

State Trends and Innovations in Medicaid Long-Term Services and Supports

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State Medicaid programs have made great strides in rebalancing the provision of long-term services and supports (LTSS) from institutional settings to home- and community-based care. Increasing consumer demand for community-based options and the need to ensure optimal cost-effectiveness of publicly-financed care have driven this transformation of Medicaid LTSS delivery systems. States are pursuing opportunities made available in the Affordable Care Act (ACA) to expand the availability of home- and community-based services (HCBS) to Medicaid beneficiaries. States are also reviewing Medicaid eligibility processes to ensure that people have the information and services they need to stay in the community, utilizing different federal authorities to better fit the goals of their LTSS programs, and moving to managed long-term service and support (MLTSS) programs.

This brief highlights states' continued efforts to: 1) rebalance LTSS options toward HCBS; and 2) develop and implement MLTSS programs to better integrate primary and acute care, LTSS, and behavioral health care. Also discussed is the rationale behind the decision made by a number of states to migrate program authority for provision of LTSS services from 1915(c) waiver authorities to comprehensive Section 1115(a) demonstration waiver authorities. Finally, the brief highlights states' continued progress in improving quality of care for LTSS.

The lessons presented in this brief resulted from the work of the Center for Health Care Strategies (CHCS) on *Implementing the Roadmaps: Innovations in Long-Term Supports and Services* funded by The SCAN Foundation. Through this project CHCS provided technical assistance to 10 states¹ to support their LTSS rebalancing efforts and migration to MLTSS delivery systems. The brief describes the innovations of the states involved in the project as well as the activities of other states that helped project participants to inform their thinking.

IN BRIEF

States continue to make strides rebalancing Medicaid long-term services and supports (LTSS) systems away from institutional settings and toward community-based care. The Affordable Care Act provided states with new opportunities that have enabled them to develop different aspects of their LTSS eligibility and delivery systems, strengthening both access to and availability of community-based services. States also are migrating from fee-for-service delivery systems to managed care to better integrate LTSS with primary and acute care and behavioral health care, as well as community supports and resources provided by other programs.

This brief highlights states' continued progress in: 1) rebalancing LTSS options toward home- and community-based services; and 2) developing and implementing managed LTSS programs to better integrate care. It describes states' progress in improving quality of care for LTSS and the decision by some states to change program authority for provision of LTSS services from 1915(c) waiver authorities to comprehensive Section 1115(a) demonstration waiver authorities.

State Rebalancing Efforts

Nationally, the provision of Medicaid LTSS is shifting away from nursing home care to community placement. All states currently have some sort of mechanism in place to provide HCBS options through federal waivers and state plan options.² In recent years, spending for Medicaid HCBS has increased, accounting for 45 percent of total Medicaid long-term care services in 2010, up from just 13 percent in 1995.³

Affordable Care Act Opportunities

The ACA created and enhanced a number of opportunities for states to expand availability of HCBS for Medicaid beneficiaries. These include the *Enhanced Aging and Disability Resource Center (ADRC) Options Counseling Program Grants*, the *Balancing Incentive Program*, extension

of the *Money Follows the Person* (MFP) demonstration projects through 2016, and the *Community First Choice Option* (CFCO) state plan amendment (Section 1915(k)). Exhibit 1 shows The SCAN Foundation project states' pursuit of these opportunities to date.

Establishing a no wrong door/single entry point (NWD/SEP) process for Medicaid eligibility is a critical step to facilitate access to HCBS. States can turn to ADRCs, State Health Insurance Assistance Programs (SHIPs) or Area Agencies on Aging (AAAs) to help direct individuals to the designated "entry point" for submitting eligibility applications. The federal *Aging and Disability Resource Center Options Counseling Program Grant* and *Balancing Incentive Program* offers funding to enhance entry points for HCBS program information and eligibility assistance.

