

Managed Long-Term Services and Supports



Contract Provisions Related to Transition and Diversion from Institutional Placement

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Since the Supreme Court's 1999 landmark decision in *Olmstead v. L.C.*, state and federal authorities have worked to support seniors and people with disabilities to transition from nursing homes and other institutions into the community. These efforts have been rooted in both cost and quality considerations, but above all are founded on the simple premise: that individuals with disabilities have a right to enjoy the freedom, autonomy and choice that can only be achieved in their own homes and communities.

To support these transitions, the federal government has adopted a number of programs designed to incentivize states to shift Medicaid long-term services and supports (LTSS) spending away from institutional services and towards Home and Community-Based Services (HCBS). In 2005, the Deficit Reduction Act created Money Follows the Person (MFP), a federal demonstration project, later re-authorized in 2010 by the Affordable Care Act, that fully reimburses state expenditures for the first twelve months after a person with a disability leaves an institution for a qualified HCBS setting. In addition to MFP and other similar incentive programs, the Department

of Justice and other disability rights legal advocates have brought suits under *Olmstead* seeking to expand access to community-based supports and continue the shift away from institutional settings.

As a growing number of states adopt Managed Long-Term Services and Supports (MLTSS) frameworks, it becomes imperative that these efforts to promote HCBS over institutional services continue and are integrated into the incentives and requirements of managed care contracts. Managed care can help states accelerate the shift towards the community—or slow and reverse it, depending on the incentives put into requests for proposals and contract language. Many states have successfully used MLTSS quality measures and other contract provisions to reward health plans for transitioning people with disabilities into community-based residences, jobs and day services. Unfortunately, others have adopted contract provisions that limit the plan's ability or incentive to provide sufficient HCBS to avoid institutional placement or bring people out of institutional settings. This policy brief seeks to outline a variety of contract incentives used by states operating MLTSS programs to prevent unnecessary

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institutional placement and support plans in transitioning members out of institutions. It includes a review of MLTSS contract language from 23 state contracts from Arizona, California, Delaware, Florida, Hawaii, Illinois, Iowa, Kansas, Massachusetts (both Senior Care Options and OneCare), Michigan, Minnesota, New Jersey, New Mexico, New York, Ohio, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin.

The Role of the Case Manager in Institutional Transition

Case management staff have significant responsibilities in plan contracts relating to transitioning people out of institutions. Many states, including Delaware, Hawaii, Michigan, Minnesota, Texas and Virginia, require case management staff to play a role in identifying and assisting members interested in transitioning from a nursing home or other institutional setting to the community. This assistance may take a wide variety of forms, including identifying members interested in transitioning to community life, informing members of available settings options, managing discharge planning, identifying HCBS providers, and leveraging community resources. Some states require case managers to regularly assess institutionalized members and justify a rationale for institutional placement; for example, Delaware explicitly requires case managers supporting members in nursing homes to “include documentation in the member’s electronic case record to justify the lack of discharge potential and that the nursing facility is the most appropriate placement.”

Such an approach effectively creates a presumption of community-based support, requiring case management staff to justify any institutional placement. **States should explicitly require case managers to justify the appropriateness of any institutional**

placement on an annual basis as long as the member remains in an institutional setting. Case managers should also be responsible for communicating periodically with members about their service options, ensuring that members receive information on the potential to transition into the community.

Minnesota requires that health plans “must provide Relocation Targeted Case Management services for any Nursing Facility resident Enrollee who is planning to return to the community and who requires support services to do so.” Minnesota’s MLTSS contract indicates that this case management support may be provided through the existing case management system or through a specialized Relocation Targeted Case Manager, in order to allow for the development of ongoing content area knowledge. Rhode Island explicitly requires 24/7 availability for transitional case management personnel during a member’s transition into the community. Tennessee requires each health plan to designate “a dedicated staff person without a caseload who meets the qualifications of a care coordinator” in each region the MCO operates for the purpose of “proactively identifying” members in nursing facilities “who are candidates to transition to the community, and to further assist with the completion of the transition process.”

The availability of specialized case management staff for individuals seeking to transition, in the process of transitioning or having recently transitioned from an institutional setting to the community constitutes a promising practice that states should require of all health plans. States should require plans to maintain specialized case management staff tasked with identifying members seeking to transition and supporting those members in the transition process. This matches well with other contract provisions

regarding specific caseload requirements for members transitioning from institutions.

