HEALTH MANAGEMENT ASSOCIATES

July 1, 2015

Managed Long-Term Services and Supports: Understanding the Impact of the New Medicaid Managed Care Regulations

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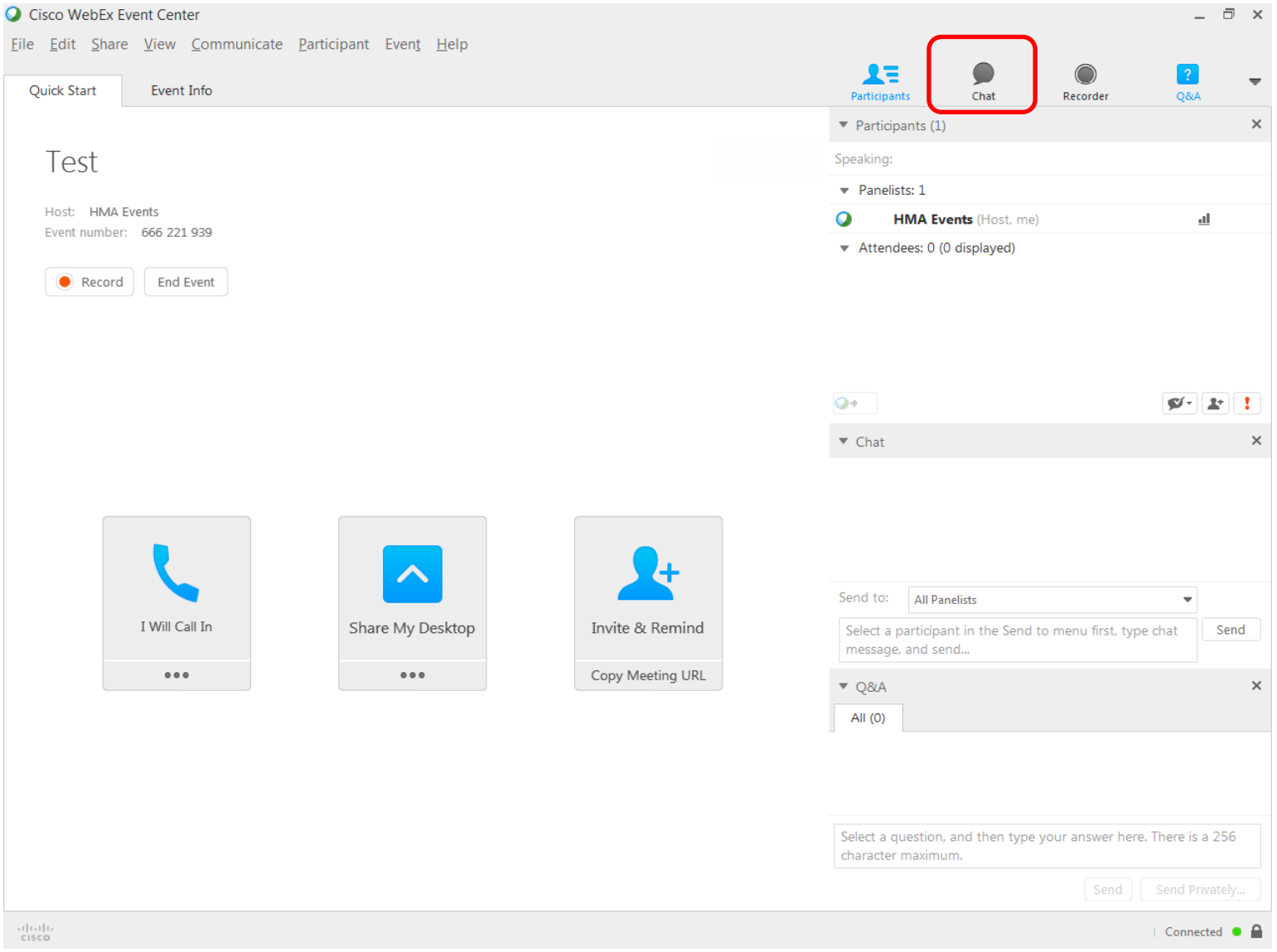
