MLTSS 101

November 2, 2021

ADVANCING STATES

Leadership, innovation, collaboration
for state Aging and Disability agencies

Agenda For Meeting

WELCOME AND INTRODUCTION

TODAY'S SPEAKERS

OVERVIEW OF ADVANCING STATES

THE BASICS OF MLTSS

FEDERAL REQUIREMENTS

FUTURE EDUCATION TOPICS

QUESTIONS

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Today's Speakers

Camille Dobson
Deputy Executive Director

Kristin Murphy
Sr. Director of Special Projects

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Background – Camille Dobson

- Currently provide intensive TA to states operating MLTSS programs
  - Develop and manage semi-annual full day conferences on MLTSS
  - Co-author of seven MLTSS Institute papers
- Senior Policy Advisor on Medicaid Managed Care at CMS
  - Primary author of CMS MLTSS guidance and MLTSS sections of Medicaid managed care regulations
- 20 years experience in Medicaid managed care policy and operations
  - Worked in Medicaid MCOs in Maryland leading operations and regulatory compliance for 10 years
  - Managed 1115 waivers focused on Medicaid delivery system reforms at CMS

Background – Kristin Murphy

- Extensive State HCBS and MCE experience
- State of Illinois, Department of Human Services
  - Managed multiple HCBS waivers
  - Oversaw FFS transition to MLTSS
- State and National MCE Leadership roles
  - As Sr. Director of LTSS, operationalized new MLTSS program in Illinois
  - National Director of Complex Care, Centene
    - Provided leadership to local plan affiliates
    - Led initiatives with external partners to promote access and workforce development

Overview of ADvancing States

ADVANCING STATES

Leadership, innovation, collaboration for state Aging and Disability agencies.

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Our mission is to design, improve, and sustain state systems delivering long-term services and supports for older adults, people with disabilities, and their caregivers.

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Provide Leadership, Technical Assistance, and Policy Support to State LTSS Systems in the Following Areas

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MLTSS INSTITUTE
Where policy and practice meet.

Resources on Managed Long-Term Services and Supports

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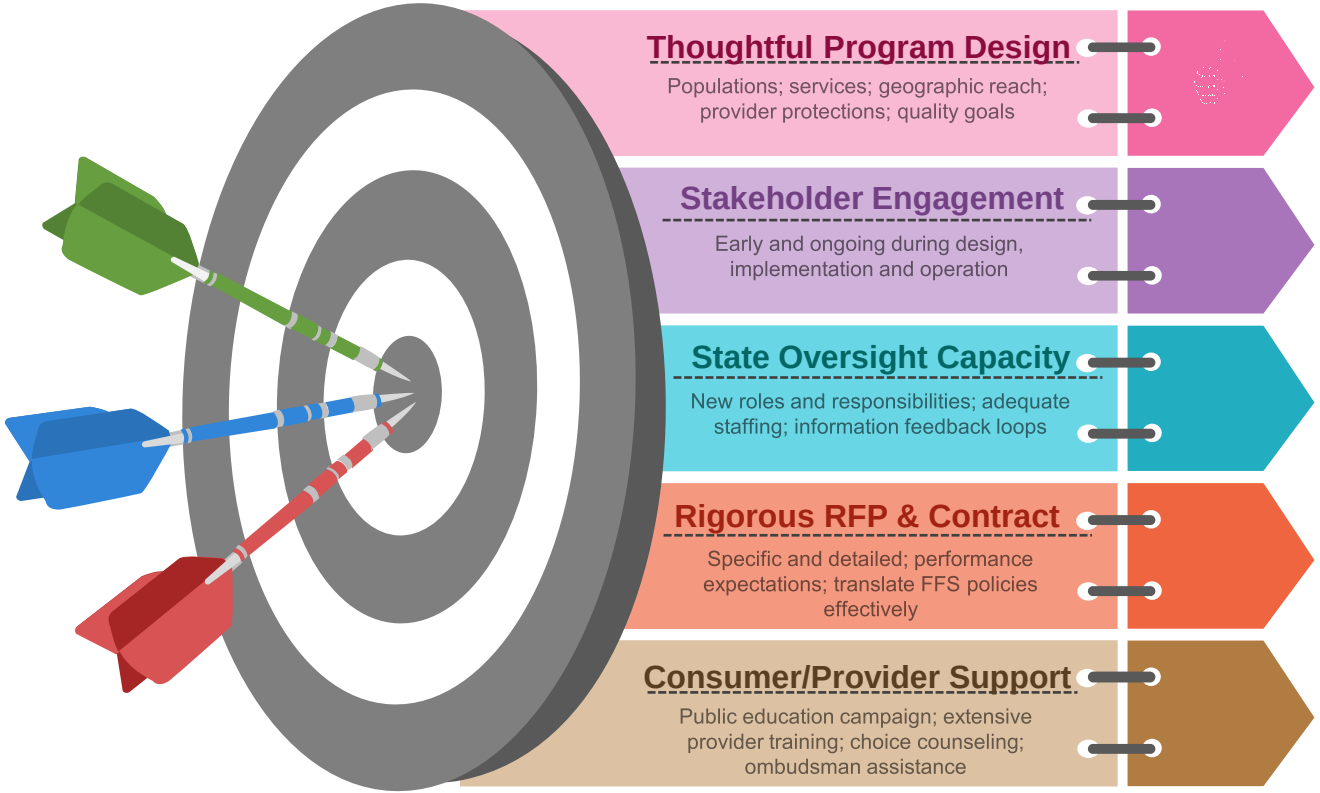
The Basics of MLTSS

