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Medicaid Managed Long-Term Services and Supports:

A Review and Analysis of Recent CMS Waiver Approvals in New Jersey and New York

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Introduction

The Centers for Medicare and Medicaid Services (CMS) recently approved Section 1115 demonstration waivers submitted by New Jersey and New York that will transition the delivery of Medicaid-funded long-term services and supports (LTSS) from a fee-for-service model to a managed care model.[1]

For each of the approved waivers, CMS issued Special Terms and Conditions (STC) that set specific requirements for the state's operation of the waiver. These STCs are significant not only for New York and New Jersey, but also for other states, as the STCs indicate CMS's current position on a multitude of public policy issues.

CMS will be making decisions on many more state managed LTSS (MLTSS) applications in the very near future. From 2004 to 2012, the number of states with Medicaid MLTSS

programs doubled from eight to 16, and is expected to increase to 26 by 2014.[2]

Recognizing this trend towards managed care, state and federal policymakers, managed care organizations, health care providers, and beneficiary advocates are engaging in conversations about how best to design MLTSS programs. Beneficiary advocates emphasize particularly the need for strong consumer protections to ensure that emphasis on cost savings does not limit access to care.

In many instances, CMS has approved policies in the two new waivers that are positive for Medicaid beneficiaries. For example, in both New Jersey and New York, benefit packages include a wide variety of services designed to allow beneficiaries to remain at home, and a beneficiary has the ability to self-direct such services. In addition, for New Jersey, CMS has approved programs designed to assist beneficiaries in moving from a nursing facility to the community, and to provide support so that a beneficiary is able to return home after a temporary hospitalization or nursing facility stay. Also in New Jersey, CMS has set standards to ensure that beneficiaries in community-based settings have certain rights —among other things, privacy, access to food, the ability to receive visitors, and control over personal schedules.

On the other hand, CMS and the states have fallen short in certain areas. For example, provisions related to person-centered care do not adequately protect beneficiaries against the possibility that health care providers will dominate care planning. The quality monitoring standards do not address exactly how incidents are to be addressed and systems improved, and do not require that the data be accessible to beneficiaries and other stakeholders. Similarly, regarding network adequacy, CMS requires that MCOs have "sufficient capacity" but offers few specifics.

In some instances, CMS has approved program features that may unduly favor nursing facility care over home and community-based services (HCBS). For example, CMS has approved benefit packages that exclude nursing facility services, even though the inclusion of nursing facility services gives MCOs a financial incentive to provide enrollees with viable alternatives to expensive nursing facility services. Also, in New Jersey, an enrollee may be forced to live in a nursing facility in circumstances where a slight extra expense to live instead in the community would be more than justified by an improved quality of life.

This paper provides a summary of how each new waiver approaches key elements of a MLTSS program and provides brief analysis of those approaches.

Managed LTSS Programs Overview

New Jersey

New Jersey's use of Medicaid managed care began in 1995 and has increased over time. As of April 2011, approximately 75 percent of the state's Medicaid beneficiaries received care through managed care organizations (MCOs).[3] Since that time, Medicaid managed care has been expanded to require enrollment of persons eligible for Medicaid and Medicare ("dual eligibles") and Medicaid beneficiaries receiving services under HCBS waivers or in nursing facilities. These expansions have included coverage for general medical and acute care, but not for LTSS.[4]

The newly-approved New Jersey demonstration, authorized under the Social Security Act's Section 1115, will broadly require older adults and persons with disabilities to receive LTSS (along with the other Medicaid-covered services) through managed care. Certain groups are excluded — specifically, PACE enrollees and partial dual eligibles (those who only receive Medicaid assistance for Medicare cost sharing via a Medicare Savings Program).[5] The demonstration will convert four pre-existing Section 1915(c) waivers to managed care: the Global Options waiver, the Community Resources for People with Disabilities waiver, the Traumatic Brain Injury waiver, and the AIDS Community Care Alternatives Program.[6]

The New Jersey STC is somewhat ambiguous regarding its treatment of nursing facility care. New Jersey consumer advocates report a general understanding that nursing facility care will be covered in managed care and, indeed, the STC's listing of services suggests that nursing facility services have been moved to managed care.[7] The New Jersey STC, however, contains language suggesting that nursing facility care will be included in managed care only for an initial 30 days (and then transferred to fee-for-service), or for up to 180 days if an HCBS recipient is expected to return from an intervening nursing facility to an HCBS setting within 180 days.[8]

The New Jersey demonstration is approved through June 30, 2017, but the New Jersey STC does not identify the exact month or months in which the demonstration will become operational for eligible Medicaid beneficiaries.

New York

Under two existing demonstration waivers, managed care has been mandatory for New York's Medicaid beneficiaries, but dual-eligibles and the "medically needy" have been excluded.[9] Also, service packages in mandatory managed care excluded LTSS until August 2011, when personal care services were incorporated into the service package for 5000 enrollees who previously had accessed those services through a prior approval system operated by local Medicaid programs. Nursing facility services and HCBS waiver services remained excluded from mandatory managed care.

New York recently received CMS approval to amend the two existing demonstration waivers to expand mandatory Medicaid managed care to include dual eligibles and to provide more substantial LTSS as part of the managed care benefit package. Under

both waivers, the Managed Long-Term Care program (MLTC program) will be mandatory for dually-eligible beneficiaries over age 21 who are found to have a need for personal care services or home health services for at least 120 days. Also, services under an HCBS waiver (the Long-Term Home Health Care Program) are expected to be transferred to mandatory managed care during 2013 and 2014, subject to CMS approving that waiver's amendment.[10]

In choosing a plan in New York, a beneficiary chooses the extent to which Medicare benefits will be included in the managed care benefits. The plans classified as "fully capitated" (either Medicaid Advantage Plus plans, or PACE plans) cover LTSS plus all Medicaid and Medicare acute care and primary care services. The plans classified as "partially capitated" cover only Medicaid LTSS plus some limited specialty care, including dental care and durable medical equipment. Under the partially capitated plans, the enrollee's acute and primary care is covered by Medicare or (at the enrollee's choice) a Medicare Advantage plan. If a beneficiary does not make an affirmative choice between a fully or partially capitated plan, he or she will be assigned to a partially capitated plan.[11]

Overall, the MLTSS program is unavailable for enrollment by persons receiving hospice services, already living in nursing facilities or assisted living facilities, or living in or eligible for Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR). In addition, a small group of populations have the right on request to be exempted from MLTSS: this includes Native Americans, and persons eligible for the Medicaid buy-in program for the working disabled.[12]

Enrollment in MLTSS began in New York City in September 2012 for personal care recipients, and soon after will expand to other eligible beneficiaries in New York City and, during 2013 and 2014, to other beneficiaries statewide.[13]

Moving Beneficiaries into Managed LTSS

Enrollment

What CMS Has Approved

In both states, the STCs set procedures for beneficiary decision-making, along with the consequences if a beneficiary fails to make a choice. The New Jersey deadlines are much shorter than those in New York.

