CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid and CHIP Managed Care Notice of Proposed Rulemaking (CMS-2390-P)

Care Coordination

Beneficiary Support System

MLTSS

Centers for Medicaid & CHIP Services

CMS-2390-P

- Notice of Propose Rulemaking (NPRM)
- Federal Register display on May 25, 2015; Federal Register publication on June 1, 2015
- Comments due no later than 5 p.m. on July 27, 2015. May be provided by:
  - Electronically at http://www.regulations.gov
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Background

This NPRM is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002

- Today, the predominant form of Medicaid is managed care using capitated, risk-based arrangements
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals newly eligible for Medicaid

Principles for Change

This NPRM supports the agency's mission of *better care, smarter spending, and healthier people*

<u>Key NPRM Principles</u>

- Alignment with Other Insurers
- Delivery System Reform
- Payment and Accountability Improvements
- Beneficiary Protections
- Modernizing Regulatory Requirements and Improving the Quality of Care

Principle: Alignment with Other Insurers

Aligning Medicaid and CHIP managed care requirements with the Marketplace or Medicare Advantage (MA) to:

- Better streamline beneficiary experience; and
- Reduce operational burdens of managed care plans across publicly-funded programs and the commercial market

<u>Examples</u>

- Medical Loss Ratio (MLR)
- Appeals and Grievances
- Marketing

Principle: Delivery System Reform

To support state and federal delivery system reforms, the NPRM strengthens:

- Strengthens existing quality improvement approaches; and
- Provides flexibility for states to adopting payment reform goals or value-based purchasing models for provider reimbursement

<u>Examples</u>

- Value-Based Purchasing (VBP)
- Withhold Arrangements
- Capitation Payments for Enrollees with a Short-Term Stay in and Institution for Mental Disease

Principle: Payment and Accountability Improvements

The NPRM retains State flexibility to meet State goals and reflect local market characteristics while:

- Ensuring rigor and transparency in the rate setting process
- Clarifying and enhancing State and health plan expectations for program integrity

<u>Examples</u>

- Better defining Actuarial Soundness
- Transparency in the Rate Setting Process and Approval
- Refined Deferral and/or Disallowance of FFP for Non-Compliance
- Program Integrity
- Encounter Data

Principle: Beneficiary Protections

Enhancing beneficiary protections in a managed care delivery system

<u>Examples</u>

- Enrollment Process
- Beneficiary Support System, Including Choice Counseling
- Managed Long-Term Services and Supports (MLTSS)
- Care Coordination and Continuity of Care

Principle: Modernizing & Improving the Quality of Care

Recognizes advancements in State and managed care plan practices and federal oversight interests

<u>Examples</u>

- Network Adequacy
- Information Standards
- Quality of Care

Topics for Today's Presentation

- Care Coordination and Continuity of Care
- Beneficiary Support System
- Managed Long Term Services and Supports

Care Coordination

The proposed rule would:

- Set standards for transition plan when a beneficiary moves into a new managed care plan
- Set standards for managed care plans to conduct a health risk assessment within 90 days of enrollment
- Ensure there is more accurate and timely data gathering and sharing
- Include enrollees with LTSS needs in the identification, assessment, and service planning processes in a person-centered manner

Care Coordination

The transition plan would include:

- Permitting the enrollee to continue to receive the services they are currently receiving from their current provider for a specified period of time;
- Referring the enrollee to an appropriate participating provider
- Assuring that the State or managed care plan provide historical utilization data
- Assuring that the enrollee's new provider is able to obtain appropriate medical records

Beneficiary Support System

- The state would offer personalized assistance before/after enrollment to:
  - Help beneficiaries understand materials and information provided by managed care plans and the State
  - Answer questions about available options
  - Facilitate enrollment
- Assistance to be available via phone, internet or in-person and include:
  - Choice Counseling
  - Training for network providers on community-based resources and supports
  - Assistance for enrollees in understanding managed care and assistance for enrollees who use or receive LTSS

Choice Counseling

- Choice counseling is the provision of unbiased information on delivery system options for Medicaid beneficiaries
- Would be available to beneficiaries when they first enroll, have the opportunity to change enrollment, or must change enrollment
- An entity providing choice counseling would be subject to existing independence and conflict of interest requirements

Managed Long Term Services & Supports

- Propose to implement the policies for MLTSS set forth in the May 2013 guidance for all Medicaid managed care authorities
- The 10 elements established in the guidance and incorporated in this proposed regulation reflect best practices identified in existing programs, ensure adequate beneficiary protections, and provide clear guidance for States seeking to implement MLTSS programs

Managed Long Term Services & Supports

Proposed definition of LTSS for purposes of part 438:

"Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purposes 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."

