




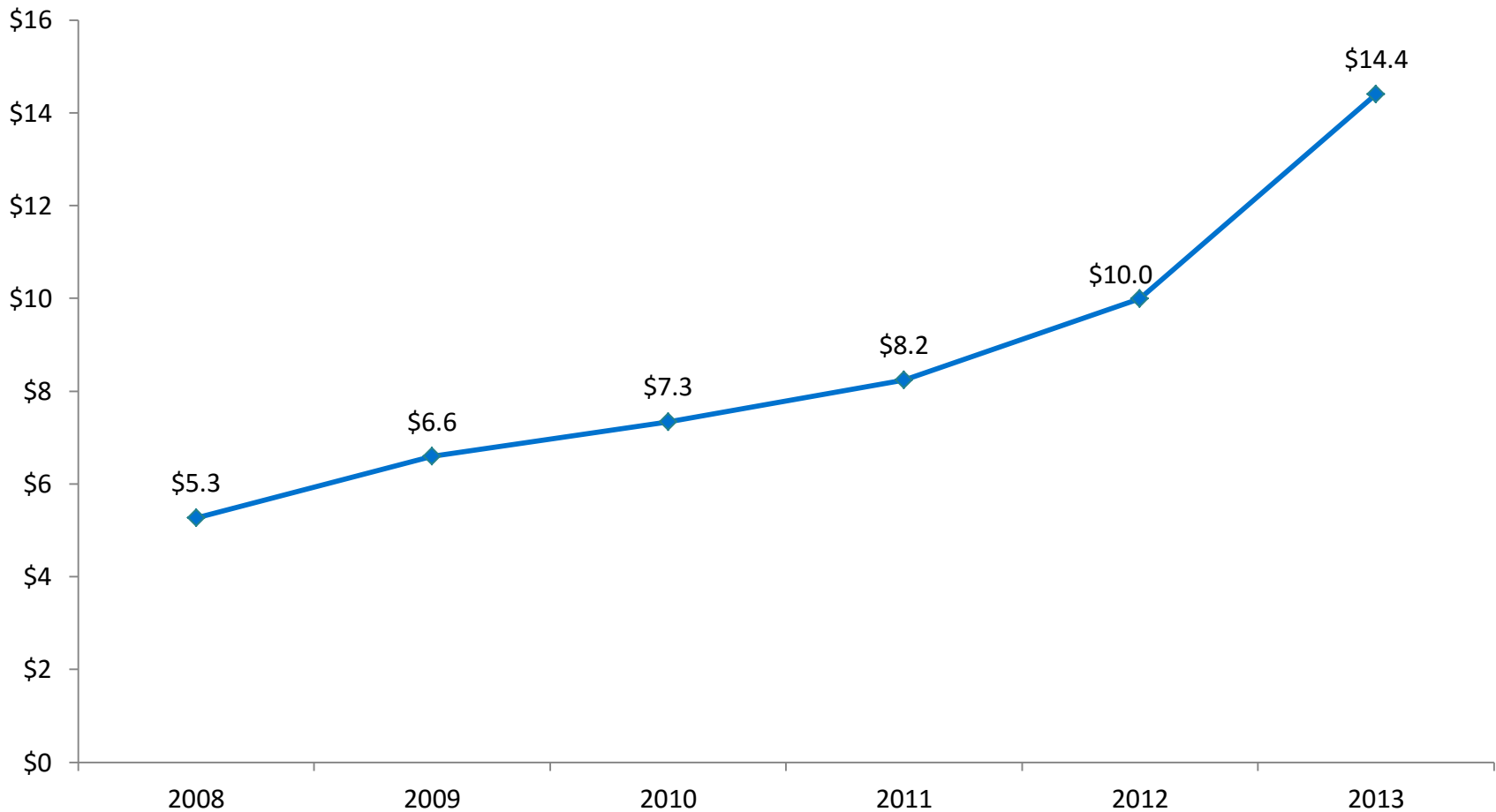
# Medicaid and CHIP Managed Care Final Rule – MLTSS



