



Alabama Medicaid Agency

Medicaid

ALABAMA'S INTEGRATED CARE NETWORK (ICN) PROGRAM



DRAFT CONCEPT PAPER

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SECTION I EXECUTIVE SUMMARY

In April 2015, the Alabama legislature unanimously passed the Integrated Care Network (ICN) legislation (*Act 2015-322*).¹ This legislation permits the Alabama Medicaid Agency (the Agency) to contract with one or more ICNs to provide medical and long-term care services to Medicaid beneficiaries who meet the nursing facility level of care, including those who are dually eligible for Medicare. While Alabama has established a successful long-term services and supports (LTSS) system to serve this population, the ICNs will build on the strengths of the current system by introducing tools to integrate the medical and LTSS needs of beneficiaries and allowing them to receive LTSS in the least restrictive setting of their choice.² With ICNs, the State will change the way it delivers and pays for LTSS by moving away from a volume-based, fee-for-service (FFS) environment to a managed care-like system, with the long-term goal of bending the cost curve on Medicaid expenditures for medical services and LTSS.

The ICNs will receive a “capitated” or fixed amount per member, per month that will incentivize them to deliver high quality health care, resulting in improved health outcomes for individuals receiving LTSS and increased ability to remain in their homes and communities. ICNs will be accountable for service delivery, case management and care coordination for their members. Per the legislation, ICNs shall begin delivering services pursuant to a risk bearing contract by October 1, 2018.

While modeled in part after the Regional Care Organization (RCO) program, the ICN program is uniquely designed to cover Medicaid beneficiaries with LTSS needs. Per the ICN legislation, beneficiaries will enroll in either an RCO or an ICN, but may not be concurrently enrolled in both programs. The majority of services included in the RCO program will also be included in the ICN program (e.g. inpatient and outpatient services, primary and specialty care). In addition, the ICN program will also cover nursing facility care, HCBS and enhanced care coordination. The Agency plans to enroll individuals currently enrolled in three of Alabama’s Medicaid HCBS waivers into the ICN program—the Elderly and Disabled waiver, the Alabama Community Transition (ACT) waiver and the HIV/AIDS waiver. Individuals enrolled in the State of Alabama Independent Living (SAIL) waiver, the Technology Assisted (TA) waiver, or one of the two waivers serving individuals with intellectual and developmental disabilities (I/DD) will not be enrolled into the ICN program. In addition, individual’s in Alabama’s Program for All Inclusive Care for the Elderly (PACE) and those who are living in an intermediate care facility for individuals with I/DD will not be included in the ICN program. Care for populations excluded from the RCO and ICN programs will continue to be administered by the State on a FFS basis.

The ICN legislation calls for a competitive procurement process through which the Agency will select entities to serve as contracted ICNs. Based on an initial evaluation of the maximum number

¹ The ICN legislation is codified at Sections 22-6-220, *et seq.* of the Alabama Code.

² For purposes of this document, the term “LTSS” includes nursing facility services, home and community based services (HCBS) and other long-term care services as defined in the ICN legislation and included in the ICN program by the Agency.

of ICNs that would allow for reasonable and actuarially sound capitation rates, the Agency expects to contract with no more than two ICNs. Before executing risk-based contracts, ICNs must demonstrate they can meet all Federal and State ICN requirements, including the ability to operate a statewide service delivery network.

To promote awareness of the program and potential changes to current systems, the Agency has conducted comprehensive stakeholder engagement with LTSS consumers, caregivers, advocates, providers and others to inform the public about the design and development of the ICN program. The Agency is using this stakeholder engagement process and the feedback received to shape the design, implementation and ongoing operations of the program. In 2016, the Agency held town hall meetings across the State (nine in June and eighteen in October) and collected stakeholder input through focus groups, surveys and workgroups. The Agency has been working collaboratively with Navigant Consulting, Inc., who provides program design and implementation assistance, and Optumas LLC, who provides actuarial consulting services needed to analyze ICN program considerations. The Agency has also initiated meetings with CMS to plan for the development of the ICN program and ensure that it will comply with all Federal regulations.³

The purpose of this concept paper is to inform the public about the design and implementation of ICNs, and allow sufficient opportunity for public comment. It incorporates themes and input from public comments received to date, provides an overview of the ICN legislation and background on LTSS in Alabama and introduces proposed ICN program design and implementation concepts. The Agency recognizes that the delivery of LTSS is intensive, frequent and highly personal, and therefore changes to the system require a thorough understanding and explanation of intended changes and enhancements. Through this concept paper, the Agency seeks to explain key elements of the ICN program, which provide structure to the initial program design. Specifically, we address the following:

- Key managed LTSS design principles
- ICN program goals and values
- Proposed ICN structure
- ICN program eligibility
- Covered services
- Care coordination services
- Rate setting approach
- Service delivery networks
- Quality measurement

³ States must gain approval from the Federal Centers for Medicare and Medicaid Services (CMS) before making major changes to their Medicaid programs.

The Agency will continue to consider components of the program design based on stakeholder feedback—including other state agencies, providers and consumers—to actively support and promote the development of an ICN program to enhance services for individuals in need of LTSS who are served by Medicaid in our State. ***Members of the public may submit comments on this concept paper through May 4, 2017, by using the following address: ICNinfo@medicaid.alabama.gov.***

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SECTION II BACKGROUND

Current LTSS System

The Alabama long-term services and supports (LTSS) system provides institutional care and HCBS to more than 23,000 elderly and disabled adults who meet the Medicaid financial eligibility requirements for long-term care and demonstrate need qualifying the individual for nursing facility level of care, as defined by the Agency.⁴ More than 200 nursing facilities provide nursing facility care to more than 16,000 Medicaid beneficiaries. Home and community-based services (HCBS) are available statewide through HCBS waivers. As of 2016, there were 10,030 waiver slots across the three waiver programs intended for inclusion in the ICN program, with the Elderly and Disabled waiver program serving the largest number of beneficiaries.

Figure 1. Key Information on Alabama HCBS Waivers, 2016

Description	Elderly and Disabled Waiver	HIV/AIDS Waiver	Alabama Community Transition (ACT) Waiver
Age Requirement	None	21 years and older	None
Enrollment Limit	9,205	150	675
Enrollment	8,299	51	81
Interest List Count	~5,000	0	0
Average Annual Spend	\$ 63,782,505	\$461,742	\$1,137,022
Administrator	Alabama Department of Senior Services	Alabama Department of Senior Services	Alabama Department of Senior Services

⁴ Alabama Medicaid Administrative Code Rule 560-X-10-.10.

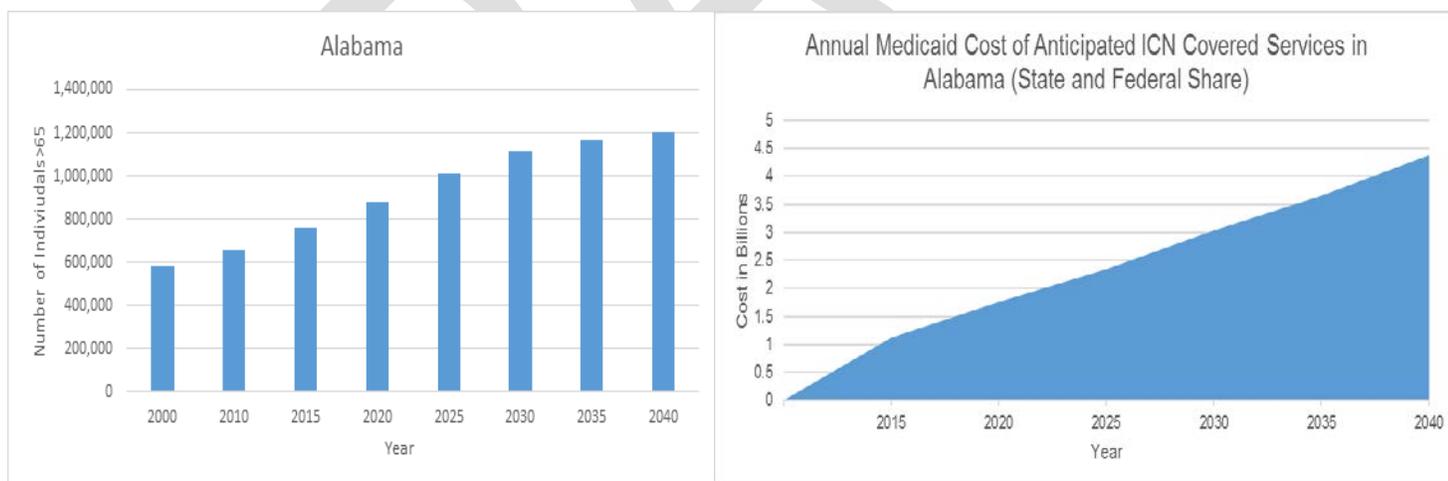
Beneficiaries covered by waivers for persons with intellectually/developmental (I/DD) disability and the SAIL or TA waiver programs will not be included in the ICN program; those waivers will continue to be administered on a FFS basis by the State.

