



# ***General Obligations of the State***

## ***Session 1***

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# Disclaimers

- The Session 1 speakers work for the Arizona and Wyoming Medicaid & CHIP programs respectively
- The information presented here is from the perspective of how Arizona and Wyoming apply federal and state requirements to their respective Medicaid and CHIP programs
- When considering these strategies in other states, adjustments may be necessary

# Disclaimer

- All opinions given today are the personal views of David Weeks and do not represent the position of the State of Tennessee or any of its Agencies.

# Session Objectives

Participants will gain knowledge and understanding of:

- The federal requirements that drive State Medicaid & CHIP programs;
- The State's role in meeting federal Medicaid/CHIP requirements;
- The State's right for "state-specific" Medicaid requirements;
- How state's apply federal/state requirements to the implementation of their programs

**Kim Elliott, PhD**

**Arizona Health Care Cost Containment System  
Administrator, Clinical Quality Management**

# Federal Medicaid Codes and Regulations

- The United States Code (U.S.C.) that applies to the Medicaid program can be found at Title 42 Chapter 7. Subchapter XIX (Medical Assistance) and Subchapter XXI (State Children's Health Insurance Program also called KidsCare in Arizona)

# Code of Federal Regulations

- The Code of Federal Regulations (C.F.R.) is the collection of formal regulations that federal agencies publish regarding the programs that they run. The federal regulations about the Medical Assistance (Medicaid) program are found at Title 42 Part 430 and Part 456. The federal regulations about the SCHIP (KidsCare) program are found at Title 42 Part 457

# The Balanced Budget Act Medicaid Managed Care

- Specific to state Medicaid programs that utilize a managed care delivery system
- Additional federal requirements for state monitoring and oversight of MCO's
- Mandates:
  - Structural and Financial Reviews
  - Quality Performance Measures
  - Performance Improvement Projects



# State Waivers

- States may apply for a Waiver that allows the state to be “waived” or not have to follow certain federal statutes and regulations
- Waiver states must run its Medicaid program under Special Terms and Conditions required by the federal government
- States must have a State Plan for the federal Medicaid program

# State Plan

- A document that describes the state's Medicaid program
- May have many amendments
- Describes covered services
- Describes excluded and /or limited services
- Is essentially a roadmap of how the Medicaid program operates in a state

# State Governance of the Medicaid Program

- Governed by state statutes and rules
- Statutes and rules grant the authority of a state agency to administer the Medicaid program
- Arizona statutes are in the Arizona Administrative Code (A.R.S.) which can be found at Title 36, Chapter 39

# State Governance of the Medicaid Program

- Arizona rules are in the Arizona Administrative Code (A.A.C.)
- It is the collection of formal rules that the Arizona state agencies publish about the programs that they run
- AHCCCS rules can be found in Title 9 of the A.A.C. Chapters 22, 28, 29, 30, 31 and 34

# State Medicaid Policies

- Document medical and program policies implemented by the state Medicaid agency for its Contractors and providers for covered services
- Include covered services for the Medicaid program
- Discuss criteria for certain covered services
- Are more specific than rules and can be updated more easily as needed

# State Medicaid Policies

- Administrative and operational policies that apply to Contractors such as Managed Care Organizations (MCO)
- Discuss deliverables to the state Medicaid agency
- Provide guidance (often in the form of Guide) for implementation of certain federal and state requirements
- Provide templates for some reporting requirements

# Contracts

- Arizona is a Managed Care Waiver state
- All members with the exception of American Indians and Federal Emergency Service are enrolled in a managed care program
- The state Medicaid program contracts with MCOs to implement the Medicaid program and provide benefits to members
- The contracts provide another layer of detail regarding requirements for the Medicaid program

# Critical Obligations of the State

- Meet federal (HHS and CMS) Medicaid requirements as well as state requirements
- Access to quality care
- Credentialed provider network
- Care is delivered in the most cost-effective manner – fiscally responsible to taxpayers
- Medicaid members receive care/services in the same manner as non-Medicaid patients
- Minimize fraud, abuse and neglect
- Leading the innovation of health care



