



*Beyond Mental Health & Addiction Parity: Are Ohioans Getting the Services They Need?*

## **Proposed CMS rules for Medicaid Managed Care and the Implications for Behavioral Health**

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**VORYS**  
Health Care Advisors

### **Basics**

- Title ~ Medicaid and CHIP Programs: Medicaid & CHIP Managed Care, Comprehensive Quality Strategies & Revisions Related to 3<sup>rd</sup> party liability
- Published Federal Register June 1, 2015
- This presentation addresses proposed rule, which will change based on comments.
- Comment period has closed
- Rule to be effective January 1, 2017
- ~200 pages, language of the regulation is the last 45 pages

# Why & Why Now?

- Almost 50% increase in Medicaid managed care in 4 years
- Regulations last revised in 2002
- Managed care includes increasing numbers of those with chronic and complex conditions
- Support the efforts to reform delivery systems for Medicaid & CHIP beneficiaries

3

## Address Areas in Need of Improvement

- OIG/HHS Access to Care: Provider Availability in Medicaid Managed Care (MMC)
- OIG State Standards for Access to Care In MMC
- GAO Report to the Committee on Finance, U.S. Senate Medicaid Integrity Increased Oversight Needed to Ensure Integrity of Growing MMC Expenditures
- OIG State and CMS Oversight of the MMC Credentialing Process
- OIG MMC: Fraud and Abuse Concerns Remain Despite Safeguards
- GAO MMC CMS Oversight of States Rate Setting Needs Improvement

4

## Dynamics & Tensions

- Is this an expanded federal **role** in the administration of the Medicaid program?
- Is it unduly tying the states' hands re: administration of the program?
- Does the rule establish the proper balance-among interests...consumer, advocacy organizations, providers, Plans, states?
- Does the rule establish the proper balance of quality/health goals, cost and individual experience/responsibility?

5

## Medicaid Behavioral Health & Managed Care



# Medicaid Behavioral Health

- Services
- Delivery mechanisms
  - Kinds of managed care entities
  - Managed care programs/authorities
- Individuals needing services
  - Populations/eligibility 'categories'
  - Types of needs
  - *Medicaid and CHIP*



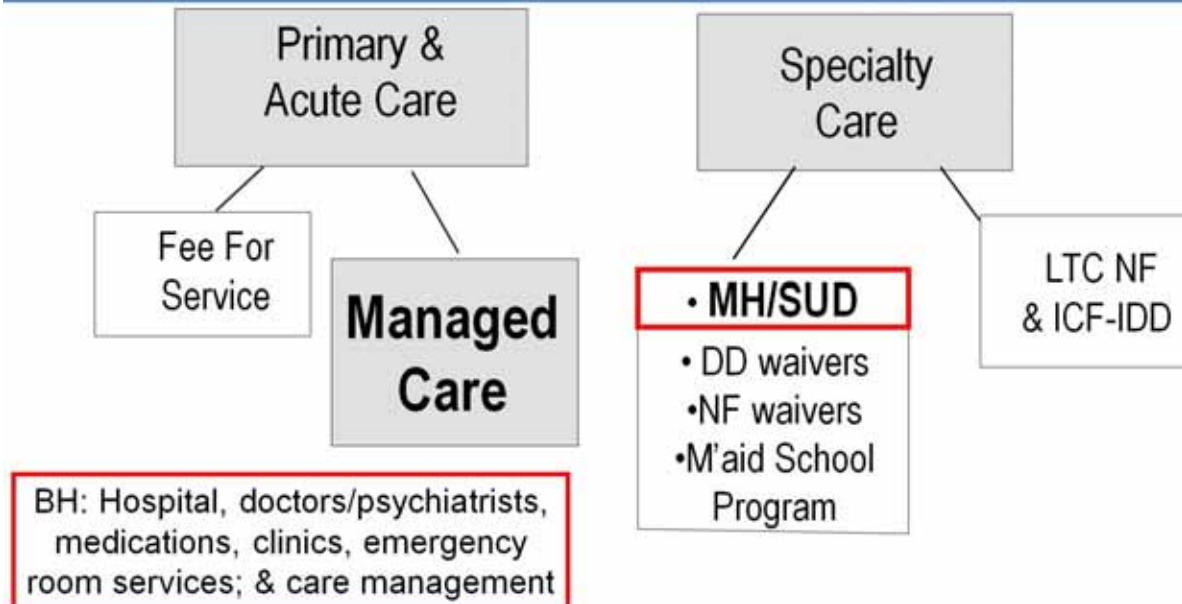
## Ohio Medicaid Behavioral Health Services

(available to Medicaid eligible children age 0 to 21)