The Role of the Case Manager in Preventing Institutionalization

Preventing institutionalization, sometimes referred to as diversion from institutional placement, is at least as important as returning institutionalized people back to their communities. Such diversion efforts play a vital role in promoting community living. Case managers may also play significant roles in diverting members at risk of future institutionalization in order to maintain their status in the community. This may take several forms. Several states specifically require case managers to evaluate the needs of community-resident members and their family caregivers, with an eye toward preventing institutionalization. For example, Hawaii requires its case managers, referred to as service coordinators in the contract, to address “social needs for member and their family...[and assess] caregivers for potential burn-out for individuals living at home receiving HCBS.” **States should also explicitly require a proactive role for case managers in identifying members at risk for institutionalization.**

In addition, multiple state contracts delineate the case manager’s responsibilities in the event that a member enters a hospital or other acute care facility or enters an institutional setting on what is intended to be a short-term, rehabilitative stay. In these circumstances, case management staff have a particularly important role in ensuring that hospitalizations do not turn into nursing home admissions or transfers to other institutional settings, and that short-term institutional stays don’t turn into long-term stays. Such efforts are particularly important given that members may lose access to community residences, should their Medicaid-funded HCBS be linked to their housing (as is the case for members in group

homes and other provider-owned residential settings). For such members, long- or even medium-term hospitalizations may result in a disruption to the member’s housing and provider relationships, requiring the case manager to work to re-establish them as part of discharge planning.

Michigan’s contract includes a requirement that the case manager, referred to as the care coordinator in the contract, follow up after being notified of any member’s “emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the member’s service plan to include additional supports and services to remain in or return to the community.” The case manager is also required to “make every effort to ensure that HCBS are in place upon hospital discharge to avoid unnecessary nursing facility placements. The Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to assure prompt initiation of appropriate HCBS. If the Enrollee is being discharged from a Nursing Facility or hospital, the Care Coordinator shall coordinate efforts with the nursing facility social worker, discharge planner, or other staff to ensure a smooth transition.”

Similarly, the Massachusetts OneCare program requires that an LTSS case manager, referred to as an IL-LTSS coordinator in the contract, “be available in the event of a contemplated admission to a nursing facility, psychiatric hospital, or other institution.” Iowa requires “that community-based case managers are actively involved in discharge planning when an LTSS recipient is hospitalized or served in any other higher level of care for less than 60 days.”

Whenever a member enters an institution, diligence on the part of the case manager can potentially prevent a short stay from turning into a permanent stay. Texas requires case managers, referred to as

service coordinators in the contract language, to “complete an assessment of the Member within 30 days of the MCO’s notification of a Member’s Medicaid-covered stay [in an institution] and develop a plan of care to transition the Member back into the community, if possible.” If the assessment supports transition back into the community, then the service coordinator is tasked with supporting the member to return to the community and to help the member and their family access appropriate services. If the assessment does not recommend a return to the community, the service coordinator must conduct a quarterly assessment afterwards to evaluate future opportunities to exit an institutional setting.

Case managers have an essential role to play in preventing institutionalization and in keeping brief rehabilitative institutional stays from turning into permanent stays.

States should incorporate a responsibility for case managers to engage with hospitalized or institutionalized members as soon as possible after admission, with the goal of supporting their rapid return to the community and securing the necessary paid and unpaid supports to allow that to take place on an expedited timetable.

To successfully fulfill these responsibilities, case management staff must have caseloads that allow them to adequately meet the needs of the population.¹ Alternatively, health plans can instead provide for specialized case management staff solely for the purpose of institutional transition and diversion.

Identifying Candidates for Transition to the Community

State MLTSS contract language approaches the issue of transition from institutional

settings in a variety of ways, some more conducive to facilitating such transitions than others. Some states create an ongoing obligation to facilitate institutional transition. As mentioned in the discussion of case manager responsibilities, plans are sometimes required to review and re-assess institutionalized members and explicitly justify continued institutionalization. Delaware, Iowa, Minnesota, New Jersey, Rhode Island, Tennessee and many other states include an explicit contract requirement that health plans proactively work to identify members in nursing homes and (in some cases) other institutional settings who wish to transition to the community.

