

Medicaid Claiming Webinar 2: Phase I (Creating a Work Plan, Engaging Partners, and Estimating Amounts)

Transcript

Ami Patel: Hello everyone, this is Ami Patel. Thank you for joining us today on the webinar, for Medicaid Claiming. I work on the initiatives here, and want to give you a quick reminder that your phones are muted throughout today's webinar. We ask that you use the chat feature for the questions throughout.

Ami Patel: The next slide is the agenda. We are going to work on the four tools in the workbook. We will have guests talk about their experiences in Medicaid claiming. Today marks the second webinar in our series, we held the first in March. If you missed that webinar you can listen to the recording and download the presentation slides on the website. After each webinar we are also hosting office hours, these are virtual networking opportunities. The first was March 22, and it was an opportunity for great peer to peer conversation and questions you have had. The next office hours will be next week on Thursday, May 17. Toward the end of today's webinar, we will provide a registration link for that office hours' time. Lastly, the third webinar will be June 7, and we will focus on the remaining workbook tools.

Ami Patel: Before we get started, we wanted to launch a quick poll to see who is on the call with us. You should see two questions. You will see which agency you represent, and who attended the first webinar. We want a sense of who is on the call and who attended the last webinar. We will give you a few seconds to answer the poll. I am looking at the results here, I do not have all of the results. Hopefully we have good representation across the agencies, on the call today. We will be touching on the importance of your roles and response abilities when it comes to Medicaid claiming. It looks like we have a few folks from the state level and the local level. That is great to see.

Ami Patel: The next slide gives a background, we brought this slide back from the first webinar because it is critical to understand the vision and how we got here. What this slide shows is ACL and its support services, and veteran services department, have brought over the years. This demonstrates the value of this function. We have been in this area since 2003 and began with grant funds. In 2012, ACL in collaboration with the state designated the function and key elements of a No Wrong Door system. In 2016, they published the Medicaid guidance. This proves that the diversity of funding needs to support the development and operation, which goes beyond grant funding. This is not a new concept. Sustainability is a critical component, and from my experience working at the state level and helping Maryland build this structure, it starts with understanding what is happening at the local level. The frontline staff at these community-based organizations are handling crisis situation calls, they are working every day to help people navigate and connect them to options about Medicaid and other services.

Ami Patel: Medicaid claiming is one way to demonstrate the value of this work. With the next slide, as I mentioned, CMS posted guidance on claiming. This set the groundwork for how Medicaid is a critical partner in this system. The guidance also provided initial steps for implementing Medicaid claiming. To provide technical assistance and support, ACL, working with several states that are also claiming this area, developed the No Wrong Door Medicaid workbook and toolkit. This workbook outlines two phases for Medicaid claiming. The first phase, in the blue area on the slide, is about creating a work plan, engaging with partners, including state Medicaid agencies, and estimating claimable amounts by

identifying claimable amounts. These tools are the ones we will focus on today, but phase 2 provides guidance for establishing agreements both at the state and local level, and support for preparing for CMS approval. This entire workbook, and each of the tools that we will talk about today, are listed on the No Wrong Door website. They are downloadable documents, and there are templates you can use. Be sure to check them out.

Ami Patel: On the next slide, going into the first tool, looking at the first step for phase 1, the most critical component is holding a relationship with key No Wrong Door partners. Looking at agencies that support No Wrong Door work this team would include the network agencies that are doing the work at the local level. They are working every day to connect people to resources. These will ultimately be the ones to track their Medicaid related time.

Ami Patel: The first thing that a claiming team will do, is develop a clear object plan. This will help to develop the administrative plan, and identify roles and responsibilities. They will work to obtain approval from CMS. Another component to think about here is including both fiscal and program staff in the system. As I noted earlier, it is important to know the potential, and what the claims are at the local level. There are matching requirements that are just as important. This is another thing to keep in mind, when we are talking about No Wrong Door claiming. It is engaging at the state and local level, and also the program and physical staff. Now that we have talked about the importance of engaging the key partners, we have another question here. We want to get a sense of the current ownerships and the relationships among those who are on the call today. The next poll we are asking about is the relationship with your agency and the state. Is it a good collaboration? Is it beyond Medicaid claiming and other components of No Wrong Door? Perhaps this is a relationship that is just beginning, or you are planning to engage now. We will wait to let people answer these questions.

