Managed Long-Term Services and Supports

Assessment, Authorization, Service Planning, and Case Management in State MLTSS Systems

Ari Ne'eman
Community Living Policy Center
University of California San Francisco

Over the course of the last decade, the United States has seen a significant increase in the use of Managed Long Term Services and Supports (MLTSS) within the Medicaid program. From 2004 to 2014, the number of states using MLTSS within their Medicaid programs has more than tripled from 8 to 26, with even further growth in subsequent years. Medicaid MLTSS offers states the opportunity to more effectively predict their cost structures while delegating the operation of their Medicaid Long-Term Services and Supports (LTSS) programs to Managed Care Organizations (MCOs) operating within a set of regulatory requirements and financial incentives designed to ensure quality of care and protection of consumer rights.

During the recession, states faced significant fiscal pressures, pushing many to explore introducing managed care or expanding existing managed care frameworks to LTSS for seniors and people with disabilities. As the economy has improved, this expansion in MLTSS has persisted, with new states considering or implementing new MLTSS frameworks each year.

In order to ensure that Managed Long Term Services and Supports systems deliver high-quality services to people with disabilities and do not involve inadequate or overly medicalized service provision, states adopt certain requirements within their procurement for and contracting with MCOs. These include requirements for how the MCO and its contractors will conduct activities previously undertaken by the state, including the assessment of individual need, service authorization, person-centered planning, and service coordination to LTSS recipients.

In September 2016, the National Quality Forum issued a report articulating domains and subdomains for the development of quality measures for Home and Community-Based Services (HCBS), which are LTSS delivered in people's home and other non-

institutional settings. This work was done in part to improve the operation of state Medicaid MLTSS frameworks. Within the domain of Person-Centered Planning and Coordination, the report identifies three key sub-domains:

- **"Assessment:** The level to which the HCBS system and providers support the person in identifying their goals, needs, preferences, and values. This process should gather all of the information needed to inform the person-centered planning process. Re-assessments should occur on a regular basis to assure that changes in consumer goals and needs are captured and appropriate adjustments to services and supports are made.
- **Person-centered planning:** The level to which the planning process is directed by the person, with support as needed, and results in an executable plan for achieving goals and meeting needs the person deems important. The plan includes the role of the paid and unpaid services or supports needed to reach those goals.
- **Coordination:** The level to which the services and supports an individual receives across the healthcare and social service system are complementary, integrated, and fully supportive of the HCBS consumer in meeting his or her needs and achieving his or her goals."[1]

This report seeks to articulate promising practices for states designing MLTSS frameworks, drawing on existing state MLTSS contract language and the National Quality Forum's report on HCBS Quality. It includes a review of MLTSS contract language from 19 state programs: Tennessee's TennCare, Senior Care Options and OneCare in Massachusetts, Virginia's Commonwealth Coordinated Care Plus,

Minnesota Senior Health Options and Senior Care Plus, New York's Fully Integrated Duals Advantage (FIDA) program, KanCare in Kansas, Rhode Island's Rhody Healthy Options, South Carolina's Healthy Connections Prime, Hawaii's Quest Integration, Florida's Statewide Medicaid Managed Care program, Delaware's Diamond State Health Plan Plus, New Jersey's Comprehensive Waiver, Michigan's MI Health Link, Vermont's Choices for Care, Wisconsin's FamilyCare and Family Care Partnership programs, and New Mexico's Centennial Care program.

LTSS Eligibility and Level of Care Assessment

Assessment represents one of the most important areas of work for Medicaid Managed Care Organizations and the states that contract with and supervise them. To accurately evaluate MCO performance for people with disabilities, states must maintain an accurate picture of the number of members enrolled in each MCO eligible for long term services and supports. In addition, LTSS eligibility – and in some instances, acuity[2] – is a factor in setting capitated rates to MCOs. Eligibility for LTSS introduces new obligations for service provision and rights protection that MCOs must abide by, and the information gathered in the assessment process is also a factor in service planning, serving as a valuable tool in setting plan goals and authorizing service provision. As such, the process by which prospective or existing program participants are assessed for LTSS eligibility and level of need is a critical component of MLTSS

---

[1] National Quality Forum. "Quality in Home

[2] Center for Medicare & Medicaid Services. "2017 Medicaid Managed Care Rate Development Guide" 2016. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/2017-medicaid-managed-care-rate-development-guide.pdf

contracts. Many states, including South Carolina, Delaware and Rhode Island, require MCOs to conduct general health risk assessments of all members to determine who may need to be referred for an assessment of LTSS needs. This helps protect against MCOs systematically under-identifying members eligible for LTSS to minimize their service obligations.