The New Jersey STC requires eligible beneficiaries to enroll in a Medicaid MCO, and the state must offer at least two MCOs to each Medicaid beneficiary. Dual eligibles are required to enroll in managed care for their Medicaid benefits only.[14] Regarding their Medicare benefits, they have the option of remaining in original Medicare (fee-for-service) or enrolling in a Medicare Advantage plan.

After receiving notice from the state that managed care enrollment will be required, a beneficiary must be given at least 10 days to choose an MCO. A beneficiary who fails to choose within that time frame will be assigned by default into an MCO. Default assignments must comply with 42 C.F.R. § 483.50(f), which requires that default

assignment processes "must seek to preserve existing provider-beneficiary relationships and relationships with providers that have traditionally served Medicaid beneficiaries." If such assignments are not possible, the state is further directed to "distribute the beneficiaries equitably among qualified MCOs."[15]

Once enrolled, whether by choice or by default, the beneficiary has a 90-day window in which to disenroll and select another MCO. When a beneficiary moves from one MCO to another, a new 90-day window opens. After a 90-day window closes, a beneficiary may move from one MCO to another only during an annual open enrollment period, or for cause (as defined by the state).[16]

In New York, as discussed above, enrollment in an MCO will be required for dual eligibles who need LTSS that will continue for at least 120 days. At least 60 days before a mandatory enrollment date, the enrollment broker will notify beneficiaries of the mandatory enrollment.[17] While not in the New York STCs, according to reports from New York consumer advocates, the state's contract with the enrollment broker requires the broker to contact each beneficiary who does not respond to the 60-day enrollment notice within 30 days, and inform the beneficiary of which plan he or she will be assigned to if no affirmative choice is made within the 60-day period.

According to New York consumer advocates, if the beneficiary does not affirmatively choose an MCO, the Department of Health has indicated that the enrollment broker's assignments will be random. This seems to conflict with a state law requiring that "[w]here a participant has not selected such [an MCO] …, the commissioner shall assign such participant to a managed long-term care provider, taking into account quality, capacity and geographic accessibility."[18] This state-law language was not incorporated in the STCs.

Once a beneficiary is enrolled, there is no lock-in period: he or she may disenroll and select another plan as frequently as once per month. As a practical matter, any enrollment is effective the first of the following month, or of the next month for requests made too late in the month.

Analysis

Advocates have consistently pushed for new MLTSS programs to utilize voluntary enrollment processes. Requiring high-needs beneficiaries to enroll in programs that do not have a track record of successfully providing LTSS exposes beneficiaries to risks, especially during the transition to the new program. If the MCOs offer a truly person-centered experience, beneficiaries will enroll without being forced to do so.

If mandatory enrollment is allowed, a 10-day notice period (as will be used in New Jersey) is not adequate. Where beneficiaries have a choice of plans they need time to evaluate the available plans and make an informed selection. Even if such a choice does not exist, more notice is needed to understand and prepare for the transition. Between these two approaches, the 60-day period used in New York offers the stronger beneficiary protection.

Specificity should be provided on the conditions under which disenrollment could be allowed "for cause." This issue already

is addressed to a certain extent in federal regulations, which find cause to disenroll if the enrollee moves out of the service area, or for "other reasons" including poor quality of care, lack of access to services, or lack of access to experienced providers.[19]

Continuity of Care, in Care Plans and Service Providers, During Transition from Fee-For-Service to Managed Care

What CMS Has Approved

For both New York and New Jersey, when an enrollee enters managed care, any pre-existing service plan continues in effect until a care assessment is performed. Pursuant to the New York STCs, in addition, an enrollee is entitled to remain under the pre-existing service plan for a minimum of 60 days. By the 30th day of that 60-day period, the MCO must assess the enrollee's needs and provide notice of its proposed new plan of care to be effective after the 60-day period.[20]

In either state, any reduction or denial of services can be appealed.[21] In addition, in New York, the MCO must submit data for state review for any notice of action that reduces split-shift or live-in services, or reduces authorized hours by 25 percent or more. The MCO also must report the number of appeals and fair hearings requested regarding these reductions.[22]

Regarding continuity of providers, New York has required all MCOs in New York City to contract with any and all agencies that have existing Medicaid contracts to provide Medicaid personal care services, as long as those agencies agree to accept the same reimbursement rate that they had previously received under fee-for-service Medicaid. For LTSS services other than personal care, each MCO must submit a plan identifying the mechanisms that will assure continuity of care, and those plans must be approved by the Department of Health. All of these requirements apply solely to New York City — the first geographic area in the state subject to mandatory MLTSS — and expire March 31, 2013. As other areas of the state transition to mandatory MLTSS, the Department of Health will release continuity of care requirements applicable to those areas.[23]

In New Jersey, continuity of care standards provide little detail — under the STC, the Department of Human Services must require MCOs to establish processes regarding continuity of care.[24]

Analysis

These requirements in New Jersey and New York are relatively limited given the significant possibility for disruption in the transition to managed care for an enrollee currently receiving LTSS. An enrollee relies upon the LTSS service provider every day, or virtually every day, and the slightest disruption in services or provider access can have disastrous effects.

The STCs could be improved by adding protections such as the following:

- A state's obligation to provide an MCO with copies of prior assessments of an enrollee's health condition and service needs.
- An MCO's obligation to identify

and protect particularly vulnerable beneficiaries — for example, persons on dialysis or receiving oxygen administration — upon their transition to managed care.

