Business Acumen for Disability Community-Based Organizations:

What CBOs Need to Know About Managed Long Term Services and Supports (MLTSS)

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Today's Speakers

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Managed Care

What is Medicaid Managed Care?

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Managed Care is a delivery system states employ to better manage access, quality and cost of Medicaid services.

- Rather than contracting directly with providers, States contract with managed care plans to arrange and deliver Medicaid services.
- Rather than paying providers service by service, managed care plans are paid a set amount each month for each member enrolled.
- Rather than trying to improve quality provider by provider, managed care plans are held to quality standards by contract.

Managed Care Goals

- Accountability for enrollees' outcomes rests with a single entity in an effort to achieve the following:
  - Improve *care coordination* among health care providers;
  - Increase capacity to measure enrollees' *health and quality of life;*
  - Improve the potential to *lower overall costs.*
- Payments allow for more budget predictability for states.
- Delivery of the right care at the right time and in the right place.
  - Example: Calling a nurse advice line to address health concerns rather than visiting the emergency room.

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Managed Care Payment

- Majority of plans are paid a capitation payment each month
- That is an amount per person for all the services covered under the contract – typically identified as a per-member per-month (or PMPM amount)
- That PMPM can vary based on the type of individual covered (child, pregnant women, older adult, person with a disability)
- MCOs must provide all services for that amount of money; if that amount doesn't cover the costs of providing services, the health plan loses money. If the services cost less than the amount paid, the plan will make money.

Types of Managed Care Plans

- The type of managed care plan depends on what services are covered under the managed care contract

- Medicaid programs must provide the following services (called mandatory benefits):

Hospital services	Nursing Facility Services
Home health services	Physician services
Clinic services	Laboratory and X-ray services
Family planning services	Transportation to medical care

Types of Managed Care Plans

- Medicaid programs MAY provide the following services (called optional benefits):

Prescription Drugs	PT/OT/ST
Optometry services	Dental Services
Chiropractic services	Private duty nursing services
Personal Care	Hospice
Case management	HCBS Services

- Most states provide most of these optional services (typical exceptions: dental and chiropractic)

Types of Managed Care Plans

- If a health plan delivers inpatient services as well as at least three of the mandatory benefits, the plan is considered comprehensive and is called a managed care organization (MCO)

- If a health plan delivers inpatient services and less than three mandatory benefits or any optional benefits, the plan is considered to offer limited benefits and is called a prepaid inpatient health plan (PIHP)

Types of Managed Care Plans

- If a health plan does not cover inpatient services and provides less than three mandatory benefits or any optional benefits, the plan is considered to offer limited benefits and is called a prepaid ambulatory health plan (PAHP)
- See example below:

MCO	PIHP	PAHP
Hospital	Hospital	Dental
Physician	Physician	
Lab/Radiology/Home Health	Laboratory	
Prescriptions	Mental Health/SUD	
Mental Health/SUD		

Predominant delivery system for Medicaid beneficiaries

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- 74% of all Medicaid beneficiaries in 2015 enrolled in a health plan (for some or all services)
  - Most are children, pregnant women and parent but include disabled and elderly adults, as well as those receiving long-term services and supports in a number of states
- Virtually all of the 11 million adults receiving coverage under the ACA are in managed care plans
- 39 states deliver some or all Medicaid benefits through either comprehensive or limited benefit health plans
- Capitated health plan payments in 2015 represented **46% of all Medicaid expenditures** *(up from 17% in 2003)*

