Proposed Medicaid Managed Care Rules: Possible Impact on Seniors and People with Disabilities

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Aging and Disability Partnership for Managed Long Term Services and Supports

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Housekeeping

Questions at the end of each section

Questions in the chat box

Questions by phone with operator assistance

Transcript will be available post-webinar

About the Aging and Disability Partnership:

Partnership established by National Association of Area Agencies on Aging (n4a) as part of the Administration for Community Living (ACL) grant “Building the Business Capacity of Aging and Disability Community-Based Networks for Managed Long-Term Services and Supports.

Partnership between:

- National Association of Area Agencies on Aging
- National Disability Rights Network
- Disability Rights Education Defense Fund
- Justice in Aging
- Health Management Associates

Presentation Purpose and Goals

- Purpose: Provide a clear overview of specific areas in the rule that may impact community-based organizations in the aging and disability network

- Goal: Empowered to participate in commenting process and prepare for potential changes to managed long-term services and supports

Presentation Agenda

- Overview of Key Areas Impacting Community-Based Organizations:
  - Enrollment and Disenrollment
  - Coverage and continuation of benefits during a fair hearing
  - Accessibility
  - Network Standards
  - Stakeholder engagement
  - Medical Loss Ratio and LTSS
  - Beneficiary Support System
  - Other general LTSS issues

Enrollment and Disenrollment-Basics

- State must develop enrollment system with consistent standards for both voluntary and mandatory managed care plans
  - 14 days for bene's to make enrollment decision
  - 14 days FFS coverage while Managed Care plan is being selected
  - Standards for passive enrollment
    - Adequate info on implications of plan decision
    - Confirm of plan enrollment within 5 days
    - Preserve existing bene/provider relationships
- Choice counseling for new enrollee or enrollee changing plans
- New "for-cause" disenrollment if enrollee would have to change b/c LTSS provider no longer in network
- Only one 90 day "without cause" disenrollment per enrollment period

Enrollment and Disenrollment-Considerations

* Is 14 days sufficient time for plan selection; is 30 or 45 days better?

* Other “for cause” reasons for disenrollment?

* Other factors states should be required to consider when selecting a plan for individuals with disabilities and seniors, other than the ones listed?

* Examples of factors that would support the preservation of the provider beneficiary relationship? And

* Examples of “adequate and appropriate information” to be provided to potential enrollees explaining the implications of not making a plan selection?

Coverage and Continuation of Benefits During Appeal-Basics

- “Ensure prior authorization periods support individuals with ongoing or chronic conditions or who require LTSS”
- Continuation of benefits “without interruption until conclusion of [timely] filed appeal”
- Changes Medical Necessity definition (promote compliance with EPSDT and “benefits of community living”

Coverage and Continuation of Benefits During Appeal-Considerations

* Support prior authorization standards and submit examples of the cost efficiency of these standards;

* Is “ensure that service authorization standards are appropriate for and do not disadvantage individuals that have ongoing chronic care conditions or need LTSS” strong enough? if not, what is alternative language?

* Is more detail needed to help states identify the types of LTSS necessary “to facilitate the opportunity for individuals with disabilities to access the benefits of community living?”

Grievance and Appeals - Basics

- Change “action” to “adverse benefit determination” (must include: medical necessity, appropriateness, effectiveness, health care setting)
- State must create formal grievance system – address grievances and appeals
- Plans may require only one mandatory level of internal appeal
- Bene’s can be required to go through this one level before seeking State hearing
- Minimum 60 calendar days for beneficiary to request an appeal

Grievances and appeals continued

- Plans must rule w/in 30 days and expedited appeals w/in 72 hours (extension of 14 days)
- Enrollees have right to information relevant to claim for benefits, free of charge. Includes medical necessity criteria, and “any processes, strategies, or evidentiary standards used in setting coverage limits”; and
- Allows plans to recoup cost from enrollees if enrollee receives a final adverse decision. CMS will provide future guidance on language of this notice – so as not to scare beneficiaries from seeking appeal

Grievances and Appeals - Considerations

- Is 60 calendar days sufficient time for a beneficiary to request an appeal?
- What model language should be required on notices indicating that in the event an enrollee receives an adverse decision on appeal the plan may seek to recoup the cost of defending the appeal?
- How might the requirement to exhaust the internal appeal process prior to pursuing a state fair hearing be an unnecessary burden on individuals with disabilities and seniors? Provide examples if available.

Accessibility – New Requirements

- From the Rule:
  - Three new proposed elements
  - Information formats – paper, electronic, online
  - Information contents – accessibility of provider network
  - Network adequacy – state's establishment of standards to include accessibility considerations
  - Standard non-discrimination contract requirements remain

Accessibility – Information Formats

- States and MCOs must provide information such as enrollee handbooks, provider directories, appeal and grievance notices, and other critical notices to enrollees and potential enrollees in a manner and format that “may be easily understood and readily accessible.”
- Alternative formats and auxiliary aids and services provided upon request and offered at no additional cost
- Taglines in non-English languages and in 18 font print

Accessibility – Information Formats - Considerations

- How will the proposed state and MCO communication obligations impact beneficiaries with disabilities and functional limitations who need alternative formats and auxiliary aids and services?
- How will CBOs within MCO networks meet their own information requirement obligations (e.g., notice of accessibility rights, website accessibility, provision of alternative formats and auxiliary aids and services)?
- "What other critical information do potential enrollees need (e.g., drug formularies)?"

Accessibility – Information Formats

- Considerations for the Aging and Disability Network:
  - How will the proposed state and MCO communication obligations impact beneficiaries with disabilities and functional limitations who need alternative formats and auxiliary aids and services?
  - How will CBOs within MCO networks meet their own information requirement obligations (e.g., notice of accessibility rights, website accessibility, provision of alternative formats and auxiliary aids and services)?

