



## ACKNOWLEDGEMENTS

On behalf of The SCAN Foundation and the Milbank Memorial Fund, as well as our colleagues at Manatt Health Strategies and the Center for Health Care Strategies (CHCS), we would like to acknowledge our informal advisory group for their valued contributions to the publication of this toolkit. They brought years of experience on state and national Medicaid policies, and their collective wisdom about publicly financed long-term services and supports (LTSS) greatly enhanced this toolkit. We thank them for their insights and willingness to provide overall guidance and specific input as this toolkit was developed.

- **Thomas Betlach**, former Director, Arizona Health Care Cost Containment System
- **Daniel Crippen, PhD**, former Executive Director, National Governors Association; former Director, Congressional Budget Office
- **Barbara Coulter Edwards**, Principal, Health Management Associates; former Director, Disabled and Elderly Health Programs Group at the Centers for Medicare & Medicaid Services
- **William Scanlon, PhD**, Consultant, former Managing Director of Health Care Issues at the U.S. General Accounting Office (GAO)

We also would like to acknowledge and thank the states and national experts who made time in their very busy schedules to inform us—and through us, the readers of this toolkit—about their important work. State officials from **Arizona, Maryland, Massachusetts, New Jersey, New York, Tennessee, Texas, Vermont, Virginia** and **Washington**, as well as leadership from **Community Catalyst** and **InnovAge**, shared their time and expertise as we drafted and revised this toolkit (see [Appendix](#)). Their contributions to this effort and ongoing work to improve LTSS across the country is deeply appreciated.

And finally, the authors would like to thank The SCAN Foundation and the Milbank Memorial Fund for their support and guidance throughout the development of this toolkit. Their vision and dedication to promoting better care and supporting states' abilities to improving care is deeply valued by many.

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## Contents

<b>FOREWORD</b> .....	<b>2</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>3</b>
<b>SECTION I: Overview and Purpose</b> .....	<b>7</b>
Medicaid-Financed LTSS in the United States.....	7
Toolkit Purpose and Methodology.....	10
Key Legal Authorities and Other Mechanisms to Advance LTSS Reform .....	13
<b>SECTION II: Rebalancing Medicaid-Financed LTSS: Matching Care Settings to Individuals' Needs</b> .....	<b>15</b>
Overview of Rebalancing Strategies .....	19
Rebalancing Strategy 1: Develop the LTSS System Infrastructure to Promote Greater Access to HCBS.....	21
Rebalancing Strategy 2: Invest in Programs and Services that Help Nursing Facility Residents Return to their Communities.....	31
Rebalancing Strategy 3: Expand Access to HCBS for "Pre-Medicaid" Individuals to Prevent or Delay Nursing Facility Utilization.....	40
<b>SECTION III: Advancing Integration of LTSS with Physical and Behavioral Health Services through Managed Care</b> .....	<b>45</b>
Overview of Integration Strategies.....	47
Integration Strategy 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries.....	49
Integration Strategy 2: Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care.....	58
Integration Strategy 3: Enroll Individuals with I/DD in Managed Care.....	63
Integration Strategy 4: Integrate LTSS Under Provider-Based Initiatives .....	66
<b>SECTION IV: Conclusion</b> .....	<b>73</b>
<b>APPENDIX: Interviews</b> .....	<b>74</b>

## FOREWORD

Low-income adults who need and use long-term services and supports (LTSS) are among the most complex, expensive, and fast-growing populations covered by Medicaid. The challenges of organizing and paying for this much needed assistance in ways that allow older adults and adults with disabilities to live full and satisfying lives are among the greatest challenges state officials face.

To help address these challenges, The SCAN Foundation and the Milbank Memorial Fund are pleased to support this updated version of the toolkit, which was originally published in 2017: *Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment*. Written by Manatt Health Strategies and the Center for Health Care Strategies, this toolkit describes a menu of promising strategies and best practices for states to advance person-centered, cost-effective LTSS options through their Medicaid programs.

This toolkit serves as an overview for anyone interested in understanding or developing state strategies for this increasingly important issue, as well as for those seeking to identify an appropriate set of evidence-based approaches for their state or community. It draws on a wellspring of innovations from multiple leading-edge states and LTSS providers who have been working hard on care in the community and integration with medical delivery systems.

The work of ensuring that adults with LTSS needs in our communities receive care that is person-centered, consistent with their own wishes, and responsive to the reality of limited resources will only grow. It will require beneficiary engagement, leadership, administrative skill, good partnerships and persistence—extending beyond any particular administration, policy, or statute. States, communities, and providers will continue to learn from one another about how to organize and finance these services and, more fundamentally, how to promote a full and rewarding aging experience for all with complex health and LTSS needs.

The *Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment Toolkit* curates a comprehensive body of knowledge that states can use productively and proactively to pursue Medicaid's programmatic flexibility. We are honored to be part of this important work and hope this toolkit is useful in advancing high-quality, cost-effective, person-centered care delivery.

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## About the Authors' Organizations

**Manatt Health Strategies** integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Combining legal excellence, first-hand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players. To learn more, visit [www.manatt.com/health](http://www.manatt.com/health).

The **Center for Health Care Strategies (CHCS)** is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit [www.chcs.org](http://www.chcs.org).

## About the Funders

**The SCAN Foundation** is an independent public charity devoted to advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. To learn more, visit [www.thescanfoundation.org](http://www.thescanfoundation.org).

The **Milbank Memorial Fund** is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. To learn more, visit [www.milbank.org](http://www.milbank.org).

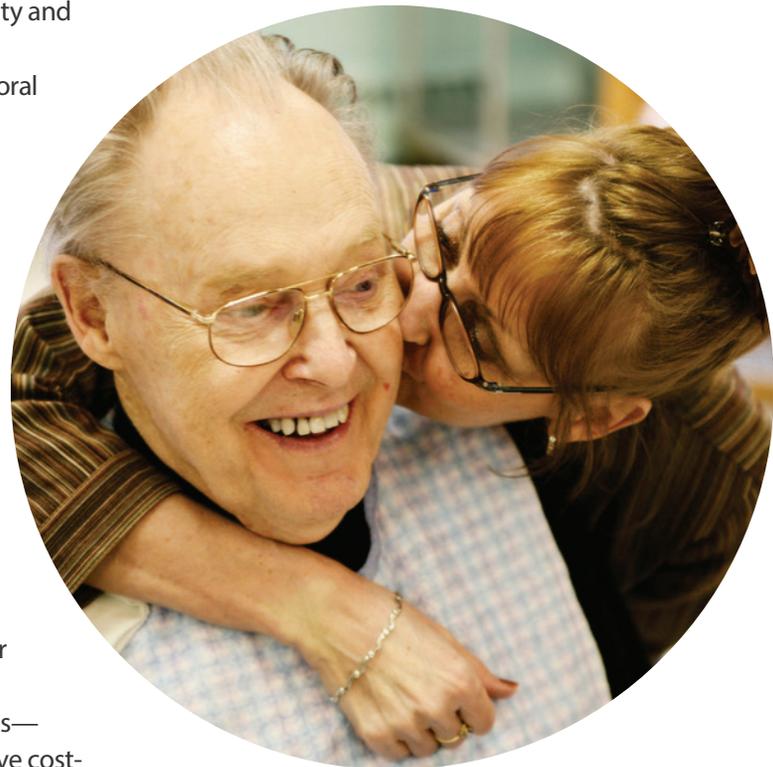
## EXECUTIVE SUMMARY

Long-term services and supports (LTSS) enable more than 12 million people, including older adults and adults and children with intellectual and developmental disabilities (I/DD), physical disabilities, and mental health conditions, among other conditions, to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With LTSS expenditures of more than \$154 billion in 2016, Medicaid is the single leading payer of these critical services. The aging population's projected growth—18 percent by 2020 and doubling by 2060—will only increase demand for LTSS and in turn, put more pressure on Medicaid at both the federal and state levels. As a result of these demographic and fiscal challenges that make the status quo untenable, as well as federal policy and funding priorities, states are seeking to reform their Medicaid LTSS systems to both improve the quality of care for beneficiaries and contain program costs.

There is no one way to implement LTSS, and the Medicaid program offers multiple approaches for designing person-centered services and opportunities for states to shape their strategies to address local needs and state-specific constraints. For states beginning to consider LTSS reform, the strategies already adopted by state innovators offer important lessons. This toolkit highlights several strategies that states are using to deliver high-quality and high-value LTSS in two key areas: (1) rebalancing LTSS to increase the proportion of LTSS provided in community-based settings and (2) integrating LTSS with physical and behavioral health services. The toolkit is intended to assist states in identifying concrete policy and programmatic strategies, operational steps, and available federal and state authorities in these LTSS reform areas, as well as the reasons why states have utilized different strategies and the challenges they have faced in designing and implementing these reforms. For each strategy, we provide: the impetus, a description, potential implementation mechanisms, results to date, and key lessons. We also offer case studies to illustrate how states have implemented each strategy. The strategies can be mixed and matched, sequenced in different ways, and modified to accommodate state preferences. Reforming LTSS is a journey, with tangible and meaningful gains achieved along the way.

### Rebalancing LTSS

Since the beginning of the Medicaid program, states have been required to guarantee nursing facility services to eligible individuals, but most home- and community-based services (HCBS) (e.g., case management and personal care services) were optional and, for many years, the federal authorities and level of federal funding for HCBS were limited. Though HCBS continues to be optional, changes in federal laws and state-initiated actions—driven by individual and family preferences, state interest, legal obligations and the relative cost-



effectiveness of providing care in the community—have led to a dramatic increase in the proportion of LTSS provided in community-based settings. Today, 57 percent of Medicaid LTSS spending supports HCBS compared to just 18 percent in 1995. And yet, these proportions vary significantly across states, as well as across populations who use LTSS. The toolkit highlights three strategies that states have used to increase the proportion of LTSS spending for services provided in community settings and presents illustrative case studies for each strategy, as well as an overarching case study on Maryland’s rebalancing efforts (see [Section II](#)):

**[Strategy 1: Develop LTSS System Infrastructure to Promote Greater Access to HCBS](#)**, which focuses on ways states are enhancing their LTSS system infrastructure, access points and direct care workforce, as well as supporting informal caregivers. [Case studies](#) include:

- **Massachusetts’** creation of a one-stop information and referral network and expansion of HCBS access;
- **California’s** implementation of paid family leave to support family LTSS caregivers;
- **New York’s** development of a uniform assessment system to standardize HCBS needs assessments;
- **New York’s** use of 1115 waiver funds to recruit and retain its long-term care direct care workers;
- **New Jersey’s** nurse delegation pilot to increase access to HCBS; and
- **Tennessee’s** LTSS workforce strategy.

**[Strategy 2: Invest in Programs and Services that Help Nursing Facility Residents Return to and Remain in Their Communities](#)**, which focuses on investments in transition services and tenancy-sustaining services and, in particular, affordable housing options. [Case studies](#) include:

- **New York’s** 1915(c) waiver to divert and transition Medicaid enrollees from nursing facilities;
- **Texas’** Money Follows the Person behavioral health pilot to enhance benefits for people with serious mental illness to support their community transitions;
- **Arizona** and **Texas’** decisions to leverage federal and state funding and private sector development to provide housing supports to individuals with disabilities exiting institutions; and
- **Tennessee’s** transition of individuals from nursing facilities to the community.

**[Strategy 3: Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Use](#)**, which focuses on expanding access to a limited set of HCBS for people who would not otherwise qualify for Medicaid to slow their likely future need for more expensive Medicaid LTSS, including institutional services. [Case studies](#) include:

- **Washington’s** use of an 1115 waiver to expand access to services for individuals at-risk of needing LTSS; and
- **Vermont’s** use of an 1115 waiver to expand HCBS to people at-risk of needing intensive LTSS.

## Integrating LTSS

While the majority of Medicaid beneficiaries nationwide are now enrolled in managed care for primary and acute care, the same does not hold true for Medicaid beneficiaries who use LTSS, including those eligible for both Medicare and Medicaid (“dually eligible beneficiaries”) and those with intellectual and developmental disabilities (I/DD). Instead, many states have kept LTSS beneficiaries in fee-for-service arrangements, in part based on beneficiary and family concerns about ensuring continued access to critical non-medical services and supports, and health plans’ limited experience with LTSS generally and HCBS in particular. More recently, though, the potential benefits of managed care—namely reducing care fragmentation, delivering person-centered and community-based care, improving health outcomes, and reducing overall program costs—have been recognized and, increasingly, states have added LTSS to their managed care delivery strategies. These efforts—often undertaken cautiously to address beneficiary and other stakeholder concerns—offer best practices and lessons learned about program design and implementation, stakeholder engagement, internal capacity, and program evaluation. In addition, several states have sought to integrate LTSS at the provider-level through models that either complement the states’ managed LTSS options or provide an alternative. These provider-based models hold providers—rather than health plans—accountable for consumers’ care coordination and health outcomes. The toolkit highlights four strategies in this area, as well as case studies, for integrating LTSS with physical and behavioral health services through managed care and provider-based models (see [Section III](#)):

**[Strategy 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries](#)**, which focuses on aligning Medicare and Medicaid financing and care delivery. [Case studies](#) include:

- **Arizona** and **New Jersey’s** paths toward alignment; and
- Aligning administrative processes for **Minnesota’s** Senior Health Options (MSHO) program beneficiaries.

**[Strategy 2: Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care](#)**,

which focuses on providing a comprehensive benefit package, including physical and behavioral health services and LTSS under a single capitated rate and coordinated delivery system. The [case study](#) highlights:

- **Virginia’s** Commonwealth Coordinated Care Plus program that integrates all LTSS, medical, and behavioral health services under one program for Medicaid-only beneficiaries.

**[Strategy 3: Enroll Individuals with I/DD in Managed Care](#)**, which focuses on the different ways states are approaching the transition of individuals with I/DD to managed care. The [case study](#) highlights:

- **New York** creates a pathway to managed care for I/DD populations.

**Strategy 4: Integrate LTSS Under Provider-Based Initiatives**, which focuses on initiatives to better coordinate comprehensive care at the provider level. [Case studies](#) include:

- **Virginia’s** PACE program, which integrates LTSS with other services at the site of care by providing comprehensive medical and social services to beneficiaries through an interdisciplinary care team.
- **Massachusetts’** Delivery System Reform Incentive Payment (DSRIP) program, in which non-dually eligible beneficiaries can enroll in Medicaid Accountable Care Organizations (ACOs) that coordinate comprehensive physical health, behavioral health and, over time, LTSS, and that partner with community-based organizations to provide complex care management.
- **Washington’s** health home-based Financial Alignment Initiative demonstration, which coordinates comprehensive LTSS, primary, acute, and behavioral health services for its dually eligible population under a managed fee-for-service payment model.

Regardless of a state’s specific direction and selected strategies for improving LTSS, states can apply these key lessons from other states to inform their approach:

- **Build and sustain beneficiary engagement and buy-in** – these stakeholders are the most important allies and the heart of any LTSS program.
- **Invest in administrative capacity** – both people and data.
- **Invest in federal partnerships** – know what you need from CMS and why, and work to get it.
- **Cultivate executive and legislative leadership** – these champions will always be necessary for systems-level change.
- **Think long term** – create and drive a vision that transcends administration and policy priorities.

Low-income adults who need and use LTSS are among the most high-need, high-cost, and fast-growing populations covered by Medicaid. The need for states to develop strategies ensuring that individuals with LTSS needs receive high-quality, cost-effective care in the settings of their choice will continue to grow. This toolkit provides comprehensive information to help states use Medicaid’s programmatic flexibility to better serve this population.

## SECTION I: Overview and Purpose

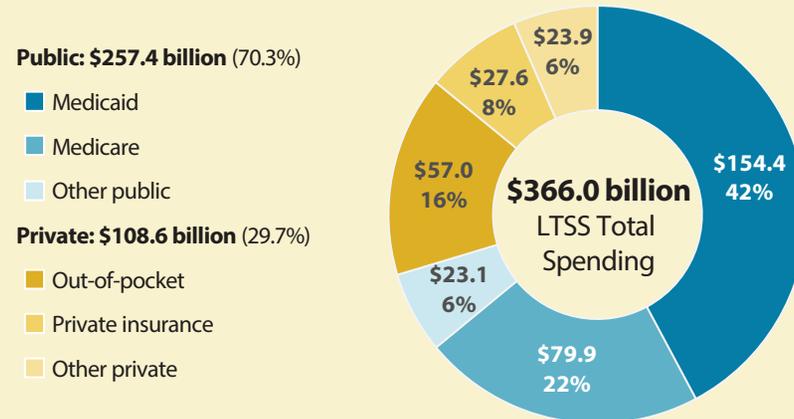
### Medicaid-Financed LTSS in the United States

Nationally, expenditures for LTSS exceed \$366 billion annually, 40 percent of which is financed by Medicaid<sup>1</sup> (**Exhibit 1**) and does not even account for the over \$470 billion in LTSS provided by informal caregivers.<sup>2</sup> LTSS expenditures are expected to rise sharply in the decades ahead due to a growing aging population and associated increased demand for LTSS.<sup>3</sup> Not only is the proportion of people who are aging growing, but also the share who are 85 and older is rising (**Exhibit 2**, page 8), and with it the need for more intensive LTSS. As a result, there is a pressing need for state and federal action to address current and looming LTSS care delivery and fiscal challenges.

Today, more than 12 million Americans use LTSS in both community and institutional settings to meet their personal care needs, such as bathing and dressing, meal preparation, and housework (see *LTSS Are a Vital Part of the Care Continuum*, page 11).<sup>4</sup> These services promote independence, support an individual’s ability to live and participate in the community, and improve overall quality of life. People who rely on LTSS include older adults, as well as adults and children with I/DD, physical disabilities, mental health conditions, substance use disorders, spinal cord or traumatic brain injuries, and other disabling, chronic conditions.<sup>5</sup> People who use LTSS have extremely diverse medical and non-medical care needs, and their total medical costs are often higher than those who do not use LTSS. A recent study found that Medicare spends nearly three times as much per capita on older adults who need LTSS compared to other beneficiaries without these needs.<sup>6</sup>

While unpaid, informal caregivers, such as family members and friends, provide the vast majority of LTSS nationally, Medicaid is the leading payer of LTSS. Neither commercial insurance nor Medicare typically covers LTSS.<sup>7</sup> While some people may be able to pay for LTSS themselves initially, over time, accessing LTSS becomes prohibitively expensive for many. One common pathway for individuals in need of continued LTSS is to exhaust their own resources by paying for their care, and then to qualify for Medicaid (i.e., Medicaid spend down).<sup>8</sup> Growth in the aging population will increase demand for LTSS, placing significant cost pressures on the Medicaid program for the foreseeable future.

**EXHIBIT 1: LTSS Total Spending by Payer, 2016, \$366.0 billion**

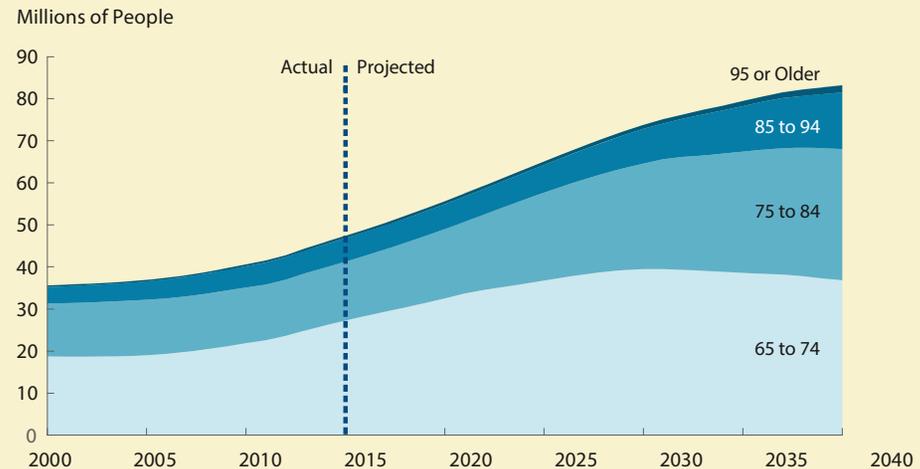


**Source:** “Who Pays for Long-Term Services and Supports? A Fact Sheet.” Congressional Research Service. August 2018. Available at: <https://fas.org/sgp/crs/misc/IF10343.pdf>.

Responding to these demographic and fiscal pressures, a growing number of states are pursuing Medicaid LTSS reforms to improve quality of care for beneficiaries, while containing program costs. These reforms range from strategies targeting LTSS populations to broader efforts to transform the Medicaid program for all beneficiaries. Early innovator states have successfully leveraged federal funding and program design flexibilities made available over the past decade to advance their LTSS reforms, including: the Real Choice System Change grants,<sup>9</sup> the Money Follows the Person (MFP) demonstration, the Balancing Incentive Program (BIP), and the Financial Alignment Initiative;<sup>10</sup> growth in the use of Medicaid waivers for managed long-term services and supports (MLTSS); and new authorities to expand access to community-based services created or enhanced by the Affordable Care Act (ACA). More recent discussions of capping federal Medicaid payments to states, which could force many states already facing budget pressures to cut their Medicaid programs, and increasing waiver flexibility are accelerating states' thinking about and timing for new LTSS reforms.<sup>11</sup>

The convergence of these factors provides states with a critical opportunity to evaluate their current LTSS systems and map out thoughtful strategies that will advance their ability both to meet LTSS beneficiaries' needs and to address state budgetary constraints, as demand for these services will inevitably grow. States that do not proactively embrace LTSS reform may find themselves over time having to limit LTSS or other benefits and eligibility, or cut provider payments to contain unsustainable program costs. Although a single policy or set of policy actions is unlikely to mitigate the current and likely worsening challenges facing states, it is imperative for states to identify and implement strategies to meet the growing demand for LTSS and the needs of an extremely high-need, vulnerable population.

**EXHIBIT 2: Elderly Adults as a Share of the U.S. Population, 2000-2040**



**Source:** Congressional Budget Office tabulations based on population projections reported in The 2015 Long-Term Budget Outlook, June 2015. Available at: <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250-LongTermBudgetOutlook-3.pdf>.

**Note:** Members of the baby-boom generation (people born between 1946 and 1964) started turning 65 in 2011 and will turn 85 beginning in 2031.

## ► Meaningful Engagement of Individuals Needing LTSS is Integral to Successful Reform

At the heart of any Medicaid program is the people it serves. Those who use LTSS are most impacted by changes that states make to Medicaid eligibility and enrollment policies, benefit packages, delivery systems, and provider networks. Moreover, they are the true experts on challenges and solutions that work. As such, engaging individuals who use LTSS and their families in LTSS reform in a meaningful way is an essential element of reform. All states interviewed for this toolkit reflected this reality, citing beneficiary engagement in design, implementation, and ongoing monitoring as a fundamental component to both initiating and continuing to advance LTSS reform efforts.

There are challenges to engaging individual users of LTSS and supporting their engagement throughout the process of designing and implementing reform. Partnering with local organizations such as churches, tenant organizations, consumer organizations, or advocacy groups can help identify interested individuals and build trust in the process. Some states have implemented more structured engagement strategies, such as establishing advisory councils or hosting ongoing consumer group meetings.<sup>12</sup>

Examples of state consumer group initiatives include:

- **Massachusetts'** comprehensive consumer engagement strategy for its One Care duals demonstration program included beneficiary focus groups, an implementation council led by consumer members, and contracted beneficiary consultants who participated in program design work groups.
- **Tennessee** conducted consumer engagement activities prior to launching its statewide LTSS reform to identify the elements that consumers report as the most impactful to their experience and quality of care. The state's identification of its need for a well-trained workforce prompted it to prioritize workforce development and capacity as a key element of its reform.

To ensure meaningful representation from individuals with diverse experiences and perspectives, it is important to invite and facilitate broad participation. Massachusetts requires 51 percent or greater of its One Care Implementation Council to be consumers of its services.



State officials and national experts also highlighted the importance of finding and meeting consumers where they are when engaging in such activities. Identifying and addressing barriers to consumer participation (e.g., providing transportation to meetings and scheduling meetings at convenient times and locations) make it possible for people to participate, and enable meaningful collaboration throughout program design, implementation, and iteration.

See also two resources from Community Catalyst:

Community Catalyst. "Stakeholder Engagement in Design, Implementation and Oversight." Available at: [www.communitycatalyst.org/resources/tools/mmltss/stakeholder-engagement-in-design-implementation-and-oversight](http://www.communitycatalyst.org/resources/tools/mmltss/stakeholder-engagement-in-design-implementation-and-oversight).

