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State Trends in the Delivery of Medicaid Long-Term Services and Supports

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IN BRIEF

States are increasingly partnering with managed care organizations, providers, and consumers to develop Medicaid managed long-term services and supports (MLTSS) programs. Their objective is to meet individuals' medical, behavioral health, long-term services and supports (LTSS), and social support needs while delivering quality, coordinated, person-centered, and cost-effective care. To meet the diverse needs of beneficiaries using LTSS, states are using various strategies to refine their MLTSS programs and create a more innovative, person-centered, and value-based delivery system.

This brief, made possible through The SCAN Foundation, draws from interviews with states operating both new and long-standing MLTSS programs to identify six major trends in the refinement of MLTSS and underlying LTSS delivery systems nationally:

- Increasing Medicare and Medicaid alignment for dually eligible individuals;
- Broadening enrollment to serve individuals with intellectual and developmental disabilities;
- Leveraging housing resources and other social services to keep people in the community;
- Focusing on workforce development and expanding scope of practice;
- Advancing value-based purchasing with LTSS providers; and
- Providing ongoing, comprehensive stakeholder engagement.

The states examined in this brief are strengthening their Medicaid MLTSS programs to serve more LTSS beneficiaries and facilitate the development of integrated care programs that reduce service fragmentation for Medicare-Medicaid enrollees, particularly through Medicare Advantage Dual Eligible Special Needs Plans.

More and more state Medicaid agencies are partnering with managed care organizations (MCOs) to create managed long-term services and supports (MLTSS) programs that serve an increasing number of individuals with disabilities and chronic conditions. The 19 states[1] that currently operate Medicaid MLTSS programs have gained considerable experience overseeing these programs and implementing strategies to smooth the transition from fee-for-service into managed care for beneficiaries and their providers.[2] Many states are now shifting their focus to expand the reach and effectiveness of their MLTSS programs and make underlying LTSS system changes.

With Medicaid programs financing 51 percent of overall long-term services and supports (LTSS) costs nationally,[3] state Medicaid agencies are eager to work with MCO partners and LTSS stakeholders to ensure that their systems deliver the highest quality, most appropriate and cost-effective services possible. The new Medicaid Managed Care rules[4] promulgated by the Centers for Medicare & Medicaid Services (CMS) and related CMS guidance[5] further underscore MLTSS as a key component in the future of care delivery for LTSS populations.

With support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) selected seven states (**Arizona**, **California**, **Kansas**, **Minnesota**, **New Jersey**, **Tennessee**, and **Texas**) to provide insights

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into current trends in both MLTSS program refinement and LTSS system reform. These states include three with well-established MLTSS programs (Arizona, Minnesota, and Texas), as well as states with more recently implemented MLTSS programs (Kansas and New Jersey). These states also are among those integrating care for dually eligible beneficiaries through Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) platforms (i.e., Arizona, New Jersey, and Tennessee), as well as through the Financial Alignment Initiative (i.e., California, Texas, and Virginia). This brief identifies six trends that apply to either state refinement of MLTSS programs or reforms of the underlying LTSS delivery systems—and includes promising practices to best serve the increasing numbers of LTSS beneficiaries.

Trends in State MLTSS Programs and Underlying LTSS Delivery Systems

1. Increasing Alignment to Better Serve Dually Eligible Beneficiaries

States are building on their MLTSS programs to further alignment between Medicare and Medicaid service delivery for the majority of Medicaid MLTSS enrollees nationally who are also eligible for Medicare.[6] The focus on increasing alignment between the two programs has included: expanding Medicare and Medicaid benefit integration for dually eligible individuals enrolled in MLTSS programs; contracting with D-SNPs including Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs); and coordinating MLTSS program enrollment and materials with individuals' enrollment in D-SNPs when feasible.

A number of states have established requirements for alignment of Medicaid MCOs and D-SNPs. States are accomplishing this alignment of contractors either through upfront enrollment design for integrated D-SNP programs (e.g., Minnesota and New Jersey) or through contract provisions that require competitively procured MLTSS plans to operate a D-SNP (e.g., Arizona and Tennessee). The states included in this scan are increasingly interested in using their state contracting authority to promote administrative alignment for D-SNPs that operate companion Medicaid MLTSS plans.[7] These integrated D-SNP arrangements have significant potential to reduce fragmentation of care and align incentives across the Medicare and Medicaid programs.

States are also developing approaches to promote enrollment of dually eligible LTSS consumers into the same health plan for both Medicaid and Medicare service delivery. Both Arizona and Tennessee have worked with their aligned MLTSS plans/D-SNPs to establish a process for "seamless conversion" of Medicaid beneficiaries into companion D-SNPs when they become newly eligible for the Medicare program.[8] This approach promotes alignment into one health plan with incentives for coordinating Medicare and Medicaid service delivery, although the health plan continues to receive separate payments and contracts from the state and CMS. Arizona and Tennessee have also established state outreach plans that encourage aligned enrollment. Arizona sends initial and annual letters to MLTSS enrollees highlighting the benefits that come from enrolling in the same health plan for Medicaid and Medicare services. Tennessee sends notices to Medicaid beneficiaries who are about to attain Medicare eligibility to encourage them to remain in or enroll in aligned plans.

