SUMMARY • MAY 2013

NSCLC
National Senior Citizens Law Center

Summary of CMS Guidance on Managed Long-Term Services and Supports

The Centers for Medicare and Medicaid Services (CMS) has released long-awaited guidance for states and stakeholders on the use of managed care for long-term services and supports (LTSS). The guidance consists of two documents, each of which sets forth 10 elements that CMS believes should be incorporated into managed LTSS (MLTSS) programs. One document summarizes these elements; the other document discusses the elements in significantly more detail.

At the same time, CMS also has released two documents prepared for CMS by Truven Health Analytics. One document discusses the transitioning of LTSS providers into managed care systems, and the other sets forth a timeline for developing MLTSS programs.

Consumers and their representatives will want to be very familiar with the CMS guidance when advocating with states regarding MLTSS. This summary sets forth some noteworthy aspects of the 10 elements, and also briefly discusses the documents prepared by Truven Health Analytics. This is not meant as a full summary of the elements, as CMS already has provided that in its documents.

Element #1: Adequate Planning and Transition Strategies

CMS requires states to engage in a thoughtful, deliberative planning process that, among other things, allows for the solicitation and consideration of stakeholder input. In initial proposals to CMS, states must specify their plans for educating stakeholders about MLTSS, and for transitioning consumers to MLTSS.

The transition to MLTSS should be designed in a way that reduces the risk to consumers, "which might mean phasing the program in gradually depending on the size of the state and program." During MLTSS implementation, each state must have a plan for rapid identification and resolution of problems. During that same implementation period, states, managed care plans, and contractors (such as enrollment brokers) must publicize how consumers can obtain support, for example, assistance from a hotline or ombudsman.

Element #2: Stakeholder Engagement

Stakeholder Involvement in Planning

CMS requires each state to implement a stakeholder engagement strategy, and report on that strategy to CMS. Among other things, the state must establish a formal MLTSS stakeholder advisory group that includes cross-disability representation of individual participants, as well as community, provider, and advocacy groups. If the advisory group has a broad charge—e.g., advising on the entire Medicaid program—the group must develop a subcommittee or other mechanism to ensure adequate attention to MLTSS.

Importantly, CMS emphasizes the importance of consumer participation in stakeholder processes: "Consumers must be offered supports to facilitate their participation, such as transportation assistance, interpreters, personal care assistants and other reasonable accommodations, including compensation, as appropriate."

To enable broad public input, states must hold events in accessible locations, and must provide other means of input for those who cannot attend in person, such as remote site technology or web-based input opportunities. States are "strongly encouraged" to maintain and publicize websites with MLTSS information; such sites ideally should include a mechanism for comments and for asking questions.

Each state should post its concept paper or related descriptive material "prior to submission to CMS" and, subsequent to submission, also should post any updated or modified materials. Submission of a proposal to CMS should include a summary of comments received and any changes made in response to such comments. It should be noted that waivers granted under Section 1115 already are subject to notice-and-comment requirements that exceed those laid out in this guidance.[1]

Stakeholder Involvement in Implementation and Oversight

CMS also requires a state to develop and report to CMS a strategy for stakeholder engagement during implementation. The strategy must include state-level advisory committees, and communications with consumers. States should involve stakeholders in the design of program evaluations and the monitoring of program performance.

In addition, states should provide educational sessions for community-based organizations (CBOs) so that those CBOs can work within the MLTSS system and answer consumers' questions. Managed care plans should be required to convene accessible local and regional advisory committees. To encourage participation in these committees, plans should provide supports such as transportation, interpreters, personal care assistants, and (as appropriate) compensation. Plans should regularly report to the state on consumer participation.

Transparency

The guidance requires states to "consider MLTSS program transparency to be an essential element of their program, such that participants, stakeholders and the

1 *See* CMS State Health Official Letter #12-001 (April 27, 2012), available at www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-001.pdf.

public may be fully informed about the operation and outcomes of the program." Unfortunately, however, CMS provides relatively little detail about what type and level of transparency might be required. The guidance requires "regular communication" with stakeholders, including development of a state webpage devoted to MLTSS, but this requirement likely falls short in the eyes of most consumer advocates. An important aspect of transparency is the ability to review and comment upon policies before they are finalized. Ongoing advocacy with CMS and the states will be necessary to obtain this level of transparency going forward.

Element #3: Enhanced Provision of Home and Community-Based Services

The guidance reminds states of their obligations under the Americans with Disabilities Act, pointing out that states and managed care plans must offer services in the most integrated setting possible. Also, states in their MLTSS benefit packages are "encouraged" to include supports for workforce participation, such as personal assistance services, supported employment, and peer support services.

