The “Re”- Balancing Act: How Medicaid Managed Care, the ACA, and Dual Eligible Demo are changing Long-Term Services and Supports

Presented by:
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The “Re”-Balancing Act

How Medicaid managed care, the ACA and the Dual Eligible Demos are changing LTSS

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The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.
Today we will discuss the forces changing the LTSS landscape

Overview: Focus on rebalancing

Dual Eligible Demonstration

State expansion of Medicaid Managed Long-Term Services and Supports

ACA LTSS Programs
Focus on Rebalancing
Three initiatives driving rebalancing

1. Medicare-Medicaid financial alignment demonstrations (dual eligible demonstrations)

2. States shifting to managed care:
   1. Medicaid managed long-term services and supports (MLTSS) through 1115, 1915(b) and 1915(c) waiver

3. States are pursuing innovative improvements to LTSS introduced in the Affordable Care Act:
   1. Balancing Incentive Payment Program (BIPP)
   2. Community First Choice Option
More states using managed care for long-term services and supports

Two forces driving the change to managed long-term services and supports (MLTSS)

Dual Eligible Demonstration (Financial Alignment Demonstration)

Growth in MLTSS (State introducing or expanding through waivers)
Medicaid managed LTSS: LTSS through capitated care

**Fee for service LTSS**
- CMS and State
- LTSS Provider
- DME
- Beneficiary

**Managed LTSS**
- CMS and State
- MCO
- LTSS*
- DME*
- Beneficiary

* If provider is part of network and service part of care plan
Dual Eligible Demonstrations
Dual eligible demonstrations: changes for a vulnerable population

Medicare and Medicaid

10.2 Million (7.4M Full)

60% Seniors
40% People with Disabilities

High needs

Low-income

High Cost

Creation of Medicare Medicaid Coordination Office
Dual eligible demonstration: new care delivery for dual eligible individuals

Medicare

Medicaid

Dual Eligible Demonstration
The dual eligible demo provides two models for states to use to align care:

1. **MFFS**
   - State provides care coordination and gets a share of resulting Medicare savings.

2. **Managed Care**
   - State and CMS pay a managed care organization a blended payment to provide Medicare and Medicaid services.
Many states participating in the demonstration

- **Blue**: Memorandum of Understanding (MOU) pending.
- **Red**: Proposal withdrawn.
- **Yellow**: Signed MOU.
- **Gray**: Not seeking demonstration. These states are not seeking to do demonstration projects.
Enrollment will begin this Fall

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<th>State</th>
<th>Latest proposed enrollment date</th>
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| California      | April, 2014 (passive for all counties, except LA)  
April-July, 2014 (voluntary for LA county) |
| Illinois        | January, 2014 (voluntary)  
April, 2014 (passive) |
| Massachusetts   | October, 2013 (voluntary)  
January, 2014 (passive) |
| New York        | Community LTSS: July, 2014 (voluntary), September, 2014 (passive)  
Institutional LTSS: October, 2014 (voluntary), Jan. 2015 (passive) |
| Ohio            | April, 2014                                                                                      |
| Virginia        | February, 2014 (voluntary)  
May, 2014 (passive) |
| Washington      | MFFS went live on July 1                                                                           |
Protections and structure detailed in the three way contract

Basic structure:

- Starting point to understand other state contracts

See: [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf) for more information
Information included in the three-way contract

• Many decisions made in the three-way contract:
  – Grievances and appeals
  – Quality standards for managed care plans
  – Information on risk corridors
  – Medically necessary determination

• Important to give feedback

Potential client issues

• Enrollment:
  – Are clients informed about voluntary enrollment?

• Notices:
  – Do clients understand their right to continuous care?

• Transparency:
  – Do the MOUs and three-way contracts clearly detail consumer rights?

• Plan readiness:
  – Do the plans have adequate networks to serve complex medical and social needs?
Potential client issues

• HCBS benefit packages:
  – Does state require the plan package to provide comprehensive home and community based services?

• Coordinated care planning:
  – Does the consumer control who is included in the planning process, or are their conflicts of interest in the development of the plan?

• Appeals:
  – Does aid paid pending continue until the resolution of an appeal?
Involvement is important to influence demonstration protections

- Stakeholder engagement as important for implementation as drafting the proposal:
  - MA: Implementation Council
  - Ongoing workgroups on quality, notices and administration

- Educate and inform state on the development of the ombuds office

- Continue to engage with your state
State Expansion of Medicaid Long Term Services and Supports
Medicaid managed long-term services and supports is growing

- MLTSS grew in the past decade:
  - 2004: 8 states with 105,000 individuals
  - 2012: 16 states with 389,000 individuals

- Three types of plans contracted for MLTSS:
  - For-profit, not-for-profit, public
  - Private for-profit contractors have the largest share of enrollment- 44%

- Half of the states only include individuals at the institutional level of care (HCBS and institutions)

States are pursuing duals demos and MLTSS

Source: NASUAD Medicaid Integration Tracker
MLTSS Info Source #1: CMS Guidance

- 10 Elements in May, 2013 CMS guidance:
  - Planning Strategies
  - Stakeholder Engagement
  - Enhanced HCBS
  - Beneficiary Support
  - Person-centered Process
  - Participant Protections
  - Payment Alignment
  - Quality
  - Comprehensive Service Package
  - Qualified Providers
MLTSS *only* compared to Duals Demo states

- Some states already have MLTSS (e.g. Arizona, Tennessee)
- Some are introducing MLTSS (e.g. New Jersey, Florida)

*Important:* **MLTSS only is managed care only for Medicaid LTSS**

- Medicare: Medicare services not included in MLTSS *only*. 
CMS reminds states of ADA obligations

- States and managed care plans must offer services in the most integrated setting possible.
- 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.
CMS requires states identify participant rights

- Be treated with dignity
- Access to adequate network of providers
- Have a voice in demonstration governance and operations
- Involve caregivers in treatment discussions and decisions
- Receive advance notice of a transfer to another treatment setting
LTSS Changes in the Affordable Care Act
ACA introduced four major non-MLTSS changes

- Balancing Incentive Program
- Section 1915(i) State Plan Amendment
- Section 1915(k) Community First Choice
- Health Homes
Balancing Incentive Program

• 16 states moving forward: AR, CT, GA, IA, IL, IN, LA, MD, ME, MO, MS, NH, NJ, NY, OH, TX

• Concept: Three principal requirements:
  – No-wrong-door/single entry point system.
  – Conflict-free case management system.
  – Standardized assessment agreement.

• In exchange for an enhanced FMAP
Examples of what states are doing with BIP

• Texas: Expanding ADRCs
• Maryland: Piloting new assessments
• New Hampshire: Separating plans of care from funding
• Mississippi: Increasing provider rates
• Georgia: Expanding slots in 1915(c) waivers
What can clients expect under BIP

• The Good
• The Bad
• The Unknown
Alphabet soup of waiver plans

POLL
State Plan Option and Community First Choice

• **1915(i) State Plan Option**
  – No institutional level of care requirement
  – Statewide, but can target by population
  – More flexible financial eligibility

• **1915(k) Community First Choice Option**
  – Statewide
  – 6% enhanced federal match
What CFCO means for clients

• The Good
• The Bad
• The Unknown
Three takeaways

- Duals demo: Be involved and engaged in changes in your state
- ACA LTSS changes: Encourage state to apply for enhanced HCBS FMAP
- MLTSS: Familiarize yourself with CMS guidance, and make sure your state adheres to it
Resources
MLTSS: State specific waiver information

http://www.nsclc.org/index.php/mltss

• Summary of CMS Guidance on MLTSS
• Florida Medicaid LTC Guides and Tips
• Review of NY and NY MLTC Waiver
Duals Demo:

www.dualsdemoadvocacy.org

• Enrollment timelines
• MOU Summaries
• Informational webinars
Contact:
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Questions?
# Advocate’s Guide

## Medicaid Long Term Services & Supports 101: Emerging Opportunities and Challenges

By Evin Isaacson, Eric Carlson, Anna Rich

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The development of this Advocate’s Guide would not have been possible without the support of the Albert and Elaine Borchard Center on Aging and The Atlantic Philanthropies. The authors thank the numerous advocacy organizations that have been our partners and allies in this important work and who used their experience and expertise to develop many of the resource materials featured in this Guide. The authors also wish to thank our colleagues at the National Senior Citizens Law Center, in particular Nancy Arevalo, Georgia Burke, Kevin Prindiville, and Scott Parkin, for their contributions and willingness to help in a variety of ways. This report is available online at www.nsclc.org.
Medicaid, the joint federal-state program that provides healthcare coverage for certain groups of low-income individuals, is the single largest purchaser of long-term services and supports (LTSS) in the United States. LTSS services are those that help older adults and people with disabilities manage chronic conditions, as well as accomplish everyday tasks such as bathing, getting dressed, fixing meals, or managing a home. LTSS services include residential care in facilities like nursing homes. But they also include home and community-based service options (HCBS) such as home health care, personal care assistance, adult day care and homemaker services that help meet peoples’ needs without institutional placement. As our population ages, the number of individuals needing help of this kind is projected to double.

Medicaid consistently spends more on institutional care than community-based care for beneficiaries with LTSS needs. Over the years, Congress has gradually expanded Medicaid’s community-based service options, but the balance of expenditures still falls on the side of nursing homes and other facilities. The current legal and political landscape presents both great opportunities to expand low-income individuals’ ability to receive needed LTSS services at home, and tremendous challenges for maintaining current access to such programs.

On one hand, in passing the Patient Protection and Affordable Care Act (ACA) in 2010, Congress took arguably its most aggressive action toward “rebalancing” Medicaid’s LTSS spending in nearly three decades. At the same time, recession-related state budget shortfalls have put hundreds of Medicaid home and community-based LTSS benefit programs at risk. While states participating in Medicaid are required to provide nursing home services, coverage of most in-home services and supports is optional – making them an easy target for policymakers looking for a quick fix to state budget woes.

This guide offers advocates a primer on the law that impacts Medicaid-funded home and community-based services. It also highlights key resources and tools to use when advocating to expand and preserve Medicaid coverage of critical LTSS services in individual states.

Part I (Survey of Community-Based LTSS Program Options) explains different programs states can use to provide home and community-based LTSS through Medicaid, including new ACA programs and managed care delivery systems.

Part II (Legal Protections 101) gives an overview of the federal standards and requirements that protect access to community-based Medicaid services,
including disability rights laws, the Medicaid Act, and due process.

Part III (Advocacy Issues) identifies trends in Medicaid LTSS and offers strategies to help advocates ensure that program changes work to the benefit of Medicaid consumers.

Each of these parts is paired with an annotated Resources table that features useful related resource materials, including issue briefs, legal primers, federal policy guidance, policy whitepapers, and advocacy tools.

Finally, a table of Recent Notable Cases offers summaries of some recent, noteworthy court challenges to community-based LTSS program cuts, as well as other cases that bear on advocates’ ability to defend against such cuts in the future.
I. Survey of Community-Based LTSS Program Options

Medicaid gives states significant flexibility to determine which services to cover, particularly with respect to home and community-based services (HCBS). In fact, the only non-institutional long-term benefit states are required to cover is home health for individuals who would qualify for nursing home care. All other non-institutional LTSS, including personal care assistance, homemaker services, and adult day care, are so-called “optional” services, meaning that state Medicaid programs can decide whether or not to offer them. Not surprisingly, the configuration of community-based services and supports available to Medicaid participants varies dramatically from state to state.

Most states do cover some combination of community-based services or supports. They can use an array of program, service and delivery vehicles to do so, each with its own rules and requirements. This section explains and highlights significant and/or recently-enacted programs states can use to offer LTSS at home or in the community: A) traditional state plan services, B) waivers (including HCBS and demonstration waivers), C) other options for community-based LTSS (including the Self-Directed Personal Assistance Program, the Program for All-Inclusive Care For the Elderly (PACE), the HCBS state plan option, Community-First Choice (CFC), and the Balancing Incentives Payment Program (BIPP)), and D) managed care.

A. Traditional State Plan Services

Traditionally, for a service to be covered under a state’s Medicaid program, that service must be included in its Medicaid State Plan. To participate in Medicaid, states develop state plans that describe the scope and nature of their Medicaid program, including what services will be covered and for whom. Each state’s plan must be approved by the federal Centers for Medicare and Medicaid Services (CMS). (See Part II.B.)

Under the rules of the Medicaid program, a state’s plan must cover at least certain “mandatory” services, including home health services for individuals who satisfy the clinical criteria for nursing home placement. State plans may also offer other optional LTSS services, such as personal care and private duty nursing, as part of the general Medicaid
benefit package. As of 2008, all 50 states, plus the District of Columbia, offered home health services through their state plans and 32 states did the same for personal care services.

All services included in a state’s regular state plan benefit package—whether optional or mandatory—are entitlements: they must be available to any person in the state who meets the relevant financial and clinical standards. They also must comply with the requirements of federal Medicaid law discussed in Part II.B. LTSS services offered as part of a state’s regular state plan benefit package are subject to the same rules, including the requirement that covered services be available statewide, and that comparable services be provided to beneficiaries with comparable medical needs. (See Part II.B.) Within those limits, however, states have the flexibility to decide the scope of services available and any relevant eligibility criteria.

**B. Medicaid Waivers**

As described above, services provided through state plans, including home and community-based LTSS, have to be administered in a way that meets all the requirements of the Medicaid Act. However, the Medicaid statute also authorizes a number of “waiver” programs through which states can get approval from the Centers for Medicare and Medicaid Services (CMS) to waive certain requirements when providing certain services or serving certain populations. There are two main waiver programs states can use to provide community-based long-term services and supports: Home and Community-Based Services (HCBS) waivers and demonstration waivers. LTSS services provided through these waivers are subject to the particular rules associated with each program, and any general Medicaid Act requirements that haven’t been explicitly waived by CMS.

### i. HCBS Waivers

The Home and Community-Based Services (HCBS) waiver program allows states to offer community-based LTSS service packages to individuals whose care needs would otherwise qualify them for Medicaid-funded institutional care in nursing homes, hospitals, or intermediate care facilities for those with mental retardation (ICF/MR). There is no limit on the number of HCBS waivers a state can operate; currently, there are more than 300 active HCBS waiver programs operating in 47 states and the District of Columbia.

HCBS waivers, sometimes called Section 1915(c) waivers after the Social Security Act Section that created them, can offer a broad combination of medical and non-medical community-based LTSS. Benefits can include case management, home health aide services, personal care, adult day health care, and respite care, as well as other services states

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2 A similar HCBS waiver, authorized under Section 1915(d), allows states to provide community-based LTSS to adults age 65 and older.
were not previously permitted to offer as state plan entitlements. In addition, states can propose “other” types of services, such as home modification assistance, aimed at diverting or transitioning individuals from institutional settings into the community.

HCBS waivers permit states to restrict and/or expand coverage for these services in ways they can’t for state plan entitlements:

• **Cost Limits.** Under the HCBS waiver program, the costs of care cannot exceed those for comparable services in an institutional setting. In contrast, when services are strict entitlements, eligible individuals have the right to receive as much care as is necessary to meet their needs, regardless of cost.

• **Geographic Limitations.** States can request to waive Medicaid’s statewideness requirement (see Part II.B) and limit coverage for particular services to certain geographic regions.

• **Population Targeting and Enrollment Caps.** States can ask to waive Medicaid’s comparability requirement (see Part II.B) and limit coverage to a particular population, such as the elderly, those with physical disabilities, or those with HIV/AIDS. States can also waive comparability to limit the number of people who can access services through a particular waiver. If more residents qualify for an HCBS waiver than there are “slots” available, states can maintain waiting lists – something they are not allowed to do for state plan services.

• **Relaxed Income and Resource Rules.** Financial requirements for Medicaid eligibility are generally more restrictive for individuals who live in the community than for those in institutions. However, because individuals must meet the clinical standards for institutional care to get 1915(c) waiver services, states can waive the community resource and income rules and use institutional financial standards for all waiver participants, even if they live at home. Individuals who enroll in an HCBS waiver under this special income category are entitled to full Medicaid benefits.

In order to offer community-based LTSS services through an HCBS waiver, states submit a waiver application to CMS. That application explains the contours of the proposed HCBS program, including the services to be provided, the target population, service eligibility criteria, and which Medicaid Act requirements the state wishes to waive. Waivers must be renewed and reapproved by CMS every three to five years.

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3 States can cap costs individually (so that the costs of a particular individual’s care in the community cannot exceed the cost of comparable institutional care for that person) or on an aggregate basis (so that the total cost of community-based care for all waiver participants does not exceed the total amount it would cost to serve that population in institutional settings).
ii. Medicaid Demonstration Waivers

States may also choose to offer LTSS through a demonstration waiver. Section 1115a of the Social Security Act gives states the option to design experimental pilot projects, known as Section 1115 waiver or demonstration waiver programs, aimed at finding better ways to administer and promote the goals of the Medicaid program. In designing these demonstrations, states can ask CMS to waive any of the requirements in Section 1396a of the Medicaid Act, among others, to the extent necessary to carry out the pilot. Currently, there are over 80 active Section 1115 waivers.

Section 1115 waivers offer states tremendous flexibility. They can be used to do things as diverse as changing Medicaid eligibility rules, moving to managed care financing and delivery models (see Part I.D), or offering coverage for services not traditionally available through Medicaid, including certain LTSS that couldn’t historically be offered as state plan services.

