

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



CHCS Center for Health Care Strategies, Inc.

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FOREWORD

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

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

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

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

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

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Manatt Health is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. Manatt Health helps clients develop and implement strategies to address their greatest challenges, improve performance, and position themselves for long-term sustainability and growth. To learn more, visit www.manatt.com/health.

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

About the Funders

The SCAN Foundation is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence. We envision a future where high-quality, affordable health care and supports for daily living are delivered on each person's own terms, according to that individual's needs, values, and preferences. To learn more, visit www.thescanfoundation.org.

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

EXECUTIVE SUMMARY

Long-term services and supports (LTSS) enable more than 12 million people, including older adults and adults and children with intellectual and developmental disabilities (I/DD), physical disabilities, and mental health conditions, among other conditions, to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With LTSS expenditures of more than \$140 billion annually, Medicaid is the single leading payer of these critical services. The aging population's projected growth—18 percent by 2020 and doubling by 2060—will only increase demand for LTSS and in turn, put more pressure on Medicaid at both the federal and state levels. As a result of these demographic and fiscal challenges that make the status quo untenable, as well as federal policy and funding priorities, states are seeking to reform their Medicaid LTSS systems to both improve the quality of care for beneficiaries and contain program costs.

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

Rebalancing LTSS

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



Today, 55 percent of Medicaid LTSS spending supports HCBS compared to just 18 percent in 1995. And yet, these proportions vary significantly across states, as well as across populations who use LTSS. The toolkit highlights the following three strategies that states have relied on to increase the proportion of LTSS spending for services provided in community settings and illustrative case studies for each strategy, as well as an overarching case study on Maryland’s rebalancing efforts (see [Section II](#)):

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

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

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

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

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

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

Integrating LTSS through Managed Care

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

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

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

[Strategy 2: Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care](#), which focuses on providing a comprehensive benefit package, including physical and behavioral health services and LTSS under a single capitated rate and coordinated delivery system. The [case study](#) highlights:

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

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

- **New York’s** 1115 waiver that creates care coordination organizations to integrate primary care, behavioral health, and social support services with LTSS for the I/DD population.

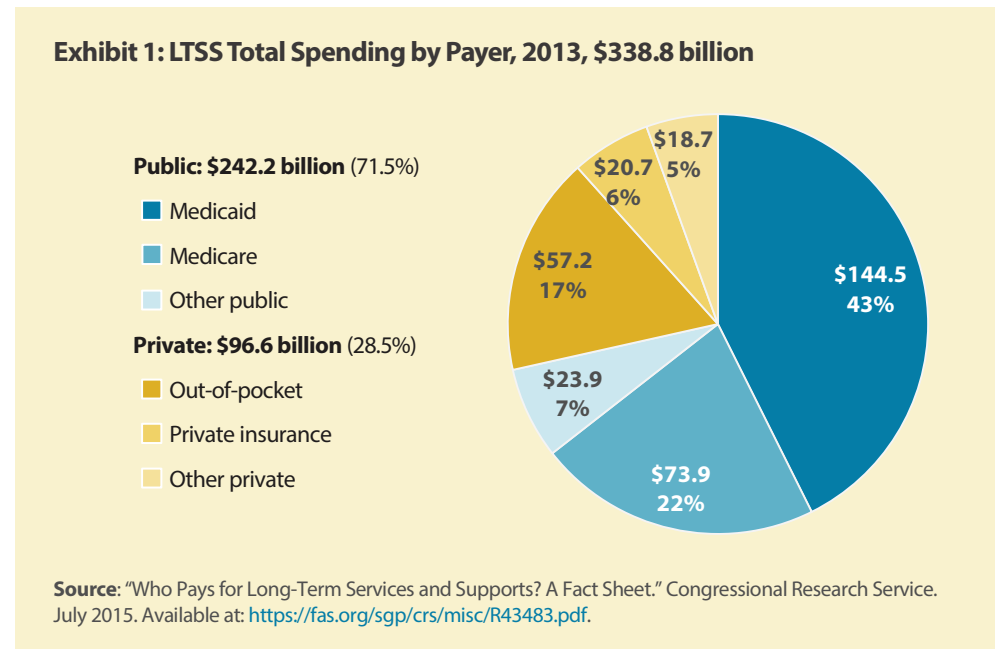
SECTION I: Overview and Purpose

Medicaid-Financed LTSS in the United States

Nationally, expenditures for long-term services and supports (LTSS) exceed \$338 billion annually, 40 percent of which is financed by Medicaid¹ (**Exhibit 1**) and does not even account for the \$470 billion in LTSS provided by informal caregivers.² LTSS expenditures are expected to rise sharply in the decades ahead due to a growing aging population and associated increased demand for LTSS.³ Not only is the proportion of people who are aging growing, but also the share who are 85 and older is rising (**Exhibit 2**, page 7), and with it the need for more intensive LTSS. As a result, there is a pressing need for state and federal action to address current and looming LTSS care delivery and fiscal challenges.

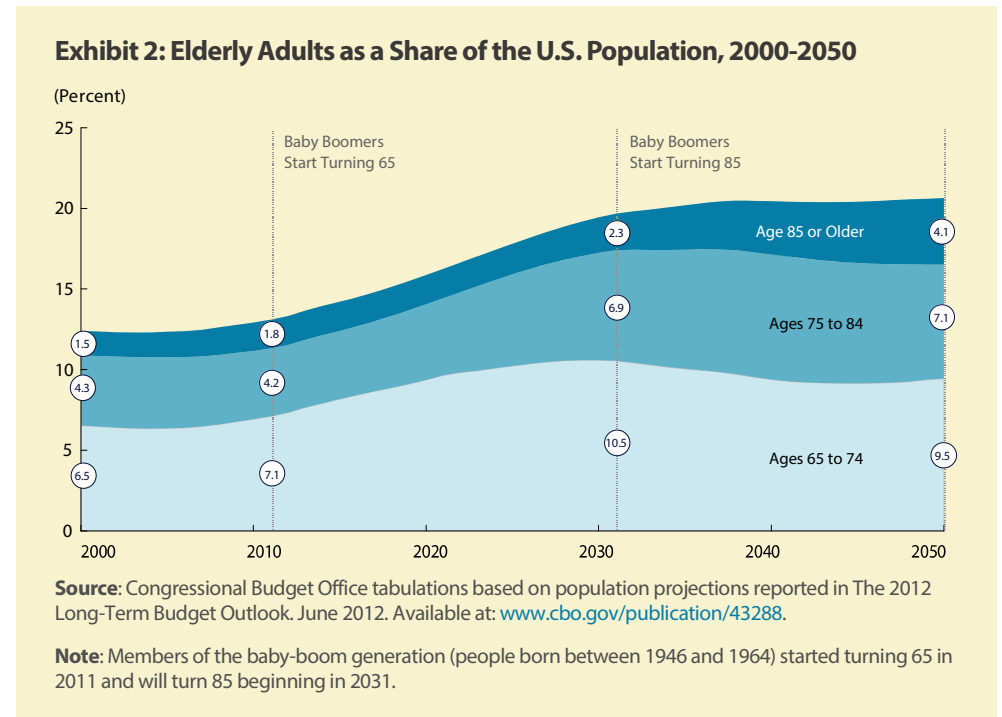
Today, more than 12 million Americans use LTSS in both community and institutional settings to meet their personal care needs, such as bathing and dressing, meal preparation, and housework (see *LTSS Are a Vital Part of the Care Continuum*, page 8).⁴ These services promote independence, support an individual’s ability to live and participate in the community, and improve overall quality of life. People who rely on LTSS include older adults, as well as adults and children with I/DD, physical disabilities, mental health conditions, substance use disorders, spinal cord or traumatic brain injuries, and other disabling, chronic conditions.⁵ People who use LTSS have extremely diverse medical and non-medical care needs, and their total medical costs are often higher than those who do not use LTSS. A recent study found that Medicare spends is nearly three times as much per capita on older adults who need LTSS compared to other beneficiaries without these needs.⁶

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



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

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



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

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

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



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

Examples of state consumer group initiatives include:

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

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

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

Toolkit Purpose and Methodology

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

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

Selection of Strategies

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

1. **Rebalancing Medicaid LTSS: Matching Care Settings to Individuals' Needs** (covered in [Section II](#)), which focuses on shifting LTSS utilization and spending from institutional to community settings; and
2. **Advancing Integration of LTSS with Physical and Behavioral Health Services through Managed Care** (covered in [Section III](#)), which provides options for providing person-centered care¹² through deeper coordination of physical health, behavioral health, and LTSS through managed care organizations.

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

LTSS Are a Vital Part of the Care Continuum

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

Examples of LTSS include:

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



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

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

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

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

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

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

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

Implementation Mechanisms

For each of the LTSS reform strategies in this toolkit, states have a variety of implementation mechanisms (i.e., legal authorities) available to them (see [Key Legal Authorities and Other Mechanisms to Advance LTSS Reform](#), pages 11-12, for complete descriptions). Some of these authorities can be used to achieve the same goal and which authority a state decides to pursue will depend on many factors, including its existing authorities (e.g., does the state already have a section 1115 or 1915(c) waiver) and the extent to which the state is broadly changing its system or is initiating a more targeted reform. A section 1915(c) waiver, for example, allows a state to target populations and cap enrollment, while a section 1915(j) state plan option allows a state to target a specific population but not cap the number of people served.

► Key Legal Authorities and Other Mechanisms to Advance LTSS Reform

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

Examples of State Plan Benefits That Can Be Used to Provide HCBS

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

State Plan Benefits Specifically Designed to Provide HCBS

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



State Plan Option to Require Managed Care Enrollment

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

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

- **1915(a):** States may institute voluntary managed care through CMS approval of a managed care contract; selective contracting is not permitted. States can use passive enrollment with an opt-out option.
- **1915(c):** States may provide HCBS to targeted groups who meet an institutional care level of need through this waiver authority. States must demonstrate cost neutrality (i.e., the initiative would not cost the federal government more than providing care in an institution) and meet provider standards, among other requirements. States can use these waivers to offer a variety of services including care management, home health aide, habilitation, respite care, supported employment, housing-related supports, and personal care services. States set the eligibility standards for these waiver programs, which include the level of care required (hospital, nursing facility, or Intermediate Care Facilities for individuals with I/DD) and the target group of beneficiaries (e.g., aged, individuals with intellectual disabilities, persons living with AIDS). States also may include other eligibility standards relating to age, condition and/or other factors, cap enrollment and use waiting lists.
- **1915(b)/(c) combined waiver:** 1915(b) waivers permit states to implement a managed care delivery system or otherwise restrict health care provider choice. Combining 1915(b) and 1915(c) waivers allows states to provide a range of state plan LTSS through managed care arrangements. These programs must meet the requirements of both waivers and states must renew each portion of the waiver separately.
- **1115:** This waiver authority allows the Secretary of Health and Human Services to permit states to launch demonstrations that the Secretary determines promote the objectives of Medicaid, including by reforming delivery systems or serving individuals not otherwise covered by the state's Medicaid program. Many states have used this authority to have managed care organizations provide some or all LTSS in the state. States must demonstrate budget neutrality, meaning that the 1115 waiver cannot cost the federal government more than it would be spending without the waiver.

Managed Care Contracts: Most states contract with health plans to deliver services to their Medicaid beneficiaries through managed care arrangements, increasingly including older adults and people with disabilities. In some cases, LTSS is carved into these contracts, but in all cases, states can use their contracts to promote coordination of services. As such, states can leverage their managed care contracts to better serve their LTSS populations.

Sources: Social Security Act Section 1905(a)(24), 42 CFR 440.167; Social Security Act Section 1915(g), 42 CFR 440.169; Social Security Act Section 1945; Social Security Act Section 1915(i), 42 CFR 440.182; Social Security Act Section 1915(j), 42 CFR Part 441, Subpart J; Social Security Act Section 1915(k), 42 CFR Part 441, Subpart K; Social Security Act 1932(a), 42 CFR 438.52; Social Security Act Section 1915(a), 42 CFR 431.54 and 431.55; Social Security Act Section 1915(b), 42 CFR 430.25, 431.54 and 431.55; Social Security Act Section 1915(c), 42 CFR 440.180, 441.300-441.310; 441.350-441.365; Social Security Act Section 1915(d), 42 CFR 431.350-431.365; Social Security Act Section 1115, 42 CFR 431.400-431.428.

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

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

Today, nursing facility care remains a mandatory service and HCBS continues to be optional, but changes in federal laws dramatically expanded states' abilities to provide care in community-based settings. These changes have been prompted by individual and family preferences, state interest, legal obligations under the Americans with Disabilities Act for states to provide care in the least restrictive setting, and the relative cost-effectiveness of providing community-based rather than institutional services. The cost issues are compelling: on average, nursing facility care costs are more than \$85,000 per year compared to \$49,000 for a home health aide.¹³ While some states worry that increasing access to HCBS will cause more people to seek out community-based services (i.e., “the woodwork effect”), research indicates that while expanding access to HCBS may result in a short-term increase in spending, LTSS spending growth was greater in states with limited HCBS benefits in one analysis. Another study found that expanded HCBS access did not appear to increase overall Medicaid LTSS spending over time.^{14,15} However, there are a variety of federal options that allow states to expand HCBS incrementally as they assess the fiscal implications of doing so.

For the most part, states have deliberately embraced opportunities to expand HCBS, and there has been a dramatic shift in national Medicaid LTSS utilization and spending from institutional to community-based settings. As of 2015, 47 states and the District of Columbia were utilizing 1915(c) waivers to expand access to HCBS for targeted populations, enrolling more than 1.5 million individuals into 341 distinct waivers.^{16,17}

Additionally, 17 states were utilizing one or more state plan HCBS options (i.e., 1915(i), 1915(j), and 1915(k)),¹⁸ while three states (Arizona, Rhode Island, and Vermont) were using 1115 waivers to expand these services.¹⁹ The most recent data available (2015) show that nationally, 55 percent of Medicaid LTSS spending supports HCBS, up from 18 percent in 1995 (**Exhibit 3**, page 14).