New Jersey launched an MLTSS program in July 2014, which provides an expanded platform for integrating care for the large proportion of the state's dually eligible population that is in need of LTSS.[9] After a successful MLTSS program implementation, New Jersey expanded its pre-existing D-SNP program to include the provision of both nursing facility (NF) and home- and community-based LTSS services. As a result of this expanded level of LTSS benefit integration, New Jersey was able to work with its existing D-SNPs to help them obtain designation as FIDE SNPs in January 2016.[10] FIDE SNPs provide both Medicaid and Medicare benefits including LTSS. FIDE SNPs are required to establish processes for alignment of administrative program features including, but not limited to, enrollment materials and appeals and grievance processes.

Other states including California, Texas, and Virginia have advanced alignment between Medicare and Medicaid by launching capitated financial alignment demonstration programs that fully integrate all

Medicare and Medicaid benefits and are jointly overseen by each state and CMS under the Financial Alignment Initiative.[11] Minnesota established an alternative alignment demonstration in 2013 in partnership with CMS that includes beneficiaries who are already enrolled in its Minnesota Senior Health Options program. This demonstration builds on Minnesota's Medicare Advantage D-SNP-based delivery system and focuses on improving beneficiary experience through increased alignment of Medicare and Medicaid program administration, increasing federal-state data sharing, and streamlining of beneficiary materials.[12]

2. Broadening Managed Care Enrollment to Serve Individuals with Intellectual and Developmental Disabilities

After successfully transitioning aged and physically disabled populations into Medicaid MLTSS programs, states are examining ways to improve care delivery for other populations using LTSS that can benefit from managed care. Building on their prior experience, states are turning their focus to serving individuals with intellectual and developmental disabilities (I/DD) in MLTSS programs. Individuals with I/DD have unique needs, and states are working with MCO partners to develop programs that can: (1) help this population achieve both employment and independent living goals; and (2) coordinate the delivery of LTSS with medical, behavioral, and other specialized services, which are often key to successful community living.

Tennessee and Texas

Both Tennessee and Texas are expanding their existing MLTSS programs specifically to serve the needs of individuals with I/DD:[13]

- **Tennessee's** TennCare CHOICES MLTSS program is implementing a new program component for individuals with I/DD, called *Employment and Community First CHOICES*.[14] Individuals with I/DD who newly enroll into Tennessee's home and community-based services (HCBS) programs will have access to this initiative after its launch date in July 2016.[15] *Employment and Community First CHOICES* provides LTSS to individuals with I/DD through CHOICES MCOs and includes targeted services to assist beneficiaries in achieving integrated, competitive employment and community living.[16]
- **Texas'** STAR+PLUS MLTSS program began enrolling non-dually eligible individuals who are receiving I/DD services through fee-for-service 1915(c) waivers and institutional settings for the delivery of acute care services in September 2014. Texas plans to implement a two-year managed care pilot that will offer service coordination and other Medicaid benefits including I/DD waiver services through an MLTSS model. The pilot is expected to launch in September 2017, and it will help Texas' Medicaid agency to prepare for the future transition of all I/DD waiver and facility-based services into managed care beginning in 2018.[17] The state developed a robust communication plan and stakeholder engagement process for this effort including establishing an Intellectual and Developmental Disability System Redesign Advisory Committee.

Kansas

Kansas was one of the first states to serve individuals with I/DD in a newly launched MLTSS program with the implementation of the KanCare program in January 2013.[18] The state took a stepwise approach to including individuals with I/DD in KanCare.[19] It began by conducting a pilot program in which 550 individuals with I/DD were allowed to opt into the program and were served by three KanCare MCOs. The pilot offered individuals and their families expanded services including targeted case management and other HCBS.[20] Both providers and MCOs benefited from this stepwise enrollment approach—MCOs were able to address the complexities and unique needs of the I/DD population on a small scale before assuming greater responsibility, and providers were able to work through kinks in billing with MCOs before taking the program to scale. The pilot demonstrated the benefits of coordinating LTSS, medical, and behavioral health services for individuals with I/DD to stakeholders, while helping prepare the I/DD population for full inclusion into KanCare in January 2014.

As a state with recent experience transitioning individuals with I/DD to an MLTSS program, Kansas offers the following lessons for other states and MCOs as they work with providers and other stakeholders to expand MLTSS program enrollment to new populations:

- **Pilot the approach to build stakeholder buy-in and prove value.** A primary issue KanCare MCOs faced as they took over responsibility for the care of individuals with I/DD was the lack of familiarity of I/DD providers with managed care and its potential benefits for individuals with I/DD. Before expanding MLTSS statewide for individuals with I/DD, KanCare made a point to demonstrate success on a small scale, which helped address I/DD provider resistance to managed care. The pilot showed providers and individuals with I/DD that the state and MCOs were committed to caring for this population. It also demonstrated that managed care could provide additional services, including transportation for caregivers and home modifications, which were not available under FFS.
- **Prioritize multi-directional, ongoing communication with all stakeholder groups and partners**. Throughout the design, pilot, and implementation phases, KanCare officials conducted robust education and outreach efforts to engage individuals with I/DD, their families, and providers. The state avoided potential communication gaps by conducting regular technical assistance calls and joint meetings that included MCOs and the Kansas Department for Aging and Disability Services both before and after implementation. An advisory workgroup of families and friends of individuals with I/DD was also established to provide feedback on the program. The state held multiple educational summits, bringing I/DD providers and other partners together with MCO care managers to learn about the I/DD population and services. This multi-directional stakeholder engagement initiated by both the state and the KanCare MCOs was critical to the success of LTSS system transformation for individuals with I/DD in Kansas.[21]