This flexibility, however, does have limits: courts have interpreted the Medicaid statute to authorize CMS approval of Section 1115 waivers only where the proposed project actually seeks to test or demonstrate something (e.g., the potential for cost savings or better health outcomes), is likely to assist in promoting the objectives of the Medicaid Act, and is limited in scope and duration to that necessary to achieve its demonstration purpose. Demonstrations must be budget neutral to the federal government, meaning the project can’t require the federal government to contribute more than it would have without the waiver. Demonstration waivers also cannot be used to waive Medicaid rules other than those specifically enumerated in Section 1115a, nor requirements imposed by the Constitution or other federal laws, such as the Americans with Disabilities Act. (See Parts II.C, II.A.)

To obtain a Section 1115 waiver, states submit to CMS a waiver application which details, among other things, the purpose of the demonstration, the services to be provided, eligibility rules, and the Medicaid Act requirements to be waived. In general, demonstration waivers are approved for a five-year period and can be renewed, typically for an additional three years.

Because demonstration waivers can make sweeping changes to the traditional Medicaid programs rules, the ACA added a requirement for greater transparency and established an opportunity for public comment during the application review process. States are required to post proposed demonstration waiver applications and any accompanying documents online at least 30 days prior to their submission to CMS. States must also hold at least two public hearings at least 20 days prior to submission of the demonstration proposal. At the federal level, CMS is required to provide at least a 30-day comment period. The application and any public comments are also posted online, along with any special terms and conditions imposed by CMS if and when the application is approved.

Key Sources of Law

Authorizing Statute: 42 U.S.C. § 1315
Application, Review, and Public Input Rules: 42 C.F.R. § 431.400-.428
1115A Dual Eligible Demonstrations

Section 1115A of the Social Security Act, enacted as part of the Affordable Care Act, grants CMS wide discretion to approve demonstration projects that test changes to Medicare and/or Medicaid to see whether they save money while maintaining or improving quality. As of July 1, 2012, 26 states have submitted proposals for financial alignment demonstration projects that would integrate the delivery of Medicaid and Medicare benefits for individuals dually eligible for both programs (dual eligibles). The majority of these dual eligible demonstration proposals, if approved, would enroll dual eligibles into capitated managed care plans responsible for providing all Medicare and Medicaid services, including LTSS.

Section 1115A authority is distinct from that available to states under the Section 1115a Medicaid demonstration waiver; states approved to integrate Medicaid and Medicare services through a Section 1115A demonstration still need separate authorization – through a Medicaid waiver or state plan amendment – in order to make changes to their Medicaid LTSS programs. For example, if a state seeks to require dual eligibles to enroll in Medicaid managed care as part of its dual eligible demonstration, the state will need to both get its dual eligible demonstration approved and apply for a Section 1915(b) or Section 1115a waiver that will permit them to do that. (See Part II.D.)

Additional information on dual eligible demonstrations is available at www.dualsdemoadvocacy.org. Additional information on Medicare coverage and advocacy can be found at www.medicareadvocacy.org.
C. Other Options for Community-Based LTSS

Since enacting Section 1915(c) in 1981, Congress has continued to authorize new, albeit less heavily utilized, Medicaid programs through which states can offer community-based services and rebalance LTSS expenditures away from institutional care. Other community-based LTSS program options of note include: i) the Self-Directed Personal Assistance Program, ii) the Program of All-Inclusive Care for the Elderly (PACE), iii) the HCBS state plan option, iv) Community First Choice (CFC), and v) the Balancing Incentive Payment Program (BIPP). The three latter programs were all either created or substantially amended in 2010 by the Affordable Care Act (ACA), which represents arguably the most aggressive action in the post-HCBS waiver rebalancing effort to date.

i. Self-Directed Personal Assistance Program

Self-directed personal assistance services (PAS), also known as 1915(j) services, involve both personal care and related services. States can provide PAS as an HCBS state plan option benefit (see Part I.C.iii) or through a 1915(c) waiver (see Part I.B.i). States have the option to waive Medicaid’s comparability requirement with respect to PAS (see Part I.B), and can also provide it to people who would otherwise only be financially eligible for Medicaid based on less restrictive institutional income criteria.

Beneficiaries who choose PAS are able to hire and train their own homecare providers, rather than going through a licensed homecare agency. Relatives and friends can serve as providers. This can include parents or spouses if the state chooses. States can also choose to give beneficiaries cash disbursements rather than paying providers. A person-centered planning process and an individualized plan of care is required.

ii. Program of All-Inclusive Care for the Elderly (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) is a state plan optional benefit that includes LTSS and other health services. It is a relatively small program, available only to people who live within a PACE organization’s service area. Eligibility is limited to those 55 years or older and clinically eligible care in a nursing home. PACE organizations are responsible for providing all Medicare and Medicaid services to their enrollees. Enrollment is voluntary; eligible participants can choose to enter or leave any time. PACE has its own unique integrated appeals process.

PACE organizations, almost all of which are non-profit or public, have a reputation as successful providers of integrated LTSS and health services. However, states have found it difficult to implement PACE on a large scale.
iii. HCBS State Plan Option

The HCBS state plan option, which was substantially amended and enhanced as part of the Affordable Care Act, allows states to offer as state plan services the same types of community-based LTSS available through the HCBS waiver. The HCBS state plan option is similar to the HCBS waiver in that it lets states waive Medicaid’s comparability requirement (see Part II.B) to limit program benefits to particular populations. However, it does not allow states to maintain waiting lists or limit services to particular areas of the state.

In addition, unlike under HCBS waivers, an individual does not have to qualify for institutional care in order to receive services through the state plan option; rather, states are required to make their state plan option clinical eligibility criteria less stringent than those for nursing home services. If state plan option enrollment exceeds projected estimates, states can (after giving CMS and the public 60 days advance notice) modify non-financial eligibility standards to try to reduce the eligible population. Grandfathering provisions protect those who were receiving LTSS prior to the adoption of the state plan option from losing services as a result of these changes.

People with incomes up to 150 percent of the federal poverty level are eligible, and the state can also choose to include those who otherwise would be eligible under an HCBS or demonstration waiver, so long as the person’s income does not exceed 300 percent of the federal Supplemental Security Income (SSI) benefit.

iv. Community First Choice Option (CFC)

The Community First Choice option (CFC), also enacted as part of the ACA in 2010, gives state Medicaid programs incentives to offer more extensive HCBS by increasing the federal Medicaid match by six percent for HCBS that meet CFC standards. Because CFC is provided through a state plan amendment rather than a waiver, CFC benefits must be made available throughout a state, not limited by enrollment caps or geographical restrictions, for example.

Beneficiaries must need nursing home care or the equivalent. Financial eligibility for CFC requires income not exceeding 150 percent of the federal poverty level or, alternatively, not exceeding the state’s special income limit for persons needing nursing home care (generally 300 percent of the federal SSI benefit).

CFC services can be made available through an agency-provider model, or through a
consumer-directed model. Individual beneficiaries have discretion to set standards for service providers, with the additional requirement in an agency-provider model that states “define in writing adequate qualifications for providers.” Family members can be hired from a service budget, as long as the family member has been trained to the beneficiary’s satisfaction.

v. Balancing Incentive Payments Program (BIPP)

The State Balancing Incentive Payments Program (BIPP), another ACA enactment, is a temporary program that provides extra money to incentivize change in states whose current Medicaid spending for community-based LTSS is less than that for LTSS in facilities. To date, eight states have been approved to participate in BIPP. In making a BIPP application to CMS, a state commits itself to spend either 25 or 50 percent (or more) of its LTSS Medicaid budget on community-based services. The 25 percent target applies to those states whose HCBS expenditures are currently under 25 percent of their total LTSS spending; the 50 percent target applies to those states currently between 25 and 50 percent. State strategies for meeting these targets must include a no-wrong-door entry point system, conflict-free case management, and a standardized assessment agreement.

If a state’s target is 25 percent, it will receive a five percent increase in its federal Medicaid match for non-institutional LTSS expenditures. For states with a target of 50 percent, however, the increase in the match declines to two percent.

vi. Money Follows the Person

The Money Follows the Person (MFP) program was authorized by 2005’s Deficit Reduction Act (DRA). Through MFP, Congress authorized payment of $1.75 billion over five years for state efforts to transition Medicaid-enrolled nursing home residents to the community. Medicaid money “follows” the Medicaid beneficiary from a nursing home or other institution to a community-based setting. For the first 12 months after the move to the community, the state’s Medicaid program receives an increased federal reimbursement rate for LTSS provided to the beneficiary. MFP assistance initially was available only to persons who had resided in an institution for at least six months; this prerequisite was reduced to 90 days in 2012. MFP is currently scheduled to last until 2016.

Forty-three states and the District of

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4 An agency model is one where the caregiver is employed by a service provider agency that receives Medicaid reimbursement for services provided and pays the caregiver a wage. A consumer-directed model is one where the caregiver is employed and directed solely by the beneficiary. In the consumer-directed model, Medicaid reimbursement can be routed through a fiscal agent, or take the form of vouchers, or cash payments directly to the beneficiary.
Columbia are participating in MFP. The program originally got off to a slow start, however, as fewer people have transitioned out of institutions than anticipated. Challenges to implementation of MFP have included lack of safe, affordable housing, and, in some states, lack of support for program administration.

D. Managed LTSS

Traditional Medicaid operates under a fee-for-service (FFS) model, meaning that states directly reimburse providers, including long-term care providers, for each approved service beneficiaries receive. States can also elect to utilize managed care delivery systems, in which Medicaid services are provided by a private organization contracted with the state.

Medicaid managed care programs vary widely. States can contract with health plans, also called managed care organizations (MCOs), to provide all or most of an enrolled beneficiary’s Medicaid services in exchange for a capped monthly payment. States can contract with limited benefit plans to provide only particular service packages like LTSS or mental health services. Or they can pay primary care case managers (PCCMs) a fee to both act as a beneficiary’s primary care provider and coordinate and arrange any outside services. Some states make enrollment in managed care optional; in others, enrollment is mandatory. States can elect to enroll all Medicaid beneficiaries or restrict enrollment to specific populations.

Historically, long-term services and supports were carved out of Medicaid managed care – i.e., explicitly excluded from the list of covered services plans were required to provide. The state continued to pay providers directly for carved-out services on a fee-for-service basis, even for managed care enrollees. However, states are increasingly integrating LTSS services into managed care. The number of states with managed LTSS programs has grown from eight in 2004 to 16 in 2012; that number is expected to increase to 26 by 2014.

States can use four different kinds of statutory provisions to enroll beneficiaries into managed care – the Section 1932(a) state plan authority or the Section 1915(a), 1915(b), or 1115a waiver authorities. (See Part I.B.ii.) Each of these authorities can be used to offer any state plan service, including state plan long-term services and supports, through managed care. To offer managed care coverage of community-based LTSS services that aren’t included in its state plan, a state can either use a Section 1115 waiver to establish its program, or combine any of the other managed care authorities with a Section 1915(c) HCBS waiver.

To mandatorily enroll individuals dually-eligible for both Medicaid and Medicare – among the heaviest users of LTSS services– into Medicaid managed care, states can use
either a Section 1915(b) waiver or a Section 1115 waiver.\textsuperscript{5}

All four managed care authorities allow states to waive the Medicaid Act rules on statewideness (to limit managed care programs geographically), comparability (to offer certain services exclusively to beneficiaries enrolled in managed care), and freedom of choice (to restrict enrollees’ choice of providers to those in the plans’ network). (See Part II.B.) In addition, whatever authority a state uses, it must comply with general Medicaid regulations that set managed care program standards in areas including health plan quality, appeal and grievance rights, provider access.

\textsuperscript{5} Mandatory enrollment of dual eligibles into managed care is a component of many of the Section 1115A dual eligible demonstration proposals currently under consideration by CMS. (See 1115A Dual Eligible Demonstrations inset, Part I.B.ii.) The Section 1932(a) state plan authority does not permit mandatory enrollment of certain populations, including dual eligibles. Section 1915(a) permits states to create voluntary managed care programs, but does not allow any mandatory enrollment whatsoever.

\begin{figure}[h]
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Key Sources of Law \\
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State Plan Authority: \\
42 U.S.C. § 1396u-2 \\
1915(a) Authority: \\
42 U.S.C. § 1396n(a) \\
1915(b) Authority: \\
42 U.S.C. § 1396n(b) \\
1115a Authority: \\
42 U.S.C. § 1315 \\
General Managed Care Rules: \\
42 U.S.C. § 1396b(m) (MCOs) \\
42 U.S.C. § 1396d(t) (PCCMs) \\
42 C.F.R. § 438 \\
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<tr>
<td><strong>A. Traditional State Plan Services</strong></td>
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<tr>
<td>1 Kaiser Commission on Medicaid and the Uninsured, <em>Medicaid Home and Community-Based Services Programs: Data Update</em> (Dec. 2011)</td>
<td>Issue brief analyzing national trends over ten years (ending in 2008) in participation and expenditures in Medicaid home- and community-based services, including the home health state plan benefit and the personal care services state plan benefit.</td>
<td><a href="http://www.kff.org/medicaid/upload/7720-05.pdf">www.kff.org/medicaid/upload/7720-05.pdf</a></td>
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<td><strong>B. Medicaid Waivers</strong></td>
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<td>2 Medicaid.gov, <em>Waivers</em></td>
<td>Online, state-by-state list of waiver types and links to copies of waiver agreements with states.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html</a></td>
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<td>3 The SCAN Foundation, <em>Long Term Care Fundamentals: What is a Waiver?</em>, Technical Brief Series No. 8 (Aug. 1, 2011)</td>
<td>Explains the various waivers available to states under Medicaid and describes those Medicaid waivers operational in California as of the date of publication.</td>
<td><a href="http://www.thescanfoundation.org/what-medicaid-waiver">www.thescanfoundation.org/what-medicaid-waiver</a></td>
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<td>4 National Health Law Program, <em>Federal Medicaid Waivers</em>, THE ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM 2.7 (June 2011)</td>
<td>Section of comprehensive Medicaid treatise exploring each waiver authority in depth. Draws from and compiles relevant Medicaid statutes and regulations, as well as federal guidance documents, and federal and state court case law.</td>
<td>Purchase or subscription only: <a href="http://healthlaw.org/index.php?option=com_c1ontent&amp;view=article&amp;id=110&amp;Itemid=183">healthlaw.org/index.php?option=com_c1ontent&amp;view=article&amp;id=110&amp;Itemid=183</a></td>
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<td><strong>i. HCBS Waivers</strong></td>
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<tr>
<td>5 Medicaid.gov, <em>Home &amp; Community-Based Services 1915(c)</em></td>
<td>Online federal government resource explaining rules and guidelines of 1915(c) Waiver program.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-c.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-c.html</a></td>
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<td>6 Kaiser Commission on Medicaid and the Uninsured, <em>Medicaid Home and Community-Based Services Programs: Data Update</em> (Dec. 2011)</td>
<td>Issue brief analyzing national trends over ten years (ending in 2008) in participation and expenditures in Medicaid home- and community-based services, including 1915(c) waivers.</td>
<td><a href="http://www.kff.org/medicaid/upload/7720-05.pdf">www.kff.org/medicaid/upload/7720-05.pdf</a></td>
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<td>7 Centers for Medicare and Medicaid Services, <em>Application for a § 1915(c) Home and Community-Based Waiver (Version 3.5): Instructions, Technical Guide and Review Criteria</em> (Jan. 2008)</td>
<td>Federal guidance on requirements of an HCBS Waiver, as well as instructions for completing the application, review and renewal.</td>
<td><a href="http://www2.ancor.org/issues/medicaid/07-28-08_Version_3.5_Instructions.pdf">www2.ancor.org/issues/medicaid/07-28-08_Version_3.5_Instructions.pdf</a></td>
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<td>8 Center for Personal Assistance Services, <em>Home and Community PAS Based Programs</em></td>
<td>Online repository for state-by-state data on participants, services, and expenditures in Medicaid community-based LTSS programs, particularly 1915(c) Waivers. Collected as part of a 5-year research project to study HCBS trends over time.</td>
<td><a href="http://www.pascenter.org/home_and_community/index.php#reports">www.pascenter.org/home_and_community/index.php#reports</a></td>
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<td>9 Medicaid.gov, <em>Section 1115 Demonstrations</em></td>
<td>Online resource explaining basics of 1115 Demonstration program, application process and public input rules. Offers link to all demonstration proposals submitted to CMS, including all active, pending, denied, and/or expired 1115 Waivers.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html</a></td>
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<td>10 Kaiser Commission on Medicaid and the Uninsured, <em>An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity</em> (May 2012)</td>
<td>Policy brief describing recent developments and trends in states’ use of Section 1115 demonstration waivers. Also provides background on the Section 1115 authority, key elements of the waiver application, and the demonstration approval process.</td>
<td><a href="http://www.kff.org/medicaid/upload/8318.pdf">www.kff.org/medicaid/upload/8318.pdf</a></td>
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<td>11 National Senior Citizens Law Center, <em>Dual Eligible Integrated Care Demonstrations</em></td>
<td>Information for advocates about dual eligible integrated care demonstration projects, including repository of comments from advocates on states’ 1115 duals demonstration proposals.</td>
<td>dualsdemoadvocacy.org</td>
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<td><strong>C. Other Options for Community-Based LTSS</strong></td>
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<td><strong>i. Self-Directed Personal Assistance Services Program</strong></td>
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<td>12 Medicaid.gov, <em>Self-Directed Personal Assistant Services 1915(j)</em></td>
<td>Online resource explaining basic 1915(j) guidelines and rules. Includes links to additional federal guidance, as well as information about self-directed services generally.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Self-Directed-Personal-Assistant-Services-1915-j.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Self-Directed-Personal-Assistant-Services-1915-j.html</a></td>
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<td><strong>ii. Program of All-Inclusive Care for the Elderly (PACE)</strong></td>
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<td>14 Medicaid.gov, <em>PACE</em></td>
<td>Online resource explaining basic PACE guidelines and rules. Includes links to additional resources like the PACE Manual – a compilation of detailed program rules for providers – and information for state about their responsibilities in administering the program.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html</a></td>
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<td><strong>iii. HCBS State Plan Option</strong></td>
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<td>16 Medicaid.gov, <em>Home &amp; Community-Based Services 1915(i)</em></td>
<td>Online resource explaining 1915(i) guidelines, rules, and state application and approval processes.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html</a></td>
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<tr>
<td>17 Centers for Medicaid and Medicare Services, Re: Improving Access to Home and Community-Based Services, State Medicaid Director Letter # 10-015 (Aug. 6, 2010)</td>
<td>Federal guidance explaining the changes to the HCBS state plan option enacted by the ACA, the requirements to qualify for the program, and procedures for states to submit state plan amendment applications to participate.</td>
<td>downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10015.pdf</td>
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<tr>
<td>19 Families USA, Long Term Services Health Reform Provisions: Community First Choice Option</td>
<td>Online resource that explains rules and guidelines for CFC program, with links to other relevant materials.</td>
<td><a href="http://www.familiesusa.org/issues/long-term-services/health-reform/community-first-choice-option.html">www.familiesusa.org/issues/long-term-services/health-reform/community-first-choice-option.html</a></td>
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<tr>
<td>20 Medicaid.gov, Balancing Incentive Program</td>
<td>Online resource explaining BIPP rules and guidelines, as well as postings of all approved state applications to participate in the BIPP program.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html</a></td>
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<tr>
<td>21 Justin Foley, Service Employees International Union Healthcare Research, BIPP Annual FMAP Increase Estimates</td>
<td>Table estimating the amount of additional federal matching funds each state and the District of Columbia could generate for their Medicaid programs each year by participating in BIPP.</td>
<td><a href="http://www.ncoa.org/assets/files/pdf/public-policy--action/SEIU-Analysis-Anticipated-BIPP-Reimbursement-JF-073012.pdf">www.ncoa.org/assets/files/pdf/public-policy--action/SEIU-Analysis-Anticipated-BIPP-Reimbursement-JF-073012.pdf</a></td>
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<td>22 Lina Walker, AARP Public Policy Institute, Health Care Reform Improves Access to Medicaid Home and Community-Based Services (June 2010)</td>
<td>Fact sheet offering a summary of the community-based LTSS changes made by the ACA, including the enactments of BIPP and CFC, and the amendments to the HCBS state plan option.</td>
<td>assets.aarp.org/rgcenter/ppi/ltc/fs192-hcbs.pdf</td>
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<td><strong>D. Managed LTSS</strong></td>
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<tr>
<td>23 Medicaid.gov, Managed Care</td>
<td>Online resource that explains various options for authorizing Medicaid managed care programs. Includes links to relevant state waiver applications.</td>
<td><a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html">www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html</a></td>
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<tr>
<td>25 Centers for Medicare and Medicaid Services, <em>Managed Long Term Services &amp; Supports: Resources for State Policy and Program Development</em></td>
<td>Online resources for state policy makers engaged in managed LTSS program design, including explanations of universal managed care features, program design options, and available program vehicles, as well as case studies, worksheets and sample managed care contracts.</td>
<td><a href="http://www.medicaid.gov/ltss">www.medicaid.gov/ltss</a></td>
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<td>26 Kaiser Commission on Medicaid and the Uninsured, <em>Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider</em> (October 2011)</td>
<td>Issue brief offering background on managed LTSS programs. Identifies key issues states should consider when covering new populations and LTSS benefits through capitated payments to traditional risk-based managed care organizations.</td>
<td><a href="http://www.kff.org/medicaid/upload/8243.pdf">www.kff.org/medicaid/upload/8243.pdf</a></td>
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II. Legal Protections 101

