Policy Issue Brief

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Can Reality Match Rhetoric? Person-Centered Service Planning in Managed Long-Term Services and Supports

Introduction

At its best, a person-centered approach in the context of managed long term services and supports (MLTSS) can be used to maximize independence, control, and autonomy.

There is general consensus among advocates and consumers that MLTSS services are more effectively delivered if the planning process is "person-centered" following the commonsense notion that services should be based on the specific needs of an individual consumer, and not on outside factors such as the administrative convenience of the managed care organization (MCO). Beneficiaries of government programs such as Medicaid should be empowered as individuals who can best determine what it means to be well and what is needed to achieve their level of wellness.

In order for person-centered to be more than an empty slogan, it must be accompanied by substantive standards. State officials will need to design and implement carefully the contract language regarding person-centered service planning so that the concept is implemented throughout an entire system.

This brief begins with a short description of service planning in the managed care context. Next, it provides an analysis of what states are doing in their managed care contracts to ensure person-centered planning. Finally, the brief describes how the new federal home and community-based services (HCBS) rule will provide service planning protections for consumers that should be included in and built upon in MCO contracts.

What is Service Planning?

Deciding which services will be provided and by whom, establishing goals for the consumer, and coordinating paid and unpaid services is all controlled through the service planning process.

Service planning, sometimes called care planning, is central to the successful functioning of MLTSS because it has a profound effect on consumers' lives.

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In the best case scenario, an MCO will offer expertise and options, and the consumer will control the ultimate decision about his/her care. In the worst case, the MCO dictates decisions to the consumer based largely on cost savings, leaving the individual in a peripheral, ineffective role. Systems that provide MLTSS should give consumers a fair chance to control the services and supports they receive to support health and dignity. Ideally, the process will bring together expertise and opinions of all the relevant participants to come to a decision about what is best.

What Are States Doing to Ensure "Person-Centeredness"?

Medicaid managed care programs differ significantly from one state to the next, and these differences often stem from the contract between the state and managed care organizations. More work is needed to ensure that all MCO contracts have provisions that will take "person-centered" from slogan to reality. Advocates need to track and monitor what states are doing to address person-centered service planning in MCO contracts. Below are examples of good and not-so-good provisions from contracts across the country that advocates can use as a tool to improve contacts in their own states.

NSCLC has developed the online Advocate's Library: State Practices in Managed Long Term Services and Supports providing a summary of relevant agreement provisions by topic along with a page number citation for each cited provision.[1] The library includes provisions governing person-centered service planning in MCO contracts from Arizona, Florida, Hawaii, New Mexico, Tennessee, and Wisconsin.

Arizona has very helpful guiding principles included in its managed care contract. "The member is the primary focus of the [MLTSS] program. The member [and representatives] are active participants in the planning for and the evaluation of services provided to them. Services are mutually selected to assist the member in attaining his/her goal(s) for achieving or maintaining their highest level of self-sufficiency."[2] Arizona makes clear that the consumer must be the primary focus and an active participant, and services must be selected to maximize self-sufficiency.

Similarly, **Hawaii** and **Tennessee** have positive language about the service planning process being "patient-centered" and "holistic."[3] The language in Hawaii and Tennessee, however, is not as strong and specific as the Arizona provisions. MCO contracts would benefit from clear guiding principles in order to facilitate a shared understanding of what person-centered planning should entail.

A key element of person-centered planning is that individuals must have control over who is included in the planning process. All states need contract provisions that protect the consumer's right to choose who is involved in the planning process, right to have a face-to-face meeting if the consumer desires, and right to have the

1 http://www.nsclc.org/index.php/ltss-contracts-index-appeals-notices/ The extensive Library contains over 1,000 citations to current managed care contracts to allow advocates to easily find the original text. The agreements themselves are also available on the site for users seeking exact contractual language.

2 AZ Contract, pp. 14-15.

3 TN Contract, p. 108 "MCO "shall provide care coordination in a comprehensive, holistic, person-centered manner"; HI RFP, p. 155 "MCO with "patient-centered, holistic, service delivery approach to coordinating member benefits across all providers and settings."

meeting at a time and place that is convenient and accessible to the individual.

