



Guidance to States  
using 1115  
Demonstrations or  
1915(b) Waivers for  
Managed Long Term  
Services and Supports  
Programs

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## **I. Introduction**

States are increasingly incorporating populations and services that have long been excluded from capitated managed care arrangements into these models of care. Providing more integrated care for populations such as those who are dually eligible for Medicare and Medicaid, and coordinating acute care with long term services and supports hold the promise of delivering better care at lower costs. At the same time, these individuals have particularly high health care needs and the application of a capitated managed care model to long term services and supports is new for many states, health plans and providers. The Centers for Medicare & Medicaid Services (CMS) is providing guidance and support to states related to the development, expansion, reconfiguration, and implementation of Medicaid managed long-term services and supports (MLTSS) programs.

This guidance is intended to share what CMS has learned from states, stakeholders, and advocates in terms of best practices for establishing and implementing MLTSS programs and to clarify expectations of CMS from states using section 1115 demonstrations or 1915(b) waivers combined with another long term services and supports (LTSS) authority in an MLTSS program. The ten key elements in this document are those that CMS expects to see incorporated into new and existing state Medicaid MLTSS programs. States have many different options for how they address these elements, and for existing MLTSS programs, CMS will take into consideration the state's current program structure and evaluate each state individually in how they meet the requirements outlined in this document.

## **II. Background**

“Managed Long-Term Services and Supports” refers to the delivery of LTSS (including both home and community based services (HCBS) and institutional-based services) through capitated Medicaid managed care programs. These programs can be operated by a variety of health plans, including a managed care organization, a prepaid inpatient health plan or a prepaid ambulatory health plan. For purposes of this paper, all capitated health plans are referred to as MCOs. Home and community-based services are services made available to support individuals living at home or in a community based setting; these may include home health care, durable medical equipment, assistive technology, chore services, nursing care, transportation, adult day care, in-home meal services, and more.

MLTSS offers states a broad and flexible set of program design options, and may be used to promote initiatives such as Money Follows the Person<sup>1</sup>, participant-directed services, and the Balancing Incentive Program<sup>2</sup>. Increasing numbers of states are using MLTSS as a strategy for expanding HCBS, promoting community inclusion, ensuring quality, and increasing efficiency. The number of states with MLTSS programs increased from 8 in 2004 to 16 in 2012, and CMS

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<sup>1</sup> The Money Follows the Person program, under section 1915(i) of the Social Security Act, was initially authorized by section 6071(h) of the Deficit Reduction Act of 2005. It was due to expire but was extended by section 2403 of the Affordable Care Act of 2010 (Pub. L. 111-148).

<sup>2</sup> The Balancing Incentive Program is authorized by section 10202 of the Affordable Care Act of 2010 (Pub. L. 111-148).

has experienced increasing interest from states in the form of concept papers, waiver applications and requests for technical assistance.

Many state Medicaid programs have extensive experience with managed care for the delivery of physical or behavioral health care services but, until recently, the largest populations receiving Medicaid long-term care services -- especially seniors and adults with physical or developmental disabilities -- were excluded from these managed care arrangements. Several states now plan to expand existing MLTSS programs, either adding new populations or expanding the geographic reach of their MLTSS programs, while others plan to move LTSS populations to managed care for the first time. Most states pursuing MLTSS intend to move quickly to deliver some or all of their Medicaid LTSS through contracts with MCOs. The cumulative impact of these changes will result in the transition of several million new beneficiaries into MLTSS programs.

States can implement MLTSS using an array of managed care authorities, including a 1915(a) voluntary program, a 1932(a) state plan amendment, a 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be 'paired' with state plan HCBS benefits offered under 1905(a), 1915(i), 1915(j) or 1915(k) or an HCBS waiver under 1915(c). Additionally, section 1115 demonstrations can be used alone to authorize both the managed care delivery system as well as the HCBS benefits offered through that delivery system, when these reforms are part of a larger demonstration project.

MLTSS programs should allow for ongoing innovation in the delivery of services such as the addition of new types of services that might better integrate care management; promote independence, employment, wellness and recovery; or detect and delay the progress of chronic disease. States will also want to evaluate how best to incorporate other available initiatives (including Money Follows the Person, the Balancing Incentives Program, or Health Homes) as well as how or whether to reinvest savings into innovation or developing community-based infrastructure and additional service capacity.

As states move in this direction, it will be essential that these new delivery systems are structured to preserve the HCBS system's emphasis on choice and consumer-driven care and services, demonstrate real progress in developing community-based infrastructure and actively promote community-based alternatives. Below, CMS discusses 10 key ingredients of well-conceived MLTSS programs. This document serves as a blueprint both for states developing new MLTSS programs and for states renewing, revising or expanding their existing MLTSS programs. CMS expects the following elements to be integrated and will use these elements to review and approve state's section 1115 demonstrations or 1915(b) waivers paired with a LTSS authority that implement an MLTSS program.