Home and community-based services (HCBS) must be provided in a home-like setting, i.e., either in a home, or in a residential care facility (such as an assisted living facility) that complies with CMS's standards for community-based care. It should be noted that there is still some ambiguity as to exactly what CMS requires for a setting to be considered "community-based." CMS proposed regulatory language in 2012, but that language has not been finalized.[2] In October 2012 and February 2013, CMS set standards for community-based settings in MLTSS waivers for New Jersey and Florida, respectively, but those standards do not automatically apply outside those state-specific waivers.

Element #4: Alignment of Payment Structures with Managed LTSS Programmatic Goals

CMS requires that rates be sufficient to ensure adequate participation of managed care plans and providers. To properly incentivize community-based alternatives to nursing home care, capitation rates should include both institutional and non-institutional services.

According to the guidance, financial incentives should include both sticks and carrots: specifically, performance-based incentives and penalties. Any incentives should be based on the state's goals for the MLTSS program—for example, on whether services are provided in the most integrated setting, or whether consumers are satisfied. A state must develop mechanisms to evaluate the efficacy of all payment structures and procedures.

Element #5: Support for Beneficiaries

According to CMS, consumers in the enrollment process should have access to choice counseling, which must be provided by an entity which is not a health plan, a service provider, or an entity making eligibility determinations. Auto-assignment

2 *See* 77 Fed. Reg. 26,362 (May 3, 2012).

to a plan should only be done when a person does not make an affirmative choice, and any assignment should follow an intelligent process that takes into account the person's current LTSS providers. All enrollments must be processed through an independent, conflict-free entity.

While enrolled in a plan, consumers should have access to independent and conflict-free assistance with any disputes with a state or plan. CMS specifically mentions an advocate or ombudsman to assist consumers with such disputes, and notes that any assistance must be provided at no cost to the consumer.

CMS specifies that a consumer must be allowed to disenroll from a managed care plan at any time when termination of a provider from that MLTSS network "would result in a disruption in their residence or employment." This is another area where additional advocacy could be beneficial both with CMS and with individual states, as the loss of a provider from a network could be extremely prejudicial and possibly life-threatening to a consumer, whether or not it disrupts the consumer's residence or employment.

Element #6: Person-Centered Processes

Under the CMS guidance, states must require managed care plans to use a standardized, person-centered and state-approved assessment instrument. Assessments must include such elements as: health status; treatment needs; social, employment and transportation needs and preferences; personal goals; consumer and caregiver preferences for care; back-up plans when caregivers are unavailable; and informal support networks.

Care planning must be conducted through a person-centered process; examples of such a process are found in the regulations for the HCBS waiver, HCBS state-plan option, and Community First Choice Option. Consistent with the standard understanding of person-centered planning, CMS in the guidance explains that such planning is performed through an interdisciplinary team of professionals and non-professionals that includes persons chosen by the consumer. The planning process is holistic in its consideration of medical and non-medical needs, and in its focus on community integration and consumer satisfaction.

For those states that offer self-directed services, that option should be incorporated into MLTSS programs. The guidance encourages states that do not currently offer self-direction to do so. When self-direction is offered, consumers should be provided with adequate assistance so that they are able to cope with the financial and business aspects of self-directing a caregiver.

Element #7: Comprehensive and Integrated Service Package

In order to promote service integration and avoid cost shifting, CMS "expects" states to incorporate physical health, LTSS, and behavioral health into a single capitation rate. Also, as discussed above in relation to payment structure alignment, a capitation rate should include both institutional and non-institutional services, so as to properly incentivize non-institutional services. Importantly, states will have the burden of justifying any carve-outs of services from a capitation rate, and of explaining "how the

goals of integration, efficiency, appropriate incentives and improved health and quality of life outcomes will otherwise be achieved."

To ensure that services are authorized adequately, any modification, reduction or termination of services must be based on an up-to-date needs assessment. States must conduct enhanced monitoring of service reductions during the transition to managed care. Benefit packages must include services that support consumers as they transition between settings.

Element #8: Qualified Providers

Provider Qualifications

Per the CMS guidance, states must establish minimum provider qualifications and credentialing requirements for all MLTSS providers. For provider types that are not licensed or certified, states are "well-advised to adopt standardized qualifications, credentialing, and training requirements." At a minimum, the guidance advises that provider qualifications should include criminal background checks and maintenance of a registry for persons found to have committed abuse.

Health plan staff must receive standardized training on MLTSS, with such trainings to include the assessment process, person-centered planning, and self-direction.

Network Composition and Access Requirements

This section of the guidance focuses on the transition to MLTSS. CMS recognizes the importance of including existing LTSS providers in managed care networks, so that consumers are able to stay with particular service providers. Unfortunately, the guidance is equivocal on how protections might be implemented, saying that states could require or "encourage" inclusion of existing LTSS providers "to the extent possible." In a related statement, CMS notes that the "transition plan in place may include elements like maintaining existing provider-recipient relationships as well as honoring the amount and duration of an individual's authorized service under an existing service plan." Similarly, CMS requires that managed care contracts include continuity of care provisions and rules for accessing out-of-network providers, but does not offer any additional detail as to the actual contractual terms.