3. Leveraging Housing Resources and Other Social Services to Keep People in the Community

State and federal policymakers increasingly recognize that addressing the social determinants of health, including supportive housing needs, is a critical component for both transitioning LTSS beneficiaries from institutional to community settings and safely maintaining individuals in the community.[22] Important social services include: transportation, food and nutrition services, and energy assistance, but perhaps the most important factor enabling people to live in the community is safe and affordable supportive housing. To this end, states launching or refining MLTSS programs are: (1) creating new partnerships between their Medicaid agencies and state housing and disability agencies to increase housing options for LTSS beneficiaries; (2) dedicating Medicaid resources to establish strong housing and MLTSS program linkages and requiring MCOs to do the same; and (3) developing new or expanded supportive housing services to address the unique needs of LTSS subpopulations. Following are examples of these efforts:

Arizona

Arizona Long Term Care System (ALTCS), Arizona's MLTSS program, provides the full range of LTSS, including community-based options, with approximately 86 percent of ALTCS beneficiaries residing in home- or community-based settings.[23] Although 68 percent of ALTCS beneficiaries already reside in their own homes,[24] the state is actively working to fill in gaps and increase collaborations that will ensure that all beneficiaries have access to housing in the least restrictive setting possible.

Over the next five years, the Arizona Project-Based Rental Assistance Program (PRA) is seeking to develop 54 rental units for extremely low-income adults ages 18 to 61 who have at least one intellectual or developmental disability. The PRA is building new infrastructure or refurbishing existing infrastructure to help individuals with I/DD reside in their own home whenever possible or in a group home setting when that is the only financially feasible option. The PRA, a U.S. Department of Housing and Urban Development Section 811 program, is the result of extensive collaboration across the Arizona Department of Housing, the Arizona Health Care Cost Containment System (AHCCCS), the Arizona Department of Health Services, and the Arizona Department of Economic Security Division of Developmental Disabilities.[25] In building

these partnerships, AHCCCS, the state Medicaid agency, found that: (1) state Medicaid agency staff benefit from keeping abreast of forthcoming Housing and Urban Development grants that can support new affordable housing options for LTSS populations; and (2) local housing authorities may require education on the needs of individuals who receive LTSS benefits, including vulnerable subpopulations that cannot afford to pay for room and board costs. Tenant selection for the PRA is scheduled to begin in October 2017, with the first housing units becoming available in 2018.

Texas

Texas' Medicaid agency recently focused its Money Follows the Person (MFP) and affordable housing-related initiatives on the needs of the LTSS subpopulation with both substance use disorders (SUD) and severe mental illness (SMI). In 2008, Texas established a pilot within its existing successful MFP program to address the unique needs of nursing facility residents with SUD and SMI. The state's MFP behavioral health pilot program integrates mental health and substance abuse services with LTSS and provides supplemental MFP services. These services include: cognitive adaptation services;[26] community-based substance abuse treatment; and Cognitive Adaptation Training (CAT), a rehabilitative service designed to help individuals establish daily routines, organize their environment, and build social skills. Supplemental MFP services are provided up to six months before discharge (pre-transition) and up to one year after discharge. These targeted services are critical as they provide tools to support skill acquisition, including improvement in medication adherence, personal care, activities of daily living, social skills, and integration into the community for LTSS consumers with SUD and SMI. Peer support is also provided and pilot participants have been able to develop lasting relationships with both peers and counselors prior to discharge, increasing their ability to maintain sobriety in community settings. To date more than 424 individuals have successfully transitioned from nursing facilities to the community. In addition, pilot participants have shown statistically significant improvements in independent functioning. Participants have increased functional status and quality of life over time, and gains achieved during the intervention persist for at least a year after the end of services.

Texas Medicaid's agency also collaborates with the state housing agency, the Texas Department of Housing and Community Affairs, and Public Housing Authorities to expand affordable, accessible housing opportunities for individuals with disabilities, including those with SMI and SUD. Texas Department of Housing and Community Affairs administers a Section 811 PRA grant in which private developers of Low Income Housing Tax Credit properties agree to set aside units for individuals with disabilities exiting institutions, young adults exiting foster care, and individuals with mental illness. Texas has also conducted outreach to more than 400 Public Housing Authorities to request set-asides of housing vouchers for individuals with disabilities exiting institutions. Texas Medicaid officials hold regular teleconferences with their MCOs, community transition teams, and families of transitioning individuals to collectively address issues, including transition efforts and affordable housing options.

4. Focus on Workforce Development and Expanding Scope of Practice to Enhance the Capacity of LTSS Delivery Systems

The development of a well-trained, motivated LTSS workforce is directly linked to the quality of LTSS delivery and beneficiary experience inside and outside of MLTSS programs. States may be limited by the capacity of the current LTSS workforce to meet the needs of a growing population of LTSS beneficiaries, so the expansion of scope of practices for LTSS providers, including nursing staff and other direct support professionals, can also influence service delivery. As a result, states are focusing on LTSS provider workforce development and expanding the scope of practice for direct support professionals.