### **III. Overview of Key Elements of MLTSS Programs**

CMS conducted an extensive review of national practices in MLTSS, including on-site visits to several states that operate MLTSS programs and also considered the recommendations of various consumer organizations. Through these reviews, it became apparent that while the specifics of the design and implementation of MLTSS will necessarily vary among States, there are universal

elements that will increase the likelihood of a high quality MLTSS program. CMS expects that states incorporate these elements into their planning and proposed MLTSS program designs. The elements, which are described in more detail later, are:

- 1. Adequate Planning:** It is essential to allow adequate time in advance of implementing new, expanded or reconfigured MLTSS programs to allow for thoughtful planning and design, incorporation of stakeholder input, and implementation of safeguards to ensure a smooth transition to MLTSS.
- 2. Stakeholder Engagement:** Successful programs have developed a structure for engaging stakeholders regularly in the development and implementation of new, expanded or reconfigured MLTSS programs. This includes cross-disability representation of individual participants as well as community, provider, and advocacy groups in order to obtain meaningful input into both the planning and operation of MLTSS programs. CMS will expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same.
- 3. Enhanced Provision of Home and Community Based Services:** All MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA)<sup>3</sup> and the Supreme Court's *Olmstead v. L.C.*<sup>4</sup> decision. Under the law, MLTSS must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation.
- 4. Alignment of Payment Structures and Goals:** States must design their payment structures so that they support the goals of their MLTSS programs and the essential elements of MLTSS. Effective programs hold providers accountable through performance-based incentives and/or penalties. On an ongoing basis, states must evaluate their payment structures and make changes necessary to support the goals of their programs.
- 5. Support for Beneficiaries:** MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, and consumer-friendly.
- 6. Person-centered Processes:** All MLTSS programs must require and monitor the implementation and use of person-centered needs assessment, service planning, and service coordination policies and protocols. MLTSS programs should encourage participant self-direction and provide opportunities for self-direction of services.
- 7. Comprehensive, Integrated Service Package:** MCOs must provide and/or coordinate the provision of all physical and behavioral health services and LTSS (including institutional and non-institutional) and must ensure that participants receive those services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.
- 8. Qualified Providers:** States must ensure that MCOs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the MCO contract. For states transitioning from Fee for Service (FFS) to MLTSS, states should encourage, or require through contract provisions, the incorporation of

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<sup>3</sup> The Americans with Disabilities Act (ADA), 42 USC 126.12101.

<sup>4</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

existing LTSS providers as MCO network providers to the extent possible. States must provide, or require MCOs to provide, support to traditional LTSS providers, which may include areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS.

9. **Participant Protections:** States must establish safeguards to ensure that participant health and welfare is assured within the MLTSS program, including a statement of participant rights and responsibilities; a critical incident management system with safeguards to prevent abuse, neglect and exploitation; and fair hearing protections including the continuation of services during an appeal.
10. **Quality:** States are expected to maintain the highest level of quality in all MLTSS operations and services through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies. The design and implementation of a quality improvement strategy must be transparent and appropriately tailored to address the needs of the MLTSS population.

#### **IV. Key Elements of Effective MLTSS Programs**

In addition to reflecting any existing statutory and regulatory requirements, the MLTSS program designs implemented through section 1115 demonstration authority or 1915(b) waiver authority, written contracts, program operations manuals, and other documents governing the relationship between a state and its managed care plans must incorporate the essential elements described in this document.

CMS intends to use these elements to review and approve state's section 1115 demonstrations or 1915(b) waivers paired with a LTSS authority that implement an MLTSS program. As previously stated, there is no "one way" to design and implement an MLTSS program, but addressing each of these elements in a way that is appropriate given the circumstances in each state will help ensure successful programs. For existing MLTSS programs, CMS will take into consideration the state's existing program structure and evaluate each state individually in how they meet the requirements outlined in this document.

**ESSENTIAL ELEMENT #1: Adequate Planning. It is essential to allow adequate time in advance of implementing new, expanded or reconfigured MLTSS programs to allow for thoughtful planning and design, incorporation of stakeholder input, and implementation of safeguards to ensure a smooth transition to MLTSS.**

##### **Planning and Design:**

States must engage in a thoughtful and deliberative planning process that permits enough time to outline a clear vision for the program; solicit and consider stakeholder input; educate program participants; assess readiness; and develop safeguards and oversight mechanisms to ensure a smooth transition to, and effective ongoing implementation of MLTSS. States are encouraged to engage in discussions with CMS to obtain technical assistance before making program design decisions.

Concept papers and proposals/applications must outline outreach and transition plans for transitioning participants and providers to MLTSS. States will be expected to demonstrate that they have coordination and communication processes in place with other state agencies that support the populations enrolled in the MLTSS program, such as the aged, those with physical, intellectual and developmental disabilities, those with chronic diseases, and those with mental health or substance abuse issues. States must also develop and present to CMS in their draft proposals a description of program governance and ongoing monitoring and oversight responsibilities with specific reference to the role of impacted state agencies.

