

Disability and Aging Collaborative Webinar

Medicaid Managed Care Rule: Implications for Managed Long-Term Services and Supports

Wednesday, June 22, 2016

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National Council on Aging

Disability and Aging Collaborative

- American Association on Health and Disability
- American Association of People with Disabilities
- AARP
- ADAPT
- Alliance for Retired Americans
- Altarum institute
- AFSCME
- ANCOR
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer's Association
- Bazelon Center for Mental Health Law
- Caring Across Generations
- Center for Medicare Advocacy
- Community Catalyst
- Dana & Christopher Reeve Foundation
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Health and Disability Advocates
- Leading Age
- Lutheran Services in America
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- National Committee to Preserve Social Security and Medicare
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- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- SEIU
- United Cerebral Palsy
- United Spinal Association
- VNAA –Visiting Nurse Associations of America



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National Council on Aging

Power Point

- Can I get a copy of the Power Point?
- Will an Archive of the webinar be available?

YES! YES! YES!

- You will receive copies in a follow up e-mail early next week. Please share with others!
- Or visit www.ncoa.org

Questions and Comments



**All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Function**

Webinar Overview

- Introduction
 - Joe Caldwell (National Council on Aging)
- Speakers:
 - Rachel Patterson, Christopher & Dana Reeve Foundation
 - Fay Gordon, Justice in Aging
 - David Machledt, National Health Law Program
- Questions and Answers (15 minutes)



CHRISTOPHER & DANA
REEVE FOUNDATION

TODAY'S CARE. TOMORROW'S CURE.®

Medicaid Managed Care:

Enrollment & Disenrollment

Network Adequacy

Stakeholder Engagement

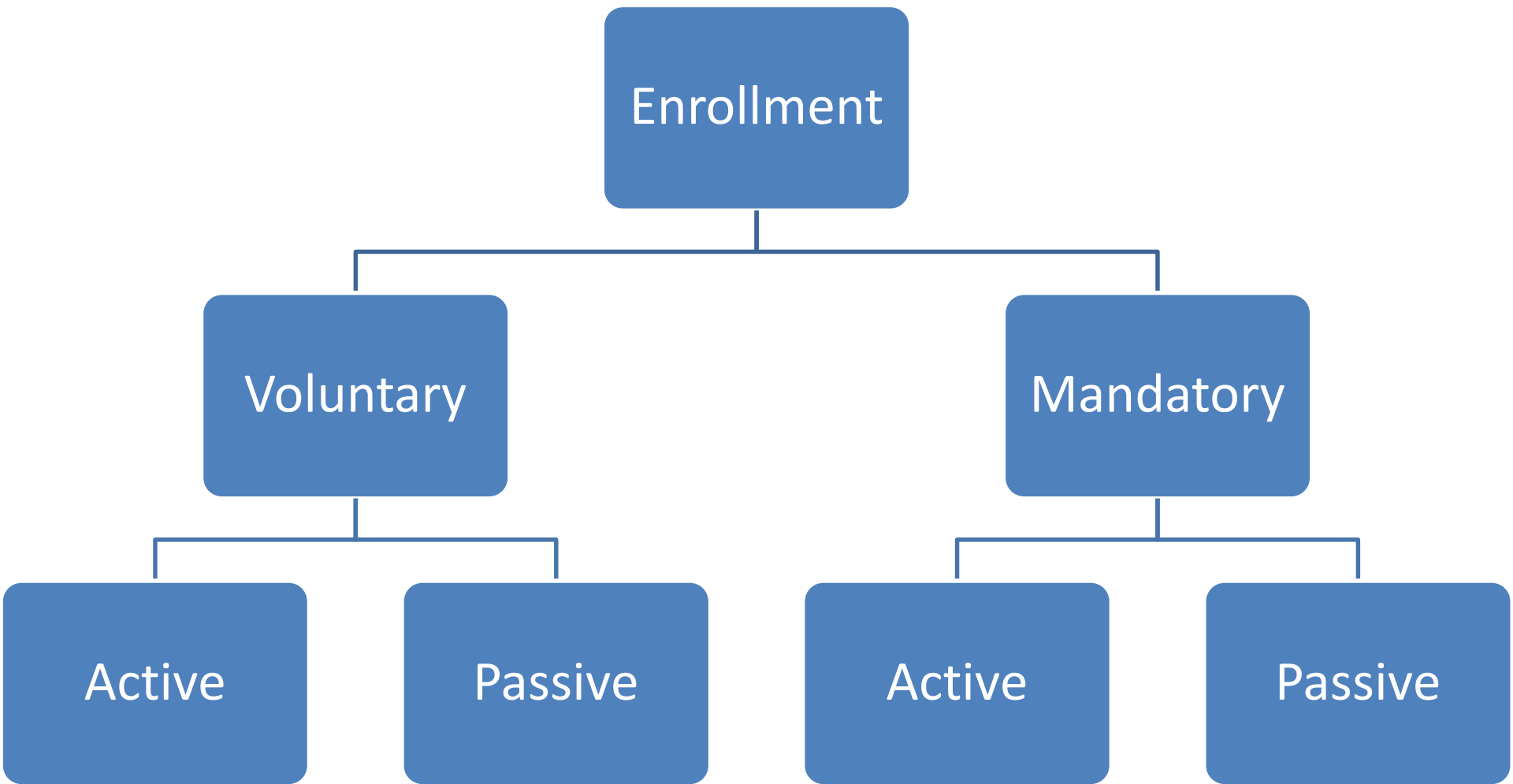
Paralysis Resource Center

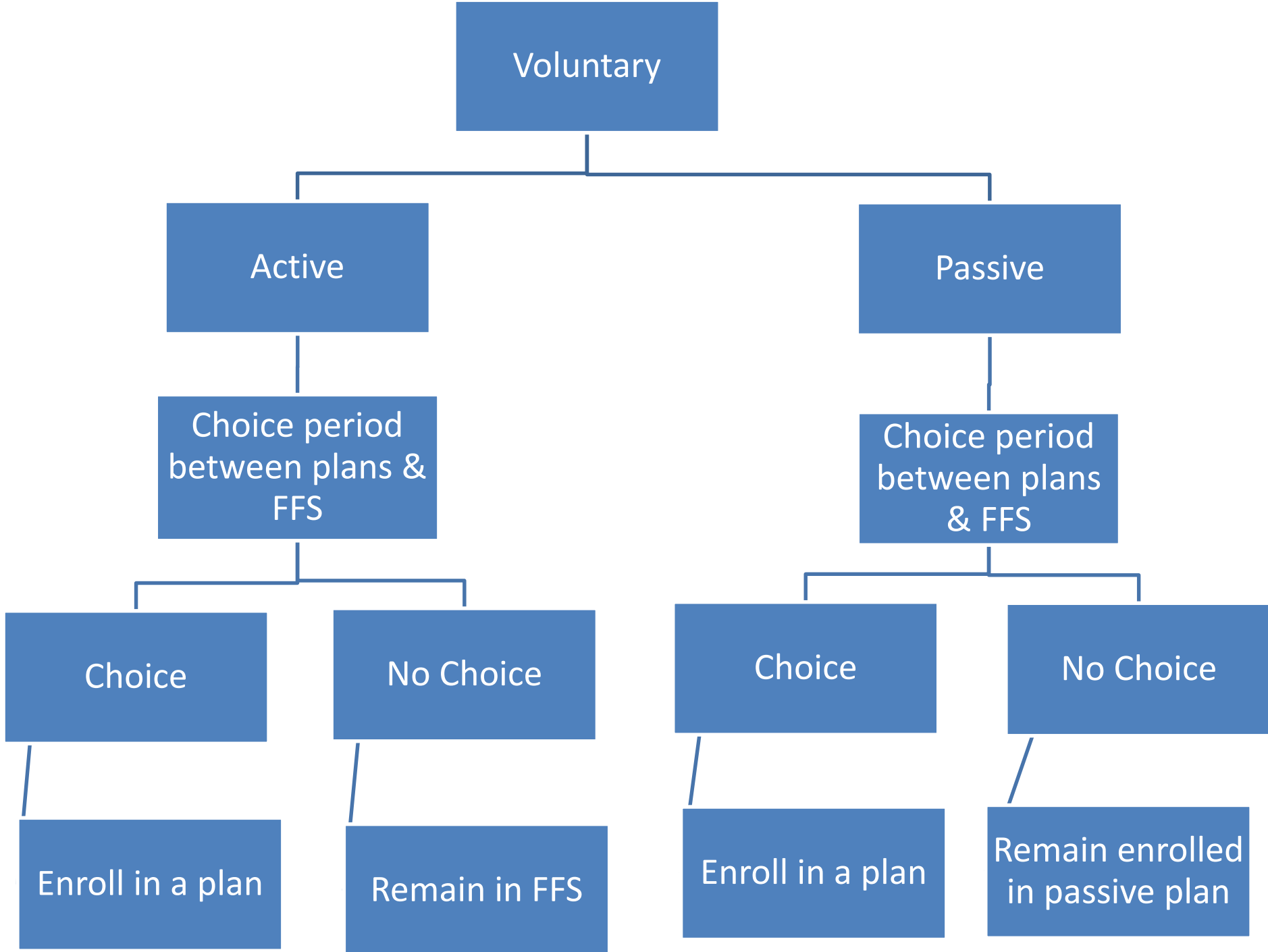
The PRC is a comprehensive national source for free paralysis information, services and programs for individuals with paralysis as well as their families and caregivers.