Aging and Disability Resource Center Counseling Program Grants

The *Aging and Disability Resource Center Options Counseling Program Grants*, announced by the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration in May 2012 assists states in creating NWD/SEP systems. ADRCs serve as a front door to the LTSS system and play an important role in ensuring that individuals consider service and support options that best meet their individual needs and preferences. The funding opportunity is split into two parts, Part A: *The Enhanced*

ADRC Options Counseling Program and Part B: *The ADRC Sustainability Program Expansion Supplemental Program*. As of August 2012, eight states – Connecticut, Maryland, Massachusetts, New Hampshire, Oregon, Vermont, Washington, and Wisconsin – were awarded a total of \$18.5 million over three years under Part A, while 36 states were awarded approximately \$200,000 each for one year under Part B. Of the 10 states in The SCAN Foundation project, one received Part A funding and eight received Part B funding (Exhibit 1). Depending on availability of funds and each state's progress toward ADRC expansion, additional funding of up to \$2.3 million may be awarded over a three-year period, ending in September 2015.

Balancing Incentive Program

The *Balancing Incentive Program* provides funds to rebalance LTSS expenditures toward HCBS provision. The *Balancing Incentive Program* will provide a targeted Federal Medical Assistance Percentage (FMAP) increase to states that achieve specified HCBS expenditure targets and undertake three specific structural reforms designed to increase nursing home diversions and access to HCBS: (1) a single point of entry system for individuals to access LTSS statewide (NWD/SEP); (2) conflict-free case management; and (3) a core standardized assessment instrument for determining eligibility for services. To date, CMS has approved *Balancing Incentive Program* applications for Connecticut, Georgia, Indiana, Iowa, New Hampshire, Maryland,

Exhibit 1: Status of Implementing the Roadmaps States in Pursuing LTSS Opportunities.

State	ACA Opportunity			
	Enhanced ADRC Options Counseling	Balancing Incentive Program	Money Follows the Person ⁴	1915 (k) Community First Choice Option ⁵
Arizona	Part B	-	-	Applying ⁶
Georgia	Part B	Approved	Approved	-
New Jersey	Part B	Applying	Approved	-
Nevada	Part B	Considering	Approved	-
Oklahoma	Part B	-	Approved	-
Pennsylvania	-	-	Approved	-
Rhode Island	Part B	Applying	Approved	Considering
South Dakota	Part B	-	Planning Grant	-
Virginia	Part B	Applying	Approved	-
Washington	Part A	-	Approved	-

Mississippi, Missouri, and Texas. Rhode Island and Virginia also have expressed interest in participating.⁷ Of the 10 states in The SCAN Foundation project, Georgia has been approved for the *Balancing Incentive Program*, New Jersey, Rhode Island, and Virginia are applying, and Nevada is considering an application (Exhibit 1).

Strengthening the relationships between Medicaid, state departments on aging, and organizations in the community, specifically ADRCs, AAAs, and SHIPs, is a cornerstone of the *Balancing Incentive Program*. CMS recognized the essential functions of ADRCs and SHIPs by making the establishment of a statewide NWD/SEP one of the *Balancing Incentive Program's* structural change requirements.

Georgia has invested significantly in building a strong NWD/SEP approach to eligibility and options counseling. The state has a network of 12 regional AAAs and ADRCs. A web-based model for submitting program eligibility applications will enable any entity throughout the state with approved access to assist with providing information about LTSS program eligibility.⁸ The state pursued continued funding of its ADRCs by applying for the *ADRC Options Counseling Program Grant* and receiving Part B funding, and successfully applying for the *Balancing Incentive Program*.

Enhanced federal funding through the *Balancing Incentive Program* may be used to provide increased offerings of or access to non-institutional LTSS. The enhanced federal funding opportunities in the *Balancing Incentive Program* and other programs discussed in this brief allow states to leverage their resources and make the investments they need to strengthen and rebalance their LTSS systems.

Money Follows the Person

Since 2005, states have had the opportunity to pursue MFP demonstrations to receive enhanced federal matching dollars to

strengthen NWD/SEP and HCBS delivery systems.⁹ The ACA provided states that had not pursued MFP an additional opportunity to apply, and it extended demonstration programs through September 30, 2016. Eight of the 10 states in The SCAN Foundation project have received MFP grants.

South Dakota is a more recent MFP demonstration state, receiving a planning grant and a demonstration grant in 2012. The state plans to build LTSS capacity and infrastructure, particularly in its more rural areas to ensure that individuals who want to transition back to or continue living at home in their communities can be adequately and safely sustained. Then the state plans to focus on transitioning young people living in nursing facilities due to traumatic brain injuries or physical disabilities. South Dakota is working to identify these individuals using data from the nursing home minimum data set (MDS) and referrals from nursing homes.