Medicaid-funded community-based long-term service benefits are subject to a range of statutory and constitutional restrictions that offer advocates potential tools to preserve and expand individuals’ access to Medicaid LTSS at home and in the community.

The availability of community-based alternatives to institutionalization implicates federal disability rights laws, which recognize that segregation of individuals with disabilities from the community is a form of discrimination. In addition, as with other Medicaid services, states must administer LTSS in a way that is consistent with the specific rules of the Medicaid program or programs through which the services are offered (see Part I), as well as all general Medicaid Act requirements not waived by CMS. In addition, because Medicaid beneficiaries have a property right in LTSS services, states must comply with the strictures of due process when making coverage decisions. Each state Medicaid program is also, of course, subject to its own state-specific laws, including any corollary state administrative procedure, due process or anti-discrimination statutes or constitutional provisions.

This section explores the three primary categories of federal protections that apply to Medicaid community-based services and supports: disability rights laws, substantive Medicaid Act protections, and constitutional and statutory due process requirements. This survey is by no means an exhaustive list of the legal requirements that apply to any particular state Medicaid program. Instead, it is intended to provide an overview of the legal lattice that protects community-based Medicaid LTSS and to spotlight some of the federal laws that may be most useful to state advocates seeking to influence the contours of those programs.

A. Disability Rights Laws

Title II of the Americans with Disabilities Act (ADA) prohibits state and local governments from discriminating against an individual with a disability by excluding that person from or denying benefits or services on the basis of that disability. Section 504 of the Rehabilitation Act of 1973, on which the ADA is modeled, sets forth similar protections against discrimination by recipients of federal funds against individuals on the basis of disability. Both laws apply to state administration of Medicaid programs, including Medicaid LTSS programs, which are partially funded by federal dollars.

Regulations implementing Title II and Section 504 specify that public entities (or their contractors) are prohibited from administering programs using criteria or methods of administration that have the effect of discriminating on the basis of disability, whether intentional or not. Likewise, states cannot use eligibility criteria that screen out or even tend to screen out individuals or classes of individuals with disabilities from “fully and equally enjoying any service, program, or activity,” unless those criteria are a necessary part of the service, program, or activity offered.
Under the ADA and Rehabilitation Acts, a state is not required to fundamentally alter a program or a service to accommodate the needs of a person with a disability, but it can be required to make a “reasonable accommodation.” Thus, states are required to make “reasonable modifications” to policies or practices when necessary to avoid disability discrimination, unless they can show that doing so would be a fundamental alteration.

Both the ADA and the Rehabilitation Act recognize that unnecessary segregation of individuals from the community is a form of discrimination. Both laws and their implementing regulations therefore contain an integration mandate, which requires public entities to administer their services, programs, and activities in the “most integrated setting appropriate” to the needs of qualified individuals with disabilities. In *Olmstead v. L.C.*, the U.S. Supreme Court held that unnecessarily forcing persons with disabilities into nursing homes violates this integration mandate when: (1) the state’s reasonable assessment determines that community-based treatment is appropriate; (2) the individual does not oppose community placement; and (3) community placement can be achieved through a reasonable modification of the state’s services or programs.

In the years since *Olmstead*, Medicaid beneficiaries have challenged numerous state policies they allege violate the ADA and Rehabilitation Act’s integration mandate. Accordingly, federal courts have interpreted the scope of a state’s obligation to prevent institutionalization, and, in many cases, enjoined cuts or restrictions to Medicaid community-based LTSS programs that would place beneficiaries at risk of unnecessary institutionalization. (See Recent Notable Cases.)

**B. Medicaid Act**

State participation in Medicaid is voluntary, but if a state decides to participate, it must comply with all the requirements of the federal Medicaid Act and its implementing regulations. In addition to the program-specific guidelines described in Part I, above, the Act imposes generally applicable rules that – unless explicitly waived by CMS – states must follow when administering

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**Key Sources of Law**

ADA, Title II: 42 U.S.C. § 12132
Rehab Act, Sec. 504: 29 U.S.C. § 794

Methods of Administration:
28 C.F.R. § 35.130(b)(3) (ADA)
28 C.F.R. § 41.51(b)(3)(I) (Rehab Act)
45 C.F.R. § 84.4(b)(4) (Rehab Act)

Improper Eligibility Requirements:
28 C.F.R. § 35.130(b)(8) (ADA)
45 C.F.R. § 84.4(b)(1)(iv) (Rehab Act)

Reasonable Accommodations/Modifications:
28 C.F.R. § 35.130(b)(7) (ADA)
28 C.F.R. § 41.53 (Rehab Act)

Integration Mandate:
28 C.F.R. § 35.130(d) (ADA)
28 C.F.R. § 41.51(d) (Rehab Act)
their Medicaid programs and services. The following are some of the substantive Medicaid Act requirements most relevant to an individual’s ability to access community-based long-term services and supports:

**Federal Approval Requirement.** To participate in Medicaid, each state’s Medicaid State Plan must be approved by the Centers for Medicare and Medicaid Services (CMS). Once a proposed plan is approved, its elements become mandatory and any subsequent changes or amendments must be approved by CMS. Likewise, a state needs CMS approval for any waiver programs it wishes to operate and any changes must be approved by CMS prior to implementation. A state that fails to comply with the terms of its approved plan or waivers violates this federal approval requirement.¹

**Statewideness Requirement.** Medicaid law requires that all offered benefits be available to all eligible beneficiaries in the state. When operating programs through a HCBS waiver, a Section 1115 demonstration waiver, or any managed care authority, states can request that CMS waive this requirement in order to limit coverage for a service to particular geographic region. (See Parts II.B.i-ii, II.D.)

**Freedom of Choice Requirement.** The Medicaid Act requires that beneficiaries have a choice of qualified service providers. All of the Medicaid managed care authorities, see Part II.D, allow states to waive this requirement in order to limit the choices of beneficiaries to those service providers who are part of their health plans’ network.

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¹ Federal approval requirements for waiver programs can be found in their respective authorizing statutes. (See Parts I.B, I.D.)

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**Key Sources of Law**

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<td>Reasonable Promptness</td>
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<td>42 C.F.R. §§ 435.911, 435.930</td>
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<td>Comparability</td>
<td>42 U.S.C. § 1396a(a)(10)(B)(i)</td>
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<td>42 C.F.R. § 440.240</td>
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<td>Reasonable Standards</td>
<td>42 U.S.C. § 1396a(a)(17)</td>
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<td>42 C.F.R. § 440.230(c)</td>
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Reasonable Promptness Requirement. Participating states must furnish medical assistance with “reasonable promptness” to all eligible individuals, without delay caused by administrative procedures, and must continue to do so until they are found to be ineligible. States must be prompt in both processing initial Medicaid applications and providing coverage for particular services, including HCBS waiver services. While the reasonable promptness requirement does not prohibit waiting lists for capped HCBS waivers, courts have found that it does prohibit unreasonable delays in processing waiver waiting lists or providing benefits for those already enrolled.

Comparability Requirement. States are obligated to provide comparable services and benefits, i.e., benefits equal in “amount, duration and scope,” to all eligible Medicaid beneficiaries with comparable medical needs, regardless of diagnosis. This comparability requirement is violated when some recipients are treated differently than others when each has the same level of need. States can request CMS approval to waive comparability to varying extents when offering services through a range of program vehicles, including HCBS waivers, demonstration waivers, the HCBS state plan option, and any of the managed care authorities. (See Parts I.B.i-ii, I.C.iii, and I.D.)

Reasonable Standards Requirement. The Medicaid Act requires states to use “reasonable standards” when determining eligibility for and the extent of the medical assistance provided by a state’s Medicaid program – i.e., who can get services and which services are covered. Such standards must be comparable for all Medicaid eligibility groups and consistent with the objectives of Medicaid program. Exclusion of a medically necessary treatment from coverage has been found to run afoul of the reasonable standards requirement. Similarly, courts have found the requirement violated when the clinical eligibility standards for covered services are not reasonably related to need for those services.2

Amount, Duration and Scope Requirement. Medicaid services must be provided in sufficient “amount, duration and scope” to “reasonably achieve their purpose.” In assessing whether a certain service level is adequate to achieve its intended ends, courts have looked both to the objectives of the specific service at issue and to the objectives of the Medicaid program generally. Thus, to comport with this requirement, community-based services must be available at a level sufficient to reasonably offer recipients the supports they need to avoid institutionalization (their intended purpose as described in the HCBS waiver regulations) and/or to retain capability for independence or self care (the general purpose of the Medicaid Act).

C. Due Process

The Due Process Clause of the Fourteenth Amendment, as interpreted by the U.S. Supreme Court in Goldberg v. Kelly, prohibits states from denying, reducing or terminating government benefits without due process of law. Due process includes the right to meaningful notice prior to the termination...
of Medicaid benefits, continued benefits pending a pre-termination hearing, and a fair and impartial pre-termination hearing. For notice to be adequate, a state must give the reasons for its action in sufficient detail for the individual to prepare a responsive defense. Age and disability heighten the need for notice to give the specific basis for the denial of benefits.

Federal Medicaid law requires that states administering Medicaid meet the due process standards set forth in *Goldberg v. Kelly* and fleshes out what due process means in a Medicaid context. Specifically, Medicaid beneficiaries have rights to written notice and an opportunity for a hearing before coverage of services, including home and community-based services and supports, can be denied, suspended, reduced or terminated, or if a claim for medical assistance is not acted upon with reasonable promptness. Notices must be mailed at least ten days before the state takes action.

A state Medicaid agency must also grant an opportunity for a hearing when an individual requests one because he or she believes that services have been denied, reduced, suspended, or terminated erroneously. If a current beneficiary requests a hearing before the action takes place, services must be continued at the same level until a decision is made on the appeal.

States are not required to grant an individual hearing if the sole reason for the loss of services is a global change to the Medicaid program (such as the legislative elimination of an optional Medicaid benefit) that affects beneficiaries automatically, *i.e.*, is not based on an individualized factual assessment of a person’s status or care needs. Plaintiffs can still challenge automatic cuts on the bases that the cuts should not apply to them, or that they violate substantive Medicaid requirements or other federal laws like the ADA. (*See Parts II.B, II.A.*)

**Key Sources of Law**

Constitutional Due Process:
U.S. Const., 14th Amendment
*Goldberg v. Kelly*,
397 U.S. 254 (1970)

Medicaid Act Due Process:
42 U.S.C. § 1396a(a)(3)
42 C.F.R. §§ 431.200-250,
435.912, 435.919
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<th>Resource and Citation</th>
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<tr>
<td><strong>A. Disability Rights Laws</strong></td>
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<tr>
<td>27 CMS, <em>Olmstead Update No. 4</em>, State Medicaid Dir. Letter # 01-006 (Jan. 10, 2001)</td>
<td>Federal guidance addressing <em>Olmstead</em>-related limits on state discretion in design and operation of 1915(c) HCBS Waivers. Explains that state cannot limit the number of waiver enrollees who receive coverage for a particular service within a waiver and that a waiver’s package of services must be sufficient to make it a safe alternative to institutional care.</td>
<td><a href="downloads.cms.gov/archived-downloads/SMDL/downloads/smd011001a.pdf">downloads.cms.gov/archived-downloads/SMDL/downloads/smd011001a.pdf</a></td>
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<td>29 U.S. Department of Justice, Civil Rights Division, <em>Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.</em> (June 22, 2011)</td>
<td>Technical guide on the ADA’s integration mandate and <em>Olmstead</em>. Contains Q&amp;A discussing each element of an <em>Olmstead</em> claim, types of state conduct that can constitute an <em>Olmstead</em> violation (including Medicaid budget cuts), and potential defenses.</td>
<td><a href="www.ada.gov/olmstead/q&amp;a_olmstead.htm">www.ada.gov/olmstead/q&amp;a_olmstead.htm</a></td>
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## Resources: Legal Protections 101

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<td><strong>B. Medicaid Act</strong></td>
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31. Disability Rights Education & Defense Fund, Health: Access to Care  
Information about accessibility of health care for people with disabilities.  
[www.dredf.org/healthcare](http://www.dredf.org/healthcare)

Comprehensive Medicaid law treatise that covers Medicaid administration, eligibility, and services, drawing extensively from numerous sources: the United States Constitution, the Medicaid Act, the Medicaid regulations, federal guidance documents, and federal and state court case law.  
Purchase or subscription only: [healthlaw.org/index.php?option=com_content&view=article&id=110&Itemid=183](http://healthlaw.org/index.php?option=com_content&view=article&id=110&Itemid=183)

Primer discussing when state attempts to eliminate or reduce Medicaid services may run afoul of the Medicaid Act and disability rights laws. Offers an assessment of when litigation might be an appropriate tool to address cutbacks.  
[www.healthlaw.org/images/stories/Responding_to_Medicaid%20cuts.10%202011.pdf](http://www.healthlaw.org/images/stories/Responding_to_Medicaid%20cuts.10%202011.pdf)

Medicaid due process primer discussing the appeal rights that apply when Medicaid services are reduced or terminated, with a particular focus on prior authorization and utilization control.  

Guide to Medicaid notice and hearing rights, with a focus on the practical steps of the appeals process. Discusses both traditional state agency hearing processes and Medicaid managed care appeals.  
[www.kff.org/medicaid/upload/8287.pdf](http://www.kff.org/medicaid/upload/8287.pdf)

**C. Due Process**

Medicaid due process primer discussing the appeal rights that apply when Medicaid services are reduced or terminated, with a particular focus on prior authorization and utilization control.  