Access to LTSS benefits is limited to individuals who meet preset criteria. For some LTSS financing streams, such as the Skilled Nursing Facility benefit or the 1915(c) home and community based services waiver, participation is limited to those who meet an institutional level of care. For others, such as the personal care state plan option or the 1915(i) state plan option, states may set their own eligibility criteria. Some states offer limited LTSS benefits to individuals who do not meet eligibility requirements for more comprehensive benefits, in hopes of mitigating or delaying future service need through the early provision of support or meeting an unmet need for support among people with more mild disabilities.

To determine whether or not an enrolled member is eligible for LTSS, the appropriate entity must conduct an assessment of need. Should the member have a level of need that meets the LTSS eligibility criteria, the MCO is then responsible for providing them with LTSS in accordance with the requirements of the contract. Under many state MLTSS frameworks, the MCO is then eligible for a higher capitated payment for the member, potentially adjusted further by the member's level of need identified in the assessment process.

Due to the importance of the Level of Care Assessment to the member, the MCO and the state, many state MLTSS contracts lay

out specific requirements for how the assessment process should be approached, including who will conduct the assessment, what will be assessed, what instrument will be utilized, and whether initial activities towards the development of a service plan will take place as part of the same assessment meeting.

In New Mexico, Delaware, New York's FIDA program and Massachusetts' Senior Care Options system, among others, level of care assessment is conducted by the MCO itself. Other states maintain dedicated personnel for level of care assessments, and may bypass the MCO entirely in conducting them. South Carolina, New Jersey, Vermont, and others continue to have level of care assessments conducted by state personnel or contractors reporting directly to the state, rather than to the MCO. This may in part relate to the conflict of interest MCOs face when conducting eligibility assessments where the outcome may determine both their obligation to provide service to an individual and the level of payment received by the MCO from the state.

It is noteworthy that different programs operating in the same state may have different requirements. For example, while New York's FIDA program allows MCOs to conduct their own assessment of level of care, New York's broader Managed Long Term Care system specifically precludes health plans from doing so. This may be because of different needs in the target population or different statutory authorities used to implement the MLTSS framework, carrying different levels of federal oversight and control.

Even where states do delegate the assessment to the MCO, they typically require level-of-care assessments be conducted using a state-approved or

developed instrument, recognizing the importance of uniformity to ensure accuracy and limit subjectivity in the assessment process. States in which the MCO conduct eligibility assessments require MCOs either to use a state-developed tool or to submit MCO tools to the state for approval.

States should adopt conflict-free assessment for their MLTSS systems, requiring individuals not yet enrolled with an MCO to be assessed for LTSS need by an entity with no MCO relationships or conflicts of interest, prior to plan selection. For individuals already enrolled who are identified as having potential LTSS needs, assessment should still be conducted by a third party designated by the state. There are multiple reasons for such an approach. Because conflicts of interest are minimized under a conflict-free assessment approach, MLTSS contracts can safely incorporate level-of-need factors into the capitated payments received by MCOs.

Case Study: New York State

In 2012, New York State received permission from the Center for Medicare and Medicaid Services (CMS) to make its Medicaid-only managed care framework for individuals with LTSS needs mandatory and began to auto-assign individuals with certain long term care needs into Managed Long Term Care Plans (MLTCPs). While MLTSS was not new in the state of New York, the introduction of auto-assignment prompted the addition of new terms and conditions by CMS as part of the approval of the state's transition to mandatory MLTSS. Among these new terms and conditions was a requirement that the state transition to a conflict-free assessment process. Prior to this point, MLTCPs were responsible for conducting an assessment to determine whether an individual is eligible for LTSS. As part of CMS' approval of New York's expansion of MLTSS, MCOs can no longer complete LTSS needs assessments for non-dually eligible individuals requesting such services prior to enrollment in a MLTCP.