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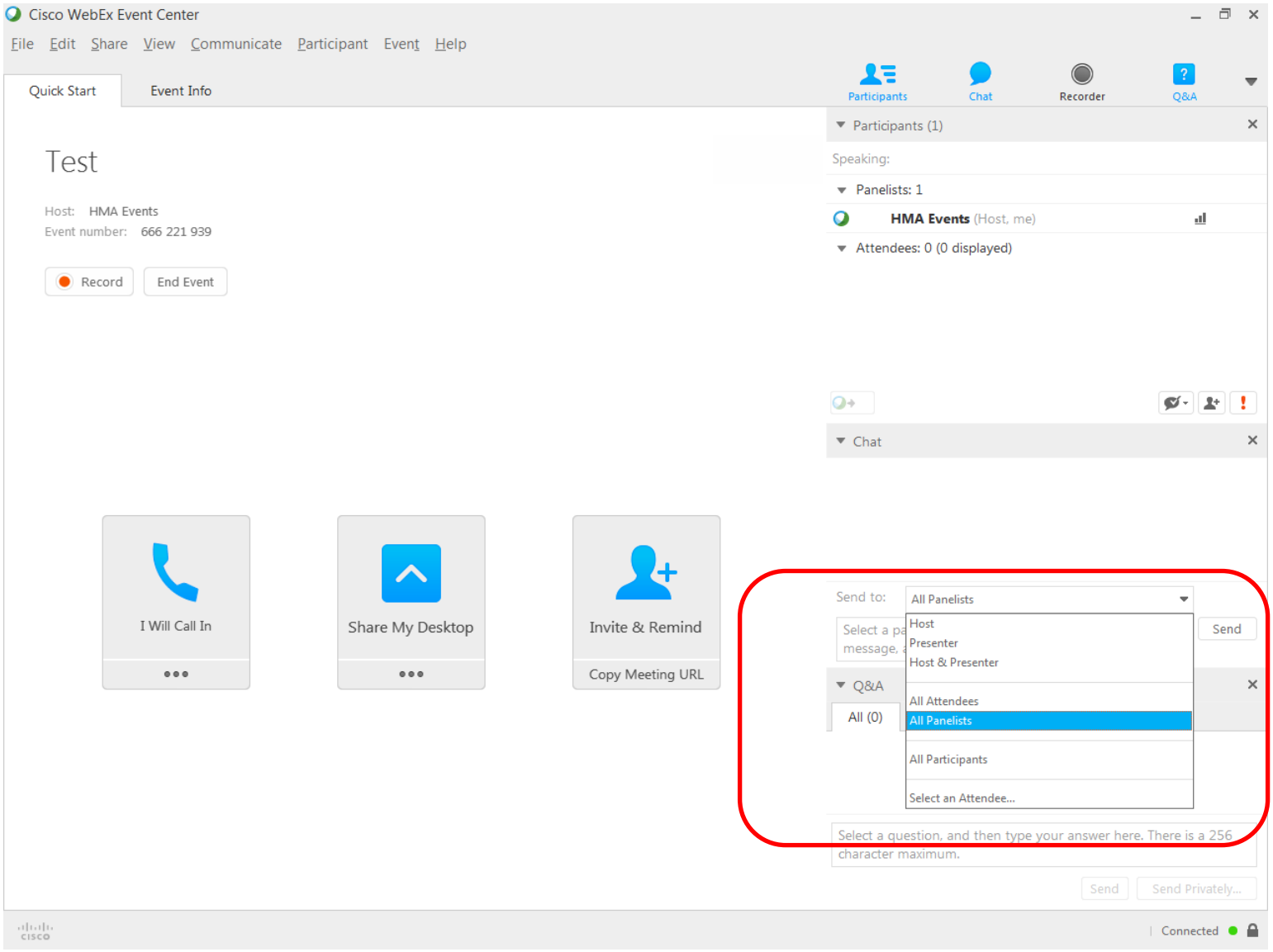
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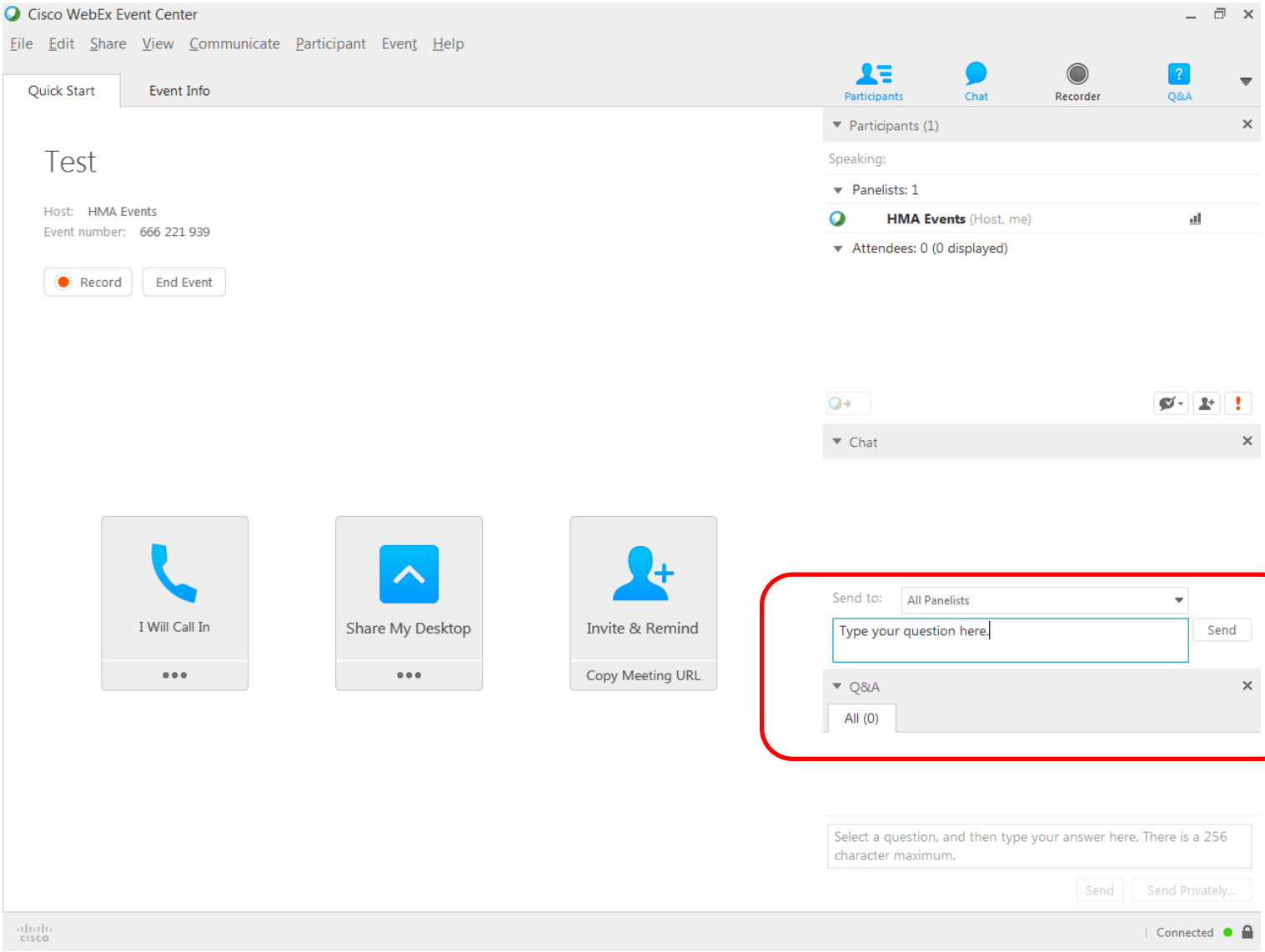
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Today's Presenters