Tennessee and New Jersey

Tennessee and New Jersey have each undertaken efforts to enhance the current capacity of the LTSS workforce to better serve beneficiaries:

- **Tennessee**, as part of the state's Quality Improvement in LTSS (QuILTSS) program, created a comprehensive LTSS workforce development strategy that includes a competency-based workforce development program and a credentialing registry for direct support professionals. (See Exhibit A details; also, see the next section for QuILTSS payment reform strategies for LTSS providers.)

  The QuILTSS workforce development program provides portable, stackable credentials for direct support professionals who complete components of the curriculum, as well as college credits that can be used toward individual certificate and/or degree program attainment. The curriculum will be used in secondary, vocational-technical, and trade schools, and community and four-year colleges with the goal of providing a career path for NF and HCBS direct support professionals. The state's program also includes mentoring, coaching, and career planning opportunities, all of which are designed to achieve the state and stakeholders' goal to develop a more competent LTSS workforce that will deliver higher quality services and supports and produce a higher quality of life for LTSS beneficiaries.[27,28]

  The state is also creating an online registry of direct support professionals that can be used by individuals, families, and providers. The registry matches LTSS beneficiaries to providers based on their needs and interests, with the goal of improving overall beneficiary experience.

EXHIBIT A: Tennessee's Quality Improvement in LTSS (QuILTSS) Program

Overview

- TennCare initiative to promote the delivery of high quality LTSS for TennCare beneficiaries (both NF and HCBS) through payment reform and workforce development.
- Creates a new payment system (aligning payment with quality) for NFs and certain HCBS based on performance on measures most important to beneficiaries and their family/caregivers.

Timeline

- Began planning in 2013 with a national scan of LTSS payment reforms and comprehensive stakeholder engagement efforts that have been ongoing.[29]
- NF value-based payment reforms implemented in August 2014; HCBS value-based payment reforms are currently under development.

Key Features

- Defines quality from the perspective of the person receiving services and their family/caregivers, so the focus is less on clinical measures and more on areas the beneficiaries and families identify as influencing LTSS beneficiaries experience of care. (See Exhibit B: Tennessee QuILTSS – Overview of Nursing Facility Quality Framework).
- Includes technical assistance to develop a comprehensive online competency-based LTSS workforce development program and payment incentive for NFs to employ staff with this training.
- Includes credentialing registry for direct support professionals.

- **New Jersey** is one of many states focused on expanding scope of practice legislation for nursing providers and related direct support professionals. The New Jersey State Board of Nursing adopted a new rule in March 2016 that increases nursing delegation activities statewide by expanding the scope of practice for licensed practical nurses (LPNs), certified homemaker-home health aides (CHHAs), and other assistive personnel.[30] This expanded scope of practice is expected to benefit LTSS beneficiaries and also help the state reduce avoidable NF admissions and decrease costs. The rule changes make it possible for registered nurses to train other workers to perform routine tasks like giving medications and helping with eye drops and catheters, with little risk to patients. By broadening the scope of practice for these workers, the proposed rule would allow registered nurses to focus on more specialized tasks at the top of their licensure.

New Jersey conducted a pilot program from 2008 to 2011 in which 19 home health agencies encouraged registered nurses to further delegate tasks to LPNs, CHHAs, and unlicensed assistive personnel for individuals with chronic conditions in long-term care. Through the pilot, the state found that people in community-based settings with expanded support from LPNs, CHHAs, and other assistive personnel experienced fewer hospital and NF admissions than individuals without this additional support. The state also found it less costly for individuals to receive care from LPNs, CHHAs, and unlicensed assistive personnel in community settings, than in nursing facilities.[32] Individuals receiving care and their families responded positively to New Jersey's pilot program. It was also well received by registered nurses, LPNs, CHHAs, and unlicensed assistive personnel, setting the stage for further efforts to expand the scope of practice.

Texas

Other states including Texas are gathering LTSS workforce data to inform future workforce development initiatives. Texas conducted a statewide survey of direct service workers, and received valuable feedback on wages, health care benefits, and training deficits. Texas also used Balancing Incentive Program funding to increase the direct service worker base wage, and is now creating additional rebalancing projects to address other deficits identified through the survey.[33]

Care Manager Training in California: Creating a Standard Curriculum for Medi-Cal Plans

Driven by Medi-Cal plans' needs, The SCAN Foundation and California HealthCare Foundation partnered with the California State University Center for Palliative Care to develop a standard curriculum for health plan care managers serving complex populations. The curriculum will assist Medi-Cal plans in: (1) training new staff to support complex populations in Medi-Cal managed care; (2) enhancing the capacity of care managers; and (3) training staff on key aspects of advanced care management support for complex and diverse populations. The curriculum addresses training needs on three levels:

1. **Foundational:** Teaches essential skills to new care managers as well as providing a review for others on fundamental knowledge and skills online and in person;
2. **Advanced Concepts:** For experienced care managers and other professionals working with diverse and complex populations online and in-person in specialty practice subject areas such as Intellectual and Developmental Disabilities or Pain Management and Impact of Chronic Opioid Use; and
3. **Leadership:** In-person series that trains supervisors, managers, and other leaders on how to supervise and mentor staff.

The first modules in the curriculum will be available in the summer of 2016. Although developed in partnership with Medi-Cal plans, this training will be broadly available to health plans nationally through Cal State University's Care Excellence Case Management Education program.[31] Individuals completing the training may be able to obtain a certification to strengthen the use of the curriculum as a career development tool. An advisory panel of health plan executives and a curriculum task force of national leaders in care management were convened to inform curriculum and training development.

