



August 6, 2012

Cindy Mann, Director  
Center for Medicaid and CHIP Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Ms. Mann:

We are pleased to provide you with the National Association of Medicaid Directors' (NAMD) policy recommendations for modernizing and strengthening federal policies and procedures for managed long term supports and services (MLTSS) programs. As noted in the Centers for Medicaid and CHIP Services (CMCS) August 6<sup>th</sup>, informational bulletin, a growing number of state Medicaid agencies are designing and implementing MLTSS programs. A strong and effective federal-state partnership with clearly aligned goals is critical to the success of these efforts.

We appreciate that CMCS recognizes the need to update its policies and business procedures for working with states. Further, we are aware of the efforts underway to bridge existing policy and programmatic silos both within CMCS and other key federal agencies within the Department of Health and Human Services. Federal and state partners would similarly benefit from coordinated goals and more efficient processes that are simultaneously designed for states with existing MLTSS programs and the many others planning to implement such programs.

The enclosed guiding principles and recommendations reflect the collective expertise and leadership of state Medicaid Directors. Directors, working through NAMD, are committed to ongoing conversations with CMCS to ensure our recommendations can inform your ongoing work in this area. Please contact Andrea Maresca with the NAMD staff at (202) 403.8620 with questions on this matter.

Sincerely,

A handwritten signature in black ink that reads "Andy Allison". The signature is written in a cursive, flowing style.

Andy Allison  
Director, Division of Medicaid Services  
State of Arkansas, Department of Human  
Services  
President, NAMD

A handwritten signature in black ink that reads "Darin J. Gordon". The signature is written in a cursive, flowing style.

Darin J. Gordon  
TennCare Director  
State of Tennessee, Department of Finance and  
Administration  
Vice President, NAMD



## **Medicaid Managed Long Term Services and Supports: Medicaid Directors' Policy Recommendations to Support Efficient, High Quality Programs**

Medicaid, and states' long-term services and supports (LTSS) programs in particular, face unprecedented challenges. Medicaid currently pays for over 40 percent of the nation's long-term care costs, making it the major source of financing for long-term care services. The long-term care population – about six percent of the Medicaid enrollees—accounts for almost half of total Medicaid program spending. Furthermore, the demand for Medicaid long-term care is expected to swell as the baby boomers age and states increasingly focus on delivering patient-centered services and supports. These trends will continue to put pressure on states to implement more effective and efficient programs to deliver appropriate and timely care to members.

Several state Medicaid agencies, including those in Arizona, Florida, Hawaii, Massachusetts, Minnesota, New Mexico, Tennessee, Texas, and Wisconsin, have long histories and valuable experiences operating managed long term services and supports (MLTSS) programs. Their experience demonstrates that managed care can be an effective tool to improve quality, control costs, and drive a member-centered approach to services and desired outcomes. States with mature MLTSS programs also play an essential role by informing the work of the many other states newly examining the use of managed care to deliver long-term services and supports. Medicaid Directors in these emerging MLTSS states seek to adapt effective practices from those states with mature MLTSS programs to achieve the shared goals of federal and state partners to best serve Medicaid members.

The National Association of Medicaid Directors (NAMD) has developed guiding principles and recommendations for federal policymakers to consider in creating a framework for states seeking to design, implement, and administer MLTSS programs. NAMD believes that these principles, based largely on successful practices in states with mature MLTSS programs, should guide federal policymakers in developing appropriate technical assistance for states interested in implementing new – or further strengthening existing – MLTSS programs.

These recommendations reflect the consensus position of state Medicaid Directors. Working through NAMD, Directors are prepared to engage with federal policymakers to ensure all states have the opportunity to build on their strengths, establish successful and efficient programs, and ultimately improve health outcomes and quality of life for Medicaid members.