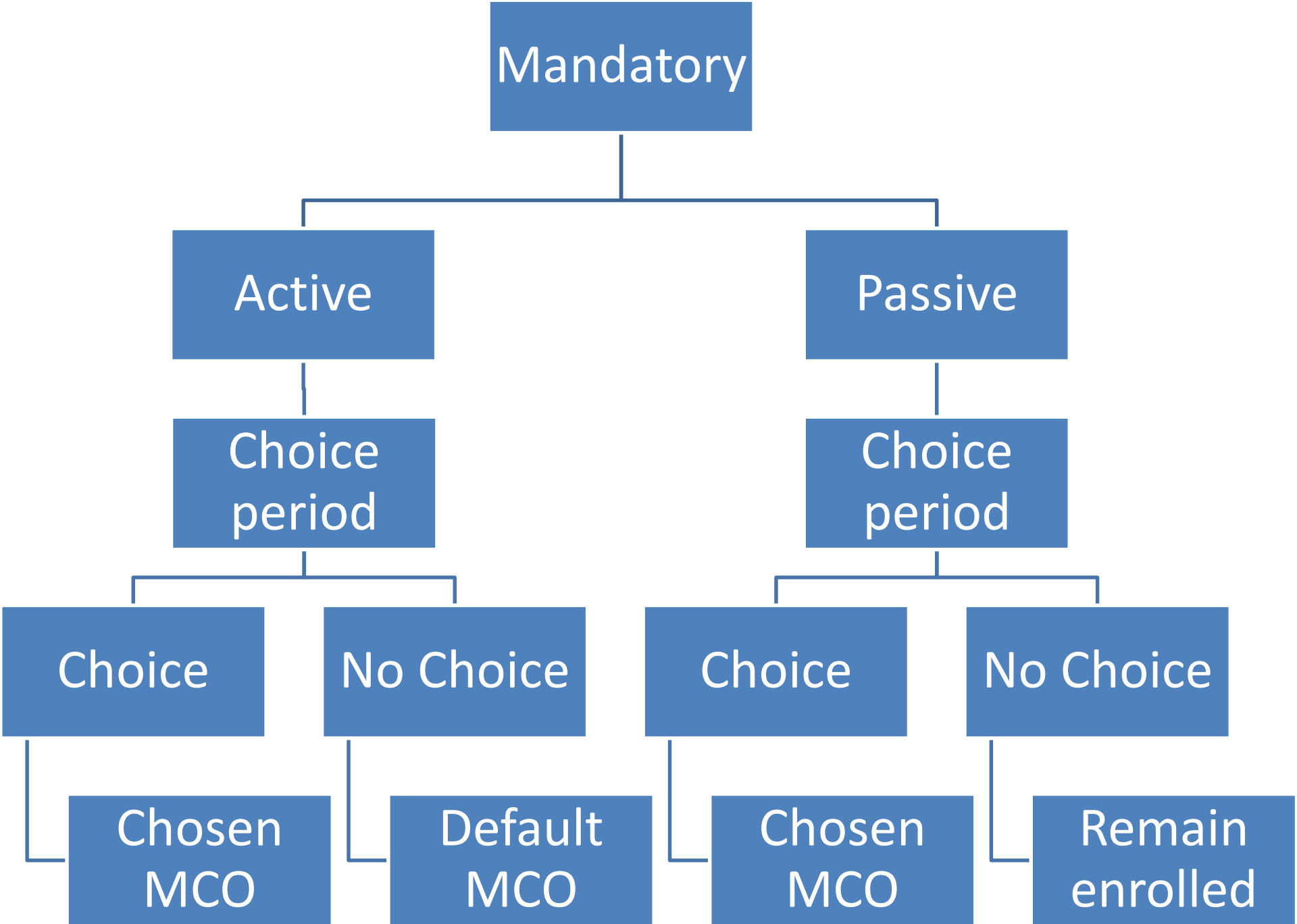




Enrollment and Disenrollment







Information for Potential Enrollees

- State must provide notices that explain
 - MCO Options
 - How to make a choice
 - The choice period
 - 90 day disenrollment period
 - Length of enrollment
 - Implications of selecting an entity, accepting the passively enrolled entity, or doing nothing
 - Contact info for Beneficiary Support System

Information to Passive Enrollees

- If the enrollee does not make a choice and remains in passive plan, the State must explain:
 - That the choice period has ended
 - That he or she is enrolled in a managed care plan
 - The disenrollment rules, including 90 day disenrollment period

Passive or Default Enrollment Considerations

- State must prioritize
 - Continued enrollment in same plan
 - Preserving existing provider-beneficiary relationships
 - Providers that traditionally serve Medicaid beneficiaries
- States may also consider
 - Family members and previous plan assignment
 - Quality assurance and improvement activities
 - Accessibility for people with disabilities

Disenrollment

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graph TD; A[Disenrollment] --> B[Requested by Plan]; A --> C[Requested by Enrollee];
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Requested by
Plan