Outpatient hospital services	<b>Community Alcohol &amp; Drug Addiction Services (Rehab option)</b>
Inpatient psychiatric hospital services for age under 21	<b>Community Mental Health Services (Rehab Option)</b>
Physicians' services, ambulatory surgery center services, vision care	Medical care or other remedial care, furnished by licensed practitioners within scope of practice per state law
Clinic services furnished by or under the direction of a physician	HCBS Waiver services
Prescribed drugs	Community BH services provided through Medicaid school program <sup>8</sup>

# Medicaid Service Delivery Systems

## Benefit Plans & Delivery Systems

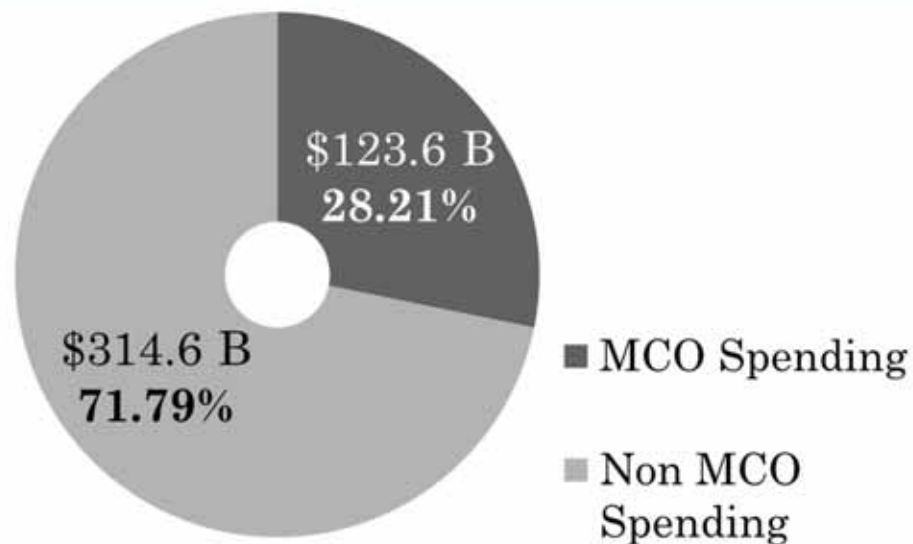


## The Medicaid Behavioral Health Infrastructure: Carve-in and Carve-Out

- In FY 2013, in 16 of the 38 state Medicaid programs that contracted with MCOs, behavioral health services were always carved out of the MCO contract and in five states, behavioral health was always carved in.
- In the remaining states, some benefits were included and other benefits were excluded from MCO contractual responsibilities (e.g., SMI care may be turned over to a state mental health agency).
- Carve-in/out policies change frequently within state Medicaid infrastructures.

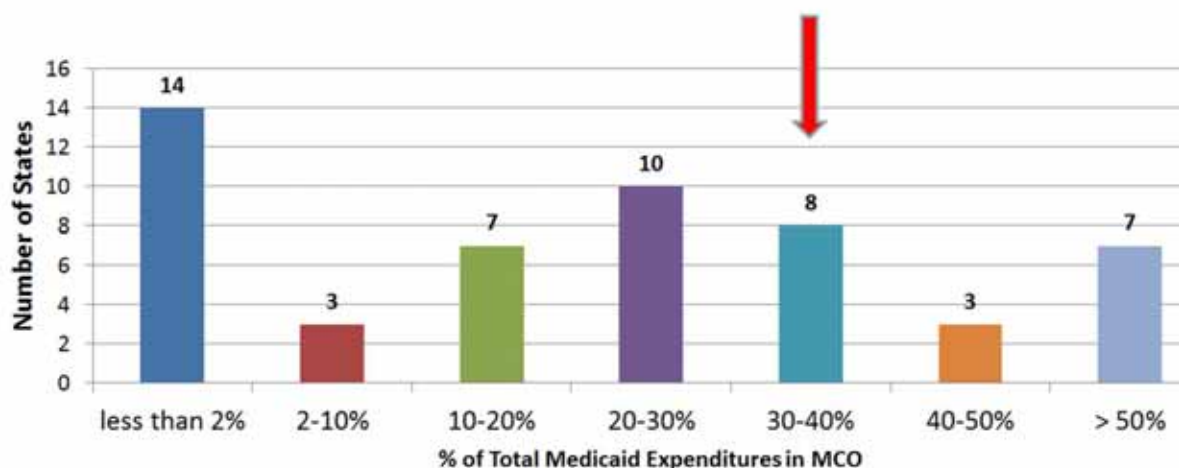
# Total Medicaid Expenditures 2013

*Managed Care is dark gray*



Source: Medicaid Managed Care Market Tracker. *Total Medicaid MCO Spending - FY 2013*. The Henry J. Kaiser Family Foundation, 2015. Available at: <http://kff.org/other/state-indicator/total-medicareid-mco-spending>. Accessed

## States' Medicaid MCO Expenditures As Percent of Total Medicaid Expenditures



Source: Medicaid Managed Care Market Tracker. *Total Medicaid MCO Spending - FY 2013*. The Henry J. Kaiser Family Foundation, 2015. Available at: <http://kff.org/other/state-indicator/total-medicareid-mco-spending>. Accessed Aug. 2015.

