



How do Managed Long-Term Services and Supports (LTSS) Programs Interact With Federal LTSS-Related Initiatives?

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Executive Summary

As states continue to shift their long-term services and supports (LTSS) programs from a fee-for-service to a managed LTSS (MLTSS) environment, there is growing interest in understanding how MLTSS programs interact with federal initiatives focused on LTSS. This brief examines the interactions of MLTSS programs in four states—Illinois, Iowa, New York, and Ohio—with the following federal initiatives:

- Money Follows the Person (MFP) demonstration, which provided grants to states to help individuals transition from institutions to home and community-based settings
- Balancing Incentive Program, which provided eligible states with enhanced federal Medicaid matching funds to increase access to home and community-based LTSS
- Health Home State Plan Option, which provides enhanced federal Medicaid matching funds for care coordination services provided through Health Homes to beneficiaries with chronic conditions
- Financial Alignment Initiative (FAI), commonly known as integrated care for Medicare-Medicaid dual eligibles, or the “dual demonstration” program

Despite some variation across states in how MLTSS programs operate concurrently with other federal LTSS initiatives, we identified the following relationships across the four study states:

- The MFP demonstration and Health Home State Plan options can complement the MLTSS benefit package when program roles and operational relationships are articulated clearly. Defining the respective roles of MFP or Health Home coordinators in relation to MLTSS service coordinators is particularly important to ensure that efforts are not duplicated and that individuals experience consistency and continuity in their care.
- The goal of the Balancing Incentive Program was to increase non-institutionally-based LTSS spending, which complemented MLTSS at the LTSS system level rather than at the service delivery level. During the demonstration, the Balancing Incentive Program provided incentives for states to increase community integration through three LTSS system reforms: (1) the No Wrong Door/Single Entry Point System; (2) Conflict-Free Case Management Services; and (3) Core Standardized Assessment Instruments. The Balancing Incentive Program’s focus on systemic change has had less direct impact on beneficiaries; therefore, the interface with MLTSS was less direct. The MLTSS plan

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within the framework established by federal statutes, regulations, and guidance, states may choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget-neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver LTSS to Medicaid beneficiaries with disabilities who need assistance with activities of daily living. Section 1115 is one of several federal authorities that states may use to operate MLTSS programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per-member-per-month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement—combined with contract requirements to protect enrollees—can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability of less costly home and community-based services as an alternative to institutional care.

representatives interviewed for this brief described less involvement with and awareness of the Balancing Incentive Program as compared to the representatives of the other federal initiatives studied.

- FAI is usually an additional, competing program option for dual-eligible beneficiaries who qualify for both a Medicaid-only MLTSS program and an FAI Medicare-Medicaid program. The Medicaid-only MLTSS has usually been implemented first, serving as a building block for FAI by giving states and plans experience with MLTSS before they offer integrated Medicaid-Medicare coverage as an added option.

MLTSS programs and other federal LTSS initiatives share the goal of promoting and improving the community-based LTSS system. At an operational level, it takes a significant commitment of time and communication among key players—state staff, MLTSS plans, and community organizations participating in other federal initiatives—to develop clear relationships and protocols across programs. States planning to implement MLTSS should articulate the ways in which MLTSS will interact with other federal initiatives and then work with stakeholders to define clear roles and points of interface across programs.

Introduction

This brief examines the interactions of managed long-term services and supports (MLTSS) programs in four states (Illinois, Iowa, New York, and Ohio) with the following federal initiatives:

- Money Follows the Person demonstration (MFP), which provided grants to states to help transition individuals from institutions to home and community-based settings
- Balancing Incentive Program, which provided eligible states with enhanced federal Medicaid matching funds to increase access to home- and community-based LTSS

- Health Homes State Plan Option, which provide enhanced federal Medicaid matching funds for care coordination provided to beneficiaries with chronic conditions
- Financial Alignment Initiative (FAI), commonly known as integrated care for Medicare-Medicaid dual eligibles, or the “dual demonstration” program

MLTSS programs and these federal initiatives share the goals of improving LTSS system balance and service coordination and have been implemented concurrently in many states (Table 1). An early study of coexisting MFP and MLTSS programs found that their synergies may be maximized by assigning clear roles to each, structuring MLTSS plan payments to ensure effective transitions, and combining the resources of the two programs to maximize capacity for particularly challenging transitions (Lipson and Valenzano 2013). A later update of the study reinforced the potential synergy of the two programs and noted that MLTSS programs may be used to sustain transition efforts after the expiration of federal MFP grants, provided that incentives are built into MLTSS programs (Libersky et al. 2015). However, little is known about the way in which other LTSS-related federal initiatives may affect access to home- and community-based services (HCBS) or other outcomes for MLTSS enrollees.

This brief explores the synergies and challenges associated with the concurrent operation of MLTSS programs with MFP, Balancing Incentive Program, Health Homes, and/or FAI in four states, drawing on recent experiences reported by state and managed care plan officials in those states. The findings will guide MLTSS program evaluations and offer lessons to other states operating concurrent MLTSS and federal LTSS initiatives.

Table 1. MLTSS states operating other federal initiatives

State	MLTSS (earliest effective enrollment date)	MFP ^a (year of grant award, grant period 2007–2016)	Balancing Incentive Program (year of grant award, grant period October 2011–September 2015 ^b)	Health Homes (earliest effective enrollment date)	FAI ^c (earliest effective enrollment date)
Arizona	Jan. 1989				
California	Apr. 2014	2007			Apr. 2014
Delaware	Apr. 2012	2007			
Florida	Aug. 2013				
Hawaii	Feb. 2009	2007			
Illinois*	May 2011	2007	2013		Mar. 2014
Iowa*	Apr. 2016	2007	2012	Jul. 2012	
Kansas	Jan. 2013	2007		Jul. 2014	
Massachusetts	Mar. 2004	2011	2014		Oct. 2013

(continued)

State	MLTSS (earliest effective enrollment date)	MFP ^a (year of grant award, grant period 2007–2016)	Balancing Incentive Program (year of grant award, grant period October 2011–September 2015 ^b)	Health Homes (earliest effective enrollment date)	FAI ^c (earliest effective enrollment date)
Michigan	Jan. 1998	2007		Jul. 2016	Apr. 2015
Minnesota	Jan. 1997	2011			
New Jersey	Jul. 2014	2007	2013	Jul. 2014	
New Mexico	Jan. 2014			Apr. 2016	
New York*	Jan. 1998	2007	2013	Feb. 2012	Jan. 2015
North Carolina	Jan. 2005	2007		Oct. 2011	
Ohio*	May 2014	2007	2013	Oct. 2012	May 2014
Pennsylvania	Jan. 2009	2007	2014		
Rhode Island	Nov. 2013	2011		Nov. 2011	Dec. 2015
South Carolina	Feb. 2015	2007 ^d			Feb. 2015
Tennessee	Mar. 2010	2011			
Texas	Jan. 1998	2007	2013		Mar. 2015
Virginia	Mar. 2014	2007			Apr. 2014
Wisconsin	Jan. 1996	2007		Oct. 2012	

Source: MFP information retrieved from Medicaid.gov, August 2017. Available at <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html>.

Balancing Incentive Program, Health Homes, and FAI: NASUAD State Health Information Tracker, April 2016 Edition. Available at http://nasuad.org/sites/nasuad/files/State%20Medicaid%20Integration%20Tracker%2C%20April%2019%2C%202016_0.pdf. Accessed August 4, 2017.

Notes: States denoted with an asterisk (*) are featured in this brief.

^a MFP grantees submitted a final FY 2016 budget in October of 2015. Any unused portion of a State grant award made in 2016 could be made available to the State until 2020 through no cost extensions.

^b The Balancing Incentive Program ended in 2015.

^c All MLTSS states' FAI programs are capitated models.

^d The South Carolina MFP grant became inactive in 2008 and was reinstated in 2011.

Background on the Study States

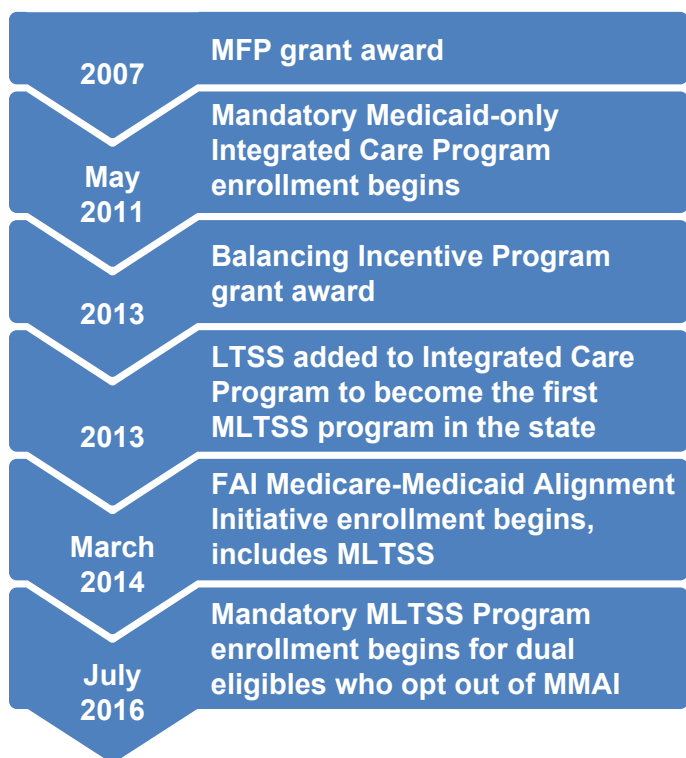
Illinois, Iowa, New York, and Ohio each operates a unique array of MLTSS programs and initiatives that are featured in this brief. This section provides an overview of the states' MLTSS programs and details on when they were implemented relative to other federal LTSS initiatives also operating in those states.