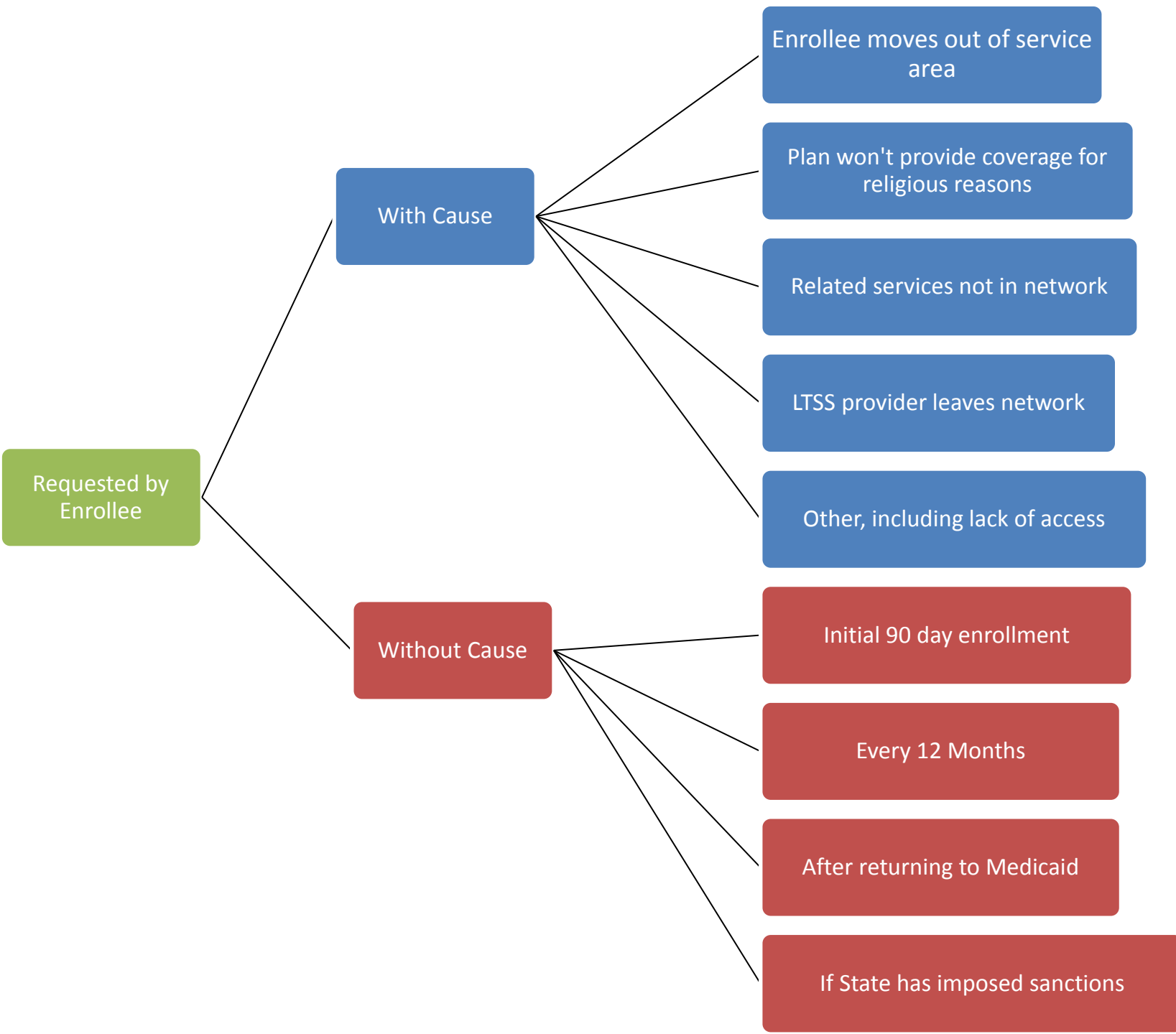
Requested by
Enrollee


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graph LR; A[Requested by Plan] --> B[Contract states reasons]; A --> C[Not for health or cost reasons]
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Requested by
Plan

Contract states
reasons

Not for health
or cost reasons



Disenrollment Timeline

- Effective date of approved disenrollment by first day of second month following the month of disenrollment request
- If state doesn't act, disenrollment is considered approved by same date

JUNE 2016						
SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
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26	27	28	29	30		

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2016 JULY						
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31						

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2016 AUGUST						
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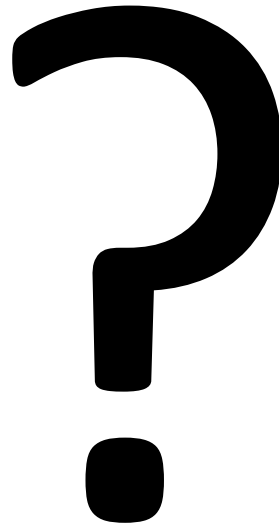
Network Adequacy

Network Adequacy

Network adequacy → Enough providers in your network to adequately serve beneficiaries

Time and Distance standards for specific acute care providers

Network Adequacy Standards for LTSS



Network Adequacy for LTSS

If enrollee must travel → Time and distance standards

If enrollee does not travel → Other standards

Network Adequacy

- States must consider:
 - Anticipated enrollment and utilization
 - Characteristics and needs of the population
 - Number and types of providers required
 - Geographic distribution
 - Ability for providers to communicate with enrollees with limited English proficiency

Network Adequacy – LTSS

- States must consider everything on the previous slide and:
 - Elements that would support an enrollee's choice of provider
 - Strategies that would ensure the health and welfare of the enrollee and support community integration
 - Other considerations in the best interest of LTSS users



Stakeholder Engagement



One State stakeholder Engagement Group



Several Member Advisory Committees, one per MCO



State Stakeholder Engagement Group

- Ensure that views of beneficiaries, providers, and other stakeholders
- Are solicited and addressed
- In the design, implementation, and oversight of State's managed LTSS program
- Composition of the group and frequency of meetings must be “sufficient to ensure meaningful stakeholder engagement”



Member Advisory Committees

- Each MCO must establish Member Advisory Committee
- Committee must include
 - “a reasonably representative sample of the LTSS populations”
 - OR “other individuals representing those enrollees”

Person-centered planning

Beneficiary Support System

Medically Necessary Services

Appeals

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.



Person-centered Planning

Person-centered planning

What's in the regulation:

The treatment or service plan must be:

“Developed by a person trained in person-centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans.”
§438.208(c)(3)(ii).

Person-centered planning

What's in the regulation (preamble):

The treatment or **service plan** must be:

“We recognize the term **treatment plan** is a general medical term...should be inclusive of their person-centered service plan or individual care plan.”

Advocacy!