Washington State had already been actively working on rebalancing its LTSS system when it applied for the MFP program in 2006.¹⁰ They had a well-established community-based LTSS system, a standardized universal assessment tool, and good data to support transitions to the community prior to the start of the MFP demonstration. Other states starting their MFP programs with less established infrastructures may consider using MFP funds to bolster the framework of their LTSS systems (developing data collection instruments, acquiring new information technology) while using other programs to fund direct service provision.^{11,12}

Community First Choice Option – Section 1915(k) State Plan Amendment

States are considering pursuing Section 1915(k) *Community First Choice Option* (CFCO) state plan amendments (SPAs). CFCO is a new option created by the ACA for states to provide community-based attendant services and supports for

Georgia has built a strong no wrong door approach to eligibility and options counseling by using funds from a Part B *ADRC Options Counseling Program Grant* and the *Balancing Incentive Program* to strengthen its regional network of AAAs and ADRCs.

States can use MFP funding to create some of the LTSS infrastructure that has been used successfully in Washington State.

beneficiaries with incomes up to 150 percent of the Federal Poverty Level (FPL) who are eligible for nursing facility or other institutional settings. States with approved SPAs will receive a six percent increase in their FMAP for CFCO services.

To date, California has submitted and received approval of a CFCO SPA (September 2012) and Arizona, Louisiana, and Oregon have submitted SPAs, which CMS is reviewing. Many states' initial priority is the *Balancing Incentive Program* and the associated enhanced federal matching funds for reinvestment into LTSS delivery systems. However, after applying for the *Balancing Incentive Program*, many states are beginning to consider the benefits of pursuing CFCO.

California's experience can help guide states pursuing CFCO SPAs. Over the first two years, California will receive an estimated \$573 million in CFCO funding to enhance Medi-Cal's community-based personal attendant and support services to seniors and persons with disabilities. California's CFCO SPA will assist in meeting the goal of supporting individuals to reside in the community rather than in institutions.

CFCO requires participating states to deliver:

- Attendant care services and supports to help eligible beneficiaries with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and other health-related tasks through hands-on supervision and/or assistance;
- Acquisition, maintenance, and enhancement of skills needed to accomplish ADLs and IADLs or other tasks;
- Back-up systems or mechanisms to ensure continuity of care and supports; and
- Voluntary training on how to select, manage, and dismiss attendants.

Optional CFCO services include:

- Expenditures for transition costs that are related to moving beneficiaries to the community from an institution (i.e., first month's rent, security deposit, household supplies, etc.); and
- Expenditures in a beneficiary's care plan to increase their independence and decrease reliance on human assistance.

California has chosen to include only the latter of the two optional services in their CFCO program. The state limits these services to only those beneficiaries that receive the Restaurant Meal Allowance (RMA). Allowable purchases under the RMA are those made in lieu of meal preparation, clean-up, and grocery shopping for those individuals with a determined need. The six percent increase in its FMAP for funds spent on these services is emphasized as being particularly important to the state in the current economy.

State Innovations – Eligibility Processes

As states continue to rebalance their LTSS delivery systems, they are looking for ways to improve the Medicaid eligibility process to ensure that individuals do not end up in institutions due to the lack of services and supports while waiting for eligibility determinations. Assessing LTSS eligibility involved a level of care determination and a rigorous financial eligibility determination process that can take up to two months or longer.

Once individuals are placed in institutions they can lose their community supports and housing, making return to the community challenging. In response, states have adopted a number of approaches to ensure support for individuals already eligible for non-institutional Medicaid and those who are applying for Medicaid LTSS while awaiting eligibility determinations. Some states have developed approaches for individuals who are not currently Medicaid eligible. For example, Vermont's 1115(a)

waiver for its Choices of Care program allows individuals with pending eligibility to receive services if they are determined to be in the highest need clinical category, based on self-declared income and resource information.¹³ Tennessee's process is referred to as "immediate eligibility." If an individual is found to meet level of care requirements, but is awaiting financial eligibility, the state can approve a limited package of HCBS for 45 days. The limited benefits include Adult Day Care, Attendant Care, Home-Delivered Meals, Personal Care Visits and Personal Emergency Response systems (PERS). Individuals do not receive full HCBS or any other Medicaid benefits until their Medicaid application is approved. If the individual is not determined eligible for Medicaid, the state may not claim FFP for these services.¹⁴