D. Stevenson. "What's Next for Medicare-Medicaid Enrollees? Findings from the Duals Symposium." Community Catalyst. January 2019. Available at: [www.healthinnovation.org/resources/publications/body/Findings-From-the-Duals-Symposium\\_Final.pdf](http://www.healthinnovation.org/resources/publications/body/Findings-From-the-Duals-Symposium_Final.pdf).

## Toolkit Purpose and Methodology

This toolkit, developed with support from The SCAN Foundation and the Milbank Memorial Fund, provides a targeted menu of existing state LTSS reform strategies that other states may replicate in whole or in part, or use to scale existing efforts. It is designed to assist states as they work to improve the delivery of LTSS by identifying concrete policy strategies, operational steps, and federal and state authorities that other states have used to advance their LTSS reforms. It also highlights opportunities and challenges that states faced in designing and implementing these reforms. Other stakeholders, such as Medicaid beneficiaries, advocates, federal and state legislators, other states agencies, LTSS providers, health plans, and federal officials, may also find the toolkit helpful to identify opportunities to collaborate with state Medicaid agencies on future LTSS reform efforts.

To develop the toolkit, Manatt Health and CHCS conducted interviews with experts and implementers in innovator states (see [Appendix](#)) to: (1) inform descriptions of reform strategies; (2) illuminate specific leading practices through case studies; and (3) identify the considerations for when or how a strategy might be employed. A project Advisory Committee provided critical guidance at each stage of the toolkit's development (see [Acknowledgements](#)). The original toolkit was published in December 2017, and revised in March 2019 with updated state case studies and new developments in federal and state LTSS policy.

### Selection of Strategies

The toolkit presents reform strategies for delivering high-quality, high-value LTSS categorized in two broad areas:

1. **Rebalancing Medicaid LTSS: Matching Care Settings to Individuals' Needs** (covered in [Section II](#)), which focuses on shifting LTSS utilization and spending from institutional to community settings; and
2. **Advancing Integration of LTSS with Physical and Behavioral Health Services** (covered in [Section III](#)), which provides options for providing person-centered care<sup>13</sup> through deeper coordination of physical health, behavioral health, and LTSS.

**Note:** A third critically important area of LTSS reform activity involves expanding public and private LTSS financing options. The toolkit does not address this topic because it involves other payers and issues beyond those facing state Medicaid programs.

There is no one-size-fits-all approach to LTSS reform, and no single pathway to achieve success in reaching a state's goals. These two areas of reform do not need to be undertaken sequentially, nor are they mutually exclusive. Within a given area, there also can be multiple pathways to reform. For example, while capitated managed care is described as one strategy for integrating LTSS with physical and behavioral health, some states have relied on health homes (a designated provider, including a provider that operates in coordination with a team of health care professionals, or health team selected by the eligible individual to provide health home services) and other mechanisms outside of managed care to accomplish that goal.

The strategies that states pursue ultimately depend on a state’s Medicaid population, its political and policy environment, programmatic and financial priorities, and capacity. However, one common theme from states that have made significant advances in their programs is that LTSS reform is an “incremental journey” undertaken in the context of demographic and budgetary realities. It is a journey best guided by a clear vision and specific goals that will transcend federal administrations and particular state leaders, time-limited funding sources, and even federal authorities.

To set themselves on this path, states ideally would articulate their system reform goals and then perform a systematic assessment of the current LTSS environment to: (1) identify strengths, gaps and barriers for beneficiaries, providers, and communities; (2) gain executive-level support for their LTSS reform effort; (3) develop a statewide reform plan; and (4) marshal all available data. In doing so, states will likely gravitate toward a certain set of strategies or opt for the use of one mechanism over another to drive implementation of the reform plan.

Like most efforts aimed at system transformation, even states that have already taken positive steps toward LTSS reform identify significant room for improvement and challenges with deploying the resources necessary to meet beneficiaries’ needs. Ongoing examination of the LTSS system to assess continued gaps is essential—particularly the overall adequacy of resources and whether the system is designed to promote person-centered care.

## ▶ LTSS Are a Vital Part of the Care Continuum

LTSS include a broad range of services and supports that assist people with **activities of daily living (ADLs)**, which are routine activities for daily self-care and functioning, (e.g., eating, bathing, and dressing) and **instrumental activities of daily living (IADLs)**, which are activities that allow an individual to live independently (e.g., housework, meal preparation, and grocery shopping).

Examples of LTSS include:

- Care coordination
- Medication management
- Adult day health services
- Personal care services
- Skilled nursing
- Housing supports

These services can be provided in institutions, an individual’s home, or in community settings:

- **Institutional settings** include nursing facilities, intermediate care facilities for individuals with developmental disabilities, and mental health facilities.
- **Community settings** include group homes, adult day health centers, and assisted living residences.



**Sources:** CMS. “LTSS Models.” Available at: [www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-models.html](http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-models.html); and AARP Public Policy Institute. “Long-Term Support and Services.” Available at: [www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf](http://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf).

## Implementation Mechanisms

For each of the LTSS reform strategies in this toolkit, states have a variety of implementation mechanisms (i.e., legal authorities) available to them (see [Key Legal Authorities and Other Mechanisms to Advance LTSS Reform](#), on pages 13-14 for complete descriptions). Some of these authorities can be used to achieve the same goal, and which authority a state decides to pursue will depend on many factors, including its existing authorities (e.g., whether the state already has a section 1115 or 1915(c) waiver), and the extent to which the state is broadly changing its system or is initiating a more targeted reform. A section 1915(c) waiver, for example, allows a state to target populations and cap enrollment, whereas a section 1915(j) state plan option allows a state to target a specific population but not cap the number of people served.

## ▶ Key Legal Authorities and Other Mechanisms to Advance LTSS Reform

**State Plan Amendments:** States can implement reforms via their state plan (no waiver required). The following optional services, if offered by a state (with some exceptions noted below), must be available statewide to any beneficiary who is eligible to receive them. However, in most cases, states have discretion to determine the level of need that will trigger eligibility.

### State Plan Benefits That Can Be Used to Provide HCBS

- **1905(a)(24) Personal Care Services:** States can provide personal care services (also known as personal attendant services, personal assistance services, and attendant care services) to people with LTSS needs so they may remain in their homes and communities. Personal care services consist of non-medical services to support ADLs (e.g., bathing, dressing, meal preparation) and are provided by a qualified provider who is not a legally responsible relative (but see section 1915(i)/(j)).
- **1915(g) Targeted Case Management:** This service assists beneficiaries who reside in their homes and communities in gaining and coordinating access to necessary medical, social, and education supports and other services to meet their needs. States may target this optional benefit to specific groups of individuals, such as those with chronic mental illness or developmental disability. States have flexibility under the law to provide targeted case management as a benefit option regardless of whether it is offered through a waiver program.
- **1945 Health Homes:** States can establish health homes to coordinate care for people with either two or more chronic conditions, one chronic condition and at-risk for a second, or one serious mental illness. States can use health homes to coordinate primary care, acute care, behavioral health services, and/or LTSS. States may target health home services by provider or geographic areas, but may not exclude dually eligible beneficiaries. During the first eight quarters of implementation of a health home, states are eligible for 90 percent federal match funding for health home services. States can implement multiple health homes and at different times, with each approved health home qualifying for eight quarters of the enhanced federal matching funds.

### State Plan Benefits Specifically Designed to Provide HCBS

- **1915(i):** States can now offer HCBS as a state plan service—without relying on a 1915(c) waiver (described below). Under this authority, states must offer a set of HCBS to individuals who are not at an institutional level of care and may also offer HCBS to individuals who have an institutional level of care. This flexibility to offer HCBS prior to an individual having an institutional level of care has allowed many states to offer HCBS to individuals with mental health and substance use disorders. States may target the benefit to specific populations but must offer benefits statewide, and may not cap enrollment or maintain waiting lists. If enrollment exceeds state projections, states may further target the benefits by tightening needs-based eligibility criteria.
- **1915(j):** States can offer self-directed personal assistance services whereby participants can hire individuals capable to performing the assigned tasks—including legally responsible relatives, neighbors, or qualified independent providers—to provide services. Participants manage their own payments for the service and make their own decisions regarding other service provision and management. States may target this option to people already receiving 1915(c) waiver services, cap the number of self-directed personal assistance services program participants, and limit the option to certain geographic areas.
- **1915(k) (Community First Choice):** States can offer HCBS on a level playing field with nursing facility care by redesigning how needs are assessed and care plans are developed. Person-centered HCBS attendant services and supports can be provided to eligible enrollees with increased federal financial support—a maximum six percentage point increase in the federal matching rate for these expenditures. Under this option, which is designed to promote equal access to LTSS, states may not cap enrollment or target the program to certain populations or areas of the state.



### State Plan Option to Require Managed Care Enrollment

- **1932(a):** States may require beneficiaries to receive services through Medicaid managed care under state plan authority in all or some geographic areas. Exceptions apply: states cannot mandate dually eligible beneficiaries, children with special needs, or American Indians to enroll, although these groups may do so voluntarily.

**Waivers:** The federal government can waive certain Medicaid program requirements at a state's request under certain conditions to increase flexibility, expand coverage to certain populations or geographic areas, or cover services not otherwise covered by the state as a state plan benefit.

- **1915(a):** States may institute voluntary managed care through CMS approval of a managed care contract; selective contracting is not permitted. States can use passive enrollment with an opt-out option.
- **1915(c):** States may provide HCBS to targeted groups who meet an institutional care level of need through this waiver authority. States must demonstrate cost neutrality (i.e., the initiative would not cost the federal government more than providing care in an institution) and meet provider standards, among other requirements. States can use these waivers to offer a variety of services including care management, home health aide, habilitation, respite care, supported employment, housing-related supports, and personal care services. States set the eligibility standards for these waiver programs, which include the level of care required (hospital, nursing facility, or Intermediate Care Facilities for individuals with I/DD) and the target group of beneficiaries (e.g., aged, individuals with intellectual disabilities, persons living with AIDS). States also may include other eligibility standards relating to age, condition and/or other factors, cap enrollment and use waiting lists.

**Sources:** Social Security Act Section 1905(a)(24), 42 CFR 440.167; Social Security Act Section 1915(g), 42 CFR 440.169; Social Security Act Section 1945; Social Security Act Section 1915(i), 42 CFR 440.182; Social Security Act Section 1915(j), 42 CFR Part 441, Subpart J; Social Security Act Section 1915(k), 42 CFR Part 441, Subpart K; Social Security Act 1932(a), 42 CFR 438.52; Social Security Act Section 1915(a), 42 CFR 431.54 and 431.55; Social Security Act Section 1915(b), 42 CFR 430.25, 431.54 and 431.55; Social Security Act Section 1915(c), 42 CFR 440.180, 441.300-441.310; 441.350-441.365; Social Security Act Section 1915(d), 42 CFR 431.350-431.365; Social Security Act Section 1115, 42 CFR 431.400-431.428. "Medicaid ACOs: Understanding Different State Approaches." Leavitt Partners. August 14, 2018. Available at: <https://leavittpartners.com/whitepaper/medicaid-acos-understanding-different-state-approaches/>.

- **1915(b)/(c) combined waiver:** 1915(b) waivers permit states to implement a managed care delivery system or otherwise restrict health care provider choice. Combining 1915(b) and 1915(c) waivers allows states to provide a range of LTSS, including both state plan and waiver services, through managed care arrangements. These programs must meet the requirements of both waivers and states must renew each portion of the waiver separately.
- **1115:** This waiver authority allows the Secretary of Health and Human Services to permit states to launch demonstrations that the Secretary determines to promote the objectives of Medicaid, including by reforming delivery systems or serving individuals not otherwise covered by the state's Medicaid program. Many states have used this authority to have managed care organizations provide some or all LTSS in the state. States must demonstrate budget neutrality, meaning that the 1115 waiver cannot cost the federal government more than it would be spending without the waiver.

**State Contracting:** Most states contract with health plans to deliver services to their Medicaid beneficiaries through capitated managed care arrangements, increasingly including older adults and people with disabilities. In some cases, LTSS is carved into these contracts, but in all cases, states can use their contracts to promote coordination of services. As such, states can leverage their managed care contracts to better serve their LTSS populations. More recently, some states are contracting directly with health systems and other providers to coordinate comprehensive services, including LTSS, at the care delivery level. These contracting models seek to hold providers accountable for individuals' total cost of care and quality-based outcomes.

## SECTION II: Rebalancing Medicaid-Financed LTSS: Matching Care Settings to Individuals' Needs

This section identifies strategies that states are using to increase the proportion of LTSS spending devoted to services provided in community settings. Historically, the vast majority of publicly financed LTSS was provided in institutional settings. When Medicaid first began in 1965, there was little in the way of paid home care services. The Medicaid statute reflected this reality, making nursing facility services for people age 21 years and older a mandatory service (meaning it is a service that all state Medicaid programs must cover), while most HCBS—particularly non-clinical benefits, such as case management and personal care—were optional. In addition, both the sources of federal authority under which states could offer HCBS and the level of federal financing available for HCBS were limited.

Today, nursing facility care remains a mandatory service and HCBS continues to be optional, but changes in federal laws dramatically expanded states' abilities to provide care in community-based settings. These changes have been prompted by individual and family preferences, state interest, legal obligations under the ADA for states to provide care in the least restrictive setting, and the relative cost-effectiveness of providing community-based rather than institutional services. The cost issues are compelling: on average, nursing facility care costs are more than \$85,000 per year compared to \$49,000 for a home health aide.<sup>14</sup> While some states worry that increasing access to HCBS will cause more people to seek out community-based services (i.e., “the woodwork effect”), research indicates that while expanding access to HCBS may result in a short-term increase in spending, LTSS spending growth was greater in states with limited HCBS benefits.<sup>15</sup> Another study found that expanded HCBS access did not appear to increase overall Medicaid LTSS spending over time.<sup>16</sup> However, there are a variety of federal options that allow states to expand HCBS incrementally as they assess the fiscal implications of doing so.

For the most part, states have deliberately embraced opportunities to expand HCBS, and there has been a dramatic shift in national Medicaid LTSS utilization and spending from institutional to community-based settings. As of 2015, 47 states and the District of Columbia were utilizing 1915(c) waivers to expand access to HCBS for targeted populations, enrolling more than 1.5 million individuals into 341 distinct waivers.<sup>17,18</sup>

### ▶ Olmstead Influence on LTSS Policy

The U.S. Supreme Court's *Olmstead v. L.C.* decision in 1999 found that under the Americans with Disabilities Act (ADA), children and adults with disabilities have the right to receive services in the most integrated setting appropriate for their needs. In the Medicaid context, this ruling required states to develop formal, comprehensive LTSS policies (“Olmstead” plans) that outline states' strategies and initiatives for expanding access to HCBS over time, ensuring community integration, and complying with the ADA.

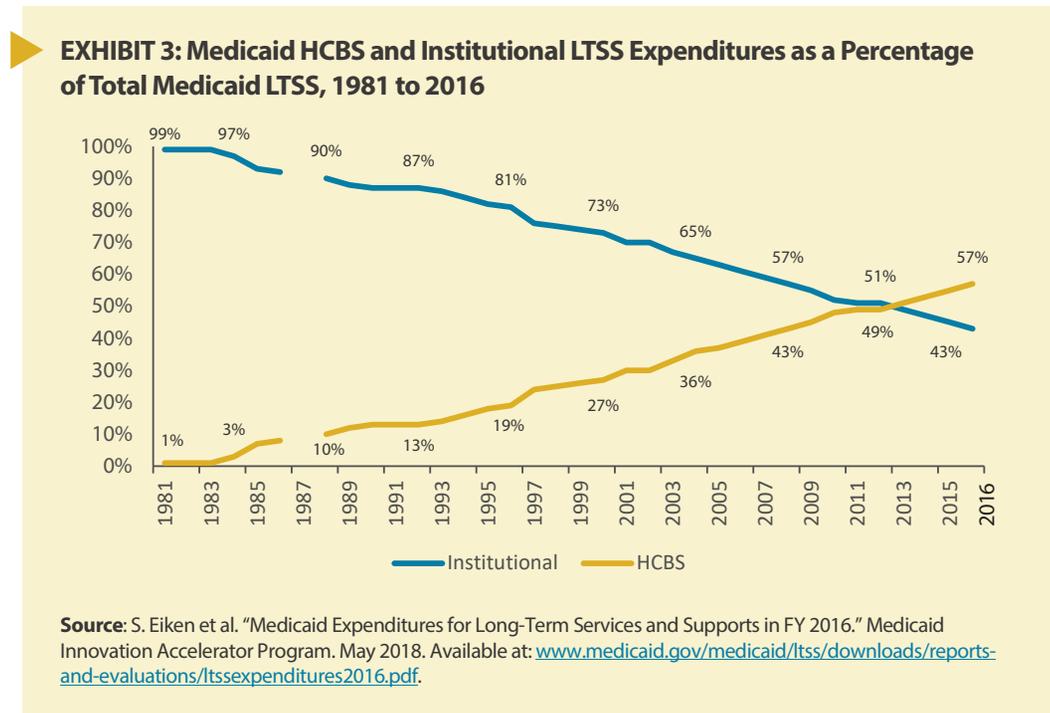


**Source:** CMS. “Olmstead State Medicaid Director Letters. Updates 1-4, 1998 to 2001.” Available at: [www.medicaid.gov/federal-policy-Guidance/index.html](http://www.medicaid.gov/federal-policy-Guidance/index.html).

Additionally, 17 states were utilizing one or more state plan HCBS options (i.e., 1915(i), 1915(j), and 1915(k)),<sup>19</sup> while three states (Arizona, Rhode Island, and Vermont) were using 1115 waivers to expand these services.<sup>20</sup> The most recent data available (2016) show that nationally, 57 percent of Medicaid LTSS spending supports HCBS, up from 18 percent in 1995 (Exhibit 3).

Yet, the proportion of spending for HCBS still varies significantly across states, ranging from a high of 81 percent in Oregon to a low of 27 percent in Mississippi.<sup>21</sup> There also is some evidence of geographic variation suggesting that the proportion of LTSS spending for nursing facility services is greater among people in rural areas than urban areas.<sup>22</sup> HCBS use also varies across populations who use LTSS. Nationally, among people with developmental disabilities, HCBS accounted for 78 percent of LTSS spending, but only 45 percent of spending for programs targeting older adults and people with physical disabilities.<sup>23</sup> As such, there are opportunities across many states to expand access to HCBS and provide care in the LTSS care setting that is most appropriate for an individual’s preferences and care needs.

This section highlights three innovative reform strategies for rebalancing Medicaid-financed LTSS. States interested in advancing rebalancing goals can leverage elements from one or more of these strategies that have been successfully deployed in other states to fundamentally transform their LTSS system. For each strategy, we provide: the impetus, a description, potential implementation mechanisms, results to date, and key lessons. The following table (pages 19-20) provides an overview of this information, and the remainder of the section goes into more detail. The section also provides case studies to illustrate how states have implemented each strategy. Notably, this is not an exhaustive set of strategies or implementation mechanisms, but includes those identified by innovator states as significantly advancing their rebalancing goals. (See [Key Legal Authorities and Other Mechanisms to Advance LTSS Reform](#) on pages 13-14, for a description of specific implementation mechanisms.)



## ► Maryland's Path to Rebalancing

Maryland has engaged in a deliberate and incremental strategy to rebalance LTSS for older adults and individuals with physical disabilities by taking advantage of numerous local, state, and federal tools. In 2004, spurred by the commitment of its consumer advocates, the state implemented the *Money Follows the Individual Accountability Act* to promote HCBS as an alternative to institutional care.

Since 2007, Maryland has received federal Money Follows the Person (MFP) and Balancing Incentive Program (BIP) funding, submitted a 1915(k) Community First Choice (CFC) state plan amendment, and streamlined existing 1915(c) waivers to advance its rebalancing strategy. Maryland's incremental and focused approach has allowed the state to leverage federal funds to accomplish key existing goals and support new ones including: (1) scaling HCBS infrastructure statewide; (2) improving assessment tools; and (3) streamlining and increasing access to services. Using BIP funding, the state expanded HCBS infrastructure by implementing *Maryland Access Points* in partnership with the State Unit on Aging and disability partners at the state's Centers for Independent Living to create streamlined entry points for individuals seeking LTSS.

Maryland also used BIP dollars to implement a uniform standardized assessment with specific tools for different populations to more effectively screen beneficiaries and connect them to needed services. Furthermore, Maryland moved as many services as possible out of its

multiple 1915(c) waivers and into the CFC state plan authority to expand access to these services and receive the CFC enhanced federal match for them—resulting in a 31 percent growth in program enrollment since 2015, while maintaining budget neutrality. In an effort to prevent overutilization and maintain budget neutrality, CFC participants are grouped into one of seven assessment-based budget categories. With BIP funding ended September 30, 2017 and MFP funding ending December 31, 2019, Maryland is now focused on sustainability and shifting from grant funding to federally matching funds under a cost allocation plan amendment requested from CMS to support *Maryland Access Points* activities.

The state acknowledges that leadership and collaboration across agencies, with champions in the state's Department of Health, Department of Aging, and the Department of Housing and Community Development, is critical for securing funding, designing programs and engaging stakeholders.



**Sources:** Interview with Maryland, October 25, 2017.; Case study update from Maryland, September 18, 2018.; Maryland Department of Health and Mental Hygiene. "Money Follows the Individual Accountability Act Report." December 2015. Available at: [http://dlslibrary.state.md.us/publications/Exec/DHMH/HG15-135\(g\)\\_2015.pdf](http://dlslibrary.state.md.us/publications/Exec/DHMH/HG15-135(g)_2015.pdf); and K. Davis, et al. "Designing a Medicare Help at Home Benefit: Lessons from Maryland's Community First Choice Program." The Commonwealth Fund. June 27, 2018, Available at: [www.commonwealthfund.org/publications/issue-briefs/2018/jun/designing-medicare-help-home-benefit-lessons-marylands-community](http://www.commonwealthfund.org/publications/issue-briefs/2018/jun/designing-medicare-help-home-benefit-lessons-marylands-community).

## ► Growth in Self-Directed HCBS

Self-directed HCBS, which enables individuals to choose what services to receive and manage the delivery of those services, has emerged as a growing approach for consumers to access HCBS in many states. As of 2016, there are 253 self-directed Medicaid-funded and Veteran-directed LTSS programs in the U.S., representing an eight percent increase since 2011.\* Enrollment in these programs, which operate in every state and in the District of Columbia, has grown by 43 percent during this time period to over 1 million people. Self-directed services can be offered under fee-for-service or managed care models, and evaluations of MLTSS states show no decrease in enrollment compared to fee-for-service programs.

States can provide enrollees with self-directed HCBS under a 1915(c) Home and Community-Based Services waiver, 1915(i) Home and Community-Based Services State Plan Option, 1915(j) Self-Directed Personal Assistance Services State Plan Option, 1915(k) Community

First Choice State Plan Option or an 1115 waiver. States can authorize a limited set of services to be self-directed, with personal care services the most frequently offered, or offer a broad set of services and goods. All Medicaid-funded, self-direction authorities must provide enrollees with access to a support broker to assist the enrollee in managing their services, and Financial Management Services to help individuals manage their budget authority as they pay for their HCBS. However, these are services that the individual or their designated representatives decide whether and how to use. Some states are seeking to significantly expand their self-directed HCBS program options.



*\*These programs include those authorized through Medicaid State Plan Amendments and waivers.*

**Sources:** CMS. "Self-Directed Services." Available at: [www.medicaid.gov/medicaid/lts/self-directed/index.html](http://www.medicaid.gov/medicaid/lts/self-directed/index.html); Ohio 1915(c) waivers: OH Passport, OH Individual Options, OH Choices, OH Assisted Living, Available at: [www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html](http://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html); M. Watts, and M. Musumeci, "Medicaid Home and Community-Based Services: Results from a 50-State Survey of Enrollment, Spending, and Program Policies." Kaiser Family Foundation, January 2018, Available at: [www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/](http://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/); and M. Edwards-Orr and K. Ujvari. "Taking It to the Next Level: Using Innovative Strategies to Expand Options for Self-Direction." AARP Public Policy Institute, April 2018. Available at: [www.aarp.org/ppi/info-2018/taking-it-to-the-next-level-using-innovative-strategies-to-expand-options-for-self-direction.html](http://www.aarp.org/ppi/info-2018/taking-it-to-the-next-level-using-innovative-strategies-to-expand-options-for-self-direction.html).