► Olmstead Influence on LTSS Policy

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

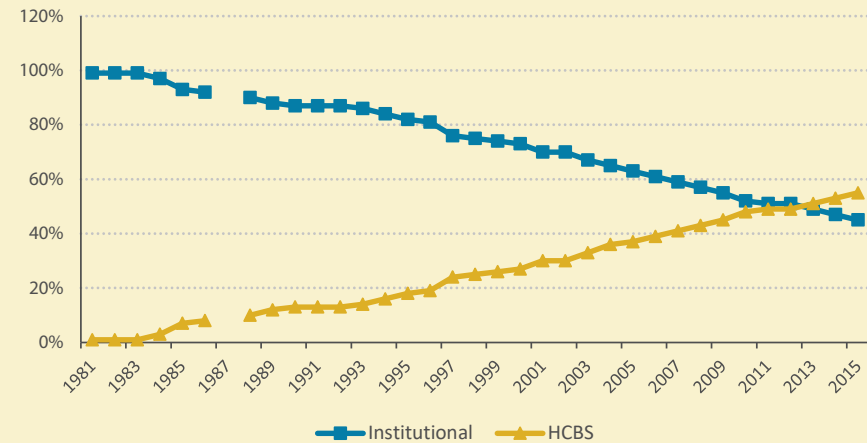


Source: CMS, “Olmstead State Medicaid Director Letters. Updates 1 – 4, 1998 to 2001.” Available at: www.nasddds.org/resource-library/employment/achieving-a-better-life-experience-act-of-2014/medicaid-hcbs-authorities/hcbs-waiver-state-medicare-director-letters/olmstead-state-medicare-director-letters/.

Yet, HCBS penetration rates still vary significantly across states, ranging from a high of 82 percent in Oregon to a low of 31 percent in Mississippi.²⁰ There also is some evidence of variation between rural and urban areas suggesting that the proportion of LTSS spending for nursing facility services is greater among people in rural areas than urban areas.²¹ HCBS use also varies across populations who use LTSS. Nationally, among people with developmental disabilities, HCBS accounted for 76 percent of LTSS spending, but only 44 percent of spending for programs targeting older adults and people with physical disabilities.²² As such, there are opportunities across many states to expand access to HCBS and provide care in the LTSS care setting that is most appropriate for an individual’s preferences and care needs.

This section highlights three innovative reform strategies for rebalancing Medicaid-financed LTSS. States interested in advancing rebalancing goals can leverage elements from one or more of these strategies that have been successfully deployed in other states to fundamentally transform their LTSS system. For each strategy, we provide: the impetus, a description, potential implementation mechanisms, results to date, and key lessons. The following table (pages 16-17) provides an overview of this information, and the remainder of the section goes into more detail. The section also provides case studies to illustrate how states have implemented each strategy. Notably, this is not an exhaustive set of strategies or implementation mechanisms, but are ones identified by innovator states as significantly advancing their rebalancing goals. (See [Key Legal Authorities and Other Mechanisms to Advance LTSS Reform](#), pages 11-12, for a description of specific implementation mechanisms.)

Exhibit 3: Medicaid HCBS and Institutional LTSS Expenditures as a Percentage of Total Medicaid LTSS, 1981 to 2015



Source: Truven Health Analytics. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.” April 2017. Available at: www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltsspendituresffy2015final.pdf.

► Maryland's Path to Rebalancing

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



Since 2007, Maryland has received federal Money Follows the Person (MFP) and Balancing Incentive Program (BIP) funding, submitted a 1915(k) Community First Choice (CFC) state plan amendment, and streamlined existing 1915(c) waivers to advance its rebalancing strategy. Maryland's incremental and focused approach has allowed the state to leverage federal funds to accomplish key existing goals and support new ones including: (1) scaling HCBS infrastructure statewide; (2) improving assessment tools; and (3) streamlining and increasing access to services. Using BIP funding,




the state expanded HCBS infrastructure by implementing *Maryland Access Points* in partnership with disability partners at the state's Centers for Independent Living to create streamlined entry points for individuals seeking LTSS.




Maryland also used BIP dollars to implement a uniform standardized assessment with specific tools for different populations to more effectively screen beneficiaries and connect them to needed services. Furthermore, Maryland moved as many services as possible out of its multiple 1915(c) waivers and into the CFC state plan authority to expand access to these services and receive the CFC enhanced federal match for them—resulting in a 31 percent growth in program enrollment since 2015, while maintaining cost neutrality. With BIP funding having ended September 30, 2017 and MFP funding ending December 31, 2018, Maryland is now focused on sustainability and in the process of shifting from grant funding to federally matching funds under a cost allocation plan amendment requested from CMS to support *Maryland Access Points* activities.

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

Sources: Interview with Maryland, October 25, 2017; Maryland Department of Health and Mental Hygiene. "Money Follows the Individual Accountability Act Report." December 2015. Available at: [http://dislibrary.state.md.us/publications/Exec/DHMH/HG15-135\(g\)_2015.pdf](http://dislibrary.state.md.us/publications/Exec/DHMH/HG15-135(g)_2015.pdf).

Overview of Rebalancing Strategies

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

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

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

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



REBALANCING STRATEGY 1:
Develop the LTSS System
Infrastructure to Promote
Greater Access to HCBS

► Impetus for Strategy

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

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

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

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



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

Many states leveraged the federally-funded **Money Follows the Person** (MFP) demonstration and the **Balancing Incentive Program** (BIP) to significantly advance their rebalancing reforms. While new states can no longer take advantage of these funding opportunities, the programmatic changes that both opportunities promote can serve as a template for other states thinking about rebalancing reforms. States will need to be creative to identify new funding streams to replace these funding sources and may even need to mix and match various federal, state, local, private, and foundation sources—and likely utilize 1115 waiver flexibility—to support rebalancing initiatives. States also should look for similar federal funding opportunities in the future.

MFP: This national demonstration helps Medicaid enrollees transition from facility-based to community-based care. In addition to offering more independence and a potentially better quality of life for individuals who participate, the program may save money by shifting spending from more costly institutional care to potentially less costly HCBS. MFP program goals include:

1. Increasing HCBS use and reducing institutionally-based service use;
2. Eliminating barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice;
3. Strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and
4. Putting procedures in place to provide quality assurance and improvement of HCBS.

BIP: Created under the ACA, BIP aimed to improve access to Medicaid LTSS in community settings by giving states an increased federal matching rate for community-based services. Eighteen states received BIP funding and were required to:

1. Implement a “no wrong door” system, core standardized assessment, and conflict-free case management;
2. Use the funds to improve access to LTSS in the community; and
3. Spend a certain percentage of total LTSS funds on community LTSS.

Based on states’ reports, the no wrong door system had the largest impact on access to community LTSS by increasing entry points, streamlining the referral process, and improving awareness of services.

States that spent less than half of their total LTSS dollars on community LTSS in 2009 receive a two percent enhanced federal match rate, while states that spent less than a quarter receive a five percent enhanced match. Under BIP, 18 states received a total of \$2.4 billion in grant funding to increase access to new or expanded services and infrastructure. Since 2007, 43 states and the District of Columbia have received over \$4 billion in MFP funding. As funding ends, states are now looking to implement sustainability initiatives within their programs to maintain the gains they have achieved in improving their community-based LTSS infrastructure.



Sources: 93.791 *Money Follows the Person Rebalancing Demonstration*. Section 2403, 2010 Patient Protection and Affordable Care Act. 2010.; 93.778 *State Balancing Incentive Payments Program*. Section 10202 Patient Protection and Affordable Care Act. 2010.; Texas Health and Human Services. “Money Follows the Person Demonstration Project.” Available at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project>; CMS. “Balancing Incentive Program.” Available at: www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html.; Mission Analytics Group and New Editions Consulting, Inc. “State Reflections and Recommendations, Balancing Incentive Program.” February 2016. Available at: www.medicaid.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf.; The Balancing Incentive Program. “Balancing Incentive Program, Summary Report.” August 2015. Available at: www.balancingincentiveprogram.org/sites/default/files/BIP_Summary_Report_8_2015.pdf.; Mathematica Policy Research “Money Follows the Person 2015 Annual Evaluation Report.” May 2017. Available at: www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf.



REBALANCING STRATEGY 1:
Develop the LTSS System Infrastructure to Promote Greater Access to HCBS

► Strategy Description

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

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

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

► Implementation Mechanisms

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

Though there is no new BIP funding available for states, states’ BIP experiences provide relevant templates in the event that the federal government appropriates future funding or states are able to leverage other funding sources to support similar goals and efforts, including private foundation grants and state appropriations. Other states have used federal and state authority to launch reforms in these areas, including: (1) 1115 waiver authority to retrain the LTSS workforce (e.g., New York); and (2) changes to state regulations and nursing practices to support workforce development and capacity efforts (e.g., New Jersey and California).²³ As New Jersey did with its nursing delegation initiative, states also can use pilot programs to test initial concepts and gain support to fund future reform efforts.



REBALANCING STRATEGY 1:
Develop the LTSS System Infrastructure to Promote Greater Access to HCBS

► Results to Date

According to a February 2016 evaluation of BIP-funded states, of the three required BIP structural changes, implementing a single entry point system for access to community LTSS is expected to result in the greatest impact on access to services. This no wrong door system increases entry points to the LTSS system for individuals (i.e., physical locations, websites, and toll-free numbers), streamlines the information and referral process for services, and increases overall awareness of the available community LTSS options.²⁴ The same evaluation found that only nine of 18 states that responded reported that implementing a uniform assessment tool significantly improved the state’s ability to conduct accurate assessments and improve care plans, though states’ responses largely varied based on what assessment infrastructure was already in place.²⁵

For instance, New York reported limited impact because efforts to create a uniform assessment tool were already underway, though the state did note that BIP funding helped expedite the tool’s automation.²⁶ The BIP evaluation also found that many states had already introduced conflict-free case management, though some states like New Jersey reported that BIP funding prompted the state to include conflict-free language in its managed care contracts.²⁷ Results related to workforce investment are difficult to measure and limited as most states are just beginning these efforts. New Jersey’s nursing delegation pilot led it to revise its nursing regulations and improved quality of life for pilot program participants—although nursing delegation is not widely used within the state. Despite strides in some states, considerable needs remain in most states for investments in LTSS infrastructure, particularly for building beneficiary awareness, ensuring equitable access to services across populations, recruiting and retaining the direct care workforce, and supporting overburdened and overwhelmed informal caregivers.

► Key Lessons

- **Engage leadership across state agencies.** Gubernatorial or executive support and direction is crucial to moving reform efforts forward, building relationships across agencies, and engendering support for new program or system changes. Maryland identified that having the support of its Secretary of Health and Mental Hygiene, Governor’s office, and Medicaid director was instrumental to advancing its rebalancing efforts. More broadly, states reported that one of the key impacts of their LTSS system redesign work was to increase coordination and collaboration across often siloed state agencies, and strong leadership was essential to pushing rebalancing initiatives forward.²⁸ Notably, New York reported that the departure of its uniform assessment tool’s administrative champion and other staffing changes slowed momentum for rolling out the tool across programs, demonstrating how critical state leadership is to strategy design and execution.
- **Engage all relevant stakeholders early and build lasting partnerships.** All states interviewed identified the importance of stakeholder engagement and buy-in, particularly among beneficiaries and their advocates, during all phases of reform—design, implementation and ongoing monitoring. New Jersey noted the importance of gaining support from the executive director and board members of the New Jersey Board of Nursing to promote nursing delegation efforts, as well as ensuring attorneys within in the Department of Law and Public Safety, which houses the Board of Nursing, understood

the program’s intent. New Jersey also developed an advisory council that included provider representatives—such as home care workers, hospital associations, and experts in nursing delegation—to assist with problem solving.²⁹ Tennessee echoed the importance of engaging stakeholders early and often, using stakeholder feedback to drive initiatives and identifying key areas of the process for stakeholders to own. Not only can meaningful and lasting partnerships help advance a state’s strategy, but also they can prevent potential challenges by providing early warnings about implementation and transition issues.

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



REBALANCING STRATEGY 1:
Develop the LTSS System Infrastructure to Promote Greater Access to HCBS



REBALANCING STRATEGY 1:
Develop the LTSS System Infrastructure to Promote Greater Access to HCBS

► Case Studies

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

Massachusetts has a long history of prioritizing “community-first” LTSS, and has provided a generous scope of community-based LTSS benefits under its Medicaid state plan and through ten HCBS waivers. In state FY 2017, 74 percent of MassHealth LTSS spending was for community-based services, up from 44.8 percent in 2009.^{30,31}

Massachusetts embarked on several efforts to further expand the availability of services to people in need of LTSS, and continues to improve the structural aspects of its LTSS system. In April 2014, the state received \$135 million in BIP funding. In addition to expanding access to HCBS—specifically for children under age nine with autism—Massachusetts also used the funding to: (1) expand choice counseling through the state’s Aging and Disability Resource Consortia (ADRCs); (2) improve eligibility assistance through co-location of Medicaid eligibility counselors and ADRCs; (3) support training of direct care workers; and (4) develop and raise awareness of the MassOptions information and referral website and call center.³²

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

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



assessment processes, facilitating more equitable access to programs and services and also eliminating duplication. It took the state approximately three years to roll out the system statewide and to all the different programs. Today, the tool is used in the state's mainstream managed care and MLTSS programs for care planning and rate-setting, but has not yet been adopted for use in its Traumatic Brain Injury and Nursing Home Transition and Diversion waiver programs or for use with its I/DD population. Ultimately, the state seeks to expand the use of the tool for use by hospitals and nursing facilities.

Some challenges noted in continued operation of the UAS-NY include maintaining DOH's focus and resources for the tool amid staffing changes, including loss of administrative champions and competing state agency priorities. Additionally, DOH has not been able to acquire the resources for comprehensive analysis of data collected, restricting its ability to use the data to inform policymaking.