Ami Patel: Looking at the results, it is a bit across all of the answers. Many have answered that there is a strong relationship. That is good to see. For those who have attempted a relationship, I would suggest that you take a look at the claiming guidance posted by CMS. In that, you will find a description of Medicaid system and not only to that but building relationships across the No Wrong Door system. Thank you for that.

Ami Patel: In the next slide, we will go into tool one of the workbook. This is what we call the project work plan. This is a work plan that outlines eight basic tasks. These all have subtasks within them. This document includes space for entering target dates or identifying staff responsible for these activities, and each timeframe we also reference the workbook tool that could be helpful for each of these tasks listed. This document is a word document that provides high level steps to get started, thinking about Medicaid claiming. Looking at a work plan, you might be thinking about how long the process can take. The next slide provides an optimal timeline, starting with engaging with the state level partners, all the way to receiving approval from CMS. What we started with, in the blue, are steps that could happen concurrently. You could be reaching out to partners, and also developing codes and methodology, or perhaps identifying potential cost. This could happen at the same time, however there are many factors that come into play. Before CMS approval, there have to be agreements in place. These timelines are just something to consider, as far as optimal timing. This is good detail, and all steps can be found in the workbook document.

Ami Patel: Moving on to tools 2 and 3. These are PowerPoint presentations. The first is for state level agencies, and the second is for local level agencies. Each provide definitions and backgrounds for No

Wrong Door. They outline potential roles and response abilities, and methodologies to consider. The purpose of this presentation is to demonstrate the value of Medicaid claiming, and why they should consider implementation. There are points here that stress how No Wrong Door can efficiently manage the Medicaid program. Again, this connects people to resources, and promotes nursing home diversion. These are good discussions to have at the state and local level when thinking about Medicaid claiming. These are presentations that are meant to be templates for you to use as a starting point when discussing Medicaid claiming. Before we go on to the next tool, identifying the required matching funds can be the most challenging component.

Ami Patel: We have heard from states that are currently claiming that it starts with identifying matching funds in the beginning. With Medicaid claiming, we know that there is a 50% reimbursement. The other 50% must be matched by non-federal dollars. We know that states are using state or local county level funds as a match. The method for identifying these funds is identifying funding strains across the area. The next tool is designed to help you navigate that process. Tool 4 is what we call the cost simulator. This again is an Excel document to identify matching funds, across all of the No Wrong Door staff. It provides a regulation for reimbursement. The best way to show you this tool is an example. We will bring this up now. The very top of this tool shows what each column means and what type of numbers we are expecting to see here. You can use that as a guide as you complete the document. As we scroll down, the first column is where you enter staff positions in the No Wrong Door system. If this is state level or local level entities completing this on their own, they would identify the staff that might be working with Medicaid claiming. We have claiming codes here, these are codes divided in the CMS document. This might be a good starting point to identify staff who are working with outreach, or referral. This is a starting point for understanding how to fill in the first column, as far as which staff we are talking about. The next is total dollars. This is where you will enter the total actual expenditures for the staff position we are talking about. In this first sample, we have the number \$2 million. In the next two columns, you identify the sources of funds, federal sources. 65% in this example, and what percentage of dollars are coming from non-federal sources such as state or local dollars. For this, we will say that is 35%. Beyond the requirement being from nonfederal sources, it must also be dollars that are not already allocated elsewhere. This column identifies which portion of the state and local dollars are eligible for match. For this example, we will say 20%. This column is an overall estimate on the spending. This is an estimate. If you would think about the types of scenarios your staff and counseling staff might encounter, you can identify a percentage of time related to Medicaid care. You could relate this to the correct code. If you have questions about outreach, you could identify that here. For this example, we will say 10%. You can fill these in as there are formulas in the cells. This is 10%, and this is estimated time in Medicaid times total dollars. Again we are talking about Medicaid claiming, so this gives you \$100,000. The last column is valuable because it calculates the amount of matching funds available based on what you identified in column J. You can put this against the total dollars available.