Medicaid Managed Care Penetration - 2016

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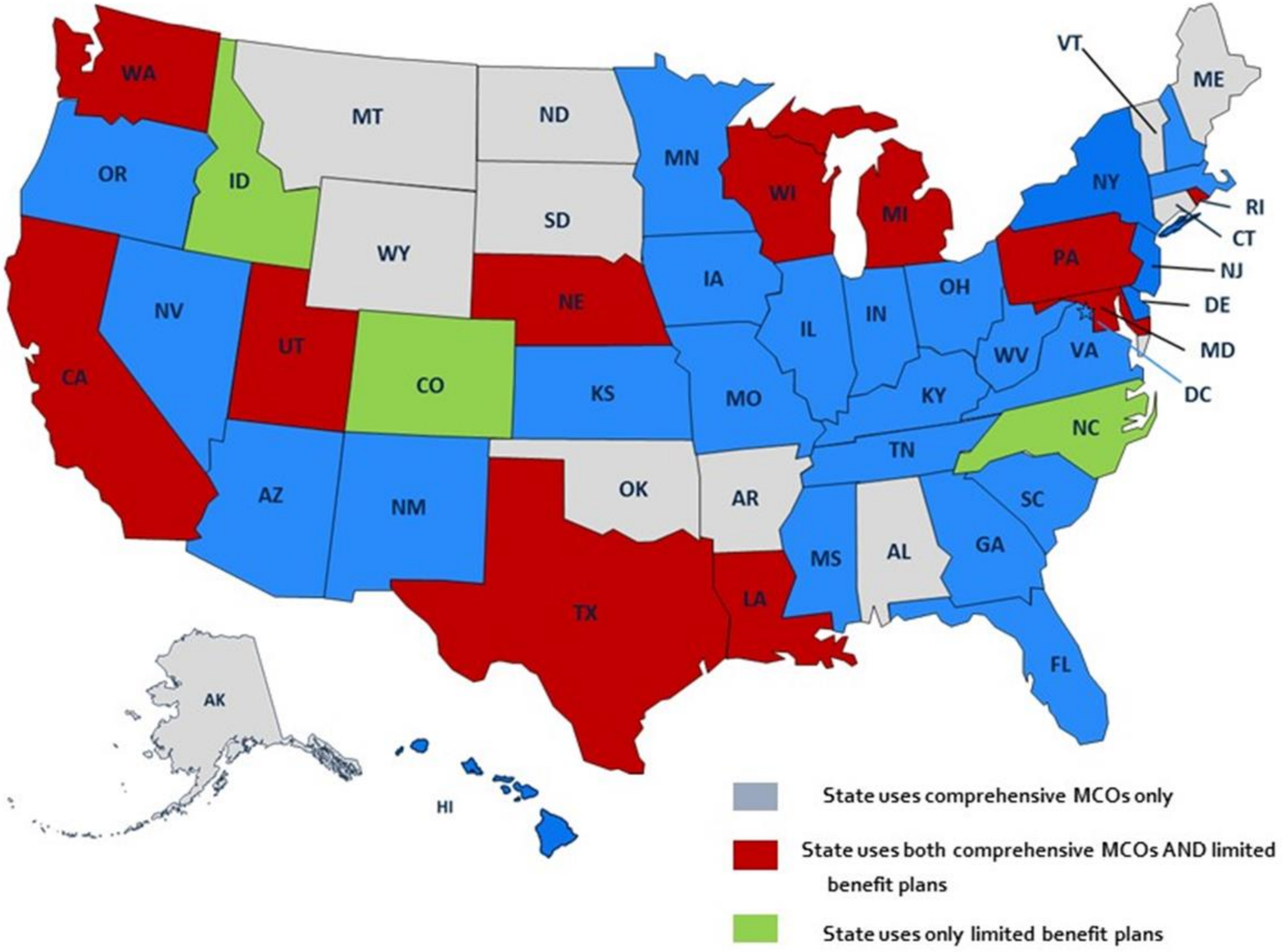

Implementing Managed Care

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- States decide how to structure their managed care program by determining:
  - Who will enroll (eligibility groups);
  - What services will be provided by the health plan;
  - Where the health plan will operate (geographic reach).

- CMS approval is necessary because managed care often "waives" several core Medicaid policies: comparability, statewideness, and freedom of choice.

Implementing Managed Care

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The Social Security Act (which authorizes the Medicaid program) provides four different ways under which states may operate managed care programs (numbers below reference sections of the SSA):

- 1915(a) - Voluntary Program for state plan services
- 1932(a) – Statutory authority for mandatory enrollment in managed care
- 1915(b) – Waiver authority for mandatory enrollment in managed care
- 1115(a) - Research & Demonstration Project

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf

Implementing Managed Care

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- Managed care authorities can be 'paired' with state plan HCBS benefits including
  - 1905(a)
  - 1915(i)
  - 1915(j)
  - 1915(k), or
  - 1915(c)

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf

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- States select the MCOs that they will contract with;
  - Typically done through competitive procurement, although some states take 'any qualified plan.'
- States have to write the MCO contract;
  - State administrative code/legislation, etc.
  - CMS has extensive Federal requirements for MCO contracts.
- States also have to set the payment rates, following CMS guidelines.
- CMS must review and approve both the MCO contract and rates;
  - Federal funds are not available to the state without both being approved.

Implementing Managed Care

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- States have to educate and inform Medicaid consumers about changes that will occur with the transition to managed care;
  - Includes public meetings, website updates, mailings, and provider communication.
- States are required to ensure that MCOs are operationally ready to serve Medicaid consumers;
  - Readiness reviews (required per CMS Final Rule, effective 7/1/17) of all systems and processes - claims, enrollment, encounter data, medical management, and quality.
- States have to ensure that their staff have the necessary skills and knowledge to provide appropriate oversight of MCOs.

