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Moving from FFS to Managed Long Term Services and Supports

Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

Training Objectives

- Review Medicaid Long Term Services and Supports (LTSS) growth trends.
- Understand the federal requirements for developing Medicaid Managed Long Term Services and Supports (MLTSS) programs.
- Understand the basic MLTSS components of the 2016 Medicaid managed care final rule.
- Identify considerations when designing and implementing MLTSS programs.

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MLTSS Definition

- **MLTSS** refers to the delivery of long term services and supports through capitated Medicaid managed care programs.
- MLTSS includes long term services and supports for beneficiaries who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the beneficiary to live or work in the **setting of their choice.**
- Managed Long Term Services and Supports include programs with capitated payments for:
  - **limited Medicaid** benefits;
  - **comprehensive** Medicaid benefit;
  - **comprehensive Medicaid** and **Medicare** benefits.

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MLTSS Growth

MLTSS is growing:

- MLTSS enrollment grew by 75 percent from 2013 to 2014, from about 916,000 in 2013 to more than 1.6 million in 2014.
- The number of states with MLTSS programs rose from 15 states in 2013 to 17 states in 2014.
- MLTSS spending increased 55 percent in FY 2014, accounting for 15 percent of LTSS spending.
- Population of individuals needing LTSS services is expected to increase by almost 70 percent in the next 20 years, particularly individuals 85 years or older.

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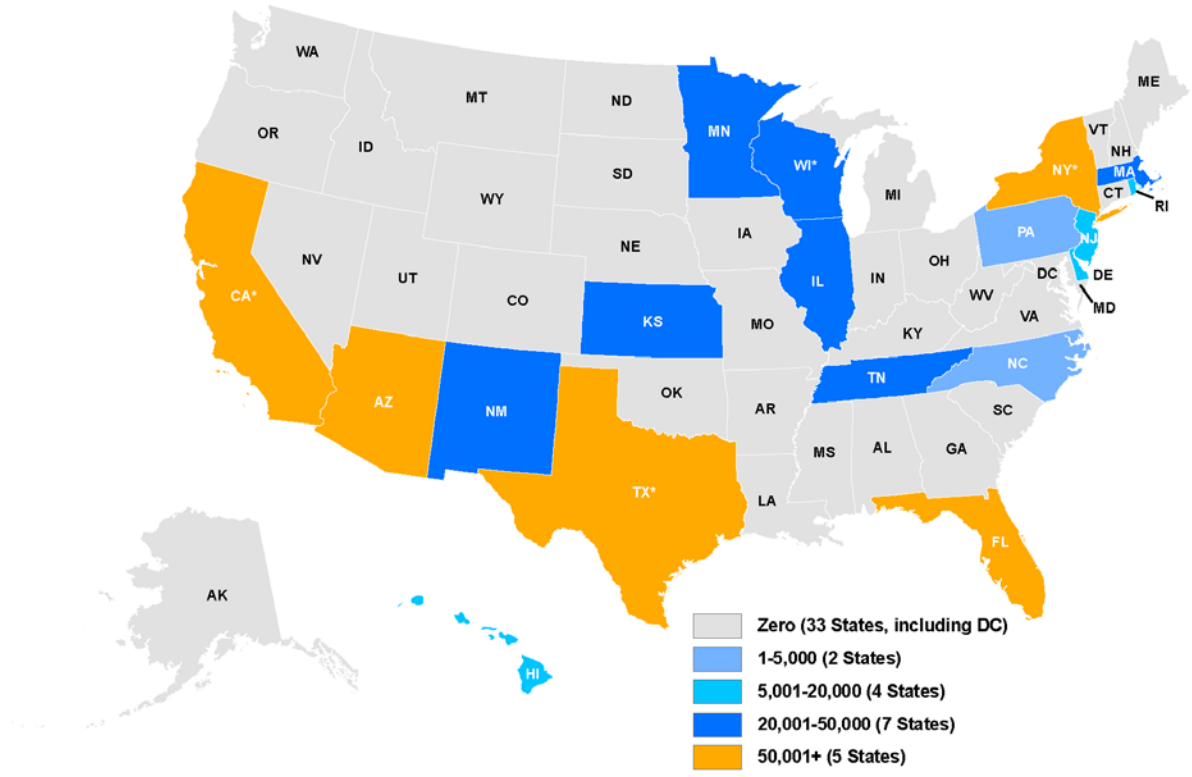
MLTSS Growth

State Counts of Users of Managed Long-Term Services and Supports (MLTSS), as of July 1, 2014.