Ohio 37.6%

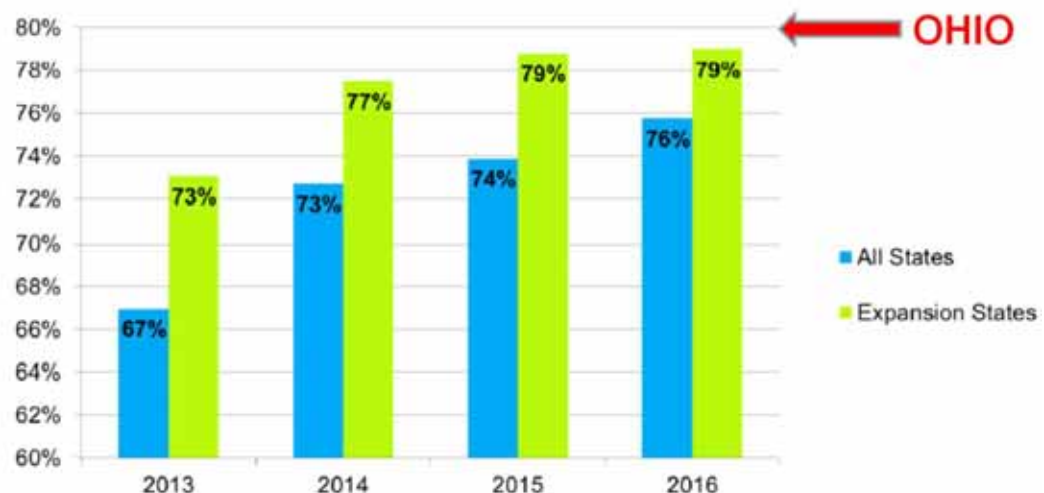


**% Change in  
Total Medicaid  
MCO  
Enrollment  
from September 2014 to  
March 2015**

Source: Medicaid Managed Care Market Tracker. *Change in Total Medicaid MCO Enrollment - March 2015*. The Henry J. Kaiser Family Foundation, 2015. Available at <http://kff.org/other/state-indicator/change-in-total-medicaid-mco-enrollment/#>

State	% Change in Enrollment
Pennsylvania	-5%
South Carolina	-3%
Minnesota	-2%
Arizona	1%
West Virginia	1%
Texas	3%
Oregon	4%
Hawaii	5%
Florida	8%
Michigan	9%
New York	9%
Washington	10%
Wisconsin	10%
Kentucky	13%
<b>Ohio</b>	<b>13%</b>
Missouri	14%
California	16%
Louisiana	121%
Illinois	205%

**Percent Medicaid & CHIP Enrollment in  
Managed Care 2013-2016\***



\*Excludes dual-eligible beneficiaries  
MCO: Managed Care Organization; CHIP: Children's Health Insurance Program  
Source: Avalere Medicaid Managed Care Enrollment Model, updated October 17, 2014  
Avalere assumes the following states opt out of the ACA Medicaid expansion in 2014 and beyond: AK, AL, FL, GA, ID, KS, LA, ME, MS, MO, MT, NE, NC, OK, SC, SD, TN, TX, UT, VA, WI, and WY.

Oct. 2014

## Example: My Care: Medicare & Medicaid

- Medical, dental, etc.
- MH & SUD services in regular managed care
- **Community MH & SUD services**
- Nursing Home
- Home & Community Based Waiver services and other Long Term Services and Supports

Proposed CMS Rules for Medicaid  
Managed Care & Implications for  
Behavioral Health



## Proposed CMS rules for Medicaid Managed Care and Implications for Behavioral Health

- Purpose
  - **Incorporates MHPAEA requirements**
- Who the regulations apply to
- Financial Considerations
- Coordination of Services & Continuity of Care
- Infrastructure for Transparency & Quality of Services
- Specific Program Components

17

## Purpose of the Rule

- “Modernize the Medicaid managed care regulations to reflect changes in the usage of Medicaid managed care delivery systems
- Align the rules with other major sources of coverage; Qualified Health Plans & Medicare Advantage Plans
- Strengthen actuarial soundness payment provisions to promote accountability of managed care rates
- Promote quality of care
- Ensure appropriate beneficiary protections
- Enhance policies related to program integrity”

18

# Who does this apply to?

Medicaid beneficiary served by these entities:

- MCO-managed care organization
- PIHP-prepaid inpatient health plan
- PAHP-prepaid ambulatory health plan
- PCCM-primary care case management

19

## Entities: MCO, PIHP, PAHP, PCCM

- Above types of entities included in definition of Medicaid managed care historically
- All of the above were included in regulations, but not equally. Intent to make regs more consistent.
  - *Today, I'll use the term "**Plan**" for all of above, unless specified*
- Includes those receiving HCBS waivers, dual eligible contracts, ICF/IDD or NF, other LTSS; **if in managed care**