Tennessee’s managed care contract requires health plans to develop a mechanism to identify members who have either the ability or the desire to transition from a nursing home to the community. Identification must include referrals from a treating physician, nursing facility, other providers, community-based organizations, family members and the member themselves; identification through the care coordination process (such as by assessment, communication with nursing facility staff or other mechanism); and review and analysis of data provided by nursing facilities.

Once a member is identified via a referral, Tennessee requires a visit to the member at the nursing facility by a care coordinator within fourteen days, to ascertain their interest in transition and, if interested, to begin orientation to the transition process. When a member is identified by means other than a referral or care coordination process (i.e., data analysis), Tennessee requires an in-facility visit be conducted within ninety days.

¹ For more details on caseload ratios, see “Managed Long-Term Services and Supports: Assessment, Authorization, Service Planning, and Case Management in State MLTSS Systems,” available at <http://communitylivingpolicy.org>.

In addition to requiring case managers to justify institutional placements, Delaware's MLTSS contract creates an ongoing obligation on plans to identify members in nursing homes "who may have the ability and/or desire to transition to the community" and identifies a variety of sources for identifying said members, including referrals from family, providers or others and identification by the case manager. Within 14 days of receiving a referral or identification, the plan is required to conduct an in-facility visit to determine the member's interest in and ability to transition. Other contracts include more unique ways to identify members suitable for transition. For example, Illinois requires health plans to make use of "predictive modeling" to identify members who may require transition services.

States should include an explicit requirement that health plans actively work to identify members who wish to transition to the community and initiate efforts to fulfill that preference within a set time period after identification or referral. This process should include both the use of existing data sources, like the Minimum Data Set Section Q, and outreach to members to communicate with them about their wants and desires regarding service setting. States should require plans to communicate with all institutionalized members to offer them the opportunity to transition to the community.

Monitoring and Supporting Members After Transition to the Community

For those members who are identified as candidates for transition to the community, Delaware's contract requires health plans to help members access housing assistance, including Section 811, and to visit the residence where the member will live to conduct an onsite evaluation and assist the member and their family with the transition.

After a transition to the member's own home, the case manager is tasked with conducting monthly home visits for the first three months after the member leaves the facility. If the member is moving to assisted living or to a family home, the case manager need only make telephone contact.

Similarly, Tennessee requires a visit by the care coordinator to the member in their new residence within 24 hours after transition, if the member is living independently or the in-facility assessment identified an elevated post-transition risk. Arizona targets its required Community Transitional Service specifically to members transitioning from an institutional setting to their own home or apartment, excluding individuals moving to assisted living facilities or group homes. Transitions to independent homes or apartments require significantly more assistance and represent a higher quality transition outcome than a shift to another residential facility, even if it is funded as HCBS.

This distinction reflects an important acknowledgment of the greater transition support needs of individuals exiting an institutional setting without family support to an independent home or apartment, as compared to individuals who are exiting to a family home or to a residential HCBS setting. **States should explicitly acknowledge within their MLTSS contracts the greater transition support needs of members who are transitioning to their own homes or apartments, acknowledging the presence or absence of family support, while continuing to emphasize independent homes or apartments as a preferred option over residential HCBS settings.**

For members are transitioning from an institutional facility to the community, state contracts often include a requirement for health plans to pay for non-recurring expenses necessary to facilitate the transition, even if the expenses would not

normally be reimbursable under fee-for-service Medicaid. For example, Michigan requires health plans to cover housing security deposits, utility hook-ups and deposits, limited moving expenses and limited furniture and appliances for members transitioning out of a nursing home after a 6-month continuous stay. South Carolina, Virginia, Wisconsin, New York's dual eligible demonstration and other state MLTSS contracts include similar provisions. New York also makes available peer mentoring as a service to members who have recently transitioned from a nursing facility.