New York Uses 1115 Waiver Funds to Recruit, Retrain and Retain Its Long-Term Care Direct Care Workers. In April 2014, CMS approved New York's Medicaid Redesign Team (MRT) amendment to the state's 1115 waiver, making \$245 million available through March 2020 for initiatives to retrain, recruit and retain direct care workers in the long-term health care sector. This initiative, referred to as the "Workforce Investment Program," will be implemented in early 2018.

The DOH will require its managed long-term care plans to contract with DOH-designated workforce training centers (Long Term Care Workforce Investment Organizations, [LTC WIOs]) to: (1) invest in initiatives to attract, recruit and retain long-term care workers; (2) develop plans to place these workers in medically underserved communities; (3) analyze the changing training and employment needs among workers served by the centers; (4) seek stakeholder input and engagement; and (5) support the expansion of home and respite care.

As of October 2017, DOH had released its LTC WIO application and was in the process of designating LTC WIOs that met the state's minimum criteria. DOH will distribute waiver funds to its managed long-term care plans, which, in turn, will provide payments to the LTC WIOs for delivering workforce development initiatives that provide training and support recruitment and retention efforts to address the needs of plan, providers and healthcare workers in long-term care sector.³³

Using 1915(c) Waivers to Support Family Caregivers

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

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

Source: AARP Public Policy Institute. "Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home- and Community-Based Service Waiver Programs." December 2013. Available at: www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicare-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf; AARP Public Policy Institute. "Emerging Innovations in Managed Long-Term Services and Supports for Family Caregivers." November 2017. Available at: www.longtermscorecard.org/~media/Microsite/Files/2017/2017%20Scorecard/AARP1202_EI_EmerInnovationLTSS_Oct31v2.pdf.



New Jersey’s Nurse Delegation Pilot Increases Access to HCBS. As part of its ongoing commitment to serve eligible residents with HCBS, New Jersey has consistently advanced innovative initiatives in this regard. Specifically, in the mid-2000’s the state looked to implement nursing delegation—the process by which a registered nurse “directs another individual to do something that that person would not normally be allowed to do.”³⁴ This plan would work to expand access to HCBS by increasing the availability of the direct care workforce to meet beneficiaries’ needs.

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

The CHHAs were able to provide delegated services only to select Medicaid beneficiaries in a “triad” model that included the nurse, the CHHA, and the individual. Nurses had to meet documentation requirements that demonstrated CHHAs had the ability to provide medication to beneficiaries during training, in order to reduce nurse liability risks. The CHHA’s training was not transferrable, which required them to retrain for each client. An evaluation of the pilot was positive, with high levels of beneficiary satisfaction with the program and no evidence of adverse health outcomes.³⁵ The pilot established evidence of best practice and provided the necessary policy momentum for the Board of Nursing to change its regulations to permit delegation of medication administration by CHHAs in January 2017.³⁶

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

Direct Care Workforce: The Need for Better Wages and Training

The direct care workforce is poorly paid with home health workers averaging just \$10 to \$13 per hour. Both increased pay and better training are needed to address the high turnover among the direct care workforce and to ensure sufficient numbers of workers to meet the projected demand for HCBS.

States are starting to take action. Massachusetts used BIP funding to set an enhanced minimum wage standard, increasing home care wages by five percent. In New York, the 1199 SEIU health care workers union joined the *Fight for \$15*, a national movement to increase the minimum wage to \$15 an hour. Additionally, 80,000 unionized city home health aides are among those who are benefiting from legislation that Governor Cuomo signed in April 2016 enacting a statewide \$15 minimum wage plan.



Sources: Center on Budget and Policy Priorities. “Medicaid Cuts in House ACA Repeal Bill Would Limit Availability of Home- and Community-Based Services.” May 2017. Available at: www.cbpp.org/sites/default/files/atoms/files/5-18-17health.pdf; Mission Analytics Group, Inc. “Innovations in the Balancing Incentive Program: Massachusetts.” CMS, February 2017. Available at: www.medicaid.gov/medicaid/lts/downloads/balancing/mass-case-study.pdf; G.A. Otis. “Home health workers join ‘Fight for \$15’ to increase minimum wage.” *Daily News*, April 13, 2015. Available at: www.nydailynews.com/new-york/exclusive-home-health-workers-join-fight-15-pay-war-article-1.2183024; New York State. “Governor Cuomo Signs \$15 Minimum Wage Plan and 12 Week Paid Family Leave Policy into Law.” April 2016. Available at: www.governor.ny.gov/news/governor-cuomo-signs-15-minimum-wage-plan-and-12-week-paid-family-leave-policy-law.



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

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

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

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

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



California was the first state to create such a program in 2002. The program is financed through a payroll tax, which is added to the state's disability insurance fund with no direct cost to employers. Eligible employees must have paid into the fund and may receive up to 55 percent of their weekly wages up to a maximum benefit (as of 2018, reimbursement will increase to 60 to 70 percent of weekly wages). Workers may take up to six weeks of leave, on an hourly, daily, or weekly basis. In FY 2012–2013, about 13 percent of claims related to care for sick family members.

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

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



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► Impetus for Strategy

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

► Strategy Description

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



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► Implementation Mechanisms

Most states pursuing this strategy have used federal funding from the MFP program to support efforts to transition individuals from institutions into community-based programs while building more effective community-based care.³⁷ Though no new MFP funding is available, states have until 2020 to use remaining MFP funds and seek alternative financing sources. This also provides time during which non-MFP states can learn from the investments that MFP encouraged.

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

Increasingly, though not focused exclusively on the LTSS population, managed care plans are devoting resources to helping their enrollees secure housing. Arizona recently issued a new contract with its health plans to require them to assess all their enrollees' housing needs, particularly individuals with an affordable housing need. It also requires the health plans to network with local housing authorities. Given that states have limited time to use MFP funding, building transition support requirements into Medicaid managed care contracts may become an increasingly used to support nursing facility transitions.

► Results to Date

The most recent MFP evaluation found that, as of December 31, 2015, cumulative MFP transitions totaled 63,337, and from 2007 through the end of 2013, transitions achieved an estimated \$204 to \$978 million in total Medicaid savings across 18 states.³⁸ States are continuing this effort, but nationally the number of transitions under MFP has been relatively modest. This is attributable to the requirement that states first move people out of nursing facilities before receiving the enhanced federal funding, limiting upfront community infrastructure. In addition, it is challenging to find affordable, accessible housing for people who long resided in institutional settings. Furthermore, these numbers do not reflect transitions of individuals residing in nursing facilities for less than 90 days, nor the number of individuals who were diverted from institutional admission as a result of the increased community resources and infrastructure developed under MFP.

It is significant to note that MFP participants consistently reported improvements in their quality of life, particularly related to living arrangements.³⁹ Since many states' nursing facility transition programs are relatively small and their programs vary, it is not clear that one state's outcomes would be transferrable to another; however, it is worth highlighting the positive impacts that programs have on individuals and the savings potential for states. In Texas, where approximately 500 people have transitioned to the community under the state's MFP-funded behavioral health pilot, 68 percent of all pilot participants and 72 percent of those who had completed the full year of specialized pilot services remained in the community. The state's Medicaid program has saved \$24.5 million from the pilot.⁴⁰ In New York, nearly 2,500 people are participating in the state's Nursing Home Transition and Diversion waiver program, with about 500 people receiving a state-funded housing subsidy.



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► Key Lessons

- **Coordinate with state and local housing authorities and private developers to secure affordable housing.** States emphasized the need to work collaboratively across agencies—particularly with state and local housing authorities—as well as with the private sector to secure housing for people exiting institutions. Since locating affordable and accessible housing for people in need of LTSS can be challenging, Arizona developed a close working relationship with its Department of Housing. The partnership resulted in a variety of affordable housing initiatives including the identification of housing opportunities for specialty populations (e.g., people with physical disabilities). Once housing opportunities are identified, the department coordinates with the Medicaid agency and its health plan contractors to facilitate movement for those in need. Critically, states should be thoughtful about where housing is located. For instance, Texas identified that many developers were seeking tax credits for housing in suburban areas, which is not ideal for people exiting institutions who often rely on public transportation, so the state created incentives for developers to focus on urban areas.
- **Separate waiver authorities that guide nursing facility transitions from those that offer housing support to maintain cost neutrality.** Acknowledging how costly housing support services can be, especially in New York, state officials decided to develop a state-funded housing support program outside of the state’s 1915(c) nursing facility transition waiver. This approach helped the state, which judged the investment in housing to be cost-effective, to prevent the cost of housing supports from diluting the actual costs of providing LTSS and to stay within the waiver’s cost neutrality requirements.
- **Analyze data to identify opportunities to target programs to specific populations.** States can collaborate with partner agencies to identify data on people in nursing facilities to help target nursing facility transition efforts. For instance, Texas, in developing a transition program for people with behavioral health conditions, identified residents who had used the mental health system and had prior discharges from psychiatric institutions into nursing facilities. Analyses like these can inform the state’s understanding about their nursing facility population’s needs and opportunities for policy development or programs targeted to promoting community living.
- **Work collaboratively with diverse stakeholders, including beneficiaries and non-traditional partners.** States should engage a diverse set of stakeholders, including Medicaid beneficiaries in nursing facilities or at-risk of institutionalization in developing nursing facility transition efforts. Texas established the “Promoting Independence Advisory Board” following the 1999 *Olmstead* decision and found its contributions to be very useful. The board continues to advise the state today. Texas also works with university partners to conduct transition related training and provide technical assistance to health plans and providers. Working with non-traditional partners can provide flexibility to states since non-traditional partners often can respond faster than states with their lengthy and involved processes, such as with rulemaking.



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- **Provide transition services, which are just as important as tenancy-sustaining services.** States can design and provide transition services, such as assisting with housing searches and paying for rental security deposits, to help individuals prepare for their transition to the community. For Texas this was essential to the success of its behavioral health focused efforts, and it reflects a general need to be more proactive and thoughtful about service planning and provision to ensure its ultimate success.
- **Adjust and adapt as the program or reform continues.** Engaging in continual programmatic reflection allows the state to identify emerging challenges and address them. Tennessee cautioned that failing to evaluate the program as it is implemented prevents the state from soliciting and incorporating valuable feedback from stakeholders. A constant quality improvement process results in better health outcomes, a better program, and lessons for other states to draw from.
- **Memorialize major programmatic requirements but maintain flexibility for evolving practices.** Texas recommended that states should document major program requirements and objectives in clear, measurable terms, but cautioned states not to embed highly detailed information (e.g., evidence-based rehabilitative techniques) into contracts or administrative rules since these practices evolve and improve over time. Texas further suggests that states recognize centers of excellence in practice, and embed requirements and/or incentives in managed care contracts to work with these centers of excellence to continuously improve practices (e.g., training, fidelity reviews).

► Case Studies

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

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

The state administers the waiver through the state's DOH, which contracts with nine Regional Resource Development Centers. These centers employ transition specialists called Regional Resource Development Specialists who are responsible for, among other things, meeting with prospective waiver participants and their family members to determine their interest



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and ability to transition to community-based care. The Regional Resource Development specialist helps enroll an individual in the waiver, makes referrals to community-based services, and with the support of a service coordinator, connects a waiver participant to providers for service coordination. To address a lack of affordable housing, New York initiated the Nursing Home Transition and Diversion Housing Subsidy program funded with state-only appropriations. DOH contracted with local housing authorities to administer the day-to-day responsibilities of the subsidy program, including executing rental agreements with waiver participants who are referred to the program by their service coordinator and approved by a Regional Resource Development specialist. As of October 2017, approximately 2,450 people are enrolled in the waiver and of those, about 545 receive a housing subsidy.

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

In response to the 1999 *Olmstead* decision, a state executive order directed the Texas Health and Human Services Commission to develop a plan to promote community-based alternatives for people with disabilities to foster independence and provide the opportunity for people to live productive lives in their home and communities.⁴¹ As a result in 2001, Texas pioneered a nursing facility transition program that predates the current MFP program. Through both the state funded program and the MFP program, Texas has transitioned more than 46,000 nursing facility residents to the community. However, after rigorously analyzing state data on those who transitioned and those who remained in nursing facilities, Texas recognized that a significant number of people with serious mental illness and substance use disorders co-occurring with physical health conditions remained in nursing facilities. This was in part because its Medicaid program lacked the necessary specialized services to support this population, whose behavioral health conditions further complicated transition.

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

As of Fall 2017, 454 individuals have transitioned into the community under the pilot. Sixty-eight percent of all pilot participants and 72 percent of those who had completed the full year of pilot services remained in the community. To date, the pilot has saved the state's Medicaid program \$24.5 million.⁴²



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As MFP funding ends, Texas plans to: (1) continue supporting the transition of individuals from nursing facilities to community settings; (2) create a statewide technical assistance program for evidence-based practices, such as cognitive adaptation training; and (3) establish policies and processes and engage stakeholders to foster inclusion of mental health self-direction in the state’s managed care system—all intended to further increase the use of HCBS.