U.S. Total (including all CA, NY, TX and WI data*): 1,677,686
U.S. Total (excluding some CA, NY, TX, and WI data*): 500,761

Source: Mathematica Policy Research, Medicaid Managed Care Enrollment and Program Characteristics, 2014. Spring, 2016

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Federal Authorities

- States can implement a managed care delivery system using three basic types of federal authorities:
  - **State plan** authority [**Section 1932(a)**];
  - **Waiver** authority [**Section 1915 (a) and (b)**];
  - **Federal Demonstration** authority [**Section 1115**].
- Waivers and Demonstrations are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid.
  - Allows for “waiver” of specific provisions of federal regulation and requirements.
  - By using 1915(c) waivers concurrently with 1915(a), 1932(a), or 1915(b) authorities, states can provide HCBS through managed care.

Federal Authorities

State Plan Authority [Section 1932(a)]:

- Mandatory managed care for certain populations on a statewide basis or in limited geographic areas without a waiver.
- Must be voluntary for certain children with special needs, for individuals dually eligible for Medicare and Medicaid, and for American Indians.

Waiver Authority [Section 1915(a) and (b)]:

- Used to authorize managed care coverage on a voluntary (1915(a)) or mandatory (1915(b)) basis.

Research and Demonstration Projects (Section 1115):

- Gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP program.
- States are given additional flexibility to design and improve their programs.

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Federal Requirements - MLTSS

- 42 CFR Part 438 provides guidance on Medicaid managed care, including quality assessment and performance standards for states that contract with managed care organizations (MCOs).

- In May 2016, CMS released a final rule regarding Medicaid Managed Care which includes rules for the provision of MLTSS. The new rule:
  - Strengthened requirements that MLTSS programs must be implemented and operated consistent with federal laws, including the Americans with Disabilities Act (ADA).
  - Creates an independent beneficiary support system to serve as centralized point of contact for **choice counseling** and to help individuals navigate the managed care delivery system.
  - Requires **person-centered processes** to ensure members' medical and non-medical needs are met and that they have quality of life and level of independence desired.

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Federal Requirements - MLTSS

- Encourages payment methodologies to support MLTSS program goals.
- Establishes standards for:
  - Readiness reviews and information provided to beneficiaries transitioning from FFS to MLTSS.
  - Coordination and referral by the plan when services are divided between contracts or delivery systems to ensure comprehensive member service plans.
  - Evaluation of MLTSS network adequacy, accessibility and qualifications and credentialing of providers.
- Creates structure for **engaging stakeholders** in ongoing monitoring of MLTSS.

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Federal Requirements - MLTSS

- Requires plans to participate in state efforts to prevent, detect and report critical incidents that adversely impact member health and welfare.
- Requires states to incorporate MLTSS-specific elements into **quality strategies.**

Considerations for States in Designing MLTSS Programs

Adequate Planning and Transition Strategies:

- There are many options for designing and implementing MLTSS programs - states have flexibility in determining covered populations, services, and delivery approach.
- States must allow sufficient time to consider program design options, involve necessary stakeholders and develop a clear vision of the program.
- States need to conduct plan readiness reviews and establish transition of care policies.

Stakeholder Engagement:

- Meaningful engagement and collaboration with key stakeholders, including beneficiaries, providers and advocacy groups helps ensure a smooth and efficient transition to MLTSS.
- Stakeholders can provide insight to the state's planning, implementation, and ongoing oversight of the program.
- Continuous involvement of stakeholders provides critical feedback necessary to improve the MLTSS program.

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Considerations for States in Designing MLTSS Programs

Enhanced Provision of Home and Community Based Services:

- Medicaid beneficiaries are entitled to receive services in the most integrated setting.
- Community based LTSS should be delivered in a way that offers the greatest opportunities for active community and workforce participation.