Ami Patel: We will provide a second example and show you that this document will identify if you do not have sufficient funds available. Let's say the total dollars spent give 80% coming from federal sources, 20% from state and local, and a very small number is eligible for match. Let's say that the counselors spent a lot of time with people. This column has turned red because there is insufficient match for the claiming amount. To replicate this approach for state and local entities who think they would use this tool, we found that it could be helpful to have each local entity deplete the tool and then add a total at the state level. We have found this tool to be helpful with identifying matching dollars and

the potential across the staff within your system. That covers the tools we wanted to discuss today. Again, you can find all of the tools we discussed today at the No Wrong Door website. We can go and show that to you at the end of this webinar. I would like to turn it over to Christina Neill Bowen so that we can hear about Alaska and Oregon and their experiences.

Christina Neill Bowen: Thank you. I am happy to be here on this webinar today. As Ami Patel was talking, I was thinking I have been around supporting this No Wrong Door grant since they started in 2003. Having these tools available to assist with Medicaid claiming and planning, and implementation, is a great gift to have for the states. It will hopefully be a catalyst for more activity. It is wonderful to hear what they have available now to support you all in your work. We have asked two of your peers to be with you here today, Alaska and Oregon. They will answer questions from you all. We heard from people in the last webinar in March, that hearing from each other is a great way to learn and apply things to your specific state based on others experiences. We are happy to have a representative from Alaska and Oregon with us today. I want to check that you are both here. Oregon, are you here – Martin, are you here?

Martin Morris: Yes.

Christina Neill Bowen: Kristin are you also on the call?

Kristi Murphy: Yes. I would also like Tatia to join me.

Tatia Halleman: Can you hear me?

Christina Neill Bowen: Yes. Just to give you some background, we have Alaska and Oregon on the call to speak with you today. They represent different experience in relation to claiming. Alaska has just begun to claim. Oregon has been expanding their claiming for some No Wrong Door additional funding like outreach and counseling. You will get to hear from a state who has had a lot of experience, but experience expanding claiming, and going through the experience of developing codes again. And another state then that has just started. This is the spectrum of what we will hear about, today. My first question is basic, what are your drivers to expand upon claiming? Martin, do you want to go first? Maybe we will ask you for a brief overview on Alaska's No Wrong Door system. How are you organized, how does this look in Alaska?

Lisa Morley: Hello this is Lisa, I will give a brief overview. I have been working with them since the grant was awarded to the state of Alaska. When we first received the awards, we divided the funding between Centers for Independent Living (CILs). In 2008 we applied for another grant, and we did a more competitive procurement, and had three agencies. These were in Anchorage, and two others for CILs. We wanted to separate and standardize the funding, and make sure we were reaching out to the senior population. It was different than all of the other ADRC's, we gradually integrated into the aging network of our main resource center. We have six centers now, we have one tribal center, two CILs, one nonprofit that started as a parent navigator nonprofit, and also one senior center that is going to operate as the ADRC. We have one to permit of social services, and our division manages all of the funds, and Medicaid waivers, in addition to our personal care services and adult protection services. We are the senior and disability services, and we work closely with our Medicaid unit, which manages all of the Medicaid claims. The reason, I will let Martin speak to after this, we are going through fiscal practices because we have been funding our ADRC through state and local funds, aside from the couple

of grants we receive. Once our state goes through a fiscal crisis, we cut back on state employees and we are going to be losing our state general funds we needed to implement this so we can expand our services. We did implemented a requirement for all individuals who were seeking long term care services and support, to go through the ADRC to for intake and options counseling. We were not able to meet that requirement due to decreased number of staff at ADRC. Go ahead, Martin.

Christina Neill Bowen: That is great background, thank you. It is good to know how it is expanding in Alaska. It sounds like the key driver is coming up with funds for the crisis that resulted in a reduction of staffing.

Martin Morris: I think that was the primary reason, we were pursuing this, state wide. As Lisa mentioned, we wanted to streamline the process for long-term care. That was to be done through the ADRC, and we recognized a need for increased staff. Through match and capacity, we needed to increase the funding to make sure we had the funds to support the additional work coming through ADRC.

Christina Neill Bowen: Great, thank you Martin. I will kick it over to Oregon, to answer that question. We have some questions from participants. Oregon, what was the key driver in having you pursue expanded Medicaid claiming, the past few years?