Arizona and Texas Leverage Federal and State Funding and Private Sector Development to Provide Housing Supports to Individuals with Disabilities Exiting Institutions. States recognize that securing affordable, accessible, and integrated housing is one of the most difficult barriers in achieving state rebalancing goals. Both Arizona and Texas are among those recently launching initiatives to assist individuals to transition from institutions to living at home or in group settings. Both states received grants from the U.S. Department of Housing and Urban Development (HUD) Section 811 Supportive Housing for Persons with Disabilities program to fund rental assistance for eligible beneficiaries to live in the community and have collaborated across agencies and the private sector to develop additional housing supports.⁴³

The Arizona Division of Developmental Disabilities uses HUD Section 811 funding to help make affordable housing available to individuals with developmental disabilities. In May 2017, the state announced that \$2.7 million in project-based rental assistance was available for eligible developers and existing properties to create up to 64 housing units for individuals wanting to move from a less integrated setting into their own home, and who were in need of affordable housing.⁴⁴ In addition, under its 1115 waiver, Arizona provides assistance for all eligible individuals leaving institutions to assist with funding and providing utility deposits, furniture, and other relevant transition items through its community transition service. Case managers authorize brokers—who are typically providers in the community already offering LTSS to the beneficiaries (e.g., attendant care services)—to assist them in procuring the services needed for the individual to transition successfully into the community. Notably, the community transition service does not provide rental assistance. Generally, utilization of this service has been relatively low since only people moving from an institutional to an individual home may use it, and not people moving from an institution to group home or group home to individual home. However, from the state’s perspective, it is an important service to promote, even if it only helps a few people each year, because Arizona is constantly looking for ways to advance its rebalancing efforts. Beginning October 1, 2017, Arizona initiated a new contract with the LTSS health plans that includes new requirements to identify and understand their enrollees’ housing needs, and partner with public housing authorities to respond to them.⁴⁵

In Texas, the Section 811 program—known as Project Rental Assistance—is administered collaboratively by the Texas Department of Housing and Community Affairs in partnership with the Texas Health and Human Services Commission and Texas Department of Family and Protective Services. Since 2015, the Department of Housing and Community Affairs has incentivized participation in the Project Rental Assistance program by creating points and threshold incentives for applicants seeking federal tax credits and other multifamily program funds, if they agree to set aside units for the program’s target population (i.e., people with disabilities exiting institutions, people with serious mental illness, and youth and young adults exiting foster care).⁴⁶ Section 811 funding subsidizes the rent and utilities in these units, making them affordable to extremely low-income individuals, while additional program rules waive the fees normally charged by properties and reduce



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security deposits. The Health and Human Services Commission and Department of Family and Protective Services conduct outreach, refer potential tenants, and provide ongoing LTSS on a voluntary basis under Medicaid.

The Texas Department of Housing and Community Affairs also operates Project Access, a program which sets aside state-administered Section 8 housing vouchers for people with disabilities leaving institutions and state psychiatric hospitals. Since demand for vouchers exceeds availability, Texas also makes rental assistance available for up to five years through its HOME Tenant Based Rental Assistance program for people on the Project Access waitlist and other housing assistance programs. By using the HOME program as a bridge, individuals are able to exit institutions while waiting to get off the Section 8 or other programs' waiting lists. Furthermore, the state uses MFP administrative grant funding and authority to partially fund positions at the Department of Housing and Community Affairs to assist in expanding housing opportunities for individuals with disabilities. MFP demonstration funds also support housing navigators at 22 Aging and Disability Resource Centers who work to increase the inventory of affordable housing for people with disabilities by building relationships with public housing authorities, local housing programs, and private developers.⁴⁷

Tennessee's Nursing Facility to Community Transition. Recognizing its long-standing reliance on institutional care for LTSS beneficiaries, Tennessee deliberately focused on increasing access to community-based services during the design and implementation of its Medicaid MLTSS system in 2010, called TennCare CHOICES.⁴⁸ The state's HCBS program was operating at the time, but under constrained funding, making it difficult to expand access to HCBS. Additionally, the LTSS system was fragmented, with health plans responsible for physical and behavioral health services and the Area Agencies on Aging and Disability overseeing community-based LTSS. Tennessee aimed to reorganize care delivery for LTSS populations by transitioning LTSS to a capitated managed care system and aligning financial incentives to encourage HCBS utilization.⁴⁹

Tennessee designed its new MLTSS program to ensure access to both nursing facility and community services for beneficiaries at nursing facility level of care by setting the fully integrated capitation payment for these beneficiaries at the same level whether the beneficiary received services in a nursing facility or in the community. This encouraged plans to drive utilization toward the most cost-effective, appropriate service option for their enrollees.⁵⁰ Furthermore, Tennessee built in specific requirements and timelines for nursing facility diversion planning to incentivize health plans to reach out to beneficiaries in nursing facilities to assist them in choosing the most appropriate care setting for their needs, and check in with them frequently on their community transition wishes. Finally, beneficiaries could receive transition allowances when they moved from institutional to community-based settings to use for rent, housing deposits, basic furnishings, and other necessary items for transitioning.⁵¹

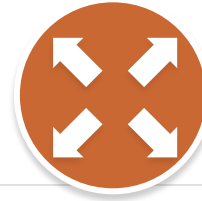
Tennessee subsequently leveraged MFP funding to support its existing 1115 and 1915(c) waiver authorities for HCBS, and to provide financial incentives for health plans around length of community stay, development of institutional alternatives, and other metrics.⁵² While enhanced MFP funds and flexibilities connected to the program will phase out over time, Tennessee believes that its health plans will continue to support its rebalancing efforts as the system has already undergone an effective transformation in moving to community-based LTSS through the capitated rate structure.⁵³

Tennessee reported significant achievements as a result of these changes, including the elimination of a waiting list for 1915(c) services and a substantial expansion of the number of beneficiaries receiving LTSS in the community. The number of beneficiaries in nursing facilities decreased from over 20,000 to fewer than 17,000, and the number in HCBS increased from 4,700 to nearly 13,000 between 2010 and 2015, with over 600 transitions a year since the inception of the program.⁵⁴ Over 2,000 beneficiaries in institutions for at least 90 days have transitioned to HCBS under the state's MFP demonstration, nearly reaching the state's rebalancing targets.⁵⁵



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



► Impetus for Strategy

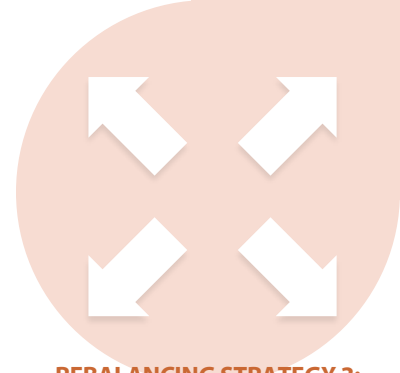
While a significant proportion of the population will eventually need LTSS, only a small subset actually plan for their long-term care needs before the need arises. Instead, most people enter the system during a crisis that is often preceded by an acute health care episode. When this happens, those in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

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

► Strategy Description

To address these issues, a growing number of states, including Washington and Vermont, are expanding access to HCBS for people at-risk of needing nursing facility care who would otherwise not yet qualify for Medicaid-financed LTSS. The goal is to prevent or delay their needing more intensive and more costly LTSS.⁵⁶

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



REBALANCING STRATEGY 3:

Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Utilization

► Implementation Mechanisms

Washington is using an 1115 waiver—one part of a comprehensive 1115 waiver approved by CMS in early 2017—to expand access to HCBS services for “pre-Medicaid” individuals, funded by Medicaid service dollars. Vermont also uses an 1115 waiver to administer its Choices for Care program, within which it expanded access to LTSS for “moderate need” individuals, leveraging 1115 waiver funding in place of state-only dollars to cover the moderate needs group’s services.

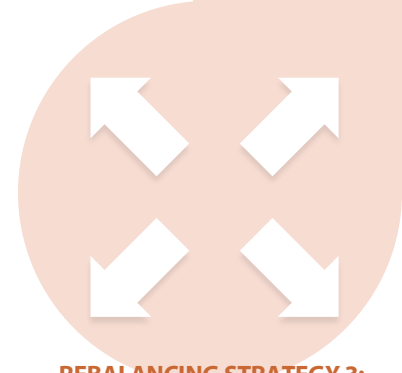
► Results to Date

Vermont partnered with UMass Medical School to annually evaluate the Choices for Care program. Overall, the most recent evaluation (published May 2015) found that Choices for Care increased access to HCBS and enabled people to be served in the care setting of their choice.⁵⁷ The state has been able to provide services without a waitlist to its “high needs” group, but as of January 2015, there were 449 individuals on the “moderate needs” waitlist, an area on which the state is continuing to focus its efforts while remaining budget neutral.

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

► Key Lessons

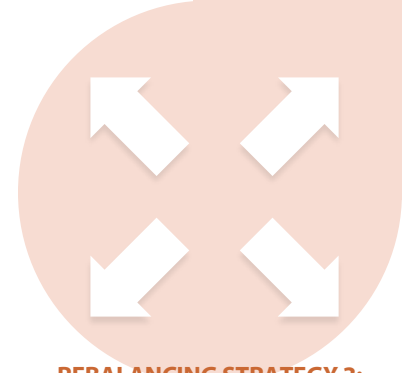
- **Engage providers, beneficiaries, legislators, and other stakeholders early and often.** In both Washington and Vermont, early and frequent stakeholder engagement was key. Washington began stakeholder events two years prior to its 1115 waiver approval, holding at least seven in-person, public meetings related to the Medicaid Alternative Care and Tailored Supports for Older Adults benefits. Washington also recently initiated a service experience team, in which beneficiaries and advocates meet to give input on how to improve programs in a collaborative setting focused specifically on understanding beneficiaries’ perspectives.⁵⁸ In Vermont, the Department of Disabilities, Aging and Independent Living worked diligently to gain community providers’ buy-in, assuring them that the existing state funding that it sought to repurpose would be returned in the form of Medicaid covered services. The department also worked closely with its state leadership, who was wary of how the state would manage the transition to more community-based care and how any savings would be spent. To address this, the state defined program savings in its annual budget bill and permitted savings to be reinvested into HCBS if they exceeded more than one percent of state spending on the waiver.



REBALANCING STRATEGY 3:

Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Utilization

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



REBALANCING STRATEGY 3:

Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Utilization

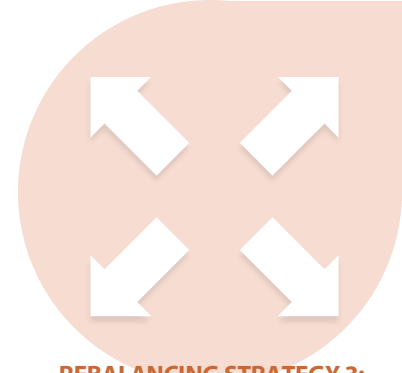
► Case Studies

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

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

- **Medicaid Alternative Care.** This new benefit package provides supports for unpaid caregivers for individuals who are eligible for Medicaid, but not currently using Medicaid-funded LTSS (as well as meets the age and financial and functional criteria described below). Washington estimates that more than 850,000 people provide unpaid care to relatives and others at a cost of nearly five times the overall Medicaid budget. This initiative aims to give individuals the supports they need to care for loved ones in the home and avoid use of more intensive, expensive services. Services include training, education, support groups, specialized medical equipment, respite, and assistance with housework, errands, and home-delivered meals.
- **Tailored Supports for Older Adults.** This initiative creates a new eligibility category for people “at-risk” of future Medicaid LTSS use who do not meet Medicaid financial eligibility criteria. To be eligible for the “at-risk” category, individuals must be age 55 or older and meet a set of financial and functional criteria (i.e., Nursing Facility Level of Care as determined through an eligibility assessment). They may also seek presumptive eligibility after completion of a prescreening interview. The new set of limited services and supports available is similar to Medicaid Alternative Care supports for individuals and unpaid family caregivers in the community.

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



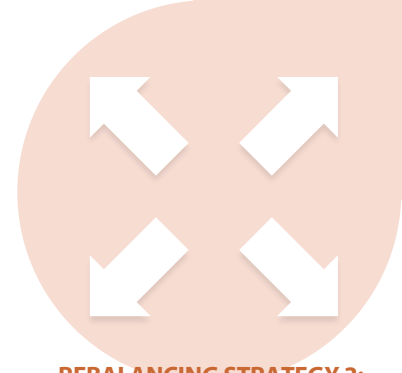
REBALANCING STRATEGY 3:

Expand Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Utilization

Vermont’s Choices for Care Waiver Expands HCBS to People At-Risk of Needing Intensive LTSS. In October 2005, Vermont’s Department of Disabilities, Aging and Independent Living implemented the Choices for Care program—a statewide initiative for older adults and adults with physical disabilities designed to reduce the use of Medicaid institutional services by managing nursing facility admissions and increasing community-based options—under an 1115 waiver to provide equal access to Medicaid LTSS regardless of care setting, a vision shared by stakeholders. Prior to the demonstration, the state only provided LTSS as an entitlement in nursing facilities and very limited HCBS under 1915(c) waivers. At the waiver’s start, only about 30 percent of all participants were receiving care at home or in an institutional care home (considered an HCBS setting at that time); today, 56 percent of LTSS is provided in home and community settings and the number of people served has grown significantly. To help alleviate budget concerns, Vermont negotiated two categories of nursing facility level of care criteria—“highest need” and “high need”—whereby those assessed as “highest need” would always be entitled to LTSS (approximately 75 percent of the Medicaid LTSS population), whereas those assessed as “high need” could be placed on a waitlist if the state encountered budget challenges, allowing the state to maintain some control over its LTSS budget and utilization of services.

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

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



REBALANCING STRATEGY 3:
Expand Access to HCBS for
“Pre-Medicaid” Individuals to
Prevent or Delay Nursing Facility
Utilization

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

This section identifies strategies that states are using to better coordinate and integrate LTSS, physical health, behavioral health, and social support services for the diverse populations who use Medicaid LTSS, including those eligible for both Medicaid and Medicare (dually eligible beneficiaries) and individuals with I/DD. As most Medicaid models that integrate LTSS with other services are built upon managed care arrangements, this section focuses on state program design and contracting strategies that can be implemented by health plans that assume financial risk and accountability for coordinating and delivering comprehensive services to Medicaid LTSS populations.

With more than 75 percent of all Medicaid beneficiaries now enrolled in a managed care program nationwide, CMS, states, and other stakeholders have recognized how managed care may help to: (1) reduce care fragmentation; (2) deliver person-centered and community-based care; (3) improve health outcomes; and (3) reduce overall program costs for LTSS populations. In recognition of the degree to which managed care has expanded, CMS, in 2016, significantly revised and modernized the Medicaid managed care regulations, which had not been updated since 2002.^{59,60} The updated regulations reference MLTSS for the first time, adding specific expectations for states and protections for LTSS populations related to stakeholder engagement, enrollment supports, care management activities, access to HCBS, and quality measurement. In adopting these rules, CMS signaled that high-performing MLTSS programs would be those that use person-centered enrollment and care planning processes and provide comprehensive, integrated service packages.