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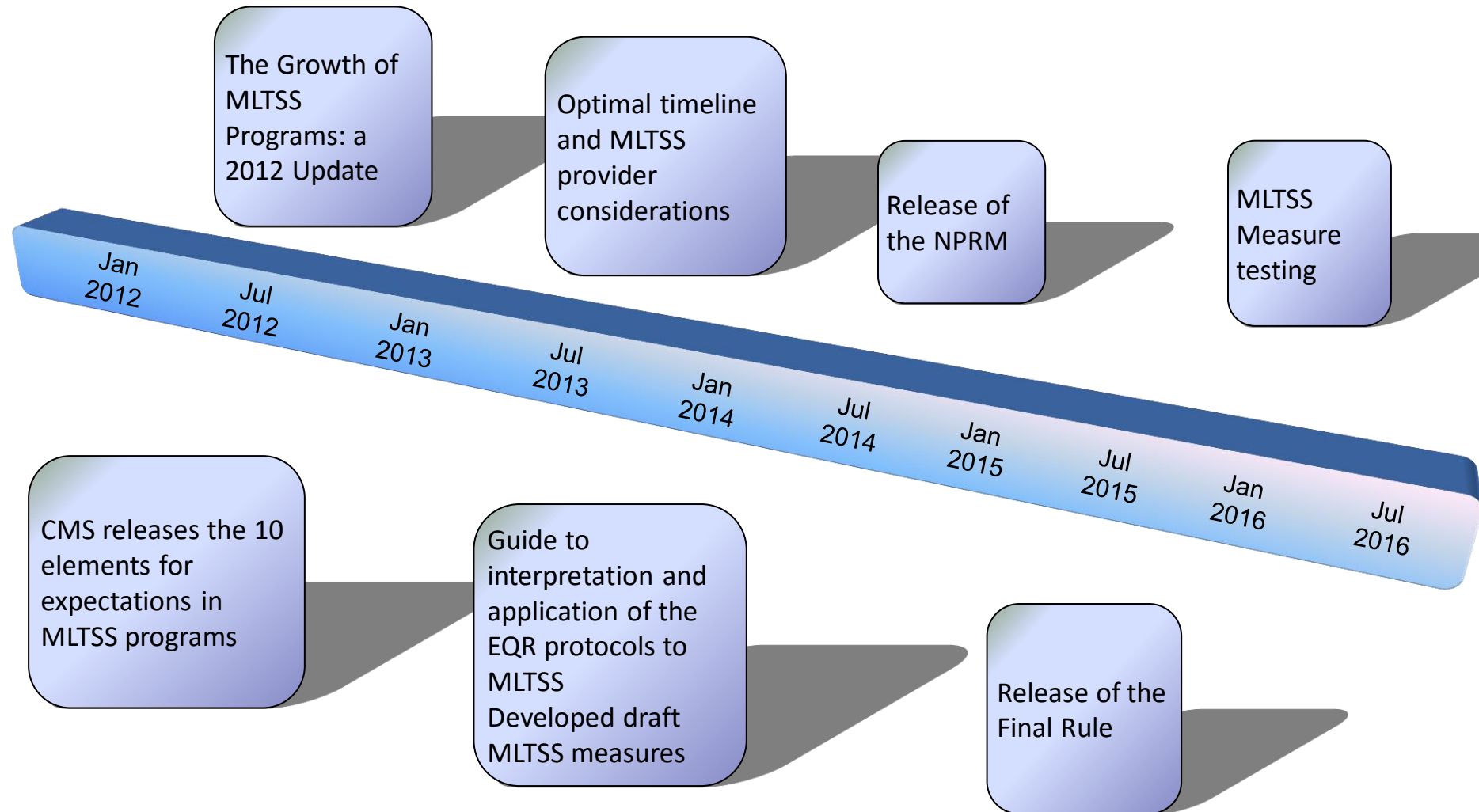
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# MLTSS Expenditures, FY 2008-2013