States must ensure that the team of staff involved in MLTSS program development includes those with expertise in managed care, LTSS services and delivery systems as well as the needs of participants likely to use them. Strong programs have allowed time in the program development process for managed care and LTSS staff to educate each other about their programs and operations and to ensure that all personnel possess a basic level of understanding sufficient to ensure a smooth implementation as well as adequate oversight and monitoring of the MLTSS program.

As part of the planning process, states will be expected to develop information technology systems, data collection, and health information technology processes within their MLTSS programs that will facilitate effective management of the program.

#### **MLTSS Readiness and MCO Readiness Evaluation:**

Each state must have a plan to assess the readiness of state entities, providers, contractors, and MCOs to effectively implement the MLTSS program. Readiness will need to be achieved at both the state and MCO levels, with sufficient time to address and correct problems prior to the implementation date of the MLTSS program. States must require that MCOs have comprehensive LTSS training, experience, and expertise incorporated into their MLTSS operations and management, including care and disease management staff. This must extend to any subcontractors that MCOs might employ to deliver services under their MLTSS contracts.

In their initial proposals to CMS, states will be expected to specify their plans for educating participants, families and caregivers, providers, contractors, community organizations, and MCOs about MLTSS. They must also identify their planned processes for transitioning non-managed care LTSS to managed care or any changes from an existing MLTSS program to a new MLTSS program. States education and outreach plans must include provider education and support, such as collaborative efforts to work with contractors and MCOs to provide educational sessions, newsletters, and notices targeted to LTSS providers.

#### **Oversight of Initial Implementation and Transition:**

Each state must have a plan for rapid identification and resolution of LTSS problems that occur during implementation. States must publicize a method for beneficiaries to obtain consumer support (e.g., hotline, ombudsman, etc.) where they can ask questions during the transition and require contractors (e.g., enrollment brokers) and MCOs to do the same.

States must have a quality strategy in place at the time of implementation of their new, expanded, or modified MLTSS program. The state should include a draft, transitional quality strategy at the time that it is requesting the new or additional authorities.

When states are transitioning existing FFS LTSS programs to managed care, they must continue to use the quality structures in place under their existing program until they have developed the quality structure they plan to use under the new Medicaid managed care authority. Additionally, states will be expected to implement a strategy to move individuals into the MLTSS program in a way that reduces risk to beneficiaries, which might mean phasing the program in gradually depending on the size of the state and program. States must require MCO reports during the implementation phase to permit adequate oversight and correction of problems under the transitional or revised state quality strategy.

The SMA must maintain oversight before, during, and after the transition from FFS to managed care. Likewise, the SMA must maintain oversight before, during, and after the revision or expansion of an existing MLTSS program.

**ESSENTIAL ELEMENT #2: Stakeholder Engagement. Successful programs have developed a structure for engaging stakeholders regularly in the development and implementation of new, expanded or reconfigured MLTSS programs. This includes cross-disability representation of individual participants as well as community, provider, and advocacy groups in order to obtain meaningful input into both the planning and operation of MLTSS programs. CMS will expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same.**

**Stakeholder Involvement in MLTSS Planning:**

Stakeholders (including participants) are essential partners in the program design and planning phases as well as the implementation and oversight phases of an MLTSS program. Each state must implement and report to CMS about its stakeholder engagement strategy through which it involves the public in the design of its MLTSS program. Each state will be expected to establish a formal MLTSS stakeholder advisory group that includes cross-disability representatives of the LTSS stakeholder community such as participants (and their families or caregivers, where appropriate) in LTSS, LTSS providers, and community-based organizations involved in the support of those using LTSS. States can organize their advisory group in any number of ways and may wish to build their MLTSS stakeholder advisory groups upon an existing Medicaid advisory committee infrastructure. If the advisory group has a broad charge beyond LTSS (e.g., advises on the entire scope of the State's Medicaid program), a sub-committee or other mechanism should be developed to ensure adequate attention to LTSS issues. 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. Each state's proposal to CMS should describe the state's advisory group and how stakeholder input has and will inform the MLTSS program design.

States must provide opportunities for broader public input into the program design, including holding events in accessible locations around their states and providing other means of input for

those who are unable to attend the meetings in person, such as the use of remote site technology or web-based input opportunities. CMS strongly encourages states to maintain and publicize a web site with current information about its MLTSS program initiative. Ideally, each website should include a mechanism for providing comments and asking questions.