# Medicaid Managed Care Staffing

- Most staff are positioned at the MCO's
- Arizona has an entire Division devoted to the management and oversight of MCO's
- Number of positions at the State averages between 80-90 focused specifically on MCOs
- State staffs similar to an MCO such as:
  - Operations, Network and Claims staff
  - IT staff
  - Quality and Medical Management staff

# How the State Conducts Oversight

- Operational reviews
- Ongoing and regular meetings with MCO's
- Deliverables and mandatory reporting
- Data, data, data – look for variances
- Complaints, grievances, appeals
- Audits and studies
- Performance measures and Improvement Projects
- Mini audits

# Example of Contract Enforcement

- State Medicaid agency's data identified extremely high volume of dental care by one provider
- State provided data to MCO's to review and investigate
- State monitored progress with the MCO work
- State Quality Management conducted peer review
- Referred to the Medicaid Office of the Inspector General

# Example of Contract Enforcement

- Referred to the Board
- State discussed issues of monitoring for poor quality, excessive utilization patterns, etc. during meetings with MCO's including
  - Dental Directors and Medical Directors
  - Chief Executive Officer/Administrator
  - Quality Management and EPSDT Coordinator
  - Suspended (or terminated) provider registration number (worked with MCO's on timing)
- Reported to federal databases and NPDB

# Result of Contract Enforcement

- Suspended or terminated provider(s) that provide poor quality of care
- Suspend or terminated provider(s) that have credible or verified allegations of abuse or neglect
- Mandated better MCO processes for monitoring data, investigating and reporting
- Mandated MCO Quality Management take a leadership role in oral health care
- Incentives for MCO's to improve utilization rates

# Results of Contract Enforcement

- Changed contract and policy
  - Dental home assignment for children
  - Changed requirements for Dental Director Key Staff position
  - Added requirement of two signed consents for care
  - Added bricks and mortar requirement
  - Added deliverables specific to oral health care
  - Added performance measures
  - Disincentives (sanctions) for poor oral health performance

# Perspectives Have Changed

- Dental is being discussed at the MCO's
- Appropriate resource being applied
- MCO's are more tuned in to potential dental fraud, waste and abuse
- Attention brought to dental quality of care
- Standards of care being emphasized – evidence based care
- Holding doctors and dentists accountable for their Medicaid obligations

# Benefits of Medicaid Managed Care

- Resources – there is a lot of work to be done
- Qualified Staff –qualified, educated and trained staff that are experts in what they do
- Change Agents –able to change quickly
- Flexible – creative approaches to network development, payment methodologies, not limited in methods used
- Establish high expectations



# Medicaid Oral Health

- Mandatory benefit under the Early Periodic Screening Diagnostic and Treatment (EPSDT) requirements
  - Preventive
  - Treatment
- Optional service adults

# Medicaid Requirements

- Network of contracted health professionals
- Access for Medicaid members should be consistent for those of the general population
- Access to care timelines should be stated for routine, urgent and emergent needs
- Outreach and reminders
- Care coordination assistance – usually through the MCO EPSDT Coordinators

# Dental Periodicity Schedule

- Separate and distinct from the EPSDT Physical and Behavioral Health Periodicity Schedule
- Developed with Medicaid community providers *or* adopted from a nationally recognized source such as the American Dental Association

# Policy Requirements for Oral Health Care

- Must be medically necessary
- Do not cover cosmetic or experimental services
- Limits on frequency of certain services
- Prior authorization of certain services
- Areas of frequent policy discussion include drug seeking behaviors, meth mouth

# Elements of a Good Contract

- Clearly outlines expectations
- Includes most critical expectations – stronger than policy language
- Identifies key staff, how many, what type, what they will do and where they should be located
- Specifies network requirements
- Specifies appointment timelines to ensure access to care

# Elements of a Good Contract

- Highlights mandatory services and incorporates policy documents as part of the contractual requirements
- Incorporates RFP responses as part of the contract – holds MCO accountable to what they said they would or could do
- Specifies minimum system requirements
- Outlines reporting requirements/deliverables