Guide to Medicaid notice and hearing rights, with a focus on the practical steps of the appeals process. Discusses both traditional state agency hearing processes and Medicaid managed care appeals.  
[www.kff.org/medicaid/upload/8287.pdf](http://www.kff.org/medicaid/upload/8287.pdf)
III. Advocacy Issues

The current legal and political landscape presents advocates with both great challenges for maintaining low-income individuals’ access to Medicaid-funded long-term services and supports at home, and opportunities to expand such programs in their states. This section identifies key trends in community-based Medicaid LTSS and offers strategies and resources to help advocates address emerging threats and take advantage of new opportunities. First, it examines common budget-driven cuts and outlines strategies state advocates have used to defend access. Second, it offers strategies and resources for use in legislative and administrative advocacy to expand state-wide access to home and community-based services and supports. Finally, it provides an overview of the issues posed by state proposals to shift long-term services and supports into managed care.

A. Defending Community-Based LTSS Programs

As the only discretionary portion of what is most states’ second-largest budget line item, optional Medicaid programs like community-based long-term services and supports make an easy target in times of scarcity. States have sought to cut and/or reduce utilization of key community-based LTSS programs in a variety of ways, most of which fall into one of five categories: service reductions or caps, eligibility restrictions, service eliminations, provider rate cuts, and informal barriers to access.

- **Service Reductions.** Benefit reductions or caps place strict limits on the amount of a service an individual can receive.

- **Eligibility Restrictions.** States may also attempt to tighten the rules concerning who can access a particular service. Clinical eligibility restrictions can include everything from requiring increased levels of need in certain activities of daily living to limiting the types of functional needs that can qualify someone for a service. Clinical restrictions might also include new limits on the diagnostic bases of a person’s needs. States may also seek to restrict financial eligibility for services, for example by eliminating the special income category for HCBS waiver recipients living in the community. (See Part II.B.)

- **Service Eliminations.** Because coverage of community-based long-term services and supports is optional under the Medicaid program, states may also seek to eliminate a service entirely. A state can try to eliminate services like personal care from the state plan Medicaid benefits package. It might also seek to remove a service from waiver coverage, or even, because waivers are themselves optional, completely terminate a waiver that offers community-based LTSS. A state might also seek to move a state plan service into a waiver, so that it can be subject to enrollment caps or other restrictions. (See Part I.B.)
• **Provider Rate Cuts.** States may effectively limit availability of Medicaid LTSS by cutting payments to providers, resulting in fewer willing qualified providers and reduced access.

• **Informal Barriers to Access.** In addition to more formal changes to Medicaid LTSS program rules or regulations, states Medicaid agencies may informally adopt policies or practices that result in more service or eligibility denials. For example, a state might alter the process it uses to evaluate eligibility for services or restrictively reinterpret existing eligibility standards. Such policy changes can be explicit, such as in a memo to providers or revised Medicaid program manual, or they may take the form of unpublished instructions to agency staff, or even general pressure to deny services.

Such program changes are subject to applicable legal requirements. (See Part II.) For example, reduced access to community-based LTSS that puts beneficiaries at risk of unnecessary institutionalization has the potential to violate the ADA and Rehabilitation Act integration mandates. Service caps have the potential to run afoul of the Medicaid Act’s amount, duration and scope. Similarly, imposing more restrictive clinical eligibility criteria may violate the Medicaid Act’s reasonable standards or comparability requirements. A state’s refusal to provide coverage for such a service when medically necessary may also violate the reasonable standards mandate. And, of course, even otherwise legal terminations or reductions of services must be implemented in a way that is consistent with due process. These legal requirements can therefore offer shields to advocates looking to defend community-based benefit programs from cuts. Stakeholders can target advocacy efforts to a range of audiences:

**State-level Advocacy.** Community stakeholders should bring potential legal violations as well as policy concerns, including potential costs from greater utilization of institutional LTSS (see Part III.B), to the attention of both state legislators and state administrative agencies. Because it is far easier to neutralize a problematic restriction prior to its adoption (particularly in the context of legislative enactments and formal rule-making), advocates should seek to intervene as early in the process as possible. Close monitoring of legislative and agency activity is key to defeating proposals that will have a harmful impact on beneficiaries.

**Federal Advocacy.** The federal Centers for Medicare and Medicaid Services (CMS) is charged with ensuring state compliance with Medicaid law, and is therefore a critical audience with which to raise concerns about proposed changes that restrict access to Medicaid community-based services and supports. Under the Medicaid federal approval requirement, any changes to Medicaid programs that diverge from the terms of a state’s existing state plan or waivers must be submitted to and approved by CMS prior to implementation. Here again, the sooner advocates bring their concerns to CMS, the greater the chance of making a difference. National organizations like NSCLC that routinely work with CMS are happy to help state advocates identify appropriate contacts within CMS.

In addition to CMS, advocates can raise concerns about the legality of restrictions to
Medicaid-funded community-based services and supports with at least two other federal agencies. The U.S. Department of Health and Human Services’ (HHS) Office of Civil Rights (OCR) is charged with enforcing the ADA and Rehabilitation Act as applied to recipients of federal HHS funds, including state Medicaid programs. Advocates can contact OCR informally or file official complaints to launch a formal OCR investigation into potential state violations of antidiscrimination laws. The U.S. Department of Justice (DOJ) is the federal government’s primary judicial enforcement arm, and can enforce federal laws, including the Medicaid Act, antidiscrimination statutes, and constitutional due process requirements. DOJ can also file statements of interest in cases brought by private individuals.

Litigation. In addition to legislative and administrative advocacy, individuals may be able to challenge cuts and restrictions to Medicaid community-based services and supports in court. (See Recent Notable Cases.) In such actions, Medicaid Act, Americans with Disabilities Act, Rehabilitation Act and due process claims can strengthen and complement each other. Medicaid beneficiaries alleging violations of those protections have successfully sued to enjoin community-based LTSS benefit cuts and restrictions in numerous states.

Litigation is, however, a limited and risky tool. Medicaid Act and disability rights protections are not silver bullets. At the end of the day, community-based LTSS programs are still “optional” benefits, and disability rights laws do not require states to alter their Medicaid programs fundamentally. Strong legal arguments should be paired with compelling plaintiffs who can show that they stand to suffer concrete harm to their health and well-being as a result of their state’s program changes.

In addition, although the ADA and Rehabilitation Acts contain explicit private rights of action that permit individuals to enforce anti-discrimination protections in court, the Medicaid Act contains no such explicit right to sue. Accordingly, the private enforcement of Medicaid requirements is controversial and some portions of the Act are more easily and directly enforceable than others. Because of the unsettled state of the law in this area, state advocates considering bringing Medicaid Act challenges should consult NSCLC or other national organizations familiar with enforceability issues before proceeding.

B. Expanding Community-Based LTSS

One way to respond to potential budget cuts is to advocate for expansion of HCBS. In most cases, HCBS will cost Medicaid programs less than would equivalent nursing home services. Substituting HCBS for nursing home services can both reduce state expenses and improve the lives of beneficiaries. In addition, states that qualify can take advantage of the substantial federal subsidies offered by new program options like Community First Choice and the Balancing Incentives Payment Program. (See Parts II.C.iv-v.)

State officials concerned about costs of expanding access to community-based LTSS often point to the so-called woodwork effect, i.e., that if necessary services are provided
in a community-based setting, individuals who are not currently receiving benefits will supposedly come out of the woodwork to sign up, increasing total costs to the state. According to H. Stephen Kaye’s recent research paper in *Health Affairs*, this premise is inaccurate: analyzing 15 years of state expenditure data, the research showed that a gradual transition to HCBS in fact reduces aggregate state LTSS expenditures.

Expenditures for LTSS should be considered together, so that reduced expenditures for institutional LTSS can be considered along with possibly increased expenditures for HCBS.

### C. Shifts to Managed LTSS

A growing number of states are proposing to place the responsibility for providing long-term services and supports to seniors and people with disabilities with managed care organizations (MCOs). In theory, when MCOs bear the cost of long-term care, they have a financial incentive to coordinate care better so as keep their beneficiaries healthy and to provide LTSS at home in the community as opposed to in more expensive institutional settings. Thus, integrating LTSS into managed care has the potential to facilitate better care coordination, resulting in better health outcomes, reduced costs, and higher utilization of community-based service options.

On the other hand, without program design that incorporates careful alignment of incentives, meaningful administrative oversight, LTSS-specific evaluation measures and robust consumer protections, MCOs may cut costs simply by denying needed services and/or decreasing provider rates to levels that threaten access for beneficiaries.

Medicaid MCOs have not historically served seniors and people with disabilities and most have limited experience providing long-term services and non-medical supports. Instead, their focus has been on serving the primary and acute care needs of children and families. This lack of experience with LTSS, as well as the ongoing, complex needs of the populations who utilize them, can undercut MCOs’ ability to administer those benefits effectively.

Advocates who seek to ensure that beneficiaries in managed LTSS programs have adequate access to services can utilize many of the same tools and strategies described in Part III.A, above. Any proposed LTSS managed care project must comply with specific rules of the relevant managed care authority, as well as the Medicaid rules applicable to all managed care programs, and receive CMS approval prior to

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1 When LTSS is provided through managed care, the managed care organization should be responsible for all LTSS expenditures, in order to provide a financial incentive for using less expensive community-based services and supports as an alternative for institutional care. (See Part III.B.)

2 Even in a managed care context, states retain ultimate responsibility for complying with federal law. Thus, where private enforcement is permitted, beneficiaries can sue the state directly to enforce rights violated by state-contracted MCOs. (See Recent Notable Cases.)
implementation. (See Part I.F.) (Where the proposal under consideration is a Section 1115 Waiver, advocates should be sure to take advantage of the additional stakeholder engagement opportunities created by the ACA public input rules. (See Part I.B.))

Managed LTSS programs are also subject to disability rights laws, due process protections, and any general Medicaid Act requirements not explicitly waived. (See Part II.)

Finally, because MCOs’ specific obligations are dictated by its contract with the state, advocates should closely monitor the development and contents of those contracts even after the contours of a managed LTSS program have been finalized.
## Resources: Advocacy Issues

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<td><strong>A. Defending Community-Based LTSS Programs</strong></td>
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<tr>
<td>37 Families USA, <em>Five Good Reasons Why States Shouldn’t Cut Home- and Community-Based Services in Medicaid</em> (July 2010)</td>
<td>Toolkit outlining arguments advocates can use to fight cuts to Medicaid home and community-based services, including economic and cost-based arguments.</td>
<td><a href="http://familiesusa2.org/assets/pdfs/long-term-care/Five-Good-Reasons.pdf">familiesusa2.org/assets/pdfs/long-term-care/Five-Good-Reasons.pdf</a></td>
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<tr>
<td><strong>Federal Advocacy</strong></td>
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<tr>
<td>38 Centers for Medicare and Medicaid Services, Organizational Chart (June 18, 2012)</td>
<td>Chart detailing the leadership and organizational structure of CMS. Advocates should target their outreach to the CMS offices that oversees the program about which they are concerned. The Center for Medicaid and CHIP Services is the office responsible for administering Medicaid.</td>
<td><a href="http://www.cms.gov/About-CMS/Agency-Information/CMSLeadership/Downloads/CMS_Organizational_Chart.pdf">www.cms.gov/About-CMS/Agency-Information/CMSLeadership/Downloads/CMS_Organizational_Chart.pdf</a></td>
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<td>40 U.S. Department of Justice, Civil Rights Division, <em>Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.</em> (June 22, 2011)</td>
<td>Technical assistance guide on the ADA’s integration mandate as interpreted by Olmstead. In Q&amp;A #18, explains how to file an Olmstead complaint with the Department of Justice.</td>
<td><a href="http://www.ada.gov/olmstead/q&amp;a_olmstead.htm">www.ada.gov/olmstead/q&amp;a_olmstead.htm</a></td>
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<tr>
<td>48 National Consumer Voice for Quality Long Term Care, <em>Consumer Perspectives on Quality Homecare</em> (Sept. 2012)</td>
<td>Report based on interviews with LTSS clients across the country, presenting varied consumer perspectives on quality LTSS at home. Includes personal stories demonstrating the importance of access to quality community-based services.</td>
<td><a href="http://www.theconsumervoice.org/consumers-for-quality-care#consumerperspective">www.theconsumervoice.org/consumers-for-quality-care#consumerperspective</a></td>
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<tr>
<td>49 National Senior Citizens Law Center and Disability Rights Education and Defense Fund, <em>Long Term Services and Supports: Beneficiary Protections in a Managed Care Environment</em></td>
<td>Online toolkit of ideas for LTSS beneficiary protection, which state advocates can use to push for strong protections in managed LTSS programs.</td>
<td>dualsdemoadvocacy.org/resources/ltss</td>
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### C. Shifts to Managed LTSS

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Conclusion

The combination of increased demand for long-term services and supports, the new program options available to states for offering such Medicaid-funded services at home, and intense pressure on state budgets have set the stage for the transformation of Medicaid LTSS. Consumer advocates have a critical role to play in this process: only their active participation can ensure that the LTSS programs that emerge will increase, not diminish, access to critical community-based care options for the elderly and those with disabilities.
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<th>Case</th>
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<tr>
<td><em>Brantley v. Maxwell-Jolly</em> 656 F.Supp.2d 1161 (N.D. Cal. 2009)</td>
<td>Challenge to cuts to California’s Medicaid state plan Adult Day Health Care benefit (suit continued in <em>Cota</em>, below). Across-the-board reduction of maximum service days from 5 to 3 days per week.</td>
<td>District Court found likely violations of ADA and Rehabilitation Act integration mandate. Beneficiaries faced serious risk of institutionalization and alternative services to help them remain in the community were not identified or in place.</td>
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<td><em>Bryson v. Shumway</em> 308 F.3d 79 (1st Cir. 2002)</td>
<td>Challenge to New Hampshire’s administration of waiting lists for slots in HCBS 1915(c) waiver for adults with brain injuries, which had capped enrollment. State maintained waiting list but apparently declined to fill some approved slots.</td>
<td>First Circuit held that Medicaid’s reasonable promptness requirement applies to applicants for HCBS waiver programs. Although states can maintain waiver waiting lists, failure to process and fill waiver slots while eligible individuals are waiting to enroll has the potential to violate the reasonable promptness guarantee. Remanded for further factual inquiry into the nature of the delay.</td>
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<td><em>Cota v. Maxwell-Jolly</em> 688 F.Supp.2d 980 (N.D. Cal. 2010)</td>
<td>Challenge to cuts to California’s Medicaid State Plan Adult Day Health Care (ADHC) benefit (continuation of lawsuit in <em>Brantley</em>, above). State imposed new, more restrictive eligibility criteria, including fewer qualifying functional impairments.</td>
<td>District Court found likelihood of success on ADA/<em>Olmstead</em>, Medicaid Act and due process claims. Current plan of care documents indicate need for ADHC to avoid institutionalization. New eligibility criteria imposed reductions based on arbitrary criteria unrelated to relative need for the service and likely violated Medicaid Act reasonable standards and comparability requirements. State cannot disclaim responsibility for issuing notices when delegating responsibility for assessment to providers.</td>
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1 This table offers summaries of some recent, noteworthy court challenges to community-based LTSS program cuts, as well as other cases that bear on advocates’ ability to defend against restricted access to such programs in the future. This list is not exhaustive. Instead, it is intended to provide a sense of the kinds of Medicaid LTSS policies advocates have challenged through litigation, and how courts have decided those cases.
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<td><em>Crabtree v. Goetz</em></td>
<td>Tennessee cut private duty nursing, home health care and home health aide care services available through TennCare, a Medicaid managed care program operating under a Section 1115 waiver. Restrictions included capping combined home services at 35 hours per week. Services provided through managed care organizations contracted with the state.</td>
<td>Based on physician and health care provider evidence, and state’s own prior determination of medical necessity, Court concluded that state’s home service cuts would force waiver beneficiaries into nursing homes and likely violate the ADA.</td>
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<td><em>Grier v. Goetz</em></td>
<td>Tennessee sought to modify an earlier consent decree to allow limit on prescription drug coverage to 5 prescriptions per month for enrollees in Medicaid managed care programs operating under a Section 1115 Waiver. A “shortlist” of drugs required to treat specific medical conditions was exempt from monthly limit.</td>
<td>The District Court determined the prescription cap, coupled with the “shortlist,” did not violate Medicaid’s amount, duration and scope requirement. It gave “substantial deference” to CMS approval of cap. The court found that, although the policy might result in some denial for medically necessary treatment, the evidence did not show that it would do so for most TennCare enrollees. Modification of consent decree premitted.</td>
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<td><em>Hiltibran v. Levy</em></td>
<td>Missouri refused to provide Medicaid state plan coverage for incontinence briefs (disposable diapers) for beneficiaries aged 21+ residing in the community, despite physician documentation of ongoing medical need. Medicaid per diem for adults residing in institutions, such as nursing homes, could be used to cover incontinence supplies.</td>
<td>Court held that Missouri’s refusal to cover medically necessary adult incontinence supplies by arbitrarily denoting them “personal hygiene items” violated Medicaid’s reasonable standards requirement. Missouri’s policies also violated ADA and Rehab Act integration mandates by requiring institutionalization in order to get coverage for medically needed supplies.</td>
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<td><strong>M.R. v. Dreyfus</strong></td>
<td>Challenge brought against cuts to Washington State’s state plan personal care service benefit. New state law imposed an across-the-board reduction in the Medicaid state plan personal care service hours.</td>
<td>District Court denied preliminary injunction, finding that cuts in hours would not deny needed services or put beneficiaries at serious risk of institutionalization, because services had previously been allocated based on state budget constraints, not minimum levels of need. No likelihood of success on claims under the ADA integration mandate or Medicaid reasonable standards, amount, duration, and scope comparability, freedom of choice, or federal approval requirements. Rejected beneficiaries’ due process claim on the basis that no notice was needed when service cuts were automatic.</td>
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<td>767 F. Supp. 2d 1149</td>
<td>Note: Reversed on appeal (see below)</td>
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<td>(W.D. Wash. 2011)</td>
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<tr>
<td><strong>M.R. v. Dreyfus</strong></td>
<td>Appeal of district court decision (see above) approving across-the-board reductions in service hours available under Washington State’s state plan personal care service.</td>
<td>Ninth Circuit held that serious risk of institutionalization is sufficient for <em>Olmstead</em> claim. Budget concerns alone not sufficient for a state to make a make fundamental alteration defense. Reversed district court and remanded for entry of a preliminary injunction.</td>
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<td>663 F.3d 1100</td>
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<td><strong>Newton-Nations v.</strong></td>
<td>CMS granted Arizona Section 1115a demonstration proposal, which waived Medicaid cost-sharing restrictions and increased copayments, so providers could decline to serve those who could not afford to pay. CMS granted Arizona’s request for waiver and approved the demonstration.</td>
<td>Reversing in part denial of summary judgement, Ninth Circuit held that CMS’s approval of co-payment increases as a purely cost-saving measure, with no experimental value or potential to promote the goals of the Medicaid Act, was arbitrary and capricious and exceeded CMS’s authority to approve demonstration waivers under Section 1115a.</td>
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<td>Betlach</td>
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<td>660 F.3d 370</td>
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| **Pashby v. Cansler**  
279 F.R.D. 347  
(E.D.N.C. 2011) | North Carolina altered Medicaid state plan personal care services (PCS) eligibility rules, increasing the level of functional impairment needed to qualify. Beneficiaries residing in institutions or adult care homes are not subject to same heightened requirements for PCS coverage. | District Court preliminarily enjoined new PCS eligibility rules. Found that application of stricter PCS eligibility criteria for those living in the community likely violates Medicaid comparability requirement. Found likely violation of ADA and Rehab Act integration mandates based on risk of institutionalization for beneficiaries no longer eligible for PCS, and likely due process violation because notices failed to provide detailed reasons for terminations. “Brutal need” from loss of PCS heightened state’s obligation to provide detailed notice. |
| **Pitts v. Greenstein**  
2011 WL 1897552  
(M.D. La. May 18, 2011) | Louisiana cut maximum weekly service hours for state plan personal care from 56 to 42 and then to 32. State waiver programs offer supplemental hours, but have age/geographic restrictions and long waiting lists. | District Court denied state’s summary judgment request, finding that change put those who need more than 32 hours of assistance per week at increased risk for institutionalization in violation of the ADA and Rehab Act integration mandates. Genuine factual questions exist as to whether maintaining higher cap on hours is a fundamental alteration or a reasonable modification. |
<table>
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<th>Case</th>
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<td>V.L. v. Wagner</td>
<td>Challenge to cuts in California’s Medicaid state plan in-home supportive services benefit. State sought to cut services using eligibility tools that rank and score beneficiaries based on the type and number of their functional impairments. State also sought to eliminate assistance with shopping and meal preparation as covered tasks.</td>
<td>District Court found likelihood of success on ADA, Medicaid Act and due process claims. Service reductions put beneficiaries at risk of institutionalization because previously awarded hours were based on the level of assistance needed to remain safely at home. Elimination of shopping and meal preparation services likely violates Medicaid sufficiency requirement. New eligibility tool would discriminate against those with mental and cognitive impairments, violating Medicaid Act comparability and reasonable standards requirements. Notice likely inadequate because not sufficiently calibrated to recipients with mental disabilities and limited ability to read English.</td>
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Introduction