Managed Long Term Services & Supports

Long term services and supports would include:

- Community based services are primarily non-medical in nature and focused on functionally supporting individuals in the community
- Home and community based services (HCBS) through 1915(c), 1915(i), or 1915(k) authorities
- Personal care services authorized under the State plan
- Individuals receiving LTSS may include those with mental health conditions and substance use disorders

Managed Long Term Services & Supports

Element One: Adequate Planning

- States would need to conduct readiness reviews for managed care plans delivering LTSS (as well as non-LTSS managed care programs)
- Information standards for potential enrollees and enrollees
  - Transition of care policies
  - Provider directory information noting physical accessibility of provider offices and equipment

Managed Long Term Services & Supports

Element Two: Stakeholder Engagement

- States would create and maintain a managed care stakeholder group to solicit feedback from beneficiaries, providers and other stakeholders
- Purpose is to ensure input in the design, implementation and oversight of the MLTSS program
- The composition of the stakeholder group and frequency of meetings must be sufficient to ensure meaningful stakeholder engagement

Managed Long Term Services & Supports

Element Three: Enhanced Provision of Home and Community-Based Services

- Ensures that MLTSS is delivered consistent with all applicable Federal and local rules including the ADA and the *Olmstead* Supreme Court decision
- Provides that services be delivered in settings and in a manner that comports with the Medicaid HCBS final rule published in March 2014

Managed Long Term Services & Supports

Element Four: Alignment of Payment Structures and Goals

- The State's Annual Program Report would include information on improvements in the population's health, beneficiary experience of care, improved community integration of enrollees, and reduced costs

Managed Long Term Services & Supports

Element Five: Support for Beneficiaries

- Beneficiary Support System would include specific supports for individuals receiving MLTSS:
  - Access point for complaints or concerns on enrollment, access to services, or related matters
  - Educate beneficiaries on grievance and appeals process and resources available outside of the managed care plan
  - Review and oversight of LTSS program data to assist the State with identification and remediation of system issues

Managed Long Term Services & Supports

Element Five: Support for Beneficiaries (cont.)

- Would create new for cause disenrollment reason when a residential, institutional or employment supports provider terminates their contract with the managed care plan

Managed Long Term Services & Supports

Element Six: Person-Centered Process

- State would have a mechanism to identify individuals needing LTSS which would also be included in the comprehensive quality strategy
- Assessments and treatment plans for individuals in need of LTSS and those with special health care needs would be comprehensive and conducted by service coordinators with appropriate qualifications
- Treatment or service plans for individuals in need of LTSS would conform with person centered planning standards in the HCBS final rule released in 2014

Managed Long Term Services & Supports

Element Seven: Comprehensive, Integrated Service Package:

- Where services are divided between contracts or delivery systems, the proposed rule would require coordination between all settings of care, including those from PIHPs, PAHPs, and/or fee-for-service arrangements

Managed Long Term Services & Supports

Element Eight: Qualified Providers

- States would establish and monitor standards for MLTSS provider access to beneficiaries
- Managed care plans would ensure that network providers have capabilities to ensure physical access, accommodations, and accessible equipment for enrollees with physical and mental disabilities
- States would establish minimum credentialing and re-credentialing policies for all providers, including LTSS providers

Managed Long Term Services & Supports

Element Nine: Participant Protections

- Managed care plans would participate in state efforts to prevent, detect and remediate all critical incidents
- Critical incidents refer to adversely impact enrollee health and welfare and the achievement of quality outcomes identified in the person-centered plan

Managed Long Term Services & Supports

Element Ten: Quality

- Quality is an element that is incorporated across the full array of managed care services and functions.
- Would require inclusion of MLTSS-specific quality elements including HCBS re-balancing, and mechanisms to assess the quality and appropriateness of care

Questions

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Contact Information

- James Golden, PhD
  Director, Division of Managed Care Plans (DMCP)
  James.Golden@cms.hhs.gov

- Nicole Kaufman, LLM, JD
  Policy Technical Director, DMCP
  Nicole.Kaufman@cms.hhs.gov