# Elements of a Good Contract

- You won't get the contract right the first time
- Amendments are your friend
- Ensure that you include language that allows the State to change expectations or requirements in a short amount of time
- Key: Include all functional areas as part of the RFP and the contract development team – less will be missed

# MCO Contract Requirements

- EPSDT paragraph that outlines general requirements for oral health care
- Covered services section that provides a limited description of oral health services
- Staff requirements include a Key Staff position of Dental Director
  - Arizona Licensed Dentist
  - Employed or contracted with the MCO
  - Not affiliated with a sub-contracted dental network
  - Participates in the MCO quality/utilization review



# MCO Policy Requirements

- Credentialing
- Quality management/assurance
  - Data trends
  - Individual case
  - Consent requirements
- Medical management
  - High dollar
  - High frequency
  - Volume by provider

# MCO Policy Requirements

- Quality Management Committee
- Medical Management Committee
- Peer Review Committee
- Network requirements
  - Specialty
  - Geography
  - Time and distance
- Non-emergency transportation

# New Requirements

- Assigned Dental Home
  - Who member already accesses for care
  - Assigns based on location if member not accessing care
  - MCO shares panel information with oral health professional
  - Encourages outreach by provider to member for routine and preventive care and services
  - Data monitoring for utilization and outcomes by MCO and Medicaid program

# Primary Care Fluoride Varnish

- Policy developed in collaboration with the Dental Association and the Arizona Chapter of the American Academy of Pediatrics
- Application by the PCP rather than office support staff in order to foster discussion of need to establish a dental home
- On-line training requirement in order to qualify for additional reimbursement

# MCO Performance Measures

- Performance Measures
  - CMS 416 oral health measures – increase by 10% by 2015 (began in 2011)
  - National Committee for Quality Assurance (NCQA) HEDIS utilization measure
  - Analysis by MCO, rural/urban, age, race/ethnicity
  - Best practices shared
  - Intervention failures shared

# MCO Performance Improvement Projects (PIP)

- Maximize activities and interventions by aligning performance measure requirements with a PIP
- May use rapid improvement cycles
- Oral Health Visit PIP Results
  - Baseline: 50.2%
  - Re-measurement post PIP 65.4%

# Medicaid Agency Monitoring and Oversight

- Utilization by MCO
- Utilization by provider
- Utilization by preventive/treatment
- Secret shopper to ensure access to care for routine/urgent, rural/urban
- Credentialing timelines for oral health distinct from physical or behavioral health providers

# Oral Health Reporting

- Federal (CMS) reporting:
  - CMS 416 Report
  - Quarterly and annual quality reports
  - External Quality Review Reports (EQRO)
    - Structural and Financial Reviews
    - Performance Measures
    - Performance Improvement Projects
  - Quarterly Oral Health Provider Lists
  - Access to care reports
  - Credentialing reports



# Lessons Learned

- Contracts need to be specific to what the federal and state requirements are
- Must go beyond requirements and begin the “how” and the “plus” in contract and policy language
- Address identified problems through contract and policy language
- Don't be afraid to sanction for poor performance, not adhering to requirements or expectations
- Require certain expertise, experience or qualifications for MCO staff

# Lessons Learned

- Keep key staff positions local and with authority to implement and take corrective action when necessary
- Limit the number of “hats” MCO staff wear
- Deliverables are your friend and alert you to potential issues
- Data is critical – the more you run reports, review the data and analyze the better the State is at managing the Medicaid program and the behaviors of the MCO’s

# What's Next?

- Mobile care versus bricks and mortar
  - What is good care?
  - Can the two models align to form a dental home?
  - How do school programs fit into the dental home concept?
  - How do Public Health programs fit into the dental home concept?
  - Home visiting for families that don't seek oral health care – can it play a role?