Challenges with the Current LTSS System

In 2015, the Agency spent over \$1.1 billion for anticipated ICN covered services for individuals receiving LTSS, and that number is expected to continue to increase. Between 2010 and 2015, the per member per month (PMPM) cost for anticipated ICN covered services increased by 16.2 percent, from \$3,368 to \$3,913, representing an average annual growth rate of 3 percent. See Appendix A for a summary of Alabama Medicaid LTSS expenditures for anticipated ICN covered services from 2010 through 2015.

Factoring projected growth of the aging population in Alabama with Alabama’s average annual growth rate of 3 percent, as described above, Alabama’s anticipated cost to Medicaid (State and Federal share) for the anticipated ICN covered services could increase from over \$1.1 billion in 2015 to approximately \$4.4 billion in 2040 as shown in Figure 2, below.⁵ This projected expenditure growth could exceed what is financially manageable for taxpayers. The State must invest in program enhancements that will bend the future cost curve for Medicaid LTSS beneficiaries.

Figure 2. Growth of the Aging Population and Costs for Projected ICN Covered Services in Alabama



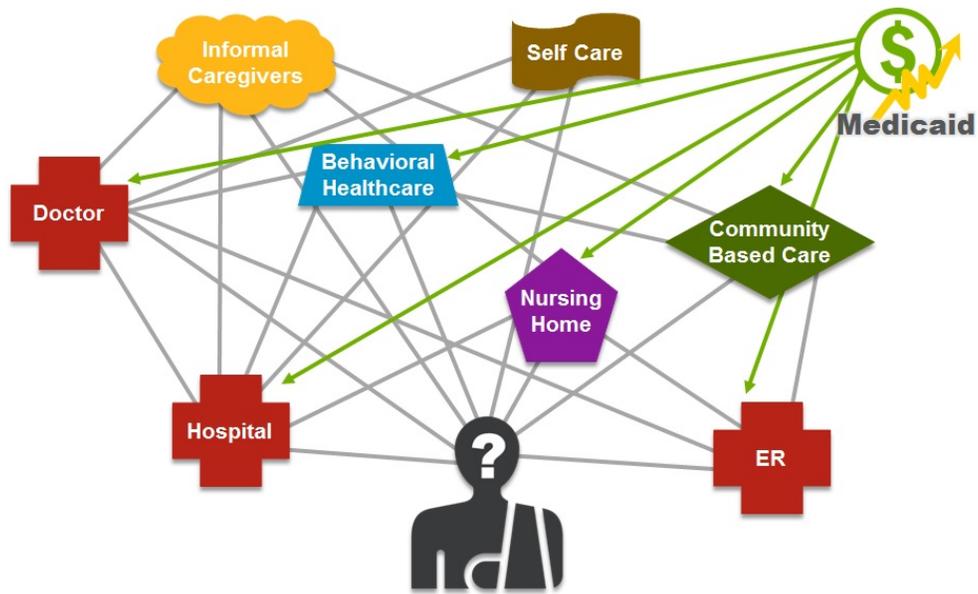
Note: Analysis of population and cost growth calculated using the following source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama, March 2015

Like many states, Alabama’s current LTSS service delivery system is fragmented and costly. As illustrated in Figure 3 below, consumers and their families are often left to navigate the complex

⁵ The 2010 U.S. Census reported a 15 percent increase in the 65+ population nationally from 2000 to 2010 and a 13.5 percent increase in Alabama.

web of healthcare services and providers themselves. Stakeholders have expressed a need for increased coordination across the care continuum at town hall meetings across the State.

Figure 3. Fragmentation in the LTSS Delivery System



Stakeholders also expressed concern over challenges they face in accessing medical, HCBS and other Medicaid services. Medicaid beneficiaries in Alabama often experience a lack of transportation to services and/or the need to travel long distances for care. In addition, many beneficiaries currently receiving Medicaid LTSS use acute care and emergency rooms to obtain urgent care or medical attention needed outside of standard business hours, including for chronic disease management. Some areas of Alabama also experience challenges with having a sufficient number of qualified front-line HCBS caregivers, such as personal care assistants and home health aides. As is the case in all states, provider shortages and transportation challenges are especially pronounced in rural communities. Furthermore, stakeholders across the State report that accessing mental health services is a challenge for many in the LTSS population, particularly for those who are homebound. Mental health counseling and other non-pharmaceutical interventions are reportedly underutilized as an option for older or physically disabled adults. ICNs will be tasked with identifying opportunities to improve access to healthcare and HCBS services throughout the State.

SECTION III PROGRAM DESIGN

A. CMS'S KEY PRINCIPLES FOR LTSS DESIGN

To guide the Agency's efforts in implementing the ICN legislation, the Agency is using the CMS Key Principles for LTSS Design as a framework for shaping the ICN program and contract requirements.⁶ CMS's key principles include:

1. **Stakeholder engagement** in the planning, implementation and oversight of managed long-term services and supports (MLTSS) programs.
2. **Planning and transition strategies** that are adequate for the design and implementation of MLTSS programs.
3. **Enhanced provision of HCBS** that offer the "greatest opportunities for active community and workforce participation" and operate consistently with the Americans with Disabilities Act (ADA), the *Olmstead* decision and CMS's home and community based setting requirements.
4. **Performance-based incentives and/or penalties** that align the payment structures with MLTSS programmatic goals.
5. **Support for beneficiaries** including independent and accessible advocacy or ombudsman services, and assistance with enrollment and disenrollment.
6. **Person-centered processes** including conflict-free needs assessments, service planning and delivery and supports for self-direction.
7. **Comprehensive integrated service package** including physical and behavioral health, institutional care and HCBS.
8. **Qualified providers** including adequate capacity and expertise to provide services that support community integration.
9. **Participant protections** including safeguards to prevent abuse, neglect and exploitation as well as fair hearings with continuation of services pending appeal.
10. **Quality** measurement, including quality of life measures.

As the Agency finalizes the ICN program and contract requirements, it will develop a robust monitoring process to ensure these requirements are upheld.

B. ICN PROGRAM GOALS

The overarching goal of the ICN program is to create a more sustainable infrastructure for the delivery of Medicaid-funded LTSS in Alabama. Through the ICN program, the Agency seeks to

⁶ Centers for Medicare & Medicaid Services, "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs." May 2013.

promote a person-centered approach to care delivery that better integrates the medical and LTSS needs of beneficiaries and allows them to receive LTSS in the least restrictive setting of their choice. With heavy emphasis on effective care coordination, the ICN will help improve quality while maintaining or lowering cost growth and ensuring that members receive the right care in the right place at the right time. ICNs will implement innovative approaches, incentives and value-based purchasing arrangements to assist in ensuring the following key values of the program are maintained or enhanced:

- Comprehensive care coordination that targets consumer satisfaction, enhanced quality of life and effective navigation of clinical and other support services
- Improved quality and health outcomes
- Person-centered planning and service delivery
- Enhanced access to HCBS through robust development of provider networks
- Assurances of patient safety and protections

C. PROPOSED ICN STRUCTURE

The ICN legislation requires that ICNs be “statewide organizations of health care providers.” Each ICN will be organized similar to managed care health plans because they will receive a capitated per member per month payment from the State to pay for the medical care and LTSS of their members. ICNs must have a governing board of directors composed of 20 members; 12 members representing risk-bearing participants in the ICN and eight members who do not represent risk-bearing participants.⁷ ICNs may be for-profit or non-profit entities. The Agency expects to contract with no more than two ICNs. The ICN(s) must demonstrate they can meet all Federal and State requirements by completing a readiness assessment to the satisfaction of the Agency. Per the ICN legislation, ICNs will be required to operate statewide and have offices in each of the State’s five RCO regions.

The Agency will hold each ICN accountable for meeting standards regarding prompt payment to providers, encounter data collection and reporting, program integrity and more. In addition, each ICN must develop an adequate service delivery network throughout the State, maintain Agency-defined financial and solvency requirements and create a citizens’ advisory committee comprised of a reasonably representative sample of the LTSS populations, or other individuals representing those members, served by the ICN.

⁷ Alabama Medicaid Administrative Code Rule 560-X-64-.03 provides the specific requirements for the composition of the ICN governing board of directors.

D. ELIGIBILITY FOR THE ICN PROGRAM

Per the ICN legislation, the Agency shall define the populations ICNs will cover. The Agency's proposed ICN eligibility criteria are described below.