## **Guiding Principles and Recommendations at a Glance**

***Principle 1: Streamline the structure and improve the timeliness of federal reviews of MLTSS programs.***

CMS should ease the pathway for states as they seek to establish MLTSS programs or modify existing MLTSS programs, including a streamlined process for consolidating the myriad of existing LTSS waiver programs and authorities as well as CMS' reporting and oversight requirements.

***Principle 2: Maintain existing state flexibility to design and implement MLTSS programs in coordination with national goals to ensure access to member-centered, quality-driven, efficient, cost-effective care in the most integrated setting.***

State flexibility is essential to enable Medicaid agencies to design and continuously administer MLTSS programs that provide member-centered, high-quality, efficient, cost effective care in the most appropriate integrated community setting. CMS should maintain states' existing authority to implement and administer MLTSS programs to coordinate state-specific goals with national-level priorities. This will help to ensure that states are able to meet the needs of different populations served in Medicaid MLTSS programs.

***Principle 3: Maintain state flexibility to define a meaningful and productive stakeholder engagement process.***

Each state must retain the flexibility to define how best to engage with and educate Medicaid members, providers, and stakeholders during the development and ongoing operation of MLTSS programs. Members, providers, and other stakeholders have different priorities and needs in every state. Consequently, a one-size-fits-all engagement framework will not produce a valuable public input process for all states.

***Principle 4: Ensure collaboration between federal and state partners in developing a framework for ongoing quality improvement and performance measurement.***

CMS should work with states to develop a framework for measuring the quality and performance of MLTSS programs on an ongoing basis.

## Guiding Principles and Recommendations

### ***Principle 1: Streamline the structure and improve the timeliness of federal reviews of MLTSS programs.***

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**Improve certainty in federal procedures.** States use two primary pathways to establish MLTSS programs: comprehensive Section 1115 waiver demonstration programs and combining a 1915(c) waiver with a 1915(b) waiver. On an ongoing basis, states evaluate and modify their MLTSS programs to ensure they are delivering high-quality, cost-effective care that meets members' needs.

However, CMS' current State Plan Amendment (SPA) and waiver application and amendment processes lack mechanisms to ensure accountability between the partners – specifically with regard to timelines for negotiating and approving states' proposals.<sup>1</sup> This ambiguity creates significant inefficiencies and delays for states trying to design and plan their programs. In addition, the federal process requires the same level of review for all changes, regardless of the nature and scope of the state's amendment. These unnecessarily lengthy processes delay the state's ability to implement necessary improvements for members, providers, and other stakeholders.

CMS should work with states to implement changes more quickly in order to enhance programmatic performance and use taxpayer dollars even more effectively. A key component of these goals is to provide states the authority to make certain changes in a timely fashion, without engaging in unnecessarily burdensome and lengthy administrative processes with CMS. This is particularly relevant for states implementing new MLTSS programs. As with any new program or change, states must have the authority to respond quickly to unanticipated situations or to implement more efficient and effective policies and procedures.

CMS also should work with states on the front end to streamline and create accountability for meeting timelines for approving a state's MLTSS proposal. In addition, CMS should work with states to develop programmatic agreements for tiered levels of review for amendments, within which procedures have been standardized and agreed upon to avoid or mitigate lengthy

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<sup>1</sup> CMS has 90 days to approve or deny the request for Section 1915(b), Section 1915(c), and b/c combination waiver, but may "stop the clock" with a request for additional information that would be needed to approve the request. Once the state formally responds to the request, a second 90-day clock begins. There is no required time frame for federal review and decision-making on Section 1115 waiver proposals.

negotiations. When such prior agreements exist, CMS can review amendments quickly and states can expediently implement improvements in their programs. An example of a review continuum might include the following types of waiver amendments:

- Changes that require notification to CMS but not approval;
- Changes for which CMS could provide states with questions and requests for information within a certain time period for example, 30 days, and approval or deemed approval within a specified time period for example, 45 days; and
- Changes for which a full amendment review process is necessary.