Other states have developed approaches for current Medicaid beneficiaries who are pursuing LTSS eligibility. States with MLTSS programs can include specific contract language to address supporting individuals currently eligible for Medicaid while pursuing eligibility for LTSS. States can require coordination with community-based LTSS and/or require the provision of supports to these individuals pending LTSS eligibility determinations. States may seek exemption of comparability and other rules via 1115(a) waiver authority, subject to CMS approval, that could enable them to offer personal care services to those at high-risk for an extended nursing facility stay. This would provide services to those most at risk of institutionalization pending eligibility decisions. Rhode Island is exploring these service and support options, referring to them as "LTSS Bridge Services," as they plan for MLTSS implementation in 2013.

Streamlining eligibility systems remains critical. States putting these services in place are focusing on overall improvement of eligibility processes to ensure that they are as streamlined and timely as possible. While Tennessee reports that immediate eligibility is not used often to support

individuals in the community pending eligibility determinations, the state has focused on expediting their eligibility determination process for HCBS.

Managed Long-Term Services and Supports

Increasingly, states are transforming their Medicaid fee-for-service LTSS delivery systems to managed LTSS (MLTSS) delivery systems as a way to reduce fragmentation between acute and primary care, behavioral health services and LTSS. Between 2004 and 2012 the number of Medicaid MLTSS programs doubled from eight to eighteen. By 2014, 26 states are projected to have MLTSS programs.¹⁵ Among the 10 states in The SCAN Foundation program, Arizona, New Jersey, New York, Rhode Island, Virginia, and Washington State have or plan to launch some form of MLTSS program by 2014. Exhibit 2 shows the progress of these 10 states in developing MLTSS programs.

With strong state oversight and incentives, MLTSS programs can provide high-quality, person-centered, and cost-effective care to eligible beneficiaries in the setting of their choice. States have used MLTSS payment structures and performance incentives to promote use of HCBS. A number of states hold MLTSS plans responsible for nursing facility and HCBS services under a blended capitation rate at full risk/profit or risk/profit sharing with the state. New Mexico pays the same blended rate for MLTSS regardless of whether the beneficiary is in a nursing facility or in the community. Additionally, states like Minnesota pay a higher reimbursement rate for HCBS services to encourage community placement. Tennessee provides a transition allowance benefit.¹⁶

Through strong contract language, states can require plans to work with beneficiaries who want to transition from nursing facilities to the community and outline service coordination requirements that

Tennessee's "immediate eligibility" process can be used to approve 45 days of limited HCBS for individuals meeting level of care requirements, but awaiting financial eligibility determination.

Exhibit 2: Status of Implementing the Roadmaps States in Creating MLTSS Programs and Changing Medicaid Authorities for HCBS.

State	MLTSS Program ^{17,18}			1915(c) ¹⁹	LTSS Inclusive 1115 Waiver Activity ^{20,21}
	Name	Overview	Status		
Arizona	ALTCS	Blended capitated rate for LTSS, plans keep a percentage for reaching HCBS targets. Care coordination model has third-party contractors for behavioral health and LTSS. Family members/friends can be LTSS care providers.	Launched late 1980s.		Arizona Health Care Cost Containment System, 1115. (Pending)
Georgia			No MLTSS program, but instead improving capacity in its six 1915(c) waivers and improving care for its behavioral health and developmental disabilities populations. Considering an Administrative Service Organization in lieu of MLTSS.	6 waivers	
New Jersey	NJ Managed Long-Term Care	All Medicaid populations (including nursing home residents) will be included; will integrate behavioral health, mental health, acute care, and LTSS.	Launching on January 1, 2013.	4 waivers	NJ Comprehensive Waiver, 1115
Nevada	Nevada Comprehensive Care Waiver (NCCW)	Working on an 1115(a) waiver that will consolidate four section 1915(c) HCBS waivers. Plan to move towards unified quality measures across programs.	Planning to use an 1115(a) waiver to create a Care Management Organization for its high-need Medicaid fee-for-service population.	4 waivers	Nevada Comprehensive Care Waiver – New 1115 Demonstration Request, 1115. (Pending)
Oklahoma			No MLTSS program planned.		
Pennsylvania				10 waivers	
Rhode Island			Planning to launch MLTSS program in January 2014 through its State Demonstration to Integrate Care for Dual Eligible Individuals.		RI Global Consumer Choice Compact, 1115. (Current)
South Dakota		Plans to focus on care transitions, integration, and stakeholder engagement.	No MLTSS program, but instead focusing on ACA opportunities and updating their waivers.	3 waivers	
Virginia		Care coordination for both dually eligible Medicare and Medicaid enrollees and LTSS will be a large focus.	Planning to launch MLTSS program in January 2014 through its State Demonstration to Integrate Care for Dual Eligible Individuals.	7 waivers	
Washington	WA Medicaid Integration Partnership (WMIP)		Planning to launch MLTSS program in January 2014 through its State Demonstration to Integrate Care for Dual Eligible Individuals.	5 waivers	