20

## Who does this apply to?

Managed Care Entities inc.	Managed Care Programs inc.	If included in LTSS Contract (Subject to HCBS regs 441.301)
MCO	1932 (a)	1915(c)
PIHP	1115(a)	1915(i)
PAHP	1915 (a)	1915(k)
PCCM	1915(b)	<i>(Definition of LTSS needs work, esp. re MH/SUD)</i>
HIO		

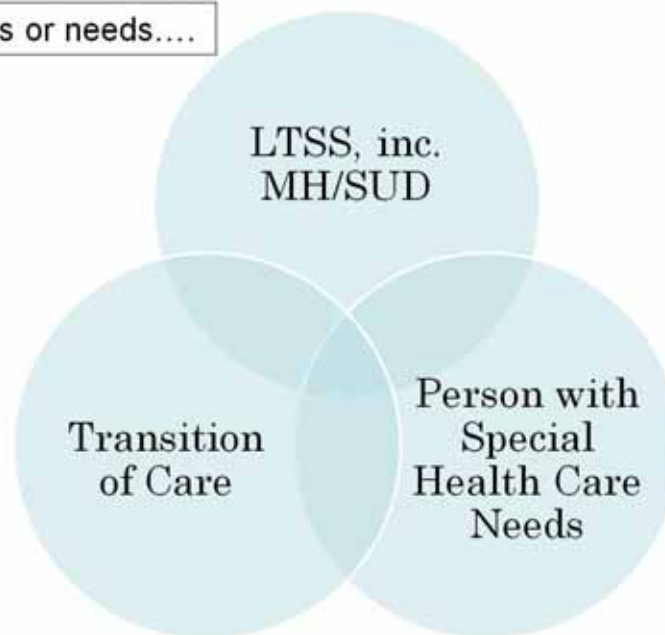
21

## 1915 c & 1915 i

- 1915 c includes Passport & other NF waivers and Individual Options & other IDD waivers
- 1915 i being developed for SMD adults
- Today: subject to Final Rule CMS 2249-F re: HCBS, 1915 i
- When incorporated into managed care, under “LTSS contract” becomes subject to these rules, when effective, Jan. 2017

# Who does this apply to?

Person who has or needs....



## Are BH Services covered by requirements associated with LTSS ? ...YES & NO

- LTSS “means service & supports ...who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the (person) to live or work in the setting of their choice” (438.2)
- LTSS contract requirements: any services covered under the contract that could be authorized through a waiver under ...1915(c), 1915(i) or 1915(k) be delivered consistent with 441.301(c)(4) (438.3)

Comments: pg. 45 (g)(1)

- “Inc. 1915(c), 1915(i), 1915(k) and personal care services otherwise authorized under the state plan.”
- “We note that LTSS “...inc. individuals with mental health conditions and substance use disorders”



## What other special needs?

### **Person with Special Health Care Needs** (438.208)

- Any special health care need,
- Determined by the state, who'll notify the MCO

### **Transition of Care Policy** (438.62(b))

- State must have a transition of care policy in place for individuals moving to managed care from FFS or from one MCO to another, when an enrollee without continued services would experience serious detriment to their health or put them at risk of hospitalization or institutionalization.

## Financial Considerations

## Financial Considerations

- Actuarial soundness and accountability of rates, including MHPAEA
- Medical Loss Ratio (MLR)
- Rate considerations
- Prohibitions on specificity of payment requirements

27

## Actuarial Soundness & Promoting Accountability of Payment Rates

- Greater specificity, incl. previously issued guidance from American Academy of Actuaries re: rate setting
- Require states to pay Medicaid Plans to “provide for all reasonable, appropriate & attainable costs” required.
- Capitation language recognizes that additional services may be necessary to comply with MHPAEA (438.3 (c))
- Payments from one rate cell must not cross subsidize other rate cells

28

## Actuarial Soundness & Promoting Accountability of Payment Rates

- CMS review of rates will consider adequacy to allow Plan to meet network adequacy and access standards
- Incentive programs must be available to contractors with Plans, public and private
- Greater authority for CMS to disallow or defer availability of FFP for all, or part of payment rate to Plan; i.e. if inpatient hospital portion of rate is determined to not be actuarially sound, that portion could be disallowed.