Interestingly, Wisconsin's Family Care managed care contract also requires health plans to cover these costs for members "who are moving from a family home to establish an independent living arrangement." This represents a promising practice, given that it facilitates a meaningful choice of residence beyond just the family home. States should consider extending this requirement to any transition to a less restrictive setting, even if it is within the scope of the HCBS continuum, in order to facilitate the transitions that will likely be required as states move towards compliance with the Home and Community Based Settings rule. **States should explicitly require plans to cover one-time expenses associated with a member moving from an institution into the community, from a family home to the member's own home, or from a more restrictive community residence into a less restrictive community residence.**

Delaware is one of several states that require health plans to engage in more robust post-transition monitoring of members after they leave an institution or other residential facility. Iowa requires plans to monitor hospitalizations and institutional readmissions to identify issues and implement strategies to improve post-transition outcomes. It also indicates that health plans must "conduct face-to-face

visits with the member, at minimum: within two days of the transition to the community; every two weeks for the first two months from discharge; and once per month for the first year after transition. More frequent contact shall occur based on an individualized assessment of the member's needs and risk factors."

Similarly, South Carolina requires its health plans to schedule transition and aftercare appointments after a member transitions to the community, including a clinical follow-up phone call or home visit within 72 hours of transition that involves documented discussions on medication management, comprehension of and compliance with discharge and transition orders, and coordination with the broader transition care team. New Mexico requires health plans to conduct an additional assessment within 75 days after transition "to determine if the transition was successful and identify any remaining needs."

Some of this post-transition monitoring is systemic rather than individual. For example, Tennessee requires health plans to monitor hospitalizations and nursing facility readmissions of members who transition so as "to identify issues and implement strategies to improve transition outcomes" across the system.

Contract Provisions Creating Barriers to Transition and Diversion

In contrast to contract provisions in most states that encourage plans to avoid institutional placement and transition institutional residents back to the community, several states include language designed to restrict the circumstances under which institutional diversion and transition can take place. Such provisions may require significant documentation and assessment of 'appropriateness' prior to either offering a member high-cost HCBS or transitioning them from an institutional setting to the community.

Case Study: New Jersey's Cost-Effectiveness Analysis Requirement

New Jersey's Medicaid Managed Care contracts require that members who meet a nursing facility level of care but do not wish to be institutionalized undergo a cost-effectiveness analysis. Under the contract, the health plan is required to compare the cost of the HCBS the member needs with an "Annual Cost Threshold Cap," a state-determined average cost of nursing home services. If a member wishes to select community-based placement despite their HCBS costs exceeding this cap, the plan must either demonstrate that the excess costs are temporary, such as if they result from the temporary loss of a primary caregiver or short-term health condition, or show that the member has complex medical needs that can only be met through private duty nursing.

In the event that a member is not willing to accept nursing home placement and does not fall under one of these two exceptions, they must indicate that "they are willing to accept the level of services determined during the assessment process and to assume the potential risks of remaining at home" with the services the health plan is willing to offer. In short, members whose HCBS costs exceed their anticipated institutional costs must agree to accept inadequate services at their own risk in order to remain in the community.

New Jersey applies this cost-effectiveness analysis to all members in HCBS settings on an annual basis, and does so more frequently for members who exceed the Annual Cost Threshold Cap. When a member's costs hit 85% of the Annual Cost Threshold Cap, the member must be advised of the program limitations and undergo a cost-effectiveness interdisciplinary team meeting at which they will be presented with the option of nursing home placement.

New Jersey seems to have created many "on-ramps" to institutional care within its MLTSS framework, a marked difference from the bulk of other states, which focus their LTSS contract provisions on creating "off-ramps" into HCBS. The bureaucratic requirements a member must undergo to remain in the community, should their costs approach or exceed those anticipated under institutional placement, constitute a structure that nudges members into more restrictive placement. The lack of any member right to access ongoing HCBS that is more costly than the LTSS component of the capitated rate likely severely limits access to the community for members with high-cost LTSS needs in the community.

While the contract also allows the health plan to deny institutional placement in the event that it would prove more costly than community-based services for a particular member, these provisions are likely to force high-acuity members, who may require more costly services for community-based placement, into institutional settings. This may represent a violation of the state's obligations under *Olmstead v. L.C.* and the Americans with Disabilities Act's integration mandate.