Person-centered planning

What's in the regulation (preamble):

“Training staff on the person-centered planning process is a legitimate administrative cost for the non-benefit component of the capitation rate.”

Pg.27648

Person-centered planning

What's in the regulation (preamble):

“(I)t is important that states use the process and plan in [the **HCBS rule**] because the service and treatment plans developed under [this regulation] should be **consistent with standards** for a person-centered process.” Pg.27648

Person-centered planning

What's *not* in the regulation:

Training requirements for MCO staff
on person-centered planning

“States are in the best position to determine whether specific training elements are needed given their unique delivery systems.” pg. 27629

Person-centered planning

What's *not* in the regulation:

A caregiver assessment for unpaid caregivers who are required to implement elements of the PCP

“Requiring a caregiver assessment is outside the scope of this regulation and inconsistent with the principle of allowing states utilizing managed care to develop their own assessment standards.” pg. 27646.

Person-centered planning

What's *not* in the regulation:

Quality measures to evaluate access to person centered care.

“While the state must identify performance measures relating to quality of life, rebalancing and community integration activities for individuals receiving LTSS, **the state may** elect to identify additional LTSS-focused areas for measurement.” pg. 27683



Beneficiary Support System

Beneficiary Support System

What's in the regulation:

Beneficiary support system is an independent system to provide choice counseling and assist enrollees post enrollment.

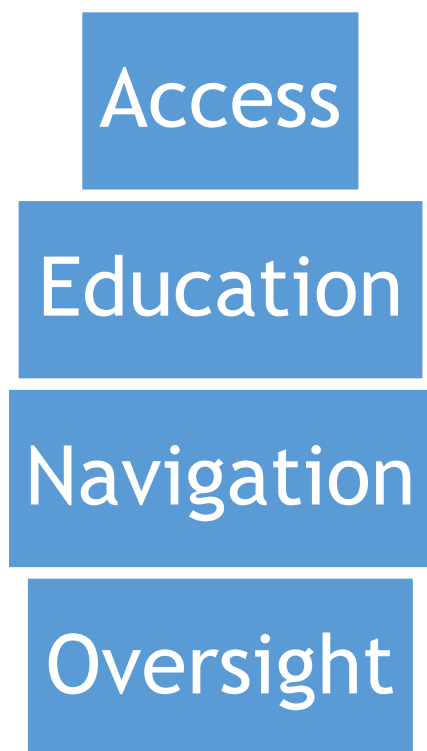
§438.71(d).

Beneficiary Support System

At a minimum-for all beneficiaries:

- Choice counseling.
- Assistance understanding managed care, including LTSS
- Outreach and accessibility to beneficiaries and/or authorized representatives

Beneficiary Support System



For LTSS enrollees, also provide:

- An access point for complaints and concerns about MCOs, services and other issues
- Education on grievance and appeals
- Assistance navigating the grievance and appeals process
- Review and oversight of LTSS systems data to inform Medicaid about systemic issues

Beneficiary Support System

CHOICE
COUNSELING



DIRECT
REPRESENTATION
AT STATE FAIR
HEARING

ONE ENTITY

Advocacy!

Beneficiary Support System

Explanation on funding in the preamble:

- Beneficiary Support System is eligible for federal financial support (FFP) as part of the Medicaid program.
- Legal representation is not an activity eligible for FFP.
- State can include an entity that receives non-Medicaid funding to represent beneficiaries at hearings only if the state requires firewalls to ensure the provisions for choice counseling are met.

Advocacy!

Beneficiary Support System

More on choice counseling
(preamble):

- Choice counseling provider = enrollment broker = conflict of interest standards*

*Exceptions for some choice counseling programs

Beneficiary Support System

What's not in the regulation:

- Requirement that BSS would provide training to MCO network providers on community based resources and supports that can be linked with covered benefits.

Beneficiary Support System

What's not in the regulation:

FUNDING (this is a regulation):

- “States permitted to draw upon and expand, if necessary, those **existing resources** to meet (these) standards.” pg. 27625

Beneficiary Support System

Conditions that must be met for the state to claim FFP for the BSS:

- Similar to current administrative claiming rules for enrollment broker services.
- Costs must be supported by allocation in state's Public Assistance Cost Allocation Plan.
- Costs do not duplicate payment for activities already offered or provided by other programs.
- Services are **NOT** eligible for the enhanced match of 75% but are eligible at the **administrative match rate**.