**Support state-tailored readiness reviews.** Comprehensive readiness reviews are a critical tool that states utilize to ensure the ability of managed care contractors. States design these reviews to certify that health plan entities can perform all of the functions necessary to administer the program, as required in the contractual agreement between the state and health plan entity. Further, on an ongoing basis, states remain integrally involved in the program’s implementation, with similar processes in place to quickly identify and resolve any issues that may arise and to monitor the health plan entities’ ongoing compliance with contractual obligations.

To develop a meaningful readiness review process, states must be able to tailor the review to the scope and maturity of the program and experience of the health plan entities. The effective readiness review practices in Medicaid managed care and MLTSS programs that exist today could help guide other states as they develop their own comprehensive readiness review tools. The following table offers examples of the critical categories of MLTSS readiness review. Consistent with current practice, states could also establish additional categories that reflect their unique priorities and expertise.

<b>Examples of core readiness review categories</b>	<b>Examples of possible elements in categories</b>
Administration and management	<ul style="list-style-type: none"> <li>• Staffing</li> <li>• Staff training/orientation</li> <li>• Policies and procedures for reporting requirements, including financial and encounter data reporting</li> <li>• Critical aspects of the health plan infrastructure</li> </ul>
Care coordination/case management (including acute and behavioral health applicable to the scope of the state program)	<ul style="list-style-type: none"> <li>• Full integration of medical management with the delivery model for LTSS, including assessments, member transitions, and care planning</li> </ul>
Quality management/monitoring	<ul style="list-style-type: none"> <li>• Long term care sites and services</li> <li>• Plan for development of quality performance measures and data collection</li> </ul>

	<ul style="list-style-type: none"> <li>• Member safety and protections</li> </ul>
IT/systems design and testing	<ul style="list-style-type: none"> <li>• Eligibility</li> <li>• Enrollment</li> <li>• Claims processing</li> <li>• Encounter data processing and reporting</li> </ul>
Provider network adequacy	<ul style="list-style-type: none"> <li>• Demonstration of sufficient provider network, consistent with scope of the state's program and contractual obligations</li> </ul>
Comprehensive program integrity strategy	<ul style="list-style-type: none"> <li>• Demonstration of understanding of the rules and responsibilities for state and plan communications to various entities, including members, providers, and the state's bureau of investigations, and with regard to federal program integrity activities</li> </ul>

Federal standardized review categories and elements across all states and programs would create significant administrative inefficiencies and disrupt alignment of the MLTSS program services with states' goals. By ignoring differences in the enrolled population, experience levels of health plan entities, and states' programmatic priorities, rigid federal standards would undermine the ability of states to provide the most efficient and effective programs possible. Instead, federal policy should preserve states' authority to choose and modify which elements are most appropriate within each category to reflect the variability in the demonstrated experience of the contractors and maturity of a state's program. For example, states with newer programs may need to invest more time relative to others in making sure that health plan entities without previous LTSS experience have adequate knowledge, business processes, and systems in place prior to the program's implementation. More experienced states should not be required to demonstrate compliance with all readiness review categories if their MLTSS programs have been operating successfully for many years.

***Principle 2: Maintain existing state flexibility to design and implement MLTSS programs in coordination with national goals to ensure access to member-centered, quality-driven, efficient, cost-effective care in the most integrated setting.***

State flexibility is essential to enable Medicaid agencies to design and continuously administer MLTSS programs that provide member-centered, high-quality, efficient, cost effective care in the most appropriate integrated community setting. CMS should maintain states' existing authority to implement and administer MLTSS programs to coordinate state-specific goals with national-level priorities. This will help to ensure that states are able to meet the needs of different populations served in Medicaid MLTSS programs.

**Preserve state-driven approaches to rate-setting structures.** CMS should preserve the existing framework that facilitates state-driven approaches to rate-setting structures – including financial incentives and penalties. States are best able to design rate-setting structures that incentivize member-centered care and placement in the most integrated setting for their Medicaid members. Federal policies should preserve states' ability to align financing mechanisms with state-specific program goals for the different populations served in Medicaid MLTSS programs, consistent with a shared vision to deliver timely, appropriate care in the right setting for the member.