ICN Eligibility

First, individuals must be Medicaid eligible and must meet the nursing facility level of care to enroll in the ICN program. The nursing facility level of care defined by Alabama Medicaid Administrative Code Rule 560-X-10-.10 incorporates a number of skilled nursing care services required by beneficiaries, as well as functional impairment of Activities of Daily Living (ADLs) such as transfer, mobility, eating and toileting, as well as intermediate Activities of Daily Living (IADLs) such as medication administration. Individuals who meet the Agency's financial eligibility criteria and who are determined by a physician to require healthcare services that must be performed by a skilled nurse, and/or ongoing, regular assistance with specific ADLs or IADLs, will be eligible to participate in the ICN program if they also fall into one of the following groups:

- **Medicaid beneficiaries receiving care within a nursing facility.** Medicaid beneficiaries who currently receive custodial, long-term care within a nursing facility will be included in the ICN program.⁸ If it is determined that a RCO enrollee needs nursing facility care on a long-term basis (currently defined as more than 90 days), the RCO enrollee will be transferred to the ICN program.
- **Medicaid beneficiaries receiving care through select HCBS waiver programs.** The Agency plans to include Medicaid beneficiaries currently enrolled in the following HCBS waiver programs in the ICN program (See Appendix B for additional waiver program information):
 - *Elderly and Disabled Waiver* – targeting individuals who are frail or physically disabled.
 - *Alabama Community Transition (ACT) Waiver* – targeting individuals currently residing in institutional long-term care who seek to transition to an HCBS setting.
 - *HIV/AIDS Waiver* – targeting individuals ages 21 and older with diagnosed HIV or AIDS.

The ICN program will also include individuals who are dually eligible for Medicaid and Medicare if they live in a nursing facility or are enrolled in one of the three HCBS waivers mentioned above. Dual eligibles will comprise a large portion of ICN enrollment—currently, more than 85 percent of Medicaid beneficiaries receiving LTSS are dually eligible for Medicare. ICNs will only be at-risk for the Medicaid-covered services (medical and LTSS) not currently covered by Medicare. While

⁸ Custodial care is nonmedical assistance with the activities of daily living (such as bathing, eating, dressing, or toileting) provided at home, in a nursing facility, or an assisted-living facility for someone who's unable to fully perform those activities without help.

not at risk for services that fall outside of Medicaid, ICNs will be expected to coordinate with Medicare and other health plans as necessary to ensure coordinated and effective patient care. It is important to note that dually eligible individuals will retain choice for their Medicare coverage; they will be able to choose whichever Medicare product they wish to provide their Medicare coverage.

The following individuals who meet the nursing facility level of care will ***not be eligible for*** the ICN program:

- Individuals enrolled in the SAIL waiver;
- Individuals enrolled in the TA waiver;
- Individuals enrolled in the Intellectual Disabilities waiver;
- Individuals enrolled in the Living at Home Waiver;
- Individuals living in an intermediate care facility for individuals with intellectual disabilities; and
- Individuals enrolled in the PACE program.⁹

ICN Level of Care Determination

Eligibility for the ICN program requires an applicant to meet both Medicaid financial eligibility, and also be certified by a qualified medical provider to meet the nursing facility level of care in accordance with Alabama Medicaid Administrative Code Rule 560-X-10-.10. Currently, Medicaid applicants who need long-term care services are assisted by their chosen nursing facility or their local Area Agency on Aging (AAA) to obtain nursing facility level of care certification and provide needed financial documents to the Agency.

Under the ICN program, the Agency will continue to determine financial eligibility, and it is anticipated that an external entity (outside of the ICNs) will be responsible to assist applicants with obtaining their initial nursing facility level of care certification and completing the Medicaid application process. Once a member has been enrolled in an ICN, the ICN will be responsible for assisting members with obtaining the documentation required to annually recertify a member's continued need for the nursing facility level of care.

E. COVERED SERVICES

ICNs will receive a monthly capitation payment to deliver ICN covered services to the eligible population. The Agency expects that ICNs will provide a comprehensive Medicaid service benefit package as detailed in Figure 4, below.

⁹ PACE is currently only available through Medicaid in Mobile and Baldwin counties.

Figure 4. Sample of ICN Covered Services

Hospital inpatient and outpatient care	Emergency room care
Primary and specialty care (office-based)	Eye care
Lab and radiology	Hospice
Nursing facility care	HCBS waiver services (those covered by the Elderly & Disabled, ACT and HIV/AIDS waivers)
Durable medical equipment	Prosthetic devices
Non-emergency medical transportation	Hearing care
Services provided by federally qualified health centers (FQHCs) and rural health centers (RHCs)	

ICNs will coordinate all covered services as well as some services a member may receive or require outside of the array of covered services, in order to fully integrate the member’s care needs and develop a holistic care plan. For example, while pharmacy is a Medicaid-covered service, the Agency anticipates that, similar to the RCO program, it will not be part of the ICN program (i.e. the Agency will continue to pay for prescription drugs on a FFS basis). However, ICNs will be responsible for coordinating pharmacy services with Medicaid or Medicare. Similarly, home health, mental health and substance abuse services will not be covered by ICNs, but ICNs will be required to coordinate with Medicare (for dual eligibles) and the Departments of Public Health and Mental Health (for non-dual-eligibles) for individuals who require these services. While specific requirements for this coordination process have not yet been determined, the Agency expects the ICNs to develop agreements with other state agencies to outline how this coordination will occur.

For beneficiaries who are currently enrolled in the Elderly and Disabled, ACT and HIV/AIDS waivers, the Agency expects ICNs to maintain their existing waiver care plans (i.e. providers, duration, type and frequency of services) for at least 90 days following ICN enrollment. After the first 90 days, the ICN care coordinator will work with the individual to develop a new ICN care plan. The Agency expects that the ICNs will work closely with the AAAs and leverage their knowledge and experience during this transition.

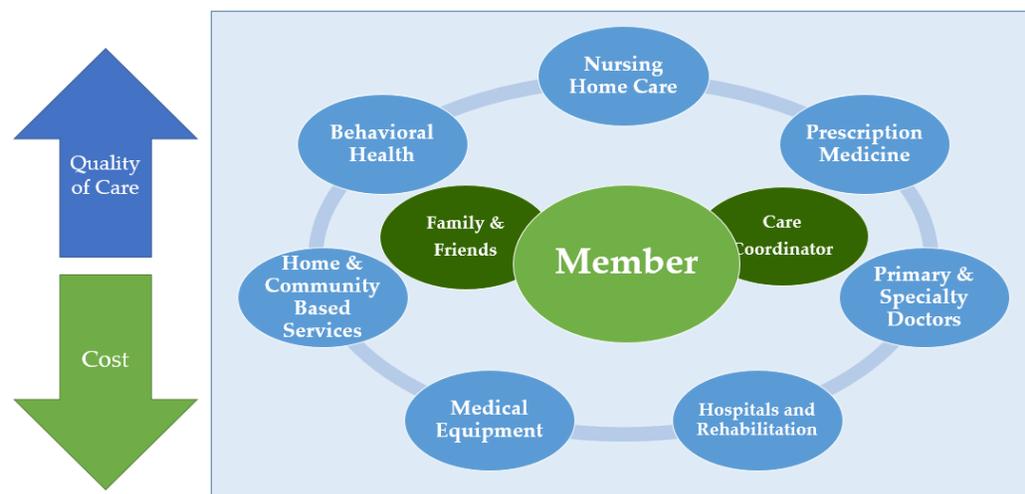
F. CARE COORDINATION SERVICES

Today, care coordination services for Medicaid beneficiaries needing LTSS are limited to case management provided to HCBS waiver participants and offer little integration with other services. Waiver case management is currently provided through AAAs operating through regional commissions, county-based agencies or local non-profits.

Under the ICN program, ICN care coordinators will become responsible for coordinating services with a variety of providers for all enrolled members to support their overall health and well-being, not just their long-term care needs. ICNs may elect to conduct care coordination in-house or to contract with outside organizations, which may include AAAs or other care management entities, for all or specialized aspects of care coordination.

The Agency recognizes that enhanced care coordination is the lynchpin to redesigning and enhancing care and overall LTSS delivery. As shown in Figure 5 below, care coordination will cover the full array of medical and LTSS services, even those that will continue to be provided by the State on a FFS basis (e.g. prescription medicine). Under the proposed ICN care coordination framework, care coordinators will work with members' family and friends (informal caregivers) to assist members with accessing and maintaining the services and supports included in their care plans. This care coordination is designed to improve quality of care and decrease avoidable costs, such as preventable hospital admissions and emergency department visits.

Figure 5. ICN Care Coordination Framework



Care coordinators will incorporate the principles of self-determination, person-centeredness, freedom of choice and conflict-free case management while promoting high quality, cost-effective service delivery. The Agency expects that ICNs will implement innovations in care coordination that align with evidence-based best practices in areas including self-management of health conditions, risk management, health literacy, care plan adherence, community inclusion and participation, informal caregiver support and other areas that impact quality of life and health outcomes.