LTSS need assessments are now conducted by the state's enrollment broker, Maximus, which maintains responsibility for assisting prospective enrollees in selecting a plan. Upon requesting an assessment, the Conflict-Free Evaluation and Enrollment Center (CFEEC) – a new program operated by Maximus – dispatches a registered nurse to conduct an evaluation of LTSS need[3]. If an individual is deemed eligible for LTSS and is also approved for Medicaid, they may enroll in a Managed Long Term Care Plan.

Because the CFEEC has no relationship with any of the state MLTCPs, assessment is considered "conflict-free" by CMS. Prior to this system, advocates had raised concerns that MLTCPs were "creaming" enrollees with the least expensive needs while counseling away or refusing to assess and enroll those with the most intensive support needs[4]. Until New York state could implement this conflict-free assessment system, CMS required the state to conduct reviews of a sample of MCO assessments of LTSS need every six months to ensure that correct determinations were being made.

---

[3] New York Legal Assistance Group. "Explanation of the CFEEC and MLTC Evaluation Process for New Applicants." December 2016. Available at: http://www.wnylc.com/health/afile/114/573/
[4] Bernstein, Nina. "Advocates Say Managed-Care Plans Shun the Most Disabled Medicaid Users." New York Times. April 30, 2013. Available at: http://www.nytimes.com/2013/05/01/nyregion/advocates-say-ny-managed-care-plans-shun-the-most-disabled-seniors.html?smid=pl-share

This is an important component of ensuring that MCOs are prepared to address the needs of complex populations with specialized needs, distinct from the average LTSS-eligible member, such as members with intellectual and developmental disabilities (who have historically been carved out of most MLTSS arrangements and have only recently been incorporated in a small number of traditional MLTSS models) or members with significant communication or behavioral challenges.

Conflict-free assessment (and the differential capitation rates it makes viable) also reduces the ability of MCOs to engage in "creaming," whereby an MCO deliberately seeks to enroll only those individuals with the least intense needs. Some may be concerned that conflict-free assessment may result in unnecessary delays, as state bureaucracy may move less quickly than an MCO's in-house assessment infrastructure. This is a credible risk. To mitigate it, states should contract with an appropriate third party to conduct eligibility and acuity assessments, clearly spelling out in the assessment contract a limit on the amount of time that can elapse from application of a member or prospective member seeking LTSS eligibility to assessment and communicating a determination to the MCO. **States must ensure that assessment takes place in a timely fashion to avoid unnecessary delays in access to service provision, and should consider attaching financial penalties for backlogs to the contract of a third-party assessment entity.**

Others may express concern that conflict-free assessment will create a burden for the member, who will then have to go through a separate service-planning assessment that may cover similar ground to the eligibility and acuity assessment process. This

challenge may be an unavoidable cost of maintaining strong conflict-of-interest protections in the assessment process. However, states should seek to mitigate this potential burden by requiring the assessment entity to transfer information garnered by the assessment to the MCO in a timely fashion, so that the member does not have to provide the same information twice.

Regardless of whether assessment sits within the MCO or a third party, states have a variety of requirements as to what personnel can conduct the LTSS assessment and what tools they use to do so. New York's Fully Integrated Duals Initiative and the Massachusetts OneCare program each requires registered nurses to conduct the assessment, while Virginia's Commonwealth Coordinated Care indicates that they must be conducted by a registered nurse with one year's experience or a person with a bachelor's degree and two years experience working with seniors and people with disabilities. In states that choose not to require licensure for those conducting level-of-care assessments, some choose to set other training requirements, either tied to experience in the field of disability and aging service-provision or specific state-approved training curricula. Some states also include assessment within the functions of the case manager or care coordinator.

Requiring that a nurse conduct assessments risks over-medicalizing the assessment process. **States should allow unlicensed personnel to conduct eligibility assessments, provided that they meet clearly articulated training requirements, have the required experience serving individuals with disabilities, and are using an assessment tool approved and validated by the state for the population being assessed.** Criteria should be established in MCO contracts. Both training

curricula and assessment instruments should appropriately take into account the different needs of different LTSS populations; for example, individuals with physical, psychiatric and developmental disabilities may have different needs, as do elderly and non-elderly individuals.