In February 2013, the Centers for Medicare and Medicaid Services (CMS) approved Florida’s proposal to provide Medicaid long-term services and supports (LTSS) through managed care. As is generally the case in Medicaid managed care, Florida’s move to managed care is being promoted by the state as a way to provide care in a more coordinated fashion, but in practice may limit access to care for many Medicaid beneficiaries.

On the positive side, for example, Florida’s managed care program will offer a broad range of community-based services, and the description of the care planning process focuses on beneficiaries’ needs and preferences. On the other hand, community-based services will be subject to an enrollment cap that essentially extends the same enrollment cap that has been in place for community-based services in recent years. Given the significant waiting list that currently...
exists for Medicaid-funded community-based services in Florida, the continuation of the enrollment cap is troubling news for Florida beneficiaries.

This paper summarizes some important aspects of the Florida program. Identification of potential problems is key; for Florida Medicaid beneficiaries and their advocates, now is the time for further systemic advocacy. Especially to the extent that the federal approval has not completely addressed important issues, the state has the authority to establish consumer protections through the contracts with the managed care organizations (MCOs) and other guidance.

These issues are relevant to beneficiaries and their advocates in other states as well. States across the country are considering the transfer of Medicaid LTSS to managed care, and advocacy on beneficiaries’ behalf, as soon as possible in the policy development process, will be vital if managed care systems truly are to provide care that is both coordinated and beneficiary-focused.

The Long Term Care Managed Care Program

The Florida Long-Term Care Managed Care Program (the Program) has been approved for three years, with an effective date of July 1, 2013. The Program will apply statewide and enrollment will be mandatory for eligible persons needing LTSS, with limited exceptions, and with the proviso that home and community-based services (HCBS) will be subject to an enrollment cap. The Program provides only nursing facility services and HCBS; non-LTSS Medicaid services (such as hospital and physician services) are the subject of a different managed care waiver application, which currently is under review by CMS. A recent letter from CMS states that the CMS and the State of Florida “have reached agreement in principle on granting the waiver,” and currently are working through various details.

Under the Program, care will be provided through managed care organizations (MCOs) paid on a capitated monthly rate for each enrollee or, alternatively, provider service networks paid on a fee-for-service mechanism that provides incentives for cost savings. Both the MCOs and the provider service networks will operate under the same rules, aside from the difference in reimbursement. For simplicity, this summary will refer to an “MCO” to describe the health plans that will provide LTSS to the Medicaid-eligible enrollees, rather than continually referencing both MCOs and provider service networks.

With limited exceptions, persons with level-of-care needs that would qualify them for nursing facility services will be required to
enroll in MCOs in order to receive LTSS. The MCOs will be responsible for providing both nursing facility services and HCBS.

For purposes of the Program, the state has been divided into 11 regions, each of which has a specified number of managed care plans. Enrollment will be phased in over an eight-month period from August 2013 through March 2014, beginning with the implementation of the Program in Region 7 (including Orlando) in August 2013.

The Program takes the place of four existing HCBS waivers that are being phased out: the Aged/Disabled Adult Waiver, the Assisted Living Waiver, the Channeling for the Frail Elderly Waiver, and the Nursing Home Diversion Waiver (the Diversion Waiver already uses managed care). The four waivers being phased out had a total enrollment cap of 35,852. The Program will operate under a comparable cap with an annual enrollment limitation of 36,795 for HCBS for each of the three years, with HCBS enrollment at any one time capped at 35,852 throughout the three-year period.

The Program will be administered by Florida’s Agency for Health Care Administration (Florida’s Medicaid agency), in partnership with Florida’s Department of Elder Affairs.

Waiver Application History

Florida originally submitted its proposal to CMS in August 2011. The proposal was presented through two separate waiver applications – one application under Section 1915(b) of the Social Security Act to allow Medicaid mandatory managed care, and a second application under Section 1915(c) to authorize HCBS as an alternative to nursing facility services.

During the pendency of the waiver applications, negotiations took place between Florida and CMS, leading ultimately to revisions in the applications. As a result, the approved applications fulfill the same purpose as documents issued by CMS in other situations to set conditions for waiver programs — for example, memoranda of understanding that set conditions for Medicare-Medicaid integration demonstration programs, and documents of Special Terms and Conditions that authorize Medicaid managed LTSS under a Section 1115 demonstration waiver.

The negotiation of revised Section 1915(b)/(c) applications resulted in much less policy detail than the issuance of Special Terms and Conditions under a request for a Section 1115 demonstration waiver. For example, Florida’s revised application under Section 1915(b) in relation to network adequacy, does no more than promise to comply with the relevant federal statutes and regulations. By contrast, Medicaid programs in New Jersey and New York recently received approvals under Section 1115 to move LTSS into managed care and, in each instance, the Special Terms and Conditions issued by CMS contain significantly more detail than do Florida’s approved applications in relation to network adequacy and many other issues.

Eligibility

The Program will be available to persons of at least age 18 who are assessed to have a need for nursing facility services. Of course, as a Medicaid program, the Program also...
will require that an applicant meet financial eligibility requirements. In this regard, SSI recipients are categorically eligible. Also eligible are persons with limited resources and monthly incomes no more than $2,130 (300% of the federal monthly SSI benefit of $710). Spousal impoverishment protections are available, to allow a beneficiary’s spouse to retain certain allocations of resources and income.

Enrollment will be mandatory for eligible persons who wish to receive LTSS, with limited exceptions, such as persons residing in intermediate care facilities for the developmentally disabled, or persons receiving services through a Program of All-Inclusive Care for the Elderly (PACE). Furthermore, as discussed above, receipt of HCBS is limited by enrollment caps, which means that if HCBS enrollment already is at the designated limit, an otherwise-eligible person will not be able to receive HCBS at that time. Instead, the person will be placed on a waiting list, and may begin receiving services in a nursing facility as an alternative to the unavailable HCBS. It should be noted, however, that Florida advocates report that nursing facility services also are effectively limited by a shortage of Medicaid-certified nursing facility beds.

In general, persons living in the community will be allowed to retain income up to the special income limit of $2,130 monthly. For assisted living residents, however, the income limit will be the sum of the assisted living basic room and board rate, the cost of three meals per day, plus 20% of the federal poverty rate ($191.50 in 2013). To the extent that an enrollee’s income exceeds the limit, he or she will be required to pay the excess as a contribution towards the cost of the health care services. MCOs are responsible for collecting such contributions, and capitation rates will be reduced slightly to take these collections into account, so that MCOs do not receive duplicate payments.

Aside from any contribution based on income level, enrollees will pay no premiums, enrollment fees, or co-payments.

**Enrollment**

As mentioned, enrollment will be phased in over an eight-month period from August 2013 through March 2014. Region 7 (which includes Orlando) will be transitioned first, with enrollment beginning on August 1, 2013. The Miami area (Region 11) and the Tampa Bay area (Regions 5 and 6) will be transitioned in December 2013 and February 2014, respectively.

Approximately four months before enrollment, each affected Medicaid recipient will be sent a notice and then an enrollment information package, with instructions to review the material and receive telephonic or face-to-face counseling. Assistance also will be provided by case managers from existing waiver programs, for recipients in those waivers. Beneficiaries will have 30 days to select a plan; if they fail to do so, they will be assigned to a plan based on whether the plan has sufficient capacity, and whether the person is already enrolled in a plan through the Nursing Home Diversion Waiver.

Choice counselors will have provider listings for each plan’s network. For persons who do not engage in the Choice Counseling Process, the state will have access to information regarding the person’s enrollment (if any) in
a Special Needs Plan or Medicare Advantage Plan, in considering how to enroll the person, so that pre-existing relationships can be continued to the extent possible.

Once enrolled in an MCO, an enrollee will be able to change plans only within 90 days of enrollment, during an annual open enrollment period, and for good cause. Good cause is determined on a case-by-case basis, with the following scenarios being identified as good cause:

- Poor quality of care
- Lack of access to covered services
- Lack of access to providers experienced with enrollee’s health care needs
- Enrollment in error
- MCO marketing violation
- State-imposed intermediate sanction

**Consumer Assistance**

CMS modified the Section 1915(b) application to ask explicitly for a description of “the state’s ability to provide beneficiary assistance through call centers, ADRC [Aging and Disability Resource Center] assistance, and the independent advocacy/Ombudsman.” National consumer advocates have recommended that managed LTSS systems include independent ombuds programs but, notably, Florida’s response in the approved application did not indicate any effort to develop such an independent program:

The current recipient support framework, which includes Medicaid Area Offices, Long-Term Care Ombudsman, Aging

and Disabilities Resource Centers, aging and disability advocacy groups and the state’s extensive open government and public policy development and adoption process (which affords significant citizen involvement), will continue to serve recipients after long-term care managed care is implemented. The state is focusing its initial outreach and education efforts on these stakeholder groups and on long term care providers, as the long term care recipients are likely to contact them with questions.

There is some indication, however, that CMS may revisit this issue. Approximately three weeks after the issuance of the approved waivers for the Program, CMS official Cindy Mann, the Director of the Center for Medicaid and CHIP Services, wrote in a letter to the State of Florida that “we will work together to ensure that a robust independent consumer support program is in operation to help beneficiaries navigate and access long-term care services and supports so that beneficiary concerns are identified and addressed,” and that “we should continue to discuss whether this activity should be assured in the [pending managed care waiver application for non-LTC services] or through an amendment to the recent 1915(b)(c) approval” for the Program.

**Exemptions from Managed Care**

Medicaid recipients will be exempted from managed care on a case-by-case basis. The application gives two examples of situations in which a recipient might be exempted from managed care enrollment: residing in a specific nursing facility, or receiving services
from a hospice that is not part of a managed care network.

Available Services

The following services will be available under the Program: adult day health care, case management, homemaker, respite, attendant care, intermittent and skilled nursing, medical equipment and supplies, occupational therapy, personal care, physical therapy, speech therapy, transportation, adult companion, assisted living, behavior management, caregiver training, home accessibility adaptations, medication administration, medication management, nutritional assessment and risk reduction, and personal emergency response. The State claims that all LTSS currently available through HCBS waivers will also be available through the new waiver, although in some cases the terminology will change.

All service providers will be required to encourage enrollee independence, inclusion, and integration in the community. MCOs must have the “maximum flexibility needed” to ensure that enrollees receive the services they need to maintain their health, safety and welfare in the community.

Federal regulations require an MCO to identify enrollees with special health care needs, develop treatment plans for those enrollees, and provide them with direct access to specialists. MCOs in the Florida program will be excused from such requirements based on Florida’s assertion in the applications that all enrollees will have special health care needs, and on the idea that the specialness of the enrollees’ health care needs can be recognized in the provision of primary, acute and behavioral health care services (all of which are provided outside of the Program).

Level of Care

Consistent with existing practice, level of care determinations will be performed by the Comprehensive Assessment and Review of Long-Term Care Services (CARES) Unit of the Department of Elder Affairs. The Unit is comprised of a physician, registered nurse, and other assessors with nursing or advanced social work degrees. The Unit’s assessors complete the level of care evaluations based on an assessment form completed by a case manager.

The State will use the following performance measures to track its performance relative to level of care determinations:

- Percentage of new applicants receiving a level of care evaluation prior to enrollment
- Percentage of enrollees receiving annual determination within 365 days of previous level of care determination
- Percentage of enrollees having a current level of care based on state-approved assessment tool
- Percentage of level of care determinations made by qualified evaluators

Care Planning

The waiver applications contain significant detail regarding care planning. A central requirement is that care plans should “enhance an individual’s independence and
quality of life through community presence, choice, competence, respect, and community participation.”

Personal goals in a care plan might include determining where and with whom to live, choosing service and supports, maintaining personal relationships, and making decisions about daily activities.

Prior to the care planning process, a case manager will conduct an assessment of the enrollee; this assessment must include health status, physical and cognitive functioning, environment, social supports and personal goals.

The approved HCBS Application states that the enrollee directs the care planning process, with the assistance of a case manager, and other individuals that the enrollee would like to include. It is somewhat unclear, however, exactly how much authority is conferred by the word “directs.” For one, development of the care plan is listed as the responsibility of the case manager, who must consult with the enrollee or guardian, and the caregiver, primary care physician, or enrollee’s representative. The enrollee must be given information about network providers so he or she can make informed choices.

To prevent conflicts of interest, the HCBS Application states that the entities or individuals who provide services, do not have responsibility to monitor service plan implementation. This claim, however, is relatively weak, as the application provides no real assurance of separation, stating simply: “The State requires that responsibility for monitoring plan of care implementation and enrollee health and welfare within the plan be independent of any direct waiver services to avoid conflict of interest issues.”

A care plan must (among other things) establish personal goals for the enrollee; such goals must be measurable and specify a plan of action for reaching those goals. The care plan also must encourage integration of formal and informal supports, including the development of an informal volunteer network to assist the enrollee. Care plans must be developed within five business days of enrollment, or within seven days for nursing facility residents.

The care planning form will include a statement informing the enrollee that he or she can request a fair hearing if services are denied or reduced, or if he or she has been denied a choice of qualified providers. The case manager “assists the enrollee with filing for an appeal;” the application provides no further detail on the extent of the case manager’s assistance.

An MCO must provide an enrollee with procedures to follow to request a fair hearing or an appeal through the MCO’s grievance procedures. In addition, the Department of Elder Affairs will audit care plans that are reduced as a result of a new MCO’s assessments.

A case manager will be required to contact the enrollee at least monthly by telephone. Care plans must be reviewed with the enrollee, face-to-face, at least once every three months.

MCOs must “develop quality assurance tools and protocols that include internal safeguards for plan of care development.” Also, MCOs must audit a representative sample of care plans for goals, interventions, and other such elements related to community integration. On a quarterly basis, such data must be
aggregated and provided to the State.

In addition, the state’s quality assurance clinical monitors review a random sample of an MCO’s care plans. MCOs will be given 15 business days to fix any deficiencies.