Care coordinators will conduct comprehensive risk evaluations, assist with the identification and obtainment of community-based services outside of the ICN and Medicaid covered service package, and regularly screen members for satisfaction with services, providers and quality of life. Additional anticipated elements of care coordination include:

- Care coordination will follow a team-based model led by a social worker and a nurse. ICNs will be required to provide their care coordination team staffing strategies to the Agency for approval, and will be monitored to ensure each ICN complies with caseload standards.
- Care coordination will be required for all ICN members, including nursing facility residents, with established minimum frequency requirements based on members' needs. HCBS members will receive a minimum monthly face-to-face contact and nursing facility residents will have contact with the care coordination team, in order to monitor the quality and outcomes of care.
- Caseload standards will be established using a weighting system, where HCBS and nursing facility members will be weighted differently, in order to calculate manageable caseload sizes.
- Protocols will be required for transitional care coordination when members are hospitalized or experience a change in their level of care, or care setting, including re-assessment and care plan revision.
- Members will have access to assistance and support outside of standard business hours, including nights and weekends.

The Agency will monitor ICNs throughout the provision of care coordination to ensure they uphold person-centered principles, including individual autonomy and freedom of choice when developing and monitoring care plans.

Beneficiary Protections: Support with Grievances and Appeals

Federal managed care regulations require ICNs to “establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.”¹⁰ Further, the regulations require MLTSS programs to offer more assistance to individuals receiving LTSS who seek to appeal plan decisions or file grievances, requiring states to provide a beneficiary support system to assist with navigating the MLTSS landscape.¹¹ Support from an entity independent of the ICNs is essential due to functional impairment, diminished cognitive acuity or other unique circumstances that often exist among those with LTSS needs and because of the highly sensitive and personal nature of many LTSS services. Thus, the Agency is exploring options to provide hands-on support from an independent entity to ICN members to help direct them through the grievance and appeals processes, help members understand their rights and responsibilities and assist them with formal or informal resolution of disputes that may occur with their providers or their ICN.

¹⁰ Medicaid and CHIP Final Rule, April 25, 2016 (*CMS-2390-F*), codified at 42 C.F.R. §438.400(a)(3)

¹¹ Medicaid and CHIP Final Rule, April 25, 2016 (*CMS-2390-F*), codified at 42 C.F.R. § 438.71(d)

G. RATE SETTING APPROACH

The ICNs will receive a capitated per member per month payment from the State to pay for all ICN covered services. The Agency plans to use a rate setting approach that encourages the use of the least restrictive, most cost effective setting for individuals in the LTSS system. The Agency anticipates that, in the first year of the ICN program, the capitation rates paid to ICNs will assume a modest level of transitions from nursing facilities to HCBS settings, with this level increasing over time. The Agency estimates that these transitions will largely occur as new individuals become eligible for LTSS.

In addition, in recognition of the significant infrastructure development required of newly formed, provider-led ICNs, the Agency expects to use risk-sharing components in the rate setting approach that will provide some financial protections. The ICN payment model will comply with all requirements established by Alabama statute and the CMS Office of the Actuary. The timetable and additional details of the rate setting approach are under development.

H. SERVICE DELIVERY NETWORKS

ICNs will build service delivery networks by contracting with Medicaid providers to ensure access to care for beneficiaries. In addition, ICNs must comply with legislative requirements to contract with any willing provider and to offer reimbursement rates that are at least at the level of Alabama Medicaid established rates. The Agency has developed network standards that ICNs must meet for clinical services, HCBS and nursing facilities, and ICNs must demonstrate that they meet these network standards before executing contracts with the Agency. These service delivery network standards can be found in Alabama Medicaid Administrative Code Rule 560-X-64-.07.¹² In this section, we describe considerations regarding ICN provider network standards and requirements for providers who wish to contract with an ICN.

Clinical Services Network Criteria

As noted above, the ICN program will include a defined set of LTSS, as well as many services that mirror the RCO program. The Agency has established service delivery network rules that pertain to primary medical providers, specialists and hospitals.

HCBS Provider Network Criteria

HCBS providers present several considerations regarding the development of network requirements:

¹² Alabama Medicaid Administrative Code Rule 560-X-64-.07 is available at: http://www.medicaid.alabama.gov/documents/9.0_Resources/9.2_Administrative_Code/9.2.1_Proposed_Agency_Rules/9.2.1_APA-17_560-X-64-07_Service_Delivery_Network_Requirements_3-31-17.pdf

- ICNs must develop networks that offer beneficiaries access to and choice among Medicaid providers in their communities. Furthermore, ICNs must monitor providers to ensure they honor individuals' rights of privacy, dignity, respect and freedom from coercion and restraint.
- Because ICNs must maintain existing HCBS care plans for members who are currently enrolled in HCBS waivers (i.e. providers, duration, type and frequency of services) for at least 90 days following ICN enrollment, ICNs must develop a protocol to reimburse out-of-network providers as necessary.
- The Agency and ICNs must consider **anticipated population growth** and changes in utilization resulting from the ICN program. The Agency is continuing to analyze the current capacity of Alabama's Medicaid LTSS in relation to the anticipated increase in demand for services and to develop criteria that incentivize ICNs to build HCBS network capacity. The State's intent is that ICNs will expand access to HCBS and assist members with accessing these services.
- Time and distance criteria are not as applicable to providers that provide services within the beneficiary's home. The Agency has developed alternative standards for these providers.

Provider Enrollment

The State will continue to be responsible for all Medicaid provider certification and credentialing to ensure all LTSS and medical providers meet Medicaid requirements and remain in good standing with the Agency.¹³

Nursing Facility Network Criteria

As of June 2015, there were more than 200 nursing facilities and more than 25,000 nursing facility beds in Alabama.¹⁴ Data from the cost reports indicate total nursing facility occupancy was 87 percent and Medicaid occupancy (beds occupied by Medicaid residents/beds available) was 60 percent. Figure 6 provides a map of nursing facilities in Alabama. As institutional care is a covered service, the Agency expects that ICNs will contract with nursing facilities to

Figure 6: Nursing Facility Locations in Alabama



¹³ Alabama Medicaid provider certification requirements can be found in provider manuals on the Agency's website.

¹⁴ June 2015 Nursing Facility Cost Reports submitted to the Agency.

meet network requirements and improve quality of care.

I. QUALITY MEASUREMENT

Nationally, there has been significant activity in defining quality measures for effective LTSS programs. The U.S. Department of Health and Human Services conducted research on MLTSS quality requirements used by states nationwide and found the following types of requirements that are included in contracts with managed care organizations:

- Staffing requirements for provider oversight and care coordination (care coordinator-to-member ratios)
- Information technology requirements in support of quality monitoring and reporting
- Critical incidents reporting/investigation requirements
- Required mechanisms for handling complaints, grievances, appeals and associated reporting
- Risk assessment and mitigation requirements
- Beneficiary experience of care and satisfaction surveys
- LTSS performance and quality of life measures¹⁵

The Agency will consider these requirements as it develops the contract for the ICN program.

Per ICN legislation, the Agency developed an ICN Quality Assurance Committee (QAC). The ICN QAC is responsible for identifying quality measures to monitor the quality and overall success of the ICN program. The ICN QAC consists of more than 20 members, representing provider associations, advocacy groups and state agencies.

The Agency, in coordination with the ICN QAC, is implementing a multi-faceted approach to ensure quality performance and monitoring of ICNs. The ICN QAC reviewed Federal regulations, state requirements, CMS guidance, best practices and existing data to identify appropriate quality measures. All ICN QAC meeting materials are available on the Agency's website.¹⁶

On January 24, 2017, the ICN QAC selected 35 quality measures that will be used to evaluate ICN performance. These measures will also complement the monitoring tasks that the Agency will conduct related to its waiver assurances and ICN contract requirements. The selected quality measures span nine different quality domains:

¹⁵ "Environmental Scan of MLTSS Quality Requirements in MCO Contracts," September 2013. Available online: <https://aspe.hhs.gov/report/environmental-scan-mltss-quality-requirements-mco-contracts>

¹⁶ The ICN QAC meeting materials are available at: http://medicaid.alabama.gov/content/5.0_Managed_Care/5.2_Other_MC_Programs/5.2.4_ICNs/5.2.4.3_ICN_QA_Committee.aspx

- 1) Clinical
- 2) Long-Term Care
- 3) Service Delivery and Effectiveness
- 4) Person Centered Planning and Coordination
- 5) Caregiver Support
- 6) Choice and Control
- 7) Community Inclusion
- 8) Holistic Health and Functioning
- 9) System Performance and Accountability

As the ICN program develops, the ICN QAC will monitor the quality measures and make adjustments based on performance and program changes as necessary.