Service Planning

Some states separate out the assessment process into multiple components, recognizing that while the level of care assessment may require additional oversight or direct state administration, MCOs are likely best situated to implement assessments related to service planning. Massachusetts' OneCare, Delaware, Rhode Island and Michigan, among others, all articulate separate assessments for service planning purposes after an individual's eligibility for LTSS is determined. In contrast, Tennessee indicates that service-

plan development will take place during the in-person intake interview.

Like LTSS eligibility/level of care assessments, the service-planning assessment and subsequent process evaluates the needs of the individual. Unlike level of care assessments, the optimal end product is both qualitative and quantitative, incorporating information on the person's authorized levels of service, their ability to access community life, the availability of natural supports, and their preferred goals and life aspirations. Furthermore, while the service-planning assessment process may go through an established framework, changes from person to person do not raise the same equity issues that would be raised by failing to implement a standardized LTSS eligibility/level of care assessment.

States should separate service-planning from the LTSS eligibility assessment, in

Table 1: Pros and Cons of Requirements for Personnel Conducting LTSS Eligibility Assessments

	Licensed Personnel	Unlicensed Personnel
Employed by or reporting to the State	Pros*:* • Greatest likelihood of fidelity to standards; • Avoids conflict of interest. Cons: • Risk of medicalization; • Potential for delays in accessing enrollment.	Pros*:* • Avoids conflict of interest; • Lower likelihood of medicalization. Cons: • Risk of subjectivity in assessment process, raising equity concerns; • Potential for delays in accessing enrollment.
Employed by or reporting to the MCO	Pros*:* • Possibility for more rapid assessment process; • Possibility to combine Level of Care and Service Planning assessments. Cons: • Risk of medicalization; • Potential for conflict of interest.	Pros: • Possibility for more rapid assessment process; • Possibility to combine Level of Care and Service Planning assessments; • Lower likelihood of medicalization. Cons: • Risk of subjectivity in assessment process, raising equity concerns; • Potential for conflict of interest.

recognition of the challenges faced in conducting a meaningful person-centered planning process in concert with the standardization of the needs assessment process. Where states have adopted conflict-free assessment, integrating the service-planning and needs assessment process is particularly unfeasible. This is because – in states with conflict-free assessment processes – the MCO case management staff responsible for implementing the service plan is not a part of the process until after the completion of the LTSS needs assessment. Where an MCO's capitated rate is determined by acuity in addition to LTSS eligibility, an acuity or level of need assessment also needs to be conducted by a third party not connected to the MCO.

Just as the eligibility assessment and (in states using capitated rates that vary by LTSS population) the level of need assessment must be conducted by a third-party, the service-planning assessment must be conducted by the plan. This is because the service-planning process should also act as the pre-authorization process. One of the challenges many people with disabilities face after the transition to MLTSS is the introduction of pre-authorization requirements. While insurers often require an additional approval process for the delivery of high-cost or unique services, pre-authorization represents a particular challenge when it is distinct and supplementary to the service-planning process. The development of a service plan that does not actually authorize the availability of the services reflected within it has limited utility to the experiences of the member, and may call into question the credibility and value of the service-planning process.

To address this, some states, including Delaware, Florida, Minnesota and others, indicate within their contract that the service-plan itself shall serve as the authorization document, requiring MCOs to authorize services sufficient to meet the member's plan of care as articulated within the service-plan document. **By combining the authorization process with the service-planning process, states reduce the likelihood of bureaucratic delays in accessing support services and give credibility to the service plan. As such, states should not allow MCOs to maintain a separate pre-authorization process for LTSS and should instead consider the service plan the controlling document for authorization purposes. To accomplish this, states must allow MCOs to conduct the service-planning assessment.**

Service-planning assessments should inform the development of an individual's service-plan. To facilitate this, states require that MCOs collect a variety of different types of information. While most states require that this assessment include information on service needs, such as a person's need for assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), many states require the collection of other relevant information, including the person's goals, preferences, and strengths, the scope of natural supports available to them, their interest in integrated employment outcomes, and other aspects of their life relevant to service-planning. The collection of this broader scope of information indicates a commitment on the part of the state for service-planning to be more than a medicalized process – instead, it should reflect the lived experiences, preferences and social and cultural environment of the individual receiving supports.