Illinois

Illinois implemented its first MLTSS program in 2011; it now operates three MLTSS programs. A mandatory Medicaid-only program that began in 2011, the Integrated Care Program (ICP), incorporated LTSS in 2013; a voluntary FAI program, the Medicare-Medicaid Alignment Initiative (MMAI), began in 2014; and the mandatory dual-eligible program for individuals who opt out of MMAI, the "MLTSS Program," began in 2016¹ (see Figure 1). In terms of years of experience with MLTSS, Illinois falls in the middle of the four study states.

The first of the federal initiatives in which Illinois participated was MFP, also known in the state as Pathways to Community Living, which began in 2007. In 2011, Illinois mandated managed care through ICP for older adults and adults with disabilities who are eligible for Medicaid but not for Medicare. ICP initially covered

Figure 1. Illinois Timeline



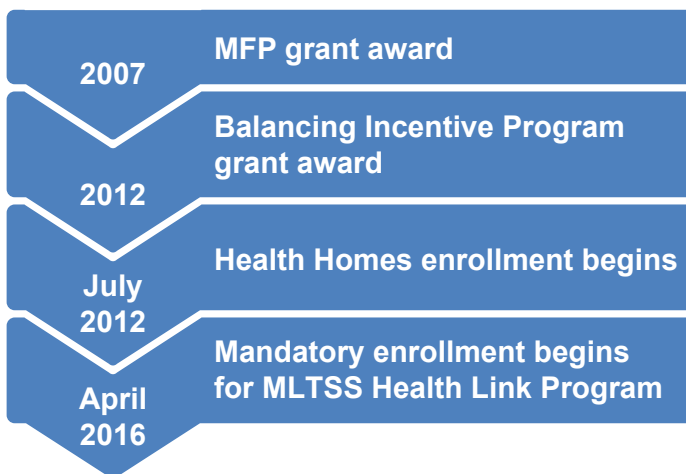
only acute, primary, specialty, and behavioral health care but added LTSS in 2013. ICP does not yet cover LTSS for individuals with an intellectual or developmental disability, although ICP covers other Medicaid benefits for this population.

After ICP added LTSS to its service package in 2013, the state took on several additional LTSS-related initiatives. During 2013, Illinois was approved to participate in the Balancing Incentive Program. In 2014, Illinois began enrollment into the state's FAI demonstration program, MMAI. In July 2016, more than two years after MMAI enrollment began, Illinois began mandatory enrollment of dual eligibles who opted out of MMAI into its third MLTSS program, called the "MLTSS Program." The "MLTSS Program" provides LTSS to dual-eligible beneficiaries with a nursing facility level of care, including both institutional and 1915(c) waiver HCBS.

Iowa

Health Link, the one MLTSS program that Iowa operates, launched in April 2016, making Iowa the most recent MLTSS state in this study (see Figure 2). Health Link coordinates care for children with disabilities, adults with physical and intellectual or developmental disabilities, and adults age 65 years and older.

Figure 2. Iowa Timeline



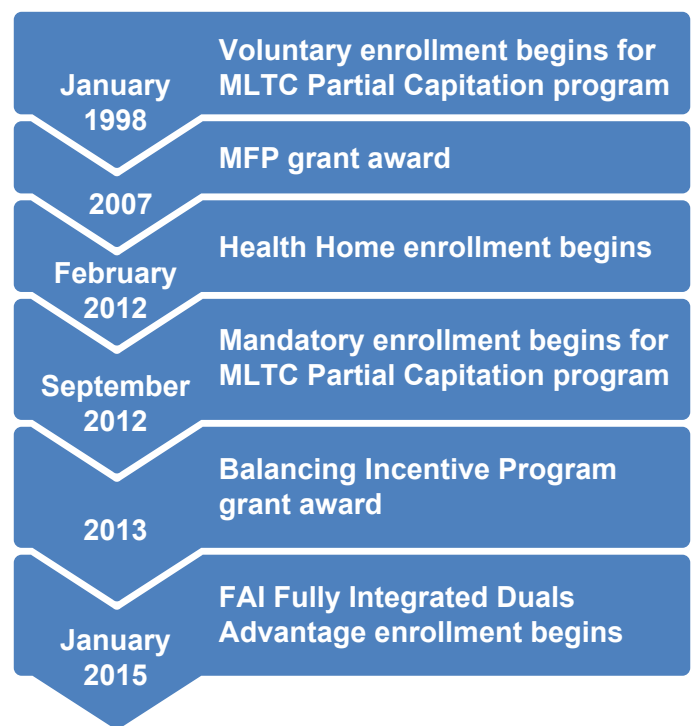
Almost 10 years before Iowa's implementation of Health Link, the state began participating in its first LTSS-related initiative—MFP—which targeted individuals with intellectual and developmental disabilities, a group that overlaps with the Health Link population. Iowa's MFP program is also known as the Partnership for Community Integration. The state also participated in two additional initiatives: (1) a Balancing Incentive Program grant, awarded in 2012; and (2) Iowa's Health Home initiative, which began enrollment in July 2012. The state's Health Home initiative serves two target populations. One target population is individuals with two or more chronic conditions or individuals

with one chronic condition and at risk of developing another. Chronic conditions include mental health conditions, substance use disorders, asthma, diabetes, heart disease, and more. The second target population includes adults and children with severe and persistent mental illness.

New York

New York implemented its first MLTSS program in 1998, making it the study state with the longest MLTSS experience (see Figure 3). The state now operates three MLTSS programs: (1) the now mandatory Managed Long-Term Care (MLTC) Partial Capitation program for older adults and adults with physical disabilities; (2) the voluntary opt-in program for Medicare-Medicaid-eligible beneficiaries, called the Medicaid Advantage Plus program, which began in 2006; and (3) the voluntary opt-out FAI program for Medicare-Medicaid-eligible beneficiaries, called the Fully Integrated Duals Advantage program (FIDA), which began in 2015.

Figure 3. New York Timeline



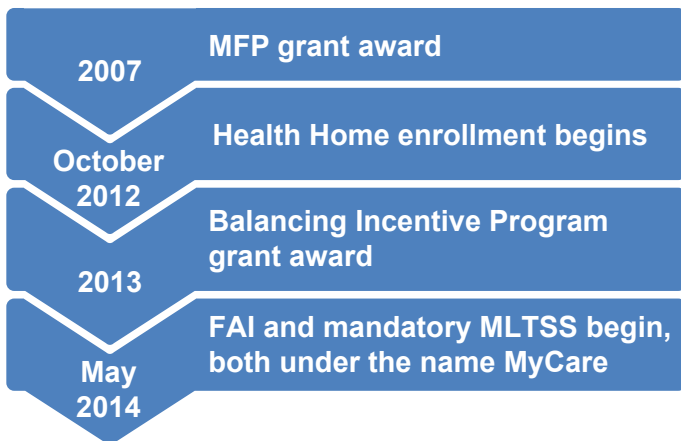
New York first experimented with LTSS system reforms through the MLTC Partial Capitation program, beginning in January 1998. The program covers only institutional and community-based LTSS; primary and acute care services are carved out and provided on a fee-for-service basis or through separate medical managed care plans. In 2007, almost 10 years after implementation of the MLTC Partial Capitation program, the state was awarded an MFP grant to support the program, also known as Open Doors. In February 2012, the state began enrollment for its Health Home initiative, with a target popula-

tion of dual eligibles with chronic behavioral health and medical conditions. Beginning in September 2012, six months after New York started enrolling individuals in Health Homes, the state expanded the MLTC Partial Capitation program through mandatory statewide enrollment. In the following year (2013), New York was awarded a Balancing Incentive Program grant. In January 2015, the state began to enroll dual eligibles in New York's FAI demonstration, the FIDA program. FIDA's eligible population is dual-eligible adults with physical disabilities and adults age 65 years and older.

Ohio

In 2014, Ohio launched its MLTSS program, MyCare, placing the state in the middle of our study states in terms of MLTSS experience (see Figure 4). MyCare embeds under one name (1) a voluntary FAI program and (2) a mandatory Medicaid services-only program for eligible individuals who opt out of the FAI program.

Figure 4. Ohio Timeline



Ohio first participated in an LTSS-related initiative through the award of an MFP grant in 2007, which initiated the HOME Choice program (Helping Ohioans Move, Expanding Choice). In October 2012, the state launched its Health Home program. Ohio's Health Home target population is individuals with severe mental illness. The following year, in 2013, the state was awarded a Balancing Incentive Program grant and, in May 2014, implemented an FAI program, MyCare. MyCare's target population is dual-eligible older adults and adults with physical or intellectual/developmental disabilities. Individuals who opt out of the MyCare FAI program are required to enroll in a Medicaid-only version of MyCare.

Findings

Each of the four federal initiatives highlighted in this brief—MFP, Balancing Incentive Program, Health Home, and FAI—are tailored to meet states' specific Medicaid goals for improving each state's health and LTSS systems. By interviewing state officials and MLTSS plan leaders from the four states, we gained insight into how the states' MLTSS programs interact with the featured federal initiatives and how concurrent operation proved advantageous or challenging or both. In this section, we describe the synergies, challenges, and sustainability of selected federal initiatives operating concurrently with MLTSS programs.

