Trust Me:
Ensuring Long-Term Planning Aligns with Medicaid and Managed Care Requirements

STETSON LAW

National Conference on Special Needs Planning and Special Needs Trusts
Boot Camp: Understanding and Accessing Long-Term Supports & Services
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1

Why Alignment *Matters*

Poor alignment can result in:

- ✓Service and support denials
- ✓Unnecessary and sometime dangerous delays
- ✓Financial ineligibility and subsequent instability
- ✓Jeopardizing a client's care and housing stability
- ✓Depletion of financial resources
- ✓Heavy tax consequences when accessing retirement funds

2

Common Legal Problem Areas

- Medicaid Financial Eligibility & Trust Misalignment
- Service Authorization & Medical Necessity Disputes under MCOs
- MLTSS Person-Centered Planning & Case Management Failures
- Appeals, Notices, and Due Process Issues
- Transitions Between Systems or Programs Failures
- Person-Centered Planning Failures

3

What do Managed Care Organizations (MCOs), well… *do?*

- Contract & Administrative Functions
- Care Delivery and Coordination
- Financial & Payment Functions
- Enrollee Services & Rights
- Quality Assurance & Improvement
- Special Roles in LTSS/MLTSS States

Sources: 42 CFR Part 438; CMS Managed Care Guidance; MACPAC Managed Care Overview.

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4

LTSS and MLTSS

- **Managed Long-Term Services and Supports (MLTSS) Goal:** Improve coordination and integrated medical/behavioral, and long-term supports to improve outcomes and fragmentation, expand HCBS options, and support aging in place.
- **States pay MCOs a capitated rate**; MCOs manage authorization, payment, and coordination of LTSS.
- **Operates under federal waiver authority** with CMS oversight.

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5

HCBS are *Optional* Benefits under Medicaid

Challenge	Implication for Planning
HCBS are optional under Medicaid	States may not offer, may limit, or may change HCBS programs at any time.
Waitlists and caps are common	Clients may face delays before receiving in-home services.
Institutional care is mandatory	Nursing home care may be the only immediate Medicaid option.
Legal documents need flexibility	POAs, trusts, and care directives should address both home and facility scenarios.
Financial planning must bridge gaps	Clients may need private funds or insurance to cover interim care.
State-specific policies differ	Attorneys must tailor strategies to *local* Medicaid rules and program availability.

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6

The Flow of Managed Care Service Delivery

Enrollee → MCO network → referrals/authorization

Utilization review → appeals → external review

Ongoing monitoring & care coordination

7

How Services Are Authorized Under Medicaid Managed Care

- **Assessment and service planning** by care coordinators or case managers employed or contracted by the MCO
- **Prior authorization** review
- **Medical necessity** review
- **Regulated Timeframes** (14 calendar days/72 hours)
- **Approval or denial:** *Who* makes the decision any why its important
- **Service plan implementation**
- **Notice and appeals rights** and **state fair hearing rights** (42 CFR §438.400–438.424)
- **State oversight**

8

Role of Care Coordinators

The Good

- Point of contact for members
- Develop and monitor person-centered plans
- Communicate among client, providers, and MCO
- Advocate for medically necessary services
- Bridge between long-term planning and managed care

The (*perhaps*) Not-so Good

- High caseloads, turnover, training gaps, limited authority, variation by program area
- Shape service plan…also employed by MCO so may face cost-control incentives
- Person-centered planning requirements (42 CFR 441.301)…effective communication services and supports(?)
- Not legal experts

9

Who Makes Decisions & Appeals

- First-level: MCO utilization review staff / medical directors
- Internal reconsideration (appeals) required
- External review options vary by state
- State agency oversight is critical
- Legal recourse through admin/judicial appeals

Source: Medicaid Managed Care Entity Checklist; Medicaid.gov

10

Decision-Making Supports & Person-Centered Planning

WHO makes decisions?

- Client (if competent)
- Legal representative (POA, SDM Team/Agreement, Guardian)
- MCO care coordinators (advocate, gatekeeper)
- State oversight agencies (e.g., fair hearings)

Reminders…

- Supported decision-making and POAs preserve autonomy.
- Guardians/representatives must be recognized by the MCO.
- Federal regulations require person-centered service planning in HCBS waivers.
- Decisions should reflect the individual's will and preference, not just what's expedient.
- Role of care coordinators and legal representatives (e.g., POA, guardian).

042 C.F.R. § 441.301(c)(1) – HCBS person-centered planning requirements

11

Key Requirements for the Person-Centered Service Plan (42 C.F.R. § 441.301(c)(1))

Must be developed through a person-centered planning process that:

(i) Includes people chosen by the individual.
(ii) Provides necessary information and support to the individual to ensure they can direct the process as much as possible.
(iii) Is timely and occurs at times and locations convenient to the individual.
(iv) Reflects cultural considerations and uses plain language.
(v) Includes strategies for resolving disagreements.
(vi) Offers choices about services and supports and who provides them.
(vii) Provides a method for the individual to request updates.
(viii) Includes informed consent and is signed by all responsible parties.
(ix) Ensures that decisions made by the individual are honored and documented.

Additional Key Principles Embedded in § 441.301(c)

- Conflict-free case management
- Review and updates
- Community integration

12

Medicaid Eligibility: Income & Asset Considerations (*generally)*

- Strict limits on income *and* countable assets
- Key Eligibility Thresholds
  - **Asset Limits:** Vary by state, but typically around $2,000 in countable assets for an individual. Certain assets (e.g., primary residence up to a set equity limit, one vehicle, personal belongings) are exempt.
  - **Income Limits:** There are caps for eligibility, which may trigger the use of Miller trusts (Qualified Income Trusts) in some states to qualify.
  - **Lookback Period:** Medicaid reviews asset transfers within a 60-month (5-year) lookback period to detect disqualifying gifts or transfers.