A consumer's transition plan must take into account how long a transition period might be necessary. CMS's guidance gives the example of a person with a residential provider needing more time to transition than a person using non-residential providers, since a switch of residential providers requires that the consumer move from one residence to another.

Provider Support During Transition to MLTSS

To ensure that existing LTSS providers are not excluded from managed care due to logistical issues, CMS instructs that states or managed care plans assist the providers with information technology, billing, systems operations, and other relevant topics.

Contract Termination Protections for Participants

According to the guidance, the contracts between states and plans must include

"expectations" regarding any phase-down of services when a plan or provider is going through contract termination. These expectations include notice to providers or consumers, and a prohibition against new enrollments during the phase-down. The state must have a heightened level of intervention when the loss of a provider means a consumer will lose employment or be forced to move.

Element #9: Participant Protections

Participant Rights and Responsibilities

CMS requires states to establish participant rights, but does not provide any specifics about the content of those rights.

Safeguards to Prevent Abuse, Neglect and Exploitation; and Critical Incident

Each state must have a system to identify, report, and investigate critical incidents, with the added capacity to track data in order to make systemic improvements. Similarly, a state must have a system to prevent, detect, report, investigate and remediate incidents of abuse, neglect, or exploitation. To aid prevention and reporting, training must be provided to MCO staff, service providers, consumers, and consumers' families. The beneficiary support system (see Element #5) must be able to assist with these problems, and as appropriate to coordinate with existing state ombudsman programs that may be available to consumers.

Fair Hearings and Continuation of Services Pending Appeal

CMS specifies that MLTSS consumers retain Medicaid fair hearing rights and also have access to MLTSS grievance systems. Also, noting the great harm threatened by inappropriate termination of LTSS, CMS "expects states to adopt policies that ensure authorized LTSS continue to be provided in the same amount, duration and scope while a modification, reduction, or termination is on appeal." This is a particularly important stipulation, and one that should be cited widely by consumer advocates. Currently, one significant problem in managed care is the frequent inability to obtain services pending an appeal when a service authorization period has expired. Nothing in the CMS guidance seems to condition continued services during an appeal on those services being within the initial authorization period.

Consistent with the monitoring addressed in Element #7 (related to service provision), CMS "expects" states to monitor plans' service authorization processes, and to intervene if those processes result regularly in consumer appeals.

Element #10: Quality

CMS requires that all states have a comprehensive managed care quality strategy that is integrated with all other relevant state quality initiatives and systems, and that provides for continuous quality improvement. CMS highlights the importance of person-level encounter data, noting that current law requires states to collect such data and report it to CMS. "To the maximum extent possible," the data should include data stratification elements such as language, race, disability status, educational level, and employment status.

States are required to utilize their external

quality review process to assess and validate quality elements related to MLTSS, but states maintain ultimate responsibility for the quality of MLTSS programs and may not delegate this responsibility. A state must have adequate resources to carry out numerous quality-related activities, including the development and implementation of MLTSS performance improvement projects, and the solicitation and analysis of consumer feedback.

States must develop managed care reports in such critical areas of MLTSS as "network adequacy; timeliness of assessments, service plans and service plan revisions; disenrollment; utilization data; call monitoring; quality of care performance measures; fraud and abuse reporting; participant health and functional status; [and] complaint and appeal actions." The relevant reporting requirements must be specified in contracts with the managed care plans. Notably, CMS "recommends" that states develop report cards that can be used by the public to evaluate and choose a managed care plan.

States, contractors, and/or managed care plans must survey MLTSS consumers to develop experience and quality of life indicators. The state must make survey results available to stakeholder advisory groups for discussion, and post the results on the state website.

Documents Prepared By Truven Health Analytics

Transitioning Long Term Services and Supports Providers Into Managed Care Programs

Based on stakeholder interviews, this report sets forth challenges faced by managed care plans and by LTSS providers, along with technical assistance made available to providers. The report concludes with nine "suggestions" for the technical assistance provided by states to LTSS providers. These suggestions include requiring technical assistance as a condition of CMS's approval of an MLTSS program, and conducting practice billing sessions prior to a program's launch date.

Timeline for Developing a Managed Long Term Services and Supports (MLTSS) Program

This report sets forth a timeline template based on three phases of program development: planning, implementation, and refinement. For each phase, the report specifies whether an activity occurs in the early, middle, or late portion of the phrase, or across two or three of those time portions. The report should be very useful for states' efforts to anticipate necessary activities and plan accordingly.

Conclusion

The CMS guidance, while extremely useful, leaves many unresolved issues for consumers and their representatives. One particular challenge will be to give meaning to the many provisions that indicate a consumer-favorable intent, but give little or no detail as to how that intent might be applied to particular situations.