Money Follows the Person

MFP is a Medicaid demonstration project that supports states in shifting LTSS spending from institutional to home and community-based care.² MFP grant funds are used to support Medicaid beneficiaries for a 365-day period to transition from long-term care institutions to qualified community residences. MFP grant funds are also used to support beneficiary transitions through a variety of services including demonstration and supplemental services. MFP demonstration services are allowable Medicaid services not currently included in the state's array of HCBS; examples include assistive technologies or qualified HCBS beyond what would be available to non-MFP Medicaid beneficiaries, such as 24-hour personal care provided 7 days a week. MFP supplemental services are HCBS not typically covered outside of 1915(c) waiver programs, including items such as an apartment security deposit, moving costs, furniture, or home modification expenses. MFP-funded transition coordinators work directly with institutional care residents and staff and with community-based organizations such as Centers for Independent Living and Area Agencies on Aging (AAA) to identify individuals eligible for the program; assess individuals interested in transitioning to the community; conduct pre-transition planning; conduct Medicaid program eligibility assessments for HCBS programs; arrange for 1915(c) waiver and state plan HCBS, housing, and other community services; and provide post-transition follow-up. Nationally, 20 states with MLTSS programs participate in MFP.

As an added incentive to the MFP program, states are eligible for enhanced Federal Medical Assistance Percentage (FMAP) when providing qualified HCBS (that is, HCBS received through states' 1915(c) and state plan services) and demonstration HCBS (that is, HCBS not currently provided through states' 1915(c) or state plan services) (Irvin et al. 2015). MFP supplemental services that are typically not reimbursable outside Medicaid waiver programs are eligible for states' regular FMAP, not for MFP-enhanced FMAP.

Table 2. Key components of MFP and MLTSS concurrent operation

Key components	Illinois—Pathways to Community Living	Iowa—Partnership for Community Integration	New York—Open Doors	Ohio—HOME Choice
MLTSS plans required to coordinate with MFP transition agencies	Yes, in MLTSS plan contract	Yes, in MLTSS plan contract	Not in MLTSS contract, but included in MFP operational protocol	Yes, in MLTSS plan contract
MFP services paid for outside MLTSS capitation rate	Yes	Yes	Yes	Yes
MLTSS payment for MFP transitions	Yes ^a	No	No	No
MLTSS and MFP care coordination: lead care coordinator entity during MFP year	MFP transition agencies	MFP transition agencies	To be determined	MLTSS plans
MLTSS plan care coordinators assigned to specific nursing facilities	Yes	Yes	Yes	Yes
MLTSS plans and MFP transition agencies cross-train staff	No	Yes	No	Yes

^aIllinois managed care plans are required to pay MFP transition agencies bonuses for successful transitions; see the text for a full discussion.

All four states in this study operate MFP programs separately from their MLTSS programs and require coordination across the two programs for individuals who participate in both. In Illinois, Iowa, and Ohio, MFP implementation predated MLTSS, and, in New York, MFP predated the inclusion of nursing homes in MLTSS. A comparison of several key components of the two programs appears in Table 2.

Recognizing the lower cost of community-based care, all four states pay MLTSS plans capitation rates that blend nursing facility/HCBS costs, thereby offering a strong financial incentive to provide care in the community rather than in nursing facilities. In the context of MFP, if an MLTSS plan lacks the capacity to transition individuals from institutional to community settings, it provides an incentive to work closely with MFP programs with such capacity.

Synergies

MLTSS plans and MFP transition service providers share an interest in promoting successful transitions to community living. State officials and staff for MLTSS plans interviewed for the study identified the synergies between MFP and MLTSS. MLTSS plans with blended rates (in which capitation rates paid to MLTSS plans consist of rates for lower-cost home- and community-based services and supports, blended with rates for higher-cost nursing facility services) benefit financially if (1) they increase the percentage of members served in community settings and (2) MFP transition service providers receive more revenue as the number of beneficiaries they serve increases. MLTSS plans' care coordination activities and analyses of nursing facility data also can increase the number of candidates identified for MFP, helping to expand the number

of individuals who transition to community settings. In addition, the services that MLTSS and MFP provide to transitioning members are often complementary and together can support transitions to the community. While MLTSS provides LTSS and coordinates those services with medical services, MFP provides specialty transition services, including peer support and coverage of expenses related to establishing a new household, such as security deposits and furnishings.

Collaborative partnership between MFP transition agencies and MLTSS plans

Illinois, Iowa, New York, and Ohio identified three main components that contributed to collaboration between MFP transition agencies and MLTSS plans: (1) state contracts or other documentation with managed care plans that require coordination between MLTSS plans and MFP transition agencies, (2) documentation detailing the process of coordination between MLTSS plans and MFP transition agencies, and (3) designation of a lead entity for coordination during a beneficiary's transition from a nursing home to the community.

From an administrative perspective, three of the featured states—Illinois, Iowa, and Ohio—used state managed care plan contract language that requires MLTSS plans to coordinate with the MFP program through local organizations (referred to as MFP transition agencies in this brief). One state, Illinois, included additional contract requirements for an MFP incentive payment structure, requiring MLTSS plans to pay MFP transition agencies for successful transitions. New York relies on a separate MFP operational protocol that includes the role of the MLTSS program (New York State Money Follows the Person Rebalancing Demonstration 2016).

Despite the MLTSS plans' contracts with the states requiring MLTSS plans to coordinate with MFP transition agencies, none of the MLTSS plans used a contract or other formal business agreement to govern its relationships with the MFP transition agencies. One MLTSS plan referred to its relationships with the MFP transition agency as "formally informal." In Illinois, a detailed flow chart outlines the MFP and MLTSS plan coordination process (Managed Care/MFP Process for All Counties in Illinois except Cook County 2015). Part of the Illinois MFP and MLTSS plan coordination process requires MLTSS plans to provide a \$1,000 incentive payment to the MFP transition agencies for each individual who makes a successful transition at 90 days and another \$1,000 incentive payment for individuals who remain in the community 365 days post-transition. Illinois MLTSS plan officials confirmed through interviews that, despite the incentive payment structure, MLTSS plans do not have contracts with the MFP transition agencies that govern the incentive payment or transition process. One MLTSS plan in Illinois explained that it did have contracts with some of the MFP transition agencies but that the contracts were for MLTSS-covered benefits, not for MFP services.

The MLTSS plan clinical staff from Illinois, Iowa, and Ohio described a high degree of coordination with the MFP transition agencies in which program staff and processes integrate well. In New York, MLTSS plan officials explained that their collaboration with MFP was relatively new and that they were meeting with state officials in order to develop a better understanding of the expectations for collaboration with MFP transition agencies. Collaboration between MLTSS plans and MFP transition agencies became more relevant in July 2015, when MLTSS became mandatory for dual-eligible adults residing in nursing facilities statewide in New York (MLTC Overview n.d.).

Designating a lead coordinating entity from the MLTSS plan or the MFP transition agency contributed to the strong collaborative nature of these entities during the MFP transition year. In Illinois and Iowa, the MFP care coordinators are responsible for providing leadership for the transition plan and services, whereas the MLTSS plans provide access to the LTSS benefits as wrap-around services and participate in MFP-led care team meetings, as necessary. In Ohio, the MLTSS plan care coordinator assumes the lead care coordinator role and uses the MFP care coordinator as a resource for transition-related items. In New York, state and MLTSS plan officials work to provide a structure around the MLTSS plan and MFP collaboration, including identification of which care coordinator will lead during the transition year.

The collaboration between the programs has contributed to success in promoting HCBS in Illinois. For example, state officials reported anecdotally that they have seen an increase in successful transitions from the nursing home setting to the HCBS setting through MFP since the implementation of ICP.³ Government officials credit this success in large part to the state's

requirement that MLTSS plans provide care coordination to nursing facility members, including the identification of individuals who want to transition to the community. Illinois also credited successful transitions to the required collaboration of the MLTSS plan with MFP transition agencies.⁴

MLTSS-covered benefits supplement MFP transition services

Consistent with findings from Libersky and others (2015), the present study found that MFP and MLTSS programs could increase their effectiveness in transitions by providing more supportive services collectively than either program can offer individually. The representatives of MLTSS plans interviewed for the study offer the following services that complement the MFP transition benefits: coordinating with primary care providers, setting up needed medical appointments, coordinating transportation, arranging for durable medical equipment and prescription drugs, and authorizing and paying for all MLTSS-covered benefits. MLTSS plans in Illinois and Ohio described MFP as complementing LTSS-covered services with peer support, first month's rent and security deposit, household furnishings, service animals, and home modifications.

Challenges

Despite a high level of synergy between the MLTSS and MFP programs, state and MLTSS plan officials identified several challenges stemming from the parallel objectives of each program: (1) defining roles and responsibilities across the two programs, (2) supporting beneficiaries in the community after the MFP transition year, (3) managing nursing home provider resistance, and (4) delineating additional state transition programs that overlap with MFP.

Defining roles and responsibilities

One challenge frequently noted by MLTSS plan officials across all four states was that of defining roles and responsibilities across staff and processes. When MLTSS was first implemented in each of the study states, its role relative to the existing MFP program was not delineated clearly enough, particularly with regard to service coordination. Study participants observed that, in retrospect, states, MLTSS plans, and MFP agencies could have more clearly specified what each party would coordinate and how it would interact with each other, particularly at key points in an individual's transition (Libersky et al 2015; Lipson and Valenzano 2013). One solution to coordinating across programs is to develop tools that outline relationships across affiliated entities. For example, Illinois developed a flowchart illustrating organizational relationships from pre-referral through transition. It addresses both the administrative and clinical responsibilities of MFP transition agencies and MLTSS plans (Appendix A). Another solution adopted by all four states was to provide initial and ongoing MFP program training for MLTSS plan care coordinators to ensure that MLTSS staff actively

coordinate with MFP staff from the beginning of the MLTSS member’s engagement with the MFP program.