At the core of this is the involvement of the member with a disability. **To ensure that service-planning accurately reflects the needs, preferences, goals and desires of the person receiving support, states must require their involvement or that of their authorized representative in service-planning. We also recommend that the service plan document that an individual be offered self-directed services as an option and that, in the event that they refuse them, their reason be documented within the service plan to ensure that members receive the opportunity to direct their own care.** All state contracts reviewed incorporated some element of member involvement in the service-planning process, with the actual scope of involvement varying significantly. Contracts also often explicitly require that member goals, strengths and preferences be reflected within the service plan.

For example, Delaware specifically requires MCOs to use a "person-centered and directed planning process to identify the strengths, capacities, and preferences of the member, as well as to identify the member's LTSS needs and how to meet those needs" developed "by the member and/or member representative with the assistance of the case manager and those individuals the member chooses to include in the care planning process." Rhode Island's contract also specifically affirms the importance of member-directed service-planning, indicating that the "member has the primary decision-making role in identifying his or her need, preferences and strengths, and a shared decision making role in determining the services and supports that are most effective and helpful to them."

It is important that states take steps to ensure that this member involvement is meaningful and that person-centered planning does not merely become a boilerplate pro forma activity. **To accomplish this, we recommend that states conduct periodic audits of plans of care to evaluate the degree of member involvement documented within them. States may wish to supplement this with "ride-alongs" for a representative sample of service-planning processes, allowing state staff to directly observe case management staff conducting service-planning with members.**

For example, South Carolina's contract notes that "Periodic audits of an Enrollee's ICP [Individualized Care Plan] may be conducted to determine the clinical appropriateness of service authorizations. Service planning, coverage determinations, care coordination, and Care Management will be delineated in the Enrollee's ICP and will be based on the assessed needs and articulated preferences of the Enrollee."

Tennessee, Massachusetts OneCare, Minnesota and Wisconsin each indicate that employment status or interest should be a part of the service-planning process, an important aspect of service-planning, particularly in light of new federal requirements that Home and Community Based Services be delivered in settings that are "integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings[5]." **To promote integrated employment outcomes, states should make employment status and interest a required component of the service-planning assessment for working-age members.**

---

[5] 42 CFR 441.530(a)(1)(i)

Information on the unpaid support drawn from the member's life – often referred to as "natural supports" or "family caregiving" – is also collected as part of many state requirements for the service planning process. Natural supports may significantly influence a person's level of need – and their sustainability over time may be an important factor in targeting interventions designed to prevent future institutionalization. Tennessee, Massachusetts OneCare and Wisconsin, among other states, all mention natural supports or similar terminology referring to the availability of unpaid support available to the individual through family or other naturally occurring relationships.

When used effectively, natural supports can be an important means of avoiding the medicalization of services and making scarce public resources go further. Unfortunately, MCOs may also use the availability of natural supports as an excuse to deny access to adequate service provision, attempting to shift responsibilities to uncompensated family caregivers. **As such, it is crucial that the service-planning process consider the sustainability of caregivers providing supports to a person with a disability, and not rely exclusively or primarily on unpaid/natural support to meet the member's basic needs and facilitate their autonomy and independence.**

Tennessee, Virginia, and Minnesota each require MCOs to conduct a separate caregiver assessment to evaluate unmet need within the context of caregiver stress and the sustainability of the natural supports an individual is receiving. Rhode Island and South Carolina also each incorporated caregiver needs within the general service-planning assessment. **Caregiver assessment represents an important promising**

practice within the service-planning process, as part of general collection of information on natural supports availability. When the member permits the interaction, it is important for case managers to directly assess caregivers through interviews and direct observation during the service-planning process.

When determining the appropriate authorization of services for a member, plans must refer back to the medical necessity language or other authorization criteria specified within their contract with the state. Often, general plan medical necessity language is either too vague or too medicalized to consistently and appropriately be applied to LTSS. **As such, it is important for states to clearly articulate authorization criteria for LTSS, which must be separate and distinct from general medical necessity standards.**

Some state contracts articulate specific authorization criteria for LTSS, either within general medical necessity definitions or as part of specific LTSS authorization criteria. Delaware's definition of medical necessity indicates that the purpose of services is to "attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community and facility environments, and activities."