Kristi Murphy Sure, thank you. The key driver was to sustain the ADRCs we had established. We got our first grant in 2010. We continued to receive grants through the years, however we really saw this as an opportunity to continue funding the ADRCs once grant funding had gone to the wayside. In Oregon, we have different types, we have type A AAAs that do Older Americans Act programs, and type b AAAs do older American programs and Medicaid. We've been doing Medicaid for some time. I will ask Tatia to speak about the waivers.

Tatia Halleman: Our Type B's have been working on case management for several years. Once again because of the budget crisis, we wanted to expand our counseling and information referral funding, so we used the state general funds, and we distribute this to 17 area agencies on aging. We have hope now to increase our funding for those two specific services.

Christina Neill Bowen: Great, thank you. We heard an overview on the key drivers, and what they were. I have some other questions for both states as far as planning teams. I will open it up here if anyone has any questions for Oregon or Alaska, about how there No Wrong Door ADRC model is set up, before we get into specific questions. I have unmuted all of the lines, if you do not want to be heard, please mute your line.

Christina Neill Bowen: You can also put your question in the chat. Kristen, maybe we should go back on mute. I am not hearing a question come through. Thank you. My second question for you all, is to describe the people and organizations involved in your planning teams around claiming. Ami Patel showed the graphic on the PowerPoint with hands coming together. This workbook that ACL has talks about establishing a claims planning team. This includes key stakeholders, and agencies, also individuals at the local level who are doing the day to day work. Martin and Lisa, can you talk to us about the Medicaid claiming team?

Martin Morris: At first it was the state agency for disability, we did research in terms of specific areas, and we began working with the state Medicaid unit, developing the partnership there. Then we engaged

in local programs. We worked with staff discussing the ideas and getting them used to the idea. We also reached out to others. Ami Patel connected us with someone in Maryland. We borrowed some of those ideas, and we also reached out and worked with Steve Lutzky from HCBS Strategies. He was a good resource, we looked at other guidance out there that could be beneficial in terms of developing how we were going to be going about implementing this process.

Christina Neill Bowen: Great, how did you end up engaging? It sounds like you did a lot of planning on the aging side. Can you describe how you engaged some of your partners?

Lisa Morley: Hello, this is Lisa. We have one unit in our department, all of our Medicaid programs are administered in the social services and we have public assistance application plans, and every division has which illustrates Medicaid activities in claiming. Most of our administrative action is done by the state organization. This is a bit different. It took us a while to convince and meaningfully engage our agencies that do Medicaid, because it was not standalone. It was not a big program, there was not a lot of knowledge about what it did. It took several years to raise enough awareness about the program, and while we were setting up meetings, talking about what these agencies and centers did, multiple times, then we rolled this out. At that point it was a requirement, and we used it as a cost savings so that individuals could get the correct services that they were eligible for, instead of more costly services. This could also be services that did not give the best support. At one time our deputy director was helpful guiding us through identifying the specific activities at the ADRC's, and what they were doing once we had that guidance. We realized we could be getting reimbursed for these activities. We saw these ADRC's work with these activities and matched funding, so when we got everyone on the same page with that message, it went faster after that. It took several years to educate everyone and raise awareness.

Christina Neill Bowen: Thank you for that, Lisa. It was reinforcing the message, over and over again, it sounds like. Using the CMS guidance was helpful at establishing your organization and what you had to tweak. I am going to kick this over to Oregon, and can you describe a bit about who is on your team, and how you formed that team as well as expanding?

Martin Morris: Our team does general administration in our area, then we engaged our stakeholders and we have 17 area agencies on aging. They discussed and decided what services we wanted to focus on. We chose, at this point, to only focus on information and referral option counseling. We worked on that, and currently in the meantime, we evolved work teams. We just started the claiming new Medicaid administration in January. We are currently working with quality assurance groups that have the same stakeholders and struggles. We have two types of AAA's, some without Medicaid and others who are already claiming under Medicaid. We are looking at how to provide quality service, under two bodies that are completely different.

Christina Neill Bowen: That is very helpful, thank you for that. You also engaged people at the local level and talked about what activities does

Martin Morris: Correct, they would actually like additional activities, actually.

Christina Neill Bowen: Was it difficult to engage these strategies?

Martin Morris: They wanted to be engaged I think. At the beginning they thought it was free money in some aspects. They were attracted to that because of the money. We have difficulty with engagement,

realizing that there is more requirement to receive the funding match than the originally thought. It is a struggle to keep them engaged.

