Managed Care Long-Term Services and Supports – Steve Gold
Information Bulletin #381 (6/ 2013)

The Center for Medicare and Medicaid Services, the federal agency that funds Medicaid on 5/20/2013 issued "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs" (MLTSS). A copy of this important new federal guidance can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf

We are quoting extensively from this CMS document because, for those States contemplating using Managed Care as the mechanism for Medicaid Expansion, as well as for those States that already include MLTSS, this document provides important advocacy handles.

Before a State can have a 1115 Demonstration or 1915(b) waiver, CMS must review and approve a State's application. If your State does not include and really provide for the following, then advocates should let CMS know their opposition to MLTSS.

Here are some points that disability and elderly advocates might want to keep in mind.

1. CMS points out that LTSS includes "both home and community based services and institutional-based services."

   The guidance encourages states to include both home and community based services and institutional programs in the managed care capitation rate. If your State is contemplating MLTSS, make sure both home and community services as well as institutional services are included and are the responsibility of the Managed Care Organization (MC0). Make sure that institutional-based services are not "carved out" in any way.

   Our assumption is if a managed care agency is financially responsible for institutional-based services, the MCO will figure out how to serve the person in the community, where on average it's less expensive. If the MCO is not responsible for institutional services, the MCO will have a financial incentive to dump people with disabilities, especially with severe disabilities, into the institution.

2. The ADA and Olmstead requirements for services apply to MLTSS. CMS points out that "under the law [ADA], MLTSS must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation." Such a setting "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." CMS writes that "States are encouraged to include in their benefit packages supports to enable workforce participation such as personal assistance services, supported employment and peer support services, as appropriate and desired by the participant." If these kinds of supports are not included in your State's managed care program, then you should advocate with CMS and State officials to get your State to include them. If CMS is not responsive to your concerns, please let us know asap!

3. Under "alignment of payment structures and goals," CMS requires States "establish rates that support the goals and objectives of their MLTSS program" In keeping with the intent of the ADA and Olmstead decision, payment structures must encourage the delivery of

community-based services and not provide disincentives, intended or not, for the provision of services in home and community-based settings."

A number of advocates have voiced serious concerns that the more severely disabled persons will not be able to live in the community because the capitation rates (the dollar amount per person the MCO receives) are too low to cover all the community needs and supports. CMS requires that "State payment structures, systems and review mechanisms must ensure that participants at all levels of need and all types of disabilities have the opportunity to choose their MLTSS providers and have appropriate access to community-based services."

There cannot be any doubt that "States must employ financial incentives that achieve desired outcomes, [such a] provision of services in the most integrated settings and consumer satisfaction." It is a failure for States not to set rates that ensure the most severely disabled persons have a meaningful choice to reside in the community. States that fail will have "financial penalties" or return of a payment if a MCO does not achieve required outcomes for the provision of services in the most integrated settings."

4. The State Medicaid agency has the legal duty to "evaluate whether payment rates and structures are adequate to achieve participant access to quality providers for covered services."

5. "Person-centered" needs assessment, service planning and service coordination are required. CMS urges that MLTSS "should encourage participant self-determination and provide opportunities for self-direction of services."

   If your State provides self-direction in its existing fee for service Medicaid program, CMS states that the MLTSS "programs are expected to continue them," and if your State does not currently offer self-direction, "it should consider providing the opportunity for self-direction within their MLTSS program.

6. "Stakeholders" [which includes us -- disability and elderly advocates] must be formally involved, including cross-disability representatives, in the planning, implementation and oversight of the MLTSS.

   You must be at the table when the State Medicaid agency is developing the contract for MLTSS. The contract sets the enforceable requirements. ALL of the above five points are just words if the contract does not require the provision of these points. In addition to these six points, the State's contracts with managed care organization should include requirements that managed care staff working with MLTSS programs receive Olmstead training to understand the importance of serving persons outside of the institution.

Steve Gold, The Disability Odyssey continues

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