DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Summary - Essential Elements of Managed Long Term Services and Supports Programs

Managed long term services and supports (MLTSS) refers to an arrangement between state Medicaid programs and managed care plans through which the managed care plans receive capitated payments for long term services and supports (LTSS), including both home- and community-based services (HCBS) and/or institutional-based services. In fully integrated models, these payments for MLTSS are combined with payments for primary, acute, and behavioral health services, and the capitation payment is more comprehensive. MLTSS programs have grown significantly over the past decade and are expected to increase even more in the coming years. Between 2004 and 2012 the number of states with MLTSS programs doubled from eight to sixteen, and the number of persons receiving LTSS through managed care programs increased from 105,000 to 389,000[1]. Since the completion of the study referenced, two more states have implemented MLTSS programs and between now and 2015 the Centers for Medicare and Medicaid Services (CMS) expects an increased uptake in this model due to the implementation of Medicare-Medicaid financial alignment models.

Recognizing this dramatic shift in delivery system design and wanting to maximize the positive experience of beneficiaries as they make the transition to more integrated service models, CMS has developed ten key principles inherent in a strong MLTSS program. These principles were developed after participating in site visits of several existing MLTSS programs where states described lessons learned as well as positive outcomes of procedures put in place. CMS also reviewed numerous published findings, as well as recommendations from internal Health & Human Services (HHS) partners and external stakeholders on best practices for MLTSS. With this knowledge in hand, we formed several workgroups with participation from HHS subject matter experts in all areas of MLTSS to develop the principles outlined below.

1. Adequate Planning and Transition Strategies: The most effective MLTSS systems are the result of a thoughtful and deliberative planning process that permits enough time to develop a clear vision for the program. An adequate planning process includes the solicitation and consideration of stakeholder input; education of program participants; assessment of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS. Examples of safeguards include appropriate transition plans for beneficiaries moving into managed care from fee-for-service or from another managed care plan and an overall phase in strategy over time allowing the state and managed care plans to remediate any lessons learned for future phase in populations. Transitioning to MLTSS will likely impact various agencies at the state and including enough time to plan for

[1] The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update, July 2012, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf

this transition will allow all agencies the opportunity to engage and implement a process for governance of the entire program.

2. Stakeholder Engagement: Stakeholders, including beneficiaries, providers and advocacy groups of all impacted LTSS populations, can provide significant insight to the state's planning, implementation, and ongoing oversight of the MLTSS program. Stakeholder engagement and collaboration are critical pieces to ensure the smooth and efficient transition to managed care for these populations. Provider and beneficiary educational tours, multiple educational mailings, transparency in design and oversight of the program by posting materials on a MLTSS website, and state and managed care plan advisory groups are all good examples of ways a state can meaningfully engage stakeholders. Ongoing involvement after implementation also provides critical feedback for program improvements.

3. Enhanced provision of Home and Community Based Services: Under the Americans with Disabilities Act[2] and the Olmstead decision of the U.S. Supreme Court[3] , Medicaid beneficiaries are entitled to receive services in the most integrated setting[4]. Along with provision of services consistent with these federal protections, community based LTSS should be delivered in settings that are aligned with requirements for home and community based characteristics[5] and in a way that offer the greatest opportunities for active community and workforce participation[6]. Including this element into the planning and oversight of an MLTSS program will ensure that progress towards community integration goals is achieved and maintained throughout the life of the program.

4. Alignment of Payment Structures with MLTSS Programmatic Goals: Payment to managed care plans should support the goals of MLTSS programs including the essential elements established in this document and support three goals of improving the health of populations, improving the beneficiary experience of care, and reducing costs through these improvements. Capitation rates that encourage the delivery of high quality services in home and community-based settings and support the goal of community integration, as well as contracts that provide performance-based incentives tied to outcome measures and penalties for poor performance or non-compliance, are effective tools to achieve those goals.

5. Support for Beneficiaries: All beneficiaries, particularly those most vulnerable, need support and education throughout their experience in the MLTSS program. This support is more readily accepted and trusted from an independent and conflict-free source. Common support resources for beneficiaries provided by the state at no cost to the beneficiary are enrollment/disenrollment services, including choice counseling and education on additional opportunities for disenrollment, and an advocate or ombudsman to help beneficiaries understand their rights, responsibilities and how to handle a dispute with the managed care plan or state.