Alignment of Payment Structures with MLTSS Program Goals:

- Payment to managed care plans should support the goals of the MLTSS program, including improving the health of populations, improving the beneficiary experience of care, and reducing costs.
- Tools may include capitation rates that support community integration or performance incentives/withholds tied to outcome measures and quality improvement.

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Considerations for States in Designing MLTSS Programs

Support for Beneficiaries:

- Beneficiary support and education is essential to ensure trust and beneficiary engagement in the MLTSS program.
- Support resources should be independent and conflict-free.
- Areas for support include enrollment/disenrollment services, choice counseling and advocacy/ombudsman services.

Person-Centered Processes:

- Active participation by the beneficiary in the service planning and delivery process supports the establishment of meaningful goals to enhance quality of life and independence.
- Assessments need to be comprehensive and conducted by service coordinators with appropriate qualifications.

Considerations for States in Designing MLTSS Programs

Comprehensive and Integrated Service Package:

- Fully integrated MLTSS programs that include integrated physical health, behavioral health, community based and institutional LTSS enable more effective, comprehensive plan oversight and care coordination across all settings.
- States should include contract provisions for coordination and referrals across delivery systems to ensure service plans are holistic and person-centered.

Qualified Providers:

- MLTSS plans are required to have an adequate network of qualified providers.
- States need to establish and monitor standards for beneficiary access to MLTSS providers.

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Considerations for States in Designing MLTSS Programs

Participant Protections:

- Contracts should include appropriate health and welfare safeguards and assurances, strong critical incident management system, and an appeals process to support patient protections.

Quality:

- Quality strategy and oversight structure allows states to incorporate meaningful goals of the program focused on quality of care and quality of life.
- States should evaluate staffing resources needed to ensure proper quality oversight under MLTSS.

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Considerations for States in Designing MLTSS Programs

Enhanced Education and Support:

- Enhanced Provider and MCO education and support can ease transition and assist with the readiness of MCOs and providers.
- Key areas for MCO education:
  - Contracting processes;
  - New billing practices;
  - Licensure/credentialing requirements;
  - Prior authorizations;
  - Tracking enrollment and disenrollment: Providers must have up-to-date information on their clients' MCO enrollment.

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Considerations for States in Designing MLTSS Programs

Enhanced Education and Support:

- Key areas for enhanced provider education and support:
  - LTSS market and LTSS provider community;
  - Payment methods for LTSS services;
  - Negotiating contracts with small non-profit entities or sole proprietors, e.g. adult day care;
  - Legal liability concerns over participant-directed services among MCOs.

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Considerations for States in Designing MLTSS Programs

Ongoing Program Oversight and Monitoring:

- Strong state oversight of MCOs is essential for effective program management.
- Additional state resources may be needed to support MLTSS program oversight and monitoring.
- States must submit an annual program report on the MLTSS program that is posted on the state's website.

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Considerations for States in Designing MLTSS Programs

- States are required to develop and establish a monitoring system that addresses:
  - Appeals and grievances;
  - Enrollee materials and customer services;
  - Finance, including Medical Loss Ratio (MLR) reporting;
  - Information systems;
  - Program integrity;
  - Provider network management;
  - Availability and accessibility of services;
  - Quality;
  - Areas related to delivery of LTSS.

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Ensuring Successful Transition from FFS to MLTSS

- Use a variety of methods and resources to communicate program information and facilitate beneficiary education.
- Consider phase-in enrollment, or other strategies to minimize disruption, and allow sufficient time for beneficiary choice.
- Engage current providers in new plan networks and allow sufficient time for transition periods.
- Include performance measures to evaluate effectiveness of transition in the first years of the program.
- Ensure availability of sufficient state resources to support ongoing monitoring of MLTSS program.

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Conclusion

- Recent policy developments have increased attention on MLTSS program design.
- Waivers allow states to create flexible MLTSS programs that align with their goals for this population.
- 2016 Medicaid managed care final rule strengthens the approaches of MLTSS programs and beneficiary protections.
- There are several key considerations states must consider as they transition to MLTSS, including increased oversight, training, and monitoring.

Questions

For questions contact:

HCBS@cms.hhs.gov

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