Supporting beneficiaries in the community after the MFP transition year

Another challenge of operating MLTSS and MFP programs together arises with providing the services that support beneficiaries in the community after the MFP transition year. Program representatives identified the end of an MFP participant’s 12-month transition period as a point when the participant may experience an abrupt decrease in services and supports if the MLTSS plan and MFP transition service providers have not closely coordinated the gradual phase-out of transition services. Some interviewees noted that, after the MFP transition year, MLTSS plan service providers were unable to offer the same level of community support that beneficiaries received through MFP. For example, beneficiaries may receive more hours of personal care during the MFP transition year than is sustainable under the cost-effectiveness requirements of a state’s MLTSS program waivers.

One way in which MLTSS plans can cover services outside the MLTSS benefit package to better support beneficiaries following the MFP year is to offer value-added services that are not contractually obligated. For example, Iowa’s MLTSS program allows each MLTSS plan to designate unique value-added services. One Iowa MLTSS plan covers value-added services for its members that support community integration, such as free cell phones, medication adherence support through electronic pill dispensers, and home-delivered meals after hospitalization (MCO Comparison Chart: Value-Added Services n.d.).

Managing nursing home provider resistance to transitioning members to the community

Some MLTSS plans noted resistance on the part of some nursing homes to identifying, referring, and supporting member transitions into the community. One strategy MLTSS plans used

to overcome nursing home resistance was to assess nursing home members directly, both at initial enrollment and over time. To facilitate the assessment, all MLTSS plans assign care coordinators to specific nursing facilities to help educate and engage nursing home staff and members about the MFP program. An Ohio MLTSS plan succeeded in its transition efforts by using third-party assessments, analyzing Minimum Data Set (MDS) assessments, and offering incentives to nursing home providers to assist in the transition process.

Delineating additional state transition programs that overlap with MFP

Another challenge identified by Illinois concerned the overlap between its MFP program and other transition programs, including three *Olmstead* consent decrees.⁵ For members who qualify for several programs, the challenge is to determine the best program to meet a member’s needs. The location of the transitioning individual is another factor, as the several *Olmstead* consent decree transition programs and MFP operate with overlapping but different geographic boundaries. For example, the *Colbert versus Quinn* consent decree in Illinois covers only Cook County nursing facility residents (*Colbert v. Quinn* n.d.), whereas MFP operates statewide.

To address this jurisdictional problem, Illinois developed a state-operated referral system that triages individuals to the most appropriate transition program. In addition, Illinois developed a state-operated web application that allows MLTSS plans and MFP staff to access MFP member information through an online portal. MFP transition agency staff document their case notes and the progress of the individuals transitioning into the community in the web application, allowing MFP and MLTSS plan staff to communicate during an MFP participant’s transition to the community.

In Table 3, we summarize the various challenges and the solutions that state and MLTSS plan officials have designed to overcome them.

Table 3. Challenges and solutions in concurrently operating MFP and MLTSS programs

Challenge	Solutions identified
Start-up coordination across MLTSS and MFP staff and processes: Defining roles and responsibilities	<ul style="list-style-type: none"> Engage staff from the state, MLTSS plans, and MFP agencies to coordinate complementary programs and staff Develop tools to define relationships across programs and staff Offer initial and ongoing training to MLTSS plans and MFP transition agencies
Transitioning to MLTSS benefits after MFP participation ends	<ul style="list-style-type: none"> Allow MLTSS plans to offer value-added services to assist members further with adjusting to community living Encourage partnerships between MLTSS plan and MFP care coordinators to ensure a smooth and gradual transition from MFP support to MLTSS support

Challenge	Solutions identified
Nursing home resistance to identifying MFP candidates	<ul style="list-style-type: none"> Require the MLTSS plans to conduct assessments directly, use a third party to conduct assessments, and/or analyze MDS assessments to identify candidates^a Assign MLTSS plan care coordinators to specific nursing facilities to build relationships with nursing home staff and members Offer nursing homes incentives for successful transitions
MFP overlap with other transition programs, including Olmstead consent decrees	<ul style="list-style-type: none"> Develop a centralized referral and triage system to identify the most appropriate transition services for Medicaid beneficiaries Develop a web application allowing both MLTSS plans and MFP transition agencies to access information easily on MFP participants who are enrolled with an MLTSS plan in the MFP transition year

^aThe MDS is a component of the Resident Assessment Instrument (RAI), a required assessment for Medicare- and Medicaid-certified nursing homes. MDS section Q is designed to record participation, expectations, and goals of the resident (and his/her family members/significant others). There are items in MDS section Q pertaining to discharge from the nursing home that help identify individuals interested in transition to the community.

Sustainability

State and MLTSS plan officials in all four study states have begun discussions about sustaining MFP-like activities through MLTSS when federal MFP authorization ends.⁶ Iowa reported that it is already planning to transition responsibility for MFP to its MLTSS programs, and the state has required MLTSS plans to assist with the development and implementation of the sustainability plan. Both state and MLTSS plan officials see value in providing transition services and promoting community living through MLTSS programs and agree that the incentives are aligned for the state, MLTSS plans, and individuals who want to transition. However, all states also agreed that the structure and benefits for transition support within the MLTSS program might not exactly mirror the MFP program as it looks today. In the future, MFP transition agencies could become network providers and receive payments from MLTSS plans. Any transition service not authorized under the state plan could be delivered as a value-added/enhanced benefit under MLTSS, funded by savings achieved through lower utilization of institutional services. MLTSS plan representatives acknowledge that they have a financial incentive to provide transition services, especially if they can keep transitioned individuals enrolled as members over time. However, the same representatives expressed concern that they may not recoup their investments if transitioned members switch to competing MLTSS plans in the community.

One of the MLTSS plans in Illinois explained that sustaining MFP through MLTSS goes beyond funding in that it also requires staff expertise. MLTSS plans will need to increase their internal capacity or contract with community agencies that have such expertise. One of the MLTSS plans in Iowa said that some MFP staff members have been hired by MLTSS plans that want in-house expertise.

The Balancing Incentive Program

The Balancing Incentive Program was a federal Medicaid initiative that provided states with incentives to increase access to home and community-based LTSS through an enhanced FMAP⁷ available from October 2011 through September 2015.⁸ States

New York used a portion of its Balancing Incentive Program funds to create a Balancing Incentive Program Innovation Fund, a grant program designed to promote provider, advocate, and community organization leadership in developing solutions to barriers for Medicaid community-based LTSS. One of the New York MLTSS plans received two Balancing Incentive Program Innovation grants: one project provided transportation for rural members to health and community services, and the other provided palliative care with the goal of reducing institutionalization.

For more information, see:

https://www.health.ny.gov/health_care/medicaid/redesign/innovation/index.htm

participating in the Balancing Incentive Program were required to demonstrate progress in developing three structural LTSS system features: (1) a No Wrong Door/single entry point system that provides information on available services and assistance with Medicaid financial and functional eligibility processes; (2) “conflict-free” case management services provided by entities that are separate from service providers and able to monitor direct service provision;⁹ and (3) a core standardized assessment instrument that enables a uniform determination of eligibility for HCBS statewide for all eligible populations, identifies service needs, and facilitates development of individualized service plans. Nationally, eight states with MLTSS programs participated in the Balancing Incentive Program. All four states in this study participated, and all four were continuing their Balancing Incentive Program system reforms after MLTSS was implemented.

The consensus among the key informants interviewed for the study is that MLTSS programs and the Balancing Incentive Program shared a similar programmatic goal of serving beneficiaries in the home and community and therefore easily interact with and complement each other. However, in contrast to MFP, the Balancing Incentive Program focused on systemic reforms rather than on provision of specific services to consumers, making its activities less visible to stakeholders. In interviews

with those in our four featured states, we discussed the three specific Balancing Incentive Program requirements individually: No Wrong Door/single point of entry, conflict-free case management, and the core standardized assessment. Synergies, challenges, and issues related to sustainability, where applicable, are described below.

No Wrong Door

Synergies

The vision of a No Wrong Door LTSS system is that, regardless of where an individual seeks LTSS assistance, he or she will receive appropriate screening and referral. If the screening indicates a need for LTSS, the No Wrong Door entity may also conduct a level-of-care assessment or connect the individual to an appropriate entity that is able to conduct the level-of-care assessment. Clear LTSS access points (that is, No Wrong Door reforms) help divert prospective MLTSS members from nursing home admissions, potentially increasing the number of members served in community settings. Eligibility for LTSS is determined by the state and state subcontractors, with a variety of organizations performing the initial screening and community organizations usually conducting the assessment to determine eligibility for services. In Iowa, AAAs/Aging and Disability Resource Centers conducted assessments before the advent of MLTSS and still provide this function with the implementation of MLTSS. In Ohio, AAAs, Centers for Independent Living (CIL), and other community agencies continue to conduct assessments. In New York, the entry point for LTSS eligibility determination is the MLTSS enrollment broker, with AAAs and CILs maintaining responsibility for the level-of-care assessment. In Illinois, the state continues to administer the LTSS eligibility determination, and the no-wrong-door feature has not yet been defined in the context of Medicaid managed care programs that include LTSS.