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[2] The Americans with Disabilities Ace, 42 USC 126.12101.
[3] Olmstead v. L.C., 527 U.S. 581 (1999).
[4] The "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 CFR Pt. 35, App. A (2010).
[5] 77 FR 26361; 42 CFR § 441.656 State plan home and community-based services under the Act. http://www.gpo.gov/fdsys/pkg/FR-2012-05-03/pdf/2012-10385.pdf
[6] For more information on Competitive Employment, see the CMCS Supported Employment Informational Bulletin available at http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf.

6. Person-centered Processes: Ensuring beneficiaries' medical and non-medical needs are met and they have the quality of life and level of independence they desire within the MLTSS program start with person-centered processes. Active participation by the beneficiary, or his/her designee, in the service planning and delivery process, meaningful choices of service alternatives, holistic service plans based on a comprehensive needs assessment which include goals that are meaningful to the beneficiary, and the opportunity to self-direct their community-based services, fostering independence, with assurances of appropriate supports are critical components that CMS will expect to see reflected in state applications.

7. Comprehensive and Integrated Service Package: Managed care plans have more impact on, and ensure quality delivery of, the services covered in their State contract. When all covered services – including integrated physical health, behavioral health, community based and institutional LTSS - are provided through the managed care plan, the managed care plan staff and/or providers developing and monitoring service plans are able to provide comprehensive person-centered service planning and oversight of care across all available settings. Even when all services are not covered through the MLTSS plan, states can include contract provisions on coordination and referral to ensure that the beneficiary's service plan is holistic and person-centered.

8. Qualified Providers: As with traditional managed care plans, MLTSS plans are required to have an adequate network of qualified providers to meet the needs of their enrolled beneficiaries. While current credentialing and network adequacy systems have been developed base on an acute and primary care service delivery model, CMS expects states to assure that managed care networks also meet the needs of MLTSS beneficiaries, including adequate capacity and expertise to provide access to services that support community integration, such as employment supports, and the provision of training and technical assistance to providers. In order to ensure the greatest provider participation in managed care networks, states can establish continuity of care standards as well as require the managed care plans to provide training and technical assistance to providers in learning new billing and coding requirements.

9. Participant Protections: A study sponsored by the National Institute of Justice discovered that of 5,000 elderly individuals surveyed, 11% reported some form of abuse in the previous year, ranging from financial exploitation, potential neglect, or emotional mistreatment[7]. This is just one of the vulnerabilities which underscore the importance of robust health and welfare safeguards, protections, and monitoring in the transition to MLTSS and ongoing operation of the program. CMS expects that states will address this vulnerability through program design and contracts with appropriate health and welfare assurances, a strong critical incident management system, and an appeals process that allows access to continuation of services while an appeal is pending.

10. Quality: The building blocks of a quality MLTSS program include both existing LTSS quality systems and managed care quality systems. Merging these two systems may provide a state with more sophisticated data capabilities and provide a new opportunity to think holistically about beneficiary outcomes. A comprehensive quality strategy and oversight structure that takes into consideration the acute and primary care, behavioral health, as well as LTSS needs of beneficiaries can provide a framework for states to incorporate more

[7] "The Prevalence of Elder Abuse" National Institute of Justice Journal No. 265, April 15, 2010

meaningful goals into the program that focus on quality of care and quality of life for beneficiaries. Quality oversight of an MLTSS program may be operationalized differently from the fee-for-service system; therefore, states will need to evaluate their resources to ensure the appropriate type and level of staff is available.

CMS believes these guiding principles, while not exhaustive and subject to further refinement as states and CMS gain further experience, are critical to the successful implementation and operation of MLTSS programs that support greater integration of care for beneficiaries with the most significant needs. CMS will use these guiding principles in our review, approval, and oversight of states' MLTSS programs under 1115 demonstration projects or 1915(b) waivers combined with another LTSS authorities.