## Overview of Rebalancing Strategies

<b>Strategy 1</b> Develop LTSS System Infrastructure to Promote Greater Access to HCBS 	<b>Strategy 2</b> Invest in Programs and Services that Help Nursing Facility Residents Return to and Remain in Their Communities 	<b>Strategy 3</b> Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Medicaid Nursing Facility Utilization 
<b>► Impetus for Strategy</b>		
Expanding HCBS coverage does not automatically assure optimal access to and use of those expanded services. Some states are investing in strategies that enhance LTSS system infrastructure, access points, and workforce.	People living in nursing facilities may prefer and be able to live safely in the community with appropriate services and supports, often at lower cost.	To access Medicaid LTSS, many people must “spend down” their income and assets until they qualify for Medicaid; this is burdensome for individuals and can be costlier than providing some state-funded LTSS at an earlier point in time.
<b>► Description of Strategy</b>		
State investments in: <ul style="list-style-type: none"> <li>■ Easy access to information and referrals for beneficiaries</li> <li>■ Equitable access to LTSS based on standardized eligibility determinations</li> <li>■ Sufficient and well-trained direct care workforce</li> <li>■ Supported informal caregiver workforce</li> <li>■ Development of person-centered care plan</li> </ul>	State investments in: <ul style="list-style-type: none"> <li>■ Transition and tenancy-sustaining services (e.g., transition counselors, housing searches, rental security deposits, and home modifications)</li> <li>■ Affordable housing options</li> </ul>	State focus on providing limited HCBS to individuals who would not otherwise qualify for Medicaid to slow likely future need for more expensive Medicaid LTSS, including institutional services.
<b>► Implementation Mechanisms*</b>		
<ul style="list-style-type: none"> <li>■ Federal funding (for grants or programs like BIP)</li> <li>■ State-only funding</li> <li>■ Private foundation funding</li> <li>■ Section 1115 waiver</li> <li>■ State-based managed care contracting authority</li> <li>■ State regulatory changes</li> <li>■ Pilot programs</li> </ul>	<ul style="list-style-type: none"> <li>■ Federal funding (e.g., MFP, Section 811 Housing and Urban Development funding)</li> <li>■ Tax credits</li> <li>■ Section 1915(c) waiver</li> <li>■ Section 1115 waiver</li> <li>■ State-based managed care contracting authority</li> </ul>	<ul style="list-style-type: none"> <li>■ Section 1115 waiver</li> <li>■ State general funds</li> </ul>
<b>► Results to Date</b>		
<p>States used the \$2.4 billion BIP funding to develop shared information technology systems, uniform assessment tools, workforce investment programs, nursing delegation initiatives, and single entry programs that have greatly expanded access to HCBS throughout the country.</p> <p>However, there are still major gaps and challenges with infrastructure development. Also, many states are focused on sustainability planning now that some of this funding is no longer available.</p>	<p>Investing in nursing facility transitions through MFP, states have transitioned 63,337 individuals from institutional settings and saved an estimated \$204 to \$978 million.</p> <p><b>Texas’</b> MFP-funded behavioral health pilot resulted in 68 percent of participants remaining in the community, saving \$24.5 million in Medicaid funds. In <b>New York</b>, nearly 2,500 people are participating in the state’s nursing facility transition and diversion program, and approximately 500 are receiving a state-funded housing subsidy.</p>	<p><b>Vermont’s</b> waiver allowed the state to expand access to HCBS and serve pre-Medicaid individuals in the setting of their choice, while remaining budget neutral. Overall, satisfaction with the program is very high, but there is a waitlist for the “moderate needs” group that the state continues to address.</p>

<p><b>Strategy 1</b> Develop LTSS System Infrastructure to Promote Greater Access to HCBS</p> 	<p><b>Strategy 2</b> Invest in Programs and Services that Help Nursing Facility Residents Return to and Remain in Their Communities</p> 	<p><b>Strategy 3</b> Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Medicaid Nursing Facility Utilization</p> 
<p>▶ <b>Key Lessons</b></p>		
<ul style="list-style-type: none"> <li>Engage leadership across state agencies</li> <li>Engage all relevant stakeholders early and build lasting partnerships</li> <li>Collect program data and ensure staff capacity to analyze and monitor its impact</li> <li>Leverage existing LTSS infrastructure</li> <li>Take a long view</li> </ul>	<ul style="list-style-type: none"> <li>Coordinate with state and local housing authorities and private developers to secure affordable housing</li> <li>Separate waiver authorities that guide nursing facility transitions from those that offer housing support to maintain cost neutrality</li> <li>Analyze data to identify opportunities to target programs to specific populations</li> <li>Work collaboratively with diverse stakeholders, including beneficiaries and non-traditional partners</li> <li>Provide transition services, which are just as important as tenancy-sustaining services</li> <li>Adjust and adapt as the program or reform continues</li> <li>Memorialize major programmatic requirements, but maintain flexibility for evolving practices</li> </ul>	<ul style="list-style-type: none"> <li>Engage providers, beneficiaries, legislators, and other stakeholders early and often</li> <li>Use Medicare and Medicaid data to analyze the nursing facility population and inform program planning</li> <li>Educate medical providers about person-centered care to help them understand the impact of HCBS on physical health and well-being</li> <li>Leverage existing community partners, but expand social networks</li> </ul>
<p>▶ <b>Case Studies</b></p>		
<ul style="list-style-type: none"> <li><b>Massachusetts</b> Creates a One-Stop Information and Referral Network and Expands Access to HCBS</li> <li><b>California’s</b> Implementation of Paid Family Leave to Support Family LTSS Caregivers</li> <li><b>New York</b> Develops a Uniform Assessment System to Standardize HCBS Needs Assessments</li> <li><b>New York</b> Uses 1115 Waiver Funds to Recruit, Retrain and Retain Its Long-Term Care Direct Care Workers</li> <li><b>New Jersey’s</b> Nurse Delegation Pilot Increases Access to HCBS</li> <li><b>Tennessee’s</b> LTSS Workforce Strategy</li> </ul>	<ul style="list-style-type: none"> <li><b>New York’s</b> 1915(c) Waiver Seeks to Divert and Transition Medicaid Enrollees from Nursing Facilities</li> <li><b>Texas’</b> MFP Behavioral Health Pilot Enhances Benefits for People with Serious Mental Illness to Support Their Community Transitions</li> <li><b>Arizona and Texas</b> Leverage Federal and State Funding and Private Sector Development to Provide Housing Supports to Individuals with Disabilities Exiting Institutions</li> <li><b>Tennessee’s</b> Nursing Facility to Community Transition</li> </ul>	<ul style="list-style-type: none"> <li><b>Washington</b> Uses its 1115 Waiver to Expand Access to Services for Individuals At-Risk of Needing LTSS</li> <li><b>Vermont’s</b> Choices for Care Waiver Expands HCBS to People At-Risk of Needing Intensive LTSS</li> </ul>

\* The implementation mechanisms listed here correspond to those used by states whose reform efforts have been highlighted in this toolkit; this is not an exhaustive list of all possible implementation mechanisms for states.

## Rebalancing Strategy 1: Develop the LTSS System Infrastructure to Promote Greater Access to HCBS



### ► Impetus for Strategy

Fiscal pressures and increasing demand for consumer-preferred, lower cost HCBS have driven and continue to drive states to invest in LTSS system changes that promote rebalancing, better predict LTSS costs, and ensure greater access to HCBS. States have steadily used waivers and more recently, new and expanded state plan options to achieve this—increasing HCBS offerings and access to these services over time. However, implementing new programs does not immediately ensure that LTSS needs are met and HCBS are expanded. States also must ensure that their LTSS system infrastructure has adequate capacity to actually support timely access to services for individuals in the community who are eligible for these LTSS. Increasingly states are recognizing the need to have:

1. A workforce with sufficient capacity to deliver HCBS;
2. A streamlined way for beneficiaries to access information about services, as well as the services themselves;
3. A uniform way for providers to assess beneficiaries' LTSS needs to ensure equitable access;
4. The ability to respond to beneficiary problems and complaints;
5. The ability to define and measure outcomes; and
6. A communication and education vehicle to connect with stakeholders and providers on an ongoing basis.

Additionally, states' efforts to expand LTSS service offerings and to make corresponding improvements to the structural aspects of LTSS systems are influenced by:

1. A state's history and commitment to delivering HCBS;
2. The availability of federal funding and new flexibilities to target services; and
3. The impact of advocates who may push the state to expand services, or providers who, when engaged, can champion LTSS reform efforts.





## ▶ Expiring Federal Funding Opportunities: Money Follows the Person and Balancing Incentive Program

Many states leveraged the federally-funded **Money Follows the Person** (MFP) demonstration and the **Balancing Incentive Program** (BIP) to significantly advance their rebalancing reforms. The programmatic changes that both opportunities promoted can serve as a template for other states thinking about rebalancing reforms. States will need to be creative to identify new funding to replace these sources and may even need to mix and match various federal, state, local, private, and foundation sources—and likely utilize 1115 waiver flexibility—to support rebalancing initiatives.

**MFP:** This national demonstration helped Medicaid enrollees transition from facility-based to community-based care, and may save money by shifting spending from more costly institutional care to potentially less costly HCBS. MFP program goals include: (1) increasing HCBS use and reducing institutionally-based service use; (2) eliminating barriers that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice; (3) strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and (4) putting procedures in place for quality assurance and improvement of HCBS.

**BIP:** Created under the ACA, BIP aimed to improve access to Medicaid LTSS in community settings by giving states an increased federal matching rate for community-based services. Eighteen states received BIP funding and were required to: (1) implement a “no wrong door” system, core standardized assessment, and conflict-free case management; (2) use the funds to improve access to LTSS in the community; and (3) spend a certain percentage of total LTSS funds on community LTSS. Based on states’ reports, the no wrong door system had the largest impact on access to community LTSS by increasing

entry points, streamlining the referral process, and improving awareness of services.

Under BIP, the 18 states received a total of \$2.4 billion in grant funding to increase access to new or expanded services and infrastructure. Since 2007, 43 states and the District of Columbia have received over \$4 billion in MFP funding. Although funding for MFP was recently extended in January 2019 for one year, the program has been dependent on temporary extensions and states have been looking to implement sustainability initiatives within their programs to prepare for potential program ending to maintain the gains they have achieved in improving their community-based LTSS infrastructure.

State MFP sustainability include efforts to continue to fund dedicated transition support staff along with MFP-like services. Several states are working to transfer staff currently funded by MFP into state-funded positions, which is crucial to maintaining transition efforts. States are also amending HCBS benefit design to include transition case management and housing supports via ongoing waiver programs (e.g., 1115 and/or 1915(c) waivers). A few states are leveraging comprehensive MLTSS programs to continue MFP activities, working with MLTSS health plans to ensure plans are dedicating care management resources to continue transition efforts and deliver transition case management supports. Some states have contract requirements that advance a greater focus on affordable housing and development of new housing partnerships at the health plan level. States can also examine flexibilities in newer HCBS authorities, such as CFC, as an option to fund pre-transition services essential to supporting individuals return to community housing.

**Sources:** 93.791 *Money Follows the Person Rebalancing Demonstration*. Section 2403, 2010 Patient Protection and Affordable Care Act. 2010; 93.778 *State Balancing Incentive Payments Program*. Section 10202 Patient Protection and Affordable Care Act. 2010; Texas Health and Human Services. “Money Follows the Person Demonstration Project.” Available at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project>; CMS. “Balancing Incentive Program.” Available at: [www.medicare.gov/medicaid/ltss/balancing/incentive/index.html](http://www.medicare.gov/medicaid/ltss/balancing/incentive/index.html); Mission Analytics Group and New Editions Consulting, Inc. “State Reflections and Recommendations, Balancing Incentive Program.” February 2016. Available at: [www.medicare.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf](http://www.medicare.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf); The Balancing Incentive Program. “Balancing Incentive Program, Summary Report.” August 2015. Available at: [www.balancingincentiveprogram.org/sites/default/files/BIP\\_Summary\\_Report\\_8\\_2015.pdf](http://www.balancingincentiveprogram.org/sites/default/files/BIP_Summary_Report_8_2015.pdf); Mathematica Policy Research “Money Follows the Person 2015 Annual Evaluation Report.” May 2017. Available at: [www.medicare.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf](http://www.medicare.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf); analysis of four state MFP sustainability plans: Louisiana Department of Health and Hospitals. “MFP Sustainability Plan.” March 2015. Available at: <http://laddc.org/files/Louisiana'sSustainabilityPlanMFP.pdf>; Vermont Department of Disabilities, Aging, and Independent Living. “Vermont Money Follows the Person Sustainability Plan.” December 2017. Available at: [https://dail.vermont.gov/sites/dail/files/documents/VT\\_MFP\\_Sustainability\\_Plan\\_02052018.pdf](https://dail.vermont.gov/sites/dail/files/documents/VT_MFP_Sustainability_Plan_02052018.pdf); New York Department of Health. “New York State Money Follows the Person Rebalancing Demonstration.” October 2017. Available at: [www.health.ny.gov/health\\_care/medicaid/redesign/2016/docs/mfp\\_sustainability\\_plan.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/2016/docs/mfp_sustainability_plan.pdf); “Massachusetts Money Follows the Person Demonstration Sustainability Plan.” April 2015. Available at: <https://www.mass.gov/files/documents/2016/09/sa/mfp-ma-sustainability-plan-posted-summary.pdf>; and “H.R.259 - Medicaid Extenders Act of 2019.” 116th Congress. Available at: [www.congress.gov/bill/116th-congress/house-bill/259/text](http://www.congress.gov/bill/116th-congress/house-bill/259/text).



## ► Strategy Description

States have focused LTSS infrastructure development on a number of key areas, leveraging BIP’s funding opportunities and program requirements improve their LTSS infrastructure. These areas include: (1) creating a “no wrong door” single entry point to the LTSS system to streamline the maze of agencies, organizations and eligibility requirements for individuals and increase awareness and information about options (e.g., Massachusetts and Maryland); (2) implementing a uniform assessment tool to assess HCBS eligibility based on clinical and functional needs so that all eligible individuals are assessed in a comprehensive manner using the same standard (e.g., New York); and (3) implementing systems to require and support person-centered care plans driven by individuals’ needs, goals and preferences rather than care coordinators’ preferences (e.g., Massachusetts).

In addition to developing new infrastructure and tools, states also are building capacity among their formal and informal workforce to ensure a sufficient number of trained and qualified workers in the community-based system to provide needed care (e.g., New York, New Jersey, California, Washington, and Tennessee).

Although not a topic of discussion in this toolkit, several states and health plans are investing in technology to improve the reach of the LTSS workforce, such as tablet-based technology to support communication between care coordinators, family caregivers and direct care workers, remote monitoring systems, and Electronic Visit Verification systems.

## ► Implementation Mechanisms

Mechanisms to support development of HCBS infrastructure include both financial and regulatory options. Several states made financial investments in system infrastructure through the use of: (1) federal funds (e.g., BIP in Massachusetts and Maryland); (2) state funds (e.g., \$5 million in New York for its standardized assessment tool), including state bond funding; and (3) private grants (e.g., Robert Wood Johnson Foundation funding for New Jersey’s nursing delegation pilot).

Though there is no new BIP funding available for states, states’ BIP experiences provide relevant templates in the event that the federal government appropriates future funding or states are able to leverage other funding sources to support similar goals and efforts, including private foundation grants and state appropriations. Other states have used federal and state authority to launch reforms in these areas, including: (1) 1115 waiver authority to retrain the LTSS workforce (e.g., New York); and (2) changes to state regulations and nursing practices to support workforce development and capacity efforts (e.g., New Jersey and California).<sup>24</sup> As New Jersey did with its nursing delegation initiative, states also can use pilot programs to test initial concepts and gain support to fund future reform efforts.



## ► Results to Date

According to a February 2016 evaluation of BIP-funded states, of the three required BIP structural changes, implementing a single entry point system for access to community LTSS is expected to result in the greatest impact on access to services.<sup>25</sup> This no wrong door system increases entry points to the LTSS system for individuals (i.e., physical locations, websites, and toll-free numbers), streamlines the information and referral process for services, and increases overall awareness of the available community LTSS options.<sup>26</sup> The same evaluation found that only nine of 18 states that responded reported that implementing a uniform assessment tool significantly improved the state’s ability to conduct accurate assessments and improve care plans, though states’ responses largely varied based on what assessment infrastructure was already in place.<sup>27</sup>

For instance, New York reported limited impact because efforts to create a uniform assessment tool were already underway, though the state did note that BIP funding helped expedite the tool’s automation.<sup>28</sup> The BIP evaluation also found that many states had already introduced conflict-free case management, though some states like New Jersey reported that BIP funding prompted the state to include conflict-free language in its managed care contracts.<sup>29</sup> Results related to workforce investment are difficult to measure and limited as most states are just beginning these efforts. New Jersey’s nursing delegation pilot led it to revise its nursing regulations and improved quality of life for pilot program participants—although nursing delegation is not widely used within the state. Despite some strides, most states still have considerable needs for investments in LTSS infrastructure, particularly for building beneficiary awareness, ensuring equitable access to services across populations, recruiting and retaining the direct care workforce, and supporting overburdened and overwhelmed informal caregivers.

## ► Key Lessons

- **Engage leadership across state agencies.** Gubernatorial or executive support and direction is crucial to moving reform efforts forward, building relationships across agencies, and engendering support for new program or system changes. Maryland identified that having the support of its Secretary of Health and Mental Hygiene, Governor’s office, and Medicaid director was instrumental to advancing its rebalancing efforts. More broadly, states reported that one of the key impacts of their LTSS system redesign work was to increase coordination and collaboration across often siloed state agencies, and strong leadership was essential to pushing rebalancing initiatives forward.<sup>30</sup> Notably, New York reported that the departure of its uniform assessment tool’s administrative champion and other staffing changes slowed momentum for rolling out the tool across programs, demonstrating how critical state leadership is to strategy design and execution.
- **Engage all relevant stakeholders early and build lasting partnerships.** All states interviewed identified the importance of stakeholder engagement and buy-in, particularly among beneficiaries and their advocates, during all phases of reform—design, implementation and ongoing monitoring. New Jersey noted the importance of gaining support from the executive director and board members of the New Jersey Board of Nursing to promote nursing delegation efforts, as well as ensuring attorneys within in the Department of Law and Public Safety, which houses the Board of Nursing, understood

the program’s intent. New Jersey also developed an advisory council that included provider representatives—such as home care workers, hospital associations, and experts in nursing delegation—to assist with problem solving.<sup>31</sup> Tennessee echoed the importance of engaging stakeholders early and often, using stakeholder feedback to drive initiatives and identifying key areas of the process for stakeholders to own. Not only can meaningful and lasting partnerships help advance a state’s strategy, but also they can prevent potential challenges by providing early warnings about implementation and transition issues.

- **Collect program data and ensure staff capacity to analyze and monitor its impact.** States identified the importance of measuring and analyzing program data and the consequences of not having the necessary staff resources to do so. Massachusetts, having learned from past experiences, suggested ensuring data collection strategies are in place prior to program launch and that strategies are consistently designed and enforced across related programs. Key program measures include access to services, beneficiary experience, and outcome measures that assess beneficiaries’ satisfaction. New York highlighted a challenge with implementation of its uniform assessment tool, noting that it has not had sufficient staff resources to analyze the data collected from the tool to inform policymaking. It suggested that other states implementing a similar model make staff resources available to meaningfully analyze and utilize the information that is collected from their assessment tools.
- **Leverage existing LTSS infrastructure.** To ensure efficient use of existing capabilities and reduce duplication, it is helpful to have a clear understanding of the state’s existing LTSS infrastructure landscape at the outset to leverage existing funding and systems wherever possible. For instance, in Texas, the state used existing workforce capacity (i.e., community transition teams) to understand regional institutionalization trends, including where the greatest community transition needs were and to work with relocation contractors on housing issues.
- **Take a long view.** Overwhelmingly, state officials reflected on the long-term commitment needed to develop and support LTSS infrastructure. As New York noted, having state leadership at the forefront of these efforts is critical to maintaining momentum, but so too is a robust sustainability plan and funding source after federal funding runs out (e.g., Massachusetts has developed a sustainability plan for each of the ongoing programs which received BIP funding). Many states, including Tennessee, secured planning funds using 1115 waivers, BIP planning grants, and CMS Center for Medicare and Medicaid Innovation grants to create and sustain cross-agency meeting structures to deliberate on the design, implementation, and ongoing operation of their LTSS system reforms. Looking ahead to sustainability planning, states may be able to leverage enhanced federal funding for eligibility and enrollment systems to reduce the cost of information technology system development and improve sustainability.





## ► Case Studies

### **Massachusetts Creates a One-Stop Information and Referral Network and Expands Access to HCBS.**

Massachusetts has a long history of prioritizing “community-first” LTSS, and has provided a generous scope of community-based LTSS benefits under its Medicaid state plan and through ten HCBS waivers. In state FY 2017, 74 percent of MassHealth LTSS spending was for community-based services, up from 44.8 percent in 2009.<sup>32,33</sup>

Massachusetts embarked on several efforts to further expand the availability of services to people in need of LTSS, and continues to improve the structural aspects of its LTSS system. In April 2014, the state received \$135 million in BIP funding. In addition to expanding access to HCBS—specifically for children under age nine with autism—Massachusetts also used the funding to: (1) expand choice counseling through the state’s Aging and Disability Resource Consortia (ADRCs); (2) improve eligibility assistance through co-location of Medicaid eligibility counselors and ADRCs; (3) support training of direct care workers; and (4) develop and raise awareness of the MassOptions information and referral website and call center.<sup>34</sup>

To help connect and coordinate the entire LTSS system—including 120 Councils on Aging, 11 ADRCs, 26 Aging Services Access Points, 11 Independent Living Centers, and multiple state agencies involved in coordinating and delivering LTSS—the Massachusetts Executive Office of Health and Human Services developed MassOptions, a website and call center that serves as a free resource for individuals (and their family members or caregivers) seeking information on LTSS. This single access point provides information about and connections to community services and supports, including caregiver support services, day services, financial assistance services, and housing, among many others. Individuals (or their families and caregivers) can communicate directly by phone, email, or online chat with trained specialists who can assess individuals’ needs and make a “warm transfer” to an expert (e.g., an Independent Living Center or Aging Services Access Point) to minimize the frustration of calling multiple agencies and navigating various networks. MassOptions’ phone line and online chat features are available 8 am to 8 pm, seven days a week. The website, available 24 hours a day, seven days a week, provides a referral form that directs an individual to an agency or organization in their community that can best meet his or her needs. Individuals can also request a “call back” and a trained specialist will respond within 24 hours.

**New York Develops Uniform Assessment System to Standardize HCBS Needs Assessments.** In the 2008-2009 state fiscal year budget, New York State Department of Health (NYSDOH) secured a \$5 million state appropriation to develop its uniform assessment system (UAS-NY). Using a uniform data set, NYSDOH’s goal was to standardize and automate a comprehensive assessment for its home- and community-based programs. The NYSDOH procured a vendor to build the UAS-NY to support development activities: (1) first releasing a request for information to inform tool development; (2) then releasing a request for proposals to select a tool; and (3) ultimately, field testing the tool. The state selected the interRAI suite of assessment instruments as the basis for the tool. Using a standardized tool increases reliability and improves consistency of the assessment processes facilitating more equitable access to programs and services and eliminating duplication.



It took the state approximately three years to rollout the system statewide to all the different programs. Today, the tool is used in the state's mainstream managed care, MLTSS, and certain fee-for-service and adult waiver programs, including Traumatic Brain Injury and Nursing Home Transition and Diversion. The state seeks to expand the use of the tool for use in state policy and service planning.

Some challenges noted in the initial launch and continued operation of the UAS-NY include maintaining NYSDOH's focus and resources for the tool amid staffing changes, including loss of administrative champions and competing state agency priorities. Additionally, NYSDOH has experienced difficulty with acquiring the resources for comprehensive analysis of data collected, restricting its ability to use the data to inform policymaking.

### ▶ Using 1915(c) Waivers to Support Family Caregivers

Informal caregivers provide the majority of LTSS in the United States and experience tremendous physical, emotional, and financial stress in doing so. Yet, their numbers are dwindling as the average family size decreases, relatives are more geographically dispersed, and more women, who typically serve as primary caregivers, are in the workforce. States are recognizing the importance of developing systems to support existing and future caregivers. In a recent AARP survey, 15 states reported including a family caregiver assessment as part of their 1915(c) waiver programs. These assessments are intended to connect informal caregivers to local support services in their communities based on their identified needs. In addition, some states, such as Washington, have implemented specific programs for unpaid caregivers who are caring for a person receiving Medicaid LTSS.

In addition to receiving respite care and other services through the state HCBS waiver, caregivers through the national Family Caregiving Support Program receive service information and assistance, caregiver educational programs, support groups, and referral to other community service programs. Some states with MLTSS programs have built these initiatives into their health plan contract requirements, to more effectively and consistently provide these supports to all family caregivers.