Beneficiary Support System

What's not in the regulation:

- Clarity on outreach requirements:
 - Must be accessible in multiple ways, including phone, Internet, in-person and auxiliary aids and services.
- Does not include stronger language about cultural and linguistic competence and outreach for limited English proficiency and/or cognitive disabilities.

Beneficiary Support System

What's not in the regulation:

- A limitation on Beneficiary Support System services:
 - “States can choose to expand the scope and types of resources available under the beneficiary support system as appropriate.”



Medically Necessary Services

Definition of Medical Necessity

What's in the rule:

State-MCO contracts will determine the definition of medically necessary services for LTSS

Definition of Medical Necessity

What's in the rule:

The definition cannot be more restrictive than what is used in the State Medicaid program and must

- Address MCO's responsibility for services and supports to:

Have access to the benefits of community living

Achieve person-centered goals

Live and work in the setting of their choice

APPEALS



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Appeals

What's in the rule:

More inclusive terminology:

~~Action~~—NOW: “adverse benefit determination” 438.400(b)

Appeals

MCOs must have ONE level of internal appeal

....But not more than one.

Individual must exhaust internal appeal before going to State Fair Hearing.

438.000(b)

Appeals

NOTICE:

New requirements for what must be included in the adverse benefit determination notice:

How to appeal, how to request expedited appeal
438.404(b)(2)).

Appeals

AID PAID PENDING:

- Individual must request continuation of benefits within 10 days, or before effective date of termination, whichever is later -- even if the authorization has expired by this time.
- Benefits *must continue during the duration of the appeal* regardless of the length of the original *authorization* period (438.20(b)).
- States must create consistent rules for beneficiary financial liability for services in FFS and MCO if enrollees are held financially liable for continued services (438.420(d)).

Advocacy!

Appeals

RECOUPMENT:

- MCOs must provide enrollees with a notice about potential for recoupment.
- CMS will provide MCOs with model notice language to ensure the notice does not discourage enrollee from pursuing an appeal

Advocacy!

MCO Appeal Processes

Internal appeals:

MCO must provide individual with “any reasonable assistance” in completing procedures.

Appeal decision must be made by persons not involved in earlier decision.

Decision-maker must have “appropriate clinical expertise” if clinical issues are involved.

Enrollee must have reasonable opportunity “in person and in writing” to make his or her case.

Info not limited to that presented to MCO at time of initial determination.



Fay Gordon

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Medicaid Managed Care Quality & Accountability

David Machledt, Policy Analyst

June 22, 2016

NHeLP

- Protects and advances the health rights of low-income and underserved individuals and families
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Presentation Overview

Review of changes in Managed Care Final Rule:

- Reporting requirements
- Quality Assessment and Performance Improvement
- State Quality Strategy
- External Quality Review (EQR)
- Quality Rating System

Advocacy tips and opportunities sprinkled in!

New Reporting requirements: Managed Care Program report

- Consolidates reporting requirements from old regulations (like grievances and appeals) and adds new ones
 - Performance data for:
 - Managed Care Organizations (MCOs)
 - Prepaid Inpatient Health Plans (PIHPs) and
 - Prepaid Ambulatory Health Plans (PAHPs)
 - Grievances and appeals
 - Provider network adequacy standards
 - Encounter data will not be included
- Now must be publicly posted as an annual program-level report

Quality Assessment and Performance Improvement (QAPI)

Required quality measures

- State selects, including Long Term Services & Supports (LTSS) if applicable
- Federal (at CMS option)

Performance Improvement Projects (PIPs)

- State selected
- Federal (at CMS option)

Over and underutilization or services

- Compare LTSS authorized hours to actual hours filled, if applicable

QAPI: LTSS and Special Health Needs

- Appropriateness of care furnished to enrollees with special health care needs.
- Quality and appropriateness of LTSS, including:
 - Authorized services versus services actually received.
 - Quality of life;
 - Enhancing LTSS availability (rebalancing)
 - Community integration

Advocacy opportunity: CMS-selected national measures and PIPs (if any) open to public notice and comment

Managed Care State Quality Strategy

- Sets priorities and goals for state quality activities
- Network adequacy standards and evidence-based clinical practice guidelines
- Description of required performance measures and PIPs
- Arrangements for annual EQR
- Description of state transition of care policies