Each state must follow all Federal statutory and regulatory requirements for state public notice. CMS expects states to publicly post its concept paper or related descriptive material prior to submission to CMS, as well as any updated or modified materials that follow. These documents should include clear statements of which LTSS populations are included in the MLTSS program and how their coverage and access to services will change when the MLTSS program is implemented. In its proposal to CMS, each state should provide a summary of comments received and any changes made to the proposal as a result of the comments. The state website should be updated as the proposal is modified. States must adhere to the Tribal Consultation Requirements as described in their existing authorities.

### **Stakeholder Involvement in Implementation and Oversight:**

Each state must articulate in its stakeholder engagement strategy and report to CMS on how it involves stakeholders in the implementation of its MLTSS program. States must develop and implement stakeholder input processes that includes state-level stakeholder advisory committees, participant feedback, and participant communication.

States must submit to CMS in their proposals and applications effective plans for educating prospective enrollees and/or their caregivers about whether/how their LTSS will change and the choices they will be able or required to make. These education and outreach plans must include information about how individuals may provide input as part of the state's stakeholder engagement strategy.

States should provide educational sessions for community-based organizations (CBOs) focused on understanding MLTSS and on the processes and elements of transitioning LTSS to managed care, as well as prepare CBOs to answer beneficiary questions. States will be expected to describe how, following implementation, they will engage stakeholders in the design of program evaluations and the monitoring of program performance against LTSS goals. Like in pre-implementation planning, states may wish to build their MLTSS stakeholder advisory groups upon an existing Medicaid advisory committee infrastructure.

States must require contractors and MCOs to maintain effective systems for engaging participants who use MLTSS. CMS expects states to require MCOs to convene accessible local and regional member advisory committees to provide feedback on MLTSS operations. To encourage participation, MCOs must provide supports such as transportation, interpreters, and personal care assistants; they may also compensate members, as appropriate. States will be expected to require contractors and MCOs to report regularly on their engagement of MLTSS participants.

### **Stakeholder Communications and Transparency of operations and outcomes:**

States must consider MLTSS program transparency to be an essential element of their program, such that participants, stakeholders and the public may be fully informed about the operation and

outcomes of the program. States must develop and adopt plans and processes for regular communication with stakeholders in advance of and throughout implementation, including development and maintenance of a state webpage dedicated to MLTSS program topics. Communications must be culturally and linguistically appropriate and available in alternative formats as required by all applicable federal and state laws and regulations to ensure that participants with Limited English Proficiency (LEP) or visual, hearing and cognitive impairments are accommodated.

**ESSENTIAL ELEMENT #3: Enhanced Provision of Home and Community Based Services.** All MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA)<sup>5</sup> and the Supreme Court’s *Olmstead v. L.C.*<sup>6</sup> decision. Under the law, MLTSS must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation. MLTSS Programs must be Operated Consistent with the ADA and Olmstead:

States are reminded of their responsibilities under the Americans with Disabilities Act (ADA)<sup>7</sup> and the *Olmstead v. L.C.*<sup>8</sup> Supreme Court decision and, in accordance with the requirements that all managed care programs must comply with all applicable laws, must ensure that the MLTSS program is operating consistently with any state Olmstead plan at both the state and MCO level. States must require MCOs to offer services in the most integrated setting possible.<sup>9</sup>

**MLTSS must provide the Greatest Opportunities for Active Community and Workforce Participation:**

States are required to ensure that non-institutional MLTSS are provided to participants in settings which comport with CMS home and community based setting requirements as defined in regulations and guidance governing 1915(c) Home and Community Based Services Waivers, 1915(i) state Plan Home and Community Based Services, and 1915(k) Community First Choice. Moreover, States are encouraged to include in their benefit packages supports to enable workforce participation such as personal assistance services, supported employment and peer support services, as appropriate and desired by the participant.<sup>10</sup>

**ESSENTIAL ELEMENT #4: Alignment of Payment Structures and Goals.** States must design their payment structures so that they support the goals of their MLTSS programs and the essential elements of MLTSS. Effective programs hold providers accountable through performance-based incentives and/or penalties. On an ongoing basis, states must evaluate their payment structures and make changes necessary to support the goals of their programs.

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<sup>5</sup> The Americans with Disabilities Act (ADA), 42 USC 126.12101.

<sup>6</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>7</sup> The Americans with Disabilities Act (ADA), 42 USC 126.12101.

<sup>8</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>9</sup> The “most integrated setting” is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” 28 C.F.R. Pt. 35, App. A (2010).

<sup>10</sup> For more information on Competitive Employment, see the CMCS Supported Employment Informational Bulletin available at <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf>.

**Rate-setting with MLTSS Objectives in Mind:**

States must establish payment rates that support the goals and objectives of their MLTSS programs and these essential elements. In keeping with the intent of the ADA and Olmstead decision, payment structures must encourage the delivery of community-based care and not provide disincentives, intended or not, for the provision of services in home and community-based settings. Inclusion of both institutional and non-institutional services in a managed care capitation rate, for example, provides plans with the flexibility to offer lower cost non-institutional services to beneficiaries and support system rebalancing towards greater use of non-institutional LTSS.