- An MCO's obligation to make reimbursement available to an existing LTSS service provider, as long as the service provider meets appropriate standards of quality. For example, in Wisconsin's current program, an MCO at an enrollee's request must purchase services from any personal care provider, nursing facility, or assisted living facility that meets the MCO's reasonably-set standards.[25]
- An MCO's obligation to take steps to ensure that logistical requirements (claims submission procedures, for example) do not prevent LTSS providers from participating in a managed care system. This protection would be particularly important for small entities and individual service providers.

Planning Services and Supports

Plans of Care

What CMS Has Approved

In both the New Jersey and New York STCs, CMS requires that planning be "person-centered." Person-centered planning is defined, in both states, as including "consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems."[26] Both STCs require that provision of home and community-based services be emphasized. The New Jersey STC states that this emphasis will include "maximizing" health and safety, while the New York STCs note that health and safety risk factors must be addressed in the planning process. In both states, a plan of care must include a back-up plan to ensure "that needed assistance will be provided in the event that the regular services and supports identified in the [plan] are temporarily unavailable."[27]

New Jersey and New York offer slightly different approaches to who makes the decisions about the care plan: the New Jersey STC speaks of "team-based" planning, while the New York STCs state that the plan is developed by the enrollee "with the assistance of the [MCO], provider, and those individuals the participant chooses to include."[28]

In both states' STCs, meetings related to the plan of care must "be held at a location, date, and time convenient to the enrollee and his/her invited participants." Plans must be reviewed at least annually and more frequently as warranted by the enrollee's circumstances.[29] In addition, the New York STCs require a process that permits an enrollee to request a change to a plan.[30]

In each state, a significant number of care planning issues are delegated to the state for resolution. These issues include qualifications for persons developing the care plan, types of assessments, how enrollees are informed

of the services available to them, and the MCO's responsibilities for implementing and monitoring the plan of care.[31]

Analysis

The care planning requirements for New Jersey and New York contain many positive provisions but also fall short in some areas. More specificity is needed to assure that plans truly are person-centered. Without more specificity, there is a danger that an enrollee will find herself in a process that is labeled as person-centered, but as a practical matter is dominated by the plan and health care providers.

CMS and the states should look to the Community First Choice option (CFC) and the Balancing Incentive Payments Program, two programs established by the Affordable Care Act that rely on the provision of person-centered care planning to increase access to HCBS.[32] The CFC regulations offer useful benchmarks for both process and substance in care planning.[33] The BIPP guidance includes strong beneficiary protections, like conflict-free case management, in the planning process.[34]

Care Coordination

What CMS Has Approved

The New Jersey and New York STCs take different approaches to care coordination requirements, with the New Jersey STC providing relatively more detail on care coordinator roles and processes.

In New Jersey, the role of care coordinators is defined, although generally. Care coordinators monitor service provision and ensure enrollees' health and safety. When care is self-directed, care coordinators must monitor the adequacy and appropriateness of services, and the adequacy of payment rates.[35]

The New Jersey STC also sets several standards for care coordination processes. The state must develop standard timelines for initial contact, assessment, development of a plan of care, and authorization and implementation of services. Care coordination must be "conflict-free," and the state is responsible, subject to CMS approval, for setting standards to determine what qualifies as "conflict-free." Safeguards could include "separation of services and other structural requirements, State/enrollee oversight, and administrative review."[36]

In contrast, in the New York program, defining these roles and processes largely has been delegated to the state. The New York STCs refer broadly to Part D of section 438 of the Code of Federal Regulations, which addresses care coordination in a general way, but does not include specific requirements for care coordinators or care coordination processes.[37]

Analysis

The STCs from both states are missing details on how the care coordination services would be delivered "conflict-free" and in a manner that prioritizes the individual's needs and preferences over the financial considerations of the MCO. The safeguards suggested by the New Jersey STC — for example, oversight by the state and/or the enrollee, or administrative review —may be

mechanisms to monitor the quality of care coordination, but do not ensure that care coordination actually is free of conflicts. One possible model is the Independent Living and Long-Term Services and Supports Coordinators authorized for Massachusetts's program to integrate Medicare and Medicaid. These coordinators will be employed by community-based organizations, working for MCOs through contracts between MCOs and community-based organization.[38] It is worth noting, also, that under New Jersey's current Global Options HCBS waiver, care coordination services are provided by Area Agencies on Aging, non-profit agencies, and similar entities.[39] Each of these approaches allows the care planning process to be guided, or influenced, by entities without a direct financial stake in the MCO.

Self-Direction

What CMS Has Approved

In both states, CMS requires the states and MCOs to provide the option of self-direction of HCBS, so that enrollees have "the opportunity to have choice and control over how services are provided and who provides the service.[40]

In New York, this self-direction represents an extension of the Consumer-Directed Personal Assistance Program (CDPAP), which has long been a voluntary option for Medicaid beneficiaries.[41] Consumers already enrolled in the CDPAP program were initially exempt from mandatory enrollment into MLTSS when it began in September 2012, because only one MCO had a contract and system in place to offer this type of service. The New York STCs, however, now require all participating MCOs to offer CDPAP, and CDPAP enrollees are no longer exempt from the managed care requirement.[42]

In both New York and New Jersey, an enrollee can have employer authority that includes all of the following tasks: recruiting, hiring, verifying employee's qualifications and ability to perform the job, evaluating, verifying time worked, and discharging as necessary. The New York STCs also mention scheduling as an enrollee's task, while the New Jersey STC mentions obtaining a criminal history or background investigation, and specifying additional staff qualification based on the enrollee's needs and preferences.[43]

The STCs in both states also require the state and MCO to provide a strong support system that includes information, training, counseling, and assistance for self-directing enrollees.[44] Also, the enrollee must receive assistance with financial and logistical issues: in both states, an IRS-approved fiscal/employer agent acts as the enrollee's agent for payroll and other employer responsibilities.[45]

At an enrollee's option, self-direction may be performed by "a non-legal representative freely chosen by [the enrollee]." A representative cannot be a provider of services, as otherwise the representative would be supervising and training himself or herself.[46]

At any time, an enrollee in either state may choose to leave the self-directed model and receive HCBS services without self-direction. In addition, the MCO may end the enrollee's self-direction program against his or her will, if the enrollee's health, safety, or welfare

needs would not be met with continued self-direction, if the enrollee consistently demonstrates a lack of ability to carry out the self-direction tasks, or if there has been fraudulent use of funds.[47]
The New Jersey STC, but not the New York STCs, describes the support for self-direction as including two components: Financial Management Services and (this is the concept missing in the New York STC) a Support Brokerage.[48]

Analysis

In general, the approach in the STCs to self-directed care is positive. Among the commendable provisions are those that require the state and MCO to provide support for self-direction.

