



Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)

**Beneficiary Experience and Provisions
Unique to Managed Long Term Services
and Supports (MLTSS)**

Center for Medicaid and CHIP Services



Background

This final rule 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, which are risk-based arrangements for the delivery of Medicaid services
- 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 in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)

Goals of the Final Rule

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

- To support State efforts to advance **delivery system reform** and **improve the quality of care**
- To strengthen the **beneficiary experience of care** and key beneficiary protections
- To strengthen program integrity by **improving accountability and transparency**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

Key Dates

- Publication of Final Rule
 - On display at the **Federal Register** on April 25th
 - Published in the **Federal Register** May 6th (81 FR 27498)
- Dates of Importance
 - Effective Date is July 5th
 - Provisions with implementation date as of July 5th
 - Phased implementation of new provisions primarily over 3 years, starting with the rating period for contracts starting on or after July 1, 2017
 - Compliance with CHIP provisions beginning with the SFY starting on or after July 1, 2018
 - Applicability dates/Relevance of some 2002 provisions

Resources

- Medicaid.gov – Landing and Managed Care Pages
 - Link to the Final Rule
 - 8 fact sheets and implementation timeframe table
 - Link to the CMS Administrator’s “Medicaid Moving Forward” blog
- ManagedCareRule@cms.hhs.gov to submit questions on the final rule

Topics for Today's Presentation

- Network Adequacy Standards
- Enrollment Process
- Information Requirements
- Appeals and Grievances
- Continuation of Benefits Pending Appeal
- Care Coordination and Continuity of Care
- Beneficiary Support System and Choice Counseling
- Managed Long Term Services and Supports (MLTSS)
- State Monitoring Requirements

Network Adequacy Standards

State Responsibilities

- States will develop and implement time and distance standards for:
 - primary care – adult and pediatric;
 - specialty care – adult and pediatric;
 - behavioral health (mental health and substance use disorder) – adult and pediatric;
 - OB/GYN; hospital; pharmacy; and
 - pediatric dental
- States will develop and implement network adequacy standards for MLTSS programs, including for providers that travel to the enrollee to render services
- States will set standards for the geographic scope of the managed care program – standards may vary due to geography

Network Adequacy Standards

State Responsibilities

At a minimum, states will be required to consider the following:

- Anticipated Medicaid enrollment and expected utilization of services
- Characteristics and health care needs of covered populations
- Number and types of providers required
- Number of providers who have closed panels
- Geographic location of providers and enrollees, considering distance, travel time, and the means of transportation used
- Ability of providers to communicate with limited English proficient enrollees in their preferred language
- Ability of providers to ensure physical access, reasonable accommodations, culturally competent communication, and accessible equipment for enrollees with physical or mental disabilities
- Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions

Network Adequacy Standards

State Responsibilities

- States will be permitted to have an exceptions process for a provider type and, if granted, will need to monitor access on an ongoing basis and include findings in the annual program report
- States will publish network adequacy standards on the State's website
- Upon request, the standards must be made available in alternative formats or through auxiliary aids for enrollees with disabilities (such as American Sign Language or TTY/TDY)

Network Adequacy Standards: Evaluating Compliance

- Managed care plans must submit documentation in a format specified by the state to demonstrate compliance
- At least annually, states will evaluate documentation from each managed care plan and provide an assurance to CMS supported by the state's documented analysis of each network
- All documentation received by the state from the managed care plans must be made available to CMS upon request
- The External Quality Review Organization will be required to validate managed care plan network adequacy during the preceding 12 months for compliance with these provisions

Network Adequacy Standards: Implementation Dates

- Implementation date: The network adequacy standards are applicable for rating period for contracts starting on or after July 1, 2018
- Until that date, the requirements at 438.206 and 438.207 from 2002 rule are applicable
- EQR requirements for evaluating network adequacy are not effective until the issuance of protocols by CMS

Enrollment

- States retain flexibility to design their enrollment processes to best meet population needs and programmatic goals
 - Whether to offer an up-front choice period
 - Use of passive enrollment processes
- State will be required to provide notices to explain implications of enrollees' choices as well as all disenrollment opportunities (without cause and for cause)
- Application of passive and default enrollment processes must preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries to the extent possible

Above provisions apply as of the effective date of the final rule

Information Requirements

- States will operate a website that provides specific managed care information (or links) including each managed care plan's handbook, provider directory, and formulary
 - The State's website may link to the information on the managed care plan's website
- States will develop definitions for key terms and model handbook and notice templates for use by managed care plans
- Subject to certain parameters, States and managed care plans may provide required information electronically if the information is available in paper form upon request and free of charge

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at 438.10 from 2002 rule are applicable

Information Requirements (cont.)