MLTSS Authority Options: The Move to 1115(a) Waivers

Federal program rules can inhibit innovation and growth for state Medicaid programs wishing to try new avenues of delivering quality and cost-effective care. 1115(a) waivers allow for program flexibility and innovation by letting states waive federal rules, subject to CMS approval. A number of states have decided to move HCBS 1915(c) waivers to 1115(a) demonstration waivers that include HCBS; as of May 2012 there were 34 states using at least one comprehensive 1115 Medicaid waiver.²² Some examples include:

- **New Jersey:** The state pursued a comprehensive section 1115(a) waiver to provide the flexibility to define who is eligible for Medicaid, the benefits to be provided, and secure a value-driven service delivery system. CMS approved the New Jersey Comprehensive Waiver (NJCW) on October 2, 2012. The NJCW consolidates several 1915(c) HCBS waivers, two Section 1115 demonstration waivers, a Section 1915(b) waiver, a 1915(j) State Plan authority for cash and counseling, New Jersey's Medicaid State Plan, a Title XXI CHIP State Plan, and various contracts with managed care organizations.²³

The NJCW enabled the state to pursue a single CMS approval process instead of numerous CMS approval and oversight processes previously required. Streamlined internal program administration; rebalanced eligibility and enrollment policies including deeming eligibility for NF level of care for certain populations²⁴; flexible benefits and revised provider payment strategies that rebalance the service delivery system toward primary care and are all benefits that New Jersey expects to gain through a single comprehensive 1115 waiver.²⁵

- **Rhode Island:** CMS approved Rhode Island's Global Consumer Choice Compact Waiver (Global Waiver) under Section 1115(a) in January 2009. This approval was the next step in the state's strategic plan to rebalance the LTSS system that began in 2006 with participation in the *Real Choice Systems Transformation Grant*. While the state's Global Waiver contains many areas of innovation, initiatives aimed at rebalancing the long-term care system to provide more services and supports in the community are a key element. Specific efforts include:
 - Promotion of availability of HCBS versus nursing facilities;
 - Changes to the clinical level of care policy and process (i.e. creation of a preventive level of care);
 - First steps toward remedying needs of high-cost utilizers;
 - Nursing facility diversion and transition projects;
 - Removal of delegated authority from hospital discharge planners; and
 - Improved access to shared living arrangements.²⁶

An independent evaluation of the state's Global Waiver found that over the three-year study period, the average number of nursing home users decreased by three percent, while users of HCBS increased by 9.5 percent.²⁷ These successes in rebalancing LTSS services resulted in \$35.7 million in savings during the three-year study period.²⁸

- **New Mexico:** The state is planning to transfer its 1915(b) and 1915(c) waivers that are supporting its Coordination of Long Term Services (CoLTS) program to a Global 1115 waiver that would include comprehensive care coordination (behavioral health, physical health and LTSS) delivered through their managed care organizations. New Mexico plans to implement their Centennial Care program on January 1, 2014.²⁹ Through this consolidation of authorities, the state hopes to address key issues facing their Medicaid program including increasing costs, administrative complexity and growing demand.³⁰

helps individuals remain stable as they transition from hospitals stays back to the community.

Key components of a strong MLTSS program include:

- Developing a communication plan and engaging stakeholders during program design, implementation and ongoing program oversight;
- Involving information technology staff at the outset of program design and planning;
- Clearly outlining MLTSS plan responsibilities and expectations in contracts;
- Creating strong state infrastructures for program monitoring; and

- Creating LTSS-specific quality measures.