MLTSS plans are a component of the LTSS system. The plans help members with existing access to LTSS maintain that access and help members who develop LTSS needs gain access to the LTSS eligibility determination process. In three of the four states studied (Illinois, Iowa, and Ohio), MLTSS plans enroll individuals without existing LTSS needs and refer them to the No Wrong Door entities for functional eligibility determinations if they develop LTSS needs. State officials in both Iowa and Ohio indicated their preference for MLTSS plans that function as an access point for their members' LTSS needs because the plans have an existing relationship with members. Iowa officials noted that one of the chief advantages of the MLTSS plan as an LTSS resource is that the MLTSS plan covers all of a member's services, including LTSS and physical health, and can offer a more integrated approach to health care. Iowa officials also remarked that MLTSS plans could support their members who are referred for a level-of-care determination. In contrast, Illinois and New York prefer to rely on community organizations to

screen individuals and refer them to services. According to Illinois government officials, their state's Balancing Incentive Program referred MLTSS members to community-based organizations; as a result, Illinois has been encouraging the MLTSS plans to develop relationships with community-based organizations. New York has used the Balancing Incentive Program to develop NY Connects, a statewide information and referral network supporting all populations with disabilities in New York, including individuals served through MLTSS programs.

Challenges

One MLTSS plan found that, by serving as a door to the LTSS system, some enrollees incorrectly believe that the plan is responsible for all components of LTSS administration and delivery. For example, although MLTSS plans in Illinois assist with enforcing the state's electronic visit verification (EVV) system that is used to monitor personal care workers, it is the state that sets EVV rules, not the MLTSS plans. Enrollees experienced frustration when the MLTSS plan did not have authority to waive or excuse a late visit, even when the enrollee believed that the personal care worker had a legitimate reason for his or her tardiness.

In one study state, officials identified another challenge with the concurrent operation of its No Wrong Door LTSS system and its MLTSS program: MLTSS plans were referring members to community No Wrong Door entities for assistance with identifying community resources when the MLTSS plans should have been providing the assistance directly to their members. State officials reported that they now monitor for inappropriate referrals and address such referrals with the MLTSS plans, as needed.

Conflict-free case management

Synergies

Part of the design elements in the Balancing Incentive Program's vision for a conflict-free case management system made reference to MLTSS plans.¹⁰ MLTSS plans can help bring states into compliance with the conflict-free case management requirement when the MLTSS plans employ or oversee MLTSS case managers and LTSS are delivered by network providers monitored by the MLTSS plans. By introducing MLTSS plans into the LTSS service delivery system, states may be able to address potential conflicts of interest that could arise if community-based LTSS organizations not only conduct level-of-care assessments but also provide HCBS case management and/or provide services to the beneficiary. Three study states—Illinois, Iowa, and Ohio—indicated that their MLTSS plans played a role in ensuring LTSS conflict-free case management by (1) providing in-house case management as a function independent of eligibility determination and service provision or (2) monitoring community-based organizations' firewalls across case management, eligibility determination, and service provision functions. However, the introduction of MLTSS plans does not automatically eliminate

LTSS case management conflicts of interest because the MLTSS plans themselves may generate conflicts, as described below.

Challenges

The conflict-free case management reforms present challenges for certain MLTSS models in which the plans subcontract with community organizations that provide case management and determine functional eligibility for LTSS. For example, in Ohio, MLTSS plans are required to subcontract with AAAs to coordinate community services for certain members, but the AAAs also conduct level-of-care assessments for certain individuals. To ensure compliance with the conflict-free provisions, MLTSS plans required AAAs to maintain firewalls between the staff conducting level-of-care assessments for the state and those coordinating services for MLTSS plans.

In Iowa, the state contracted with one of the MLTSS plans through two separate contracts to provide two distinct services: providing MLTSS services and performing level-of-care assessments. Aware of the potential conflict of interest between coordinating LTSS and determining LTSS eligibility, the MLTSS plan hired a subcontractor to conduct all level-of-care assessments in order to maintain an appropriate firewall between the two functions.

Core standardized assessment

Synergies

Through the Balancing Incentive Program, states were allowed to use their existing assessment tool, adapt or supplement their existing assessment tool, or develop a new assessment tool as long as their core dataset was collected across all target populations including people with mental health conditions (The Balancing Incentive Program: Implementation Manual 2013). Illinois, Iowa, and Ohio implemented a new standardized assessment tool as part of their Balancing Incentive Program reforms, and New York used grant funds to update and improve an existing tool. In Illinois, reliance on a standardized tool considerably streamlined the assessment process for MLTSS plans. Under Illinois's previous system, several state departments maintained and administered separate tools and processes for their respective population groups. As a result of the core standardized assessment (CSA) reform, Illinois now administers its assessment tool through a centralized online portal. In Ohio, MLTSS plans participated as stakeholders in the selection of a CSA tool, providing input on the CSAs under consideration and exchanging clinical expertise. In Iowa, the state had completed its CSA selection process by the time of MLTSS implementation; therefore, MLTSS plans were not involved in the selection process.

Challenges

Illinois and Ohio identified a short-term challenge to implementing a new CSA instrument, which has implications for how data are

transferred to MLTSS plans. Once a person is determined eligible for LTSS, the assessment results need to be transferred quickly to the MLTSS plan to permit the development of an individualized service plan. In most cases, however, the MLTSS plan's care coordination system needs to be modified to accept data from the new tool. Both state officials and MLTSS plans said that the data transfer challenge was significant, though it could be addressed over time through changes in MLTSS plans' information systems.

Sustainability for the Balancing Incentive Program

MLTSS plans offered neither advantages nor disadvantages for sustaining reforms to the Balancing Incentive Program, according to state and plan officials. Many of the reform costs were one-time administrative costs, such as developing a CSA instrument. The cost of maintaining such administrative systems is considered to be the responsibility of the Medicaid agency, whether the LTSS delivery system is a fee-for-service or managed care system.

Health Homes

Health Homes are optional Medicaid state plan benefits that provide enhanced coordination, such as comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referral to community and social support services.¹¹ Eligible Medicaid beneficiaries are individuals with two or more chronic conditions, one chronic condition and risk for a second chronic condition, or one serious and persistent mental health condition. Chronic conditions include a serious and persistent mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and a body mass index greater than 25. States may identify other chronic conditions for approval by the Centers for Medicare & Medicaid Services (CMS). Designated providers and a team of health professionals provide Health Home services. States that adopt Health Homes receive an enhanced federal Medicaid match for the Health Home services specified in the state's program. Enhanced federal matching is available for the first eight quarters of Health Home operation for each enrollee.

MLTSS enrollees often have chronic conditions that also make them eligible for Health Homes. In states where MLTSS and Health Homes operate in overlapping geographic areas, both programs may serve beneficiaries, requiring MLTSS plans and Health Homes to delineate roles, particularly regarding care coordination. Iowa, New York, and Ohio operated Health Homes that overlapped with the geographic areas and populations covered by their MLTSS programs (Table 4, see next page).

New York requires coordination between its Health Homes and MLTSS plans, but the state reimburses Health Homes directly as a fee-for-service benefit. In New York, Health Home services cover individuals with qualifying chronic physical and mental health conditions. MLTSS plans are required to provide their members with access to Health Homes, but they are not required

to contract with Health Homes as in-network providers. New York uses an administrative services agreement to delineate care management roles for the Health Home and the MLTSS plans (Statewide Administrative Health Home Services Agreement between Managed Long Term Care Plan and Health Homes n.d.).

Iowa and Ohio require MLTSS plans to contract with Health Homes as network providers, and those states can specify care coordination functions within that business relationship. Iowa operates two Health Home initiatives that target distinct populations: individuals with chronic physical health conditions and those with chronic mental health conditions. MLTSS plans are required to contract with Health Homes as in-network, participating providers. At the time of our interviews, Iowa’s MLTSS program had been in operation for only about four months, and the state had not yet formally delineated roles and responsibilities. During the initial implementation phase of Iowa’s MLTSS program, state goals included improved coordination between MLTSS and Health Homes and development of a consistent approach to integrating care between the two programs.

In Ohio, the state’s Health Home initiative covers individuals with severe and persistent mental illness. As with Iowa’s initiative, Ohio MLTSS plans are required to contract with Health Homes as

in-network, participating providers. At the time of our interviews, the Health Home initiative in Ohio was scheduled to be phased out in December 2017. At that time, managed care organizations (MCO) and the delegated Health Home care coordinators were to transition enrollees to services available as part of a new behavioral health benefit package implemented in July 2017.

Synergies

State and MLTSS plan officials in the three study states with overlapping programs (Iowa, New York, and Ohio) identified several areas of synergy between MLTSS plans and Health Homes programs. Health Homes can extend an MLTSS plan’s expertise and capacity in identifying needs and coordinating services for individuals with specific conditions, particularly through in-person interaction with members. MLTSS plans also noted that, because Health Home coordinators are provider-based, they have opportunities to engage both the provider and the beneficiary at the point of service, whereas MLTSS plan service coordinators must establish relationships with members and providers through telephone calls and visits to homes and offices. The on-site presence was particularly important for members living in rural areas, given the challenges for representatives of MLTSS plans to visit members regularly.