Managed Care Plan Requirements

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Key requirements

- Sufficient providers to ensure access to services (network approved and monitored by state);
- Coordinate care for members who have special needs or use long term services and supports (LTSS);
- Measure and report to the state on quality of care;
- Provide access to member services by phone, web, and email;
- Authorize (when appropriate) and pay providers timely for services;
- Have an appeal process for disagreements on service access;
- Spend at least 85% of payments from the state on services and quality activities (effective 7/1/17);
- Implement activities to minimize fraud, waste and abuse.

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Managed Long Term Services and Supports

What are Managed Long Term Services and Supports?

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- The delivery of LTSS *(including both home and community based services (HCBS) and institutional-based services)* through capitated Medicaid managed care programs
- LTSS populations include:
  - Seniors,
  - Individuals with behavioral health needs,
  - Adults with physical or intellectual/developmental disabilities.
- In many cases, plans are covering medical services as well, which provides a comprehensive delivery system for beneficiaries

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf

Current State of MLTSS

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National Association of States United for Aging and Disabilities

Why are States Looking at MLTSS?

- Predictability of cost for state budgets
- Shift of risk
- Administration simplification for states
- Improves care coordination
- Utilizes quality standards to monitor performance

Medicaid Priorities

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Strategies

- Integration Physical and Behavioral Health
- Opioid Harm Reduction
- Value Based Purchasing
- Focus on Social Needs
- Managed Long-Term Services and Supports
- ACO, Episode of Care, Health Homes, DSRIP

Populations

- Seriously Mentally Ill
- Criminal Justice Involved
- Elderly and Disabled
- Duals

Goals

- Cost Containment
- Increase Access
- Improved Outcomes
- Improved Population Health

SOURCE: Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2016.

The Role of Federal Government

- Establishes basic rules and criteria States must follow in the design and operation of a Medicaid program
- Covers a significant portion of the costs of Medicaid (varies by state and population)
- Approves contracts and rates between states and managed care entities

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The Role of State Governments

- Establish program rules, benefits, eligibility, contract provisions and the rates managed care plans will be paid to administer the Medicaid program
- Compensates the managed care plans using a per member per month capitated rate

The Role of the MCO

- Administer the Medicaid program according to the terms of the contract with the state for their assigned Medicaid beneficiaries
- Measured on ability to support their members in receiving preventive treatment, achieving state goals, and meeting other quality metrics established by the state
- Established contracts with providers

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The Role of the MCO

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Managed care plans are required to:

- Have sufficient providers to ensure access to services (network approved and monitored by state)
- Coordinate care for members who have special needs or use long-term services and supports
- Measure and report to state on quality of care
- Provide access to member services (by phone/web/email)
- Authorize (when appropriate) and pay providers timely for services

CMS Guidance to States for MLTSS

1. Adequate Planning and Transition Process
2. Stakeholder Engagement
3. Enhanced Provision of HCBS (Olmstead/ADA)
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/State Oversight
10. Quality

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

1. Adequate Planning and Transition Strategies

- States should use a thoughtful and deliberative planning process with *enough time to outline a clear vision for the program*.
- Elements:
  - Solicitation and consideration of stakeholder input;
  - *Education of program participants*,
  - *Assessment of readiness at both the state and managed care plan level*, and
  - Development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition to and effective ongoing implementation of MLTSS.
  - Development of information technology systems, data collection, and health information technology processes within their MLTSS programs that will facilitate effective management of the program

2. Stakeholder Engagement

- Stakeholders can provide significant insight to the state's planning, implementation, and ongoing oversight of the MLTSS program.
- Stakeholder engagement and collaboration are critical pieces to ensure the smooth and efficient transition for these populations.
- Elements:
  - Provider and beneficiary educational tours,
  - *Multiple educational mailings*,
  - *Transparency in design and oversight of the program*, and
  - State and managed care plan advisory groups
- To encourage participation, MCOs must provide supports such as transportation, interpreters, and personal care assistants; they may also compensate members, as appropriate.