It should be noted, however, that the STCs generally address employer authority, but not budget authority, in which a Medicaid beneficiary has authority over a particular amount of money with some significant discretion as to how that money is used. More expansive self-direction would allow enrollees to exercise both employer authority and budget authority. A good model is found in the federal regulations for Medicaid self-directed personal assistance services programs. Under these regulations, a service budget must explain how the enrollee may make changes to the budget and, in a related matter, how the enrollee might "reserve funds to purchase items that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance."[49]

Also, states and MCOs could support self-direction further by providing logistical assistance as necessary to persons providing care. An individual service provider is unlikely, at least initially, to have the technical capacity to bill an MCO. Without such assistance, many or most individual service providers will not be able to provide services under a managed care model.

Coordination of Medicare Services for Dually Eligible Enrollees

What CMS Has Approved

Neither the New Jersey nor New York STCs include Medicare benefits and services in the plan benefit package. Under both STCs, the state must require an MCO to conduct adequate coordination with services provided through Medicaid on a fee-for-service basis, and for services not covered by Medicaid, but, while dual eligibles are mandatorily enrolled into Medicaid MCOs under both states' programs, the STCs do not specifically mention coordination with Medicare-funded services.[50]

Analysis

The STCs' lack of detail about how MCOs will or will not coordinate Medicare services for dual eligibles is problematic. An MCO managing only Medicaid benefits for a dual eligible has little incentive or ability to coordinate care, since Medicare is the primary payer for physician services, prescription drugs, hospitalizations and even certain types of long-term care. Given that Medicaid MCOs lack responsibility for Medicare services, it's important that those Medicaid MCOs do not interfere with

relationships dually eligible enrollees have with Medicare providers or existing Medicare treatment regimes. For example, MCOs may need to be instructed to not assign dually eligible enrollees to a primary care physician since Medicare covers that service and making such an assignment may disrupt the enrollee's access to care.

Covered Services

Provision of LTSS

What CMS Has Approved

In New Jersey, all Medicaid-covered services will be provided through the waiver.[51] In New York, however, a beneficiary will have a choice between a fully capitated plan and a partially capitated plan, with only the fully capitated plan including full Medicaid benefits (along with Medicare benefits).[52]

The New Jersey waiver includes a significant number of LTSS options, including the following:

- Adult family care
- Assisted living care
- Attendant care
- Care management
- Chore services
- Community transition services
- Environmental accessibility adaptations, i.e., home modifications
- Home-based supportive care
- Home-delivered meals
- Home health rehabilitation services
- Medical day care
- Personal care assistance
- Personal emergency response systems
- Respite care
- Social adult day care
- Training for enrollees and caregivers on living independently
- Transitional care management
- Transportation to medical appointments, and to provide access to waiver and other community services specified in the care plan[53]

Nursing facility care also is included although, as discussed previously, there is some ambiguity in the STC as to whether nursing facility care is completely delegated to managed care, or is delegated only for an initial 30 days, and for up to 180 days if an HCBS recipient is expected to return to an HCBS setting after an intervening nursing facility stay of no more than 180 days.[54]

In New York, the covered LTSS services include all of the following:

- Adult day health care
- Home-delivered meals
- Home health care (including assistance from a nurse or home health aide, along with physical, occupational and speech therapy)
- Non-emergency transportation
- Nursing facility care (although nursing facility residents are excluded from mandatory enrollment)

- Personal care
- Personal emergency response systems
- Social and environmental supports, and personal emergency response systems[55]

In both states, an MCO must ensure that services are delivered in accordance with the plan of care.[56]

Analysis

Each of these states has a broad package of LTSS benefits, which is a very positive feature. In practice, it will be important to ensure that these broad benefits are actually authorized by the plans and provided in sufficient amount, duration, and scope. It is not clear whether and how MCOs will apply the authorization standards that have been used under fee-for-service programs. In most states, such standards are the product of years of policy development, and often offer important protections for beneficiaries.[57]

The positive impact of including a broad package of LTSS in the benefit package is undercut by New York's decision to carve nursing facility coverage out of the benefit package. The New Jersey STC is ambiguous on this issue. If MCOs are to be incentivized to actually provide a robust package of HCBS to enrollees, they must be financially at risk for the more expensive nursing facility services.

Cultural Competence

What CMS Has Approved

The recent CMS STCs say relatively little about the cultural competence of service provision. The New Jersey STC states simply that "[s]ervices must be delivered in a culturally competent manner." One of the New York STCs, in relation solely to a hospital-medical home demonstration, includes a short section entitled "Enhance Interpretation Services and Culturally Competent Care," consisting of five requirements:

- Analyzing gaps in access to language services, and implementing language access policies and procedures.
- Hiring, training, and/or certifying interpreters, or determining other methods for increasing patients' access to appropriate language services.
- As an option, using remote video and voice technology for instantaneous qualified health care interpretations.
- Developing evidence-based training to improve staff cultural competence and awareness.
- Generating prescription labels in patient's primary language with easy to understand instructions.[58]

Analysis

Future STCs approved by CMS must be more explicit about what cultural competence encompasses. Those MCOs that value cultural competence likely need more direction and guidance to improve their programs. Those MCOs that are not inclined

to improve in this area will have little reason to make improvements without specific and significant evaluation criteria. Some useful standards can be drawn from, among other sources, the National Standards on Culturally and Linguistically Appropriate Services (CLAS) (developed by the Office of Minority Health of the U.S. Department of Health and Human Services).[59]

Rebalancing the System

Nursing Facility Diversion and Transition

What CMS Has Approved

For both New Jersey and New York, the STCs contain provisions designed to lessen the likelihood or duration of a nursing facility stay. The New Jersey provisions offer more specifics.

