MAXIMUS Webinar Series

Introductions

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Today's Plan

- We're starting with a high-level look critical changes that will impact state systems.
- We'll focus on the beneficiary support requirements, including enrollment supports and choice counseling.
- We'll delve into the MLTSS related beneficiary supports.
- And we will discussion BSS related issues program integrity and system requirements: particularly reporting and provider management.
- We'll examine these specific sections, but there may be ripple impacts from other parts of the regulation or future CMS direction.

Themes and trends in the new rule

- More standardized approach to managed care across and within states.
- Stronger and clearly delineated beneficiary support systems—from eligibility onward.
- Particular policy standards and requirements related to MLTSS.
- Places considerably more provider management responsibility with the state.
- Quality strategy still to be developed.

What do states need to do

- Each state will be in a different place in the approach they take to respond and things they already have in place.
- Assess your current policies and prepare for change.
  - Legislation may be required and should be built into the schedule.
- Look at your data systems and oversight processes to identify gaps.
- Effective dates are complicated.
  - https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf
  - Compare your contracting cycles with effective dates.

Our agenda

- General Beneficiary Supports
  - Cathy Kaufmann: former Enrollment Program Director at Families USA and various health policy leadership roles in Oregon.
- Beneficiary Supports for MLTSS
  - Sharon Lewis: specializes in HCBS issues. Comes to HMA from her role as Principal Deputy at the Administration for Community Living at HHS.
- Preparing for Compliance
  - Heidi Robbins Brown: focuses on program integrity and compliance. Formerly served as Deputy Medicaid Director at Washington's Health Care Authority.

Strengthening the Consumer Experience

Cathy Kaufmann

Beneficiary Support System

- States must develop and implement a Beneficiary Support System (BSS) that includes:
  - Choice counseling for all beneficiaries
  - Assistance for enrollees in understanding managed care
  - Must perform outreach and be accessible in multiple ways (phone, Internet, in-person), as well as via auxiliary aids and services when requested.
- Subject to existing HHS independence and conflict of interest requirements
- Enrollment broker function incorporated here and expanded to address these new requirements.
- Additional requirements for LTSS enrollees.

Sharing Information with Beneficiaries

- Full range of electronic communications is permitted (email, texts and website posting of required information)
  - Beneficiaries must be able to obtain paper materials upon request at no cost.

- Marketing: Clarifies the limitations do not apply to QHPs even if have a Medicaid line of business

Limited English Proficiency (LEP) & Disabilities Support

- Important member materials must be provided in state's "prevalent" languages:
  - "Prevalent" left undefined, up to states to determine
- Taglines in large print and in locally prevalent languages are required on all written materials.
- Plans required to provide interpretation services in all languages (not just prevalent), as well as auxiliary aids and services for enrollees with disabilities (upon request and free of charge) and to notify enrollees about how to access these services.

Standardization by the State

- States are required to develop standard models for definitions of key terms, member handbooks, and member notices for plans to use.
- States are required to maintain a Medicaid managed care website that provides member handbooks, provider directories, and drug formulary lists.
  - Information can be provided via a link to the managed care plan's website.

Provider Directories

- Provider Directories may be provided online (and by print via request) but updated no later than 30 days after plan receives updated provider information.
  - Printed provider directory must also be updated monthly
- Provider information must include the provider's cultural and linguistic capabilities, including languages spoken and whether the provider has completed cultural competence training.
- Must also note whether the provider's office/facility is accessible for people with physical disabilities.

Enrollment

- Choice period. Eliminated 14-day FFS enrollment requirement in preliminary rule
  - Instead, state must provide potential enrollee, “the opportunity to actively elect to receive covered services through the managed care or FFS delivery system.”
- Standards for voluntary and mandatory plan enrollment processes and notices to beneficiaries
- CHIP: Standards for assignment of a child to a plan when the family does not select a plan
- Significant emphasis on beneficiary education and personalized support when it comes to enrollment

Disenrollment

- If State limits disenrollment by beneficiary choice, plan contracts must provide that a beneficiary may request disenrollment:
- For cause, at any time
- Without cause, at the following times:
  - During the 90 days following the date of the beneficiary's initial enrollment, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later.