29

## Medical Loss Ratio (MLR)

- State need not impose any MLR, but, if it does, must use minimum MLR 85%, 15% retained for administrative functions and profit
- Numerator incl. a) claims, b) expenditures for compliance, fraud prevention, provider enrollment, various reporting activities, and c) expenditures that improve health care quality, HIT and external quality activity §438.8(e)

30

## Medical Loss Ratio (MLR)

- With greater complexity of Medicaid populations...”CMS believes that the definition of activities that improve health care quality in Section 158.150 is broad enough to encompass...activities related to services coordination, case management and activities supporting state goals for community integration of individuals with more complex needs such as individuals using LTSS.”
- Applies to rate years after 1/1/17

31

## States Prohibited from Directing Plan Payments to Certain Providers

- **But**, there are exceptions with federal approval, including:
- Requiring Plans to participate in value based purchasing models (P4P, bundled payments, etc.)
- Require Plans to participate in multi-payer delivery system reform or performance improvement, or
- Requiring Plans to adopt minimum fee schedules or uniform rate increases across providers

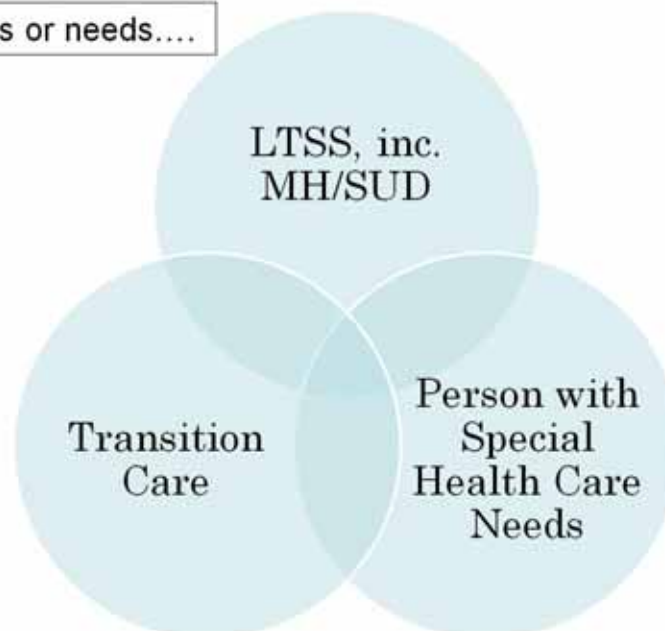
32



## Coordination of Services & Continuity of Care

### Coordination & Continuity of Care People with Priority Considerations

Person who has or needs....



## Coordination & Continuity of Care People with Priority Considerations

There are some additional care coordination responsibilities for these groups of individuals:

**LTSS** “means service & supports ...who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the (person) to live or work in the setting of their choice” (438.2)

**Transition Care:** Continued access to services during a transition when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. (438.62)

**Person with Special Health Care Needs:** Identified by the State & determined through an assessment to need a course of treatment or regular care monitoring

35

## Coordination & Continuity of Care Enrollment & Assessment-Everyone

- Mandatory enrollment requires 14 days FFS to allow active choice
- Requires procedures for passive enrollment to enhance continuity of care
- Limits without cause disenrollment to 1<sup>st</sup> 90 days, then annually thereafter
- Require Plans to make “best effort” to “conduct an “initial assessment of each enrollees needs” within 90 days of enrollment (438.208(b)(3))
- Require Plans to ensure that providers share an enrollee health record.

36

## Coordination & Continuity of Care: LTSS & Persons with Special Health Care Needs

- State must address in contract with Plans & must identify LTSS/PSHCN to the Plan
- LTSS/PSHCN must be identified in the state's comprehensive quality improvement strategy
- Plan must have process to "comprehensively assess" needs, using appropriate professionals or LTSS service coordinator or the Plan, as appropriate. (438.208(c)(2))

37

## Coordination & Continuity of Care: LTSS & Persons with Special Health Care Needs

- Plan must provide enrollees with special health care needs direct access to specialists (It does not specify this same requirement for LTSS)
- CMS maintains the statutory requirement that prevents states from mandating enrollment in managed care for children under 19 y.o. who are eligible based on disability, receive SSI under Title XVI or are foster children. However, CMS allows mandatory inclusion under waiver authority. (438.50)

38



## Coordination & Continuity of Care: LTSS & Persons with Special Health Care Needs

- If the state requires Plans to produce a treatment or service plan, AND if the LTSS or PSHCN is determined to need a course of treatment or regular care monitoring, the plan shall be...
  - Developed by the provider, with enrollee participation
  - Developed by a person trained in person centered planning (per 441.301(c)(1) & (2))
  - Approved by Plan timely, if approval is necessary,
  - Reassessed at least every 12 months OR when circumstances change significantly OR request of person (441.301(c)(3))

39

## Coordination & Continuity of Care: Transition of Care Policy

- Require states to have a 'transition of care' policy with minimum standards, inc. allowing individual to receive care from current provider for a period of time.
- Transition to or between any/all types of managed care entities
- For those who would **“suffer serious detriment to their health or be at risk of hospitalization or institutionalization”** if services were not continued.
- Maintain access to provider for period of time, even if provider out of network (not limited to LTSS or persons with special health care needs)
- Ensure referral to other qualified providers and that records are transferred.