New Mexico requires inclusion of "individuals whom the Member wishes to participate in the planning process."[4] **Florida** goes a step further and requires face-to-face discussion with the consumer, consumer's representative, and any other consumer-approved person.[5]

Although it is imperative that consumer participation be more than just a façade, current state contracts are weak on describing and enforcing exactly what consumer participation should entail. States use language such as "in conjunction," "cooperating," and "consultation" that without more explanation, provide slim assurance of person-centeredness.[6]

Better contractual provisions are more equipped to ensure that the individual's participation is substantial. **Wisconsin** requires MCOs "to ensure that each member has a meaningful opportunity to participate in the initial development of, and updating of, his/her member-centered plan."[7] Additionally, the MCO must provide support to the consumer in order to facilitate informed service decisions and allow the consumer to participate meaningfully.[8]

Similarly, the **New Mexico** contract obligates the MCO to have policies ensuring that the member "is involved and in control, to the extent possible and desired by the Member of development of the" service plan.[9]

Strong contractual language will help consumers to be an active, powerful participant in the service planning process. *MCO contracts should include strong guiding principles and specifically describe how meaningful consumer participation will be achieved.*

Regardless of the specific language in a contract, however, states and managed care plans must abide by both state and federal law. New Medicaid regulations, described in detail in the next section, establish baseline requirements for person-centered planning. These regulations, in turn, rest on Medicaid Act rules that services reflect individual's needs and preferences, as well as meet their needs for health and welfare.[10] Person-centered planning is also one of the means by which states meet their obligations under section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act and the Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).[11] Finally, some state laws specifically require person-centered planning in the context of long-term supports and services.[12]

4 NM Contract, p. 44.
5 FL Contract, Att. II, Exh. 5, p. 36.
6 HI RFP, p. 162; MN Contract, p. 111; NY Medicaid Advantage Plus Contract, sect. 10, p. 10.
7 WI Contract, p. 48.
8 WI Contract, p. 48.
9 NM Contract, p. 44.

10 See, e.g., 42 U.S.C. §§ 1396n(c)(1) (authorizing HCBS waiver services pursuant to a written plan of care), 1396n(i)(1)(G) (requiring individualized care plan for individuals receiving state plan HCBS services), 1396n(j) (authorizing state plan option for self-directed personal assistance services) and 1396n(k)(1)(A)(i)(option for home care pursuant to person-centered plan of services and supports).
11 See 79 Fed. Reg. 2948, 2951 (Jan. 16, 2014) (explaining that one goal of new HCBS regulations is to ensure that Medicaid supports states in meeting ADA and *Olmstead* obligations).
12 See, e.g., California Welfare & Institutions Code § 14182.17(d)(4)(A)(requiring that dual eligible managed care plans reflect "member-centered" approach to care planning consistent with CMS models and federal requirements). This approach is further developed in the state's care coordination standards, available online at http://www.calduals.org/2013/02/20/cc_standards/.

What Will the New HCBS Rule Require Going Forward?

In addition to MCO contract provisions, person-centered planning in the managed care context must also follow new federal Medicaid rules which apply broadly to Medicaid-funded home and community-based services (HCBS).[13] The new standards took effect in March 2014, but many implementation details are being worked out by individual states, subject to review and approval by the federal government. Stakeholder involvement and advocacy will be critical as state Medicaid programs transition through implementation of the new rule.[14]

Consumer Control. The new rule provides an opportunity for advocates to push states to include robust person-centered service planning requirements in their MCO contracts. However, the HCBS rule is a floor, not a ceiling, and states should use the rule as a starting point for creating a process that protects consumer control and dignity. *From a review of current contracts, more detail is needed in state contracts to flesh out the details of person-centeredness under the rule.*