Table 4. Key components of Health Homes and MLTSS concurrent operation

Key components	Iowa	New York	Ohio
Target groups for both Health Homes and MLTSS	<ol style="list-style-type: none"> Members with two or more chronic conditions or one chronic condition and risk of developing another Members with serious and persistent mental illness 	Medicaid beneficiaries with two or more chronic conditions or one qualifying chronic condition: HIV/AIDS, serious mental illness (adults), or serious emotional disturbance/complex trauma (children)	Members with serious and persistent mental illness
Relationship of Health Home providers to MLTSS plan	Participating provider	For members eligible for the Health Home program: MLTSS plans required to provide access to Health Homes and coordinate case management with Health Homes via an administrative services agreement	Participating provider
Enrollment process for Health Homes	<ol style="list-style-type: none"> Eligible members opt in at Health Home practice The state may also attribute members to a Health Home Members are offered the choice to opt out 	<ol style="list-style-type: none"> State assigns members to a Health Home Members are offered the choice to opt out 	<ol style="list-style-type: none"> Eligible members opt in at Health Home practice The state may also assign members to a Health Home Members are offered the choice to opt out
Payment	State gives MLTSS plans a capitated rate, and MLTSS plans pay the Health Homes on a tiered, subcapitation basis.	State reimburses Health Home services directly; not a covered MLTSS program benefit.	State includes a cost-based rate tailored to each Health Home in the capitated rate, which the MCO passes through to the provider.

Note: For additional information on Health Homes in Iowa, New York, and Ohio, see Centers for Medicare & Medicaid Services, “Medicaid Health Homes: SPA Overview,” available at <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-overview.pdf>. Accessed August 3, 2017

State and MLTSS plan officials also described the importance of establishing effective ways to collaborate and communicate across the two programs in order to take advantage of each other's areas of expertise and to share information. In New York, to coordinate across the two programs, the state created an administrative services agreement to delineate the roles and responsibilities of the two programs' staff.¹² One MLTSS plan described development of an interface between its MLTSS program and Health Homes: the Health Homes established data feeds and portals so MLTSS plans could access and communicate health information about their shared members, and MLTSS plans and Health Homes developed a framework for future integration and coordination of services.

Challenges

The greatest challenge identified by state and MLTSS plan officials was the definition of clear and distinct coordination roles for MLTSS plans and Health Homes—"coordinating the coordinators." MLTSS care coordinators and Health Home care coordinators often had overlapping responsibilities that required intentional coordination across the two programs. States and MLTSS plans agreed that coordination took a significant amount of time and occurred largely after MLTSS implementation; it would have been preferable to clarify roles before implementation.

In two of the three states, MLTSS plans reported significant variability in the staffing and resources available through the Health Homes. For example, some Health Homes have staff expertise in coordinating both clinical and nonclinical services for the target population, whereas others have only clinical expertise. In addition, some Health Homes had the resources to host care conferences and develop new data exchanges with MLTSS plans, but others were unable to secure resources beyond the Health Homes' core services. Such variability makes it challenging for MLTSS plans to formulate standard delegation agreements and standard payment rates across Health Homes. This issue was further complicated in Ohio, where the state required MLTSS plans to pay a uniform rate to all Health Homes; the Health Homes, however, were not providing a uniform level of service.

Sustainability

Officials in the study states had varied views about whether they wanted to sustain Health Homes, regardless of their interface with MLTSS. Representatives of states and MLTSS plans agreed that MLTSS offers a potential vehicle for sustaining Health Homes

after the expiration of enhanced federal matching funds, assuming that representatives of the MLTSS plans see value in the specialized care coordination that Health Homes offer and that rates can be individually negotiated with Health Homes to reflect the services offered. Depending on the capacity of the Health Homes, an MLTSS plan may want to limit its role to management of certain conditions or may prefer to delegate the entire care coordination role. Ohio is discontinuing its Health Homes program for behavioral health services in favor of a new model using patient-centered medical homes, but representatives of MLTSS plans in that state indicated an interest in continuing their relationships with Health Homes, which is permissible as part of their network management. In New York, MLTSS plans described the growing relationship with Health Homes as increasingly beneficial in supplementing the skills of its own staff and indicated an interest in sustaining and building on those relationships.

The Financial Alignment Initiative (FAI)

FAI is a partnership between CMS and states to test two new models of care that integrate acute, primary, behavioral health, and LTSS covered by Medicare and Medicaid for individuals who are dually enrolled in both programs.¹³ The goal of FAI is to provide Medicare-Medicaid dual-eligible beneficiaries with integrated care and to align financial incentives between the Medicare and Medicaid programs. Through the FAI, states can test one of two models: (1) a capitated model in which the MLTSS plan receives capitated Medicare and Medicaid payments and provides comprehensive, coordinated care or (2) a managed fee-for-service model in which CMS and a state enter into an agreement allowing the state to be eligible to share in Medicare savings that result from the FAI program. All MLTSS states' FAI programs are capitated models.

Illinois, New York, and Ohio operate capitated FAI demonstrations and concurrent mandatory MLTSS programs (Table 5, see next page). Under federal law, Medicare beneficiaries cannot be required to enroll in managed care. All FAI programs are therefore voluntary, although—concurrent with Medicare Advantage rules—CMS allowed states to auto-assign beneficiaries in the Medicare-Medicaid Plans (MMP) that provide services under the FAI demonstrations so long as beneficiaries had the ability to opt out before being enrolled or, once enrolled, opt out on a month-to-month basis. In all three states, eligible members who opt out of integrated MMPs (i.e., FAI demonstrations) are enrolled in the mandatory MLTSS program for Medicaid services.

Table 5. Key components of FAI programs

Key components	Illinois Medicare-Medicaid Alignment Initiative	New York Fully Integrated Duals Advantage Program	Ohio MyCare
FAI enrollment	Auto-enroll with opt-out	Auto-enroll with opt-out	Initially, Medicaid mandatory enrollment with Medicare opt-in (May 2014), followed by auto-enroll with opt-out (January 2015)
Timing of FAI implementation	FAI implemented in Illinois after ICP (mandatory Medicaid managed care, including LTSS for Medicaid-only beneficiaries), but three years before MLTSS, (mandatory MLTSS for dual-eligible beneficiaries)	FAI implemented after New York's MLTC partial capitation program became mandatory statewide	FAI and MLTSS (both called MyCare) implemented concurrently
Relationship of MLTSS to FAI demonstrations	Dual eligibles who use LTSS may opt out of FAI but are required to enroll in MLTSS	Dual eligibles who use LTSS may opt out of FAI but are required to enroll in the partial capitation program or in other voluntary options offered in their areas (i.e., Medicaid Advantage Plus or PACE [Programs of All-Inclusive Care for the Elderly])	MLTSS and FAI are product lines within the same MLTSS plan; those who opt out of FAI still receive Medicaid-covered LTSS from the MLTSS plan

Synergies

Individuals interviewed for the study identified several synergies between FAI and MLTSS programs. In Illinois and New York, MLTSS programs were launched as a first step toward implementing FAI. Medicaid MLTSS created a base of knowledge and experience for the states, for managed care plans, and for LTSS providers, with Medicare eventually added to that base. Implementation of MLTSS can help build a base of managed care experience and infrastructure before integrating Medicare funding and services through FAI. The natural progression from a Medicaid MLTSS program to the FAI for dual-eligible beneficiaries requires sequencing in program implementation and procurement strategy. One Illinois MLTSS plan that participated in both MLTSS and FAI reported that the MLTSS plan applied lessons learned from MLTSS to FAI and focused on the significant addition of Medicare during FAI implementation. Similarly, Ohio employed a soft opening for FAI by requiring dual eligibles to enroll in Medicaid managed care but allowing them to opt into Medicare managed care before subsequently moving to auto-enrollment for Medicare with opt-out.

In cases in which plans operate both MLTSS and FAI programs, another potential synergy is seamless transition for members who switch between MLTSS and FAI. In the study states, FAI demonstrations and MLTSS serve as options from which the overlapping population group (dual-eligible beneficiaries with LTSS needs) may select. The greatest opportunity for synergy of state MLTSS programs occurs when the same MLTSS plans offer both programs, enabling MLTSS members to transition seamlessly from product to product within the same MLTSS plan as, for example, when a Medicaid-only beneficiary becomes eligible for Medicare.

However, interviewees described the transition between the two programs as a challenge, as described below.

Challenges

The greatest challenge identified by state government and MLTSS plan interviewees in the concurrent operation of FAI and MLTSS programs was the lack of a seamless transition of enrollees between the two programs, which requires support by state eligibility and enrollment policy. For example, Illinois designed its MLTSS program, the Integrated Care Program, exclusively for non-dual eligibles. When an enrollee in that program becomes eligible for Medicare, the individual is required to disenroll from managed care and enroll in the state's Medicaid fee-for-service system before enrollment in FAI, creating a barrier to seamless transition.

Another challenge lies in explaining the MLTSS and FAI options to beneficiaries, particularly when several plans are available. Such a challenge is most pronounced in downstate New York where beneficiaries may choose from more than 20 managed care plans participating in FAI, the MLTC Partial Capitation Program, Medicaid Advantage Plus, and PACE.

Another state reported that the FAI demonstration involves significantly more administrative requirements than MLTSS, creating disincentives for MLTSS plans and providers to encourage dual-eligible beneficiaries to enroll in FAI demonstrations. For example, one of the study states initially required the FAI MLTSS plans to mandate prior authorization for many more services than other state MLTSS programs, creating additional work for both providers and participating MLTSS plans.

Sustainability

State and MLTSS plan officials identified MLTSS as only one of many factors influencing the sustainability of FAI. For beneficiaries who are eligible for both programs, MLTSS is a competing option to FAI. In New York and Ohio, certain beneficiaries have additional competing options: both states offer PACE in selected areas, and New York offers an integrated Medicare Advantage Special Needs Plan for dual eligibles called Medicaid Advantage Plus (MAP). Beneficiaries in all three states may also select from several Medicare Advantage options that provide Medicare services through a managed care plan. State and MLTSS plans experienced difficulties in explaining the advantages of integrated care to beneficiaries, and the task is more challenging in an environment offering a wide array of competing options.