In New Jersey, each MCO must implement a "NF Diversion Plan" in compliance with requirements to be established by the state; such plans must be approved by both the state and CMS. As part of these plans, each MCO must monitor hospitalizations and short-stay nursing facility admissions for at-risk enrollees.[60]

For nursing facility residents who are capable of transitioning to the community, and who have requested such a transition, New Jersey MCOs must implement a "NF to Community Transition Plan." Under these plans, MCOs must identify nursing facility residents who can benefit from transition and work with state entities that can provide necessary services. Also, each MCO must monitor hospitalizations, re-hospitalizations, and nursing facility admissions to identify issues and improve enrollee outcomes.[61]

The New York STCs do not contain specific diversion and transition requirements but, in order to facilitate transitions, the STCs apply a more lenient income standard for a nursing facility resident enrolling in the MLTSS program in order to move from the nursing facility and receive community-based services and supports. The income standard consists of the HUD fair market rent minus 30 percent of the Medicaid income level for a single-person household. In order to identify good candidates to utilize this income standard, the state is obligated to work with nursing facility staff, health plans, and beneficiaries' family members.[62]

Analysis

Specific diversion and transition programs are a necessary feature for any MLTSS system.[63] Every effort should be made to build incentives and explicit program requirements that promote safe and appropriate transitions of beneficiaries from nursing facilities to home and community-based services. The results of such programs should be made publicly available.

Weighing Expense of Community Care and Nursing Facility Care

What CMS Has Approved

The New Jersey STC sets specific standards for determining how cost influences a decision

whether to provide care in the community or in a nursing facility, but the New York STCs do not address this issue.

In New Jersey, enrollees needing LTSS will receive "a cost-effective placement, which will usually be in a community environment." HCBS expenses, however, cannot exceed the expense of nursing facility care, with three exceptions:

- The enrollee is transitioning from institutional care to community-based placement.
- The enrollee is experiencing a change in health condition that involves significant additional costs but is expected to last no more than six months.
- There are "special circumstances where the state determines an exception must be made to accommodate an enrollee's unique needs."[64]

In the case of the "special circumstances," the state must establish a review procedure to be used by the state and the MCOs to describe the relevant criteria, and CMS must approve the procedure.[65]

If the costs of recommended HCBS exceed the cost of a nursing facility, and the enrollee chooses to remain in the community-based setting with a less-than-recommended level of HCBS, the enrollee and MCO must complete a risk assessment detailing risks, outlining safeguards, and establishing a back-up plan.[66] If an enrollee wants to live in a nursing facility but the MCO is authorizing a less expensive community-based placement, the MCO has the authority to require a community-based placement, provided that the plan of care "provides for adequate and appropriate protections to assure the enrollee's health and safety."[67]

The New Jersey STC notes that its provisions do not in any way relieve the state of its obligations under the Americans with Disabilities Act.[68]

Analysis

MLTSS programs should require that MCOs provide home and community-based services as an alternative to nursing facility care, especially when cost effective. Limiting, however, the provision of these services to cases where the cost of alternative services is less than the cost of a nursing facility ignores the many reasons other than cost for providing services in the community.

Retention of Community Needs Allowance During Nursing Facility Stay

What CMS Has Approved

As discussed above, a provision in the New Jersey STC states that nursing facility coverage is provided through managed care for stays of 180 days or less, if the enrollee is receiving HCBS and expects to receive HCBS after the intervening nursing facility stay. During such "short-term" nursing facility stays, the enrollee's maintenance needs allowance (the amount of money that he or she is allowed to retain from monthly income) will be the community maintenance needs allowance (currently $150 monthly), rather than the allowance for nursing facility residents ($35 monthly).[69] Allowing retention

of the community allowance is done "in order to allow sufficient resources for the member to maintain his or her community residence back to the community."[70]

The New York STCs do not contain a comparable provision.

Analysis

Standard Medicaid procedures give a state the option of allowing a nursing facility resident to retain additional income, if a physician has certified that the resident is likely to return home within six months.[71] The New Jersey provision is somewhat more favorable to consumers, as no physician's certification is required. Unfortunately, a $150 monthly maintenance needs allowance is inadequate.

Characteristics of Home and Community-Based Settings

What CMS Has Approved

Although HCBS are meant to provide an alternative to residence in an institution such as a nursing facility, Medicaid HCBS funding has long been used to fund care for beneficiaries living in assisted living facilities and other group residences. Some stakeholders see no conflict, arguing that assisted living facilities and similar facilities are homelike and provide a welcome alternative for persons who prefer, due to necessity or choice, to live in a group residence rather than in an individual house or apartment. Other persons argue strenuously that group residences cannot honestly be considered community-based, and that HCBS funding, particularly in an environment of strained HCBS budgets, should not be expended for services provided in an assisted living facility or other group residence. CMS has released proposed regulations on this issue but, in part because of the many divergent stakeholder positions on this issue, has not yet released any final regulations.[72]

The New Jersey STC represents the first time that CMS has set forth enforceable standards for community-based settings. In New Jersey, all community-based settings must provide enrollees with all of the following:

a. Private or semi-private bedrooms, including decisions associated with sharing a bedroom.

b. An option to receive home and community-based services in more than one appropriate residential setting.

c. Private or semi-private bathrooms that include provisions for privacy.

d. Common living areas and shared common space for interaction between enrollees, guests, and other residents.

e. Access to a food storage or food pantry area at all times.

f. An opportunity to make decisions about day-to-day activities, including visitors, and when and what to eat.

g. The right to be treated with respect, choose to wear personal clothing, have private space for personal items, have privacy to visit with friends or family, use a telephone with privacy,

choose how and when to spend free time, and have opportunities to participate in community activities.

The New York STCs do not address this issue; as discussed above, assisted living residents are excluded from enrollment in New York.

Analysis

The New Jersey standards are a step in the right direction but equivocate on important points. Private occupancy is vital for a non-institutional setting, where there should not be a "decision" regarding a shared bedroom unless the sharing is done with a spouse or partner. Similarly, standards should be more specific regarding privacy in bathrooms; it is unclear what "provisions for privacy" would be in a semi-private bathroom.