**Source:** AARP Public Policy Institute. "Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home- and Community-Based Service Waiver Programs." December 2013. Available at: [www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf); and AARP Public Policy Institute. "Emerging Innovations in Managed Long-Term Services and Supports for Family Caregivers." November 2017. Available at: [www.longtermcarecard.org/~/\\_/media/Microsite/Files/2017/2017%20Scorecard/AARP1202\\_EI\\_EmerInnovationLTSS\\_Oct31v2.pdf](http://www.longtermcarecard.org/~/_/media/Microsite/Files/2017/2017%20Scorecard/AARP1202_EI_EmerInnovationLTSS_Oct31v2.pdf).

### New York Uses 1115 Waiver Funds to Recruit, Retrain and Retain Its Long-Term Care Direct Care Workers.

In April 2014, CMS approved New York's Medicaid Redesign Team (MRT) amendment to the state's 1115 waiver, making \$245 million available through March 2020 for initiatives to retrain, recruit, and retain direct care workers in the long-term health care sector. This initiative, referred to as the "Workforce Investment Program," was implemented in early 2018.

The NYSDOH requires its managed long-term care plans to contract with NYSDOH-designated workforce training centers (Long Term Care Workforce Investment Organizations, [LTC WIOs]) to: (1) invest in initiatives to attract, recruit and retain long-term care workers; (2) develop plans to place these workers in medically underserved communities; (3) analyze the changing



training and employment needs among workers served by the centers; (4) seek stakeholder input and engagement; and (5) support the expansion of home and respite care.

In October 2017, NYSDOH released its LTC WIO application and launched the process of designating LTC WIOs that met the state's minimum criteria. NYSDOH distributes waiver funds to its managed long-term care plans, which, in turn, provide payments to the LTC WIOs for delivering workforce development initiatives that provide training, and support recruitment and retention efforts to address the needs of plan, providers and healthcare workers in long-term care sector.<sup>35</sup>

### ▶ Direct Care Workforce: The Need for Better Wages and Training

The direct care workforce is poorly paid with home health workers averaging just \$10 to \$13 per hour. The LTSS home care workforce experiences a 45 to 66 percent annual turnover rate, with nearly 25 percent of nursing assistants and home health aides reporting actively looking for another job. Private home care aides report one of the highest workforce injury and illness rates of all occupations, while home health aides experience a higher rate than the national average. Both increased pay and better training are needed to address the high turnover among the direct care workforce and to ensure sufficient numbers of workers to meet the projected demand for HCBS.

States are starting to take action. Massachusetts used BIP funding to set an enhanced minimum wage standard, increasing home care wages by five percent. In New York, the 1199 SEIU health care workers union joined the *Fight for \$15*, a national movement to increase the minimum wage to \$15 an hour. Additionally, 80,000 unionized city home health aides are among those who are benefiting from legislation that

Governor Cuomo signed in April 2016 enacting a statewide \$15 minimum wage plan. In July 2018, Vermont finalized a Collective Bargaining Agreement with AFSCME, guaranteeing a minimum wage to Independent Direct Support Workers, who provide HCBS to LTSS participants who self-direct their services. In 2017, Mississippi and Montana similarly increased payment rates to direct care workers and provider agencies that employ them to attract and retain these workers, targeting provider recruitment in rural areas of the state. Beginning in 2017, all independent care workers in Washington earn at least \$15 an hour, and will receive a raise every six months for the following three years.<sup>36</sup>



**Sources:** "2017 Home Care Benchmarking Study." Home Care Association of America. April 25, 2017. Available at: <https://benchmarking.homecarepulse.com/>; "Personal and Home Care Aide State Training (PHCAST) Demonstration Program Evaluation: Report to Congress." Department of Health and Human Services Health Resources and Services Administration. July 12, 2016. Available at: [www.hrsa.gov/sites/default/files/about/organization/bureaus/bhw/reportstocongress/phcastreport.pdf](http://www.hrsa.gov/sites/default/files/about/organization/bureaus/bhw/reportstocongress/phcastreport.pdf); "Paying the Price: How Poverty Wages Undermine Home Care in America." Paraprofessionals Health Institute. 2017.; Center on Budget and Policy Priorities. "Medicaid Cuts in House ACA Repeal Bill Would Limit Availability of Home- and Community-Based Services." May 2017. Available at: [www.cbpp.org/sites/default/files/atoms/files/5-18-17health.pdf](http://www.cbpp.org/sites/default/files/atoms/files/5-18-17health.pdf); Mission Analytics Group, Inc. "Innovations in the Balancing Incentive Program: Massachusetts." CMS, February 2017. Available at: [www.medicaid.gov/medicaid/ltss/downloads/balancing-mass-case-study.pdf](http://www.medicaid.gov/medicaid/ltss/downloads/balancing-mass-case-study.pdf); G.A. Otis. "Home health workers join 'Fight for \$15' to increase minimum wage." *Daily News*, April 13, 2015. Available at: [www.nydailynews.com/new-york/exclusive-home-health-workers-join-fight-15-pay-war-article-1.2183024](http://www.nydailynews.com/new-york/exclusive-home-health-workers-join-fight-15-pay-war-article-1.2183024); New York State. "Governor Cuomo Signs \$15 Minimum Wage Plan and 12 Week Paid Family Leave Policy into Law." April 2016. Available at: [www.governor.ny.gov/news/governor-cuomo-signs-15-minimum-wage-plan-and-12-week-paid-family-leave-policy-law](http://www.governor.ny.gov/news/governor-cuomo-signs-15-minimum-wage-plan-and-12-week-paid-family-leave-policy-law); Case study update from Vermont, September 14, 2018.; and Government Accountability Office. "Medicaid Home- And Community-Based Services: Selected States' Program Structures and Challenges Providing Services." October 2018. Available at: [www.gao.gov/products/GAO-18-628](http://www.gao.gov/products/GAO-18-628).



**New Jersey’s Nurse Delegation Pilot Increases Access to HCBS.** As part of its ongoing commitment to serve eligible residents with HCBS, New Jersey has consistently advanced innovative initiatives. Specifically, in the mid-2000s the state looked to implement nursing delegation—the process by which a registered nurse “directs another individual to do something that that person would not normally be allowed to do.”<sup>37</sup> This plan was designed to expand access to HCBS by increasing the availability of the direct care workforce to meet beneficiaries’ needs.

At that time, the New Jersey Nurse Practice Act permitted registered nurses to delegate *some* tasks, such as temperature taking and blood pressure reading, but they were not permitted to delegate medication administration to certified home health aides (CHHA) in home settings. Further, nurses reported that they were generally unaware of their ability to delegate health-related tasks or reticent to do so because of liability concerns. Therefore, from November 1, 2007 to October 30, 2010 the New Jersey Department of Human Services, with permission from the New Jersey Board of Nursing and a \$300,000 grant from the Robert Wood Johnson Foundation, launched the New Jersey Nurse Delegation Pilot to expand the list of delegable health care related tasks among nurses, pilot the delegation of medication administration, and ultimately, increase access to HCBS. Under the voluntary pilot, nurses from 19 agencies trained, supervised, and delegated certain health maintenance tasks, including medication administration, to CHHAs.

The CHHAs were able to provide delegated services only to select Medicaid beneficiaries in a “triad” model that included the nurse, the CHHA, and the individual. Nurses had to meet documentation requirements that demonstrated CHHAs had the ability to provide medication to beneficiaries during training to reduce nurse liability risks. The CHHA’s training was not transferrable, which required them to retrain for each client. An evaluation of the pilot was positive, with high levels of beneficiary satisfaction with the program and no evidence of adverse health outcomes.<sup>38</sup> The pilot established evidence of best practice and provided the necessary policy momentum for the Board of Nursing to change its regulations to permit delegation of medication administration by CHHAs in January 2017.<sup>39</sup>

**Tennessee’s LTSS Workforce Strategy.** As a central component of its Quality Improvement in LTSS (QuILTSS) program, which promotes the delivery of high-quality LTSS through payment reform, Tennessee created a comprehensive LTSS workforce development program. This effort complements the state’s value-based payment strategies for LTSS by aligning the opportunities for direct service worker training and degree attainment with LTSS quality measures and rewarding providers that employ a well-trained workforce.

Prior to QuILTSS’ launch, TennCare—Tennessee’s Medicaid agency—conducted extensive stakeholder engagement activities to identify program elements that have a large reported impact on LTSS quality and beneficiary experience. Having a well-trained, competent, and reliable workforce was one of the highest priorities reported by individuals who use LTSS. The LTSS workforce development program provides targeted training to direct service workers who participate in TennCare, coupled with an educational initiative that creates a new career path for workers to earn credits for a post-secondary certificate and/or degree program.



The curriculum for the workforce development component of the program was developed using CMS' Direct Service Workforce core competencies, and modified based on input from stakeholders and subject matter experts to better align with the state's workforce needs. It will be used in colleges of applied technology and community colleges. The state also plans to embed courses at the high school level to allow students to earn college credits in this field, targeting their recruitment into the industry, while also preparing them to enter the workforce with the competencies they need to be successful. The program includes mentoring, coaching and career planning, and a state-developed registry that will link participants together and track training and educational achievement. The state focused on the development of a career path, as opposed to limited certification opportunities not linked to a degree program, to encourage new workforce entrants and worker retention. Lastly, the program is competency-based, requiring workers to demonstrate learning and capacity outside of a classroom or an online course. As part of implementing the program, TennCare plans to implement an incentive structure that will reward participants with higher compensation as they advance in their completion of courses and the certificate.

Tennessee had a grant from the Robert Wood Johnson Foundation to support initial research and stakeholder engagement for the development of QuILTSS, and is now using a combination of state and federal funding (including the CMS State Innovation Model grant) to support curriculum and infrastructure development. TennCare staff noted that the LTSS workforce development program was bolstered by an overarching state priority to make post-secondary education and other job training more accessible to those who want it. However, the state anticipates that the program will become self-sustaining. TennCare staff is creating a business plan to support additional program components including ongoing curriculum development that is translatable across different settings, the online registry of direct support professionals, and accessible assessment centers to demonstrate competency-based learning.

TennCare also plans to address the direct service workforce shortage by using existing Money Follows the Person (MFP) funds to engage national subject matter experts to develop a workforce survey on direct service worker hiring, retention, and compensation practices to develop and measure improvement efforts over time. Providers will receive incentives to complete the survey, and TennCare will use the data to inform value-based payment strategies. Providers will also receive technical assistance from national subject matter experts on proper data collection and submission, how data analysis can be used to address workforce issues, and workforce recruitment and retention best practices.

## Rebalancing Strategy 2: Invest in Programs and Services that Help Nursing Facility Residents Return to their Communities



### ► Impetus for Strategy

Strong commitment among advocates, the *Olmstead* decision and settlements, as well as states' own recognition of the high rates of institutionalization among LTSS beneficiaries, have spurred states to invest in strategies to support the transition of nursing facility residents to the community. States recognize that to successfully transition a person in need of LTSS from an institutional to a community setting—when appropriate for that individual—requires the availability of and access to sufficient community-based services and an affordable and accessible place to live, a particularly difficult barrier that many states have worked to address. Specific services and supports for individuals returning to the community include: (1) assistance locating available housing, paying security deposits, and making home modifications; (2) an adequate supply of direct service workers; and (3) accessible transportation, in addition to other community programs and services. However, comprehensive statewide resources to support institutional to community-based transitions are often lacking. Transition programs need to be developed, and funding for these resources needs to be identified. Doing so requires considerable advanced planning at the state level.

### ► Strategy Description

Many states have invested in programs that help support transitioning from nursing facilities back to the community. These programs provide individualized care planning and an array of services that allow people to live safely in their community of choice. Prior to transitioning to the community, specially trained counselors meet with individuals living in nursing facilities and their family members, as applicable, to determine their desire to transition to community living and assess their needs to successfully reintegrate to the community. Based on a person-centered plan of care, these counselors make referrals to community-based agencies to assist with their transition and community integration components. In addition to transition supports, states often provide tenancy-sustaining services, such as employment supports and housing-related assistance, to help beneficiaries to remain in the community after they have transitioned out of nursing facilities. Given the diverse needs of people living in nursing facilities, some states like Texas have developed targeted programs for specific populations, such as people with serious mental illness and substance use disorders to make their community re-integration successful.





## ▶ Paid Family Leave Programs Can Be Used to Support Family Caregivers of LTSS Beneficiaries

Four states (California, New Jersey, New York, and Rhode Island) have created paid family leave programs that allow individuals to take paid leave to care for a newborn or ailing family member, including one with LTSS needs. These programs have benefits for both caregivers and consumers of LTSS. Paid family leave not only provides protection for family caregivers from losing their jobs, but also enables people to age in their homes and communities. States determine paid time off amounts based on operational and fiscal decisions, but with more states adopting paid family leave, future evidence may inform the amount of paid time off that is most helpful for LTSS beneficiaries and caregivers.

California was the first state to create such a program in 2002. The program is financed through a payroll tax, which is added to the state's disability insurance

fund with no direct cost to employers. Eligible employees must have paid into the fund and may receive up to 55 percent of their weekly wages up to a maximum benefit (as of 2018, reimbursement will increase to 60 to 70 percent of weekly wages). Workers may take up to six weeks of leave, on an hourly, daily, or weekly basis. In FY 2012-2013, about 13 percent of claims related to care for sick family members.



**Source:** Manatt Health. "Massachusetts Long-Term Services and Supports: Achieving a New Vision for MassHealth." May 2016. Available at: [https://bluecrossmafoundation.org/sites/default/files/download/publication/MassHealth\\_LTSS\\_report\\_FINAL%205.11.16.pdf](https://bluecrossmafoundation.org/sites/default/files/download/publication/MassHealth_LTSS_report_FINAL%205.11.16.pdf); AARP Minnesota. "The Case for Paid Family Leave." October 2016. Available at: <http://states.aarp.org/case-paid-family-leave/>.

## ▶ Implementation Mechanisms

Most states pursuing this strategy used federal funding from the MFP program to transition individuals from institutions into community-based programs while building more effective community-based care.<sup>40</sup> Funding for MFP was recently extended in January 2019 for one year, although states have until December 31, 2021 to spend the funds.<sup>41</sup> This also provides time during which non-MFP states can learn from the investments that MFP encouraged.

States also may use 1915(c) waivers, as New York did for its Nursing Home Transition and Diversion waiver. To support housing efforts, Arizona, Texas and Maryland are among states that have received federal U.S. Department of Housing and Urban Development funding through the Project Rental Assistance (PRA) Section 811 program. Under the PRA program, Texas uses tax credits and other sources of multi-family development capital to incentivize rental housing developers to set aside housing units for people transitioning from institutions to the community.

Increasingly, though not focused exclusively on the LTSS population, managed care plans are devoting resources to helping their enrollees secure housing. Arizona recently issued a new contract with its health plans to require them to assess all their enrollees' housing needs, particularly individuals with an affordable housing need. It also requires the health plans to

network with local housing authorities. Given that states have limited time to use MFP funding, building transition support requirements into Medicaid managed care contracts may become increasingly used to support nursing facility transitions.

## ► Results to Date

As of December 31, 2015, there have been 63,337 MFP-supported transitions and, from 2007 to 2013, MFP transitions achieved an estimated \$204 to \$978 million in total Medicaid savings across 18 states.<sup>42</sup> States are continuing this effort, but nationally the number of transitions under MFP has been relatively modest. This is attributable to the requirement that states first move people out of nursing facilities before receiving the enhanced federal funding, limiting upfront community infrastructure. In addition, it is challenging to find affordable, accessible housing for people who long resided in institutional settings. Furthermore, these numbers do not reflect transitions of individuals residing in nursing facilities for less than 90 days, nor the number of individuals who were diverted from institutional admission as a result of the increased community resources and infrastructure developed under MFP.

It is significant to note that MFP participants consistently reported improvements in their quality of life, particularly related to living arrangements.<sup>43</sup> Since many states' nursing facility transition programs are relatively small and their programs vary, it is not clear that one state's outcomes would be transferrable to another; however, it is worth highlighting the positive impacts that programs have on individuals and the savings potential for states. In Texas, where approximately 500 people have transitioned to the community under the state's MFP-funded behavioral health pilot, 68 percent of all pilot participants and 72 percent of those who had completed the full year of specialized pilot services remained in the community. The state's Medicaid program saved \$24.5 million from the pilot.<sup>44</sup> In New York, nearly 2,500 people are participating in the state's Nursing Home Transition and Diversion waiver program, with about 500 people receiving a state-funded housing subsidy.

## ► Key Lessons

- **Coordinate with state and local housing authorities and private developers to secure affordable housing.** States emphasized the need to work collaboratively across agencies—particularly with state and local housing authorities—as well as with the private sector to secure housing for people exiting institutions. Since locating affordable and accessible housing for people in need of LTSS can be challenging, Arizona's Medicaid agency developed a close working relationship with the state's Department of Housing. The partnership resulted in a variety of affordable housing initiatives including the identification of housing opportunities for specialty populations (e.g., people with physical disabilities). Once housing opportunities are identified, the department coordinates with the Medicaid agency and its health plan contractors to facilitate movement for those in need. Critically, states should be thoughtful about where housing is located. For instance, Texas identified that many developers were seeking tax credits for housing in suburban areas, which is not ideal for people exiting institutions who often rely on public transportation, so the state created incentives for developers to focus on urban areas.



- **Separate waiver authorities that guide nursing facility transitions from those that offer housing support to maintain cost neutrality.** Acknowledging how costly housing support services can be, especially in New York, state officials decided to develop a state-funded housing support program outside of the state’s 1915(c) nursing facility transition waiver. This approach helped the state, which judged the investment in housing to be cost-effective, to prevent the cost of housing supports from inflating the actual costs of providing LTSS and to stay within the waiver’s cost neutrality requirements.
- **Analyze data to identify opportunities to target programs to specific populations.** States can collaborate with partner agencies to identify data on people in nursing facilities to help target nursing facility transition efforts. For instance, Texas, in developing a transition program for people with behavioral health conditions, identified residents who had used the mental health system and had prior discharges from psychiatric institutions into nursing facilities. Analyses like these can inform the state’s understanding of their nursing facility population’s needs and opportunities for policy development or programs targeted at promoting community living.
- **Work collaboratively with diverse stakeholders, including beneficiaries and non-traditional partners.** States should engage a diverse set of stakeholders, including Medicaid beneficiaries in nursing facilities or at-risk of institutionalization in developing nursing facility transition efforts. Texas established the “Promoting Independence Advisory Board” following the 1999 *Olmstead* decision and found its contributions to be very useful. The board continues to advise the state today. Texas also works with university partners to conduct transition related training and provide technical assistance to health plans and providers. Working with non-traditional partners can provide flexibility to states since non-traditional partners often can respond faster than states with their lengthy and involved processes, such as with rulemaking.
- **Provide transition services, which are just as important as tenancy-sustaining services.** States can design and provide transition services, such as assisting with housing searches and paying for rental security deposits, to help individuals prepare for their transition to the community. For Texas this was essential to the success of its behavioral health-focused efforts, and it reflects a general need to be more proactive and thoughtful about service planning and provision to ensure its ultimate success.
- **Adjust and adapt as the program or reform continues.** Engaging in continual programmatic reflection allows the state to identify emerging challenges and address them. Tennessee cautioned that failing to evaluate the program as it is implemented prevents the state from soliciting and incorporating valuable feedback from stakeholders. A constant quality improvement process results in better health outcomes, a better program, and lessons for other states to draw from.



- **Memorialize major programmatic requirements but maintain flexibility for evolving practices.** Texas recommended that states document major program requirements and objectives in clear, measurable terms, but cautioned states not to embed highly detailed information (e.g., evidence-based rehabilitative techniques) into contracts or administrative rules since these practices can evolve and improve over time. Texas further suggests that states recognize centers of excellence in practice, and embed requirements and/or incentives in managed care contracts to work with these centers of excellence to continuously improve practices (e.g., training, fidelity reviews).

## ► Case Studies

### **New York’s 1915(c) Waiver Seeks to Divert and Transition Medicaid Enrollees from Nursing Facilities.**

New York received approval for its 1915(c) Nursing Home Transition and Diversion Medicaid Waiver on July 30, 2007, and began enrolling people in 2008. The impetus for the waiver came from the state legislature in response to advocacy from the disability community. After the legislation passed, the state developed its waiver with stakeholder input and implemented a 5,000 person cap on the program to control costs. The waiver provides an array of services for younger individuals with physical disabilities and older adults, including respite, service coordination, assistive technology, community integration counseling, congregate and home delivered meals, environmental modifications, home and community support services, and community transitional services (e.g., paying for security deposits, moving belongings, furnishings, and setting up utilities). All waiver participants—whether they are transitioning out of nursing facilities or accessing waiver services to remain in the community—have access to the same services, with the exception of community transitional services, which are solely for people transitioning from a nursing facility to a home or apartment in the community.

The state administers the waiver through the state’s DOH, which contracts with nine Regional Resource Development Centers. These centers employ transition specialists called Regional Resource Development Specialists who are responsible for, among other things, meeting with prospective waiver participants and their family members to determine their interest and ability to transition to community-based care. The Regional Resource Development Specialist helps enroll an individual in the waiver, makes referrals to community-based services, and with the support of a service coordinator, connects a waiver participant to providers for service coordination. To address a lack of affordable housing, New York initiated the Nursing Home Transition and Diversion Housing Subsidy program funded with state-only appropriations. DOH contracted with local housing authorities to administer the day-to-day responsibilities of the subsidy program, including executing rental agreements with waiver participants who are referred to the program by their service coordinator and approved by a Regional Resource Development Specialist. As of August 2018, approximately 2,480 people are enrolled in the waiver and, of those, about 530 receive a housing subsidy.





### **Texas' MFP Behavioral Health Pilot Enhances Benefits for People with Serious Mental Illness to Support Their Community Transitions.**

In response to the 1999 *Olmstead* decision, a state executive order directed the Texas Health and Human Services Commission to develop a plan to promote community-based alternatives for people with disabilities to foster independence and provide the opportunity for people to live productive lives in their home and communities.<sup>45</sup> As a result in 2001, Texas pioneered a nursing facility transition program that predates the current MFP program. Through both the state funded program and the MFP program, Texas has transitioned more than 46,000 nursing facility residents to the community. However, after rigorously analyzing state data on those who transitioned and those who remained in nursing facilities, Texas recognized that a significant number of people with serious mental illness and substance use disorders co-occurring with physical health conditions remained in nursing facilities. This was in part because its Medicaid program lacked the necessary specialized services to support this population, whose behavioral health conditions further complicated transition.

In 2008, with funding from the federal MFP demonstration, the Department of State Health Services and Department of Aging and Disability Services partnered to create a MFP Behavioral Health Pilot, integrating mental health and substance abuse services into the existing standard HCBS benefit. Adults who lived in nursing facilities for at least three months, met nursing facility medical criteria, and had a serious mental illness or a behavioral health condition with serious functional impairment were eligible for the pilot. The pilot used cognitive adaptation training to help individuals establish daily routines, build social skills, make environmental modifications, and ultimately, gain increased independence. It also included substance use services such as individual counseling, group therapy and referral to community programs to help individuals maintain sobriety in the community. Critically, the pilot made these services available to participants for up to six months prior to transition (i.e., while the participant was in the nursing facility) and up to one year after community transition. These services were provided in addition to the ongoing HCBS that all participants receive. Over the course of the pilot, additional features were added to address unmet needs, such as enhanced relocation services and limited case management.

As of fall 2017, 454 individuals had transitioned into the community under the pilot, saving the state's Medicaid program \$24.5 million.<sup>46</sup> Sixty-eight percent of all pilot participants and 72 percent of those who had completed the full year of pilot services remained in the community.