SECTION IV STAKEHOLDER ENGAGEMENT

Because the Agency believes adequate planning and stakeholder engagement are high priorities when designing a new LTSS program, it launched a comprehensive stakeholder engagement plan in June 2016, in preparation for the creation of the ICN program. This concept paper incorporates themes and suggestions from public comments received to date, including:

- **Improved access to HCBS and medical services:** Consumers, caregivers and providers all expressed support for a more comprehensive array of available HCBS and expanded access to medical services. They described a lack of providers to choose from in some areas of the State and increasing difficulty in finding qualified medical providers who accept Medicaid. Stakeholders also expressed the desire to see modernization in how these services are delivered, including availability of services outside of standard business hours and more opportunities for participant direction.
- **Need for person-centered approaches:** Stakeholders have advised that the State has an opportunity to improve the use of person-centered approaches to developing HCBS care plans. The current system restricts choice and ability for consumers to develop a care plan that is tailored to their specific wishes and needs, and the Medicaid system is limited in its ability to achieve personalized goals using consumers' care plans.
- **Enhancing opportunities for community inclusion:** Stakeholders acknowledged that many who receive LTSS, either in an institution or in their homes, lack meaningful opportunity to engage with the community at large. Stakeholders have expressed the need for consideration of quality of life and promotion of purpose driven daily living, with enhanced offerings for social programs, non-emergency transportation and respite care.

The overall stakeholder engagement strategy has been multi-faceted. The Agency engaged stakeholders through the following strategies:

1) Solicit Stakeholder Input Through a Long Term Care Workgroup

Starting in early 2015, the Agency commissioned a **Long Term Care (LTC) Workgroup** to study Medicaid's long-term care programs. The Workgroup then provided a report to Governor Bentley based on its findings and recommendations. Workgroup members include delegates from many key stakeholders within the statewide LTSS delivery system, including representatives from the Alabama Nursing Home Association, the Home Care Association of Alabama, AARP of Alabama, PACE, the Alabama Department of Senior Services and others. The LTC Workgroup's report to Governor Bentley advocated for a managed LTSS program model, which evolved into development of the legislation that authorized creation of the ICNs.

The LTC Workgroup played a critical role in advancing ICN development. For example, members completed a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of the State's current service provider network, helped to refine and implement the stakeholder engagement processes and will be engaged moving forward to assist with continuing program design, stakeholder education and public outreach efforts. The LTC Workgroup members were provided flash drives in early 2016, which contained uploaded research documents, best practices from other states and other pertinent information, and are encouraged to download documents and links as released by the Agency. Additionally, the LTC Workgroup was provided an overview of key concepts in 2016, which allowed them an opportunity to have formal input into program design elements.

Although the formal LTC Workgroup has concluded its work, having submitted a report to the Governor, the Agency recognizes the value of continued stakeholder input and intends to establish an advisory committee for ICN development. Membership will likely include many of the LTC Workgroup members, as well as additional members including LTSS consumers, caregivers and representatives from other segments of the healthcare system included in the ICN program. The Agency plans to convene this committee on an ongoing, regular basis and is finalizing details regarding this committee.

2) Engage Stakeholders Through Town Hall Meetings:

The Agency conducted *town hall meetings* in nine cities throughout the State during June and October 2016. The objective of these meetings was to engage stakeholders in the ICN planning process and educate them about the purpose and goals of the ICN program, including the key principles of managed care. In total, nearly 1,000 individuals attended these meetings; attendees included consumers, caregivers, community members, direct service providers, trade and advocacy organization representatives, as well as representatives from organizations interested in applying to become an ICN. A recording of the town hall presentation is available on the Agency's website.¹⁷

In October 2016, the Agency completed a second round of town hall meetings in nine areas of the State using a focus group format. The meetings targeted both consumer-focused topics, such as care management, quality of life and care transitions, and provider-focused topics such as billing, claims and network adequacy. See Appendix C for a summary of stakeholder input the Agency received during the second round of town hall meetings held in fall 2016.

3) Stakeholder Survey:

In August 2016, the Agency launched *web-based and paper surveys* with four targeted tracks for consumers, caregivers, direct service providers and advocates. The goal of the

¹⁷ The recording of the town hall is available at:
http://www.medicaid.alabama.gov/content/5.0_Managed_Care/5.2_Other_MC_Programs/5.2.4_ICNs.aspx

survey was to engage stakeholders who wished to provide input but were unable to attend a town hall meeting. At the recommendation of the LTC Workgroup, the Agency also distributed paper copies of the survey at Alabama's 13 AAAs and the Alabama Department of Rehabilitation Services offices, who assisted community members with completing the paper survey. In total, more than 2,700 responses were submitted, including more than 2,000 paper responses.

4) ICN Website:

The Agency has created an *information-rich website* to provide meeting notices, past presentations, published documents and FAQs regarding the ICN program. The website address has been included on publications, surveys and publicized during informational town hall and focus group meetings.¹⁸

5) Educate the Public through a Published Key Concepts Document

In September 2016, the Agency published a list of 16 "Key ICN Concepts," which served as a precursor to release of the concept paper. The key concepts were released in an effort to respond to frequent questions received from stakeholders during public meetings that occurred in the first half of 2016, as well as to provide a high-level understanding to entities interested in forming an ICN who had requested clarity around proposed ICN qualifications. Topics covered at a high level included:

- Covered populations
- Covered services
- Projected number of ICNs
- ICN solvency and reserve requirements
- Allowable corporate structure for ICNs (e.g. non-profit vs. for-profit status)

The Agency presented key concepts to the LTC Workgroup in September 2016, before posting them to the Agency's ICN website. The public had 30 days to submit comments to the Agency

6) Educate the Public through a Published Concept Paper

This *draft concept paper* provides an overview of the ICN program design and implementation concepts. The public will have the opportunity to comment on this draft concept paper from April 5, 2017 to May 4, 2017 by emailing questions or comments to the following address: ICNinfo@medicaid.alabama.gov.

¹⁸ The ICN website is accessible at:
http://medicaid.alabama.gov/content/5.0_Managed_Care/5.2_Other_MC_Programs/5.2.4_ICNs.aspx.

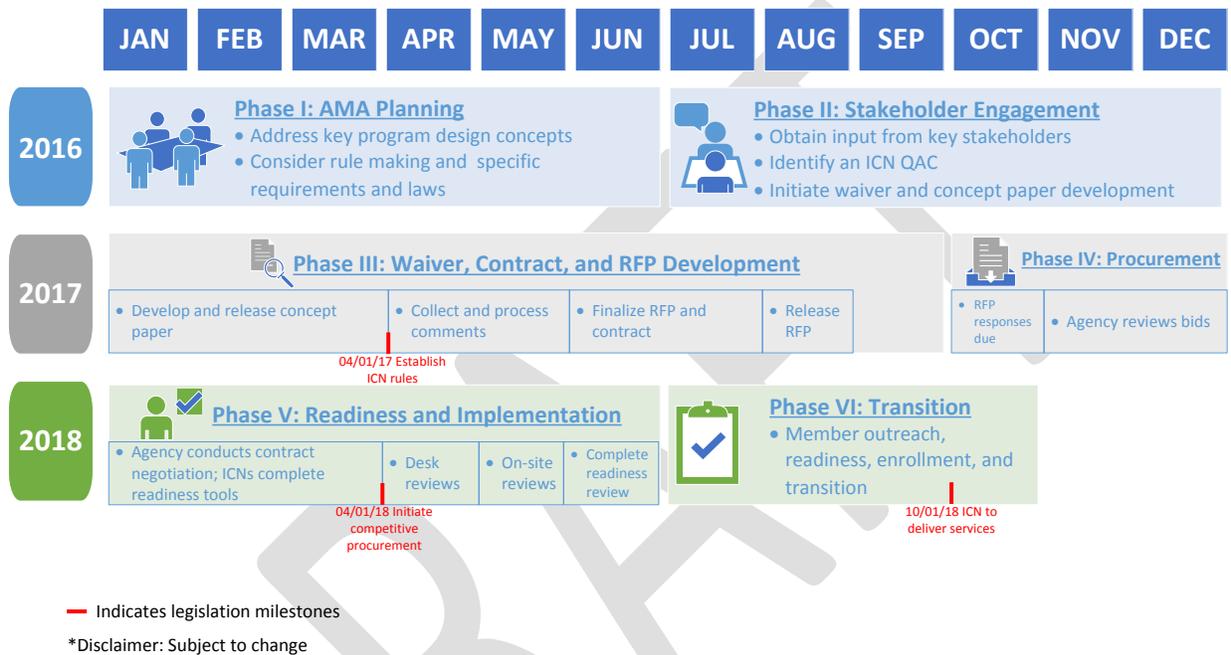
Moving forward, the Agency intends to continue stakeholder engagement, including continuing education and dialogue with the public. The Agency values stakeholder engagement in program design, and is committed to implementing an ICN program that is respectful of stakeholders' needs, particularly consumers and their families, and involves them on an ongoing basis after program implementation.

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SECTION V IMPLEMENTATION TIMELINE

Per the legislation, ICNs will begin delivering services pursuant to a risk bearing contract by October 1, 2018. Significant activity is required to implement the ICN program as illustrated in Figure 7, below.