Reporting Rebalancing Data

What CMS Has Approved

Both New Jersey and New York are required to submit data to CMS related to the states' rebalancing efforts. For New Jersey, these data include:

- Number of beneficiaries receiving HCBS and nursing facility services prior to waiver implementation.
- Number of enrollees receiving HCBS and nursing facility services during each 12 month period.
- HCBS and nursing facility expenditures for managed LTSS as percentages of total LTSS expenditures during a 12 month period.
- Average HCBS and nursing facility expenditures per enrollee during a 12 month period.
- Average length of stay in HCBS settings and nursing facilities during a 12 month period.
- Percent of new managed LTSS enrollees admitted to nursing facilities during a 12 month period.
- Number of enrollees transitioning from nursing facilities to the community, or from the community to nursing facilities, during a 12 month period.[73]

The New York STCs are much less detailed on this issue, requiring only that the state report rebalancing efforts including but not limited to the total number of enrollees transitioning in and out of nursing facilities quarterly.[74]

Analysis

The data described in the New Jersey STC could be an important tool in evaluating these waivers' efficacy. Such data should be made broadly available on an MCO-specific basis.

Quality of Care

Network Adequacy

What CMS Has Approved

In both New Jersey and New York, network adequacy standards are relatively open-

ended, leaving a considerable amount of discretion with the MCOs and the states.

The New Jersey STC provides that enrollees must have access to non-network providers when required services cannot be provided under applicable timeliness standards. Also, enrollees with "special health care needs must have direct access to a specialist."[75]

More broadly, in both New Jersey and New York, each MCO must provide adequate assurances that it has "sufficient capacity" — an undefined term — to provide required benefits to expected enrollees. The state must verify these assurances by "reviewing demographic, utilization and enrollment data for enrollees," along with data on the location and capacity of providers. Each state must submit the relevant data to CMS on an annual basis and (in the case of New Jersey) along with the initial contract between the state and the MCO.[76]

Specific to LTSS, New York is required to establish network adequacy standards that "take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services."[77]

Analysis

These requirements are heavy on data, but relatively light on usable standards. If CMS, a state, or an MCO is to be expected to determine in the future whether certain networks are adequate, CMS must set more specific, measurable standards.

Furthermore, there is no mechanism for network adequacy information to be shared with outside stakeholders. Enrollees and their representatives should have access to relevant information, in order to monitor and judge whether networks are truly in a position to meet enrollees' needs.

Quality Measures and Data Collection

In evaluating HCBS generally, CMS follows a quality oversight process that uses discovery, remediation, and then system improvement. The problem is discovered, the individual situation is addressed, and then information about the problem is used to inform systemic changes.[78] This general strategy is outlined in the New Jersey and New York STCs, although the New Jersey STC provides significantly more detail.

In New Jersey, the state must develop a comprehensive quality strategy with quality measures addressing LTSS as well as all other types of services provided under the waiver. The state must obtain input from beneficiaries and other stakeholders in developing the strategy, which then must be made available for public comment. When completed, the strategy must be submitted to CMS at least 90 days prior to implementation; similar process requirements apply when the strategy subsequently is revised.[79]

Under the New Jersey STC, the quality improvement process must address each of the following areas:

- Quality of life outcomes.
- Service plan development.
- Level of care determinations.
- Adherence to provider qualifications, including standards when care is self-directed.
- Critical incidents (such as incidents of abuse or neglect)

Monitoring relating to these areas is to be conducted by the state and/or the external quality review organization.[80]

In New York, as in New Jersey, the state's quality strategy must be informed by stakeholder input and made available for public comment. The strategy must be submitted to CMS within 90 days of CMS approving the waiver amendment. Regarding the strategy's content, the requirements are relatively limited: the state (and/or an external quality review organization) must ensure that MCOs are adequate in conducting assessments, creating and implementing service plans, credentialing providers, and identifying and addressing incidents of abuse, neglect or exploitation.[81]

Analysis

These standards lack detail regarding how remediation and systems improvement might be conducted and fail to require transparency in the process. Collection of data is not enough — data must be acted upon as appropriate, and the general public should have access both to the data and to the actions taken by the state and/or the external quality review organization. The STCs, however, provide little specificity regarding these important issues, leaving too much discretion to the process of developing and approving a state's quality strategy.

Enrollee Remedies

Appeals and Grievances

What CMS Has Approved

The appeal and grievance procedures in both the New Jersey and New York STCs defer generally to existing law governing Medicaid managed care. The New Jersey STC largely incorporates existing federal regulations governing appeals and grievances in Medicaid managed care.[82] Explicitly relating to MLTSS, the New Jersey STC also notes that fair hearing rights attach to an MCO decision to reduce services or a service budget, or to deny a requested budget adjustment. This provision is located within the STC's discussion of consumer-directed care, but is not limited by its terms to consumer-directed care.[83]

By comparison, the New York STCs provide significantly fewer details regarding grievances and appeals. Regarding consumer-directed personal assistance services, an enrollee is entitled to a fair hearing on any reduction, suspension, or termination of authorized services, or a denial of a request to change services.[84]

Although this requirement is not in the New York STCs, a model contract between the New York Department of Health, and an MCO

requires that an enrollee exhaust a plan's internal appeal processes before requesting a Medicaid fair hearing.[85]

Analysis

As noted, the approval documents follow relevant federal regulations.[86] This is both good and bad news for enrollees. The good news is that the federal regulations are relatively faithful to due process protections within the fair hearing process. The bad news is that the federal regulations fall short in several instances.

One shortfall relates to access to fair hearing procedures. The federal regulations allow states to force an enrollee to exhaust an internal MCO appeal process before seeking a fair hearing.[87] Although, as discussed above, such exhaustion of internal procedures is required in a New York model contract, this procedural hurdle is counterproductive for enrollees, and serves in many cases to deprive enrollees of necessary services. An enrollee should have the ability from the outset to have his or her appeal heard by an objective state hearing officer, without being forced first to seek relief from a representative of the same MCO that took the adverse action in the first place.