Rates must be sufficient to encourage adequate MCO and provider participation, as well as to appropriately meet the needs of participants. State payment structures, systems and review mechanisms must ensure that participants at all levels of need and all types of disabilities have the opportunity to choose their MLTSS providers and have appropriate access to community-based services.

**Performance-based Incentives and/or Penalties must be used to support the goals of the MLTSS program:**

States must employ financial incentives that achieve desired outcomes and/or impose penalties for non-compliance or poor performance. The incentives must be based on the state's goals for the MLTSS program. These goals may reward MCOs for activities such as providing supports to aid participants in achieving competitive employment, the provision of services in the most integrated setting, and consumer satisfaction. Penalties should discourage operations and outcomes that are contrary to state goals and may include, for example, financial penalties for not meeting contractual deadlines or return of a payment if an MCO does not achieve required outcomes for the provision of services in the most integrated setting. Similarly, MCO contracts must be explicit in what, if any, sanctions will be used, how they will be used and how they will achieve programmatic goals.

**Oversight and Evaluation of Payment Structure:**

States must develop policies and procedures for oversight and evaluation of payment structures, their potential impact on MLTSS objectives, to inform areas of exploration for future program modifications. States must oversee and evaluate whether the payment rates are supporting the goals and objectives of their MLTSS programs and these essential elements and whether payment structures encourage the delivery of community-based care. States must also evaluate whether payment rates and structures are adequate to achieve participant access to quality providers for covered services.

**ESSENTIAL ELEMENT #5: Support for Beneficiaries. MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, meaningful, and consumer-friendly.<sup>11</sup>**

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<sup>11</sup> States wishing to consider implementing the conflict free case management provisions required by the Balancing Incentive Program (BIP) should refer to <http://www.balancingincentiveprogram.org/resources/what-design-elements-does-conflict-free-case-management-system-include>

**Individual Conflict-Free Choice Counseling and Independent Enrollment/Disenrollment:**

To support consumer-directed informed choice of MLTSS plan, states must provide participant choice counseling, to potential participants and/or their caregivers to support them in understanding their MLTSS options. Such counseling can be provided in any number of ways, but to ensure independence, counseling must be provided by an entity that is not a health plan, a service provider, or an entity making eligibility determinations. Participants should only be auto-assigned to a MCO if they do not make an affirmative choice through the participant choice counseling process and, if assigned, this must be done through a process of intelligent assignment that takes into account their LTSS providers. MCOs may not be involved in any eligibility determination or functional assessment processes for a potential participant prior to that participant enrolling in the MCO. Further, all MLTSS program enrollments must be processed through an independent, conflict-free entity. Individuals enrolled in MLTSS programs retain all the applicable Medicaid-required appeal rights.

**Independent Advocacy or Ombudsman Services are Available at no cost to participants:**

In addition to providing choice counseling and independent enrollment and disenrollment from an entity free of the conflicts described above, states must ensure an independent advocate or ombudsman program is available to assist participants in navigating the MLTSS landscape; understanding their rights, responsibility, choices, and opportunities; and helping to resolve any problems that arise between the participant and their MCO.

**Enhanced Disenrollment Opportunities:**

Provider network changes can have a significant impact on those enrolled in MLTSS programs, since such providers are typically integral to residential and work services and supports. Therefore, if the state does not permit participants enrolled in MLTSS to switch to another MCO or FFS Medicaid at any time, states must permit participants to disenroll and switch to another MCO or FFS, whichever the state makes available as part of participant choice, when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment.

**ESSENTIAL ELEMENT #6: Person-centered Processes. All MLTSS programs must require and monitor the implementation and use of person-centered needs assessment, service planning, and service coordination policies and protocols. MLTSS programs should encourage participant self-determination and provide opportunities for self-direction of services.**

**Consistent, Uniform, Person-Centered and State-Approved Needs Assessments:**

States must require all MCOs to use a standardized, person-centered and state-approved instrument to assess the participant's physical, psychosocial, and functional needs. The instrument must include such elements as current health status and treatment needs; social, employment, and transportation needs and preferences; personal goals; participant and caregiver preferences for care; back-up plans for situations when caregivers are unavailable; and informal support networks. Approved instruments must be capable of producing a similar assessment result from MCO to MCO.

### **Person-centered Service Planning and Services Delivery:**

States must require MCOs to use a person-centered service planning process. Examples of this process can be found in the regulations governing the Community First Choice (CFC)<sup>12</sup> program, the 1915(i)<sup>13</sup> and 1915(c)<sup>14</sup> authorities. It includes the use of an interdisciplinary team of professionals and non-professionals including individuals chosen by the participant. The professionals and non-professionals involved in the planning and decision making process must have adequate knowledge, training, and expertise around community living and person-centered service delivery. The process must promote self-determination principles and actively engage the participant and individuals of their choice.