*Medicaid Expenditures for Long Term Services and Supports in 2013: Home and Community-Based Services were a Majority of LTSS Spending*  
Prepared for CMS by Truven Health Analytics, June 2015

# MLTSS: Key Milestones



# Recent Trends in MLTSS

- Seeing more states move to larger, more comprehensive models that integrate the acute, physical, behavioral and LTSS
  - Tend to use larger, national companies
- Case management more often done in house at the MCO, but some plans still use contracted agencies
- Predict the next wave of MLTSS requests will include the addition of individuals with intellectual or developmental disabilities in states that already have MLTSS for individuals with physical disabilities

# Managed Care Final Rule

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

## Key Goals

- ❖ To support State efforts to advance **delivery system reform** and **improve the quality of care**
- ❖ To strengthen the **beneficiary experience of care** and key beneficiary protections
- ❖ To strengthen program integrity by **improving accountability and transparency**
- ❖ To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

# Key Dates

## ❖ Publication of Final Rule

- On display at the **Federal Register** on April 25th
- Published in the **Federal Register** May 6<sup>th</sup> (81 FR 27498)

## ❖ Dates of Importance

- Effective Date is July 5<sup>th</sup>
- Provisions with implementation date as of July 5th
- Phased implementation of new provisions primarily over 3 years, starting with the rating period for contracts starting on or after July 1, 2017
- Compliance with CHIP provisions beginning with the SFY starting on or after July 1, 2018
- Applicability dates/Relevance of some 2002 provisions

# 10 Elements of Medicaid MLTSS

- Adequate Planning and Transition Strategies
- Stakeholder Engagement
- Enhanced Provision of HCBS
- Alignment of Payment Structures with Goals
- Support for Beneficiaries
- Person Centered Processes
- Comprehensive and Integrated Service Package
- Qualified Providers
- Participant Protections
- Quality

# Adequate Planning and Transition Strategies

## ❖ 438.10

- Provider directories must include LTSS providers
- Directory must note if the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment

## ❖ 438.62

- States must implement a transition of care policy for FFS to managed care and from one plan to another. This policy must be communicated to beneficiaries in the quality strategy and informational materials

## ❖ 438.66

- States must perform readiness reviews of their programs including both a desk review and an on site review with results submitted to CMS during the contract and rate review process



# Stakeholder Engagement

## ❖ 438.70

- States need to develop a group to solicit the input of stakeholders during the design, implementation, and oversight of the state's MLTSS program
- States can use already existing stakeholder groups to meet this requirement, but will need to show CMS that the group composition and meeting frequency offers sufficient opportunity to get meaningful input

## ❖ 438.110

- Each managed care plan must establish and maintain a member advisory committee focused on the delivery of LTSS to the applicable populations

# Enhanced Provision of HCBS

## ❖ 438.2

- Added a definition for long-term services and supports

## ❖ 438.3

- Contracts must comply with federal laws such as the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act
- The managed care plan must provide services meeting the HCBS settings requirements in a timeframe consistent with the statewide transition plan

# Alignment of Payment Structures with Goals

## ❖ 438.6

- Clarifications to Incentive and Withhold arrangements
- Process for contract approval with provider directed payments, including being tied to the quality strategy

## ❖ 438.66

- The State's Annual Program Report will include information on beneficiary experience of care, improved community integration of enrollees, and reduced costs

# Support for Beneficiaries

## ❖ 438.54

- Information notices at time of enrollment or annual selection period must include contact information for the beneficiary support system

## ❖ 438.56

- Added a for-cause reason for disenrollment: for enrollees that use MLTSS, if the enrollee would have to change their residential, institutional, or employment supports provider because of a change in network status – they can change their MCO, PIHP or PAHP outside of the annual period

## ❖ 438.71

- States must develop and implement a beneficiary support system that includes choice counseling, assistance in understanding managed care, and functions specific to LTSS activities, including: access point for complaints and concerns about plan performance, education on grievance and appeal rights, assistance with the appeals and grievance process, and review and oversight of LTSS program data to provide guidance to the state Medicaid Agency