Developing a comprehensive communication plan to engage stakeholders during program design, through implementation, and in ongoing program oversight is essential to ensuring that stakeholder priorities and values are upheld by the MLTSS program. During the design and implementation of its CoLTS program New Mexico held monthly stakeholder meetings with its managed care providers and stakeholders, including beneficiaries, family members, providers, provider organizations and advocacy and community groups. Beneficiaries and their families became familiar with leadership and staff of managed care organizations. Similarly, New Jersey recognized the importance of engaging stakeholders with its health plans,

Aligning Quality Efforts in Long-Term Services and Supports Programs

Historically, LTSS quality measurement efforts have been driven by 1915(c) waiver requirements for states to report to CMS. These initiatives are often not coordinated with other state measurement strategies and result in a fragmented perspective of quality. Although some states are beginning to adopt cross-cutting measures focusing on care coordination and specific needs of high-risk groups such as Medicare-Medicaid enrollees, most continue to rely on standard measures for skilled nursing facility care for all their LTSS quality measurements. These measures are also usually utilization-based measures (i.e., re-admittance rates, admittance from hospital or home, etc.), leaving much to be desired in terms of cross-cutting measures of quality.

LTSS quality efforts have posed a significant challenge to many state Medicaid agencies that are trying to align measures across institutional long-term care and HCBS. Nearly three decades after HCBS began gaining attention nationally there remains no core or standardized set of LTSS quality measures. As a result, states have developed a variety of unique approaches. Across states, the most frequently used measures include: timeliness in initiation of community-based LTSS, member satisfaction, level of care assessments and measures that ensure receipt of services in patient care plans. Emerging quality measurement tools and state efforts include:

- **Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES):** Wisconsin's PEONIES uses person-centered statements to evaluate a broad set of individual experiences such as whether the beneficiary is living in their preferred setting and making their own decisions about their daily schedule.
- **National Core Indicators for Individuals with Developmental and Intellectual Disabilities:** The National Core Indicators were developed through a collaborative process and published by the Human Services Research Institute.
- **Assessment of Health Plans and Providers by People with Activity Limitations (AHPPPAL):** This is a modified version of CAHPS that specifically addresses the needs of adults with physical, sensory, and/or cognitive disabilities. AHPPPAL survey questions cover domains such as communication, accessibility of physicians' offices, and management of pain and fatigue.
- **Behavioral Risk Factor Surveillance System (BRFSS):** States may use the BRFSS to identify measures they are performing poorly on and subsequently require their contractors to include those measures on their quality of life surveys for LTSS beneficiaries.
- **New Jersey:** As New Jersey embarks on migration to a MLTSS system, the state is focusing its efforts on the development of LTSS quality measures. Emphasis is also being placed on the creation of a performance improvement strategy for the state's new MLTSS program. New Jersey has established an internal workgroup to identify MLTSS-specific measures around specific areas such as: level of care; plan of care; critical incident management system; complaints, grievances, and appeals; and additional measures. The state has also brought together stakeholders and convened a Quality and Monitoring Workgroup that reported recommendations to New Jersey's MLTSS Steering Committee.
- **Nevada:** Nevada has prioritized the development of a unified quality measurement and performance improvement strategy for HCBS. Nevada established a workgroup specifically tasked with identifying and unifying approaches to quality measurement and performance improvement across the state's HCBS waiver and state plan LTSS services. The state plans to use development of a single data entry and care management system as a platform to unify quality efforts.

so during the design of its MLTSS program and pending CMS approval of its 1115(a) waiver, the state held stakeholder workgroup meetings that included health plan participation.

In implementing CoLTS, New Mexico quickly learned that it needed to involve information technology staff early in program design, implementation, and monitoring. During transition and implementation states need to share information with plans on eligibility and enrollment data, provider lists and care/service plans (electronically if possible.) Successful program reporting and monitoring

require service codes for encounter data. Identifying and addressing information system limitations early on helps beneficiaries to become eligible and receive services; health plans to approve and oversee service delivery; and states to effectively monitor program quality and expenditures.

States are pursuing new ways to use health plan contracts to better coordinate HCBS. Most states start with very prescriptive contracts and monitoring practices and, if plan performance is consistently high, move their focus to high-risk, high-cost areas. States have addressed the following key areas in contracts:

- Transition policies;
- Network adequacy;
- Care/service coordination;
- Member education;
- Member complaint resolution;
- Reporting; and
- Performance measurement and quality improvement.