The service plan must reflect the participant's or caregiver's needs and preferences and address how their needs will be met by a combination of covered services and available community supports. Person-centered service planning is holistic in addressing the full array of medical and non-medical services and supports provided both by the MCO or available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. Participants must be permitted to include individuals of their choosing, along with their service providers, as part of their interdisciplinary team. CMS expects participants will have the ability to choose which team members should serve as the lead and the participant's main point of contact; if the participant does not want to choose a team lead, the interdisciplinary team will make the decision.

### **Opportunities and Supports for Self-Direction:**

States that offer self-direction in their FFS LTSS programs are expected to continue them under MLTSS. States that do not currently offer self-directed LTSS service options should consider providing the opportunity for self-direction within their MLTSS program.

When self-direction is offered the state must ensure that participants have adequate supports to understand and effectively use the various self-directed service options, such as budget authority and/or employer authority, and, where applicable, that participants are able to handle the financial and business aspects of self-direction (i.e. financial management services (FMS) and Supports Broker). Contract language must reflect state expectations around self-direction opportunities (including the availability of an individual to educate and assist the participant in self-direction) and how to facilitate participant self-direction.

**ESSENTIAL ELEMENT #7: Comprehensive, Integrated Service Package: MCOs must provide, and/or coordinate the provision of, all physical and behavioral health services and LTSS (including institutional and non-institutional) and must ensure that participants receive those services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.**

### **Complete Array of Services:**

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<sup>12</sup> 42 CFR 441.510.

<sup>13</sup> Section 1915(i) of the Social Security Act (42 USC 1396(n)) provides for a state Plan Amendment Option to Provide Home and Community-Based Services for Elderly and Disabled Individuals.

<sup>14</sup> Section 1915(c) of the Social Security Act (42 USC 1396(n)) provides for Home and Community-Based Services waiver.

CMS expects that states will incorporate physical health, behavioral health, and LTSS services (including institutional and non-institutional LTSS) into the MCO capitation payment as this can promote service integration, increase efficiency, avoid cost shifting and disincentives to the provision of services, and enhance health outcomes and quality of life. The state will be expected to justify service ‘carve-outs’ and explain how the goals of integration, efficiency, appropriate incentives and improved health and quality of life outcomes will otherwise be achieved.

Service packages should be broad enough to support participants and their family or caregivers in receipt of all services based on the goals articulated in the person-centered plan. State stand-alone MLTSS programs (those that are not part of integrated managed care programs which also include physical and behavioral health services) should include institutional services in the capitation payment to minimize MCO disincentives for the provision of services in the most integrated setting. States that exclude specific services from their MLTSS programs will be expected to routinely assess whether there is any negative impact as a result of the exclusion and whether there are any violations of federal requirements, including the ADA or Olmstead. The results of this assessment should be made available to participants and other stakeholders. States must be prepared to take appropriate action as necessary to ensure no violation of federal requirements to provide services in the most integrated setting, including violations of ADA and Olmstead requirements, and to promptly remediate any violations found.

#### **Service Decisions Based on Current Assessment of Needs:**

MCO decisions about the authorization of services must be based on a comprehensive and individualized needs assessment that addresses all needs (not just those for LTSS) and a subsequent person-centered planning process. Services must not be reduced, modified, or terminated absent an up-to-date assessment of needs that supports the reduction, modification, or termination. SMAs should monitor to ensure that identified participant needs and preferences are incorporated into service plans, and must provide enhanced monitoring of any service reductions (should there be any) during the transition to managed care.

#### **Fully Developed Plan for Transitioning Care between Service Settings:**

States should ensure that their service packages include services to support participants as they transition between settings, such as between a hospital and back to the individual’s home following a hospitalization. Ensuring that policies, plans, and procedures are in place to prepare for transitions between care settings can improve the quality of care for all participants, reduce avoidable re-hospitalizations, and allow individuals to live and receive services in the setting of their choice for as long as possible.

**ESSENTIAL ELEMENT #8: Qualified Providers. States must ensure that MCOs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the MCO contract. For states transitioning from Fee for Service (FFS) to MLTSS, states should encourage or require through contract provisions the incorporation of existing LTSS providers as MCO network providers to the extent possible. States should provide, or require MCOs to provide, support to traditional**

**LTSS providers, which may include areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS.**

**Network Composition and Access Requirements:**

During the initial transition of a beneficiary into an MCO including LTSS (either from a FFS system or from a different MCO), CMS expects states to include contract language around continuity and coordination of care for the transition. 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 services under an existing service plan. Transition plans must be carefully crafted and take into account potential differences in the length of time a transition should occur based on the services within the service plan. For instance, an individual using a residential provider may need longer to transition to a different network provider than those individuals using non-residential providers.