Today, about a third of states—up from six states in 2009—operate some type of MLTSS program, and this number is growing. Given the heterogeneity of the LTSS population and different state program characteristics, states take varying approaches to designing these programs. Some states, like New York, operate MLTSS programs that include only LTSS in a capitated payment to managed care plans (“partially capitated” model), but expect health plans to coordinate beneficiary access to other services, which may be covered by Medicare (for dually eligible beneficiaries) or Medicaid fee-for-service (for Medicaid-only beneficiaries).⁶¹ Recently, more states (e.g., Virginia, Texas and Tennessee, among others) have been developing initiatives to integrate LTSS with physical and behavioral health services (i.e., a “fully integrated” model), driven by expectations that integration will improve care coordination and quality, and align incentives for health plans and providers to deliver services in the most cost-effective and least restrictive setting. Other states, like Massachusetts, have developed initiatives to better manage their fee-for-service LTSS systems, among other initiatives.⁶²

States interested in advancing integration goals can learn from other states’ experiences in moving to MLTSS. These learning opportunities include best practices and other lessons around program design and implementation, stakeholder engagement, internal capacity, and program evaluation. These experiences can inform other states’ strategic approaches and help them avoid pitfalls, such as failing to obtain and maintain stakeholder support or unintentionally creating new siloes and barriers to person-

centered care. Most states that have implemented these programs have moved cautiously in transitioning LTSS populations from the Medicaid fee-for-service system to managed care programs, particularly to address beneficiary and family concerns about protecting access to critical non-medical services and providers. Smaller HCBS providers are also concerned about contracting with managed care organizations, something which many of them have never done before. Following are different ways that states are successfully using managed care plans as a platform for person-centered integration.

► Provider-Led Reforms Offer another Option for LTSS Integration

While most states are pursuing LTSS integration through managed care, several have long-standing or new initiatives to better coordinate care delivery at the provider level. In doing so, states aim to hold providers accountable for care coordination, quality performance, and health outcomes. These strategies include:

- **Medicaid ACOs:** A few states are developing Medicaid Accountable Care Organizations (ACOs) that integrate LTSS into ACOs' "total cost of care" responsibility. For example, in 2018 Massachusetts will allow MassHealth non-dually eligible beneficiaries who use LTSS to enroll in new Medicaid ACOs to receive comprehensive physical health, behavioral health, and LTSS under a 5-year extension of the state's 1115 waiver. In addition, Maryland is in the initial planning stages of developing a Medicare-Medicaid ACO for dually eligible beneficiaries.
- **Health Homes:** Section 2703 of the Affordable Care Act created an optional state plan benefit to allow states to establish health homes to coordinate care for Medicaid beneficiaries with chronic conditions. Washington is the only state currently using the model to coordinate LTSS for its dually eligible population.

■ Programs of All-Inclusive Care for the Elderly




(PACE): By providing comprehensive medical and social services to beneficiaries, PACE integrates LTSS with other services at the care delivery level. An interdisciplinary team of home-based and PACE center (typically adult day health center) providers assist beneficiaries in fulfilling their care needs in the community rather than at a nursing facility. PACE providers receive and fully integrate both Medicare and Medicaid funding for dually eligible beneficiaries. While the PACE model of care originated in 1971 and was tested through Medicaid waiver options starting in 1990, PACE became an official Medicare and Medicaid provider type in 1997. Currently, 31 states have PACE programs (123 programs nationally), serving more than 40,000 enrollees. Program flexibilities created by the PACE Innovation Act of 2015 may provide opportunities for states to expand these programs to new populations and sites of care.






Sources: National PACE Association. "PACE by the NUMBERS." Available at: www.npaonline.org/sites/default/files/2057_pace_infographic_2.0_lo.pdf; CMS. "Health Homes." Available at: www.medicaid.gov/medicaid/ltss/health-homes/index.html; Interview with Massachusetts October 6, 2017 Interview with Maryland October 25, 2017.; Manatt, Phelps & Phillips, LLP. "Health Update." October 24, 2017. Available at: www.manatt.com/Insights/Newsletters/Health-Update/A-New-Look-at-Digital-Health-Business-Models.

This section highlights three innovative reform strategies for advancing integration of LTSS with physical and behavioral health services through managed care. States interested in advancing integration can use elements from these strategies that have been successfully deployed in other states. For each strategy, we provide the impetus, a description, potential implementation mechanisms, results to date, and key lessons. The following table (pages 42-43) gives an overview of this information, and the remainder of the section goes into more detail. The section also provides case studies to illustrate how states have implemented each strategy. Notably, it is important for states to understand their current LTSS landscape prior to selecting an integration strategy or strategies. Having an understanding of the state's strengths, gaps and barriers, among other areas, is critical to carrying out managed care-led integration strategies. As in Section II, this is not an exhaustive set of strategies or implementation mechanisms, but are ones identified by innovator states as significantly advancing their integration goals.

Overview of Integration Strategies

<p>Strategy 1 Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries</p> 	<p>Strategy 2 Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care</p> 	<p>Strategy 3 Enroll Individuals with I/DD in Managed Care</p> 
<p>► Impetus for Strategy</p>		
<p>Aligning Medicare and Medicaid’s financing and delivery of services can improve quality of care, minimize confusion for beneficiaries, and lower costs.</p>	<p>Historically, states have excluded LTSS populations and services from managed care, but now recognize managed care may help reduce fragmentation of care, increase access to community services, and improve quality and lower costs.</p>	<p>The expansion of managed care to special populations has prompted a few states to transition individuals with I/DD from the fee-for-service system into their managed care programs.</p>
<p>► Description of Strategy</p>		
<p>States are creating or expanding their MLTSS programs to align them with Medicare managed care products for dually eligible beneficiaries with the goal of streamlining access to services, provider networks, and administrative processes.</p>	<p>Some states are expanding their managed care programs to include LTSS populations and services to create a comprehensive benefit package that includes physical and behavioral health services as well as LTSS under a single capitated rate.</p>	<p>States are taking different approaches to including I/DD populations in managed care, such as: (1) transitioning LTSS benefits into existing managed care programs; (2) creating care coordination entities as a pathway to managed care contracting arrangements; and (3) integrating all LTSS with medical, behavioral, and social services into managed care.</p>
<p>► Implementation Mechanisms*</p>		
<ul style="list-style-type: none"> ■ Financial Alignment Initiative** ■ Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) ■ Aligned MLTSS and D-SNPs through state Medicaid agency contracting authority ■ Section 1115 waiver 	<ul style="list-style-type: none"> ■ Section 1932 state plan amendment ■ Section 1915(a) waiver ■ Section 1915(b) waiver ■ Section 1915(c) waiver ■ Section 1115 waiver 	<ul style="list-style-type: none"> ■ Section 1115 waiver ■ Section 1945 health home state plan amendment
<p>► Results to Date</p>		
<p>Studies of states’ Medicare-Medicaid integrated care initiatives report fewer emergency department admissions, shorter hospital stays, increased preventive care utilization, lower readmission rates, and some evidence of cost savings.</p>	<p>Although limited data are available, a survey of 12 MLTSS state programs found: (1) improvements in quality of life since joining the MLTSS plan; (2) decreases in hospital stays and duration; (3) increases in non-emergency transportation utilization; (4) decreases in waiting list times; (5) improved access to services; and (6) more reliable budget predictability, although results varied by state.</p>	<p>These programs are limited to a few states, and data are preliminary and show mixed results. However, Arizona’s I/DD integration has resulted in high client satisfaction, improved health outcomes, and eliminated waitlists for services. New York reports high voluntary enrollment in both of its managed care initiatives for individuals with developmental disabilities.</p>

Continues on page 43 ►

<p>Strategy 1 Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries</p> 	<p>Strategy 2 Integrate Comprehensive Care for Medicaid-Only Beneficiaries under Capitated Managed Care</p> 	<p>Strategy 3 Enroll Individuals with I/DD in Managed Care</p> 
<p>▶ Key Lessons</p>		
<ul style="list-style-type: none"> ■ Provide ongoing, targeted beneficiary education ■ Engage providers so they understand and are trained in care philosophies and models relevant to these populations ■ Collect good data for planning/design, risk adjustment, resource allocation, monitoring, and evaluation purposes ■ Be flexible with program requirements to the extent possible ■ Set sufficient reimbursement rates 	<ul style="list-style-type: none"> ■ Integration requires careful planning, Medicare expertise, and resource commitments ■ Consider a phase-in strategy ■ Define program goals and collect data relevant to achieving those goals from the outset ■ Communicate with and educate all stakeholders 	<ul style="list-style-type: none"> ■ Promote stakeholder engagement and support ■ Transition incrementally ■ Utilize data reporting and health information technology in a way that engages and connects individuals and their families to providers
<p>▶ Case Studies</p>		
<ul style="list-style-type: none"> ■ Arizona and New Jersey – Two Paths toward Alignment ■ Aligning Administrative Processes for Minnesota’s Senior Health Options (MSHO) Program Beneficiaries 	<ul style="list-style-type: none"> ■ Virginia’s Commonwealth Coordinated Care Plus Program Integrates All LTSS, Medical, and Behavioral Health Services Under One Program for Medicaid-Only Beneficiaries 	<ul style="list-style-type: none"> ■ New York’s 1115 Waiver Creates Care Coordination Organizations to Integrate Primary, Behavioral Health, and Social Support Services with LTSS for the I/DD Population

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

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

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



INTEGRATION STRATEGY 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries

► Impetus for Strategy

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

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

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

In 2006, these demonstrations transitioned into state contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), a new Medicare health plan option that combines Medicare and Medicaid benefits for dually eligible beneficiaries. But these arrangements only allow states to achieve a certain level of integration based, in part, on the requirement to have two separate contracts with the health plan (one with Medicare and one with Medicaid).

More recently, the ACA established the Medicare-Medicaid Coordination Office (MMCO, and referred to as the “Federal Coordinated Health Care Office” in statute) at CMS in 2010. MMCO launched the federal Financial Alignment Initiative (i.e., “duals

demonstrations”) in 2011 and has also supported greater state activity in expanding contracting with Medicare Advantage D-SNPs. Both the Financial Alignment Initiative via Medicare-Medicaid Plans and certain D-SNP arrangements have made it easier for states to use managed care contracts to align many or some administrative requirements, care management models, beneficiary materials, covered benefits, and financing.

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





INTEGRATION STRATEGY 1:
Integrate Medicare-Medicaid
Benefits for Dually Eligible
Beneficiaries

Population characteristics and utilization patterns of the 11.4 million dually eligible beneficiaries support the need for a more coordinated system of care.⁶³ Dually eligible beneficiaries are more likely than other Medicare beneficiaries to experience chronic, co-morbid physical and mental health conditions — with 60 percent of dually eligible beneficiaries have three or more chronic conditions and 41 percent have at least one mental health diagnosis.⁶⁴ They also are more likely than other Medicare beneficiaries to use nursing facility services or other LTSS, and visit the emergency department.⁶⁵

Additionally, although dually eligible beneficiaries represent only 20 percent of Medicare enrollment and 15 percent of Medicaid enrollment, they account for 35 percent and 34 percent of program expenditures respectively.⁶⁶ Dually eligible beneficiaries are more than twice as likely to use LTSS compared to other Medicaid beneficiaries, and more than five times as likely compared to other Medicare beneficiaries.⁶⁷ Notably, 62 percent of Medicaid expenditures (\$91.8 billion) for dually eligible beneficiaries were for LTSS in 2011.⁶⁸ Aligning the financing and delivery of services between Medicare and Medicaid for dually eligible beneficiaries presents an opportunity to improve care and lower costs for this high-need, high-cost population by creating incentives to deliver care in the right settings and at the right time.

► **Strategy Description**

States are building upon their MLTSS programs to align Medicare and Medicaid service delivery for the majority of Medicaid MLTSS beneficiaries who are also Medicare-eligible. While there are a few different approaches to aligning Medicare and Medicaid, the underlying goal is to better coordinate care and streamline access to services, provider networks, and administrative processes across the programs. Although opportunities have been limited to the federal Financial Alignment Initiative (“duals demonstration”) to date, states are interested in sharing any savings resulting from integrated care delivery with federal partners. Shared savings could address potential state concerns that increased access to LTSS and behavioral health interventions that help delay or prevent hospital and emergency department use would only benefit Medicare.

► **Implementation Mechanisms**

States are aligning Medicare and Medicaid in different ways to better coordinate care delivery for people who are covered by both programs.⁶⁹ The most integrated models used by states include the provider-led PACE program and the state-led demonstrations under the Financial Alignment Initiative; however, the opportunity for states to pursue a financial alignment demonstration is now closed. The most promising mechanism available to states at this time to better integrate the delivery of Medicaid benefits with Medicare is through D-SNP contracting, particularly for states developing a MLTSS program. All D-SNPs must have signed contracts with the state Medicaid agency in any state they operate that must meet minimum requirements.⁷⁰ However, minimum requirements do not achieve a high level of integration or alignment, and the degree to which states can achieve integrated, aligned care through the D-SNP platform depends on state investments in D-SNP contracting and program oversight. States have broad discretion to add additional D-SNP requirements that can increase coordination and alignment, such as care coordination, opportunities for aligned enrollment in both Medicare and



Medicaid products from the same health plan, data sharing and reporting, and other areas that focus on integrating Medicare and Medicaid benefits and administrative processes.

► Dual Eligible Special Needs Plans and Fully Integrated Models

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

When Congress first authorized them in the Medicare Modernization Act of 2003, D-SNPs were not required to have any formal relationship with state Medicaid agencies. However, to facilitate coordination of Medicare and Medicaid services, the Medicare Improvements for Patients and Providers Act of 2008—as amended by the ACA—required all D-SNPs to have contracts with the states in which they operate. This D-SNP contracting authority can be used by states to control the degree of Medicare-Medicaid integration attained through D-SNPs.

To launch an integrated program using D-SNPs, states must have an interest in using their D-SNP contracting authority to improve care for dually eligible individuals, and health plans need to be interested in operating these products within the state.