As MFP funding ends, Texas has continued supporting the transition of individuals with serious mental illness from nursing facilities to community settings by creating a statewide training and technical assistance program for evidence-based practices, such as cognitive adaptation training, and fostering inclusion of mental health self-direction in the state's managed care system through a performance improvement project.<sup>47</sup>



**Arizona and Texas Leverage Federal and State Funding and Private Sector Development to Provide Housing Supports to Individuals with Disabilities Exiting Institutions.** States recognize that securing affordable, accessible, and integrated housing is one of the most difficult barriers in achieving state rebalancing goals. Both Arizona and Texas are among those recently launching such initiatives to assist individuals to transition from institutions to living at home or in group settings. Both states received grants from the U.S. Department of Housing and Urban Development (HUD) Section 811 Supportive Housing for Persons with Disabilities Project Rental Assistance (PRA) program to fund rental assistance for eligible beneficiaries to live in the community, and they have collaborated across agencies and the private sector to develop additional housing supports.<sup>48</sup>

The Arizona Division of Developmental Disabilities uses HUD Section 811 funding to make affordable housing available to individuals with developmental disabilities. In May 2017, the state announced that \$2.7 million in project-based rental assistance was available for eligible developers and existing properties to create up to 64 housing units for individuals wanting to move from a less integrated setting into their own home, and who were in need of affordable housing.<sup>49</sup> In addition, under its 1115 waiver, Arizona provides assistance for all eligible individuals leaving institutional settings to assist with the provision of independent housing-specific supports, including utility deposits, furniture, and other relevant transition items through its community transition service. Case managers authorize brokers—who are typically providers in the community already offering LTSS to the beneficiaries (e.g., attendant care services)—to assist individuals with developmental disabilities in procuring the support items needed to transition successfully into the community. Notably, the community transition service does not provide rental assistance. Use of this service has been relatively low since only people moving from an institutional setting to an individual home may use it, and not people moving from an institution to group home or group home to individual home. However, from the state’s perspective, it is an important service to promote, even if it only helps a few people each year, because Arizona is constantly looking for ways to advance its rebalancing efforts. Beginning October 1, 2017, Arizona initiated a new contract with its MLTSS plans that includes new requirements to identify and understand their enrollees’ housing needs, and partner with public housing authorities to respond to them.<sup>50</sup>

In Texas, the Section 811 PRA program is administered collaboratively by the Texas Department of Housing and Community Affairs (TDHCA) in partnership with the Texas Health and Human Services Commission and Texas Department of Family and Protective Services. Since 2015, the Department of Housing and Community Affairs has incentivized participation in the program by creating points and threshold incentives for applicants seeking federal tax credits and other multifamily program funds, if they agree to set aside units for the program’s target population (i.e., people with disabilities exiting institutions, people with serious mental illness, and youth and young adults exiting foster care).<sup>51</sup> Section 811 funding subsidizes the rent and utilities in these units, making them affordable to extremely low-income individuals, while additional program rules waive the fees normally charged by properties and reduce security deposits. The Health and Human Services Commission and Department of Family and Protective Services conduct outreach, refer potential tenants, and provide ongoing LTSS on a voluntary basis under Medicaid.



TDHCA also operates Project Access, a program which sets aside state-administered Section 8 housing vouchers for people with disabilities leaving institutions and state psychiatric hospitals. Since demand for vouchers exceeds availability, Texas also makes rental assistance available for up to five years through its HOME Tenant Based Rental Assistance program for people on the Project Access waitlist and other housing assistance programs. By using the HOME program as a bridge, individuals are able to exit institutions while waiting to get off Section 8 or other programs' waiting lists. In September 2018, TDHCA was awarded nearly \$400,000 from HUD to provide 50 vouchers to Project Access households under the Section 811 Mainstream Housing Choice Voucher Program.<sup>52,53</sup> Furthermore, the state uses MFP administrative grant funding and authority to partially fund positions at the Department of Housing and Community Affairs to assist in expanding housing opportunities for individuals with disabilities. MFP demonstration funds also support housing navigators at 22 Aging and Disability Resource Centers who work to increase the inventory of affordable housing for people with disabilities by building relationships with public housing authorities, local housing programs, and private developers.<sup>54</sup>

**Tennessee's Nursing Facility to Community Transition.** Recognizing its long-standing reliance on institutional care for LTSS beneficiaries, Tennessee deliberately focused on increasing access to community-based services during the design and implementation of its Medicaid MLTSS system in 2010, called TennCare CHOICES.<sup>55</sup> The state's HCBS program was operating at the time, but under constrained funding, making it difficult to expand access to HCBS. Additionally, the LTSS system was fragmented, with health plans responsible for physical and behavioral health services and the Area Agencies on Aging and Disability overseeing community-based LTSS. Tennessee aimed to reorganize care delivery for LTSS populations by transitioning LTSS to a capitated managed care system and aligning financial incentives to encourage HCBS utilization.<sup>56</sup>

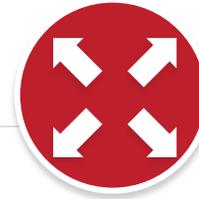
Tennessee designed its new MLTSS program to ensure access to both nursing facility and community services for beneficiaries needing nursing facility level of care by setting the fully integrated capitation payment for these beneficiaries at the same level whether the beneficiary received services in a nursing facility or in the community. This encouraged plans to drive utilization toward the most cost-effective, appropriate service option for their enrollees.<sup>57</sup> Furthermore, Tennessee built in specific requirements and timelines for nursing facility transition planning to incentivize health plans to reach out to beneficiaries in nursing facilities to assist them in choosing the most appropriate care setting for their needs, and check in with them frequently on their community transition wishes. Finally, beneficiaries could receive allowances when they moved from institutional to community-based settings to use for rent, housing deposits, basic furnishings, and other necessary transition costs.<sup>58</sup>

Tennessee subsequently leveraged MFP funding to support its existing 1115 and 1915(c) waiver authorities for HCBS, and to provide financial incentives for health plans around length of community stay, development of institutional alternatives, and other metrics.<sup>59</sup> While enhanced MFP funds connected to the program will phase out over time, Tennessee believes that its health plans will continue to support its rebalancing efforts as the system has already undergone an effective transformation in moving to community-based LTSS through the capitated rate structure.<sup>60</sup>

Tennessee reported significant achievements as a result of these changes, including the elimination of a waiting list for 1915(c) services for older adults and adults with physical disabilities, and a substantial expansion of the number of beneficiaries receiving LTSS in the community. The number of beneficiaries in nursing facilities decreased from over 23,000 to fewer than 17,000, and the number in HCBS increased from 4,700 to more than 13,000 between 2010 and 2015, with an average of nearly 600 transitions a year since the inception of the program.<sup>61</sup> Nearly 2,400 beneficiaries in institutions for at least 90 days have transitioned to HCBS under the state's MFP demonstration as of June 30, 2018, exceeding the state's rebalancing targets.<sup>62</sup>



## Rebalancing Strategy 3: Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Utilization



### ► Impetus for Strategy

While a significant proportion of the population will require LTSS at some point, only a small subset actually plan for this eventuality before the need arises. Instead, most people enter the system during a crisis that is often preceded by an acute health care episode. When this happens, those in need of LTSS are often surprised to learn that Medicare and private insurance coverage do not pay for these services. As a result, many people pay out of pocket for LTSS, and at some point they “spend down” their income and assets on services and qualify for Medicaid. Spending down to meet Medicaid eligibility is complicated and expensive, and can create uncertainty for individuals since coverage for HCBS can vary across states.

Reliance on Medicaid for LTSS by a rapidly aging population also increases state and federal Medicaid costs, even beyond the costs of LTSS; once an individual reaches the spend down threshold, that person becomes eligible for full Medicaid benefits. Thus, states pursuing this strategy are seeking to provide supports to likely future Medicaid beneficiaries before they spend-down to Medicaid eligibility, not only to improve beneficiaries’ quality of life, but also to decrease LTSS spending for both beneficiaries and the state.

### ► Strategy Description

To address these issues, a growing number of states, including Washington and Vermont, are expanding access to HCBS for people at-risk of needing nursing facility care who would otherwise not yet qualify for Medicaid-financed LTSS. The goal is to prevent or delay their needing more intensive and more costly LTSS.<sup>63</sup>

Washington is providing a limited set of Medicaid-financed LTSS benefits—including specialized medical equipment, respite care, and assistance with housework, errands, and home-delivered meals—to individuals age 55 and older who are otherwise at-risk of becoming eligible for Medicaid in order to access LTSS. Similarly, Vermont provides limited Medicaid-financed LTSS benefits—including case management, homemaker, adult day services, and flexible funding to promote independent living (e.g., personal emergency response systems or home modifications)—to pre-Medicaid eligible adults who are assessed as having “moderate needs” to prevent their decline into a higher need category. States use different risk stratification methods for identifying individuals at-risk of nursing facility care who are eligible for the programs.





## ► Implementation Mechanisms

Washington is using an 1115 waiver—one part of a comprehensive 1115 waiver approved by CMS in early 2017—to expand access to HCBS services for “pre-Medicaid” individuals, funded by Medicaid service dollars. Vermont also uses an 1115 waiver to administer its Choices for Care program, within which it expanded access to LTSS for “moderate need” individuals, leveraging 1115 waiver funding in place of state-only dollars to cover the moderate needs group’s services. Under the Choices for Care Moderate Needs Group program, applicants do not need to be eligible for Medicaid, but must have income no greater than 300 percent of the SSI Federal Benefit Rate (FBR) and meet an asset test.<sup>64</sup>

## ► Results to Date

Vermont partnered with UMass Medical School to annually evaluate the Choices for Care program. The most recent evaluation (published May 2015) found that Choices for Care increased access to HCBS and enabled people to be served in the care setting of their choice.<sup>65</sup> The state has been able to provide services without a waitlist to its “high needs” group, but as of January 2018, there were over 800 individuals on the “moderate needs” waitlist, an area on which the state is continuing to focus its efforts while remaining budget neutral. In 2018, Vermont implemented the first round of its National Core Indicators-Aging and Disabilities (NCI-AD) survey, which will measure consumer perception and alignment with federal HCBS regulations. The first results from the survey will be available in January 2019.<sup>66</sup>

Washington’s waiver was only implemented in September 2017, so outcomes will be evaluated in the future. However, as part of the evaluation protocol that was approved by CMS, the state will track both individual and caregiver outcomes for both the new Medicaid Alternative Care and Tailored Supports for Older Adults benefits, described in the Washington case study below. The state also will evaluate impacts to Medicaid expenditures.

## ► Key Lessons

- **Engage providers, beneficiaries, legislators, and other stakeholders early and often.** In both Washington and Vermont, early and frequent stakeholder engagement was key. Washington began stakeholder events two years prior to its 1115 waiver approval, holding at least seven in-person, public meetings related to the Medicaid Alternative Care and Tailored Supports for Older Adults benefits. Washington also recently initiated a service experience team, in which beneficiaries and advocates meet to give input on how to improve programs in a collaborative setting focused specifically on understanding beneficiaries’ perspectives.<sup>67</sup> In Vermont, the Department of Disabilities, Aging and Independent Living worked diligently to gain community providers’ buy-in, assuring them that the existing state funding that it sought to repurpose would be returned in the form of Medicaid covered services. The department also worked closely with its state leadership, who were wary of how the state would manage the transition to more community-based care and how any

savings would be spent. To address this, the state defined program savings in its annual budget bill and permitted savings to be reinvested into HCBS if they exceeded more than one percent of state spending on the waiver.

- **Use Medicare and Medicaid data to analyze the nursing facility population and inform program planning.** States can use multiple data sources to identify the target population at-risk for becoming LTSS users and their likely needs. Data on both Medicaid and Medicare beneficiaries should be included, as many of these individuals are over 65 and might be Medicare beneficiaries whose Medicare utilization could indicate worsening health status. Washington’s Department of Social and Health Services uses a risk management tool to support resource planning and program design that incorporates Medicaid, Medicare, and other social service data from payment and assessment systems to predict which “pre-Medicaid” individuals will have the greatest expenditures. In designing their programs, both Washington and Vermont identified challenges with how to define their respective “at-risk” and “moderate needs” groups—such as defining population parameters, documenting reporting needs and service use, determining whether individuals had access to similar services in other publicly funded programs, and establishing requirements around spousal impoverishment protections.
- **Educate medical providers about person-centered care to help them understand the impact of HCBS on physical health and well-being.** Vermont noted that while conceptually, medical providers were generally in agreement about the need for expanded HCBS, some felt wary about permitting their patients to engage in what they perceived as “riskier” life choices (i.e., living at home or in a congregate setting versus a more controlled institutional setting). The state found it helpful to educate providers about person-centered, person-directed care and independent living philosophies, encouraging them to allow people to make choices about their care needs and futures.
- **Leverage existing community partners, but expand social networks.** Individuals who are at-risk for becoming Medicaid LTSS users may access social support or other health-related or community-based services for different needs. Community-based organizations or other public entities can be helpful resources for information and service delegation, particularly if individuals already have ties to them. Washington leveraged existing community services to support caregiver activities and delegated some services to Area Agencies on Aging, which has been an important support for program implementation. However, Washington noted difficulties with merging the infrastructure, funding structures, and policies of these entities with Medicaid when their program rules, provider eligibility and payment systems, and other administrative processes did not align with Medicaid requirements or systems.





## ► Case Studies

### Washington Uses 1115 Waiver to Expand Access to Services for Individuals At-Risk of Needing LTSS.

Washington State’s Health Care Authority received CMS approval for its 1115 Waiver, Medicaid Transformation Demonstration, on January 9, 2017. In addition to other systemic reforms that the state advanced through this vehicle, the 1115 waiver created two new LTSS benefit packages and one new eligibility category. Driven by expectations that its population age 65 and over will double in the next 25 years and a desire to create more choices for Washington residents, these LTSS reforms expand access to community-based care and supports for individuals who are at-risk of needing LTSS to prevent further deterioration, higher service utilization, and delay or prevent spending down to impoverishment:

- **Medicaid Alternative Care.** This new benefit package provides supports for unpaid caregivers for individuals who are eligible for Medicaid, but not currently using Medicaid-funded LTSS (as well as meeting the age and financial and functional criteria described below). Washington estimates that more than 830,000 people provide unpaid care to relatives and others at a value of nearly five times the overall Medicaid budget. This initiative aims to protect caregiver health and well-being by providing the supports they need to care for loved ones in the home and avoid use of more intensive, expensive services. Services include training, education, support groups, specialized medical equipment, respite, and assistance with housework, errands, and home-delivered meals.
- **Tailored Supports for Older Adults.** This initiative creates a new eligibility category for people “at-risk” of future Medicaid LTSS use who do not meet Medicaid financial eligibility criteria. To be eligible for the “at-risk” category, individuals must be age 55 or older and meet a set of financial and functional criteria (i.e., Nursing Facility Level of Care as determined through an eligibility assessment). They may also seek presumptive eligibility after completion of a prescreening interview. The new set of limited services and supports available is similar to Medicaid Alternative Care supports and serves both unpaid family caregivers and individuals without caregivers in the community.

The state modeled the Medicaid Alternative Care and Tailored Supports for Older Adults benefits after the successful model of care under the state-funded Family Caregiver Support program. The cost per member varies depending on the level of services an individual is receiving, but the state has calculated an upper threshold of \$550/month.

**Vermont’s Choices for Care Waiver Expands HCBS to People At-Risk of Needing Intensive LTSS.** In October 2005, Vermont’s Department of Disabilities, Aging and Independent Living implemented the Choices for Care program—a statewide initiative for older adults and adults with physical disabilities designed to reduce the use of Medicaid institutional services by managing nursing facility admissions and increasing community-based options—under an 1115 waiver to provide equal access to Medicaid LTSS regardless of care setting, a vision shared by stakeholders. Prior to the demonstration, the state only provided LTSS as an entitlement in nursing facilities and very limited HCBS under 1915(c) waivers. At the waiver’s start, only about 30 percent of all participants were receiving care at home or in an institutional care home

(considered an HCBS setting at that time); today, 56 percent of LTSS is provided outside of a nursing facility in home and residential care settings, and the number of individuals served has grown significantly. To help alleviate budget concerns, Vermont negotiated two categories of nursing facility level of care criteria—“highest need” and “high need”—whereby those assessed as “highest need” would always be entitled to LTSS (approximately 75 percent of the Medicaid LTSS population), whereas those assessed as “high need” could be placed on a waitlist if the state encountered budget challenges, allowing the state to maintain some control over its LTSS budget and utilization of services. After engaging in advocacy for several years, Vermont successfully instituted the requirement that the Choices for Care program maintain a one percent budgetary reserve to prevent a high-need waitlist, and any unspent appropriations above that reserve amount must be reinvested into HCBS at year’s end.<sup>68</sup>

In addition to providing LTSS for those most in need of LTSS, Vermont recognized that providing limited Medicaid services to those with “moderate needs” could prevent people from requiring a higher level of care or becoming impoverished to meet financial eligibility rules to qualify for Medicaid. The Department of Disabilities, Aging and Independent Living worked closely with provider partners to whom the state had been paying small grants for homemaker services and adult day services, and repurposed that funding into Medicaid-covered services with mandatory case management to prevent or delay further decline. Services would be available to individuals with incomes at or below 300 percent of the SSI benefit with assets over \$10,000 factored into the income adjustment, and who scored at a “moderate” risk level on the state’s assessment (i.e., do not meet all the Choices for Care clinical criteria for long-term services but are at-risk of institutionalization). To gain provider buy-in and support for the provision of services for at-risk individuals, the state promised partners that it would reinvest the money the providers had been receiving into the limited benefit package for the moderate needs group and reinvest savings to better support providers and entities that provide services for the moderate needs group. Though some participants are Medicaid-eligible, that is not a requirement for people to get these services, as long as they meet the income and asset tests. In 2014, Vermont increased the funding for individuals with moderate needs and added new “flexible funds” services that allow participants to purchase uncovered essential items or to hire a personal caregiver. However, because the moderate needs option is not an entitlement, the state must carefully budget for the services. It does this by setting the budget and permitting providers to serve as many people as possible, placing people on a waitlist if they run out of funding.

Vermont’s LTSS reform efforts are driven by the value the state places on a person’s right to choose where they receive their services and to make informed decisions about their life. That philosophy has led the state to continually find new ways to fund community-based services, such as Adult Family Care and Flexible Choices, and to encourage people to actively participate and be fully-informed about their care planning process.



## SECTION III: Advancing Integration of LTSS with Physical and Behavioral Health Services through Managed Care

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This section identifies strategies that states are using to better coordinate and integrate LTSS, physical health, behavioral health, and social support services for the diverse populations who use Medicaid LTSS, including those eligible for both Medicaid and Medicare (dually eligible beneficiaries) and individuals with intellectual and development disabilities (I/DD). As most Medicaid models that integrate LTSS with other services are built upon managed care arrangements, the first three strategies focus on state program design and contracting approaches that can be implemented by health plans that assume financial risk and accountability for coordinating and delivering comprehensive services to Medicaid LTSS populations. The fourth strategy, *Integrate LTSS Under Provider-Based Initiatives*, describes both long-standing (e.g., Programs of All-Inclusive Care for the Elderly (PACE)) and emerging care delivery models (e.g., Medicaid Accountable Care Organizations (ACOs) and Health Homes), that aim to more effectively coordinate comprehensive services at the provider level. These four strategies may be implemented independently as alternative approaches to reforming LTSS within a state, or in alignment with one another as complementary models.

With more than 80 percent of all Medicaid beneficiaries now enrolled in a managed care program nationwide, CMS, states, and other stakeholders have recognized how managed care may help to: (1) reduce care fragmentation; (2) deliver person-centered and community-based care; (3) improve health outcomes; and (4) reduce overall program costs for LTSS populations.<sup>69</sup> Recognizing the degree to which managed care has expanded, in 2016 CMS significantly revised and modernized the Medicaid managed care regulations, which had not been updated since 2002.<sup>70,71</sup> The updated regulations reference MLTSS for the first time, adding specific expectations for states and protections for LTSS populations related to stakeholder engagement, enrollment supports, care management activities, access to HCBS, and quality measurement. In adopting these rules, CMS signaled that high-performing MLTSS programs would be those that use person-centered enrollment and care planning processes and provide comprehensive, integrated service packages.

Today, 24 states—up from six states in 2009—operate some type of MLTSS program, and this number is growing.<sup>72</sup> Given the heterogeneity of the LTSS population and different state Medicaid program characteristics, states take varying approaches to designing these programs. Some states, like New York, operate MLTSS programs that include only LTSS in a capitated payment to managed care plans (“partially capitated” model), but expect health plans to coordinate beneficiary access to other services, which may be covered by Medicare (for dually eligible beneficiaries) or Medicaid fee-for-service (for Medicaid-only beneficiaries).<sup>73</sup> Recently, more states (e.g., Virginia, Texas and Tennessee, among others) have been developing initiatives to integrate LTSS with physical and behavioral health services (i.e., a “fully integrated” model), driven by expectations that integration will improve care coordination and quality, and align incentives for health plans and providers to deliver services in the most cost-effective and least restrictive setting. Other states, like Massachusetts, have developed initiatives to better manage their fee-for-service LTSS systems, among other initiatives.<sup>74</sup>

States interested in advancing integration goals can learn from other states' experiences in moving to MLTSS and/or provider-based, coordinated care programs. These learning opportunities include best practices around program design and implementation, stakeholder engagement, internal capacity, and program evaluation that can inform other states' strategic approaches and help them avoid pitfalls, such as failing to obtain and maintain stakeholder support or unintentionally creating new siloes and barriers to person-centered care. States have moved cautiously in transitioning LTSS populations from the Medicaid fee-for-service system to capitated managed care programs, in particular, to ensure they address beneficiary and family concerns about protecting access to critical non-medical services and providers. Smaller HCBS providers are also concerned about contracting with managed care organizations, something that many of them have never done before. In addition, some states are seeking to make PACE a new or larger player in their comprehensive LTSS strategies, and potentially grow enrollment by improving effective marketing of the program and preserving it as a beneficiary option. States developing new provider-based models, either as alternatives to managed care or in addition to, could consider adopting elements of the coordinated care model that work well in existing PACE programs.

This section highlights four innovative reform strategies for advancing integration of LTSS with physical and behavioral health services through managed care or provider-based initiatives. For each strategy, we provide the impetus, a description, potential implementation mechanisms, results to date, and key lessons. The following table (pages 47-48) gives an overview of this information, and the remainder of the section goes into more detail. The section also provides case studies to illustrate how states have implemented each strategy. Notably, it is important for states to understand their current LTSS landscape prior to selecting an integration strategy or strategies. Having an understanding of the state's strengths, gaps and barriers, among other areas, is critical to carrying out managed care-led integration strategies. As in Section II, this is not an exhaustive set of strategies or implementation mechanisms, but are those identified by innovator states as significantly advancing their integration goals.