5. Advance Value-Based Purchasing with LTSS Providers

States with MLTSS programs are eager to increase the involvement of LTSS providers in value-based purchasing (VBP) arrangements, and states are at varying places in terms of influencing the use of alternative payment strategies by MLTSS health plans. Minnesota has encouraged VBP arrangements since 2013 through a wide array of Integrated Care System Partnership projects between its Minnesota Senior Health Options plans and providers.[34] The state is currently compiling statewide lessons and an inventory of Integrated Care System Partnership projects and measures to inform future VBP efforts. Other states, such as Tennessee and Arizona, are incrementally implementing LTSS provider payment reforms by paying for quality with a subset of providers in Tennessee and using MCO incentives that are passed to providers in Arizona.

Tennessee

TennCare's QuILTSS initiative is seeking to improve the quality of LTSS through payment reforms in addition to its workforce development focus (see page 6). In rolling out VBP for LTSS, TennCare started by implementing a NF quality improvement program prior to expanding its quality improvement focus to HCBS. The state's NF payment reform initiative began in October 2013 with a rigorous stakeholder engagement period to identify what quality outcomes matter for individuals receiving services with a focus on those that impact the beneficiary's experience of care. The process included 18 community forums across the state with beneficiaries, family members, and providers, as well as an online survey.

Based on feedback from beneficiaries, family members, and providers, the state identified four major measurement domains for NF quality: (1) satisfaction of residents, family members, and staff; (2) culture change and quality of life; (3) staffing and staff competency; and (4) clinical measures. (See Exhibit B for list QuILTSS measurement domains, topics, assigned values, and the mode of performance assessment.)

EXHIBIT B: Tennessee QuILTSS – Overview of Nursing Facility Quality Framework

Measurement Domains, Topics, and Weights	Examples of Performance Assessments Used*
Satisfaction (35 points)	
1. Resident (15 points) 2. Family (10 points) 3. Staff (10 points)	■ Conducting resident, family, and staff surveys ■ Taking actions to improve satisfaction based on survey results
Culture Change/Quality of Life (30 points)	
4. Respectful treatment (10 points) 5. Resident choice (10 points) 6. Resident and family input (5 points) 7. Meaningful activities (5 points)	■ Culture change/person-centered practices NF self-assessment ■ Changes in care policies/practices, environment, etc. to improve person-centered care and create a home-like environment including documentation of resident choice (including choice of meal time, menu, sleep, wake, and bathing times) ■ Respectful treatment training plan and staff training rosters ■ Narrative descriptions of care practices that ensure resident choice and documentation in care plans ■ Documentation of resident/family council input and improvements ■ NF quality improvement plan focused on meaningful activities
Staffing/Staff Competency (25 points)	
8. Registered nurse hours per day (5 points) 9. Certified nursing assistant hours per day (5 points) 10. Staff retention (5 points) 11. Consistent staff assignment (5 points) 12. Staff training (on-boarding and continuing) (5 points)	■ Medicare Nursing Home Compare data ■ Staff retention spreadsheet ■ Evidence of policy for consistent staff assignment ■ Measuring consistent staff assignment ■ Training plan and staff training rosters
Clinical Performance (10 points)	
13. Antipsychotic medication 14. Urinary tract infection	■ Medicare Nursing Home Compare data
Bonus Points (10 points)	
■ Participation in Advancing Excellence Campaign Membership in Eden Registry ■ Achievement of the Malcolm Baldrige Quality Award[35] ■ Accreditation by the Commission on Accreditation of Rehabilitation Facilities ■ Joint Commission accreditation	■ Current evidence of qualifying awards or accreditations

**The examples of performance assessment change overtime and this exhibit provides a snapshot of things that NFs have done to establish quality improvement processes and improve quality.*

Each quarter, NFs submit information to the state on their quality improvement activities through an online portal. For example, for some measurement periods, NFs submitted documentation outlining resident and family member input received and subsequent actions taken toward improvement.[36] NFs also completed a self-assessment of culture change and person-centered practices and provided documentation of the improvements they have made based on those assessments. TennCare has also required NFs participating in the VBP initiative to submit information on staff training exercises and staff retention efforts, and the state reviews NF residents' care plans to ensure resident and family member participation is taken into account. Early on in the QuILTSS program, TennCare offered online quality

improvement trainings for NF staff and the state has continued open communication with providers to set expectations and review where improvement is needed. Information collected from NFs is combined with key data points from CMS' Nursing Home Compare database and evaluated by TennCare staff who use this data to determine individual facility rate adjustments.

Tennessee made a number of key decisions in designing the QuILTSS program including: (1) measuring quality from the beneficiaries' experience even though there are no nationally recognized measures available; (2) accepting that measure development would be an iterative, incremental process; (3) recognizing that quality improvement and data collection processes had to be established by LTSS providers before the state could pursue broader quality improvement goals; and (4) creating a statewide VBP approach to eliminate the administrative burden for plans and potential confusion for providers that can occur when VBP approaches are delegated to plans.

After the first six quarters of NF data submission, TennCare CHOICES health plans have distributed more than $30 million in payments for quality-based rate adjustments and the state has seen a steady increase in quality improvement scores. The state has also seen a significant increase in the number of facilities: (1) seeking input from residents, families, and staff; (2) completing self-assessments of culture change and person-centered planning; and (3) taking demonstrable actions to improve quality from residents' perspectives. The state is now continuing stakeholder engagement processes to develop its HCBS quality improvement framework.