**David Weeks, JD**

**Tennessee Health Care Financing Agency  
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Contracting

Using

*THE CHAIN OF AUTHORITY: The Key  
to Managing Your Program*

# Introduction and Definition

- Chain of Authority is the line of statute, rules, policy, contract and guidelines that establish the legal duties and responsibilities of the State program, an MCC a provider person or a provider entity.

# Chain of Authority as GPS

- Get with an attorney early to help develop Chain of Authority
- Use each “link” in chain to focus your questions
- Use “weak link” or “absent link” to sell policy and language changes

# MOST IMPORTANT SLIDE EVER!

- **No clear authority no wrong conduct!**
- **If you have no cite you have no Authority!!**



# Build a “Chain of Authority”

Remember...the questions are more important than the answers.

# Chain of Authority

- Federal Statute
- Federal Regulations{Comments are your friends!}
- Federal Agency Guidance
- State law
- State rules
- State policy or Guidance or Manuals
- MCC contract
- Provider Agreements
- Provider manuals
- Coding/Billing manuals & determinations
- The wildcard- case law

# 2<sup>nd</sup> MOST IMPORTANT SLIDE EVER!

- ALWAYS check and see if State rules you might have, that generally effect insurance companies, on such topics as:
  - Any Willing Provider
  - Enrollee appeals
  - Network adequacy
  - Prompt pay rules

*Exclude the Medicaid/CHIP programs*

# 3 Step Analysis

- STEP 1-Do I need a link?
  - Example: Link to medical records
- STEP 2-How strong is the connection?
- STEP 3-How strong is the link itself?
- REPEAT STEPS-until chain is complete
  - Testing the chain
  - Improving the chain

# General Chain of Authority Issues

- Know legal weight of various components
- Know state law on rules verses policy
- Know role of ALJs
- Know basic rules re: contract construction
- Great way to forge relationship with your OGC!

# Questions

**Susie Scott**

**Wyoming Medicaid  
Medicaid Kid CHIP Manager**

# There's a new Sheriff in town....

- From Medicaid Look-a-Like to Separate CHIP
    - Why this works in Wyoming
      - *“Keep skunks, bankers and lawyers at a distance.”*
- Public – Private Partnership akin to wearing a white hat.  
Fully Insured program, contractor assuming claim liabilities provides budgetary predictability.



# Public-Private Partnership; Meeting Our Obligations

- *“When there’s a drought everybody is dry; when it rains everybody gets wet; mother nature makes no distinction.”*
- Partnership allows us to meet 42 CFR, Section 457 obligations.
- *“Spring calving makes you forget the hard winter.”*
- Request for Proposal (RFP) process, although arduous, is the mechanism for making certain obligations are met.

# Public Involvement in Program Development

42 CFR, 457 Subpart A

- *“If you’re riding ahead of the herd, take a look back now and again to see if they’re still with you.”*
- Governor appointed Health Benefits Committee.
  - Purpose is to approve proposed benefit package, advise regarding co-pays and exclusions.

# Enrollment Assistance and Information Requirements

42 CFR, 457 Subpart A

- *“ Your fences need to be horse high, pig-tight and bull-strong.”*
- Contractor needs to be capable of accepting CHIP enrollment information in a secure manner compliant with collective privacy and security rules.
- A partner in the design and implementation of new, integrated eligibility system.

## (continued)

- *“Whether a horse turns out to be a good cow horse or a poor one generally depends on the handler.”*
- Contractor responsible for enrollment packet and handbook (customer service).
  - Change notifications for benefits and providers.
  - CHIP specific information on Contractor website.
  - Customer Call Center with identified resources for CHIP member and provider services.

# Assurance of access, quality and appropriateness of care

42 CFR 457 Subpart D

- *You can warm your socks in the oven but that don't make 'em biscuits."*
- Contractor responsible for provider screening, enrollment and credentialing.
  - Consumer Assessment of Healthcare Providers and Systems.
  - Accreditation
  - Required provider enrollment numbers.