- Enrollee materials will include taglines in each prevalent non-English language explaining the availability of written materials in those languages and interpreter assistance, if requested, and at no cost to the enrollee
- Managed care plans will post provider directories online
 - Updating schedule: paper – monthly; electronic - 30 calendar days after managed care plan receives updated provider information
- Managed care plans will post drug formularies online and make available in paper form upon request

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at 438.10 from 2002 rule are applicable

Appeals and Grievances

- Definitions and timeframes for resolution of appeals are consistent with the private market and Medicare Advantage
- Extends managed care appeals and grievance requirements to Pre-paid Ambulatory Health Plans (PAHPs)
- Managed care plans will perform one level of internal appeal for enrollees to use before proceeding to a State Fair Hearing (SFH)
 - The enrollee must exhaust the internal appeal before proceeding to SFH
 - Managed care plans must provide only one level of internal appeal
- Deemed exhaustion of internal appeal if managed care plan does not comply with timing and notice requirements
- States have the option to offer enrollees an external review so long as that process does not extend timeframes for the appeals process

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at subpart F from 2002 rule are applicable

Continuation of Benefits Pending Appeal

- Consistent with the 2002 rule, the enrollee must request continuation of benefits before the expiration of the original authorization
- Benefits must continue for the duration of the appeal or State Fair Hearing rather than the current requirement of continued benefits for the length of the original authorization period
- Because enrollees may be held financially liable for continued services if the final decision is adverse to the enrollee, States must create consistent rules for beneficiary financial liability for services in FFS and managed care

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at subpart F from 2002 rule are applicable

Care Coordination

- Requires managed care plans to make a “best effort” to conduct a health screening within 90 days of enrollment
- Ensures that each provider furnishing services to enrollees maintains and shares , as appropriate, an enrollee health record in accordance with professional standards
- Expands requirements for identification, assessment and service planning to enrollees with long term service and support (LTSS) needs and requires service planning to be conducted in a person-centered manner

These provisions apply to any rating period for contracts starting on or after July 1, 2017. Until that date, requirements at 438.208 from 2002 rule are applicable

Transition of Care Policies

Requires the State to have a transition of care policy that is also adopted by managed care plans to ensure continued services during a transition from FFS to managed care between plans when the enrollee, in absence of continued services, would suffer serious detriment to health or be at risk for hospitalization or institutionalization.

- Enrollee will have access to services consistent with access they had previously and is permitted to retain their current provider for a period of time if that provider is not a network provider
- Enrollee is referred to appropriate network providers and new provider(s) are able to obtain the enrollee's medical records (consistent with Federal and State laws)
- If transitioning from FFS to managed care, the State complies with timely with requests for historical utilization data from the managed care plan
- Transition of care policy must be described in the quality strategy and provided in materials to potential enrollees and enrollees in accordance with 438.10

Provisions apply to any rating period for contracts starting on or after July 1, 2018.

Until that date, requirements at 438.62 from 2002 rule are applicable.

Beneficiary Support System (BSS)

- Requires the State to arrange for an independent system to 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
 - Assistance for enrollees in understanding managed care and assistance for enrollees who use or receive LTSS

Applies to any rating period for contracts starting on or after July 1, 2018 ¹⁹

Choice Counseling

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

Applies to any rating period for contracts starting on or after July 1, 2018

Managed Long Term Services & Supports (MLTSS)

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 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 worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.”