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Objectives

1. Understand the framework for MLTSS as outlined in the proposed rule.
2. Learn about CMS' proposed definition of long-term services and supports.
3. Gain an understanding of the framework around which the proposed rule seeks to regulate MLTSS, including:
   - Changes to network adequacy standards as well as person-centered planning and care coordination standards for MLTSS.
   - CMS' quality focus for Managed Long Term Services and Supports.

Setting the Stage

- Medicaid managed care regulations last codified in 2002
- Managed long-term services and supports (MLTSS) were not nearly as prevalent
- CMS acknowledges important shift in Medicaid managed care with proposed rule due to the growth in MLTSS
- Proposed rule has strong emphasis on community living

Proposed Definition of LTSS

- CMS proposes to add a definition for LTSS for purposes of applying the rules specifically in 42 CFR §438
- The proposed definition is: "services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting."

- CMS is requesting comment on this definition.

Proposed Rule Would Codify MLTSS Guidance

- 2013 CMS Guidance on MLTSS offers framework for MLTSS provisions in proposed rule

- 10 elements of MLTSS reflecting best practices in states with operational MLTSS programs

1. Adequate Planning

- Proposes that there is appropriate state monitoring and accountability of MLTSS that includes readiness reviews (§438.66)
- Proposes additional standards for enrollee and potential enrollee materials, including information on transition of care, who to contact for support, and other standards for provider directories (§438.10)
- CMS acknowledges that these standards apply broadly to all managed care programs but specifically calls out LTSS, where it is a covered service under a contract

2. Stakeholder Engagement

- A new provision (§438.70): The State must ensure the views of beneficiaries, providers, and other stakeholders are solicited and addressed during the design, implementation, and oversight of a State's MLTSS program.
- A new provision (§438.110): When LTSS are covered under a managed care contract, the managed care organization must establish and maintain a member advisory committee that includes at least a "reasonably representative sample of the LTSS populations covered under the contract."