*For details on D-SNPs and FIDE SNPs, and the CMS rules governing them, see the CMS Medicare Managed Care Manual, Chapter 16b (Rev.123, 08-19-16). Available at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

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

Some D-SNPs can request designation from CMS to operate as a **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)**. These FIDE SNPs must coordinate and be at-risk for coverage of Medicaid LTSS, have procedures in place for administrative alignment of Medicare and Medicaid processes and materials, and may be eligible to receive additional Medicare Advantage payments that reflect the frailty of the beneficiaries they enroll. They also can offer additional supplemental benefits not typically covered by Medicare. The presence or absence of FIDE SNP status in a state's integrated program is dictated by the integration and LTSS goals and priorities of the states in which D-SNPs operate.



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

- 1. Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs):** FIDE SNP, a special type of D-SNP created under the ACA, is a fully integrated Medicare and Medicaid product offered by a single health plan. D-SNPs must meet certain requirements and get CMS approval to achieve FIDE SNP status; namely, they must cover Medicaid LTSS under their contract with the state, have an aligned Medicare and Medicaid care management model, and align certain administrative functions. FIDE SNPs that serve a high proportion of frail, high-risk beneficiaries may also be eligible for Medicare Advantage incentive payments to encourage plans to participate. As of November 2017, there were eight states operating FIDE SNPs, serving 153,101 beneficiaries: Arizona, California, Idaho, Massachusetts, Minnesota, New York, New Jersey, and Wisconsin.⁷¹ States may require D-SNPs that wish to operate in their state to achieve a FIDE SNP designation making them potentially eligible for small, incentive payments and CMS flexibility related to offering of Medicare

supplemental benefits. However, as noted below, states that focus on aligning D-SNP and Medicaid health plans as well as robust state contracting and oversight can achieve a high degree of alignment without the designation.

- 2. Aligned D-SNP:** States may require health plans that offer D-SNPs to offer “companion” Medicaid MLTSS products as a condition of allowing D-SNPs to participate in the state’s market. Similarly, states can also require Medicaid MLTSS health plans to operate a companion D-SNP. States may make enrollment into capitated Medicaid managed care plans mandatory for all or some dually eligible beneficiaries (e.g., LTSS users), but cannot require dually eligible beneficiaries to enroll into Medicare managed care. However, having the option to enroll in the same health plan for both programs provides an opportunity for more integrated care. These models are usually most effective when a high percentage of beneficiaries enroll in the same, aligned health plans. States face challenges when beneficiaries enroll in a D-SNP sponsored by one entity and a Medicaid plan operated by a competing entity, likely reducing care coordination and increasing administrative complexity. The extent to which these programs are aligned depends on what the state requires in its contracts including whether the state requires that the population eligible for the D-SNP matches the population eligible for the MLTSS program. Some aligned D-SNPs resemble FIDE SNPs relative to their level of care integration, while others are much less coordinated. Under both FIDE SNP and aligned D-SNP models, state decisions regarding which populations will be enrolled have a significant impact on the level of administrative alignment achieved.



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Beneficiaries

► Results to Date

CMS has reported statistically significant improvements in certain health outcomes among individuals participating in D-SNPs.⁷² Some studies have found that dually eligible beneficiaries enrolled in coordinated D-SNPs had fewer emergency department admissions, shorter hospital stays, and increased use of preventative care.⁷³ A 2012 independent study of Arizona’s D-SNP program compared its 60,000 dually eligible beneficiaries in managed care to those in traditional Medicare fee-for-service and found that the aligned beneficiaries demonstrated a 31 percent decrease in hospitalizations, 43 percent fewer days in the hospital, nine percent lower emergency department use, and 21 percent lower readmission rate.⁷⁴ An evaluation of Minnesota Senior Health Options (MSHO) D-SNPs found that MSHO beneficiaries, when compared to dually eligible beneficiaries in a Medicaid-only program, were 48 percent less likely to have a hospital stay, 13 percent more likely to receive HCBS, and six percent less likely to have an emergency department visit. They were also more likely to access primary care services which could support state efforts to improve coordination of care and community integration for LTSS users.⁷⁵

States engaging in Financial Alignment Initiative demonstrations have reported early signs of improvements in care coordination, expanded beneficiary safeguards, and preliminary evidence of some cost savings.⁷⁶ While the Financial Alignment Initiative initially garnered significant interest among states, many states exited the initiative after developing or nearing development of a memoranda of understanding due to concerns around rate sufficiency and program complexity, leaving 13 states currently participating. Notably, early results from Massachusetts’ financial alignment demonstration (“One Care”) found that One Care beneficiaries had a lower 30-day readmission rate compared to non-beneficiaries.⁷⁷

► Key Lessons

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



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

► Case Studies

Arizona and New Jersey – Two Paths toward Alignment. Arizona has operated its MLTSS program, Arizona Long Term Care System (ALTCS), since 1989 under 1115 waiver authority, relying on competitively selected health plans to deliver all Medicaid services, including LTSS. Arizona enrolls all beneficiaries, including older adults and those with physical or developmental disabilities who need LTSS. Arizona requires all ALTCS plans to offer D-SNP products, and leverages Medicaid authority and D-SNP contract requirements to promote aligned enrollment for all dually eligible beneficiaries, including those eligible for the ALTCS program.⁷⁸ To promote aligned enrollment, Arizona uses authority under its 1115 waiver to automatically assign eligible populations to Medicaid health plans. The state developed multiple pathways for beneficiary enrollment into aligned health plans, including encouraging the enrollment of ALTCS beneficiaries into the Medicare D-SNP operated by their Medicaid health plan. To support this, the state sends periodic mailings to ALTCS beneficiaries to inform them of the benefits of being enrolled in the same health plan for Medicare and Medicaid. Arizona also periodically reassigns beneficiaries' Medicaid acute care health plan to align with their D-SNP, thus encouraging long-term coordination of care. This re-assigned population includes beneficiaries who may benefit from enhanced care coordination because they will likely become LTSS eligible (i.e., "pre-duals"). Lastly, Arizona also limits D-SNP marketing activities by only allowing direct marketing to those individuals enrolled in the health plan's own Medicaid product.

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



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

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

- **Seamless Conversion.** Seamless conversion is a federal statutory and regulatory enrollment mechanism under the Medicare Advantage program that allows a D-SNP to passively enroll Medicaid beneficiaries who are newly eligible for Medicare (i.e., just turning age 65 or at the end of the two-year Social Security Disability Insurance waiting period), if they are already enrolled in that health plan's companion Medicaid product.^{79,80} Arizona implemented seamless conversion in partnership with its D-SNPs in 2016 and is successfully enrolling over 400 newly eligible Medicare beneficiaries into aligned D-SNPs each month as a result. Arizona required its D-SNPs to each request CMS approval to seamlessly convert existing Medicaid health plan beneficiaries into a companion D-SNPs product. To use this authority to promote aligned enrollment, Arizona provides data to D-SNPs to help them identify those enrollees in their Medicaid-only health plan that are about to become Medicare eligible. The state also issued a letter of support for D-SNP health plans' seamless conversion proposals to CMS and found that state readiness review prior to launching of seamless conversion is essential. New Jersey continues to be interested in pursuing conversations around implementing seamless conversion. The state proposed requesting the authority to use seamless conversion as an enrollment strategy under its 1115 Comprehensive Demonstration Waiver renewal, but removed the proposal in response to stakeholder comment and CMS' suspension of any new seamless enrollment proposals.⁸¹
- **Building Medicare and D-SNP Contracting Expertise.** After launching its MLTSS program, New Jersey made its D-SNPs incrementally responsible for the provision of both facility- and community-based LTSS. The state's pre-MLTSS investment in D-SNP contracting and its phased-in approach to carving in LTSS benefits gave it a greater understanding of complex Medicare regulations and policy, as well as the intersections of Medicare and Medicaid benefits that can be challenging to administer.



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

Building on a long history of health care innovation for older adults, the MSHO D-SNP-based program was established in 1997 and serves dually eligible individuals age 65 and over. Minnesota has consistently sought opportunities to increase alignment between the Medicare and Medicaid programs and integrate service delivery as a means to increasing access to HCBS and improving experience of care for beneficiaries. Building upon its pioneering demonstration success with better managing care for dually eligible beneficiaries, it now has a statewide program that currently operates under 1915(a)/(c) combination authorities, and in 2013 the state signed an agreement with CMS to operate an alternative alignment demonstration program, the *Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience*. The demonstration tests new approaches to integrating and aligning certain administrative functions in Medicare and Medicaid for MSHO beneficiaries.

Minnesota found the enrollment design for integrated programs to be of fundamental importance. Minnesota uses voluntary Medicaid enrollment coupled with strategic D-SNP contracting to achieve the greatest degree of administrative alignment possible. The state matches the categories of dually eligible beneficiaries enrolled in the D-SNP to those enrolled under the MSHO program, which is limited to full benefit dually eligible beneficiaries.⁸² The state also developed a single enrollment process across both Medicare and Medicaid by processing enrollments for most of the D-SNPs operating in the state. This allows for streamlined enrollment and improved alignment of appeals, marketing, and beneficiary and provider notifications when one integrated set of benefits is delivered. Other states can exercise similar discretion as to which groups to include under both the Medicare D-SNP and Medicaid managed care contracts.

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



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



INTEGRATION STRATEGY 2:
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► Impetus for Strategy

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

► Strategy Description

Some states are expanding their managed care plans for the LTSS population to provide a comprehensive benefits package that includes physical and behavioral health services and LTSS under a single capitated rate.⁸³ Under these fully integrated MLTSS arrangements, a single entity (i.e., the health plans contracting with the state) is responsible for coordinating the complex needs of these beneficiaries. States often phase-in managed care enrollment by region and population. For instance, under a regional roll out strategy, states may start with more densely populated regions in which plans can more easily meet network adequacy requirements, and then roll out to more rural regions. With a population phase-in strategy, states could initially exclude certain sub-populations (i.e., individuals receiving LTSS in a nursing facility or other institutional setting), and include them at a later date after the state and health plans build capacity. Additionally, in some cases states have gained experience with an MLTSS pilot program or a voluntary enrollment model before transitioning to mandatory MLTSS enrollment. As part of this strategy, it is critical to ensure that small HCBS providers are able to contract with and get timely payments from health plans, with whom these providers are often engaging with for the first time.

► Implementation Mechanisms

To administer Medicaid MLTSS, states must combine authority for delivering services through Medicaid managed care with authority for providing comprehensive Medicaid LTSS, including HCBS. States may operate Medicaid MLTSS under a Section 1932 state plan amendment or through various waiver authorities including 1915(a), 1915(b), 1915(c) and 1115 waivers.⁸⁴ Section 1915(a) waivers allow states to establish managed care programs with voluntary enrollment, while 1915(b) and 1115 waivers allow mandatory enrollment. Section 1915(b) waivers also give states more flexibility to engage in regional implementation of managed care, rather than requiring managed care benefits to be provided across the entire state, as well as provide varied benefits to different Medicaid populations. States may combine Section 1915(b) with 1915(c) waivers to combine managed care authority with HCBS authority in launching MLTSS programs.

Finally, 1115 waivers, which also provide flexibility for regional implementation and variation in benefits, can include allowances for federal matching funds for Medicaid expenditures that otherwise would not qualify for funding.⁸⁵ As an example of state flexibility, Virginia originally intended to implement its integrated MLTSS program (Commonwealth Coordinated Care Plus) through an 1115 waiver. However, it realized after several months of planning and negotiations that Virginia's existing Medicaid program cost trends made the 1115 cost neutrality requirements challenging, especially if unanticipated future costs arose for this vulnerable population. Instead, Virginia changed course and worked closely with its CMS central office to migrate to a 1915(b)/(c) waiver, which provided the flexibilities needed for their program.⁸⁶

► Results to Date

There is limited data available that compare individuals enrolled in MLTSS programs to those in fee-for-service, or that assess the same individuals before and after enrollment. CMS has contracted for a national level evaluation of state MLTSS programs implemented via 1115 waivers. However, the ability to compare outcomes across states and the ability to access data needed to assess MLTSS program performance may be limited. In an informal survey, seven of 12 MLTSS states surveyed by CHCS and the National Association of States United for Aging and Disabilities reported improved health outcomes as a result of their MLTSS programs.⁸⁷ One state reported that 77 percent of respondents to a consumer satisfaction survey said their quality of life had improved since joining an MLTSS plan.⁸⁸ Some state MLTSS programs reported decreases in hospital stays and duration of those hospital stays, and increases in non-emergency transportation utilization, potentially indicating increased provider visits.

From a programmatic standpoint, eight states reported that MLTSS has promoted rebalancing their LTSS delivery systems, which aligns with national trends: fiscal year 2013 was the first year that HCBS accounted for just over half, or 51 percent, of LTSS spending in the United States.⁸⁹ A few states reported decreasing or eliminating waitlists for certain services, thereby increasing access to those services. Other states were able to expand the number of services offered due to reductions in cost from implementing an MLTSS program, such as non-medical transportation and vision services. Seven states reported employing data collection to demonstrate cost and utilization trends, with one state confirming meeting savings targets and many others reporting increased budget predictability.⁹⁰ Despite these early successes, states have experienced and continue to experience challenges in moving LTSS populations into managed care, including setting appropriate health plan capitation rates, developing sufficient LTSS provider networks, particularly in rural areas, and establishing meaningful LTSS quality metrics.

► Key Lessons

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



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

States must be able to invest in sufficient planning and implementation resources to launch a comprehensive managed care program with care coordination across fragmented points of care.⁹¹ Dedicated staff with expertise in primary care, behavioral health, and LTSS is critical to ensure a smooth transition from fee-for-service or an otherwise siloed system into a cohesive program for LTSS populations. As noted in the Virginia case study (see next page), states may consider potential agency reorganization strategies to support the transition of internal operations from oversight of fee-for-service providers to management and oversight of managed care plans. Offering both targeted small and full agency trainings, which should include visible leadership participation, can help staff prepare for new roles and also is an important element of internal readiness.