Arizona

Arizona has leveraged strong, established relationships with health plan partners to extend VBP efforts under its acute care contracts to the state's Elderly and Physically Disabled program contracts, which includes the ALTCS system. Arizona's contracts for the Elderly and Physically Disabled program have included shared savings requirements since October 2012; however, the state recently decided to rebrand and align this effort as part of its broader Value-Based Purchasing Initiative, now in its third year of operation. The initiative is detailed in both policy and MCO contract language and it gives health plans the flexibility to develop new payment arrangements with providers while also promoting competition among the plans.[37]

Arizona's approach includes requirements for provider-level VBP as well as a quality withhold component for health plans serving MLTSS enrollees in the ALTCS program. Under the quality withhold component, the state retains one percent of the capitation payment pending plan performance on select quality measures (see Exhibit C). The plans must meet minimum standards on these measures to be eligible for the quality withhold payment. Each plan is ranked against its competitors across this set of measures and the ranking is used to determine how much of the one percent is returned.

As a complement to the state-level VBP incentive, ALTCS plans are required to provide a percentage of total medical payments to ALTCS providers under value-based arrangements. The state developed guidance for plans outlining potential provider payment strategies, which range from performance-based programs, to shared savings or shared risk arrangements, to full capitation with performance-based requirements.[38] As of 2016, the state requires that 15 percent of ALTCS payments must be made under value-based arrangements. To improve care delivery and influence VBP efforts for dually eligible Elderly and Physically Disabled beneficiaries, the state also requires that all MCOs offer a D-SNP, and it is mandating that those contracts also meet the 15 percent target for the D-SNP line of business. The state has an overarching goal that by 2018 at least 50 percent of Arizona's spending will be in VBP contractual arrangements, and although the state has initially focused on medical payments, it is working with ALTCS plans to expand their VBP arrangements to incent quality improvement in NF, HCBS, and care management service delivery.

EXHIBIT C: ALTCS/Elderly and Physically Disabled Contractor Quality Management Performance Measures	
Quality Withhold Performance Measure	**Minimum Performance Standard**
Comprehensive Diabetes Management:	
▪ HbA1c Testing	83%
▪ LDL-C Screening	75%
Flu Shots for Adults, aged 18+	60%
ED Utilization	TBD
Readmissions within 30 days of discharge	TBD

6. Provide Ongoing, Comprehensive Stakeholder Engagement as States Build and Refine MLTSS Programs

As states work to refine their MLTSS programs or include new populations in existing programs, an essential element in the reform of LTSS delivery is ongoing, comprehensive stakeholder engagement. Some states including California, New Jersey, and Texas used communication work plans to help ensure the success of their MLTSS programs and other LTSS system enhancements.[39] In addition to beneficiaries, advocates, partner agencies, and MCOs, states are increasingly engaging LTSS providers for post-implementation stakeholder feedback to inform state policymakers on program successes and potential areas of concern.[40]

New Jersey

New Jersey's Division of Medical Assistance and Health Services launched its MLTSS program in July 2014 as part of the state's Medicaid program, called NJ FamilyCare.[41] In March 2012, more than two years prior to program launch, the state formed a steering committee to review a set of MLTSS principles and develop a report that was used by state staff to guide policy development as well as negotiations with CMS on key program elements.[42] New Jersey's MLTSS steering committee included state Medicaid and aging and disability staff, MCOs, aging and disability consumer advocates, and provider associations. Subcommittees were created with expanded representation to dive deeper into areas such as: assessment processes; appeals protections; assuring access; provider transitions; and quality measure selection to help finalize the design of key program features.[43] Along the way, the MLTSS steering committee recommended that the state follow a stepwise implementation approach to help smooth the transition for LTSS providers by transitioning nursing facility and HCBS providers to managed care on a staggered timeline.

New Jersey found that continuing stakeholder dialogue post-implementation and having multiple direct channels for provider and consumer input has been critical to ensuring smooth implementation and oversight of its MLTSS program (Exhibit D). As other states move forward with underlying LTSS system changes and MLTSS program enhancements, they can build similar mechanisms to foster stakeholder engagement.

EXHIBIT D: New Jersey's Ongoing MLTSS Stakeholder Input Mechanisms

- ***MLTSS Steering Committee.*** New Jersey presents a variety of information at steering committee meetings, including: data from its MLTSS program dashboard of early program indicators (with updates on MLTSS program impact on state rebalancing goals); MCO and state roles in determining eligibility; assisted living and nursing facility policy; and implementation and early results from MLTSS quality improvement activities. The state sets aside discussion and feedback time at all meetings using a neutral convener to facilitate conversations.
- ***MCO Communications.*** When New Jersey's MLTSS program launched, the state had daily, one-hour calls with MCOs to troubleshoot issues, provide guidance, and hear success stories. Over time, the frequency of the calls became bi-weekly group conference calls with all MCOs and the content focused on ensuring consistent communication of state policies.
- ***Public Feedback Forums.*** Sessions were held statewide for advocates and consumers to share their thoughts about the MLTSS program rollout. Topics included: access to services; person-centered approach; care plans based on care needs; and beneficiaries' rights and responsibilities.
- ***Provider Surveys.*** Early after program launch, the state surveyed assisted living providers to identify billing issues, which the state then resolved promptly. This approach can be repeated to address other provider issues as they arise.
- ***Consumer Survey.*** New Jersey is participating in the National Core Indicators-Aging and Disabilities Initiative[44] to get direct feedback from consumers inside and outside the MLTSS program.
- ***Medicaid Advisory Committee.*** The MLTSS program is a standing agenda item at quarterly Medicaid Medical Assistance Advisory Committee meetings which include broad stakeholder representation.
- ***Provider Communication Tools.*** New Jersey uses multiple tools to facilitate communication specifically with providers including: dedicated e-mail and telephone lines for inquiries and complaints; newsletters; frequently asked questions; and a series of videotaped educational sessions held at program launch.