Figure 7. ICN Implementation Timeline*



To date, the Agency has completed Phase I and Phase II of the timeline shown above in Figure 7. The Agency began Phase I (Planning) in early 2016, which included consideration of key program design concepts and reviewing applicable Federal and State laws and regulations. The Agency reconvened the LTC Workgroup to discuss proposed decisions and progress on the ICN program. The Agency also met with CMS’s Integrated Care Office to explore options for dually eligible beneficiaries. The Agency began Phase II (Stakeholder Engagement) in July 2016, which consisted of two series of statewide public town hall discussions and surveys aimed to inform stakeholders of the ICN legislation and to obtain feedback on key areas of program design.

The Agency has also been working on aspects of Phases III (Waiver, Contract and RFP Development) and IV (Procurement), which will be the primary focus during 2017. The Agency is still developing the aspects of the later Phases of ICN implementation; therefore, the dates and timeframes discussed herein are subject to change.

The Agency plans to submit applications to CMS in mid to late 2017 for requisite 1915(b) and 1915(c) waivers needed to implement the ICN program, to obtain CMS's approval by mid-2018.¹⁹ Concurrent with drafting waiver applications, the Agency will also develop a draft ICN contract and issue a Request for Proposal (RFP) for entities interested in serving as an ICN. The Agency anticipates the procurement process will be a multi-stage approach with specified milestones, which may include required infrastructure development, (e.g. governance, solvency, network adequacy) and attendance of mandatory meetings for entities interested in becoming ICNs. Such milestones and other requirements will be defined in Chapter 64 of the Alabama Medicaid Administrative Code and the RFP.

The Agency plans to conduct Phase V (Readiness Reviews) during the first half of 2018, during which the Agency will review selected ICNs to ensure that they have the necessary processes and resources in place to begin providing services by October 1, 2018. Readiness reviews will entail desk reviews of documents submitted by ICNs to the State and onsite reviews of ICN offices. Finally, Phase VI (Transition) will begin in July 2018, which involves member outreach, enrollment support and transition assistance.

¹⁹ As mentioned in Section III.C., the Agency plans to include three 1915(c) waivers in the ICN program: the Elderly and Disabled Waiver, HIV/AIDS Waiver, and the ACT, along with their designated waiver slots and associated funding.

SECTION VI CONCLUSIONS

The ICN program will change the way Alabama delivers and pays for Medicaid-funded LTSS by moving from a volume-based FFS environment toward a managed care environment where the financial risk and accountability for service delivery and care coordination will shift from the State to ICNs. ICNs will receive a monthly capitation payment to deliver covered services to the eligible population: Medicaid-eligible individuals who meet the nursing facility level of care. The overarching goal of the ICN program is to create a more sustainable infrastructure for the delivery of LTSS—one that better integrates the medical and long-term care needs of Alabama’s most vulnerable Medicaid beneficiaries, one that gradually shifts LTSS service delivery and expenditures from nursing home care to HCBS and that ultimately bends the cost curve for medical and LTSS expenditures for elderly and disabled Medicaid beneficiaries.

With heavy emphasis on effective care coordination, the ICN program will help improve quality and ensure that members receive the right care in the right place at the right time. Care coordination will cover the full array of medical and LTSS services and manage transitions across care settings. ICN care coordinators will incorporate the principles of self-determination, person-centeredness and freedom of choice while promoting high quality, cost-effective service delivery.

Comments on this draft concept paper will be accepted during a 30-day period from April 5, 2017 to May 4, 2017. Individuals may email questions or comments to the Agency using the following address: ICNinfo@medicaid.alabama.gov. The Agency expects to publish a final concept paper in June 2017 that reflects public input and any changes to program design that may occur between April and June.

SECTION VII APPENDICES

APPENDIX A: ALABAMA MEDICAID LTSS EXPENDITURES

The tables below provide data on Medicaid expenditures for beneficiaries living in nursing facilities, enrolled in HCBS waivers or receiving hospice from 2010 through 2015.

Figure 8. Total Medicaid Paid by Fiscal Year*

Population		2010**	2011	2012	2013	2014	2015
Nursing Facility	Dual	\$767,022,229	\$799,320,065	\$811,700,273	\$794,704,613	\$814,617,232	\$833,606,508
Nursing Facility	Non-Dual	\$89,087,594	\$109,794,611	\$118,925,456	\$123,188,991	\$126,735,171	\$139,162,269
Waiver	Dual	\$76,344,919	\$76,662,158	\$61,454,602	\$47,356,567	\$53,128,618	\$57,311,903
Waiver	Non-Dual	\$35,202,183	\$44,135,224	\$39,561,012	\$33,790,335	\$39,794,569	\$39,663,400
Hospice	Dual	\$36,938,126	\$40,004,293	\$43,260,331	\$46,021,930	\$44,421,277	\$46,930,813
Hospice	Non-Dual	\$8,483,915	\$12,625,688	\$14,536,636	\$15,766,602	\$13,291,712	\$12,425,144
Total		\$1,013,078,964	\$1,082,542,040	\$1,089,438,310	\$1,060,829,039	\$1,091,988,579	\$1,129,100,039

Figure 9. Medicaid Paid Per Enrollee per Month by Fiscal Year*

Population		2010**	2011	2012	2013	2014	2015
Nursing Facility	Dual	\$4,206	\$4,463	\$4,584	\$4,584	\$4,633	\$4,799
Nursing Facility	Non-Dual	\$5,327	\$6,476	\$6,890	\$6,937	\$6,974	\$7,450
Waiver	Dual	\$1,113	\$1,132	\$976	\$784	\$830	\$908
Waiver	Non-Dual	\$1,705	\$2,192	\$2,169	\$1,920	\$2,028	\$2,035
Hospice	Dual	\$3,545	\$3,720	\$3,893	\$3,907	\$3,914	\$4,002
Hospice	Non-Dual	\$4,163	\$5,864	\$6,258	\$6,701	\$6,890	\$7,020
Weighted Average		\$3,368	\$3,647	\$3,770	\$3,745	\$3,754	\$3,913

* Expenditures reflect anticipated ICN covered services only.

** All years except FY 2010 include hospital access payments.

APPENDIX B: CURRENT WAIVER PROGRAMS COVERED UNDER THE ICN PROGRAM

The figure below provides a brief description of the three Medicaid HCBS waivers that the Agency plans to include in the ICN program.

Figure 10. Waiver Program Descriptions

	Elderly and Disabled Waiver	HIV/AIDS Waiver	Alabama Community Transition Waiver
Target Population	Individuals meeting the nursing facility level of care	Individuals with a diagnosis of HIV or AIDS and related illnesses	Individuals with disabilities or long term illnesses currently residing in a nursing facility
Services Provided	<ul style="list-style-type: none"> • Case Management • Homemaker Services • Personal Care • Adult Day Health • Respite Care (Skilled and Unskilled) • Adult Companion Services • Home Delivered Meals 	<ul style="list-style-type: none"> • Case Management • Homemaker Services • Personal Care • Respite Care • Skilled Nursing • Companion Services 	<ul style="list-style-type: none"> • Case Management • Transitional Assistance • Personal Care • Homemaker Services • Adult Day Health • Home Delivered Meals • Respite Care (Skilled and Unskilled) • Skilled Nursing • Adult Companion Services • Home Modifications • Assistive Technology • Personal Emergency Response Systems • Medical Equipment Supplies and Appliances • Personal Assistant Services

APPENDIX C: SUMMARY OF ROUND TWO ICN TOWN HALL MEETINGS

The Center for Medicare and Medicaid Services (CMS) lists ten essential elements for the design and implementation of a long-term services and supports (LTSS) program. One of the foundational elements in this list is stakeholder engagement. To align with this guidance, the Alabama Medicaid Agency (the Agency) has invested in a comprehensive stakeholder engagement strategy. Doing so allows the Agency to obtain authentic feedback from those currently receiving and rendering services, as their first-hand experiences and insights are invaluable.

The Agency initiated this effort in June 2016 with key partners including the Alabama Department of Senior Services (ADSS), Alabama Department of Rehabilitation Services (ADRS), the state's 13 area agencies on aging (AAAs) and AARP of Alabama. Consumers asked questions related to the ICN program following a 45-minute presentation on the ICN program, its intended structure and goals.

For the second round of stakeholder forums, the Agency selected nine locations throughout Alabama, representing both rural and urban areas of the State. In total, 18 sessions were held with nearly 1,000 attendees representing consumers, caregivers and providers. The second round forums used a focus group style of data collection. This format allowed for robust dialogue with stakeholders and allowed the Agency to update consumers on ICN program development and MLTSS requirements, while also gaining insight into the state of current healthcare and LTSS delivery to the ICN-eligible population.