A second shortfall relates to the ability to receive continued funding pending appeal of a proposed termination or reduction of a specific service. Federal regulations require "aid paid pending" in many situations, but one exception is a situation in which the prior authorization for the requested service has expired.[88] Such a policy is not appropriate in the context of long-term services and supports, which frequently are needed indefinitely even when a particular prior authorization has been written only for a relatively short period of time.[89]

According to New York consumer advocates, the New York Department of Health has indicated that the STC provisions relating to appeal rights are being amended after discussions between the state and CMS. The amendment reportedly will clarify that appeals of reductions upon the initial transition from the former fee-for-service plan of care will include the right to aid paid pending. According to the state's representation, the amended STCs requiring aid paid pending rights will be limited to reductions at the initial transition to MLTSS, and will not apply to subsequent reductions.

One additional appeals-related issue warrants discussion, although it is not as directly related to the federal MCO regulations on appeals. An enrollee should be given a clear right to appeal care plan provisions with which he or she does not agree, given the general disparity in bargaining power. In Wisconsin, for example, the contract between the state Medicaid program and MCOs specifies that beneficiary appeal rights attach to "a member-centered plan" if the plan forces the enrollee to live in an "unacceptable" place, the MCO does not provide services that the enrollee needs, or the plan requires the member to accept treatment that is unwanted or unnecessarily restrictive.[90]

Advocacy Support for Enrollees

What CMS Has Approved

The New Jersey STC references advocacy

support for enrollees, but it is unclear whether new, meaningful support will actually be provided. Under the New Jersey STC, each enrollee will have "access" to an independent advocate or advocacy system that is not involved in providing waiver services or overseeing the waiver. But the STC does not indicate a specific entity that will be funded and contracted with to provide this assistance. Instead, the STC implies that existing agencies and funding will be relied upon to provide the assistance.[91]

The New York STCs do not reference advocacy support.

Analysis

CMS should require that states establish and fund independent advocacy entities to provide MCO enrollees with support in obtaining services, negotiating, and pursuing grievances and appeals, and to formally represent enrollees as necessary.[92]

Stakeholder Participation

Advisory Committees

What CMS Has Approved

Both states have been required to create a managed care advisory committee. In New Jersey, the committee is comprised of persons impacted by the demonstration's use of managed care, and membership must be periodically updated to ensure adequate representation of persons receiving LTSS.[93] In New York, committee members are appointed by the Legislature and governor and, to the extent possible, should be qualified to speak on behalf of seniors and persons with disabilities who are impacted by the provision of LTSS through managed care.[94]

Analysis

The requirements in the STCs contain no assurance that a committee's recommendations will be heard and acted upon. At a minimum, a state should be required to consider and respond in writing to a committee's recommendations. Also, the current requirements do not require advisory committees for MCOs; such committees would be beneficial in keeping MCOs well-informed of concerns from consumers and other stakeholders.

ENDNOTES

1 New York's waiver was approved by CMS on August 31, 2012. New Jersey's was approved on October 2, 2012.

2 Paul Saucier et al., Truven Health Analytics, *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: An 2012 Update* 1 (2012).

3 *New Jersey's Section 1115 Demonstration Comprehensive Waiver Application*, at 63 (Sept. 9, 2011).

4 New Jersey's Section 1115 Demonstration Comprehensive Waiver Application, at 2 (Sept. 9, 2011).

5 *NJ STC* at 12-33.

6 NJ STC at 2-3.

7 NJ STC at Attachment B, p. 10.

8 NJ STC at 34-35, and Attachment B, p. 10.

9 These two waivers are the Federal-State Health Reform Partnership Medicaid Section 1115 Demonstration, and the Partnership Plan Medicaid Section 1115 Demonstration.

10 *Letter from Marilyn Tavenner*, CMS Acting Administrator, to Nirav Shah, M.D., Commissioner of New York Department of Health (Aug. 31, 2012) (CMS NY Approval Letter); *NY Health Reform STC* at 43-45; *NY Partnership STC* at 64-66. Under the Partnership Plan demonstration approved in 1997, most Medicaid beneficiaries were enrolled into managed care. In 2006, mandatory managed care was expanded to include the SSI population and authority for this group was transferred to a new demonstration, the Federal-State Health Reform Partnership.

11 A good resource is a table entitled "*Summary of Managed Care Plans in Medicare and Medicaid*," prepared by the Evelyn Frank Legal Resources Program of Selfhelp Community Services, Inc. *See also* Saucier et al., supra n. 2, at 40-47.

12 NY Health Reform STC at 12-13; NY Partnership STC at 14-15.

13 NY Health Reform STC at 6-7, 19-20, 43-45; NY Partnership STC at 3, 6, 22, 64-66.

14 NJ STC at 11, 37.

15 NJ STC at 38.

16 NJ STC at 38.

17 NY Health Reform STC, Attachment C; NY Partnership STC, Attachment G.

18 N.Y. Pub. Health Law 4403-f(7)(b)(vi).

19 42 C.F.R. § 438.56(d)(2).

20 NJ STC at 47; NY Health Reform STC at 15; NY Partnership STC at 17.

21 NJ STC at 47; NY Health Reform STC at 15; NY Partnership STC at 17.

22 NY Health Reform STC at 15; NY Partnership STC at 17.

23 *Continuity of Care Policy for Managed Long Term Care*, N.Y. Dep't of Health.

24 NJ STC at 84.

25 *WI Dep't of Health Services, Family Care Contract between Department of Health Services, Division of Long Term Care and [MCO]* , at 95, 104 (contract as amended on Apr. 13, 2011, applicable to calendar year 2012).

26 NJ STC at 40; NY Health Reform STC at 14; NY Partnership STC at 16.

27 NJ STC at 40; NY Health Reform STC at 14; NY Partnership STC at 16.

28 NJ STC at 40; NY Health Reform STC at 14; NY Partnership STC at 16.

29 NJ STC at 40; NY Health Reform STC at 14; NY Partnership STC at 16.

30 NY Health Reform STC at 14; NY Partnership STC at 16.

31 NJ STC at 40; NY Health Reform STC at 14; NY Partnership STC at 16.

32 The CFC program is authorized by 42 U.S.C. § 1396n(k). CFC provides an incentive for state Medicaid programs to offer more extensive HCBS: specifically, for an approved state program, CFC increases the federal Medicaid match by six percent for HCBS that meet CFC standards. The BIPP program is authorized by section 10202 of the Affordable Care Act. 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 currently under 25 percent; the 50 percent target applies to those states currently between 25 and 50 percent. An approved state receives an increase of five or two percent in its federal reimbursement for HCBS, based respectively whether the state's target is 25 or 50 percent of LTSS expenditures.