## Overview of Integration Strategies

<b>Strategy 1</b> Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries 	<b>Strategy 2</b> Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care 	<b>Strategy 3</b> Enroll Individuals with I/DD in Managed Care 	<b>Strategy 4</b> Integrate LTSS Under Provider-Based Initiatives 
<b>► Impetus for Strategy</b>			
Aligning Medicare and Medicaid’s financing and delivery of services can improve quality of care, minimize confusion for beneficiaries, and lower costs.	Historically, states have excluded LTSS populations and services from managed care, but now recognize managed care may help reduce fragmentation of care, increase access to community services, and improve quality and lower costs.	The expansion of managed care to special populations has prompted a few states to transition individuals with I/DD from the fee-for-service system into their managed care programs.	Some states are seeking to integrate LTSS through provider-based models that aim to coordinate comprehensive services at the site of care, and hold providers accountable for care coordination, quality performance, and health outcomes.
<b>► Description of Strategy</b>			
States are creating or expanding their MLTSS programs to align them with Medicare managed care products for dually eligible beneficiaries with the goal of streamlining access to services, provider networks, and administrative processes.	Some states are expanding their managed care programs to include LTSS populations and services to create a comprehensive benefit package that includes physical and behavioral health services as well as LTSS under a single capitated rate.	States are taking different approaches to including I/DD populations in managed care, such as: (1) transitioning LTSS benefits into existing managed care programs; (2) creating care coordination entities as a pathway to managed care contracting arrangements; and (3) integrating all LTSS with medical, behavioral, and social services into managed care.	Models for provider-based LTSS integration vary widely, including: (1) providing comprehensive medical and social services, including LTSS, at the care delivery level through PACE; (2) Medicaid ACOs that coordinate and integrate LTSS with other services; and (3) integrating LTSS within the health homes model for dually eligible beneficiaries.
<b>► Implementation Mechanisms*</b>			
<ul style="list-style-type: none"> <li>■ Financial Alignment Initiative**</li> <li>■ Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)</li> <li>■ Aligned MLTSS and D-SNPs through state Medicaid agency contracting authority</li> <li>■ Section 1115 waiver</li> </ul>	<ul style="list-style-type: none"> <li>■ Section 1932 state plan amendment</li> <li>■ Section 1915(a) waiver</li> <li>■ Section 1915(b) waiver</li> <li>■ Section 1915(c) waiver</li> <li>■ Section 1115 waiver</li> </ul>	<ul style="list-style-type: none"> <li>■ Section 1115 waiver</li> <li>■ Section 1945 health home state plan amendment</li> </ul>	<ul style="list-style-type: none"> <li>■ Program of All-Inclusive Care for the Elderly (PACE)</li> <li>■ Section 1115 waiver</li> <li>■ Section 1945 health home state plan amendment</li> </ul>

Continues on page 48 ►

<p><b>Strategy 1</b> Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries</p> 	<p><b>Strategy 2</b> Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care</p> 	<p><b>Strategy 3</b> Enroll Individuals with I/DD in Managed Care</p> 	<p><b>Strategy 4</b> Integrate LTSS Under Provider-Based Initiatives</p> 
<p>► <b>Results to Date</b></p>			
<p>Studies of states' Medicare-Medicaid integrated care initiatives report fewer emergency department admissions, shorter hospital stays, increased preventive care utilization, lower readmission rates, and some evidence of cost savings.</p>	<p>Although limited data are available, a survey of 12 MLTSS state programs found: (1) improvements in quality of life since joining the MLTSS plan; (2) decreases in hospital stays and duration; (3) increases in non-emergency transportation use; (4) decreases in waiting list times; (5) improved access to services; and (6) more reliable budget predictability.</p>	<p>These programs are limited to a few states, and data are preliminary and show mixed results. However, <b>Arizona's</b> I/DD integration has resulted in high client satisfaction, improved health outcomes, and eliminated waitlists for services. <b>New York</b> reports high voluntary enrollment in both of its managed care I/DD initiatives.</p>	<p>Evaluations of <b>PACE</b> have found reduced inpatient hospitalizations, improved care quality and lower mortality rates, although data is inconclusive on cost savings. No results are available on <b>Massachusetts'</b> ACO initiative. An evaluation of <b>Washington's</b> health home program identified \$103.4 million in Medicare savings between 2014 and 2016.</p>
<p>► <b>Key Lessons</b></p>			
<ul style="list-style-type: none"> <li>■ Provide ongoing beneficiary education</li> <li>■ Engage providers in care philosophies and models relevant to these populations</li> <li>■ Collect good data for planning/design, risk adjustment, resource allocation, monitoring, and evaluation purposes</li> <li>■ Be flexible with program requirements</li> <li>■ Set sufficient reimbursement rates</li> </ul>	<ul style="list-style-type: none"> <li>■ Integration requires careful planning, Medicare expertise, and resource commitments</li> <li>■ Consider a phase-in strategy</li> <li>■ Define goals and collect data relevant to achieving those goals from the outset</li> <li>■ Communicate with and educate all stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>■ Promote stakeholder engagement and support</li> <li>■ Transition incrementally</li> <li>■ Utilize data reporting and health information technology in a way that engages and connects individuals and their families to providers</li> </ul>	<ul style="list-style-type: none"> <li>■ Support efforts to enable PACE's growth, and actively monitor to ensure high-quality care</li> <li>■ View PACE as complementary to, not competitive with, MLTSS</li> <li>■ Engage stakeholders early and often</li> <li>■ Use program data to secure funding</li> </ul>
<p>► <b>Case Studies</b></p>			
<ul style="list-style-type: none"> <li>■ <b>Arizona</b> and <b>New Jersey</b> – Two Paths toward Alignment</li> <li>■ Aligning Administrative Processes for <b>Minnesota's</b> Senior Health Options (MSHO) Program Beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>■ <b>Virginia's</b> Commonwealth Coordinated Care Plus Program Integrates All LTSS, Medical, and Behavioral Health Services Under One Program for Medicaid-Only Beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>■ <b>New York</b> Creates a Pathway to Managed Care for I/DD Populations</li> </ul>	<ul style="list-style-type: none"> <li>■ <b>Virginia's</b> PACE Program Is a Key Component of a Comprehensive Integration Strategy</li> <li>■ <b>Massachusetts'</b> 1115 Waiver Extension Creates A System of Medicaid ACOs to Integrate Care for Non-Dually Eligible Individuals</li> <li>■ <b>Washington's</b> Health Home-Based Financial Alignment Initiative Demonstration Coordinates LTSS for its Dually Eligible Population</li> </ul>

\* The implementation mechanisms listed here correspond to those used by states whose reform efforts have been highlighted in this toolkit; this is not an exhaustive list of all possible implementation mechanisms for states.

\*\* The Financial Alignment Initiative is no longer available to states as an integration mechanism because CMS is not approving new demonstrations.

## Integration Strategy 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries



### ► Impetus for Strategy

For dually eligible beneficiaries, Medicare pays for almost all hospital, physician, and prescription drug services, while Medicaid pays for most institutional and community-based LTSS and some behavioral health services. Some services, like skilled nursing facility and home health services, are covered by both Medicare and Medicaid at different points. As a result, Medicare and Medicaid historically have had incentives and opportunities to shift beneficiaries—and costs—between care settings and the two programs. Having two separate insurers for their physical health and LTSS needs also creates tremendous confusion for dually eligible beneficiaries, who traditionally have two or three insurance cards and must navigate two distinct and complex provider delivery systems and grievance and appeals processes, among others. The fragmentation and misaligned incentives between Medicare and Medicaid may lead to discontinuity and duplication of care, poor health outcomes, and stressful beneficiary experiences.

Population characteristics and utilization patterns of the more than 12 million dually eligible beneficiaries support the need for a more coordinated system of care.<sup>75</sup> Dually eligible beneficiaries are more likely than other Medicare beneficiaries to experience chronic, co-morbid physical and mental health conditions—with 68 percent of dually eligible beneficiaries have three or more chronic conditions and 41 percent have at least one mental health diagnosis.<sup>76</sup> They also are more likely than other Medicare beneficiaries to use nursing facility services or other LTSS, and visit the emergency department.<sup>77</sup>

Additionally, although dually eligible beneficiaries represent only 20 percent of Medicare enrollment and 15 percent of Medicaid enrollment, they account for 34 percent and 32 percent of program expenditures respectively.<sup>78</sup> Dually eligible beneficiaries are more than twice as likely to use LTSS compared to other Medicaid beneficiaries, and more than five times as likely compared to other Medicare beneficiaries.<sup>79</sup> Notably, 62 percent of Medicaid expenditures (\$91.8 billion) for dually eligible beneficiaries were for LTSS in 2011.<sup>80</sup> Aligning the financing and delivery of services between Medicare and Medicaid for dually eligible beneficiaries presents an opportunity to improve care and lower costs for this high-need, high-cost population by creating incentives to deliver care in the right settings and at the right time.

### ► Strategy Description

States are building upon their MLTSS programs to align Medicare and Medicaid service delivery for the majority of Medicaid MLTSS beneficiaries who are also Medicare-eligible. While there are a few different approaches to aligning Medicare and Medicaid, the underlying goal is to better coordinate care and streamline access to services, provider networks, and administrative processes across the programs. In addition, states are very interested in sharing any savings resulting from integrated care delivery with federal partners, which could address potential state concerns that increased access to LTSS and



behavioral health interventions that help delay or prevent hospital and emergency department use would only benefit Medicare. However, opportunities for shared savings have been limited to the federal Financial Alignment Initiative (“duals demonstration”) to date.

## A History of Integrating Medicare and Medicaid for Dually Eligible Beneficiaries

States and their federal partners have been actively pursuing a more integrated system of care for dually eligible beneficiaries for over two decades. The Program of All-Inclusive Care for the Elderly (PACE), which became a formal waiver option for states to pursue in 1990, was the first avenue for integrating Medicare and Medicaid for dually eligible beneficiaries. Nearly a decade later, three states participated in a Medicare-Medicaid demonstration program as another early effort to integrate care outside of PACE: Minnesota (Minnesota Senior Health Options or MSHO), Massachusetts (Senior Care Options or SCO), and Wisconsin (Wisconsin Family Care Partnership).

In 2006, these demonstrations transitioned into state contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), which was a new Medicare health plan option that combined Medicare and Medicaid benefits for dually eligible beneficiaries. However, in part because health plans were required to have two separate contracts for Medicare and Medicaid, these arrangements only allowed states to achieve a certain level of integration.

In 2010, the ACA established the Medicare-Medicaid Coordination Office (MMCO) at CMS, also referred to in statute as the “Federal Coordinated Health Care Office”). MMCO launched the federal Financial Alignment Initiative (i.e., “duals demonstrations”) in 2011 to test new approaches to alignment between the Medicare and Medicaid program. In the years since the office was established, it has also supported greater state activity in expanding contracting with Medicare Advantage D-SNPs. States’ managed care contracts with Medicare-Medicaid Plans (via the Financial Alignment Initiative and D-SNPs arrangements have made it easier to align many or some administrative

requirements, care management models, beneficiary materials, covered benefits, and financing. In February 2018, the Bipartisan Budget Act (BBA) preserved D-SNPs as a permanent feature of the Medicare program and created new opportunities to advance integration of care dually eligible beneficiaries. The BBA included significant provisions to more effectively coordinate high-quality care, such as instituting new D-SNP integration-focused requirements (e.g., directing CMS to develop unified grievance and appeals processes and establish new minimum standards of Medicaid integration for D-SNPs), and expanding supplemental and telehealth benefits. The BBA also designates MMCO as the key point of contact for states to address Medicare and Medicaid misalignments and promote integration of D-SNPs and Medicaid managed care moving forward.

Still, there are factors that can affect growing enrollment in these integrated arrangements, including CMS’ prohibition on requiring Medicare beneficiaries to enroll in managed care, challenges with provider resistance to managed care, a need for more beneficiary education about the benefits of integrated care, and challenges with setting rates that reflect a high-need, complex population. States continue to explore creative strategies for best aligning these programs for dually eligible beneficiaries.



**Sources:** “History.” National PACE Association. Available at: <https://www.npaonline.org/pace-you#History>; H.R. 1892. Bipartisan Budget Act of 2018, 115th Congress Public Law No. 115-123. Congress.gov. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/1892/text>; and Integrated Care Resource Center. “Comments Invited on D-SNP provisions of the Bipartisan Budget Act of 2018.” March 2018. Available at: [https://www.integratedcareresourcecenter.com/pdfs/2018\\_03\\_14\\_Comments\\_Invited\\_on\\_D-SNP\\_provisions\\_of\\_the\\_Bipartisan\\_Budget\\_Act\\_of\\_2018.pdf](https://www.integratedcareresourcecenter.com/pdfs/2018_03_14_Comments_Invited_on_D-SNP_provisions_of_the_Bipartisan_Budget_Act_of_2018.pdf).





## ► Implementation Mechanisms

States are aligning Medicare and Medicaid in different ways to better coordinate care delivery for people who are covered by both programs.<sup>81</sup> The most integrated models used by states include the provider-led PACE program and the state-led demonstrations under the Financial Alignment Initiative; however, the opportunity for states to pursue a financial alignment demonstration is now closed. The most promising mechanism available to states at this time to better integrate the delivery of Medicaid benefits with Medicare is through D-SNP contracting, particularly for states developing an MLTSS program. All D-SNPs must have signed contracts with the state Medicaid agency in any state they operate that must meet minimum requirements.<sup>82</sup> However, minimum requirements do not achieve a high level of integration or alignment, and the degree to which states can achieve integrated, aligned care through the D-SNP platform depends on state investments in D-SNP contracting and program oversight. See *Dual Eligible Special Needs Plans and Fully Integrated Models* below.

### ► Dual Eligible Special Needs Plans and Fully Integrated Models

**D-SNPs** are a specialized type of Medicare Advantage managed care plan that offer a higher level of integration than regular Medicare Advantage plans or traditional Medicare fee-for-service.\* D-SNPs enroll dually eligible beneficiaries only, are required to have a care management model uniquely focused on meeting this population’s needs, and must either arrange for or provide enrollees with Medicaid benefits.\*\*

When Congress first authorized them in the Medicare Modernization Act of 2003, D-SNPs were not required to have any formal relationship with state Medicaid agencies. However, to facilitate coordination of Medicare and Medicaid services, the Medicare Improvements for Patients and Providers Act of 2008—as amended by the ACA—required all D-SNPs to have contracts with the states in which they operate. This D-SNP contracting authority can be used by states to control the degree of Medicare-Medicaid integration attained through D-SNPs. To launch an integrated program using D-SNPs, states must have an interest in using their D-SNP contracting authority to improve care for dually eligible individuals, and health plans need to be interested in operating these products within the state.

Historically, D-SNP contracts had to meet minimum requirements for Medicare and Medicaid coordination. On November 1, 2018, CMS published a notice of

proposed new rulemaking for Medicare Advantage and Part D that would implement provisions of the Bipartisan Budget Act of 2018 related to integration of Medicare and Medicaid services and unification of Medicare and Medicaid grievance and appeals procedures by D-SNPs. The proposed regulations include significant changes to the minimum contract requirements for all D-SNPs. To meet these coordination standards once they are established, D-SNPs must:

- Contract with the state to provide Medicaid LTSS and/or Medicaid behavioral health benefits; and/or
- Share information with the state on care transitions, particularly for high-risk individuals. Examples of information sharing could include D-SNP working with the state Medicaid agency to establish a process to share information with the state or the state’s designee (such as a Medicaid managed care organization) on hospital and skilled nursing facility admissions of high-risk individuals who are enrolled in the D-SNP.



\*For details on D-SNPs and FIDE SNPs, and the CMS rules governing them, see the CMS Medicare Managed Care Manual, Chapter 16b (Rev.123, 08-19-16). Available at: [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf). CMS published the [notice of proposed rulemaking](#) in the *Federal Register* on November 1, 2018.

\*\* See Public Law 110-275, Section 164(c)(4) and 42 CFR §422.107.



A proposed rule, which promulgates the D-SNP integration provisions of the Bipartisan Budget Act of 2018, will increase the minimum requirements for coordination to some degree.<sup>83</sup> States will continue to have broad discretion to add additional D-SNP requirements that can increase integration and alignment, such as care coordination, opportunities for aligned enrollment in both Medicare and Medicaid products operated by the same health plan, data sharing and reporting, and other areas that focus on integrating Medicare and Medicaid benefits and administrative processes. States may also be able to work with D-SNPs to influence product design particularly when a state is contracting with the D-SNP to also offer Medicaid benefits. Strategic D-SNP program design could include working with D-SNPs to adopt enrollment mechanisms that can help grow enrollment or assessing opportunities to tailor D-SNP benefit offerings such as cost sharing coverage or supplemental benefit offerings. For the latter, it is notable that the Bipartisan Budget Act of 2018 also expands what scope of supplemental benefits that Medicare Advantage plans can offer to chronically ill enrollees to include non-medical benefits that support functional status, that have a “reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.”<sup>84</sup>

The two D-SNP contracting options with the greatest degree of integration available to states today are:

- 1. Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs):** FIDE SNP, a special type of D-SNP created under the ACA, is a fully integrated Medicare and Medicaid product offered by a single health plan. D-SNPs must meet certain requirements and get CMS approval to achieve FIDE SNP status — namely, the state D-SNP contract must be risk-based and cover specified Medicaid primary, acute care, and LTSS benefits to the extent required by state policy, have an aligned Medicare and Medicaid care management model, and align certain administrative functions. FIDE SNPs that serve a high proportion of frail, high-risk beneficiaries may also be eligible for an additional risk-adjustment payment, similar to PACE, to encourage plans to participate. As of December 2018, there were ten states operating FIDE SNPs, serving 181,844 beneficiaries: Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New York, New Jersey, Tennessee, and Wisconsin.<sup>85</sup> States may require D-SNPs that wish to operate in their state to achieve a FIDE SNP designation. The presence or absence of FIDE SNP status in a state’s integrated program is dictated by many factors, including: (1) current LTSS integration status and goals for increasing integration within the delivery system; (2) desire to contract with D-SNPs to provide Medicaid benefits; and (3) potentially using FIDE-SNPs as a mechanism for promoting alignment into plans that offer all or most benefits. However, as noted below, states that focus on aligning D-SNP and Medicaid health plans as well as robust state contracting and oversight can achieve a high degree of alignment without the FIDE SNP designation.
- 2. Aligned D-SNP:** States may require health plans that offer D-SNPs to offer “companion” Medicaid MLTSS products as a condition of allowing D-SNPs to participate in the state’s market. Similarly, states can also require Medicaid MLTSS health plans to operate a companion D-SNP. States may make enrollment into capitated Medicaid managed care plans mandatory for all or some dually eligible beneficiaries (e.g., LTSS users), but cannot require dually eligible beneficiaries to enroll into Medicare managed care. However, having the option to enroll in the same health plan for both programs provides an opportunity for more integrated care. These models are usually most effective when a high percentage of beneficiaries enroll in the same, aligned health plans. States face challenges when beneficiaries enroll in a D-SNP



sponsored by one entity and a Medicaid plan operated by a competing entity, likely reducing care coordination and increasing administrative complexity. The extent to which these programs are aligned depends on what the state requires in its contracts including whether the state requires that the population eligible for the D-SNP matches the population eligible for the MLTSS program. Some aligned D-SNPs resemble FIDE SNPs with regard to their level of care integration, while others are much less coordinated. Under both FIDE SNP and aligned D-SNP models, state decisions regarding which populations will be enrolled have a significant impact on the level of administrative alignment that can be achieved.

## ► Results to Date

Several evaluations found positive impacts on outcomes from enrollment in integrated care programs. CMS reported statistically significant improvements in certain Healthcare Effectiveness Data and Information Set (HEDIS) measures among individuals participating in D-SNPs.<sup>86</sup> Another study found that dually eligible beneficiaries enrolled in coordinated D-SNPs had fewer emergency department admissions, shorter hospital stays, and increased use of preventative care.<sup>87</sup> A 2012 independent study of Arizona’s D-SNP program compared its 60,000 dually eligible beneficiaries in managed care to those in traditional Medicare fee-for-service and found that the aligned beneficiaries demonstrated a 31 percent decrease in hospitalizations, 43 percent fewer days in the hospital, nine percent lower emergency department use, and 21 percent lower readmission rate.<sup>88</sup> An evaluation of Minnesota Senior Health Options (MSHO) D-SNPs found that MSHO beneficiaries, when compared to dually eligible beneficiaries in a Medicaid-only program, were 48 percent less likely to have a hospital stay, 13 percent more likely to receive HCBS, and six percent less likely to have an emergency department visit. They were also more likely to access primary care services which could support state efforts to improve coordination of care and community integration for LTSS users.<sup>89</sup>

States engaging in Financial Alignment Initiative demonstrations reported early signs of improvements in care coordination, expanded beneficiary safeguards, and preliminary evidence of some cost savings.<sup>90</sup> Notably, early results from Massachusetts’ financial alignment demonstration (“One Care”) found that One Care beneficiaries had a lower 30-day readmission rate compared to non-beneficiaries.<sup>91</sup>

In November 2018, CMS released several new reports with state findings from the Financial Alignment Initiative demonstrations.<sup>92</sup> These reports include the first evaluation reports for the demonstrations in California, Illinois, and Ohio, and the second evaluation reports for the demonstrations in Minnesota and Washington. Despite some limitations, including timeliness (the first year reports cover 2014 to 2015) and variations in the availability of Medicare and Medicaid data, the reports describe some encouraging results. For example, demonstrations in Illinois, Ohio, and Washington showed significant decreases in inpatient utilization of 15 percent, 21 percent and five percent, respectively. Future reports will contain that information as well as additional information on enrollee satisfaction and experience of care.

## ► Key Lessons

- **Provide ongoing, targeted beneficiary education.** States that have implemented managed care-based integrated care models report the importance of clearly articulating information to dually eligible beneficiaries about different enrollment options. Two particularly important areas to emphasize are: (1) the value to individuals who enroll of better care coordination; and (2) individuals have the option to opt out of any Medicare managed care arrangement. Some states, such as California and Massachusetts, have pilot-tested draft marketing materials with beneficiaries before release to ensure they are clear and understandable. Arizona permits D-SNPs to send marketing materials only to those individuals enrolled in the health plan's own Medicaid product to avoid confusion among beneficiaries and to attempt to prevent enrollment into different health plans for Medicare and Medicaid services. Massachusetts embarked on a comprehensive beneficiary engagement process as part of its One Care demonstration development that included: (1) focus groups with beneficiaries to identify the key impacts of Medicaid and Medicare fragmentation; (2) the creation of a One Care implementation council, an advisory group in which consumers comprise of more than half the members that monitors program implementation and serve as an early warning system for systemic issues; and (3) hiring beneficiary consultants to serve on topical design workgroups.
- **Engage providers so they understand and are trained in care philosophies and models relevant to these populations.** States recognize that provider engagement and buy-in is critical to the success of launching new, managed care-based integration models for dually eligible beneficiaries. Effective provider engagement can help to build provider network capacity and address a potential lack of provider willingness to participate in managed care. Providers are generally a trusted source of health care information for their patients, and educating them positions them to facilitate beneficiary enrollment in the program and connect beneficiaries to helpful resources and services. States can improve engagement levels by including providers in the design and implementation of the program from the outset, and offering training and technical assistance to providers.
- **Collect good data for planning/design, risk adjustment, resource allocation, monitoring, and evaluation purposes.** One benefit of an integrated Medicare-Medicaid platform is the potential to collect data on both Medicare and Medicaid utilization to have a complete clinical profile for each beneficiary. Many states either do not have access to or the analytic capabilities to use Medicare data, but states can use D-SNP contracts to require health plans to share data in different forms. Data can support many important functions. For example, states can use eligibility data to facilitate enrollment into integrated products. New Jersey is building the capacity needed to assess FIDE SNP impacts and help build evidence of the effectiveness of aligned D-SNP/MLTSS plans. It will use a combination of Medicare claims and health plan encounter data to measure effects on coordination and quality of care.



- **Be flexible with program requirements to the extent possible.** Beneficiaries and providers report that care management program flexibility is needed to effectively adapt the program to beneficiaries' changing needs and providers' limited availability. Several states participating in a financial alignment demonstration revised their original care management models, such as their interdisciplinary care team requirements, to better meet beneficiaries and providers' needs. In addition, states that have launched integrated or aligned health plans have considered various ways to encourage beneficiaries to enroll in the same health plan for both Medicaid and Medicare service delivery and integrating LTSS benefits into D-SNP contracts. States have been flexible in how they have approached these alignment efforts, paying attention to a number of factors including the health plan landscape in their states, and where beneficiaries currently receive care.
- **Set sufficient reimbursement rates.** Given the high needs and costs associated with this population, it is important for states to set sufficient rates that ensure health plan participation and a strong provider network and beneficiary access. Many states use rate cells or other risk stratification mechanisms to tier payments for beneficiaries based on acuity or LTSS functional needs and/or settings of care to account for the diversity of health care conditions and care needs. Note that states do not have authority over the Medicare rate component for dually eligible beneficiaries.

## ► Case Studies

**Arizona and New Jersey – Two Paths toward Alignment.** Arizona has operated its MLTSS program, Arizona Long Term Care System (ALTCS), since 1989 under 1115 waiver authority, relying on competitively selected health plans to deliver all Medicaid services, including LTSS. Arizona enrolls all beneficiaries, including older adults and those with physical or developmental disabilities who need LTSS. Arizona requires all ALTCS plans to offer D-SNP products, and leverages Medicaid authority and D-SNP contract requirements to promote aligned enrollment for dually eligible beneficiaries, including those eligible for the ALTCS program.<sup>93</sup> To promote aligned enrollment, Arizona uses authority under its 1115 waiver to automatically assign eligible populations to Medicaid health plans. The state developed multiple pathways for beneficiary enrollment into aligned health plans, including encouraging the enrollment of ALTCS beneficiaries into the companion Medicare D-SNP operated by their Medicaid health plan. To support this, the state sends periodic mailings to ALTCS beneficiaries to inform them of the benefits of being enrolled in the same health plan for Medicare and Medicaid. Arizona also periodically reassigned beneficiaries' Medicaid acute care health plan to align with their enrolled D-SNP, thus encouraging coordination of care. This may include beneficiaries who could benefit from enhanced care coordination due to subsequent LTSS eligibility (i.e., "pre-duals"). Lastly, Arizona also limits D-SNP marketing activities by only allowing direct marketing to those individuals enrolled in the health plan's own Medicaid product.

Although New Jersey only launched its MLTSS program in July 2014, it has been successful in creating a robust FIDE SNP program in a short amount of time. The state began contracting with D-SNPs in 2012 prior to the launch of its MLTSS program. From the program's inception, New Jersey focused on improving care integration and administrative alignment.



New Jersey currently requires D-SNPs to be approved by the state as standard Medicaid health plans, and as of January 2016, the program is a fully integrated model now offering MLTSS and expanded behavioral health and substance use disorder treatment benefits. New Jersey uses its state plan and 1115 waiver authority to auto-assign beneficiaries who select FIDE SNP enrollment to the same organization's Medicaid health plan. This ensures that both beneficiaries and providers have a more seamless experience as they interact with a single health plan. The strategic design decision allows for the greatest level of clinical, financial, and administrative integration; it mirrors the approach Minnesota took with the MSHO program and draws upon the approach that CMS took with the Financial Alignment Initiative demonstrations. New Jersey's decision to invest in D-SNP contracting prior to launching MLTSS was driven by the opportunity to share in savings generated by D-SNPs as a result of enhanced Medicare quality payments available at that time, and afforded the state time to acquire experience in integrating Medicare and Medicaid services for full benefit dually eligible beneficiaries before attempting to deliver MLTSS under an integrated model.