Consumer Feedback

Facilitators conducted two separate focus groups each day. *Morning sessions* focused on dialogue with consumers and caregivers, although providers did attend as well and spoke on behalf of their consumers. The Agency organized each meeting to solicit input on the following topic areas:

- Care Transitions
- Case Management
- Community Inclusion and Quality of Life
- Covered Services and Network Adequacy
- Quality

Care Transitions

Key Takeaways

Attendees expressed similar goals around care transitions, including effectively maintaining individuals in a community-based setting for as long as possible, improving health literacy and self-management and coordinating care to reduce avoidable healthcare utilization and emergencies. The ability to drive these sorts of outcomes is limited by a fragmented system in

which the continuum of providers works in segments with limited communication or coordination with one another.

- Much of the burden of coordinating transition falls to the consumer or caregiver, who is expected to keep providers informed of when changes in their situation occur. This becomes especially problematic when a consumer does not have stable caregivers, which was reported as a common circumstance.
- There is widespread support for a model of care coordination that follows a consumer throughout all the components of their health and LTSS delivery, and broad recognition that this type of role does not exist today.

Barriers

- Consumers and caregivers report that when they enter the system they feel overwhelmed and inundated with confusing information, much of which is complex and difficult to understand. A new care coordination model will need to take into account crisis management and caregiver strain in order to be truly impactful. The system will also have to address poverty, social isolation, illiteracy and other social determinants of health.
- There is limited infrastructure to share information, and a system relying on telephone calls or provider initiated information sharing will be difficult to maintain and unreliable. Technology and streamlined notifications are a need.
- Providing education to the community was identified as a barrier. It is difficult to identify individuals in the community who need support until they are in crisis. There are many pathways to increase awareness about available supports and services available to consumers and their caregivers.

Opportunities for Improvement

- Improved access to community resources spread across all consumer touch points. Many suggested “stewards” of information be designated and trained, including physicians, community agencies, volunteer fire departments, peer supports, etc.
- Promoting a more holistic or team approach to service delivery and coordination.
- Improving access and training for informal supports, available services or available housing to allow for quicker and smoother transition from nursing facility care.
- Increasing the role of the physician in educating consumers and encouraging them to access services and supports was identified as a strong way to drive early access and avoid preventable interventions for consumers.

Case Management

Key Takeaways

Overall, understanding and appreciation of case management services was lacking. It was clear consumers’ understanding was driven by personal experience and limited to social supports currently offered within their home and community based waivers. Those with experience were

satisfied with their case manager, and noted the socialization component derived from the service. This limited view of case management highlights the need for improved education and training as the state moves to a more comprehensive approach to case management with the ICN program. Consumers and caregivers want to know what case management is and what it offers, and how that will differ from today's approach.

Barriers

- Comprehensive care coordination will require a workforce with increased understanding of acute and sub-acute services, and relationships with medical providers. Today, case management is sometimes placed on hold when a consumer enters acute or sub-acute care, and thus case managers may have limited interface with this part of the continuum.
- Limited service provider networks and restrictive service menus limit the CMs from assisting in developing person-centered plans.

Opportunities for Improvement

- Consistent tools are required to evaluate the quality of case management; numerous comments indicated that case managers served as a social support, and that continuity of a personalized relationship drove consumer's perception of whether the case management they received was high or low quality.
- Attendees indicated the following elements that drove successful care planning and case management:
 - In-person contact
 - In-home contact
 - Frequent and consistent contact with the case manager
 - Direct access to the case manager via phone, between visits
 - An ongoing relationship with a stable case manager
 - The need for local understanding and awareness of services to truly be impactful
- Case managers, families, and consumers all felt that case management/care coordination should remain local/regional and not stem from a centralized call center.

Community Inclusion and Quality of Life

Key Takeaways

Community-based attendees overwhelmingly reported challenges to providing community integration options due to limited community consumers, providers and service options, including transportation to these community resources. The Agency should consider design options and incentive opportunities to improve community integration for HCBS consumers.

Barriers:

- Lack of providers and options can limit a true choice for HCBS, resulting in nursing facility placement. Some attendees questioned if residing in a nursing facility may be preferable in the future if they remain unable to address social isolation. HCBS settings

are currently seen as isolating, and HCBS consumers are prone to depression and loneliness.

- Many consumers reside in rural locations that are difficult to access. This makes community access even more challenging.
- Access to transportation was cited as the foremost influence on whether individuals experienced community integration. Developing a network of providers including accessible transportation options for those with unique needs such as wheelchair transit, as well as how to fund the demand that exists for non-emergency transportation will be important considerations.

Opportunities for Improvement

- Develop specialized programs allowing social opportunities for community-based disabled adults, especially for those who are not cognitively impaired or developmentally delayed. Current adult day programs tend to be geared toward those with cognitive impairments or developmental delays and thus are not a good fit for those with cognitive ability.
- Those residing in congregate living sites identified that they had increased community access compared to those living alone in single-family type environments. Partnership with local housing sites that are successfully implementing avenues for increased community participation may present opportunity for ICNs.
- On a few occasions, representatives of the disabled adult community articulated the desire to have jobs.
- Caregivers expressed concern that their quality of life also suffered, as they were unable to participate in social activities or community events due to the burden of providing care, and having little to no respite services available. Enhancing caregiver supports and respite options may pose greater opportunities to stabilize households and prevent crisis.

Covered Services and Network Adequacy

Key Takeaways

Many consumers and caregivers indicated they have had difficulty identifying services, or having a lack of availability and choice of providers. Common provider and service deficiency areas cited included:

- Primary care physicians
- Adult day health programs
- Skilled in-home care
- Skilled respite
- Non-emergency transportation

Consumers and caregivers often cited issues with the amount of covered services available as well, and difficulty understanding and selecting the best waiver program to meet their needs due to the differences across waiver menus.

Barriers

- There is a decreasing number of primary and specialty physicians willing to accept Medicaid and dual-eligible consumers. Those who did identify providers were often traveling long distances, which made it challenging to comply with appointments. Three forum locations in particular stood out:
 - Russellville – many consumers go to neighboring states for their care
 - Anniston - most travel to Birmingham for their care
 - Demopolis – many travel as far as Birmingham and Mobile to receive care
- Reimbursement rates were cited as the most frequent reason why providers across the system were unwilling to work with Medicaid consumers.

Opportunities for Improvement

- There is a need for an increase in mental health services geared toward older and disabled consumers. For nursing facilities, substance abuse issues were identified as a chronic challenge. Many indicated an increasing desire to have mental health and substance abuse services, and a lack of available providers.
- Consumers cited assisted living and other intermediate settings as low cost and desirable alternatives to nursing facility placement.
- Expanding the use of innovations such as tele-health and home-visit models were identified as opportunities, particularly when serving rural and homebound consumers.
- Examining policies around the replacement of durable medical equipment and increasing the availability of equipment and supplies, as is done on certain HCBS waivers, was offered as a solution to high-cost acute and sub-acute care.

Quality

Key Takeaways

Consumers and caregivers had challenges identifying specific quality measures they would be interested in, but consumers were able to provide some high-level traits of a good provider:

- Primary Care Physicians
 - Effective communicators who make things understandable, especially when there are complex health issues
 - Responsive to calls and requests to complete forms
 - Respect time both by giving adequate attention and not requiring long waits during appointments

- Engage with other providers, including specialists, nursing homes and case managers
- Nursing Facilities
 - Talk to you about your personalized needs
 - Have consistent staffing for direct care workers
 - Provide pleasant environments in which to live
- HCBS
 - Staff consistently arrive when scheduled
 - Services are delivered in a timely fashion
 - Communicate effectively
 - Offer some degree of choice or flexibility when scheduling services

Barriers

- One of the foremost challenges to delivering high quality LTSS is the statewide shortage of qualified, reliable direct care workers. Many indicated that the direct care staff drove the perception of quality. Some of this shortage was attributable to rates, but there is a shortage of healthcare workforce in general, which is beyond the Agency's control.

Areas of Opportunity

- Improving back-up plans and communication with consumers and their designated caregivers when there are service disruptions helped to drive the perception of quality.
- Many reported a need for increased education among medical providers, to ensure their knowledge and ability to discuss LTSS services with patients. Many look to their primary care provider for these types of resources.
- Consumer-directed options, which have recently expanded to statewide, were described as a service option to drive service delivery according to consumers' specific needs.
- While nursing facilities have quality measures in place, HCBS is lacking in defined quality measures. There was support for these types of measures among HCBS consumers, caregivers and providers.