40



## Emergency & Poststabilization Services includes BH

- Emergency services must be paid for, even if out of network
- Standard: Prudent layperson... reasonably expect... health in serious jeopardy, impairment or serious dysfunction to bodily function
  - Emergency can not be limited by list of diagnosis or symptoms
- Can't be denied payment for failure to notify Plan, if notified within 10 calendar days
- Poststabilization coverage & payment required by MCO (per 422.113(c))
- Determination of whether person is sufficiently<sub>41</sub> stabilized rests with ER doc or treating provider.

## Infrastructure Requirements: Transparency & Quality of Care

## Infrastructure for Transparency & Quality of ALL Services

- Access, network adequacy & choice counseling
- EPSDT
- Emergency & post stabilization services
- Other Quality requirements
- Consumer appeals & grievances
- Readiness review & annual reassessment
- Monitoring & quality Measurement
- Comprehensive system of program integrity

43

## Access & Network Adequacy

- While current law has requirements for access to care, reasonable timeframes, etc.; OIG identified significant variation among states re: network adequacy. Proposed rule addresses this.
- CMS would have authority to require time and distance standards for provider types, other than those specified in regulations
- State must certify the adequacy of network annually, and if there is a significant change in the composition of the network.
- State can grant exceptions to their network adequacy requirements.

44

## Access & Network Adequacy

- Requires “Time and distance standards” for specific provider types and be specified in the Plan’s contract. Could vary the time and distance by type of provider and geographic areas.
- Specific PROVIDER TYPES incl. primary care, specialists (adults & kids); Ob-Gyn, BEHAVIORAL HEALTH, hospital, pharmacy, pediatric dental & LTSS
- Additional “ELEMENTS” that states must consider:
  - Health care providers ability to communicate with enrollee with limited English proficiency
  - Characteristics and health needs of the population

45

## Access & Network Adequacy

(cont.)

- Continue to require state standards for timely access to routine, urgent and emergency care.
- Timely and adequate access to out of network providers and no greater financial burden for out of network care.
- Plan provider selection procedures can not discriminate against high risk clients or those specializing in their care. If provider excluded, must give written explanation.
- States publish standards on website.
- Plan directory must inc. MD/DO, specialists, BH, LTSS, and pharm; for each specialty, cultural/linguistic, physical accessibility.

46



## Access & Network Adequacy-LTSS

- Separate time and distance requirements for LTSS providers, including but not limited to, institutional, community and residential. Also for those traveling to the person's home.
- Reporting re sufficiency and geographic access, etc. would now including LTSS
- Beneficiary can disenroll with cause if their LTSS provider becomes an out of network provider.
- Requires each Plan to have an LTSS member advisory committee (438.110)

47

## Access: Info re: Benefits

- State or contracted representative would be required to provide potential enrollee with information related to covered benefits, including which benefits are covered by the plans, provider directory information, any cost sharing requirements, and requirements to provide adequate access to covered services including network adequacy standards.

48



## Choice Counseling (438.71)

State must provide system of support for all beneficiaries, include, at a minimum:

- Choice counseling for all beneficiaries
- Training for network providers specified.
- Assistance to enrollees to understand mgd care
- Assistance to those requesting/receiving LTSS... access, education grievance, rights; assistance if requested; data/oversight re: systemic issues.

Counselors would have to follow conflict of interest standards, excluding Plans or providers from serving as Choice Counselors

49

## Quality of Care

### **Transparency**

- Require states to develop a managed care quality rating system based on a) clinical quality management, b) member experience, and c) plan efficiency, affordability and management (438.334)

### **Alignment with other systems**

- Plan must undergo a performance review at least as stringent as that of private accreditation entities, prior to contracting with state. (State determined process or accept CMS recognized accrediting organizations)

50

## Quality of Care (cont.)

### **Comprehensive quality strategy for FFS & managed care**

- at least every 3 years, & publicly available  
438.330 & 438.340
- Requires assessment of quality & appropriateness of LTSS, inc. community integration; and PSHCN.
- Must assess under/overutilization
- Must include Transition of Care policy
- May use CHIP child core measure sets

51

## EPSDT, incl. BH Needs

Contracts with the Plans must include provisions

- Specify definition of “medically necessary services” must meet EPSDT requirements. Plan must meet reqts. for EPSDT, inc. physical, mental...to “correct or ameliorate”.
- May not arbitrarily deny or reduce services because of diagnosis, type of illness or condition.
- Permits Plans to place appropriate limits on service, on the basis of criteria or for utilization control, with qualifications
  - adequately support individuals with ongoing or chronic conditions or who require long-term services and supports.
- Services covered by Plan must be no less than FFS in amount, scope and duration & requires that the service is “sufficient to reasonably achieve the purpose for which it is furnished”