**Support state selection of enforcement mechanisms.** As it does today, CMS should preserve states' authority to choose from a menu of appropriate contract enforcement tools. Strong enforcement mechanisms to hold health plan entities accountable and to protect member health and safety are crucial to successful MLTSS programs. Permitting states to draw from a list of options strengthens the agency's ability to tailor its enforcement tools to the size of the state and its MLTSS program and to adapt as the state's program and marketplace matures.

**Support dynamic approaches to create and modify state access to care frameworks.** In designing their MLTSS programs, states are moving beyond the standard medical model approach for access to care. Development of network adequacy standards and ongoing monitoring of access to care are shaped by several key, state-specific factors, including the characteristics of the individual state's health care market, the geographic diversity of the population, and the availability of community-based structures that may incorporate non-traditional providers. Network standards reflect each state's overall philosophy for providing timely access to appropriate services and supports in the right setting for the member. Federal policy should maintain each state's authority to develop dynamic standards that will evolve as the state grows its program and identifies targets for improvement. This approach also allows states to secure participation from providers that commit to delivering high-quality care consistent with the state's MLTSS goals.

Medicaid Directors recommend that federal policymakers support a state-to-state learning model whereby CMS would facilitate conversations among states as Medicaid agencies develop their framework for defining appropriate networks and access to care standards. States can learn from the policies and procedures others have adopted on various network adequacy topics, including network adequacy methodologies, standards for certain populations, monitoring and evaluation tools, exceptions processes, and provider training tools. This approach by the federal government would recognize the inherent diversity and needs of Medicaid members rather than dictating detailed standards that are not feasible or appropriate across all states. By providing such a venue, CMS would formally recognize the current practice whereby states seek to learn from each other and adopt best practices.

**Retain state flexibility to establish tailored requirements for care coordination/case management.** Care coordination/case management is a critical component of MLTSS programs, particularly for Medicaid members that are high-risk or who have multiple, unique and/or complex health care needs. Currently, states are successfully utilizing various models for care coordination/case management tailored to a state's programmatic priorities and the needs of its members. For example, several states are adopting or building upon the models used in the Program for All-Inclusive Care for the Elderly (PACE), the state's Primary Care Case Management (PCCM) delivery system model, and the new Medicaid Health Home program.

CMS should support state flexibility to clearly define the requirements and expectations for care coordination/case management in state contracts with health plans and provider entities. It is essential that federal policy maintain state authority to adopt a range of effective models and develop standards that are specific to the size, population characteristics, and caseload ratios applicable to each state's program. Currently, states focus on the most appropriate requirements and expectations in certain key categories of care coordination/case management. Some states choose to expand upon these to align with additional state-specific goals. Examples of the key categories of care coordination/case management contracting requirements include the following:

- Timeliness standards for a systematic assessment and reassessment of member needs
- Development of an Individualized Plan of Care
- Implementation of the Plan of Care, including coordination of care that actively links the member to providers and support services
- Program evaluation (satisfaction and effectiveness)

***Principle 3: Maintain state flexibility to define a meaningful and productive stakeholder engagement process.***

Each state must retain the flexibility to define how best to engage with and educate members, providers and stakeholders during the development and ongoing operation of MLTSS programs. Members, providers, and other stakeholders have different priorities and needs in every state so a one-size-fits-all engagement framework will not produce a valuable public input process for all states.

**Preserve state authority to develop constructive public engagement process.** A public process at the state level that is designed to elicit meaningful input can help strengthen Medicaid, including MLTSS programs. Federal policy should allow states to develop and submit to CMS a stakeholder engagement plan that describes how and when states would engage and educate members, providers, and other interested stakeholders. Such a plan would also describe the role of members, providers, and stakeholders in program evaluation activities. State-specific mechanisms inherently reflect the culture and climate within the individual state. In contrast, a federally-designed process specifying certain activities and levels of engagement is likely to result in ineffective means of gathering input and an inefficient use of state and federal resources.