Such policies may exacerbate New Jersey's longstanding poor record of providing community-based services. As of FY 2016, the state is 5th from the bottom in Medicaid HCBS expenditures as a percentage of total Medicaid LTSS spending (38.8%), behind only Mississippi (27%), Louisiana (35.3%), Indiana (31.9%) and Florida (33.5%).² While New Jersey has a poorer than average record in providing HCBS for all its populations, it is particularly poor at the delivery of such services to seniors and people with physical disabilities, the populations who are subject to the MLTSS framework. In FY 2016, less than 20% of Medicaid LTSS spending for these populations was in the community.

² <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf>

New Jersey, for example, requires MCOs to conduct an interdisciplinary team cost-effectiveness analysis when a member "meets nursing facility level of care but does not agree" to being placed in a nursing facility. This cost-effectiveness analysis limits the ability of members to select community-based services if institutionalization would represent a cheaper option for the health plan.

Iowa specifically restricts transfer from a residential facility (including one funded via an HCBS waiver or state plan benefit) unless "(i) the member or his/her representative specifically requests to transition; (ii) the member or his/her representative provides written consent to transition based on quality or other concerns raised by the Contractor, which shall not include the residential provider's rate of reimbursement; or (iii) the provider has chosen not to contract with the Contractor." This requirement, likely put in place to limit the ability of plans to inappropriately transition members who wish to remain in a residential facility, may have the consequence of significantly hampering the health plan's capacity to facilitate transition from inappropriate residential placements towards more integrated settings.

States should maintain a structural preference in favor of HCBS within their managed care contract language. This includes ensuring that health plans maintain responsibility for offering adequate HCBS to meet the needs of all members, including those whose HCBS needs exceed the cost of institutional placement. Members must possess an absolute right to community-based supports, regardless of acuity level or associated costs, provided that these are determined based on an appropriate assessment instrument approved by the state. At the same time, the contract should allow the plan to deny coverage for ongoing institutional care if it is

deemed inappropriate on either cost or quality grounds. This reflects the overarching quality improvement and cost containment functions of an MLTSS framework.

While New Jersey's cost-effectiveness analysis requirements are particularly detailed, a number of other states incorporate cost as an explicit component of placement decisions. Hawaii requires health plans to "offer and document in the member's record the choice of institutional services or HCBS to members who meet the institutional LOC when HCBS are available and are cost-neutral." The plan is required to document good faith efforts to establish cost-neutral service plans and must receive approval from the state prior to disapproving a request for HCBS. Hawaii does not require the member to be offered HCBS if the member requires more than 90 days per benefit period of 24 hours of HCBS per day, there are not appropriate providers or the member is otherwise determined not to be able to served safely in the community.

Wisconsin's contract language indicates that health plans must "provide services in the most integrated residential setting consistent with the member's long-term care outcomes, and identified needs, and that is cost-effective when compared to alternative services that could meet the same needs and support similar outcomes." Interestingly, this is not limited to comparisons between institutional and community-based services. The contract language explicitly indicates that a cost-effectiveness analysis must be done to authorize residential care services - defined as services through which a member is supported to live outside their own home. The contract indicates that residential care services are appropriate when a "member's long term care outcomes cannot be cost-effectively supported in the member's home" and where those services "are a cost-effective option for meeting that member's long-term care needs." Such a provision has

advantages and disadvantages. It could be used to limit access to group home placements and other overly restrictive residential services within the HCBS continuum, when a member is more appropriately served in a more integrated setting. Alternatively, it could be used to force an individual who requires intensive services into a residential setting despite their preference to remain in their own home.

Such contract language reinforces the importance of ensuring that every member has access to community-based services in their own home, not just the broader option of HCBS as a whole. **States should require plans to offer members who want to remain in their own homes adequate services to allow them to safely have their needs met in such a setting, including for members who have 24/7 support needs.**

Diversion from Institutional Placement

Iowa, Delaware, Massachusetts (Senior Care Options), Minnesota, New Jersey, New York (FIDA), Tennessee and a number of other states have each included contract requirements instructing health plans to take steps to divert members from institutional placement. These contract requirements typically focus on members who are awaiting institutional care or are at risk of institutional placement as a result of a change in circumstances or health status. For example, the member may lose a family caregiver or a long-standing service provider, or may experience a medical crisis resulting in a sudden increase in service need.