States transitioning from fee-for-service to MLTSS will require new or expanded staff competencies to develop, manage, and oversee this new type of care delivery arrangement. States need to train existing staff or recruit new staff to develop and oversee contracts with managed care plans focused on meeting high quality care delivery and efficiency metrics. The single state Medicaid agency can partner with sister agencies, such as aging, disability and behavioral health, with specific expertise needed for monitoring plan performance. Collaboration includes tapping into these agencies' expertise for quality measures and strategies.

Quality and performance oversight of MLTSS programs requires creating LTSS-specific measures from the outset. Many states track process measures but do not have LTSS-specific measures that assess outcomes or quality of life. As states pursue

MLTSS programs, they are looking for best practices in other states to enhance their ability to gather LTSS-specific quality data.

Conclusion

States continue to make strides rebalancing LTSS systems toward more community-based care rather than institutional care. The ACA provided states with new opportunities enabling them to work on different parts of the LTSS eligibility and delivery system, strengthening community-based service access and capacity. A number of The SCAN Foundation project states pursued these initiatives.

States are also finding ways to provide support services to individuals in the community pending Medicaid LTSS eligibility determinations while also seeking ways to streamline eligibility processes. In addition, states have pursued the greater flexibility and streamlined program administration afforded by 1115(a) waiver authorities, and they are also moving from fee-for-service to MLTSS delivery systems. Finally, states are working to put quality measures and strategies in place that focus on LTSS as they continue to rebalance and improve their LTSS delivery systems.

States transitioning to MLTSS systems must plan for the changing roles of state staff in these new arrangements. They will need to build infrastructure for recruiting and training staff and management skills for monitoring and overseeing contracts with managed care plans.