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3. Enhanced Provision of HCBS (Olmstead/ADA)

- Requires MLTSS is delivered consistent with all applicable Federal and local rules including the ADA and the Supreme Court Olmsted decision.
- MLTSS must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation.
- Requires services are delivered in settings and in a manner consistent with the Medicaid HCBS final rule (March 2014)

4. Alignment of Payment Structures and Goals

- Rates shall support the goals and objectives of the MLTSS program
- Payment structures should incent HCBS services over institutional placements

5. Support for Beneficiaries

- MLTSS participants must be offered:
  - Conflict-free education
  - Enrollment/disenrollment assistance, and
  - Advocacy in a manner that is accessible, ongoing, and consumer-friendly.
- Participant choice counseling to understand MLTSS options
- Independent advocate or ombudsman program to assist participants in navigating the MLTSS landscape
- Ability to disenroll and switch to another MCO or FFS when the termination of a provider results in a disruption of a participant's residence or employment

6. Person-Centeredness

- *Compliance with new CMS regulations on person-centered planning*

- Elements:
  - Active participation by the beneficiary, or his/her designee, in the service planning and delivery process,
  - *Meaningful choices of service alternatives*,
  - Opportunity to self-direct community-based services with assurances of appropriate supports.

- Person-Centeredness addresses:
  - Identify what is Important *TO* the person - what makes a person, *satisfied, content, comforted, fulfilled and happy*.
  - Identify what is Important *FOR* the person - what is needed to protect the *person's health and safety, **and** make the person a valued and contributing member of their community.*

7. Comprehensive, Integrated Service Package

- MCOs must provide and/or coordinate the provision of
  - all physical and behavioral health services and
  - LTSS (including institutional and non-institutional) and
  - must ensure participants receive those services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.

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https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

8. Qualified Providers

- MLTSS plans must have an adequate network of qualified providers to meet the needs of their enrollees.
- CMS expects states to assure that MCO networks meet the needs of MLTSS beneficiaries, including adequate provider capacity and *expertise to provide services that support community integration*.
- During transition, states must establish continuity of care standards as well as *mandate the managed care plans to provide training and technical assistance to providers*.
  - Information Technology
  - Billing
  - Systems Operation

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9. Participant Protections

- Those with disabilities and the elderly are at greater risk of abuse, neglect and exploitation, and health disparities.
- Robust *health and welfare protections and monitoring the transition and ongoing operation* of the MLTSS program are critical.
- Essential elements to include in contracts:
  - Statement of participant rights and responsibilities
  - Health and welfare assurances
  - *Critical incident management system* with pathways for reporting known to all entities involved
  - *Strong appeals process* – including fair hearing protections - which allow for continuation of services while appeals are pending

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9. Examples of Participant Protections

- Supported in the most integrated setting available
- Fair compensation for labor
- Able to own property
- Access to Human Rights Committee
- Right to presumptive competency
- Right to be free from excessive medications and regular review of medications if used to modify behavior
- Freedom from abuse, neglect and exploitation
- Privacy

10. Quality

- States should use existing quality systems (waivers and managed care) to create their MLTSS quality framework.
- A *comprehensive quality strategy and oversight structure* that takes into consideration the acute care, behavioral health, as well as LTSS needs of consumers, can provide a framework for states to incorporate more meaningful goals into the program that focus on quality of care and quality of life for the beneficiary.
- States, contractors and/or MCOs must measure key experience and quality of life indicators for MLTSS participants.
- The measures must be specific to the needs of MLTSS participants and data must be collected using best practices for reaching special populations (e.g. face-to-face or telephone interviews, not just mail).

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MLTSS Considerations for people with disabilities

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- Treat people with disabilities with dignity and respect.
- Honor, support and implement person-centered practices and consumer choice.
- Access information understandable to people with disabilities
- Access to the durable medical equipment, assistive technology and technology enabled supports to function independently and live in the most appropriate integrated setting.
- Provide support over the lifespan in addition to a person's episodic needs
- Promote an Employment First philosophy

http://www.ancor.org/sites/default/files/ancor-principles-of-mltss-09052014.pdf

MLTSS Considerations for people with disabilities

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- Maintain a robust and diverse network
- Engage eligible individuals in the transition
- Result in choice for the beneficiary in the most appropriate integrated setting.
- Effectively coordinate primary and specialty health services with any long term services and supports an individual might require.

http://www.ancor.org/sites/default/files/ancor-principles-of-mltss-09052014.pdf

What People with Disabilities Tell Us…

- We want to be safe
- We want support to be independent
- We want to live where we choose
- We want to live with people we love
- We want real jobs

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Managed Care Resources

- **CMS Managed Care Rule:** http://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf
- **Explanation of MLTSS-specific Provisions in Rule:** http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/strengthening-the-delivery-mltss-fact-sheet.pdf
- **CMS MLTSS Principles:** https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf
- **Managed Care State Profiles:** http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-profiles.html

Thank You!

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Next Webinar: June 28th 12:30 p.m. – 1:30 p.m. (EST)