52

## Proposed regs allow MCO to purchase adult MH/SUD services in IMD

- IMD: Institutions for Mental Diseases
- Since enacted in 1965, Medicaid excludes coverage for the payment of Medicaid services for ADULT patients (21-64) in an IMD. (SSA§1905(a)(29)(B))
- IMD defined as hospital, NF or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care to persons with mental diseases, including medical attention, nursing care and related services. 42CFR §435.1010
- Current law allows IMD services for kids if inpatient hospital or PRTF.
- This new proposed reg. does not apply for children under 21 or 65 plus

53

## Clarification of Current Policy- “In Lieu of” Services

- Plan could be paid monthly cap rate if served in IMD (438.3(u))
- “so long as the facility is an inpatient hospital facility or subacute facility providing crisis residential services” and
- It’s a short term stay for MH/SUD of less than 16 days in the period of the “monthly capitation payment”
- This is clarification of current policy re: Plans flexibility to provide services in cost effective alternatives; “in lieu of services”
- This alternative can’t be mandated by the Plan, but can be used as an option

54



## IMD Example

- Let's assume Mary is served by Molina, so they receive a monthly capitation payment to serve her.
- In past, if Mary was admitted to an IMD, she would not lose Medicaid eligibility per se, but Medicaid couldn't pay for her services
- Per proposed rule, now, if she is admitted to an IMD for MENTAL HEALTH or AOD services on July 20 and discharged on Aug. 10, MCO will receive normal monthly payment for both July and August.
  - Total of 21 days, but 11 days in July and 10 days in August

Resource:

<http://www.vorys.com/publications-1517.html>

55

## Ohio may use the new option

- The Administration has expressed support for the use of this option
- Option only possible with managed care for BH because it requires a capitated arrangement
- Will be important that provider and Plan monitor where IMD exclusion starts and stops to ensure proper payment of the MCO

56



## Consumer Appeals & Grievances

- Appeal timeframes require quicker response
  - 30 days for appeal, rather than 45 days
  - 72 hours for expedited appeal, rather than 3 business days
- If requested, the enrollee's benefit must be continued during an appeal, until state fair hearing is reached, or 10 days after the plan mails the adverse decision to the enrollee.
- Plan may recover cost of services during appeal, if decision is adverse
- Grievance must be addressed within 90 days.

57

## Plan Readiness Reviews & Annual Assessment

- Includes readiness reviews prior to start dates and submit results to CMS before Plan contract can be approved.
- Readiness review addresses: operations and administration, service delivery system, financial management, and systems management.
- Requires state to submit annual program assessment within 150 days of end of Plan period of performance.

58

## Monitoring, Quality Measurement & Availability of Data

- Require states to have a monitoring system that addresses 14 specified areas.
- Comprehensive annual quality assessment and performance improvement program provided to state for services furnished under plan
- 61 separate submissions of information from states and Plans, est. cost of \$112m

59

## Comprehensive System for Program Integrity Required of State

- Screen, enroll and reevaluate all network providers
- Review ownership and control disclosures submitted by plans and subcontractors
- Conduct routine checks of federal databases for exclusion status and ownership interest
- Conduct or contract for period independent audits of encounter and financial data of Plans (at least once every 3 yrs.)
- Review and investigate whistleblowers re: integrity issues, re: plans, subcontractors or network providers.
- Make available plan contracts, state independent audits and data reports in variety of specified areas.

60

## Increased accountability & focus associated with LTSS

### LTSS & Managed LTSS

- **Definition LTSS:** 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.
- **LTSS Contract:** Incorporated into the definition of capitation payments for Plans
- **Remember the intersection with behavioral health!**



# MLTSS: Guidance in 10 Areas

1. Adequate Planning:
2. Stakeholder Engagement:
3. Enhanced Provision of HCBS Services
4. Alignment of Payment Structures and Goals
5. Support for Beneficiaries
6. Person-Centered Processes
7. Comprehensive Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

*4 slides with more detail below for reference* <sup>63</sup>

## Recap: Mgd Care & LTSS

#1 Managed Care-Medical + BH carved in	Carved Out HCBS 1915(c)
<ul style="list-style-type: none"><li>• Rule applies to medical &amp; BH services</li><li>• Coordinate all services per 438.208 (b)(2)</li><li>• BH: subject to LTSS?</li></ul>	<ul style="list-style-type: none"><li>• MLTSS requirements DON'T apply</li><li>• Might be specified as Person with special health care needs</li><li>• Might meet Transition Care Policy</li></ul>
#2 Managed Care-Medical + BH carved in	Managed Care HCBS (1915c or Duals)
<ul style="list-style-type: none"><li>• Rule applies to medical &amp; BH services</li><li>• Coordinate all services per 438.208 (b)(2)</li><li>• BH: subject to LTSS?</li></ul>	<ul style="list-style-type: none"><li>• MLTSS requirements DO apply</li><li>• Might also be specified as Person with special health care needs</li><li>• Might meet Transition Care Policy</li></ul>