Unlike the other federal initiatives covered in this brief (that is, MFP, the Balancing Incentive Program, and Health Homes), FAI operates as an alternative to MLTSS for dual eligibles. In the three study states that operate both FAI and MLTSS, it is mandatory that MLTSS becomes the default when dual-eligible beneficiaries opt out of the voluntary FAI demonstration. It is unclear how this enrollment dynamic affects enrollment in MMPs and therefore the viability of FAI over time.

Conclusion

Twenty states have implemented federal LTSS and related initiatives in the context of an MLTSS service delivery system. Interviews with state government and MLTSS plan officials in four states revealed a high level of synergy between MLTSS programs and the other federal LTSS initiatives featured in this brief—Money Follows the Person, the Balancing Incentive Program, the Health Home State Plan Option, and the Financial Alignment Initiative. MFP and

Health Homes demonstrated the greatest degree of integration with MLTSS programs—MFP and Health Homes' services are complementary to MLTSS-covered benefits, thus providing an incentive to coordinate across programs. However, each program coordinates an aspect of services, creating a need to "coordinate the coordinators." States and MLTSS plans addressed this challenge by developing clear protocols, roles, and responsibilities for interaction between the programs. The Balancing Incentive Program was complementary to MLTSS in terms of its goal of improving access to community services, but, given that it functioned at the system level, its interface with MLTSS was not as apparent at the enrollee services level. MLTSS plans will continue partnering with their state counterparts to increase community integration through the Balancing Incentive Program's LTSS system reforms. As for FAI and MLTSS, the programs operate largely on parallel tracks as mutually exclusive options for dual eligibles. Informants reported that the transition of enrollees between the two programs can be more cumbersome than necessary because the programs' enrollment policies are not aligned.

The degree to which other federal LTSS initiatives overlap with MLTSS will influence findings from the national evaluation of MLTSS programs. To isolate the effects of delivering LTSS through managed care as opposed to fee-for-service systems, evaluators must identify and control for the effects of another initiative on outcomes for MLTSS enrollees. However, the synergies generated by other initiatives profiled in this study (such as additional care coordination, streamlined access to assessments and services, competing program options) are nearly impossible to control for with administrative data alone. Instead, evaluators must rely on qualitative information, such as the findings presented here, to understand the effects and biases that other federal initiatives may potentially have on MLTSS programs operating within a state.

METHODS AND DATA SOURCES

From August 2016 through April 2017, Truven Health conducted hour-long semi-structured telephone interviews with Medicaid and other state government officials representing MLTSS programs and other initiatives in four states. Truven researchers subsequently held additional hour-long semi-structured telephone interviews with representatives of MLTSS plans in each of the four states.

From the universe of states with active MLTSS programs, Truven Health identified and interviewed program representatives in Illinois, Iowa, New York, and Ohio. The selection of the four states was based on the states' implementation of both the Money Follows the Person and State Balancing Incentive programs and on at least one of the two remaining featured initiatives: the Health Homes program and the Financial Alignment Initiative. In addition, states were selected to represent a range of MLTSS program maturity, providing an opportunity to explore the impact of the age of MLTSS programs on their concurrent operation relative to other key federal initiatives.

For interviews with plan representatives, researchers based their selection of MLTSS plans on several factors: recommendation from state government officials participating in key informant interviews, size of MLTSS enrollment in the MLTSS plan relative to total enrollment in the state's MLTSS program, length of time the MLTSS plan has been active with the MLTSS program, and whether the MLTSS plan is also participating in the Financial Alignment Initiative.

After the interviews, researchers asked state officials and MLTSS plans to provide data and other evidence discussed during the interviews. State officials and MLTSS plans had an opportunity to review a draft of this brief for accuracy.

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- State officials: John McCarthy, Kim Donica, Jim Tassie, Tonya Hawkins, and Peggy Smith
- MLTSS plan officials: Anthony Evans and Tonya Perry from Ohio CareSource; Sandy Ferguson, Tracey Davidson, Jackie Lewis, and Kim Crandall from United Healthcare

Illinois

- State officials: Laura Phelan, Laura Ray, Michelle Maher, Lauren Tomko, Bonnee Hartman-Walter, and Kris Classen
- MLTSS plan officials: Felicia Spivak, Karen Brach, Colleen Dore, Jill Hayden, and Ben Salentine from Meridian; Nicole Sunder from Aetna BetterHealth

Iowa

- State officials: Rick Shults and Deb Johnson
- MLTSS plan officials: Kelly Espeland, Leigh Davison, and Amy Ingham from Amerigroup of Iowa, Inc. (Anthem affiliate plan); Chad Piper, Dr. Meghan Harris, and Cheryl Harding from AmeriHealth

New York

- State officials: Andrew Segal, Dave Hoffman, Karen Meier, Eric Henderson, Kirk Dobson, and Kalin Scott
- MLTSS plan officials: Gabriel Martinez, Daniel Lowenstein, Jaime McDonald, Esther Conteh, and Natachia Ramsey from Visiting Nurse Service of New York; Andrea Laquay, June Castle, Deb Maciewicz, and Cheryl Manna from VNA Homecare Options

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References

"The Balancing Incentive Program: Implementation Manual." February 2013. Available at <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/bip-manual.pdf>. Accessed January 18, 2018.

Colbert v. Quinn, Illinois Department of Healthcare and Family Services. Available at <https://www.illinois.gov/hfs/info/legal/Colbert%20v%20Quinn/Pages/default.aspx>. Accessed August 3, 2017.

Irvin, Carol V., Noelle Denny-Brown, Alex Bohl, John Schurrer, Andrea Wysocki, Rebecca Coughlin, and Susan R. Williams.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the CMS contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to guide CMS's decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The briefs will inform an interim outcomes evaluation report in 2017 and a final evaluation report in 2019.

"Money Follows the Person 2014 Annual Evaluation Report." Cambridge, MA: Mathematica Policy Research, December 18, 2015.

Libersky, J., D. Lipson, and K. Liao. "Hand in Hand: Enhancing the Synergy between Money Follows the Person and Managed Long-Term Services and Supports." Washington, DC: Mathematica Policy Research, July 2015.

Lipson, D., and Valenzano, C.S. "Toward a More Perfect Union: Creating Synergy between the Money Follows the Person and Managed Long-Term Services and Supports Programs." Washington, DC: Mathematica Policy Research, February 2013.

"Managed Care/MFP Process for all Counties in Illinois except Cook County." January 8, 2015. Available at http://nursing-mfp.webhost.uic.edu/MCO/ManagedCare-MFP_Workflow.pdf. Accessed August 4, 2017.

"MCO Comparison Chart: Value-Added Services." Available at <https://dhs.iowa.gov/sites/default/files/Comm480.pdf>. Accessed August 4, 2017.

"MLTC Overview." Available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_overview.pdf. Accessed August 4, 2017.

"New York State Money Follows the Person Rebalancing Demonstration." Operational Protocol version 2.0, February 2016. Available at https://www.health.ny.gov/health_care/medicaid/redesign/2016/mfp_operat_protocol_v2.htm. Accessed August 4, 2017.

Statewide Administrative Health Home Services Agreement between Managed Long Term Care Plan and Health Homes. Available at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/statewide_admin_hh_services_agreement_bt看_mltc_and_hh.pdf. Accessed August 3, 2017.

Endnotes

¹ Throughout this brief, MLTSS is used generically to describe a managed care program that includes long-term care services and support. Illinois has named one of its programs the MLTSS Program. To distinguish Illinois's specific program from generic references to MLTSS, the Illinois program is presented in quotation marks ("MLTSS Program").

² MFP was initially authorized as part of the Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act (2010). See "Money Follows the Person" at <https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html>. Accessed August 4, 2017.

³ Transitions are considered successful when MLTSS members transition out of nursing homes to the HCBS setting and remain in the community for a period of time. Although Illinois did see an increase in successful MFP transitions after implementation of the Medicaid managed care program (the Integrated Care Program), the increase in transitions could not be conclusively associated with MLTSS, absent rigorous evaluation.

⁴ Illinois also credited its Medicaid managed care blended reimbursement rate with offering a strong financial incentive to providing care in the HCBS setting.

⁵ *Olmstead v. L.C.* (527 U.S.581 [1999]) is a U.S. Supreme Court ruling that public entities must offer community-based options to individuals with disabilities as appropriate, if the individual so chooses and the placement can be reasonably accommodated. Illinois has three consent decrees related to *Olmstead*, covering three populations: individuals with intellectual disabilities, individuals residing in nursing homes, and individuals residing in institutions for mental disease. Although Illinois was the only state that identified overlap across the three *Olmstead* consent decrees with MFP

as a challenge, it is possible that overlapping *Olmstead* consent decrees or other transition programs are not unique to Illinois. We did not, however, explicitly ask other states about this possibility.

⁶ Federal funds for MFP were allocated through 2016 and may be expended by state grantees through 2020. Further federal funding would require congressional reauthorization.

⁷ States using less than 50 percent of their Medicaid LTSS expenditures on HCBS were eligible for the Balancing Incentive Program. In a state where HCBS expenditures were less than 25 percent of total LTSS spending, the enhanced FMAP was 5 percent; the FMAP was 2 percent in states where HCBS expenditures were between 25 and 50 percent of total LTSS spending.

⁸ The Patient Protection and Affordable Care Act (2010), section 10202, authorized the Balancing Incentive Payments Program, or Balancing Incentive Program.