33 42 C.F.R. § 441.540.

34 Affordable Care Act, § 10202(c)(5)(B).

35 NJ STC at 49-50.

36 NJ STC at 50.

37 NJ STC at 41-42; NY Health Reform STC at 21; NY Partnership STC at 25.

38 *Memorandum of Understanding (MOU)* Between the Centers for Medicare and Medicaid Services (CMS) and the Commonwealth of Massachusetts Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees: Demonstration to Integrate Care for Dual Eligible Beneficiaries, at 26, 58 (Aug. 22, 2012).

39 Global Options Waiver, Application for a § 1915(c) Home and Community-Based Services Waiver, Apendix C-1/C-3: Service Specifications (as approved by CMS, effective Oct. 1, 2011).

40 NJ STC at 41-42; NY Health Reform STC at 18; NY Partnership STC at 21.

41 N.Y. Soc. Serv. Law 365-f; see also Medicaid Consumer-Directed Personal Assistance Program (CDPAP) in New York State, a*vailable at* *http://wnylc.com/health/entry/40*, with links to laws, regulations, and policy directives.

42 *See* N.Y. Dep't of Health, Consumer/Designated Representative Acknowledgement of the Roles and Responsibilities for Receiving CDPAP (Oct. 1, 2012), *available at* *www.health.ny.gov/health_care/medicaid/redesign/docs/cdpap_member_plan_mou_final.pdf*.

43 NJ STC at 41-42; NY Health Reform STC at 18; NY Partnership STC at 21.

44 NJ STC at 41; NY Health Reform STC at 18; NY Partnership STC at 21.

45 NJ STC at 41; NY Health Reform STC at 18; NY Partnership STC at 21.

46 NJ STC at 41; NY Health Reform STC at 18; NY Partnership STC at 21.

47 NJ STC at 42; NY Health Reform STC at 18-19; NY Partnership STC at 21.

48 NJ STC at 41.

49 42 C.F.R. § 441.470(c), (d); *see also* 42 C.F.R. § 441.482(a) (ability to purchase items that increase independence or substitute for human assistance, instead of using those funds for human assistance).

50 NJ STC at 36; NY Health Reform STC at 21; NY Partnership STC at 24.

51 NJ STC, Attachment B.

52 *See supra*, note 11 and accompanying text.

53 NJ STC, Attachment B (home health rehabilitation services and personal care assistance), Attachment C.2.

54 NJ STC at 34-35, and Attachment B, p. 10.

55 NY Health Reform STC at 39; NY Partnership STC at 57.

56 NJ STC at 40; NY Health Reform STC at 14; NY Partnership STC at 16.

57 *See*, *e.g.*, Medicaid Personal Care or Home Attendant Services (citations relating to personal care services in New York), *available at* *http://wnylc.com/health/entry/7*.

58 NY Partnership STC at 30.

59 HHS Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services (CLAS), available at, *http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15*

60 NJ STC at 47.

61 NJ STC at 47-48.

62 NY Health Reform STC at 10; NY Partnership STC at 12.

63 *See, e.g.*, *Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: Consumer Advocate Recommendations for New York State* (March 2012).

64 NJ STC at 49.

65 NJ STC at 49.

66 NJ STC at 49.

67 NJ STC at 49.

68 NJ STC at 49.

69 NJ STC at 35.

70 NJ STC at 35.

71 42 C.F.R. §§ 435.725(d), 435.733(d), 435.832(d).

72 *See* 74 Fed. Reg. 29,453 29,454-55 (2009) (CMS intending to issue guidance regarding character of community-based settings); 76 Fed. Reg. 10,736, 10,740-41 (2011) (proposed regulations); 76 Fed. Reg. 21,311, 21,312-13 (2011) (same); 77 Fed. Reg. 26,362, 26,378-80, 26,382-84 (2012) (same).

73 NJ STC at 83-84.

74 NY Health Reform STC at 26, 28, 40-42; NY Partnership STC at 38, 41, 60-62.

75 NJ STC at 36.

76 NJ STC at 36-37; NY Health Reform STC at 22; NY Partnership STC at 25.

77 NY Health Reform STC at 22; NY Partnership STC at 25.

78 *See, e.g.*, CMS, *Quality of Care in Home and Community-Based Services (HCBS) Waivers*.

79 NJ STC at 68, 70.

80 NJ STC at 68-70, 83-85.

81 NY Health Reform STC at 21; NY Partnership STC at 24-25.

82 NJ STC at 39; (including cross-reference to Subpart F of section 438 of Title 42 of the Code of Federal Regulations).

83 NJ STC at 42.

84 NY Health Reform STC at 19; NY Partnership STC at 22.

85 N.Y. Dep't of Health, *Managed Long Term Care Partial Capitation Contract*.

86 *See* 42 C.F.R. §§ 438.400 - 438.424.

87 42 C.F.R. §§ 438.402(b)(2)(ii), 438.404(b)(4), 438.408(f)(1).

88 42 C.F.R. § 438.420(b)(4).

89 This issue is explored at length in a letter recently sent to CMS by the National Health Law Program, on behalf of itself and other organizations including the National Senior Citizens Law Center. Letter from Jane Perkins, National Health Law Program, to Cindy Mann, Deputy Administrator and Director, Center for Medicaid, CHIP, and Survey and Certification (Sept. 24, 2012).

90 WI Family Care Contract, *supra* note 25, at 137.

91 NJ STC at 41. This provision is located within the discussion of self-directed care but, under the provision's language, does not seem limited to self-directed care.

92 *See* AARP et al., *Designing State-Based Ombuds Programs in MLTSS and the Duals Eligible Demonstrations* (2012).

93 NJ STC at 37.

94 NY Health Reform STC at 22; NY Partnership STC at 26.

NSCLC
National Senior Citizens Law Center

1444 Eye St., NW, Suite 1100 | Washington, DC 20005 | (202) 289-6976 | (202) 289-7224 Fax
3701 Wilshire Blvd., Suite 750 | Los Angeles, CA 90010-1938 | (213) 639-0930 | (213) 368-0774 Fax
1330 Broadway, Suite 525 | Oakland, CA 94612 | (510) 663-1055 | (510) 663-1051 Fax