3. Enhanced Provision of Home- and Community-Based Services

- The proposed rule confirms that all MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* decision
- A new provision (§438.3(o)): Managed care contracts covering LTSS should provide services that could be authorized through a waiver under section 1915(c) or a state plan amendment through section 1915(i) or 1915(k) be delivered consistent with the settings standards in the final HCBS rule (§441.301(c)(4)).

4. Alignment of Payment Structures and Goals

- Rate setting framework proposed in the rule does not specifically call out MLTSS
- CMS posits that payment to managed care organizations should support the goals of MLTSS programs to "…support the beneficiary's experience of care, support community integration of enrollees, and reduce costs"

5. Support for Beneficiaries

- A new provision (§438.71): "Beneficiary Support System", which would include assistance for enrollees who receive or desire to receive LTSS.
- In §438.71(e), the proposed rule lays out four functions of a Beneficiary Support System specific to LTSS, including:
  - An access point for complaints and concerns about managed care enrollment
  - Education on enrollees' grievance and appeal rights
  - Assistance in navigating the grievance and appeal process
  - Review and oversight of LTSS program data
- CMS recognizes that provider network changes can have a significant impact on those enrolled in MLTSS programs, and is therefore amending §438.56(d)(2)(iv) to add a new for cause reason for LTSS enrollees to disenroll

6. Person-Centered Processes

- The proposed rule:
  - Changes §438.208(c) to require identification, comprehensive assessment and person centered planning for individuals receiving LTSS who are enrolled in an MCO, PIHP or PAHP
  - References 42 CFR §441.301 so that treatment or service plans developed for those in need of LTSS conform with the person centered planning standards
- CMS is not distinguishing between a treatment plan, service plan or who prepares - either a health care professional or a service coordinator

7. Comprehensive, Integrated Service Package

- The proposed rule expands §438.208(b)(2) so that MCOs, PIHPs or PAHPs coordinate care between settings of care, with services received through fee-for-service and with any other plan
- The intent is to ensure robust coordination and referral, particularly when services are divided between contracts or delivery systems so that the enrollee's service plan is comprehensive and person-centered

8. Qualified Providers

- CMS proposes to amend §438 to provide guidance so that managed care networks also meet the LTSS needs of beneficiaries, including capacity and expertise
- CMS considers the ability of the enrollee to choose a provider to be a key protection that must be considered when developing network standards for MLTSS

8. Qualified Providers, cont'd.

- The proposed rule amends §438.68(b)(2) requiring states to establish time and distance standards specifically for MLTSS programs
- Amends §438.214(b)(1): states must establish a credentialing and re-credentialing policy that addresses all the providers, including LTSS providers, covered in their managed care program regardless of the type of service provided by such providers

8. Qualified Providers, cont'd.

- Amends §438.206(c)(3): plans must ensure that network providers have capabilities to ensure physical access, accommodations and accessible equipment for enrollees with physical and mental disabilities
- Amends §438.207(b)(1): plans must submit documentation to the State to demonstrate that it complies with offering the full range of preventive, primary care, specialty care, and LTSS services adequate for the anticipated number of enrollees

9. Participant Protections

- CMS proposes to incorporate participant protections by adding a contract standard in §438.330(b)(6) whereby plans would be required to participate in States' efforts to prevent, detect, and remediate critical incidents
- The State must specify the MCO, PHIP or PAHP's roles and responsibilities related to these activities in the contract

10. Quality

- CMS frames MLTSS quality in the context of quality for a state's entire managed care program, but specifies that it should include MLTSS specific quality elements
- These measures must assess the quality of life of beneficiaries and the outcomes of MCO, PIHP or PAHP's rebalancing and community integration activities for beneficiaries receiving LTSS
- The proposed rule limits its reach to self-direction by asking States to consider including performance measures specific to self-direction

Potential Impact of the Rule

- Because CMS issued guidance in 2013 for the provision of LTSS in a managed care environment, many States have already incorporated some or all of the elements through contractual requirements with MCOs.
- The network adequacy provisions will have an important impact on state MLTSS programs.
- The MLTSS quality provisions may add more responsibility to plans for data collection than is currently done across states.
- With regard to stakeholder engagement, most states have engaged stakeholders during the development and implementation phases of MLTSS programs but some may need to do more in the oversight role.
- This proposed rule reinforces the existing HCBS settings regulations.

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HMA Information Services Webinar