RESOURCES FOR INTEGRATED CARE
Resources for Plans and Providers for Medicare-Medicaid Integration

Transitioning to Managed LTSS: Key Considerations for Providers

As more states move to managed long-term services and supports (LTSS), your provider organization may need to change how it structures its operations and care delivery. Instead of contracting directly with a state, your provider organization will contract with health plans responsible for managing the delivery of services to enrollees. This document outlines some key considerations for your organization as it move into a managed LTSS system.

Key Considerations

- **Prepare for changes in how you interact with your state.** As a provider, you should familiarize yourself with your state requirements and the planned program changes. The way in which you interact with both the state and the health plans operating in the state may vary. Some states delegate oversight and management of key requirements to managed care entities, which then direct and oversee services delivered by the providers. Other states continue to retain authority over specific requirements, including prior approval of all contracts. States may also continue to oversee provider program participation through oversight of provider background checks, credentialing, licensing, certification requirements, and liability or malpractice insurance requirements. State and local professional organizations may provide assistance, support, and information related to program changes in your state and service area.
- **Engage health plans that operate in your state.** You will most likely have the opportunity to work with multiple health plans operating in your state. The entities may range from national managed care organizations to provider and local government plan organizations. You should determine what health plans will be operating in your service area and engage these plans to address any questions you may have. It will be important for your organization to engage each health plan as the policies and practices of across health plans may vary.
- **Under the needs of the clients you will be serving.** You may be required to serve an expanded population from your current experience, as programs move from only Medicaid or Medicare to delivering care and services to both. The needs of these clients will vary and depend, in part, on the populations moving into managed care and on each health plan's enrolled populations. It is important for you to work with your health plans to improve care and increase understanding of your clients' various needs and to obtain any needed training or information to support your care delivery.
- **Understand your accountabilities and responsibilities.** Your organization should prepare for changes in accountabilities and responsibilities as it shifts to a managed care environment. Possible changes include:
    - **Contracting process.** The process of negotiating contracts and managing contractual risk may be more formal and complex than the process that you engaged in when working directly with the state. You may also want discuss your pricing structure with your health plan if your fees are adequately covering your costs.

- **Claims submission.** As a provider you should review the claims or encounter data submission requirements. If contracting with a plan, you may be required to use new standardized claim forms for billing. You may want to discuss opportunities for claims submission training with the health plan and local associations.
- **Training and credentialing.** The plans that you contract with may have licensure/credentialing requirements to participate in their network that you may not have encountered before.
- **Client eligibility.** Health plans may change members' access to certain services, whether related to home and community-based services (HCBS) or for other specific programs such as care management. You will want to know how quickly health plans will be moving members into new programs and in which service areas, so that you are better able to plan. You will also need to know whether enrollment in a given plan will be mandatory or voluntary; this will impact enrollment outcomes and may impact your expected patient volume.
- **Prior-authorization.** Health plans may have requirements for prior authorization (obtaining plan approval prior to delivering services), visit/ service caps (limits to the numbers of visits/ services that the plan will pay for per patient), and other potential service restrictions. Health plans will also have formal processes in place to make these determinations and for patients to appeal the decision. Understanding these requirements and policies and ensuring that these requirements are met is critical for avoiding payment delays and potential cash flow challenges.
- **Care coordination.** Health plans may implement new care coordination and/or service planning programs; as a provider, you will need to understand your role in these activities and identify any training or support provided by the health plans.
- **Reporting and record-keeping**. Many states will delegate responsibility for enforcing specific requirements for clinical, quality, utilization, and financial reporting to health plans. Health plans may pass these requirements on to you and other network providers; specific performance expectations should also be clarified. Verify the types of financial and/or administrative records that you will need to maintain. You may also want to review your office information systems and record storage capabilities to determine whether current capacity will meet health plan requirements.