Endnotes

- ¹ Participating states included: Arizona, Georgia, New Jersey, Nevada, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Virginia and Washington.
- ² American Association of Retired Persons (AARP). "Across the States: Profiles of Long-Term Services and Supports." 2012. Available at <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-aarp-ppi-ltc.html>.
- ³ Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long-Term Care Services and Supports." 2012. Available at <http://www.kff.org/medicaid/upload/2186-09.pdf>.
- ⁴ Centers for Medicare & Medicaid Services. "Money Follows the Person (MFP)." Available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>.
- ⁵ K. Poisal. "1915(i) State Plan Home and Community-Based Services (HCBS)." Available at http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&ved=0CEMQFjAG&url=http%3A%2F%2Fwww.rehab.cahwnet.gov%2FTBI%2FTBI-AC-Minutes-Docs%2FROBIN1915%28i%29%2520State%2520PlanRC%2520add%2520ons.pptx&ei=eattUK6VFMbo0QHxi4HgCg&usq=AFQjCNEJ3KQh4nzVNq0P0NgGyFgZeX_q4g&sig2=wSEs1-krmPsP4Q7gB0LYgA.
- ⁶ Centers for Medicare & Medicaid Services (CMS). "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." 2012. Available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicare-Managed-Long-Term-Services-and-Supports-MLTSS.html>.
- ⁷ More details on the *Balancing Incentive Program* can be found in: S. Barth and A. Lind. *Balancing Incentive Program: Strengthening Medicaid Community-Based Long-Term Services and Supports*, Center for Health Care Strategies, September 2012. Available at http://www.chcs.org/usr_doc/LTSS_Balancing_Incentive_Program3.pdf.
- ⁸ Georgia Department of Community Health Application for Balancing Incentive Program Grant. March, 2012.
- ⁹ Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP and Survey and Certification, Initial Announcement, Invitation to Apply for FY2011 Money Follows the Person Rebalancing Grant Demonstration, July 26, 2010 provides: "The enhanced FMAP funding, as well as significant financial resources to support the administration of the demonstration are available for the implementation of broader infrastructure investments. These investments include initiatives such as: creating systems for performance improvement and 7 quality assurance, developing housing initiatives, supporting staff for key transition activities, improving the direct care workforce, and building "no wrong door" access to care systems."
- ¹⁰ S. Barth, J. Klebonis, and N. Archibald. *Long-Term Services and Supports Opportunities in the Affordable Care Act*. Center for Health Care Strategies, December 2011. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261325.
- ¹¹ Centers for Medicare and Medicaid State Medicaid Director Letter # 10-012, June 22, 2010, page 2 states "the MFP Demonstration Program offers an enhanced FMAP, as well as significant financial resources, to support the administration of the demonstration and implementation of broader infrastructure investment . . . [that] include initiatives such as: creating systems for performance improvement and quality assurance, developing housing initiatives, supporting staff for key transition activities, improving the direct care workforce, and building 'no wrong door' access to care systems."
- ¹² S. Barth, J. Klebonis, and N. Archibald, op. cit.
- ¹³ "New applicants will have a clinical assessment to determine potential eligibility for the Demonstration and the appropriate category of need – Highest, High or Moderate. They will also be screened in terms of financial eligibility. If the applicant meets the clinical criteria for the Highest Need group, and based on self-declared income and resource information appears to meet the financial criteria, she/he will be presumptively enrolled so that services can begin immediately. The Department of Prevention, Assistance, Transition and Health Access (PATH) will make the financial eligibility determinations for all Demonstration enrollees. If the presumptive eligibility process proves successful, it will be expanded to include individuals entering the High Needs group as well." For more information see Vermont's waiver, "The Long-Term Care Plan." Available at: State of Vermont, Department of Disabilities, Aging, and Independent Living. "Choices for Care Section 1115 Waiver Renewal Application." June 2010.
- ¹⁴ Tennessee's operational protocol for CHOICES states, "Under CHOICES, the Bureau can make a preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group. This determination allows enrollment in CHOICES Group 2 and immediate access to a limited package of HCBS, while waiting for a final determination of eligibility. The qualifications for Immediate Eligibility in CHOICES are found in TennCare rule 1200-13-01-.02. Immediate Eligibility shall be only for specified HCBS (no other covered services) and for a maximum of 45 days for individuals who are not already enrolled in TennCare. TN rules: <http://www.tn.gov/sos/rules/1200/1200-13/1200-13-01.20120629.pdf> (immediate eligibility—definitions are in .02 and more detail in .05) and in the MCO contracts at <http://www.tn.gov/tenncare/forms/middletnmco.pdf> (immediate eligibility)." Tennessee reports immediate eligibility is rarely used to support individuals in the community pending eligibility determinations. Instead, the state has focused expediting their eligibility determination process for HCBS.
- ¹⁵ These states include: Arizona, California, Delaware, Florida, Hawaii, Massachusetts, Michigan, Minnesota, New York, New Mexico, North Carolina, Pennsylvania, Tennessee, Texas, Washington, and Wisconsin. For more information see: Truven Health Analytics. "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." 2012. Available at http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf
- ¹⁶ Mildred Consulting -- Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services -- Recommendations for California. 2012. Available at: http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf
- ¹⁷ K. Poisal, op. cit.
- ¹⁸ Source: SLIDES, slide #27, #36 – Trends_Medicaid Reform Presentation NASUAD.
- ¹⁹ Waivers Available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1115#wavers>.
- ²⁰ Kaiser Commission on Medicaid and the Uninsured. "An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity." 2012. Available at <http://www.kff.org/medicaid/upload/8318.pdf>.
- ²¹ Waivers Available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1115#wavers>.
- ²² Kaiser Commission on Medicaid and the Uninsured. "An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity," op. cit.
- ²³ New Jersey Department of Human Services, Division of Medical Assistance and Health Services. "State of New Jersey Section 1115 Demonstration 'Comprehensive Waiver' Concept Paper." 2012. Available at <http://www.state.nj.us/humanservices/dmahs/home/Comprehensive%20Waiver%20Concept%20Paper.pdf>.
- ²⁴ Section 1115 Comprehensive Waiver, State of New Jersey, Department of Human Services in Cooperation with the Department of Health and Senior Services and the Department of Children and Families, p. 86.
- ²⁵ New Jersey Department of Human Services, Division of Medical Assistance and Health Services, op. cit.
- ²⁶ The Lewin Group. "An Independent Evaluation of Rhode Island's Global Waiver". 2012. Available at http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf.
- ²⁷ The Lewin Group, op. cit.
- ²⁸ The Lewin Group, op. cit.
- ²⁹ Parker Dennison. "NM 1115 Waiver Re-Submitted." 2012. Available at <http://parkerdennison.com/nm-1115-waiver-filed>.
- ³⁰ New Mexico Human Services Department. "Centennial Care Concept Paper." 2012. Available at <http://www.hsd.state.nm.us/Medicaid%20Modernization/index.html>.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. Its program priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. For more information, visit www.chcs.org.

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