## Remember: 1915 c & 1915 i

- 1915 c includes Passport & other NF waivers and Individual Options & other IDD waivers
- 1915 i being developed for SMD adults
- Today: subject to Final Rule CMS 2249-F re: HCBS, 1915 i
- When incorporated into managed care, under “LTSS contract” becomes subject to these rules, when effective, Jan. 2017

## MLTSS Summary

- Reinforces existing HCBS setting requirements
- Operationalizes the integration of managed care and LTSS
- Focus on network adequacy
- More data collection than current
- More stakeholder engagement
- Requires specific quality standards for LTSS

## Resources: Medicaid.gov LTSS & MLTSS

- **Rule:** 42 CFR Part 430, 431 et al. Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule CMS 2249-F
- **Guidance to States** using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs (5/20/13)
- **Summary-Essential Elements of MLTSS Programs**
- **Transitioning Long Term Services and Supports Providers Into Managed Care Programs** (May 2013)

## LTSS: Guidance in 10 Areas

1. **Adequate Planning:** States must develop appropriate monitoring and accountability programs: readiness reviews, adhere to new standards regulating materials distributed to enrollees and potential enrollees.
2. **Stakeholder Engagement:** States must create and maintain a stakeholder group in order to solicit stakeholder input in the design, implementation, and oversight of the MLTSS program. Seems to contemplate something other than MCAC.
3. **Enhanced Provision of HCBS Services:** All MLTSS programs must be consistent with the Americans with Disabilities Act and the U.S. Supreme Court's decision in Olmstead, bias toward community-based care over institutional care.

## LTSS: Guidance in 10 Areas

### 4. Alignment of Payment Structures and

**Goals:** Payment to Medicare managed care plans should support the goals of MLTSS programs to improve health, improve experience of care, support community integration, and reduce costs.

### 5. Support for Beneficiaries:

Beneficiary support systems must provide support to beneficiaries both pre and post enrollment in a Medicaid managed care plan. Requires an access point for complaints and concerns, resources and education on enrollee grievance rights, assistance in filing and appealing grievances, and review of program data to inform the state Medicaid agency on systemic issues.

### 6. Person-Centered Processes:

States must establish processes, including comprehensive needs assessments and service planning, with the objective of improving quality of life and independence.

69

## LTSS: Guidance in 10 Areas

### 7. Comprehensive Integrated Service

**Package:** States must promote robust coordination and referral between settings of care.

### 8. Qualified Providers:

Provides guidelines to states for network adequacy standards. These include credentialing and time and distance standards. CMS not dictating the standards, but gives authority to states to establish standards regarding utilization, population needs, the number of providers and their geographic mix, the ability to communicate with enrollees with limited proficiency in English, in order to ensure access to services for enrollees with physical or mental disabilities.

70



# LTSS: Guidance in 10 Areas

**9. Participant Protections:** Plans must participate in state efforts to prevent, detect, and remediate incidents that adversely impact enrollee health and welfare, as well as the achievement of quality outcomes described in person centered plan.

**10. Quality:** States should incorporate MLTSS-specific provisions within their existing quality standards, including specific quality of life assessment mechanisms and assessment of appropriateness of care.

71

## Final Observations

- Greater consistency across states managed care programs. Little here is new, it hasn't been consistently utilized.
- Increased Plan accountability; anticipate trickle down to providers
- Data, data, data
- Recognizes the intersection of managed care and traditionally FFS specialty systems-BH, IDD, Child Welfare.

72



## Final Observations

- Adds protections for more vulnerable populations.
- Encompasses LTSS & increases protections
- There is a great deal to pay attention to with regards to behavioral health, but
- We'll need to pay close attention to the degree to which the definition of LTSS includes some individuals with behavioral health needs, thereby bringing those specific requirements to bear.

73

## Wrap Up

- Questions & Discussion
- Resources
  - Subpart list on next page
  - References throughout
  - [WWW.VorysHCAdvisors.com](http://WWW.VorysHCAdvisors.com)

**NOTE:** There is a very helpful extensive list of terminology & key terms included on pg. 31099 (3<sup>rd</sup> pg.) of the rule

74

## 42 CFR 438-Medicaid Managed Care Subparts A - K

- Subpart A- General provisions (major revisions)
- B- State responsibilities (major revisions)
- C- Enrollee rights and protections (major revisions)
- D- Quality assessment & performance improvement (new)
- E- External quality review (new)
- F-Grievance system (major revisions)
- G- (Reserved)
- H- Certifications and program integrity (major revisions)
- I- Sanctions (minor conforming edits)
- J-Conditions for financial participation (adds new language on disallowances and deferrals, LTSS and encounter data)
- K- (Reserved)
- *Also 42 CFR Parts 431, 433, 440, 457 and 495*

### About Vorys Health Care Advisors

Vorys Health Care Advisors, LLC helps health care providers, business decision makers and professional associations to achieve their objectives in a constantly changing governmental and business health care environment and to assist them in making well informed, strategic and tactical decisions tailored to their individual goals, needs and aspirations.

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