State contracts with MCOs must specify network composition and access requirements for MLTSS including continuity of care provisions and rules for when and how participants may access out-of-network providers. MCO reports must address compliance with state network composition and access standards and financial incentives/disincentives should be considered as a management tool to support state expectations.

**Meaningful Provider Qualifications, Credentialing, and Training Requirements:**

States must establish minimum provider qualifications and credentialing requirements for all MLTSS providers. Many existing LTSS service providers are not licensed and do not have any specific certification or professional credentials. In order to assist MCOs in including LTSS providers in their networks, States are well-advised to adopt standardized qualifications, credentialing, and training requirements for non-licensed or non-certified providers for MCOs to employ in developing their MLTSS provider networks. Minimum provider qualifications and requirements must include applicable requirements for criminal background, abuse registry, or other clearance checks. The provider qualification requirements must be specified in the MCO contract.

MCO staff and enrolled providers must be provided with standardized training on operating a successful MLTSS program, including such topics as the assessment process, person-centered planning, population specific training and self-direction.

**Provider support during transition to MLTSS:**

States will be expected to develop plans for supporting providers of LTSS in the move to managed care arrangements and, where applicable, minimizing disruption to participants’ services during the transition to MLTSS. These plans must be submitted to CMS upon request. States must provide existing providers with training to assist them in the transition to MLTSS, including developing the proper administrative capabilities to effectively operate within a managed care environment.

**Contract Termination Protections for participants:**

State contracts with MCOs must include expectations around MCO and provider phase-down when MCOs or providers are terminating their contract with, or having their contract terminated

by, the state or the MCO. These expectations must include the required amount of time for provider and participant notification and rules around the prohibition of new enrollments during the phase-down period. There must be a heightened level of intervention by the state in instances where a participant's residence and services are linked, and therefore where the loss of the provider also means that the participant might lose employment and/or have to move in order to maintain services.

**ESSENTIAL ELEMENT #9: Participant Protections. States must establish safeguards to ensure that participant health and welfare is assured within the MLTSS program, including a statement of participant rights and responsibilities; a critical incident management system with safeguards to prevent abuse, neglect and exploitation; and fair hearing protections including the continuation of services during an appeal.**

**Participant Rights and Responsibilities are established and honored:**

States must establish, and MCO contracts must reflect, a statement of participant rights. States must ensure that participants are advised of their rights and provided with additional support, as needed, to understand their rights as well as their responsibilities.

**Safeguards to Prevent Abuse, Neglect and Exploitation and Critical incident management systems:**

States must have a system in place to identify, report, and investigate critical incidents that occur within the delivery of MLTSS as well as to track and trend results in order to make systems improvements. As states plan for the process of transitioning their FFS programs to managed care, they must consider what modifications, if any, are needed to their existing incident reporting systems, including those that are electronic in nature. States must clarify roles, expectations and responsibilities for themselves, providers and MCOs in the managed care contract and program descriptions. The SMA must monitor findings as well as MCO compliance efforts. The SMA must maintain overall responsibility for the operation of the identification, reporting, and investigation system and should engage in continuous process improvements.

States must have systems in place to prevent, detect, report, investigate, and remediate abuse, neglect, and exploitation. These systems as well as roles and responsibilities must be explicit in MCO contracts. MCO staff and providers must be provided with training and education to understand abuse, neglect, exploitation and all prevention, detection, reporting, investigation and remediation procedures and requirements. Individuals receiving services and their families must be provided with initial and ongoing training and education programs on abuse, neglect, exploitation, and reporting. The MLTSS beneficiary support program must be available to assist with these problems, and coordinate with existing state Ombudsman programs that are available to participants.

**Fair Hearings and Continuation of Services Pending Appeal:**

MLTSS participants retain Medicaid fair hearing rights while participating in MLTSS programs. They also must have access to MLTSS grievance systems. States must assist participants in understanding their fair hearing rights. Because of the significant reliance participants have on

receipt of LTSS and the potential harm resulting from abrupt 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. CMS expects states to know and monitor MCO service authorization processes and intervene if those processes regularly result in participant appeals of service authorization reductions or expirations.

**ESSENTIAL ELEMENT #10: Quality. States are expected to maintain the highest level of quality in all MLTSS operations and services through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies. The design and implementation of a quality improvement strategy must be transparent and appropriately tailored to address the needs of the MLTSS population.**

**Comprehensive Quality Strategy:**

All states must have a Comprehensive Managed Care Quality Strategy (Quality Strategy) that includes MLTSS and addresses the key elements of MLTSS reflected in this guidance and is integrated with all other relevant state quality initiatives and systems, including but not limited to any developed for Community First Choice, Health Homes, the Adult Health Quality Program, the Balancing Incentive Program (BIP), or Money Follows the Person (MFP). The Quality Strategy must include a system for continuous quality improvement (CQI) that builds upon previous and current development efforts and resources, reduces duplication, and fosters standardization of core elements across Medicaid authorities including quality measures that are focused on outcomes and critical processes; an appropriate, representative, statistical sampling methodology where applicable; and mechanisms for the tracking and aggregation of data, remediation and systems improvement efforts.

