to remain in an unaligned Medicare service delivery system.

8. **Will there be any guardrails put in place so that members aren't requesting to switch MCE's without a just reason?**

A member may choose a new MCE during the annual plan selection period, whenever the member's D-SNP and MCE become unaligned, once per year without cause or reason, or at any time for a just cause reason. There is a defined list of criteria for just cause plan changes. Those include: Receiving poor quality of care; Failure to provide covered services; Failure of the Contractor to comply with established standards of medical care administration; Lack of access to providers experienced in dealing with the member's health care needs; Significant language or cultural barriers; Corrective action levied against the Contractor by the office; Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence; A determination that another MCE's formulary is more consistent with a new member's existing health care needs; Lack of access to medically necessary services covered under the Contractor's contract with the State; A service is not covered by the Contractor for moral or religious objections; Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk; The member's primary healthcare provider dis-enrolls from the member's current MCE and re-enrolls with another MCE; or Other circumstances determined by the office or its designee to constitute poor quality of healthcare coverage.

**Section 5: Member Supports**

**9. Will someone be responsible to help the member if they lose Medicaid?**

The MCE's are allowed to reach out to members to remind them of their redetermination time frames. However, they can't assist beyond basic assistance. A MCE can't fill out the application for a member, but they can help the member identify materials. There are navigators in the state, FSSA Division of Family Resources, and AAA team members to assist members with the redetermination process. FSSA is also looking at enrollment services vendor functions to have some requirements to help members with Medicaid eligibility and as part of required beneficiary support services, there will be support for members related to appeals processes. These are the types of details that may not necessarily be in the MLTSS scope of work because they are not MCE responsibilities.

**10. How will the fair hearings process work?**

If a member has a complaint, the member should first submit it to their MCE. The member will receive a ruling/feedback from the MCE. The member can appeal this ruling to the state fair hearing.

The MCE is required to send information to members about the appeals and grievances process. Grievance and appeal information must be included in any notice of action (such as a denial of an authorization), in the member handbook, and on the MCE's member website.

Eligibility determinations, which are performed by FSSA, are appealed directly to state fair hearings. The notification letter to the member will include the process.

**Section 6: Care Coordination (Case Management, Service Coordination)**

**11. Will NCQA accreditation also be required for Care Management entities?**

No, this is not a requirement within the MLTSS scope of work. If a MCE contracts with care management entities, the contracted entity must meet the same NCQA standards and contract requirements the MCE is required to meet. The care management subcontractor wouldn't necessarily have to be accredited by NCQA. If MCEs partner with care management entities, the MCEs are expected to conduct oversight of their care management subcontractors to ensure those contractors are meeting NCQA and the scope of work care management requirements.

**12. How does the Care Management/Care Coordination Manager duties connect with the Utilization Management Manager Duties?**

A member's care and service coordinators will be responsible for developing the care plan in partnership with the member and as the member desires, their interdisciplinary care team. The care plan will include all necessary LTSS services for those who meet functional and financial eligibility. The care plan approval process serves as the utilization management approval, and no further utilization management will be needed for LTSS services. Medical services (e.g., surgeries) still must go through any required utilization management process with the Medicare or Medicaid plan, depending on which plan is providing the services.

**13. Would the quality improvement goals and performance improvement activities be the same across the various MCEs that are selected as subcontractors providing direct services? Could these targets/goals be different between the multiple MCEs?**

Broadly FSSA has defined a quality framework for the MLTSS program (person-centered service and supports, access to services, and smooth transitions), and FSSA would expect to see this framework woven into quality improvement and performance improvement activities. However, each MCE may choose to subcontract different functions and subcontract with different entities, thus there may be variation in specific quality improvement goals and performance improvement activities as they relate to the specific relationship and duties of the subcontractor, as well as, over time, that subcontractor's performance.