# Strategic Objectives and Goals

42 CFR, 457 Subpart G

- *“Once you know where you’re goin’, jump in the saddle, stay on the trail ‘til you get there.”*
- Operational Objectives: improvements in population health and delivery systems.
  - Contract with state’s largest insurer allows opportunity to address substantive issues.
- Goals: strengthening data collection systems, advancing best practices.

# Data Collection and Reporting

42 CFR, 457 Subpart G

- *“When you see a turtle sitting on a fence post, you may not know how it got there, but you can be darn sure it had help.”*
- *Contractor provided claims data, payments, expenditures and utilization enables federal and state reporting.*
  - *Annual, semi-annual, quarterly and monthly reporting.....and the occasional by close of biz!*

# Outreach and Marketing

42 CFR, 457 Subpart A

- *“The time to dance is when the music is playing.”*
- *Contractor markets the CHIP product along with other offerings.*
- *Contractor provides additional event venues not otherwise available to CHIP.*



# Managing the Contract

- Request for Proposal (RFP) is the platform for building the contract.
  - Defines Responsibilities
  - Identifies Scope of Work
- Mitigates the risk of being “all hat and no cattle.”

# Toolbox for Contract Management

- A well-written contract and RFP.
- Communication, Communication, Communication, Communication for all parties involved:
  - Contractor, sub-contractor, CHIP staff, Department of Health leadership.
  - Established communication cadence.
- Appropriate level of resources.

# Questions

# Kim Elliott, PhD

Dr. Elliott is the Administrator of the Clinical Quality Management Unit of the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid and CHIP Agency. Kim participates in numerous Agency and community initiatives including care integration, policy development, contract requirements, quality and performance measures, quality improvement, health home, program evaluation, pay for performance, meaningful use and care coordination. She has been with AHCCCS since 2001, most of which as Administrator of the Agency's Quality Management Unit which includes Quality Assurance/Management, EPSDT/Maternal, Child and Oral Health, Prevention and Wellness, Quality Improvement and the Behavioral Health programs. Kim has participated in CMS Expert Panels related to Medicaid Access to Care and in the development of Core Measure sets. Kim has her Doctorate in Health Sciences, a Masters in Organizational Management, a Bachelors in Business Administration, and is Certified by the National Association for Healthcare Quality as a Professional in Healthcare Quality. Kim is also a Stanford Certified Master Trainer of the Chronic Disease Self-Management Program.

# David Weeks, JD

David Weeks, J.D. is currently an Attorney in TennCare's OGC and has oversight responsibility for both contracting and the Bureau's Program Integrity programs. In this role he was involved with setting up programmatic components of TennCare's enhanced Program Integrity functions such as the Provider Review Committee (PRC), implementation of the Recovery Audit Contractor (RAC) program and drafting the MOU between the Bureau and several other State agencies and coordinates investigations with the U.S. HHS-OIG, the FBI, the U.S. Attorney General's Office and others. In addition, Mr. Weeks works on the review and drafting of the many contracts required to keep the TennCare's system functioning. Mr. Weeks is also a current faculty member at The CMS Medicaid Integrity Institute.

# Susie Scott

Susie is Director of Kid Care CHIP, the Wyoming Children's Health Insurance Program. As Director, she administers the overall direction and management of the program including budget development, federal and state reporting, contractor oversight, strategic planning, policy development and Affordable Care Act implementation pertinent to CHIP. She currently is a member of the National Academy for State Health Policy Eligibility Technical Advisory Group.

Susie's responsibilities within the Division of Healthcare Financing have included external contracting for the Department of Health in the development of the Total Health Record, a certified electronic medical record system available to Medicaid providers and network development for a Health Information Exchange (HIE).

Prior to coming to the Wyoming Department of Health (WDH) Division of Healthcare Financing, she was Director of the Wyoming Healthcare Commission. The Healthcare Commission was legislatively charged with researching and making recommendations regarding the cost, quality, access and obstacles to health reform in Wyoming. In addition, Susie was the public representative on the Wyoming Board of Medicine.

Susie is a fourth generation "Wyoming-ite" with three grown children and three grandchildren.

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