Service Plan Development. The HCBS rule uses slightly different language to describe consumer control in the waivers and state-plans. In HCBS waivers, the consumer leads the planning process "where possible." If, due to incapacity, the consumer cannot lead, the consumer's representative steps into the leadership role. If the consumer has a representative but is capable of leading, the consumer's representative should participate "as needed and defined by the [consumer]." The key is how MCOs will decide when it is "possible" for an individual consumer to lead the process. *Contract language should include more detail to ensure that consumers maintain the maximum amount of control.*

In HCBS state-plan services, the service plan is developed or approved by the State. The plan's development is done jointly with the consumer or (if applicable) the consumer's representative, with the planning process being "driven by" the consumer. *MCO contracts should include additional information on how the process is controlled in order to ensure that the individual is truly driving the process.*

Participation by Third Parties. While consumer participation in service planning is essential, the additional people who participate in or are restricted from the process are equally important. In both HCBS waivers and state-plan services, consumers have control over who does (and does not) participate in the service planning process under the rule.[15] *MCO contracts should include a process for ascertaining who the consumer does and does not want to participate, and should take into account the special needs of consumers with dementia.*

Service Planning Document. The service plan is the keystone of the person-centered process. The rule makes clear what must, at a minimum, be included in a service plan.

- Setting: The plan must indicate that the consumer selected the setting in which

13 79 Fed. Reg. 2948 (Jan. 16, 2014).

14 For more information on the service planning requirements set forth in the new HCBS rule, as well as information on important provisions of the rule, see NSCLC, "Just Like Home: An Advocate's Guide to Consumer Rights in Medicaid HCBS," (May 2014) available at http://www.nsclc.org/wp-content/uploads/2014/04/Advocates-Guide-HCBS-Just-Like-Home-05.06.14-2.pdf.

15 79 Fed. Reg. at 3,005 "[T]he final rule clearly indicates that individuals are allowed to choose who does or does not attend the meeting . . . ."

he or she resides. The State must ensure that the setting supports full integration of Medicaid-eligible consumers into the greater community.

- Goals and strengths: The plan must reflect the consumer's strengths and preferences, and identify individual goals and desired outcomes.
- Services and supports: The plan must indicate the services and supports (paid and unpaid) that will assist the consumer in achieving identified goals, along with the providers of those services and supports.
- Risks: The plan must include risk factors along with measures in place to minimize risk, such as individualized backup plans and strategies.
- Monitoring: The plan must identify the person and/or entity responsible for monitoring the plan.

Once developed, the plan is not a permanent document, it must be reviewed and revised at least every 12 months, when the individual's circumstances change, and at the individual's request. *MCO contracts should include the minimum requirements of a service plan, and advocates can push for additional elements to be included in plans.*

Modifications to the Service Plan. The plan must document any modification to requirements that would otherwise apply under the rule. For example, if an individual would benefit from set meal times rather than access to food at any time, as is required by the rule, it must be supported by a specific, assessed need and documented in the service plan. *MCO contracts should make clear who is responsible for determining whether a specific need requires a modification and whether that modification continues to be needed. The same individual or group should not be responsible for both functions.*

Conflict of Interest. The HCBS rule includes provisions limiting conflict of interest that are particularly important in the managed care context. In general, the service planning (or case management) cannot be performed by an HCBS service provider for the consumer, or any person who has an interest in or is employed by an HCBS service provider for the consumer. The rules, however, do not prevent a service provider from being in attendance during service planning if the consumer chooses. *MCO contracts should clarify that these rules should not apply to the provisional service plans used to initiate HCBS as soon as possible.*[16]

Conclusion

Person-centered planning is critical to the well-being of consumers of long-term services and supports. It works by identifying the strengths, preferences, needs, and desired outcomes of the individual. In order for "person-centeredness" to be more than an empty slogan, it must be accompanied by substantive standards set forth in MCO contract language. Some states have begun to include person-centered planning requirements in their contracts, but more work is needed before all states have a full framework. The new HCBS rule provides a floor of protections for states to add to when creating their service planning system. States and advocates will need to work together to realize the promise of person-centered planning.

16 CMS, Olmstead Update No. 3, Atch. 3-a (July 25, 2000).