States approach diversion through different mechanisms. Delaware requires health plans to contract with an existing diversion program operated by Aging and Disability Resource Centers. Iowa requires plans to "propose a comprehensive institutional diversion program" subject to state review and approval. Because Iowa is one of the

few states that have included people with Intellectual and Developmental Disabilities (I/DD) in their MLTSS framework, it includes diversion from institutional (ICF-DD) placement as a priority in addition to diversion from nursing facility placement.

In contrast, Texas's contract language indicates that plans are required to consider the availability of the Program of All-Inclusive Care for the Elderly (PACE) option prior to referring a member to a nursing facility or other long-term care facility. This provides members with an overly restrictive set of options, given that while PACE can forestall institutionalization, it has also been criticized for maintaining an overly congregate model and represents only one of many HCBS funding options. While PACE may be appropriate for some seniors, it should not be considered the only appropriate model of institutional diversion.

As part of their efforts to divert members from institutional placement, many states include contract provisions that allow the delivery of community-based services to members who do not meet an institutional level of care. This practice is designed to prevent later, more costly institutionalization by delivering targeted services prior to health or functional impairment worsening. Minnesota, Tennessee, Wisconsin, Vermont, South Carolina, Rhode Island, Hawaii and California each have contract provisions allowing the delivery of home and community-based services to individuals who do not meet level of care requirements, largely as a mechanism for diverting individuals from future institutional placement.

Money Follows the Person

Several states maintain state-operated or contracted MFP programs, to which health plans may refer members wishing to transition from a nursing facility or other institutional setting. As of this writing,

Congress had reauthorized Federal MFP grants to the states on a short-term basis, but future funding remains uncertain.

Iowa and Delaware both indicate that health plans can refer members to or collaborate with a state-operated or contracted MFP program outside the typical MLTSS framework. New York contracts with the New York Association on Independent Living to operate Open Doors, a program designed to support people with disabilities (including those enrolled in New York's MLTSS framework) in transition from institutional settings to community-based ones.

Usually, the state-operated or contracted MFP program collaborates with the health plan to facilitate transition. However, in some cases, members receiving MFP services are carved out of the MLTSS framework. For example, in Virginia members who are enrolled in the Money Follows the Person program are disenrolled from the state's MLTSS program, though they are re-enrolled after their twelve months of MFP eligibility is complete (provided that they continue to meet eligibility requirements). Interestingly, members who are transitioning are offered a choice of enrolling in MFP or participating in a transition process managed by their MCO with many similarities to MFP. For example, health plans are still required to cover non-recurring costs like security deposits and furnishings, similar to MFP, up to \$5,000/member.

Other states make available funding to support MFP transitions through payments to MCOs. South Carolina, for example, funds MCOs at up to \$3,000 per person transitioned and remaining in the community for at least twelve months. Wisconsin provides for a \$1,000 payment to the MCO for each member transitioned to the community consistent with MFP requirements. Still others require the health plan to pay an MFP provider: Illinois, for

example, requires a \$1,000 payment from the health plan to an MFP provider who supports a member to transition and to remain in the community for at least 90 days, with an additional \$1,000 payment available should they remain in the community for one year.

Interestingly, some states seem to have limited their state MFP assistance to certain populations. Iowa, for example, includes in their contract that "MFP assistance is available to individuals with a diagnosis of an intellectual disability or brain injury who have lived in an ICF/ID or nursing facility for at least three months," seemingly excluding people with physical disabilities from their MFP transitions. In most states, it is unclear what will happen to these contract provisions after the expiration of the Money Follows the Person demonstration at the end of 2018, should it not be extended by Congress. For example, Iowa's contract language requires health plans to "assist with the development and implementation of the sustainability plan," but offers no details as to how this will be accomplished or what it will include. Illinois specifically indicates that its MFP contract provision "will no longer apply in the event that this grant project ends during the duration of this contract."

There are, however, some states that have clearly indicated their intent to continue MFP regardless of the continued availability of federal funds. New York, for example, has indicated that it intends to use Medicaid administrative funds to sustain its MFP project, Open Doors, even after the current federal MFP program ends. **Should the MFP program continue, states should clearly articulate how MCOs will advance progress under MFP requirements. Should MFP expire, states should maintain comparable contractual requirements incentivizing health plans and providers to facilitate community transitions.**