Christina Neill Bowen: Thank you, I am looking at the chat questions that are coming in. I am trying to pull the ones that are relevant to this discussion. I do not know if you want to take this question. Are there disadvantages to the Medicaid agencies? This question is asking what some of the pushback is that you have received or disadvantages that are seen, do either one of you want to take this question?

Lisa Morley: This is Lisa, I can speak for Alaska. Most of our Medicaid administrative claiming activities work is done by state employees. There was a bit of fear in that we were having these sub recipients, and grantees who were doing that activity. I think there is a level of making sure we have quality assurance so that if there is an audit we can go back and demonstrate the percentage in match activity that it was really being done. That is something we have had to work with our Medicaid agencies. We want to make sure that we have a strong policy in place.

Christina Neill Bowen: How about you, Oregon?

Martin Morris: We are a bit behind on that process, but it is the same thing. We need to get them to understand the quality needed for this type of program, especially for our AAA's who have not had exposure to any Medicaid program.

Ami Patel: This is Ami, Just to add to that question, I think that the simple answer is that there are no disadvantages to Medicaid agencies because it is about understanding how the local entities are helping to manage the Medicaid system. They are doing the triage and intake to better understand a person's needs. There is an institutional phase, so in the long run this is saving Medicaid. I think it is important in the beginning to demonstrate that value when discussing the potential value of Medicaid.

Christina Neill Bowen: Thank you for that, Ami. That is important to keep in mind. The other questions that were on the chat are specific to local levels. Is there a way for the local ADRC to pursue this without the state level doing it? Ami, do you want to do that question and talk about the work? Do you want to answer that?

Ami Patel: The work book posted on our website that we have been talking about, certainly provides a lot of examples about the functions happening at the local level that could be eligible for Medicaid planning. We do not have one specific to local levels planning. We do show what their roles and response these might be throughout the process, so you will see that when considering the workbook and toolkit.

Christina Neill Bowen: Thank you, Ami.

Ami Patel: One ADRC pursuing Medicaid claiming as opposed to statewide, we know of states like New Jersey for example, who have rolled this out in phases. They have a few ADRC's participating right now. They are not state wide yet so that is definitely an option, when you want to consider what opportunities you need. You may have a few ADRC's participating initially.

Christina Neill Bowen: Yes, this is Christina, I am trying to think about what the CMS guidance talks about when establishing an MOU with an agency that is not a state Medicaid agency, that you are able to make the cash flow work. I think it is important to talk about how some states have rolled it out in certain areas, and not initially statewide. That was good to say that, as well. Another question from the

chat, asks about whether or not the state Medicaid agency is looking for return on investment before pursuing this, did that come up in either of your questions Alaska, or Oregon?

Lisa Morley: This is Alaska, we have already done a pilot project that demonstrated cost savings for the centralized intake that the ADRC's are going to administer air that was considered a cost savings program. It was not intended to create a cost savings as a whole, it was more being able to continue that with the understanding that it was good for the Medicaid program. At this point, we are not tracking cost savings.

Christina Neill Bowen: Thank you for that Lisa, you were able to demonstrate for this requirement that people go through ADRC for intake and counseling, and that was a potential savings, is that what you are talking about?

Lisa Morley: Yes.

Martin Morris: This is Oregon, it was not viewed as a cost savings, and we feel the same. We were not sure that we were doing things according to their expectation, and they did not look at cost savings.

Christina Neill Bowen: Great, thank you. This is great, we are getting a lot of questions, and this is fun. I am going to ask another basic question that has to do with how long it took to establish the process. It sounds like, Lisa, you said it took two years to get Medicaid on board? What would you say it took for the whole process, in terms of initiating that to actual claiming and approval?

Lisa Morley: We were starting to actually engage with our Medicaid agencies in July 2015, and then Martin took the ball running and focused on it. He did a lot of the research and first we had to do a time study with our local programs, and see what the potential reimbursement could be. Martin started that whole process. Can you tell us what you had to do?