# Person Centered Processes

## ❖ 438.208

- The state must implement mechanisms to identify, assess and develop treatment plans for those who may need LTSS
- Treatment plans need to be developed by an individual meeting LTSS service coordination requirements and in consultation with any providers caring for the enrollee
- Must be developed by a person trained in person-centered planning
- Service plans must be reviewed and revised upon reassessment of functional need, at least every 12 months, when the enrollee's circumstances or needs change, or at the request of the enrollee

## ❖ 438.210

- Contract must require the plans to authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered plan

# Comprehensive and Integrated Service Package

## ❖ 438.62

- States must implement a transition of care policy for FFS to managed care and from one plan to another. This policy must be communicated to beneficiaries in the quality strategy and informational materials

## ❖ 438.208

- The state must implement a policy where services are coordinated between delivery systems if they are not all delivered through one entity

# Qualified Providers

## ❖ 438.68

- States must develop network adequacy standards for LTSS providers, both time and distance and other measures. These must be posted publically.

## ❖ 438.206

- Each state must ensure that all services covered under the state plan are available and accessible for enrollees in a timely manner
- Managed care plans must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for enrollees with physical and/or mental disabilities

# Qualified Providers

## ❖ 438.207

- Managed care plans must provide supporting documentation showing they offer an appropriate range of preventive, primary and specialty care, and LTSS that is adequate
- Documentation provided at least annually, with the state providing an assurance to CMS with contract submission

## ❖ 438.214

- States are required to establish minimum credentialing and re-credentialing policies for all providers, including LTSS providers



# Participant Protections

## ❖ 438.210

- Any decision to deny or reduce a service authorization must be made by someone with appropriate expertise in addressing their LTSS needs
- Enrollee must receive written notice of the decision to deny or reduce services, or when the services are authorized in an amount less than requested

## ❖ 438.330

- Managed care plans are required to participate in state efforts to prevent, detect and remediate all critical incidents

## ❖ 438.408

- Standard resolution for appeals is now 30 days and expedited is 72 hours

# Participant Protections

## ❖ 438.420

- The managed care plan may only recover the funds expended on services provided while on appeal if the decision of the appeal was upheld and the recovery policy is consistent with the state's policy on FFS payments

## ❖ 438.816

- The beneficiary support system must be independent of the managed care plan or other health care provider in the state, and must be free from conflict of interest in order for the state to collect federal match

# Quality

## ❖ 438.330

- Quality assessment and performance improvement programs must include mechanisms to assess appropriateness of care between care settings and a comparison of services received vs. what was authorized, as well as participating in efforts to protect the enrollee's health and welfare
- The state must identify performance measures, to be measured and reported annually, that relate to quality of life, rebalancing and community integration
- The state must review the effectiveness of this program annually including results of community integration activities

# Quality

## ❖ 438.340

- The state's quality strategy must include the state's goals and objectives for continuous quality improvement which must be measurable and take into consideration all populations served
- Include a description of the quality metrics used and how the state will identify and assess those individuals needing LTSS
- Make the strategy publically available prior to submission to CMS and update the strategy once every 3 years

## ❖ 438.358

- The External Quality Review must validate the plan performance on network adequacy requirements

# Oversight and Transparency

## ❖ 438.66

- State must implement a monitoring system that looks at all areas of the program, and specifically MLTSS to improve the performance of the plans
- States must provide a report to CMS related to the outcomes of their annual monitoring of the managed care plans 180 days after the end of each contract year
  - This will include performance of the beneficiary support system and any specific LTSS activities evaluated, and must be posted publically

# Next Steps

- CMS continues to meet with stakeholders to understand MLTSS issues in operation and implementation to guide our oversight
- CMS intends to publish guidance related to the MLTSS provisions in the final rule
- States expanding their MLTSS programs or implementing new programs must show CMS that they and their plans are ready for the transition

# Questions



# Contact Information for the Final Rule

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