Key aspects of Arizona and New Jersey's approaches to integrating Medicare-Medicaid benefits include:

- **Default Enrollment.** Default enrollment (referred to as “seamless conversion” prior to 2018) is a federal statutory and regulatory enrollment mechanism under the Medicare Advantage program that allows a D-SNP to facilitate enrollment into managed care arrangements in which dually eligible individuals receive all of their Medicaid and Medicare services through the same organization. With state approval and involvement, D-SNPs may automatically enroll Medicaid beneficiaries who are newly eligible for Medicare (i.e., just turning age 65, or at the end of the two-year Social Security Disability Insurance waiting period), if they are currently enrolled in that health plan's companion Medicaid product and receive adequate notice of their right to opt-out of enrollment at specific points.<sup>94,95</sup> Arizona required each of its D-SNPs to request CMS approval to seamlessly convert existing Medicaid health plan beneficiaries into a companion D-SNPs product. Arizona implemented default enrollment in partnership with its D-SNPs in 2016 and is successfully enrolling over 400 newly-eligible Medicare beneficiaries into aligned D-SNPs each month. To use this authority to promote aligned enrollment, Arizona provides data to D-SNPs to help them identify those enrollees in their Medicaid-only health plan who are about to become Medicare-eligible. The state also issued a letter of support for D-SNP health plans' default enrollment application proposals to CMS and found that state readiness review prior to launching of default enrollment is essential. New Jersey continues to be interested in pursuing conversations around implementing default enrollment. The state proposed requesting the authority to use default enrollment as an enrollment strategy under its 1115 Comprehensive Demonstration Waiver renewal, but removed the proposal in response to stakeholder comment and CMS' suspension of any new default enrollment proposals.<sup>96</sup>
- **Building Medicare and D-SNP Contracting Expertise.** After launching its MLTSS program, New Jersey made its D-SNPs incrementally responsible for the provision of both facility- and community-based LTSS. The state's pre-MLTSS investment in D-SNP contracting and its phased-in approach to carving in LTSS benefits gave it a greater understanding of complex Medicare regulations and policy, as well as the intersections of Medicare and Medicaid benefits that can be challenging to administer.



### **Aligning Administrative Processes for Minnesota’s Senior Health Options (MSHO) Program Beneficiaries.**

Building on a long history of health care innovation for older adults, the MSHO D-SNP-based program was established in 1997 to serve dually eligible individuals age 65 and over and currently operates under 1915(a)/(c) combination authorities. In 2013, the state signed an agreement with CMS to operate an alternative alignment demonstration program, the *Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience* that uses MSHO’s FIDE SNPs to test new approaches to integrating and aligning certain administrative functions in Medicare and Medicaid for MSHO beneficiaries.

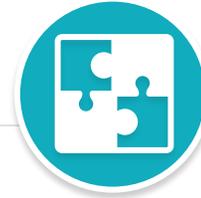
Minnesota found the enrollment design for integrated programs to be of fundamental importance. It uses voluntary Medicaid enrollment coupled with strategic D-SNP contracting to achieve the greatest degree of administrative alignment possible. The state matches the categories of dually eligible beneficiaries enrolled in the D-SNP to those enrolled under the MSHO program, which is limited to full benefit dually eligible beneficiaries.<sup>97</sup> The state also developed a single enrollment process across both Medicare and Medicaid by processing enrollments for most of the D-SNPs operating in the state. This allows for streamlined enrollment and improved alignment of appeals, marketing, and beneficiary and provider notifications when one integrated set of benefits is delivered. Other states can exercise similar discretion as to which groups to include under both the Medicare D-SNP and Medicaid managed care contracts.

Minnesota’s demonstration also has allowed the state to advance integration by testing new provider network standards and review methods. State and federal officials report that the joint network adequacy review process allows them to develop better, more consumer-friendly network standards. Minnesota’s FIDE SNPs have noted that the trial network adequacy review process more accurately reflects the needs of dually eligible populations. Although this process is limited to Minnesota currently, other states are eager to jointly review network adequacy as well.





## Integration Strategy 2: Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care



### ► Impetus for Strategy

Historically, states have “carved out” or excluded Medicaid-only LTSS beneficiaries from managed care. Instead, they have provided these services in a fee-for-service system, or provided LTSS on a fee-for-service basis and physical and/or behavioral health services through managed care, often resulting in siloed and uncoordinated care. Now, many states are including their Medicaid-only LTSS populations in their existing or new managed care programs to address this fragmentation and the resulting poor health and financial outcomes.

### ► Strategy Description

Some states are expanding their managed care plans for the LTSS population to provide a comprehensive benefits package that includes physical and behavioral health services and LTSS under a single capitated rate.<sup>98</sup> Under these fully integrated MLTSS arrangements, a single entity (i.e., the health plans contracting with the state) is responsible for coordinating the complex needs of these beneficiaries. States often phase-in managed care enrollment by region and population. For instance, under a regional rollout strategy, states may start with more densely populated regions in which plans can more easily meet network adequacy requirements, and then rollout to more rural regions. With a population phase-in strategy, states could initially exclude certain sub-populations (i.e., individuals receiving LTSS in a nursing facility or other institutional setting), and include them at a later date after the state and health plans build capacity. Additionally, in some cases states have gained experience with an MLTSS pilot program or a voluntary enrollment model before transitioning to mandatory MLTSS enrollment. As part of this strategy, it is critical to ensure that small HCBS providers are able to contract with and get timely payments from health plans, with which these providers are often engaging with for the first time.

### ► Implementation Mechanisms

To administer Medicaid MLTSS, states must combine authority for delivering services through Medicaid managed care with authority for providing comprehensive Medicaid LTSS, including HCBS. States may operate Medicaid MLTSS under a Section 1932 state plan amendment or through various waiver authorities including 1915(a), 1915(b), 1915(c) and 1115 waivers.<sup>99</sup> Section 1915(a) waivers allow states to establish managed care programs with voluntary enrollment, while 1915(b) and 1115 waivers allow mandatory enrollment. Section 1915(b) waivers also give states more flexibility to engage in regional implementation of managed care, rather than requiring managed care benefits to be provided across the entire state, as well as provide varied benefits to different Medicaid populations. States may combine Section 1915(b) with 1915(c) waivers to combine managed care authority with HCBS authority in launching MLTSS programs.

Finally, 1115 waivers, which also provide flexibility for regional implementation and variation in benefits, can include allowances for federal matching funds for Medicaid expenditures that otherwise would not qualify for funding.<sup>100</sup> As an example of state flexibility, Virginia originally intended to implement its integrated MLTSS program (Commonwealth Coordinated Care Plus) through an 1115 waiver. However, it realized after several months of planning and negotiations that Virginia's existing Medicaid program cost trends made the 1115 cost neutrality requirements challenging, particularly if unanticipated future costs arose for this vulnerable population. Instead, Virginia changed course and worked closely with its CMS central office to migrate to a 1915(b)/(c) waiver, which provided the flexibilities needed for its program.<sup>101</sup>

## ► Results to Date

There is limited data available that compare individuals enrolled in MLTSS programs to those in fee-for-service, or that assess the same individuals before and after enrollment. CMS has contracted for a national level evaluation of state MLTSS programs implemented via 1115 waivers. However, the ability to compare outcomes across states and the ability to access data needed to assess MLTSS program performance may be limited. In an informal survey, seven of 12 MLTSS states surveyed by CHCS and the National Association of States United for Aging and Disabilities reported improved health outcomes as a result of their MLTSS programs.<sup>102</sup> One state reported that 77 percent of respondents to a consumer satisfaction survey said their quality of life had improved since joining an MLTSS plan.<sup>103</sup> Some state MLTSS programs reported decreases in hospital stays and the duration of those hospital stays, and increases in non-emergency transportation utilization, potentially indicating increased provider visits.

From a programmatic standpoint, eight states reported that MLTSS promoted rebalancing their LTSS delivery systems, which aligns with national trends: fiscal year 2013 was the first year that HCBS accounted for just over half, or 51 percent, of LTSS spending in the United States.<sup>104</sup> A few states reported decreasing or eliminating waitlists for certain services, thereby increasing access to those services. Other states were able to offer additional services (e.g., non-medical transportation and vision services) due to cost reductions from implementing an MLTSS program. Seven states reported employing data collection to demonstrate cost and utilization trends, with one state confirming meeting savings targets and many others reporting increased budget predictability.<sup>105</sup> Despite these early successes, states continue to experience challenges in moving LTSS populations into managed care, including setting appropriate health plan capitation rates, developing sufficient LTSS provider networks, particularly in rural areas, and establishing meaningful LTSS quality metrics.



## ► Key Lessons

States with established MLTSS programs reported that a variety of initial and ongoing capacities are required for a successful transition to a comprehensive capitated model:

- **Integration requires careful planning, Medicare expertise, and resource commitments.**

States must be able to invest in sufficient planning and implementation resources to launch a comprehensive managed care program with care coordination across fragmented points of care.<sup>106</sup> Involvement of dedicated staff with expertise in primary care, behavioral health, and LTSS is critical to ensure a smooth transition from fee-for-service or an otherwise siloed system into a cohesive program for LTSS populations. As noted in the Virginia case study (see next page), states may consider potential agency reorganization strategies to support the transition of internal operations from oversight of fee-for-service providers to management and oversight of managed care plans. Offering both targeted small and full agency trainings, which should include visible leadership participation, may help staff prepare for new roles and is an important element of internal readiness, adaptability, and collaboration.

- **Consider a phase-in strategy.** States may want to consider phasing in their managed care program over time, whether by provider type, enrollee population, and/or geographic region. Implementing managed care payment and system delivery reforms over time gives health plans time to build experience with these provider, beneficiary, and geographic groups. Virginia, as well as many other states, has used this strategy successfully when implementing its transition from fee-for-service to managed care. This approach may help states work through implementation issues and mitigate concerns from beneficiaries, as well as smaller HCBS entities, around contracting and timely payments from health plans, particularly in rural areas.

- **Define program goals and collect data relevant to achieving those goals from the outset.** States recommend starting early with building a case to demonstrate program value to adequately respond to requests for information on outcomes and financial sustainability from legislators, advocates and other stakeholders. However, there are several challenges with quality measurement in these programs. There is a lack of standardized LTSS quality measures that are used consistently across state and federal programs, and consumer advocate concerns that existing measure sets do not adequately measure what is most important to beneficiaries and their families—including functional status, cognitive

## ► Independent Ombudsman Requirement

CMS' 2016 Medicaid managed care rule requires states to establish an independent beneficiary support network that offers education on enrollee rights, a streamlined access point for filing complaints, assistance during the grievance and appeals process, and data collection and review of systemic issues to better inform the state on how to address them. Furthermore, CMS announced funding to support demonstration ombudsman and counseling programs for states' Medicare-Medicaid Financial Alignment Initiative.



Currently there is limited information on the impact of these initiatives on service access and delivery outcomes as states are in the initial implementation phases.

**Sources:** CMS. "Funding to Support Ombudsman Programs". September 2016. Available at: [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html).





health, and safety. While there are extensive LTSS quality reporting requirements in use, it may be difficult to determine what data are best to assess whether program goals are being met. It also may be difficult to objectively assess the reliability of self-reported data about beneficiary satisfaction and quality of life, even though these are important cornerstones of MLTSS programs. In addition, collecting and analyzing survey or in-person assessment data can be labor intensive for states and plans. To be best positioned to report on outcomes related to new reforms, states recommended: (1) collecting baseline health status, cost, and utilization data prior to launch; and (2) defining program goals upfront and designing targeted quality measurement and data collection requirements around those goals.

- **Communicate with and educate all stakeholders.** States cited the importance of soliciting beneficiary and family members' input and feedback, as well as engaging in clear communication with stakeholders, specifically around network adequacy and provider payment rates to generate positive engagement and buy-in.<sup>107</sup> In addition, securing support from other state constituencies is important. Virginia made concerted efforts to educate state legislators on a one-to-one basis to help them understand program goals and state oversight protocols during design phases for its MLTSS program. Securing informed legislative champions prior to implementation to assist their ability to respond to constituents was a high priority. It also proactively sought feedback about desired program results and implementation concerns to be able to report back on the status of these goals and concerns.

## ► Case Study

**Virginia's Commonwealth Coordinated Care Plus Program Integrates All LTSS, Medical, and Behavioral Health Services Under One Program for Medicaid-Only Beneficiaries.** Virginia's Department of Medical Assistance (DMAS) began a phased geographic rollout of its new mandatory MLTSS program in August 2017. Commonwealth Coordinated Care Plus (CCC Plus) is now operating statewide and provides all medical, behavioral health, substance use disorder services, and LTSS for individuals age 65 and older, children and adults with disabilities, and others eligible to receive LTSS. DMAS launched this program following a legislative mandate to improve quality and budget predictability by transitioning LTSS users from a fee-for-service delivery model into an integrated managed care arrangement.

DMAS originally intended to implement CCC Plus through an 1115 waiver. However, it realized after several months of planning and negotiations that current program trends made it unlikely to meet the 1115 budget neutrality requirements. Instead, DMAS changed course and worked closely with its CMS central office to migrate to a 1915(b)/(c) waiver.

Virginia previously operated a financial alignment demonstration, Commonwealth Coordinated Care (CCC), a voluntary program that provided comprehensive, integrated services—including LTSS—for dually eligible individuals in certain regions of the state. Although CCC concluded on December 31, 2017, it provided the foundation of the CCC Plus program. Virginia incorporated many successful elements from CCC to the new statewide program, and further benefited from the stakeholder engagement work completed for CCC as many stakeholders were already familiar with the concept and benefits of a

managed care model for this population. CCC Plus plans must offer a companion D-SNP to offer dually eligible beneficiaries the option to enroll in aligned plans for Medicare and Medicaid services.

To help prepare for the managed care transition internally, DMAS conducted an internal reorganization of certain units, evolving its focus on management and oversight of managed care. It also created a new unit to support care management activities that will provide health plans with ongoing training, support high-risk care management activities, and provide a “safe place” for plans to discuss concerns with compliance and other care delivery issues.



## Integration Strategy 3: Enroll Individuals with I/DD in Managed Care



### ► Impetus for Strategy

Traditionally, certain high-need populations, such as individuals with I/DD, have been “carved out” of managed care and remained in fee-for-service arrangements. In part, this has been due to significant concern from the I/DD community that the Medicaid managed care model could not address the diverse clinical, functional, and employment support needs of this population. Specific concerns center on continuity of care and health plans’ perceived lack of familiarity with the needs of this population. However, the rise in managed care in both Medicaid and Medicare, as well as states’ recognition of challenges that the I/DD population faces in the fee-for-service environment, has prompted more states to carve in these populations and services to improve coordinated care delivery and contain costs. These efforts seek to improve community integration and reduce the fragmentation of care that individuals with I/DD experience across the complex medical and social services that Medicaid typically provides.

### ► Strategy Description

States are taking a few different approaches to better integrate care for the I/DD population, while ensuring the consumer experience and services are maintained.<sup>108</sup> Some states have transitioned LTSS benefits into managed care, keeping physical and behavioral health services separate, as a starting point to move toward fully integrated managed care. Other states are creating care coordination entities that will be responsible for coordinating beneficiary care across funding streams as a first step toward transitioning this population to managed care. The most comprehensive approach underway at the state level is to move the I/DD population into fully integrated managed care, whereby a single health plan oversees and coordinates all services for this population, including LTSS, medical, behavioral health, and social services.

### ► Implementation Mechanisms

States have used varying methods to improve integration for I/DD populations. Under the managed care approach, Arizona designated the Arizona Department of Economic Security, Division of Developmental Services to manage all MLTSS for individuals with I/DD under a single agency.<sup>109</sup> New York operates the only financial alignment demonstration in the country for this population, Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD), which integrates both Medicaid and Medicare services and covers acute, long-term care, and habilitation services. In 2017, New York also submitted to CMS a proposal to begin the transition of the I/DD population into managed care through a concurrent 1915(c) waiver<sup>110</sup> The State received federal approval to expand its Medicaid health home model to serve individuals with I/DD through Care Coordination Organizations that began operating on July 1, 2018. As the initial phase of



New York's I/DD managed care transition, the state intends to use this model to strengthen care coordination for the I/DD population under a single comprehensive plan.<sup>111</sup> If successful, the state hopes to eventually move to mandatory managed care enrollment, and potentially include value-based payment arrangement requirements to improve care outcomes and reduce costs for this population.<sup>112</sup>

## ► Results to Date

With years of successful integration of additional services for individuals with I/DD into its MLTSS program, Arizona has never had a waitlist for services, and has reported both high client satisfaction and strong performance on health, welfare, and consumer experience metrics.<sup>113</sup> New York reports over 20,000 individuals with I/DD are voluntarily enrolled in Medicaid managed care for their acute care benefits, while its FIDA-IDD demonstration has close to 1,100 enrollees. These two initiatives represent the initiation of the state's long-term transition to fully integrated provision of services for individuals with I/DD under a comprehensive Medicaid managed care structure.<sup>114</sup> However, I/DD consumer advocates in some states that have moved or are considering moving to managed care report concerns with limited access to services. In Kansas, advocates submitted these concerns during public comment periods for the KanCare system, including the lack of engagement and communication with stakeholders during the program design process.<sup>115</sup>

## ► Key Lessons

States with experience in integrating I/DD populations into managed care reported three main recommendations to other states considering pursuing this path:

- **Promote stakeholder engagement and support.** The advocacy community has raised significant concerns with moving this population into managed care, driven in part by people's fear that they will lose access to much-needed services. Launching consumer advisory groups, arranging stakeholder meetings, and ensuring clear communication are some of the steps states have taken to improve the implementation process and engender stakeholder support. New York has developed carefully targeted messages during managed care transitions that focus on how a managed arrangement can increase access to mental, physical, and specialty health services such as dental care, while there are gaps between these services under the current fee-for-service arrangement. Furthermore, states reported that using a case manager as a single point of contact for beneficiaries and their families, in conjunction with integrated care teams, is helpful in establishing a clear line of communication and coordinating care for the beneficiary. Other states solicited input from community-based organizations and consumer advocates to shape MLTSS design for I/DD populations and to support development of a care continuum that meets their needs and enables a smooth implementation process.<sup>116</sup>
- **Transition incrementally.** New York, in particular, emphasized the value of moving to managed care in a staged process. The state is using a multi-year transition period to move from voluntary to mandatory enrollment. Furthermore, New York intends to continue maintaining fee-for-service provider rates for the initial phase of the transition to managed care to



support access under the new system and also to prepare health plans and providers to implement the capitated payment model. By pursuing this transition in phases, New York has been successful in addressing some advocates' concerns regarding the managed care model. Finally, New York recommended that other states build off their existing provider delivery system (i.e., health home authority in New York) to scale their infrastructure and care coordination capabilities effectively. In addition, states might consider a regional rollout plan as well.

- **Utilize data reporting and health information technology in a way that engages and connects individuals and their families to providers.** Implementing an electronic health record or other health information technology tools facilitates care coordination by capturing data in a single system to allow states to monitor and report on cost and quality metrics.<sup>117</sup> New York recommended electronically connecting health plans with providers, beneficiaries, and their families to improve data sharing and care coordination. Compared to a paper documentation system, which can impede service delivery through inefficiencies and care gaps, this is generally an appealing change for providers and beneficiaries.

## ► Case Study

**New York Creates a Pathway to Managed Care for I/DD Populations.** The New York State Department of Health requested CMS authorization for a specialized managed care model for I/DD populations to operate concurrently with the 1915(c) waiver authority for habilitation services. This model creates a pathway to managed care for I/DD populations via two steps: (1) creating care coordination organizations (CCOs) for care management services; and (2) transitioning to managed care over time. By integrating primary care, behavioral health, social support services, and LTSS under the CCOs, the state seeks to improve care coordination for this population. The 1115 waiver amendment will give New York will begin with voluntary enrollment opportunities and ultimately seek the authority to move the I/DD population to mandatory managed care, which is the state's long-term goal. Today, over 20,000 individuals with I/DD are voluntarily enrolled in the managed care system for their acute care benefits and 1,100 dually eligible beneficiaries with I/DD are enrolled in the FIDA-IDD demonstration for their integrated Medicaid and Medicare services. The state also operates a specialized PACE program that serves senior beneficiaries with and without I/DD.

The New York Office for People with Developmental Disabilities (OPWDD) established the CCOs under the state's existing health home authority.<sup>118</sup> These CCOs (or health homes) must demonstrate in their application that their governance structure and leadership has experience providing or coordinating developmental disability, health, and LTSS for individuals with I/DD.<sup>119</sup> The CCOs launched in July 2018 with beneficiary enrollment on a voluntary basis. This model provides a person-centered approach to service planning and promotes the delivery of integrated care that supports the needs of individuals with I/DD. It is expected that, over time, CCOs or existing providers of I/DD services will: (1) form managed care plans, which will be called "Specialized I/DD Plans"; or (2) enter into agreements with existing mainstream Medicaid managed care plans to manage the I/DD benefits provided to individuals with I/DD. OPWDD seeks to meet beneficiaries' and their families' care needs in the most comprehensive way possible, promoting the achievement of quality outcomes and improvement across the service delivery system.<sup>120</sup>





## Integration Strategy 4: Integrate LTSS Under Provider-Based Initiatives



### ► Impetus for Strategy

While many states are pursuing LTSS integration through capitated managed care programs, several states have initiatives to better coordinate care management at the provider or care delivery level, either as an alternative to or in addition to MLTSS programs. Provider-based models seek to hold providers directly accountable for care coordination for multiple services, quality performance, and health outcomes—rather than placing accountability at the health plan level—and can be embedded in Medicaid fee-for-service or managed care environments. States may consider varied provider-based approaches for different subsets of the LTSS population and geographic regions, depending on their service needs, available infrastructure, and the most appropriate care model to deliver those services.

### ► Strategy Description

Provider-based LTSS integration models vary widely, but the most common model is PACE, which provides comprehensive medical and social services to beneficiaries by integrating LTSS with other services at the care delivery level. An interdisciplinary team of home-based and PACE center (typically an adult day health center) providers assist beneficiaries in fulfilling their care needs in the community rather than at a nursing facility.<sup>121</sup> Most PACE enrollees are dually eligible, and PACE providers receive a blended Medicare and Medicaid payment for dually eligible beneficiaries. Currently, 31 states have PACE programs (127 programs nationally), serving more than 45,000 enrollees.<sup>122</sup> Program flexibilities created by the PACE Innovation Act of 2015 may provide opportunities for states to expand these programs to new populations and sites of care. Twenty-two states and the District of Columbia are using health homes to enhance integration and coordination of primary, behavioral health (both mental health and substance abuse) and LTSS for high-need, high-cost Medicaid populations, including dually eligible beneficiaries.<sup>123</sup> A few states are developing Medicaid ACOs for their Medicaid-only populations that provide comprehensive physical, behavioral health, and LTSS.

### ► Implementation Mechanisms

While most states pursuing provider-based integration models are doing so through PACE, some states use other approaches to serve a broader population than is eligible under PACE. Virginia has incorporated PACE programs into its comprehensive LTSS integration strategy since the launch of its Blueprint for the state's acute and long-term care delivery systems in 2007. Virginia launched the state's first PACE sites that year, but was unable to implement the MLTSS component of its LTSS strategy due to stakeholder concerns in 2014 when it launched its first MLTSS program through the Commonwealth Coordinated Care (CCC) financial alignment demonstration.<sup>124,125</sup> Massachusetts' 1115 waiver extension created an entirely new ACO-



based delivery system, in which non-dually eligible beneficiaries can enroll in one of three types of Medicaid ACOs to receive comprehensive physical health, behavioral health, and over time, LTSS.<sup>126</sup> Maryland is considering developing a Medicare-Medicaid ACO for dually eligible beneficiaries as well.<sup>127</sup> States use the Section 1945 state plan option to implement health homes. Washington is the only state currently using the state plan benefit to coordinate LTSS for its dually eligible population, and launched its program in 2013 using a managed fee-for-service financial alignment demonstration model. The program is jointly administered at the State level by the Washington Health Care Authority, which oversees the State Medicaid program, and the Department of Social and Health Services, which administers LTSS, developmental disabilities, and behavioral health services.<sup>128</sup>

## ► Results to Date

National PACE evaluations have found an association with reduced inpatient hospitalizations compared with fee-for-service LTSS programs, as well as improved care quality and lower mortality rates.<sup>129</sup> However, estimates of cost savings across PACE programs are inconsistent, with some states experiencing savings and some experiencing higher costs compared to their fee-for-service programs. Additionally, PACE struggles with limited growth potential due to its adult day health center-based model of care, the finite beneficiary population, high start-up costs and scale needed for interested provider organizations, and potentially limiting state policies, such as enrollment caps. Given the recent implementation of Massachusetts' ACO program, no savings or health outcomes are yet available. However, the Special Terms and Conditions in Massachusetts' 1115 waiver requires an independent evaluator to conduct an assessment of the demonstration's impact on costs, clinical quality, coverage, coordination of care, safety net capacity, and other performance metrics using a CMS-approved evaluation design. The interim evaluation will be submitted in June 2021 and the final evaluation within 500 days of the demonstration ending on June 30, 2022.<sup>130</sup> An evaluation of Washington's health home-based managed fee-for-service demonstration found gross Medicare savings of \$34.9 million in its first 18 months, \$30.2 million in the next 12 months, and \$42 million in the 12-month period after that; however, due to lags in Medicaid data availability, these figures do not include Medicaid savings or costs and will be updated when these data are available.<sup>131</sup> A portion of these savings will be shared back with the state.