Massachusetts' OneCare system requires MCOs "to meet Enrollees' needs for assistance with ADLs and IADLs" and to "consider the medical and independent living needs of the Enrollee." For personal assistance and other essential elements of HCBS, MCOs are required to authorize at least the amount of services that the person would receive in the fee-for-service system. MCO may consider "cueing or monitoring" needs of the enrollee, which are particularly

important for dementia and I/DD services, apart from the need for physical assistance.

In Minnesota, MCOs are required to authorize personal care assistance services as determined in the assessment process. Unlike most other states reviewed, home and community based services are explicitly excluded from medical necessity requirements.

South Carolina also indicates that MCOs must provide LTSS at a level at least equal to that of the state's fee-for-service LTSS system – though they maintain medical necessity criteria as the authorization rules for services. Criteria include that services "contribute to the health and independent living of the Enrollee in the least restrictive setting." Critically, South Carolina also indicates that the decisions of the planning team developing the individual's service plan serve as the authorization for services, avoiding a separate pre-authorization requirement. South Carolina also explicitly allows MCOs to use "cost-effective alternative services, whether listed as covered or non-covered…when the use of such alternative services is medically appropriate and is cost-effective." As an example, the contract indicates that MCOs may serve individuals who do not meet the level of care requirements to receive LTSS where the provision of home and community based services is able to more rapidly facilitate a transition from an acute care setting back to the community or preclude or delay a future nursing facility placement.

Where fee-for-service Medicaid continues to be available as an option for LTSS, tying service authorization levels to it may represent a useful promising practice for personal care services. This approach may be less appropriate for residential or day services, where MCOs may be well advised

to transition away from legacy infrastructure, such as group homes or facility-based day habilitation. In addition, **service authorization criteria should explicitly permit MCOs to serve individuals who do not meet level of care, where doing so can assist in mitigating other costs or preventing a future institutional placement.**

Case Management

Case management is an essential function of any well run LTSS system, including those operating under a managed care framework. People with disabilities receiving LTSS generally have more intense case management needs than non-LTSS users, and as such, MLTSS contracts must clearly articulate requirements for MCO case management and care coordination activities. These requirements must ensure that LTSS users receive appropriate case management resources and at ratios that adequately meet their needs and support community integration.

States frequently articulate specific case management responsibilities for MCOs within their MLTSS contracts. One of the most important practices is determining appropriate caseload ratios for case managers supporting members receiving LTSS in different settings and life circumstances. States frequently set specific caseload requirements for individuals based on diagnosis, service setting, level of need and public program. Table 2 reflects caseload requirements reflected within four different state MLTSS contracts, noting the different categories, ratios and ranges used by each state.

Not all states set caseload ratio requirements with MLTSS contracts or RFPs, with some preferring to allow MCOs to submit proposed or actual caseload ratios to the

Table 2: Selected Examples of State Case Management Caseload Ratio Requirements

	Delaware	Tennessee (average/maximum)	Arizona	Hawaii	Virginia
Institutional setting	1:120		1:96	1:120	1:175
Institutional Setting with Serious Mental Illness (SMI)			1:68		
Children in Institutional settings		1:46/1:66			
Individuals transitioning from Institutional settings		1:46/1:66			
General HCBS	1:60	1:46/1:66		1:50	1:70
HCBS (own home)			1:43		
HCBS (own home) with SMI			1:32		
HCBS (residential facility)			1:53		
HCBS (residential facility) with SMI			1:50		
At Risk for Institutionalization but below Level of Care Need		1:57/1:82			
Self-Directed Services	1:30			1:30	
Money Follows the Person	1:30				

state for approval. States that do set such requirements – or accept MCO assurances based on their proposed ratios – will typically allow some form of "blended" caseloads, in which a case manager will serve multiple populations, with members from populations with lower caseload ratio requirements receiving a greater "weighting," reducing the overall number of members supported by that case manager.

Caseload requirements are taken seriously by states, with the potential for sanctions in the event that they are not complied with. For example, Tennessee doubles penalties for MCO errors in the level of care assessment process in the event that caseload requirements are not met[6]. In other states, caseload ratios may be a factor in

quality measurement, with the potential for significant financial penalties for failure to comply.

While state requirements vary greatly, certain common themes emerge across contracts. States typically require much lower caseload ratios for members in institutional settings, assuming that members in such settings will require relatively little active management to support their ongoing needs and that institutional providers will themselves take over care coordination roles.