The State will use the following performance measures to monitor the adequacy of care plans:

- Percentage of services delivered in accordance with care plan, regarding service type, amount, frequency, duration, and scope
- Percentage of care plans meeting all assessed needs and risks
- Percentage of care plans with personal goals and community integration goals
- Percentage of care plans distributed within 10 days to primary care physician
- Percentage of care plans signed by enrollee
- Percentage of care plans reviewed and updated every three months
- Percentage of care plans updated when enrollee’s needs change
- Percentage of care plans indicating choice of provider, choice between HCBS and facility services, and choice of services and subcontractors

**Participant-Directed Services**

Florida’s current Medicaid LTSS system allows for participant direction, and the State expects 10 percent of enrollees to direct their own services under the Program. During enrollment and the care planning process, enrollees will receive information about participant direction. Participant direction is offered for the following services: adult companion, homemaker, attendant care, intermittent and skilled nursing care, and personal care.

Direction of services may be performed by the enrollee or by a non-legal representative selected by the enrollee. Once appointed, the representative can hire and fire workers and sign worker timesheets. The enrollee can change representatives at any time.

In any of the following situations, the State may involuntarily terminate participant direction: if the enrollee is unable to employ or manage workers, is admitted to a long-term care facility, moves out of the State, fails to choose a representative, or submits inaccurate time sheets.

**Transition**

The Program contains some protections to ensure continuity of care for new enrollees. Most prominently, an MCO must continue a new enrollee’s services for 60 days or until care plan assessment and service planning are completed. If an enrollee appeals, the right to continuing services will continue until the appeal is determined.
As mentioned, the Program is taking the place of four existing HCBS waivers. In order to continue services, current participants in these waivers will be required to enroll in an MCO through the Program. Transition from the phased-out waivers will be facilitated by the independent enrollment broker who will, among other duties, transfer provider enrollment files to the new providers. For continuity of care, the State will ensure payment to existing providers during the transition period, and MCOs will pay for out-of-network service until new person-centered care plans have been developed with the enrollee and then implemented.

MCOs currently participating in the Nursing Home Diversion Waiver will be required to develop transition plans for all enrollees, whether or not the MCO will be participating in the new Program.

Under state statute, participating MCOs for the first year must offer network contracts to all nursing facilities, hospices, and current aging services providers in the region. After that year, the MCO can exclude any of these providers only for failure to meet quality or performance criteria.26

**Quality Of Care**

The waiver applications contain numerous quality of care provisions, many of which focus on data collecting and monitoring. One such requirement is that MCOs must submit monthly, quarterly, and annual reports on enrollee complaints, grievances, appeals, missed services, performance measures, and provider complaints.

Also, the State will conduct contract compliance monitoring with desk reviews, on-site visits, and face-to-face visits with a sample of enrollees. As part of the State’s annual review, the State ensures that MCOs are contracting only with qualified providers; if any deficiency in this area involves health and safety issues, the deficiency must be remedied immediately.

The State will use the Health Plan Survey of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to gather information from enrollees. The State also will analyze records of grievances and appeals, disenrollment requests, and denials of requests for referrals.

An MCO annually must submit two performance improvement plans to the State and the External Quality Review Organization (EQRO); if the EQRO discovers a deficiency, the MCO must submit a corrective action plan.

The Department of Elder Affairs (DOE) is required to submit monitoring reports to the Medicaid Agency. AHCA will use these reports as evidence-based validation of AHCA’s assurances to CMS.

AHCA will measure systemic quality improvement by reporting its status to CMS in areas such as: how many level of care determinations were complete by the enrollment date, what percentage of waiver expenditures are less than or equal to appropriated funds, and the percentage of long-term care direct calls processed by the enrollment broker.

In addition to the measures above, within 18 months of a contract award, each MCO must receive accreditation by at least one national accreditation organization.
MCO Selection

MCOs generally are selected through a competitive procurement process. There is an exception for Medicare Advantage plans or Medicare Advantage Special Needs Plans if the plan’s Medicaid enrollees are comprised exclusively of persons eligible for both Medicaid and Medicare. Such a plan can participate in the Program automatically, without going through the procurement process.

The procurement was completed prior to CMS approval of the waiver applications. Every region has between two and seven plans. American Eldercare, which is a provider service network rather than a capitated MCO, has been selected to participate in each of the regions.

Network Adequacy

The State has assured CMS that it will comply with federal statutory and regulatory standards pertaining to network adequacy. The Medicaid agency and Department of Elder Affairs will conduct a readiness review of each MCO. This review will include review of the MCO’s provider network for service adequacy and credentialing. Review also will include review of policies, written materials (whether for the general public, enrollees, or providers), information technology, and MCO staff. MCOs will be monitored on-site on an annual basis.

Service Provider Qualification

Under the Program, the State and MCOs are required to ensure that all provider requirements are satisfied. The MCO will be required to remedy any observed problems, and penalties or sanctions will be imposed as appropriate. Sanctions will range from a corrective action plan to suspended enrollment.

To ensure that providers meet standards, the State will collect the following data:

- Percentage of new MCOs that satisfy provider qualifications prior to delivering services
- Percentage of licensed subcontractors, by type, within the MCO provider network, that meet provider qualifications prior to delivering services
- Percentage of licensed subcontractors that meet provider qualifications continuously
- Percentage of MCOs continuously qualified on an annual basis

Enrollee Health And Safety

This section of the HCBS waiver application focuses on negative events such as accidents and abuse. For example, providers must report critical incidents to the MCO within 24 hours of the incident. Within 24 hours of knowing of a death or adverse incident, an MCO is required to report the incident to the State, which in turn must submit an annual report on adverse incidents to the Florida Legislature.
To protect enrollees’ health and welfare, the State will collect and monitor the following measures:

- Percentage of enrollees with substantial reports of abuse, neglect or exploitation that had appropriate follow-up by the MCO
- Percentage of enrollees with handbooks containing directions on reporting abuse, neglect and exploitation
- Percentage of enrollee case files indicating that advance directives were discussed with the enrollee
- Percentage of health and safety welfare issues reported in adverse incident reports within 48 hours
- Percentage of reports of abuse, neglect or exploitation whose investigations were commenced within 24 hours of being reported to Adult Protective Services
- Percentage of enrollees who received a telephone contact at least every 30 days to assess health status, satisfaction with services, and any additional needs
- Percentage of enrollees with information on reporting grievance and complaint procedures as evidenced by a signed acknowledgement
- Percentage of grievances that received recommended follow-up

Assisted Living Facilities

An issue receiving increased attention at the national level is whether and when assisted living facilities are suitably community-based to be considered a non-institutional option for Medicaid reimbursement. In line with this increased attention, MCOs in Florida will be required to ensure that their assisted living facilities offer the following features:

- Choice of private or semi-private room
- Choice of roommate in semi-private room;
- Lockable door to living unit
- Choice of schedule in eating and sleeping
- Access to telephone without limit to length of use
- Choice of facility and community activities
- Unrestricted ability to have visitors
- Snacks as desired, with ability to prepare snacks

An MCO will be allowed to disenroll an enrollee for residing in an assisted living facility that has not complied with the Program’s requirements.

Accessibility Requirements

Under the waiver applications, an MCO will be required to provide materials in languages other than English if at least five percent of the county’s population speaks that language. In speaking with persons whose primary language is not English, an MCO will be required to provide in-person interpreter services when practical, and otherwise over
the telephone. For persons with hearing, speech, or vision impairments, translation requirements include TTY/TDD services, Braille materials, and audiotapes.

**Marketing Requirements**

An MCO will not be allowed to conduct face-to-face marketing, but will be able to use mass marketing strategies approved by the state. “Marketing is permitted at health fairs and public events for the primary purpose of providing community outreach. All marketing activities must be approved by the State in advance of managed care plan participation and all marketing materials must be approved by the State prior to distribution.”

By state statute, MCOs may not provide inducements to Medicaid recipients to obtain enrollees, and cannot prejudice recipients against other MCOs.

**Conclusion**

As shown by this summary, the Program will be a complex undertaking. Much work remains to be done to ensure that the Program operates as intended and provides enrollees with the coordinated, high-quality LTSS that they require.

In some instances, the approved waiver applications are inadequate, and additional consumer protections should be developed through the contracts between the State and the MCOs, or through other mechanisms. In addition, even in instances where the waiver applications adequately address an issue, continued attention and effort will be required to analyze the various data collected and to otherwise monitor the Program’s performance.
ENDNOTES

1 Florida’s proposal was made through two separate waiver applications – one application under Section 1915(b) of the Social Security Act to allow Medicaid mandatory managed care, and a second application under Section 1915(c) to authorize home and community-based services (HCBS) as an alternative to nursing facility services. Subsequently, to refer to the managed care application and the HCBS application, this summary uses the citations “MC App.” and “HCBS App.”, respectively. The Basic Information section of this paper is based on HCBS App., pp. 1-3, 12-13, 34, 213; and MC App., pp. 5, 18-21, 48-49.

2 Letter from Cindy Mann, Director of Center for Medicaid and CHIP Services, to Justin Senior, Florida Agency for Health Care Administration (Feb. 20, 2013).

3 The approved applications and other approval documents are available from the Florida Agency for Health Care Administration (Florida’s Medicaid agency) at http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml.

4 MC App., p. 32.

5 See National Senior Citizens Law Center, Medicaid Managed Long-Term Services and Supports: A Review and Analysis of Recent CMS Waiver Approvals in New Jersey and New York (March 2013).

6 HCBS App., pp. 31–45, 217; MC App., pp. 21-22.

7 MC App., pp. 36-37, 47-51, 54-58, 60.

8 See also Fla. Stat. § 596.800 (good-cause reasons for disenrollment).

9 MC App., pp. 52-53.

10 MC App., p. 52.


12 MC App., p. 52.

13 Letter from Cindy Mann, Director of Center for Medicaid and CHIP Services, to Justin Senior, Florida Agency for Health Care Administration (Feb. 20, 2013).

14 MC App., p. 59.

15 HCBS App., pp. 56-145; MC App., pp. 35-36.

16 42 C.F.R. § 438.208(c).

17 HCBS App., pp. 44–53.

18 HCBS App., pp. 54, 145-70; MC App, pp. 50-51.

19 HCBS App., p. 148.

20 HCBS App., p. 146.

21 HCBS App., p. 154.

22 HCBS App., p. 147.

23 HCBS App., p. 146.


25 HCBS App., pp. 9-12; MC App., pp. 11-12, 23-24, 54-58.


27 HCBS App., pp. 15-16, 28-30, 154-71; MC App., pp. 73-75.

28 MC App., p. 16.

29 See also Fla. Stat. § 409.981(5).

30 HCBS App., pp. 152-53; MC App., p. 32.

31 HCBS App., pp. 132-43.

32 HCBS App., pp. 183-201.

33 HCBS App., pp. 125-26; MC App., pp. 53-54.

34 HCBS App., p. 55; MC App., pp. 44-46.

35 HCBS App., p. 55; MC App., p. 44.

36 MC App., p. 44.
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

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. 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

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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.
Summary of California’s Dual Eligible
Demonstration Memorandum of Understanding
The Nation’s Largest, Most Aggressive Plan for Integration

On March 27, 2013, the Centers for Medicare and Medicaid Services (CMS) released a Memorandum of Understanding (MOU)\(^1\) with the state of California that represents the nation’s largest, most aggressive plan yet for integrating Medicare and Medicaid (Medi-Cal in California) services and financing for dual eligibles using a capitated managed care model.

California was one of 26 states to submit to the Medicare-Medicaid Coordination Office (MMCO) at CMS a proposal to participate in CMS’ Dual Eligible Financial Alignment Demonstration. The state first produced a high-level summary of the demonstration in October 2011, and authorizing state legislation was signed into law on June 27, 2012.\(^2\) California is the fifth state to enter into a demonstration MOU.\(^3\) California’s demonstration is called “Cal MediConnect.” Passive enrollment in most counties is set to begin as soon as October 1, 2013. California’s current schedule allows just six months between the signed MOU and the beginning of passive enrollment—less time than any other state.

While Cal MediConnect, the dual eligible integrated care demonstration, is itself a major undertaking, it is important to note that it is just one part of a larger state project, called the Coordinated Care Initiative (CCI). In addition to Cal MediConnect, the CCI provides for simultaneous, mandatory enrollment of dual eligibles into Medi-Cal managed care plans and inclusion of all long-term services and supports (LTSS) in those Medicaid managed care plans. Historically, California has generally excluded dual eligibles from mandatory Medi-Cal managed

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\(^1\) Memorandum of Understanding between the Centers for Medicare & Medicaid Services (CMS) and the State of California Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees; California Demonstration to Integrate Care for Dual Eligible Beneficiaries, available online at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf.


\(^3\) The others, in order of the date which each MOU was signed, Massachusetts, Washington, Ohio and Illinois. All MOUs can be found at http://dualsdemoadvocacy.org/state-profiles.
care requirements and LTSS from Medi-Cal managed care benefit packages. The CCI changes this.  

The terms of the MOU apply only to Cal MediConnect, the dual eligible demonstration, not the mandatory Medicaid managed care and LTSS changes the state is proposing. The state needs to seek separate authority from CMS to make those changes.

As with other MOUs, a number of questions and details remain to be determined in the three-way contracts between CMS, the state and managed care plans. The following summary provides a high level overview of the MOU and its impact beneficiaries.

**Basics**

Under the MOU, California and CMS will contract with managed care plans (called “Participating Plans”) to provide Medicare and Medi-Cal services to dual eligibles in certain counties. Participating managed care plans will be paid on a capitated basis to provide all Medicare and Medi-Cal services, including long-term supports and services, to enrollees. The demonstration will last for approximately three years, from October 1, 2013, to December 31, 2016.

Cal MediConnect will be implemented in eight of the state’s most populous counties: Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange and Riverside.

**Authority**

Like other dual eligible demonstration projects, Cal MediConnect is a new, integrated delivery model for dual eligible individuals authorized by section 1115A of the Social Security Act, 42 U.S.C. § 1315a. Existing Medicare and Medicaid managed care rules and regulations will apply to Cal MediConnect, unless explicitly waived in the MOU. While the MOU is an important step

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4 For more information about the CCI, see www.calduals.org. The National Senior Citizens Law Center will also produce an advocates’ guide to the CCI, forthcoming in early May 2012, which will be available online at www.nsclc.org and http://dualsdemoadvocacy.org/california.

5 There are limited carve-outs from the capitated rate for some county-run specialized behavioral health and drug treatment services.

6 The state has indicated that its longer term plan is to expand Cal MediConnect to additional counties.

7 MOU p. 4, pp. 39-40 (Appendix 4, Medicare Authorities and Waivers), pp. 41-42 (Appendix 5, Medicaid Authorities and Waivers). Medicare rules are waived to allow passive enrollment, to allow a joint Medicare-Medicaid process for setting plan payment rates, to require both CMS and state approval of marketing materials, to provide for alternative grievance and appeal processes (see infra _), and to permit plans to waive Part D cost-sharing for non-institutionalized individual duals. MOU pp. 39-40. Medicaid statewideness rules are waived to provide plans only in certain geographical areas, and contract requirement rules are waived to allow a joint Medicare-Medicaid process for setting plan payment rates. MOU p. 42.
toward implementation of Cal MediConnect, California must receive additional CMS authority for related, proposed Medi-Cal program changes before enrollment begins. Specifically, California still needs to obtain CMS approval to mandatorily enroll dual eligibles into Medi-Cal managed care plans and to integrate LTSS into managed care plan benefit packages. Both of these changes are intended to be implemented simultaneously with Cal MediConnect. The state plans to amend its current 1115a waiver in order to make these program changes.

As with other MOUs, the California MOU and its appendices “are not intended to create contractual or other legal rights between the parties.” These legal rights between the parties – and the rights and protections that apply to beneficiaries – will be detailed in the three-way contracts between CMS, California and the plans. The MOU explicitly defers to the contracting process for the development of further details in 40 different places involving beneficiary safeguards and plan reporting requirements. A list is attached to this summary outlining where in the MOU the three-way-contracts are referenced. In many other places, it is clear that more detail than is included in the MOU will be needed.

**Eligible Population**

The MOU indicates that California will enroll as many as 456,000 full dual eligible individuals into Cal MediConnect. Los Angeles County’s enrollment is capped at 200,000 enrollees. There are no enrollment caps in the other seven Cal MediConnect counties.

The MOU specifies that the following groups of individuals will **not** be eligible to enroll in Cal MediConnect:

- Individuals under age 21;
- Those with other private or public health insurance;
- Clients of regional centers, state developmental centers, or intermediate care facilities for individuals with developmental disabilities;
- Individuals living in Veterans' Homes in California;
- Dual eligibles with a share of cost who are not in a nursing facility, enrolled in MSSP, or certified as meeting their share of cost using IHSS;
- Those living in certain rural zip codes in Los Angeles, San Bernardino and Riverside counties; and
- Individuals with a diagnosis of end stage renal disease before enrollment.

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8 MOU p. 4.
9 MOU pp. 8-11.
Other groups of individuals may choose to enroll in Cal MediConnect, but will not be passively enrolled.\textsuperscript{11}

- Those living in certain rural zip codes in San Bernardino county where there is only one plan option;
- Individuals enrolled in a 1915(c) home and community based waiver;\textsuperscript{12}
- Program of All-Inclusive Care for the Elderly (PACE) enrollees;
- AIDS Healthcare Foundation enrollees; and
- Kaiser enrollees.\textsuperscript{13}

Dual eligibles who are not listed above will be passively enrolled into Cal MediConnect, including:

- Medically needy dual eligibles with a share of cost who are nursing home residents or are enrolled in the Multipurpose Senior Services Program (MSSP).\textsuperscript{14}
- Dual eligibles with a share of cost who receive In-Home Supportive Services (IHSS), California’s personal care services program, if they meet their share of cost on the first day of the month in the fourth and fifth months prior to the date of their effective passive enrollment.\textsuperscript{15}
- Current Medicare Advantage plan enrollees, though they will not be passively enrolled until January 1, 2014.