Martin Morris: We started in July 2015, and we started to identify and report this activity, looking at what the ADRC's are currently doing and how they could fit within the activity that was approved within the allocation fund. We talked about the methodology and forms, and planned a pilot time study. We wanted to capture this rate, and funding that could match that. We wanted to introduce that, and this was completed in November 2015. The cost allocation plan was submitted in December 2015, and we received initial approval in May 2016. That was the initial one, we initially started with a partial time study, for consecutive weeks. After agencies realized it was not an efficient use of time, we began to develop a random moment email base time study. Starting in January, we started with IBA solutions. We worked with them and amended and submitted a new cost allocation plan. It was June 2016, and that was approved in October 2017.

Christina Neill Bowen: That is great, do you have some results that you are able to share in terms of how much you have been able to draw down? You may not be able or prepared to answer that.

Martin Morris: Alaska has a smaller budget, so when Ami threw out numbers we were laughing. \$900,000 was the annual budget in 2017 and 2018. We increased the ADRC program from \$900,000 to \$1.6 - 1.7 mil. We have increased this to the Fairbanks area. We are moving statewide.

Christina Neill Bowen: This is great, considering where you started from what you are able to do is impressive.

Martin Morris: We doubled the amount of money available now to our ADRC's. That is with all of the ADRC specialists identified. We are actually focusing on all of the activities, and we don't only use this for outreach and referral, it is when a ADRC specialist receives an email stating they need to record their time, they go in and there is a decision tree that helps them decide what they are doing and whether or not it is applicable to Medicaid processes or not. That is linked back to our service delivery and client tracking system. Martin put together a really great RMS manual. It outlines the project, and outlines the process for our local ADRC's. That is helpful as well, I do not know if you want to look at that. We can share that, if you would like.

Christina Neill Bowen: Absolutely, that would be great. So I am seeing some questions come in about the codes that states are using and whether or not they are claiming training. We planned to focus on specific functions in the June webinar. I would encourage people to call in next week to the office hours and ask specific questions, in terms of codes and function. Are you including training, Alaska and Oregon? Lisa Morley: Yes, we do training.

Ami Patel: This is Ami, we have a question in the chat "Do state unit on aging staff need to use a time study for claiming, or can the unit expenses be included in the Medicaid cost allocation pool?" "The answer is yes there has to be some methodology, so as you heard that states are using random limit time studies or 100% time tracking. In addition, there is an option for using the eligibility ratio to calculate those percentages. There has to be some methodology at the state and local level.

Christina Neill Bowen: Thank you. Thank you for clarifying, I hope that that was clear. New Jersey, we mentioned, has a few agencies. The contractual relationship is at the state. As I am scanning the states right now, Ami, I cannot think where this goes directly from Medicaid to a local entity. Can you?

Ami Patel: No, there would have to be an agreement between CMS and the state agency, and then the state agency and the local entity.

Christina Neill Bowen: Hopefully that verifies that, and we did not confuse anyone there. This is great. It is wonderful to hear from both of you, in terms of how this has been going. It is nice to hear how many entities are on board. In Alaska, you have all of the ADRC's reporting?

Martin Morris: Yes. But our tribal ADRC is not claiming, they do not have good connectivity to the Internet.

Christina Neill Bowen: Thank you. Anything else that you might want to share? I am looking at the time and we are coming to a close. Is there anything else that you want to share with your peers from Oregon or Alaska?

Martin Morris: This is Martin, with Alaska. The one thing that led to us successfully implementing this is working with the ADRC's and developing prospects and explaining it. We really explained it that they make it additional funding for activities that they are already doing. That was something that really got them at the initial stakeholder meeting. That gave them buy-in, and it made the question and answer process better.

Christina Neill Bowen: That is a good lesson learned, thank you. I want to thank both of you for being on. Ami I will turn it back over to you, to invite everyone to office hours.

Ami Patel: This has been a fantastic discussion, thank you all for joining us on the call today. With the last slide, we encourage you to join us for the office hours on Thursday, May 17. We have sent the registration link, through the chat feature. We will also send an email out. You may always reach out to us if you have additional questions. Thank you so much.

Christina Neill Bowen: This is Christina. We are doing outreach now for states that are starting claiming to talk about functions you are claiming for, and how you are using the state matching funds. We will be doing those over the next month, and we hope to share some of that information in the June webinar. We want to track this as it grows nationally. You may be hearing from us, thank you for that. That is all I have, Ami. This has been a great call.

Ami Patel: Thank you all, again.

Christina Neill Bowen: Everyone have a great afternoon, thanks.