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

■ **Define program goals and collect data relevant to achieving those goals from the outset.**

States recommend starting early with building a case to demonstrate program value to adequately respond to requests for information on outcomes and financial sustainability from legislators, advocates and other stakeholders. However, there are several challenges with quality measurement in these programs. There is a lack of standardized LTSS quality measures that are used consistently across state and federal programs, and consumer advocate concerns that existing measure sets do not adequately measure what is most important to beneficiaries and their families—including functional status, cognitive health, and safety. While there are extensive LTSS quality reporting requirements in use, it may be difficult to determine what data are best to assess whether program goals are being met. It also may be difficult to objectively assess the reliability of self-reported data about beneficiary satisfaction and quality of life, even though these are important cornerstones of MLTSS programs. In addition, collecting and analyzing survey or in-person assessment data can be labor intensive for states and plans. To be best positioned to report on outcomes related to new reforms, states recommended: (1) collecting baseline health status, cost, and utilization data prior to launch; and (2) defining program goals upfront and designing targeted quality measurement and data collection requirements around those goals.

► **Independent Ombudsman Requirement**

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

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

Sources: Kaiser Family Foundation. "Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies." January 2017. Available at: www.kff.org/report-section/medicaid-section-1115-managed-long-term-services-and-supports-waivers-key-findings/; CMS. "Funding to Support Ombudsman Programs". September 2016. Available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html.

- **Communicate with and educate all stakeholders.** States cited the importance of soliciting beneficiary and family members' input and feedback, as well as engaging in clear communication with stakeholders, specifically around network adequacy and provider payment rates in order to generate positive engagement and buy-in.⁹² In addition, securing support from other state constituencies is important. Virginia made concerted efforts to educate state legislators on a one-to-one basis to help them understand program goals and state oversight protocols during design phases for its MLTSS program. Securing informed legislative champions prior to implementation to assist their ability to respond to constituents was a high priority. It also proactively sought feedback about desired program results and implementation concerns to be able report back on the status of these goals and concerns.



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► Case Study

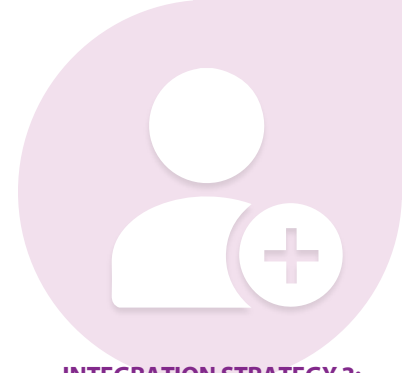
Virginia's Commonwealth Coordinated Care Plus Program Integrates All LTSS, Medical, and Behavioral Health Services Under One Program for Medicaid-Only Beneficiaries. Virginia's Department of Medical Assistance (DMAS) began enrollment in one region for its new mandatory MLTSS program in August 2017. Commonwealth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

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

Virginia is also operating a financial alignment demonstration, Commonwealth Coordinated Care (CCC), a voluntary program that provides integrated services for individuals eligible for Medicare and Medicaid in certain regions that will phase out on December 31, 2017. CCC has provided comprehensive benefits, including MLTSS, and a foundation for Virginia's planning and launch of CCC Plus. Virginia was able to adopt many successful elements from integrating services in CCC to the new statewide program, and also benefited from the stakeholder engagement work it did for CCC as many stakeholders were already familiar with the concept and benefits of a managed care model for this population. CCC Plus plans must offer a companion D-SNP to offer dually eligible beneficiaries the option to enroll in the same plan for Medicare and Medicaid services.

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

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



INTEGRATION STRATEGY 3:
Enroll Individuals with I/DD in
Managed Care

► Impetus for Strategy

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

► Strategy Description

States are taking a few different approaches to better integrate care for the I/DD population.⁹³ Some states have transitioned LTSS benefits into managed care, keeping physical and behavioral health services separate, as a starting point to move toward fully integrated managed care. Other states are creating care coordination entities that will be responsible for coordinating beneficiary care across funding streams. The most comprehensive approach underway at the state level is to move the I/DD population into fully integrated managed care, whereby a single health plan oversees and coordinates all services for this population, including LTSS, medical, behavioral health, and social services.

► Implementation Mechanisms

States have taken different approaches to improving integration for I/DD populations. Under the managed care approach, Arizona designated a Division of Developmental Services to manage all MLTSS for individuals with I/DD under a single agency.⁹⁴ New York operates the only duals demonstration in the country for this population, the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDDD), which integrates both Medicaid and Medicare services and offers acute, long-term care, and habilitation services. New York also recently submitted an 1115 waiver for CMS approval that will improve care coordination for the I/DD population under state plan health home authority by integrating all 1915(c) habilitation services under a single comprehensive plan.⁹⁵ If successful, the state hopes to eventually move to mandatory managed care enrollment, and potentially include value-based payment arrangement requirements to improve care outcomes and reduce costs for this population.⁹⁶

► Results to Date

With years of successful integration of individuals with I/DD into its MLTSS program, Arizona has eliminated its waitlist for services, and reported both high client satisfaction and strong performance on health, welfare, and consumer experience metrics.⁹⁷ New York reports over 20,000 individuals with I/DD are voluntarily enrolled in Medicaid managed care for their acute care benefits. Its FIDA-IDD has close to 600 beneficiaries, and these two initiatives represent the state's long-term transition to fully integrated provision of services for individuals with I/DD under a comprehensive Medicaid managed care structure.⁹⁸ However, I/DD consumer advocates in some states that have moved or are considering moving to managed care report concerns with limited access to services. In Kansas, advocates submitted these concerns during public comment periods for the KanCare system, including the lack of engagement and communication with stakeholders during the program design process.⁹⁹

► Key Lessons

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

- **Promote stakeholder engagement and support.** The advocacy community has raised significant concerns with moving this population into managed care, driven in part by people's fear that they will lose access to much-needed services. Launching consumer advisory groups, arranging stakeholder meetings, and ensuring clear communication are some of the steps states have taken to improve the implementation process and engender stakeholder support. New York has developed carefully targeted messages during managed care transitions that focus on how a managed arrangement increases access to mental, physical, and specialty health services such as dental care, while there are gaps between these services under the current fee-for-service arrangement. Furthermore, states reported that using a case manager as a single point of contact for beneficiaries and their families, in conjunction with integrated care teams, is helpful in establishing a clear line of communication and coordinating care for the beneficiary. Other states solicited input from community-based organizations and consumer advocates to shape MLTSS design for I/DD populations and to support development of a care continuum that meets their needs and enables a smooth implementation process.¹⁰⁰
- **Transition incrementally.** New York, in particular, emphasized the value of moving to managed care in a staged process. The state is using a multi-year transition period to move from voluntary to mandatory enrollment, as well as in implementing managed care regionally first rather than across the entire state. Furthermore, New York intends to continue maintaining fee-for-service provider rates for the initial phase of the transition to managed care to support access under the new system and also to prepare health plans and providers to implement the capitated payment model. By pursuing this transition in phases, New York has been successful in addressing some advocates concerns regarding the managed care model. Finally, New York recommended that other states build off their existing provider delivery system



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(i.e., health home authority in New York) in order to scale their infrastructure and care coordination capabilities effectively. In addition, states might consider a regional roll out plan as well.

- **Utilize data reporting and health information technology in a way that engages and connects individuals and their families to providers.** Implementing an electronic health record or other health information technology tools facilitates care coordination by capturing data in a single system to allow states to monitor and report on cost and quality metrics.¹⁰¹ New York recommended connecting health plans with providers, beneficiaries, and their families electronically to improve data sharing abilities and care coordination. Compared to a paper documentation system, which can impede service delivery through inefficiencies and care gaps, this is generally an appealing change for providers and beneficiaries.

► Case Study

New York’s 1115 Waiver Creates Care Coordination Organizations to Integrate Primary Care, Behavioral Health, and Social Support Services with LTSS for the I/DD Population. The New York State Department of Health submitted a request to CMS for a section 1115 waiver amendment that would encompass all 1915(c) habilitation services, after experiencing a significant delay negotiating amendments to its 1915(c) waiver and realizing that it did not provide the flexibility necessary to implement the changes it was seeking for the I/DD population. The 18-month negotiation on the state’s 1915(c) waiver amendment (ultimately resulting in the state’s decision to request an 1115 waiver as identified above), as well as the state’s desire to transition to a managed care delivery system, spurred a deeper look at the challenges individuals with I/DD face within the fee-for-service system and the need for a more holistic structure. The 1115 waiver amendment would give New York the authority to move the I/DD population to mandatory managed care, which is the state’s long term goal and has been over the past eight years. Today, over 20,000 individuals with I/DD are voluntarily enrolled in the managed care system for their acute care benefits.

Through its existing health home authority, the New York Office for People with Developmental Disabilities’ new five-year initiative will establish care coordination organizations to integrate primary care, behavioral health, community, social support, and long-term care services under a single comprehensive care plan, eventually transitioning this to managed care under 1115 waiver authority.¹⁰² The state is currently reviewing care coordination organizations (or health home) applications, which must demonstrate a history of providing or coordinating developmental disability, health, and long-term care services to individuals with I/DD. Care coordination organizations are anticipated to launch in July 2018 on a voluntary enrollment basis.



INTEGRATION STRATEGY 3:
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SECTION IV: Conclusion

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

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

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

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

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

Regardless of a state's specific direction, states can apply these key lessons from other states to inform their approach:

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

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

APPENDIX: Interviews

National Experts	
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State Leadership	
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Washington	<ul style="list-style-type: none"> ■ Alice Lind, Manager, Washington State Health Care Authority ■ Karen Fitzharris, Washington Department of Social and Health Services

ENDNOTES

- ¹ K. Colello and S. Talaga. “Who Pays for Long-Term Services and Supports? A Fact Sheet.” Congressional Research Service. July 27, 2015. Available at: <https://fas.org/sgp/crs/misc/R43483.pdf>.
- ² K. King, L. Sedlezky, E. Robbins. “Understanding Your HCBS Direct Service Workforce’s Strengths and Preparing the Workforce to Serve All Populations with Core Competency Training.” Centers for Medicare & Medicaid Services, National DSW Resource Center presentation, September 10, 2013. Available at: http://www.nasuad.org/documentation/HCBS_2013/Presentations/9.10%204.00-5.15%20Potomac%202.pdf; Bureau of Labor Stats.
- ³³ Congressional Budget Office. “Rising Demand for Long-Term Services and Supports for Elderly People.” June 2013. Available at: <https://www.cbo.gov/publication/44363>.
- ⁴ United States Senate, Commission on Long-Term Care. “Report to the Congress.” September 30, 2013. Available at: <http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf>.
- ⁵ The Kaiser Commission on Medicaid and the Uninsured. “Medicaid and Long-Term Services and Supports: A Primer.” The Henry J. Kaiser Foundation, December 15, 2015. Available at: <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.
- ⁶ J. Windh, A. Tumlinson, J. Mulcahy, J. Wolff, A. Willink, J. Kasper, et al. “Medicare Spending on Older Adults Who Need Long-Term Services and Supports.” Long-Term Quality Alliance. Available at: http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Medicare-Spending-for-Older-Adults-Who-Need-LTSS_Research-Brief_Final.pdf.
- ⁷ S. Eiken, K. Sredl, B. Burwell, R. Woodward. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.” Truven Health Analytics, April 14, 2017. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-expenditures-fy2015-final.pdf>.
- ⁸ S. Anthony, K. Nevitt, C. Raphael. “Massachusetts Long-Term Services and Supports: Achieving a New Vision for MassHealth.” Manatt Health, May 2016. Available at: https://bluecrossmafoundation.org/sites/default/files/download/publication/MassHealth_LTSS_report_FINAL%205.11.16.pdf.
- ⁹ In 2001, Congress authorized the funding of Real Choice Systems Change Grants to states to encourage restructuring their long-term care systems to focus more on HCBS rather than residential living. The grant funding was intended to assist states in developing the regulatory, administrative, program and payment infrastructure to accomplish this restructuring. The grant funding ranged from \$300,000 to \$800,000 to be paid out over three to four years, and was targeted at a specific area of the state’s HCBS system in order to incentivize new initiatives or investment in expanding existing ones. There were a variety of categories and specific grant areas within Systems Change grant funding, including Person-Centered Planning Grants and the Person-Centered Hospital Discharge Model. Between 2001 and 2010, CMS distributed over \$288 million through Systems Change grants, with many states receiving more than one. As the program has continued, CMS has disseminated less money to fewer states, with approximately \$2 million being awarded to six states in 2011. Sources: Centers for Medicare & Medicaid Services. “Real Choice Systems Change Grant Program.” Available at: <https://www.medicaid.gov/medicaid/ltss/real-choice/index.html>; M. Kehn and D. Lipson. “The Real Choice Systems Change Grant: Building Sustainable Partnerships for Housing.” Mathematica Policy Research, March 24, 2014. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/final-rcsc-report.pdf>.
- ¹⁰ In 2011, CMS launched two Financial Alignment models to improve care coordination for dually eligible beneficiaries within Medicaid and Medicare. States have the option to propose a Financial Alignment Demonstration under either a capitated or managed fee-for-service model that integrates primary, acute, behavioral health, and LTSS under a streamlined financial arrangement. In the capitated model, the state engages in a three-way contract with CMS and a health plan in which the state pays the health plan a prospective, blended payment to provide integrated services to the dually eligible population. In the managed fee-for-service model, the state and CMS engage in a contract whereby the state can receive shared savings resulting from care coordination programs that successfully reduce costs and improve quality of care for the target population. A review of beneficiary experience in 2017 found that participants reported increased access to services and improved care coordination, with some complaints of limited provider networks. As of October 2017, eleven states were in various stages of implementing, renewing, or phasing out their Financial Alignment Initiatives. Sources: Centers for Medicare & Medicaid Services. “Financial Alignment Initiative for Medicare-Medicaid Enrollees.” Available at: <https://innovation.cms.gov/initiatives/Financial-Alignment/>; RTI International. “Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative.” March 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf>; Centers for Medicare & Medicaid Services. “Financial Alignment Initiative for Medicare-Medicaid Enrollees.” Available at: <https://innovation.cms.gov/initiatives/Financial-Alignment/>.
- ¹¹ T. Price and S. Verma. The Secretary of Health and Human Services. “Letter to Governors”. March 14, 2017. Available at: <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>.
- ¹² “Person-centered care” means that individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires. Source: Person-Centered Care: A Definition and Essential Elements The American Geriatrics Society Expert Panel on Person-Centered Care. *J Am Geriatr Soc* 64:15– 18, 2016. Available at: <http://onlinelibrary.wiley.com/doi/10.1111/jgs.13866/pdf>.
- ¹³ Genworth Financial, Inc. “Compare Long Term Care Costs Across the United States.” Available at: <https://www.genworth.com/about-us/industry-expertise/cost-of-care.html>. For an overview of additional research regarding the cost-effectiveness of delivering LTSS through HCBS, see J. Accius and B. Flinn, “Stretching the Medicaid Dollar: Home and Community-Based Services are a Cost-Effective.” AARP Public Policy Institute, April 27, 2016. Available at: <https://www.aarp.org/ppi/info-2017/stretching-the-medicaid-dollar.html>.
- ¹⁴ S. Eiken, B. Burwell, K. Sredl. “An Examination of the Woodwork Effect Using National Medicaid Long-Term Services and Supports Data.” *Journal of Aging & Social Policy*, 25, no. 2 (2013): 134-145. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23570507>.
- ¹⁵ Kaye, H. S., LaPlante, M. P., and Harrington, C. 2009. “Do Noninstitutional Long-term-care Services Reduce Medicaid Spending?” *Health Affairs* 28(1): 262–72.
- ¹⁶ S. Eiken, et al., op. cit. (2017).
- ¹⁷ Centers for Medicare & Medicaid Services. “State Waivers List.” Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>.
- ¹⁸ AR, CA, CO, CT, FL, IA, IN, LA, MD, MT, NJ, NV, NY, OR, TX, WA, WI
- ¹⁹ S. Eiken, et al., op. cit. (2017).
- ²⁰ *Ibid*.
- ²¹ A. Coburn, E. Griffin, D. Thayer, Z. Croll, E. Ziller. “Are Rural Older Adults Benefiting from Increased State Spending on Medicaid Home and Community-Based Services?” Maine Rural Health Research Center. June 2016. Available at: <https://muskie.usm.maine.edu/Publications/rural/Medicaid-Home-Community-Based-Services-Rural.pdf>.

²² S. Eiken, et al., op. cit. (2017).

²³ Though BIP funding is no longer available, its requirements (see text box: Goals of the Balancing Incentive Program) provide examples to other states of the critical importance of establishing infrastructure to support community-based services.

²⁴ Mission Analytics Group, Inc. "State Reflections and Recommendations, Balancing Incentive Program." Centers for Medicare & Medicaid Services, February 2016. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/state-reflections-and-recommendation-report.pdf>.

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ Mission Analytics Group, Inc., op. cit. (2016).

²⁹ State of New Jersey, Department of Human Services, Division of Disability Services. "FINAL NARRATIVE REPORT, There's No Place Like Home: New Jersey Nurse Delegation Pilot Project." May 21, 2011. Available at: <http://www.state.nj.us/humanservices/dds/documents/DDS%20FINAL%20NARRATIVE%20REPORT.pdf>.

³⁰ Mission Analytics Group, Inc. "Innovations in the Balancing Incentive Program: Massachusetts." Centers for Medicare & Medicaid Services, February 2017. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/balancing/mass-case-study.pdf>.

³¹ Correspondence with Massachusetts, November 21, 2017.

³² Mission Analytics Group, Inc., op. cit. (2017).

³³ New York State, Department of Health, Office of Health Insurance Programs. "MRT Waiver Amendment: MLTC Workforce Investment." Presentation, May 25, 2017. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/2017/docs/2017-05-25_workforce_investment_program.pdf.

³⁴ J. Farnham, H.M. Young, S. Reinhard, N. Petlick, T. Reinhard, V. Santillan. "New Jersey Nurse Delegation Pilot Evaluation Report." Rutgers Center for State Health Policy, April 2011. Available at: <http://www.state.nj.us/humanservices/dds/documents/Report%20Formatted%2010may11%20with%20covers.pdf>.

³⁵ *Ibid.*

³⁶ New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing. N.J. Admin. Code §§ 13:37-1.1 through 14.17 (June 19, 2017). Available at: <http://www.njconsumeraffairs.gov/regulations/Chapter-37-New-Jersey-Board-of-Nursing.pdf>.

³⁷ See Money Follows the Person sidebar on page 19 for more information.

³⁸ C.V. Irvin, N. Denny-Brown, A. Bohl, A. Wysocki, K. Stewart, R. Coughlin, et al. "Money Follows the Person 2015, Annual Evaluation Report." Mathematica Policy Research, May 11, 2017. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf>.

³⁹ *Ibid.*

⁴⁰ Updated MFP BHP Medicaid Cost Analysis, Provided by TX on 10/19/17.

⁴¹ Tex. Exec. Order No. GWB 99-2 (September 28, 1999). Available at: <http://www.lrl.state.tx.us/scanned/govdocs/George%20W%20Bush/1999/GWB99-2.pdf>.

⁴² Updated MFP BHP Medicaid Cost Analysis, Provided by TX on 10/19/17

⁴³ U.S. Department of Housing and Urban Development. "Section 811 Supportive Housing for Persons with Disabilities." Available at: https://www.hud.gov/program_offices/housing/mfh/progdesc/disab811

⁴⁴ Arizona Department of Housing. "Section 811 Project Rental Assistance Program Notice of Funding Availability." May 31, 2007. Available at: <https://housing.az.gov/sites/default/files/documents/files/5-31-17-HUD-811-NOFA.PDF>.

⁴⁵ Interview with Arizona, October 12, 2017.

⁴⁶ The Texas Department of Housing and Community Affairs. "Section 811 Project Rental Assistance Program." Available at: <https://www.tdhca.state.tx.us/section-811-pra/>.

⁴⁷ Interview with Texas, October 19, 2017.

⁴⁸ Tennessee Division of TennCare. "TennCare Timeline". Available at: <https://www.tn.gov/tenncare/article/tenncare-timeline>.

⁴⁹ Interview with Tennessee, October 30, 2017.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ *Ibid.*

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

- ⁵⁶ M. O'Malley Watts, M. Musumeci, and P. Ubri. "Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies". The Kaiser Family Foundation. January 31, 2017. Available at: <https://www.kff.org/report-section/medicaid-section-1115-managed-long-term-services-and-supports-waivers-key-findings/>.
- ⁵⁷ L. Long-Bellil, C. Cumings, A. Henry, W. Trafton. "Vermont Choices for Care: Evaluation of Years 1-9." University of Massachusetts Medical School, Commonwealth Medicine, May 2015. Available at: http://asd.vermont.gov/sites/asd/files/documents/Choices_for_Care_Evaluation_Report_May2015.pdf.
- ⁵⁸ Interview with Washington, October 4, 2017.
- ⁵⁹ Centers for Medicare & Medicaid Services. "Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." 81 FR 27497. Available at: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>
- ⁶⁰ The Trump administration is reviewing the MMC rule.
- ⁶¹ New York also operates several fully integrated programs for dually eligible beneficiaries that integrate LTSS with other services.
- ⁶² Massachusetts recently procured a third-party administrator to manage its fee-for-service LTSS system through enhanced provider utilization review and performance monitoring.
- ⁶³ Centers for Medicare & Medicaid Services. "People Enrolled in Medicare and Medicaid." August 2017. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.
- ⁶⁴ *Ibid.*
- ⁶⁵ The Kaiser Commission on Medicaid and the Uninsured. "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS." The Henry J. Kaiser Family Foundation, August 2011. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8215.pdf>.
- ⁶⁶ Medicaid and CHIP Payment and Access Commission. Medicare Payment Advisory Commission. "Beneficiaries Dually Eligible for Medicare and Medicaid." January 2017. Available at: <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/>.
- ⁶⁷ Congressional Budget Office. "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies." June 2013. Available at: <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf>.
- ⁶⁸ The Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long-Term Services and Supports: A Primer." The Henry J. Kaiser Foundation, December 15, 2015. Available at: <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.
- ⁶⁹ State of North Carolina, Department of Health and Human Services, Division of Health Benefits. "Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries." N.C. Sess. Law 2015-245, § 5(11). January 31, 2017. Available at: https://files.nc.gov/ncdhhs/documents/files/DHHS-NC-Dual-Eligibles-JLOC-Report_SL2015-245_2017-01-31.pdf.
- ⁷⁰ 42 CFR §422.107. Centers for Medicare & Medicaid Services. U.S. Department of Health and Human Services. Available at: <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec422-107.pdf>.
- ⁷¹ Better Medicare Alliance. "Medicare Advantage Special Needs Plans." July 2017. Available at: www.bettermedicarealliance.org/sites/default/files/2017-07/BMA_SNP_IssueBrief_2017_07_17.pdf.
- ⁷² National Committee for Quality Assurance. "Medicare Special Needs Plans Performance Results: HEDIS 2015." Centers for Medicare & Medicaid Services, November 30, 2015. Available at: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/2015-HEDIS-Report.pdf>.
- ⁷³ V. Murugan, E. Drozd, K. Dietz. "Analysis of Care Coordination Outcomes / A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries." Avalere Health, July 2012. Available at: http://avalere.com/research/docs/20120627_Avalere_Mercy_Care_White_Paper.pdf.
- ⁷⁴ *Ibid.*
- ⁷⁵ W. Anderson, Z. Feng, and S. Long. "Minnesota Managed Care Longitudinal Data Analysis." Office of the Assistant Secretary for Planning and Evaluation. March 31, 2016. Available at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.
- ⁷⁶ B. Chernof. "Perspectives: Good Start, Now Get to Goal — Lessons Learned from California's Duals Demonstration." The SCAN Foundation, August 2016. Available at: <http://www.thescanfoundation.org/perspectives-good-start-now-get-goal-lessons-learned-californias-duals-demonstration>.
- ⁷⁷ Community Catalyst. "Long-Awaited Evaluation of Mass Duals Demo is Out!" October 19, 2016. Available at: <https://www.communitycatalyst.org/blog/massachusetts-is-first-up-with-evaluation-of-its-dual-eligible-demonstration#.We-QYtSyUk>.
- ⁷⁸ Arizona also integrates physical and behavioral health care for Medicaid beneficiaries with serious mental illness through contracts with Regional Behavioral Health Authorities (RBHA). To support the state goal to further integration of service delivery for dually eligible individuals including those with serious mental illness, the RBHA contractors are also required to operate companion D-SNPs.
- ⁷⁹ See 42 CFR 422.66 for regulatory guidance related to coordination of enrollment and disenrollment through MA organizations. CMS put a temporary moratorium on approval of new requests to conduct seamless enrollment from all MA health plans, including D SNPs, as of October 21, 2016, while it reviews current policies. "Seamless enrollment of individuals upon initial eligibility for Medicare," (10-21-16 memo). Retrieved from https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf
- ⁸⁰ In October 2016, following inquiries about how health plans are using this mechanism and related beneficiary protections, CMS placed a temporary moratorium on new health plan approvals for seamless conversion while it reviews current policies, although already-approved health plans may continue.
- ⁸¹ Interview with New Jersey, October 12, 2017.
- ⁸² State Medicaid agencies are required to specify which dually eligible beneficiaries can be enrolled in D-SNP contracts.

⁸³ Centers for Medicare & Medicaid Services. “Summary - Essential Elements of Managed Long Term Services and Supports Programs.” Available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-summary-elements.pdf>.

⁸⁴ C. Dobson, S. Gibbs, A. Mosey, L. Smith. “Demonstrating the Value of Medicaid MLTSS Programs.” National Association of States United for Aging and Disabilities. Available at: <http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>.

⁸⁵ *Ibid.*

⁸⁶ Though both 1115 waiver and 1915(c) waivers have budget/cost neutrality requirements, cost neutrality under a 1915(c) waiver is more standardized and an easier threshold to meet compared to a 1115 waiver. More information available: <https://www.macpac.gov/subtopic/waivers/>.

⁸⁷ C. Dobson, et al., op. cit.

⁸⁸ *Ibid.*

⁸⁹ S. Eiken, K. Sredl, B. Burwell, and P. Saucier. “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014: Managed LTSS Reached 15 Percent of LTSS Spending.” Truven Health Analytics. April 2016. Available at: <https://www.medicaid.gov/medicaid/lts/downloads/lts-expenditures-2014.pdf>.

⁹⁰ C. Dobson, et al., op. cit.

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ B. Hogan, K. Bazinsky, B. Waldman. “Approaches to the Integration of Services for Individuals with Intellectual and Other Developmental Disabilities (I/DD).” Bailit Health Purchasing. Available at: http://www.bailit-health.com/publications/010515_bhp_rwjf_approaches_integration_services.pdf.

⁹⁴ *Ibid.*

⁹⁵ Interview with New York, October 18, 2017.

⁹⁶ *Ibid.*

⁹⁷ B. Hogan, et al., op. cit.

⁹⁸ Interview with New York, October 18, 2017.

⁹⁹ D. Ranney. “Kansas with disabilities concerned about proposed KanCare changes”. The Kansas Health Institute. December 15, 2014. Available at: <http://www.khi.org/news/article/kansans-disabilities-concerned-about-proposed-kanc>.

¹⁰⁰ The Kaiser Commission on Medicaid and the Uninsured. “People with Disabilities and Medicaid Managed Care: Key Issues to Consider.” The Henry J. Kaiser Family Foundation, February 2012. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8278.pdf>.

¹⁰¹ B. Hogan, et al., op. cit.

¹⁰² New York State Department of Health. “Frequently Asked Questions (FAQ), Care Coordination Organizations / Health Homes (CCO/HH).” July 28, 2017. Available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/frequently_asked_questions.pdf.