Conclusion

Medicaid MLTSS programs are far from static and the states represented in this scan – Arizona, California, Kansas, Minnesota, New Jersey, Tennessee, and Texas – are breaking new ground in refining MLTSS programs. These states are pursuing many different reforms to improve underlying LTSS systems and expand the potential for both new and existing MLTSS programs to deliver high quality care and services to the growing number of Medicaid beneficiaries in need of LTSS. The trends highlighted in this brief include approaches that other state Medicaid agencies can consider adapting and implementing to best suit the unique needs of their own LTSS beneficiaries and providers.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

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 consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] States with MLTSS programs: AZ, CA, DE, FL, HI, IL, KS, MA, MI, MN, NC, NJ, NM, NY, OH, RI, TN, TX, and WI.

[2] A. Kruse. “Strategies to Facilitate Managed Care Implementation for Medicare-Medicaid Enrollees.” Center for Health Care Strategies, June 2014. Available at: http://www.chcs.org/media/CHCS-INSIDE-Strategies-to-Facilitate-Managed-Care-Implementation-2.pdf.

[3] E. Reaves and M. Musumeci. “Medicaid and Long-Term Services and Supports: A Primer.” Kaiser Family Foundation, December 2015. Available at: http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[4] Centers for Medicare & Medicaid Services. “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability.” *Federal Register*, May 6, 2016. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.

[5] Centers for Medicare & Medicaid Services. “Summary - Essential Elements of Managed Long Term Services and Supports Programs.” Undated. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf.

[6] J. Verdier, Mathematica Policy Research. Personal communication. July 7, 2016. Based on: L. Kimmey and J. Verdier. Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options for States. Integrated Care Resource Center, April 2015. Available at: http://www.integratedcareresourcecenter.com/PDFs/ICRCReducingAvoidableHospitalizations%20508%20complete.pdf.

[7] Effective January 2013, the Medicare Improvements for Patients and Providers Act (MIPPA) required D-SNPs to obtain a state Medicaid agency contract prior to receiving CMS approval to operate these specialized Medicare Advantage plans. States can use this state contracting authority with D-SNPs to promote alignment and establish robust coordination requirements for D-SNP enrollees. See: Centers for Medicare & Medicaid Services. “Medicare Managed Care Manual. Chapter 16b. Special Needs Plans (Rev.119, 11-28-14).” Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

[8] For additional information on the use of seamless conversion in integrated programs see: Centers for Medicare & Medicaid Services. “Medicare Advantage Seamless Conversion.” January 2014. Available at: http://www.integratedcareresourcecenter.net/pdfs/ICRC%20Seamless%20Conversion.pdf

[9] New Jersey has over 200,000 dually eligible beneficiaries, many of which are also eligible for the state’s MLTSS program that was launched in July 2014.

[10] As of January 2016, New Jersey’s Medicaid/D-SNP contractors received CMS approval as FIDE SNPs. Requirements for FIDE SNP designation are specified in Section 40.4.3, Chapter 16B of the Medicare Managed Care Manual. Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf.

[11] Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. “Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.” SMD Letter# 11-008. July 8, 2011. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[12] Minnesota’s demonstration is being implemented under the Medicare-Medicaid Coordination Office’s Alignment Initiative, and is not a Financial Alignment Demonstration.

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[13] New York recently launched a new integrated care program for dually eligible beneficiaries with I/DD through a Financial Alignment Initiative demonstration known as Fully Integrated Duals Advantage-I/DD. The program, which began voluntary enrollment in March 2016 in the New York downstate region, offers enrollees an increased ability to direct their own services, live independently in the community, and be involved in care planning.

[14] LTSS Environmental Scan Interview with Tennessee, April 17, 2015.

[15] For an overview of Employment and Community First CHOICES, see: State of Tennessee. Division of Health Care Finance & Administration. Bureau of TennCare. "Employment and Community First CHOICES." Available at: http://www.tennesseeworks.org/wp-content/uploads/ECF-CHOICES-Overview-for-ThinkEmployment-Summit_September-16.pdf.

[16] State of Tennessee. Division of Health Care Finance & Administration. Bureau of TennCare. "Employment and Community First CHOICES, TennCare II demonstration: Amendment #27: Employment and Community First CHOICES TennCare II demonstration (No. 11-W-00151/4)." Available at: http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf.

[17] Texas' Medicaid agency is administered by the state's Health and Human Services Commission.

[18] Minnesota operated the Minnesota Disability Health Options program for people with development disabilities (MnDHO-DD) between 2006 and 2008. MnDHO –DD was a voluntary managed care program for people with development disabilities between the ages of 18-65 that included the entire Medicaid Medical Assistance benefit set including MLTSS.