Spousal impoverishment eligibility rules will apply to individuals receiving LTSS, including to those living in the community.\textsuperscript{16}

\textsuperscript{10} There are some exceptions to this: those with an ESRD diagnosis are eligible for Cal MediConnect in Orange and San Mateo county, as are ESRD patients who are already enrolled in a separate line of business operated by the “Prime Contractor.” MOU p. 8.
\textsuperscript{11} MOU pp. 9-11.
\textsuperscript{12} Specifically, these are the Nursing Facility/Acute Hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver.
\textsuperscript{13} Kaiser is not referred to by name, but is the only California plan that meets the MOU definition on p. 9 (“a non-profit health care services plan with at least 3.5 million enrollees statewide…”).
\textsuperscript{14} MOU p. 7.
\textsuperscript{15} MOU p. 7.
\textsuperscript{16} MOU p. 7-8.
Enrollment Process

The MOU authorizes the use of a passive enrollment process and does not include a ‘lock-in’ for Medicare benefits. Dual eligibles subject to passive enrollment will receive a notice informing them that if they take no action they will be automatically enrolled into a Participating Plan. The state will use prior claims data and an algorithm to assign passively enrolled individuals into the plan that appears to be the best match.

As an alternative to the passive enrollment process, dual eligibles can either select their own Cal MediConnect plan or opt out of the demonstration altogether. Individuals will have the right to opt out of the demonstration prior to the passive enrollment taking effect. They will also retain the right to disenroll from Cal MediConnect or switch plans at anytime during the year. Assuming California receives all necessary additional authority from CMS, opting out of the demonstration, will not exempt dual eligibles from the requirement that they enroll in Medi-Cal managed care plans to receive Medi-Cal services like LTSS.

Prior to passive enrollment taking effect, dual eligibles will receive three notices. The first notice will be sent 90 days prior to enrollment. The second notice will be sent 60 days prior and the third notice will be sent 30 days in advance.

In all counties, passive enrollment will be phased, with considerable variation in the process from one county to the next. In San Mateo County, all passive enrollments will occur on one of two days, October 1, 2013 and January 1, 2014. In Los Angeles County, implementation will begin with only voluntary enrollments starting no sooner than October 1, 2013. Passive enrollment in Los Angeles County would not begin until January 1, 2014. While the MOU indicates that passive enrollment will be phased over 12 months in Los Angeles County, it indicates that the exact process to be used has not yet been developed. The MOU requires California to develop and share with stakeholders for a 30 day comment period a plan for phasing enrollment in the county.

The remaining six counties will all conduct a 12 month passive enrollment process starting as soon as October 1, 2013. Dual eligibles in these counties will generally be passively enrolled on the first day of their birth month. There are, however, at least six exceptions to this general rule and the exact rules vary among counties.
### Covered Benefits and Medical Necessity

Participating plans must provide all Medicare and Medicaid services, including primary and acute care, prescription drugs, behavioral health and LTSS. Participating plans must also cover supplemental benefits that are not otherwise available under California’s Medicaid program, including dental care, vision care, and non-emergency medical transportation. Plans have discretion to provide other home and community-based services, but they are not required benefits. Medicare hospice benefits will be paid under Medicare fee-for-service.

For overlapping Medicare and Medicaid benefits, the more generous of the Medicaid or Medicare medical necessity standards will apply. The MOU also specifies that “Any services will be provided in a manner that is fully compliant with requirements of the ADA, as specified by the Olmstead decision.”

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17 MOU p. 68.
18 MOU pp. 12-13, 92.
19 MOU p. 93.
20 MOU pp. 93-94. These additional HCBS include personal care hours beyond the limits of the state plan option; in home therapies; respite care; nutrition; licensed residential care facilities, home maintenance or home or environmental adaption, etc.
21 MOU p. 94.
22 MOU p. 92.
23 MOU p. 92.
Personal Care Services (IHSS) and Self-Direction

The MOU follows applicable state law in preserving In-Home Supportive Services (IHSS), California’s personal care benefit. Plans must enter into agreements with the counties, which will continue to administer IHSS, including conducting needs assessments, authorizing hours, providing background checks for home care providers and more.\textsuperscript{24} Beneficiaries will continue to have the right to self-direct services, including hiring, firing and supervising personal care providers.\textsuperscript{25} California’s language on self direction is stronger and more specific than in other state MOUs.

Care Continuity

California’s MOU provides a longer transition period during which enrollees can continue to see current providers who are out of the plan’s network than any other state’s MOU. The types of providers the care continuity protection applies to, however, is limited. Participating plans must allow enrollees to continue to see their current Medicare providers and maintain their current service authorizations for six months, and their current Medi-Cal providers for 12 months, if the beneficiary: (1) has seen the provider at least twice within the previous 12 months; (2) the provider is willing to accept payment from the plan at the applicable Medicare or Medi-Cal rates; and (3) the provider meets applicable state, federal and plan standards.\textsuperscript{26} Continuity of care protections do not apply, however, to durable medical equipment, medical supplies, transportation, and other ancillary services.\textsuperscript{27}

Care Coordination

Participating plans will be required to offer care coordination services to all enrollees. The MOU requires that care coordination follow the beneficiary’s direction, and include both medical and long term supports and services.\textsuperscript{28} Plans must offer “Interdisciplinary Care Teams” with expertise in “person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery and wellness principles.”\textsuperscript{29} Beyond describing the team as interdisciplinary, the MOU does not spell out qualifications for the care team or clearly designate a care coordinator. Plans must conduct a health risk assessment of all enrollees. Individuals identified by a risk stratification mechanism or

\textsuperscript{24} MOU pp. 78-79.
\textsuperscript{25} MOU p. 77.
\textsuperscript{26} MOU p. 95-96.
\textsuperscript{27} MOU p. 96.
\textsuperscript{28} MOU p. 69.
\textsuperscript{29} MOU p. 70.
algorithm as higher-risk must be assessed within 45 days of enrollment; all others must be assessed within 90 days. Reassessments must be conducted at least annually.  

Grievances and Appeals

In the MOU, California and CMS agree to develop an integrated grievance and appeals process that combines both Medicare and Medicaid. In the first year of the demonstration, however, the existing Medicare and Medi-Cal appeals systems will remain available to enrollees. Pursuant to state law, IHSS disputes will be appealed directly and only through the state fair hearing process and not through an internal plan process since county agencies, not the plans, assess the need for IHSS.

While all other state MOUs include a new beneficiary protection, aid paid pending for Medicare services during an internal plan appeal, the California MOU does not. Aid paid pending rights for Medi-Cal covered services remain.

Enrollment Counseling & Ombudsman

Under the MOU, CMS and the state will “work to support” the State Health Insurance Assistance Program (SHIP) (called HICAP in California), Aging and Disability Resource Centers (ADRCs), and other community-based organizations. These organizations will provide one-on-one enrollment counseling to help dual eligibles decide whether to join Cal MediConnect and, if they do elect to join, select a plan.

The MOU also describes an ombuds program that will “conduct impartial investigations” and “support individual advocacy and oversight” on behalf of those dual eligibles that enroll in the demonstration. The MOU does not clarify if the ombuds office will be independent, and it does not indicate where the ombuds office will be housed or how it will be funded.

Network Adequacy

The MOU requires that participating plans meet Medicaid network adequacy standards for long term services and supports, and Medicare standards for pharmacy and other Medicare services, unless the applicable Medicaid standards are more stringent. For services like home health

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30 MOU pp. 70-71.
31 MOU p. 18.
32 MOU p. 99.
34 MOU p. 14.
35 MOU p. 83.
and durable medical equipment that are covered by both programs, the more stringent network standards apply.

For LTSS, the MOU contains no specific numbers for how many providers each plan must contract with. Instead terms like ‘sufficient number’ and ‘adequate number’ are used without specific reference to an existing standard defining these terms. The MOU does require that plans have an MOU with each county regarding the administration of IHSS; each MSSP program (with a commitment to maintain MSSP funding for 19 months); and all willing, licensed and certified Community Based Adult Services (CBAS) providers (also known as adult day health care). Plans may contract with nursing facilities in covered and adjacent zip codes. The MOU notes that continuity of care provisions will likely keep nursing facility residents in place for the first 12 months, but is silent on the likelihood that beneficiaries will have to switch facilities after the 12 month continuity of care protection expires. The MOU specifically mentions the need to ensure physical accessibility.

**Readiness Review**

The MOU indicates that CMS and the State will require each Participating Plan to pass a readiness review before that plan can accept any enrollment. It is not clear whether notices regarding enrollment will be sent to passive enrollees prior to the successful completion of the readiness review process. The readiness review will involve a desk review and “may” involve a site visit as well.

**Quality**

The MOU includes a long list of quality measures by which Participating Plans will be evaluated. The list builds off of current quality metrics used for Medicare Part D and Dual Eligible Special Needs Plans. Limited additional measures directed at evaluating the quality or amount of long term services and supports provided are included.

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36 MOU pp. 84-85.
37 MOU p. 85.
39 MOU p. 31.
40 MOU pp. 108-115
Financing

The California MOU includes a spending reduction that is more aggressive than other states that have signed MOUs relying on capitated managed care models. The California MOU sets a statewide, minimum savings rate and then adds county-specific interim savings percentages that act as savings maximums. The minimum savings rates are 1% in the first year, 2% in the second year, and 4% in the third year.41 The maximum rates are county specific and when added to the minimum savings rates bring the total savings rates as high as 1.47%, 3.5% and 5.5% in each respective year. These percentages are higher than those found in other MOUs.

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The California MOU also contains provisions for limited risk adjustment and risk corridors.42

In addition to these spending reductions, a quality withhold will be applied to plan payments each year. Plans will have amounts withheld from their rates equal to 1% in the first year, 2% in the second year and 3% in the third year.43 Each plan must meet certain quality standards to have these withheld amounts released.

This memo is a summary of the MOU; however, a number of policy and operational questions are still outstanding. For more information, go to www.dualsdemoadvocacy.org, or subscribe to the National Senior Citizens Law Center’s health policy alerts at www.nslc.org/index.php/store/subscriptions/. Questions about the California MOU can be directed to Amber Cutler, Anna Rich or Kevin Prindiville.

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41 MOU p. 57
42 MOU pp. 57-58.
43 MOU pp. 52-54
California MOU References to the Three-Way Contract

The California MOU includes forty references to information and agreements that will be “further specified in a three-way contract to be executed among the Prime Contractor Plans, the State and CMS.”

- p. 2: Specifications on program specific and evaluation requirements
- p. 3: Further detail on flexibilities and specific beneficiary safeguards
- p. 3: Participating plans' responsibilities and operational and technical requirements
- p. 4: Information for plans re: waivers of sub-regulatory guidance (Medicare)
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- p. 13: Participating plan service capacity
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Illinois MOU Summary

On February 22, the Centers for Medicare and Medicaid Services (CMS) entered into a Memorandum of Understanding with the State of Illinois approving the Illinois Medicare-Medicaid Alignment Initiative. Illinois is the fourth state to execute a MOU under the demonstration and the third state to employ a risk-based capitated model.

Illinois will enroll as many as 135,000 dual eligibles in the Greater Chicago and Central Illinois region into capitated health plans (Demonstration Plans) beginning on January 1, 2014. The plans will be responsible for delivering all covered Medicare and Medicaid services to plan enrollees. Illinois already has selected plans to participate in the demonstration.

In contrast with previous state MOUs, this MOU:

- Establishes a plan for a phased passive enrollment that includes monthly caps on enrollment;
- Requires savings targets in the second and third year that are higher than any previous agreement; and
- Does not require plans to provide any new supplemental services for beneficiaries.

This summary of the Illinois MOU emphasizes elements related to beneficiary protections. As this is the third MOU approving a capitated program, the Illinois agreement offers some insight into how state demonstrations will vary, and the overall direction of the Financial Alignment demonstration.

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2 The other three states with approved MOUs are Massachusetts and Ohio (risk-based capitated model) and Washington (managed fee for service model). See http://dualsdemoadvocacy.org/state-profiles for summaries of these three MOUs.
3 In November, Illinois selected the eight plans that will serve the dual eligible individuals under the Medicare-Medicaid Alignment Initiative. See http://www3.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=2&RecNum=10692.
Enrollment

_Illinois will use an initial voluntary enrollment period and will then passively enroll beneficiaries as plans demonstrate their capacity for new members._

**Timing:** Demonstration Plans will begin to offer coverage October 1, 2013.\(^5\) For the first three months, from October to January, eligible beneficiaries will be able to voluntarily enroll in a demonstration plan. CMS and the State will use this three-month window to monitor each Demonstration Plan’s ability to manage enrollment.\(^6\) Beginning on January 1, 2014, the State may begin to enroll beneficiaries passively into Demonstration Plans that have the capacity for new enrollees.\(^7\)

Under the passive enrollment mechanism, beneficiaries will be automatically assigned to plans by the State unless they affirmatively opt out of the demonstration.\(^8\) The passive enrollment will be phased. The MOU sets numerical limits on the rate of plan enrollment. In the Greater Chicago region, the State will passively enroll a maximum of 5,000 beneficiaries per month per the Demonstration Plan over a six-month period. In the Central Illinois region, the State will passively enroll no more than 3,000 beneficiaries per month per plan.\(^9\) The State will only enroll beneficiaries into a plan after the State and CMS determine the Demonstration Plan has the capacity to take on new beneficiaries.

The State will develop an “intelligent assignment” algorithm for passive enrollment. The algorithm will consider the beneficiaries’ previous managed care enrollment and historic provider utilization.\(^10\)

**Counseling and enrollment entities:** Independent enrollment and options counseling assistance will be offered by the State’s Independent Client Enrollment Services.\(^11\) The MOU also designates the Aging and Disability Resource Networks (ADRNs)\(^12\) as the entity to provide additional enrollment options counseling to beneficiaries. It is unclear how the state or CMS will fund this assistance.

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\(^5\) IL MOU at 9: No earlier than 90 days prior to October 1, 2013, eligible individuals will have the opportunity to elect to enroll into the Demonstration to begin receiving services on October 1, 2013.

\(^6\) IL MOU at 57.

\(^7\) IL MOU at 57. A Demonstration Plan’s capacity will be determined by its ability to manage the voluntary enrollments and the prior month’s passive enrollments (once applicable).

\(^8\) IL MOU at 58. The State will provide notice of passive enrollment at least 60 days and no more than 90 days prior to the passive enrollment effective date, and will accept opt-out request before the enrollment date.

\(^9\) IL MOU at 58.

\(^10\) IL MOU at 59.

\(^11\) IL MOU at 12.

\(^12\) IL MOU at 12.
Enrollment mechanics: CMS and the State will use an independent, third party entity to facilitate enrollment into the demonstration plans. All enrollment and disenrollment transactions, including transfers between plans, will be processed through the Illinois Client Enrollment Services (CES), the state’s Medicaid enrollment broker. The State contracted with Maximus to operate CES, and CES is conducting enrollment for the State’s entire Integrated Care program. The State or Maximus will submit enrollment transactions to the CMS MARx enrollment system directly or via a third party CMS designates to receive the transactions. Over-the-phone enrollment through the CES is the primary method of enrollment.

Written materials: CMS and the State will develop uniform enrollment and disenrollment letters and forms. Also, all enrollee materials must be integrated, and will be required to be accessible and understandable to the enrollee, the prospective enrollee and their caregivers. This includes individuals with disabilities, individuals with cognitive limitations, individuals with functional limitations, and those with limited English proficiency. If the Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with limited English proficiency will apply. The proposal addendum provides more detail on language access requirements. For example, when there is a prevalent single-language minority within the service area, the Demonstration Plan’s written materials must be available in that language as well as English.

The State or its vendor will provide notices, as approved by CMS, to ensure information is provided in concert with other Medicare communications. CMS may also send notices to beneficiaries and will coordinate notices with the State.

Eligibility for enrollment: Most full benefit dual eligible individuals over age 21 in the Greater Chicago and Central Illinois region will be eligible for the demonstration. Exceptions are limited to the spend down Medicaid population, individuals receiving developmental disability institutional services, or those who participate in an HCBS waiver for Adults with Developmental Disabilities, individuals in the Illinois Medicaid Breast and Cervical Cancer

13 IL MOU at 9.
15 IL MOU at 56.
16 IL MOU at 56.
17 IL MOU at 56.
18 IL MOU at 13.
19 IL MOU at 13.
21 The service area is described as the Department of Human Services local area. IL Addendum at 13.
22 IL MOU at 60.
program, and individuals who have comprehensive third party insurance. All other full benefit dual eligibles, including those with End Stage Renal Disease (ESRD) and those in waiver programs for the elderly, persons with disabilities, HIV/AIDS, brain injury and supportive living are eligible.

Beneficiaries in Medicare fee-for-service and those enrolled in Medicare Advantage plans operated by the same parent organization that operates a Demonstration Plan will be eligible for passive enrollment, unless they opt out. Beneficiaries currently enrolled in a Medicare Advantage plan operated by a parent organization offering a Demonstration Plan will be passively enrolled into that parent organization’s Demonstration Plan.

Total enrollment cap: The State originally proposed to enroll 172,000 dual eligibles into the demonstration, while the MOU approves enrollment for 135,000 individuals. The demonstration is a component of Illinois’ Medicaid Reform, which requires that 50% of all Medicaid clients will be enrolled in managed care by 2015.