State Quality Strategy: Disparities

- Plan to “identify, evaluate, and reduce...health disparities based on age, race, ethnicity, sex, primary language, and disability status.”
- How state identifies enrollees with LTSS or special health needs

Advocacy Opportunity:

Update required at least every 3 years and after significant changes

- Public notice and comment required

External Quality Review (EQR)

External

- Enhanced match for using External Quality Review Organization (EQRO)
- Independence & competency standards
- Few companies cover most states

Quality Review

- Includes all MCOs and PIHPs
- Mandatory activities:
 - Validation of performance measures
 - Validation of PIPs
 - Compliance review every 3 years
- Optional Activities
- Annual Technical Report

EQR: What's new?

- Expanded to include PAHPs and certain PCCM entities
- Tweaks to strengthen independence standards
- New mandatory activity: validating network adequacy
 - Direct testing of provider networks required in preamble
 - How to assess LTSS network adequacy?
- New option for activities related to star rating system
- Changes to non-duplication rules
- Publicly posted annual report by April 30 each year
- **Lower federal match for entities that are not MCOs**

EQR: Advocacy Opportunities

Federal level – Revising EQR protocols

- Key details on direct testing and active compliance review
- What qualifies for star rating activities

State level – Choices for EQR activities

- Taking up optional activities
- Testing new performance measures or beneficiary surveys
- Maintain archive of EQR reports to track performance, response to recommendations

Quality Rating System

- Parallel to Marketplace system, which is still under development for Qualified Health Plans
- Informed consumer choice is one of the best quality assurance strategies
- Key issues:
 - Choice of applicable measures
 - Relative weight of LTSS
 - Risk adjustment of measures

Quality Rating System: Advocacy

- CMS formal public comment process
- State-level alternative methodologies
 - Optional for states, but requires public notice and comment
 - CMS approval required

Advocacy Tips

- Review CMS recommended core measure sets
- Consider potential beneficiary evaluation tools
- Review National Quality Forum HCBS Quality work group for potential measures for LTSS

Additional Resources

NHeLP Medicaid Managed Care Regulation Issue Briefs:

- [Health Equity](#)
- [Grievance & Appeals Systems](#)
- [Network Adequacy & Access](#)
- [Quality and Transparency](#)
- More coming!!

NHeLP [Comments](#) on Managed Care proposed rule.



THANK YOU

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Questions

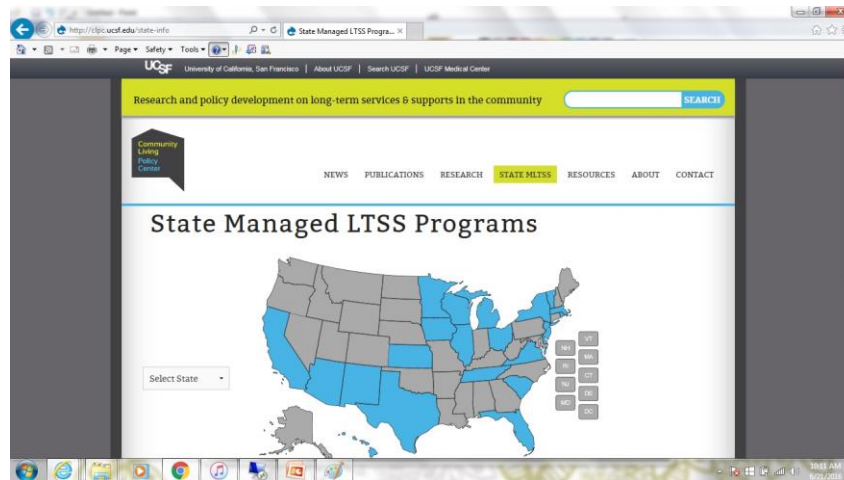
Use chat function in bottom right hand corner

Community Living Policy Center

New State MLTSS tool available

- Information about MLTSS Program
- Access Program Documents
 - contracts, MOUs, agreements, quality documents

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www.communitylivingpolicy.org



National Council on Aging

Thank You

- Everyone who registered will receive a follow up email with the power point and recording
- To access this previous Disability and Aging Collaborative Webinars: www.ncoa.org/hcbswebinars

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