**Foundation for MLTSS Quality Strategy must be existing quality structures and frameworks in managed acute care and LTSS:**

When converting an existing FFS LTSS program to MLTSS or migrating from one authority to another, states must review the existing LTSS quality strategy in conjunction with any other state Medicaid quality strategies, to determine what changes are necessary to reflect the new managed care delivery system and to align efforts throughout the state's Medicaid program. The extent of modification will depend on the MLTSS program, the Medicaid authorities used for the MLTSS program, and the nature and extent of other existing LTSS quality strategies. CMS expects that states will integrate MLTSS into the state's overall approach to assessing and improving care for the managed care programs.

Person-level encounter data is critical for quality oversight and monitoring. States must collect such data and report it to CMS as required by current statute and regulation. To the maximum extent possible, data stratification elements such as language, race, disability status, educational level and employment status should be collected as well to provide a robust picture of the state's quality system.

States that operate managed acute care programs will be expected to leverage their existing quality structures and determine what changes might be needed to adequately address the quality oversight necessary for the MLTSS program. For example, the state should establish systemic performance improvement projects (PIP) specific to the common elements of MLTSS for all MCOs providing MLTSS (i.e., related to deinstitutionalization).

States are required to utilize their External Quality Review (EQR) process to assess and validate critical quality elements related to MLTSS with a focus on individual outcomes and critical processes. If the state uses an External Quality Review Organization (EQRO) to conduct some or all of the EQR activities required by Federal regulations, the state needs to demonstrate that the EQRO has sufficient expertise and experience to adequately carry out this function and is capable of analyzing and validating MLTSS processes, data, and outcomes.

### **Resources for Quality Monitoring and Oversight:**

SMAAs maintain ultimate responsibility and accountability for the quality and operation of MLTSS programs, and may not delegate this responsibility. States must provide adequate oversight and monitoring of MLTSS systems and MCOs. State contracts must clearly specify state and MCO responsibilities, and clarify that MCO subcontractors are accountable to the MCO.

States must have a sufficient and sustainable state infrastructure for monitoring MCO quality that reflects the size and complexity of the MLTSS program, including the number of MCOs operating in the state. There must be sufficient resources for the state to:

1. Evaluate contractually required quality reports and financial reports;
2. Evaluate impact or effectiveness of incentive programs;
3. Conduct quality-focused audits;
4. Provide quality-related technical assistance;
5. Validate that MCO corrective actions have been implemented;
6. Analyze quality findings and develop reports to assess quality trends and to identify areas for improvement;
7. Develop, implement and evaluate performance improvement projects for MLTSS;
8. Solicit and analyze participant feedback; and
9. Investigate and follow-up on critical incidents and sentinel events.

States will be encouraged to access Medicaid funding opportunities, including Federal grant programs and enhanced federal match for information technology systems, to assist in standardizing and enhancing quality strategies under various existing state initiatives. These funding opportunities can also be a resource for monitoring MLTSS quality.

### **Reporting and Transparency:**

States must develop mandatory MCO reports related to the critical elements of MLTSS, including areas such 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; complaint and appeal actions. These reporting requirements must be specified in the MCO contract. States must analyze MCO reports as part of its quality oversight and based on the results, take

corrective action as needed. States must provide reports to CMS to demonstrate their oversight of the key elements of the MLTSS program. CMS recommends that states use performance measures from their Quality Strategy/reports to develop MCO report cards that are public, transparent, easily-understandable and useful to participants in choosing a MCO.

To minimize administrative burden on all parties, CMS recommends that states require reports to be submitted electronically using standardized systems that allow for reported information to be tracked and trended over time. States must have the capacity to analyze and manipulate information, respond to that analysis with appropriate changes in the quality system, and provide summary data to CMS upon request.

#### **Quality of Life Measures:**

States, contractors and/or MCOs must measure key experience and quality of life indicators for MLTSS participants. The measures must be specific to the needs of MLTSS participants and data must be collected using best practices for reaching special populations (e.g., phone or in-person as opposed to mail). Results of the surveys must be maintained by the state and CMS, along with any action(s) taken or recommended based on the survey findings. The EQRO should validate the survey results for the state. The state must analyze the results, make them available to its stakeholder advisory groups for discussion, publicly post the results on its website, and provide the results in print upon request for individuals without access to a computer.

## **V. Conclusion**

Many states are pursuing or considering pursuing MLTSS. MLTSS is a service delivery option that could increase the breadth, availability, and quality of LTSS available to those who require them. This guidance clarifies CMS expectations for section 1115 demonstrations or 1915(b) waivers paired with a LTSS authority that implement an MLTSS program, and identifies program elements that CMS believes will assist states to design and implement a successful MLTSS program.