Demonstration Authority

**Illinois must seek additional waiver authority from the Centers for Medicaid and CHIP Services before implementing the demonstration.**

The authority for the Medicare changes that are part of the demonstration comes from 1115A of the Social Security Act, codified at 42 U.S.C. 1315a, which authorizes the Center for Medicare and Medicaid Innovation to test new Medicare and Medicaid payment and delivery models. The State must also submit Section 1915(c) waiver amendments and State Plan amendments before the demonstration may begin.

The State is also proposing to enroll dual eligibles mandatorily into Medicaid managed care plans for all Medicaid services, including long-term services and supports. Enrollment in Medicaid managed care would be required even of dual eligibles that opt-out of the demonstration. The MOU does not address that proposal, which will require separate Medicaid approval.

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23 IL MOU at 8.
24 IL Proposal Addendum, at 6. The addendum explains that the State will work with CMS during readiness reviews to ensure that Plan networks have the capacity to serve beneficiaries with ESRD. Plans will also consider modifying the passive enrollment algorithm to ensure beneficiaries are aligned with networks best capable of meeting their needs.
25 Illinois Care Coordination, available at, [http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx](http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx).
26 IL MOU at 39.
Ombudsman

*Illinois will support an independent Ombudsman office, with CMS support for ombudsman training.*

The State plans to support an Ombudsman office that will be independent of the State Medicaid agency. Its role will be to advocate and investigate on behalf of demonstration enrollees, including recipients of long term services and supports, and to serve as an early and consistent means of identifying systemic problems with the demonstration. The Ombudsman will support individual advocacy and independent systemic oversight for the Demonstration, with a focus on compliance and principles of community integration, independent living, and person-centered care in the home and community-based care context. The Ombudsman will be responsible for gathering and reporting data on Ombudsman activities to the State and CMS via the Contract Management Team, and provide input about timeliness of responses to beneficiary enrollment requests.

CMS and the State will provide ongoing technical assistance to the Ombudsman. The MOU is silent on how ombudsman activities will be funded. It also does not state where the ombudsman function will reside.

**Americans with Disabilities Act (ADA) and Civil Rights Act of 1964**

*The Illinois MOU includes general requirements for State and plan ADA and Olmstead compliance.*

The MOU requires all plans and providers to demonstrate a commitment and ability to accommodate an individual’s physical needs, including providing flexible scheduling. They must also commit to providing interpreters for those who are deaf or hard of hearing or who do not speak English and accommodations for beneficiaries with cognitive limitations. The State and CMS agreed to work with stakeholders and beneficiaries to develop further learning opportunities, monitoring mechanisms, and quality measures to promote ADA compliance by the plans and providers.

The Illinois MOU is silent on additional protections that were included in previous state MOUs.

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27 IL MOU at 12. Illinois is the second state to include a plan for ombuds in the MOU. Ohio also included an ombudsman provision in its MOU. Massachusetts did not; however, the Commonwealth plans to develop an ombuds oversight office for the demonstration.

28 IL MOU at 12.

29 IL MOU at 12.

30 IL MOU at 56.

31 IL MOU at 13.
For example, the Ohio MOU included provisions that ongoing surveys, readiness and implementation reviews would address *Olmstead* compliance; that demonstration plan training would include ADA and *Olmstead* requirements; and that plans would be required to provide all medically necessary services in compliance with the ADA, as specified by the *Olmstead* decision. Those protections are not spelled out explicitly in the Illinois MOU, though there is a general commitment to “continue to work with stakeholders on these issues.”

**Baseline Spending and Plan Payments**

*Illinois’ savings of 1%, 3%, and 5% are higher than all previous state MOUs.*

In February 2013, CMS updated its guidance to states on the rate setting process for plan payments under the demonstration. Illinois will follow this guidance with Medicare and Medicaid each contributing to a total capitation payment. The contribution each program makes will be determined by following a series of steps.

**Setting baseline rates:** Spending contributions will be set for Medicare and Medicaid. CMS will determine the Medicare baseline spending amount based on what Medicare would have spent on Part A and B services for beneficiaries in the absence of the demonstration. Illinois’ Medicaid agency will set the Medicaid baseline based on historical State data and spending for Medicaid services provided to dual eligible beneficiaries. CMS contractors and staff will validate the state baseline. Payment for Part D services will follow existing Part D rules.

**Risk adjustment:** The Medicare and Medicaid rates will each be risk adjusted. CMS will use the existing CMS-HCC risk adjustment methodology for the Medicare rate. For Medicaid, the rate will be stratified by age, geographic service area, and setting-of-care. Plans will be paid differently depending on how many enrollees are in each of four settings-of-care: nursing facility (NF), Waiver, Waiver Plus and Community. The Community rate is for individuals who do not meet nursing facility level of care. The Waiver rate is for individuals qualifying for the HCBS waiver. The Waiver Plus rate is provided for the first three months after an individual has

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32 IL MOU at 13.
34 IL MOU at 41. This rate will be based on a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year. It will be weighted by the duals population who meet the criteria and who are expected to transition into the demonstration.
35 IL MOU at 42.
36 IL MOU at 43. Two age categories: 21-64 and 65 and up.
37 IL MOU at 43. Two geographic categories: Greater Chicago and Central Illinois.
38 IL MOU at 43.
39 IL MOU at 43.
transitioned from a NF to a Waiver category. The rate cell for NF will be paid for individuals residing in an NF. For individuals that transition from the Waiver category to a NF, the plan will continue to be paid at the Waiver rate for 3 months.

**Savings:** After establishing the rates, the rate estimate will be reduced by a predetermined savings amount, guaranteeing state and federal savings.

For the first year, both the Medicare and Medicaid baseline rates will be reduced by 1%. For the second and third year, that amount is 3% and 5%, respectively. The second and third year savings are higher than any previous state MOU. The two previous MOUs (Massachusetts and Ohio) reduced spending by 2% and 4% for the second and third year, respectively.\(^{40}\) The Illinois MOU does not provide a detailed explanation of why significantly greater savings are expected in Illinois. Although it states that Illinois has one of the highest rates of potentially avoidable hospital admissions among dual eligibles, the MOU does not explain why its savings rate should be greater than that of Ohio, which has an even higher rate of avoidable hospital admissions\(^{41}\) and also a similar rate of institutional placement.

**Quality withholds:** Both Medicare and Medicaid will withhold a portion of their contribution to the rate, and this amount will be paid at the end of each year subject to the Demonstration Plan’s meeting certain quality requirements. Consistent with other state MOUs, the quality withholds in year 1, 2 and 3 will be 1%, 2%, and 3% respectively.

The measures on which quality payments are based change from the first year to the second and third year. The first year measures include seven measures, most of which are process measures (e.g., timely comprehensive risk assessments, establishment of an advisory board).\(^ {42}\) For the second and third year, nine different measures are used, including outcome measures (e.g., members moved out of institutions, hospital readmissions).\(^ {43}\)

**Medical Loss Ratio:** Consistent with the Ohio MOU, Illinois Demonstration Plans will be required to meet a Medical Loss Ratio of at least 85%.\(^ {44}\) In Illinois, the MLR begins in 2014, when Demonstration Plans will be required to meet a Target MLR of 85%. Demonstration Plans will be required to remit money back to the Medicare and Medicaid program if their MLR is below the target. Further information will be included in the three-way contracts.

\(^{40}\) IL MOU, 47-49.
\(^{42}\) IL MOU, 47-49.
\(^{43}\) IL MOU, 49-51.
\(^{44}\) IL MOU at 52.
Care Teams and Assessments

The plans will assess each enrollee and build a care plan based on the enrollee’s level-of-care needs.

The Demonstration Plans will assess the medical, behavioral health, long-term services and supports, and social needs of their members, and use this assessment to place the member into a care team.45 All enrollees will be assigned a care coordinator and a care team.46 Led by the care coordinator, the care team will provide care management, assure appropriate and efficient care transitions, provide medication management, assist with referrals, and assist in the development, implementation and monitoring of the care plan.47

The Demonstration Plans will conduct an assessment to determine if a member is low, moderate or high risk.48

The plan will administer a health screening within 60 days after enrollment. It is unclear if this assessment is conducted based on existing data or with direct in-person or telephonic contact with the beneficiary. Enrollees will be stratified into three levels: low-, moderate-, and high-risk. Those enrollees stratified to moderate-or high-risk levels will receive a further comprehensive enrollment within 90 days after enrolment.49 The plan will use predictive modelling and surveillance data for this assessment. It is unclear what the comprehensive assessment involves, and it is also unclear if the comprehensive assessment will be comparable across Demonstration Plans.

The Illinois MOU is the first to set specific caseload and stratification requirements. The plans will use the risk categories to determine care management services, care coordinator case loads and care management services.50 For low risk individuals, the care coordinator caseload must be no more than 1,600; for moderate risk, 1:150, and for high risk, 1:75.51

Demonstration Plans will use the assessment to stratify no less than 5% of enrollees as high-risk. Demonstration Plans will be required to stratify no less than 20% of enrollees to

45 CMS Fact Sheet, CMS and Illinois Partner to Coordinate Care for Medicare-Medicaid Enrollees, available at http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4547&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.
46 IL MOU at 62.
47 IL MOU at 63.
48 IL MOU at 61.
49 IL MOU at 61.
50 IL MOU at 62.
51 IL MOU at 64.
moderate-and high-risk levels combined.\textsuperscript{52}

**Network Adequacy Standards**

*Plans will be required to enter into and maintain contracts with HCBS providers who provided 80% of fee-for-service services in 2012.*

The MOU does not detail specific time, geographic, and number of provider standards in explaining the network requirements for demonstration plans. Instead, the MOU’s network adequacy appears to be built on three principles: maintain the existing LTSS network in the first year, include at least 80% of the current HCBS network, and adhere to Medicare network adequacy requirements.

For the first year, plans are required to contract with all willing nursing facilities (NF), supportive living facilities (SLF), and LTSS providers in the service area.\textsuperscript{53} After the first year, Demonstration Plans have 90 days to establish quality standards and contract only with the providers who meet those standards. The State must approve the quality standards; however, it is not clear what criteria the State will use to evaluate the Demonstration Plan specific standards.

If the Demonstration Plan terminates contracts, it must have a plan to transition beneficiaries prior to terminating the contracts. For NF and SLF, the plans must maintain the adequacy of its provider networks in each county served. For services provided under the HCBS waiver, the Demonstration Plan must maintain contracts with providers who provided at least 80% of the fee-for-service services during 2012.

If Medicare requirements are stricter than described above, the Medicare requirements must be followed.

**Medical Necessity Determinations**

*The MOU does not explain which standard will be used for services provided by both Medicare and Medicaid.*

The MOU uses existing State and CMS definitions for medically necessary services for Medicaid and Medicare, respectively. The MOU diverges from the previous capitated MOUs by not affirming that when there is overlap between Medicare and Medicaid coverage for a service, the definition most favorable to the beneficiary will be used.\textsuperscript{54} Instead, the MOU indicates that

\textsuperscript{52} IL MOU at 61.
\textsuperscript{53} IL MOU at 68.
\textsuperscript{54} IL MOU at 71.
the three-way contract will determine which standard will be used.

Benefits

*The MOU does not require supplemental services. It does include care continuity provisions.*

Scope of benefits: Plans will be required to provide all Medicare services and all State Plan Medicaid services and services under 1915(c) waivers. Plans have discretion to offer flexible benefits.

Plans will not be responsible for eligibility determinations for 1915(c) waivers but will be responsible for HCBS service planning and implementation. In an addendum to its proposal, the State clarifies that Demonstration Plans will be required to provide HCBS waiver services to any enrollee determined eligible for an HCBS waiver under current waiver procedures.

The MOU does not require that plans provide any new supplemental services. The MOU states that plans will have discretion to use the capitated payment to offer flexible benefits appropriate to address the enrollee’s needs, but does not require them to do so and does not establish any right for beneficiaries to receive services other than those currently available to them. This lack of required supplemental services contrasts with the significant lists of such services found in the Massachusetts and Ohio MOUs.

Care continuity: Plans must offer 180 day transition period in which enrollees may maintain a current course of treatment with an out-of-network provider. The care continuity protection covers all providers, including behavioral health and LTSS providers. Out-of-network PCPs and specialists providing ongoing course of treatment must be offered single case management agreements to continue to care for enrollees beyond the 180 days if they remain outside the network.

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55 IL MOU at 10
56 IL MOU at 66
58 IL MOU at 71. In comparison, the Ohio MOU explains that plans will provide all current waiver services, along with services not previously provided under the state plan, including: adult day health, personal care, homemaker, emergency response system service, home delivered meals, home modification, maintenance and repair, out-of-home respite, home care attendant services, chore services, community transition service, enhanced community living, independent living assistance, nutritional consultation, home care attendant service, alternative meals service, pest control, assisted living service. Services that are currently offered under the state plan, but will be expanded under the waiver, include: transportation, nursing service, home medical equipment and supplemental adaptive device services, and social work counseling.
59 IL MOU at 72.
Existing HCBS service plans cannot be changed for the first 180 days of plan membership without the consent of the enrollee and a comprehensive assessment. Transitions to a new Primary Care Provider before the end of the 180-day period can only take place if the enrollee consents and if the individual has already been assigned a medical home, appropriate screenings have been completed, the Demonstration Plan had determined that the medical home is accessible, competent and appropriate and a transition care plan is in place.

Appeals

The MOU does not change the Medicare Part D appeals process but it does make significant changes to Medicare A and B and Medicaid appeals.

Plan enrollees will be notified of all Medicare and Medicaid appeals rights in a single, integrated notice.

Beneficiaries must initially file all appeals with the Demonstration Plan. This requirement is consistent with the Ohio MOU but different from the Massachusetts MOU, which permits the enrollee to go directly to a state fair hearing for Medicaid services. If the plan does not resolve the issue in favor of the beneficiary, for services covered by Medicare, appeals will be automatically forwarded, by the plan, to the Independent Review Entity (IRE). For services covered by Medicaid, it is up to the enrollee to request a State Fair Hearing (SFH).

Aid Paid Pending (APP): The MOU seems to indicate that during the initial, plan-level of appeal, the plan must provide benefits pending appeal if the benefits are Medicare Part A or B benefits as long as the beneficiary files the appeal within the 60 day appeal timeframe. For the beneficiary to receive aid paid pending during an appeal about Medicaid-only and Medicare-Medicaid overlap services, however, the appeal must be filed within 10 calendar days of the Notice of Action.

The Illinois MOU differs from the Massachusetts and Ohio MOUs, in that the Illinois MOU sets different standards for APP at the plan level depending on whether the service being appealed is covered by Medicare or Medicaid.

At the next level of appeal, the beneficiary is entitled to aid paid pending for Medicaid services pending the resolution of a SFH. When an appeal is filed with the IRE, aid paid pending will be provided if the service is one that could be covered by Medicare or Medicaid, but not if it is a

60 IL MOU at 66.
61 IL MOU at 72
62 IL MOU at 77.
63 IL MOU at 77.
service only covered by Medicare.\textsuperscript{64}

Oversight

The State and CMS will form a Contract Management Team that will be responsible for day-to-day monitoring of each demonstration plan. The team’s responsibilities will include regular meetings with each demonstration plan, coordinating review of grievance and appeals data, and reviewing reports and responses from the Ombudsman.\textsuperscript{65} Neither the state nor CMS will take a unilateral enforcement action related to day-to-day oversight without notifying the other party in advance.\textsuperscript{66} It is unclear who will serve on the Contract Management Team for the State. The CMS members of the team will include the state lead from the Medicare-Medicaid Coordination Office, the Regional Office Lead from the Consortium for Medicare and Children’s Health Operations, and an account manager from the Consortium for Health Plan Operations. The State recently hired additional staff charged with analyzing current policies and procedures to develop enhanced monitoring for the demonstration.\textsuperscript{67}

Quality Measures

As mentioned in previous state MOUs, the State and CMS are still working on quality measures. The MOU includes a list of potential quality measures that will be refined and specified in the three-way contracts. The LTSS measures appear to be a work in progress, and are all determined by the State. They include measures of: medication adherence, transitions between community, waiver and long-term care services, and an Illinois-specific measure of the Participant Outcomes and Status Measure (POSM) Quality of Life Survey.\textsuperscript{68}

Stakeholder Engagement

The MOU provides an overview of an ongoing stakeholder engagement process, with few specific requirements for the State. The State is required to establish a plan for gathering and incorporating stakeholder feedback on an ongoing basis during the demonstration.\textsuperscript{69} Demonstration Plans are required to develop an independent beneficiary advisory committee that reflects the diversity of the demonstration population. The MOU also requires the State to

\textsuperscript{64} IL MOU at 77. If the service is only covered by Medicaid, the appeal would need to be filed with the SFH, not the IRE.
\textsuperscript{65} IL MOU at 82.
\textsuperscript{66} IL MOU at 81.
\textsuperscript{67} IL MOU at 55.
\textsuperscript{68} IL MOU at 98.
\textsuperscript{69} IL MOU at 29.
maintain a website to provide updates on the demonstration progress.  

**Conclusion**

Between now and October 1, when Demonstration Plans will begin to offer coverage, a tremendous amount of work must be completed by CMS, the State, the Demonstration Plans and community organizations. The State must complete readiness reviews, distribute notices to affected beneficiaries, train and hire staff, prepare enrollment brokers, conduct outreach to beneficiaries, providers, and community organizations, establish oversight and monitoring structures, develop the ombuds program, prepare the ADRNs to assist with enrollment counseling, and more.

For more information on the progress of the demonstration, and information on other state MOUs, visit [www.dualsdemoadvocacy.org](http://www.dualsdemoadvocacy.org).

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70 IL MOU at 14.