Managed Long-Term Services and Supports

- MLTSS is a delivery system that uses managed care entities(MCEs) to deliver long-term services and supports (LTSS) to specified Medicaid beneficiaries
- State decides which LTSS services the MCEs will be responsible for
- MCEs are also often responsible for acute and preventive care services

Key Elements for a Successful MLTSS Program



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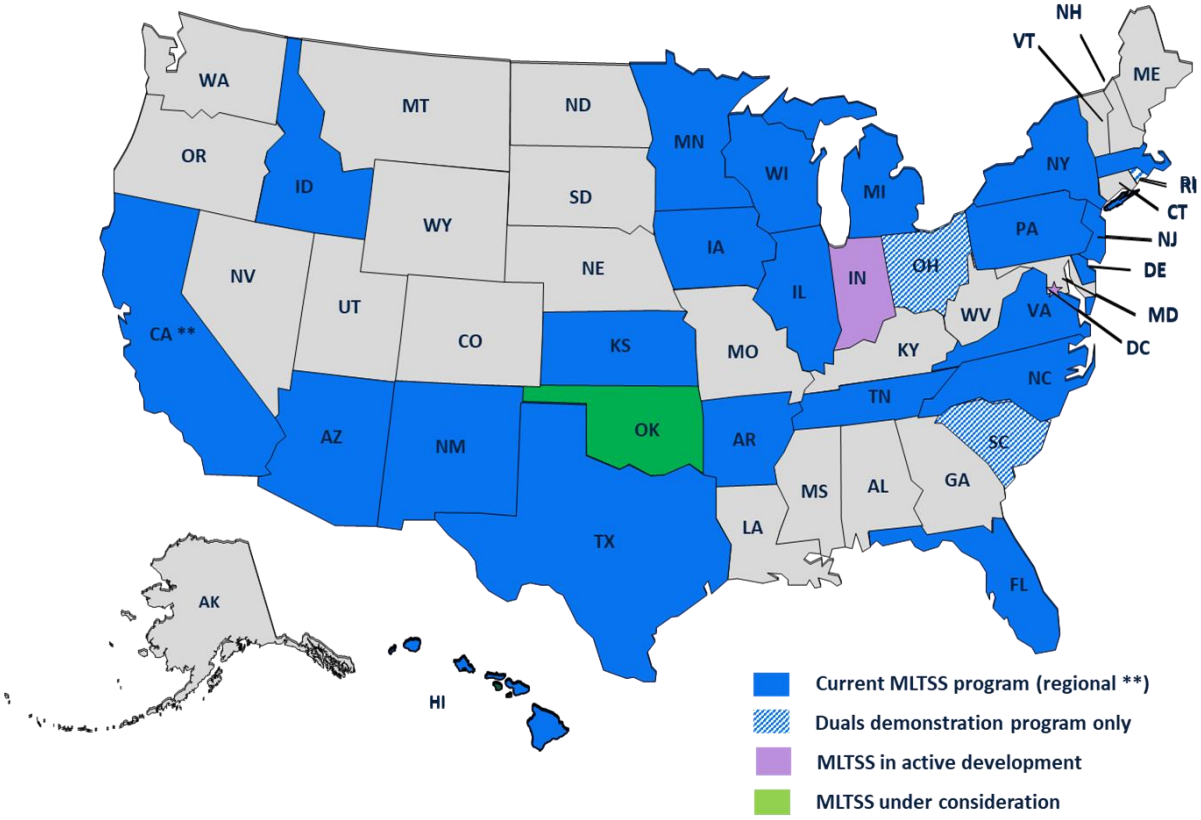
Typical State Goals for MLTSS Programs

Accountability	• State can drive performance through contracting with few entities • Eliminates state-run insurance company
Access	• Reduce HCBS waiting lists • Increased use of primary and preventive care
System Balance	• Increase HCBS options (consistent with consumer desire) • MCEs have incentive to maximize aging at home opportunities
Innovation and Quality	• MCEs have more flexibility in service array than the state • Focus on integrated care and services • Can better measure health and quality of life outcomes
Budget Predictability	• Capitation minimizes unanticipated spending • May slow growth in per-person costs

MLTSS Across the Country – November 2021



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Key Characteristics of MLTSS

Capitated Payment

- MCEs are paid a monthly fee for each enrollee (‘capitation’)
- MCE is responsible for coordinating and ensuring receipt all authorized and covered services.
- MCE is ‘at risk’ in this arrangement:
  - if costs exceed payment, MCE loses money;
  - if payment exceeds costs, MCE makes money.