**Support meaningful consumer education and decision-making.** Providing Medicaid members with access to meaningful quality and performance information about health plan entities, providers, and services can assist members in making informed decisions about their health care. However, in making such information publicly available, states must strike a careful balance with state statutes that protect certain proprietary information and detailed financial data from health plan entities, particularly if it is not directly relevant to members' health care decision-making. Federal policy should refrain from dictating the specific information that is provided to members.

***Principle 4: Ensure collaboration between federal and state partners in developing a framework for ongoing quality improvement and performance measurement.***

CMS should work with states to develop a framework for measuring the quality and performance of MLTSS programs on an ongoing basis.

**Meaningful and actionable quality measures.** A multitude of national level efforts are underway to identify and develop quality measures targeted to the populations that need long-term services and supports. In the future, these efforts could help further inform states' existing frameworks for improving quality in MLTSS programs across the care continuum. However, nationally developed measures should be consistent with each state's overall quality management strategy.

States must be allowed to incorporate those national measures that are relevant to its MLTSS members. This approach would ensure that the measures fit both with the scope of benefits that the state Medicaid agency has the authority to deliver and the state's strategy for integrating Medicaid services across the care continuum.

The following are guiding principles for federal-state collaboration on a quality measures framework:

- Develop a consistent core set of quality measures targeted strictly to Medicaid-only members and the services within the scope of the Medicaid program.
- Quality measures must align with the state's overall philosophy for integrated care and MLTSS goals for members.
- Quality measurement requirements for HCBS and managed care 1915(b) and (c) waivers should be aligned and streamlined to reduce burden while implementing meaningful quality and performance programs.
- The core set of quality measures should include only those nationally benchmarked measures appropriate for the Medicaid population. The core set should not include measures that presume Medicaid can affect the outcomes related to services provided by Medicare, except in integrated programs under development for dual eligible populations.
- Quality measures for any population should be derived from evidence-based clinical and non-clinical practices and tied to actionable interventions to improve health outcomes and/or the quality of life for members, consistent with the state's priorities for its MLTSS program.
- Quality measures should be appropriate for a managed care delivery system. The core set of measures should reflect that the indicators used in fee-for-service models may not add value in a managed care model.

Using these guiding principles, states can each develop a comprehensive quality strategy that incorporates quality assurance monitoring and ongoing quality improvement processes from several key domains. Within these domains, the state would determine the measures that are responsive to their system and the desired outcomes and interventions.

**Purposeful and consistent federal oversight.** Medicaid Directors place a high priority on improving CMS oversight so as to allow states to demonstrate measurable improvement in quality for members and, in turn, the performance of MLTSS programs generally. Directors offer the following recommendations for ways CMS can best assist states in their efforts to achieve a high performing MLTSS program.

- A core component of federal oversight efforts should include providing technical assistance and facilitating pathways for communication among states. States need additional mechanisms to share information and promising practices among similarly situated states. These types of activities are among the most effective in improving performance.
- Develop a process for regular collaboration and communication with states on LTSS and MLTSS policy issues. Such a process must be adaptable as state MLTSS programs continue to evolve in the years ahead. States welcome the opportunity to provide input into any new directions for federal policies that may be considered and to help inform the federal activities that could assist states.
- CMS' oversight should be based on an explicit plan for improved coordination between the federal and state partners. CMS' oversight activities should align with the federal agency's capacity and ensure that its monitoring activities do not impede states' MLTSS operations.
- Any federal reporting requirements should take into account the expected maturation of state MLTSS programs. Inflexible and stagnant requirements will become obsolete as MLTSS programs evolve over time. In addition, CMS should eliminate conflicts caused by differences reporting timeframes.
- Any federal data collection requirements should directly relate to programmatic goals and elicit meaningful information. This information should be used to allow CMS to engage states in critical discussions and evaluations of MLTSS program performance, not compare states to normative standards.