Grievances & Appeals

- Requires plans to continue coverage of services pending an appeal decision.
- If an enrollee requests services within an authorization period, the plan may not end coverage at the end of that authorization period.

Care Coordination & Transitions of Care

- States must have a continuity of care policy to ensure continued access to ongoing sources of care during beneficiary transitions (FFS to plan, or from one plan to another)
- Standards expanded to include coordination between settings and with services provided outside the plan (either through a different plan or FFS)
- Plans must make best effort to complete health risk assessment within 90 days of enrollment for new enrollee.

MLTSS Beneficiary Supports

Medicaid Managed Care Final Rule

MLTSS: Overall Approach

- Recognize and codify LTSS within the managed care delivery system
- Focus on both integration of care and community integration
- Shift from medical, acute care only perspective to include the provision of non-medical LTSS
- Incorporates LTSS standards into managed programs
- Requires states to include MLTSS in quality strategies
- Improves MLTSS beneficiary protections, including continuity

Key MLTSS Provisions

- Defines Long-term services and supports (LTSS)
- Includes MLTSS in readiness reviews
- Stakeholder engagement requirements
- Requirements related to HCBS settings
- Alignment of payment structures and goals
- Person-centered planning, coordination across delivery systems
- MLTSS network adequacy and qualified providers
- MLTSS quality and performance measurement
- Reminder of non-discrimination obligations: ADA, Rehabilitation Act, §1557

MLTSS Choice Counseling

- Independent, knowledgeable navigation resource
- Personalized assistance
- Can use existing organizations and systems (must be conflict-free)
- Timeliness in beneficiary assistance
- Additional assistance requirements

MLTSS-Specific Beneficiary Support Functions

- Provide an access point for complaints and concerns
- Education on enrollees' rights, including grievance, appeal, state fair hearing process
- Assistance in navigating the grievance and appeal process, adverse benefit determinations
- FFP is available for this assistance, subject to certain conditions

Conditions for FFP for LTSS BSS Functions

- Allocation methodology in the State's approved Public Assistance Cost Allocation Plan
- Do not duplicate payment for activities
- Conflict-of-interest requirements
- Contract or MOA for services to be reviewed and approved by CMS

Enrollment for MLTSS beneficiaries

- States beneficiary support systems: a tool “to ensure that enrollees fully understand their enrollment and disenrollment options”
- Loss of *required* 14-day choice period, still *allowable*, can be for targeted populations if a state chooses
- No special requirements for LTSS enrollees under §438.54 Enrollment, but additional protections under §438.56 Disenrollment

Disenrollment for MLTSS beneficiaries

- Plan requested disenrollment:
  - Prohibition on disenrollment due to “enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs”
- Enrollee requested disenrollment:
  - 90-day and 12 month protections, no cause required
  - Loss of residential or employment provider can be cause
  - MLTSS subpopulations: “lack of access to providers experienced in dealing with the enrollee's care needs”

Assessments, Care Coordination, Person-Centered Planning

- State must identify persons who need LTSS or special health care needs
- Plans responsible for assessment
- Care and supports coordination required across plans, FFS, community resources
- Consistency in HCBS person-centered planning across authorities
- Service authorizations must reflect ongoing nature of LTSS

Grievances, Appeals and Complaints for MLTSS enrollees

- Complaints and concerns access point
- Assistance in navigating grievance and appeals
- Continuation of benefits pending appeal and hearing
- “Firewall” provision: entities doing choice counseling/legal support
- Consistency of recoupment policy across system

Review and oversight of LTSS program data

- Beneficiary Support System to review LTSS data to provide guidance to the State on identification, remediation and resolution of systemic issues
- States define how Plans must participate in efforts to prevent, detect, and remediate all critical incidents and **the achievement of quality outcomes described in the person centered plan.**

MLTSS changes: Important Actions

- Establishment of Beneficiary Supports System and Functions
- Establish MLTSS network adequacy requirements
- Determine care coordination roles/responsibilities
- Establish MLTSS quality and performance standards
- Ongoing structured MLTSS stakeholder engagement
- Ensure alignments with HCBS regulations
- Review of complaint, grievance and appeals requirements, recoupment policy
- Contract provisions: Do they integrate MLTSS?