Provider Feedback

Afternoon sessions focused on direct service providers and other professionals, and drew the attendance of a wide swath of providers across the continuum of ICN covered services. Attendees often included representatives from ADSS, ADRS, AAAs, home health, hospice, home care, nursing facilities, durable medical equipment providers, disability rights advocates and several medical providers. Topic areas were developed for these meetings along with a sample of possible questions for the facilitator. The following topics were covered across session locations, with each topic covered in a metropolitan and rural region of the State:

- Billing and Claims
- Eligibility and Coordination of Benefits
- Engaging with a New ICN/MLTSS System
- Quality Measures
- Transition of Care/Service Delivery Issues

Billing and Claims

Key Takeaways

Discussion around billing and claims almost always circled back to the use of a paper-based system for HCBS. Providers had a number of challenges with the paper-based system, including a higher likelihood of error, the amount of time required to maintain this type of system and the difficulty in coordinating receipt and review of paperwork across direct service providers and multiple agencies, all of whom devote significant staff resources to the process. There was a commitment to ensuring that billing is as accurate as possible, and widespread acknowledgment that the amount of time devoted to billing and claims could be reduced with technology, allowing resources to be more focused on clinical and operational services.

Barriers

- Many HCBS providers are not using technological solutions beyond Excel spreadsheets. Those that do expressed concern that their technology may not interface with a third-party ICN.
- Case managers are currently responsible for the review of billing, which is not likely to continue in a MLTSS model. Direct service providers will have to adjust to changes in their contacts and authorities when moving into a new system, and it may not include working with people they already have a relationship with due to day-to-day operations and service delivery.

Opportunities for Improvement

- Streamlining the different gates that billing must go through will improve the billing and claims process and reduce lag-times in receiving payment.
- Attendees were excited to hear about innovations coming in the next year, including the Electronic Visit Verification (EVV) system. Continuing to engage direct service providers in the process of identifying solutions poses opportunity for the Agency.

Eligibility and Coordination of Benefits

Key Takeaways

Attendees seemed actively involved in assisting consumers and their families to complete the application process, and the process varied across different parts of the LTSS system. All acknowledged that the financial documentation required was cumbersome for applicants, and resulted in the biggest hurdle. Many indicated that there have been improvements in the system in recent years, including re-distribution of cases among district offices, improvements in the

process for nursing facilities, etc. Attendees reported that because consumers come into the LTSS system with a high need, there is a sense of urgency to move through the system as efficiently as possible. Once deemed eligible and receiving services, providers identified challenges with overlapping service dates, making it difficult to coordinate eligible benefits for consumers who move from program to program (i.e. HCBS waiver to hospice).

Barriers

- Third-party entities such as financial institutions, who charge fees for certain documentation, influence the eligibility process. There is no direct way to impact the roles of these third party entities, other than to drive education and partnership with them. The five-year lookback was most frequently cited as a barrier for applicants when working with banks.
- Much of the eligibility process is dependent on disclosure from the applicant and/or applicant's family. Many attendees indicated that consumers often fail to recall certain assets, and sometimes choose not to disclose items that end up being identified later in the process.
- Many of the requirements to demonstrate eligibility are prescribed at the federal level, and thus the high volume of documentation and attestation required by applicants is not something the State can impact.

Opportunities for Improvement

- Providers indicated repeatedly that another barrier to determining eligibility for LTSS was obtaining medical certification of eligibility. Several forum locations noted that some local physicians refuse to complete the form all together. Improved partnership with providers, up to and including quality measures on turn-around time for medical certifications at application and recertification poses ample opportunity to drive efficiency.
- HCBS providers expressed interest in the electronic interfaces available to nursing facilities when submitting eligibility information for their residents. Expanding this access to AAAs may pose opportunity to streamline the system for HCBS applicants.
- Many voiced opportunity to overhaul forms and applications to make them more consumer friendly and less cumbersome for users.
- Consumers were pleased to hear about pending electronic asset verification, and advised that would be highly beneficial moving forward.
- Information sharing platforms that alert providers to enrollments or changes in level of care would help to reduce overlapping service that can occur due to lack of knowledge that a consumer has initiated or experienced a service change.

Engaging with a New ICN/MLTSS System

Key Takeaways

Providers had a number of questions about moving into an MLTSS model, and seek education on the changes and how they will be impacted. Consumers with experience with MLTSS models

in other states praised movement toward MLTSS as positive change. Common concerns revolved around payment rates, ability to contract with an ICN and whether administrative burden would increase or decrease in a new system.

Barriers

- Providers are concerned about the administrative burden that may occur if they contract with more than one ICN. Many indicated they do not feel prepared for working with commercial managed care. This concern was particularly high for those providers also contracting with an RCO.
- Providers often receive their direction from a local AAA. This has led to some degree of confusion about policies and regulations, depending on the strength of the local network. This will pose a challenge moving to a statewide system.

Opportunities for Improvement

- Many providers expressed interest in the network development component of moving to a MLTSS model, and are interested in discussing rate negotiation with a third party ICN, which has not been negotiable in the FFS model.
- Providers largely approved of the plan to move toward a consolidated waiver for the ICN program that merges included 1915(c) waivers into a more comprehensive benefit package on the HCBS side.
- Further education is needed about the specific program design envisioned by the Agency. Providers are struggling to plan for the future because their concept of how the program will impact them is vague. There were many instances where misinformation or misconceptions were evident amongst attendees. Education is critical to stay on top of the “churn” of public information about the ICN program, and help providers to plan for the future.

Quality Measures

Key Takeaways

Almost all providers that attended reported that they had some sort of quality tracking in place. For nursing facilities, this tied back to CMS measures. HCBS providers rely heavily on the requirements of their scope of service as defined in current waivers, including periodic nurse supervisory visits and satisfaction questionnaires completed during those visits. HCBS providers disagreed on the extent to which nursing supervisory visits were productive, and agreed that more qualitative measures would be useful. Many indicated they mostly tracked administrative and billing oriented quality indicators, based on the State audits.

Barriers

- Nursing facilities are hesitant to adopt new measures due to the current influx of measures they are now held to, introduced in 2016 for both short and long-term stay residents.

- Providers have a very difficult time identifying social indicators of success in LTSS programs, or how to track more subjective elements like satisfaction with community inclusion, caregiver burn-out or perceived quality of life.
- Many direct service providers do not have outcomes they are tracking outside of administrative and financial processes, and may have difficulty tracking and monitoring any new measures that impact them due to limited infrastructure.

Opportunities for Improvement

- There is a blank canvas for introducing HCBS outcome measures, and providers indicate they are receptive to measures that are evidence-based and outcome-focused.
- Attendees agreed that identifying measures that would impact more than one provider type would drive coordination and collaboration across parts of the system.
- Current quality measurement is very subjective in nature and hinges on consumer responses. Consumers are hesitant to provide honest feedback as providers conduct the survey. Introducing neutral third-parties to engage in quality monitoring and surveying satisfaction increases the likelihood that consumers will be honest without fear of negative impact to services.
- Many quality issues connected back to lack of communication, thus shared information systems and the ability to alert providers of changes in status could drive outcomes positively.

Transition of Care/Service Delivery Issues

Key Takeaways

Transition of service and changing service providers is common amongst consumers, and poses challenges in day-to-day operation. Providers rely heavily on case managers to mediate when there are service issues, and there are often layers of communication between the consumer, provider and case manager to resolve a service issue or request to change. Providers identified a number of reasons that make it difficult to serve consumers, including increasing consumer demands, lack of awareness about risks in a consumer's home, misuse and waste across services and difficulty staffing cases consistently. Nursing facilities also struggle with transition of care and, while nursing facilities indicated a desire to help transition short-term stay residents back to the community, they often lacked information about the person's home setting, and often found when the time came to discharge informal support and housing were often absent.

Barriers

- The shift in generational culture and inter-generational care structures has introduced new dynamics into LTSS delivery that providers are still adjusting to. Baby boomers expect more tailored delivery of services, and their informal supports are not always compliant with program regulations.
- Community-based, non-medical resources are lacking, particularly in the areas of housing, food, utility assistance and other key services required for the health and safety of consumers who seek to move home. Many expressed concern about the housing

environments of those they serve, and acknowledged the difficulties in meeting the need for safe, affordable housing and community resources.

- Providers are struggling to work with de-institutionalized individuals who have transitioned from the State's mental health facilities. There are more individuals with severe, persistent mental illness and meeting their needs poses a challenge that carries high-risk for all LTSS providers.

Opportunities for Improvement

- Providers indicated there is a need for heightened response to incidences of fraud, waste and abuse. While case managers attempt to address reported waste and abuse, many feel limited in what they can say. Increasing consumer accountability through formal mechanisms like a strengthened disclosure of rights and responsibilities could drive reduction in waste and abuse.
- Many service issues come from gaps in communication that result from the lack of a point-person that guides consumers across the continuum of care. Having a designated care coordinator, who can help liaison transitions presented as a significant opportunity.
- Many consumers are accessing care from numerous medical and acute care providers, and there is a need to centralize medical management to a single primary care provider who can then coordinate with other providers, particularly in rural areas of the State.
- Several regions of the State have undertaken care transitions programs either through local coalitions, Medicare demonstrations, or other designs. These programs offer an opportunity for examining best practices that exist in the State.