13

Special Needs Trusts (SNTs), ABLE Accounts & Medicaid Eligibility

- First-Party SNTs
- Third-Party SNTs.
- Medicaid Asset Protection Trusts (MAPTs)
- ABLE Accounts
- Conflicts Between Trust Distributions & Medicaid Covered Services

14

Real Property & Home Planning

- **Medicaid Home Exemption**
- **Estate Recovery**
- **Life Estates & Deeds**

15

Look Back and Transfer Penalties

Transfers for less than fair market value during the 5-year lookback can result in penalty periods during which the individual is ineligible for Medicaid.

- Track the date and amount of transfers carefully.
- Avoid last-minute gifting, except in structured crisis planning strategies
- Explain implications to clients

16

Spousal Impoverishment Protections

- **Community Spouse Resource Allowance (CSRA):** Allows the spouse to keep a portion of the couple's assets (varies by state, often between ~$30,000 and ~$154,000).
- **Monthly Maintenance Needs Allowance (MMNA):** Allows diversion of some income to the community spouse.
- **Spousal Refusal**: In some states, the community spouse can refuse to contribute to care costs, shifting the obligation to Medicaid (with potential state recovery later).

17

POA & Advance Directives

Durable Power of Attorney (DPOA)

- Include gifting powers that are broad enough to execute Medicaid planning strategies (e.g., funding trusts, transferring assets, executing deeds).
- Authorize creation and funding of SNTs or MAPTs.
- Provide authority for long-term care planning decisions, not just financial transactions.

Advance Directive

- Healthcare Power of Attorney (or Proxy)
- Living Will: Specifies your preferences for medical treatments, including:
  - Life-sustaining treatments
  - Comfort care
  - Cardiopulmonary Resuscitation (CPR)
- Instructions for End-of-Life Care:

18

Common Pitfalls

- Failing to update trust usage with evolving managed care policies.
- POAs or trustees authorizing payments inconsistent with MCO-covered services.
- Lack of communication between attorneys, MCOs, and trustees.
- Failure to confirm allowable expenses.
- Assuming all MCOs have the same coverage rules.

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19

Effective Advocacy That Honors Client's Will and Preference

- **Presume capacity**
- **Elicit the client's preferences early**.
- **Separate will and preference from others' opinions**
- **Provide effective communication and support:**
  - Use plain language and accessible formats
  - Allow extra processing time and repeat key points without rushing the client.
  - Involve interpreters, augmentative and alternative communication tools, or support persons if needed to facilitate understanding.
  - Document communication preferences and use them consistently.
  - Confirm understanding by asking the client to explain decisions in their own words rather than relying on yes/no answers.
- **Use Supported Decision-Making** rather than substituted decisionomaking whenever possible.

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20

Best Practice & Advocacy Strategies

- **Document client preference.** Consider informal tools: Stoplight Tool, Trajectory, SDM Agreements, etc.
- **Early alignment:** Incorporate Medicaid & MLTSS considerations at the planning stage, not after eligibility or service issues arise.
- **Track authorizations & renewals**: MLTSS plans often require frequent reauthorizations; missing these can lead to service gaps.
- **Collaborate with care coordinators:** Build relationships with MCO care managers and state Medicaid contacts.
- **Document *everything*** (and encourage your client to do so, too): Notices, service plans, MCO communications — critical for appeals.
- **Educate clients & families:** Empower them to recognize and respond to improper denials or reductions.
- **Know your state's managed care grievance and appeal processes.**

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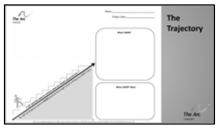
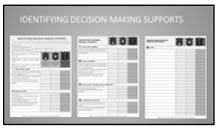
21

Tools: Honoring Client Will & Preference





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22

Key Takeaways & Best Practices

- Confirm trust distributions complement, *not* duplicate, Medicaid-covered services.
- Build collaborative relationships *early* with:
  - Care coordinators
  - Trust administrators
  - Families & support networks
- Ensure SNTs reflect managed care realities — review language annually.
- Advocate for the client's will and preference within regulatory frameworks and flexibility for managed care changes.
- Train fiduciaries – or provide state specific resources – on how Medicaid and managed care intersect.
- Keep documentation and communication transparent across all teams.
- Escalate when:
  - Services are denied despite medical need.
  - Care plan is not person-centered.

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23

Additional Resources and References

- Medicaid.gov – https://www.medicaid.gov
- 42 U.S.C. § 1396p – Medicaid Trust Rules
- Social Security POMS – SI 01120.199
- Kaiser Family Foundation – Medicaid MCO Tracker
- National Health Law Program – https://healthlaw.org
- Justice in Aging – https://justiceinaging.org
- *Your* state's Medicaid manual / MCO contracts

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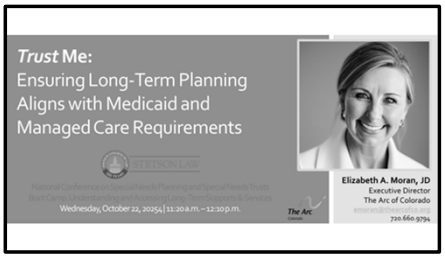
24

Thank You!



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25