⁹ Although states were required to adhere to the Balancing Incentive Program's conflict of interest standards during the course of their participation in the program, all states providing Medicaid 1915 (c) HCBS are required to adhere to similar conflict of interest standards as defined in 42 CFR 441.301(c)(1)(vi).

¹⁰ See the Balancing Incentive Program Manual, available at <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/bip-manual.pdf>, pp. 30. Accessed August 5, 2017. MLTSS plans are referenced as key stakeholders that support beneficiaries in submitting grievances and appeals related to choice, quality, eligibility, determination, service provision, and outcomes.

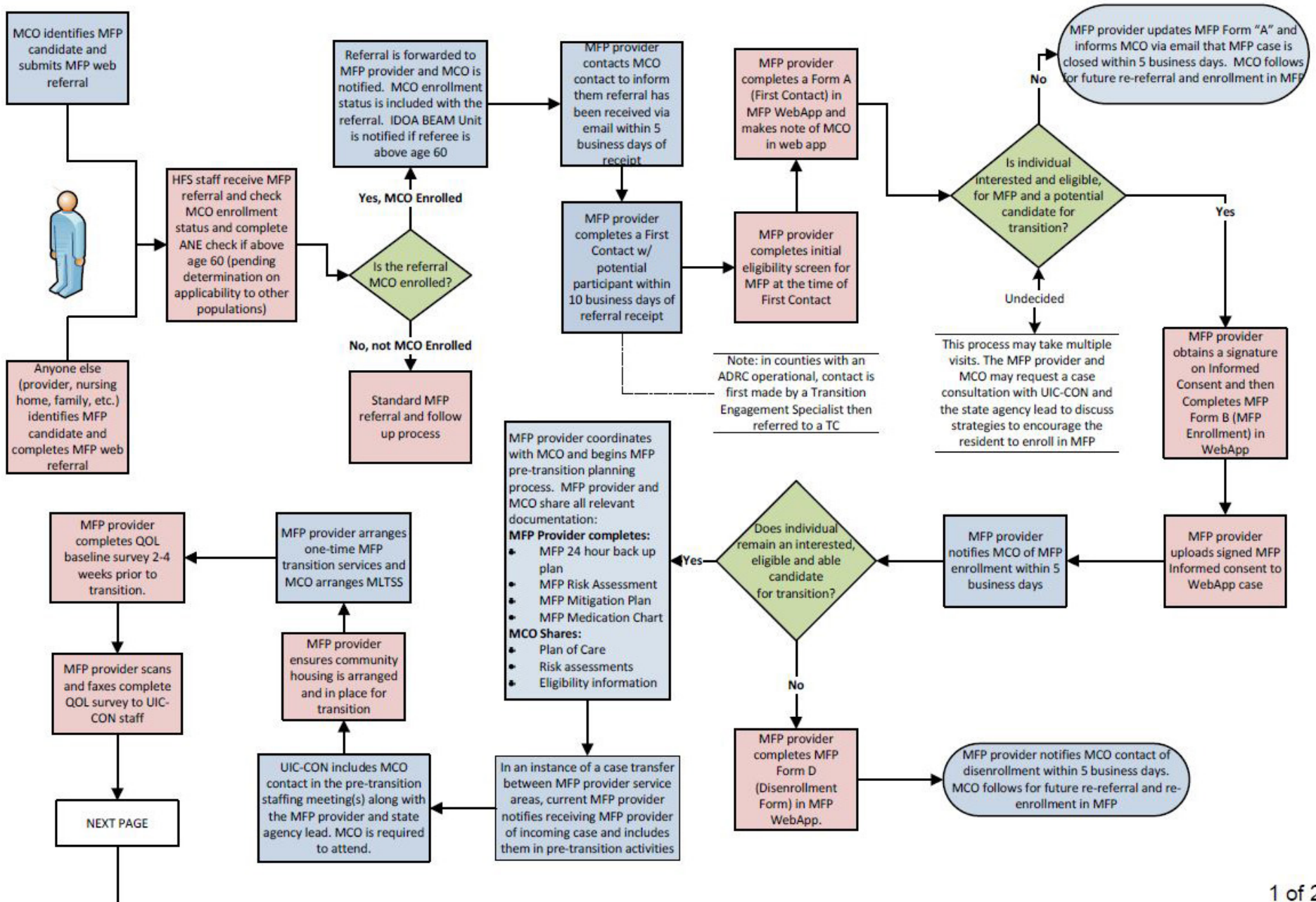
¹¹ The Patient Protection and Affordable Care Act of 2010, section 2703, authorized Health Homes. See <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>. Accessed August 5, 2017.

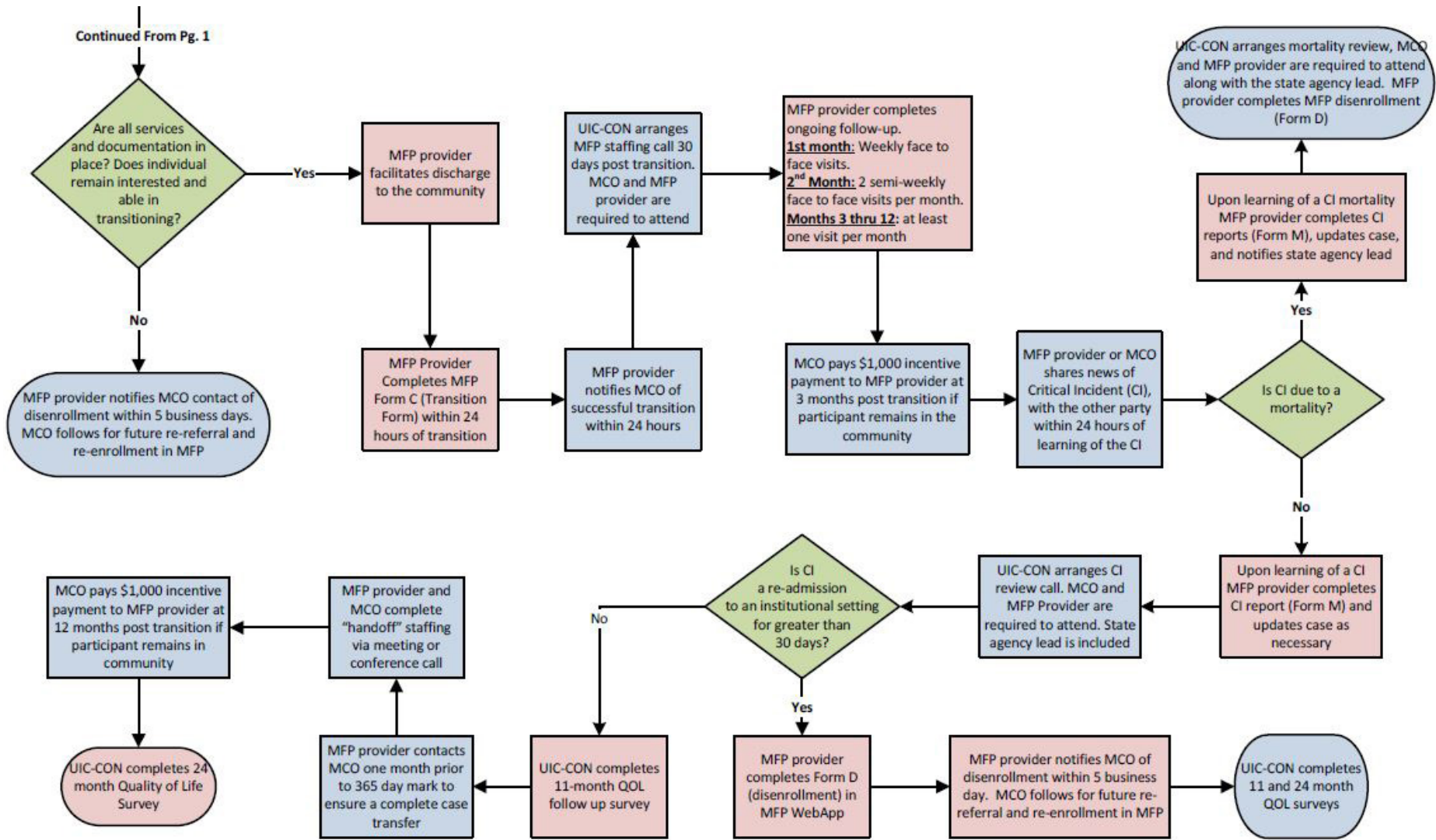
¹² Available at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/administrative_health_home_services_agreement.pdf. Accessed August 5, 2017.

¹³ The Medicare-Medicaid Coordination Office and the CMS Innovation Center, which jointly administer FAI demonstrations, were authorized by the Patient Protection and Affordable Care Act (2010). See <https://innovation.cms.gov/initiatives/Financial-Alignment/>. Accessed August 6, 2017.

APPENDIX A: ILLINOIS MEDICAID MANAGED CARE (INCLUDING LTSS) AND MFP FLOW CHART

Managed Care/MFP Process For All Counties in Illinois Except Cook County MMAI, ICP and VMCO Managed Care Vendors





- Acronyms**
- ANE – Abuse, Neglect and Exploitation
 - CI – Critical Incident
 - MFP Provider – Center for Independent Living, Care Coordination Unit, or local mental health center
 - MCO – Managed Care Organization
 - QOL – Quality of Life Survey
 - MDS Q – Minimum data set assessment, section Q (nursing home assessment)
 - MLTSS – Managed Long Term Care Services and Supports (Waiver and mental health State Plan services)
 - UIC-CON – University of Illinois at Chicago, College of Nursing (MFP quality assurance vendor)