However, such an approach may leave institutionalized persons without access to support for transition into the community. For this reason, Tennessee chose to apply the caseload ratio for individuals receiving HCBS for members in institutional settings who have been assessed as "a candidate for transition to the community." Virginia incorporated within its MCO contracts a requirement that each MCO have a care coordinator in each region with no other

---

[6] Center for Health Care Strategies. "Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights." August 16, 2016. Available at http://www.chcs.org/media/MLTSS-Rate-Setting-webinar-081616.pdf

caseload than individuals in transition from nursing facilities, hospitals, inpatient rehabilitation and other institutional settings to community-based supports.

Enhanced case management for members potentially transitioning from institutional services to HCBS represents a promising practice that states should incorporate into MLTSS contracts. Operating on the principle that community should be available to all, states should make such enhancements available to any member who expresses interest in community placement, not just those who are assessed as candidates through a medical assessment.

In addition, states often set lower caseload ratios for members self-directing their own services, out of recognition that self-direction often comes with a heightened set of administrative obligations, in the absence of an agency provider to serve as a coordinating entity. Hawaii and Delaware each adopt lower case management ratios for self-directing people with disabilities, while Arizona distinguishes between HCBS provided in residential settings and HCBS provided in an individual's own home or family home, recognizing a similar greater organizational burden for those in non-provider owned or controlled settings. **Enhanced case management for individuals who are self-directing their own services, in less restrictive HCBS settings, or who have expressed an interest in transitioning to less restricting HCBS settings, may represent a valuable promising practice for states seeking to support individuals into less restrictive service settings within the HCBS continuum.** This may also represent a valuable tool in promoting compliance with the Home and Community Based Settings rule within the context of state MLTSS

frameworks. States should consider incorporating provisions regarding MLTSS case management and other aspects of MLTSS settings transition into their transition plans indicating how they intend to come into compliance with the Settings Rule.

Case managers are typically employed through one of several models. Under an in-house model, MCOs use their own staff for case management. This may present certain advantages for administrative efficiency, with MCOs able to avoid the transactional costs associated with contracting for case management staff. There may also be advantages to case managers being organizational insiders, who can more easily contact other staff within the organization and leverage institutional authority and relationships to get their members what they need. However, this may also present challenges for locating case managers with adequate local experience and relationships necessary for supporting meaningful community integration, especially in new markets for an MCO. Some states and MCOs resolve this problem by hiring existing case management staff and adopting flexible telework requirements or regional office structures, allowing case managers to work near the members they support. Under a delegated model, MCOs contract with external entities to conduct case management. This approach allows MCOs to tap geographic or population-specific expertise, a vital component of effective case management for individuals receiving HCBS or with complex care needs. However, it may also create challenges both in terms of administrative complexity and the potential for conflicts of interest.

One of the most common case management models in MLTSS systems is a hybrid between delegation and in-house case

management: the shared functions model, where an MCO retains certain case management obligations internally while contracting out others to a community-based organization. In MLTSS frameworks, this may involve contracting out LTSS case management for all members or for specific sub-populations, while the MCO retains in-house case management for acute care services.

Some state contracts specifically reference potential community-based organizations to serve as case management entities – for example, Virginia's CCC+ contracts reference Centers for Independent Living (CILs), Community Services Boards, and Area Agencies on Aging as possible care coordination entities. In the same contract provision referencing these organizations, the contract specifies that "Administrative firewalls should exist to ensure that staff within the contracted CBOs who perform direct care services, such as personal care, are not the same staff who provide care coordination services."

This approach can combine the best of both models, allowing for delegation only where an external entity has specialized expertise not possessed by the MCO. However, it also splits case management obligations in a way that may reduce the quality of care coordination for an individual member, for example, by separating out coordination of their LTSS and acute services.

Each model has pros and cons, and as such, each state may choose to adopt its own structure for case management based on the unique needs and preferences of stakeholders. The critical question is not the use of one model or another – rather, it is whether the model selected by the state or MCO ensures that the case manager has expertise and understanding appropriate to

allow them to be effective in making sure that a member's person-centered plan is executed faithfully and that the member receives what they require to facilitate autonomy and independence. Where case management staff are employed by an entity separate from the MCO or the state, contract language frequently incorporates specific conflict of interest requirements. While conflict-free assessment requires that assessment personnel be separate from the MCO to avoid conflicts, conflict-free case management does so by separating case management personnel from service-provision organizations.