Capitated Payment

- State needs to guard against underutilization
  - encounter data analysis; medical/loss ratio reports; case audits; complaint data
- Rates must be actuarially sound
- State may pay differential rates per enrollee (rate cells) to MCE based on enrollee's health status
- Value-Added Services (VAS)
  - Not included in payment but many MCEs choose to provide a variety of VAS out of their own funds:
    - memberships to fitness programs;
    - additional hearing/vision benefits;
    - OTC medications

Accreditation

- Most states require MCEs to get NCQA accreditation
- NCQA imposes strict requirements in all the following areas:

Quality Management	Population Health Management
Network Management	Utilization Management
Credentialing	Member Experience

- MCE is expected to ensure that requirements flow down to providers (where appropriate)
- Specific quality measures are required (HEDIS)

Member Services

- Staff available at 800 # to help find provider, answer benefits and other questions
- 24- hour nurse call line to minimize non-urgent use of ED
- Required to provide interpreters (for any member-facing activity)

Provider Network Management

- Detailed provider contract
  - separate from Medicaid provider enrollment process
- Network adequacy & accessibility standards for LTSS providers
- Credentialing process – consistent with state/waiver requirements
- More expansive reporting requirements

Provider Network Management

- Payment
  - State may mandate payment floors as well as move from fee-for-service to Value-Based Payment arrangements
- Special Investigative Unit (provider fraud)
- Formal compliance program to regulate internal processes and external partners and ensure consistency with state/federal requirements

Claims Payment

- Training on each MCE's system
- Timeliness of billing submissions from providers as well as payment to providers
  - Process is virtually always electronic, although state may require acceptance of paper claims
  - Service authorization needs to match
  - Provider billing info needs to match
- Appeals process
- Basis of encounter data reported to state

Case Management/Service Coordination

- Responsible for coordinating full suite of member benefits – both Medicaid and Medicare

- Designated LTSS Care Manager/Coordinator (point of contact)
  - Requires regular assessments, LTSS service planning, and medical care planning
  - May have mandatory caseload sizes and requirements surrounding frequency of visits
  - Communicates regularly with member and providers

- May have subcontracts with service coordination agencies – complexity in knowing who is managing care plan

Case Management/Service Coordination

- Support navigation of service options and benefits (medical, transportation, pharmacy, dental, etc.)
- Population health interventions (risk stratification/disease management programs)
- Transition of Care management (between settings)
- Provide education to individual, families, caregivers (anyone in the circle of support)

Quality

- Formal structure – often will require provider reporting to document process and outcomes
- Medical as well as LTSS metrics - HEDIS
- Member experience/satisfaction surveys (NCI-AD, CAHPS, home-grown surveys, etc)
- Annual external quality review and performance improvement projects (PIPs)

Federal Requirements for MLTSS Programs

Federal Requirements for MLTSS Programs

- The 2016 Medicaid managed care final rule included provisions specific to MLTSS programs
  - all ‘regular’ managed care rules apply, including appeals and grievances, quality, network management, care management, etc.

- They were based on the May 2013 guidance published by CMS outlining expectations for new MLTSS programs using 1915(b) or 1115 authority

Federal Requirements for MLTSS Programs

- The ten essential elements that states are expected to include in their MLTSS programs are:

1. Adequate planning and transition strategies	6. Support for beneficiaries
2. Stakeholder engagement	7. Person-centered processes
3. Enhanced provision of HCBS	8. Qualified providers
4. Alignment of payment structures with MLTSS programmatic goals	9. Participant protections
5. Comprehensive and integrated service package	10. Quality

Federal Requirements for MLTSS Programs

- Application of HCBS regulations to all managed care programs
  - Settings (with appropriate transition period)
  - Conflict of interest
- Network adequacy standards required (including for LTSS providers that travel to members)
- Allow MCE change if NF/residential/ employment provider leaves network

Federal Requirements for MLTSS Programs

Person-Centered Processes

- Service plan must be developed by individuals who are trained in person-centered planning and who meet State's LTSS service coordination requirements
- HCBS characteristics in the HCBS final rule apply to MCE network providers
- State must permit, as part of time-limited transition of care policy, consumer to continue services they had prior to MCE enrollment with current providers (if not in MCE network)

Federal Requirements for MLTSS Programs

Transition of Care Policies

- State must permit enrollee to continue services they had prior to MCE enrollment with current providers (if not in MCE network)
- Federal minimum – 90 days
- State may provide longer transition period for specific services and/or providers

Federal Requirements for MLTSS Programs

Beneficiary Supports

- States must assure choice counseling, an ombudsman-like function, other supports
- States must assure that prior authorization and performance expectations reflect LTSS goals (community integration)
- States and plans must establish stakeholder advisory groups
- Services continue during appeal of denial
- Enrollees must complete internal appeals before State Fair Hearing

Questions

Future Education Topics

Poll

Select the THREE topics that are of most interest to you:

Contracting/Provider Management	Credentialing
Case Management/Service Authorizations	Claims Payment
Data/Technology Expectations	Value Based Payments
Utilization Management	Self-Direction

Thank you!

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