## ► Key Lessons

Four key recommendations for states considering provider-led integration models based on others' experiences include:

- **Support efforts to enable PACE's growth, and actively monitor to ensure high-quality care.** Both for states new to the PACE model and those with years of experience, Medicaid directors have opportunities under existing program rules to increase PACE enrollment in their states. For example, states can eliminate caps on enrollment that limit the size of the program, especially for those states that have not assessed those limits in several years. States should also ensure provider reimbursement rates are sufficient and consistent, to the extent appropriate, across the state. Virginia noted the value of



allowing competition if feasible in the state, for example if there is a city or area with sufficient capacity for multiple PACE providers, multiple providers may be encouraged to “apply” for those areas. Such competition is allowable under CMS regulations. Virginia emphasized the need to reduce administrative burden wherever possible by aligning state PACE requirements with CMS requirements. For example, the state’s PACE auditing and monitoring unit conducts the audits alongside CMS, with state medical and administrative staff present, to streamline the process and avoid additional administrative burden for the PACE sites.<sup>132</sup> Finally, Virginia noted that its largest barrier to enrollment is beneficiaries’ clear understanding of the varied benefits of the program. States can address this by improving direct-to-consumer marketing and communication of the program, as well as including the PACE option in beneficiary enrollment letters and other communication materials.<sup>133</sup>

In 2015, Congress allowed for-profit organizations to establish PACE programs.<sup>134</sup> Although early studies found limited differences between for-profit and non-profit programs prior to congressional authorization, with a recent increase in the number and types of new PACE programs and enrollment, it important for states to closely monitor enrollee satisfaction, outcomes, and provision of services to ensure that programs are focused on delivering high-quality care.<sup>135</sup> Some states have raised concerns about PACE program accountability and transparency, compared to other MLTSS programs, given they operate primarily under federal statutory and regulatory schemes. Establishing a comprehensive oversight approach, similar to Virginia’s, described below, is important for effective state monitoring.

- **View PACE as complementary to, not competitive with, MLTSS.** Virginia noted that PACE played a significant role in introducing managed care to the MLTSS market in the state, and currently serves as a vital option for 1,240 dually eligible individuals age 55 and older, and 82 non-dually eligible beneficiaries seeking coordinated care and an alternative to nursing home care so that they may remain in their homes and communities.<sup>136</sup> States should not overlook PACE as a critical component of a comprehensive LTSS strategy for certain beneficiaries who want the experience of comprehensive provider-based integration approach, and a range of face-to-face beneficiary services in a single setting. Virginia highlighted the importance of protecting PACE as a beneficiary option alongside MLTSS as states transition to MLTSS, noting that it tends to be deprioritized given states’ many competing priorities and its limited growth potential.<sup>137</sup>
- **Engage stakeholders early and often.** Massachusetts designed a comprehensive and open stakeholder engagement process to encourage broad perspectives into the design of the state’s restructuring of its care delivery system. MassHealth created eight work groups, each focused on a different topic within payment and care delivery transformation, including behavioral health and LTSS. The state selected the members of each work group based on their application, technical or subject matter expertise, and the likelihood of their being impacted by the work group topic’s policy decisions.<sup>138</sup> Virginia was successful in addressing any potential concerns from nursing facility or home health worker groups regarding the launch of PACE sites in the state through targeted in-person communications on the program and its services.<sup>139</sup> Other states may consider these approaches when implementing provider-based initiatives as opportunities to engage both consumer and provider stakeholders early in the design and implementation process.

- **Use program data to secure funding.** Data collection and analysis of the Washington health home demonstration was critical in demonstrating cost savings and improved health outcomes when funding was at risk midway through the program.<sup>140</sup> The state was able to use data analytics to calculate a real-time return on investment and performance results, and build a compelling, interim narrative for the legislature and administration to ensure continued funding for the program. States may consider the importance of continual data collection and interim evaluation of this data to be an opportunity to demonstrate program efficacy and request continued legislative or federal funding.

## ► Case Study

**Virginia’s PACE Program Is a Key Component of a Comprehensive Integration Strategy.** In 2006, the Virginia legislature passed a law with support from former-Governor Tim Kaine directing the Department of Medical Assistance Services (DMAS) to draft a Blueprint for the integration of the acute and long-term care delivery systems in the state, targeting seniors and individuals with disabilities who made up 30 percent of the Medicaid population yet 70 percent of the costs at the time.<sup>141</sup> The Blueprint proposed two approaches to integrate acute and long-term care services for the state’s Medicaid enrollees: PACE and MLTSS. DMAS conducted community stakeholder meetings to solicit feedback on the Blueprint and the proposed approaches, including consumers, families, providers, other state agencies, and legislators.

Signaling its commitment to developing PACE in particular, the state allocated an initial \$250,000 in start-up funds to grow PACE, ultimately approving \$1.5 million for six sites. With strong support from the state administration, legislature, and DMAS executive leadership, Virginia implemented PACE in 2007, but was unable to launch MLTSS at the time due to stakeholder and consumer advocate concerns about restricted provider choice, limited availability of services, and decreased quality of care.<sup>142</sup> To address stakeholder concerns with PACE in particular, including home health agencies viewing the model as competition, Virginia visited local social service departments and provider agencies to train and educate on the program, the benefits to beneficiaries and families, and how its services were complementary to those already being provided in the community. This stakeholder engagement was successful in mitigating concerns from nursing facility groups in particular, and the launch of the sites was successful.<sup>143</sup> Non-profit, for-profit, and Area Agency on Aging provider organizations currently operate 11 PACE sites around the state, serving over 1,300 beneficiaries.<sup>144</sup>

To be eligible for PACE in Virginia, participants must be 55 or older, reside in the PACE service area, and be able to live safely in the community. Participants must also be screened by a nursing facility pre-admission team using the Virginia Uniform Assessment Instrument (UAI) and Patient Choice Form and be determined to have a verified need for nursing home-level care.<sup>145</sup> Virginia reports that these screening teams will soon be required to complete mandatory training and certifications. Participants are able to dis-enroll from PACE and resume their traditional Medicare and/or Medicaid benefits at any time. PACE services provided by the state include all Medicaid and Medicare services as well as additional social and wellness services, including physical therapy, personal care, home health, prescription drug, medical, nursing facility, transportation, and assisted living facility services.<sup>146</sup>





DMAS employs an entire unit within the Division of Aging and Disabilities dedicated to PACE to monitor PACE performance, oversee rate setting, perform quality reviews, collect and track data, and support providers. The auditing team that performs the annual quality management review utilizes a similar staffing model to the CMS team that oversees the PACE sites, with two clinical and two administrative analysts. Virginia emphasized the value of having clinical staff on the team to oversee PACE operations and provide guidance. Virginia has engaged in both a three-way agreement with CMS and the PACE sites that specifies regular communication between the parties, as well as an additional bilateral agreement between the state and the PACE sites to greater clarify state program expectations. The state strongly recommended the additional bilateral agreement.

**Massachusetts’ 1115 Waiver Extension Creates A System of Medicaid ACOs to Integrate Care for Non-Dually Eligible Individuals.**

In November 2016, CMS approved an extension of Massachusetts’ Section 1115 waiver, which governs its Medicaid program (MassHealth), to reform the MassHealth care delivery system to better integrate physical, behavioral health, LTSS and health-related social needs for roughly 1.2 million of the program’s 1.8 million enrollees. The waiver created three new care delivery options for MassHealth’s managed care-eligible population, which includes individuals under age 65 who are not in institutions and do not have third-party coverage, including Medicare. Individuals eligible for managed care, including roughly 68,000 children and adults who use LTSS, are required to enroll in either one of three new Medicaid ACO models, an managed care organization (MCO), or the state’s Primary Care Clinician plan.<sup>147</sup>

The three new ACO models—Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs—vary in terms of their level of financial risk for services and their reliance on MassHealth managed care infrastructure for administrative and other support.<sup>148</sup> Primary Care ACOs directly contract with MassHealth and coordinate care across MassHealth’s fee-for-service provider network, as well as MassHealth’s capitated behavioral health contractor, the Massachusetts Behavioral Health Partnership. Accountable Care Partnership Plans, in which an ACO partners with a single MCO, and MCO-Administered ACOs, which can contract with more than one MCO, coordinate and deliver comprehensive care for their enrollees. Massachusetts first tested its ACO model in December 2016 through a one-year pilot program with six ACOs managing the care of 160,000 members across the state. The state began delivering care through its ACOs in March 2018 and as of June 2018, ACO enrollment totaled 867,000.<sup>149</sup> Starting in July 2018, all ACOs and MCOs were required to contract with newly-created Community Partners, which are community-based entities that help to identify and coordinate care for an estimated 35,000 enrollees with complex behavioral health needs and up to 24,000 enrollees who use LTSS.<sup>150</sup>

A primary goal of Massachusetts’ reform is to base Medicaid payments on value and outcomes by requiring ACOs and MCOs to assume financial and performance accountability for their enrollees’ comprehensive services. At the outset, the ACOs and MCOs will be responsible for an enrollee’s physical health and behavioral health services, in addition to certain LTSS, including short-term nursing facility, home health services, therapies and durable medical equipment. During the five-year waiver period, MassHealth intends to integrate more LTSS into this arrangement, including personal care, adult day health, and adult foster care services. All of the ACO and MCO contracts include quality metrics to hold the contractors accountable



for their performance across seven domains: (1) prevention and wellness; (2) chronic disease management; (3) behavioral health/substance use disorder; (4) LTSS; (5) avoidable utilization; (6) progress towards integration; and (7) member care experience.<sup>151</sup>

Some stakeholders have shared concerns with the delay in fully integrating LTSS into the ACOs' and MCOs' package of benefits, stating that it continues the state's current fragmented system of care, at a high cost to both beneficiaries and taxpayers. However, others cite it as an important opportunity for the state to adequately prepare for the eventual carve-in of LTSS, and for the ACOs and MCOs to gain valuable experience in caring for enrollees' complex LTSS needs through their relationships with LTSS Community Partners. Massachusetts intends to conduct a comprehensive state readiness review prior to fully carving in LTSS to assess whether the ACOs and MCOs have sufficiently built the necessary capabilities, including provider credentialing and contracting, IT systems, and grievance and appeals rules.<sup>152</sup>

**Washington's Health Home-Based Financial Alignment Initiative Demonstration Coordinates LTSS for its Dually Eligible Population.** Part of a larger state effort to improve care coordination for Medicaid beneficiaries with complex needs, Washington State received approval for two Medicaid State Plan Amendments (SPAs) on July 1, 2013 under the Section 1945 Health Homes state plan benefit created by Section 2703 of the Affordable Care Act.<sup>153</sup> The state's Financial Alignment Initiative demonstration, authorized via one of the Medicaid SPAs, used this Medicaid health home program as a foundation to provide comprehensive LTSS, primary, acute, and behavioral health services for dually eligible beneficiaries under a managed-fee-for-service model. The state targeted this high-cost, high-risk population in an effort to reduce costs and improve health outcomes using intensive care coordination and a person-centered care model. The demonstration is jointly administered at the state level by the Washington Health Care Authority (HCA), which oversees the state Medicaid program, and the Department of Social and Health Services (DSHS), which administers LTSS, developmental disabilities, and behavioral health services.<sup>154</sup>

In the Washington health home program, beneficiaries are auto-enrolled to a health home lead entity that is responsible for coordinating their services, including LTSS, across both Medicaid and Medicare.<sup>155</sup> In an effort to improve health outcomes through enrollee engagement, health home care coordinators help enrollees to define their develop a Health Action Plan (HAP), using information about the individual's past service utilization stored in the state's web-based clinical support tool, Predictive Risk Intelligence System (PRISM), such as hospitalizations and medication usage.<sup>156</sup> The care coordinators help improve enrollees' self-management skills and identify necessary interventions or community supports that may be useful to the enrollees in achieving their goals.

Under the managed fee-for-service demonstration, beneficiaries have full choice of providers and services for both Medicaid and Medicare. However, enrollees have the option to dis-enroll from or change their assigned health home, and their Medicaid and Medicare services are not affected if they do so. Washington used a competitive Request for Application process to select the health homes, and used a phase-in process to implement the demonstration throughout the state over time.<sup>157</sup>

In October 2015, the state planned to end the demonstration, citing questions regarding its projected savings and a challenging budget climate. HCA and DSHS compiled internal data on the program’s projected savings and health outcome improvements, which were found to be significant.<sup>158</sup> As a result of this effective data analysis and advocacy the state legislature approved further payments to health homes that meet target goals.



## SECTION IV: Conclusion

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The authors undertook the development of this toolkit to provide state officials with a comprehensive set of strategies and examples to design, implement, and advance LTSS system reform. The toolkit also may be useful to state partners—including beneficiary advocates, federal and state legislators, state aging and disability officials, providers, health plans, and federal officials—to identify opportunities for collaboration with state Medicaid agencies on future LTSS reform efforts.

There is no one-size-fits-all approach to the challenge of LTSS system reform. A useful starting point for all states is to assess their current LTSS landscape and to reflect on challenges and successes and the reasons behind them. Based on that assessment, states can then set a strategic vision and course of action, selecting strategies from the toolkit as appropriate.

States embarking on LTSS reform will be at different starting points and move at varying paces. Regardless of the starting point and the strategies, efforts to improve efficiency and access to services and to modernize care delivery for vulnerable populations is a commendable and visionary action.

It is both possible and preferable to approach the challenge of reforming statewide LTSS systems with a general overall strategy, while understanding that the progress made will be incremental for most states. For example, thinking about the integration of physical and behavioral health services can and should be aligned with systemic efforts to rebalance LTSS, and may be one success in a long-term strategy to improve integration of care for LTSS populations.

States will need to creatively leverage funding sources and new flexibilities to support their reforms. For the majority of states that use managed care, it can play a fundamental role in facilitating and shaping care delivery, but states themselves must continue to drive the policy agenda and the broad vision for change beyond the existing service delivery system.

Regardless of a state's specific direction and selected strategies for improving LTSS, states can apply these key lessons from other states to inform their approach:

- **Build and sustain beneficiary engagement and buy-in** – these stakeholders are the most important allies and the heart of any LTSS program.
- **Invest in administrative capacity** – both people and data.
- **Invest in federal partnerships** – know what you need from CMS and why, and work to get it.
- **Cultivate executive and legislative leadership** – these champions will always be necessary for systems-level change.
- **Think long term** – create and drive a vision that transcends administration and policy priorities.

Low-income adults who need and use LTSS are among the most high-need, high-cost, and fast-growing populations covered by Medicaid. The need for states to develop strategies ensuring that individuals with LTSS needs receive high-quality, cost-effective care in the settings of their choice will continue to grow. This toolkit provides comprehensive information to help states use Medicaid's programmatic flexibility to better serve this population.

## APPENDIX: Interviews

National Experts	
<b>Community Catalyst</b>	<ul style="list-style-type: none"> <li>■ Alice Dembner, Director of the Substance Use Disorders Project</li> <li>■ Leena Sharma, Senior Policy Analyst/Project Manager</li> </ul>
<b>InnovAge</b>	<ul style="list-style-type: none"> <li>■ Cynthia Jones, Senior Vice President, Government Relations</li> </ul>
State Leadership	
<b>Arizona</b>	<ul style="list-style-type: none"> <li>■ Dara Johnson, Arizona Health Care Cost Containment System</li> <li>■ Melissa Arzabal, Arizona Health Care Cost Containment System</li> <li>■ Thomas Heiser, Arizona Health Care Cost Containment System</li> </ul>
<b>Maryland</b>	<ul style="list-style-type: none"> <li>■ Aaron Larrimore, Maryland Department of Health and Mental Hygiene</li> <li>■ Elizabeth Kasameyer, Maryland Department of Health and Mental Hygiene</li> <li>■ Lorraine Nawara, Maryland Department of Health and Mental Hygiene</li> </ul>
<b>Massachusetts</b>	<ul style="list-style-type: none"> <li>■ Elizabeth Goodman, MassHealth</li> <li>■ Corrinne Altman Moore, MassHealth</li> </ul>
<b>New Jersey</b>	<ul style="list-style-type: none"> <li>■ Joseph Bongiovanni, New Jersey Department of Human Services</li> <li>■ Maribeth Robenolt, New Jersey Department of Human Services</li> <li>■ Elizabeth Wood, New Jersey Department of Human Services</li> <li>■ Carol Grant, New Jersey Department of Human Services</li> <li>■ Dwight Torlay, New Jersey Department of Human Services</li> </ul>
<b>New York</b>	<ul style="list-style-type: none"> <li>■ JoAnn Lamphere, Office for Persons with Developmental Disabilities</li> <li>■ Kate Marlay, Office for Persons with Developmental Disabilities</li> <li>■ Mark Kissinger, New York State Department of Health</li> <li>■ Maribeth Gnozzio, New York State Department of Health</li> <li>■ David Hoffman, New York State Department of Health</li> </ul>
<b>Tennessee</b>	<ul style="list-style-type: none"> <li>■ Patti Killingsworth, TennCare</li> <li>■ Jeremiah Morton, TennCare</li> <li>■ Meghann Galland, TennCare</li> </ul>
<b>Texas</b>	<ul style="list-style-type: none"> <li>■ Joyce Pohlman, Texas Health and Human Services Commission</li> <li>■ Elizabeth Jones, Texas Health and Human Services Commission</li> <li>■ Joy Kearney, Texas Health and Human Services Commission</li> <li>■ Dena Stoner, Texas Health and Human Services Commission</li> <li>■ Jennie Costilow, Texas Health and Human Services Commission</li> </ul>
<b>Vermont</b>	<ul style="list-style-type: none"> <li>■ Megan Tierney-Ward, Vermont Agency of Human Services</li> </ul>
<b>Virginia</b>	<ul style="list-style-type: none"> <li>■ Karen Kimsey, Virginia Department of Medical Assistance Services</li> <li>■ Jason Rachel, Virginia Department of Medical Assistance Services</li> <li>■ Tammy Whitlock, Virginia Department of Medical Assistance Services</li> </ul>
<b>Washington</b>	<ul style="list-style-type: none"> <li>■ Alice Lind, Manager, Washington State Health Care Authority</li> <li>■ Karen Fitzharris, Washington Department of Social and Health Services</li> </ul>

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- <sup>9</sup> In 2001, Congress authorized the funding of Real Choice Systems Change Grants to states to encourage restructuring their long-term care systems to focus more on HCBS rather than residential living. The grant funding was intended to assist states in developing the regulatory, administrative, program and payment infrastructure to accomplish this restructuring. The grant funding ranged from \$300,000 to \$800,000 to be paid out over three to four years, and was targeted at a specific area of the state's HCBS system in order to incentivize new initiatives or investment in expanding existing ones. There were a variety of categories and specific grant areas within Systems Change grant funding, including Person-Centered Planning Grants and the Person-Centered Hospital Discharge Model. Between 2001 and 2010, CMS distributed over \$288 million through Systems Change grants, with many states receiving more than one. As the program has continued, CMS has disseminated less money to fewer states, with approximately \$2 million being awarded to six states in 2011. Sources: Centers for Medicare & Medicaid Services. "Real Choice Systems Change Grant Program." Available at: <https://www.medicaid.gov/medicaid/ltss/real-choice/index.html>; M. Kehn and D. Lipson. "The Real Choice Systems Change Grant: Building Sustainable Partnerships for Housing." Mathematica Policy Research, March 24, 2014. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/final-rcsc-report.pdf>.
- <sup>10</sup> In 2011, CMS launched the Financial Alignment Initiative to improve care coordination for dually eligible beneficiaries within Medicaid and Medicare. States had the option to propose a capitated or managed fee-for-service model demonstration that would integrate primary, acute, behavioral health, and LTSS under a streamlined financial arrangement. In the capitated model, the state engages in a three-way contract with CMS and a health plan in which the health plans are paid a prospective, blended payment to provide integrated services to the dually eligible population. In the managed fee-for-service model, the state and CMS engage in an agreement whereby the state can receive shared savings when the demonstration successfully reduces costs and improve quality of care for the target population. A review of beneficiary experience in 2017 found that participants reported increased access to services and improved care coordination, with some complaints of limited provider networks. As of January 2018, nine states (CA, IL, MA, MI, NY, OH, RI, SC, and TX) were operating capitated model demonstrations and one (WA) was operating a managed fee-for-service demonstration. Demonstrations in CO and VA ended as of December 31, 2017. Sources: Centers for Medicare & Medicaid Services. "Financial Alignment Initiative for Medicare-Medicaid Enrollees." Available at: <https://innovation.cms.gov/initiatives/Financial-Alignment/>; RTI International. "Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative." March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>; Centers for Medicare & Medicaid Services. "Financial Alignment Initiative for Medicare-Medicaid Enrollees." Available at: <https://innovation.cms.gov/initiatives/Financial-Alignment/>.
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## Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States

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## Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States

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## Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States

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<sup>92</sup> For more information about the evaluation reports, refer to: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.

<sup>93</sup> Arizona also integrates physical and behavioral health care for Medicaid beneficiaries with serious mental illness through contracts with Regional Behavioral Health Authorities (RBHAs). To support the state goal to further integration of service delivery for dually eligible individuals including those with serious mental illness, the RBHA contractors are also required to operate companion D-SNPs.

<sup>94</sup> See 42 CFR 422.66 for regulatory guidance related to coordination of enrollment and disenrollment through MA organizations. CMS lifted a temporary moratorium implemented on October 21, 2016 on approval of new requests to conduct seamless enrollment from all MA health plans, including D SNPs, in August 2018 under 42 CFR 422.66(c)(2). . “Seamless enrollment of individuals upon initial eligibility for Medicare,” (10-21-16 memo). Retrieved from [https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS\\_Memo\\_Seamless\\_Moratorium.pdf](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf)

<sup>95</sup> In October 2016, following inquiries about how health plans are using this mechanism and related beneficiary protections, CMS placed a temporary moratorium on new health plan approvals for seamless conversion while it reviews current policies, although already-approved health plans were allowed to continue. In August 2018, CMS lifted the moratorium for eligible D-SNPs pending CMS approval under 42 CFR 422.66(c)(2), effective October 1, 2018. “Default Enrollment Option for Newly Medicare Advantage Eligible Medicaid Managed Care Plan Enrollees (formerly known as “Seamless Conversion Enrollment”)”. CMS. August 31, 2018. Available at: [https://www.integratedcareresourcecenter.com/sites/default/files/CY%202019\\_Default%20Enrollment%20Transition%20Guidance\\_8-29-18.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/CY%202019_Default%20Enrollment%20Transition%20Guidance_8-29-18.pdf).

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<sup>101</sup> Though both 1115 waiver and 1915(c) waivers have budget/cost neutrality requirements, cost neutrality under a 1915(c) waiver is more standardized and an easier threshold to meet compared to a 1115 waiver. More information available: <https://www.macpac.gov/subtopic/waivers/>.

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<sup>110</sup> New York State Department of Health. "Individuals with Intellectual and/or Developmental Disabilities (I/DD) 1115 Waiver Transition". Available at: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/draft\\_idd\\_1115\\_waiver.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm).

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<sup>117</sup> B. Hogan, et al., op. cit.

<sup>118</sup> New York State Department of Health. "Frequently Asked Questions (FAQ), Care Coordination Organizations / Health Homes (CCO/HH)." July 28, 2017. Available at: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/frequently\\_asked\\_questions.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/frequently_asked_questions.pdf).

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<sup>121</sup> CMS. "Program of All-Inclusive Care for the Elderly." Available at: <https://www.medicaid.gov/medicaid/ltss/pace/index.html>.

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<sup>127</sup> Case study update from Maryland, September 18, 2018.

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