Service-provision organizations have an inherent conflict of interest in providing case management services to a member they also provide support to. Since case managers are typically tasked with assisting a member in obtaining services and authorizing them from the MCO, **it is generally inappropriate for a service-provider to also act as an individual's case manager**. Such a structure would involve an entity authorizing services for payment (as a case manager) to that same entity (as a service-provider), an unacceptable conflict of interest under most circumstances. Occasional exceptions may be appropriate in areas with a limited potential provider network with adequate expertise – however, when they are made, they must come with state oversight and scrutiny to ensure a separation between provider and case management functions.

CMS articulated specific requirements for conflict-free case management through the state Balancing Incentive Program, which required states to adopt conflict-free case management to received enhanced federal financial participation for HCBS. CMS expanded on these requirements with rules for the person-centered planning process

embedded within the Home and Community Based Settings Rule in January 2014[7]. These rules indicate that those "who are responsible for the development of the service plan" must not be:

"**(1)** Related by blood or marriage to the individual, or to any paid caregiver of the individual.

(2) Financially responsible for the individual.

(3) Empowered to make financial or health-related decisions on behalf of the individual.

(4) Holding financial interest, as defined in § 411.354 of this chapter, in any entity that is paid to provide care for the individual.

(5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified agent to perform independent assessments and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the State plan for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process."

As such, states face a significant obligation to prevent conflicts of interest in the service-planning process, an obligation that persists after the transition to MLTSS. **States must prevent conflicts of interest by prohibiting case management personnel from being employed by an LTSS**

provider. Almost all MLTSS contracts reviewed with delegated or shared functions models of case management had their own version of conflict of interest requirements. Contract language in Delaware, Massachusetts OneCare, Minnesota, Rhode Island and Kansas all prohibit case management or care coordination staff from being employed by an LTSS provider, except under limited exceptions. Interestingly, many states that require conflict-free case management for LTSS allow for providers of acute care to provide case management services. This may be due to the relatively clear cut nature of "medical necessity" for acute care services, whereas service authorization requirements are more complex and harder to audit for LTSS.

Some states with delegated or shared function models of case management also separate out the LTSS and acute care case management responsibilities. This allows for case management for LTSS to be conducted with lower caseload ratios and by personnel with more specialized expertise than general case management tasks. Such an approach may also limit the degree to which acute care and LTSS are effectively coordinated.

Under Massachusetts' Senior Care Options program, there is a specific requirement that LTSS case management tasks be taken on by Aging Services Access Points, non-profits established by the state whose boards are 51% persons aged 60 or older and appointed by local Councils on Aging. In the Massachusetts OneCare program, MCOs are specifically required to contract with a Center for Independent Living, where geographically feasible in the plan's service area. **States that adopt delegated or shared functions case management models may wish to designate specific community-based organizations run by people with disabilities for case management tasks, such as Centers for**

---

[7] 42 C.F.R. § 441.730(b)

Independent Living. Where CILs or other similar disability community-based organizations are also LTSS providers, states must articulate clear "firewall" standards for separating out case management and service-provision functions. This may prove necessary in areas where there are not enough community-based organizations that meet contract requirements to avoid providers altogether.

Regardless of the model of case management services, the training and experience available to case management personnel represents an important part of effective MLTSS implementation. Under MA Senior Care Options, case managers must be licensed social workers employed by an Aging Services Access Point or have at least a bachelor's degree with two years' experience in aging services, including at least one year's experience in a health care setting. Under MA OneCare, LTSS case managers must have a bachelor's degree in social work or human services or at least

two years' experience in a human services field with the eligible population. The contract also articulates certain training competencies, such as knowledge in the completion of person-centered planning processes, knowledge of home and community-based services, experience conducting LTSS needs assessments, cultural competency and other related areas of expertise. **It is important for states to set clear requirements for case managers, including training, credentials and prior experience with the population served.**

Other state contract language reviewed articulates more general experience and training requirements, particularly where there is not a requirement that MCOs subcontract case management tasks to community based organizations. Tennessee, South Carolina and Delaware, among others, impose general requirements that care coordination staff have training in LTSS competencies.