New Program Integrity and Reporting Requirements

Heidi Robbins Brown

Goals of the new regulations

The new Medicaid Managed Care Regulations endeavors to achieve four primary goals:

- Support state delivery system reform efforts
- Improve the consumer experience and key consumer protections
- **Strengthens program integrity by improving accountability and transparency**
- Align key rules with those of other health coverage programs

This Section of our presentation will focus on the program integrity and compliance sections of the new regulations and their impacts on states and their contractors.

Strengthening program integrity by improving accountability

What does it mean?

According to CMS, the final rule strengthens Medicaid/CHIP managed care fiscal transparency by:

- requiring transparency in the managed care rate setting process
- adding a standard for the calculation and reporting of medical loss ratios
- **identifying minimum standards for provider screening and enrollment**
- **expanding managed care plan responsibilities in program integrity efforts**
- **adding requirements related to encounter data submissions**

Within each of these areas are tens additional actions that states and their contracted partners need to take in order to implement these rules while maintaining ongoing operations.

Provider Screening and Enrollment

Mandatory Enrollment of Network Providers

- Enrollment in the Medicaid program is now mandatory and will be performed by State Medicaid Programs.
- This change would impose an additional administrative burden on both state agencies and providers that are not currently enrolled with the state agency.
- MCOs would have to update contracting and credentialing processes to account for this new requirement.
- Managed Care Entities can issue temporary provider agreements for up to 120 days pending state-approved enrollment.

Other Enrollment and Review Functions

- States must review ownership and control disclosures submitted by the MCOs.
- States must perform routine checks with federal databases.
- States are also required to perform periodic revalidation of all MCO providers as well.

Strengthening Encounter Data and Data Submissions

Encounter Data Validation

- By contract, states must require MCOs to submit complete, timely and accurate encounter data in the detail and format required by CMS.
- CMS may withhold federal funding for managed care expenditures if the State's ED submission to CMS fails to be submitted in a timely, accurate and complete manner.

Data Certification and Audit Requirements

- The new rule requires MCOs to certify that they have conducted a ”reasonably diligent” review of the data, documentation and information submitted.
- MCOs must submit signed certification that that the data is accurate, complete and truthful.
- Further states must conduct audits of encounter and financial data submitted by MCOs at least once every three years.

Expanding Managed Care Plans' Responsibilities in Program Integrity Effort

Mandatory Disclosures

- MCOs must implement procedures providing for the prompt referral of any **potential** fraud, waste, or abuse
- MCOs must report changes to enrollees eligibility status and to a provider's ability to participate
- MCOs must report to the State within 60 calendar days when it has identified overpayments in the capitated payments

Overpayment Reporting and Payment Suspensions

- MCOs must also establish a procedure for a network provider to report when it has received an overpayment, to return the overpayment and provide the reason
- States must include a defined overpayment recovery process within its MCO contract ***and*** take MCO recoveries into consideration during the rate setting process.
- MCOs must suspend payments to providers at state's request based upon a credible allegation of fraud

Compliance Program Requirements

States must impose new compliance program requirements on MCOs through their contracts:

- MCOs must designate a compliance officer reporting to the top.
- The compliance officer must be an employee of the MCO and must periodically report to the governing body.
- MCOs must establish compliance training and education.
- Dedicated staff are required for internal monitoring and auditing and verification that services billed by providers were actually provided to members.

While many states contracts already include these requirements, states will need to expand or create audit plans to verify these activities.

Summary of Key State Impacts

- Each one of the policy changes and reporting requirements in the proposed rule will require analysis, dedicated staff time, contract amendments, and other programmatic changes that will require significant resources to implement.
- Some of CMS's final program integrity provisions promote consistency with other federal health care program requirements
- Other provisions extend beyond these established standards or incorporate nuances that differentiate the requirements from others standards with which MCOs may be familiar.
- These updates change the legal standards governing disclosure of fraud, waste and abuse, as well as certification of data accuracy, resulting in a significant impact on the potential legal exposure of MCOs and other stakeholders.

Questions | Discussion

Thank You!

Want to discuss further?

Contact:
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