[19] For a profile of Kansas' Medicaid managed care program see: Centers for Medicare & Medicaid Services. "Managed Care in Kansas." Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/kansas-mcp.pdf.

[20] While targeted case management and other HCBS services were available to Kansas' I/DD population through an existing HCBS waiver, these services were expanded through the managed care pilot to address a range of issues that could impact an individual's ability to live independently in a community setting, such as transportation for caregivers and home modifications.

[21] LTSS Environmental Scan Interview with Kansas, May 14, 2015.

[22] For more information, see: Centers for Medicare & Medicaid Services. Center for Medicaid and CHIP Services. "Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities." June 2015. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

[23] Arizona Health Care Cost Containment System. Arizona Long Term Care System. Annual HCBS Report CY 2015. March 2016. Available at: https://www.azahcccs.gov/Shared/Downloads/HCBS/AnnualHCBS_CMSReportCYE2015.pdf.

[24] Ibid.

[25] The U.S. Department of Housing and Urban Development operates the Section 811 Supportive Housing for Persons with Disabilities program to provide funding to develop and subsidize rental housing with the availability of supportive services for very low- and extremely low-income adults with disabilities. Available at: http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811.

[26] Cognitive adaptation services help individuals with SMI control their environment through techniques customized to each individual's unique situation. These services could involve training an individual to use an alarm clock or a calendar to carry out daily living tasks.

[27] State of Tennessee. Division of Health Care Finance & Administration. Bureau of TennCare. "SIM Model Test Project Narrative." Available at: https://www.tn.gov/assets/entities/hcfa/attachments/ProjectNarrativeTNSIMgrant.pdf.

[28] LTSS Environmental Scan Interview with Tennessee, April 17, 2015 and July 13, 2015.

[29] For the report developed from this stakeholder process see: Lipscomb University. School for TransformAging. "Technical Assistance Report to Bureau of TennCare on the Quality Improvement in Long Term Services and Supports (QuILTSS) Initiative." Available at: http://www.lipscomb.edu/transformaging/tareport.

[30] See State of New Jersey, Department of Law & Public Safety, Division of Consumer Affairs, Rule Adoption notice dated March 7, 2016, for additional information: http://www.njconsumeraffairs.gov/Adoptions/nurado_030716.pdf. For the proposed rule see: http://njpublicsafety.com/ca/proposal/nur_proposal_02022015.htm.

[31] Descriptions of the training curriculum and training modules will be posted online as they are released. See: https://careexcellence.org.

[32] *NJ Spotlight*. "Delegating Tasks can Benefit Home Care Nurses, Health Aides, and Patients." March 16, 2015. Available at: http://www.njspotlight.com/stories/15/03/15/delegating-tasks-can-improve-home-care-for-nurses-health-aides-and-patients/.

[33] CHCS LTSS Environmental Scan interviews with Texas, April 27, 2015 and July 27, 2015.

[34] For information on Minnesota's Integrated Care System Partnership projects, see: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_180116.

[35] This includes AHCA Bronze, Silver, or Gold Award and the TN Center for Performance Excellence Award.

[36] Follow up material from Patti Killingsworth, after April 17, 2015 CHCS LTSS Environmental Scan interview with Tennessee.

[37] For state policy and MCO guidance on Arizona's VBP strategies, see: (1) VBP policy available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/318_CYE16.pdf; (2) health plan quality performance measures available at: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/318_16_B.xlsx.

[38] For a description of Arizona's approved VBP LTSS provider payment strategies see: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/138_16_A.pdf

[39] California and Texas developed comprehensive stakeholder engagement strategies as part of planning and design efforts for new Community First Choice programs. For key steps and a work plan template to develop a communication work plan for MLTSS programs, see: S. Barth and B. Ensslin. "A Communications Work Plan to Engage Stakeholders in Medicaid Managed Long-Term Services and Supports Program Development." Center for Health Care Strategies, May 2013. Available at: http://www.chcs.org/resource/a-communications-work-plan-to-engage-stakeholders-in-medicaid-managed-long-term-services-and-supports-program-development/.

[40] For tips on how to engage providers in building a managed care delivery system, see: S. Barth and J. Klebonis "Engaging Providers in Building Managed Care Delivery Systems: Tips for States." Center for Health Care Strategies, April 2014. Available at: http://www.chcs.org/resource/engaging-providers-in-building-managed-care-delivery-systems-tips-for-states/.

[41] New Jersey's recently launched MLTSS program expanded the benefits and populations covered under the NJ FamilyCare program by both new and existing Medicaid managed care health plan contractors.

[42] New Jersey's MLTSS Steering Committee includes principles and recommendations for program development. For more information see: State of New Jersey Managed Long Term Services and Supports. "Final Recommendations from the Steering Committee to the New Jersey Department of Human Services Division of Medical Assistance and Health Services & New Jersey Department of Health and Senior Services Division of Aging and Community Services." June 2012. Available at: http://www.nj.gov/humanservices/dmahs/home/NJ_MLTSS_Steering_Comm_Recommendations_Report.pdf.

[43] Ibid.

[44] National Association of States United for Aging and Disabilities. "National Core Indicators – Aging and Disabilities." Available at: http://www.nasuad.org/initiatives/national-core-indicators-aging-and-disabilities.