Accessibility – Information Contents

- From the Rule:

- MCO provider directories must include information about "whether the provider's office/facility is accessible for people with physical disabilities, including offices, exam room(s) and equipment"
- This is a new obligation that the rule recognizes as necessary because MCOs are increasingly providing services to persons with disabilities, who cannot meaningfully access "the full scope of services at a provider's office" without accommodations.

Accessibility – Information Contents

- Considerations for the Aging and Disability Network:

- How will the structural and physical accessibility of the healthcare professional network be consistently assessed?
- How can information about reasonable accommodations and effective communication best be collected accurately and in the detail require by enrollees with disabilities?
- Directories – how will updated info be collected – what is the best way to ensure and maintain accuracy?
- The rule appears to recognize the need for non-physical accommodations such as auxiliary aids and services, yet appears to be limited to enrollees with “physical disabilities”?

Accessibility – Network Capacity

- From the Rule:

- Overall approach – state's establishing standards for MCO network capacity and working to "ensure" standards met
- Standards must consider physical accessibility, reasonable accommodations, culturally competent communications, accessible equipment
- Deliberate intention to ensure that there are sufficient and adequate "healthcare professionals" within the MCO network for enrollees with disabilities and LEP individuals, with sufficient access to services
- LTSS providers are encompassed within these obligations

Accessibility – Network Capacity

- Considerations for the Aging and Disability Network:

- What will be the impact on LTSS providers of network standards that extend beyond structural accessibility to accommodations, communication and equipment?
- How can MCOs assist LTSS providers to meet their obligations?
- How can CBOs with accessibility knowledge and expertise work with MCOs to achiever greater overall network accessibility?
- What are effective ways for states to monitor and enforce how MCO provider networks meet physical accessibility and accommodation standards?

Network Capacity – LTSS

- The rule's approach to network capacity establishes states as the overarching responsibility agency that will both establish network capacity standards, monitor MCOs, and enforce the standards
- The rule does establish time distance standards as the fundamental means of establishing network adequacy for medical providers, including mental and behavioral health
- LTSS approach a little different – time distance where enrollees travel to the provider, and standards "other than time distance" where providers travel to the enrollee's home
- CMS establishes a number of additional elements for states "to consider" when establishing both time distance and other standards

Network Capacity - LTSS

- Considerations for the Aging and Disability Network:
  - How has your state monitored and enforced MCO network adequacy in the past and would it meet the needs of Medicaid eligible seniors and people with disabilities?
  - What are other ways that LTSS network adequacy can be measured if providers go to an enrollee's home? What if the provider *does travel* to provider homes (impact of time & distance on provider availability)? Does the division make sense?
  - What are the kinds of "significant changes' in an LTSS network that should trigger MCO notices to enrollees (the examples given in the rule are medical)?
  - Is CMS involvement in network capacity sufficient to support changes under the proposed rule?

Stakeholder Engagement-Rule

- Emphasizes importance of stakeholder engagement.
- Adds a new section requiring states to create state level-stakeholder groups.
- States have flexibility to shape state groups
- MCOs providing LTSS must establish a member advisory committee.

Stakeholder Engagement-Considerations

- What kind of supports do consumers, family members, caregivers, and CBOs need to participate in the stakeholder process?
- How can states and MCOs better engage CBOs in the design, implementation and oversight of MLTSS?
- What information should MCOs and states share with stakeholders?

Medical Loss Ratio and LTSS-Rule

- From the Rule:
  - Medicaid only program that does not utilize MLR.
  - 85% MLR to ensure alignment.
  - LTSS included as health care activity in numerator.
  - Health care activity broad and includes outreach, engagement and service coordination.

Medical Loss Ratio and LTSS-Considerations

- Health care quality definition adequately encompass LTSS?
- What types of activities do MCOs contract with CBOs to provide under existing arrangements?
- Do activities fall under service coordination, case management and community integration support?
- How do these activities improve care and services?

Beneficiary Support System-Rule

- From the Rule:
  - General guidance on choice counseling and four LTSS features.
  - Concept is “similar” to State Health Insurance Programs (SHIPs).
  - All services must be accessible and available in multiple mediums.
  - Funding: minimum cost burden on state.
    - States permitted to draw on and expand existing resources.

Beneficiary Support System-Considerations

- Considerations for Aging and Disability Network:
  - Requirement for MCO training on community based services.
    - Cost estimate: creating and updating provider training materials.
  - Choice counseling cannot have a relationship with MCO as a contracted provider.
  - Entities providing non-Medically financed protections may be able to provide choice counseling with appropriate firewalls.

Beneficiary Support System-Considerations

- Conflict of interest:
  - Firewalls between choice counseling and other federally funded advocacy functions?
  - How to design effective firewalls?
  - Implications of prohibition on CBOs with an MCO contract to serve as a choice counselor?
- Training:
  - How should the System train the MCOs on the Network of community-based services?
  - What should that training include?
- Outreach:
  - What is included in effective outreach to persons with disabilities and older adults?

General LTSS-Rule

- Broad definition of LTSS.
- Medically necessary services definition: must include opportunity to receive LTSS services.
- Capitation rate must be adequate to pay for care coordination and care continuity.
- Service plan must be developed with enrollee participation an incompliance with person-centered planning regulations.

General LTSS-Considerations

- How would you define long-term services and supports?
- Is “opportunity” for LTSS a clear directive to authorize home and community-based services as a medically necessary service?
- How can regulations strengthen consumer rights in the service planning process?

Thank you!

Please contact us with questions:

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