

The top portion of the cover features a dark blue background with white silhouettes of several people in a meeting. One person is pointing towards the right, while others are looking in various directions, suggesting a collaborative discussion.

*Innovations and
Best Practices in*

Medicaid Managed Long-Term Services and Supports

A guide for AUCD network members and partners

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AUCD

ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES

THE LEADERSHIP, EDUCATION, ADVOCACY & RESEARCH NETWORK

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Preface

The network of University Centers for Developmental Disabilities (UCEDDs) is uniquely positioned to take a leadership role in the implementation of Medicaid Managed Long-Term Services and Supports. UCEDDs can help make certain that stakeholders have knowledge on this systems change so that they can be active and engaged. UCEDDs can also become directly involved with MLTSS implementation. For example, they could contract with the state to evaluate the managed care organizations, provide education to MCO staff on person-centered planning or even contract with the MCOs to improve the accessibility for individuals with disabilities or propose new services.

This paper is intended to be a reference for individuals with disabilities, family members, disability policy leaders, and other stakeholders to understand MLTSS and have tools to help advocate for best practices. This brief provides an in-depth guide to MLTSS and also provides specific examples of innovations occurring in states and new models that are being implemented across states. The information in this brief was gathered from an extensive literature review and interviews of policy specialists, leadership of Managed Care Organizations (MCOs), disability leaders and individuals that have been directly impacted by MLTSS implementation. The appendix offers additional resources with hyperlinks that will provide more detailed information by topic. We hope that this brief will offer members of the AUCD network, individuals with disabilities, their families, our partners and stakeholders the tools and resources needed to better understand and be involved in MLTSS implementation and operation. A second more condensed brief has also been created to help individuals with disabilities, family members, and other stakeholders to better understand MLTSS and have the tools to help advocate for best practices.

Respectfully,

Sarah Swanson
Denise Rozell
John Tschida

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Respectfully,



Quick Reference Guide

Accountable Care Organizations (ACOs): A provider-based organization that assumes financial risk for managing the care of enrollees, typically in exchange for a share of the medical expenditure savings generated by effective care management and coordination.

Center for Medicare and Medicaid Services (CMS): A federal agency that partners with states to offer Medicaid Services.

Community Based Organization (CBO): A local organization which offers services and supports to improve the health, well-being, independence, and community participation of people with disabilities and older adults. CBOs include Centers for Independent Living, developmental disability organizations, University Centers for Excellence in Developmental Disabilities, behavioral health organizations, Protection and Advocacy Agencies, Aging and Disability Resource Centers, Area Agencies on Aging, aging services organizations, faith-based organizations, and Native American tribal organizations.¹

Fee-for-Service: When providers are paid for each individual service delivered. (Payment for volume as opposed to value)

Home and Community Based Services (HCBS): Services and Supports provided in an individual's home or provided in a community setting as opposed to an institutional setting.

Long-Term Services and Supports (LTSS): Non-medical services and supports provided to individuals who need assistance with activities of daily living or instrumental activities of daily living. In this paper it refers to Medicaid-financed services and supports.

Managed Care Organization (MCO): Typically a non-profit or for-profit insurance company which contract with states to manage parts of the state Medicaid program.

Managed Long-Term Services and Supports (MLTSS): When a state contracts out the management of the LTSS programs to a managed care entity.

Medicaid Rebalancing: This refers to when a state shifts the financing of LTSS programs from institutional based settings to home and community-based settings.

Medicaid State Plan: An agreement between each state and the Center for Medicare and Medicaid Services that details how the state administers the Medicaid program.²

Medicaid Waivers: A vehicle which allows states to 'waive' Medicaid certain rules to provide Medicaid to individuals who would likely be ineligible or provide new services.³

Value-Based Purchasing (VBP): There are many models but the most simple level, it's when providers are paid a set amount which incentivizes them to identify the best quality care at the lowest cost.

1 <https://www.aginganddisabilitybusinessinstitute.org/event/what-cbos-need-to-know-managed-long-term-services-and-supports-mltss/>

2 <https://www.macpac.gov/subtopic/state-plan/>

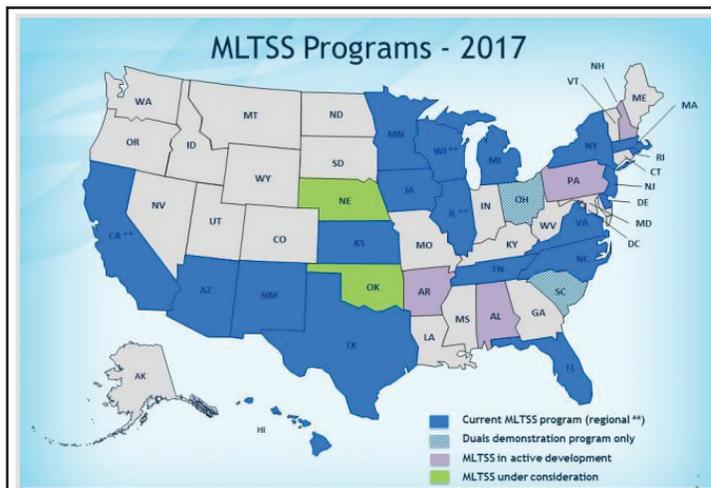
3 <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/state-medicaid-policies.html>

Background

An increasing number of states are moving the management of Medicaid Long-term Services and Supports (MLTSS) programs to Managed Care Organizations (MCOs – Insurance Companies) and are including more complex populations.⁴ Over the past four decades, states have shifted Medicaid

management to MCOs in an attempt to improve quality, decrease costs, reduce duplication of services, and most importantly, to help better predict state expenditures.⁵

Historically, states have turned to MCOs to manage Medicaid acute care programs and have excluded certain populations and also LTSS programs. However, as states have struggled with budget deficits and increasing Medicaid expenditures, they are also shifting management of LTSS programs to MCOs and including populations that historically have been excluded. For example, many states have excluded (carved out) those with intellectual and developmental disabilities (IDD)⁶ but now are bringing the management of acute and LTSS programs under one umbrella and including those with IDD as well. States such as **Iowa** and **Kansas** have included all services and populations under managed care, including those with IDD, and **Nebraska** has indicated that they will also be moving in this direction.^{7,8}



Between 2012 and 2017, state MLTSS programs more than doubled from 19 to 41.⁹ According to the Medicaid and CHIP Payment and Access Commission (MACPAC), the number of states implementing MLTSS programs grew from eight states in 2004 to 24 in January 2018.¹⁰ Currently, there are more than 12 million individuals who need LTSS and rely on Medicaid to help meet their personal care needs, retain independence and remain in their communities.¹¹ In the past year, Medicaid LTSS costs totaled \$140 billion dollars¹² and with our aging population and few individuals with private coverage for LTSS services, Medicaid cost projections are expected to grow.

Medicaid expenditures are becoming one of the largest budget lines for states¹³ and the aging population is adding urgency to state efforts to reform LTSS.¹⁴ Current estimates predict that individuals age 65 or older are expected to increase Medicaid enrollment by 18 percent by 2020 and double by 2060.¹⁵ Demand for Home and Community

Year	Number of MLTSS Programs More Than Doubled
2012	19
2017	41

Source: MACPAC, 2018

Year	Number of States Implementing MLTSS Tripled
2004	8
2018	24

Source: Truven, 2018

4 http://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2017/04/HMA-webinar-slides_CBOsMedicaid_Kaschak3.1.17.pdf

5 <https://www.academyhealth.org/events/2018-05/webinar-managed-long-term-services-and-supports-potential-medicare-managed-care-integrate-acute-and-long-term-care>

6 <https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

7 <http://dhhs.ne.gov/Pages/Medicaid-Long-Term-Care-Redesign-Project.aspx>

8 MLTSS Programs - 2017 Map: NASUAD, 2017.

9 <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-timeline.pdf>

10 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

11 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

12 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

13 <https://www.mdedge.com/internalmedicineneeds/article/154490/business-medicine/medicaids-share-state-budgets-continues-grow>

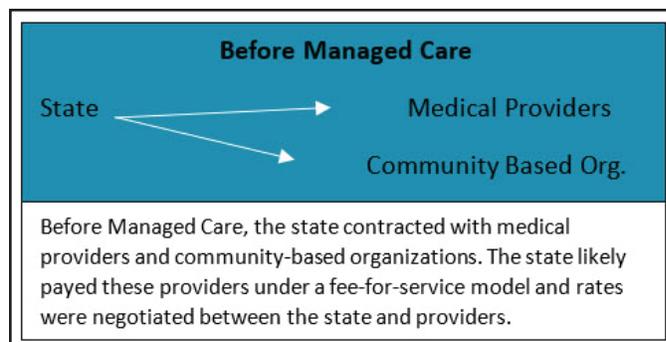
14 https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077

15 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

Based Service (HCBS) programs continues to grow and now represents more than 55 percent of all Medicaid spending¹⁶ with over 300,000 people with disabilities on waiting lists for HCBS across the country.¹⁷ States are also being pressured to meet the Supreme Court’s Olmstead ruling to provide services and supports in the community rather than institutional settings^{18, 19} which frequently means that states must provide access to HCBS. Therefore, the demands for HCBS, the trends in growing Medicaid expenditures and also the aging population are driving forces influencing states’ growing shift to MLTSS.

“Managed care is defined as the efforts to coordinate, organize, and rationalize the delivery of health care services and supports in a manner designed to improve service access and quality while avoiding unnecessary expenditures.”²⁰ Managed health care first emerged in the 1930s in response to the growing cost of medical services in the United States.²¹ Initially, LTSS began as Medicaid coverage for care provided in nursing homes and other institutional settings. Home and community-based services emerged in 1983 after Congress amended the Social Security Act, which provided states a ‘waiver’ over the Medicaid rules of institutional care.²²

When Medicaid first started, it used a fee-for-services (FFS) model in which the provider would bill for each service provided. With managed care, states contract with an organization to manage the care for Medicaid-eligible clients. The Managed Care Organization (MCO) is often paid by the state a capitated or set per member per month rate.²³ In this “full-risk” arrangement, the MCO assumes financial risk for managing the care of program participants.²⁴ The MCO assumes that some members in their care will likely spend more on services while others will likely utilize less services and thereby hopefully come in under budget. Under this model, the MCO is liable for any cost overages, however, they also are allowed to keep any savings.²⁵ Sometimes states may implement other models that minimize risk for the managed care plan or share the risk between the state and managed care plan. This could include the state paying for high-cost, outlier enrollees above a certain financial threshold. States may also pay a higher capitation rate if a participant utilizes certain services or they may opt to exclude certain services from the MCO management altogether.²⁶ They can also use bonuses or withholds to the capitation rate to plans that meet specific quality goals.²⁷ Ultimately, rates will be set by the state, but also must be approved by CMS.^{28, 29}

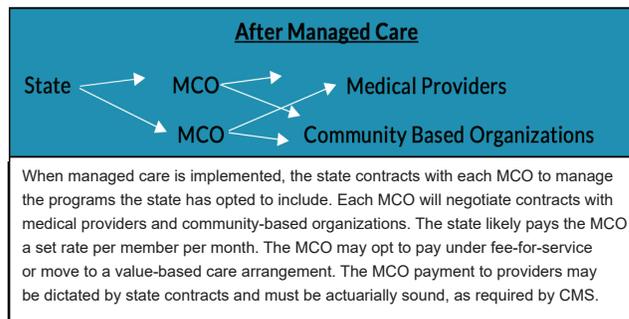


With MLTSS, the MCO can contract with community-based organizations (CBOs such as UCEDDs, disability providers, home health agencies and Centers for Independent Living) to provide services or keep them in-house and build internal capacities.³⁰ Subsequently, if community-based organizations

16 https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077
 17 <https://www.thearc.org/what-we-do/public-policy/policy-issues/long-term>
 18 https://www.olmsteadrights.org/about-olmstead/#From_Olmstead_to_the_Present
 19 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>
 20 https://ncd.gov/rawmedia_repository/20ca8222_42d6_45a5_9e85_6bd57788d726.pdf
 21 https://ncd.gov/rawmedia_repository/20ca8222_42d6_45a5_9e85_6bd57788d726.pdf
 22 <https://www.medicaid.gov/medicaid/hcbs/authorities/index.html>
 23 <http://www.nasddds.org/uploads/webinars/Managedcareauthwebinar.pdf>
 24 <https://www.chcs.org/media/CHCS-Risk-Mitigation-Strategies-in-Medicaid-MLTSS-08-22-16.pdf>
 25 <https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/>
 26 <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>
 27 https://www.chcs.org/media/MLTSS-Rate-Setting_Final1.pdf
 28 <http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care>
 29 <https://www.chcs.org/media/CHCS-Risk-Mitigation-Strategies-in-Medicaid-MLTSS-08-22-16.pdf>
 30 <https://www.ahcancal.org/advocacy/solutions/Documents/Final%20MLTSS%20Contracting%20Toolkit.pdf>

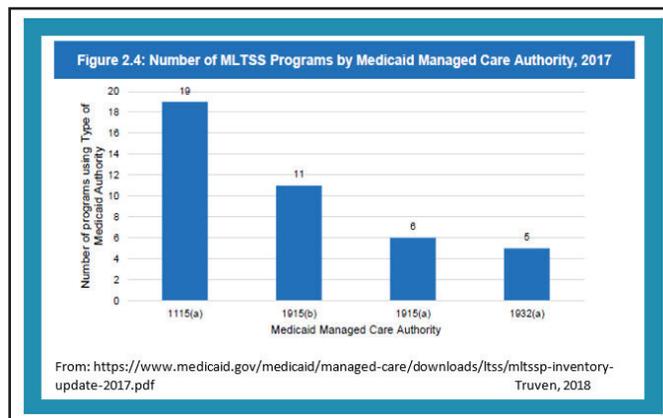
want to have involvement in service delivery under MLTSS, they will have to negotiate and finalize contracts and establish payments with MCOs rather than simply contracting with the state.

As the shift of the management of LTSS has transferred from states to MCOs, there are concerns with the ability of CBOs to negotiate with MCOs and determine the appropriate level of financial risk.³¹ There is a need for CBOs to enhance skills in negotiating contracts, and for advocates to understand the opportunities that are available and how to avoid unnecessary pitfalls.³² The Administration for Community Living (ACL) launched the “Business Acumen initiative” in 2016 to counsel providers on how to contract with plans. ACL states that their goal with the Business Acumen project is to help states and CBOs develop innovative business models that enable them to market their services, compete in a changing marketplace, ensure funding for services, and help payers achieve quality goals and cost savings.³³



There are many options and a great deal of flexibility that states have when considering MLTSS for the Medicaid program. States can implement MLTSS using different federal authorities including 1115 demonstrations, 1915(a) voluntary program, a 1932(a) state plan amendment, or a 1915(b) waiver. Additionally, any of those managed care authorities can be ‘paired’ with state plan HCBS benefits offered under 1905(a), 1915(i), 1915(j) or 1915(k) or an HCBS waiver under 1915(c). Waivers and amendments are proposed by states and approved by CMS.³⁴

Movement to managed care can help to decrease the fragmentation of services which in turn can reduce the complexity for participants. For example, some states have combined primary care, behavioral health, pharmacy and LTSS programs under the management of MCOs.³⁵



³⁶ Many states have also implemented “Dual Eligible” programs to enhance the coordination of benefits between Medicare and Medicaid for those who are eligible for both. This subpopulation has traditionally been the most difficult to serve and the most expensive.

Having one entity coordinate all these services helps to ensure that the care recipient is getting the appropriate services, helps to place the individual at the center of the delivery system rather than the services they need. This ensures person-centeredness, breaks down siloed programming and simplifies the administrative burden for states.³⁷ When there are different organizations that authorize services and separate organizations that provide the services, each may not have complete information or be financially motivated to pay for needed services. For example, an individual who has behavioral health needs may see both a psychologist and/or psychiatrist, and may also have prescriptions to help manage their condition. However, if one MCO manages the pharmacy benefits and another manages the behavioral health services, the two companies likely do not coordinate the delivery of these services or monitor outcomes. Bringing the management of both the pharmacy and behavioral health

31 <https://www.aginganddisabilitybusinessinstitute.org/event/what-cbos-need-to-know-managed-long-term-services-and-supports-mltss/>
 32 <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/transitioning-ltss.pdf>
 33 <https://www.acl.gov/programs/strengthening-aging-and-disability-networks/improving-business-practices>
 34 <https://www.medicare.gov/medicaid/managed-care/authorities/index.html>
 35 https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077
 36 <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Summary-Elements.pdf>
 37 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be>

services under the umbrella of one organization helps to see the full set of needs and ensures that the appropriate and needed services are authorized.

Historically, disability advocates have fought the implementation of managed care, fearing that MCOs have neither the experience nor

expertise to manage LTSS programming.^{38, 39}

Frequently, an identified concern is the MCO's use of the medical model as opposed to a person-centered approach that recognizes all the LTSS needed for the individual to access their community and have a high quality, meaningful and engaged life.⁴⁰ At the same time, many disability advocates and leaders are acknowledging this is

Concerns about MLTSS

- The primary goal of MCOs is to make money.
- MCOs will limit or deny services.
- MCOs will only approve services that are 'medically necessary' and won't consider quality of life or inclusion.
- MCOs won't have the doctors or specialists needed within their network.
- MCOs won't involve community-based organizations in their contracting.
- MCOs won't recognize the importance of the peer-to-peer model.
- MCOs don't have experience managing LTSS programs

Hopes with MLTSS

- MCOs will provide services that support the whole person and improve the individual's quality of life.
- MCOs can provide services that Medicaid cannot.
- MLTSS can provide states budget predictability.
- MLTSS will improve care coordination and make things simpler for the recipient.
- MCOs can help transition individuals in nursing or institutional setting to home and community-based settings.
- MLTSS will reduce Medicaid expenditures.

an inevitable shift and are working to influence managed care implementation. Further, as more states adopt MLTSS and more MCOs are gaining experience in this domain, many disability leaders are recognizing that MCOs can be a powerful ally in helping remediate long-standing systems issues.⁴¹ For example, MCOs have the flexibility to offer enhanced benefits and can work with community-based organizations to tackle historical systems issues such as inaccessible housing, low employment, barriers to transportation, and inadequate social support networks.

Addressing the Social Determinants of Health

According to the Center for Health Care Strategies, Inc., "Health care delivery drives only 20 percent of health outcomes, with behavioral and social determinants — including income, living environment, employment status, and access to transportation and healthy food — playing a much bigger role in overall health. There is growing recognition among policymakers that integrating health care with social supports and services is critical to improving broad population health, advancing health equity, and reducing health care spending."⁴²

With this growing recognition that social determinants of health impact individual health outcomes⁴³ insurers are starting to pay for the delivery of these services.⁴⁴ For example, in June 2018, the Centers for Medicare and Medicaid Services (CMS) reinterpreted a law that will now allow for payment of

Identifying ways to address the social determinants of health is still an emerging innovation.

-Mary Lou Breslin,
Senior Policy Analyst

38 <https://dredf.org/public-policy/health-access-to-care-old/ltss-in-a-managed-care-environment/>

39 <http://www.justiceinaging.org/resources-for-advocates/mltss-in-managed-care-toolkit/managed-care-context/>

40 <http://www.nasddds.org/uploads/webinars/Managedcareauthwebinar.pdf>

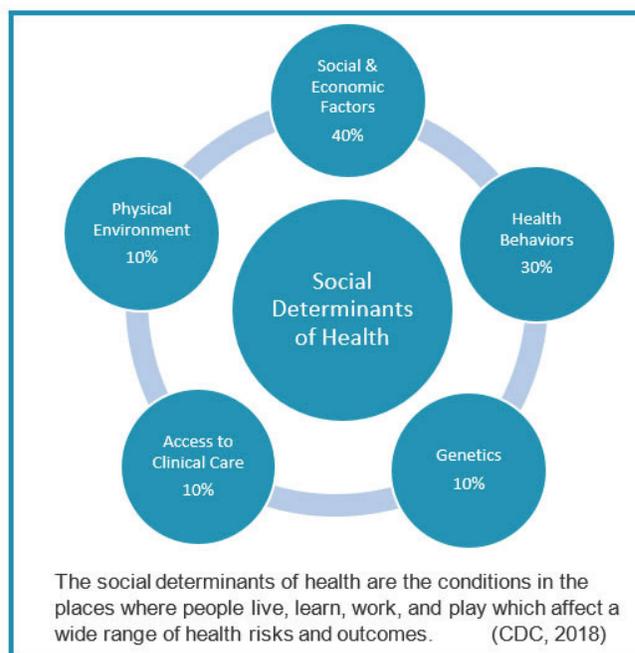
41 Interview, Sarah Triano. 2018.

42 <https://www.chcs.org/topics/social-determinants-of-health/>

43 <http://files.kff.org/attachment/issue-brief-beyond-health-care>

44 <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

'health-related services' in Medicare Advantage Plans.⁴⁵ Insurers offering these plans may now provide transportation to doctors' offices, modifications in beneficiaries' homes, such as installing grab bars in the bathroom, or providing aides to help with daily activities in order to meet the non-medical services that impact patient health.⁴⁶ Other programs are moving in this direction as well. CMS has several initiatives that link the delivery of medical and community services.⁴⁷ For example, in 2017, the CMS Center for Innovations funded 32 organizations to test the Accountable Health Communities initiative. This was the first time CMS funded approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs).⁴⁸ The PACE program has historically only served the frail elderly through a capitated model that allows for the provision of comprehensive medical and social services to be provided, but now the PACE Innovation Act (PIA) provides authority for CMS to test care delivery models for individuals under 55 for those who are at risk of institutionalization.^{49, 50} States are also using Accountable Care Organizations (ACOs) for Medicare, Medicaid^{51, 52} and dual-eligible populations to implement value-based care and also address the social determinants of health.⁵³ Many states are working to integrate all systems to serve the 'whole person' by bringing services together to meet the full needs of the individual⁵⁴ so, several states are bringing the management of physical, behavioral and LTSS care under the management of one entity. The National Institute on Disability, Independent Living and Rehabilitation Research (NIDILRR) funded the University of Pittsburgh to investigate if utilizing an integrated model of care and partnering with community-based organizations will help to achieve the triple aim.⁵⁵ UPMC's Disability Rehabilitation and Research Program (DRRP) model is using the PACE program targeting individuals with disabilities between ages 55-64 and the iMHERE web-based portal technology platform to empower individuals with chronic conditions to self-manage their condition with clinician oversight.⁵⁶



States are also using ACOs or MCOs as the vehicles to break down the historical silos between systems. Additionally, the CMS' Medicaid Managed Rule of 2016, financially incentivizes MCOs to address non-medical services and be included as covered services when calculating the capitated rate and medical

45 <http://www.m2hcc.com/paying-to-address-social-determinants-of-health-medicare-advantage-to-offer-supplemental-benefits.html>

46 <https://khn.org/news/medicare-advantage-plans-cleared-to-go-beyond-medical-coverage-even-groceries/>

47 <https://innovation.cms.gov/initiatives/ahcm/>

48 <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>

49 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PAACE/PACEInnovationAct.html>

50 <https://www.npaonline.org/house-passes-pace-innovation-act-0>

51 <https://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/>

52 <https://www.chcs.org/resource/aco-general-design/>

53 <https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf>

54 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be>

55 https://search.naric.com/research/research_record.cfm?search=1&type=all&criteria=brad%20dicianno&phrase=no&rec=3470

56 <http://www.imhere.pitt.edu/2017/04/03/prospect-for-stakeholders/>

loss ratios.⁵⁷ (A medical loss ratio is a financial measurement that shows how much value a health plan provides to its members. For example, a medical loss ratio of 90% means that 90% of its premiums go to direct services while 10% of its premiums go to overhead costs.)⁵⁸

As indicated above, the shift to managed care offers opportunities for new innovations which can be accomplished in multiple ways. These innovations can occur as a state requirement identified in the contract with the MCO, through the MCO's enhanced benefits, or through the MCOs' contracts with community-based organizations. There are many new models and innovations that are being tested or across states to help streamline service delivery, improve individual and population health and reduce costs. MCOs are starting to address the social determinants of health to improve both the quality of health and overall outcomes for their clients.⁵⁹ While the social determinants of health have been receiving greater attention across the health system, they have been recognized as a critical component of the MLTSS programs since their inception.⁶⁰

Defining Long-Term Services and Supports

Most long-term care is not medical care, but instead is the services and supports necessary to help the individual gain access, improve functioning and increase independence. Generally, these can be broken down into 7 overarching categories including: **Personal Care and Assistance, Health-Related Services, Specialty Services, Adaptive Services, Family and Caregiver Supports, Social Supports, and Case/Care Management or Service/Care Coordination.**⁶¹ (These are described in detail in the appendix.)

LTSS can be provided in both home and community-based settings or nursing/institutional facilities and can be provided through formal (paid) care or by informal (unpaid) care providers. It is important to note that the largest *funder* of LTSS is provided through Medicaid, however, the majority of LTSS are provided by non-paid family caregivers.⁶² LTSS services can be provided through different Medicaid vehicles such as the Medicaid State Plan or Medicaid waivers. Waivers are a vehicle under specific federal authorities which provide states the flexibility to waive mandatory Medicaid requirements and can be used to complement and expand traditional state Medicaid Services.⁶³ Medicaid requires that states offer nursing and institutional care as a mandatory service while home and community-based services (HCBS) are an optional service. This means that in order for HCBS to be offered, states must select how they will provide this services and obtain CMS approval to do so. Waivers are limited to a specific population, limited to a certain number of slots and are an optional Medicaid benefit. They vary widely from state to state.

The movement to Medicaid Managed LTSS also is typically done through a waiver which requires CMS approval. While there are certain requirements that CMS requires of states, the state has significant flexibility in what they will require of an MCO. For example, states can include their LTSS Medicaid HCBS waivers or carve out certain populations or waiver programs from the MCO contracts⁶⁴ or they can require the MCO to provide new services which they define in their contracts as well as in their waiver application with CMS. The services provided by MCOs are detailed through negotiated contracts with the state.

Below are examples of how states might use MCOs to manage and coordinate care for individuals who need LTSS.

57 <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicare-managed>

58 <https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/>

59 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be>

60 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

61 <https://aspe.hhs.gov/basic-report/understanding-medicare-home-and-community-services-primer#Chap4>

62 <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>

63 <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/state-medicare-policies.html>

64 <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>

Meet Tom

Tom is a 14-year-old-boy who has intellectual and developmental disabilities and high medical needs. Because Tom meets a ‘nursing home level of care,’ he is eligible for his state’s (1915c) Aged and Disabled Medicaid Waiver. His state has included the Medicaid waiver into the contracts with the MCO. Now the MCO that Tom’s family has selected will be in charge of helping to coordinate both Tom’s medical and LTSS care. The MCO will be responsible for contracting with Tom’s primary care and specialty care providers. They will also have contracts in place with pharmacies and the Durable Medical Equipment provider where Tom’s family will get his specialized formulas and also the supplies for his g-buttons and catheter equipment. Since both of Tom’s parents work, Tom goes to a specialized childcare provider after school and during the summer. The MCO will also have a contract with the childcare provider. The MCO provides a services coordinator that helps Tom’s family coordinate all of these services. Additionally, their MCO also provides enhanced benefits which allows his family to use Equine (horse) therapies which help Tom gain and retain his strength and mobility. The MCO also pays for Tom to attend one week of camp during the summer. This is another enhanced benefit that his MCO believes improves Tom’s social connections, his overall well-being and also allows his family to get a break from caregiving.

Meet Raul

Raul is a young adult with autism. He does not have high medical needs but instead needs habilitative services (services to help an individual acquire, retain and improve skills). His family applied for services when he was in elementary school. Unfortunately, he is on the waiting list. Many states have waiting lists for these optional LTSS services. His family has been told they are number 1,400 which puts them right in the middle. His parents are getting older and are concerned about his future. They are unsure of what his future might look like. They’d like him to have the opportunity to work in a competitive setting but fear that his work might not understand his needs. The state was recently approved for a 1915c Support Waiver. His family has attended state meetings to learn more about this and believe that the “Community Supports Waiver” might be what they need. This waiver is for individuals on the waiting list and does not provide residential supports but provides \$20,000/year which Raul and his parents can use to do some job exploration, hire a job coach, pay for transportation and respite services. Because this waiver is managed under the MCOs, his parents have to figure out if they need to apply for this waiver with the state or with the MCO. They believe that they will be able to self-direct these services-meaning that they will hire and fire the individuals who work for Raul, but they aren’t certain. They also must figure out if they can hire individuals from agencies. The state will be having another informational meeting and they plan to attend to learn more.

Meet Jade

Jade is an adult woman with a physical disability. Services available under the Medicaid state plan have allowed her to maintain her independence throughout life. Medicaid pays for her home care aides who help her get up, get dressed, prepare meals get groceries and clean her house. Jade self-directs her services. This means that she hires, trains and fires her providers. The state uses a Fiscal Intermediary Agency so that Jade does not have to worry about paying her providers or collect taxes or FICA. Instead, the Fiscal Intermediary Agency does this. The Agency also helps shoulder the risk to her independent providers and her by covering liability insurance. When the state moved to MLTSS they included the LTSS services in the Medicaid state plan. Jade still self directs her services as the MCO has contracted with the Fiscal Intermediary Agency. The MCO also contracted with a Center for Independent Living which provides a Services Coordinator which Joni used to help her get an appointment with a specialist who was not covered under her plan. The Services Coordinator was able to help get a one-time visit set up so that she could see the specialist her primary care doctor had ordered. When Jade shared with her Services Coordinator that she was afraid she would fall when transferring to bathe because she had hurt her arm, the Services Coordinator worked with the MCO to see if they would pay for a ceiling Hoyer lift. The MCO agreed to cover the lift, believing that it was less expensive than an extended stay in a nursing facility, which likely would have been needed had Joni fallen. The MCO also offers their enrollees a membership to a gym, which provides accessible exercise equipment as an added benefit.

As you can see in the examples provided above, the state has flexibility in deciding what LTSS they want included in the MCO contracts. However, MCOs have even more flexibility in deciding the services they want to provide and can provide services that are not allowable through the state Medicaid program.⁶⁵

Best Practices

States play a powerful role in ensuring the success of MLTSS implementation. For example, there are specific actions they can take to prepare participants, stakeholders, legislators and providers for this systems change. States can also use the contracts with the MCOs to prioritize their goals with MLTSS implementation. This section offers a summary of actions and innovations being implemented across states during the planning, contracting and full implementation phases.

What's the state's intent to move to MLTSS? The state should have a goal and it should not just be about saving money- though that certainly should be a consideration.

-Disability Policy Specialist

Best Practices before MLTSS is Implemented

There are several steps that need to be considered before MLTSS is operational. States that have taken time, engaged stakeholders and developed a strong structure for MLTSS have seemed to do better than states who rushed for full implementation.⁶⁶ Below are specific examples of activities taken in states which have helped to make MLTSS implementation successful.

Allow Time for Planning and Pilot Roll-out before Full Implementation⁶⁷

⁶⁵ <https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/>

⁶⁶ <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

⁶⁷ <https://www.medicicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-summary-elements.pdf>

States that have taken the time to plan, communicate the plan with stakeholders and program recipients, transition the full implementation in stages, assess the implementation and strive for transparency seem to do better than those who rush through these processes.⁶⁸ Three states that took this approach include **Tennessee**, **Delaware** and **Hawaii**. Additionally state leadership worked with health plans in each state to ensure all systems were ready and that there was adequacy of LTSS providers.⁶⁹ **Hawaii** met with stakeholders monthly for two years prior to implementation and continued with stakeholder meetings another year post implementation.⁷⁰ **Delaware** issued policy briefs on the proposed changes, opened them up for public comment, made revisions based on the comments and rolled the implementation out in stages.⁷¹ **Virginia** phased in their MLTSS integration in six different rollouts region by region. This helped to trouble-shoot problems on a smaller scale before implementation was rolled out statewide. Additionally, before each regional roll-out, the state held stakeholder forums where individuals could ask questions to clarify the MLTSS program.⁷²

Involve People with Disabilities and their Family Members in the Design, Implementation and Evaluation of MLTSS⁷³

The 2016 Medicaid Managed Care Rule required that states involve stakeholders in the design and make many performance measures available, such as posting the state Medicaid Managed Care quality strategy and the annual external quality reports on a website.⁷⁴ CMS implemented these requirements to ensure transparency and allow stakeholders to be involved in the quality assurance process. Involving people with disabilities in the design and overall implementation of MLTSS also holds true of the disability community's philosophy: nothing about us without us. Engaging stakeholders who are grounded in knowledge about program needs and the initial planning and design of any MLTSS delivery system greatly increases the likelihood of the support of and success for system reform.⁷⁵

Stakeholder engagement can be initiated by both the state and the MCOs. When **Tennessee** began exploring movement

The Medicaid director held listening sessions across the state before they implemented MLTSS. During these sessions, there were many families who expressed frustration that some individuals got everything and others got nothing. Many also expressed concerns for those who were in crisis and wanted to make certain that they had priority placements. This became the basis for the support Waivers that the state implemented.

-Tennessee Stakeholder

Rather than selecting individuals with leadership and knowledge, the state randomly selected stakeholders to participate on the advisory council. Unfortunately, this weeded out those with advocacy skills and systems knowledge.

-Illinois Stakeholder

to MLTSS, they held stakeholder sessions across the state in which key themes emerged, including: frustrations that those who were receiving services got a lot and there were too many waiting for services that got nothing. Overall, there was consensus that too few people were being served in HCBS, the state needed to reduce the waiting list, supports need to be in place before there was a crisis situation, more choices needed to be provided in community settings, and employment supports were needed. Based on this feedback, the state created the Employment and Community First CHOICES

68 <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-timeline.pdf>

69 https://www.communitycatalyst.org/doc-store/publications/putting_consumers_first_LTSSmanagedcare_execsummary.pdf

70 https://www.chcs.org/media/MLTS_Roadmap_112210.pdf

71 Interview. Pat Nobbie. 2018

72 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

73 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

74 <https://www.medicaid.gov/medicaid/managed-care/downloads/improving-quality-of-care.pdf>

75 <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>

(ECFC) MLTSS program.⁷⁶ While CMS requires states to have a state advisory council for MLTSS and also plans to have advisories,⁷⁷ there are ways to enhance the involvement of people with disabilities and their family members. Having an advisory composed of individuals who are receiving services, professionals who provide services and stakeholders who are knowledgeable about MLTSS programs can help the MCO and the state obtain feedback on their delivery systems, troubleshoot problems, and ensure overall success. **Texas** also created a communications plan and an IDD Advisory Committee as the state planned to move all IDD Waivers into MLTSS.⁷⁸ **Arizona** and **New York** require an advisory committee specifically for individuals with intellectual and developmental disabilities. These advisories are composed of individuals with IDD and their family members.⁷⁹ Other examples of stakeholder engagement includes hiring individuals with disabilities and family members as part of the MCO team, participating in disability events and conferences, asking disability organizations and other stakeholders to participate in services coordinator training and holding regularly scheduled stakeholder meetings in different locations.⁸⁰

Establish a No Wrong Door/Single Entry into LTSS systems

Navigating the multiple programs and services in LTSS can be very time-consuming and difficult. To help overcome these difficulties, the Administration for Community Living has promoted the use of Aging and Disability Resource Centers (ADRCs) and No Wrong Door Systems where individuals in need of supports and services and their families can get the same information no matter the access point.⁸¹ This is often considered the infrastructure that provides the backbone for the state's LTSS system.⁸² Several states even use the ADRC/NWD as the starting point for assessment into LTSS programs, use person-centered planning to ensure that individuals are receiving the services that they want, and help individuals get connected to both privately and publicly-funded programs.⁸³ Funding for ADRCs has been financed through federal grants, using 1115 Waiver flexibility,⁸⁴ Medicaid matching funds and state appropriations.⁸⁵ Many activities performed by ADRC are likely eligible for matching funds through Federal Financial Participation (FFP) because they are related to Medicaid administration.⁸⁶ In **Wisconsin**, the FFP pays for a third of the funding for their ADRCs.⁸⁷ Several states are using 1115 Waivers, state funding and creative provider and MCO contracting to expand and sustain ADRCs.⁸⁸

The National contractor our state used to help us prepare for MLTSS implementation identified an Aging and Disability Resource Center/No Wrong Door system as a priority and the backbone for the state's long-term care system. Unfortunately, very little funding was allocated to the disability partners. Instead, the Offices on Aging hired their own disability options counselors. What young adult or parent of a child with a disability wants to go the Office on Aging for information and support? There's something philosophically wrong with that.

-Nebraska Stakeholder

76 <https://www.tn.gov/content/dam/tn/tenncare/documents/introductionToEcfChoices.pdf>

77 <http://files.kff.org/attachment/CMSs-Final-Rule-on-Medicaid-Managed-Care>

78 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

79 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

80 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

81 <https://nwd.acl.gov/pdf/NWD-National-Elements.pdf>

82 <https://www.acl.gov/programs/connecting-people-services/aging-and-disability-resource-centers-program-no-wrong-door>

83 <https://nwd.acl.gov/pdf/NWD-National-Elements.pdf>

84 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

85 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

86 <https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html>

87 <http://dhhs.ne.gov/Reports/ADRC%20Evaluation%20Year%202%20Report%20-%202017.pdf>

88 <http://dhhs.ne.gov/Reports/ADRC%20Evaluation%20Year%202%20Report%20-%202017.pdf>

Provide Technical Assistance and Training to Community Based Organizations

According to Health Management Associates, health plans and states need community-based organizations (CBOs) to engage, manage the care, assess, and deliver the services for participants in MLTSS. (2018)⁸⁹ CBOs can help improve care coordination, ensure a person-centered delivery, and connect participants to social services to address the social determinants of health.⁹⁰ CBOs have been providing these services for decades. Yet, with the shift to MLTSS, CBOs need to decide if they want to work in the MLTSS programs as they likely will need to expand their scope, meet more rigorous quality assurance outcomes and identify and implement new business models.⁹¹ Since movement to MLTSS means that providers of LTSS will be negotiating contracts with each MCO rather than the state and also learning and implementing new processes for billing, there is a need for both MCOs and LTSS providers to learn and understand each other's business models. Some states have helped to facilitate this transition process to ensure that both the MCOs and the LTSS providers are on the same page and that any potential glitches are worked out prior to implementation. For example, states have organized forums where providers and MCOs come together to learn more about each other and sponsored practice billing sessions before the 'go live' date to make sure that claims were not being denied from LTSS providers.⁹² Helping the MCOs and LTSS providers work together helps ensure the continuity of care for the recipient of LTSS and also will help to prevent problems at implementation.

Service Coordinators that were provided by community based organizations are not being used by the MCOs. Instead, the MCOs are hiring their own services coordinators rather than contracting this service out. They want service coordinators to be licensed. (Embracing the Medical model)

-Illinois Stakeholder

Create an Independent Ombudsman Program

One fear that has been stated in movement to MLTSS is that services will be determined by medical necessity and in using this as a determination choice and autonomy will not be considered as they typically aren't considered in acute medical care.⁹³ Advocates in **New York, Florida, and Illinois** said that after MLTSS was implemented, MCOs reduced both the number and duration of services for some and individuals in **Arizona** and **Wisconsin** reported service reductions during periods of state budget shortfalls.⁹⁴ One way to curb concerns about MCOs limiting services is by creating an independent ombudsman program. This program could be embedded into community-based organizations whose staff could assist beneficiaries with any denial of benefits, track denials and report to the state, monitor compliance of MCOs and act as an advocate for consumers who encounter problems.⁹⁵ Nine states have an ombudsman program specifically authorized to assist beneficiaries with the appeals process (**CA, HI, IL, KS, MN, NM, NY, OH, TX**) and **Hawaii, Kansas and Minnesota** even allow that the ombudsman can assist beneficiaries in appeals at the administrative fair hearing.⁹⁶ In **Hawaii**, the state has contracted with the state's Family2Family Health Information Center to act as the Ombudsman for all 300,000 of the state's Medicaid beneficiaries.⁹⁷ Now, under CMS' managed care rule, MCOs are required to track each appeal/grievance, the date the appeal was received and reviewed, a general summary and the

89 http://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2017/04/HMA-webinar-slides_CBOsMedicaid_Kaschak3.1.17.pdf

90 <https://www.healthmanagement.com/wp-content/uploads/HMA-Webinar-Assessing-Health-Plan-Partnerships-with-Community-Based-Organizations-12-7-16.pdf>

91 http://nasuad.org/sites/nasuad/files/CBO%20Readiness%20for%20MLTSS%20Dec.%202014_0.pdf

92 <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/transitioning-ltss.pdf>

93 <http://www.justiceinaging.org/resources-for-advocates/mltss-in-managed-care-toolkit/managed-care-context/>

94 <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-managed-long-term-services-and-supports-themes-from-site-visits-to-five-states>

95 <http://www.justiceinaging.org/resources-for-advocates/mltss-in-managed-care-toolkit/ombudsman/>

96 <http://files.kff.org/attachment/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers-issue-brief>

97 <http://www.nasuad.org/sites/nasuad/files/MLTSS%20ombudsman%20case%20studies%20Dec.%202014.pdf>

outcome, provide these to the state and make available to CMS upon request.⁹⁸ Further, CMS expects that states adopt policies that require MCOs to provide the same amount and duration of LTSS while a reduction, modification, or termination is being appealed.⁹⁹

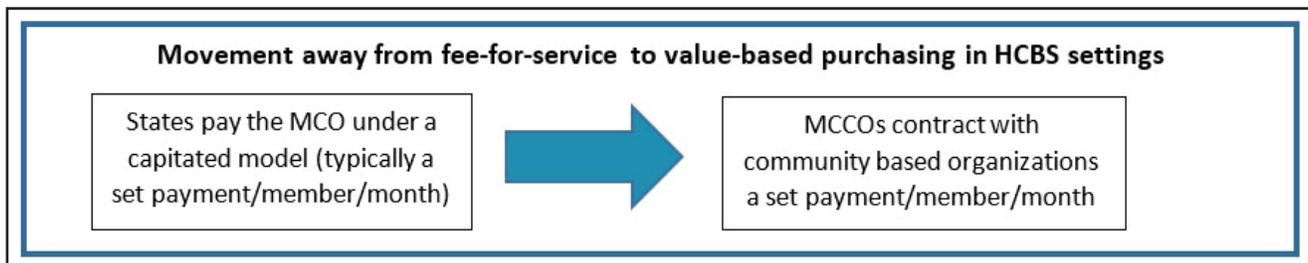
The State's Contract with MCOs

Because “in many states, managed care is viewed as the chief vehicle for transforming the delivery of Medicaid services to beneficiaries with chronic disabilities and illnesses”¹⁰⁰ states are using the contracts with MCOs to influence service delivery and drive systems change.

Many states are building requirements into MCO contracts and also using financial incentives to help shift institutional placements to home and community-based settings (HCBS).¹⁰¹ These contracts define the services that are to be required, set the payment structure and outline the penalties that will be enacted if the MCO doesn't meet the identified performance measures. States will outline in both their request for proposals and their contracts with the MCO what they will require of both the MCO and its contractors. For example, it will detail how MCOs will assess individual need, service authorization, person-centered planning, and service coordination for recipients of LTSS.¹⁰² In 2016, the CMS rule on Medicaid Managed Care allowed states for the first time to direct and align how health plans pay their providers.¹⁰³ This means that states can, for example, require plans to tie payments to performance. Typically, in a capitated model payment system, the state will pay the MCO a set per member per month rate and the MCO can then negotiate their payment rates with their subcontractors. Several states are starting to require the MCOs to implement a value-based payment model with community providers to help improve efficiencies and drive innovations.¹⁰⁴

The state reimburses us a higher rate for those with disabilities or chronic conditions. The rate is based on historical claims.
-Minnesota MCO

Shifting from the fee-for-service model to a value-based payment within HCBS offers community-based organizations the opportunity to offer innovations which improve recipient health and quality of life while being financially rewarded for doing so. Many MCOs are financially motivated to identify ways to improve outcomes as states frequently add incentives within the contracts which reward the MCO for meeting certain goals.¹⁰⁵ CBOs can help MCOs achieve these goals.



With MLTSS, the role of the state changes, shifting from being the administrator of LTSS to that of a ‘watchdog.’ The state is obligated to hold the MCOs accountable for adhering to the contract requirements and the federal government holds the state accountable.¹⁰⁶ The state can withhold

98 <https://www.gao.gov/assets/690/686550.pdf>

99 <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf>

100 https://ncd.gov/rawmedia_repository/20ca8222_42d6_45a5_9e85_6bd57788d726.pdf

101 http://nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17_0.pdf

102 <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/MLTSS%20Assessment%20Authorization%20Planning%20Management%2011-13-17.pdf>

103 <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicaid-managed>

104 <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>

105 https://www.ncqa.org/Portals/0/Programs/Accreditation/NCQA1086-0917_LTSSWhitePaper_Web.pdf?ver=2017-12-12-085014-077

106 <https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care/>

payments or penalize the MCO for not meeting the minimum standards.¹⁰⁷ It is important to note that MCOs are only bound to provide the services that are outlined in their contract with the state.¹⁰⁸ This is why it is often said that the MLTSS programs are only as good as the state contract with the MCOs.¹⁰⁹ There are many things that states can incorporate into contracts (and many things stakeholders can advocate for) which will ensure that quality services are provided. The following are examples that states are incorporating into contracts to ensure quality services:

Establish Robust Quality Measures That are Easy to Access and Understand

When CMS issued the Medicaid Managed Care new rule in 2016, they required states to develop *standard performance measures* for MLTSS plans, effective on or after July 1, 2017, related to quality of life, rebalancing, community integration activities, transitional care, and whether the consumer received the services and supports outlined in the care plan.¹¹⁰ While there is a lot of work being done in this area, there are no universally-agreed upon MLTSS standards. This means that to comply with the CMS Managed Care rule, each state will need to decide what these measures will be and no two states will likely have the same measures. The National Core Indicators (NCI) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) HCBS are two examples of tools used to measure LTSS programs in states.¹¹¹ In 2017, members of the National MLTSS Health Plan Association came together to develop thirty-six performance measures which they hope to incorporate into their plans and help to build consensus for the adoption of nationally-agreed upon measures.^{112, 113}

Having robust quality measures which are easily accessed and understood by stakeholders can help to improve service delivery. Individuals can select the care plan based on the quality of services provided by the MCO. When states tie quality measures to MCO contracts and align these with the MCO payments, they incentivize the MCO to meet the specific measures identified within the state contract. These measures can help to drive systems change and help improve beneficiary outcomes as they will be the areas the MCO prioritizes. For example, MCOs in **Minnesota, Tennessee, Texas, and Wisconsin** are offered performance incentives or pay-for-performance bonuses when they meet or exceed quality standards.¹¹⁴

Texas is one state that stands out for their reporting of LTSS performance measures.¹¹⁵ Many states are using the NCI to identify outcomes for HCBS and stratify by Managed Care Organizations.¹¹⁶ **Texas**

When the state moved part of our Medicaid Waivers under the management of Managed Care Organizations it created confusion for recipients who were not certain who to contact if there were problems. Many weren't sure if they should contact the state or one of the Managed Care Organizations.

-Tennessee Stakeholder

Texas has invested more funding to expand the minimum 400 surveys required by NCI. This is important if you're going to use NCI to evaluate MCOs. The sample size of 400 surveys isn't large enough to be considered statistically valid to rate quality. If you have 3 MCOs, this means you're only surveying 133 individuals in each plan.

-Disability Researcher

107 https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf

108 <https://www.macpac.gov/subtopic/key-federal-program-accountability-requirements-in-medicaid-managed-care/>

109 Interview. Alan Bergman, 2017.

110 <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>

111 <http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf>

112 <https://www.chcs.org/advancing-medicaid-managed-long-term-services-supports-programs-whats-next>

113 Interview. Joe Caldwell, 2018.

114 https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf

115 Interview. Joe Caldwell, 2018.

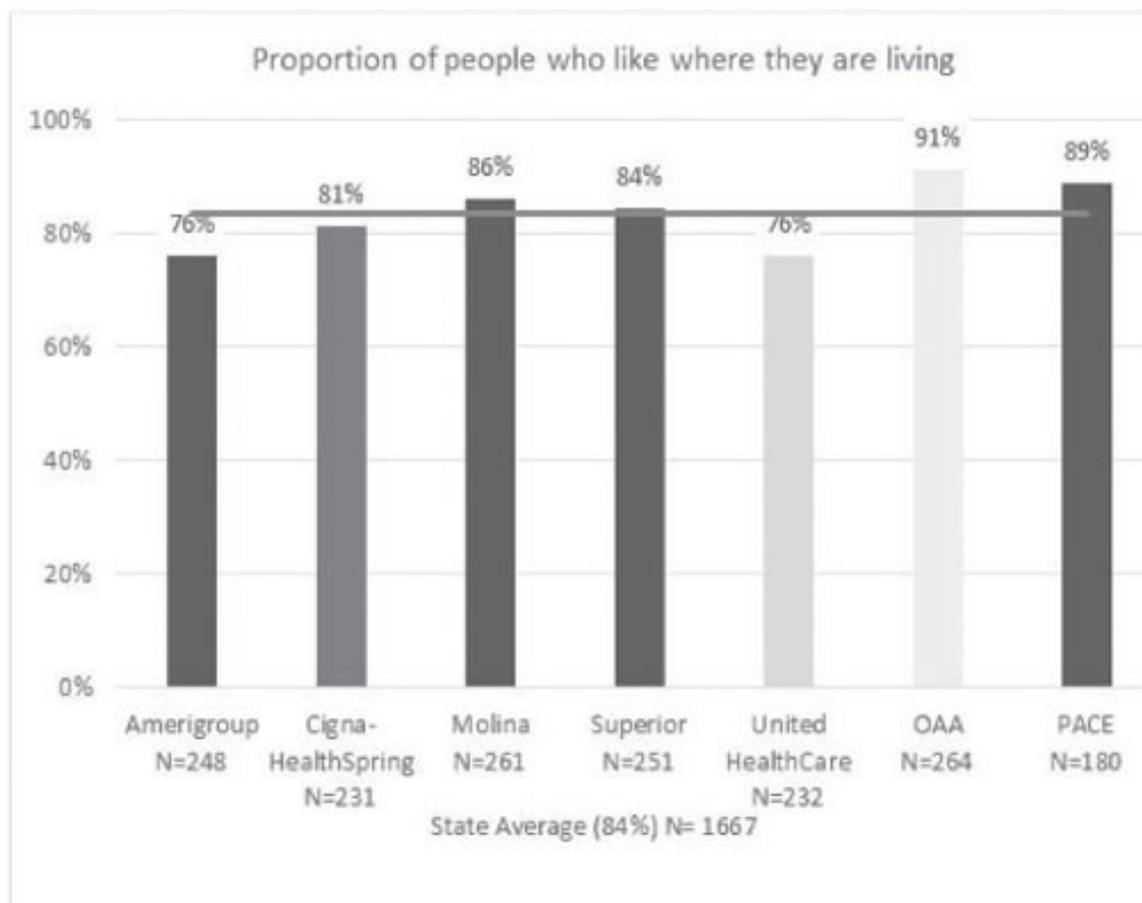
116 <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>

uses the NCI-Aging and Disability state data to detail managed care organizations’ performance to stakeholders and other interested parties.¹¹⁷ These performance measures allow stakeholders to compare the services delivered through the MCOs which in turn can be used to help individuals select the MCO which offers the best service or who offers better quality in a service that the individual prioritizes. It also allows states to look broadly at their systems and make needed changes.¹¹⁸ **Kansas** requires their MCOs to use NCI data in their quality improvement strategies.¹¹⁹

It’s important to note the NCI is designed to evaluate a state’s long-term care *system*, and states use a sampling approach to collecting data. While some states (such as Minnesota) oversample, not every LTSS recipient gets a survey. Many other efforts are currently underway to better understand the landscape of potential LTSS measurement indicators and tools. These include the Research and Training Center on Outcome Measurement, funded by NIDILRR at the University of Minnesota, and the recent work of the National Quality Forum. A separate NIDILRR-funded RRTC on Community Living Policy has also engaged in this policy area. It is now located at the Lurie Institute for Disability Policy at Brandeis University.

Examples of 2 Measures from National Core Indicators-AD Survey (Texas 2015-16 Report)

Graph 8. Proportion of people who like where they are living

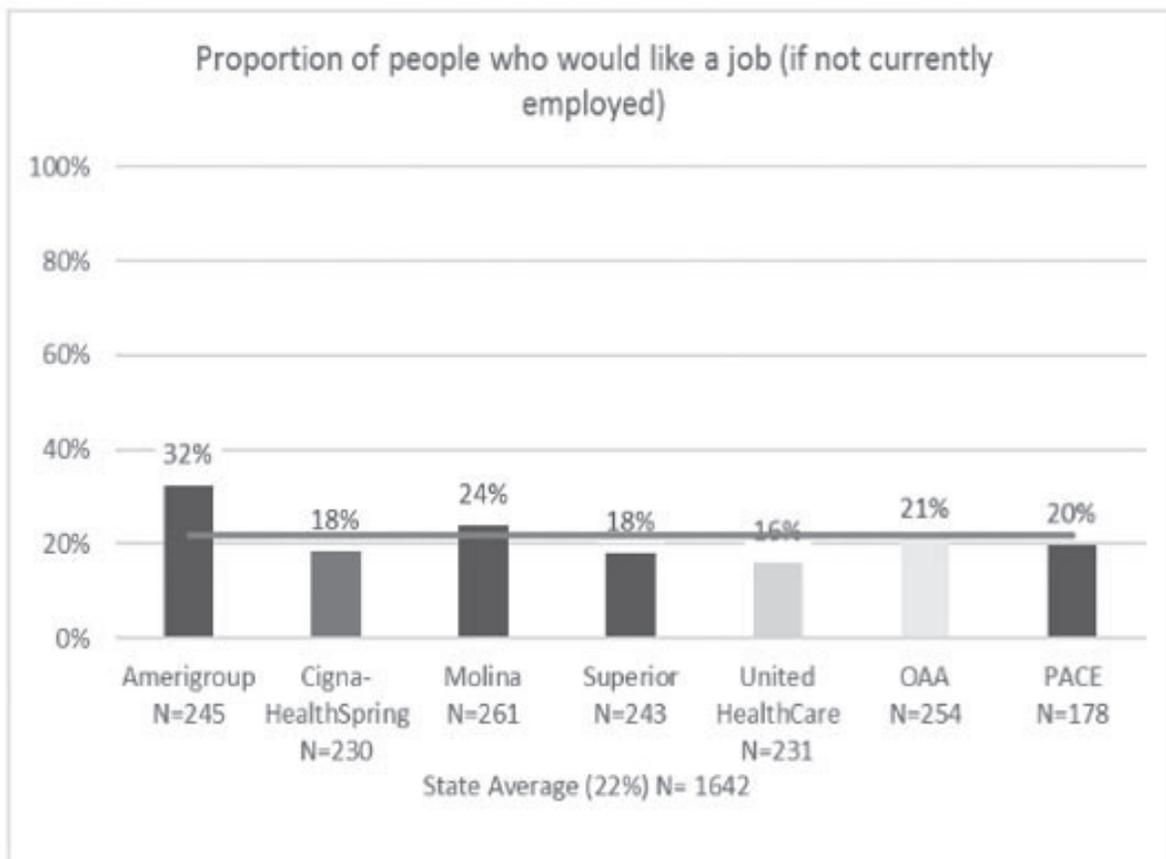


117 https://nci-ad.org/upload/state-reports/NCI-AD_2015-2016_TX_state_report_FINAL_1.pdf

118 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be>

119 <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>

Graph 102. Proportion of people who would like a job (if not currently employed)



Rebalancing Institutional LTSS to HCBS

MLTSS presents the opportunity for states to set their contracts in a manner that will incentivize MCOs to provide care in home and community-based settings and rebalance or shift expenditures from institutional settings to HCBS.¹²⁰ States can also structure their payment model to adjust annually so that they can meet defined targets.¹²¹ Several states with MLTSS have seen a rebalance from institutional to HCBS settings after MLTSS implementation. For example, **Arizona** has been running a MLTSS program for over 25 years. In that time they've slowly transitioned away from institutional settings with 86 percent of MLTSS consumers in community settings and 68 percent living in their own homes in 2016.¹²² **Tennessee** began its MLTSS program in 2010 and since that time has shifted and increased the number of participants in community settings from 17

MCOs don't have experience with long-term care and their case coordinators don't have training. When the state moved Money Follow the Person (a program that helps individuals transition from nursing and institutional settings to HCBS), away from the Centers for Independent Living to the management of the MCOs, we saw a decline in the program. The MCOs did not have the passion for the program like the Centers for Independent Living.

- Illinois Stakeholder

120 http://nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17_0.pdf

121 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

122 <http://nasuad.org/hcbs/article/demonstrating-value-medicaid-mltss-programs>

percent to 44 percent.¹²³ Patty Killingsworth, Assistant Commissioner and Chief of Long-Term Services and Supports, Bureau of TennCare says that she attributes some of the success they've seen by viewing the costs of both institutional and home and community services as one global budget and including both institutional settings and HCBS benefits into the MLTSS Managed Care program.¹²⁴ For example, **Tennessee** provides the same payment to MCOs whether the care recipient resides in a HCBS setting or in an institutional setting. Recognizing that typically it costs less to serve individuals in HCBS, providing the same capitated payment to MCOs for individuals in HCBS settings and institutional settings incentivizes the MCO to transition the individual who needs supports to HCBS and help them remain in the community. Under this payment structure, the MCO will be responsible for paying for the more expensive institutional setting but will not receive any additional payment. The savings realized by the MCO can be reinvested for other services or be reinvested in the MCO plan.¹²⁵ Finally, the state has leveraged the Money Follows the Person (MFP) program by offering MCOs \$2,000 for each person who transitions from institutional care and \$5,000 if that person stays in the community for an entire year.¹²⁶

127

Some states have reallocated savings achieved through MLTSS by rolling it back into the Medicaid program. For example, **Kansas'** waiver designates savings to increase the number of 1915(c) HCBS waiver slots to serve beneficiaries on the waiting list, subject to state legislative appropriations while **Vermont's** waiver states that the state will add resources equivalent to at least 100 additional HCBS waiver slots per year over 10 years to further the demonstration's goal of serving more beneficiaries.¹²⁸

Ensure Adequate Provider Networks

Within MLTSS, CMS requires states to develop network adequacy standards. Monitoring adequacy for acute care was defined by CMS, however CMS allows states to develop standards other than time and distance for LTSS providers that travel to a consumer to deliver services, effective on or after July 1, 2018.¹²⁹ This is a significant requirement because it sets the standards for the number of providers that MCOs will contract with within a geographic area.

Technology is frequently being used to help monitor network adequacy. For example, states are using geo-tracking to identify providers, tracking Electronic Visit Verification (EVV) system reports, monitoring the time between service request and service delivery, tracking member complaints and grievances, providing member and provider satisfaction surveys and monitoring the provider network turn-over.¹³⁰

Three states (**DE, TN and NJ**) required plans to submit annual network adequacy plans that describe their existing provider network, how they monitor the timeliness of care, and how they will address deficiencies.¹³¹ "**New Jersey's** contract is unique because

In Pennsylvania, the University of Pittsburgh Medical Center (UPMC) is one of three Managed Care Organizations and currently has the majority of participants. An advantage to UPMC being a large medical system means that UPMC has a large provider network of both primary care and specialists. Many individuals probably selected this plan due to name recognition. However, for those that did not select a plan, the formula used to auto enroll individuals into the plans likely took network adequacy into consideration. Since UPMC has a large provider network, this likely skewed the enrollment.

-Pennsylvania Stakeholders

123 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

124 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/> (from 23:50)

125 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

126 <https://www.chcs.org/resource/strengthening-long-term-services-supports-reform-strategies-states/>

127 <http://files.kff.org/attachment/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers-issue-brief>

128 <http://files.kff.org/attachment/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers-issue-brief>

129 <http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf>

130 <https://www.healthmanagement.com/wp-content/uploads/12-8-15-HMA-Provider-Network-Adequacy-Webinar-1.pdf>

131 <http://www.nasuad.org/sites/nasuad/files/Final%20HCBS%20Network%20Adequacy.pdf>

they developed a survey that MCOs are required to use to evaluate both programmatic and physical accessibility of their provider network.”¹³²

Provide Support to Family Caregivers

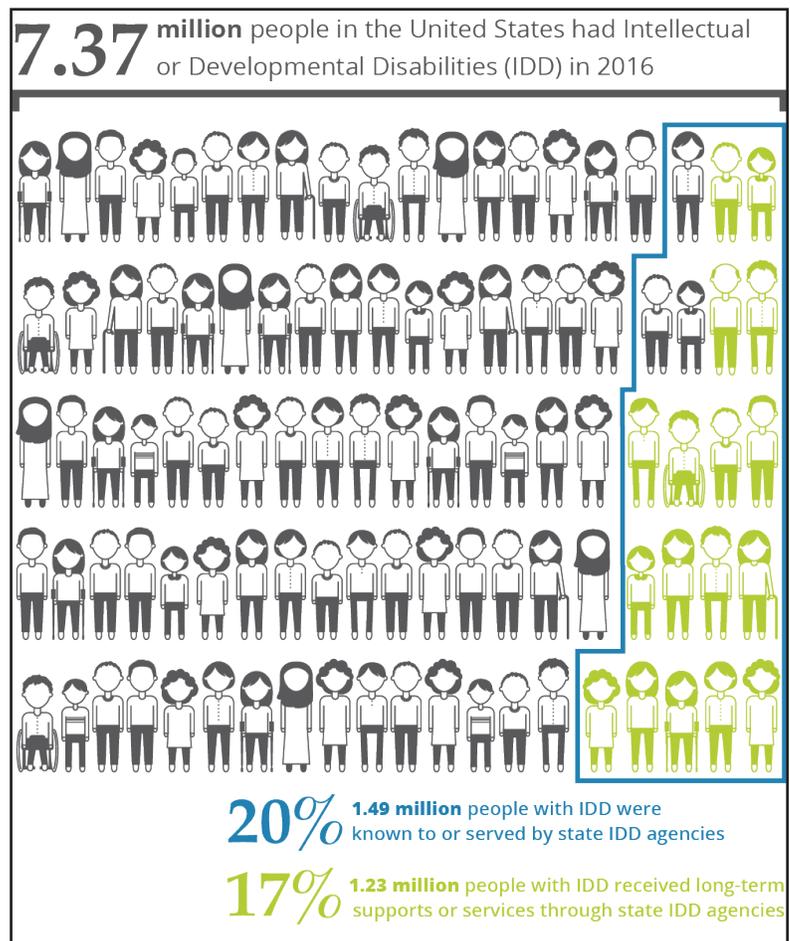
Family caregivers are the backbone of our long-term services and support systems. In the U.S., the majority of LTSS is provided by unpaid caregivers—family or friends.¹³³ Their economic impact of uncompensated care in 2013 surpassed total Medicaid spending (\$449 billion) and nearly equaled the annual sales (\$469 billion) of the four largest U.S. tech companies combined (Apple, Hewlett-Packard, IBM and Microsoft).¹³⁴

Of the estimated 6.2 million people in the United States with intellectual or developmental disabilities (IDD), most live with their families.¹³⁵ Recent studies from the University of Minnesota¹³⁶ estimate that less than 1/5 of individuals with IDD are actually being served by IDD agencies.

MCOs have an opportunity to support families in their caregiving role which in turn will likely keep the care recipient in the home setting. MCOs are starting to identify ways they can help decrease caregiver stress and burnout and improve the health of both the caregiver and care recipient.

In **South Carolina, Texas, and Tennessee**, MCOs are required to assess the needs of family caregivers and help address the caregivers’ needs as there is recognition that overall wellbeing of the care provider often impacts the care of the care recipient.¹³⁷ **Tennessee** also requires the MCOs to provide referrals for family supports, provide the family caregiver the name and contact information of the Care Coordinator.¹³⁸

California, New Mexico, Massachusetts, and Wisconsin have adopted optional Medicaid policies to provide training to family caregivers to help them carry out caregiving tasks in the home.¹³⁹ **Wisconsin’s** Family Care Benefit Design requires the MCOs to cover independent living skills training for the participant, training and education for the family caregiver and provides consultative therapeutic and clinical services for caregivers.¹⁴⁰ Ameri Health Caritas in **South Carolina** has a caregiver quality improvement goal to increase the use of respite by 10 percent each year to reduce caregiver burnout.¹⁴¹



132 <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Promoting%20Physical%20and%20Programmatic%20Accessibility%20in%20MLTSS.pdf>

133 <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer>

134 <https://www.aarp.org/caregiving/financial-legal/info-2017/family-caregiving-costly-jj.html>

135 <http://aaid.org/news-policy/policy/position-statements/community-living-and-participation#.WqH5369X6M8>

136 Graphic courtesy of Residential Information Systems Project: Minneapolis: University of Minnesota, Research & Training Center on Community Living, Institute on Community Integration. <https://risp.umn.edu/>. (2018)

137 http://www.longtermscorecard.org/~media/Microsite/Files/2017/2017%20Scorecard/AARP1202_EI_EmerInnovationLTSS_Oct31v2.pdf

138 http://www.longtermscorecard.org/~media/Microsite/Files/2017/2017%20Scorecard/AARP1202_EI_EmerInnovationLTSS_Oct31v2.pdf

139 <https://www.healthmanagement.com/wp-content/uploads/Caregiver-Supports-in-Medicaid-MLTSS-Webinar-2-28-2018.pdf>

140 http://www.longtermscorecard.org/~media/Microsite/Files/2017/2017%20Scorecard/AARP1202_EI_EmerInnovationLTSS_Oct31v2.pdf

141 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

Employment Supports

Employment helps lift individuals out of poverty, gain independence, meet friends and make individuals feel valued. Individuals with disabilities often face many barriers in obtaining employment. To help overcome some of the systems issues, states are working with MCOs to offer enhanced job coaching, exploration and benefits counseling. States are also starting to integrate these programs into MLTSS. For example, in **Tennessee's** Employment and Community First CHOICES (ECFC) MLTSS program, one of their benefit groups allows eligible individuals an annual budget of \$30,000 to help facilitate competitive, integrated employment and help the individual meet their career goals.¹⁴² Services that are available include job exploration, job coaching, benefits counseling, community transportation, independent living skills training, and respite, as examples.¹⁴³ **Wisconsin** offers a Family Care Benefit Package which includes daily living skills training, day treatment, pre-vocational services, and supported employment. Other Family Care services, such as transportation and personal care also help people meet their employment goals.¹⁴⁴

Sunflower Health Plan, a subsidiary of Centene runs the Project SEARCH program for the state.

-MCO Representative

Technology Innovations

States are using technology to improve the efficiencies of MLTSS. To support functional eligibility, states like **Connecticut, Indiana, Iowa, Nebraska, North Dakota and Tennessee** are using technology for pre-admission screening into nursing facilities for those with mental health conditions or who have IDD, which is federally mandated before these populations can be admitted. A level I assessment, or the Preadmission, Screening and Resident Review (PASSR), required for anyone entering a nursing facility to prevent inappropriate placements,¹⁴⁵ screens for clinical triggers to identify those with mental health conditions or IDD. Those who show any potential clinical signs go to another assessment. A face-to-face screening is limited to those most likely to have IDD or mental health.¹⁴⁶

Other states such as **Maine** and **New Jersey** are using financial transaction analysis technology to help prevent abuse and fraud related to the financial eligibility process. It can help identify assets and missing information reported on applications. These systems significantly reduce the amount of labor needed for these reviews and are also improving accuracy.¹⁴⁷

Remote monitoring and cell phone apps are being used to help support chronic disease management by transmitting data to care providers and also reminders to the care recipient. These same systems are being used to support Employment applications. **Tennessee** has implemented this technology in its Employment Waiver. For example, cell phones can be programmed to include directions for specific job tasks and allow access to a caregiver or job coach who is not immediately present but who can still lend support.¹⁴⁸

Expand and Improve Quality of the Direct Care Workforce

There is increasing recognition that having a well-trained, motivated LTSS workforce is directly linked to the quality of LTSS programs.¹⁴⁹ However, there are challenges within this workforce. For example, there is a serious shortage of individuals working in this field. The pay is low, with the average median

142 https://www.tn.gov/content/dam/tn/didd/documents/news/2017/waiver-reform/Amendment_27_ECF_CHOICES.pdf

143 <https://www.tn.gov/content/dam/tn/tenncare/documents/MemberBenefitTable.pdf>

144 <https://www.dhs.wisconsin.gov/familycare/whatisfc.htm>

145 <https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html>

146 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

147 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

148 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

149 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

earnings around \$10.49/hour and this workforce is aging.¹⁵⁰ In an effort to address the LTSS direct care workforce shortages and high turnover rates, 17 states reported that in FY 2017 or FY 2018 they planned to increase wages for direct care workers and/or engage in workforce development activities (recruiting, training, credentialing, etc.)¹⁵¹ For example, **Tennessee** has focused on workforce development to improve the quality of the workforce and also to help address the estimated shortage. Specifically, they are providing training and technical assistance using evidence-based methods for recruitment and mentorship in order to have better trained staff who can be retained and at the same time incentivize providers to adopt the practices that will improve the workforce. Additionally, they are working to leverage dollars for students coming out of school or adults going back to school. They are also working with secondary schools to offer college credits for those who are in the direct workforce and also pay a higher wage as workers obtain more skills.¹⁵² **New York** successfully amended an 1115 Medicaid Waiver in 2014 to provide up to \$245 million through March 2020 for initiatives to retrain, recruit and retain healthcare workers in the long-term care sector through their *Workforce Investment Program*. This program provides funding to organizations who can retrain, help retain and recruit individuals to work in the long-term care workforce. The primary goal of the program is controlling Medicaid costs by developing skilled staff who are able to work and provide supports in home and community based settings.¹⁵³

Housing-related activities and services

Access to affordable, accessible housing is often a barrier to community living. Further, SSI payments often are not sufficient to pay for a one room apartment.¹⁵⁴ Two states, **Arizona** and **Texas**, have focused activities on building affordable, accessible housing. While Arizona's MLTSS program has 68 percent of their beneficiaries who reside in their own homes,¹⁵⁵ the state is using the HUD Section 811 program to improve housing for individuals with disabilities. Arizona's project is called the Project-Based Rental Assistance Program (PRA) which is working to develop 54 rental units for extremely low-income adults 18 to 61 who have IDD. The PRA is a collaboration between across the Arizona's Department of Housing, Department of Health Services, Department of Economic Security Division of Developmental Disabilities and the Arizona Health Care Cost Containment System (AHCCCS). **Texas** also has a Section 811 PRA grant in which private developers of low income housing tax credit properties agree to set aside units for individuals with disabilities exiting institutions, young adults exiting foster care, and individuals with mental illness. In addition, Texas Medicaid leadership hosts regular teleconferences with MCOs, their community transition teams, and families of transitioning individuals to discuss transition issues and accessible, affordable housing options.¹⁵⁶

Because there is an increasing recognition by State Medicaid agencies and MCOs that inaccessible housing creates barriers to community living, "some states launching or refining MLTSS programs are: (1) creating new partnerships between their Medicaid agencies and state housing and disability agencies to increase housing options for LTSS beneficiaries; (2) dedicating Medicaid resources to establish strong housing and MLTSS program linkages and requiring MCOs to do the same; and (3) developing new or expanded supportive housing services to address the unique needs of LTSS subpopulations."¹⁵⁷ MCOs are also starting to focus on access to housing. For example, TennCare uses a Housing Specialist to help the MCOs identify housing resources, hold monthly conference calls for complex cases and also coordinates a housing conference to increase networking opportunities for builders, providers and housing authorities.¹⁵⁸

150 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be> (Sharon Lewis)

151 <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>

152 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

153 https://www.health.ny.gov/health_care/medicaid/redesign/2017/mltc_invest.htm

154 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be> (Sharon Lewis)

155 https://www.azahcccs.gov/Shared/Downloads/HCBS/AnnualHCBS_CMSReportCYE2015.pdf

156 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

157 <https://www.chcs.org/media/CHCS-MLTSS-Scan-7-20-16.pdf>

158 https://www.eiseverywhere.com/file_uploads/a5487da6f8a00e4142e0ff91e98285_Housing.pdf

Enhanced Benefits Offered by MCOs

One of the benefits of shifting the accountability for service delivery to MCOs is that they have the flexibility to provide benefits that are not in the Medicaid State Plan.¹⁵⁹ These services are called enhanced or value-added benefits. Typically these are offered to attract participants to select the MCO's health plan or because the MCO believes that the 'extra' services will reduce costs or improve the member's health or quality of life.¹⁶⁰ These benefits may improve a plan's ability to address members' unmet needs and prevent high-risk individuals from further medical or functional decline that would require admission to a hospital or nursing facility, or utilize other more expensive services.¹⁶¹ They can also help plan address the social determinants of health.

Common examples of enhanced benefits include an air conditioner for a child with asthma who has had frequent trips to the emergency room¹⁶² or providing gift cards to families who keep well-baby check-ups. **Florida's** MLTSS plans offer expanded services such as supports for nursing home transitions, dental and pharmacy benefits, vision services, hearing evaluations, non-medical transportation and over-the-counter medications.¹⁶³ **Tennessee** allows its MCOs to provide "cost-effective alternatives" if the services are less expensive than Medicaid or if it prevents the individual from institutional placements.^{164, 165} A 'transition allowance' is one such example and allows up to \$2000 for rent, utilities, and additional attendant care.¹⁶⁶ **Kansas'** plans offer enhanced benefits that include extra hours of respite,^{167, 168} additional days of attendant care,¹⁶⁹ free smart phones,¹⁷⁰ and payment for caregivers to accompany members to Medicaid-covered appointments.¹⁷¹ Some MCOs are providing home modifications to recipients with physical limitations, viewing it as a less expensive alternative than providing care in a nursing facility.

The doctors and state will say that MCOs offer case management and will improve outcomes, but in reality people who need care are ranked by risk and case management is only really offered by those who are 'high' risk- or those that cost a lot.

-Illinois stakeholder

One MCO has contracted with Centers for Independent Living to ensure that healthcare providers' services are both programmatically and physically accessible.¹⁷² Having MCOs work with the disability community and healthcare providers is one example of how a MCO can use their contracting power to help influence accessibility standards. MCOs are providing membership to gyms, offering gift cards to participants for staying current on vaccinations and annual physicals. Some are even providing respite benefits. MCOs have tremendous latitude regarding the innovations and benefits they offer.

Innovations for Individuals with IDD

Many states have moved medical services for individuals with IDD into Medicaid managed care but have carved out MLTSS. Concerns about the unique needs of individuals with IDD, the limited

159 http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202017/17-29,17-30/McCarthy%20Oklahoma%20Legislative%20Committee%20v2.pdf

160 http://www.chcs.org/media/PRIDE-Value-Added-Services_012617.pdf

161 http://www.chcs.org/media/PRIDE-Value-Added-Services_012617.pdf

162 http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202017/17-29,17-30/McCarthy%20Oklahoma%20Legislative%20Committee%20v2.pdf

163 <http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

164 <https://www.tn.gov/content/dam/tn/tenncare/documents2/ben08001.pdf>

165 <http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

166 <http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

167 <https://www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Sunflower-member-handbook-English.pdf>

168 https://www.myamerigroup.com/Documents/KSKS_SSI_LTC_W_ValueaddedBenefits_ENG.pdf

169 https://www.myamerigroup.com/Documents/KSKS_SSI_LTC_W_ValueaddedBenefits_ENG.pdf

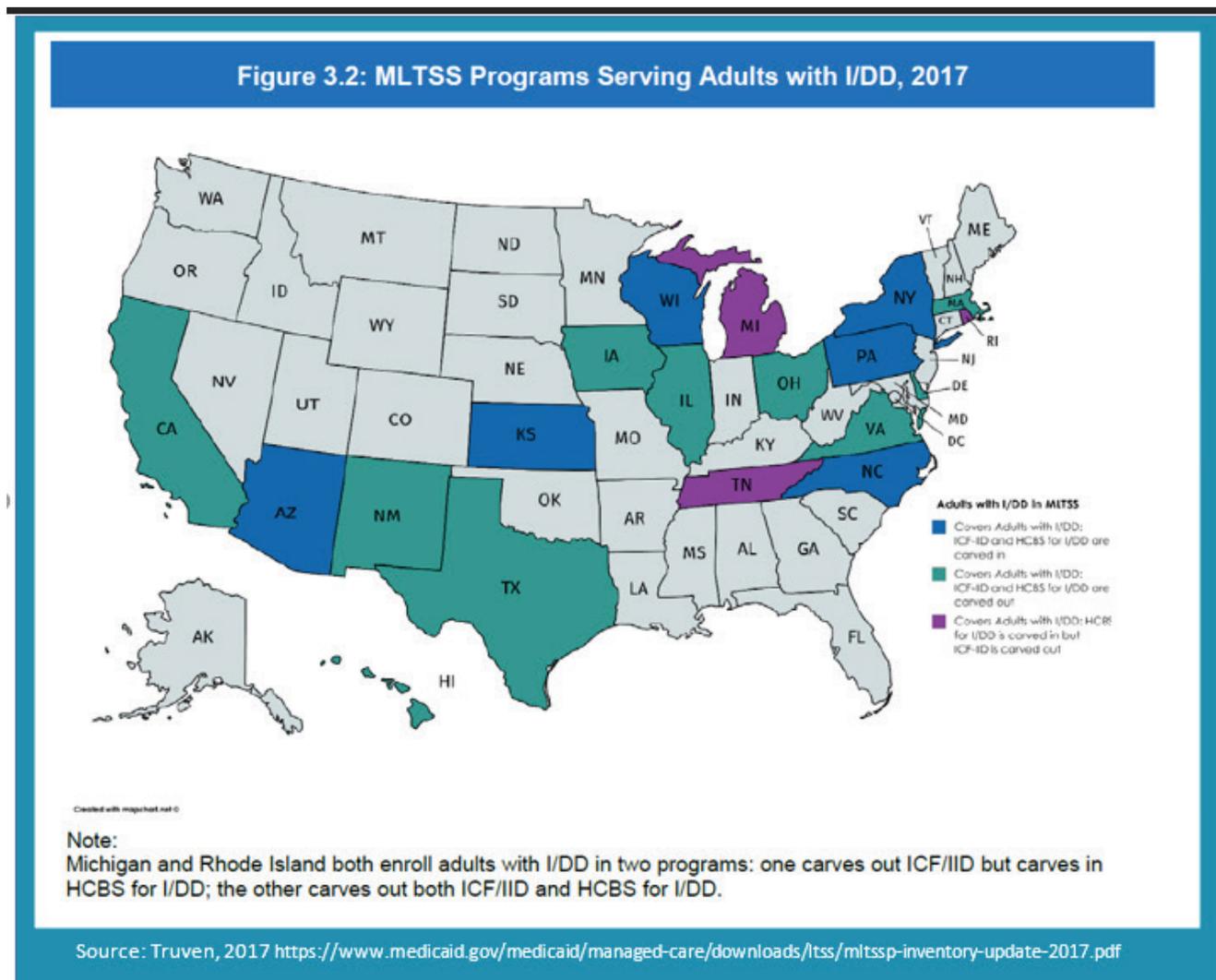
170 <https://www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Sunflower-member-handbook-English.pdf>

171 https://www.myamerigroup.com/Documents/KSKS_SSI_LTC_W_ValueaddedBenefits_ENG.pdf

172 Interview. Sarah Triano. 2018.

experience of commercial MCOs in managing this population, and lack of experienced care coordinators who have served individuals with IDD and their families have been identified as reasons.¹⁷³ However, state interest in enrolling individuals with IDD into managed care is growing.¹⁷⁴ For example, **Kansas** and **Iowa** have implemented mandatory MLTSS for Individuals with IDD while **Tennessee** has a MLTSS waiver that individuals with IDD can opt into. Several states, such as **Nebraska** and **Pennsylvania**, are taking steps to move in this direction as well and other states are exploring this option, including **Florida** and **New Hampshire**.¹⁷⁵ As states try to control costs and decrease fragmented care delivery and as states and MCOs have gained more experience there will likely be momentum in this arena.¹⁷⁶ For example, when **Texas** issued their request for proposals for MLTSS, they asked for a description of how the MCO would serve individuals with IDD.¹⁷⁷

Following are examples of how states are incorporating MLTSS to support individuals with IDD.



173 <http://www.nasddds.org/uploads/webinars/Managedcareauthwebinar.pdf>

174 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

175 <http://www.nasddds.org/uploads/webinars/Managedcareauthwebinar.pdf>

176 http://www.nasud.org/sites/nasud/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17_0.pdf

177 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be> (Sharon Lewis)

Support Waivers

A relatively new model that is being used by states to support individuals with IDD is a “Support Waiver.” These waivers are limited in their services but offer budget predictability for states as there is a set budget and a set number of slots. States that have started to use “Support Waivers” are doing so to complement other waivers, help to provide limited services to help avoid crisis placements or more costly interventions, and embed them in the DD delivery system continuum.¹⁷⁸ These waivers acknowledge that families provide many informal supports and help to support caregivers.¹⁷⁹ For example, **Tennessee** created a Support Waiver called the ‘the Employment and Community First CHOICES (ECFC), which is managed by the MCOs. This is a voluntary program for those who are already receiving services through the state’s 1915c ID waiver but mandatory for any new enrollees seeking HCBS.¹⁸⁰ When this MLTSS program became approved by CMS, **Tennessee** became the first state in the country to develop and implement an integrated, home and community-based services program, aligning incentives toward promoting and supporting integrated, competitive employment and independent living as the first and preferred option for individuals with intellectual and developmental disabilities.¹⁸¹ The program has three benefit groups for individuals with IDD. The **Essential Family Supports** provides \$15,000 annually for families caring for a child under age 21 who has an IDD and lives at home. Funds can be self-directed to pay for respite, transportation, specialized childcare, etc. The **Essential Supports for Employment and Independent Living Support Waiver** provides an annual budget of \$30,000-\$36,000 for services for adults age 21 and older who have an IDD but do not qualify for a nursing home level of care. This waiver will pay for job coaching, independent skills training, pre-employment services, respite, transportation, etc. (A person age 18-21 with IDD may be enrolled in this group, if the person cannot live with his or her family anymore.) The Comprehensive Supports provides an annual budget of \$45,000 to provide services for adults 21 and older who would qualify to get care in a nursing home. (A person age 18-21 with IDD may be enrolled in this group, if the person can no longer live with his or her family.)

Support Waivers are great because they are providing services to individuals with disabilities and families -taking them off of the state waiting list. However, are they a ‘false promise’? Meaning that those on the waiting lists have been waiting for a full set of comprehensive services and the support waivers offer a set budget with less services.

-Disability Policy Specialist

Recent Family Support Waivers were approved for both Pennsylvania and Maryland.¹⁸²

Maryland also offers two support waivers. Implemented in 2018, **Maryland’s Family Support Waiver** provides individual and family supports for children birth to 21 with developmental disabilities and reduces the state IDD waiting list by 400 individuals.¹⁸³ It offers families a per person capped budget of \$12,000 to access community-based service options for after school, nights, and weekends.¹⁸⁴

Maryland also implemented a **Community Support Waiver** in 2018 which is also anticipated to reduce their IDD waiting list. This lifespan waiver offers a capped budget of \$25,000 and is limited to 400 slots.¹⁸⁵ It enables participant and family self-direction and offers a variety of community-based service options including employment and meaningful day and support services.¹⁸⁶ It also offers flexibility to

178 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be> (Sowers)

179 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be>

180 <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

181 <https://www.tn.gov/content/dam/tn/tenncare/documents/introductionToEcfChoices.pdf>

182 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be> (Sowers from 35:20-38:05)

183 https://dda.health.maryland.gov/Pages/DDA_FAMILY_SUPPORTS_Waiver.aspx

184 <https://dda.health.maryland.gov/Documents/ARC%20MD%20Convention%20-%20DDA%20Family%20Supports%20and%20Community%20Supports%20Waivers%20-6-2-17.pdf>

185 https://dda.health.maryland.gov/Pages/Community_Supports_Waiver.aspx

186 <https://dda.health.maryland.gov/Documents/DDA%20Community%20Supports%20Waiver%20%20Webinar%208-9-17.pdf>

move dollar amounts among line items within the approved person-centered plan to meet emerging and changing needs of the recipient.¹⁸⁷

Pennsylvania’s Person/Family Directed Support Waiver was approved by CMS in 2017¹⁸⁸ and provides individuals with DD and autism access to a budget of \$33,000 annually which can be exceeded by \$15,000 for advanced supported employment or supported employment services.¹⁸⁹

New Models

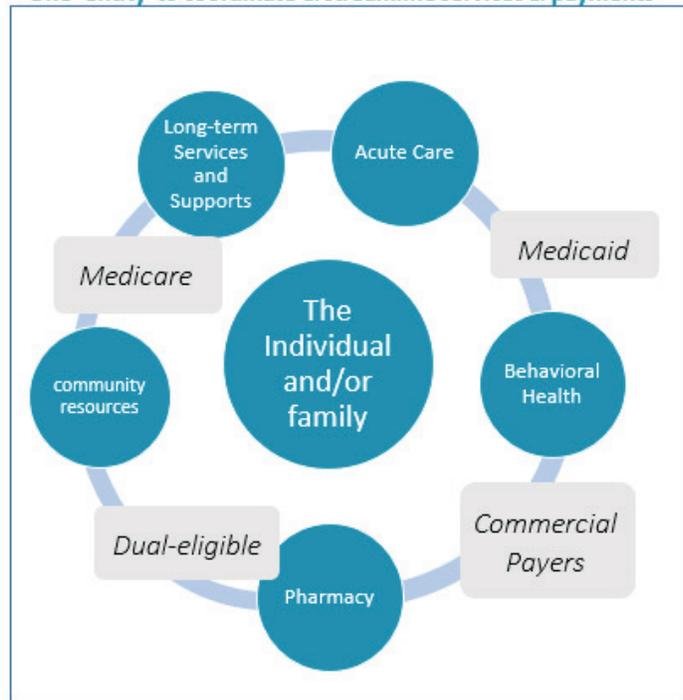
Several states are working to bring the management of both service providers and payers under one umbrella to better serve the ‘whole person’ and decrease the fragmentation across delivery systems. For example, many states are building from the Dual-Eligible Demonstrations offered by the Centers for Medicare and Medicaid Services (CMS) to better coordinate the financing between Medicare and Medicaid. This is also likely a priority for states as dually-eligible individuals have the highest needs and also have the highest costs¹⁹⁰ of MLTSS program enrollees.

There are approximately 10.2 million people who are eligible for both Medicaid and Medicare (called dual eligibles) and individuals with disabilities under the age of 65 comprise about 41 percent (4.1 million) of that number. About 7 percent of duals are individuals with IDD.¹⁹¹ Individuals dually enrolled in Medicare and Medicaid receive most of their primary and acute care services from Medicare and LTSS and other services from state Medicaid programs. Medicaid wraps around Medicare’s coverage by providing assistance with Medicare premiums and cost sharing and by covering some services that Medicare does not cover, such as LTSS.¹⁹² The financing differences can lead to fragmented, uncoordinated care.¹⁹³ States are looking for ways to increase the coordination of these programs and decrease costs.¹⁹⁴

New York IDD Duals Demonstration

Started in 2015, this 1915a waiver program supports individuals with IDD who are eligible for both Medicare and Medicaid services. As of November 2017, 701 individuals were participating in this voluntary program.¹⁹⁵ The Fully Integrated Duals Advantage for individuals who have IDD (FIDA-IDD) program brings the management of Medicare, Medicaid, Developmental Disabilities non-waiver and waiver services and community and natural supports under ‘Partners Health Plan,’ a non-profit MCO.¹⁹⁶ Participants

One ‘entity’ to coordinate & streamline services & payments



187 https://dda.health.maryland.gov/Pages/Community_Supports_Waiver.aspx

188 <https://www.nasddds.org/news/cms-approves-two-waiver-renewals-for-pa-with-big-changes-to-day-and-employ/>

189 <http://www.dhs.pa.gov/learnaboutdhs/waiverinformation/personfamilydirectedsupportwaiver/index.htm>

190 <https://www.integratedcareresourcecenter.com/sites/default/files/DuallyEligibleIndividualsFactSheet03112019.pdf>

191 <https://www.thearc.org/what-we-do/public-policy/dual-eligibles>

192 <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>

193 http://www.chcs.org/media/MLTSS_FactSheet-06-26-17.pdf

194 https://www.macpac.gov/wp-content/uploads/2015/01/Duals_DataBook_2015-01.pdf

195 <https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

196 https://opwdd.ny.gov/sites/default/files/documents/FIDA-IDD_Individual_Families_presentation2.pdf

are assigned a two-person care team who help to coordinate care by assessing needs, scheduling appointments, and arranging for transportation.¹⁹⁷ Participants also have access to an ombudsman who can help participants navigate benefits, understand their rights and appeal any denials or file an appeal with the plan.¹⁹⁸ The goal of the program is to “improve the participant experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost-shifting between Medicare and Medicaid and achieve cost savings for the state.”^{199 200}

Provider-led Models

An emerging alternative to health plans is the provider-led model where these entities act much like a MCO, assuming some level of financial risk and making decisions about care utilization (or contracting with administrative entities). Both **New York** and **Arkansas** are using emerging provider-led managed models.²⁰¹

Arkansas

“The Provider-led Arkansas Shared Savings Entity (PASSE) is a new model of care where providers of specialty and medical services enter into partnerships with experienced organizations that perform the administrative functions of managed care. These providers and their managed care partners will serve individuals who have high behavioral health needs and intellectual and developmental disabilities who are eligible for Medicaid.”²⁰² Providers must maintain ownership of 51 percent of the PASSE. Each PASSE must operate statewide, meet the federal managed care rules, register with the Arkansas Department of Insurance and agree to report to both the Department of Insurance and the state Department of Human Services.²⁰³

New York

New York is using the Health Home provision of Medicaid to enhance care coordination and improve the person-centered planning processes to support individuals with IDD across systems.²⁰⁴ A health home is a Medicaid optional State Plan benefit established under the Affordable Care Act to help coordinate care for individuals with chronic conditions.²⁰⁵ The state implemented the Health Home program in 2012 targeting adults primarily with mental health conditions with the intent to expand to serve other populations.²⁰⁶ In July 2018, the People First Care Coordination Organization Health Homes (CCO/HH) program was launched. The CCO/HH will be the first phase and foundation for the transition to managed care serving individuals with IDD.²⁰⁷ The state also transferred the services offered under their 1915c HCBS waiver to an 1115 waiver to help with the transition to managed care and also movement to value-based payments.²⁰⁸ In phases two and three, the program will move from fee-for-service to value-based payment and also from voluntary to mandatory enrollment.²⁰⁹ The focus of the

197 https://opwdd.ny.gov/sites/default/files/documents/FIDA-IDD_Individual_Families_presentation2.pdf

198 https://opwdd.ny.gov/sites/default/files/documents/FIDA-IDD_Individual_Families_presentation2.pdf

199 <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

200 <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOUIDD.pdf>

201 <https://www.youtube.com/watch?v=ukDikyDxl7c&feature=youtu.be> (Lewis. 2018. starting at 10:20)

202 <https://medicaid.mmis.arkansas.gov/general/programs/passe.aspx>

203 https://medicaid.mmis.arkansas.gov/Download/general/programs/PASSE_Bkgrd.pdf

204 <https://www.youtube.com/watch?v=XXIGoXmOvM8&feature=youtu.be>

205 <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>

206 <https://www.youtube.com/watch?v=XXIGoXmOvM8&feature=youtu.be>

207 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm

208 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/1115/final_revised_draft_transiton_plan_feb_2018_for_publication.pdf

209 https://www.youtube.com/watch?v=5IBTQfxKF_o

Health Home is to provide comprehensive case management that works to integrate services among hospitals, mental health providers, primary care, LTSS and community programs to help make the individual successful.

Accountable Care Organization (ACO) Models

Massachusetts

The state uses an 1115 Medicaid Waiver Demonstration, approved in 2016, to create Accountable Care Organizations (ACOs), provider-led organizations who are responsible for the quality and the cost of care for its members.²¹⁰ These ACOs select from three different models which combine the state's existing MCOs²¹¹ and Community Based Organizations (CBOs) to better integrate acute care, behavioral health, LTSS and health-related social needs.²¹² The LTSS programs are those limited to the Medicaid state plan and do not include the state's 1915c waivers.²¹³ The state received federal approval to use Delivery System Reform Incentive Program (DSRIP) funds through ACOs to implement flexible funding to address health related social needs.²¹⁴ The DSRIP funds will pay for things not traditionally reimbursable under Medicaid. For example, the DSRIP will pay for an air conditioner for a child with asthma to decrease hospitalization or Emergency Room visits or pay for home modifications needed to keep an individual in their home rather than a nursing facility. These flexible funding options are selected by the ACO²¹⁵ to help address the social determinants of health²¹⁶ and offered to improve individual health outcomes and decrease overall costs. The Massachusetts system is working to integrate providers, payers and CBOs to implement a system that drives innovations to improve both individual and population health.

Minnesota's Altair Accountable Care for People with Disabilities

Lutheran Social Services and Altair are working together to bring primary care, behavioral health and social services together to support individuals with IDD.²¹⁷ This initiative brings together four behavioral health specialists, six disability service providers, one primary care provider entity, and two local public health departments to partner in the delivery of care for over 6,500 people with disabilities in the Twin Cities, Minneapolis and St. Paul.²¹⁸ Behavioral health providers are incorporated into the state's certified Health Information Exchanges so they can access information and work with other members of the care team to address the needs of individuals with IDD in real-time.²¹⁹ Individuals who live in a traditional group home receive primary medical care onsite. Individuals who live in their own home or apartment can be treated through a clinic without walls approach that includes mobile services at home or in the workplace.²²⁰

210 <https://www.mass.gov/files/documents/2016/08/vk/mass-health-restructuring-overview-document.pdf>

211 <https://www.manatt.com/Insights/White-Papers/2017/Integrating-MassHealth-LTSS-Considerations-for-AC>

212 <https://www.chcs.org/massachusetts-medicaid-aco-makes-unique-commitment-addressing-social-determinants-health/>

213 https://bluecrossmafoundation.org/sites/default/files/download/publication/MassHealth_LTSS_2017_report_REVISIED%20FINAL.pdf

214 <https://www.chcs.org/massachusetts-medicaid-aco-makes-unique-commitment-addressing-social-determinants-health/>

215 <https://www.masspartnership.com/pdf/ACOMassHealthDeliverySystemProviderOverview.pdf>

216 <https://www.chcs.org/massachusetts-medicaid-aco-makes-unique-commitment-addressing-social-determinants-health/>

217 <http://dashconnect.org/wp-content/uploads/2016/10/Altair-LSSMN.pdf>

218 <http://dashconnect.org/2016/09/01/integrated-care-for-people-with-disabilities-lessons-from-an-accountable-care-organization/>

219 <http://dashconnect.org/wp-content/uploads/2016/10/Altair-LSSMN.pdf>

220 <http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs-285050.pdf>

<i>Managed Care Organizations</i>	<i>Accountable Care Organizations</i>
Typically are health plans run by either for-profit or non-profit insurance companies.	Are groups of doctors, hospitals and other health care providers who work together to coordinate care.
Care is provided through a network of providers establish by the MCO through agreements.	An individual’s primary care provider and their team work with you and their network of providers to meet your needs.
Their network of providers include Primary Care Providers, specialists, hospitals, behavioral health providers, and if LTSS is included, community based organizations.	The network is established by the Accountable Care Organization.

Rhode Island

Rhode Island has implemented an Accountable Entity (AE) Program to work with the state’s MCOs and utilize ‘Accountable Entities’, which are healthcare providers who will work with the MCOs to serve high risk populations and help to “build partnerships across payment systems, delivery systems and medical/ social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families.”²²¹ “An Accountable Entity (AE) is Medicaid’s version of an Accountable Care Organization (ACO) in which a provider organization is accountable for quality health care, outcomes, and the total cost of care of its population.”²²² They plan to roll out the program in three phases. The first phase will be the comprehensive care phase which will bring together providers who will manage acute, behavioral health and social support services. The second phase will include a specialized LTSS pilot where interested LTSS providers come together to create a continuum of care. Finally, the third phase includes a Medicaid pre-eligible pilot program. This program will be working to identify strategies which will help keep individuals who are at high-risk of nursing home placements in home and community settings.²²³ A primary goal of the AE Programs is to rebalance long-term care expenditures and utilization to home and community-based settings.²²⁴

Shared Savings Program

A shared saving program operates much like an ACO except the provider network agrees to be tracked on total costs and quality of care for the patients it serves, in exchange for the opportunity to share in any savings achieved through better care management.²²⁵ Provider participants in ACOs are financially incentivized to improve the quality and costs of healthcare.

Vermont

Vermont has utilized federal funding to transform its entire healthcare system. Vermont is using its’ All Payer Model and Medicaid Pathways programs to transform the state’s healthcare systems. These initiatives bring together all the major payers of health insurance-Medicaid, Medicare and commercial insurance to better support the integration of physical health, LTSS, mental health, developmental disabilities, substance use disorder treatment and children’s service providers.²²⁶ The overall goal of the All Payer model is an integrated health system that improves population health through the triple

221 <http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx>

222 <http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx>

223 http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/MedicaidAERoadmap.pdf

224 http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/MedicaidAERoadmap.pdf

225 http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SSP_and_ACO_FAQ_and_Chart_7.8.14.pdf

226 <https://legislature.vermont.gov/assets/Legislative-Reports/Act-113-Sec-12-Medicaid-Pathway-Report-12-30-16.pdf>

aim of improved health, decreased costs and improved patient satisfaction.²²⁷ Vermont has three Accountable Care Organizations and all have agreed to participate in the Shared Savings Program.²²⁸ CMS approved a five-year extension of Vermont's section 1115(a) Medicaid demonstration, Global Commitment Medicaid Waiver, which enables Medicaid to be a full partner in the Vermont All-Payer ACO Model. Medicaid and the Vermont All Payer ACO is an approach that helps the state explore alternative payment models and positions the state to take a 'one model' approach across federal payers.²²⁹

Oregon

Oregon was an early adopter of the Coordinated Care Organization (CCO) model. A CCO is a network of all types of health care providers (physical health care, addictions, mental health care, and LTSS) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). Currently, there are 16 CCOs who operate across the state.²³⁰ Before the CCO, the systems-delivery was siloed. Now, interdisciplinary teams are brought together to coordinate and provide person-centered care.²³¹ A strength of the Oregon CCOs is the transparent and continuous monitoring of quality measures, financial outcomes and other benchmarks being used to transform the state's healthcare system.²³²

Summary

Movement to MLTSS is gaining momentum across states and new and pioneering models are emerging. With this shift, stakeholders need to understand how these changes can impact service delivery and also understand that they can help states design quality MLTSS programs. Implementation of MLTSS is an opportunity to innovate and improve LTSS programs and UCEDDs are uniquely positioned to take a leadership role in this arena. Innovations occur through the state contract, through enhanced benefits by the MCOs or even by the community-based organizations that contract with the MCOs. It is our hope that this policy brief provides specific examples of new programs that have been developed through this systems change and also highlights states that are implementing quality programming in their LTSS programs. These examples can be referenced as states create new MLTSS programs and also renew or amend existing MLTSS programming and MCO contracts.

227 <http://www.csg-erc.org/wp-content/uploads/2016/07/VT-Medicaid-slides.pdf>

228 <https://healthcareinnovation.vermont.gov/sites/vhcup/files/documents/Final%20Vermont%20SIM%20Sustainability%20Plan%206.30.17.pdf>

229 http://gmcboard.vermont.gov/sites/gmcb/files/files/meetings/presentations/APM-GC-Waiver-for-GMCO_092916.pdf

230 <https://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx>

231 <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/LTC/Documents/MOU-Guidance.pdf>

232 <https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Pages/index.aspx>

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Appendix

For the most recent updates on state MLTSS implementation visit:

- Truven Analytics: <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>
- National Association for States United for Aging and Disability (NASUAD): <http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-map>
- The Centers for Medicare and Medicaid Services' State Profiles on MLTSS programs: <https://www.medicaid.gov/medicaid/managed-care/state-profiles/index.html>
- National Association for States United for Aging and Disability (NASUAD) MLTSS for IDD: <http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success.pdf>
- CMS' State Waiver list: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>
- Community Living Policy Center, University of California, San Francisco: <http://clpc.ucsf.edu/state-info>

LTSS Defined in Detail

Personal Care and Assistance: Are services that are most likely provided by a paid worker to help the individual who needs assistance meet basic care needs. Also called 'activities of daily living' (ADL) basic need examples include: dressing, eating, bathing, toileting, and transferring (such as from the bed to a chair). Personal assistance also includes Instrumental activities of daily living (iADL) which are defined as tasks performed that help an individual remain independent. Examples of iADLs include taking medication, managing money, housework, or shopping. (Administration on Aging, 2018) Personal care for an individual with a cognitive disability might include cueing or reminders to complete these activities. Source: <https://aspe.hhs.gov/basic-report/understanding-medicaid-home-and-community-services-primer#Chap4>

Health-Related Services: These include both skilled and unskilled services which help meet healthcare needs. Examples include: tube feedings, catheterization, and might also supplement (or provide coverage for) services not covered in the Medicaid state plan.

Specialty Services: Are services provided to help improve the overall function and abilities of the person who needs support. For example, a person with an intellectual disability may need cueing or a job coach to help obtain competitive employment or an individual with a physical disability may need a motorized wheelchair for mobility. Both habilitative services (services to help an individual who never had the skills acquire, retain and improve skills) and rehabilitative services (services provided to help an individual relearn skills) are covered under this category.

Adaptive Services: These are services which provide modifications to environmental settings to help individuals with physical disabilities overcome barriers to access. Examples may include widening doorways, or modifying a bathroom or vehicle.

Family and Caregiver Supports: These are supports which help the family caregiver continue in their caregiving role. An example includes providing the family caregiver a break- or Respite from their caregiving. Also included under this category includes providing training and education for caregivers in order to meet the needs of the person they are providing care.

Social Supports: These include providing companion services so that individuals who need LTSS are able to access and participate in community activities.

Case/Care Management or Service/Care Coordination: Includes assigning an individual who helps the care recipient and/or family navigate and coordinate medical and LTSS.

Examples of Timelines for Program Implementation

Pennsylvania infographic of MLTSS implementation timeline: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_227013.pdf

For the more information on “No Wrong Door/Single Entry into LTSS”

- ACL: <https://www.acl.gov/programs/aging-and-disability-networks/aging-and-disability-resource-centers>
- No Wrong Door: <https://nwd.acl.gov/index.html>
- Key Elements for a No Wrong Door System: <https://www.acl.gov/sites/default/files/programs/2016-10/NWD-National-Elements.pdf>
- Medicaid Claiming: <https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html>

For more information about LTSS Ombudsman Programs

- National Long Term Care Ombudsman Resource Center: <http://ltombudsman.org/>
- ACL & AoA Consumer Voice Conference: <http://theconsumervoice.org/uploads/files/issues/BeckyKurtzPPT.pdf>
- State Long Term Care Statutes/Regulations: <http://ltombudsman.org/uploads/files/support/links-to-sltcop-statutes-regs-feb16.pdf>

For more information about Network Adequacy

- Macpac: <https://www.macpac.gov/wp-content/uploads/2017/04/Managed-Long-Term-Services-and-Supports-Network-Adequacy-for-Home-and-Community-Based-Services.pdf>
- Truven: <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>
- Health Management Associates: <https://www.healthmanagement.com/wp-content/uploads/HMA-Webinar-2-25-16-MLTSS-Network-Adequacy.pdf>
- National MLTSS Health Plan Association: <http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf>

For more information about Supporting Family Caregivers

- Supporting Individuals and Families Information Systems Project: <https://ici.umn.edu/projects/view/142>
- Family Support Research and Training Center: <http://fsrtc.ahslabs.uic.edu/about-fsrtc/>
- ARCH National Respite Network Resource Center: <https://archrespite.org/contact-us>
- National Center on Caregiving: <https://www.caregiver.org/national-center-caregiving>
- United Healthcare Family Caregivers: Challenges and Opportunities: http://www.nasuad.org/sites/nasuad/files/TL_FamilyCaregiver.PDF

Technical Assistance Resources for Community Based Organizations

- Aging and Disability Partnership Toolkit: <https://www.aginganddisabilitybusinessinstitute.org/resources/managed-long-term-services-supports-mltss-toolkit-assessments/>
- HCBS Business Acumen Center: <http://www.nasuad.org/initiatives/hcbs-business-acumen-center>
- CBOs and MLTSS: http://nasuad.org/sites/nasuad/files/CBO%20Readiness%20for%20MLTSS%20Dec.%202014_0.pdf

MLTSS Performance Measures

- National MLTSS Health Plan Association: <http://mltss.org/2017/05/04/national-mltss-association-quality-framework-domains-measures/>
- National Core Indicators: <https://www.nationalcoreindicators.org/indicators/>
- CAHPS-HCBS: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html>
- Conceptual Framework for Quality and Outcome Measurement in LTSS: <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/CLPC%20LTSS%20Quality%20%26%20Outcome%20Framework%202%20pager.pdf>
- United Healthcare: <https://www.uhcommunityandstate.com/content/uhccomstate/content/articles/a-framework-for-success-for-mltss.html>



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