MLTSS

Long term services and supports include:

- Community based services, 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

MLTSS

Element One: Adequate Planning

- States 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

These provisions apply to any rating period for contracts starting on or after July 1, 2017, except that transition of care policies are in effect as of the rating period for contracts starting on or after July 1, 2018

MLTSS

Element Two: Stakeholder Engagement

- States need to 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

*These provisions apply to any rating period for contracts starting on or after
July 1, 2017*

MLTSS

Element Three: Enhanced Provision of HCBS

- Requires that MLTSS is delivered consistent with all applicable Federal and local rules including the ADA
- Requires that services are delivered in settings and in a manner that comports with the Medicaid HCBS final rule (March 2014)
 - *Provisions apply as of the effective date of the final rule*

Element Four: Alignment of Payment Structures and Goals

- The State's Annual Program Report will include information on beneficiary experience of care, improved community integration of enrollees, and reduced costs
 - *Provision applies to the rating period for contracts that start after release of CMS guidance on the annual program report*

MLTSS

Element Five: Support for Beneficiaries

- Beneficiary Support System includes 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
 - *Applies to rating period for contracts starting on or after July 1, 2018*
- Creates a new for cause disenrollment reason when a residential, institutional, or employment supports provider terminates their provider agreement and it results in a disruption to the enrollee's residence or employment
 - *Applies to rating period for contracts starting on or after July 1, 2017*

MLTSS

Element Six: Person-Centered Process

- State needs to 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 must be comprehensive and conducted by service coordinators with appropriate qualifications
- Treatment or service plans for individuals in need of LTSS need to conform with person-centered planning standards in the HCBS final rule released in 2014

Provision applies to any rating period for contracts starting on or after

July 1, 2017

MLTSS

Element Seven: Comprehensive, Integrated Service Package

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

*Provision applies to any rating period for contracts starting on or after
July 1, 2017*

MLTSS

Element Eight: Qualified Providers

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

Provision applies to any rating period for contracts starting on or after

July 1, 2017

MLTSS

Element Nine: Participant Protections

- Managed care plans are required to participate in state efforts to prevent, detect and remediate all critical incidents
- Critical incidents refer to those incidents that adversely impact enrollee health and welfare and the achievement of quality outcomes identified in the person-centered plan
 - *Provision applies to any rating period for contracts starting on or after July 1, 2017*

Element Ten: Quality

- Requires inclusion of MLTSS-specific quality elements in QAPI programs, including HCBS re-balancing and mechanisms to assess the quality and appropriateness of care
 - *Provision applies to any rating period for contracts starting on or after July 1, 2017*

State Monitoring Requirements: Operational Oversight

States are required to develop and establish a monitoring system for all managed care programs that addresses at least the following:

- Appeals and Grievances
- Enrollee Materials and Customer Services (including the BSS)
- Finance (including the MLR)
- Information Systems (including encounter data reporting)
- Program Integrity
- Provider Network Management (including provider directory standards)
- Availability and Accessibility of Services (including network adequacy)
- Quality
- Areas related to the delivery of LTSS

Provisions apply to any rating period for contracts starting on or after

July 1, 2017

State Monitoring Requirements: Readiness Reviews

- States must assess the readiness of each managed care plan:
 - Prior to the implementation of a new managed care program
 - When the managed care plan has not previously contracted with the state
 - When the managed care plan contracting with the state will cover new populations
- Readiness reviews include desk and onsite reviews and must be:
 - Started at least 3 months prior to the effective date of the events above
 - Completed in sufficient time to ensure smooth implementation and submitted to CMS to support contract approval

Applies to any rating period for contracts starting on or after July 1, 2017

State Monitoring Requirements: Annual Program Report

- States must submit an annual program report on each managed care program 180 days after each contract year
- For States that operate their managed care program under 1115(a) authority, submission of an annual report that may already be required may be deemed satisfactory
- The program report must be posted on the state's website, be provided to the state's medical care advisory committee, and be provided to the LTSS stakeholder consultation group

Applies the rating period for contracts that start after release of CMS guidance on the annual program report

Questions



Future Presentations

In the coming weeks, we will host in depth presentations on the following topics:

- All Times are 12:00-1:30 EST
- May 19 - Quality
- May 26 - Program Integrity
- June 2 - Rate Setting, DSR, and MLR
- June 9 – CHIP
- June 16 – Covered Outpatient Drug

Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

ManagedCareRule@cms.hhs.gov

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations