

Working PAPER

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Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States

March 2016

ABSTRACT

State Medicaid purchasing strategies for long-term services and supports (LTSS) are increasingly shifting from fee-for-service (FFS) to managed care. To better understand the rapid growth of managed long-term services and supports (MLTSS) programs and the diversity of ways in which states have structured their programs to achieve their goals, we conducted site visits in the summer of 2014 to five states that operate MLTSS programs: Arizona, Florida, Illinois, New York, and Wisconsin. We find that approaches to program design, protecting beneficiaries and providers in the transition to MLTSS, ongoing operations and oversight, and program evaluation and improvement are shaped by the institutions and stakeholders unique to each state. We also find that the ultimate goals of MLTSS – to improve access to and quality of care while holding down costs and rebalancing the long-term care system toward home and community-based services – are shared across states, but progress towards those goals varies according to each state’s previous experience with MLTSS. Our findings can inform the design and implementation of future MLTSS programs, and suggest opportunities for future research.

Keywords: Medicaid, managed care, long-term services and supports, home and community-based services

The research reported here was supported by the Medicaid and CHIP Payment and Access Commission (MACPAC), contract number MACP14306T2. The opinions expressed are those of the authors and do not represent views of MACPAC.

I. INTRODUCTION

To better understand the rapid growth of Medicaid managed long-term services and supports (MLTSS) programs and the diversity of ways in which states have structured their programs to achieve their goals, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Mathematica to conduct a series of five site visits to states that operate MLTSS programs. MACPAC and Mathematica visited five states – Arizona, Florida, Illinois, New York, and Wisconsin – that provided an opportunity to study how variations in state approaches to the design, implementation, and oversight of MLTSS programs may influence patient outcomes, access to care, quality of care, and cost of care across states.

This paper presents the predominant themes that emerged from conversations we had between August and September 2014 with stakeholders in each of the five site visit states. It highlights how differences in state MLTSS program features may contribute to patients' outcomes and to their satisfaction with programs. Also presented are crosscutting lessons to explore through further research. The major themes are organized by the four phases of a program life cycle: (1) design, (2) transitioning to MLTSS, (3) ongoing operations and oversight; and (4) evaluation and improvement. Study methods are described in Appendix A.

II. BACKGROUND

State Medicaid purchasing strategies for LTSS are increasingly shifting from fee-for-service (FFS) to managed care. As many as two dozen states are planning to have MLTSS programs in place by the end of 2014, up from eight in 2004 (Saucier et al. 2012). States have moved to managed care for a variety of reasons. First, the lingering effects of the recession—including reduced tax revenue, high unemployment, and high demand for Medicaid and other social services—are prompting states to both control the growth in costs and make payments more predictable (Gifford et al. 2011). Second, given that individuals who use LTSS need assistance with activities of daily living and often have one or more chronic health conditions, they tend to use more services from more providers across more settings than do people without a disability, thereby increasing the need for effective care coordination. Third, consumers' preferences for remaining in their current residence for as long as possible and the 1999 *Olmstead* decision that affirmed an individual's right to receive services “in the most integrated setting appropriate” have motivated states to “rebalance” their LTSS system in favor of home and community-based services rather than institutional care (O'Shaughnessy 2012).

In an MLTSS program, a state Medicaid agency contracts with managed care organizations (MCOs) and pays them a predetermined “capitation” amount per member per month to provide a set of beneficiaries with a set of LTSS with or without primary, acute, behavioral, and other services. MCOs then bear the financial risk for providing all covered services within the paid amount. In view of the MCO's financial incentive and ability to centralize information on care needs and utilization, states look to MCOs to improve care coordination and improve health outcomes. By including institutional and community-based LTSS in the capitation rate, an MCO has a strong financial incentive to favor less costly community placement (Lipson and Valenzano 2013).

Though states may turn to MLTSS for similar reasons, the ways in which they choose to structure and oversee their programs varies widely along several dimensions. States differ in the length of time for which they have been operating MLTSS, with the oldest program (Arizona) having been in place for more than 20 years. There is also variation in the number of plans that states contract with to provide MLTSS; as of 2012, there was one plan each in California and Pennsylvania and 21 in New York. States vary in the number of beneficiaries receiving MLTSS, from just 90 people in Pennsylvania to more than 400,790 in Texas (Mathematica analysis of Saucier et al. 2012). Finally, state programs vary in the range of services they cover, from home and institutional LTSS only, such as Wisconsin’s Family Care program and New York’s Managed Long-Term Care program, to programs in other states that cover the full continuum of care, including acute and primary care, pharmacy services, LTSS, and behavioral services. These differences contribute to variation in each state’s approach and resources devoted to MLTSS oversight (Lipson et al. 2012).

Given the rapid growth of MLTSS and the diversity of ways in which states have structured their respective programs, several questions emerge about how states should design, operate, and oversee MLTSS programs to achieve program objectives. Moreover, fixed capitation payments may create an incentive for plans to restrict access to services for individuals with costly health and LTSS needs. Therefore, it is critical to understand how states monitor MCOs’ compliance with contract requirements regarding members’ access to and quality of care (Connolly and Paradise 2012). In addition, the Centers for Medicare & Medicaid Services (CMS) recently issued guidelines for states seeking federal authority to operate MLTSS programs (CMS 2013), but the guidelines still afford states the flexibility to design and operate these programs to fit their unique circumstances.

III. FINDINGS

To explore state variations in MLTSS, we visited five states that differ from one another along a number of key dimensions—including how long the program has been operating, its geographic reach, whether enrollment is mandatory or voluntary, what services are included in the benefit package, and the number of plans with which the states contract. All of these factors can influence whether and the extent to which MLTSS programs achieve their goals. (See Appendix B for a table of key program features in each state.)

The most noteworthy difference across the five states is their experience operating MLTSS programs. Arizona and Wisconsin have “mature” programs, which have been in operation for over 15 years and cover the majority of LTSS users in the state (though Wisconsin is currently expanding its Family Care program to additional counties in the northwest region of the state). Florida and New York operated small, voluntary MLTSS programs in the past, but both states recently expanded mandatory MLTSS to beneficiaries across the state. Illinois is newest to MLTSS and implemented its mandatory program in a limited area of the state just three years ago.

The states also differ in the breadth of services covered in the benefit package and included in the capitation rate paid to the plans. Arizona and Illinois cover both acute care and LTSS for Medicaid-only beneficiaries, whereas the primary programs in Florida, New York, and Wisconsin exclude or “carve out” LTSS services and provide them through a separate managed

care program. New York and Wisconsin also operate small MLTSS programs that cover acute care and LTSS for Medicare-Medicaid eligible individuals. In addition, the five states have contracted with a range of managed care plans, from just one or two in each county in Wisconsin, to over 10 plans in some regions of New York. Additional themes and variations are discussed below.

Program design

When designing a new MLTSS program, a state's choices—regarding whether to carve out LTSS or integrate both acute and LTSS, require mandatory or voluntary enrollment, and contract with few or many plans—may be influenced by legislative directives, previous experiences with LTSS, and the capacity of existing or new managed care plans to serve large numbers of beneficiaries and manage medical and LTSS benefits. The way in which each of these factors influenced MLTSS program design is described below.

Medicaid agencies often worked with state legislatures to design their MLTSS programs, but the degree of legislative direction regarding specific program features varies. The Medicaid agencies in three of the five states—Florida, Illinois, and New York—worked with their legislatures in different ways to develop and launch their program. The nature of the collaboration reflects differences in each state's political environment, motivations for program change (for example, budget pressures, and interest in expanded access and/or increased coordination), and previous experiences working with the legislature. In New York, budget pressures before 2011 prompted the governor to appoint a Medicaid Redesign Team (MRT) to recommend cost savings reforms, one of which included expanding the existing Managed Long-Term Care (MLTC) program statewide on a mandatory basis and developing a set of guiding principles for the expanded program. The Medicaid agencies then designed the MLTC program within the bounds of the MRT/legislature's recommendations.

In Florida, the Medicaid agency worked very closely with a variety of stakeholders to develop legislation that set out the terms of the program, including the time line for both releasing a request for proposal (RFP) to the plans and implementing the program, the duration of contracts (five years), and a requirement that capitation rates be set so as to guarantee an aggregate savings of at least five percent in year one. Though defining many of the program requirements in statute limited the state's ability to change course, it helped Florida to enforce the implementation time line and program requirements when stakeholders tried to delay the pace of implementation and alter key design features. In contrast, the Illinois Medicaid agency made considerable progress designing the key features of the Integrated Care Program (ICP) before seeking authorization for both the program's implementation schedule and mandatory enrollment from the state legislature.

Existing LTSS programs and managed care infrastructure influenced the states' ability to include medical and other services in the MLTSS benefit package. All states cited care coordination and long-term care system rebalancing as major goals of their MLTSS programs and, therefore, important influences on program design. However, the degree to which they are able to integrate medical and LTSS services under managed care, and therefore achieve these goals, depends on the LTSS programs currently in place and the number and experience of plans providing LTSS that will participate in the managed care market going forward. When Arizona

launched the Arizona Long Term Care System (ALTCS) in 1989, it built on its existing program, in which all medical services were provided through managed care. That foundation gave the state the ability to fully integrate medical and LTSS under managed care without having to reshape a well-established FFS HCBS waiver program. Illinois also chose to integrate medical care and LTSS in ICP. Though it had a variety of HCBS waiver programs in place before launching ICP in 2011, Illinois felt that its Medicaid agency and the commercial managed care plans entering the market could draw on the experience of states like Arizona and Tennessee and learn to manage both HCBS and medical services.

In contrast, New York's voluntary MLTC program relied on a number of regional, provider-led LTSS plans, which the state felt were in the best position to help expand enrollment under mandatory MLTC. Florida's legislature did not integrate medical and LTSS as part of the Statewide Medicaid Managed Care (SMMC) legislation, and the state did not believe that enough MCOs in the state had the expertise to cover both medical and LTSS. Wisconsin's Family Care program also covers only LTSS because it was built on a strong network of county-based managed care entities that evolved from the county agencies that formerly ran home and community-based (HCBS) waiver programs; however, these agencies were not connected to acute and primary care providers, so medical services were not integrated into the MLTSS benefit package.

Though the five states were interested in integrating all services in the managed care benefit package to promote coordinated care, most made incremental progress toward integration over time by adding services and populations gradually in order to give health plans time to learn how to manage a broader set of benefits. With the exception of Arizona, which already covers Medicaid acute, LTSS, and behavioral health services for all ALTCS members, the states we visited were planning to add services to the benefits managed by the plans in their MLTSS programs. New York and Wisconsin are adding behavioral health services to MLTSS. Illinois is planning to add services for individuals with developmental disabilities. Florida would like to encourage more State Medicaid Managed Care (SMMC) plans to offer both medical and LTSS service packages. At the time of the visit, all five states were also planning to integrate the Medicare and Medicaid benefits for individuals who qualify for both programs; New York and Illinois were doing so through federal Financial Alignment Demonstrations, and the other three states were contemplating contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNP) to better integrate the benefits. Moreover, New York has been gradually adding populations to its MLTC program. The first phase, which began in September 2012, enrolled all HCBS users and new nursing home residents; the second phase, which will likely begin in 2015 (HMA 2014), will enroll existing nursing home residents.

Mandatory enrollment is common in large MLTSS programs and may help states minimize adverse selection. Mandatory enrollment ensures managed care plans have enough enrollees to make their participation in MLTSS financially viable. It also reduces the potential for plans to “cherry pick” people with better health and minimal LTSS needs, which can occur during voluntary enrollment periods. By requiring individuals to enroll in managed care, states can better predict the size of enrollment and the risk that enrollees will use certain services. States can then use this information to develop payment rates that both support the expected cost of the program and attract enough qualified managed care plans to participate. For these reasons, all of the site visit states except Wisconsin require that individuals enroll in managed care for their

LTSS services. New York and Florida previously allowed voluntary enrollment in their small MLTC and Nursing Home Diversion programs, respectively, but in order to expand the number of individuals enrolled in MLTSS, both states now make participation mandatory.

Despite its benefits, mandatory enrollment cannot prevent adverse selection entirely. In the four states with mandatory enrollment, enrollees are given a period of time during which they can elect a plan of their choice; if they do not do so, they are automatically assigned into a plan based on criteria that are pre-determined by the state. These periods of voluntary enrollment, even when followed by auto-assignment, present an opportunity for plans to “cherry pick” or for providers to steer members towards preferred plans with which they might have more favorable contracts or payment rates. In New York, these periods of voluntary enrollment allowed adult day health centers to recruit healthier patients and collect improper payment (Bernstein 2013).

Though Wisconsin allows Medicaid-eligible individuals who need LTSS to voluntarily enroll in Family Care, most counties do not make a traditional FFS HCBS waiver alternative available to beneficiaries. In 44 of the 57 counties in which Family Care is offered, the only alternative to managed care is a self-directed program called IRIS. As of July 2014, about 10,800 people, or about one-quarter of all those enrolled in Family Care plans, chose to self-direct their LTSS (Wisconsin Department of Health Services 2014). In the remaining 13 counties, individuals who are dually eligible for Medicare and Medicaid can also choose to enroll in Family Care Partnership and PACE programs; as of July 2014, only 3,607 individuals elected to enroll in an integrated option (Wisconsin Department of Family Services 2014).

Three of the four states that competitively procure managed care plans limit the number with which they contract to ensure that plans have enough volume to bear financial risk and to make it easier for the state to oversee each plan’s performance. Arizona, Florida, and Illinois restricted the number of plans with which they contract for MLTSS in order to find the “sweet spot”: enough plans such that beneficiaries are assured of having a choice but not too many such that beneficiaries are distributed too thinly across too many plans, which could lead to financial problems for smaller plans. Contracting with a relatively small number of plans has several additional benefits, such as reducing the burden on the state to oversee and manage each plan while sustaining both competition between plans and enough capacity to guard against the adverse consequences associated with a plan going out of business or leaving the market for other reasons (Howell et al. 2012).

These contracting decisions influenced the number of plans participating in MLTSS programs. For example, Arizona estimated that each plan would need to enroll at least 20,000 members to be financially solvent, so it elected the minimum number of plans needed to cover its enrolled population; as of September 1, 2014, four plans covered about 53,500 enrolled individuals total (Arizona Health Care Cost Containment System [AHCCCS]). Florida had difficulty overseeing the 20 plans that participated in the former Nursing Home Diversion program, so for its long term care (LTC) program it elected the fewest plans permissible in the SMMC legislation (a minimum of two to five plans is required, depending on the region).¹ Illinois currently contracts with 10 plans, a number that the state says allows for enough competition between plans because the state can “fire” a plan without disrupting access to care.

¹ Florida House Bill 7107, Section 409.981, 2011.

In contrast, New York allows any willing plan to participate in its MLTSS programs and contracts with 48 companies, 33 of which participate in mandatory MLTC.² Almost all respondents we spoke with in New York expressed concerns about the large number of contracted plans: consumers are finding it too hard to select a plan; providers are struggling to bill each plan correctly; and the state is concerned about its ability to adequately monitor plan performance.

Over time, states standardized MLTSS contract requirements to institutionalize the practices they want to be consistent across all plans. Using program design choices as a blueprint, states must define in its contracts with managed care plans the details of how a program will operate (for example, how plans will enroll members, how many providers will be included in their networks, and how plans will report on performance to the state). The difference in experience between states that have recently expanded MLTSS and those that operate mature programs suggests that, over time, operations tend to become more standardized.

In states with new or expanding MLTSS programs (Florida, Illinois, and New York), stakeholders raised the concern that difference across plans (for example, billing processes or procedures for filing appeals and grievances) have created confusion for providers and consumers. In contrast, Arizona and Wisconsin have added the same requirements to different contracts when they found inconsistencies across plans that were counterproductive. For example, Wisconsin created standard notices to beneficiaries of service actions so that all plans report changes to an individual's services in the same way; the state also created a resource allocation decision (RAD) tool that standardizes the process by which plans authorize services. Arizona had difficulties communicating with staff in various positions a MCOs, so it included in its contract a requirement that MCOs employ 26 specific staff positions, including a contract compliance officer who serves as the primary point of contact for the Arizona Health Care Cost Containment System (AHCCCS). Despite these standard requirements, plans in Wisconsin and Arizona are still able to differentiate themselves from their competitors in terms of the breadth of their provider networks, the types of valued-added services they offer (such as fresh vegetables and supportive employment), and the models of care they use to attract prospective beneficiaries.

MLTSS care management holds potential for more coordinated care, flexible service packages, and self-directed options. MLTSS offers the opportunity for better coordinated, higher quality, and more flexible services. Respondents in all states reported that having a single care coordinator responsible for managing all LTSS services represented a major benefit of the program; the potential benefit was even greater for Arizona and Illinois, where plans are responsible for coordinating both LTSS and medical services. The care coordination model gives enrollees and providers a single point of contact to ask questions, centralizes responsibility to monitor members' needs and service use, and makes it easier to share information across providers. Contracting for LTSS services also provides the opportunity for higher quality services if managed care plans and states monitor provider quality and remove or remediate low quality providers. In addition, capitation can allow funds to be used more flexibly to provide person-centered services and supports tailored to each member. Several plans reported using capitation payments to provide value-added services, like air conditioners or home

² The count includes MLTC, Medicaid Advantage, Medicaid Advantage Plus, and PACE programs. See New York Department of Health (2014).

modifications, which would not have been authorized under FFS but can support an individual's health and wellbeing.

All site visit states also offered self-directed services options through MLTSS. These models provide individuals the opportunity to control what, when, how, and by whom services are provided. Self-direction offers the opportunity to lower costs by avoiding or delaying the need for institutional care while increasing member choice, independence, and satisfaction (Carlson et al. 2007; Dale and Brown 2007). Among the site visit states, however, the level of participation in self-directed options varied. Wisconsin reported high participation rates (almost one quarter of a plan's members self-direct some services, most frequently personal care). Respondents in Arizona, however, report that take-up is low, which they believe is because the existing care management model is strong and more familiar to many people.

Protecting beneficiaries and providers in the transition to MLTSS

When launching a new MLTSS program or expanding an existing program to additional regions or population groups, states should make careful efforts to ease the transition between the old and new care delivery systems. The timeline and sequencing by which states enroll providers and beneficiaries into managed care must be orchestrated and monitored so as to minimize service disruptions. The processes for both evaluating functional eligibility and developing care plans must be designed to minimize conflicts of interest. Providers must fully understand the billing process so that they can be paid on time and consumers can easily access services.

This section focuses on the experiences of three "transition" states—Florida, Illinois, and New York—that recently enrolled or are currently enrolling the majority of beneficiaries statewide into MLTSS; where relevant, the experience of Wisconsin, which is expanding its Family Care program to seven additional counties in the northwest region of the state, is also discussed.

Stakeholders often felt that the time line for implementing MLTSS, however long, was too short to allow consumers and providers to adapt to the new system of care. To minimize disruptions in ongoing care for vulnerable beneficiaries and to ensure that traditional LTSS providers can learn the authorization, billing, and other managed care processes, CMS recommends that states engage in "thoughtful and deliberative planning," which includes "appropriate transition for beneficiaries moving into managed care from fee-for-service or from another managed care plan" (CMS 2013a). However, stakeholders in the three transition states we visited—particularly advocates and providers—felt that the MLTSS was implemented too quickly. Florida introduced the long-term care portion of its SMMC program across the state in eight months (August 2013 to March 2014). Illinois added LTSS to ICP over the course of one year (February 2013 to March 2014). New York is expanding MLTC to half of the state's 33 most populous counties over the course of two years (2012 to 2014) and the remaining half over the subsequent year (2015). Despite real variations in their implementation timelines, respondents in all states cautioned that implementation should be slow and deliberate to ensure that they can quickly identify systemic problems and correct them before they cause harm to large numbers of beneficiaries. That said, the respondents also suggested that any change would feel fast to the groups affected.

All states phased in enrollment into new MLTSS programs by region, starting in large population centers to allow managed care plans enough time to build provider networks. LTSS providers are typically more available in dense population centers, which give MCOs the best opportunity to contract with enough providers to guarantee access for new members. As a result, each of the four of the transition states (including Wisconsin) first introduced their programs in large population centers and later expanded to rural regions. New York and Illinois began MLTSS enrollment in their largest cities (New York City and the “collar” counties surrounding Chicago), whereas Florida started in Orlando so as to give itself an opportunity to learn from that experience before expanding in Miami, its largest city. Wisconsin also established its Family Care program in the more populated central and southern regions of the state before attempting to expand to the north. While not explicitly required, CMS strongly encourages this phased approach (2013a).

For states that introduced multiple Medicaid managed care service packages at the same time, staggering the programs’ entry into an area can help to ensure that plans have the capacity to provide services and that the states themselves can oversee plan performance. When the same set of plans offers both medical services and LTSS, introducing one set of services before another allows plans time to build staff capacity, develop processes, and secure an adequate network of providers. When a different set of plans offer medical and LTSS, adding new plans over time allows the state to gradually build its oversight capacity.

Illinois and Florida, for example, introduced medical managed care options in conjunction with their MLTSS programs and sequenced the phase-in of these two benefit packages in different ways. Illinois introduced medical services first (ICP Service Package I) and then phased in LTSS (Service Package II) by adding these services to the same plans. In contrast, Florida introduced managed LTC before managed medical assistance (MMA). Florida’s decision to introduce LTC before MMA received mixed support: some said that enrolling the smaller LTC population first put the state in a better position to successfully introduce the larger MMA expansion, while others felt that it would have been easier to roll out MMA first because LTC member needs and provider networks are more complicated than their MMA counterparts.

Concerns about capacity to conduct functional assessments and care planning prompted states to test the bounds of, or request exemptions from, federal rules that an “independent entity” perform each process. Medicaid rules require states to use an “independent” entity that is not financially associated with health plans or providers to perform eligibility assessments or to develop care plans for their members (*Federal Register* 2014). This rule is intended to prevent conflicts of interest between health plans and their enrollees such that an individual’s needs are the primary driver of the assessment. In the three transition states, however, MCOs play some role in assessing or developing plans of care. Because New York was concerned about whether vendors and/or state employees would be able to assess the large number of new MLTC enrollees, it allows MCOs to both conduct functional assessments and use the information for care planning. Because of concerns raised by consumer advocates and CMS that this arrangement presented a conflict of interest, the state agreed to transfer the responsibility for conducting functional assessment from the MLTC plans to a third-party entity, which will be selected next year.

In contrast, Illinois³ and Florida require state agency staff to conduct the assessment for functional eligibility but allow MCOs to use the initial functional assessment information to conduct care planning and annual re-determinations. According to federal rules, MCOs are allowed to both conduct service planning and provide case management services only if the state can demonstrate that the MCOs are the only “willing and qualified” agents in a geographic area. The state must also devise conflict-of-interest protections to ensure that there is some separation between the entities conducting assessments and those providing services, and provide consumers with a “clear and accessible process” for resolving disputes. Though we did not discuss whether the arrangements in Illinois and Florida comply with federal rules, neither state indicated that it had plans to change the functional assessment and care planning process.

Stakeholders in many states were concerned that inadequate provider networks, service reductions, HCBS waitlists would prevent enrollees from accessing care. To ensure access to care, managed care companies must contract with a sufficient number, mix, and location of providers relative to the needs of members, and the providers with which they contract must be open and accepting new patients. In all states, however, respondents expressed concerns about the mix and availability of high-quality providers, which could affect access to care. In Illinois, for example, consumer advocates reported that large hospitals and specialty providers were slow to participate in ICP, creating networks that were “woefully underdeveloped.” Staff from the Medicaid agency and managed care plans in Florida and Illinois reported difficulties contracting with transportation providers and convincing them to provide services during the transition to managed care. They also received complaints that providers did not always pick up enrollees at the correct time, drop them off at the correct location, or use appropriate equipment (for example, accessible vans instead of taxis). Transportation was thought to be particularly critical for members because it impacts an individual’s access to other services as well as their ability to lead a meaningful life in community.

Out-of-date provider directories were also cited as a barrier to access. Though states like Arizona, Florida, and Wisconsin reported conducting ad-hoc “mystery shopper” calls to verify that providers are accepting new patients, enrollees cannot know whether listed providers are currently participating in the plan network without calling them directly. MCOs report that keeping this information up to date is a challenge for all plan types, not just Medicaid, because there are a large number of steps involved and many opportunities for information to become outdated. To contract with a plan, providers must obtain the appropriate provider licenses and identification numbers. To be included in the directory, managed care plans must credential providers by verifying, in writing, their academic degrees and qualifications. If a provider leaves the network (for example, in the event he or she dies), it is up to that provider’s office to notify the MCO to update their directory. The provider’s office is also responsible for notifying the MCO if it is no longer accepting new patients.

Respondents in all states were also concerned that the incentive to contain costs could lead to fewer and lower quality services over time. Consumer advocates in New York, Florida, and Illinois reported that, following the transition to MLTSS, managed care plans reduced the

³ Illinois uses a combination of state agency staff and community agencies subcontracted with state agencies to conduct the assessment. MCOs conduct care planning, but the annual re-determination for waiver services is done by state agency staff or community agencies subcontracted with state agencies.

number and duration of services for some individuals; Arizona and Wisconsin, like other states, reported reducing services during periods of state budget austerity. In addition, advocates in Florida reported that managed care plans substituted hot meals delivered in person each day for weekly, bulk frozen meals. Advocates were concerned that some recipients did not have the capacity to store or cook the food, and that less frequent drop offs eliminated the opportunity to check on an individual's functional status and identify early needs. It was not clear whether these services would be restored over time.

Though MLTSS has the potential to expand access to community-based services, wait lists for HCBS persist in many states. Florida and Illinois, which operate under 1915(b)/(c) waivers, only allow individuals who qualify for a nursing home level of care to gain access to HCBS; as a result, advocates report that large numbers of people who express interest in receiving these services but do not qualify for waiver slots are not served. Though Florida's legislature funds additional HCBS slots each year, advocates are disappointed that statewide MLTSS cannot extend HCBS to everyone who reports a need.

States instituted a variety of transition protections to help enrollees, plans, and providers adjust to the new program. All transition states (including Wisconsin) require their MLTSS programs to maintain the services, providers, and payment levels under the FFS programs for a set period of time, allowing enrollees, plans, and providers enough time to adjust to managed care. However, the mix of protections and the time during which they have been in place vary by state. For example, Florida, Illinois, and New York require individuals enrolling in MLTSS from FFS to maintain their previously authorized set of services for 60, 180, and 90 days, respectively. Illinois required managed care plans to contract with all willing providers for the first year of the program. During the first year of the program Florida, required that plans offer contracts to all nursing facilities and hospices in their region, along with aging services providers who had been providers through an aging-related HCBS waiver in the past year. Similarly, Wisconsin requires its MCOs to contract with an enrollee's choice of personal care provider as long as that provider meets the MCO's requirements and accepts its payment rate. Moreover, New York and Illinois require MCOs to pay providers the same rate they received under FFS for 90 and 180 days, respectively. Plans, provider organizations, and consumer advocates generally support these protections, though providers and advocates in at least one state (New York) requested that the protections be left in place for a longer period.

New providers in all states have struggled to learn and navigate various MCO billing processes. New providers in all states, including those in transition or with mature programs, reported difficulties learning and navigating the MCO billing processes. The difficulties were particularly acute for smaller providers with few staff or narrower profit margins, as well as providers who contracted with a large number of MCOs (for example, those in New York). States and managed care plans reported that providers who did not understand the billing processes would submit incomplete or inaccurate bills; providers who did not know how to check a member's program eligibility or follow plan authorization processes filed claims with the wrong plan or for the wrong amount, resulting in delayed reimbursement. Such payment delays are especially challenging for small providers whose cash reserves for support in the event of delays are limited.

To help providers who are new to managed care understand billing requirements, MCOs, Medicaid agencies, and provider organizations in all states offered technical assistance in the form of webinars, meetings, and one-on-one assistance. Transition states put extra emphasis on such assistance. For example, MCOs in Illinois met with nursing facility management companies to describe the billing process, and the Florida Medicaid agency sent its staff to provider sites to assist them with paperwork.

While provider organizations supported these educational efforts, several called for common standards or templates that could be used to bill across plans. Standardization, they argued, would reduce their reporting burden, resulting in more accurate and timely reimbursements. One MCO mentioned, however, that it must “walk a fine line” between collaboration and perceived collusion. MCOs may also resist collaborating so that they may continue to differentiate themselves from their competitors.

Ongoing operations and oversight

To effectively monitor health plan performance and beneficiary access to care, states must allocate enough resources to the following two functions: deploying staff with the right skills to oversee MLTSS and contracting with vendors for specialized services such as quality review, actuarial rate setting, and services provided by enrollment brokers. The ways in which staffing, vendors, plan reporting, stakeholder communications, enrollee education, and provider payment facilitate or challenge the ongoing operations of MLTSS are discussed below.

Depending on the skills and capacity of in-house staff, states use a different mix of staff and vendors to oversee programs; the level of effort they devote to monitoring also varies according to their resources. As states transition from FFS to managed care, they must hire staff or contract with vendors who are qualified to perform oversight, monitoring, and communications. States generally rely on a mix of staff and vendors to perform key functions like monitoring contract requirements and performance, reviewing the adequacy of provider networks, communicating with stakeholders and enrollees, and informing enrollees of the services available to them and their rights that are protected under managed care. New York and Florida, which operated small scale MLTSS programs in the past, designed their program and conducted most oversight functions in house. In contrast, Illinois, which had never before overseen an MLTSS program, hired a consultant (Navigant) to teach staff to monitor plan reporting, build a SharePoint site to track reports and workflow, and streamline reporting requirements. New York, Florida, and Illinois used enrollment brokers to counsel prospective enrollees on their managed care options and enroll them in a plan. Illinois and Wisconsin relied heavily on their external quality review organizations (EQRO) to review managed care plan readiness, audit data, and conduct ad-hoc analyses.

Despite upgrading their staffs’ skills and securing help from external vendors, most states felt that their staffs were stretched to capacity during the transition and expansion periods and did not have enough time to monitor implementation as closely as they would have liked. When asked how they would allocate additional resources, several states noted that they would add analytic capacity for data-based ad-hoc analyses, audits, and case reviews; others wanted more capacity to communicate with stakeholders, particularly through in-person meetings. Arizona was a noteworthy exception; despite recent budget cuts, it employed 85 staff in the Division of

Health Care Management to oversee the AHCCCS and ALTCS managed care plans. The agency as a whole employed nearly 1,000 staff to manage all aspects of the AHCCCS program, including rate setting, data analysis, IT support, and legal counsel. According to the state, turnover was low, the quality of the work environment was high, and employees were generally satisfied with their jobs.

The presence of staff with program-relevant skills was associated with the focus of state monitoring activities. For example, though Florida state staff reported being “stretched” during the program’s expansion, they said that they had enough capacity to regularly analyze trends in performance data submitted by plans, as well as appeals and grievances, and complaints submitted through the state’s online system. On the other hand, they did not have the capacity to carefully monitor the rollout of the transportation benefits or participant-directed options. New York also reported an uptick in its ability to monitor trends in performance, though it did not have the capacity to validate plan-reported data or to audit plan performance. Illinois reported that staff at its Medicaid agency did not have time to conduct ad-hoc monitoring or to field direct feedback from consumers through a complaint line.

States must balance the need to collect enough information from plans to assess performance and quality with the need to avoid overburdening plans with reporting requirements. All states require a number of reports and measures of plan performance, and many states are working to strike a balance between having “enough” information to ensure quality of care without unduly burdening plans. This balance should give states the ability to review detailed indicators of plan performance, financial status, and quality of care for members without distracting plans from their primary focus and responsibility, which is to provide care. Several states mentioned that their programs require plans to submit a large number of reports on performance (some of which are an artifact of 1915(c) HCBS waiver reporting requirements), but over time the states and plans have worked together to ensure that plans focus on the most critical measures of performance. Plans in New York are working with the state to (1) collect information on whether enrollees follow medication regimens as prescribed instead of on whether they take medications independently and (2) discontinue the survey of member satisfaction administered upon disenrollment.

Florida, New York, and Wisconsin are also in the process of adding LTSS quality measures, though progress is slow because there are no standard national measures. Officials in these states are frustrated by the lack of national measures of MLTSS quality. Without such measures, states evaluate plan performance based on the process of care (for example, percentage of new members who are screened and treated for falls) as opposed to its quality (for example, percentage of members who were at risk and experienced falls). States are looking at measures of care coordination and quality of care across care settings, and also considering whether quality could be measured through members’ satisfaction and ability to maintain a stable level of functioning (for example, percent of members remaining in the home). Each state developing quality measures felt that it was doing so alone; one state requested that the federal government make resources available to support its efforts.

All states cited strong partnerships with managed care plans as the best tool for improving MCO performance, but using financial sanctions to enforce requirements is also critical. Most MCO contracts list a variety of sanctions that the state can exercise to remedy problems

with plan performance (for example, corrective action plans for reporting incomplete or low-quality encounter data, freezes on enrollment for insufficient provider networks, and financial sanctions for failing to meet quality or performance standards), but many states prefer to work with MCOs before resorting to stronger action. In fact, all states reported that strong partnerships with MCOs are an ingredient to a successful program.

The partnerships between state staff and MCOs that were described most positively were characterized by transparency, mutual respect, and frequent, two-way communication. For example, Arizona's MCOs recently collaborated with state staff to analyze optimal case-load weights and proposed that the state lower the case-manager-to-enrollee ratio; the state agreed with the proposal and revised the capitation rates to support the hiring of additional case managers.

At the same time, Arizona, Florida, and New York emphasized the importance of using financial sanctions when technical assistance is not sufficient. Florida frequently applies financial penalties so that plans know the state is serious about enforcing contract requirements. Arizona applies strict financial penalties (up to \$100,000 per violation in quality measure reporting) and publishes corrective action requirements ("notices to cure") on its website so that plans and stakeholders can see when plans have violated performance standards. New York froze new enrollment into a large MCO when it was found to be enrolling adults who did not qualify for MLTSS into adult day health programs. This approach not only protected beneficiaries from predatory practices but also put financial pressure on the plan to reform its practices so that it could once again enroll and serve new members.

Strong relationships with a range of consumer, provider, and community organizations, as well as other stakeholders, and transparent communications are critical to the success of an MLTSS program. Building strong relationships with stakeholders through partnerships and transparency is an important state investment in the development and implementation of an MLTSS program (CMS 2013c). Respondents in all states believed that frequent and meaningful interaction facilitated program success. For example, Arizona and Wisconsin convene stakeholder groups to get regular feedback on policy and operational issues. Arizona stakeholders reported that state staff who participated in these groups were receptive to their ideas. Similarly, Wisconsin stakeholders felt that its Family Care program benefitted from a long history of state and stakeholder collaboration. Its Long Term Care Advisory Council has enabled stakeholders, Aging and Disability Resource Centers (ADRCs), and state staff to discuss policy and operational issues for LTSS programs on a monthly basis for over 20 years. Staff from Wisconsin's Medicaid agency also initiate topic-specific work groups for MCOs and other stakeholders when common issues arise. For instance, one work group focused on members with complex behaviors.

Despite these efforts, representatives from beneficiary and provider groups did not always feel included in important discussions. One nursing home provider group in Illinois believed that ICP was designed by the state and MCOs and did not solicit much input from its members or respond to its recommendations, which was a departure from the collaborative process used to develop previous managed care programs in the state. Although staff from the Illinois Medicaid agency formally met with consumer advocates and provider organizations, this occurred only once or twice a year, whereas the state had more frequent communication with MCOs. In

Florida, state staff conducted outreach with MCOs and provider organizations, which helped to bolster support for the LTC program. However, some consumer advocates in Florida felt they did not have much of a voice in the process and that “it was all [designed by] headquarters.”

Though stakeholders value transparency in their interaction with the state Medicaid agency, the degree of transparency varies across states. From the states’ perspective, written information and recorded webinars have been useful in streamlining communications, but consumer advocates and providers suggested that face-to-face, two-way communication remains essential for program development and implementation. Arizona and Wisconsin provided a wealth of information on their websites for stakeholder education. Florida also posted webinars and FAQs on its website; however, consumer advocates felt that beneficiaries require more one-on-one assistance than the state could provide through its “canned” webinars and a 130-page FAQ document that provided conflicting information. Consumers in Illinois were also confused about the program. One advocate felt that the program evaluation reports produced by a state contractor were too dense to be useful to beneficiaries when choosing a plan. This advocate also lamented the fact that the more consumer-friendly information that was once posted on the state’s website had recently disappeared.

Consumer advocates frequently cited educational materials for enrollees as confusing, and they recommended improving communications by providing in-person assistance and standardizing processes across plans. Respondents in all states noted that informational and marketing materials were difficult for people with disabilities to access and understand, especially because each plan has its own forms and policies. Because information in the form of letters, handbooks, and other materials is not useful to all beneficiaries, consumer advocates in Illinois, New York, and Wisconsin reported that offering in-person customer assistance—including counseling on choice and assistance from peers or entities that know the populations they serve well—helps to ensure all enrollees can get objective information about their options from trusted sources. In Wisconsin, ADRCs play this role and serve as a central source for information on managed care and other community-based resources. In Illinois, the Centers for Independent Living (CILs), community-based organizations directed and managed by people with disabilities, provide consumer education and advocacy. In contrast, New York, which has a robust nonprofit advocacy community, relies on organizations—such as the New York Legal Aid Society the Center for Disability Rights, Medicare Rights Center—to inform and assist plan members. However, at the time of our visit, stakeholders in New York were working to create an official ombudsman program dedicated to MLTSS to resolve complaints from enrollees.

Many consumer advocates suggested that allowing processes for service authorization, grievances, and appeals to differ across plans creates additional confusion for consumers. Respondents favor as much standardization as possible to address this issue. Stakeholders supported efforts in Wisconsin to develop a template for notices to consumers of proposed action and a program-wide member handbook. Consumer advocacy groups in Florida were working with state staff to standardize notice of denial forms. MCOs generally expressed a willingness to both collaborate with other plans and improve processes, so long as they are able to maintain their competitive advantage.

Health plan payments to providers, particularly for home care workers or personal care attendants, are a concern in most states. Regardless of a state’s experience with MLTSS,

provider organizations in all states are concerned that low or slow reimbursement rates paid by health plans could jeopardize their business and prevent access to high quality LTSS. New labor requirements regarding payment for home care workers and personal care attendants, who are often low-paid, low-skilled workers, are a particular concern. Citing both a new U.S. Department of Labor rule requiring personal care attendants to be paid overtime and travel expenses, and a state wage parity law that raises payments to home care workers, respondents in Illinois and New York, respectively, are concerned that capitation rates paid to plans would not cover the additional costs of complying with these requirements. Respondents in Arizona are concerned about a federal requirement to provide health insurance to home care workers who work more than 30 hours a week, which they predicted would prompt home health agencies to use more part-time workers to care for beneficiaries, thereby disrupting the continuity of care. Respondents in Wisconsin also noted that payment to MCOs have increased in recent years but have not been passed through to providers. Payment levels in Arizona have also increased, but providers did not raise concerns over equity because state contracts with managed care plans require that they pay providers a rate that ensures that there are enough health care workers to deliver all of the services for which an individual qualifies.⁴

Program evaluation and improvement

In order to continually improve their programs, states must periodically evaluate progress toward program goals. They can do this through a number of indicators, including regular reports from MCOs on compliance with managed care contracts, quality of care measures (for example, HEDIS, CAHPS, or state-specific measures of LTSS quality), reports on member appeals and grievances, and plan-specific performance improvement programs. These indicators are often validated by and summarized in independent evaluations conducted by EQROs or other research organizations.

While each of the states cited a recent or upcoming evaluation of its MLTSS program, most states said that complaints, appeals, grievances, and member satisfaction surveys are the most useful means to monitor and improve programs. Member feedback is often more valuable than retrospective evaluations because it is more timely. As one respondent noted, member complaints are like “the canary in the coal mine,” alerting the state to issues that are occurring system wide; though comprehensive evaluations may present a more complete picture of performance, complaints can alert state staff to these same issues much farther in advance. Compared with evaluations of program quality, member feedback may also present an opportunity for more concrete solutions. For example, reacting to member complaints about transportation providers not showing up on time may be more straightforward than a responding to evidence that members used fewer transportation services than they did before the switch to MLTSS. Respondents in New York and Florida also noted that they use member satisfaction results as indicators of quality, for example, by incorporating member satisfaction scores into quality incentive programs.

⁴ In August 2004, a ruling by United States District Court for the State of Arizona in the case of *Ball v. Biedess* instructed AHCCCS to “offer a rate of pay to health care workers so as to deliver adequately those services to which an individual qualifies, that is, to attract enough health care workers to deliver all of the services for which an individual qualifies.” The ruling is available at: <http://phinational.org/legislation-regulations/ball-vs-biedess-district-arizona-circuit-court-ruling>.

Conclusion and opportunities for future research

The goals of MLTSS are often shared across states: to improve access to and quality of care while holding down costs and rebalancing the long-term care system toward home and community-based services. The way in which states have made progress toward these goals, however, varies according to their previous experience with MLTSS. States that are newer to MLTSS may focus on expanding access to more people who need LTSS. Florida sought to serve more people on HCBS waiver waiting lists and offer services in more regions. New York focused on adding behavioral health services, whereas Illinois offered additional HCBS services for individuals with disabilities. Florida, Illinois, and New York are also attempting to integrate Medicare and Medicaid for dually eligible beneficiaries; Florida is facilitating integration through D-SNP contracts, and Illinois and New York are doing so through participation in the Financial Alignment Demonstration. States with long-standing MLTSS programs—Wisconsin and Arizona, for example—have already achieved widespread access to comprehensive services, so they focused on incremental improvements designed to increase competition between plans (Wisconsin), integrate Medicare and Medicaid benefits through data sharing (Arizona), and expand consumer choice and community participation (both states).

Progress toward these goals, however, has been slowed by a number of factors, including limitations in the number and skills of staff, competing policy initiatives, complex administrative infrastructure, outdated data systems, and new federal regulations (for example, the recent rule requiring “independent assessments” for HCBS). States have also faced other challenges, including finding ways to pay managed care companies adequately in the face of persistent demands for budget cuts from the governor or legislature and facilitating sufficient and timely payments from managed care companies to providers, which is more difficult when a large number of providers are new to managed care. Respondents from some states also attributed weakness in the oversight of MLTSS programs to an inadequate level of staff. In states that had recently expanded, several respondents asked that the program be given time to work. Though some respondents are concerned that MLTSS will eventually mean reduced access to services, others are hopeful that disruptions in care experienced during the transition were temporary. A consumer advocate in Illinois summed up the hope pinned on MLTSS by saying, “Whenever [a program] impacts the lives of people, it’s got to work. We’ve got to be able to expand services ... and do more for people, not less.”

While the site visits highlighted important variations in state program design and features, the ways in which these variations have affected the ultimate program goals has not been rigorously examined. The following questions could be explored through future research:

- Does including medical services and LTSS in the benefit contribute to more effective care coordination and cost savings?
- Does contracting with fewer managed care plans allow states to achieve better quality and access (for example, as reflected in HEDIS and other performance measures), compared with states that contract with a large number of plans?
- Is there a minimum number of enrollees required for managed care plans to be financially viable? For plans that have relatively few enrollees, what mechanisms help them spread risk (for example, risk-sharing arrangements with the state)?

- Do variations in the time over which beneficiary and provider transition protections are in place contribute to better access or continuity of care?
- To what extent do provider payment protections increase costs to managed care plans and/or the state?
- In any given program, does the standardization of certain processes or contract requirements across plans contribute to better access to care or more timely payment to providers?
- How do differences in state staff capacity and oversight (number and skills, type and frequency of monitoring, etc.) affect MCO contract compliance and performance?

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APPENDIX A

METHODS

To learn about the variation in state approaches to MLTSS, MACPAC and Mathematica conducted site visits to five state capitols—Albany, New York; Tallahassee, Florida; Madison, Wisconsin; Springfield, Illinois; and Phoenix, Arizona—over a two- or three-day period in August and September 2014. MACPAC and Mathematica selected these five states because of the variation in their experience with managed care, their geographic location, and whether they included individuals with intellectual or developmental disabilities (I/DD) in their MLTSS programs. In selecting these states, we did not consider states that (1) would have had fewer than six months experience operating MLTSS at the time of the site visit, (2) had recently and significantly changed their Medicaid programs such that the fate of MLTSS was in question, and (3) were operating MLTSS programs solely in conjunction with financial alignment demonstrations for Medicare-Medicaid eligibles. States that had recently been the subject of similar studies were also not considered.

In total, we interviewed 124 staff from Medicaid and other state agencies, consumer advocacy organizations, ombudsmen, provider organizations, and managed care plans. We identified the relevant staff in each category by reviewing publicly available sources (for example, state Medicaid websites, managed care plan websites, state planning documents, and state plans and waivers), discussing potential respondents with current state staff, and soliciting ideas about relevant stakeholders from former administrators and researchers who were familiar with the state programs but not currently involved in their operations. Examples of these individuals include staff from the United Hospital Fund, the New York State Health Foundation, Georgetown University Center for Children and Families, the Center for Health Care Strategies, and the Agency for Community Living. The final array of respondents included 39 organizations representing a sample of different perspectives within and across states.

In the five site visit states, we conducted 51 one-hour interviews. Each interview included one to 13 individuals with similar affiliations (that is, from the same organization or from organizations that frequently work together, such as consumer advocacy groups). Most interviews were conducted in person using a semi-structured format; six interviews were conducted by phone because the organizations were not able to meet in person. Two individuals from MACPAC and two from Mathematica participated in each interview.

The semi-structured interview format allowed researchers to cover all intended topics while encouraging an ad hoc, fluid conversation with interviewees. Though the interviews for all respondents covered the same content, we tailored the protocol for each respondent group and each state. State respondents were asked about all topics of interest, and other respondents were asked about the facets of MLTSS programs that were relevant to their experience. When necessary, we added supplemental questions to capture each state's unique program details or policy environment. For example, states hosting financial alignment demonstrations were asked whether and to what degree the demonstration influenced their MLTSS programs.

After completing each visit, Mathematica prepared transcripts of each interview and organized the information according to major themes. We used Atlas.ti (a qualitative coding software) to apply basic codes that helped us draw out details on each of the eight topics covered during the interviews and the extent to which this information facilitated or challenged program operations or oversight. We used these findings as the basis for developing the state-specific and cross-state themes presented in the individual and combined reports, respectively.

APPENDIX B

SITE VISIT STATE FEATURES

Table B.1. Site visit state features (current as of September 2014, unless otherwise noted)

State and Program	Start date	Number of LTSS users	Geographic reach	Services covered by capitation	Mandatory or voluntary enrollment	Number of participating plans	Average number of LTSS users per plan
Arizona Arizona Long Term Care System (ALTCS)	1989	56,119 ^a	Statewide	Medical and LTSS	Mandatory	4	14,030
Florida Statewide Medicaid Managed Long Term Care Program	2013	84,074 ^b	Statewide	LTSS only	Mandatory	7	12,011
Illinois Integrated Care Program (ICP)	2011	36,079 ^c (Feb 2013)	29 counties	Medical and LTSS	Mandatory	10	3,608
New York Mandatory Managed Long Term Care (MLTC)	1998	118,615 ^d (Dec 2013)	58 counties	LTSS only	Mandatory	32	3,707
Medicaid Advantage Plus (MAP)	2006	4,826 ^d (Dec 2013)	24 counties	Medical and LTSS	Voluntary	8	603
Wisconsin Family Care Partnership	1996	2,907 ^e (July 2014)	14 counties	Medical and LTSS	Voluntary	3	969
Family Care	1999	37,790 ^e (July 2014)	57 counties	LTSS only	Voluntary	7	5,399

Source: State websites, unless otherwise noted.

Note: Illinois and Wisconsin do not publish data on ICP and Medicaid enrollment from the same period. LTSS users as a percent of all Medicaid enrollees represents an estimate based on the best available information.

^a Arizona Health Care Cost Containment System (AHCCCS). AHCCCS Population Highlights, October 2014. Available at: http://www.azahcccs.gov/reporting/Downloads/PopulationStatistics/2014/Oct/AHCCCS_Population_Highlights.pdf. Accessed October 6, 2014.

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^d New York Department of Health. Available at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2014/docs/en08_14.pdf.

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Suggested citation: Libersky, Jenna, Cara Stepanczuk, Rebecca Lester, Kristie Liao, and Debra Lipson. "Medicaid Managed Long Term Services and Supports: Themes from Site Visits to Five States." Working Paper 43. Washington, DC: Mathematica Policy Research, February 2016.

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